REFORMING MEDICAID IN LOUISIANA

A BETTER WAY: REFORMING MEDICAID IN LOUISIANA

CHRIS JACOBS

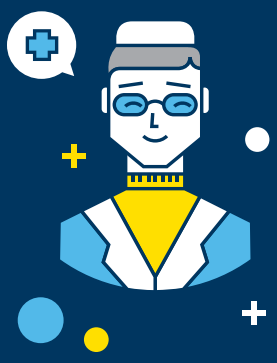
Two years ago, the incoming administration of Gov. John Bel Edwards (D-LA) pledged that expanding Medicaid to able-bodied adults, as permitted under Obamacare, would help solve Louisiana's ongoing structural budget shortfalls. Unfortunately, the Governor's promises have not come to fruition. Enrollment in the Medicaid expansion has exceeded projections—as have the costs associated with that expansion. As a result, Louisiana faces a scenario plaguing many states that expanded Medicaid: Rising spending on expansion crowding out other important budgetary priorities like education, transportation, and law enforcement.

The governor and some legislators have already proposed a series of tax increases to "solve" the state's fiscal crisis.[1] But that "solution" misses the point—and won't actually solve the problem. Rather than raising taxes yet again, to pay for more unaffordable health care spending, Louisiana should both right-size and reform its Medicaid program. Right-sizing the program would involve unwinding the massive expansion to the able-bodied—working-age adults without dependent children—to return Medicaid to serving the populations for which it was originally designed—pregnant women, children, senior citizens, and individuals with disabilities.

After right-sizing the Medicaid program, state leaders should then work to reform and modernize Medicaid for the 21st century. Specifically, Louisiana should work with the Trump Administration to enact a comprehensive Medicaid reform waiver. This waiver could include components to improve coordination of beneficiary care, introduce consumer choice elements into Medicaid, provide a smoother transition to work and employer-based coverage for those who are able to work, and improve program integrity to use scarce taxpayer dollars most effectively.

Individually and collectively, the policy solutions outlined in this paper—unwinding Medicaid expansion and embracing a comprehensive waiver to enact additional reforms—would help put Louisiana on a more sustainable fiscal trajectory, eliminating the need for the tax-and-spend battles of the past several years. By so doing, the state could focus more on enacting reforms necessary for the economy to thrive, bringing jobs back to Louisiana.

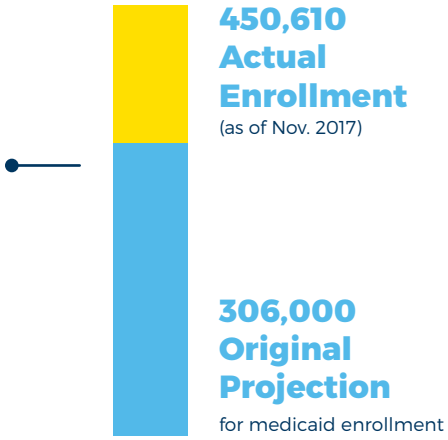
"Right-sizing the program would...return Medicaid to serving the populations for which it was originally designed—pregnant women, children, senior citizens, and individuals with disabilities."



1. Melinda Deslatte, "Louisiana Governor Offers Tax Ideas to Close $1 Billion Budget Gap," Associated Press December 18, 2017, https://apnews.com/58833e0c265f4de6b26e465004c01c25/Louisiana-governor-offer.

MASSIVE EXPANSION

Fewer than two years since Louisiana first expanded Medicaid under Obamacare to able-bodied adults, enrollment in the expansion has already shattered expectations. While officials first projected about 306,000 previously uninsured individuals would gain coverage through expansion, within days of Gov. Edwards signing the executive order authorizing Medicaid expansion, state officials revised their estimates dramatically upward. At that time, officials claimed that as many as 450,000 Louisianans could be added to the Medicaid rolls by expansion.[2] However, even this projection turned out to be an under-estimate, as by December 2017 enrollment reached 456,004, exceeding the higher projection.[3] Louisiana officials admit that, as enrollment exceeds the original 306,000 projection, costs to the state will increase, reducing the state's supposed fiscal savings.[4]



The fact that Louisiana's Medicaid expansion has exceeded enrollment projections should come as no surprise. In fact, virtually every state that expanded Medicaid to the able-bodied under Obamacare has seen vastly more enrollees than they had originally planned for. A November 2016 study by the Foundation for Government Accountability (FGA) showed that 24 states' Medicaid expansion had within two years exceeded projections for the maximum number of individuals that would ***ever*** enroll in the Obamacare expansion by an average of 110%.[5]

An earlier report by FGA, issued in April 2015, found that enrollment had exceeded estimates in 17 states. Collectively, those 17 states exceeded their maximum enrollment projections by an average of "only" 61%.[6] By comparison, just eighteen months later, a total of 24 states had exceeded their maximum enrollment projections by more than 110%—amounting to over 6 million enrollees more than projected.[7] More states continue to enroll many more individuals than projected in Medicaid expansion, even after many states already exceeded projections in the expansion's first year.

The enrollment explosion in "free" Medicaid contrasts with more limited enrollment in Obamacare's other venue for coverage expansion—health insurance Exchanges. While Medicaid enrollment vastly exceeded projections, as of the 2017 open enrollment period, effectuated Exchange enrollment stood at only 10.3 million individuals.[8] This enrollment figure

2. Kevin Litten, "Louisiana's Medicaid Expansion Enrollment Could Grow to 450,000," Times-Picayune January 20, 2016, http://www.nola.com/politics/index.ssf/2016/01/medicaid_expansion_500000.html.

3. Louisiana Department of Health, "Louisiana Medicaid Expansion Dashboard," http://www.ldh.la.gov/HealthyLaDashboard.

4. Litten, "Louisiana's Medicaid Expansion Enrollment Could Grow."

5. Jonathan Ingram and Nicholas Horton, "Obamacare Expansion Enrollment Is Shattering Projections," Foundation for Government Accountability, November 16, 2016, https://thefga.org/download/ObamaCare-Expansion-is-Shattering-Projections.PDF, p. 5.

6. Jonathan Ingram and Nicholas Horton, "The Obamacare Expansion Enrollment Explosion," Foundation for Government Accountability," April 20, 2015, https://thefga.org/wp-content/uploads/2015/04/ExpansionEnrollmentExplosion-Final3.pdf.

