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Automobile Injuries: Who Pays?

By Arthur Croft, DC, MS, MPH, FACO

Costs are going up and out of proportion to the rate of inflation. So says NFO Research Inc. in a report of their research that was sponsored by the Insurance Research Council (IRC). In fact, in contrast to the few percentage points of inflation accruing during the same period, medical expenses, wage loss, and other expenses for the average person's auto injuries rose 518% during the 1977-1992 period. Recall that these escalating costs to insurers were identified as the raison d'etre for the Quebec Task Force on Whiplash-Associated Disorders -- a study funded by an association of insurance companies. And, while public health concerns about the ill effects of whiplash usually take precedence in the minds of health care providers, our clinical interventions are potentially compromised by the cost saving strategies promoted by big business -- strategies such as no-fault initiatives, the traducing of personal injury protection into managed care systems, adoption of rigid and constricted treatment guidelines, etc.

The IRC includes Aetna, Allstate, CNA, Farmers, Liberty Mutual, Nationwide, Prudential, SAFECO, State Farm, and Wausau, among the more prominent members. In this NFO research, 180,000 households were contacted, from which approximately 5,500 individuals provided information about their experience with auto accident injuries for the year of the study (1992). The report's title, "Paying For Auto Injuries: A Consumer Panel Survey of Auto Accident Victims," makes no pretensions about the purpose of the study -- clinical issues are not discussed in any detail. Still, the document provides some interesting statistics.

For example, most people used more than one benefit source to pay for their auto injury. Auto insurance paid 71% of the reimbursement, with health insurance providing another 19%. Attorney involvement in auto accident injury claims has more than doubled in the last 15 years, growing from 19% in 1977 to 42% in 1992. Attorneys are hired mostly when claims are filed against another driver's insurer (49%) and when claims against both their own and another driver's insurer (61%) are filed.

Residents of New York, New Jersey, California, and Pennsylvania -- apparently the most irascible in America -- are more likely to hire attorneys than in other states. About half said they contacted attorneys just to make sure they were adequately protected, while 32% did so at the recommendation of a friend or family member. And about half made attorney contacts within the first week; 25% contacted an attorney within a month. In only about 18% of cases did the attorney make a doctor recommendation. It was further reported that claimants who hired attorneys actually received a lower net reimbursement, on average, after deducting their economic losses, attorney fees, and legal expenses. In addition, claims with attorneys took longer to settle, relied on more benefit sources, and left claimants less satisfied with the overall amount received.

Although this appears as a prima facie indictment against attorney involvement in these claims (which include whiplash and all other injuries), the researchers did not consider other possible factors explaining this trend. For example, insurers became progressively more recalcitrant in settling soft tissue claims during this 1977-1992 period, and while this may be a direct response to mounting claims, it is also possible that the difficulties encountered by claimants in securing benefits resulted in the rise in attorney involvement. Reasons given for attorney contact in the previous paragraphs would seem to support this.

It is also likely that the claims that involve attorneys are not entirely comparable to those that settle or resolve without them. The heightened degree of case complexity associated with an assortment of potential confounding variables which might differentially require more attorney assistance may explain the lower satisfaction rate of claimants when attorneys are involved, as well as increased benefit use and settlement time. In other words, the lower satisfaction rate, benefit use, and settlement time may be because injuries/disabilities are more extensive, and that the client's expectations for reimbursement were unrealistically high. This is to be expected when a man can win a virtual jackpot of seven figures for getting hot coffee spilled in his lap! Attempts to exculpate attorneys in this report were conspicuous only in their absence!

From a statistical standpoint, about one in five households had a member involved in an auto accident between 1989 and 1992, with about a fourth of them sustaining some type of injury. As is usually the case, about 60% were female, and 40% male. More than half reported strains and sprains to the neck (53%); 45% reported them to the back. Other injuries of note included minor cuts and bruises (43%); "other" strain/sprain (21%); psychological and emotional disturbance (18%); serious cuts/bruises (18%); concussion (12%); other fracture (11%); fractured leg, knee, foot, back, or neck (8%); scars/disfigurement (8%); and

TMJ syndrome (2%). About 67% of the claimants reported strains and sprains as their most serious injury.

The research of the 1995 RAND report, "The Costs of Excess Medical Claims for Automobile Personal Injuries,"[1] was supported by the Institute for Civil Justice which is in turn supported by corporations, trade and professional associations, and private foundations, et al. The authors noted that between 1980 and 1991 insurers' costs for compensation for bodily injury grew 167% (which contrasts sharply with the IRC report), attributing 60% of this growth to inflation and rising health care costs (which also contrasts with the IRC report) and 40% to increases in the number and size of claims.

To investigate the problem further, the authors drew upon a large database of individual claims. Details of the database were not provided in the report and the methods used to arrive at conclusions were based partly on presumptions. They note, for example, that since "compensation for general damages is typically thought to be a multiple of the victim's economic loss" under the tort system, higher medical bills would result in higher compensation and, therefore, would provide an incentive for excess claiming. Similar incentives were outlined for the dollar no-fault system where suits cannot be filed until a certain dollar figure has been reached, thus providing an incentive to reach that threshold.

