

Louisiana Healthcare Issues

Louisiana is the least healthy and one of the poorest states in the nation. Three of the biggest health issues facing Louisiana citizens are: the high incidence of HIV/AIDS, the high cost of elder care, especially for those on Medicaid and the high cost of health insurance

HIV/AIDS

Louisiana has a serious HIV/AIDS problem. In 2003, the state was in 6th place nationally in AIDS case rates [per 100,000 population], and 11th in the number of AIDS cases reported, according to the Center for Disease Control and Prevention. People with HIV/AIDS reside in every parish in the state, but the Baton Rouge and New Orleans areas have very high concentrations of cases. Metro Baton Rouge ranked 7th and New Orleans was 9th in the nation in AIDS case rates in 2003.

As of March, 2004, a cumulative total of 24,222 HIV/AIDS cases had been detected in Louisiana. The HIV/AIDS epidemic will impact public health in the state for decades: lifetime cost for one AIDS patient is over \$100,000, primarily paid by the government. New cases will obligate Louisiana to about \$120 million in future medical costs each year.

Once contracted, HIV, which is spread mainly through sexual activity and injection drug use, can cause AIDS, which, in turn, can lead to death. Because there is no cure, the most effective way to curb the epidemic is to prevent HIV infections.

The problem is especially severe in the African American population, where high-risk heterosexual activity is the leading exposure category. About 3 out of 4 newly-detected HIV and AIDS cases are in this group.

Some critics of HIV/AIDS public policy claim that the mainstream media and national agencies such as the CDC saw AIDS as disease primarily of white gay men, leading many African Americans to believe that it was not a significant problem for their communities. As new AIDS cases started to decline among the white population, public attention by the media, government agencies, funders, and concerned citizens diminished, while AIDS rates among African Americans grew.

At the same time, Black media and institutions – notably, churches, which are traditionally the bedrock of community-based activism in African American neighborhoods – have been reluctant to become involved in AIDS awareness. This may be due, in part, because of the stigma of homosexuality associated with the disease.

The federal government provides Louisiana about \$7 million each year for HIV counseling, testing programs and public information campaigns. A separate program

funds HIV/AIDS prevention education in schools. Most of the lessons emphasize abstinence as the best way to avoid HIV and other sexually transmitted diseases. An additional \$2.6 million in federal funding goes to abstinence-only-until-marriage programs. Most of these funds are administered by the Governor's Program on Abstinence.

Louisiana's Sexuality Education Law allows sexuality education to be offered after the fifth grade, but does not require schools to offer such courses. Opposition to comprehensive sexuality education by conservative religious groups is strong in many parts of Louisiana. These groups worry that discussion or promotion of techniques other than abstinence may encourage sexual activity and/or lead to negative health outcomes.

Proponents of comprehensive sexuality education claim multiple risk-reduction activities should be discussed, including abstinence and condoms. They cite CDC statements that "correct and consistent use of the male latex condom can reduce the risk" of spreading sexually transmitted diseases [STD], such as gonorrhea or syphilis. These diseases can make a person more susceptible to the human immunodeficiency virus, which causes AIDS. According to data from the state Office of Public Health, Louisiana is first in the nation in gonorrhea case rates, second in chlamydia and third in syphilis.

In an effort to reduce the rates of STD and HIV/AIDS, the state has been distributing condoms since 1993, making them available in places such as bars, barber shops, liquor stores, motels and restaurants. Opponents of the program succeeded in getting the Louisiana House of Representatives to approve an amendment to the state's budget that prohibited the Office of Public Health from using federal funds to purchase and distribute condoms. [The Senate later removed the amendment from the final budget bill.]

Supporters of the program cited a study in the peer-reviewed American Public Health Association journal which showed that in the first four years of the Louisiana condom distribution program, the rate of new syphilis cases dropped by 79 percent, and the rate of new gonorrhea cases fell by 35 percent in neighborhoods where condoms were given out.

Long Term Care

Long term care for the elderly and disabled is big business in Louisiana. In 2003, over a quarter the \$1.2 billion in Medicaid spending in the state went for such services. The pattern of distribution of these funds has long been a source of contention among policy makers, health experts, providers and clients.

At the heart of the debate over how Long Term Care [LTC] dollars should be spent, is the matter of choice.

Louisiana's unusually strong emphasis on institutions as the preferred setting for LTC has been around in for a long time. But it wasn't until 1999 that things slowly began to change. That's when the US Supreme Court, in the Olmstead decision, ruled states had to provide services in "the least-restrictive environment". A year later, the state was sued by Louisiana nursing-home residents and potential residents who said they could live in their homes with help. They claimed the state, by not providing community-based services, was unconstitutionally forcing them into nursing homes. The lawsuit came at a time when the U.S. Department of Health and Human Services was demanding that Louisiana develop a plan that provided "freedom of choice" and a broader range of living options. The state settled, agreeing to pay \$120 million over a four year period.