7. Ingram and Horton, "Obamacare Expansion Enrollment Is Shattering Projections."

8. Centers for Medicare and Medicaid Services, "2017 Effectuated Enrollment Snapshot," June 12, 2017, https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf. Effectuated enrollment represents coverage for which individuals have both selected an insurance plan and paid at least one month's premium.

represents less than half the 23 million individuals the Congressional Budget Office estimated at the time of Obamacare's enactment would sign up for Exchange coverage in 2017.[9]

Moreover, studies suggest that only individuals who qualify for the most generous subsidies have joined insurance Exchanges in significant numbers. The consulting firm Avalere Health concluded that more than four in five (81%) eligible individuals with incomes of under 150% of the federal poverty level—who qualify for both the richest premiums subsidies and reduced deductibles and co-payments—have signed up for Exchange coverage.[10] By comparison, only about one-sixth (16%) of those with incomes between three and four times the poverty level—who qualify for much smaller premium subsidies, and receive no help with cost-sharing—purchased Exchange coverage.[11] Put simply, while individuals quickly sign up for "free," or nearly free, health insurance coverage, including through Medicaid, they have signed up much more slowly for health plans for which they must make a financial contribution.

81% of candidates
signed up for coverage

16.7% of candidates
signed up for coverage

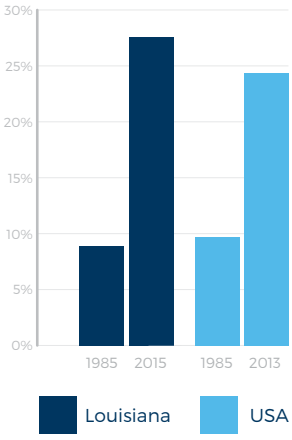
MASSIVE—AND RISING—COSTS

Even prior to Obamacare, Medicaid had grown exponentially over the past several decades to become a larger and larger share of Louisiana's state budget. In fiscal year 1985, Medicaid represented 8.9% of Louisiana's total budgetary expenditures.[12] Thirty years later, in fiscal year 2015, Medicaid had more than tripled as a share of the state budget, rising to 27.6% of total expenditures.[13]

The rising tide of Medicaid spending in Louisiana echoes national trends. In fiscal year 1985, Medicaid consumed an average of 9.7% of total state expenditures across all 50 states.[14] By comparison, in fiscal year 2013, the last year before Obamacare's expansion took effect, Medicaid represented an average of 24.4% of state spending.[15] Over a quarter-century, then, Medicaid spending more than doubled as a share of state spending—before most of Obamacare's effects kicked in.

However, even when compared to other states, Louisiana suffered from

Medicaid percentage of total budgetary expenditures



9. Congressional Budget Office, estimate of H.R. 4872, Health Care and Education Reconciliation Act, in concert with H.R. 3590, Patient Protection and Affordable Care Act, March 20, 2010, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf, Table 4, p. 21.

10. Avalere Health, "The State of Exchanges: A Review of Trends and Opportunities to Grow and Stabilize the Market," report for Aetna, October 2016, http://go.avalere.com/acton/attachment/12909/f-0352/1/-/-/-/-/20161005_Avalere_State%20of%20Exchanges_Final_.pdf, Figure 3, p. 6.

11. Ibid.

12. National Association of State Budget Officers, "The State Expenditure Report," July 1987, https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/ER_1987.PDF, Medicaid Expenditures as a Percentage of Total Expenditures, p. 30.

13. National Association of State Budget Officers, "State Expenditure Report," November 2016, https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/State%20Expenditure%20Report%20(Fiscal%202014-2016)%20-%20S.pdf, Table 5: State Spending by Function as a Percentage of Total State Expenditures, p. 13.

14. National Association of State Budget Officers, "The State Expenditure Report."

15. National Association of State Budget Officers, "Fiscal Survey of States: Spring 2014," https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/Fiscal%20Survey/NASBO%20Spring%202014%20Fiscal%20Survey%20(security).pdf, p. xi.

skyrocketing Medicaid spending prior to Obamacare expansion taking effect. The Pew Charitable Trusts noted that, during the years 2000-2015, Medicaid grew the fastest in Louisiana when measured as a share of the state's own spending. During that time, Medicaid grew by 12.8 percentage points—from 10.5% of the state's spending to 23.3% of state dollars.[16] As a result of that growth in Medicaid spending, Louisiana was the state most dependent on federal funds in fiscal year 2015, using money from Washington to comprise 42.2% of its budget—again, before Obamacare's Medicaid expansion ever took effect in Louisiana.[17]

States like Louisiana that chose to expand Medicaid to the able-bodied face additional rising costs, due to both higher than expected enrollment in Medicaid expansion and higher than expected per-beneficiary spending for those expansion enrollees. In late 2016, the Centers for Medicare and Medicaid Services' (CMS) Office of the Actuary released its annual report on the state of the Medicaid program. The report found that, contrary to projections that expansion enrollees would have per-beneficiary costs ***lower*** than previously eligible Medicaid beneficiaries, states actually faced ***higher*** per-beneficiary costs for the

In 2000, Medicaid was 10.5%
of the LA state budget

As of 2015, Medicaid was 23.3%
of the LA state budget

> **"As a result of that growth in Medicaid spending, Louisiana was the state most dependent on federal funds in fiscal year 2015."**

expansion population than their prior enrollees.[18] In 2016, expansion enrollees cost the Medicaid program an average of $5,926, compared to average spending of $5,215 for non-expansion adults.[19]

The higher spending on Medicaid expansion enrollees has now persisted for several years, contrary to predictions before the coverage expansion took effect. At first, the CMS actuary thought that the higher spending came from pent-up demand for health care—previously uninsured enrollees using their newfound Medicaid coverage to cover heretofore-neglected health conditions.[20] However, the 2014, 2015, and

16. Pew Charitable Trusts, "Fiscal 50: State Trends and Analysis," http://www.pewtrusts.org/en/multimedia/data-visualizations/2014/fiscal-50#ind7, Change in State Medicaid Spending as a Share of Own-Source Revenue, 2000 and 2015.

17. Ibid., http://www.pewtrusts.org/en/multimedia/data-visualizations/2014/fiscal-50#ind1, Percentage of State Revenue from Federal Funds, Fiscal Year 2015.

18. For an analysis of the ways that the CMS actuary and the Congressional Budget Office have changed their baseline projections of Medicaid spending over time, see Brian Blase, "Evidence Is Mounting: The Affordable Care Act Has Worsened Medicaid's Structural Problems," Mercatus Center, September 2016, https://www.mercatus.org/system/files/mercatus-blase-medicaid-structural-problems-v1.pdf, pp. 15-20.

