After Katrina
Rebuilding Opportunity and Equity into the *New* New Orleans
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Initial Health Policy Responses to Hurricane Katrina and Possible Next Steps

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Hurricane Katrina destroyed much of the New Orleans health care system. With more than a dozen hospitals damaged and thousands of doctors dislocated, virtually all New Orleanians lost access to their usual health care providers. Individuals with acute or chronic conditions were particularly hard hit. According to U.S. government officials, 2,500 hospital patients in Orleans Parish alone were evacuated (Nossiter 2005). In addition, dialysis centers across Louisiana with caseloads of between 3,000 and 3,500 patients were destroyed, and only half of these patients were accounted for several weeks after the storm hit (McCarthy 2005).

The devastation of New Orleans' health care system was especially profound for the low-income uninsured, most of whom depend heavily on a handful of providers, especially Charity Hospital, one of the nation's oldest health facilities dedicated to treating the poor and disadvantaged. In many ways, however, the uninsured were no different from insured New Orleanians: both lost access to their usual sources of care. Importantly though, those with either private or public coverage were able to see providers elsewhere in the country and could be confident that, at least temporarily their care would be covered. By contrast, the low-income uninsured could not.

Although the immediate crisis has subsided, state and national officials, employers, and insurers must confront a wide array of difficult health care challenges in Katrina's aftermath. In particular, what happens to the individual who had insurance through an employer that is now out of business? How should care for uninsured individuals be financed? What happens to a Louisiana Medicaid beneficiary who evacuated to another state? How should the New Orleans's health care system be reconstructed, especially the safety net?

Focusing on the low-income population,

Long before the onslaught of Hurricane Katrina or the chaos of evacuation, New Orleans' social infrastructure was failing. News coverage of the overcrowded Superdome and the city's flooded streets exposed the poverty and vulnerability of many residents, especially African Americans. As New Orleans begins to rebuild, can the city avoid the mistakes of the past, instead creating more effective social support for low-income and minority residents? Innovation and experience from other U.S. cities offer promising strategies for reducing the risks of poverty and opening up opportunities for economic security and success. This essay is from an Urban Institute collection that addresses employment, affordable housing, public schools, young children's needs, health care, arts and culture, and vulnerable populations. All these essays assess the challenges facing New Orleans today and for years to come and recommend tested models for making the city's social infrastructure stronger and more equitable than it was before Katrina.

we examine some of the early responses to the many health care issues that surfaced in Katrina's wake. We also discuss some of the emerging issues that both private and public decisionmakers will face. We present background on basic health status indicators for Louisiana and an overview of health care use and patterns of health insurance in the state. We also highlight basic features of the state's Medicaid program and discuss some of the early health care policy actions by state and federal officials. We conclude with ideas about rebuilding the health care system for low-income people in New Orleans.

Background

Health Status

Although Hurricane Katrina created many health problems, a wide range of indicators suggests that Louisianans had poor health status even before the storm hit. According to the United Health Foundation's 2004 State Health Rankings, for example, Louisiana ranked lowest overall in the country (United Health Foundation 2004). It numbered among one of the five worst states for infant mortality, cancer deaths, prevalence of smoking, and premature deaths (defined as years of life lost to deaths before age 75 per 100,000 people). Louisianans also had among the nation's highest rates of cardiovascular deaths, motor vehicle deaths, occupational fatalities, infectious disease, and violent crime.

Health Care Service Use

While information on patterns of health care use is not comprehensive, available data document that Louisianans received more hospital care than residents of other states. For example, Louisianans, on average, were more likely to be hospitalized or to visit an emergency room or other hospital outpatient department, compared with residents of other states (table 1). In addition, hospitals in Louisiana were much more likely to be publicly owned and operated than in other states. Almost four out of ten hospitals in Louisiana were public hospitals operated primarily by the state, versus one out of four nationally. As for services rendered, public hospitals provided 45 percent of emergency room visits, 31 percent of inpatient days, and 36 percent of other outpatient visits. In all three of these service categories, the national average share provided in public hospitals was about 16 percent in 2003.

Louisiana's heavy reliance on public hospitals appears to be part of the state's strategy for serving its large uninsured population. As in other communities, public hospitals and clinics have been the providers of last resort for the uninsured in New Orleans. Historically, the city's uninsured received the bulk of their health care from Charity Hospital and its clinics, which were severely damaged by Katrina. This dependence on public health care facilities may also explain Louisiana's significantly lower use of federally qualified health centers (FQHCs), a common source of ambulatory care for the uninsured in many states.[1] For example, the number of FQHC visits per capita among Louisianans was only about 40 percent of the average state (table 1).

