



Health Care in New Orleans: Before and After Katrina

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For Hearing on:

“Post Katrina Health Care:
Continuing Concerns and Immediate Needs in the New Orleans Region”

Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
United States House of Representatives

March 13, 2007

**Summary of Testimony by Diane Rowland, Sc.D.
For Hearing on
Post Katrina Health Care:
Continuing Concerns and Immediate Needs in the New Orleans Region**

Before Katrina, Louisiana had a strained “two-tier” health system.

- A quarter of the population was below poverty and 20 percent were uninsured
- Health care for the poor and uninsured was provided through the state-run Charity hospital system financed by Medicaid DSH dollars
- More community-based care and broadened health coverage was needed

After Katrina, the New Orleans health system was devastated.

- Loss of health facilities and closure of Charity Hospital
- Dispersion of health care workers
- Confusion and disrupted care for people, especially the poor and uninsured

There has been slow progress in restoring health services.

- No streamlined way to provide emergency coverage under Medicaid
- Severe workforce shortages and limited hospital and clinic capacity
- Critical shortage of mental health services
- Growing uninsured population with new labor force
- On-going negotiations over how to rebuild and finance the health system

Steps could be taken in the short-term to help restore capacity and provide access to care.

- Maintain Medicaid and LaCHIP coverage for low-income children
- Expand coverage to reduce uncompensated care
- Provide incentive payments to rebuild workforce
- Develop additional community health centers
- Increase availability of psychiatric services

Adequate financing is necessary to support rebuilding efforts.

- Greater flexibility over access and use of already-allocated DSH funds
- Additional federal assistance

Introduction

Mr. Chairman and members of the Subcommittee, I want to thank you for your attention to the health care needs facing the residents of Louisiana and for the opportunity to testify today on what can be done to address the health care challenges in Louisiana in the aftermath of Hurricane Katrina. I am Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. From 2004 to 2006, I served as a member of Louisiana's Health Care Reform Task Force charged with assessing how to improve health and long-term care services in Louisiana. Unfortunately, as we will hear today, Hurricane Katrina dramatically changed the planning and resources available for that effort.

The destruction and devastation in Katrina's aftermath was unparalleled in our nation's history. The path to recovery has been slow and the outcome uncertain. I am pleased the Subcommittee recognizes the importance of restoring health care services and is examining the efforts and progress in rebuilding health care coverage and capacity in New Orleans. I am honored to participate in this hearing today with so many local leaders and health care providers who have worked tirelessly to provide and improve health care services in Louisiana since Katrina struck and New Orleans flooded in 2005.

My comments today will draw on our studies and analysis of health care in Louisiana before and after Katrina to provide an overview of the health care system in New Orleans, assess

the impact of the storm on availability and access to health care services, and offer some perspectives on the progress and challenges of rebuilding the health care system in New Orleans.

Health Care in Louisiana Pre-Katrina

Hurricane Katrina devastated a health care system that was already straining to provide necessary health services to its population. Louisiana is one of the nation's poorest states and ranks at the bottom of all 50 states on most measures of the health of its residents. Louisiana had high rates of chronic diseases and ranked among the worst in the nation for infant mortality, AIDS cases, and diabetes mortality (Figure 1). Nearly one in four (23%) Louisiana residents lived in families with incomes below the federal poverty level (\$16,600 for a family of 3 in 2006), including nearly a third of Louisiana's children (Figure 2).

Low rates of job-based health coverage, coupled with the high rates of poverty and limited assistance for adults through public programs, left almost one in five non-elderly Louisiana residents without health coverage. The lower percentage of residents with employer-sponsored health coverage (56% vs. 61% nationally) was tied to the large numbers of small businesses in the state and employment in the tourism and service sectors, which have high turnover and low offer rates for health benefits (Figure 3).

Medicaid and the State Children's Health Insurance Program (SCHIP, called LaCHIP in Louisiana) covered about 20% of the population, but eligibility for parents and other adults lagged far behind that of children. Children in families with incomes below 200% of poverty

were eligible for coverage under Medicaid and LaCHIP, but income eligibility for working parents was limited to 20% of poverty or \$3,320 a year for a family of three (Figure 4). Adults without dependent children were ineligible for public coverage no matter how poor. Thus, while Medicaid and LaCHIP could potentially assist nearly half of all children in Louisiana, few adults qualified for coverage despite high levels of poverty. As a result, an estimated 750,000 Louisianians were uninsured in 2005.

