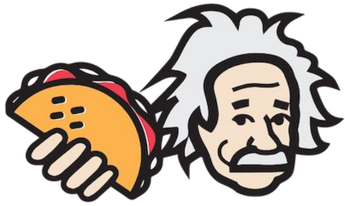

FOOD FOR THOUGHT

Health Insurance & Medicaid 101

May 19, 2026

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Without Coverage, One Bad Day Can Cost $200,000

Coverage is financial protection — and Americans overwhelmingly value the coverage they have

What is health coverage? Financial protection against unexpected medical bills — a predictable monthly premium so that hospital stay, cancer diagnosis, or accident doesn't wipe out a family budget.

82%
are satisfied with their insurance

81%
call their plan "excellent" or "good"

88%
of employers say health coverage is critical to hiring

WITHOUT COVERAGE, HERE'S WHAT A PATIENT COULD FACE

$30K
3-day hospital stay

$77K
NICU Admission

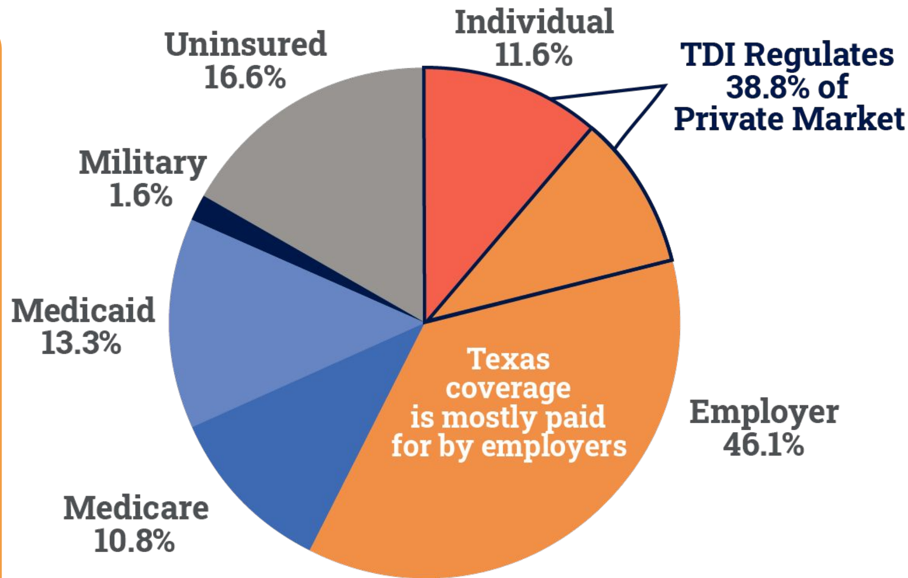
$135K
Stage 4 breast cancer

$200K
Heart bypass

Sources: NBC News/SurveyMonkey Poll (December 2025); KFF Survey on Consumer Experiences with Health Insurance; KFF Employer Health Benefits Survey 2025; CMS; American Hospital Association.

Texas Health Plans Cover More than 25 million Texans

Texas coverage is mostly paid for by employers — government and individual markets fill in the rest



15M EMPLOYER COVERAGE
Largest single source - about 4 of 5 employees are in ERISA self-funded or level-funded plans

4M INDIVIDUAL MARKET
Quadrupled since 2020 (1M → 4M)

7.6M GOVERNMENT COVERAGE
Medicaid (4M) + Medicare (3.6M) = 25% of Texans

5M UNINSURED
Lack of job-based coverage cited as #1 reason

Private market = 58% of Texans. Employers purchase coverage for about 80% Texans covered in the private market. TDI regulates 39% of the private market - the fully insured share. Remainder of market under ERISA.

Source: U.S. Census Bureau (2024); Texas Department of Insurance; KFF Employer Health Benefits Survey 2025

Not All Health Coverage is Health Insurance

Texas employers cover workers through three different structures — only one is regulated by Texas as insurance.

