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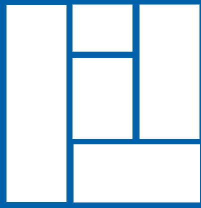

NEW FEDERALISM

HIGHLIGHTS OF STATE POLICIES

Health Policy for Low-Income People in Georgia

Frank Ullman

During the 1990s, state politics in Georgia have been dominated by a fiscally conservative Democratic governor, Zell Miller, and an increasingly Republican state legislature. Health care issues were not a high priority early in the Miller administration, although they gained prominence over time. As in other states, the top health priority is Medicaid, which claims a large share of Georgia's budget and has been a target for cuts. The state has sought to promote managed acute care for its Medicaid population, but with mixed success. Spending growth has been controlled by limiting payments to providers and targeting fraud and abuse. The state is implementing a new health care program, PeachCare, specifically targeted to low-income children ineligible for Medicaid.

The private insurance market in Georgia is changing rapidly. Blue Cross and Blue Shield (BCBS) of Georgia, the state's largest insurer, converted to for-profit status in 1995 and was recently acquired by another insurer. Hospitals in the metro-Atlanta area are financially sound, but those in rural areas are struggling. Concern about rural hospitals has prompted the state to increase Medicaid payment rates to rural hospitals and to ensure that they can obtain managed care contracts.

Health care issues have not enjoyed a high profile, although the magnitude of the state's Medicaid budget ensures that the program consistently attracts policymakers' attention.

State Characteristics

Sociodemographic Profile

Georgia, with over 7 million people, is the tenth-most-populous state in the nation. In recent years, the state's population has been growing at 2 percent per year, about twice the national average, and Atlanta's suburbs have been growing faster than most other areas of the state.[1] The state's population resembles the race and age mix of its neighboring states but differs from the rest of the nation. Approximately one-third of the state's population is black, a much larger share than in the rest of the nation, while Georgia's Hispanic population is small (table 1).

Economic Indicators

Georgia has enjoyed strong economic growth throughout the 1990s. Between 1993 and 1996, the state added over half a million jobs. Growth in per capita personal income has exceeded the national average, although per capita income remains below the national average, and unemployment remains below the national rate (table 1). Georgia's economic growth has coincided with a significant increase in population, mainly because of immigration of workers from other states and, increasingly, other countries. Most new jobs are being created in the state's metropolitan areas. Long-term

A product of "Assessing the New Federalism," an Urban Institute Program to Assess Changing Social Policies