19. Centers for Medicare and Medicaid Services Office of the Actuary, "2016 Actuarial Report on the Financial Outlook for Medicaid," report to Congress, 2016, https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2016.pdf, p. 22.

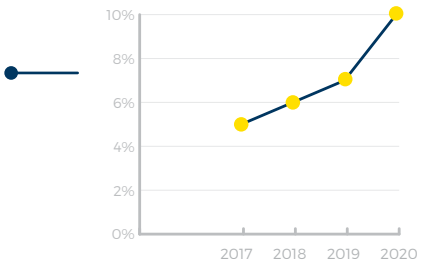
20. Centers for Medicare and Medicaid Services Office of the Actuary, "2014 Actuarial Report on the Financial Outlook for Medicaid," report to Congress, 2014, https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2014.pdf, pp. 36-38.

2016 annual reports on Medicaid all demonstrated higher per-beneficiary spending for expansion populations than those eligible prior to Obamacare.[21]

Echoing the national trends, Medicaid per-beneficiary spending in Louisiana remains higher for expansion enrollees than previously eligible beneficiaries. State officials admit that in fiscal year 2017, spending for expansion enrollees totaled $6,712 per adult—more than 20% higher than the $5,575 spent on non-expansion enrollees.[22] Liberal supporters of the expansion claim that the disparity arises from pent-up demand by new enrollees—the same assumption federal actuaries made.[23] However, the higher spending by expansion enrollees over several years at the federal level suggests that higher spending by expansion enrollees may persist in Louisiana as well.

With enrollment higher than initial projections, and spending on those new enrollees averaging more than anticipated, many states now face fiscal crises brought on by their Medicaid expansions. Under the Obamacare statute, states began to pay a share of the costs for the Medicaid expansion in calendar year 2017. Moreover, states' 5% share of expansion enrollees' health costs in 2017 will double over the next few years, rising to 6% in calendar year 2018, 7% in calendar year 2019, and 10% in calendar year 2020.[24] Given the vast sums that states already devote to their Medicaid programs, paying five percent—let alone ten percent—of expansion costs will add significant new stresses to state budgets.

States' share of expansion costs



Even as Louisiana expanded Medicaid to the able-bodied, other states began facing expansion's negative effects, with budget shortfalls looming because the expansion exceeded projected costs. Kentucky's estimated costs of expansion in fiscal years 2017 and 2018 rose from $107 million to $257 million—a more than doubling of costs that will take money away from other state priorities like education, transportation, or law enforcement.[25] Likewise, Ohio's budget for Medicaid expansion more than doubled compared to the state's prior projections, leaving legislators scrambling to cut money from other programs to stem the shortfall.[26]

With Medicaid expansion squeezing state budgets, even Democratic state legislators across the country have contemplated what some liberals might consider apostasy—scaling back and right-sizing the Medicaid program to reflect competing fiscal priorities. Consider

21. Centers for Medicare and Medicaid Services Office of the Actuary, "2015 Actuarial Report on the Financial Outlook for Medicaid," report to Congress, 2015, https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2015.pdf, p. 27.

22. Cited in Jeanie Donovan, "Setting the Record Straight on Medicaid," Louisiana Budget Project, August 4, 2017, http://www.labudget.org/lbp/2017/08/setting-the-record-straight-on-medicaid/.

23. Ibid.

24. 42 U.S.C. 1396d(y)(1), as codified by Section 2001(a) of the Patient Protection and Affordable Care Act, P.L. 111-148.

25. Christina Cassidy, "Rising Cost of Medicaid Expansion is Unnerving Some States," Associated Press October 5, 2016, http://bigstory.ap.org/article/4219bc875f114b938d38766c5321331a/rising-cost-medicaid-expansion-unnerving-some-states.

26. Ibid.

comments from New Mexico state senator Howie Morales, a Democrat:

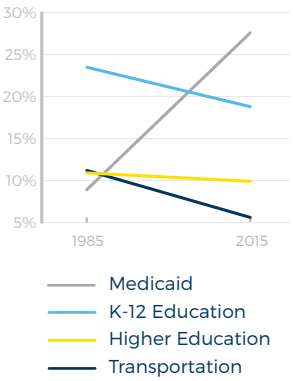
When you're looking at a state budget and there are only so many dollars to go around, obviously it's a concern. The most vulnerable of our citizens—the children, our senior citizens, our veterans, individuals with disabilities—I get concerned that those could be areas that get hit.[27]

Other legislators agree, with Oregon Democratic State Senator reflecting on his state's $500 million budget shortfall by stating that "the only way to keep this [budget situation] manageable is to keep those costs under control, get people off Medicaid."[28]

The growth in Medicaid spending has resulted in cascading effects across states—including in Louisiana. As the state's budget history demonstrates, a dollar of spending on Medicaid results in fewer dollars for other programs. For instance, as the share of Louisiana's budget devoted to Medicaid more than tripled from 1985 through 2015, the share of the budget dedicated to primary and secondary education fell from 23.5% to 18.8%, the share dedicated to higher education fell from 10.9% to 9.9%, and the share dedicated to transportation fell by half, from 11.2% to 5.6%.[29] If Louisiana continues down its current path, schools, universities, and roads will face a continued squeeze as Medicaid consumes more and more state resources.

Moreover, the current Medicaid-imposed woes that states face assume that the enhanced federal match remains static—a far from safe assumption. With the federal debt recently topping $20 trillion, the belief that Washington will continue to pay 90 percent of states' expansion costs in 2020 and every year thereafter may strike some as an overly rosy scenario.[30] Indeed, President Obama himself once proposed reducing the federal Medicaid match by $100 billion over ten years through a so-called "blended rate" policy.[31] Only an outcry from liberals, combined with the 2012 Supreme Court ruling that made Medicaid expansion optional for states, eventually persuaded President Obama to abandon the proposal.[32] However, given Washington's own dire fiscal situation, the concept could well return in future years.

Percentage of total state budgetary expenditures by category



27. Christina Cassidy, "Medicaid Enrollment Surges, Stirs Worry about State Budgets," Associated Press July 19, 2015, http://www.bigstory.ap.org/article/c158e3b3ad50458b8d6f8f9228d02948/medicaid-enrollment-surges-stirs-worry-about-state-budgets.

28. Ibid.

29. "The State Expenditure Report," Primary and Secondary Education Expenditures as a Percentage of Total Expenditures, Higher Education Expenditures as a Percentage of Total State Expenditures, and Transportation Expenditures as a Percentage of Total State Expenditures; "State Expenditure Report," Table 5: State Spending by Function.

