BREAKING BARRIERS

Improving Health Insurance Enrollment and Access to Care in Louisiana

March 2015

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ALLIANCE FOR A JUST SOCIETY

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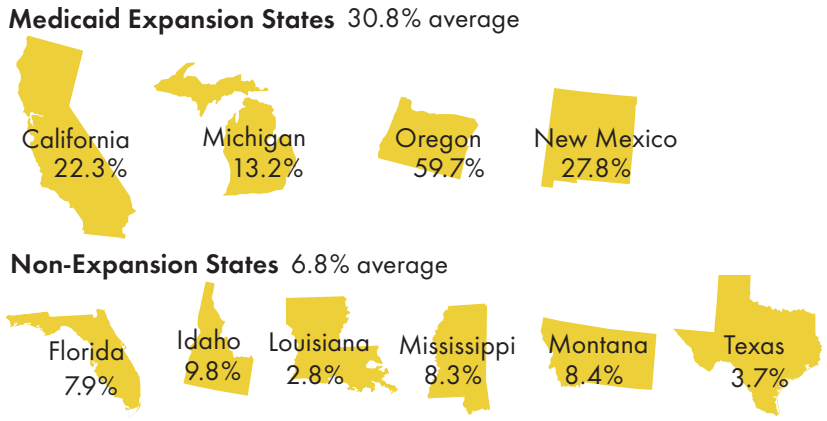
DESPITE ADVOCACY BY LOCAL GROUPS, MULTIPLE PROJECTIONS that the state's economy would benefit financially, and attempts by Democratic members of the state legislature in 2013 and again in 2014 to introduce a constitutional amendment to mandate Medicaid expansion, Louisiana did not expand Medicaid.[1] Through its refusal, the state effectively stranded about 422,000 of its residents without medical insurance.[2] Louisiana has the third highest poverty rate in the nation at 19.8 percent (only Mississippi, 24.0 percent, and New Mexico, 21.9 percent, rank higher),[3] more than one-third of its people live in medically underserved areas,[4] and about one in five adults lack health insurance.[5] Republican Governor Bobby Jindal led the opposition to Medicaid expansion: "Expansion," Jindal explained, "would result in 41 percent of Louisiana's population being enrolled in Medicaid. We should measure success by reducing the number of people on public assistance."[6]

Aggressively trumpeting that he would "not allow President Obama to bully Louisiana into accepting an expansion of Obamacare,"[7] Jindal chose instead to invest in a more "cost-effective" approach that focused on privatizing the current Medicaid program and "transforming" ten state-owned charity hospitals. This transformation would be accomplished by closing two hospitals and providing services instead in privately-run hospitals, and transferring the operations of seven other hospitals to the private sector.[8] The state expected Medicaid privatization to save $135 million in the 2012-2013 fiscal year and to "slow" the growth of Medicaid in subsequent years.[9] The results? From 2013 to mid-2014, encompassing the first Affordable Care Act (ACA) open enrollment period, Louisiana's uninsured rate for adult residents declined by only 3.3 percentage points, below the national average.[10] The number of people receiving Medicaid/CHIP benefits actually declined by 7,904.[11] Hailed by Jindal as a cost-saving measure, privatization of Medicaid and formerly-state-owned hospitals increased the state's Medicaid spending by $950 million.[12] In addition, the inspector general for the U.S. Department of Health and Human Services found that the state Children's Health Insurance Program failed to meet federal requirements for bonus payments in the 2009 through 2011 budget years, and recommended the state refund more than $7 million to the federal government. [13]

This report, part of a national study, reviews enrollment efforts and consequent consumer attempts to access health care by low-income Louisianans in the African American, white, and, where applicable, Latino, Asian-Pacific Islander, and Native American populations. The methodology includes key actor interviews with Louisiana-based navigators, policy and health care professionals, and advocates as well as 130 surveys in Spanish and English with low-income community residents. The report compares and contrasts the enrollment and "coverage-to-care" trends shown through the interviews and surveys to reported Louisiana outcomes and, when appropriate, to national trends. Analyses of these results serve as the basis for the report's recommendations.

