THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED

"NEW MATERIALS RELATED TO HEALTH COVERAGE AND HURRICANE KATRINA"

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OPERATOR: This is the Diane Rowland call with the Henry J. Kaiser Family Foundation for 9:30 a.m. Eastern time on September 9, 2005. Thank you very much for holding. We are now ready to begin. We have do have Diane Rowland online. Your lines are in a listen-only mode. We'll be taking questions later in the call with instructions given at that time. I'll now turn the call over to Diane Rowland. You may begin.

DIANE ROWLAND: Thank you. And thank you all for joining us this morning for this briefing on health coverage in the wake of Hurricane Katrina. The purpose of today's gathering is to really try and highlight the health situation in the wake of Hurricane Katrina, and to really look at some of the challenges being faced by the affected states, by the low-income residents of those states who depend on public coverage or largely go uninsured for their healthcare, and on the states that are the states of refuge where the evacuees have been taken.

We really want to review for you the situation now in Louisiana. And we're very pleased that we're going to be joined on this conference call by Ruth Kennedy, who is the Medicaid deputy director for the State of Louisiana. She is in Baton Rouge, and is going to try to highlight some of their progress in coverage for children, some of the challenges they faced in coverage for their low-income population, what the scope of coverage was on the eve of the storm.

And we're posting statistics today on our website, www.kff.org that show you the Medicaid enrollment on the eve of the hurricane by parish so that you cans see where the individuals in the affected areas are. And Ruth will highlight some of the challenges ahead for us.

We'll then be turning to Barbara Edwards, the deputy director of the Ohio Department of Health and Human Services, to speak with us a bit about some of the implications of the hurricane for state Medicaid programs across the country, and especially for those where the largest numbers of evacuees have gone.

And then I'm going to turn to Jeanne Lambrew, the associate – an associate professor at George Washington University, to really bring us up to date on some of the kinds of proposals for assistance that are under consideration, and thought it's evolving every minute, what the state of play is with trying to provide assistance on the health side to the individuals in the affected states as well as the state of refuge.

I think we need to bear in mind as we think about this, just the tremendous disparity in access to care and in healthcare coverage that existed on the eve of this hurricane, and what the implications are for some of the nation's poorest states. And in Louisiana alone, 22 percent of the population was under the poverty level. That is about $16,000 a year for a family of three or $1,300 a month. Most of those individuals

obviously today are totally without income and totally dependant. One-third of the children in Louisiana lived in poverty.

We also know from work that I have had the good fortune to work on along with Jeanne Lambrew on a taskforce the governor for Louisiana set up some 18 months ago that Louisiana ranks 50th in terms of the health status of its population and high rates of diabetes, asthma, heart disease, AIDS, real health challenges that were being faced by the state. Twenty-two percent uninsured, 19 percent of the population on Medicaid in the State of Louisiana, large dependence on the charity hospital system, which has basically been wiped out by the storm – other states, Mississippi, Alabama, also suffering severe loss of both individuals and infrastructure.

And so today I really wanted to be able to bring some of these issues to light to help you as we weather the storm of Katrina and the coverage from it to keep in mind the health issues and especially the coverage issues that are so important in many of the low-income individuals affected by this storm, and to the people trying to help them in their states.

So I am going to turn it now over to Ruth Kennedy to really give you from the ground a view of what Louisiana was trying to do, what they had achieved, what is happening now, and what some of the issues are for the future. And then turn to Barbara and Jeanne, and open it up to your questions as well.

Now, Ruth, why don't you take it from here?

RUTH KENNEDY: Thank you, Diane. To start with where we were, when Governor Blanco took office in January of 2004, she made health reform one of her top priorities, recognizing the poor health status, and the high number of uninsured people in the state. Ironically, the Thursday before Katrina hit, August 25, the governor held a press event to celebrate the dramatic decline that we have seen in uninsured children in the state. It was 25 percent in the late-'90s and we now have it in single digits. And she also urged parents who still had uninsured children to apply for Medicaid or LaCHIP.

The census data that was released last month indicated that the percentage of uninsured children in Louisiana has actually been reduced to 8 percent. It is actually below the national average for low-income children – 6.8 percent of low-income children under 200 percent of poverty are currently uninsured. That was pre-Katrina. And of course all of that now is at stake, that progress.

The governor had made expanding coverage to children a priority but she also recognized the plight of parents of those children, adults. The state covers working parents only to about 20 percent of the federal poverty level. And that translates to about $270 a month for a family of three. If someone has income higher than that, that parent is not eligible for coverage.

So we know that Medicaid has worked for kids in Louisiana. We have done significant work not only in identifying and informing and enrolling eligible kids, but in keeping them enrolled. So to see that no child loses coverage as long as they are eligible. We are very aggressive. We have actually simplified the process not only for applying but for renewing. We don't even require a signed renewal form. We can do a review of eligibility by phone. We do a – we call people if they don't send paperwork to us. We use other systems. So by doing that, we have been able to reduce the number of children who lose coverage solely because of some procedural reason, so less than 5 percent statewide. And that was well over 30 percent before we started that initiative.

Where are we now? Well, as of August 29th, we had just under a million people in Louisiana with Medicaid. And two-thirds of those were living in areas impacted by Katrina. Now, in addition to that, hundreds of thousands of people, many of them with very, very low income – not to speak of the working poor – have no health insurance at all. Because of Katrina and the displacement, many more people are now eligible for Medicaid due to the loss in their jobs and income. Before the 29th of August, they would not have been eligible. Now they have no income and are eligible.

Another thing that has become increasingly evident to us is that many of the people who have evacuated, either who are in shelters or who evacuated in their own vehicles are staying at hotels and with friends, that they have significant unmet health needs, and they need to be enrolled for health coverage as soon as possible.

Because of the poverty in the state and the historical act of primary and preventive care, many people in Louisiana with major unmet health needs, it appears to us that they are people who would have qualified all along for Medicaid. All they would have needed to do was pursue and apply, and for whatever reason they have not done so.

Many of our current enrollees have been displaced and so – in our other states. It is not only the adjacent states. I personally handle calls – grabbed ringing phones the last two nights. One was from a woman – she was in Cincinnati with her sister with three children, not previously on Louisiana Medicaid, but wanted to know how to – if she could get Medicaid. Another from someone in Los Angeles, who was calling for his 89-year-old mother, who does have Louisiana Medicaid but had gone to a pharmacy down in Los Angeles and just was not able – didn't know what to do to be able to get her medicine. So I want to emphasize that, that it's not only just those directly adjacent states, or even states in the South here where these evacuees are going to be going.

