Louisiana State Planning Grant
Interim Report

Submitted to Secretary Michael O. Leavitt
U.S. Department of Health and Human Services
October 31, 2005

Louisiana State Planning Grant
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EXECUTIVE SUMMARY

In September 2004, Louisiana was one of eight states to be awarded a State Planning Grant (SPG) from the Department of Health and Human Services, Health Resources and Services Administration (HRSA). The Louisiana Department of Health and Hospitals (DHH) is the lead agency of the SPG and is responsible for administering the $801,319 grant. The State Planning Grant provides the state the necessary resources to better understand the uninsured and develop coverage options based on the needs and characteristics of the uninsured.

Louisiana has the third highest uninsured rate in the nation. Approximately 866,000 Louisianians do not have health insurance – or one out of every five people. The policy options that are currently under consideration by the state include a range of public and private sector strategies. Additional attention is being paid to adults—where the uninsured rate is the highest (one in four adults are uninsured). However, state discussion is likely to change from this point forward in light of the effects of Hurricane Katrina.

Hurricane Katrina made landfall in Louisiana on August 29, 2005. Most of the affected parishes are located in the New Orleans area—which also comprises nearly a quarter of the state's population. The effects of Hurricane Katrina on the uninsured are not yet known, but the topic will be discussed during the remainder of the grant. Any options to cover the uninsured will factor in the state's current situation.

The Louisiana State Planning Grant has four goals:

1. The Louisiana Department of Health and Hospitals (DHH) and its consultants will collect and analyze quantitative and qualitative data related to the uninsured that will support further development and refinement of options for coverage expansion and assist in building consensus among key stakeholders for the plan to address accessibility of affordable health insurance coverage.
2. DHH will establish a Technical Advisory Committee on Uninsurance to support the Governor's Health Care Reform Panel in its decision making by providing a means for the active participation of diverse stakeholders in the detail work behind any coverage expansion recommendations.
3. The Governor's Health Care Reform Panel, supported by the Technical Advisory Committee on Uninsurance, will review research results and possible coverage expansion options and will recommend to the Legislature and the Governor, action steps to address the accessibility of affordable health insurance coverage.
4. DHH will prepare and submit a report to the U.S. Department of Health and Human Services (DHHS) on Louisiana findings, including its plan for coverage expansion.

Louisiana had already taken steps in better defining its uninsured population prior to the State Planning Grant. The Department of Health and Hospitals commissioned the state's first health insurance survey in 2003. Louisiana State University's (LSU) Public Policy Research Lab conducted the 10,000 household survey between May 15 and October 1, 2003. This survey (Louisiana Health Insurance Survey) is the most comprehensive survey ever conducted on the status of health coverage for Louisiana residents. It provides information on why people are uninsured, how the uninsured get needed medical care, and feedback on proposed state

programs. The state also conducted focus groups on low-income uninsured adults in 2004 to inform the state of the issues facing its largest uninsured demographic.

The previous work by the state laid the groundwork for the State Planning Grant. The State Planning Grant is providing the state the opportunity to further its study of the uninsured. To date, Louisiana has developed four summary reports on previously collected data, conducted a survey of uninsured state employees, refined and improved the LHIS survey instrument, convened a Technical Advisory Group, and developed a website to communicate to the public the issues of the uninsured. Future work will be guided by the new challenges Louisiana faces since Hurricanes Katrina and Rita.

This Interim Report, as required by HRSA, will provide an update on the progress of the goals of the grant to date. Additionally, questions specifically posed by HRSA will be answered. The Louisiana State Planning Grant will conclude by August 31, 2006.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

Overview

Louisiana is a mid-sized state, with its population numbering 4.4 million and ranking 24th in size among states.[i] It is geographically and culturally diverse, with Interstate 10 being the dividing line between fishermen, and crawfish, rice and sugar cane farmers on the one side and timber and cotton interests on the other. Louisiana also has one of the highest rates of uninsured—twenty percent of the state's population is uninsured.

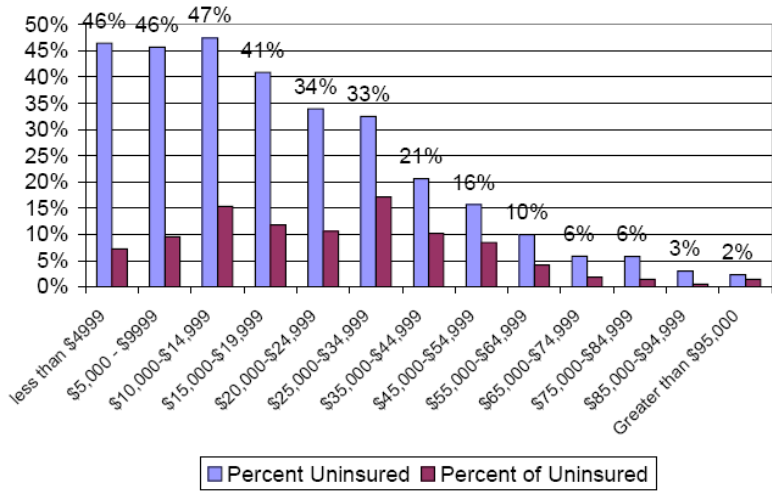
The state has a number of data resources to inform policy decisions, including the Current Population Study (CPS), the Medical Expenditure Panel Survey – Insurance Component (MEPS-IC), and the Louisiana Health Insurance Survey (LHIS). CPS data is the primary source in answering the questions below. When CPS data is not used, an alternate data source is noted.

1.1Overall level of uninsured in Louisiana

The rate of the uninsured in the state of Louisiana is 20%, which is 4% above the U.S. average of 16 %.

1.2 Characteristics of the Uninsured

Figure 1: Uninsured Louisiana Residents, 19-65, by Household Income (LHIS)



Income

Sixty-nine percent of uninsured non-elderly adults are low-income (200% or less of the Federal Poverty Level). Forty-two percent are below the federal poverty level. As indicated in *Figure 1*, the lower the income, the more likely residents lack health insurance coverage.

Age

The majority of the uninsured in Louisiana are non-elderly adults. Approximately 80% of all uninsured Louisianans fall into the 19-64 age group, while the remaining 20% are 18 years and under. The uninsured can be further broken into the following age groups:

- 14.7% are 1-14 years;
- 6.6% are 15-18 years;
- 54.8% are 19-44 years;
- 23.4% are 45-64 years; and
- 0.5% are 65 years or older.

Gender

The uninsured in Louisiana are nearly evenly split between male and female. Men account for 48.4 percent of the uninsured and women account for 51.6 percent of the uninsured.

Family Composition

Less than half (42.3%) of the uninsured population is married. Over 40 percent of families are headed by a single female, while 16.2% of families are headed by a single male.

Health Status

According to the LHIS, the uninsured are less likely to report excellent or very good health status when compared to the insured. Approximately 50 percent of uninsured respondents classified their health status as "excellent" or "very good," while over 65 percent insured respondents reported "excellent" or "very good" health status. As indicated in *Figure 2*, uninsured respondents were also more likely than insured respondents to report "fair" or "poor" health status.

Figure 2: Self-Reported Health of Household Members by Insurance Status *(LHIS)*

	All Residents		Insured		Uninsured	
	Percent	Number	Percent	Number	Percent	Number
Excellent	37.5	1,675,900	39.5	1,433,400	28.7	241,100
Very Good	25.8	1,153,000	26.4	958,000	22.9	192,400
Good	23.2	1,036,800	22.2	805,600	28.3	238,800
Fair	9.6	429,000	8.4	304,820	15.2	127,700
Poor	3.8	169,800	3.5	127,000	5.0	42,000

Availability of Private Coverage

Most Louisianians (52%) obtain coverage through employer sponsored insurance (ESI) or the individual market. This is slightly less than the national average of 59 percent. According to MEPS-IC data, 50 percent of all establishments in Louisiana offer health insurance coverage and nearly 85 percent of employees work at one of those establishments. Over 59 percent of the employees at establishments that offer health insurance enroll in coverage.

Availability of Public Coverage

Louisiana's Medicaid Program provides coverage to approximately 16% of the state's population. Generally, Medicaid coverage is available for low-income children and pregnant women. Coverage is more limited for adults—parents must have incomes below 13% of the Federal Poverty Level (FPL) and childless adults are not eligible for Medicaid coverage unless they are disabled. A complete listing of Medicaid eligibility and coverage appears in Appendix I. Twelve percent of the state's population is enrolled in Medicare.

Employment Status

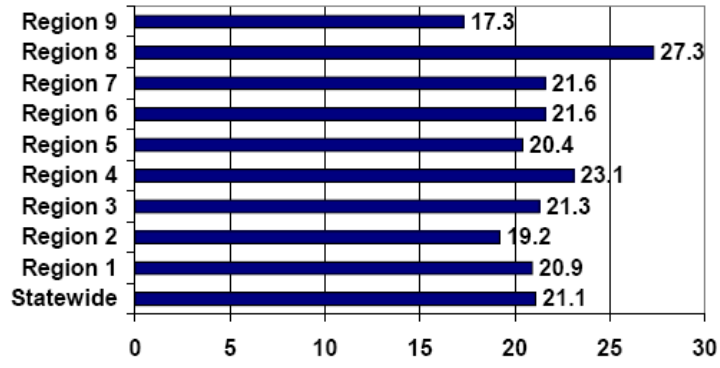
The majority (57.8%) of the uninsured are employed, which is slightly lower than the national average (60.5%). According to LHIS, 17.5 percent of the uninsured are self-employed; the majority of the working uninsured work for an employer. Another key fact about the working uninsured is that nearly 70 percent are not salaried employees—but hourly employees.

Since Hurricane Katrina hit, Louisiana's unemployment rate has doubled to 11.5 percent.[ii] The direct impact on the working uninsured is unknown but it is anticipated that it will affect the percentage of working uninsured.

Race/Ethnicity

Generally speaking, Louisiana's population is 63 percent white and 32 percent black. The remaining five percent of the population is classified as Hispanic (3%) or other. Nearly 52 percent of the uninsured are white and almost 44 percent of the uninsured are black. Hispanics account for about four percent of the uninsured. The interesting comparisons are made against national statistics. There is little difference in the uninsured rate of whites, but the uninsured rates differ greatly for blacks and Hispanics. Nationally, 15.1 percent of the uninsured are black and nearly 30 percent are Hispanic, compared to 44 percent black and 4.3 percent Hispanic in Louisiana.

Figure 3: Uninsured Adults (19-65) by Region *(LHIS)*



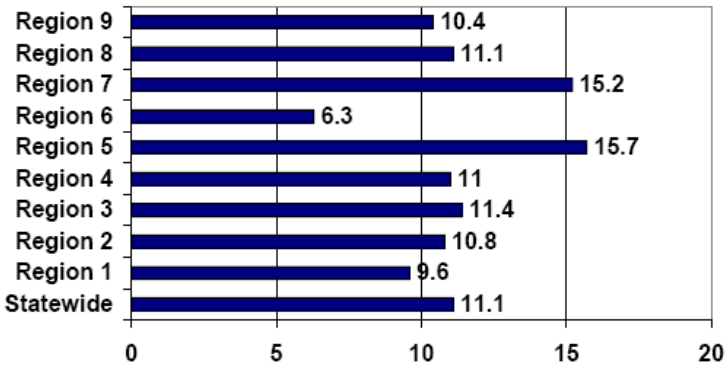
Immigration Status

Nearly all Louisianians are native born. The uninsured consist mostly of native born (95.7%) and foreign born (3.2%).

Geographic Location

Louisiana has 8 metropolitan areas in the state and four in five people live in metropolitan areas across the state. The Department of Health and Hospitals divides the state into 9 regions. A map detailing the regions is in Appendix IV.

Figure 4: Uninsured Children (under 19) by Region *(LHIS)*



The bulk of the State's population lines the I-10 corridor which runs east to west, from New Orleans to Lake Charles. Fully one-quarter of all State residents live in the New Orleans area alone, with Orleans, Jefferson and St. Tammany Parishes accounting for more than a million residents. The cities and towns to the west of New Orleans along I-10, namely Baton Rouge, Lafayette and Lake Charles, claim almost another million.

The parishes in the central and northern Louisiana are far less populated by comparison, with the largest parishes (Bossier, Caddo, Ouachita, and Rapides) containing the largest cities (Shreveport, Monroe, and Alexandria) and claiming close to a half million residents between them. Nearly half of Louisiana's 64 parishes have populations of less than 25,000, and nearly all of these parishes are located in the central and northern part of the State.

Before Hurricane Katrina made landfall, the two heaviest populated regions were New Orleans (region 1) and Baton Rouge (region 2). The New Orleans area was home to quarter of the state's population—its current population is unknown. The Baton Rouge area still has one of the largest populated areas due to the addition of a large number of people that evacuated to Baton

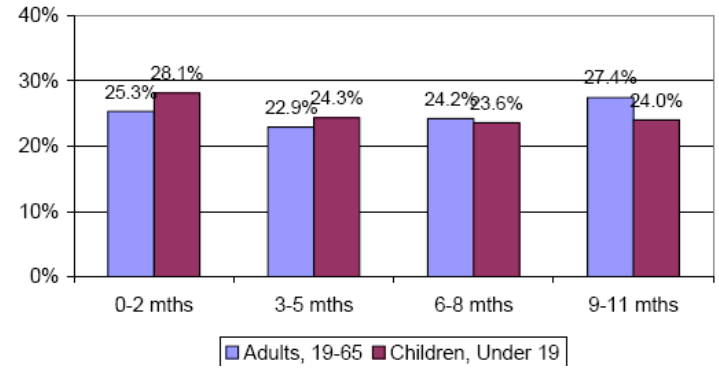
Rouge from New Orleans.

LHIS estimates breakdown uninsured adults and children from each region in the state. Region 8 has the highest rate of uninsured adults (27.3%) and Region 9 has the lowest rate at 17.3 percent uninsured. The highest rate of uninsured children is in Region 5 (15.7%) and the lowest rate is reported in Region 6 (6.3%). Complete breakdowns of the uninsured by region are in *Figures 3* and *4*.

Duration of Insurance

To understand the scope of uninsurance, the LHIS asked insured respondents whether or not they had maintained continuous coverage for twelve months. Approximately six percent of the insured respondents experienced a lapse in coverage. Interestingly, as shown in *Figure 5*, the duration of uninsurance is nearly equal across timeframes. This indicates that there is no common bare period and that coverage options for short and long-term bare periods may be necessary.

