

A man with a beard and mustache, wearing a blue and white plaid button-down shirt, is shown from the chest up. He has his right hand pressed against his forehead and eyes, looking down with a distressed or frustrated expression. The background is a dark, textured wall.

*USING A  
MEDICAID EXPANSION  
TO TARGET  
GEORGIA'S UNINSURED  
ADULTS IN POVERTY*

*WRITTEN BY: TIMOTHY SWEENEY*

*Community Voices*

HEALTHCARE FOR THE UNDERSERVED

# Community Voices

**C**ommunity Voices: Healthcare for the Underserved is working to make health care available to all. With eight sites across the country and managed by the National Center for Primary Care at the Morehouse School of Medicine, Community Voices is helping to ensure the survival of safety-net providers and strengthen community support services. Launched in 1998 by the W.K. Kellogg Foundation, the sites are part of a national effort to sort out what works from what does not in meeting the needs of those who receive inadequate or no health care.

# PREAMBLE

by Henrie M. Treadwell, Ph.D.

Community Voices: HealthCare for the Underserved has worked since 1998 across the United States to engage into health services, the poor, the underinsured, the uninsured, and the underrepresented. The primary goal has to been to use community ingenuity and know-how to solve some of the vexing problems that impede the ability of many in America's diaspora to enjoy good health that enables them to life, liberty and the pursuit of happiness. A second major goal of Community Voices is to ensure that the process of engaging all in community into healthcare services did not do damage to the safety net system. Early in the process, but later than we should have, we discovered that poor men in America, particularly poor men of color are less than equal with regard to access to the healthcare system. The establishment of a Medicare, and later a Medicaid, system that gave attention only to pregnant women and later to men unfortunate enough to develop a chronic condition that threatened life itself, left out of the network poor men of color that even today can access care only episodically through emergency rooms or some community clinics. These single adults (largely men, but many women, too) are poorly connected to a continuum of care. Data that report on providers for poor men's healthcare needs do not take into account the large numbers of men that never see a provider, physician or dentist until an emergency or life-threatening condition develops.<sup>1,2,3</sup> These men are left out of the policy dialogue unless stricken with HIV/AIDS, renal failure, diabetes with compromised ability to walk, or unless more men of color are needed for clinical trials without any guarantee of follow up health care to address adverse reactions once experimentation has ceased. As a result, they cannot care for their physical health that includes mental and oral health services. It is established fact that the health of men of color is significantly compromised.<sup>4,5</sup>

The Community Voices initiative has learned that communities cannot do it alone IF there are no nationally mandated and enforced programs that ensure a payor for culturally competent, quality health care for all. Community Voices has learned that some policymakers are needed in order to ensure that America is the healthiest nation in the world. The Medicaid Model promulgated in this document represents an opportunity for the State of Georgia, and by extension other states in the Union, to implement at a pilot level a program that would enroll single adults that still are healthy and not enrolled on Medicaid, SSI, SCHIP, or any other health payor program and that are, in fact, ineligible for these public programs by virtue of gender and/or the ability or desire to have children. An emphasis is proposed for poor men as studies have shown that the health of poor men of color is the most compromised in the nation, a status that has virtually gone unchanged since slavery, as measured by comparative morbidity and mortality data.

Visionary leadership can work with communities that are ready and willing to solve local problems. But communities cannot provide health services if safety-net institutions are not able to be compensated for services, are not able to reach out and enroll those at greatest risk of being uninsured and unserved, and if the taxpayer supported programs are not available to each American regardless of ability to pay.

History still leaves a harsh legacy in some communities. Blame aside, it is no accident of numbers alone that finds African Americans and Latinos who live in or near poverty with the worst health status. Simple comparison of who is insured and who is not, by virtue of no work, low-wage work and inability to pay for insurance in the private market reveals a racial thread. While the racial thread may be ignored in some deliberations, debilitating disease and death should not be visited upon single adults who happen to be from communities of color and who are poor in disparate numbers. Racism, happenstance, bad luck, whatever the cause, America and its people can do better. The plan in these pages represents a first step that can be taken by all men and women of good will that embrace liberty and justice for all.

