Louisiana State Planning Grant Application

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Louisiana Department of Health and Hospitals

Project Abstract Summary

Project Title: State Planning Grants Program
Applicant Name: Louisiana Department of Health and Hospitals
Applicant Address: 1201 Capital Rd, P.O. Box 2870, Bin 30
Baton Rouge, Louisiana 70821-287-
Applicant Phone #: 225-342-1400
Applicant E-mail: MByrd@dhh.la.gov.

Current Status of Access to Health Insurance in Louisiana

In 2001-2002, Louisiana had the 3rd highest rate of uninsured in the nation, with 19% of its total population lacking health insurance coverage. 56% of the State's residents were covered by private health insurance, and over one-quarter were covered by public programs (14% by Medicaid and 12% by Medicare.) National findings reveal that the uninsured have worse health outcomes than those with health care coverage. The United Health Foundation's composite index of state health ranks Louisiana second worst in the nation with prevalence rates showing Louisianans are sicker and die earlier than many other Americans. Louisiana's poor health care status reflects a health care delivery system characterized by limited preventive and primary care access and a reliance on acute care hospitals, especially emergency rooms. With far fewer community health centers than similarly situated states, the primary point of access to care for low-income uninsured persons is a set of 10 state-owned and state-operated "charity" hospitals and clinics.

Earlier Efforts to Expand Access to Health Coverage

In recent years, the sustainability of this "safety net" hospital approach has come into question. Prompted by legislative committees, standing commissions and task forces on the topic of indigent care and uninsurance, Louisiana has increasingly made efforts to change its approach to one of health insurance coverage, by making private insurance more affordable and accessible and expanding Medicaid and LaCHIP eligibility to low-income children and adults. To date, public-sector approaches have had greater success in expanding health insurance coverage in Louisiana than private market approaches. An early effort at private market, low cost "basic insurance" failed, while a small scale high risk pool has been successfully implemented with significant State subsidies. The success of recent efforts at private market, low cost "minimum benefit policies" and public subsidies to reduce premium rates for small employers is still unknown. By contrast, a number of public-sector coverage expansions have been successfully implemented. This includes expanding Medicaid eligibility to children and pregnant women with incomes to 200% of FPL and to women with breast and cervical cancer; paying the employee costs of job-based health insurance for working poor families, and allowing low-income disabled workers to buy into the Medicaid program. Finally, with the Governor's and Legislature's support, the State is currently pursuing a HIFA waiver to cover low-income parents and childless adults with Medicaid funding, including disproportionate share funds.

Louisiana Proposed SPG Project

In order to develop and refine a plan for providing access to affordable health insurance coverage to all Louisianans, the following four project goals have been established:

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 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 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.

Building on previous data and planning activities, data collection efforts will be targeted to filling in knowledge gaps (e.g., regional data on uninsured, cost of uninsurance, impact to employers). In addition to serving as an educational tool on the need for coverage expansion, this data will be used to further develop coverage options for uninsured persons above 200% of FPL and to refine the State's Medicaid expansion plan, especially in terms of addressing regional needs and developing viable financing strategies for covering low-income adults.

Lead Agency and Collaborators

Successful completion of the project goals is assured through the project's strong governance structure. DHH which oversees the State's Medicaid, public health, mental health, developmental disabilities and addictive disorders programs has been designated by the Governor as the lead agency responsible for carrying out Louisiana's SPG project. As the lead agency, DHH will be responsible for the oversight and coordination of all grant activities and will be supported in this endeavor by two experienced staff persons, one new hire and a host of in-state and national contractors. DHH will be able to build sufficient public and political consensus and support for the resulting plan by actively involving two key stakeholder groups. The Technical Advisory Committee on Uninsurance, representing key stakeholders in the area of health care coverage and uninsurance, will provide input and assistance in the development of specific action steps to address the accessibility of affordable health insurance coverage for Louisiana's uninsured citizens. The Governor's Health Care Panel comprised of 29 influential individuals appointed by the Governor (e.g., Secretary of DHH, who serves as chair; the Governor's Commissioner of Administration; key legislative leaders; national health care experts and representatives of regional health care reform efforts) will consider the options for expanding coverage in Louisiana and will make the final recommendations.

Projected Results

As a result of this project, Louisiana will gain a more thorough understanding of the uninsured and attitudes regarding health coverage and will have refined and adopted a plan with specific action steps for providing access to affordable health insurance coverage to all uninsured in the State. This plan which will be submitted as part of the final project report to DHHS will serve as the implementation guide for years to come in Louisiana. Outside Louisiana, it will offer valuable insights into how coverage expansions can work in states with large numbers of poor and uninsured and limited state capacity to finance coverage expansions without leveraging significant Federal and local government support and employer and patient cost sharing.

PROGRAM NARRATIVE

Current Status of Health Care Coverage in Louisiana

State of Louisiana

Louisiana is a mid-sized state, with its population numbering 4.3 million and ranking 24th in size among states in the 2000 U.S. census. It is geographically and culturally diverse, with Interstate 10 being the dividing line between Southern Catholics, fishermen, and crawfish, rice and sugar cane farmers on the one side and Northern Protestants, timber and cotton interests on the other.

Four in five people in Louisiana live in metropolitan areas, with the majority living "South of I-10." 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.

Louisiana's population is predominantly white, with non-Hispanic whites accounting for 63% of the total State population. Louisiana's African American population (33%) comprises a larger share of the State's citizens than any state other than Georgia and Mississippi. The greatest concentration of African Americans is in the cities of New Orleans and Baton Rouge and the parishes of the Mississippi River Delta. Other races are far less numerous, with Hispanics and other races accounting for just 3% and 2% of the State's citizens, respectively.

Louisiana ranks 4th highest in the nation in the rate of poor residents; people with family incomes below the Federal Poverty Level (FPL) make up 22% of the total State population. It also ranks fourth in the rate of low-income residents with 44% of the State's residents with family incomes below 200% of FPL. The highest poverty rates are in the 11 Mississippi River Delta parishes in the northeast part of the State and in Orleans Parish, followed by the band of parishes running from north to south along the ankle and arch sections of the boot-shaped state, where as much as three-quarters of the population is low-income. Median family income in Louisiana is just $21,020 (vs. $25,230 for the U.S.).[1]

Current Status of Health Insurance Coverage and Rates of Uninsurance

In 2001-2002, Louisiana had the 3rd highest uninsurance rate in the nation, with 19% (832,890) of the total population or nearly one in every five people in the State lacking health insurance coverage.[2] African Americans had a much higher rate of uninsurance (28%), accounting for

[1] Kaiser Family Foundation, State Health Facts Online (2001-2002 Census Bureau data). Unless indicated otherwise, the statistical information provided in the State of Louisiana and Current Status of Health Insurance Coverage and Rates of Uninsurance sections is from the Kaiser Family Foundation.

44% of all uninsured in Louisiana. A little more than half of the State's residents were covered by private health insurance (56%), and over one-quarter were covered by public programs (14% by Medicaid and 12% by Medicare.)

