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Abstract
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This paper explores the historical development leading up to the 1984 attempts to amend the Medicare Laws, the impact of the presently enacted laws for third party payments in the public sector, and the current legislative directions pursued by ophthalmologists and optometrists.

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THE DEVELOPMENT OF
THIRD PARTY PAYMENTS LEADING TO MEDICARE

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ABSTRACT

In 1984, the introduction of the Medicare Reform Act, HR 3010, sought to expand coverage so that the elderly would receive reimbursement from both ophthalmologists and optometrists. Since 1965, there have been numerous attempts to have the Federal government redefine the role of optometry in the delivery of vision care. This new definition recognizes the fact that optometrists may provide vision related services other than refraction. This bill along with a companion bill, HR 3009, which was drafted to expand medicare services to the low vision population, failed to be enacted into law. Both bills signal attempts to redefine legislature's understanding of what optometry is providing.

This paper explores the historical development leading up to the 1984 attempts to amend the Medicare Laws, the impact of the presently enacted laws for third party payments in the public sector, and the current legislative directions pursued by ophthalmologists and optometrists.
METHODS

This paper was produced by searching references through the DIALOG Information Services provided by the Harvey W. Scott Memorial Library on the campus of Pacific University, Forest Grove, OR.
Providing primary health care to all individuals in our society is one possible goal of health care professionals in United States. Providing vision care to individuals is one aspect of primary care. Third party programs such as Medicare demonstrate that access to vision care by the public sector has been restricted by legal and by political definitions of who is qualified to provide care, rather than whose services could be used more efficiently. There are numerous factors to consider in the development of a cost effective system of vision care. These include: soaring medical costs, legislative development, public enlightenment about optometry, redefinition of optometry by lawmakers, competition between the professions for patients' dollars, increasing reliance on private third party insurance programs and public third party governmental programs such as Medicare and Medicaid—these and more leverages are factors into the struggle to fashion a cost effective system of vision care. This paper will explore the development of Medicare and of vision care provision within Medicare.

The development of third party payments for twentieth century health care has been a slow evolution. Preserving the principles of economic competition, fulfilling the patients' expectations of accessible vision care, and retaining flexibility for patients' free choices of health care providers are difficult guidelines to implement third party payments in the public sector.(1) Medicare, in particular, has not recognized optometry's potential for delivering economical and efficient vision care and has not been receptive in defining optometry as a primary health care provider. How has all this come about? What is optometry's role in primary health care in the next several years?
Origin of Public Funds for the Sick

The first third party payment in the public sector was established by Prussia in 1848. Taxes were collected from workers and employers, and administered by private insurance companies and the state. By 1903 this system provided ten million people with medical care. In Britain, at the turn of the century, free choice of doctor and preservation of competition were accomplished by a system of simple capitation taxes rather than a "fee for services" regimen. Effective cost containment relied on each person paying the capitation tax, reduced the need for a large bureaucracy and allowed the insurance principles to become established.(2)

America in the early 1900's

Management of public health care in the early 1900's relied on responsibility of the states' control. The Flexnor Report (1910) sparked a revolution in instituting qualified and consistent care among medical practitioners. The consumers gained faith in medical care. During the 1920's, patients sought care as individuals, not as a member of any group in electing care. During the first decade of the century, political reformers interested in the national health insurance were politically naive and were not able institute any changes. Executives from private insurance organizations (notably Prudential Insurance Company) successfully campaigned against such health referendum legislation during the 1920's.(3) The Great Depression changed the tide.

