



WELCOME TO
BUILDING A HEALTHY GEORGIA:
*Widening the Safety Net and Ensuring
Greater Access to Care*

November 30, 2011
Coastal Georgia Center

THE SOCIOECONOMIC DETERMINATES OF HEALTH OUTCOMES:

A PERSPECTIVE FROM URBAN STUDIES AND PLANNING

A Perspective

- The unequal distribution of health outcomes in the United States is widely attributed to structural ‘social determinates’ such as income, education and place.
- Notwithstanding these structural constraints on the working poor, the policy adoption of ‘equal access’ to healthcare as a ‘social benefit’ or ‘entitlement’ is still controversial in the United States, as is the role of government in this sector.
- U.S. Census and the Department of Housing and Community Development have classified Savannah as being ‘hyper-segregated’ by race and class. This means that that structural disparities are clustered in particular low income neighborhoods (zip codes) and that place matters.

Free Market vs. Welfare State?

- The current healthcare debate is framed by a tired ideological polemic between those who espouse 'free market' principles and those who assert that healthcare is a 'social right' to be guaranteed by government.
- The neoliberal movement since the 1970s has changed the actual material relationship of government to healthcare, but popular rhetoric has not incorporated this reality.
- Insurance and pharmaceutical companies are making record profits while individuals earning in the lowest income quintile are paying higher percentages of their income on health insurance. The new neoliberal 'government by network' as facilitated this net growth.

Economic Restructuring (1972 – 1983) and Growing U.S. Poverty

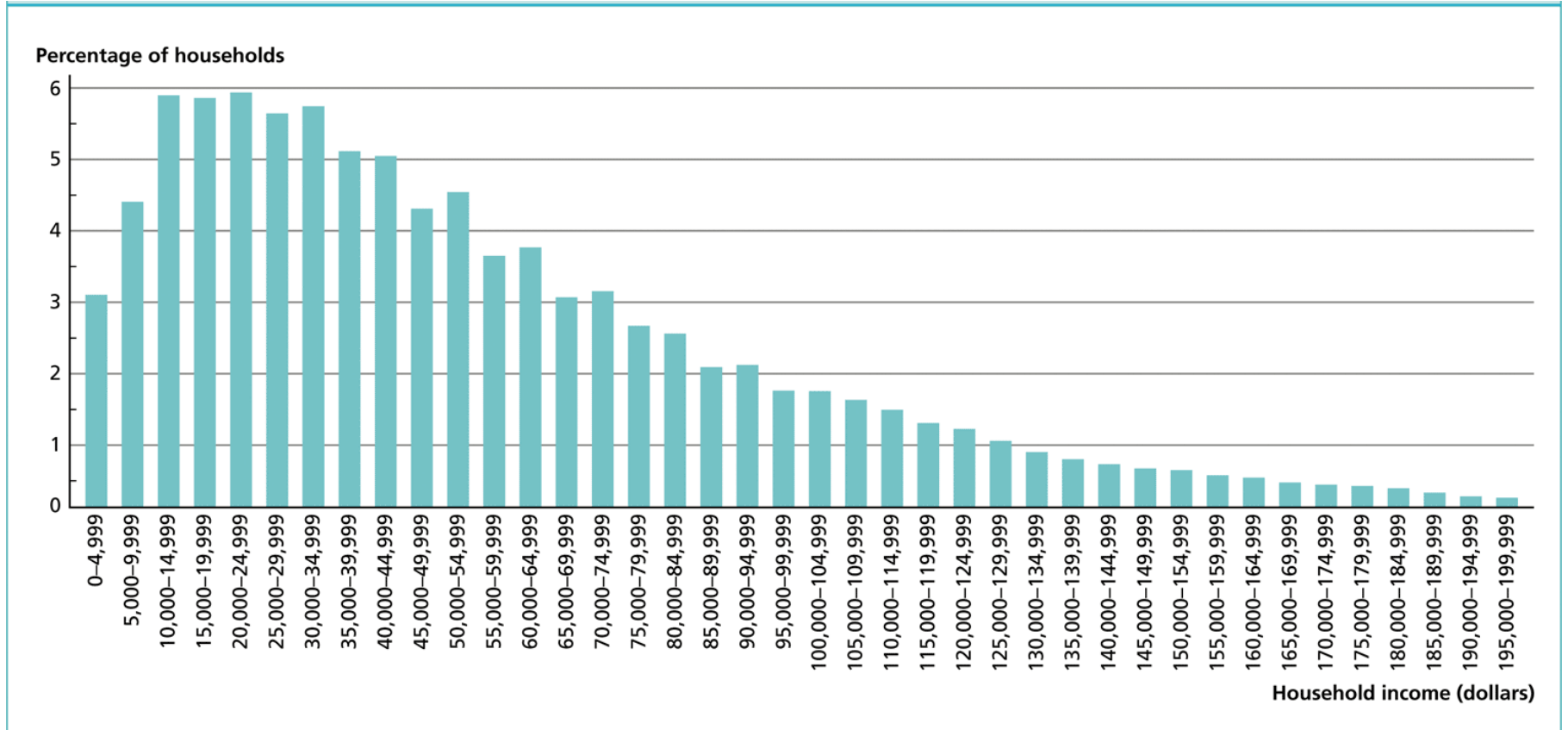
- Wages stagnant for U.S. Labor since the 1960s
- Globalization of U.S. Production – Flexible Accumulation
- Post WWII Suburbanization
- Property Tax Based Education System
- Ronald Reagan – 'Reaganomics'
2/3 cut in social services, reduced municipal funding +
Pure Free Market Economics - Deregulation

