RESEARCH BRIEF
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Medicaid expansion needs better analysis to project long-term impact in Louisiana

EXECUTIVE SUMMARY

Like all states, Louisiana is faced with a decision of whether to participate in the expansion of Medicaid coverage to low-income adults under the federal Affordable Care Act. So far Louisiana has opted not to participate in the expansion, which begins in 2014. The state has the option of changing its mind at any point in the future, under this governor or the next.

There may be no more important health care question facing Louisiana at the moment than whether to expand Medicaid eligibility for adults under the federal Affordable Care Act.

Such a decision is packed with financial, health care, political and moral consequences. The impact on Louisiana would be greater than in some other states that already offer more generous coverage to adult populations. A reasonably accurate projection of the long-term impact is needed.

PAR recommends that the governor and Legislature undertake a thorough analysis of the cost and benefits of covering uninsured adults in Louisiana's Medicaid program. The hundreds of thousands of Louisianans who do not have health insurance deserve a comprehensive examination of the expansion option. Also, Louisiana taxpayers deserve an accurate analysis of the estimated costs and benefits.

Estimating the projected financial impact of a Medicaid expansion is challenging but essential. Some estimates have, indeed, been conducted about the fiscal impact on Louisiana. PAR finds these existing analyses limited in several aspects. But more comprehensive analyses can and should be performed. Other states have produced reports that estimate savings and costs in a more detailed manner than has been done for Louisiana. There are also resources available to assist states in such analyses.

The U.S. Supreme Court in its ruling[1] upholding the Affordable Care Act set forth that the Medicaid eligibility expansion is at the states' option. Other important provisions of the Act are not optional, which means that Louisiana and its citizens in many respects are moving into a new health care and regulatory environment. In addition, the state is implementing many management reforms. Therefore, a decision on Medicaid expansion must be made in the context of these new federal and state health care systems, not on the assumption that the public health system can remain as it is today.

If Louisiana chooses not to expand, then what is the plan for caring for the uninsured in Louisiana? Or is there possibly a compromise plan between the state and federal governments?

The decision to expand Medicaid coverage should weigh several key factors. The impact to health outcomes for Louisianans should be a significant consideration. Additionally, consideration should be given to the impact of a Medicaid expansion on private businesses, employer-sponsored health insurance and the availability and pricing of coverage in the private insurance market. Some measure should be taken of the impact on Louisiana's bond rating, if any, under the expansion. Although these are important considerations, this paper is focused mainly on the question of the estimated fiscal costs and savings to Louisiana government.

There are resources readily available to help complete a thorough and timely analysis of the cost and benefits of a Medicaid expansion for adults, and Louisiana deserves no less.

INTRODUCTION

There may be no more important health care question facing Louisiana at the moment than whether to expand Medicaid eligibility for adults under the federal Affordable Care Act (ACA). The U.S. Supreme Court in its June 2012 ruling upholding the ACA set forth that the eligibility expansion is at the states' option. So far, the governor has indicated that he does not support such an expansion for Louisiana although he has offered to have a discussion with the president about Medicaid reforms.

Medicaid is a program regulated by the federal government and administered by the states. It is aimed primarily at low-income people. Among its chief beneficiaries are children, pregnant women, adults with disabilities and nursing home patients. Generally speaking, adults ages 19-64 are not eligible for Medicaid in Louisiana except for certain special conditions. Federal dollars provide the majority of funds for the program while the states provide a certain level of matching dollars depending on the type of service. In Louisiana, approximately 1.3 million people are covered by Medicaid, including 775,448 children.

The Affordable Care Act gives Louisiana and all other states the option of expanding their Medicaid rolls in 2014 to include adults earning 138 percent or less of the federal poverty level. As we shall see below, the estimates of the number of people affected by this change vary widely. Current estimates indicate there are approximately 291,188 to 419,700 uninsured adults ages 19-64 in Louisiana who could be covered by the ACA's increased eligibility standards. Additionally, adults with private insurance could switch to Medicaid if they meet the income standard.

Health care coverage, whether provided by Medicaid or through private and employer-sponsored plans, usually provides better management of health care problems and leads to more efficient care with healthier outcomes. Uninsured adults are more likely to seek care in a hospital or emergency room, often after an injury or ailment has become difficult and costly to treat. Some of the cost of providing emergency and hospital care to the uninsured is covered by the federal and state governments. For this reason, Medicaid or insurance coverage can cost money to provide but also can save money overall.

To evaluate Louisiana's long-term costs, these offsetting factors and other considerations must be taken into account. In an attempt to assess the fiscal implications of a Medicaid expansion for Louisiana, PAR has analyzed the models produced by the Kaiser Family Foundation and Mercer, which is the actuary for the state Department of Health and Hospitals. PAR finds these models to be incomplete. The models are for varying time periods and contain different assumptions that affect estimated cost and benefits.