As far as administratively, we have about 880 Medicaid eligibility employees. Of those 221 are in areas, live in areas where they cannot return to their homes. They are displaced for the long term. We have actually only been able to contact or been contacted by 53 of those. And of those 53, 11 are out of the state. What does that mean? That in addition to this exponential increase in our workload, we have significantly reduced our workforce.

In the northern half of the state, above I-10, that was not directly impacted, we are now getting large numbers of displaced people from Mississippi who are moving there seeking medical assistance, as well as our own from Louisiana. People evacuated did not take any documents with them and those documents – they cannot get that. They are exposed to additional physical and mental health risk. The public health infrastructure in New Orleans – the safety that New Orleans Charity Hospital has traditionally provided is gone as well as all of our other safety net providers and regular providers. So there are so many difficulties here.

Our concerns at this time: first, time is of the essence. To me each day that passes without us knowing and other states knowing exactly what the Medicaid relief package is going to include is adversely affecting not only our state and the evacuees but other states who are getting our evacuees. We are concerned about the continued loss of jobs and income and the economic fallout, which we believe is going to be major here. The fact our Medicaid recipients are being increasingly dispersed all over the country and the infrastructure –

The last thing that would mention is our Medicare – people who receive Medicare and the implementation of the Medicare prescription drug plan that was – is scheduled for January or 2006 – all of the essential pieces of mail such as the 2006 Medicare new handbook, which is scheduled to be mailed in early October – because of the relocation of this population, they are not going to be getting mail, whether they are full-dual eligible or whether they get Medicare only. So that is an issue also that we feel – that is one of our concerns.

And with that I will turn it over to Barbara.

DIANE ROWLAND: Thank you, Ruth. And, Barbara, I think Ruth is giving you a good way to kick off your comments.

BARBARA EDWARDS: Yes, Ruth has done a great job of pointing out the reality of what really began happening the day of the storm and even before the storm. States all over the country have already reported evacuees moving into the state. Even states that haven't yet had any official airlift through the FEMA organization know that we have – and that includes Ohio – we know that we have people in the state.

Ruth mentioned someone in Cincinnati. We are hearing from people all over the state, from our caseworkers. We're hearing from nursing homes. We are hearing from local community action agencies. The folks that are coming in Ohio right now are coming either on their own because they are coming to family or they are being brought through local organizations that have reached out and brought people in. One of the challenges of that is that we don't have any central information about who is coming, who is here, and that makes sort of a different kind of challenge in terms of responding.

With regard to responding to the official evacuation efforts, states have been very active in coordinating across multiple health-related agencies – health departments,

human services agencies, public safety agencies, mental health agencies – to bring together response teams that can greet people literally as they come off the plane to provide on-sight healthcare, short-term emergency triage, get people referred into a healthcare system, to find a provider longer term.

There is a lot of thought and a lot of effort going into this, including mobilizing volunteer clinical staff in various areas. And, again, that sort has been – seems to be working pretty well in many states. The bigger challenge in some ways is dealing with the folks who are coming in on their own or through unofficial sources where there isn't that kind of an organized response team available for people when they get there.

Obviously states are being impacted very differently. A state like Texas, which has hundreds of thousands of people that have shown up and need immediate help, even Louisiana that is reporting getting evacuees from Mississippi seeking help, those states are just inundated with the demands – the logistical demands and the financial demands. Across the country, the rest of us are getting folks in the hundreds and the thousands are trying as well to respond.

CMS has been working with us, with states, and has suggested that they are going to create a Medicaid option for states to create an 1115 waiver that would be processed very quickly by the regional offices, would be allowed to reach back to a retro-effective date, which is not the way 1115 waivers normally are allowed to operate. It would be a time-limited program that would – with the intention of allowing states to act very rapidly to get healthcare cards into the hands of individuals and families.

It is clear that states – in my conversations with states that many states are assuming that if people come from Louisiana, Mississippi, Alabama, with a Medicaid card from that state, or that we can – or can self-declare that they have been on a Medicaid in that state that they would be deemed presumed to be eligible for Medicaid in the host state for this temporary program.

More challenging is figuring out what to do with all of those folks Ruth was describing who before this disaster were not covered by Medicaid health coverage but now need it and qualify for it, because we then have to figure out how to process them through an eligibility. That is a conversation that is ongoing with CMS in terms of what waivers states can have, what standards states could use. It is clear that CMS and states are contemplating self-declaration. We recognize that people were not able to show up with documents and official kinds of information on income and citizenship, and, again, the reason for thinking for thinking of this as a temporary program.

There is another – two outstanding questions in addition to what eligibility standard states can use. The first one is whether or not states are going to receive 100 percent reimbursement from the federal government to reimburse states for the cost of these populations that are showing up. And it is obviously critically important for states like Texas that have such huge numbers of folks – remember, states can't run deficits; we

have to have a balanced budget so we can't borrow to cover the costs of this emergency. So states are working hard to be able to accommodate the needs of these folks.

And the second issue is what about folks that are not categorically eligible under the Medicaid health plan. The people who are needing health services as they come out of this disaster include a lot of folks who don't fit any of the categories of Medicaid eligibility, particularly adults that don't have dependent children, but who aren't old enough to qualify as aged and may not have a disability that could be documented. So that is another question that is being discussed with CMS at this point. It sort of points out one of the complexities of trying to use Medicaid, the Medicaid framework as an emergency health response for people who have been broadly affected, not just those who fit in neat little categories of the program.

Longer term, I think most states are contemplating that as folks move out of the temporary program, they would then need to either move through the regular eligibility termination processes for the host state, or in fact recognize that some of these families may be relocated to other states or back to home.

I think that I'll start there and let folks move on to hearing what some of the proposals are that folks are contemplating.

MS. ROWLAND: That is great, Barbara. And I think one thing we all ought to bear in mind is that the health needs of this population probably just substantially increased in terms of the stress, the trauma, the mental needs, as well as the effects of going for some of the chronically ill without medication or a substantial amount of time.

MS. EDWARDS: We are absolutely hearing that. We certainly heard that from Louisiana and Mississippi and Alabama early in this situation where they were reporting that states who were receiving evacuees needed to be prepared for the fact that not only were folks coming out of nursing homes, or out of group homes for mental health or MR consumers, but were in fact clearly going to find a lot of folks, who, because they have now lost their home in the community are in need of some sort of higher level care whose health status has declined because of the trauma, and that people really need to be prepared for the fact that the population, at least short term, are going to be much more fragile than the normal Medicaid population.

MS. ROWLAND: Jeanne wanted to walk us through the state – (inaudible).

