INTRODUCTION

First, I'd like to thank the Subcommittee for traveling to Louisiana and for conducting your hearings here. Being on the ground and witnessing first hand our long road to recovery will itself provide you with invaluable insights as you think about how to protect our communities from large-scale external threats to public health and healthcare. It's a privilege for me to appear before you this afternoon to share what Katrina and Rita have taught us about our vulnerabilities.

I'm President and CEO of Blue Cross Blue Shield of Louisiana. I moved to Louisiana from Connecticut to assume this position just ten months before the hurricanes hit. More recently, I have served as chair of the Health Systems Redesign Workgroup under the Louisiana Recovery Authority. This effort has now evolved into the LA Healthcare Redesign Collaborative chaired by Dr. Fred Cerise, Secretary of Department of Health and Hospitals.

To give you context for my observations, let me take a minute to give you some background on our company. We are a traditional Blue Cross organization. By that I mean we are an exclusive state-wide Blue Cross Blue Shield licensee, governed by a local board of directors. We are a not-for-profit, but tax paying organization owned by our policyholders. We employ about 1400 Louisianians. We are the manager of medical benefits for just over one million of Louisiana's 4.4 million residents, representing just about half of those with private health insurance.

My observations are drawn from the vantage point of assisting our one million members in securing the healthcare services they needed during the immediate crises and this long and continuing aftermath. This has meant working closely with not just these members, but just as importantly, their care providers. We have also worked closely with their employers and with our agents and brokers who serve them. Having said that, my observations are personal ones and do not necessarily reflect those of our company or of the Redesign Collaborative.

The Public Health Side of Hurricanes Katrina and Rita

Televised images of the hurricanes' physical and emotional toll on the citizens of South Louisiana are already seared into our consciousness. Comprehensive histories of Katrina and Rita and their immediate aftermath have already been documented and need no embellishment here. However, from a public health standpoint, there is an aspect of Katrina's and Rita's legacy which, while less obvious, is even more important. This legacy is that of peoples' inability to access critical healthcare services when needed and the inability of caregivers to provide care that is most appropriate.

While these issues existed to some degree before the hurricanes, they turned extraordinarily acute after the hurricanes, teaching us four very important lessons.

LESSON 1 A Metropolitan Area's Healthcare Capacity Is Easily Overwhelmed.

- Pre-Katrina, the New Orleans area, by almost any measure, appeared to have excess clinical capacity, at least in terms of in-patient beds, nursing home beds, and clinical specialists. Katrina's decimation of the health system created an unexpected shortage.

- Katrina's toll on the healthcare capacity in the New Orleans area was swift and deep. Only three out of the 15 or so hospitals in the area remained open throughout the ordeal.

- Shortly after the hurricane, shock waves of excess demand for healthcare services spread quickly throughout the state as evacuees from the affected areas arrived, many in need of care.

- Today, most of the hospitals in the New Orleans area remain closed, including Big Charity. Those few that have since reopened (e.g., Tulane) are operating at reduced capacity.

- While many area residents left and are still gone, doctors and nurses who had been practicing in the New Orleans area left in even greater proportions. Based on Blue Cross Blue Shield of Louisiana claims data, about three quarters of the some four thousand independent physicians who were practicing in Orleans, Jefferson or St. Bernard parishes prior to Katrina remain unaccounted for, i.e., have not submitted claims since the hurricane.

- According to many service providers on the ground in the New Orleans area, the per capita need for healthcare has increased significantly due to hurricane related causes (mental health, accidental injury and stress-induced increases in morbidity). This surge occurred without the spike from potential hurricane-related disease outbreaks that some had feared. Thank goodness.

LESSON 2 Logistical And Communication Issues Make It Difficult To Properly Use The Limited Healthcare Capacity Available.

- In the period immediately following Hurricane Katrina, many needed and willing medical professionals already within the area or coming into the area were not engaged due to credentialing or licensing issues, fear of professional liability and the lack of centralized coordination.

- Loss of contact between physicians and the ill patients they were attending prior to the hurricanes rendered appropriate clinical follow-up with these patients impossible.

- Normal referral patterns among independent providers have been thoroughly disrupted, leading to disruptions in patient care itself.

