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The Contributions of the Patient Protection and Affordable Care Act (PPACA) on Reducing Health Disparity in the United States: The Case of Louisiana[1]

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Abstract
This paper investigates the impact of the Patient Protection and Affordable Care Act (ACA for short) of 2010, which was created to reduce the number of those without health insurance coverage in the United States, with focus on Louisiana. It will also examine the challenges the ACA has faced especially the "repeal and replace" efforts by the United States Congress. The problem of people having no health insurance coverage in the United States has been a long-standing issue, and there are many reasons for this condition. The most obnoxious reason is the "pre-existing condition" clause which many insurers practice which make it difficult to obtain basic health care services and policy coverage for many people. This has resulted to diminishing access to care and persistent gaps in health quality. In addition, the rising health care costs in the U.S. have imposed enormous economic burdens on the country. Latest report indicates that the U. S. spent $3.6 trillion (17.7% GDP) on health care in 2018 (up 4.6% from the previous year), or $11,172 per person, up 64.4% in ten years from $6,797 in 2009. Globally, it has been found that there is a "strikingly persistent and pervasive pattern of inferior health" in the U.S. than in peer countries that spend less. These problems have adversely impacted the health of many Americans which has created an underclass unable to access health amenities. As a relief, the ACA was introduced to address these issues. Using Louisiana as a case study, this paper argue that the ACA has helped to broaden health care access and reduce health disparity in the U. S., and the efforts by Congress to "repeal and replace" the health law would undermine health care access, and induce negative economic impacts. In addition, it strengthens the case for universal health coverage in the U. S., and underscore the efficacy of evidence-based policy solutions in addressing population health, especially in the face of the COVID-19 pandemic, which has further illuminated the depth of health disparity in the United States. Methodically, the paper will review and analyze publicly available data on health access since the ACA, government reports, and published survey and research findings. The findings will add to the body of knowledge on health care reform toward developing a sound public policy.
Keywords:ACA, health disparity, Black, White, Medicaid expansion, access, affordability, repeal, United States, Louisiana.
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I. Introduction

There is the problem of millions of people in the United States with no health insurance coverage and the number has been rising steadily (Economic Report of the President, 2010, chap. 7; Gunja & Collins, 2019; Tolbert & Orgera, 2020). The literature suggests that more and more Americans as well as businesses do not have insurance coverage because of the barriers they encounter in seeking to obtain coverage (Seshamani, 2010; Agency for Healthcare Research and Quality, 2013; Collins, Gunja, & Aboulafia, 2020; HealthyPeople.gov). These barriers include but are not limited to "pre-existing" health status, high and rising health care costs, high out-of-pocket costs and deductibles, lack of health care professionals in the rural areas, transportation difficulties, limited healthcare supply, irregular care, age, social isolation (McWilliams, 2009; Stanford Rural Health, 2010; Mandal, 2014; Antos & Capretta, 2020; Collins, Gunja, & Aboulafia, 2020). The effects of these barriers have resulted in escalating health care costs, diminishing access to care, and persistent gaps in health quality (State Health Access Data Assistance Center [SHADAC] & Robert Wood Johnson Foundation, 2009; The White House, 2010; Davis, et al., 2014; Kaiser Family Foundation [KFF], 2016; Garfield, Majerol, Damico, & Foutz, 2016; Congressional Budget Office [CBO] 2017). At the same time, rising health care costs in the United States have imposed tremendous economic burdens on families, employers, and governments at every level (Economic Report of the President, 2010, chap. 7; RAND Corporation, 2011; Cowan et al., 2002; Gee & Spiro, 2019; Altman & Mechanic, 2018; Bivens, 2018; Nunn, Parson, & Shambaugh, 2020). Furthermore, the COVID-19 pandemic has made a bad situation worse (Evans, 2020), further manifesting the depth of health disparity in the

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United States, and its concomitant disproportionate impact on the community of color, including "excess deaths" (Cooper & Williams, 2020). Writing in the *Journal of the American Medical Association*, for example, Yancy (2020) offers a sobering and definitive observation: "In Chicago, more than 50% of COVID-19 cases and nearly 70% of COVID-19 deaths involve black individuals, although blacks make up only 30% of the population. Moreover, these deaths are concentrated mostly in just 5 neighborhoods on the city's South Side. In Louisiana, 70.5% of deaths have occurred among black persons, who represent 32.2% of the state's population. In Michigan, 33% of COVID-19 cases and 40% of deaths have occurred among black individuals, who represent 14% of the population. If New York City has become the epicenter, this disproportionate burden is validated again in underrepresented minorities, especially blacks and now Hispanics, who have accounted for 28% and 34% of deaths, respectively (population representation: 22% and 29%, respectively."

Before the ACA (known as Obamacare), reports indicated that the number of uninsured Americans would increase to 57.7 million in 2014, and to 65.7 million by 2019 (Holahan, Bowen, Headen, & Lucas, 2009). Also, there was the nagging problem of those with health conditions that insurance companies qualify as "pre-existing condition" (a medical condition that pre-dates enrollment in a new health insurance plan). Using the caveat of preexisting condition as a justification, insurers denied coverage, charged higher premiums, and or limited benefits to individuals, and it is estimated that up to 133 million Americans may have a pre-existing condition (U. S. Department of Health and Human Service [HHS], 2017; U.S. Government Accountability Office, 2011; Claxton, et al., 2016 and 2019; Huelskoetter, 2017), ranging from life-threatening illnesses like cancer to chronic conditions like diabetes, asthma, or heart disease (U. S. Centers for Medicare & Medicaid Services, n.d.). On the international level, the U. S. Institute of Medicine has reported that there is a "strikingly persistent and pervasive pattern of higher mortality and inferior health" in the United States than in other high-income countries (Woolf & Aron, 2013; Anderson, Willink, & Osborn, 2013). Ultimately, these problems have adversely impacted the health of many Americans. In response, the President and Congress had to act to bring much needed relief in health care access through the instrumentality of the ACA.

On March 23, 2010, then President Barack Obama signed into law a landmark comprehensive health reform legislation, the Patient Protection and Affordable Care Act (PPACA) (KFF, 2013). (PPACA is called the Affordable Care Act, ACA, for short). At the bill signing ceremony President Obama declared: "We are a nation that faces its challenges and accepts responsibilities…That is what makes us the United States of America…the core principle that everybody should have some basic security when it comes to their health care." Together with the Health Care and Education Reconciliation Act of 2010, the ACA represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965 (Vicini & Stempel, 2012; Adkinson & Chung, 2014), and possibly since the New Deal programs of the 1930s (Rushefsky, 2013). Categorically, the law implemented comprehensive reforms designed to improve accessibility, affordability, and quality of care (Obama, 2016).

The thrust of the ACA required U.S. citizens and legal residents to have health insurance by providing financial assistance to help people pay for health coverage (KFF, 2013; Rosenbaum, 2011). Also, the ACA required most Americans especially people under 30 years old to obtain health coverage or pay penalty (Jost, 2017; Miller, 2017), reform the private insurance market, expand Medicaid to the working poor with income up to 133% of the federal poverty level (Silvers, 2013; Blumenthal, Abrams, & Nuzum, 2015). Furthermore, the ACA required employers with more than 50 employees to offer employer sponsored insurance (ESI) to their workers (Askin & Moore, 2012). As such, it goes without saying that effective health policies and allocation of public health resources can substantially improve public health (Brownson, Seiler, & Eyler, 2010). For instance, each of the ten great public health achievements of the 20th century, such as, immunizations, seat belt laws, workplace safety, control of infectious diseases, fluoridation of drinking water, to name a few, was influenced by policy change (U.S. Centers for Disease Control and Prevention, 2013). Access to health insurance coverage in the United States is no exception. The remainder of the paper is organized as follows: Part II is the ACA and health care access; Part III is Louisiana Medicaid Expansion; Part IV presents attempts to repeal the ACA, Part V are the findings, part VI conclude the paper.

II. ACA and Health Care Access

The ACA is a watershed in U.S. public health policy. Full implementation of the ACA began on January 1, 2014, when the individual and employer responsibility provisions took effect, state health insurance Exchanges started to operate, the Medicaid expansions took effect, and the individual and small-employer group subsidies became effective (Rosenbaum, 2011). The ACA uses two major approaches to expand health care coverage. The first mechanism is financial assistance subsidy offered through marketplace insurance exchanges (Abraham, 2014). The second is through an expansion of Medicaid eligibility, in which states have the option to offer coverage to all individuals with a family income at or below 138% of the federal poverty level (Abraham, 2014). Louisiana implemented Medicaid expansion beginning July 1, 2016. Discussion of the ACA health access expansion measures follows beginning with financial assistance.

