

medicaid
and the uninsured

Addressing the Health Care Impact of Hurricane Katrina

On August 29, 2005, Hurricane Katrina inflicted massive damage on three of the poorest States in the country: Louisiana, with a poverty rate of 22 percent; Mississippi, with a poverty rate of 23 percent; and Alabama, with a poverty rate of 20 percent. Katrina also caused the evacuation of a major American city, where 23 percent of residents lived in poverty before the levees were breached. Of the 1.1 million Americans forced to leave their homes in New Orleans and other devastated areas, the majority appear to have relocated elsewhere within their States. Perhaps as many as half a million have been relocated to Texas and other States of refuge, many of which have high rates of poverty themselves (22 percent of Texans live in poverty).

Undoubtedly, Katrina has raised both the number of people in poverty and the number of uninsured living in the States hit by Katrina as well as in the States of refuge; the only issue is the magnitude of the increase. An estimated 400,000 jobs have been lost; many of those who lost their jobs have lost not only their source of income but also the health insurance coverage that their former employers offered. Hospitals, clinics, nursing homes, pharmacies, and other facilities have been damaged or destroyed. Areas that, prior to Katrina, faced shortages of needed health care providers now have either fewer resources or none at all. Underserved populations with substantial health disparities before Katrina are now at risk for falling even further behind the rest of America.

At this early stage in the recovery from Katrina, no systematic assessment of its impact on health care is yet available. The federal government has begun addressing the immediate medical needs of evacuees, taking actions such as establishing and staffing 40 emergency medical shelters in the region. However, as the magnitude of the damage caused by Katrina is better understood, the need for a thorough assessment of the ongoing health needs and resources available to meet them becomes clearer. This background issue brief is a first effort to begin that assessment and to review some of the policy options available to the federal government. The brief begins with a summary of the implications for the health of the population and its access to needed care. It then outlines the implications for affected States – those directly hit by Katrina as well as the States of refuge – and for health care coverage in those States. Finally, the brief looks at ways in which the federal government could respond. Given the evolving nature of the current federal response, this brief will be updated periodically to reflect additional developments.

Implications for Health and Access

Katrina threatens to lower the health status of Americans in the Gulf Coast region and to increase health care disparities among racial and ethnic groups living there. The situation is fluid and much of the information available at this time is anecdotal. Based on what we now know, it appears that the nation faces at least seven different but interrelated challenges:

- **Public health:** The flooding, and the extensive damage to drinking water and sanitation systems, have created new threats to public health in affected areas that require immediate attention. In addition, pre-existing public health efforts to prevent the spread of communicable diseases (e.g., the HIV pandemic) have been interrupted and need to be resumed as quickly as possible. The nation's chief public health officer, Surgeon General Richard Carmona, M.D., states that "these public health needs are going to be very, very large, and they are going to go on for some time."
- **Emergency / trauma care:** The emergency and trauma care capacity in the areas directly affected by Katrina has been destroyed or badly compromised and needs to be restored. For example, "Big Charity" Hospital, the largest public hospital serving the city of New Orleans, was also the Level I Trauma Center for the entire Gulf Coast region. The closest other Level I facilities are located 350 miles away in Birmingham, Alabama and Houston, Texas. In 2003, Big Charity handled nearly 144,000 Emergency Department visits. "Big Charity" has suspended operations altogether, and no decision has been made whether the hospital will resume providing emergency and trauma care after the City has been drained.
- **Primary care:** The capacity of primary care providers to serve low-income populations remaining in directly affected areas has been reduced or eliminated. For example, a primary care physician from a clinic on the Alabama coastline reported in an e-mail that "The town got a 25 ft surge. Of the 2300 pop in Bayou La Batre, 2000 have no livable homes. The building looked ok on the outside, however we got 5 ft of water and lost everything inside." Obviously such clinics will need to be repaired and restocked, and other clinics will need to be completely rebuilt. The National Association of Community Health Centers estimates that over 100 health center sites have been affected by Katrina, and at least seven centers and their multiple sites are completely destroyed. In addition, primary care providers in areas receiving those displaced by Katrina will need to increase their capacity to deliver services.
- **Medications:** The damage in directly affected communities like Bayou La Batre was not limited to the clinics. As the clinic's physician reported, "many of our patients lost their routine meds, diabetic supplies, asthma machines, etc. in the flood." Ensuring that those displaced by Katrina have continued access to the medications they need will pose major logistical and financial challenges. Many

