LOUISIANA DEPARTMENT OF INSURANCE
TIMOTHY J. TEMPLE
COMMISSIONER

April 3, 2025

The Honorable Kirk Talbot, Chairman
Senate Committee on Insurance
Baton Rouge, La. 70802
talbotk@legis.la.gov
Sent via email

The Honorable Michael "Gabe" Firment
House Committee on Insurance
Baton Rouge, La. 70802
firmentg@legis.la.gov
Sent via email

Louisiana State House of Representatives
C/O The Honorable Chad Brown
Baton Rouge, La. 70802
brownc@legis.la.gov
Sent via email

RE: Report of Study Findings as Requested by House Concurrent Resolution 96 of the 2024 Regular Legislative Session

Dear Vice Chairman Brown and Chairmen Talbot and Firment,

The Louisiana Legislature requested through House Concurrent Resolution 96 of the 2024 Regular Legislative Session (Resolution) that the Louisiana Department of Insurance (LDI) create the Louisiana Alternative Funding Program Task Force (LAFPTF) to study the impact of alternative funding programs on patient access to affordable prescription drugs. Specifically, the LAFPTF is charged with studying the following:

- The history and prevalence of alternative funding programs in the United States and Louisiana, including but not limited to the types of health insurance products that utilize, all or in part, alternative funding programs to provide access, coverage, or discounts for prescription drugs;
- The business model of alternative funding programs;
- The impact of alternative funding programs on patient assistance programs for prescription medications, including but not limited to long-term stability of those patient assistance programs if an upswing in alternative funding programs is realized across an increased number of health insurance products; and
- The impact of alternative funding programs on coverage of prescription medications if the utilization of alternative funding programs is expanded across additional insurance products, including but not limited to commercial health coverage plans, health coverage plans offered to public employees, and health coverage plans offered to individuals in the state's health insurance exchange.

The Resolution instructs the LAFPTF to report its study findings along with recommendations for legislation no later than December 31, 2024.

The LAFPTF initially convened on August 20, 2024. After setting a work plan, the task force held a series of public meetings with various experts in health insurance and alternative funding programs to receive information regarding alternative funding programs. The materials from those meetings are attached hereto as an appendix. After all willing experts presented for the task force, it met an additional time to review the reporting requirement and set a drafting plan. The LAFPTF would like to note that no alternative funding program companies were represented on the task force, nor did any such company testify among the experts before the task force. The LAFPTF reached out to numerous alternative funding program companies but was unable to identify a willing participant. The task force now submits this report as the completion of its work.

I. Background

Alternative funding programs exist within the larger landscape of pharmacy benefits. To effectively describe these programs and their effects, it is necessary to provide a general background on pharmacy coverage within health coverage plans. As a preliminary matter, it is important to understand that there are many types of health coverage plans – employee welfare benefit plans, fully-insured plans, self-funded governmental plans, federal employee plans – and that each type of coverage has significant differences in both its ability to use alternative funding programs and how it is regulated by state and federal agencies. When referring to these plans collectively, this report will use the term "health insurance plan."

Health insurance plans uniformly include coverage of pharmacy benefits. That coverage typically has a formulary – a list of drugs that are covered – and that formulary comprises one or more tiers, which govern the insured's level of cost sharing. Most insureds will be familiar with a common formulary distinction – brand versus generic drugs – but loss of coverage under a health insurance plan and the subsequent shift to an alternative funding programs often turns on a much less common definition: specialty drugs.

There is not a universal definition of "specialty drug," but they are typically classified as high cost and high complexity drugs that often treat rare or chronic diseases. These prescribed medications may be taken orally, but are often administered via injection or infusion. They may also have specific requirements for administration and storage, which often prevent them from being dispensed at a retail pharmacy. Medicare Part D defines its specialty tier based on a price threshold currently set at $950 per 30 day supply, with any drug exceeding that threshold being classified as a specialty drug and subject to greater cost sharing. Specialty drugs date back several decades but have grown significantly in both number and in cost in recent years, growing from about 10 specialty drugs on the market in 1990 to over 400 today.[1] A recent analysis by CarelonRx, a subsidiary of Elevance Health and pharmacy benefit manager for many of the Blue Cross Blue Shield Association member companies, found that specialty drugs accounted for over 60% of its total drug spending, despite only 3% of plan members taking these medications.[2]