Non-elderly adults (19 – 64 years of age) were more than twice as likely to be uninsured as children. According to the Louisiana Health Insurance Survey, uninsurance rates for children were 11% compared with 21% for non-elderly adults. While private coverage rates for non-elderly adults were higher (66%) than for children (56%), public coverage rates were significantly higher for children. Children were five times more likely to be covered by Medicaid and the Louisiana Children's Health Insurance Program (LaCHIP) (32%) than non-elderly adults (6%). The higher coverage rates among children reflect recent LaCHIP eligibility expansions (to 200% of FPL for children under 19), and lower coverage rates for adults reflect the State's very restrictive Medicaid eligibility (to 14% of FPL for parents and 0% of FPL for childless adults who are not pregnant or disabled). Although poor and near-poor people make up less than half (44%) of the non-elderly population in the State, they make up the vast majority of all non-elderly uninsured (70%).

In Louisiana, both the percentage of private-sector employers offering health insurance (51.9%) and the percentage of employees eligible for health insurance in establishments that offer health insurance (68.8%) were lower than for the U.S. as a whole (58.3% and 77.9% respectively).[3] Additionally, lack of access to insurance was more of a problem in the small size firms (less than 50 employees) with only 36.3% of these small private-sector firms offering health insurance to its employees.

There have been several recent efforts within the State to more clearly understand Louisiana's uninsured population: the Health Access Barriers (H.A.B.I.T.S.) survey, a questionnaire designed to assess the barriers that people in Louisiana face when trying to access care, and a recent survey of Louisiana's uninsured commissioned by the Louisiana Department of Health and Hospitals (DHH).

The Louisiana Rural Health Access Program (LRHAP), a participant in the Robert Wood Johnson Foundation Southern Rural Access Program, serves to improve access to primary health care in rural communities in the southwest region of the state. To guide its work, LRHAP partnered with the University of Louisiana at Lafayette's Health Informatics Center of Acadiana to conduct and analyze the Health Access Barriers in the State (H.A.B.I.T.S.) survey. The initial survey was conducted in one southern parish in 1999, and since then has been conducted in each of the seven LRHAP pilot rural parishes. The Rapides Foundation of Central Louisiana also commissioned the H.A.B.I.T.S. survey in each of its 11 Central Louisiana parishes.

Much has been learned from these surveys over the past five years about the barriers people in south and central Louisiana face when accessing health care services. As expected, all of the parishes report that financing the cost of their own health care services, specifically maintaining health insurance, is the primary barrier to receiving health care. The survey results that document the proportion of respondents without health insurance, provide insight into the make-up, (e.g., usage patterns, health status, demographics), of the uninsured population in these 18 parishes.

[2] 2001 Medical Expenditure Panel Survey – Insurance Component.

But the parish-level H.A.B.I.T.S surveys leave a number of gaps in knowledge about uninsurance in the State. National and local financial support for the surveys has been significant but fragmented, supporting work in a single or a few parishes at a time. Funding has been insufficient to complete the surveys in every parish of the regions surveyed to date. Neither has it supported a complete analysis of the data nor synthesis reports to present a regional perspective of the problem of uninsurance. In addition, the survey results from selected parishes are not generalizable to the rest of the State.

To address the need for statewide data, in early 2003 DHH commissioned a telephone survey of 10,000 Louisiana households. The survey was paid for by the state Medicaid program for the purpose of measuring the effectiveness of LaCHIP in reducing the State's number of uninsured children, and determining the level of uninsured children and families remaining in the State. The survey instrument was adapted from one used by the University of Florida, and aimed to obtain more timely and accurate information on uninsurance in the state than that currently available from national sources. The survey was conducted by Louisiana State University and a final report was released in May 2004. This survey has some key limitations in terms of being used for planning insurance coverage expansions. These limitations are discussed later in the text (see discussion under Goal 1, Task 1.2 in the Project Narrative section).

Key Health Issues Related to Access to Health Insurance and Uninsurance

The Institute of Medicine and its Committee Consequences of Uninsurance[4] findings showed that the uninsured:

- Are less likely to have any physician visits within a year or a regular source of primary care.
- Receive fewer screening and preventive health services, poorer care in the hospital and care in less appropriate settings (e.g., emergency room).
- Are more likely to receive too little medical care, receive it too late, and have increase risk for adverse events and decrease life expectancy.

In short, the uninsured are sicker and die earlier than people with health care coverage.

With among the highest uninsured rates in the nation, Louisiana health status data appear to support these national findings. People in Louisiana are sicker and die earlier than many other Americans with some of the highest mortality rates due to diseases such as diabetes, heart disease and cancer. The 2003 United Health Foundation's composite index of states' overall health status ranked Louisiana second worst in the nation; it has been last or second to last for the past four years.[5] More recently, the Kids Count Data Book ranked Louisiana 49th in the overall well-being of its children when considering factors such as health, adequacy of income and educational attainment.[6] Additionally, a 2004 focus group study conducted with low-income uninsured individuals across the State, found the low-income uninsured could not afford health insurance even if it was available, would go to great lengths to avoid costly doctor office visits and would use the charity hospital system as their first line of defense.

[4] Insuring America's Health, Principles and Recommendations, Institute of Medicine of the National Academies, 2004.
[5] United Health Foundation, America's Health: State Health Rankings – 2003 Edition.
[6] Kids Count 2004 Data Book Online, The Anne E. Casey Foundation, 2004.

Louisiana's Health Care Delivery System and Its Adequacy in Serving the Uninsured

Louisiana's health care delivery system is characterized by limited preventive and primary care access and a reliance on acute care hospitals, especially emergency rooms for access to health services. Louisiana has the 15th highest rate of community hospitals per population (a rate nearly twice that of the U.S.) and the 9th highest rate of community hospital beds per population. The State's inpatient days and emergency visits are similarly ranked. By contrast, 9 out of 10 Louisiana parishes are designated as Primary Care Health Professional Shortage Areas (108 designations in 41 of the State's 64 parishes), signifying a patient to primary care physician ratio that falls short of the federally recommended benchmark of adequate access to preventive and primary care services that can often avoid illness and the need for acute care hospital inpatient and emergency services.

Louisiana recently has focused its efforts at increasing its primary care access, and is planning to double the number of Federally Qualified Health Centers (FQHCs) by 2005. Today, Louisiana has 31 FQHCs providing primary and preventive health care services in medically underserved areas – far fewer FQHCs than similarly situated states. For example, with half the population and comparable poverty rates and health rankings, Mississippi has four times as many FQHCs as Louisiana. In 2001, Louisiana's community health centers served 81,339 patients, 46.3% of whom were uninsured.

There are 10 State-owned public hospitals in Louisiana that are operated by the Louisiana State University (LSU) Health Sciences Center. The Medical Center of Louisiana in New Orleans and University Hospital in Shreveport are the principal referral hospitals for the system. The other hospitals in the system are located in Bogalusa, Independence, Baton Rouge, Lafayette, Lake Charles, Houma, Pineville, and Monroe. The system primarily serves low-income and uninsured patients. In 2002, there were more than 2 million outpatient visits and 83,000 admissions and more than 750,000 active patients (defined as having one of more visits in the prior 24 months). 71% of these patients were uninsured. In addition to the State-owned hospitals, Louisiana has 109 non-state acute care hospitals, including 44 small rural and critical access hospitals (11) and affiliated and unaffiliated rural health clinics (52). These hospitals primarily serve publicly and privately insured patients, but also provide an increasing share of uncompensated care to the uninsured.

