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Divider Title: Special Populations

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White House Commission on Complementary and Alternative Medicine Policy

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Deputy Assistant Secretary for Minority Health

Department of Health and Human Services

May 14, 2001

Thank you for the opportunity to frame the issues and identify questions regarding the use of complementary and alternative medicine by racial and ethnic minorities.

The Office of Minority Health (OMH) was created by the U.S. Department of Health and Human Services (HHS) in 1986, in response to the 1985 *Report of the Secretary's Task Force on Black and Minority Health*. This report analyzed the continuing disparity in health status experienced by Blacks/African-Americans and other minorities when compared to the population as a whole, as reported in the 1983 issue of *Health, United States*. OMH advises the Assistant Secretary for Health and the Secretary on public health issues affecting Blacks/African-Americans, Hispanics/Latinos, American Indians and Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders. OMH strives to encourage change through improving and strengthening the public health infrastructure necessary to address the disparities in health and health care that impact racial and ethnic minority populations. In addition, OMH advocates for improved data

collection and analysis, supports demonstration programs and program evaluations; conducts important information dissemination activities and policy analyses; and, in general, provides leadership through coordination and development activities such as conferences and publications.

Today, there are continuing disparities in the burden of illness and death experienced by racial and ethnic minorities compared to the total U.S. population. These disparities demand national attention, in spite of noteworthy progress in the overall health of the Nation. The demographic changes that are anticipated over the next decade will magnify the importance of addressing disparities in health status. Population groups currently experiencing poorer health status are expected to grow as a proportion of the total U.S. population. Therefore, the future health of Americans will be influenced substantially by the Nation's success in improving the health of racial and ethnic minorities. A national focus on disparities in health status is particularly important as major changes unfold in the way in which health care is delivered and financed.

Eliminating racial and ethnic disparities in health will require greater efforts to prevent disease, promote health, and deliver appropriate, quality health care. Enhancements will entail improved collection and use of increasingly standardized data to identify high-risk populations and to monitor the effectiveness of the health care interventions targeting them. Research on the relationships among health-status variables and racial and ethnic minority identities will help to establish a better understanding of new ways to apply the existing knowledge base in ultimately achieving the goal of eliminating disparities. Improving access to quality health care and delivering prevention and treatment services will require working closely with communities to

identify culturally competent strategies.

In January 2000, the national disease prevention and health promotion agenda for the year 2010 was launched–Healthy People 2010. For the first time, this agenda contains an overarching goal of eliminating disparities. To achieve this ambitious goal, we are asking that organizations in both the public and private sectors (the States and territories, private foundations, local government agencies, community organizations, and the Congress) join efforts. Assistance is needed to (1) inform youth about careers in medicine and health, (2) ensure that congressionally funded programs are designed to increase the number of minority students enrolling in and graduating from professional and allied health care occupational training programs, (3) enhance our efforts in health promotion and education of racial/ethnic minority communities, (4) promote personal responsibility for healthier lifestyles, (5) enhance medical school curricula to improve physician/patient communication, (6) fund research on the underlying causes of disparities in health status and health care, and (7) ensure equal access to quality health care services and equal protection under the law. In applying sound scientific principles and empirical evaluation findings to public health policy and program development, and, in educating individuals and communities about prevention and the health care system, we will stimulate policy, research, and the health care interventions that improve the Nation's health as a whole.

In response to the question, "is there a role for CAM in efforts to eliminate health disparities?" I would answer, "Yes." In each of the areas I have just outlined.

As defined by the National Institutes of Health: Complementary and alternative medicine (CAM) covers a broad range of healing philosophies, approaches, and therapies. Generally, it is defined as those treatments and healthcare practices not taught widely in medical schools, not generally used in hospitals, and not usually reimbursed by medical insurance companies.

Several studies have been conducted on the use of CAM by race and ethnicity. I would like to share with you a few examples of these studies. Nationally representative studies such as the Agency for Healthcare Research and Quality's Medical Expenditures Panel Survey have found the use of CAM medical providers to be lower for Hispanics and African Americans than whites. The use of chiropractors was also found by the RAND Health Insurance Experiment to be higher for Whites than for racial and ethnic minorities. Conversely, Wolsko et al found race and ethnicity were not predictors of using a CAM practitioner among clinic attendees. Among Mexican-Americans, the use of traditional healers has ranged from 4% reported in the Hispanic Health and Nutrition Examination Survey to 20% in a small study of caregivers at a pediatric primary care facility in Houston.

Boutin et al also found that race did not predict the use of CAM among outpatients and physicians at a municipal hospital, although the use of manual healing and herbal medicine did differ by race. Use of traditional folk remedies was associated with Hispanic ethnicity by Palinkas in the SURNET study.

These findings suggest that the use of more expensive therapies such as chiropractic care by

racial and ethnic minorities is lower than the general population, while the use of herbal teas and other less expensive therapies may actually be higher. What is clear from these findings is that it is important for studies to distinguish specific CAM providers and therapies when determining the use of these modalities. We are therefore encouraged that NIH's National Center for Complementary and Alternative Medicine is working with the National Center for Health Statistics (the main statistical agency of the Department of Health and Human Services) to include approximately 10 minutes worth of questions on the use of CAM providers and therapies on the National Health Interview Survey in 2002. Since this is the largest national health interview survey, this will enable future analyses of the use of CAM providers and therapies by race and ethnicity, as well as other socioeconomic and demographic variables.

Recognizing the importance of including this fast changing health care field in delivery of care, the Health Resources and Services Administration (HRSA) established a Integrative Medicine and Alternative Health Practices (IMAHP) Initiative to provide guidance and technical assistance with the integration of CAM with conventional primary care at BPHC-funded programs. On October 3, 2000, HRSA/BPHC issued a Program Assistance Letter to community health centers, migrant health centers and grantees to provide guidance regarding privileging and credentialing CAM providers, written policies and procedures for CAM modalities, and Federal Tort Claims Act Coverage. As this letter notes, "to be culturally and linguistically appropriate, it is necessary to integrate complementary and alternative therapies with conventional medicine, indigenous healing practices, as well as the primary language of the patient."

The Indian Health Service also recognizes that many American Indian and Alaska Native people use traditional healers instead of Western medicine or in conjunction with Western medicine. In many cases, it is crucial to their healing process to know they have access to both. Some will only take Western medicine after consulting with the traditional healer. Most AI/AN are more comfortable talking to their Western doctor if they know that the Western doctor knows and understands the importance of traditional healing ways. This is why at IHS clinics, traditional healers are now seen as important members of the health care team. These healers are paid by the tribes.

This past year, the National Institutes of Health developed a five-year strategic plan to reduce and ultimately eliminate disparities in health. The National Center for Complementary and Alternative Medicine (NCCAM) is working with the new National Center on Minority Health and Health Disparities to incorporate CAM research issues for racial and ethnic minorities in this strategic plan. NCCAM's Institutional Research Training grants support research training at minority and minority-serving institutions for individuals who are training for careers in biomedical, behavioral, and clinical research related to CAM.

The Agency for Healthcare Research and Quality has been supporting research on CAM since they were created in 1989. In addition to their earlier work on the use of CAM for low back pain and the MEPS findings on the use of CAM which I shared with you earlier, they have been working closely with the NIH to improve the methodology for studying alternative therapies.

During 1995, OMH established a "center without walls", the Center for Linguistic and Cultural Competency in Health Care to encompass existing and new policy, partnering, communications, service demonstrations and evaluation activities related to cultural competency. Activities of this center have included development of a comprehensive research agenda for culturally and linguistically appropriate care. Another project is to develop cultural competency curriculum at the University of Texas Health Science Center. In December 2000, OMH published National Standards on Culturally and Linguistically Appropriate Standards in Health Care. Public comments were incorporated. These recommended standards, if followed, would include more sensitive use of CAM. The first recommendation states "Health Care Organizations should ensure that patients/consumers receive from staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language." This means that providers are familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrate these approaches into treatment plans.

Of concern is that approximately 40-50% of the United States population who use CAM, do not currently share this information with their health care providers. This may result in adverse effects (e.g., contraindications, unnecessary use of prescribed drugs or too high dosage, and interference with prescribed drugs). Contraindications are a concern, especially for those with chronic diseases such as diabetes. And, racial and ethnic minorities are more likely to have a chronic disease such as asthma, diabetes, hypertension and kidney disease.

Although rarely discussed in the environmental health literature, culturally related factors can also increase the susceptibility of a member of a minority group or could even be the source of a toxic exposure. Potential sources of toxic exposure include use of traditional medicines such as "azarcon" and "greta" (lead-containing treatments for gastrointestinal distress) brought to the United States by immigrants or well-meaning friends of relatives, and contaminants such as salmonella in rattlesnake capsules pose health risks. Newly arrived immigrants have tragically mistaken toxic plants in the United States for safe, edible plants from their native country.

The most important barrier to receiving safe and effective CAM for racial and ethnic minorities, though, is ability to pay. Racial and ethnic minorities are more likely to live in poverty and have fewer assets. Although we are aware that CAM providers offer sliding fees, our biggest concern is that lack of general health insurance is much more common among racial and ethnic minorities than the general population. In 1998, almost 1 out of 5 African-Americans and Asian or Pacific Islanders, and 1 out of 3 Hispanics under the age of 65 did not have health insurance compared to 1 out of 6 Whites. Since racial and ethnic minorities use CAM to complement Western medicine (not instead of Western medicine), providing general health coverage is of primary importance.

Other barriers to access to CAM which are important to consider for racial and ethnic minorities include differential access to specialists. Attention needs to be paid to location of providers, transportation issues, availability of child care and after work hours, and consideration of preferred language and literacy needs. OMH is sponsoring an Institute of Medicine study on "Understanding and Eliminating Racial and Ethnic Disparities in Health Care." This 17 month

study is in response to a Congressional mandate that a study be conducted on the extent to which bias impacts medicine and health care and its relationship to demonstrated racial and ethnic inequalities in health. Meetings and public workshops are publicized on the National Academy of Sciences website (www.nas.edu).

In addition to learning more about the IOM study and possibly participating in future meetings, we encourage you to become involved in discussions regarding options to cover the more than 39 million uninsured in this country. We also recommend that all patients be asked by health care providers regarding use of CAM, preferably at every visit. Our brief literature review of the use of CAM among racial and ethnic minorities suggests that more research is needed regarding the use of CAM by racial and ethnic minorities, and content of training of health care professionals in CAM–with more detail as to specific modalities. Further research and stronger monitoring efforts are needed to ensure the safety and effectiveness of CAM treatments. We also recommend that providers and third party payors consider the cultural competency standards in their efforts to improve cultural competency of their health care delivery system.

TESTIMONY TO
WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY
UNDERSTANDING COVERAGE AND REIMBURSEMENT

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Thank you for the opportunity to present to this important Commission and panel. You have asked members of this panel to address the issue of how coverage and reimbursement issues affect access to Complementary and Alternative Medicine (CAM) services for minorities, the uninsured and underinsured. In my comments, I will address the larger issues of coverage for the under and uninsured, making some references to how lack of coverage may affect access to CAM services.

The lack of health insurance remains one of the most glaring examples of how the United States differs from other countries. Despite a robust economy, the number of uninsured nonelderly persons increased steadily in the 1990s, reaching 43.9 million in 1998 before dropping slightly in 1999, to 42.1 million. This welcome decline in the number of uninsured persons, however, offers no guarantee that the overall trend has changed. Health care costs and insurance premiums are once again increasing rapidly, just as the economy is slowing. If these trends persist, the number of uninsured persons in the United States is likely to grow. Let me try to address - questions that I believe are critical in any discussion of this important area.

- Who Are the Uninsured?
- What Difference Does Health Insurance Make?
- Where Do the Uninsured Get Medical Care?
- What are the Obstacles to the Expansion of Health Insurance Coverage?
- What Strategies are under Discussion in Congress?

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Who Are the Uninsured?

The uninsured are invisible to most Americans, yet they are all around us. More than 80 percent of uninsured persons are from families in which at least one member is employed. They care for children, build homes, mow lawns, drive taxis, and work in low-wage jobs in restaurants, bookstores, and gas stations. Almost two thirds of uninsured persons are under the age of 35 years, and more than half are in families with incomes below 200 percent of the federal poverty level, or less than $34,100 for a family of four. Hispanics represent only 13 percent of the overall population in the United States but account for more than one quarter of uninsured persons.

What Difference Does Health Insurance Make?

Not having health insurance does make a difference. Those who have it are likely to receive more and better health care. Those who do not have it are more likely to delay obtaining necessary, even life-saving care. According to a recent report by the American College of Physicians and the American Society of Internal Medicine, uninsured persons are much more likely than insured persons to refrain from seeking needed care and to suffer the consequences of delayed or forgone care. For example, those without health insurance are more likely to have had hospitalizations that could have been prevented and to have received a diagnosis of cancer at an advanced stage. Although many of the studies summarized in this report did not control for selection bias, other research confirms that these discrepancies persist after adjustment for demographic, clinical, and socioeconomic factors. Lack of health insurance has financial consequences as well; medical expenses are a leading cause of family debt and bankruptcy.

Where Do the Uninsured Get Medical Care?

The uninsured obtain most of their care from private physicians, but they also receive care from government-funded and private clinics and hospitals. Despite the availability of charity and emergency care, uninsured persons are substantially less likely than those with insurance to have a usual source of care.

Private hospitals bear over 60 percent of the costs of uncompensated care, and private, office-based physicians provide more than 75 percent of ambulatory care for uninsured patients and those with Medicaid coverage. Furthermore, over 75 percent of doctors report that they provide at least some charity care -- on average, more than 10 hours a month. Government-sponsored clinics and hospitals are another important source of care for uninsured patients. However, recent fiscal strains caused by declining private and public reimbursement rates have limited the capacity of these institutions to act as a safety net. In addition, financial pressures may be eroding charity care in the private sector by reducing the time physicians spend providing such care. Physicians practicing in communities with high proportions of people enrolled in managed care (high market penetration) give 25 percent less charity care than their counterparts in low-penetration areas. Physicians who derive most of their practice revenue from managed-care plans provide less charity care than those who receive little revenue from such plans. Uninsured patients in areas with high managed-care penetration are less likely to visit physicians

or to have a usual source of medical care and are more likely to have unmet health care needs than are patients in low-penetration areas.

What are the Obstacles to the Expansion of Health Insurance Coverage?

