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Race, Health Disparities and the Decision to Expand Medicaid

An Investigation of Two States: Florida & Georgia

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Strategies for Medicaid Expansion:
A Solution for Health Disparities in Florida



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Acronyms

ACA	Patient Protection and Affordable Care Act
CHIP	Children's Health Insurance Program
FPL	Federal Poverty Level
QHP	Qualified Health Plan
STI	Sexually Transmitted Infection
HIT	Healthy Incentives for Tennesseans

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Executive Summary

The Problem:

Health disparities and the uninsured

Southern Health Partners has requested an analysis of the potential use of Medicaid expansion as a policy tool to address health disparities in Florida, and in particular, reproductive health disparities. Our analysis suggests that the provision of insurance will reduce these disparities by increasing access to preventative care and treatment of ailments which currently disproportionately affect uninsured Floridians and Floridians of color, two closely related groups.

The Solution:

Medicaid expansion leads to improvements for Florida's population and economy

To recommend the optimal option for Florida, we analyze three different states who have dealt with reducing the uninsurance rate through Medicaid expansion: a traditional expansion state, a waiver expansion state, and a non-expansion state. Regardless of which model of expansion is adopted, Medicaid expansion would be financially beneficial to Florida in increased savings, revenue, and economic productivity compared to the status quo. Until December 31, 2016, the federal government will cover 100% of the cost of Medicaid expansion. This number gradually decreases to the baseline of 90% in 2020, which the federal government will provide in perpetuity for the approximate 877,000 Florida residents who would be in the expansion population. For those newly insured, they would have access to preventative care and treatments before their illnesses become dire and expensive, increasing quality of life and reducing emergency costs for healthcare providers. Insured people will go to emergency rooms less often, which means cost-savings for hospitals who take on patients without coverage and increased revenue for primary doctors and physicians. As Florida's healthcare stands, uncompensated care costs hospitals over 3 billion dollars each year. By expanding access, uncompensated costs are almost entirely eliminated which leads to additional savings of up to 1.3 billion dollars. The benefits of expansion economically could lead to the creation of 70,000 new jobs in the health sector and could provide a boost to the state economy of over $8 billion.

Background on Florida

Florida's most needy population for Medicaid are minorities and poorer, nonelderly adults—the group most benefitted by Medicaid expansion. Florida's health as a state is among the bottom half in the nation (America's Health Rankings, 2015). Its rates for total population health, rates of infant mortality, obesity, and diabetes are higher than the national average (et al). Medicaid expansion in Florida may decrease some of the chronic illnesses impacting Floridians disproportionately, relative to the national average.

With a population of approximately 20.3 million residents, Florida's expansion would have lasting ramifications socially and economically (Chardy, 2015). The population is 55.3 percent White, 24.5 percent Hispanic or Latino, 16.8 percent Black, 2.8 percent are Asian, and 0.5 percent Native American. Medicaid expansion in Florida may decrease some of the chronic illnesses impacting Floridians disproportionately, relative to the national average.

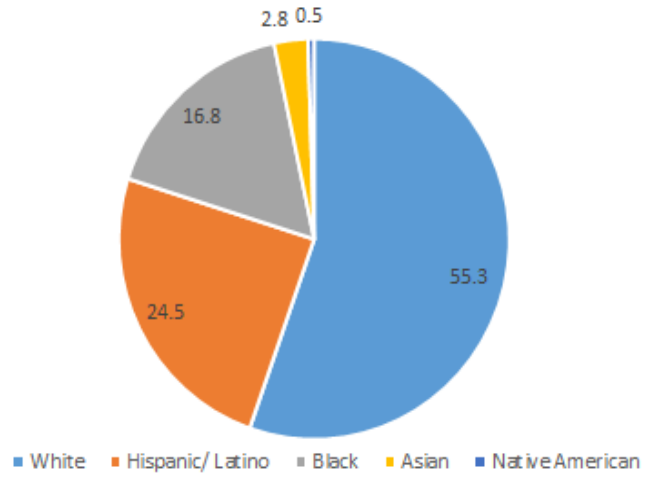


Figure 1. Florida's Racial Breakdown

Florida is a swing state in national elections, but predominantly Republican in state elections. The Republican Party controls two-thirds of the state House and nearly two-thirds of the state Senate seats. The Florida legislature has been divided on Medicaid expansion. In June 2015, the House and Senate fought bitterly on a Medicaid expansion compromise bill. The Senate backed the bill, but the House voted it down 72-41. Governor Rick Scott (R) also opposed the bill although he originally supported limited expansion of Medicaid in 2013 (Governor of Florida, 2013).

A majority of Floridians, however, support Medicaid expansion. 67 percent of voters support Medicaid expansion, and 27 percent oppose it (University of Florida, 2014). Republicans are evenly divided on support and opposition of expansion, while 88 percent of Democrats express support (Holt and Denslow, 2014).

Health Disparities in Florida

In particular, we focus on reproductive health: of all states, Florida has the seventh-highest rate of HPV-associated cervical cancer (CDC, 2016), fifth-highest rate of gonorrhea (Florida Department of Health, 2012), and the second-highest rate of HIV diagnosis (CDC, 2016). And all of these diseases have significantly different rates between different races/ethnicities. A prominent example in Florida is HIV/AIDS, of which the state has one of the highest rates in the country (CDC, 2016), yet it is dramatically unequal between white, Hispanic/Latino, and black populations (see Figure 1). Other sexually transmitted infections (STIs) have a similar pattern. The rate of STI infection (chlamydia, gonorrhea, syphilis) among white Floridians is 176 per 100,000 people, whereas for black Floridians it is over six times higher, at 1,159 per 100,000. A related issue is teen pregnancy. Rates are far higher among black teens than white teens, and they are also elevated for Hispanic teenagers (DHHS, 2014).

Reproductive health is particularly important in the context of emerging public health challenges such as Zika virus. Although reproductive health is anathema to certain parts of Florida's political leadership, it is poised to become a pressing issue. There is now robust evidence of sexual transmission, with significant impacts on pregnant mothers and as-yet undetermined impacts on others. Furthermore, transmission rates and impacts in immunocompromised individuals, such as those with HIV/AIDS, are unknown. Addressing the systemic issues that contribute to health disparities will prevent zika from becoming another disease with broadly unequal distribution and impacts between different Floridians.

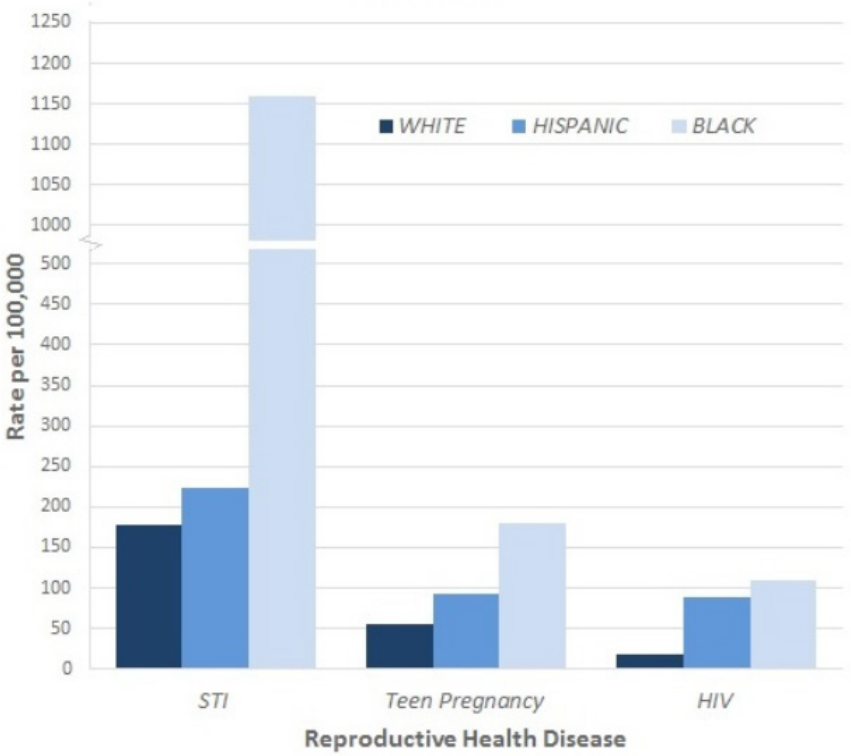


Figure 2. Reproductive Health Disease Rates in Florida by Race/Ethnicity. STI includes gonorrhea, chlamydia, and syphilis. Adapted from data from Foster (n.d.); FloridaHealth (2012); and US Office of

Linking Health Disparities and Uninsurance

The most obvious way for the State government to address health disparities is through the provision of adequate health insurance. Having health insurance enhances access to screenings, preventative care, and treatment that may reduce the occurrence and severity of numerous conditions. Current insurance coverage, and hence access to care, is unequal. This may not eliminate disparities, but it is a crucial step towards health equity. A 2015 Kaiser Family Foundation analysis found that close to 4 million Floridians (20 percent) are uninsured, and 567,000 are in the "coverage gap" between Medicaid and federal healthcare subsidies. The majority of the uninsured are people of color (Kaiser, 2015). Undocumented residents also contribute to the data on health disparities and to the number of people without insurance, but are not eligible for Medicaid (Chardy, 2015).