30. United States Treasury, "The Debt to the Penny and Who Holds It," total public debt outstanding as of October 26, 2017, https://www.treasurydirect.gov/NP/debt/current.

31. White House Office of the Press Secretary, "Fact Sheet: The President's Framework for Shared Prosperity and Shared Fiscal Responsibility," April 13, 2011, https://obamawhitehouse.archives.gov/the-press-office/2011/04/13/fact-sheet-presidents-framework-shared-prosperity-and-shared-fiscal-resp.

32. NFIB v. Sebelius, 567 U.S. 519 (2012), https://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf; Sam Baker, "White House Drops Support for Major Medicaid Cut," The Hill December 10, 2012, http://thehill.com/policy/healthcare/272041-white-house-drops-support-for-major-medicaid-cut; Centers for Medicare and Medicaid Services, "Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid," December 10, 2012, https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.

More recently, Congress has begun taking action to rein in another enhanced match provided to states as part of Obamacare. Specifically, Section 2101 of the law provided a 23 percent increase in the federal match to State Children's Health Insurance Programs (SCHIP) across the country.[33] As a result of the increase, Louisiana's SCHIP match rate in the current fiscal year ending September 30 stands at 97.58%, instead of the usual 74.58%.[34] A total of 12 states, plus the District of Columbia, currently receive a 100% match for their SCHIP programs, meaning the federal government effectively funds all of the health costs of these states' SCHIP enrollees.[35]

However, the costs of the enhanced federal SCHIP match on Washington's budget have led Congress to eliminate that enhanced match within the next few years. SCHIP legislation signed into law earlier this month will phase out the enhanced match—lowering the 23 percent match to 11.5 percent in fiscal year 2020, while eliminating it altogether in fiscal 2021.[36] With bipartisan agreement within Congress on eliminating Obamacare's enhanced SCHIP match rate, state lawmakers would do well to consider whether and when Congress will likewise eliminate the enhanced match for Obamacare's Medicaid expansion to the able-bodied.

DIFFICULTIES FOR THE MOST VULNERABLE

In addition to skyrocketing enrollment and costs, the Medicaid expansion has hurt some of the most vulnerable Americans in society, because Obamacare effectively gives state programs financial incentives to discriminate against individuals with disabilities.[37] Traditionally, the federal government provides states with a Medicaid match through a statutory formula comparing a state's average income to the national average. For their traditional beneficiaries—that is, pregnant women, children, the aged, medically frail, and individuals with disabilities—states receive a federal Medicaid match ranging from 50% to 83%. For the current fiscal year, Louisiana will receive a 63.69% match rate for these populations.[38]

However, as noted above, Obamacare gives states a much greater federal match to cover its expansion population—indi-

33. 42 U.S.C. 1397ee(b), as amended by Section 2101(a) of PPACA.

34. Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures," Federal Register November 15, 2016, pp. 80078-80080, Table 1, https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-27424.pdf.

35. Ibid.

36. Section 3005 of the HEALTHY KIDS Act, P.L. 115-120.

37. See also Chris Jacobs, "How Obamacare Undermines American Values: Penalizing Work, Citizenship, Marriage, and the Disabled," Heritage Foundation Backgrounder No. 2862, November 21, 2013, http://www.heritage.org/research/reports/2013/11/how-obamacare-undermines-american-values-penalizing-work-marriage-citizenship-and-the-disabled.

38. "Federal Financial Participation in State Assistance Expenditures."

"Obamacare effectively gives state Medicaid programs financial incentives to discriminate against individuals with disabilities."

viduals with incomes of under 138 percent of the poverty level ($34,638 for a family of four in 2017). For calendar year 2017, states received a 95% federal match, which will fall slightly to 94% in 2018, 93% in 2019, and 90% in 2020.[39] Put another way, Louisiana will receive over 30 cents more on the dollar from the federal government to cover the expansion population this year than it will to cover traditional beneficiaries eligible for Medicaid prior to Obamacare.

This yawning disparity in the federal match favoring expansion enrollees over traditional beneficiaries comes despite noteworthy characteristics of the individuals who qualify for Obamacare's Medicaid expansion. Specifically, the liberal Urban Institute found that nationwide, 82.4% of the expansion population consisted of able-bodied adults of working age.[40] In Louisiana, nearly three-quarters (74.9%) of projected expansion enrollees represented adults without dependent children.[41]

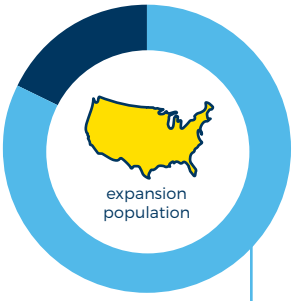
In other words, the federal government offers—and under the current governor, Louisiana accepted—an arrangement whereby states receive a significantly greater federal match to provide services to able-bodied adults of working age than to provide services to the individuals for whom Medicaid was traditionally designed: The medically frail, aged, and individuals with disabilities. Moreover, this disparity comes as many of the latter need critically important services, which they cannot currently obtain from Louisiana's Medicaid program.

While the federal Medicaid statute requires state programs to provide medical coverage to individuals with disabilities, it does not require them to provide personal care services outside a nursing home setting. Because the law makes such home and community-based services (HCBS) optional, states can utilize waiting lists to control access to such services—and many, including Louisiana, do just that. Overall, more than 640,000 individuals with disabilities remain on lists waiting to access HCBS nationwide—including 62,828 in Louisiana.[42]

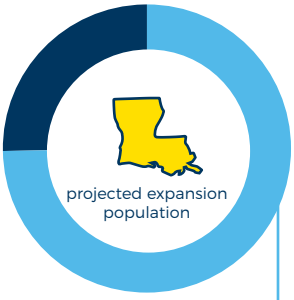
Prior to Louisiana accepting Obamacare's Medicaid expansion to the able-bodied, the state prioritized coverage for individuals with disabilities. Instead of pushing to expand Medicaid under Obamacare, efforts instead focused on providing funds necessary to reduce the state's HCBS waiting list for individuals with disabilities.[43] However, the current administration has taken the exact opposite tack—prioritizing an expansion of coverage for the able-bodied over the personal care needs of the most vulnerable Louisianans. As a result, able-bodied

Federal Match for Medicaid

Louisiana will receive **over 30¢ more** on the dollar to cover the expansion population



82.4% able-bodied adults of working age



74.9% working age adults without dependent children

39. 42 U.S.C. 1396d(y)(1), as codified by Section 2001(a) of PPACA.