With Medicaid and Medicare enrollees accounting for 26% of the total population, many health care providers struggle financially because of low public payment rates. Adding to the uncompensated cost burden is another 19% of the total population with no health care coverage at all, who often require high cost services for chronic or other severe conditions exacerbated by the lack of coverage. State data for 1999-2000 indicate an uncompensated cost burden of nearly $75 million from the care of uninsured patients by hospitals in Louisiana. Rural providers are especially hard hit with less private insurance coverage and more dependence on public payments than their urban counterparts, on top of the financial disadvantages associated with lacking economies of scale.

To date, managed care penetration has been weak in Louisiana relative to other states. In 1998, managed care organizations (HMOs) accounted for just over half of the commercial major medical policy market. In 2000, HMO penetration peaked at roughly two-thirds of the market,

and HMO market share in the market has since declined, with the insolvency of carrier after carrier. In Medicaid, managed care has taken shape in the form of "CommunityCARE," a Primary Care Case Management (PCCM) model, which has been in place statewide since 2003.

Understanding of Other State and National Activities to Reduce the Uninsured

Louisiana constantly monitors national and state activities related to health insurance coverage for opportunities to apply policy opportunities and best practices to the State's unique situation as well as to learn from the challenges that other states have faced in trying to reduce the number of uninsured. This is accomplished through literature reviews, e-mail news alerts, participation in national organizations (e.g., NGA, NASMD) and meetings (e.g., SHADAC, SCI) and the use of national health care experts as both consultants and participants on task forces/committees related to health care coverage and the uninsured. It is expected that through the SPG project, Louisiana will be able to further strengthen this understanding by having ready access to the wealth of experience and knowledge that SPG states have obtained in trying to reduce the number of uninsured through their SPG grants.

While the SPG project will afford new opportunities to benefit from the experience of others states, Louisiana has always evaluated the merit of national initiatives and reviewed other states' experience in its ongoing effort to reduce the number of uninsured. For example, Louisiana is currently in the process of developing a Health Insurance Flexibility and Accountability (HIFA) waiver proposal that would incorporate two employer-focused coverage approaches. The federal emphasis on employer-sponsored insurance blends well with the interest on the part of key Louisiana legislators to develop approaches targeting the "working poor." One of these approaches, LaChoice, is being primarily modeled after the Healthy New York program, a reduced-premium product available to uninsured small businesses, sole proprietors, and self-employed individuals in that state. In developing its HIFA waiver, Louisiana also studied the coverage approaches used in developing the HIFA waiver proposals for New Mexico and Arkansas, where an employer-based subsidized health insurance product serves as the cornerstone for the states' HIFA proposals. Although New Mexico's program is approved but not implemented, and the Arkansas program is still under review by Center for Medicare and Medicaid Services (CMS), Louisiana has carefully reviewed these programs for any elements that are worth applying to its employer-sponsored model. One example is the subsidy approach that will be used in LaChoice, rather than the more complicated stop-loss mechanisms that was used in Healthy New York.

Earlier Efforts to Reduce the Number of Uninsured Residents

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 only 385 policy holders currently 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[7], 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[8] 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 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.

[7] 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.
[8] 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.

- 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.

At this time the State's effort to reduce the number of uninsured is primarily focused on the development of a HIFA waiver. The Governor, Legislature and Louisiana's Health Care Commission's Subcommittee on Covering the Uninsured are all actively supporting this strategy with legislation being passed in 2003 authorizing DHH to seek approval of a Medicaid HIFA waiver and funding appropriated in SFY 2003-2004 ($500,000) for DHH to develop the HIFA waiver application. With input from a broad-based advisory work group and technical assistance from the EP&P Consulting and William Mercer actuaries, DHH recently developed a plan that sets forth four different approaches (or strategies) for addressing the multitude of factors that contribute to uninsurance. These are:

1. Increase the number of low-income workers who take up existing employer sponsored insurance, through an expansion of DHH's current HIPP program (detailed above) through the inclusion of uninsured parents of Medicaid and LaCHIP children;

2. Increase the number of small employers that provide health insurance, through implementation of the LaChoice program (detailed above) using federal matching funds for subsidies for low-income participants;
3. Extend the reach of State-funded programs for persons denied individual coverage by commercial insurers due to their "high risk" status, by seeking federal matching funds for eligible low-income enrollees in the State's high risk pool (detailed above); and
4. Provide affordable, basic health insurance coverage for low-income adults without access to employer sponsored insurance.

The HIFA waiver proposal was presented to the House and Senate Health and Welfare and Insurance Committees in March 2004 and in April the Joint Legislative Committee on the Budget authorized the submission of the waiver to CMS by July 2004. Further, the Legislature is currently considering SFY 2004-2005 funding ($1.7 million) for implementation of the waiver. This funding would be used primarily to support the implementation in early 2005 of the first phase of the waiver, which includes approaches one through three outlined above (i.e., administrative support for HIPP, start-up costs for LaChoice and premium subsidy payments for LaChoice). Another $450,000 has also been requested to support development of an implementation plan associated with the second phase (i.e., coverage of low-income adults without access to employer sponsored insurance) tentatively targeted for implementation in mid-2006.[9]

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

[9] SPG grant funds will complement any State funds appropriated, enabling the State to be able to move to the implementation of this second phase by providing the necessary funds to allow for further planning and refining of the basic model and for collecting the necessary data needed to build the support for the expansion effort.

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.[10]
- 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

[10] 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.

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.

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.

One of the primary shortcomings in the State's efforts to expand coverage has been a lack of overall coordination. Many parallel efforts have been undertaken independently and without knowledge of other efforts, resulting in duplication of effort and inefficient use of limited resources (e.g., Task Force on the Working Uninsured, Louisiana Health Care Commission, Baton Rouge Area Foundation study). Poor communication and information sharing among the efforts has limited the efforts' individual and collective impact. In addition, the efforts have typically been short-term, scarcely staffed, and unfunded, making it difficult if not impossible to clearly identify key concerns, adequately frame the questions to be addressed, and diligently pursue the answers with the appropriate expertise.

How the Proposed Grant Activities Help To Support the Earlier Efforts or Create New Initiatives

The proposed SPG grant activities, build directly upon earlier public- and private-sector expansion efforts as well as the newly developed HIFA waiver expansion proposal that Louisiana hopes to implement in the near future. While money has been appropriated to support the implementation of phase one of the proposed HIFA waiver, a more concerted planning effort is still needed with regard to phase two of the HIFA wavier – expanding health care coverage to low-income adults without access to employer sponsored insurance. This second phase of the HIFA waiver is certainly the more ambitious and costly of the two (i.e., potentially reducing the number of uninsured by 435,000 as opposed to an estimated reduction of 4,500 in the number of uninsured under phase one).

Through Louisiana's proposed SPG project, the State would be able to:

- Complete the data collection and analysis necessary to accurately project the costs of different financing strategies to support the expansion of coverage to low-income adults;
- More readily take into consideration the experiences of other states that have been involved in coverage expansion efforts especially as consideration is given to options for expanding coverage to the uninsured above 200% of FPL; and
- Develop a broad-based plan for coverage expansion along with recommended action steps that will serve as an implementation guide for the State for years to come.