Louisiana essentially had a “two-tier” health system, in which the insured population (including those with Medicare and Medicaid) had access to a range of community hospitals and physicians, while the poor and uninsured were mostly cared for through the LSU-run safety-net system of ten state-funded inpatient hospitals and a network of more than 350 clinics. For New Orleans, the “Charity System” was called the Medical Center of Louisiana at New Orleans (MCLNO), which included the iconic Charity Hospital (“Big Charity”), University Hospital, and affiliated clinics.

MCLNO served a largely poor, uninsured, and African-American population and accounted for 83% of inpatient and 88% of outpatient uncompensated care costs in the New Orleans area in 2003.¹ It was also the dominant provider of psychiatric, substance abuse, and HIV/AIDS care in the region, and housed the lion’s share of the region’s inpatient mental health beds. Further, Charity Hospital was home to the Gulf Coast’s only Level One trauma center and the busiest emergency department in the city, and it served as the major teaching hospital for both the Tulane and LSU medical schools. Additionally, with only two federally qualified health

¹ Rudowitz, R., Rowland, D. and A. Shartzter, “Health Care in New Orleans Before and After Hurricane Katrina,” Health Affairs, August 29, 2006.

centers in the New Orleans area, a lack of private providers willing to treat the uninsured, and the state's use of Medicaid disproportionate share hospital (DSH) funds to finance inpatient and outpatient care primarily at the state-run hospitals, the clinics at Charity Hospital were a dominant source of ambulatory care for the low income, providing 350,000 outpatient visits at more than 150 primary and specialty care clinics.² However, despite its substantial role, Charity Hospital was faced with shrinking public resources, a high burden of uncompensated care, and a lack of capital to make much-needed infrastructure improvements.

The two-tiered and institutionally based system of providing care to the uninsured in Louisiana was largely driven by the way in which it was financed. Medicaid represented not only a system of health care coverage for low-income people in Louisiana but also a mechanism of financing health care for the uninsured. Louisiana was a major user of Medicaid DSH funding; in 2005, Louisiana's \$1 billion in DSH funds accounted for nearly 20% of all Medicaid spending in the state (compared with about 6% nationwide).³ DSH payments are made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. In Louisiana, the state channeled most of its Medicaid DSH payments to the LSU system to finance care for the uninsured. Louisiana's use of Medicaid DSH funds in this way created a dependence on institutional hospital care for the poor, rather than outpatient or ambulatory care settings, because states generate DSH dollars through inpatient use. Using Medicaid to expand eligibility to the uninsured population would have allowed Medicaid funds to be directed toward

² Ibid.

³ Ibid.

more non-hospital-based care but would have eroded Medicaid funding to support the Charity Hospital system.

State and local policymakers were looking to reform the structure and financing of Louisiana's health care system even before Hurricane Katrina devastated the system. In March 2004, at the beginning of her administration, Governor Blanco convened a health care summit and then appointed a Task Force of state leaders and national experts to provide recommendations for reform. There was wide recognition that more extensive health coverage for the low-income population was needed, particularly for adults. Given the deterioration of the aging Charity Hospital, consideration was also given to whether a new facility should be built and the need to shift from a hospital-heavy model of care to greater use of ambulatory care located in the community. To this end, the state submitted a Medicaid waiver to the U.S. Department of Health and Human Services to use a portion of its DSH funding to finance coverage expansions and local initiatives providing access to primary and preventive care. This waiver was pending at the time Katrina struck.

Katrina's Devastation

As we all know, the damage wrought by Hurricane Katrina and the levee breaches on Louisiana is staggering—over 1,400 lives lost and 900,000 people displaced, 18,750 businesses destroyed, over 200,000 homes damaged or destroyed, and over 220,000 jobs lost.⁴ The immediate impact of Katrina on the health system was the destruction of health care services in New Orleans as hospitals flooded and patients were evacuated. Some on this panel remained in

⁴ Louisiana Recovery Authority, "Hurricane Katrina Anniversary Data for Louisiana," August 2006.

facilities where patients were unable to evacuate and heroically kept working amidst power outages and rising floodwaters, while others were in the Superdome delivering healthcare in the days after the storm. And then, they began the arduous process of restoring health services in their city.

