Managed Care

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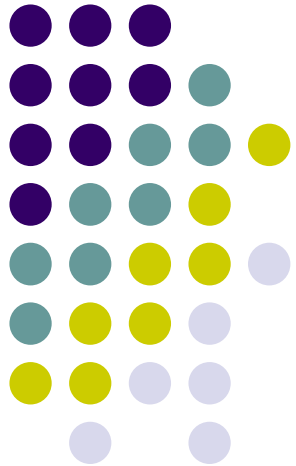
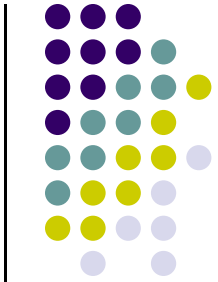
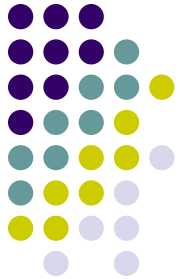


Rising costs of healthcare



- Rapidly developing (& expensive) technology
- Drug therapy advances prescription cost increases
- Shifting demographics (aging population)
- High expectations about life expectancy
- Consumer demand for more say & control
- Medical malpractice & defensive medicine

Rising costs (cont.)



- High administrative costs
- Inefficient/poor quality care
- High incomes of providers unrelated to outcomes
- Costly compliance with regulations
- Limited public dollars aggravating cost shifts
- Cost shifting within the health system

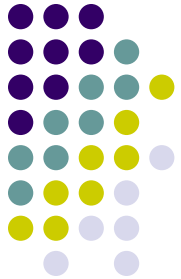
Before managed care

- Western Clinic Tacoma WA 1910
  - $.50 per member per month for range of services
  - Available only to lumber mill owners/employees

Before managed care

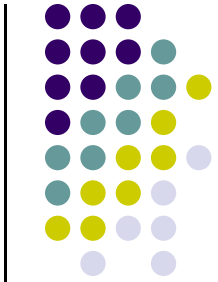
- Dr. Michael Shadid 1929
  - Cooperative plan for farmers in Oklahoma
  - Charged members $50 to build a hospital
  - Lost his medical license due to outrage by other doctors in OK

Before managed care



- Baylor Hospital in Texas 1929
  - Provided 1500 teachers prepaid hospital care for $6 per month

Before managed care



- Kaiser Foundation in California 1937
  - Provided company paid healthcare at work sites in remote areas and later urban work sites

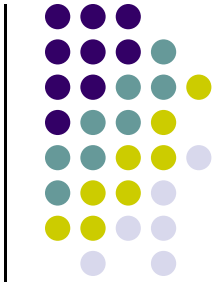
Before managed care

- Group Health Association 1937
  - Home owners loan corporation to provide medical care in order to avoid mortgage defaults

Before managed care

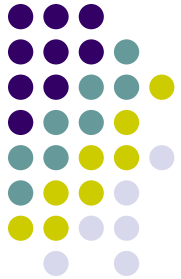
- Health Insurance Plan (HIP) 1944
  - New York City created for its employees

Before managed care



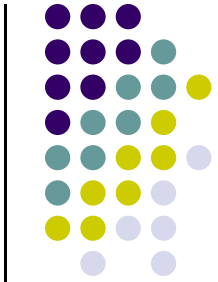
- Group Health Cooperative 1947
  - 400 families in Seattle area (Puget Sound)
  - Each family contributed $100

Since 1970….HMOs



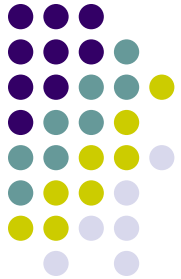
- 1973 Enactment of the Health Maintenance Organization Act
- Paul Ellwood, M. D. “father” of the HMO as we now know it
- Health Maintenance Organization (HMO) replaced the term prepaid group practice

First Generation



- Single funding stream
- Contracts for delivery of services (benefits)
- Management by benefits
  - hospitals and doctors in network covered
  - Providers out of network not paid

Second Generation

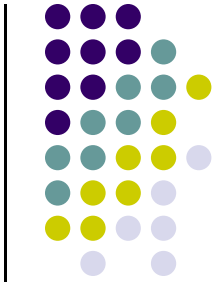


- Managed Networks
- Contracts with doctors & hospitals placed requirements upon them in order for them to be paid
- Anything other than emergency admissions must be “precertified”
- Advent of “medical necessity”

Third Generation manage care

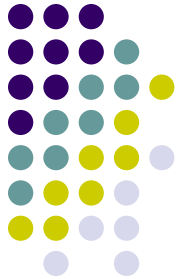
- Treatment protocols, first efforts at best practices, intrusion into practice of medicine
- “Denials” non payment commences in earnest
- Disease management
- Formularies implemented restricting covered medicines encouraging use of “generics”

Fourth Generation



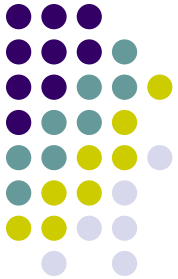
- Outcomes management
- Tighter restrictions on elective/experimental procedures
- Goals to reduce medical mistakes & outlier practices
- Medicare announces that subsequent treatment for avoidable bad outcomes may not be paid

Fifth Generation?



- National requirement that all be covered in some way?
- Attempts to minimize cost shifting
- Beginning of the end of “private care” covered by insurance
- More exploration of Healthcare Reimbursement Accounts & High Deductibles

Public Policy issues



- Beginning of Life issues
- End of life issues
- Quality of life issues
- Healthcare service access a right?/responsibility? Both?
- Personal choice examined in new ways
- More transparency about actual costs for healthcare services