Evidence-Based Benefit Design: The Intrinsic Value of Comprehensive Chiropractic Coverage

Current evidence supports the positive long- and short-term therapeutic and economic impact of services delivered by doctors of chiropractic[1-3]. Current healthcare policy benefit design lags behind best practices and published practice guidelines, creating barriers to high-value non-pharmacologic pain care and impeding the practice of evidence-informed care[4,5].

The purpose of this document is to advocate for benefit design that promotes best practices for evidence-informed, comprehensive, multi-modal nonpharmacologic treatment as the first-line strategy for non-cancer pain.

Detailed here is the objective body of evidence to substantiate the exigent need for policy coverage determinations that promote access to chiropractic management of acute and chronic pain syndromes and public policy initiatives that support the integration of chiropractic physicians into current and evolving healthcare delivery systems, including Medicare and Medicaid.

Outlined below are the pressing challenges and strategic considerations to improve access to the services performed by doctors of chiropractic in an effort to minimize financial barriers, reduce overall healthcare expenditures, minimize healthcare disparities, improve social drivers of health, promote front-door access to the most appropriate provider-type and reduce opioid exposure.

Current Challenges

The Functionally Uninsured Patient: Rising costs associated with premiums and out-of-pocket expenditures have created a class of functionally uninsured patients. While insured, these patients self-pay for all or most of their health care due to coverage limitations and benefit design. The economic consequence of self-pay for the functionally uninsured may cause a patient to delay necessary treatment, which may contribute to chronicity and increased downstream expenditures. Lack of adequate coverage may cause the functionally uninsured patient to seek out the lowest out-of-pocket option, which is typically the generic prescription benefit.

Deductibles: Large deductibles have presented new and unexpected challenges. While the patient is meeting the deductible, the patient is simultaneously depleting the visit limit for the health plan. Therefore, a patient with a plan that includes a very large deductible and an annual visit limit may exhaust the benefits for that service without the insurer contributing to the overall cost of the episode of care. Furthermore, after the deductible is met, the patient has no benefit remaining for that service for the remainder of the year.

Co-payments: High co-pays affect care decisions5 and often lead to the failure to initiate or complete a course of care as prescribed, which may result in poor clinical outcomes for the patient. In addition, high co-payments for nonpharmacologic treatment are a deterrent for patients to seek alternative care pathways as an integral part of opioid avoidance and opioid de-prescribing by another member of the patient's healthcare team. This creates a

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barrier to best practices for prescribing physicians seeking to follow opioid prescribing guidelines. Further, co-payments in excess of the fee schedule for individual or bundled services create an illusory benefit, which is described below.

Coinsurance: Coinsurance is typically expressed as the percentage of the cost a patient will pay for services once their deductible has been met. For patients who already have a high deductible and an even higher max out-of-pocket responsibility, this can prolong the increased cost burden to care and also contribute to patients either not seeking care or not following through with the prescribed plan of care[17].

Illusory Benefits: Escalating co-payments have created an illusory benefit structure for the patient. Fee schedules have not kept pace with inflationary challenges such as rising labor costs and rising business expenditures. As the allowable charges have remained stagnant, co-payments, deductibles and premiums have continued to rise for the patient. Currently, it is not uncommon for a patient's co-pay to exceed the allowable amount for the same service. This is not a traditional insurance benefit for the patient, as the patient self-pays for the entire cost of the service. Moreover, in effect, the insurer is not financially responsible for paying for the service; the insurer is merely the administrator of a discounted fee schedule that is purchased from the insurer by the patient or the employer.

Premiums: Rising premiums have increased the overall cost of health care for individuals before the patient enters the healthcare delivery system. Premiums absorb the healthcare budget for many households, causing the insured patient to delay care or seek other methods of non-supervised pain management.

Negative Impact on Care Pathways: In addition, benefit structure can impede guideline concordant care and may direct patients into a care pathway that may not be consistent with best practices and evidence-based care[6]. For example, benefit design incentivizes patients with low back pain to seek care with a primary care physician with minimal out-of-pocket expense, while patients of high-value conservative care providers are subject to higher out-of-pocket costs.

