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GEORGIA: INDIVIDUAL STATE REPORT

State-Level Field Network Study
of the Implementation of the
Affordable Care Act


December 2015

Rockefeller Institute of Government
State University of New York

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Contents

Part 1 – Setting the State Context	1
1.1. Decisions to Date	3
Part 2 – Implementation Tasks.	9
2.1. Exchange Priorities	9
2.5. Outreach, Consumer Education, and Navigational Assistance.	9
2.6. Interagency and Intergovernmental Relations	11
2.6(a) Interagency Relations	11
2.6(b) Intergovernmental Relations.	13
2.7. QHP Availability and Program Articulation	15
2.7(a) Qualified Health Plans (QHPs)	15
2.7(b) Clearinghouse or Active Purchaser Exchange	17
2.7(c) Program Articulation	17
2.7(d) States That Did Not Expand Medicaid..	17
2.8. Data Systems and Reporting	18
Part 3 – Supplement on Small Business Exchanges	19
3.1. Organization of Small Business Exchanges	19
Part 4 – Summary Analysis	19
4.1. Policy Implications	19
4.2. Possible Management Changes and Their Policy Consequences	23
Endnotes	25

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Part 1 – Setting the State Context

Georgia is one of twenty-four states with a Republican “tri-fecta” – control of the governor’s office and both houses of the state legislature. In the 2002 general election, Republican Sonny Perdue defeated incumbent Democratic Governor Roy Barnes, and Republicans also captured control of the state Senate, winning thirty of the fifty-six seats. In the 2004 election, Republicans increased their control of the state Senate by an additional four seats and also captured a majority of seats in the General Assembly (99 of 189). Perdue served as Georgia’s governor for two terms, and former U.S. Representative Nathan Deal succeeded him and was reelected to a second term in the 2014 general election. In the 2014 election, Republicans gained supermajority status in both houses of the state legislature.

Georgia has also been a claret red state in national politics for much of this time period. In 2003, eight of the state’s thirteen congressional seats were held by Republicans. Today, Republicans control ten of the state’s fourteen seats, and since 2005, both of Georgia’s senators have been Republicans. In presidential elections, Georgia has voted for the Republican candidate in seven of the last eight elections; the exception was 1992, when Georgia cast its sixteen electoral votes for Bill Clinton.

Georgia’s shift from a state where Democrats were the dominant political party to Republican is part of a larger transformation of politics in the South and largely the result of a shift in the electorate. In Georgia, as in the other states in the former Confederacy, white conservatives and many white moderates have left

the Democratic Party to align with the Republicans. The Democratic Party, in turn, is now predominantly the political home to African Americans, liberal and moderate whites, and Hispanics. As Merle Black observes, “the emergence of the Republican party as a realistic alternative to the Democrats is the most dramatic story in southern politics during the late twentieth and early twenty-first centuries.”¹

Given the state’s demographics and the results of recent elections, the Republican Party has become far more than a realistic alternative. Georgia Republicans have been able to use redistricting to translate the gains made over the past decade to solidify their hold on the state legislature. In the most recent election, only thirty-two of the 180 seats for the state House had both a Democratic and a Republican candidate on the ballot; of the fifty-six seats in the state Senate, only fifteen were contested elections. By contrast, in the 1996 election there were 107 competitive races in the general election for state legislative seats.²

As a result of these changes, the primary elections have taken on increased importance. The emergence of the tea party movement has also been a strong force in Georgia Republican politics, particularly in the primaries. There are dozens of local tea party groups throughout the state, with their strongest presence in northern Georgia, and they have been very active in national, state, and local elections. Though Georgia tea partiers were unsuccessful last year in securing the Republican nomination for the state’s open U.S. Senate seat for their preferred candidate (U.S. Representatives Paul Broun or Phil Gingrey, both members of the House tea party caucus), two of the state’s current congressmen are members of the House tea party caucus (Representatives Tom Price and Lynn Westmoreland), and many of Georgia’s Republican state legislators are also aligned with the tea party.

Georgia’s conservatism is strongly reflected in the state’s public policies and has been so for quite some time. According to the Tax Foundation, in fiscal 2012 Georgia ranked forty-ninth among the fifty states in terms of state tax collections per capita (\$1,680) and fiftieth in terms of state revenue per capita (\$3,673).³ In fiscal 2013, Georgia ranked forty-fourth on total state per capita expenditures (\$4,247).⁴ More specifically, in terms of spending on health, Georgia ranks forty-ninth in statewide health care spending per capita and fiftieth in total Medicaid spending per patient.⁵ If one factors in all public spending on health — federal, state, local — Georgia’s ranking improves to thirty-seventh (\$18.48 per capita in fiscal years 2013 and 2014), though still well below public health spending in other southeastern states such as Alabama (\$59.22), Arkansas (\$47.94), and Tennessee (\$43.97).⁶ In terms of overall health spending — all public AND private sources — Georgia (\$5,467) ranks forty-ninth out of the fifty states and the District of Columbia, 20 percent below the national average (\$6,815).

Georgia is also a high needs state. According to the Census Bureau's most recent poverty data, Georgia has the nation's tenth highest poverty rate (17.2%) among the fifty states based on the 2012-13 two-year estimates. Georgia also has a high percentage of uninsured residents (16%), ranking seventh-highest among the fifty states in 2013.⁷ Based on rankings and analysis compiled by the United Health Foundation, which provides the nation's longest running state-by-state rankings of the factors affecting the nation's health, Georgia has consistently ranked in the bottom tier of states over the past twenty-five years. It's most recent ranking, based on the 2014 report, is thirty-eighth. According to the report, Georgia's challenges are its low high school graduation rate (forty-eighth), its high prevalence of low birthweight babies (forty-sixth), lack of health insurance (forty-sixth), and limited availability of dentists (forty-fifth). Its strengths include a low prevalence of binge drinking (ninth), a low rate of drug deaths (tenth), and a low occupational fatalities rate (sixth).⁸

Georgia's state health system also receives relatively low marks compared with other states based on the Commonwealth Fund's ranking of state health system performance for low-income populations. Overall, Georgia ranked in the bottom tier of states (forty-fifth), ranking in the bottom quartile for access and affordability and prevention and treatment, and in the third quartile for potentially avoidable hospital use and healthy lives.⁹

1.1. Decisions to Date

Like most states with Republican governors, Georgia opted not to establish its own health insurance exchange or to expand its Medicaid program. Given the firm control conservative Republicans held over the state's political institutions along with the state's political culture that embraced a low-tax, low-spend approach to public policymaking these decisions on the fundamental elements of the Affordable Care Act (ACA) were not surprising.