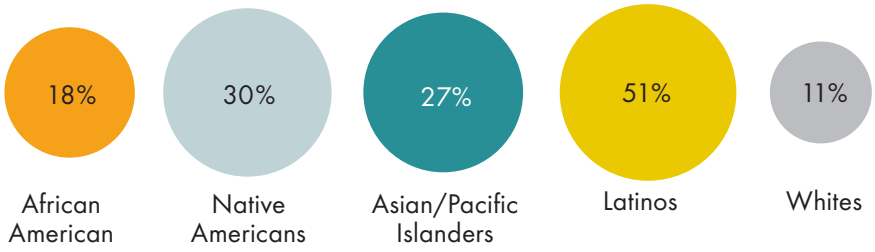
ENROLLMENT

CHART 1. Percent Medicaid and CHIP Enrollment Increase from 2013 Pre-Enrollment to August 2014[14]



Between 2013 and mid-2014, Louisiana's uninsured rate for adult residents declined from 21.7 percent to 18.4 percent, a decrease of 3.3 percentage points. The number of Medicaid and CHIP enrollees in the state increased by just 2.8 percent, less than in the other non-Medicaid-expansion states in this study and far below the increases seen in the states studied that elected to expand Medicaid. With a poverty rate of 19.8 percent, it is not surprising that an estimated 166,000 people fall into the Medicaid coverage gap—those who would have been eligible for Medicaid had their state opted for Medicaid expansion but whose incomes are too low to qualify them for premium subsidies in the state's health care marketplace.

CHART 2. Percentage Uninsured by Race



Approximately 22 percent of the state's population was uninsured in 2013. Given the racial disparity in uninsured rates, with uninsured rates for people of color far higher than for whites, it is reasonable to assume that enrollment data would reflect expanded outreach efforts in communities of color. As the data below will show, however, this does not appear to be the case. Charts 3-5 break out enrollment data for specific racial groups.

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CHART 3. Latino Enrollment

Percent of state population	5.0%
Percent of marketplace enrollees	2.2%*
Percent of Latino survey respondents who are new enrollees	33.3%

*Additional Special Enrollment Period Activity Report, excludes "race unknown"

Although the Latino population in Louisiana is relatively small, it is significant to note that the enrollment numbers are not congruent with either the Latino percentage of the population or the relatively high percentage of uninsured Latinos in the state. Only 43 percent of Latinos surveyed were insured. Of these, only one-third were new enrollees. As one Latino respondent said to our surveyors, "Louisiana used to have pretty good free (charity) care here in New Orleans. They never spoke much Spanish so I would have to bring my daughter to translate. Now, the lines for the charity care are way too long … and the paperwork is too much."[15]

CHART 4. White Enrollment

Percent of state population	60%
Percent of marketplace enrollees	50.2%
Percent of white survey respondents who are new enrollees	33.3%

Of the 101,800 Louisianans enrolled in the period ending April 30, 2014, 50.2 percent of those with known race/ethnicity were white. Of white survey respondents, 43 percent had insurance and only one third were new enrollees. However, some of the white enrollees we surveyed pointed to a number of enrollment difficulties. One student in her mid-20s said that the process took her three tries due to website difficulties and "I was not familiar with the terms."[16] Another young male enrollee said that "the sign-up wasn't that bad, but it's gonna take me almost three months to see a doctor."[17]

CHART 5. African American Enrollment

Percent of state population	32%
Percent of marketplace enrollees	37.9%
Percent of African American survey respondents who are new enrollees	25.8%

