



Third Party Health Insurance Exchange

**As Required by the
2014-15 General Appropriations Act, S.B. 1
83rd Legislature, Regular Session, 2013
(Article II, Department of State Health Services, Rider 75)**



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Executive Summary

This report was required by the [2014-15 General Appropriations Act S.B. 1, 83rd Legislature, Regular Session, 2013](#) (Article II, Department of State Health Services, Rider 75). Rider 75 requires the agency to submit a report to the Governor and the Legislative Budget Board (LBB) to measure the caseload and fiscal impact of the federal health insurance marketplace on certain safety net programs and services administered by the Department of State Health Services (DSHS). The Rider requires DSHS to report on activities required by the enactment of [S.B. 1057, 83rd Legislature, Regular Session, 2013](#):

- The number of attestation forms distributed to clients accessing DSHS services,
- A description of consumer awareness efforts related to the Federal Health Insurance Marketplace (the Marketplace), and
- An analysis of these policies with recommendations for maximizing alternative sources of coverage for clients served through certain DSHS safety net programs.

DSHS monitored the fiscal and caseload impact of the Marketplace in fiscal year 2014 for 18 safety net programs identified in Rider 75. For those DSHS programs projected to be affected by the Marketplace, DSHS has been unable to attribute any caseload or fiscal impacts directly to the Marketplace primarily because DSHS is unable to collect data on the costs and services avoided from individuals receiving services through private health insurance provider networks. DSHS received reductions in 18 budget strategies in S.B. 1 that were a result of the anticipated impact of the Marketplace. In addition, 12 out of the 18 safety net programs identified in Rider 75 were appropriated additional general revenue funds for exceptional item requests or other specified appropriations.

Key factors about enrollment statistics, health insurance coverage policies, and the impact of the availability of private health insurance on individuals served through DSHS programs contribute to the ongoing fiscal and caseload assessment to determine the actual effect of the Marketplace on the agency and its services. In addition, current DSHS programs and their provider networks face certain challenges to effectively maximize third party payer systems due to several issues, including:

- The inability for certain providers to be enrolled providers with private health insurance plans;
- The challenges with quantifying the impact of the Marketplace when newly insured clients seek services from non-DSHS providers; and
- Eligible clients being unable to access certain benefits or services through a health plan due to cost, certain limitations or exhaustion of benefits, enrollment period limitations, or other coverage issues.

Based on the analysis of the policies set forth in S.B. 1057, there are certain options that could be considered in order for DSHS to maximize alternative sources of coverage for clients served through certain DSHS safety net programs:

- Continuing to provide consumer awareness about the Marketplace;
- Building opportunities for DSHS service providers to be credentialed with private insurance health plans so that providers can effectively bill third party payers; and

- Identifying alternative payment mechanisms, such as health insurance premium payments, to maximize existing General Revenue funding for individuals who may be eligible for private health insurance.

Introduction

The [2014-15 General Appropriation Act, S.B. 1, 83rd Legislature, Regular Session, 2013](#) (Article II, DSHS, Rider 75) requires that out of funds appropriated to DSHS in budget strategies A.2.1, Immunize Children and Adults in Texas; A.2.2, HIV/STD Prevention; A.2.3, Infectious Disease Prevention, Epidemiology and Surveillance; A.3.3, Kidney Health Care; A.3.4, Children with Special Health Care Needs; A.3.5, Epilepsy and Hemophilia Services; A.4.1, Laboratory Services; B.1.2, Women and Children's Health Services; B.1.4, Community Primary Care Services; B.2.1, Mental Health Services for Adults; B.2.2, Mental Health Services for Children; B.2.3, Community Mental Health Crisis Services; B.2.4, NorthSTAR Behavioral Health Waiver; B.3.3, Indigent Health Care Reimbursement (UTMB); C.1.1, Texas Center for Infectious Disease; C.1.2, South Texas Health Care System; C.1.3, Mental Health State Hospitals; and C.2.1, Mental Health Community Hospitals, the Department of State Health Services shall submit a report containing the following information:

- The fiscal impact of the third party health insurance exchange on the above strategies;
- The caseload impact of the third party health insurance exchange on the above strategies; and
- Contingent on the enactment of Senate Bill 1057, or similar legislation by the Eighty-third Legislature, Regular Session, 2013, DSHS shall report on:
 - The number of attestation forms distributed by each above strategy,
 - A description of third party health insurance exchange consumer awareness efforts that were implemented by each above strategy, and
 - An overall analysis of these policies with recommendations for maximizing alternative sources of coverage for clients served in the above strategies.

DSHS shall submit the report to the Governor's Office and the Legislative Budget Board (LBB).

Background

DSHS has approximately 20 safety net programs that cover clients ranging from 21 percent of the federal poverty level (FPL) up to 200 percent FPL. The clinical services that are provided by DSHS through state and/or federal funding streams also vary within these 20 programs depending on the population or medical condition served through these programs. Traditionally, DSHS has provided clinical and additional support services to those clients who have

- Historically not been able to access health insurance due to pre-existing conditions (e.g. persons living with HIV and persons with a serious mental illness);
- Limits in medical benefits (e.g. Medicaid benefit limits such as three prescription drug limits for Supplemental Security Income (SSI) clients with diagnosis of HIV and 30 day length of stay limits for an inpatient psychiatric stay); and
- No access to other services that limit overall medical costs (e.g. home health, respite care, short term residential services, employment assistance).

As a result of federal requirements, DSHS expected select consumers served through DSHS safety net programs to obtain private health insurance coverage. In fiscal year 2012, DSHS conducted an analysis of the potential fiscal and caseload impact on DSHS safety net programs that serve individuals above 100 percent of the FPL. This analysis demonstrated that although a portion of DSHS consumers would be eligible to enroll in private health insurance coverage

through the Federal Health Insurance Marketplace (the Marketplace), these individuals may still access DSHS safety net programs for those services where there may be limits on the amount, duration and scope of benefits available through the health insurance plans offered through the Marketplace.

The LBB also made recommendations in the 2013 *Texas Government Efficiency and Effectiveness Report* (GEER) to reduce DSHS appropriations to realize the net savings and revenue gains in fiscal years 2014 and 2015 for DSHS' budget strategies projected to have reduced costs due the potential enrollment of clients into medical benefit coverage offered through the Marketplace.

Impact on DSHS Safety Net Program Appropriation and Policies

S.B. 1, 83rd Legislature, Regular Session, 2013, reduced funding for 18 DSHS programs by \$17,336,805 for the 2014-15 biennium to reflect the anticipated fiscal impact of the Marketplace portion of the Federal Patient Protection and Affordable Care Act (ACA) of 2010. S.B. 1 also assumed that for DSHS facilities, such as the state mental health hospitals and the state laboratory, additional revenue would be generated as a result of more newly insured individuals accessing benefits through their health plan. It was assumed that this revenue could offset reductions made to the current appropriation.

S.B. 1 assumed that of those individuals who were eligible to enroll in private health insurance through the Marketplace, 50 percent would enroll in fiscal year 2014, but the fiscal impact would only be realized in the last three months of the fiscal year. S.B. 1 also assumed 50 percent of those eligible to enroll would do so in fiscal year 2015, and the fiscal impact would be realized in all 12 months of the fiscal year. Table 1 in Appendix A lists the DSHS budget strategies that received a reduction in fiscal years 2014 and 2015 due to the anticipated impact of individuals enrolling in health care coverage through the Marketplace.

In addition, new requirements were established through S.B. 1057, 83rd Legislature, Regular Session, 2013, that required certain DSHS safety net programs to collect an attestation statement from individuals indicating whether they have access to private health insurance coverage for the services, benefits, or assistance they are seeking through DSHS programs. In addition, it also directed DSHS to not provide services to individuals who have access to those services, benefits or assistance through a private health insurance plan unless the individual provides the information and authorization necessary to bill third party payers.