MS. LAMBREW: Sure, and I'll just basically talk quickly about current law and what can and can't be done, talk about proposals that were introduced yesterday, and talk about the major policy issues that are at play.

Starting out with current law, the administration has, through waivers and policy guidance, tried to do as much as it can, meaning trying to waive some of the burden of documentation and presumptive eligibility rules, clarifying interstate payment agreements so that if a person from Louisiana goes to a different state, there is some way to pay those

providers from Louisiana to those other states, and provider rules, so that providers who ordinarily wouldn't be certified to provide care to Medicaid beneficiaries could do so in this emergency situation.

However, there is a limit to how much the government can do without legislation. This issue of who pays is clearly a major one. The government cannot fully finance the care of these individuals without legislation, and there are other areas of rules that would need to be changed by law in order to be in effect.

So, given that there has been lots of discussion on Capital Hill about what healthcare legislation would look like, yesterday there were two proposals introduced. One was the Reid (?)-Landrieu bill on the Senate side. The other was a Dingell-Pelosi and the delegation bill on the House side. The bills are largely the same; the only real difference is how long they last.

I will say, in addition, Senator Lincoln took the Medicaid piece of this and made it an amendment to the Commerce, Justice appropriation bill that was being considered yesterday. It did not have a vote, so we had no action on it yet. So, effectively there is one temporary disaster relief Medicaid piece of legislation out there. That legislation has three major parts. The first is, how do you care for Katrina survivors?

A Katrina survivor in this legislation is any individual who was in one of these emergency-designated counties or parishes in Louisiana, Mississippi or Alabama, or people from those states who have lost their job as a result of the hurricane. So this is a national category called Katrina Survivors. Those people will be automatically eligible for Medicaid no matter where they go. If Mississippi people go to Louisiana, Louisiana people go to Ohio, these Katrina survivors will be automatically eligible for Medicaid in whatever state they apply.

The rules for how you get into the program would be dramatically simplified – a single simple application. The documentation will also be waived. There will be some attempts on the state's part to verify that – (inaudible) – these places, but it basically is a very simple process, simple application. And per Barbara's – (inaudible) – the costs of these people will be fully federally funded – 100 percent federal SMAP, as the term is in Medicaid, for these Katrina survivors no matter where they get care. I will say it's also 100 percent administrative costs because the states have really had an administrative challenge in finding these people and getting them in.

So piece one is Katrina survivors. Piece two is how do we affect the states that are affected by this? For Louisiana, Mississippi and Alabama, for their regular programs they would receive 100 percent federal funding for a temporary period of time. Why is this? You heard Ruth talk about the fact that the needs of their existing population are swelling at a time when their state revenue base has declined significantly. So, the legislation was saved for those directly affected states. The federal government will, for this duration, pay 100 percent of their Medicaid costs.

In addition, legislation would cancel the scheduled declines in the matching rate in Medicaid that will go into effect on October 1 without any change to this law. This is to reflect the fact that gas prices have gone up. There is a general economic effect of this hurricane. So the scheduled decline and the federal matching rate scheduled for October 1 would be cancelled.

And the third major piece had to do with what Ruth mentioned at the end, which is putting aside what happened last week, there has been this scheduled implementation of the Medicare drug benefit, which is a major administrative tasks for states. Given what's happened with the state residents moving, the challenges that Ruth faces with her clearly diminished workforce, this will be for those directly impacted states, so that Mississippi, Louisiana, as well as the ones that have experienced signification influx of these evacuees. Named in the legislation are Arkansas, Oklahoma, Texas and Florida. These states would also not have the required end of Medicaid matching payments or dual eligible drug benefits. They would not have to immediately pay that call back payment to finance the Medicare drug benefit. They wouldn't have their residents having to prove that they have – you know, their assets test for the new low-income drug benefit, the documentation requirement could be waived. And there is a – (inaudible) – penalty for this Medicare drug benefit. That also was delayed.

So lots of kind of technical issues but basically the required scheduled implementation of the Medicare drug benefit would be delayed in these states.

So that's the crux of this legislation. I would say a couple of things about the potential proposals that are coming out. Barbara mentioned this idea of CMS seeking enhanced waiver options. There are other proposals I think that people are contemplating. There are three big issues that the policymakers must grapple with. The first is this issue of who is eligible. The legislation introduced yesterday creates a national category, so a Katrina survivor, no matter where they go, is eligible.

There are two alternative options. One is what we've seen in Texas is that they're using Texas's own eligibility rules. So where people go may determine how they get eligible. So if you go to Minnesota, you might be eligible. If you're – (inaudible) – at one level, you go to Texas, you may not be eligible because each state has different eligibility rules.

So an alternative option is destination state eligibility rules. Whip that around, you also could conceivably apply the home state eligibility rules. Ruth has been getting some questions about Louisiana's eligibility rules in Medicaid. One option being considered is to say a person in Texas or Minnesota or Ohio would only be eligible if they would have been eligible in Louisiana, depending on where they come from. Either options is being considered and they have clearly different implications for who gets help and what the requirements are for people like Barbara in different states for how they determine that eligibility.

The other question is how they're covered. We're primarily talking about Medicaid today but I think there have been discussions about trying direct services type of programs. You could imagine that CMS could create some sort of program to fund hospitals or clinics to really try to provide this care. This creates its own set of questions and issues – will the right hospitals or clinics get that reimbursement, is it a new program, how will that really be managed – versus Medicaid because actually we have all those rules in place already.

And a third major policy question is how is this care financed? Medicaid is a matching-payment program, meaning that the federal government will match whatever the costs are that are incurred. So if – (inaudible) – Louisiana because of what's been going on, the federal share will be higher. Vice versa – if it turns out that Ohio doesn't have as many people, the matching payments would be lower.

So, given the fact that it was hard to document who is going where and how this would work, Medicaid funding will fluctuate, versus a fixed grant program. So if you went through a FEMA grant or some sort of – (inaudible) – grant program, that will be more difficult to calibrate because you're trying to, in advance, figure out what may go on. And frankly, in waiver programs, if you look at the waiver authority that the administration is considering, those waiver agreements have in their so-called terms and conditions, which is the document that people have signed to really make this effective. Budget numbers: typically those are capped waivers, so that a state would have to kind of in advance agree on the maximum amount of federal funding. We don't know if that's going to be in the waiver authority that the administration is granting, but if it is, it really makes a difference for whether or not the states that need the funding get that full federal funding, or if they're going to have waiting lists or other sorts of ways to ration care for these Katrina survivors.