In June 2011, Governor Deal issued an executive order authorizing the creation of an advisory committee to determine whether Georgia should establish a state-based health insurance exchange. A couple of months earlier, the governor was forced to withdraw a bill that would have established a health exchange in Georgia just as the General Assembly was getting ready to vote on the bill, due largely to tea party opposition to the ACA and its provisions.¹⁰

The Georgia Health Exchange Advisory Committee consisted of twenty-five members, including State Insurance Commissioner Ralph Hudgens; Commissioner David Cook (Department of Community Health); several state legislators; health industry representatives (insurers, brokers, providers); business representatives; consumer groups; and tea party activists. The focus of the committee's work was on "the potential benefits of establishing a Georgia small business marketplace and, if appropriate, to

provide foundational recommendations on how such a marketplace should be structured and operated using free-market principles.”¹¹ The committee was also charged with reviewing “the impact of federal control of an American Health Benefits Exchange (AHBE) and/or Small Business Health Options Program (SHOP) in Georgia.” The committee’s final report noted that “a core driver in decision-making and recommendation development was the critical need to ensure current state authority over the private health insurance market in Georgia remains fully intact and is not ceded to the federal government.”¹²

The advisory committee established four subcommittees (governance, operations and finance, insurance markets, and contingency plans) and held listening sessions with small businesses throughout the state during June and July 2011. The committee also met with key officials from existing private, small business marketplaces operating in other states (e.g., Florida, New York) and also reviewed a variety of research data on Employer-Sponsored Insurance (ESI) offerings and participation rates compiled by Georgia State University and based on their survey of small businesses in Georgia.

In October 2011, the advisory committee’s subcommittees gave their reports that recommended the creation of a Georgia Health Insurance Marketplace Authority, which would be structured as a quasi-governmental nonprofit corporation governed by a single board and with responsibility for operation of two separate risk pools, one for small businesses and one for individual consumers.¹³ The advisory committee’s final report, delivered to the governor in December 2011, recommended the creation of a state-based small business health insurance marketplace as either a wholly private or limited quasi-governmental entity. The advisory committee did not recommend the establishment of a state-based exchange for individual consumers.

In January 2012, the Republican legislative leadership and Governor Deal announced they had agreed not to push a health insurance exchange bill in the upcoming legislative session. According to a spokesman for the governor, “with the Supreme Court set to issue a landmark decision on Obamacare this spring, the governor does not want to move forward until the court has ruled.... Plus, the governor was concerned about mandates concerning exchanges from the Obama administration’s Department of Health and Human Services (HHS).”¹⁴

On June 28, 2012, the U.S. Supreme Court issued its ruling on the Affordable Care Act (*National Federation of Independent Business v. Sebelius*), affirming by a vote of five to four the Affordable Care Act, noting that the requirement that all Americans obtain health insurance or face a penalty was a tax and not an individual mandate. The ruling, however, also allowed states to determine whether or not they would expand eligibility for Medicaid.

Four hours after the Supreme Court decision, Governor Deal held a press conference to announce that the state would delay

two of its most important decisions – whether to go forward with an expansion of its Medicaid program and whether to create a state-run health insurance exchange – until after the November presidential election. According to Deal, “obviously, the elections in November will determine a lot of these decisions that will have to be made by the state at some point in time. We are probably just going to be in a holding pattern until such time as we see what the events of November bring us.”¹⁵

Two months later, Governor Deal revealed in an interview with *The Atlanta Journal-Constitution*, *11 Alive* (an Atlanta television news program), and *Politico* at the Republican National Convention that he would not expand Georgia’s Medicaid program. Deal told reporters that “I do not have any intentions of expanding Medicaid. I think that it is something our state cannot afford. And even though the federal government promises to pay 100 percent for the first three years and 90 percent thereafter, I think it is probably unrealistic to expect that promise to be fulfilled in the long term, simply because of the financial status that the federal government is in.”¹⁶ On November 6, 2012, Barack Obama was reelected president. Ten days later, Deal informed the Obama administration that Georgia would not be establishing a state-based health exchange and that “the State of Georgia takes seriously its legal authority over the state’s Medicaid program. We will continue to determine eligibility for all individuals seeking Medicaid in our state.”¹⁷

Given the greater clarity regarding the framework of federal health reform provided by the Supreme Court ruling and Obama’s reelection, Georgia in turn opted to double down on its opposition to the Affordable Care Act, or as Republican leaders preferred to call it, Obamacare.

In September 2013, state insurance commissioner Ralph Hudgens told a gathering of Republicans at an event in northern Georgia that “we have a problem, and the problem is Obamacare. Let me tell you what we’re doing: everything in our power to be an obstructionist.”¹⁸ Hudgens went on to detail the steps his office was taking to increase the requirements needed to be licensed as a health care navigator. In a later interview with *Georgia Health News*, Hudgens noted that “I guess my mouth got away from me.... There’s nothing I can do to be an obstructionist.” He added that there was very little the Georgia insurance department could do to affect the federal law, and that outside of licensing navigators he had no role in implementing the Affordable Care Act in Georgia.¹⁹

In December 2013, just prior the start of the 2014 state legislative session, a group of five Georgia Republican legislators announced they were launching an attack on the Affordable Care Act that they hoped other conservative states would follow. According to the lead sponsor, Republican Representative Jason Spencer, “our [proposed legislation] simply says the state of Georgia and any political entity, any agency, any public

university or college will simply not be able to implement Obamacare at all.”²⁰

In early January 2014, in his State of the State speech, Governor Deal told lawmakers that “the Affordable Care Act is anything but affordable and is costing our state \$327 million this year.” Deal noted that the expansion of Medicaid under the ACA would cost Georgia even more, adding, “We will not allow ourselves to be coerced into expansion.”²¹ State Representative Pat Gardner, a Democrat and a participant in a panel the next day on health reform sponsored by Georgians for a Healthy Future, disagreed with Deal’s assessment, pointing out that a recent study by a Georgia State University health economist estimated that Georgia would receive \$40 billion in federal aid over the next ten years under Medicaid expansion whereas the state’s spending over that time period would only be about \$2 billion.²²

A few days after the governor’s address, the Moral Monday Georgia movement, a coalition of civil rights groups, faith leaders, labor unions, and health care groups concerned about public policies that negatively affect low-income and working-class people, held a rally encouraging Georgia to expand its Medicaid program. State Senator Vincent Fort, a Democrat, spoke at the rally and told attendees that the group was prepared to utilize nonviolent civil disobedience if Deal continued to refuse to expand Medicaid. Two weeks later, Fort and nine other members of the Moral Monday Georgia movement, including several clergy members, were arrested inside the governor’s office after refusing to respond to repeated police orders to leave. The group had assembled in the reception area of the governor’s office, waiting for an opportunity to deliver their letter to him, which urged the governor to expand the state’s Medicaid program.²³