Studies attempting to link health insurance and improved health outcomes have had mixed results. A high-profile study of Oregon's expansion of Medicaid, providing healthcare to 30,000 previously uninsured people through a lottery, suggested that access to insurance coverage increased the use of preventive services, and nearly eliminated catastrophic out-of-pocket medical expenditures (Baicker, 2013). Provision of insurance did

not affect the outcomes of certain physical conditions, although this may have been due to the study's relatively short (2 year) duration. Other studies have described how preventative health services could save lives at little or no cost by calculating the total life-years that could have been saved with preventative methods (Maciosek, 2010).

However, other studies on reproductive health have drawn a stronger positive link. Geisler et al. (2006) found that insurance coverage was associated with a lower rate of chlamydia amongst sexually active teenagers. A Journal of Health Economics article found that for HIV, insurance protects against premature death, although these results were tempered by restrictive Medicaid prescription drug policies that limited access to the best treatment (Bhattacharya et al., 2003). The federal Ryan White program currently provides care for patients who are low income, HIV positive, and have little to no insurance. A part of the Ryan White Initiative, the Minority AIDS Initiative, specifically targets people of color who are affected by HIV/AIDS (U.S. Department of Health and Human Services). However, these services are *reactive*. The advent of PrEP, a preventative daily pill which dramatically reduces the rate of transmission HIV, makes insurance coverage all the more important to preventing HIV for those who are at risk - and currently ineligible for Ryan White services.

Nearns (2009) concluded that young women with insurance were more likely than the uninsured to use prescription contraceptives, and thus access to comprehensive health insurance is an appropriate strategy to address the high rates of teen pregnancy. Much like HIV, there are numerous programs which provide prenatal care to low-income women. However, nsurance provides proactive access to contraceptives, which can reduce the baseline pregnancy rate.

Medicaid Expansion: A Solution to Health Disparities

Medicaid Status Quo

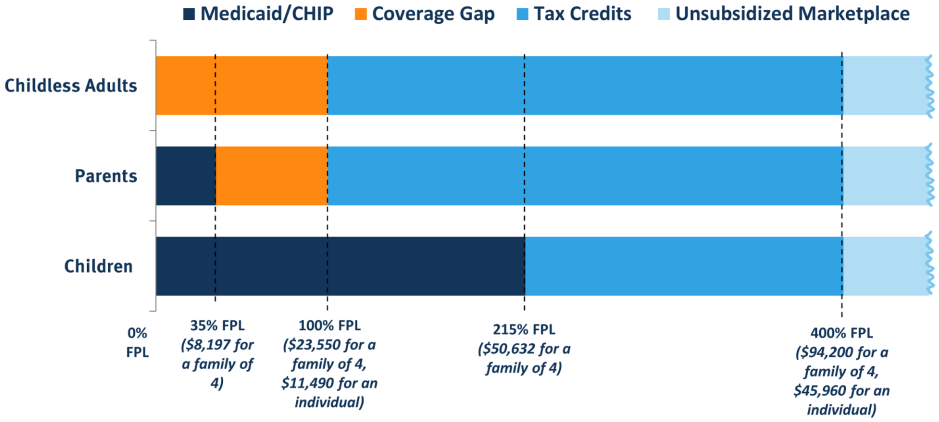
Currently, 75,000 Floridians rely on Medicaid for their health insurance. Eligibility in Florida is determined by the Department of Children and Families or the Social Security Administration, and is based on individual incomes and group classification as identified by the state. Groups include parents, caretakers of children, children, pregnant women, former foster care individuals, non-citizens with medical emergencies, and aged or medically frail individuals not currently receiving Supplemental Security Income. Children aged 0 to 18 are covered up to 210 percent of FPL (Center for Medicaid and CHIP Services, 2016). The group not covered under current Medicaid policies were childless, non-medically frail adults between the ages of 19 to 64 below who were not eligible for Medicaid before the passage of the Affordable Care Act (ACA) but could not afford private insurance. In Florida, 567,000 people are in the coverage gap. Medicaid expansion in Florida would cover up to 306,000 of those in the gap. If Medicaid expansion went up to 138% of the FPL, a single mother with two kids making below about $28,000 would be eligible. The FPL for this household of 3 is $20,160. In order for this mom to qualify under the current program her income would have to stop at under just $6,000 dollars a year.

Medicaid Expansion

Expanding Medicaid coverage to nearly all low-income adults of working age would reduce the numbers of uninsured people in the state. The nonprofit Urban Institute, in a study funded by the Robert Wood Johnson Foundation, argues that adopting Medicaid expansion in 2017 would reduce Florida's uninsured population by about 877,000 people (Chang, 2016). This will, at least, partially address the health disparities.

Figure 1

Income Eligibility Levels for Medicaid/CHIP and Marketplace Tax Credits in Florida as of 2014



Notes: Medicaid eligibility is based on current Medicaid eligibility rules converted to MAGI. Applies only to MAGI populations. Medicaid eligibility levels as a share of poverty vary slightly by family size; levels shown are for a family of four. People who have an affordable offer of coverage through their employer or other source of public coverage (such as Medicare or CHAMPUS) are ineligible for tax credits. Unauthorized immigrants are ineligible for either Medicaid/CHIP or Marketplace coverage.
Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels.

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Figure 3. Current coverage in Florida. Source: Kaiser Family Foundation (2015).

Option I: Standard Expansion

In states that have expanded Medicaid coverage, eligibility is based solely on income. If a household income is below 138% of the federal poverty level (FPL), then that household qualifies for Medicaid. Individual states can opt to adjust the poverty level to their own standard. (U.S. Centers for Medicare & Medicaid Services, 2016).

Benefits

The benefits of expansion are numerous. It will, first and foremost, lift the significant financial burden of uncompensated care from hospitals and other care providers. In 2009, Florida hospitals were responsible for $3 billion in costs for services provided to uninsured and underinsured patients. The reduced amounts of uncompensated care costs could result in a possible savings of $1.3 billion keeping Florida's health care system strong and solvent (FamiliesUSA, 2013). Florida will experience economic growth and job creation due to increasing payments from Medicaid for health goods and services. In 2016, federal dollars from expansion could have supported about 71,300 new jobs across all sectors and an $8.9 billion increase in economic activity (FamiliesUSA, 2013).

To encourage more states to expand, the President has proposed allowing states who have not yet expanded to start the clock for the Federal match rate the year the state expands. This would mean that the Federal government will pay all the costs for Medicaid expansion for the first three years and then 90% thereafter (FamiliesUSA, 2013). In this case, the state's costs for the first three years would be approximately zero.

Drawbacks

The expansion will lead to additional administrative costs, the cost of covering a newly eligible population, and the cost of covering those that are eligible but not enrolled. Florida has a budget of about $74 billion (65 percent state funds and 34 percent federal funds). According to the Georgetown University Health Policy Institute, state spending on Medicaid in Florida accounts for one-fifth (20 percent, or $9.5 billion) of all state expenditures ($48 billion). It should be noted that Florida allocates 23% and 13% of its budget to elementary/secondary education programs and higher education, respectively. In 2014, a total $23 billion was spent on Medicaid, however, only 41 percent ($9.5 billion) comes from state expenditures. The federal government covers the other 59%, or $13.5 billion.

Ohio Comparison

Ohio's health care system, like that of other states, shows initial benefits from Medicaid expansion. Cleveland's MetroHealth System, an early pilot that provided coverage to poor adults, caused emergency room visits to drop and doctor's visits to rise. Other Ohio health systems are beginning to see positive outcomes from the statewide Medicaid expansion. The system seems to be working and producing needed results (Policy Matters Ohio). Ohio's expansion of Medicaid has offered reassurance for those who are working, yet who would have fallen in the coverage gap. More than 300,000 workers now have access to healthcare and a peace of mind that if a sudden illness or accident was to strike, they are now covered (FamiliesUSA, 2013). Furthermore, the expansion of Medicaid also created insurance for workplaces that cannot afford to offer their low-income employees insurance. Ohio now has a $2 billion surplus and an unemployment rate of 5 percent. Among the state's residents, Kasich boasts an approval rating of over 60 percent, despite his embrace of Medicaid expansion (Zak, 2016). In sum, Medicaid expansion can be considered a success in Ohio.

