Alternative Health: What About Us?

Managed care is the enemy, folks. Organize.

October 1, 1994 By Bob Lederer

As we stumble toward a new era of sick-care financing -- a.k.a. health care reform -- people with HIV face even bleaker prospects for insurance reimbursements of alternative treatments than in the current system. But rising consumer demand for options is winning openings in some plans' coverage.

Surveys have shown that 25 to 30 percent of people with AIDS use non-standard treatments, usually in addition to conventional medicine. Among the most common are acupuncture, massage, herbs and high-dose vitamins and minerals. Preliminary data suggest some approaches bring varied degrees of symptom relief, immune boosting, improved quality of life and, occasionally, long-term stabilization.

But few insurance plans pay for either the treatments or visits to practitioners prescribing them. Nonprofit buyers clubs offer some alternative treatments at reduced prices, but many PWAs -- whether poor to start with or impoverished by the disease -- can't afford the expense.

Private insurance plans, which cover an estimated 30 to 40 percent of HIV positive people, generally exclude such non-physician practitioners as acupuncturists, herbalists and homeopaths. Sympathetic physicians have their hands tied by requirements that treatment be medically necessary, which is usually defined very conservatively. For example, most prescription plans will only reimburse doctor-prescribed low-dose nutrient replacement to treat deficiencies, not the high doses many nutritionists recommend in HIV infection as prophylaxis or treatment.

Since the early 1980s, after consumer lawsuits won reimbursement of a few alternative treatments under medically necessary clauses, many companies have added tighter language to their policies. Empire Blue Cross/Blue Shield of New York wrote a typical such requirement that treatments be generally accepted by the medical profession -- guaranteeing exclusion of most alternatives by physicians never trained to understand or respect them. Other companies specifically exclude any treatment not approved by the Food and Drug Administration (FDA), which, for PWAs, cuts out all non-pharmaceuticals and all but a handful of drugs.

Meanwhile, Medicaid, the federally funded but state-administered medical plan for the poor (used by about 40 percent of people with HIV) is a crazy quilt of 50 different sets of state rules. But no

state offers more than minimal, if any, coverage of alternatives. For example, in New York, acupuncture is the only non-mainstream treatment covered and is only reimbursed for state clinics treating substance abuse.

Prospects for more inclusive coverage are threatened by the accelerating trend toward managed care. Preoccupied with boosting profits, that approach empowers insurance paper pushers to second-guess doctors who bill for amounts and types of services considered unnecessary or too expensive.

In this brave new world of managed care, each doctor's pattern of prescriptions and medical tests is closely analyzed. Databases and flowcharts, often interpreted by non-physicians, determine acceptable procedures without regard to individual circumstances. According to Mark Hannay, a public policy associate at Gay Men's Health Crisis in New York City, this will further restrict the already tight space for alternatives. "If the cookbook says prescribe AZT, but the doctor instead, say, gives lots of vitamin drips, they'll call him or her in and ask what's going on, disallow some charges or even cancel that doctor's contract. This already happens."

Restricted health networks such as health maintenance organizations (HMOs) are spreading quickly. HMOs not only exclude non-member practitioners but may require gatekeepers -- primary-care physicians who must approve all referrals to specialists. Given the prejudices of the conventional doctors who dominate HMOs, this is especially bad news for alternative practitioners. Fueling the exclusionary trend is the mad dash of HMOs and insurance companies to merge into giant networks with hospitals and drug companies.

Whichever health care reform bill passes, Congress -- influenced by heavy insurance-industry contributions and lobbying -- will accelerate the drive toward managed care. That sad fact was signified by the apparent lack of votes for the highly popular Canadian-style proposal for the federal government to become the single payer directly reimbursing doctors and hospitals. This plan would have covered everyone, eliminated for-profit health insurers (saving vast administrative costs) and perhaps stopped the relentless drive to cut corners.

In contrast, the likely new set-up, favoring managed-care plans while guaranteeing more people coverage, will create larger markets for mammoth insurance companies. "That will eliminate most of their competition," says William Dailey, an attorney who directs the Center for the Advancement of Law and Medicine in Encino, California. He predicts that many small companies, lacking large networks of participating hospitals and specialized doctors, will be unable to attract enough business to survive. The result: A near monopoly by a handful of already big firms. Indeed, Dailey says, the Clinton plan was largely modeled on a proposal by the Jackson Hole Group, a gathering of officials from these companies and other Fortune 500 corporations, to achieve that result. And such interests have been among the largest campaign contributors and best-funded lobbyists of the key legislators in this battle.

The final health care bill will probably standardize the benefit package to match that of most current private insurance. The only alternative health coverage mentioned in any bill is

chiropractic, due to lobbying by that large, wealthy profession. Ominously, the Clinton bill sets up new federal programs to develop practice guidelines that could be the basis for rigid insurance cookbooks.

The net result for people living with HIV? According to Hannay, the consumer subsidies for premiums and the elimination of pre-existing condition clauses will allow more people at least some coverage. “But based on the experience to date with managed care, obsessed as it is with cost cutting, there will be an incentive to undertreat in general and to exclude alternatives in particular,” he says.

“The consolidation of power in insurance management’s hands will give them more control over the type of care provided,” Dailey says. Karin Timour of ACT UP/New York’s Health Care Access Committee agrees. “Many PWAs assume health care reform can’t be worse than what we have now. Chance are high it will be much worse. The next few years will bring radical restrictions on treatment and care for HIV positive people.”

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