A legislative hearing was held early in the 2014 legislative session by the Georgia General Assembly to consider House Bill 707, sponsored by Spencer. HB 707 would prohibit state institutions and employees from implementing any of the provisions contained in the Affordable Care Act. The bill would also prohibit the state from establishing its own health insurance exchange. In his opening remarks, Spencer noted that federal health reform was increasing costs for Georgians and that “federal action under the ACA is ‘repugnant’ to the U.S. Constitution, in that the federal government cannot force states and local governments to act against their interests.”²⁴ Representative Trey Kelley, a Republican, added that “We don’t want a dime of state resources to go to implement this law.” Other speakers at the hearing included Carolyn Crosby of Georgians for Healthcare Freedom, whose group led a petition drive that collected more than 37,000 signatures opposing the ACA. Cosby told the legislators that the federal health law is “unworkable, unaffordable and unconstitutional.”²⁵ Another speaker from Gilmer County, who wore a tea party shirt, said the purpose of the bill is to “tell the federal government that the state of Georgia is still a sovereign state.”²⁶

A second bill to address health reform was also introduced in the 2014 state legislative session. House Bill 990, filed by the Republican leadership in the Georgia House, would require the legislature to approve any decision on Medicaid expansion. State Representative Jan Jones, House speaker pro tempore and the bill's main sponsor, said, "The Medicaid program already costs the state \$3 billion a year and that expansion would add to that tab. It's vitally important that expansion require a vote of the legislature."²⁷ House Majority Leader Larry O'Neal added, "We felt, and the governor felt, like this should be a joint effort ... to make such a step with taxpayer money."²⁸ HB 707 passed by a vote of 115 to fifty-nine and HB 990 passed by a vote of 118 to fifty-seven. Supporters of the federal health law opposed both bills. Gardner said the General Assembly's action "forgoes what is good public policy in the name of good politics. It is our responsibility to try to make the Affordable Care Act better and implement it well."²⁹ Timothy Sweeney, a health care policy expert at the Georgia Budget and Policy Institute, noted that "at the end of the day, the debate needs to be about whether and how to ensure poor Georgians get the health care that they need, not just about who makes the ultimate decision whether to expand." Sweeney said "if Georgia is not going to expand, there should be some solutions put forward as to what the alternative is to address these issues."³⁰

On April 29, 2014, Governor Deal signed House Bill 990, which observers noted was "the biggest roadblock yet to expanding Medicaid in Georgia under the Affordable Care Act." The legislation "ensures that even if a Democrat were elected governor, he or she couldn't expand Medicaid without legislative approval — an improbable scenario as long as Republicans remain in power."³¹ Deal also signed House Bill 943 into law, which contained the provisions in House Bill 707 filed by Spencer, that would prohibit "state or local governments in Georgia from advocating for Medicaid expansion or from creating a state-run health insurance exchange." The law also forces the University of Georgia to terminate its health insurance navigator program, which had provided training and outreach activities to assist Georgians in signing up for coverage through the federally run health insurance exchange in Georgia.³² Cindy Zeldin, executive director of Georgians for a Healthy Future, said, "These bills are so disappointing because they send a message to our state's low-income uninsured that their elected officials have made a deliberate decision to block their access to basic health care services." In addition, more than six in ten Georgians were supportive of Medicaid expansion under the Affordable Care Act based on polls conducted by *The Atlanta Journal-Constitution* over the past sixteen months.³³

Although public opinion has been supportive of Medicaid expansion and many of the state's low-income and health care advocacy groups had mobilized in support of Medicaid expansion, the health care industry — particularly providers — have

been relatively inactive in the push for Medicaid expansion in Georgia, unlike in other states. As the 2015 legislative session opened, the Georgia Hospital Association (GHA), the state's largest hospital association, crafted a Medicaid expansion plan that "would be both beneficial and fiscally wise."³⁴ According to the group's proposal, which was shared with *Georgia Health News*, the state would use federal funds available through the Affordable Care Act to expand Medicaid through the state's existing Medicaid managed care companies for two years. The plan would have a sunset provision for 2017 and also create "a commission that would study the financial effects of expansion on state and local governments, and develop a comprehensive health care strategy for Georgia."³⁵ GHA claims its plan would "create tens of thousands of new jobs and would generate far more in new state tax revenues than is needed to cover the state's costs."³⁶

The hospital association is particularly concerned about how the cuts from the Affordable Care Act will directly impact hospitals (estimated to be \$727 million in Georgia) and has shared those concerns with state officials. Five Georgia hospitals have closed since 2013 and many others, particularly those that serve rural communities, are facing severe financial challenges. In addition to the GHA, another hospital group, the Georgia Alliance of Community Hospitals, has also announced its support for Medicaid expansion, and an association of rural hospitals "has said that Medicaid expansion would help, but that it's not a silver bullet for financial problems these facilities face."³⁷

Despite the support of the hospital groups and several legislators (both Republicans and Democrats) who encouraged the General Assembly to hold hearings on Medicaid expansion in the 2015 legislative session, there was not much support among Republican leaders to do so. As a result, the legislature took no action on Medicaid expansion during the 2015 session. Governor Deal did sign a budget bill that authorized the state's Department of Community Health to begin discussions with HHS regarding a Section 1115 waiver that would permit the state to draw down additional Medicaid matching funds through an experimental network of hospitals (Grady Health System in Atlanta, Memorial Health in Savannah, and a small group of rural hospitals would be the initial sites) to provide coverage for the uninsured and then manage their care.³⁸

Many Republican legislators, however, remain skeptical of the plan. Spencer, lead author of House Bill 707, obtained an opinion from the state attorney general's office saying a budget bill could not be used to change state law. Spencer and three other Republican legislators then sent a note to the state's Medicaid director with a copy to Deal advising them of the attorney general's opinion. According to Spencer, "this letter is an advisory warning letter that we probably ought not to pursue this until we have a debate on it. If we're going to do Medicaid waivers that could potentially lead to Medicaid expansion under the Affordable Care

Act, then we need to have that debate.”³⁹ On August 13th, the commissioner of the state’s Medicaid agency announced that the state would not move forward on the Grady plan for a Medicaid waiver as it would bring “significant costs to the state” to implement the plan. The commissioner added that “federal officials indicated they would consider the waiver proposal only if Georgia were willing also to expand its Medicaid program – something Georgia political leaders have emphatically declined to do.”⁴⁰

Part 2 — Implementation Tasks

2.1. Exchange Priorities

Georgia opted not to establish a state-based health exchange, though initial consideration was given to establishing a private or quasi-governmental health exchange for small business. In the end, Georgia opted to rely on the federal government to operate the health exchange in Georgia, and state officials did very little to promote the exchange.