CDC's 2011 Health Disparities and Inequalities Report

Disparities in morbidity and mortality by class and race are linked to inequalities in:

1. Income and Education
2. Environmental hazards, including unhealthy housing and poor air quality
3. Access to healthcare and preventive services
4. Behavioral risk

U.S. Income Distribution - 2006



Source: DeNavas-Walt, Proctor, and Smith (2006).

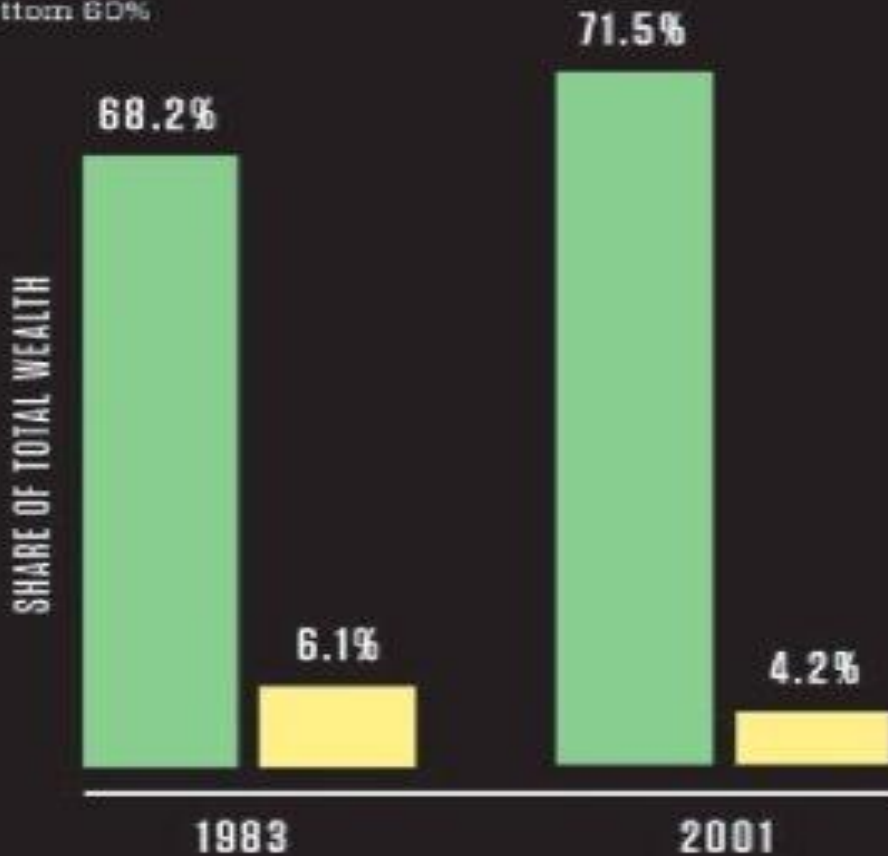
U.S. Wealth Inequality

WEALTH INEQUALITY

Concentration of wealth in the U.S. between 1983 and 2001.