And the last thing I would say, there is kind of this larger question about Congress versus the administration. It's an interesting time in the administration versus congressional relations, with lots of – what do they call it? The blame game is I think is what they're – even on TV now – who is responsible for what? Congress I think has been – the question in the Medicaid legislation is will Congress create a program or will Congress delegate to the administration the creation of a program? If CMS is coming in or the administration is coming in and saying, we want waiver authority, what they're effectively doing is saying, trust us; we'll do it. And I think that in this current climate, that's going to raise policy as well as political questions.

So I think I'll stop there because my colleagues on the phone are the ones you probably want to talk to.

MS. ROWLAND: Thank you very much. I think we've heard quite a number of issues raised here, and I think it's time to really queue up the questions for people who are on the phone. And we have some people with us as well. So let's turn to the operator to queue up the questions and then lets get going in terms of your questions. Please direct

them to a particular speaker if you would like to, and please identify yourself when you ask the question. Thank you.

OPERATOR: Thank you. At this point, if you would like to ask a question, please press star 1 on your touchtone phone now. Questions will be taken in the order in which they were received. Anytime you would like to remove yourself from the questioning queue, please press star 2. Again, if you have a question, please press star 1.

The first question comes from Marilyn Serafini with the National Journal.

Q: Hi. I have a question. We've talked a lot about how we're going to give coverage to people, but I'm wondering how, in these affected areas that have lost clinics, that have lost community health centers, that have lost hospitals, how we actually get the physical plant back, how we actually get the doctors back in place, how we actually get the true, real delivery of the care.

MS. LAMBREW: This is Jeanne. I would just say that we have definitely been focusing in this conversation about providing medical assistance to individuals. There are people certainly discussing this and trying to figure this out. But the truth is we do have existing mechanisms. I mean, FEMA grants could be, in part, used for this by different states. There are different authorities that this could be done through. And I think that, given what Ruth said, which is every day that passes these people potentially are going without assistance, the priority has been on this, and then we're going to go to the rebuilding.

There have been waivers through this 1135 emergency waiver authority to allow doctors, nurses and other providers to help provide care in these states, and I think that that's been – and Ruth could probably speak to this about whether or not that's worked.

MS. KENNEDY: One of the things to note, that is still law, and very much an issue is that we're not only talking about the safety net providers and those providers who provide healthcare to our Medicaid population but also to people who have health insurance and who have the means to pay. All of that concentration of healthcare providers in the greater New Orleans area, they're incapacitated right now.

So that is – I know that the CDC, and as Jeanne mentioned, FEMA, are very much involved. The folks who work in public health are working on that. Now, that's not my area so I'm not really prepared to speak to that other than just what I hear on the periphery like you all do.

MS. ROWLAND: Okay. Next question.

Q: This is for Jeanne. Is there any way to estimate how much this 100 percent SMAP or the other costs for providing care are going to be? And the second question – I open it up to the folks on the phone – the president seemed to say yesterday, just basically, send us the bill and we'll figure it out later and everything will be taken care of.

Does that give you any comfort that these providers will be paid, and do you have any local estimates of how much you think this is going to cost for the federal government to kick in for these costs?

MS. LAMBREW: I'll speak a little bit to the costs, having looked into at least the – (inaudible) – thing pre-hurricane costs. If you look at Louisiana and Mississippi and Alabama and look at what the administration actually projected, they would be spending in the year 2006, without this all happening, the state share of those costs would have been a little bit less than $4 billion. Whether or not that will increase or decrease – I mean, there is this challenge, which is people are leaving, so some of that $4 billion is going to be costs that go elsewhere, but at the same time, as Ruth mentioned, people are moving from Mississippi to Louisiana. So what exactly the cost of care in those states is going to be is a big question mark. So that's $4 billion is the state share of the Medicaid costs pre-hurricane.

Then the costs of these Katrina survivors who leave is a big question mark. If you've been trying to follow the numbers question, we really don't know yet. I mean, I've seen documented numbers – and this is in the issue brief – of people who have literally gone to evacuee sites of about 300,000, but some are claiming up to a million people. So, you know, if we're talking about a million people who need healthcare, that could be in the range of – at the maximum, I guess, $6 billion depending on Medicaid costs, because Medicaid is one of the more efficient programs out there, so it wouldn't cost necessarily as much, but we don't know their healthcare needs. So I think it's less than 10 billion – probably significantly less than 10 billion, but I've not seen any official estimates.

MS. KENNEDY: One of the challenges that we have with doing projections on the cost is that we have no history that we can use, and what's apparent to us is that the data that we have on our expenditures for our enrollees cannot be used for projections because the utilization is going to be greater for this population because of the increased acuity of their condition. Their needs are greater as a result of this, so we can't use our historic costs for purposes of projection.

MS. : And as Ruth had pointed out as well, this is going to be a much larger group of people potentially needing help because so many people's income stream has stopped.

MS. : Yeah, and I actually want to pause and say that's if assistance were provided for a full year, which the current legislation introduced in the Senate really is a six-month provision, and there is an extension if the need persists. The legislation introduced in the House – the only difference between the two is the House would say that assistance will continue for a year or stop earlier if it's not needed. So one is six months with an extension; the other is a year, and it could stop earlier if needed.

MS. KENNEDY: This is an observation that I'm going to make, is that the costs for long-term care are – within the Medicaid program, long-term care costs are the

biggest driver. What we are seeing is individuals who their long-term care needs were being met by natural supports – by family in a home. Now that they not in that home, the family is not able to care for them and so they're entering our long-term care system. And so this is unprecedented and something that neither Louisiana or any other state has experience with.

MS. : I think that's a hugely important point, Ruth. People have lost all of that community support, both in terms of housing and in terms of the family and friendship support that they were getting.

MS. ROWLAND: Is there another question from –

Q: I just wanted to just follow up with that second question – do you take comfort in what the president was talking about yesterday, basically send us the bill and –

MS. EDWARDS: This is Barbara. I think many states heard the president's message yesterday as an answer to the question, will there be 100-percent reimbursement for this emergency response? I think the challenge is going to be that we heard that but that was after having heard from the administrative agencies that in fact they weren't able to do that. So I think we still don't – I think it was reassuring to many states but we really are very much wanting to know, how will you do it? Is it going to take an act of Congress? Can the president issue an executive order and cause that to happen? And so we'd like to sort of see the rest of the answer, but I certainly have heard from many of my colleagues who were happy to hear the president make that statement.

MS. KENNEDY: There is going to be a dramatic difference what the income standard is for eligibility. Is it going to be the income standard for the home state? If so, the income standards for Louisiana are very, very low: 20 percent for people who have earned income; even less if their income is unearned. If a woman gets child support of $250 a month and she has two children, she's not going to be eligible because her income is over 13 percent of poverty.