First, public opinion about the uninsured does not always reflect the facts, and this is a major impediment to the expansion of coverage. Despite the evidence that health insurance matters, many people believe the uninsured get all the care they need from emergency rooms, public clinics, private physicians, and other sources. In October 2000, 57 percent of the public believed this to be true, as compared with 43 percent in 1993. Yet most physicians know how difficult it is for people without health insurance to obtain primary and specialty care, radiological and laboratory tests, and prescription medications. In addition, many people do not realize that more than 80 percent of uninsured persons are from families that have one or more employed members but they just scrape by and cannot afford to pay for premiums or large co-payments with after-tax dollars. Given the average monthly premium for an employer-sponsored family policy, which was $529 in 2000, it is not surprising that many low-wage workers are either not offered coverage by their employers or cannot afford to pay their share of the premium.

Second, strong political constituencies move issues through Congress, and the uninsured are not a strong constituency. Compare the level of congressional interest in a Medicare drug benefit, patients' rights, or women's health with the degree of concern about the uninsured. Issues involving the elderly, members of health maintenance organizations (HMOs), and women trump those involving the uninsured, who have lower voting rates, are less likely to contribute to political campaigns, and lack an organized group to represent their interests.

Third, expanding health insurance coverage costs money. Exactly how much depends on the number of uninsured persons who would be covered, the benefits they would receive, and the extent to which those already insured could take advantage of the new subsidies. Also important are the savings from charity care that would no longer be required, as well as savings from avoidable hospitalizations. According to recent estimates, the net annual costs to the public sector could range from $20 billion to $40 billion, for a program that would reduce the number of uninsured persons by up to 25 percent, to over $300 billion, for universal coverage. Although the current federal budget surplus would cover the costs, there are competing claims on these dollars, including proposals for cutting taxes, reducing the national debt, increasing military spending, improving education, and protecting the environment. There are also competing

priorities for health care: pharmaceutical benefits for elderly persons, long-term care insurance, and increased reimbursements for teaching hospitals, HMOs, nursing homes, and home health care providers. This may be the biggest challenge to this Commission as you explore ways to expand coverage for Complementary and Alternative Medicine. The private sector often takes its lead from Medicare policy and getting expanded benefits for CAM would seem very difficult.

Finally the proportion of the population that is uninsured varies widely among the states and depends mainly on the numbers of employers that provide health insurance. During the recent presidential campaign, much was made of the large number of uninsured persons in Texas (25 percent of the nonelderly population). However, only 67 percent of persons in Texas have employer-sponsored or other private coverage, as compared with 86 percent in Minnesota. Thus, for everyone to have coverage, the proportion of the state population enrolled in public programs would be much higher in Texas than in Minnesota. There are also large variations in the percentage of uninsured persons among communities. For example, 32 percent of children in Los Angeles are uninsured, 17 percent in Miami, 4 percent in Syracuse, and 3 percent in Boston.

What Strategies are under Discussion in Congress?

Three different strategies were discussed in the 106th Congress and are being reconsidered in the 107th: changing the tax policy with respect to health insurance; expanding public programs such as the State Children's Health Insurance Program, Medicaid, and Medicare; and instituting market reforms to lower the cost of health insurance for small employers.

Tax Policy

Under current law, employer-sponsored health insurance coverage is heavily subsidized through the tax system. Employers' contributions toward health benefits are exempt from income and payroll taxes, reducing federal revenues by as much as $115 billion in the year 2000. These subsidies benefit high-income taxpayers the most.

Several recent proposals would use the tax code to subsidize an expansion of health insurance coverage. Most of these proposals build on the existing system of tax subsidies, although at least one would revamp the entire tax-subsidy structure, redistributing subsidies to low- and moderate-income people. These revisions of the tax code would require complex administrative procedures for accounting purposes, to ensure equity, and to prevent fraud.

Most of the proposals would provide tax credits to taxpayers, allowing them to reduce their federal tax payments by some or the entire amount spent for health insurance. Generally, such credits would be refundable, enabling low-income families to claim the credit even if they owed no taxes. Refundable tax credits would essentially be the equivalent of vouchers for the purchase of health insurance.

An alternative approach is to expand existing tax deductions for purchasing health insurance. Currently, self-employed taxpayers can claim "above-the-line" deductions for part of their health insurance costs (i.e., the deduction is available to those who take the standard deduction as well as to those who itemize deductions). The deduction is not available, however, to people who are not self-employed but who purchase nongroup (i.e., individual) coverage. Some proposals would allow people who did not have access to employer-sponsored coverage and who purchased coverage themselves to claim the deduction as well. Of course, tax deductions benefit only those who pay taxes and therefore do not help the poorest families. And the deductions provide greatest relief to those with the highest incomes.

Supporters of tax-based subsidies argue that they separate health insurance from employment and thus give consumers a greater choice of plans. Critics counter that subsidizing the purchase of individual coverage could erode the existing employment-based system, since employers might drop coverage or workers might purchase individual coverage and then bargain with their employers for higher wages. In addition, actually achieving substantial gains in coverage would be costly for the federal government. Subsidies would have to be large to encourage participation by the uninsured, and many of those eligible for subsidies would already have coverage. Moreover, critics argue that regulation of the individual-insurance market varies widely from state to state. Therefore, some people might have to pay considerably more for individual coverage than they do now for similar coverage under an employer-sponsored plan. However, supporters claim that a large increase in the number of people with individual policies could help stabilize the individual-insurance market.

Establishing tax credits also raises complex questions about implementation. Would credits be made available only to persons without access to employer-sponsored coverage? If so, how would their eligibility be verified? Would the credit be a flat amount or would it vary according to income or the amount spent for coverage? Would it be made available before coverage was purchased? If so, would some type of tax adjustment be required if a person's income changed during the year? The administrative feasibility of specific tax proposals will be determined by how they address such questions.

Another tax-based strategy for expanding coverage is to provide tax credits to small employers. Proponents of this approach believe that it would encourage small employers to offer coverage to employees. In the past, however, subsidizing small employers resulted in disappointingly low percentages of workers who signed up for subsidized coverage. Moreover, just as it would be difficult to provide individual tax credits only to persons who would otherwise be uninsured, it would also be a major challenge to offer tax credits only to employers who would otherwise not provide insurance coverage (or who would pay only a small percentage of the premium). Quite apart from the issue of equity, this restriction on eligibility would be difficult to enforce, especially given the turnover of employers in the small-business market.

Some economists and conservative politicians have long favored medical savings accounts, in conjunction with high-deductible plans that provide coverage for catastrophic costs. Persons with high-deductible plans can use these accounts, which are tax-preferred personal savings accounts; to pay for deductibles, coinsurance, and other uncovered medical expenses. Those who support this approach argue that it gives people the flexibility to decide how to use their health insurance dollars and encourages them to be more cost-conscious. Critics claim that medical savings accounts contribute to adverse risk selection by selectively appealing to people who are healthy and wealthy. Medical savings accounts are also faulted for requiring complex accounting procedures, and they have not proved popular in the recent national demonstration.

Expansion of Existing Public Programs

Another proposal for increasing health care coverage is to expand the scope of existing public programs for the uninsured. Prominent options include raising the maximal income level for enrollment in Medicaid and the State Children's Health Insurance Program, extending the latter program to include low-income adults, and opening up Medicare to early retirees.

Supporters of this approach argue that it makes sense to expand existing public programs. But some critics view Medicaid and the State Children's Health Insurance Program as overly complex and in need of simplification. Others fear that an increased federal role in health care will lead to increased taxes and burgeoning government bureaucracies. With the Federal budget under active debate, policies in this are a very much a moving target.

Market Reforms

Almost one third of small firms (those with fewer than 50 employees) that offer health insurance coverage purchase it through a pooled arrangement. Some members of Congress are interested in creating new forms of pooled

purchasing that would be exempt from certain state insurance regulations, as a way of reducing the costs associated with state-mandated benefits as well as administrative costs, spreading risks of unequal use of medical resources among larger groups, and expanding the choice of health plans. However, the Congressional Budget Office has estimated that these proposed changes would result in a minimal expansion of health insurance coverage, since most of the participants would be insured in any case.

Are minorities, the uninsured and underinsured more vulnerable to questionable CAM practices?

As we see shifts in the demographics of our population, with increased immigration from Asia, the Caribbean and Latin America, people are bringing traditional health beliefs and practices that include the use of CAM. In addition, some minority groups such as U.S. born African-Americans have folk health remedies that have been passed on through the generations for treatment of a certain ailment. I spent many years working in a low income clinic in inner city San Francisco, where the percentage of the uninsured was around 70%. Many of my patients were first and second generation immigrants from Texas and Louisiana. For some of my older patients, even though they were U.S. born, English was a second language because they were raised speaking French Creole. When some of these patients ran out of money to buy the medicine for treatment of their high blood pressure, they turned to drinking garlic juice instead of purchasing a prescribed diuretic or beta-blocker. Clinically, I used this information as a sign that my patients were concerned about their health and tried to provide them with counsel regarding the effectiveness of their chosen folk remedy, where evidence existed, but I worked even harder to get them the traditional medicines needed at low or no cost. To the extent that CAM is a part of one's health belief system, these populations may use CAM in conjunction with use of traditional medical treatments. For those people who lack access to traditional medical services, they may substitute use of a folk remedy for a medication, thinking that the treatments are equivalent. Lack of widespread knowledge of the efficacy of CAM services exists for people of all socioeconomic groups; however low income people may be more vulnerable, due to lack of money to pay for traditional, prescribed therapeutics.

Final comments

Lack of insurance coverage is a complex problem, and the obstacles to its solution are formidable. Skeptics might conclude that this is not a promising time to expand health insurance coverage. However, there are reasons for optimism. The fact that Congress is split evenly between the two parties could force partisans to seek common ground. The Robert Wood Johnson Foundation has been committed to reducing the numbers

of uninsured since its founding more than 25 years ago. We have invested hundreds of millions of dollars into solving this problem and will continue to do so. I urge this Commission to not only address the coverage of CAM, but to put any recommendations in the context of what I consider to be a national embarrassment- that we still have over 42 million people without basic health insurance.

Thank you

Questions for the Panel on Special Populations: Minorities

What are the functions of your office? Are you aware of any efforts to use complementary and alternative medicine (CAM) to improve the health of minorities? Are there any data?

Does your office focus on cultural diverse health care practices? Is there a link between culturally competent health care services and CAM?

In your efforts to reduce and eliminate health disparities, is there a role for CAM?

What are the coverage and reimbursement issues for CAM use by minority populations? Do these issues vary among different minority groups, and from the general population?

Can you offer any ideas for coverage or payment mechanisms that would increase access to CAM services and products among minorities?

Are minority populations more vulnerable to questionable CAM products and services? If yes, how can this be addressed?

Do you have any suggestions for the Commission to consider as it develops a report and recommendations to the President and Congress?

Questions for the Panel on Special Populations: Underinsured and Uninsured

Describe the uninsured and underinsured populations in the U.S. and why these exist. What programs are in place to provide health care services to the underinsured and uninsured?

Are you aware of any efforts to use complementary and alternative medicine (CAM) to improve the health of these populations? Are there any data on CAM use?

What are the coverage and reimbursement issues for CAM use among the underinsured and uninsured populations? Do these issues vary within these groups and why?

As to access to CAM, can coverage and payment issues for the underinsured and uninsured be addressed by the same or different mechanisms from the general population? Are there other access issues?

Can you summarize the proposals for helping the uninsured and underinsured? Can you offer any ideas for coverage or payment mechanisms that would increase access to CAM services and products among these special populations?

Are the underinsured and uninsured more vulnerable to questionable CAM products and services? If yes, how can this be addressed?

Do you have any suggestions for the Commission to consider as it develops a report and recommendations to the President and Congress?

Nathan Stinson, M.D.

Office of Minority Health, DHHS

Doriane C. Miller, M.D.

Dr. Miller joined the Robert Wood Johnson Foundation staff as program vice president in July 1997. She brings to the Foundation 15 years' experience as a community-based primary care provider who has worked with under-served, minority populations with special issues in mental health and substance abuse. She most recently served as medical director of the Maxine Hall Health Center of the San Francisco Department of Health, while also serving as assistant clinical professor of medicine in the Department of Medicine at San Francisco General Hospital, University of California, San Francisco.

As a 1993 winner of an RWJF Community Health Leadership Award, she directed the Grandparents Who Care Support Group, which she co-founded in 1989. The Program provides psychological help and community resources to relatives who are raising children because the child's parents are mentally ill, incarcerated or have substance abuse problems.

At the Foundation, she heads the Clinical Care Management Team of the Health Care Group. She is responsible for coordinating strategies and funding in the area of clinical care management and quality improvement. Dr. Miller continues her professional practice by volunteering at the Chandler Clinic in New Brunswick a half day per week.

Daniel R. Hawkins, Jr.

Vice-President for Federal and State Affairs
National Association of Community Health Centers, Inc.

Dan Hawkins is Vice-President for Federal and State Affairs at the National Association of Community Health Centers, Inc. (NACHC), where for the past 20 years he has provided NACHC's membership with federal and state health-related policy development, policy research, analysis, information, advocacy, and technical assistance services. During his tenure at NACHC, federal support for health centers has grown from $350 million to over $1 billion annually, and the number of people served by health centers has grown from 5 million to over 11 million. Prior to joining NACHC, Dan served as a VISTA volunteer, Executive Director of a migrant and community health center located in south Texas, and as an assistant to HHS Secretary Joseph Califano during the Carter Administration. He has written numerous books and articles on health care and health center issues, currently oversees production of several NACHC publications annually, and has provided testimony before several Congressional Committees. Dan has also lectured on health policy at Harvard, Johns Hopkins, Brandeis, and other universities. He has been named one of America's 1000 most influential health policy makers.