Insurance Coverage

Mirroring its high poverty rate, Louisiana's uninsured rate is among the nation's highest; only Texas and New Mexico have higher rates. To the extent that the hurricane caused drops in employment and job-based health insurance, Louisiana's uninsurance rate will increase. Data from 2003 and 2004 show Louisiana's low rate of private health insurance (62 percent versus 69 percent nationally; see table 2). Further, eligibility standards for publicly sponsored health

Table 1. Selected Characteristics of Health Care in Louisiana and the United States, 2003

	United States	Louisiana
Total population (in thousands)	290,810	4,496
Number of hospitals		
Total community hospitals	4,895	127
Total per 1 million population	16.8	28.2
Ownership distribution		
State and local government (%)	23	39
Not for profit (%)	61	27
Investor owned (%)	16	34
Hospital utilization and distribution by ownership status		
Total admissions per 1,000 population	119	154
State and local government (%)	13	32
Not for profit (%)	74	42
Investor owned (%)	13	26
Emergency room visits per 1,000 population	382	556
State and local government (%)	16	45
Not for profit (%)	71	30
Investor owned (%)	13	26
Impatient days per 1,000 population	676	861
State and local government (%)	16	31
Not for profit (%)	72	41
Investor owned (%)	12	28
Outpatient visits per 1,000 population	1,937	2,409
State and local government (%)	17	36
Not for profit (%)	75	45
Investor owned (%)	8	18
Federally qualified health centers (FQHCs)		
Total FQHCs (%)	890	16
Total per 1 million population (%)	3.1	3.6
Service delivery sites per 1,000 population (%)	42	19
Patient encounters or visits per 1,000 population (%)	170	65

Sources: 2004 Area Resource File; 2005 AHA Hospital Statistics; Kaiser Family Foundation State Health Facts.

insurance programs such as Medicaid were comparatively low, so public coverage only partially offset the low private coverage rate. While public coverage in Louisiana was common among children in low-income families, with about one out of two children (52 percent) covered through a public program, it was only slightly higher than the national rate of 46 percent. However, only 19 percent of adults in Louisiana's low-income families had public coverage, below the national average of 22 percent. The low rate of private health insurance and limited public coverage account for the state's high uninsurance rate, which was 22 percent, compared with the national rate of 18 percent.

Medicaid in Louisiana

Medicaid is a national program that provides insurance to some low-income Americans, including children and their parents, the disabled, and the elderly. Jointly financed by the federal and state governments, Medicaid is the nation's largest insurer and at the heart of state health insurance programs for the poor.

Within broad federal guidelines, each state designs its own Medicaid program, which makes for extensive variation in eligibility, service coverage, provider payment, and other program features. Louisiana has set strict Medicaid eligibility rules for parents, contributing to the state's low rate of public coverage for adults. For example, only working parents with family incomes below 20 percent of the federal poverty level (FPL) are eligible for coverage. Nationally, the median eligibility level for working parents is 67 percent of the FPL considerably higher than the level in Louisiana (Kaiser Family Foundation 2005).

Louisiana spent about $5.1 billion on Medicaid in 2004 (excluding payments for program administration), with about 74 percent ($3.8 billion) coming from the federal government (Kaiser Family Foundation 2005). The balance ($1.3 billion) came from the state. Louisiana spent about $3,251 per enrollee, 20 percent less per capita than the national average of $4,011, reflecting the relatively large share of children on its Medicaid rolls. In fact, nondisabled adults enrolled in Louisiana's Medicaid program had high health care needs and relatively high program spending per adult enrollee. Specifically, Louisiana spends about 30 percent more per enrollee on its nondisabled adults than the national average ($2,280 versus $1,736).

Louisiana's extensive network of public hospitals and clinics enabled the state to develop and maintain a large Medicaid disproportionate share hospital (DSH) payment program. DSH payments, supplements to basic Medicaid payments for hospital inpatient care that are designed to help hospitals providing a large share of services to Medicaid and uninsured patients, accounted for 18 percent of Louisiana's total Medicaid spending in 2003, much higher than any other state (Kaiser Family Foundation 2005).

Although DSH payments are an important funding source for safety net hospitals, requiring them to supplement payments for inpatient rather than outpatient care weakens a state's incentives to seek opportunities to move care from inpatient to outpatient settings. This distortion is particularly great when DSH payments comprise a sizable share of a state's Medicaid spending, as in Louisiana's program. Moreover, centering health care for the uninsured and Medicaid beneficiaries around inpatient and other hospital-based care is likely to be less efficient and effective at delivering quality care than relying on community-based care. However, federal rules limit DSH payments to hospitals and thus can sometimes skew state investment away from other parts of the health care system.