Reimbursement Challenges for Providers: Reimbursement challenges ultimately reduce the availability of conservative healthcare providers for consumers. Although chiropractic accounts for less than 1% of the healthcare expenditure in the United States[7], insurers cite containing premium costs as the rationale for fee schedules that have remained stagnant or have decreased for over a decade. As value-based practitioners are eliminated by economic forces imposed by this disparate reimbursement climate, patients and insurance carriers will have fewer, more expensive and more invasive alternatives for the management of acute and chronic musculoskeletal conditions.

Health Care Disparities: Reimbursement challenges for providers contribute to healthcare disparities. Reimbursement levels that are not consistent with the cost of delivering high-quality care and disproportionate to the cost of the providers' education have significantly reduced the availability and willingness of providers to deliver services within communities with the highest socioeconomic need. Rural and urban regions alike present challenges to meet basic cost-of-business expenditures that deter providers from practicing in certain zip codes, resulting in a population that has a disproportionate need for care and provider availability that is perpetuated by benefit design.

When doctors of chiropractic are excluded or cannot afford to participate in a healthcare delivery system, the patients will consequently be underserved, causing delays in care, complications for patients and increased downstream costs to the healthcare system.

Social drivers of health (SDOH) are critical elements of personal health. Inequalities in SDOH lead to health disparities that are difficult for the healthcare system to overcome[18]. Addressing SDOH is critical for health equity, including treating musculoskeletal conditions. Healthcare, without adequately addressing SDOH needs, creates a lose-lose-lose relationship for patients, providers, and payers. Improving access to high-value care is a direct way to improve some of the challenges faced by those experiencing unmet SDOH needs. In alignment with the goals of Healthy People 2030, it is encouraged to improve access to quality care and improve health equity[19]. By addressing SDOH, increased compliance and continuity of care is observed[20].

Coverage Limitations for Chronic Patients: In order to deliver a quality-driven experience for patients with chronic pain, patients must be allowed access to benefits for diverse, multimodal treatment options and clinicians must be offered adequate coverage parameters to manage exacerbations and remissions of chronic musculoskeletal conditions. Chronic spinal pain may present as a recurring disorder or may be a constant, lifelong ailment that requires conservative management on a more consistent, ongoing basis. Current benefit design for chiropractic care uses the narrow model of "acute" care, with the limited vantage that every patient's trajectory of pain is predictable, self-limiting and has a specific start and end point. This is in direct juxtaposition to the manner in which chronic pain patients present to providers of all disciplines. The acute-episode, symptom-based payment model fails to account for the individual needs of each patient and the practical and clinical imperatives of functional improvement, maintaining optimal levels of independence and quality of life, curtailed relapses, reduction of future exacerbations, maintaining and preventing further deterioration, and enhanced general well-being.

Network Adequacy: True network adequacy includes providers with broad ranges of clinical acumen and experience. Currently, there are networks that have been "closed" for periods longer than a decade. This reduces patient access to highly skilled, evidence-informed providers who have received their professional training in the current collaborative care models.

Plan Exclusions: Despite the evidence to support access to services performed by doctors of chiropractic, some self-insured health plans offered by employers do not have a chiropractic benefit. This results in limited access to conservative, evidence-based, non-pharmacologic care pathways. For existing statute barriers that limit care, we are actively working legislatively to improve access to care. This includes limitations around the loss of benefits or benefit changes from one season of life to another.

Strategic Considerations for Aligning Evidence-Based Practice with Benefit Design for Patient-Centered Access to Conservative Care

Evidence-based practice aligns the best scientific evidence, the clinical experience of the practitioner and patient values. Likewise, coverage and payment models from insurers must also advance in a manner that is congruent with

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these factors and is consistent with the prolific body of retrospective claims data and publications generated internally within the industry that support the cost-effectiveness of the services provided by doctors of chiropractic in the reduction of opioid prescriptions[1, 8, 9], advanced imaging and spinal surgeries[10, 11].

Recommendations for Inclusion of Contemporary Strategies in Benefit Design:

Improve Access to Care that is Consistent with Patient Values: Data obtained in a Gallup poll reveals that 78% of Americans prefer to manage their pain without pharmaceutical intervention12. Likewise, the Triple Aim emphasizes the importance of patient engagement.