Financial Assistance

The major impediment to health coverage in the United States is cost (Kullgren et al., 2012; Osborn, et al., 2016; Rowan, McAlpine, & Blewett, 2013; Sohn, 2017; Collins, Gunja, & Aboulafia, 2020). A brief overview of the cost problem will be in order. In the United States, nearly one in every six dollars spent goes to health care, yet, almost one in every six American lack coverage that would ensure access to medical care (Brauchli, 2010). A recent report indicated that 46% of uninsured adults said that they tried to get coverage but did not because it was too expensive (KFF, 2016), while 53% had problems paying household medical bills in the past year (Hamel, et al., 2016). Overall, 70% of Americans who have faced medical bill problems report that they cut back spending on food, clothing, and basic household items (Hamel, et al. 2016), while, cost-related prescription non-adherence (CRN) - Americans who do not fill a prescription because they could not afford it continue to be a problem (Kennedy & Wood, 2016). At the same time, “premiums, deductibles, and other out-of-pocket costs continue to be an extraordinary burden on millions of households” (Goodnough, et al., 2020). In conjunction, medical expenses have become a leading cause of personal bankruptcy in America (Kutile, 2016). A 2007 seminal Harvard university study found that medical expenses contributed to 62% of all bankruptcies in the United States, up 50% from 2001 (Himmelstein, et al., 2007).

In addition, healthcare costs continued to grow faster than the economy and has maintained upward trend (Chernew, Hirth, & Cutler, 2003; Torio & Andrews, 2011; USDHHS - Office of the Assistant Secretary for Planning and Evaluation, 2012; Peter G. Peterson Foundation, 2019). To put it in historical perspective, U.S. health spending as a share of the Gross Domestic Product (GDP) was 5.3% in 1960, 5.9% in 1965, 7.4% in 1970, 13.8% in 2000 (Rushefsky, 2013), reaching 17.7% in 2018, the latest. Furthermore, the United States health care system is the most expensive in the world, but comparative analysis consistently show that the U.S. lags relative to other advanced countries on most performance indicators including life expectancy, access, efficiency, and equity (Davis et al., 2014). Estimates, for example, suggest that the United States spends $98 billion in excess administrative costs and $66 billion in excess drug costs, compared to other wealthy nations with a single-payer system (Krugman, 2007). McKinsey & Company, the consulting firm, report that the United States spend $650 billion more in health care compared to other rich countries (McKinsey & Company, 2008).

Latest report show that the United States spent $3.6 trillion (17.7% GDP) on health care in 2018 (up 4.6% from the previous year), or $11,172 per person, up 64.4% in ten years from $6,797 in 2009 (U.S. Centers for Medicare & Medicaid Services, 2020). America’s health care portion of the GDP of 17.8% is twice the average (8.9%) among developed nations (Organization for Economic Cooperation and Development, [OECD], 2016), and it is expected to rise to 20.1% in 2025 (Keehan, et al., 2016). Linked to the cost problem is uncompensated hospital care costs – “health care provided by hospitals for which no payment is received from the patient or insurer” (American Hospital Association, [AHA], 2020). According to the American Hospital Association, an industry advocate, since 2000 American hospitals have provided more than $660 billion in uncompensated care to their patients (AHA, 2020). Policymakers are among those who are increasingly concerned about the growing burden of medical care expenses on governments, consumers, and insurers (Torio & Andrews, 2013; Melhado, 2006; U.S. Institute of Medicine, 2003; Gee & Gurwitz, 2018). In light of the health care costs burden, the ACA stepped in to help alleviate the problem.

According to the Kaiser Family Foundation (KFF), a non-profit health advocacy, “Health insurance can be expensive, and is therefore often out of reach for lower and moderate income families. To make coverage obtainable for families that otherwise could not afford it and to encourage broad participation in health insurance, the Affordable Care Act (ACA) includes provisions to lower premiums and out-of-pocket costs for people with low and modest incomes” (KFF, 2020). The ACA provides financial assistance to reduce monthly premiums and out-of-pocket costs in an effort to expand access to affordable health insurance for people with moderate and low-income – particularly those without access to affordable coverage through their employer, Medicaid, or Medicare (KFF, 2020).

There are two types of financial assistance offered under the ACA for enrollees through health insurance Marketplaces (also called Exchanges): premium tax credit and cost-sharing subsidy (PPACA, 2010 or Public Law 111-148). The health insurance market place have four “metal” categories of coverage: bronze (cover 60% of benefit plan), silver (cover 70%), gold (cover 80%), and platinum (90%) (KFF, 2011). The discussion of the two types of financial assistance follows.

Premium tax credit - assistance works to reduce enrollees’ monthly insurance coverage payments, and starting in 2021 enrollees must meet the following criteria (KFF, 2020):

- Have a household income from one to four times (100%-400%) of the Federal Poverty Level (FPL) (**Table 1**), which for the 2021 benefit year will be determined based on 2020 poverty guidelines. In 2021, the subsidy range in the continental U.S. is from $12,760 to $51,040 for an individual and from $26,200 to $104,800 for a family of four.
- Not have access to affordable coverage through an employer (including a family member’s employer).
- Not eligible for coverage through Medicare, Medicaid, the Children’s Health Insurance Program

(CHIP), or other forms of public assistance.

- Have U.S. citizenship or proof of legal residency (lawfully present immigrants whose household income is below 100% FPL and are not otherwise eligible for Medicaid are eligible for tax subsidies through the Marketplace if they meet all other eligibility requirements.)
- If married, must file taxes jointly in order to qualify.

For the purposes of the premium tax credit, household income is defined as the Modified Adjusted Gross Income (MAGI) of the taxpayer, spouse, and dependents (KFF, 2020). The MAGI calculation includes income sources such as wages, salary, foreign income, interest, dividends, and Social Security (KFF, 2020). In states that expanded Medicaid, tax credit eligibility ranges from 138% to 400% of the poverty level (because almost all people with incomes below 138% of poverty are eligible for Medicaid and therefore are not eligible for subsidized Marketplace coverage). In states that did not expand Medicaid, tax credit eligibility ranges from 100% to 400% of poverty. Residents of these states who have incomes below 100% of poverty and who do not qualify for Medicaid under their state's eligibility criteria are also not eligible for any premium tax credits (KFF, 2020).

Table 1: Premium Subsidy Ranges, by Income in 2020 and 2021

Income % Poverty	Income Range in Dollars for the **2020** benefit year		Income Range in Dollars for the **2021** benefit year	
	Single Individual	Family of Four	Single Individual	Family of Four
Under 100%	Less than $12,490	Less than $25,750	Less than $12,760	Less than $26,200
100% – 133%	$12,490 – $16,612	$25,750 – $34,248	$12,760 – $16,971	$26,200 – $34,846
133% – 150%	$16,612 – $18,735	$34,248 – $38,625	$16,971 – $19,140	$34,846 – $39,300
150% – 200%	$18,735 – $24,980	$38,625 – $51,500	$19,140 – $25,520	$39,300 – $52,400
200% – 250%	$24,980 – $31,225	$51,500 – $64,375	$25,520 – $31,900	$52,400 – $65,500
250% – 300%	$31,225 – $37,470	$64,375 – $77,250	$31,900 – $38,280	$65,500 – $78,600
300% – 400%	$37,470 – $49,960	$77,250 – $103,000	$38,280 – $51,040	$78,600 – $104,800
Over 400%	More than $49,960	More than $103,000	More than $51,040	More than $104,800

NOTES: Alaska and Hawaii have different poverty guidelines. Note that tax credits for the 2021 benefit year are calculated using 2020 federal poverty guidelines, while tax credits for the 2020 benefit year are calculated using 2019 federal poverty guidelines.

Source: Adapted from Kaiser Family Foundation (October 30, 2020). "Explaining Health Care Reform: Questions About Health Insurance Subsidies."
https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/.

The premium tax credit available to individuals is determined based on the cap an individual or family must spend on their monthly payments for health insurance if they enroll in a "benchmark" plan (KFF, 2020). The tax credit limit depends on the family's income, with lower-income families having a lower cap and higher income families having a higher cap (**Table 2**) (KFF, 2020). The "benchmark" for determining the amount of the subsidy is the second-lowest cost silver plan available to the individual or family through their state's Marketplace (KFF, 2020). If the cost of the enrollee's benchmark silver plan is higher than their premium cap, then the federal government will pay any amount over the cap (KFF, 2020). Therefore, the amount of the tax credit is equal to the difference between the individual or family's premium cap and the cost of the benchmark silver plan (KFF, 2020). Suppose, for example, an individual's income in 2021 is $31,900 at 250% poverty level (Table 1). Suppose the second-lowest cost silver plan available to the person in the Marketplace is $500 per month. Under the ACA, with an income of $31,900 per year, the person would have a cap of 8.33% (Table 2) of income for the second-lowest cost silver plan. This means that the person would have to pay no more than $221 per month (8.33% of $31,900, divided by 12 months) to enroll in the second-lowest cost silver plan. The tax credit available to the enrollee would therefore be $279 per month ($500 premium minus $221 cap). The enrollee can then apply this $279 per month discount toward the purchase of any bronze, silver, gold, or platinum Marketplace plan available (KFF, 2020).