An Overview of Community Health Centers

Dan Hawkins
National Association of Community Health Centers

May 14, 2001

Brief History of Health Centers

- Origins: Turn-of-Century Dispensaries, Milk Clinics
- Hospitals: Movement to Specialty OPDs
- Public Health Agencies: Maternal and Child Health Program
- Opposition from Organized Medicine
- OEO/War on Poverty: A Way Around Entrenched Political/Medical Powers

Brief History of Health Centers

- Unique Public-Private Partnership: Resources Directly to Community-Owned Organizations
- Health Centers: Two-Fold Purpose -
  - Be *Agents of Care* in Communities With Too Little of the Same
  - Be *Agents of Change*, Giving Communities Control of their Health Care System

Brief History of Health Centers

- Health Centers: Four Basic Characteristics -
  - Location in *high-need areas*
  - *Comprehensive* health and related services (especially 'enabling' services)
  - Open to all residents, *regardless of ability to pay*, with charges prospectively set based on income
  - Governed by *community boards*, to assure responsiveness to local needs

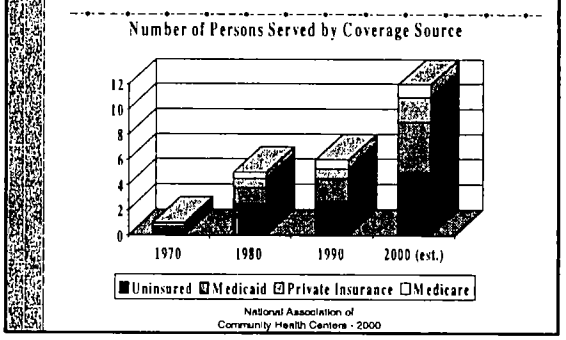
National Association of Community Health Centers - 2000

Accomplishments of Health Centers

- *Health Care Home for 12 Million Americans*
  - 1 of 10 Uninsured Persons (4.7 million)
  - 1 of 8 Medicaid Recipients (4.1 Million)
  - 1 of 6 Low-Income Children (4.9 million)
  - 1 of 5 Low-Income Births (400,000)
  - 1 of 10 Rural Americans (6.2 Million)
  - 7.5 Million People of Color, 600,000 Farmworkers, 500,000 Homeless Persons

National Association of Community Health Centers - 2000

Growth of Health Centers: 1970-2000



National Association of Community Health Centers - 2000

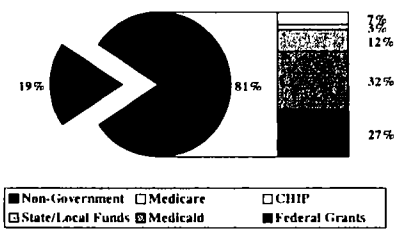
Accomplishments of Health Centers

- *Excellent Quality of Care*: More Effective Care, Better Use of Preventive Care, Fewer Infant Deaths
- *Higher Cost-Effectiveness*: Lower Overall Costs, Lower Specialty Referrals and Hospital Admissions, Substantial Medicaid Savings
- *Significant Community Impact*: Employment and Economic Effects, Contribution to Community Well-Being, Development of Community Leaders

National Association of Community Health Centers - 2000

Public Support is a Significant Part of Health Center Budgets

Percent of $4 Billion Annual Budgets From...



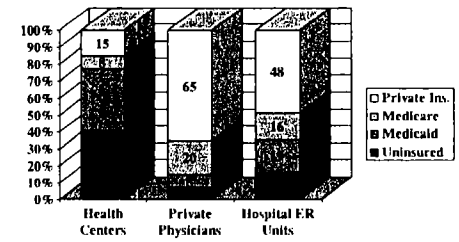
National Association of Community Health Centers - 2000

Other Forms of Public Support for Health Centers

- Federal Tort Claims Act (FTCA) Coverage
- PHS Drug Pricing Discounts
- Vaccines for Children (VFC) Program
- Medicaid Enrollment Worker Outstationing
- National Health Service Corps (NHSC) - Assignment of Health Professionals
- Exemption from Federal, State and Local Taxes (income, sales, property)

National Association of Community Health Centers - 2000

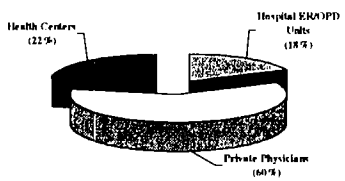
Health Centers' Patient Mix is Unique Among Ambulatory Care Providers



National Association of Community Health Centers - 2000

Health Centers Provide One-Fifth of All Ambulatory Care for Uninsured...

Proportion of Visits by Uninsured, 1999
(N = 93 Million)



National Association of Community Health Centers - 2000

...And Face Many of The Same Challenges as Other Safety Net Providers

- ***Growth in Uninsured***: National Drop in '99 Contrasts with 250,000 Increase at Centers
- ***Effects of Welfare Reform***: Loss of Medicaid Coverage for 2+ Million Still-Eligible Persons
- ***Decline in Charity Care***: Cutbacks by Private Providers Squeezed by Managed Care
- ***Loss of Medicaid Revenues***: Combined Impact of Managed Care Systems and Payment Cuts

National Association of Community Health Centers - 2000

Health Centers and Complementary & Alternative Medicine

- Health Centers Serve almost 8 Million People of Color
- Health Centers Strive for Linguistically and Culturally Appropriate Care
- Many Health Centers Use CAM Modalities
  - Traditional Folk Healers (e.g., *Curanderos*)
  - Native Hawaiian/Native American Services
  - Other Services (e.g, herbal medicine, acupuncture

National Association of Community Health Centers - 2000

Barriers to Greater Use of CAM by Health Centers

- Refusal of Medicare and Most State Medicaid/CHIP Programs to Cover CAM
- Non-Acceptance of CAM Services and Providers by Mainstream Health Providers
- Lack of Awareness, Appreciation of CAM by Many Health Center Clinicians
- Difficulty Identifying CAM Providers Locally
- Financial Pressures Due to Surge in Uninsured

National Association of Community Health Centers - 2000

Steps to Resolve Identified Barriers to CAM Use by Health Centers

- BPHC Establishment of Integrative Medicine and Alternative Health Practices Initiative
  - Further Integration of CAM With Traditional Primary Care Services
  - Technical Assistance to BPHC-Supported Centers
  - Information on Provider Credentialing, FTCA Coverage, Policies on Clinical Use of CAM
- Collaboration Between BPHC and NCCAM
- Incentives for State Medicaid/CHIP and Medicare Coverage of CAM

National Association of Community Health Centers - 2000

kaiser commission on medicaid and the uninsured
KEY FACTS

THE HENRY J. KAISER FAMILY FOUNDATION

January 2001

THE UNINSURED AND THEIR ACCESS TO HEALTH CARE

Health insurance makes a substantial difference in the amount and kind of health care people are able to obtain. The consequences of not getting needed medical care are not trivial and can result in unnecessary hospitalizations and serious health problems, as well as affect a person's financial well being.

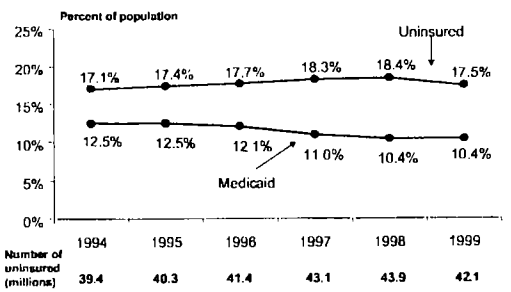
Nearly all of the elderly are covered through Medicare, so most uninsured Americans are individuals under the age of 65. While two-thirds of Americans receive health insurance coverage through their employers, millions of Americans lack access to health coverage either because their employer does not offer it or they cannot afford to pay for it. Medicaid, and now the State Children's Health Insurance Program (CHIP), play an important role by covering millions of low-income people, especially children. However, limits to public programs and gaps in employer coverage leave over 40 million Americans uninsured.

HOW MANY ARE UNINSURED?

In 1999, 42 million Americans—nearly 18% of the total nonelderly population—were uninsured (Figure 1). The number of uninsured has grown by nearly 10 million over the past decade. A smaller share of Americans have health insurance for themselves and their dependents through their jobs today than ten years ago, and even more would be uninsured were it not for eligibility expansions and enrollment growth in the Medicaid program. In 1999, the modest increases in private coverage due to the robust economy, as well as improvements in public coverage with the implementation of CHIP and stabilization of Medicaid enrollment, led to the first decline in the number of uninsured in over a decade.

Figure 1

Trends in Coverage for the Nonelderly Population, 1994-1999



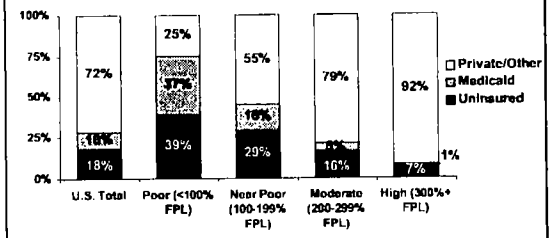
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of March 1995-2000 Current Population Survey

WHO ARE THE UNINSURED?

Low-income Americans (those who earn less than 200% of the federal poverty level, or $26,580 for a family of three in 1999) run the highest risk of being uninsured. Nearly 40% of the poor and 30% of the near-poor lack health coverage (Figure 2). The poor and the near-poor constitute nearly two-thirds (65%) of the uninsured population (Figure 3).

Figure 2

Health Insurance Coverage by Poverty Level, 1999

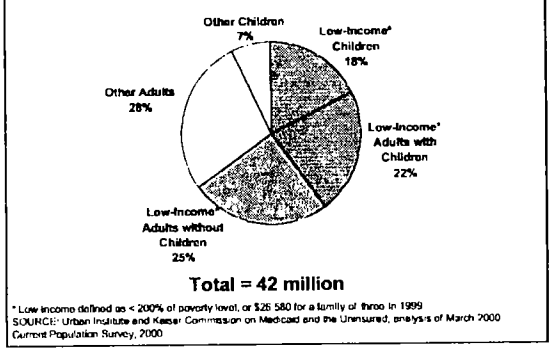


Note: The federal poverty level for a family of three in 1999 was $13,290.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2000 Current Population Survey, 2000.

There are disproportionately more adults than children among the uninsured, as coverage under Medicaid and CHIP focuses primarily on children. Nearly two-thirds of uninsured adults have incomes less than 200% of the poverty level.

Figure 3

The Uninsured Population, 1999



* Low income defined as < 200% of poverty level, or $26,580 for a family of three in 1999
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2000 Current Population Survey, 2000

Regardless of income, however, the majority (83%) of the uninsured are in working families—71% are full-time and 12% part-time. Low-wage workers are at greater risk of being uninsured, as are unskilled laborers, service workers, and those employed in small businesses.

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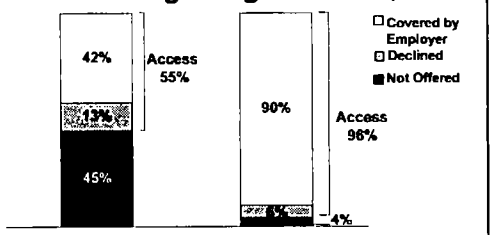
WHY ARE SO MANY AMERICANS UNINSURED?

The expense of insurance makes private coverage unavailable to many Americans, particularly low-wage workers. They are far less likely than higher wage workers to be offered insurance as a benefit, either through their own job or a spouse's job (Figure 4). Individually purchased insurance is often not a viable option, as these plans typically charge very high premiums or offer limited benefits.

Figure 4

Access to Employer-Based Coverage for Low and High Wage Workers, 1996



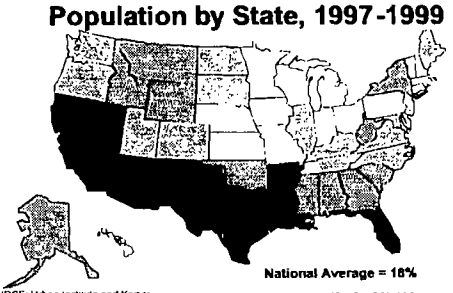
Note: Access to job-based coverage includes through a worker's own job or a family member's job. Annualized wage income (based on a 35-hour work week, 52 weeks a year) for low-wage workers would be ≤ $12,740 and for high-wage workers > $27,300.
SOURCE: Cooper P. and Schone B., 1997.

Medicaid fills in gaps in coverage for 40 million low-income Americans; however, coverage for adults is very limited. Nonelderly adults must meet stringent income eligibility standards, and even the poorest are generally ineligible if they do not have children. Parents may qualify for Medicaid, but their income eligibility levels are generally set much lower than their children's. In addition, neither Medicaid nor CHIP has reached its full enrollment potential, leaving many eligible children uninsured.

Uninsured rates vary widely across states largely because of differences in industries and employer-sponsored coverage, the share of families who live on low incomes, and the scope of state Medicaid programs. Nearly a three-fold difference exists between the state with the lowest and highest uninsured rates (Figure 5). Texas, Arizona, and New Mexico have the highest uninsured rates in the nation.

Figure 5

Uninsured Rate Among the Nonelderly Population by State, 1997-1999



SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of 3 year-pooled data from March 1998, 1999, and 2000 Current Population Survey, 2000

☐ <14% (16 states) ☐ 16-22% (11 states and DC)
☐ 14-17% (15 states) ■ >22% (8 states)

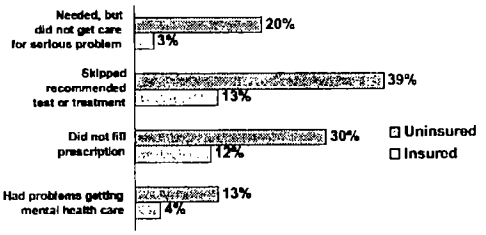
WHAT DIFFERENCE DOES HEALTH INSURANCE MAKE?

Health insurance affects access to health care as well as the financial well-being of families. Nearly 40% of uninsured adults and 25% of uninsured children have no regular source of health care, and, coupled with a fear of high medical bills, many delay or forego needed care (Figure 6).

- Uninsured children are 70% more likely than insured children not to have received medical care for common conditions like ear infections and 30% less likely to receive medical attention when they are injured.
- Nearly 40% of uninsured adults skipped a recommended medical test or treatment, and 20% say they needed but did not get care for a serious problem in the past year.

Figure 6

Percent of Nonelderly Adults with Barriers to Care, by Insurance Status, 2000



SOURCE: *The NewsHour with Jim Lehrer*/Kaiser Family Foundation National Survey on the Uninsured 2000

- Both uninsured adults and children are less likely to receive preventive care. Uninsured adults are over 30% less likely than insured to have had a check-up in the past year. Similarly, a third of uninsured children did not see a doctor in the past year.

Delaying or not receiving treatment can lead to more serious illness and avoidable health problems, which ultimately makes a difference in how healthy people are.

- The uninsured are more likely than those with insurance to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes.
- The uninsured with various forms of cancer are more likely to be diagnosed with late stage cancer. Death rates for uninsured women with breast cancer are significantly higher compared to women with insurance.
- In addition to health consequences, the financial impact of being uninsured can be substantial: few uninsured say they have received health services for free or at reduced charge, and nearly 30% of uninsured adults say that medical bills had a major impact on their families' lives.