Key Factors Related to the Impact of the Federal Health Insurance Marketplace

Prior to certain federal rules and Marketplace policies being finalized, DSHS used several assumptions about the Marketplace and the enrollment process to analyze the potential impact to select DSHS programs. DSHS assumed the following:

- Continuous enrollment would be offered for Marketplace plans,
- Health care coverage would begin immediately upon enrollment in a health plan offered through the Marketplace,
- Qualifying individuals from 133 percent to 400 percent of the FPL would be income eligible for federal subsidies for purchasing private insurance,

- Benefits and service differences would exist in private insurance coverage compared to current benefits offered in DSHS safety net programs,
- There would be differences in the scope of services and benefits provided by private insurance companies compared to DSHS safety net programs, and
- Health plans offered through the Marketplace would be offered statewide.

Once federal rules were finalized and the Marketplace open enrollment period began, the assumptions originally used to guide the Marketplace analysis were modified to reflect how federal policies were established and Marketplace enrollment processes were implemented. The revised assumptions are outlined below.

- The Marketplace would only be open during specific enrollment periods unless an individual had a qualifying life event.
- The date an individual receives coverage through their health plan is dependent upon the day of the month the individual enrolled in the health plan.
- For states that did not expand Medicaid, individuals between 100 percent and 400 percent FPL would be income eligible for federal subsidies for purchasing private insurance.
- Qualified Health Plans within the Marketplace vary in the amount, duration and scope of certain services, including covered clinical services. Certain services, such as dental, vision and hearing may vary by level of plan.
- Qualified Health Plans vary by geographic location within the state.

The revised assumptions have guided the DSHS analysis of the caseload and fiscal impact and of related policies for this report. DSHS has identified some factors related to caseload and fiscal impacts that have presented challenges in being able to fully assess the impact of the Marketplace.

Caseload

DSHS assumed that there would be minimal impact to the number of individuals served through its programs because some consumers with private health insurance may access their clinical services through other sources (e.g. private physician), but due to certain limitations in coverage through their health plan and medical necessity, those individuals may require additional clinical services from DSHS programs. DSHS also assumed that there would be minimal impact to program caseloads because for many DSHS programs, the need for certain services often exceeds the current capacity. For programs, such as Children with Special Health Care Needs (CSHCN) and Adult and Child Mental Health services, when the need exceeds current capacity, these programs have historically had to develop client waiting lists for services. In fiscal year 2014, DSHS received additional appropriations to reduce and/or eliminate existing lists for these programs.

DSHS has also had challenges with identifying any changes to caseload impacts because programs are not currently able to report on individuals who are no longer seeking services through DSHS programs. DSHS assumed that as clients became covered under private health insurance, there would be clients that would obtain services through private provider networks, but currently there are no structures in place to track clients' movements as to where they access their health care services. In addition, DSHS cannot solely attribute the Marketplace to these

shifts as individuals may have also received coverage through employment, or other life events may have qualified an individual for other types of public benefits.

Fiscal Impact

DSHS assumed that current levels of funding would be maintained and early analyses did not include program growth due to inflation or population growth. DSHS also assumed that no new programs would be developed that may carry a potential impact related to the Marketplace. DSHS received an additional \$176 million in appropriated general revenue (GR) in fiscal year 2014 for 12 of the 18 budget strategies referenced in Rider 75. The total net (positive) change for the 18 budget strategies referenced in this report was over \$165 million, which accounts for both the Marketplace-related reductions from S.B. 1 and the additional appropriated funds. These funds were appropriated to create new programs such as Expanded Primary Health Care and enhancing of mental health services. The funding for these programs was applied to budget strategies that had received a reduction due to the Marketplace. Therefore, based solely on the change in expenditures and numbers served from fiscal year 2013 to fiscal year 2014, DSHS has not been able to determine the impact of clients enrolling in private health insurance coverage through the Marketplace on DSHS safety net programs.

Secondly, not all DSHS safety net programs receive third party revenue from private insurance companies, nor do all programs report on program income, which is generally defined as revenue generated from activities or services provided under a DSHS contract. This may be due to:

- Statutory requirements that state the program can only provide services to individuals with no other payer source;
- Traditional providers (i.e. local health departments) for certain direct public health services, such as immunizations and tuberculosis testing and treatment, have had challenges with enrolling and becoming credentialed with private health insurance plans; and
- Individuals receiving certain direct public health services, such as the testing and treatment of tuberculosis, are generally not asked about payer source since the program is required to test and treat individuals in order to protect the health and safety of others.

In addition, current accounting structures do not differentiate between Marketplace and non-Marketplace health insurance plans. This makes it difficult to quantify any actual amount of revenue that has been generated by certain programs that would be specifically attributable to payments received from Marketplace plans.

Lastly, factors specific to the Marketplace contribute to the ongoing DSHS assessment of the impact of the Marketplace on DSHS safety net services and programs. These key factors include health insurance enrollment and coverage policies, actual Marketplace enrollment statistics, provider networks established by the health plans, and financial assistance through premium tax credits and cost-sharing reductions.

Federal Health Care Coverage Requirement

Beginning January 1, 2014, the ACA required most Americans to have minimum essential health care coverage, or they would be subject to a shared responsibility penalty fee that would be assessed when they filed their income tax return. Eligible individuals could purchase health insurance coverage through the Marketplace to meet this federal requirement. Health insurance

companies offering plans through the Marketplace are required to offer plans with various tiers of coverage. These tiers (Bronze, Silver, Gold, and Platinum) are based on the percentage of full actuarial value of the health plan benefits that the healthplan covers. Insurers participating in the Marketplace are required to offer at least one plan at the Silver level (70 percent of the full actuarial value) and one plan at the Gold level (80 percent of the full actuarial value).

Timing of Enrollment and Health Care Coverage

The federal government began providing health insurance benefit coverage through the Marketplace on January 1, 2014 for those who enrolled in health insurance plans between October 1, 2013 and December 21, 2013. The initial open enrollment period closed March 31, 2014, unless an individual had a qualifying life event. Additionally, for individuals who began the enrollment process on or before March 31, 2014, those individuals had until April 19, 2014, to complete the enrollment process.

For individuals who select a health plan and pay for the health insurance premiums through the Marketplace, insurance coverage does not begin the same day as enrollment. The effective coverage date is dependent upon the day of the month the individual enrolls.¹ Coverage begins a minimum of 15 days and up to 6 weeks after the date of enrollment.

Premium Tax Credits and Cost-Sharing Reductions

The ACA established financial assistance options for individuals and families who are purchasing health care coverage through the Marketplace that meet certain eligibility criteria. Financial assistance is available to individuals in the form of premium tax credits or cost-sharing reductions. Eligible individuals who qualify for premium tax credits have the option to receive advanced premium tax credits where premium payments are made directly to the insurer on behalf of the individual. Alternatively, they may choose to receive a tax credit when they file their income tax return. In states deciding not to expand Medicaid coverage, premium tax credits are available to eligible individuals with incomes between 100 and 400 percent of the FPL.

For individuals with incomes up to 250 percent FPL, who have selected a Silver level plan, and are receiving premium tax credits, these individuals are eligible for additional cost-sharing reductions, which lower a person's out-of-pocket costs (i.e. co-payments or deductibles).

Provider Networks

The ACA required Marketplace health plans to have at least 20 percent of their provider network include providers that serve predominately low-income, medically underserved individuals and that there is sufficient geographic distribution of these providers. DSHS assumed there would be a sufficient provider network in the Marketplace for those DSHS services that are traditionally covered by private health insurance products. DSHS also assumed that in some rural and frontier areas, DSHS or its contracted providers may be the only service provider for some services, such as mental health and substance abuse.