MS. : Again, I think states are very concerned about this whole issue of people who don't – that the people who need health coverage, it's going to be a larger group of people than those that might technically fit any one state's category of Medicaid eligibility, and that's an issue that we're still asking for guidance on, or in some cases, asking that the federal – the temporary program, many states believe ought to be tasked more broadly than a Medicaid program would be cast. And again, that probably takes congressional involvement.

I also think that while this sounds mundane to talk about, the technical issue of getting 50 state programs able to quickly respond absolutely requires that whatever these answers are are simple. They cannot be complex, because if I have to reprogram my computer systems in order to support what Congress does or what the administration allows us to do, that could take a year. So we've got to do something that is simple and straightforward, and we've got to sort of resist our worst instincts – (chuckles) – as

bureaucrats on this and as auditors on this because we're going to have to have some way to do this in a straightforward matter.

MS. ROWLAND: Right, and I would say the legislation that was introduced yesterday did have this one simple category, no resource test, no income test. It was just if you're one of these people from one of these places, lost your job from one of these states, you are eligible. I will say it's interesting because there is growing bipartisan support for this and it's coming from these states who are experiencing this. There was a letter from Senators Hutchinson and Cornine yesterday from Texas who basically in the letter said, we need to have a waiver from these eligibility rules. We need 100 percent matching rate. We need this assistance quick.

MS. : I think the other thing to keep in mind, and Reese, you might want to speak to this is, Medicaid has historically required documentation of who you are and what your income is, and as you mentioned, many of these individuals left without any documentation at all. And I think this is an area where the usual rules, as Barbara put it, won't apply, because these individuals won't have it.

MS. ROWLAND: And it even goes beyond that because, do you count a home or a car that is left behind? Do you count bank accounts that may be somebody's only source of resources if they're unemployed for six to eight months? I mean there's a lot of – even the usual rules, if you try to think through them, don't really apply in these circumstances.

MS. : Well, and how do you deal with issues of reliability? I mean many states require that people help pay their costs, particularly if they're higher income but needing the nursing home care. Again, will people's income streams have been disrupted even for people who are retirees who have social security checks, who have other kinds of income coming in, will they have access to it in the short term? There's a lot of complexity here, which is why it's very important that we get the parameters of this nailed down now so that we can begin working through those issues to get these cards in people's hands. I think Texas was particularly articulate about this a week ago about how critical it was that they be able to begin getting people coverage, and because the answers weren't available, it's been very difficult. States are kind of having to take a leap and do something and hope it's going to fit into whatever eventually gets done and I want to stress that this is an issue of people now needing help, not in three months or six months when we can figure this out.

One of the things that's been very challenging here, and it's something that didn't happen with the 9/11 disaster, was people leaving, crossing state lines. And in fact, Medicare as a vehicle for this is awkward because Medicaid is 50 – 54 if you count the territories – different programs. They have a common framework and they have a common federal parameter but they are literally administered separately. Medicare might have been a better vehicle for a national response, and many states have raised that question to the feds. Why not use Medicare? I think the challenge is that Medicare

doesn't provide the scope of benefits that Medicaid does, including this long-term care needs that is such a big part of the needs of this population.

MS. ROWLAND: Question from in the room?

Q: That last response is actually a nice segue way into my question, which is I am struck by all of the different rules and different dates and the complexity of solving these problems, and I wonder if you think this would be easier to respond to if we had a national health care system?

MS. : Well, I'll be brave, yes. (Laughter.)

MS. : Actually, I don't even think it's really a question of bravery. (Chuckles.)

MS. : But I mean this is desperate times. I mean you have people, I think, the public, and people who have clearly demonstrated sympathy for these survivors trying to figure out how do we care for these people. It doesn't matter, you know, if they're from Mississippi or Alabama. It doesn't matter where they go. I mean doesn't it make sense for us as a nation to say, people in need should get access to basic mental health care, basic health care, basic hospitalization care. I think this is a reflection of a larger set of issues and I think that America's ability to kind of support this sort of effort will be an indication of do we really want to reconstruct our safety net?

MS. : Certainly a disaster like this shows you all the cracks in our health care system, and we've talked here about low-income population. I mean there's a whole nother set of issues that I've seen for people with HIV/AIDS and the implications for the ADAP programs that are trying to provide drugs for them, and the Texas ADAP program I know has set up a whole new set of guidelines because they've got large numbers of people now going onto this capped program to try and get assistance for their drug medications that they need to live with HIV/AIDS. So this really shows us all the pieces of our health system and how fragile it really is when something like this occurs, and especially fragile for the low-income population that don't have the resources to either travel out of the state during an evacuation or provide for their own care once they're gone. And we are seeing this devastation hit in three states that are very low income that have large low-income populations that have had a large dependence on public coverage for coverage, have large uninsured populations, and relied on the safety net. And so the infrastructure is gone, the health coverage is gone, and what we're really talking about is building at least for the evacuees a national health system that will work in whatever state they end up in.

MS. KENNEDY: And I think I want to reiterate – this is Ruth – the vulnerability of those individuals who did evacuate before Katrina hit, in their own vehicles who are staying sometimes as many as fifteen or twenty in a hotel room or we're getting reports from our employees that they're at some relative's but can't continue to stay, or that they're in a hotel room and can no longer continue to pay the hotel, so these people are

very, very vulnerable who are not in the more formal support system in an official shelter. They are facing increasing obstacles here and difficulties.

MS. : And as you point out, particularly in doing even simple things like getting a prescription refilled, first of all, they may not have the records of what their prescription was, their meds may not be with them, they've got a Medicaid card that doesn't work in the state they're in. That's why we've got to – as states have been pushing – we've got to be able to answer these questions now and get these cards out to folk.

MS. : And just to add one little thing, which is this is where when you think about those potential policies that Congress will be considering, will waivers address that? Will they lock in 50 state programs or will they really kind of facilitate them through a national response? Will they receive eligibility? Will it be maintained? I think that's still an open question. Will there be some new program? I mean this Congress is ambivalent about Medicaid as a vehicle for doing this. I mean will there be some new program or will it build in the existing system? These are all, I think, the policy questions we'll be grappling with in the coming days.

MS. KENNEDY: And I think as you review the action Congress and the president are going to take, we've hopefully given you some of the criteria that you ought to think about. Who is being helped and who is being covered? How is it being paid for? How is it going to fill in for some of these major cracks in the health care system? What really is providing the kind of assistance to make people whole again, as we've heard from the – (inaudible) – for this initiative?