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1 "Addressing Racial and Ethnic Disparities in Health Care," Agency for Healthcare Research and Quality. February 2000.

2 "Prevention and Men of Color in the U.S.: Findings from the National Healthcare Disparities Report," Challenge: A Journal of the Morehouse Research Institute. 2005.

3 "Failing Health: The Crisis of Health Care for Indigent Offenders and for Community," Eric J. Miller, LLM, LLB. 2007.

4 "Where Are The Men? The Impact of Incarceration and Reentry on African-American Men and Their Children and Families," Natasha H. Williams. November 2006.

5 "Prison Health and The Health of the Public: Ties that Bind," Natasha H. Williams. December 2006.

# Using a Medicaid Expansion to Target Georgia's Uninsured Adults in Poverty

## Introduction

In 2005, approximately 1.4 million adults in Georgia were uninsured, and nearly half of these individuals had incomes below 200 percent of the Federal Poverty Guidelines.<sup>1</sup> The uninsured rate for adults below 200 percent of poverty was roughly 44 percent.<sup>2</sup> This lack of health coverage among so many adults in Georgia is one of the most important health policy issues facing the state. A large uninsured population reduces efficiency within the healthcare system and leads to cost-shifting onto those with health insurance in order for healthcare providers to serve those without coverage. The lack of access to primary and preventive care also can lead to lower health outcomes, further driving up healthcare costs for all Georgians. The concentration of the uninsured among lower-income adults further exacerbates these problems and has added significance as the state examines potential policies to increase coverage.

While the issue of the growing uninsured population has generated a great deal of attention across the political spectrum, much of the focus in Georgia has been about how tax-incentives may be used to help individuals purchase private insurance. This particular solution may help motivate upper-income adults who choose to be uninsured to instead purchase coverage; however, these proposals are not likely to have a significant impact on low-income individuals and families.<sup>3</sup> Instead, solutions seeking to address the high uninsured rates of low-income Georgia adults most likely need to include direct subsidies to solve current access and affordability issues.

This brief will examine the current healthcare situation for adults in Georgia and will explore one option that would significantly increase access to health insurance for some of Georgia's lowest income adults: a Medicaid expansion. Because Medicaid expansions targeting large numbers of Georgians may be costly, this brief will also examine the feasibility and potential costs of targeted or localized pilot projects.

## Background<sup>a</sup>

According to U.S. Census Bureau data, approximately 1.4 million non-elderly adults in Georgia went without health insurance in 2005. This total represents approximately one-quarter of the state's non-elderly adult population and places Georgia's rate roughly 20 percent above the national rate (which is 21 percent). While the ranks of the uninsured span all demographic and economic groups, Georgia's uninsured are disproportionately concentrated among minorities, men, young adults, and most fundamentally, low-income Georgians.

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### (Endnotes)

On March 23, 2007, the U.S. Census Bureau identified an error resulting in the overcounting of the uninsured from 1995 to 2005. In particular, the Census Bureau reports that national data overestimated the 2004 uninsured population by 0.7 percent and the 2005 uninsured population by 0.6 percent. Georgia specific data (not broken by population) overestimated the 2004-2005 average uninsured rate by 0.5 percent, though it is uncertain whether this overestimation affected all populations within Georgia equally.

Throughout this report statistics are cited using Census Bureau data as a direct source as well as from other publications using 2005 and 2006 Census Bureau data. Some national data has been re-released, however as of May 8, 2007, revised, population-specific (such as non-elderly adults) data for Georgia alone is unavailable. As a result, data cited in this report may overstate the number of uninsured individuals in Georgia; however, data examining the makeup of the uninsured may be less significantly affected by the over counting error described by the Census Bureau. For more information, see the Census Bureau website:

<http://www.census.gov/hhes/www/hlthins/usernoteusernote3-21rev.html>

## Community Voices: Healthcare for the Underserved

### Demography of Georgia's Uninsured

Overall, non-elderly Hispanic individuals (including children) are most likely to be uninsured in Georgia (46 percent), while non-elderly African Americans (20 percent) are also more likely to be uninsured compared to whites (14 percent).<sup>4</sup> Nationally, non-elderly African-American adults in particular are over-represented in the uninsured population. While approximately 15 percent of all non-elderly uninsured adults in the U.S. are African American, the group makes up only about 12 percent of the overall non-elderly adult population. Non-elderly adults with Hispanic backgrounds (of any race) also make up a larger portion of the uninsured population (28 percent) than of the overall non-elderly adult population (14 percent).<sup>5</sup>

