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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	WHCCAMP roster (partial) (1 page)	10/19/2000	b(6)

COLLECTION:
Federal Records
White House Commission on Complementary and Alternative Medicine Policy [WHCCAMP]

OA/Box Number: 43232

FOLDER TITLE:
WHCCAM Commissioner Briefing Book (1), May 14 - 16, 2001 [1]

2011-0568-S
kc815

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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White House Commission on Complementary and Alternative Medicine Policy

May 14-16, 2001

Academy for Educational Development
Washington, DC

- Special meeting - last of the issue specific meetings
- 7th meeting and four Town Hall meetings in the last 11 months (David Beesley and
- Focus of the meeting will be on — Thank yo
  - Coverage and Reimbursement - Maureen Mulder
  - Research challenges and Coordination of CAM Research Gerry Polben
- Each of these issues will have a Break-out session with the development of Recommendations to be reported back to the Commission for discussion
- Additionally, There will be a Break-out Session this afternoon on Access to and Delivery of CAM Practices and Products (= the Commission
- Thank you Speakers for sharing your Experience + Expertise
- Members of the Public are invited to attend these sessions. However your participation will be restricted to us presenting written comments or recommendations to the Commission staff who will be present
- Encourage Web site Visits - We now have Agendas, F.R. Announcements and Transcripts of each of the meetings posted
- The next meeting will be held on July 2-3 Discussion will center on the Interim Report and the Development of Recommendations for the Final Report

White House Commission on Complementary and Alternative Medicine Policy

6707 Democracy Boulevard, Suite 840, MS-5467, Bethesda, MD 20892
tel. 301-435-7592, fax 301-480-1691, e-mail: whccamp@mail.nih.gov, website: whccamp.hhs.gov

Fact Sheet

The White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) was established by Executive Order 13147 on March 7, 2000, to develop a set of legislative and administrative policy recommendations that will maximize the benefits of complementary and alternative medicine (CAM) practices and products for the general public. The Commission has been charged to submit a report to the President and Congress by March 2002.

The President's Executive Order outlined four broad topic areas for consideration by the Commission:

1. coordinated research to increase knowledge about CAM practices and products;
2. the provision to health care professionals of reliable and useful information about CAM that can be made readily accessible and understandable to the general public;
3. guidance for appropriate access to and delivery of CAM; and
4. the education and training of health care practitioners in CAM.

Commission Membership

Twenty Commissioners have been appointed by the President, representing a diverse range of expertise in medical, scientific and CAM fields. The Commissioners include the Chair, James S. Gordon, M.D., and George M. Bernier, Jr., M.D.; David E. Bresler, Ph.D.; Thomas M. Chappell; Effie Poy Yew Chow, Ph.D.; George T. DeVries, III; William R. Fair, M.D.; Joseph J. Fins, M.D.; Veronica Gutierrez, D.C.; Wayne B. Jonas, M.D.; Charlotte R. Kerr, R.S.M.; Linnea S. Larson, LCSW; Tieraona Low Dog, M.D., A.H.G.; Dean Ornish, M.D.; Joseph E. Pizzorno, Jr., N.D.; Conchita M. Paz, M.D.; Buford L. Rolin; Julia Scott; Xiaoming Tian, M.D.; and Donald W. Warren, D.D.S.

Full Commission Meetings

The Commission will focus on one or more of the four major topic areas during each of its full group meetings. The October 5-6- meeting focused on Coordinated CAM Research and December 4-5 on Access and Delivery of CAM Services and Products. Meetings in 2001 will focus on Education, Training and Credentialing for CAM Practices; Dissemination of CAM Information to the Public; Coverage and Reimbursement; and Wellness and Prevention. There may be additional meetings to revisit one or more of these topics. All meetings are open to the public and will be held in Washington, D.C.

Town Hall Meetings

To maximize the opportunity to receive public input, the Commission is conducting Town Hall Meetings around the country, including San Francisco, Seattle, New York City and Minneapolis. Additionally, the public will be invited to present comments during Commission meetings held in Washington, D.C. throughout the coming year. Written comments may be sent electronically, by fax or mail to the addresses below. More information about the Commission is available on its website.

Contacting WHCCAMP:

Stephen C. Groft, Pharm.D.
Executive Director
OR
Michele M. Chang, CMT, MPH
Executive Secretary

6707 Democracy Boulevard
Suite 840, MS-5467
Bethesda, MD 20892

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WEBSITE: http://whccamp.hhs.gov

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release March 8, 2000

EXECUTIVE ORDER 13147

WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App.), and in order to establish the White House Commission on Complementary and Alternative Medicine Policy, it is hereby ordered as follows:

Section 1. Establishment. There is established in the Department of Health and Human Services (Department) the White House Commission on Complementary and Alternative Medicine Policy (Commission). The Commission shall be composed of not more than 15 members appointed by the President from knowledgeable representatives in health care practice and complementary and alternative medicine. The President shall designate a Chair from among the members of the Commission. The Secretary of Health and Human Services (Secretary) shall appoint an Executive Director for the Commission.

Sec. 2. Functions. The Commission shall provide a report, through the Secretary, to the President on legislative and administrative recommendations for assuring that public policy maximizes the benefits to Americans of complementary and alternative medicine. The recommendations shall address the following:

(a) the education and training of health care practitioners in complementary and alternative medicine;

(b) coordinated research to increase knowledge about complementary and alternative medicine practices and products;

(c) the provision to health care professionals of reliable and useful information about complementary and alternative medicine that can be made readily accessible and understandable to the general public; and

(d) guidance for appropriate access to and delivery of complementary and alternative medicine.

Sec. 3. Administration. (a) To the extent permitted by law, the heads of executive departments and agencies shall provide the Commission, upon request, with such information and assistance as it may require for the purpose of carrying out its functions.

(b) Each member of the Commission shall receive compensation at a rate equal to the daily equivalent of the annual rate specified for Level 1V of the Executive Schedule (5 U.S.C. 5315) for each day during which the member is engaged in the performance of the duties of the Commission. While away from their homes or regular places of business in the performance of the duties of the Commission, members shall be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in Government service (5 U.S.C. 5701-5707).

(c) The Department shall provide the Commission with funding and with administrative services, facilities, staff, and other support services necessary for the performance of the Commission's functions.

(d) In accordance with guidelines issued by the Administrator of General Services, the Secretary shall perform the functions of the President under the Federal Advisory Committee Act, as amended (5 U.S.C. App.), with respect to the Commission, except that of reporting to the Congress.

(e) The Commission shall terminate 2 years from the date of this order unless extended by the President prior to such date.

WILLIAM J. CLINTON

THE WHITE HOUSE,
March 7, 2000.

# # #

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release September 15, 2000

EXECUTIVE ORDER

AMENDMENT TO EXECUTIVE ORDER 13147, INCREASING THE MEMBERSHIP OF THE WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App.), and in order to increase the membership of the White House Commission on Complementary and Alternative Medicine Policy from not more than 15 members to up to 20 members, it is hereby ordered that the second sentence of section 1 of Executive Order 13147 of May 7, 2000, is amended by deleting "not more than 15" and inserting "up to 20" in lieu thereof.

WILLIAM J. CLINTON

THE WHITE HOUSE,
September 15, 2000.

# # #

White House Commission on Complementary and Alternative Medicine Policy

6707 Democracy Boulevard, Room 840, MSC-5467, Bethesda, Maryland, 20892-5467
tel: 301-435-7592, fax: 301-480-1691, e-mail:whccamp@mail.nih.gov Website: whccamp.hhs.gov

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[001]

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Groft, Stephen (NCCAM)

From: Mary Jo Kreitzer [kreit003@tc.umn.edu]
Sent: Friday, April 27, 2001 3:33 PM
To: Groft, Stephen (NCCAM)
Subject: WHC follow-up/flack

I appreciate very much your follow-up and the concern you expressed for post Town Hall meeting flack. I think that your offer to write a letter is a good idea for a number of reasons. I suggest that you address the letter to the president:
President Mark Yudof
Office of the President
100 Church Street SE
200 Morrill Hall
Minneapolis, MN 55455-0110

I think that it would be good to have you cc this to Frank Cerra as well as the planning committee members which will include Diane.

Points to make:

- your overall assessment of the success of the Town Hall meeting - commissioners feedback etc.
- you understand that questions have been raised regarding the planning process leading up to the event - your desire to clarify the role that the WHC requested me to assume:
  - in a letter dated 1/24/01 - I was asked to be the coordinator of the Town Hall Meeting and to convene a local planning committee
  - you were pleased with the broad representation of the planning committee
  - you requested that I be the contact person with the WHC and that we NOT attempt to have conference calls as had been requested by members of the local planning committee.
  - you are aware that the local planning committee identified relevant topics for the panels and recommended speakers. As you were personally cc'd on numerous e-mails, you are aware of how collaborative the process was and the extensive opportunity that the MN Nat HH Coalition had for input. MJK forwarded numerous names that the NHCC requested (true) - and in fact - strongly recommended that each panel included both broad community representation as well as specific representation from the NHCC. At no time, did I attempt to obstruct or limit their participation. The WHC staff retained full authority and discretion in appointing the speakers ...
- While the WHC staff was interested in the bill that was passed last July - the legislation was in no way the sole or even primary reason for convening the meeting in Minnesota.
- You might also add that I went out of my way to assure that the U of MN did not dominate. Out of 75 speakers, only 7 were affiliated with the Academic Health Center. One additional faculty person from the Humphrey Institute was requested by the NHCC. Any announcements that I sent out relative to the event, I avoided using University or Center letterhead so as to not give the impression that this was a U of MN event.
- found me to be both respectful and inclusive.

It is quite amazing that this has turned into such a convoluted tale. I appreciate again your offer of assistance. Use whatever above works for you. MJ

Mary Jo Kreitzer PhD, RN
Director, Center for Spirituality and Healing
University of Minnesota
C593 Mayo Memorial Building
Mayo Mail Code 505
420 Delaware Street S.E.

Minneapolis, MN 55455

(o) 612-625-3977
FAX 612-626-5280
Secretary: Linda 612-626-5307

Groft, Stephen (NCCAM)

From: Groft, Stephen (NCCAM)
Sent: Friday, April 27, 2001 4:54 PM
To: 'Mary Jo Kreitzer'
Subject: RE: WHC follow-up/flack

Mary Jo,

Happy to follow up with a letter. I will run a dcraft by you first.
Thanks for the overview. Have a good weekend.
Steve

-----Original Message-----
From: Mary Jo Kreitzer [mailto:kreit003@tc.umn.edu]
Sent: Friday, April 27, 2001 3:33 PM
To: Groft, Stephen (NCCAM)
Subject: WHC follow-up/flack

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Comments on Notes from discussion of CAM definition at lunch meeting on March 27th

Wayne B. Jonas

Key issues:

- Need description of way CAM has traditionally been defined

See description of previous definitions handed out. Also note below.

Complementary and alternative medicine (CAM) is defined as a subset of medical and health care practices that are not an integral part of conventional (western) medicine. This relationship occurs for several reasons including:

1. The explanatory model of the practice is not generally accepted and so additional criteria are required for "proof". (e.g. homeopathy, prayer).
2. The origin of the practice is outside of the dominant system (e.g. acupuncture).
3. The amount of data, or type of data is considered insufficient or otherwise inadequate (e.g. herbalism, megavitamin therapy).
4. The use of the practice is marginalized, in that it is not available within conventional hospitals (e.g. relaxation techniques).
5. The teaching of the practice is marginalized, in that it is not generally taught within medical, nursing or graduate schools of the dominant institutions (e.g. nutritional therapy).
6. The amount of research funding, infrastructure, and capacity for investigating the practice is low. (e.g. cancer, chiropractic).
7. The practice is not reimbursed by insurance companies and third party payers.
8. The practice is not readily used, either for feasibility, acceptability, or other reasons (e.g. clinical ecology, complex lifestyle programs).
9. The practice is not regulated or licensed in most states (e.g. naturopathy).
10. An aspect of the therapy is marginalized through it is studied under other names or subdivisions (e.g. antineoplastons, shark cartalige).

The following illustrates areas that are within or overlap with CAM.

EXAMPLE AREAS USUALLY CONSIDERED CAM	*EXAMPLE AREAS CONSIDERED CAM WHEN EXPLAINED AND APPLIED IN UNCONVENTIONAL WAYS*
• **Chiropractic Medicine** • **Acupuncture** • **Naturopathy** • **Homeopathy** • **Ayruvedic Medicine** • **Native American Medicine** • **Massage** • **"Healing" and Therapeutic Touch**	• **Mind/body methods** (when explained with unorthdox theories or used in unconventional ways) • **Diet/lifestyle therapies** (extreme or unusually diets or unusual uses of diets for therapeutic and preventive purposes) • **Herbal therapies** (when investigating therapeutic effects of whole plants or plant combinations rather than "active ingredients" for drug development) • **Nutritional supplements** (when used by CAM practitioners in unorthodox ways or in "mega" doses)

- **Spirituality and prayer**

- **Pharmacological therapies**
(when used by CAM practitioners and the public or in unorthodox ways)

The Spectrum of CAM

CAM involves a broad spectrum that can be divided roughly into three categories based on the degree to which the practice is generally accepted and used by conventional medicine in the United States.

I: Integrating topics - These are research on topics that may be considered conventional but are of interest for CAM practices. Examples include the action of popular supplements such as melatonin, DHEA, vitamins, minerals and anti-oxidants, dietary therapies and mind-body medicine.

II: Emerging CAM topics - Emerging CAM topics are those that involve common areas of interest for CAM and conventional medicine. Examples include acupuncture and herbalism (phytotherapy) and the use of high doses of combination nutritional supplements.

III: Frontier topics - Frontier topics are those that challenge our conceptual and paradigmatic assumptions about the nature of biological or scientific reality. Examples are homeopathy, prayer and healing practices such as therapeutic touch.

- Spell out limitations

Currently the definition revolves around the sociological phenomena of exclusion from dominant medical practice, either by availability, training, country or culture of origin, amount of research support, theoretical explanation and other factors. This approach results in a wide and diverse range of practices with no single theoretical or conceptual basis.

- Elaborate key words

The terminology used to describe unconventional medicine is varied and confusing. For the purposes of this report we use the term 'complementary and alternative medicine' (CAM) to designate practices that are not an integral part of conventional, western medicine. The terms 'conventional' and 'orthodox' are used interchangeably. 'Traditional' medicine will be used to refer to indigenous practices that are part of long-standing native healing systems. Except where noted, no distinction is implied between practices refereed to by the terms 'complementary' (when used to supplement conventional medicine), 'alternative' (when used instead of conventional medicine), or 'integrating (integral)' (when used in a coordinated fashion with conventional medicine) as any one CAM practice may be used in any or all of these ways at different times.

- Acknowledge fundamental characteristics of CAM systems—e.g., "vitalism"

While this definition results in a heterogeneous group of systems, theories, interventions, and claims, the major systems within CAM share some common characteristics:

a) Clinically derived - Many of these practices have evolved out of clinical experience, from small groups who use the intervention (e.g. neural therapy, polarity) to widely used, elaborately detailed systems such as Traditional Chinese Medicine.
b) Systems oriented - CAM systems tend to emphasize a complete or combination systems approach that includes multiple simultaneous

interventions with individualization, or variation of those interventions during the course of treatment. They often assume that the entire system is required as a package independent of the isolated effects of its individual components (e.g. whole plant extracts).

c) Healing processes - CAM systems tend to emphasize the stimulation or support of natural healing processes and seek to enhance those processes in order to accelerate the natural course of recovery, rather than cure or the elimination of the disease. (e.g. nutritional & diet therapy for rheumatic diseases rather than immunosuppressants.)

d) Self Care - CAM practices tend to rely on low technology, often emphasizing procedures delivered in the context of the continuity of care. They tend to emphasize communication and interventions that incorporate quality of life, patient preferences and patient satisfaction into the therapeutic and diagnostic decision making processes. They emphasize a partnership approach looking at optoins and responsibility for self.

- Definition needs to include concept of "healing"

See above

- Scope of CAM depends on where one is: "inside" versus "outside"

See above on limitations and list of previous definitions.

- Definition that Commission uses must be focused on the outcomes of the report.

Refer to mission statement section.

Commissions Responsibility:

- To facilitate integration of CAM therapies where evidence dictates
- To establish a process for integration/dialogue/cooperation
- State explicitly that integration is a process

Points of Consensus:

- Commission should not get bogged down in trying to define CAM, but rather should focus on its mission with attention to the legislative language in the Executive Order.
- The Commission needs to develop a strategy and overall philosophy for the report
- The focus of the report needs to be integrative and catholic (i.e., broad-minded)

Next Steps:

Wayne Jonas will meet with the Commission staff to develop language on the Commission's criteria for the scope of the report and to work out a process for developing a mission statement. The Commission staff will put aside some time during the next Commission meeting (in May) to work on the mission statement.

Guidelines for Setting Priorities in by the Commission

I. Identifying priority areas: The practice:

- is extensively used by the public or CAM and traditional practitioners;
- is not an integral part of conventional practice already;
- has at least some reasonable supportive data behind it;
- may have an desired theoretical rationale or perspective on healing.

