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Money in the Bank and Boots on the Ground: A Law-Policy Proposal to Make the Affordable Care Act Work in Louisiana

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INTRODUCTION

Kilbourne, a village in northeast Louisiana, lies snug against the Arkansas border. This area is among the poorest in the country.[1] Because

1. Twenty-five percent of West Carroll Parish residents, of which Kilbourne is a part, live below the federal poverty level. *State & County QuickFacts: West Carroll Parish, Louisiana*, U. S. CENSUS BUREAU, http://quickfacts.census.gov

it is a rural location, its residents find it difficult to access healthcare.[2] They must travel down miles of bumpy country roads to reach the nearest hospital. Few here possess the luxury of private insurance, and Louisiana maintains some of the strictest requirements for Medicaid eligibility, leaving many without any healthcare coverage at all.[3] In the 1920s, some Arkansas families crossed the border and relocated from southern Arkansas to Kilbourne to take advantage of Huey Long's program that provided free textbooks to students.[4] Now, in 2015, a few families in Kilbourne might look to move a few hundred feet north to take advantage of Arkansas's expansion of Medicaid that covers many of the working poor Louisiana currently leaves behind.[5]

Louisiana, like Arkansas, is a state that has long struggled to provide its citizens with access to adequate healthcare, but, with the passage of the Affordable Care Act ("ACA"),[6] these two states have taken radically different approaches to healthcare policy. Louisiana has steadfastly refused

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/qfd/states/22/22123.html [http://perma.cc/NS6K-R79E] (last updated Aug. 31, 2015, 1:06 PM).

2. A Health Professional Shortage Area ("HPSA") encompasses all of West Carroll Parish according to the Health Resources and Services Administration on-line data warehouse. *See HPSA Find*, HRSA, http://hpsafind.hrsa.gov/HPSASearch.aspx [http://perma.cc/PXA4-MFPK] (last visited Sept. 18, 2015) (select "Louisiana" for state; then select "West Carroll Parish" for county; then select "Primary Care" for HPSA discipline). An HPSA is determined by the Secretary of Health and Human Services based on data provided by the state governments. *See* 42 C.F.R. § 5.3 (2014). An HPSA is an area that has a ratio greater than or equal to one primary care physician per 3,500 residents, or one primary care physician per 3,000 residents if the area's population has an unusually high need for service. *Id.*

3. *See Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level*, KAISER FAM. FOUND., http://kff.org/medicaid/state-indicator/Medicaid-income-eligibility-limits-for-adults-at-application-2014/ [http://perma.cc/C39W-A2BZ] (last visited Sept. 18, 2015); *Understanding the Impact of a Medicaid Expansion in Louisiana: Considerations, Assumptions and Uncertainties*, DEP'T HEALTH & HOSPS. (2013), http://dhh.louisiana.gov/assets/medicaid/docs/mdcdexpntnimpct_march13.pdf [http://perma.cc/ASA6-W38B].

4. This author's grandfather, the youngest of 10 children, moved from Arkansas to Kilbourne with his family, because his father could not afford to send his children to school if he had to purchase textbooks.

5. *See* ARK. CODE ANN. §§ 20-77-2401 to 20-77-2408 (West Supp. 2015). Arkansas is the only Deep South state to expand Medicaid. *Status of State Action on Medicaid Expansion Decision*, KAISER FAM. FOUND., http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ [http://perma.cc/69FS-8LN2] (last updated Sept. 1, 2015).

6. ACA refers to the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

to expand Medicaid while Arkansas has embraced the expansion but engaged in negotiations to shift new enrollees into the private insurance marketplace.[7] Although both states claim that they are moving towards privatization of healthcare services,[8] Louisiana is actually leaving itself vulnerable to changes in Medicaid funding under the ACA that will cause Louisiana to have less flexibility in meeting future healthcare needs. At the same time, Louisiana faces a critical shortage of doctors, which hurts communities from Kilbourne to New Orleans.[9] Louisiana can best ensure access to healthcare services by adopting a Medicaid expansion plan that uses federal funds to place eligible recipients on a state-run insurance exchange, while expanding the scope of practice for non-physician healthcare workers.

In Part I, this Comment reveals the scope of the challenge, highlighting the factors that contribute to Louisiana's shortage of healthcare providers. Part II provides an overview of the ACA's changes to Medicaid and the legislation's impact on doctors and hospitals. Part III discusses Louisiana's reaction to the ACA, focusing on how the state's actions have decreased available funding for healthcare providers. Part IV offers solutions to the healthcare provider crisis, including a discussion about the benefits of Medicaid expansion for Louisiana and the lessons Louisiana can learn from Arkansas and other states grappling with similar doctor shortages.

I. LOUISIANA FACES A CHRONIC SHORTAGE OF DOCTORS

Louisiana's chronic problems with poverty and sickness have plagued efforts to ensure better healthcare coverage in Louisiana.[10] The state is not alone; many other states face similar shortages of healthcare providers.[11] This shortage will become even more severe in the near future, as increased demand for healthcare places further strain on an already overburdened system.[12] Although the entire nation faces this problem, Louisiana has an

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7. *See infra* Part IV.E.

8. *The Big Transition – Sizing Up Louisiana's Private Approach to Public Health Care*, BUS. REP. (Aug. 19, 2014), https://www.businessreport.com/article/the-big-transition-sizing-up-louisianas-private-approach-to-public-health-care [https://perma.cc/4KUV-LJZE].

9. *See infra* Part I.B; Sabrina Tavernise & Robert Gebeloff, *Millions of Poor are Left Uncovered by Health Law*, N.Y. TIMES (Oct. 2, 2013), http://www.nytimes.com/2013/10/03/health/millions-of-poor-are-left-uncovered-by-health-law.html?pagewanted=all&_r=0.

10. *See* Robin Rudowitz, Diane Rowland & Adele Shartzer, *Health Care in New Orleans Before and After Hurricane Katrina*, 25 HEALTH AFF. 393, 394 (2006).

11. Jennifer Lorio, Comment, *Physician Reimbursement, Impending Shortages, and Healthcare Reform*, 21 ANNALS HEALTH L. 11, 15 (2011).

12. Edward Salsberg & Atul Grover, *Physician Workforce Shortages: Implications and Issues for Academic Health Centers and Policymakers*, 81 ACAD. MED. 782, 782 (2006).

even greater challenge because of the severity of the state's preexisting healthcare shortage.[13]

A. Louisiana's Doctor Shortage is Part of a National Trend

The entire nation suffers from a critical shortage of doctors that will only grow more severe if significant numbers of new physicians do not enter the workforce rapidly. Over one quarter of the nation's physicians are 60 or older, so many doctors are curtailing their practices and preparing for retirement.[14] Estimates place the current physician shortage at approximately 7,000 doctors.[15] The Association of American Medical Colleges ("AAMC") predicts that the country will face a shortfall of over 90,000 doctors by 2020.[16] A national shortage of healthcare providers means patients have to wait longer to see a physician because a doctor can only see so many patients in a day.[17] Although sheer numbers are important when determining whether there is an adequate supply of doctors, numbers alone do not tell the whole story.[18]

In addition to the sheer number of doctors, both geographic location and specialization of physicians play a critical role in determining whether there

13. *See, e.g.*, Campbell Robertson, *Louisiana Has Much at Stake in Healthcare Debate*, N.Y. TIMES (Dec. 19, 2009), http://www.nytimes.com/2009/12/20/health/policy/20louisiana.html.

14. ASS'N OF AM. MED. COLLS., 2011 STATE PHYSICIAN WORKFORCE DATA BOOK 21 (2011) [hereinafter 2011 STATE PHYSICIAN WORKFORCE DATA], *available at* https://www.aamc.org/download/263512/data/statedata2011.pdf [https://perma.cc/RU8D-RA7W].

15. U.S. DEP'T OF HEALTH & HUMAN SERVS., PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS TO 2020, at 30 (2006) [hereinafter PHYSICIAN SUPPLY & DEMAND], *available at* http://bhpr.hrsa.gov/healthworkforce/supplydemand/medicine/physician2020projections.pdf [http://perma.cc/Y2PU-K6JJ].

16. Michael Ollove, *Are There Enough Doctors For the Newly Insured?*, KAISER HEALTH NEWS (Jan. 3, 2014), http://www.kaiserhealthnews.org/Stories/2014/January/03/doctor-shortage-primary-care-specialist.aspx [http://perma.cc/HQ3U-LPV7]. The nation will face a shortage of 45,000 primary care doctors and 46,000 specialists. *Id.* However, some dispute exists concerning the exact number of new doctors needed. *See* PHYSICIAN SUPPLY & DEMAND, *supra* note 15, at 31–32 (noting that the number of new doctors needed is uncertain and varies from specialty to specialty). Still, demand for physicians will outpace supply if current trends continue. ELAYNE J. HEISLER, PHYSICIAN SUPPLY AND THE AFFORDABLE CARE ACT 6 (2013), *available at* http://op.bna.com/hl.nsf/id/myon-93zpre/$File/crsdoctor.pdf [http://perma.cc/TAF2-UE3J] (summarizing studies that estimate the shortage of physicians growing over the next decade from 55,000 to 150,000 physicians).

17. *See* Jenny Gold, *In Cities, the Average Doctor Wait-Time is 18.5 Days*, WASH. POST (Jan. 29, 2014), http://www.washingtonpost.com/blogs/wonkblog/wp/2014/01/29/in-cities-the-average-doctor-wait-time-is-18-5-days/ [http://perma.cc/9FHJ-4NK8].

18. *See* HEISLER, *supra* note 16, at 1.

are enough doctors to satisfy the healthcare needs of a community.[19] Doctors must set up practices in urban and rural locations, and the population of doctors should contain an adequate proportion of doctors, both primary care providers and specialists,[20] to meet demand in their particular fields. Although 20% of all Americans live in rural areas, only 9% of doctors live in rural areas, creating geographic disparities in access to care.[21] Furthermore, America has a lower proportionate share of primary care physicians compared to other industrialized nations[22] and many specialist concentrations, such as Oncologists,[23] face severe shortfalls in the number of physicians needed.[24] Today, one-in-five Americans live in Health Professional Shortage Areas ("HPSAs")—an area where the federal government determines there are too few healthcare providers to meet the demands of the population.[25] With too few doctors available, patients have to wait longer for treatment, or even forgo care altogether if a provider is simply unavailable in their area.[26]

B. Louisiana Faces a More Severe Healthcare Crisis than the Nation as a Whole

Louisiana faces an even greater challenge ensuring it has an adequate number of doctors to meet the healthcare needs of the state. Poverty and sickness "left Louisiana before Katrina with more than one in five . . . residents without health insurance and one of the highest uninsurance rates in the country."[27] The two scourges of poverty and sickness still plague

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19. *Id.*

20. A primary care physician is a physician that has first contact with a patient, diagnosing and treating illnesses regardless of cause or disease. *Primary Care*, AAFP, http://www.aafp.org/about/policies/all/primary-care.html [http://perma.cc/H6YB-QLA4] (last visited Sept. 18, 2015). A specialist is a physician who has expertise in an area of medicine, such as a specific disease, body part, or organ system. *Specialty Definitions*, MEDICARE.GOV, http://www.medicare.gov/physiciancompare/staticpages/resources/specialtydefinitions.html?AspxAutoDetectCookieSupport=1 [http://perma.cc/BN9Y-7EES] (last visited Sept. 18, 2015).

21. Roger A. Rosenblatt, *Physicians and Rural America*, 173 W. J. MED. 348, 348 (2000).

22. *See* HEISLER, *supra* note 16, at 13 (noting that only about one-third of doctors in the United States are primary care physicians compared to about half of the doctors in other industrialized nations).

23. An oncologist is a specialist that treats cancer patients. Dennis Thompson, *U.S. Could Face Shortage of Cancer Doctors*, CBS NEWS (Mar. 11, 2014, 11:03 AM), http://www.cbsnews.com/news/us-could-face-shortage-of-cancer-doctors/.

24. *Id.*

25. Ollove, *supra* note 16. For the statutory definition of an HPSA, see 42 C.F.R. § 5.3 (2014).

26. *See* Sidney D. Watson, *Mending the Fabric of Small Town America: Health Reform & Rural Economies*, 113 W. VA. L. REV. 1, 10 (2010).