Health insurance plan administrators have reacted to this specialty drug proliferation with a number of cost containment strategies. One such set of measures, developed by third parties, who are not insurers, are known as "alternative funding programs" (AFPs). AFPs are programs

[1] Specialty Growth is Here to Stay. CarelonRx. https://www.carelonrx.com/perspectives/specialty-drug-growth.
[2] Id.

that require enrollees to apply for third-party sources of assistance as a condition of drug coverage, eligibility for an exception process request, or eligibility for a coverage determination appeal. Drug manufacturers and charitable organizations often offer financial assistance or free access to prescription drugs to uninsured and underinsured individuals through patient assistance programs (PAPs). AFPs determine whether a consumer's prescription medication is funded, or otherwise available at a lower cost, through a source other than the health plan.[3] Consequently, AFPs seek to enroll insured patients in PAPs or through non-profit foundations to defray the cost of specialty drugs by designing health insurance to exclude coverage in a way that qualifies otherwise-insured patients for the related funding source. In a typical AFP arrangement, the health plan sponsor chooses to exclude coverage for certain specialty drugs in their health benefits plan, insureds are directed or required to enroll in a program administered by an unaffiliated (and unregulated) third-party AFP company, the AFP company secures outside funding for the prescribed, noncovered drugs through a PAP or other funding source, and the patient receives their medication once that outside funding is secured by the AFP. When a plan sponsor decides to incorporate an AFP into its coverage, it does so only for a specified drug or set of drugs. The remaining specialty drugs remain covered through the "traditional" health benefit model. Currently, self-funded employee plans – a category which includes self-funded governmental plans – are the predominant users of AFPs.

In other instances, the AFP may broker personal drug importation on behalf of the patient with unlicensed foreign pharmacies. This subjects the patient to take medication that is not FDA-approved or subject to the FDA's track-and-trace program that ensures medication efficacy and potency.[4]

If the AFP is unable to find a funding source, the AFP may work with the health plan sponsor to cover the drugs for those enrollees not eligible for the PAP. However, in recurring cases, there has been a stand-off between the AFP and PAP in which the PAP refuses to provide free drug because they believe the patient is insured and the AFP repeats that they are uninsured and won't cover the drug. Unfortunately, this often results in the patient being unable to access their medications. The purpose of this arrangement is to allow the health coverage plan sponsor to avoid the cost of the specialty drug while still allowing insureds to obtain funding for the drug through PAPs and other sources.

It is critical to understand the purpose of PAPs in the overall prescription drug funding structure. Typically PAPs are sponsored by drug manufacturers – although a small number are managed by private charities or foundations – to provide financial support in purchasing prescription drugs for uninsured and underinsured patients who need help paying for and accessing medicine. These programs are designed to support and assist patients who are truly unable to access and afford their medication because they are either uninsured or have insurance coverage that exposes them to high out-of-pocket costs they cannot afford, i.e., the underinsured. This important source of assistance can help to improve patient adherence and lead to improved patient outcomes.

---

[3] Angela Maas, *Industry Experts Question Alternative Funding Companies That Carve Out Some Specialty Drugs, 'Abuse Charities,* https://www.mmitnetwork.com/aishealth/spotlight-on-market-access/industry-experts-question-alternative-funding-companies-that-carve-out-some-specialty-drugs-abuse-charities/.

[4] [4] The Partnership for Safe Medicines. *Alternative Funding Programs: Offshoring patients, importing risks*. April 2024, https://www.safemedicines.org/2024/04/afps-offshoring-patients-importing-risks.html

Significant shifts in the use of PAPs by individuals who would not otherwise be uninsured or underinsured may threaten the funding, viability, and availability of PAPs over time.

One important distinction should be made at this point between AFPs and another cost mitigating strategy used by health insurance plan administrators, specifically, "Copay Accumulator" and "Copay Maximizer" programs, which do not exclude drugs from coverage, rather they adjust benefits to increase member cost share amounts and subsequently use manufacturer copay assistance to cover the member's portion, resulting in a lower net cost to the payor and zero cost to the member. This entire process takes place at the point of sale. These programs should not be considered under the definition of an AFP.