40. Genevieve M. Kenney et al., "Opting in to the Medicaid Expansion Under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?" Urban Institute, August 2012, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412630-Opting-in-to-the-Medicaid-Expansion-under-the-ACA.PDF, p. 9, Appendix Table 2.

41. Ibid.

42. Kaiser Family Foundation, "Waiting List Enrollment for Medicaid Section 1915(c) Home- and Community-Based Services Waivers," Kaiser Commission on Medicaid and the Uninsured 2015 survey, http://kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

43. Bobby Jindal, "Obamacare Is Anything But Compassionate," Politico February 9, 2014, http://www.politico.com/magazine/story/2014/02/obamacare-costs-jobs-hurts-most-vulnerable-103299?paginate=false.

adults with low incomes can qualify for Medicaid immediately, while individuals with developmental disabilities must wait an average of seven years just to be evaluated for home-based care for their personal needs.[44]

Several states that expanded Medicaid under Obamacare before Louisiana provide evidence of the damage that expansion has caused for society's most vulnerable. In Arkansas, while Gov. Asa Hutchinson pledged to reduce his state's HCBS waiting lists in half under his administration, the rolls have risen 25 percent—even as the state continues its Medicaid expansion to the able-bodied.[45] Since the state expanded Medicaid to the able-bodied, at least 79 individuals with disabilities have died while on waiting lists seeking access to home-based care.[46]

Vulnerable residents in other states have likewise suffered as a result of Obamacare's Medicaid expansion. In Ohio, the administration of Gov. John Kasich reduced eligibility for 34,000 individuals with disabilities, even while expanding Medicaid to the able-bodied.[47] In Illinois, lawmakers voted to allow Cook County to expand Medicaid early on the same day in which they also voted to reduce medication access for individuals with disabilities.[48] In that state, at least 752 residents with

disabilities have died awaiting access to home-based care since the state embraced Obamacare's Medicaid expansion.[49]

The claims of its proponents to the contrary, any policy that prioritizes able-bodied adults over the most vulnerable in society represents the antithesis of compassion. As more and more individuals crowd on to the Medicaid rolls, literally hundreds of thousands of individuals with disabilities wait for access to care—and in some cases, die well before they receive it. Any compassionate

44. Louisiana Department of Health and Hospitals, "Medicaid Waiver Services," http://www.dhh.la.gov/index.cfm/page/1555.

45. Jason Pederson, "Waiver Commitment Wavering," KATV June 15, 2016, http://katv.com/community/7-on-your-side/waiver-commitment-wavering.

46. Chris Jacobs, "Obamacare Takes Care from Disabled People to Subsidize Able-Bodied, Working-Age Men," The Federalist November 18, 2016, http://thefederalist.com/2016/11/18/obamacare-takes-care-disabled-people-subsidize-able-bodied-working-age-men/.

47. Ibid.

48. Nicholas Horton, "Illinois' Medicaid Expansion Enrollment Continues to Climb, Putting Vulnerable at Risk," Illinois Policy Institute, November 1, 2016, https://www.illinoispolicy.org/illinois-medicaid-expansion-enrollment-continues-to-climb-putting-vulnerable-at-risk/.

49. Nicholas Horton, "Hundreds on Medicaid Waiting List in Illinois Die While Waiting for Care," Illinois Policy Institute, November 23, 2016, https://www.illinoispolicy.org/hundreds-on-medicaid-waiting-list-in-illinois-die-while-waiting-for-care-2/.

society should focus its greatest efforts on protecting the most vulnerable, meaning no state should expand Medicaid to the able-bodied without first having eliminated entirely its waiting list of individuals with disabilities seeking home-based care.

“Any compassionate society should focus its greatest efforts on protecting the most vulnerable.”

While disadvantaging the most vulnerable in society, who literally wait for years for access to personal care paid for by Medicaid, expansion of the Medicaid entitlement also disadvantages the expansion’s purported beneficiaries—able-bodied adults within working age—in several respects. Medicaid generally provides poorer health outcomes than most other forms of coverage, such that some analysts have questioned whether its patients fare worse than the uninsured.[50]

In general, states provide low reimbursement levels to doctors and hospitals treating Medicaid patients, in large part due to the fiscal pressures discussed above. However, these low reimbursement rates mean many medical providers do not accept Medicaid patients. One study found that specialty physicians denied appointments for two-thirds of Medicaid patients, compared to only an 11% denial rate for patients with private insurance. Moreover, “the average wait time for Medicaid” enrollees who did obtain an appointment “was 22 days longer than that for privately insured children.”[51] Through their “secret shopper” survey, the authors “found a disparity in access to outpatient specialty care between children with public insurance and those with private insurance.”

Louisiana does not deviate from the general pattern of state Medicaid programs providing poor reimbursements to physicians, as the state’s reimbursement levels stand slightly below the already low national average. Overall, the state pays physicians 70% of Medicare reimbursement levels, below the national Medicaid average of 72% of Medicare levels.[52] In primary care, Louisiana reimburses doctors at 67% of Medicare rates, one percentage point above the national average of 66%.[53] And in obstetrics, Louisiana reimburses doctors 70% of Medicare rates, eleven points below the national Medicaid average of 81%.[54] The comparatively paltry rates that Louisiana pays obstetricians come despite the fact that nearly two-thirds (65%) of babies born in the

50. Scott Gottlieb, “Medicaid Is Worse than No Coverage at All,” Wall Street Journal March 10, 2011, http://www.wsj.com/articles/SB10001424052748704758904576188280858303612.

51. Joanna Bisgaier and Karin Rhodes, “Auditing Access to Specialty Care for Children with Public Insurance,” New England Journal of Medicine June 16, 2011, http://www.nejm.org/doi/full/10.1056/NEJMsa1013285.

52. Stephen Zuckerman, et al., “Medicaid Physician Fees after the ACA Primary Care Fee Bump,” Urban Institute March 2017, https://www.urban.org/sites/default/files/publication/88836/2001180-medicaid-physician-fees-after-the-aca-primary-care-fee-bump_0.pdf, Table 1, p. 5.

