

## **Vision Control and Autonomy Constraints: Managed Care Confronts Alternative Medicine**

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### **Abstract:**

Managed care's incorporation of some complementary alternative medicine (CAM) raises new questions about how CAMs are altered by this incorporation process and why some CAMs are not incorporated at all. This paper analyzes the relationship of one non-incorporated CAM, behavioral optometry, to managed care and to the larger medical community. I use behavioral optometry as a case study to illuminate the forces at work behind managed care policy decisions on CAM. I argue that managed care dismisses behavioral optometry because of its individualized approach and its conflict with existing conventional medicine (ophthalmology). I also claim that managed care policy decisions in regard to acceptable vision care can have an influence in moving American health care ideologies away from individual autonomy.

### **Introduction**

The impact of managed care programs upon the American health care market has been well documented (Macdonald 1996; Kertesz 1995; Christensen 1995; Gray 1991). Recent trends show the increasing incorporation of complementary alternative medicine (CAM) into managed care settings (Weeks 1997a). Health maintenance organizations (HMOs), in particular, have turned to CAM in response to patient demand for therapeutic care and low cost alternatives to conventional therapies with dubious or low efficacy (Kelner & Wellman 1997; Edlin 1997). HMOs favor cost-efficient, complementary treatments that can be standardized and do not pose a threat to mainstream medical practice (Weeks 1997b). For chronic conditions, chiropractic, massage, meditation, and naturopathy meet these criteria (Patton 1997; Weeks 1997a). HMOs seemingly ignore the more alternative end of the CAM therapeutic spectrum; individualized therapies that serve as replacements for conventional medicine tend to get selected out. Because behavioral optometry, a specialty field within optometry, has a non-standardized approach and

an institutional location as an alternative to ophthalmology, and because it has not fared well with the transition to managed care, it can shed valuable light on the complex relationship between managed care and CAM in the U.S..

This paper argues that the reasons for managed care's exclusion of behavioral optometry have little to do with efficacy concerns. Managed care has failed to incorporate behavioral optometry into its sphere of coverage because behavioral optometry challenges the existing, conventional medical practice of ophthalmology and defies standardization, thereby making it contentious within medical politics and unstable for economic projections. The absence of behavioral optometry from managed care plans leads doctors and patients to doubt its efficacy. Thus, managed care policy decisions can have an insidious effect on shaping treatment ideologies: doctors and patients may come to devalue treatments, such as those prescribed by behavioral optometrists, that require patients to take additional responsibility for the maintenance of their health.

After explaining my research methods, I weave my argument through three main sections. The first section sets the stage for a discussion of behavioral optometry by introducing the current politically charged relationship between managed care and private practice optometry. The second section explores some reasons for the exclusion of behavioral optometry from managed care plans. The final section examines the social implications of managed care plans that rule out holistic, individualized treatment options, such as those offered by behavioral optometry.

## Methods

This paper represents one component of a larger research project on the development of behavioral optometry as a specialty within the profession of optometry. I base this paper on an extensive review of the current academic and trade literature on optometry and managed care. I reviewed three prominent optometric journals, *Journal of the American Optometric Association*, *Journal of Optometric Vision Development* and *Journal of Behavioral Optometry*, from 1994 to 1998. I conducted a similar review of a primary optometric trade publication: *Review of Optometry*.

In addition to this literature review, this paper draws on short-term participant-observation. I made several trips in 1997 to one of the leading optometry schools advocating a behavioral philosophy to vision care: Pacific University College of Optometry, located in Oregon. At Pacific, I had an examination with a behavioral optometrist and began a preventive vision therapy treatment regimen. (Optometric vision therapy (VT) regimens combine eye exercises and body activities with the use of prisms, lenses, filters, and occlusion to alter mind-body organization (Press 1997: 10). Patients learn to overcome conflicts in processing and responding to visual information during VT sessions; this acquired knowledge assists them in completing real-world tasks.) Furthermore, in 1997, I attended the annual meeting of the key organization of behavioral optometrists in America: College of Optometrists in Vision Development (COVD).

To supplement the literature review and participant-observation, I conducted semi-structured phone interviews with three COVD doctors in upstate New York. (I obtained from COVD a list of their “Certified Fellows” and “Associate Members” and contacted members from that list.) The purpose of the interviews was to check the accuracy of and get more details

on the representations of behavioral optometry and managed care that were emerging in the literature and at the conference. My main questions for these doctors centered upon their experiences with managed care coverage (or lack of coverage) for behavioral optometry's primary treatment modality — vision therapy (VT). (Unless otherwise indicated this paper uses the term vision therapy and its abbreviation, VT, to refer to optometric vision therapy prescribed by behavioral optometrists.) I also asked them to comment on the types of regimens they prescribe and to reflect upon managed care's effects on doctor-patient relationships. I conducted a similar semi-structured phone interview with another optometrist who had written a letter, posted on the COVD web page, designed to assist patients in receiving insurance company reimbursement.

