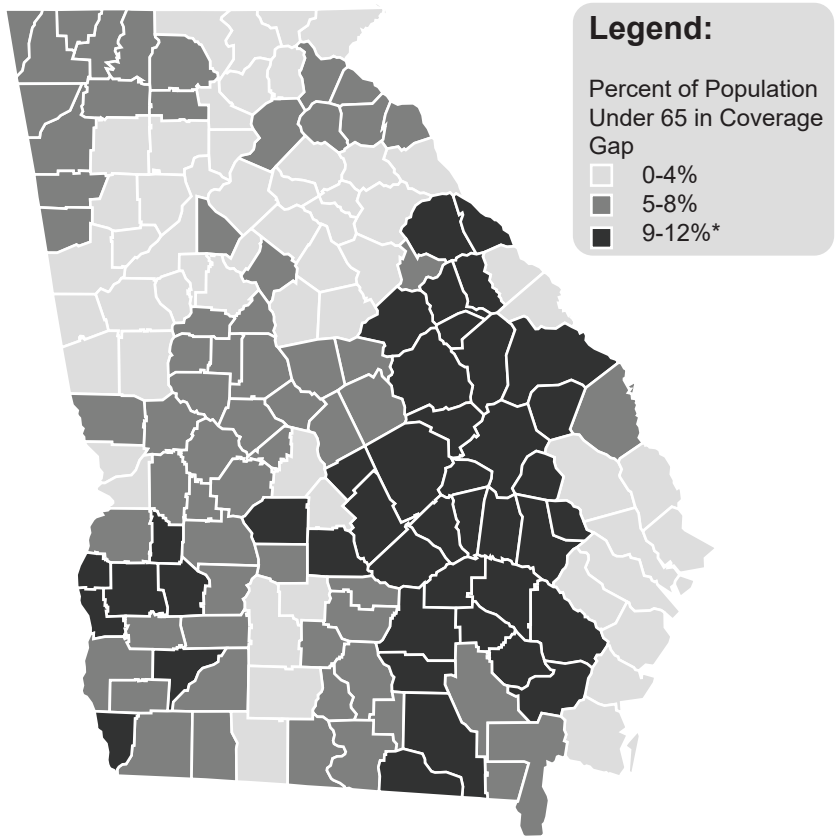
The State of Georgia's Healthcare System

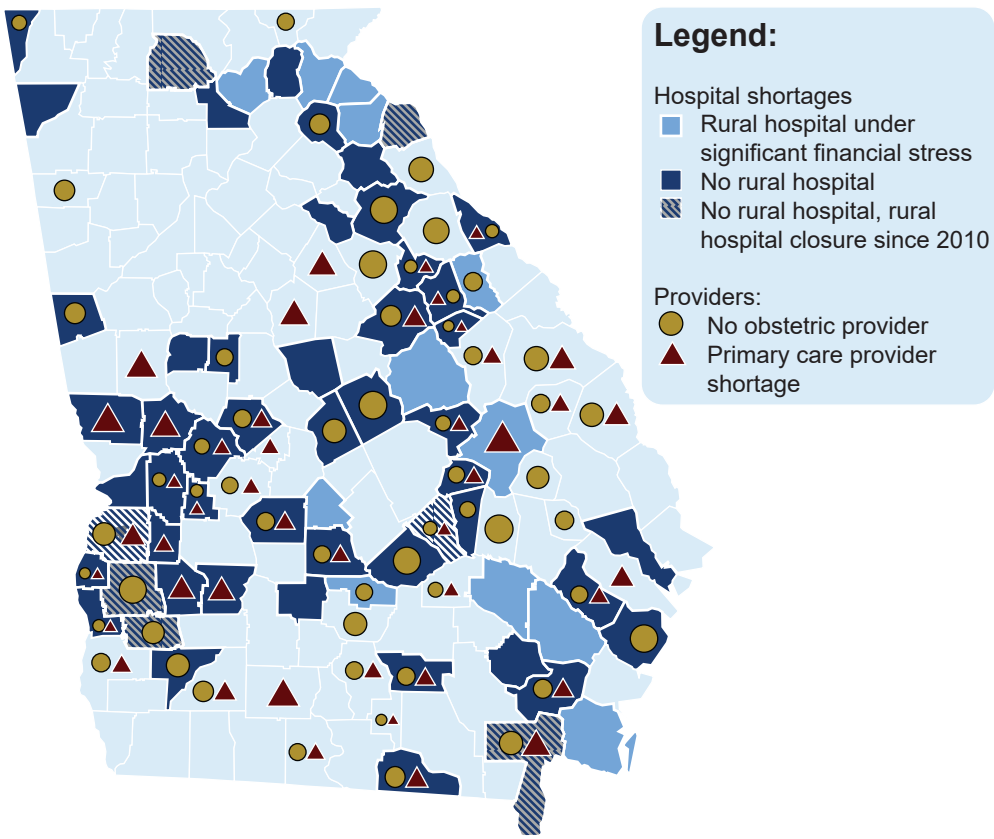
Georgia's healthcare system is under pressure, and the impact is greatest in rural Georgia.