Missing from the models is:

- An estimate of state cost savings from moving some adults now covered by Medicaid at a lower federal match rate into ACA expansion coverage at a higher match rate or into the newly created Exchange system
- An estimate of the impact on health care expenditures paid for with state general funds
- A specific estimate for the LSU hospital system of the impact on uncompensated care expenditures
- An estimate of the impact on state revenues
- An estimate of the impact on the state economy
- An estimate of the impact on the new Charity hospital in New Orleans

This paper examines the latest information and analysis regarding the proposed Medicaid expansion in Louisiana. It looks at how the expansion affects Louisiana, identifies key trends in the state's Medicaid coverage and scrutinizes the models used so far to estimate the direct financial impact on the state. The paper then discusses the various costs and savings that should be taken into account to form a new estimate of the impact on Louisiana. The recommendations provide a path forward for a re-examination of this issue leading toward a more transparent and informed decision by the state.

MEDICAID ELIGIBILITY EXPANSION UNDER ACA

In 2010 Congress passed and the president signed into law both the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, which together are known as the Affordable Care Act.

For the first time, the federal government under ACA set forth a national eligibility standard for Medicaid. Under the Medicaid expansion provided by ACA, all adults who earn 138 percent or below of the federal poverty level (FPL)[2] can enroll in Medicaid beginning in 2014 if their state chooses to expand coverage. For example, that current earnings threshold would be $1,285 monthly for an individual or $2,651 monthly for a family of four. In the states that accept the expansion, citizens at this income level who are uninsured or have private insurance can participate in Medicaid.

This expansion would have a relatively larger impact in Louisiana than in some other states. In the current environment (prior to ACA), states are required to cover certain populations but may, at the state's option and with federal approval, cover other populations in the Medicaid program. In fact, substantial variations have been adopted across the states with respect to eligibility policies under Medicaid. While some other states currently have more generous eligibility criteria for adults, Louisiana has traditionally offered robust Medicaid coverage for children, but very limited coverage for parents and no coverage for most childless adults. Louisiana does offer Medicaid coverage now for certain low-income groups of adults, such as the elderly, disabled adults and pregnant women. (Of note, the disabled group accounts for 19 percent of program enrollment but 47 percent of costs.) So the increased eligibility standards under ACA would bring a large new group of Louisiana adults into the Medicaid system, and more so than in other states that already cover some of this group.

LOUISIANA UNINSURED

In discussing the uninsured and the impact of the Affordable Care Act, it is important to first note the inherent challenges in accurately estimating the uninsured population at the income level that could be affected by a Medicaid expansion. Adults at or below 138 percent of the federal poverty level could be eligible for Medicaid coverage if Louisiana participated in the expansion (See Appendix 1). A key first step is estimating how many adults in Louisiana are at 138 percent of FPL and do not have health insurance today. In addition, individuals who are at this income level but have private insurance could be eligible for the Medicaid expansion and might switch to the government program.

PAR finds existing analyses of cost/benefits of Medicaid expansion to be incomplete.

The Census provides one estimate of this group of uninsured that is commonly utilized by national research groups. The Census number cited is a two-year average produced by the Kaiser Family Foundation and is based on recent Census data. Louisiana State University provides another estimate[3] through an annual survey wherein survey participants are asked about health insurance. For incomes at or below 138 percent of the FPL, the Kaiser Family Foundation estimates in StateHealthFacts[4] that Louisiana had 419,700 uninsured adults in 2011, while the LSU survey estimated 291,188 adults were uninsured. The expansion would apply to this uninsured low-income group of adults, as well as to privately insured adults at these income levels. Mercer, DHH's actuary, estimates[5] there are approximately 86,000 parents of Medicaid eligible children and 64,000 childless adults with private insurance who would switch to Medicaid under the expansion.

Precisely estimating the number of uninsured adults at this income level is challenging. People move in and out of jobs with varying degrees of health coverage. Some adults may experience cycles of coverage and non-coverage through periods of full employment, part-time employment and unemployment.

The ACA created American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, to be administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Businesses with more than 100 employees can purchase coverage in the SHOP Exchange beginning in 2017 and individuals

can purchase coverage in 2014. All exchanges, both federal and state run, will launch open enrollment in October 2013. A Federally-facilitated Exchange (FFE) will operate in states that have chosen not to build their own exchange. State run exchanges must be financially self-sustaining by 2015. Gov. Jindal has elected not to build a state exchange in part because of the financial constraints.

This system enables individuals and families to apply for coverage using a single application and have their eligibility determined for all insurance affordability programs through one simple process. The federal government is establishing a system to determine consumer eligibility and a mechanism for consumers to enroll in a qualified health plan (QHP). The federal government will also fund a Navigator grant program in FFE states to provide consumers with fair, unbiased help in determining if they are eligible for tax credits, comparing QHPs and the application process for health coverage. More information on health exchanges can be found in Appendix 2.

TRENDS IDENTIFIED BY THE 2011 LOUISIANA HEALTH INSURANCE SURVEY CONDUCTED BY LSU

A significant trend identified in the 2011 survey is the continuing expansion of coverage for children. From 2003-2011, the percent of uninsured children declined from 11.1 percent to 3.5 percent, translating into 101,162 fewer uninsured Louisiana children. Declines were seen both among uninsured children and among children eligible for Medicaid but not enrolled. In sum, more children are covered with health insurance and this trend continues.