Table 1
State Characteristics

Sociodemographic	Georgia	United States
Population (1994–95) (in thousands)[a]	7,138	260,202
Percent under 18 (1994–95)[a]	27.3%	26.8%
Percent 65+ (1994–95)[a]	10.6%	12.1%
Percent Hispanic (1994–95)[a]	2.0%	10.7%
Percent Non-Hispanic Black (1994–95)[a]	33.1%	12.5%
Percent Non-Hispanic White (1994–95)[a]	63.8%	72.6%
Percent Non-Hispanic Other (1994–95)[a]	1.1%	4.2%
Percent Noncitizen Immigrant (1996)[b]	2.1%	6.4%
Percent Nonmetropolitan (1994–95)[a]	34.6%	21.8%
Population Growth (1995–96)[c]	2.0%	0.9%
Economic		
Per Capita Income (1996)[d]	$22,977	$24,426
Percent Change in Per Capita Personal Income (1995–96)[d]	4.9%	4.6%
Percent Change in Personal Income (1995–96)[d]	7.0%	5.6%
Employment Rate (1997)[e, f]	66.2%	63.8%
Unemployment Rate (1997)[f]	4.5%	4.9%
Percent below Poverty (1994)[g]	13.4%	14.3%
Percent Children below Poverty (1994)[g]	19.1%	21.7%
Health		
Vaccination Coverage of Children Ages 19–35 Months (1996)[h, i]	80.0%	77.0%
Low Birth-Weight Births (<2,500 g) (1995)[j]	8.8%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1996)[k]	9.0	7.2
Premature Death Rate (Years Lost per 1,000) (1995)[l]	56.2	46.7
Violent Crimes per 100,000 (1996)[m]	638.7	634.1
AIDS Cases Reported per 100,000 (1996)[n]	32.8	25.2
Political		
Governor's Affiliation (1998)[o]	D	
Party Control of Senate (Upper) (1998)[p]	33D-23R	
Party Control of House (Lower) (1998)[p]	101D-79R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.
b. Three-year average of the CPS (March 1995–March 1997, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship.
c. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1997* (117th edition). Washington, DC, 1997. 1995 population as of April 1. 1996 population as of July 1.
d. Bureau of Economic Analysis, U.S. Department of Commerce, January 1998.
e. U.S. Department of Labor. *State and Regional Unemployment, 1997 Annual Averages.* USDL 98-78. Washington, DC, February 27, 1998.
f. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.
g. CPS three-year average (March 1994–March 1996, where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.
h. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. "National Immunization Survey, 1996." *Morbidity and Mortality Weekly Report* 46 (29). Hyattsville, MD, July 25, 1997.
i. 4:3:1:3 series: four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of any MCV, and three or more doses of *Haemophilus influenzae* type b vaccine.
j. S.J. Ventura, J.A. Martin, S.C. Curtin, and T.J. Mathews. "Advance Report of Final Natality Statistics, 1995." *Monthly Vital Statistics Report* 45 (11), supp. Hyattsville, MD: National Center for Health Statistics, 1997.
k. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for June 1996." *Monthly Vital Statistics Report* 45 (12). Hyattsville, MD: Public Health Service, 1997.
l. Rate was calculated using years of potential life lost from age 65 (National Center for Health Statistics. Multiple Cause of Death Mortality Tapes, 1995) as the numerator and population estimates (U.S. Bureau of the Census. ST-96-1. Estimates of the Population of States: Annual Time Series, July 1, 1990, to July 1, 1996) as the denominator.
m. U.S. Department of Justice, FBI. *Crime in the United States, 1996*. September 28, 1997.
n. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 8 (2), 1996.
o. National Governors' Association. *The Governors, Political Affiliations, and Terms of Office, 1998.* January 15, 1997.
p. National Conference of State Legislatures. *1998 Partisan Composition.* D indicates Democrat and R indicates Republican.

prospects for economic growth seem favorable.[2]

The state's overall poverty rate, 13.4 percent in 1994, is a percentage point below the national average (table 1). Atlanta's income distribution is more bimodal than that of other large American cities: There is a large pool of high-income individuals and a large pool of individuals with low incomes, but a small middle class.[3]

Health Indicators and Health Insurance Status

Georgia scores worse than national norms on various health care indicators—rates of low birth weight, infant mortality, premature death, violent crime, and AIDS cases. The state's higher-than-average immunization rate for children is a notable exception (table 1).

Georgia's health insurance coverage is similar to national patterns: In the mid-1990s, 16.0 percent of the state's population was uninsured versus 15.5 percent for the nation (table 2). Roughly one-quarter of low-income individuals in Georgia were uninsured, as in the nation overall. Employers' contribution to coverage was similar to the national average, while Medicaid contributed slightly more (table 2).

Table 2
Health Insurance Coverage

Health Insurance, 1994–1995	Georgia	United States
Nonelderly Population		
Percent Uninsured [a]	16.0%	15.5%
Percent Medicaid [a]	13.0	12.2
Percent Employer-Sponsored [a]	65.4	66.1
Percent Other Health Insurance [a, b]	5.6	6.2
19–64 Population		
Percent Uninsured [a]	19.5	17.9
Percent Medicaid [a]	7.2	7.1
Percent Employer-Sponsored [a]	66.4	67.8
Percent Other Health Insurance [a, b]	6.9	7.2
0–18 Population		
Percent Uninsured [a]	8.5	10.4
Percent Medicaid [a]	25.3	23.1
Percent Employer-Sponsored [a]	63.2	62.5
Percent Other Health Insurance [a, b]	3.1	4.0
<200 Percent of the Federal Poverty Level, Nonelderly Population		
Percent Uninsured [a]	24.2	25.3
Percent Medicaid [a]	35.7	34.1
Percent Employer-Sponsored [a]	34.8	33.9
Percent Other Health Insurance [a, b]	5.4	6.7

a. Two-year concatenated March CPS files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.
b. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.