Figure 5: Months Without Continuous Health Insurance Coverage (LHIS)



Other

Education

According to data collected from the Louisiana Health Insurance survey, 39.7% of the uninsured have less than a high school education, 26.2% have a high school education, and at least 34.8% has had some college education or beyond.

State Employees

Preliminary data from the survey of uninsured state employees reveals that over a third of state employees who do not participate in the state's health insurance coverage program (Office of Group Benefits – OGB) do receive health insurance coverage under a spouse's policy; about a tenth of those employees participate in the individual market. Nearly a third of state employees that do not participate in OGB are uninsured. Affordability is cited as a primary reason for not taking up coverage. The draft survey instrument is in Appendix V.

Uninsured Parents of Medicaid and SCHIP Kids

Parents of Medicaid and SCHIP kids are a group for which the Department of Health and Hospitals (DHH) has substantial data, which is collected in order to establish eligibility for their children. Parents with incomes between 13% and 200% of the FPL constitute a significant percentage of Louisiana's uninsured population. There were 250,145 non-Medicaid eligible parents between the ages of 19 and 64 in households with Medicaid and SCHIP children according to January 2004 DHH data. This represents 38.6% of all Louisianans from ages 19 through 64 who are uninsured, and 29.0% of all non-elderly uninsured Louisiana residents. An issue brief summarizing the data on uninsured parents of Medicaid and SCHIP kids is in Appendix VI.

1.3 What population groupings were particularly important for your State in developing target coverage expansion options?
This question will be addressed in the Final Report

1.4 What is affordable coverage?
Individuals surveyed under the LHIS provided estimates of what they would be willing to pay per month for health insurance. For single coverage insurance, 21.6% felt that $25 was the limit they would be willing to pay on insurance. Approximately 24% responded that $25-$49 was an affordable amount to pay for coverage; 25.9% were willing to pay $50-$99; and 19.15% responded that $100-$150 would be reasonable for them to purchase insurance.

Questions 1.5-1.10
These questions will be addressed in the Final Report

1.11 How are the uninsured getting their medical care needs met?
It is more common for the uninsured to receive medical care in a clinic (29.3%) or outpatient clinic (18.5%) than from a doctor's office, according to the LHIS. Only 41 percent of uninsured Louisianans receive their regular medical care from a doctor's office versus over 60 percent of the insured. Only 5.6 percent of uninsured reported using the emergency room for medical care.

There are 10 State-owned public hospitals in Louisiana that are operated by the Louisiana State University (LSU) Health Sciences Center. This system primarily serves low-income and uninsured patients. About half of the uninsured population reported utilizing the LSU charity hospital system in a twelve month period; 76 percent say the charity system is their primary source of care. Only 17 percent of the insured reported utilizing the charity system for care.

A series of focus groups on the low-income uninsured was conducted in 2003 to guide the state's HIFA waiver development process. According to the final report, participants reported that they relied on a vast array of formal and informal supports for assistance in paying for medical care. Most of the participants also reported that they would change their health care related behavior if they did have health insurance. For example, participants said they would be more likely to seek care and address longstanding health issues if they had health insurance. The response for the focus group participants suggests that the health care needs of the uninsured are not being met. A summary of the focus group report appears in Appendix VII.

Questions 1.12 – 1.13
These questions will be addressed in the Final Report

SECTION 2. EMPLOYER-BASED COVERAGE

Overview
Historically, Americans rely on employer based coverage as the source for obtaining health insurance coverage. Forty-seven percent of Louisianians receive health care coverage through an employer. Furthermore, most Louisianians are employed by small businesses—which are less likely than larger businesses to offer health insurance.

Most employer information related to coverage is obtained through MEPS-IC data. Additional information comes from the LHIS, although it is from the employee perspective. To gain a better understanding of employer based coverage, the state will conduct a series of employer focus groups that represent the diversity of the state's employer population by industry, firm size, and geography. Through the focus groups, the state will gain a better insight of the barriers employers face in offering health insurance and the impact of uninsurance on businesses. Additionally, the state will use the focus groups to solicit input on potential coverage options and their viability.

This section answers the basic questions regarding characteristics of firms that do and do not offer health insurance coverage. Further detail will be developed through the focus groups and will be reported in the Final Report.

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Employer Size

There are over 90,000 private sector establishments in Louisiana, according to 2003 MEPS-IC data. The majority (74.9%) of these businesses are small businesses—or have less than fifty employees. About seven percent of businesses have 100-999 employees and nearly 15 percent employ over a thousand employees.

Industry Sector

According to the Louisiana Department of Labor's *Employment and Wages 2003 Annual Report*, the primary industries in the state are: health care and social assistance; retail trade; educational services; and accommodation and food services.

Uninsured specific industry data is also obtained through CPS data. Over forty percent of the uninsured are classified as "not eligible," meaning they are either children or nonworkers. The top industries for the working uninsured are: construction (9.3%), educational and health services (9.1%), leisure and hospitality (8.3%), and wholesale and trade (7.6%). The top industries for the working insured differ: educational and health services (10.4%), wholesale and trade (6.7%), professional and business services (4.2%), manufacturing (3.7%), and financial activities (3.7%).

Employee Income Brackets

Establishments with a higher number of full-time, higher wage employees have a greater chance of offering coverage in Louisiana. 55.9 % of establishments that have 75% or more full-time workers offer coverage, while 45.7% of establishments with less than 50% of its workforce qualifying as full-time offer coverage. Only 35.6% of all establishments offer coverage when 50% or more of its workforce is listed as low wage. Only 52% of the state's population is currently enrolled in a private coverage plan whether it is employer sponsored or individual.

Percent of Part-Time Workers

A quarter of the working uninsured, or about 126,664 people, are employed part-time. This is significantly lower than the working insured—where only sixteen percent are employed part time. This is particularly relevant because only about 50 percent of part-time employees are

eligible for health insurance coverage in private firms.[iii] Furthermore, less than half (48.3) of part-time workers eligible for coverage actually enroll. Comparatively speaking, 86 percent of full-time employees are eligible for health insurance in private firms and about 80 percent of those employees enrolled in coverage.

Cost of Policies
Average total single premium (in dollars) per enrolled employee at establishments that offer health insurance is $ 3,317.22. Average total family premium (in dollars) per enrolled employee at establishments that offer health insurance is $8,734.99. (MEPS-IC, 2003)

Level of Contribution
Single coverage employer contribution is 81% compared to U.S. average of 83%. Family coverage employer contribution is 70% compared to U.S. average of 75%.

Percent of Employees Offered Coverage Who Participate
According to MEPS-IC, in 2003, 84.7% of employees worked at firms that offered health insurance. About 75 percent of employees of firms that offer health insurance are eligible for coverage. Nearly sixty percent (59.1%) of the eligible employees actually enroll in health insurance coverage.

Questions 2.2 – 2.7
These questions will be addressed in the Final Report

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

Overview
In planning a comprehensive strategy to cover the uninsured, it is important to understand the current health insurance marketplace. This is because any successful strategy (or set of strategies) to cover the uninsured will likely involve the use of existing public and private coverage mechanisms to some degree. Other sections in this report discuss the extent of public and private coverage in Louisiana, but this section looks at such environmental factors as the makeup of the health insurance industry and health insurance products available across the state.

To date the State of Louisiana has not undertaken an exhaustive study of the health insurance marketplace throughout the State. Therefore, rather than being a detailed review, the information presented in this section is a preliminary overview of the health care marketplace in Louisiana based on publicly available information. It is worth noting that the marketplace as it exists today is subject to change as the full effects of Hurricane Katrina on the State's economy become known.

The information presented in this chapter covers:
- Commercial insurers in the State;
- Managed care, in both the public and the private sectors;
- Coverage of public employees;
- Louisiana's high-risk pool; and
- Legislative initiatives that may affect the market in the future.

In addition, there is a brief discussion of areas for further study in the future.

Commercial Insurers

The commercial insurance marketplace in Louisiana is dominated by a small number of carriers. According to total premium revenue data provided by the Department of Insurance, in 2004 Blue Cross captured 27.8% of the market share, and Humana had 17.2%. As can be seen from Table 1 on the following page, the top 5 carriers together (two of which are Blue Cross companies) account for more than 65% of total premium sales.

It is not known whether this distribution is typical across states, or whether this creates special advantages or disadvantages to Louisiana when devising strategies to cover the uninsured. Such questions are possible topics for further study as the SPG activities continue in the coming year.

Table 1: 2004 Premium Revenues and Market Share for Top 20 Carriers[iv]

COMPANY NAME	HOME STATE	TOTAL PREMIUM REVENUE	MARKET SHARE	CUMULATIVE MARKET SHARE
LA Health Service & Industry Co. (aka Blue Cross)	LA	1,214,945,375.00	27.81%	27.81%
Humana Health Benefit Plan of LA Inc.	LA	753,365,458.00	17.24%	45.05%
Tenet Choices Inc.	LA	326,559,172.00	7.47%	52.52%
Hmo LA Inc. (owned by Blue Cross)	LA	276,677,646.00	6.33%	58.85%
United Healthcare Insurance Co.	CT	270,777,349.00	6.20%	65.05%
Coventry Health Care of LA Inc.	LA	208,753,870.00	4.78%	69.83%
United Healthcare of LA Inc.	LA	95,125,929.00	2.18%	72.01%
American Family Life Assurance Co. of Columbus	NE	60,456,665.00	1.38%	73.39%
Health Plus of LA Inc.	LA	53,366,708.00	1.22%	74.61%
Vantage Health Plan Inc.	LA	43,414,339.00	0.99%	75.60%
Unum Life Ins. Co. of America	ME	42,102,075.00	0.96%	76.57%
Metropolitan Life Ins. Co.	NY	39,321,535.00	0.90%	77.47%
Aetna Life Ins. Co.	CT	34,001,567.00	0.78%	78.25%
State Farm Mutual Auto Ins. Co.	IL	33,950,943.00	0.78%	79.02%
Physicians Mutual Ins. Co.	NE	31,095,792.00	0.71%	79.73%
Colonial Life & Accident Ins. Co.	SC	30,697,922.00	0.70%	80.44%
Sterling Life Ins. Co.	IL	29,887,190.00	0.68%	81.12%
New York Life Ins. Co.	NY	28,838,485.00	0.66%	81.78%
Fortis Benefits Ins. Co.	IA	19,983,793.00	0.46%	82.24%
State Mutual Ins. Co.	GA	16,979,562.00	0.39%	82.63%

Managed Care

In Louisiana, the extent of managed care penetration has historically been very different in the public sector compared to the private sector. Overall, the penetration is low. On the public side, Louisiana has never enrolled Medicaid beneficiaries in traditional capitated managed care. In 1994, the State prepared a proposal for a section 1115 Medicaid demonstration that, if approved, would have enrolled the bulk of the State's Medicaid enrollees in managed care organizations. However, the proposal was never approved. This was largely because of financing concerns.

However, the state has successfully implemented a primary care case management (PCCM) program called CommunityCARE for the Medicaid program. This model also provides care in the State's Children's Health Insurance Program, called LaCHIP. This system uses managed care principles in that enrollees are required to select a primary care provider who coordinates their care. Reimbursement is provided on a fee-for-service basis and a monthly care management fee is also provided.

On the private side, the picture is very different, with commercial insurance carriers offering a range of managed care options through employers. The Medical Expenditure Panel Survey Insurance Component (MEPS-IC) collects data on the types of products offered by employers who offer coverage to their workers. MEPS-IC looks at two types of managed care arrangements: "exclusive provider" organizations (e.g., health maintenance organizations), where enrollees are required to use a closed network of providers; and "preferred provider" organizations, where enrollees may use any provider, but there is a cost incentive to use a particular network of providers.

In 2003, of all firms offering health care coverage in the U.S., 91% offered at least one managed care option. Exclusive provider organizations were offered in 38.4% of the firms offering coverage, and preferred provider organizations were offered in 67.4% of the firms.

The proportion of firms offering managed care products as one of their options in Louisiana is higher than the U.S. average. Of Louisiana firms that offer health insurance coverage, 93.9% offer at least one managed care product. A total of 29.4% of the firms that offer coverage have an exclusive provider organization arrangement as part of their offerings, and 76.8% of the firms offering coverage have a preferred provider organization option.[v] Therefore, the proportion of Louisiana firm offering managed care in some form is higher than the national average. However, the offerings are more likely to be in the form of preferred provider organizations than exclusive provider organizations when Louisiana is compared to the nation as a whole.

Public Employees

No discussion of the health coverage marketplace is complete without mention of public coverage. Besides the Medicaid and LaCHIP programs discussed elsewhere in this report, the State of Louisiana plays an important role in the health coverage marketplace as a purchaser of group coverage for public employees.

The Office of Group Benefits (OGB) administers life and health benefits for state employees, participating school boards, and certain political subdivisions. More than 130,000 employees are

enrolled in these programs. When spouses and dependents are counted, more than 245,000 individuals are covered by OGB.

Unlike most other states, Louisiana's public employee health benefits are both self-funded and self-administered (Utah is the only other state that has a public employees program that is both self-funded and self-administered). As is the case with many other large employers, OGB offers a range of coverage options. There are fully-insured HMOs, whereby OGB pays a monthly premium to the Ochsner and Vantage health plans. In addition, there are self-insured managed care arrangements—both a preferred provider organization and an exclusive provider organization.

High-Risk and HIPAA Pools

One option available for individuals who are unable to obtain insurance through traditional means is the Louisiana Health Plan (LHP), which provides a comprehensive benefit package. The LHP was created during the 2000 Legislative session and includes two pools: a State-subsidized high-risk pool to provide affordable coverage for individuals who cannot obtain health insurance due to pre-existing conditions, and the HIPAA individual market portability option.

The LHP functions as an indemnity insurance product and offers a range of premium/deductible combinations that vary by region and tobacco usage. As is the case in many states, enrollment in the pools administered by the LHP is low, due mainly to the cost to the enrollee. The State is attempting to lower the cost for low-income individuals by securing an infusion of federal funds for the LHP through a Health Insurance Flexibility and Accountability (HIFA) waiver.