Progress to restore health services has been slow. One year after the storm, only three of Orleans Parish's nine acute care hospitals were operational and at substantially reduced capacity. Charity Hospital, the center of the region's health care safety net, has remained shuttered since the days shortly after the storm. Some clinic services, however, were being provided in temporary facilities while University Hospital was being repaired. In neighboring Jefferson Parish, most hospitals, including Oschner and East and West Jefferson, continued to operate, helping to absorb some of the needs of people displaced from Orleans Parish, but were limited by staffing shortages and incurred large uncompensated care burdens.

The destruction of the health care system in New Orleans and the displacement of hundreds of thousands of individuals made it extremely difficult for people to obtain health care after the storm. The Kaiser Family Foundation conducted a series of structured interviews with Katrina survivors living in New Orleans, Baton Rouge, and Houston about six months after the storm to learn more about their health care experiences following the storm.⁵ These interviews revealed that although survivors often experienced health problems before Katrina, they were now facing even more daunting challenges in obtaining needed health care. Despite suffering emotional and mental trauma from the storm, with many experiencing anxiety, depression, and

⁵ Perry, M. et al, "Voices of the Storm: Health Experiences of Low-Income Katrina Survivors," Kaiser Family Foundation, August 2006, <http://www.kff.org/uninsured/7538.cfm>.

trouble sleeping and eating, almost none had received formal counseling services for themselves or their children.

Beyond these traumatic impacts, some survivors also experienced problems caring for the physical and mental health problems they had before the hurricane. A number of interviewees had been unable to obtain critically needed care or prescription drugs, even up to six months after the storm. Several bipolar and schizophrenic interviewees endured weeks without their prescriptions. Survivors expressed difficulty finding pharmacies, reconnecting with former providers or finding new ones, and paying for their care. Access to specialty care was particularly challenging; some pregnant women were unable to find prenatal care. Some attributed negative impacts on their or their children's physical or mental health to their lack of care. In the absence of care, some were trying to manage their conditions themselves—for example, trying to control diabetes through diet rather than insulin while living in a FEMA hotel without kitchen facilities.

Even those with private coverage or Medicaid faced challenges obtaining health care. Survivors in Baton Rouge and Houston had difficulty as a result of unfamiliarity with health resources in their new communities as well as lack of transportation. Those who returned to New Orleans had difficulty finding providers because of the loss of hospitals and providers and the closure of Charity Hospital—problems exacerbated by the overcrowding and long waits for care at the hospitals that continued to operate.

Health issues were further complicated by unstable living and financial situations, because some were having difficulty meeting their basic needs such as housing and food. Overall, how well people were faring reflected both their situation before the storm and their ability to connect with assistance after the storm. Unfortunately, some of the most vulnerable survivors who were interviewed, including elderly people, appeared to be disconnected from assistance. Separated from their family members and established support communities many were unable to get needed care and prescriptions.

Clearly, as they struggled to rebuild their lives and return home after Katrina, the people of New Orleans needed both to be able to access health care services for their ongoing medical needs and to receive assistance with new conditions and the emotional stress after the hurricane. Yet, the health services available to them were limited and difficult to access.

Progress and Challenges Since Katrina

The challenge of restoring health care services in New Orleans is magnified by the devastation to the overall health care system; the loss of numerous health care providers and staff; questions about the stability of state and local revenues; and the uncertainties around the size, composition, and timing of the population returning to New Orleans. A population survey sponsored by the federal Centers for Disease Control (CDC) and the Louisiana Department of

Health and Hospitals determined that less than half of Orleans Parish's population (191,139 versus 444,515 in 2004) had returned and was living in the city one year after the storm.⁶

Coverage Issues

Health care coverage provides the means for people to access health care services and financing to support the health care system. When Katrina struck, Louisiana already had one of the highest percentage of its population uninsured—20% statewide and 28% in New Orleans. Following Katrina, more people undoubtedly became uninsured as they lost their jobs and their health insurance. Some low-income Katrina survivors were able to turn to Medicaid for assistance, but because the eligibility standards for Louisiana Medicaid were not changed after the storm, many others were not able to access this coverage. For example, eligibility workers were forced to reject at least a third of all applications because they were for childless adults who did not meet the program's categorical eligibility requirements.⁷

There are no emergency provisions in Medicaid that provide flexibility to simplify the rules and extend Medicaid coverage with federal financing in a crisis situation such as this. After 9/11, Disaster Relief Medicaid in New York City provided a model for using Medicaid to provide immediate coverage by streamlining the process and the rules, but the federal response

