

Louisiana State Planning Grant Interim Report

**Submitted to Secretary Michael O. Leavitt
U.S. Department of Health and Human Services
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*Louisiana State Planning Grant
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EXECUTIVE SUMMARY

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

Since the grant award date, DHH requested and received a one year no-cost extension to provide more time to accomplish the grant goals. The Louisiana State Planning Grant's four goals are:

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

Hurricane Katrina made landfall in southeast Louisiana just as Louisiana was about to embark on the second year of the SPG grant period. A few weeks later, Hurricane Rita made landfall in southwest Louisiana. Extensive devastation to the state's health care system was wrought by both storms. Not only was the health care safety net destroyed, but it is estimated that 100,000 Louisianians lost health insurance coverage as a result of the storms.

This devastation left the state planning grant with many uncertainties. First, the state is further challenged in planning how to provide health insurance coverage to the uninsured. Prior to Hurricanes Katrina and Rita, Louisiana had the 3rd highest uninsured rate in the nation. The need for the resources of the SPG is more important now than before. The original tasks outlined under the Louisiana SPG are not as relevant to the state now that previously known information is no longer applicable. For example, the state no longer has basic demographic information on the uninsured. This included uninsurance levels, population size, family composition, and income. Additionally, the ability to conduct statewide focus groups or telephone surveys has been stymied by the destruction in the affected areas.

In response, Louisiana has shifted its focus and revised the tasks of the state planning grant. First, the TAC has shifted to the recently formed Louisiana Health Care Redesign Collaborative,

which is chaired by DHH Secretary Frederick P. Cerise. The Collaborative is in part a result of the charge by the HHS Secretary Michael O. Leavitt to the state to develop a process for the planning and for the re-building of the Orleans region health care system.

Since this process is guiding the development of coverage options for the uninsured, the state believes it is necessary to work in tandem with this process. Additionally the state believes that it is more prudent to revise the tasks of the SPG to respond to the current landscape and support the activities of the Collaborative. As a result, the state has requested and received a second no-cost extension. The extension will provide the state the opportunity to fully support the work of the Collaborative as it works towards creating a blueprint for the redesigned health care system for the Orleans region. It is the expectation that the blueprint will serve as a model for the rest of the state, as well as the nation.

This Interim Report, as required by HRSA, will provide an update on the progress of the goals of the grant to date. Additionally, questions specifically posed by HRSA will be answered. The Louisiana State Planning Grant will conclude by August 31, 2007.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

Overview

Louisiana is a mid-sized state, with its population numbering 4.4 million and ranking 24th in size among states.¹ It is geographically and culturally diverse, with Interstate 10 being the dividing line between fishermen, and crawfish, rice and sugar cane farmers on the one side and timber and cotton interests on the other. Louisiana also has one of the highest rates of uninsured—twenty percent of the state’s population is uninsured.

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Many questions regarding population and uninsured remain unanswered a year after Hurricane Katrina devastated the southeast portion of the state and Hurricane Rita devastated the southwest portion of the state. An issue brief on the uninsured was presented the Governor’s Health Care Reform Panel shortly after Hurricane Katrina. The brief provides a succinct comparison of the state and the uninsured before and immediately post-Katrina. This brief is in Appendix IV.

It is known that as a result of Katrina, nearly 650,000 people evacuated the New Orleans region, with approximately 289,000 evacuating to other parts of LA and 359,652 leaving the state (see Figure 1). Recent work by the Collaborative (see Appendix V for the Region 1 Health Care Profile) estimates that 650,000 people reside in the Orleans area, including 160,000 Medicaid eligible citizens and 100,000 uninsured citizens.

The state has a number of traditional data resources to inform policy decisions, including the Current Population Study (CPS), the Medical Expenditure Panel Survey – Insurance Component (MEPS-IC), and the Louisiana Health Insurance Survey (LHIS). DHH, in collaboration with the Louisiana Recovery Authority, the Louisiana Public Health Institute, the Census Bureau, and the Centers for Disease Control and Prevention, is conducting a survey of the affected parishes. This survey will help identify the health care, education, and economic needs of the state’s citizens. The survey results should be complete in October 2006. More information on this effort is available online at: <http://www.dhh.louisiana.gov/offices/page.asp?id=88&detail=6858>.

CPS data is the primary source in answering the questions below. When CPS data is not used, an alternate data source is noted.

1.1 Overall level of uninsured in Louisiana

The rate of the uninsured in the state of Louisiana is 19%, which is 3% above the U.S. average of 16%.

Figure 2: 2005 Working Uninsured Adults (19-64) as a Percent of Adult (19-64) Population within Their Poverty Level Group (LHIS)

	Louisiana	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
<50	23.8%	31.8%	27.2%	25.5%	19.0%	20.0%	11.7%	27.2%	18.0%	8.3%
50-100	20.7%	22.2%	21.9%	20.1%	17.6%	24.5%	23.6%	19.7%	21.4%	14.9%
100-150	21.4%	22.1%	18.4%	14.2%	20.1%	21.6%	17.6%	25.7%	25.5%	23.6%
150-200	21.1%	24.7%	13.7%	20.2%	15.0%	28.1%	21.8%	22.4%	27.5%	16.2%
Over 200	8.4%	5.5%	7.1%	7.5%	8.5%	11.2%	13.9%	8.8%	10.5%	9.9%

1.2 Characteristics of the Uninsured

Income

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

As shown in Figure 2, the LHIS reported the percentage of the working uninsured by region in the state of Louisiana. For example, in 2005, 23.8% of Louisiana adults (19-64) that lived below 50% of the Federal Poverty Level were both working and uninsured

Figure 3: 2005 Working Uninsured Adults (19-64) as a Percent of Total Adult (19-64) Population (LHIS)

	Louisiana	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
<50	1.1%	1.6%	1.4%	1.0%	1.1%	0.7%	0.6%	1.4%	0.4%	0.2%
50-100	2.6%	2.6%	2.7%	2.5%	2.2%	2.2%	3.3%	3.1%	3.2%	1.3%
100-150	2.7%	3.1%	2.0%	1.7%	2.4%	3.2%	2.1%	3.3%	3.9%	2.1%
150-200	2.2%	2.5%	0.8%	2.1%	1.8%	3.6%	2.3%	2.4%	2.6%	1.9%
Over 200	5.1%	3.2%	4.7%	4.6%	4.9%	6.7%	8.1%	4.9%	6.1%	6.8%
Total	13.6%	13.1%	11.6%	11.9%	12.4%	16.4%	16.4%	15.1%	16.3%	12.2%

The LHIS also reported on uninsured working adults as a percentage of all adults, as shown in Figure 3. When reviewing the total number of uninsured adults, it was found that 1.1% of the adults in Louisiana are below 50% of the Federal Poverty Level. Overall, the report reveals that regions 5 (Southwest) and 6 (Central) have the largest percentage of working uninsured adults.

Age

The 2005 Louisiana Health Insurance Survey reported on the age group of Louisianans most affected by uninsurance. The report shows the uninsured rate of young adults (19-24) and (25-34) age groups in the state. According to the data collected from the LHIS, more than 28% of the state's uninsured are young adults between the ages of 19-24. Only 48% of this population is enrolled in an employer sponsored insurance plan. Increases in age show an increase of uninsured up to 30%, with the number of those enrolled in an employer sponsored insurance plan increasing by 4%.

Figure 4: Insurance Coverage by Age for Non-Elderly Adults (LHIS)

% of the Insured by Coverage	Employer	Former Employer	Purchased Coverage	Not in Household	Medicare**	Military	Medicaid	Uninsured
19-64 (Official Report)	48.6%	4.1%	8.2%	1.0%	4.2%	2.7%	12.5%	23.4%***
19-24	48.4%	2.4%	9.1%	na*	0.7%**	8.1%	3.3%	28.1%
25-34	52.5%	1.4%	7.5%	na*	0.7%**	5.0%	2.6%	30.3%

Gender

The uninsured in Louisiana are nearly evenly split between male and female. Men account for 48.4 percent of the uninsured and women account for 51.6 percent of the uninsured. The 2005 LHIS indicates that males in the 19-34 age groups are more likely than females to be uninsured. The 25-34 year olds are more likely to be uninsured regardless of gender.

Family Composition

Less than half (42.3%) of the uninsured population is married. Over 40 percent of families are headed by a single female, while 16.2% of families are headed by a single male. (LHIS, 2003)

Health Status

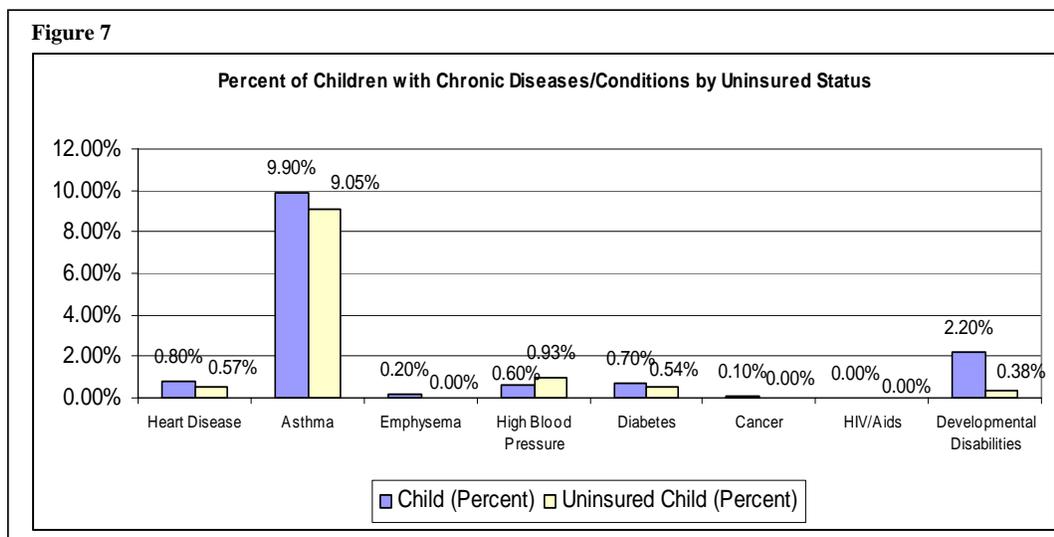
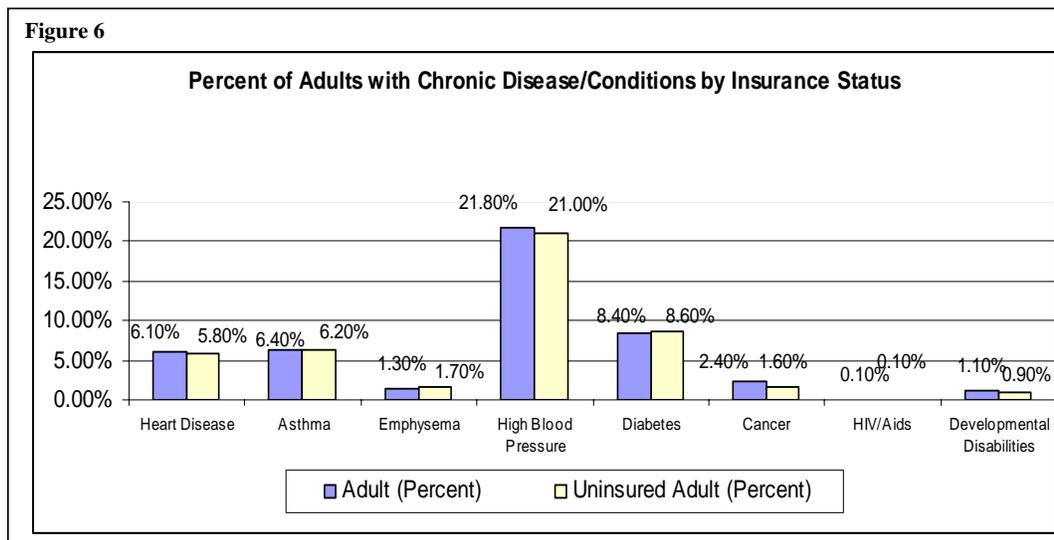
In the past, over 70 percent of the uninsured in Louisiana have reported their health status as good, very good, or excellent, compared to over 85 percent for the insured. In 2005, Louisiana improved its overall health ranking. According to the United Health Foundation's health rankings, Louisiana has shown adequate improvement in prenatal care with nearly 82 percent of women receiving prenatal care.

Louisiana's challenges include high prevalence of obesity at nearly 27 percent, high rate of cancer at 223.5 deaths per 100,000, high infant mortality rate, high incidence of infectious diseases at 32.3 percent per 100,000 populations. The United Health Foundation attributes Louisiana poor health ranking to the high number of uninsured.

Figure 5: Uninsurance Rates by Sex, 2005 LHIS

Uninsurance Rates by Sex	male	female	Total
19-64 (Official Report)	23.8%	21.2%	24.0%
19-24	29.6%	26.7%	28.1%
25-34	31.8%	29.1%	30.3%

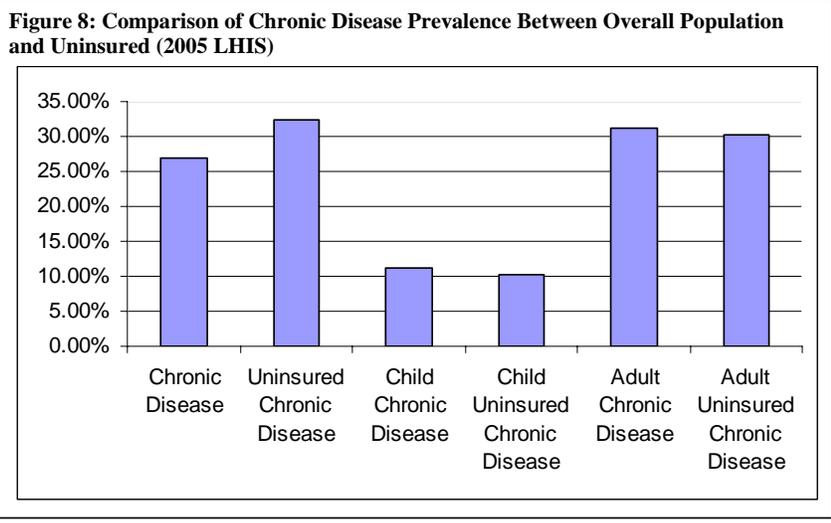
According to the LHIS, there is little evidence of having a chronic condition and insurance status. The 2005 LHIS reviewed adults and children that reported being told by a physician that they had heart disease, asthma, emphysema, and or various other chronic conditions/diseases. This analysis is shown for adults in Figure 6 and children in Figure 7.



As shown in Figure 8, it was also found that Louisiana citizens with a chronic disease were only marginally more likely to be uninsured than those citizens without chronic conditions. According to the data collected from the LHIS, once aggregated across each of the chronic conditions,

uninsured residents do appear to be more likely to have some chronic disease: 32% of uninsured respondents report having some chronic disease or condition compared to 27% for all respondents.