More importantly, the SPG planning process will allow the State to pull together the diverse groups working on trying to address the issue of the uninsured and build the necessary support among the key stakeholders for the recommended plan. This consensus building effort is essential if further coverage expansion is to be successfully implemented in the State. Lastly, the SPG project will be able to capitalize on Governor Blanco's newly created Health Care Panel charged with the design of short- and long-term solutions to the State's health care problems, including the uninsured. Major advantages of this Panel not enjoyed by earlier expansion efforts include that it is a high priority initiative of the Governor, structured to include the most powerful state decision makers (including key legislative leaders), guided by leading national experts, and explicitly intended for its output to inform State action over the next two years.

Statement of Project Goals

In order to develop and refine a plan for providing access to affordable health insurance coverage to all Louisianans, the following four project goals have been established:

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 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 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.

Project Description

A. Detailed Project Narrative

Goal 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.

Task 1.1 Develop summary reports of quantitative and qualitative data collected and analyzed during the State's HIFA waiver development process, specifically hospital discharge data, uncompensated cost data, data on parents of children enrolled in the State's Medicaid and LaCHIP programs, and data from focus groups with low-income uninsured individuals

During the development of the HIFA waiver, DHH contracted with Washington, D.C.-based EP&P Consulting, Inc (EP&P) to provide technical assistance with the process and to analyze the following three key sources of existing State data on uninsurance:

- Inpatient hospital discharge data, including diagnosis, procedure, charge and patient demographic data, to discover any significant differences between insured and uninsured patients to inform decision making on covered services under a HIFA waiver.
- Uncompensated cost data reported by acute care hospitals to DHH for the purposes of Disproportionate Share eligibility determination and payment purposes in order to better understand the amount and distribution of uncompensated cost across the state, within regions, and among state and non-state providers.
- Data on parents of children enrolled in the state's Medicaid and LaCHIP programs to get a clearer picture of the population of low-income parents potentially eligible for coverage under a HIFA waiver, including the size of the population at the state and parish levels, and the distribution of this population by income (FPL) and sex.

The analyses were presented to a HIFA advisory work group primarily in the form of voluminous Excel data tables not easily accessible to a general audience or busy policy makers.

In addition, EP&P conducted a set of eight focus groups with low-income, uninsured, non-elderly adults, and produced a lengthy narrative report detailing participant experiences with health status, health care access, employer-sponsored insurance, and health insurance affordability, and participant attitudes toward different HIFA waiver coverage options, including covered benefits and providers, premiums, co-payments, and deductibles.

To make the information more accessible for use by all parties involved in the SPG project, (e.g., subcontractors, Technical Advisory Committee on Uninsurance (TAC), the Governor's Health Care Panel), DHH will contract with EP&P to translate the lengthy narrative report and voluminous Excel data tables into four readily comprehendible reports. These reports will be in a format that is clear, concise, and easily transmittable, specifically visually attractive, AcademyHealth-style briefs not to exceed two pages in length. These reports will also serve as a tool to educate other stakeholders on the issue of uninsured and as a resource for health care policymakers in other states.

Task 1.2 Develop regional/parish-level estimates on the uninsured population, with households defined by State Medicaid eligibility rules and stratified by income expressed as a percentage of the Federal Poverty Level (FPL)

To measure the effectiveness of the LaCHIP in reducing the State's number of uninsured children and determine the level of uninsured children and families remaining in the state, the State Medicaid program commissioned a telephone survey of 10,000 Louisiana households in early 2003. The survey instrument was adapted from one used by the University of Florida. The LSU Public Policy Research Lab conducted the survey in summer and fall 2003, and a final report was released in conjunction with the State's National Covering the Uninsured Week events in May 2004. While the survey provides important information on the uninsured population in the State it does not include the more detailed regional- or parish-level data desired by policy decision makers, particularly to support further development of phase two of the State's proposed HIFA waiver, i.e., low-income adults.

As originally conceived, the fourth HIFA waiver strategy to provide affordable, basic health insurance coverage for low-income adults without access to employer sponsored insurance was proposed to begin statewide in April 2005. This included an income eligibility limit of 50% FPL for parents of dependent children and childless adults and an enrollment cap of 50,000. But given the high price tag, the state Division of Administration, while cautiously supportive of the concept, roundly urged a more affordable, incremental plan for moving forward (see discussion under Task 1.4). The leading alternative suggested by legislative leadership and executive branch officials, as well as key stakeholders outside government, was a regional pilot, potentially preceding a region-by-region phase in of the program statewide.

The short-term barrier to developing a concrete plan for coverage expansion for this population on a regional pilot and/or region-by-region phase-in of the program statewide is a lack of parish-level data on the uninsured population 1) by household as defined by state Medicaid eligibility rules and 2) stratified by income expressed as a percentage of the FPL. While both data elements are needed to develop accurate estimates of the cost for any proposed publicly-subsidized coverage expansions, these elements were not included as a component of the LSU household survey data. This is because the survey

- Defined households as reported by the survey respondent, as opposed to households as defined by Medicaid eligibility rules. For example, a grandmother, her adult daughter and the daughter's three dependent children constitute a single household in the survey data, whereas Medicaid would count the grandmother as one household and the daughter and dependent children as a second household. The likely result is an undercount of

potential Medicaid eligibles and subsequent underestimates of projected program expenditures.

- Provided only household income data. The households are, as explained above, reported by survey respondent, as opposed to households as defined by Medicaid eligibility rules. In additions, the income data is an aggregate estimate by the respondent and not the sum of the incomes of individual household members. To the extent that the survey combines one or more Medicaid households and their incomes, any estimate of the distribution of potential eligibles along the Federal Poverty Level scale is likely to be inaccurate. Medicaid eligibility is fundamentally dependent on a combination of two factors: 1) the number of individuals in a household and 2) the sum total of the incomes of individual household members. For example, take the illustration above wherein a survey household combines two Medicaid households. Survey data indicate that the number of individuals in the household is five and the household income is $21,000. Assume that the eligibility limit for the HIFA waiver program is set at 100% of FPL and know that the 2004 Poverty Level Guidelines define 100% of FPL for a family of 5 as $22,030. It appears that the household is eligible, but it is not. The Medicaid household comprised of the daughter and her three children account for all of the family income and the total number of individuals in the household is four. The 2004 Poverty Guidelines define 100% of FPL for a family of 4 as $18,850. Therefore, the daughter's income exceeds 100% of FPL making her ineligible. The Medicaid household comprised of the grandmother alone is ineligible because she is 66 years old and the program covers only non-elderly adults (ages 19 to 64).

To develop more accurate estimates of potential eligibles and program expenditures, survey households need to first be disaggregate into Medicaid households and then impute individual incomes to Medicaid household members to arrive at more accurate aggregate incomes for these households. In order to accomplish this data analysis, DHH will contract with the University of Minnesota's State Health Access Data Assistance Center (SHADAC), a research and data policy center. Building on the LSU household survey data, SHADAC will partner with LSU faculty and DHH staff to develop and apply a method to arrive at parish-level estimates of the uninsured population by Medicaid household and stratified by income expressed as a percentage of FPL.[11] Basic demographic characteristics of the local population such as income level, age, sex, household size, will be generated. The resulting data, along with the completion of Task 1.5 (i.e., modeling of financial strategies) will be instrumental in supporting the development of a coverage expansion plan by the TAC and the Governor's Health Care Panel especially as it relates to a possible regional phase-in (most likely multi-parish regions paralleling the catchment areas of state charity hospitals) of both low-income adults as well as other non-low-income groups who are without access to employer health insurance coverage.

