

ASK JOE MARCH '03



WHAT IS THE HISTORY OF MANAGED CARE, HOW HAS IT EVOLVED, AND HOW WILL IT AFFECT THE FUTURE OF HEALTHCARE?

A: Although Managed Care Organizations (MCOs) have received much attention over the last ten years or so, the concepts, as well as some successful models have been in place since the early 1930's. It is important to keep in mind that the entire health insurance industry is relatively young and still evolving. The idea of employers offering health insurance as a benefit to employees is very much part of the industrialization post World War II. As the US advanced as an industrial giant, unions and collective bargaining helped to secure additional benefits for workers. Health insurance was a relatively inexpensive option over salary and was used by companies to meet demands of labor. The cost was low because the risk was low. Most health care was basic and significant expenses only incurred with catastrophic illness or injury. Care was paid for on simple, often modestly priced fee-for-service schedules. Many health plans were traditional indemnity plans with beneficiaries paying significant out of pocket monies for routine outpatient care and medication. The cost of health care was modest since the offerings were limited. Premature infants didn't survive before 30 weeks gestation; there were no routine heart surgeries; no hip/joint replacements; no organ transplants and no biotech drugs. It is easy to forget that two of the largest and most well-known health benefit providers, Medicare and Medicaid are less than 40 years old, enacted in 1965 as part of President Johnson's "Great Society" package.

A BRIEF HISTORY OF HEALTH MAINTENANCE ORGANIZATIONS (HMOS)

HMO is a broad term covering a number of different business models of health coverage that include Staff Model Groups, Preferred Provider Organizations, and Point of Service Plans, just to name a few. The common thread among all HMOs is the control of cost. Managed care has often been accused of being "managed money."

Probably the most well known HMO is Kaiser-Permanente. At the height of the depression a young surgeon named Sidney Garfield, MD started a hospital in the middle of the desert to serve the medical needs of the men building the Los Angeles Aqueduct. Few men had any insurance and those that did rarely paid in a timely manner (little has changed). For five cents per day workers were provided with health care for treating work related injuries, for an additional five cents workers could get treated to non-work related illness. With this model the prepayment and staff model concepts were born. Industrialist Ed Kaiser recruited Garfield to establish a health care system for 6,500 workers and families at the largest construction site in history, the Grand Coulee Dam. Upon the completion of this project in 1941 Garfield followed Kaiser to the Kaiser shipyards in California and developed the Kaiser health system that continues through today.

ADVANCES IN HEALTHCARE

Health care, technology and pharmaceuticals are advancing at lightening speed. With the quantum leaps in science and care over the last 15-20 years in medicine, people are starting life earlier and are living longer lives -from 24 week premature infants and crowded NICUs to geriatric patients living well into their 80's and 90's in assisted living centers. The advances in care and treatment have outpaced the insurance industry models. Add in a highly litigious environment and rising malpractice costs and you get a recipe for financial disaster.

SO, WHERE ARE WE NOW?

All of the "at risk" payers, including Medicare and Medicaid are racing to find ways to reduce the skyrocketing costs of care. The first method is simply to ratchet down payments to providers, a practice that most HMOs have been practicing the last ten years. However, this is only a short term fix and doesn't address the long term needs of society. Unfortunately it seems this appears to be the primary solution.

On March 3, 2003 the office of President Bush released his outline for improving Medicare. The document, entitled "21st Century Medicare: More Choices—Better Benefits" outlines the President's proposal to update and fix Medicare. This proposal includes an additional \$400 billion over the next ten years, monies from a budget that seems over-committed. To read the complete document, please visit our website at www.rcmed.com.

Along with Medicare and Medicaid we are going to continue to see HMOs look to reduce expenditures, particularly in areas they view as over-priced. It is common knowledge that drugs and outpatients treatments are primary targets for such reductions in payment, not because these are the best and lowest cost points of care that improve the quality of life of the patients but because they are easy, high dollar targets.

WHAT CAN WE DO?

We need to educate patient groups about the quality care they are receiving in the outpatient setting vs. being forced to receive treatment in the hospital. **We can say "no" to bad HMO contracts (don't sign on to plans that pay below the cost of service).** It is important for physicians to 1-analyze true value of the contract, 2- get a better handle on your practice's overhead costs and costs of labor, 3- completely understand what it costs to administer a patient in your practice. Physicians must stay active and continue to support ASCO and other organizations that are lobbying for the best interest of oncologists and patients.

In dealing with managed care, we need to understand that it's more than just managed care, it's understanding the market environment and cost analysis. We are held to difficult standards of quality in an environment where the insurance companies are trying to push risk and cost to someone else.

Joseph Lewarski, OA's Chief Operating Officer and Co-founder, answers the frequently asked questions posed by OA's membership. Contact him with your questions at jlewardski@rcmed.com.