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Divider Title: State & National Perspectives

Questions for the Panel on State and National Perspectives

Insurance Associations

Does your association have a policy statement addressing CAM? What are the views of your membership regarding the increased utilization and expenditures nationally on CAM practices and products?

Have you observed any trends regarding coverage and reimbursement of CAM among your membership? Do you have any opinions as to the most promising areas of CAM practice?

What ideas, issues and concerns do indemnity insurers and managed care organizations have with regard to adding CAM benefits? Do you have any suggestions for successful incorporation of CAM benefits?

What ideas, issues, and concerns do indemnity insurers and managed care organizations have with regard to estimating costs, establishing premiums, rating groups and individuals, etc. for CAM benefits?

What ideas, issues, and concerns do indemnity insurers and managed care organizations have with regard to paying CAM providers? For example, you could address the applicability of available reimbursement methodologies to CAM, maintaining networks, credentialing such providers, and coding.

What ideas and suggestions do you have for health services research related to access, coverage, and payment for CAM services and products?

What ideas, issues, and concerns regarding coverage and payment for CAM can you provide the Commission as it develops its policy recommendations and report to the President and Congress?

State Association

What trends do you see in States with regard to coverage and reimbursement for CAM services and products? How does the increase use of CAM interrelate with other trends in health insurance, such as medical savings account, defined contribution plans, etc.?

What issues do State officials see with regard to CAM benefits, such as consumer protection, quality and health plan accountability, practitioner qualifications, etc.?

To your knowledge, is there any concern or activity among the States with regard to criteria, standards, or policies for dietary supplements?

Do you have ideas, concerns or suggestions for health services research related to access, coverage, and payment for CAM services and products? What policy recommendations can your organization provide the Commission as it develops its report to the President and Congress?

JOY JOHNSON WILSON

Ms. Wilson is Federal Affairs Counsel and Director of the Health Committee at the National Conference of State Legislatures (NCSL). NCSL represents the legislatures of the 50 states, its commonwealths, territories and the District of Columbia. As Federal Affairs Counsel, she assists with overall government relations and public affairs activities in the NCSL Washington Office. The NCSL Health Committee guides the development of NCSL policy on health care issues. As Director of the Health Committee, she designs and implements the lobbying strategy for the conference on these issues.

Ms. Wilson has been with NCSL since 1978. She took a leave of absence in 1989 to serve on the staff of the U.S. Bipartisan Commission on Comprehensive Health Care, better known as the "Pepper Commission." On the Pepper Commission staff, she was the liaison to groups representing state and local elected officials, organized field hearings and worked on issues related to the impact of health care reform on small business.

She received a Bachelor of Science from Keene State College in New Hampshire and a Master of Regional Planning degree from the University of North Carolina at Chapel Hill.

April 2001

NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

Jim Costa
State Senator
California
President, NCSL

Diane Bolender
Director, Legislative Service Bureau
Iowa
Staff Chair, NCSL

William T. Pound
Executive Director

TESTIMONY OF
JOY JOHNSON WILSON

ON BEHALF OF THE
NATIONAL CONFERENCE OF STATE LEGISLATURES

BEFORE THE
WHITE HOUSE COMMISSION ON
COMPLEMENTARY AND ALTERNATIVE MEDICINE

REGARDING
STATE LEGISLATIVE/REGULATORY INITIATIVES RELATED
TO
COMPLEMENTARY AND ALTERNATIVE MEDICINE

May 14, 2001

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Mr. Chairman and Members of the Commission:

My name is Joy Johnson Wilson. I am a Federal Affairs Counsel and Director of the Health Committee at the National Conference of State Legislatures (NCSL). It is a pleasure to be here with you today to discuss state legislative and regulatory initiatives related to complementary and alternative medicine.

Much of the history regarding state legislative and regulatory initiatives related to complementary and alternative medicine has yet to be written. In many ways complementary and alternative medicine is a moving target. Therapies, treatments and providers who may have been considered "non-traditional" or "alternative" five years ago, may in fact be relatively mainstream today.

Certainly as some of the "non-traditional" providers and the treatments and therapies associated with those providers have found widespread acceptance, the treatment of those providers by state lawmakers has tended to look more like the treatment afforded traditional providers. In other words, state legislative and regulatory initiatives tend to focus on: licensure, scope of practice, educational/accreditation requirements, reimbursement, insurance coverage, and disciplinary/malpractice concerns.

"Health Freedom" Laws

Currently 12 states (Alaska, Colorado, Florida, Georgia, Massachusetts, New York, North Carolina, Ohio, Oklahoma Oregon, Texas, and Washington) have enacted "health freedom" laws. These laws protect health practitioners, primarily physicians, from disciplinary actions resulting from their use of non-traditional treatments or therapies. Most of these laws were enacted in the 1990's, however, the earliest was enacted in 1907 and the most recent, a Florida law (S.1324), became law this month. The Florida law, establishes the right of health care practitioners to offer complementary or alternative health care treatments **and the right of patients to**, "...make informed choices for any type of health care they deem to be an effective option for treating human disease, pain,

injury, deformity, or other physical or mental condition." Finally, two states, Louisiana and South Dakota, have "health freedom" laws that pertain specifically to chelation therapy.[1] These laws bar disciplinary action against physicians who use chelation therapy, it the disciplinary action is based solely on the fact that they provide chelation therapy.

"Health Freedom" Regulations

In addition to the Texas law, the state has an extensive body of regulation. Nevada also has regulations in this area. The basis for the Texas law and regulations is a provision in the Texas State Constitution that prohibits any state law from giving preference by school of medicine. In this case, school of medicine means, as clarified by case law, "system, means or method employed or schools of thought accepted by pratitioner." (Ex parte Halstead, 182 S.W.2d 479, 1944). The Texas regulations found in Texas Administrative Code: 22 TAC §§200.0-200.3 is designed to allow physicians, "....a reasonable and responsible degree of latitude in the kinds of therapies they offer their patients. The Board also recognizes that patients have a right to seek integrative and complementary therapies." At the same time, the regulation also incorporates some patient protections by establishing practice guidelines for physicians practicing integrative or complementary medicine. These guidelines require the physicians to: (1) perform patient assessments and establish a medical treatment plan; (2) document their findings, including any findings regarding the appropriateness of conventional treatments; and (3) obtain informed consent from the patient. The Nevada regulation, Chapter 650 of the Nevada Annotated Code, is very similar to the Texas regulation. These regulations, adopted in Texas in 1998 and in Nevada in 2000, may represent the emerging trend in the treatment of complementary and alternative medicine in state law and regulation. It is important to note that the recently enacted law in Florida incorporates if not the specifics, certainly the spirit of these rules.

[1] Chelation therapy is a somewhat controversial therapy that uses an organic or synthetic agent to bind with minerals and remove them from the body. The most common chelating agent is edetate sodium (EDTA), is used by many physicians to treat lead poisoning. Chelation therapy is also used to treat hardening of the arteries.

Chiropractic and Acupuncture

Two providers/treatments that have gained widespread recognition and acceptance in recent years are chiropractic and acupuncture. Today, 45 states provide universal licensure and reimbursement equity to chiropractors. This year, the following legislation related to chiropractic services was enacted:

- Washington enacted SB 6199 requiring insurance carriers to provide enrollees with direct access to chiropractic care without prior referral;
- Arizona enacted HB 2600 requiring insurers to cover chiropractic services and establishing limits on the number of covered visits;
- New Hampshire enacted SB 147 addressing self-referral, numbers of visits and reimbursement of chiropractic services; and
- Indiana enacted HB 1197 making licensed chiropractors eligible for privileges to provide patient care at a county hospital.

Thirty-five states (Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Hawaii, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin) and the District of Columbia recognize acupuncture by licensure, certification, or registration. The following legislation regarding the practice of acupuncture was enacted this year:

- Virginia enacted HB 1588 to clarify that acupuncture detoxification specialists who are certified by the National Acupuncture Detoxification Association and who are currently exempt from licensure when they are supervised by a physician acupuncturist or acupuncturist licensed by the body, may perform auricular acupuncture[2], for chemical dependency treatment programs for patients eligible for federal, state, or local public funds.

[2] Auricular therapy is a technique of stimulating acupuncture points on the outer ear to treat pain or other symtems in various other parts of the body.

- Maryland enacted SB 1324 that permits certain licensed or certified health care providers to provide auricular detoxification under the supervision of a licensed acupuncturist; and
- Nebraska and Indiana established licensing requirements for acupuncturists.

Massage Therapy

Massage therapy is well on its way to becoming a mainstream therapy. Currently, 29 states (Alabama, Arkansas, Connecticut, Delaware, Florida, Hawaii, Iowa, Louisiana, Maine, Maryland, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin) and the District of Columbia license or regulate message therapists. Laws enacted in 2000 and 1999 centered on scope of practice and educational requirements for therapists.

Emerging Alternative and Complementary Medical Providers/Treatments

- Homeopathy

  Three states (Arizona, Connecticut, and Nevada) have separate Homeopathy Boards. This year the legislature in Nevada considered legislation that would require individuals regulated by the Board of Homeopathic Medical Examiners to report any claim for malpractice or negligence and the disposition. In Oklahoma, the legislature considered legislation that would establish the licensure of homeopathic physicians, and would create the Board of Homeopathic Medical Licensure and Supervision.

- Naturopathy

  Eleven states (Alaska, Arizona, Connecticut, Hawaii, Maine, Montana, New Hampshire, Oregon, Utah, Vermont, and Washington) consider naturopaths licensed health care providers.

- Nutritional Providers

  Last year Hawaii enacted HB 749 establishing a dietitian licensure program within the Department of Commerce Affairs. It further provides that a person who submits evidence of current registration in the American Dietetic Association is deemed to have met the educational and supervised practice experience requirements for licensure. Mississippi enacted HB 714 amending the state's dietetic practice act to include, "one engaging in medical nutrition therapy" within the definition of dietitian.

As you can see the states have been and continue to be very active participants in developing the legal and regulatory structure for the practice of complementary and alternative medicine. It also appears that there is a growing effort to accommodate the needs of the practitioners and the patients, while at the same time, providing for important and necessary patient protections.

Before I close, I would like to acknowledge the sources for the bulk of this presentation. The Foundation for the Advancement of Innovative Medicine and its remarkable website was invaluable. I would also like to thank Carla Plaza and Stephanie Norris of the Health Policy Tracking Service at NCSL for additional assistance on state laws and state legislation.

Thank you for this opportunity to share with you some of the activities going on in the state legislatures across the country. I would be happy to answer any questions you may have.

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

Merilyn D. Francis

Merilyn Francis is the Director of Quality Management and Health Services Research for the American Association of Health Plans (AAHP) Department of Medical Affairs. AAHP is the largest national trade association representing more than 1,000 health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other similar health plans that provide health care coverage to more than 140 million Americans. As director, she is responsible for coordinating activities related to accreditation, managed care industry standards and quality management policy. Further, Ms. Francis is responsible for directing the AAHP chronic disease initiatives for diabetes and asthma.

Prior to coming to AAHP in 1998, Ms. Francis had worked as a Program Analyst for the District of Columbia Medicaid Managed Care program where she was responsible for the development of the performance program and the oversight of the participating health plans' quality management and data reporting. Her responsibilities also included supervision of the quality management program for the District's children with special needs managed care program.

Ms. Francis is an oncology nurse an extensive background in oncology and HIV/AIDS clinical research management having worked at the University of California, San Francisco, the National Cancer Institute, Howard University Cancer Center, and the Georgetown University, Lombardi Cancer Center. In these positions, Ms. Francis developed an expertise on issues involving the ethics of using human subjects in new drug trials, privacy and informed consent, as well as the rules and regulations surrounding all phases of clinical research.

Ms. Francis holds a BA degree in economics from Simmons College and a BSN from the University of the District of Columbia. She also holds a Master's of Public Policy from the American University School of Public Affairs.

American Association of
HEALTH PLANS

Testimony

of

Merilyn D. Francis, RN, MPP

for

White House Committee
on
Complementary and Alternative Medicine

May 14, 2001

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Good morning my name is Merilyn Francis and I am the Director of Quality Management and Health Services Research for the American Association of Health Plans (AAHP). The American Association of Health Plans represents more than 1,000 health maintenance organizations (HMOs), preferred provider organizations (PPOs), and similar network health plans providing coverage to more than 150 million Americans. AAHP and its members are dedicated to a philosophy of care that puts patients first by providing high quality, coordinated, comprehensive health care. The association thanks the White House Commission on Complementary and Alternative Medicine for the opportunity to speak here today and we commend the Commission's efforts in bringing together all stakeholders to have this important dialogue.

General Comments

Over the past twenty years, consumer demand and the availability of complementary and alternative medicine (CAM) have steadily increased. Health plans make decisions on benefit coverage based on the demand and availability of specific services and their clinical efficacy, safety, and potential cost-effectiveness. The two critical challenges health plans face when deciding which CAM therapies to offer in their benefit packages are the lack of licensing and practice standards for certain disciplines and a paucity of research on efficacy.

Many health plans offer such CAM options as chiropractic medicine, acupuncture, massage therapy, and nutritional counseling in their core benefit offerings. These therapies have research evidence that demonstrates efficacy and there are standards for education, licensure and practice. Chiropractic medicine, for example, has licensure requirements in all fifty states and

the other therapies mentioned have requirements in almost half of the states. These standards along with the research evidence allow health plans to set their credentialing, performance measurement and quality improvement programs as they do for their allopathic medicine programs. These three factors are central to health plan quality agendas.

In other cases, health plans may offer optional riders for other CAM therapies such as herbal therapy, reflexology and yoga that do not have clearly defined standards, or a body of research evidence but the level of interest and demand by members and/or purchasers is high. In these instances, members may be offered discounts or services at a contracted rate without primary care referral if the member uses the health plan's network of alternative medicine providers.

Health plans are committed to evidence-based care and selection of qualified providers based on training, experience, licensure and/or certification. While there are many issues of importance related to the integration of CAM therapies into health plan benefit packages, the issues I will focus on are: 1) evidence-based care; 2) credentialing; and 3) practice standards as these are three basic considerations in benefit decision-making.

Evidence-based Care

Health plans have supported the use of evidence-based care in allopathic medicine. The development and use of evidence to determine the most appropriate care has been advanced by the efforts of the Agency for Healthcare Quality and Research (AHRQ) and other research organizations. These efforts were further supported by the recent Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, which offers that, "Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or

from place to place)." Before CAM therapies can become more integrated into allopathic health care systems the evidence to support safety and efficacy of CAM must be developed.

