TEXAS ASSOCIATION HEALTH PLAN FREQUENTLY ASKED QUESTIONS

What is an Association Health Plan?

An Association Health Plan (AHP) is a type of group medical insurance for employers that allows smaller companies to access the health insurance savings associated with large group medical coverage. AHPs have been around for decades and Texas regulations allow for businesses to band together and sponsor an AHP based on a shared profession, line of business, or geographical region, in this case agriculture. AHPs aren't a new category of health insurance but an instrument by which small employers can access the existing (and less-expensive) large company health insurance market.

Is there a fee to join the association?

No, there is no fee to join the association.

What are the features of this AHP in Texas

- This is a self-funded program meaning the employer member groups fund the plan with their premiums
- All groups that join become part of one larger group
- The plan will be made up of agriculture employers
- The AHP will have a wide variety of plan designs
- There is a feature called Reference Based Pricing (RBP) and a PPO network options
- Members must make a 3-year commitment

What is a charter member and what are the benefits of being a charter member?

Charter members are those that sign on and commit to the inital enrollment date of January 1, 2025, however, groups currently on a 4th quarter renewal, can join on their current renewal date and rates will hold until January 1, 2026. Charter members can waive medical underwriting.

Is this plan medically underwritten?

Yes, for non-charter members. In order for us to provide a quote, we will need employees to complete a simple medical questionnaire. It asks about health history and current medications the employee and their family are taking. If you are a larger employer, instead of medical questionnaires we can accept claims information from your current carrier to develop the quotes. Medical underwriting is important because it protects the employers coming into the plan by allowing us to assess the risk of the population.

Why do I have to make a 3-year commitment?

Our Texas AHP is a new program and we must demonstrate the AHP has employers committed to the program for three years. We want to make sure this is a sustainable and viable program for the long term. Ensuring we have membership in the program and continuing to grow membership will allow us to keep premiums down and ensure long term viability.

What if I do not honor the 3-year commitment?

If an employer does not honor the 3-year commitment to stay in the program, they will be required to pay 10% of premiums contributed by the employer to the plan for the 2 months prior to termination, subject to a $3,000 minimum.

BENEFITS AND PLAN OFFERINGS

What types of plans are offered?

We have both PPO and Health Savings Account (HSA)-Qualified High Deductible Health Plans available with a wide array of deductible amounts. Deductibles on the PPO plans range from $500 to $8,550. Deductibles on the HSA-Qualified plans range from $1,650 to $7,000.

How are deductibles handled if we join later in the year and employees have contributed to their deductible amounts? If we go to this plan, will they start over?

No, we have a process in place to apply any deductible credits for employees that have met all or a portion of their deductible amounts. For example, if an employer renews their health insurance on January 1, all of their deductibles and out of pocket maximum amounts reset or start over. If that employer chose to move to the AHP on December 1, we would take any deductible amounts met by each employee and apply a credit for those amounts on the new plan. Then everything would reset on the following January.

The plan uses CVS Caremark for prescription drugs. Do you have to get prescriptions from CVS?

No, you can use any pharmacy in the network which includes most major pharmacies.

ABOUT REFERENCE BASED PRICING

What is Reference Based Pricing (RBP)?

In a traditional PPO the health plan provides a network of doctors and hospitals with which it has negotiated payments. Those payments are typically a reduction of the provider's billed charges and can still be very expensive. RBP pays a set amount above Medicare reimbursement which is much lower than the negotiated payments described above. Medicare reimbursement is a widely accepted payment methodology as it is deemed fair and reasonable.

Here is an example of how a major hip and knee replacement would be handled:

- A hospital's average charge is $55,000
- The traditional PPO plan may negotiate a payment of $27,000
- Medicare pays $14,000
- RBP will pay $17,000 which is fair and reasonable
- The lower RBP payment will reduce out of pocket costs for patients and keep premiums down

What doctors and hospitals can I see with RBP?

With RBP, you can see any physician or go to any facility you want. There are certain physicians, labs and pharmacies that are considered in-network. The only difference between in-network visits and out-of-network visits is how services are billed for/negotiated between the provider and insurance carrier. You should not be balance billed but if you are call the number on the back of your card.

Why would hospitals accept RBP?

ERISA law requires plan fiduciaries to pay only the "reasonable expenses of administering the plan with care, skill, prudence and diligence." Sometimes we may need to negotiate with the hospital but in the large majority of cases, they accept the RBP payment as payment in full. What the plan pays providers is considered fair and reasonable.

SEEING A DOCTOR

What happens if I go for care and I am denied at the door for a scheduled appointment or procedure?

This rarely happens but it could. If that does happen, we ask that the employee call the number on the back of their ID card. Our people will call the hospital, facility or physician provider directly to ensure the employee gets the services they need at that time. Prior to a scheduled visit, employees can call the number on the back of you ID card, so member services can contact the provider to ensure no issues upon arrival. Also keep in mind that hospitals and facilities cannot deny anyone for emergency care.

What if the provider asks me to pay for my procedure up front?

The only out of pocket expense you should pay at the time of service is a copay or deductible (if applicable). You would just call the number on your ID card to confirm amounts or if the facility and physician will not perform treatment without additional funds.

What happens if I get a bill after I have had services done?

Again, this rarely happens but it can. If that happens, you call the phone number on the ID card and provide the information to them, our team takes over from there. We will call the hospital, facility or physician directly. You will never be responsible for more than your regular out of pocket expenses including any deductible, coinsurance or copays. We will be in regular contact with you through the process until the issue is resolved. If you get any other bills, you should send them to us as well.

How often does balance billing happen with RBP?

Our Third-Party Administrator (TPA) has been administering RBP for over 12 years and according to their experience, balance billing - when a patient receives an additional bill - happens about 1% of the time.

What if I need help finding a doctor or hospital?

You will have a link to a provider directory to find any in network doctors. But whether you are looking for a doctor, hospital or any other type of provider, you can call our advocates and they will help you find high quality, low-cost providers.