2.5. Outreach, Consumer Education, and Navigational Assistance

Two groups in Georgia received federal grants to train and deploy navigators to help consumers enroll in health insurance through the Affordable Care Act. SEEDCO (Structured Employment Economic Development Corporation) received \$2.2 million to work with fourteen community partner organizations, including Georgians for a Healthy Future, Healthy Mothers Healthy Babies Coalition, Georgia Watch, and Mental Health America of Georgia. In addition, the University of Georgia College of Family and Consumer Sciences and Cooperative Extension Service received \$1.7 million to place navigators in several communities outside metro Atlanta. It was estimated that the federal grants Georgia received would support fewer than 100 navigators throughout the state.⁴¹

In addition to the federal support, Enroll America, a nonprofit organization funded by health insurers, hospitals, doctors, pharmaceutical companies, employers, consumer groups, faith-based organizations, civic organizations, and philanthropies, made Georgia one of ten states that it would devote special attention to.⁴² According to Enroll America’s Georgia director, the organization has most frequently connected with African-American churches, which have hosted educational and informational events on the Affordable Care Act. Rev. Arthur Carson, Jr., president of New Era Baptist Convention, which represents eighty-five churches in Georgia, notes that African American pastors have been supportive of the education and outreach efforts because “many of our churches serve people of low-income who are uninsured.”⁴³

Also, Blue Cross, the state's largest health insurer, partnered with Univision and HolaDoctor to provide public education and information on the Affordable Care Act to Hispanic consumers throughout the state, and also partnered with the Hispanic Health Coalition of Georgia (HHCG) for an education campaign in the metro Atlanta area. According to Heidy Guzman, HHCG's executive director, about half of Georgia Hispanics are uninsured.⁴⁴

The state of Georgia, however, given its opposition to the Affordable Care Act, did not provide any resources in support of education and outreach. Indeed, the state actually took several actions to thwart these efforts. For example, Georgia's attorney general joined with twelve other state attorneys general who wrote HHS Secretary Kathleen Sebelius expressing concern that HHS's rules do not do enough to protect the personal privacy of consumers seeking to access the health exchanges and related navigational assistance programs.⁴⁵ More notably, Governor Deal signed a bill passed in the 2013 legislative session that requires individuals seeking to serve as health insurance navigators to be licensed by the state. Among the requirements for licensure were completion of "not less than 35 hours of instruction in health benefit insurance, the exchange provisions of the federal act, and [the state's Medicaid and PeachCare for Kids programs] through a training program" approved by the commissioner of insurance and passage of an examination as required by the commissioner. Applicants for a renewal license are required to complete continuing education classes as approved by the commissioner.⁴⁶

Cindy Zeldin, executive director of Georgians for a Healthy Future, noted that the bill "could potentially scare away organizations that really would be good fits for the navigator program and who we'll need if we want to get all of the people enrolled who need to get enrolled."⁴⁷

A report by the University of Georgia on health navigator assistance during the first enrollment period found that nearly two-thirds of the consumers assisted by SEEDCO, the lead organization that supplied navigators in Georgia, were African Americans and that many were financially insecure and had a very limited understanding of the health law and/or health insurance concepts. According to the report, more than half of the individuals assisted noted "they had put off at least one health care visit during the past year because they could not afford it. One-third said they had deferred three or more visits."⁴⁸

Two groups received \$3.3 million in federal grants from HHS for navigational assistance during the second enrollment period. SEEDCO received \$2.2 million to support about 20 health care navigators, and a Macon-based nonprofit, Community Health Works, received \$1.1 million to form an alliance of six regional cancer coalitions and other agencies to provide navigator assistance. The Community Health Works program replaces the University of Georgia's program, which provided navigational assistance during the first enrollment period. UGA was barred

from continued participation in the navigator program by an act of the state legislature that passed during the 2014 legislative session.

Thirty-one Federally Qualified Health Centers also received federal funding through the Health Services and Resources Administration for enrollment assistance. In addition, Enroll America was also active in the second enrollment period as were several education, outreach, and enrollment assistance programs supported by private sources.⁴⁹ Also providing enrollment assistance during the second enrollment period were certified application counselors (CACs) working under sixty-six organizations that agreed to support CACs with their own funds, funds from private philanthropic sources, or to host CAC volunteers. The primary difference between CACs and health care navigators concerns the nature of their funding. Duties performed, training, and state-based licensing requirements were the same for both navigators and CACs.

Among the lessons learned from interviews with enrollment assisters active in the second enrollment period conducted by Georgians for a Healthy Future were the following:

- One of their best methods for reaching consumers was building upon existing relationships with community organizations.
- Enrollment events served as valuable opportunities for assisters to efficiently reach large numbers of people.... These events were marketed in the local media using radio spots, newspaper ads, and movie theater ads.
- Confusion and political hostility created significant barriers to outreach and enrollment. [Passage of state legislation] prohibiting state and local governmental entities from operating a navigator program, among other provisions, led to confusion among local health departments and other governmental entities regarding their participation in helping consumers enroll in health insurance... Most of these entities opted for caution, which meant that potentially powerful partnerships for enrollment were missed.⁵⁰

2.6. Interagency and Intergovernmental Relations

2.6(a) Interagency Relations. There are four health agencies serving the state of Georgia.

The Department of Community Health, one of the largest state agencies, is responsible for the state's Medicaid and PeachCare for Kids (Children's Health Insurance Program) programs, the State Health Benefit Plan, health care facility regulation, and health information technology. The department was created in 1999 when the Georgia General Assembly passed reorganization legislation that transferred functions and duties performed by three state health agencies to the newly created department. In 2009, the health care facility regulation division

was formed (via transfer from the Department of Human Resources) as was the Office of Health Information and Technology and Transparency (now the Health Information Technology Division).

The Department of Human Services (formerly Department of Human Resources) is responsible for aging services, child support services, family and children services, and residential child care.

The Department of Public Health (DPH) is the lead agency for prevention of disease, injury, and disability; promoting health and well-being; and disaster response regarding public health issues. In 2011, the Georgia General Assembly passed reorganization legislation that established DPH as a freestanding state department after more than thirty years as a unit of other departments, most recently the Department of Human Resources. DPH's primary functions include health promotion and disease prevention, maternal and child health, infectious disease and immunization, environmental health, epidemiology, emergency preparedness and response, emergency medical services, pharmacy, nursing, volunteer health care, the Office of Health Equity, vital records, and the state public health laboratory. In addition, DPH funds and collaborates with the state's 159 county health departments and eighteen public health districts.

The Department of Behavioral Health and Developmental Disabilities provides treatment and support services to people with behavioral health challenges and addictive diseases, and assists individuals who live with developmental disabilities.

A fifth state agency, **the Department of Insurance**, which is led by the state insurance commissioner, a constitutionally elected official, is responsible for licensing insurance companies and ensuring that the licensed companies remain solvent and compliant with all the requirements of Georgia laws and regulations. The department's Life and Health Division is responsible for solving both technical and practical problems in the regulation of insurers through oversight of life and health insurance policy contracts in Georgia.

