Protecting Health Coverage in Louisiana Task Force

Final Report

Gov. John Bel Edwards established the Protecting Health Coverage in Louisiana Task Force through Executive Order Number JBE 19-4 (with amendments in Executive Order JBE 19-11). The Task Force was charged with studying the impacts of the loss of health coverage and health protections that will occur if the *Texas v. United States* lawsuit is successful, thus ending some or all of the provisions of the Affordable Care Act (ACA). This report summarizes the impact and outlines how Louisiana law compares to current federal protections. In addition, the report shows the fiscal costs involved if *Texas v. United States* is successful, thus providing a roadmap of both the policies and funding needed to maintain health coverage and health protections for Louisianans.

The task force met four times and heard reports and analysis from Stephen Barnes of the University of Louisiana, Sarah Balog of the Leukemia and Lymphoma Society, Korey Harvey of Blue Cross Blue Shield, and Stacey Roussel of the Louisiana Budget Project, among others.

KEY TAKEAWAYS:

- Louisiana stands to lose $3.6 billion from the federal government if the Affordable Care Act is invalidated, with an estimated 494,000 Louisianans losing health coverage.
- The outcome of *Texas v. United States* could invalidate some or all of the provisions of the ACA, making it difficult to quantify the exact funding necessary today to ensure no change in health coverage status for Louisianans.
- It would cost more than $536 million for Louisiana to “backfill” the loss of federal subsidies for those enrolled in the federal marketplace and keep key pre-existing condition protections, as imagined in Act 412 of the 2019 Regular Legislative Session. Without this funding, key individual market pre-existing condition protections do not exist.
- Without additional funding from the federal government or additional action from Congress, if *Texas v. United States* is successful, the state would be left to fill budget holes, Medicaid coverage for working adults would be diminished or cut altogether and Louisiana’s uninsured rate would be at risk of going from a historic low of 8 percent in 2018 back to pre-ACA levels, which were more than 17 percent.

Protecting Health Coverage in Louisiana Task Force

Members of the Task Force:

- **Lance Barbour**, *Louisiana Government Relations Director for the American Cancer Society Action Network (At-large appointee representing a consumer health group)*
- **Stephen Barnes**, PhD, *Director, Kathleen Babineaux Blanco Public Policy Center, University of Louisiana at Lafayette (At-large appointee with expertise in economics)*
- **Senator Regina Barrow***, (Senate Health & Welfare Committee designee)*
- **Matthew Block**, *Governor's Executive Counsel (Governor's designee)*
- **Jeanie Donovan**, *Policy Director at Louisiana Department of Health (Secretary of Health's designee)*
- **Jeff Drozda**, *CEO at the Louisiana Association of Health Plans (At-large appointee representing the insurance industry)*
- **Korey Harvey**, *Vice President and Deputy General Counsel at Blue Cross and Blue Shield of Louisiana (At-large appointee representing the insurance industry)*
- **Beverly Haydel**, *President/CEO, Sequitur Consulting (Attorney General's designee)*
- **Christina Lord,** MD, *Physician (At-large appointee representing health care providers)*
- **Tiffany Netters**, *Executive Director, 504HealthNet (At-large appointee representing a consumer health group)*
- **Frank Opelka**, *Deputy Commissioner of Health, Life, & Annuity at Louisiana Department of Insurance (Commissioner of Insurance's designee)*
- **Representative Joe Stagni**, *(House Health & Welfare designee)*

General Background

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA), which was signed into law on March 23, 2010. The law was designed to expand health insurance coverage and implemented a number of patient protections. The law accomplished this by introducing a series of requirements for individuals, employers and insurers and by offering states an opportunity to expand the Medicaid program with costs predominantly borne by the federal government. These goals were supported by a significant commitment of federal dollars generated through new taxes and fees targeted primarily at the pharmaceutical and insurance sectors. Since the passage of the law, the number of Americans without health benefits has fallen dramatically, especially in states like Louisiana that expanded Medicaid under the ACA.

