Dynamic Chiropractic

Indemnity, Workers' Compensation, Managed Care ... Does History Repeat Itself?

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History tends to repeat itself. A brief review of insurance history makes the point. The insurance concept began in Germany in the 1880s; it first appeared as a way to pay for wages lost as a result of sickness,[1] not to pay for costs of care. The United States evolved this concept into health insurance by financing medical care. The first crisis in the cost of health care occurred in the 1920s when the high medical costs threatened the economic viability of families. The model for indemnity insurance was created to empower access for the middle class.

Initially, such coverage was aimed at catastrophic illness and prolonged, heavy expenses. As companies sought to extract profits from insurance premiums, they sought greater enrollments. The sovereignty of medicine of the time defied external management of medical practice, and therefore the two practical means to increase the number and stability of their subscribers. Both were by means of competitive product development. Insurer strategies included entry into new markets and underpricing product to gain market share, followed by an escalation of the premiums to cover costs and generate profits. For more established and stable markets, they developed new products offering a spectrum of benefits as riders that could be added on to the basic packages.

It was this latter vehicle that, coupled with the political pressure of DCs and their patients, resulted in the inclusion of chiropractic as a rider benefit. This evolved, with continued competition and political lobbying, into the mix of indemnity, workers' compensation, PIP and Medicare benefits available to the public by the end of the 1980s.

This system incentivized the American public's expectations for economically painless utilization of the health care system. In addition, it incentivized a cavalier attitude among many providers in ordering and performing diagnostic and therapeutic procedures. These factors, among others, conspired to inflate the costs of care again. The social response was to seek health care reform.

By this time, health care as a whole and medicine in particular had tarnished their cultural authority and lost their position of sovereignty. Decades of stasis in the American populace rankings in world health and infant mortality conspired with the increasingly frequent news of medical (with a small "m") avarice, fraud, and abuse to foster an atmosphere that demanded external management systems for health care. Beginning with the Medicare act that empowered utilization review, an increasingly intrusive set of tools have been poised over our shoulders. Credentialing for panel membership, precertification of services, utilization review, guidelines, protocols and pathways of care and, now, criminal investigation are the tools that society (not just insurance companies) feel smug to use.

In the meantime, the insurance industry (in all of its forms) has suppressed utilization, mostly by limiting access to providers and services. At the same time, they have reaped an economic harvest and layered the system with strata of bureaucracy that are often inconsistent from one payer to another.

Such systems serve to make the use of health care so cumbersome as to frustrate the patient and provider from its use by its sheer weight of complexity, or to empower payment denial for failure to comply with individual criteria. The frequent changing of plans by employers and employees, legislative patient-protection initiatives and lawsuits against payers are symptoms of the increasing frustration.

In the mid-90s, the managed care system was called a success because of the stemming of health care costs as a proportion of the GNP. The superficiality of that claim may now be surfacing. For the past two years we have heard the warning that costs are beginning to rise again. Indeed, recent news in the Dallas-Fort Worth area reported "massive" losses for area HMOs in 1997.[2] For the top 10 HMOs, only two were profitable. Where did the money go? Certainly, it did not go to the providers. My hypothesis aims at the costs of the administrative layers that the payers have installed. Indeed, the percentage of expenses the HMOs reported that were actually spent on actual health care services fell to a range of 55.3%-90%. Increased premiums of 10 percent in 1998 and larger ones in the future are forecast. Ominously, they also signal "less coverage for the consumer."

If history is to repeat itself, we are now to see a flurry of competitive activity where payers attempt, once again, to increase and stabilize their subscriber base. In fact, a loosening of the reins on access to providers has already begun by the introduction of POS (point-of-service) plans. Like indemnity care of the past, companies are moving into markets and underbidding their competitors as loss-leaders, bragging of premiums and diversity of products. In addition to the riders already available through some HMO and PPO plans that offer chiropractic services, it is likely that chiropractic will become a primary enticement. In fact, an article by Patricia Gray in Business and Health essentially predicts that day has arrived. Her "Benefits Bulletin" was entitled "Chiropractic: the new benefit staple."[3] It credits the impact of scientific advances in chiropractic and the impact of consensus panels (RAND) and guidelines (AHCPR -- ironically, appreciated more by DCs than is Mercy, yet less permissive) as moving chiropractic form the "alternative" ranks. Her article reports the positive experiences of employers and patients.

So the cycles and the irony continue. Hopefully we can capitalize on the advances we have made and the lessons of history available to be learned. It is unlikely that the devices of management in managed care are going to go away even as they have evolved. It is unlikely that we or other health care providers will ever ascend to the sovereignty of old. Medicine has lost its luster, but retained much of its scientific and political authority. All health care disciplines have become suspect as having the potential to exploit the system. If we are to avert the turmoil of the past decade for our children and the DCs that follow us, we must learn how to become integral parts of the system and influence decisions from within. We must learn how to obtain and package the evidence of our accountability, competence and legitimacy within the health care team. Through these methods we can demonstrate our ability to meet the needs of our constituents (patients, employers, payers, and health care policy makers). For the next round, we have the opportunity to define our cultural authority.

References

1. Ensmann Dr. Surviving in health care. Mosby 1997.
2. Ornstein C. Area's HMOs report massive losses in '97. The Dallas Morning News, March 13, 1998, pg 1.
3. Gray PM. Benefits Bulletin -- Chiropractic: the new benefit staple. Business & Health, March 1998, pg 45.

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