Legislative Initiatives

There have been some past legislative initiatives aimed at changing the health insurance marketplace to one degree or another. The first, referred to as the Louisiana Safety Net Health Insurance Program, authorized in 2003, allows the State's self-insurance program and qualified private insurers to offer "minimal benefit hospital and medical insurance policies" that would not be comprehensive, major medical policies. These policies would be exempt from state benefit mandates. Private insurers may offer policies only to small employers who have not recently offered coverage and employers of low-income workers, provided that the employer pays at least half of the employee premium and enrolls at least half of eligible employees. Policies must preclude "balance billing" by providers and may be offered in conjunction with employer-funded personal care accounts that are not taxable to the employee. To date, this program has not been implemented. It remains to be seen whether there is any renewed legislative or carrier interest in this initiative in the aftermath of Katrina.

While the Safety Net initiative sought to influence the marketplace itself by opening it to so-called "bare bones" policies, the LaChoice program, also created by the Legislature in 2003, came at the issue of uninsurance from the employer perspective. Under LaChoice, the State will create a pilot health insurance program aimed at increasing the number of small employers who provide health insurance by making coverage more affordable. The "LaChoice" concept was developed by the Louisiana Health Care Commission, Subcommittee on Covering the Uninsured, in consultation with Dr. Kenneth Thorpe of Emory University. In order to be eligible, employers must not previously have offered group insurance for six months, have a workforce

that numbers less than 50 and have at least one-third low-income workers, and pay at least half of the employees' premium. LaChoice is also a component of the State's HIFA waiver proposal.

Areas for Further Study
This section discusses questions the State of Louisiana intends to explore during the extension period for the SPG. This is intended to be a preliminary list of questions. As the SPG activities continue, the state may identify additional areas of interest.

The fundamental area of focus in the short term will be around the area of the impact of the recent natural disaster on the state's health coverage marketplace. Given that Louisiana is a state already dominated by a relatively small number of carriers, it may be that becomes even more the case if the other carriers that have gained a foothold are unable to continue because of Hurricane Katrina's impact on its customers. Connected to this will be an analysis of whether the marketplace in Louisiana is markedly similar to or different from that in other states in terms of the concentration of business in a relatively small number of carriers.

In addition, it is unclear at this point what impact Katrina will have on the individual marketplace. Surely there will be more uninsured individuals as a result of the disaster, provided they stay in the State. Financial pressures may preclude their purchase of individual health insurance policies, however. As of the writing of this interim report, it remains to be seen whether the assistance that may be offered through possible Congressional action will make it possible for these individuals to maintain their coverage.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

Overview
The state is still reviewing and assessing options to expand coverage. To guide the process, the state has convened a Technical Advisory Committee of key stakeholders. The TAC has developed a set of Guiding Principles to aide in the decision-making process. The four overarching guiding principles by which the TAC will evaluate the appropriateness of each potential approach are:

- Decisions about which approaches to use must be data-driven;
- Optimum approaches will use a mixture of financing sources;
- Priority should be given to approaches that foster improvement in health care quality; and
- The coverage approaches should be designed with evaluation in mind.

The complete set of Guiding Principles is in Appendix VIII.

To best inform the TAC, presentations and other information detailing the demographics of the uninsured and various potential coverage strategies has been provided by SPG staff. Additionally, SPG staff prepared a Background Paper on the Uninsured, which is in Appendix IX. The TAC has broken into smaller groups to discuss in detail coverage options; official work groups will also be established. A brief listing of the options under consideration is below.

4.1 Which coverage expansion options were selected by the State?

The state is currently considering several coverage options, including:

- Bare-bones / limited benefit policies
- Group purchasing arrangements
- Extension of state continuation period
- Expansion of definition of dependent
- Individual market reforms
- Small group market reforms
- Employer mandates
- Individual mandates
- Expansion of state employee health plan
- Premium assistance
- State-funded reinsurance
- State-local initiatives
- Public coverage expansions (Medicaid and SCHIP)

4.2-4.19
These questions will be addressed in the Final Report

SECTION 5. CONSENSUS BUILDING STRATEGIES

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure?
The key components of the governance structure are the Governor's Health Care Reform Panel, the Technical Advisory Committee (TAC), and SPG Grant support staff. The Governor's Health Care Reform Panel is comprised of 29 influential individuals appointed by the Governor (e.g., Secretary of the DHH, the Governor's Commissioner of Administration; key legislative leaders; national health care experts and representatives of regional health care reform efforts) and is responsible for considering the options for expanding coverage and will make the final recommendations to the Governor and Legislature to address accessibility of health insurance coverage.

The TAC, representing key stakeholders in the area of health care coverage and uninsurance, provides guidance to DHH on SPG related activities; review results of data collection and analysis; assess the feasibility of various options; and develop a set of recommended action steps to address the accessibility of affordable health insurance coverage for Louisiana's uninsured citizens. Finally, the SPG project director, along with the SPG project manager, will serve as the primary staff support to the TAC and the Panel for this initiative. The combination of these three components provides a broad-based panel of interested parties backed up with the staff support needed to follow-up on questions and recommendations that arise during the course of the proceeding.

Please refer to Appendix X for a chart on the governance structure.

5.2 What methods were used to obtain input from the public and key constituencies?
The primary source for obtaining input from the public and key constituencies is through the Technical Advisory Committee. Another source is the Health Care Reform Panel quarterly

meetings. The issue of the uninsured has been a main topic for at least three of the Panel meetings. All Panel meetings are open to the public. Additionally, the meetings are aired on a local television network and meeting transcripts are made available to the public through the DHH website.

The Louisiana Health Insurance Survey (LHIS) is also a source for public input. The first LHIS was conducted in 2003 and the second LHIS is near completion. The LHIS surveys over 10,000 Louisiana households and is the most comprehensive assessment of the uninsured for the state. Questions ranging from affordability of health insurance to interest in pilot coverage programs have been included in the LHIS. The survey instrument may be viewed in its entirety on the DHH website (http://www.dhh.louisiana.gov/reports.asp?ID=119&Detail=29).

Further input from the public and key constituencies will be gathered during the remainder of the grant.

5.3 What other activities were conducted to build public awareness and support?
The Louisiana State Planning Grant developed and maintains a website in order to inform the public and the TAC members of the work of the State Planning Grant. The website is part of the Health Care Reform section of the Department of Health and Hospital's website. The website provides information on the goals and activities of the grants, TAC meeting minutes, resources on the uninsured, and SPG grant reports.

5.4 How has this planning effort affected the policy environment?
The state is currently focused on recovery efforts related to Hurricanes Katrina and Rita. It is unknown if coverage expansion proposals will be implemented. Currently, the Congressional Budget Office estimates state revenue losses at $3 billion since Hurricanes Katrina and Rita. Given the likely budget situation, it will probably be difficult to implement coverage expansion proposals. However, the state is proceeding with obtaining approval of its HIFA and Family Planning waivers.

Please refer to Appendix XI for a fact sheet on the HIFA waiver and Appendix XII for a fact sheet on the Family Planning waiver.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES
This section will be addressed in the Final Report.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT
This section will be addressed in the Final Report.

APPENDIX I.
BASELINE INFORMATION

Population:
Louisiana's estimated population count from the 2002-2003 US Census Bureaus was 4,515,770.

Number and percentage of uninsured:
According to the US Census Bureau, the 2002-2003 uninsured population was 866,390 with an uninsured rate of 20% for the total population count.

Average age of population:
The average age of Louisiana residents during the 2002-2003 US Census was 35.1.

- Children 18 and under 1,249,080 28%
- Adults 19-64 2,639,710 60%
- Adults 65+ 525,280 12%
- Adults 65-74 299,640 7%
- Adults 75+ 225,640 5%

Percent of population living in poverty:
In 2002-2003, 22% of all Louisianans lived at 100% of the federal poverty level.

- 31% of children 18 and under lived at or below the poverty level
- 19% of adults 19-64 lived at or below the poverty level
- 16% of adults 65+ lived at or below the poverty level

Forty-two percent of the non-elderly uninsured are below the poverty level.

Primary industries:
According to the Louisiana Department of Labor, the primary industries are: health care and social assistance; retail trade; educational services; and accommodation and food services.

Number and percent of employers offering coverage:
CPS data reveals that 34.9% of the firms with fewer than 50 employees offer coverage, while 94.8% of the firms with 50 employees or more offer insurance coverage.

Number and percent of self-insured firms:
According to 2003 MEPS-IC data, 31.7 percent of private sector firms (that offer health insurance) self-insure at least one plan.

Payer mix:
The 2002-2003 Current Population Survey show the following population distribution for insurance status.

- 47% -Employer
- 5% -Individual
- 16% -Medicaid
- 12% -Medicare
- 20% -Uninsured

Provider competition:
This question will addressed in the Final Report

Insurance market reforms:
This question will addressed in the Final Report

Eligibility for existing coverage programs (Medicaid/SCHIP/other):

Louisiana Medicaid Eligibility Groups and Coverage

Category	Eligibility Tests	
	Income	**Resources**
1. Low-income families & children	(1) $72 (2) $138 (3) $190 (4) $234 (5) $277	NONE
2. CHAMP Children		
Ages 1-6	133% FPL	NONE
Ages 6-18	100% FPL	NONE
3. LaCHIP (SCHIP)	200% FPL	NONE
4. Transitional Medicaid (§1925)		NONE
5. Pregnant Women	133% FPL	NONE
LaMOMS	185% FPL*	NONE
* 15% 1902(r)(2) disregard		
6. Families and Children Regular and Spend-Down Medically Needy	(1) $100 (2) $192 (3) $258 (4) $317 (5) $375	NONE
(Income increased $50 per person for larger households)		
7. SSI Recipients	$579 (FBR)	$2000/$3000
8. QMBs	100% FPL	$4000/$6000**
9. SLMBs	120% FPL	$4000/$6000**
10. Qualified Individuals (QIs)	135% FPL	$4000/$6000**
11. QDWIs	200% FPL	$4000/$6000**
12. Special Income Level (spousal resource max $95,100)	$1737/$3474	$2000/$4000**
13. Extended Medicaid groups	SSI FBR	$2000/$3000

(disabled and early widows, widowers, DACs, 4913 children, pickles (COLA))		
14. TB infected individuals	SSI FBR	$2000/$3000**
15. Breast & cervical cancer women (declared income < 250% FPL at CDC screening)	NONE	NONE
16. TWWIIA (basic coverage) coverage for individual only; no spouse to spouse deeming *countable income is compared to this after applying the standard SSI income disregards	250% FPL*	$25,000
17. SSI Medically Needy Spend-down	(1) $100 (2) $192	$2000** $3000**

** The State allows a $10,000 burial fund exclusion, and a cash surrender value exclusion of all life insurance policies with a face value of $10,000 or less.
Note: Eligibility and Coverage is reported as effective on August 24, 2005

Use of Federal waivers:
A complete listing of existing Medicaid waivers for Louisiana is provided on the Centers for Medicare and Medicaid Services website at http://www.cms.hhs.gov/medicaid/waivers/lawaiver.asp.

Additionally, Louisiana submitted a HIFA waiver on July 19, 2005 and a Family Planning Waiver on September 9, 2005. Additional information regarding the HIFA waiver is in Appendix XI; additional information regarding the Family Planning waiver is in Appendix XII.

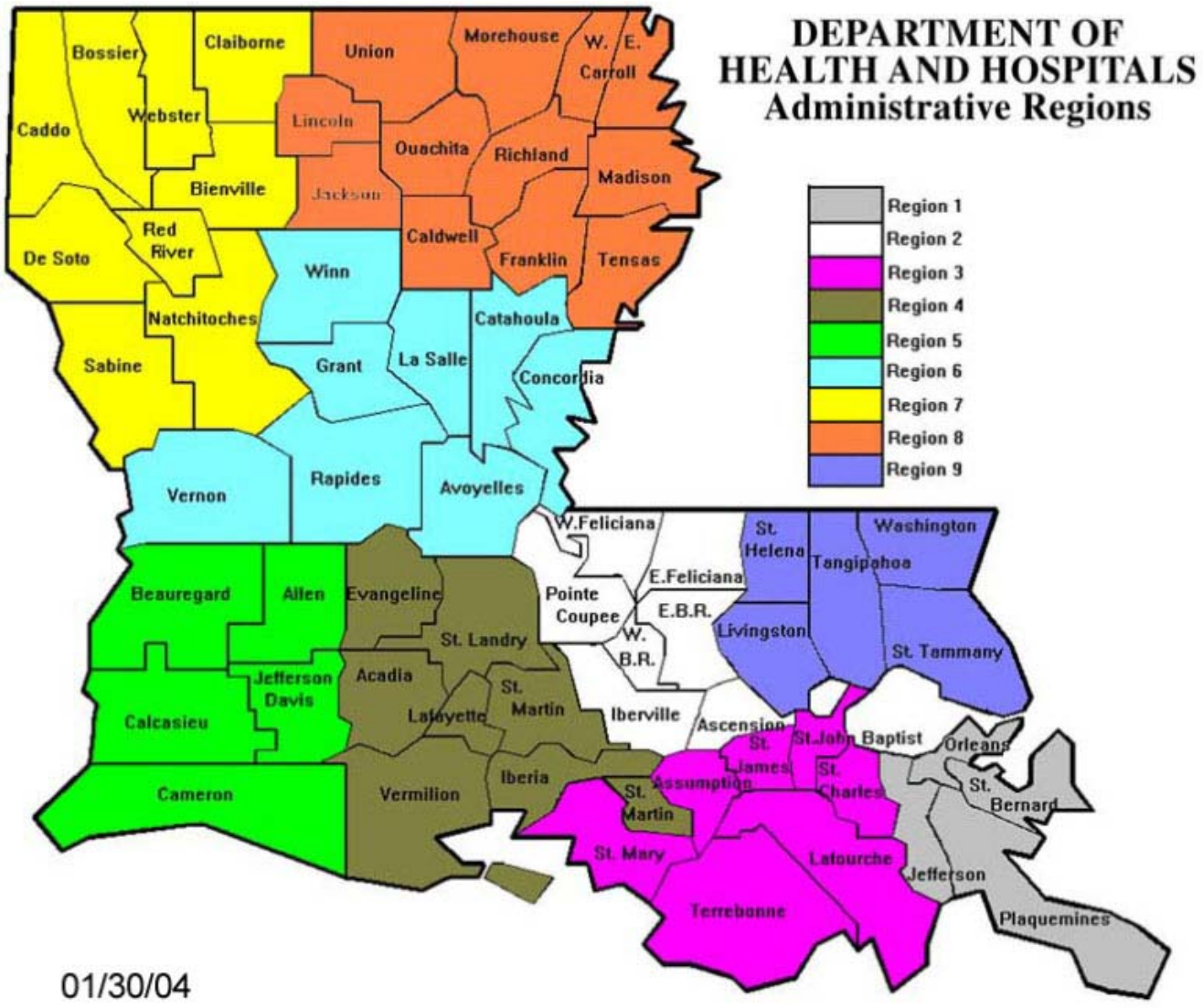
APPENDIX II.
LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Additional information regarding the work of the Louisiana State Planning Grant may be found at the Louisiana State Planning Grant website: http://www.dhh.louisiana.gov/offices/?id=168.