⁶ "2006 Louisiana Health and Population Survey Report: Orleans Parish," January 17, 2007, conducted by Louisiana Public Health Institute on behalf of LRA, LA DHH, CDC, and the US Chamber of Commerce. Available at www.popest.org

⁷ Ross, D.C. and V. Wachino, "Medicaid Categorical Eligibility Rules are Providing a Major Obstacle to Getting Health Coverage to Impoverished Katrina Victims in Louisiana," September 2005.

to Katrina followed a different path.⁸ In September 2005, the U.S. Department of Health and Human Services set up special Medicaid waivers to allow low-income survivors from Louisiana, Mississippi, and Alabama to enroll in temporary Medicaid coverage in the states in which they were residing as long as they met the categorical eligibility requirements. Under these waivers, states could provide up to five months of Medicaid or SCHIP coverage to eligible groups of survivors and could also create an uncompensated care pool to reimburse providers for uncompensated care costs. The waivers did not allow states to expand coverage for adults without dependent children, regardless of income, and did not include any funding to support the temporary coverage or uncompensated care pools. Federal funding did not become available until the Congress authorized \$2 billion for the Medicaid coverage and uncompensated care pools nearly six months after the storm through the Deficit Reduction Act of 2005.

At the state level, Louisiana made attempts to try to maintain Medicaid coverage for as many enrollees as possible, including many who moved out of state. The Louisiana Department of Health and Hospitals delayed eligibility renewals until the end of 2006 and the state has allowed individuals who are out-of-state to continue to receive Louisiana Medicaid coverage if they indicate an intent to return. However, the difficulty of contacting beneficiaries—for many, the last known address was prior to Katrina and is no longer accurate—combined with enrollment losses related to increased documentation requirements passed in the DRA, has contributed to a Medicaid enrollment decrease of over 70,000 people statewide. Most dramatic was the change for Orleans Parish where 134,249 were covered by Medicaid on the eve of Katrina compared to only 59,023 Medicaid enrollees in Orleans parish as of January 2007.

⁸ Perry, M., “New York’s Disaster Relief Medicaid: Insights and Implications for Covering Low-Income People,” Kaiser Commission on Medicaid and the Uninsured in Collaboration with the United Hospital Fund, August 2002, <http://www.kff.org/medicaid/4062-index.cfm>.

Many of those who lost coverage are children, reflecting the movement of many families out of New Orleans. The state is planning an extended outreach effort for the spring to try to reach eligible individuals in the state who are not enrolled.

Caring for the uninsured is unlikely to abate as an issue for the New Orleans region. Many residents remain uninsured, and the problem is particularly acute for the low-income adult population. Though the unemployment rate in the New Orleans area has stabilized from its peak at almost 18% in September 2005 to just under 5% in December 2006, many are not offered health benefits at their current job.⁹ The influx of new workers, usually Hispanic, for construction jobs in rebuilding efforts will undoubtedly swell the uninsured population given the high uninsured levels among Hispanics, the low levels of job-based health insurance in the construction industry, and the prohibition on coverage of recent or undocumented immigrants in public programs. This, in turn, will put even greater pressure on the available health care services and uncompensated care funds. Further, providers will need to develop new language skills and cultural competencies to provide care to this population, which, historically, did not have a large presence in the New Orleans region.

Restoring Health Services

As of January 2007, the Brookings Institution's Katrina Index reported that only 52% of state-licensed hospital beds were in operation. Further, the number of physicians filing claims for medical services has fallen by roughly half, the number of safety-net community clinics in

⁹ Louisiana Department of Labor, Bureau of Labor Statistics. Reported in The Brookings Institution's *The Katrina Index*, February 2007, available at www.gnocdc.org

the region has dropped from 90 to 19, and a large share of the region's long-term care capacity remains destroyed.¹⁰ There are severe shortages in the health care workforce at all levels — physicians, nurses, attendants, laboratory technicians, dieticians, and housekeeping staff—that are essential to patient care, as many have relocated elsewhere in the state or out-of-state.

However, over the last 18 months, some progress in restoring health care capacity in the New Orleans area has slowly been made. After operating clinics out of tents in the Convention Center and then in an abandoned department store, LSU refurbished and reopened parts of University Hospital in November 2006, over a year after Katrina struck. Services are limited, but there is once again a 'Charity Hospital' presence in the city. This February, trauma care was transferred from a rented space at Elmwood Hospital to the reopened University Hospital. Once the University Hospital has been reopened and staffed, it is expected to have 140 staffed beds, considerably smaller than the former combination of Charity Hospital and University Hospital, but a resource for the poor and uninsured who continue to be a substantial share of the city's population.