The body of scientific knowledge on the effectiveness and appropriate standards of care is spare or absent for many of the centuries old systems of CAM such as Ayurvedic medicine as well as newer therapies such as light therapy. Current research efforts by the National Center for Complementary and Alternative Medicine and other research organizations are making headway in developing this body of knowledge. This is an important step in determining the effectiveness, efficacy and safety in using CAM therapies for specific medical conditions. Further, the knowledge gained from these research activities will support the development of practice standards that are essential for accountability and meaningful monitoring and evaluation of quality.

The difference in philosophies between CAM and allopathic medicine makes it both difficult to fit CAM into the health care structure that is dominant in the United States and attractive to patients and professionals desiring a holistic approach to care. Where alternative practitioners view health as a balance between mind, body and spirit, the allopathic practitioners view health as the absence of disease. The rigorous evaluation of balance between mind, body and spirit for evidence-based care is difficult at best. For this reason support of research in CAM is crucial for building the body of scientific data necessary.

Evidence-based care is a steady theme in the health care quality improvement agenda for health plans as well as other health care entities. In light of the IOM report on the need for quality improvement throughout the health care system and its inclusion of evidence-based care as an aim for realizing this improvement, an open exchange for dialogue, such as we have here

today, and then a platform for developing strategies for integrating this theme into CAM practices is a valuable effort.

Credentialing

Evidence-based care is only part of the picture. Professionals delivering that care should have the appropriate skills and training as documented through education, licensure and/or other types of certification. The credentialing process is used to verify that health care professionals have the necessary skills and ability to provide safe, high quality care. Further the process is used to determine if the provider has had any quality problems, such as malpractice suits, legal actions or professional sanctions against them. Accreditation programs developed by organizations such as the National Committee for Quality Assurance (NCQA), Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) and URAC also known as the American Accreditation of Health Care Commission have been beneficial in standardizing and increasing the effectiveness of credentialing processes. While the credentialing process used by health plans and other health care entities is not foolproof, it is the best tool health plans and consumers have to determine the baseline ability of a health care professional to practice their discipline.

The education and licensing requirements for physicians, nurses and other mainstream health care professionals practicing conventional medicine are well known and clear. Requirements for certain CAM professionals, such as chiropractors, acupuncturists and massage therapists are also well defined. However, there are many complementary and alternative medicine disciplines that do not have clear standards for defining a "qualified" practitioner. This is an obstacle for determining the options of CAM providers and therapies to be included in health plan benefits.

Education and training to become a practitioner of CAM therapies varies widely from a few weekends of training to several years of education plus a fellowship leading to certification and/or licensure. If there is no state licensing or other certification process, what methodologies should be used to assess the practitioner's baseline qualifications for performing their therapies? Some health plans use advisory boards to facilitate the process for defining the qualifications necessary where there is little guidance found in the form of certification or licensing standards from the profession or through state regulation.

In general, health plans offering complementary and alternative medicine to their enrollees use methods that parallel those used for their allopathic providers where possible. These include a review of:

- Practitioner databanks and other types of data to determine if there are any sanctions or legal actions documented;
- The number of years the practitioner has been in practice - health plans may require that the practitioner be in practice for at least two years for example;
- Education, fellowships or residencies and the extent of the program attended including examination requirements; and
- A site visit to assess if the office is appropriate and equipped for the type of treatments the practitioner plans to provide.

These are important actions taken by health plans for determining the basic level of preparedness for a CAM practitioner, especially for those in a discipline that does not require any form of licensing or secondary vetting.

Strategies for developing to define consistent national standards for education, training and possibly licensure that are appropriate for the various CAM therapies are needed.

Additionally, ensuring that these standards are publicly available to health plans, consumers and other health care entities is important for the support of benefit decision-making.

Standards of Practice

Defined standards for the level education and training combined with scientific evidence of care provide a framework for developing standards of practice. Health plans are held accountable by governments, purchasers and/or accrediting organizations for ensuring that their systems and processes support the providers' use of these standards. In turn, health plans hold their providers accountable for using accepted standards of practice. These standards are based on evidence, best practices and consensus of the professional community and are important for ensuring timely, efficacious and quality care. The use of critical pathways and case management techniques by health plans and their providers have also been effective strategies for improving quality, reducing unnecessary variation in practice and for reducing the risk of errors or adverse events. There are complementary and alternative medicine disciplines that also have rigorous standards and use similar pathways and/or case management techniques. Osteopathy and chiropractic medicine are good examples.

Research and development of practice standards within each CAM discipline is important for the community to consider. Health plans and other health care entities often cite the lack of these standards for certain CAM therapies as an impediment for deciding to offer these therapies to their members as a core benefit. Without standards, evaluation of the quality of care provided and the development of interventions for improvement are difficult.

The evidence of safety, efficacy and standards of care should be available to all interested parties. Another important recommendation made in the recent IOM report for redesigning health care processes is important here. That is, " The need for transparency - the health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital or clinical practice, or choosing among therapy alternatives. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction." As a move towards integrating CAM with allopathic medicine continues, the development of strategies for allowing this transparency in practice standards for therapies that currently do not have them is worthwhile.

Summary

Consumers want options for CAM from their health plans. Health plans, in meeting our members' desires for these options must consider the evidence, the standards for identifying qualified practitioners and the standards of practice. These factors are critical for health plans to be confident that the choices offered are effective, safe and appropriately delivered. Quality and accountability underscore the systems and processes health plans use for arranging and monitoring the delivery of care. There are some CAM disciplines that have a base of evidence that integrate well with health plan agendas for advancing quality and accountability and some that are a more difficult fit. As a result those that have clear systems for supporting quality and accountability goals are often integrated into the core benefits offered by health plans. Those that do not may be offered as benefit riders providing access to these therapies at a discount out-of-pocket cost to consumers.

The support of research to evaluate CAM and the development of strategies for aligning and coordinating CAM with an evidence-based, accountable health care system approach is vital. The agenda for health system change put forth by the Institute of Medicine and other national efforts such as that by the National Quality Forum provided a useful framework and thoughtful process that could be instructive.

Collaboration and the exchange of ideas, concerns and potential strategies are important steps for allopathic medicine and CAM to increase the responsiveness to the demands of health care consumers while moving forward to improve the quality of the overall health care system. The Commission in forums such as this can provide further opportunities for stakeholders to educate one another and to work towards the common goal of improving the health of the nation's population.

AAHP thanks the Commission for the opportunity to speak here today. We again commend the Commission for organizing this three-day dialogue and AAHP looks forward to continue working with the Commission in the future. Thank-you.

Oral Statement of Dr. Allan M. Korn to the White House

Commission on Complementary and Alternative Medicine

May 14, 2001

I sincerely appreciate the opportunity to speak to you today on behalf of the Blue Cross and Blue Shield Association (BCBSA) about health insurance perspectives on complementary and alternative medicine. The Blue Cross and Blue Shield Association is the national coordinating body of 45 independent Blue Cross and Blue Shield Plans that provide health coverage to 1 in 4 (more than 80 million) Americans. All Blue Cross and Blue Shield Plans are members of the BCBSA which licenses the Plans to use the Blue Cross and Blue Shield names and trademarks. Blue Cross and Blue Shield Plans constitute the largest, most experienced provider of health care coverage in the country. Blue Plans are autonomous organizations that operate independently in their own local service areas where

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they have the flexibility to respond to local market demands and health care needs

Over the past several years, health plans have become interested in complementary and alternative services due to strong public demand. Published studies suggest that more than 600 million visits are made annually to CAM providers - more than the total number of visits to all primary care physicians. Recent surveys conducted by BCBSA indicate that a third of responding Blue HMOs and PPOs accommodate member demand for acupuncture services while 8% accommodate naturopathy and 7% homeopathy. PPOs were more likely to accomodate homeopathy and 18% reported doing so. I would like to clarify that BCBSA does not consider chiropractic services to be CAM for the purpose of this statement. I believe that chiropractic has become a stakeholder in the "politically dominant" health system of the U.S. The NIH Office of Alternative Medicine defines CAM as healing resources outside the politically dominant system.

Why are Blue plans offering CAM programs at this time? There are three main reasons for providing a discount network or contractual benefit for CAM services. The first and most prevalent reason is to respond to competitive pressures by visibly meeting consumer demand. Health plans may differentiate themselves in the competitive market and appeal to different segments of the population by offering these popular programs. A second reason is compliance with state mandates for coverage. A third reason for health plans to offer a program for CAM is the potential for use of these services to theoretically reduce health care costs through:

- emphasis on health maintenance leading to improved health status and lower use of other clinical services, and/or
- serving as an alternative to higher cost services. CAM services typically have lower per unit charges than conventional biomedical services. However, existing data indicate that CAM services are used as an adjunct rather than alternative to conventional care.

Issues in Developing Benefits for CAM

Health plans interested in offering a CAM program must consider a number of important issues and design options. BCBSA has made no recommendations to Blue Plans on providing benefits for these services. CAM can be integrated into insured benefits by being added to basic benefits or by offering a separate rider with an additional premium. Alternatively, improved access to CAM services can be achieved through a value-added program that does not entail an additional premium. Value-added programs may provide access to a credentialed network of CAM providers at a discount. Members would self-refer and pay for the discounted services out-of-pocket.

Integrating CAM benefits into existing insured medical benefits coverage confronts several difficult obstacles. Integration would require applying the same contractual definitions and exclusions to CAM that apply to conventional biomedical services. In our litigious environment, contract provisions and policy must be defensible and applied consistently. Health plans use two contract provisions in

adjudicating benefits included in the benefit contract. Health plans determine, first, if the service in question is investigational. If not, the health plan would then determine if the service is medically necessary – that is, appropriate for the patient's condition. Blue Cross and Blue Shield Plans typically define investigational services as those that have not been shown through clinical evidence to improve health outcomes when compared to alternatives. Health plans have made great strides in applying evidence-based standards to coverage determinations. Health plans try to make decisions based on scientific evidence or, if necessary, on well documented expert consensus, generally based on soon-to-be-published studies or published studies with small numbers of patients, but not by anecdote. My written statement refers to the TEC criteria used by some plans to define "investigational."

Can CAM services meet investigational and medical necessity criteria? Most CAM therapies would fail an evidence-based definition of "non-investigational." The effectiveness of most CAM services at improving health outcomes has not been evaluated in scientifically

valid clinical trials. Clinical trials for most CAM therapies would be difficult to validate because therapies are often individualized to subjective complaints. The elimination of bias from protocols and outcome measures could be difficult if not impossible due to the customization of therapy and the subjectivity of results. At this time, adequate non-anecdotal outcomes data for CAM are unavailable. Such evidence would be welcomed by those who would consistently apply them in adjudication processes.

The next step in the benefits adjudication process evaluates the medical necessity and appropriateness of the service for the individual patient's condition. To make medical necessity determinations, health plans refer to criteria that delineate indications for particular services and modalities. These criteria may be developed by professional organizations, government bodies such as NIH or AHRQ, academic centers, or consulting organizations. Clinical evidence, expert consensus, and utilization data are the foundations of medical necessity criteria. Developing patient selection and appropriateness criteria for CAM services may prove

difficult due to the disparate philosophies of CAM disciplines and practitioners, and to whether specific categories of CAM services will be intended for preventive care and promotion of well-being as opposed to treatment or diagnosis of specific conditions or disorders.

If health plans opt to integrate CAM services into basic health care benefits, they may be forced to employ different standards for medical necessity determinations than they employ for traditional biomedical services, undermining the plan's coverage adjudication process. For example, the TEC program has completed 17 clinical effectiveness analyses of positron emission tomography (PET) since 1989 for central nervous system, cancer, and cardiac indications. Based on analysis of scientific evidence from well-designed clinical trials, only 7 indications met the TEC criteria. To conduct a comparable analysis of indications for acupuncture, for example, it would be necessary to evaluate the location and number of each needle and degree of patient-reported pain relief for each placement. The issues for a health plan will always be: how many do we do for how long, for

EACH diagnosis. This analysis for multiple different massage therapy modalities would be even more difficult.

Reliance on a separate rider with a separate premium component could eliminate this potential conflict. A separate rider could specify a designated number of eligible CAM visits, an annual dollar limit, and/or a selected network of providers. Separate riders that will carry a separate premium are also much easier to price since the number of visits and universe of contracted providers is known in advance of utilization. Health plans lack the data on local use of CAM providers and substitution between biomedical and CAM services that would be necessary to project a premium for an open-ended benefit.

Discount networks do not require benefit adjudication criteria because the consumer determines which services he wishes to purchase. Plans may offer these networks to enter the CAM market quickly and to gain some experience with CAM providers and member use before considering a more integrated benefit.

I believe credentialling and licensure issues have been addressed by previous speakers.

I would like to address one further issue before concluding my remarks. Coding poses a potential issue for reimbursement of CAM services. Under HIPAA, only nationally recognized code sets may be submitted and processed electronically. CPT codes for medical and surgical services are one of the recognized code sets for HIPAA. Certain CAM services, specifically acupuncture and massage, have CPT codes. It is unclear, however, whether CPT would recognize additional CAM services for code development. Under HIPAA, health plans cannot develop local codes for these services. The coding issue for CAM services requires further analysis.

Conclusion

To conclude, health plans are exploring CAM programs due to strong member interest. Unfortunately, inclusion of CAM services in basic benefits may undermine health plan evidence-based benefits

adjudication processes. Reliance on separate riders or value-added discount networks will help alleviate this concern while providing members access to the CAM services they desire.

Limiting such benefits to licensed or certified CAM providers will address credentialling concerns and provide an objective basis for offering new benefits. Health plans will want to collect outcomes and utilization data to refine future benefits and establish appropriateness criteria. Health plans will also need to develop mechanisms to assure continuity of care between biomedical and CAM providers for individual patients.

More research is urgently needed to evaluate the effectiveness of CAM services in improving health outcomes. It will also be important to study how CAM care relates and supports conventional biomedical services. Can CAM services substitute appropriately for some biomedical services, or will CAM always be additive? The impact of CAM services on improving health and moderating health care costs must be studied and proven to be of value based on clinical evidence. Such studies must use metrics that will withstand the legal and

professional scrutiny to which plans are subject prior to the inclusion of CAM in actuarially-driven health care products.