Data examining the racial and ethnic make-up of Georgia's uninsured, non-elderly adult population, in particular, is unavailable however, data examining the make-up of the below-poverty population is available. Non-elderly adult African Americans account for roughly 26 percent of the non-elderly adult population in Georgia, yet make up approximately 45 percent of Georgia's non-elderly, adult population below the poverty level.<sup>6</sup> If non-elderly, African-American adults in Georgia below the poverty line have the same access to health insurance as do non-elderly, white adults below poverty, then African Americans would be overrepresented among the state's non-elderly adult uninsured population on account of their overrepresentation in the poverty population. Such a situation would also be consistent with national data.

The lack of employer-sponsored insurance is a significant issue within minority communities. Nationally, roughly 66 percent of white, non-elderly adults receive insurance through an employer plan (not necessarily their own employer). Non-elderly adult African Americans only receive employer insurance roughly 53 percent of the time, however and non-elderly adults with Hispanic backgrounds only receive employer insurance approximately 43 percent of the time. Even controlling for citizenship, only 46 percent of Hispanic-American citizens (all ages) are insured through an employer.<sup>7</sup>

Men are also overrepresented among Georgia's uninsured. Based on census data, non-elderly males account for slightly less than 49 percent of Georgia's non-elderly adult population; however, men made up just above 54 percent of the uninsured non-elderly adult population. Interestingly, men and women experienced similar rates of uninsurance among the young adult (18-24) and older adult (45-64) populations. On the other hand, men ages 25-44 were 30 percent more likely to be uninsured than women. One of the driving factors in this difference could be the fact that women in this age group were approximately 23 percent more likely to have Medicaid coverage, due at least in part to the program's more generous coverage of pregnant women.

The uninsured problem among adults in Georgia is especially significant for male and female Georgians ages 18 to 24. Thirty-eight percent of Georgians in this age group were uninsured in 2004, compared to 19 percent of Georgians ages 25 to 64.<sup>8</sup> Not surprisingly, younger adults are less likely to have private insurance through an employer (41 percent) when compared to older adults (69 percent). While access to employer-sponsored insurance is not high among young adults in Georgia, this population has few other options, as only 12 percent of young adults are enrolled in Medicaid.<sup>9</sup>

### Low-income adults lack adequate access to affordable health insurance

Likely the most important factors influencing an individual's access to, and likely possession of, health insurance are economic in nature. In particular, low-income adults in Georgia often have few, if any, realistic options for private health coverage, leading to high uninsured rates among this population. For the purposes of this report, the term "low-income" will refer to adults (and families) whose income is below 200 percent of poverty, while adults or families in poverty will refer to those with incomes below 100 percent of poverty. Table 1 shows the federal poverty guidelines for various family sizes.

**Using a Medicaid Expansion to Target Georgia’s Uninsured Adults in Poverty**

**Table 1 2007 Federal Poverty Guidelines**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>100% FPL:</b>	\$ 10,210	\$13,690	\$17,170	\$20,650	\$25,130
<b>200% FPL:</b>	\$20,420	\$27,380	\$34,340	\$41,300	\$48,260

In 2005, only 18 percent of non-elderly adults with incomes below the poverty level had employer sponsored insurance, while approximately 45 percent of adults (more than 300,000 individuals) in this income range were uninsured.<sup>10</sup> Access to private insurance increases slightly for adults with incomes between 100-199 percent of poverty, though only 35 percent of these adults have employer-sponsored insurance. The uninsured rate for this income range remains high, at 43 percent.<sup>11</sup>

In general, there are many factors that lead to these high uninsured rates for low-income adults in Georgia. Lower-wage workers are less likely to be offered employer-sponsored insurance in the first place and are less able to afford such coverage when it is offered. These problems are exacerbated for part-time workers. In 2006, for example, businesses with more than 35 percent of their employees earning less than \$20,000 per year sponsored health insurance only 42 percent of the time, compared to 65 percent for other firms.<sup>12</sup> Likewise, employers with higher percentages of part-time workers were also much less likely to offer insurance compared to employers with fewer part-time employees.