Some DSHS programs provide access to specialized provider networks specific to certain health conditions (such as tuberculosis and HIV/AIDS), so DSHS assumed that Qualified Health Plan

¹ Individuals enrolling between the 1st and 15th of the January had coverage beginning the 1st of February. Individuals enrolling between January 16th and the end of January had coverage beginning the 1st of March.

provider networks and coverage of specific specialty services would need to be assessed to ensure access to care. DSHS also assumed that traditional providers may not be equipped to manage certain conditions, such as severe mental illness. As provider networks for Marketplace plans were established, many traditional providers of DSHS services were not included in the health plan networks.

Federal Health Insurance Marketplace Enrollment Statistics

The Marketplace opened for enrollment on October 1, 2013. As of May 1, 2014, 23 percent (n=733,757) of individuals in Texas eligible to enroll in the Marketplace had selected a Marketplace plan.^{2,3} The Marketplace enrollment period closed on March 31, 2014. The majority (66 percent) of individuals in Texas who selected a plan during the initial open enrollment period made their selection in the last two weeks of March 2014. For those individuals who enrolled between March 15 and April 15, 2014, health insurance coverage began on May 1, 2014.

Fiscal and Caseload Impact of the Federal Health Insurance Marketplace on Select DSHS Budget Strategies

In fiscal year 2014, DSHS assumed that most of the fiscal and caseload impact of the Marketplace on its safety net programs would occur in the last three months (May through August 2014) of the fiscal year. DSHS conducted an analysis of the following items to assess the fiscal and caseload impact:

- A comparison of expenditures for fiscal years 2013 and 2014⁴;
- A comparison of program caseloads or related key performance measures for fiscal years 2013 and 2014;
- A comparison of revenue generated from private health insurance or reported program income, if available, by budget strategy for fiscal years 2013 and 2014;
- A focus on any relevant changes occurring after the date (January 2014 or after) when individuals could have begun receiving coverage through Marketplace health plans; and
- Any additional programmatic impacts such as shifts in service provision, implementation of state or federal policies, or other public health-related events that could have impacted DSHS expenditures or caseloads.

Overall, DSHS has not been able to measure a fiscal or caseload impact to its programs due to individuals enrolling in private health insurance coverage through the Marketplace. For each

² Assistant Secretary for Planning and Evaluation (ASPE) reports only provide the number of individuals who have selected a plan; this number does not take into account the number of individuals who have selected a plan but not yet paid for it. Center for Medicare and Medicaid Services (CMS) has not released comprehensive data about effectuated enrollment (the number of individuals who have effectuated their enrollment and gained coverage through payment of the first premium). However, some issuers have made public statements indicating that 80 percent to 90 percent of the people who have selected a Marketplace plan have made premium payments. *Health Insurance Marketplace: Summary enrollment report for the initial annual open enrollment period*. Retrieved from http://www.aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf Accessed May 4, 2014.

³ Take up rate is calculated by dividing the total number of individuals who have selected a plan (733,757) by the total estimated number of individuals in Texas who are potential marketplace enrollees (3,143,000).

⁴ The comparison of fiscal year 2014 caseloads, expenditures and revenue to fiscal year 2013 provide a comparison of a limited time period and may not accurately represent historical service and spending data or trends.

budget strategy outlined in Rider 75, a brief summary is provided below addressing any factors associated with changes to expenditures or caseloads.⁵ Appendix B provides detailed fiscal and caseload information for each budget strategy outlined in Rider 75.

Disease Control and Prevention Programs and Services

The programs described below are responsible for public health services to prevent the spread of communicable and infectious diseases through screening, testing and treatment services.

A.2.1 - Immunize Children and Adults in Texas

The immunization program services are provided to prevent, control, reduce and eliminate vaccine-preventable diseases in children and adults with an emphasis on children less than 36 months of age. The immunization program received a \$234,369 reduction in GR funds as a result of the anticipated impact of the Marketplace in fiscal year 2014. In addition, the immunization program received an additional appropriation of \$8.5 million specifically to purchase more adult vaccines to prevent conditions such as Hepatitis B, pertussis, influenza, pneumonia. With the additional appropriation and the associated increased caseload, DSHS is unable to determine the actual impact of the Marketplace on the immunization program.

DSHS assumed that with the potential increase of children enrolling with their parents in private insurance and the federal requirement for health insurance plans to cover Advisory Committee on Immunization Practices recommended vaccines, fewer children would require vaccines administered through Texas Vaccines for Children (TVFC). Despite these changes, in fiscal year 2014, there were more doses administered annually than what was originally estimated for fiscal year 2014 and significantly higher than fiscal year 2013. One reason for the increase is that more providers administered TVFC doses, which may be a result of an increase in TVFC eligible populations. The TVFC program also had an increase in the number of vaccines provided and program expenditures in the summer of 2014. This is due to the additional vaccines that were ordered and administered as part of the public health response to the significant increase in the number of Unaccompanied Alien Children (UAC) who were intercepted at the Texas border for not having legal status in the United States. While some of the increase in the administration of vaccines related to the surge in UAC who were placed in shelters in 2014, the TVFC program did not see a measurable decrease in demand for vaccines due to Marketplace participation.

Alternatively, the amount of vaccines administered through the Adult Safety Net (ASN) program was lower in fiscal year 2014 than in fiscal year 2013. ASN providers did not order or administer as many vaccines as was initially projected. It is unclear as to whether the decrease in the number of vaccines administered is due to enrollment in private insurance or federal requirements for minimum essential coverage benefits offered by the health plan at zero cost-sharing for the client, or if it is better compliance with program rules about administering ASN vaccines to individuals without coverage.

Revenue earned through billing third party payer sources for fiscal year 2014 remained consistent with revenue earned in fiscal year 2013. Historically, TVFC providers such as local

⁵ All data, including expenditure and caseload (or key performance measure), reported in this section and Appendix B is based on the DSHS Monthly Financial Report as of August 31, 2014. Program data may be updated in months following to allow for submission of year-end reporting and final fiscal year vouchers to be processed.

health departments have had challenges with becoming credentialed and enrolled providers with managed care organizations, so it is anticipated that as long as TVFC providers are not credentialed providers with private health insurance plans, TVFC will continue to see limited increases in private insurance revenue even with increased enrollment in private health care coverage.

A.2.1 - HIV/STD Prevention

The HIV medication program and outpatient medical services program did not receive a reduction in fiscal year 2014 so that the maintenance of effort (MOE) amount required by the Health Resources Services Administration (HRSA) was maintained. Fiscal year 2014 caseloads and expenditures for the HIV medication program and outpatient medical services remained consistent with the previous fiscal year.

Alternatively, beginning in the second quarter of fiscal year 2014, the HIV program providers reported an increase in the amount of program income attributable to private health care insurance revenue. In early fiscal year 2014, HRSA issued policy guidance requiring state Ryan White programs to enhance efforts to ensure that Ryan White funds are used as the payer of last resort. DSHS HIV program providers have not historically been enrolled or credentialed providers with managed care organizations, and their ability to bill third party payers has been limited. As a response to these challenges, the DSHS HIV program provided technical assistance and training to many of their providers, including local health departments, to increase their knowledge about billing third party payers so that they may be able to generate additional revenue from Marketplace payments.

A.2.3 - Infectious Disease Prevention, Epidemiology and Surveillance (Tuberculosis)

The tuberculosis (TB) program's GR funding was reduced by \$158,972 in fiscal year 2014. The TB program received an additional \$1.85 million in GR-Dedicated (GRD) funds to implement a more rapid type of testing for TB, which lessened the impact of the reduction in S.B. 1. The number of cases and suspects from fiscal year 2014 remained fairly consistent with the number of cases and suspects in fiscal year 2013.