- There is no centralized information or database from which patients or referring physicians can determine which nurses and doctors have remained in or have returned to the affected areas.

- Resource shortages in certain key areas cause bottlenecks throughout the care continuum, e.g., the inability to discharge hospitalized patients due to the shortage of home healthcare nurses needed for follow-up.

LESSON 3 The Widespread Loss Of Patient Records Put Large Numbers Of Patients At Risk.

- Paper medical records housed in affected physician offices were entirely destroyed.

- Many ill patients who evacuated left without their medications or prescriptions.

- Doctors and hospitals in surrounding areas who were seeing many patients for the first time had little or no patient medical history or other pertinent information to go on as they were treating these patients.

- Post-hurricane efforts to reconstruct meaningful medical record proxies either through claim histories (as done for Blue Cross Blue Shield of Louisiana members) or through pharmacy data (as done collaboratively through katrinahealth.org) were technically successful; in practice, they did not garner much uptake at the time as the requisite provider awareness and education could not be achieved in a timely manner.

LESSON 4 The Normal Methods of Reimbursement which Healthcare Providers Rely On Are Easily Disrupted.

- During the height of the emergency and its aftermath, providers were preoccupied with meeting immediate patient needs and not with gathering patient documentation which would later be needed to submit claims, particularly in the case of Medicaid patients and the uninsured.

- Some of the unique aspects of healthcare financing in Louisiana, particularly the dependence on the "Charity" system for indigent care and our heavy dependence on Medicaid and "Disproportionate Share" funding, have created unanticipated systemic vulnerabilities. Some examples:

    - Closure of LSU's Big Charity Hospital left LSU Health Services and Tulane and LSU Schools of Medicine without significant revenue sources.

    - Charity's closure significantly increased the percentage of uninsured and Medicaid patients treated by other hospitals in the area which are not normally compensated for providing those services.

- Prolonged inpatient lengths-of-stay due to difficulties in discharging are creating losses on Medicare-based DRGs.

- Independent physicians, particularly those serving the Medicaid population, face difficulties maintaining their practices due to the dispersion of their former patients and the lack of critical mass in most neighborhoods for developing new patient bases.

- Private insurance has so far remained resilient to Katrina-induced demographic and economic disruption. Of the more than 800,000 whose group insurance is provided by Blue Cross Blue Shield of Louisiana, about 30,000 have lost their employer provided coverage. Lapse rates in individually purchased coverage have been lower than normal. However, per capita claims levels in the immediate hurricane-affected areas have remained somewhat lower (10%) than expected, due apparently to the compression on the healthcare delivery system for the reasons stated above. For providers, this reduction in services to privately-insured patients, while modest, adds to their financial strain.

- Many new workers in the New Orleans area are arriving at hospitals needing medical attention, but are uninsured even for workers' compensation.

CONCLUSION

To respond appropriately to a major community-wide or regional disaster, whether natural or man-made, we must overcome the systemic weaknesses exposed by Katrina and Rita. In redesigning our health system in Louisiana following the hurricanes, we have the opportunity to build a new system that is sufficiently flexible and adaptable in the face of disasters. Specifically, we need to-

- Insure reliable, real time communication capabilities exist among first responders, government officials and the many involved in the management and delivery of healthcare for the immediate and surrounding area;
- Establish plans in advance for networking with other clinical resources, both those in the area and those from out of the area, to establish capacity for dealing with a surge in demand following a disaster-induced shut down in clinical capacity in the immediately affected area;
- Better communicate and integrate the efforts of all parties, public and private into the immediate emergency response;
- Quickly and effectively coordinate public policy follow-up to resolve acute and structural issues associated with the aftermath of the disaster;
- Establish electronic patient health records for everyone;
- Maintain a real time electronic registry of healthcare professionals in the area with complete tracking of those moving into or leaving the area;
- Redesign public reimbursements for health care services to make sure they work for all providers delivering care during and following a disaster;
- Consider requiring businesses involved in the affected area's redevelopment to provide workers' compensation and health insurance benefits to their workers;
- Provide temporary support to people losing their employer-provided health insurance through a mechanism such as the Health Coverage Tax Credit available to those losing their jobs under international trade agreements.

Thank you for your kind attention. I would be happy to respond to any questions you might have.