Even so, in Louisiana today, 81% of LTC funds still go to institutional care and only 19% are spent on home and community-based services [HCBS]. In other words, four out of five dollars go to nursing homes, and one in five go to home/community care. Nationally, states spend only two out of three dollars for nursing homes, while fully one in three dollars goes to home care.

Louisiana's LTC picture differs from the national one in other ways. The state has higher than average nursing home bed capacity per elder population. Since 1994, Medicaid nursing home occupancy rates dropped from 87 % to 77%. Louisiana has higher use of large state institutions than other states. The national trend is to close large state institutions.

Long Term Care Problems:

- Strong bias within the existing system toward institutional care
- No integration of acute and LTC funding
- Lack of funding for additional Home & Community Based Services for elderly & disabled
- Lack of family network for many elderly. Half of elderly with long term needs who don't have family network, wind up in nursing home. Only 7% of those with family network wind up in nursing homes.
- Competing priorities vie for limited dollars needed for LTC choices
- Resistance to change from nursing home interests who fear financial losses
- Resistance to change from advocacy groups who fear their constituencies may be adversely affected if status quo is altered

Most health care reform advocates agree that Long Term Care money needs to follow the patient, not the provider. They believe this would provide financial incentives for nursing homes to diversify and develop new options.

But opponents in the industry fear that, with limited health care funding, such a proposal would squeeze nursing home operators. With no "new" dollars, they say, money would be shifted from the neediest elderly [those in full-service nursing homes] to the least needy [those who still can care for themselves with limited assistance].

Community care proponents want to eliminate waiting lists and improved choices in the types of care settings available. They want easier access to services and a decrease in fragmentation of service providers. They also want more consumer control and direction and a decrease in the size of institutions.

Nursing Home operators want to ensure continued funding and consolidation of regulatory activity. They want to have flexibility in carrying out a plan of voluntary diversification and conversion of their facilities. They worry that downsizing may lead to a reduction or elimination of choices for institutional services, and to facility closures

Whatever changes do occur in the existing system, they need to account for:

- assistance for family caregivers
- disability rights movement
- move toward diversification of services
- Olmstead decision: "the least-restrictive environment".

Currently, Louisiana has a waiting list of 11,000 for Home & Community Based Services. Experts project a 60% increase in the 65+ population in Louisiana by 2020.

Health Insurance

40% of Louisiana residents rely on the state for medical care in some fashion.

Louisiana is 3rd in nation in the rate of citizens without health insurance. About 19% – over 830,000 individuals – lack medical coverage.

Louisiana is also one of the poorest states. Many who have jobs live near the poverty line; many workers cannot afford insurance.

LaChoice is a Louisiana initiative intended to reduce the number of uninsured working residents. It will use federal money to purchase reinsurance for medical losses between \$30,000 and \$90,000 for small employers.

Government-based reinsurance like LaChoice, provides insurers with relief from certain types of risk. Financial pressure is taken off the insurers. Programs like these can significantly lower premiums.

Governor Blanco has proposed linking state aid [in the form of tax breaks] to a company's willingness to offer health insurance to employees. Some opponents fear such a plan might make the state less competitive in attracting new businesses. A wide range of other ideas are being considered by other states:

- Employers with more than 100 full-time employees in the state reimburse the state for the cost of their receiving services through Medicaid. [Arizona]
- Employers would be required to either provide health care benefits or pay into a state-run program to provide healthcare. [Connecticut]

- State would create a health care pool. Employers not providing health insurance for their employees would have to pay a surcharge amount that would be placed in the uncompensated care pool. [Massachusetts]
- State would create a single public agency ["single payer"] responsible for the collection and disbursement of funds to provide health care services for every resident of the state. [Massachusetts]

A number of approaches to cost control involve reducing benefits and or increasing out-of-pocket expenses. Proponents of flexible benefits want less mandated coverage of certain illnesses or procedures. Opponents worry that too many options may confuse consumers. Higher deductibles and selective coverage could wind up costing patients more than current insurance.

Other proposals include tax breaks for health care costs, which opponents say would result in the loss of revenue for government. Another tax-related plan allows individuals to set up Health Saving Accounts. Money in these accounts can only be used for health care, but are sheltered from federal taxes. Proponents say there can be tax advantages for users, but some economists are skeptical. They say only the wealthier users would see much tax relief.

Some health insurers favor limiting state and federal mandates on coverage. Proponents claim that without these mandates to cover certain potentially costly procedures, the cost of insurance could be lowered. Opponents say the health insurance market would become too confusing for the consumer.

Other proposals also depend on creating or extending limits on the type or quantity of health care options for the consumer. These include restrictions on the maximum amount of benefits, which could be costly for some. Limits on the types of claims allowable, or on payments for doctor visits, surgery or prescriptions would reduce cost, but, according to opponents, could lead to bad health care choices.