of these individuals no longer have their prescriptions, their medical records have been lost or destroyed, and their physicians and pharmacists may have been displaced themselves. In addition, many are impoverished and uninsured. Failure to provide medications for those with chronic illnesses like diabetes and asthma and hypertension, or to those with acute mental health conditions, can result in health declines and the use of costly emergency room care or inpatient hospital services.

- **Acute hospital care:** As in the case of primary care services, the capacity of hospitals in areas directly affected by Katrina to deliver inpatient, outpatient, and emergency services has been compromised at a time when the need for these services has almost certainly increased. All but three of the hospitals in New Orleans remain closed and the hospitals that have reopened are only managing very limited operations. As noted, “Big Charity” hospital is no longer operational, and no decision has been made as to whether it will resume operations once the flood waters recede. Before Katrina, Big Charity served as the primary safety net hospital for tens of thousands of New Orleans residents, providing more than 25,000 discharges and more than 407,000 outpatient visits per year (including 144,000 emergency department visits) both at the hospital campus and through a network of satellite clinics. An astonishing 51 percent of its patients were uninsured and another 32 percent were covered by Medicaid. Hospitals located in communities receiving large inflows of individuals displaced by Katrina are facing increased demand. In Houston, for example, the Harris County hospital district has assumed responsibility for the health care of 23,000 evacuees living in the Reliant Astrodome. In Baton Rouge, hospitals are struggling to meet the health care needs of a population that has doubled in size.
- **Long-term care:** Significant numbers of elderly and disabled individuals in the affected States, whether displaced by Katrina or not, require home- and community-based care or nursing home care. However, in areas directly affected by Katrina, frail elderly and disabled individuals who were living in the community have in many cases lost their homes and their family and community supports and are now at much greater risk for needing nursing home care. In addition, nursing homes, personal care attendants, and other long-term care providers may no longer be providing services in these areas, and their patients may have been transferred to facilities in other areas. Long-term care providers in areas receiving displaced individuals will have to increase staffing and physician support in order to properly manage the increased need.
- **Mental health care:** The psychological stress and trauma caused by the destruction of homes, the loss of jobs, the separation of families, and the death and devastation surrounding those in the areas hit by Katrina will lead to increased need for mental health services. Many already suffering from mental health conditions may have gone days or weeks without needed medication and will need help in recovering and integrating into their new communities. The horrific conditions endured by many of those impoverished and displaced by Katrina puts large number of individuals at risk. Surgeon General Carmona cites

mental health issues as one of the foremost long-term challenges resulting from Katrina: “The psychological wounds are the ones that really go on for a lifetime and devastate people and affect their ability to reintegrate into society...The literature is clear, that after disasters of a much smaller magnitude, once people get back on their feet physically, divorce rates go up, suicide rates go up...These types of situational disorders that arise – depression, suicide, divorce rates, and so on – are to be expected.”

Impact on States

The brunt of the physical damage caused by Katrina was borne by Louisiana, Mississippi and Alabama and, to a lesser extent, Florida. Within each State are counties or parishes where the storm wreaked havoc and areas that were spared. The areas that were spared within these directly affected States have in some cases become places of refuge for those displaced by the storm. Baton Rouge, for example, has absorbed half a million evacuees and doubled in size. City officials estimate that the population of East Baton Rouge Parish has grown from 425,000 to roughly 850,000 in one week, stretching existing health facilities and other public infrastructure beyond their capacity. These States, then, face the multiple challenges of addressing the public health needs in the counties or parishes directly affected; delivering needed health care to the displaced; and ensuring the continued delivery of health care services to residents of the other areas.