Option II: Alternative Expansion

Option IIA: Michigan

Recipient cost contributions put an emphasis on individual responsibility.

This approach, based on Michigan's state-specific waiver for a unique Medicaid expansion plan under the ACA, has two key components. The first is the **health savings account**, which all Medicaid beneficiaries contribute to monthly via:

- **Co-payment contributions:** all beneficiaries make payments based on their average co-payments for services used in the previous six months, up to 5% of total income.
- **Premium contributions:** beneficiaries from 100-138% FPL to make income-based premium payments, up to 2% of income.

Payments can be reduced by doing specified healthy behaviors. Failure to pay copayments or premiums does not result in a loss of Medicaid eligibility.

The second component is **Medicaid premium assistance** for beneficiaries between 100% and 138% FPL, which can be applied to Marketplace Qualified Health Plan (QHP) coverage, including private plans and some non-Medicare or Medicaid government plans.

Benefits of Michigan-style expansion are much the same as non-waiver expansion. Economically, impacts have been indistinguishable from other states, and Michigan was estimated to generate money, through savings and revenue, totalling over $270 million in FY 2015. Since savings will vanish once a new baseline is established, Governor Snyder proposed placing these savings in a "lock box" for future use, although this has not happened. Additional benefits to Michigan's method include an ability to customize expansion to the political and cultural climate of Florida by requiring individual contributions, which can also contribute additional revenue to the program. Furthermore, since this model of expansion has already been approved, it has a high likelihood of being approved for Florida. Finally, since participants have to contribute to their health insurance, it may reduce stigma associated with government assistance.

The plan also has drawbacks. Those on Medicaid are by definition low-income, so copays may be a financial challenge. Furthermore, as the Federal government reduces its contribution and costs rise, Florida's costs may exceed savings by around 2020 (Kaiser, 2015).

Option IIB: Tennessee

A plan to encourage healthy behavior and proper use of healthcare services

Another approach to Medicaid expansion is a healthy incentives plan similar to the one Tennessee Governor Bill Haslam (R) proposed, according to a 2015 Kaiser Family Foundation report. The Healthy Incentives for Tennesseans (HIT) Account is an option for adults eligible for Medicaid under the new expansion. The HIT Account allows member to ascertain a certain amount of credit by undertaking healthy behaviors and proper use of healthcare services. Examples include: completing an annual health risk assessment, participating in a disease management program, or refraining from using the emergency room for non-emergency services.

Use of health services in these ways reduces costs of healthcare and ensures a healthier population. The HIT Account system will better ensure that members get treatment before their diseases progress. In this way, the state will save money by providing treatment before illnesses become terminal, which is when costs are greatest. The program will also improve the health of the population by encouraging healthy behavior.

This is a more politically palatable way to expand Medicaid, as it had the support of a sizeable portion of Republicans in the Tennessee state legislature, including the Senate Majority Leader Mark Norris (R). Tennessee U.S. Senators, Lamar Alexander (R) and Bob Corker (R) also supported the plan. Because Florida's state legislature is also majority Republican, this alternative plan to expand Medicaid would be more politically feasible.

Responses to Criticism of Medicaid

One criticism of Medicaid expansion is that it does not solve the problem of inadequate access to necessary services. Doctors and health care providers receive low payment rates for Medicaid patients and also have burdensome administrative requirements (Rosenbaum, 2011). However, reforms to address access to services can take place along with Medicaid expansion. As Florida introduces a plan for Medicaid expansion, state legislators have the opportunity to implement the program to address these access needs and restructure the Medicaid program to improve the system.

Another concern regarding expansion is whether or not states will have the capacity to take care of the new enrollees if the state chooses to expand soon. We anticipate a gradual increase in the number of healthcare service providers and hospitals for new medicaid recipients in the future. Currently, Florida's hospitals already serve many people in this population as uninsured, uncompensated people. With expansion, these people become insured and reduce uncompensated cost to hospitals.

Conclusion

Conclusion

Medicaid expansion uplifts the health and economy of Florida's population. It is the state legislature and its commitment to striking down expansion that hinders Florida's growth. Issues of reproductive health, coronary heart disease, and diabetes are among the disparities that fuel the gap between white and nonwhite population health-- the most prominent being HIV/AIDS. With 576,000 uninsured individuals in question, Florida's current health model disproportionately affects people of color ages 21-64, who are mostly single, childless adults-- potential employees who could contribute to a robust economy. Expansion is Florida's solution to reduce the disparity by providing manageable health coverage to individuals with incomes up to 138% of the FPL. Of the options described from Ohio, Michigan, and Tennessee, the optimal option for Florida is to expand following Michigan's model of Medicaid.

Although Ohio's form of expansion has seen economic benefit from traditional Medicaid expansion, as a swing state the model does not prove politically feasible for Florida. Tennessee has yet to expand, leaving little results to analyze. The Michigan model decreases the amount of uninsured, childless individuals ages 19-64. Requiring enrollees to play into the system up to 5% of their respective incomes calms the political fight back that uses the cost of Medicaid as its primary reason for refusing to consider legislation. Florida needs a solution that mitigates the political pushback, addresses the health disparities, and relieves hospitals unbearable costs. That solution comes in Michigan's expansion model.

Recommendations for Next Steps

Successful expansion depends on a united community interest. We recommend that Southern Health Partners place resources into building a coalition within the state, bringing together chambers of commerce, hospitals and local businesses who have a financial interest, and the public, who has social and personal interest. We suggest that the most effective way to extend coverage is through Medicaid expansion following an alternative model from Michigan. This option would increase healthcare access to Florida's low-income, childless adults, while requiring beneficiary contributions that mitigate costs and align with Florida's political landscape. Expanding Medicaid in Florida enhances the health of the state's population and will have numerous social and economic benefits. In Michigan's model, single, childless and non-medically frail adults ages 19-64 who are eligible for Medicaid would pay on sliding scale up to 5% of their annual income toward co-payments and premium contributions. This approach strengthens the pro-expansion coalition by helping state legislators develop a plan suitable for the state's budget and political climate.

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Expanding Access, Narrowing Gaps

Health Disparities, Rural Black Populations, and Medicaid Expansion in Georgia

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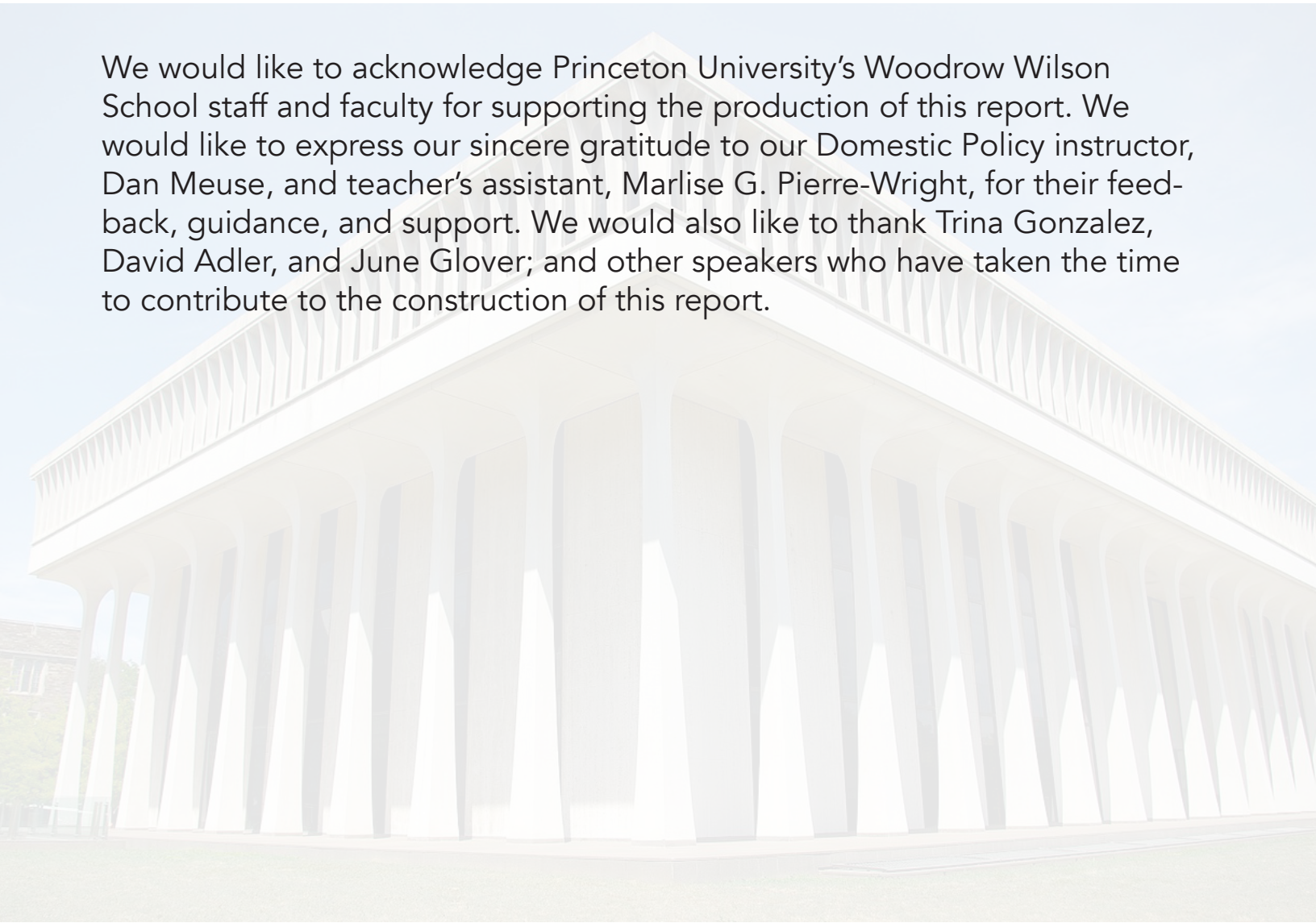