27. Rudowitz et al., *supra* note 10, at 394.

Louisiana. In 2012, only New Mexico and Mississippi had a higher percentage of their states' population living below the Federal Poverty Level ("FPL").[28] Louisianans also have higher instances of chronic diseases, such as cancer, diabetes, and heart disease, when compared to the national average,[29] which increases demand on healthcare providers. Healthcare providers prefer patients to have some form of healthcare coverage because receiving compensation for services is easier when the patient has insurance.[30] The state's demographics make Louisiana far less attractive to new doctors who have to pay back substantial student loans.[31]

As a result of these longstanding problems, too few Louisianans have adequate access to care. Of Louisiana's 64 parishes, 61 have at least one primary care HPSA within their borders, and the federal government designates 26 parishes entirely HPSAs.[32] These HPSAs encompass one-third of Louisiana's population, and an estimated two million Louisianans do not have adequate access to specialists.[33] Even major urban hospitals in Louisiana struggle to find enough doctors to serve patients.[34]

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28. ALEMAYEHU BISHAW, POVERTY: 2000 TO 2012, at 3 tbl.1 (2013), *available at* https://www.census.gov/prod/2013pubs/acsbr12-01.pdf [https://perma.cc/M5P6-LWD4] (In 2012, 19.9% of Louisiana's population lived below the federal poverty level). For 2014, the federal poverty level was $11,670 per year for a single person and $23,850 per year for a family of four. Dep't of Health & Human Servs., *2014 Poverty Guidelines*, ASPE (Dec. 1, 2014) [hereinafter *2014 Poverty Guidelines*], http://aspe.hhs.gov/poverty/14poverty.cfm [http://perma.cc/6S9H-4PBM].

29. NKENGE JONES-JACK ET AL., 2013 LA COORDINATED CHRONIC DISEASE REPORT: EXPLORING THE RELATIONSHIP BETWEEN CHRONIC DISEASES AND THEIR RISK FACTORS IN LOUISIANA 1 (2013); *see also* John V. Jacobi, *Medicaid Evolution for the 21st Century*, 102 KY. L.J. 357, 378 (2014) ("In low-income populations, poor health outcomes are often driven by poverty and related social issues, including unstable housing and employment, problems getting transportation, and insufficient access to a nutritious diet." (quoting Tricia McGinnis & David Marc Small, *Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design*, CHCS (Feb. 2012), http://www.chcs.org/media/Creating_ACOs_in_Medicaid.pdf [http://perma.cc/V4BL-VT6Y] (manuscript at 3–4)).

30. Telephone Interview with Blake Kramer, J.D., Administrator, Franklin Medical Center (Jan. 16, 2015) (on file with author). Providers have a less difficult time receiving payment when the patient has insurance. *Id.*

31. *See Medical Student Education: Debt, Costs, and Loan Repayment Fact Card*, AAMC (Oct. 2014), https://www.aamc.org/download/152968/data/debtfactcard.pdf [https://perma.cc/3ELR-JFAC]. The average medical school graduate has over $175,000 of debt upon graduation. *Id.*; *see also* John N. Kennedy, *Louisiana Needs a Med School in Lafayette*, LA. DEP'T TREASURY (Mar. 12, 2014), http://www.treasury.state.la.us/Lists/SiteArticlesByCat/DispForm_Single.aspx?List=c023d63e-ac65-439d-af97-da71d8688dff&ID=810 [http://perma.cc/48ZC-Z48C].

32. *HPSA Find*, *supra* note 2.

33. Kennedy, *supra* note 31.

34. *See, e.g.*, *Woman's, OLOL Partner in ICU Telemedicine Program*, WOMAN'S (Oct. 21, 2014), http://www.womans.org/news/2014/10/telemedicine-

Despite having three medical schools in the state, Louisiana has not been able to train or attract enough doctors to keep up with demand.[35] Louisiana ranks among the bottom of states in physicians per capita.[36] Louisiana hospitals depend on doctors trained in Louisiana to serve patients,[37] but many doctors trained by the state's medical schools leave the state after completing training.[38] It comes as no surprise that Louisiana's medical residencies have seen slower growth than the rest of the nation.[39] Without an influx of new doctors, Louisiana's doctor population is aging rapidly.[40] Louisiana's large rural population[41] adds to the shortage because doctors are less inclined to practice in rural areas.[42] Although a mix of state and federal tax incentives and loan forgiveness programs encourage doctors to set up practice in medically underserved areas in Louisiana,[43] local hospitals have had difficulty recruiting doctors

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press-release/ [http://perma.cc/T84Y-J7LC]. As a result of a shortage of intensivists—doctors that treat critically injured patients—Woman's Hospital in Baton Rouge contracted with Our Lady of the Lake to remotely monitor Woman's patients. *Id.*

35. *See* Kennedy, *supra* note 31 (advocating for a new medical school to increase the number of doctors in Louisiana). However, because of the structural challenges discussed *infra*, a doctor shortage would likely still remain.

36. 2011 STATE PHYSICIAN WORKFORCE DATA, *supra* note 14, at 9. Louisiana ranks thirtieth in the number of active physicians per 100,000 population, with 232.7 doctors per 100,000 population. *Id.* The state fares even worse with primary care providers. *Id.* at 13. The state ranks thirty-sixth, with just 78 primary care providers per 100,000 population. *Id.*

37. *See* Rebecca Catalanello, *Wonders of Modern Medicine: University Medical Center in Mid-City is Astounding in Its Mass and Magnitude*, TIMES–PICAYUNE (New Orleans), Oct. 11, 2013, at A1 (stating that 80% of doctors at one New Orleans hospital come from LSU medical schools).

38. Laura Maggi & John Pope, *In Changing Med. School Climate, Tradition Continues But Fewer Staying in State for Residencies*, TIMES–PICAYUNE (New Orleans), Mar. 16, 2013, at A1 (stating that, in 2013, 56% of graduating seniors at LSU Health Sciences Center New Orleans remained in Louisiana for residency; 39% of LSU Health Sciences Center Shreveport class remained in the state; but just 18% of Tulane's class remained).

39. From 2000 to 2010 Louisiana ranked forty-second in the number of new residencies created. 2011 STATE PHYSICIAN WORKFORCE DATA, *supra* note 14, at 45.

40. In 2010, 27.5% of Louisiana's doctors were over the age of 60. *Id.* at 21.

41. LA. DEP'T. OF HEALTH & HOSPS., LOUISIANA RURAL HEALTH PLAN 2011-15, at 1 (2011). About 1.1 million Louisianans live in rural areas. *Id.*

42. *See* Rosenblatt, *supra* note 21, at 348 (noting that healthcare professionals tend "to locate and practice in relatively affluent urban and suburban areas").

43. 42 U.S.C. § 254*l*–1 (2012) (providing loan forgiveness to healthcare professionals); LA. REV. STAT. ANN. § 40:1300.4 (Supp. 2015) (establishing state participation in the federal loan forgiveness program); *id.* § 40:1300.9 (establishing scholarships for doctors); *id.* § 47:297(H) (providing tax incentives of $5,000 for 5 years for doctors in rural areas).

who do not have personal ties to the geographic areas.[44] Doctors also face the temptation of more lucrative job opportunities in cities once incentives end.[45]

Louisiana has also yet to recover fully from the damage that Hurricanes Katrina and Rita wrought on healthcare infrastructure in a state already struggling to provide adequate healthcare.[46] Katrina shuttered two of Louisiana's three medical schools for an extended period of time and displaced many doctors from the New Orleans metro area, the state's most populous region.[47] It took over a decade after Katrina for the replacement to Charity Hospital, the largest hospital in New Orleans, to open.[48] Residents had to make do with a smaller, interim hospital prior to the opening of the new University Medical Center on August 1, 2015.[49] Furthermore, many doctors who relocated outside of Louisiana after the storm never returned.[50] Although Louisiana has seen an increase in the number of physicians trained in state since Hurricane Katrina, "the restoration is not yet complete," and the Louisiana Medical Education Commission in their 2013 report listed "[t]he repair and rejuvenation of Katrina damaged institutions [as] the number one recommendation."[51]

II. THE AFFORDABLE CARE ACT WILL INCREASE DEMAND FOR DOCTORS

Louisiana's current shortage of doctors makes the state disproportionately vulnerable to any increased strain on the healthcare system, which the ACA creates through greater demand for medical services by newly insured patients.[52] In 2010, Congress passed the ACA with the intention of providing

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44. Telephone Interview with Blake Kramer, *supra* note 30. The tax incentives do help convince doctors with ties to the area to come home, but tax incentives alone rarely convince doctors to relocate. *Id.*

45. *Id.* Because these hospitals typically recruit doctors who have ties to the local area, many remain even though the doctors acknowledge better employment opportunities exist elsewhere. *Id.*

46. Rudowitz et al., *supra* note 10, at 399–400; Catalanello, *supra* note 37.

47. Rudowitz et al., *supra* note 10, at 393; Kevin B. O'Reilly, *Katrina's Legacy, Moving Beyond the Storm*, AMEDNEWS.COM (Aug. 16, 2010), http://www.amednews.com/article/20100816/profession/308169942/4/ [http://perma.cc/25UZ-GXPK].

48. Press Release, Univ. Med. Ctr., University Medical Center Opens (Aug. 1, 2015), http://www.umcno.org/News/August12015UniversityMedicalCenterOpens?showBack=true&PageIndex=0 [http://perma.cc/DA2Q-G7L7].

49. *Id.*; *see also* Catalanello, *supra* note 37.

50. O'Reilly, *supra* note 47.

51. LA. MED. EDUC. COMM'N, SIXTEENTH ANNUAL REPORT: 2013, at 24, 39 (2013), *available at* http://www.lsuhsc.edu/mec/docs/Medical%20Education%20Commission%202013%20web.pdf [http://perma.cc/CP2W-537E].

52. *See* Marshall B. Kapp, *Conscripted Physician's Services and the Public's Health*, 39 J.L. MED. & ETHICS 414, 415 (2011) (describing how Medicaid expansion

healthcare coverage to millions of Americans;[53] however, the legislation has fallen short in providing the newly insured with access to care due to long wait times and doctors that are far from patients.[54]

A. The ACA Expands Healthcare Coverage

The ACA reduces the number of uninsured by expanding access to private insurance and Medicaid.[55] To encourage participation in the healthcare market, the ACA requires that all individuals have healthcare coverage or pay a penalty in the form of a tax.[56] The ACA ensures that individuals with low incomes will have affordable access to private health insurance plans by subsidizing coverage for individuals and families enrolled in insurance exchanges.[57] These subsidies are awarded on a sliding scale for households with incomes between 100% and 400% of the FPL.[58] However, these households must not qualify for Medicaid

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can lead to more emergency room visits); Austin Frakt, *When Health Coverage Expansion Means Longer Waits for a Doctor*, N.Y. TIMES (Nov. 24, 2014), http://www.nytimes.com/2014/11/25/upshot/when-health-coverage-expansion-means-longer-waits-for-a-doctor.html?abt=0002&abg=1 (noting that increased healthcare coverage increases demand for care because "uninsured people avoid and delay care more than insured people").

53. Jacobi, *supra* note 29, at 357.

54. *See, e.g.*, Robert Pear, *For Many New Medicaid Enrollees, Care Is Hard to Find, Report Says*, N.Y. TIMES (Sept. 28, 2014), http://nyti.ms/1nkaSYL. Another issue faced by consumers is the increasing prevalence of high deductible plans on the healthcare marketplace. Bob Herman, *High-Deductible Plans Dominate the Next Open Enrollment*, MOD. HEALTHCARE (Nov. 13, 2014), http://www.modernhealthcare.com/article/20141113/NEWS/311139966 [http://perma.cc/7KZ5-EZKA]. The average deductible has more than doubled since 2006. *Id.* These high deductible plans cause people to avoid doctor visits because of cost, decreasing access to care. *Id.*

55. Rick Mayes & Benjamin Paul, *An Analysis of the Political and Legal Debates Concerning Medicaid Coverage in Virginia*, 18 RICH. J.L. & PUB. INT. 23, 27 (2014).