Political Situation

Democrats have historically dominated Georgia politics and today have majorities in both houses of the state legislature. However, the number of Republicans has grown rapidly, and the state's Congressional delegation recently shifted dramatically from primarily Democratic to mostly Republican. In the early 1990s, Georgia's U.S. Representatives were eight white Democrats, one black Democrat, and one white Republican (Newt Gingrich). Today there are no white Democrats, three black Democrats, and eight white Republicans.[4] As in many states, Georgia's major cities are heavily black and Democratic, while the suburbs are increasingly Republican.

Democrat Zell Miller has been Georgia's governor for the last eight years. He was constitutionally barred from seeking a third term, so the governorship will shift in January 1999 to newly elected Democrat Roy Barnes. Governor Miller leaves as a very popular governor; 85 percent of Georgians polled said that he has done a good job.[5] His initial election in 1990 was viewed as a referendum on his proposal to create a state lottery, enacted shortly thereafter. Proceeds from the lottery have funded various education initiatives that have gained national attention, including the state's HOPE scholarship program, which has provided college scholarships to over 300,000 students. In addition to focusing on education issues, Governor Miller and the state legislature have restrained general budget spending and cut taxes, eliminating the sales tax on groceries and increasing the personal income tax exemption. Health care issues have not enjoyed a high profile, although the magnitude of the state's Medicaid budget ensures that the program consistently attracts policymakers' attention.

Health Care Programs and Coverage

Medicaid

Eligibility. The Medicaid program is the top health priority in Georgia. As in other states, Medicaid claims a large share of the Georgia budget—including the federal contribution, nearly one-fifth of state expenditures in 1997.[6] According to Urban Institute estimates, 13.0 percent of the state's nonelderly population is enrolled in Georgia's Medicaid program, slightly above the national average (table 2).[7]

The state's Medicaid eligibility standards for adults and children are more generous than those of many states. For example, before implementation of the PeachCare program, Georgia provided Medicaid coverage for pregnant women and infants in families with incomes up to 185 percent of the federal poverty level (FPL), children ages 1 through 5 with incomes up to 133 percent of the FPL,

Table 3
Medicaid Expenditures
by Eligibility Group and Type of Service,
Georgia and United States
(Expenditures in Millions)

	Georgia				United States			
	Expenditures	Average Annual Growth			Expenditures	Average Annual Growth		
	1996	1990–92	1992–94	1994–96	1996	1990–92	1992–94	1994–96
Total	**$3,730.8**	**24.9%**	**14.5%**	**4.8%**	**$160,968.6**	**27.1%**	**9.4%**	**6.2%**
Benefits								
Benefits by Service	3,217.4	18.2	15.5	5.0	140,290.1	18.8	11.2	7.7
Acute Care	2,280.9	19.5	19.4	4.0	84,666.5	22.3	13.5	9.0
Long-Term Care	936.5	15.5	7.0	7.6	55,623.6	14.6	8.1	5.9
Benefits by Group	3,217.4	18.2	15.5	5.0	140,290.1	18.8	11.2	7.7
Elderly	630.5	17.8	4.6	−0.3	42,418.5	16.7	8.3	6.2
Acute Care	234.6	18.9	11.9	4.9	11,229.3	18.9	12.4	11.0
Long-Term Care	395.8	17.3	1.4	−3.1	31,189.2	16.0	7.1	4.6
Blind and Disabled	1,352.3	13.5	18.7	10.6	56,601.3	17.6	13.8	10.5
Acute Care	823.6	13.9	20.8	6.5	33,880.1	22.9	16.7	12.3
Long-Term Care	528.7	12.9	14.9	18.1	22,721.2	11.9	10.2	7.8
Adults	604.1	19.5	14.1	0.2	16,956.6	21.4	9.2	4.8
Children	630.6	29.5	26.9	4.6	24,313.8	23.8	12.8	6.5
Disproportionate Share Hospital	372.2	1370.9	8.8	2.3	15,102.6	263.4	–2.1	–5.7
Administration	141.1	4.2	9.2	8.5	5,575.9	9.8	13.1	7.1

Source: The Urban Institute, 1998. Based on HCFA 2082 and HCFA 64 data.

and children ages 6 through 18 up to 100 percent of the FPL. Before PeachCare was enacted in 1998, these eligibility levels for pregnant women, infants, and children ages 6 through 18 exceeded federally mandated levels, while coverage for children ages 1 through 5 met federal minimums. Eligibility thresholds for the aged, blind, and disabled exceed the national average: Georgia is one of 36 states that provide coverage to the aged, blind, and disabled through a medically needy program and one of 35 states that provide coverage for the institutionalized disabled with incomes up to 300 percent of the FPL.