	Fully Insured Traditional insurance	Level-Funded Hybrid / ERISA	Self-Funded ERISA
WHO TAKES THE RISK?	The insurer collects premiums and pays claims.	The employer pays claims, with stop-loss insurance for catastrophic costs.	The employer fully assumes the risk of paying claims.
WHO REGULATES IT?	**Texas (TDI)** All state mandates apply.	**Federal (ERISA)** No state mandates.	**Federal (ERISA)** No state mandates.
WHO USES IT & WHY?	**Individuals and small/large businesses** For predictable premiums and full state consumer protections.	**Small and mid-size employers** Flexibility with cost predictability, off-ramp from fully insured.	**Very large employers** Flexibility to design benefits and innovate without state mandates.

THE BOTTOM LINE FOR THE LEGISLATURE

Texas can only regulate the fully insured market — about 20% of employer coverage in Texas. State mandates cannot apply to the 80% of Texans with employer coverage in level-funded or self-funded ERISA plans.

Source: Employee Retirement Income Security Act of 1974 (29 U.S.C. §1144); TAHP 2026 Texas Health Insurance Market analysis.

Most Texans with Employer Coverage Have Moved Away from State Mandates

Employers choose ERISA self-funded plans for flexibility and affordability - and that's where the majority of the private market now lives

TDI REGULATED · STATE MANDATES APPLY

~7M Texans

Individual market and small/midsize group fully insured plans. State mandates apply.

ERISA FLEXIBILITY · FEDERALLY REGULATED

~12M Texans

About 4 of 5 employer-covered Texans. Self-funded and level-funded plans that give employers the flexibility to design affordable coverage for their workers. State mandates do not apply.

Inside the TDI-regulated ~7M: ~4M individual market · ~670K small group (2-50 employees) · ~2.6 midsize and large fully insured employer coverage.

Why this matters: When the Legislature debates a mandate or a regulation, it's setting the rules for 7M Texans - not for the 12M whose employers have chosen ERISA. Mandates that drive up fully insured premiums push more employers to leave for self-funded plans, shrinking the regulated market further.

Source: NAIC; KFF, TAHP Analysis

The ACA Fundamentally Changed the Health Insurance Market

The 2010 Affordable Care Act did two things: set baseline patient protections across most of the market, and built a new individual market for Texans without employer coverage.

PATIENT PROTECTIONS APPLIED TO MOST OF THE MARKET

These ACA rules apply to fully insured plans, ERISA self-funded plans, and the individual market.

- No denial or higher rates for pre-existing conditions
- No annual or lifetime caps on coverage
- Preventive care with no cost-sharing
- Essential Health Benefits (10 categories)
- Dependents covered to age 26
- Medical Loss Ratio (MLR) — rebates if MLR < 80–85%

A NEW INDIVIDUAL MARKET FOR TEXANS WITHOUT EMPLOYER COVERAGE

Before 2014, Texans with health conditions and no employer plan had limited options. The ACA changed that.

Guaranteed issue
Insurers must offer coverage to any applicant regardless of health history.

Cost-sharing reductions
Lower deductibles and copays for enrollees earning 100–250% of the poverty line.

Premium tax credits (subsidies)
Income-based federal subsidies that cap a f amily's premium as a share of income.

The Marketplace (Healthcare.gov)
A single shopping platform where Texans compare plans, qualify for subsidies, and enroll.

TEXAS INDIVIDUAL MARKET
<700K → 4M
covered Texans

Before the ACA, fewer than 700,000 Texans had individual-market coverage. Today, ~4 million Texans buy coverage through the individual market — and 97% receive federal subsidies to lower the monthly premium.

Source: Affordable Care Act (42 U.S.C. §18001 et seq.); CMS Marketplace Open Enrollment data (2025); KFF Texas individual market analysis.

Health Plan Types and How Texas Regulates Networks

PPO
Preferred Provider Organization

Most purchased. Higher premiums. Out-of-network benefits at higher cost. No referrals. Large & small group market.

HMO
Health Maintenance Organization

No out-of-network benefits (except ER). Requires PCP referrals. Primarily individual market.

EPO
Exclusive Provider Organization

No out-of-network benefits (except ER). No PCP referrals. Primarily individual market.

TDI HAS ADOPTED THE STRONGEST NETWORK ADEQUACY REQUIREMENTS IN THE U.S.

Network Adequacy standards
Texas adopted strict federal standards for drive time and distance, but goes beyond in requiring insurers to contract with multiple providers of every type.