Gil + UM Quality of Care Report

Statement of Dr. Allan M. Korn to the White House Commission on Complementary and Alternative Medicine

May 14, 2001

I appreciate the opportunity to speak to you today on behalf of the Blue Cross and Blue Shield Association (BCBSA) about health insurance perspectives on complementary and alternative medicine. The Blue Cross and Blue Shield Association is the national coordinating body of 45 independent Blue Cross and Blue Shield Plans that provide health coverage to more than 80 million Americans. All Blue Cross and Blue Shield Plans are members of the BCBSA which licenses the Plans to use the Blue Cross and Blue Shield names and trademarks. The BCBSA provides technical assistance, advice, and public representation for our member Plans. The BCBSA is also a federal government contractor and provides technology assessment services through the TEC program to

CHAMPUS and to HCFA through an interagency agreement. We are also proud to be an evidence-based practice center as designated by AHRQ.

Blue Cross and Blue Shield Plans constitute the largest, most experienced provider of health care coverage in the country. More than one in four Americans enjoy the benefits of Blue Cross and Blue Shield coverage. Blue Plans are autonomous organizations that operate independently in their own local service areas where they have the flexibility to respond to local health care needs. Blue Cross and Blue Shield Plans are also national leaders in managed care. Fifty-eight million members, or 73% of the total, are enrolled in managed care products, which include HMOs, PPOs, and point-of-service products.

Over the past several years, health plans have become interested in complementary and alternative medicine services due to strong public demand. A 1997 survey by David Eisenberg and others found that 42% of respondents reported using at least one alternative

therapy (including chiropractic) in the past year. (Eisenberg DM, et.al. Trends in Alternative Medicine Use in the United States, 1990-1997 JAMA, November 11, 1998, vol.280, No.18). At least 46% of this use was directed to CAM providers, as opposed to products such as vitamins. Visits to CAM providers increased 47% from 1990 to 1997. Extrapolation of these findings suggests that more than 600 million visits are made annually to CAM providers - more than the total number of visits to primary care physicians. The indications for use most frequently cited by consumers included treatment of chronic conditions such as back pain, anxiety, depression, and headaches.

Recent surveys conducted by BCBSA indicate that a third of responding Blue HMOs and PPOs accommodate member demand for acupuncture services while 8% accommodate naturopathy and 7% homeopathy. PPOs were more likely to accomodate homeopathy and 18% reported doing so. Exclusive of benefits for chiropractic services, slightly more than 10% of responding plans offered CAM coverage as part of a basic benefit package. In general, programs for acupuncture and massage therapy appear to be most common

nationally. The BCBSA survey did not include questions about massage therapy.

Why are Blue plans offering CAM programs at this time? There are three main reasons for providing a discount network, or benefit for CAM services. The first and most prevalent reason is to respond to competitive pressures by visibly meeting consumer demand. Health plans may differentiate themselves in the competitive market and appeal to different segments of the population by offering these popular programs. Studies indicate that CAM use is most common among people age 25-49 with a college education and higher income. The income finding may be related to the fact that payment for most CAM services is out-of-pocket.

Since many CAM therapies stress a healthy lifestyle and promote lifestyle changes, users of CAM programs may be more health conscious and may take greater responsibility for their own health. A 1997 found that 58% of CAM consumers used CAM in the hope of preventing illness. (Eisenberg) This is a population that health plans

want to attract. Conversely, a 1998 study found that users of CAM services were more likely to report poorer overall health and CAM users may be those who have exhausted other clinical options (Astin JA. Why patients use alternative medicine. JAMA 1998; 279:1548-53) In either case, if offering a CAM program meets a strong consumer demand, it may improve member satisfaction and retention for the health plan.

A second reason to offer CAM programs is state mandates of coverage of CAM providers. By the end of 2000, insurance reimbursement of acupuncturists was mandated in seven (7) states. Coverage of naturopaths was mandated by four (4) states, and coverage of massage therapists by two (2) states. Forty-four (44) states mandate coverage of chiropractors. However, for purposes of this statement, chiropractic is not considered to be complementary and alternative medicine. BCBSA believes that chiropractic has become a stakeholder in the "politically dominant health system" of the U.S.. According to the NIH Office of Alternative Medicine, CAM is

part of a broad domain of healing resources other than those intrinsic to the politically dominant health system of a country or society. (EB 1)

A third reason for health plans to offer a program for CAM is the potential for use of these services to reduce health care costs. Availability of CAM services could reduce costs through:

- emphasis on health maintenance leading to improved health status and lower use of other clinical services by members
- serving as an alternative to higher cost services. CAM services typically have lower per unit charges than conventional biomedical services.

However, data seem to indicate that CAM services are used as an adjunct rather than alternative to conventional care.

Issues in Developing Benefits for CAM

Health plans interested in offering a CAM program must consider a number of important issues and design options. BCBSA has made

no recommendations to Blue Plans on providing benefits for these services. CAM can be integrated into insured benefits by adding CAM to basic benefits or by offering a separate rider with an additional premium. Alternatively, improved access to CAM services can be achieved through a value-added program that does not entail additional premium payment. Value-added programs may provide access to a credentialed network of CAM providers at a discount. Members would self-refer and pay for the discounted services out-of-pocket.

Integrating CAM benefits into existing insured medical benefits coverage confronts several difficult obstacles. Integration would require applying the same contractual definitions and exclusions to CAM that apply to conventional biomedical services. Health plans use two contract provisions in adjudicating benefits included in the benefit contract. Health plans determine, first, if the service in question is investigational. If the service is not investigational, the health plan would then determine if the service is medically necessary – that is, appropriate for the patient's condition. Blue Cross and Blue

Shield Plans typically define investigational services as those that have not been shown through clinical evidence to improve health outcomes when compared to alternatives. Many Blue Plans further define investigational services and technologies as those that do not meet the TEC criteria established by the BCBSA Technology Evaluation Center (TEC). The criteria follow:

1. The technology must have final approval from the appropriate government regulatory bodies.
2. The scientific evidence must permit conclusion concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternative.
5. The improvement must be attainable outside the investigational setting.

To integrate CAM benefits into existing insured medical benefits, it would be necessary to apply the same contractual adjudication provisions that apply to medical benefits. Can CAM services meet the investigational and medical necessity criteria? Most CAM

therapies would fail an evidence-based definition of "investigational." The effectiveness of most CAM services at improving health outcomes has not been evaluated in scientifically valid clinical trials. The development of clinical trials for most CAM therapies would be difficult because many CAM therapies are highly individualized to subjective complaints. Application of uniform trial protocols and outcome measures could be difficult if not impossible due to customization of therapy and subjectivity of results. At this time, adequate outcomes data for CAM are unavailable.

Given the paucity of outcomes data, health plans could look to expert consensus to evaluate the effectiveness of CAM services. In biomedicine, expert consensus may be employed when clinical trial data are unobtainable. CAM advocates argue that, while evidence-based evaluation of effectiveness is widely used by health plans for new technologies, the majority of existing biomedical therapies (up to 70%) has been diffused without validation from clinical trials. Health plans are strong advocates of expanding the evidence basis of biomedical therapies as well as CAM therapies and promotes this

goal with physician and research organizations. The use of some biomedical therapies has been based on empirical observations and teaching by one physician to another, passed through the generations. This process also describes some CAM modalities, particularly as practiced by some alternative health care systems that have been in place for some 5000 years. Consensus panels could be established for CAM modalities to develop expert opinion of their effectiveness for specific indications.

The next step in the benefits adjudication process evaluates the medical necessity and appropriateness of the service for the individual patient's condition. To make medical necessity determinations, health plans refer to criteria that delineate indications for particular services and modalities. These criteria may be developed by professional organizations, government bodies such as NIH or AHRQ, academic centers, or consulting organizations. Clinical evidence, expert consensus, and utilization data are the foundations of medical necessity criteria. Developing patient selection and appropriateness criteria for CAM services may prove

difficult due to the differing philosophies of CAM disciplines and practitioners. Another issue to be addressed both through benefit design and appropriateness criteria is whether specific categories of CAM services will be covered for prevention and promotion of well-being as opposed to treatment or diagnosis of specific conditions or disorders only.

If health plans opt to integrate CAM services into basic health care benefits, they may be forced to employ a lower standard of evidence or different standards for medical necessity determinations than they employ for traditional biomedical services. This could undermine the plan's coverage adjudication process. Reliance on a separate rider with a separate premium component would eliminate this potential conflict. A separate rider could specify a designated number of eligible CAM visits, an annual dollar limit, and/or a selected network of providers. Separate riders that will carry a separate premium are also much easier to price since the number of visits and universe of contracted providers is known in advance of utilization. Health plans lack the data on local use of CAM providers and substitution between

biomedical and CAM services that would be necessary to project a premium for an open-ended benefit.

Other implementation issues to consider in designing a rider or core benefit include credentialing of CAM providers and linking CAM services to biomedical services by requiring referrals by primary physicians or follow-up from the CAM provider. Linking CAM and biomedical care assures that the primary care physician is aware of CAM services received by his patient. It also facilitates communication about the patient between the CAM and biomedical provider. This type of shared information is important to maintain continuity of care and to optimize the quality of care from all sources. Treating physicians need to know if their patients are taking mega-vitamins, herbal treatments or supplements, or are undergoing invasive procedures. Shared information is critical to promoting safe high quality care.

Credentialing – Determining Which Providers Will be Eligible for Claims Payment

Benefits or a rider for CAM would need to specify the modalities subject to the coverage and/or the types of providers eligible to file claims independently with the health plan. Health plans, particularly managed care plans, typically credential independent practitioners. Accreditation programs such as NCQA require health plans to establish policies and procedures to verify education, licensure, and certification, where applicable. Given this framework, most health plans will prefer to rely on licensed or certified practitioners when devising benefits, riders, or discount networks for CAM. State licensure or certification provides an objective standard by which to begin providing a new program in CAM. Health plans may limit payment for specified CAM services to licensed practitioners. Licensed practitioners include physicians, (MDs, DOs, DCs,and DPMs), dentists, nurses, advance practice nurses, and acupuncturists (licensed in 31 states), massage therapists (licensed in 25 states) and naturopaths (licensed in 14 states). The practice of

homeopathy is incorporated in the scope of practice of other licensed medical providers in most states.

In states without licensure regulations, health plans could require certification by a specialty organization and a minimum period of practice. However, health plan liability associated with credentialing unlicensed CAM providers for network participation remains unknown and could be substantial. Plans that opt to provide coverage in their benefits contracts for massage therapy, for example, could pay claims for the designated covered services submitted by licensed practitioners that have massage therapy within their scope of practice. Plans may currently reimburse massage codes when the service is provided by physical therapists and physicians. Massage therapists, accupuncturists, and naturopaths could be added to the list of providers who may bill insurers for massage in states where these practitioners are licensed or otherwise regulated and where massage therapy is included in their scope of practice. These services could also be reimbursed through a supervising physician rather than directly to the CAM practitioner. More importantly,

massage services must be covered in the contractual scope of benefits and purchasers must be made aware of the premium cost implications of such coverage.

Coding poses a potential issue for reimbursement of CAM sevices. Under HIPAA, only nationally recognized code sets may be submitted and processed electronically. CPT codes for medical and surgical services are one of the recognized code sets for HIPAA. Certain CAM services, specifically accupuncture and massage, have CPT codes. It is unclear, however, whether CPT would recognize additional CAM services for code development. Naturopaths provide some services, such as evaluation and management and minor surgery, that are performed by physicians. CPT codes for these services could be employed by naturopaths, although they were not designed for this purpose. Naturopaths provide some services that are not common to biomedical physicians and these services will not have CPT codes. Under HIPAA, health plans cannot develop local codes for these services. The coding issue for CAM services requires further analysis.

Conclusion

Consumers are increasingly using CAM services in addition to conventional biomedical care. Some health plans are opting to offer CAM programs to their members for competitive reasons to attract and retain members and, potentially, in the hope of reducing health care costs. Due to lack of outcomes data and clinical trials on the effectiveness of many CAM services, incorporation of CAM services in basic benefits may undermine health plan evidence-based benefits adjudication processes. Reliance on separate riders or value-added discount networks will help alleviate this concern while providing members access to the CAM services they desire. Because medical necessity for CAM services is difficult to evaluate in the absence of outcomes data and utilization experience is not available to many health plans, provision of a fixed benefit will make it easier for health plans to price the product and make it available to consumers. Under a fixed benefit, consumers are free to determine how to allocate their fixed benefit dollars to the credentialed CAM providers of their choice without the need for referrals. Limiting such benefits to licensed or

certified CAM providers will address credentialing concerns and provide and objective basis for offering new benefits. Health plans will want to collect outcomes and utilization data to refine future benefits and establish appropriateness criteria. Health plans will also need to develop mechanisms to assure continuity of care between biomedical and CAM providers for individual patients.

More research is badly needed to evaluate the effectiveness of CAM services in improving health outcomes. It will also be important to study how CAM care relates and supports conventional biomedical services. Can CAM services substitute appropriately for some biomedical services, or will CAM always be additive? The impact of CAM services on improving health and moderating health care costs should be studied before consumers become entrenched in new patterns of care.

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Health Policy

Current Trends in the Integration and Reimbursement of Complementary and Alternative Medicine by Managed Care Organizations (MCOs) and Insurance Providers: 1998 Update and Cohort Analysis

Kenneth R. Pelletier, John A. Astin, 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 into conventional medicine.*

Methods. *A literature review and information search was conducted to determine which insurers had special policies for CAM. Telephone interviews were conducted with a definitive sample of 9 out of 10 new MCOs or insurers identified in 1998 and a cohort of eight MCOs and insurers who responded both to the original survey in 1997 and again in 1998 to determine trends.*

Results. *This study constitutes the results of the second year of a 3-year ongoing survey. For 1998, 10 MCOs and insurance carriers initiated CAM coverage. Survey results are analyzed for these 10 new providers as well as the results of a cohort of eight insurers surveyed in both 1997 and 1998 to determine current trends. A majority of the insurers interviewed offer some coverage for the following: nutrition counseling, biofeedback, psychotherapy, acupuncture, preventive medicine, chiropractic, osteopathy, and physical therapy. All new MCOs and 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, consumer interest, demonstrable clinical efficacy, and state mandates. 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 MCOs and insurance companies to assess the benefits of incorporating CAM. Outcomes studies for both conventional and CAM therapies are needed to help create a health care system based upon treatments that work, whether they are conventional, complementary, or alternative. (Am J Health Promot 1999;14[2]:125–133.)*

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INTRODUCTION

CAM has been commonly defined as "medical interventions not taught widely at U.S. medical schools or generally available at U.S. hospitals."[1] Among the most commonly used practices are nutritional supplements, herbal therapy, chiropractic, relaxation techniques, massage, and acupuncture.[1–6] In 1997, nearly half (50.1% in the West and 42.1% elsewhere) of the U.S. adult population used CAM. Also, the estimated number of visits to CAM providers, 629 million, was greater than the number of visits, 386 million, to all primary care doctors in that same year. Total 1997 expenditures for professional services were $21.2 billion, a 45% increase since the earlier 1990 data. Expenditures for professional services, herbals, vitamins, diet products, books, and classes totaled $27 billion.[1] Five surveys conducted since 1990 report frequent use of CAM, ranging from 30 to 73% by patients suffering from conditions such as cancer, arthritis, acquired immunodeficiency syndrome, multiple sclerosis, and acute back pain.[1–5]

Use of CAM varies significantly by gender, with women at 48.9% vs. men at 37.8%. Use is more frequent for highly educated, high income, non-Black 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.[7] Major users of CAM are either between the ages of 25 and 49 years or over 65.[1,8,9] Data indicate that the current market for CAM is being created by middle-aged and older individuals, some of whom are investing to improve their health and some of whom find it necessary due to their health conditions to invest in their own health.