Because so many of those displaced were impoverished before Katrina, and because many more have become impoverished, it is not realistic to expect those displaced, many of whom now have no income and no health coverage, to bear the cost of needed health care services. The ability of these States and localities to finance the provision of needed services is also problematic given Katrina’s damage to their economies. For example, the New Orleans area was home to more than half a million workers (nearly 1/3 of all workers in the State), nearly all of whom have been relocated, with the vast majority unable to work. The economies of both Louisiana and Mississippi have been greatly disrupted. Both States will likely lose revenue from the temporary shutdown of many industries located in the affected regions, including the oil, natural gas, refining, petrochemical, shipping and shipbuilding, agriculture and seafood industries; the shutdown of the Port of New Orleans; the destruction of the large casinos in Mississippi and New Orleans; and the collapse of the tourism industry through which travelers spent an estimated \$5.2 billion in Louisiana last year – mostly in the New Orleans area.

In addition to the massive intrastate migrations, Katrina has caused the largest interstate migration of Americans since the Dust Bowl in the 1930’s. Preliminary estimates are that, as of September 5, some 239,000 evacuees from New Orleans and other areas hit by Katrina were residing in shelters or hotels in Texas, 59,000 were relocated to Arkansas, and 13,000 to Tennessee. Many other States report receiving evacuees as well. Even the States directly hit by Katrina are experiencing in-migration; Louisiana officials report that their State has received Katrina survivors from Mississippi.

Most States of refuge are expecting more evacuees. It is unclear when or whether these displaced individuals will be able to return to their communities.

Many of these States of refuge, like Texas, had high rates of poverty and uninsurance prior to this influx. These States and their localities face the challenges of delivering health care to the displaced, many of whom are in poor health, while at the same time ensuring the continued delivery of health care to their own residents as well as administering their Medicaid, public health, and cash assistance programs. The economic effect of Katrina is likely to undermine the capacity of these States to meet this rapid, unexpected expansion in the numbers of impoverished people with significant health and mental health care needs.

Impact on Coverage

Before Katrina, 22 percent of Louisiana's population, 19 percent of Mississippi's population, and 15 percent of Alabama's nonelderly population were uninsured. In Louisiana and Mississippi, just under three fifths of the population had private insurance coverage. The difference in uninsured rates was Medicaid coverage: Mississippi ranked first in the nation, with 23 percent of the non-elderly population enrolled in Medicaid, while Louisiana ranked 11th, with 19 percent enrolled.

The principal States of refuge also had large numbers of uninsured residents before Katrina. Texas, the State with the largest numbers of evacuees, ranked first among States in the percentage of uninsured (28 percent). In Arkansas, 20 percent lacked health coverage. Tennessee, with only 13 percent of its population uninsured, is about to end Medicaid coverage for an estimated 190,000 currently enrolled individuals, many of whom will become uninsured.

It is likely that many if not most of those displaced by Katrina are now jobless, and many of those who lost their jobs will also lose their employer-sponsored health insurance coverage. Many of these evacuees are newly impoverished, and have chronic health care needs that will place additional, costly demands on the health care systems in the areas to which they have located, both within directly affected States and elsewhere. It is unlikely that, having lost their incomes, these evacuees will be able to afford to extend their employer group coverage by paying COBRA continuation premiums or replace their employer's policy with individual health insurance. In short, many previously insured individuals and families are likely to become uninsured as well as impoverished.

Many of those displaced by Katrina were uninsured, and large numbers were enrolled in Medicaid. For example, nearly two-thirds of Louisiana's Medicaid enrollees – over 650,000 low-income aged, disabled, and parents and children – lived in the impacted parishes as of August 29. Those individuals who have been relocated to other States will generally become residents of those other States for Medicaid purposes, since they will be living and looking for work there. Whether they qualify for

Medicaid in the State to which they have been relocated depends on the financial eligibility rules of that State. Those who are unable to qualify will likely be uninsured.