***II. Addresses important health care needs*:** The condition for which it is used produces a high burden such as:

- prevalence: the number of people with a particular problem;
- mortality: the number of deaths caused by a disease;
- morbidity: the degree of disability and suffering produced by a disease
- loss of productive years: the degree to which a disease cuts short a normal, productive, comfortable lifetime;
- costs: the economic and social costs of a disease, and
- urgency: the need to find solutions rapidly.
- Or it affects wellness and so mitigates the tendency to dis-ease in general

III. Provides the top target CAM benefits: The practice may contribute to:

- prevention, treatment or improved management of chronic disease;
- improving quality of life (increased wellness, reduced symptoms or side effects);
- reduction of health care costs;
- providing a new understanding of healing and disease mechanisms.

Clinton Presidential Records
Digital Records Marker

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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Divider Title: Agenda

White House Commission on Complementary and Alternative Medicine Policy

Meeting Site: Academy for Educational Development
1825 Connecticut Avenue, N.W., Academy Hall, 8th Floor
Washington, DC

May 14-15, 2001

AGENDA I

DAY ONE: MONDAY, MAY 14, 2001

7:30 a.m. **Registration opens**

Meeting Topic I. Complementary and Alternative Medicine: Understanding Coverage and Reimbursement

8:15 a.m. **Opening Remarks and Introductions**

- *Dr. Stephen C. Groft, Pharm.D., Executive Director*
  White House Commission on Complementary and Alternative Medicine Policy

- *Dr. James S. Gordon, M.D., Chair*
  White House Commission on Complementary and Alternative Medicine Policy

8:30 a.m. **Panel Session I: Overview of Health Care Financing in the United States**

1. *Michael O'Grady, Ph.D.*
   Project Hope, Center for Health Affairs — 30 minutes

- Discussion — 25 minutes

9:25 a.m. **Panel Session II: Federal Purchasers**

2. *John Whyte, M.D.*
   Health Care Financing Administration — 30 minutes

3. *Abby Block, M.A., M.S.W., M.B.A.*
   U.S. Office of Personnel Management — 20 minutes

- Discussion — 30 minutes

10:45 - 11:00 a.m. **BREAK**

11:00 a.m. **Panel Session III: State and National Perspectives**

4. *Joy Johnson Wilson*
   National Conference of State Legislatures

5. *Merilyn Francis, R.N., M.P.P.*
   American Association of Health Plans

6. *Alan Korn, M.D.*
   Blue Cross Blue Shield Association

◆ Discussion

12:00 – 1:00 p.m. **LUNCH BREAK**

1:00 p.m. **Panel Session IV: Employer Perspectives**

7. *Tom Sawyer*
   William M. Mercer, Inc.

8. *Kathleen King*
   Washington Business Group on Health

9. *Judith MacPherson*
   CACI International Inc

◆ Discussion

2:10 p.m. **Panel Session V: Health Plan Perspectives**

10. *Rick Gallion*
    Blue Cross Blue Shield of South Carolina

11. *John Kelly, M.D.*
    Aetna/U.S. Healthcare

12. *John Weeks*
    The Integrator

◆ Discussion

3:10 – 3:25 p.m. **BREAK**

3:25 p.m. **Panel Session VI: Special Populations: Minorities, Uninsured, Underinsured**

13. *Nathan Stinson, M.D., Ph.D., M.P.H.*
    Office for Minority Health, DHHS

14. *Doriane Miller, M.D.*
    Robert Wood Johnson Foundation

15. *Daniel Hawkins*
    National Association of Community Health Centers

◆ Discussion

4:15 p.m. **Breakout Groups: Access and Delivery***
**(Review of December 4-5, 2000 Meeting Discussion)*

5:15 p.m. **Group Reports and Discussion**

6:00 p.m. **ADJOURN**

DAY TWO: TUESDAY, MAY 15, 2001

7:30 a.m. **Registration Opens**

Meeting Topic I. Complementary and Alternative Medicine: Understanding Coverage and Reimbursement (continued)

8:00 a.m. **Opening Remarks**

- *Dr. Stephen C. Groft, Pharm.D., Executive Director*
  White House Commission on Complementary and Alternative Medicine Policy
- *Dr. James S. Gordon, M.D., Chair*
  White House Commission on Complementary and Alternative Medicine Policy

8:05 a.m. **Panel Session VII: Issues and Ideas**

16. *Melinna Gianninni*
    Alternative Link, Inc. — 10 min.
17. *Linda Bedell-Logan*
    Solutions in Integrative Medicine — 10 min
18. *Wayne Sickles, M.T.S., M.DIV.*
    Massage Therapist — 10 min

◆ Discussion — 20 min

Call up Separately

19. *Max Heirich, Ph.D.*
    University of Michigan — 15 min.

◆ Discussion — 15 min

9:25 - 10:50 a.m. **Break/Breakout: Small Group Discussion (CAM Reimbursement)**

10:50 a.m. **Group Reports and Discussion**

11:30 a.m.-12:30 p.m. **LUNCH BREAK – ADJOURN MEETING TOPIC I**

White House Commission on Complementary and Alternative Medicine Policy

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12. *John Weeks*
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◆ Discussion

3:10 - 3:25 p.m. **BREAK**

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◆ Discussion

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6:00 p.m. **ADJOURN**

DAY TWO: TUESDAY, MAY 15, 2001

7:30 a.m. **Registration Opens**

Meeting Topic I. Complementary and Alternative Medicine: Understanding Coverage and Reimbursement (continued)

8:00 a.m. **Opening Remarks**

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    Solutions in Integrative Medicine

18. *Wayne Sickles, M.T.S., M.DIV.*
    Massage Therapist

- Discussion

19. *Max Heirich, Ph.D.*
    University of Michigan

- Discussion

9:25 - 10:50 a.m. **Break/Breakout: Small Group Discussion (CAM Reimbursement)**

10:50 a.m. **Group Reports and Discussion**

11:30 a.m. - 12:30 p.m. **LUNCH BREAK – ADJOURN MEETING TOPIC I**

White House Commission on Complementary and Alternative Medicine Policy

Meeting Site: Academy for Educational Development
1825 Connecticut Avenue, N.W., Academy Hall, 8th Floor
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May 15-16, 2001

AGENDA II

DAY TWO: TUESDAY, MAY 15, 2001

Meeting Topic II. Complementary and Alternative Medicine: Research Challenges

12:30 p.m. **Opening Remarks**

- ◆ *Dr. James S. Gordon, M.D., Chair*
  White House Commission on Complementary and Alternative Medicine Policy

12:40 p.m. **Panel Session I: Overview of CAM Research Challenges**

20. *David Eisenberg, M.D.*
    Harvard University

- ◆ Discussion

1:25 p.m. **Panel Session II: Foundation Support for CAM Research**

21. *M. Bridget Duffy, M.D.*
    Medtronic Foundation

22. *Doriane C. Miller, M.D.*
    Robert Wood Johnson Foundation

23. *Susan Braun*
    Susan G. Komen Breast Cancer Foundation

24. *Ronald Chez, M.D.*
    Samueli Institute for Information Biology

- ◆ Discussion

2:35 – 2:50 p.m. **BREAK**

2:50 p.m. **Panel Session III: Approaches to Evaluating Research Literature**

25. *Donald A. Lindberg, M.D.*
    National Library of Medicine, NIH

26. *Douglas B. Kamerow, M.D., M.P.H.*
Agency for Healthcare Research and Quality

27. *Brian Berman, M.D.*
University of Maryland

◆ Discussion

4:10 p.m. **Panel Session IV: Concerns about CAM and CAM Research**

28. *William M. London, Ed.D., M.P.H.*
National Council Against Healthcare Fraud

29. *Simeon Margolis, M.D., Ph.D.*
Johns Hopkins University

30. *Arthur P. Grollman, M.D.*
State University of New York at Stonybrook

◆ Discussion

5:30 p.m. **ADJOURN**

DAY THREE: WEDNESDAY, MAY 16, 2001

7:30 a.m. **Registration Opens**

Meeting Topic II. Complementary and Alternative Medicine: Research Challenges (continued)

8:00 a.m. **Panel Session V: Research Methodology**

31. *John A. Chabot, M.D.*
Columbia University

32. *Marcia Angell, M.D.*
Editor-in-Chief, Emeritus, New England Journal of Medicine

33. *Jennifer Jacobs, M.D., M.P.H.*
American Institute of Homeopathy

34. *B. Alex White, D.D.S., Dr.P.H.*
Kaiser Permanente Center for Health Research

35. *Bruce Rabin, M.D., Ph.D.*
University of Pittsburgh

◆ Discussion

9:25 a.m. **Panel Session VI: Training of Conventional and CAM Investigators**

36. *Nancy Pearson, Ph.D.*
National Center for Complementary and Alternative Medicine, NIH

37. *Neal West, Ph.D.*
National Center for Complementary and Alternative Medicine, NIH

38. *Robert H. Blanks, Ph.D.*
University of California at Irvine

39. *Russell Phillips, M.D.*
Harvard University

40. *Richard Hammerschlag, Ph.D.*
Oregon College of Oriental Medicine

◆ Discussion

10:35 – 10:50 a.m. **BREAK**

10:50 a.m. **Panel Session VII: Publication of Peer-Reviewed CAM Research Results**

41. *Edward W. Campion, M.D.*
New England Journal of Medicine

42. *Jackie C. Wootton, M.Ed.*
Journal of Alternative and Complementary Medicine

43. *Phil B. Fontanarosa, M.D.*
Journal of the American Medical Association

44. *David Riley, M.D.*
Alternative Therapies in Health and Medicine

45. *Christine Laine, M.D., M.P.H.*
Annals of Internal Medicine

46. *Arnold Relman, M.D.*
Editor-in-Chief, Emeritus, New England Journal of Medicine

◆ Discussion

12:30 - 1:30 p.m. **LUNCH BREAK**

1:30 p.m. **Breakout: Small Group Discussion (CAM Research Challenges)**

2:50 p.m. **Group Reports and Discussion/Adjourn Meeting Topic II**

4:00 p.m. **BREAK**

4:15 p.m. **Public Comment Session: 3-Minute Oral Statements**

47. James Sensenig, American Association of Naturopathic Physicians
48. Candace Campbell, American Preventive Medical Association
49. Diane Davis Cole, University of Virginia Cancer Center
50. Katherine Jane Gorton, American Dietetic Association
51. Audrey Di Maria, Art Therapy Credential Board
52. Judy Simpson, American Music Therapy Association

◆ Discussion

53. Richard Goldberg, Private Practice
54. Nancy Kristine Haller, Feldenkrais Guild of North America
55. Julie Merrill, American Association of Oriental Medicine
56. Su Liang Ku, Florida Institute for Traditional Chinese Medicine
57. Sharon Stevenson, National Center for Homeopathy

◆ Discussion

58. Matt Ward Russell, National Integrative Medicine Council
59. Carolyn Jones Sabatini, Pharmavite Corporation
60. Christina Walker, The Shenk Human Energetic Institute
61. Alan Dumoff, Private Practice

◆ Discussion

5:30 p.m. **MEETING ADJOURN**

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- Discussion

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◆ Discussion

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5:15 p.m. **Group Reports and Discussion**

6:00 p.m. **ADJOURN**

DAY TWO: TUESDAY, MAY 15, 2001

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Meeting Topic I. Complementary and Alternative Medicine: Understanding Coverage and Reimbursement (continued)

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11:30 a.m.-12:30 p.m. **LUNCH BREAK – ADJOURN MEETING TOPIC I**

White House Commission on Complementary and Alternative Medicine Policy

Meetings on
CAM: Understanding Coverage and Reimbursement
CAM: Research Challenges

May 14-16, 2001

Academy for Educational Development, Washington, DC

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Joy Johnson Wilson
National Conference of State Legislators

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The Logic of Health Insurance

Michael J. O'Grady, Ph.D.
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Role of Insurance

- Replace an unpredictable and potentially catastrophic cost with a predictable, manageable cost
- Health Insurance is really a hybrid of classic insurance and annual budgeting of health expenses

Common Forms of Health Insurance

- Traditional Fee-for-Service (FFS)
- Health Maintenance Organizations (HMO's)
- Preferred Provider Organizations (PPO's)
- Point-of-Service (POS) plans

Traditional Fee-for-Service

- Limited or no management by insurer
- Payment per procedure
- The more procedures you do the more money you make
- Limited incentive for cost efficiency
- Insurance company holds the financial risk

Health Maintenance Organizations (HMO's)

- Capitated payment
- HMO holds the financial risk
- Strong incentives for cost efficiency
  - Quality?
- Incentives to use more cost efficient alternatives to physicians and hospitalization

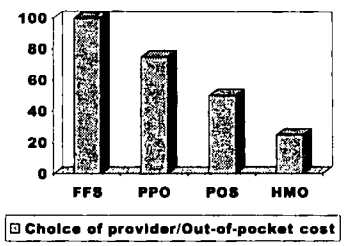
Preferred Provider Organizations (PPO's)

- FFS's response to HMO's and premium pressures
- In-network and out-of-network design
- Subscribers enjoy reduced cost sharing for using in-network providers
- Providers offer discounts to join network
- Turns oversupply to insurer's advantage

Point-of-Service (POS) plans

- HMO's response to complaints of limited provider choice
- In-network and out-of-network design, but referral required
- Closes gap with PPO's in continuum of management

Tradeoffs in Choice of Provider and Out-of-Pocket Costs



Coverage Logic

- If covering a new benefit increases costs:
  - Is there enough clear advantage to the subscriber that they will except the extra cost?
  - Example, prescription drug coverage

Coverage Logic (con't)

- If covering a new benefit is cost neutral:
  - Insurer can remain agnostic as long as protected from unpredictable expense
    - Treatment for specific, limited conditions
    - Capitated payments (someone else holds risk)
    - More value, same cost (e.g., home health)

Coverage Logic (con't)

- If covering a new benefit decreases costs:
  - Win-win – adds value, reduces premium growth
  - Improves insurers competitive position

Final Points

- Not that productive to blame insurers for responding rationally to incentives.
- Final decisions are in the hands of the entity that holds the financial risk
  - Employers/government (traditional)
  - HMO's (capitated)

Tom Chapell - Reinsurance/budgeting for CAM services re Long term Catastrophic

Grant - Medicare not real flexible
FEHBP - more flexible in approach
→ Grant can be a reinsurance provider

Cost Effectiveness studies - essential - more so than traditional treatment programs

Joe P. Medical Savings Plans ⇒
$250 deductible → $2,500 deductible, should ↓ premium, put extra $ into a medical savings plan

JDeV - Gradual implementation - Supplemental rider,
- Behavioral Health Care (Carve out - Doctors) Sharing Risk
- Insurers respond rationally as entrepreneurially.

JP
CK - Rx Drug coverage - ? Students evaluate alternatives for medicare / or Reps from CAM in Planning teams

general and family practitioners and other office-based specialties.

Current Trends in the Integration and Reimbursement of Complementary and Alternative Medicine by Managed Care, Insurance Carriers, and Hospital Providers

Kenneth R. Pelletier, Ariane Marie, Melissa Krasner, William L. Haskell

Abstract

Objectives. *To assess the status of managed care and insurance coverage of complementary and alternative medicine (CAM) and the integration of such services offered by hospitals.*

Methods. *A literature review and information search was conducted to determine which insurers had special policies for CAM and which hospitals were offering CAM. Telephone interviews were conducted with a definitive sample of 18 insurers and a representative subsample of seven hospitals.*

Results. *A majority of the insurers interviewed offered some coverage for the following: nutrition counseling, biofeedback, psychotherapy, acupuncture, preventive medicine, chiropractic, osteopathy, and physical therapy. Twelve insurers said that market demand was their primary motivation for covering CAM. Factors determining whether insurers would offer coverage for additional therapies included potential cost-effectiveness based on consumer interest, demonstrable clinical efficacy, and state mandates. Some hospitals are also responding to consumer interest in CAM, although hospitals can only offer CAM therapies for which local, licensed practitioners are available. Among the most common obstacles listed to incorporating CAM into mainstream health care were lack of research on efficacy, economics, ignorance about CAM, provider competition and division, and lack of standards of practice.*

Conclusions. *Consumer demand for CAM is motivating more insurers and hospitals to assess the benefits of incorporating CAM. Outcomes studies for both allopathic and CAM therapies are needed to help create a health care system based upon treatments that work, whether they are mainstream, complementary, or alternative. (Am J Health Promot 1997; 12[2]:112–123.)*

Key Words: Managed Care, Insurance, Hospital, Reimbursement, Complementary Medicine, Alternative Medicine, Providers, Disease Management, Health Promotion

INTRODUCTION

Complementary and alternative medicine (CAM) can be defined as "medical interventions not taught widely at U.S. medical schools or generally available at U.S. hospitals."[1] The most commonly used practices are consumption of vitamins and health foods, herbal therapy, chiropractic, relaxation techniques, massage, and acupuncture.[1–5] In 1990, approximately one in three persons in the U.S. adult population used CAM, and the estimated number of visits to CAM providers was greater than the number of visits to all primary care medical doctors in that year.[1] Five surveys conducted since 1990 report frequent use of CAM, ranging from 30[1,2] to 73%[6–8] by patients suffering from conditions such as cancer, arthritis, acquired immunodeficiency syndrome, multiple sclerosis, and acute back pain.