> *Improved Benefit Design*: Access to nonpharmacologic providers and nonpharmacologic care pathways for acute and chronic pain management should be equal or greater than pharmacologic providers and care pathways.

Additionally, most individuals wish to be involved in their healthcare decision-making. Discussions around trade-offs of care are often neglected, yet when shared medical decision-making is enacted, patients' satisfaction and health outcomes improve[21].

Remove Barriers to Access the Most Conservative Provider First: Back pain and neck pain are among the most common reasons patients visit a primary care physician's office[13, 14], creating a strain on primary care providers, particularly in rural areas and underserved communities. Data supports that when a patient begins an episode of care for spinal disorders with a primary care physician, the likelihood of pharmaceutical intervention, imaging and likelihood of surgery is significantly higher[8, 10]. For those who sought spinal manipulation as part of a complementary and alternative care method, wellness and health prevention measures were taken during their encounters. Further, the Agency for Healthcare Research and Quality (AHRQ) and the American College of Physicians continue to recommend chronic musculoskeletal pain be treated initially through non-pharmacologic approaches[18]. Additionally, by eliminating unnecessary steps for accessing high-value care first, strain on the primary care physician workforce will be minimized and overall capacity is improved.

> *Improved Benefit Design*: Patient cost-share and out-of-pocket expense for services provided by a Doctor of Chiropractic should be equal to the primary care physician, creating the opportunity for early and equal access to care.

Create Care Pathways that Promote Non-Pharmacologic Pain Management: Universally, the generic prescription benefit in health plans is lower than the out-of-pocket expense for a single chiropractic office visit[5]. Currently, high co-pays and high deductibles push patients toward their much lower cost generic prescription benefit. An initial chiropractic visit is cost-prohibitive to many patients when compared to a less expensive prescription benefit, particularly for those individuals with inherent socioeconomic and geographical barriers to accessing conservative treatment. The RAND corporation predicts the opioid settlement is expected to generate over $50 billion in funds for state and local governments to help offset the consequences of the opioid crisis. Still, policies restricting the

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prescription of opioids aren't enough. The use of non-pharmacologic therapies for pain, including services provided by doctors of chiropractic such as spinal manipulation, is recommended and has continued to be endorsed by the Joint Commission[24]. Yet, there has been a slower than desired implementation around benefit changes.

> *Improved Benefit Design*: Patient cost-share and out-of-pocket expense for services provided by a Doctor of Chiropractic should be equal or less than a generic prescription for opioids, decreasing the financial incentive for a patient to seek out opioid pain management.

Adopt Medicare's Approach to Visit Limits: Currently, Medicare plans (excluding Medicare Advantage or Medicare Replacement Plans) do not impose a visit limit on their beneficiaries for chiropractic treatment plans. Medicare provides coverage for active treatment, including acute complaints, chronic complaints, or acute exacerbations of complaints, expecting medical necessity has been demonstrated in appropriate documentation. Some chronic conditions, which may not show objective measures of improvement or resolution, are still well-managed using chiropractic services. Clinical judgement is relied upon more in these cases, but appropriate monitoring should still include standardized PROMs relevant to the condition and the patient's quality of life. Medicare does provide benefits for skilled care, which maintain the patient's current condition or prevent or slow further deterioration. Such care is not the same as the historical definition of maintenance care used by Medicare.

Follow federal and state guidelines that are not yet requirements: The Centers for Medicare and Medicaid Services (CMS) encourages states to help their enrollees facing health-related social needs (HRSN) and unmet SDOH needs. Following such guidelines, including public health, can improve health and quality of life for individuals and populations[27].

Create the Opportunity for Patients to Utilize Visit Limits after the Deductible Phase: Many patients with high-deductible plans currently exhaust their visit limits for the year while meeting their deductible, creating an absence of any benefit for Chiropractic.

> *Improved Benefit Design*: Visit limits should only be counted if the insurer is reimbursing all or part of the service. Visit limits should not count when the patient's out-of-pocket expense is 100% and the insurer's cost-share is eliminated completely due to the high-deductible plan design.

