

1 an integrated pain management team that will be actually
2 run by the department of anesthesia.

3 The formula that we are using is that we are
4 using the Center for Integrative Medicine as a proving
5 ground to credential and evaluate potential practitioners
6 for the in-patient setting, and then the CIM, the Center
7 for Integrative Medicine, and the credentialing committee
8 of our center will make recommendations to the
9 credentials committee of the medical staff.

10 Without having the groundwork, the credentials
11 committee chairman basically said, you know, we wouldn't
12 be able to do this, because they didn't want to deal with
13 it, essentially. So that is what has happened here, and
14 we are planning to start that in January. Up to this
15 point, it has been a little bit of massage therapy and
16 that is it, really, in the in-patient setting.

17 DR. MERRELL: We have credentialed both in-
18 patient and out-patient chiropractic massage and
19 acupuncture for CAM services, and then anyone who has a
20 license essentially can do mind-body therapy, whether it
21 is a Ph.D. or RN, NP, et cetera, and that already exists
22 and actually our nursing program has developed, with the

1 approval of the chairs of the department of surgery, a
2 pre-op surgery program that provides patients with
3 imaging hypnosis before Reikian therapy and touch during
4 and after surgery, institution-wide. What is required in
5 credentialing is that in order to have chiropractic
6 acupuncture in the medical setting, the attending
7 physician of the hospitalized patient has to request it,
8 and actually the chair has to approve it, but the chairs
9 have all said that they approve it if the attending asks
10 for it. So they don't need to go to that second level.

11 We are just beginning now to have chiropractic
12 available in the spine center for low back pain and
13 acupuncture beginning particularly for post-surgery
14 patients. So we are just open five months, so we are
15 just beginning to get into the in-patient settings, but
16 the plan is to expand it and make it available to every
17 department, and more than that, have each department have
18 their own people so they don't keep calling us in to
19 provide the services, but that they take ownership so it
20 is integrated to their department. Not that it is some
21 boutique or separate department that is occasionally
22 providing services to the institution.a

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1 DR. GORDON: I'm sorry, I am not sure I
2 understood. You are providing all the services, or they
3 have their own providers?

4 DR. MERRELL: No, at the moment, we are
5 providing them, so we want them to provide their own,
6 eventually. We are helping to work with them to actually
7 -- if they want there to be a department of integrative
8 medicine, eventually there will be, but not to provide
9 services throughout all the hospitals, more to provide
10 guidelines on credentialing, to try and coordinate
11 things. But we really hope that each department, in and
12 of itself, will hire the practitioners to do their own
13 services, so that it is not one separate department, but
14 each department takes ownership. Right now we are the
15 only game in town, so practically we are doing it.

16 DR. GORDON: So you provided the credentialing
17 system that has been accepted by the hospital, and then
18 within that system, they would then hire their own
19 people?

20 DR. MERRELL: Yes. Each department could hire
21 its own people with the same credentialing guidelines.
22 It is not just for us, it is for the whole institution.

1 DR. GORDON: Do you have any sense of the
2 demand that might occur in this, or how many patients can
3 actually request it, use it, or --

4 DR. MERRELL: Yes. The demand is huge in the
5 surgical program, and in-patients that come in already
6 have increased the patients using chiropractic and
7 acupuncture, have already started asking for the
8 services. It is only the fact that we don't have enough
9 personnel to schlepp over to the hospital to do all these
10 things has prevented us from doing more in-patient work,
11 because the patients, now that they know this is
12 available, they are beginning to request it.

13 DR. GORDON: Maybe one of your fellows could be
14 an exploratory venture into a CAM hospital. Is there
15 something like that?

16 DR. MERRELL: To the fellows, that will be a
17 definite role for them.

18 DR. GORDON: Julia.

19 MS. SCOTT: Thank you.

20 This is for Dr. Merrell. Earlier one of the
21 Commissioners asked if these CAM services were available
22 to the underserved, underinsured, and medically unserved,

1 and you responded that these populations were served by
2 two affiliated clinics. My question is, are the CAM
3 services offered different than those at the academic
4 center? And if so, what are the differences?

5 DR. MERRELL: No. I think this is a unique
6 situation. I was trying to figure how you could make
7 this applicable to the rest of the nation, but we are in
8 a uniquely fortunate situation. Actually the department
9 of family medicine is hooked up with the Institute of
10 Urban Studies, and for 10 years has had a Sidney Hillman
11 center that originally was private, now state-funded to
12 provide care to the uninsured, underinsured Medicaid, and
13 they have been routinely providing care and nutrition and
14 nutritional therapies, Chinese medicine, acupuncture,
15 mind-body therapies to patients with classes on yoga and
16 massage, meditation, tai chi, and that has been for over
17 a decade.

18 There is also a clinic that is semi-private,
19 but is actually affiliated with the hospital, that serves
20 primarily Hispanic and African-American population. That
21 has also for decades been providing those services.
22 Again, it is a Title 28 facility, largely state-funded,

1 providing all those services. So we are fortunate in
2 that we couldn't afford financially to make a go of it
3 just serving a high percentage of the population, but
4 within the system we have it worked out so that that is
5 already available.

6 The formula of how you incorporate all that
7 under one roof obviously requires a degree of subsidy in
8 a center, unless it is a fairly bare-bones set-up.

9 MS. SCOTT: Thank you.

10 DR. GORDON: Thank you. Thank you all three
11 very much for the richness of the presentations.

12 We will take a five-minute break, and then we
13 will have the next panel.

14 [Recess.]

15 DR. GORDON: We are going to begin with the
16 next panel now, so if the panelists can come forward, and
17 the Commissioners can come sit.

18 One of the things I want to say at this point
19 is to very much thank the subcommittee that has worked on
20 this program, and also our staff. This has been a labor
21 of love. Part of the labor of love has been to
22 orchestrate a program in which we see both specific

1 examples of different kinds of integration and different
2 kinds of CAM programs, and at the same time we are
3 enabled to take a larger view. This is one of the
4 larger-view panels.

5 We have two people on the panel who represent
6 managed care organizations, and a third, Lori Bielinski,
7 who works with the Washington State Insurance
8 Commissioner and has a major role in helping to design
9 and implement plans of health care. So, in a sense, it
10 is a kind of -- I don't know what you would call it,
11 oversight supervisory regulation.

12 What we are going to do is we are going to
13 begin first with James Dillard, and then Anna Silberman,
14 and then Lori Bielinski will be third.

15 So, James Dillard.

16 DR. DILLARD: Thank you, Dr. Gordon.

17 I am glad to be here to talk to you. I am an
18 acupuncturist chiropractor and medical doctor. I have
19 had a chance to do a lot of different things in the
20 alternative medicine arena.

21 In 1995 and '96, I was asked to consult with
22 Oxford Health Plans based in Connecticut at that time,

1 still is, basically doing business in the tri-state area
2 of New York, New Jersey, and Connecticut, to help build a
3 comprehensive CAM program inside the insurance company.
4 Dr. Rasama That was the business director, I was the
5 first medical director in October of 1996.

6 We built a program, and I am sure many of you
7 are familiar with the program. We credentialed almost
8 3000 providers and six provider types, and went live
9 January 1 of 1997. It has been a model program in many
10 ways, and pretty successful.

11 Unfortunately, the company had some financial
12 challenges at the end of 1997, their stock dropped
13 precipitously, and so it has been an interesting but in
14 some ways an incomplete experiment in building a CAM
15 program inside a managed care organization, simply
16 because we have had financial challenges since the
17 beginning of 1998 until recently.

18 Fortunately, the company has done a very
19 remarkable financial turnaround and is one of the more
20 solvent insurance companies, managed care companies, in
21 the country right now, thanks to our CEO, Dr. Norman
22 Payson.

1 The reality is -- and you can ask me more
2 questions about the program, if you like -- the reality
3 is that a lot of managed care companies aren't doing so
4 well financially. Ten years ago they were the darlings
5 of Wall Street.

6 Now, they are not considered to be great
7 investments. A lot of them are having trouble making
8 profits, difficulties with their projections, and I think
9 it has changed the whole environment for building these
10 kinds of programs inside managed care. It has become
11 much more of a challenge.

12 Our chief medical officer, Alan Muney, would
13 want me to tell you that we really should not endorse or
14 try to weave in things that don't have very strong
15 evidence, because the reality is that we just can't pay
16 for it right now. We have limited resources. We don't
17 want to have things that represent duplicative services,
18 that may have marginal outcomes.

19 The idea of somebody seeing the acupuncturist
20 and pulmonologist for their asthma at the same time, that
21 are certainly additive costs. We don't have the kind of
22 data we need to comprehensively dovetail these things.

1 But the Oxford program is still a very interesting model.
2 It is a three-tiered model consisting of standard
3 benefits, an alternative medicine rider, and contracted
4 network of providers, what we call affinity plans being
5 referred to as now.

6 But the question also comes down to, where are
7 you going to spend the money. We just don't necessarily
8 have the money to do everything for everybody as is
9 necessarily wise or even effective.

10 I think the Oxford program did represent access
11 inside a large managed care company which was considered
12 to be one of the silk-and-satin plans on the East Coast.
13 It was middle class, upper middle class, upper class. We
14 insure a lot of the big Madison Avenue firms. It was
15 part of the boutique quality of the plan, and continues
16 to be a major part of its identity today.

17 I can address some issues of integration,
18 trying to create integration inside a managed care
19 organization. We made some, I think, successful attempts
20 at that. In some ways, we were not able to fully
21 execute, even though our plan was pretty good, because of
22 the financial challenges of 1998 and 1999. Some of those

1 plans are still on the drawing board, and we may have the
2 opportunity to carry some of those things through.

3 There are a number of barriers to that
4 integration. There is resistance on the part of the
5 physicians, there is resistance on the part of the CAM
6 practitioners, and also the patients tend to
7 compartmentalize quite a bit, which has already been
8 talked about.

9 It also takes a lot of time to do the
10 integration, and it is not easy to do, particularly in
11 terms of the managed care plan. When we actually started
12 this, we wanted to be able to share all our records
13 between the CAM practitioners and the 14,000 primary care
14 physicians at Oxford.

15 We got a strong push-back in focus groups and
16 from other patient groups, that they didn't want us to
17 share those records. They didn't want us to tell their
18 primary care physician that they were seeing the
19 acupuncturist, and under law, they have the right to do
20 that. The patient's record belongs to the patient.

21 If a patient tells us we are not supposed to
22 tell their internist that they are going to see a massage

1 therapist or a nutrition counselor, we have no choice.
2 We cannot create integration. We saw some rather strong
3 push-back on that when we first created the program,
4 which I think is another interesting point. Many of us
5 have been talking about whether or not it is possible to
6 fully integrate these things.

7 So I would simply say that, overall, it is
8 appropriate to create access to the therapies we consider
9 to be safe, and embrace reimbursement, only for those
10 therapies which have strong evidence base.

11 Thank you.

12 DR. GORDON: Thank you very much.

13 Anna Silberman.

14 MS. SILBERMAN: My preference is to present an
15 example of access and delivery issues that have been
16 solved by High Mark Blue Cross/Blue Shield in Pittsburgh,
17 Pennsylvania.

18 Yesterday, you heard the testimony of Rick
19 Collins, our medical director for the Dean Ornish Program
20 out in Nebraska, and Walter Czapliewicz, a patient from
21 Pittsburgh.

22 In 1997, High Mark made medical pair history by

1 becoming the first insurance company in the country to
2 both provide and pay for the Ornish program for any of
3 our members who have any of our products absolutely free
4 of charge, because what we learned is that if heart
5 disease is just bypass with surgery, without also
6 addressing the causes, then the problems tend to come
7 back again. That is why bypass surgeries are often
8 repeated within 10 years, and angioplasties within six
9 months.