56. 26 U.S.C. § 5000A (2012). Some exemptions exist. *See* 42 C.F.R. § 1.5000A–3 (2014) (exempting certain members of religious sects, nonresident aliens, people without access to affordable coverage, inmates, members of Indian tribes, people below the filing threshold of Federal income tax returns, and individuals who lack coverage for less than three months out of the year). The Supreme Court held that this penalty was actually a tax. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2601 (2012).

57. 26 U.S.C. § 36B (2012). The Supreme Court recently affirmed that section 36B allows subsidies for individuals enrolled in federal, as well as state, exchanges. King v. Burwell, 135 S. Ct. 2480, 2496 (2015). The Court's ruling ensures that millions of people in states with federal exchanges will continue to have access to health insurance on the exchanges. *See id.* at 2493–94.

58. 26 C.F.R. § 1.36B–2 (2013). A family of four earning between $23,850 and $95,400 would qualify for a subsidy under 2014 poverty levels. *See 2014 Poverty Guidelines*, *supra* note 28.

coverage.[59] States may set up their own exchanges, but in states that have declined to create exchanges, the Department of Health and Human Services ("DHHS") has set up a federal insurance exchange.[60]

In addition to expanding access to private health insurance, the ACA expands the Medicaid program to increase coverage.[61] Medicaid is a cooperative state–federal program that provides healthcare to qualifying low-income individuals.[62] State participation in Medicaid is voluntary.[63] Yet every state has adopted some form of Medicaid because of the massive amounts of federal money available.[64] In 2013, federal and state governments covered over 60 million Americans and spent over $400 billion in health insurance through the Medicaid program.[65] Medicaid is the largest health program in the country, larger even than Medicare.[66] Medicaid has become "an essential part of the U.S. healthcare landscape."[67]

Although the Medicaid program injects hundreds of billions of dollars into the healthcare system annually, the program suffers from low physician participation.[68] This is largely because of the three major sources of healthcare coverage—private insurance, Medicare, and Medicaid—Medicaid pays the lowest reimbursement rates for physicians.[69] Many doctors are reluctant to take on Medicaid patients because of the program's poor reimbursement rate, which makes it harder for enrollees to access

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59. 26 C.F.R. § 1.36B–2.

60. 42 U.S.C. § 18041(b)–(c) (2012).

61. Jacobi, *supra* note 29, at 357.

62. Mark A. Hall, *States' Decision Not to Expand Medicaid*, 92 N.C. L. REV. 1459, 1459 (2014). Traditionally, Medicaid required coverage for four key segments of the population: (1) pregnant women and children, (2) people qualifying for public welfare, (3) the disabled, and (4) the elderly who can no longer afford their share of Medicaid contributions. Mayes & Paul, *supra* note 55, at 25–26.

63. Mayes & Paul, *supra* note 55, at 25.

64. *Id.*

65. KAISER COMM'N ON MEDICAID & THE UNINSURED, KAISER FAMILY FOUND., MEDICAID: A PRIMER 1, 25 (2013) [hereinafter MEDICAID: A PRIMER], *available at* http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf [http://perma.cc/SX5B-GMJV].

66. Mayes & Paul, *supra* note 55, at 24. Medicare is the federal insurance program for people over 65 and other limited individuals with disabilities. *Glossary*, MEDICARE.GOV, http://www.medicare.gov/glossary/m.html [http://perma.cc/ETE3-4LCS] (last visited Sept. 18, 2015). Most healthcare spending occurs at the end of life, and many elderly enter nursing homes on Medicare, but after exhausting Medicare they shift to Medicaid to cover the cost. *See* MEDICAID: A PRIMER, *supra* note 65, at 26–28.

67. Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 6 (2006).

68. *See* Hall, *supra* note 62, at 1462.

69. *Id.*

needed services.[70] In addition to low payments, participation in Medicaid triggers exposure to strict fraud and abuse liability, scaring many doctors away from the program.[71] All of these factors lead to "widespread physician non-participation, particularly in the case of specialty care."[72]

Another problem for individuals seeking coverage under Medicaid is the wide amount of variance allowed between state plans.[73] To qualify for Medicaid, states must submit a plan that meets baseline care standards for enrollees,[74] and the Secretary of Health and Human Services must approve the state plan.[75] So long as the state Medicaid program meets minimal coverage standards,[76] the federal government will cover a share of the expenses.[77] The state's share of the expense can range from 26% to 50% of the cost depending on the state's per capita income.[78] States may choose to expand their Medicaid programs to cover additional services, and the federal government will continue to pay its matching rate.[79] States can also receive waivers from federal Medicaid plan requirements for experimental or demonstration projects aimed at delivering healthcare more efficiently.[80] This open-ended structure led to disparities in Medicaid coverage: some states vastly expanded coverage compared to federal baseline standards, and other states provided only minimal coverage.[81] States have an enormous

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70. Phil Galewitz, *Study: Nearly A Third Of Doctors Won't See New Medicaid Patients*, KAISER HEALTH NEWS (Aug. 6, 2012), http://khn.org/news/third-of-medicaid-doctors-say-no-new-patients/ [http://perma.cc/D9QN-DW42]. In 2011, only about 62% of Louisiana's doctors were willing to take on new Medicaid patients. *Id.*

71. David W. Hilgers & Sidney S. Welch, *Physicians Post-PPACA: Not Going Bust at the Healthcare Buffet*, 23 HEALTH LAW., no. 3, Feb. 2012, at 1, 3.

72. Sara Rosenbaum & Benjamin D. Sommers, *Rethinking Medicaid in the New Normal*, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 127, 135–36 (2011).

73. *See* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 448–49 (2011).

74. 42 U.S.C. § 1396a (2012).

75. *Id.* § 1396a(b).

76. *See* 42 U.S.C. § 1396; *see also Benefits*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html [http://perma.cc/TL2X-8HVQ] (last visited Oct. 12, 2014) (providing a list of mandatory and optional benefits for states' Medicaid programs).

77. 42 U.S.C. § 1396a(c).

78. Mayes & Paul, *supra* note 55, at 24–25. The state's matching fund is determined under a formula, the FMAP, which averages the per capita income from three previous years. LA. DEP'T. OF HEALTH & HOSPS., LOUISIANA MEDICAID ANNUAL REPORT: STATE FISCAL YEAR 2012/13, at 15 (2014) [hereinafter ANNUAL REPORT]. Additionally, Congress can adjust the formula to account for exigent circumstances, such as Hurricane Katrina. *See id.*

79. *See* 42 U.S.C. § 1396(d)(A) (listing services that qualify for reimbursement).

80. *See id.* § 1315. The state plan requirements are found in United States Code, Title 42, Sections 302, 602, 654, 1202, 1352, 1382, and 1396a.

81. *See* Huberfeld, *supra* note 73, at 448–49.

amount of flexibility in determining not only who to cover, but also how to cover individuals, leading one commentator to remark that "the Medicaid program is really 50 very different programs serving different populations and providing different benefits."[82]

Congress sought to even out this disparity by creating a more uniform Medicaid program through the ACA.[83] Medicaid became the vehicle of choice to cover all low-income Americans who did not qualify for subsidized private insurance.[84] The ACA extended eligibility for Medicaid to all adults under the age of 65 who do not fall into a category of mandatory Medicaid coverage and whose income does not exceed 133% of the FPL.[85] For individuals who receive coverage under the ACA's expansion of Medicaid, the federal government will pay a much greater share of the program's cost.[86] The federal government will cover 100% of the Medicaid expansion for the first three years and will gradually reduce its share to 90% by the year 2020.[87] The ACA also included a stiff penalty to enforce this expansion: states that chose not to expand Medicaid to cover the newly eligible population would lose all Medicaid funding.[88] The

82. Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 857 (1990). This remark predates the current crisis of healthcare providers by almost a quarter-of-a-century, at a time when many experts predicted a surplus in doctors and before the apocalyptic cost projections that provided the impetus for passing the ACA. CONG. BUDGET OFFICE, THE LONG-TERM OUTLOOK FOR HEALTH CARE SPENDING 9, 12 (2007), *available at* https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/11-13-lt-health.pdf [https://perma.cc/C9Q9-A9TP] (projecting that without changes in federal law, healthcare spending would double to 31% of the GDP by 2035 and comprise almost 50% of the GDP by 2060); *see also* Vinita Andrapalliyal, *"Healthcare for All"? The Gap Between Rhetoric and Reality in the Affordable Care Act*, 61 UCLA L. REV. DISC. 58, 70 (2013) (describing how ballooning healthcare costs and uninsured individuals led to the political will to pass the ACA, where other reform efforts in the past had failed).

83. Huberfeld, *supra* note 73, at 432–33.

84. MEDICAID: A PRIMER, *supra* note 65, at 3. This decision was not preordained; some early debate centered on whether or not to include a Medicare buy-in option to the ACA that would have allowed uninsured age 55 and older to enroll in the more generous Medicare program. *See* J. Michael McWilliams, *Serving the Greater Good*, N.Y. TIMES, (Dec. 10, 2009), http://roomfordebate.blogs.nytimes.com/2009/12/10/medicare-for-50-somethings/?_r=0. Concerns about cost and opposition by the AARP out of fear it could drain the Medicare trust fund led to Congressional opposition. *See* 155 CONG. REC. S12664–02 (daily ed. Dec. 8, 2009) (statement of Sen. Charles Grassley). There was also fear that expanding Medicare instead of Medicaid would lead to a backdoor public option. *Id.*

85. 42 C.F.R. § 435.119 (2014).

86. *See* 42 U.S.C. § 1396d(y)(1)(A)–(E) (2012).

87. *Id.*

88. *See* 42 U.S.C. § 1396c (granting the Secretary the power to suspend all Medicaid payments to states not in compliance with the program).

Supreme Court struck down this provision, making Medicaid expansion voluntary and ensuring that access to Medicaid will continue to vary widely from state to state.[89]

B. Fallout from NFIB v. Sebelius

In *National Federation of Independent Business v. Sebelius*, the Supreme Court held that the federal government could not eliminate all Medicaid funding for states that refuse to participate in the expansion of Medicaid.[90] Now, states have the option of expanding Medicaid and receiving the enhanced reimbursement rate from the federal government, or states can keep their current Medicaid program without losing any federal funding.[91] While this may seem like a win for the states, this ruling has created unforeseen problems that impact patients' access to care.[92]

Since the Supreme Court's ruling in *Sebelius*, 22 states, including Louisiana, have declined to participate in the Medicaid expansion.[93] The non-profit Urban Institute estimates that 422,000 new Louisianans would qualify for Medicaid if the state participated in the expansion.[94] The vast majority of those individuals, 325,000, do not meet the threshold to purchase subsidized healthcare on the exchanges; these people fall into a gap where the current state Medicaid program ends and the federal subsidies

89. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2607 (2012).

90. *Id.* at 2607 ("Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.").

91. Elizabeth Weeks Leonard, *Crafting a Narrative for the Red State Option*, 102 KY. L.J. 381, 406–07 (2014).

92. *Cf.* Hall, *supra* note 62, at 1462 (discussing how Congress drafted other parts of the ACA with the assumption that Medicaid expansion would cover a large number of uninsureds).

93. *See* Pear, *supra* note 54.