Availability of Private Coverage
 Most Louisianians (53%) obtain coverage through employer sponsored insurance (ESI) or the individual market. This is slightly less than the national average of 59 percent.



According to MEPS-IC data, 45 percent of all establishments in Louisiana offer health insurance coverage and nearly 80 percent of employees work at one of those establishments. Over 62 percent of the employees at establishments that offer health insurance enroll in coverage.

Availability of Public Coverage

Louisiana’s Medicaid Program provides coverage to approximately 15% of the state’s population. Generally, Medicaid coverage is available for low-income children and pregnant women. Coverage is more limited for adults—parents must have incomes below 12% of the Federal Poverty Level (FPL) and childless adults are not eligible for Medicaid coverage unless they are disabled. A complete listing of Medicaid eligibility and coverage appears in Appendix I. Twelve percent of the state’s population is enrolled in Medicare.

Medicaid Undercount

The 2005 LHIS included a research supplement on Medicaid undercount issues. This research, which was conducted by Louisiana State University (LSU) with technical assistance provided by the State Health Access Data Assistance Center (SHADAC), included a survey of Medicaid enrollees to estimate the Medicaid undercount and to adjust subsequent estimates of uninsured populations.

Since it is common for Medicaid enrollees to misreport their insurance status by reporting uninsured or as an enrollee of private insurance, Louisiana’s high proportion of respondents on Medicaid/LaCHIP are likely to produce a substantial number responses that would produce Medicaid undercounts.

To estimate the Medicaid bias, LSU conducted a separate survey of known Medicaid households to develop baseline estimates of how Medicaid enrollees report their insurance status. Approximately 80% of children are correctly reported as being covered by LaCHIP, 6% reported being uninsured, and 8% report being insured through an employer.

For adults, the proportions are more staggering: just over half of adults (51%) report being enrolled in Medicaid, 21% report being uninsured, 8% report having private insurance, and 10% report being insured through Medicare. Adjusting for the Medicaid undercount means that LSU discounted their estimates of “false positives” from reported uninsurance rates. This discount is based on: (1) The proportion of the population on Medicaid or LaCHIP; and (2) The estimate of the proportion of respondents misreporting as uninsured. (LHIS, 2005)

The technical paper on the Medicaid undercount is in Appendix VII.

Figure 9: Uninsured Non-elderly Adults by Race / Ethnicity

<i>Uninsurance Rates by Race</i>	<i>white</i>	<i>black</i>	<i>native American Indian</i>	<i>Asian / pacific</i>	<i>Hispanic</i>	<i>other</i>
19-64 (Official Report)	21.5%	32.6%	na	na	na	na
19-24	26.8%	31.8%	22.7%	24.4%	30.8%	21.0%
25-34	26.8%	38.5%	45.3%	14.9%	41.3%	49.6%

Employment Status

The majority (61.8%) of the uninsured are employed, which is slightly lower than the national average (69%). According to LHIS, 17.5 percent of the uninsured are self-employed; the majority of the working uninsured work for an employer. Another key fact about the working uninsured is that nearly 70 percent are not salaried employees—but hourly employees.

Race/Ethnicity

Generally speaking, Louisiana’s population is 63 percent white and 32 percent black. The remaining five percent of the population is classified as Hispanic (3%) or other. Nearly 49 percent of the uninsured are white and almost 45 percent of the uninsured are black. Hispanics account for about four percent of the uninsured.

When taking race into consideration among those young adults (see Figure 9), the LHIS indicated that the race with the largest population of the uninsured is the state’s Native American and Hispanic population in the 25-34 age groups. With the low number of Native Americans and Hispanic population in Louisiana, the uninsured rate is affected more by the uninsured rate of blacks and whites in the state. Blacks have shown a 7% increase in the number of uninsurance when the group enters the 25-34 age groups.

Immigration Status

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

Geographic Location

Through direct support of the SPG, the 2005 was also able to complete parish level estimates of uninsured for adults and children. The map in Figure 10 reflects the levels of uninsured by parish level with those in the 19-64 age groups. The report shows that more generally rates of uninsurance tend to be higher in north Louisiana than south Louisiana. With regard to some of the largest parishes in the state such as Orleans Parish, the rate of uninsured adults was estimated at 26.1%, Jefferson at 20.9% and East Baton Rouge parish at 20.6%.

Overall, the results suggest that the proportion of Louisiana residents age 19-64 without insurance rose from 21.1% in 2003 to 23.4% in 2005. In terms of population, the largest change was Orleans parish where an addition 13,223 persons in the age group joined the ranks of the uninsured. On a positive side, the 2005 estimates indicate that 2,103 fewer Ascension Parish residents in the 19-64 age groups were uninsured in 2005 than in 2003.

The LHS also compared the level of uninsured by parish level with those who fall under the age of 19 in the state of Louisiana, as shown in Figure 11. Grant and Winn Parishes located in the central region of the state had the highest estimated rates of uninsured children for 2005. However, due to their much larger populations, East Baton Rouge, Jefferson, and Orleans had the largest number of uninsured children by a significant margin over the next highest parish.

This report located in Appendix VI contains detailed Louisiana parish level estimates of the rates of uninsurance for both those under 19 and between the ages of 19 and 64. Not surprising, the results indicate that rates of uninsurance are highly correlated with parish income for those 19 to 64. With regard to those

Figure 10: Parish Level Estimates of Uninsured Non-Elderly Adults (2005 LHS)

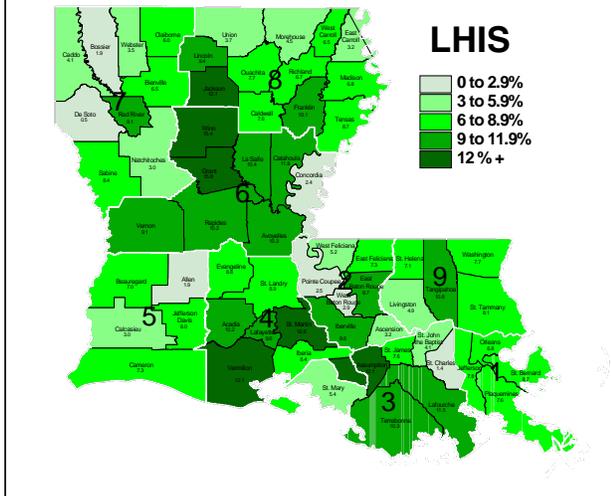
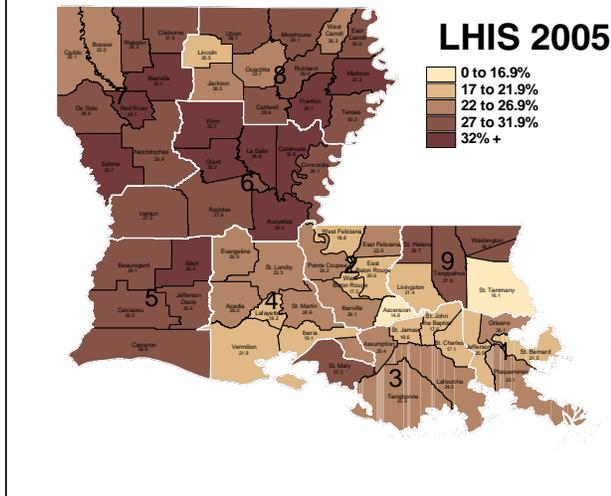


Figure 11: Parish Level Estimates of Uninsured Children (2005 LHS)

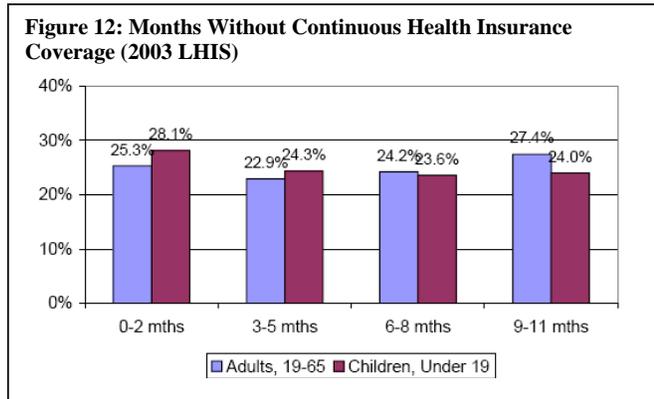


under 19, LaCHIP and Medicaid coverage helps break the linkage between income and the lack of insurance. In particular, aggressive outreach programs in some parishes appear to have been successful in lowering the rates of uninsured children under 19 substantially relative to the 2003 LHS estimates.

Duration of Insurance

To understand the scope of uninsurance, the 2003 LHS asked insured respondents whether or not they had maintained continuous coverage for twelve months. Approximately six percent of the insured respondents experienced a lapse in coverage. Interestingly, as shown in Figure 12, the duration of uninsurance is nearly equal across timeframes. This indicates that there is no common bare period and that coverage options for short and long-term bare periods may be necessary.

In the 4 months after Hurricane Katrina, estimates indicate that over 100,000 Louisianians dropped private insurance coverage.



Other

Education

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

As the education of young adults increase (see Figure 13), the likelihood that the individual will be insured also increases. Persons with a high school education or less are more likely to be uninsured in the state than those with a college education. Nearly 60% of persons with less than a high school education in the 25-34 age groups are uninsured in the state. This age group shows a significant drop off when they obtain a college degree with 14% of this age category falling victim of being uninsured. Once this age group enters graduate school, there is an increase in the number of uninsured by 3% and a decrease once the student graduates from a graduate program.

Figure 13: Uninsured Rates by Education

Uninsurance Rates by Education	less HS	HS	some college	college	some graduate	graduate
19-64 (Official Report)	40.3%	26.6%	18.6%	9.5%	na*	4.9%
19-24	43.7%	35.0%	21.8%	17.1%	24.9%	31.2%
25-34	58.5%	40.6%	28.4%	14.3%	17.6%	13.1%

*"Graduate School" was the next category in the report after "College"

1.3 What population groupings were particularly important for your State in developing target coverage expansion options?

This question will be addressed in the Final Report

1.4 What is affordable coverage?

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

Questions 1.5-1.10

These questions will be addressed in the Final Report

1.11 How are the uninsured getting their medical care needs met?

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

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

Since Katrina, uninsured utilization of inpatient and outpatient hospital services in the region's private (non-LSU) hospitals has increased dramatically. This may be due, in large part, to the lack of LSU-HCSD Charity Hospital beds currently available in the region (Louisiana Department of Health and Hospitals, 2006).

Health care utilization has also been altered due to a shortage of nurses, certified nurse aids and direct service workers. A recent survey conducted by Louisiana Health Works Commission reported 969 nursing and certified nurse aid vacancies in the New Orleans region, over half of which were in hospitals (Louisiana Department of Health and Hospitals, 2006).

The Region 1 Health Care Profile, a study conducted in collaboration with the Louisiana Health Care Redesign Collaborative and the Louisiana Department of Health and Hospitals Bureau of Primary Care and Rural Health, found that the New Orleans region currently has a shortage of available health services to treat the uninsured population. There is a significant decrease in the overall population (35%) in the region and the shortage of primary care physicians, dentists or psychiatrists to treat the Medicaid and uninsured populations. The health care shortage is the more severe in Orleans Parish (Louisiana Department of Health and Hospitals, 2006). The Profile is located in Appendix V.

Questions 1.12 – 1.13

These questions will be addressed in the Final Report

SECTION 2. EMPLOYER-BASED COVERAGE

Overview

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

Most employer information related to coverage is obtained through MEPS-IC data. Additional information comes from the LHIS, although it is from the employee perspective. This section answers the basic questions regarding characteristics of firms that do and do not offer health insurance coverage. Further detail will be reported in the Final Report.

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

Employer Size

According to the 2004 MEPS-IC, the number of private sector establishment in Louisiana decreased by over 700 establishments with the decrease occurring in businesses that employee less than 50 employees. The MEPS-IC also indicated a decrease in the number of employees employed at small businesses by nearly 2%. Louisiana has shown increases in the number of employees employed at businesses with 1,000+ employees and businesses with 50 or more employees when compared to the 2003 MEPS-IC. In establishments with less than 10 employees, only 19.8 percent offered health insurance in 2004. Overall, only 27.6 percent of small businesses offered coverage compared to 95.1 of the large businesses in the state.

Industry Sector

According to the Louisiana Department of Labor's *Employment and Wages 2004 Annual Report*, the primary industries in the state are: health care and social assistance; retail trade; educational services; and accommodation and food services.

Employee Income Brackets

The most recent MEPS-IC data shows that less establishments with 75% or more full-time workers offered coverage in 2004. The 2004 data reflects that only 50.4% of these establishments offer coverage compared to 55.9% for 2003. Only 31.5% of establishments with less than 50% of its workforce qualifying as full-time offered coverage in Louisiana. The state also has shown a decline in the number of establishments that offer coverage when 50% or more of its workforce is listed as low wage. Only 32% of these establishments offer coverage leaving many low wage Louisianans without the option for employer-sponsored insurance coverage.

Percent of Part-Time Workers

A quarter of the working uninsured, or about 133,617 people, are employed part-time. This is significantly lower than the working insured—where only sixteen percent are employed part

time. This is particularly relevant because only about 50 percent of part-time employees are eligible for health insurance coverage in private firms.ⁱⁱ Furthermore, less than half (49.4) of part-time workers eligible for coverage actually enroll. Comparatively speaking, 80 percent of full-time employees are eligible for health insurance in private firms and about 76 percent of those employees enrolled in coverage. (MEPS-IC, 2004)

Cost of Policies

The cost of health insurance premiums increased in 2004 for single premiums to \$3,485.00 from \$3,317.22 in 2003. Family premiums increased to \$10,211.00 from \$8,734.99 in 2003. (MEPS-IC, 2004)

Level of Contribution

The amount of employer contribution decreased to 79% in 2004 compared to the U.S. average of 82%. Family coverage employer contribution increased to 72% with the U.S average remaining the same as the 2003 average. (MEPS-IC, 2004)

Percent of Employees Offered Coverage Who Participate

The total number of employees working at firms that offering health insurance coverage in Louisiana decline to 80%. More employees are eligible for health insurance at firms that offer coverage with 5% more of employees being eligible in 2003 than in 2004. With this increase in eligibility, 62.0% enrolled in health insurance in 2004 in the state compared to 59% in 2003. (MEPS-IC, 2004)

Questions 2.2 – 2.7

These questions will be addressed in the Final Report

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

Overview

Immediately after Hurricane Katrina, the Louisiana Department of Insurance issued Emergency Rule 17 to help maintain coverage for those who lived or were employed in seven primary parishes and seven secondary parishes around New Orleans. The emergency rule expired on November 30, 2005. Some of the components of emergency rule were:

- Any and all restrictions regarding out-of-network access to health care services are waived, as are requirements for medical certifications or pre-certifications, referrals, medical necessity reviews and notification of hospital admissions;
- Suspends all cancellation, termination, nonrenewal and nonreinstatement provisions;
- All health insurance that is subject to renewal between August 26, 2005 and January 1, 2006 is suspended and shall be deferred until January 1, 2006. Rate increases are suspended until 1-1-06. Additionally, all health insurance in effect on August 26, 2005 shall continue in full force until 1-1-06; and
- If a carrier pends a claim(s) as allowed pursuant to ER 17 and is subsequently entitled to cancel or terminate a policy for non-payment of premium, health insurance issuers,

HMOs, PPOs, and MCOs shall pay those claims to the health care providers or health care professionals (generally 50% of the contracted rate).