The state insurance commissioner and the commissioner of the Department of Community Health both served on the advisory committee Governor Deal created in 2011 to explore options regarding the establishment of a health insurance exchange. Georgia opted not to create its own exchange and decided to rely instead on the federal government to manage and operate the health insurance exchange in Georgia.

Most state health agencies have been focused on their own missions and responsibilities. There has been little effort, now or in the past, to craft a comprehensive approach to health care in Georgia. In addition, efforts within agencies to promote a more coordinated approach to health care often move slowly or fail to fully materialize. Two recent examples illustrate these challenges.

In May 2015, the Department of Community Health announced that it would not be proceeding "at this time" with its

plans to coordinate care for the state's Medicaid beneficiaries who are elderly or disabled. This marked the second time state efforts to improve coordination stalled, and in each instance, cost was a major factor contributing to delays in moving forward.⁵¹

A second example is the loss of a federal family planning grant. In July 2014, HHS awarded a three-year, \$7.8 million family planning services grant to a coalition of agencies, including Family Health Centers of Georgia, the lead agency; other federally qualified health centers in Georgia; Grady Health System; and Planned Parenthood, to provide family planning services and to provide health care, primarily to low-income women. This marked the first time in thirty years that the grant did not go to Georgia's public health agency, though the department did apply for it.⁵² According to Dr. Michael Brooks, CEO of Family Health Centers, a primary goal of the grant "is to create coordinated care for women in Georgia. We can improve health outcomes."⁵³ Brooks noted that Georgia has the highest rate of maternal mortality in the country, and that the grant will do several things to improve women's health. These include: funding health services for women who are not yet pregnant but may become pregnant, focusing on chronic conditions and smoking; providing prenatal care; delivering postbirth education; teaching women how to space out their pregnancies; and providing birth control for those seeking to prevent unwanted pregnancies.⁵⁴

2.6(b) Intergovernmental Relations. State officials have had a cool and distant relationship with federal officials regarding the Affordable Care Act. The primary concerns among state officials have been cost and perceptions of infringement of state authority. Federal officials, on the other hand, have raised concerns about the state's approach to health care reform regarding both its decision not to expand Medicaid and its support of the federally facilitated health insurance exchange.

Backlog of Medicaid applications. On July 9, 2014, federal officials at the Centers for Medicare & Medicaid Services (CMS) sent a letter to Georgia's Medicaid director, saying that it will look into the backlog of Medicaid applications in Georgia that were filed through the health care law's insurance marketplace. CMS officials said in the letter that they "will look at how many people are being affected, how long they have been waiting, and what technical challenges or gaps have contributed to the substantial backlog." While nearly 89,000 people in Georgia who applied for health insurance through the federal website learned they could be eligible for Medicaid under existing eligibility rules (i.e., no expansion), only about 13,000 had heard back from Georgia Medicaid officials on the status of their applications filed before the March 31st enrollment deadline.⁵⁵

State officials maintain they did not receive the data they needed from the federal health insurance exchange until May 1st. A state Medicaid official noted that "we are individually processing these files as quickly as possible and comparing applicants

through the federal marketplace with people who have also applied for Medicaid directly through the state.” By the end of July, the state had processed about 70 percent of the account transfers, and of these, an estimated 18,000 (or about 28%) were enrolled in the state’s Medicaid or PeachCare for Kids programs, with the vast majority of those enrolled being children. Six other states (Arkansas, Illinois, Indiana, North Carolina, Virginia, and Wyoming) received similar notices from CMS regarding backlogs in processing their Medicaid applications.⁵⁶ Timothy Sweeney, health policy director at the Georgia Budget and Policy Institute, noted that “Georgia’s backlog troubles may be a sign that the state isn’t investing enough in new technologies and other resources to make sure people who are eligible for Medicaid actually get covered.”⁵⁷ Sweeney also compared the Medicaid backlog to the state’s recent backlog in processing food stamp applications, which he said may show “there’s not significant capacity to deal with the demand for services.”⁵⁸

Medicaid Reimbursements to Nursing Homes. In December 2014, CMS officials sent a letter to the state’s Medicaid director informing him that Georgia should return more than \$100 million in Medicaid payments made to a group of nursing homes in fiscal 2010 and 2011 that violated federal program regulations. CMS officials also asked the state to return any “similarly inappropriate payments for more recent fiscal years as well,” which could bring the total amount of funds to be repaid to \$250 million. The dispute concerns Georgia’s use of the Upper Payment Limit (UPL) funding formula, which allows the state to receive a higher payment rate (at Medicare levels) for delivering Medicaid services.

According to CMS officials, the state maintains that the nursing homes in question were owned by local development authorities that were the source of the “intergovernmental transfers” used to provide matching funds to get UPL dollars. CMS, on the other hand, claims that the nursing homes were private facilities, not owned by a public agency as required by the program’s regulations.⁵⁹ Clyde Reese, commissioner of the state’s Medicaid agency, contests the federal ruling, calling it “factually and legally incorrect.”⁶⁰ In his response to CMS, Reese pointed out that the local development authorities are public agencies under Georgia law, similar in status to local hospital authorities, and also noted that CMS had approved the agency’s state share of UPL funding every year since the program began in 2001.

Medicaid Claims Processing. Medicaid reimbursements to nursing homes is not the only dispute between federal and state officials regarding payments under Georgia’s Medicaid program. Earlier this year, a federal judge ruled that Georgia should receive \$90 million in Medicaid funds it mistakenly returned to the federal government in 2005 and 2006 even though the state made its claim to the funds after the two-year window to do so had closed. Federal officials rejected the claim. Georgia subsequently appealed to a Medicaid administrative board, and when that

failed, filed a lawsuit in 2013. According to U.S. District Court Judge Gladys Kessler's ruling, issued on February 10, 2015, "Georgia's ineptitude in making errors and delay in discovering them is confounding, but does not justify permitting the federal government to keep the \$90 million in credits to the detriment of Georgia's 1.89 million Medicaid recipients."⁶¹

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs). Nine health insurance companies offered plans to Georgia consumers during the second open enrollment period, up from five the first year. The returning insurers were Blue Cross and Blue Shield of Georgia, the state's largest insurer in terms of market share (51%), Alliant Health Plans, Kaiser Permanente of Georgia, Peach State Health Plan, and Humana. The four new insurers were Assurant Health, Cigna, Coventry, and UnitedHealthcare. Collectively, these nine insurers accounted for nearly 90 percent of the health premiums issued in the individual market in 2013.⁶² Three of the nine insurance carriers that provided plans during the second enrollment period did so statewide compared with only one during the first enrollment period. On average, there were forty-one health plans available for Georgia consumers to select from during the second open enrollment period, nearly double the number of available plans (twenty-two) in the first open enrollment period.⁶³