Estimates from the U.S. Census Bureau's American Community Survey show a steady decrease in Louisiana's overall uninsured rate since the enactment of the ACA. This data shows the uninsured rate

dropping from 17.8 percent in 2010 to 8.0 percent in 2018.[1] In 2015, the LSU Health Insurance Survey showed an uninsured rate of 22.7 percent for adults. Due to the ACA's individual and group market subsidies and protections along with the state's adoption of Medicaid expansion in 2016, the LSU Health Insurance Survey found that the uninsured rate was cut in half by 2017 to 11.4 percent. According to the survey, the number of uninsured adults in Louisiana fell from 644,217 to 321,477 between 2015 and 2017.[2] The Urban Institute estimates that 494,000 fewer Louisianans would have health insurance if the ACA is overturned.[3]

Texas v. United States background/status

A group of twenty states, led by Texas and including Louisiana, sued the federal government in February 2018, challenging the constitutionality of the Affordable Care Act in its entirety. Since the initial suit was filed, two states have withdrawn from the lawsuit.

The plaintiffs, including Louisiana Attorney General Jeff Landry, argue that the statutorily required shared responsibility payment of zero dollars for individuals who fail to maintain minimum essential coverage (commonly referred to as the individual mandate) is unconstitutional. In *NFIB v. Sebelius* the Supreme Court of the United States found that the individual mandate could not pass constitutional muster under the Commerce Clause but could be read with a "saving construction" which is permissible under the taxing power whereby the individual mandate serves only as a condition triggering the valid tax represented by the shared responsibility payment.[4] The *Texas v. United States* plaintiffs reason that the decision to reduce the shared responsibility payment to zero dollars in the 2017 Tax Cuts and Jobs Act precludes the continued use of this saving construction to uphold the constitutionality of the individual mandate under the taxing power. Plaintiffs argue that the entire ACA should fall along with

[1] Stacey Roussel, "Louisiana's uninsured rate remains low as national rate rises." September 10, 2019. https://www.labudget.org/2019/09/louisianas-uninsured-rate-remains-low-as-national-rate-rises/

[2] Stephen R. Barnes et al., "Louisiana Health Insurance Survey 2017," http://ldh.la.gov/assets/media/2017-Louisiana-Health-Insurance-Survey-Report.pdf.

[3] Linda J. Blumberg, Matthew Buettgens, John Holahan, Clare Pan. "State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA." The Urban Institute. March 2019. https://www.urban.org/sites/default/files/publication/100000/repeal_of_the_aca_by_state_2.pdf (see page 9)

[4] NFIB v. Sebelius, Supreme Court of the United States, https://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf

the individual mandate. In their filing, the plaintiff states note that if the court will not go this far, the court should "at the very minimum" strike down the core preexisting condition protections – guaranteed issue and community rating.

Those defending the law point out that in NFIB, the Supreme Court wrote that the shared responsibility payment provides people "a lawful choice" of whether or not to purchase health insurance. That lawful choice remains today, they argue, with the caveat that now the statutorily required tax amount set by the 2017 Congress is zero dollars.

On December 14, 2018, District Judge Reed O'Connor agreed with the plaintiff states in full, declaring the individual mandate unconstitutional and deciding that the entire law should fall along with the mandate. On December 18, 2019, the Fifth Circuit Court of Appeals affirmed the District Court's decision regarding the constitutionality of the individual mandate but sent the case back to Judge O'Connor for a more thorough analysis of what provisions would be severed along with the individual mandate. The Fifth Circuit does not provide any analysis of its own, stating:

> *"It may still be that none of the ACA is severable from the individual mandate, even after this inquiry is concluded. It may be that all of the ACA is severable from the individual mandate. It may also be that some of the ACA is severable from the individual mandate, and some is not."*[5]