While this is a commendable trend, a different story emerges among adults in Louisiana. In 2011, there were 93,453 more uninsured adults (across all income levels) than there were in 2009 even as the number of uninsured children declined. The survey showed that the number of uninsured adults at all income levels has increased significantly since 2009 from 540,490 to 633,943. Although these data are for all Louisiana adults regardless of income, the disparities in the prevalence of uninsured are highly correlated with differences in income. The less income an individual earns, the less likely they are to have health insurance. Low-income adults have limited access to Medicaid coverage in Louisiana and coverage provided by employers varies.

The LSU survey had previously found encouraging trends for employer-sponsored insurance in Louisiana. The 2009 survey found an increase in employer-provided insurance for both adults and children. However, in the most recent survey this trend had reversed and declines in employer-sponsored insurance were found among adults and children. While children may be able to access Medicaid, much of this difference for adults translated into a higher uninsured rate.

Percent of Louisianans Covered by Employer-Sponsored Insurance
2011 Louisiana Health Insurance Survey

	2005	2009	2011
Children	35.7	45.7	41.8
Adults	48.5	56.4	53

The estimates of the uninsured are a key data component in determining the projected costs and benefits of expanding Medicaid. There is disparity in estimates ranging from 291,000 to 419,000 uninsured adults at or below 138 percent of FPL in Louisiana in 2011. To accurately estimate the costs and benefits of expanding Medicaid, a reasonable estimate must be used as a base.

LOUISIANA COST/BENEFIT ESTIMATES

Analysts have provided varying estimates of the costs should Louisiana choose to participate in the Medicaid expansion. The models summarized in the next section estimate how many from various groups at or below 138 percent of the federal poverty level would likely move to the new expanded Medicaid coverage, should it become available in Louisiana. Each analysis has particular assumptions that shape the final estimated costs. These assumptions are critical as they can widely swing the cost estimates. All of the following models include cost considerations for three groups: 1) currently ineligible adults at or below 138 percent of FPL who would become eligible; 2) the currently eligible but un-enrolled parents of Medicaid eligible

children; and 3) those adults at or below 138 percent of FPL with private insurance now who will switch to Medicaid under the expansion, also known as crowd-out. The ACA expansion does not provide coverage for undocumented (illegal) aliens. We will provide a brief overview of the various analyses.

EARLY KAISER ESTIMATE

The Kaiser Commission on Medicaid and the Uninsured issued an analysis[6] to estimate the costs of a Medicaid expansion for Louisiana in May 2010 for the years 2014-2019. In this analysis they offered two scenarios, a Standard Participation Scenario and an Enhanced Outreach Scenario.

None of the early models incorporated potential savings that would occur under an expansion.

The Standard Participation Scenario assumes moderate levels of participation similar to current trends among those made newly eligible for coverage and little additional participation among those currently eligible. According to this scenario, Louisiana's uninsured rate would drop by 50.7 percent by 2019, leaving 313,000 adults uninsured[7]. The Medicaid expansion would cost Louisiana $337 million in state dollars and the federal government $7.27 billion over the five-year period.

The Enhanced Outreach Scenario examines the impact and reach of Medicaid assuming a more aggressive outreach and enrollment campaign by federal and state governments as well as key stakeholders, including community-based organizations and providers. The outreach would bring more robust participation among those newly eligible. According to this scenario, Louisiana's uninsured rate would be reduced by 74.8 percent by 2019, leaving 160,000 adults uninsured. The expansion would cost Louisiana $536 million in state dollars and the federal government's cost would be $8.94 billion over the five-year period.[8]

MERCER ESTIMATE

The Department of Health and Hospitals' (DHH) in 2010 hired an outside actuary, Mercer, to produce an estimate of the cost of the ACA expansion for the period 2014-2023. The period used by Mercer is longer than in the Kaiser models, an important assumption because the state's share of costs over time increases as the federal match rate diminishes.

The results of this model show that Louisiana's uninsured rate would be reduced by 95 percent by 2023, leaving 5 percent of Louisianans at all income levels uninsured[9]. This model projects $3.69 billion in state spending and $35.7 billion in federal dollars for the timeframe of 2014-2023.

CONTRAST OF EARLY MODELS

These early models use different assumptions and time periods. The Mercer model used by the state has the advantage of using actual Louisiana claims data for cost projections. The Mercer model is for a longer period of time than the Kaiser model and contains more aggressive assumptions concerning take-up rates and "crowd-out" from citizens leaving private insurance coverage for Medicaid. Kaiser did not estimate administrative costs while the Mercer model reflects $200 million in administrative costs for the period from 2014-2023.

While these models are now dated, it was important to include them in this analysis as they may have provided information for initial decisions as to whether Louisiana should participate in the Medicaid expansion. Much has transpired since the spring of 2010 to bring clarity to ACA cost projections.

UPDATED KAISER ESTIMATE

The Kaiser Commission on Medicaid and the Uninsured issued an updated cost analysis[10] in November 2012 for the period 2013-2022.