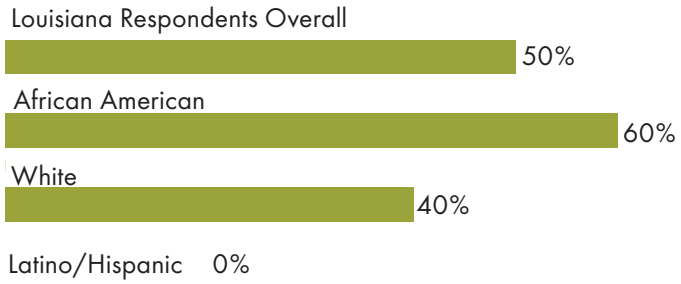
Given both the high percentage of uninsured African Americans and the fact that they comprise almost one-third of the state's population, the enrollment figures are underwhelming. While 69 percent of our African-American survey respondents had insurance, only a little more than a quarter (26 percent) were new enrollees. As one navigator reflected, "there is very little outreach in the Black community. We've done some health fairs and some outreach to churches but people have to come in to your office, you have to get them an email address and ask them personal questions. That takes a lot of time. Sometimes people have to come back two or three times. Mostly, young people will not do it."[18]

BARRIERS TO ENROLLMENT

CHART 6. Attempted to Get Coverage

If you are not covered by health insurance, did you try to get coverage?

Percentage tried to get coverage, by race



For respondents without insurance, 60 percent of African Americans, 40 percent of whites and 0 percent of Latinos attempted to get coverage. The most frequent open-ended response from both African Americans and whites as to why they did not get coverage was "did not qualify."

CHART 7. Difficulty with Enrollment

Was the enrollment process easy, somewhat difficult, or very difficult?

Percent somewhat or very difficult

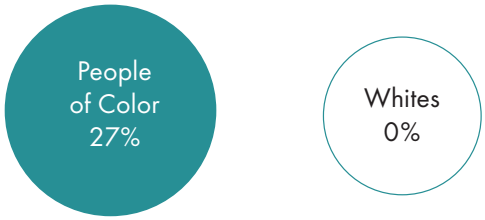
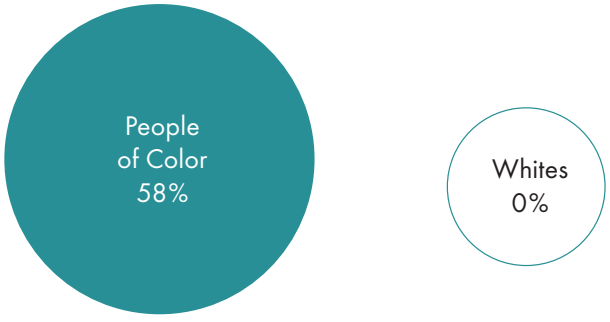


CHART 8. Assistance with Enrollment

Did anybody help you enroll?

Percent Yes



Although new enrollees of color had assistance in almost six in ten enrollment efforts, a quarter still found the process somewhat or very difficult. The process was especially daunting for Latinos, a third of whom had difficulty with the application. White respondents who did not have assistance did not find the process difficult.

"There has been a huge conversation about how a mixed status family or mixed Indian certification status (e.g., mom is a tribal member and the kids aren't) aren't being served. Being a mixed family jeopardizes your eligibility. The process doesn't allow for the fact that there are many people who have multiple identities and status in a family."

Beyond the enrollment question, however, insurance coverage does not necessarily translate into quality care, which includes access to providers, a relationship with a personal doctor, and access to both medication and other forms of treatment.

CHART 9. Email Address

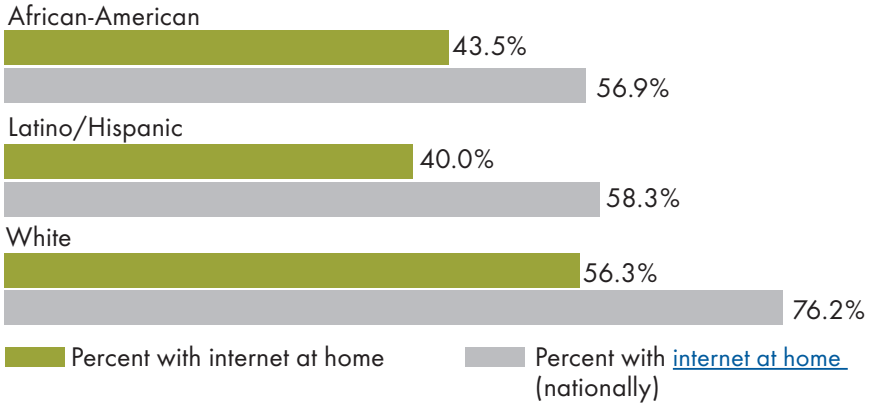
Do you have an email address?