Waivers & public hearings
Plans that can't meet standards must request a TDI waiver with an access plan — TDI holds public hearings before approval.

Surprise billing protections
Bans out-of-network bills in emergencies or when patients couldn't choose their physician (e.g., anesthesiologists). Dispute resolution sorts out payment between providers and plans.

Source: Texas Insurance Code; Texas Department of Insurance network adequacy rules; SB 1264 (86R); federal No Surprises Act; TAHP analysis.

Cost-sharing: How Plans Split Costs with Patients

THE FUNDAMENTAL TRADE-OFF

Patients pay monthly premiums (the monthly cost of coverage) and out-of-pocket costs sharing at the point of care. Higher cost-sharing = lower premium. Employer contributions or individual market tax credits can offset the premium cost.

WHAT COST-SHARING INCLUDES (BEYOND THE PREMIUM)

Deductible
What you pay before the plan starts paying. Resets each year.

Copay
A flat dollar amount per visit or prescription (e.g., $30 per doctor visit).

Coinsurance
A percentage you pay (e.g., 20% of the bill); the plan pays the rest.

Out-of-pocket max
The annual cap on what you pay. After this, the plan covers 100%.

INDIVIDUAL MARKET ONLY — THE ACA'S METAL LEVELS

Bronze
~60%

Lowest premium, highest cost-sharing

Silver
~70%

Subsidy benchmark.

Gold
~80%

Higher premium, lower cost-sharing

Platinum
~90%

Highest premium, lowest cost-sharing

Source: 42 CFR §156.140 (ACA actuarial value tiers); CMS plan design rules; TAHP analysis.

Prior Authorization in Texas: Extensive Patient Protections

WHAT IS A PRIOR AUTHORIZATION?

Prior authorizations (PAs) are a type of utilization review that helps patients receive safe and appropriate care, improve health outcomes, and keep care affordable. Emergency care never involves PAs.

Goldcarding

Physicians with a 90% PA approval rate are exempted from future PAs for that service. Unique to Texas.

Timeliness

3 days standard · 24 hours urgent · 1 hour inpatient — among the fastest in the country.

Prohibited PAs

No PA allowed for emergency care or stage IV cancer drugs.

Evidence-based criteria

All PA criteria must be based on evidence and clinical standards developed and adopted by the medical community.

Transparency

PA lists, criteria, and approval/denial statistics must be posted on plan websites and filed with TDI.

Appeals

Right to appeal any PA denial to an independent physician, plus the right to file complaints with TDI.

Source: Texas Insurance Code Chapters 1217, 1369, 4201; HB 3459 87R & HB 3912 89R (Goldcarding).

Existing Transparency Requirements

Already in state & federal law

Hospital & facility price transparency
Must post machine-readable files of charges, negotiated rates, and cash prices, plus consumer-friendly pricing for common shoppable services. Physicians are exempt.

Health plan price transparency
In-network negotiated rates and out-of-network allowed amounts published in machine-readable files.

Health plan patient cost calculators
Real-time tools showing patient expected out-of-pocket costs, negotiated rates, and coverage details before care.

Formulary transparency
Public access to drug coverage details including whether a drug is covered and its formulary tier placement.

All-payer claims database (APCD)
All health plan claims (except ERISA) submitted to the state's research database.

Aggregate rebate reporting
State law requires PBMs to report total rebates and the amount passed through to plan sponsors.

Real-time API access
Patients and providers get real-time electronic access to coverage, PA status, claims data, and cost-sharing through standardized APIs.

Detailed rebate reporting (Jan 2028)
PBMs must provide employers drug-level and plan-level detail on rebates, fees, spread pricing, and other compensation — including retained rebate.

Prior authorization criteria
Transparent, physician determined, medical necessity and PA criteria insurers use to evaluate coverage.

Provider directory transparency
Publicly accessible, monthly-updated directories showing which providers are in-network and accepting new patients.

Source: CMS Transparency in Coverage final rule; Consolidated Appropriations Act '21 & '26; Texas Insurance Code; TAHP analysis.

Texas Medicaid: Who it Covers and How it Works

Safety-net health insurance for Texans who need it most — children, mothers, grandparents, and Texans with disabilities. 97% of Texas Medicaid is delivered through managed care.