Medicare beneficiaries will also be affected by Katrina. Katrina struck just four months before the scheduled implementation of the Medicare Part D prescription drug program. Among the first to enroll in the new Part D plans are low-income elderly and disabled Medicare beneficiaries who are also enrolled in Medicaid, which is currently the source of their coverage for prescription drugs. As of January 1, 2006, their Medicaid drug coverage will terminate; they will instead receive drug coverage through Part D plans into which they will be auto-enrolled. There are over 360,000 dual eligibles in Alabama, Louisiana, and Mississippi combined. It is unknown how many of those have been displaced by Katrina or where those who have been displaced have relocated.

What Can the Federal Government Do?

Hurricane Katrina has created immediate dangers to public health. It has destroyed or degraded the capacity to deliver emergency care, primary care, inpatient hospital services, long-term care, and mental health care. And it has dramatically increased the number of uninsured and impoverished Americans. Addressing these problems will require significant funding. Because many of those displaced by Katrina are impoverished and unemployed, it is unrealistic to look to them as the source of this funding. Similarly, it is unrealistic to expect States and localities whose economies have been severely damaged by Katrina to share in this funding, at least until their economies recover. Federal assistance is, therefore, an important component of disaster relief.

The federal government already makes large amounts of health care funding available to the affected States. It pays for almost all Medicare benefits, the large majority of the Medicaid benefits, the entirety of the Veterans Hospital and Military Hospital care, the health care of its own employees, and provides large amounts of categorical funding for State and local public health activities and primary care clinics in urban and rural areas. These existing commitments need to be maintained if further deterioration in health care in affected States is to be avoided. But the existing level of funds will not be sufficient to repair the devastation caused by Katrina or to address the threats to public health and health care that it presents.

The federal government, building upon existing programs, can take immediate steps to address the loss of health care coverage; to repair the damage to the health care infrastructure; and to avoid a disruption of prescription drug coverage for displaced dual eligibles. The need for immediate action is underscored by situations such as the following one. As described by a Louisiana Medicaid official, an uninsured New Orleans resident with a growing brain tumor was scheduled for surgery at "Big Charity" Hospital. After Katrina forced the closure of the Hospital, the patient was referred to the public hospital in Baton Rouge, Earl K Long Charity Hospital, which in turn referred him to a

large private hospital with the capacity to perform the surgery. That hospital refused to take the patient because of his lack of insurance.

Addressing the Loss of Coverage. Because so many of those displaced by Katrina are impoverished, the federal government could adopt time-limited changes to Medicaid as a vehicle for temporarily assisting those without coverage. Medicaid provides insurance coverage and long-term care benefits for low-income Americans. It pays for a range of services, including public health services, primary and specialty care, prescription drugs, hospital care, and long-term care services, as needed by a beneficiary. Medicaid funds “follow the person” – that is, payments for services that are medically necessary to beneficiaries are made to the providers actually serving the beneficiaries. In this respect, Medicaid is the most accurate mechanism for targeting federal assistance to the areas, providers, and low-income individuals who most need it, regardless of where they are now living or where they migrate.

Most of the funding for Medicaid is federal, but a significant portion – ranging from 40 percent in Texas, to 29 percent in Alabama and Louisiana, to 23 percent in Mississippi – is paid by the States as their share of costs under program’s matching formula. If individuals displaced to other States by Katrina meet the financial and non-financial requirements for Medicaid eligibility in these States of refuge, they are entitled to Medicaid coverage in these States. Increasing Medicaid enrollment will place additional demands on the budgets of these States of refuge, because they are responsible for their share of Medicaid administrative and service costs for the displaced populations. At the same time, the displaced individuals who qualify for Medicaid will not be able to contribute to the tax revenues of these States until they have found employment. The resulting increased demands on State funds may lead to reductions in Medicaid eligibility, benefits, or provider payments for the entire population in the States of refuge.

In the case of the three States directly impacted by Katrina, one option is for the federal government to obtain legislative authority to pay 100 percent of the costs of Medicaid coverage for those impoverished or displaced by Katrina who are still living in those States. A broader option is for the federal government to pay 100 percent of the costs of Medicaid coverage for all Medicaid beneficiaries in these States, whether they were displaced by Katrina or not. Under either approach, the 100 percent federal matching rate would apply to the cost of services as well as administration. This temporary enhanced matching rate would be lowered to the State’s regular matching rate after a defined period of time or when the State economy has recovered sufficiently to enable the State to resume financing its share of Medicaid costs.