While low-income adults generally have little access to employer-sponsored health insurance options, they also often do not have access to public programs, since these programs overwhelmingly target children, the elderly, disabled individuals, and pregnant women. Currently, Medicaid eligibility for low-income parents extends to approximately 57 percent of poverty for parents, which is less than \$12,000 a year for a family of four. While this income threshold for parents is very low, low-income adults in Georgia without children are ineligible for Medicaid regardless of income.<sup>13</sup> As a result of these low-eligibility thresholds, non-pregnant, non-elderly/non-disabled adults make up less than ten percent of the overall Medicaid population.<sup>14</sup> Below, Table 2 shows the current Medicaid eligibility thresholds for working parents on Medicaid compared to family income that would place the family at the federal poverty level.

**Table 2 Current Medicaid Eligibility Compared to Poverty Level**

Family Size:	<u>Childless Adults</u>			<u>Working Parents</u>	
	<u>1</u>	<u>2</u>	<u>2</u>	<u>3</u>	<u>4</u>
Current Eligibility Threshold:	N/A	N/A	\$7,803	\$9,787	\$11,771
100% FPL:	\$10,210	\$13,690	\$13,690	\$17,170	\$20,650

Due to these low-income eligibility thresholds, low-income adults without access to employer-sponsored insurance generally have only the individual insurance market as an option for coverage. Unfortunately, individually purchased private insurance is often unaffordable for low-income workers. Products that are affordable often include very high deductibles and other out-of-pocket costs, which make obtaining healthcare services very difficult. As a result of the unaffordable nature of this market, less than seven percent of low-income Georgia adults have private insurance *not* obtained through an employer.<sup>15</sup>

## **Community Voices: Healthcare for the Underserved**

### **Why Adult Health Insurance is Important**

The prevalence of health insurance among adults in Georgia is particularly important for many reasons.

First, access to the healthcare system is greatly enhanced by having health insurance. Countless studies have examined access to care and the healthcare received by those with and without insurance, with results clearly showing that uninsured individuals are less likely to have adequate access to healthcare. In addition, the insurance status of parents affects the insurance status and thus healthcare access for children. This issue presents itself in two ways. Low-income children may be less likely to be enrolled in public programs when their parents are not also eligible for benefits. Also, navigating the child's healthcare plan may be easier for parents who are also part of that same healthcare plan. Finally, there is an efficiency argument to be made regarding the importance of health insurance since a greater coverage rate will reduce cost-shifting within the healthcare system.

### **Importance of Insurance for Access to Healthcare**

One of the primary benefits of adequate health insurance is that it gains individuals access to the healthcare system. Without adequate access to healthcare services, uninsured individuals are more likely to put off needed healthcare services because they are unable to afford such care. When circumstances present that necessitate healthcare services, the lack of health insurance can create significant financial hardships for uninsured individuals and families.

Countless studies throughout the years have examined the lack of access to healthcare services faced by those without health insurance. Across the board, these studies have found evidence that access limitations lower the likelihood that individuals receive a variety of preventive care and treatment services. In addition to the fact that uninsured individuals are less likely to receive any medical care in a given year, studies have also focused on some specific types of services that uninsured individuals are less likely to receive. The 2003 Kaiser Health Insurance Survey found:<sup>16</sup>

- 42 percent of uninsured individuals lack a regular source of care (9 percent for those with insurance)
- 47 percent of uninsured postponed seeking care because of the cost (15 percent for insured)
- 35 percent reported that they needed care but did not get it (9 percent for those with insurance)
- 37 percent did not fill a prescription because of cost (13 percent for insured individuals)
- 35 percent skipped a recommended treatment because of cost (13 percent for those with insurance)