I. History and Prevalence of Alternative Funding Programs

Available literature does not provide an exact start date for AFPs, but one of the largest AFP companies, PayerMatrix, was established in Pennsylvania in 2016. Another prominent AFP company, RxFree4Me, was established in Michigan in 2018 under the name PayorRx before adopting its current name in 2020. Two other major AFP companies, PaydHealth and SHARx, were established in 2019 in Texas and Missouri, respectively.

Similarly, data on uptake of AFP programs is limited and mixed. Virtually no uptake data is available prior to 2021, coinciding with the period of growing interest in and concern about AFPs. Since that time, Gallagher Research & Insights (Gallagher) and Pharmaceutical Strategies Group (PSG), both of which are research organizations owned by two national insurance brokerage firms, have studied AFP uptake as part of their annual market trend analysis. Gallagher surveyed the very large employer (≥5000 employees) market and found that 10% of plans used AFPs in 2021 and 4% of plans used AFPs in 2022.[5] PSG has studied AFP uptake more extensively as part of its past three annual analyses, finding 6% of employers using AFPs in 2021, 14% in 2022, and 8% in 2023.[6] Both Gallagher and PSG also found that between 20% and 30% of employers are either using or considering use of AFPs.[7] The Gallagher analysis found that over 85% of those not considering use of AFPs had either not evaluated AFPs or were not familiar with them, while slightly less than 15% had actively opted not to implement them.[8] PSG also found strong skepticism of AFPs among both employers and health insurance plans, with 71% of employers and 74% of health plans believing AFPs to be "not at all sustainable" or only "slightly sustainable" when asked. Only 3% of employers and no health plans believed AFPs to be "very sustainable."[9]

---

[5] Gallagher Research & Insights, Employer Market Trends, 2022 & 2023 Reports. https://www.benfieldresearch.com/pdf/Gallagher%20Research%20&%20Insights_2023%20Employer%20Market%20Trends%20Report_Alt%20Funding%20Vendor%20Data.pdf

[6] Pharmaceutical Strategies Group, 2022 Trends in Specialty Drug Benefits Report, 2022 Trends in Specialty Drug Benefits Report, and 2024 Trends in Specialty Drug Benefits Report. https://www.psgconsults.com/industry-report/2022-trends-in-specialty-drug-benefits-report/; https://www.psgconsults.com/industry-report/2023-trends-in-specialty-drug-benefits-report/; https://www.psgconsults.com/industry-report/2024-trends-in-specialty-drug-benefits-report/

[7] Gallagher and PSG, supra.

[8] Gallagher, supra.

[9] PSG, 2024 Trends in Specialty Drug Benefits Report.

II. Business Model of Alternative Funding Programs

Fundamentally, AFPs involve coordination between two entities, a health plan sponsor and an AFP company, to design coverage around qualifying insureds for funding from a third-party entity in lieu of coverage by the plan. This design requires administrative effort to link patients with appropriate sources, including PAPs, to help them qualify, to requalify after the funding period ends, and to arrange for plan coverage if the insured is denied PAP funding or if eligibility terminates. In designs reviewed by the LAFPTF, health insurance plans using AFPs require insureds to enroll with the AFP company as a condition of coverage. This enrollment provides AFP companies with the enrollee's information necessary to perform all of the administrative work associated with the AFP, including HIPAA-protected information. The AFP company charges an administrative fee for this service or may charge the plan sponsor a percentage of the plan savings, which funds the operations of the AFP company. From the perspective of the health plan sponsor, the AFP company's administrative fee is more than offset by the removal of high-cost specialty drugs from the claims risk of the coverage, resulting in significant savings to the plan net of the new administrative fee.

This model has received a number of significant criticisms from patient advocates, providers, pharmaceutical manufacturers, non-profit foundations, and insurance companies in recent years. Primary among these is that the process of being denied under the health insurance plan, seeking and receiving funding through a PAP or other source, and obtaining the drug creates significant delays in access compared to traditional coverage of a drug under a health insurance plan. Complicating this issue is that many specialty drugs are needed to treat illnesses for which timeliness of intervention is critical to positive outcomes. In order for patient access to be unimpacted by AFPs, coverage delays must be reduced to align with traditional coverage, and there is no clear path to achieving that reduction.

