Louisiana Department of Health

Response to SR 49 of the 2020 2nd Extraordinary Session

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Introduction

After seeing the uninsured child population decrease to its lowest point on record in 2017, Louisiana experienced the largest increase in both the number and rate of uninsured children in over a decade. Between 2017 and 2019, the uninsured rate increased from a historic low of 3.1% in 2017 to 4.4% in 2019 and the number of uninsured children increased from 36,000 to 50,000. Children living in households with incomes below 255% of the Federal Poverty Level (FPL), the cutoff for Louisiana's Children's Health Insurance Program (LaCHIP), accounted for roughly 59%, or 27,500, of uninsured children in 2019. An additional 22% of uninsured children lived in households making between 250% and 399% of the FPL and were likely eligible for subsidized coverage on the federally-facilitated health insurance exchange.[1] As evidenced by this data, many children in Louisiana are eligible but not enrolled in free or low-cost coverage options. To determine why this is the case, the Louisiana Department of Health (LDH or "the Department") has examined federal and state policy changes and other factors that have contributed to the child uninsured rate as directed by Senate Resolution (SR) No. 49 of the 2020 Second Extraordinary Session and included recommendations for possible changes that might reduce uninsured rates.

Section 1 - Health insurance programs for children and youth

Section 1.1 – Children's Health and Maternity Program (Title XIX)

The Children's Health and Maternity Program (CHAMP), created by the Louisiana legislature in 1986, provided Medicaid benefits to pregnant women and children and youth under the age of 19 in households with monthly incomes above the cutoff for Medicaid. Since the passage of the Affordable Care Act (ACA) in 2010, CHAMP has been folded into Louisiana's Medicaid program and is now a category of Medicaid-enrolled children and youth under the age of 19 with monthly household incomes up to 142% of the FPL (147% including the 5% disregard).

Coverage Trends

Figure 1.2: Number of Unduplicated Medicaid CHAMP Enrollments in Louisiana, 2017 – 2020

	SFY 17	SFY 18	SFY 19	SFY 20
CHAMP[2]	617,865	619,134	601,001	589,043

Section 1.2 – Children's Health Insurance Program (Title XXI)

The Children's Health Insurance Program (CHIP) is a medical assistance program that primarily covers low-income, uninsured children and youth under the age of 19. CHIP was created by Congress in 1997 to extend insurance coverage to children in households that could not afford private insurance coverage and did not qualify for Medicaid. CHIP, unlike Medicaid and other public assistance programs, must be reauthorized by Congress periodically.

CHIP is administered jointly by the states and the federal government. The federal government finances at least 65% of a state's CHIP expenditures and sets broad guidelines as to how states may design their

[1] *Louisiana Children Health Uninsured Rates Census 2019*. Louisiana Budget Project. October 2020. Available at: https://www.labudget.org/wp-content/uploads/2020/10/Census-2019_-Child-Health-Insurance.pdf

[2] LDH enrollment data

CHIP programs. These guidelines require that states cover children and youth whose monthly household income is above the cutoff for Medicaid and provide a benefit package that meets certain standards based on whether the state operates CHIP as a separate program from Medicaid, as an expansion of Medicaid, or as both a separate program and an expansion of Medicaid.

LaCHIP covers children and pregnant women in households with monthly incomes above the income cutoff for Medicaid and up to 212% (217% including the 5% disregard) and 214% of the FPL, respectively. Louisiana also extends CHIP coverage to children in households with monthly incomes up to 250% (255% including the 5% disregard) of the FPL for a $50 per household monthly premium. With the enhanced federal funding under the Families First Coronavirus Response Act (FFCRA), federal reimbursement for Louisiana's CHIP expenditures is set at 81.85% (77.51% without enhancement) for state fiscal year 2022. Louisiana has opted to provide an LaCHIP benefit package that is identical to the benefit package provided by Louisiana Medicaid. This simplifies administration of benefits while ensuring that children have access to comprehensive services.

Figure 1.1: Income Limits for Louisiana Medicaid and CHIP (with 5% disregard included)

Coverage Trends

Figure 1.2: Number of Unduplicated Medicaid CHIP Enrollments in Louisiana, 2017 – 2020

	SFY 17	SFY 18	SFY 19	SFY 20
LaCHIP[3]	119,934	175,418	192,079	189,761

Section 1.3 – Federally-Facilitated Exchange and Individual Health Insurance

The Federally-facilitated Exchange (FFE), also known by its web address HealthCare.gov, is a health insurance exchange operated by the US Department of Health and Human Services through which consumers can apply for and enroll in individual health insurance (IHI). Health insurance exchanges were created by the Affordable Care Act (ACA) in 2014 as a means to find coverage for individuals who are ineligible for Medicaid and not offered or able to afford health insurance through their employer. In states like Louisiana that have opted not to create their own state-based exchange (SBE), consumers must apply for insurance on the FFE. Consumers can apply for insurance for themselves, for their household, or separately for dependents. However, purchasing coverage separately for a dependent is often prohibitively expensive. This is because premiums are based on a percentage of household income, regardless of how many members of the family are covered. A parent purchasing coverage for their dependent must pay full price for the policy if he or she has access to employer-sponsored coverage that would cost less than 9.8 percent of their income for individual coverage, regardless of the cost of family coverage.