In light of the federal government's decision not to defend the law, a group of states, led by California, along with the U.S. House of Representatives intervened. Amicus briefs filed siding with intervenor states include: the American Hospital Association, the Federation of American Hospitals, the Catholic Health Association of the United States, America's Essential Hospitals, the Association of American Medical Colleges, the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, America's Health Insurance Plans, the American Cancer Society, American Diabetes Association, American Lung Association, and March of Dimes.[6]

[5] Texas v. Azar, United States Court of Appeals for the Fifth Circuit, https://www.ca5.uscourts.gov/opinions/pub/19/19-10011-CV0.pdf

[6] See page 2 of this fact sheet from the Center on Budget and Policy Priorities: https://www.cbpp.org/sites/default/files/atoms/files/11-4-19health2.pdf

Following the Fifth Circuit's decision, the intervening states petitioned the Supreme Court of the United States to review the case to relieve the "uncertainty over the future of the healthcare sector." A decision by the Supreme Court on whether or not to take the case is pending.[7]

Medicaid expansion and preexisting condition protections in Louisiana

The consequences of a full invalidation of the ACA, as the plaintiffs seek, would have profound and complex consequences in Louisiana. The Medicaid expansion population represents a strong example of the scale of this effect. To date, approximately 456,000 people are enrolled in Louisiana Medicaid by virtue of their eligibility under Medicaid expansion,[8] supported in part by federal spending of approximately $3.5 billion in Medicaid matching funds at the enhanced expansion match rate.

While some Medicaid enrollees with insurance through expansion would have access to other sources of Medicaid or private insurance coverage, the effect would be significant and beyond the state's means to fully address without significant supplemental federal funding. An LSU report released in August of 2019 showed that expansion is supporting more than 14,000 jobs across Louisiana, and a Tulane report shows improvements in access to care from expansion.[9]

Beyond expansion, the ACA is both the primary source of individual market preexisting condition protections and an important supplement to the existing group market preexisting condition protections provided by the federal Health Insurance Portability and Accountability Act (HIPAA) and by state law. While most individuals with health benefits in Louisiana participate in the group markets or receive government-sponsored benefits, the ACA's preexisting condition protections represent an important safety net for anyone needing individual coverage. Additionally, the ACA built upon HIPAA's portability provisions in the group markets by restricting waiting periods to 90 days and eliminating much of the need to continuously maintain creditable coverage to receive preexisting condition protections.

As of April 8, 2019, 125,551 Louisianans received health insurance through the individual market.[10] The most recent Kaiser Family Foundation estimates show that 932,000 non-elderly adult Louisianans have a

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[7] See: https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/19-840.html

[8] LDH Medicaid Expansion Dashboard. Results as of December 16, 2019. http://www.ldh.la.gov/HealthyLaDashboard/

[9] See: http://ldh.la.gov/index.cfm/newsroom/detail/5255

[10] Louisiana Department of Insurance

"declinable preexisting condition" based on pre-ACA underwriting practices, which is about 33 percent of the non-elderly adult population in Louisiana.[11] While most Louisianans access health insurance through their employer or receive government-sponsored insurance, a change in job or health care status could mean a person with a preexisting condition who is currently covered would not be able to access adequate coverage through the individual market in the future.

Act 412

During the 2019 Regular Session, Sen. Fred Mills introduced SB 173 (signed into law as Act 412)[12] in collaboration with the Attorney General's office and the Louisiana Department of Insurance. The bill included a number of provisions which would only be applicable if the premium tax credit authorized by the ACA is "held to be valid by a court of competent jurisdiction or is otherwise enforceable at law, or unless adequate appropriations are timely made by the federal or state government in an amount that is calculated in a similar manner as the tax credit in Section 1401 of the Patient Protection and Affordable Care Act." In other words, Act 412's key preexisting condition protections would only kick in if courts give a partial ruling that strikes down existing protections but leaves in place federal funding, or if Congress subsequently sends states hundreds of millions of dollars to uphold tax credits. Without additional or replacement state or federal funding, key parts of Act 412 will never go into effect. Provisions contingent upon funding include the prohibition on preexisting condition exclusions and the requirement of essential health benefits. A table with a full summary of ACA provisions compared to current Louisiana law is included in the subsequent section.