Demand for CAM by the general public is increasing, despite the fact that its use is largely paid for by consumers without coverage 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 is growing at a rate of approximately 20% per year.[8] 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, it will depend upon the results of clinical and cost outcomes research.

Among the most frequently cited reasons for the recent increased consumer use of CAM include (1) consumer dissatisfaction with the limitations of conventional medicine[8–10]; (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[2,9,11]; (3) a greater awareness of medical practices from other cultures[8,12]; (4) a growing body of scientific literature suggesting that diseases are linked to nutritional, emotional, and lifestyle factors[8,12]; (5) a desire and expectation of wellness by baby boomers[2,8]; (6) consumer desire to take fewer medications and decrease side effects, especially seniors[9]; (7) consumer desire to reduce personal health care spending, especially seniors[9]; and (8) support of nationally renowned clinicians.[13]

Evolving CAM coverage is occurring within the context of broader changes in the delivery of health care in the U.S. and internationally throughout industrialized nations, particularly in Germany, France, the United Kingdom, 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 MCOs, 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.[14,15] Among the influences driving health care delivery reform are rising medical care costs and the aging of the U.S. population, of which the latter also affects health care costs since seniors are the largest utilizers of medical treatments.[12,13,16] This may result in a need for less expensive medical care, including the appropriate use of CAM, although there are absolutely no data to support this 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, research has demonstrated that cardiovascular disease can be reduced through a combination of a low-fat vegetarian diet, exercise, and stress management.[17,18] As a result, several insurers are funding this program, including Mutual of Omaha, American Medical Securities, Blue Shield of California, and Principal Mutual. CAM 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,[2,11] which in turn may help decrease unnecessary office visits due to anxiety or miscommunications between physician and patient.[3,19]

In 1997, a research team at the Stanford University School of Medicine conducted mail and telephone interviews with a definitive sample of 18 insurers and a representative subsample of seven hospitals. A majority of the insurers interviewed offered some coverage for the following: nutritional 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 cost-effectiveness based on consumer interest, demonstrable clinical efficacy, and state mandates. Some hospitals are also responding to consumer interest in CAM, although most hospitals can only offer CAM therapies for which local, licensed practitioners are available. Among the most common obstacles to incorporating CAM into mainstream health care are lack of research on efficacy, economics, ignorance about CAM, provider competition and division, and lack of standards of practice.[20] 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.[20]

In 1998, for the second year of this 3-year study, we conducted a comprehensive database search, a literature review, and a definitive survey of 10 MCOs and insurance companies identified with new CAM offerings in 1998 in order to determine the current MCO and insurance coverage for such therapies. All responses are reported as group data only since the survey participants requested that the research not link their names to specific outcomes. In the Results section, there is a summary of the obstacles to integrating CAM into conventional health care. The Discussion section describes the overall findings, conclusions, study limitations, and future research directions.

METHODS

Literature Review and Information Search

A comprehensive review of existing literature on the insurance cover-

age of CAM was initiated in January 1996 and updated in September and December 1998. 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 National Institutes of Health's Office of Alternative Medicine (now, the National Center for Complementary and Alternative Medicine—NCCAM); (3) literature sent by the NCCAM centers; and (4) consultation with experts at the Stanford University School of Medicine, UCSF/Stanford Health Systems, and the Stanford University Graduate School of Business.

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. CAM 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 would 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, semi-structured, and open-ended interviews. A random sampling is inherently inappropriate; therefore, the research team identified a second, definitive national sample of MCOs and insurance providers offering some new coverage of CAM as of 1998. As a result, the managed care/insurance carrier sample is a definitive case sample subject to qualitative methods.

This database search, literature review, and information search may not be definitive because the market in the area of CAM is changing so quickly. Nonetheless, the completeness of the information search is suggested by the fact that the researchers began to receive referrals to the same MCOs and insurers that were already identified earlier in our search.

Sample

For the second year of the survey and analysis in 1998, 10 new managed care and insurance companies were identified and subsequently surveyed between April and October 1998 for year 2 of this ongoing study. Among these 10 new companies, there were three larger "Blue" plans, including Anthem Blue Cross/Blue Shield of Ohio, Blue Cross/Blue Shield of Michigan, and Hawaii Medical Services Association. Additionally, the 1998 group included four more conventional health maintenance organizations: Matthew Thornton, Healthnet, HealthPartners, and United Healthcare. Finally, there were three CAM-oriented HMOs: Group Health Cooperative, Landmark Healthcare, and American Health Specialty Program (AHSP). Among the 10 companies, there were two Midwest companies and one from the East Coast, with the remaining being based in the western states of California, Arizona, Washington, and Hawaii. Nine of the 10 companies (90%) responded to our written survey.

Response rate in the cohort from year 1 of the study was considerably lower, with only 8 of the original 18 companies responding to our resurvey for a 44% response rate. There are several possible reasons for this. First, from the time we conducted our initial survey in 1997, a number of the research contacts within the companies were lost to turnover, which is a common phenomenon in the industry today. This made it considerably more difficult to sustain any continuity of contact within the companies for our follow-up resurvey. Second, high levels of stress and uncertainty resulting from the rapidly changing managed care/insurance industries may have made participation less likely. It is possible that the resurvey was seen as yet another unwelcome demand on time. This latter explanation seems quite plausible, given that nonresponders who said they would respond failed to do so despite multiple telephone reminders and, in several cases, remailing and/or faxing of surveys. Lastly, one carrier, American Western Life Insurance, had gone out of business since the original survey.

Structured Interviews

Research team members informed the potential respondents of the survey that this was 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. Mail surveys were sent by a Stanford researcher, with telephone follow-up calls to increase the response rate and to clarify specific points. All participants sent actual copies of their policies and materials, which are on file in the CAMPS office. We asked about 34 specific therapies from the NCCAM classification of alternative medical practices. Interview questions were both structured for baseline information and open ended to allow participants to express their beliefs and experiences without the constraints imposed by closed questions.

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. CAM 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 per week from HMOs that are considering teaching relaxation techniques to their members.[21] 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."[22] 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. First, 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 cost about 1/10 that of allopathic care.[8] 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.[11] 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.[21] 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, which has since gone out of business, 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.[23,24] 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.[25]

Table 1

CAM Therapies Covered by Insurers

Therapy	Percentage Offering Some Coverage: First Sample 1997 (n = 18)	Percentage Offering Some Coverage: Second Sample 1998 (n = 9)	Cohort of Original Companies (1997 and 1998) (n = 8)
Chiropractic	(100%)	(100%)	(100%)
Acupuncture	(94%)	(77%)	(88%)
Naturopathy	(38%)	(44%)	(63%)*
Massage	(61%)	(44%)	(88%)†
Traditional Chinese medicine	(22%)	(22%)	(13%)
Stress management/meditation	(22%)	(22%)	(50%)
Homeopathy	(44%)	(22%)	(63%)‡
Herbal medicine	(22%)	(11%)	(50%)‡

* Two companies added coverage in 1998.
† Two companies added, one dropped coverage in 1998.
‡ One company added coverage in 1998.
Note: Additional therapies for which coverage was added were craniosacral, biofeedback, and ayurvedic. Additional therapies dropped were acupressure and guided imagery.

RESULTS

Nine of the 10 new companies we surveyed in 1998 responded to our mailed questionnaire. The number of insurers or MCOs 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 companies we surveyed offered extensive coverage of CAM. Of those, the smaller companies offered more extensive coverage of CAM.

All of the nine new MCOs and insurers interviewed are currently considering additional coverage of CAM. Furthermore, all nine of the MCOs and insurers indicated that market demand was their primary motivation for offering coverage of CAM, and consumer interest was cited as a key factor in determining coverage of CAM.

Table 2

Factors that Were Most Influential in Decision to Offer CAM (n = 17)*

Reasons	Mear Rating (1 = not important; 3 = very important)
Demand from consumers	2.42
Demand from purchasers	2.25
Market research	2.23
Attract new enrollees	2.23
Retain existing enrollees	2.13
Legislative mandate	1.94
Potentially less invasive care	1.94
Demonstrated efficacy	1.93
Experience of payor executives	1.84
Perceived cost-effectiveness	1.77
Attract new (ethnic) populations	1.37

* Mean ratings averaged across both the new sample and cohort's (1997–1998) responses to this item.

Companies were asked to rate on a scale of 1 to 3 the most important factors influencing their decision to offer coverage for CAM. As can be seen in Table 2, demand from both consumers and purchasers as well as the results from market research appear to be the most important determinants. These findings are consistent with our initial study in 1997

Table 3

Therapies or Systems Designated as Having "Licensed Practitioner" 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 Dietic Association, Midwifery Alliance of North America, Upledger Institute, Touch Research Institute, American Osteopathic Association, and American Physical Therapy Association.

Note: Many states certify practitioners of biofeedback, massage, and other alternative and complementary therapists. However, this table specifically lists 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.

that identified consumer demand as the most critical factor underlying the decision to offer CAM coverage. When asked in open-ended fashion what factors would determine whether they would offer coverage for additional CAM therapies in the future, the majority of companies in our new sample again stated market demand, with demonstrated clinical efficacy cited second most frequently. In response to this question, our cohort from years 1 and 2, while again noting the importance of market factors, also cited demonstrated clinical efficacy as the most important reason.

Table 4

Obstacles to Incorporating CAM into Mainstream Health Care

Obstacles	Percentage of Companies that Cited		
	% First Sample (1997) (n = 18)	% Second Sample (1998) (n = 9)	% Cohort (1997–1998) (n = 8)
Need for more research on efficacy	44	55	75
Economics	22	44	13
Ignorance about CAM	17	0	0
Provider competition and division	22	11	0
Need for practice and license standards	33	0	13
Fear of change by medical establishment	6	55	25
Cultural biases and prejudice	11	0	0
Lack of utilization data on CAM	11	0	0
Lack of consumer or employer demand	11	0	13
Lack of insurance reimbursement	0	11	0
Lack of CAM provider networks	6	0	0
Fear of liability for referring to CAM	0	22	0

Reimbursement was described as depending on (1) market-driven rates, (2) the practitioner's license, (3) 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 procedures are being administered. They did not think this 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. Among the new companies surveyed, five stated that they were in the process of or anticipated developing CPT codes, while one company from the 1997–1998 cohort stated they were developing such codes.

Overall, a vast majority of CAM covered by insurers was covered only if the treatment was medically necessary for a specific diagnosis, and reimbursement was given only for a certain number of visits or dollar limit. Defining "medical necessity" varies from insurer to insurer but, in general, requires that 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."[25] Additionally, 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 even 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.

Summary of Obstacles to Integrating CAM

Table 4 lists the responses of insurers 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 4 list the 12 most frequently cited reasons.

Among the primary obstacles to incorporating CAM into mainstream health care as listed by insurers in our study were (1) lack of research on efficacy, (2) economics, (3) ignorance about CAM, (4) provider com-

petition and division, and (5) lack of standards of practice. Of the obstacles listed, the only one that is unique to CAM is ignorance about CAM. Research on efficacy is lacking in much of conventional medicine as well as 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, and other clinicians, as well as between conventional and CAM providers. Finally, studies of conventional medicine evidence 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.

DISCUSSION

In the interviews with insurers, the researchers inquired about 34 specific therapies from the NCCAM classification of alternative medical practices. Results indicate that some of these therapies are now covered by most insurers (e.g., chiropractic, osteopathy, and acupuncture), while other therapies are covered only by a few, smaller insurance companies (e.g., traditional Chinese Medicine and 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 usually 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 and/or cost-effectiveness.

CAM Coverage

Nonetheless, all of the nine new MCOs and insurers interviewed are currently considering additional coverage of CAM. Among our cohort of companies that were resurveyed, we observed several changes in terms of the types of therapies covered from years 1 to 2. There was an increase in the percentage of companies offering coverage for naturopathy (with two companies adding coverage for these services). There was also a slight increase in coverage for massage, with two companies adding coverage and one discontinuing coverage of this CAM therapy. Finally, we also observed marginal increases in coverage for both homeopathy and herbal medicine, with one company adding coverage for each of these therapies. Additional therapies for which coverage was added were craniosacral, biofeedback, and ayurvedic medicine. Additional therapies dropped by the cohort in 1998 were acupressure and guided imagery. In our 1998 resurvey, consumer demand continued to be the most frequently cited reason for offering CAM coverage among our original cohort of insurers and MCOs. However, there did appear to be a growing, and we believe positive, trend in terms of the cohort's mentioning demonstrated clinical efficacy as a critical factor in deciding to offer any new or additional coverage for CAM.

All nine of the MCOs and insurers interviewed indicated that market demand was their primary motivation for offering coverage of CAM, and consumer interest was cited as a key factor in determining coverage of CAM. Although insurers also stated that proof of clinical efficacy was 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 was not efficacious in terms of clinical and/or cost outcomes, when the actual cause was inadequate or token provision of such services. Relevant questions for such scenarios might include: what constitutes an adequate length of care for chronic pain with acupuncture; how effective is homeopathy with otitis media for children vs. antibiotics; 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 and insurers. Alternatively, the pressure to differentiate from other third-party payers may convince some insurers to offer coverage of a CAM therapy that is not proven to be 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.