[3] https://ldh.la.gov/assets/docs/LegisReports/LaCHIPSFY2092020.pdf

There are four levels or tiers of IHI available on the FFE. Tiers are based on actuarial value, which is the percentage of total average costs for covered benefits that a plan will cover. Bronze plans have an actuarial value of 60 percent, Silver plans have an actuarial value of 70 percent, Gold plans have an actuarial value of 80 percent, and Platinum plans have an actuarial value of 90 percent. Premiums tend to increase and cost-sharing decrease for plans with a higher actuarial value.

Premium tax credits that subsidize the cost of coverage purchased on health insurance exchanges are available for consumers with income between 100 percent and 400 percent of the Federal Poverty Level. Additionally, enrollees with income at or below 250 percent of the Federal Poverty Level receive cost-sharing reductions. Subsidies increase inversely to household income so that eligible households with lower incomes receive larger subsidies. Consumers who qualify for Medicaid or CHIP do not qualify for subsidies.

It should also be noted that Louisiana is a determination state. This means that persons who apply for coverage through the FFE but meet the state's Medicaid or LaCHIP eligibility criteria are determined eligible for Medicaid or LaCHIP by the FFE on behalf of the state and automatically enrolled in Louisiana Medicaid when Louisiana receives the account transfer from the FFE. As such, in addition to IHI enrollments, the FFE determines Medicaid and LaCHIP eligibility.

Figure 1.3: Number of Individual Health Insurance Enrollments Processed through Federally-Facilitated Exchange in Louisiana for Age Groups Under 25, 2017 – 2020

	0-17	18-25	Total
2017	10,521	13,841	24,362
2018	8,763	8,788	17,551
2019	7,309	7,079	14,388
2020	6,941	6,369	13,310

Figure 1.4: Percentage Change in Individual Health Insurance Enrollments Processed through Federally-Facilitated Exchange in Louisiana for Age Groups Under 25, 2017-2020

	Percentage Change in Applications	
	Medicaid	FFE
Absolute Change (2017 to 2020)	-38.30%	-14.80%
Absolute Change (2018 to 2020)	-6.00%	-38.90%
Absolute Change (2019 to 2020)	-5.00%	-20.10%
Average Yearly Change	-13.30%	-5.60%

Figure 1.5: Number of Individual Health Insurance Enrollments Processed through Federally-Facilitated Exchange in Louisiana by Region, 2017 & 2020

Region	0-17			18-25		
	2017	2020	% Change	2017	2020	% Change

1	2,127	3,617	-39.1%	1,295	1,290	-64.3%
2	1,386	2,474	-25.3%	1,035	1,160	-53.1%
3	204	771	34.8%	275	374	-51.5%
4	1,276	1,420	-32.2%	865	611	-57.0%
5	448	506	-14.5%	383	281	-44.5%
6	367	537	-14.2%	315	157	-70.8%
7	827	1,312	-14.6%	706	414	-68.4%
8	430	876	15.6%	497	363	-58.6%
9	1,739	1,850	-34.1%	1,146	1,020	-44.9%

Section 1.4 - Group Health Insurance

The majority of Americans have some form of group health insurance coverage. Group health insurance is bought by or on behalf of multiple people that are not members of the same household, most commonly employees of a firm (an arrangement referred to as employer-sponsored insurance). Group health insurance plans contrast with individual health insurance plans, which are purchased directly by the individual on the FFE, state-based exchange, or through an insurance broker for plans that do not meet the minimum essential coverage requirements. In employer-sponsored insurance, the employer purchasing coverage pays a share of the cost of the premium for employees while individuals enrolled in other types of group coverage (such as AARP coverage) generally pay the full cost. As with IHI, a person enrolled in a group plan may be able to cover members of their household, but employers typically contribute less toward family coverage, if they contribute at all.

The cost of and benefits covered by group health insurance vary widely by plan. The ACA included a number of regulations intended to impose some degree of uniformity and ensure that most who have access to group coverage can afford it. These regulations include:

- Prohibiting variation in premiums within a plan except on the basis of age, tobacco use, and whether single, two-person, or family plan
- Allowing young adults to remain on their parent's insurance plan up to age 26
- Banning lifetime or annual limits on coverage
- Insurers are restricted from denying coverage or charging higher premium costs because of pre-existing conditions
- Plans must provide benefits that meet the standards of minimum essential coverage

Notwithstanding these regulations, access to coverage is still largely dependent on employment. During economic downturns, those with insurance through their employer are at a distinct risk of losing coverage, as millions did during the COVID-19 pandemic in 2020. Furthermore, many firms have dropped coverage for their employees. According to a survey of private and non-federal public employers by the Kaiser Family Foundation,[4] the percentage of firms offering health benefits declined nearly 10% over the past two decades.