A number of health clinics have also opened to help provide the community with primary and preventive health care. These clinics provide an invaluable source of care for returning residents who previously depended on the clinics at Charity for care, but are also increasingly becoming a source of care for the growing population of Hispanic workers and their families. Yet, enormous health care demands remain in the city, as evidenced by the thousands of individuals who attended the "Medical Recovery Week" health fair in late January to obtain free medical services, including dental care, vision and medical exams, and cardiology. According to

¹⁰ Rudowitz, R., Rowland, D., and A. Shartzer, op. cit.

news reports, people began arriving as early as 2 a.m. to wait for the health fair to open and crowds gathered so quickly that those arriving after 8 a.m. were unable to get in. Clearly, many residents of New Orleans are going without basic care if so many wait in long lines at community health fairs.

Financing

Financing is a major stumbling block in the recovery efforts. As noted, prior to Katrina, health care for the uninsured was largely financed through DSH funds that were generated through patients' use of the state-run charity hospital system. When Katrina struck and both Big Charity and University Hospitals were closed, the state could no longer access these DSH dollars because the inpatient hospital care for Medicaid and uninsured patients on which DSH payments are based was gone. Because care of the uninsured was concentrated in the state-run charity system, only these facilities—and not the private hospitals—were designated by the state to be eligible for DSH payments. In order to reallocate DSH funds to private hospitals caring for the uninsured after the storm or community-based clinics or to use the funds for coverage expansions, the state needs a waiver from the federal government.

Restoration of health services and reform of the health care system thus remain major issues for Louisiana. The Louisiana Health Care Redesign Collaborative was formed in July 2006 by the state legislature and Department of Health and Hospitals to help guide the rebuilding process. A proposal emphasizing primary and preventive care, coverage expansions to a greater share of the population, health information technology, and evidence-based medicine was

submitted to the U.S. Department of Health and Human Services in October 2006. The ultimate outcome of these negotiations will shape the future of health coverage and services in the reformed Louisiana health care system. A key issue in these negotiations is whether the coverage provided will be publicly or privately sponsored and the future size and role of a public hospital replacing Charity Hospital versus distribution of low-income patients among the private hospitals. These decisions will shape how the dollars flow in the reformed health system.

Next Steps

While the debate over how to rebuild the health care system in New Orleans and what the appropriate mix of public versus private resources should be goes on, the people living in New Orleans continue to confront an inadequate health care system. In the fall of 2006, one year after Katrina struck, the Kaiser Family Foundation surveyed 1,504 individuals in Orleans, Jefferson, Plaquemines, and St. Bernard Parishes to assess their experiences one year after Katrina and learn more about their health needs.

Preliminary results from our Kaiser household interview survey to be released this spring underscore the public's concerns:

- 40% of respondents cited getting medical facilities and services up and running as one of their top priorities for the city, and a third of respondents felt there had been little or no progress in getting medical services and facilities back up;

- Nearly 4 in 10 (36%) were very worried that health services may not be available when they need them (and another 45% were somewhat worried);
- An overwhelming 88% said they did not think there were enough hospitals, clinics and medical facilities currently operating in New Orleans; and
- 88% said they did not think there were enough health services available for the uninsured in New Orleans.

When asked what should be done about health care services in New Orleans, the vast majority of respondents strongly favored reinvesting in the health care infrastructure and health coverage by rebuilding Charity Hospital, building more community-based clinics, and expanding public programs like Medicaid and LaCHIP to extend health coverage.

The perception of the people of New Orleans that progress in restoring health services has been slow and that more should be done to meet their health care needs mirrors the reality as one assesses both the progress and availability of care across the city. On site visits to medical facilities in the area, it has become clear that while very dedicated workers are trying tirelessly to piece back together the frayed health system, more needs to be done now to restore capacity and coverage. Long-range plans are fine, but immediate needs must also be addressed.