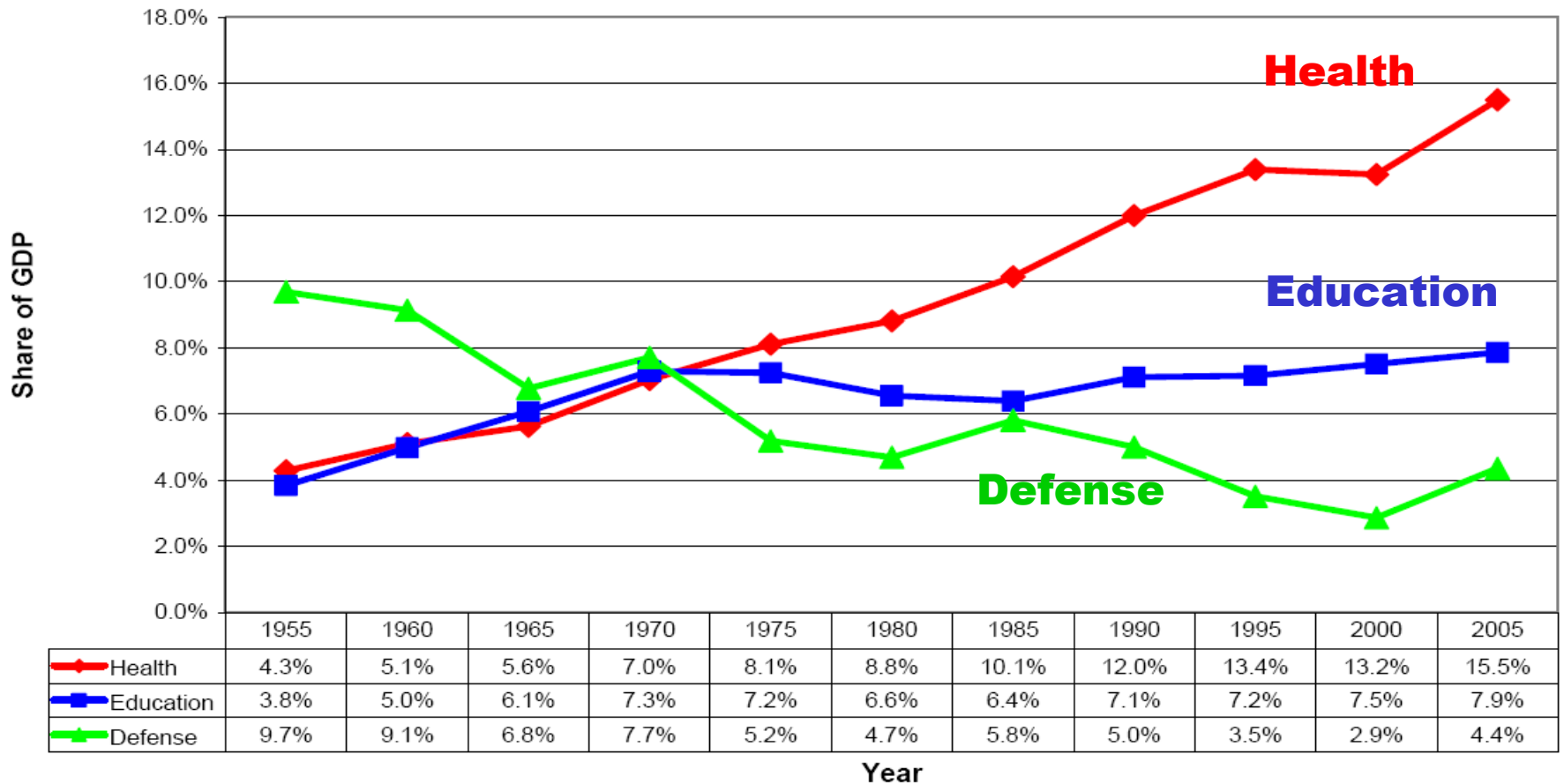
■ Top 10%

■ Bottom 60%



Health Care Expenses

HEALTH, EDUCATION, AND DEFENSE SHARES OF U.S. GDP, 1955 - 2005



Source: Dr. Palley, Memorial Health University Center

America's Rankings

- #1 - Health Care Dollars Spent Per Capita
- #1 - Health Care Technology
- #1 - Research Dollars Spent Per Capita
- #20 - Health Care Outcomes (e.g. life expectancy, infant mortality, and immunizations)
- #37 - Health Care System
- #54 - Fairness (tied with Fiji)

Sample: Health Insurance Profit & Revenue 2005-2007

Rank	Company	1,000 revenues rank	REVENUES		PROFITS	
			\$ millions	% change from 2005	\$ millions	% change from 2005
1	United Health Group	21	71,542	58	4,159	26
2	Wellpoint	35	56,953	26	3,095	26
3	Aetna	85	25,569	12	1,702	4
4	Humana	110	21,417	49	487	58

Fortune 500, 2007

Sample: Pharmaceutical Companies

Profit & Revenue 2008-2010

Rank	Company	Fortune 500 rank	Revenues		Profits	
			\$ millions	% change from 2008	\$ millions	% change from 2008
2	Pfizer	40	50,009.0	3.5	8,635.0	6.6
3	Abbott Laboratories	75	30,764.7	4.2	5,745.8	17.7
4	Merck	85	27,428.3	15.0	12,901.3	65.2
5	Eli Lilly	112	21,836.0	7.2	4,328.8	N.A.
6	Bristol-Meyers	114	21,634.0	1.3	10,612.0	102.2