### **Tensions Between Managed Care and Optometry**

This section examines the current relationship between managed care and private practice optometry. First, managed care's emphasis on standardization and cost-efficiency compels optometrists to standardize and commodify their services; these pressures challenge the professional autonomy of optometrists and discourage the development of doctor-patient relationships. Second, some private practice optometrists unionize in response to managed care's threats to their practices. The overall purpose of this section is to provide a context for analyzing behavioral optometry's uniqueness as a CAM excluded from managed care environments.

#### **A. Standardization and Commodification Pressures on Optometric Practice**

Private practice optometrists whose business depends upon return patients and patient

referrals typically spend close to an hour with each patient; they require this time in order to sufficiently acquaint themselves with the unique visual processes and needs of each patient. In a routine eye exam, optometrists not only analyze the functioning of a patient's visual system and determine a method of treatment; they also search for vision-threatening conditions — such as a detached retina or glaucoma — and for signs of other health-threatening conditions which manifest themselves in the visual system — such as diabetes. There is simply no way for these optometrists to cut down on the amount of time they spend with patients without also cutting down on the quality of care they typically provide.

Limited vision-coverage by managed care organizations (MCOs) fiscally constrains optometric practitioners with patients on managed care plans. In an article in *Review of Optometry*, Scott A. Edmonds, O.D. remonstrates:

When an MCO pays fee-for-service, it pays fees that it sets, not the doctor. These fees are discounted, often drastically. For example, one of the largest MCOs in my region pays me only 25 percent of my usual fee. Where there's more competition among plans, optometrists are accepting just 10 to 15 percent of their normal fees. (Edmonds 1996)

MCOs' discounted fees threaten the viability of enough private optometric practices that optometrists are now forming unions to help combat this danger.

MCOs may cover all of patients' basic vision care fees, but the quality of care patients receive suffers because of managed care structural and fiscal constraints upon optometrists. The "Managed Care Survival Kit" guide in *Review of Optometry* advises practitioners to minimize the time doctors spend with patients by having office staff perform more of the doctor's duties (Lee 1997). Robert Davis, O.D., of Pembroke Pines, Florida, has implemented such "doctor cloning" procedures in his practice: "The tech does all the testing with automated instruments,

measures blood pressure, V.A., sets up the biomicroscope for the O.D., puts the Rx into the phoropter [an instrument used to find the best optical correction for the eyes] and places nearpoint cards exactly where the doctor wants them” (Lee 1997). How can an optometrist spend less time with patients yet supposedly administer the same high quality examinations and develop the same doctor-patient relationships that they did before managed care?

Aside from doctors spending less time with patients in offices such as Davis’, these managed-care-friendly offices routinely schedule managed care patients for the least desirable time slots and reserve the better weekend and evening time slots for their private patients (Lee 1997). In other words, the patients that will bring more money into these practices are treated, at least from a scheduling standpoint, better than managed care patients. The “Managed Care Survival Kit” concludes with this caveat to doctors: “Patient records are the holy grail of managed care. If it isn’t written down, it wasn’t done in the eyes of the managed-care plan. That means you won’t get paid” (Lee 1997). While few doctors would interpret the advice given in this article as “place managed care’s needs above your patients’ needs,” a workplace environment attuned to cost-efficiency, discriminatory scheduling, and record keeping — the demands of the managed care structure — must encounter some dissonance when trying to simultaneously respond to patients’ health needs.

Given the constraints upon practice operation, why would optometrists join MCOs at all? Some doctors, including the ones I interviewed, simply do not join organizations that would alter the way they conduct their practices. In regions where managed care dominates the market, many optometrists have no choice but to join managed care plans; they would not receive enough patients to maintain their practices otherwise. In other instances, doctors willingly adopt an assembly-line approach to health care in order to capitalize upon profits they make from

dispensing many pairs of glasses and contacts. In these later cases, practitioners' dependency upon the material forms of glasses and patient records as necessary means to achieving profits encourages the commodification of vision care on a scale that infringes upon the health care functions of optometric practices.