Race/Ethnicity	Percent of respondents who have an email address
African American	52.4%
Latino/Hispanic	25.0%
White	80.0%

An email address is a necessary component of the enrollment process. Although relatively easy to get, *not* having an email address suggests that the potential enrollee has minimal familiarity with Internet communications. As the figures above indicate, the racial divide is significant. Whites have an email address at a rate almost 30 percentage points higher than for African Americans and more than three times the rate for Latinos.

CHART 10. Internet Access at Home

Do you have Internet access at home?
(Percentage of survey respondents compared with national percentages.)



Although Internet access is not absolutely necessary for ACA enrollment, without it a potential enrollee must either use a public Internet access point, such as a library, or get assistance from a private insurance broker or an organization with navigators. The chart above illustrates that the digital gap in Louisiana between whites and African Americans (approximately 13 percentage points) and Latinos (approximately 16 percent points) is smaller than the gap nationally. However, it is significant to note that Internet access for survey respondents is much lower in these low-income Louisiana communities than for these same racial groups nationally.

COVERAGE TO CARE

Overall enrollment data points to very small increases in health insurance coverage in Louisiana. Beyond the enrollment question, however, insurance coverage does not necessarily translate into quality care, which includes access to providers, a relationship with a personal doctor, and access to both medication and other forms of treatment. Although the developing ACA infrastructure is still in formation, in this section we examine some key issues related to access and treatment.

CHART 11. Chronic Medical Conditions

Do you have one or more medical conditions that have affected you for more than 3 months?

Race/Ethnicity	Percent Yes
African American	54.2%
Latino/Hispanic	57.1%
White	59.3%

If the incidence of chronic conditions is any indication, the ACA may have arrived just in time. Chronic diseases cause seven of every ten deaths. In addition, health care costs for an individual with one or more chronic diseases are five times the costs for an individual without chronic disease.[19] In this context, it is significant to note that six in ten whites reported one or more chronic illnesses, as did more than half of the African American and Latino respondents.

CHART 12. Personal Doctor

Do you have a personal doctor?

Race/Ethnicity	Percent Yes
African American	64.5%
Latino/Hispanic	66.7%
White	81.8%

CHART 13. Frequency of Doctor Visits

When was the last time you saw a doctor or health care provider?

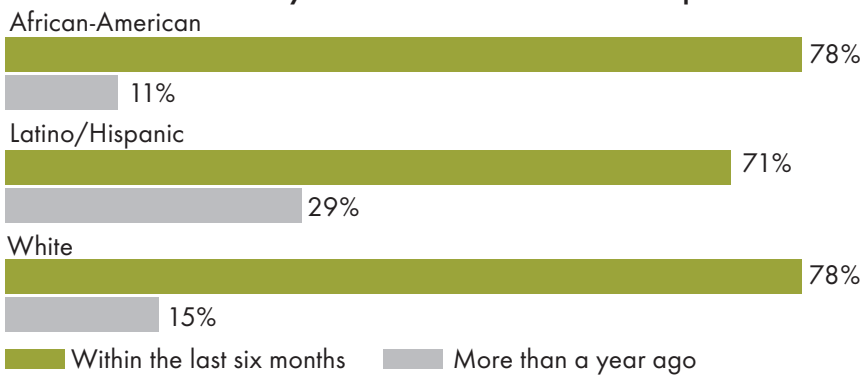


CHART 14. Medical Home

Percentages of respondents who go to a clinic or individual physician for their primary health needs, by race.