Task 1.3 Develop estimates of the cost of uninsurance in Louisiana, providing quantitative data on the impact of uninsurance on individual businesses, state government, and the state economy as a whole

[11] Parish-level estimates will be developed where statistically valid and regional-level estimates where the parish samples size is to small to generate statistically valid estimates.

As in many states, health insurance coverage and the high rate of uninsured is one of many competing priorities for attention in Louisiana. Among the highest of these competing priorities is economic development, which is widely acknowledged to have the long-term potential to improve employment and earnings rates and in turn positively impact health insurance coverage rates and health status. Less widely acknowledged among the public and policymakers, is the adverse effect uninsurance has on the ability of businesses in Louisiana to succeed and grow and of the State's economy as a whole to prosper. This relationship has also never been systematically quantified in Louisiana so that the public and key policymakers can readily understand the relationship.

There are, however, multiple ways in which uninsurance may compromise the economic potential of businesses in Louisiana:

- National research shows that uninsured workers are more likely to have poor health status than insured workers. Sick workers translate into lower productivity, either through absenteeism (sick days) or presenteeism (when workers come to work sick). Lower productivity has a direct impact on a firm's ability to compete successfully in the marketplace.
- Uncompensated cost of caring for the uninsured borne by health care providers is paid by businesses as taxpayers through state and federal Medicaid Disproportionate Share (DHS) payments to hospitals that provide care to the uninsured. Businesses also pay for the uncompensated cost of caring for the uninsured through insurance premiums, as the costs are shifted to insured patients through charges inflated to cover the cost of the insured's care and that of the uninsured. This "cost shifting" in part accounts for the double digit premium growth rates in health insurance premiums in recent years.
- Compounding the problem of uninsurance, the increasing unaffordability of health insurance premiums leads businesses to cut back on benefits or increase the cost sharing requirements of employees through larger employee contributions to the premium payments and higher deductibles and co-payments. In cases where premium increases threaten the overall profitability of a firm, business owners choose to stop providing health insurance coverage at all – forgoing federal tax subsidies for health insurance premium payments and potentially adversely affecting the firm's ability to recruit and retain qualified workers. Likewise, in cases where premium increases threaten the ability of workers to cover basic expenses such as food, housing and transportation, workers opt not to take up available employer-sponsored insurance.

In addition to businesses, uninsurance also adversely impacts state government in Louisiana by:

- Increasing state expenditure required to support indigent health care programs. In SFY 2002 - 2005, Louisiana will spend three-quarters of a billion on Medicaid DSH payments (including a quarter of a billion in State matching funds generated from business taxes among others) to reimburse eligible hospitals for the uncompensated cost of providing health care to the uninsured. Further, to the extent that lack of health insurance precludes timely access to preventive and primary care and results in avoidable illness and inpatient hospital admissions as well as inappropriate emergency room use, Louisiana state government – and the taxpayers who finance it – bears the burden of inefficient state health care spending.

- Compromising Louisiana's potential for economic development and related state government revenue growth. Unlike Louisiana, states with higher rates of health insurance coverage and healthier workforces enjoy higher personal income tax rate growth (healthy workers have higher earnings) and higher business income taxes (healthy workers make more productive firms).

Capitalizing on the public's and policymakers' interest in Louisiana's economic development, DHH will, as part of the SPG project further the debate and decision making on the expansion of health insurance coverage by developing economic estimates on the impact that the State's large uninsured population has on businesses, State government and the Louisiana economy as a whole. The analysis will also model how coverage expansions might change both the level and distribution of such costs (i.e., generation of cost savings). Finally, the existing safety net system will be examined to determine the economic impact of its participation in coverage efforts. DHH will contract with a leading economist(s) in this field, such as those at the Urban Institute, Mathematica Policy Research, Inc. to conduct this economic analysis of uninsurance in Louisiana. In addition, in developing the study approach DHH will consult with other states that are considering or have completed similar type of analysis, e.g., District of Columbia as part of their SPG project.

Task 1.4 Develop economic estimates of State revenue that might be generated from various financing strategies to support the State's effort to improve the accessibility of affordable health insurance coverage

One of the primary barriers to expanding coverage to low-income adults without access to employer sponsored insurance is limited State revenues (see discussion under Task 1.2). While the Legislature and Governor are broadly supportive of the proposed HIFA waiver, only the first three of the waiver's four strategies will be funded for implementation in the coming fiscal year (SFY 2004 - 2005). At a State cost of just $1 million, the first three strategies (i.e., increase enrollment HIPP, LaChoice and the State high risk pool) are easy for State money managers to support.

Unlike the other three HIFA waiver strategies, the fourth wavier proposal – the expansion to low-income adults has the potential to make a major impact on the rate of uninsurance in Louisiana. The other three strategies are likely to have limited reach (4,500 is the estimated enrollment for next year), having only a small impact on reducing the State's uninsured rates. The fourth waiver proposal, however, could provide access to affordable health insurance coverage for as many as 435,000 low-income parents and childless adults. If fully implemented, the program would more than halve the State's rate of uninsured. The cost of such implementation, at an estimated $200 per member per month, would top $1 billion a year. As such, State money managers want to see further development of more affordable options for the fourth HIFA waiver program prior to committing the necessary State matching funds for operating such a program.

In order to develop more affordable options, DHH will develop economic estimates of State revenue that might be generated from various financing strategies. Specifically, the project will contract with LSU economist, Dr. James A. Richardson to develop economic estimates of State revenue options, including but not limited to payroll taxes, broad-based health care provider taxes, value-added taxes on health services, health insurance premium taxes, and local

government millages for health care services. Dr. Richardson is the John Rhea Alumni Professor of Economics and Director of the Public Administration Institute at Louisiana State University at Baton Rouge, and a longstanding member of Louisiana's Revenue Estimating Conference.

Coupled with the analysis of the costs of uninsurance (outlined in Task 1.3), Louisiana will have a clear picture of how much money is spent on the uninsured, how much of that money is recoverable through coverage expansions, and how new dollars can be leveraged. Defining the available financial resources will be instrumental along with the regional/parish-level estimates on uninsured (outlined in Task 1.2) in determining which policy options to cover low-income adults are feasible, including the feasibility of a regional pilot or phase-in approach and in the formulation of additional strategies for providing non-low income populations with access to affordable health insurance.

Task 1.5 Conduct focus groups of Louisiana employers to provide qualitative data on the impact of uninsurance on individual employers and to gauge employer support for various options to address the accessibility of affordable health insurance coverage

As discussed under Task 1.3, there is a multiplicity of ways in which employers pay for the cost of the uninsured (e.g., lower productivity, increase in insurance premiums). To better understand these issues in the Louisiana context, DHH will conduct a total of 16 employer focus groups. The focus group sites will be selected to represent the diversity of the State's employer population by industry, firm size, and geography. The focus groups will be conducted in two rounds of eight. The first round of focus groups will focus on the impact of uninsurance on employers and the second round of focus groups will focus on employer support for various options to address the accessibility of affordable health insurance coverage.

