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## History Shows What Steps Trump Administration and Congress Can Take to Ensure Access to Health Care for Those Affected by the Hurricanes

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In the aftermath of Hurricanes Maria and Irma, people with health conditions in Puerto Rico and the U.S. Virgin Islands are reportedly struggling to get the health care services they need.<sup>1</sup> Some of these U.S. citizens need treatment, and many have evacuated to states where they have family. Others remaining on the islands may need to leave to get needed care. To ensure that people from Puerto Rico and the U.S. Virgin Islands have access to treatments and services, Congress and the Trump Administration should quickly take steps to make Medicaid and marketplace coverage available to those who need it.

Federal responses to previous disasters provide a model for current policymakers to follow, but that's just a start. Congress and the Trump Administration can take several steps to ensure health care access for those affected by Hurricanes Maria and Irma, including:

- enacting legislation to temporarily increase Puerto Rico's and the Virgin Islands' Medicaid block grants, temporarily increase their federal match rates, and eventually uncap their federal Medicaid funding, as well as grant Medicaid coverage to evacuees in other states;
- taking administrative actions to streamline Medicaid access, such as a simplified application process, delayed eligibility redeterminations, and standardized disaster relief waivers; and
- improving access to marketplace coverage through outreach and application assistance to consumers.

The federal government picks up a fixed share of state Medicaid costs — now averaging 64 percent — meaning that federal Medicaid funding increases to immediately respond to higher costs

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<sup>1</sup> Jack Healy and Luis Ferré-Sadurní, “For Many on Puerto Rico, the Most Coveted Item is a Plane Ticket Out,” *New York Times*, October 5, 2017, <https://www.nytimes.com/2017/10/05/us/puerto-rico-exodus-maria-florida.html>; Jeremy W. Peters, “In the Virgin Islands, Hurricane Maria Drowned What Irma Didn't Destroy,” *New York Times*, September 27, 2017, <https://www.nytimes.com/2017/09/27/us/hurricane-maria-virgin-islands.html>.

resulting from natural disasters and public health emergencies. After the 9/11 attacks, New York temporarily covered 350,000 individuals through Medicaid and financed about \$670 million in health care costs resulting from the attacks.<sup>2</sup> But Medicaid's existing financial flexibility isn't always enough to deal with the impact of disasters. For example, Congress and the George W. Bush Administration needed to step in and provide supplemental funding to states directly affected by Hurricane Katrina as well as to states covering large numbers of people evacuated to other states. Similar action is now needed for Puerto Rico and the Virgin Islands.

The need is especially dire in those two jurisdictions because unlike the states, they get fixed Medicaid funding through a block grant, which was already insufficient before Hurricanes Maria and Irma hit. Both Puerto Rico and the Virgin Islands won't be able to finance their current share of Medicaid costs anytime soon in the aftermath of the hurricanes. For example, while Puerto Rico's and the Virgin Islands' Medicaid programs remain responsible for paying health care costs for Medicaid beneficiaries who temporarily relocate, payments to evacuees' host states may not be feasible given the islands' financial situation. Without congressional action to provide additional funding, evacuees and those needing to evacuate may go without access to essential health care.

## **Waivers and Congressional Action Helped States Recover and Rebuild After Past Disasters**

Past administrations and Congresses have taken additional legislative and administrative steps to provide enhanced support to states and communities after disasters, building on Medicaid's existing financial flexibility to respond to natural disasters and public health emergencies. Similar bipartisan legislative and administrative efforts would provide much-needed support to Puerto Rico and the Virgin Islands after Hurricanes Maria and Irma.

Section 1115 of the Social Security Act allows states to seek federal approval to deviate from various requirements of federal law when necessary to implement demonstration projects that promote the Medicaid program's objectives.<sup>3</sup> Section 1115 demonstration waivers can expand Medicaid eligibility and benefits, and help states rebuild and redesign their health care infrastructure. However, 1115 waivers cannot be used to eliminate the responsibility of states to pay their share of Medicaid costs.