Another recent study examined how health insurance status may affect whether an individual receives appropriate follow-up care after an unintentional injury or the onset of a new chronic condition. In this study, the researchers found that “uninsured individuals were significantly less likely to see a clinician following an unintentional injury or a new chronic condition.”<sup>17</sup> Furthermore, while uninsured individuals were no less likely to be referred for follow-up care when they did visit a clinician, they were significantly more likely to receive none of the recommended care and less likely to receive all of the recommended care.<sup>18</sup> The study also found that individuals were less healthy in follow-up interviews and more likely to be no longer receiving treatment.<sup>19</sup>

In addition to findings documenting the difficulty of those without health insurance in obtaining healthcare services, studies have also examined the health status implications of being uninsured. One study found that hospital rates for avoidable conditions were 50 percent higher for uninsured individuals as compared to those with private insurance.<sup>20</sup> Uninsured individuals were more likely to get diagnosed in later stages of cancer when compared to those with health insurance and to have higher relative risks of death.<sup>21</sup>

## Using a Medicaid Expansion to Target Georgia's Uninsured Adults in Poverty

While the lack of health insurance can bring with it significant barriers to healthcare services, the lack of insurance can also create financial hardships for individuals and families when needed healthcare services must be paid for out-of-pocket. Such costs are especially burdensome on the lowest income families who have significantly less ability to afford high medical costs. Studies examining these financial burdens found that more than one-third of the uninsured report difficulty paying medical bills and that nearly one in four uninsured individuals has been contacted by a collection agency regarding medical bills.<sup>22</sup> Given these statistics, it is no surprise that roughly 50 percent of all personal bankruptcies in the U.S. stem at least in part from medical costs.<sup>23</sup>

While those without any health insurance are particularly vulnerable to the access and financial concerns stated above, some individuals and families with insurance are also vulnerable to these problems. Individuals and families with bare-bones insurance coverage that require significant out-of-pocket expenditures can face similar financial difficulties and barriers accessing healthcare services.

### Importance of Parental Health Insurance for Children

While the presence of health insurance is especially important for the individual, parental insurance is also important for children. In fact, one reason many support Medicaid expansions targeted at low-income parents in particular is simply because expanding parental access to public programs also increases children's participation in these programs. In addition, evidence also suggests that parents are better able to navigate their children through their healthcare program if they too are able to participate in it.

One study published in 2001 examined the patterns of health insurance coverage between children and their parents, focusing particularly on the percent of covered children whose parents have either separate insurance or no coverage – defined in the study as discordant coverage. Among other findings, the study found that approximately 21.5 percent of low-income children (defined as children below 200 percent FPL) had parents with discordant coverage and that more than two-thirds of these children had parents with no coverage (as opposed to other coverage).<sup>24</sup> At this rate, discordant coverage is more than four times as prevalent among low-income children and their parents as it is for children in families above 200 percent of poverty (4.5 percent).<sup>25</sup> Among children on public health insurance programs the results were even more dramatic, as 36.5 percent of these children had an uninsured primary parent, while only 8.1 percent of these children had parents with private health insurance.<sup>26</sup>

The issue of discordant coverage is important because insured children with uninsured parents or with parents with separate coverage are at a disadvantage when it comes to navigating their health plan in particular and even the healthcare system in general.<sup>27</sup> Therefore, providing Medicaid coverage to parents of children already enrolled in the program could increase the effectiveness and efficiency of public programs.

In addition to problems that arise from discordant coverage among children and their parents, some studies have also found evidence to suggest that low-income children are less likely to be enrolled in public health insurance programs such as Medicaid and SCHIP when their parents are not also eligible for coverage. Because of this possibility, some states have implemented parental Medicaid expansions with the expressed goal of increasing children's enrollment in those programs.

One study in particular examined state expansions targeted at parents and the effects on children's participation rates in Medicaid and SCHIP. This study found that in three states implementing such expansions, participation among already-eligible children increased at a higher rate than in states not implementing such expansions. The study found that child participation rates increased by 16 percentage points (from 51 to 67 percent) in these three states, while participation rates only increased by three points in other states (from 51 to 54 percent).<sup>28</sup>

## **Community Voices: Healthcare for the Underserved**

### **Importance of Insurance for Healthcare Coverage System Efficiency**

The efficiency of the healthcare system is negatively affected by high uninsured rates in several ways. In particular, any time an uninsured individual receives “uncompensated care” the healthcare system becomes less efficient. When healthcare providers (often hospitals) incur administrative costs trying to get reimbursed for services provided to those without coverage, the efficiency of the system suffers. Of greater concern, however, is that providers with significant uncompensated care costs or bad debt must “pass-on” these costs to other “customers.” These other customers are generally privately insured individuals.