Despite the efforts of the state, it is still estimated that 100,000 citizens dropped private coverage in the aftermath of Hurricane Katrina.

The Marketplace

The commercial insurance marketplace in Louisiana is dominated by a small number of carriers. According to total premium revenue data (major medical only) provided by the Department of Insurance, in 2005 Blue Cross captured over 50% of the market share and Humana captured the second largest share of the market at 16.77%. As can be seen from Table 1 on the following page, the top 5 carriers together (two of which are Blue Cross companies) account for more than 88% of total premium sales.

Managed care penetration in Louisiana is relatively low at 10 percent. However, the proportion of firms offering managed care products as one of their options in Louisiana is higher than the U.S. average. The offerings are more likely to be in the form of preferred provider organizations than exclusive provider organizations when Louisiana is compared to the nation as a whole.

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

In Louisiana, the Office of Group Benefits (OGB) administers life and health benefits for state employees, participating school boards, and certain political subdivisions. More than 245,000 individuals are covered by OGB, including employees, spouses, and dependents. Decreases in the number of people in Region 1 covered through OGB were experienced as a result of Hurricane Katrina.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions?

This question will be addressed in the Final Report.

3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

The benefits among non-group, small group, and large group can vary extensively. Additionally, there are state mandates that apply uniformly to small and large groups. Only some of the state mandates apply to the non-group market.

3.3 How prevalent are self-insured plans in your State?

According to the Department of Insurance, in 2005, approximately 40 – 45 percent of the state's citizens covered through employer sponsored insurance were in a self-insured plan.

3.4 What impact does your State have as a purchaser of health care?

The state has a large impact as a purchaser of health care. According to the Kaiser Family Foundation, Louisiana expended over \$6.3 billion on health care in fiscal year 2003. This includes state-funded health care expenditures for Medicaid, CHIP, state employees' health benefits, and other. A 2006 PricewaterhouseCoopers report on Louisiana's Healthcare Delivery and Financing System estimates pre-hurricane spending at approximately \$1.5 billion in state funds for the Medicaid program. This includes spending for Medicaid, CHIP, the dually eligible and the uninsured.

3.5-3.9

These questions will be addressed in the Final Report.

Table 1: 2005 Premium Revenues and Market Share for Top 20 Carriers (major medical only)

(Source: Louisiana Department of Insurance)

COMPANY NAME	HOME STATE	TOTAL PREMIUM REVENUE	MARKET SHARE	CUMULATIVE MARKET SHARE
Louisiana Health Service & Indemnity Co. (aka Blue Cross)	LA	1,231,184,964	43.85%	43.85%
Human Health Benefit Plan of Louisiana	KY	470,882,890	16.77%	60.62%
HMO of Louisiana, Inc. (aka Blue Cross)	LA	281,642,077	10.03%	70.65%
United Healthcare Ins. Co.	CT	275,863,245	9.83%	80.48%
Coventry Health Care of Louisiana, Inc.	LA	225,434,673	8.03%	88.51%
Health Plus of Louisiana, Inc.	LA	54,082,071	1.93%	90.44%
Vantage Health Plan, Inc.	LA	45,813,856	1.63%	92.07%
United Healthcare of Louisiana, Inc.	LA	45,399,997	1.62%	93.69%
Aetna Life Ins. Co.	CT	26,712,326	0.95%	94.64%
State Farm Mutual Automobile Ins. Co.	IL	19,596,305	0.70%	95.34%
New York Life Ins. Co.	NY	14,752,760	0.53%	95.87%
Time Ins. Co.	WI	14,650,830	0.52%	96.39%
Tenet Choice	LA	11,987,334	0.43%	96.82%
Mega Life & Health Ins. Co.	TX	10,766,219	0.38%	97.2%
Principal Life Ins. Co.	IA	10,336,197	0.37%	97.57%
Mutual of Omaha Ins. Co.	NE	6,699,837	0.24%	97.81%
Mid-West National Life Ins. Co. of TN	TX	6,339,966	0.23%	98.04%
Unicare Life & Health Ins. Co.	CA	5,399,057	0.19%	98.23%
Connecticut General Life Ins. Co.	PA	5,086,494	0.18%	98.41%
United American Ins. Co.	TX	4,480,582	0.16%	98.57%

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

Overview

The state is still reviewing and assessing options to expand coverage. The TAC has shifted to the Louisiana Health Care Redesign Collaborative. The Collaborative is a 40 member panel that is charged to develop, and oversee the implementation of a practical blueprint for an evidence-based, quality driven, health care system for Louisiana. This blueprint will serve as a guide to health care policy in Louisiana and for the recovery and rebuilding of health care in the hurricane-affected areas of the state. The membership is made up of representatives from state and local government, providers, health plans, etc. The Collaborative's vision is: "healthcare in Louisiana will be patient-centered, quality-driven, sustainable and accessible to all citizens." Additional information on the vision and initial concept are in Appendix VIII.

The Collaborative has also developed twelve guiding principles, including:

- 1. All health care organizations, professional groups, public and private purchasers, and other health system participants will commit themselves to continually reducing the burden of illness, injury, and disability, and to improve the health and functioning of the people of Louisiana.*
- 2. Individuals and their families will be expected to assume personal responsibility to the best of their ability for their own health, supported by public health initiatives and community-based services; individuals and their families will pursue healthful lifestyles, manage known health risks and chronic illnesses, access appropriate health services in a timely manner, make informed health care decisions, accept the practical limitations of standard medical care, and contribute appropriately and within their means to the cost of their coverage and care.*
- 3. Everyone will have access to, enroll in, and contribute appropriately and within their means to an affordable, dependable public or private insurance program or other mechanism to ensure regular access to a medical home, through which access to a core system of quality-driven health care will be financially secured.*
- 4. Patient-provider relationships grounded in mutual respect will engage providers and their patients in the common pursuit of desired patient outcomes. Providers will be culturally competent, avoiding disparities in treatment and partnering with patients in decision-making so as to best respond to their individual needs and values.*
- 5. The foundation of health care delivery will be accessible, integrated, community-based, ambulatory care that is multi-disciplinary. This delivery system will be well suited to disease prevention, to the management of chronic illnesses and disability, and to episodic care. All primary care, specialty care hospital services, after-care and community-based services will be effectively coordinated and patient-centered.*
- 6. Health care services will be treated as a valuable resource, prioritized toward care for which objective evidence demonstrates that the patient is likely to receive a beneficial outcome*
- 7. Providers will be fairly compensated, and providers and health plans alike will be held accountable for the costs and quality of their services; patient choice and other market forces will reward them for helping to achieve optimal patient outcomes in the most cost-effective way possible.*

8. *The health care system will leverage system-wide, interoperable health information technology that meets national standards to: connect patients and clinicians; inform clinical practice; personalize patient care; improve safety; enable transparency of cost and quality of care; improve performance; and improve population health.*
9. *The redesigned health care system will support medical education, training, and retention of health care professionals upon which it relies, recognizing the various institutions involved in these efforts.*
10. *The health care system will become more cost effective and affordable as the unnecessary utilization for resources is reduced, as financial payments and incentives are more properly aligned, as operational efficiencies are realized, and as inequities in the sharing of system costs are eliminated.*
11. *The health care system will be driven by dynamic forces which encourage adaptation to emerging knowledge, patient and population needs, and longer-term economic conditions.*
12. *An all-hazards approach for effective emergency preparedness will be incorporated into the health care system.*

Although the initial focus of the Collaborative is the Orleans area (Jefferson, Orleans, Plaquemines, and St. Bernard parishes), the intent is to identify initiatives that could be replicated statewide. A brief listing of the options under consideration is below.

4.1 Which coverage expansion options were selected by the State?

The State is currently considering several coverage options, including:

- Cover categorically eligible with Medicaid
- Expand coverage to children from 200% FPL to 300% FPL
- Provide premium assistance for childless adults, ages 19-64
- Establish a health insurance “connector”
- Establish a purchasing pool
- Expansion of definition of dependent
- Mandates (employer and individual)

Additional information on the strategies for coverage, potential structure of a benefit package and other information is in Appendix IX.

4.2-4.19

These questions will be addressed in the Final Report

SECTION 5. CONSENSUS BUILDING STRATEGIES

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure?

Originally, the key components of the governance structure were the Governor’s Health Care Reform Panel, the Technical Advisory Committee (TAC), and SPG Grant support staff. The Governor’s Health Care Reform Panel tenure was set up for two years – this obligation was fulfilled and subsequently the Panel ended with its final meeting in March 2006. As the focus of

the state and subsequently the SPG changed, the TAC was disbanded and replaced with the legislatively created Louisiana Health Care Redesign Collaborative.

House Concurrent Resolution 127 established the Louisiana Health Care Redesign Collaborative in June 2006. The Collaborative is a 40 member panel that is made up of representatives from state and local government, providers, health plans, etc. Appendix X provides a list of the Collaborative members. The Collaborative review results of data collection and analysis; assess the feasibility of various options; and will develop a set of recommended action steps to address the accessibility of affordable health insurance coverage for Louisiana's uninsured citizens. Finally, the SPG staff will provide support to the Collaborative for this initiative.

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

5.2 What methods were used to obtain input from the public and key constituencies?

The primary source for obtaining input from the public and key constituencies is through the Louisiana Health Care Redesign Collaborative and its workgroups. Although the Collaborative's membership is set through the House Concurrent Resolution, the Collaborative's workgroups have insured broader participation from the public. Thus far, six workgroups have been established, including: Staying Healthy, Getting Better, Living with Illness and Disability, Coping with the End of Life, Current State Analysis, and Short-Term Priorities. The workgroups average about 20-30 members.

All Collaborative and workgroup meetings are open to the public. Additionally, the meeting agendas, meeting minutes, and other related materials are all available on the Collaborative website.

The Louisiana Health Insurance Survey (LHIS) is also a source for public input. The first LHIS was conducted in 2003 and the second LHIS was finalized in September 2005. The LHIS surveys over 10,000 Louisiana households and is the most comprehensive assessment of the uninsured for the state. Questions ranging from affordability of health insurance to interest in pilot coverage programs have been included in the LHIS. The 2003 and 2005 survey results may be viewed in their entirety on the DHH website (<http://www.dhh.louisiana.gov/offices/?id=168>).

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

5.3 What other activities were conducted to build public awareness and support?

The Louisiana State Planning Grant and the Louisiana Health Care Redesign Collaborative developed and maintain websites in order to inform the public and the Collaborative members.

5.4 How has this planning effort affected the policy environment?

The Louisiana Health Care Redesign Collaborative is the state's current mechanism for developing a redesigned system of care for the Orleans region. Additionally, there is a committee of the Collaborative that is focused on the Hurricane Rita affected parishes in Southwest Louisiana. It is expected that the work of the Collaborative will include recommendations related to the expansion of health insurance coverage. The Collaborative has

the federal support of the Department of Health and Human Services as well as the Office of the Federal Coordinator for Gulf Coast Rebuilding. The support from the federal agencies, coupled with the diverse stakeholder representation of the Collaborative, will certainly have influence on the policy environment in the state.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

This section will be addressed in the Final Report.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

This section will be addressed in the Final Report.

SECTION 8. OVERALL ASSESSMENTS OF SPG PROGRAM ACTIVITY

This section will be addressed in the Final Report.

APPENDIX I. BASELINE INFORMATION

Population:

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

Number and percentage of uninsured:

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

Average age of population:

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

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

Percent of population living in poverty:

In 2002-2003, 22% of all Louisianans lived at 100% of the federal poverty level.

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

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

Primary industries:

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

Number and percent of employers offering coverage:

CPS data reveals that 34.9% of the firms with fewer than 50 employees offer coverage, while 94.8% of the firms with 50 employees or more offer insurance coverage.

Number and percent of self-insured firms:

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

Payer mix:

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

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

Provider competition:

This question will be addressed in the Final Report

Insurance market reforms:

This question will be addressed in the Final Report

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

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

(disabled and early widows, widowers, DACs, 4913 children, pickles (COLA))

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

** The State allows a \$10,000 burial fund exclusion, and a cash surrender value exclusion of all life insurance policies with a face value of \$10,000 or less.

Note: Eligibility and Coverage is reported as effective on August 24, 2005

Use of Federal waivers:

A complete listing of existing Medicaid waivers for Louisiana is provided on the Centers for Medicare and Medicaid Services website at

http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/08_WavMap.asp.

**APPENDIX II.
LINKS TO RESEARCH FINDINGS AND METHODOLOGIES**

Additional information regarding the work of the Louisiana State Planning Grant may be found at the Louisiana State Planning Grant website: <http://www.dhh.louisiana.gov/offices/?id=168> and the Louisiana Health Care Redesign Collaborative website: <http://www.dhh.state.la.us/offices/?ID=288>.

APPENDIX III.
SPG SUMMARY OF POLICY OPTIONS

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

APPENDIX IV ISSUE BRIEF ON THE UNINSURED – MOVING FORWARD (12/15/05)

The Governor's Health Care Reform Panel was formed after the first annual statewide health care summit in March 2004. Providing care to the uninsured was identified as one of the six priority areas the Panel would focus on during its two year tenure. Since the Panel first convened in June 2004, the Department of Health and Hospitals has accomplished many activities related to providing care to the uninsured. This includes:

- Reducing the number of uninsured children;
- Submitting a HIFA waiver to CMS;
- Submitting a Family Planning waiver to CMS;
- Being awarded a HRSA State Planning Grant;
- Implementing the 340B drug pricing program; and
- Facilitating the development of new FQHCs.

The Department of Health and Hospitals is now further challenged in providing care to the uninsured because of the devastation wrought by Hurricane Katrina. Hurricane Katrina made landfall in August 2005 and resulted in a diaspora of the citizens of New Orleans and the collapse of the health care system in the area. This paper will outline uninsured statistics prior and post-Katrina and next steps in providing care to the uninsured in the New Orleans region.