[4] *2020 employer health benefits survey*. Kaiser Family Foundation. October 8, 2020. Available at: https://www.kff.org/report-section/ehbs-2020-summary-of-findings/

*Figure 1.6: Enrollment in Group Insurance Coverage in Louisiana for Ages 0-25, 2017 – 2020**

Year	0-25		
	Count	% of Total Statewide Group Enrollment	Change from Prior Year
2017	240,018	30.1%	--
2018	236,212	30.0%	-1.6%
2019	237,881	30.2%	0.7%
2020	228,868	29.8%	-3.8%

*Does not include Vantage, Healthy Blue, ITS/Blue Card, or National Partnership ASO plans.

Section 1.5 - Military Coverage

Active-duty and retired service members and their dependents can enroll in TRICARE, a health insurance program managed by the U.S. Department of Defense. TRICARE offers a variety of benefit packages based on factors such as a person's status in the armed forces or relationship to their sponsor (the service member to whom they are related), age, and location. Tricare enrollees must pay premiums and cost-sharing.

Section 2 - Drivers of the increasing uninsured rate among children and youth

In reviewing the possible various drivers of the rising uninsured rate for children over the last few years, consistent themes continued to arise. It is clear that federal policy change makes a large impact on the decisions of families and on states effectuating various forms of coverage. Policies commonly observed to have the greatest impact on the decisions of families and on states effectuating coverage are reviewed below.

Section 2.1: Administrative complexity and system changes

In November 2018, Louisiana Medicaid implemented a new eligibility and enrollment system known as the Louisiana Medicaid Eligibility Determination System (LaMEDS). To simplify the enrollment process for Medicaid- and CHIP-eligible Louisianans, increase administrative efficiency, and strengthen program integrity, LaMEDS uses electronic data interfaces available from multiple sources to verify information the applicant self-reports when applying for or renewing coverage and at quarterly income verification. Per federal regulations, LDH must contact applicants to request information not available through or not consistent with electronic data. Currently, LaMEDS only contacts applicants to request additional information by mail.

Coinciding with the implementation of LaMEDS, LDH began to verify income for Medicaid enrollees on a quarterly basis. Quarterly wage checks are intended to ensure that only those with incomes that meet program criteria remain enrolled. While enrollment for children and pregnant women is not directly impacted by quarterly wage checks due to continuous eligibility requirements, requests for information may lead to confusion as well as loss of coverage when eligible family members do not respond or fail to respond within the specified timeframe. When eligible parents or family members lose coverage, eligible children are also at greater risk for becoming uninsured. Any income reported for these persons is considered when assessing Medicaid eligibility for other members of their household.

While these changes are intended to simplify the enrollment and renewal process and strengthen program integrity, the requirement that Medicaid or CHIP-eligible or enrolled individuals account for discrepancies in self-reported and electronically-available data, coupled with quarterly wage checks, may make it more cumbersome. As LaMEDS is better able to detect differences between self-reported data and electronic data than the prior mainframe-based system Louisiana previously used, applicants and enrollees may be required to submit information to verify their eligibility more frequently. Failure to respond within the given deadline (10 days from the date on the mailed request for a request for information and 30 days from the date on the mailed request for a standard renewal) will result in loss of coverage. This imposes an administrative burden on many eligible Medicaid members who do not update their contact information in the event of a change or who lack a stable address. Quarterly wage checks compound these issues, causing eligible Louisianans to repeatedly lose and regain coverage, a process referred to as churning. Income fluctuations due to variable hours, seasonal employment, or overtime hours contribute to churning.

Nonresponse is likely to become more of an issue after the resumption of renewals in January 2021 and the resumption of terminations once the public health emergency ends. In order to stabilize access to health care during the COVID-19 pandemic, states are able to draw down an additional 6.2 percentage points in the Federal Medical Assistance Percentage (FMAP) if they maintain eligibility or enrollment

standards and provide continuous Medicaid coverage through the end of the public health emergency. Renewals and periodic income checks were suspended in March 2020 when Congress enacted the Families First Coronavirus Response Act (FFCRA)-- consequently, a Medicaid enrollee can only be disenrolled if they die, move out of state, or request to be disenrolled. Many members who have enrolled in Medicaid or CHIP during the pandemic may be unaware that they or their dependent can lose coverage for failing to complete the renewal process or for not providing paperwork to prove eligibility when the PHE ends.

Section 2.3: Changes to the public charge rule

The public charge rule is a longstanding immigration policy which is used to identify and deny permanent residency to immigrants who are likely to depend on the government for support in the future (i.e., become a public charge) based on characteristics such as age, health, and education. The Trump administration sought to broaden the characteristics that could be used as grounds for denial of residency to include use of any public program by an immigrant, an immigrant's un-naturalized dependents, or by an immigrant's lawfully present dependents. Under the final rule enacted in 2020, characteristics considered to contribute to an immigrant's likelihood of becoming a public charge were broadened to include the use of adult Medicaid, SNAP, housing subsidies, and cash assistance. The final rule did not count an eligible dependent's use of Medicaid or CHIP or other public assistance programs against the person applying for assistance.