10 So High Mark decided it would actually be
11 ethically and financially irresponsible not to offer this
12 alternative to bypass surgery. Our decision was easy for
13 two reasons:

14 Number one, it makes sense for the patient. As
15 you heard, the Ornish program works, it is the right
16 thing to do; and number two, it makes good financial
17 sense. It pays for us to invest in proven alternative
18 therapies to reduce utilization.

19 The Ornish program has four components:
20 moderate aerobic exercise; group social support; a low
21 fat vegetarian diet, with supplements; and stress
22 management, which includes meditation, yoga, progressive

1 relaxation, and guided imagery.

2 So you see this is truly health care and not
3 just sick care.

4 The program is delivered by a team of
5 physicians, exercise physiologists, registered
6 dietitians, yoga instructors, behavioral health
7 clinicians, and other professionals, both alternative and
8 conventional, all executed by the ninth largest health
9 insurance company in the country.

10 The team services patients for 10 hours a week,
11 helping them to integrate better health practices and
12 self management into their lives. We also help them
13 develop meaningful relationships in a supportive and very
14 loving environment.

15 It is a very odd thing to see at the corporate
16 headquarters of a large insurance company, but our senior
17 management supported the Ornish program because of the
18 science behind it. It can reverse heart disease, and it
19 has.

20 Our patients have 57 percent less angina; 50
21 percent less depression; cholesterol improved by an
22 average of 22 points; and body fat by 10 percent. All of

1 these biometric and psycho-social risk factor
2 improvements are statistically significant.

3 I believe you all have a chart in your books
4 with even more dimensions.

5 But most importantly, there has not been a
6 single heart attack or death since 1977, when we
7 implemented this program. There has been one bypass
8 surgery, one stroke, and four angioplasties among these
9 400-plus very high risk patients.

10 The point is these cardiac events are far below
11 what would otherwise be expected with conventional
12 treatment.

13 DR. GORDON: Excuse me. Let me interrupt for
14 just a second. It is Tab J, Roman numeral V, Tab J.
15 Roman numeral V, Tab J.

16 MS. SILBERMAN: So we would expect 77 percent
17 of our patients with this type of risk profile to
18 experience some type of adverse cardiac event. The
19 Ornish program is completely safe, there is no risk,
20 there is no downside. So this alternative is actually
21 very conservative medicine at its best.

22 The outcome data challenges the progressive

1 nature of heart disease and the progressive expense
2 histories for cardiac claims. Our actuaries agree. They
3 have calculated savings of \$17,000 per patient, which
4 translates into a little over \$8 million in savings.

5 The preliminary results of our matched control
6 group study indicate a \$297 per member, per month
7 difference between our treatment and control groups.

8 So we were able to draw on a lot more than good
9 intentions here when we decided to start a new company to
10 roll this out across the country. It is called Lifestyle
11 Advantage, and the purpose of Lifestyle Advantage is to
12 change the way or somehow influence the way heart disease
13 is managed and financed.

14 In our view, providers and payers must come
15 together to do what is right and to do what is cost-
16 effective. You need reimbursement for CAM services to
17 become permanently ingrained in our health care system.

18 It is one of the reasons we formed Lifestyle
19 Advantage. With this union, our new company is well
20 positioned to increase reimbursement and access by using
21 the relationships that High Mark already has with other
22 Blue Cross/Blue Shield plans.

1 In fact, many have already chosen to reimburse
2 for the Ornish program, and we have reimbursement codes
3 that are now available to be used nationally.

4 In summary, our program is less painful, less
5 expensive, more effective in the long run. It is one of
6 the things a health plan can do to be socially and
7 financially responsible, and for High Mark it gives us a
8 great opportunity to earn customer respect, trust and
9 genuine patient satisfaction, build bridges between the
10 alternative and conventional communities, and I will go
11 into my recommendations in a few minutes.

12 But thank you so much for representing our core
13 values.

14 DR. GORDON: Thank you very much.

15 Lori Bielinski.

16 MS. BIELINSKI: Good morning, Dr. Gordon and
17 members of the Commission. It is my honor to address you
18 today regarding access and delivery of complementary and
19 alternative medicine services.

20 I will start with some of the background about
21 how the Washington State Every Category of Provider law
22 is being implemented since there are great

1 misunderstandings.

2 Although the law has taken great criticisms, it
3 is important to note that it is one of the few sections
4 of Washington's 1993 Health Care Reform Act, part of the
5 act that was not repealed. It was the most controversial
6 and most popular reform, and ultimately was let stand by
7 the U.S. Supreme Court.

8 The law has taken into account the attempt of
9 managed health care to save money, as well as giving
10 patients some access to choice and involvement in their
11 health care options. This is not in any way a provider
12 law, nor is it a mandated benefit law. It allows
13 consumers a choice of the provider who will treat the
14 condition in which they are seeking care.

15 There are currently several different coverage
16 models of CAM services used in Washington State. Neither
17 the OIC nor any of its collaborative work groups have
18 recommended a right way of including these benefits.
19 Each approach has advantages and limitations for various
20 constituencies.

21 The first is the dollar cap method, which is a
22 straightforward benefit that generally applies a maximum

1 dollar amount given per coverage year for a set range of
2 CAM services. Acupuncture, massage therapy, and
3 naturopathic medicine are the most commonly included
4 services under this model.

5 CAM benefits may require referral from a
6 primary care provider and patients must pay necessary co-
7 pays and deductibles. When the limit has been placed on
8 more than one profession or all of CAM services, the
9 Office of the Insurance Commissioner would deny approval
10 of that benefit limit.

11 The condition-based model bases benefits on
12 allowances related to specific clinical diagnoses or
13 conditions, such as acupuncture for chemical dependency,
14 or naturopathic care for migraine headaches.

15 The covered benefit may require specific
16 clinical regimens to have been followed prior to the
17 referral of CAM services. An example is requiring a
18 physical therapy service prior to authorizing massage
19 therapy services.

20 The condition-based approach is usually
21 requiring a PCP referral and co-payments and deductibles
22 apply.

1 The gatekeeper method is frequently employed
2 under managed care strategies. A unique difference with
3 this model is that in some cases the naturopathic
4 physician is eligible to be a primary care provider.

5 Patients seeking CAM services to be covered
6 under their insurance benefits need to have a referral
7 from their PCP, whether that is an MD, DO or ARNP. The
8 benefits are subject to medical necessity requirements
9 and established by the insurer that may be determined by
10 the at-risk PCP group as well.

11 The open access model is built on strong care
12 coordination and quality infrastructure, allowing
13 integration of CAM and conventional practitioners and
14 their services. Enrollees are allowed access to network
15 providers of all categories without a PCP referral. In
16 fact, there is no PCP or gatekeeper required.

17 The self-referral method allows patients to
18 directly access all providers and preventive care
19 services and usually a separate rider.

20 Although the self-referral approach method does
21 not usually require a PCP referral, benefits are subject
22 to medical necessity determinations.

1 Frequently the self-referral approach may be
2 implemented in conjunction with a preventive care
3 benefit. Preventive care benefits are not usually part
4 of the policy, but can be negotiated by the purchaser.

5 The discount networks are where some insurers
6 have begun to negotiate discounts with CAM providers
7 through a contract of network for their policyholders, in
8 exchange for being listed in the carriers' approved
9 provider guide. These carriers do not provide
10 reimbursement for the enrollees' expenses and costs are
11 paid directly by the patient.

12 This is not in compliance with our statute and
13 rules related to the other category of provider law,
14 since the patient doesn't actually engage their benefits
15 when seeking care from CAM providers.

16 Carriers have the right to set coverage limits,
17 including services of CAM providers and the OIC rules
18 state that these limits may not be unreasonable and may
19 not be set by provider type but can be set by covered
20 services. The carriers can't exclude a particular
21 category of provider altogether, nor can it cover certain
22 provider types only by a separately priced optional

1 benefit.

2 Reasonable limit has yet to be defined, and the
3 filed limits by each of the carriers is something
4 currently under review. A data call related to the
5 criteria used by insurers to establish limits for health
6 care services is currently under way by our agency.

7 After a preliminary review of this data, I can
8 tell you there is no established pattern of how these
9 limits are set. In text, I have provided you some of the
10 preliminary results, but consequently, when carriers
11 contract with outside entities to provide these panels,
12 there seems to be a disconnect to the very concept of
13 integrative medicine.

14 To close, I will reference a chart I submitted
15 in advance, outlining the reported coverage that insurers
16 in Washington State indicate is available to their
17 enrollees.

18 I would like to point out that there is
19 conflicting information from many of the carriers
20 regarding what they file as benefits, what the cost of
21 the benefit is to them or their purchaser, and what they
22 report in policy increase as to how they manage the

1 benefit.

2 I will end there.

3 DR. GORDON: Okay. Well, thank you. We will
4 come back to you.

5 All right, we have questions. We will start
6 with George. Go ahead. And then George.

7 DR. DeVRIES: Dr. Dillard, first of all, within
8 the CAM managed care industry, you have certainly earned
9 a position of respect throughout the country, and we
10 really appreciate you being here today, and what you have
11 done at Oxford has been significant.

12 You have talked about access to some extent.
13 Can you share with us the degree of success Oxford has
14 had with the supplemental benefit programs for
15 chiropractic or acupuncture, I believe, as well as
16 naturopathy, and perhaps the perception you have of
17 employers' willingness to pay for the benefits, but then
18 potentially the difference between member accessing care
19 under those programs versus perhaps through other systems
20 you have, where members can access CAM benefits within
21 Oxford?

22 DR. DILLARD: Sure. There is a lot in that

1 question.

2 Our program is the three-tiered program, just
3 to remind you. We have some standard benefits. We have
4 an alternative medicine rider, which is available at a
5 group level for a slight increase in premiums per year.
6 And then we have a contracted network of providers that
7 is available at a set rate, the Oxford rate.

8 We already had a small benefit for chiropractic
9 when we were building the program. We went to a standard
10 benefit for chiropractic for all three states we were
11 doing business in at that time, and we treated the
12 chiropractors just like other medical specialists. They
13 would require a referral by a primary care physician, and
14 the primary care physicians didn't want to manage that
15 benefit. They said we would be more comfortable if you
16 manage it. We will make the referral, you manage it, and
17 so we gave them eight visits before they had to send us a
18 care plan to allow the majority of the care to pass under
19 the utilization management threshold. So that is in all
20 three states standard benefit for chiropractic.

21 There is also a mandated benefit in Connecticut
22 for naturopathic services which we treat exactly the same

1 way as we do chiropractors.

2 Acupuncture was put into a rider which was sold
3 to about 60 large groups, medium to large groups, and was
4 delivered in the same way and managed the same way as the
5 chiropractic was in terms of an eight-visit limit.

6 Our recent surveys have shown that the most
7 popular parts of the program have been chiropractic,
8 nutrition, massage and acupuncture, probably in that
9 order. I did supply you with a more recent survey, one
10 that was done in 1999, and two in 2000, which will give
11 you some of that raw material.

12 The question becomes what is access? Is access
13 something that is paid for? Is it just having a
14 practitioner available? We felt we were creating access
15 by having a vetted network of practitioners whom we have
16 looked at pretty closely, and we felt that that
17 represented a value added to the member. It is access,
18 it is not reimbursement. Those are not the same. Of
19 course, they are related.

20 So I think again the highest area of
21 utilization was undoubtedly chiropractic. I think
22 massage and nutrition were somewhere after that, but

1 those were in the contracted rate program, and that is
2 all in the survey.

3 I don't know if I answered your question fully.
4 Was there something I --

5 DR. DeVRIES: Well, perhaps have you seen in
6 your survey work that in terms of patient access of care,
7 have you seen a difference between when services are
8 covered as a benefit, versus your discount access
9 programs? Are more members utilizing CAM professions
10 under benefit programs than under simply discount
11 programs?