An anonymous source, not a doctor, at a private practice using one of the country's largest managed care vision-care providers, Vision Service Plan (VSP), related to me the details of this plan's reimbursement arrangement with that office. Where the two optometrists in this small practice usually charge \$79 for a basic examination, VSP reimburses them only \$40 per exam. This practice cannot afford to drop VSP, because over 80% of their patients originate from the plan. The practitioners still spend about an hour with each patient per examination, but the only way they can compensate for revenues lost is by selling glasses to patients. This private practice can also regain an additional \$5 for each claim filed by re-structuring their present claim-filing system to VSP's specifications: namely, if they file claims over the Internet (using VSP software) instead of filing by phone.

Innocuous as this change of electronic claim filing may seem, it signals yet another way that the technology of managed care's corporate structure infiltrates and alters the daily functions this health care profession. As with the previously discussed record keeping and dispensing changes, electronic filing of patients' claims contributes to a gradual shift in private practice ideology away from patients' needs and toward MCOs' needs.

Quality care and doctor-patient relationships suffer when practitioners must see many patients a day and sell many pairs of glasses to them in order to stay in business. This is not to say that optometrists working with MCOs do not value quality care or relationships with their patients; rather, these optometrists face pressure to commodify all aspects of vision care. The

corporate model of vision care provides a poor setting for idealistic, altruistic, and holistic treatment philosophies.

Practitioners who enter the field of optometry because they want to provide the best possible vision care can become disillusioned when faced with MCO pressures to restructure their practices and challenges to justify their treatments for patients. In discussing this topic, one of my interviewees confessed: “If I were just coming into the field, I would probably look for something else to do.” A 1997 survey of practitioners who graduated from Pacific University College of Optometry, suggests that insurance company pressures of the kind I have been describing apply to a wide range of practicing optometrists. This study, *Practitioner Satisfaction Survey on the Influence of Managed Care in Optometry*, petitioned 1,000 graduates of Pacific University and received 197 responses. Of these respondents, one-third agreed with the statement that “The impact of managed care has required me to perform a less complete exam” (Cook & Polster 1997: 6). The question of “requiring” a doctor to perform a less complete exam does not take into account doctors who do so without being forced to. Thus, the number of affirmative responses might have been greater had the researchers asked the practitioners to respond to the following: “I perform a less complete exam because of managed care pressures.” The same criticism applies to another of this study’s profound findings: two-thirds of the respondents agreed with the statement “Managed care has forced me to spend less time with my patients” (9).

Managed care cost constraints may save MCOs and patients money in the short run, but these constraints do so by encouraging the technocratization of vision care. Generally speaking, this restructuring leads to the dissatisfaction of practitioners with the conditions for providing patient care. The next section documents a movement by some optometrists to battle managed

care hegemony over vision care coverage.

## **B. Unionization — An Imperfect Solution**

In order to combat managed care's threat to the autonomy of optometrists and the integrity of their practices, a number of optometrists have begun to unionize. In 1997, optometrists in Philadelphia created the Pennsylvania Optometric Guild (POG) in affiliation with AFL-CIO to provide O.D.s and patients with a forum for expressing their concerns over the path health care is taking in this country. (One of my interviewees indicated that a group of optometrists in New York is working to create a similar union.)

For many optometrists in Philadelphia, POG is a last ditch effort for them to regain control over their businesses. Independent Blue Cross' dominance over the market in Philadelphia forces local optometrists into joining its vision-care provider, Davis Vision. With 76.2% of Philadelphia's patients on managed care plans, optometrists who fail to join Davis Vision risk a critical loss of patients (Eisenberg 1998: 57). Yet, those who do join have difficulty providing the discount cost services that Davis Vision demands. The founder of POG, Aaron Chasan, O.D., articulates this point: "If we cannot meet our chair cost formula, we are putting our practices and our livelihoods in jeopardy" (57). Optometrists in Philadelphia, as well as those around the rest of the country, feel that "deep-discount vision plans have become today's sweatshops" (Kirkner 1998: 17) and that this change makes it difficult for optometrists to provide quality services for patients (Edmunds 1996; Lee 1997; Cook & Polster 1997).

The AFL-CIO accepted affiliation with POG to address the dissatisfaction of AFL-CIO members with managed care. Many patients in the Philadelphia area find that they must use Davis Vision providers for their vision care needs, that Davis Vision offers few vision care plans

to choose from, and that it fails to cover quality optical products or vision therapy (Eisenberg 1998: 56) With 13 million AFL-CIO members and 85 percent of them on employer-provided care programs, this union could demand that managed-care programs, Davis Vision in this case, use union providers such as POG (58). If Davis Vision fails to comply, the union could opt for another program that accepts their request.