94. *See* GENEVIEVE KENNY ET AL., MAKING THE MEDICAID EXPANSION AN ACA OPTION: HOW MANY LOW-INCOME PEOPLE COULD REMAIN UNINSURED 2 tbl.1 (2012), *available at* http://www.urban.org/UploadedPDF/412606-Making-the-Medicaid-Expansion-an-ACA-Option.pdf [http://perma.cc/DH9N-GR79]. The Urban institutes bases its analysis on surveys to determine the uninsured and their income levels. *Id.* at 1. The State of Louisiana estimates a more modest, but still significant, 213,897 would qualify for Medicaid expansion based on its own survey data. LA. DEP'T. OF HEALTH & HOSPS., UNDERSTANDING THE IMPACT OF MEDICAID EXPANSION IN LOUISIANA 4 (2013) [hereinafter UNDERSTANDING]. The wide discrepancy in the reports relates to survey methodology and demonstrates the challenge of predicting the full impact of the newly insured on the healthcare system.

begin.[95] Approximately 4.8 million people nationwide who would have received healthcare coverage under the ACA do not qualify for state Medicaid plans or subsidies on the insurance exchange.[96] The people hardest hit by this gap in coverage are the working poor and, in the Deep South, African-American adults.[97]

The hospitals that treat large numbers of these uninsured patients are also losing resources.[98] The assumption when passing the ACA was that most of the people without healthcare would find coverage under the Medicaid expansion.[99] For this reason, the ACA cuts Medicaid payments to hospitals that "serve a disproportionate number of low income patients with special needs."[100] The Medicaid program reimburses these disproportionate share hospitals ("DSH"),[101] but the ACA reduces such payments by $18 billion.[102] The drafters believed hospitals would have fewer patients without healthcare coverage, which would reduce the need for DSH payments.[103] These funds are critical to healthcare providers that serve low-income populations because Medicaid DSH funds are a major source of revenue for healthcare providers that treat the uninsured.[104] Louisiana's healthcare spending places an outsized reliance on DSH payments when compared to

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95. *See* KENNY ET AL., *supra* note 94, at 2 tbl.1. Of course, not everyone who qualifies for Medicaid coverage would enroll in the program, but there is no agreed upon method to measure the number of people who would enroll in Medicaid. UNDERSTANDING, *supra* note 94, at 5. DHH estimates that 95% of those newly eligible for Medicaid would enroll by 2019. *Id.* at 11.

96. Rachel Garfield, Anthony Damico, Jessica Stephens & Saman Rouhani, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update*, KAISER FAM. FOUND. (Apr. 17, 2015), http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ [http://perma.cc/85Q5-HAPD].

97. Tavernise & Gebeloff, *supra* note 9.

98. Hall, *supra* note 62, at 1462.

99. Tavernise & Gebeloff, *supra* note 9.

100. 42 U.S.C. § 1396r-4(a)(1) (2012).

101. *See id.* Louisiana sets the standards for a hospital to qualify for DSH payments under its Medicaid plan. LA. ADMIN. CODE tit. 50, pt. V, § 2503 (2013).

102. Hall, *supra* note 62, at 1462. The reductions phase is from 2017 to 2024 beginning at $1.8 billion, increasing sharply to $4.7 billion, and maxing out at $5 billion. 42 U.S.C. § 1396r-4(f)(7)(A)(i)(II). The formula used to determine reductions on a state-by-state level takes into account factors such as the percentage of uninsured individuals, the volume of Medicaid and uninsured patients at hospitals, and state waiver plans or other special provisions. § 1396r-4(f)(7)(B).

103. Hall, *supra* note 62, at 1462.

104. *See* DON GREGGORY & ALISON NEUSTROM, A NEW SAFETY NET: THE RISK AND REWARD OF LOUISIANA'S CHARITY HOSPITAL PRIVATIZATIONS 16 (2013), *available at* http://www.parlouisiana.org/s3web/1002087/docs/parhospital2013.pdf [http://perma.cc/6NN6-LE59].

other states,[105] so this reduction in payments will affect Louisiana healthcare providers more severely.

C. The Consequences of Expanded Coverage

Eight to eleven million previously uninsured people have healthcare coverage under the ACA, and this number will increase in the coming years as the provisions of the ACA become fully implemented and as more states expand their Medicaid programs.[106] Although the newly insured will have the ability seek out medical care, many individuals have experienced trouble finding doctors willing to take on new patients.[107] Though the state chose not to participate in the Medicaid expansion, Louisiana's healthcare system will see a large increase in demand for services because the individuals who obtained coverage on the exchanges will seek medical care at a higher rate than they would without insurance.[108] In January 2015, over 137,000 Louisianans signed up for healthcare on the federal exchange, which exceeded the roughly 102,000 who signed up in 2014.[109] Individuals

105. Rudowitz et al., *supra* note 10, at 397; Robin Rudowitz, *Health Care in New Orleans Before and After Hurricane Katrina*, 25 HEALTH AFF. 393, 397 (2006) (noting in 2004, 20% of all Louisiana Medicaid payments were DSH payments, while the national average was 6%).

106. Troy Griggs et al., *Is the Affordable Care Act Working?*, N.Y. TIMES (Oct. 26, 2014), http://www.nytimes.com/interactive/2014/10/27/us/is-the-afford able-care-act-working.html?_r=0.

107. *See* Steve Jacob, *The Doctor is Not in: Reform Will Highlight Shortage of Primary Care Physicians*, HEALTHCARE J. NEW ORLEANS, July–Aug. 2012, at 36, 37. Studies conducted after the Massachusetts healthcare reform, which was the basis for the ACA, showed wait times to see physicians increased an average of 15 days and more patients sought care in emergency rooms. *Id.* Massachusetts has a larger number of doctors per capita than Louisiana, which means that Louisiana may face an even more severe shortage. *Id.*; *see also*, Lisa Stiffler, *As Newly Insured Seek Care, Rural Doctor Shortage Worsens*, SEATTLE TIMES (Sept. 1, 2014), *available at* http://seattletimes.com/html/localnews/2024441142_acarural accessxml.html [http://perma.cc/3DYT-DVR8] (relating the story of a clinic that has to turn away 250 callers a week seeking a doctor appointment due to increased demand).

108. John Holahan & Stan Dorn, *What Is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the States?*, TIMELY ANALYSIS IMMEDIATE HEALTH POL'Y ISSUES (Urban Inst.), June 2010, at 3; *see also* DEP'T. OF HEALTH & HUMAN SERVS., THE PHYSICIAN WORKFORCE: PROJECTIONS AND RESEARCH INTO CURRENT ISSUES AFFECTING SUPPLY AND DEMAND 41 (2008) [hereinafter PHYSICIAN WORKFORCE], *available at* http://bhpr.hrsa.gov/healthworkforce /reports/physwfissues.pdf [http://perma.cc/TF8Q-HBKB]. Of course, many other factors also contribute to the number of patients seeking medical care, such as the relative age, sex, and affluence of the healthcare population. *See id.* at 38–50.

109. *Louisiana Enrollment Tops 137,000 for 'Obamacare'*, ADVOCATE (Jan. 21, 2015, 3:07 PM), http://theadvocate.com/news/11394519-123/louisiana-enroll ment-tops-137000-for [http://perma.cc/EQ88-RBUM].

who have healthcare coverage generally see the doctor more often and receive more procedures and tests, increasing strain on the healthcare system.[110] The previously insured also suffer, as the influx of new patients leads to increased wait times to see doctors.[111]

D. Provisions in the ACA Aimed at Increasing the Doctor Supply Fall Short

The ACA contains provisions aimed at increasing the number of physicians to handle the influx of patients through increased training, incentives, and reimbursements; however, many of these programs are either inadequate to address the size of the crisis or expire after a few years.[112] Because doctors take between 11 and 19 years to train, depending on their specialty, any program passed with the ACA is already too little too late.[113] The ACA funds 600 new residencies for doctors over two years.[114] This is far short of the 10,000 to 15,000 new slots the AAMC requested the government fund, "but that provision was trimmed to keep the ACA from costing more than a trillion dollars over 10 years."[115] To encourage primary care doctors to take more Medicaid patients, another provision in the ACA reimbursed Medicaid primary care physicians at the same rate as Medicare providers, which resulted in more generous payments to see Medicaid recipients.[116] This provision, however, expired at the end of 2014, when Congress failed to extend it for another year.[117]

Other provisions do provide important fixes to increase the number of doctors.[118] Before the ACA, residency positions attached to a particular teaching hospital.[119] When that hospital closed or the residency positions remained unfilled, those residency positions were lost.[120] The ACA ended this practice by providing a mechanism to reallocate those residency

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110. PHYSICIAN WORKFORCE, *supra* note 108, at 42.
111. *See* Kapp, *supra* note 52, at 415; Stiffler, *supra* note 107.
112. *See* HEISLER, *supra* note 16, at 24.
113. *Id.* at 2.
114. 42 U.S.C. § 293k(a)–(c) (2012).
115. Ollove, *supra* note 16.
116. 42 U.S.C. § 1396a(a)(13)(C) (2012).
117. Robert Pear, *As Medicaid Rolls Swell, Cuts in Payments to Doctors Threaten Access to Care*, N.Y. TIMES (Dec. 27, 2014), http://www.nytimes.com/2014/12/28/us/obamacare-medicaid-fee-increases-expiring.html?_r=0. As a result, payments to Medicaid primary care providers will fall as much as 43%. *Id.*
118. *See, e.g.*, 42 U.S.C. § 1395ww(h) (funding direct graduate medical education costs).
119. *Direct Graduate Medical Education (DGME)*, CMS.GOV, https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/dgme.html [https://perma.cc/UZE2-WBKQ] (last modified Dec. 31, 2014).
120. *Id.*

positions to hospitals in medically underserved areas.[121] Under the Centers for Medicare and Medicaid Services ("CMS") rules, 30% of unused slots must go to residencies in rural areas of the ten states with the most citizens in HPSAs—including Louisiana.[122] The other 70% go to the 13 states and territories with the lowest percentage of residencies.[123] Although this provision keeps the number of residencies funded by the government from decreasing and helps to redistribute doctors to underserved areas, this program does not actually increase the number of residencies, which experts say is necessary due to increasing demand for doctors.[124]

III. LOUISIANA'S RESPONSE TO DOCTOR SHORTAGE IS EXACERBATING ITS HEALTHCARE CRISIS

Louisiana's refusal to expand Medicaid and to instead rely on a patchwork of funding for healthcare harms doctors and patients, while draining resources that could be spent on other state programs.[125] Like other states, Louisiana has faced challenges in adequately funding payments to doctors and hospitals.[126] Louisiana faces rising demands for healthcare services and decreasing sources of revenue, especially as Louisiana's recurring state budget shortfalls have forced steep cuts to healthcare spending.[127]

Even without the ACA's expansion, Louisiana relies enormously on the Medicaid program to provide healthcare to low-income individuals.[128] Approximately 1.4 million Louisianans are covered under Medicaid, or 31% of the State's total population.[129] Medicaid made a total of $6.2

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121. 42 U.S.C. § 1395ww(h)(H)(vi).

122. 42 C.F.R. § 413.79 (2014); *see also*, Am. Coll. Physicians, Redistribution of Graduate Medical Education Slots 2 (2013) (unpublished work) [hereinafter Redistribution of Graduate Medical Education Slots], *available at* http://www.acponline.org/advocacy/where_we_stand/assets/iii4-redistribution-graduate-medica-education-slots.pdf [http://perma.cc/VR6F-YJHN].

123. These states are Montana, Idaho, Alaska, Wyoming, South Dakota, Nevada, North Dakota, Mississippi, Indiana, Puerto Rico, Florida, Georgia, and Arizona. Redistribution of Graduate Medical Education Slots, *supra* note 122, at 2.

124. PHYSICIAN SUPPLY & DEMAND, *supra* note 15, at 31.

125. *See* Bruce Alpert, *Louisiana Residents Paying for Health Care They Won't Receive Because State Rejected Medicaid Expansion, Says New Study*, NOLA.COM (Dec. 5, 2013, 10:42 AM), http://www.nola.com/politics/index.ssf/2013/12/louisiana_residents_paying_for.html [http://perma.cc/6QMP-RYFJ].

126. *See, e.g.*, Stiffler, *supra* note 107.

127. Mark Ballard, *Political Horizons: Bad to Worse for Jindal Budget*, ADVOCATE (Jan. 17, 2015, 2:36 PM), http://theadvocate.com/columnists/11354876-55/political-horizons-bad-to-worse [http://perma.cc/HJE6-PCNP].

128. *See* ANNUAL REPORT, *supra* note 78, at 14.