12 DR. DILLARD: Yes. That is a good question.
13 We do have a discounted network program for chiropractic,
14 which means they don't have to necessarily get a primary
15 care physician referral. They can go to a chiropractor
16 and simply pay the Oxford rate.

17 We think that the vast majority of utilization
18 has been through the benefit with the primary care
19 physician referral. We have not been able to fully
20 capture that data. We were entering into a comprehensive
21 research contract with Dr. Eisenberg's group at Harvard
22 in 1997, when we had the financial challenges that I

1 described, and we had to cancel that contract,
2 unfortunately. I think we could have gotten a lot of
3 this kind of interesting data. I am not sure about all
4 those, George. I mean there are some details there that
5 I don't have.

6 DR. DeVRIES: And one other follow-up. Just
7 the difference in access between when services are direct
8 access, when there is direct access to the complementary
9 health care provider versus going through physician
10 referral, have you seen any differences related to access
11 there?

12 DR. DILLARD: The product of alternative
13 medicine rider was a direct access program. It allowed
14 direct access without the primary care physician
15 involved.

16 Again, we have not been fully able to study
17 that, but we think that that was a fairly popular
18 product, that people liked that. There are always
19 difficulties with gatekeepers in conventional
20 utilization. I think a lot of people are uncomfortable
21 with having to go to their gatekeeper to go see an
22 obstetrician-gynecologist. It is a common complaint.

1 I think there is a strong possibility we could
2 look at more non-gatekeeper products. But again, there
3 is a challenge in knowing how to price them.

4 DR. GORDON: George.

5 DR. BERNIER: I have a question for Anna
6 Silberman. Those are really impressive numbers, the
7 \$17,000 per participant that you saved, and the win/win
8 situation. Are you looking forward to using other CAM
9 modalities in such a terrific way?

10 MS. SILBERMAN: I have to say that George was
11 one of the original members of our board of directors
12 before he moved on to Texas, so I am surprised to see him
13 here after eight or 10 years.

14 What we have is a delivery system called Health
15 Place. We have 17 centers that deliver CAM programs on a
16 daily basis to about 40,000 people a month. Some of
17 those services include all of the things that we talked
18 about today. I think our most popular service is
19 nutrition counseling, both in a preventive way and for
20 people who have chronic conditions.

21 One of the programs that I am especially proud
22 of is called Hope, and that is a program for

1 osteoporosis. We have two arms of that, one for people
2 who already have the diagnosis, and a preventive program
3 for those who do not. It centers around nutrition,
4 strength training, all kinds of health promotion
5 modalities. This is really unusual, I don't think it
6 would be considered CAM, but our building engineers
7 actually go into the homes of our members who are at risk
8 for osteoporosis and clean up any hazards that are there,
9 and install grab bars and so on.

10 But the bottom line is, is the results of the
11 program, and since we have implemented that about three
12 and a half years ago, we haven't had a single fall or
13 fracture. So it is nice to do these kinds of
14 interventions, but when it comes back as a cost savings,
15 it really helps it continue on and grow.

16 DR. GORDON: Thank you.

17 Toni.

18 DR. LOW DOG: Well, that is great. That was
19 really my fear.

20 I have questions for everybody, but since I can
21 only have one, I will ask Lori. When we were up in
22 Seattle, it was staggering to see what has been done up

1 there and, of course, we had the benefit of coming in
2 after all this work had sort of been done.

3 Now that you have got some of it behind you, do
4 you have any pearls of wisdom for us and recommendations,
5 or things that you would have done differently, or
6 better, or problems, any advice for us that we can take
7 after reviewing all this material and spending that
8 weekend in Seattle?

9 MS. BIELINSKI: I think the significant thing
10 from my perspective is that I always get confused when I
11 have to explain the law to somebody. It is baffling to
12 me how many times I explain it to the same person and
13 they still think it is a mandated benefit law, and that
14 it doesn't honor managed care. So the one thing I would
15 say is keep reading the explanations I have given you
16 because even the only cost-benefit analysis that I have
17 seen on CAM services from Milliman Robertson, which is
18 one of the more significant actuarial firms, still
19 declared our law a mandated benefit law, which is the
20 only reason it got through the Ninth Circuit Court of
21 Appeals, is because it is not a mandated benefit.

22 So in each state where there are various laws,

1 pay very close attention to that.

2 The other side of it is where the independent
3 networks have a relationship with the Office of the
4 Insurance Commissioner and the carriers that we regulate.
5 The Office of the Insurance Commissioner in some states
6 is elected, some it is appointed, and it is about a 50-50
7 split.

8 For our agency, we are elected, and so we have
9 a very consumer advocacy role for the consumers, as well
10 as how we work with all the entities that we regulate.
11 We don't regulate the networks, the primary care
12 organizations, the CAM services networks, and when there
13 are relationships established between the independent
14 networks that we don't regulate and the carriers that we
15 do regulate, sometimes there are problems with how the
16 independent contracted entity, for lack of a better term,
17 is going to treat the providers that fall under various
18 regulations that we do have. And significantly, right
19 now in our state, there is one contracted network for CAM
20 services that has obtained the contract with the largest
21 carrier in the state. They haven't completed that
22 relationship, yet they are contacting and discussing and

1 contracting with providers. It has consumed nine weeks
2 of my time, just on that one issue. It is a huge
3 problem. The contracts for the providers are regulated
4 by our agency, yet we haven't seen it because the carrier
5 and the network haven't finished their relationship. The
6 carrier would have to file that contract with our agency.

7 So they are disbursing a contract that has not
8 been approved by the agency that they use in a different
9 state, with different laws, and the providers are -- I
10 have 2000 complaint letters in my office right now that I
11 have to respond to. So I would say, to summarize my
12 point, have the carriers and the networks complete their
13 relationship first. Think about what you are doing to
14 the providers in the context of continuity of care.
15 Every single patient that these providers are seeing is
16 going to be affected if their provider is included in the
17 new network or cut out. This particular network will cut
18 the chiropractors and massage therapists current network
19 in half, at least. So patients that are seen by half of
20 those networks are going to lose their doctors. Open
21 enrollment for the largest self-insured entity just
22 closed November 30th, so you can imagine the ripple

1 effect of what is going to happen.

2 DR. GORDON: Veronica?

3 DR. GUTIERREZ: Thank you.

4 My question was on the same subject, so unless
5 you would like to expand on any time remaining on the
6 discussion, I am fine, thank you.

7 MS. BIELINSKI: I think that is enough said.

8 DR. GORDON: Wayne.

9 DR. JONAS: I had a question for Ms. Silberman.

10 In answering your first question, why and how did you
11 select the Ornish program, you described the data and
12 that type of stuff, which is great. I am wondering, were
13 there any individuals who were in the management
14 hierarchy of Blue Cross that have had personal experience
15 with the Ornish program?

16 MS. SILBERMAN: In this case, no. In some of
17 our other sites across the country, there are 12 of them,
18 that is true. In the case of High Mark Blue Cross/Blue
19 Shield, no, there hadn't been anybody at that point in
20 time. Once we implemented the program, some of our
21 executives took advantage of it, for both themselves and
22 their family members. It was simply a matter of, you

1 know, I heard Dr. Ornish speak at a conference, and to me
2 it made good sense, and they received it very well.

3 DR. JONAS: So you brought it to them, then?

4 MS. SILBERMAN: Yes, I did. There were a
5 number of skeptics, of course, internally who -- you
6 know, they called me Anna Alternative and all kinds of
7 things like that, so we had our share of those folks who
8 were asking me if my VW bus was outside. There were a
9 lot of skeptics who are the very same people who are now
10 attending our program.

11 DR. GORDON: Tom, and then George.

12 MR. CHAPPELL: James, I am just wondering about
13 the economic sustainability of your approach to this, and
14 whether you envision this becoming a highly profitable
15 and sustainable approach for your company.

16 DR. DILLARD: It is a good question. I don't
17 think that Oxford approached this from the viewpoint --

18 MR. CHAPPELL: I heard you say that, but I am
19 wondering whether you envision -- is this ready for
20 commercial profits, as well as social profits at this
21 point?

22 DR. DILLARD: I don't know specifically what

1 our ROI would be. It has not been fully calculated. I
2 wish I could give you that information. The perception
3 has been that this has been a pretty low cost program to
4 roll out inside a managed care company.

5 The fact is that during 1997, the company grew
6 from 1.4 million members to over 2 million, almost 2.2
7 million members, with the alternative medicine program as
8 one of the major pieces of its marketing and public
9 relations. It was considered to be a very successful
10 program for this reason.

11 How to interpret that and place that into
12 profitability, the company was doing very, very well at
13 that point. The 52-week was 89, and after we had a
14 rather bad projected earnings in October 27th of 1997, it
15 went down to a 52-week low of six, which had actually
16 nothing to do with the alternative medicine program. I
17 really want to make that clear because a lot of people
18 think about the Oxford program, they go, hmmm,
19 interesting program, alternative medicine, tanked the
20 company. Not true.

21 I think we still see it, not necessarily
22 directly in the revenue stream, but something that lends

1 a lot to the brand, and is considered to be still by our
2 operating officers as being a major part of the Oxford
3 brand.

4 DR. GORDON: George, and then Joe.

5 DR. DeVRIES: Lori, could you help the
6 Commission maybe understand how the Department of
7 Insurance in Washington looks at -- and I am thinking of
8 your regulatory requirements related to access to CAM
9 providers, and how you look at that to comparison to
10 medical providers, whether it be access ratios, providers
11 to total number of patients, or members, or access in
12 terms of geographic distance, how you look at access?

13 MS. BIELINSKI: Sure. Let me start first with
14 the carriers set their own network adequacy requirements
15 based on their enrollment and the geographic location of
16 the majority of their enrollment. They have to file that
17 standard with our agency. We don't have a formula and
18 statute or a rule, but I understand that it is probable,
19 and I am sure there is some drafting currently going on,
20 we are in a transition situation with a new commissioner,
21 so some of this will be delayed. But there have been
22 significant complaints filed by consumers about lack of

1 access, and the one thing I will say in Washington is CAM
2 is not really differentiated with conventional medicine
3 any more. It is just do you have access to your
4 providers, are they primary or specialty, and specialty
5 includes cardiologists and massage therapists. So that
6 is where we come from in our mindset.

7 The network adequacy requirements are generally
8 one per thousand. I did just a review of this in terms
9 of how carriers are setting limits on specifically CAM
10 services, but all services, and the survey included all
11 types of providers. So it is one per thousand members in
12 a geographic location, usually broken down by zip code.
13 The ratio or the requirement for driving distance usually
14 is eight miles in a metropolitan area, 15 miles in a
15 suburban area, and 60 miles in a rural area, which in
16 some of our rural communities, it sounds like a long way,
17 but it is not.

18 So that is generally the amount. The part
19 where it gets to be confusing is when they set an
20 arbitrary limit. I heard James Dillard mention eight
21 visits. That, in our agency, is considered arbitrary, so
22 we are undergoing a review right now of again CAM and

1 conventional services based on primary versus specialty,
2 and how you set any limit, or what criteria, standards,
3 guidelines are you using, and cite the most significant
4 reference for all of it. What conditions are you
5 limiting? How are you limiting it, and why? Why do the
6 chiropractors want 22 visits a year to treat X number of
7 conditions, versus the carriers wanting to pay for eight
8 a year? What makes one less arbitrary than the other is
9 where we are trying to get to.