In the case of the States of refuge, the federal government could finance 100 percent of the costs of enrolling those displaced and impoverished by Katrina in Medicaid and of providing needed services to them. This would greatly reduce the financial burden of the Katrina displacement on the States of refuge and affected localities. It would also greatly simplify the ability of providers to receive reimbursement for services furnished to those displaced, since they need only bill their own State

Medicaid agency, with which they already have established reimbursement arrangements. The availability of Medicaid reimbursement, in turn, will help those providers meet the increased demand for emergency services, primary care, hospital services, long-term care, and mental health care. Raising the federal matching rate to 100 percent, even temporarily, will require Congress to enact legislation; the Secretary of HHS does not have the authority to raise a State's matching rate by waiver.

In order to make Medicaid work as a source of coverage for all individuals displaced or impoverished by Katrina in both the directly affected States as well as the States of refuge, current limits on program eligibility will need to be changed. Generally, Medicaid does not cover individuals unless they fall into certain categories – i.e., they must be children, parents of dependent children, pregnant women, individuals with disabilities, or elderly. Those adults who are not elderly, disabled, or pregnant, and who do not have dependent children, are not eligible for Medicaid, regardless of their poverty status. It seems likely that many of those displaced or impoverished by Katrina are childless single adults or couples, including older adults with chronic health conditions. To help these individuals, the federal government could make 100 percent federal matching funds available for the cost of furnishing Medicaid services to evacuees without regard to the categorical requirements that normally apply.

Normal Medicaid enrollment procedures and documentation requirements will not meet the need for rapid extension of temporary health care coverage to the hundreds of thousands of individuals displaced by Katrina. A streamlined enrollment process would greatly facilitate the coverage of Katrina evacuees. This process could be modeled on the Disaster Relief Medicaid program implemented in New York City during the months after 9/11, which provided eight months of continuous Medicaid coverage for over 350,000 New York City residents. Such a process could include a single page application form, self-attestation of residence and income information, and issuance of temporary Medicaid cards to eligible individuals at the time of initial application. To fully realize the benefits of the Disaster Relief Medicaid model, a single income eligibility standard could be applied to those displaced and impoverished by Katrina regardless of the State in which they are living at the time of application. In the absence of such a standard, each State will otherwise apply its own Medicaid income and resource standards, which vary substantially from State to State.

Repairing the Health Care Infrastructure. To help repair and rebuild hospitals, clinics, and other providers damaged or destroyed by Katrina, the federal government could make additional funds available through existing categorical grant programs. Some of these funds may be available through FEMA, although these funds are likely to fall short of the capital requirements for rebuilding the necessary infrastructure. Additional funds will be needed and could be channeled through existing programs.

For example, the federal government provides grant funds to health centers at over 3,700 sites in underserved urban and rural communities throughout the country; these centers provide primary care services to some 14 million low-income and uninsured Americans. Some of these grants funded the establishment and operation of

more than 100 health centers in or near the directly impacted areas. These operating funds are supplemented by reimbursements from Medicaid, Medicare, and privately-insured patients. The federal government could increase the amount of funds appropriated for this program to fund the repair or replacement of health centers damaged by Katrina as well as the construction of new sites in areas of need.

Another example of an existing categorical grant program is section 1011 of the Medicare Modernization Act, in which Congress provided \$250 million per year for four years to make payments to hospitals, physicians, and ambulance providers for the unreimbursed costs of delivering emergency medical services to undocumented immigrants. This program might be modified by adding new funds and targeting those additional funds on hospitals, physicians, and clinics damaged by Katrina to enable them to restore their capacity to furnish emergency and non-emergency services.