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Executive Summary

There is growing concern for the overall health status of the people of Georgia as the state has yet to expand Medicaid. The vast collection of data about the health status of Georgians shows that the state consistently performs poorly when compared to all 50 states in terms of improving health outcomes, addressing health disparities, and increasing access to healthcare. In this report, we argue how and why expanding Medicaid in Georgia could improve the state's performance in all of the aforementioned areas.

Our conclusion is that Medicaid should be expanded in Georgia as soon as possible in order to address the widening health disparities experienced by rural black Georgians throughout the state. It is important to note that while we specifically focused on the rural black Georgian population, Medicaid expansion would provide benefits for many and various groups not mentioned in this report. While we acknowledge the limitations of and arguments against expanding Medicaid, the consequences of not doing so far outweigh the challenges associated with expansion. We contend that it is in the best interest of Georgians, and therefore in the best interest of Georgia, to expand Medicaid.

Background

Georgia has the second-highest rate of uninsured people in the country.[1] More than one in five Georgians went without insurance in 2012, and more recent estimates indicate that the rate of uninsured citizens in Georgia has only grown in relation to other states since then.[2] Many of these uninsured citizens are working Georgians: they hold regular jobs, but they have no way of obtaining affordable health insurance.[3] They fall into Georgia's "coverage gap," which means that they earn too much money to qualify for our current Medicaid system, but also do not earn enough to qualify for subsidies on the private insurance exchange.[4] Currently, there are 600,000 such uninsured Georgians living at or below 138% of the Federal Poverty Level (FPL) for their household size.[5] Medicaid expansion—as outlined in the Affordable Care Act of 2010 (ACA)[6] and as implemented by 32 other states[7]—would extend healthcare coverage to these Georgians at very low (or no) effective cost to the state.[8]

So far, Medicaid has not been expanded in Georgia, and these 600,000 Georgians continue to live without health insurance. Governor Deal and Republican majorities in the statehouse have primarily tried to justify rejecting expansion on the basis of cost: they have argued that the expansion would drain the state budget even though the federal government has committed to finance 100% of expansion costs for the first three years and 90% thereafter.[9] These arguments have overlooked the budgetary evidence from states that have already expanded, which indicates that Georgia would likely save money by expanding Medicaid.[10] They have also overlooked the financial impact that refusing to expand has had, is having, and will have on the state. If Georgia continues its opposition to Medicaid expansion, it will be on track to miss out on $40.5 billion federal dollars

1 Timothy Sweeney, "Georgia Falls to Second Worst Uninsured Rate in U.S.," Georgia Budget and Policy Institute, March 03, 2015. http://gbpi.org/georgia-falls-to-second-worst-uninsured-rate-in-u-s/.

2 Henry J. Kaiser Family Foundation, "The Georgia Health Care Landscape," Rep. Menlo Park: Henry J. Kaiser Family Foundation, 2014, http://kff.org/health-reform/fact-sheet/the-georgia-health-care-landscape/

3 Ibid.

4 Rachel Garfield, Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid – An Update." The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid – An Update. January 21, 2016. http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/

5 Greg Bluestein, Misty Williams, "Medicaid Expansion Could Be In Play In Georgia After Election Day." Kaiser Health News. October 29, 2014. http://khn.org/news/medicaid-expansion-could-be-in-play-in-georgia-after-election-day/.

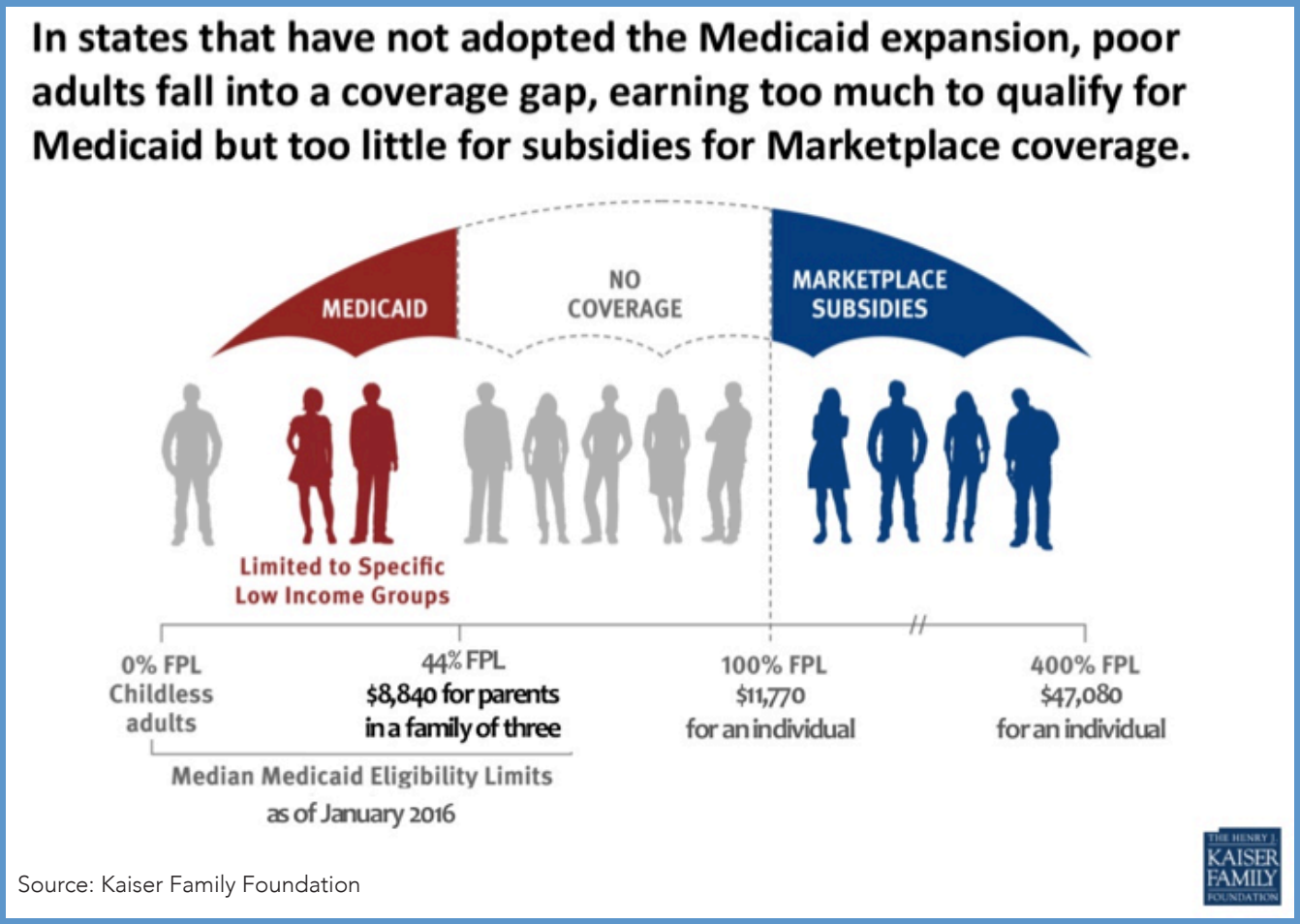
6 "Affordable Care Act," Medicaid Home, Accessed July 26, 2016. https://www.medicaid.gov/AffordableCareAct/Affordable-Care-Act.html.

7 "A 50-State Look at Medicaid Expansion," Families USA. March 2016. http://familiesusa.org/product/50-state-look-medicaid-expansion.

8 "States Expanding Medicaid See Significant Budget and Savings and Revenue Gains,"Robert Wood Johnson Foundation, March 2016. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097.