129. *Id.* at 26.

billion in payments on behalf of patients in Louisiana during the 2012 to 2013 fiscal year.[130] Despite the large percentage of Louisianans relying on the Medicaid program, Louisiana severely restricts adult eligibility for Medicaid.[131] Louisiana only allows parents of eligible children to join Medicaid if their income is 24% of the federal poverty level—slightly over $3,800 per year for a single-parent household—and does not allow any non-disabled adults without children to enroll in Medicaid.[132] In spite of Louisiana's decision not to expand the Medicaid program, enrollment has increased steadily over the past few years.[133]

In recent years, Louisiana has struggled to adequately fund its Medicaid program, impeding access to care. In the face of mounting budget deficits, Louisiana has slashed reimbursement rates to doctors under Medicaid, resulting in reductions of payments to doctors and hospitals of approximately 26% since 2009.[134] Lower Medicaid reimbursement rates correlate to lower participation rates in the program among doctors.[135] Patients with Medicaid coverage have found it increasingly difficult to find providers willing to see them.[136] Many doctors rely on patients with private healthcare coverage to offset the cost of providing care for Medicaid patients, but in rural parts of the state, doctors can have client bases that consist of over 80% Medicaid patients.[137]

One recently enacted constitutional amendment seeks to stabilize the drastic cuts to hospitals by creating a fund that pools resources from hospitals to receive matching federal Medicaid dollars.[138] Hospitals that take Medicaid payments pay an assessed fee into a fund that is invested and grows interest.[139] The hospitals then receive reimbursement in the

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130. *Id.* at 14.

131. *See Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level*, *supra* note 3. Only Alabama, Texas, and Missouri have more restrictive requirements for Medicaid eligibility. *Id.*

132. *Id.*; *2014 Poverty Guidelines*, *supra* note 28.

133. ANNUAL REPORT, *supra* note 78, at 26.

134. *See, e.g.*, Bill Barrow, *Jindal Administration Announces Steep Medicaid Cuts; LSU Hospitals Hit Hard*, NOLA.COM (July 13, 2012, 3:50 PM), http://www.nola.com/politics/index.ssf/2012/07/jindal_administration_announce.html [http://perma.cc/SP45-YZZ5].

135. *See* Galewitz, *supra* note 70.

136. *See, e.g.*, Robert Pear, *Cuts Leave Patients with Medicaid Cards, but No Specialist to See*, N.Y. TIMES (Apr. 1, 2011), http://www.nytimes.com/2011/04/02/health/policy/02medicaid.html.

137. Greg Hilburn, *Hospitals: Amendments Would Stabilize Medicaid Funding*, NEWS-STAR (Sept. 24, 2014, 12:39 PM), http://www.thenewsstar.com/story/news/local/2014/09/24/hospitals-amendments-stabilize-medicaid-funding/16153663/ [http://perma.cc/HV35-B3EC].

138. LA. CONST. art. 7, § 10.13.

139. *Id.*

form of enhanced Medicaid payments.[140] The legislature, however must implement the amendment by adopting a funding formula and renewing it annually, which it has not done.[141] Even if the fund is implemented, it will not solve all of Louisiana's budgetary woes.[142]

On top of Louisiana's budgetary constraints, recent developments from the CMS threaten a significant source of Medicaid revenues, deepening the strain on the program.[143] Louisiana attempted to shift administrative costs from the state government to private hospital entities, similar to a program underway in Texas.[144] Louisiana then used these funds to finance direct care, which receives a more generous matching rate.[145] CMS flagged Texas's program as potentially violating regulations that prevent state private hospitals from giving a donation to the state in exchange for additional Medicaid funds.[146] The federal government recently suspended $72 million in payments to Texas hospitals because of this scheme.[147] Louisiana's Low Income and Needy Care Collaborative Agreement ("LINCCA"), a $400 million program, relies on a similar funding mechanism.[148] The recent audit of the Texas program casts doubt on the viability of LINCCA moving forward.[149] Additionally, the federal government has become much more aggressive under the Recovery Auditor Contractor Program that reviews hospital records to determine whether expenditures were medically necessary and, if not, requires reimbursement from hospitals.[150] Louisiana hospitals have found themselves making payments to the federal government for procedures that go back years, further squeezing small hospitals.[151]

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140. *Id.*
141. *Id.*
142. Ballard, *supra* note 127.
143. Marsha Shuler, *Federal Questions on Medicaid Funding Worry Louisiana Hospitals*, ADVOCATE (Oct. 28, 2014), http://theadvocate.com/news/10526208-123/federal-questions-on-medicaid-funding [http://perma.cc/FW3X-9UJB].
144. *Id.*
145. *Id.*
146. 42 C.F.R. § 433.54 (2013).
147. Notice from Kyle L. Janek, Exec. Comm'r, Tex. Health & Human Servs. Comm'n, Notice of Deferral of Federal Funds Relating to Certain Federal Hospital Payments (Oct. 1, 2014), *available at* http://www.tha.org/HealthCareProviders/Issues/HHSC%20Notice_of_Deferral.pdf [http://perma.cc/3EP7-YAKJ].
148. Shuler, *supra* note 143.
149. *Id.*
150. *Recovery Audit Program*, CMS.GOV, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/ [http://perma.cc/B247-EE7P] (last modified Apr. 9, 2015).
151. Telephone Interview with Blake Kramer, *supra* note 30.

Finally, Louisiana will continue to struggle to find funding for healthcare services as it continues the process of leasing out the formerly state-run charity hospital systems.[152] Louisiana's charity hospitals received the bulk of DSH payments.[153] As of July 2014, the LSU Board of Supervisors had leased nine of the ten public hospitals through no-bid contracts.[154] Originally, the state planned to use lease payments to match state Medicaid dollars, but CMS refused to accept such a lease and the state abandoned the plan.[155] The two sides eventually reached a compromise, but as part of the agreement, Louisiana will have to refund the federal government $190 million for payments CMS rejected.[156] The state projects that these public-private partnerships will ultimately save money, which can be used to cover other healthcare expenditures, but Louisiana has not fully realized the expected savings so far.[157] Most of the savings come through terminating almost 7,000 state employees when private entities take over the hospitals.[158] The contracts also rely on frontloaded lease

152. *See* GREGGORY & NEUSTROM, *supra* note 104, at 27.

153. Rudowitz et al., *supra* note 10, at 398. The state operated charity hospitals provided free care for any Louisiana resident whose income did not exceed 200% of the FPL. LA REV. STAT. ANN. § 46:6 (2015).

154. Melinda Deslatte, *Louisiana Spotlight: Decision on Hospital Good for Jindal, Less so for Others*, ADVOCATE (Jan, 17, 2015), http://theadvocate.com/news/opinion/11292959-123/louisiana-spotlight-decision-on-hospital [http://perma.cc/YC4Q-T8VN]. The Louisiana State University Board of Supervisors did not need legislative approval to lease the hospital. Act 906 of the 2003 Louisiana Legislative session deleted language in Louisiana Revised Statutes section 17:1519.3(A)(3) (now Revised Statutes section 17:1519.5) that made the leasing of state hospitals subject to legislative approval. The new law, Louisiana Revised Statutes section 17:1519.5, permits the Board of Supervisors "[t]o enter into such contracts and agreements with any state or federal agency . . . or any other public or private party as may be necessary." LA. REV. STAT. ANN. § 17:1519.5(B)(5) (2013); Act No. 906, 2003 La. Acts 2899–2905.

155. Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to J. Ruth Kennedy, Medicaid Dir., Dep't of Health & Hosps., 2–3 (May 2, 2014), *available at* http://new.dhh.louisiana.gov/assets/medicaid/PPP/SPA13-23_13-25_13-28DenialLetter.pdf [http://perma.cc/JN7D-8AAH]. Even though the hospital payments to the states were termed an "advanced lease," CMS viewed the payments as "provider-related donations," which would qualify the hospitals for additional federal funds. *Id.* Essentially, the state would have been offsetting the money by the hospitals with Medicaid money proportional to the amount of money received by the state. *Id.* at 3–4; *see also* 42 C.F.R. § 433.54 (2014).

156. Deslatte, *supra* note 154. The appeal of this decision is expected to continue for the next five to seven years. *Id.*

157. Associated Press, *LSU Hospital Privatization Deals Cost Less than Expected*, NOLA.COM (July 16, 2014, 1:06 PM), http://www.nola.com/politics/index.ssf/2014/07/lsu_hospital_privatization_dea_1.html [http://perma.cc/QSA9-XDWY].

158. Marsha Shuler, *Government Workers Down 30k Over 6 Years*, ADVOCATE (Oct. 11, 2014, 8:59 PM), http://theadvocate.com/news/politics/10435729-123/government-workers-down-30k-over [http://perma.cc/2498-VB5Y].

payments to offset the immediate shortfalls on healthcare spending, leaving future funding uncertain.[159]

Since the privatization of the charity hospital system, other hospitals in the state have seen an influx of patients without healthcare coverage.[160] Only the hospitals that signed leases to take over management of formerly state-run hospitals receive increased reimbursement from the state for treating those without healthcare coverage.[161] All hospitals have to treat the uninsured patients that show up at emergency rooms,[162] but they do not receive the generous subsidies of the hospitals chosen to manage the former public hospitals.[163] After the closure of Earl K. Long Medical Center, Baton Rouge General cited the increased cost of treating the uninsured as a reason for shutting down its emergency room.[164] The state agreed to pay the hospital $18 million to keep the emergency room open.[165] But the emergency room hemorrhaged money, "losing upwards of $2 million a month treating thousands of uninsured patients in its ER."[166] Ultimately, the hospital had no choice but to shut down its emergency room.[167] With less funding to cover medical coverage for the uninsured, Louisiana will either have to expend state funds to make up for the gaps in coverage or hospitals will cut back on services offered, which will hurt the insured as well as the uninsured.

The vast majority of these employees stayed on as employees of the private hospitals. *Id.*

159. GREGGORY & NEUSTROM, *supra* note 104, at 23.

160. *See* Greg Hilburn, *CEO: St. Francis Neonatal Unit in Jeopardy*, NEWS STAR (Dec. 1, 2014, 5:55 PM), http://www.thenewsstar.com/story/news/local/2014/12/01/ceo-st-francis-neonatal-unit-jeopardy/19753443/ [http://perma.cc/ADE6-HKJC]; Cole Avery, *Monroe Hospital to Cut 300 Jobs, Newspaper Reports*, NOLA.COM (Sept. 11, 2014, 12:03 PM), http://www.nola.com/politics/index.ssf/2014/09/monroe_hospital_to_cut_300_job.html [http://perma.cc/8R35-DVNQ].

161. *See id.*

162. The Emergency Medical Treatment and Active Labor Act ("EMTALA") mandates that emergency rooms screen and stabilize all patients who come seeking care, regardless of ability to pay. 42 U.S.C. § 1395dd (2012).

163. Hilburn, *supra* note 160.

164. *Id.*

165. *Id.*

166. Stephanie Riegel, *Under the Knife: Baton Rouge General is Closing the Doors on Its Emergency Room. But That May Just be the Beginning*, GREATER BATON ROUGE BUS. REP. (Mar. 18, 2015), https://www.businessreport.com/business/knife-baton-rouge-general-closing-doors-emergency-room-may-just-beginning [perma.cc/6YS6-8CG7].

167. *Id.*

IV. SOLUTIONS TO LOUISIANA'S PHYSICIAN SHORTAGE MUST INVOLVE INCREASED RESOURCES AND BOOTS ON THE GROUND

The national healthcare shortage requires federal action; however, Louisiana faces an immediate predicament and cannot afford to wait and hope for favorable national legislation.[168] The state should aggressively pursue options that will have the most immediate impact on Louisiana's healthcare providers in lieu of federal action. By refusing to participate in the Medicaid expansion, Louisiana has placed itself at a disadvantage against states set to receive billions of dollars in funding.[169] Louisiana risks falling further behind other states that are competing over the same limited number of physicians.[170]

A. National Legislation to Supplement the ACA

Because the ACA represents an unprecedented national expansion of healthcare coverage,[171] the solution to the impending healthcare provider shortage requires national legislation. Under one such solution, Congress would lift a longstanding cap on the number of new residencies for doctors funded by the federal government.[172] The caps were created at a time when many were predicting the United States would produce a surplus of doctors, which has not come to pass.[173] Raising the cap would reimburse the training of new doctors in areas of high population growth and with healthcare shortages, supplementing the few residencies created in the ACA.[174] Costs could quickly balloon out of control, however, which is the reason Congress instituted the caps in the first place.[175]

If Congress were to enact such legislation, the legislation should fund residencies only in locations and practice areas facing the most severe

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168. *See supra* Part I, III.