Charitable physicians and the safety net of community clinics and public hospitals do not substitute for health insurance. Lack of coverage clearly matters for the millions of uninsured Americans—affecting job decisions, financial security, access to care, and health status.

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United States General Accounting Office

GAO

Testimony

Before the Committee on Finance, U.S. Senate

For Release on Delivery
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Thursday, March 15, 2001

HEALTH INSURANCE

Proposals for Expanding Private and Public Coverage

Statement of William J. Scanlon
Director, Health Care Issues

GAO-01-481T

Health Insurance: Proposals for Expanding Private and Public Coverage

Mr. Chairman and Members of the Committee:

I am pleased to be here today as the Committee begins considering options to expand health insurance coverage for the 1 in 6 nonelderly Americans (under 65) who are uninsured. These 42 million people represent a heterogeneous population. As we noted in our testimony before your Committee earlier this week,[1] the majority of the uninsured are working, often for small businesses or in certain industries such as agriculture or construction that are less likely to offer health insurance, or are low-income persons who are ineligible for or not enrolled in public programs. A disproportionate share of young adults, Hispanics, and residents of southern or western states are uninsured. But the uninsured population also includes people employed by larger-sized firms and other industries as well as those of all income levels, ages, races and ethnicities, and geographic locations. Given the heterogeneity of this population, a variety of approaches have been proposed in the Congress and by proponents to increase private or public health insurance coverage in ways that may match the needs of different uninsured persons and maximize the potential impact for expanding coverage.

Several recent congressional efforts represent important steps toward increasing the availability of health insurance for workers and low-income families, including

- improving the availability of private health insurance for individuals changing jobs or with preexisting health conditions,
- increasing the percentage of health insurance premiums that self-employed individuals can deduct from their taxable income,
- giving additional flexibility to states to expand Medicaid eligibility to a larger group of low-income children and their parents, and
- establishing the new federal-state State Children's Health Insurance Program (SCHIP), which had already enrolled more than 3 million low-income children in 2000.

[1]See *Health Insurance: Characteristics and Trends in the Uninsured Population* (GAO-01-507T, Mar. 13, 2001).

These steps help millions of Americans, and the full effect of some of these actions likely has not yet been realized. Despite these efforts, however, millions of Americans remain uninsured.

To assist the Committee as it considers the variety of proposals offered to expand coverage to the uninsured, my remarks today will provide an overview of potential approaches for increasing private or public coverage and considerations that could impact their effectiveness in reaching significant numbers of the uninsured. Specifically, I will focus on

- proposed additional tax incentives, such as deductions or credits, to encourage individuals to purchase private health insurance or employers to offer coverage;
- proposed expansions to public programs, including expanding Medicaid and SCHIP to additional low-income children and adults, and allowing near-elderly individuals not yet 65 to "buy in" to Medicare; and
- the potential for unintended consequences of private and public coverage expansions on existing private health insurance coverage.

My comments are based on our prior and ongoing work on the uninsured population, private health insurance, Medicaid, and SCHIP, as well as other published research.[2] We reviewed key elements of major proposals that have been introduced in the 106th and 107th Congresses, as well as several put forth by various proponents.

In summary, the success of proposals to provide additional tax incentives to promote private health insurance—which already is the primary source of health coverage for most nonelderly Americans—will depend on whether they are large enough so that more uninsured individuals will purchase insurance or more employers will begin offering coverage or increase their contribution to premiums. Because most uninsured individuals either pay no taxes or are in the lowest marginal tax rate bracket, a refundable tax credit would provide a larger net reduction in premium costs for low-income uninsured individuals than would allowing a deduction from taxable income. Tax credits also will be more effective if available when low-income persons purchase coverage rather than in the next year when tax returns are filed. Most of the proposed tax credit amounts represent less than half of premiums for many individuals, which

[2]A list of related GAO products appears at the end of this statement.

some analysts conclude is not large enough to induce most low-income uninsured individuals to begin purchasing health insurance. Some proposed credits for small employers or those with many low-wage workers would be provided for a limited period of time, which may make affected employers hesitant to begin offering coverage or increasing their premium contribution if the continued availability of the credit is uncertain.

Other proposals would expand eligibility for existing public programs to more low-income children and adults. These include

- giving states the option of increasing income eligibility limits under Medicaid or SCHIP;
- expanding these public programs to persons who are not now eligible, such as most childless adults for the Medicaid program or the parents of children eligible for SCHIP; and
- allowing near-elderly individuals who are not yet Medicare-eligible to pay premiums and thereby buy in to Medicare.

The success of these efforts in reducing the number of uninsured is contingent upon (1) the willingness of states to pursue options to expand Medicaid and SCHIP eligibility and (2) the effectiveness of outreach to enroll eligible individuals, since at present many eligible individuals are not participating.

Proposed approaches to expand insurance coverage may result in some individuals or employers dropping current coverage in order to take advantage of a new tax subsidy or public program that would reduce health insurance costs associated with individual or employment-based coverage. While some steps may be taken to reduce the potential for this phenomenon—known as "crowd-out"—some level of such displacement of existing private coverage may be an inevitable cost of efforts to decrease the number of uninsured Americans.

Background

Employers voluntarily offering private health insurance benefits are the predominant source of coverage for nonelderly Americans, and publicly sponsored programs also enroll many low-income people. Two-thirds of nonelderly Americans obtain private health insurance through employment. The federal tax code provides incentives for employers to subsidize health benefits by making their premium contributions tax

deductible as a business expense; this subsidy also is not considered taxable income for employees. In addition, tax benefits are available to individuals who purchase nongroup private insurance directly from insurers (referred to as "individual insurance") if the person is self-employed[3] or has premium and medical expenses combined that exceed 7.5 percent of his or her adjusted gross income.

However, private insurance is not accessible to everyone. Some workers, including those working for small firms or in certain industries such as agriculture or construction, are less likely to be offered employment-based health coverage. Health insurance may also be expensive and potentially unaffordable for those paying the entire premium individually rather than receiving employment-based coverage where employers typically contribute to some or all of the cost. In addition, while all members of a group plan typically pay the same premium for employment-based insurance regardless of age or health status, in most states individual insurance premiums are higher for older, sicker individuals than for young, healthy individuals, potentially making them unaffordable.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided several important protections to improve the availability of private health insurance, particularly for individuals changing jobs or with preexisting health conditions. HIPAA included guaranteed access to coverage for those leaving group coverage and for small employers; however, it did not address issues of affordability. In addition, many states have enacted reforms that guarantee access to health insurance for certain high-risk individuals and small groups and that sometimes limit the premiums these persons and groups pay. While these federal and state private insurance market reforms provide important protections for certain individuals and groups, recent research finds little, if any, effect from these reforms on overall private insurance coverage rates.

Public programs such as Medicaid and SCHIP cover certain low-income or disabled individuals. However, eligibility for these programs is often restricted to selected groups, such as children, parents of eligible children, pregnant women, or disabled individuals, and depends on the applicant's age, income, and other factors. For example, childless adults, unless disabled, are generally not eligible for Medicaid. States must set income thresholds to meet certain minimum federal standards but may opt for

[3]For 2001, self-employed individuals may deduct 60 percent of eligible health insurance expenses from taxable income; this share is scheduled to rise to 100 percent in 2003 and thereafter.

higher eligibility standards as long as they are within federal guidelines. SCHIP was established in 1997 to give states the choice of receiving enhanced federal funding to cover additional low-income children who do not qualify for Medicaid, generally those in families whose incomes are up to 200 percent of the federal poverty level. Unlike Medicaid, SCHIP is not an entitlement program, and states can halt enrollment once budgeted funds are exhausted.[4] As of September 2000, HCFA reported that 3.3 million children were enrolled in SCHIP. Although Medicare primarily insures most Americans 65 years or older, it also provides coverage for some nonelderly individuals who are disabled or have end-stage renal disease.

Impact of Proposed Tax Incentives Will Depend on Their Size and Timing

Additional tax incentives proposed to encourage people to purchase health insurance vary in terms of who would be eligible, whether the tax incentive is provided to individuals or employers, and whether the incentive is a deduction that reduces taxable income or a credit that reduces total tax liability. The proposals share challenges that will affect their success in covering newly insured individuals. These challenges include (1) making the reduction in premiums large enough to induce uninsured persons to purchase health insurance or to encourage employers to offer coverage or increase their contributions to premiums, and (2) timing a subsidy to be available for low-income individuals at the time they pay their premiums, rather than after the end of the tax year.

Tax Deductions

Some proposals would allow people who purchase individual, nongroup health insurance to deduct the cost of premiums from their taxable income, with the intention of both increasing coverage and making the tax treatment of individually purchased and employment-based insurance more uniform. These proposals vary as to whether tax filers would have to itemize deductions in order to receive the health insurance deduction or could make the deduction an "above-the-line" adjustment to gross income without itemization.[5] Some proposals would also allow employees' contributions to employment-based health insurance to be deducted from

[4]As an entitlement program, states must enroll all individuals who apply and meet state and federal Medicaid requirements.

[5]In 1998, nearly 31 percent of tax filers itemized their deductions.

their taxable income—potentially important if the employee must pay most or a large share (more than half) of the plan's premium, since these employees are more likely to turn down employment-based coverage.

A tax deduction may be limited in its ability to induce uninsured individuals to purchase private insurance because most uninsured individuals do not earn enough for a deduction to make any or a significant difference in their net health insurance costs. In 1999, about 40 percent of the uninsured either did not file income tax returns or were in the 0 percent marginal tax rate and would not benefit from the deduction if they purchased individual insurance. Nearly 50 percent of the uninsured were in the 15 percent marginal tax rate, which, if they purchased qualifying health insurance, would allow them a 15 percent net reduction in their insurance cost.[6] Analysts have generally agreed that this level of reduction would encourage few additional uninsured individuals to purchase health insurance. The remaining 10 percent of the uninsured, based on their marginal tax rates, would be eligible for a 28 to nearly 40 percent net reduction in the cost of their health insurance.[7] While this level of reduction in net premiums may induce some individuals in higher tax brackets to purchase health insurance, it is less than some analysts have concluded would be necessary to lead to a widespread increase in coverage. For example, the Congressional Budget Office (CBO) reported that tax subsidies "would have to be fairly large—approaching the full cost of the premium—to induce a large proportion of the uninsured population to buy insurance."[8]

Tax Credits

Other proposals would allow individuals purchasing health insurance to receive a tax credit. In contrast to a deduction, the amount of the credit depends not on the filer's marginal tax rate but how the credit is designed. Some proposals involve providing tax filers below a certain income threshold a flat credit if they purchase individual health insurance, such as up to $1,000 for single coverage or $2,000 for family coverage, while

[6]In 1999, the 15 percent tax bracket included single tax filers with taxable income of $25,750 or less, head-of-household tax filers with taxable income of $34,550 or less, and joint tax filers with taxable income of $43,050 or less.

[7]The 28 percent tax bracket included single tax filers with taxable income of $25,751 to $62,450, head-of-household tax filers with taxable income of $34,551 to $89,150, and joint tax filers with taxable income of $43,051 to $104,050. The 39.6 percent tax bracket included any tax filer with income over $283,150.

[8]CBO, *Options to Expand Federal Health, Retirement, and Education Activities* (Washington, D.C.: June 2000).

higher-income individuals could be eligible for a partial credit or no credit. Because more than half of uninsured individuals would not have had enough income tax liabilities in 1999 to receive the full credit amount, some proposals would make the credit refundable so that more low-income tax filers and a number of those who would not otherwise file could receive a larger portion or all of the amount.[9]

The number of individuals eligible for a tax credit would vary depending on the income thresholds specified in a proposal. For example, we estimate that in 1999 22 million uninsured Americans were in families that potentially would have been eligible for a tax credit available to single tax filers with $30,000 in taxable income and joint or head-of-household tax filers with $50,000 in taxable income. A recent study estimated that a tax credit of $1,000 for single coverage and $2,000 for family coverage with these taxable income thresholds could enable about 4.2 million—or nearly 20 percent of eligible individuals—to become newly insured.[10] If income eligibility levels were twice as high, we estimate that 3 million additional uninsured individuals would have been in families potentially eligible for the tax credit, and the study estimated that a credit at this higher income eligibility level would result in another 0.5 million newly insured.[11]

A fixed-dollar tax credit would represent a varying proportion of the health insurance cost, since health insurance premiums can vary widely with the locality, age, and health of the individual and the level of benefit and plan type. In 1999, we reported some examples of annual premiums in the individual health insurance market for single coverage, including

- a low premium of $744 for a healthy 30-year-old male in Arizona,
- a mid-level premium of $2,658 in a rural New York county, a state that has community rating and therefore does not allow variation by age or health status of the individual, and

[9]By being refundable, a tax credit allows tax filers whose income tax liability is less than the value of the credit to receive a refund in excess of their federal tax liability.

[10]Unpublished data from Jonathan Gruber based on Jonathan Gruber and Larry Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits," *Health Affairs* (Jan/Feb 2000), pp. 72-85. The authors estimate that the number of uninsured that would be newly covered would be higher (about 6 million) if the credit was payable in advance but lower (about 2 million) if it excluded anyone with employer-based coverage.

[11]Gruber and Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits."

- a high premium of $7,154 for a 60- to 64-year-old smoker in urban Illinois.[12]

Thus, in some states, a $1,000 tax credit could represent all or most of the premium for a young, healthy male or for someone purchasing a plan with a high deductible or limited benefits. On the other hand, a $1,000 credit could represent a small proportion of the premium for a comprehensive health plan for an older person or someone with existing health conditions. For many individuals, a $1,000 tax credit would likely represent less than half of a typical premium.

A tax credit's ability to induce uninsured individuals to purchase coverage will also depend on the timing of the credit. Some low-income individuals who want to take advantage of a credit to purchase health insurance may find it difficult to do so if they must pay the premiums up front but cannot receive the credit until the following year after filing their tax return. To alleviate this problem, some proposals would allow advance funding of a credit, so that eligible individuals could receive the credit at the time they purchase the health insurance. There is limited experience with advance payments of tax credits for individuals, and establishing an effective mechanism could be administratively challenging. Procedures and resources to assess eligibility based on partial-year income information would need to be available nationwide. In addition, efficient and equitable procedures for end-of-year reconciliations and recovery of excess payments would be necessary.