53. Ibid.

54. Ibid.

state in 2015 (i.e., before Medicaid expansion took effect) were paid for by Medicaid—the third highest rate of births paid for by Medicaid nationwide.[55]

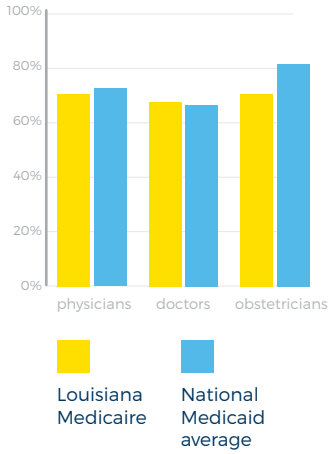
The lack of access to physician care helps explain Medicaid's middling performance in improving health outcomes. Most notably, the Oregon Health Insurance Experiment—which compared the health of individuals randomly selected to enroll in Medicaid with those who remained uninsured—found no measurable improvement in physical outcomes for the former group when compared to the latter.[56] The Oregon study also found that Medicaid beneficiaries utilized the emergency room 40 percent more than uninsured patients, a difference which persisted over time. These data suggest that patients lack a usual access to primary care that could alleviate medical conditions before necessitating emergency treatment—a further indication that Medicaid leaves much to be desired as a form of health coverage.[57]

Both Medicaid administrators and beneficiaries acknowledge the program's shortcomings in providing access to care. One former program head called a Medicaid card a "hunting license"—a government-granted permission slip allowing beneficiaries to try to find a physician who will treat them.[58] With beneficiaries not even considering Medicaid "real insurance," some would question the wisdom of consigning such a large—and growing—number of individuals to a program that provides such an uneven quality of care.[59]

DISCOURAGING WORK

In addition to providing beneficiaries with poor quality care, Medicaid expansion includes an in-built "poverty trap" that discourages entrepreneurship and social advancement. Specifically, the law includes numerous effects that will discourage work, and ultimately keep low-income individuals trapped in poverty for longer periods, while also stunting economic growth. According to the Congressional Budget Office (CBO), the Medicaid expansion represents one part of a larger Obamacare scheme that will reduce the labor supply nationally by the equivalent of 2.5 million full-time jobs by 2024.[60]
CBO believes that Medicaid expansion will reduce overall incentives to work. Most notably, Medicaid expansion creates an "income cliff,"

Physician Reimbursement Rates



55. Kaiser Family Foundation, "Births Financed by Medicaid," State Health Facts, https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22%25%20Births%20Financed%20by%20Medicaid%22,%22sort%22:%22desc%22%7D.

56. Katherine Baicker, et al., "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes," New England Journal of Medicine May 2, 2013, http://www.nejm.org/doi/full/10.1056/NEJMsa1212321.

57. Amy Finklestein et al., "Effect of Medicaid Coverage on ED Use—Further Evidence from Oregon's Experiment," New England Journal of Medicine October 20, 2016, http://www.nejm.org/doi/full/10.1056/NEJMp1609533.

58. Statement by DeAnn Friedholm, Consumers Union, at Alliance for Health Reform Briefing on "Affordability and Health Reform: If We Mandate, Will They (and Can They) Pay?" November 20, 2009, http://www.allhealthpolicy.org/wp-content/uploads/2016/12/TranscriptFINAL-1685.pdf, p. 40.

59. Vanessa Fuhrmans, "Note to Medicaid Patients: The Doctor Won't See You," Wall Street Journal July 19, 2007, https://www.wsj.com/articles/SB118480165648770935.

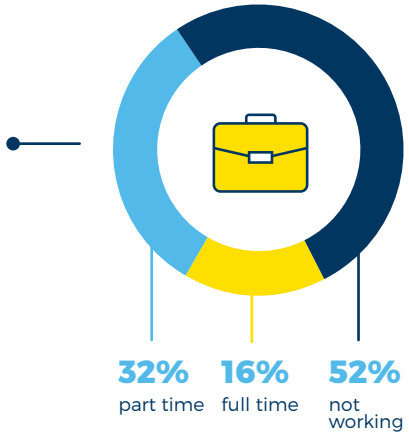
60. Congressional Budget Office, "The Budget and Economic Outlook: 2014 to 2024," February 2014, http://cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf, Appendix C: Labor Market Effects of the Affordable Care Act: Updated Estimates, pp. 117-27.

whereby one additional dollar of income will cause a family to lose Medicaid eligibility entirely—subjecting them to hundreds, if not thousands, of dollars in health insurance premiums, deductibles, and co-payments as a result. As a result, CBO believes that the expansion will reduce beneficiaries' labor force participation by about 4 percent by "creat[ing] a tax on additional earnings for those considering job changes."[61] In other words, individuals will specifically avoid seeking a promotion, additional hours, or a bonus, because it will cause them to lose eligibility for Medicaid—the definition of a "poverty trap" that discourages low-income individuals from advancing their social strata.

Data from the liberal Urban Institute released prior to Obamacare taking effect suggest that most beneficiaries who qualify for Medicaid expansion represent individuals who could be in work, or preparing for work. In Louisiana, more than seven in eight adults who qualify for the expansion are of prime working age—either ages 19-24 (24.5%), 25-34 (25.7%), or 35-54 (37.4%).[62] With nearly three-quarters of Louisianans who qualify for expansion adults without dependent children, as noted above, many of these individuals should be able to work, or prepare for work.

Unfortunately, national data suggest that most beneficiaries enrolled in Medicaid are not working. Specifically, 2015 Census Bureau data indicate that more than half (52%) of non-disabled, working-age Medicaid beneficiaries are not working.[63] Only about one in six (16%) non-disabled Medicaid beneficiaries work full-time year-round, while about one in three (32%) work part-time, or for part of the year.[64]

Employment of Non-Disabled, Working-Age Medicaid Beneficiaries



If able-bodied individuals who currently qualify for Obamacare's Medicaid expansion pursued full-time employment, many of them would no longer qualify for the expansion. The expansion applies to individuals with household income below 138 percent of the federal poverty level—which in 2018 equals $16,753 for a single individual, $22,715 for a couple, and $34,638 for a family of four.[65] At these levels, a couple each working 35 hours per week, 50 weeks per year, making the federal minimum wage of $7.25 per hour, or an individual working 40 hours per week, 50 weeks per year, making $8.50 per hour, would earn enough income to exceed the Medicaid eligibility thresholds.

While CBO believes Medicaid expansion will discourage work, evidence suggests that unwinding the expansion would increase employment, and employment-related search activity. A study of the Medicaid program in Tennessee, where the state scaled back the program

61. Edward Harris and Shannon Mok, "How CBO Estimates Effects of the Affordable Care Act on the Labor Market," Congressional Budget Office Working Paper 2015-09, December 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/workingpaper/51065-ACA_Labor_Market_Effects_WP.pdf, p. 12.