Cindy Zeldin, of Georgians for a Healthy Future, said "this shows the marketplace is thriving and insurers are expecting Georgia consumers to continue seeking coverage. For many Georgians who are uninsured, cost is the biggest barrier to enrolling in coverage. Competition helps to keep rates down, and there is also financial help available for consumers, but still many Georgians are stretching their budgets to purchase health insurance."⁶⁴

According to an analysis by *Kaiser Health News*, which examined premiums for the lowest cost silver plan in the thirty-four states, including Georgia, that rely on the federal government to run their exchanges, the average price for the cheapest plan in Georgia fell 4 percent. The analysis also found that about a third of Georgia counties saw their premiums rise, with 11 percent experiencing increases of 10 percent or more. Premium changes from 2014 to 2015 for the least expensive silver plan ranged from a 24 percent decline in Coffee County to a 25 percent increase in Laurens County. Georgia State University health economist William Custer pointed out that "many of the areas where prices went up the most were in rural regions where the population turned out to be sicker than insurers anticipated. A lack of outreach in those areas also meant there were fewer — and sicker people — signed up to spread the risk over."⁶⁵

In June 2015, the federal government released a report of proposed 2016 premium increases of 10 percent or more. Seven Georgia health insurers were included in the report: Aetna (10.95% to 20.3%), Alliant (37.85%, only one plan), Blue Cross and Blue

Shield of Georgia (11.42 to 21.58%), Humana (10.62 to 19.44%), Kaiser Foundation Health Plan (10.23 to 10.52%), Time Insurance Co. (13.03 to 64.2%), and UnitedHealthcare (18.64 to 29.69%).⁶⁶ The report did not list proposed increases less than 10 percent and also noted that premium changes would not be final until later in the fall. A spokesman for the Georgia Department of Insurance noted that “the proposed Georgia premium increases have been sent to outside actuaries for analysis to make sure they’re thoroughly vetted.” He added that “we can reject rates that are excessive, inadequate or overly discriminatory.” The state review is expected to be completed by the end of August.

While the increase in the number of insurance providers and the plans offered over the first two open enrollment periods bodes well for increased competition in the Georgia health insurance market, a recent announcement by Aetna that it plans to acquire Humana, a deal involving two of the nation’s largest health insurance companies, has raised some concerns. If the merger is approved by state and federal regulators, it would double Aetna’s enrollment in Georgia to about 1.4 million. According to experts, “such an acquisition could lead to higher insurance premiums and contribute to an ongoing trend toward limiting a consumer’s choice of medical providers.”

Discussions regarding consolidation among other health insurers are also underway. These include Centene’s (parent company of Peach State Health Plan in Georgia) proposed acquisition of Health Net and Anthem’s (parent of Blue Cross and Blue Shield of Georgia) purchase of Cigna. The latter would leave the state with three large for-profit health insurers compared with five. In addition, UnitedHealthcare, one of the state’s five largest insurers, is reportedly considering a proposal to acquire Aetna.⁶⁷

Insurers see significant gains from the mergers, including reduced administrative costs and greater clout in negotiating prices with hospitals and other medical providers as well as pharmaceutical companies regarding prescription drug prices. Physician and hospital groups in Georgia have expressed serious concern over the proposed mergers. A spokesman for the Georgia Hospital Association said “these types of mergers could result in significant increase in market power for the insurance companies while placing health care providers and consumers at a distinct disadvantage at the negotiating table. Increased premiums may lead to even more individuals without access to affordable health care.”⁶⁸

As an example of the tensions between insurers and providers and consumers, former State Insurance Commissioner John Oxendine in July 2015 filed a lawsuit on behalf of eleven surgical centers, their patients, and a claims filing service against Blue Cross and Blue Shield of Georgia, accusing it of overcharging customers for health insurance and at the same time reducing payments to doctors outside of their coverage network.⁶⁹ The lawsuit seeks to attain class action status. Blue Cross is the state’s largest health insurer and is disputing the charges. Oxendine has also

contacted the state's current insurance commissioner and encouraged him to look into the issue, which Hudgens told *The Atlanta Journal-Constitution* he intends to do. During his tenure as insurance commissioner, Oxendine battled several times with Blue Cross over concerns that the company's practices stifled competition and kept prices high.⁷⁰

2.7(b) Clearinghouse or Active Purchaser Exchange. Not applicable.

2.7(c) Program Articulation. Program articulation in Georgia was largely handled by nonprofit organizations and associated enrollment assisters and volunteers. As noted earlier, the state did not take any formal education, public information, or outreach actions to assist low- and moderate-income households in connecting to the most appropriate health insurance plan for their needs and circumstances. Indeed, as elaborated on above, the state actually took an obstructionist position toward implementation of the Affordable Care Act, which many observers noted actually created confusion among both consumers and potential partner organizations. In addition, as pointed out above, there were significant technical issues that hindered the sharing of information between the federal health insurance exchange and the state agency responsible for determining eligibility for Medicaid and PeachCare for Kids. Those difficulties resulted in a backlog of processing nearly 89,000 applications submitted through the federal exchange during the first enrollment period.

2.7(d) States That Did Not Expand Medicaid. Georgia has one of the nation's lowest eligibility levels for the Medicaid program. While Medicaid expansion through the Affordable Care Act would increase eligibility to cover all adults at or below 138 percent of the federal poverty level (FPL), in Georgia current eligibility levels for aged, blind, or disabled adults is 76 percent of the FPL and 38 percent of the FPL for parents of minors. Childless adults are not eligible at all. Thus, Georgia has one of the nation's highest coverage gaps, fourth highest among the 21 states not expanding Medicaid, according to a recent analysis by the Kaiser Commission on Medicaid and the Uninsured.⁷¹ The report estimates the coverage gap in Georgia at 282,000, with three-fourths of those adults without dependent children, more than half (52%) female, and 57 percent in a working family. In addition, the coverage gap in Georgia, as in other states not expanding Medicaid, disproportionately affects poor uninsured black adults. Nearly half of the black adults nationally who fall into the coverage gap reside in three states: Texas (18%), Florida (14%), and Georgia (14%).⁷²

To date, state officials have taken no formal action to address the coverage gap in Georgia, and it is unlikely they would do so before the 2016 legislative session convenes in January. There were exploratory conversations underway regarding a possible Medicaid waiver that would use federal matching dollars to provide coverage to the uninsured through a network of hospitals

and Federally Qualified Health Centers, with the dollars needed to generate the additional Medicaid match coming from private and nonprofit/philanthropic sources. Governor Deal and Republican legislative leaders have made it clear that any additional money needed to generate the matching funds would have to come from sources other than state funds.