The Earned Income Tax Credit (EITC), a refundable tax credit that offsets much of the impact of Social Security taxes paid by low-income workers in order to encourage them to seek work rather than welfare, does provide an option allowing recipients to receive 60 percent of the credit in advance. The share payable in advance is limited to 60 percent to reduce the risk to recipients of having to repay erroneous payments and to reduce the risk of overpayments. However, very few EITC recipients—about 1 percent—have received an advance payment for their EITC.[13] This low participation is in part because many EITC recipients are unaware of the advance payment option or prefer to receive the full credit at the end of the tax year. While the EITC experience suggests that it may be difficult to make an advance payment option work effectively for a health insurance tax credit, more low-income individuals may use this option for health

[12] *Private Health Insurance: Potential Tax Benefit of a Health Insurance Deduction Proposed in H.R. 2990* (GAO/HEHS-00-104R, Apr. 21, 2000).

[13] For more information on the EITC, see *Federal Taxes: Information on Payroll Taxes and Earned Income Tax Credit Noncompliance* (GAO-01-487T, Mar. 7, 2001).

insurance because they are required to spend money up-front to get the tax credit, whereas EITC is an addition to income, not a reimbursement for an expense.

Tax Incentives for Small Employers or Those With Many Low-Wage Workers

To encourage more employers to offer coverage, some proposals would provide a tax subsidy to small firms or those with low-wage workers that often do not offer health insurance to their employees. Although at least 96 percent of private establishments with 50 or more employees offered coverage in 1998, only 36 percent of private establishments with fewer than 10 workers and about 67 percent of private establishments with 10 to 25 workers offered coverage. Also in 1998, among private establishments in which half or more of the workers were low-wage, only 31 percent offered health insurance to their employees, while other private establishments were nearly twice as likely to offer health insurance.[14]

As with tax credits to individuals, if employer tax credits are to increase insurance coverage, they must be large enough to induce employers to begin offering coverage and to make the employee share affordable. Generally, credit amounts proposed to date for small employers would represent much less than half of the annual cost of coverage per employee, which is typically about $2,400 for single coverage and almost $6,400 for family coverage.[15] For example, one proposal would provide a temporary tax credit for employers with 2 to 50 employees that had not offered health insurance in the past 2 years and that began purchasing coverage through a qualified coalition. The credit would amount to 20 percent of employer contributions to the insurance, up to $400 per year for individual coverage and $1,000 per year for family coverage. Massachusetts and Kansas recently began offering a tax credit to small businesses, and Massachusetts also offers a tax credit to low-income employees. However, these policies are too new to fully assess their effects on coverage. Another proposal would provide a credit to employers to encourage them to pay a larger share of premiums for low-wage workers. This is intended to encourage more low-wage workers who are offered employment-based health insurance to accept it.[16] One study estimated

[14]Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, 1998 Medical Expenditure Panel Survey, Insurance Component.

[15]The Kaiser Family Foundation and Health Research Educational Trust's *Employer Health Benefits: 2000 Annual Survey* reports that average premiums in 2000 were $2,426 for single coverage and $6,351 for family coverage.

[16]See Charles N. Kahn III and Ronald F. Pollack, "Building a Consensus for Expanding Health Coverage," *Health Affairs*, Vol. 20, No. 1 (Jan./Feb. 2001), pp. 40-48.

that in 1996 37 percent of workers earning less than $7 per hour were offered coverage but turned it down, while only 14 percent of workers earning $15 or more per hour turned down coverage.[17]

Many proposed or already available state-offered tax credits for employers provide only a temporary subsidy for the first few years an employer offers coverage. This may limit their potential for inducing employers to initiate and keep offering coverage. Experts we have consulted in our private insurance work told us that small employers are not likely to begin offering health insurance if they do not believe they will be able to do so permanently.

Some proposed employer tax credits are linked to small employers obtaining health insurance through a purchasing cooperative. We reported last year that several existing cooperatives gave small employers the ability to offer a choice of plans, but typically at premiums similar to those available outside of the cooperative. We also reported that most current cooperatives represented a small share of their local small group market (5 percent or less) and several had recently been discontinued or faced declining insurer or employer participation.[18] Some analysts suggest that small employer purchasing cooperatives could be more effective in making coverage more affordable if they represented a larger share of the market. A significant employer tax credit linked to a small employer purchasing cooperative might stimulate participation and create larger market share, making them better able to secure lower-cost coverage for participants.

Success of Public Program Expansions Depends on State Responsiveness and Outreach

While expansions of Medicaid and the implementation of SCHIP in recent years have given states the ability to cover more low-income individuals, a significant number of this group remain uninsured. A variety of factors contribute to this situation. Some groups of low-income persons generally are ineligible, such as adults without children. Also, while some states have exercised options that allow them to increase existing limits on income eligibility thresholds for low-income children and parents, many states with high uninsured rates have not done so. Several proposals would further expand Medicaid and SCHIP to cover populations that are

[17]Philip F. Cooper and Barbara S. Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, Vol. 16, No. 6 (Nov./Dec. 1997), pp. 142-149.

[18]*Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices* (GAO/HEHS-00-49, Mar. 31, 2000).

not currently eligible (such as childless adults) or raise income and asset eligibility standards. Another proposal would allow some near-elderly persons to buy in to Medicare. But many low-income people who currently are eligible for these public programs have not enrolled. Therefore, state outreach efforts to low-income individuals are key to the success of current and proposed programs.

Medicaid and SCHIP Expansions

Despite mandatory and optional state Medicaid expansions and the implementation of SCHIP in recent years, millions of low-income children and adults remain uninsured. Nearly 3 million children in households below the federal poverty level were uninsured in 1999 even though they would typically have been eligible for Medicaid.[19] And although SCHIP now covers more than 3 million children, in 1999 there were nearly 6 million uninsured children in families with incomes below 200 percent of the federal poverty level (about $34,000 for a family of four)—the income threshold targeted by many SCHIP programs. Another 16.3 million adults with family incomes below 200 percent of the federal poverty level were uninsured, and nearly half of these had family incomes below the federal poverty level.

The federal statutes create some gaps in the ability of public programs to cover low income individuals (such as generally not allowing coverage for childless adults), but they also give states flexibility to cover children and parents at higher income levels. States vary considerably in the extent to which they have taken advantage of existing options for expanding eligibility for Medicaid or SCHIP. Some states have used Medicaid waivers and other authority to expand eligibility for their programs beyond traditional groups and income thresholds. For example, 12 states have obtained section 1115 research and demonstration waivers[20] from the Health Care Financing Administration for Medicaid to increase income thresholds for existing eligibility groups and in some cases to add new eligibility groups, such as childless adults. Recently, three states—New Jersey, Rhode Island, and Wisconsin—obtained section 1115 waivers to

[19]Section 6401 of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) required states to provide Medicaid coverage for pregnant women and children up to age 6 in families with income below 133 percent of the federal poverty level. Section 4601 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) required, in effect, that states expand Medicaid coverage to older children living in families with incomes below the federal poverty level annually until October 2002, when children through the age of 18 will be eligible.

[20]Section 1115 refers to a section of the Social Security Act that allows the Health Care Financing Administration to exempt states from many title XIX and XXI requirements, thus allowing demonstration projects likely to assist in promoting program objectives.

use SCHIP funds to cover eligible children's parents—but few other states have sought to do so. Also, 30 states have expanded Medicaid eligibility under section 1931 of the Social Security Act to disregard portions of an applicant's income or assets when determining eligibility, which effectively increases the level of income and assets an eligible individual may have.

States' willingness and ability to use additional federal flexibility will be key to efforts to expand public coverage. States with high uninsured rates typically have lower income eligibility thresholds for Medicaid than those with low uninsured rates. For example, the average Medicaid eligibility level for parents in the 13 states with high uninsured rates is 54 percent of the federal poverty level, compared with an average of 99 percent of the federal poverty level for the 29 states with low uninsured rates. Furthermore, states with low uninsured rates have been more likely to use available authority to expand coverage than states with high uninsured rates. Whereas 10 of the 29 states with uninsured rates significantly lower than the U.S. average have used section 1115 waivers to expand Medicaid eligibility, only 1 of the 13 states with uninsured rates significantly higher than the U.S. average has done so. Appendix I summarizes selected eligibility requirements and options that states have adopted for Medicaid and SCHIP.

States' financial capacity may be a factor in what states have done to expand Medicaid and SCHIP to cover additional low-income individuals. States with high uninsured rates tend to be poorer and already cover a larger share of their population in Medicaid. On average, 16 percent of the nonelderly populations in the 13 states with high uninsured rates are in poverty compared with 10 percent in the 29 states with low uninsured rates. These high uninsured states also cover a higher proportion of their nonelderly residents through Medicaid (9 percent) than do states with low uninsured rates (7 percent).

Medicare Buy-In

Another proposed public program expansion known as a Medicare "buy-in" would allow some near-elderly individuals to pay premiums to enroll in Medicare. This proposal targets the more than 3 million uninsured near-elderly individuals between ages 55 and 64. This population is of particular concern because near-elderly individuals approaching retirement now are less likely to have employment-based retiree coverage available than in the past. As we reported in 1998, fewer employers

sponsored retiree health benefits in 1997 than in 1991.[21] Recent employer surveys indicate that this decline has not reversed since 1997.[22] Further, with the aging of the baby boom generation, over the next decade the number of near-elderly individuals not yet eligible for Medicare will grow, which likely will increase the number of uninsured persons in this age group.

CBO estimates that few individuals would be able to afford the full premium that would be necessary to buy-in to Medicare—$300 to more than $400 per month initially.[23] High-cost individuals who would face higher than average premiums in the individual insurance market would be most likely to opt for a Medicare buy-in, which would likely lead to premium increases over time. Subsidies to low-income individuals would encourage more lower-cost near-elderly individuals to buy in to Medicare.

Outreach Is a Key to Success of Public Program Expansions

Many low-income individuals who are eligible for Medicaid and SCHIP do not enroll. Some may be unaware that they or their children may be eligible, while the administrative complexity of enrolling and other reasons may discourage other eligible individuals from participating. Thus, outreach to low-income individuals to enroll in existing or expanded public programs is key to the success of the programs. We reported in 1996 that 3.4 million Medicaid-eligible children—23 percent of those eligible under federal standards—were uninsured.[24] Another study found that in 1998 16 percent of children under 200 percent of the federal poverty level were eligible for Medicaid or SCHIP but were uninsured.[25]

Lessons from the Medicare program also illustrate the importance of effective outreach for low-income beneficiaries. We reported that about 43 percent of low-income Medicare beneficiaries that were eligible in 1996

[21]See *Private Health Insurance: Declining Employer Coverage May Affect Access for 55- to 64-Year-Olds* (GAO/HEHS-98-133, June 1, 1998). A forthcoming GAO report will update trends in retiree health coverage for early and Medicare-eligible retirees.

[22]See Mercer/Foster Higgins, *National Survey of Employer-Sponsored Health Plans 2000* and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2000 Annual Survey*.

[23]CBO, "Medicare Projections and the President's Medicare Proposals" (Apr. 1999).

[24]*Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies* (GAO/HEHS-98-93, Mar. 20, 1998).

[25]Kaiser Family Foundation, based on Urban Institute simulations of 1997 Current Population Survey March Supplement, projected to 1998.

for federal-state assistance for paying Medicare premiums and/or other out-of-pocket expenses not covered by Medicare were not enrolled.[26] Recognizing the low participation by these individuals eligible for the Qualified and Specified Low-Income Medicare Beneficiary programs, last year the Congress enacted requirements that the Social Security Administration identify and notify potentially eligible individuals, and that the Department of Health and Human Services develop and distribute to states a simplified uniform enrollment application.[27]

Proposals Could Unintentionally Lead to Crowd-Out Among Those Already Privately Insured

Efforts to expand private or public coverage to those currently uninsured can also provide new incentives to those already having private health insurance. Some currently insured individuals may drop employment-based coverage to get tax-subsidized individual insurance or enroll in Medicaid or SCHIP. While there was disagreement among analysts about the extent of crowd-out of private health insurance resulting from the Medicaid expansions in the late 1980s and early 1990s,[28] concern led the Congress to include a requirement in SCHIP that states devise methods to avoid such crowd-out. While several approaches may offset the extent of crowd-out, some degree of crowd-out may be an unavoidable cost of expanding private or public coverage to insure those that are currently uninsured. For example, CBO analysts suggested that some displacement of private insurance is inevitable, particularly since some low-income families move in and out of private insurance coverage and public programs can allow these low-income families to achieve more stable insurance coverage.

Expanding tax preferences are also not immune from potential crowd-out. Tax deductions or credits to subsidize uninsured individuals to purchase individual health insurance would also provide a tax subsidy to the approximately 13 million nonelderly individuals who purchased individual health insurance in 1999. While this tax expenditure to those already insured would make more equitable the tax treatment of individually-purchased and employment-based health insurance, it also increases the

[26] *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment* (GAO/HEHS-99-61, Apr. 9, 1999).

[27] These requirements were enacted under sections 709 and 911 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 that was incorporated by reference in P.L. 106-554.

[28] See, for example, Lisa Dubay and Genevieve Kenney, "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?" *Health Affairs*, Vol. 16, No. 1 (Jan./Feb. 1997), pp. 185-193, and David M. Cutler and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs*, Vol. 16, No. 1 (Jan./Feb. 1997), pp. 194-200.

federal cost per newly insured person since much of the subsidy goes to those already covered. Moreover, some employers currently offering health insurance to their employees may discontinue offering coverage if their employees have tax preferences available for individually-purchased insurance.[29] Similarly, even if employers continued sponsoring coverage, some employees—especially those who are young and healthy—may be able to purchase lower-cost insurance in the individual market, which could over the long-term increase the costs for some remaining in the group employment-based market. One study estimated that, among people electing a tax credit, nearly half would already be purchasing individual insurance, about one-quarter would shift from employment-based coverage, and another one-quarter would have previously been uninsured. Of those shifting from employment-based coverage, about one-fourth would be because the firm dropped coverage.[30]

Similarly, when eligibility for public programs is expanded, employers with many low-income individuals eligible for public coverage may decide to discontinue coverage or individuals offered employment-based coverage may shift to public programs where they have lower or no premiums or other out-of-pocket costs. The absence of measures to reduce crowd-out can be significant. For example, a recent report indicated that one state that extended Medicaid coverage to parents with eligible children without a waiting period found that nearly one-third of those that became newly enrolled had previously had private health insurance.[31]

Several approaches have been tried or proposed to minimize crowd-out, but none may completely eliminate it. For example, some tax subsidies or public program expansions would exclude anyone offered employer-subsidized health insurance or where the employer contributes to most of the cost of coverage. Requiring a waiting period between the time the individual had employment-based coverage and when they are eligible for a tax subsidy or public program could also reduce crowd-out. For example, some states in accord with the federal requirement to establish mechanisms to reduce crowd-out behavior, have established waiting

[29]Employers that decide to no longer offer health insurance may increase their employees' compensation a comparable amount in wages or other benefits. The net cost to the federal budget from providing a tax deduction or credit to those dropping employment-based coverage for tax-subsidized individual insurance would be largely offset if employees' wages were increased and subject to income taxes.