10 Summarily I can tell you in a brief review of
11 this that I did on the plane, there is no pattern, and it
12 is very arbitrary, and I am not sure what anybody is
13 going to do about it. So if I were to leave you with a
14 second recommendation, I would say find out what the
15 criteria, what is the most common guideline used for any
16 medical necessity definition to setting a limit on
17 anything? Because otherwise the carriers could be
18 allowed to sell what is considered in our world an
19 illusory benefit. Six visits to a chiropractor a year
20 doesn't treat most conditions I am aware of, and thank
21 goodness for my medical background.

22 DR. DILLARD: If I can just clarify the one

1 point. The eight-visit limit is not the visit limits.
2 That is the point at which we ask for any information
3 from the provider. That is when utilization starts, and
4 that was based upon numbers that came from the Canadian
5 report published by Pramanga, and I can give you the
6 citations I am referring to.

7 MS. BIELINSKI: I wasn't trying to pick a
8 fight.

9 [Laughter.]

10 DR. GORDON: Wayne.

11 DR. JONAS: It is a related question, actually.
12 I wanted to ask Dr. Dillard a little bit about how you
13 establish the benefit package which you have sort of
14 begun to answer, but ask you about the appeals process
15 and whether you have had problems with "overutilization"
16 and, if so, how do you deal with it, what kind of
17 mechanisms are in place to address the appeals process?

18 DR. DILLARD: Well, that is a huge topic. The
19 benefits that we decided to go with -- first of all, we
20 took six provider types from a survey, those were the
21 ones that our members were already using, they were the
22 most popular provider types, not rocket science. We went

1 with mandated benefits. We knew that there was going to
2 be a mandated benefit coming down, and instead of New
3 York, we decided to be proactively involved with that.
4 We actually had some input into the writing of that bill.
5 Proactively, before that bill came out with benefits that
6 were fully in compliance with the Insurance Equality Act,
7 it was signed by George Petaki.

8 In terms of the appeal process, this is all a
9 peer-based appeals process. I didn't know any other way
10 to do this. The programs were structured using peer
11 advisory boards, and the appeals process was by using
12 practicing acupuncturists and chiropractors and
13 naturopaths in the community, to look at this care and
14 say what is reasonable, what is falling outside of
15 reasonable standards of care, looking at documentation,
16 is the patient getting any better. We used really
17 mechanisms with very similar conventional utilization.

18 DR. FINS: These were external reviews, though?

19 DR. DILLARD: No, they were internal.

20 DR. FINS: They were internal.

21 DR. DILLARD: Yes. We hired expertise from the
22 community.

1 DR. FINS: So you have a conflict of interest,
2 presumably? The people who are reviewing are on the
3 Oxford payroll in some way or another?

4 DR. DILLARD: That is correct.

5 DR. FINS: Has that been satisfactory to your
6 membership, as far as the appeal process?

7 DR. DILLARD: Our statistics tend to indicate
8 that the majority of the network is pretty happy with
9 what we do. We are considered to be the most generous
10 payer in the Mid-Atlantic, by the way, and I think they
11 haven't had too much of a problem. We have maybe 5
12 percent of the network, maybe 10 percent, that we
13 consider to be somewhat of a problem. We are doing the
14 provider profiling on that right now, and we will be
15 looking much more closely at those practitioners to see
16 the people who are trying to go up to 48 visits for a
17 year, 52, 76, and look at those providers more
18 specifically. But it has all been based upon peer
19 review.

20 DR. GORDON: Any other questions before we
21 close this panel?

22 MR. CHAPPELL: I think I have one more

1 financial question. Do you have any sense of the
2 relationship of income from CAM services versus all other
3 services is?

4 DR. DILLARD: The income from our CAM program
5 specifically?

6 MR. CHAPPELL: Yes. I haven't quite asked it
7 the way I wanted to.

8 Can you tell me what share of reimbursement is
9 going for CAM services versus non-CAM services?

10 DR. DILLARD: I know what our costs per member
11 per month would be, and they are fairly in line with
12 standard numbers that you are going to hear on the
13 Atlantic Coast.

14 Let me make one thing clear. We did not raise
15 our rates because we built this program. There was no
16 cost that was passed on directly.

17 MR. CHAPPELL: Yes, I read that, James. Let me
18 just repeat the question. Maybe I am not asking it
19 right.

20 What share of your reimbursement is going to
21 CAM practitioners versus non-CAM practitioners?

22 DR. DILLARD: The percentages, I don't know off

1 the top of my head. I could probably get that data for
2 you.

3 MR. CHAPPELL: It would be very helpful because
4 that is such a valued model. I mean is it less than 5
5 percent, is it --

6 DR. DILLARD: I would estimate that it is less
7 than 5 percent. We have the big ticket items that all of
8 the managed care companies have, the maternity care, the
9 typical things that you see.

10 MR. CHAPPELL: I am trying to get a feel for
11 how big a question we are asking for here, if we want to
12 integrate reimbursement in existing management.

13 DR. DILLARD: Oh, yes, it is a critical issue.
14 I can share with you what our PMPMs, and I can try to get
15 some ratios with our conventional costs, if that would be
16 helpful.

17 MR. CHAPPELL: That really would be great.

18 DR. DILLARD: Okay.

19 MR. CHAPPELL: Thank you.

20 DR. GORDON: I want to thank you all. One of
21 the things I am realizing as I am sitting here is the
22 wonderful collegial spirit that we feel with the three of

1 you, and as well as with other presenters, and in line
2 with Tom's request, I am wondering if all of you would
3 help us even more with the next stage, by telling us what
4 is working and what is not with what you are doing,
5 because you all have exemplary programs.

6 So, with the Insurance Commissioner's Office,
7 Lori, should this be a model standard? And if so, why?
8 And if not, where should it improved? And similarly with
9 each of you. I think that will be a long way to helping
10 us as we make our decisions later on.

11 Thank you very much. We will take five
12 minutes, and only five, and then we will come back.

13 DR. GORDON: This panel, which we welcome now,
14 is somewhat different from the other panels in that what
15 we have been talking about earlier in bringing in some of
16 those who have developed innovative services is
17 integration, and we asked these three presenters to come
18 to talk with us about models that are really
19 fundamentally based on other systems of health care,
20 other healing traditions other than Western medicine,
21 although they may be studied or examined or understood in
22 Western medical terms as well.

1 So I am very happy to invite the three of you
2 to come to present to us.

3 Our first presenter will be Dr. Robert
4 Schneider.

5 DR. SCHNEIDER: Thank you, Mr. Chairman, and
6 members of the Commission.

7 I think everyone here is aware of the recent
8 survey in JAMA which reported that 40 percent of the
9 American population, or nearly 100 million people, not
10 only use CAM services, but in addition, and not
11 necessarily the same people, suffer from one or more
12 chronic disorders. This is despite this country having
13 the most advanced health care system in the world.

14 Therefore, it is clear, since half of our
15 people have chronic diseases, that a new, more effective
16 approach or complement to our conventional health care
17 system is needed.

18 Ayurveda, the topic of my discussion this
19 morning, is part of a larger, more complete system of
20 natural medicine derived from the ancient Veda tradition
21 of India. This is called Vedic medicine, or the more
22 recent restoration of this system, including the range of

1 diagnostic and therapeutic approaches has been called
2 Maharishi Vedic medicine which includes 40 approaches for
3 dealing with influences of health, from levels of mind,
4 physiology, behavior, the near environment, the distant
5 environment, and even the public environment or public
6 health perspectives.

7 Over the past 30 years, there have been about
8 600 published scientific studies on the effectiveness of
9 Vedic medicine approaches for the prevention and
10 treatment of disease. These have been conducted at more
11 than 100 independent institutions in more than 30
12 countries around the world.

13 These include a series of randomized control
14 trials conducted by our group and others sponsored by the
15 National Institutes of Health on the effects of Vedic
16 medicine approaches on prevention and treatment of
17 cardiovascular disease.

18 Reprints of these studies and review of
19 literature is included in your Section K of your
20 notebook, and in the reprints handed out this morning.

21 But briefly, the clinical syndromes that have
22 shown to be most responsive by control of clinic research

1 to these various approaches of Vedic medicine, which
2 include meditation, herbal approaches, diet, purification
3 therapies, behavioral approaches, even the influences of
4 architecture in an environment, include first
5 cardiovascular disease, its risk factors, hypertension,
6 smoking, psycho-social stress, high levels of oxidized
7 lipids, cardiovascular morbidity, cardiovascular
8 mortality, and related health costs.

9 The second area, which has shown considerable
10 effects are psychological disorders, depression, anxiety,
11 and related behavioral disorders, such as substance
12 abuse. There is preliminary evidence on cancer
13 prevention and treatment in terms of quality of life
14 improvements, as well as potentially on mortality rates.

15 Chronic pain has been very responsive. Age-
16 related disorders in mood, physical function, cognitive
17 function, and quality of life have been responsive in a
18 range of primary care disorders, or disorders commonly
19 seen in primary care, such as insomnia, digestive
20 disorders, chronic fatigue, and women's reproductive
21 disorders, menstrual and menopausal symptoms.

22 Second, in terms of cost effectiveness, several

1 studies, which are reviewed in your handout and in your
2 reprints, have reported 50 to 80 percent reductions in
3 health care utilization and related health care costs,
4 with the approach of transcendental meditation, part of
5 Vedic medicine, and other Vedic medicine approaches.
6 This has been true for both in-patient and out-patient
7 utilization.

8 Patient satisfaction is reflected in relatively
9 high compliance rates with these modalities which in
10 published reports have ranged from 80 to 97 percent
11 regularity with these recommendations, which contrasts
12 with modern recommendations, with compliance with modern
13 pharmacotherapy, which is 33 to 50 percent, at least for
14 anti-hypertensive regimens. So roughly twice as great.

15 Based on these data, we have three main policy
16 recommendations for this commission.

17 One, regarding access, it is largely, although
18 not exclusively, based on reimbursement policies.

19 Therefore, we recommend that this Commission further
20 recommend that natural medicine services, in this case
21 Vedic medicine services that are shown to be effective
22 and cost-effective in published, peer-reviewed scientific

1 research, be reimbursed by third-party payers, including
2 government payers, such as Medicare and Medicaid, and
3 even recommendations for private reimbursers.

4 Second, regarding delivery of services, this is
5 largely determined by availability of qualified
6 practitioners and their legal ability to practice in
7 their respective area. In this domain, we recommend a
8 two-stage process related to practice by qualified
9 practitioners, to be phased in over a five-year period.

10 First, that certified practitioners be allowed
11 to practice in their areas, following the Minnesota model
12 currently. Certified practitioners will be those who
13 have successfully completed an approved course of study
14 at a recognized and accredited institution of higher
15 learning, and second, who are certified by national
16 professional award in their field.

17 Second, we recommend that over time states
18 adopt a licensure procedure for natural medicine
19 practitioners, including Vedic medicine practitioners,
20 and licensure would be dependent on certification and
21 completion of other state licensing requirements, such as
22 an exam or experience requirements.

1 Thirdly, in terms of delivery of services, this
2 largely dependent on a continued stream or training of
3 qualified practitioners. Therefore, in the area of
4 education, we recommend that the Commission further
5 recommend to the federal government the granting of
6 grants, the provision of grants by the government, not
7 for research as NCAM does, but in this case, grants to
8 educational institutions of higher learning for the
9 training of natural medicine practitioners, in
10 particular, Vedic medicine practitioners. These
11 institutions would be recognized in their field and also
12 accredited by standard accrediting associations.

13 In further consideration of delivery, whether
14 it be within the exclusive framework on integrated with
15 conventional health care delivery systems, my colleagues
16 and I actually recommend both approaches.

17 For example, there is now a series of maharishi
18 Vedic medical centers being constructed in each
19 Congressional district in this country, several of which
20 are already up and running, which are examples of focus,
21 providing natural medicine services within the community,
22 and also within integrated health care services.