What steps can be taken now to help restore capacity and provide adequate access to health care services for the people of New Orleans? Among some of the options to consider are to:

- Maintain Medicaid and LaCHIP coverage for low-income children. Today, given the low incomes of families, a substantial number of children in New Orleans rely on Medicaid and the LaCHIP program. Maintaining that coverage will promote access to care for these children as well as provide payment to the clinics, doctors, and hospitals that treat them. Outreach efforts are also necessary to reach more children who are eligible but not enrolled in the program.
- Expand coverage to reduce uncompensated care. For low-income adults, Medicaid coverage is very limited. Extending coverage to at least the parents of the covered children through a Medicaid expansion would help promote their access to primary care, reduce uncompensated care costs, and support community based providers, whereas uncompensated care funds mainly assist institutional providers. The state would need to obtain a waiver to expand coverage for childless adults.
- Provide incentive payments to rebuild workforce. Restoring capacity is about more than bricks and mortar—it is about bringing back and retaining a health care workforce. Incentives for providers (physicians, nurses, therapists, etc.) are essential for recruitment back to a city that is still struggling with housing, schools, crime, and uncertainty. Having an

“incentive payment pool” could both provide recruitment bonuses but also help provide setup and capital financing as medical practices are being re-established.

- Develop additional community-health centers. More primary care services throughout the community, and especially in neighborhoods that are being rebuilt, would both provide access to care for residents and a stable practice setting for returning doctors and health workers.
- Increase availability of psychiatric services. In addition to the mental stress from the devastation of Katrina, the city needs additional resources to deal with the chronically mentally ill. The shortage of psychiatric beds, the lack of community-based crisis centers, and the inadequate supply of mental health workers are critical needs. Extension of funding through the Social Services Block Grant in combination with workforce incentives and broadened Medicaid coverage of people with mental disabilities could help alleviate the shortages.

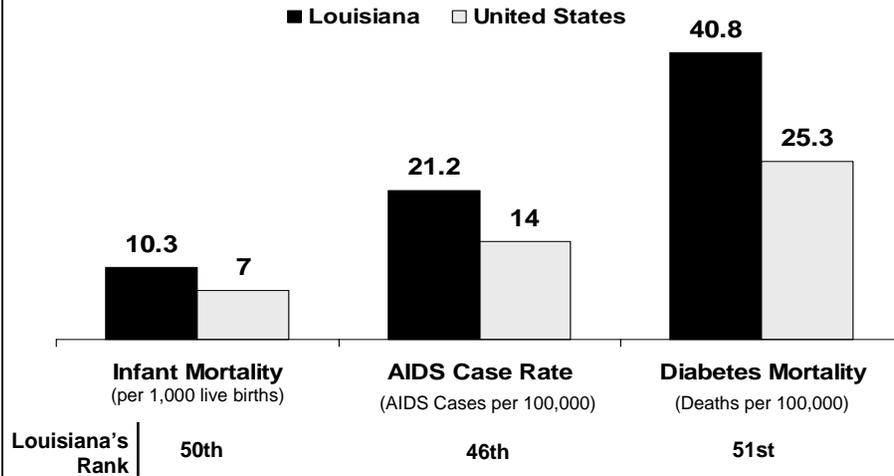
These steps are the kind of actions that could be taken in the short term to help restore health services for the community and ease the transition back to a rebuilt New Orleans. They would be building blocks to provide a solid foundation on which to build the “ideal reformed health system” for New Orleans that stakeholders are now debating. However, the ability to implement these steps is obviously related to the availability of adequate financing. Because of the destruction of Charity Hospital, the state is no longer able to draw down its full Medicaid DSH allotment, leading to a sharp reduction in available financial resources for the state’s health

care system. Giving the state greater flexibility over how it might access and use its DSH funds could help offset uncompensated care costs among private hospitals and community clinics and support efforts to expand Medicaid coverage, but is unlikely to be sufficient to rebuild Louisiana's health care workforce and system.

Thank you for the opportunity to testify today.

Figure 1

Selected Health Status Characteristics of Pre-Katrina Louisiana Compared to the U.S.