Fortune 500, 2010

Health Insurance as a Share of Market Income, by Income Group, 1979 & 2007

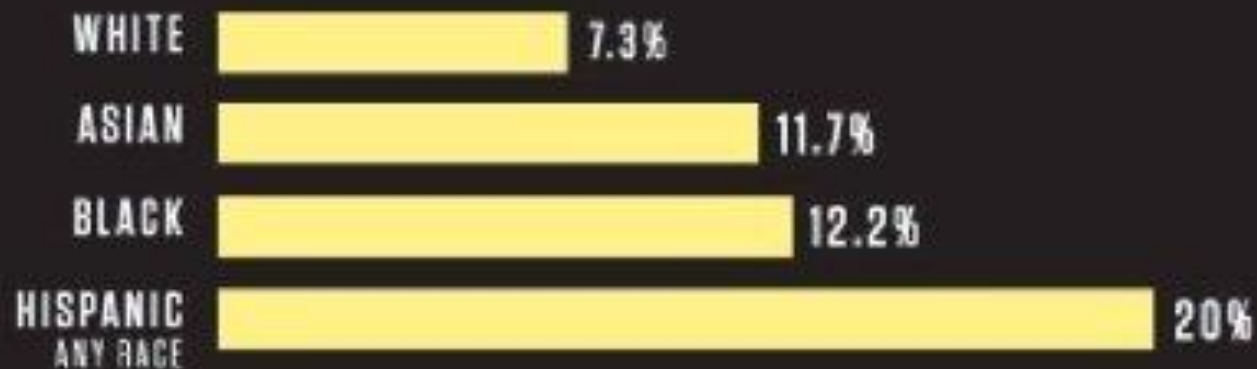
Income Group	Employer Sponsored Health Insurance 1997	Employer Sponsored Health Insurance 2007	Medicare: Average Cost 1979	Medicare: Average Cost 2007	Medicaid & CHIP: Average Cost 1979	Medicaid & CHIP: Average Cost 2007
Lowest Quintile	1%	1.4%	10.7%	29.1%	4.9%	20.9%
Middle Quintile	4.1%	6.9%	1%	4.8%	0.2%	1.6%
Top 1%	0.5%	0.5%	0.2%	0.2%	0%	0%

HEALTH INSURANCE

In 2007, 8.1 million children under 18 years old were without health insurance. Children in poverty and Hispanic children were more likely to be uninsured.

8,100,000
CHILDREN UNDER 18 YEARS WERE UNINSURED

Percentage of children by race who were uninsured in 2007.





Place Matters

Health Disparities, Hyper-segregation and
Environmental Risk

Hyper-segregation

- Deindustrialization
- Suburbanization
- Economic Restructuring
- Property tax based education system

In American cities...



Environmentally-based health disparities are common across racial and class lines. Inner-city minority and low income communities are disproportionately affected by air, water and soil pollution. Inadequate abatement of negative externalities from historical industrial manufacturing activities and the use of lead based fuel has left a toxic environmental legacy.

Housing and Health Disparities

Older and under-maintained housing is a source of health disparities due to higher frequencies of exposure to lead and other industrial toxins, mold, and pests; lack of adequate insulation and modern heating or air conditioning; and health threats such as hypertension and other stress-related illnesses due to housing insecurity and slumlord activity.