Use of CAM does not significantly vary by gender or insurance status, but use is more frequent for highly educated, high income, nonblack Americans who live in the western U.S.[1] Likewise, use of vitamin supplements is most common by those living in the western U.S. with a college degree and an income of $50,000 or more.[6] Major users of CAM are either between the ages of 25 and 49 years or over 65.[1,7,9] Data indicate that the current market for CAM is being created by middle-aged and older individuals, who are investing to improve their health, and by indi-

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This manuscript was submitted for publication December 26, 1996; revisions were requested February 27, 1997; the manuscript was accepted for publication June 17, 1997.

Am J Health Promot 1997;12(2):112–123.

0890-1171/97/$5.00 + 0

viduals suffering from chronic illnesses and diseases that are not adequately treated by conventional medicine.

Demand for CAM by the general public is increasing, despite the fact that its use is largely paid for by consumers "out of pocket" without coverage or reimbursement by third-party payors. In 1990, Americans spent an estimated $11.7 billion for visits to CAM providers and an additional $2 billion for commercial diet supplements and over-the-counter megavitamins.[1] In 1991, the market for herbal therapy was $1.3 billion and growing at a rate of approximately 20% per year.[7] In 1990, sales of homeopathic medicine reached $150 million in the U.S., which was a 50% increase in sales from 1988.[9] Businesses that offer CAM are capitalizing quite successfully on consumer interest. Whether this commercialization of CAM is good or bad has not been established and is highly debated, but ultimately will depend upon the results of clinical and cost outcomes research.

There are eight frequently cited reasons for the recent increased consumer use of CAM:

(1) consumer dissatisfaction with the limitations of conventional medicine,[7-9]
(2) consumer perception that the Western model of medicine treats patients as if they were mechanical processes rather than human beings with psychological and spiritual lives,[9,10]
(3) a greater awareness of medical practices from other cultures[7,13]
(4) a growing body of scientific literature suggesting that diseases are linked to nutritional, emotional, and lifestyle factors,[7,11]
(5) a desire for and expectation of wellness by baby boomers,[7]
(6) consumer desire, especially in seniors, to take fewer medications and decrease side effects[9]
(7) consumer desire to reduce personal health care spending, especially seniors,[9] and
(8) support of nationally renowned clinicians.[12]

Evolving CAM coverage is occurring within the context of broader changes in the delivery of health care in the United States, and internationally throughout industrialized nations, particularly in Germany, France, the U.K., the Netherlands, and throughout Asia. Some characteristics of this health care reform include a demand for decreased costs and improved clinical outcomes, increased enrollment of patients and physicians in managed care organizations, development of clinical practice guidelines and clinician quality reviews, a move to capitated managed care, an emphasis on preventive care, intensified competition among third-party insurers, and a national debate over how to provide continuity of care and insurance coverage for everyone.[13,14] Among the things driving health care delivery reform are rising medical care costs and the aging of America's population, of which the latter also impacts health care costs since seniors are the largest utilizers of medical treatments.[11,12,15] This may result in a need for less expensive health care, including the appropriate use of CAM, although there are absolutely no data to support the frequently cited claim.

Advocates of CAM suggest that some CAM therapies could play a significant role in preventing diseases and helping contain medical care costs. For example, a recent study demonstrated that cardiovascular disease could be reduced through a combination of a low-fat vegetarian diet, exercise, and stress management. As a result, several insurers are funding the Ornish nutrition-based program, including Mutual of Omaha, American Medical Securities, Blue Shield of California, and Principal Mutual.[16] Complementary and alternative medicine therapists may also help improve the quality of health care through their holistic approach, which may allow patients to feel more in control of their health and more satisfied with their medical care,[10] which in turn may help to decrease unnecessary office visits due to anxiety or miscommunications between physician and patient.[2,17]

Researchers at the Stanford University School of Medicine conducted a comprehensive database search, a literature review, and a definitive survey of 18 insurance companies and a representative subsample of seven hospitals in order to determine the current insurance coverage for CAM therapies and the profile of these being provided as a clinical service by hospitals. The main objective of this project was to review the status of reimbursement for CAM, as well as the integration of such services offered by hospitals. Results of this pilot survey are presented in two sections reflecting the main categories of the survey: insurers and hospitals. In each section, a brief literature review is presented as both the research background for determining the interview questions and as a context for the responses. This review is followed by the specific questions and responses (reported as group data only, since the survey participants requested that the research not link their names to specific outcomes). The results section concludes with a summary section on the obstacles to integrating CAM into mainstream health care. Finally, the discussion section describes the overall findings, conclusions, and next stage for research.

METHODS

Literature Review and Information Search

A comprehensive review of existing literature on the insurance coverage of CAM was initiated in January 1996. Literature searches were undertaken in several databases, including ABI, BIOSIS, ERIC, LEXIS/NEXIS, MAGS, MEDLINE, PAIS, PSYC, SOCA, and the Internet. In addition to the literature review, the researchers received information from experts on CAM and the health care industry via: (1) an electronic mail request for information sent to members of an alternative medicine Health Online course; (2) an electronic mail request for information sent to directors of the 10 research centers established by the Office of Alternative Medicine (OAM), National Institutes of Health; (3) literature sent by the OAM centers; and (4) consultation with experts at the Stan-

ford University School of Medicine, Stanford Health Systems (SHS), Stanford Graduate School of Business, and the Arizona Center for Health and Medicine of Catholic Healthcare West in Phoenix, Arizona.

Most importantly, this rapidly evolving area of CAM necessitates a suitable qualitative methodology since it is an emerging area of inquiry where little scientific study has been done. Complementary and alternative medicine practices and acceptance vary tremendously from one location to another. Terminology is not consistent among practitioners, sponsors, or consumers. Actual practices may have been masked by the apparently common practice of misusing Current Procedure Terminology (CPT) codes for services so that the services will qualify for payments by insurers. This is the kind of complicated, emerging phenomenon that is best studied by using purposive selection of case studies or case institutions with well-designed, semistructured, and open-ended interviews. A random sampling is inherently inappropriate and the research team identified a definitive national sample as of December 1996 offering CAM therapies by managed care/insurance providers. As a result, the managed care/insurance carrier sample is a definitive case sample subject to qualitative methods. Hospital interviews were more limited and only those seven hospitals offering the broadest array of CAM therapies were selected for a more limited qualitative analysis.

This database search, literature review, and information search could not be exhaustive because the market in the area of CAM is changing so quickly. In addition, some relevant information was not available to us due to cost, such as a book titled *Self-treatment in Managed Care: HMO Involvement in OTC and Alternative Therapies,* which is sold for $3000 by Decision Resources of Boston, Massachusetts, as well as a newsletter titled *Business Report on Alternative and Complementary Medicine* marketed by St. Anthony's Publishing (J. Elkis, unpublished data). Nonetheless, the completeness of the information search is suggested by the fact that the researchers began to receive referrals to the same insurers or hospitals that were already identified earlier in our search.

Sample

Based upon our literature review and information search, the research team identified insurers that had or were developing policies to cover CAM. Telephone surveys were conducted of those companies between April and October 1996. The companies interviewed were: Alliance for Alternatives in Healthcare Inc. (Alternative Plan), American Medical Securities, American Western Life Insurance (Wellness Plan), Blue Cross of Washington and Alaska, Kaiser of Northern California, King County Medical Blue Shield in Washington, Mutual of Omaha, and Oxford Health Plans. Researchers also interviewed The Alternare Group, which was contracted by one of the above insurers to facilitate the development of their policies for CAM coverage.

In addition, researchers added insurance or managed care companies that did not have proactive policies to cover CAM, but were of interest because they represent major national managed care and insurance providers. After identifying large national carriers, the following companies were identified and interviewed based upon the information search and their large advertisements in the yellow pages of a Santa Clara County, California, telephone directory: Aetna, Blue Cross of California, Blue Shield of California, CIGNA, Foundation Health Corporation, HealthSource Provident Administrators, Medicare, NYLCare, Principal Mutual Life Insurance, and Prudential.

Also, the research team conducted interviews with representatives of hospitals associated with CAM centers. We were interested in understanding why these hospitals were offering CAM therapies and how they chose those particular therapies. Based upon the literature review and information search, the researchers identified hospitals that have incorporated several modalities of CAM. Our respondent hospitals are the American Holistic Center in Chicago, Ancilla System's Healing Art Center, North Hawaii Community Hospital, Center for Health and Well-Being at St. Luke's Hospital, Center for Complementary Medicine and Pain Management at St. Vincent's Hospital, The Franciscan Wholistic Health Center in Cincinnati, and the University of Miami Courtelis Center. We did not interview hospitals that offer three or fewer CAM therapies. Therefore, the sample universe of hospitals is small, since there are few hospitals that have chosen to incorporate several CAM therapies.

Interviews

Research team members informed the potential respondents of the survey that this is a study by researchers at the Complementary and Alternative Medicine Program at Stanford (CAMPS) that was designed to assess the status of and reimbursement for CAM. Interviews were conducted by two Stanford researchers by telephone, with follow-up calls to clarify specific points. All participants also sent actual copies of their policies and materials, which are on file in the CAMPS office. We asked about 34 specific therapies from the OAM classification of alternative medical practices. Interview questions were both structured for baseline information and open ended in order to allow participants to express their beliefs and experiences without the constraints imposed by closed questions.

RESULTS

Literature Review of Managed Care/ Insurance Providers and CAM

Managed care providers and insurers want to know whether a particular therapy is clinically efficacious, preferably with few complications or side effects. Complementary and alternative medicine may be helpful for chronic illnesses, such as back pain, with the potential to be less costly and have fewer side effects than pharmaceuticals or surgery. Studies also suggest that CAM may play a particular role in preventive care, especially the prevention of stress-related disorders, as some insurers have already determined. For example, Harvard Medical School's

Mind/Body Institute has reported as many as five calls a week from HMOs that are considering teaching relaxation techniques to their members.[18] Likewise, a Blue Cross/Blue Shield Association (BCBSA) survey "indicates that 70 percent of BCBSA plans are either developing or marketing programs that include health education programs and healthy lifestyle incentives."[19] However, until there is clear scientific proof of the efficacy of particular CAM therapies, each insurance company is left to decide for itself whether the effectiveness may exceed the costs of covering a particular therapy.

Insurers want to know whether or not a particular therapy is cost-effective. Advocates claim that insurers can save money by offering coverage of CAM for the following reasons. One is that CAM usually is less expensive than allopathic treatments. For example, a large study by the RAND Corporation published in 1990 found that chiropractors were more successful at treating patients with chronic low-back pain and that chiropractic care was about one-tenth the cost of allopathic care.[7] Likewise, a survey by the French government found that the cost of all services provided by homeopathic doctors was about half as much as services provided by allopathic physicians using conventional services.[10] However, these are two of a very limited number of studies that have evaluated the cost-effectiveness of particular types of CAM, and even fewer have evaluated both clinical efficacy and cost-effectiveness. A second reason for CAM coverage is that insurers that advertise such coverage may attract healthier members, which is supported by the fact that the heaviest users of CAM are highly educated with high incomes and are between the ages of 25 and 49.[18] However, CAM is also widely used by people over the age of 65 and by very sick people who have no other alternatives, so it is difficult to say whether the total CAM users pool will be low risk. Thirdly, insurers that offer access to CAM providers may save money because many providers of CAM focus on preventive medicine, which can decrease the need for costly treatments. Preliminary information suggests that insurers that cover CAM along with major medical expenses, such as American Western Life and Alliance for Alternatives in Healthcare Inc., are competitive with more conventional plans/insurers, and may even save money on the treatment of certain conditions, such as arthritis, ear infections, and high blood pressure.[20,21] Although cost-benefit analyses are hotly debated, there are little empirical data brought to bear on whether CAM will indeed decrease costs, or whether coverage of CAM will be an added expense.[22]

Interviews with Insurers

A total of 18 insurance companies were contacted for telephone interviews, and interviews were completed at all 18 companies. The number of insurers that reported coverage to any extent on one or more of their policies for a particular complementary medical practice is summarized in Table 1. A minority of the insurers sampled offered extensive coverage of CAM. Of the insurers sampled, the smaller companies offered more extensive coverage of CAM (Figure 1). Twelve of the 18 insurers said that market demand was their primary motivation for offering CAM.

Nine out of the 18 insurers were looking into coverage of additional therapies as follows: acupuncture (2), hypnotherapy (2), naturopathy (2), Qi Gong (1), craniosacral therapy (1), reiki (1), homeopathy (1), guided imagery (1), biofeedback (1), psychotherapy (1), and chiropractic (1). Three insurers did not disclose which therapies they were looking into for possible coverage. Five companies stated that they did not anticipate additional coverage of CAM. Four other companies said that they might consider additional coverage for one of the following reasons: (1) a particular therapy was proven effective in peer-reviewed medical literature; (2) coverage was mandated by state law; (3) there was high market demand; or (4) there existed potential cost-savings. Two insurance companies have retracted some of their CAM benefits (specifically, massage and health foods) due to the difficulty in estimating and controlling utilization.

Table 1

Coverage Reported by Insurers to Any Extent on Any Policy (n = 18)

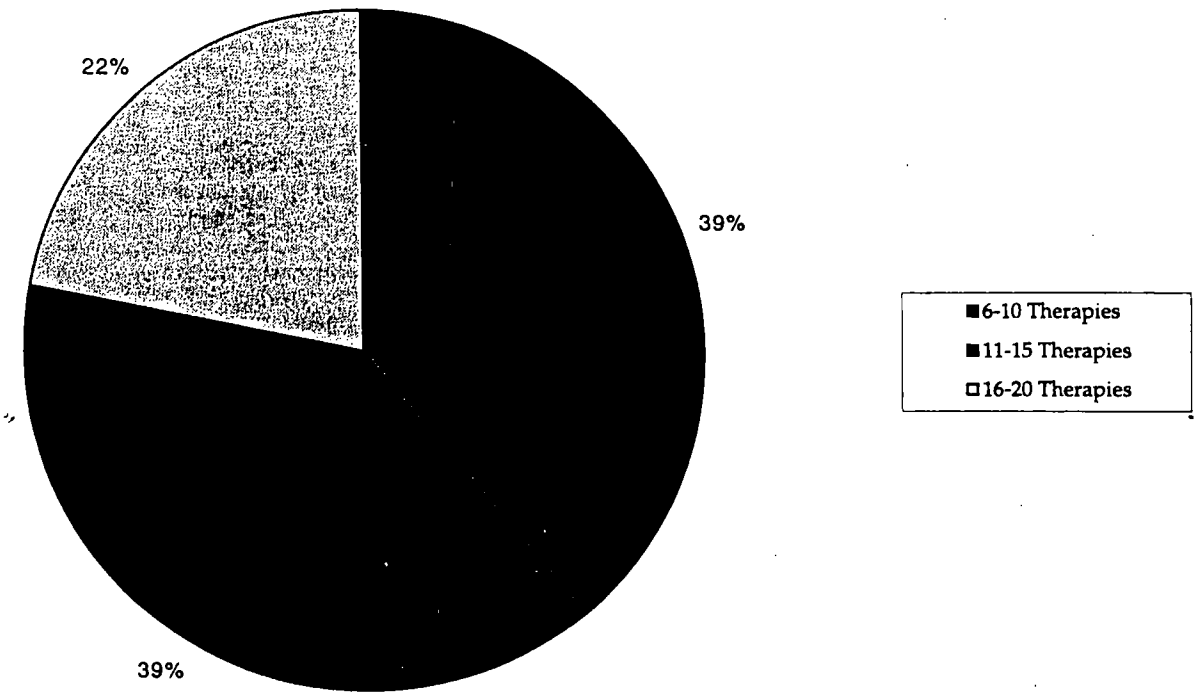
Complementary Medical Practices	Number of Insurers
Diet, nutrition and lifestyle changes:	
Herbal medicine	4
Nutrition counseling	12
Ornish program	6
Mind/Body control:	
Aromatherapy	0
Art therapy	0
Biofeedback	16
Guided imagery	5
Hypnotherapy	10
Martial arts	0
Meditation	4
Psychotherapy	17
Qi Gong/Ch'i Kung	1
Support groups	4
Yoga therapy	2
Alternative systems:	
Acupuncture	17
Ayurveda	3
Homeopathy	8
Naturopathy	7
Tibetan medicine	1
Chinese medicine	4
Preventive medicine	15
Manual healing:	
Acupressure	9
Alexander technique	1
Chiropractic	18
Craniosacral	2
Massage therapy	11
Naprapathy	1
Osteopathy	18
Physical therapy	18
Reflexology	2
Reiki	1
Rolfing	2
Shiatsu	4
Tragerwork	2

However, to promote wellness, these insurance companies are offering a discount on health foods and vitamins.