1 In conclusion, Vedic medicine, including
2 Ayurveda, but not limited to Ayurveda, much expanded
3 beyond aruyveda, has been shown by extensive scientific
4 research to be clinically effective and cost-effective.

5 DR. GORDON: I think we will come back and we
6 will have some very specific questions about the
7 inclusion of that provision of services. Thank you.
8 Sorry to cut you off, but we have gone well over time.

9 DR. SCHNEIDER: Thank you.

10 DR. GORDON: Next will be Dr. Tori Hudson.

11 DR. HUDSON: Thank you, Dr. Gordon. Thank you
12 for the invitation and the opportunity to be here today,
13 and I really appreciate you including the voice of
14 naturopathic physicians and attention to women's health,
15 in particular.

16 I usually start my lectures and presentations
17 with a joke, but it cost me too much time. So I am open
18 to solicitation later.

19 Essentially, naturopathic physicians are
20 licensed primary care family physicians with a specialty
21 in natural medicine. We utilize nutrition and lifestyle
22 counseling. We prescribe nutritional supplements, plant

1 extracts, and other natural therapeutic substances and
2 techniques, as well as selected pharmaceuticals.

3 The seven principles of naturopathic medicine
4 and the two additional integrative principles, as I
5 discussed in my written testimony, could actually serve
6 as the cornerstone of a new medical model, one that many
7 of us are calling integrative medicine. But we must be
8 careful, I think, to define integrative medicine, because
9 if we do it right, it actually has a potential to
10 fundamentally transform the quality of health care, the
11 accessibility of health care, the cost of health care,
12 and therefore the health and quality of life of our
13 communities.

14 My vision of integrative medicine is basically
15 a cadre of health care disciplines and practitioners,
16 each with their own scope of practice, each with their
17 own tools of their trade, but also each with a common
18 understanding, a common respect, and a shared commitment
19 to coordinate care, cross-refer, and co-manage patients.

20 The federal government could go a long way
21 towards providing a framework in which all of this can
22 take place. The framework, however, must impact the

1 psychological, the cultural, the political, financial and
2 logistical limitations and biases that currently exist.

3 As it is now, the conventional model has
4 monopolized and dominated medical education, medical
5 research, medical reimbursement, and medical practice in
6 this country, and remarkably, there are other medical
7 approaches that are most often safer, often less
8 expensive, and usually effective, but not always, in
9 handling about 90 percent acute and chronic health care
10 problems.

11 In women's health, an integrative medical
12 framework from the top to the bottom of the system could
13 actually bring us reliable treatments for very little
14 understood and very poorly treated conditions, such as
15 interstitial cystitis and vulvodinia, and fibromyalgia.
16 It could bring attention to the extensive scientific data
17 on the prevention of breast cancer with soy and fiber and
18 fish oils and green tea, or the proven successful
19 alternative treatments for cervical dysplasias. It could
20 study outcomes of breast cancer patients who receive both
21 conventional and alternative treatments.

22 Much more common is the issue of menopause. By

1 the year 2015, 50 percent of the U.S. female population
2 will be menopausal. I will let you pause there, just to
3 contemplate that.

4 [Laughter.]

5 DR. HUDSON: What conventional medicine
6 dominantly has to offer those women is that all women
7 should take a prescription, hormone replacement therapy,
8 that might lower their risk of heart disease, while at
9 the same time definitively increase their risk of breast
10 cancer.

11 Why routinely use a drug that poses an
12 increased risk of one disease to all, while decreasing
13 the risk of another to only some?

14 An integrative model would better identify
15 individual risk factors for individual patients, not a
16 one-size-fits-all approach, but individual assessment
17 with an individualized treatment approach.

18 Imagine intentional, structural, collegial,
19 coordinated health care clinics and hospitals and
20 research centers across the country, with MD, DC, DO,
21 Ph.D., LAC, LMT, Ph.D., and all other allied
22 practitioners working together to provide the best that

1 each has to offer in the co-management of issues like
2 osteoporosis and heart disease and breast cancer. But
3 also a very common, every-day women's problem such as PMS
4 and fibrocystic breasts, pelvic infections, menopause,
5 endometriosis, and uterine fibroids.

6 To me, integrative medicine is about maximizing
7 the strengths of each discipline, while minimizing the
8 weaknesses of each, so that we can have the best possible
9 outcome for the patient.

10 Women want their practitioners to work
11 together. This can be seen in survey after survey.
12 Women are hungry for education about their options. They
13 are hungry for respect of their choices by their health
14 care practitioners, and they are hungry for communication
15 and coordination between their practitioners.

16 Women, I would assert, are not only seeking
17 this kind of coordinated, integrative health care, but
18 the female patient, in my opinion, is actually making it
19 happen, especially in the menopausal woman. Eighty to 90
20 percent of menopausal women who are prescribed hormone
21 replacement therapy discontinue their hormone replacement
22 therapy within the first year of use, and they seek

1 alternatives, in many cases, and others receive no
2 treatment at all, but they are especially engaging in a
3 fairly complicated educational process of deciding when
4 to use HRT, when to use botanicals, when to use
5 supplements, and when to use a combination of those
6 things.

7 My experience in Portland, Oregon is one of
8 having a women's integrative clinic with ND, MD, DC,
9 acupuncturists, massage therapists and counselor working
10 together, referring back and forth, discussing the co-
11 management of shared patients. In my community we have a
12 naturopathic medical school, a conventional medical
13 school, a chiropractic college, an acupuncture college,
14 two massage schools, and three schools of nursing. We
15 have many examples in integration: costs or discipline
16 preceptorships; and individual physician offices. We
17 have referrals amongst all disciplines. We have joint
18 research studies between the conventional medical school
19 and the naturopathic medical school. We have integrative
20 medical meetings, and continuing medical education into
21 several integrative clinics, shared adjunctive faculty
22 appointments, residency exchanges, and an integrative

1 medicine residency.

2 It appears obvious that the time has come for
3 this concept of a team approach to health and well being,
4 rather a multi-disciplined, truly integrative, safe,
5 effective, affordable system of health care that respects
6 the choices of individuals, the wisdom of many minds, and
7 the spectrum of all that nature and humans have to offer.

8 Thank you.

9 DR. GORDON: Thank you very much, Tori.

10 Next is Robert Duggan. Bob, good morning.

11 MR. DUGGAN: Thank you. I am honored to be
12 here and have a moment to speak with you. You have a
13 written paper. I am going to make a few comments off of
14 that.

15 First of all, I would like to say that I have
16 been practicing acupuncture for 30 years. I am the
17 president of a school with 220 graduate students. We
18 have 700 graduates across the country. Eighty-four
19 percent of our graduates 10 years later are earning good
20 incomes and higher than the national average for
21 acupuncturists, and among our graduates, not a single
22 graduate has ever defaulted on a federal student loan.

1 I say that by way of credential. I am not here
2 speaking on behalf of the acupuncture profession, but
3 rather on behalf of some issues that confront
4 acupuncturists, acupuncture practitioners and acupuncture
5 schools.

6 The first critical issue is that our students
7 are trained not only in the modality of acupuncture, the
8 skill of acupuncture, but in the art of healing. I think
9 there is a conversation to be had that all of CAM and
10 perhaps all of medicine in the country at the moment, is
11 divided between modalities looked at in a reductionist
12 mode, and the context of that modality within the art of
13 healing or culture of healing.

14 We have done studies that indicate patients
15 keep looking for that art of healing, and then their
16 satisfaction rate increases, and I can give you the
17 reference to that.

18 Your questions to me were about integration of
19 acupuncture in mainstream and complementary medicine,
20 integration of acupuncture with herbs, with the other
21 parts of Oriental medicine, and the simple position that
22 we have taken at the institute in Columbia, Maryland for

1 25 years is great diversity. Our graduates practice in
2 an enormous range of situations, in hospitals, in private
3 practice, and there should be just a fostering of
4 enormous diversity.

5 It takes 10 years to be a good acupuncturist.
6 You can learn various skills, but that is one of the
7 major things, and we have had a clear policy through
8 those years of avoiding turf battles and been very
9 conscious of that.

10 One of the major -- and I suppose these are
11 some of the policy implications that come out of our work
12 over these years
13 -- is when the conversation is who is the primary care
14 provider, the patient is the primary care provider. The
15 patient is the primary care provider. We will only shift
16 the cost, quality, access dilemma in American health care
17 when we understand that by making the patient the primary
18 health care provider, we will move 70 percent of the
19 visits out of the sick care system into a wellness
20 culture. We know that is critical to the success of our
21 acupuncturists. We know that the ones who see themselves
22 as educators of the empowerment of the patient do better

1 than those that are simply delivering a modality.

2 I think we need to consider the economics. My
3 graduates, our graduates, are being socialized into a
4 reimbursement model that favors the modality over the
5 healing art of the individual patient. We have one
6 program we do with a corporation where the practitioner
7 guarantees free treatment after a certain point if the
8 patient hasn't taken on their own quality of care.

9 Some other specifics that you might recommend,
10 that all schools of medicine, complementary or
11 mainstream, foster relationship-centered care, built on
12 the recommendations for mainstream medical schools, and
13 take that into all the complementary schools.

14 Second, that there be a separate agency
15 established to deal with the issue of the quality of
16 herbs. We are well aware in traditional Chinese medicine
17 of those issues, and the usual way of looking at it,
18 which is not the same economics, not the same philosophy,
19 that there be a separate and distinct agency. An issue
20 that has come up locally in Maryland is in using some of
21 the tobacco settlement money to encourage the use of the
22 lands now devoted to tobacco growing for the growing of

1 herbal products, high quality herbal products, and
2 organic foods.

3 There is a bill in Congress at the moment on
4 the student loan repayment program to induce
5 practitioners of complementary care to work in a city and
6 areas of economic need. I think that is a bill that
7 should be fostered, and anything that pushes the CAM
8 providers in the direction of doing pro bono work should
9 be supported in the community.

10 I think CAM and wellness education from the
11 first grade onward is an important outcome. I spend most
12 of my clinical day educating people into simple realities
13 that they should have learned in the grade school, and I
14 think that is a background. The present licensing
15 systems in most states for acupuncture forces the schools
16 to devote all their time to technique and specific
17 knowledge-based, rather than relationship-based
18 educational-based learning.

19 I think there is a policy that should move some
20 of the research that is being done so that the research
21 outcomes translate across into clinical practice. It is
22 one thing to see the research outcomes. I rarely, in my

1 clinical practice, experience that those research things
2 are known in the local physician's office or the other
3 CAM providers.

4 I think that research on quality of life
5 outcomes, rather than on mechanisms, should be fostered.
6 There is an enormous expenditure trying to understand the
7 mechanism of acupuncture or of an herb, and we know very
8 little about the overall quality of life outcome. We
9 have for 25 years at the institute refused to do clinical
10 studies because we knew that patients were asking the
11 question, my asthma has become my teacher. It is not
12 that my asthma goes away, my symptom has become my
13 teacher. So we ask the wrong question in research.

14 There are other policy things that I have put
15 in the papers. I would leave it there, and I am happy to
16 take your questions.

17 DR. GORDON: Great. Thank you. Thank you all
18 three.

19 There are obviously a tremendous range of
20 issues on which each of the speakers can comment. I
21 would like for us to focus pretty intensively on delivery
22 of services in our questions. We can always ask them

1 other questions afterwards, or indeed ask them to come
2 back and sit on other panels.

3 So if we could begin, please.

4 DR. TIAN: I have a question for Professor
5 Duggan. I admire your work and your institution has done
6 a lot in developing acupuncture in Oriental medicine.

7 Regarding delivery of service, regarding the
8 herbal remedies, as I understand you to state, that the
9 federal government stopped regulating, and do you think
10 that should be handed to care by CAM providers because
11 herbs can be divided into therapeutic and nutritional.
12 If I try to use this to divide it into two. So how do we
13 do that, in your opinion?