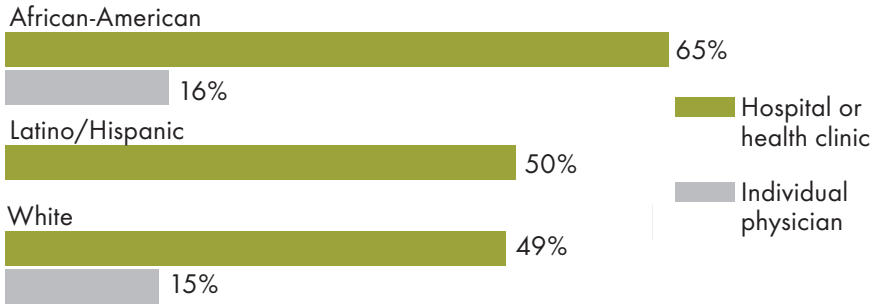


CHART 14A. Medical Home

Percentage of respondents who have no regular place or use emergency rooms for their primary health needs.

Race/Ethnicity	ER/ no regular place to go
African American	19%
Latino/Hispanic	50%
White	37%

Over two-thirds of survey respondents have a personal doctor, with white respondents the most likely at 82 percent. However, less than 14 percent of respondents get their primary health needs met by an individual doctor; 35 percent either use the emergency room or have "no regular place to go" for medical care.

CHART 15. Medical Tests

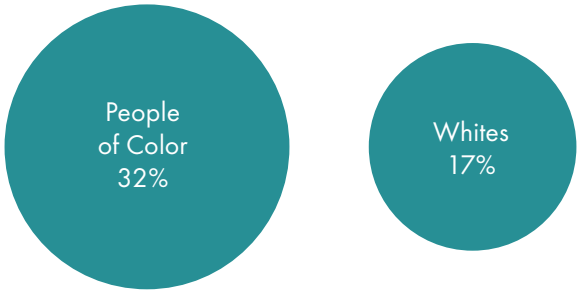
In the last 6 months, did a doctor or other health care provider order a blood test, x-ray, or other test for you?

	Percent "yes"
African American	68.8%
Latino/Hispanic	100%
White	87.5%

CHART 16. Access to Urgent Care

In the last 6 months, when you tried to get an appointment for care you needed right away, how long did you usually have to wait between trying to get an appointment and actually seeing someone?

Percent waiting more than 7 days



Healthcare providers ordered blood tests or x-rays for 100 percent of Latinos, 87.5 percent of whites and 68.8 percent of African Americans within the last 6 months. However 32 percent of people of color versus only 17 percent of whites reported that they had to wait a week or more for urgent care.

CHART 17. Awareness of Financial Support

When you enrolled in a health plan were you informed about financial support for low-income people?

Race/Ethnicity	Percent replying "yes"
African American	55%
Latino/Hispanic	66%
White	27%

CHART 18. Extra Payments

Not including copayments, have you ever had to pay extra for doctor visits or medicines that your plan doesn't cover?

Race/Ethnicity	Percent who have had to pay extra
Louisiana Respondents Overall	41.0%
African American	38.1%
Latino/Hispanic	66.7%
White	36.4%

Over 60 percent of people of color compared to 27 percent of whites were told about financial support for low-income people. However, two-thirds of Latino respondents and over a third of African American and white respondents have had to pay extra for medical services. One insured African American told a surveyor in New Orleans, "I have a regular copayment, but if I have to go to a specialist, or get new medicine, it always costs more … and you never know how much it's gonna be."

CHART 19. Non-Medical Treatment

In the last 6 months, how often did a doctor or other health provider talk with you about non-medical things like diet, exercise, meditation, or chiropractic care to treat or prevent illness?

Race/Ethnicity	Percent always/usually
People of Color	37%
White	33%

CHART 20. Discussing Only Self-Care Approaches

Of those whose doctors discussed non-medical methods, percent who discussed only diet and/or exercise, by race

African American	69%
Latino/Hispanic	67%
White	50%

The variation is quite small between percentages of respondents of color and whites whose doctors mentioned non-medical interventions. However, differences in the percentages of whites and people of color whose doctors mentioned *only* self-care approaches relating to diet and/or exercise are significant: half of white respondents versus more than two-thirds of people of color.