Even successful AFL-CIO leverage tactics, however, would not ensure fair reimbursement for unionized doctors. The union cannot engage in collective bargaining for POG because Federal antitrust regulations prohibit such activity for independent providers: “only doctors who are employees of a hospital, staff model HMO or some other organization have this option under the National Labor Relations Act” (58). The best that POG doctors or other unionized private practice optometrists can hope for is that increased media attention to the problem will motivate managed care to reduce some of its restrictions upon optometric practitioners.

### **Managed Care’s Exclusion of Behavioral Optometry**

This section sheds light on some of the reasons for the exclusion of behavioral optometry from managed care settings. I begin with a general introduction to behavioral optometry and an assessment of vision therapy’s efficacy. Next, I explore and comment upon conventional medicine’s influence, through the field of ophthalmology, upon managed care’s policy decision to exclude behavioral optometry. Finally, I critique the reasons for managed care’s exclusion of optometric vision therapy as a treatment option.

## **A. Philosophy of Behavioral Optometry and Efficacy of Vision Therapy**

Where conventional optometrists mainly identify a patient's refractive error and correct it with prescribed prostheses, the treatment philosophy of behavioral optometry, exemplified by the writings of one of the field's founders, A.M. Skeffington, O.D., deviates dramatically from this approach. Skeffington writes: "The role of behavioral optometry is to restore as nearly as possible optimal performance in a visual system already hampered by adaption to an energy, or to initiate programs to prevent the development of visual problems . . ." (Hendrickson 1989: 2). Behavioral optometry, then, takes the patient's refractive error into account but emphasizes a holistic analysis of the patient's complete visual system, including the environmental stressors placed upon that system.

From this behavioral perspective, a patient's visual system includes "perception, cognition, memory, and imagery . . ." (Press 1997: x), and these processes work in conjunction with all of the senses, not just that of sight. Behavioral optometrists often incorporate therapy into the treatment process because they recognize that patients can improve their vision by enhancing their information acquisition and processing skills. As one of the behavioral optometrists I interviewed commented: "You see with your brain; you don't see with your eyes." Vision relies upon information gathered both presently and previously from the other senses — memory contributes to interpretation of a light stimulus; the deemed importance of a stimulus also affects its interpretation by the visual system (Hendrickson 1989: 3-4).

Non-behavioral optometrists intimately understand the human visual system, but they do not usually prescribe therapeutic treatments based upon this knowledge; behavioral optometrists, on the other hand, regularly do. For example, behavioral optometrists will prescribe vision therapy regimens to help patients overcome strabismus (eye-turns), vision-related learning

difficulties, or traumatic brain injury. They will also prescribe VT regimens to help patients prevent or postpone the onset of vision difficulties — such as myopia developed from protracted work in a constricted environment.

An interviewed optometrist offered an example of the complexity of the visual system as seen from a behavioral optometrist's standpoint. He described the difficulties one can encounter in reading and processing written material: "If I cannot see what I'm looking at and where I am to look next, and do this simultaneously, I'm going to lose my place." To read and comprehend what we read, we must process information on two separate levels: central identification and peripheral localization. This optometrist calls the necessary peripheral processing component "making contact with context." Routine eye exams, however, do not test for this type of visual information processing.

Before attributing the exclusion of behavioral optometry from managed care settings to its non-standardizable approach or its overlap with conventional medicine, the question of its efficacy should be explored. Vision therapy finds its origins in a field dedicated to the straightening of the eyes — orthoptics. As early as mid-nineteenth century, French ophthalmologist Javal was utilizing non-invasive orthoptic therapy with success, and the field persists to this day (Press 1997: 2). Managed care has embraced orthoptics and ophthalmological therapy-related eye treatments but not optometric VT.

Nonetheless, the research on optometric VT reveals some astounding results. For example, Wold et al. (1978) have documented the response rate of one-hundred consecutive vision therapy patients to a standardized eye-movement performance test. Prior to VT, only 6% of the tested children passed the eye movement portion of this test; after VT 96% were able to

pass (Press 1997:348). In another case, Fujimoto et al. (1985) conducted a controlled clinical trial to test saccadic fixation training. (Saccades are rapid eye movements that assist in reading and similar activities.) The groups that underwent VT showed a statistically significant improvement in saccadic fixation over those who did not (Press 1997: 348). In a controlled study of pursuit eye movements (smooth eye movements used for tracking moving objects), Busby (1985) found a significant improvement among special education students who underwent VT:

The subjects were rated on their ability to maintain fixation on a moving target. The rating procedure was shown to have a high interrater reliability. The results showed statistically significant improvement by the experimental group in pursuit eye movement and persistence of the therapeutic effect on retesting at a 3-month interval after conclusion of the therapy. (Press 1997: 348)

Many similar controlled experiments citing the efficacy of VT have been published in *Journal of the American Optometric Association*, *Journal of Behavioral Optometry*, and *Journal of Optometric Vision Development*. Additionally, a number of reviews of the literature on the efficacy of optometric VT have been compiled (Flax & Duckman 1978; Press 1988; Suchoff & Petito 1986; Cohen, Lowe, Steele, et al. 1988). These examples document, through many controlled experiments, the efficacy of optometric VT. If managed care knows of this research literature and still excludes optometric VT from its range of services, then other explanations must account for this exclusion.

### **B. New Manifestations of an Old Rivalry: Ophthalmologists vs. Optometrists**

Because of vision therapy's documented efficacy, an explanation of behavioral

optometry's exclusion from managed care plans must consider institutional factors. The rivalry between ophthalmologists and optometrists first surfaced at the end of the nineteenth century in America when optometrists, who were then called "refracting opticians" (as opposed to "dispensing opticians"), moved to form a legally recognized profession. Ophthalmologists perceived this emerging profession as a threat to their livelihoods and fought to prevent its formation. The most outspoken ophthalmologist of the time, D. B. St. John Roosa, M.D., even threatened to have proponents of optometric professionalization jailed (Cox 1957: 34). Roosa justified such an extreme position by arguing that refracting opticians who were charging patients for this service lacked the medical background and medical licensing necessary to treat patients. In other words, Roosa felt that opticians of the day should remain within their trade organization and make spectacles for the populace; if opticians wanted to refract (that is, to diagnose the prescription patients required), then Roosa believed they should undertake the necessary medical schooling and obtain an M.D.. In spite of ophthalmology's professional status and close relationship to the American Medical Association at the time, ophthalmologists were unable to prevent legislation legalizing optometry as a profession (Miller & Brown 1996: 32).

Many ophthalmologists and optometrists have since developed close working relationships based upon mutual respect (Glenn 1998; Freeman 1997), but the fiscal challenges that MCOs push upon these professions have also reignited the old disputes over medical qualifications (Press 1997: 362-65). One interviewee commented that in environments where fiscal considerations are absent, such as in the VA hospital system, the two professions often work quite amiably together; however, "Where the dollars come in, . . . [they] look at each other primarily as competitors versus colleagues."

Despite vision therapy's efficacy, behavioral optometrists have not gained prominence

over the vision care field. The non-research origins of behavioral optometry may contribute to this lack of widespread acceptance. At the inception of behavioral optometry with A.M. Skeffington's teachings in the late 1920s, these optometrists existed mainly outside of academic research environments. Behavioral optometrists, in other words, were primarily practitioners prescribing therapy regimens that they found effective. In the last couple of decades, behavioral optometrists have documented more of their findings in research literature; nonetheless, behavioral optometry's long absence from educational research settings has confounded the profession's ability to justify their treatments to MCOs. Ophthalmologists, in contrast, have used their medical standing to lobby MCOs for financial support of their opposing treatments. As David Hess notes in his research on alternative theories of cancer etiology, ideas excluded by the mainstream medical community, regardless of their veracity, become characterized as pseudoscience (Hess 1997: 77). Therefore, the refusal by the medical community to acknowledge the validity of existing research on VT also influences MCOs to ignore that literature.

Leonard J. Press, a Fellow of College of Optometrist in Vision Development (COVD), discusses the politics of ophthalmology and behavioral optometry research in his book *Applied Concepts in Vision Therapy* (1997). Press asserts that managed care's emphasis on cost containment pressures the medical community to doubt publically the efficacy of the competing treatments of vision therapy: "The American Medical Association has classified visual training as an 'alternative' health method" (Press 1997: 363) that is both unproven and unscientific. Press observes the hypocrisy in such claims by the medical community when much of their research does not hold up to the scientific criteria they use to evaluate VT (when they choose to acknowledge VT's existence at all):

A survey of clinical ophthalmology reveals that several of its procedures have gained acceptance before scientific studies supported their efficacy . . . Strabismus surgery is a prime example of a procedure that originated as cosmetic experimentation on patients that was presented as a therapeutic modality, reinforced by medical referral patterns, and reimbursed with little challenge by third party providers. (363)

Ophthalmology appears to have a privileged relationship with insurance providers that cannot be explained strictly in terms of its superior medical research. One of my interviewees summed up the situation:

The health professions . . . have been dominated by medical practice. And medical practice has never taught or learned or done anything in the fields of vision training. So not knowing about it, they pooh-pooh it . . . and in doing such, they're also controlling the insurance companies, telling them [that it is not valid].