Michigan and New York have verbal no-fault laws in which damages can only be sought for specific types of injury, including death, dismemberment, loss of a bodily part or sense, or fracture. The authors assumed that all hard claims (fracture, dismemberment, etc.) were generally real and that claims for nonexistent (read that fraudulent) soft tissue injuries in these states would be rare, since victims can receive treatment but not compensation. They then developed an index which compared the number of hard claims to the number of soft claims. Michigan and New York had an index of 0.7 -- 7 soft claims for every 10 hard claims. Using this method, Hawaii (dollar no-fault) had an index of 0.9 and California an index of 2.5 -- 25 soft claims per 10 hard claims. On this basis alone, it was estimated that, overall, 35-42% of medical costs submitted were excessive with a potential net result of increasing the costs to insurers $9-13 billion annually. This, of course, made great headlines for a week or so, and I have been told that the RAND document was recently placed in the hands of the Hawaii state legislature (which is now in session) by an insurance company spokesperson in an apparent attempt to garner political assistance in limiting care for soft tissue injuries.

According to the IRC report, considering all injuries, 26% were treated by chiropractors, with 27% being treated by physical therapists, and the remainder by medical and "other" health care providers. For strain/sprain injuries, medical practitioners treated patients an average of seven times, whereas chiropractors

administered an average of 32 treatments and physical therapists 23. In about 40% of the cases, however, patients received 15 or fewer treatments from chiropractors. The median number of visits was 20, which agrees well with my guidelines.[2,3]

Although the authors of this study reported that "the evidence did not suggest that the cases treated by chiropractors and physical therapists were special or more serious than those treated by other health care providers," the nature of the evidence and basis for that conclusion was not provided. Merely comparing diagnostic codes, for example, would not have been sufficient, yet it is clear that personal interviews and examinations were not conducted. Moreover, it is common for patients with chronic pain -- those that might be considered clinical failures from the non-chiropractic quarter -- to eventually end up in chiropractic clinics as a last ditch effort to salvage a difficult problem. If a significant proportion of chiropractic cases are this type, the cases would probably not be comparable.

Nevertheless, it does raise an important question about the quality of care provided. As was pointed out by the Quebec Task Force on Whiplash-Associated Disorders in 1995, the evidence supporting chiropractic care as effective in the treatment of whiplash is lacking. This is not because any formal studies have failed to show effectiveness, but simply because no such studies have been undertaken. That is a serious failing on our part.

When we do get around to comparing medical treatment (seven visits per case) with chiropractic (32 visits per case) and physical therapy (23 visits per case), in addition to ensuring that the cases are comparable with regard to the seriousness of injury, it is important to compare apples and apples. For example, in several such comparison studies, chiropractic care costs have been compared to medical care costs based on doctor's fees alone. This can be misleading, because medical doctors are more likely to send out for radiographs and physical therapy treatment -- costs that are not billed through the doctor's office.

Chiropractors, on the other hand, frequently provide these services in-house and they are thus reflected in (and relatively inflate) their total fees. Prescription medicine, which can be quite costly, is usually not included in the physicians' fees either.

Once these factors have been accounted for, it is important to evaluate several parameters in the overall efficacy of care: 1) Is there a beneficial short-term effect? 2) Is there a beneficial long-term effect? The additional 25 visits (32 minus 7) may well be justified, for example, if the patient has fewer days off work, or if the long-term disability is reduced, or if there is a significant subjective benefit attributable to

chiropractic care. Studies comparing chiropractic and medical treatment of low back injuries in the workers' compensation arena, for example, have indeed demonstrated such advantages.[4-8]

As for the issue of reimbursement, soft tissue injuries (i.e., strains and sprains) generated the highest relative reimbursements per dollar of economic loss of the top 14 categories of injury. And, of the health care providers, reimbursements were higher in cases involving chiropractors -- 41.5% higher than for physical therapists and 23% higher than for medical doctors and osteopaths. This may be reflective of the generally higher treatment costs associated with chiropractic management, a greater willingness for chiropractors to participate in medicolegal proceedings, or it may be further evidence that the cases treated by chiropractors and medical providers are not entirely comparable.

From examining the statistics on claims filed in the IRC report, it is clear that the expected ratio of "soft claims" to "hard claims" in California is exactly what we would expect to see, particularly in view of the fact that about 78% of rear-impact auto accident injuries occur at collision speeds of under 12.4 mph. The RAND report, developed on the basis of a rather logically dubious hypothesis that was never actually tested or validated, finds no support in the IRC report, but the reverse is also the case in spite of the fact that both projects appear to have had the same purpose.

Whatever the true figure is, costs have risen substantially over the years, and chiropractors clearly play a large role in the care and management (and yes, costs) of auto injuries today. I believe it is possible to improve the quality of care while substantially reducing costs through the development and adoption of rational treatment guidelines.

Arthur C. Croft, DC, MS, FACO
San Diego, California
E-mail: dr_croft@4dcomm.com

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