Table 2: Premium Cap, by Income in 2020 and 2021

Income % Poverty	Premium Cap Max % of income for 2nd lowest silver plan	
	2020	2021
Under 100%	No Cap	No Cap
100% – 133%	2.06%	2.07%
133% – 150%	3.09% – 4.12%	3.10% – 4.14%
150% – 200%	4.11% – 6.49%	4.14% – 6.52%
200% – 250%	6.49% – 8.29%	6.52% – 8.33%
250% – 300%	8.29% – 9.78%	8.33% – 9.83%
300% – 400%	9.78%	9.83%
Over 400%	No Cap	No Cap

NOTES: Alaska and Hawaii have different poverty level guidelines. Note that the premium tax credits for the 2021 benefit year are calculated using 2020 federal poverty guidelines, while tax credits for the 2020 benefit year are calculated using 2019 federal poverty level guidelines.

Source: Adapted from Kaiser Family Foundation (October 30, 2020). "Explaining Health Care Reform: Questions About Health Insurance Subsidies."
https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/.

Cost-sharing subsidy - is designed to minimize enrollees' out-of-pocket costs for a doctor visit or hospital stay including deductibles, copayments, and coinsurance (KFF, 2020). People who qualify to receive a premium tax credit and have household incomes from 100% to 250% of poverty are eligible for cost-sharing subsidies (KFF, 2020). In contrast to the premium tax credit (which can be applied toward any metal level of coverage), the cost-sharing subsidies can only be applied toward a silver plan (KFF, 2020). In addition, unlike the premium tax credit, there is no option for cost-sharing reductions to be paid to the enrollee (KFF, 2020). By reducing out-of-pocket costs, the cost-sharing subsidies increase the actuarial value of the silver plan to 73, 87, or 94 percent depending on the enrollee's income (KFF, 2020). Without the cost-sharing subsidy, the out-of-pocket (OOP) maximum may not exceed $8,550 for an individual and $17,100 for two or more people in 2021 (KFF, 2020). With the cost-sharing reduction, the out-of-pocket maximum can be no more than $2,850 to $6,800 for a person, or $5,700 to $13,600 for a family in 2021, depending on income (KFF, 2020). **Table 3** shows the reduced out-of-pocket maximums and increased actuarial values after cost-sharing subsidies are applied, within each income range. Typically, silver plans have an actuarial value of 70%, meaning that on average the plan pays 70% of the cost of covered benefits for enrollees, with the remaining 30% of total costs being covered by the enrollees in the form of deductibles, copayments, and coinsurance (KFF, 2020).

Table 3: Maximum Annual Limitation on Cost-Sharing, 2021

Income (% Federal Poverty Level)	Actuarial Value of a silver plan	OOP Max for Individual/Family	
		2020	2021
Under 100%	70%	$8,150 / $16,300	$8,550 / $17,100
100% –150%	94%	$2,700 / $5,400	$2,850 / $5,700
150% – 200%	87%	$2,700 / $5,400	$2,850 / $5,700
200% – 250%	73%	$6,500 / $13,000	$6,800 / $13,600
Over 250%	70%	$8,150 / $16,300	$8,550 / $17,100

SOURCE: "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021," *Federal Register* 85 FR 29164.

Source: Adapted from Kaiser Family Foundation (October 30, 2020). "Explaining Health Care Reform: Questions About Health Insurance Subsidies."
https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/.

The second approach to increase health coverage is Medicaid expansion. The ACA expanded Medicaid coverage for adults with incomes at or below 138% of poverty (**Table 4**) in states that have adopted Medicaid

expansion including Louisiana (KFF, 2016). **Table 5** portrays Monthly Income limits for Medicaid Programs in Louisiana.

III. Medicaid Expansion in Louisiana

In November 2015, then Louisiana Governor-elect John Bel Edwards (Democrat) declared that "Medicaid expansion was among his highest priorities" (Litten, 2015). (The former Republican Governor, Bobby Jindal, had opposed Medicaid expansion). Upon taking office, as promised, Mr. Edwards' "first official act as Governor" was to sign Executive Order JBE 16-01 on January 12, 2016 to expand the Medicaid program (Louisiana Department of Health [LDH], 2017). At the issuing of the Executive Order the Governor declared: "This will not only afford them [Louisianans] peace of mind, but also help them from slipping further into poverty and give them a fighting chance for a better life" (Ballard, 2016). The LDH added, "By receiving Medicaid coverage, these Louisianans, many of them working adults in important industries like food service and construction, are finally able to get the regular, preventative and primary care that best promotes health and wellness" (https://ldh.la.gov/index.cfm/page/2327).

Following federal guidelines, Louisiana implemented Medicaid expansion[1] beginning July 1, 2016. Under the Medicaid expansion program, enrollment of qualified adults is based on the following eligibility criteria: aged 19 to 64 years old, has household income below 138% of the federal poverty level, doesn't already have Medicaid or Medicare, must meet citizenship requirement, no asset test (Louisiana Department of Health, 2018). In 2013, prior to expansion, the U.S. Census Bureau reported that Louisiana's uninsured rate was 16.6 percent (CMS, Center for Program Integrity, 2020). Since Medicaid expansion, Louisiana's uninsured rate fell 50 percent from 2013 to 2017 (Norris, 2018), and from 2016 to 2017 one year in particular, Louisiana's uninsured rate dropped from 10.3 percent to 8.4 percent – the largest drop among states (Louisiana Office of the Governor, September 12, 2018). Also, according to an Urban Institute study, while the state would spend $1.2 billion over 10 years on expansion, conversely, if Louisiana had continued to reject Medicaid expansion during the same time period, the state would have lost $15.8 billion in federal Medicaid funding and $8 billion in hospital reimbursements (Dorn, McGrath, & Holahan, 2014).

Table 4: 138% of the Federal Poverty Level for 2021

Household Size	Weekly	Bi-Weekly	Monthly	Yearly
1	$342	$684	$1,482	$17,784
2	462	925	2,004	24,048
3	583	1,166	2,526	30,312
4	703	1,407	3,048	36,576
5	824	1,648	3,570	42,840
6	944	1,889	4,092	49,104

Source: Louisiana Department of Health, "About Healthy Louisiana."
https://ldh.la.gov/index.cfm/page/2327

Table 5: Medicaid Program Limits by Family Size in Louisiana, 2021
(Effective March 1, 2021)

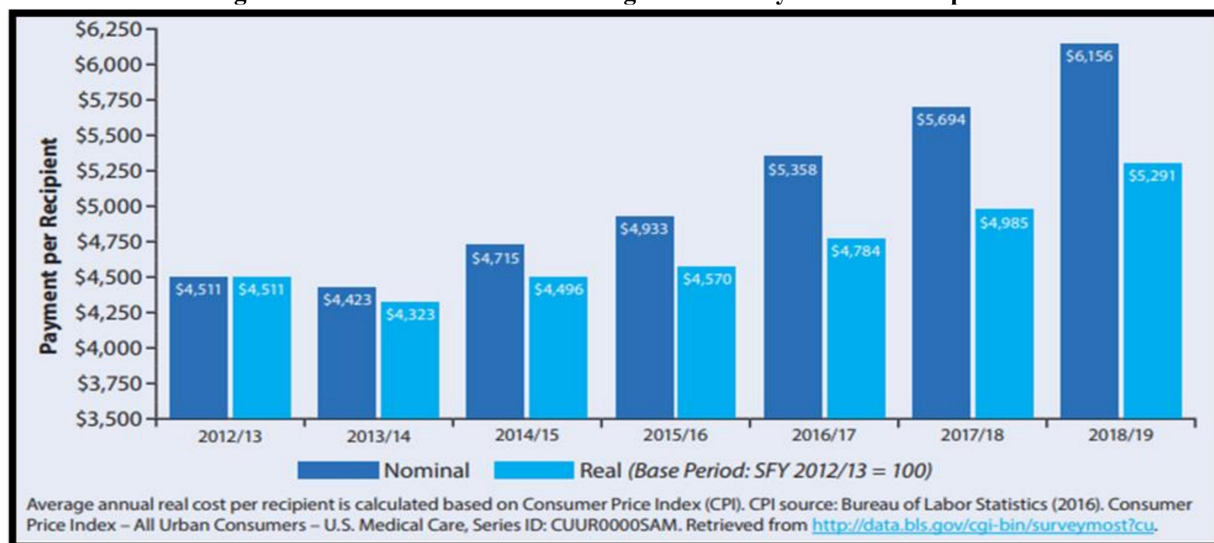
Program	Family Size/Monthly Income Limits							
	1	2	3	4	5	6	7	8
Family Opportunity Act - for children with disabilities	$3,220	$4,355	$5,490	$6,625	$7,760	$8,895	$10,030	$11,16
LaCHIP - for children	$2,330	$3,151	$3,972	$4,793	$5,614	$6,435	$7,256	$8,077
LaCHIP Affordable Plan - for children	$2,737	$3,702	$4,667	$5,632	$6,596	$7,561	$8,526	$9,491
LaMOMS - for pregnant women		$2,004	$2,526	$3,048	$3,570	$4,092	$4,614	$5,136
Medicaid Purchase Plan - for workers with disabilities	$1,074	$1,452						
Medicare Savings Program - for payment of Medicare premiums, copays & deductibles	$1,074	$1,452						
Medicare Savings Program - for payment of Part B premiums only	$1,449	$1,960						
TAKE CHARGE PLUS - Family Planning Services	$1,482	$2,004	$2,526	$3,048	$3,570	$4,092	$4,614	$5,136
Adult Group (Medicaid Expansion) - ages 19 through 64 without Medicare	$1,482	$2,004	$2,526	$3,048	$3,570	$4,092	$4,614	$5,136