APPENDIX III.
SPG SUMMARY OF POLICY OPTIONS

This section will be addressed in the Final Report. Please refer to Section 4 of the Interim Report to review proposed policy options that the state is considering.

APPENDIX IV
DHH REGIONS MAP



APPENDIX V
SURVEY INSTURMENT FOR THE SURVEY ON UNINSURED STATE EMPLOYEES

Survey of Uninsured State Employees
Survey Instrument
DRAFT

Hello, I am calling from Public Policy Research Lab. We are conducting a survey to determine the type of health care insurance used by state employees and teachers. The survey will only take 5 minutes to complete and all responses will remain strictly CONFIDENTIAL.

Would you be willing to participate?

Firstly, are you a state employee who participates in one of the programs offered by the Office of Group Benefits?

Please indicate below the type of health care coverage you have.
[If you have no health care coverage, please code appropriately below]

1 Insurance through spouse
2 Individual policy
3 Medicare
4 Medicaid/LACHIP
5 Tri-Care/CHAMPUS
6 No health insurance
7 Other (specify)

-8 Don't Know
-9 Not Available

How many people, including yourself, live in your household?

How many OF THESE ARE 18 or younger?

How many members of your HOUSEHOLD are covered by insurance?

Are there any members of your family that do have one of the forms of insurance I mentioned above or a government program for children like LACHIP?

How many adults (age 19 and older) are covered?

How many children (under 19) are covered?

"Is there a particular PLACE that you go to if sick or need medical care?"
What kind of place is it?

1 Private doctor
2 Hospital/emergency room
3 Clinic
4 Parish health unit
5 Other (specify)

How many years have you been employed by a state agency?

How long it has been since you last had coverage?

What is the main reason that you do not have health insurance?

1 Medical problems/pre-existing condition
2 Too expensive/can't afford it/premium too high
3 Don't believe in insurance
4 Don't need insurance/usually healthy
5 Free or inexpensive care is readily available
6 Other (specify)

What is your best estimate of how much you would be willing or able to pay per month for health insurance coverage for just yourself?

1 LESS THAN $25
2 $25-$49
3 $50-$99
4 $100-$150
5 $150-$200
6 More than $200

What is your best estimate of how much you would be willing or able to pay per month for health insurance coverage for all uninsured members of the household?

1 LESS THAN $25
2 $25-$49
3 $50-$99
4 $100-$150
5 $150-$200
6 More than $200

For everyone who lives here that is related to you by blood, marriage or adoption from all sources, what is the gross (before taxes) yearly family income? Your best guess is fine. This information is will be used only for statistical purposes and it confidential.

1. Less than $4,999
2. $5,000 to $9,999
3. $10,000 to $14,999

4. $15,000 to $19,999
5. $20,000 to $24,999
6. $25,000 to $34,999
7. $35,000 to $44,999
8. $45,000 to $54,999
9. $55,000 to $64,999
10. $65,000 to $74,999
11. $75,000 to $84,999
12. $85,000 to $94,999
13. $95,000 or more

Thanks for your time. We are surveying state employees who do not participate in one of the programs offered by the Office of Group Benefits. That is all the questions we have for you today. Thank you for your time and consideration.

APPENDIX VI
SUMMARY REPORT ON PARENTS OF MEDICAID AND SCHIP KIDS

This paper, the third in a series on Louisiana's uninsured, focuses on parents of Medicaid and State Children's Health Insurance Program (SCHIP) children. While children are eligible for coverage up to 200% of the federal poverty level (FPL), their parents are eligible only if their income is below 13% of the FPL. Parents with incomes between 13% and 200% of the FPL constitute a significant percentage of Louisiana's uninsured population. Moreover, this is a group for which the Department of Health and Hospitals (DHH) has substantial data, which is collected in order to establish eligibility for their children. This paper looks at these individuals in terms of:

Total numbers
Gender
Income
Employment status

Total Numbers There were 250,145 non-Medicaid eligible parents between the ages of 19 and 64 in households with Medicaid and SCHIP children according to January 2004 DHH data. This represents 38.6% of all Louisianans from ages 19 through 64 who are uninsured, and 29.0% of all non-elderly uninsured Louisiana residents. Expanding Medicaid coverage to all parents of Medicaid and SCHIP children would have a substantial impact in the uninsured. However, the cost of such an expansion would likely be prohibitive. The distribution of uninsured parents by income level is shown in Table 1.

Gender There are significantly more females than males in the population of uninsured adult parents. When broken out by gender, 78% of the 250,145 uninsured adults in households with Medicaid and SCHIP children are women. Twenty-two percent are men. This is not surprising because single parent households are more often run by mothers than fathers; as of March 2003, 84% single parent households were run by females and 16% by males.

Income Most of the uninsured parents are concentrated at the lower end of the income scale. As Table 1 illustrates, parents with incomes from 50% to 100% of the FPL comprised the largest group of uninsured parents. However, even in the 150% to 200% income group, there are a substantial number of parents without insurance coverage in Louisiana.

Employment Status There are more uninsured parents with some form of earned income than with unearned or no income. Specifically, 59.8% of uninsured parents have some form of earned income. Earned income represents multiple combinations of earned and self-employed forms of income. Unearned income denotes any source of revenue that is not derived from workforce participation, i.e. disability and child support.

Summary It is well known that Louisiana has a large uninsured population; in 2002 and 2003, Louisiana was one of 18 states to have an uninsurance rate higher than 18%. Because the state has been generous to children through its Medicaid and SCHIP programs, there is a great deal of data on the uninsured that are living in households with Medicaid and SCHIP children. Given that 29.0% of all Louisiana uninsured residents ages 19 through 64 are parents living in households with Medicaid and SCHIP children, just covering this group up to 50% of the FPL would cut Louisiana's non-elderly uninsurance rate by at least 9.3%. Going higher would reduce the uninsurance rate even more. In the final analysis, any coverage strategies that are developed will need to balance the number of individuals who can be covered with the cost of insurance coverage. Given that most individuals do have some form of earned income, employer-based strategies can be considered as well.

Table 1:

Distribution of Uninsured Parents of Medicaid/SCHIP Children, Ages 19-64 by Income Level

% FPL	Uninsured	%	All*	%
0% to 50%	80,205	32.0%	106,572	37.2%
>50% to 100%	82,089	32.9%	88,746	31.0%
>100% to 150%	54,890	22.0%	57,051	19.9%
>133% to 150%	15,313	6.1%	15,807	5.5%
>150% to 200%	32,762	13%	33,654	11.8%
200% or more	199	0.1%	216	0.1%
Total	250,145	100.0%	286,239	100.0%

* "All" represents both ineligible/uninsured and eligible (not on table) parents

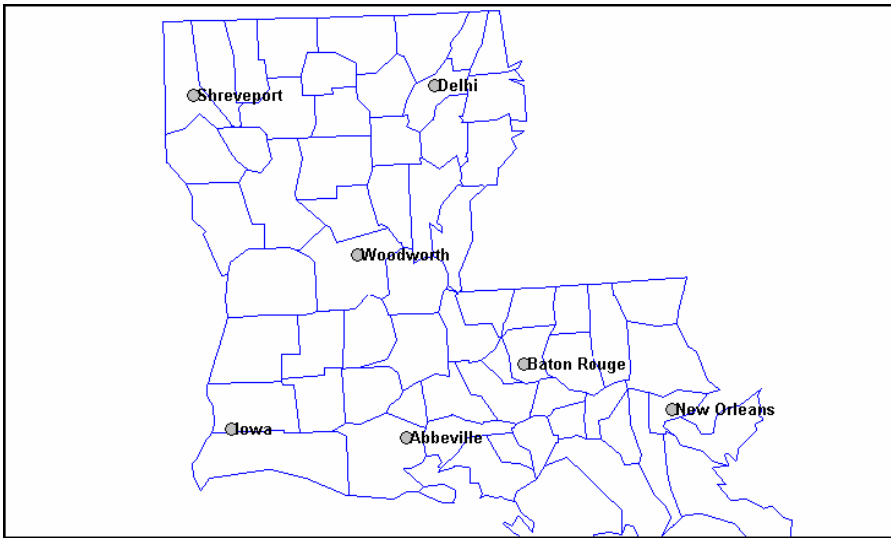
APPENDIX VII
SUMMARY REPORT ON THE LOW-INCOME UNINSURED FOCUS GROUPS

The paper, part of a series in Louisiana's uninsured, summarizes the Low-Income Uninsured Focus Group report that was commissioned by the Department of Health and Hospitals in 2004. Twenty percent of Louisiana residents lack health insurance coverage. However, when children and the elderly (who are covered in LaCHIP and Medicare respectively) are excluded, the number of uninsured increases to 25%, or one in four for people aged 19 to 64. Furthermore, when individuals with incomes above 200% of the federal poverty level (FPL), ($36,800 for a family of four) are excluded the uninsured rate for those remaining non-elderly low-income adults is 43% or more than 435,000 adults.[1]

To better understand the low-income uninsured, 8 focus groups of low-income adults, ages 19-64, were conducted. The focus groups were a mixture of individuals with and without dependent children, and individuals who currently access care through a variety of means including federally qualified health centers, rural health centers, charity hospitals, and other providers. Forty-two of the 61 focus group participants were employed; 19 participants were unemployed. Fourteen of the employed participants reported having access to employer-sponsored insurance and some of the focus groups participants reported that they had been insured at some point in the past.
This paper focuses on:

- Overall viewpoints on insurance;
- Patterns of care for the uninsured;
- What people want from insurance, and how their patterns of care would change, and;
- Thoughts on stigma and related issues.

Map of Focus Group Locations
for Uninsured Residents in Louisiana



[1]Source: Current Population Survey (CPS) combined data for 2000-2003

Overall Viewpoints on Insurance
The focus group participants seem to consistently have the same response and concerns across the board about what health insurance means to them. The two most common views about health insurance were that it is unaffordable and that having insurance means having security. Although many of the participants had access to insurance through an employer, those who had access indicated it was too expensive for them to purchase. Participants said they did not consider insurance to be a good value for the money because of high cost of monthly premiums, and the required deductibles and co-payments that must be paid.

Insecurity is a major issue because the uninsured live with the constant fear of how and where to access medical care , long-tem effects of not receiving primary care, and the fear of getting sick and losing everything due to healthcare bills. A consistent response from the focus group was the fear of being sick and not knowing it because tests are unaffordable. Members of this focus group spoke very eloquently about their fears of illness and financial ruin, and said they would not be as worried about these things if they had coverage.

Patterns of Care
Some of the strategies our participants said they used to avoid seeking medical care include:

- Living with home remedies or use over-the-counter medications
- "Live with it" or "Wait it out"
- Diagnosing their own problems, by researching medical conditions via the Internet
- Obtaining medications during visits to Mexico
- Obtaining unused antibiotics from friends
- "I try to make myself not get sick"

Nearly every participant in the focus groups mentioned using the LSU charity hospitals and their associated clinics for medical care. Respondents gave feedback on their individual experiences. One person stated, "It pays to go to [local charity hospital] because health insurance is so expensive." Participants frequently mentioned concerns with long waits to be seen in the emergency room and if it wasn't life threatening took their chances and went back home. Employers in the focus group mentioned the fact that they could count on an employee missing a full day of work if they went to the charity hospital for care. Continuity of care was a concern because many of the participants reported that they rarely see the same doctor twice.

Another theme that emerged was that low-income residents of Louisiana lean on a vast array of formal and informal supports such as free clinics, pharmacy assistance programs, or having family help with payment of medical bills.

What People Would Want from Insurance and How Their Patterns of Care Would Change
Focus group participants were asked these two questions and the answers were consistent. Many participants talked about choosing their own doctors. Inquiring to their doctors based on their symptoms was a common response and some mentioned using the emergency room less for routine care. Several respondents like the idea of having an option of preventative care and receiving regular check ups. Participants would rather use private doctors rather than the charity system if the insurance allowed them. Additionally, participants would be more likely to follow medical advice because they could afford to.

Participants were asked what benefits they would like from health insurance. The table below presents the rankings of the various benefits across the focus groups. The 5 categories represent what participants think are most important in an insurance program. The participants ranked these benefits according to their health status and on an assessment of risk. Note that not all participants ranked each benefit.

Benefit Category	Frequency of Rank Order				
	1st	2nd	3rd	4th	5th
Hospital Care	27	7	7	10	6
Outpatient Surgery	0	6	6	14	26
Doctor Visits	24	14	8	4	7
Lab/x-ray	1	9	17	21	5
Prescription Drugs	7	23	16	6	6

Thoughts on Stigmas and Related Issues on Private or Public Insurance

One response that was not consistent among participants was related to treatment by health professional or office staff because of insurance status. Some participants reported that they were treated poorly, while others reported that they did not experience differential treatment.

Focus group participants were adamant in their responses that health insurance coverage is important and it does not make a difference if it is private or public insurance. Only a few respondents said they would rather carry a private insurance card rather than a Medicaid card.

Summary

If there is one overwhelming conclusion to be drawn from the focus group discussions, it is that coverage is sorely needed, and the sooner the better. Focus group participants said that having health insurance would improve their lives, in that they would feel more secure, would be more likely to follow through on treatment, and would be able to choose their own doctors and hospitals. It is clear that potential barriers, such as burdensome premiums and cost sharing obligations, should be considered in health insurance coverage options for the low-income uninsured.