14 MR. DUGGAN: I think we have to start in the
15 grade school, with individuals relearning their
16 relationship to plants and nature. So you start from
17 food and you begin to move from food to plants, and then
18 you define the line where you have some very highly
19 specialized folks who know a great deal about specific
20 herbs.

21 I think we start that conversation in the wrong
22 place by turning plants into products, and we have just

1 been approved to start a three-year graduate degree
2 program that will address these issues, both for Eastern
3 herbs and Western herbs. But to recover that plants are
4 part of the ways that we learn to heal itself, and that
5 all the foods we eat are plants.

6 What we have done in this culture in a
7 reductionist way is turn the plant into a product where
8 we are looking for the active ingredient. That is not
9 the culture of the medicine that I learned. It is the
10 culture that the medicine I know about is being
11 socialized into. So the policy issue would be how do you
12 restore an awareness of plants as healing and then begin
13 to define where is that line between what is food, what
14 is part of every-day grade school, high school learning,
15 and what must be professionalized. And I think we are
16 just beginning to explore it.

17 DR. TIAN: By the way, regarding the quality
18 control of the herbal product, at the national level or
19 at the state level, how can we do that? Because there is
20 no such organization or like a consumer report.

21 MR. DUGGAN: That is why I recommend it. I
22 think there needs to be a separate agency so the

1 questions are addressed differently, because there is a
2 major, major issue here of both the quality of the
3 products, whether the products are properly labeled, all
4 of those issues. Ideally, the industry would take it on
5 itself, and there needs to be an agency that will support
6 that. It is a major issue in Chinese medicine.

7 DR. FINS: Bob, I don't want to sound
8 redundant, but this is the fourth time I have asked this.
9 I agree completely with the two major points you made of
10 first empowering the patient, and how important that is,
11 and I never realized this until I was a patient. I mean
12 as a physician, we can pay lip service to it, but I never
13 realized. I think that is extremely important and one of
14 the major reasons for use of CAM.

15 The second thing is education, and as I brought
16 up before, I just have the feeling that we are failing in
17 education for lifestyle changes. I know, and you know
18 more than I do, that there are a number of private
19 organizations. Ernest Winner of the American Health
20 Foundation was a major proponent of going into schools
21 and giving education, and yet somehow it doesn't
22 translate into lifestyle changes in the adults.

1 So I am going to ask you specifically should
2 this Commission be even considering the step of asking
3 our legislators to mandate that there be classes in
4 nutrition and lifestyle, wellness living, in all schools?

5 I mean should that be part of a national education
6 policy? How do we do this?

7 MR. DUGGAN: Absolutely. Absolutely. It has
8 to start from the first grade, and it has to start with
9 awareness of breathing, of drinking, of sleeping, of
10 eating. The clinical experience that came to me the
11 other day, talking about women's medicine, a woman
12 brought me in a pile of clinical reports from the best
13 medical centers in this country and from every one of the
14 notable CAM providers in this country, a report. She had
15 a series of vague symptoms. It was 2:00 in the
16 afternoon, and this was a highly educated, highly
17 successful, wealthy woman who could afford that stack of
18 reports, and it was 2:00 in the afternoon, and I realize
19 you have been sitting here working hard all morning, and
20 I don't know how healthy the schedule is, and I said what
21 have you eaten? She said a cup of coffee at 7:00 this
22 morning. What did you eat last night? Hamburger. When

1 did you last get some exercise? Three weeks ago.

2 After a while I said do these symptoms ever go
3 away? A long pause. When I went on vacation in Canada,
4 they went away.

5 So, yes, absolutely. And I think insurance
6 must de-incentivize the providers from covering that
7 stack of reports, without asking the basic home-grown
8 question, are you taking care of yourself?

9 DR. FINS: Well, I am just trying to think of
10 some specific question. On my automobile insurance, if
11 you take a course -- in my case, my wife takes the course
12 for both of us, I don't know that works, but --

13 [Laughter.]

14 DR. FINS: But anyhow, she takes the course and
15 we get a 10 percent reduction on the insurance.

16 MR. DUGGAN: Same thing. Absolutely.

17 DR. FINS: Do you advocate things like taking a
18 course in wellness --

19 MR. DUGGAN: Absolutely.

20 DR. FINS: -- and then there would be a
21 reduction in your health care policy. It would have to
22 be a government plan or something.

1 MR. DUGGAN: But you have to watch cherry-
2 picking. You wind up getting only the educated that
3 lower rates, and that transfers the rates. That is why I
4 think you need a whole session just on the economics
5 because graduates of our school are being socialized into
6 an economics that doesn't serve what they are trained to
7 do. And you are absolutely right, that is a very complex
8 issue, Bill, and it should start from the first grade,
9 though, and you should mandate that there be wellness,
10 and I don't mean prevention, because we are not talking
11 about 30 year out prevention, we are talking about the
12 sense of wellness today so it is an immediate, same-day
13 return on investment.

14 I know from my food that I am getting back and
15 I feel better. I play better football in high school.
16 All of that should be integrated. But this cannot start
17 with the 50 year old who is then in trouble.

18 DR. GORDON: Just one more question.

19 DR. FINS: But I guess, to be more precise, I
20 am saying my perception, and I could be wrong, is that
21 the current policies are not effective enough. Do we
22 need to look at more innovative policies and maybe more

1 legislation? I am not a great fan of overwriting federal
2 legislation, but is this a case where we need to
3 recommend some mandates in educational procedures?

4 MR. DUGGAN: I think to get it started, there
5 are going to have to be some incentives to make it move,
6 because my experience is the institutions will keep doing
7 what they are doing, unless there is some leverage forced
8 into them, to have them do it differently. So you have
9 got to find those tiny leverage points that push in the
10 awareness of Ayurveda and naturopathy in the second
11 grade.

12 Why should I have a child saying to a nurse I
13 know about the pulses, and starts to tell the nurse about
14 the 12 pulses, and the nurse goes quiet, because this
15 child has grown up with Chinese medicine. And when the
16 nurse is reading the blood pulse in school in the third
17 grade, the child says, oh, I know all about the pulses.
18 And the nurse doesn't know what the child is talking
19 about.

20 We now get a significant number of, I think it
21 is 20 percent of the new entrants to our graduate degree
22 program each year, come straight out of college because

1 they have never in any significant way experienced
2 allopathic medicine. They have been treated by herbs and
3 acupuncture since birth. They come straight in to
4 school, they have no awareness, the thought doesn't cross
5 their mind. You are absolutely right, though.

6 DR. GORDON: Tierney?

7 DR. LOW DOG: This sort of dovetails because I
8 agree very much about where the culture of plants comes
9 from, and all of the products that are driven today
10 actually come from traditions that use them, and
11 ointments, unguents, teas in very simple forms.

12 My question would go to any of you about
13 products, because if we are talking about access and
14 delivery, part of that has to be about the delivery of
15 product. I know that many CAM practitioners make a
16 significant amount of their income from the sale of
17 products, and many companies actually specialize in just
18 providing products that can only be purchased through a
19 provider that you can't just go and get at the health
20 food store.

21 Does that affect delivery of those products?
22 Is there any concern about that? I would just like to

1 hear some comments on that since we are talking about
2 access and delivery, and if you are restricting access,
3 or you are basically funneling people through, saying the
4 only product you can get is from me, you can't get it
5 through the health food store, how does that affect this
6 whole dialogue of access and delivery? Anybody?

7 DR. HUDSON: Well, one of the -- I think there
8 is the medical aspects of your question, and then there
9 is, I think, conflict of interest aspects of your
10 question.

11 In terms of the conflict of interest, yes, I
12 think there is a conflict of interest when you provide
13 and sell products, you recommend products that you sell
14 out of your office. And naturopathic physicians do that.
15 But I would also point out dermatologists,
16 ophthalmologists, optometrists do that, and probably
17 others that I'm not aware of. An OB-GYN who recommends a
18 pelvic surgery that they then perform is also potentially
19 a conflict of interest. So I think there is a conflict
20 of interest, and I think that right now we are sort of
21 relying on an honor system, and maybe as more money is
22 involved and companies like Phillip Morris own Boca

1 Burgers and other things, that maybe we will have to
2 attend to this in something other than just an honor
3 system.

4 The medical aspect is that there are herbs and
5 nutrients and doses of herbs and nutrients that people
6 should not be prescribing for themselves, or taking
7 themselves, as you well know.

8 I might treat a woman even with something as
9 simple as PMS and I recommend a certain combination of
10 ingredients, and she will say, oh, I already tried Chase
11 Tree or I already tried Natural Progesterone, and then I
12 will clarify, well, what dose did you really use, and for
13 how long did you really use it? And clearly she was
14 undertreating herself, and merely just doing the same
15 items in a different pattern, in a different frequency,
16 in a different strength, yields completely different
17 results.

18 The health food store aisle medicine is
19 different than medicine delivered by a knowledgeable
20 practitioner, and I think the consumers themselves are at
21 the moment kind of determining, well, when do I want to
22 try this myself, and when do I want to go to a

1 practitioner? And that is really kind of an individual
2 choice issue, which I think at the moment is okay to
3 leave it that way, the individual choice. They would get
4 better results, often, if they didn't just aisle
5 medicine, natural food store aisle medicine.

6 But I think just as we educate people better
7 and better and better, it will become clear. That is one
8 of the things I tried to do in my book was have a
9 section, when should you see a licensed health care
10 practitioner. Not when should you see an MD, but when
11 should you see a licensed practitioner.

12 Well, when your bleeding gets to be this way
13 and that way, and your pain gets to be this way and that
14 way, that is when you should not be using the things in
15 this book, and go talk to someone. I think just
16 education will help go a long way towards making those
17 distinctions.

18 DR. SCHNEIDER: In the field of Vedic medicine,
19 I would say there are three levels: One is lifestyle;
20 second, is over-the-counter products; and third, would be
21 professionally recommended products.

22 The first, which is probably the most

1 important, is the area of lifestyle, that is diet and
2 daily routine are very important to prevention and
3 maintenance of well being, and those don't require a
4 doctor's prescription, but they do require education from
5 the ground up. At our university, by the way, there is a
6 primary and secondary school where all the children from
7 age five years to 18 years meditate together twice a day,
8 and also have other aspects of healthy lifestyle, and
9 they are much more healthy and productive in their school
10 than comparison children. So that is the first,
11 lifestyle, which is free, and doesn't require a
12 professional intervention, and it is not a profit center
13 for anyone other than the grocery store owner, which
14 knowledge everyone should have from the ground up.

15 Second, in the field of Vedic medicine, there
16 are over-the-counter products available where people can
17 make their own choices according to their own knowledge,
18 and hopefully they have had some basic education, and
19 those are products that can be used by the general public
20 and, as Tori mentioned, are in combinations that are
21 useful for the public.

22 The third level, there are combinations and

1 items in Vedic medicine as in other traditions that do
2 require a high level of expertise to use, and when used
3 properly, they are very effective and without harmful
4 side effects.

5 So I think one has to have that third level.
6 Whether or not a practitioner sells those himself or
7 herself, or whether that is a separate dispensary, modern
8 pharmacies are in most cases separate from physicians'
9 practices, that could be done also in the field of
10 natural medicine. I think that would be fine.

11 Of course, it is also true that a physician
12 often recommends procedures that he or she performs, so
13 there is a precedent in modern medicine for that also.
14 But I don't think that is the major issue, profit, and it
15 could be dealt with in that way.

16 MR. DUGGAN: I would simply add that I would
17 favor you taking policies favoring disclosure rather than
18 setting policies or regulation. Disclosure, disclosure,
19 disclosure, so it is out front, whatever. If you make a
20 15 percent profit on your product, disclosure rather than
21 regulation.