Table 2. Health Insurance Coverage of the Nonelderly, by Age and Income, 2003–2004

		Percent distribution by coverage type (%)				
		Private		Public		
	Total (millions)	Employer	Non-group	Medicaid/ SCHIP	Other	Uninsured
Total, nonelderly						
United States	253.9	63.6	5.4	11.0	2.3	17.8
Louisiana	3.9	56.4	5.6	13.9	2.6	21.5
Low-income children						
United States	33.3	30.7	3.5	44.3	1.5	19.9
Louisiana	0.7	26.1	3.4	51.3	0.6	18.7
Low-income adults						
United States	55.7	29.8	7.4	17.6	4.7	40.6
Louisiana	1.0	28.9	6.6	13.9	4.7	45.9

Sources: 2004 and 2005 Current Population Surveys.

Early Responses to Hurricane Katrina

Immediately after the storm hit, health care and emergency services providers worked feverishly to get patients out of harm's way. The loss of health care facilities spurred creative solutions ranging from using the Louis Armstrong New Orleans International Airport as both a triage center and temporary morgue, to constructing mobile treatment centers in commercial parking lots, to installing medical equipment in athletic arenas and vacant stores, to deploying navy hospital ships to the New Orleans seaport (Moller 2005; Romano 2005; Upshaw 2005). In addition, the federal government established and staffed 40 emergency medical shelters in the region (Schneider and Rousseau 2005).

The State of Louisiana also quickly implemented policies to ensure that its Medicaid program continued serving beneficiaries (Baumrucker et al. 2005). One move was issuing temporary cards to beneficiaries who lost theirs in the hurricane. The state also waived all prior authorization requirements, so that any in-state or out-of-state provider willing to accept Medicaid payments from Louisiana could render services to beneficiaries. In addition, Louisiana stationed Medicaid workers in FEMA Family Assistance Centers and shelters to help prospective beneficiaries fill out necessary application forms. To free up staff to deal with the anticipated surge in new applications, the state also postponed eligibility recertification for current enrollees.

Federal officials also began crafting a strategy to provide health services to persons affected by Katrina, especially those with low incomes. Medicaid emerged as the center of the federal strategy (Baumrucker et al. 2005; Park 2005), but the Bush administration and Congress disagreed on the approach. At the heart of the discussion was whether to provide temporary, fully federally funded Medicaid coverage to low-income individuals affected by Katrina (including childless adults and others not typically eligible for the program) or to work within current Medicaid structure. Some senators endorsed the broader strategy, while the administration favored the state-focused approach, which was the policy ultimately implemented.

Medicaid Waivers

The administration opted to rely on state Medicaid "waivers"—in particular, Section 1115 waivers. Under Section 1115 of the Social Security Act, the secretary of Health and Human Services has broad authority to waive certain Medicaid statutory requirements, including eligibility rules and the delivery and coverage of services. Three weeks after Katrina, on September 16, 2005, the administration issued a new waiver initiative under Section 1115 aimed to help states provide temporary Medicaid coverage to Katrina evacuees.

However, given Medicaid's unique federal and state partnership, structuring a waiver policy to cover program beneficiaries who moved across state lines posed a challenge to federal officials. Using an expedited review process, the new waiver policy allows host states to cover selected groups of evacuees for up to five months, during the period of August 24, 2005 to June 30, 2006. The waivers also established uncompensated care pools to help pay for services furnished to uninsured evacuees and Medicaid beneficiaries not covered by the host state's program. As of January 2006, 17 Katrina waivers had been granted.[2]

Under Katrina waivers, states can follow either eligibility guidelines suggested by Health and Human Services (HHS) or the Medicaid eligibility rules of an evacuee's home state. To date, most of the waivers use the HHS guidelines, which for Louisiana

represent an expansion in eligibility. For example, Louisiana's parent evacuees with incomes up to 100 percent of the federal poverty level ($19,350 for a family of four in 2005) are now covered in host states whereas under regular Louisiana Medicaid rules, only parents with incomes up to 20 percent of the poverty level would have been eligible. Benefits provided under waivers to Katrina enrollees are the same as what the host state's Medicaid program normally offers, though states are free to offer a more limited package.