The inconsistencies in the medical community's condemnation of VT extends even further when one realizes that ophthalmologists prescribe VT regimens under the euphemistic label of "functional ophthalmology" for their treatment of patients with convergence insufficiency (difficulty in getting both eyes to turn in) (Press 1997: 365). Evidently, the American Medical Association only applies the term "alternative medicine" to VT treatments prescribed by someone other than a doctor of medicine.

Press moves beyond rationales of scientific validity to raise alternate reasons for ophthalmology's uneasiness with VT. MCOs hold all optometrists to the educational standards of ophthalmologists, in terms of an advanced understanding of disease, pharmacology, and anatomy, as a condition for reimbursement; ophthalmologists, on the other hand, have had little incentive to attain an understanding of the visual system on par with behavioral optometrists.

One could conclude that ophthalmologists now perceive a threat to their patient base. A discussion in the *Transactions of the American Ophthalmological Society* articulates this fear: “Many ophthalmologists do not fully appreciate the role and function of the process of accommodation and convergence, their interrelationship, and how to study their dysfunctions. Thus proper treatment is not given. Many of these patients end up under the care of optometrists” (cited in Press 1997: 364). Instead of expanding their education into the realm of behavioral optometry, ophthalmologists have responded by attacking the scientific validity of VT prescribed by optometrists. An interviewee observed:

Vision therapy is a unique service. It’s not easy to do — you get picked on by the medical community who works against you and who doesn’t buy into what we do. A lot of it’s just turf battle; a lot of it’s philosophical battle . . . [VT’s] probably one of the best kept secrets in health care.

Thus, the managed care environment catalyzes turf battles similar to those that occurred between ophthalmologists and optometrists at the turn of the century.

Interestingly, this marginalization of VT treatments by the American medical community does not find its parallel on the international level. A survey of both the American Association for Pediatric Ophthalmology and Strabismus and the International Strabismological Association reveals that the “international group used nonsurgical treatments much more frequently (85% vs. 52%)” (Press 1997: 365). The author of this survey, Paul Romano, M.D., postulates three main reasons for the variation in his findings between American physicians and their international counterparts: 1) Non-U.S. insurance companies compensate less for eye surgery and employ stricter criteria for pretreatment approval; 2) U.S. surgeons risk losing more money with non-surgical treatments because most do not have therapy facilities in-office; 3) U.S. surgeons fear

that, because they lack training in vision therapy, if they acknowledge the efficacy of VT, they will lose patients to optometrists and orthopticians (365). It follows that the economic concerns of ophthalmologists in the U.S. provide them with sufficient reasons for using their medical community clout to convince MCOs of the questionable efficacy of optometric VT.

Nonetheless, MCOs would most likely save money in the long run if they provided reimbursement for VT treatments in favor of ophthalmological treatments of the same conditions. In diagnoses of convergence insufficiency, for example, patients may experience symptoms that completely incapacitate them: “headache, browaches, neck pain, dizziness, intermittent double vision, and blurring of vision” (365). Over a period of time, treatment of these symptoms with prescription drugs or lenses, coupled with the cost of diagnostic tests, will cost much more to MCOs than vision therapy. The vision therapy of orthoptics for treating convergence insufficiency costs less than treating its symptoms or defaulting to surgery; Press warns that if one foregoes VT, convergence insufficiency sometimes requires multiple surgeries to correct (365). An interviewee emphasized that for this particular condition, which is “the number one, non-refractive, eye problem in the country, . . . Research has shown that the number one treatment for this condition is vision therapy, and its success rate is phenomenal — 85-95% depending on the paper that you read.”

If VT treatments for convergence insufficiency and for other visual problems are so effective and can save MCOs money in the long run, why do MCOs not challenge the medical community’s verdict on optometric VT? For one, MCOs and third party insurance providers may simply be unaware of the extant research on VT efficacy. The mainstream, conservative medical community also currently influences MCOs, and according to one interviewee: “[MCOs] have their own agenda, and they’re not looking for a new agenda.” Moreover, MCOs

have tied themselves into a corporate-like businesses structure that emphasizes short-term economic gain; this structural constraint may prevent them selecting long-term, holistic treatments for their members even if they did acknowledge both the efficacy of such treatments and the long-term economic gain they would stand to make by sanctioning those treatments.