"I have a regular copayment, but if I have to go to a specialist, or get new medicine, it always costs more … and you never know how much it's gonna be."

In a state where one in five people are poor and that ranks fourth worst among states in deaths due to cancer and heart disease, the decision not to extend Medicaid to 422,000 uninsured residents, when national data suggest over half of those who fall into the Medicaid coverage gap are people of color, exacerbates existing racial disparities and poses a major barrier to a healthy citizenry in the state.

SUMMARY OF FINDINGS

Louisiana enrollment numbers were low and did not reflect an effort to target uninsured populations, particularly in communities of color where 27 percent of survey respondents found the enrollment process difficult and navigators reported almost a third of African American applicants fell into the coverage to care gap.[20] In a state where one in five people are poor and that ranks fourth worst among states in deaths due to cancer and heart disease, the decision not to extend Medicaid to 422,000 uninsured residents, when national data suggest over half of those who fall into the Medicaid coverage gap are people of color, exacerbates existing racial disparities and poses a major barrier to a healthy citizenry in the state.

Lack of access to the Internet and email, again exacerbated by racial differences, will continue to play a role in determining outreach and enrollment success, especially if Louisiana continues to use the federal website for enrollment. This dearth of electronic access is even more acute in rural areas where cuts in libraries and other public venues leave residents with few options for internet access.

Survey respondents had high levels of chronic illnesses; well over half reported one or more. And while most respondents report that they have a personal doctor, over half use clinics for care while one-third either use the emergency room or have "no regular place to go." Urgent care was particularly hard to get for people of color, a third of whom had to wait more than seven days, almost double the percentage of whites.

Well over half of our survey respondents had heard of financial assistance for low-income residents, yet over 40 percent have paid extra for either medicine or doctor visits.

Finally, pathways to alternative health modalities are highly limited, with less than half of doctors talking with patients about non-medical health approaches. Of the doctors that do mention alternatives, more than 50 percent of the time the emphasis is on the standard patient self-help recommendations—diet and exercise.

RECOMMENDATIONS FOR IMPROVING OUTREACH, ENROLLMENT, AND COVERAGE TO CARE IN LOUISIANA

Louisiana made an anemic attempt to enroll its residents in the ACA marketplace. Special outreach efforts and resources for culturally appropriate outreach were not readily available. As one navigator lamented, "this is gonna take some serious outreach. My organization has the connections but not the resources, but the state does not give us a lot to work with."[21] In order to improve enrollment and care options, we recommend the following:

I. SAFEGUARDING ACCESS TO HEALTH INSURANCE

Increase enrollment and federal funding by expanding Medicaid. The

current plan to privatize and merge state hospitals has proven more costly and less effective than projected. At this point, the rational policy alternative is to increase enrollment eligibility for low-income residents by taking advantage of federal funds available for Medicaid expansion.

Target for enrollment low-income residents already enrolled in income-based programs. The state should immediately increase low-income health insurance enrollment by automatically enrolling in Medicaid people who already receive need-based benefits like SNAP (food stamps), Supplemental Security Income (SSI), WIC, or free or reduced-price school meals, as well as people released from incarceration with no immediate source of income or assets.

Improve language access. Culturally appropriate language access is still not an everyday reality in the state. Complete multilingual application materials and website access are not readily available. Louisiana should expand its pool of interpreters and require plans to continually update information about which providers are in their networks. Provider directories must be available in multiple languages and list addresses, phone numbers, languages spoken, hospital affiliations, and specialties. The state should regularly assess plans' compliance with language access requirements.

Simplify the insurance-shopping experience. The state should simplify print and electronic descriptions of plans and benefits, especially deductibles, co-pays, preventive services available at no cost, and the significance of providers being in- or out-of-network, making costs transparent and ensuring easy comparison of services available with no co-pay. It should also require plans to continually update information about which providers are in their networks.