In state fiscal year (SFY) 1998, pregnant women and children who are not receiving cash assistance were the largest group of enrollees (42 percent), while nondisabled adults and children receiving cash assistance represented a smaller share (17 percent). The blind and disabled constituted about 18 percent of the state's Medicaid population, and the elderly, 8 percent.[8] As is typical, most expenditures were targeted toward the elderly, blind, and disabled.

Governor-elect Barnes has proposed that the new tobacco settlement funds be placed in a Medicaid trust fund and used to improve health care throughout Georgia. The state's share of the multi-state agreement signed in November 1998 is expected to be $4.8 billion over the next 25 years.

Expenditure Trends. As the dominant health program in Georgia, Medicaid accounts for roughly 12 percent of the state's general-fund spending but about 20 percent of the budget when the federal contribution is included.[9] In SFY 1997, Medicaid expenditures exceeded $3.7 billion. As in many states, Medicaid was the fastest-growing budget item during the early 1990s, and the state Department of Medical Assistance (DMA) has been pressured to reduce Medicaid costs. DMA's cost-cutting measures have been controversial, especially the state's efforts to control prescription drug use, cap nursing home reimbursements, and limit payments to physicians and hospitals.

Between 1990 and 1992, Georgia's Medicaid spending increased at an average annual rate of 24.9 percent, compared to the national average of 27.1 percent (table 3). Nearly 20 percent of the expenditure growth was due to an expansion of the state's disproportionate share hospital (DSH) program, which provides funds to hospitals that serve large numbers of indigent patients. Average annual growth in benefits payments in the 1990–92 period mirrored the national average (18.2 percent versus 18.8 percent). Between 1992 and 1994, Georgia's annual growth in benefits payments exceeded the national average (15.5 percent versus 11.2 percent), but between 1994 and 1996, Georgia's growth in benefits payments lagged behind the national average (5.0 percent versus 7.7 percent).

During the 1994–96 period, the average annual growth rate in expenditures per elderly enrollee held constant, those per blind and disabled

Table 4
Medicaid Enrollment and Expenditures per Enrollee: Contributions to Total Expenditure Growth

	Georgia				United States			
		Average Annual Growth				Average Annual Growth		
	1996	1990–92	1992–94	1994–96	1996	1990–92	1992–94	1994–96
Elderly								
Total expenditures on benefits (millions)	$630.5	17.8%	4.6%	–0.3%	$42,418.5	16.7%	8.3%	6.2%
Enrollment (thousands)	105.0	11.1	1.8	–0.5	4,103.2	5.1	4.0	0.3
Expenditures per enrollee	$6,003	6.0	2.7	0.1	$10,338	11.0	4.2	5.8
Blind and Disabled								
Total expenditures on benefits (millions)	$1,352.3	13.5	18.7	10.6	$56,601.3	17.6	13.8	10.5
Enrollment (thousands)	208.0	6.7	10.2	5.7	6,698.2	9.8	10.8	5.8
Expenditures per enrollee	$6,502	6.4	7.7	4.6	$8,450	7.1	2.7	4.4
Adults								
Total expenditures on benefits (millions)	$604.1	19.5	14.1	0.2	$16,956.6	21.4	9.2	4.8
Enrollment (thousands)	250.9	18.2	7.8	–0.8	9,225.0	11.4	6.8	–1.5
Expenditures per enrollee	$2,408	1.1	5.8	0.9	$1,838	8.9	2.2	6.3
Children								
Total expenditures on benefits (millions)	$630.6	29.5	26.9	4.6	$24,313.8	23.8	12.8	6.5
Enrollment (thousands)	691.2	20.2	12.5	5.3	21,270.5	13.1	6.6	–0.1
Expenditures per enrollee	$912	7.7	12.8	–0.7	$1,143	9.5	5.8	6.7

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

enrollee increased moderately, and those per adult enrollee increased slightly (table 4). Average annual growth rates in spending per elderly and adult enrollee were below the national average while the growth rate in spending per blind and disabled enrollee exceeded the national average. The average annual growth rate in expenditures per child enrollee actually decreased slightly, while the national rate increased.