Source: Louisiana Department of Health, "Monthly Income Limits for Medicaid Programs."
https://ldh.la.gov/index.cfm/page/1371

[1] Expansion Group enrollees receive care through Medicaid's managed care program, Healthy Louisiana. This includes full Medicaid benefits as well as access to the value added benefits provided by the managed care organizations that deliver care (*Louisiana Medicaid 2019 Annual Report*, p. 48).

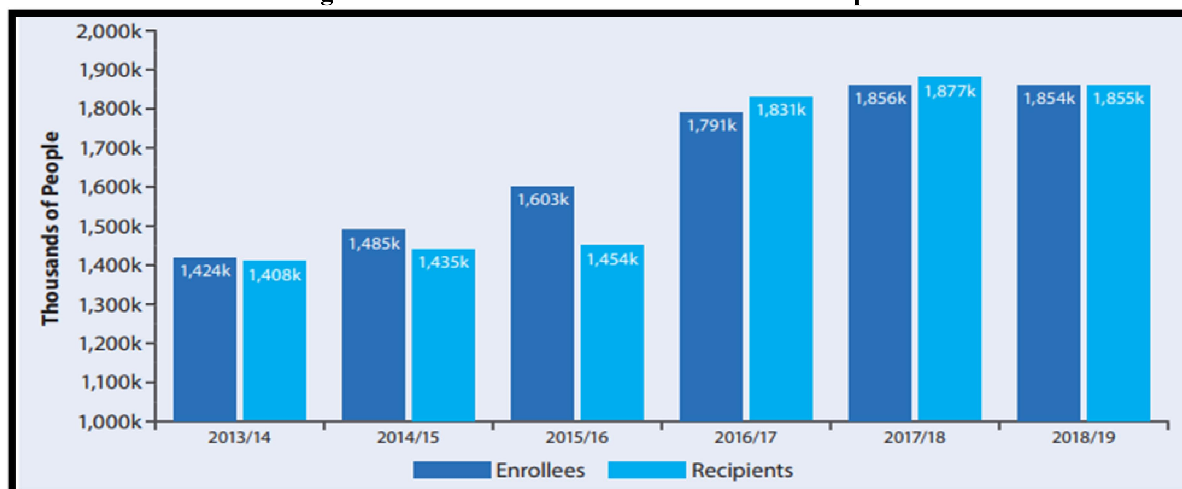
As of May 2021, Louisiana has enrolled 1,745,824 individuals in Medicaid and CHIP — a net increase of 71.19% since the first Marketplace Open Enrollment Period and related Medicaid program changes in October 2013 (Medicaid.gov https://www.medicaid.gov/state-overviews/stateprofile.html?state=Louisiana). In addition, Louisiana has adopted one or more of the targeted enrollment strategies outlined in CMS guidance issued on May 17, 2013, designed to facilitate enrollment in Medicaid and CHIP (Medicaid.gov https://www.medicaid.gov/state-overviews/stateprofile.html?state=Louisiana). In the 2018/19 State Fiscal Year (latest annual report), the state made Medicaid payments totaling over $11.4 billion, on behalf of about 1.9 million recipients (Figure 2), averaging about $6,156 per recipient (Figure 1) (Louisiana Department of Health, 2020, SFY *2018/19 Medicaid Annual Report*, p. 35). In the SFY 2018/19 reference period, the state expended over $3 billion on Medicaid expansion (Figure 3), and enrolled more than 690,000 through October 1, 2021 (Table 6), accounting for approximately 29% of Louisiana Medicaid enrollment (Figure 3). During SFY 2018/19, 1,853,660 Louisianans enrolled in Medicaid, representing 39.8% of the state 4,659,978 estimated population (p. 50).

Figure 1: Louisiana Medicaid Average Annual Payment Per Recipient



Source: Louisiana Department of Health (2020). *Louisiana 2019 Medicaid Annual Report*, p. 35. https://ldh.la.gov/assets/medicaid/AnnualReports/MedicaidAnnualReport2019.pdf.

Figure 2: Louisiana Medicaid Enrollees and Recipients

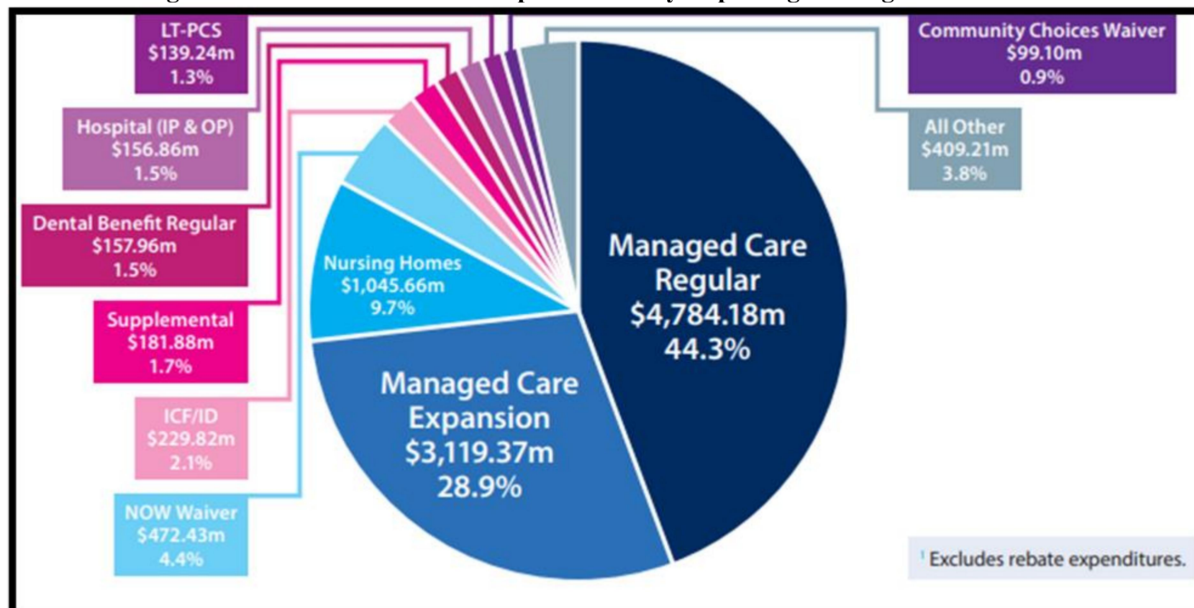


Source: Louisiana Department of Health (2020). *Louisiana 2019 Medicaid Annual Report*, p. 36. https://ldh.la.gov/assets/medicaid/AnnualReports/MedicaidAnnualReport2019.pdf

Note on Figure 2 - A **"Medicaid enrollee"** is a Medicaid eligible person who applied for and was approved by the Medicaid program to receive benefits regardless of whether he or she received any service and/or any claims or managed care encounters were filed on his or her behalf. A **"Medicaid recipient"** is an enrollee with at least one Per-Member-Per-Month (PMPM) payment to a Managed Care Organization, a Fee-for-Service processed

claim or any person with Medicare Buy-in and Part D premiums paid on his or her behalf during the time period involved (*Louisiana 2019 Medicaid Annual Report*, p. 50).

Figure 3: Louisiana Medicaid Expenditures[1] by Top Budget Categories of Service[1]



Source: Louisiana Department of Health (2020). *Louisiana 2019 Medicaid Annual Report*, p. 40. https://ldh.la.gov/assets/medicaid/AnnualReports/MedicaidAnnualReport2019.pdf.