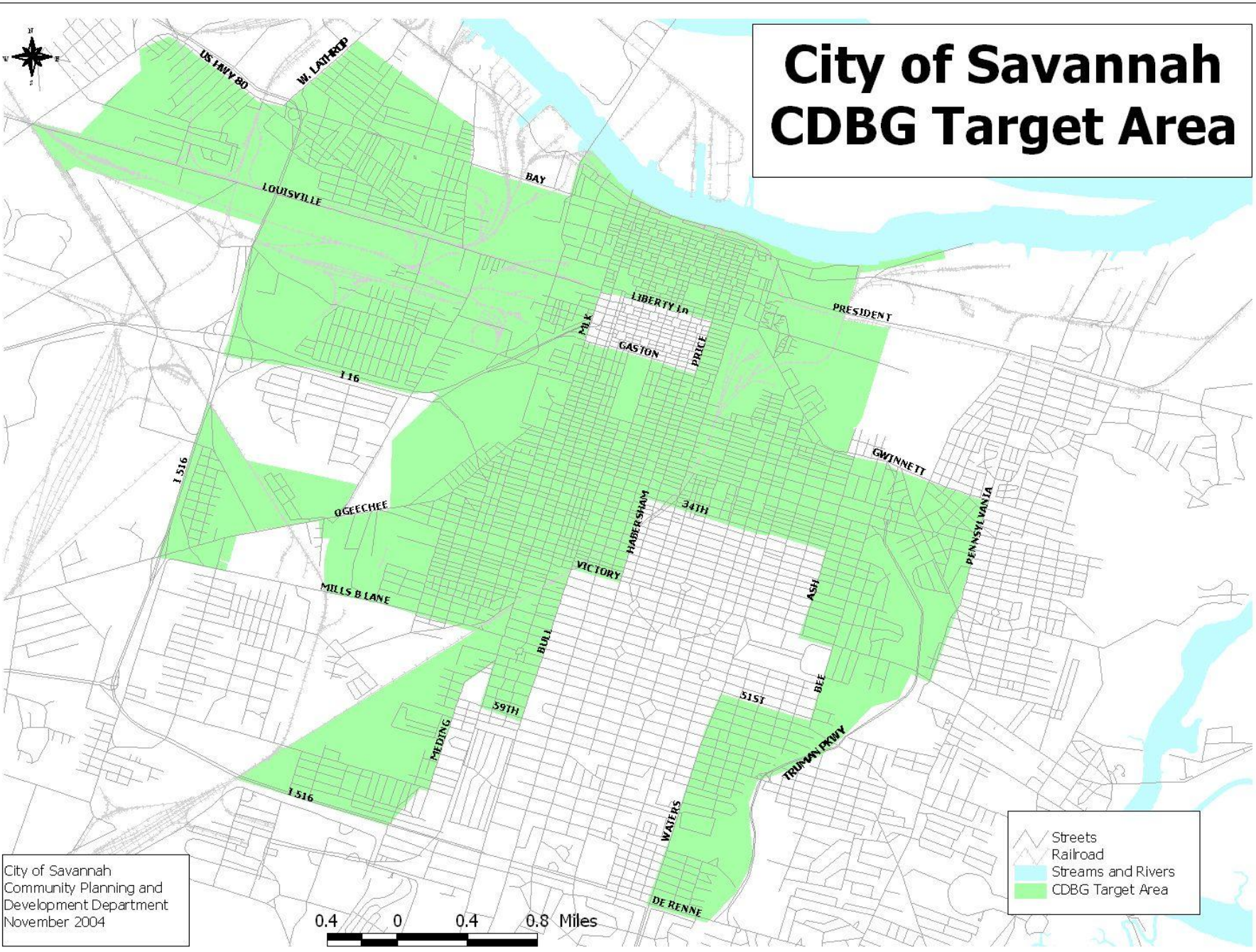
In addition,



Due to spatial and socioeconomic segregation, disadvantaged communities have unequal access to such environmental goods as fresh, nutritious food; green parks and outdoor recreation facilities; health care clinics and quality schools, public transportation, and secure employment. In other words, where people live, in many ways, affects their life chances.

Place Matters....


City of Savannah CDBG Target Area



City of Savannah
Community Planning and
Development Department
November 2004

- Streets
- Railroad
- Streams and Rivers
- CDBG Target Area

0.4 0 0.4 0.8 Miles



It is one of the greatest of contemporary social injustices that people who live in the most disadvantaged circumstances have more illnesses, more disability and shorter lives than those who are more affluent.

-- Benzeval, Judge, & Whitehead, 1995, p.xxi, *Tackling Inequalities in Health: An Agenda for Action*.



GEORGIANS FOR A
HEALTHY FUTURE

Sound Policy. Effective Action.

The Affordable Care Act: Implications for Georgia

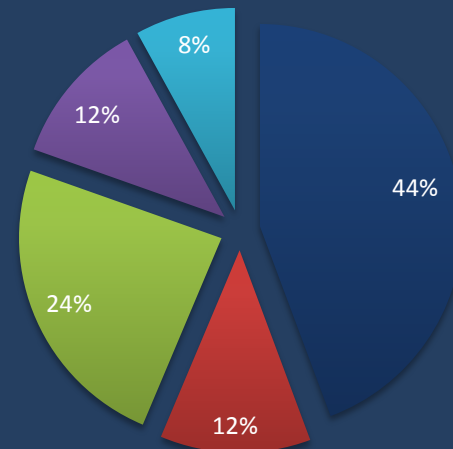
Cindy Zeldin

Executive Director, Georgians for a Healthy Future

November 30, 2011

The Big Picture, The Big Opportunity: Covering the Uninsured

- Nearly two million uninsured; one-fifth of the population and one-fourth of working-age adults
- Georgia consistently ranks in the top 10 among the states in number and percentage of uninsured
- Distribution of the uninsured in Georgia by income:
 - <100% FPL..... 44%
 - 100-138% FPL... 12%
 - 139-250% FPL... 24%
 - 251-399% FPL.... 12%
 - 400% FPL+ 8%.....8%



Source: CPS data, 2-year average '08-'09 (Kaiser State Health Facts)

ACA: Overall Approach to Coverage

- Everyone is eligible for something
- Maintain employment-based health insurance system
- Expand Medicaid for low-income individuals and families
- Restructure the individual and small group health insurance marketplace to facilitate choice, competition, and value through exchanges and new regulations
- Individual mandate to get nearly everyone in the health insurance system