Additionally, critics have raised concerns about the effects of AFP programs on PAPs. While, the arrangement is financially advantageous to both AFP companies – in the form of their administrative fee – and health plan sponsors – in the form of savings by narrower coverage – these benefits are realized almost entirely by shifting costs onto PAPs. At the current take-up rates, AFP programs may not be operating at sufficient volume to materially affect PAP terms or availability, but that could easily shift as these AFPs become more common.

Finally, advocates have highlighted issues with coverage in cases in which an AFP is in place but the patient either fails to qualify for the PAP or qualifies but exhausts eligibility and continues to need the specialty drug. In both cases, the general AFP design is to work with the health insurer to arrange traditional coverage. This strategy raises significant potential for noncompliance with state and federal nondiscrimination laws as PAP-eligible insureds strongly tend to be lower[10] income than PAP-ineligible insureds and as coverage eligibility is potentially unrelated to risk. This backstop also represents further delay in care relative to traditional coverage. Finally, the health insurance plan's coverage of the drugs for PAP-ineligible insureds is also likely

[10] La. R.S. 22:34 prohibits discrimination between individuals of similar risk based on factors unrelated to permissible insurance factors. Providing different levels of coverage to individuals based on the availability, for example, of income-related financial assistance, as in a PAP/AFP relationship, may place a health plan in violation of that section.

excluded from a typical plan's stop loss coverage. In addition to this general strategy, experts also testified that the AFP may attempt to arrange to import the medication from outside of the United States, which presents potential conflicts with FDA regulations, or to obtain grants or funds from non-profit organizations, taking those resources from truly uninsured or underinsured individuals.

III. Impact of Alternative Funding Programs on Patient Assistance Programs

As discussed, above, there is significant concern about the effect of AFPs on PAPs, and other available funding sources. Drug manufacturers and non-profit foundations have already begun responding to this issue, with a recent Milliman review finding that four of the seven major manufacturers of specialty drug explicitly prohibiting AFPs from participating in the PAP.[11] The ability of manufacturers to actually detect AFPs and exclude them from the PAP is unclear.

Proliferation of AFPs is likely to lead to reduced availability of PAPs and non-profit foundation funding, either in reduced funding availability or in narrower eligibility criteria, or both. PAPs are currently designed based on unmet need and known community means. AFPs alter both factors by creating new unmet demand and altering the profile of the community's uninsured population for purposes of specialty drug coverage. Employers and health insurers both appear well-attuned to this risk as the low "sustainability" estimates in the PSG study reflect.

IV. Impact of Alternative Funding Programs on Coverage of Prescriptions

Currently, the use of AFPs is generally restricted to self-funded employee plans, which often include state employee health plans. State-regulated commercial health insurance plans are subject to both state and federal laws and regulations that provide more stringent requirements for prescription drug coverage. Specifically, the Affordable Care Act (ACA) requires individual and small group non-grandfathered health plans to provide coverage meeting a set of minimum criteria across ten categories of essential health benefits. For the prescription drug category, the ACA's implementing regulation requires plans to "cover[] at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or the same number of prescription drugs in each category and class as the EHB[essential health benefits]-benchmark plan."[12] Additionally, such plans are required to maintain and revise their formulary drug lists through the use of pharmacy and therapeutics (P&T) committees designed to provide disinterested, clinical input on the pharmacy benefit. Moreover, formulary drug lists are required to be filed with the Exchange or state and are subject to compliance review.

Self-funded employee plans, large group insurance products, and grandfathered plans, on the other hand, are not subject to the essential health benefit coverage requirement, instead facing restrictions on limitations those plans may place when they *do* cover an essential health benefit. This distinction provides far greater ability for the health insurance plan sponsor to interpret prescription drug coverage narrowly, including determining that specialty drugs are non-essential health benefits and not subject to the limitations imposed in law.