169. *See, e.g.*, Alpert, *supra* note 125 (discussing how Louisiana tax dollars are paying for other states to expand healthcare services while receiving nothing in return).

170. *Id.*

171. Ann Marie Marciarille, *The Medicaid Gamble*, 17 J. HEALTH CARE L. & POL'Y 55, 55 (2014).

172. Balanced Budget Act of 1997, Pub. L. No. 105-33, §§ 4621, 4622, 11 Stat. 251, 475–77. The cap later raised to 130% of then existing residencies. Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, § 407(b), 113 Stat. 1501, 1501A–374.

173. HEISLER, *supra* note 16, at 6.

174. John K. Iglehart, *The Residency Mismatch*, 369 NEW ENG. J. MED. 297, 297 (2013).

175. *See* Catherine Dower, *Graduate Medical Education*, HEALTH AFF. (Aug. 16, 2012), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=73 [http://perma.cc/U8H8-HUDW].

shortages,[176] which could help keep costs under control. Drawing on the ACA, Congress could develop a formula that allocates new residency positions based on need.[177] It could also restrict the scope of new residencies, funding only positions for specific doctor populations with shortages, such as primary care physicians.[178] Political opposition to new spending programs is likely to hamper any efforts to create a comprehensive bill to address the doctor shortage because of the new Congressional majority's vow to cut the size of government.[179] Long-term efforts to stabilize the healthcare system will ultimately need to come from national legislation, but Louisiana must take immediate steps to reduce its physician shortage.

B. Expand Medicaid

Louisiana can quickly and easily provide healthcare professionals with billions of dollars in new funding by simply expanding Medicaid.[180] For most states that have expanded Medicaid, "the strongest, seemingly irrefutable, argument in favor of Medicaid expansion is economic."[181] Louisiana would receive an additional $15.8 billion for healthcare services over the next ten years by expanding Medicaid.[182] This money would shore up funding that has become increasingly scarce in recent years, and have a significant stimulus impact that will generate substantial economic activity.[183] The state of Louisiana did not consider the stimulus aspect of the Medicaid expansion when weighing potential benefits.[184] Studies from

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176. *See supra* Part I (discussing how rural areas, primary care physicians, and certain specialists face more severe shortages). Such proposals even predate the ACA. For instance, President Clinton proposed that 55% of all residencies funded train primary care physicians and that positions be allocated based on medical specialty and location. Katherine Huang, Note, *Graduate Medical Education: The Federal Government's Opportunity to Shape the Nation's Physician Workforce*, 16 YALE J. ON REG. 175, 202–03 (1999).

177. *Cf.* 42 U.S.C. § 1395ww(h)(H)(vi) (2012); 42 C.F.R. § 413.79 (2014) (establishing rules for redistributing existing residencies based on need). These formulas or similar ones could easily apply to new residencies.

178. Huang, *supra* note 176, at 202–03.

179. Jonathan Weisman & Ashley Parker, *Democratic Seats Fall in Seven States — Repudiation of President Obama*, N.Y. TIMES, Nov. 5, 2014, at A1.

180. *See* Tony Pugh, *States Forgo Billions with Medicaid Expansion Refusal*, ADVOCATE (Baton Rouge), Sept. 7, 2014, at 16A.

181. Leonard, *supra* note 91, at 410.

182. Pugh, *supra* note 180.

183. UNDERSTANDING, *supra* note 94, at 8–9.

184. *Id.* For instance, while noting that the state would receive additional revenues from Louisiana Revised Statutes section 22:84, which taxes the premium on insurance, the state considered this increase "ancillary" and decided indirect revenues "should not play an influential role" in the state's policy decision. *Id.* This reasoning is inconsistent with other analyses done by the state; Louisiana

other states that have included analysis of the economic activity created by Medicaid expansion have shown that the stimulus benefits can be massive.[185]

The Louisiana Hospital Association has endorsed Medicaid expansion because it would mean more stable funding for hospitals.[186] With additional money flowing in, hospitals can hire additional staff and increase services.[187] Increased job opportunities can help reduce the number of people living in poverty who would otherwise qualify for Medicaid.[188] Furthermore, doctors' quality of life also improves, which not only attracts new doctors, but also reduces the number of early retirements among healthcare professionals.[189] Quality of life improves from increased financial security due to a more reliable stream of payments and from better work environments due to upgraded facilities.[190] Money will begin to flow to Louisiana's healthcare providers the moment the state opts into Medicaid expansion.[191]

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often considers potential revenues that are at least as attenuated when considering other investments of the taxpayer's money. For instance, in the realm of economic development, the state often touts the number of indirect jobs that a project receiving a state incentive package will create. *See, e.g.*, *Gov. Jindal and Bell Helicopter CEO John Garrison Announce Construction Start for Louisiana Helicopter Assembly Facility*, OFF. GOV. BOBBY JINDAL (Aug. 27, 2014), http://gov.louisiana.gov/index.cfm?md=newsroom&tmp=detail&articleID=4659 [http://perma.cc/LY68-2BET] (citing the creation of 136 indirect jobs in a development project with approximately $30 million in incentives from the state).

185. *See, e.g.*, WILLIAM S. CUSTER, THE ECONOMIC IMPACT OF MEDICAID EXPANSION IN GEORGIA 4 (2013), *available at* https://www.statereforum.org/system/files/economic_impact_medicaid_ga.pdf [https://perma.cc/JE84-VMBF] (estimating that, in addition to the $40.5 billion in additional federal funding that Medicaid expansion would bring to Georgia over ten years, it would also create over 70,000 new jobs, which would contribute $8.2 billion in additional economic output and $276.5 million in additional tax revenue).

186. Press Release, La. Hosp. Ass'n, Statement from Louisiana Hospital Association Regarding Medicaid Expansion in Louisiana (Apr. 9, 2013), *available at* http://c.ymcdn.com/sites/www.lhaonline.org/resource/resmgr/imported/Medicaid%20Expansion.pdf [http://perma.cc/4FN4-K5KH].

187. Misty Williams, *Arkansas' Medicaid Expansion Boosts Rural Hospitals*, MYAJC (Mar. 25, 2015, 2:00 PM), http://www.myajc.com/news/news/state-regional-govt-politics/arkansas-medicaid-expansion-boosts-rural-hospitals/nkfKR/ (noting that Arkansas' expansion of Medicaid "enables small hospitals to think less about survival and more about making improvements to their buildings and improving services to the community").

188. *See* Hall, *supra* note 62, at 1474–75.

189. *See* Pugh, *supra* note 180.

190. *Id.*

191. *Id.*

Arguments that Medicaid expansion will cost the state money are unpersuasive.[192] Over the same ten-year period, Louisiana would have to pay approximately $1.2 billion to expand Medicaid.[193] Although an additional $120 million per year seems significant for a state that is facing enormous budget shortfalls,[194] the state would receive almost $1.6 billion a year in federal matching funds.[195] Finally, Louisianans are already paying for the Medicaid expansion in other states and getting nothing in return.[196] Over the ten-year period, $5.7 billion in taxes collected in Louisiana will go towards paying for the Medicaid expansion in other states.[197]

Another common concern is that Louisiana cannot rely upon the federal government to continue funding its share of the expansion at the generous 90% reimbursement rate.[198] But Congress is unlikely to alter the matching rate formula for the Medicaid expansion.[199] Historically, the federal government has never cut back the rate at which it funds Medicaid.[200] The Medicaid expansion far exceeds the scope of the previous Medicaid program, however, so the conventional assumption about the federal government continuing to reimburse states at the same rate may not hold true.[201] Still, Congress chose to expand Medicaid over several options that could have provided healthcare coverage to the uninsured.[202] In spite of well-known challenges with doctor participation, Congress chose to place low-income individuals on Medicaid instead of other options because it would cost the federal government less.[203] So, the

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192. *See, e.g.*, Bobby Jindal, *Gov. Bobby Jindal: Why I Opposed Medicaid Expansion*, NOLA.COM (July 23, 2013, 11:30 AM), http://www.nola.com/opinions/index.ssf/2013/07/gov_bobby_jindal_why_i_opposed.html [http://perma.cc/S6HN-D55U] (citing *inter alia* the amount of money Louisiana would have to pay to expand Medicaid to justify opposition to the program).

193. Pugh, *supra* note 180.

194. Associated Press, *Louisiana's Budget Shortfall for Next Year is Now Pegged at $1.2 Billion*, NOLA.COM (Aug. 14, 2014, 8:30 PM), http://www.nola.com/politics/index.ssf/2014/08/louisianas_budget_shortfall_fo.html [http://perma.cc/7GER-Z75Q].

195. Pugh, *supra* note 180.

196. *Id.*

197. *Id.*

198. *See, e.g.*, Jindal, *supra* note 192.

199. *See* Hall, *supra* note 62, at 1476–77.

200. *Id.* at 1476.

201. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2605–06 (2012) (plurality opinion).

202. *See* 155 CONG. REC. S12664–02 (daily ed. Dec. 8, 2009) (discussing several options proposed to cover the uninsured, from a public option and expanding Medicare, to placing everyone on private insurance).

203. *See* Jacobi, *supra* note 29, at 368 (citing TERESA A. COUGHLIN, SHARON K. LONG, LISA CLEMANS-COPE & DEAN RESNICK, WHAT DIFFERENCE DOES MEDICAID MAKE?: ASSESSING COST EFFECTIVENESS, ACCESS, AND FINANCIAL

Medicaid expansion occurred as a compromise to control future costs, which makes it less likely the federal government will lower the reimbursement rate in the future.[204] Even if the government does cut payments to states, participation in the Medicaid program remains voluntary, so Louisiana could opt out of the expansion if the burden of providing matching funds ever becomes too great.[205]

In the 2014 midterm elections, the Republican Party seized control of both houses of Congress, vowing to repeal and replace the ACA.[206] This election cast some doubt on the future of the ACA, but drastic changes to the ACA will probably not occur in the near future.[207] For one, President Obama still has over one year left in office and would certainly veto any significant alterations to the ACA.[208] Secondly, although some Republicans remain vocal about repealing the ACA, the caucus is divided about whether to force a showdown on the law or to move on to other issues.[209] Congress does have more control over funding of the ACA, but current efforts focus on smaller tweaks to the law that have some bipartisan support, such as repealing the tax on medical devices, instead of gutting the Act entirely.[210] In addition to the political considerations, economic ramifications from scrapping the ACA would prove staggering.[211] States, red and blue, that

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PROTECTION UNDER MEDICAID FOR LOW-INCOME ADULTS 7 (2013), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf [https://perma.cc/Y8RS-GKRL]).

204. *Id.*

205. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., FREQUENTLY ASKED QUESTIONS ON EXCHANGES, MARKET REFORMS AND MEDICAID 11 (2012), *available at* http://www.medicaid.gov/federal-policy-guidance/downloads/FAQ-12-10-2012-Exchanges.pdf [http://perma.cc/4FS5-4C73].

206. Weisman & Parker, *supra* note 179.

207. Stephanie Grace, Opinion, *Regardless of Election, Obamacare Staying Put*, ADVOCATE (Baton Rouge), Oct. 25, 2014, at B1.

208. *Id.* At this time, the Republican majority in the Senate does not approach the 67 votes necessary to overturn a presidential veto. Weisman & Parker, *supra* note 179.

209. Andrew Taylor, *GOP Divided Over Using Budget Process to Derail Obamacare*, PBS (Jan. 19, 2015, 11:44 AM), http://www.pbs.org/newshour/rundown/gop-divided-using-budget-process-health-care-law [http://perma.cc/QKJ7-7DD9].

210. Sarah Ferris, *GOP Tactics on ObamaCare Move Away from Full Repeal*, HILL (Jan. 16. 2015, 6:00 AM), http://thehill.com/policy/healthcare/229730-gop-tactics-on-obamacare-move-away-from-full-repeal [http://perma.cc/W2S7-HUQA].