Georgia's ratio of expenditures on acute care relative to expenditures on long-term care exceeded the national average. In 1996, roughly 70.9 percent of Georgia's expenditures on benefits were targeted toward acute care, compared with 60.4 percent nationwide. Georgia spends a large share on acute care expenditures relative to the national average because the state's long-term care expenditures per elderly and blind and disabled enrollee are significantly below the national average. For example, the state's long-term care spending per elderly enrollee ($3,800) is half the national average ($7,600). A full analysis of factors affecting long-term care use and price is beyond the scope of this report.

Acute care spending per elderly enrollee is also somewhat lower than average, about $2,200 in Georgia versus $2,700 in the United States overall. In sum, the state spends roughly $6,000 per elderly enrollee, compared with a national average of over $10,000 (table 4). Moreover, the state spends approximately $6,500 per blind and disabled enrollee while the national average is nearly $8,500.

About 80 percent of Georgia's long-term care expenditures in SFY 1998 paid for nursing home care, and about 16 percent paid for home and community-based waiver programs. However, DMA's primary goal in the future is to expand the availability of noninstitutional services.[10] In the SFY 2000 budget cycle, DMA requested funding to eliminate waiting lists for two long-term care home and community-based care waiver programs: the Community Care Services Program, which serves the frail elderly, and the Independent Care Waiver Program, which serves primarily younger persons with disabilities.

Enrollment Trends. Large enrollment increases, which have varied by eligibility group, have been responsible for much of the growth in Georgia's Medicaid spending since 1990 (table 4). In the early 1990s, enrollment growth among the elderly, adults, and children exceeded national averages, while enrollment growth among the blind and disabled was below the national average. Since 1992, enrollment growth among the elderly has lagged behind the national average, whereas enrollment growth among the blind and disabled has resembled national averages. Since 1995, enrollment of adults has decreased both nationally and in Georgia, the likely cause being a decrease in the number of adults obtaining cash assistance, which has historically been linked to enrollment in Medicaid.

Overall enrollment among children in the state has increased throughout the 1990s. At the beginning of the decade, the average annual increase in enrollment among children in Georgia

was 20.2 percent. This increase was primarily due to the federal Medicaid expansions for children that were enacted in the late 1980s and early 1990s. Between 1994 and 1996, the state's overall enrollment of children increased at an average annual rate of 5.3 percent. Enrollment among those children receiving cash assistance actually decreased by 6.6 percent annually, while enrollment growth among those not receiving cash assistance increased at an average annual rate of 15.8 percent.

The Children's Health Insurance Program: PeachCare

On September 3, 1998, Georgia received federal approval to implement PeachCare, the state's health insurance program for low-income children not eligible for Medicaid.[11] PeachCare responded to the federal Children's Health Insurance Program (CHIP), which provides state grants to help create and expand insurance programs for low-income children through age 18. States must supply matching funds, but at a lower percentage than for Medicaid. Georgia's CHIP matching rate is 70 percent of its Medicaid match, which is 40 percent, making the initial CHIP match 28 percent.

The state created PeachCare, a Medicaid look-alike program for children through age 18 who are ineligible for Medicaid coverage and whose family income falls below 200 percent of the FPL. Although PeachCare's benefit package mirrors Medicaid's, PeachCare is not an entitlement, and the state may impose cost-sharing requirements and cap enrollment.

PeachCare began on September 1, 1998, with a pilot project in central Georgia to test eligibility and enrollment systems. Statewide enrollment will begin in December 1998, with coverage to begin January 1, 1999. Between 65,000 and 100,000 children are expected to be eligible for coverage under this expansion.[12]

Insurance Regulation and Health Care Coverage

Small-Group and Individual Market Regulation. In Georgia, as elsewhere, most insurance coverage is employment based. Georgia's rate of employer-sponsored coverage, 65.4 percent, is similar to the national average of 66.1 percent (table 2). Among people with incomes below 200 percent of the FPL, 34.8 percent have employer-sponsored coverage, compared with a national average of 33.9 percent.