62. Kenney, "Opting in to the Medicaid Expansion," Appendix Table 1, p. 8.

63. Cited in Nic Horton and Jonathan Ingram, "The Future of Medicaid Reform: Empowering Individuals Through Work," Foundation for Government Accountability, November 14, 2017, https://thefga.org/wp-content/uploads/2017/11/The-Future-of-Medicaid-Reform-Empowering-Individuals-Through-Work.pdf, p. 4.

64. Ibid.

65. Department of Health and Human Services, notice regarding "Annual Update of the HHS Poverty Guidelines," Federal Register January 18, 2018, https://www.gpo.gov/fdsys/pkg/FR-2018-01-18/pdf/2018-00814.pdf, , pp. 2642-44.

in 2005 due to significant cost overruns, found that the reduction in Medicaid eligibility encouraged beneficiaries to look for work, and ultimately increased employment, as individuals looked for employment-based coverage.[66] Whereas Obamacare's skewed incentives discourage work, scaling back Medicaid expansion could have salutary economic effects, by expanding the labor force in ways that could grow the economy.

WHAT LAWMAKERS SHOULD DO

The evidence shows the damage caused by Medicaid expansion, both in Louisiana and across the country. Soaring enrollment and higher-than-expected costs have led to fiscal crises in many states—crises that will only grow as states' share of expansion costs increase in the coming years. Meanwhile, the urgent needs of many vulnerable citizens have taken a back seat, as Obamacare gives states more incentives to cover able-bodied adults than individuals with disabilities.

As the legislature considers its policy options, it should focus on both short-term and long-term solutions. In the short term, Louisiana should begin the process of winding down the Medicaid expansion to able-bodied adults, as one way of alleviating immediate budgetary pressures. In the longer term, the state should take advantage of the flexibility promised by the Trump Administration to consider more innovative reforms to the Medicaid program.

Enrollment Freeze:

The best way to end the high costs associated with the Medicaid expansion would involve freezing enrollment to new entrants.[67] Such a policy would allow individuals who already qualified for the expansion to remain as long as they maintain eligibility for the program. This proposal, passed by legislators in places like Ohio and Arkansas, would provide an orderly wind-down of the expansion, reducing costs to the state over time, while allowing people to transition into employer-sponsored insurance or other coverage as they lose Medicaid eligibility. [68]

One study released in early 2017 calculated the savings from a nationwide Medicaid freeze beginning in fiscal year 2018.

66. Craig Garthwaite, Tal Gross, and Matthew Notowidigdo, "Public Health Insurance, Labor Supply, and Employment Lock," National Bureau of Economic Research, NBER Working Paper 19220, July 2013, http://www.nber.org/papers/w19220.

67. Chris Jacobs, "Putting Obamacare in a Deep Freeze," National Review December 7, 2016, http://www.nationalreview.com/article/442820/obamacare-repeal-replace-enrollment-freeze-first-step.

68. Kim Palmer, "Ohio Lawmakers Vote to Freeze Medicaid Expansion," Reuters June 28, 2017, https://www.reuters.com/article/us-ohio-budget/ohio-lawmakers-vote-to-freeze-medicaid-expansion-idUSKBN19K0B8; Caleb Taylor, "House Passes Medicaid Expansion Freeze," The Arkansas Project March 1, 2017, http://www.thearkansasproject.com/house-passes-medicaid-expansion-freeze/.

> **"Soaring enrollment and higher-than-expected costs have led to fiscal crises in many states... Meanwhile, many vulnerable citizens have taken a back seat."**

Over a decade, this Medicaid freeze would generate approximately $56-64 billion in savings to state Medicaid programs, along with more than half a trillion dollars in savings to the federal government.[69] These savings would come ***without*** terminating Medicaid participation for a single beneficiary currently eligible for the program. The sizable savings provided to both the states and the federal government under a potential Medicaid freeze illustrates the need to wind down Medicaid's expansion to the able-bodied in an orderly way, to restore the program's focus to the populations for which it was originally intended.

Comprehensive Waiver:

Last March, then-Health and Human Services Secretary Tom Price and CMS Administrator Seema Verma sent a letter to the nation's governors indicating their desire to expand state flexibility within the Medicaid program.[70] Since then, several organizations have published reports highlighting elements and policies that states could use to reform their Medicaid programs.[71] A bold waiver incorporating many of these policies could transform Medicaid programs across the country.

Louisiana should consider submitting a comprehensive waiver request to CMS. Such a waiver could include:

- **Consumer-Oriented Options:** Using Health Savings Account-like mechanisms would encourage beneficiaries to serve as smart shoppers of health care—generating savings that they could use once they leave the Medicaid program. Whether through Health Opportunity Accounts—an innovation passed by Congress in 2005, but effectively repealed under the Obama Administration—"right-to-shop" programs that give beneficiaries a chance to share in the savings from obtaining lower costs for non-emergency medical procedures, or other programs, giving beneficiaries financial incentives to act as smart health care consumers could benefit them as well as the Medicaid program.[72]

- **Wellness Incentives:** As with the consumer options above, providing incentives for healthy behaviors would encourage beneficiaries to improve their health, while giving them a potential source of financial savings. During the debate on Obamacare in 2009-10, wellness incentives proved one of the few sources of bipartisan agreement, thanks to the way in which Safeway and other

"This Medicaid freeze would generate approximately $56-64 billion in savings to state Medicaid programs, along with more than half a trillion dollars in savings to the federal government."

69. Foundation for Government Accountability, "Freezing Medicaid Expansion Enrollment Will Save Taxpayers More Than Half a Trillion," February 2017, https://thefga.org/wp-content/uploads/2017/02/MedEx-Freeze-Savings-Table.pdf.

70. Letter by Health and Human Services Secretary Tom Price and Centers for Medicare and Medicaid Services Administrator Seema Verma to state governors regarding Medicaid reform, March 14, 2017, https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf.

71. See for instance Chris Jacobs, "Reforming Medicaid to Serve Wyoming Better," Wyoming Liberty Group Wyoming Policy Review Issue 101, June 2017, https://wyliberty.org/images/PDFs/Wyoming_Policy_Review-Jacobs-Reforming_Medicaid-101.pdf, and Naomi Lopez Bauman and Lindsay Boyd, "Medicaid Waiver Toolkit," State Policy Network, August 2017.