Sen. Mills presented the bill in the Senate Health and Welfare Committee initially on April 24, 2019 and deferred the bill for one week. Sen. Mills saw that the Committee was unlikely to approve the bill after facing numerous questions about how it would be funded.

The major amendment added to the bill on May 1 was the Guaranteed Benefits Pool, a provision that did not solve the problem of lack of funding. This section provided for the Louisiana Department of Insurance to conduct a study and create a framework for an invisible high risk pool and to review other

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[11] "Estimated Number of Nonelderly Adults with Declinable Pre-existing Conditions under Pre-ACA Practices," https://www.kff.org/other/state-indicator/estimated-number-of-non-elderly-adults-with-declinable-pre-existing-conditions-under-pre-aca-practices/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[12] SB 173/Act 412, http://www.legis.la.gov/legis/BillInfo.aspx?i=236231

states' experiences with high risk pools. A significant amount of discussion in committee focused on Maine's Guaranteed Access Reinsurance Association.[13] During the committee debate, Commissioner of Insurance Jim Donelon also discussed the reinsurance proposal his office supported during the 2018 legislative session, which died in the Legislature after the bill passed the House but was not successful in the Senate. The Guaranteed Benefits Pool is a form of reinsurance policy, by which insurers who take on costlier members are able to receive compensation from the pool, thus allowing insurers to keep their premiums down.

Commissioner Donelon noted that there was $100 million of federal money available to help finance the pool along with state funds.[14] These funds, however, are available through the ACA, which *Texas v. United States* seeks to invalidate. To date, 12 states have received federal approval of their reinsurance proposals.[15] The similarities between reinsurance and the Guaranteed Benefits Pool were also discussed during the Protecting Health Coverage in Louisiana Task Force Meetings. Commissioner Donelon's designee, Deputy Commissioner Frank Opelka, discussed some of the stakeholder comments submitted on the Guaranteed Benefits Pool. The comments reflected many of the positions taken by stakeholders on the 2018 reinsurance bill.

The Employee Retirement Income Security Act (ERISA) provides that states cannot regulate employer-sponsored plans that are "self-funded," meaning that the employer is responsible for paying for their employees' health care. These so-called "ERISA plans" expressed concern over being subject to the assessment that would fund the Guaranteed Benefits Pool. Deputy Commissioner Opelka reported that LDI is evaluating funding models with assessments that both include and exclude the ERISA plans. Act 412 charges LDI with submitting the actuarial analysis for the Guaranteed Benefits Pool by March 1, 2020 to the Joint Legislative Committee on the Budget. Any new assessment would need to be passed by the Legislature in order to fund and implement the Guaranteed Benefits Pool. The source of the funds has not yet been identified.

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[13] See Maine's 1332 waiver application to CMS: https://www.shadac.org/publications/resource-state-based-reinsurance-programs-1332-state-innovation-waivers

[14] Donelon testimony, Senate Health & Welfare, May 1, 2019.

[15] State Health Access Data Assistance Center, "State-Based Reinsurance Programs via 1332 State Innovation Waivers," https://www.shadac.org/publications/resource-state-based-reinsurance-programs-1332-state-innovation-waivers

Current status of ACA provisions in Louisiana law

Some pieces of the ACA are now included in Louisiana law, although many of them are triggered only under circumstances requiring significant funding by the federal government or state legislature. This section provides definitions for the ACA's preexisting condition protections and two tables. The first table compares the ACA preexisting condition provisions with current Louisiana law, while the second summarizes other ACA provisions that would be lost if the entire law is wiped away by the courts.