The provider network responsible for the majority of TB testing and treatment in Texas is state and local health departments. As such, the majority of the local health departments are not billing, nor receiving, revenue from third party payers. The amount of program income reported in Appendix B represents revenue from all payer types, including Medicaid and sliding scale fees, but is revenue from only 10 out of the 31 TB contractors. Similar to the provider network for HIV services, the TB service providers have not historically been successful with enrolling as in-network providers with health insurance plans. Out of the ten contractors reporting revenue from third party billing, only four reported receiving payment through private insurance that totaled approximately \$5,700.

Primary and Specialty Care Programs

The programs described below provide an array of health care benefits and services for persons with various health care conditions. Many of the benefits provided through these programs may also be covered benefits through private insurance plans; however, these programs provide other critical support services not traditionally covered by private insurance such as case management

and family support services. These primary and specialty care programs mainly serve individuals who are not eligible for other health care coverage, including Medicaid, or whose health insurance coverage does not cover these specialty care benefits and services.

A.3.3 - Kidney Health Care

The Kidney Health Care (KHC) program provides medical and drug benefits and transportation services through a network of hospitals, dialysis facilities and physicians to individuals with end stage renal disease (ESRD). Clients are income eligible for KHC program benefits if their annual income is less than \$60,000 per year. The program received a reduction of \$398,655 in GR funds in fiscal year 2014 due to the anticipated impact of clients enrolling in private health insurance. The KHC program did not experience any impact to its caseload or expenditures from individuals enrolling in private health care insurance. One primary reason is that there continues to be an increasing number of individuals with ESRD in the diabetic and hypertensive populations, as well as an increasing number of aging individuals requiring KHC program benefits and services.

The KHC program is a benefit program that enrolls providers who are reimbursed for services rendered to eligible KHC clients. DSHS is unable to collect information on costs avoided due to another payer source. The provider network would generate revenue from any changes to a client's insurance coverage since there would be a payer source for the client and KHC benefits would not be necessary; therefore, no program income is reported in Appendix B for this strategy.

A.3.4 - Children with Special Health Care Needs

The CSHCN services program provides an array of benefits to children with special health care needs and people of any age with cystic fibrosis. The CSHCN services program does provide services to individuals with private health insurance for those medically necessary services that may not be currently covered benefits through a client's private health insurance plan such as certain types of genetic screening or radiological tests; however, the program is the payer of last resort.

The CSHCN services program received a \$215,262 reduction in GR funds in fiscal year 2014. In addition, the program received an additional \$3.3 million to remove children from the wait list in fiscal year 2014. There was an increase in the number of clients served through the program for fiscal year 2014. Any reduction in clients due to clients obtaining coverage through the Marketplace was tempered by the ongoing need for services.

The CSHCN program is a benefit program that enrolls providers who are reimbursed for services rendered to eligible CSHCN clients. DSHS is unable to collect information on costs avoided due to another payer source. The provider network would generate revenue from any changes to a client's insurance coverage; therefore, there is no program income reported with this strategy in Appendix B.

A.3.5 - Epilepsy and Hemophilia Services

The Epilepsy program and the Hemophilia Assistance Program (HAP) provide specialized services for individuals with epilepsy and hemophilia to reduce disability and premature death

related to these conditions. The entire budget strategy received a Marketplace-related reduction in GR funds of \$95,381 in fiscal year 2014; however, this reduction was lessened by an increase in GR funds to restore funding to fiscal years 2010 and 2011 appropriated levels. The programs did experience a decrease in the number of clients served in fiscal year 2014. Specific reasons for the decrease are unclear. It may be due, in part, to clients obtaining coverage through the Marketplace, or could also be due to factors such as higher costs for specialized treatments for both conditions.

Appendix B does not report any third party or revenue from third party payments for the Epilepsy Program or the HAP. The Epilepsy program may assess a fee or co-payment for services provided to an individual and that fee may vary in how it is assessed at the contractor level. This fee is not considered income from third party payments, but is categorized as self-pay collections. The HAP is a limited benefit program that only pays for blood factor products and does not receive any revenue from third party billing. Neither program will provide services or benefits to an individual who has another payer source for the service or benefit being provided. Both programs ensure that any other third party payer source is exhausted prior to paying any benefits, including private health insurance.

A.4.1 - Laboratory Services

The DSHS Laboratory Services Section provides laboratory testing to diagnose and investigate community health problems and health hazards. This includes the processing of human and non-human specimens for laboratory testing including lead screening in children, newborn screening, infectious disease screening of pregnant women, and support for clinical testing for patients of the Texas Center for Infectious Disease and the Rio Grande State Center Outpatient Clinic. The laboratory did not have a budget reduction in fiscal year 2014, but it was assumed that the lab would begin to generate revenues for certain lab tests in fiscal year 2015. The laboratory experienced a decrease in the number of specimens that were tested in fiscal year 2014. A significant portion of the decrease in the laboratory's caseload is due to an ongoing decrease in specimens submitted on behalf of the Texas Health Steps program for lead screening and hemoglobin testing since these tests can now be performed in physicians' offices or by other commercial laboratories.

Additionally, revenue from third party payers, including Medicaid, has increased due primarily to an increase in the number of births in Texas, as well as billing third party payers for a newborn laboratory test for Severe Combined Immunodeficiency (SCID), which was added to the newborn screening panel in fiscal year 2013 (See Appendix B). The state laboratory has also experienced challenges with becoming credentialed as an in-network laboratory with health plan carriers, so a limited portion of the third party payments are from private health insurance plans since generally the laboratory will only be paid at an out-of-network rate, if the lab receives payment at all.

B.1.2 - Women and Children's Health Services (Breast and Cervical Cancer Screening Program)

The Breast and Cervical Cancer Screening (BCCS) program provides breast and cervical cancer screening and diagnostic services to women below 200 percent FPL with no other third party payer source for these services. The BCCS program received a \$1,937 reduction related to the anticipated impact of the Marketplace.

The number of individuals served through the BCCS program decreased slightly in fiscal year 2014. The program has observed a shift in the type of services that are being billed for by their service providers since the program operates as a fee-for-service program. Historically, the primary services provided were screening-related (e.g., mammograms). However, over the past year, there has been a greater demand for diagnostic tests rather than screening services. This may be related to the fact that the ACA required preventive screenings to be a covered benefit by health insurance plans beginning in January 2014.

Individuals with access to a third party insurance source are not allowed to receive services from the BCCS program; therefore, the program does not receive income or revenue from third party payers.

B.1.4 - Community Primary Care Services

The Primary Health Care (PHC) program provides comprehensive medical assessments, health screening and lab tests, and client education for uninsured, underinsured or indigent persons who are not eligible to receive the service from another source. The Expanded Primary Health Care (EPHC) program is a new program established with funds appropriated for fiscal years 2014 and 2015. EPHC has a particular focus on women's health services and provides family planning, breast and cervical cancer services, prenatal services, and prenatal dental services, in addition to other preventive and primary care services to women age 18 and above. PHC and EPHC services are provided through contracts across the state and many of the activities for EPHC program have been focused on expanding the provider base across the state. The budget strategy received a Marketplace-related reduction in S.B. 1 for fiscal year 2014 in the amount of \$244,736. The PHC program served approximately 10,000 more individuals in fiscal year 2014, but with the addition of the new EPHC program it is difficult to attribute any impact of the Marketplace to either of the programs.

Current Texas law does not allow individuals who are eligible for services covered by another benefit program to be eligible for those services through the PHC and EPHC programs. However, individuals may be able to receive services through the PHC program that are not covered by other payer sources if they meet other program eligibility requirements. Additionally, individuals can receive assistance with the co-payments and/or other out of pocket expenses so that they can receive necessary services.