Background – Pre-Katrina

The state of Louisiana is home to almost 4.5 million people. Prior to Hurricane Katrina, nearly a quarter of Louisiana's population resided in the New Orleans area. According to the 2005 Louisiana Health Insurance Survey, the statewide figures for the uninsured were 720,000 uninsured adults and 97,403 uninsured children. Additionally, the New Orleans region nearly mirrored the state average of uninsured adults and children.

Poverty

Louisiana is 5th in the nation for highest rate of poor residents. People with family incomes below the Federal Poverty Level (FPL) make up 22 percent of the total state population. Louisiana also ranks 3rd in the rate of low-income residents – 45 percent of the state's residents have family incomes below 200 percent FPL. Additionally, the median household income in the state is \$35,523 compared to the national median household income of \$44,473.ⁱⁱⁱ

Employment

Over three million Louisianians live in a household with one or more full-time workers. The average weekly wages of Louisiana workers is \$619.^{iv} The unemployment rate for the state in October 2004 was 5.8%.^v

Uninsured

In 2003-2004, Louisiana had the fourth highest uninsurance rate in the nation, with about 20% of the total population classified as uninsured. This translates into about one in every five Louisiana citizens lacking health insurance. A little less than half of the state's residents were covered by private health insurance (48%), and over one-quarter were covered by public programs (15% by Medicaid and 13% by Medicare).¹ Non-elderly adults (19-64) were more than twice as likely as children to be uninsured.

In Louisiana, both the percentage of private-sector employers offering health insurance and the percentage of employees eligible for health insurance in establishments that offers insurance were lower than for the U.S. as a whole (58.3% and 77.9% respectively). Additionally, lack of access to insurance was more of a problem in the small size firms (2-50) with only 36.3% of these small private-sector firms offering health insurance to employees.

Medicaid and the Public Hospital System

The public-sector side of the uninsured includes the state Medicaid program and the state public hospitals. The Louisiana Medicaid program is a \$5.3 billion program that provides coverage to over a million people. In addition, a large amount of indigent care to the uninsured is provided through the disproportionate share funds program (DSH), also known as uncompensated care cost (UCC) payments.

The Medicaid program expended nearly \$5 billion in state fiscal year 2003-2004. The federal medical assistance percentage (FMAP) for Louisiana is approximately 70/30 (federal/state); the administrative match is shared equally between the state and federal governments. In state fiscal year 2003-2004, the total state share was almost \$1.3 billion; the total federal share was nearly \$3.7 billion.

The ten state-owned public hospitals and over 350 outpatient clinics primarily serves low-income and uninsured citizens. The final appropriation for the state public hospitals in fiscal year 2004 was \$790.1 million.^{vi} In fiscal year 2003, the ten facilities provided over 2 million outpatient visits, of which nearly 1.5 million were outpatient clinic visits and about half a million were emergency department encounters.

Specifically, the Medical Center of Louisiana at New Orleans collected over \$123 million in Medicaid funds and over \$225 million in UCC funds. The patient population for a two year period was about 275,000.^{vii}

The public hospital system receives the vast majority of the state DSH dollars. Non-state (primarily rural) hospitals received about 9 percent of DSH dollars in 2004. Private hospitals also provide care to the uninsured, and are reimbursed approximately

¹ Although the Census reports that 15% of Louisianians are enrolled in Medicaid, DHH enrollment information reveals that nearly 25% of Louisianians are enrolled in Medicaid. Further detail and analysis of the Medicaid undercount issue is in the 2005 Louisiana Health Insurance Survey.

\$5 million in DSH per year. The total DSH payments made in SFY 2004 were \$855,743,108.

Facilities

Prior to Katrina, the New Orleans area was home to the backbone of the public hospital system: Medical Center of Louisiana and University Hospitals. The Medical Center also served as the one of the state's two Level One trauma centers. Additionally, 19 other acute care hospitals operated in the region; there were 4300 staffed beds and the average daily census was 2500 in the region.^{viii}

Health Care Professionals

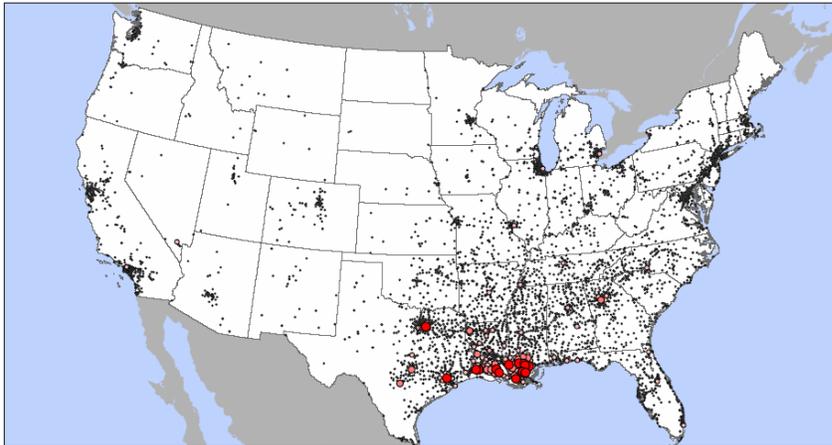
Approximately 4300 medical doctors and 13,000 registered nurses worked in the New Orleans regions. However, a shortage of health care professionals persisted. The shortage prior to Katrina was approximately 830 health care personnel.^{ix}

Today's Picture – Post-Katrina

Many questions regarding population and uninsured remain unanswered approximately three months after Hurricane Katrina devastated New Orleans and the Gulf Coast. However, preliminary results are being reported that shed some light on the situation in the New Orleans area. It is known that as a result of Katrina, nearly 650,000 people evacuated the New Orleans region, with approximately 289,000 evacuating to other

Figure 1: Louisiana Applicants current location as of 10/31/05

Source: FEMA



parts
of LA
and

359,652 leaving the state (see *Figure 1*).^x

The City of New Orleans, in partnership with the Centers for Disease Control and Prevention (CDC), has developed and implemented a rapid population estimate survey. The initial results show a range in current population estimates from 43,500 to 277,400 for the East Bank, and 14,400 to 69,100 for the West Bank. October 2005 re-population

estimates from DHH factor in historical public school enrollment figures, the ratio of enrollment to the general population, and FEMA uninhabitable area estimates. They are 30% for Orleans Parish, 20% for St. Bernard Parish, 57% for Jefferson Parish, and 20% for Plaquemines Parish.^{xi}

Poverty

The full affect of Katrina on the level of poverty in the state is unknown. However, the impact is recognizable through job loss and increases in Medicaid enrollment. The Louisiana Department of Labor (DOL) has paid 310,938 storm-related Unemployment Insurance and Disaster Unemployment Assistance claims. The eight-week total of Katrina-related claims is 284,528; typically, the DOL processes about 24,000 claims in an eight week period. Over 200,000 people are eligible for unemployment insurance and another 84,000 are the recipients of disaster benefits ^{xii}

Additionally, Medicaid enrollment was 1,013,151 as of October 28, 2005. When Katrina struck, enrollment was 996,534. Medicaid and LaCHIP (the state's children's health insurance program) are available for children up to 200% FPL; Medicaid is available for parents up to 13% FPL. The increase in enrollment suggests that some people may have become eligible for Medicaid because of Katrina-related reasons, such as job loss.

Employment

Although the total number of households with one or more workers is unknown, the impact on employment is known. The Louisiana Department of Labor reports that the state's unemployment rate for October 2005 was 11.3% - which is almost double the unemployment rate from October 2004.^{xiii} The national unemployment rate is 5%.^{xiv}

Uninsured

The rate of uninsured post-Katrina is unknown. It has been suggested that for every one percent increase in unemployment, there will be a 0.75 percent to 1 percent increase in the uninsured. On that premise alone, Louisiana's uninsured rate has likely increased between 4% and 5.5%. However, this very rough estimate does not account for the population shifts (specifically those who left Louisiana) and newly enrolled Medicaid people.

As for private insurance, the Louisiana Department of Insurance issued Emergency Rule 17 immediately after Katrina to maintain coverage for those who lived or were employed in seven primary parishes and seven secondary parishes around New Orleans. The emergency rule expired on November 30, 2005. Some of the components of emergency rule were:

- Any and all restrictions regarding out-of-network access to health care services are waived, as are requirements for medical certifications or pre-certifications, referrals, medical necessity reviews and notification of hospital admissions;

- Suspends all cancellation, termination, nonrenewal and nonreinstatement provisions;
- All health insurance that is subject to renewal between August 26, 2005 and January 1, 2006 is suspended and shall be deferred until January 1, 2006. Rate increases are suspended until 1-1-06. Additionally, all health insurance in effect on August 26, 2005 shall continue in full force until 1-1-06; and
- If a carrier pends a claim(s) as allowed pursuant to ER 17 and is subsequently entitled to cancel or terminate a policy for non-payment of premium, health insurance issuers, HMOs, PPOs, and MCOs shall pay those claims to the health care providers or health care professionals (generally 50% of the contracted rate).^{xv}

Medicaid and the Public Hospital System

New Orleans played a major role in the state's economy. Nearly one-third of the state's tax base was located in New Orleans. After Katrina, the state revenues took a blow due to the loss of tourism, business, and industry in New Orleans. Louisiana's state budget is approximately \$18 billion – of which \$7.2 billion is state general funds. After Katrina, the state had a \$1.5 billion shortfall – nearly one-seventh of the state budget. This shortfall directly impacts Medicaid, which is one of the two largest budget items.

The Medicaid shortfall, sans any temporary federal relief, is \$648 million. This equates to a 25% program reduction over 6 months. A request for 100 percent federal financial participation for the Medicaid program is included in federal legislation.

Additionally, DHH has worked with the Centers for Medicare and Medicaid Services (CMS) on a special Katrina 1115 waiver.² The waiver accomplishes two things: 1) waives certain administrative rules for providing Medicaid and SCHIP coverage and services to those Louisiana Medicaid eligibles displaced as a result of Hurricane Katrina and 2) enrolls Katrina evacuees from Mississippi and Alabama into Louisiana Medicaid for five months with no state match requirement. The approximate period of the demonstration is August 2005 through January 2006.

The uncompensated pool will provide low-income Katrina evacuees (ages 19-64) that are not otherwise eligible for Title XIX Medicaid programs or do not have another source of coverage with Medicaid services and benefits. People with disabilities and people aged 65 and older with income below 300 percent SSI are also eligible under the UCC pool. Additionally, the UCC pool will allow providers to directly submit claims for costs incurred as a result of Katrina for services provided to Katrina evacuees that are not covered by any other mechanism. The waiver was approved on November 10, 2005; however, the UCC pool component is still pending approval.

² Additional information on the Louisiana Katrina 1115 waiver can be accessed at: <http://www.cms.hhs.gov/katrina/1115wvr.asp>

As for the DSH program, which traditionally funds uncompensated care in the state, expenditures have been reduced. University Hospital and Charity hospital in New Orleans are closed, therefore they are not expending a normal amount DSH funds. Furthermore, LSU HCSD received a \$136 million reduction in DSH funds and a \$36.7 million reduction in Medicaid financing. The remaining 8 state run public hospitals, as well as non-state hospitals, have experienced increases in UCC as a result of Katrina and the population shifts.

Facilities

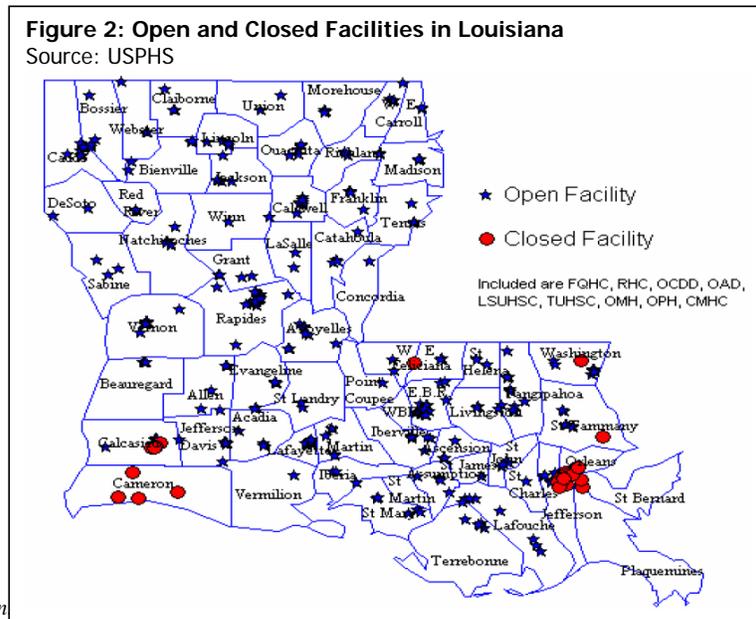
Only seven of the twenty-one acute care hospitals are currently operational. One of the state's two trauma centers is closed (MCLNO; Shreveport is open). The staffed beds in the region have been reduced to 1300 and the average daily census is now 1250. LSU is in negotiations to lease about 140-160 beds in two separate facilities. The VA Hospital is expected to re-open its out-patient clinic in December. Finally, Tulane may open by January.^{xvi} Figure 2 provides a statewide look at open and closed facilities.

The United States Public Health Service (USPHS) reports that at this time, New Orleans is able to keep up with the ER and inpatient care. However, the USPHS raises serious concerns about the long-term issues, including retaining health care professionals, additional re-population and health care capacity, and the flu.

Health Care Professionals

The University of North Carolina at Chapel Hill's study on medical manpower in Hurricane Katrina affected areas shows that almost 6,000 active, patient-care physicians were dislocated by the storm. Over two-thirds – 4,486—of those were in the three central New Orleans parishes that were evacuated. The study also estimates that over 35% of the dislocated physicians in the three central New Orleans parishes are primary care physicians.

DHH estimates that if sufficient levels of primary health care services were provided to the general and low-income populations that are estimated to return to Orleans, St. Bernard, Jefferson and Plaquemines Parishes there will be a need for 191 full-time equivalent



primary care providers. A total of 95.5 new primary care practices are needed if two primary care providers make up each practice. If all practices need to be built from scratch, it is estimated it could cost almost \$90 million for construction and equipment costs. These costs do not include medical personnel and staffing costs.

Next Steps

The state is now challenged with providing health care services to the existing population in New Orleans, while re-establishing a health care system that can and will meet the changing needs of the region. The immediate steps are underway: assessments of facilities, population, health care needs and the resurrection of basic health services. The Katrina waiver and UCC pool are also pieces of the immediate steps in providing health care services to the low-income and insuring reimbursement to providers for services. The longer-term steps include determining how the health care system in New Orleans should look post-Katrina, recruitment and retention of health care professionals, and how the health care system can aid the economic development of the region.

Since the New Orleans region is different today than it was prior to Katrina, new opportunities in providing health care to people emerge. The opportunity to instill more consistent reliance on evidence based medicine, nationally recognized quality standards, and health information technology is more realistic now than ever before. Another potential opportunity is to provide coverage to low-income uninsured adults of the area.