This new model assumes an enrollment rate of 60.5 percent, which is about midway between its two previous models. The results of this revised model estimate that Louisiana's new uninsured rate would be reduced by 60.1 percent by 2022[11]. Spending from 2013-2022 in Louisiana would include $1.24 billion in state dollars and $15.79 billion in federal dollars. The report estimates that Louisiana would save $267 million in uncompensated care expenditures during the period.

These three analyses have different assumptions of timeframes, enrollment rates and administrative costs.

Only one of these models begins to project savings from a potential Medicaid expansion. These are some of the considerations that should be taken into account in an updated analysis.

COST/SAVINGS CONSIDERATIONS

An examination of the various models shows gaps in the analyses. States should consider at a minimum the following in making a cost and benefit estimate of the eligibility expansion under ACA:

COSTS

Unquestionably, there will be costs associated with the implementation of the ACA Medicaid expansion. In fact, the state also may face new costs if it chooses not to participate. The amount of the expenses is uncertain although ranges of estimates could be made. We list some of the financing and cost considerations below.

The state match: The most obvious cost is the state's matching share of the Medicaid expansion. The federal government will pay 100 percent from 2014 to 2016 to cover newly eligible adults. States must begin paying a percentage of health care expenses starting in 2017. Federal funding gradually falls to 90 percent in 2020 and will remain at that level unless the rules of the match are changed. It is important to note that while a state may opt in at any point, the 100 percent coverage is designated specifically for the years 2014 through 2016. This new state match is a prominent cost figure for Louisiana in the models used to estimate the eventual costs of state participation. Throughout any such expansion of Medicaid, the federal government would continue to pay its usual lower matching rate for regular Medicaid coverage for children and those adults currently eligible for full Medicaid services. Only the expanded group is entitled to the 100 percent to 90 percent federal match schedule.

Enrollment: States need to consider the likely proportion of newly-eligible adults who will enroll. Not all eligible adults are likely to enroll immediately, so the number of people signing up will grow during the early years of the program. Also, many people who will be newly eligible for Medicaid are currently insured through their employer plans or other private coverage. Some estimates range from 100,000 to 150,000 Louisiana residents in this category. Cheaper Medicaid coverage might draw many of them into the government program, while those receiving regular care through their private plans might prefer to keep their coverage. States also need to consider the average health care costs of newly-eligible adults, who are likely to be more expensive than children.

Uncompensated care (UCC) payment reductions: Federal uncompensated care funding, commonly referred to as Disproportionate Share Hospital funding or DSH, through Medicaid will likely decline. The federal government spent $15.2 billion on UCC nationwide in 2010. These are federal funds matched by the states to cover some of the uncompensated costs of care provided by hospitals to the uninsured. Louisiana is among the most significant users of uncompensated care funds, at approximately $826 million (both federal and state funds) in fiscal year 2010. The potential reduction is particularly important for Louisiana. ACA requires the federal health secretary to implement a plan to reduce federal uncompensated care expenditures for the nation by $500 million in 2014 and by increasing amounts each year after[12]. In sum, $18 billion of uncompensated care funding will be reduced nationally by 2020.

The federal government will reduce federal uncompensated care expenditures over the next seven years. Louisiana is among the most significant users of these funds.

This funding source that has been essential to Louisiana might be reduced for the state over the next seven years. Financing of the safety-net LSU hospital system is highly dependent on such funding, having accounted for approximately $578.5 million of the state's UCC expenditure in fiscal year 2010. An impact of the pending reduction in federal uncompensated care expenditures on Louisiana in general and the LSU hospital system in particular has not been made.

What the specific reduction to Louisiana will be is not yet known. It is possible that other states currently drawing federal uncompensated care funds will need less in the future as they expand their adult Medicaid

enrollments under ACA. In all states that implement the Medicaid expansion, uncompensated care costs incurred by providers will decline, according to the Kaiser report, because more individuals will have health care coverage. Fewer states will need the same level of UCC dollars due to their participation in the Medicaid expansion. How the new UCC pool of funding will be allocated in general and specifically for Louisiana is unknown. A prudent forecast would assume a decline in this funding.

The coverage gap: If the state chooses not to participate in the Medicaid expansion, a quirk occurs in which a large category of low-income people will not be able to qualify for Medicaid coverage and also will not be eligible for federal subsidies available through the new insurance exchanges. With the expansion, adults with incomes up to 138 percent of the federal poverty level would for the first time be eligible for Medicaid coverage. Without the expansion, Louisiana adults with incomes from 11 percent to 100 percent of the poverty level would have no Medicaid coverage and also would be ineligible for federal subsidies to purchase insurance in the private market. However, adults with incomes between 100 percent and 400 percent of the poverty level would be eligible for subsidies or tax credits through the insurance exchanges. States that do not adopt the Medicaid expansion will place lower-income adults at a disadvantage compared to those with higher incomes. To summarize, in Louisiana, higher-income people, at 100 percent to 400 percent of the poverty level, will receive more assistance with health care insurance costs than individuals making 11 percent to 100 percent of the poverty level. This coverage gap, sometimes called a doughnut hole, will affect the cost and volume of care for the uninsured. More generally, Louisiana will continue to confront uncompensated care costs if the state opts out of a Medicaid expansion.