To conduct this work, DHH will engage an in-state contractor, in partnership with the University of Minnesota's State Health Access Data Assistance Center (SHADAC) and the State's leading employer trade associations. Based on its experience with similar efforts in other states, SHADAC will provide technical assistance to the in-state contractor on the design of focus group questions, logistics (selecting meeting places, times and participant stipend rates that appeal to employers) and participant recruitment methods. Additionally, DHH staff will collect information from other states (e.g., Alabama, Delaware, Hawaii, New Jersey) on successful methods or lessons learned in conducting employer focus groups. The in-state contractor will partner with leading employer trade associations, such as the National Federation of Independent Business, Louisiana Business Group on Health, Louisiana Association of Business and Industry, and the Louisiana Association of Independent Businesses, to recruit participants. The in-state contractor, however, will be singularly responsible for conducting the focus groups and preparing focus group reports.

The results of these focus groups will provide DHH with qualitative data on the impact of uninsurance on employers and will be used to complement the economic analysis on uninsurance described above in Task 1.3. The focus groups will also provide a means to gauge employer support for various options to address the accessibility of affordable health insurance coverage and along with the results from the previously conducted focus groups with uninsured residents will be used to educate the key decision-makers and to build public support for the agreed upon expansion options.

Task 1.6 Conduct two telephone surveys of 600 respondents each to gauge public opinion on the extent to which uninsurance is a problem and to gauge public support for various options to address the accessibility of affordable health insurance coverage

The voices of constituents are very important to lawmakers responsible for decision making on policy options to address the accessibility of affordable health insurance coverage. Although important, the organizations and individuals represented on the Governor's Health Care Panel and the Technical Advisory Committee on Uninsurance do not necessarily reflect the values, concerns or preferences of the general public throughout the State. Neither do the employer focus groups surveyed under Task 1.5 represent the diversity of people who take an active role in choosing the leadership of state and local government. Nor does any amount of quantitative and qualitative data collected speak simply and directly to the core concern of elected officials: What do my constituents think?

In order to obtain this critical information, DHH will conduct a public opinion telephone survey. As with the previous task, DHH staff will collect information from other states on successful methods or lessons learned in conducting public opinion polls. DHH will contract with an in-state contractor to conduct two rounds of telephone surveys of 600 people selected to represent the geographic diversity of the state's voters. The first round will gauge public opinion on the extent to which uninsurance is a problem and the second round will gauge public support for a variety of options to address the accessibility of affordable health insurance coverage.

The results from these surveys along with the results from the employer focus groups (see Task 1.5) as well as the results from the previously conducted focus groups with uninsured residents will be used to educate the key decision-makers and to build public support for the agreed upon coverage expansion options.

Task 1.7 Develop and maintain a website and list serve for the SPG project

In order to communicate to interested stakeholders about Louisiana's SPG grant activities, DHH will host a website to serve as a central source for information about the problem of uninsurance and potential solutions in Louisiana. This website will also serve as a resource for other researchers or states involved in addressing coverage issues. Among the items to be posted are a calendar of SPG and related events (such as ongoing research, the Governor's Annual Health Care Summit and Technical Advisory Committee meetings); announcements (such as SPG Requests for Proposals), SPG and related reports, and tabulated data for public use, as well as links to local, state, and national resources.

DHH will contract with an in-state marketing firm to develop and maintain the website and list serve. The firm will be responsible for facilitating information sharing via website postings and email alerts on new developments and electronic communication among interested individuals and organizations via group email. Additional responsibilities includes limited desktop publishing and graphic design to assure that project publications are attractive and easy to read, upkeep of a web-based calendar of events and other opportunities for collaboration among participants in the SPG project and related efforts on covering the uninsured.

Goal 2 DHH will establish a Technical Advisory Committee on Uninsurance to support the Governor's Health Care Panel in its decision making by providing a means for the active participation of diverse stakeholders in the detail work behind any recommendations.

The Technical Advisory Committee on Uninsurance (TAC) will be assembled by DHH, in close partnership with the Governor's Office. The TAC will include key stakeholders on the issue of health insurance coverage and uninsurance, such as Legislative staff, Governor's Office staff, DHH staff, other State agency staff (e.g., Department of Insurance, Division of Administration and representatives of safety net and non-state urban and rural hospitals, Federally Qualified Health Centers and rural health centers, free clinics, health care professionals, health insurers, employers, consumers, public health advocates and academics, non-governmental researchers, and other policymakers). Committee members will be selected on the basis of their experience and substantive knowledge on the subject and their commitment to continuous and active participation in related efforts, e.g., Governor's Health Care Summit and regional pre-summits. In composing the Committee, close attention will be paid to issues of geographic and racial diversity, in addition to the sectoral representation indicated above. Lastly, in order to facilitate communication among the various health care related committees a concerted effort will be made to include individuals on the TAC who are also actively involve in related committees or task forces such as the Louisiana Health Care Commission, the HIFA waiver advisory work group, Task Force on the Working Uninsured. (See Appendix C for a list of letters of support for the Louisiana SPG project which is reflective of the organizations likely to be represented on the TAC.)

In essence the TAC will serve as a work group to the Governor's Health Care Panel and will be responsible for reviewing SPG project data collection and analysis results; assessing the feasibility of various coverage expansion options for the uninsured in the State and developing, a plan including a set of action steps to address the accessibility of affordable health insurance coverage in the State. Through the DHH SPG staff and TAC committee members, the findings and deliberations of the TAC will also be communicated to other key stakeholder groups such as the Louisiana Health Care Commission and presentations will be made at various public forums / conferences such as the Governor's Annual Health Care Summit.

DHH will contract with EP&P Consulting, Inc. (EP&P) to facilitate a process through which the TAC will develop its recommendations. EP&P who has in-depth experience in strategic planning and facilitation is uniquely positioned to help Louisiana in achieving this goal. EP&P has worked extensively with public and private sector organizations in designing, implementing, evaluating and improving health care and public policy programs for over eleven years. This firm offers a unique combination of resources qualified to address the full continuum of policy, operational, systems and financing issues and has assisted states across the nation in group facilitation, program development, and survey development. In addition, EP&P is intimately familiar with Louisiana's coverage efforts, Medicaid program, and political landscape through its work in developing the State's HIFA waiver, as well as staff involvement from previous consulting employment in the State's 1995 Medicaid 1115 waiver application. This combination of a working understanding of the local environment with an outside perspective and nationally recognized credibility will be invaluable in working with the TAC, helping them to make the

tough decisions on coverage expansion options that might work for the State and strategies for implementation.

There will be a series of six TAC meetings held during the course of the one year SPG grant with the following being accomplished at each of the meetings:

- Meeting 1 (October): orientation of the TAC members to the grant goals, tasks, and timelines
- Meeting 2 (December): a review of the inventory of policy options from other states and assessment of what works in different contexts (prepared by EP&P in partnership with AcademyHealth); the Louisiana context as characterized by state and national source data (prepared by DHH staff); and a review of EP&P-prepared summary reports on hospital discharge data, uncompensated cost data, data on parents of children enrolled in the State's Medicaid and LaCHIP programs, and data from focus groups with low-income uninsured individuals
- Meeting 3 (February): development of guiding principles, prioritization of options, and a review of the results from the economic analyses, focus groups, opinion polls and issue briefs.
- Meeting 4 (March): finalize the preliminary report on data collection and analysis results and policy options.
- Meeting 5 (April): begin development of overall coverage plan including identification of recommended action steps for SFY 2005-2006 and continued review of data collection and analysis results.
- Meetings 6 (June): finalization of coverage plan including recommended action steps for SFY 2006-2007 and SFY 2007-2008.