Prior to Katrina, the health care dollars invested in the New Orleans region were not sufficient to provide coverage to the uninsured in the region. Is that different today? If so, how could it work? One potential solution is to create a managed care-like entity for the low-income uninsured that utilizes the safety net.

Obviously, the implementation of an MCO takes time and health care services are needed now. As noted above, the Katrina 1115 waiver has the opportunity to provide services to the uninsured for five months. After the Katrina waiver expires, the state could use the DSH safety net care pool (as defined in the HIFA waiver) for six months to provide a scaled-back benefit package to low-income uninsured Katrina evacuees. For those with access to employer sponsored insurance, a premium assistance program will be available to aid the participation in private health insurance coverage.

In approximately a year, the state believes that a strong and sufficient safety net will be in place to support implementation of a pilot program that incorporates managed care principles and provides coverage to low-income uninsured adults. *Figure 3* further details the actions and progress over a one and a half year period.

New Orleans has a different landscape today – one that we are still trying to understand, but one that could open the door to opportunities that were non-existent before.

APPENDIX V
REGION 1 HEALTH CARE PROFILE

The Region 1 Health Care Profile is available online at <http://www.dhh.state.la.us/offices/publications.asp?ID=288&Detail=1300>. The profile is not included in this report due to its length.

Parish Level Estimates of Louisiana's Uninsured Population (December 2005 update)

A Report from the 2005 Louisiana Health Insurance Survey

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EXECUTIVE SUMMARY

The goal of this report is to use econometric models to provide a December 2005 update for parish level estimates of Louisiana's uninsured population first developed in the Louisiana Health Insurance Survey (LHIS) conducted in July 2005. In particular, the models estimate the relationship between insurance status and changing demographic and economic characteristics. We used observed changes in demographic and economic characteristics within each parish to predict the change in the proportion of uninsured persons in the parish. Separate models are estimated for the under 19 population and adults 19 through 64.

The results of the econometric model show that poverty status and LaCHIP/Medicaid enrollment are the most important predictors of insurance status for those under 19. Likewise for adults, the most important factor in determining health insurance status is whether or not the adults exceed our poverty threshold of 185% of the Federal Poverty Level (FPL). The econometric model also indicates that the higher unemployment rates increase the proportion of uninsured.

The next step in developing these estimates requires checking existing statistical measures for changes in economic and demographics. Due to Hurricane Katrina, poverty measures, Medicaid enrollment data, and/or unemployment rates were either unavailable or might be considered unreliable for Orleans, Jefferson, Plaquemines, and St. Bernard parish. However, we were able to use our model to update estimates of the percent uninsured for all other Louisiana parishes.

Excluding DHH Region 1, there was a small decline (.1%) in the estimated percent of those under 19 without health insurance insured and an increase of 2.5% in the rate of uninsured adults. Statewide results excluding Region 1 must be interpreted with caution because the

overall insurance rate would change if the region were included. Likewise, some of those from Region 1 were displaced to other regions and the demographic characteristics of those persons are not currently known. However, some observations can be made about factors influencing the pattern and regional changes in health insurance coverage.

First, the lack of any increase in uninsured children reflects a 2.1% rise Louisiana Medicaid/LaCHIP enrollment following Hurricane Katrina. A closer look at the regional results reveals a strong relationship between Hurricanes Rita and Katrina and reductions in insurance coverage. In particular, Region 9 with both direct damages from Katrina and an influx of evacuees experienced the largest increase in percent uninsured. Region 2, the Baton Rouge metropolitan area, also saw an influx of evacuees and an increase in estimated percentage of the population without health insurance. Region 5, the Lake Charles area, was recovering from Hurricane Rita and also saw increases in the percent of the population lacking health insurance. The report below presents details of the analysis and the full set of results.

This report summarizes parish level estimates of the uninsured population for December 2005 and the approach used to generate those forecasts. The basic approach is to build econometric models to forecast health insurance status using individual level data from the 2005 Louisiana Health Insurance Survey (LHIS). These econometric models are intended to model the basic relationships between demographic characteristics of Louisiana citizens and their insurance status. We then substitute parish averages for these characteristics to estimate parish levels of insurance coverage.

The dependent variable in our regression models is set equal to one if the individual has health insurance and zero otherwise. Thus, the basic econometric approach models the probability of having insurance, not the probability of being uninsured. Models for both children and adults are estimated using ordinary least squares. With one exception, the explanatory variables are the same for both models.

The first variable in our econometric model is the proportion of adults in the household who are unemployed. For forecasts purposes, parish unemployment rates are available monthly. We anticipate that a higher unemployment rate reduces the probability of being insured. December unemployment rates were not available for Orleans parish.

The second variable is a measure of poverty, a dummy variable set equal to one if the household income is under 185% of the poverty level and zero otherwise. The value 185% corresponds to the requirements of the free and reduced school lunch program and allows estimates of the proportion in this category by parish using this data. Holding other things constant, we hypothesize that poverty will reduce the probability of being insured for both children and adults. For Orleans parish, the estimated ratio of total population to school enrollment changed from 7.0 pre-Katrina to 133 in December post-Katrina. This increase and

rises in other parishes led to concern about this measure of poverty in Region 1. Hurricane Rita did not have the same affect on region 5 ratios. Though Cameron parish lost population, the ratio of total population to school enrollment was 5.2 pre-Katrina and 5.4 in December post Katrina.

The model for children also includes a dummy variable set equal to one for those with Medicaid/LaCHIP coverage and zero otherwise. Previous results suggest that exceptional efforts to enroll children were responsible for reductions in the uninsured rate in some areas. This suggests that this variable may be a key factor in predicting the insurance status of children. For forecasting purposes, data on Medicaid/LaCHIP enrollment is available from the Louisiana Department of Health and Hospitals.

The next variable in the model is household income. We anticipate a negative relationship between household income and health insurance coverage. Because many low income children are eligible for Medicaid or LaCHIP, a weaker relation is expected for children. To obtain forecasts, we begin by estimating the relationship between household income and quarterly wages using a regression model. Average wages by parish are released quarterly with a roughly six month delay, but can be used with our regression model to obtain an estimate of household income when available.

The next two variables are dummy variables for gender and race. These variables allow for the possibility that females differ from males or blacks differ from whites in the probability of obtaining insurance, even holding our other variables constant.

The final variable included in both models is age. For adults, one unambiguously expects that older adults will be more likely to have health insurance coverage. For kids, the expectation

is less certain, though one might hypothesize that teens are less likely to be covered than younger kids.

The results of econometric model conform to our expectations and are included as a technical appendix. The econometric model is then used to forecast the change in the proportion insured or uninsured for each parish by plugging changes in explanatory variables between July and December into the econometric models in Appendix Tables 1a and 2a. These predicted changes are added to the parish level estimates of the uninsured developed in July 2005 through the Louisiana Health Insurance Survey to produce December 2005 estimates. Aggregation yields estimates of the uninsured for DHH regions and the state.

Figure 1
DHH Regions



Due to lack of data, no estimates for region 1 were available. In particular, the school age population declined so dramatically in most of these parishes that poverty estimates created from free and reduced school lunch figures may be inaccurate. Likewise, updates to the LaCHIP/Medicaid enrollment figures were to some extent inflated as of December 2005 due to the fact that efforts to conduct annual eligibility reviews which would have identified kids that moved out of state were deferred and unemployment rates were not available for Orleans and St. Bernard parish.

Tables 1 and 2 contain state and regional updates. With the exception of three regions, a slight improvement in average income and reduction in unemployment led to small reductions in estimates of the proportion of Louisiana residents who are uninsured. A closer look reveals that the three regions with increases in the uninsured were most impacted by hurricanes Rita and Katrina.

Table 1
Estimates of the Uninsured Under 19 by Region

DHH Region	Percent Under 19 Uninsured (July 2005)	6/20/06 Percent Under 19 Uninsured (December 2005)
1	7.39%	NA
2	8.29%	8.69%
3	8.39%	7.85%
4	9.80%	9.65%
5	4.18%	4.31%
6	10.24%	9.80%
7	3.81%	3.48%
8	7.22%	6.66%
9	7.72%	8.57%
State	7.55%	7.44%***

*** Excluding Region 1

Table 2
 Estimates of the Uninsured 19-64 by Region

dhhregion	Percent 19-64 Uninsured (July 2005)	6/15/06 Percent 19-64 Uninsured (December 2005)
1	23.21%	NA
2	20.09%	20.99%
3	23.40%	23.17%
4	21.85%	20.85%
5	29.16%	29.93%
6	30.05%	28.40%
7	26.43%	25.91%
8	26.21%	24.71%
9	21.67%	24.16%
State	24.00%	26.56%***

*** Excluding Region 1

For both children and adults, the largest increase in the proportion uninsured occurs in region 9, the north shore of Lake Pontchartrain. This region experienced both direct damage from Katrina and an influx of evacuees. This influx of evacuees also impacted region 2, the Baton Rouge area and increases in poverty rates were a key factor in the predicted increase in the proportion uninsured for both regions. The Lake Charles area in region 5 faced the wrath of hurricane Rita and this translated into higher rates of uninsurance there.

Tables 3 and 4 contain parish level estimates of the uninsured. The largest increase in the proportion uninsured occurs in Cameron parish for both groups. Jackson parish exhibited the largest predicted decline in uninsured for those under 19 and St. Landry has the largest decline in proportion uninsured for adults.

Table 3
Parish Level Estimates of the Uninsured Under 19

Parish	DHH Region	Percent Under 19 Uninsured (July 2005)	Percent Under 19 Uninsured (December 2005)
Jefferson	1	7.78%	NA
Orleans	1	6.76%	NA
Plaquemines	1	7.65%	NA
St. Bernard	1	8.73%	NA
Ascension	2	3.21%	3.32%
East Baton Rouge	2	9.69%	11.31%
East Feliciana	2	7.28%	7.57%
Iberville	2	9.58%	9.40%
Pointe Coupee	2	2.53%	1.48%
West Baton Rouge	2	2.95%	3.40%
West Feliciana	2	5.19%	4.98%
Assumption	3	12.06%	12.89%
Lafourche	3	11.54%	10.94%
St. Charles	3	1.39%	1.82%
St. James	3	7.62%	6.79%
St. John the Baptist	3	4.11%	3.46%
St. Mary	3	5.37%	3.86%
Terrebonne	3	10.30%	11.34%
Acadia	4	10.23%	9.27%
Evangeline	4	8.85%	8.91%
Iberia	4	8.40%	8.15%
Lafayette	4	9.58%	10.59%
St. Landry	4	8.86%	6.94%
St. Martin	4	12.81%	12.69%
Vermilion	4	12.11%	11.45%
Allen	5	1.94%	0.92%
Beauregard	5	6.99%	7.23%
Calcasieu	5	3.05%	3.02%
Cameron	5	7.27%	16.90%
Jefferson Davis	5	7.96%	7.71%
Avoyelles	6	10.29%	9.24%

Table 3 (continued)
 Parish Level Estimates of the Uninsured Under 19

Parish	DHH Region	Percent Under 19 Uninsured (July 2005)	Percent Under 19 Uninsured (December 2005)
Catahoula	6	11.79%	11.18%
Concordia	6	2.43%	3.48%
Grant	6	15.82%	15.01%
La Salle	6	10.38%	9.86%
Rapides	6	10.15%	9.81%
Vernon	6	9.06%	9.37%
Winn	6	15.42%	14.24%
Bienville	7	6.51%	5.64%
Bossier	7	1.94%	1.74%
Caddo	7	4.13%	3.87%
Claiborne	7	5.98%	4.92%
De Soto	7	0.55%	0.27%
Natchitoches	7	2.97%	2.67%
Red River	7	9.09%	7.80%
Sabine	7	8.42%	8.04%
Webster	7	3.49%	3.81%
Caldwell	8	7.63%	7.73%
East Carroll	8	3.18%	2.12%
Franklin	8	10.12%	9.28%
Jackson	8	12.13%	9.84%
Lincoln	8	9.45%	10.06%
Madison	8	6.83%	5.90%
Morehouse	8	4.48%	3.39%
Ouachita	8	7.73%	6.69%
Richland	8	6.69%	5.64%
Tensas	8	8.74%	10.43%
Union	8	3.72%	2.09%
West Carroll	8	6.52%	5.69%
Livingston	9	4.87%	5.52%
St. Helena	9	7.10%	9.49%
St. Tammany	9	8.12%	9.31%
Tangipahoa	9	10.77%	11.16%
Washington	9	7.67%	7.41%

Table 4
Parish Level Estimates of the Uninsured 19-64

Parish	DHH Region	Percent 19-64 Uninsured (July 2005)	Percent 19-64 Uninsured (December 2005)
Jefferson	1	20.87%	25.45%
Orleans	1	26.14%	NA
Plaquemines	1	23.09%	NA
St. Bernard	1	21.46%	NA
Ascension	2	14.75%	14.07%
East Baton Rouge	2	20.56%	22.48%
East Feliciana	2	22.87%	21.65%
Iberville	2	26.14%	25.08%
Pointe Coupee	2	24.21%	21.37%
West Baton Rouge	2	17.54%	16.41%
West Feliciana	2	18.76%	17.72%
Assumption	3	25.45%	26.72%
Lafourche	3	24.49%	24.00%
St. Charles	3	17.10%	19.12%
St. James	3	18.59%	16.60%
St. John the Baptist	3	17.57%	15.42%
St. Mary	3	27.27%	23.38%
Terrebonne	3	25.28%	28.40%
Acadia	4	25.99%	23.73%
Evangeline	4	26.87%	26.25%
Iberia	4	19.11%	18.00%
Lafayette	4	19.18%	20.66%
St. Landry	4	23.28%	17.88%
St. Martin	4	24.59%	23.95%
Vermilion	4	21.90%	20.89%
Allen	5	32.50%	29.61%
Beauregard	5	29.08%	29.75%
Calcasieu	5	28.52%	28.98%
Cameron	5	28.96%	53.13%
Jefferson Davis	5	30.41%	30.16%
Avoyelles	6	33.95%	31.47%

Table 4 (continued)
 Parish Level Estimates of the Uninsured 19-64

Parish	DHH Region	Percent 19-64 Uninsured (July 2005)	Percent 19-64 Uninsured (December 2005)
Catahoula	6	35.76%	35.61%
Concordia	6	29.14%	29.11%
Grant	6	32.23%	30.28%
La Salle	6	34.90%	32.09%
Rapides	6	27.55%	25.38%
Vernon	6	27.02%	28.35%
Winn	6	35.68%	34.40%
Bienville	7	35.03%	32.55%
Bossier	7	21.99%	21.60%
Caddo	7	25.15%	24.90%
Claiborne	7	31.81%	30.68%
De Soto	7	28.93%	29.20%
Natchitoches	7	28.95%	27.93%
Red River	7	34.14%	32.71%
Sabine	7	33.65%	32.70%
Webster	7	28.28%	29.38%
Caldwell	8	28.85%	30.82%
East Carroll	8	30.62%	28.37%
Franklin	8	35.11%	36.11%
Jackson	8	26.51%	23.65%
Lincoln	8	20.47%	20.55%
Madison	8	33.26%	30.58%
Morehouse	8	28.08%	25.73%
Ouachita	8	23.73%	21.84%
Richland	8	28.96%	27.77%
Tensas	8	30.33%	37.56%
Union	8	28.06%	27.15%
West Carroll	8	26.33%	24.21%
Livingston	9	21.44%	21.95%
St. Helena	9	29.72%	30.95%
St. Tammany	9	16.10%	21.39%
Tangipahoa	9	27.83%	28.56%
Washington	9	28.46%	30.47%

Technical Appendix

Table 1a presents the coefficient estimates from a regression of insurance status on demographic and economic characteristics for the LHIS sample of those under 19. Table 2a presents similar results for adults. The coefficients are estimated for individuals, but are used to forecast at a parish level. For example, consider the first regression coefficient in Table 1a of -.118 on the variable P(Unemployed). In the individual regression, this implies a one unit increase (100%) in the proportion of adults in the household that are uninsured decreases the probability of a child having health insurance by 11.8% holding other variables constant. In other words for a household with a single adult, a job reduces the probability of no insurance for children in that household by 11.8%. Summing over all households in a parish provides the estimated impact of the unemployment rate on health insurance for children. A 10% increase in the unemployment rate increases the proportion of unemployed adults in parish households by 10%, thus reducing the estimated proportion of insured children by 1.1% holding other things constant.