Several insurers have developed major medical plans that specifically include coverage of CAM. For example, subscribers to American Western Life Insurance's (AWLI's) Wellness Program are encouraged to visit a wellness doctor, who may be an allopathic doctor, Ayurvedic doctor, acupuncturist, hypnotherapist, or other type of provider. A comprehensive health history is taken initially by a wellness doctor, and suggestions are

Figure 1

Managed Care and Insurance Plan Coverage of Complementary and Alternative Medicine (n = 18)



made for healthy lifestyle changes.

uropathic doctors staff a 24-hour
istic hotline, give suggestions for self-care, and operate as gatekeepers for additional office visits. According to one spokesperson, less than 2% of callers intended to self-treat when they called for a referral, but almost 19% elected self-care after speaking with a Wellness Line doctor (J. Elkis, unpublished data). AWLI's Wellness Program pays for herbal and homeopathic medicines, as well as for vitamins that are prescribed for certain conditions. Alliance for Alternatives in Healthcare Inc. offers the Alternative Plan, which pays for services provided by "any licensed physician acting within the scope of their license, both office and hospital visits, to treat any illness or injury or to provide preventive services," and pays for up to $500 a year for homeopathic and herbal medicine prescribed by a licensed physician. A few other insurers are currently experimenting with plans specific to CAM, such as Blue Cross of Washington and Oxford Health Plans.[20,23] Most of the in-
ers interviewed did not have special health plans for CAM, but included coverage of some CAM in their regular plans.

Important factors determining coverage decisions as listed by insurers included: (1) consumer interest indicated by quantitative consumer research or employer demands. All of the insurers interviewed said that large employers in particular could customize their plans. Furthermore, 12 of the 18 insurers said that market demand was their primary motivation for offering coverage of CAM; (2) proof of clinical efficacy as indicated by randomized controlled trials in peer-reviewed journals or consultation with regional and national experts; and (3) state-mandated coverage of CAM (Table 2).

Reimbursement was described as depending on: (1) market-driven rates; (2) the practitioner's license; (3) Current Procedure Terminology (CPT) codes; and (4) the particular health plan. With regard to CPT codes, most insurers interviewed thought it common for currently acceptable CPT codes to be used when in fact alternative medicine proce-

Table 2

State-mandated Reimbursement for Alternative Providers

Providers	Number of States
Acupuncturists	8
Chiropractors	41
Dietians	3
Massage therapists	1
Midwives	15
Naturopaths	3
Osteopaths	17
Physical therapists	10
Podiatrists	35

Sources: National Association of Insurance Commissioners Mandated Benefits Summary (1995); Washington Insurance Commissioner Providers Licensed Under Title 18 (1996).
Note: The National Association of Insurance Commissioners summarized state statutes or regulations mandating that "certain providers must be reimbursed if the treatment is a covered expense and is within the scope of the provider's license." Information on counselors and psychologists was excluded from this table. Also, no distinction is made in this table between nurse midwives and licensed midwives.

dures are being administered. They did not think this was as common for Diagnosis Related Groups (DRGs), since DRGs are mostly used for hospital billing and alternative/complementary therapists are usually more involved in outpatient visits. Most of the insurers did not believe that the American Medical Association (AMA) would develop CPT codes specific to CAM any time soon. Five insurers said that they use "dummy" CPT codes for CAM. The Alternare Group has developed a conversion method for reimbursing CAM based on CPT codes.

Overall, a vast majority of CAM is covered by insurers only if the treatment is medically necessary for a specific diagnosis, and reimbursement is given only for a certain number of visits or dollar limit. Defining "medical necessity" varies from insurer to insurer, but in general a "particular procedure or pattern of treatment must have scientifically provable efficacy, be administered by medical professionals, and be subject to decision-making case by case and treatment by treatment."[22] Also, in general, insurers reimburse providers who are legally defined by individual states as "licensed practitioners." For this reason, Table 3 summarizes the number of states that consider particular therapists to be licensed practitioners. Clearly, the predominant factor cited by managed care companies when selecting providers for their managed care plans was that the provider be licensed or board certified by an officially recognized entity. Other important selection factors were that the provider: (1) possess malpractice insurance; (2) be part of a network of practitioners; (3) follow national quality assurance standards; and (4) be trained in a needed specialty.

Table 3

Therapies or Systems Designated as Having "Licensed Practitioners" by Number of States

CAM Therapy or System	Number of States
Acupuncture	33
Ayurvedic medicine	0
Biofeedback	0
Chiropractic medicine	50
Craniosacral therapy	0
Herbal medicine	0
Homeopathic medicine	3
Massage therapy	23
Midwifery	15
Naturopathic medicine	11
Nutritionists or dietitians	26
Osteopathy	50
Physical therapy	50
Tibetan medicine	0
Traditional Chinese medicine	1

Sources: Maharishi Ayurvedic University, National Center for Homeopathy, American Association of Naturopathic Physicians, Official Office of Tibet, American Association of Acupuncture and Oriental Medicine, East West Academy of the Healing Arts, American Chiropractic Association, American Dietetic Association, Midwifery Alliance of North America, Upledger Institute, Touch Research Institute, American Osteopathic Association, American Physical Therapy Association.
Note: Many states certify practitioners of biofeedback, massage, and other alternative and complementary therapists. However, this table is specifically listing categories of providers who are legally considered "licensed practitioners," and therefore receive insurance reimbursement in those states. Also, California requires reimbursement of all providers who are licensed to provide service if that benefit is offered. However, HMOs can pick and choose their providers.

Literature Review of Hospitals and CAM

From our research, we learned that several hospitals are collaborating with centers that offer CAM or actually have a clinic providing CAM within the hospital. Of the 14 hospitals identified that offer CAM, the most common types offered are eight hospitals with meditation, acupuncture, massage, and nutrition counseling; seven with guided imagery; and six with t'ai chi chuan. Not listed in Table 4 are medical centers that offer an 8-week stress reduction and mindfulness course based on the work of Dr. Jon Kabat-Zinn at the University of Massachusetts Medical Center in Worcester, Massachusetts. Also, several centers offer a behavioral medicine program developed by Dr. Herbert Benson, which includes elicitation of the relaxation response, cognitive-behavioral strategies to enhance coping skills, exercise/activity programs, and nutrition management (Morristown Memorial Hospital in New Jersey, Riverside Methodist Hospital in Ohio, Mercy Hospital and Medical Center in Illinois, Memorial Healthcare System in Texas, Baptist Hospital in Tennessee, and St. Peter's Medical Center in New Jersey). Other hospitals have an acupuncture clinic or offer acupuncture, such as Johns Hopkins in Maryland, University of California at Los Angeles, Kaiser in Vallejo, California, and Cooper Hospital in New Jersey. In addition, other major hospitals are currently considering the addition of a clinic for CAM, such as the Stanford University Hospital of Stanford Health Services (SHS), Mount Diablo Medical Center, Marin General Hospital, and Cornell Medical College.

Some of the hospitals in Table 4 have business relationships with third-party insurers. For example, the Integrated Health Services PPO is capitalizing on the relationship between Grant Hospital and the Chicago Holistic Center.[24] Within the Samaritan Health Systems, Arizona's third largest HMO, members are allowed to pick primary care providers at the Arizona Center for Health and Medicine.[25] Also, participants in the California Pacific Medical Center community wellness center receive a 50% discount if they are HealthNet members.

Interviews with Hospitals

Hospitals from Table 4 that offered the largest number of CAM therapies were selected for interviews. A total of nine hospitals were contacted for interviews, and interviews were completed at seven of these hospitals. Hospital CAM program directors were asked how the collaboration between the hospital and the CAM center was initiated. Two of the programs were started by a senior medical director in one site and one by a senior vice president administrator who was helped by personal clinical success with CAM. Two were started after CAM practitioners suggested the idea to hospital administrators, two were started by hospital administrators interested in responding to consumer demand, and one was started as an expansion of a preexisting pain management program in response to consumer interest. Complementary and alternative medicine program directors were also

Table 4

Hospitals Associated with Centers and CAM Offered

Name of Hospital and Center	CAM Offered			
Columbia/HCA Grant Hospital and American Holistic Center Chicago	Alexander technique Ayurveda Bach flower counseling Biofeedback Body centered therapy Chiropractic	Craniosacral therapy Educational therapy Guided imagery/visualization Homeopathy Hypnotherapy Massage/Shiatsu	Meditation/Relaxation Midwifery/Doula services Naprapathy, naturopathy Nutrition counseling Oriental medicine Psychoneuroimmunology	Psychotherapy Reflexology Reiki, skin care T'ai Chi Chuan Wellness counseling Yoga
Ancilla Systems and Healing Art Center in Mishawaka, Indiana	Acupuncture Aromatherapy Art therapy Ayurveda Biofeedback	Energy work, flower essence Healing touch Herbal therapy Homeopathy Lymphedema treatment	Massage/Shiatsu Meditation/Visualization Mental health counseling Nutrition counseling Reflexology	Reiki Spiritual counseling Stress reduction program T'ai Chi Chuan Yoga
Franciscan Hospital Mount Airy and Franciscan Wholistic Health Center in Cincinnati, Ohio	Acupuncture Aromatherapy Alexander technique Art therapy Biofeedback	Craniosacral therapy Feldenkrais method Guided imagery Healing touch Massage	Meditation Reflexology Self-hypnosis Spiritual counseling T'ai Chi Chuan	Yoga Zero balancing
Mercy Healthcare Arizona of Catholic Healthcare West and Arizona Center for Health and Medicine	Acupuncture Aromatherapy Biofield healing Feldenkrais method	Guided imagery Herbal therapy Homeopathy Mind/Body medicine	Massage Nutritional counseling Craniosacral therapy Spiritual counseling	T'ai Chi Chuan Tragerwork Yoga
St. Vincent Hospital and Center for Complementary Medicine and Pain Management in Indianapolis, Indiana	Acupuncture Art therapy Biofeedback Craniosacral therapy	Energy work Guided imagery Herbal therapy Hypnotherapy	Massage Meditation Nutrition counseling Mental health counseling	Relaxation methods Support groups
University of Miami Hospital and Clinics and The Courtelis Center, Sylvester Comprehensive Cancer Center	Acupuncture Biofeedback Guided imagery	Massage Meditation Mental health counseling	Nutrition counseling Spiritual counseling Physical therapy	Self-hypnosis Support groups
California Pacific Medical Center and Institute for Health and Healing in San Francisco	Art/Movement therapy Guided imagery	Living stories project Psychoneuroimmunology	Stress reduction programs Support groups	T'ai Chi Chuan/Qigong Yoga
St. Luke's Hospital in Cedar Rapids, Iowa, and Center for Health and Well-Being	Healing touch Holistic nurse consultation	Massage Meditation	Reflexology Support groups	T'ai Chi Chuan Yoga
North Hawaii Community Hospital	Acupuncture Chiropractic	Healing/Therapeutic touch Massage	Mental health counseling Naturopathy	
Deaconess Hospital and Division of Behavioral Medicine at Harvard in Massachusetts	Cognitive therapy Exercise	Meditation Nutrition counseling	Relaxation methods Yoga	
Kaiser in Vallejo, California, Vallejo Alternative Medicine Clinic	Acupuncture	Acupressure	Meditation/Relaxation	Nutrition counseling
Imperial Point Medical Center and Center for the Healing Arts in Fort Lauderdale, Florida	Biofeedback	Guided imagery/visualization	Relaxation methods	Support groups
Community Health Center of King County and Bastyr University in Seattle, Washington	Acupuncture	Naturopathy	Nutrition counseling	
Mercy Hospital and Medical Center and Wellspace Program in Chicago, Illinois	Feldenkrais method	Meditation/Visualization	Zero balancing	

Table 5

Obstacles to Incorporating CAM into Mainstream Healthcare

Obstacles	Number of Responses		
	Total (n = 25)	Insurers (n = 18)	Hospitals (n = 7)
Need more research on efficacy	9	8	1
Economics	8	4	4
Ignorance about CAM	6	3	3
Provider competition and division	6	4	2
Need standards of practice and licensing	6	6	0
Fear of change by medical establishment	4	1	3
Cultural biases and prejudice	2	2	0
Lack of utilization data on CAM	2	2	0
Lack of consumer or employer demand for CAM	2	2	0
Lack of insurance reimbursement for CAM	1	0	1
Lack of provider networks including CAM	1	1	0
Resistance to methods of medical establishment	1	1	0

Note: "Economics" refers to any response indicating that financial considerations limited the willingness of insurers, employers, or health care providers to participate in offering CAM. "Provider competition and division" refers to the lack of collaboration and cooperation both among and between CAM and allopathic healthcare providers. .

asked how they decided what therapies to include in their programs. Reasons given and the number giving the reasons are as follows: availability of licensed or certified practitioners (5), advice from a committee of experts (3), therapies supported by scientific research (2), therapies familiar to medical staff and public (2), director's personal experience and interest (2), therapies specific to needs of patients (1), and compatibility with hospital's overall mission (1). None of the seven clinic directors interviewed had any conclusive results yet on the clinical or cost-effectiveness of their CAM programs, but all said that their programs were extremely popular with both patients and hospital administrators, the latter because of the potential of the program to be used as a marketing tool and an additional source of revenue. Three of the directors mentioned in particular that the physicians in their hospitals, some of whom were initially skeptical, were referring an increasing number of patients to CAM providers because of the favorable outcomes.

Summary of Obstacles to Integrating CAM

Table 5 lists the responses of insurers and hospital CAM program directors to the questions: What changes need to be made in order to incorporate CAM into the mainstream? and, What is at the root of the sentiment opposing CAM? In effect, these questions were asked to determine the perceived barriers to the more widespread implementation and/or insurance coverage for CAM. Results in Table 5 list the 12 reasons that were most often cited in descending order of frequency, with "Need more research on efficacy" cited most frequently.

DISCUSSION

In the interviews with insurers, the researchers inquired about 34 specific therapies from the OAM classification of alternative medical practices. The results indicate that some of these therapies are now covered by most insurers (e.g., osteopathy, physical therapy), while other therapies are covered only by a few, smaller insurance companies (e.g., Tibetan Medicine, reflexology). Furthermore, the majority of insurers interviewed do not offer CAM coverage to enhance wellness or prevent disease. Rather, like conventional therapies, CAM therapies are covered only if treatment is medically necessary for a specific diagnosis, and reimbursement is given only for a certain number of visits and/or dollar limit. Thus, although the popular media report that an increasing number of insurers are offering coverage of CAM, the current status of CAM coverage is quite limited. This is not too surprising since for most types of CAM there is limited, if any, research on clinical efficacy and cost-effectiveness.

CAM Coverage

Nonetheless, half of the 18 insurers interviewed are currently looking into additional coverage of CAM. Furthermore, 12 of the 18 insurers interviewed said that market demand is their primary motivation for offering coverage of CAM, and consumer interest was sited as a key factor in determining coverage of CAM. Although insurers also stated that proof of clinical efficacy is an important factor in determining coverage of CAM, the influence of consumer interest on insurers could lead to an increasing number of insurers offering inappropriate coverage of CAM. "Token" or inadequate coverage CAM therapies may be offered mainly to attract new enrollees. This in turn could lead to data indicating that the therapy did not work, when the actual cause was inadequate or token provision of such services. Relevant issues for such scenarios are what constitute an adequate length of care for chronic pain with acupuncture; how effective is homeopathy vs. antibiotics for children with otitis media; what is the appropriate dosage and duration of an herbal remedy for sinusitis or allergic rhinitis; and numerous other issues of what constitutes a clinically defined, effective course of therapy vs. what is allowed or limited in the CAM policy. These are major issues not yet addressed but requiring further research as well as both clinical and cost documentation by managed care, insurer, and hospital providers. Alternatively, the pressure to differentiate from other third-party payors may convince some insurers to offer coverage of a CAM therapy that has not been proven safe or efficacious. Since there is such a range of CAM services being offered with an equally

wide variance in the extent of scientifically based clinical studies to warrant these services, it is certainly possible that some services may be determined as not efficacious and even of potential harm in future research findings.

Legislation is one means of regulating CAM coverage. Indeed, state-mandated coverage of particular therapies was listed as a third dominant factor influencing whether or not insurers would offer coverage for CAM. Also, in general, insurers reimburse services that are provided by a licensed practitioner, although the definition of a "licensed practitioner" varies from state to state. Thus, lobbying for or against state licensure and state-mandated reimbursement of a particular CAM therapy is one avenue by which consumers as well as CAM practitioners are seeking to influence insurance companies.

From the database search, literature review, and selected interviews, we found that several hospitals are collaborating with centers that offer CAM and several others are including stress reduction and behavioral medicine programs in their services. In our interviews with seven hospital CAM directors, the research team inquired why they decided to offer CAM therapies and how they selected particular therapies. Four of the seven CAM programs were started by individuals or practitioners specifically interested in CAM, and three were started to meet consumer interest in CAM. The majority of hospital CAM directors interviewed selected particular therapies based upon availability of licensed or certified practitioners. This suggests that some hospital administrators, like insurers, are responding to consumer interest in CAM. However, hospitals can only offer CAM therapies for which local, licensed practitioners are available. All of the seven program directors said that their programs were growing in popularity among the hospital administration and staff primarily because of the enthusiastic response of their patients. However, since none of the programs have been in existence more than a year, none of the directors could offer any conclusions on the outcomes of their programs.