APPRENDIX VIII
TAC GUIDING PRINCIPLES

The goal of the State Planning Grant (SPG) is to develop a strategy for providing coverage to the uninsured in Louisiana. Having coverage means that individuals have a reasonable expectation of being able to access health care services, including but not limited to primary and specialty care, diagnostic services, and inpatient and outpatient hospital care. In order to accomplish this goal, the Technical Advisory Committee recognizes that a combination of approaches may be needed. In other words, there is no single best approach or "silver bullet."

In addition, the TAC recognizes that consumer education about the benefit of obtaining and maintaining health care coverage is a crucial element in implementing a successful strategy. Lastly, the TAC recognizes that some strategies may be more feasible in the short term than others given the fiscal constraints that exist in today's environment. An appropriate approach would be one that constitutes an effective use of public and/or private resources, considering such factors as the number of people in need, the resources available, and the potential to yield measurable improvement in health status.

The four overarching guiding principles by which the TAC will evaluate the appropriateness of each potential approach are:

1. Decisions about which approaches to use must be data-driven;

2. Optimum approaches will use a mixture of financing sources;

3. Priority should be given to approaches that foster improvement in health care quality, and, as a consequence, health status of Louisiana citizens; and

4. The coverage approaches should be designed with evaluation in mind.

The following page lists additional detail/examples pertaining to each of the four guiding principles.

Decisions about which approaches to use must be data-driven.

- Decisions are guided by reliable data about the uninsured population, including age, income, employment status, special health care needs, usual patterns of care, geographic location, and other applicable factors.

- Decisions are based on the lessons learned in other states and communities where successful coverage strategies have been implemented.

Optimum approaches will use a mixture of financing sources.

- The approaches optimize and recognize the roles of both the private and public sectors in financing health care coverage for the citizens of Louisiana.

- The approaches leverage additional public and private funds wherever possible, including funds paid by or on behalf of the insured individuals.

- The approaches recognize and reinforce the responsibilities that multiple parties, including individuals and employers, share in financing coverage.

- The approaches seek to reduce cost shifting and increase the cost effectiveness of health care spending across the various payers, and are not based on the interests of one payer over all others (e.g., the state as a health care payer).

Priority should be given to approaches that foster improvement in health care quality, and, as a consequence, health status of Louisiana citizens.

- Approaches are designed to improve health status by:
  - Emphasizing primary and preventive care
  - Focusing on wellness
  - Providing timely access to needed services.

- The approaches seek to improve the coordination and management of care in a systematic fashion that anticipates the health care needs of Louisiana's citizens, including those with chronic diseases.

The coverage approaches should be designed with evaluation in mind.

- The approaches incorporate provisions and opportunities to monitor, evaluate, and improve the model(s) based on the evaluation findings over time.

APPENDIX IX
BACKGROUND PAPER ON THE UNINSURED

Introduction

According to the Current Population Survey (CPS), 23.2% of Louisiana residents under age 65 were not covered by any type of health insurance in 2001, compared to 17.6% for the nation as a whole.[1] In Louisiana, as in other states, the rate of uninsurance has become a priority for policymakers who are well aware of the human and economic costs of not having health care coverage. These costs come in the forms of avoidable hospitalization and disability, decreased productivity, and lost work and school time.

In addition, for the uninsured, the emergency room tends to serve as a de facto family physician. This leads to inappropriate allocation of health care resources, not to mention being a very inefficient and unsatisfying way to access care from the perspective of the individual. Lastly, having a large number of uninsured individuals strains the health care safety net, which consists of public hospitals and federally qualified health centers (FQHCs) and rural health clinics (RHCs).

In developing options to cover the uninsured, it is important to understand Louisiana's starting place. Toward that end, this paper looks inside Louisiana's health coverage situation to examine who is covered and how coverage is provided, with particular attention to implications for future decisions on coverage expansion. How care is accessed by individuals without health care coverage is also examine because this is an important consideration in planning future approaches. Lastly, Appendix A reviews current and past efforts to tackle the issue of covering Louisiana's uninsured residents.

Health Insurance Coverage

In looking at health insurance coverage and other factors such as employment and income, this paper draws heavily from two data sources. For comparisons with other states and with national statistics, the Current Population Survey (CPS) is used. The CPS is a monthly survey of 50,000 households that is conducted by the Bureau of Labor Statistics for the Census Bureau. For comparisons within Louisiana, the data source is the Louisiana Health Insurance Survey (LHIS), a survey of 10,000 households in the state conducted by the Louisiana State University Public Policy Research Lab for the Department of Health and Hospitals. This survey provides a detailed profile of Louisiana's uninsured, including age, employment, income level, and other demographic breakdowns.

In order to understand the coverage picture in Louisiana, it is important to understand both public and private coverage. For the purposes of this paper, public coverage means Medicaid and the State Children's Health Insurance Program (SCHIP). Discussion of Medicare is outside the

[1] CPS Annual Demographic Survey, March supplement, available at http://ferret.bls.census.gov/macro/032002/health/h05_000.htm, accessed March 10, 2005. (Residents age 65 and older are excluded from this analysis because of the presence of Medicare coverage.)

scope of this paper. Private coverage is taken to mean employer-based coverage, since this constitutes the vast majority of non-public coverage.

Public Coverage

Medicaid and SCHIP play an important role in covering Louisiana residents. To illustrate this, while 76.8% of non-elderly (64 years old or younger) Louisiana residents had some type of health insurance coverage during the year in 2003, 61.8% of non-elderly Louisiana residents reported having private health insurance coverage. This leaves 19.9% of Louisiana residents covered at some point during the year in 2003 by a public health care program, compared with 17.1% for the nation as a whole.[2] This likely reflects Louisiana's high rate of poverty compared to the rest of the nation. In 2003, 22% of Louisiana residents were living below the federal poverty level (FPL) ($14,680 for a family of three), compared to 17% for the U.S. as a whole. In addition, 44% of Louisiana's population is considered low-income (defined as having income below 200% of the FPL or $29,360 for a family of three), compared to 36% for the nation as a whole.[3]

Louisiana's public coverage level is higher than the rest of the nation, but not high enough to equalize the uninsurance rate with that of other states. In order to understand this scenario in greater detail, it is important to know something about the Medicaid and SCHIP programs in general and Louisiana's programs in particular.

Medicaid and SCHIP Eligibility Rules

Medicaid eligibility is a complex matter indeed. In order to be eligible for Medicaid, an individual must:

- Be a member of a "category" of individuals specified in the federal statute
- Meet eligibility criteria for that particular category, as specified by a combination of state and federal requirements

There are both optional and mandatory categories of Medicaid beneficiaries, and there are minimum coverage levels for some categories. States have flexibility to go above these levels in most cases, but do not have flexibility (except in a waiver) to add categories of individuals not mentioned in the statute. Examples of categories are parents, children, pregnant women, and aged, blind, and disabled residents. The implication of this is that non-disabled adults without dependents cannot qualify for Medicaid under normal rules, no matter how low their income. In Louisiana, approximately 86% of the Medicaid enrollees are mandatory; approximately 13% of the enrollees fall under the optional category.

Making matters more complicated, even though there are minimum coverage levels for certain groups, the coverage levels can still vary widely from state to state. A couple of illustrative examples follow:

[2] CPS Annual Demographic Survey, March supplement, available at http://ferret.bls.census.gov/macro/032002/health/h05_000.htm, accessed March 10, 2005.

[3] Henry J. Kaiser Family Foundation, "State Health Facts Online," accessed March 10, 2005 from http://www.kff.org.

- Sometimes the minimum coverage level is tied to an underlying standard that can vary by state. For example, states must cover parents at no less than the income standard employed in the state's former Aid to Families with Dependent Children (AFDC) program. However, each state's AFDC level differed. In Louisiana, this level translates to 13% of the FPL – just $2,037 per month for a family of three according to 2004 HHS poverty guidelines.[4] By contrast, the median upper income limit for parents across the U.S. is 47% of the FPL.[5]

- Sometimes the minimum coverage level is a set amount, but states can still have different coverage levels because of the use of income disregards. For example, the minimum coverage level for infants up to age 1 and pregnant women is 185% of the FPL,[6] but the "real" level can be much higher depending upon income disregards. For example, a state may choose to disregard a certain dollar amount or percentage of earned income.

In SCHIP, eligibility is more straightforward but can still vary by state. In order to be eligible for SCHIP, a child must qualify as a targeted low-income child as defined by the statute,[7] and be covered under the particular rules of the state. For example, although states could cover children up to 200% of the FPL or up to 50 percentage points above the income level for states, not all states chose to do so.

Louisiana's Medicaid and SCHIP Eligibility Requirements

In general, Louisiana employs a generous income standard for children and pregnant women, but less generous standards for coverage of parents. The following table summarizes coverage levels for various groups.

Table 1
Income Standards for Medicaid and SCHIP Coverage in Louisiana

Coverage Group	Income Standard (as a % of FPL)
Children (Medicaid and SCHIP)	200%
Pregnant Women (Medicaid)	200%
SSI Recipients (Medicaid)	74%
Parents (Medicaid)	13%
Medically Needy (Medicaid)	14% (individuals) and 20% (couples)[8]

[4] Congressional Budget Office, Budget Options, February 2005, available at http://www.cbo.gov/showdoc.cfm?index=6075&sequence=12, accessed March 10, 2005.
[5] The Commonwealth Fund, "How the Slowing U.S. Economy Threatens Employer-Based Health Insurance," by Jeanne M. Lambrew of George Washington University, November 2001, page vi.
[6] In some cases the minimum level for these individuals is 133% of FPL – this depends upon the state's coverage level at the time Congress set the required levels.
[7] In general, a "targeted low-income child" is a child not otherwise eligible for Medicaid or covered by private insurance whose income is no more than 50 percentage points above the Medicaid eligibility level for children (although this level can be altered by income disregards).
[8] After medical expenses are deducted.

Source: State Health Facts Online, http://www.kff.org, and Louisiana State Planning Grant application, 2003.

Private Coverage

Employer-based coverage is the norm in the U.S. for privately insured individuals. According to CPS data, of non-elderly Americans, 66.4% of the total population, 80.9% of the insured population, and 92% of the privately insured population have employment-based health coverage.[9] The comparable figures for non-elderly individuals in Louisiana are 58%, 74%, and 90%. These figures are depicted in the table below.

Table 2: Individuals Having Employer-based Coverage as a Percentage of Selected Comparison Groups

Comparison Group	Louisiana	United States
All Residents	55.6%	65%
Insured Residents	70.2%	78.6%
Privately Insured Residents	90.9%	91.8%

Source: CPS Data. In all cases the comparison group does not include elderly residents.

In general, as illustrated in Table 2, Louisiana residents are less likely to be covered by employer-based coverage than in the nation as a whole. However, the gap between Louisiana and the U.S. narrows when the comparison populations are insured residents or privately insured residents... This likely reflects the impact of the relatively stringent income guidelines in Louisiana's Medicaid program for adults, which has the net effect of making the universe of insured individuals smaller. The fact that there is only a slight difference between Louisiana and the U.S. in the third category reflects the phenomenon that employer-based coverage constitutes the vast majority of private coverage available, both in the U.S. and Louisiana.

In order to understand why Louisiana residents are less likely in general to be covered in an employer plan, it is important to understand the state's employer base. According to Census Bureau data, 85% of Louisiana's businesses had fewer than 20 employees in 2001.[10] The smaller the business, the less likely it is that the business will offer health insurance to its employees.

Adding to the problem, employees in firms with fewer than 20 employees are not eligible for COBRA coverage[11] under federal law. COBRA provides limited assistance with uninsurance (about one in five individuals who lose their jobs purchase COBRA coverage), but the fact is that employees in the vast majority of Louisiana's businesses are not even eligible for this coverage.

Size of the employer is an important part of the equation in determining the likelihood that an individual has access to employer-based coverage, but it does not tell the whole story. While Louisiana does have a significant proportion (46.4%) of its workforce employed by companies

[9] CPS Annual Demographic Survey, March supplement, available at http://ferret.bls.census.gov/macro/032002/health/h05_000.htm, accessed March 10, 2005.
[10] Data from the Census Bureau, available at http://www.census.gov/epcd/susb/2001/la/LA--HTM, accessed March 10, 2005.
[11] COBRA allows workers who lose health insurance when they leave a job to continue to purchase their coverage for a period of 18 months by paying 102% of the premium for such coverage.

with 500 or more workers, the largest share of firms of this size is in the category of retail trade.[12] This is an industry characterized by large numbers of part-time, low-wage workers who do not qualify for or cannot afford employer-based coverage. To illustrate this, the average income per person (derived from Census Bureau data on industry payrolls) employed in retail trade in Louisiana was $17,342, compared to $39,864 in the manufacturing category. And for every person employed in manufacturing in Louisiana, 1.4 are employed in retail trade.

In addition to concerns about coverage levels, there are concerns about benefits offered through employment-based insurance. According to a Commonwealth Fund report, by January 2002, one-third of working adults with employer-sponsored insurance had seen their deductibles or premiums raised or had their benefits reduced compared to the previous year. Low-income workers were the most likely to experience these reduced benefits and increased health care costs.[13] To the extent that Louisiana workers are disproportionately employed in low wage occupations, this can be expected to be an increasing problem in the state.

These observations have implications for future program design. In addition to finding a way to cover extremely low-income adults (whether parents or childless adults) who have no connection to the workforce, it may be important for Louisiana to develop a model that promotes workplace-related coverage of low-income wage earners.

Accessing Care for the Uninsured

In order to develop models for covering the uninsured, it is important to understand where the uninsured currently receive health care. This is important from several standpoints:

- Louisiana may want to build on the current health care access "system" for the uninsured, and/or learn from any potential shortcomings in designing a new system.
- Providers who currently serve the uninsured can provide useful insights into designing new approaches to covering them.
- In order to perform outreach relating to any new program that is designed, it will be important to find potential enrollees. The locations where they access care can be an important part of that strategy.

Health care for the uninsured in Louisiana is based on access to hospital-based providers, and care tends to be provided on an episodic basis. In part, this is a natural outgrowth of the structure of the overall health care system in the state. Louisiana has an oversupply of hospitals beds compared to the rest of the nation, in contrast with a severe shortage of primary care health professionals. Louisiana ranks 15th in the nation in the rate of community hospitals per population (at a rate nearly twice that of the US average) and 8th in the rate of community hospital beds per population.