[30]Gruber and Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits."

[31]Academy for Health Services Research and Health Policy, *State of the States*, produced for the Robert Wood Johnson Foundation's State Coverage Initiatives (Jan. 2001).

Clinton Presidential Records
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Divider Title: Financing Alternatives

Melinna Giannini
President, Alternative Link

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Alternative Link publishes codes, pricing and legal guides to train alternative medicine practitioners and advanced nurses to bill legal services to insurance companies. The company also licenses databases for any or all states to edit claims from 13 licensed healthcare providers to assure that all claims are within state scope of practice laws. As president and founder of this company, I have:

- Designed a national coding system for alternative medicine and nursing services
- Designed a national database that ties the codes to state laws
- Developed process controls to verify annual updates to state laws inside the database.
- Created contracting methods to add alternative practitioner services to managed healthcare using JCHCO and NCQA guidelines.
- Designs insurance benefits, medical management controls and management training to add alternative medicine and advanced nursing services to conventional insurance benefits.
- Acted as government liaison to standards development organizations
- Been elected a board member of the Computer-Based Patient Record Institute

I held a third party administration license in New Mexico until 1999 and I designed, sold and monitored self-funded medical plans for large multi-state corporations from 1988-1996. My practice included:

- Health insurance
- Life Insurance
- Investments
- Property and Casualty
- Estate Planning

Professional Memberships:

American National Standards Institute X-12N
American Health Information Management Association
American Holistic Medicine Association
Computer Based Patient Record Institute
Health Level 7

Speaking Engagements Related to Alternative Medicine:

American Preventive Medical Association Annual Meeting, Palm Springs, CA, October 1996.

National Acupuncture and Oriental Medical Association Convention, Santa Fe, NM, May 1997

New Mexico Health Information Management Association, Albuquerque, NM, February,1998

New Mexico Massage Therapy Association, Ruidoso, NM, March 1998

Depak Chopra Institute, San Diego, CA. "How to Code Alternative Medicine", May 1998.

Data Interchange Standards Association Third Annual Meeting, "Overcoming Coding Problems for Alternative Medicine" Chicago, Ill, November 1998

National Managed Health Care Congress, "Creating a Successful Business Plan for Alternative Medicine" Atlanta, GA, March 1999

"Nursing Informatics and Coding", American Nurses Association, Washington, DC, August 1999.

Invited to testify before the National Committee of Vital and Health Statistics at the US Department of Health and Human Services as this committee was reviewing national code sets, Washington DC, May 1999.

Kaiser Institute Faculty Member, Complementary and Alternative Medicine Symposium. May 1999, May 2000, and scheduled for June 2001

Computer Based Patient Record Institute Annual Meeting, "Legal Issues Facing Healthcare Practitioners", February 5, 2001.

Books and Articles

"The CAM and Nursing Coding Manual", Alternative Link Systems, Inc. and Delmar / Thompson Learning, publishers. Las Cruces, NM and Albany, NY. January 2001.

"The State Legal Guide to Complementary and Alternative Medicine and Nursing", Delmar / Thompson Learning.
Albany, NY, May 2001.

"The State Legal Guide to Nursing", Delmar /Thompson Learning. Albany, NY. May, 2000.

"How to Add Alternative Medicine to Insurance (and Keep your Shirt)", Benefits & Compensation Solutions, A Publication of Intermedia Solutions, Inc., May 2000.

"Integrating Complementary Medicine Into Health Systems". Chapter 54 co-authored with Nancy Faass, Aspen Publications, March 2001.

"Monitoring laws and regulations in electronic health care information", Chapter 9 of "The Consumer's Guide to the Electronic Patient Record", Computer-based Patient Record Institute, due out in September of 2001.

Articles about Alternative Link

"Popularity of Alternative Medicine Creates Need for Electronic Billing Codes", Healthcare IS/IT Market Report, Fist Issue, November 1999.

"Diverting Alternative Medicine Toward the Mainstream", Employee Benefit News, Vol. 14, No. 1, January 200.

"Business Model Allows Full CAM Integration", International Journal of Integrated Medicine Biomedical Therapy, Vol. XVIII No. 1, January 2000.

"Family Ties; Alternative Medicine and E-Commerce Together", Managed Healthcare Magazine, February 2000.

"Medical Codes for 2001", Massage Bodywork, Feb./March 2001.

Testimony from Melinna Giannini of Alternative Link
Presented on May 15th, 2001

The White House Commission on Complementary and Alternative Medicine Policy

"Resolving Coding and Billing Problems for CAM Services"

Honorable Commissioners:

I appreciate the invitation to testify before this commission about a national set of 4000 procedures, services and supply item codes created by Alternative Link to support insurance reimbursement to CAM providers.

But before I explain how and why these codes were created, I would like to provide the commission with a brief background on coding.

Coding is not mysterious, or unique to healthcare. Numbers or letters, which we call codes, represent services and supply items for anything from a piece of jewelry on QVC to a fuel pump for a 99 Lincoln Town Car purchased at Auto Zone. Codes are computer shorthand to precisely describe which item or service is being purchased. And, if too many fuel pumps are ordered for that 99 Lincoln Town Car, Ford Motors learns that the car has a design flaw and they can, or should, recall the cars to replace the fuel pump.

New treatment patterns also grow from reviewing and measuring data. The most exciting prospect of looking at CAM coded data, in conjunction with conventional medical statistics, is that we will all learn which combinations of CAM and conventional medicine are the most effective way to treat different diseases.

So not only do codes allow us to measure patient outcomes, they can also be used to measure costs. Health insurance coding also represents the fee attached to the code for services and supplies. Codes must convey as much detail as is necessary to make sure that the right payment is made for the service or supply being billed to the insurance payer.

Insurance companies constantly review coded data from claims to learn what premium to charge for healthcare policies. An insurance company knows how many times a disease is likely to strike each 100,000 people they insure and what the average cost will be to treat each patient by reviewing coded information.

Health insurance industry software, used to pay claims to doctors, is also used to capture treatment patterns and cost information from the HCFA 1500 form. All

doctors are required by law to file claims to insurance companies using this form. The standard form required of hospitals and clinics to file insurance claims, is called the UB-92. These paper standard forms are soon to become standard electronic forms as the health insurance industry moves towards doing business electronically.

Once the information from the standard forms is entered or sent to the computer system at the insurance company, codes also create interesting statistical data that help insurance companies figure out the amount of premium to charge for a healthcare policy.

CAM treatments, even when found effective, may be of more interest to insurers and purchasers of health care (i.e., employers, Medicare, etc.) if cost data is available, and cost-savings are measurable.

So you see, CAM codes are necessary to create useable claims data, that in turn is monitored to measure patient outcomes and costs and also, to develop premiums for CAM services.

So, why was Alternative Link the one to develop codes for alternative medicine?

In August of 1996, the Health Insurance Portability and Accountability Act was made law. HIPAA was passed, in part, to automate health care claims from all providers. Standards must be supported by all insurance companies to reduce paperwork burdens on providers, lower the cost of processing claims and allow all business partners in healthcare to communicate what is actually going on in the patient encounter.

There were no codes for alternative medicine to bring these efficiencies to CAM. I originally tried to get the support of national associations of alternative medicine to participate in developing codes. However, by the middle of 1997, I realized that very few practitioner associations understood the significance of coding and I could not get the cooperation that was necessary to build quality codes.

So, in addition to building a database to track which practitioners were allowed to practice certain services in each state, my company made the commitment to develop this code set to support claims from licensed alternative practitioners.

We have gathered information from around the country and paid experts in each field of CAM to add and edit the terms and definitions to each of the codes in our system. The code set before this commission was developed or review by faculty members from nationally certified schools, experts in each field of CAM medicine, state boards that govern alternative practitioners, and state and national associations.

Related Values for CAM

We have also made a financial commitment of over $150,000 a year to participate in the standards development process that began in 1996 and is culminating in the HIPAA regulations.

Here is a brief outline of the things we have accomplished since we made the commitment to build these codes.

In November of 1997, the National Library of Medicine asked us to insert these codes into the Unified Medical Language System. We delivered the codes to them in August of 1998 and updated the information in March of 2001.

In 1998, by request of many different nursing organizations, Alternative Link included concepts from three nursing terminologies to support advanced practice nurses with codes that could be used to accurately bill for nursing services.

In 1999, we were invited to testify before the National Committee of Vital and Health Statistics on behalf of this code set.

The ABCcodes™ were voted into the American National Standards Institute X12 guide for standard electronic commerce in 1999.

In 2000, these codes were mentioned in the Final Rule, under the Administrative Simplification Rules, as a potential national standard for coding alternative medicine.

We have since been following a process created by the Department of Health and Human Services in conjunction with the standards development organizations, requesting to be added to the original list of codes that were named in 1996.

The American Dental Association has codes for dentistry, the American Medical Association has codes for conventional physicians, the National Committee for Prescription Drug Products has prescription drug codes and state Medicaid agencies have codes that are being included in the Healthcare Procedure Coding System developed by HCFA. Alternative Link has designed codes (that fit into all electronic healthcare software standards) for alternative medicine and nursing.

The ABCcodes™ support the following services: codes support all that have State License

Acupuncture, Ayurvedic Medicine, Body Work, Botanical Medicine, Chiropractic, Clinical Nutrition, Conventional Nursing, Holistic Medicine, Holistic Nursing, Homeopathic Medicine, Indigenous Medicine, Massage Therapy, Mental Healthcare, Midwifery, Naturopathic Medicine, Oriental Medicine, Osteopathic Medicine, Physical Medicine and Somatic Re-education

Many national organizations have already sent letters to the Secretary of DHHS, Tommy Thompson, on behalf of the ABCcodes™ requesting that they be named a national standard code set.

This code set is critical to CAM. The committee could greatly advance the ability of CAM providers to do business with insurance companies by supporting the ABCcodes™ as a national standard for the following reasons:

- Codes are tied to fees that will be paid for each service. Without accurate descriptions of services, fees cannot be developed
- All procedure codes within the ABCcodes™ are paired with relative value units that were scientifically created by the authors of "Relative Values for Physicians", a pricing system supported by 90% of claims payment systems in the US.
- Accurate codes reduce the need for written reports that cost the provider and the insurance company money and time.
- HIPAA enforces fines as high as $10,000 per coded item for filing or paying for a fraudulent service, and CAM providers are using codes that do not describe what they do.
- No national cost or patient outcome data is available when CAM providers use CPT™ because it was not designed to capture provider-specific data.

This coding manual and these other three books are being published, distributed and used today.

Some of the companies that use our coding system are:

American Healthcare Alliance, a national network of regional PPOs, that services 23 million policyholders.

Mitchell Medical, a software developer that electronically edit automobile and personal injury claims for over 65% of automobile insurance companies including State Farm, Allstate and Geico.

The Accident Fund of Michigan, a worker's compensation fund operated by Blue Cross and Blue Shield.

Preferred Health Systems, the largest HMO in Kansas and the insurance company for Boeing Aircraft.

Via Christi Hospital, the largest hospital system in Kansas

Brokerage Services, Inc., a third party administration company doing business in New Mexico, Arizona and Texas

Bridges in Medicine, an integrated clinic in Albuquerque, New Mexico, that has contracted with St. Joseph's HMO to service Medicare patients.

The American Medical Association has said that it will code alternative medicine. There are approximately 7000 codes to describe physicians' services in CPT™. Over the last 30 years, CPT™ has created four codes to describe chiropractic services and two codes to describe acupuncture. In my humble opinion, having the AMA code alternative medicine to support appropriate reimbursement to CAM is akin to having Ford Motors responsible for coding the parts and services of General Motors.

Evaluation and management or E&M codes in CPT™ are developed in conjunction with the Health Care Finance Administration that describe time elements for physician patient intake. All physicians are able to diagnose. The "Evaluation and Management Guidelines" for appropriate use of E&M services do not describe the way that most alternative practitioners are assessing patients. Using E & M codes put CAM providers, especially those who are prohibited from developing a diagnosis, at great risk of fraud. Alternative Link has developed codes that were designed for CAM patient evaluations and our training manual clearly point to codes for providers who are diagnosticians and also to codes for providers who are not allowed to diagnose.

HIPAA requires that the Department of Health and Human Services name codes for electronic commerce to meet the needs of all qualified health care providers. CAM providers who hold a state license are considered qualified health care providers. Alternative Link has the only fully developed code set before the Department of Health and Human Services that accurately describe alternative medicine and advanced nursing services. Standards for electronic claims filing are scheduled to go into force on October 16th of 2002.

The ABCcodes™ will solve the coding issue facing approximately 300,000 providers, licensed to file claims to insurance companies. These providers are currently seeing about 600 million patients each year, yet they lack coding to communicate services, and therefore fees, to insurance companies. This commission can help solve the reimbursement issues surrounding CAM by recommending that Secretary Thompson name the ABCcodes™ as one of the national standard code sets for communicating claims to insurance companies.

I thank the commission for their time and attention and look forward to answering any questions that you may have.

Sincerely,

Melinna Giannini, President
Alternative Link

SOLUTIONS IN INTEGRATIVE MEDICINE

POST OFFICE BOX 207 SACO, MAINE 04072-0207

Linda L. Bedell-Logan
Biographical Sketch

Linda L. Bedell-Logan attended the University of Southern Maine Business Administration program. She worked for Medicare B in Provider Affairs from 1985-1988. During 1988-1990 she was the administrator of a large family practice which included minor surgery, physical therapy, radiology, lab and triage.

Linda started Solutions in Integrative Medicine in 1990 after the death of her 25-year-old sister from cancer and her 33-year-old brother from AIDS. A caregiver to both siblings during their illnesses, she witnessed firsthand the lack of choices available to those battling chronic disease within conventional healthcare delivery systems. Viewing her own losses as a catalyst to work for change, she realized there is a great need for patient advocacy in the insurance arena for complementary and alternative medicine (CAM). It also became clear that there is an even greater need for the integration of CAM alongside allopathic medicine in existing healthcare delivery systems.