Although the final version of the rule affected fewer immigrants than the rule initially proposed in 2017, it led many to avoid applying for public assistance programs out of a belief that doing so would jeopardize their residency or lead to their deportation, a phenomenon known as the "chilling effect." Because of this effect, more than one in four adults in immigrant families with children between 2018 and 2019 reported that they or a family member avoided a public benefit such as SNAP, Medicaid, CHIP, or housing subsidies in 2019 for fear of risking future green card status (Urban).[5] Furthermore, nearly half of adults reportedly avoiding noncash government benefit programs because of green card concerns said their families avoided Medicaid/CHIP or SNAP, compared to a third avoiding housing subsidies.[6]

President Biden has signaled his intent to rescind these changes to the public charge rule. In a statement issued by the White House in February, the President directed agencies to conduct a review of the rule.[7]

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[5] Berstein, Gonzalez, Karpman, & Zuckerman. *Amid confusion over the public charge rule, immigrant families continued avoiding public benefits in 2019*. Available at: https://www.urban.org/research/publication/amid-confusion-over-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-2019

[6] Berstein, Gonzalez, Karpman, & Zuckerman. *Amid confusion over the public charge rule, immigrant families continued avoiding public benefits in 2019*.

[7] *President Biden outlines steps to reform our immigration system by keeping families together, addressing the root causes of irregular migration, and streamlining the legal immigration system*. The White House. February 2, 2021. Available at: https://www.whitehouse.gov/briefing-room/statements-releases/2021/02/02/fact-sheet-president-biden-outlines-steps-to-reform-our-immigration-system-by-keeping-families-together-addressing-the-root-causes-of-irregular-migration-and-streamlining-the-legal-immigration-syst/

Section 2.4: Elimination of individual mandate penalties

The individual mandate, one of the main provisions of the ACA, requires that all Americans have minimum essential health insurance coverage, which may include group or individual coverage, Medicaid, CHIP, Medicare, Tricare, veterans' health benefits, or other forms of coverage that meet standards set by the ACA. Prior to the passage of the Tax Cuts and Jobs Act in 2017, those without minimum essential health insurance coverage would be assessed a penalty called a "shared responsibility fee" during the annual tax filing process (subject to some exceptions).[8] The Tax Cuts and Jobs Act repealed the shared responsibility fee, leaving the individual mandate in place but effectively unenforceable.

The elimination of penalties used to encourage compliance with the individual mandate has contributed to an increase in the uninsured rate, although the magnitude of the increase is unclear. Using a variety of different models based on factors such as consumer behavior, knowledge of the penalties, and probability of paying the penalty, a study by the Commonwealth Fund estimated that anywhere from 2.8 to 13 million Americans may have lost coverage in 2020 as the result of the repeal of the shared responsibility fee.[9] Broken down by source of coverage nationally, the study estimates that the number of Americans with employer-sponsored insurance would decline by between 0.8 and 3 million, that the number with Medicaid would decline by between 1.4 and 6.3 million, and that the number with coverage purchased through an exchange would decline by between 0.2 and 7.5 million.

Section 2.5: Cutbacks in enrollment assistance and marketing

Enrollment assistance programs have been a key part of state and federal efforts to expand health insurance coverage. Many who would benefit from reforms intended to make health insurance more accessible are unfamiliar with or have difficulty completing the application process for Medicaid, CHIP, or find it challenging to navigate the federally-facilitated exchange. By marketing and providing education and hands-on assistance throughout the application process, these programs help consumers secure coverage when doing so by themselves might be too challenging or complex.

There are two main enrollment assistance programs. These programs are described below:

Navigators

The Navigator program was created by the Affordable Care Act to provide one-on-one enrollment assistance to persons applying for individual coverage (or Medicaid/CHIP if eligible) through the federally-facilitated or state-based exchanges. Navigators are specially trained and certified to assist with the process of applying for insurance coverage and are funded either through the federal government in states that use the FFE or by the state in states that operate

[8] Persons exempt from paying the shared responsibility fee include those with incomes below the tax filing threshold ($10,400 for a single individual or $20,800 for a married couple in 2017), those who would have to pay more than 8 percent (increasing each year) of their income to enroll in the cheapest available plan, and those with incomes below 138% of the Federal Poverty Level in states that did not expand Medicaid.

[9] Eibner & Nowak. *The effect of eliminating the individual mandate penalty and the role of behavioral factors*. July 11, 2018. The Commonwealth Fund. Available at: https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors#:~:text=The%20U.S.%20Supreme%20Court%20ruled,%2C%20effective%20January%201%2C%202019.

an SBE. Navigators are obligated to provide assistance in the best interests of the individual and are required to be free of conflicts of interest to be certified.

Certified Application Counselor (CAC) at Certified Designated Organizations (CDOs)

CDOs are organizations which can include nonprofits, community health centers, other health care providers that have entered into an agreement with CMS to provide enrollment assistance. In Louisiana, these organizations are referred to as Medicaid Application Centers (MACs). MACs are not funded directly by the FFE but can be funded by the state. Certified application counselors (CACs), who are trained to provide assistance applying for coverage through the FFE, assist individuals applying for coverage. Because MACs are required to conduct face-to-face interviews with applicants, MAC-facilitated application assistance activities were temporarily suspended during the COVID-19 pandemic due to safety concerns. Many MACs will resume providing application assistance when vaccines become more widely available.