Should Louisiana not expand Medicaid, individuals earning between 11-100% of poverty will receive no health insurance coverage assistance while those making more – between 100 and 400% of poverty – will be eligible for assistance with premium costs.

A significant number of citizens will remain uninsured and dependent on the safety net in Louisiana, which in turn will increase the cost of uncompensated care.

The woodwork effect: With a Medicaid expansion, the state could incur new costs caring for adults who are already eligible for Medicaid under the current program but who are not enrolled. This category includes very low income parents of Medicaid-eligible children. Under ACA, once penalties are in place for those not having health care insurance, these unenrolled adults will have an added incentive to sign up for Medicaid coverage. If these adults enroll in Medicaid, even during an expansion with ACA, then Louisiana would have to pay the standard share of Medicaid costs at the regular match rate, which is generally cited as a 70/30 split, but has been declining over recent years and was 68.5/31.5 in fiscal year 2010. This is dubbed the "woodwork effect" as it is expected these currently eligible citizens will "come out of the woodwork" to avoid a penalty for not having health insurance in those states that accept the Medicaid expansion. It reflects a cost of care that the state might be paying now if the eligible parents were enrolled. As a side note, it is not anticipated that these adults at or below 138 percent of FPL would face the penalty provisions for being uninsured if they reside in a state that elects not to expand coverage.

Administrative costs: A Medicaid expansion could cost the state additional operational costs, including a need for an upgraded computer system and more human capital to deal with the bigger population of government-insured citizens.

SAVINGS

Missing from all models is the state cost savings from a variety of places. This appears to be a fundamental gap in the analysis of the fiscal impact of the Medicaid expansion on Louisiana.

Savings from better coverage: Uninsured adults place a cost-burden on the state by using uncompensated health care services. By moving from the uninsured ranks to Medicaid, these adults would alleviate costs that providers and state and federal governments would incur for serving uninsured people. Medicaid

coverage also offers the advantage of providing managed care, which can reduce costs and bring better health outcomes. Some savings might take time to materialize. For example, people with chronic illnesses will likely get better and ultimately less expensive care under Medicaid versus being uninsured. But the cost savings in better health management for these people will not be realized overnight.

Overall, the state could cut its non-Medicaid spending on health care for poor and near-poor uninsured adults who would receive mostly federally-funded Medicaid under the expansion. Examples include mental health services and state payments to hospitals for uncompensated care. We have not seen computed savings, but the Office of Behavioral Health alone could possibly save more than $150 million over the first 10 years in state general fund services to currently non-Medicaid eligible adults. The Office of Public Health could also recognize state general fund savings for programs that currently serve non-Medicaid eligible adults.

Cost shifting for certain adults: The state could see a cost shift to the federal government for certain currently eligible adults. Those adults in designated Medicaid programs — such as Family Planning, Breast and Cervical Cancer and Medically Needy Spend-down — currently receive limited services. If the state designs the expansion so that all adults receive the same benefits, the costs for adults in these limited programs would be covered initially at 100 percent by the federal government and at a declining rate to a 90 percent match over time. ACA lets states cover as "newly-eligible adults" people who qualify for a type of Medicaid under current law that provides less than full or benchmark Medicaid benefits. We have not seen computed savings for Family Planning, Breast and Cervical Cancer and Medically Needy Spend-down, but such state general fund savings from these and other programs could possibly be more than $500 million over the first 10 years of the expansion.

Revenue effect: State income and sales tax revenue could increase because the state would receive more federal Medicaid dollars, which could increase total economic activity. Primarily using new federal dollars, the Medicaid expansion would increase the volume of health care goods and services bought within the state. With more revenue, companies and individuals working in the health care sector would buy other goods and services, much of it within the state's borders. This economic activity could increase employment and boost state revenue, either through state income taxes, sales taxes or other general revenue mechanisms. For example, Arkansas officials estimate[13] that, with the Medicaid expansion, Arkansas' receipt of new federal health care dollars under ACA would increase state revenue by $254 million from 2014 through 2021. While this revenue projection can be viewed with skepticism, it is nonetheless worth noting.

Insurance premium taxes: A state with insurance premium taxes might gain additional revenue under a Medicaid expansion. Louisiana and some other states apply insurance premium taxes to payments that certain health plans receive from Medicaid. If the Medicaid expansion boosts enrollment in such plans, premium tax revenue would increase. With ACA's Medicaid expansion, the vast majority of such increased payments — hence the vast majority of new premium tax revenue — will come from the federal government. Georgia's Department of Community Health estimates[14] that, due to higher Medicaid and Children's Health Insurance Program enrollment, full ACA implementation would raise the state's premium tax revenue by more than $70 million a year, once the law's effects are fully felt. The Louisiana insurance premium tax is controversial because the state's rates are considered high. There is regular discussion about changing these rates.

RECOMMENDATIONS

Should Louisiana participate in the Medicaid expansion? PAR believes a more robust analysis is needed before turning away from this program, given the hundreds of thousands of uninsured citizens among us and the potential taxpayer consequences. The cost and benefit models produced for Louisiana so far are incomplete at best.