Obstacles to Using CAM

Among the primary obstacles to incorporating CAM into mainstream health care as listed by insurers and CAM program directors that participated in our study were: (1) lack of research on efficacy; (2) economics; (3) ignorance about CAM; (4) provider competition and division; and (5) lack of standards of practice. Of the obstacles listed, the only one unique to CAM is ignorance about CAM. Research on efficacy is lacking in much of conventional medicine as well as in CAM. Financial considerations are driving mainstream health care reform and are part of what makes it so difficult to meet the different interests of insurers, employers, health care providers, and consumers. Provider competition and division occurs among conventional doctors, nurses, physician assistants, etc., as well as between conventional and CAM providers. Finally, studies of conventional medicine show wide variations in practice by regional economics and cultural norms, which suggests that standards of practice are needed among conventional providers as well as CAM providers.

Study Limitations

Eight of the 18 insurers and all of the seven hospitals were selected specifically because they are reimbursing or offering CAM. Thus, the sample is skewed toward participants who are attempting to incorporate CAM, and conclusions are limited due to the inherently small sample sizes. Also, since each insurer has multiple policies with different restrictions, detailed information on coverage variation within insurers was not obtained. However, copies of actual policies are on file for future review. In addition, the status of insurance coverage of CAM may be affected by changes in legislation, such as the Access to Medical Treatment Act (H.R. 2019, S. 1035, referred to committee as of September 1996), which would allow patients to receive any medical treatment they want so long as the practitioner agrees and the administration does not violate any licensing laws. An additional provision is that a practitioner would be able to provide any treatment so long as it is not a danger to the individual and the individual has been informed that the treatment has not been approved. In addition, a recent statute passed by Washington state requires all insurers to cover claims for "every category of provider," but has not been received well by several of the state's health plan carriers who have filed complaints against this law.[26,27] Results of these and other legislative initiatives around the country, in California, Oregon, Arizona, and Vermont as well as 15 other states, could alter who determines whether coverage of CAM is offered.

Recommendations for Future Research

Based on our research, the following paragraphs contain recommendations for future research focused on clinical and cost outcomes, which address some of these obstacles listed by insurers and CAM program directors that participated in this study.

Since the general area of "CAM" is very broad, a survey of what CAM therapies are considered most useful by allopathic and CAM providers will help determine potentially effective treatments. Such a survey will allow researchers to determine which CAM treatments are most likely to yield clear results in controlled clinical trials. A survey of which CAM therapies are considered useful by consumers will also help determine what treatments may be worth investigating. In addition, it would be desirable to conduct a consumer survey CAM therapy use focused on older adults (> 65), since seniors use health care services the most and are instrumental in shaping future health care trends.

Research that emphasizes the development of common terminology for CAM with both allopathic and nonallopathic doctors is needed to compare outcomes. One aspect of developing common terminology is to develop CPT codes for CAM. Although the AMA is likely to be resistant to this idea, the designation of CPT codes for CAM (even if the CPT code specifies that the treatment is experimental) will allow large studies on the effectiveness of specific CAM. The current lack of CPT codes for

CAM makes it difficult to determine which CAM is being used and what the appropriate reimbursement should be.

Cost-effectiveness analyses are needed on individual clinically efficacious treatments, as well as on combinations of allopathic and complementary treatments. Some of the hospitals associated with centers for CAM (identified in Table 4) may be ideal settings for researchers to test the clinical efficacy as well as the costs and benefits of a variety of treatments. Also, such research could compare the success of integrated allopathic and CAM care to allopathic care only. In addition, integrated clinics serve as educational resources to help reduce ignorance about CAM.

Information needs to be disseminated to combat ignorance about CAM, especially centralized information about how CAM is being considered and used by insurers, employers, and hospitals. (A pilot survey suggests that an increasing number of employers are considering including CAM coverage as one of their bid specifications for competing insurance plans.) This study and follow-up studies are needed to provide information on what other insurers, employers, and hospitals are offering and what seems to be successful in terms of clinical and/or cost outcomes. This information may help facilitate the responsible acceptance of CAM into mainstream health care.

Longitudinal outcomes studies and the creation of outcomes assessment databases will help transcend the politics of the health care community. Evaluating standards for uniform reporting of outcomes such as those under the National Committee for Quality Assurance (NCQA) and the Health Plan Employer Data and Information Set (HEDIS) will increasingly include areas of prevention and ultimately CAM therapy outcomes standards. The Foundation for Accountability (FACCT), located in Oregon and incorporated in November 1995, should prove particularly useful in this endeavor. According to the FACCT brochure, this is a nonprofit organization that will "endorse a series of health system performance measures, advocate widespread adoption of those measures by existing oversight, contracting, and consumer organizations, and promote consumers' use of the data that arise from these measures to make better healthcare decisions." They also state specifically that "the diverse arrangements for delivering and financing healthcare call for measures that are universal in their recognition of the human experience, not specific to any particular setting or system."[28] With this model to evaluate health care, the distinctions among "conventional," "complementary," and "alternative" health care will be irrelevant.

Providers of CAM need to develop standards of practices and licensing, which will help them to fit into the existing diagnosis-based system.[1,15,28,29] This is easier said than done. For example, some complementary therapies are predominantly used as preventive medicine, and therefore cannot be easily evaluated by a diagnosis-based system. In addition, many CAM practitioners emphasize unique treatments for each patient, which makes it difficult to develop standards of practice guidelines.[28] Thus, the integration of complementary therapies that emphasize preventive medicine and a focus on individual variation in treatments would inevitably change either or both the complementary therapy and the current medical model.

Advocates of CAM agree that there is a need for research on CAM standards of practice and licensing, but research funding is already very competitive in general, and even more so for methods that are less mainstream. In addition, a great deal of medical research is funded by pharmaceutical and medical equipment companies who have less to gain from proving the effectiveness of mind/body techniques or herbs that cannot be patented. The NIH Office of Complementary and Alternative Medicine, which has already funded 10 research centers as well as over 45 independent studies, will be helpful in facilitating the evaluation of CAM. However, with a budget of only $7.4 million in fiscal year 1996, additional funding sources are clearly required.

SO WHAT? Implications for Health Promotion Practitioners and Researchers

An increasing number of insurers and hospitals are including CAM in order to meet consumer demand. Motivations for offering CAM range from thorough searches of available clinical efficacy research to questionable attempts to capture market share, attract new enrollees, and/or to retain enrollees by offering inadequately documented services. Both federally funded and managed care/insurance provider research is needed to determine what differentiates clinically effective services from token services, which may not provide adequate time or intensity of the CAM offering to be effective in terms of clinical and cost outcomes. Despite these research caveats, it is equally certain that there is a rapidly growing consumer demand for CAM with or without research evidence and with or without reimbursement due to consumer willingness to pay out of pocket and purchase over-the-counter remedies. However, a great deal more research on clinical efficacy and cost outcomes is needed in order to responsibly include CAM in mainstream health care. Emphasis on what is validated by sound clinical and cost outcomes research rather than what is considered "alternative" or "conventional" will be critical to reducing health care utilization and containing rising medical care costs.

Acknowledgments

Research was supported by a grant (#AR43558) from the National Institute of Arthritis and Musculoskeletal and Skin Diseases; National Institutes of Health—Office of Alternative Medicine; the Fetzer Institute; the Nathan Cummings Foundation; and the American Health Association.

We are grateful for the support of the NIH Office of Complementary and Alternative Medicine, Adeline Hwang, Ann Fyfe, Penny Stroud, Sara Singer, Ellen DiNucci, and Dr. David Eisenberg.

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Appendix A: Interview Questions for Insurance Companies

CAM = Complementary and Alternative Medicine.

Coverage

1. Do you cover chiropractic, acupuncture, nutritional, etc.?
2. For each field of practice covered, what are your policies? Copies of those policies?
3. Do you serve different states? Does your coverage of CAM vary by state? Why?
4. Does your coverage of CAM vary with different employers? Why?
5. What alternative fields of practice do you anticipate covering? Why? When?
6. Do you have a wellness plan? If not, do you anticipate developing one? Why? When?

Coverage: Areas of Investigation

1. How do you decide what fields of practice to cover?
2. What information do you need?
3. In what form do you need this information?
4. Do you have a database to evaluate clinical and cost outcomes of CAM?
5. Would you be interested in co-developing or using such a database?

Criteria for Reimbursement

1. How do you determine whether a patient can be reimbursed for CAM therapy and how much to reimburse?
2. Is there portability of care, that is, if a patient chooses a chiropractor who does not help his condition, can he then go to an acupuncturist or orthopedic surgeon?
3. What kind of coverage limits are imposed? Number of treatments? Cost?
4. What kind of pre-authorizations are required? Do recipients self-refer?
5. Are alternative therapies restricted to specific conditions, for example, a patient can only see an acupuncturist if s/he has chronic pain, or are they broadly available?
6. How does your CAM coverage vary, if at all, with the age of the patient?
7. What age-related factors influence your coverage of CAM?

Definitions

1. Do you believe that currently acceptable Current Procedural Terminology (CPT) is used when in fact alternative medicine procedures are being administered? How often?
2. Do you believe that specific Disease Related Groups (DRG) are used to describe undiagnosed conditions (e.g., "dry wind" described as "sinusitis")? How often?
3. Do you anticipate developing CPTs/DRGs for alternative med.?

Providers

1. How do you select providers?
2. What training do you require of providers? MD? RN? PhD? OD? DO? PA? Other?
3. How do you monitor their effectiveness?

Issues and Obstacles

1. What is your motivation for covering CAM?
2. Are you influenced by lobbying groups? Which ones?
3. What do you perceive to be the greatest obstacles to integrating alternative medicine into mainstream insurance coverage?

Comments

Please comment on the future of alternative medicine in mainstream insurance coverage.

Appendix B: Interview Questions for Hospitals

CAM = Complementary and Alternative Medicine.

1. How was the collaboration between the hospital and your CAM center initiated?
2. How did you decide which complementary and alternative therapies to include in your program?
3. What additional complementary and alternative therapies do you anticipate including in your program?
4. Would you say that including complementary and alternative therapies has been successful clinically?
5. Would you say that including complementary and alternative therapies has been cost-effective?
6. How are you evaluating the success of your program?
7. What do you perceive to be the greatest obstacles to integrating complementary and alternative medicine into mainstream health care?

The basics of defined contribution health insurance

By Vicki Lankarge
insure.com

In the 1980s, managed care was the nation's ammunition of choice to combat runaway medical costs. But the Health Maintenance Organization (HMO) magic bullet turned out to be a dud. Now the latest health insurance concept is called "defined contribution" health plans. These health plans are being heralded in much the same way HMOs were touted in the 1980s. But the concept can be a confusing one, complicated by the fact that health care analysts, researchers, and benefits managers often define it differently.

This first of a four-part series discusses the history of health insurance and introduces defined contributions.
Part 2: What's in it for the employee? examines defined contributions from the employee's perspective.
Part 3: What's in it for the employer? looks at defined contributions from the employer's perspective.
Part 4: What needs to change to make them a reality? explores what needs to happen to make defined contributions widely accepted.

"The term 'defined contributions' has been used to describe a wide variety of very different approaches that employers could use to provide employees with health benefits," says Paul Fronstin, a senior research associate at the Employee Benefit Research Institute (EBRI), a national nonprofit organization based in Washington, D.C.

There are several variations to the defined contribution approach. In one scenario, your employer pre-screens and pre-selects a variety of health plans and then gives you cash (or vouchers) to buy a policy from one of them. The employer contracts with the pre-selected insurers for group health insurance and still retains some control over your health insurance options.

Under the most controversial and yet untested arrangement, your employer hands you a fixed amount of money — let's say $5,000 for the year — and then leaves your health insurance purchase entirely up to you. If you choose a plan costing more than your employer's contribution, you must pay the difference.

Today, the various types of health insurance include:

- **Indemnity plans:** The medical provider submits a claim to the patient's health plan for services rendered. This is also known as "fee-for-service" health insurance. You're free to choose any general practitioner or medical specialist.
- **HMOs:** Health Maintenance Organizations provide members with specific medical services for a fixed price and for a given period of time. With an HMO, you must choose a primary care physician (PCP). This PCP acts as a "gatekeeper" for medical services to specialists. An HMO doesn't allow you to see a physician outside of its network.
- **POS plans:** Point-of-service plans offer more preventive care and well-being services than HMOs, but they also require you to select a PCP.
- **PPOs:** Preferred provider organizations contract with medical providers for a discounted rate on medical services. A PPO allows you to see any physician, but you may have to pay a deductible if you go outside the network. PPO plans pay their physicians on a fee-for-service basis.
- **Cafeteria plans:** A cafeteria plan, also called a flexible spending plan, is an IRS-approved way for employees and employers to save money by reducing pre-tax income when purchasing health insurance and other benefits. It allows you to decide where your benefit dollars will be spent. You can choose to put more of your money into a comprehensive health insurance plan, or set more aside for dependent care benefits, such as child care.

The main difference between the defined contribution approach and cafeteria plans, which are funded with pre-tax dollars, is the tax consequence. If your employer hands you cash to buy your own individual health benefits — in effect giving you a "raise" — the Internal Revenue Service currently considers this money taxable income.

The main difference between the defined contribution approach and cafeteria plans, which are funded with pre-tax dollars, is the tax consequence.

The defined contribution approach offers workers more choice, according to E. Thomas Garman, distinguished fellow in the Association for Financial Counseling and Planning Education, a nonprofit organization dedicated to improving personal financial management education, and the American Council on Consumer Interests, a nonprofit organization that provides research-based information on topics of consumer interest.

"It's especially good for young workers who don't make many claims," says Garman. "Let's say the employer contributes $2,500 annually toward its workers' health insurance. A 24-year-old in good health can shop around and probably find suitable coverage for around $1,000 a year. He or she is then ahead by $1,500."

But the defined contribution system is not without drawbacks, not the least of them being the tax disadvantage for workers. However, even if the current tax laws were changed to favor a system of defined contributions, you could still stand to lose two of the major benefits of group health insurance: the cheaper premiums that come with a group plan's increased purchasing power, and protection against exclusion from coverage of your (and your dependents') pre-existing medical conditions.

The reality today is that there are few insurers that offer individual health plans, according to Fronstin. Given the small numbers of these insurers and the degree of difficulty that people currently have in obtaining coverage under individual plans due to pre-existing medical conditions, Fronstin cautions, "There's not even a market out there right now for these people to go to." For more information on this type of coverage, see Tips for buying individual health insurance.

"There's not even a market out there right now for these people to go to."

Whether you view the defined contribution approach as positive or negative, one fact is certain: It shifts the financial and decision-making responsibility for your health insurance from your employer to you.

Continue to Part 2: What's in it for the employee?

This first of a four-part series discusses the history of health insurance and introduces defined contributions.
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Part 2: The basics of defined contribution health insurance

By Vicki Lankarge
insure.com

What's in it for the employee?

As an employee, the biggest advantage of defined contribution health insurance is that it offers you control over your own health care. You decide which benefits you need and how much you're willing to pay for them. But do you *really* want the responsibility that comes with this freedom of choice?

When your employer hands you the reins to your own health insurance, you're responsible for comparing the different plans, making the final decision, filling out all the paperwork, and for making sure the premiums are paid on time.

You should know the answers to a minimum of 14 questions for each insurer you investigate before buying health insurance, according to the National Association of Insurance Commissioners:

- What does the plan pay for?
- What does the plan not pay for/exclude?
- What are the limits on pre-existing medical conditions?
- Will the plan pay for preventive care, immunizations, well-baby care, substance abuse, organ transplants, vision care, dental care, infertility treatment, durable medical equipment, or chiropractic care?
- Will the plan pay for prescriptions?
- Will the plan pay for mental health benefits?
- Will the plan pay for long-term physical therapy?
- Do rates increase as you age?
- How often can rates be changed?
- How much do you have to pay when you receive health care services (co-payments and deductibles)?
- Are there any limits on how much you must pay for health care services you receive (out-of-pocket maximums)?
- Are there any limits on the number of times you may receive a service (lifetime maximums or annual benefit caps)?
- Has the company had an unusually high number of consumer complaints?
- What happens when you call the company's consumer complaint telephone number? How long does it take to reach a real person?

But it doesn't end here. Once you've researched potential insurers, you must make cost comparisons. The cheapest health plan won't necessarily be the best value. You must decide which benefits meet your personal and/or family needs and compare costs between types of health insurance plans and the insurers who offer them. This is what employers should do before they contract with health insurance companies.

You may be in for sticker shock.

You may be in for sticker shock, particularly if you have to buy individual health insurance on the open market. "There is no such thing as an average premium in the individual market," says Deborah Chollet, a senior fellow researching the individual health insurance market for Mathematica Policy Research, a Washington, D.C., think tank. According to Chollet, individual policies are underwritten to take into account your age, gender, health status, occupation, and even the ZIP code in which you live.