MS. ROWLAND: And can it be implemented quickly enough to be of any use to anybody?

MS. KENNEDY: Quick and simple.

MS. ROWLAND: Yes. There is a question here.

Q: This is Kevin Faraki (ph) with the Associated Press. Have you all done any ballpark estimates of how many more people you believe will be eligible for Medicaid as a result of the storm? Is it going to be in the millions?

MS. KENNEDY: Well, if you add up the – the number would be less than that. The number that we had submitted to – the CMS had asked us for this information. We're thinking, you know, maybe roughly – and this is just very, very rough, maybe 125,000 people. And it all depends on what that eligibility criteria is. But even in our own eligibility limit, 13 percent of poverty for parents and not covering any adults without minor children, our projection is 125,000. So that would not hold true if we were to make it available to more of those people in need.

MS. EDWARDS: I mean this is a good example. In Ohio, our parent income test today is 100 percent of poverty.

MS. KENNEDY: Whereas it's 13 percent in Louisiana.

MS. EDWARDS: So again, that's one of the questions that people are wrestling with is whose standards? And whose standard will then answer how many of the people get help. And Ruth, as I recall, on the eve of the storm, there were some 850,000 people in Louisiana who were uninsured.

MS. KENNEDY: That's correct, and we have the third highest total percentage of uninsured. Now, for children, we've done a significantly better job because we cover children to 200 percent of poverty. And we demonstrated that we can identify and enroll those people. But –

MS. EDWARDS: But Ruth, I think one of the things that we're also trying to deal with again on this issue of who is covered, and part of the reason I think we ought to be thinking simpler is, to the extent that you can safely presume that anybody that had a job in New Orleans doesn't have a job that is paying them income right now –

MS. KENNEDY: That is correct.

MS. EDWARDS: Well, the fact is, they're all below anybody's standard of income.

MS. KENNEDY: Even employees of the state of Louisiana., our employees, they're guaranteed payment. The division of administration says that they will be paid through September 30th. Beyond that, it is unknown. They will not be able to return to work in New Orleans for months, so they could possibly be without work, without a paycheck after September 30th. That's an unknown at this point.

MS. LAMBREW: We had done the health insurance issues with that. You know, there is global continuation coverage that most of these people – some of these people will be eligible for if they're in large employers, but already some work in this area has proven that can be really hard to figure out how to do that. If these people are moving, if you try to figure out how you get the information to them, it's typically done through mail, mail addresses.

MS. EDWARDS: Well, and if they don't have income to pay the premium costs, I mean God lord.

MS. LAMBREW: Exactly. So can they – I mean average premium for employer-based health insurance is $10,000. Or it was last year, and so that $10,000 is a high price to pay for these families who just lost their jobs.

MS. EDWARDS: So here we're talking about states including Mississippi and Alabama with large numbers of people who were poor before Katrina and a whole new class of people who have lost their jobs and become poor as well, and a set of programs that were stretched thin to begin the Medicaid programs for adults, especially limited in this space that now we have millions of people who are at risk of being low-income, uninsured, and displaced from their homes and their jobs.

MS. KENNEDY: And I would also – we've focused on the income limit for parents, but the income limit for those people who are over age 65 or who have a disability, Louisiana covers those individuals to 74 percent of federal poverty or $579 a month. If your income is more than $579 a month in Louisiana, you are not eligible for ongoing regular Medicaid if you're in the community. Now, a number of states cover that population to 100 percent of poverty so that's another difference there where the significant I think because we see the health needs in this population, their health has been dramatically affected, both people who already have disabilities and were elderly.

MS. EDWARDS: And unlike families that are working age, a lot of these folks, whatever their income stream is, is in fact an income stream that continues, presuming they can get access to those accounts.

Q: One follow-up – how is America's health care system responding to these people who don't have documentation? Are pharmacists filling prescriptions? Are nursing homes in Arkansas taking these people in? Or are a lot of people, are they unable to get the health care that they need.

MS. EDWARDS: This is Barbara. From what I'm hearing, it's both. In some cases, providers are providing the service. We've certainly had calls about people that can't get their insulin prescriptions filled because they don't have a health card or cash that works in this state. We have also been getting phone calls, and I know that Texas and Arkansas and those states are working to get people admitted into the nursing homes as they come in and need those care. We know that we've got people being brought to Ohio that need nursing home care. And again, the providers are seeking assurance from the state that they're going to get reimbursed through Medicaid.

MS. LAMBREW: So the admissions, I think, are taking place in places like nursing homes, but with the states being asked to assure that there is going to be a reimbursement.

MS. KENNEDY: Where it's more spotty is just, for example, being in Los Angeles and trying to get your meds refilled.

MS. EDWARDS: The pharmacies generally don't give credit.

MS. ROWLAND: Okay, next question.

MS. KENNEDY: A fantasy – until that person until there is relief here for other states that would make it possible for them to enroll them in their own state's Medicaid program with their own state Medicaid providers, there is the Medicaid eligibility factor of residents, which means if a person is in California and states that they intend to return to Louisiana, then they are a Louisiana resident and California could not certify them for Medical. Which means that in order for that California pharmacy would have to enroll as a Louisiana Medicaid provider in order to be reimbursed. And that is the reason that it's so important that every state be able to enroll these folks in their state's Medicaid program with their Medicaid provider network. It's important first and foremost for those people who are relocating so that they can get quick access to services and then to the states as well.

Q: I was curious. This is Sarah Lee (sp) from the Wall Street Journal. I was curious to hear from Barbara and Ruth what – if you could shed any light on what your hearing from CMS officials, what sort of is their direction in trying to solve some of these problems and also just what do you think about how the idea of a waiver, an 1115 waiver of some type would work?

MS. EDWARDS: CMS is, in fact, proposing to create an 1115 waiver that would be expedited in terms of processing, would be retroactive, which is again, not what they normally do with a waiver, and which would allow states to waive a lot of these eligibility barriers, including things like documentation, residency, some of those kinds of issues, for a temporary program. So CMS is working on that task. They were working on a template that they could give to states that they hoped would make it easier and more standardized in terms of how it would be reviewed. I think it's the devil in the details is still what – and I think we'd like to think we're going to get the final on this this week so that we can move, but I think that there are still these issues of is there going to be 100 percent indemnification? Will there be ability to cover non-categorical groups? Whose standards? Can we use the host state or do we have to use the home state? What is going to be the expectation, and we've got to get clarity on that for us to be able to pull any triggers in terms of us actually being able to process.

Q: And that was something they were planning to do without legislation?