Other states have done this analysis and continue to do so. For example, the State of Utah issued a request[15] in October 2012 to procure an analysis of the cost and benefits of a Medicaid eligibility expansion in that state.

PAR believes that such an analysis need not take long or cost a considerable amount of money because much work has already been done that can be built upon. The University of Minnesota's State Health Access Data Assistance Center (SHADAC) is funded by The Robert Wood Johnson Foundation to help states monitor rates of health insurance coverage, understand factors associated with access to care, and utilize data for implementation of health reform. The SHADAC Projection Model[16] was designed to provide a tool for analysis that is timely, state-specific, relatively inexpensive and flexible for testing alternative assumptions to predict the coverage impacts of policy changes at the state level. The model was constructed specifically to help states project the coverage impacts of ACA and is available to assist Louisiana in a full and detailed analysis. Additionally, The Urban Institute's Health Policy Center released a paper[17] in August 2012 outlining how states should approach a thorough analysis of cost and benefits under an expansion of eligibility.

The Affordable Care Act allows states to begin participating in the adult Medicaid expansion in 2014. If Louisiana is not prepared to join come January, then it could join at a later time if the reasons for participating can be justified by the financial and health care considerations.

With these points in mind, PAR makes the following recommendations:

Recommendation 1: The governor and Legislature should jointly undertake a thorough analysis of the cost and benefits of covering uninsured adults in Louisiana's Medicaid program. Once that is done, a more fully informed decision can be made on whether to expand Medicaid eligibility for adults under the Affordable Care Act.

Recommendation 2: The Legislature should assert its authority and take the lead in providing input and guidance into the decision of whether to participate in the Affordable Care Act. PAR has previously recommended that the Legislature establish a special committee or commission to provide oversight and verification of the state's Medicaid health care program implementation.

Recommendation 3: The governor should lay out his alternative path for health care coverage for Louisiana's uninsured if he chooses not to expand Medicaid, and the Legislature should play a role in shaping that policy. The administration has said its health care plans are under development. The governor's plans, in general, are based on assumptions of a reduction in the uninsured population due to affordable coverage available through the health insurance exchanges, the continuance of Uncompensated Care funding from the federal government and services from the public-private partnerships under way to replace the LSU Charity Hospital system. Regardless of whether Louisiana expands Medicaid, changes to Louisiana's financing of public health care are coming and the governor should clearly delineate his alternative plan for the long term for providing affordable health care.

An updated analysis is badly needed and should not take considerable time or money, given existing resources and tools.

Recommendation 4: A "cookie cutter" approach may not work for Louisiana. The governor is encouraged to approach the U.S. Department of Health and Human Services in a spirit of creativity and compromise regarding specific policy proposals. In broad terms, the governor has identified aspects of the existing Medicaid system that are in need of reform. He has requested a dialogue with the president to share these ideas. If such meetings could take place in a truly productive manner with open minds on both sides, they would be worthwhile. An alternative path for Louisiana, with federal approval, appears to be a distant possibility. But such a compromise plan, if pursued, should be considered soon. Meanwhile, Louisianans deserve to know the specifics of the governor's plan to address health care coverage. He has outlined the flexibility he wants for Medicaid, and more details would be helpful. He also should describe his plan for Louisiana's uninsured in the event flexibility is not granted and Louisiana does not expand Medicaid.

CONCLUSIONS

Estimating the number of uninsured Louisiana adults ages 19-64 is complex and organizations that devote

considerable resources to the effort arrive at markedly different findings. Estimating the cost and benefits of insuring this population under Medicaid is even more complex and requires careful consideration. That does not mean that such estimates cannot or should not be done. To the contrary, whether to expand Medicaid coverage for adults is such an important question for Louisiana that it deserves the state's highest attention and most complete analysis possible.

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APPENDIX 1

Louisiana Medicaid Eligibility Manual — Charts

FEDERAL POVERTY INCOME GUIDELINES
Z - 200
Effective April 1, 2012

Family Size	100% Monthly	118% Monthly	120% Monthly	133% Monthly	135% Monthly	138% Monthly	140% Monthly	145% Monthly	150% Monthly	175% Monthly	185% Monthly	200% Monthly	250% Monthly	300% Monthly
1	931	1,099	1,117	1,239	1,257	1,285	1,304	1,350	1,397	1,629	1,723	1,862	2,328	2,793
2	1,261	1,488	1,513	1,677	1,703	1,740	1,766	1,829	1,892	2,207	2,333	2,522	3,153	3,783
3	1,591	1,878	1,909	2,116	2,148	2,196	2,228	2,307	2,387	2,784	2,944	3,182	3,978	4,773
4	1,921	2,267	2305	2,555	2,594	2,651	2,690	2,786	2,882	3,362	3,554	3,842	4,803	5,763
5	2,251	2,656	2,701	2,994	3,039	3,107	3,152	3,264	3,377	3,939	4,165	4,502	5,628	6,753
6	2,581	3,046	3,097	3,433	3,485	3,562	3,614	3,743	3,872	4,517	4,775	5,162	6,453	7,743
7	2,911	3,435	3,493	3,872	3,930	4,017	4,076	4,221	4,367	5,094	5,386	5,822	7,278	8,733
8	3,241	3,825	3,889	4,311	4,376	4,473	4,538	4,700	4,862	5,672	5,996	6,482	8,103	9,723