---

[11] Milliman. Pharmacy Benefit Alternative Funding Programs: Key Considerations for Self-Funded Plan Sponsors.
[12] 45 C.F.R. § 156.122

The 2025 Notice of Benefit and Payment Parameters Final Rule[13] in 2024 prohibits the use of non-essential health benefits (EHB) designation in individual and small group plans and stated that the 2025 rule was codifying existing policy. It is therefore questionable whether the use of the non-EHB designation has been permissible. The Department of Health and Human Services (HHS) signaled a future Tri-Agency (The Departments of Labor, HHS, and the Treasury) FAQ to address the applicability of prescription drugs as an EHB in self-insured group health plans and large group market plans.[14]

While this division acts as a backstop against much potential proliferation by AFPs, it is far from absolute. Self-funded governmental plans, which cover about half as many lives in Louisiana as the entire state-regulated commercial market, could adopt AFPs without limitation. Grandfathered coverage and large group coverage may also adopt AFPs, although expert testimony received by the LAFPTF indicated that the federal agencies charged with overseeing self-funded employee plans and implementation of the Affordable Care Act – the Employee Benefits Security Administration (EBSA) and the Center for Consumer Information and Insurance Oversight (CCIIO), respectively – intend to act to restrict this ability through future regulation.

The consequence of these varying requirements is that, were AFPs to become popular and continue to enjoy few restrictions, self-funded employee plans would likely continue to be the primary coverage adopting such programs, self-funded governmental plans would likely have a somewhat slower take-up rate, followed by large group and grandfathered coverage. This behavior may also result in small group and individual coverage being placed at a cost disadvantage relative to the other forms of coverage. This is especially problematic for small group coverage, as this market is unsubsidized and competes relatively directly with the self-funded market to attract employers. In the extreme scenario, the availability of AFPs in the self-funded market and not in the small group market could cause migration of employers with healthier employees into the self-funded market with its lower rates and those with sicker employees into the small group market with its more generous coverage. Because the small group market is community rated and relatively consolidated, this adverse selection effect would act to raise rates across the entire small group market.

V. Potential Legislation

Understanding potential legislation first requires a discussion of how state laws affect the various types of health insurance plans in the market. For these purposes, there are four types of health coverage that are critical – fully-insured coverage, self-funded employee plans, self-funded governmental plans, and federal health benefit plans.[15] Fully-insured coverage is subject to state laws, typically found in the Louisiana Insurance Code, Title 22 of the Louisiana Revised Statutes (Insurance Code). Self-funded governmental plans are subject to state laws but are generally excluded from the Insurance Code. They may be carved into a section of the Insurance Code, but

---

[13] CMS. HHS Notice of Benefit and Payment Parameters for 2025 Final Rule. https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-final-rule

[14] HHS Notice of Benefit and Payment Parameters for 2025 Final Rule. https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-final-rule

[15] Medicare and Medicaid are not considered here, as neither are subject to general insurance laws and each has significant requirements that make AFPs untenable within their programs.

this must be done expressly. Self-funded governmental plans include the plan administered by the Office of Group Benefits, but they also include other statewide health benefit plans administered for public employees, including LSU First, as well as self-funded plans sponsored by nonstate governmental entities, such as parishes, municipalities, police or fire districts. Laws located in the Insurance Code and only carving in the Office of Group Benefits will not apply to these remaining self-funded governmental plans. Federal health benefit plans (the Federal Employees Health Benefit Plan[16] and TRICARE[17]) preempt any state laws that are inconsistent with the terms of their health coverage contracts.

In Louisiana, approximately 650,000 lives fall within the regulated commercial market and would be directly affected by state law changes regarding AFPs. Additionally, approximately 323,000 lives are covered by governmental plans and could be carved in to Insurance Code changes addressing AFP activities within the state.

Self-funded employee plans are subject to a much more complex preemption requirement under the Employee Retirement Income Security Act (ERISA),[18] including Taft-Hartly multiemployer plans utilized by labor unions.[19] The application of ERISA's preemption clause to state insurance laws has complex history that remains developing and unsettled fifty years after the law was enacted. The generally accepted interpretation of the current state of the law after the Supreme Court's most recent ERISA ruling, *Rutledge v. PCMA* (2020), is that a state law of general applicability is not preempted and is applicable to a self-funded employee plan so long as the law does not directly affect central matters of plan administration or "forc[e] plans to adopt a particular scheme of substantive coverage."[20] Louisiana would benefit from further analysis on how *Rutledge v. PCMA* (2020) would allow states to regulate the use of AFPs and whether it would impose a change in substantive coverage to ERISA plans.