In 2005, Georgia healthcare providers incurred roughly \$1.3 billion in uncompensated care costs. This figure is projected to increase to more than \$1.8 billion in 2010.<sup>29</sup> Georgia taxpayers and healthcare consumers pay these costs indirectly through public spending on hospitals and other healthcare providers, and higher health insurance premiums for those with coverage. One study examining the additional costs passed on to privately insured individuals estimated that in 2005, Georgia families paid approximately \$746 (*Georgia Budget and Policy Institute May 2007*) more per year in health insurance premiums to account for the costs of the uninsured – over 7 percent of their health insurance premiums. This study went on to project that by 2010 the amount Georgia families pay to offset uncompensated care costs would increase to \$1,246 annually, nearly 8 percent of annual health insurance premiums.<sup>30</sup>

### **Addressing High Uninsured Rates among Adults with a Medicaid Expansion**

One solution the state could examine to help low-income parents and childless adults obtain needed health insurance coverage would be to expand the state’s existing Medicaid program. As previously discussed, Georgia’s Medicaid eligibility threshold for adults is very low. Parental eligibility extends only to the very lowest income families, and non-elderly childless adults without disabilities are ineligible for Medicaid at any income level. At the same time, adults whose income is below 100 percent FPL rarely have affordable options for private health insurance coverage. Though expanding Medicaid to adults with incomes below the poverty level would address the uninsured problem in its entirety, it would open the door to healthcare services for thousands of Georgians currently without adequate access to care.

While expanding coverage to currently uninsured Georgians would yield benefits throughout the healthcare system and throughout the state, such an expansion would also increase Medicaid expenditures by the state. Estimating the costs and benefits of expanding Georgia’s Medicaid program is a complicated effort. While the budgetary costs to the state are certainly the most obvious aspect of the overall financial impact of such an expansion, it is only one component of the overall financial and social impacts an expansion would have. Other impacts would be felt throughout the healthcare system, as providers would see a reduction in uncompensated care and as increased access to preventive medicine could help avoid higher treatment costs at a later date. Furthermore, since a Medicaid expansion would bring in millions of dollars in the form of federal Medicaid funds, increased spending by the Medicaid program would have a positive economic impact throughout the state. These secondary effects are likely significant and would certainly offset at least a portion of the state expenditures to implement the expansion. Due to the difficulty of assessing the precise financial benefits, however, estimating healthcare system savings resulting from reduced uncompensated care and increased preventive services, for example, proves very difficult. Thus, these benefits will be discussed on a conceptual level, though some data is available to illustrate the potential scale of these effects.

## Using a Medicaid Expansion to Target Georgia’s Uninsured Adults in Poverty

### Budgetary Costs to the State

The budgetary costs of the expansion are the most straightforward; however, estimating these costs can be a complex exercise. The estimates put forth in this brief rely on several assumptions that are unable to be fully tested. For example, the estimates calculated in this brief use current Medicaid capitation rates (also referred to as per member/per month, pm/pm, amounts) to forecast total costs, under the assumption that the targeted population is similar in healthcare needs to the current low-income adult population enrolled in Medicaid. (Please see the attached methodology section for a further discussion of the cost estimates, as well as the assumptions used and the possible limitations of these assumptions.)

Estimating the costs of Medicaid expansions also contains inherent uncertainty regarding the number of individuals who will seek coverage under an expanded program. While it was stated earlier that more than 300,000 uninsured adults in Georgia have incomes below the poverty level, it is unlikely that all of these individuals would immediately enroll in an expanded Medicaid program. The rate at which newly eligible individuals seek coverage is uncertain. In addition, coverage expansions also bring with them increased enrollment among currently eligible individuals. For example, there are currently approximately 100,000 uninsured children in Georgia in families below poverty. Most of these children are currently eligible for Medicaid coverage. The state would likely see increased enrollment among kids as their newly eligible parents present for coverage. Because of the uncertainty surrounding enrollment growth, this brief presents cost estimates based on multiple take-up scenarios and thus produces a range for the expected state costs of such an expansion.