Community Mental Health Services

Community-based mental health services are provided through a network of 38 community mental health centers (the Centers) across the state. The adult, child and crisis mental health services are contracted with the Centers through a performance based contract. Most of the reporting about the fiscal and caseload impact for the strategies B.2.1, B.2.2., and B.2.3 is aggregate data, including the amounts of revenue generated from third party payers since revenue amounts are reported to DSHS for the performance contract in its entirety.

B.2.1 - Mental Health Services for Adults

This strategy provides funding for community mental health services for adults including clinical assessments, service coordination and case management, medication related services, inpatient

and outpatient mental health services, psychiatric rehabilitative services, crisis resolution, Assertive Community Treatment (ACT), dual diagnosis services, supported housing and supported employment services.

The adult mental health services program received a Marketplace-related reduction of \$1,112,522 for fiscal year 2014. In addition, the program also received additional funding to remove individuals from the waiting list for services. The program served more clients in fiscal year 2014. Any reduction in clients due to clients obtaining coverage through the Marketplace was tempered by the ongoing need for services.

B.2.2 - Mental Health Services for Children

This strategy provides funding for community mental health services for children and adolescents ages 3 through 17 including clinical assessments, service coordination and case management, medication related services, inpatient and outpatient mental health services, and respite services. Services are delivered by community mental health centers across the state.

The children's mental health services program received a Marketplace-related reduction of \$214,999 in fiscal year 2014 through S.B. 1. This program also received additional funding to remove children from the waiting list for services, therefore any reduction in clients that would have been a result of individuals obtaining health care coverage through the marketplace was tempered by the ongoing need for services. With the increase in funding, the program was able to increase the average number of children served per month by approximately 1,700 children.

B.2.3 - Community Mental Health Crisis Services

Community mental health crisis service funds are used to improve the response to mental health and substance abuse crises. Each of the Centers receives crisis funding for a crisis hotline, a mobile crisis outreach team, and to provide walk-in crisis services. A select number of the Centers receive additional funding for crisis residential services and to implement community-based alternatives to hospitalization and incarceration for persons with mental illness.

The crisis services budget strategy received a \$101,566 reduction in GR funds due to the anticipated impact of the Marketplace on crisis-related services.

The average monthly number of individuals receiving crisis services has reduced due to the additional appropriation since DSHS has expanded the number of persons enrolled in ongoing services. However, caseloads for crisis residential services and outpatient services have increased since the Centers are able to enroll more individuals in ongoing care.

For budget strategies B.2.1, B.2.2, and B.2.3 (Adult, Child and Crisis mental health services), the Centers have reported collecting an additional \$6.7 million in patient fees, insurance and reimbursement revenue in fiscal year 2014. Included in that amount is over \$4 million that has been collected by the Centers from private insurance payments since January 2014. However, DSHS is unable to determine whether the increase in patient fees, insurance and reimbursement revenue is attributable to payments from Marketplace plans. As more individuals gain access to clinical behavioral health services through private insurance benefits, the Centers may observe a shift in the array of services that are being provided with DSHS GR funds since services such as

supportive housing and supported employment are not services traditionally covered by private insurance products.

B.2.4 - NorthSTAR Behavioral Health Waiver

The NorthSTAR program provides behavioral healthcare services (mental health and chemical dependency) to persons in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties. NorthSTAR is a collaborative effort integrating diverse funding streams at the state and local levels into a single managed care system. The program covers both indigent and Medicaid clients with mental health and/or chemical dependency issues, for a seamless system of care.

The NorthSTAR program received a \$486,762 reduction as a result of the anticipated impact of the Marketplace. The NorthSTAR program received an additional \$7 million in appropriated GR funds in fiscal year 2014, which lessened the impact of the reduction; however, DSHS is also unable to attribute any impact due to the Marketplace. NorthSTAR saw a decrease in the average number of clients served per month in fiscal year 2014.

Revenues from third party payers are reported to DSHS by the managed care entity DSHS contracts with for the NorthSTAR program, ValueOptions. The amount of revenue collected in fiscal year 2014 has decreased, which has likely been caused by an increased effort by the providers in ValueOptions network to recover payments from third party payers for services provided to individuals with another payer source.

Community Indigent Care

B.3.3 - Indigent Health Care Reimbursement (UTMB)

H.B.1799, 76th Legislature, Regular Session, 1999, established the State-Owned Multi-Categorical Teaching Hospital Account and requires the deposit into this account of unclaimed lottery prize monies. The General Appropriations Acts of the 76th - 82nd Texas Legislatures authorized DSHS to transfer monies from this account to reimburse the University of Texas Medical Branch (UTMB) at Galveston for unpaid health care services provided to indigent patients. The UTMB received a \$338,037 reduction related to the anticipated impact of the Marketplace. The budget reduction decreased the amount of funds transferred to UTMB for indigent health care services provided by the hospital.

DSHS Hospital Services

C.1.1 - Texas Center for Infectious Disease

Texas Center for Infectious Disease (TCID) is a specialty hospital that provides inpatient treatment services for individuals with TB and outpatient treatment for Hansen's disease. Patients are admitted by court order or clinical referral for TB, Hansen's disease or other diseases that are too severe for treatment elsewhere. Patients admitted to TCID require extensive lengths of stay that demand complex nutritional management, laboratory services, radiology monitoring and clinical support by TB specialists.

TCID serves primarily indigent patients, and serves very few clients who may have an alternative payer source for the treatment of their TB disease. TCID received a reduction of \$8,238 in fiscal year 2014 due to the anticipated impact of the Marketplace. Revenue from third

party payers at TCID is impacted by a patient's length of stay and complexity of medical needs. The number of admissions and revenues were down in fiscal year 2014 from fiscal year 2013.

C.1.2 - South Texas Health Care System

South Texas Health Care System (STHCS) at Rio Grande State Center serves as an outpatient clinic for four counties in the Rio Grande Valley. Services include outpatient primary care/internal medicine clinic; health education on disease prevention, exercise, nutrition and life style changes.

STHCS received a \$1,294 reduction in their fiscal year 2014 appropriation due to the anticipated impact of the Marketplace. For fiscal year 2014, STHCS saw an increase in the number of outpatient visits that were conducted over the number of outpatient clinic visits in fiscal year 2013. Alternatively, there was a slight decrease in the amount of revenue generated in fiscal year 2014 from fiscal year 2013. However, STHCS has been working with private insurance health plans in the four-county coverage area to become an in-network provider so that more revenue can be generated from the provision of outpatient services.

C.1.3 - Mental Health State Hospitals

The role of the state psychiatric facilities is closely integrated with the behavioral health services offered in communities. Approximately 50 percent of the average daily hospital census are civil commitments, while approximately 50 percent of the average daily census are forensic commitments. Admissions to state hospitals have been decreasing over the past few years as a result of the increase in the number of forensic commitments to the state hospitals who often have longer lengths of stay in the hospital.

The state hospitals received a \$317,527 reduction in fiscal year 2014 as a result of the anticipated impact of the Marketplace. Consistent with the trend in admissions to DSHS state mental health hospitals over the past several years, the hospitals experienced a decrease in the number of admissions in fiscal year 2014. In addition to the increasing number of forensic commitments, the reduction in admissions may also be due in part to more mental health inpatient hospital beds being purchased by DSHS through community-based hospitals.

Alternatively, revenue generated from private commercial insurance has increased by approximately \$2 million in fiscal year 2014. DSHS is unable to determine the impact of the Marketplace as the increase in private insurance revenue may not be solely due to an increase in newly insured individuals. In addition to not having the level of detail to determine whether marketplace plans were used, DSHS also had implemented a state hospital quality improvement initiative to improve the billing and collection process for third party payers, which may have impacted collections.