MS. EDWARDS: Yes, right now CMS is trying to figure out what they can do without legislation, and that's why these conversations about what Congress might do are very interesting, but again, we need to know quickly because if you start down one path, the fact that there then becomes a new option is a mixed blessing. We'd really like to know which path we're on. In the meantime, a lot of states, including Ohio, are telling our county case workers that people are coming in and asking for help, try very hard to figure out a way to get them into Ohio's Medicaid program. But again, that's without any of our standards being waived, so it would be – we could do this better if we could get a waiver.

Q: Question that why I think Congress is interested in doing this.

MS. EDWARDS: Yes, I think CMS has, at least to date, indicated that they don't believe they have the authority to do that.

Q: So this would have been a waiver under the current matching rate in the state.

MS. EDWARDS: Right.

MS. LAMBREW: Which obviously does not give the state the extra federal assistance that would come from 100 percent match, but as I understand it, the one piece of the Medicaid statute that can't be waived is the matching limit.

MS. EDWARDS: And in fact, CMS, at least at this point, is telling us they don't believe this waiver could be used to bring in non-categorical groups, which again is an issue then of people who, if they don't meet one of the slots in Medicaid, there will be people we have to turn away.

MS. KENNEDY: Which would largely apply to childless adults and to parents in some cases where, depending on what eligibility standard issues.

MS. EDWARDS: Although I would just say, that's a policy choice, not a legal choice, because states have used 1115 waivers for exactly that purpose. This is how the state of Maine, for example, has covered childless adults up to I think 125 percent of poverty at this point. This is – waivers, 1115 waiver have specifically been used in the past for covering childless adults. So to the extent that the administration is saying no to that, that's a policy call, not a legal call.

Q: And how would the budgeting have worked, Barbara? Do you know what they were thinking? Would it have been a certain amount that the state would have had to use or a time limit? How would it have worked?

MS. : I'm not sure what you mean by budgeting.

MS. : I mean, if it's a waiver, doesn't it have to be limited in the money that can be spent?

MS. : Well, I don't know. CMS has indicated to us that they would presume cost neutrality so that states wouldn't have to document cost neutrality, which is part of what sometimes takes, you know, many, many, many months in negotiating that. But, you know, the point you raised was a good one about, would it – because you're right. 11, 15 waivers generally gives the federal government a guaranteed upper payment. And that's really not been the – I'm not aware of what the answer to that one is.

MS. : I just want to say, I mean, I keep hearing that what we might see is the administration asking for legislative authority for a waiver authority. So they may kind of come to Congress and say, well, we want 200 hits (?) to a waiver, but give us 100

percent matching. That will lead, I think, the state back to the same question, which is, you know, what do it mean for eligibility? What does it mean for these non-categorical people – the childless adults? What does it mean for budget neutrality? As it is, we have had, you know, over a decade's worth of, you know, congressional questions about how Congress has used its authority going back to the early '90s when Oregon was doing its 11-15 (?) waiver. And so there's always this tension, and so the Congress comes, you know – the administration coming to Congress and saying at the time of emergency give us more of this power. I think, you know, it'll be interesting to see how Congress reacts.

MS. : And I will say that, while I think CMS offering a waiver is what they believe is the best they can do at this point, I do think it's fair to point out that many states express frustration at the thought that 50 different states have to file 50 different waiver requests with several different regional offices rather than there being some sort of a national program where you just say, yes, I'm going to do that. And the parameters are set and everybody knows the rules from the beginning. You know states are in different places. I think from many of us, though, we just would like to know what the rules are going to be so we can move forward with some confidence.

Q: Hi, I'm Christina from Hearst Newspaper, and I'm wondering if there's any hope for generosity to be shown by private healthcare providers to the people that they insured that have now temporarily or permanently lost their jobs?

MS. : Are you asking about the case that people may be losing their health insurance?

Q: Right. If they had health insurance before the storm that now are not currently employed or not receiving paychecks – I mean, is there any hope that for a certain amount of time that they'll continue to be covered.

MS. : That's a great question, and I don't know how private insurers will – well, I mean the fact is that means that the premiums won't be paid for these folks.

MS. : (Inaudible) – the only anecdote that I've heard is about employers, not insurers. There was one, I think, one of the casinos in Mississippi – Harrod's – had said it was going to cover its employees, pay their employees' wages and health insurance, I think, for 90 days. Wal-Mart said three days. I mean, different employers have different policies about how much they're going to continue both payment and their employee benefits. But I think it's just hard to document.

MS. : But the response appears to come from employers and not from the insurance companies saying, we'll wave premiums and cover people for – (inaudible).

MS. : We have heard, of course, that providers themselves have been trying to chip in, you know, with – you know, there was a story in today's New York Times about HCA helped evacuate – (inaudible) – in New Orleans. Some of the drug companies have

been, you know, donating supplies to for these affected areas. But, again, it's all very anecdotal.

MS. : I've heard the same things that, you know, even some of the larger pharmacies or even some of the local pharmacies, again, might make a choice that if someone is an evacuee to fill an emergency prescription or to give somebody, you know, some help. That really is at a provider level, and I'm confident that many providers would be willing to give some – some of them obviously are even volunteering to go and work and go to the affected areas to relieve those providers that have been working non-stop there. But I don't think that's an organized effort. I mean, the volunteerism is, but I don't think that what doctors do in their private offices and what hospitals do – it's going to be something that's hard to document.

Q: I was curious about the Medicare drug benefit, and I wanted a little bit of clarity. Is there definitely going to be a delay in getting the eligible enrolled in some kind of coverage? And do you think the residents of the affected states who would be getting the drug benefits through a standalone plan or through their, you know, employee or retiree coverage – do you think they will be affected as well?

MS. EDWARDS: You know, I think that – I was intrigued that the though that the relief on – or the sort of putting off the effective date and the penalty dates was only be contemplated for states viewed as being most significantly impacted. I would just point out that to the extent that the people who have left those states to move to other states temporarily might find themselves with no drug benefits at all, even they are covered by Medicaid because the Medicaid benefit in Ohio is going to stop January 1st for dually eligible people. And if I haven't been able to identify that person to get them into the assignment to an Ohio plan, they won't have coverage.

So I guess people are thinking about the fact that Medicaid coverage stops on January 1st for people that have Medicare coverage regardless of where they are living.

Q: And, Barbara, the legislation as I read it would say because that individual is a Katrina survivor, they will qualify for 100 percent federal matching payment even for drugs.

MS. EDWARDS: So my Medicaid system has to figure out how to identify them and keep paying their drugs, even though they are in a category for which I am shutting off that benefit. (Chuckles.) That is a technical problem that we have got to know about because I have got to figure out how to make that happen.