SIM Billing and Practice Management provides billing and patient advocacy services focused on obtaining insurance reimbursement for patients treated in an integrative setting. The billing system is also capable of creating outcomes data that not only helps the practitioners to work more efficiently but can also show cost offsets and efficacy to the insurers and to legislators.

SIM Consulting has become a nationally recognized firm involved in establishing integrative medicine centers throughout the United States. Examples of such centers include: Arizona Center for Health and Medicine, Phoenix AZ; Presbyterian Center for Integrative Medicine, Charlotte NC; American Holistic Centers, Chicago IL; Integrated Medical Center, Carbondale IL; Center for Holistic Medicine at United Hospital Medical Center, Port Chester NY; Complementary Alternative Medicine Program at Danbury Hospital, Danbury CT; The Medicine Tree, St. Ignatius, MT. Linda consulted on research studies conducted at the Center for Alternative Medicine Research and Education at Harvard Medical School/Beth Israel Deaconess Medical Center, Boston MA. Linda has been invited faculty for the CME programs in CAM at both Harvard and Stanford medical schools.

SIM Educational Programs include programs focused on educating practitioners, consumers, insurers, administrators, and legislators about the evolving role of integrative medicine in today's healthcare environment. Linda was invited to testify before Congress on "Women's Cancer Issues" and was the Chair of the Health Freedom Working Group Science Committee charged with educating Congress about CAM. Linda speaks nationally to promote and educate about integrative medicine services, please see attached list of national lectures.

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Linda L. Bedell-Logan

Invited Presentations

1996

Panelist. "Insurance Reimbursement for Combined Decongestive Therapies," The Second National Lymphedema Network Conference, Burlingame CA. September 19-22, 1996.

Lecture. "Insurance Reimbursement Issues for Complementary & Alternative Medicine," Integrating Complementary Medicine and Managed Care, Institute for International Research, Washington DC. October 7-8, 1996.

1997

Lecture. "Alternative Medicine, Lymphedema, and Breast Health," National Consortium of Breast Centers, Inc., Orlando FL. April 3-6, 1997.

Lecture. "Manual Lymphatic Therapies and Insurance Reimbursement," First Annual Conference, North American Vodder Association of Lymphatic Therapy, Mount Holyoke College, South Hadley, MA. June 25-29, 1997.

Lecture. "Insurance Issues & Reimbursement for Lymphedema Treatments," First Annual Open Meeting, American Society of Lymphology, Charlotte NC. July 27, 1997.

Lecture. "Choices for Care Under the Emerging Health Care System," The Seventh Annual Summer Institute on Aging, New Perspectives in Health Care for the Elderly, University of New England, Biddeford ME. August 11, 1997.

Lecture. "Reimbursement: Alternatives in General & How to Integrate Them in Your Practice," Third Annual International Congress on Alternative & Complementary Therapies, Arlington VA. September 7, 1997.

Keynote lecture. "Insurance and Practice Management Issues for Acupuncture,"
Panelist. "Acupuncture and Insurance," The Acupuncture Society of New York Annual Meeting, New York NY. October 25, 1997.

Lecture and Panel Moderator. "Working With Insurance Companies and Policy Makers to Expand Coverage of Integrative Practices," First Annual W. Hadley Hoyt Conference on Health and Healing: Mind/Body Medicine, University of New England and Maine Medical Center, Biddeford ME. November 8, 1997.

1998

Lecture. "Alternative & Complementary Medicine in Pain Management," Pain Support Group, Unitarian Universalist Church, Saco ME. March 17, 1998.

Lecture. "Billing & Reimbursement Issues for Mainstreaming Acupuncture," Fourth Annual Business Meeting and Conference, The Acupuncture Society of Massachusetts, Boston MA. April 4, 1998.

Lecture. "Reimbursement Issues Related to Complementary and Alternative Medicine," The Benefits of Mainstreaming Complementary and Alternative Medicine in a Managed Healthcare Environment, Connecticut Hospital Association, Cromwell CT. April 30, 1998.

Lecture. "Choices for Care Under the Emerging Healthcare System," Eighth Annual Geriatrics Conference, Evolving Systems and Practices, Department of Veteran Affairs, Continuing Health Education Partnership, Inc., and Rural Geriatric Consortium, Bar Harbor ME. June 5, 1998

Lecture. "Making Integrative Medicine Work: Billing, Credentialing & Quality"
Panelist. "Challenges & Opportunities for Hospitals & Physicians," The New Hampshire Hospital Association and Foundation for Healthy Communities Annual Meeting, Integrative Medicine: Challenges & Opportunities for Hospitals and Physicians, Bretton Woods NH. September 14-15, 1998.

Panelist. "Insurance Reimbursement for Combined Decongestive Therapies," The Third National Lymphedema Network Conference, San Francisco CA. September 17, 1998.

Panelist and Lecture. "Billing, Reimbursement, and Practice Management in Integrative Medicine," The Fourth Annual International Congress on Alternative & Complementary Therapies, Arlington VA. October 1-4, 1998.

Presenter. "Integrating Alternatives in a Hospital Setting," Quorum Health Resources, LLC, Trustee Education Program, Portland ME. November 10, 1998.

1999

Presenter. "Billing, Reimbursement, and Network Strategies," Center for Alternative Medicine Research and Education, Beth Israel Deaconess Medical Center, Harvard Medical School Department of Continuing Education course: Alternative Medicine: Implications for Clinical Practice, Boston MA. March 1-2, 1999.

Presenter. "Integrative Medicine Practice Management: Coding and Reimbursement," Complementary and Alternative Medicine: Practical Applications and Evaluations, Complementary and Alternative Medicine Program, Stanford University School of Medicine and Center for Alternative Medicine Research and Education, Beth Israel Deaconess Medical Center, Harvard Medical School, San Francisco CA. October 15-17, 1999.

Lecture. "Gaining Integration Without Losing Integrity: Acupuncture and Integrative Medicine," New England School of Acupuncture, Annual Research Lecture Series, Watertown MA. March 16, 1999.

Lecture. "Who Pays for Integrative Medicine? Practice Management Strategies," Second Annual W. Hadley Hoyt Conference on Health and Healing: Mind/Body/Spirit, University of New England, Biddeford ME. April 10, 1999.

Lectures. "Practice Management I: New Visions for Re-Uniting Business and Medicine" and "Practice Management II: Negotiating Integration Without Compromise," Integrative Medicine: Business & Clinical Management, Solutions in Integrative Medicine and CambridgeHealth Resources, San Francisco CA. June 3-4, 1999.

Lecture. "Mainstreaming Integrative Medicine Without Compromising Care," National Association for Healthcare Quality, 24th Annual Educational Meeting, Atlanta GA. September 27, 1999.

Testimonial. "Complementary, Alternative, and Integrative Medicine: Impact on Treating Breast Cancer and Lymphedema in Women." Testimony before the United States House of Representatives, Committee on Government Reform in relation to the Department of Health and Human Services budget. Washington DC. June 10, 1999.

Panelist. "Finding Coverage for Alternative Cancer Treatments," Comprehensive Cancer Care II: Integrating Complementary and Alternative Therapies, Center for Mind-Body Medicine, Arlington VA. June 12, 1999.

2000

Presenter. "Billing, Reimbursement, and Network Strategies," Center for Alternative Medicine Research and Education, Beth Israel Deaconess Medical Center, Harvard Medical School Department of Continuing Education course: Alternative Medicine: Implications for Clinical Practice, Boston MA. March 12-15, 2000.

Presenter. "Finding Coverage for Alternative Cancer Treatments," Comprehensive Cancer Care II: Integrating Complementary and Alternative Therapies, Center for Mind-Body Medicine. Arlington VA. June 2000

Presenter, "Touch the Future" 17th Annual AMTA New England Regional Conference : Massage Therapy and Third Party Reimbursement, Framingham, MA March 23 – 26, 2000

Presenter, "Insurance Reimbursement and Legal/Administrative Consideration in the Utilization of Alternative Therapies", Foundation for the Advancement of Innovative Medicine: Integrative Medicine: The Bridge to Vitality in the 21st Century: How to Incorporate Alternative Therapies into Your Practice, Brooklyn, NY March 26th, 2000

Presenter, "How to Best Optimize Care Through Complementary Care Services and Conventional Medicine", NMHCC/2000, Atlanta Georgia, April 16-19,2000

Panelist. "Insurance Reimbursement for Combined Decongestive Therapies," The Fourth National Lymphedema Network Conference, Orlando FL, September 14-17, 2000.

Presenter, "The Fifth Annual Disease Management Congress and Exposition" Integrative Medicine Workshop. Hynes Convention Center, Boston MA. September 25 – 27 2000

Presenter. "Integrative Medicine Practice Management: Coding and Reimbursement," Complementary and Alternative Medicine: Practical Applications and Evaluations. Complementary and Alternative Medicine Program, Stanford University School of Medicine and Center for Alternative Medicine Research and Education, Beth Israel Deaconess Medical Center, Harvard Medical School, Hawaii. October 28 – 30, 2000.

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for patients suffering from chronic disease and negotiating with managed care companies to reimburse these cost saving programs. The US Public Health Services estimates that 70% of the health care budget is spent on 20% of the population, that segment of the population which suffers from chronic diseases.

Testimony

The recommendations that follow are intended for healthcare as it exists today, for the urgent needs of patients without choice, providers without the right to make clinical decisions, and payers without answers.

The origin of CPT was created by the desire to obtain utilization data for conventional medicine techniques and procedures. The role of CPT in the eyes of the AMA was to categorize conventional medical services in effort to objectify services rendered in the physicians office. The license to use these codes is then purchased by the insurer and the CPT books are sold to physicians offices. This mass distribution of CPT resulted in the creation of a standard language used to submit information to insurance carriers. There are three main factors that have attributed to the demise of the clinical usage of CPT, the administrative paper war associated with CPT and the crash of managed care systems because of the misuse of CPT.

First, the clinical usage of CPT in the physicians office was severely misused and abused in the 70's and 80's. The crack down by Medicare's fraud investigation unit discovered huge abuses in the way services were reported and began to create guidelines around how long a physician could spend with a patient with a given disease and how that service needed to be coded in order to be paid. Once the commercial insurers caught on to this same kind of abuse, meetings began to take place with the large insurance companies in the country and Health Maintenance Organizations (HMO), and the advent of Managed Care resulted.

The **second** factor of the demise of the administrative side of health care was when the simple use of the CPT, used to track utilization and cost data, became the tool for measuring best practices in managed care. Actuarial firms all over the country purchased large quantities of CPT data from many sources, and from those data decided what were the best practices in medicine. Then, these firms sold the analyses of their data to managed care and insurance companies who started to create software that would "kick out" claims if the ICD 9 (diagnosis code) did not match the best practices analyses generated from the CPT data previously collected.

Picture this..... if every physician decided to treat terminal cancer patients by significantly changing their diet – given the way we make best practices decisions today – chemotherapy might cease to be considered best practice. Just because the data indicate a treatment is most widely used, it does not prove the efficacy of that treatment. CPT data should be used only as it was intended to be used – for utilization review and not the determination of best clinical practices. In making these data best practices guidelines, we have increased the cost of health

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care significantly by giving many patients the wrong treatments ***for them*** because it was the only thing the insurer would cover. Using CPT to provide best practices guidelines assumes we are all the same. That is an assumption that will continue to increase health care costs in this country until we stop and realize that the way we capture data must change.

Finally, we must record some objectified measurement of patient outcomes and/or progress at the encounter level to assist the payers with controlling overutilization. A potential example of how we might do is as follows:

- The provider submits a protocol with a estimated number of treatments and specific objective treatment goals
- For each subsequent claim, the patient indicates on a scale of 1-10 his/her perceived rating of the current status of the presenting problem and progress towards treatment goals
- The provider enters this patient rating on one of the "open" fields on the current HCFA 1500 form
- That we begin the coding of innovative treatments by starting with HCFA at the HCPCS level and then adopt codes into CPT as their meaning and utilization are studied. This gives the insurers time to update their systems and provide for education in the use of these new codes and speeds up the amount of time it will takes to get these new codes accepted by CPT/AMA.
- I believe we should not try to replace CPT but instead to enhance its use and provide a bridge for consumers to access therapies that cannot be coded legally today.

If no progress is being made or no improvement is shown (patient reported) then the patient would be switched to a new treatment plan. This approach allows **all of us to choose the kinds of treatment we want to receive, patients and providers to collaborate on treatment options, providers to responsibly innovate in the treatments they offer patients, and payers to control cost – all better than we are now**. Waste is minimized, and administrative costs are slashed because providers no longer must generate huge volumes of paperwork to convince payers to consider coverage for innovative treatments. Health services research at the patient encounter level provides a valuable realworld corroboration of the results of randomized controlled trials. It measures the appropriateness and the outcome of treatment plans to which both the patient and the provider have agreed, with which both can willingly comply, and which improve the odds of a positive outcome.

Best practices are only best for those patients who respond best to them. The rigidity with which we are now managing care puts physicians into ethical quandaries, and puts patients into the predicament where they are receiving the wrong treatment plan **for them** because that is what is covered by insurance.

SOLUTIONS IN INTEGRATIVE MEDICINE

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White House Commission on Complementary and Alternative Medicine Policy Meeting
May 14th – 16th, 2001

Linda L. Bedell-Logan

Medicine in the United States was at one time as diverse as the cultures that came here to build new lives. There was an integration of Native American Medicine, and Eastern and European medical philosophies and techniques.

By the mid 1800's biomedicine began to dominate with the discovery that bacteria was the cause of disease and therefore vaccines and antitoxins became the complete focus of medical research in the United States.

Similar to the balancing act between offensive action and defensive action in war, medicine in the United States became focused on offensive medical practices. In other words, innocent bacteria and cells were being killed in the movement toward killing all disease.

Within the past thirty years medical research has refocused on defense/preventive techniques used in the past as well as new non-pharmaceutically based research that has transformed other countries both from the standpoint of prevention as well as disease intervention. The evolution has proven to reduce the cost of overall healthcare in other countries as well as increase the quality of care delivered.

First the Office of Alternative Medicine (OAM) and now the National Centers for Complementary and Alternative Medicine (NCCAM). Are convinced through pointed research that botanical medicine, mind body interventions, manual healing techniques, diet and nutrition and eastern medical techniques and philosophies are not only important in the role of disease prevention but also in disease intervention.