The 1930's Introduce a New Nationalism

Dr. Wilbur in his 1932 report, "Medical Care for the American People," brought a new consciousness in the medical profession. While advances in science was rapidly providing effective knowledge in medical care and new
advances in successful treatment, the administration of medical care was inaccessible for many parts of the country and its citizens. Health care was becoming an expected right, rather than a purchase of the rich. (4) In response to this growing change of opinion, medical insurance provisions were drafted into the Social Security Laws of 1935. Medical and insurance lobbies prevented this from being enacted into law, despite a New York Times report in 1938 that stated seventy percent of the doctors in the New York area favored some form of national health insurance. (5)

Influence of WW II and Trade Unions

In the 1940's, the concept of health care access for everyone was promoted by the experiences of thousands of soldiers returning home after WW II. They had the opportunity to see health care in Britain administered on a "need" basis rather than a "fee for service" basis. Every person in Britain was treated without regard to ability to pay. This vision of health care by American soldiers provided the impetus for the new concept of health care access for everyone.

Health care insurance became a commodity that trade unions used as a bargaining tool for during labor and management negotiations. Shipyard workers in the American Kaiser company received health care benefits in compensation for limited wages during WW II and the postwar decade. American reformers modeled their health care system ideals on the National Health Service of Great Britain, which was developed in 1946. (6)

Health as a Political Issue

In 1948, as part of the Democratic platform, health care became an issue. After Truman was elected, the American Medical Association devoted one million dollars (in 1985 dollars, this equivalent to $5 million) to
prevent his plan for a national health insurance from being enacted into law. Concurrently, however, Blue Cross, Blue Shield, Kaiser-Care, and other private insurance companies had enrollments increase from 9% in 1940 to 66% of the American populace in 1956. Increased competition between health insurance companies, however, did nothing to reduce health care expense. Health insurance did little more than protectively cushion subscribers from the increased medical expenses which grew 42% between 1953 to 1960. Lay people grew "reticent about questioning" the necessity of the procedures, which had become complex and expensive, because the services were paid for by private third parties.

The Kerr Mills Plan

Rural and new urban poor as well as the non-earning elderly were groups most often unable to afford health insurance. The AMA supported the Kerr-Mills health plan in 1960 in an attempt to reduce this negligence. In this plan, federal money was to be used to provide care to those over 65 by disbursement of funds through individual states. Medicare was enacted into law in 1964 and Medicaid was approved soon thereafter.

Medicare Definition

Medicare is the health care program for medical and hospital benefits for those receiving Social Security. Medicaid derived its money from the general tax coffers and was a state directed and awarded health insurance for those eligible for welfare and the medically indigent. Health care benefits of newly developed drug and treatment regimens were now available to those whose access had been limited by restricted income. Medicaid's impact on the poor and disadvantaged can be illustrated by a single statistical change of mortality rate of non-white
Populations: the decline from 40.5 deaths per thousand in 1965 to 22.9 deaths per thousand in 1975.(11)

Optometry in 1965

The optometric patient who became eligible for Medicare or Medicaid in 1965 was faced with one doctor whose services were reimbursed and one doctor whose services were not reimbursed. The law determined that only a physician was to get paid for vision care rendered under the Medicare program. Medicare did not recognize that optometrists provided diagnostic services or primary health care to Medicare eligible patients. Medicare law prohibited optometrists from receiving reimbursements for vision care services identical to those services provided by ophthalmologists. Patients eligible for third party payments in the public sector chose ophthalmologists for vision care services.(12) There was no chance for competition among health care providers; the government precluded free choice of any practitioner, since only one profession was singled out as a provider of vision care.

The 1967 AOA Campaign

In 1967 the AOA lobbied for reimbursement for optometrists for any service within their licensure. The duration of an agreement between the House and Ways Committee and the AOA for this provision was brief. A bill was drafted to allow optometrists to be reimbursed for diagnosis and detection of eye diseases only where licensed to treat such diseases. The bill was omitted, and a study (to become known as the Cohen Report) was issued by Health, Education and Welfare Department to determine the scope of optometrists' qualifications as well as those other non-physician health care providers.(13)
The Transition of the 1970’s