MS. KENNEDY: There are two issues that is actually – this is Ruth. One is for those people who have both Medicare and Medicaid, who have been displaced. They are – but they are not going to get any of the important correspondence that is going to be coming in the next few months. They were scheduled, if they have not chosen a drug plan – they were scheduled to be automatically assigned to a Louisiana drug plan that is going to be – and forms via mail, and given the option to choose another one. Well, that

piece of mail will not get to them. They are likely not in Louisiana so the Louisiana drug plan may not be in that place where they are living now in the other states. That is one issue.

Then the ones that have full Medicare and Medicaid, full Medicaid, while they don't – they will not be aware that Medicaid is not going to be covering their drugs and they won't know who is. The second group are those people who are – who only receive Medicare, that don't get Medicaid. They are going to have the same issue – is they will not have – get their mail about choosing a drug plan. And so they won't have that benefit January 1st.

Then there are those individuals who have applied for extra help and the letter that they are going to get telling them whether or not they got the extra help and how to sign up – all of – this – it's the issue with the mail and informing people that I feel is the problem with the Medicare drug implementation.

Q: And short of legislation – I mean, you have to have legislation to address this because by federal law there is no way around this. As of January 1, there is no making matching payments for drugs if you're eligible.

MS. : That is right.

Q: That is clear; there can't be any waiver about that as far as legislation?

MS. : I would say that you are going to lose three categories. You know, with the legislation that is out there would do would be for the – get to those who are eligible. So we put that up for one of these plans and get into the system, but if they don't, this Medicaid matching payment will still be there for them.

Second, for these people with absolutely nothing else – it's the Medicare-only folks, if they don't sign up there is not late-moment penalty like there would otherwise be. So they have a little bit more time to sign up.

And then for the third category, people applying for extra assistance, the legislation would wave all of the documentation requirements because there is an asset and income tax associated with that extra assistance, so at least that would be waived. It doesn't mean that that solves all of the problems. I think that the problem that Barbara raised is a real one, as with Ruth, but it –

MS. : Well, including if I'm not paying a callback on that person, how I get them out of the category that CMS is using to bill me for my callback. (Laughter.) Because otherwise I'll be paying the callback and someone will be paying the drugs for them.

MS. : Mm-hmm. But that law would have to pass. That legislation would have to pass for those effects –

MS. : Yeah.

MS. : Wow. (Laughter.)

MS. : We have a question from the conference call.

OPERATOR: The next question is from Lusia Mint (sp) with AHA.

Q: Hi, I wanted to clarify something. Actually, I'm just a little bit confused. It is my understanding that dual eligibles are going to be automatically signed up for drug coverage under Medicare as of January first. So it more an issue of them not knowing where their coverage is coming from more so than being an issue than being covered at all?

MS. : Well, I think that yes because you were – if they are showing up – because you have to understand how they are being auto-enrolled. They are being auto-enrolled based on a state data file. So at this point if it continues moving forward, the folks that were in Louisiana Medicaid program will get assigned to a Louisiana part B plan and they may now be living in North Dakota.

Q: I see.

MS. : So that is a big-darn deal. If they have moved to Wyoming and they get assigned to a Wyoming plan in the meantime, again, they may not have hit the – they may not have gotten into the state soon enough to get into Wyoming's auto assignment data file. So there is a real danger of losing these folks or having them assigned to a plan that is not accessible to them.

Q: Okay, now, are the states sharing their data files?

MS. : Can you repeat that question?

Q: Are the state Medicaid programs sharing their data files, so it would be quick – fairly easy to verify, say, in Wyoming that this displaced resident of Louisiana actually was a Medicaid recipient.

MS. KENNEDY: Well, each state is providing a file for their dual eligible – for the prescription drug plan, but that file is being sent monthly. That is – I would question whether that is quickly because, I mean, this is going to be fast moving here – the last quarter here in regard to automatically assigning these individuals to a drug plan, informing of them plan they have been assigned to, and giving them the option to choose someone else that better meets their needs. So that is our plan for October through December. So it's not like a daily upload or a weekly upload that the states are giving to social security CMS for the Medicare prescription drug plan.

MS. : There is an effort on the part of the – if the disaster states – the states with the evacuees who have made – have offered to make their eligibility filed available – and I think APHSA is the attempting to facilitate this – so that once we know what our emergency systems are going to be, we will have some ability to do some after-the-fact matching to verify that people were in that – you know, that people have – when they said, gee, I was on Medicaid in Alabama, that we would actually be able to verify that.

MS. KENNEDY: And what Louisiana has done is we have started to APHSA the file of the 997,000-or-thereabouts people, who were on Medicaid in Louisiana as of August 29th. And so they have that eligibility file that other states, host states, can look at to confirm that someone was indeed eligible for Louisiana Medicaid pre-Katrina.

MS. : Yeah, it's probably likely that that kind of verification will be done after putting someone on the system, however. I mean, some states may have the capacity to build that in real time but many will have to back and do a retro-review.

MS. ROWLAND: I wanted to thank both Ruth and Barbara for joining us on the phone, and Jeanne for joining us here in Washington. I hope that this gave you enough information to know this is a major story, it's a major issue to follow, and what happens to these individuals is really something that I think we're going to be counting on the press to keep in the public spotlight just as the press so well documented the tragedies occurring the aftermath of the hurricane itself.

I think we should really listen carefully to the comments that Ruth has made about the needs and who these people are and where they are going, and how important healthcare can be to them, to Barbara's comments about simplicity and time is of the essence. We're probably talking about something that should have happened yesterday and not something that may happen this week or next week or in the weeks ahead because the health needs are there today, not in the next month.

We are going to try to keep abreast of the changes and to provide some background information, data, statistics, the numbers, on our website. So if you want to continue to check kff.org, we'll try and have a section of it devoted to some of the issues related to the hurricane aftermath.

And I wanted to alert you to the fact that we're also planning with the Alliance for Healthcare Reform a briefing on Monday that will focus on looking at Hurricane Katrina, and that is at noon in the Dirksen Building and through the alliance for health reform.

And we will be having some speakers: Jim Tallon, who heads our Kaiser commission on Medicaid and the uninsured, but was instrumental in working with disaster relief Medicaid in New York, will be there, along with Ray Scheppach, from the National Governor's association, and Surgeon General Carmona, as well as Bob Helms from the American Enterprise Institute to really talk a little more about some of the health needs and about some of the federal response options. And by then we may even know more about what is happening on the legislative front.

So thank you all for participating. And thank you for carrying about this issue and being willing to cover it.

(END)