72. 42 U.S.C. 1396u-8, as codified by Section 6082 of the Deficit Reduction Act of 2005, P.L. 109-171; Section 613 of the Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3; Josh Archambault and Nic Horton, "Right to Shop: The Next Big Thing in Health Care," Forbes August 5, 2016, http://www.forbes.com/sites/theapothecary/2016/08/05/right-to-shop-the-next-big-thing-in-health-care/#6f0ebcd91f75.

firms reduced health costs through such reforms.[73] Particularly given the state's high rates of obesity, Louisiana should consider bringing the "Safeway model" to the state's Medicaid program.[74]

- **Premium Assistance:** Providing more flexible benefits to individuals with an offer of employer-sponsored coverage would allow Medicaid to supplement that coverage, thereby reducing costs and giving individuals access to higher-quality private insurance. Other policies in this vein might include a beneficiary waiting period designed to prevent "crowd-out"—individuals dropping private coverage to enroll in government programs—and Health Savings Account coverage, currently prohibited under two separate premium assistance programs.[75] These changes would help beneficiaries make a smoother transition off of the Medicaid rolls and into a life of work.

- **Home and Community-Based Services:** Focusing on ways to deliver care to beneficiaries outside of nursing homes could reduce costly Medicaid spending in institutional settings. Most importantly, it would enable patients to stay in their homes—most beneficiaries' desired outcome. For instance, a state waiver could cap the number of nursing home slots available, or require beneficiaries to try receiving care at home prior to entering a nursing facility.[76] Collectively, these policies should create an affirmative bias in favor of care at home, rather than care at a nursing institution.

- **Work Requirements:** Unlike the Obama Administration, the Trump Administration has indicated a willingness to accept work requirements as part of a Medicaid waiver request.[77] Earlier this month, CMS issued a letter to state Medicaid directors indicating parameters to guide states as they prepare community engagement requirements—a document that reiterated the positive effects that work can have on beneficiaries' economic success, self-sufficiency, and overall health.[78] Requiring that appropriate adult populations either work, look for work, or prepare for work, while exempting individuals with disabilities and other medically frail individuals, would further promote a transition from welfare into work.

- **Program Integrity:** Verifyinwg eligibility on a regular basis would ensure that state and federal resources remain targeted to those

73. Steven Burd, "How Safeway is Cutting Health Care Costs," Wall Street Journal June 12, 2009, http://www.wsj.com/articles/SB124476804026308603.

74. Louisiana currently ranks fifth in the nation for adult obesity, with an obesity rate of 35.5%. See Trust for America's Health, "The State of Obesity," https://stateofobesity.org/states/la/.

75. 42 U.S.C. 1397ee(c)(10)(B)(ii)(II) and 42 U.S.C. 1396e-1(b)(2)(B), as codified by Section 301 of CHIPRA.

76. See for instance testimony of Patti Killingsworth, TennCare Chief of Long-Term Supports and Services, before the Commission on Long-Term Care on "What Would Strengthen Medicaid LTSS?" August 1, 2013, http://ltccommission.org/ltccommission/wp-content/uploads/2013/12/Patti-Killingsworth-Testimony.pdf. The author served as a member of the Commission.

77. Mattie Quinn, "On Medicaid, States Won't Take Feds' No for an Answer," Governing October 11, 2016, http://www.governing.com/topics/health-human-services/gov-medicaid-waivers-arizona-ohio-cms.html.

78. Centers for Medicare and Medicaid Services, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," State Medicaid Director letter SMD-18-002, January 11, 2018, https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf

most in need—an important priority given the way in which scam artists in Louisiana have sought to abuse the Medicaid program.[79] Increasing penalties for fraud would halt scam artists, and could lower Medicaid's rate of improper payments.[80] More robust asset recovery measures—ensuring Medicaid remains the payer of last resort, not that of first instance—would help preserve scarce state and federal resources for those who need them most.[81]

The state of Rhode Island demonstrates the power of a comprehensive waiver to transform a Medicaid program. Its global compact waiver, approved in the waning days of President George W. Bush's Administration in January 2009, allowed that state to improve Medicaid by providing more, better, and more timely care to beneficiaries. Thanks to the global compact waiver, Rhode Island actually reduced its per beneficiary Medicaid costs in absolute (i.e., before-inflation) terms over a four-year period[82]—and did so not by cutting access to care, but by improving it.[83] The success of the Rhode Island experiment illustrates the way in which Medicaid reform, done right, can simultaneously save money and improve health—a lesson the legislature should look to bring to Louisiana.

CONCLUSION

Given the state's structural budget shortfall, and the significant costs associated with Medicaid expansion, Louisiana stands at a turning point. The legislature could continue down their current path, and hope that yet another series of tax increases will sate the growing health care costs that threaten to consume the state's entire budget.

Thankfully, legislators have another option. Unwinding the Medicaid expansion gradually, while laying the groundwork to submit a comprehensive Medicaid waiver request to CMS, would in combination help turn the fiscal tide. Freezing Medicaid enrollment for able-bodied adults would re-direct the program towards the most vulnerable in society—those for whom Medicaid was originally designed. Likewise, a comprehensive waiver would re-orient and update Medicaid for a 21st century health care system, saving money by providing better care.

Given the two options, the choice for Louisiana seems clear. The state should use the flexibility promised by Washington to unwind Medicaid expansion for the able-bodied, and modernize and re-orient the program toward the program's original intended beneficiaries. By so doing, the state can go a long way towards resolving its structural fiscal shortfalls, while also improving the care provided to some of Louisiana's most vulnerable residents.

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79. Louisiana Office of the Attorney General, "Over $2 Million in Medicaid Fraud Uncovered in New Orleans," October 16, 2017, https://www.ag.state.la.us/Article/3470/5.

80. Jonathan Ingram, "Stop the Scam: How to Prevent Welfare Fraud in Your State," Foundation for Government Accountability, April 2, 2015, https://thefga.org/wp-content/uploads/2015/04/Stop-The-Scam-research-paper.pdf.

81. See for instance Government Accountability Office, "Medicaid: Additional Federal Action Needed to Further Improve Third Party Liability Efforts," GAO Report GAO-15-208, January 2015, http://gao.gov/assets/670/668134.pdf.

82. Testimony of Gary Alexander, former Rhode Island Secretary of Health and Human Services, on "Strengthening Medicaid Long-Term Supports and Services" before the Commission on Long Term Care, August 1, 2013, http://ltccommission.org/ltccommission/wp-content/uploads/2013/12/Garo-Alexander.pdf.

83. Lewin Group, "An Independent Evaluation of Rhode Island's Global Waiver," December 6, 2011, http://www.ohhs.ri.gov/documents/documents11/Lewin_report_12_6_11.pdf.

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