The Cohen Report of 1968 did not recommend the inclusion of diagnostic services by optometrists, unless refractions and eyeglass provisions were part of the health care benefit. In 1972, efforts to include direct reimbursement to optometrists for examination of the aphakics (patients whose ocular lenses have been surgically removed) was approved by Congress. (14) The passage of the bill was tailored to restrict optometrists to providing only aphakic refractive prescriptions, and did not provide an inclusion of reimbursement for other services by optometrists. In 1976, the Bureau of Health Manpower published a study by three ophthalmologists, three optometrists, one optometric educator and two consumers. (15) The results of this study revealed that aphakic services, low vision care, and other diagnostic services should be reimbursed to optometrists; that joint development of diagnostic drug legislation should be initiated by ophthalmologists and optometrists; that optometrists were indeed qualified in providing these services. During 1978, however, the Senate and the House passed separate versions affirming reimbursement for aphakic care and expanding services reimbursed to optometrists based upon the Bureau of Health Manpower. Adjournment of the U.S. Congress prohibited the separate bills from becoming law. (16)

Discrimination Revealed

Soroka in 1980 claimed that there was an inequity of reimbursement from Medicare for similar routine vision exams by the professions of optometry and ophthalmology. (17) Discrimination was illustrated by the fact that diagnostic services provided by optometrists were not paid for by
Medicare. Since 1972, only dispensing services for aphakic patients were considered reimbursements allowable for optometrists. (18) Thus, elderly patients wishing vision care would be more inclined to select ophthalmologists which were completely reimbursed by Medicare, than remain with their family optometrist or initiate a new relationship with an optometrist. Instead of discriminating between diagnostic services, Medicare discriminated between professions. This provided inflated costs for taxpayers. Four factors which inflated costs of the vision care for Medicare patients and which discriminated against optometry were:

1) Medicare refused to recognize that optometrists performed diagnostic services identical to ophthalmologists. Medicare assumed that an optometric exam and a refractive examination were completely identical. Although, optometric exams included many diagnostic evaluations beyond the limited definition given by Medicare. As an example, cataracts are detected in many of the elderly by optometrists. Cataracts have a prevalence of 18.0% in ages 65 to 74 and 45.9% in those aged 75-85. "Since most cataracts are minimal or peripherally located they do not interfere with vision." (19) The only elective treatment for the condition is surgery. When an elderly patient has routine vision care by an ophthalmologist, she/he were covered by Medicare. Both optometrists and ophthalmologists would observe the patient for "impairment of the individual's functional
abilities and/or when the cataract presents a risk for phakomorphe or phakogenic glaucoma or uveitis." (20)
Yet despite the identical diagnostic services being identically performed by both professions, optometrists were not paid by Medicare.

2) The cost of an exam for an ophthalmologist is higher than an optometrist. In a survey by Soroka, one out of four Medicare patients indicated that needing glasses was the purpose of seeking a physician. In 1980, New York city optometrists and ophthalmologists were receiving $18 and $44.45, respectively for vision examinations, and New York State optometrists and ophthalmologists were receiving $21 and $39.86 for their respective vision exams. Because ophthalmologists generally receive more for their exams, Medicare unwittingly inflated its cost effectiveness at least for one quarter of the population which needed only refractions. (21)

3) The public is misinformed by offices of ophthalmologists. Despite the fact that refractive services are excluded by Medicare and despite which practitioner gives the service, the advice given to patients by ophthalmologists is that Medicare includes all services. In a survey of 167 ophthalmological offices in New York State and New York City, 80% responded that Medicare would pay for the "cost of an annual check up of their eyes." (22)
4) Confusion exists with respect to what is included in an ophthalmological examination. Blue Cross/Blue Shield was the deliverer of payment for the Medicare program in New York. Under its coding procedures and payment for eye care services ophthalmologists received more for a "Complete Eye Exam, refraction excluded" ($38.30), than for a "Complete Eye Exam, refraction included" ($30.30). During 1981 only 6.4% (8932 out of 138,925 claims) of the claims filed with Blue Cross were coded for "Complete Eye Exam, refraction included." (23)