The U.S. Department of Health and Human Services (HHS) also has authority under section 1135 of the Social Security Act to temporarily waive certain requirements under Medicaid, the Children's Health Insurance Program (CHIP), and Medicare in the event of a declared public health emergency. Under this authority, HHS can waive conditions of participation for providers and facilities, program participation and preapproval requirements, and physician licensure requirements, allowing providers to quickly provide care in an emergency. While 1115 demonstration waivers can be approved for several years, 1135 waivers typically end no later than 60 days after approval. HHS

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<sup>2</sup> Jocelyn Guyer and David Rosales, "Medicaid's Role in Public Emergencies and Health Crises," Manatt Health, April 2017, <https://www.manatt.com/getattachment/8597c8c4-4ece-44d1-a47a-306204e8577b/attachment.aspx>.

<sup>3</sup> Judith Solomon and Jessica Schubel, "Medicaid Waivers Should Further Program Objectives, Not Impose Barriers to Coverage and Care," Center on Budget and Policy Priorities, August 29, 2017, <https://www.cbpp.org/research/health/medicaid-waivers-should-further-program-objectives-not-impose-barriers-to-coverage>.

may extend the waiver for additional periods of up to 60 days until the end of the emergency period.<sup>4</sup>

Policymakers have granted these authorities to respond to past unanticipated events:

- **The September 11, 2001 attacks.** After the 9/11 attacks, New York implemented the Disaster Relief Medicaid program (DRM), using 1115 demonstration authority to expand Medicaid eligibility and expedite enrollment. Although New York City temporarily lost access to the system to process Medicaid applications, within seven days of the attack, the governor of New York announced that low-income city residents would be eligible for four months of Medicaid benefits. A total of 350,000 individuals enrolled in this temporary coverage.<sup>5</sup>

DRM increased eligibility for parents from 87 percent of the federal poverty level to 133 percent, and raised eligibility for adults without dependent children from 50 percent of the poverty level to 100 percent. DRM also extended Medicaid eligibility to all legally present immigrants.<sup>6</sup> The application for DRM was simplified to a single page, and applicants could self-attest to their eligibility rather than provide documentation.<sup>7</sup> New York also expanded the sites where individuals could apply for DRM by designating 25 community organizations to provide enrollment assistance, in addition to the existing community Medicaid offices across the city. After the initial four months of coverage, DRM initiated a transition period giving beneficiaries an opportunity to apply for traditional Medicaid or other coverage.<sup>8</sup>

- **Hurricane Katrina.** Tens of thousands of people were displaced from their homes after Hurricane Katrina struck the Gulf states in August 2005. Many people sought coverage through Medicaid after the hurricane, both in their home states and in the host states to which they evacuated. This demand for Medicaid services raised several issues for state Medicaid agencies:
  - individuals newly applying for Medicaid did not have the documents typically required to verify eligibility;
  - displaced individuals and families were seeking coverage in states that were not their state of residence;
  - host states saw significant increases in their state costs for Medicaid as evacuees enrolled in Medicaid; and

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<sup>4</sup> Centers for Medicare & Medicaid Services, 1135 Waivers, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers.html>.

<sup>5</sup> Guyer and Rosales 2017, *op cit*.

<sup>6</sup> Michael Perry *et al.*, “New York’s Disaster Relief Medicaid: Insights and Implications for Covering Low-Income People,” Kaiser Commission on Medicaid and the Uninsured-United Hospital Fund, July 30, 2002, <http://www.kff.org/medicaid/report/new-yorks-disaster-relief-medicaid-insights-and/>.

<sup>7</sup> Kathryn Haslanger, “Radical Simplification: Disaster Relief Medicaid in New York City,” *Health Affairs*, January 2003, <http://content.healthaffairs.org/content/22/1/252.full>.

<sup>8</sup> Perry 2002, *op cit*.