211. Rick Newman, *One Economic Risk Few Have Noted: Obamacare Repeal*, YAHOO! FIN. (Jan. 12, 2015, 2:25 PM), http://finance.yahoo.com/news/one-economic-risk-nobody-has-noticed--obamacare-repeal-192517550.html [http://perma.cc/95PB-MC3E]. If the Supreme Court decides federal subsidies do not apply to the exchanges and Congress does not restore the subsidies, eight to

have adopted Medicaid expansion would heavily protest to their congressional delegation about decreases in federal funding that would result from repealing the ACA. Still, some Republicans continue to mount challenges to the ACA. In November, the House of Representatives filed suit over the administration's implementation of the ACA.[212] Although the 114th Congress may continue to fight against the ACA, the main factor that led to the ACA's Medicaid expansion—exploding costs to provide medical treatment—means that most of the alternative proposals retain many elements of the ACA.[213] Recognizing this reality, political opposition has dampened recently and some Republican-controlled states have begun to accept Medicaid expansion.[214]

Even though Congress is unlikely to completely repeal the ACA, the rhetoric out of Washington does not leave much hope for Congress passing a comprehensive piece of national legislation to address the doctor shortage.[215] The Louisiana legislature may remain more open to proposals that aim to cure Louisiana's healthcare woes. In the 2014 session, the legislature voted down a bill that would have expanded Louisiana's Medicaid program.[216] The debate, however, is far from over: the four major 2015 gubernatorial candidates—three Republicans and one Democrat—have suggested they would reexamine expanding Medicaid in some form.[217]

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nine million people will lose coverage. *Id.* Premiums could spiral out of control, harming both insurers and their customers. *Id.*

212. Complaint at 3–4, U.S. House of Representatives v. Burwell, No. 1:14-CV-01967 (D.D.C. Nov. 21, 2014) (alleging that the Obama administration violated the separation-of-powers doctrine by expending funds on the ACA not appropriated by Congress and unilaterally imposing changes to the legislation).

213. Jonathan Weisman, *G.O.P.'s Assault on Health Law Fades in Races*, N.Y. TIMES, Nov. 1, 2014, at A1.

214. Amy Lischko & Beth Waldman, *Understanding State Resistance to the Patient Protection and Affordable Care Act: Is It Really Just Politics As Usual?*, 9 J. HEALTH & BIOMED. L. 101, 112–13 (2013).

215. Weisman & Parker, *supra* note 179.

216. H.B. 759, 2014 Reg. Sess. (La. 2014) ("Provide that eligibility standards for medical assistance program benefits in Louisiana Conform to the minimum eligibility standards as provided in the Patient Protection and Affordable Care Act . . . and codified in federal regulations relative to medical assistance program coverage.").

217. *See* Julia O'Donoghue, *Louisiana's Governor's Race Forum: 4 Takeaways*, NOLA.COM (Apr. 23, 2015, 2:53 PM), http://www.nola.com/politics/index.ssf/2015/04/louisiana_governor_medicaid_ex.html [http://perma.cc/B4TR-KDC9]. As of September 1, 2015, Arkansas is the only Deep South state to accept Medicaid expansion. *Status of State Action on Medicaid Expansion Decision*, *supra* note 5. Only one of the states, Utah that has not expanded Medicaid has ongoing discussions about expansion. *Id.*

C. The Arkansas Plan: Using Medicaid Expansion Funds to Purchase Private Insurance

So far, proposals to modify Louisiana's healthcare system have relied on merely expanding Louisiana's existing Medicaid program.[218] The state should explore other options, which could increase the state's flexibility when crafting its Medicaid expansion. For instance, Arkansas expanded its Medicaid program by using the money received to buy private insurance on the state exchange for new enrollees instead of dumping them into the already existing Medicaid program.[219] In addition to the political appeal of the plan—that it places people in private insurance rather than in a government program—the Arkansas plan alleviates some of the challenges created by Medicaid's traditionally low reimbursement rates.[220]

By placing Medicaid recipients on the insurance exchange, both the Medicaid enrollees and other members of the exchanges benefit from the larger pool of consumers, which Arkansas hopes will entice more healthcare companies to participate, compete, and lower costs.[221] Medicaid enrollees specifically will benefit from greater access to healthcare providers because Medicaid-managed health plans usually rely on smaller networks of providers than private insurance.[222] Private insurance plans should entice more specialists and primary care physicians to participate in the program because of higher reimbursement rates than these doctors would receive under traditional Medicaid.[223] These insurance plans would alleviate Medicaid's persistent problems with attracting doctors.[224] But how much of the reluctance to accept Medicaid patients comes from poor reimbursement

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218. *See* H.B. 759, 2014 Reg. Sess. (La. 2014); *see also* UNDERSTANDING, *supra* note 94, at 7.

219. ARK. CODE ANN. §§ 20-77-2401 to 20-77-2408 (West Supp. 2015); Letter from Marilyn Tavenner, Admin., Ctrs. for Medicare & Medicaid Servs., to John Selig, Dir., Ark. Dep't of Human Servs. (Dec. 31, 2014), *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf [http://perma.cc/7CLN-LVBD]; CTRS. FOR MEDICARE & MEDICAID SERVS., No. 11-W-00287/6, ARKANSAS HEALTH CARE INDEPENDENCE PROGRAM (PRIVATE OPTION) (2013) [*hereinafter* PRIVATE OPTION].

220. Leonard, *supra* note 91, at 422.

221. Letter from Dawn Stehle, Dir., Div. of Med. Servs., Ark. Dep't of Human Servs., to Sylvia Mathews Burwell, Sec'y, U.S. Dep't of Health & Human Servs. (Sept. 15, 2014), *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-pa.pdf [http://perma.cc/3PLH-AC4Y].

222. Sidney D. Watson, *Medicaid, Marketplaces, and Premium Assistance: What is at Stake in Arkansas? The Perils and Pitfalls of Medicaid Expansion Through Marketplace Premium Assistance*, 102 KY. L.J. 471, 478 (2014).

223. Leonard, *supra* note 91, at 423.

224. *See* Hall, *supra* note 62, at 1462.

rates and how much comes from fear of liability is unclear.[225] So, how many more doctors would participate is also unclear.

Arkansas additionally creates more certainty for doctors seeking payments from low-income wage earners.[226] Many people with low incomes have earnings that fluctuate month-to-month.[227] If these low-income individuals are near the cut-off for Medicaid eligibility, they may find themselves constantly switching between Medicaid coverage and subsidized insurance on the exchange.[228] These individuals would switch between provider networks, making it harder to receive consistent care.[229] Alternatively, under Louisiana's current strategy, people would fluctuate between subsidized insurance and no coverage. Under the Arkansas plan, individuals in such situations could keep the same coverage whether they qualified for Medicaid or subsidized insurance.[230] Beneficiaries seeking healthcare coverage would become more familiar with their healthcare providers because patients would stay within the same network of doctors, leading to better healthcare outcomes through continuity of care and steadier business for doctors who will have a stable base of patients.[231] The state, however, must develop a system to coordinate Medicaid and the insurance exchange to ensure seamless coverage because Medicaid and the insurance purchased on the exchanges have different baselines of coverage.[232]

Additionally, Louisiana has no guarantee that the state will receive approval to adopt a plan similar to Arkansas's because such a plan requires a CMS waiver, which the federal government must approve.[233] Furthermore, placing people on private insurance plans is more expensive than placing people on Medicaid because of the higher reimbursement rates paid by private insurance.[234] Under Arkansas's agreement, the federal government must have a "comparable" expense to traditional Medicaid.[235] But recent

225. *See* Rosenbaum & Sommers, *supra* note 72, at 135–36.
226. *Cf.* Leonard, *supra* note 91, at 423 (the greater continuity of care the Arkansas plan offers for patients also aids physicians, who will not have to worry about their patients losing coverage month-to-month).
227. Sara Rosenbaum & Benjamin D. Sommers, *Using Medicaid to Buy Private Health Insurance — The Great New Experiment?*, 369 NEW ENG. J. MED. 7, 8 (2013).
228. Leonard, *supra* note 91, at 423.
229. *See id.*
230. *Id.*
231. *See id.*
232. *See* Watson, *supra* note 222, at 478.
233. *See* PRIVATE OPTION, *supra* note 219, at 3.
234. Jacobi, *supra* note 29, at 368.
235. Watson, *supra* note 222, at 488; *see also* 42 C.F.R. § 435.1015(a)(4) (2015) ("The total cost of purchasing such coverage . . . must be comparable to the cost of providing direct coverage under the State plan.").

reports show that the federal government pays more than it would when expanding existing Medicaid programs,[236] which increases the risk that the Federal government will discontinue funding the program or will refuse to grant waivers similar to the one granted to Arkansas. However, this is contradicted by the fact that DHHS has a long history of granting waivers that are not cost neutral,[237] and four other states—Iowa, Michigan, New Hampshire and Indiana—have received waivers to expand their Medicaid program through non-traditional means, such as offering private insurance.[238] Additionally, Pennsylvania had received a waiver but later transitioned to a traditional Medicaid model.[239] Louisiana has precedent from these agreements and will be dealing with an Obama administration hungry to see Medicaid expand,[240] so the state should act quickly if it wants to leverage the best deal possible with the federal government.

D. Increased Use of Non-Physician Healthcare Providers

Medicaid expansion will create increased demand for physician services, but, even without Medicaid expansion, Louisiana still faces a critical shortage of doctors that must be addressed.[241] Doctors and patients have increasingly come to depend on trained non-physicians to provide primary healthcare services, but protectionist state regulations have limited the autonomy of these individuals in making healthcare decisions for patients.[242] Physician extenders, such as nurse practitioners and

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236. Letter from Katherine M. Iritani, Dir., U.S. Gov't Accountability Office, to Orrin Hatch, Senator, U.S. Senate, & Fred Upton, Representative, U.S. House of Representatives, Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns 3 (Aug. 8, 2014) [Hereinafter GAO Letter], *available at* http://www.gao.gov/assets/670/665265.pdf [http://perma.cc/2MDZ-2QYA]. The Secretary of Health and Human Services can only grant a waiver to Medicaid if the program is cost neutral to the federal government. *See* 42 U.S.C. § 1315(a) (2012).

237. GAO Letter, *supra* note 236, at 5.

238. *Medicaid Expansion in Pennsylvania*, KAISER FAM. FOUND. (Aug. 3, 2015), http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-pennsylvania/. Another state, Indiana, has a waiver still pending, but that plan uses a different mechanism—high deductible health savings accounts. *Id.*

239. *Id.*

240. *Medicaid Expansion in Arkansas*, KAISER FAM. FOUND. (Feb. 12, 2015), http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/ [http://perma.cc/TT94-FX2S]. (noting the Obama administration eagerly worked out a deal to expand Medicaid).

241. *See supra* Parts II, III.

242. *See, e.g.*, Jessica Wolf, Comment, *Eliminating Scope of Practice Barriers for Illinois Physician Assistants*, 23 ANNALS HEALTH L. 16, 17–18 (2013).

physician assistants,[243] receive their scope-of-practice restrictions from individual states.[244] So, Louisiana can act unilaterally to ease the workload on its already over-burdened doctors. These physician extenders can enter the labor force faster because they do not require nearly as much training as doctors.[245] These professionals also cost about four times less to train than doctors.[246] Although Louisiana has increased training for physician extenders, the number of these professionals in Louisiana lags behind those in other states.[247]

Despite Louisiana's critical need for primary healthcare providers, the state's physician assistants and nurse practitioners have scopes of practice that are limited compared to counterparts in other states.[248] In Louisiana, nurse practitioners must enter into a collaborative practice agreement with a physician,[249] which can make working in medically underserved areas harder because fewer doctors that the nurse practitioners could enter into an

243. Nurse practitioners are registered nurses who have received additional training—usually a master's degree—and provide primary care to patients. Colin Goodman, Comment, *Nurse Practitioners: Comparing Two States' Policies*, 23 ANNALS HEALTH L. 168, 170–71 (2013). Physician assistants hold a bachelor's degree and complete a two-year, nationally accredited course of study. Margo Pierce, *Frustrated Dream or Possible Reality?*, HEALTHCARE J. NEW ORLEANS, May–Jun. 2014, at 26, 28.