A prominent feature on the hospital landscape is the Louisiana State University (LSU) hospital system. There are 10 public hospitals in the state that are operated by the LSU Health Sciences Center, with the Medical Center of Louisiana in New Orleans and University Hospital in

[12] Same as footnote 10 above.

[13] The Commonwealth Fund, "The Erosion of Employment-Based Health Coverage and the Threat to Workers' Health Care," by Jennifer N. Edwards, Michelle M. Doty, and Cathy Schoen, (Issue Brief), August 2002.

Shreveport serving as the principal referral hospitals for the system. By contrast, nine out of 10 Louisiana parishes are designated as Primary Health Care Professional Shortage Areas by the Health Resources and Services Administration.[14]

Given this structure, it is highly likely that the uninsured receive their care through the hospital system as opposed to from community physicians. Such a scenario is supported by the design of the Medicaid program, which has a specific funding stream to cover uncompensated costs (such as the cost of covering the uninsured) for hospitals, but not for other types of providers. This funding stream is known as disproportionate share hospital (DSH) funding. This will need to be taken into consideration in designing any new system. Some states have received federal waivers from the Centers for Medicare and Medicaid Services (CMS) to use a portion of their DSH funds for health care coverage rather than to directly pay hospitals for uncompensated care.

It is impossible to tell whether Louisiana's uninsured seek care in hospitals because hospitals are the most plentiful providers, or whether the hospital system has grown because there are so many uninsured and hospitals can be paid for caring for them. In any event, such a health care structure will provide challenging to any approaches to health coverage that rely on expanded access to primary care while seeking to decrease utilization of hospitals and emergency rooms.

It will be important to devise approaches that can provide incentives for individuals to seek care outside of hospitals, while designing the financing structure in such a way as to not precipitously disrupt the public hospital system. At the same time, it will be necessary to develop a robust primary care infrastructure.

Conclusion

Louisiana faces many challenges, including high poverty and uninsurance rates, a health care system that has a strong hospital base but a shortage of primary care providers, and an employment base consisting of small businesses, making it more difficult for employers to offer health care coverage to their employees. However, there are a number of encouraging initiatives under way, the work of the Governor's Health Care Reform Panel and the development and implementation of the HIFA demonstration waiver. As the State Planning Grant Technical Advisory Committee moves forward, the crucial goal will be to develop options that provides for maximum opportunity to cover the largest number of people possible. This should be done using models that have been tested elsewhere, and/or have potential to work in Louisiana because of the state's unique circumstances.

[14] Louisiana 2003 State Planning Grant application.

Appendix A

Current and Past Efforts to Expand Access to Care for the Uninsured

Current State Efforts to Expand Access to Care:
Louisiana has undertaken several efforts to expand access to care for the uninsured. The state is expanding access to care through coverage expansions and increased access to services or exploring expansions through:

- Increased LaCHIP outreach and enrollment
- Medicaid Waivers – HIFA and Family Planning
- FQHC and RHC Expansion Planning (Act 36)
- Mental Health Services
- Department of Insurance Efforts
- HRSA State Planning Grant
- DSH Funding

LaCHIP Outreach and Enrollment

As of December 1, 2004, the total number of children under 19 in Louisiana with publicly funded health insurance (LaCHIP or Title 19 Medicaid) is 649,513. Since the Governor's Health Care Summit in March 2004, there has been a net increase of 26,873 children have been enrolled in LaCHIP. The increase surpasses by over 7,500 the initial short-term goal of enrolling 25% of the 77,000 eligible but un-enrolled children identified by the LSU Household Insurance Survey (LHIS).

In the summer of 2004, DHH engaged in a large-scale Back-to-School LaCHIP Enrollment effort involving major coordination with schools. Telephone calls to the LaCHIP hotline and applications received increased dramatically during the month of August. Additionally, the Department engaged in strategic targeting of uninsured children using the LHIS results which showed that Northwest and Southwest Louisiana had higher percentages of uninsured children than other areas through:

- Intensive all-day conferences in Shreveport and Lake Charles where at least 300 community partners (representing schools, providers, other state agencies, advocates, etc.) were empowered through presentations of promising practices and brainstorming for development of local solutions.
- Coordinated public awareness campaign during back-to-school months including radio commercials by DHH, television commercial by the non-profit Louisiana Covering Kids and Families, and billboard advertising by the state Department of Education.
- Expanded outreach through which actual applications were sent home with students in five of the nine parishes (Bossier, Caddo, Claiborne, Red River, and Bienville) supplying over 70,000 families with the actual tool needed to enroll their children.
- Focus on retaining eligible children at their annual renewal and minimizing closures for procedural reasons.

Louisiana HIFA Waiver
Act 813 of the 2003 Legislature directed the Department of Health and Hospitals to develop a Health Insurance Flexibility and Accountability (HIFA) waiver. The waiver was officially submitted to CMS in November 2004. The work of an Advisory Committee resulted in a HIFA

waiver application that expands eligibility to parents and childless adults through four main components:

1. Expand DHH's current Health Insurance Premium Payment (HIPP) program.

- HIPP will make it more affordable for low-income workers to take up existing employer-sponsored insurance by providing a public subsidy to low-income parents to pay for the employee share of a family coverage premium when the subsidy does not exceed the cost of covering eligible children in Medicaid/ LaCHIP in the aggregate. The expansion is estimated to benefit 2,000 families.

2. Implement the Department of Insurance's new LaChoice program (see Appendix B for the proposed LaChoice benefits package)

- LaChoice will make it more affordable for small employers to provide health insurance through a public subsidy to reduce the premium costs for a limited benefit plan to be offered by commercial insurers to small employers (2-50 employees) that have not offered insurance in the past 6 months. The subsidy is limited to 3,000 low-income workers.

3. Federalize the current Louisiana Health Plan.

- Louisiana is seeking federal matching funds for low-income enrollees in the Louisiana Health Plan (LHP). The LHP is a state-funded program that provides affordable health insurance coverage to persons denied for individual coverage by commercial insurers or federally eligible and for HIPAA coverage, will extend the reach of the plan's current state funds limit. The federalization of the LHP is estimated to benefit 250 people.

4. Regional Public Expansion Pilot

- Louisiana will explore a coverage expansion for parents and childless adults in the form of a regional pilot. The pilot will be phased in slowly by income and geography. The timeline for implementation is state fiscal year 2005-2006 or later and is subject to the availability of state matching funds. An enrollment and/or expenditure cap is also subject to state appropriations.

The HIFA waiver will increase access to health care services to the uninsured through health insurance coverage. A comprehensive health benefit plan will be available through the LHP. The LaChoice benefit plan is a limited benefits package. The benefit package offered by the employer for HIPP participants will be the HIFA benefit package; children covered through HIPP will continue to receive wrap-around coverage through Medicaid/LaCHIP.

Since the waiver falls under the Medicaid program, the Medicaid federal matching rate will apply to the waiver costs. The federal/state match for Louisiana is approximately 70/30. The cost for Phase 1 of the waiver (HIPP, LaChoice, and LHP) is defined in the chart below. Additional costs for Phase 2 (regional pilot) are unknown and will be subject to the availability of state matching funds.

The benefit of the HIFA waiver to the state is that it will provide health insurance coverage to uninsured low-income non-elderly adults – the largest demographic of uninsured in Louisiana. Medicaid is only an option for parents at or below 13 percent of the federal poverty level; childless adults are not eligible for Medicaid unless pregnant or disabled. State fiscal constraints make any significant Medicaid expansions to parents and childless adults difficult. HIFA's flexibility to control expenditures and cap enrollment is a great benefit to the state and is why the expansion is possible. The expansion also does not rely solely on state government, but includes public/private partnerships.

However, the expansion is limited in scope. If the demonstration meets its full expectations, the number of uninsured low-income non-elderly adults will be decreased by just 2.3 percent. Early experiences from other states indicate that take-up of premium assistance programs can be slow, thus blocking progress. Despite this, the HIFA demonstration will be an opportunity for the state to explore additional options for covering the uninsured while expanding the base of participation to include more employee and individual contributions.

Family Planning Waiver

Inadequately spaced pregnancies result in poorer health for the mother and poorer birth outcomes including premature births, low birth-weight and related disabilities which may require publicly supported health care for the life of the individual. Access to family planning services would enable the woman to adequately space pregnancies to facilitate improved birth outcomes.

Currently many Louisiana women below 200% of the federal poverty level lack the access to the family planning services which would allow them to plan and space their pregnancies for their benefit, the benefit of the baby and the overall socio-economic benefit of the family unit.

According to the Alan Guttmacher Institute, approximately 309,360 women in Louisiana need publicly supported contraceptive services and supplies. Medicaid covers family planning services for the approximately 100,000 females (ages 19-45) certified for Temporary Assistance for Needy Families (TANF), Low-Income Families with Children (LIFC) or Supplemental Security Income (SSI). Approximately 50,000 pregnant women per year are eligible for Medicaid based on income and may receive family planning services for 60 days post partum. Family planning services through DHH's Office of Public Health's federal Title X funding reaches an additional 39,000 women ages 19-45 below 205% of poverty but some areas have waiting lists as demand exceeds Title X funding.

Family planning services only would be provided under an 1115 Demonstration Waiver (if approved by CMS) to women, ages 19-45 that, if pregnant, would be eligible for Medicaid based on income. Services will include all family planning services currently available to Medicaid recipients including initial and annual physician visits as well as sterilizations and contraceptives—oral, injectables, etc.

In the first year of an approved family planning waiver, approximately 89,000 women are expected to seek services. When phase-in is completed in SFY2006-2007, the total number of participants is estimated at 124,000 women. If outreach and education efforts about the benefits of spacing pregnancies are extremely effective, a greater take-up rate may be achieved.

In addition to family planning services, CMS requires that states ensure access to primary care for recipients in the family planning waiver. This requirement can be fulfilled by referring recipients to FQHCs/RHCs for primary care services as well as the LSU hospital outpatient clinics. DHH will be working with these public providers to develop the appropriate referral arrangements.

First-year implementation costs for services are estimated at $12,989,359 at a 90/10 federal match rate and operation costs are estimated at $5,286,558 at a 50/50 federal/state match. First-year savings will be limited since the program is in phase-in and few births are expected to be averted. Waiver costs in future years are anticipated to be offset by a lower birth rate and related costs for women who, if pregnant, would be eligible for Medicaid and for the costs of care for the baby for the first year of its life.

A recently released study, conducted on behalf of CMS, found that all six of the state 1115 Family Planning waivers reviewed met the federal requirement for budget neutrality and, in fact, resulted in substantial savings. Savings for the states, 2000-2001, ranged from $1.3 million in New Mexico to $76 million in California.

Affording increased access to family planning services can have a greater impact if the entire target population is all women 19-45 years of age whose family income is less than 200% of federal poverty, but this also increases the up-front costs before savings are realized. Growth can potentially be controlled by limiting to only those women who have had a Medicaid reimbursed birth, but the overall impact on health outcomes would be lessened due to the smaller target population.

FQHC and RHC Expansion Plan

Act 36 (Senate Bill 690), enacted in the 2004 Regular Louisiana Legislative Session, promotes the development of federally qualified health centers (FQHCs) and rural health clinics (RHCs) to provide primary health care services for the uninsured and underinsured in Louisiana's medically underserved and health professional shortage areas.

As a result, DHH's Bureau of Primary Care and Rural Health, the Louisiana Primary Care Association (LPCA), the Louisiana Rural Hospital Coalition, the Louisiana Rural Health Association, the Louisiana Public Health Institute and other health care representatives were charged with developing a plan for the RHC and FQHC expansion in Louisiana. The plan defines the FQHC and RHC primary care delivery models, describes the state's current primary care service needs, current RHC and FQHC expansion environment and identifies recommendations to alleviate current barriers to expanding RHCs and FQHCs.

The recommendations focus on:

- Capital Resources
- Advocacy
- State Funding
- Local Technical Support and Education
- Reimbursement

- Workforce Development

According to the LPCA, Louisiana's health centers plan to apply for federal grant funding to support 14 new or expanded access points, raising the total number of FQHC sites to 53, to serve an additional 39,025 unduplicated uninsured patients. DHH has certified eligibility for 32 RHC requests. Currently, a number of these 32 RHCs are in development and seeking licensure.

In total, there are 46 new RHC and FQHC sites planned or anticipated over the next five years. This number corresponds to a need for an additional 48 new primary care sites to serve more than 200,000 patients.

Mental Health Services

In an effort to improve access to mental health services for the uninsured and others, the DHH Medicaid and the Office of Mental Health (OMH) and is working on a Crisis Response System and a Demonstration to Maintain Independence and Employment.

The Office of Mental Health is proposing to enhance the system to alleviate some of the burden on hospital emergency rooms and to provide more efficient mental health care. The cost for psychiatric crisis presentations should significantly decrease because non-hospital based alternatives will be used. The system will be enhanced by:

- Proposed expansion of Crisis Intervention Units;
- Proposed expansion of Crisis Respite/Residential Supports; and
- Mobile Crisis Services/ Telemedicine Services.

DHH recently received notice of award from CMS for a $25 million grant (to add to the state's $3 million state general funds match) to provide the full range of Medicaid-like services to 400 uninsured working Louisiana residents who have job-threatening serious mental illnesses. This will be a five-year project that integrates mental health treatment with practical employment support for adults with serious mental illness in the Baton Rouge area. The research project will examine the cost-effectiveness of providing benefits to this currently ineligible population by tracking the effect of benefits on an individual's ability to maintain employment and prevent enrollment in SSDI.

Louisiana Department of Insurance

The Department of Insurance has a number of projects related to the uninsured and is responsible for implementing legislation that targets insurance and the uninsured. Current efforts include:

- The Louisiana Health Care Commission
- The Task Force on the Working Uninsured
- LaChoice – Act 751
- The Federal Health Coverage Tax Credit Program – Act 843
- Safety Net - Act 493
- Flexible Benefit Policies Act 799

Louisiana Health Care Commission

The Louisiana Health Care Commission is a 49-member policy board that reports directly to the Commissioner of Insurance on matters related to the availability, affordability and delivery of quality health care in the state. The commission examines a number of issues including the rising costs of health care in the state, the cost of administrative duplication, the costs associated with excess capacity and duplication of medical services, and the costs of medical malpractice and liability, the formation and implementation of insurance pools that better assure citizens the ability to obtain health insurance at affordable costs and encourage employers to obtain health care benefits for their employees by increased bargaining power and economies of scale for better coverage and benefit options at reduced cost. Further, the commission monitors and reports on the implementation issues related to national health care reform initiatives. The commission meets approximately six times a year and has been in existence since 1992.