Chollet's research into the individual market has turned up wide variations in premiums. For example, in Seattle, Wash. (where state insurance regulations actually prohibit gender from being used as a factor in setting health insurance premiums), a healthy 20-year-old in one ZIP code pays $1,400 annually in individual health insurance premiums, while a slightly older, but still healthy, 25-year-old pays $2,328 in a different ZIP code.

The discrepancy between premiums in different ZIP codes rises dramatically with older insureds. In Seattle, a healthy 60-year-old in the "cheaper" ZIP code pays $3,732 annually for premiums in the individual market, while a healthy 60-year-old shells out $8,724 in the "expensive" ZIP code. And this is for the same amount of coverage for a healthy 60-year-old adult. There is nearly a $5,000 difference in premium and the only factor that is changed in the equation is the ZIP code — never mind a pre-existing condition which could very well nix the chance that the individual would even be offered a policy, or, at the very least, would raise the premiums even higher.

Factors other than personal characteristics drive up rates as well. Drug

prices are soaring, rising twice as fast as the inflation rate, according to the Center for Policy Alternatives, a nonpartisan Washington, D.C., legislative think tank. According to the Kaiser Family Foundation's "Employee Health Benefits Annual Survey 2000," 67 percent of employers surveyed say that higher spending for prescription drugs is contributing "a lot" to health insurance premium increases.

In light of the complicated nature of choosing good quality, cost-effective health insurance plans, current research shows that workers aren't sure they're up to the task. Forty-three percent of the workers surveyed in the "2000 Health Confidence Survey," conducted by the Employee Benefit Research Institute (EBRI), say they are either "extremely" or "very" confident that the employer sponsoring their health insurance has selected the best available health plan for its workers. In contrast, only 32 percent of those polled say they are confident in their own abilities to select the best health plan if their employer should stop offering health insurance, and 25 percent say they are "not too confident" or "not confident at all."

Studies show that increased stress is a consequence of the additional responsibility that comes with managing your own 401(k), according to EBRI senior researcher Paul Fronstin. That burden is likely to be compounded with a defined contribution health plan, he says. In a worst-case defined contribution scenario, your employer may opt for the "Yellow Pages" approach, as in, "Here's your money and here's the telephone book: Have a nice day." Even if you're a savvy consumer, armed with information, you may feel overwhelmed by the task.

Fronstin questions whether the increased choice offered by the defined contribution philosophy is always a plus for the consumer. The sickest workers, he says, are the ones most likely to frequently use their health insurance, encounter problems, and complain. But because they're in the minority, their complaints are not likely to drive change in the individual insurance marketplace. If they have a wide choice of insurers, those who are unhappy may simply switch plans. The original insurer is probably glad to see its sickest (and most costly) members drop out.

Here's your money and here's the telephone book. Have a nice day.

That changes under a group plan. Let's say one insurer provides health coverage for an employer's group of 10,000 workers. If the sicker members are unhappy and can't opt out of the plan and obtain coverage somewhere else, they will go to the employer to complain. Then the employer has the clout to demand that health insurance problems be addressed or it can threaten to take its business elsewhere.

The defined contribution idea that employers would simply add to their

workers' paychecks to purchase health insurance and that their employees would spend the money wisely is troublesome and raises questions that no one has yet answered, says Dr. Harvey S. Frey, director of the Health Administration Responsibility Project (HARP) in California.

"What forces, if any, will guarantee that [the employer's money] is used to buy health insurance rather than a large-screen TV?" asks Frey. "Will this result in an increase in the number of those voluntarily uninsured? How will they be handled when they or their families need medical care?"

Continue to Part 3: What's in it for your employer?

The first part of this four-part series discusses the history of health insurance and introduces defined contributions.
Part 2: What's in it for the employee? examines defined contributions from the employee's perspective.
Part 3: What's in it for the employer? looks at defined contributions from the employer's perspective.
Part 4: What needs to change to make them a reality? explores what needs to happen to make defined contributions widely accepted.

Part 3: The basics of defined contribution health insurance

By Vicki Lankarge
insure.com

What's in it for the employer?

As far as employers are concerned, the jury is still out on the merits of a defined contribution approach to health insurance. The greatest advantage for employers is that it allows them to focus more on their core business and move away from the business of providing employee health benefits. It also gives them tighter control over benefits spending. Because employers can't raise their employees' contribution as fast as health care costs are escalating, the defined contribution approach allows them to draw a line in the sand by saying, "Here's what we're giving you for your health benefits. If you want more, you have to pay the difference."

If you want more, you have to pay the difference.

Yet a majority of the employers surveyed by the Employee Benefits Research Institute (EBRI) express their reservations about defined contributions. Most (84 percent) say they believe some of their workers would not get coverage under such a system, either due to chronic illness, or because they couldn't afford it, or because they felt they didn't need the coverage.

And, while the majority (55 percent) say it's impossible to predict the impact that a general move to a defined contribution approach would have on the overall cost of health insurance, 28 percent say they believe it would actually raise costs, while only 8 percent say they believe it would lower costs.

Despite much media speculation, no major employer has publicly announced a plan to give workers a fixed annual cash amount and let them pick their own individual health insurance plans (the most controversial defined contribution approach). In fact, employers as a whole are lukewarm about the whole idea, according to consulting giant William M. Mercer Inc.

Many employers are reluctant to tinker with their employees' benefits.

Only 5 percent of the employers surveyed in Mercer's December 2000 study on employer-sponsored health plans say they would be "very receptive" to the defined contribution approach, even if the nation's current tax laws were changed to favor it. (The survey is statistically weighted to represent nearly 600,000 employers. For additional information on the Mercer study, read More employers to pass health costs on to workers.)

Furthermore, employers are reluctant to tinker with their employees' benefits. Their concern is that a defined contribution health plan may be viewed by their workers as a benefit take-away, rather than an enhancement — a ploy solely to reduce the employer's expenses and involvement with workers' complicated health care decisions. "Defined contributions have gotten some really bad press," says Blaine Bos, a consultant with William M. Mercer. "And in a tight labor market, many employers are reluctant to upset workers with 'bad' news about their medical benefits."

Xerox learned that lesson last year when a company official spoke at a conference sponsored by the Robert Wood Johnson Foundation, a national philanthropy dedicated to improving health care, and said the company was planning to move toward a defined contribution approach. The news sparked a major employee protest and a firestorm of media coverage. Xerox has since publicly backed down from its plan.

Despite serious misgivings, the talk continues

While employers are reluctant to be the first to adopt defined contribution health plans, interest in and discussion about these plans will continue, according to Sally Trude, a researcher for the Center for Studying Health System Change (HSC), a non-partisan policy research organization based in Washington, D.C. In speaking with employers for an HSC article on defined contributions, Trude says she found that while companies are being careful not to jump too quickly on the defined contributions bandwagon, their interest in the approach is being fueled "mostly by the overall lack of vision" being provided by the nation's economic and political leaders in solving the current health insurance crisis.

And the discussions will continue because employers are just plain reluctant to be the middleman in their workers' personal health care decision making, according to Heather Loebner, a consultant with accounting and human resource services giant PricewaterhouseCoopers. "Employers are asking themselves, 'Why should we be so involved in whether Sally Jo's husband's Viagra is covered?'" Loebner says.

Continue to Part 4: What needs to change to make them a reality

The first part of this four-part series discusses the history of health insurance and introduces defined contributions.
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Part 4: What needs to change to make them a reality? explores what needs to happen to make defined contributions widely accepted.

Part 4: The basics of defined contribution health insurance

By Vicki Lankarge
insure.com

What needs to change to make them a reality?

For an employer to be the first to step up to the plate and adopt a defined contribution system, sweeping changes would have to take place. The largest would have to be a change in the tax code, allowing workers to deduct the cost of their health insurance premiums from their taxes. Additionally, an economic recession would loosen the tight labor market and employers would worry less about using their health benefits package as a prime way to attract and retain workers. Further, few choices for individual health insurance currently exist.

"No one is going to flip a switch and everyone wakes up tomorrow with a defined contribution health plan."

Factors that will continue to fuel the interest in defined contribution health plans include:

- Congress continues to debate a Patients Bill of Rights, which could remove ERISA protection for employers, putting them at a higher risk for being sued over health plan coverage decisions.
- More healthy workers are seeking the choice to drop full-service managed care plans and select low-cost, high-deductible "catastrophic" coverage.
- More workers are demanding access to services often not covered by their HMOs, including infertility treatment or alternative medicine, such as chiropractic care or acupuncture. The number of Americans using an alternative therapy increased from about 33 percent in 1990 to more than 42 percent in 1997, according to the National Center for Complementary and Alternative Medicine, an office of the National Institutes of Health.

Other changes may prove too difficult to bring about a move toward defined contributions. They include:

- Labor unions may have to support the defined contribution approach and view it as an enhancement to their health benefits packages, rather than a take-away.
- Insurers would have to find ways to form alternative risk pools to accommodate individual policyholders. Insurers like to cover large groups, not only for the premiums, but also because they come to the insurer as the only "naturally occurring" group that doesn't form expressly for the purpose of buying health insurance. That means the pool contains healthy as well as sick members. If only the "sick" employees who needed to take advantage of insurance joined a particular plan, the high number of resulting claims could cause the payouts of the plan to soar and threaten it with financial collapse, a phenomenon known as "adverse selection."

When all is said and done, the defined contribution approach is probably best seen as a long-range option, a transition from the managed care model on our way to somewhere else, according to Loebner. "No one is going to flip a switch and everyone wakes up tomorrow with a defined contribution health plan," she says.

The first part of this four-part series discusses the history of health insurance and introduces defined contributions.
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Note to Commissioners:

The American Hospital Association, in its annual hospital survey, now collects data on the number of hospitals that offer CAM services. The data is available for two years, 1998 and 1999 – and is attached.

The survey provision reads as follows:

> **Complementary medicine services. Organized hospital services or formal arrangements to providers that provide care or treatment not based solely on traditional western allopathic medical teachings as instructed in most U.S. medical schools. Includes any of the following: acupuncture, chiropractic, homeopathy, osteopathy, diet and lifestyle changes, herbal medicine, massage therapy, etc.**

A copy of sections of the survey tool are available if you would like further information about the hospital survey.

In addition, the American Hospital Association now offers a "turn key" consulting product for implementing CAM services in the hospital setting.

Community Hospitals Offering Complementary Medicine Services By Census Region and Bed Size, 1998 and 1999

Region	1998	1999	Percent Change
New England	30	41	36.7%
Middle Atlantic	65	86	32.3%
South Atlantic	53	57	7.5%
East North Central	92	120	30.4%
East South Central	12	15	25.0%
West North Central	37	69	86.5%
West South Central	27	30	11.1%
Mountain	13	26	100.0%
Pacific	23	31	34.8%
US total	352	475	34.9%

Number of Beds	1998	1999	Percent Change
Under 25	5	8	60.0%
25 to 49	30	47	56.7%
50 to 99	42	48	14.3%
100 to 199	78	105	34.6%
200 to 299	60	90	50.0%
300 to 399	42	67	59.5%
400 to 499	28	35	25.0%
500 or more	67	75	11.9%
US total	352	475	34.9%

SOURCE: Health Forum, 1998 & 1999 AHA Annual Survey of Hospitals

These data include only hospital-based services as reported by responding community hospitals on the 1998 and 1999 Annual Surveys.

Complementary medicine services include acupuncture, chiropractic, homeopathy, herbal medicine, massage therapy, etc.

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PARTNERSHIP OFFERS HOSPITALS TOOLS TO MEET CONSUMER DEMAND FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE

SAN FRANCISCO (11/2/00) - The Health Forum, a subsidiary of the American Hospital Association (AHA), today announced its collaboration with Integrative Medicine Communications to help hospitals meet the growing demand for complementary and alternative medicine services.

The number of community hospitals offering these types of services jumped by one-third from 1998 to 1999 - with more than 11 percent of hospitals utilizing services - according to the American Hospital Association (AHA) Survey of Hospitals, the results of which will be published later this year.

Through the partnership, health care organizations that want to develop or expand CAM programs, centers or treatment options to patients can obtain resources to do so.

"We are seeing a dramatic move toward complementary and alternative medicine because patients are asking for it," said Neil Jesuele, AHA executive vice president and president of Health Forum. "We are committed to responding to this demand by providing first-class services that support our members developing sound clinical and business practices in integrative medicine."

Integrative Medicine's CEO Jan Bruce said, "This joint program is especially gratifying for us. Having always focused on providing information solutions that professionals recognize as the source of scientific information in this field, we feel that this initiative further establishes our

position as the provider of choice for integrative medicine development."

The services that will be made available to hospitals consist of four core components:

- **Integrative Medicine Business Advisory Services** - An in-depth, continuous report program for health care professionals offering strategic planning and implementation solutions, financial guidelines, and complementary and alternative medicine feasibility case studies.

- **Professional Medical Tools** - The scientifically researched and peer-reviewed information service on complementary and alternative medicine, which includes in-depth analysis of: treatment options, herbs and supplements, interactions and depletions, as well as modalities and practice guidelines. The tools are tailored to meet an institution's needs and are designed to help physicians make clinical decisions.

- **Interactive Consumer Education Services** - Developed by independent health delivery and wellness experts, the education services provide the tools for consumers needing scientific information on complementary and alternative medicine.

- **Training and Educational Programming** - Ongoing training and educational programs that enable organizations, in a seminar-based environment, to initiate or enhance business and clinical practices for complementary and alternative medicine programs, clinics or treatment options. .

"This opportunity underscores Integrative Medicine's commitment to offer unbiased products and premier services that continually improve the delivery of health care," said Bruce.

Health Forum's partnership with Integrative Medicine is one of several initiatives taken to help hospitals meet consumer demand for complementary and alternative medicine services. Other Health Forum efforts have included providing information on these services to hospitals through educational programs, conferences, Health Forum publications and manuals.

The AHA is a not-for-profit association of health care provider organizations and individuals that are committed to the health improvement of their communities. The AHA is the national advocate for its members, which includes 5,000 hospitals, health care systems, networks, other providers of care and 37,000 individual members. Founded in 1898, the AHA provides education for health care leaders and is a source of information on health care issues and trends. For more information, visit the AHA Web site at www.aha.org.

Health Forum is the enterprise created through the union of The Healthcare Forum and the American Hospital Association's publishing and data and information subsidiaries. Health Forum offers health care leaders access to new information and fresh ideas, which they can use to strengthen their organization's clinical and business performance. Its Web site is www.healthforum.com.

Integrative Medicine (www.onemedicine.com) is an information services company empowering healthcare professionals, consumers and executives to combine the best of conventional and alternative medicine for optimal healthcare. The Company delivers a suite of unbiased, science-based clinical information for professionals and consumers as well as

unrivaled business intelligence and advisory services. The Company's primary focus is in four main areas: professional clinical information, consumer clinical information, professional training, and the business and implementation of integrative medicine. The Company serves individual healthcare providers as well as large institutions, professional associations and information providers including HealthGate, the American Society of Health System Pharmacists, the American Academy of Physician's Assistants and Health Trust Alliance. Integrative Medicine's products are not sponsored by any manufacturer and are peer reviewed by a 87-member board of health professionals.

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Note to Commissioners:

The following information on direct reimbursement for dental services was provided by the American Dental Association.

DR IMPLEMENTATIONS

2001 Results as of March 28, 2001:
108 new DR plans
25,225 covered employees
59,127 covered lives

2000 Year End Results:
432 new DR plans
60,538 covered employees
141,901 covered lives

Cumulative Totals:
3256 total DR plans
624,600 covered employees
1,464,062 covered lives

Direct Reimbursement is an innovative approach to self-funding employee dental benefits. It is strongly supported by the American Dental Association as a cost-effective way to provide a dental plan for employees that gives them the freedom to choose their dentists.

How it *works*

One of the most attractive features of a Direct Reimbursement dental plan is its simplicity of operation. Under a Direct Reimbursement (DR) plan, the employee and covered dependents visit the dentist of their choice, receive the necessary treatment and usually pay the dentist's bill directly to the dental office. The employee then presents a paid receipt or other proof of treatment to the employer or its third-party administrator and is reimbursed for all or part of the expense, depending on the plan design.

Benefits are stated as a maximum dollar limit per year per eligible individual, or a percentage thereof. Reimbursement is based on dollar expenditures rather than on treatment received. Unlike conventional plans, there are typically no exclusions and few if any limitations on specific treatments.

Unlike medical costs, dental costs are low enough for the employees to participate in the cost of treatment, and to make sure that the work is satisfactory. In other words, with Direct Reimbursement, the plan sponsor expects the employees to be responsible for the best use of the benefit dollars available. Additionally, employees are involved in the cost containment process through cost-sharing provisions such as annual maximums and co-payments.