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. In general, insurers reimburse services that are provided by a licensed practitioner, although the definition of a "licensed practitioner" varies from state to state (see Table 5).

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.

Study Limitations

All nine of the new MCOs and insurers were selected specifically because they were 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,

Table 5

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.

copies of actual policies are on file for future reference. In addition, the status of insurance coverage of CAM may be affected by changes in national legislation, such as the Access to Medical Treatment Act (H.R. 2019, S. 1035), which would allow patients to receive any medical treatment they want as 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 as 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] Despite litigation by Washington state insurance carriers, this statute was upheld by the State Supreme Court in 1998. Results of these and other legislative initiatives around the country, in California, Oregon, Arizona, and Vermont as well as in 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 MCO insurers 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 conventional and CAM providers will help determine potentially effective treatments. Such a survey will allow researchers to determine what 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 of 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. Our research group currently has a manuscript under review that examines predictors and patterns of CAM use among a Medicare population.

Research that emphasizes the development of common terminology for CAM with both conventional and alternative providers is needed to compare outcomes. One aspect of developing common terminology is to develop CPT codes for CAM. Designation of CPT codes for CAM, even if the CPT code specifies that the treatment is experimental, would facilitate large randomized clinical trials (RCTs) as well as clinical and cost outcomes studies on the effectiveness of specific CAM therapies. The current lack of CPT codes for CAM makes it difficult to determine what CAM therapy is being used and how to determine appropriate reimbursement.

Cost-effectiveness analyses are needed on individual clinically efficacious treatments, as well as on combinations of conventional and complementary treatments. Such research could compare the success of integrated, conventional, and CAM care to conventional care only. In addition, integrated clinics serve as educational resources to help reduce ignorance about CAM.[28]

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 by the Stanford research group 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 conventional 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. In Oregon, the Foundation for Accountability (FACCT), incorporated in 1995, could prove particularly useful in this endeavor. According to the FACCT brochure, this organization 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."[29] With this model to evaluate health care, the distinctions among "conventional," "complementary," "alternative," and "integrative" health care will be irrelevant. According to a recent editorial in the *New England Journal of Medicine*, "There cannot be two kinds of medicine—conventional and alternative—there is only one kind of medicine that has been adequately tested and medicine that has not, medicine that may work and may or may not work. Once a therapy has been tested rigorously, it no longer matters whether it was considered alternative at the outset. If it is found to be reasonably safe and effective, it will be accepted."[30] This is a position with which we concur, with the one caveat and observation that the vast majority of conventional medical care fails to conform to this standard of quality.

Providers of CAM need to develop standards of practice and licensing, which will help them fit into the existing diagnosis-based system.[1,16,31,32] This is more easily stated than accomplished. Many 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.[31] 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 conventional 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 and even more so for interventions 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. Surely, the NIH NCCAM, which has already funded 12 research centers as well as over 45 pilot studies and three major ongoing RCTs, will be helpful in facilitating the evaluation of CAM. However, with a relatively modest budget of only $50 million in fiscal year 1999, additional funding sources are clearly required.

SUMMARY AND CONCLUSIONS

An increasing number of MCOs, insurers, and hospitals are including CAM 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 what may be inadequately documented services. Both federally funded and managed care/insurance provider research is needed to determine what constitutes clinically effective services versus token services that 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, there needs to be a great deal more research on clinical efficacy and cost outcomes in order to responsibly incorporate CAM into mainstream health care. Emphasis on what is validated by sound clinical and cost outcomes research rather than what is considered "alternative" vs. "conventional" will be critical to reducing excessive medical care utilization and containing rising medical care costs.

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References

1. Eisenberg DM, Davis RB, Ettner SL, et al. Trends in alternative medicine use in the United States. JAMA 1998;280:1569–75.
2. Astin JA. Why patients use alternative medicine: results of a national study. JAMA 1998; 279:1548–53.
3. Singh N, Squier C, Sivek C, et al. Determinants of nontraditional therapy use in patients with HIV infection. Arch Intern Med 1996;156:197–201.
4. Coleman LM, Fowler LL, Williams ME. Use of unproven therapies by people with Alzheimer's disease. J Am Geriatr Soc 1995;43:747–50.
5. Fawcett J, Sidney JS, Hanson MJ, et al. Use of alternative health therapies by people with multiple sclerosis: an exploratory study. Holistic Nurs. Pract. 1994;8:36–42.
6. Sutherland LR, Verhoef MJ. Why do patients seek a second opinion or alternative medicine? J Clin Gastroenterol 1994;19:194–7.
7. Cohen CJ, Eisenberg DM, Mayer, et al. Prevalence of non-conventional medical treatments in HIV-infected patients: implications for primary care. Clin Res 1990;8:692A. Abstract.
8. Perelson GH. Alternative medicine: what role in managed care? FHP J Clin Res 1996;5:32–38.
9. Mitchell S. Healing without doctors. Am Demogr 1993;15:46–49.
10. Carey TS, Garrett J, Jackman A, et al. North Carolina Back Pain Project. The outcomes and costs of care for acute low back pain among patients seen by primary care practitioners, chiropractors, and orthopedic surgeons. N Engl J Med 1995;333:913–7.
11. Ullman D. The mainstreaming of alternative medicine. Healthcare Forum J 1993;3:24–30.
12. Sabatino F. Mind and body medicine: a new paradigm? Hospitals 1993;67:66–72.
13. Brown E. Alternative medicine converts its skeptics. Managed Healthcare 1996;6:24–27.
14. Southwick K. Kaiser showcases innovative research projects. Managed Healthcare 1995 6–8.
15. Edelson M. Can the new medicine cure yc Washingtonian Feb. 1996:68–85.
16. Gruman JC. Should alternative medicine stay alternative? Adv J Mind–Body Health 1995;11: 65–69.
17. Ornish D, Brown SE, Scherwitz LW, et al. Can lifestyle changes reverse coronary heart disease? The lifestyle heart trial. Lancet 1990; 336:129–133.
18. Ornish D, Scherwitz LW, Billings JH, et al. Intensive lifestyle changes for reversal of coronary heart disease. JAMA 1998;280:2001–7.
19. Lloyd P, Lupton D, Wiesner D, et al. Choosing alternative therapy. Aust J Public Health 1993;17:135–44.
20. Pelletier KR, Marie A, Krasner M, et al. Current trends in the integration and reimbursement of complementary and alternative medicine by managed care insurance carriers, and hospital providers. Am J Health Promot 1997; 12:112–23.
21. Russell S. HMOs try dose of alternative medicine. San Francisco Chronicle 22 Jan. 22, 1996:1,4.
22. Simmons SJ. The economics of prevention. Am Nurs Assoc Publ 1993;(CH-27 5M):1–9.
23. Austin P. As demand for alternative therapy grows, coverage lags behind. Maine Times 4 Apr. 1996:2.
24. Baar K. Insurance coverage for all healthcare. Nat Health 1995;25:74.
25. Padgug RA. Alternative medicine and health insurance. Mount Sinai J Med 1995;62:152–62.
26. Mabry M. Insurance companies study their alternatives. News Tribune. 1 Jan. 1996.
27. Knickerbocker B. Who pays for alternative medical care? Christian Science Monitor 1 Mar. 1996.
28. Gaudet TW. Integrative medicine: the evolu-

tion of a new approach to medicine and medical education. Integrative Med 1998;1: 67–73.
29. Foundation for Accountability Backgrounder. Leaflet.
30. Angell M, Kassirer JP. Editorial. N Engl J Med 1998;339:241-2.
31. Colgate MA. Gaining insurance coverage for alternative therapies. J Health Care Marketing 1995;5:24–8.
32. Johnson NP. Insurer endorses alternative medicine. Business Insur 1993;27:1,7.

Appendix

Interview Questions for MCO Insurance Companies

Coverage

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

Coverage: Areas of Investigation

- How do you decide what fields of practice to cover? What information do you need? In what form do you need this information? Do you have a database to evaluate clinical and cost outcomes of CAM? Would you be interested in codeveloping or using such a database?

Criteria for Reimbursement

- How do you determine whether a patient can be reimbursed for CAM therapy and how much to reimburse? 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? What kind of coverage limits are imposed? Number of treatments? Cost? What kinds of preauthorizations are required? Do recipients self-refer? 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? How does your CAM coverage vary, if at all, with the age of the patient? What age-related factors influence your coverage of CAM?

Definitions

- Do you believe that currently acceptable CPT is used when in fact alternative medicine procedures are being administered? How often? Do you believe that specific DRGs are used to describe undiagnosed conditions (e.g., "dry wind" described as "sinusitis")? How often? Do you anticipate developing CPTs/DRGs for alternative medicine?

Providers

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

Issues and Obstacles

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

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

Clinton Presidential Records
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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: Employers' Perspectives

Questions for the Panel on Employer Perspectives

What trends do you see for employee benefit plans now and for the future? What trends do you see for complementary and alternative medicine (CAM) benefits?

What factors influence your decisions regarding benefit plans and coverage? (for example, industry patterns of employee benefits, employee interest, employee retention, cost or price concerns, research, available resources, etc.)

Can you provide us with written materials describing your benefit plans? Do you or have you considered offering employees CAM benefits? How do you determine which CAM benefits to offer? What types of parameters would you use to control cost and utilization -- for example, co-payments or other payment incentive, dollar limits, required referral, preauthorization, benefit limits such as number of visits or type of condition, benefit periods, etc.? Do you have any comments on the effectiveness or impact of such limits?

Describe your experience, including concerns and issues, in considering CAM benefits, and the outcome. (for example: coding issues, training and qualification of providers, etc.)

Describe generally (non-proprietary information) how premiums for your health benefit plans are established, including costs of types of services, utilization, rating, etc. How would cost and charges be addressed in adding a CAM benefit to your plan? What are your concerns and issues?

What ideas or concerns can you offer the Commission as it develops policy recommendations regarding coverage and reimbursement of CAM?

WHITE HOUSE COMMISSION on COMPLEMENTARY

and ALTERNATIVE MEDICINE POLICY

TESTIMONY

Tom Sawyer, PhD

ON BEHALF OF WILLIAM M. MERCER, INCORPORATED (MERCER), I THANK YOU FOR THE OPPORTUNITY TO PROVIDE TESTIMONY TO THE COMMISSION. THE INTEREST OF EMPLOYERS IN COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) BENEFITS HAVE, IN LARGE PART, PARALLED BUT LAGGED BEHIND THE GENERAL CONSUMER INCREASE IN UTILIZATION OF CAM SERVICES.

EMPLOYERS INTERESTED IN ENCOURAGING USE OF CAM THERAPIES HAVE GENERALLY ADOPTED ONE OF SIX MODELS OR STRUCTURES:

- CAM INFORMATION PROGRAMS, WHERE THE MEMBER MAY RECEIVE TELEPHONIC OR INTERNET-BASED INFORMATION ABOUT CAM ISSUES,
- CAM DISCOUNT PROGRAMS, WHERE THE MEMBER MAY RECEIVE A PRE-NEGOTIATED DISCOUNT FROM A PANEL OF PRESCREENED PROVIDERS,
- CAM BENEFIT ACCOUNT, WHERE THE MEMBER IS GIVEN A FIXED ANNUAL MAXIMUM FOR CERTAIN CAM EXPENSES AND USUALLY REQUIRING A COPAY,
- CAM INDEMNITY/PPO COVERAGE, WHERE THE PLAN MEMBER CAN ACCESS THOSE SERVICES COVERED UNDER THE PLAN WITHIN PLAN LIMITS,
- CAM RIDER, WHERE MEMBERS CAN ACCESS SERVICES UNDER AN HMO PROVIDED PLAN THAT ALSO MANAGES UTILIZATION AND LIMITS THE NUMBER AND KIND OF CONDITIONS WHICH ARE COVERED, AND
- ON-SITE CAM SERVICES, WHERE EMPLOYEES MAY ACCESS CERTAIN SERVICES ON-SITE SUCH AS MASSAGE THERAPY AT DISCOUNTED PRICES.

PRIMARILY BECAUSE OF EMPLOYEE DEMAND FOR SUCH SERVICES, EMPLOYERS HAVE INCREASINGLY IMPLEMENTED CAM PROGRAMS INTO THEIR SPONSORED PPO, POS, HMO, AND INDEMNITY PLANS. A 1999 EMPLOYER SURVEY SPONSORED BY THE INTERNATIONAL SOCIETY OF CERTIFIED EMPLOYEE BENEFIT SPECIALISTS INDICATED THAT THE PRIMARY REASON TO IMPLEMENT CAM PROGRAMS WAS EMPLOYEE RELATED, AS REPORTED BY 37% OF RESPONDENTS. THESE RESPONDENTS FELT THAT CAM BENEFITS SHOWED THEIR RESPONSIVENESS TO EMPLOYEE REQUESTS OR GAVE THEM A COMPETITIVE EDGE IN ATTRACTING AND RETAINING EMPLOYEES. TWENTY-THREE PERCENT OF RESPONDENTS GAVE A REASON RELATED TO THE POTENTIAL FOR IMPROVED HEALTH OR MEDICAL CARE, AND 13% STATED THE NEED FOR STATE MANDATED

COMPLIANCE AS THE PRIMARY REASON TO IMPLEMENT CAM BENEFITS. ANOTHER 27% DID NOT ANSWER THE QUESTION.

SINCE 1998, MERCER HAS SURVEYED EMPLOYERS' INCLUSION OF CAM BENEFITS THROUGH ITS BENCHMARK MERCER/FOSTER HIGGINS NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS. THE FOLLOWING TABLES ARE TAKEN FROM THE 2000 SURVEY, INDICATING CURRENT AVAILABILITY OF CAM BENEFITS BY THERAPEUTIC MODALITY, REGION, INDUSTRY, SIZE OF EMPLOYER, AND TYPE OF HEALTH PLAN.

[INCLUDE TABLES HERE]

COVERAGE BY MODALITY

RESULTS OF THE 2000 SURVEY CONTINUE TO SHOW THAT CHIROPRACTIC CARE IS THE MOST FREQUENTLY COVERED ALTERNATIVE THERAPY. EIGHTY-FOUR PERCENT OF PPOS AND INDEMNITY PLANS COVER THIS THERAPY, A SLIGHTLY HIGHER PERCENT THAN THE PREVIOUS YEAR. AMONG HMO PLANS, 66 PERCENT OF EMPLOYERS OFFERED CHIROPRACTIC CARE. OF THE FIVE MODALITIES SURVEYED, BIOFEEDBACK WAS LEAST OFTEN COVERED. AS COMPARED TO THE 1998 SURVEY, THE PERCENT OF EMPLOYERS OFFERING THESE MODALITIES HAS INCREASED FROM THREE PERCENT (MASSAGE THERAPY) TO TWENTY-ONE PERCENT (CHIROPRACTIC), REGARDLESS OF TYPE OF HEALTH PLAN.