Results from a survey of consumers conducted by the Kaiser Family Foundation highlight the importance of enrollment assistance. The survey found that four in ten consumers would not have gotten the same coverage without assistance and 60% who received no help would have sought assistance were it available. Furthermore, respondents gave enrollment assistance high marks -- 97% of those surveyed said that assistance applying for or renewing Medicaid/CHIP and insurance coverage was at least somewhat helpful.[10]

Nevertheless, funding for marketing and enrollment assistance has been reduced substantially over the past four years. The Trump administration cut total federal funding across all FFE states for Navigators from $63 million per year in 2016 to $10 million in 2018[11] and eliminated the requirement that each state that uses the FFE have at least two navigator programs serving the state.[12] In Louisiana, Navigator funding decreased 87% from 2016 to 2020. Only one Navigator program currently serves the state. Furthermore, there is no direct state appropriation for outreach, marketing, and consumer assistance in Louisiana to offset the reduction in federal funding.

These cutbacks have forced many Navigators and CDOs to scale back enrollment assistance. Many Navigator programs that have not been able to secure additional funding have taken to “front loading” funding during the six-week open enrollment period and cutting staff thereafter.[13] Limited resources and staffing shortages are compounded by the often large geographic areas that Navigator programs

[10] Pollitz, Tolbert, Hamel, & Kearney. *Consumer assistance in health insurance: Evidence of impact and unmet need*. Kaiser Family Foundation. August 7, 2020. Available at: https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/

[11] Pollitz & Tolbert. *Data note: Limited navigator funding for federal marketplace states*. Kaiser Family Foundation. October 13, 2020. Available at: https://www.kff.org/private-insurance/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/

[12] Pollitz & Tolbert. *Opportunities and resources to expand enrollment during the pandemic and beyond*. Kaiser Family Foundation. January 25, 2021. Available at: https://www.kff.org/health-reform/issue-brief/opportunities-and-resources-to-expand-enrollment-during-the-pandemic-and-beyond/

[13] Pollitz & Tolbert. *Opportunities and resources to expand enrollment during the pandemic and beyond*.

serve. For Louisiana's sole Navigator program, the state's sizable footprint makes providing in-person assistance for all eligible persons who need it difficult. This negatively affects consumers, especially the uninsured in African American and Latino communities, who rely more on in-person assistance than other groups.[14]

In Louisiana, where a child lives and how old they are may impact how likely they are to have health insurance. The parishes with the largest number of uninsured children are East Baton Rouge, Bossier and Jefferson. The parishes with the largest increase in the number of uninsured children from 2017 to 2019 are Bossier, Caddo and East Baton Rouge parishes according to data from the U.S. Census Bureau. The uninsured rate increased for both young children (birth to 5 years) and school age children (age 6 to 18 years), though it is highest for school age children, which account for 73% of uninsured children or 36,000, in 2019. Creating a feedback loop with community partners and assisters that serve especially vulnerable areas and age groups can help make outreach more effective.

Section 3 – Recommendations

Section 3.1: Provide state support for navigators and CACs

To compensate for cutbacks in federal grants, Louisiana policymakers could explore making funding available for navigators and CACs/MACs through CHIP administrative funds. Per 42 CFR 457.90, states are required to, as part of the CHIP State Plan, include a description of the state's procedures to inform families of children likely to be eligible for public coverage and to assist them in enrolling their children. Outreach strategies may include, but are not limited to, education and awareness campaigns and application assistance. While costs associated with outreach and public education cannot exceed 10% of the state's total CHIP expenditures, this spending cap does not apply to expenditures for outreach activities to families likely to be eligible for premium assistance subsidies. Appropriations for CHIP administrative funding dedicated to enhancing outreach and public education could potentially improve child coverage rates.

Section 3.2: Building and leveraging community partnerships

Research has shown that effective outreach engages community groups, in particular those in minority and other hard-to-reach communities, in education and enrollment assistance efforts. Latinos, among whom the child uninsured rate is highest, tend to be less trusting of state and local government. These groups may be more receptive to education and enrollment assistance efforts organized by established community groups and by peers, who have the advantage of being known and trusted by members of the communities of which they are a part, than efforts organized by state and local governments. In building these partnerships, outreach efforts should be directed at the Latino community, among whom the child uninsured rate is the highest. LDH could work internally through its Office of Community Partnerships and Health Equity to create clear communications regarding the implications of federal policy (including the public charge rule) for children's benefits through branded, consumer-oriented webpages, letters to community advocates, and trainings with community partners. With appropriate legislative funding, LDH could also carry out Spanish-language outreach campaigns, including online advertisements, social media ads and posts, and pamphlets located in community hubs. The state

[14] *In-person assistance maximizes enrollment success*. Enroll America. March 2014. Available at: http://champsonline.org/assets/files/ToolsProducts/OEResources/In-Person-Assistance-Success.pdf

agency should strengthen partnerships with community organizations that work with immigrant families including workers' groups for sectors with high Latino employment, school nurses, and libraries.