Flexibility

The details of a Direct Reimbursement plan may vary widely depending on the level of benefits the employer wishes to provide. The employer is in total control of the plan design and customizes the plan to meet its specific needs and budget requirements. Some of the options to be considered in designing the plan include:

- employees only or employees and dependents
- co-payment provisions
- annual benefit maximums (individual or family)
- immediate benefits or a waiting period for eligibility

Several examples of possible Direct Reimbursement benefit designs illustrate this flexibility:

PLAN A

100% of the first $100 of dental expenses
80% of the next $500
50% of the next $2,000
total annual maximum benefit of $1,500 per individual*

PLAN B

100% of the first $100 of dental expenses
80% of the next $250
50% of the next $2,000
total annual maximum benefit of $1,300 per individual*

PLAN C

100% of the first $100 of dental expenses
80% of the next $500
50% of the next $1,000
total annual maximum benefit of $1,000 per individual*

PLAN D

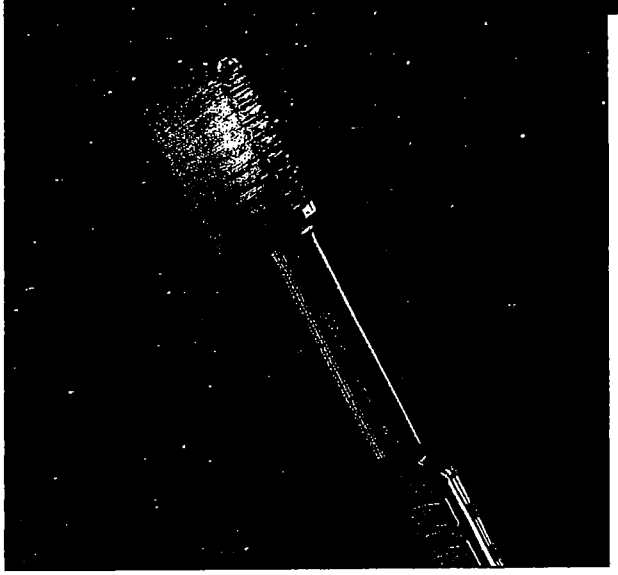
50% of $1,000 of dental expenses
total annual maximum benefit of $500 per individual*

The variations on the concept are limited only by the degree of financial commitment the employer is prepared to make. An employer may begin its plan by offering a conservative annual maximum. After analyzing a few years' experience with the plan, the employer may revise the benefit levels.

** Totals could be a family maximum*

DIRECT REIMBURSEMENT

An Introduction



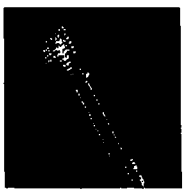
The **Dental** Benefits Plan *for* **Smart** *Companies*

ADA.

Direct Reimbursement: An Introduction

Direct Reimbursement (DR) is an innovative approach to self-funding a company's dental plan. DR is strongly supported by the American Dental Association and many benefits professionals as a simple, cost effective way to provide a dental plan for employees — one that gives them complete freedom to choose their dentists.

In this brochure, you'll find the most common questions employers raise regarding Direct Reimbursement dental plans. Once you've read the material, we think you'll agree that Direct Reimbursement is the dental benefits plan for smart companies.



First Questions

What is Direct Reimbursement?

Direct Reimbursement (DR) is a simple, cost-effective dental plan that guarantees you the following important benefits:

- No premiums. Instead, you pay when actual treatment is received.
- Virtually all of the money spent goes toward dental treatment — *not* to extraneous overhead or administration.
- Employees are free to visit any dentists they choose, including their current dentists.
- Potential cost savings, decreased employee complaints about plan restrictions and ease of administration — all from a dental benefits concept so *simple* you won't believe you never thought of it yourself.

DIRECT
REIMBURSEMENT

How does Direct Reimbursement work?

Under a Direct Reimbursement plan, the employee and covered dependents visit the dentist of their choice, receive the necessary treatment and typically pay the dentist's bill directly to the dental office. The employee then presents a paid receipt or proof of treatment to his/her employer or to the TPA (third-party administrator) who administers the plan, and the employee is reimbursed according to the straight-forward plan design. Plan designs are selected by companies based on their budgets and therefore vary accordingly.

How is DR unlike other dental plans?

With DR, benefits are based on *dollars spent* on dental care rather than on *type of treatment* received. This eliminates detailed claims reviews and hassles about what is covered and what isn't. Unlike some dental plans, DR frees patients to plan treatment with their dentists alone. The ADA promotes DR as part of its continuing effort to see that patients are free to select any dentist for care, including their current dentist.

I'm looking for a plan that allows me to control costs within my budget. Is DR flexible in this way?

Yes. The details of a Direct Reimbursement plan may vary depending on the level of benefits the employer wishes to provide. Some of the options to be considered in designing the plan include:

- employees only or employees and dependents
- co-payment provisions
- annual benefit maximums (individual or family)
- immediate benefits or a waiting period for eligibility

Several examples of possible Direct Reimbursement benefit designs illustrate this flexibility:

Example A

100% of the first $100 of dental expenses
80% of the next $500
50% of the next $2,000

Maximum Annual Benefits Paid: $1,500*

Example B

100% of the first $100 of dental expenses
80% of the next $250
50% of the next $2,000

Maximum Annual Benefits Paid: $1,300*

Example C

100% of the first $100 of dental expenses
80% of the next $500
50% of the next $1,000

Maximum Annual Benefit Paid: $1,000*

Example D

50% of $1,000 of dental expenses

Maximum Annual Benefits Paid: $500*

** These totals can represent either an individual or a family maximum.*

The variations on the concept are limited only by the degree of financial commitment the employer is prepared to make. An employer may initially want to offer a conservative annual maximum. After analyzing a few years' experience with the plan, the employer may choose to enhance the benefit levels.

By eliminating exclusions and limitations on treatment, DR allows patients the freedom to plan the appropriate treatment with their dentist with no interference from a third-party payer or insurance company. At the same time, DR allows employers to ultimately *control* costs by the plan design and annual maximum.

How do I design a DR plan?

Your benefits consultant or broker may have information for you to use when designing a DR plan. In addition, American Dental Association staff, and in some cases, state or local dental society staff, all are available to assist you with any questions or concerns you may have. Of course, your attorney, benefits consultant or CPA should review the plan to make sure it complies with all applicable laws.

Will Direct Reimbursement work for companies of any size?

Yes. Both large and small employers have instituted Direct Reimbursement programs to assist employees. With Direct Reimbursement, an employer can individualize the plan to suit the needs of the employees while creating the maximum benefit provisions to satisfy the company's financial goals.

Do employees like Direct Reimbursement?

Yes. Direct Reimbursement offers significant advantages to employees, who appreciate the following benefits:

- DR allows employees to receive treatment from the dentists of their choice.
- With DR, employees can easily calculate, in advance, what their share of their dental expense will be.
- Employees receive benefits for all types of dental needs, not limited to insurance plan restrictions. (Traditional forms of dental benefits plans may discriminate based on age by covering *fully* the needs of young employees and covering only *partially* the needs of older employees. DR covers all procedures — from cleanings to prosthodontics to periodontics — equally.)

Direct Reimbursement plans typically require that the patient must pay the full bill "up front" before receiving reimbursement from the employer. Does the policy cause employees to put off needed dental treatment?

Current available data on Direct Reimbursement indicate that utilization of Direct Reimbursement dental plans does not differ significantly from that seen with other types of plans. However, if "up front" payments do present a problem for some patients, the flexibility of a DR plan design may allow employers to establish reimbursement mechanisms to counter the situation. The design of a Direct Reimbursement plan should be adapted to the needs of the employer and the patient.

For example, if credit card payments are accepted by a dentist, and reimbursement is prompt, the patient may charge dental services and receive the reimbursement before the credit card payment is due. In some instances, patients may establish a deferred payment plan with the dentist.

Also, if the employer chooses, reimbursement to the patient can be made upon the presentation of proof of treatment, rather than proof of payment. Some companies arrange for an "authorization of payment" (or "assignment of benefit") directly to the dentist. In these ways, the up-front payment can be greatly reduced or avoided altogether.

An added advantage of Direct Reimbursement is that if the employee does have to pay the dentist prior to reimbursement, the employee can know, in advance, exactly what the final out-of-pocket expense will be. (Under plans which pay the benefit based on "usual and customary" or on a fee schedule basis, the final calculated amount of benefit may not be known in advance.) Again, as long as employee reimbursements are prompt, up front payment by the patient probably won't be a problem in the first place.

Direct Reimbursement plans do not have usual and customary or fee schedule limits. How will I control my costs without these mechanisms in place?

Usual, customary and reasonable (UCR) fee determinations, and fee schedules, have been established by insurance companies to determine payment limits for dental benefits. These controls were considered to be necessary to limit the insurer's exposure to losses. This system was already used with medical insurance, so the system was extended to dental plans.

Dental plans based on UCR determinations or fee schedules typically insulate patients from dental costs. Consequently, the patient may have little awareness of or involvement in the direct payment of dental costs. On the other hand, Direct Reimbursement enhances patient involvement and awareness of dental costs and payment. The patient will determine whether the charges made for dental treatment received are reasonable. Patients become involved in the plan by their participation with co-payments, annual maximums and, when required, "up front" payment of the costs of treatment.

Direct Reimbursement benefits are expressed in terms of dollars only. This means that the dentist's charges are important to an employee, since the plan design encourages the employee to make the most efficient use of the benefit dollars. Under Direct Reimbursement, patients have the freedom to receive treatment from the dentist who they feel will give them the best value for their dental benefit allowance.

Cost & Funding Questions

A Direct Reimbursement dental plan gives the employer immediate control over the level of benefits offered. By instituting cost sharing measures into the plan design (e.g. co-payments and annual maximums), the employer is protected against discretionary utilization and wide fluctuations in benefit costs.

Unlike conventional insured programs where the premium rate is frequently determined by the pooled experience of many groups, the expense for a Direct Reimbursement program is based only on the company's experience, plus applicable TPA or benefit consultant fees, if any. In addition, employer funds that are typically held in reserve and invested by a third party are held and invested by the employer to generate additional interest income which may be applied against the cost of the program.

Perhaps the most clearly discernible savings to the employer is in the minimal administrative costs of a Direct Reimbursement plan. The simplification of claim forms and other extraneous paperwork reduces much of the transactional costs of administration. Further, a Direct Reimbursement program has no premium tax liability as do conventional insurance plans. Finally, a decision to self-administer the program may greatly reduce the charges usually made by an insurance company for overhead, such as marketing costs and profit-and-risk margins.

Brokers, benefits consultants, the ADA and/or your local dental society can recommend options for developing an administrative system, if your company does not already have one. In a small company, DR administration may simply take the form of a spreadsheet program. The ADA makes available information about Direct Reimbursement administrative software programs that will assist companies with this function. Moreover, the employer may elect to have a third-party administrator (TPA) manage the Direct Reimbursement plan. Whether an employer chooses to self-administer or use the services of a TPA, the savings in administration and overhead that a DR plans offers can be significant.

How can I estimate how much a plan will cost?
Because Direct Reimbursement is a self-funding strategy, costs will vary from month to month. There are no monthly premiums. Therefore, an employer incurs no expense until an employee receives dental treatment and requests reimbursement.

Although it is impossible to state an exact monthly cost for a Direct Reimbursement plan, dental expenses are quite predictable. The ADA and many state dental societies offer cost estimates to companies upon request. Through a formula designed by a national actuarial firm, trained association staff can help companies to closely estimate the cost of a DR plan, based on simple data supplied by the company. Your broker, benefits consultant, the ADA and many state dental societies are available to provide DR cost estimates to employers upon request

Should employees contribute to plan cost?
This is up to the individual employer. However, it should be kept in mind that by virtue of the plan design, employees do contribute by sharing the cost of treatment. Most people do not incur extensive dental costs in a given year, so a significant regular payroll deduction could easily exceed their annual routine expenses.

If a company designs a plan for 250 individuals with an annual maximum of $1,000, will it spend the full $250,000?
This is highly unlikely. While that is the maximum potential cost of the program, it is not at all close to the actual experience of any Direct Reimbursement dental plan known to the American Dental Association. Plans do not reach their maximum potential for several reasons. First, as a national average, approximately 40-45% of all people with dental benefit coverage do not receive any dental treatment in any given year. Second, of those who do receive treatment, most incur dental costs of less than $200 a year. Employers who are especially concerned about the risk of self-funding can explore purchasing stop-loss insurance to cover the risk of excessive claims.

Without monitoring by a third party payer or insurance company, does Direct Reimbursement increase the possibility of fraud on the part of the dentist and employee?
Documented cases of fraud in dental benefits plans are extremely rare Nevertheless, the cost sharing aspect of Direct Reimbursement plans is important because it helps control abuse by both patient and dentist. The use of a claim form with both the dentist's and the employee's signature also helps to assure a valid claim.

If an employer is especially concerned about fraud, it may elect to periodically verify claims and notify employees that falsified claims may be grounds for disciplinary action. Fraud on the part of the dentist may result in loss of license to practice and/or prosecution. In addition, a TPA or benefits consultant can serve this function by monitoring usage and patterns among employees, as part of its normal administrative services.

Administrative Questions

By removing many of the complex administrative features associated with most dental plans (e.g. detailed claim forms and service limits and exclusions), a Direct Reimbursement (DR) plan is well-suited to employer self administration or to a third party administrator (TPA).

The only routine administrative actions are: 1) verifying patient eligibility; 2) calculating the benefit reimbursement; 3) issuing the reimbursement check; 4) maintaining records of amounts paid to each employee; and 5) educating employees about DR.

Simple documents required to be filed with the federal government, such as IRS disclosure reports and summary plan documents, may be prepared by qualified in-house staff, third-party administrators (TPAs), benefits consultants or brokers.

As with all types of benefits plans, an employer may consider retaining the services of an experienced benefits consultant in order to establish an appropriate plan design and effective administrative procedures. The employer may also elect to have their current TPA administer the DR plan.

Where do I go to find a TPA?
Seek out a company that specializes in benefits plans. In addition to your broker or benefits consultant, the ADA and your state or local dental society may be able to assist you in identifying some of the third-party administrators in your area who administer DR plans for companies similar to yours.

Even if administration of a Direct Reimbursement plan is done in-house, aren't there still costs involved?
There are administrative costs involved with any program. Direct Reimbursement administrative costs are generally harder to identify than those of an insured plan. Aside from the costs associated with employee communications, administration may be simply a small portion of each day's clerical functions, rather than a specific individual's or department's full-time concern. Administering DR is usually as easy as a simple check-writing process.

Even if an employer chooses to have a third party administrator manage the reimbursements and the necessary record keeping, the charges for these services are usually less than those associated with other kinds of dental plans due to this same simplicity that DR offers.

Direct Reimbursement puts employers directly in contact with the claims process. Doesn't this also put them in the uncomfortable position of being responsible for claim review or denial?

Yes, but that position should not be uncomfortable under a Direct Reimbursement program. The only reasons for claim denial would be in a case where the employee was not eligible for the benefit or had reached the maximum benefit payment, or if the claim appeared to be fraudulent. In the first two cases, the basis for denial could be easily documented, and would not be a problem for the employer. In the case of fraud, the employer will need to be closely involved since such deception may be grounds for disciplinary action.

The other side of the employer involvement with the claims process is that the employees receive the benefit in the form of a check paid directly from the employer. This helps the employees to realize that the benefit is real money, paid by the company they work for, to assist in payment for their dental care.

Can Direct Reimbursement work with flexible spending accounts?

Yes. Section 125 of the IRS code permits employers to establish a plan under which employees can elect to set aside a portion of their salaries or wages by designating a specific amount of their pre-tax dollars to be deposited into a fund. These funds are called flexible spending accounts (FSAs). Each individual fund is then used for reimbursement of the contributing employee's health, dental and/or other allowable expenses for the upcoming year that are otherwise not covered or reimbursed under other plans. The employee determines the amount to be deducted from his/her gross wages each pay period. A conservative estimate of these expenses may be advised since funds which are deposited in the FSA but not spent in a given year are forfeited, according to the IRS code.

Under a Direct Reimbursement plan, the employer would reimburse the employee the portion determined by the design of the plan. The employee could then be reimbursed for the balance from the funds in the FSA. This results in the employee being able to pay for these expenses with pre-tax income.

An additional benefit of this arrangement is that the employer and employee each experience tax savings on the money in the fund. Employees do not pay income tax on the contributed amounts, and since the funds do not qualify as income, the employer is not responsible for paying wage sensitive taxes (e.g. FICA and FUTA) on the amount set aside.

Employers interested in setting up an FSA should contact an attorney or other benefits professional familiar with IRS Section 125 regulations. Many TPAs also offer Section 125 services.

Next Steps

This brochure is intended to address the most common questions you may have regarding DR, as well as its benefits to employers and employees. For additional information on how to implement and administer a DR plan yourself, or for an actuarial cost projection for a Direct Reimbursement dental plan, please feel free to contact ADA staff at **1-800-232-7698**. You may also contact your local dental society, benefits consultant or broker.

Buyer's Guide to Dental Benefits

Since 1986, the American Dental Association's Council on Dental Benefit Programs has operated the Purchaser Information Service, which offers free information to employers and benefits professionals.