In an effort to promote private insurance, state legislation has reformed both the small-group and individual insurance markets. In 1995, Georgia limited insurers' ability to deny coverage in the small-group market based on preexisting conditions. Two years later, modifications were passed to comply with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires guaranteed issue of all small-group health insurance products to any group with 2 to 50 workers, regardless of past claims experience or health status, as well as requiring guaranteed renewal and group-to-individual portability.

The state also went beyond HIPAA requirements by passing a 1997 law limiting insurers' ability to deny coverage in the individual market to persons with preexisting conditions. Other 1997 legislation permits the formation of health plan purchasing cooperatives.

Other Insurance Market Regulation. In 1996, Georgia became the first state to authorize certain provider organizations to compete with health maintenance organizations (HMOs). These provider-sponsored health care corporations (PSHCCs) may be owned by doctors, hospitals, and other health providers. As of mid-1998, seven PSHCCs were in operation, a number expected to double within a year. Furthermore, in 1998, Georgia enacted a law that allows self-employed people to deduct 100 percent of their health insurance premiums from state taxes, up from 45 percent.

Market Changes and Low-Income Consumers

Private Market Developments

Until the 1990s, Georgia's insurance market was dominated by indemnity insurance, particularly Blue Cross and Blue Shield of Georgia. Despite the large number of new insurers that have entered the market since the late 1980s, BCBS remains a dominant player, with roughly 1.5 million enrollees.

Penetration by HMOs has increased markedly. The first managed care company entered the Georgia market in 1979, but by 1990 there were only two HMOs in the state, serving a limited number of enrollees. By August 1998, 18 HMOs, serving roughly 1.6 million enrollees, were licensed; an additional 2.2 million people were enrolled in other types of managed care, such as preferred provider organizations (PPOs).[13] Managed care penetration in the state's urban areas—Atlanta, Augusta, Columbus, Macon, and Savannah—is high. In the Atlanta region, managed care has nearly displaced the historical indemnity insurance market: 59 percent of persons with commercial insurance are in HMOs, and an additional 30 percent are in PPOs.[14] PPOs also have significant penetration rates throughout rural Georgia.

Statewide, Georgia's HMO penetration has lagged behind the national average, 8.2 percent versus 20.0 percent in 1995.[15] The largest HMOs enroll most recipients; over half of the HMOs serve fewer than 10,000 enrollees each. HMOs with small numbers of enrollees face great financial difficulties, so further consolidation of the HMO market is likely. Although most HMOs earned a profit in 1996, only one major HMO, Kaiser, earned a profit in 1997. The first three quarters of 1998 have shown mixed results. The largest HMOs are gaining membership, but many continue to lose money. However, the HMO market is showing signs of stability, as the same companies continue to appear atop the list of total HMO enrollees.[16]

Blue Cross and Blue Shield of Georgia

To compete in the changing market, BCBS of Georgia converted from nonprofit to for-profit status in December 1995, making it only the second Blue Cross plan in the country to do so. Thereafter, BCBS aggressively moved its members from the company's indemnity insurance market into its

managed care plan called HMO Georgia, now the largest HMO in the state.

In the fall of 1997, nine nonprofit organizations filed suit against BCBS of Georgia, seeking to maintain as public assets hundreds of millions of dollars realized when the company converted to for-profit status.[17] In July 1998, the parties agreed to settle. As part of the settlement, BCBS of Georgia agreed to put money and stocks, initially estimated to be worth $80 million, in an independent foundation, Healthcare Georgia, for the "advancement of healthcare for all Georgians."[18] Following the settlement, WellPoint Health Networks acquired BCBS of Georgia. WellPoint was previously a California-based Blue Cross/Blue Shield company that had converted to for-profit status in 1992.

BCBS is also being sued jointly by the Medical Association of Georgia and the American Medical Association over recent changes in the plan's payment rates, which effectively lower reimbursement for most providers. If private insurers pay physicians lower rates, levels of care provided to public patients may be affected, as physicians would be less able to shift costs from public to private-paying patients. Physician payments are also being affected by changes in Medicaid reimbursement. Physicians are reimbursed based on a methodology used by Medicare, but Medicaid payment rates are lower than Medicare's rates and have been eroding over time.