Table 1a
Econometric Model for Probability of Having Health Insurance
for Those <19

Variable	Coefficient Estimate	t-statistic
P(Unemployed)	-0.11804	-6.67
<185% poverty	-0.20677	-22.51
Medicaid/LaCHIP	0.28896	30.35
Household Income	-0.00004	-1.82
Black	-0.02770	-2.9
Female	0.00965	1.26
Age	-0.00238	-3.15
Intercept	0.93364	94.02

Note: This model was estimated based on 5,637 observations. The R-squared=.164.

The second coefficient of $-.20677$ implies that children in households under 185% FPL are 20.7% less likely to have health insurance holding other things constant. It is important to note that this interpretation holds Medicaid/LaCHIP enrollment constant. For a parish, increasing the proportion of households below 185% FPL by 10% reduces the proportion of children insured by 2.1%.

Our model estimates that a child in a household with at least one child enrolled in Medicaid or LaCHIP is 28.9% more likely to have health insurance, holding other factors such as poverty status and income constant. At the parish level, this implies that a 10% increase in Medicaid/LaCHIP enrollment increases the estimate proportion of insured children by 2.9%.

The estimated impact of household income holding employment status, poverty status, and other variables constant is small and the sign is the opposite of expectations. A \$10,000 increase in household income reduces the probability of a child having insurance by 4%. Given the small size and the possibility that the variable is accounting for nonlinearities or omitted variables, we leave it in our forecasting model. Models with this income variable omitted yield very similar predictions given the small coefficient.

African American children are 2.7% less likely to have insurance based on the model's coefficient estimates. Female children are slightly more likely to be covered by health insurance, though the coefficient is statistically insignificant. Older children appear more likely to be uninsured. One additional year of age reduces the probability of having health insurance by .24%. In other words, an 18 year old is 2.4% less likely to be covered by health insurance than an 8 year old. There is no data available on changes in race, gender or age distribution between July and December for parishes. Thus, these variables do not affect forecasts in this update, though they are included in the model for completeness and for use in future updates.

Table 2a presents coefficient estimates for the econometric model estimates for the LHS sample of adults 19-64. The estimation is again at the individual level and results are again used for forecasting at the parish level. Employed adults are 27% more likely to have insurance holding other things constant. Those in poverty (below 185% FPL) are 29.9% less likely to be covered by health insurance and \$10,000 of additional household income increases the probability of coverage by 1.1%.

African Americans are 1.7% less likely to have coverage holding income and other factors constant. Females appear slightly (1.0%) more likely to have coverage, though that coefficient is not statistically different from zero. The results echo previous studies and find that older adults are more likely to have coverage. Ten years of age increases the probability of coverage by 1.3% holding other variables constant.

Table 2a
Econometric Model for Probability of Having Health Insurance
for Those 19-64

Variable	Coefficient Estimate	t-statistic
P(Unemployed)	-0.27338	-14.22
<185% poverty	-0.29894	-39.08
Household Income	0.00011	4.00
Black	-0.01752	-2.02
Female	0.01042	1.50
Age	0.00134	5.51
Intercept	0.80110	65.01

Note: This model was estimated based on 13,927 observations. The R-squared=.151.

The results from Table 2a are again used at the parish level for forecasts. Due to no information on variation in race, gender, and age demographics between July and December, those variables did not affect forecasts. A 10% increase in the unemployment rate reduces the estimated proportion of insured adults by 2.7%. Likewise a 10% increase in households under 185% FPL reduced the estimated percentage of insured adults by 2.9%. A \$10,000 rise in average parish household income would lead to a 1.1% rise in the estimated proportion of adults covered by health insurance.

APPENDIX VII TECHNICAL PAPER: SAMPLING, WEIGHTING, AND ADJUSTMENT FOR THE MEDICAID UNDERCOUNT

In 2003, the Public Policy Research Lab at Louisiana State University conducted the largest and most comprehensive study of the state's uninsured populations ever undertaken. While the study focused on the uninsured more generally and included questions on medical care and utilization, the primary focus of the work was to estimate the number of uninsured children statewide and at the regional level to better target state outreach efforts.

Prior to this study, estimates of the number of non-elderly uninsured in Louisiana were based on Current Population Survey's March Supplement. The CPS estimates have been invaluable as the only consistent overtime, statewide estimates of the uninsured, but have historically been limited both in terms of the overall sample size for any given state and the geographic distribution of respondents. Recently, the CPS has addressed some of these concerns by increasing the number of households included in the sample, and diversifying the strata from which these households are drawn. CPS currently includes 2186 households from Louisiana.³ While the increase in sample size makes the CPS a better estimate of statewide uninsured populations, it remains limited in its capacity to generate regional and parish-level estimates.

The 2003 Louisiana Health Insurance Survey (LHIS) sought to remedy this shortcoming in existing data by collecting insurance status from over 10,000 Louisiana households representing over 27,000 individuals. Results from this study were reported in April 2004, and provided detailed estimates of uninsured populations by region and key demographic characteristics, including race, income, and education. A follow-up study used these data to generate parish-level estimates of the uninsured adults and children. These estimates, however, were limited in several ways. First, the sampling design - which was based on health insurance surveys conducted in Florida - was crafted to ensure adequate representation of relatively poor, minority Louisianans by over sampling from telephone prefixes below statewide median income and above the statewide percent of African-American residents. Such a sampling design was appropriate for statewide and regional estimates, but left several parishes with very few households for estimating parish-level uninsured rates. There were also significant disparities across regions in the number of households included in the sample, and particularly in the number of households with children. In Tables 1 & 2, we present the sample distributions for households and individuals for the 2003 and 2005 Louisiana Health Insurance Survey by Department of Health & Hospital region. In 2003 regions 6, 7, and 8 (Central Louisiana, Northwest, and Northeast Louisiana), there were fewer than 300 households with children present, and in region 9 there were only 340 households with children present.

³ Technical Paper 63RV: Design and Methodology. Current Population Survey.

Table 1: Comparison of Households Sampled by Region

<u>Region</u>	<u>2005 Total Households</u>	<u>2003 Total Households</u>	<u>2005 U19 Households</u>	<u>2003 U19 Households</u>
New Orleans 1	1,292	1880	471	691
Baton Rouge 2	1,097	1636	446	739
Houma-Thibodeaux 3	893	1381	427	611
Acadiana 4	1,463	1581	645	687
Southwest 5	1,019	926	425	420
Central 6	988	624	452	283
Northwest 7	1,242	592	476	240
Northeast 8	1,018	622	417	263
Northshore 9	1,087	787	476	339
Statewide	10,099	10,029	4,235	4,273

Table 2: Comparison of Individuals Included in Sample by Region

<u>Region</u>	<u>2005 Total Individuals</u>	<u>2003 Total Individuals</u>	<u>2005 U19 Individuals</u>	<u>2003 U19 Individuals</u>
New Orleans 1	3,287	4680	849	1190
Baton Rouge 2	2,896	4401	822	1291
Houma-Thibodeaux 3	2576	4059	755	1236
Acadiana 4	3,988	4412	1183	1368
Southwest 5	2,753	2515	769	722
Central 6	2715	1656	829	452
Northwest 7	3,204	1574	855	430
Northeast 8	2,707	1630	767	455
Northshore 9	3,003	2199	851	650
Statewide	27,129	27,126	7,680	7,794

In response to concerns about the distribution of the 2003 sample, the 2005 Louisiana Health Insurance Survey utilized a sampling strategy based on assuring minimal households within each parish and within each region. The sampling design was similar in structure to a survey conducted in Missouri by the University of Minnesota's State Health Access Data Assistance Center. The initial sampling target was to generate at least 65 households from each parish and 800 households from each DHH region. To assure adequate sampling of minority and poor residents, an over sample 1000 respondents from telephone prefixes where the median income was below the statewide median was also conducted. The results - as can be seen in Tables 1 & 2 - are a more even distribution of households and individuals across region, and a corresponding increase in confidence in estimates from regions where sample size has increased (regions 5-9). While there is some decline in confidence in regions with fewer households sampled in 2005 (regions 1, 2, 3, 4), the sample sizes are generally large enough to provide reasonably accurate estimates of uninsured populations.

Second, in the 2003 survey, we utilized income data from a categorical, omnibus measure of household income. For estimating uninsured populations for various income and poverty levels, we used only those cases with valid income data. Practically speaking, this meant relying on fewer households to generate parish and regional estimates (with resulting decreases in the confidence of our estimates). In Table 3, we illustrate the number of households with valid data on this omnibus measure for both the 2003 and 2005 surveys. By eliminating those cases without valid income data, we limited our sample sizes to under 200 households in regions 6, 7, and 8, and to 268 in region 5 and 227 households in region 9.

Table 3: Comparison of Percent of Households with Valid Income Data, 2003-2005

Region	2003 Households With Valid Income Data			2005 Households With Valid Income Data		
	U19 HH	W Income	Percent	U19 HH	W Income	Percent
New Orleans 1	682	410	60.1%	471	333	70.7%
Baton Rouge 2	712	496	69.7%	446	342	76.7%
Houma-Thibodeaux 3	671	404	60.2%	427	295	69.1%
Acadiana 4	696	432	62.1%	645	432	67.0%
Southwest 5	396	268	67.7%	425	316	74.4%
Central 6	245	187	76.3%	452	322	71.2%
Northwest 7	246	165	67.1%	476	314	66.0%
Northeast 8	267	160	59.9%	417	315	75.5%
Northshore 9	359	227	63.2%	476	337	70.8%

*Comparisons are based on responses to categorical, omnibus income question.

Limiting the analysis to only those households with valid income data also meant making an implicit assumption that respondents who report income are relatively similar to respondents who did not report income. This turns out not to be the case as can be seen in Table 3. In Table 3, we present the estimates of uninsured children by region and missing income status for the 2005 Louisiana Health Insurance Survey. Households with reported income were much more likely to also report that children in the household were also insured.

Table 3: Comparison of Uninsured Rates for Respondents with Valid and Missing Income Data, 2005

<u>Region</u>	<u>U19 Uninsured All Respondents</u>	<u>U19 Uninsured W/Valid Income</u>	<u>U19 Uninsured W/Missing Income</u>
New Orleans 1	9.8%	8.2%	13.1%
Baton Rouge 2	11.3%	8.8%	21.5%
Houma-Thibodeaux 3	10.0%	9.4%	11.4%
Acadiana 4	12.1%	11.6%	13.4%
Southwest 5	6.9%	5.9%	9.8%
Central 6	13.3%	10.8%	18.4%
Northwest 7	7.4%	5.7%	10.4%
Northeast 8	8.6%	7.0%	13.4%
Northshore 9	10.1%	9.5%	11.8%

One consequence of this finding is that estimates of the uninsured by income level or poverty status in the 2003 Louisiana Health Insurance Survey are likely to be understated as they exclude households with missing data. To address this shortcoming, the 2003 Louisiana Health Insurance Survey used "hotdecking" to impute values for households with missing income. Hotdecking matches respondents based on similar, known characteristics (e.g., race, education, uninsured status, age) and then randomly selects income values for respondents with missing data from a group or "deck" of similarly situated respondents. For example, a Caucasian, less than a high school education, insured, and between 45-54 years old respondent would be matched with all respondents matching this description and randomly ascribed an income value. These imputed income values are then used in estimates of uninsured status by income and poverty levels.

The effect of imputing missing values on estimates on the uninsured are nontrivial and generally increase the proportion of respondents reported as uninsured. In Table 4, we present estimates of the uninsured children under 200 percent of poverty for all respondents and for respondents with valid income data on the categorical, omnibus question. Our statewide estimate of uninsured children increased by over two percentage points when missing income data are replaced with imputed values. Looking across regions, estimates of uninsured children under 200 percent of poverty increased by as much as 4 percentage points in region 3, while only decreasing in region 9 and then by less than a percentage point. *Importantly, the impact of imputation on uninsured rates is not consistent across region and affects some regions more than others.*

Table 4: Comparison of Estimates of Uninsured Children Under 200% Federal Poverty Level Using Imputed Income Data

<u>Region</u>	<u>2005 Estimate W/Imputed Income</u>	<u>2005 Estimate W/Valid Income Only</u>
New Orleans 1	18.2%	15.1%
Baton Rouge 2	16.0%	12.2%
Houma-Thibidoux 3	14.2%	9.9%
Acadiana 4	17.4%	14.5%
Southwest 5	10.1%	8.7%
Central 6	16.9%	14.2%
Northwest 7	9.2%	6.8%
Northeast 8	7.8%	6.8%
Northshore 9	17.3%	17.9%
Statewide	14.5%	12.1%

Third, we also made changes in how post-stratification weights were applied to the data. In the 2003 LHIS, the weighting strategy was developed by James Geaghan, a Professor of Experimental Statistics at Louisiana State University. Professor Geaghan developed the weighting strategy based on previous studies conducted at the University of Florida, and focused primarily on developing sampling weights consistent with a series of Florida Health Insurance Surveys. In the 2005 LHIS, sampling weights were constructed based on the number of households interviewed in a given prefix, the population prefix, and the size of the household. Post-stratification weights were further developed based on comparisons between sample respondent education, race, and age compared estimates from the Census Bureau's 2004 American Community Survey. The 2004 American Community Survey provides the most recent and reliable estimate of population demographics available. As is often the case with survey data, the initial sample was more highly educated, wealthier, and slightly more Caucasian than the general population. A comparison of the weighted survey estimates of key demographic characteristics with the American Community Survey is provided in Table 5. As can be seen in Table 5, the weighted 2005 LHIS sample characteristics nicely mirror estimates of the best available estimates of these population characteristics. This is particularly true in terms of estimates of the percent of respondents under the federal poverty line, and under 200% of poverty.