- health care providers experienced increased uncompensated care burdens related to uninsured displaced individuals.<sup>9</sup>

HHS released a new model Medicaid waiver to address these problems. “Katrina waivers” allowed states to provide up to five months of Medicaid or CHIP coverage to certain individuals and families, and provided reimbursement to providers for the increased costs of caring for uninsured evacuees through uncompensated care funding. Fifteen states, the District of Columbia, and Puerto Rico used this pathway to provide care to evacuees.<sup>10</sup>

Katrina waivers allowed host states to choose whether to determine evacuees’ Medicaid eligibility based on the eligibility criteria of their home states *or* eligibility guidelines suggested by HHS for this purpose. Notably, all states chose to use the HHS criteria.<sup>11</sup> While these criteria were generally more generous than those of evacuees’ home states, they maintained the categories of eligibility in place before the Affordable Care Act (ACA) expanded Medicaid to adults without dependent children.<sup>12</sup> This left large numbers of people affected by Katrina ineligible for Medicaid, even if they had serious medical conditions.<sup>13</sup>

Sixteen of the 17 states with approved Katrina waivers allowed evacuees to self-attest to their displacement, income, and citizenship or immigration status, rather than requiring documentation to verify their status.<sup>14</sup> Eight of the 17 waivers also provided uncompensated care funding to help host states reimburse providers for increased costs related to care for uninsured evacuees.<sup>15</sup>

Evacuees’ home states were financially responsible for host states’ increased Medicaid costs.<sup>16</sup> However, Hurricane Katrina’s devastating effects had already created significant financial hardship for the Gulf states. While the Katrina waivers created a mechanism to provide

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<sup>9</sup> Kaiser Commission on Medicaid and the Uninsured, “A Comparison of the Seventeen Approved Katrina Waivers,” January 1, 2006, <https://www.kff.org/medicaid/fact-sheet/a-comparison-of-the-seventeen-approved-katrina/>.

<sup>10</sup> Edwin Park, “Failing to Deliver: Administration’s Medicaid Waiver Policy Excludes Many Katrina Survivors and Provides No Guarantee of Full Federal Financing,” Center on Budget and Policy Priorities, revised September 29, 2005, <https://www.cbpp.org/research/failing-to-deliver-administrations-medicaid-waiver-policy-excludes-many-katrina-survivors>.

<sup>11</sup> Kaiser Commission on Medicaid and the Uninsured 2006, *op cit*.

<sup>12</sup> Donna Cohen Ross, “Medicaid Categorical Eligibility Rules are Proving a Major Obstacle to Getting Health Coverage to Impoverished Katrina Victims in Louisiana: Pending Legislation Would Address Coverage Gaps in Louisiana and Other States,” Center on Budget and Policy Priorities, revised September 26, 2005, <https://www.cbpp.org/research/medicaid-categorical-eligibility-rules-are-proving-a-major-obstacle-to-getting-health>.

<sup>13</sup> Park 2005, *op cit*.

<sup>14</sup> Florida, the one state that did not permit self-attestation, required individuals who were claiming Medicaid eligibility on the basis of a disability to provide physician verification. *See* Kaiser Commission on Medicaid and the Uninsured 2006, *op cit*.

<sup>15</sup> Kaiser Commission on Medicaid and the Uninsured 2006, *op cit*.

<sup>16</sup> Office of the Inspector General, Department of Health and Human Services, “Memorandum Report: Medicaid Payments and Services Related to Hurricanes Katrina and Rita, OEI-05-06-00140,” July 25, 2007, <https://oig.hhs.gov/oei/reports/oei-05-06-00140.pdf>.

temporary Medicaid coverage to evacuees from affected states, as noted, HHS doesn't have the authority to adjust states' financial responsibilities.<sup>17</sup> In order to ease the financial burden on these states, Congress in February 2006 provided up to \$2 billion in federal funding to pay the non-federal share of Medicaid costs provided under Katrina waivers.<sup>18</sup>

## Medicaid Financing Rules Differ in Puerto Rico and the Virgin Islands

Replicating past waivers provided to disaster-stricken states would be an essential step in assisting Puerto Rico and the U.S. Virgin Islands. The territories, however, are certain to need additional assistance due to their capped financing structure. Although large numbers of evacuees may ultimately choose to permanently move to the continental United States, in the interim, Puerto Rico and the Virgin Islands are financially responsible for a significant share of their Medicaid costs.