Georgetown University's Center for Health Insurance Reforms provides the following definitions for the ACA's protections[16]:

- *Guaranteed issue*. Health insurers are prohibited from denying an individual or employer group a policy based on their health status.
- *Community rating*. Health insurers may not use an individual or small employer group's health status to set premiums, and the small group market and individual markets exist as single risk pools, which spreads the risk of all claims among all individuals and groups.
- *Preexisting condition exclusions.* Health insurers and employer group plans are prohibited from refusing to cover services needed to treat a preexisting condition.
- *Essential health benefits*. Health insurers selling to individuals and small employers must cover a minimum set of 10 "essential" benefits: ambulatory services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; and pediatric services, including oral and vision care.
- *Cost-sharing protections*. Health insurers and employer group plans must cap the amount enrollees pay out-of-pocket for health care services each year.
- *Annual and lifetime limits*. Health insurers and employer group plans are prohibited from imposing annual or lifetime dollar limits on essential health benefits.
- *Preventive services*. Health insurers and employer group plans are required to cover evidence-based preventive services without any enrollee cost-sharing.

[16] Sabrina Corlette and Emily Curran, "Can States Fill the Gap if the Federal Government Overturns Preexisting-Condition Protections?" October 29, 2019, https://www.commonwealthfund.org/blog/2019/can-states-fill-gap-preexisting-condition-protections

- *Nondiscrimination*. Health insurers must implement benefit designs for individuals and small employers that do not discriminate based on age, disability, or expected length of life.

Only two ACA protections – dependent coverage for children 25 or younger along with a prohibition on lifetime and annual limits – are fully enshrined in Louisiana law. Most provisions are contingent upon funding from the federal government.

TABLE 1: Affordable Care Act Preexisting Condition Protections and Current Louisiana Law

Policy	**Does Louisiana law replicate ACA protections if the ACA is repealed?**	**Notes and Revised Statute citations**
Guaranteed issue	No	Louisiana law provides for availability of coverage for individuals with continuous coverage. ***RS 22:1073 and RS 22:1074***
Community rating	Uncertain	If “adequate appropriations are timely made,” Act 412’s age rating provision triggers which would allow insurers to charge older adults 5 times as much as younger adults. If the appropriations are not made, the current 3:1 ratio for age rating would remain, as it is both part of the ACA and included in current Louisiana law. ***RS 22:1095, RS 22:1126***
Preexisting condition exclusions	Not unless “adequate appropriations are timely made.”	***RS 22:1062, RS 22:1067, RS:1072, RS 10:74, RS 1095, RS 22:1123*** ***Note: “Adequate appropriations” are estimated at being more than $500 million by the Legislative Fiscal Office.***
Essential Health Benefits	Not unless “adequate appropriations are timely made”	***RS 22:1128*** ***Note: “Adequate appropriations” are estimated at being more than $500 million by the Legislative Fiscal Office.***
Cost-sharing protections	No	Act 412 instructs the Commissioner of Insurance to promulgate rules on cost sharing if the ACA is repealed and “adequate appropriations are timely made” ***RS 22:1128***

Annual and lifetime limits	Yes	Instituted by Act 212 of 2019 Regular Session ***RS 22:1066.1***
Preventive services	No	Act 412 instructs the Commissioner of Insurance to promulgate rules on cost sharing if the ACA is repealed and "adequate appropriations are timely made" ***RS 22:1128***
Nondiscrimination	No	
Coverage for dependent children	Yes	Instituted by Act 912 of 2010 Regular Session

The Affordable Care Act includes numerous other provisions beyond the preexisting condition protections. These provisions are not a part of state law.

TABLE 2: Summary of Key Coverage-Related and Other Provisions of the ACA
Adapted from Kaiser Family Foundation[17]

Provision	Description
Medicaid Eligibility Expansion	Medicaid eligibility is expanded to include adults with income up to 138% of the Federal Poverty Level (FPL); however, the Supreme Court ruling in 2012 essentially made Medicaid expansion optional for states.
Subsidies for Non-Group Health Insurance	Eligible individuals who buy coverage through the Marketplace receive subsidies based on income: premium tax credits for those with income 100-400% FPL; cost-sharing subsidies for those with income 100-250% FPL.
Health Insurance Marketplace	Establish new marketplaces where qualified health plans are offered to individuals. Marketplaces certify that qualified health plans meet all ACA requirements, provide subsidies to eligible individuals, operate healthcare.gov to facilitate application and comparison of health plans,