> *Improved Benefit Design:* Visit limits for chronic conditions, which includes chronic pain, should not be capped for non-pharmacologic treatments, which is consistent with policies for pharmacological interventions.

Redefine the Relationship of Discount Fee Plans and Insurance: As co-pays and deductibles have risen and allowable fee schedules have remained unchanged, many plans are structured in a manner that the patient now self-pays for the entire service which, in effect, the allowable fee schedule now functions as a discounted fee schedule. This illusory benefit is deceptive to patients who believe that they have purchased insurance coverage for chiropractic care when in-effect the insurer pays nothing while charging the patient a premium for the benefit.

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Improved Benefit Design: When the structure of the benefit and associated fee schedule consistently results in the patient incurring the total cost and the provider discounting services with no-cost share from the insurer, it must be clearly explained to the patient in the Summary of Benefits that the insurer is only serving to negotiate fees with the provider and will not likely pay for services on behalf of the patient.

Enhance Provider Contracting and Reimbursement Consistent with High-Value Care: While contracting with insurers is at the discretion of the provider, the current insurance climate allows no capacity for providers to negotiate the provisions of these contracts, which promotes fee schedules inconsistent with RVUs and CPI indicators. In addition, limited and closed networks create barriers for newer providers and other evidence-based practitioners to enter networks.

Improved Benefit Design: Allow qualified and willing providers into historically closed networks to allow patients full access to the clinical acumen of a broad range of providers. Create high-performance networks with evidence-based practitioners and incentivize patient participation with providers delivering high-quality, guideline-concordant care and reimbursement for chiropractic services in a manner that is consistent with the value-added, downstream cost savings as supported by retrospective claims data.

Assure that Benefits Design Aligns with Current Practice Guidelines: Current practice guidelines, including The American College of Family Physicians15 as well as the Joint Commission[28], recommend spinal manipulation; however, patient access to this essential benefit remains limited, promoting healthcare disparities.

Improved Benefit Design: Published clinical guidelines promote public health initiatives, and benefit design should be congruent with the care pathways supported by the most current data available.

Innovative Benefit Design: United HealthCare Embraces Data

In an innovative push to incentivize patients to choose the most-cost effective provider for lower back pain, United Health Care has utilized retrospective claims data[16] to re-design a benefit structure that significantly reduces the patient's initial out-of-pocket expenditure to initiate care with a conservative care provider, including doctors of chiropractic. This shift in benefit design reduces the expense to the patient, improves clinical outcomes with the anticipated reduction of healthcare expenditures for lower back pain of $250 million per year.

In contrast, in direct opposition to large-scale data analysis reviews, most other plans are still using antiquated benefit design models including increasing copayments and deductibles with low visit limits to chiropractors and other conservative care providers. In addition, insurers significantly increase the administrative burden and subsequent cost of delivering care by utilizing third-party administrators to limit access to the visits purchased within the patient's plan. These barriers to care may reduce short-term expenditures for insurers but the long-term effect of limiting access to evidence-based conservative care has been shown to increase cost to the system with detrimental effects to the individual patient and community health.

Advancing MSK Care in a Payer-Provider Collaborative Model

In a rapidly evolving climate for health care, benefit design and reimbursement structures for the management of acute and chronic musculoskeletal pain have not evolved in a manner that is consistent with best practices, clinical guidelines and the available body of evidence. Current payment models do not adequately reward high-performing providers, which impedes the development of critical infrastructures and care pathways for evidence-based care.

It is critical for insurers and providers to collaborate to create and foster models for conservative, non-surgical management of chronic and acute musculoskeletal conditions. Members of the American Chiropractic Association are committed to being trusted members of the healthcare community and are championed with promoting best practices and evidence-informed care. Likewise, benefit design and reimbursement structures should incentivize and promote the care pathways that optimize the management of acute and chronic musculoskeletal conditions, focusing on value, sustainability, social determinants of health and patient satisfaction. Affordable health care must strike a balance between containing costs for the patient, while also maintaining an environment in which the provider is willing and financially able to participate in the care-delivery system. Patients of all demographics, in all geographic regions, should have equal access to conservative chiropractic providers, particularly when the evidence supports early access to the services provided by doctors of chiropractic.

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