Section 3.3: Increasing state outreach and communications footprint

As noted above, all CHIP State Plans must describe how the state will inform families with eligible children of health insurance options. Louisiana advertises LaCHIP to families of low-income children through a back-to-school and lunch flyer. The flyer presents monthly income limits for LaCHIP eligibility, lists covered services, and provides an informational hotline number and a website link that families can access to apply for coverage. The state has also implemented a streamlined eligibility determination process for children, called express lane eligibility, which simplifies the Medicaid application and renewal processes by relying on the eligibility findings verified by Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). LDH can also make real time eligibility decisions using its new, automated eligibility and enrollment system and self-service portal.

With the state still seeing a declining child insured rate, LDH should consider ways other than Medicaid Application Centers to promote coverage through the FFE and Medicaid/CHIP more effectively. There is a substantial body of research that reflects best practices and promising strategies in covering children. In addition to outreach and consumer assistance, it's important to ensure that all eligible children stay enrolled. This section includes a summary of some of the more important lessons learned.[15]

Targeted and Ongoing Outreach

The most effective outreach should be targeted to uninsured children who are likely eligible. As discussed above, particular attention should be focused on the best ways to reach and engage families of uninsured children through nurturing community partnerships, supporting application assistance, and planning outreach campaigns. Targeting involves monitoring disaggregated data on insurance status, such as geography, age, or race/ethnicity, as well as enrollment trends to focus limited outreach and assistance resources on the children who are likely to be eligible. Targeting also involves the distribution of assistance and outreach materials in prevalent languages using culturally competent assistance and communications. Targeted outreach will be especially important to address Louisiana's high rate of uninsured Latino children.[16]

Families continually experience changes that impact their children's access to health coverage. System changes can also have a sudden impact on the enrollment of eligible children. Recent history has shown that successes in covering children can be quickly reversed without active monitoring to identify when corrective actions are needed. To this end, it is helpful to dedicate responsibility for such monitoring, as well as managing outreach and application resources. To effectuate this recommendation, additional staffing resources experienced in population health and analytics will be needed in the Department. Funding for an additional position would be required.

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[15] Brooks, Park & Roygardner, *Medicaid and CHIP Enrollment Decline Suggests the Child Uninsured Rate May Rise Again,* Georgetown University Center for Children and Families, May 2019. Available at https://ccf.georgetown.edu/2019/05/28/medicaid-and-chip-enrollment-decline/.

[16] There are a variety of Latino outreach resources that have been used in other states to address the chilling effect. One example is a toolkit developed by the Children's Defense in Texas, and is available at https://cdftexas.org/protecting-immigrant-communities/public-charge-and-private-dilemmas/.

Create a Team Dedicated to Outreach and Support of Community Partners

Policymakers might consider appropriations to create a dedicated outreach team that includes regionally-based coordinators to provide technical assistance and training to the field and to nurture a strong outreach and assistance program among community based organizations (CBOs), schools, health care providers, faith-based organizations, and other groups. Such a program can also serve as an effective feedback mechanism for the state to hear first-hand how policy, systems, or procedural changes are playing out in real time.

Use Other Mediums to Reach Members

The Department may consider using other mediums, in addition to social media, to advertise to current and prospective members. Currently, the Department uses social media via Facebook, Instagram, Twitter as well as its website to disseminate messages targeted to current and prospective members, stakeholders and the general public. These messages are targeted at informing and educating about various Medicaid programs, resources and tools. Social media posts often focus on specific healthcare programs and public health campaigns, Medicaid application and renewal information, Medicaid policy updates, and general health topics. Social media effectiveness is measured on a monthly basis and focuses on message reach, engagement rate and audience growth. In addition to Facebook, the state could distribute "point-of-sale" materials at locations or through organizations that serve children and families, such as health care provider offices, child care centers, faith-based organizations, family resource centers, and other community-based organizations. In the past, the Department has created flyers for provider offices as well as info cards for distribution to faith-based organizations and community partners. Simple distribution had little success, which is why this strategy is best paired with the recommendations under building community partnerships and potentially the creation of dedicated, regionally-based coordinators discussed above.

Ensure that Notices Are Easy to Understand

A long-standing issue in Medicaid and CHIP is that notices are confusing and don't always convey information in plain language. In response, the Department went through an in depth notice restructure in 2019 to improve the often confusing structure and phrasing in its notices and showed them to member focus groups for feedback. Additionally, the Department has been working with state health literacy experts and getting training on how to better craft messaging. It is important to continue to field test notices to ensure that beneficiaries understand the content of the notice and specifically what actions they need to take to maintain coverage. The department is working to build out member advisory councils and can leverage these groups to help provide ongoing feedback.

Medicaid Innovation Challenge Showcase

Starting in 2019, Adaptation Health, an incubator program that works with state Medicaid programs, was enlisted to support the Louisiana Medicaid program by identifying Medicaid-focused and market-ready innovative solutions for member engagement. This initiative provided information on opportunities to incorporate the best practices and proven strategies detailed above. There were two key elements to Adaptation's efforts as part of the Innovation Challenge – a series of statewide focus groups and drafting and releasing a Request for Information (RFI), followed by the coordination of a showcase of a handful of vendors.