Medicaid Managed Care

The state provides Medicaid coverage through two different managed care delivery systems: the Georgia Better Health Care (GBHC) program, and Georgia's capitated managed care program, which provides a lump sum or capitated fee for each recipient who voluntarily enrolls in an HMO. Medicaid recipients who do not receive coverage through these managed care systems continue to obtain coverage through the traditional fee-for-service system.

Georgia Better Health Care Program. The GBHC program, begun in 1993, is the state's primary care case management program. It pays primary care physicians $3 per member per month to coordinate care for Medicaid recipients. GBHC is a mandatory program for most Medicaid-eligible populations except for those residing in institutions and those eligible for Medicaid because of time-limited conditions such as pregnancy. In 1997, 58.6 percent of Georgia's Medicaid recipients were enrolled in GBHC.[19] A study of GBHC showed high levels of satisfaction among both recipients and providers. The study also suggested cost savings between 3 and 5 percent over traditional fee-for-service costs.[20]

Capitated Managed Care. In 1995, DMA created a voluntary capitated Medicaid managed care program. Governor Miller's stated goal was to enroll nearly all of Georgia's Medicaid recipients into HMOs and save 10 percent in Medicaid costs. However, enrollment has lagged, and the large cost savings originally projected have not been achieved. As of mid-1998, only 54,000 of 930,000 eligible Medicaid recipients were enrolled in HMOs.[21] Even though managed care is a booming industry in the state, HMOs have been reluctant to serve Medicaid recipients at state reimbursement rates. State officials are limited in their ability to raise capitation rates, as federal law mandates that capitation rates paid to managed care organizations be lower than a state's fee-for-service rates. From 1995 to mid-1997, FamilyPlus, an HMO affiliated with Egleston's Children's Hospital in Atlanta, was the only HMO enrolling Medicaid recipients. Shortly thereafter, a second HMO, AmeriCan Medical Plans of Georgia, entered the Medicaid market, followed by an HMO formed by the Grady Health System, the state's largest Medicaid provider.

The Grady Health System, located in Atlanta, plays a major role in Georgia's Medicaid program. In 1995, over 30 percent of Grady's revenue, $160 million out of $510 million, was generated by Medicaid recipients. About 40 percent of Grady's patients have no health insurance.[22] Grady submitted an application for an HMO license in December 1995 but did not have the capacity to enroll Medicaid recipients until the fall of 1997, when Georgia granted Grady a temporary managed care license until the health system could establish a risk-bearing HMO. The state decided to support Grady because of the system's reliance on Medicaid revenue.[23] Although the Medicaid program provides a large percentage of Grady's revenue, another 22 percent comes from taxes on residents in Fulton and DeKalb counties.

This local funding has generated controversy. After a citizens' group called Lower Our Grady Tax received legislative attention in the early 1990s, Grady responded by cutting reliance on county taxes. Fulton and Dekalb contributed $97.6 million in 1997, down from $113.6 million in 1992.[24] Concurrently, Grady's revenues from Medicaid and Medicare have been declining; hospital officials expect to lose $40 million more over the next three years.[25] These developments are exacerbating Grady's financial problems.

In July 1998, the state announced that only one HMO, Grady Healthcare, would be serving Medicaid recipients. FamilyPlus withdrew, as the company had lost more than $8 million in its two years of existence. The plan had hoped to sell its membership to another HMO but was unable to find a buyer, so the plan returned its members to the state.[26] AmeriCan too was having financial difficulties, and was taken over by the state Insurance Department because it could not meet the Georgia solvency requirements. Two other HMOs were negotiating to participate in Medicaid in Athens and Savannah as of November 1998.

Hospitals and the Health Care Safety Net

Hospital Market Developments

In 1995, there were 210 hospitals in Georgia, 158 of them community hospitals.[27] Nonprofit hospitals, public hospitals, and for-profit hospitals were about equal in numbers, but nonprofits had over half the beds and nearly two-thirds of statewide revenue. Nonprofits also provided nearly two-thirds of uncompensated hospital care, $266 million out of $413 million in 1995.[28]

Georgia's hospitals have low occupancy rates, averaging about 50 percent.[29] The overbedded market is promoting rapid change. Numerous

mergers and consolidations—but few closures—have occurred. Some hospitals have formed loose affiliations to capture managed care contracts while remaining financially independent.