### **C. The Insurance Coverage Challenge**

Where conventional optometry encounters difficulty in dealing with managed care, behavioral optometrists seeking reimbursement for their patients face even greater challenges. Most major medical insurance companies and managed care organizations (MCOs) classify vision therapy as an alternative and unreliable medical practice. Major medical insurance companies will occasionally offer partial coverage for VT, but according to my research, MCOs rarely reimburse for VT. The lack of managed care coverage for the vision therapy treatments often prescribed by behavioral optometrists deters many patients from seeking out these services. By controlling behavioral optometry's patient base in this manner, managed care organizations, operating in close, established relationships with mainstream medical practitioners, ensure the continued marginalization of behavioral optometry.

While MCOs will not reimburse for vision therapy, behavioral optometrists can often convince other major medical providers, like Blue Cross or Blue Shield, to offer partial patient reimbursement for VT. According to one optometrist interviewed, when patients have access to managed care *and* a third-party, major medical provider, managed care will cover the "non-medical" or "vision care" part of the evaluation, and the major medical will usually cover the medical component of the evaluation. This same interviewee related that "vision care" typically refers to an "assessment of refractive error and the prescribing of glasses or contact lenses." The

medical eye-care classification, on the other hand, serves as a catch-all for any other treatments (secondary examinations of different visual functions or vision therapy, for example).

Oftentimes, patients and physicians must argue with major medical providers for reimbursement on the therapy component of treatment, but this interviewee expressed confidence in the effects of these contestations in getting at least part of the therapy covered. In sum, patients with the luxury of managed care and major medical coverage can, with great effort, get reimbursed for most examinations and some VT.

Patients who are only covered by managed care medical plans, such as HMOs, have little luck in getting secondary examinations (to test visual functions with greater accuracy) or VT covered at all, even if they and their doctors challenge the MCOs with scientific literature citing the efficacy of VT. An interviewed optometrist related: “Most of the [managed care] groups that I’ve seen are primarily concerned about cost effectiveness and not necessarily concerned about quality . . . They want the quick fix. They want it done as inexpensively as possible, or they don’t want it done.” In these situations, the burden of payment falls entirely upon the patient. One interviewee capitulates to MCOs in these instances: “We make it very clear to [the patient] that [VT] is not a covered service and that if they want to try to fight the insurance company, they have to do so on their own.” Patients usually cover their own expenses in these instances. Those added patient expenses prevent behavioral optometry’s growth and widespread acceptance: costs deter some of the already small minority of patients aware of this vision care option.

One can trace MCOs’ reluctance to cover VT back to a complicated web of economic and political forces. On an economic level, MCOs avoid covering any type of open-ended therapy because these therapies might turn into extended and costly treatments. MCOs value

short-term treatments, such as lens prescription, over holistic long-term ones, such as VT, for counterintuitive reasons. They do not place primary importance upon long-term economic considerations — VT can save MCOs money in the long-run through prevention of visual difficulties. The behavior of MCOs indicates that they fear long-term commitment to patients and loss of control over treatment options more than loss of capital. An interviewee provided an example of this that nicely transitions to the political realm of MCOs' reluctance to cover VT:

Even though we can show a higher success rate [than ophthalmological treatments] and less cost on treating certain problems like strabismus . . . at a fraction of the cost, it doesn't fit into [MCOs'] model of treatment. So, they'd rather pay many thousands of dollars for a surgical procedure that has a 43% success rate, rather than pay half of that for vision therapy cause that's going to require six months of visits — even though we have an 85% success rate.

This example illustrates the control aspect of MCOs' behavior; they would prefer to ignore medical literature citing the efficacy of VT because if they condoned VT treatments, they would lose control over the details of that treatment. They would have to address vision problems on behavioral optometrists' terms and acknowledge that treatment of patients depends upon the unique attributes of each patient's visual system and environmental activities. Such an acknowledgment would require MCOs to cede some control to behavioral optometrists.

Refractive surgery by ophthalmologists, on the other hand, is a fairly clear-cut procedure; not much holistic evaluation of the patient's visual system is required. VT treatment of that same patient depends upon the subjective evaluation, by a behavioral optometrist, of that patient's entire visual system. Of course, behavioral optometrists use all the traditional fact-finding techniques that other optometrists use, namely the twenty-one point exam, but they supplement

examinations with other tests when they suspect a vision difficulty. Behavioral optometrists then develop a VT treatment regimen that incorporates an added component to this analytic appraisal. I should also point out that VT and surgery are not mutually exclusive procedures; many optometrists and ophthalmologists work together to treat such patients, but the long-term rivalry between these two professions complicates these collaborative treatment efforts (Freeman 1997).