**Table 3** **Cost Estimates for Adult Expansion Under Three Scenarios:**

	<u>Low</u>	<u>Moderate</u>	<u>High</u>
<u>Enrollment:</u>			
Initial Month	18,000	27,000	37,000
End of Year 1	62,000	98,500	136,000
End of Year 2	98,000	146,500	220,000
Year 1 Monthly Avg.	40,000	62,750	86,500
Year 2 Monthly Avg.	81,500	124,500	181,500
<u>Cost Estimates:</u>			
Year 1 – PM/PM	\$294.01	\$308.71	\$323.41
Year 2 – PM/PM	\$308.71	\$324.15	\$340.36
Yr. 1 St. Funds (millions)	\$52.2	\$86.0	\$124.2
Yr. 1 Fed. Funds (millions)	\$88.9	\$146.5	\$211.5
Yr. 2 St. Funds (millions)	\$111.7	\$179.2	\$274.3
Yr. 2 Fed. Funds (millions)	\$190.2	\$305.1	\$467.0

Source: Authors calculations using data from per-member/per-month (pm/pm) data from the Department of Community Health.

Based on three enrollment growth scenarios analyzed by GBPI, Table 3 shows the potential state costs in the first year of a Medicaid expansion to adults below poverty. As shown in this table, roughly 63 percent of the overall costs of the expansion would be paid for with federal Medicaid funds, while the remaining funding would be the responsibility of the state. As a result, an investment by the state of \$52 to \$124 million would bring in additional funding of \$89 to \$212 million in the first year. Depending once again on the take-up of benefits by both newly eligible individuals and those already eligible, costs in the second

## Community Voices: Healthcare for the Underserved

year of an expansion would be higher than in the first. Using various enrollment trends assumptions, the GBPI estimated range for the state cost in the second year under the three scenarios increases to between \$112 and \$274 million.<sup>31</sup>

In addition to increased costs for adults targeted in the expansion, children's Medicaid enrollment would also likely increase even though these children are already eligible for coverage. Because these children are eligible but currently not enrolled, it is difficult to predict how many of these children may seek Medicaid coverage. If enrollment steadily increased such that half of the 100,000 eligible-but-not-enrolled children were covered by the end of the year, average monthly enrollment would total approximately 27,000 children. Under this scenario, the state could expect increased Medicaid costs of approximately \$18 to \$20 million (depending on the ages of the children). In addition, this enrollment growth would bring with it \$28 to \$33 million in additional federal Medicaid funds.<sup>32</sup>

### Healthcare System and Other Benefits

While the financial costs to the state budget are likely significant, this additional spending brings significant benefits as well. Additional federal funding for Georgia healthcare providers, reduced uncompensated care, health system efficiency gains from reduced cost-shifting, and economic and social gains stemming from health status improvements are all potential benefits from a significant expansion of Georgia's Medicaid program. These benefits are often difficult to quantify, but they can be explained in concept quite easily.

One of the primary benefits of a Medicaid expansion would be the additional federal Medicaid funding flowing into Georgia's healthcare system. Because Medicaid spending is primarily directed to healthcare providers in Georgia, Medicaid spending is an economic benefit to the state. One study looking at Medicaid spending found that for every \$1 million Georgia spends on Medicaid, approximately 31 jobs are created and \$3.4 million in business activity is created.<sup>33</sup> Based on the cost estimates presented above, a Medicaid expansion could generate approximately \$280 to \$525 million in new business activity in Georgia and approximately 2,200 to 4,400 new jobs.

As a result of increasing the number of Georgians with health insurance, Georgia safety-net providers could also expect to see a decline in uncompensated care, which would address some of the efficiency concerns previously stated. Declining uncompensated care costs would be beneficial not simply for Georgia's hospitals, but also for privately insured Georgians who see higher insurance costs as a result of the growing uninsured population. By paying for health insurance on the front end and reducing cost-shifting to privately-insured individuals on the back end, coverage expansions have the potential to reduce overall healthcare costs and to reduce the cost of private insurance.