Aside the peace of mind that comes with having health insurance coverage, there are enormous health wellness benefits as well, especially on children. Studies indicate that children with health coverage are better prepared to learn in school, complete high school, and succeed in life ([SHADAC, 2007]; Cohodes, et al., 2016). Evidence from prior children coverage and the broader children health insurance expansions in the ACA suggest that children who gained health care access will also see improved health, education, labor market outcomes later in life (Furman & Fielder, 2016). Another study found that pre-teen and early-teen children who had Medicaid coverage resulted in better health including lower mortality in their late-teen years (Sommers, Baicker, & Epstein, 2012), as well as lower hospitalization rates in adulthood (Wherry, Miller, Kaestner, & Meyer, 2015). A related study found that female children who had Medicaid or Children Health Insurance Program (CHIP) coverage in childhood had higher earnings in adulthood (Brown, Kowalski, & Lurie, 2015).

[1] **Managed Care Regular** - Per-Member-Per-Month (PMPM) payments for Louisiana Medicaid state plan core benefits and services provided through Medicaid managed care program. Healthy Louisiana Plans are operated by private providers. **Managed Care Expansion** - Per-Member-Per-Month (PMPM) payments for Louisiana Medicaid state plan core benefits and services provided through Medicaid managed care program to individuals made eligible for Medicaid coverage through Medicaid expansion beginning July 1, 2016. Healthy Louisiana Plans are operated by private providers (*Louisiana Medicaid 2019 Annual Report*, p. 138).

Table 6: Louisiana Medicaid Expansion Outcomes thru October 1, 2021

Lives Affected	Measure	Outcome
690,162	Health Insurance	Adults enrolled in Medicaid Expansion as of October 1, 2021
529,851	Doctor Visits	Adults who visited a doctor and received new patient or preventive healthcare services
73%	Doctor Visits	Percentage of adults who had a doctor's office visit during the year
112,851	Breast Cancer	Women who've gotten screening or diagnostic breast imaging
1,489	Breast Cancer	Women diagnosed with breast cancer as a result of this imaging
68,275	Colon Cancer	Adults who received colon cancer screening
21,070	Colon Cancer	Adults with colon polyps removed: colon cancer averted
958	Colon Cancer	Adults diagnosed with colon cancer as a result of this screening
30,746	Newly Diagnosed Diabetes	Adults newly diagnosed and now treated for Diabetes
81,635	Newly Diagnosed Hypertension	Adults newly diagnosed and now treated for Hypertension
150,423	Mental Health	Adults receiving specialized outpatient mental health services
41,585	Mental Health	Adults receiving inpatient mental health services at a psychiatric facility
29,429	Substance Use	Adults receiving specialized substance use outpatient services
33,307	Substance Use	Adults receiving specialized substance use residential services
31,727	Substance Use	Adults receiving medication-assisted treatment (MAT) for opioid use disorder

Source: Louisiana Department of Health, LDH Medicaid Expansion Dashboard.
https://ldh.la.gov/HealthyLaDashboard/

Medicaid Expansion and Louisiana Economy

According to Governor John Edwards "through Medicaid expansion, we are bringing our federal tax dollars back to Louisiana to save lives and improve health outcomes for the working poor people of our state" (LDH, *Medicaid Expansion Annual Report 206/17*, p.2). A 2018 Louisiana State University study stated, Medicaid expansion "provided for a 97.5% federal contribution for state fiscal year 2017, a 94% federal contribution in calendar year 2018, a 93% federal contribution in calendar year 2019, and a 90% federal contribution from calendar year 2020 and beyond, assuming no further changes in Medicaid at the federal level." "This federal infusion" argued the report in turn "creates and sustains economic activity in the healthcare sector which then impacts all other sectors of the state's economy" (Richardson, Llorens, & Heidelberg, 2018, p. 2). Specifically, Louisiana received estimated $1.85 billion in SFY 2017, approximately $1.77 billion in SFY 2018, and anticipated $1.8 billion in SFY 2019 in federal dollars to support its Medicaid Expansion program (Richardson, Llorens, & Heidelberg, 2019, p. 5). Aside fiscal contribution, Medicaid expansion federal dollars inject employment, earnings, payments and tax receipts into the state economy (Tables 7, 8, 9).

Table 7: Estimated Economic Impact of Medicaid Expansion by Health Districts for SFY 2018 (millions of dollars for categories measured in dollars)

Health Districts	Personal Earnings	Employment	State Tax Receipts	Local Tax Receipts
District 1 (New Orleans)	$137.8	2,101	$11.4	$8.3
District 2 (Baton Rouge)	$128.4	1,841	$10.7	$7.7
District 3 (Houma-Thibodaux)	$77.2	980	$6.4	$4.6
District 4 (Lafayette)	$132.5	1,912	$11.0	$7.9
District 5 (Lake Charles)	$31.9	457	$2.6	$1.9
District 6 (Alexandria)	$55.8	787	$4.6	$3.3
District 7 (Shreveport-Bossier)	$100.5	1,490	$8.3	$6.0
District 8 (Monroe)	$88.5	1,266	$7.3	$5.3
District 9 (Northshore)	$136.4	1,664	$11.3	$8.2
State*	$889.0	14,263	$83.8	$60.6

*State includes Administration expenditures.

Source: Adapted from James A. Richardson, Jared J. Llorens, & Roy L. Heidelberg (August 2019). *Medicaid Expansion and the Louisiana Economy, 2018 and 2019*. p. 18.
https://ldh.la.gov/assets/media/3and4.2019FinalReportMedicaidExpansionstudy.pdf

Table 8: Economic Impact of Medicaid Expansion Program on Louisiana Economy Based on Payments to Managed Care Organizations, State Fiscal Year 2017 ($ in millions)

Type of Activity	Federal Payment	Business Activity	Personal Earnings	Employment	State Tax Receipts	Local Tax Receipts
Hospitals: Inpatient Care	$495.5	$939.9	$350.4	5,311	$29.1	$21.0
Outpatient Care	$297.8	$564.8	$210.2	2,593	$17.5	$12.6
Pharmacy	$284.5	$539.7	$201.2	3,825	$16.7	$12.1
Physicians and other Professions	$441.1	$836.5	$311.9	4,420	$25.9	$18.7
Other Medical Services	$64.6	$122.4	$41.6	1,150	$3.4	$2.5
Administration of Program	$266.5	$476.8	$124.8	1,818	$10.4	$7.5
Total Activity of Medicaid Expansion	$1,850.0	$3,480.1	$1,118.2	19,195	$103.2	$74.6

Source: Adapted from James A. Richardson, Jared J. Llorens, & Roy L. Heidelberg (March 2018). *Medicaid Expansion and the Louisiana Economy,* p. 4.
https://gov.louisiana.gov/assets/MedicaidExpansion/MedicaidExpansionStudy.pdf

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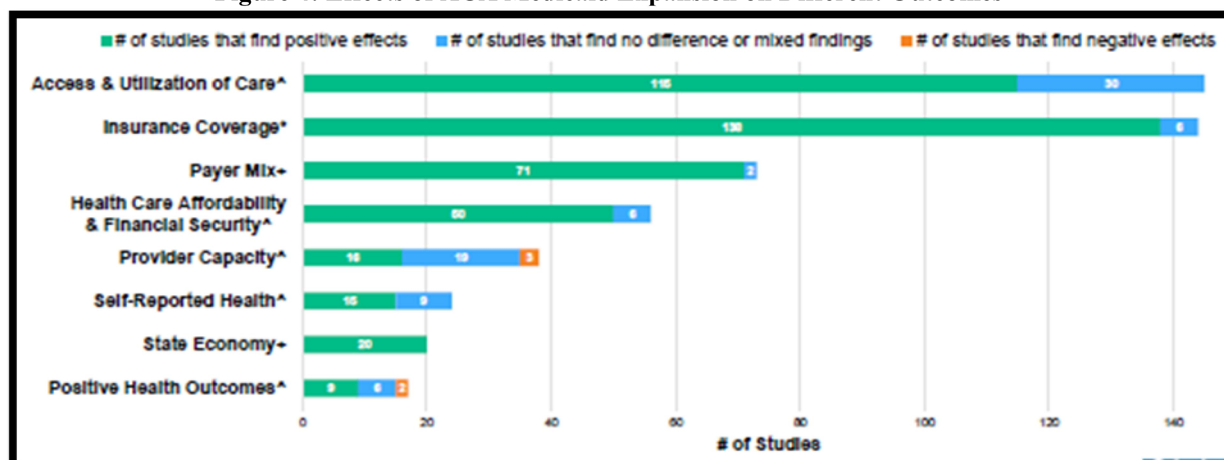
Table 9: Total Payments by Type of Healthcare Expenditure for Medicaid Expansion Program, FY 2017 ($ in millions)

Expenditures	Federal Contribution	State Share	Total Expenditures	% of Total
Hospitals	$495.6	$12.7	$508.3	26.8%
Outpatients	$297.8	$7.6	$305.4	16.1%
Pharmacy	$284.5	$7.3	$291.8	15.4%
Physicians and Professionals	$441.1	$11.3	$452.3	23.8%
All Other Healthcare Spending	$64.6	$1.7	$66.3	3.5%
Administration	$266.4	$6.8	$273.2	14.4%
Total	$1,850.0	$47.4	$1,897.4	