9 Daniel Malloy, "Deal Rejects Expansion of Medicaid." AJC.com: Atlanta Georgia News, AJC Sports, Atlanta Weather, August 28, 2012. http://www.ajc.com/news/news/state-regional-govt-politics/deal-rejects-expansion-of-medicaid/nRMfK/.

10 "States Expanding Medicaid See Significant Budget Savings," Robert Wood.



for the state, 70,000 potential jobs, and $277 million in additional state tax revenue between 2014 and 2023.[11]

As a result of Georgia refusing to expand Medicaid, Georgians have very limited access to Medicaid dollars, which places many at a healthcare coverage disadvantage when compared to Americans living in expansion states. In expansion states that followed the bare-minimum framework established by the ACA, Medicaid eligibility has been extended to cover individuals, including poor adults, with an income at or below 138% of the FPL for their household size.[12] In Georgia, Medicaid eligibility is limited to families living at or below 40% of the FPL for their household size, and it is not extended to childless adults in any state of poverty.[13]

At the same time that Georgia confronts these coverage shortages and considers the economic implications of expansion, the state must also be attentive to the alarming health disparities that exist within the state. Though the majority of Georgia's residents are white, the majority of Georgia's uninsured citizens—a full 60% of them—are people of color.[14] Georgia's black residents are a population of particular concern: they experience poverty at more than twice the rate of white Georgians (33% vs. 15%) and they comprise 48% of all poor, uninsured adults in

11 Kaiser, "Georgia Health Care Landscape"
12 "Affordable Care Act." Medicaid Home.
13 Kaiser, "Georgia Health Care Landscape."
14 Ibid.

the state.[15] Georgia's black residents living on low incomes in rural spaces face even greater challenges and risks across a range of health outcome and access issues. They are among the 140,000 rural Georgians without health coverage, and in addition to the systemic disparities that they face as black Georgians, they must additionally confront the systemic (and often intersectional) disparities experienced by rural Georgians. These compounded health disparities—those experienced by Georgians who are both rural and black—are exacerbated by the fact that they unfold in parts of the state where there are dramatic shortages of medical professionals[16] and where many of the few remaining hospitals are slated to close if Medicaid is not expanded soon.[17]

There have been organized efforts to expand Medicaid in Georgia, the most prominent of which has been spearheaded by House Minority Leader Stacey Abrams (D-89). In the last session, she filed HB 823: the "Expand Medicaid Now Act."[18] The bill did not pass, but it did illustrate the growing intensity of Democratic calls for expansion and the waning of some Republican legislators' resistance.[19] As longtime state senator Fran Millar (R-40) commented: "I believe we will expand Medicaid," before adding "I don't know when."[20]

The time is now. The intense health disparities in Georgia—particularly for rural black Georgians—demand a carefully considered policy response that expands access to care and reduces (or at least minimizes) health inequities. Medicaid expansion is a highly effective strategy for achieving this policy goal, as it would reduce these disparities and protect the health interests of some of Georgia's most vulnerable residents. To that end, this report focuses on diabetes as a health issue that disproportionately burdens both rural and black populations in Georgia. Diabetes can be used as a case study that is representative of the many health disparities faced by rural, black, and rural black Georgians; it can also be used as a lens for understanding the potential impact of Medicaid expansion on these disparities.

Defining Health Disparities for Georgia

Before moving into a more specific discussion of *health disparities* in Georgia, it is important to first understand what we mean when we reference this term within the context of this report. According to the Georgia Department of Community Health, *health disparities* are the "differences in health status among distinct segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities."[21] In other words, *health disparities* can be viewed as inequalities in the distribution, intensity, and longevity of certain health conditions among different subsets of the population as defined by various identifying or descriptive factors. In

15 Ibid.

16 "Health Disparities Report 2008: A County-Level," Georgia Health Equity Initiative, 2008. http://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/site_page/Georgia Health Equity Initiative.pdf.

17 Timothy Sweeney, "Rural Georgians Stand to Benefit Most from Medicaid Expansion." Georgia Budget and Policy Institute, October 2013. https://gbpi.org/wp-content/uploads/2013/11/Rural-Georgians-Stand-to-Benefit-Most-from-Medicaid-Expansion.pdf.

18 Aaron Sheinin. "Democratic Leader Says Medicaid Expansion's Time Has Come," Atlanta Journal Constitution, January 27, 2016. http://www.ajc.com/news/news/state-regional-govt-politics/democratic-leader-says-medicaid-expansions-time-ha/nqDMF/.

19 "Georgia Legislative Navigator," MyAJC Legislative Navigator, January 26, 2016. http://legislativenavigator.myajc.com/#bills/HB/823.

20 Ibid.

21 Ann Travis Honeycutt, Jaime Altamirano, Pamela Craft, et al., Georgia Health Equity Initiative. Rep. Georgia Department of Community Health, 2008. Web.

this report, we use the term *health disparities* to refer to the health inequalities encountered by black Georgians, people living in rural Georgian communities, and black Georgians living in rural communities.

Factors that Influence the Health of a Population

A person's *health status* is affected by various external and internal factors. The Georgia Department of Community Health outlines the following conditions as a few factors that can be used to help determine a person's health status:

- Level of educational attainment
- Type of employment
- Socioeconomic status
- Living location (rural vs. urban)
- Diet
- Physical activity
- Drug and alcohol consumption[22]

It is important to note that living conditions (such as the factors listed above) are among the primary drivers of a person's holistic health status. Inequalities in these circumstances between different populations can lead to *health disparities* among those respective populations.[23] Additionally, it is pivotal to emphasize that a disproportionate lack of access to health care can lead to the prevalence of health disparities between different populations.[24] For example, a person living in poverty is more likely to develop chronic illnesses (like asthma, diabetes, high blood pressure, or even depression) than someone who is better-off economically.[25] Similarly, someone living far away from their local health care provider may have poorer health outcomes than someone living in relatively close proximity to a hospital or medical clinic.[26] There are many factors that can increase an individual's susceptibility to different health-related issues relative to their neighbors, and these factors often intersect and overlap to create intense, entrenched disparities.

Georgia's Substandard Health: An Overview

Georgia has some of the most significant health disparities and poorest health outcomes in the nation. According to the Kaiser Family Foundation, Georgia's population health ranks below the national average.[27] In fact, a 2015 United Health Care Foundation report found that Georgia ranked 40th out of the 50 states for population health.[28] Georgia's poor health status—and the grim health outlook for its poor residents—is made worse by the state's poverty rates and racial disparities. As an illustrative case, black Georgians are significantly more likely to be diagnosed with diabetes than their white counterparts.[29] This health disparity is intricately

22 Ibid.

23 "Health Disparities Report," Georgia Health Equity.

24 Marsha Blanton, "The Role Of Health Insurance Coverage In Reducing Racial/Ethnic Disparities In Health Care," Health Affairs, July 2016. http://content.healthaffairs.org/content/24/2/398.full.

25 Alyssa, Brown "With Poverty Comes Depression, More Than Other Illnesses," Gallup.com, last modified October 30, 2012. http://www.gallup.com/poll/158417/poverty-comes-depression-illness.aspx?utm_source=alert&utm_medium=email&utm_campaign=syndication&utm_content=morelink&utm_term=All%20Gallup%20Headlines

26 "Health Care Disparities in Rural Areas," Agency for Healthcare Research and Quality, last modified May, 2005, http://archive.ahrq.gov/research/ruraldisp/ruraldispar.htm.http://archive.ahrq.gov/research/ruraldisp/ruraldispar.htm

27 Kaiser, "Health Care Landscape."

28 Anna Schenck, Dennis P Andrulis, Jamie Bartram, Bridget Booske Catlin, et al, "The America's Health Rankings® Annual Report," American Public Health Association, last modified May, 2015, http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/2015AHR_Annual-v1.pdf

29 Kaiser, "Health Care Landscape."

related to the fact that black Georgians are more than twice as likely to live in poverty than white Georgians,[30] as it has been shown that poverty increases a person's risk factor for developing type 2 diabetes.[31] Georgia not only has a relatively high rate of diabetes—it also has significantly higher mortality rates for diabetes than other states.[32] These disparities (both in terms of distribution and intensity) contribute to Georgia's low rankings for population health, and they represent a significant threat to Georgia's black communities—particularly when black Georgians make up a substantial portion of Georgia's uninsured population (35%) and consequently have little to no access to care for diabetes.[33] As Georgia's statewide health rankings continue to plummet below national levels, the severity of health disparities encountered by low-income, black populations will continue to increase throughout the state.