COVERAGE BY REGION

REGIONAL DIFFERENCES FOR COVERAGE OF ALL MODALITIES CAN BE NOTED. GENERALLY, EMPLOYERS IN THE NORTHEAST AND WEST MORE FREQUENTLY OFFER COVERAGE FOR CAM THERAPIES, REGARDLESS OF TYPE OF PLAN OFFERED. ONE NOTABLE EXCEPTION IS THE LESS FREQUENT COVERAGE OF CHIROPRACTIC CARE IN THE WEST FOR PPO AND HMO PLANS.

COVERAGE BY INDUSTRY

EMPLOYERS IN THE GOVERNMENT, FINANCIAL SERVICES, SERVICE, AND HEALTH CARE SECTORS ARE GENERALLY MORE LIKELY TO OFFER CAM BENEFITS, REGARDLESS OF TYPE OF PLAN. AS A MODALITY, HOMEOPATHY COVERAGE IS LEAST CONSISTENTLY OFFERED ACROSS INDUSTRY SECTORS. THE RETAIL MANUFACTURING AND TRANSPORTATION/COMMUNICATIONS/UTILITIES SECTORS ARE LEAST LIKELY TO OFFER CAM COVERAGES.

COVERAGE BY SIZE OF EMPLOYER

REGARDLESS OF HEALTH PLAN TYPE, EMPLOYERS WITH 20,000 OR MORE EMPLOYEES WERE MORE LIKELY TO OFFER COVERAGES FOR ACUPRESSURE/ACUPUNCTURE, BIOFEEDBACK AND CHIROPRACTIC WHILE

COVERAGE FOR HOMEOPATHY AND MASSAGE THERAPY WERE MORE INCONSISTENTLY COVERED. EMPLOYERS WITH FEWER THAN 20,000 EMPLOYEES WERE MORE INCONSISTENT IN THEIR COVERAGE PATTERNS.

COVERAGE BY TYPE OF HEALTH PLAN

ACUPRESSURE/ACUPUNCTURE, BIOFEEDBACK, AND CHIROPRACTIC WERE ALL MORE LIKELY TO BE OFFERED IN A PPO OR INDEMNITY PLAN THAN AN HMO PLAN. POS PLANS CLOSELY PARALLEL PPO PLANS IN PATTERNS OF COVERAGE ACROSS ALL MODALITIES. THE MOST SIGNIFICANT DIFFERENCES IN FREQUENCY OF COVERAGE OCCURRED WITH CHIROPRACTIC CARE, WHERE 84 PERCENT OF EMPLOYERS OFFERING PPO OR INDEMNITY PLANS OFFER THIS MODALITY WHILE ONLY 66 PERCENT OF HMO PLANS DID. EMPLOYER-SPONSORSED HMOs OFFERED NO CAM BENEFITS 31 PERCENT OF THE TIME COMPARED WITH 15 PERCENT OF PPO AND INDEMNITY PLANS NOT OFFERING CAM BENEFITS.

CAM PROGRAM COSTS

COSTS FOR CAM PROGRAMS ARE LOW TO MODEST AND VARY WITH THE TYPE OF PROGRAM OFFERED. INFORMATION ONLY, DISCOUNT AND ON-SITE PROGRAMS USUALLY ARE LESS THAN $1 PER EMPLOYEE PER MONTH. ON THE OTHER HAND, OFFERING BROAD CAM BENEFITS CAN COST $10 TO $20 PER EMPLOYEE PER MONTH, DEPENDING ON PLAN DESIGN, LOCATION, EMPLOYEE DEMOGRAPHICS, PROVIDER CONTRACTING, UTILIZATION MANAGEMENT, AND OTHER FACTORS. MOST PROGRAM COSTS FALL BETWEEN $1 AND $10 PER EMPLOYEE PER MONTH. SAVINGS FROM TRADITIONAL MEDICAL CLAIMS, REDUCED DISABILITY COSTS, AND DECREASED ABSENTEEISM AND TURNOVER MAY OFFSET THESE COSTS. HOWEVER, IT IS RARE TO FIND WELL-DONE EVALUATION RESEARCH OF THIS TYPE IN PRACTICE.

ISSUES WITH CAM PROGRAMS

EMPLOYERS ARE FACED WITH SEVERAL ISSUES WHEN CONSIDERING CAM PROGRAMS FOR THEIR EMPLOYEES:

- FIRST AND FOREMOST IS THE MANAGEMENT OF FINANCIAL RISK,
- GEOGRAPHIC VARIATION IN PROVIDER LICENSURE AVAILABILITY AND REQUIREMENTS FROM STATE TO STATE,
- TAX AND COMPLIANCE ISSUES REGARDING SECTION 213 OF THE INTERNAL REVENUE CODE, AND
- HOW TO MEASURE PROGRAM SUCCESS.

CHALLENGES FOR THE FUTURE

THE CHALLENGE FOR THE FUTURE OF CAM IS THE ABILITY TO ESTABLISH SAFE, RELIABLE TREATMENTS THAT ARE BOTH CLINICALLY EFFECTIVE AND AFFORDABLE. EMPLOYERS ARE NOT SCIENTISTS OR PROVIDERS. AS PAYORS, THEY LOOK TO THE SCIENTIFIC AND HEALTH DELIVERY COMMUNITY TO BRING TREATMENTS TO THE MARKET THAT WILL MEET DEFINITIONS OF GOOD VALUE IN TERMS OF PROMOTING EMPLOYEE HEALTH AND PRODUCTIVITY. THE ABILITY TO INTEGRATE THESE MODALITIES INTO TRADTIONAL HEALTH DELIVERY WILL BE DIFFICULT UNTIL THESE CHALLENGES ARE MET.

THANK YOU

Alternative Medicine Therapies

Traditional Medical Indemnity Plans

	Percentage of employers who cover:				
	Acupressure/ acupuncture	Biofeedback	Chiropractic	Homeopathy	Massage Therapy
Large Employers	25%	11%	84%	8%	13%
By Region					
West	33%	21%	83%	16%	9%
Midwest	15	9	83	4	10
Northeast	34	10	89	9	16
South	21	9	78	6	14
By Industry					
Manufacturing	27%	11%	85%	9%	11%
Wholesale/Retail	14	5	80	6	8
Services	24	10	87	8	13
Transport/Communic/Utility	39	8	80	6	11
Health Care	14	23	73	8	16
Financial Services	42	10	91	8	10
Government	28	16	85	17	25
By Number of Employees					
500-999	24%	13%	89%	12%	17%
1,000-4,999	25	10	79	6	11
5,000-9,999	22	10	87	5	8
10,000-19,999	21	8	83	1	6
20,000 or more	38	16	84	11	11
All Employers	19%	5%	79%	8%	10%
Small Employers	19	5	79	8	10

Percents do not total 100 due to multiple responses

n=658

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Kathleen M. King
Vice President
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Kathleen King has worked in health policy and administration for more than twenty years. She is currently Vice President of the Washington Business Group on Health (WBGH), where she is responsible for overall management of the organization, strategic planning and resource development. WBGH is a national nonprofit organization devoted to the analysis of health policy and related work site issues. WBGH members include 165 of the nation's largest and most innovative public and private sector employers that provide health coverage to more than 39 million American workers, retirees and their families. WBGH's mission since 1974 has been to represent employers in promoting market-based, performance-driven health care delivery systems that improve the health and productivity of companies and communities.

Immediately before coming to WBGH, she was with the Health Care Financing Administration, the federal agency responsible for the administration of Medicare, Medicaid and the State Child Health Insurance Program. From 1995 to 1998, she was Executive Assistant to Administrator Bruce Vladeck. As chief assistant to Dr. Vladeck, and member of the senior management team, she worked closely with the agency's leadership to define issues, resolve problems and assure that key priorities were met. She then served as Executive Associate Administrator with Nancy-Ann DeParle from 1998 through 2000. She functioned as the chief of staff, the third ranking official in the agency, and oversaw many agency operations, including human resources. She was a key advisor to the Administrator on both policy and operational issues.

Prior to that, she was Professional Staff Member of the Senate Finance Committee, where she worked on Medicare policy and payment issues and health care reform. She has also worked for the Congressional Research Service, the Indiana State Budget Agency, the Intergovernmental Health Policy Project at George Washington University, the Ohio Department of Human Services and the Ohio Legislative Service Commission.

Complementary and Alternative Medicine: The Employer Perspective

Statement of

Kathleen King

Washington Business Group on Health

Before the

White House Commission on Complementary and Alternative Medicine Policy

May 14, 2001
Washington, DC

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Good afternoon members of the White House Commission on Complementary and Alternative Medicine Policy. It is an honor to be here today to speak with you about a new wave in consumer-driven health care options, complementary and alternative medicine.

The Washington Business Group on Health is a national nonprofit organization devoted to the analysis of health policy and related work site issues from the perspective of the large employer. Our members include 165 of the nation's largest and most innovative public and private sector employers that provide health coverage to more than 39 million American workers, retirees, and their families. WBGH's mission since 1974 has been to represent employers in promoting market-based, performance-driven health care delivery systems that improve the health and productivity of companies and communities.

Employers' Growing Interest in CAM

Employers have a real stake in the health of their workforce, because the vitality of their businesses depends on it. A healthy workforce translates to lower absenteeism, reduced workers' compensation costs, increased productivity, and decreased direct medical expenses. A healthy workforce promises more efficiency and productivity than a sick population. In this way, employers have a very real and direct interest in ensuring that their workforce is in the best health.

Employer interest in complementary and alternative medicine (CAM) responds to a variety of changes in the health care market. Health care consumers today are better informed and want to take charge of their own health care. The health care community values prevention and overall wellness more than ever. Today's workforce is multicultural and has a different set of ideas about health care that include CAM along with the traditional medical services. Employers recognize that by providing these benefits, they can satisfy the demand of their employees for alternative and relatively low cost health care options.

One of the primary reasons that CAM has grown in popularity in recent years is that consumers today are more involved in their treatment and actively work with their health care providers to determine the course of their own care. Empowered with more information about health care options, consumers want their health plans to cover a range of options as they take charge of their own health. The interest in such options is illustrated in a recent online survey conducted by *Modern Healthcare.* The majority or 69% of respondents said that they want health insurance to cover such treatments and 77% of respondents want more research dedicated to alternative medicine. About half or 49% of respondents reported that their organization's health plans cover some types of CAM.

Another change in the health care environment is the move toward a holistic approach to health. This approach aims to treat the whole person, rather than focusing on specific

ailments or illnesses. Many CAM health care services are holistic. Massage therapy, for instance, often works to reduce overall stress and prevent illness, in addition to working to resolve specific health problems. As health promotion and disease prevention have become more widely accepted and valued, CAM health care services have also gained acceptance. For example, some employers offer nutritional counseling or reduced rates on vitamins and herbal remedies, benefits that appeal to people who actively participate in caring for their own health and preventing illnesses.

In addition, today's workforce has many faces. Our population is growing more diverse, as the results of the 2000 census indicate. As the U.S. becomes increasingly multicultural and multiracial, the influences of other cultures become pervasive. For example, CAM approaches such as acupuncture, acupressure, tai chi and use of medicinal herbs that have their roots in Eastern cultures have become much more widely accepted. The aging of the U.S. population is also contributing to a shift in health care practices. As baby boomers age, they are turning increasingly toward practices such as massage therapy and yoga to extend and prolong their vitality.

CAM has also become more widely recognized and respected in the health care community. While CAM options still sit outside of the traditional types of health care treatments, they enjoy more acceptance from the health care community because of the rise

in clinical evidence showing effectiveness. The development of clinical guidelines for CAM options has also helped to validate these services as viable treatments.

The changes in the marketplace and approaches to health care set the tone for the kinds of benefits that employers offer their employees. From the employer perspective, offering CAM options to supplement other health benefits is a way to provide a relatively low cost benefit that is highly valued. Moreover, to the extent that they substitute for or prevent the need for more costly health services, they are also cost-effective. Offering CAM benefits enhances employee recruitment and retention efforts and has the potential to improve health, productivity, and morale.

CAM Options Offered by Employers: Case Examples

A variety of large and small employers offer CAM to their employees. While chiropractic care is the most frequently covered service, acupuncture/acupressure is also increasingly covered, as is massage therapy when prescribed by a physician. I am sure my colleague from Mercer will speak more about a 2000 survey conducted by William M. Mercer[1]; which found that 70% of employers cover chiropractic care (up from 62% in 1999), 17% of plans cover acupressure/acupuncture (up from 12% in 1999), and 12% cover massage therapy (up from 7% in 1999). A growing number of employers permit flexible spending

account (FSA) reimbursement for out-of-pocket payments for CAM benefits. Others are offering access to a discounted network of CAM providers. Still others offer services directly at the worksite. In addition, employers who are adding internet-based, or e-health options that permit the customization of benefits in varying degrees, often include CAM benefits in the menu of choices available to employees.

The following examples illustrate some of the various employer approaches to offering CAM benefits to their employees.

- A large quasi-government agency offers yoga, tai chi, and aerobics classes to its employees. It also offers "Alternative Therapies for Menopause" workshops, with presentations from herbalists, acupuncturists and allopathic OBGYNs. Employees may seek reimbursement of CAM expenses through their flexible health care spending accounts. Reimbursement for classes requires a minimum level of attendance.
- A hearing aid manufacturer provides a full-time rolfer on site after experiencing skyrocketing workers' compensation costs due to carpal tunnel syndrome (rolfing is a type of massage therapy). The health plan now covers rolfing, chiropractic and acupuncture. This employer reports very positive outcomes, including reduced workers' compensation costs and increased productivity.