Medicaid Expansion

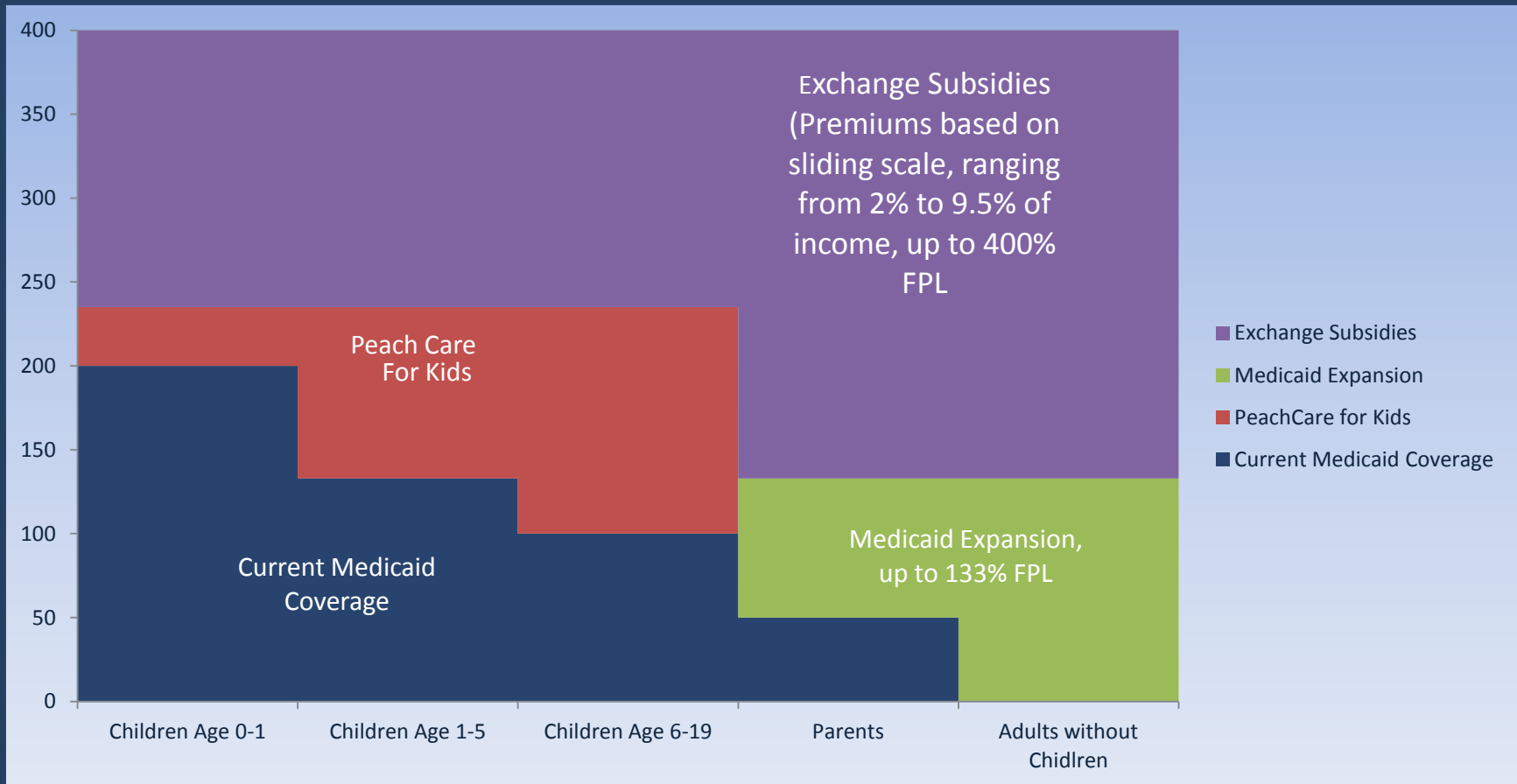
Expansion to 138% FPL

- Up to 138% FPL in income (\$15,028 for an individual or \$25,571 for a family of 3), Medicaid-eligible regardless of “category”
- Estimated 645,000 – 900,000 new Medicaid enrollees by 2019 (mostly childless adults) in Georgia
- Maintenance of Effort (MOE) requirement: prohibits states from restricting the eligibility standards, procedures, and methodologies in place on March 23, 2010 (until January 2014 for adults and October 2019 for children)

Medicaid Expansion, cont'd

- Estimated 40% increase in enrollment in Georgia, as compared to an estimated increase of 27% nationally (Source: KFF)
- Expansion initially financed with 100% federal dollars (2014-2016) and then scales down such that by 2020 and thereafter the expansion population is 90% federally financed
- Increased enrollment will lead to a 28.9% increase in federal spending and 2.7% increase in state spending relative to baseline (Source: KFF)
- Temporary increase in Medicaid reimbursement rates for primary care providers to parity with Medicare rates (federally financed) from 2013-2015