Focus Groups

Adaptation conducted a series of community forums at key Medicaid service delivery sites (primarily provider offices). Their goal was an assessment of the role of member engagement, or lack thereof, in the disenrollment increase. Adaptation worked with 12 healthcare organizations around the state, gathering information from Medicaid members on their communications preferences and their understanding of Medicaid materials and enrollment and application processes. Findings from those forums are available in a separate research brief drafted by Adaptation.

Innovation Challenge Request for Information

Using the lesson's learned from the focus groups, Adaptation drafted a Request for Information (RFI) seeking vendors who could provide best-in-class solutions to improve our communication and engagement with Medicaid members. Of special interest were solutions that would work to address health disparities within underserved and marginalized/vulnerable populations in the state. More than 30 vendors responded to the RFI. Five were invited to present during a virtual showcase in September 2020.

While the primary purpose of the innovation challenge was information gathering, the showcase provided a forum to educate a wide-ranging audience – from Medicaid agency leadership from Louisiana and several other states, to managed care organizations, federal oversight agencies and provider organizations – on the innovations and opportunities available to improve member engagement and, in turn, healthcare outcomes. Louisiana Medicaid is still considering ways to implement this knowledge, including seeking out collaborative efforts that focus on bringing greater resources and value to our members. A barrier to implementation has been funding, especially given state revenue shortages due to the PHE; however, a possible route to leveraging these technologies is through innovations in our managed care programs. Another route could be through a CHIP Health Services Initiative (HSI). Both of these options would require additional appropriation.

Section 3.3: Consider implementing a new CHIP Buy-In program

Under the HEALTHY KIDS Act, Congress clarified federal policy related to CHIP buy-in programs. States may use a blended risk pool – combining CHIP and buy-in enrollees when considering rates. In terms of Louisiana Medicaid, this means that the two populations can be combined when actuaries are setting the per member, per month (PMPM) rates for the managed care organizations (MCOs), as long as the benefits in the buy-in are identical to the benefits in the state's CHIP plan. Louisiana currently operates one buy-in program in CHIP called the LaCHIP Affordable Plan (LAP). It offers coverage to children in families with income between 218% and 255% of the FPL and the family pays a $50 per month premium. LAP is a component of the state's CHIP program as it falls below the state's federally approved eligibility levels and, therefore, draws federal financial participation (FFP) at the enhanced CHIP match rate.

One option policymakers could consider would be to expand eligibility for LAP to 300% of the federal poverty level, perhaps with a higher premium tier. Doing so would require appropriation of state matching funds. State and federal costs are determined after subtracting the premiums paid by families. A second premium tier would also help families transition to purchasing a plan privately or through a full-cost CHIP buy-in program, another option described below that builds on LAP.

In addition to expanding CHIP-financed coverage in LAP, policymakers could create and fund a new full-cost CHIP buy-in program with the expectation that families pay the full cost of the premium, or

managed care PMPM, for their coverage. This would only apply to those children who are not eligible for Medicaid or CHIP, and it would be separate and apart from LAP, meaning that no federal financing is available to assist with the cost of the program; however, families would bear their own healthcare costs.

There would be some administrative costs for the premium administration for which additional appropriation would be necessary. LDH could continue to partner with the Office of Group Benefits for the collection of premiums. The current cost is $7.50 PMPM for premium collection and $2.50 PMPM for out-of-pocket cost calculations for federal compliance ($10 PMPM total or $120 per member annually). A subsidized CHIP buy-in would require both premium collection, as well as the monitoring of the cost-sharing cap of 5% of family income. But a full cost buy-in program is not subject to this cap. A different option for a full-cost buy-in program would be to have the MCOs collect the premiums, as some other states do in their CHIP buy-in programs.[17] This option for administration would incorporate the administrative costs into the premiums that the member pays in the CHIP buy-in program.

A state buy-in option would likely be a less costly alternative for families to purchasing coverage on the individual market through the health exchange or potentially to employer sponsored coverage. In fact, premiums are lower than private insurance by leveraging the lower PMPM rates negotiated for the large group of children the state covers. Another key benefit of the full-cost CHIP buy-in approach is that benefits would be more comprehensive and better meet the needs of children, particularly in the critical early childhood development years. Coverage would be through Louisiana Medicaid under the managed care program – Healthy Louisiana. The current children's Healthy Louisiana PMPM per the July 1, 2020, rate certification as a weighted average across all regions and age groups is $254.23. This varies slightly with each new rate certification (about twice a year), and premiums for families would go up or down accordingly. However, this does not account for the $11,357 that the state pays the managed care plans for each Medicaid birth/delivery, and this would have to be factored into any program costs.

Conclusion

In conclusion, there are multiple drivers and trends amongst growing child uninsured rates. This report seeks to draw attention to these areas while proposing strategies and best practices for addressing them. With all medical science showing that early childhood development and health are directly linked to coverage and access to care. Insurance provides the necessary linkage to coverage for children's development and improving health outcomes. As a state we are incentivized to ensure ongoing access to health insurance for children, not only to reduce downstream healthcare spending and overutilization of public resources, but more importantly, to improve the lives and health of our children as they grow into maturity.