Findings from a report on best practices and lessons learned from the second open enrollment period by Georgians for a Healthy Future concluded that addressing the coverage gap is one of the biggest barriers to addressing the uninsured facing the state. The report noted that “some assister organizations estimated that over half of the consumers they worked with fell into the gap. Enrollment assisters were able to provide these consumers with a list of resources where they could go to get free or low cost care, but indicated frustration at not being able to do more to help.”⁷³

2.8. Data Systems and Reporting

The Georgia Health Policy Center, a unit of Georgia State University’s Andrew Young School of Policy Studies, convened a Health Reform Symposium in October 2010 that brought together stakeholders from fifteen diverse groups (e.g., provider organizations, rural and community-based groups, small and large businesses, professional associations, state and local governments) to explore the implications and challenges of health reform. According to a summary of the proceedings, “the general sentiment among symposium participants was that information technology (IT) needs and requirements vary ... The most likely IT capacity needs involve: designing patient management and clinical management systems, sharing data between systems, building IT systems to handle additional claims, provider information, etc., and developing data system standards for health.”⁷⁴

The symposium summary also said “several attendees lamented over the lack of collaboration, coordination, and sharing of data and information among various state agencies. In some cases, IT systems ‘cannot talk to each other’ because of technological, bureaucratic, political, or organizational barriers preventing data sharing.”⁷⁵ The summary said suggested actions for addressing these issues were “the need to approach vendors, budget strategically and seek technical assistance in defining a common data set with prevention, primary care measures, using the banking system as a model, and compiling and disseminating best practices.”⁷⁶

Georgia’s Medicaid Management Information System (GAMMIS), managed by the Georgia Department of Community Health, began operations on November 1, 2010, and is the department’s claims processing system for Medicaid and PeachCare for Kids. GAMMIS has since implemented several state and federally mandated system changes, including the Medicaid Modified Adjusted Gross Income (MAGI) changes (January 2014), and is currently beta testing the transition to ICD-10 code set standards used to differentiate diagnoses and procedures in virtually all

treatment settings. DCH anticipates it will be ready to fully deploy this project by the federal deadline of October 1, 2015.⁷⁷

Georgia has not made extensive use of its state data systems and reporting practices to better understand the nature and extent of health needs and disparities in Georgia. In 2008, the Department of Community Health, through its Office of Health Improvement and Minority Health Advisory Council, issued a health disparities report that focused on racial disparities based on an analysis of county-level data.⁷⁸ In 2010, following a reorganization of state agencies, the Georgia Department of Public Health was formed and it established an Office of Health Equity. There has not been an updated report on health needs and disparities to the 2008 DCH report.

The Department of Public Health does maintain OASIS (Online Analytical Statistical Information System), which provides interactive access to a suite of web-based tools for creating tables, maps, or charts from the department's standardized health data repository. Topics included in the data archive cover mortality/morbidity (e.g. hospital discharge, emergency room visits, sexually transmitted disease), maternal and child health, infant mortality, population characteristics, behavioral surveys (Youth Risk Behavior Survey, Behavioral Risk Factor Survey), and motor vehicle crashes. Data is generally available at the county level and for public health districts. Data can be obtained for census tracts through OASIS' mapping function, though the indicators are grouped into five-year aggregates and the user has little control over the class intervals used for displaying the data. DPH will respond to individual requests for customized extracts of public health data, but unlike many other states, is generally unwilling to provide health indicators at the census tract level (or block group) on an annual basis, which limits the ability to assess the spatial distribution of health needs and disparities below the county level.

Part 3 — Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

Not applicable.

Part 4 – Summary Analysis

4.1. Policy Implications

The Affordable Care Act has created opportunities for more than 400,000 low-income Georgians to gain health insurance, based on cumulative marketplace enrollment figures through June 30, 2015. According to estimates from the Kaiser Family Foundation, 38 percent of the potential marketplace population has enrolled in a health plan in Georgia, above the national rate of 35 percent and sixth highest among the nineteen states that have not expanded their Medicaid programs.⁷⁹

Table 1. Summary of Marketplace Enrollments by Georgia Consumers

	<i>Open Enrollment Period 1 October 1, 2013 – March 31, 2014</i>	<i>Open Enrollment Period 2 November 15, 2014 – February 15, 2015</i>
Number of individuals who selected a marketplace plan	316,543	541,080
Number of individuals determined or assessed eligible for Medicaid/CHIP by the marketplace	91,914	63,083
Percent of individuals eligible to enroll in a marketplace plan who selected a plan	29%	50%
Consumer demographics		
Female	57%	NA
Age 18-34	37%	34%
Percent of individuals selecting a marketplace plan who received financial assistance	87%	90%
Percent of Individuals who selected a Silver plan	71%	NA
Distribution of consumers by type		
New enrollees	NA	55%
Re-enrollees	NA	45%
Percent of re-enrollees who switched plans	NA	26%

Sources:

"Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period. For the period October 1, 2013 – March 31, 2014, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, May 1, 2014.

"Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report for the period November 15, 2014 – February 15, 2015," U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, March 10, 2015).

"Mapping Marketplace Enrollment: What Share of Potential Marketplace Enrollees Signed up for Coverage in 2015," Henry J. Kaiser Family Foundation, n.d.

The state has experienced a sizeable "woodwork" effect as more than 60,000 Georgians who were already eligible for Medicaid assistance under the state's existing eligibility requirements have gained coverage through the federally facilitated marketplace in Georgia or applied directly to the state, likely as a result of increased public education and outreach brought about by the ACA (Table 1).⁸⁰ Georgia's Medicaid enrollment increased nearly 6 percent during the first open enrollment period, a rate more than twice as high as that recorded by all of the states not expanding Medicaid (Table 2). During the second open enrollment period, Georgia's Medicaid enrollment increased by about one percent, compared to a 2.5 percent decline in states not expanding Medicaid and a 6.5 percent increase in expansion states. Overall, Georgia's Medicaid enrollment increased by about 4 percent between July-September 2013 and March 2015, compared to a decline of 8.5 percent in all nonexpansion states and an increase of 28.7 percent in expansion states.

In many respects, these results are even more remarkable when one factors in the oppositional approach Georgia's elected

Table 2. Medicaid and SCHIP Enrollments, Georgia and Selected States, July 2013–March 2015
Enrollments in thousands

	<i>Georgia</i>	<i>States Not Expanding Medicaid</i>	<i>States Expanding Medicaid*</i>
<i>Enrollment Period I</i>			
Monthly average, July–September 2013	1,703	24,731	34,125
Enrollment, March 2014	1,801	25,352	38,305
Percent change, July–September 2013 to March 2014	5.8%	2.5%	12.2%
<i>Enrollment Period II</i>			
Monthly average, July–September 2014	1,753	23,232	41,235
Enrollment, March 2015	1,769	22,641	43,908
Percentage change, July–September 2014–March 2015	0.9%	-2.5%	6.5%
Percentage change, March 2014–March 2015	-1.8%	-10.7%	14.6%
Percentage change, July–September 2013–March 2015	3.9%	-8.5%	28.7%

* For comparability over time excludes enrollment figures for Connecticut, Delaware, Indiana, North Dakota, and Pennsylvania. Source: Centers for Medicare and Medicaid Services, *Monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Reports*, various months.

officials have taken toward the implementation of the ACA, which has resulted in a number of actions that have made it more difficult for Georgians to secure health insurance. Nonetheless, these gains in reducing the ranks of the uninsured have been relatively modest compared with states that opted to expand their Medicaid programs.