Unlike state Medicaid programs, federal funds for Medicaid in the U.S. territories are provided through a highly inadequate block grant — a fixed amount of federal funding that falls well below the territories' actual Medicaid costs. Moreover, while states' federal matching rates are based on their per capita income relative to the nation, territories like Puerto Rico and the Virgin Islands and receive a set match rate of 55 percent. (If Puerto Rico's matching rate were set under the same formula as used for the states, it would receive a matching rate of 83 percent.) Once Medicaid expenditures exceed the federal block grant amount for the territory, the territory is responsible for all Medicaid costs going forward. For example, before the ACA, the federal government was effectively only picking up 15 to 20 percent of Puerto Rico's Medicaid costs.

The ACA provided an additional \$7.3 billion in federal Medicaid funding to the territories, available from July 2011 through September 2019. Puerto Rico has nearly exhausted its share of those funds so Congress provided an additional \$295 million this past year. But all of Puerto Rico's supplemental funds are likely to be spent by early spring 2018, resulting in a fiscal cliff. If Puerto Rico does not receive additional funding, it would likely have to remove up to 900,000 people from its Medicaid program (more than half of total enrollment).

But that was before the hurricanes. Now, many more residents of Puerto Rico and the Virgin Islands will likely need Medicaid and their medical needs may also be much greater. Moreover, the hurricanes have likely drastically reduced Puerto Rico's and the Virgin Islands' fiscal capacity to maintain their current Medicaid contributions. As a result, it's critical that additional federal funding be provided to Puerto Rico and the Virgin Islands to sustain their underlying Medicaid programs and address the increased demands as the islands recover.

Providing only \$1 billion to Puerto Rico and \$30 million to the Virgin Islands, as the bill recently reported by the House Energy and Commerce Committee would do, falls well short of what's needed. First, the bill would still require Puerto Rico and the Virgin Islands to increase their own Medicaid spending to obtain the additional funding, which is highly unrealistic since the hurricanes have drastically reduced their ability to maintain, let alone increase, their current spending.

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<sup>17</sup> Park 2005, *op cit.*

<sup>18</sup> Enacted under the Deficit Reduction Act of 2005. Office of the Inspector General 2007, *op cit.*

Second, even if providing matching funds is possible, the funding isn't enough. The additional \$1 billion to Puerto Rico would allow the Commonwealth to sustain its pre-hurricane Medicaid program for well less than an additional year.

## What Congress and the Trump Administration Should Do

The bipartisan efforts to support states after 9/11 and Hurricane Katrina provide a clear model for Congress and the Trump Administration in the coming weeks; however, even more is needed to address Puerto Rico and the Virgin Islands' unmet needs. Short- and long-term funding could help ensure that people get the health care they need and help rebuild and sustain overwhelmed health care systems in Puerto Rico, the Virgin Islands, and other states recovering from recent hurricanes. Moreover, permanent changes in policy could make it easier for states to respond to future disasters.

### Ensure Access to Medicaid Through Legislation

- **Provide short-term financial assistance to Puerto Rico and the Virgin Islands.** Puerto Rico's and the Virgin Islands' block grants need to be temporarily increased by a sufficient amount to sustain their underlying programs *and* address the higher demands placed on their Medicaid programs by the hurricanes. The federal matching rate should rise as well — to 100 percent on a temporary basis — since neither Puerto Rico nor the Virgin Islands will be able to finance their current share of Medicaid costs anytime soon.
- **Ensure full federal funding for states providing Medicaid coverage to evacuees.** As with Hurricane Katrina evacuees, the federal government should ensure 100 percent federal funding for state Medicaid costs related to treatment of evacuees from Puerto Rico and the Virgin Islands
- **Guarantee long-term equity for the territories.** Policymakers should eliminate the cap on federal Medicaid funds for Puerto Rico, the U.S. Virgin Islands, and other territories. Over time, federal Medicaid matching rates for the territories should be based on per capita income as for the states. (As a condition of the matching rate increase, the territories should come into full compliance with minimum Medicaid eligibility levels and federal benefit standards.)