TEXANS ON MEDICAID	OF TEXAS BIRTHS	OF TEXAS CHILDREN	OF NURSING HOME RESIDENTS
~4M	51%	47%	58%
13% of all Texans	covered by Medicaid	covered by Medicaid	covered by Medicaid

HOW TEXAS DELIVERS IT — MANAGED CARE

HHSC pays MCOs a monthly premium

Called a PMPM (per member per month). HHSC actuaries set the rate each year, certified by an independent actuary and CMS.

MCOs take on full financial risk

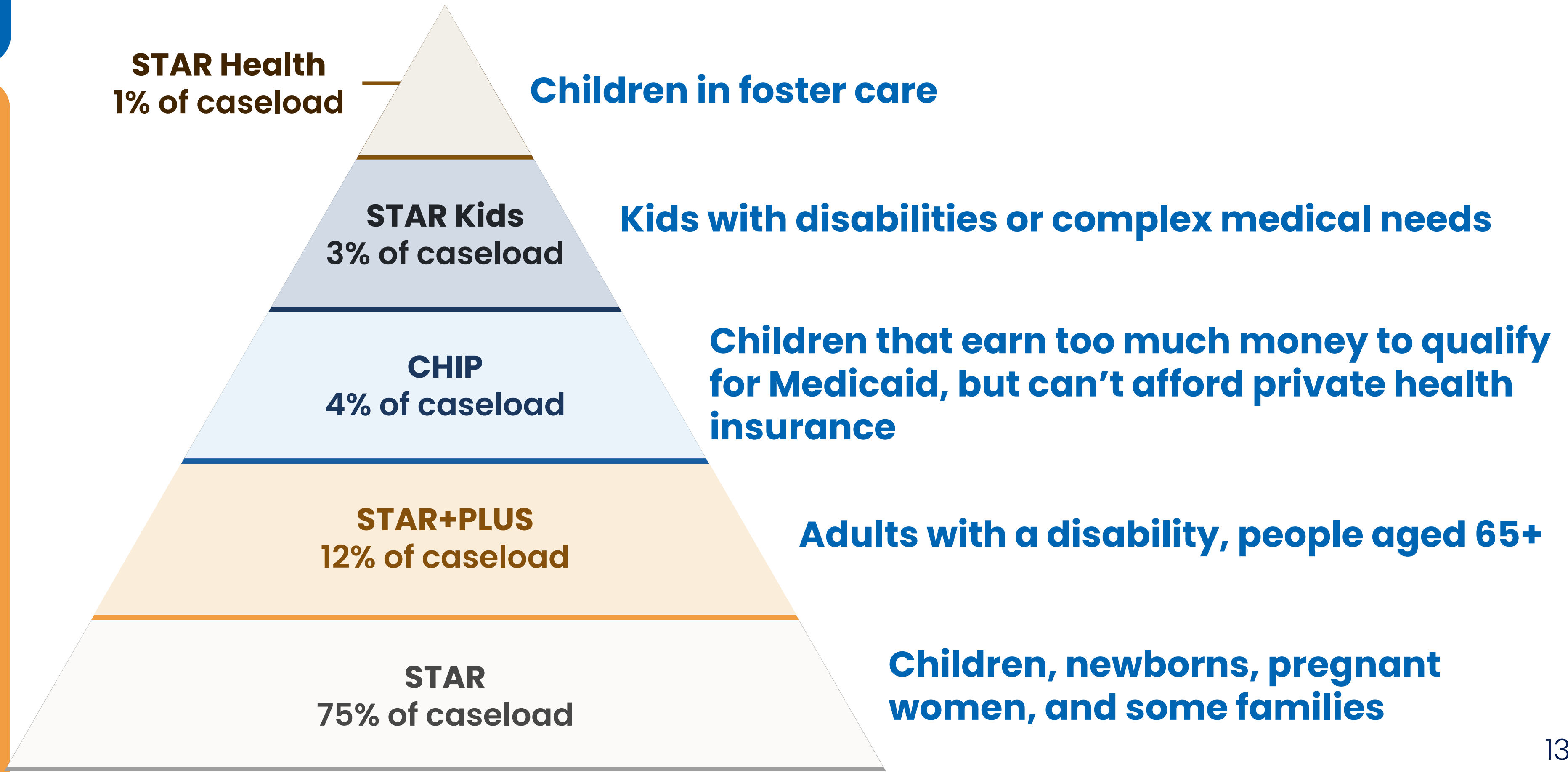
MCOs are responsible for all costs exceeding the premium, including fraud, waste, and abuse — giving the state budget certainty.