However, ophthalmologists do regularly include refraction as part of their diagnostic vision exam and patients regularly seek refraction services. In substantiation of this fact, are statistics from the Summary and Critique of Available Data on Prevalence and Economic and Social Costs of Visual Disorders and Disabilities (National Institute of Health). The Summary reports that 29.45% (9,175 of the 31,155 million visits) of the "reasons for visits" to ophthalmologists were diagnosed "refractive error." (24) If 29.45% of the visits were for the purpose of diagnosing and prescribing corrections for refractive errors, and if price advantages between service by optometrists and ophthalmologists saved ($39.86-$21) 47.3% = ($39.86), Medicare reduction of spending would have amounted to 158.7 million dollars if optometric services had been used for vision exams with respect to Blue Cross filing claims and to New York State surveyed exam fees of 1981. [(9.175 visits @ $38.30= $351.4 million) - (9.175 visits @ $21.00= $192.7 million) = $158.7 million] In addition to the economic inflation, a question of impropriety is raised concerning the
disparity of services sought and services claimed. However, the submission of 16% of the total Medicare claims citing the inclusion of refraction as part of the vision exam by ophthalmologists of New York State (Blue Cross claims of Complete Eye Exam, including refraction and Subsequent Eye Exam, including refraction) represents a small approximation of the 29.45% of the "reasons for visits" to ophthalmologists as presented by the National Institute of Health.(25)

The 1980 Medicare Law

An expansion of optometric participation occurred in December 1980. (The law, passed in Dec 1980, became effective in July 1981) Reimbursement of examination services performed for aphakic patients included optometrists for the first time. These services were delineated by the Health Care Financing Administration. Optometric services were reimbursed for the following areas: Case History, External Examination, Ophthalmoscopy, Biomicroscopy, Tonometry, Ocular Motility, Binocular Function, and Contact Lens evaluation for an aphakic prosthesis.(26)

Cost Effectiveness of the 1980 Law

The report, "Cataract and Aphakia Related Services Under Medicare Today and Tomorrow" (1983), projected that including optometric care for aphakic patients will increase the cost to Medicare from an estimated $10 million (when the legislation was brought into law in 1980) to an estimate of $36.5 million for the years 1982 to 1985. The study estimated reimbursement for optometric services will increase from $53.8 in 1982 to $254 million for the years of 1982 through 1985. (27) Soroka criticized the assumption of the report, stating that the cost for an eye exam by an ophthalmologist was $30: "The average fee of $30 for an ophthalmological
examination appears to be grossly underestimated." (28)

Once again one can look to the findings of vision examination fees of New York State. The average of 167 ophthalmologists' eye examination fee was $39.86 (1980). (29) This study cited that inclusion of optometrists would raise Medicare expenses by increasing the frequency a patient is seen by an optometrist and by redundant visits to both optometrists and ophthalmologists. However, the study assumed two visits to an optometrist within one year of the newly aphakic patient and the fees would be in addition to the global fee that is reimbursed to the surgeon-ophthalmologist. "Medicare pays a global fee for cataract surgery which is intended to include post-operative care (up to three months) for the aphakic patients." (30) The study states this care by optometrists would be redundant and inflate costs. However, the study omits the prospect that the global fee would be reduced and made specific to the services performed without regard to which profession performed the service. If patients should receive "duplicitative services from another practitioner, either an optometrist or an ophthalmologist, those charges should be rejected." (31)

Elimination of Medicare Abuse

In 1983, Health Care Financing Administration (HCFA) conducted a survey of the reimbursement policies regarding aphakic care in Florida and Georgia. Medicare prohibits payments to physicians for lab work ordered by the physician. No additional profit or markup is allowed. The survey, however, revealed that physicians, optometrists, and opticians have been "marking up" the lab cost of contact lenses and spectacles used as prosthetic lenses. Medicare in the 1981 HCFA report revealed that inflated charges billed to Medicare were:
1. $325 for a $53.50 hydro-curve contact lens
2. $90 for a $35.00 replacement contact lens
3. $250 for an $84 Welch 4-drop bifocal
4. between $122 and $164 for fitting services
5. an unlimited number of prosthetic lenses were ordered by patients as desired