[1] William M. Mercer, *National Survey of Employer-Sponsored Health Plans 2000*

- A research and technology company offers CAM as a recruitment and retention tool. It finds that offering CAM helps to reinforce its corporate image as an innovative leader. This employer offers a 50% discount for yoga, acupuncture, nutritional counseling, and holistic care for pets through certified provides in order to decrease absenteeism and lower health care costs.
- A large telecommunications company offers employees a weekly massage day and provides space for two visiting massage therapists. Employees can purchase 10-minute massages for $8. In addition, this employer provides lunchtime classes in aerobics, yoga and tai chi. Chiropractic care is included as part of the standard health benefit.
- A large health plan offers discounted access to vitamins, minerals, and herbal supplements through a partnership with a supplier.
- A hospital in Virginia added massage therapy to its benefits after an employee survey revealed a high demand for this option. Employees pay about half the cost of massage therapy, and this expansion led to the development of a stress reduction program.
- A high tech company on the West Coast began offering CAM benefits through a carve-out program in response to rising health costs. This employer offers herbal supplements with a $5 co-pay and chiropractic and acupuncture with a $10 co-pay for up to 40 visits.

- A specialty food manufacturer provides biweekly on-site massages, spending over $10,000 on the benefit.

These case examples illustrate the wide range of CAM benefits that employers offer. In addition, some employers respond to needs that go beyond the "traditional" alternative options of massage therapy, acupuncture, and chiropractic care. For example, other benefits gaining the attention of employers include homeopathy, meditation, and spiritual counseling.

More Research Needed

While employees value the addition of CAM as a benefit option and some data support on its effectiveness, employers still need more information about the costs and benefits of CAM. The ability of CAM to improve recruitment and retention, enhance corporate images, decrease absenteeism, improve morale, lower health care costs, and decrease disability costs remains to be seen in concrete research. Before CAM coverage becomes a standard health benefit, employers will need more information to ensure that providing CAM meets the health needs of the workforce and is a cost-effective way to spend already scarce health care dollars. Further research on the clinical effectiveness and cost-effectiveness of CAM therapies would be very beneficial.

That concludes my remarks today. Thank you for your time today as you consider this issue facing employers and other health care stakeholders. I appreciate the opportunity to share the Washington Business Group on Health's perspective on this issue and welcome any questions from the commission.

Judith E. MacPherson is the Corporate Benefits Manager for CACI International Inc, an Arlington, Va. based government contracting company. She also serves as an advisor to CACI's 401k Investment Committee. Her previous experience includes employment as the Manager of Employee Services for QuesTech, Inc. for 9 years where she managed both the Benefits and Payroll functions of the company. She has worked in the insurance industry for both Mutual of New York and USAA and has held life, health and NASD licenses. She represents CACI in a local consortium of employers who meet to share their experiences and concerns in trying to provide competitive and cost effective benefits to their employees. She is a member of the Society for Human Resource Management.

Changes in Employee Health Coverage By Small Businesses

Small businesses are key to job growth in the United States, accounting for more than three-quarters of job expansion in most years. Over 40% of all employees work in firms with fewer than 100 employees or are self-employed. Yet this source of economic opportunity and growth is also the weakest link in America's employer-based health insurance system. The problems of the uninsured are closely tied to the availability and cost of health insurance in the small employer sector—where one out of every four workers is uninsured.

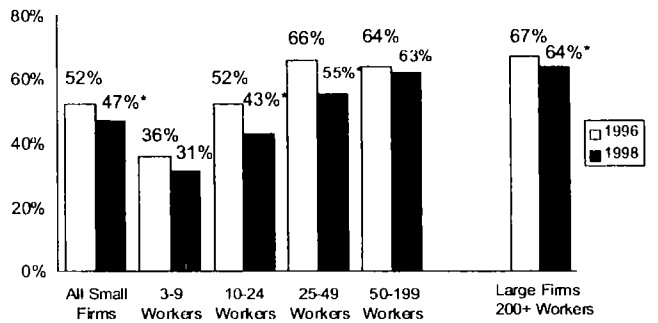
As part of the Kaiser Family Foundation's efforts to monitor changes in America's uninsured, it commissioned researchers at KPMG Peat Marwick to conduct national surveys of small businesses' health benefits in 1996 and 1998, as well as a new report prepared by Jon Gabel and associates, entitled Health Benefits of Small Employers in 1998. Key findings about the health benefits offered by small employers (firms with less than 200 employees) are summarized here, including changes in health premiums, cost-sharing requirements, eligibility for health benefits, and shifts in the types of plans small companies now offer.

Decreasing Health Coverage

During a period of robust economic growth between 1996 and 1998 the percentage of small business employees with coverage through their employer decreased from 52% to 47%. Decreases occurred across most sizes of firms, including large businesses. The erosion of coverage was most severe among firms with 25-49 workers, where 55% of all workers were covered by their own employers' plan in 1998, down from 66% in 1996 (Fig. 1)

Figure 1

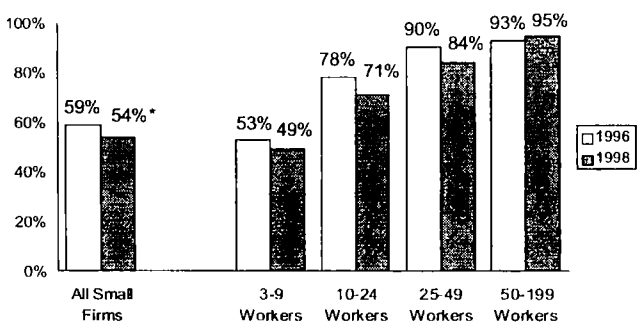
Percentage of Employees Covered by Own Employers' Health Plan, 1996-1998, by Firm Size



*Changes between 1996 and 1998 are statistically different (p <.05)

Figure 2

Percentage of Small Firms Offering Health Benefits, 1996-1998, by Firm Size



Note: Data for large firms are not available; however, almost all large firms offer health benefits
*Changes between 1996 and 1998 are statistically different (p <.05)

The decline in coverage is likely due to fewer small firms offering health benefits in 1998 than had in 1996—59% down to 54% (Fig. 2). Small business employees are as willing to participate in health plans as employees in larger firms. This is true across all sizes of small employers, despite the fact that premium contributions are greater in smaller firms and employees are earning less than workers in large firms. Health coverage may also be decreasing in part because employers are tightening the eligibility rules for coverage. Job-based health benefits in 1998 were less accessible to part-time workers in small businesses than in 1996 and the waiting period before an employee can enroll in the company's health plan increased.

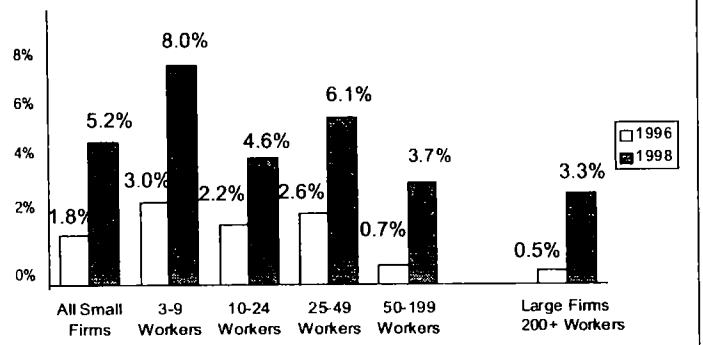
Increasing Health Insurance Costs

Cost to the Employer

Premiums for small employers increased 5.2% overall between 1997 and 1998 (Fig. 3). The smallest employers (3-9 workers) experienced the greatest premium increase of 8%. While modest by historic standards, the 1998 premium increase substantially exceeded the rate of 1.8% for small businesses in 1996. Small employers (<200 workers) have typically experienced higher annual increases in their premiums than larger employers (200+ workers) employers by one to two percentage points, which continued to hold true in 1998.

Figure 3

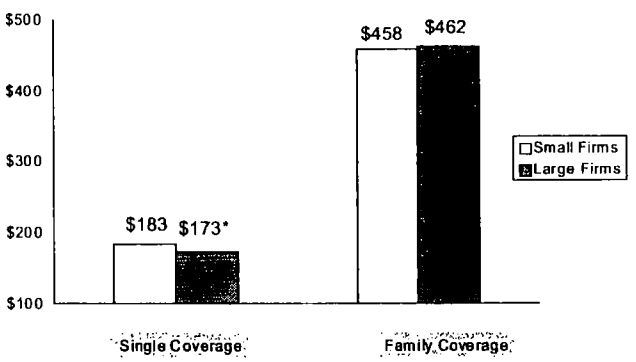
Percentage Increase in Family Premiums, 1996 and 1998, by Firm Size



*Changes between 1996 and 1998 are statistically different for all firm sizes ($p < .05$)

Figure 4

Monthly Premiums by Firm Size, 1998



*Premiums between small and large firms are statistically different ($p < .05$)

The monthly cost of premiums in 1998 was about the same for small and large employers. Premiums for single coverage cost $183 for small firms and $173 for large firms on average (Fig. 4). Costs for family coverage were almost identical at about $460. An important exception is the substantially higher premiums paid by the smallest businesses (3-9 workers), where for example, monthly family coverage cost $520. While large businesses experienced increases in premiums for family coverage but not for their single coverage, small businesses experienced significant increases in both between 1996 and 1998.

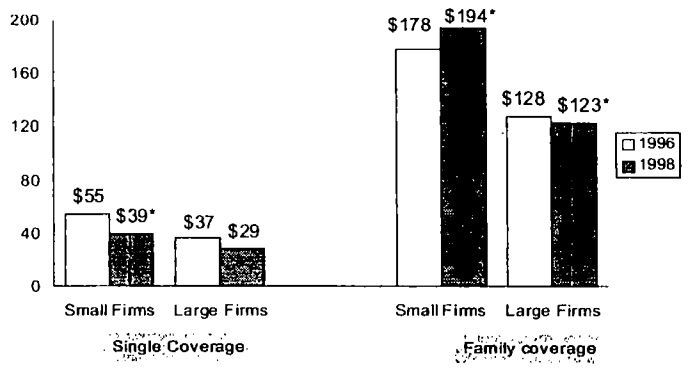
Increasing Health Insurance Costs

Costs to the Employee

Even though premiums are similar for small and large companies, employees in small firms pay a much larger share of the health premium than do employees of large firms. Family coverage for workers in small businesses was $194/month in 1998 compared to $123/month for large firms' employees. Cost-sharing for single coverage was also higher for employees of small businesses (Fig. 5).

Figure 5

Change in Monthly Employee Contributions 1996-1998, by Firm Size



*Changes between 1996 and 1998 are statistically different (p <.05)

Employee contributions for single coverage—in terms of absolute dollars—decreased among small businesses between 1996 and 1998, despite the fact that premiums increased for small employers. Contributions for family coverage however, did increase. It seems that small employers, in making trade-offs between the types of plans they offer and keeping employee contributions affordable, have decreased cost-sharing for single coverage of their own workers, but have not extended that to their workers' dependents.

Besides paying premiums, employees also shoulder the additional costs for deductibles. Workers in small firms pay more out-of-pocket here also. For example, their average preferred provider organization (PPO) single coverage deductible was $246 last year compared to $163 for workers in large firms. Employees of the smallest businesses (3-9 workers) paid the highest average deductibles, the most expensive being family conventional coverage at $948 in 1998.

In effect, health insurance offered to workers in small businesses is far less of a value. They contribute substantially more for premiums and also pay higher deductibles—both without the benefit of being able to choose among different types of health plans.

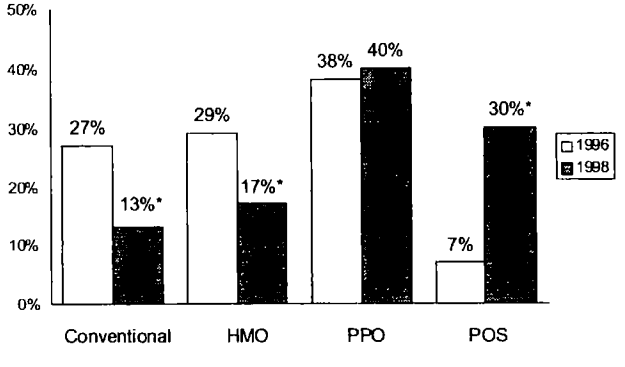
Increasing Health Insurance Costs

Shifting Away from HMOs

To temper premium increases, small employers have moved in recent years from more expensive conventional plans to less expensive managed care plans. However, between 1996 to 1998, small firms not only dropped conventional coverage, but they also dropped HMO coverage—perhaps in an effort to better balance premiums and choice in health providers. This pattern was also true for large businesses. Because HMOs do not require deductible amounts to be paid before the insurance covers some or all of the health services, they are the least expensive type of health plan from the employee's perspective.

Figure 6

Market Share of Health Plans Among Small Firms, 1996-1998



*Changes between 1996 and 1998 are statistically different ($p < .05$)

Firms dropping conventional coverage tend to move to PPOs, while employers dropping HMO coverage opt for point-of-service (POS) coverage. In fact, the largest shift in market share between 1996 and 1998 occurred in the percent of workers in small business who are covered by a POS plan—30% in 1998 compared to only 7% in 1996 (Fig. 6).

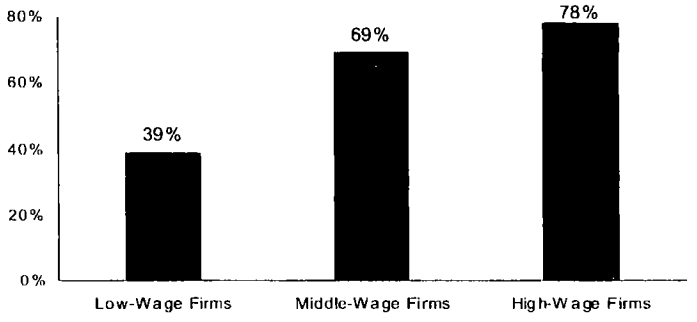
It's important to bear in mind that over 90% of small business employees who are offered health benefits have no choice in the type of health plan; only one is offered. Consequently, when small companies switch from an HMO plan to a POS plan, often to expand choice in health providers, employees will have to pay more. Even when HMO and POS premiums are the same, employees are now also responsible for the annual deductible when they incur medical expenses—and POS deductibles can be even higher than conventional plans' deductibles when using non-network providers.

Double Jeopardy for Workers:
Small businesses and Low Wages

Whether or not a firm offers health insurance coverage is a function not only of its size, but also its wage structure. Small businesses with many low-wage employees are far less likely to offer coverage than small firms with mostly higher-wage workers (Fig. 7). Among small businesses in 1998, "low-wage" companies (where 35% or more of the workforce earns less than $20,000/year) were half as likely to offer health benefits as "high-wage" companies (where 10% or less of the workforce earns less than $20,000).