Texas caps admin & profit

Health plans must share savings back to the state through the experience rebate when they come in under budget.

Source: TAHP analysis; Texas HHSC.

Medicaid is Vital Safety Net Coverage in Texas



Medicare 101: The Basics

Federal coverage for Americans 65+ and people with qualifying disabilities

TEXANS ON MEDICARE	IN MEDICARE ADVANTAGE	AVG MA PLANS PER TEXAN
4.85M	**54%**	**~35**
3rd-largest state population	matches national rate	plans available in your county

PART A HOSPITAL INSURANCE

Covers inpatient hospital stays, skilled nursing, hospice, and some home health. Funded by payroll taxes — most beneficiaries pay no premium.

PART B MEDICAL INSURANCE

Covers doctor visits, outpatient care, preventive services, and durable medical equipment. Beneficiaries pay a monthly premium plus deductibles and coinsurance.

PART C MEDICARE ADVANTAGE

A private-plan alternative to Original Medicare. Plans must cover everything Parts A and B do, usually include Part D drug coverage, and often add dental, vision, and hearing benefits.

PART D PRESCRIPTION DRUG COVERAGE

Covers outpatient prescription drugs. Sold by private insurers, either as a standalone plan or bundled into a Medicare Advantage plan.

Source: CMS Medicare Monthly Enrollment data (2024–2026); KFF Medicare Advantage Spotlight (2026); Texas HHS.

Medicare: Two Paths for Every Texan

When a Texan signs up for Medicare, they pick one of two paths. 54% choose Medicare Advantage; 46% stay on original Medicare.

PATH 1

Original Medicare

Parts A + B (and usually D)

Run directly by the federal government. Broad provider access — virtually any U.S. doctor or hospital that accepts Medicare. No annual out-of-pocket cap.

42% PAIR WITH MEDIGAP

Covers Medicare's 20% coinsurance gap. One 6-month guaranteed-issue window at age 65. 2026 10-15% premium increase.

PATH 2

Medicare Advantage

Part C plan from a private insurer

Private insurance that bundles A, B, and usually D into one plan. Often adds dental, vision, and hearing. Network-based with an annual out-of-pocket cap. 54% of Texas Medicare beneficiaries choose this path.

FEDERALLY REGULATED

Medicare Advantage plans are overseen by CMS — Texas cannot mandate benefits, set rates, or impose state-level requirements on these plans.

A CRITICAL GAP: MEDICARE DOESN'T COVER MOST LONG-TERM CARE

Neither path covers nursing home care, assisted living, or most home-based services — only limited post-hospital skilled nursing. ~712,000 Texans are "dual eligibles" — qualifying for both Medicare for acute care and Medicaid for long-term care.

Source: 42 U.S.C.Medicare & Medigap; KFF Medicare Advantage Spotlight (2026); MACPAC Dual-Eligibles Data Book (Dec 2025).

How Prescription Drug Benefits Work: PBMs

WHAT A PBM IS

A pharmacy benefit manager (PBM) is a third-party administrator that manages prescription drug coverage for health plans and employers. With tens of millions of patients across many plans, PBMs negotiate prices no single plan could — the only player in the drug supply chain whose job is to lower drug costs.

Negotiate with drugmakers

Secure rebates from manufacturers, then pass savings to plans.

Build the formulary

The list of covered drugs, organized by clinical effectiveness and cost — often in tiers.

Manage pharmacy networks

Contract with retail, mail-order, and specialty pharmacies for in-network coverage.