One example of abuse of Medicare was illustrated by a patient who received two new pair of glasses each year from 1976 to 1980 for a total cost of $1248. (32)

HCFA is looking for ways to cut costs. The following recommendations are:
1. restrict the number of subsequent lenses required after the initial prescription
2. provide automated screening of claims for subsequent lens needs
3. utilize a review process for validating lens prescription changes
4. restrict payments to the cost of the lenses plus a reasonable fee for the fittings and the dispensing (33)

The Number of Medicare Eligible

The future demographics of the United States is going to dramatically alter the direction of Medicare and the utilization of optometry in providing vision care. The size and the age distribution of the population are key components in determining directions for health care requirements and health care expenses. Life expectancies in the year 2003 (18 years from 1985!) are 75.6 years for males and 85.1 years for females. The distribution of percent increases for age groups during the years 1953-78
and 1978-2003 illustrate this point:

<table>
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<tr>
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<tr>
<td>under 20 years</td>
<td>28.4%</td>
<td>8.5% (declining mortality)</td>
</tr>
<tr>
<td>20-44</td>
<td>39.6</td>
<td>22.0</td>
</tr>
<tr>
<td>45-64</td>
<td>35.9</td>
<td>54.8</td>
</tr>
<tr>
<td>65 and older</td>
<td>76.3</td>
<td>58.5</td>
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People under 20 years represent the slowest growing age group. In 1953 this group accounted for one-third of the population, in 2003 they may only account for one quarter of the population. Of those over 65 years: in 1953 they represented 9% of the population; in 1978, 11%; and in 2003 it is projected they will be 14% of the population due to expected declining mortality rates. HCFA projects that between 1978 and 2003, Medicare costs will increase by 30 to 37%. That is, costs will grow from $36 billion in 1978 to $47-50 billion in 2003. It also predicts that expenditures for people between 20 and 64 years will change very little. Nursing home care and hospital care expenditures are expected to increase 56% and 32-43%, respectively, from 1978 to 2003. In 1980, Americans spent $247 billion for hospital care, physicians' care, nursing home care, dentists' services, optometric services, drugs, eyeglasses, etc. By the year 2000 these health expenses are expected to be $1000 billion dollars ($400 billion in 1975 dollar values).(34) One major consequence to all the health professions will be the development of geriatrics and gerontology. With this expansion of the proportion the older patient, optometry will be in the foreground to provide low vision care, geriatric care, and refraction (which the optometrist is specifically the only licensed professional in each state).
The power of one individual to help another individual is the prime motivation that has led humans to extend health care to other members of their society. How that health care was delivered has taken a variety of expressions to be accomplished. We need to align the best services and the most efficient services for the most people. We need to avoid the pitfalls of political power persuading government to restrict competition. The past two decades of Medicare has been an example of the optometric profession being unnaturally selected against in the competitive marketplace of providing vision care to the elderly and/or Medicare eligible. Initially, Medicare refused to recognize that vision care provided by optometrists identical to that which was provided by ophthalmologists was feasible and cost effective. Only of late, is this discrimination being absolved. The amendment to include optometric participation in aphakic care has allowed one step toward the concept of pay for service provided, regardless of the provider. The recognition that optometry will serve the growing numbers of older patients via the Medicare system is slowing occurring. The re-examination of what services and what exact materials are provided to the Medicare eligible, will provide the basis for equitable reimbursement to all health care practitioners. Let optometry be utilized for the economical and accessible primary health and vision care profession that it is for all the citizens, and especially those who are Medicare eligible.
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Additional references which influenced my thesis:


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