Make faster decisions on enrollment applications. The state should require decisions on ACA and Medicaid applications within two weeks of filing.

II. MOVING CONSUMERS FROM COVERAGE TO CARE

Expand and extend the role of navigators. Many enrollees are new to health insurance coverage. Not only are they unfamiliar with medical terminology, they have had little interaction with the medical system or the insurance system and may need both an introduction and an acclimation. Navigators are in an ideal position to perform this role. The state should extend the role of navigators to encompass teaching new enrollees how to use insurance coverage and recruiting enrollees to participate in marketplace-sponsored evening and weekend clinics focusing on health education, specific mobile services (exams, immunizations, etc.), and access to different medical modalities (e.g., acupuncture, chiropractic care).

Address racial health disparities. 58 percent of the new enrollees of color in our survey exhibited one or more chronic conditions. Louisiana should enforce ACA statutory provisions that require insurers to act to reduce racial disparities and continually monitor implementation of insurers' disparity-reduction plans and programs, especially outreach and outcomes.

Increase payment rates to primary care physicians. Since payment levels strongly affect providers' willingness to see Medicaid patients, Louisiana

should use state funds to continue Medicare-level payments to primary care physicians who serve Medicaid beneficiaries after federal support for increased payment levels ended on Dec. 31, 2014, as 15 states (AK, AL, CO, CT, DE, HA, IA, MD, ME, MI, MS, NE, NM, NV, SC) plan to do.

Require plans to adopt geographic access standards ensuring that, for at least 90 percent of enrollees, primary care providers are available within 10 miles or 30 minutes average driving or public transit time and specialists within 45 miles or one hour, whichever is less, as New Jersey does (N.J. Admin. Code § 11:24A–4.10). Vermont imposes similar requirements. Enrollees who live farther from providers should be offered free transportation.

Require plans to include in their networks at least one full-time primary care provider for every 2,000 patients and ensure that enrollees are able to make appointments with their primary care providers within 10 business days of seeking an appointment.

Reinforce the ACA-mandated women's right to no-cost "well-woman preventive" care by ensuring that all plans available through the marketplace include reproductive health care services.

Require that new enrollees have the opportunity for a free physical exam and appropriate screening tests within 60 days of enrollment.

Expand and standardize preventive services, ensuring that non-grandfathered plans offer preventive services (yearly check-ups, immunizations, counseling, and screenings) at *no out-of-pocket cost* and penalize plans in which fewer than 70 percent of enrollees receive these services.

Require plans to track health outcomes, disaggregated by race, ethnicity, primary language, gender, disability, and sexual orientation.

III. BUILDING AN INFRASTRUCTURE TO PROMOTE PREVENTIVE HEALTH CARE

Offer incentives to plans that adopt a broad view of health benefits and tackle underlying social determinants of health. Louisiana is a poor state with 9 percent of its residents living in extreme poverty.. Insurance is one step toward better health but in order to address the prevalence of chronic diseases, the state must encourage innovation and experimentation to address the underlying causes of poor health—particularly in poor rural communities.

Expand medical-legal partnerships as an avenue toward the broad array of issues that lead to poor health in low-income communities (e.g., mold in housing, domestic violence). While three-quarters of states and seven of the ten states studied already have at least one such partnership, through which medical and legal professionals collaborate to look holistically at barriers to health and wellness and work jointly to remove the barriers, the partnerships already in place cannot begin to meet the need.

Invest in school-based health centers. Seek funds from HHS' Health Resources and Services Administration or use state funds to expand school-based health centers, especially in medically-underserved communities, to mitigate the lack of other health care options (Section 4101 of the ACA, 42 U.S.C. § 280h-4).

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14. Table 1: Medicaid and CHIP: July and August 2014 Preliminary Monthly Enrollment accessed at: http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/august-2014-enrollment-report.pdf

15. (Spanish) Conversation with surveyor , July 2014.

16. Conversation with author, July 2014.

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20. Interview with AJS staff, July 2014.

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