Avoiding Disruption in Drug Coverage for Dual Eligibles. Under current law, federal matching funds for Medicaid prescription drug coverage terminate on December 31, 2005. The assumption is that all dual eligibles will receive their drug coverage through Medicare Part D plans starting on January 1, 2006. Auto-enrollment of this population in Part D plans is scheduled to begin next month and to be completed by the end of December. However, the termination of Medicaid drug coverage will occur even if a dual eligible is not enrolled in and receiving drug coverage through a Medicare Part D plan on January 1. And, as part of this transition, States will be required to make monthly “clawback” payments to the federal government to help fund the costs of Medicare Part D.

Katrina displaced an unknown number of elderly and disabled dual eligibles. Many of these people are dependent on medications to function independently and remain in the community; the consequences of an interruption in drug coverage could be unnecessary hospitalization or premature nursing home placement. Simply locating and obtaining new contact information for these individuals over the next few months will be difficult for States and federal agencies. Enrollment of all of these individuals in an appropriate Part D plan by January 1 seems virtually impossible. To avoid a disruption in drug coverage for this population, the federal government could, at a minimum, postpone the December 31 termination of Medicaid drug coverage for all dual eligibles living in Alabama, Louisiana, and Mississippi for at least 6 months, or until they are successfully enrolled in a Part D plan, whichever is earlier. The same policy could be applied to all duals displaced by Katrina to another State. In addition, the “clawback” payments that States would otherwise be required to make to Medicare Part D on behalf of these dual eligibles could be suspended for this period.

Conclusion

The magnitude of destruction resulting from Hurricane Katrina is unprecedented in the U.S. Over a million people, many of whom are poor, elderly, and suffering from a range of chronic conditions and disabilities, have been displaced from their homes and are now relocated in other parts of their own States or are widely dispersed across the

U.S. The health care infrastructure in many of the areas directly hit by Katrina has been destroyed. In the wake of this disaster, three health issues have emerged that warrant an immediate national response: addressing the loss of health coverage by hundreds of thousands of impoverished Katrina victims; restoring the shattered health care infrastructure in the impacted areas; and avoiding further disruption in access to medications for dual eligibles.

The Medicaid program provides an immediate and practical solution for addressing the health care coverage needs of low-income survivors. Medicaid's availability in every state, coverage of a range of health and long-term care services, established payment arrangements with providers, and targeting of coverage to low-income beneficiaries make it uniquely equipped to assist the low-income individuals who need medical or mental health services quickly. Policymakers have already recognized that normal documentation requirements will be impossible for most Katrina survivors to fulfill and are taking steps to streamline enrollment.

Facilitating a quick and effective Medicaid response at the State level also requires the federal government to address two primary issues: the level of federal financing and eligibility for assistance. The federal government could support efforts to extend Medicaid to Katrina survivors by enacting legislation to temporarily provide 100 percent federal financing for those impoverished or displaced by Katrina to ease the financial burden on the States directly affected by the hurricane as well as the States of refuge where large numbers of evacuees are located. To extend Medicaid coverage to all low-income individuals displaced by Katrina, federal legislation could temporarily suspend current categorical limits on program eligibility, allowing the affected states to obtain full federal financing for health coverage provided to affected individuals. To facilitate the enrollment of those eligible, the federal government could allow States to streamline their eligibility procedures in the way New York City did in the aftermath of 9/11, and could establish a single income standard for eligibility that applies to those displaced by Katrina regardless of the State in which they are living.

The destruction of the health care infrastructure in Louisiana, Mississippi and Alabama will create challenges in delivering services, coordinating care, and assessing health status for residents who remain and return to these areas for years to come. The rebuilding process is likely to take significant time and investment. As Surgeon General Carmona has said, "these public health needs are going to be very, very large, and they are going to go on for some time." As the recovery effort progresses, it will be critical to carefully monitor the health impacts on Americans in the Gulf Coast region and provide periodic updates on the progress toward restoring health care in affected areas.

This brief was prepared by Andy Schneider of Medicaid Policy, LLC, and David Rousseau of the Kaiser Commission on Medicaid and the Uninsured, who thank the entire staff of the Commission for their help in preparing this brief.

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