Table 5: Demographic Comparisons of 2005 LHIS to the 2004 American Community Survey

	2004 America Community Survey		2005 Louisiana Health Insurance Survey Weighted Estimates	
	<u>Population Estimate</u>	<u>Proportion Estimate</u>	<u>LHIS Weighted Estimate</u>	<u>LHIS Population Estimate</u>
	Population	4,383,224		
Sex				
Male	2,102,485	48.0	46.6	2,032,336
Female	2,280,739	52.0	53.3	2,325,097
Age				
Under 19	1,284,806	29.3	28.4	1,242,579
19-65	2,662,957	60.8	67.1	2,932,012
Under 18	1,160,909	28.0	28.3	1,170,377
18-24	458,325	9.0	10.6	440,496
25-34	565,386	12.9	12.3	508,094
35-44	631,655	14.4	15.7	651,376
45-54	638,923	14.6	17.6	729,929
55-64	433,750	9.9	15.5	640,979
65 and over	494,276	11.3		181,471
Education				
Less than High School	629,172	19.9	19.3	603,771
High School Graduate	1,070,975	33.9	36.7	1,149,754
Some College/Associates	829,436	26.3	24.4	763,194
College	428,984	13.6	15.3	480,324
Graduate Degree	198,666	6.3	4.4	136,479
Household Income				
Less than \$4,999	89,579	5.2	4.7	78,152
\$5,000-\$9,999	144,349	8.4	7.9	130,450
\$10,000-\$14,999	146,310	8.5	11.0	181,454
\$15,000-\$19,999	129,574	7.6	6.8	112,091
\$20,000-\$24,999	129,213	7.5	7.4	122,603
\$25,000-\$34,999	223,318	13.0	11.4	187,449
\$35,000-\$44,999	184,648	10.8	10.2	168,098
\$45,000-\$54,999	138,113	8.1	9.7	159,707
\$55,000-\$64,999	112,370	6.6	6.1	101,137
\$65,000-\$74,999	96,245	5.6	5.0	82,957
\$75,000-\$84,999	72,341	4.2	4.7	76,694
\$85,000-\$94,999	60,787	3.5	3.1	51,025
\$95,000	187,286	10.9	11.9	196,614
Poverty				
Less than 100%	844,235	19.3	18.5	830,743
Less than 200%	1,782,964	40.7	42.2	1,882,921
Over 200%	2,585,002	59.2	57.8	2,485,918

In the 2003 LHIS, for example, 31% of respondents were under 200% of poverty compared to approximately 41% in the American Community Survey and 42 percent in the 2005 LHIS. As with imputation, the effect of more accurate weighting procedures is to drive up estimates of the uninsured. Using the raw (unweighted) data, we would estimate that 9.6% of children under 19 are uninsured. Applying the sampling weights only (a rough equivalent to the weighting strategy employed in the 2003 LHIS), the estimate of uninsured children would actually drop slightly to 8.9 percent. Applying the sampling and post-stratification weights, the estimate increases to 10.1 percent. In Table 6, we present the estimates according to weighting procedure: (1) raw (unweighted) estimates; (2) Estimates with sample weights only; and (3) Estimates with sample and post-stratification weights.

Table 6: Comparison of Unweighted and Weighted Sample Estimates, 2005 LHIS

	Raw (Unweighted)	Sample Weights Only	Sample & Post-Stratification Weights
New Orleans 1	9.7%	8.5%	9.8%
Baton Rouge 2	8.9%	8.2%	11.3%
Houma-Thibodeaux 3	10.3%	10.4%	10.0%
Acadiana 4	11.2%	10.0%	12.1%
Southwest 5	6.4%	6.0%	6.9%
Central 6	11.5%	11.6%	13.3%
Northwest 7	8.5%	7.5%	7.4%
Northeast 8	9.9%	9.8%	8.6%
Northshore 9	8.9%	8.7%	10.1%
Statewide	9.6%	8.9%	10.1%

In terms of methodology, the 2005 Louisiana Health Insurance Survey improves upon work from the 2003 Louisiana Health Insurance Survey. The net effect of these changes is to provide more conservative (higher) and more accurate initial estimates of the uninsured. Including imputed income and changing the weighting schemes to better reflect the overall population clearly has the effect of increasing our estimates of the number of uninsured children and adults. As part of the survey, we are currently grappling with yet another methodological issue - the Medicaid undercount - in which respondents with Medicaid and LaCHIP coverage incorrectly report being uninsured or being covered by private insurance. Taking into the Medicaid undercount will effectively reduce our estimates of the uninsured by reducing the number of false positives in the uninsured category.

A second implication of these changes is that comparisons between surveys are - unfortunately - unlikely to be very meaningful. For example, our best comparison for the change in the number of uninsured children would be between the 2003 LHIS estimate - which placed the percent of uninsured children at 11.1% - and the 2005 LHIS estimate that includes only sample weights - which place the percent of uninsured children at 8.9%. If we were to calculate changes in the number of children without insurance, we would estimate that the number of

uninsured children decreased from roughly 143,000 in 2003 to 115,000 in 2005.⁴ However, it is important to keep in mind that the better estimate for uninsured children is from the estimates that include both the sampling and post-stratification weights, but that this estimate is not directly comparable to the 2003 estimate. Though notably, even with the changes in methodology (which places the percent of uninsured children at 10.1%), we would estimate that the number of uninsured children has decreased by approximately 14,000 children.

Looking more specifically at the percent of children uninsured under 200% of poverty and approximating the methodology of the 2003 survey (which would include only sampling weights and would not include imputed income), we would estimate a decrease from 12.9% in 2003 to 12.1% in 2005. According to these estimates, the number of uninsured children under 200% of poverty has declined by approximately 5000 children. As was the case with uninsured children more generally, the best estimate of uninsured children under 200% of poverty is 14.5% but there is currently no comparable estimate from the 2003 survey.

Medicaid Eligibility: A further improvement in the 2005 Louisiana Health Insurance Survey involves identifying the Medicaid eligible population. Medicaid eligibility for uninsured children is often determined by a fairly simple means test - if household income is under 200% of federal poverty they are considered eligible, otherwise they are ineligible. Yet, such a calculation ignores the fact that many households over 200% of poverty include Medicaid eligible children. In the 2005 Louisiana Health Insurance Survey, we have worked to better identify these children by more fully accounting for family relationships and income deductions. Here we briefly outline the procedure for identifying Medicaid eligible households and illustrating differences in uninsured status for children under 200% of federal poverty and Medicaid eligibility.

- All children under 200% of poverty are considered eligible for Medicaid. According to the estimates from the 2003 Louisiana Health Insurance Survey, this would include 625,483 Louisiana children (or roughly 1/2 of Louisiana's children);
- All children over 200% of the federal poverty level but reported as covered by Medicaid or LaCHIP. This adds an additional 100,923 children to the Medicaid eligible category, all of whom are reported as insured. This assumes that none of this reports are "false positives," that is respondents who might report LaCHIP coverage but who are uninsured or covered by private insurance. Because income is imputed for many of these household, it may be that respondent income is overestimated through the "hotdecking" procedure. These may also be respondents whose income falls close to 200% but are made eligible because of family or income deductions.
- Foster children and children living with grandparents or other relatives were counted as Medicaid eligible. According to our estimates, this would represent roughly 959 foster children and 110,531 children living grandparents or other relatives. Of the 110,531 children living with grandparents or other relatives, 24,176 were not currently covered by LaCHIP or living under 200% of poverty, meaning that these additional cases were captured as Medicaid eligible.

⁴ To assure the best comparison, we relied on population estimates from the 2004 American Community Survey. As such, these estimates is slightly different from what appeared in the 2003 Louisiana Health Insurance Survey Report.

- For children living with stepparents, income was recalculated based only on the biological parents estimated income. If the income was less than 200% of poverty, children in the household were counted as eligible. A couple of problems emerge with this measure. One, we can only determine stepchild status for the respondents and not for other members of the household. Second, since adopted children and own child are treated as separate categories, many "stepchildren" are likely to be missing from these calculations. Overall, there are an estimated 17,212 children living with stepparents. Of these, roughly 3,301 are now classified as Medicaid eligible who otherwise would have not been included.
- Finally, we deduct standard deductions from income and recalculate respondent income. Included deductions are: (1) \$90 per month for each working parent; (2) Child support payments; and (3) Child care expenses. With these income adjustments an additional 29,942 children are included as Medicaid eligible.

Taking into account all of these factors, we would estimate that the Medicaid eligible population in Louisiana is 783,826. Or perhaps stated differently, an additional 158,343 children would be considered Medicaid eligible using these more specific criteria than would be considered had we simply considered income under 200% of federal poverty. Moreover, our estimates of uninsured rates for the Medicaid eligible are substantially lower than our estimates for under 200% poverty. Statewide the Medicaid eligible estimate is 2.2 percentage points lower, though difference ranges from 0.7 percentage points in region 7 to 5.4 percentage points in region 1.

Table 7: Comparison of Medicaid Eligible to Under 200% of Poverty for Uninsured Children

<u>Region</u>	<u>Uninsured U19 Under 200% Proportion</u>	<u>Uninsured U19 Under 200% Population</u>	<u>Medicaid Eligible U19 Uninsured Estimate</u>	<u>Medicaid Eligible U19 Population Estimate</u>
New Orleans 1	18.2	21729	12.8	21874
Baton Rouge 2	16.0	12837	14.8	14092
Houma-Thibodeaux 3	14.2	6747	12.7	8249
Acadiana 4	17.4	15536	15.0	15798
Southwest 5	10.1	3632	8.9	3831
Central 6	16.9	8830	15.2	9660
Northwest 7	9.2	8935	8.5	9093
Northeast 8	7.8	4512	7.1	4896
Northshore 9	17.3	8136	13.9	9079
Statewide	14.5	90894	12.3	96572

Comparison of Estimates Across Years: With all these caveats in place, we begin examining differences in estimates across the two surveys at the regional level. We begin looking at adult uninsured rates. According to the Kaiser Family Foundation, the adult uninsured rate is 26%, our estimate nicely mirrors this estimate at 26.9%. Notably, however, it is considerably higher than estimates from the 2003 Louisiana Health Insurance Survey. The differences reflect changes in sampling design and weighting strategies, and the better consistency with other statewide estimates is indicative of the improvement in methodology. Looking across regions, our estimates of uninsured adults range from a low of 24.3% in region 9 (Northshore) to a high of 33.2% in region 7 (Northwest).

Table 8: Comparison of Adult Uninsured Rates

Region	2005 Adult Uninsured Estimate (Proportion)	2005 Adult Uninsured Estimate (Population)	2003 Adult Uninsured Estimate (Proportion)	2003 Adult Uninsured Estimate (Population)
New Orleans 1	27.2	179,823	20.9	131,000
Baton Rouge 2	22.5	82,644	19.2	71,400
Houma-Thibodeaux 3	25.4	65,551	21.3	48,300
Acadiana 4	24.5	89,737	23.1	73,800
Southwest 5	31.3	61,885	20.4	34,200
Central 6	33.2	66,389	21.6	38,100
Northwest 7	29.6	103,224	21.6	65,300
Northeast 8	29.1	68,759	27.3	56,000
Northshore 9	24.3	71,860	17.3	45,300
Statewide	26.9	789,872	21.1	576,500

Moving to uninsured children, we see greater variability in the estimates over the years, but particularly in regions 5, 6, and 7. This is partly to be expected given that the number of households with children is a subset of total households. As such, our margin of error is always larger when we examine uninsured children. Three regions, however, stand out as having unexpectedly large variation across the two years - regions 5, 6, and 7. Regions 6 and 7 were noteworthy as having relatively few households included in the 2003 survey (only 283 were included in region 6 in 2003 and only 240 in region 7), and as such estimates of uninsured children had a larger confidence interval. In the 2003 report, the approximate margin of error for these three regions were respectively, 3.7% in region 5, 4.7% in region 6, and 4.8% in region 8. The changes in the estimates, however, were beyond what one would expect on the basis of sampling error alone.

Other changes in the survey might also account for these differences. However, as noted throughout the report, most of these changes are likely to result in higher estimates of the uninsured. Yet, regions 5 and 7 experienced comparable declines - 7.9 and 6.8 percentage points - in the estimated percent of insured children, while region 6 experiences a comparable increase (7.0 percentage points). The variability across regions suggests random as opposed to systematic bias in the estimates, and points to sampling factors as likely culprits in the differences across

years. Unlike the adult estimates (presented in Table 8), there is no consistent upward trend in the estimates (which one might expect), but instead substantial differences across regions with the largest differences in regions where we have the least confidence in the 2003 estimates. As we illustrate below, this is an even greater problem with estimates of uninsured children under 200% poverty.

Table 9: Comparison of Uninsured Children

Region	2005 Children Uninsured Estimate (Proportion)	2005 Children Uninsured Estimate (Population)	2003 Children Uninsured Estimate (Proportion)	2003 Children Uninsured Estimate (Population)
New Orleans 1	9.8	24,930	9.6	27400
Baton Rouge 2	11.3	17660	10.8	18700
Houma-Thibodeaux 3	10.0	11753	11.4	13500
Acadiana 4	12.1	20469	11.0	18300
Southwest 5	6.8	5113	15.7	12900
Central 6	13.3	12659	6.3	5500
Northwest 7	7.4	10947	15.2	22700
Northeast 8	8.6	8865	11.1	11400
Northshore 9	10.1	12647	10.4	13600
Statewide	10.1	125,043	11.1	135,400

As with estimates of uninsured adults overall, estimates of uninsured adults under 200% federal poverty are generally higher in 2005. The notable exceptions are region 4 (Acadiana) which experienced a drop in estimated uninsured rates of roughly 5 percentage points and region 8 which witnessed a more modest 2.3 percentage point drop. All the other regions increased, generally quite modestly, and generally within the realm of what one would expect given changes in sampling design, weighting, and income imputation. The one notable jump beyond what one would expect is region 5 where the estimated adult uninsured under 200% of poverty increased from 37% to 51%. This is particularly puzzling given that the percent of uninsured children in the region declined.

