VIEWPOINT

MAJOR MEDICAL INSURANCE THE NEW CHALLENGE

Nathan Flax, O.D., M.S.

In the mid-1950s several patients informed me that they were being reimbursed for vision therapy services under their health insurance policies because their family physician wrote a note recommending my services. This was disquieting. It was obviously beneficial for the patient to be reimbursed, but it also aroused concern regarding the value of my license to practice. I contacted the insurance companies and was told that they did not honor an optometric signature.

When attempts to interest the New York State Optometric Association in pursuing this matter were not fruitful at that time, I personally hired their attorney. At his suggestion, a syndicate of five optometrists interested in vision therapy was formed to pay the $500 consultation fee. This proved to be an excellent long-term investment for the profession of optometry. Based on that initial investigation, the attorney subsequently reported to the NYSOA that this should be made a priority matter, requiring legislative changes. This process culminated in passage of a "Freedom of Choice" law in New York state which became the model for other similar state laws.

Despite frustrations and initial slow compliance, there has been acceptance by the insurance industry of the optometrist as an independently licensed practitioner. Consequently, the optometrist has become included in the spectrum of health practitioners whose services are covered under major medical insurance. The growth of vision therapy as a treatment modality, with a wider utilization by more patients, is at least partially based upon acceptance of vision therapy as an insurable health service. The inclusion of primary care optometry in third party programs actually started with vision therapy in 1962.

Now the health care delivery system itself is undergoing major revision. While the insuring of "fees for services" has helped to expand availability of medical services, it has also increased the total cost to society to levels that perhaps cannot be maintained. Thus, the emphasis is now on developing cost-efficient models of health care delivery. The watch word is cost containment and the movement is away from fees for services, toward negotiated fees and limitation of services.

In this climate there is need to plan carefully so that vision therapy can be integrated into the developing systems of health service delivery. New initiatives are called for. Data bases must be developed so that optometric vision therapy can appropriately become part of health maintenance organizations, prepaid plans, preferred provider organizations, etc. Some of the new plans actually utilize "gate keeper" mechanisms in an attempt to reduce utilization of secondary services by offering financial incentives to the gate keeper to not refer for secondary care. This discussion is not directed toward the morality of such an approach, although it certainly warrents discussion. The immediate concern is to alert the vision therapy community to the need to take the necessary steps for inclusion in those programs which sincerely wish to offer optimum care to their patients or clients.

The concept in all of these plans is that rates are contractually arrived at based upon projected utilization and costs. The participating providers are generally asked to accept reduced fees in return for an assured supply of patients. Unfortunately, the existing Freedom of Choice laws may not protect in this new delivery model since each arrangement is based upon specification of conditions to be treated. Disease entities may be excluded depending upon what takes place at the negotiating table, and negotiations are difficult without good data.

Primary care optometry and routine refractive services can be subjected to a cost analysis with reliable projections. This type of analysis is not as easily accomplished in the area of vision therapy. There is pressing need to develop more precise optometric vision therapy syndromes with data as to prevalence and treatment costs. This must be in terms of both time and dollars. Without such firm data in hand, it is not possible to enter contractual negotiations.

This, then, is the problem and the challenge. More than a quarter of a century of development within the insurance model is coming to a close. The economics of health care delivery are changing. The change is going to emphasize cost containment and payment based on diagnosis. It is vital that optometrists offering vision therapy become acquainted with the new systems and that appropriate actions be taken to insure that vision therapy is, as it should be, included in the spectrum of services offered.

Corresponding author:
Nathan Flax, O.D.
585 Stewart Avenue
Garden City, NY 11530
Date accepted for publication:
November 16, 1991