C.2.1 - Mental Health Community Hospitals

DSHS contracts with community mental health centers or other state or local governmental entities to provide inpatient psychiatric and crisis stabilization services not operated by DSHS in communities across the state. These facilities provide an alternative for persons in need of inpatient treatment. The Community Mental Health Hospital budget strategy received a Marketplace-related reduction of \$213,044 in fiscal year 2014. In addition, DSHS allocated \$1.2

million to purchase additional community hospital beds for inpatient mental health services. In fiscal year 2014, the community hospitals admitted 129 more individuals. The inpatient services provided through this budget strategy are designed to be used by individuals who have no other payer source for inpatient mental health services; therefore, no revenue from third party payers should be generated. Most of the entities DSHS contracts with for these services also provide inpatient hospital services to individuals with private insurance, but these individuals would not be captured through program income for this budget strategy.

Third Party Payer Attestation Collection

In accordance with state law, DSHS policy and rules, and certain federal grant requirements, DSHS and its contractors generally are required to ensure that when they provide services to a client, other sources of payment for services have been identified and exhausted prior to utilizing program funds. S.B. 1057 required certain DSHS safety net programs to collect an attestation statement from individuals indicating whether they have access to private health insurance coverage for the services, benefits, or assistance they are seeking through DSHS programs. In addition, it also directed DSHS to not provide services to individuals who have access to those services, benefits or assistance through a private health insurance plan unless the individual provides the information and authorization necessary to bill third party payers. For most programs identified in Rider 75, the attestation is collected through the financial eligibility determination process.

Through a comprehensive review of the current eligibility and financial assessment forms used by DSHS programs identified in Rider 75 and S.B. 1057, it was determined that most of the programs gathered the information required by S.B. 1057 with the exception of a few needing to add a statement authorizing the assignment of benefits. Financial forms and other eligibility documentation were updated to reflect this addition, which would allow for DSHS, or an agent acting on its behalf, to submit a claim to a client's health insurance plan for reimbursement for the benefit, service or assistance provided.

Rider 75 required DSHS to report on the number of attestation forms distributed by the programs identified in S.B. 1057. For purposes of this report, the number of forms distributed includes two different sources of data.

- The number of individuals who were screened for the program by the contractor. This may include new clients but it may also include the number of clients who were screened as part of an annual financial assessment.
- The number of times the financial assessment form available through the DSHS website was downloaded for programs such as CSHCN, PHC, EPHC, Epilepsy, KHC, and HAP.

In January 2014, programs began reporting to DSHS the number of attestation statements distributed, which is consistent with the month when individuals would begin to gain coverage through the Marketplace. From January to August 2014, over 460,000 attestation forms were distributed by DSHS safety net programs. Table 3 in Appendix A provides the number of third party attestation forms distributed by programs referenced in S.B. 1057^{6,7}.

⁶ The numbers of attestations collected were only gathered by those programs referenced by statute in S.B. 1057 and for the corresponding budget strategy referenced in Rider 75. Per S.B. 1057, statutory references for Infectious

Consumer Awareness Efforts

S.B. 1057 stated that DSHS may develop educational materials about the Marketplace and the subsidies, in the form of advanced tax credits, available to individuals who fell between 100 and 400 percent FPL to purchase private health insurance. S.B. 1057 required DSHS to distribute these educational materials to individuals between 100 and 400 percent FPL, who attested that they did not have access to services, benefits or assistance through a private health insurance plan. DSHS considered developing its own materials about the Marketplace, but determined that a more cost-effective way to provide the information would be to use existing materials provided, free-of-charge, by the United States Department of Health and Human Services (HHS). DSHS contractors directed eligible consumers to the Marketplace and connected them with the resources necessary to assist in the enrollment process, including www.healthcare.gov, the federal website for the Marketplace. Some DSHS contractors had also received federal funds for navigator services or had been designated as a Certified Application Counselor location where clients could go to seek assistance for enrollment in the Marketplace.

Most DSHS programs engaged in similar consumer awareness activities about the Marketplace, such as referring potentially eligible individuals to Marketplace Navigators or Certified Application Counselors, posting information in public spaces, and conducting general community outreach about the Marketplace in forums such as health fairs and other community events. For certain programs, direct client outreach was conducted to those consumers who were determined to be eligible to enroll in the Marketplace. Those efforts did not yield significant results for clients enrolling in the Marketplace.

Table 4 in Appendix A provides a summary of the educational outreach activities.

Analysis of Current Policies and Recommendations for Maximizing Alternative Sources of Coverage for Clients in Select DSHS Programs

S.B. 1057 required certain DSHS safety net programs to collect an attestation from clients indicating whether they had access to the services, benefits or assistance through a private health insurance plan for the services they were seeking access to through a DSHS provider. S.B. 1057 also required DSHS to not provide services to individuals who have access to service, benefit, or assistance coverage through private health insurance unless the individuals provide the information and authorization necessary to bill the third party payer source. This policy is consistent with current program policies and rules for most of the programs outlined in S.B. 1057 to ensure that all other potential payer sources are exhausted prior to using DSHS funds.

In fiscal year 2014, most programs did not see a decline in their caseload that could be attributable to individuals having access to benefits through a private health insurance plan, nor did these same programs see an increase in the amount of revenue received from third party

Disease Prevention, Epidemiology, and Surveillance; Rio Grande State Center; and Women and Child Services were for unrelated statutes or references for programs the agency did not anticipate an impact.

⁷ In addition, the DSHS Laboratory and Texas Center for Infectious Disease were not included in S.B. 1057, so were therefore not required to report on the attestation and educational material element of Rider 75.

payments from private insurance as a result of clients authorizing an assignment of benefits. Although DSHS programs were required to collect an authorization to bill the third party payer source, it was assumed that DSHS program providers would generate additional revenue by billing third party payers.

Most DSHS programs are required either through statute or program policy to ensure that all other potential sources of funding are exhausted prior to using state funds for certain services, and clients are assisted with enrollment into other public assistance programs, such as Medicaid or CHIP. However, it is difficult to measure the impact of the Marketplace since DSHS is unable to collect information on the costs avoided due to individuals receiving benefits and coverage through another payer source. Unlike public insurance sources, such as Medicaid, there is not a centralized portal to verify whether an individual is enrolled and receiving medical benefit coverage through a private insurance plan.

While requirements ensuring that state funds are used once all other source are exhausted are not new, the following are recommendations for how DSHS can ensure that state funds are maximized through all potential payer sources, including health insurance plans offered through the Marketplace.

Increasing Consumer Awareness about Health Insurance Coverage

S.B 1057 required DSHS to distribute educational materials to individuals between 100 and 400 percent FPL who indicated they did not have access to services, benefits, or assistance through a private insurance plan. These materials were to provide information about the Marketplace and about the subsidies that may be available to these individuals to assist in purchasing health insurance. DSHS clients received information through many different venues including print materials, referrals to navigators or other Certified Application Counselors, and through other public media sources. However, enrollment in health plans through the Marketplace was lower than what was initially anticipated since 23 percent of eligible individuals enrolled, and it was assumed that 50 percent would enroll in the first enrollment period.

In addition, for some populations, insurance is a new concept, so providing education is necessary so that individuals are able to understand what is available to them. For some programs, such as HIV services, a significant amount of client education was necessary about health insurance and what it means to be covered since this population has historically been uninsured due to pre-existing condition limitations. Alternatively, providing direct outreach through letters to clients who were eligible to enroll did not prove to be a successful strategy in other programs as enrollment numbers resulting from those outreach efforts were minimal.

To address the need for ongoing consumer education about the Marketplace and the availability of subsidies through the Marketplace, DSHS provides the following strategies for consideration:

- DSHS should continue to direct clients to established resources, including Navigators, to receive information on the Marketplace and the subsidies available to help purchase private health insurance; and
- DSHS should provide ongoing education to its staff about the Marketplace so that information can be passed on to clients and contracted providers.