[17] "Potential Impact of Texas v. U.S. Decision on Key Provisions of the Affordable Care Act," https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/

	provide a no-wrong-door application process for individuals to determine their eligibility for financial assistance, and provide in-person consumer assistance through navigators.
Minimum Medical Loss Ratios	Require all non-grandfathered private plans to pay a minimum share of premium dollars on clinical services and quality. Insurers must provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets.
Consumer Information and Transparency	All non-grandfathered health plans must provide a brief, standardized summary of coverage written in plain language. All non-grandfathered health plans must periodically report transparency data on their operations (e.g., number of claims submitted and denied).
Large Employer Mandate	Requires employers with at least 50 full time workers to provide health benefits or pay a tax penalty.
Waiting Periods	Employers that impose waiting periods on eligibility for health benefits (e.g., for new hires) must limit such periods to no more than 90 days.
State Consumer Assistance Programs	Authorize federal grants for state Consumer Assistance Programs to advocate for people with private coverage. Notice of claims denials by non-grandfathered private plans must include information about state CAPs that will help consumers file appeals.
Simplification of the Enrollment Process	States are required to simplify Medicaid and CHIP enrollment processes and coordinate enrollment with state health insurance exchanges.
Long-Term Care Services and Supports	Expands financial eligibility for 1915(i) home and community-based services (HCBS), creating a new eligibility pathway to allow people not otherwise eligible to access full Medicaid benefits, allows states to target services to specific populations, and expands the services covered. Creates a new Medicaid state plan option to cover attendant care services and supports with 6% enhanced Federal Medical Assistance Percentage (FMAP).
Behavioral Health Parity	Mental health and substance use disorder services must be included in Medicaid Alternative Benefit Packages (ABPs) provided to Medicaid

	expansion adults and other adults, and the services must be covered at parity with other medical benefits.
Medicaid Eligibility for Former Foster Care Youth up to Age 26	Requires states to provide Medicaid to young adults ages 21 through 26 who were formerly in foster care.
Medicaid Drug Rebate Percentage	Increase Medicaid drug rebate percentage for most brand name drugs to 23.1% and increase Medicaid rebate for non-innovator multiple source drugs to 13%. Extend drug rebate program to Medicaid MCOs.
Medicare Provisions	
Part D Coverage Gap	Gradually close the Medicare Part D coverage gap ("donut hole"): Phase down the beneficiary coinsurance rate for brand and generic drugs in the Medicare Part D coverage gap from 100% to 25% by 2020. Require drug manufacturers to provide a 50% discount on the price of brand-name and biologic drugs in the coverage gap. Reduce the growth rate in the catastrophic coverage threshold amount between 2014 and 2019 to provide additional protection to enrollees with high drug costs. Has been partially updated by the 2018 Bipartisan Budget Act.
Preventive Services	Eliminate cost sharing for Medicare covered preventive services. Authorize coverage of annual comprehensive risk assessment for Medicare beneficiaries.
Cost Sharing in Medicare Advantage (MA)	Prohibit MA plans from imposing higher cost-sharing requirements than traditional Medicare for chemotherapy, renal dialysis, skilled nursing care, and other services deemed appropriate by the Secretary of HHS. This prohibition was extended to most Medicare-covered services
Restructure Medicare Advantage Payments	Reduce federal payments to Medicare Advantage plans to bring payments closer to the average Medicare spending for beneficiaries in traditional Medicare. Provide quality-based bonus payments to Medicare Advantage plans.