Task Force on the Working Uninsured - HCR 105

The task force was originally created during the 2002 session and was recently recreated during the 2004 Regular Session of the Louisiana Legislature. This task force examines ways to make coverage more affordable for employers. The Department of Insurance provides support staff and is represented on this task force.

LaChoice - Act 751

LaChoice is a subsidized insurance product for eligible uninsured small businesses in Louisiana. LaChoice is a product of the Louisiana Health Care Commission Subcommittee on Covering the Uninsured which studied the issue of the uninsured extensively before recommending LaChoice as a solution as is the Department of Health and Hospitals.

LaChoice is a component of a federal Health Insurance Flexibility and Accountability Act (HIFA) Waiver application. The waiver is a joint project of the Louisiana Department of Insurance and the Louisiana Department of Health and Hospitals. State and federal funding will be used to fund the premium subsidy. LaChoice will also be available to higher income individuals not covered by the HIFA waiver subsidy.

Federal Health Coverage Tax Credit Program - Act 843

Act 843 requires the Department of Insurance to develop a pilot program to administer the federal Health Coverage Tax Credit program. The federal program provides a 65 percent tax credit of the eligible health plan premium for two groups of individuals: Trade Adjustment Assistance Participants and Pension Benefit Guaranty Corporation (PBGC) recipients.

In order to be eligible under the Trade Adjustment Assistance Program the individual must have been displaced due to a federal trade agreement. In order to be eligible under the PBGC you must be between the ages of 55-65, and currently receiving pension benefits from the PBGC. The remaining 35 percent of the premium is paid by the eligible individual. The tax credit is available only for qualified health plans. Health plans must meet certain requirement to become a qualified health plan.

Safety Net - Act 493

Act 493 transfers the administration and oversight of Safety Net to the Department of Insurance from the Louisiana Health Plan. The Safety Net product is a new type of product to be sold by the insurance industry to small employer groups and individuals including:

1. Employees of the State of Louisiana, and political subdivisions thereof, who have not been covered by health insurance for at least one year and are eligible for coverage through the Office of Group Benefits.
2. Employers who have not offered group health insurance coverage to their employees for at least one year.
3. Employers who currently offer coverage but who employ persons with an annual family income of not more than two hundred percent of the federal poverty level may offer the insurance only to those employees whose family income is not more than two hundred percent of the federal poverty level even if there are employees whose annual family income exceeds two hundred percent of the federal poverty level.

The required benefit under safety net is that a hospital will contract with insurance carriers to accept a set amount for billable charges. The "safety net" policy will have a set amount that is paid to the hospital for services that have been provided. The amount will be determined by the insurance carrier. The patient cannot be billed for any charges in excess of the policy maximum.

Flexible Benefit Policies - Act 799

Act 799 authorizes health insurers and health maintenance organizations to offer flexible health benefits policies, contracts and agreements without state health insurance mandates or certain other requirements.

The Louisiana State Planning Grant

The federal Health Resources and Services Administration's State Planning Grants (SPG) Program provides one-year grants to states to develop plans for providing access to affordable health insurance coverage to all their citizens. Louisiana applied for a SPG in 2003 and was approved, but unfunded. Louisiana reapplied for a SPG in 2004 and was approved and funded. The SPG is a one-year grant that began on September 1, 2004, and will end on August 31, 2005. The grant is fully supported by federal funds and does not require any state matching funds. The grant award is in the amount of $801,319. The state is providing an in-kind match of $113,181 in the form of staff salaries, fringe benefits, supplies and equipment.

The four goals of the Louisiana SPG are as follows:

1. The Louisiana Department of Health and Hospitals (DHH) and its consultants will collect and analyze quantitative and qualitative data related to the uninsured that will support further development and refinement of options for coverage expansion and assist in building consensus among key stakeholders for the plan to address accessibility of affordable health insurance coverage.

2. DHH will establish a Technical Advisory Committee on Uninsurance to support the Governor's Health Care Reform Panel in its decision making by providing a means for the active participation of diverse stakeholders in the detail work behind any coverage expansion recommendations.
3. The Technical Advisory Committee on Uninsurance will review research results and possible coverage expansion options and will recommend to the Governor's Health Care Reform Panel action steps to address the accessibility of affordable health insurance coverage.

4. DHH will prepare and submit a report to the U.S. Department of Health and Human Services (DHHS) on Louisiana findings, including its plan for coverage expansion.

Although there have been several state efforts to address the issue of the uninsured, the efforts have not always been coordinated. The SPG requires that the state convene a diverse group of stakeholders and provides the funding for data collection and analysis. The SPG will function as the mechanism to coordinate the efforts to address the uninsured. It will also allow the state to focus on the uninsured in its entirety – not just one demographic. Historically, most efforts have been aimed toward the low-income population or children. Through the SPG, the state will develop options for coverage for all of the uninsured.

Additionally, the HRSA SPG program is expanding. In 2004, the SPG added two grant opportunities: the Continuation Limited Competition Grant and the Pilot Planning Limited Competition Grant. A condition of eligibility includes that a state must be a prior recipient of the SPG funds. Having secured the SPG, Louisiana will have the opportunity to apply for these additional grants and continue the work and progress toward decreasing the number of uninsured Louisianians.

Disproportionate Share Hospital (DSH) Funding

DHH developed the Preliminary Report to the Governor's Health Care Reform Panel to identify both short- and long-term objectives for improving access and delivery of health care in the state. The report recommends that the Department "develop an integrated system of care that emphasizes preventive and primary health care and includes sound financing strategies for the uninsured with existing traditional and safety net providers, including the LSU "State Hospital" System.

One of the strategies identified to implement the recommendation is to revise the DSH payment methodology to encourage increased delivery of hospital-based primary and preventive health care services and to distribute DSH regionally according to relative need. The strategy also includes pursuing alternatives for local match and utilizing the parish health units for delivery of care.

The state will spend its entire federal DSH cap in state fiscal year 2005 because of the 175 percent payment provisions. However, it is anticipated that there will be in excess of over $250 million (total) of DSH cap available in state fiscal year 2006. The state does not have the general funds to provide the match to draw down the federal funds. Therefore, the Department is engaged in reviewing mechanisms that other states use to draw down DSH, including the

incorporation of local match. The Department aims to develop the new strategies for DSH by early 2005.

Parish Health Unit Integration

A logical and practical alternative for improving the availability of primary care in communities is to include primary care services in existing health units through out the state. Each parish has at least one parish health unit. Parish health units currently provide immunizations, WIC, family planning, STD/TB, environmental health services, and other preventive services. Some of the recently built facilities can accommodate primary care services within the existing structure because they were built with the intention of having primary care as part of the scope of services. After modest renovation, other facilities could be made ready for primary care.

Several former health units currently provide both preventive and primary health care. These providers render both the traditional public health as well as primary care services. Those facilities such as the St. Charles Community Health Center (FQHC), in Lulling; the St. Martin Parish Community Clinic, in Breaux Bridge; the North Caddo Hospital Clinic in Vivian, are all examples of parish health units which have been fully transitioned from state operated to private provider operations. These models validate the concept that parish health units can be modified to include primary care. Departmental efforts are underway to identify additional integration sites to expand services to include primary care.

Past Efforts to Expand Access to Care:
Over the past decade, the sustainability of Louisiana's "safety net" hospital approach for providing care to the uninsured has come into question and Louisiana has increasingly made efforts to change its approach to one of health insurance coverage. This effort has involved a two-prong approach by first, trying to make private insurance more affordable and accessible and secondly by expanding public supported coverage under Medicaid and LaCHIP to low-income children and adults. These change efforts have often been initiated and supported by executive branch and legislative interim study committees, standing commissions or ad hoc task forces on the topic of indigent care and uninsurance.

Private Insurance Related Efforts
Legislative and executive branch efforts to make private health insurance more affordable and accessible have included:

- The Louisiana Basic Health Insurance Plan Pilot Program ("LaHealth"), authorized in 1993, was designed to serve low-income uninsured via private health insurance products, covering unlimited primary care provider visits and a limited amount of inpatient and outpatient hospital services, diagnostic testing and mental health care. Premiums were capped at roughly half of the average rates for similar plans, and modest co-payments but no deductibles applied. In 1994, three carriers applied to offer the plan, but debate during the 1995 legislative session regarding Medicaid managed care and eligibility expansions delayed implementation pending submission of a Medicaid 1115 research and demonstration waiver. With the tabling of the Medicaid 1115 waiver, LaHealth was never implemented.

- The Louisiana Health Plan, a State-subsidized high risk pool, was established in 2000 to provide affordable coverage to people who cannot obtain health insurance because of pre-existing medical conditions. Due to the severity of illnesses of pool policyholders, premium payments are insufficient to pay claims. Plan costs are subsidized by fees on insured patients' hospital charges and by State appropriations. Enrollment in the pool is limited by funding constraints, with approximately 1200 (December 2004 enrollment numbers for the high risk and HIPAA pools) policy holders being served. The proposed HIFA waiver will provide some relief to this program by drawing federal matching funds to offset the State cost of covering low-income individuals, who comprise roughly 13% of the risk pool's enrollees.

- Louisiana Safety Net Health Insurance Program, authorized in 2003, allows the State employee health insurance program (i.e., Office of Group Benefits) and qualified private insurers to offer "minimal benefit hospital and medical insurance policies" that are exempt from state-mandated insurance benefits and not a comprehensive, major medical policy. Private insurers may offer policies only to small employers who have not recently offered coverage and employers of low-income workers, provided that the employer pays at least half of the employee premium and enrolls at least half of eligible employees. The Office of Group Benefits may offer policies to eligible employees of State and political subdivisions who have not been covered by health insurance for at least one year. Policies must preclude "balance billing" by providers and may be offered

in conjunction with employer-funded personal care accounts that are not taxable to the employee. Implementation of this program has been in flux with some program development by the Office of Group Benefits. Also at the current time legislation is pending to transfer administration and oversight of the program from the Louisiana Health Plan to the Department of Insurance. However, the basic goal of the Safety Net Health Insurance Program will be incorporated into the LaChoice program that is slated for implementation in 2005 (see discussion below).

- LaChoice authorized in 2003, will create a pilot health insurance program aimed at increasing the number of small employers who provide health insurance by making it more affordable. The "LaChoice" concept was developed by the Louisiana Health Care Commission, Subcommittee on Covering the Uninsured[15], in consultation with Dr. Kenneth Thorpe of Emory University and is based on the Healthy New York model (see discussion in previous section). Eligible employers must not previously have offered group insurance, have a workforce that numbers less than 50 and have at least one-third low-income workers, and pay at least half of the employees' premium. The program is currently under development by the State Department of Insurance and DHH, as a component of Louisiana's HIFA waiver, and slated for implementation in April 2005.

Public-Sector Expansion Efforts

In general the public-sector approaches to expand access to health coverage have fared better in Louisiana than the private insurance market approaches and have had a greater impact in reducing the number of uninsured residents. The one exception was the submittal of a Medicaid 1115 waiver in 1995 to enroll the State's Medicaid population into managed care and utilize savings to expand Medicaid eligibility to individuals with family incomes less than 250% of FPL. The waiver was tabled by Health Care Finance Administration, and was never implemented. Since then with the support of the Legislature, DHH has made considerable progress at expanding Medicaid eligibility beyond the federally mandated Medicaid populations. In particular the House Select Committee on Fiscal Affairs[16] played an important role by reframing the State "charity" hospital debate as one of health care for the uninsured, emphasizing that an alternate approach to access to care is coverage expansion and then subsequently supporting the enactment of public coverage expansion in subsequent Legislative sessions. Medicaid program coverage expansions that have occurred in recent years include:

- Creation of the Louisiana Children's Health Insurance Program (LaCHIP). LaCHIP was implemented in three phases: the first phase expanded Medicaid eligibility to children in families with incomes up to 133% of FPL in November 1998, the second to 150% of FPL in October 1999, and the third to 200% of FPL in January 2001. The LaCHIP expansion ultimately made more than half of all Louisiana children eligible for public-sector heath

[15] The Louisiana Health Care Commission is a standing body of insurers, employers, providers, advocates, consumers and other stakeholders in the health care arena. Over the past two years, the Commission's Subcommittee on Covering the Uninsured has worked on identifying drivers of uninsured and the populations/organizations impacted, understanding the demographics of the uninsured and narrowing policy options based on other state's experiences. Helene Robinson, SPG project director, is a member of this Commission.

[16] The House Select Committee on Fiscal Affairs was created by House leadership in 2000 to study all areas of State government in search of opportunities for containing cost growth and minimizing the need to make tough final decisions in the future.

insurance coverage and significantly reduced the number of uninsured children in the State. As of April 2004, 99,346 children were enrolled in LaCHIP, and an additional 216,630 children have enrolled in Medicaid since the start of LaCHIP outreach. The January 2003 Kaiser Commission on Medicaid and the Uninsured Report confirms the State's progress, showing that Louisiana's percentage of uninsured children dropped from 20.4 % to 14.4 % from 1999 to 2001. This six percentage-point reduction was the best among all states, and moved Louisiana from a national ranking of 3rd for uninsured children to 8th.

- Expanded Medicaid eligibility to certain categories of low-income adults, including women with breast and cervical cancer in January 2002, and to pregnant women (LaMOMS) with family incomes to 200% of FPL (from 133%) in January 2003. Further, in January 2004, a Medicaid buy-in program for the working disabled (Ticket to Work) was implemented. In 2001 the Legislature authorized DHH to cover poor parents as new funding became available, but as yet DHH has not had new funding to start the program.