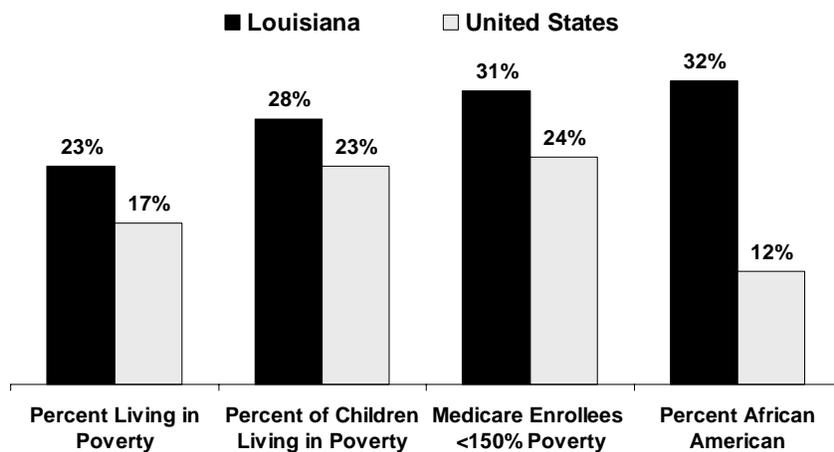


Note: Rankings include DC.
 SOURCE: Kaiser *statehealthfacts.org*, 2006. Infant Mortality data for 2002, Diabetes Mortality for 2003, and AIDS Case Rate for 2005. All data from CDC.

K A I S E R C O M M I S S I O N O N
M e d i c a l d a n d t h e U n i n s u r e d

Figure 2

Key Characteristics of Pre-Katrina Louisiana Compared to the U.S., 2004-2005

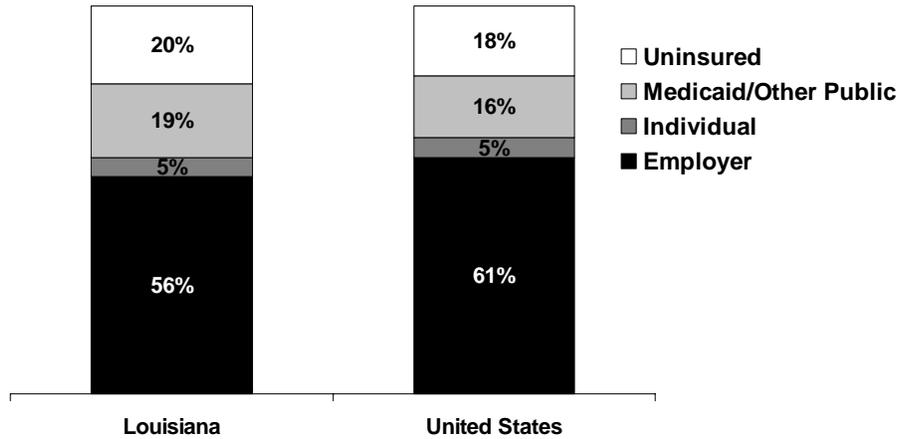


SOURCE: Kaiser *statehealthfacts.org*, 2006. Data is from the Census Bureau's March 2005 and 2006 Current Beneficiary Survey.

K A I S E R C O M M I S S I O N O N
M e d i c a l d a n d t h e U n i n s u r e d

Figure 3

Health Insurance Coverage of the Nonelderly, Louisiana and the United States, 2004-2005



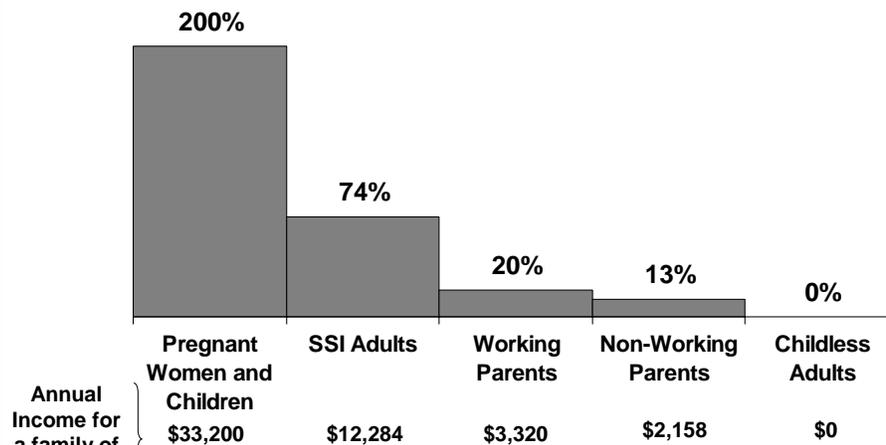
Note: Medicaid/Other Public also includes SCHIP, other state programs, Medicare, and military-related coverage. Data may not total 100% due to rounding.
 Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of March 2005 and 2006 Current Population Survey.

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 Medicaid and the Uninsured

Figure 4

Medicaid Eligibility in Louisiana

Percent of the Federal Poverty Level:



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 Medicaid and the Uninsured