	Require Medicare Advantage plans to maintain a medical loss ratio of at least 85 percent.
Other Provider Payments	Reduce the rate at which Medicare payment levels to hospitals, skilled nursing facilities, hospice and home health providers, and other health care providers are updated annually. Allow providers organized as Accountable Care Organizations (ACOs) that meet quality thresholds to share in cost savings they achieve for the Medicare Program.
Medicare Income-related Premiums	Freeze threshold for income-related Medicare Part B premiums for 2011 through 2019. Establish new income-related premium for Part D, with the same thresholds as the Part B income-related premium. Has been partially updated by 2018 Bipartisan Budget Act.
Other Provisions	
FDA Approval of Biosimilars	The U.S. Food and Drug Administration (FDA) is authorized to approve generic version of biologics (biosimilars) and grant biologics manufacturers 12 years of exclusive use before generics can be developed.
Innovation Center	Establishes innovation Center within the Center for Medicare and Medicaid Services (CMS) to test, evaluate and expand different payment structures and methods to save costs while maintaining or improving quality of care.
Prevention and Public Health Fund	This fund supports activities related to prevention, wellness and public health activities.
Nonprofit Hospitals	Requires non-profit hospitals to do the following to maintain their tax-exempt status: Conduct a community needs assessment every 3 years and adopt a strategy to meet identified needs. Adopt and widely publicize financial assistance policies on the availability of free or discounted care and how to apply.

	Limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients. Make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions.
Breastfeeding breaks and separate rooms	Employers with 50 or more employees must now provide adequate break time for breastfeeding women and a private space that is not a bathroom for nursing and pumping.
Nondiscrimination	The ACA prohibits discrimination against individuals on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities, under Section 1557, which builds on long-standing and familiar Federal civil rights laws. In addition to enforcement by the Office of Civil Rights at the US Department of HHS, individuals can file a civil lawsuit to challenge a nondiscrimination violation under Section 1557.
Menu labeling	Restaurants and retail food establishments with 20 or more locations and owners of 20 or more vending machines must include nutrition information, including calories, for their standard menu items.

Fiscal considerations and conclusions

The Louisiana Department of Health reports that based on the Fiscal Year 2020 forecast, the state would lose $3.5 billion from the federal government associated with Medicaid expansion if the ACA is invalidated.

In addition, the Legislative Fiscal Office – in consultation with the Louisiana Department of Insurance – included an analysis of the level of state funding necessary to “backfill” the loss of federal subsidies. Based upon 92,948 enrollees in the individual market with 91% of these enrollees receiving a premium tax credit, the LFO estimated a $536.18 million cost to the state in order to maintain the preexisting condition protections included in Act 412 (outlined in Table 1 above). [18]

Blue Cross Blue Shield of Louisiana had a similar but slightly lower estimate of the individual market fiscal impact. In a white paper, BCBSLA estimated that the cost to maintain advanced premium tax credits would be $437 million and the cost to maintain cost sharing reductions at $45 million for a total of $482 million.

[18] SB 173 Fiscal note, see page 2, June 1, 2019, Legislative Fiscal Office, http://www.legis.la.gov/legis/ViewDocument.aspx?d=1140854

An independent analysis by The Urban Institute estimated that invalidation of the ACA would cost the state $3.6 billion in federal funding.[19] Research shows that if the state were left alone to find the funding without significant federal support, Medicaid coverage would almost surely be diminished.[20]

These fiscal considerations are the paramount issue with a ruling that overturns the ACA. By detailing the fiscal impact and summarizing the key provisions in the ACA, this report provides a blueprint for the Legislature moving forward. As discussed at length in legislative committees and in the Task Force, the efficacy of Act 412 is premised on new federal legislation authorizing and appropriating federal funds currently in place through the ACA. However, state policymakers have no guarantee that this will take place.

[19] Linda J. Blumberg, Matthew Buettgens, John Holahan, Clare Pan. “State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA.” The Urban Institute. March 2019. https://www.urban.org/sites/default/files/publication/100000/repeal_of_the_aca_by_state_2.pdf (see page 9)

[20] Jorge Barro & Stephen Barnes, 2016. "Federal Subsidization and State Medicaid Provision," Review of Economic Dynamics, Elsevier for the Society for Economic Dynamics, vol. 21, pages 29-45, July.