Billing and Credentialing with Managed Care Organizations

DSHS assumed that as clients became knowledgeable about health insurance coverage and became enrolled in a health plan, clients would be able to enroll in health plans that met the clients' needs and that the health plan included an adequate supply of specialty providers within the health plan provider networks comparable to the specialty providers available through DSHS programs. As provider networks were established with health plans, many of the DSHS providers were not asked to be or accepted as enrolled providers. This includes entities such as local health departments, state mental health hospitals, and other specialty care providers.

It was also assumed that by requiring certain programs to collect an authorization to bill a private insurance company, providers had a mechanism to bill third party payers. Certain public health services (i.e. HIV testing and treatment services, TB testing and treatment, administration of immunizations, and primary care services) are provided through both state and local health departments. Currently, only a select number of full-service local health departments bill third party payers as in-network providers for services since most local public health departments do not meet the minimum requirements for becoming credentialed with managed care health insurance plans. Some of the requirements that have created challenges for local health departments becoming credentialed include maintaining hospital admitting privileges, maintaining certain levels of liability insurance coverage, and providing 24 hour a day, 7 days a week access for managed care clients. Additionally, health insurance plans may also require an onsite physician for the delivery of certain services, which also creates a limitation for most local health department clinics that are mainly staffed by nurses who may provide the majority of the services.

As a mechanism to maximize alternative sources of payment for DSHS programs, DSHS should be considered for in-network status for its State Public Health Laboratory, DSHS Regional Offices, which share similar functions and provide similar services to local health departments, and the state operated facilities. Even though the service delivery is located within the DSHS operating structure, the challenges to being a credentialed and enrolled provider with private health insurance plans exist and, for the regional offices are similar to those of the local health department. To address these issues, DSHS provides the following strategies for consideration:

- DSHS could consider developing an educational opportunity for health plans, public and private, to learn about the role, structure and operations of state and local health departments in Texas.
- DSHS, in coordination with the Texas Department of Insurance, and interested stakeholder groups, may consider the development of a public health provider type to allow for local and state public health departments to become credentialed as in-network providers.
 - Considerations for developing a public health provider type should include:
 - The current operational structure of a local public health department;
 - The statutory functions a local public health department and their relationship to billable services offered as covered benefits through health plans; and
 - A study of the potential fiscal impact to state health departments, and local public health departments and their affiliated city or county governments, including potential revenue generation and resource needs.

DSHS contracts with small community-based organizations that may not have the resources or experience to successfully bill third party payers. As a result, there may be missed opportunities for local providers to generate revenue from third party payers for billable services. The revenue could be used to offset some of the costs for the GR-funded services. To address this issue, DSHS provides the following strategy for consideration:

- DSHS, in coordination with health insurance carrier stakeholders, may provide support for infrastructure and capacity building of DSHS and its contractors so that the respective organizations may effectively bill and receive payment from third party payers.
- DSHS may consider working with external entities to provide training and technical assistance to specialty providers who may not have the experience of working with insurance products or carriers.

Increasing Access to Health Care Coverage through Premium Assistance or Other Assistance for Out-Of-Pocket Costs

For some clients served through DSHS safety net programs, insurance premiums, deductibles and other out-of-pocket costs may not be affordable for certain health care services. Certain diagnostic tests, medications and other specialty services may have certain limitations or out-of-pocket costs through a health plan benefit that may limit the affordability of these services for some clients. Several DSHS programs have experienced clients needing to access GR-funded services due to the inability to access certain benefits through their existing health care coverage.

For certain DSHS programs, such as the CSHCN services program, offering premium assistance as a program benefit has demonstrated to be a cost-effective way to ensure clients have access to the care they need, particularly for those that have higher health care expenses. In addition, federal agencies are encouraging states to use their federal funding to consider paying for insurance premiums in programs where the cost of services exceeds that of an annual insurance premium payment. This benefit, offered in a limited number of DSHS safety net programs, is generally provided when the costs associated with the services an individual would receive through these DSHS programs exceeds the cost of an individual's health insurance premiums and, for some, the maximum out-of-pocket expenses. To address this issue, DSHS provides the following strategies for consideration:

- DSHS may explore the cost benefit of paying for health insurance premiums for certain safety net programs, if allowed by federal and state guidelines or laws, by developing and implementing a pilot program offering premium assistance to clients and gathering data during the pilot as an ongoing assessment of the benefit to the agency.
- As part of the pilot program development, DSHS would need to consider operational, fiscal and policy implications for paying for premiums and to identify the populations where the most benefit will be realized.
- DSHS clients may also benefit from premium assistance in that it would reduce their need for receiving services funded by general revenue funds from other safety net programs.

Conclusion

DSHS monitored the fiscal and caseload impact of the Marketplace in fiscal year 2014 for 18 safety net programs identified in Rider 75. For those DSHS programs projected to be affected by the Marketplace, DSHS has been unable to attribute any caseload or fiscal impacts directly to the Marketplace primarily because DSHS is unable to collect data on the costs and services avoided from individuals receiving services through private health insurance provider networks. DSHS received reductions in 18 budget strategies in S.B. 1 that were a result of the anticipated impact of the Marketplace. In addition, 12 out of the 18 safety net programs identified in Rider 75 were appropriated additional general revenue funds for exceptional item requests or other specified appropriations.

Key factors about enrollment statistics, health insurance coverage policies and the relationship to the individuals served through DSHS programs contribute to the ongoing fiscal and caseload assessment to determine the actual effect of the Marketplace on the agency and its services. In addition, certain limitations exist for current DSHS programs and their provider networks to effectively maximize third party payer systems due to several issues:

- The inability for certain providers to be enrolled providers with private health insurance plans;
- The challenges with quantifying the impact of the Marketplace when newly insured clients seek services from non-DSHS providers, and
- Eligible clients being unable to access certain benefits or services through a health plan due to cost, certain limitations or exhaustion of benefits, enrollment period limitations, or other coverage issues.

Based on the analysis of the policies set forth in S.B. 1057, certain options should be considered in order for DSHS to maximize alternative sources of coverage for clients served through certain DSHS safety net programs. These strategies include:

- Continuing to provide consumer awareness about the Marketplace;
- Building opportunities for DSHS service providers to be credentialed with private insurance health plans so that providers can effectively bill third party payers; and
- Identifying alternative payment mechanisms, such health insurance premium payments, to maximize existing General Revenue funding for individuals who may be eligible for private health insurance.

Appendix A: Tables and Charts/Graphs

Table 1. DSHS FY 2014-2015 Budget Changes due to Impact of the Federal Health Insurance Marketplace

DSHS Budget Strategy	FY 2014-2015 General Revenue	FY 2014-2015 General Revenue- Dedicated	FY 2014-2015 Other	Total
A.2.1 Immunizations	(1,171,846)		(755,183)	(1,927,029)
A.2.2 HIV/STD Prevention	(326,772)			(326,772)
A.2.3 Tuberculosis	(794,859)			(794,859)
A.3.3 Kidney Health Care	(1,993,275)			(1,993,275)
A.3.4 Children with Special Health Care Needs	(1,076,305)			(1,076,305)
A.3.5 Epilepsy/Hemophilia	(476,903)			(476,903)
A.4.1 Laboratory	(376,286)	376,286		0
B.1.2 Women and Child Health	(9,685)			(9,685)
B.1.4 Primary Health Care	(1,223,681)			(1,223,681)
B.2.1 Mental Health Adult	(2,767,759)			(2,767,759)
B.2.2 Mental Health Children	(560,305)			(560,305)
B.2.3 Mental Health Crisis Services	(421,476)			(421,476)
B.2.4 NorthSTAR	(1,838,866)		1,838,866	0
B.3.3 Indigent Health Care		(1,690,235)		(1,690,235)
C.1.1 Texas Center for Infectious Disease	(74,766)			(74,766)
C.1.2 South Texas Health Care System	(7,219)		5,126	(2,093)
C.1.3 State Hospitals	(1,837,633)		1,837,633	0
C.2.1 Mental Health Community Hospitals	(1,065,219)			(1,065,219)
Total	(16,022,855)	(1,313,949)	2,926,442	(14,410,362)

Table 2. Net Budget Impact from ACA General Revenue (GR) reductions, Additional Appropriated General Revenue Related (GRR) funds, and GR Base Alignment.