- A Health Insurance Premium Payment Program (HIPP) was implemented in 1990 to reimburse parents for the employee share of job-based coverage for the family when the State cost of the premium payment is equal to or less than the cost of covering only the eligible child or children under Medicaid. To date, program participation has been limited (to about 150 families statewide) by eligibility staff resource constraints and complex administrative requirements regarding federal cost effectiveness tests. A system to automate many now manual HIPP functions has been designed and will be implemented under DHH's new fiscal intermediary contract for 2005. Additionally, as part of its HIFA waiver application, the State will seek authority to apply an aggregate, rather than individual, cost effectiveness test for program applicants and to cover parents when their coverage is optional, rather than only mandatory, in order to enroll the children in employer-sponsored insurance. Finally, the DHH's budget request for implementation of the HIFA waiver that has passed the House and is under consideration by the Senate, seeks to increase the number of eligibility workers assigned to HIPP, from 1 to 5. All of these efforts are anticipated to increase program enrollment from 150 to 1,500 families by the end of SFY 2004 - 2005.

In addition to the adoption of these coverage expansion programs, the State has also been able to reduce the number of uninsured through the Louisiana *Covering Kids & Families Program.* This program is operated by the New Orleans-based, non-profit organization, Agenda for Children, which is the State grantee for the Robert Wood Johnson State Coverage Initiative to increase Medicaid enrollment among eligible children. Louisiana Covering Kids & Families supports one statewide and three regional coalitions to connect uninsured, eligible children and families to LaCHIP. The State Coverage Initiative has recognized Louisiana for its outstanding performance in simplifying eligibility determination and enrollment processes for the Medicaid and LaCHIP programs.

Besides the Louisiana Health Care Commission there have been a number of study committees, and initiatives that have contributed to the State deliberations on the uninsured. These have included:

- The Task Force on the Working Uninsured that was created in 2002 to study and make recommendations to the Legislature on options to make health insurance coverage more affordable for small employers and low-income employees. To date this group has met only briefly, developing a short list of original recommendations on data collection on health insurance coverage and supporting the recommendations of the Louisiana Health Care Commission's Subcommittee on Covering the Uninsured.
- The Baton Rouge Area Foundation and the Rapides Foundation of Central Louisiana, private grant making foundations in two regions, have independently engaged The Lewin Group to develop viable solutions to the problem of health care access for the uninsured in their region. The final reports detailing Lewin's analysis of existing data on the finance and delivery of health care to the uninsured and recommended options for improving access to care are due shortly for public release. These reports should prove to be an invaluable resource for the SPG project and will be taken into consideration by DHH in both completing the data collection and analysis tasks and in developing a plan to provide access to affordable health insurance coverage.

While much of the State's recent effort has focused around reducing the number of uninsured through statewide coverage expansion, there is still in some areas of the State, local legislative support to stop the eroding State support for the "charity" hospital system. This effort resulted in legislative action in 2003 to create:

- A multi-Parish hospital service district for the purposes of raising local tax revenues to finance construction of a new physical facility that could be leased to the State, addressing the deteriorating physical infrastructure of the State-owned and State-operated Earl K. Long Medical Center in Baton Rouge.
- Through a resolution, a regional health care planning council to develop an integrated plan of medical care for the indigent in the Lafayette area in which the State-owned and State-operated University Medical Center is located. Supporters of this resolution have expressed interest in the creation of a service district with taxing authority to finance care of the uninsured in the Lafayette area, through a local "three-share" coverage program.

Additionally there have been a number of study committees and taskforces that have also focused on this issue of the charity hospitals as well as Disproportionate Share (DSH) payments paid to them. This includes:

- Two legislative interim study committees that focused on Disproportionate Share (DSH) and issues of uncompensated care to the uninsured by seeking to maximize federal financial participation in the State's DSH program, as Louisiana had not yet reached its congressionally-set allotment or "DSH cap."
- Two additional DSH-related legislative interim study committees in 2001 and 2002 that sought to rewrite State DSH rules to comply with a 2001 legislative mandate to "let the dollar follow the patient" to the hospital of their choice. The mandate represented a major redirection of State policy, which until that time dedicated virtually all DSH payments to State-owned and -operated "charity" hospitals. These study committees also developed data elements and collected hospital-specific uncompensated cost data for two

years (SFY 1999-2000 and SFY 2000-2001), demonstrating that while the majority of uncompensated care is still provided in State hospitals, a significant and increasing amount of it is provided in non-state hospitals largely without reimbursement. The data also supported rulemaking through a consensus process with State and non-state hospitals, making all hospitals that provide at least 3% uncompensated care eligible for DSH payments, and making individual DSH payments based not on ownership (state v. non-state) but on the share of total uncompensated cost in the State provided by a hospital and the share of uncompensated cost in the hospital's total book of business.[17]

- The Louisiana State University Board of Supervisors Task Force on Indigent Care and Medical Education, a blue ribbon panel, assembled in late 2002 by the State "charity" hospital system to study and make recommendations on the future of indigent care and medical education in Louisiana. In March 2003, the Task Force issued a series of recommendations for changes to the governance, mission, operation, and financing of the hospitals. A key outcome of the Task Force was passage of a bill to give the hospitals greater authority in managing their operations within the limits of funding appropriated by the Legislature.

Successes and Implementation Problems of Earlier Efforts

Generally speaking, public-sector approaches have fared better in Louisiana than private market approaches to covering the uninsured, and modest incremental approaches have fared better than ambitious sweeping ones.

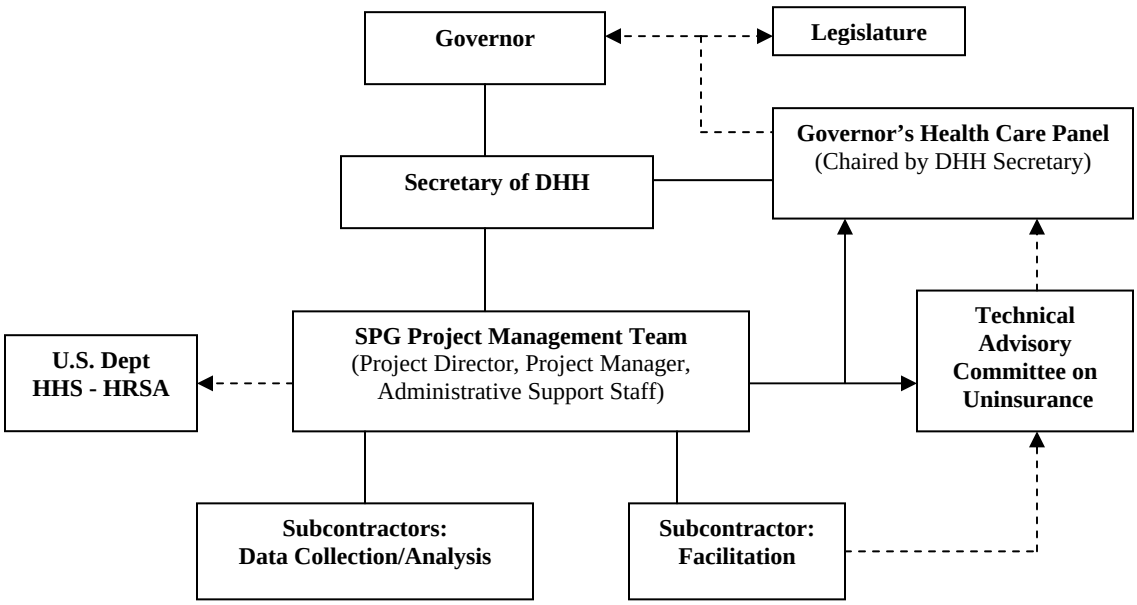
Of the two private market approaches attempted to date, only the State-subsidized high risk pool has been successfully implemented, albeit a very small program with limited reach. The LaHealth basic insurance program was never implemented, despite attracting private carrier applications to offer the product, likely because of its entanglement with the State's overambitious 1115 waiver application. At the time, the State lacked any significant experience with managed care, making it doubtful that Medicaid could have successfully enrolled its entire existing eligible population, plus hundreds of thousands of uninsured persons. It is clear that any savings realized through Medicaid managed care would have been outstripped by the cost of expanding Medicaid eligibility to anyone with family incomes below 250% of poverty, or more than half of all Louisiana residents.

The fate of recent efforts at prompting the private market to offer affordable, basic health insurance products is still uncertain. The Louisiana Safety Net Health Insurance Program, once intended for the private market as well, appears to be under development only by the State Employees Office of Group Benefits. The LaChoice program which recently obtained the necessary legislative appropriation to fund program start up and ongoing operation, is slated for implementation in April 2005 assuming that CMS approval of the waiver is obtained.

[17] During legislative deliberations on the SFY 2003-2004 appropriations bill, non-state hospitals agreed to delay implementation of the new rule for a year in order to avoid Medicaid rate cuts that would otherwise have been required by state revenue shortfalls. The Governor's Recommended Budget for SFY 2004-2005 includes funding to cover approximately half of the uncompensated cost payable to non-state hospitals under the rule ($15 million). If retained by the Legislature in the annual general appropriations bill, the funding will begin implementation of the rule in July 2004, providing relief to non-state hospitals that have taken on an increasing share of uncompensated cost in providing care to the State's uninsured.

The State's efforts at Medicaid eligibility expansions have, with the exception of the 1115 waiver, been successfully implemented. HIFA waiver opportunities appear to have more potential for success because the waiver parameters substantially address the fiscal concerns of Louisiana. The waiver allows Louisiana, a poor state in a challenging budget context, the ability to leverage existing resources through public-private partnerships whenever feasible. Support for the HIFA waiver has built substantially around the federal flexibility to avoid a "runaway entitlement program" by paring benefits and capping enrollment and spending. It also leverages employer employee contributions for the cost of job-based private insurance premiums, co-payments and deductibles.

APPENDIX X.
SPG GOVERNANCE STRUCTURE



APPENDIX XI.
FACT SHEET ON LOUISIANA'S HIFA WAIVER

What is a HIFA Waiver?

- HIFA stands for the Health Insurance Flexibility and Accountability waiver
- Created by the US Department of Health and Human Services in August 2001, a HIFA waiver allows states flexibility under Medicaid and SCHIP in benefits, cost sharing, financing, and populations covered.
- A HIFA waiver *must*:
  - Expand health insurance coverage;
  - Include a Employer Sponsored Insurance (ESI) component;
  - Set goals and include methodology for measuring changes in coverage;
  - Promise to meet state maintenance of effort; and
  - Meet federal budget neutrality requirements.
- A HIFA waiver *may not* reduce services to mandatory Medicaid eligibles or provide coverage to individuals with incomes above 200% of FPL.

Why a HIFA waiver for Louisiana?
The Louisiana Department of Health and Hospitals was directed to develop a HIFA waiver application by Act 813 of the 2003 Regular Session.

The Purpose of the Louisiana HIFA Waiver
To create a funding pool using the state's Disproportionate Share Hospital (DSH) allotment and use the funds to increase insurance coverage and provide greater access to primary health care services for non-Medicaid individuals with income less than 200% of the federal poverty level (FPL).

The funding pool will:

- Provide UCC payments for inpatient and outpatient hospital services;
- Provide payments for physician services at state owned and operated hospitals;
- Provide funding for *LaChoice* and the *Louisiana Health Plan* (LHP); and
- Provide funding for the *Health Partnership for Access and Coverage* program.

LaChoice
LaChoice will make it more affordable for small employers to provide health insurance through a public subsidy for eligible employees (parents and childless adults under 200% FPL) to reduce the premium cost for a limited benefit plan to be offered by commercial insurers to small employers that have not offered insurance in the past 6 months

The Louisiana Health Plan
The state will seek matching funds for low-income enrollees in the Louisiana Health Plan.

Health Partnership for Access and Coverage(HealthPAC)
HealthPAC will expand access to preventive and primary care and to health insurance coverage to approximately 28,000 low-income adults. Additionally, disease management principles will be integrated into the program.

Premise: Parishes will have the opportunity to draw down federal DSH dollars for access or coverage programs for low-income adults by providing the state's share of match.

How will this work? The HealthPAC portion of the funding pool will be allocated among the state's 64 parishes. Each parish will be allocated a capped amount of funds based on level of uninsured, poverty, and other factors. In order to draw down the funds, a parish must:

- Identify an acceptable form of match to be used as the nonfederal share; and
- Present an access or coverage proposal that meets DHH's requirements in terms of benefit package, disease management, maintenance of effort; and other factors.

Expanding Access to Preventive and Primary Care
If a parish pursues an access project, the parish will partner with an eligible health care entity to establish a network for excellence in chronic care; expand the services of a parish health unit to include a full range of primary care services; or convert a public inpatient facility to a community clinic that offers preventive and primary care services. A minimum set of services must be included in any access project (they are outlined in the waiver application). Additionally, an expansion of services to the uninsured must be demonstrated.

Expanding Health Insurance Coverage
If a parish pursues a coverage project, the parish may choose to fund additional LaChoice "slots", create a premium assistance program or other coverage option (such as a three-share model).

APPENDIX XII.
FACT SHEET ON LOUISIANA'S FAMILY PLANNING WAIVER

Date Waiver Proposal Submitted: September 9, 2005

Anticipated Start Date: April, 2006

Primary Goal: To reduce the occurrence of unintended pregnancies in the target population by increasing access to family planning waiver services

Target Population: Women at or below 200% of the federal poverty level, between the ages of 19 and 44

Enrollment Cap: Year 1: 75,000
Years 2 & 3: 48,750 additional new per year;
Years 4 & 5: 25,370 additional new per year

Total Enrollees -Waiver life: 223,000

Geographic area: Statewide

Benefit Package: Services currently identified as family planning which include initial and annual medical exams, necessary lab tests and contraceptive services, including sterilizations

Period of Eligibility for Waiver Participation: Eligibility is redetermined annually

Providers: Title X Family Planning Clinics (OPH) and any enrolled Medicaid physician, NP, FQHC, or RHC

Outreach: OPH, Medicaid

[i] Kaiser Family Foundation, www.statehealthfacts.org, accessed on October 31, 2005.
[ii] Louisiana Department of Labor, *Press Release: Hurricane Katrina Causes Unemployment Rate to Double*, October 25, 2005.
[iii] MEPS-IC, 2003.
[iv] Louisiana Department of Insurance, *Health Care Commission, e-mail transmission*, September 20, 2005
[v] MEPS-IC data for 2003 accessed October 26, 2005 at http://www.meps.ahrq.gov/MEPSDATA/ic/2003/Index203.htm