244. In Louisiana, the State Board of Nursing governs the licensure of nurse practitioners. LA. REV. STAT. ANN. § 37:920 (2010). Nurse practitioners must (1) hold a registered nurse license, (2) hold a master's degree in advanced nursing, and (3) receive certification from a national certification agency. *Id.* § 37:920(A)(2). The State Board of Medical Examiners governs the licensure of physician assistants. *Id.* § 37:1360.24(A)(2).

245. *Occupational Outlook Handbook*: *Physicians and Surgeons*, BUREAU OF LAB. STAT. (Jan. 8, 2014), http://www.bls.gov/ooh/healthcare/physicians-and-surgeons.html [http://perma.cc/L4E6-G3X6] (noting the number of new physicians is expected to increase 18% from 2012–22); *Occupational Outlook Handbook*: *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners*, BUREAU LAB. STAT. (Jan. 8, 2014), http://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.html [http://perma.cc/5H9P-658Y] (noting that the number of physician extenders is expected to increase 31% in the same time period).

246. Kathy Finn, *Physician Assistants Help Fill Doctor Void*, ADVOCATE (Baton Rouge), Dec. 7, 2014, at 1E.

247. *Id.*

248. Currently, Louisiana is rated as a state with "reduced practice" which falls into the middle of the spectrum of nurse practitioner scope of practice. *State Practice Environment*, AM. ASS'N. NURSE PRAC. http://www.aanp.org/legislation-regulation/state-legislation-regulation/state-practice-environment [http://perma.cc/WT7N-APAE] (last visited Sept. 18, 2014); *see also* Pierce, *supra* note 243, at 27 (noting restrictive regulations on physician assistants).

249. LA. REV. STAT. ANN. § 37:913(9) (2007) ("'Collaborative practice agreement' means a formal written statement addressing the parameters of the collaborative practice which are mutually agreed upon by the advanced practice registered nurse [nurse practitioner] and one or more licensed physicians . . . .").

agreement with practice in these regions.[250] Louisiana's physician assistants must have a doctor sign off on every progress note on a patient's chart within a 24 hour period, and a doctor may only supervise 2 physician assistants at a time.[251] If doctors could delegate greater authority to physician extenders, it could help prevent any increase in patients due to the ACA from overwhelming physicians.

Although some contend that physician extenders can take away business from physicians,[252] this economic argument appears exceedingly unpersuasive in light of Louisiana's current doctor shortage.[253] In a state that is struggling to find enough doctors, nurse practitioners and physician assistants are unlikely to take away existing business from doctors.[254] Expanding Medicaid would also increase the amount of money and patients coming into the system, which would create new business for everyone.

The public safety concerns, however, are much more serious; doctors have far more years of study and practice before treating patients.[255] Studies, however, have shown "comparable outcomes" between patients treated by physician extenders and patients treated by doctors.[256] Physician extenders also face lower rates of medical malpractice suits when compared to doctors.[257] Even so, the state should remain vigilant and craft legislation that provides adequate protection against patient neglect due to inadequate oversight of physician extenders.[258] Louisiana can draw upon existing legislation from the many states that have expanded the scope of practice for physician extenders to protect public safety without handicapping individuals who have adequate training to treat patients.[259]

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250. Goodman, *supra* note 243, at 180.

251. LA. ADMIN CODE. tit. 46, pt. XLV, § 4507 (2013).

252. *See, e.g.*, Emily Lane, *Louisiana Legislation Allows for Vaccination Without a Prescription: Snapshot*, NOLA.COM (May 14, 2014, 2:22 PM), http://www.nola.com/politics/index.ssf/2014/05/vaccine_immunization_pharmacis.html [http://perma.cc/WJK6-RDD6] (Discussing how some fear that increasing the scope of practice for non-physicians will "siphon business away from doctors").

253. *See supra* Part I.B.

254. *See* Pierce, *supra* note 243, at 27–29 (discussing the increasing demand on primary care providers and how nurse practitioners can expand physicians' practices by seeing more patients).

255. Goodman, *supra* note 243, at 176.

256. Ann Ritter & Tine Hansen-Turton, *The Primary Care Paradigm Shift: An Overview of the State-Level Legal Framework Governing Nurse Practitioner Practice*, 20 HEALTH LAW., no. 4, Apr. 2008, at 21, 22.

257. Pierce, *supra* note 243, at 29.

258. *See id.* at 29 ("Regulation of medical care is necessary to make sure exploitation or neglect don't occur.").

259. Goodman, *supra* note 243, at 168 (noting the states that have expanded the scope of practice of nurse practitioners); *see also* Pierce, *supra* note 243, at 28 (stating that 42 states had expanded the scope of practice for physician extenders by the end of 2013).

In 2012, the Louisiana Legislature's House Committee on Health and Welfare declined to take action on a bill that would have exempted nurse practitioners in medically underserved areas from collaborative agreements, effectively killing the proposed legislation.[260] The proposed legislation required nurse practitioners to complete a specific course of study, but the bill did not include a clinical component.[261] States, such as Oregon, that have expanded their nurse practitioner's autonomy include some clinical component, so that nurse practitioners have practical experience when treating patients.[262] So, any future proposal to expand the scope of practice for nurse practitioners would benefit from including a clinical component, which would allay some of the public safety concerns. No legislative action occurred in recent years to expand the scope of practice for physician assistants, but model legislation suggests eliminating the restrictions on the number of physician assistants supervisors can oversee and delegating authority away from the legislature to the supervising physician to determine the scope of practice.[263] Regulations on physician extenders that fall in line with those in the majority of states would provide greater access to healthcare services in a state that already faces a severe healthcare crisis.[264]

E. The Impact of Medicaid Expansion on Healthcare Providers

By refusing to expand Medicaid, Louisiana merely disguises the true need for healthcare professionals in the state by artificially decreasing the demand.[265] In spite of the challenges Medicaid faces, quality of life and access to care increases when people have healthcare coverage.[266] One of the most influential studies on the impact of Medicaid expansion found that self-reported quality of life and health increased significantly for those with

260. LA. STATE LEGS. https://legis.la.gov/legis/BillInfo.aspx?s=12RS&b=HB 951&sbi=y (select "Bills" on the homepage, then select "Other Sessions" and select "2012 Regular Session," place HB into the drop-down box and ender 951).

261. H.B. 951, 2012 Reg. Sess. (La. 2012). The nurse practitioner would have had to hold a master's degree and successfully complete "coursework in physical assessment, advanced pharmacology, and advanced pathophysiology." *Id.*

262. *See* OR. ADMIN. R. 851-050-0002 (2013) (requiring nurse practitioners to complete a one year course of studies that include a clinical component)*; see also* Goodman, *supra* note 243, at 174.

263. AM. ACAD. OF PHYSICIAN ASSISTANTS, AAPA MODEL STATE LEGISLATION FOR PAS 4–5 (2015), *available at* https://www.aapa.org/WorkArea /DownloadAsset.aspx?id=548 [https://perma.cc/JGM6-ZN9Q].

264. *See* Pierce, *supra* note 243, at 29.

265. *See* Ted Griggs, *Hikes Sought in Health Coverage Rates*, ADVOCATE (July 29, 2014, 7:20 PM), http://theadvocate.com/home/9849885-125/hikes-in-health-coverage-rates [http://perma.cc/7MRR-W85Y].

266. Rosenbaum, *supra* note 67, at 23 n.127.

healthcare coverage under the expansion.[267] People with healthcare coverage tend to have better health outcomes because they have better access to preventative care, which reduces more expensive and time consuming inpatient care.[268] Most of the increased demand from the newly insured falls onto primary healthcare providers.[269] Increased use of physician extenders would reduce the need to rely on doctors, relieving the stress on primary care providers.[270] So, although the time to see a doctor for a routine checkup may increase, the total burden on the healthcare system as a whole will become more manageable.[271]

Reform of Louisiana's healthcare system is long overdue, and will prove necessary even in the absence of Medicaid expansion.[272] First, demands on the healthcare system will increase even if Medicaid is not expanded.[273] Louisiana will see an influx of newly insured patients from the federal healthcare exchanges.[274] Also, people without health insurance do not forego doctor visits altogether, so these patients already place a burden on the healthcare system.[275] Finally, many of the continuing problems with access to care are structural; rural areas lack adequate healthcare because doctors have been reluctant to live in areas with large numbers of uninsured people.[276] To the extent Medicaid expansion makes the practice of medicine more lucrative, rural areas should begin to see more doctors willing to relocate to these areas.[277]

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267. Katherine Baicker et al., *The Oregon Experiment — Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1717 (2013). The study tracked over 10,000 individuals in Oregon over a two-year period who signed up for a lottery for the state's limited Medicaid expansion that began in 2008. *Id.* at 1713. The data on objective measures of health, such as diabetes screening and diagnosis of depression, remained inconclusive and mixed. *Id.*

268. MEDICAID: A PRIMER, *supra* note 65, at 20.

269. Jacob, *supra* note 107, at 37.

270. Finn, *supra* note 246.

271. *See* HEISLER, *supra* note 16, at 9 (citing studies).

272. *See supra* Parts I.B., III.

273. By January of 2015, over 137,000 Louisiana signed up for healthcare under the ACA, which exceeded the roughly 102,000 who signed up in 2014. *La. Health Plan Enrollment Tallied*, ADVOCATE (Baton Rouge), Jan. 22, 2015, at 6A.

274. DEP'T. OF HEALTH & HUMAN SERVS., HEALTH INSURANCE MARKETPLACE: SUMMARY ENROLLMENT REPORT FOR THE INITIAL ANNUAL OPEN ENROLLMENT PERIOD 34 tbl.C2 (2014), *available at* http://aspe.hhs.gov/sites/default/files/pdf/ib_2014Apr_enrollment.pdf [http://perma.cc/GU94-8QCS]. Just over 100,000 Louisianans signed up for healthcare coverage under the exchange. *Id.* DHHS estimates that 87% of those who signed up for healthcare on the exchange were previously uninsured. Brett LoGiurato, *Here's How Many People Actually Gained Insurance Because Of Obamacare*, BUS. INSIDER (May 1, 2014, 3:58 PM), http://www.businessinsider.com/how-many-people-signed-up-for-obamacare-2014-5 [http://perma.cc/38UA-WCDR].

275. Hall, *supra* note 62, at 1473.

276. *See* HEISLER, *supra* note 16, at 18, 20–21.

277. *Id.*

CONCLUSION

Louisiana should expand Medicaid to provide doctors with the resources necessary to treat patients, while pursuing policies that increase the number of healthcare providers able to serve Louisiana's residents. The state faces a critical shortage of doctors that is caused in large part by persistent poverty and high rates of uninsured patients.[278] The ACA sought to expand access to healthcare for millions of Americans, but the Supreme Court's decision in *NFIB v. Sebelius* provided states with a greater number of options when deciding whether to expand coverage.[279] The state's existing Medicaid program faces an uncertain future as sources of funding seem to disappear daily.[280] Although the ACA included some provisions to increase the number of physicians, the law did not go far enough and a national fix does not appear on the horizon. Though Louisiana has a variety of options to pursue, the best option is to expand Medicaid by using Medicaid dollars to place qualifying individuals on private insurance through a state-run exchange. By expanding Medicaid, Louisiana will receive vast amounts of money that will improve neglected healthcare infrastructure and put it on a level playing field with other states. Louisiana can increase the success of Medicaid expansion by adopting a plan similar to Arkansas's. Placing newly eligible Medicaid enrollees in private insurance will provide better access to healthcare services.[281] Increasing the scope of practice for physician extenders can help relieve the increased demand on the healthcare system.[282] Louisiana's working poor desperately need healthcare coverage, and the state's refusal to expand Medicaid harms these patients and the doctors that serve them. Greater access to healthcare will prevent Louisianans from heading north of the border at Kilbourne. Instead, the state will reverse the flow, with money and new healthcare practitioners pouring into the state.

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278. *See supra* Part I.B.
279. *See supra* Part II.B.
280. *See supra* Part III.
281. *See supra* Part IV.C.
282. *See supra* Part IV.D.

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