Based on Gallup's survey of the uninsured population in the states, Georgia's uninsured rate dropped slightly between 2013 and 2014, declining from 21.4 percent to 20.2 percent, leaving the state with the third highest percentage of uninsured residents (Texas, 24.0%, and Mississippi, 20.6%). Though state-level data are not yet available for 2015, based on Gallup's second quarter national results (the national uninsured rate fell to 11.4 percent, which is the lowest rate recorded since Gallup began regularly tracking health insurance coverage in 2008), it is conceivable that the 2015 figures will show continued improvement in Georgia's uninsured rate.⁸¹ It is highly unlikely, however, that Georgia will see gains comparable with those recorded by other states that have more enthusiastically embraced health reform. Last year, Gallup reported that Arkansas and Kentucky recorded the largest reductions in their uninsured rates, with each state essentially cutting its uninsured rate by half. Gallup reported that ten of the eleven states with the greatest reductions in their uninsured rates

expanded their Medicaid programs and took an active role in the health insurance marketplace by either establishing a state-based exchange or a state-federal partnership exchange. Montana, which tied for tenth, was the only exception.⁸²

Given the size of Georgia's "coverage gap" – currently estimated at about 300,000, fourth highest among the twenty-one states that have not expanded Medicaid – it is hard to fathom how the state can make further progress in addressing its uninsured population without some type of Medicaid expansion. Yet, Governor Deal remains steadfast in his opposition to expanding a program he maintains is broken (he has advocated for converting Medicaid to a block grant to give the state more control), and, more importantly, one he argues the state cannot afford.

Similar sentiments are held by many in the Republican-controlled state legislature (super majorities in both houses). Spencer, the state representative and one of the most outspoken critics of the Affordable Care Act, says "Medicaid expansion will actually make people more dependent on the system. It would cut jobs and lead to cuts in higher education. We have a broken model in Georgia and nationwide, and expanding Medicaid will only create more problems."⁸³

The economic arguments against expanding Medicaid in Georgia, however, are at odds with current economic realities in the health care industry (e.g., hospital closures and the increasing number of hospitals in financial distress) and with analyses that have been completed on the economic impact of Medicaid expansion in Georgia. In February 2013, Georgia State University health economist William Custer released a report that estimated the ten-year effect of Medicaid expansion in Georgia (2014-23).⁸⁴ In addition to the \$40.5 billion in Medicaid funds the state would receive through Medicaid expansion, Custer estimated that those funds would generate an additional 70,000 jobs statewide – about half in the health care sector – which, in turn, would add an average of \$8.2 billion in new statewide economic output that would yield, on average, \$276 million annually in increased state and local tax revenue.

Alan Essig, former director of the Georgia Budget and Policy Institute, wrote in a blog published in March 2014 that "an honest accounting shows the net cost of expansion is about half of the numbers expansion opponents cite as unaffordable – \$210 million per year beginning in 2017, rising to \$500 million per year by 2023. Of course, that is only one side of the ledger. Once you count increased revenues, Georgia's net cost is about half that. And, of course the state will make a profit through 2016 [federal government pays 100% of expansion cost during the first three years]."⁸⁵

While state officials continue to stand firm that Medicaid expansion is too expensive for Georgia, the state's hospitals face severe financial distress and many rural counties have a severe shortage of primary care physicians. Several rural hospitals have closed, and many have pared back the services they do offer. For example, more

than forty Georgia counties lack obstetrical providers and less than half of the hospitals in the state have labor and delivery units.⁸⁶ The financial stress faced by Georgia hospitals is due, in part, to the provisions in the Affordable Care Act that phase out the Medicaid Disproportionate Share Hospital (DSH) payments, which were included on the assumption that the states would opt to expand their Medicaid programs, thus increasing coverage and reducing the amount of uncompensated care hospitals would have to absorb. Since Georgia opted not to expand Medicaid, the reduction in uncompensated care has not materialized, increasing the financial pressures on Georgia hospitals. According to one recent story, “the Georgia Hospital Association says its members are facing the most difficult financial conditions they’ve ever seen.”⁸⁷ A report released by the Obama administration in June noted that Georgia’s uncompensated care costs would be \$410 million lower in 2016 if Medicaid expansion were fully in effect.⁸⁸

Health reform in Georgia has largely been framed as a cost issue, despite all the rhetoric about the dangers of big government and Obamacare. Put simply, according to Deal and the Republican leadership in the state legislature, the state cannot afford to do more. That position, which state leaders have been reluctant to soften, has closed opportunities for more deliberative discussions on the complexity of the problem and potential solutions. The economic impacts of health reform go well beyond state government and affect a broad and diverse group of stakeholders — consumers, advocates for the needy, insurers, hospitals, doctors, and other health care providers, among others. Tensions have already surfaced among these interests, particularly insurers versus consumers and health care providers, and it remains to be seen whether each group will fend for itself or whether a more inclusive dialogue involving all key stakeholders will take place, yielding a consensus solution.

4.2. Possible Management Changes and Their Policy Consequences

The most significant challenge Georgia faces in the implementation of health reform is addressing the sizeable number of individuals caught in the coverage gap and the implications that failure to act have on the financial stability of the state’s hospitals. This issue is especially acute for those hospitals that bear a disproportionate burden in providing uncompensated care to low- and moderate-income families and individuals.

This challenge is especially acute given the state’s political culture, which for generations has embraced a low-tax, low-spend philosophy and a strong preference for private sector solutions over public ones. Whether the state can craft a collaborative, cross-sector solution to the coverage gap, an approach that will likely be needed to effectively address this issue, remains to be seen. The proposed Medicaid waiver that Grady Health Systems and its partners developed was a promising step in that direction,

though it failed to gain the support of the state's political leaders who maintained the plan was too expensive for the state. Unlike many other states, however, Georgia has not been particularly creative in addressing health care issues, generally preferring to be a late adopter as opposed to an early innovator. As in the past, the failure to embrace the Grady waiver proposal is consistent with the state's approach to the Medicaid program in that Georgia has simply not been aggressive in terms of using waivers to test out methods for reducing the number of uninsured. However, with the continued flexibility that states have in shaping alternative expansion pathways — such as Arkansas has done — Georgia officials may prefer to sit back and watch what other states do to address the uninsured without necessarily “expanding” Medicaid. Since 2016 is a presidential election year, they may also choose to kick the can down the road again in the hopes that Republicans capture the White House and the Senate in the national elections and finally repeal Obamacare.

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