Finally, Georgia could also expect social and economic benefits from increasing individual's access to healthcare services. With increased access to preventive care in particular, and all healthcare services in general, low-income working adults could see health status gains as well as productivity gains from being healthier. To the extent that an adult expansion increases enrollment among children, the state could also see benefits associated with increased children's coverage, such as fewer missed school days. As complex as it is to quantify the gains to the healthcare system associated with less uncompensated care and increased federal funding, quantifying these social gains is even more difficult. It is worth noting, however, that the growing uninsured population does have social consequences for Georgia and the U.S. as a whole. The Institute of Medicine estimates that at least 18,000 Americans die prematurely each year because they lack health coverage. Other research has suggested that a 5 to 15 percent reduction in mortality could be achieved if the uninsured were to gain continuous health coverage.<sup>34</sup>

## Using a Medicaid Expansion to Target Georgia’s Uninsured Adults in Poverty

### Pilot Program Yields Lower Costs, Benefits

A smaller scale option Georgia could consider would be to implement a pilot project for Medicaid expansion targeted to a geographical area. While a pilot project would not address Georgia’s adult uninsured population on such a large scale as a statewide expansion, it would allow Georgia to gain a better understanding of what to expect under a statewide expansion. Implementing a smaller-scale expansion would give state officials more information that could be used to make a statewide expansion more successful and to more accurately assess the potential costs and benefits of a larger-scale expansion. A pilot program could assist state officials in estimating potential take-up rates and could also assist officials in developing outreach campaigns to identify and enroll eligible individuals.

Much like the potential costs of a statewide expansion, the costs of implementing a pilot project will depend on many factors.

**Table 4** Cost Estimates for a Pilot Program

	<b><u>Low</u></b>	<b><u>Moderate</u></b>	<b><u>High</u></b>
<b><u>Enrollees</u></b>	<b>20,000</b>	<b>20,000</b>	<b>20,000</b>
Est. PM/PM	\$294.01	\$308.71	\$323.41
Total Cost (millions)	\$70.9	\$74.1	\$77.6
State Funds (millions)	\$26.1	\$27.4	\$28.7
Federal Funds (millions)	\$44.5	\$46.7	\$48.9

One of the benefits of a smaller-scale pilot project, however, is that the financial costs can be more easily controlled by the design of the program. While aspects of even a limited expansion will lead to some uncertainty in forecasting the costs of the program (health status and utilization patterns of new enrollees, for example), simply limiting the pilot program to a defined number of participants can control much of the financial uncertainty. Based on the per-enrollee costs used in the previous estimates, and as shown in Table 4, a pilot program targeting 20,000 participants for an entire year could cost the state approximately \$26 to \$29 million, assuming federal participation at the Medicaid match-rate generates an additional \$45 to \$49 million. While these costs are lower than the costs of a full-scale expansion, many of the secondary benefits of the larger expansion would also be less significant.

### **Conclusions**

Expanding Georgia’s Medicaid program would provide much needed access to health coverage for thousands of adults in poverty currently without health insurance. Though this expansion does not target individuals above the poverty level who also have little access to coverage, expanding access for the lowest-income adults is an important first step in increasing access to care across all income ranges. Increasing health coverage for parents could also increase the likelihood that eligible children would enroll in Medicaid and receive healthcare services once they are covered. While an expansion would increase state spending on the Medicaid program, this spending would benefit the state’s healthcare system significantly. Along with additional federal funds generated through the expansion, this spending would be an economic benefit to the state and would create jobs. Furthermore, paying for health insurance on the front-end would ease the burden Georgia’s safety net providers currently face as a result of the growing uninsured population. This would reduce current cost-shifting that drives up private insurance costs.

## Community Voices: Healthcare for the Underserved

Georgians already pay for healthcare services for uninsured individuals in the form of rapidly increasing health insurance costs and tax-dollars that go to support healthcare providers in the wake of ever-increasing uncompensated care. By providing health insurance for currently uninsured adults in poverty, a Medicaid expansion would help make the current healthcare system more efficient while substantially improving access to healthcare services for thousands of Georgians currently without such access.

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