### **Implications for American Health Care Ideologies and Practices**

Managed care excludes behavioral optometry for two main reasons: behavioral optometry's individualized, non-standardizable vision therapy treatments and its threat to existing conventional medicine (ophthalmology). As illustrated in the section on managed care and conventional optometry, quick technological fixes and commodified health care (through corrective lens prescriptions) effectively discourage patients from guarding their visual health; more and more, optometrists must depend on dispensing glasses in order to sustain their businesses. This is not to say that optometrists prescribe lenses unnecessarily, only that patients may never be exposed to behavioral optometric techniques for preventing the loss of visual functions. Patients may come to perceive vision deterioration as a given, something that they have no control over. In fact, I believe that this is the case for most Americans. This resignation to the inevitability of vision loss is accompanied by an increased dependence on technological solutions to vision deterioration. In essence, many Americans are blindly abdicating responsibility for their health to technology.

In cases where managed care provides coverage for ophthalmological surgery but fails to cover non-invasive therapy options, the impact upon social health care ideologies may be even

greater. Take, for example, the use of strabismus surgery to correct misalignment of the eyes. VT has been shown to succeed 65-91% of the time depending on the type of strabismus treated (Ziegler et al. 1982). Despite VT's efficacy in treating strabismus or its documented benefits as a complementary, post-surgery modality, some ophthalmologists consider VT downright dangerous for their strabismus patients (Press 1997: 102).

Managed care's decision to cover strabismus surgery but not VT conveys a message to patients and health care practitioners that only quick solutions to health problems count. In these cases, surgical artifacts (scalpels or lasers) and instrumental techniques gain supremacy over any active, personal investment in one's own health. However, these patients relinquish even more control over their own health than those depending upon corrective lenses: strabismus patients risk irreversible damage through surgery in lieu of completely reversible VT. It seems unlikely that patients and physicians subscribing to these health care ideologies do not internalize some of the values implicit within these ideologies. In other words, they begin to value technological artifacts and place increasing faith in them; at the same time, they devalue investing time and effort to maintain their own health.

Quick technological solutions to vision difficulties, such surgery or corrective lenses, coupled with the technocratization of optometric practices under managed care systems reflect and inform deeper societal attitudes about health care. Vision therapy requires people to take responsibility for their own visual health; surgery and lens prescriptions send messages to patients that they need not guard their sense of sight — technology will fix their “errors.” These quick technological solutions contribute to the inactivity and passivity of people, becoming what Foucault termed “docile bodies.” The rapid treatment of patients in assembly-line style, which is encouraged and in some cases enforced by managed care programs, also hinders the

development of doctor-patient relationships (Cram 1997; Thurston 1996): communications between doctors and patients become extraneous interactions. In these situations, readings from technological instruments take precedence over verbal exchanges.

Behavioral optometrists are working to educate MCOs about the efficacy of VT, but they frequently encounter resistance from disbelieving M.D.s sitting on the quality assessment and utilization committees of MCOs (Wright 1997). Ironically, managed care programs may be suffering from myopia in not recognizing that in many cases VT is more cost-efficient than the quick technological fixes of surgery or corrective lenses.

The case of behavioral optometry provides unique insight into the forces and values influencing managed care decisions on the incorporation of complementary alternative medicine (CAM). When alternative medicine conflicts with extant conventional medical practice (that is, when it is not just complementary), managed care will most likely exclude it. When randomized controlled trials exist for alternative treatments and those treatments are standardizable, managed care will most likely incorporate those treatments to be administered by current caregivers. Ophthalmologists practicing vision therapy under the rubric of “functional ophthalmology” is an example of this. Finally, when an alternative treatment is individualized yet does not conflict with conventional medicine, managed care may incorporate it as long as the treatment saves money. The incorporation of acupuncture by HMOs for the treatment of chronic pain is an example of this (Patton 1997).

These types of decisions pose some threats that should be guarded against. Those interested in maintaining the integrity of CAM in managed care settings should fight against standardization that risks the loss of holistic assessments; managed care may corrupt these treatments by only using portions of them that do not conflict with existing conventional

treatments. Those interested in obtaining the best possible health care from managed care providers should demand that options for less threatening treatments not be kept from them for reasons other than efficacy and cost. Finally, we should all strive against internalizing a corporate model of health care that increases our dependence upon technology at the expense of personal autonomy.

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