Source: Adapted from James A. Richardson, Jared J. Llorens, & Roy L. Heidelberg (March 2018). *Medicaid Expansion and the Louisiana Economy,* p. 25.
https://gov.louisiana.gov/assets/MedicaidExpansion/MedicaidExpansionStudy.pdf

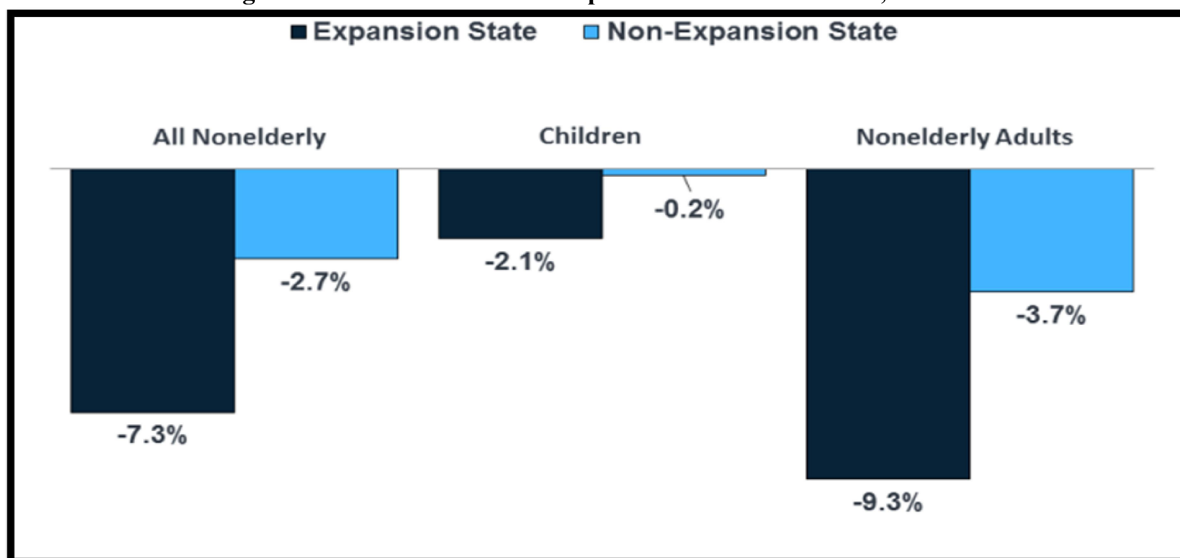
It will be in order to touch briefly on the nationwide impact of state Medicaid expansions under the ACA. A recent national report by Kaiser that summarized findings from more than 400 studies on the effect of Medicaid expansions found "general positive effects of the ACA on Medicaid expansion on different outcomes" including (Figure 4) "gains in coverage, improvements in access, financial security, and some measures of health status/outcomes, and economic benefits for states and providers" (KFF, 2020). Further review of the literature show that Medicaid expansion has not only resulted in coverage gains, but also, resulted (Figure 5) in "coverage gains without diverting coverage from traditional groups" (Rudowitz & Antonisse, 2020), and at the same time induced "numerous positive economic effects including state budget savings, revenue gains, employment expansion, and general economic growth" (Rudowitz & Antonisse, 2020) (Figure 6).

Figure 4: Effects of ACA Medicaid Expansion on Different Outcomes



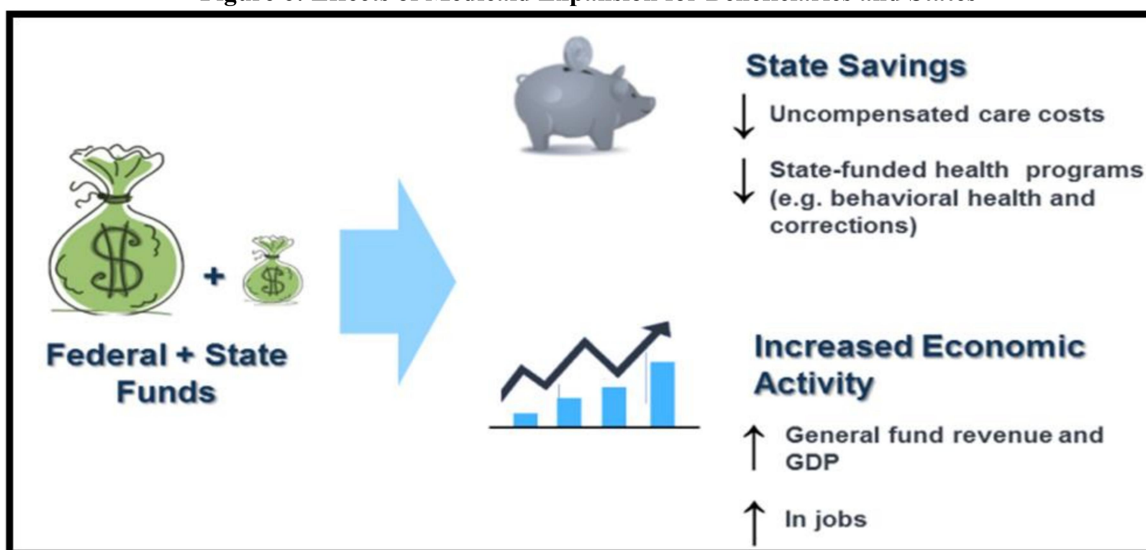
Source: Adapted from Madeline Guth, Rachel Garfield, & Robin Rudowitz (March 2020). *Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*. Kaiser Family Foundation.
http://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findings-from-a-Literature-Review.pdf.

Figure 5: Effects of Medicaid Expansion on the Uninsured, 203-2017



Source: Adapted from Robin Rudowitz & Larisa Antonisse (May 18, 2018). *Implications of the ACA Medicaid Expansion*: *A Look at the Data and Evidence*. Kaiser Family Foundation. http://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findings-from-a-Literature-Review.pdf.

Figure 6: Effects of Medicaid Expansion for Beneficiaries and States



Source: Adapted from Madeline Guth, Rachel Garfield, Robin Rudowitz (March 2020). *Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*. Kaiser Family Foundation. http://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findings-from-a-Literature-Review.pdf.

In spite of the attested successes of the ACA, there has been attempts to dismantle it, especially by the United States Congress.

IV. Attempts to Repeal ACA

The ACA divided Americans like few other issues in recent memory (Balz, 2010). No sooner had the ACA health care reform proposal became law in 2010 than the fight to repeal it began. The battle has been fierce and the attacks vociferous including the "spurious claim that the ACA would establish death panels that would have the power to decide whether Grandma and Grandpa lived or died" (Balz, 2010). According to Thompson, Gusmano, and Shinohara (2018, p. 396) "since the passage and implementation of the ACA, instead of cooperative federalism between the federal government and the states, the ACA has faced growing partisan polarization… intergovernmental intransigence, conflict, and even "war." Congress especially Republican leaders and Tea Party activists have played a big role in the fight to eliminate the ACA, forcefully expressed in

their continued crusade over the past 10 years to "repeal and replace" the ACA. The U. S. Congressional Research Service (the research arm of Congress) noted, "Since the ACA's enactment, lawmakers opposed to specific provisions in the ACA or the entire law have repeatedly debated its implementation and considered bills to repeal, defund, delay, or otherwise amend the law. During the 112th (2011-2012), 113th (2013-2014), and 114th (2015-2016) Congresses, the Republican-led House passed numerous ACA related bills, including legislation that would repeal the entire law" (Redhead & Kinzer, 2017).

Their main objection and hostility to the law is that the ACA is a modern day "socialized medicine" (Moore, 1945; Himmelstein & Woolhandler, 1986; Faria, 2018; Sen 2015) that "ration medicine access" (Diener, 1983) and "would make private insurance more expensive, undermine Medicare for seniors, and generally wreck everything that was good about the US health care system" (Cohn, 2020). Also, Congressional Republicans charge that the ACA would impose big financial burdens on states, diminish the quality of care, and limit choices (Jost, 2017; Shaffer, 2013; Willison & Singer, 2017). As a demonstration of their anti-ACA efforts, House Republicans have voted 74 times to repeal the law (YouTube, *Huffington Post*, 2017). The ACA has also faced court challenges. In June 2012, the U.S. Supreme Court ruled that states did not have to expand Medicaid for the poor and disabled (Barnes, 2012).

