A thletic trainers have long been the primary caregivers to athletes injured in sports. But athletic health care is going through a process of evolution. With task force and advisory groups in education and reimbursement, athletic trainers are beginning to evaluate their future role in the health care system. The concept of managed care is catching on throughout the U.S.

Athletic therapists need to evaluate managed care to see where they fit in this system. In recent years, managed care organizations have increased their share of the marketplace. Fee-for-service insurance programs are on the decline as members move to managed care programs (Harden, 1994).

Given the increase in managed care programs such as HMOs and PPOs (respectively, health maintenance and preferred provider organizations), athletic trainers have an excellent opportunity to use their skills within these systems.

**Traditional Settings: Managed Care?**

When we evaluate the managed care system and look at the traditional athletic training setting, it becomes obvious that athletic trainers have provided managed care for many years. Concerning the athletic training budget, there is a specific amount of money to spend for the entire program. General operating expenses include supplies, deductibles, insurance premiums, and capital equipment.

Paying a provider a fixed amount of money per member of a managed care plan for providing coverage to those members is called capitation. The amount is provided regardless of the number of patient illnesses or injuries. Risk is shifted from third-party payer to the provider.

The athletic training program has providers (team physicians, clinics, hospitals) that they use. For its part, PPO is a health care arrangement between one group to provide coverage for individuals of a health care group. Although this terminology is loosely defined, it does shed some light on the concept of managed care and the fact that this has been practiced in most settings in which athletic trainers work.

Athletic trainers provide many services to injured athletes. They need to couple this with the entrepreneurial spirit in order to find areas in which they can provide a quality service to HMOs and PPOs.

**Physician Extenders**

The athletic trainer and the physician have long had a good relationship. Few health care duos share such a close relationship. Physicians have long used other health care providers to extend their care to patients, whether it is a nurse giving an injection or a physician assistant doing a general health screen. Services provided by the athletic trainer can go far
to increase the effectiveness of the physician.

Managed care with capitation affords the athletic trainer the opportunity to provide services in the physician’s office, training room, or at the scene. Cost savings to the physician can be realized by the athletic trainer providing exercise programs, brace fittings, evaluation of sports injuries, and other related professional services in schools, clinics, or hospitals.

**HMOs and PPOs for Athletics**

Hospitals, independent physician associations (IPAs), exclusive provider organizations (EPOs), and other health care services form a group to provide coverage to HMOs and managed care organizations. In so doing they can provide a health care service and make a profit.

Some athletic trainers are evaluating the possibility of providing athletic HMOs and PPOs to school districts, parents, sports organizations, and managed care programs. The system would be organized much like traditional PPOs except that it would be used for athletes participating in sports programs. Undertaking this type of operation would be time consuming. Exclusions, co-payments, and secondary policy features would have to be decided. It would be difficult to provide a full multispecialty service in rural settings, but it could be done.

Existing services should be evaluated carefully, as well as previous health care expenditures by schools and sports organizations. This would give some indication of the total cost for services to be provided by the athletic PPO.

Costs of setting up the new health care plan, its operation, and risk factors such as dealing with catastrophic injuries also need to be considered.

The final concern would be profitability. How long would it take to realize profits? Would the service increase the number of patients being seen? Would the athletic PPO result in more people choosing a particular least-coverage plan over their desire to have this service?

**Athletic Trainers and IPAs**

With IPAs there is an organized effort to provide a total package to a managed care service. The athletic trainer can provide services to enhance the IPA program and reduce the cost for the association. Athletic trainers can outline a set service for the IPA to achieve this goal. It can be, say, providing rehabilitation services in the clinic, assisting the physician in the office, or providing outreach services to the schools that the IPA covers.

This can be contracted through a clinic or an independent network of athletic trainers. Care can be provided at reduced costs, and many patients with sports injuries may not need referral to more expensive segments of the health care system.

**Lobbying**

The managed care industry would gain much from athletic trainers being hired by high schools and colleges. Each of these plans has members with dependents who participate in school sports programs. The athletic trainer might save money for schools by affording them lower premiums for health care coverage. HMOs and insurance companies alike can benefit when the school based athletic therapist is able to provide quality care for most injuries without expensive interventions such as:

- Emergency room visits for minor injuries like sprained ankles;
- Unnecessary ambulance calls;
- Rehabilitation services that would be referred to physical therapy clinics;
- Re-injury due to a premature return to activity.

The insurance lobby is very powerful. It can defeat legislation and pass other legislation that it feels will help it. This industry could be the key to the long-standing efforts of many health care professionals to place athletic trainers in high schools.

According to a recent survey, only 20% of the athletic trainers in school at this time are getting teacher certification (Curtis, 1995). If we are to continue emphasizing placement of athletic trainers in high schools, we need to review their position as health care providers in the school setting and justify these positions as being worthy of remuneration.

**Conclusion**

Managed care is a concept that looks to reduce medical costs for the consumer. Athletic training in the traditional setting of high schools and colleges was instituted to help reduce medical costs and provide quality health care for the injured athlete. There are similarities in managed care operations and those of school based athletic training operations.