Table 10: Comparison of Uninsured Adults Under 200% Federal Poverty Level

Region	2005 Adult Uninsured Estimate (Proportion)	2005 Adult Uninsured Estimate (Population)	2003 Adult Uninsured Estimate (Proportion)	2003 Adult Uninsured Estimate (Population)
New Orleans 1	51.2	141,190	46.5	103,800
Baton Rouge 2	41.4	52,252	40.3	47,200
Houma-Thibodeaux 3	44.4	43,570	41.5	31,700
Acadiana 4	38.0	59,420	43.5	54,900
Southwest 5	50.9	40,167	37.4	26,700
Central 6	48.6	40,493	39.7	27,600
Northwest 7	47.2	73,543	45.1	50,000
Northeast 8	44.7	44,035	47.0	38,500
Northshore 9	43.1	40,460	35.9	28,400
Statewide	45.9	535,130	42.5	400,000

As with children overall, there is considerably more variation when looking at uninsured children under 200% of poverty. We generally would expect consistent increases across regions, though regions 2, 5, and 7 defy this expectation. In region 2, the difference is slight, in region 4 the difference is more modest, and in region 7 the difference is much more substantial. Sampling error undoubtedly plays an important role in this variation. When we consider only households with children under 19 and income under 200% of poverty we are greatly limited our sample. For example, in 2003 in region 7, we are limited to 160 households with children and under 200% of federal poverty, while in region 6 our estimates are limited to 165 households.

Our poverty estimates are also more limited, estimating the number of children under 200% at 34% in 2003 as opposed 48% in 2005. It is not clear that the smaller estimate of children in poverty in 2003 would increase estimates of the uninsured, but the smaller the estimate of the under 200% of poverty the less confidence we have in our estimates. Also, the difference appears to be primarily in the 100% - 200% group as the percentages reporting as under 100% poverty are roughly equivalent across the two years (19% in 2003 and 22% in 2005), but the percentage reporting between 100%-200% is considerable large (15% in 2003 and 25% in 2005). Collectively, this may means that the estimate for the uninsured in region 7 was weighted more heavily toward the very poor in 2003.

While the difference in region 6 is also significant, it appears to reflect an increase in uninsured estimates across groups (uninsured adults, uninsured children, uninsured adults under 200%, and uninsured children under 200%). The estimates for Acadiana are more troubling, as they do not appear to reflect a more general pattern, or a relatively small sample size. Early we did observe an increase in these estimates due to both changes in weighting procedures and imputing income - though the changes were relatively modest (approximately 2% due to imputation and 1% due to weighting). This leaves a substantial gap - approximately 7-8% - to explain.

Table 11: Comparison of Uninsured Children Under 200% of Federal Poverty

Region	2005 Children Uninsured Estimate (Proportion)	2005 Children Uninsured Estimate (Population)	2003 Children Uninsured Estimate (Proportion)	2003 Children Uninsured Estimate (Population)
New Orleans 1	18.2	21,729	13.2	19832
Baton Rouge 2	16.0	12,837	17.6	13437
Houma-Thibodeaux 3	14.2	6,747	13.1	7190
Acadiana 4	17.4	15,536	6.6	5735
Southwest 5	10.1	3,632	15.7	5877
Central 6	16.9	8,830	7.7	3723
Northwest 7	9.2	8,935	24.8	20026
Northeast 8	7.8	4,512	9.2	5470
Northshore 9	17.3	8,136	16.5	8726
Statewide	14.5	90,894	12.9	83494

APPENDIX VIII VISION PAPER – LOUISIANA HEALTH CARE REDESIGN COLLABORATIVE

Vision Statement

Healthcare in Louisiana will be patient-centered, quality-driven, sustainable and accessible to all citizens.

Definition of Terms in the Vision Statement

Patient-centeredness ensures that the healthcare system is designed to serve the needs of patients, and to ensure that they are fully informed and empowered and participate in their care delivery whenever possible. By focusing on the patient, the charge of redesign shifts away from proxy metrics—essentially monitoring transactions within a system—towards fundamental metrics such as effects on quality of life. In a patient-centered system, care is readily available, accessible and convenient to use and minimizes productivity loss at work or other activities for the patient. The system communicates effectively with the consumer who participates in a process of shared decision-making about their care. The system offers reasonable choice of providers and care. The care that is delivered is both culturally and medically appropriate. For these reasons, patient-centeredness is at the core of the redesigned healthcare system in both planning and implementation.

The Collaborative adopts the definition of *quality* in healthcare set out by the Institute of Medicine: the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. The dimensions of quality include measures of system performance and patient experience such as safety, effectiveness, timeliness (accessibility), efficiency, and equity.

Sustainability refers to ensuring fiscal discipline in the redesigned health care system. Sustainability will be determined on the basis of satisfying the above guidelines while operating within the same or better total cost structure than that which previously existed. Combining *quality* and *sustainability* in the redesigned system guides healthcare to interventions that maximize value to both the patient and the community.

The redesigned system is intended to improve the health and care delivery services for *all* citizens of Louisiana without regard to payer or level of medical complexity.

Conceptual Model for the Redesigned Healthcare System

The right care for the right patient in the right place—the first time.

The system of care will be responsive to a person’s level of medical complexity and need (see *Figure 1* below). At each level of complexity, the fundamental goal of the system will be to facilitate a continuous healing relationship between a given patient and the appropriate set of healthcare providers.

As shown below, the vast majority of the population is mostly healthy, requiring wellness checkups and preventive care; episodic care for acute and chronic conditions; and special attention to maternal and child health. The proportion of the population with multiple chronic conditions requires more aggressive medical management—and caring for a patient with 5 or more chronic conditions necessitates an even greater degree of specialized intervention. The varying medical needs of the population lead directly to a rational approach for structuring the healthcare system.

For mostly healthy people, this calls for a ‘medical home’ or ‘coordinated point of care’. A medical home will ensure that patients receive evidence-based prevention services (e.g., adhering to USPHS guidelines) and primary intervention, including behavioral health services. Access to these services may be operationalized in a number of non-traditional ways (such as via the web or telemedicine) in addition to traditional office visits.

When necessary, this home will provide seamless, timely and patient-centered referrals for diagnostic services, specialty care and hospital care to providers who have established relationships with the person’s medical home. Enabling all of this will be state of the art health information technology systems; disease management programs; health education and promotion programs; appropriate pharmaceutical access; and other services such as transportation support where appropriate.

As a person’s level of medical complexity rises, so will the intensity of services available to them to support their return to good health and functionality. The system of care for a patient with a chronic condition will focus more on specialist coordination and appropriate reimbursement for efficient interaction with specialists (e.g., electronic communication). The central source of care provision may be at a center of excellence or tertiary facility, rather than with a traditional community-based primary care provider. Persons with more complex disease will require more intensive wraparound services such as allied health services, pharmaceutical support and social services. Persons with the most medical complexity, such as those with multiple chronic conditions, will require the most intensive resources. For these patients, care management programs and other formalized institutional support systems will be available. In all circumstances, care should be practiced based on the best available scientific evidence.

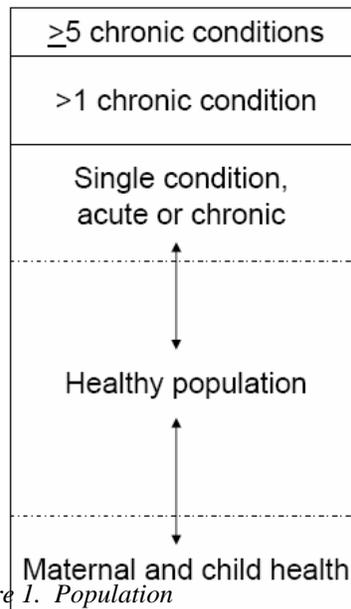


Figure 1. Population stratification by medical complexity and needs.

The will

It should be emphasized that organizing healthcare redesign by population strata does not imply the construction of care silos. A patient-centered vision calls for an integrated healthcare network that anticipates a given person’s transition between the categories of medical complexity. The system must also take into account unique issues surrounding end-of-life care. Therefore, the conceptual redesign described here points toward a truly dynamic, interdependent system (see *Figure 2* below).

The work of the Collaborative begins with an understanding of the population and its health care needs based upon health status and standards of personal responsibility. Practice patterns and processes must align with those needs and be applied at the point of care to produce the best outcomes. The care itself should be delivered collaboratively and in accordance with the guiding principles by healthcare workers who are supported by appropriate infrastructure. These healthcare workers and resources are to be compensated and rewarded by properly-designed methods of reimbursement by purchasers who have budgeted the necessary levels of funding to serve that purpose.

Figure 2. The scope of the Collaborative’s work is defined by the medical needs of Louisiana citizens and components of the system required to address them.

		Linked Components of the Healthcare System →				
Level of medical complexity ↓	Segment of the population as defined by medical complexity	I. Population and needs	II. Practice patterns and processes	III. Workforce and infrastructure	IV. Reimbursement	V. Funding
	Staying Healthy					
	Getting Better	Each sub-group will focus on describing in detail the components of the conceptual model for each defined segment of the population.				
	Living with Illness and Disability					
	Coping with End of Life					

**APPENDIX IX
PRESENTATION ON THE CONCEPTUAL PLAN – LOUISIANA HEALTH CARE
REDESIGN COLLABORATIVE**

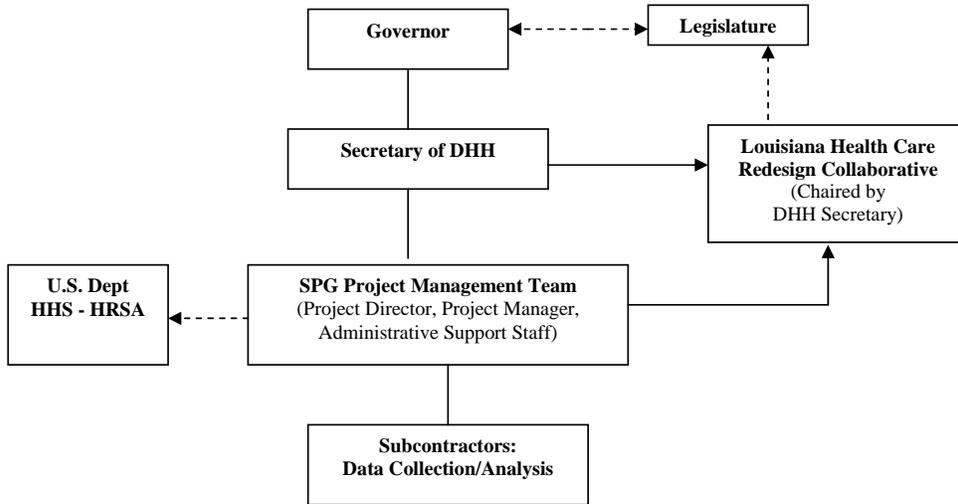
The presentation on the conceptual plan is available as a powerpoint presentation on the Louisiana Health Care Redesign Collaborative website. The presentation may be accessed by the following link: <http://www.dhh.state.la.us/offices/publications/pubs-288/9-15-06%20Collaborative%20Mtg%20FINALppt.ppt>.

**APPENDIX X
MEMBERSHIP LIST – LOUISIANA HEALTH CARE REDESIGN COLLABORATIVE**

Members	Representing
Sandra Adams	Maternal and Child Health Coalition
Michael Andry	Excelth Federally Qualified Health Center
Kyle Ardoin	Louisiana Independent Pharmacists Association
Janet Barnes, M.D.	Louisiana Medical Association
Gery Barry	LRA-Public Health & Health Care Task Force Workstream on Redesign
Yakima Black	Consumer Advocate - Behavioral Health
Floyd Buras, M.D.	Louisiana State Medical Society
Jim Cairo, Ph.D.	Healthworks Commission
Fred Cerise, M.D., MPH	Louisiana Department of Health and Hospitals
Joe Donchess	Louisiana Nursing Home Association
Gil Dupre	Louisiana Association of Health Plans
Representative Sydnie Mae Durand	House Health and Welfare Committee
Donna Fraiche	Louisiana Recovery Authority
Representative Cheryl A. Gray	Louisiana State Representative
Warren Hebert	HomeCare Association
Larry Hebert, M.D.	President of Senate Designee
Larry Hollier, M.D.	LSU-Health Sciences Center - New Orleans
Dan Juneau	Louisiana Association of Business & Industry
Jan Kasofsky, Ph.D.	Capital Area Human Services District

Members	Representing
Julia Kenny	Consumer Advocate - Elderly
Scott Kipper	Louisiana Department of Insurance
Jennifer Kopke	Jefferson Parish Human Services District
John Matessino	Louisiana Hospital Association
John McDonald, M.D.	LSU-Health Sciences Center – Shreveport
Senator Joe McPherson	Senate Health and Welfare Committee
Barry Meyer	Consumer Advocate – Developmental Disability
Susan Nelson, M.D.	Lake Senior Care Center
Butch Passman	Business Group on Health and Louisiana Health Care Alliance
Patrick Quinlan, M.D.	Ochsner Clinic Foundation
Bill Rouselle	New Orleans Area Consumer
Representative Joe Salter	Speaker of House
Don Smithburg	LSU-Health Care Services Division
Kevin Stephens, Sr., M.D., J.D.	New Orleans Health Department
Tony Sun, M.D.	Louisiana Health Care Review
Michael Teague	Metropolitan Human Services District
Paul Verrette, M.D.	St. Bernard Parish
Dave Ward	Health Care Services Recovery Council
Melanie Watkins	Florida Parishes Human Services District
Linda Welch	Louisiana Rural Hospital Coalition
Paul Whelton, M.D.	Tulane School of Medicine

**APPENDIX XI.
SPG GOVERNANCE STRUCTURE**



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- ⁱ Kaiser Family Foundation, www.statehealthfacts.org, accessed on October 31, 2005.
- ⁱⁱ MEPS-IC, 2003.
- ⁱⁱⁱ Kaiser State Health Facts (www.statehealthfacts.org), accessed on December 9, 2005.
- ^{iv} U.S. Bureau of Labor Statistics, November 21, 2005 Press Release (Average Weekly Wages In Louisiana: First Quarter 2005)
- ^v Louisiana Department of Labor, November 22, 2005 Press Release
- ^{vi} LSU HCSD 2004 Annual Report
- ^{vii} Ibid.
- ^{viii} U.S. Public Health Service, *Public Health and Clinical Services Status*, November 2005
- ^{ix} Ibid.
- ^x Louisiana Recovery Authority, *Overview of Comparative Damage from Hurricane Katrina*, December 9, 2005
- ^{xi} U.S. Public Health Service
- ^{xii} Louisiana Department of Labor, October 31, 2005 Press Release
- ^{xiii} Louisiana Department of Labor, November 22, 2005 Press Release
- ^{xiv} United States Department of Labor, *Employment Situation Summary*, November 2005
- ^{xv} Louisiana Department of Insurance, *Final Emergency Rule 17 – Health Insurance*, 2005
- ^{xvi} U.S. Public Health Service