330	Add to the 100% monthly for each additional family member	3,960	Add to the 100% yearly for each additional family member
390	Add to the 118% monthly for each additional family member	4,673	Add to the 118% yearly for each additional family member
396	Add to the 120% monthly for each additional family member	4,752	Add to the 120% yearly for each additional family member
439	Add to the 133% monthly for each additional family member	5,267	Add to the 133% yearly for each additional family member
446	Add to the 135% monthly for each additional family member	5,346	Add to the 135% yearly for each additional family member
456	Add to the 138% monthly for each additional family member	5,465	Add to the 138% yearly for each additional family member
462	Add to the 140% monthly for each additional family member	5,544	Add to the 140% yearly for each additional family member
479	Add to the 145% monthly for each additional family member	5,742	Add to the 145% yearly for each additional family member
495	Add to the 150% monthly for each additional family member	5,940	Add to the 150% yearly for each additional family member
578	Add to the 175% monthly for each additional family member	6,930	Add to the 175% yearly for each additional family member
611	Add to the 185% monthly for each additional family member	7,326	Add to the 185% yearly for each additional family member
660	Add to the 200% monthly for each additional family member	7,920	Add to the 200% yearly for each additional family member
825	Add to the 250% monthly for each additional family member	9,900	Add to the 250% yearly for each additional family member
990	Add to the 300% monthly for each additional family member	11,880	Add to the 300% yearly for each additional family member

CHAMP (Children 6 or older) Income is less than or equal to 100% FPIG (See Z-1900)	**Med Purchase Plan** (MPP) Countable Income less than or equal to 250% FPIG
(Children under 6) Income is less than or equal to 133% FPIG (See Z-1900)	**QDWI** Income less than or equal to 200% FPIG (See Z-600)
CHAMP PW Income is less than or equal to 200% FPIG (See Z-2100 *)	**QI** (Group 1) Income is equal to or greater than 120% but less than 135% FPIG
Family Opportunity Act (FOA) Income less than or equal to 300% FPIG	**QMB** Income less than or equal to 100% FPIG (See Z-500)
LaCHIP Income is less than or equal to 200% FPIG	**SLMB** Income is greater than 100% but less than 120% FPIG (See Z-1600)
LAP (LaCHIP Affordable Plan) Gross income does not exceed 250% FPL	**TAKE CHARGE** Income (after deductions) is less than or equal to 200% FPIG
LaMOMS Income is less than or equal to 200% FPIG (See Z-2100 *)	

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Revised/added text indicated by underscore

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Deleted text indicated by "*"

APPENDIX 2

ROLE OF THE EXCHANGES UNDER ACA

The Affordable Care Act creates a system of coverage between Medicaid, the Children's Health Insurance Program (CHIP) and Affordable Insurance Exchanges. This system is supposed to let individuals and families apply for coverage using a single application and have their eligibility determined for all insurance affordability programs through one simple process.

All exchanges, both federal and state-run, will launch open enrollment in October 2013. A Federally-Facilitated Exchange (FFE) will operate in states that have chosen not to build their own exchange. State-run exchanges must be financially self-sustaining by 2015. Gov. Jindal and Insurance Commissioner Donelon have elected not to build a state exchange.

The federal government is establishing a system to determine consumer eligibility and a mechanism for consumers to enroll in a qualified health plan (QHP). The federal government will also fund a Navigator grant program in FFE states to provide consumers with fair, unbiased help in determining if they are eligible for tax credits, comparing QHPs, and navigating the application process for health coverage.

PREMIUM ASSISTANCE UNDER THE EXCHANGE[18]

To make coverage obtainable for families that otherwise could not afford it and to encourage broad participation in health insurance, ACA includes provisions to lower premiums and cost-sharing obligations for people with low and modest incomes.

For people with incomes somewhat higher than Medicaid (up to 400 percent of poverty), ACA provides tax credits that reduce premium costs. People with incomes up to 250 percent of poverty also are eligible for reduced cost sharing (e.g., coverage with lower deductibles and co-payments) paid for by the federal government.

PREMIUM TAX CREDITS

Citizens and legal residents in families with incomes between 100 percent and 400 percent of poverty who purchase coverage through a health insurance exchange are eligible for a tax credit to reduce the cost of coverage. People eligible for public coverage are not eligible for premium assistance in exchanges. In states without expanded Medicaid coverage, people with incomes less than 100 percent of poverty will not be eligible for exchange subsidies, while those with incomes at or above poverty will be.

The amount of the tax credit varies with income such that the premium a person would have to pay for the second lowest cost plan would not exceed a specified percentage of his or her income (adjusted for family size), as follows:

Income Level	Premium as a Percent of Income
Up to 133 percent FPL	2 percent of income
133-150 percent FPL	3 – 4 percent of income
150-200 percent FPL	4 – 6.3 percent of income
200-250 percent FPL	6.3 – 8.05 percent of income
250-300 percent FPL	8.05 – 9.5 percent of income
300-400 percent FPL	9.5 percent of income

Premium tax credits would be refundable and advanceable. A refundable tax credit is one that is available to a person even if he or she has no tax liability. An advanceable tax credit allows a person to receive assistance at the time that he purchases insurance rather than paying his premium out of pocket and waiting to be reimbursed when filing his annual income tax return.