Process pharmacy claims

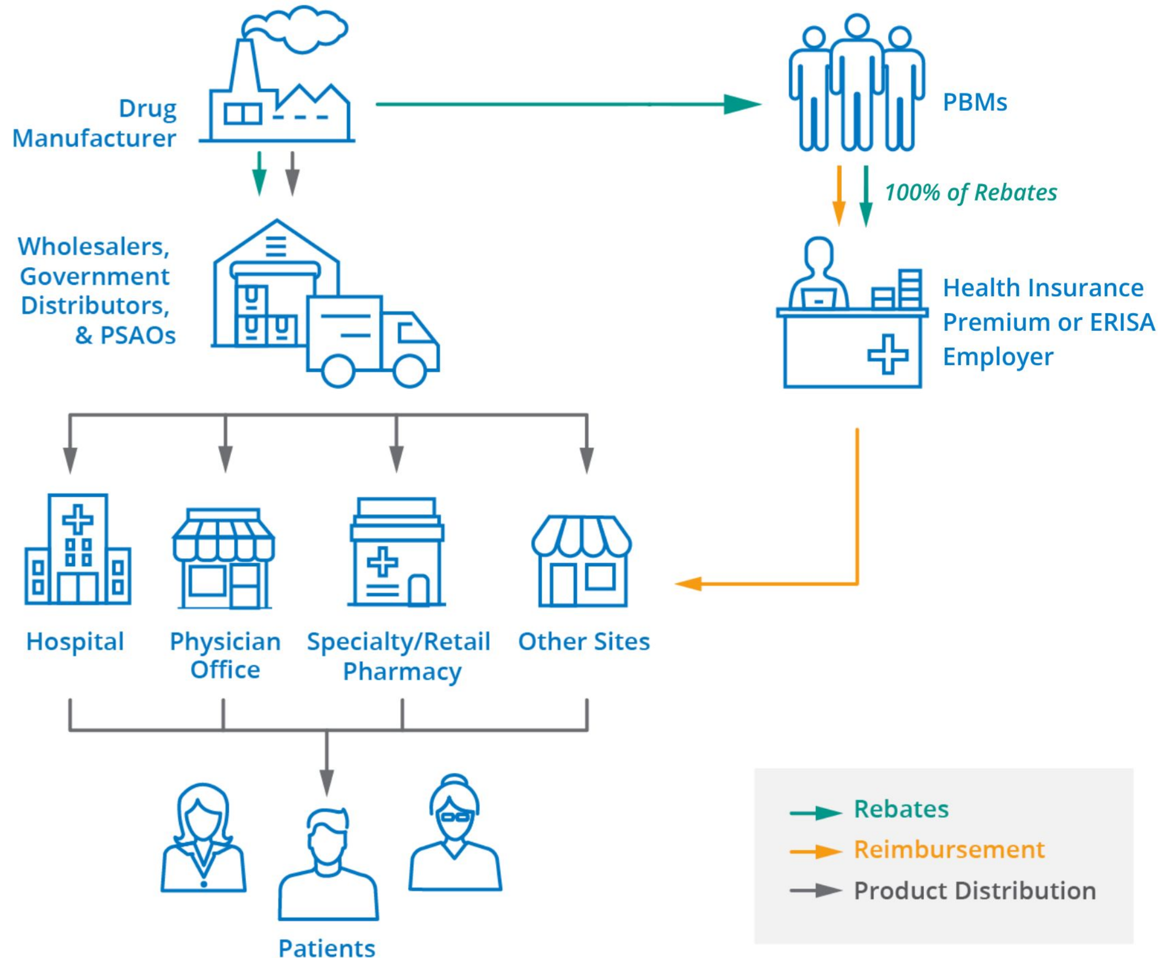
Adjudicate every prescription at the point of sale, applying coverage rules and patient cost-sharing in real time.

Overview of the Drug Supply Chain

Health plans and PBMs do not set drug prices -They negotiate rebates to lower prices.

Congress recently passed substantial PBM reforms: 100% Rebate Transparency & 100% Rebate Pass-Through

What's missing? State and federal laws reforms should focus on the whole supply chain - not just pbms - and focus on savings or costs on consumers.



Existing Rebate Requirements

Why rebates exist, and the state and federal rules governing them

WHY REBATES EXIST AT ALL

Legal action in the 1990s by independent pharmacists limited bulk price discounting from drug makers leaving rebates as the dominant mechanism to get lower prices from drug companies. Medicaid, Medicare, and commercial plans all use rebates to create savings on brand name drugs.