[17] Examples include Pennsylvania and New York. See: *Children's Health Insurance Program (CHIP) Procedures Handbook*, Pennsylvania Department of Human Services (December 2018, page 105). Available at: https://www.chipcoverspakids.com/Eligibility/Documents/CHIP%20Procedures%20Handbook.pdf; and, "Make your Child Health Plus Premium Payment," BlueCross BlueShield of Western New York. Available at: https://www.mybcbswny.com/wny-members/make-your-child-health-plus-premium-payment.html.

Appendices

Please see attached additional materials and studies that helped to guide the findings and recommendations of this report.

A. Options for Extending CHIP Coverage
B. Citations List
C. Louisiana Children Health Uninsured Rates Census 2019 (Louisiana Budget Project)

Appendix A - Options for Extending CHIP Coverage

	Current Plan: LaCHIP Affordable Plan (LAP)	**Option 1:** Expand LAP	**Option 2:** Expand LAP and Create Full-Cost CHIP Buy-In Program
Description	Separate CHIP program with one premium tier.	Separate CHIP program with two premium tiers.	Separate CHIP program with two premium tiers and buy-in option. Buy-in combines risk pool with other tiers for setting rates for MCOs and monthly premiums.
Income Limits	217-255% FPL	*Tier 1:* 217-255% FPL *Tier 2:* 256-300% FPL	*Tier 1:* 217-255% FPL *Tier 2:* 256-300% FPL *Tier 3:* 301% up to 400% FPL
Premium	$50/family/month	*Tier 1*: $50/family/month *Tier 2:* TBD, less than full premium	*Tier 1*: $50/family/month *Tier 2:* TBD, Over $50 but less than full premium *Tier 3:* Full premium
Federal Match	CHIP Match	*Tier 1:* CHIP Match *Tier 2:* CHIP Match	*Tier 1:* CHIP Match *Tier 2:* CHIP Match *Tier 3:* No federal financing available
LDH Premium Collection Cost Considerations	$120/member/year for premium collection and federal compliance	*Tier 1:* $120/member/year for premium collection and federal compliance *Tier 2:* $120/member/year	*Tier 1:* $120/member/year for premium collection and federal compliance *Tier 2:* $120/member/year *Tier 3:* Premium collection costs could be incurred by the state or included in the full-cost buy-in premium if administered through MCOs.

Appendix B - Citation List

Alvarez Caraveo et al., "Barriers to Medicaid and CHIP Coverage for Eligible but Uninsured Latinx Children: A Texas Case Study," Urban Institute (February 2021). Available at: https://www.urban.org/sites/default/files/publication/103471/barriers-to-medicaid-and-chip-coverage-for-eligible-but-uninsured-latinx-children-a-texas-case-study_1.pdf.

Artiga, Rudowitz, and Tolbert, "Outreach and Enrollment Strategies for Reaching the Medicaid Eligible but Uninsured Population," Kaiser Family Foundation (March 2016). Available at: https://www.kff.org/medicaid/issue-brief/outreach-and-enrollment-strategies-for-reaching-the-medicaid-eligible-but-uninsured-population/.

Capitman, "The Effectiveness of a Promotora Health Education Model for Improving Latino Health Care Access in California's Central Valley," Central Valley Health Policy Institute. Available at: http://www.fresnostate.edu/chhs/cvhpi/documents/cms-final-report.pdf.

Cousineau, Stevens, and Farias, "Use of Outreach and Enrollment Strategies in California," State Health Access Data Assistance Center (January 2009). Available at: https://www.shadac.org/sites/default/files/publications/IssueBrief_Cousineau_2009Jan_0.pdf

Florea, "A Snapshot of State Efforts to Reach and Enroll Children for State Medicaid and CHIP Programs," National Academy for State Health Policy (July 2019). Available at: https://www.nashp.org/a-snapshot-of-state-efforts-to-reach-and-enroll-children-for-state-medicaid-and-chip-programs/

Foster and Martin, "How Can My Organization Connect Children to Coverage? A Guide to Fundamentals and Promising Practices," InsureKidsNow.gov (Spring 2018). Available at: https://www.insurekidsnow.gov/downloads/library/misc/outreach-and-enrollment-fundamentals.pdf

Hatch, et al., "Barber Shops, Salons, and Spas: The Complexity- and Simplicity- of Implementing Outreach and Enrollment Contracts Under the Affordable Care Act," *Journal of Public Management and Social Policy* 26(2) (May 2020). Available at: https://digitalscholarship.tsu.edu/jpmsp/vol26/iss2/3/

"'¡Si Se Puede!': Tips for Increasing Medicaid and CHIP Enrollment in Hispanic Communities," InsureKidsNow.gov (October 6, 2016). Available at: https://www.insurekidsnow.gov/newsletter/2016/10/06/index.html

Wachino and Weiss, "Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children" National Academy for State Health Policy (February 2009). Available at: https://www.nashp.org/wp-content/uploads/2009/08/Max_Enroll_Report_FINAL.pdf

Appendix C

Louisiana Children Health Uninsured Rates Census 2019
By: Louisiana Budget Project

https://www.labudget.org/wp-content/uploads/2020/10/Census-2019_-Child-Health-Insurance.pdf

[attached]