22 DR. GORDON: Thank you. Effie, Charlotte, and

1 then Joe.

2 DR. CHOW: I really appreciate the
3 presentations, and the wellness and the focus on the
4 whole person with all of you. I am familiar with some of
5 your work, and I appreciate it.

6 There is a big question that as CAM becomes
7 more accepted, and we strive to survive and go through
8 research and become validated, and that we like our
9 practitioners to survive, of course, in the same
10 lifestyle manner that we were used to, and that is
11 wonderful, Bob, your students are doing that.

12 Then there is a population we are talking
13 about. It sort of seems like only the middle class have
14 access, and even then it is tough. What are you folks
15 doing in your own institutions to help that, reaching out
16 to the poor and the ethnic groups, and as someone
17 mentioned earlier, it was not just the ethnic group. I
18 have real concern because I have been in this a long
19 time, and it seems like it is the middle class were sort
20 of forced into it. But if you folks could mention -- and
21 what kind of recommendations do you have to do that?

22 DR. HUDSON: I have done a lot of thinking

1 about that one. I think it is a responsible thing to do,
2 to think about one's privilege, and who is privileged to
3 work with you from an economic point of view. In my own
4 personal case, in our clinic, just from the physicians'
5 standpoint, we have three tiers of pricing, you might
6 say, and it is based on experience. We have a resident,
7 and her fees are a certain level, and then we have the
8 people who are second year or third year physicians, and
9 then the third level. So there are three different
10 pricing categories that people could have the option.
11 There is quite a bit of difference between those.

12 Secondly, for myself, I work one day a month at
13 a rural clinic where the prices are two-thirds less than
14 my normal urban prices. Then I also work at the
15 naturopathic college that has a sliding fee scale.

16 In our clinic, we have payment plans and
17 outreach in terms of some free clinic time in different
18 communities in the Portland area, whether that is by
19 ethnic group or economic group, or some combination of
20 both.

21 MR. DUGGAN: We put about \$200,000 a year,
22 about 5 percent of our budget, into running an inner city

1 clinic, and we add to that specified time among all of
2 our senior clinical year students to work in those at
3 about five or six clinical programs in Baltimore. I am
4 aware that at least six or seven of our graduates have
5 established similar clinics, and that is why I mentioned
6 the policy recommendation of promoting the return to pro
7 bono service. I do every Friday morning in an inner city
8 clinic, to be of service, and a good number of our
9 graduates do. So it is a very specific policy of the
10 school to promote, and our board has been very
11 deliberate, that whatever we are doing in Columbia,
12 Maryland to demonstrate this among the very economically
13 privileged, we must be doing at the corner of
14 Pennsylvania and North in inner city Baltimore, to show
15 that the same world applies and serves, and actually
16 saves a fair amount of money for the city of Baltimore
17 health system.

18 DR. HUDSON: I want to add just one brief
19 thing. It is one thing that could go a long way for
20 people accessing naturopathic medicine, is that student
21 loans -- we cannot go, after we get our \$100,000 student
22 loan, we cannot go work on a reservation or in the

1 neighborhood in Baltimore and get any part of our loan
2 forgiven. That would be something that I think you would
3 see a lot of naturopathic physicians wanting to go to
4 those areas because of the natural resonance and
5 compatibility with ethnic medical practices. In those
6 communities we have had a lot of naturopathic physicians
7 wanting to go to rural areas. I mean they want to be
8 around all those trees and plants.

9 DR. SCHNEIDER: Our institution is part of a
10 federally funded CAM center which is a consortium that
11 includes two of the nation's four historically black
12 medical schools, and this CAM center specializes in
13 research and demonstration practices of CAM in high risk
14 minority populations. For the past 12 years, we have
15 conducted a series of randomized trials --

16 DR. GORDON: You said the magic word.

17 DR. SCHNEIDER: We have conducted a series of
18 randomized trials, the only trials to date of mind-body
19 approaches in high risk African-Americans for the
20 treatment and prevention of cardiovascular disease. Some
21 of those reprints are in your packets.

22 So we have been very involved with the nation's

1 historically black medical institutions in rolling out
2 CAM approaches in lower socioeconomic, ethnic
3 communities, particularly African-American communities.

4 Our next initiative is in Native American
5 communities and Hispanic communities and other ethnic
6 communities after that, as part of our federal CAM
7 center.

8 DR. CHOW: We appreciate your volunteerism, but
9 perhaps if you have -- that is what a lot of CAM people
10 are doing now, you know, and if you have recommendations,
11 specific recommendations to see how that can be
12 rectified. I mean continue to volunteer, but how can we
13 make it more kind of viable? I would appreciate that.

14 DR. SCHNEIDER: I think it is reimbursement
15 policies. Many of our participants receive their care
16 through Medicare and Medicaid, and if those reimbursement
17 policies were in place for CAM, we and others have shown
18 high levels of patient satisfaction, compliance and
19 efficacy.

20 MR. DUGGAN: Actually, in inner city Baltimore,
21 I think in the project we run, if we were looking at
22 outcomes, cost outcomes and quality of life outcomes,

1 rather than mechanism, we would show that the cost of
2 care for the individuals coming through our clinic
3 through the Medicaid system is probably a great saving.
4 But the design of a study to show that is extremely
5 complex and expensive. But we are quite positive we save
6 the city and Medicaid an enormous amount of money each
7 year through that, often by simple education.

8 DR. HUDSON: I would echo that Medicare-
9 Medicaid reimbursement is nonexistent, basically, for
10 naturopathic medicine.

11 DR. GORDON: Thank you.
12 Charlotte.

13 SISTER KERR: Yesterday I said that I thought
14 the role of the prophet was one of imagination, and so I
15 want to ask you prophets, can you imagine any other ways
16 to help to help make CAM more easily accessible, other
17 than by insurance reimbursement or Medicare or Medicaid?
18 And is reimbursement really the solution? We think about
19 reimbursing acupuncture, naturopathic, but what is the
20 basic nutrient? What are we going to do about
21 reimbursing people who buy bottled water, or we may need
22 oxygen masks soon to go into certain sections of America?

1 Maybe that will be part of a reimbursement. Or should we
2 subsidize the people who are buying organic food for
3 their medicine? So I want to ask you, either now or in
4 the future, to send recommendations for other ways. Bob
5 did cover that already, I think.

6 MR. DUGGAN: We did a small study, Charlotte,
7 as you know, with the corporation where we put in one of
8 our graduates who happened to be a tai chi teacher, but
9 also was still making money as the key personnel benefits
10 director of a fairly significant corporation, put in
11 minor CAM interventions, and that corporation cut costs
12 by 20 percent over five years.

13 What we believe actually happens with the
14 educational component of CAM is that it becomes water
15 cooler medicine, and so people learn around the water
16 cooler simple ways of dropping out of the sick care
17 reimbursement system.

18 The insurance reimbursement, the mechanism in
19 that is that it is the self-insured large corporations
20 that understand where the dollar saving is. It is not
21 the insurance companies. Almost all the insurance
22 companies are making a quarter point profit on a transfer

1 between the corporation and the beneficiary. The person
2 paying the bill is the large corporate employer, and the
3 moment they realize that they can 20 percent off by
4 simple educational programs, when you are looking at 100
5 percent increase over 10 years. So it is the same thing
6 that happened with Allied Signal in '87, in the
7 development of managed care and the explosion of that.
8 Some large corporation is going to take it and do that.
9 I don't think Medicare and Medicaid can do it. The ideal
10 thing would be for Medicaid to save a lot of funds by
11 doing that. I think it has to happen in the private
12 sector first. But that is why I urge a session on
13 rethinking the economics because all the economics now
14 are designed to disempower the patient, disempower the
15 practitioner.

16 I asked a group of our graduates yesterday,
17 thinking of today, do they want me to speak for insurance
18 reimbursement? And to a person they said no, because it
19 perverts us and our patients. They don't want insurance
20 reimbursement, and the other side of the coin is the
21 group you are talking about, Effie, the poor, those who
22 have no access to this, we have to find a mechanism that

1 provides that access. But the driving force where the
2 big money is, is disincentives to wellness across the
3 board.

4 So, yes, you need a very good economist to sit
5 down and rethink the policy or CAM is simply going to
6 look like the rest of the health care system.

7 DR. GORDON: I have a question just before we
8 move ahead.

9 Do you have a recommendation for someone whom
10 we could work with on that?

11 MR. DUGGAN: I know of two. I will check them
12 and get them for you. But I think it is a very important
13 conversation to have. There is somebody at Princeton,
14 and I don't want to mention names, but there are two or
15 three people who understand that issue.

16 DR. GORDON: And we very much welcome working
17 with you as well.

18 MR. DUGGAN: I will get that for you. Thank
19 you.

20 DR. HUDSON: We probably need new Nintendo
21 games, would be my guess, on this topic. But more
22 seriously, other ideas that don't have to do with

1 reimbursement might be again coming back to this
2 education in the schools. I think that is really where
3 it needs to start. I see that. It is very sad for me in
4 my practice to be talking for the first time to a 50 year
5 old woman about calcium in her diet, and who already has
6 osteoporosis, when it was a totally and absolutely
7 preventable disease, if we had been talking about it much
8 earlier.

9 Perhaps discounts on disability insurance for
10 people who have certain health practices. Perhaps some
11 kind of, I don't know if it is a tax benefit or some
12 other benefit, if you have a garden, a vegetable garden
13 where you are growing food. Perhaps a tax benefit to
14 companies who are involved in the natural products
15 industry. And then I think always leadership, you know,
16 leadership in the form of our president, our senators,
17 our legislators, that somehow if something could catch on
18 and one of them really popularizes it and becomes a
19 leader in this area. That is kind of what we need, is a
20 leader.

21 DR. SCHNEIDER: Besides education and
22 reimbursement, perhaps the most important issue would be

1 access to CAM services for everybody, and that would be
2 in terms of practitioners. Now it is not legal for many
3 or most CAM practitioners to practice their art or
4 science in most states. Much is practiced, but not
5 legally. If those practice laws could be liberalized,
6 like in Minnesota, so CAM practitioners who are certified
7 and gone through proper training could practice, I think
8 that would go a long way outside of reimbursement and
9 education.

10 After all, most of the \$60 billion a year spent
11 in this country already on CAM is not reimbursed by
12 third-party payers, and is out of pocket, and almost half
13 of Americans use those services now if they are
14 accessible.

15 DR. GORDON: Joe.

16 DR. FINS: Mr. Duggan's testimony talked about
17 sort of understanding fundamentally what this movement is
18 all about, and that prompted me to look at Dr. Hudson
19 technically a little differently, and I was wondering if
20 you have had the opportunity to think about the
21 relationship between the CAM movement, because I think
22 demand really drives access of delivery, and the

1 development of the CAM movement and the women's movement
2 in self care and natural childbirth. There is sort of an
3 implicit message and I was wondering if you could say
4 more about that and help us make sense of this phenomenon
5 a little better.

6 DR. HUDSON: Well, you can help steer me if I
7 get off track here, but I can, I think, best try to
8 answer that by my own experience. People often ask, you
9 know, how did I become a naturopathic physician, and my
10 answer is that really it is I am 48 years old, and my
11 life experiences include graduating from high school in
12 1970 with the first Earth Day movement. It was also in
13 the early '70s you had the feminist movement, the self
14 help movement, the back-to-the-land movement, and all
15 those have converged, I think, in my life at this age to
16 evolve this interest and passion and drive about
17 alternative medicine. I think those are probably common
18 forces on many people, both practitioner and consumer.
19 The feminist movements, women's movements, is certainly
20 about empowering one's self and taking responsibility for
21 one's life, and being more self directed, and calling
22 upon inner forces to fully evolve. And I think all that

1 language is applicable.