100% Rebate Pass-Through (Jan 2028)

PBMs must pass 100% of rebates to ERISA self-funded employers and fully insured health plans.

Complete Rebate Transparency (federal)

PBMs must provide aggregate rebate and pricing detail to all group plans, with drug-level reporting for large employers.

Rebates Reduce Premiums

Rebates passed through from PBMs are required to be factored into premiums under the ACA's medical loss ratio rule and rate setting laws.

Aggregate Rebate Data (TX State Law)

Texas law requires PBMs to report the amount of rebates retained or passed through to plan sponsors.

Source: Consolidated Appropriations Act 2021; ACA medical loss ratio rule (42 U.S.C. §300gg-18); Texas Insurance Code; In re Brand Name Prescription Drugs Antitrust Litigation (1996); TAHP analysis.

TAHP
The Texas Association of Heal

Existing PBM and Pharmacy Benefit Requirements

State and federal rules already in place

Gag Clauses Banned

PBMs may not prohibit pharmacists from sharing lower-cost options.

SB 1076 85R · HB 711 88R · SB 493 89R

PBM Clawback Ban

No retroactive reduction of pharmacy reimbursement after claim adjudication. *HB 1763 87R*

Claims Adjudication Fees Banned

PBMs may not charge pharmacists for claims adjudication. *SB 94 84R*

Formulary Freeze

No mid-year formulary changes, even for biosimilars and lower-cost options. *HB 1405 82R*

Affiliated Steering Banned

Limits on steering to PBM's affiliated pharmacy, even with lower patient costs. *HB 1919 87R*

Contract Change & Audit Limits

Limits on PBM audits and contract changes without pharmacy approval. *SB 1236 89R*

Copay Coupon Mandate

Drugmaker coupons must count toward deductibles even if patient didn't pay.

HB 999 88R

Prior Authorization Limits

No PA at 90%+ approval rate. Max 1 PA/year for autoimmune drugs. Standard form required.

HB 3812 89R · HB 755 88R · SB 644 83R

Step Therapy Limits

Extensive exceptions to step-therapy use by plans and PBMs.

SB 680 86R

S

65¢ of Every Premium Dollar Goes to Hospitals and Drugs

Federal law requires plans to spend at least 80-85% of premiums on medical care.

HOSPITALS + DRUGS

65¢

Inpatient, outpatient, ER + Rx — the biggest drivers of premium increases.

DOCTORS + OTHER CARE

19¢

Physician visits and outpatient services

ADMIN, TAXES, PROFIT

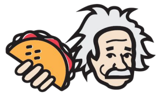
16¢

Including just 2.4¢ profit

FULL BREAKDOWN

- Drugs 24.2¢
- Inpatient 17.6¢
- Outpatient 19.9¢
- ER 3.2¢
- Doctor visits 11.6¢
- Other outpatient 7.2¢
- Admin 7.3¢
- Taxes 3.4¢
- Business 3.3¢
- Profit 2.4¢

Source: AHIP, "Where Does Your Health Care Dollar Go?"