Focusing in on Health Disparities: Black Georgians and Diabetes

In a given year, twice as many black Georgians will die from diabetes than white Georgians.[34] Diabetes—like many other chronic diseases—disproportionately affects communities of people who cannot afford or easily access medical care.[35] Not having access to care can complicate a person's health outcomes and diminish their life expectancy. According to the American Diabetes Association, the condition of a person who does not have medical coverage and care (and whose diabetes is not properly controlled as a result) is likely to worsen and to elevate their level of risk for heart attacks, strokes, and micro- and macrovascular diseases that complicate their health.[36] In other words, when a chronic disease like diabetes is not supervised by a doctor, then that disease can lead to health outcomes that may be terminal. For black Georgians—more likely to be poor, more likely to be uninsured, and more likely to have chronic conditions like diabetes—not having access to a medical doctor who can monitor their diabetes means that they run a higher risk of dying from this disease. This higher risk means that diabetes is more likely to be terminal for black Georgians than it is for white Georgians. This is particularly true for black women, who are twice as likely to die from diabetes as white women.[37] Not having access to medical care and having a higher probability of developing chronic diseases like diabetes are problems that significantly affect black Georgians.

Compounded Risks: Rurality and Black Georgians

For some black Georgians, health disparities take on an additional burdensome dimension: rurality. There are enormous health disparities between rural Georgians and urban Georgians across all races.[38] Furthermore, existing disparities between races are exacerbated in rural spaces.[39] To put things into perspective,

30 Ibid.

31 Yongwen Jiang, and Deborah N. Pearlman, " The Link Between Poverty and Type 2 Diabetes in Rhode Island," Rhode Island Medical Journal, last modified November, 2013, http://www.rimed.org/rimedicaljournal/2013/11/2013-11-42-health-diabetes.pdf

32 Kaiser, "Health Care Landscape."

33 Ibid.

34 "State of Georgia Rural Health Plan," Georgia Department of Community Health, last modified September, 2007, http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/21/19/970432432007_Rural_Health_Plan.pdf.

35 Ibid.

36 Xuanping Zhang, Kai McKeever Bullard, Edward W. Gregg, Gloria L. Beckles, et al, "Access to Health Care and Control of ABCs of Diabetes,"Diabetes Care 35, last modified July, 2012, http://care.diabetesjournals.org/content/diacare/35/7/1566.full.pdf

37 Honeycutt, et al., Georgia Health Equity Initiative.

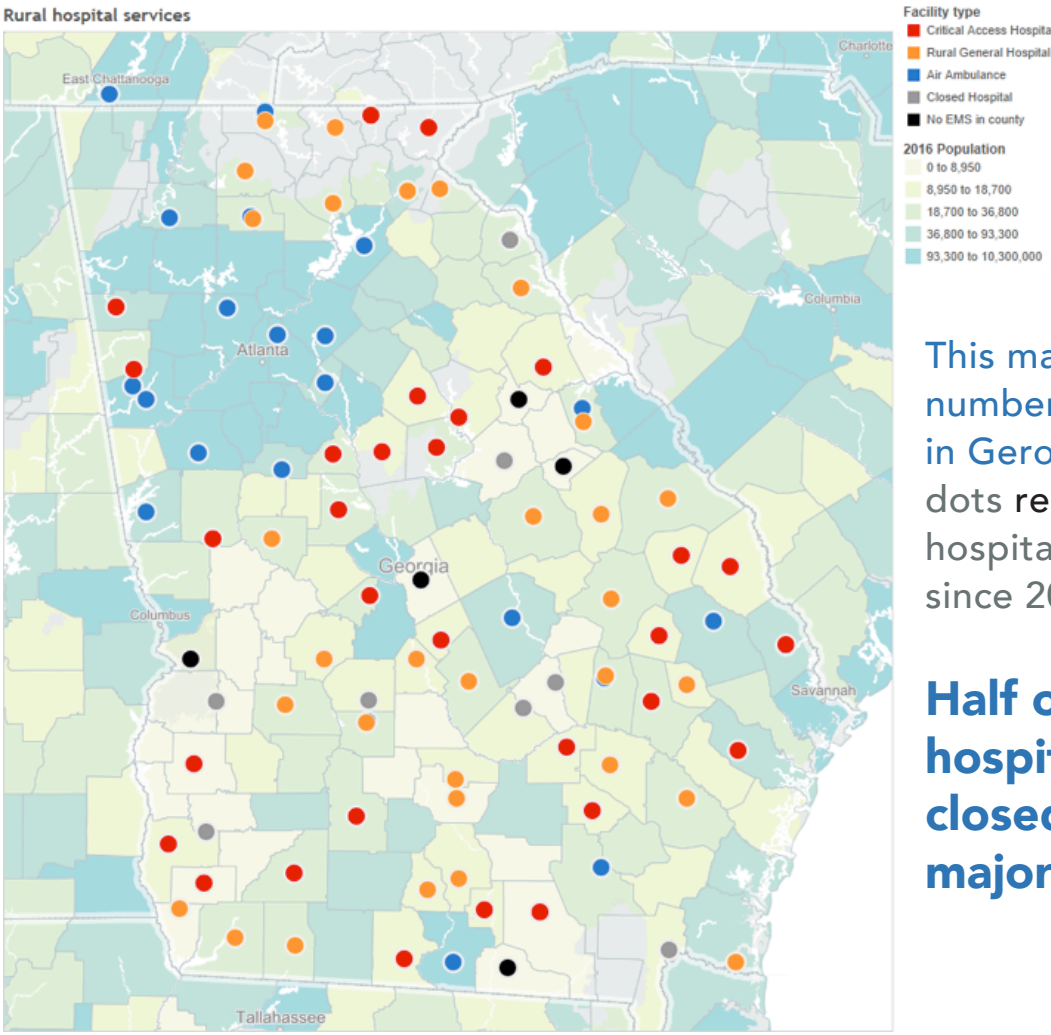
38 Ibid.

39 Ibid.

there are 159 counties in the state of Georgia.[40] 118 of them (74%) are considered to be rural.[41] Many of the people living in rural Georgia live in extreme poverty conditions. In fact, according to the Georgia Department of Community Health, 58% of the state's 118 rural counties are considered to be impoverished.[42] The health disparities in rural Georgian communities are linked to this poverty,[43] and they are linked to the fact that hundreds of rural Georgians will die from diabetes in a given year.[44] With these percentages in mind, and knowing that black Georgians are already at an elevated risk for diabetes and a host of other ailments, it is important to emphasize that rural black Georgians experience intensely compounded risks for these health disparities. Stated differently, black persons living in rural counties without health coverage run higher risks of developing chronic and terminal diseases than both white and black Georgians living in urban areas.

40 Ibid.
41 Ibid.
42 Ibid.
43 Ibid.
44 Ibid.

Remaining Rural Hospitals in Georgia: 61



This map shows the total number of rural hospitals in Gerogia. The eight grey dots represent the rural hospitals that have closed since 2001.

Half of all rural hospitals that have closed have been in majority black counties.

Source: http://www.myajc.com/georgia-rural-hospitals/ © OpenStreetMap contributors

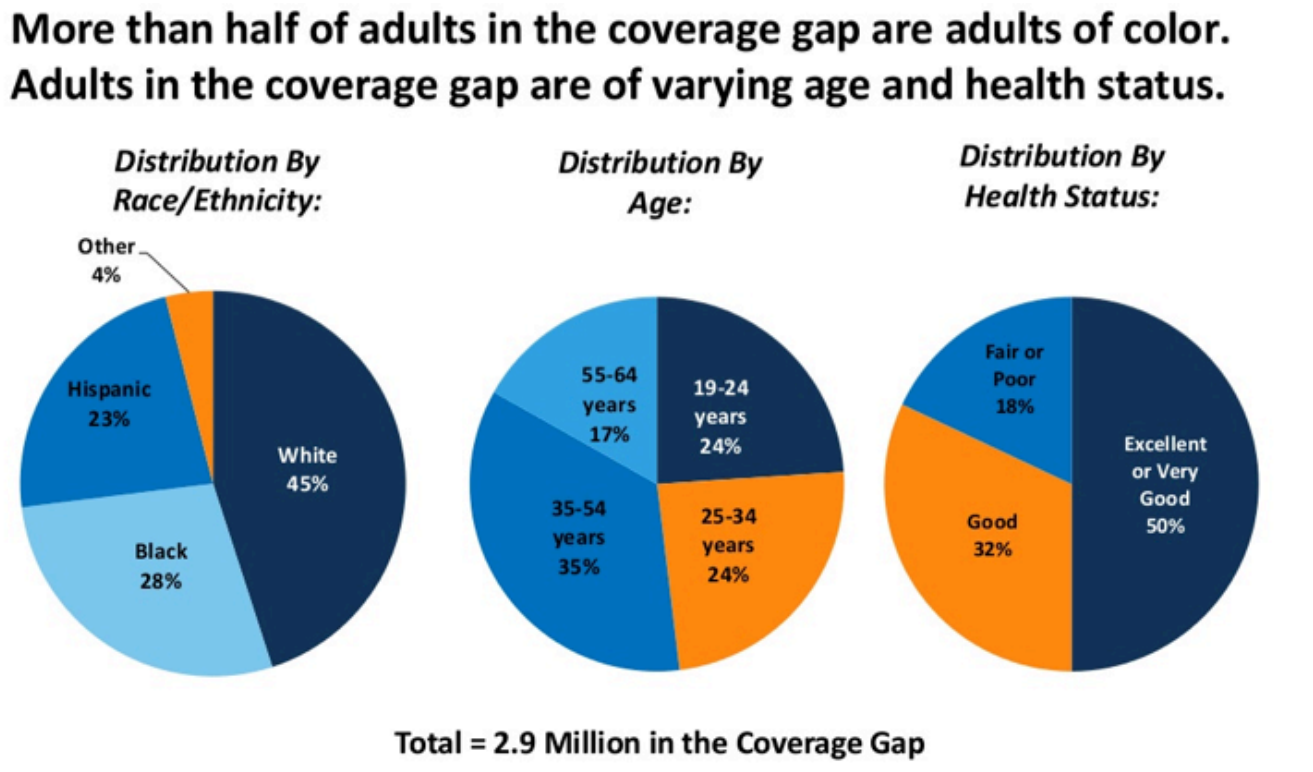
Why Decreasing Health Disparities in Georgia is Crucial:

There have been many hospital closures in rural areas over the past several years, which has added a great deal of strain to already-distressed populations of rural Georgians with limited access to healthcare providers. The ever-expanding geographic barriers to care adversely affect the health of these Georgians and subsequently aggravate the disparities that they experience. According to the Atlanta Journal Constitution, eight hospitals have been forced to close their doors due to a lack of funding since 2001:

- 2001, Hancock County: Hancock Memorial Hospital
- 2001, Dooly County: Dooly Medical Center
- 2008, Telfair County: Telfair Regional Hospital
- 2012, Hart County: Hart County Hospital
- 2013, Calhoun County: Calhoun Memorial Hospital
- 2013, Charlton County: Charlton Memorial Hospital
- 2013, Stewart County: Stewart Webster Hospital
- 2014, Lower Oconee County: Lower Oconee Community Hospital[45]

These closures have expanded the disparities experienced by rural black Georgians, especially those who do not have health coverage. These closures mean that people living in these rural counties do not have hospitals close enough to access emergency services, they do not have a local medical provider to monitor their

45 Misty Williams, "The Emergency at Georgia's Rural Hospitals," The Atlanta Journal-Constitution, January 3,2015, http://www.myajc.com/news/news/state-regional/the-emergency-at-georgias-rural-hospitals/njfTh/



Note: Totals may not sum to 100% due to rounding.
Source: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels updated to reflect state Medicaid expansion decisions as of January 2016 and 2015 Current Population Survey data.

health conditions, and even worse, they do not have anyone to provide them with effective preventative care to avoid developing health complications. It is a problem that requires immediate attention.

To Address this Healthcare Crisis: Expand Medicaid in Georgia

Georgia should expand Medicaid immediately under the standard framework and conditions outlined in the Affordable Care Act.

This expansion would entail remodeling the existing eligibility requirements for Medicaid enrollment in the state. Current policy in Georgia holds that eligibility is limited to those who live on exceptionally low incomes: the eligibility ceiling is an annual income equal to 40% of the Federal Poverty Level (FPL), which is equivalent to less than $8,000 per year for a single parent of two children.[46] Under a standard Medicaid expansion, Georgia's Medicaid eligibility requirements would evolve to cover any citizen whose income is equal to or less than 138% of the FPL for their household size.[47] This model would extend eligibility to an estimated 600,000 Georgians who are currently living without health insurance on low incomes.[48]

Increasing Access for Rural Black Georgians

The ability to afford healthcare is essential to quality health outcomes, and insurance is essential to ensuring that medical services remain consistently and sustainably affordable.[49] Reducing the population of uninsured people is what Medicaid expansion does first, foremost, and best. In states that have expanded, the number of uninsured residents has fallen rapidly after expansion: Kentucky's rate of uninsured residents dropped from 20.6% in 2013 to 9.9% in 2014, and Arkansas' rate fell from 24.1% in 2013 to 12.2% in 2014.[50] California saw similarly sharp reductions in its number of uninsured residents, experiencing a 7% reduction in the number of uninsured residents living at or below 138% of the FPL in the year following expansion.[51]

In Georgia, expanding Medicaid would similarly transform the lives of 600,000 uninsured residents profoundly impacting the lives of rural black Georgians. Black Georgians make up a disproportionately large 35% of the uninsured population in the state.[52] As previously discussed, this racial disparity in coverage is exacerbated for rural black residents whose counties in southern and central Georgia contain the highest proportions of uninsured residents anywhere in the state.[3] Without insurance, many rural black Georgians are currently going without access to care.

This is concerning for the health of those residents, as we know that a lack of insurance often translates into a lack of access and an inability to address the health disparities previously described in this report. To place the scope of this issue in context, it is estimated that 27% of uninsured Americans in 2014 went

46 Kaiser, "Healthcare Landscape."

47 *Medicaid: A Primer. Rep. Menlo Park: Henry J. Kaiser Family Foundation, 2013. Web.*

48 Kaiser, "Health Care Landscape."

49 Honeycutt, et al., Georgia Health Equity Initiative.

50 United Health Group. "Successful Medicaid Enrollment Strategies." United Health Group, 2015.http://www.unitedhealthgroup.com/~/media/UHG/PDF/2015/UNH-Brief-Medicaid-Enrollment-Uninsured.ashx?la=en

51 Ezra Golberstein, Gilbert Gonzales, and Benjamin D. Sommers, "California's Early ACA Expansion Increased Coverage And Reduced Out-Of-Pocket Spending For The State's Low-Income Population," Health Affairs 34, no. 10 (2015): 1688-694.

52 Kaiser, "Health Care Landscape."

without necessary health care because they did not have insurance to cover their medical expenses.[53] Relatedly, 73% of uninsured adults went without any preventative care in 2014,[54] and there is compelling evidence that uninsured adults who develop chronic conditions (including diabetes) receive significantly less care than their insured counterparts.[55] Recognizing the extraordinary health disparities that are experienced by rural black Georgians, and recognizing how essential coverage is for receiving adequate treatment beyond emergency services, it is deeply concerning that so many rural black Georgians should remain uninsured and unable to afford access to critically needed care. Expanding Medicaid will grant this population of concern access to a full range of medical services that were previously unavailable, which will in turn begin to make a dent in the disparities that they experience.

Keeping Rural Health Providers in Business

As essential as insurance coverage is for quality health outcomes, it can only be useful and effective if there is a healthcare provider within a reasonable geographic proximity to the patient. It is on this second front that Medicaid is also urgently needed as hospitals in rural areas across Georgia continue to close due to high levels of uncompensated care. Among the 61 rural healthcare providers in Georgia that have managed to remain open into 2016, at least 40 lost money for either four or five of the years between 2010 and 2015.[56] Half of all rural hospitals that have closed have been in majority black counties.[57] Hancock County, Georgia, for example, recently lost its hospital.[58] Hancock County is a rural county that is 72% black.[59] At least 35% of the population lives in poverty, and more than 17% of the population is uninsured.[60] In Calhoun—another rural county that lost its provider—the population is 62% black, nearly 40% of the residents live in poverty, and nearly one in four residents is uninsured.[61] Uncompensated care continues to create an enormous strain on these providers. The population of Stewart County—yet another rural county that has lost its provider—is 52% black, 40% impoverished, and 20% uninsured.[62] There is a pattern at play here: rural closures driven by uncompensated care disproportionately affect rural black Georgians and diminish their ability to receive care. If nothing changes, providers will continue to close. If providers continue to close, the situation will become even direr for rural black Georgians: "We're approaching third-world care in the state of Georgia," said Jimmy Lewis, the CEO of Hometown Health (a network of rural Georgia hospitals). "The future has pain in it; there's just no way around it."[63]

53 Henry J. Kaiser Family Foundation, "Key Facts about the Uninsured Population," Kaiser Family Foundation, 2015, http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

54 Ibid.

55 Jack Hadley, "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition," Journal of the American Medical Association 297, no. 10 (2007), http://jama.jamanetwork.com/article.aspx?articleid=206024

56 Misty Williams, "The emergency at Georgia's rural hospitals," Atlannta Journal-Constitution, January 3, 2015, http://www.myajc.com/news/news/state-regional/the-emergency-at-georgias-rural-hospitals/njfTh/

57 United States Census, "Welcome to QuickFacts: Hancock County, Georgia," United States Census, n.d., http://www.census.gov/quickfacts/table/PST045215/13141,13,00