2 DR. FINS: And I would just add one other
3 point, is that the feminist movement has been very good
4 at getting us to ask questions about hierarchies and
5 power relationships.

6 DR. HUDSON: Yes.

7 DR. FINS: So I think it would help for us to
8 sort of put this new movement into the context of
9 movements with which we are more familiar, and we might
10 have had 20 or 30 or 40 years of experience with because
11 there is a lineage, and I think your testimony sort of
12 raises that. So thank you.

13 DR. HUDSON: Thank you for asking that.

14 DR. GORDON: Wayne and Tom. We need to end by
15 12:30, so we can have an hour for lunch, and if we have
16 time, but I really want to end promptly so we don't hurry
17 through our lunch.

18 DR. HUDSON: A good health practice.

19 DR. JONAS: Well, as usual, the profound
20 questions have already been asked, so I will go back to
21 the mundane.

22 [Laughter.]

1 DR. JONAS: I had a question for Dr. Schneider.
2 It seems to me like you have pretty significant data, at
3 least as good as the orange data, in terms of significant
4 improvements in health and cost benefit, and this type of
5 stuff, and I am just wondering, have there been any
6 insurance companies that have picked up and said we are
7 going to do a demonstration project, or we are going to
8 incorporate this like has occurred in that program that
9 we just heard about?

10 DR. SCHNEIDER: Yes, there are several large
11 corporations, several Fortune 500 companies, which now
12 reimburse their employees for learning the TM program,
13 the major mind-body approach of Vedic medicine, and they
14 do that because of noted reductions in health care costs
15 and improved productivity.

16 There are indemnity insurance companies and
17 HMOs are considering Vedic medicine, but right now it has
18 been largely in the corporate sector and self-insured
19 sector.

20 DR. GORDON: It would be useful for us to have
21 that data as well, in terms of making recommendations.

22 DR. JONAS: May I just extend that to the other

1 panelists, to see are there others that have had that
2 picked up by insurance companies or corporate companies,
3 their entire practice? I am not talking about elements
4 of it, but the practice itself? I think we have heard a
5 fair amount, actually, about some of the naturopathic
6 stuff that is going on in the Northwest, but has that
7 happened, Bob, in D.C.?

8 MR. DUGGAN: It is getting a major commitment
9 with the large corporations. We have two relationships
10 with getting the research component in them, working with
11 making the distinction for corporations between -- what
12 we have worked on is making distinctions between
13 acupuncturists who are educationally-oriented and
14 acupuncturists who are technique-oriented, and what we
15 know in that study, we did the same study at six clinics.
16 In all six clinics, the symptomatic outcomes were the
17 same, but the two clinics where there was a lot of
18 education, the patients had a different level of
19 satisfaction. It was a very different statistical
20 outcome, and we have two corporations now, in fact, one
21 very large corporation shifted their whole insurance
22 program recently, and we had designed a very specific

1 program which led, if the practitioner didn't educate
2 people in self care, they wound up having to deliver free
3 care. And when the corporation tried to end that
4 program, although as far as we know, no one is delivering
5 free care, it has been very successful, the corporation
6 couldn't end that. They couldn't fold it into the brand
7 new national program, and they had to put that as a
8 special set-aside program for them. A company with about
9 4000 employees. And we were surprised that the benefits
10 manager found that she could not shift that design that
11 was in there.

12 DR. JONAS: Why?

13 MR. DUGGAN: Why?

14 DR. JONAS: Was it because of the --

15 MR. DUGGAN: Educational component.

16 DR. JONAS: Yes.

17 DR. GORDON: Tom.

18 MR. DUGGAN: The employees protested when it
19 was about to disappear.

20 MR. CHAPPELL: If you could just respond or
21 brainstorm with me for the couple of minutes that I have
22 got left on the question of how do we provide the supply

1 of funds for the freedom of choice of services? If it is
2 not the reimbursement model, and we certainly struggle
3 with that, then the only other things that I know of that
4 are going on in our society are Social Security, which is
5 a deduction we could have for wellness promotion, as well
6 as Social Security. We could have a payroll deduction at
7 corporations that are income tax deductible to those
8 corporations that are providing some contribution to that
9 individual's wellness program. I mean, for me, this has
10 been a self-help, self-care initiative for the 20 years,
11 30 years that we have been around, and it still is, in my
12 opinion, no matter how much we work with the professional
13 context of this, it is still being driven by consumers,
14 increasingly self-educated, self-regulated consumers.

15 So I am struggling with how can we put money in
16 their hands, rather than that in private managed care
17 hands, who will tell you how much you are going to get
18 for your procedures and so on. So I am thinking of how
19 do we get the supply of money into the hands of the
20 consumers first.

21 MR. DUGGAN: I believe, I don't know the exact
22 statistic, but the amount of money spent in the six

1 months before death is probably 25 percent of the
2 national health care budget. Deeling Evangeles' [ph]
3 book in 1974, "Limits to Medicine," points out that a
4 culture that attempts to prevent death will spend itself
5 out of existence in that attempt. The cultures that have
6 a different attitude towards death spend about 8 to 9
7 percent of GNP. We are close to 16. So I say to
8 consumers, if you work to reorient the concept with the
9 aging population, we have to deal with this.

10 I was at a meeting the other night of the
11 leading corporate executives in Howard County, Maryland,
12 and we had the head of a hospital system and the head of
13 an insurance system. The head of the hospital system was
14 talking about the new high tech care coming on line. The
15 head of the insurance system said, well, we can't afford
16 to pay for all of that. We don't know what we are going
17 to do, and I thought I was going to have to get up and
18 say something, but thank God, one of the physicians who
19 is head of the hospital physicians' practice got up and
20 said, well, everybody in the room has a lot of suffering,
21 and we are all going to die, and we have to rethink our
22 relationship to suffering and death. I think the

1 economics would show if you reorient the way we deal
2 with dying, and if you reorient the way we deal with
3 functional, nonpathologic visits to any health
4 professional, you then move a significant economy into
5 that free base to support wellness. That is why I am
6 talking about the economic design has to be shifted.

7 My mother -- and I went it through this year
8 with my stepmother -- she was ready to die, and I wasn't
9 there, but the automaticness was for her to spend three
10 weeks in a hospital where we had to get her back off the
11 tubes, rather than have said, mom, it is time for a good
12 bottle of Irish whiskey. Let's all sit down together, we
13 are going to let you die at home, without all the tubes.
14 She was 91.

15 Now I have been through that three times with
16 family in the past year. The enormous expense in those
17 last six months of life, well documented, is where the
18 pot of money is. And the other pot of money is in
19 whatever percentage it is that corporations spend on
20 MRIs, when it is pretty clear that the person is not
21 eating breakfast, lunch and supper, and they have a
22 headache.

1 Now that is the educational component. The
2 money is there, it is not adding a new tax base to
3 finance this. The corporations aren't going to do that,
4 the government isn't going to do it. We have to
5 understand where the pot of money is that has to be
6 shifted. That is why I put in as one of my
7 recommendations a strong sense of the relationship of
8 CAM, hospice, and palliative care, so that we reshift --
9 and if we don't do that pretty quickly for the elderly
10 population, we are not going to afford the care that is
11 demanded for the aging population. So there is a pretty
12 sophisticated economic analysis that goes on here. But
13 the money is there. It is just now being used in the
14 wrong ways.

15 DR. GORDON: Effie?

16 DR. CHOW: I am very excited about the gist of
17 this conversation because we have been primarily talking
18 about how can we research CAM, and talking about
19 techniques and methodologies, and I would love to -- no
20 time for discussion now
21 -- but I would love for you people to send more input on
22 this avenue.

1 For example, Tori, you talked about, let's
2 teach people to go back to the garden, like have your own
3 vegetable garden, because organic food stores are very
4 expensive.

5 DR. GORDON: Thank you. Thank you all. Thank
6 you for opening the discussion and deepening it for us as
7 well.

8 We will adjourn now for lunch until 1:30. We
9 will start promptly at 1:30.

10 [Lunch recess taken at 12:30 p.m.]

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A F T E R N O O N S E S S I O N [1:40 p.m.]

Public Comment

DR. GORDON: We are going to have time for public comment now. We have a couple of additional speakers. I am going to call the panels in groups of five. Bruce Nordstrom, Neal Barnard, Doreen Chen, Gary Sandman, and Danny Freund.

Each of you will have three minutes to speak, and then the Commissioners will have a chance to ask some questions.

So we will begin with Bruce Nordstrom.

DR. NORDSTROM: Good afternoon. Thank you for allowing us to come.

On behalf of the American Chiropractic Association, this afternoon, I would like to encourage the Commission to focus on wellness. The key principle behind chiropractic care as well as many other complimentary and alternative therapies is wellness. CAM practices such as chiropractic have a history and a focus of promoting health and increasing the quality and span of life.

Unfortunately, there remains the challenge of

1 how to encourage insurers to recognize and reimburse CAM
2 providers for health promotion. Increasingly complex
3 lifestyles, flaws in workplace ergonomics, and longer
4 life spans have created an inherent need to move from
5 injury and disease management to a more primary role that
6 is more wellness oriented and focused on preventative
7 care. Insurance companies are slow to move in this
8 direction. Third party payers must be encouraged to
9 offer preventative alternative therapies as paid benefits
10 rather than a patient-paid responsibility.

11 By providing early conservative chiropractic
12 intervention, it is hypothesized that we can prevent many
13 conditions that have a neural musculoskeletal origin from
14 becoming chronic and requiring more invasive procedures.
15 In many instances, chiropractic care can reduce the risk
16 of certain iatrogenic diseases from some certain
17 medicinal and surgical interventions.

18 Payers as well as policy makers need to
19 understand that illness/injury prevention and wellness
20 care can, in many instances, minimize losses in
21 productivity and increase the quality of life, and
22 thereby decrease the overall cost of health care.

1 The value of health care delivery in the
2 context of a wellness paradigm has been virtually lost in
3 budget neutrality wars, administrative benefit cuts, and
4 other scenarios, leaving this yet again as another
5 patient-paid benefit. Once payers and policy makers
6 begin to see the bottom line savings involved in wellness
7 in the promotion of health, one would hope that they
8 would embrace early and regular interventions as a viable
9 option.

10 An example of how prevention is cost effective
11 can be found in an organization called Alternative
12 Medicine, Inc., AMI. It is a fully integrated medical
13 delivery system that utilizes doctors of chiropractic as
14 traditional gatekeepers in one Illinois HMO. AMI
15 stresses prevention, and where possible, the use of
16 conservative treatments first, and pharmaceuticals and
17 surgery last. Patients are encouraged to see either
18 chiropractic regularly once every few weeks.

19 Although the program is still in its infancy,
20 according to AMI president, Dr. Surnod [ph], AMI has
21 reduced the rate of hospitalization by about 75 percent.

22 DR. GORDON: Okay, thank you. We are going to

1 be pretty strict with these time limits, because we need
2 to be.

3 Neal Barnard. Welcome.

4 DR. BARNARD: Thank you. Good afternoon. I am
5 Neal Barnard. I am president of the Physician's
6 Commission for Responsible Medicine, and I appreciate the
7 opportunity to speak with you this afternoon.

8 Nutrition is the most fundamental medical
9 treatment. Everyone eats, and as they do so, they tip
10 the balance either for health or against it. Research
11 proves that when patients change their diets enough,
12 often in combination with other lifestyle changes, they
13 can reduce cholesterol levels, reverse heart disease,
14 improve and sometimes even cure Type II diabetes and
15 hypertension.

16 These treatments are so safe and effective that
17 they should be our routine forms of therapy with
18 medications considered alternatives. Among patients'
19 greatest difficulties, however, is finding a physicians
20 equipped to recognize the need for nutritional
21 interventions, let alone prescribe them.

22 Doctors know not much more about nutrition than