### Streamline Access to Medicaid Through Administrative or Legislative Actions

- **Allow self-attestation of eligibility factors.** Medicaid and CHIP agencies in affected areas and in states hosting evacuees should be allowed to temporarily accept self-attestation of eligibility factors such as citizenship, identity, immigration status, and income at the time of enrollment and when completing redeterminations of eligibility. Survivors of disasters often lose vital documents and have difficulty replacing them. States directly affected by Hurricanes Katrina and Rita and states that hosted evacuees were provided authority to do this under emergency section 1115 demonstration projects in 2005.
- **Simplify applications and delay eligibility redeterminations.** Medicaid and CHIP agencies in affected areas and in states hosting evacuees should temporarily use abbreviated application forms and delay scheduled redeterminations of eligibility. People may be temporarily displaced and experience delays in receiving and responding to requests sent through the mail. Delaying redeterminations can also give agencies more time to handle the likely increased volume of new applications. Similar steps were taken by New York City after the September 11 attacks

- **Streamline disaster relief waivers.** Section 1115 and 1135 waivers offer states important flexibility after disasters, but there is no single, streamlined waiver application process for states immediately following disasters. HHS could support states’ ability to respond quickly after a disaster by creating a streamlined waiver template that encompasses all waiver authorities available in the event of a disaster, allowing states to customize as needed.

### **Improve Access to Marketplace Coverage**

HHS can take additional steps to ensure those affected by hurricanes and other disasters can enroll and maintain access to coverage in marketplace subsidies as well. The department has already announced it’s extending enrollment periods (open enrollment and 2017 special enrollment periods) until at least December 31, 2017 for hurricane-affected individuals (as defined by the Federal Emergency Management Agency), and will monitor the situation to determine if it needs to further extend these deadlines.<sup>19</sup> To the extent islanders have moved to the mainland and want to enroll in marketplace coverage, they and other hurricane-affected individuals would greatly benefit from HHS taking additional steps to ensure people have adequate opportunity to enroll, including:

- **Allowing self-attestation of eligibility factors.** Eligibility for people applying for marketplace coverage must be verified. For most individuals, this is done electronically through data matching with trusted data sources like the Social Security Administration. When eligibility factors such as income and citizenship or immigration status can’t be verified electronically, consumers must provide documents to prove their circumstances within 90 or 95 days depending on what needs to be verified. Individuals living in affected areas and those who have relocated to other areas may need additional time to secure documents, which HHS could allow through a blanket good-cause exception.
- **Provide additional outreach and application assistance support.** Communities affected by hurricanes are dealing with multiple priorities, and some organizations like hospitals, food pantries, brokers, and insurance companies that otherwise could get involved in outreach may have had to spend extra efforts on dealing with hurricane-related matters and will not be able to fully engage in open enrollment period outreach. HHS should ensure there is sufficient funding for outreach and enrollment assistance in hurricane areas
- **Make special efforts to reach marketplace consumers.** The marketplace and issuers provide important open enrollment-related notices to consumers through mail. Consumers affected by the hurricanes may get this mail only after significant delays, if at all. To ensure consumers are provided sufficient notice about important changes related to open enrollment, the marketplace should call consumers and use email and text messages to make sure they know what their subsidy eligibility will be for the coming open enrollment period and the plan they will be auto-enrolled in, as well as to encourage consumers to update their information and select a plan that best meets their needs.

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<sup>19</sup> Center for Consumer Information and Insurance Oversight, “2017 Hurricane Disasters – Special Enrollment Periods (SEPs), Termination of Coverage, and Grace Period Flexibilities,” September 28, 2017, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2017-Hurricane-Disasters-Guidance.pdf>.