For the coverage component of the Katrina waivers, host states do not have to provide additional Medicaid funding. States must simply report their costs for evacuees through the standard joint federal-state Medicaid funding procedures to get fully reimbursed by the federal government. Eventually the home states will have to reimburse the federal government for the share of evacuee costs that they would have paid for beneficiaries who were residents of their states before the storm. Few details on how this part of reimbursement process will work are known; however, the home states of Louisiana, Mississippi, and Alabama have signed memoranda of understanding agreeing to repay the federal government for their share of evacuees' Medicaid costs. As mentioned, some Katrina waivers allow states to establish uncompensated care pools to reimburse health care providers who supply "medically necessary services and supplies" to Katrina evacuees without health care coverage.[3] The pools can also be used to pay for care provided to Medicaid beneficiaries beyond what host states cover.

The nonfederal share of host states' Medicaid and uncompensated care costs will come from a combination of FEMA's National Disaster Medical System funds and a special appropriation made under the recently passed Deficit Reduction Act of 2005. Specifically, the appropriation provides a limit of $2 billion in federal aid across all of the states that received Katrina waivers. The federal government's financial obligation is not open-ended, as would be the case normally for Medicaid, but is akin to a block grant. As of this writing, it is unclear if the limit on federal funding provided to states will impose a real constraint on payments made through the Katrina waivers for the nonshares of Medicaid costs. In addition, given the connection between Medicaid and the uncompensated care pools, the funding levels for the pools and the distribution of funds available for this purpose among the states remains unclear.

Problems for the Privately Insured

Individuals with private health insurance also faced numerous problems in Katrina's aftermath. Many individuals had employer-based private health insurance but lost it along with their jobs. Most private health insurers tried to ease the immediate impact on their enrollees (America's Health Insurance Plans 2005) by, for example, giving people more time to pay premiums, dispensing with rules such as those requiring prior authorization and referrals for specialty care, and for payment purposes, treating all providers as if they were "in network." However, such provisions had expiration dates that have now passed. Many insurers reinstated their usual protocols, especially vis-à-vis premium collection. Individuals and employers who do not resume premium payments are likely to see coverage lapse.

The Senate drafted legislation to help cover some premium payments for private health insurance. Under a September 2005 proposal (Senate Bill 1769), premiums for small businesses (with not more than 50 employees), their employees, and individual purchasers of health insurance would have temporarily been shouldered by the

government. But the legislation never came before the full Senate, and there has been no direct federal policy response aimed at privately insured individuals affected by Hurricane Katrina.

Rebuilding the Health Care System in New Orleans

The responses to Hurricane Katrina so far should be viewed as efforts to simply stabilize a chaotic situation. The community's ongoing recovery will also require immediate consideration of public health needs and the development of new approaches to service delivery in New Orleans.

Short-Run Needs

Environmental hazards and community mental health needs present major public health concerns. The environment is damaged by sediment, including high concentrations of heavy metals (e.g., arsenic), petroleum components, and pesticides. The State Department of Environmental Quality and the federal Environmental Protection Agency (EPA) have been evaluating and will continue to evaluate these factors before areas are resettled. Press reports suggest that state officials are urging federal agencies "to issue a clean bill of health," but the EPA is still engaged in testing in some areas (Brown 2005). Private testing done by environmental groups has raised questions about the state's conclusions regarding the safety of some areas (Natural Resources Defense Council 2005). Some of the toxins that might be in the sediment could put the population at a higher risk of contracting certain cancers, neurological problems, and kidney or liver damage.

In addition to these physical problems, serious mental health conditions are also likely in communities that experience catastrophes on the scale of Katrina. It is common for people to exhibit symptoms related to Post-Traumatic Stress Disorder in situations like this one. However, when people go through major disasters, they also often struggle with major depression and other longer-term psychological problems (Lister 2005). New Orleans must deal with these public health challenges as it begins to rebuild, by ensuring a safe environment to its public and increasing the availability of mental health services, especially to uninsured low-income individuals.

Longer-Run Needs

The health care challenges now faced by New Orleans would be repeated in other parts of the country if a natural disaster struck. Without exception, every state and city have some uninsured individuals who typically rely on publicly subsidized clinics or hospital emergency rooms for their health care. Further, Medicaid beneficiaries anywhere would face similar problems getting care if they evacuated to another state. In short, if a disaster of similar proportions struck New York City, Chicago, Houston, Los Angeles, or any other major city, low-income people would lack ready access to health care services in much the same way that New Orleans' uninsured did when Katrina hit.