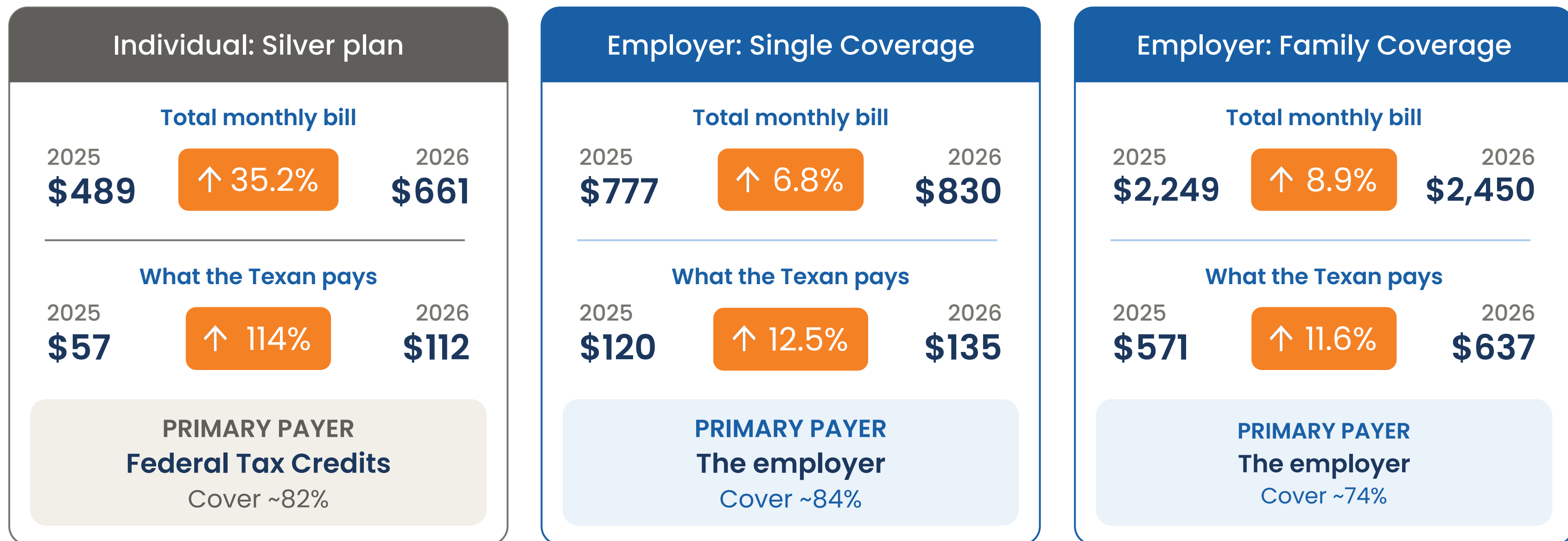


FOOD FOR THOUGHT

TAHP

Texans Face the Biggest Premium Increase in Years

2026 monthly premium estimates — what Texans pay and who covers the rest



Every Texan is paying more in 2026. Individual market sees "extraordinary" 35% spike — driven largely by tax credits expiring. Employer coverage rises 6-9%, the steepest increase in over a decade.

Sources: TDI 2026 Rate Filings; KFF 2025 Employer Survey; Mercer 2026 Forecast; Texas 2036.

It's Not More Care – it's More Expensive Care

Nearly 75% of premium increases are tied to rising prices, not more visits to the doctor

SHARE OF PREMIUM INCREASE

75%

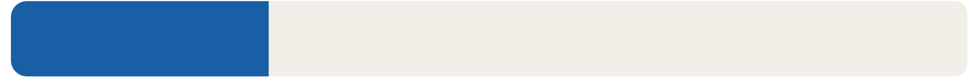
due to prices

Texans aren't going to the doctor more — every visit just costs more.

PER-PERSON SPENDING GROWTH, 2018-2022

Prices +13.9%

Utilization (how often Texans get care) +4.4%



Prices drove 75% of the increase in per-person health spending from 2018-2022. Utilization barely moved.

Sources: Health Care Cost Institute.

FOOD FOR THOUGHT

TAHP

Three Forces Driving Up Costs — and One Lever to Fix Them

Texas is the 5th most expensive state for health care in the nation. Three drivers explain why — and the Legislature can address all three.

PRICE INFLATION

75%

of premium increases are prices

Hospital prices are biggest driver — 40% of national spending growth, with hospital service prices up 281% since 2000. Texas consolidation pushes prices 15–30%.

FRAUD, WASTE, & ABUSE

10%

of all health care spending

New schemes like AI-driven upcoding and other abusive billing continue to inflate bills but TDI authority is limited in addressing fraud, waste, and abuse.

MANDATES & OVERREGULATION

3rd

most mandate-heavy state

Texas's mandates outpace other states and exceed federal requirements — forcing employers and families into expensive, one-size-fits-all plans.

THE LEGISLATURE

Addressing

Texas-specific drivers

Repeal harmful mandates, prevent new ones, require real transparency, and protect employer flexibility.

Source: Forbes Advisor 2024 state health care cost rankings; KFF analysis of CMS NHEA (2026); Texas 2036; TDI; PwC Behind the Numbers 2026.