Figure 7

Percentage of Small Firms Offering Health Coverage, by Wage Structure, 1998

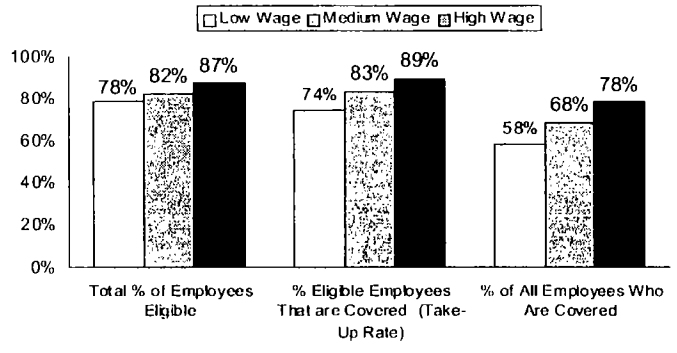


Note:
Low-wage firms—35% or more of workforce earn less than $20,000/year
Medium-wage firms—between 10.01 - 34.99% of workforce earn less than $20,000/year
High-wage firms—10% or less of workforce earn less than $20,000/year

Source: Gabel, J., for the Kaiser Commission on Medicaid and the Uninsured

Figure 8

Eligibility, Participation, and Coverage in Small Firms with Health Benefits by Wage Structure, 1998



Source: Gabel, J., for the Kaiser Commission on Medicaid and the Uninsured

When health benefits are offered, take-up rates (the proportion of workers who choose to participate) in low-wage firms are remarkably high at 74% (Fig. 8). Almost 90% of workers in high-wage firms chose to participate in their own company's health plan in 1998. Low-wage firms require their employees to bear a somewhat greater share of the premium than high-wage firms, which may partially account for the differences in take-up rates. In addition, fewer employees are even eligible for benefits in low-wage firms. The result is that among small firms that offer health benefits, only 58% of low-wage companies' employees have health benefits through their job compared to 78% of employees in high-wage companies.

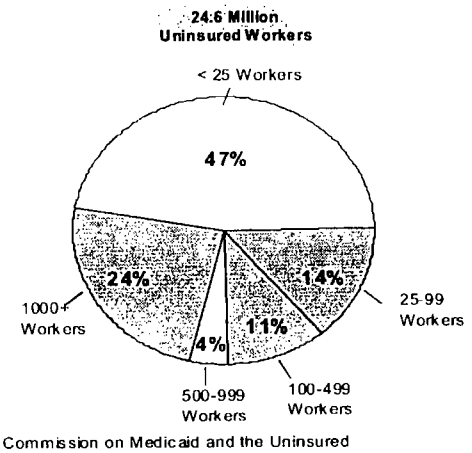
Uninsured Workers Disturbing Trends

The proportion of Americans insured through job-based coverage decreased significantly between 1987 and 1993, but has stayed relatively stable since then. These findings suggest the trend may begin to turn downward again.

Twenty five million workers—more than one in six workers in the United States was uninsured in 1997. Over 60% of uninsured workers are employed by businesses with fewer than 100 employees (fig. 9). More than three-quarters of the uninsured working in small companies are full-time employees. Most of these full-time workers are working for businesses that do not offer health benefits at all. In companies where benefits are offered some of the uninsured are new employees waiting to become eligible, some are part-time or temporary employees and will never be eligible, and others are choosing not to participate. More than two-thirds of uninsured workers make less than $20,000 a year, which makes buying individual health insurance coverage—and even paying part of an employer's plan—increasingly difficult.

Figure 9

Percentage of Uninsured Workers by Firm Size, 1997



Source: Kaiser Commission on Medicaid and the Uninsured

In the past decade nearly every state has enacted some form of health insurance reform to expand access to health plans for small businesses. Separating the impact of these laws from premium changes that occurred over the same period is difficult. Whether or not these laws have actually effected workers health coverage is not clear, at best they may have slowed the downward trend.

The changes in small business' health coverage are worrisome. Offer rates are declining and eligibility requirements are tightening even in these times of relatively lower premium growth (compared to double-digit premium inflation earlier in the decade). Should substantial inflation in health insurance premiums reoccur, the willingness of small employers to offer health benefits is likely to suffer further and even more workers may lose their health insurance.

Good afternoon ladies and gentlemen. My name is Judy MacPherson and I am the corporate Benefits Manager for CACI International Inc.

CACI International Inc is a worldwide leader in information technology, e-Business, and network solutions. Founded on simulation technology in 1962, the company has evolved a diverse solutions portfolio for today's net economy. From across the technology spectrum, CACI integrates the networks, systems, and software for telecommunications, e-Commerce, information assurance, and all forms of information management with approximately 5,000 employees and more than 90 offices in the U.S. and Europe.

Providing a competitive package of health and wellness benefits for these employees is a challenging and increasingly costly undertaking.

Since the 1800s, employers in this country have had a practical interest in the health of their employees. Industries in remote areas often provided company doctors to care for their injured or sick workers. Some of these early employment based programs covered care for not only workers but their families and the community as well. These programs were often funded by deductions from workers' wages. The concept of prepaid health care began to spread with funding from foundations and hospitals, which eventually led to the formation of Blue Cross. World War II accelerated the growth of employment-based benefits.

However, it was not until 1954 when the IRS made it clear that the employer cost of providing health benefits was not taxable to the worker but was still tax-deductible to the employer as a business expense that employer provided health insurance grew to become the most common source of health insurance in the United States.

Over the past 50 years, the majority of working Americans have looked to employers as the source of their health insurance. In 1999, 66% of all Americans were covered by employment-based health plans. What started with manufacturing, grew with the unions, and then the Blue Cross system has become an expected entitlement of traditional employment. Employers who do not offer health benefits or whose health benefits are not up to community standards have greater difficulty attracting and retaining employees. According to a recent survey, sixty-five percent of workers

responding rated employment-based health insurance as their most important employee benefit.

As recently as the mid-80s, health care was a relatively cheap and easily managed benefit for employers to provide to their employees. Everybody had a $100 deductible and 80/20 co-insurance. Over the last 10 years, the industry has changed to the point that everyone now expects to pay $10 to go to the doctor and $10 to fill a prescription. Unfortunately, those expectations are becoming no more realistic today than the $100 deductible. Managed care was touted as the salvation of an increasingly costly system. The fact is that it was simply a stopgap measure, which contained health care cost for several years but reached a saturation point. We are now at that point - where most of the savings that could be squeezed out of the health care delivery system, have been. In addition, both patients and providers have become frustrated and are demanding more control over how health care dollars are spent.

As an employer, I hear the complaints daily. They range from dissatisfaction with their managed care plan to requests for more managed care. Truthfully most employees want it all. They want a choice of physicians but they do not want to pay more for it. I have also personally experienced doctors and hospitals dropping out of networks across the country; either because the insurer is paying them too little or too slowly or because there is little competition in their particular area and therefore no incentive to join or stay in a managed care network. Just this week a local HMO in the Midwest announced that it was going out of business – right in the midst of our open enrollment!

Within the last several years, we have seen the cost of providing health benefits begin climbing again. This has been attributed to advances in technology, our aging population and the appearance of hundreds of new drugs being marketed directly to consumers. Pharmacy benefit costs alone have risen from 15 – 25% in the last 3 years.

In a recent survey of Certified Employee Benefit Specialists conducted by Deloitte and Touche and the Society of Certified Employee Benefit Specialists, the key objective driving benefit policy and design is employee attraction and retention and the top objective for the year 2000 was to control health and welfare costs. This is the first time in the survey's history

that the same issue has been identified as the top priority for two years in a row.

These increases translate into higher costs for the employee as well as the employer. In businesses such as ours with low profit margins, more of the cost increases have to be shared with the employee. In order to keep monthly premiums down, co-pays and deductibles have to be raised.

When we go to the marketplace to obtain quotes for the benefits we provide, we are finding fewer and fewer options. As insurance providers have merged in order to maintain their profit margins, competition among carriers has nearly vanished for companies of our size and complexity.

On the one hand, employers have to make a profit. On the other, in order to attract and retain the best employees in a tight job market, the employer must offer a competitive and attractive benefits package. Employees are demanding and getting more and more unconventional work place perks.

In this environment, ancillary programs become more important. Many health insurance carriers are beginning to add discount programs for vitamins, herbs and alternative care such as acupuncture and massage therapy to their services. Employees themselves want more corporate support for non-conventional treatment options.

According to an article by Dr. Michael Steinberg, M.D., in the February 2000 issue of Baltimore Health Quest, complementary and alternative medicine is the fastest growing sector of the health care industry. The public's desire and demand for something more than pills and shots for the treatment of symptoms is fueling the demand for corporate support for these types of services.

The interconnection of the mind and body on the overall health of an individual is well documented. Financial difficulties, marital problems, substance abuse – the list goes on. All of these have a direct impact on the health and productivity of our workers. The costs of illness to employers are far greater than the cost of health insurance claims. It includes lost time, lowered productivity and mortality among workers. It is in our interest as employers to promote the health and well being of our employees and their families.

As alternative therapies have become more popular, employees now expect their health plans to cover them. This leaves the employer with the dilemma of wanting to provide additional "wellness" benefits but fearful of endorsing unproven therapies.

Just a few years ago, most plans limited benefits for chiropractic care. Now it is generally covered at the same rate as any other health service. The change was driven by employee demand and the recognition of the benefits of chiropractic in treating lower back pain.

CACI has chosen to promote healthy lifestyles by providing informational materials; encouraging wellness by including benefits for such things as well baby care, mammograms and annual physicals in our health plans; providing a confidential Employee Assistance Program; and by adding a separate, voluntary program which provides discounts for complementary and alternative medicine. Adding discount programs either through the insurance carrier or as a stand-alone program is one way that we can currently add value to our program without adding cost.

It may seem intuitive that if employees take advantage of complementary and alternative therapies, it will ultimately reduce their usage of the traditional health care system and thereby reduce employer costs. Once again, this could be a two-edged sword. If employees eschew traditional medicine in favor of alternative therapies there is always the possibility that they will ignore serious health issues that could lead to the need for more expensive treatment later.

It is a universal dilemma and one with which I am keenly familiar. Recently in the local area a consortium has been formed of employers like mine who are meeting regularly to explore the possibility of creating a group buying cooperative for pharmacy services and to discuss other employee benefits issues in general. These are companies who are competing for the same labor in the same market and yet are actively seeking to share knowledge to improve not only our delivery of health and welfare benefits to our employees but to explore ways to alleviate some of the administrative burden of doing so.

When I speak of administrative burden, there are a number of areas to consider. There is still a certain expected paternalism in many companies and employees have become used to having an employer representative to

talk to about their health care enrollment, help them with their claims problems and generally help them through the maze of modern health care – utilization review, predetermination of benefits, proof of medical necessity etc. etc.

As a medium sized employer, CACI employs seven (7) benefits staff level administrators who are solely devoted to administering our benefit programs. Five (5) of them are devoted solely to health and welfare issues. What do all these people do? The answer is - mostly paperwork. A huge amount of time goes into making sure that employee benefit enrollments and changes are processed to our internal systems and to the outside benefit providers. The staff also answers employee questions, assists in claims processing and reconciles and pays bills.

Each year the law requires us to perform discrimination testing on some of our plans and to file returns with the Department of Labor. We must maintain up to date plan descriptions for written materials and for our website.

We are also challenged by the need to communicate effectively with employees in far flung locations.

Because we maintain fully insured health plans, one of our biggest challenges is meeting the requirements of mandated state benefits. While not all mandated benefits apply to plans of companies headquartered elsewhere, many do and changes come often. We must be aware of and respond to them quickly.

In order to stay competitive, employers such as CACI participate in industry and regional surveys. Completing these surveys takes up a considerable amount of time. A single benefit survey can require 2-3 days of a staff member's time. Each year we complete 5-7 benefit related surveys. We do this in order to measure ourselves against our competition. In addition, we peruse trade publications and online newsletters to stay abreast of trends.

As an employer representative, I can assure you that considerable research and thought go into choosing benefits for our employees.

And yet surveys show that employees are becoming less satisfied with their benefits. According to findings of the 2000 Health Care Survey, Americans

are becoming more critical of the health care system. The survey shows continued concern about escalating health care costs and a lack of confidence in the future of the health care system.

Speaking personally I see a trend beginning - back to more choice and protection for patients and more indemnity-like benefits in health plans. The employee is beginning to understand that he, as well as the employer, is a consumer of health care. In order to become a smart consumer, the employee needs to be aware of the true cost of pharmaceuticals and services.

If there is one thing I would like you to take away from this discussion, it is the assurance that Benefits professionals in business are committed to helping their companies attract and retain qualified employees and are open to new ways to promote the health and welfare of their employees. The challenge remains to do so while containing costs and easing administration.

I'd like to thank you for giving me the opportunity to provide our views on this important subject.

Coverage – What Should be Covered!!
– Must distribution on Clinical + Cost Effectiveness of PBM
Productivity
Cost effectiveness/Wellness is a 4x return on Productivity
Employer Should needed to do cost effectiveness studies.
Wellness could be Applied to employees by employers

References:

Fronstin, Paul, 2001. "The History of Employment Based Health Insurance: The Role of Managed Care". Benefits Quarterly, 2nd Quarter 2001.

Employee Benefit Research Institute. Findings From the 2000 Health Confidence Survey. Vol.22, no.4, April 2001;

Employee Benefit Research Institute. Job-Based Health Benefits Continue to Rise While Uninsured Rate Declines. Vol.21, no 11, November 2000.

Steinberg, Michael, " Not Just Pill Pushers & Poppers", Baltimore Health Quest, February 2000.

ISCEBS Survey of Top 5 Benefit Priorities for 2001, November 29, 2000.

Breakout Sessions - Responsibilities of Chair

- 0 Conducts Session - Please Note the Need to Preclude Public Participation Because of Time Limitation. If Observers Have Any Comments or Suggestions, They Should Provide Them in Writing to the WHCCAMP Staff Member Present at The Session.

- 0 Guides Discussion

- 0 Moves Panel to Consensus.

- 0 Constructs Recommendations, Themes, and Concerns On the Issues

- 0 Writes Each Recommendation or Themes, and Concerns on Flip Chart After Reaching Consensus.

- 0 Brings Discussion to Conclusion.

- 0 Presents Breakout Summary to Commission.