Perhaps, the most glaring example to undermine the ACA is the rejection of Medicaid expansion by some Republican state officials (e.g. Florida, Georgia, and Texas), consequently "millions of low-income people remain uninsured" (Cohn, 2020). Not the least, even President Trump has professed his intention to undo the ACA (Friedman, Andrews, & Humphreys, 2017), bordering on "sabotage" (Thompson, 2020), and "no replacement plan" (Obama, 2017) whatsoever upon "repeal-and-replace" of the ACA. More poignantly, "the Trump administration has attacked the objectivity of the nonpartisan Congressional Budget Office (CBO) whose periodic scoring of Republican proposals forecast that it would greatly increase the number of uninsured" (Thompson, Gusmano, & Shinohara, 2018, p. 400). Specifically, according to the CBO, elimination of the ACA would increase the number of uninsured people by 17 million in 2018, rising to 27 million and 32 million in 2020 and 2026, respectively (CBO, 2017).

On his first day in office, Trump issued an executive order directing federal agencies to dismantle the ACA "to the maximum extent permitted by law" and "minimize the unwarranted economic and regulatory burdens" of the ACA. The order included instructions to agencies to "exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications" (The White House, January 20, 2017). In another instance, President Trump said that "politically the best thing to do would be to let the ACA "explode" (Center on Budget and Policy Priorities, 2017). In yet another occasion, Trump declared, "let Obamacare fail…I'm not going to own it" (Yglesias, 2017). Another statement from the Trump White House added: "Congress needs to repeal and replace the disastrous Obamacare and provide real relief to the American people" (Goldstein & Eilperin, 2017). Moreover, the message on Trump Administration White House ACA website is apt: "Obamacare has led to higher costs and fewer insurance options for millions of Americans. The 2010 healthcare law has brought the American people rising premiums, unaffordable deductibles, fewer insurance choices, and higher taxes. President Trump promised to repeal and replace this disaster, and that is exactly what he is working with Congress to achieve" (The White House, 2017). For the sake of brevity, this paper will examine three key ACA repeal efforts: American Health Care Act (AHCA), Graham-Cassidy Repeal Bill, and Individual Mandate repeal.

1. American Health Care Act (AHCA)

On March 6, 2017, the House Republican leadership introduced the American Health Care Act (AHCA) to repeal and replace the ACA (Jost, 2017). On May 4, 2017 by a vote of 217 to 213, the House of Representatives passed the AHCA, all Democrats and twenty Republicans voted against the bill (Wilensky, 2017). In the main, the AHCA proposed to repeal portions of the ACA by eliminating especially ACA's mandate penalties, insurance premium subsidies, and Medicaid expansion eligibility (CBO, 2017). Further, the AHCA converted Medicaid from a fiscal entitlement where the federal government must match whatever a state spends to a "capitated" block grant with an upper limit on the federal subsidy (Thompson, Gusmano, & Shinohara, 2018, pp. 400-401). The AHCA as proposed would make several unprecedented changes to Medicaid in particular and health care in general (Dobson, Davanzo, & Haught, 2017; Fiedler, Aaron, Adler, and Ginsburg, 2017). First, it would effectively end ACA's Medicaid expansion provision, which would result to loss of coverage to estimated 32 million people by 2026 (CBO, 2017). Second, it would increase premiums in the non-group market (exchanges) to about 50% in the first year following the elimination of the Medicaid expansion and the marketplace subsidies, and premiums would double by 2026 (CBO, 2017). Third, the AHCA would change the longstanding arrangement between states and the federal government by placing limits on federal financial

support to states (Dobson et al., 2017). The most recent CBO calculation of the House passed version of the AHCA indicates that this would reduce federal Medicaid support to states by a total of $834 billion over a 10-year period, 2017-2026, representing a 26% cut in federal Medicaid payments (CB0, 2017). On the same vein, the CBO estimate that the repeal of the ACA would trigger a net increase of federal budget deficits by $109 billion over the 2013-2022 period (CBO, 2012), while the number of the uninsured will rise to 18 million in the first year of the repeal, then increase to 27 million, and then to 32 million in 2026 (CBO, 2017).

Furthermore, repeal would have wider economic impacts including $140 billion loss in federal funding for health care in 2019, resulting to the loss of 2.6 million jobs (mostly in the private sector) across all states (Ku, Steinmetz, Brantley, & Bruen, 2017). And if replacement plans are not in place, from 2019-2023, there will be a cumulative loss of $1.5 trillion in gross state products and a $2.6 trillion reduction in business output (Ku et al, 2017). On July 27, 2017, in a 49 to 51 vote, the Senate rejected scaled-down ("Skinny Repeal" – termed Health Care Freedom Act) Republican AHCA plan to repeal parts of the ACA (Pear & Kaplan, 2017). Senator John McCain, Republican of Arizona, cast the decisive vote to defeat the proposal, joining two other Republican senators, Susan Collins of Maine and Lisa Murkowski of Alaska, in opposing it (Pear & Kaplan, 2017). Mr. McCain offered an explanation of his vote on Twitter: "Skinny repeal fell short because it fell short of our promise to repeal & replace Obamacare w/ meaningful reform" (McCain, 2017).

2. Graham-Cassidy Repeal Bill

On September 13, 2017, two Republican senators, Lindsey Graham (South Carolina) and Bill Cassidy (Louisiana) introduced another Obamacare repeal bill (Haberkorn, 2017). Broadly, the Graham-Cassidy proposal would revamp and cut Medicaid, redistribute federal funds across states, and eliminate coverage for millions of poor Americans (KFF, 2017). Under Graham-Cassidy, five major things will take effect: end federal funding for current ACA coverage and partially replace that funding with a block grant that expires after 2026; redistribute federal funding from Medicaid expansion states to non-expansion states through the block grant program penalizing states that broadened coverage; prohibit Medicaid coverage for childless adults and allow states to use limited block grant funds to purchase private coverage for traditional Medicaid populations; cap and redistribute federal funds to states for the traditional Medicaid program for more than 60 million low-income children, parents, people with disabilities and the elderly; eliminate federal funding for states to cover Medicaid family planning at Planned Parenthood clinics for one year (KFF, 2017). Preliminary analysis of the Graham-Cassidy proposal by the CBO indicate that "if this legislation is enacted, millions of additional people would be uninsured compared with CBO's baseline population projections each year over the 2018-2026 period, and federal funding for Medicaid would be reduced by about $1 trillion over the 2017-2026 period" (CBO, 2017). On September 26, 2017, citing "lack of support," Senate Republicans announced that the Senate would not hold a vote on the Graham-Cassidy bill, effectively killing the measure (Kaplan & Pear, 2017).

3. Individual Mandate

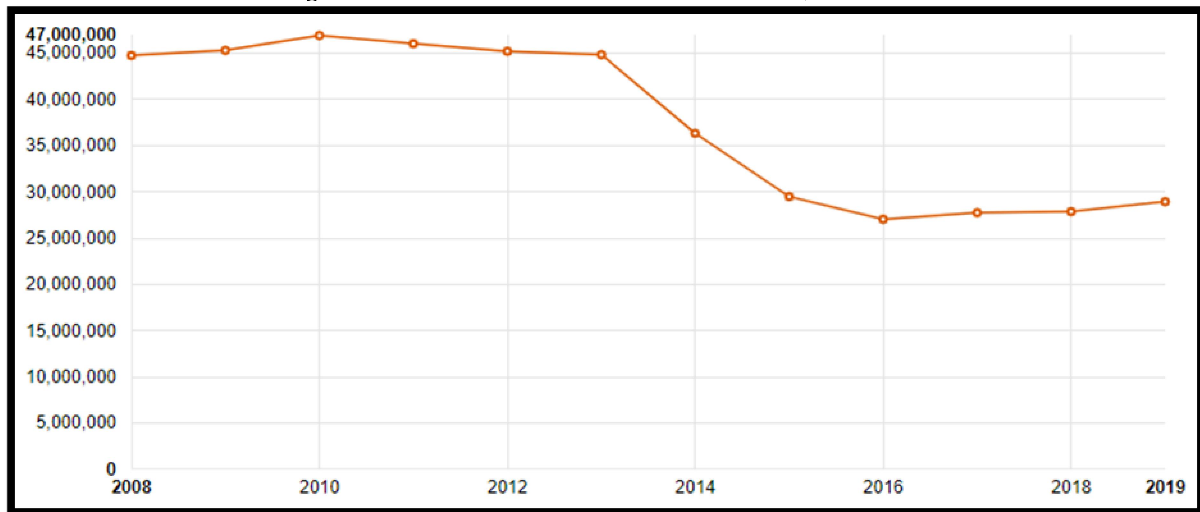
On December 22, 2017 President Trump signed a tax law that effectively repealed ACA's core provision (Section 5000A of the ACA) that required most Americans obtain health coverage or pay penalty effective in 2019 (Jost, 2017; Miller, 2017). In addition, the tax bill capped the federal deduction for individuals paying state and local taxes to a maximum of $10,000, meaning that states with more generous Medicaid programs would likely need to generate additional tax revenues to sustain their current spending on the program (Thompson, Gusmano, & Shinohara, 2018, p. 402). Furthermore, the Congressional Joint Committee on Taxation (2017) projected that the tax bill would increase the federal debt by over 1 trillion dollars over ten years. However, the tax law did not completely repeal the individual mandate, rather, specifically, the "legislation reduced to zero both the dollar amount and the percentage of tax penalty for not having health insurance coverage" (Jost, 2017). Also, Section 5000A is still part of the ACA and still provides that: "An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month." Moreover, other provisions of the ACA that support the individual mandate remain in force (Jost, 2017). Section 6055 of the Internal Revenue Code, adopted through the ACA, requires anyone who provides "minimum essential coverage," including insurers, employers, and government programs, to report specific information to the Internal Revenue Service (IRS) regarding covered individuals, and to provide covered individuals with a statement evidencing this coverage (Jost, 2017). It further imposes penalties on entities that fail to report (Jost, 2017). The tax bill repeals neither the reporting requirement nor the penalties (Jost, 2017).