These sets of laws, especially the ERISA preemption requirements, lead the LAFPTF to suggest two separate species of potential legislation, if the Louisiana Legislature wishes to limit or prohibit the use of AFPs within Louisiana. First, a direct prohibition on the use of AFPs by health insurance plans in the state; and, second, an indirect prohibition on AFPs by prohibiting AFP companies from operating within the state. Each of these options has benefits and drawbacks, both in effectiveness and in applicability/preemption.

A. Direct Prohibition on Alternative Funding Programs

A statute imposing a direct prohibition on alternative funding programs must set out a definition of such programs, including the exclusion of certain drug coverage, the linkage to an AFP company, and the intent to pair this exclusion with an alternative funding source. This definition should distinguish AFPs from copay accumulator and maximizer programs, which

---

[16] 5 U.S.C. § 8902(m)(1)
[17] 10 U.S.C. § 1103
[18] 29 U.S.C. § 1144
[19] National Association of Insurance Commissioners. Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation. 2022
[20] *Rutledge v. Pharmaceutical Management Association* (2020), pg. 2, citing *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*

achieve cost savings without the same level of patient disruption and delay experienced with AFPs, and should be written to differentiate drug coverage exclusion for the purpose of an AFP from exclusion for permissible reasons of formulary design and plan management.

The benefit of this approach is that the language of the act can be tailored to directly and specifically prohibit AFPs without allowing health insurance plans to creatively redesign coverage to avoid the law. The core downside, however, is that such an approach is virtually certain to be preempted under ERISA.[21] Although the law would be one of general applicability, prohibiting the use of a particular program or mandating coverage of a category of prescription drugs are both very clearly in line with other state laws that have been held to require particular schemes of substantive coverage under the Supreme Court's ERISA jurisprudence. In the absence of a reversal of well-established precedent by the Court, this avenue of state law would not apply to self-funded employee plans, which are primarily the plans currently using AFPs nationally. It would also not apply to Taft-Hartley trusts that identify bona fide collectively-bargained plans, which also fall under ERISA.[22] The law would serve to prohibit self-funded governmental plans, large group coverage, and grandfathered plans from adopting AFPs in Louisiana.

B. Indirect Prohibition on Alternative Funding Programs

The second avenue available to the state would be not to dictate health insurance plan design, but rather to limit or prohibit AFP companies from operating within the state. Such a law could, for example, prohibit any entity or individual from performing the administrative functions of an AFP for compensation within Louisiana. This approach would need to be carefully written to capture in-state activities performed by out-of-state actors while not restricting the activities of the health insurance plan itself, even with regard to the plan contracting for AFP services. This is critical to avoid the ERISA preemption issue discussed above.

The benefit of this approach is that, if properly drafted, it would result in a law of general applicability that does not affect central matters of plan administration or force plans to adopt a particular scheme of substantive coverage. In fact, it is closely in line with traditional state regulation of health care providers and other market participants. Moreover, because AFP companies are, by definition, administering benefits that are *excluded* from the plan itself, the typical argument that prevents states from regulating third-party administrators working for self-funded employee plans is inapplicable in the case of an AFP company. The approach presents two critical difficulties: the regulation of out-of-state actors; and the ability of plans to design around the prohibition. It would be a significant challenge to draft a law that effectively prohibits AFP company operation in Louisiana without expressly restricting health insurance plan activities, triggering Dormant Commerce Clause concerns, or failing to reach non-Louisiana AFP companies. Even in the event such a law were drafted, there is a substantially higher likelihood that health insurance plans seeking to adopt AFPs could simply redesign their programs to avoid the

[21] As well as the Federal Employees Health Benefit Plan and TRICARE statutes if either coverage adopted AFPs, but the preemption clauses for those two categories of coverage are so broad as to be unavoidable.

[22] National Association of Insurance Commissioners. Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation. 2022

prohibition precisely because this second option cannot include restrictions on the health insurance plan itself.

Both available state options have significant benefits but also face significant challenges. As with any issue primarily involving self-funded employee plans, the simplest and cleanest solution would be federal action. Still, either of the two sets of options could serve to restrict AFP activity in the state until such federal action is taken.

If you have questions or concerns, please contact me.

Sincerely,

Frank Opelka
Deputy Commissioner
Office of Health, Life and Annuity
(225) 342-1355, fax (225) 342-5711
(800) 259-5300
frank.opelka@ldi.la.gov