COST SHARING

Cost-sharing subsidies help low-income people with high out-of-pocket costs of health insurance at the point of service. ACA sets maximum out-of-pocket spending limits. People with incomes at or below 400 percent of poverty have their out-of-pocket liability capped at lower levels, as follows:

Income Level	Reduction in Out-of-Pocket Liability
100-200 percent FPL	Two-thirds of the maximum
200-300 percent FPL	One-half of the maximum
300-400 percent FPL	One-third of the maximum

NOTES

[1]National Federation of Independent Business, et al., vs. Sebelius, et al., 567 U.S._, 2012 WL 2427810 (U.S. June 28, 2012).

[2]Nominally, the Medicaid expansion, with enhanced federal matching funding, is limited to people with incomes at or below 133 percent FPL. However, 5 FPL percentage points are subtracted from gross income in determining eligibility. Accordingly, the gross income threshold for Medicaid eligibility under the expansion is 138 percent FPL. See attached FPL Chart from DHH website. http://bhsfweb.dhh.louisiana.gov/onlinemanualspublic/eligibility/mem/Z-200.pdf

[3]Louisiana's Uninsured Population, A Report from the 2011 Louisiana Health Insurance Survey, dated January 2012, sponsored by DHH and located at: http://new.dhh.louisiana.gov/assets/medicaid/LHIS/2011LHIS/LHIS_Layout_FINAL_000.pdf

[4]Uninsured rates derived from the ACS (Census) http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=779&cat=3&sub=177

[5]Louisiana Medicaid - High Level Estimated Impact of Federal Health Care Reform – May 10, 2010.

[6] The Kaiser Commission on Medicaid and the Uninsured. http://www.kff.org/healthreform/8076.cfm

[7]Kaiser's Standard Participation Scenario assumes 57 percent participation among the newly eligible uninsured and lower participation across other coverage groups. Louisiana's uninsured rate would be reduced by 50.7 percent by 2019. This reduction assumes 366,318 new Louisiana Medicaid participants would be enrolled. Approximately 313,000 adults (based on Census data) at all income levels would remain uninsured. Total spending for this expansion would cost $7.61 billion. 95.6 percent of the cost is federal.

[8]Kaiser's Enhanced Outreach Scenario assumes 75 percent participation among the newly eligible that are currently uninsured and lower participation across other coverage groups and higher participation among those currently eligible for coverage than in the standard scenario. This model projects enrolling 507,952 new Medicaid participants. Approximately 25.2 percent or 160,000 adults (based on Census data) at all income levels would remain uninsured. Total spending from 2014-2019 in Louisiana for the Medicaid expansion would total of $9.48 billion. 94.3 percent of the cost is federal

[9]The model assumes 80 percent of eligible participants would participate in 2014, 85 percent in 2015, 90 percent in 2016, and 95 percent by 2017. Approximately 5 percent or 32,000 adults (based on Census data) at all income levels would remain uninsured. 90.6 percent of cost is federal.

[10]The Kaiser Commission on Medicaid and the Uninsured. http://www.kff.org/medicaid/8384.cfm

[11]Approximately 39.9 percent of the previously uninsured or 253,000 adults (based on Census data) at all income levels would remain uninsured. This assumes the 398,000 new Medicaid participants would be enrolled.

Spending from 2013-2022 in Louisiana would include $1.24 billion in state dollars and $15.79 billion in federal dollars for a total of $17.03 billion. 92.7 percent of the cost is federal.

[12]UCC will be reduced by $600 million in 2015, $600 million in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019 and $4 billion in 2020.

[13]Arkansas Department of Human Services. July 17, 2012. Estimated Medicaid-Related Impact of the Affordable Care Act with Medicaid Expansion

http://humanservices.arkansas.gov/director/Documents/ACApercent20impactpercent20estimatepercent20withpercent20expansionpercent20FINAL.pdf

[14]Georgia Dept. of Community Health. June 14, 2012. Medicaid Financial Update: Presentation to: DCH Board. http://dch.georgia.gov/vgn/images/portal/cit_1210/7/21/186139580Medicaid_Update_for_Board_June_2012.pdf

[15]State of Utah, Solicitation Number NS13009 dated October 30, 2012. http://purchasing.utah.gov/vendor/currentbids.html

[16]State Health Access Data Assistance Center's Projection Model.

http://www.shadac.org/publications/predicting-health-insurance-impacts-complex-policy-changes-new-tool-states

[17]Urban Institute, Health Policy Center, Considerations in Assessing State-Specific Fiscal Effects of the ACA's Medicaid Expansion, August 2012. http://www.urban.org/publications/412628.html

[18] The Kaiser Commission on Medicaid and the Uninsured. EXPLAINING HEALTH CARE REFORM: Questions About Health Insurance Subsidies, July 2012.