The resulting coverage plan setting forth the recommended action steps, including the identification of funding strategies and partnerships necessary partnerships for successful implementation will be submitted to the Governor's Health Care Panel for approval in July 2005. The TAC will close its first year of work by submitting a final report including the results of all the study findings, summary of the committee's deliberation and a copy of the resulting plan and recommended action steps submitted to the Panel. This report will be shared with the Legislature and the Governor.

Goal 3 The Governor's Health Care 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 in Louisiana.

Governor Kathleen Babineaux Blanco's Health Care Panel is an outgrowth of the Governor's 2003 campaign pledge to solve the health care crisis in Louisiana, including a first-ever statewide health care summit (held in March 2004), co-chaired by U.S. Senator John Breaux, that brought together diverse, local, state and national interests in the field to begin to work collectively on a state strategic plan for health care reform. The Governor has charged the Panel with the design of short- and long-term solutions to the State's health care problems, including uninsurance. As part of this charge the Panel will make the final decisions on the coverage plan

and the recommended action steps to address the accessibility of affordable health insurance coverage.

The 29 members of the Health Care Panel are appointed by the Governor. Current membership on the Panel includes the Secretary of the DHH, who serves as chair; the Governor's Commissioner of Administration; the Senate and House President and Speaker and Pro Tempores; the Chair of the House and Senate Health and Welfare and Budget Committees; national health care experts, such as Diane Rowland of the Kaiser Family Foundation, Reed Tuckson of the United Health Foundation, and Alice Burton of Academy Health; and members of the public representing regional health care reform efforts in each of the State's nine geographic regions.

The Panel will meet for the first time in late June 2004 and quarterly thereafter for two years. The SPG project director will support the efforts of the Panel as it relates to options for coverage expansion and the Technical Advisory Committee (TAC) on Uninsurance will technically serve as a "work group" to the Panel. As discussed under Goal 2, the TAC will develop a report outlining the recommended action steps to address the accessibility of affordable health insurance coverage for Louisiana's uninsured citizens and submit the report to the Panel for review and approval at its quarterly meeting in August 2005. In addition, progress reports on the SPG project will be provided to the Panel at each of their quarterly meetings along with summaries of any important findings that have emerged as a result of the SPG data collection and data analysis efforts.

Goal 4 The Department of Health and Hospitals 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 expansions.

Through the efforts of SPG participants, including Technical Advisory Committee participants, Governor's Health Care Panel members, DHH staff and subcontractors, the project will culminate in the submittal of a final report to DHHS on the Louisiana findings. This final report will be prepared by the SPG management team, in particular the SPG project manager. In addition to documenting the decision making process and related information (both policy options identified and data collection and analysis to inform the prioritization of options), the report will identify the characteristics of the uninsured within the State and a coverage plan for providing access to affordable health insurance coverage to all uninsured citizens in the State. This coverage plan will set forth the recommended action steps, including the identification of funding strategies and the partnerships necessary for successful implementation. (See Report to the Department under the Governance section for a description of the process used to develop and finalize the report.)

In addition to posting the report on the SPG project website, the final report will be distributed to the members of the TAC, the Governor's Health Care Panel, the Governor, other key stakeholders (e.g., legislative members/staff, advocacy groups, provider organizations not serving on the TAC or Panel).

It is expected that the coverage plan contained in the report will serve as the implementation guide for coverage expansion in Louisiana for years to come. Outside Louisiana, the report will offer valuable insights into how coverage expansions can work in states with large numbers of

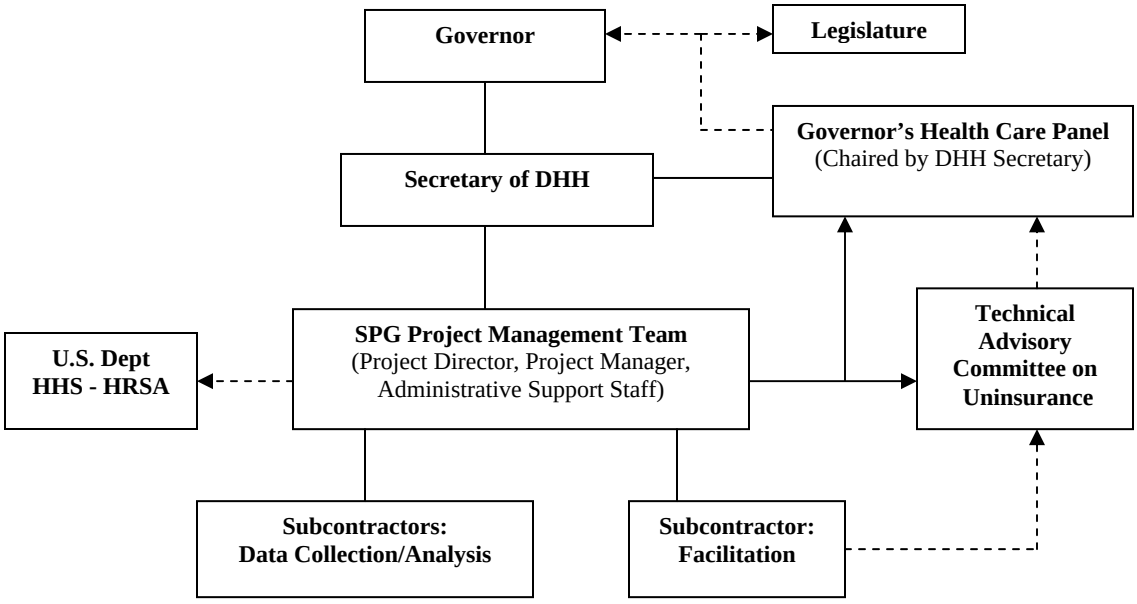
poor and uninsured and limited state capacity to finance coverage expansions without leveraging significant Federal and local government support and employer and patient cost sharing. The latter will be particularly relevant to states that are still faced with tight state budgets and yet are actively seeking funding strategies for maintaining or expanding coverage to those without any source of health insurance. Additionally, the data collection and analysis methodologies and lessons learned from such undertakings will be useful for other states that are considering undertaking similar types of analyses, e.g., determining cost of uninsured, conducting employer focus groups.

B. Governance

Successful completion of the project goals is assured through the project's governance structure and strong support of the project from both the Governor and Legislative leadership (see Figure 1). Additionally, the governance structure draws upon existing structures (i.e., Panel) and use of key current staff, allowing for immediate implementation of grant activities.

DHH, which oversees the State's Medicaid public health, mental health, developmental disabilities and addictive disorders programs, has been designated by the Governor as the lead agency responsible for carrying out Louisiana's SPG project. As the lead agency, DHH through its SPG project management team will be responsible for the oversight and coordination of all grant activities. This team consists of two highly qualified and experienced DHH staff, Helene Robinson who will serve as project director with 50% of her time allocated to the project and Melisa Byrd who will serve as project manager with 85% of her time allocated to the project. In addition, DHH will use SPG funds to hire by no later than November 2004 an administrative support staff person who will devote 100% of his/her time to the project (see Staffing Plan Section for a detailed description of their responsibilities and qualifications). In addition to overall project management, the SPG management team will be directly responsible for developing and finalizing the subcontracts and subsequently monitoring the subcontractors, meeting with them regularly to understand and guide activities, review findings and ensure timely receipt of deliverables. The SPG management team will meet weekly (at least initially) to review and track progress and resolve any emerging problems.