This brochure is intended to educate readers about the variety of dental plan types in the market, in order to ensure that high-quality and affordable dental care is available to you. It offers specific questions for you to ask before changing or selecting a new dental plan. It also will help you to determine who should be covered under your plan, and how coordination of benefits should be determined. Near the end, a glossary of terms is provided. Finally, you will be encouraged to utilize the ADA's Plan Analysis Service, which provides a review of your current or proposed plan at no charge.

If you have further questions, please contact your broker, benefits professional, state dental society or the Purchaser Information Service directly at 312-440-2746.

Why Offer a Dental Benefit?

Offering a dental benefits plan makes economic sense. A frequently overlooked reason for employee absences or poor work performance is dental disease or discomfort. And as every human resources professional knows, days lost can mean money lost.

In addition to promoting oral health, a quality dental benefits plan can aid in the recruitment and retention of employees. Dental benefits are consistently cited as one of the most sought after employee benefits.

The Difference between Medical and Dental Needs and Treatments

Fortunately, offering a dental benefits plan to employees can be affordable.

Due to the dental profession's promotion of fluoride, sealants and other preventive dental care, oral health in America has generally improved. According to data provided by the U.S. Department of Labor's Bureau of Labor Statistics, the cost of dental treatment has risen significantly less than the cost of medical treatment in the past few decades. In addition, dental needs and treatments differ from medical needs and treatments. The points below illustrate the differences between the two:

MOST MEDICAL NEEDS AND TREATMENTS ARE:	MOST DENTAL NEEDS AND TREATMENTS ARE:
Unpredictable	Predictable
Catastrophic	Non-catastrophic
High cost	Low cost
An insurable risk	Low risk

As such, the design of a dental plan can differ from that of a medical plan. Dental disease is most often preventable; with the exception of damage due to an accident, dental treatment begins with relatively low-cost diagnostic procedures, such as exams and x-rays. If decay or disease is detected, the sooner it is treated, the less expensive that treatment will be. The dental needs of an employee group are highly predictable. For this reason, a dental benefits plan can often be self-funded. Extremes in cost and utilization (evident in many medical benefits) are rarely observed with dental statistics.

In summary, when deciding whether to self-fund or fully-insure a dental benefit plan, remember the following important points:

- Dental disease is preventable.
- Early detection and treatment of dental disease is most efficient and least costly.
- The need for dental care is universal and ongoing rather than episodic.
- The public's need for dental care is highly predictable.
- The dental needs of individuals within a specific group, however, may vary considerably.

Before Selecting or Changing Your Dental Plan

Before selecting or changing a dental plan, there are some important things to consider. Some plans require patients to choose a dentist from a limited list of dentists. Choosing from a list is not the same thing as freedom of choice. If your dentist is not on such a list, don't hesitate to ask why he or she has elected not to participate.

Dental plans are typically business arrangements between an insurance company and an employer. Most plans are designed to pay only a portion of your dental expenses. However, dental plans may exclude or discourage certain treatments, such as dental sealants, which can prevent tooth decay and save you money later on. Carefully read the plan and know its limitations. If a plan doesn't cover a procedure that is recommended by your dentist, this does not mean that the treatment isn't appropriate or needed.

Also, some plans do not cover pre-existing conditions, such as missing teeth. Others may not cover dental implants, specialist referrals and other dental needs. Even when you and your dentist agree on the appropriate treatment method for your condition, the contract provision of the dental plan may only pay a portion, or pay only for the least expensive alternative treatment (LEAT) as determined by the insurance company.

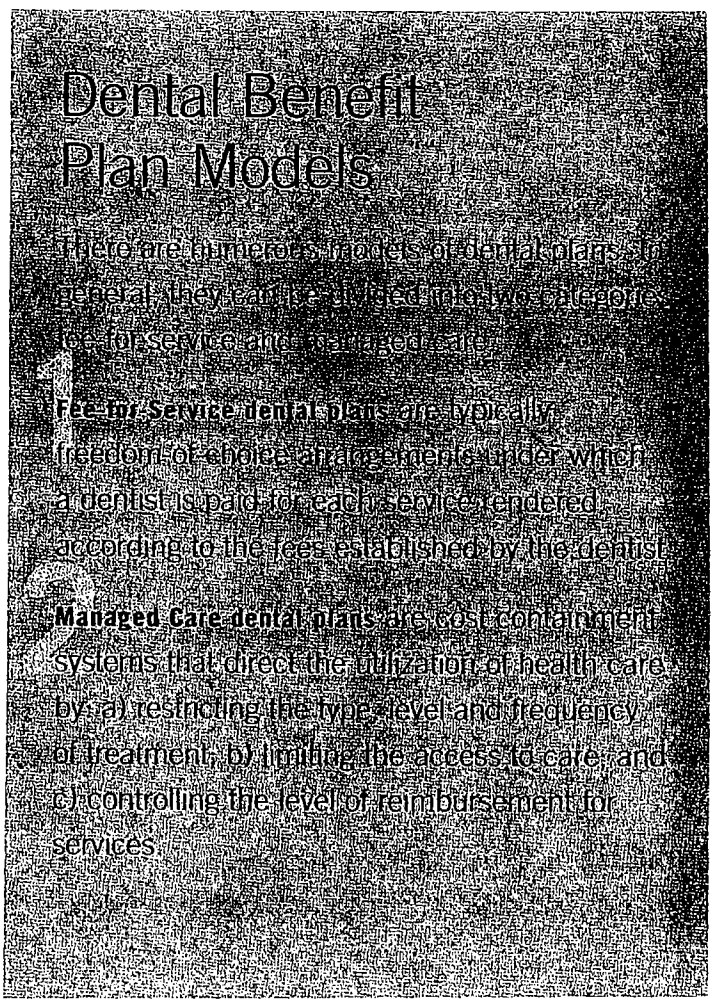
Dental plans may use the terms "usual, customary and reasonable" (UCR) to determine the portion of the dental treatment fee they will pay. UCR reimbursement levels are determined by different methods by the dental plan administrators. They may vary a great deal among plans – even when those plans operate in the same area.

The fee the insurance company determines to be "customary" may be very low compared to the area's average professional fee for the same services. The plans then generally pay a certain percentage of the UCR level. The patient may then be required to pay a greater portion of the treatment costs.

Ask yourself the following questions before selecting a new plan:

- Will employees retain the freedom to choose their own dentists?
- Is the type of treatment determined by the patient and the dentist?
- Does the plan cover diagnostic, preventive and emergency services? Will it cover preventive services such as sealants and fluoride treatments, which may save patients money in the future? Will it provide for regular dental exams and cleanings? Will it provide for full-mouth x-rays?
- What type of routine dental care is covered? Does the plan cover crowns and bridges, braces, root canals, oral surgery and treatment of periodontal diseases?
- What major dental care is covered? Does the plan cover dentures, implants or treatment for temporomandibular disorders?
- Will the plan allow for referrals to specialists? If so, will the dentist be limited to a list of specialists from which to choose?
- How does the plan provide for emergency treatment? What provisions are made for emergency care when you are away from home?
- If the plan requires monthly premiums, what percentage of that money goes to actual care and not to overhead or administration?

Dental health is a key factor to preserving one's general health. Treatment decisions are made by the patient and the dentist. While dental benefit coverage should be taken into account, it should not be the deciding factor in determining your choice of treatment.



Dental Fee-for-Service Plans

Direct Reimbursement

Direct Reimbursement (DR) is a self-funded dental benefits plan that reimburses patients according to *dollars spent* on dental care, not type of treatment received. It allows the patient complete freedom to choose any dentist. Instead of paying monthly insurance premiums, even for employees who don't use the dentist, employers pay a percentage of actual treatments received. Moreover, employers are removed from the potential responsibility of influencing treatment decisions due to plan selection or sponsorship. DR is the ADA's preferred method of financing dental treatment

The design of the DR plan is selected by the employer to fit the employer's budget, and can therefore vary widely among companies. For example, one plan may reimburse 100% of the first $200 of dental expenses and 80% of the next $1,000, resulting in a total annual maximum benefit of $1,000 per covered individual. Another company may reimburse 75% of the first $1,000 of dental expenses, resulting in a total annual maximum benefit of $750 per covered individual. The totals can be individual or family maximums.

The ADA, as well as state dental societies, brokers and benefits consultants, can assist a company in estimating how different designs will affect costs. To utilize this service, call the ADA at 800-232-1890.

If you are considering a Direct Reimbursement dental plan, the following questions should be addressed:

- What co-payments and annual maximum should be established?
- Will the plan be administered in-house or by a third party?
- What records will be useful to keep?
- What percentage of the cost will go toward administration? (Experience shows that between 5% and 10% of the money spent on DR will go to administration.)
- What safeguards and educational programs are in place to ensure that employees use their dental dollars wisely?

Indemnity

An *indemnity plan* is a fully insured or self-insured plan where an assigned payment is provided for specific services, regardless of the actual charges made by the provider. Payment may be made to enrollees or, by assignment, directly to dentists.

Usual, Customary and Reasonable (UCR) indemnity plans usually allow patients to go to the dentists of their choice. These plans pay a set percentage of the dentist's fee or the plan administrator's "reasonable" or "customary" fee limit, whichever is less. These limits are the result of a contract between the plan purchaser and the third-party payer. Although these limits are called "customary," they may or may not accurately reflect the fees that area dentists charge. There is wide fluctuation and no regulation on how a plan determines the "customary" fee level.

If the plan purchaser is reviewing an indemnity dental plan with a UCR schedule, the following are points to consider:

- What data has been used to establish the UCR fee levels? How often are the fee levels updated?
- At what percentile is payment made? For what percentage of claims in the last year has the plan denied patients coverage for a part of their dentist's charges because of the "customary" fee screen?
- What percentage of the premium is used for administration and not for dental care?

Table of Allowance (sometimes called "schedule of allowance") indemnity programs determine a list of covered services with an assigned dollar amount. That dollar amount represents just how much the plan will pay for those services that are covered. Most often, it does not represent the dentist's full charge for those services. The patient usually pays the difference.

If a plan calculates benefits according to a table of allowances, the purchaser should consider the following:

- What is the difference between the allowed coverage and a typical dentist's fee for the listed procedures? What is the level of benefits?
- What provisions are in the plan for adjusting the table for inflation and changes in dental procedures?
- What provisions are in place for determining coverage for necessary procedures that are not included in the table?
- Is the terminology in the table consistent with the ADA's *Current Dental Terminology* guide?

Dental Managed Care Plans

Preferred Provider Organization

Preferred Provider Organization (PPO) programs are plans under which patients select a dentist from a network or list of providers who have agreed, by contract, to discount their fees. In PPOs that allow patients to receive treatment from a non-participating dentist, patients will be penalized with higher deductibles and co-payments. PPOs can be fully insured or self-insured. PPOs are usually less expensive than comparable indemnity plans and are regulated under the appropriate insurance statutes in the insurance company's state of domicile and operation.

When reviewing a PPO dental plan, the plan purchaser should consider the following:

- What percentage of the premium is used for administration?
- Will the amount of the discount influence patients to change their dentist? Will the amount of the discount the dentist is required to offer affect the number of treatment options for the plan's covered individuals?
- What is the liability for the employer if the plan influences provider selection or treatment?
- What are the criteria for selection of providers for the plan? Does it have enough dentists under contract to adequately serve the group? What is the geographic distribution of patients to dentists? Does it provide for specialist referrals? Are dentists limited to referring patients to contracted specialists?
- How does the program provide for emergency treatment? What provisions are in the program for emergency care away from home?

Dental Health Maintenance Organization / Capitation Plan

Dental Health Maintenance Organization (DHMO) or capitation plans pay contracted dentists a fixed amount (usually on a monthly basis) per enrolled family or individual, regardless of utilization. In return, the dentists agree to provide specific types of treatment to the patient at no charge (for other treatments, a co-payment is required). Theoretically, the DHMO rewards dentists who keep patients in good health, thereby keeping costs low. DHMO models typically offer the least expensive dental plans.

If the plan purchaser is reviewing a DHMO or capitation plan, the following factors should be considered:

- What percentage of the premium is used for administration?
- Does the employer have access to sufficient information to determine the level and amount of treatment received by each member of the group?
- What is the utilization rate for patients in this program? What is the average waiting period for an initial appointment? What is the average period between appointments?
- What is the dentist/patient ratio for the program? What are the criteria for selecting dentists to participate in the program? What is the geographic distribution of patients to dentists?
- What is the ratio of dentists accepted to the program to those who applied to participate? How many dentists voluntarily withdrew from the program over the past two years?
- What is the capitated rate of compensation for the dentists? Is it sufficient compensation for the needs of the covered patient population? What provisions are made for dentists with unforeseen utilization or difficult cases?
- What are the benefits for patients requiring a specialist's care? How are specialists selected and compensated? Does the plan have adequate specialist participation?
- How does the program provide for emergency treatment? What provisions are in the program for emergency care away from home?

Other Types of Dental Plans

The following two plan types also are common in the market. These plan types rarely stand alone, however, and are generally featured as aspects of other plans.

Discount / Referral Plans – are arrangements in which employers direct employees to a limited number of providers who have agreed to discount their normal fees in exchange for a larger patient pool. There is no reimbursement to the patient or to the provider. A third-party marketer will package and sell a discount program for a fee, in order to cover costs and profits.

Point of Service Plans – are arrangements in which patients with a managed care dental plan have the optio of seeking treatment from an "out-of-network" provider. The reimbursement for the patient is usually based on a low table of allowances, with significantly reduced benefits than if the patient had selected an "in network" provider.

Who Should be Covered Under the Plan?

In addition to covering employees, most dental plans cover spouses and dependents as well. Some dental plans require that new employees work a minimum amount of time (for example, six months) before coverage begins. In addition, most plans will terminate coverage of dependent children at a certain age: for example, at age 19 or until completion of academic studies.

The ADA recognizes the importance of extending dental benefits to retirees. Plan puchasers should continue dental coverage for retiring employees if it was offered in the past, or as an option for retirees to purchase at their own expense if it is not part of an employee retirement package.

Coordination of Benefits

Coordination of Benefits takes place when a patient is entitled to benefits from more than one dental plan. Plan sponsors should be certain that the plan they select speci fies its method for coordinating benefits with other plans.

In general, the following rules apply:

1. When a patient has coverage under two or more dental plans, the coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan. The aggregate benefit should be more than that offered by any the plans individually, but not such that the patient receives more than the total charges for the dental services received.
2. In coordinating benefits between plans when the treating dentist has agreed to a contractual ceiling in at least one of the plans, the maximum allowed payment should be determined by the primary plan.
3. The following rules should apply in determining which plan is primary:
   - **a)** The plan covering the patient other than as a dependent is the primary plan.
   - **b)** When both plans cover the patient as a dependent child, the plan of the parent whose birthday occurs first in a calendar year should be considered as primary.
   - **c)** When a determination cannot be made in accordanc with the above, the plan that has covered the patien for the longer time should be considered as primary
   - **d)** When coverage for a service is available under a medical plan and a dental plan, and a determinatio cannot be made in accordance with the above, the medical plan should be considered as primary.

More information about coordination of benefits can be received by contacting the ADA's Purchaser Informatio Service at 312-440-2746.

Glossary

The following is intended to provide a quick reference for terms relating to dental benefit plans which are not covered earlier in the booklet:

Contract Dentist - A provider who agrees to offer specified services at specific levels of reimbursement under the terms and conditions stipulated by the contract.
Contract Term -The period of time, usually 12 months, for which a contract is written.
Deductible - The amount of dental expense for which the beneficiary is responsible before a third party will assume any liability for payment of benefits. The deductible may be an annual or one-time charge, and may vary from program to program.
Eligibility Date – The date an individual and/or dependents become eligible for benefits under a dental benefits contract. Often referred to as the "effective date."
Exclusions - Dental services not covered under a dental benefit program.
Fee Schedule – A list of the charges for specific dental procedures established or agreed to by a dentist.
Flexible Spending Account (FSA) - Employee reimbursement account primarily funded with employee designated salary reductions. Funds are reimbursed to employee for health care (medical and/or dental), dependent care, and/or legal expenses, and are considered a nontaxable benefit.
Freedom of Choice - The concept that a patient has the right to choose any licensed dentist to deliver his or her oral health care without any type of coercion.
Pre-authorization/Pre-determination - Administrative procedures that may require a dentist to submit a treatment plan to a third-party payer for approval before treatment is begun.
Premium – The regular (typically monthly) fee charged by third-party insurers and used to fund the dental plan.
Reimbursement - Payment made by a third party to a beneficiary, or to a dentist on behalf of the beneficiary, toward repayment of expenses incurred for a service covered by the contractual arrangement.
Self-funding - A program for providing employee benefits financed entirely through the employer, in place of purchasing such coverage from a commercial carrier.
Third Party Administrator (TPA) – An individual or company that processes and pays claims for self-funded dental plans. The TPA undertakes no financial risk for claims incurred. A TPA typically charges a fee for these services.
Utilization - The extent to which the members of a covered group use a program over a stated period of time; specifically measured as a percentage determined by dividing the number of covered individuals who submitted one or more claims by the total number of covered individuals.