V. Findings/Impact of the ACA

"On balance the ACA has proved resilient" (Thompson, 2020). Since inception, the ACA has led to widespread increases in health insurance coverage and remarkable reductions in health care costs (Blumenthal, Collins, & Fowler, 2020; Blumenthal & Abrams, 2020). Estimated 16 million people in the United States gained coverage

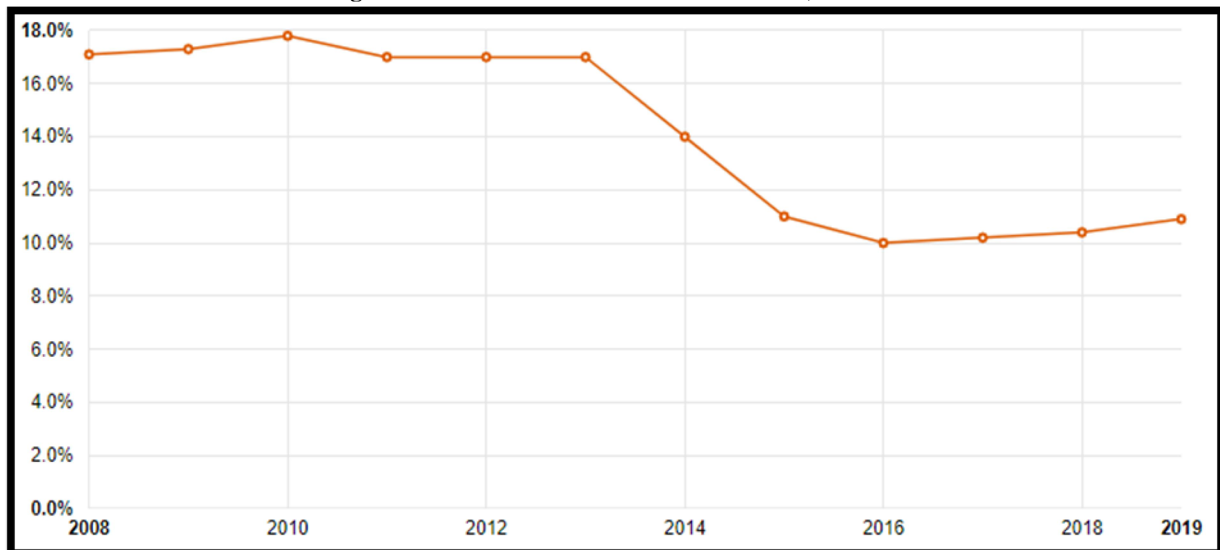
from 2008 through 2019 (Figure 7), while the uninsured rate for all persons dropped by 57% from 17.0% to a remarkable low of 10.9% (Figure 8) during the same period. Gains in health coverage have occurred across all income groups, races and ethnic groups, and geographies between 2010 and 2015 (HHS, 2016; Avery, Finegold, & Whitman, 2016). HHS and Avery et al. (2016) found that among all non-elderly adults, uninsured rate declined by nearly half from 22.2% to 13.0% between 2010 and 2015. Similarly, the urban and rural populations have shared in the uninsured rate decrease. Sommers, et al., Gunja, Finegold, and Musco (2015) found that coverage rate increased 8.0% in rural areas and 7.9% in urban areas. Studies indicate that ACA has helped to slow down the cost per case growth of health care from 2.9% to 2.0% including hospital and physician reimbursements (Cox, et al., 2016; Martin, et al., 2014).

Figure 7: Uninsured* Number for All Persons, 2008-2019



* includes those without health insurance and those who have coverage under the Indian Health Service only.
Source: Kaiser Family Foundation, State Health Facts. Retrieved November 30, 2020.

Figure 8: Uninsured Rate* for All Persons, 2008-2019



* The proportion of the population or subpopulation with no insurance.
Source: Kaiser Family Foundation, State Health Facts. Retrieved November 30, 2020.

In addition, the ACA has helped to reduce individual prescription drug costs by $1,061 (Haven, 2013). Also, the non-partisan Congressional Budget Office (CBO) estimates that the ACA will reduce deficits by about $130 billion over the 2012-2019 period, plus another $15 billion reduction in subsidies induced by Medicare and Medicaid cost savings through the marketplace health insurance exchanges (CBO, 2011). In conjunction, the CBO estimates that by 2023 an additional 13 million people will obtain coverage through Medicaid and 24 million will have exchange based plan (CBO, 2014). Furthermore, research indicate that the ACA have positive impact on employment. A 2017 Stanford University study, for example, found that employment growth in the first year after the ACA was the highest since the 1990s and 30% more compared to the previous three years

(Duggan, Goda, & Jackson, 2017). The impact of the ACA extend to Louisiana.

Since Louisiana implemented Medicaid expansion on July 1, 2016, as of October 1, 2021 more than 690,000 newly eligible adults have enrolled in Medicaid expansion (LDH, 2021). In addition, Louisiana received estimated $1.85 billion in SFY 2017, approximately $1.77 billion in SFY 2018, and anticipated $1.8 billion in SFY 2019 in federal dollars to support its Medicaid Expansion program (Richardson, Llorens, & Heidelberg, 2019, p. 5). Aside fiscal contribution, Medicaid expansion federal dollars inject employment, earnings, payments and tax receipts into the state economy.

VI. Conclusion

This paper shows that the ACA has played a major role in the reduction of the number of people without health insurance coverage in the United States. The following three observations go a long way to demonstrate the impact of the ACA in addressing health disparity. "But for all its well-documented flaws, the ACA has clearly provided the public with something that it values. That is no small thing" (Cohn, 2020). "Passage of the ACA broke the political logjam that long stymied national progress toward equitable, quality, universal, affordable health care. It extends coverage for the uninsured who are disproportionately low income and people of color, curbs health insurance abuses, and initiates improvements in the quality of care" (Shaffer, 2013). "The law did not achieve universal coverage, but it brought about a historic drop in the number of Americans without health insurance" (*The New York Times*, March 23, 2020).

In Louisiana as of October 1, 2021 more than 690,000 previously uninsured adults have gained coverage since the state implemented Medicaid expansion in July 2016. By 2013, the year before the major coverage provisions of the ACA took effect, more than 43 million people in the United States lacked health coverage (Cohen, Martinez, & Zammitti, 2016). However, since the ACA became effective, estimated 20 million adults in the U.S. have gained coverage (Goodnough, et al., 2020) and the uninsured rate has declined by 36%, from 16.0% in 2010 to 10.3% in 2019 (Cohen et al., 2020), because of the law's reforms. Medicaid and CHIP enrollment have also increased nationally because of the ACA. Overall as of March 2020, 71.6 million individuals are enrolled in Medicaid or CHIP, and enrollment increased by 14.0 million among the 49 states reporting data, representing 24.7% increase (MACPAC – Medicaid and CHIP Payment and Access Commission). In conjunction, for the states that have expanded Medicaid, enrollment increased by 12.4 million or 32.6% through January 2020 (MACPAC – Medicaid and CHIP Payment and Access Commission).
https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/.

Research also show related improvements in access to care since the ACA (gains in health coverage across all income groups, races, ethnicities, and geography); reduction in uninsured rate among non-elderly adults by nearly half (from 22.2% to 13.0%); 8% coverage increase in urban-rural populations; financial security (e.g. an estimated reduction in debts sent to collection of $600-$1000 per person gaining Medicaid coverage); reduction in individual prescription drugs cost by $1,061; slowed down the growth of per care cost from 2.9% to 2.0%. Also, according to the CBO, the law will reduce the federal deficit by estimated $130 billion over the 2012-2019 period, including additional $15 billion cost savings through the market exchanges. Furthermore, the ACA has boosted employment gains and other sectors of the economy. Despite these progress, challenges remain, especially, the efforts to repeal and replace the ACA. Public policy must continue to build on the progress made by the ACA by supporting ongoing reforms, coverage expansions, increasing federal health care financial support, and prescription drugs cost reduction.

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