58 Adam Ragusea, "When rural hospitals close, towns struggle to stay open," Marketplace, April 10, 2014, http://www.marketplace.org/2014/04/10/health-care/when-rural-hospitals-close-towns-struggle-stay-open

59 Census, "Welcome to QuickFacts: Hancock County." http://www.census.gov/quickfacts/table/PST045215/13141,13,00

60 Ibid.

61 United States Census, "Welcome to QuickFacts: Calhoun County, Georgia," United States Census, n.d., http://www.census.gov/quickfacts/table/PST045215/13037,13093,13259,13141,13,00

62 United States Census, "Welcome to QuickFacts: Stewart, Georgia," United States Census, n.d., http://www.census.gov/quickfacts/table/PST045215/13259,13141,13,00

63 Andy Miller, "Official: Approaching Third World Care in Georgia," Albany Herald, November 20, 2014, http://www.albanyherald.com/news/official-approaching-third-world-care-in-georgia/article_784aaf08-3e57-53bf-b0b9-dedc2ee3d42f.html

Medicaid expansion in other states has already demonstrated that the amount of uncompensated care will decrease sharply after expansion. After Arkansas expanded their Medicaid program, for example, the amount of uncompensated care decreased by $17.2 million.[64] This trend was mirrored in other parts of the country, including in Detroit-area hospitals, which experienced an 85% reduction in uncompensated care costs.[65] Expanding Medicaid in Georgia will not only open up a wider range of services to the 600,000 Georgians (including tens of thousands of rural black Georgians) in question, but it will also alleviate the driving issue behind rural hospital closures. Expanding coverage will ensure that more care is provided to patients and more care is compensated for the rural providers, both of which will be of enormous benefit to the health of rural black Georgians.

Decreasing Disparities for Rural Black Georgians

While we know that increasing coverage rates and keeping rural hospitals open will both be good for the health of rural black Georgians, it is worthwhile to return to the disparities that we have focused on to provide a targeted look at how Medicaid expansion would directly affect the health disparities currently being experienced by rural black Georgians. Beginning with diabetes, it is prudent to note that there are extraordinary and well-documented disparities between the health outcomes experienced by those who have health insurance as compared to those who do not.[66] Looking specifically at the population of diabetic patients who live at or below 138% of the FPL, it has been shown that those with insurance receive care at nearly three times the rate of those who are uninsured.[67] The uninsured were also far less likely to have access to prescriptions related to their diabetes, which contributed to them having less favorable health outcomes.[68] There are measurable, substantial differences in health outcomes between those who have controlled diabetes and those who have uncontrolled diabetes. The determining factor sorting diabetics between these two populations is whether or not they have access to medical services—services that depend both upon insurance to pay for care and geographically proximate facilities from which to receive that care. If patients are not able to receive professional medical advice, treatment, prescriptions, or referrals to reduce their risk factors, then their health outcomes will be demonstrably worse than those who are able to receive the aforementioned. Rural black Georgians, who experience an elevated and compounded risk for diabetes and many other ailments, cannot see reductions in the health disparities that they experience until they are able to see a physician.

Imperfection and Opportunities

As previously identified, the primary line of critique that has been levied against Medicaid expansion in Georgia is budgetary in nature, with Governor Deal stating that it "is something our state cannot afford."[69] Fortunately, there is

64 Georgia Budget and Policy Institute, "Understanding Medicaid in Georgia and the Opportunity to Improve It," Georgia Budget and Policy Institute, 2015, https://gbpi.org/wp-content/uploads/2015/09/Georgia-Medicaid-Chart-Book.pdf

65 Ibid.

66 Derek S. Brown and Timothy D. McBride,"Impact of the Affordable Care Act on Access to Care for US Adults with Diabetes, 2011-2012," Centers for Disease Control and Prevention 12, no. E64, (2015) http://www.cdc.gov/pcd/issues/2015/pdf/14_0431.pdf

67 Ibid.

68 Ibid.

69 Daniel Malloy, "Deal rejects expansion of Medicaid," Atlanda GA News, August 28, 2012 , http://www.ajc.com/news/news/state-regional-govt-politics/deal-rejects-expansion-of-medicaid/nRMfK/

significant evidence to quell these concerns. Governor Deal and other state officials have highlighted often and loudly that Medicaid expansion is expected to cost $4.5 billion over the next 10 years, but as Timothy Sweeney (the director of health policy at the Georgia Budget and Policy Institute) notes, this figure is mostly bandied about for shock value.[70] $4.5 billion spaced out over 10 years comes out to $450 million per year, which is barely 2% of Georgia's annual budget of more than $19 billion.[71] While we can concede that 2% of the state budget is significant, we can also recognize that there are significant dividends that Georgia can expect from this investment. Most relevantly, the experiences of other states have shown that Georgia is likely to save money by expanding Medicaid—a scenario that would completely alleviate the primary concern voiced by opponents of expansion. Under Georgia's current health policy framework, the state spends about a fifth of its budget on healthcare ($4.1 billion out of $20.8 billion).[72] While Governor Deal and others have worried that Medicaid expansion might cause this share of the budget to grow, other states have seen the share of their budgets dedicated to healthcare decrease after expanding Medicaid, including Kentucky, which saved an estimated $14 million in 2015, and Arkansas, which saved an estimated $24.4 million in 2015.[73] These savings were the product of states reducing or eliminating various expenses related to previously uninsured populations, and they were supplemented by increases in revenue from existing taxes on insurers and providers.[74] These savings and additional revenues can be used to effectively offset the state's burden of expanding Medicaid, and they can even be leveraged to increase levels of investment in other areas of state interest.[75] Best of all, Medicaid expansion acts as an economic multiplier for the entire state: expansion would attract more than $30 billion in federal funds to Georgia over the next 10 years, and it would also create an estimated 70,000 new jobs over the same period of time.[76] It would also funnel $8 billion into Georgia's rural communities over the next 10 years, which would be wildly valuable for parts of the state that experience higher levels of poverty and more stagnant local economies.[77]

A second common critique encountered by past proponents of Medicaid expansion in Georgia is that Medicaid pays too little to providers and should therefore not be considered for expansion.[78] While Medicaid payout levels can and should be part of the conversation moving forward, it is important to remember that providers are receiving *no* compensation for many of their services in the present, which means that Medicaid payouts at any level would still be a substantial improvement (especially for rural health providers currently struggling to keep their doors open). Many medical professionals and associations across the state agree, which is why the Doctors Association of Georgia, the Medical Association of Georgia, Georgia's chapter of the American College of Physicians, and the Georgia Hospital Association have all urged for Medicaid expansion in Georgia.[79] The providers—those best suited to know the impact of low Medicaid payout levels—support expansion in full knowledge of this line of criticism, even when (in some cases) it is a critique they share. They understand that though private insurance would pay better, Medicaid payouts are better than the current crisis in completely uncompensated care[80] and also

70 Ibid.

71 Ibid.

72 Georgia Budget and Policy Institute, "Overview of Georgia's 2015 Fiscal Year Budget," Georgia Budget and Policy Institute, 2014, https://gbpi.org/wp-content/uploads/2014/01/Georgia-Budget-and-Policy-Institute-2015-Budget-Overview.pdf

73 Backrach, Deborah, "States Expanding Medicaid See Significant Budget Savings and Revenue Gains," Robert Wood Johnson Foundation, 2016 http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

74 Kaiser, "Georgia Health Care Landscape."

75 Ibid.

76 Misty Williams, "Medicaid expansion critical, hospitals and Mds say," Georgia Budget and Policy Institute, , n.d., http://gbpi.org/medicaid-expansion-critical-hospitals-and-mds-say/

77 Georgia Budget and Policy Institute. "Rural Georgians Stand to Benefit Most."

78 Williams, "Medicaid expansion critical."

79 Kaiser, "Key Facts of the Uninsured."

80 James Rickert, "Do Medicare And Medicaid Payment Rates Really Threaten Physicians with Bankruptcy?," October

Conclusion

There is an urgent health crisis embodied in the systemic and significant disparities experienced by many thousands of rural black Georgians. The state has a compelling interest to reduce those disparities in a responsible manner. Medicaid expansion in Georgia shows every indication of addressing the pressing issue at hand while remaining fiscally responsible. Indeed, there are even likely to be a host of positive externalities that emerge from expanding Medicaid, as has been the case in states that have already expanded. While this report specifically focused on rural black Georgians, it is important to note that expansion of Medicaid would provide benefits for many and various groups in Georgia. Expanding Medicaid for the state aligns with the ACA's goal of universal health coverage and brings every Georgian citizen one step closer to being insured. It is in the interest of Georgians, and therefore in the interest of Georgia, to expand Medicaid as soon as possible, so as to reduce the health disparities enumerated in this paper and experienced every single day in communities across the state.

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