Everyone is eligible for something



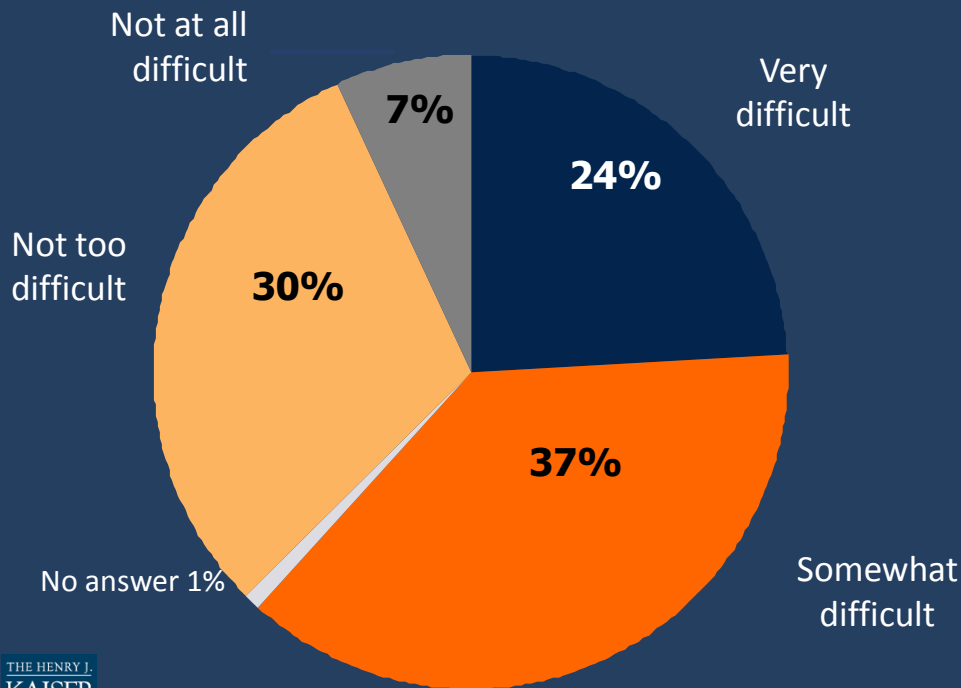
*Note that kids ages 6-19 between 100-133% FPL will move from CHIP to Medicaid eligibility

Why Reform the Individual Insurance Market?

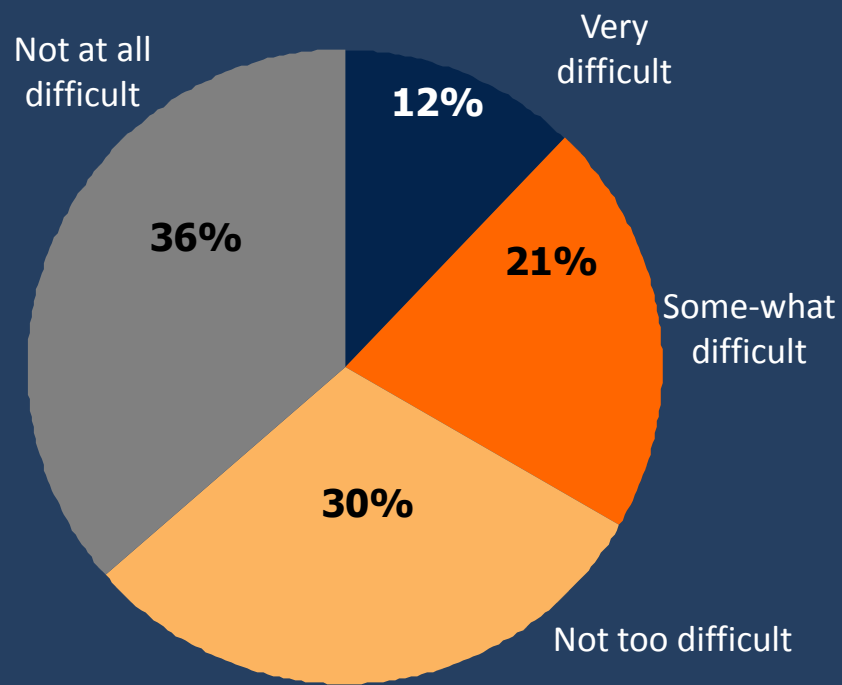
Reported Difficulties Paying for Health Care

How difficult is it for you to pay for your health care costs, including health insurance premiums and all other out-of-pocket costs?

Self-purchasers 2010



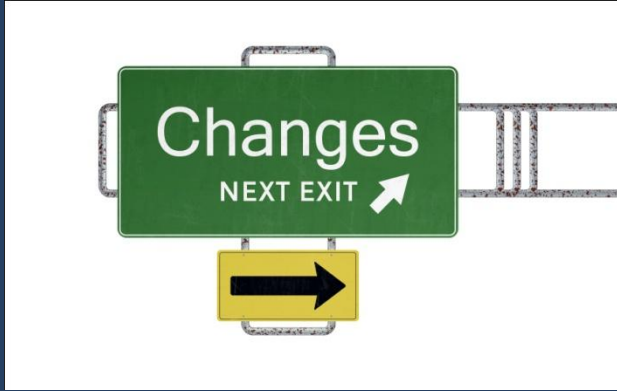
Employer coverage 2008*



*Note: Results shown for those ages 18-64 who say they have health insurance provided by an employer.