There are various indicators to measure the vitality of the state's healthcare system, including accessibility, affordability and workforce trends. The two maps below display three different indicators: 1) the proportion of county residents under 65 living in the coverage gap; 2) rural counties with no hospital -including those with a hospital closure since 2010 - and counties with a hospital under significant financial stress; and 3) counties with no obstetric care provider, a primary care provider shortage or both.

Coverage Gap by County



Hospital and Provider Shortages by County



**Glascock county is an outlier at 14%*

Notes: Percent of population in coverage gap is based solely on income level, age, and uninsurance status. Hospital shortage analysis does not include recent hospital closures in non-rural counties, including Northridge Medical Center in Commerce (2020), Wellstar Atlanta Medical Center in Atlanta (2022), and Wellstar Atlanta Medical Center South in East Point (2022). This map excludes partial geographic primary care provider shortage areas, including Northwest Savannah (Chatham County), West Atlanta (Fulton County), and North Effingham County. This map also excludes population-specific health professional shortages, such as primary care provider shortages for low-income populations within counties.

Closing the Coverage Gap

Georgia can strengthen the state's healthcare system and generate state budget savings by closing the coverage gap. Currently, the federal government pays about 66% of health care costs for Georgians covered under traditional Medicaid. If the state expands access to health care for Georgians earning up to 138% of the federal poverty level, the federal government will cover 90% of the cost for those newly eligible for health care coverage. The federal government would send more than $1 billion in additional federal funds to the state in the first two years (thanks to an enhanced federal match for traditional Medicaid enrollees) as a signing bonus.[1] Those funds would be more than enough to offset the state cost for two years. Even without that signing bonus, the increased revenue and state budget savings from closing the coverage gap mean that states often pay only a fraction of the 10% state cost.[2] Among a range of benefits, other states have also seen economic impacts related to rural hospitals and obstetric care, mental health and substance use services and public safety.

What is the coverage gap?

People in the coverage gap do not qualify for traditional Medicaid coverage and do not earn enough to qualify for the tax credits that make marketplace plans affordable. They are 19-64 years old and earn at or below the federal poverty level (about $31,000 or less per year for a family of four). Although most are in a family with at least one worker, many work in critical but low-paying jobs, such as food service or construction, that often do not offer employer-sponsored health care coverage.[3]

Other States See Positive Economic Impacts as They Close the Coverage Gap

↓ in hospitals' uncompensated care, ↑ in hospital operating margins, and ↓ in hospital and obstetric unit closures, particularly in rural areas[4]

Example: Arkansas closed its coverage gap in 2014. 58 rural hospitals have permanently closed in states neighboring Arkansas since 2012, while no rural hospital in Arkansas has closed during that time without being reopened or replaced.[5]

↓ in state budget spending on mental health and substance abuse treatment as more uninsured individuals gain coverage and the federal government covers most of the cost[6]

Example: The state auditor estimates that Department of Behavioral Health and Developmental Disabilities would generate $21 - $60 million in state savings per year on mental health and substance abuse services – allowing the agency to apply those funds to other critical needs.[7]

↓ in state budget spending on correctional healthcare and ↓ in arrests, particularly drug-related arrests, as fewer individuals in crisis interact with the criminal-legal system[8,9]

Example: The state auditor estimates that the Department of Corrections would generate $21 - $24 million in state savings per year as some justice-involved individuals have inpatient hospital stays covered by the 90% federal match, allowing the agency to apply those funds to other critical needs.[10]

For methodology and references, follow this QR code or visit GBPI.org/StateHealthcareSources