DSHS Budget Strategy	FY 2014	FY 2014	FY 2012/2013	Net Change
	ACA GR Reduction	Additional Appropriated GRR Funds	GR Base Alignment	
A.2.1 Immunizations	(234,369)	8,855,000 ⁸	1,000,000	9,620,631
A.2.2 HIV/STD Prevention	-	-	-	-
A.2.3 Tuberculosis	(158,972)	1,850,000	291,788	1,982,816
A.3.3 Kidney Health Care	(398,655)	(7,195,455)	(1,150,100)	(8,744,210)
A.3.4 Children with Special Health Care Needs	(215,261)	3,300,000	-	3,084,739
A.3.5 Epilepsy and Hemophilia	(95,381)	1,229,603	-	1,134,222
A.4.1 Laboratory	-	-	(1,531,329)	(1,531,329)
B.1.2 Women and Child Health	(1,937)	492		(1,445)
B.1.4 Primary Health Care	(244,736)	50,000,000	3,500,000	53,255,264
B.2.1 Mental Health Adult	(1,112,522)	52,360,247	(1,301,061)	49,946,664
B.2.2 Mental Health Children	(214,999)	20,318,312	(8,840,602) ⁹	11,262,711
B.2.3 Mental Health Crisis Services	(101,566)	22,091,792	-	21,990,226
B.2.4 NorthSTAR	(486,762)	7,041,108	(\$3,727,645)	2,826,701
B.3.3 Indigent Health Care	(338,047)	-	-	(338,047)
C.1.1 Texas Center for Infectious Disease	(8,238)	-	1,057,500	1,049,262
C.1.2 South Texas Health Care System	(1,293)	-	2,587	1,294
C.1.3 State Hospitals	(317,527)	15,599,764	(12,508,095)	2,774,142
C.2.1 Mental Health Community Hospitals	(\$213,044)	1,200,000	15,800,000	16,786,956
Total	(4,143,309)	176,650,863	(7,406,957)	165,100,597

⁸ A.2.1 – Exceptional Item funding for Adult safety net; A.2.3 – TB testing; A.3.3 – Reduction in drug rebates; A.3.4 – Additional funding for CSCHN Waiting List; A.3.5 – Restored funding levels to Fiscal Year 2010-2011 amounts; B.1.2 – Breast and Cervical Cancer Screening program adjustments for FMAP changes; B.1.4 – Exceptional Item funding for expanded primary health care services; B.2.1 – Additional funding for Rental assistance MH Adult Waiting List, MH Treatment waiver, Underserved LMHAs, Public Awareness, Veteran's Initiative, Jail Diversion, FMAP adjustments; B.2.2 – Additional funding for MH Children Wait List, MH Treatment for YES Waiver, Prevention and Early Identification, Underserved LMHAs, Public Awareness, MH Treatment Non Waiver; B.2.4 – Additional funding for increase in substance abuse service rates; DFPS set asides; MH treatment non-waiver clients; Underserved LMHA NorthSTAR adjustment; Rental Assistance and Care Retirement; C.1.3 - Additional funding for Psychiatric Nursing Assistance Pay, State Hospital Patient Safety, Laundry Services, Vehicles, Resident Stipends, Victory Fields, Care Retirement, FMAP adjustments

⁹ Relinquishment slots FMAP Change

Table 3. Number of Attestation Forms Distributed by Budget Strategy

DSHS Strategy	Number of Attestation Forms Distributed
A.2.1 Immunize Children and Adults	79,400
A.2.2 HIV/STD Prevention	2,847
A.2.3 Infectious Disease Prevention, Epidemiology and Surveillance	-
A.3.3 Kidney Health Care	4,376
A.3.4 Children with Special Health Care Needs	5,960
A.3.5 Epilepsy and Hemophilia Services	999
A.4.1 Laboratory Services	-
B.1.2 Women and Children’s Health Services	36,485
B.1.4 Community Primary Care Services	180,034
B.2.1 Mental Health Services for Adults	32,265
B.2.2 Mental Health Services for Children	Included in B.2.1
B.2.3 Community Mental Health Crisis Services	Included in B.2.1
B.2.4 NorthSTAR Behavioral Health Waiver	72,588
B.3.3 Indigent Health Care Reimbursement (UTMB)	-
C.1.1 Texas Center for Infectious Disease	-
C.1.2 South Texas Health Care System	35,182
C.1.3 Mental Health State Hospitals	11,194
C.2.1 Mental Health Community Hospitals	Included in B.2.1
Total	461,397

Notes: The number of attestations distributed includes the number of eligibility forms downloaded from websites for the following budget strategies: A.3.3, A.3.4, A.3.5, B.1.2, and B.1.4.

Table 4. Summary of Consumer Awareness Activities about the Federal Health Insurance Marketplace by DSHS Budget Strategy

DSHS Budget Strategy	Financial eligibility review process	Referral to Healthcare.gov	Referral to ACA Navigator/CAC	Direct assistance with application	Navigator entity, grantee, or navigator trained	Community outreach (general)	Public meeting/ community forum/ health fair	Direct outreach to uninsured	Distribution of enrollment information	Developed a resource guide	Posters and information displayed	Social media	Outreach to business owners
A.2.1 Immunize Children and Adults	X	X	X		X	X	X	X	X	X	X		
A.2.2 HIV/STD Prevention	X	X		X	X	X	X	X	X	X	X		
A.2.3 Infectious Disease Prevention, Epidemiology and Surveillance (Tuberculosis)	X	X	X		X		X	X	X	X	X		
A.3.3 Kidney Health Care		X						X	X		X		
A.3.4 Children with Special Health Care Needs		X						X	X	X	X	X	
A.3.5 Epilepsy and Hemophilia Services	X	X	X					X			X	X	
A.4.1 Laboratory Services													
B.1.2 Women and Children's Health Services (BCCS)	X	X	X		X				X				

DSHS Budget Strategy	Financial eligibility review process	Referral to Healthcare.gov	Referral to ACA Navigator/CAC	Direct assistance with application	Navigator entity, grantee, or navigator trained	Community outreach (general)	Public meeting/ community forum/ health fair	Direct outreach to uninsured	Distribution of enrollment information	Developed a resource guide	Posters and information displayed	Social media	Outreach to business owners
B.1.4 Community Primary Care Services	X	X	X		X				X				
B.2.1 Mental Health Services for Adults	X	X		X	X	X	X	X	X	X	X	X	X
B.2.2 Mental Health Services for Children	X	X		X	X	X	X	X	X	X	X	X	X
B.2.3 Community Mental Health Crisis Services	X	X		X	X	X	X	X	X	X	X	X	X
B.2.4 NorthSTAR Behavioral Health Waiver						X		X	X				
B.3.3 Indigent Health Care Reimbursement (UTMB)	X		X	X		X	X		X		X		
C.1.1 Texas Center for Infectious Disease													
C.1.2 South Texas Health Care System	X	X	X						X		X		
C.1.3 Mental Health State Hospitals	X	X	X						X		X		
C.2.1 Mental Health Community Hospitals	X	X		X	X	X	X	X	X	X	X	X	X