Source: NPR/Kaiser Family Foundation/Harvard School of Public Health, *The Public on Requiring Individuals to Have Health Insurance* (conducted Feb. 4-14, 2008)

Coverage Opportunities: The Exchange and New Private Insurance Rules



New Rules of the Road for Insurance Companies

Beginning in 2014: health insurance exchanges, new rating rules, and a range of new consumer protections

New Rules of the Road for Insurers

- Guaranteed Issue & Renewability
- Modified Community Rating
 - Based on age (3:1), geographic region, family size, and tobacco use (1.5:1)
- No pre-existing condition exclusions; in effect now for children and in 2014 for adults

New Rules of the Road for Insurers, Cont'd

- No lifetime benefit maximums
- No annual caps (being phased in currently)
- No rescissions except for fraud (in effect already)
- Qualified health plans must meet certain requirements (such as provider networks, uniform enrollment form, required reporting)

Restructuring the Insurance Marketplace: the Exchange

- Each state must establish an exchange by 2014 for the purchase of individual and small-group health insurance
 - The exchange can be a government agency or a nonprofit entity
 - States can establish an exchange for individuals and one for small businesses, or a single exchange for both
- If Georgia chooses not to establish an exchange, there will be a federal exchange

Restructuring the Insurance Marketplace: the Exchange

What is an Exchange?

- Insurance plans sold on the exchange must include “essential health benefits”
- Four tiers of value to facilitate consumer choice; insurers can offer plans in multiple tiers
 - Bronze: 60% actuarial value
 - Silver: 70% actuarial value
 - Gold: 80% actuarial value
 - Platinum: 90% actuarial value

The Exchange: Affordability Provisions

- Individuals can purchase health insurance on the exchange or outside the exchange, but tax credits are only available within the exchange
- Sliding scale credits that limit the percentage of income that can be spent on premiums:
 - Up to 133% FPL: 2% of income
 - 133-150% FPL: 3 -4% of income
 - 150-200% FPL: 4 – 6.3% of income
 - 200 – 250% FPL: 6.3 – 8.05% of income
 - 250 – 300% FPL: 8.05 – 9.5% of income
 - 300 – 400% FPL: 9.5% of income
- Credits also available to help with out-of-pocket costs

Coverage Opportunities: The Exchange

The Exchange in Georgia

- September 2010: Governor's Office of Planning & Budget received \$1M planning grant
- March 2011: Legislation to create an exchange was introduced but did not pass
- June 2011: Governor Deal issued an Executive Order creating the Georgia Health Insurance Exchange Advisory Committee
- December 2011: Final report of the Committee due
- 2012: Legislation expected

Pre-Existing Condition Insurance Plan (High Risk Pools)

- States could establish their own or allow Georgia consumers in their state to enter a federal pool; Georgia opted for the federal pool
- To qualify for coverage:
 - You must be a citizen or national of the US or lawfully present in the US
 - You must have been uninsured for at least the last six months before you apply
 - You must have a pre-existing condition

The Big Challenges: Structural, Budgetary, and Political Climate

- Need to coordinate efforts and invest in the process
- Difficult budget climate; federal \$ should be maximized
- Political climate: health reform is still a political hot potato

Structural Challenges: Coordinating a Transparent and Systematic Effort

To implement well, consider:

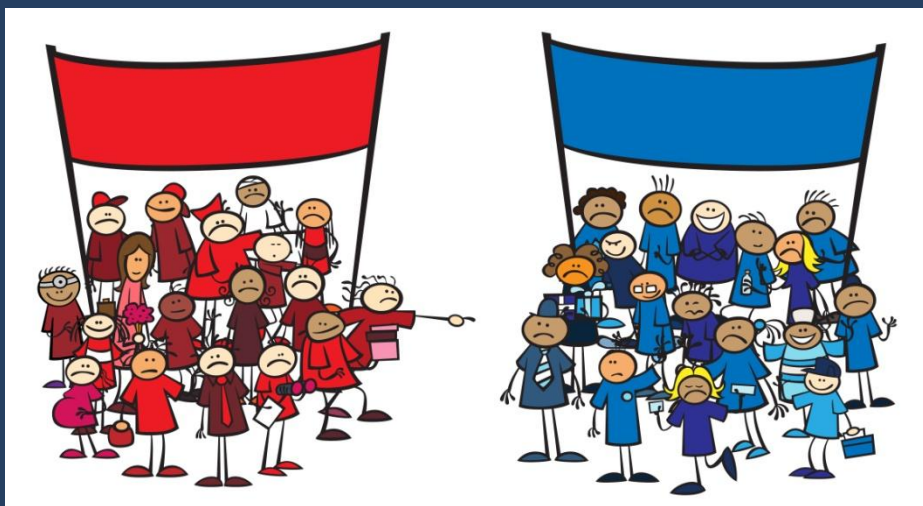
- Coordination between pertinent state agencies/Exec Branch commitment to process:
 - Department of Community Health (including Public Health)
 - Department of Insurance
 - Department of Human Services
- Stakeholder Input
- Local and Community Involvement
- Possible Legislative action

Structural Challenges: Provider Capacity, Systems Readiness

- Primary Care Physician Shortages in Georgia, particularly in rural areas
- Medicaid Provider Reimbursement Rates Relatively Low
- Need to ensure the newly insured get covered, stay covered, and get care

Political Challenges: Still Political Hot Potato

Need to move from here...



To here...



Questions & Follow Up



Contact me at:

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