Given the current uncertainty surrounding New Orleans' fate, it is difficult to predict what the city's health care system will look like in the future. At the same time, health care is a basic service and central to any reconstruction effort. Indeed, reliable and comprehensive health care services are absolutely essential to attracting people back to the city.

Decisions about building an efficient, practical health care infrastructure in New Orleans should be driven in part by the number and circumstances of the people who return. What is their age distribution? Income

distribution? Employment status? The kinds of economic activities that take root in the city are also key considerations, as are the type and number of returning health care providers. For example, will the city be largely a service-based economy in which relatively few businesses offer employer-sponsored insurance? How many and what type of physicians will establish practice in New Orleans? Enough to staff a major medical center or a trauma center? Also, the level of federal and state financial support will be a determining factor in reconstruction. Finally, what political and health care leaders envision for the city will be key in the rebuilding. Whatever decisions are made, the result should be a system capable of meeting the health care needs of the returning population, especially the most vulnerable among them.

One policy response to coverage problems would be to expand public insurance to all low-income individuals regardless of their household status or to subsidize the purchase of private coverage. But, since the federal government has already rejected broad short-term expansions of Medicaid coverage in the wake of Katrina, any longer-term federally financed expansion seems unlikely. Alternatively, the state could expand coverage, but Louisiana has not historically opted for broad eligibility in its public insurance programs. Also, given the negative fiscal impact Katrina has had on the state, a coverage expansion even partially financed by Louisiana seems remote.

Assuming that near-universal coverage is not politically or financially feasible, the silver lining in the destruction of New Orleans is the new opportunity to design a health care system that meets the needs of residents more efficiently. In rebuilding the health care safety net, local officials will most likely prefer to lead with their strength by working with Charity Hospital, long the heart and soul of New Orleans's indigent health care system. In fact, Louisiana State University's Health Care Services division, administrator of Charity Hospital, favors using any FEMA money available to the city to build a new hospital that has been in planning for a decade, rather than renovating the current damaged facility (Connolly 2005).

If a repaired or rebuilt Charity Hospital is at the core of the health care rebuilding efforts, there are several directions that policymakers could take. More particularly, federal and state disaster relief funds could be used to build a new Charity Hospital, more or less maintaining the basic features of the city's pre-Katrina safety net. An alternative is to build a safety net based on a continuum of care to low-income residents, moving away from New Orleans' hospital-centric system. One decentralization option might be integrating a network of community clinics with a new but smaller Charity Hospital. The aim would be to substitute timely ambulatory care for some more-costly episodic use of hospitals (especially emergency rooms), thereby increasing efficiency and quality while lowering costs. This type of reorganization has worked in other cities, including Tampa, Florida, and Boston, Massachusetts (Bovbjerg, Marsteller, and Ullman 2000). In fact, even before Katrina hit, Louisiana officials had submitted a waiver request to federal officials seeking permission to redirect part of Louisiana's Medicaid DSH dollars away from public hospitals to support more locally driven health care initiatives that emphasize primary and preventative care, among other things (State of Louisiana 2005).

More broadly, the city could combine organizations such as the public health department, social services, or school-based clinics that already exist within standard health care services to provide a fully integrated system. Denver took this approach in the 1990s (Gabow et al. 2002). Systems like Denver's offer the entire spectrum of care and

tap into a wide range of diverse funding streams. For example, a rebuilt health care system in New Orleans could incorporate more FQHCs as a way of attracting more federal dollars to support the safety net and care for the uninsured.

The scale and the scope of the damage from Katrina will make rebuilding Louisiana's health care safety net a massive undertaking. But with the immediate post-storm chaos now over, the state and the nation have a rare chance to design a high-quality, efficient health care safety net that could serve as a model to other cities.

Notes

1. FQHCs are nonprofit, consumer-directed health care corporations that provide comprehensive primary and preventive health care services and either (1) receive grants under the U.S. Public Health Service Act (i.e., Community Health Centers, Migrant Health Programs, Health Care for the Homeless Programs, Health Care in Public Housing Programs, Indian Tribal Health Centers, Urban Indian Centers) or (2) do not receive these grants, but meet the standards for funding (see http://www.nachc.org).

2. The 17 waivers are for Alabama, Arkansas, California, the District of Columbia, Florida, Georgia, Idaho, Indiana, Louisiana, Maryland, Mississippi, Nevada, Ohio, Puerto Rico, South Carolina, Tennessee, and Texas.

3. Centers for Medicare and Medicaid Services, 2005, Waiver approval letter to Mr. Albert Hawkins, Texas Health and Human Services Commission, September 15.

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