As of early 1997, only three hospitals had converted from nonprofit to for-profit status. Nonetheless, community hospitals and state legislators were concerned enough to pass a 1997 law regulating conversions.[30] The statute requires financial disclosure on acquisition of any nonprofit hospital, and any such acquisition would be subject to public hearings, supervised by the state attorney general. During the 1998 legislative session, opponents unsuccessfully sought to repeal the law, arguing that it imposes financial burdens on hospitals.[31]

Hospital Reimbursement

Medicaid Payment Rates and Disproportionate Share Hospital Payments. In late 1996, the state switched hospital reimbursement from a per-case rate (flat fee, regardless of the diagnosis) specific to each hospital to diagnosis-related groups. Reimbursement also includes a per admission fee, scaled to patient condition and age. According to the Georgia Hospital Association, the change resulted in significant cuts in Medicaid hospital reimbursement. Hospitals are expected to receive payments of $415 million in 1998 through the state's DSH program. The state's share of these funds is generated through Georgia's indigent care trust fund, which provided approximately $150 million in 1998.[32]

Urban versus Rural Hospitals. Urban hospitals are in much better financial shape than their rural counterparts. More than half of Georgia's hospitals are located in rural areas, although they account for less than a third of inpatient beds or inpatient days. Eight rural hospitals have closed since 1990, and up to 40 more are in dire fiscal shape;[33] in 1995, roughly 40 percent of rural hospitals in Georgia lost money.[34] The key problem is low patient volume, exacerbated by managed care contracts that often channel inpatient care to regional hospitals.

In SFY 1997, the state implemented a second indigent care trust fund, designed to assist small rural hospitals that serve a disproportionately high share of poor people. More than $3 million was allocated for the first year. In October 1997, DMA implemented a new payment formula, based on historical data reported by hospitals to DMA, that resulted in a 19 percent difference in payment rates between urban and rural hospitals. Rural hospitals were outraged. Shortly thereafter, in December, the Medicaid program's governing board agreed to phase out the "urban-rural split" over a four-year period, with much of the phaseout occurring during the first two years.[35]

To further assist rural hospitals, the state enacted the Essential Rural Health Provider Access Act in April 1998. This law is designed primarily to give small rural hospitals with 100 or fewer beds the right to bid on insurance business, as long as 40 percent or more of the hospital's revenue is generated from the Medicare and Medicaid programs. The law enables rural hospitals to contract with insurers, provided the hospitals agree to payment methodologies similar to those between the insurers and other hospitals. The law is designed to apply to roughly 70 rural hospitals.[36]

Conclusion

Georgia's health care system faces several challenges for the future. A key issue for state policymakers is how to use funds from the tobacco settlement. One continuing challenge will be serving residents without health care coverage, as the uninsured impose a significant burden on Georgia's hospitals, especially Atlanta's Grady hospital and most rural hospitals. Implementing the expansion of children's health insurance coverage may also prove difficult, as the state tries to reach and enroll eligible children. In the Medicaid program, policymakers may have to increase reimbursement rates in order to promote managed care for Medicaid populations. The state also faces challenges in refocusing its long-term care system. While Georgia has shown considerable interest in expanding home and community-based service options for the elderly and disabled, most long-term care expenditures are still targeted toward institutionalized care.

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Funders

The project has received funding from The Annie E. Casey Foundation, the W.K. Kellogg Foundation, The Robert Wood Johnson Foundation, The Henry J. Kaiser Family Foundation, The Ford Foundation, The John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, The David and Lucile Packard Foundation, The Commonwealth Fund, the Stuart Foundation, the Weingart Foundation, The McKnight Foundation, The Fund for New Jersey, and The Rockefeller Foundation. Additional funding is provided by the Joyce Foundation and The Lynde and Harry Bradley Foundation through a subcontract with the University of Wisconsin at Madison.

This series is a product of *Assessing the New Federalism*, a multi-year project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs and their effects. In collaboration with Child Trends, the project studies child and family well-being.

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Publisher: The Urban Institute, 2100 M Street, N.W., Washington, D.C. 20037

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