Figure 1. Governance Structure for Louisiana's State Planning Grant Project



DHH will be able to effectively gain public and private collaboration and build political consensus for the resulting coverage expansion plan by actively involving two key stakeholder groups in the decision making process: the Technical Advisory Committee on Uninsurance (TAC) and the Governor's Health Care Panel. The TAC, representing key stakeholders in the area of health care coverage and uninsurance, will provide 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 (see Goal 2 under Project Description). These recommendations in turn will be reviewed and approved by the recently established Governor's Health Care Panel. This Panel comprised of 29 influential individuals appointed by the Governor (e.g., Secretary of the DHH, who serves as chair, the Governor's Commissioner of Administration; key legislative leaders; national health care experts and representatives of regional health care reform efforts) will consider the options for expanding coverage and will make the final recommendations to the Governor and Legislature to address accessibility of health insurance coverage (see Goal 3 under Project Description). 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.

Grant Monitoring Plan and Report to the Department (DHHS)

A. Monitoring Plan

The SPG project manager will have the primarily responsibility for tracking and monitoring the SPG grant activities to ensure that the grant's goals and tasks are completed timely and

successfully. Using the project plan set forth in this proposal, a more detailed work plan will be established upon receipt of the grant. This project plan will be updated continuously and reviewed on a weekly basis at the SPG management team meeting to ensure that all tasks are being completed according to the timelines set forth in the work plan. Immediate steps will be taken to resolve any identified issues. If delays in completion of specific tasks are encountered, adjustments to the work plan will be made accordingly and steps taken (e.g., reallocation of resources) to ensure that any delay of specific tasks will not jeopardize achieving the SPG project goals. Any issues that cannot readily be addressed by the SPG management team will be brought to the attention of the Secretary of DHH for resolution. The TAC and the Governor's Health Care Panel will serve as outside entities for evaluating and monitoring the progress of the SPG project.

In addition to the timely completion of the tasks, project monitoring will also include a qualitative component to ensure that what is accomplished is of the highest quality and will result in the development of a solid plan for addressing accessibility to health care insurance. A key for accomplishing this will be the close monitoring of the work of the subcontractors by the SPG management team. As discussed under the Governance section, the team will meet regularly with the subcontractors to both guide and monitor their activities and will carefully review their findings asking subcontractors to make revisions to required deliverables to ensure that they effectively meet the needs of the project. Another key component that will be used to evaluate the progress of the SPG project will be the successful completion of key milestones by the TAC. This includes the prioritization of coverage options and the development of a plan to implement the coverage options, including a strategy for funding the options. However, the ultimate determinant that will be used to evaluate the project's progress will be the final adoption by the Governor's Health Care Panel of the recommend coverage plan and action steps by which such a plan can be accomplished.

Aside from monitoring and evaluating the completion of specific project goals and tasks, the SPG project manager will also be responsible for monitoring grant funds expenditures, ensuring that the funds are appropriately expended and accounted for. A key tool used for monitoring these funds will be monthly financial management reports for the SPG grant funds, showing current grant expenditures and obligated funds (see Management of Grant Funds under Budget Justification for additional details).

B. Report to the Department

DHH is committed to working with Federal SPG program staff to both ensure the complete and timely submission of the required SPG project report to the U.S. Department of Health and Human Service (DHHS) as well as to provide the DHHS with any other requested data or information (see Goal 4 under Project Description). The SPG Project management team (in particular the SPG project manager) will be responsible for preparing the report using the reporting format set forth by the Federal SPG staff, including the inclusion of any requested key data elements. The report will incorporate the plan and the recommended action steps adopted by the Governor's Health Care Panel to address the accessibility of affordable health insurance coverage to all Louisiana citizens. In addition all written products resulting from the SPG

project will be included as appendices in the report. The draft report will be reviewed by the Secretary of DHH. Once any identified revisions have been made the final project report will be submitted to the Secretary of DHHS on or before the date designated by the Federal SPG program staff (i.e., 30 days after the end of the grant period). Additionally, the report will be posted on DHH's SPG website and copies will be provided to all interested stakeholders.

APPENDICES

Appendix A.

No additional tables or charts about the project are being attached.

Appendix B: Letters of Agreement and Descriptions of Proposed/Existing Contracts

Louisiana is not able to legally commit to specific contractors prior to the SPG grant award. Once the grant is awarded, DHH is legally able to enter into contracts with selected contractors without going through an RFP process if the contract is under $50,000. For those contracts that are $50,000 or greater, DHH is required to go through an RFP process.

Appendix C: Support for Project

In an effort to minimize the length of the grant application, the only letter of support that is attached is from State Representative John Alario, Appropriations Committee Chair and Vice-Chair of the Joint Legislative Committee on the Budget. The list below is intended to substitute for the inclusion of individual letters of support for the proposed project provided to DHH by diverse stakeholders.

- Louisiana Governor Kathleen Babineaux Blanco
- Commission of Administration, Jerry Luke LeBlanc
- United States Senator for Louisiana, Senator John Breaux
- Louisiana Senate Finance Committee, Chairman and Joint Legislative Committee on the Budget, Chair, Senator Francis Heitmeier
- Louisiana House Appropriations Committee, Chair and Joint Legislative Committee on the Budget, Vice-Chair, John Alario
- Louisiana Senate President, Donald Hines
- Louisiana Department of Health and Hospitals, Secretary, Frederick Cerise, MD, MPH
- Louisiana Medicaid Program, Director, Ben Bearden
- Louisiana Office of Public Health, Assistant Secretary, Sharon Howard
- Louisiana Office of Primary Care and Rural Health, Director, Kristy Nichols
- Louisiana Department of Insurance, Commissioner Robert Wooley
- Louisiana State Office of Group Benefits, Director, Kip Wall
- Louisiana Health Plan, Director, Leah Barron
- Louisiana Association of Health Plans, CEO, Gil Dupre
- American Health Insurance Plans – Louisiana, Director, Charles Lea
- National Federation of Independent Business – Louisiana, Charlie Hodson
- Louisiana Business Group on Health, Director, Butch Passman

- Louisiana State Medical Society, Executive Director, Dave Tarver
- Louisiana Primary Care Association, Director, Rhonda Litt
- Louisiana Hospital Association, President and CEO, Lynn Nicholas
- Louisiana Rural Hospital Coalition, Director, Linda Welch
- Louisiana Public Health Institute, Director, Joseph Kimbrell
- Louisiana Health Care Commission, Chairperson, Donna Fraiche
- Louisiana AARP, Director, Patricia DeMichele
- Agenda for Children, Director, Judy Watts
- Louisiana Coalition for Child and Maternal Health
- American Academy of Pediatrics, Louisiana Chapter
- Council for a Better Louisiana, Director, Barry Erwin
- Public Affairs Research Council, Director, Jim Brandt