This exciting and promising research is extremely important to the future of medicine in the United States. However, long before organized research began in this field, consumers were being treated by alternative medicine providers. Once a number of excellent national surveys were published and the use of alternative medicine was realized conventional physicians all over the country began to ask their patients if they used alternative medicine and began to realize they were actually sharing patients with providers they knew nothing about.

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As conventional physicians found their hands tied in treating chronic conditions such as chronic fatigue syndrome, migraine headaches, depression and anxiety, fibromyalgia and multiple sclerosis, they started to do literature searches based on the alternative medicines their patients were using. These physicians found that there was in fact sufficient efficacy information on many of the techniques that were considered outside of mainstream or conventional medicine. Many of these providers not only began to support their patients use of these therapies but actually added alternative medicine providers to their practices. This mutual respect of diverse medical practices led to what we now call Integrative Medicine.

Currently, there are hundreds in integrative medical practices in this country that range from private free standing clinics to hospital based centers to academic health centers that have integrated with a focus on health services research.

Our current system of objectifying medical procedures and encounters is the CPT or Current Procedural Terminology developed by the American Medical Association (AMA). This system of coding is an excellent way to provide a tool for billing insurance carriers for medical procedures. These codes can also be of great use when researching best practices and utilization data. The challenge for the integrative practices that are already treating patients is to find the proper codes within this system to objectify services rendered in an effort to obtain insurance reimbursement. The AMA has come a long way in creating codes for this purpose but falls short in providing a comprehensive system of coding for the integrative or alternative practice. The AMA must find a way to embrace integrative and alternative services with the help of research entities like NCCAM and provide coding for these practices or it will be very difficult to measure utilization and best practices so we may move toward a more efficient delivery system.

The AMA has created acupuncture codes, codes to denote massage, hypnosis, biofeedback and nutritional counseling, however these few codes are not comprehensive and much work needs to be done in the area of the expansion of CPT to include alternative techniques. This process however should not be done in a vacuum but should include a panel of CPT experts as well as providers of these services in an effort to appropriately capture the service rendered in a coding scheme. Much of this work has already been done by professionals outside of the AMA and until both administrative sides of health care integrate their knowledge and systems, the delivery side will never truly be able to thrive and the American consumer will be left to pay out-of pocket for choice. Medicine that is potentially cost saving to the insurers will continue to be rich peoples medicine. For instance, if you have a terminal illness and you have the money, you may be able to avoid potentially toxic pharmaceutical interventions and recover through nutritional and botanical interventions, but if your disposable income is not sufficient to support both an insurance premium as well as the out-of pocket expense your only option is the conventional defense that **may** kill diseased cells and most certainly kills the healthy ones.

In my experience over twelve years of providing billing and practice management services to integrative and alternative practitioners, I have seen first hand the cost offsets and efficacy apparent in alternative techniques. Many of these clinics are creating cutting edge programs for patients suffering from chronic disease and negotiating with managed care companies to reimburse these cost saving programs. The US Public Health Services estimates that 70% of the health care budget is spent on 20% of the population, that segment of the population which suffers from chronic diseases.

Integration of these diverse areas of medicine will lead health care reform into the future. However, without administrative changes to support these diversities, access for consumers will be out of reach for most patients.

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Wayne Sickles
Massage Therapist

White House Commission on Complementary and Alternative Medicine Policy
Meetings on Reimbursement and Research, May 15, 2001
Testimony - Wayne O. Sickels, M.T.S., M.Div., C.M.T.

Members of the Commission,

Thank you for your invitation to speak to you today. This morning I am not trying to represent any group or organization . I offer only my personal viewpoint and experience 'from the trenches' of a fast-growing, young profession, after 16 years of practice in the field of therapeutic massage and bodywork. My view is strongly influenced and informed by my personal experience in pursuit of "health" and "healing", being in the ministry, my experience with clients in clinical practice, much discussion with other massage therapists, and dialogue with and thoughtful reflection on the experience and path of other more 'mainstreamed' and 'integrated' health care professionals in professions such as Physical Therapy, Chiropractic, Psychotherapy and Pastoral Counseling. While I do not pretend to have solutions to the complicated questions before you, I hope that some of my thoughts and questions as I consider the future path of my profession, are in some small way useful in your exploration of the issues before the Commission.

The growth of my profession parallels and reflects the growth of alternative and complementary care in this country, and its newfound attention given the discovery of the "invisible mainstream" which has been paying out of pocket for the resources they found in a number of "non-medical, adjunctive, and alternative care modalities" such as massage. My primary concerns focus on

what may be lost with the complete absorption of manual/manipulative therapies, somatic or body-oriented education and facilitation "methods", into the belly of modern medicine and the mainstream healthcare payment and delivery system. I also find myself questioning some assumptions about and motivation for getting into the healthcare payment and delivery system.

When I teach massage therapists, I teach that there are two kinds of touch, *procedural touch* and *expressive touch*. Many of my own clients implicitly know this difference and come to me precisely because I am VERY conscious of the difference and am skilled at doing both. Professional therapeutic massage, when most effectively and ethically applied, marries the two. The healthcare payment and delivery system only recognizes the procedural form and application. I have come to recognize that much of the potency and value of what I do comes from the fact that I work *with* whole people, not *on* them or pieces of their anatomy; and that this is true no matter the technique used or outcome sought. I believe that this is precisely the 'alternative' that the lions' share of people who seek our services find so 'complementary' (with or without reimbursement).

When I worked in a doctor's Physical Medicine and Rehabilitation office alongside a Physical Therapist early in my practice, I would see the patients often after the doctor and either

before or after the PT. Cases involving auto accidents, falls, cervical strain, herniated discs, and chronic pain would be sent to me to work on the neuromuscular and myofascial components of their painful and guarded conditions. When I left the doctor's practice for my own, the Physical Therapist wanted desperately to know what it was that I had been doing to the patients I had seen. What techniques was I using so that she could perhaps go learn them too? I had to honestly say to myself and to this colleague that if there was anything consistent and identifiable about the time that I spent with these people, it was less the application of a particular manual protocol method or technique, and more the quality of the time that I spent with them, listening carefully to their stories and experience both with my ears and with my hands, validating and supporting them in *their* process of gradually *letting go* of their holding, guarding and fear, responding and feeding back to them what I was hearing and feeling through my hands in ways that helped them become aware of what *they* were doing and choices they might have. I listened, heard and acknowledged with my hands what their bodies and words were telling me. Various massage and neuromuscular protocols, which were always carefully recorded for tracking patient progress and keeping the treatment record, were the platform and excuse for them to receive safe, responsive, intelligent, caring touch. I cared for them. These skills cannot be learned from books, published studies, and the hard

sciences. These are the softer arts, and they, like expressive-type touching and exquisite sensitivity to boundaries, are mostly set aside in the mainstream healthcare service industry to make room for the efficiency of procedures.

I learned a great deal from that experience about healing, and what Rachel Naomi Remen points out about the differences between 'helping', 'fixing', and 'being of service'. She writes that, "fixing and helping are the basis of curing, but not of healing. Only being of service heals." She also notes that all the focus on fixing and helping leaves us wounded in some important and fundamental ways.

It has also been my experience that perhaps a majority of persons in our culture have largely and sometimes exclusively experienced touch (be it procedural or expressive) that communicates primarily one or more of three things to the body/mind: expectation, demand, or threat. This includes much of the touch that passes between persons in private and intimate relationships as well as the typically procedural type touch provided in medical exams or rehab intervention. I tell my students that for some of their first-time massage clients in particular, that may be the first time in their life in which they experience a quality of touch that does not only express or communicate some form of expectation, demand, or threat. Keep in mind that most procedural touch is focused only on the desired outcome but not the *person*. It

breaks, loses or never even establishes real *contact with* the person, but instead emphasizes the separation, difference, distance, power differential, and of course the outcome or goal that *is* being focused on. This is quite naturally and often received as a subtle aggression, from a position of power-less-ness and vulnerability; doing something *to* someone to *make* them other than they are in that moment. It has been my role, and I suspect the role of numerous other 'alternative health care' professionals to "counteract the level of vulnerability conferred upon the patient by the curative processes and associated technical administrations."[1]

The demands of the healthcare system as it is currently structured and oriented will lend even more momentum to a tendency I already see within my profession as it grows and seeks mainstream legitimacy. That is to focus primarily (and often exclusively) on *techniques* or tools in the toolbox, and *theory* for application in fixing or curing presenting problems (just like the Physical Therapist whose entire focus and only question was what had I been *doing to* the patients we had both been seeing in the doctor's office). With the theory comes research justification sought and framed within a mechanistic medical model, and expressed only in the language of physiology. Meanwhile contact with the interpersonal, expressive, and phenomenological qualities of the interaction (from the point of view of subjective experience in the

[1] Nathan B 1999 Touch and Emotion in Manual Therapies p.95. Churchill Livingstone

moment), and skill development in observing, noting dynamics, and relating in this regard, fall to the back of the curriculum, or off of it entirely. So we learn techniques to 'help' and 'fix', things we do *to* someone *for* them, with less focus given to teaching or developing the skills of presence, attention, listening to, being with and educating, in order to truly be of some service to a client.

Techniques are then strung together into 'protocols' and procedures used *on* anatomy (no longer persons) by healthcare providers, including massage therapists. Bevis Nathan points out that "Holding, rocking, rubbing and stroking touches...are procedurised versions of expressive touch forms."[2] While we ascribe physiological rationales to our techniques in an attempt to become or remain scientifically acceptable and to gain access to the mainstream medical reimbursement system, we must continue to recognize, as Nathan puts it, that our "therapeutic pedigree is rooted in primitive and instinctive healing behavior of the expressive touch variety."[3] We cannot expect all our answers and justifications to come from the language of anatomy and physiology. In fact, "We may have become over-reliant upon a small physiology section of a very large library of the human constitution."[4] "...an answer may instead arise in terms of the meaning of a caress, rather than the

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[2] Ibid. p.94
[3] Ibid. p.95
[4] Ibid. p.21

physics of it."[5] "...the meaning of a touch to an individual is a far subtler notion than is the mere stimulation of a postural reflex pattern."[6] How do we quantify, control, and or reimburse for the meaning someone makes of an interaction, expression and communication via touch during a session?

Prescribed remedies depend little or not at all upon interpersonal transactions. They are in part expressive of the passive, non-participatory stance towards health that looks for and sees 'healing' as something that comes from outside of ourselves (an expert, authority, technique, or drug), and that does something *to* and *for* us to *make* us 'better'. Far too little of our experience within the present healthcare system highlights in resourceful and empowering ways the actual commitment (and cost in terms of choices and change) required from the patient for lasting change or actual "healing" to occur.

Consistently in my years of practice, clients who are playing the system, asking first and foremost "how can I get someone *else* to pay for this," to *make* the change *happen to them for them*, and those who have actually had my services "covered", are less likely and slower to heal. These persons have often been more interested in the process not costing them much or anything, rather than being motivated to learn and then do, what it takes to be or get well.

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[5] Ibid. p.20
[6] Ibid. p18

Real change costs us something.

I support and encourage integration, coverage, and reimbursement for the minority of persons who really *need* alternative and adjunctive services such as massage therapy, and cannot, even if they choose to seek them, afford to pay for them. But my experience is that this is only the case for a small minority of persons who seek and use our services. While a truly excellent preventative health care and self-care resource that virtually everyone *could* benefit from, and some choose to use, most common application and use of massage therapy does not meet the 'medically necessary' criterion for coverage. Again, this is not to deny the validity and value of forms of "medical massage", for those who truly need it, provided for and reimbursed by the system. What is more in question is the limiting definition and control of these and other alternative care services through integration, in a way that compromises some of their essential ingredients and redirects some of their most creative focus and gifts, in effect limiting both quality and access. These essentials for massage therapy and somatic education lie in the area of expressive contact and presence (including touch and touch skills) and strategic, responsive, interpersonal interaction focused on the whole person; and in exquisite attention given to boundaries and to a person's physical and emotional responses to the care giver's presence, pace, contact, touch, and intervention strategy.

Finally, it has also been my observation that quick and uncritical allegiance to the "benefits of access" to the healthcare payment and delivery system often has more to do with a profession's and professional's access to and control of marketshare, than the real interests or needs of clients/patients in their pursuit of resources for health and healing. Too many therapists are sold on the idea of becoming a "preferred provider" and gaining (the assumption and packaging says) easier access to more clients as referrals are provided you through the network. Meanwhile they have little awareness of the implications to their practice, time and attention, their possible dependency upon, and the costs of securing this effortless marketing and referral source.

It seems entirely possible to me as well that our future in an integrated landscape of medically oriented healthcare may leave less viable the creative, individual, entrepreneurial, and small scale practices of professional massage therapists. Given the terms of Preferred Provider Network contracts that I have been sent in the last year and a half, I would personally have to close my independent clinical practice entirely and go back to work in a health club, spa, chiropractor's or doctor's office, or a group practice, to remain at all viable. The fee scale limit in the two contracts I was invited to sign, is less than the amount charged by a new graduate of basic massage training in the Washington area, who is just beginning a practice.

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I am much more interested in what we now have as a profession and can perhaps bring to the current system (i.e. our focus on presence and contact skills, and the gift of expressive touch and interaction married to procedural touch) than on getting into it so that we can get something out of it (clients, income, or legitimacy).

Eleven years ago I spoke with a Physical Therapist in a continuing education course we were both taking. What I remember most was her saying, "Believe me, you don't want to get into the insurance game. My profession and much of my time is run by it. It means someone else has control over your time, treatment decisions and direction. And to do *anything* requires that you do it thinking about describing and justifying *everything* you do in terms of what the insurance company needs or wants to hear (not necessarily what the patient actually needs). A lot of treatment time and paperwork is made up or bent to fit, just to be sure to get coverage and get paid. Then there's the considerable time and overhead required to do and submit the paperwork. What the game is focused on is getting coverage, continuing to secure or advocate further coverage, and getting paid, not meeting the actual needs and healing of the patient where they are." She said she sometimes felt like "the real healing work I do with patients is despite the medical insurance system." I have since heard similar attitudes expressed by other healthcare providers who either have separated

themselves from the insurance reimbursement system or wish they could. This continues to keep me thinking and asking more questions, not just making assumptions about the "benefits of access" or the value to me and to the consumer of becoming integrated and subsumed under the language, model, and current structure of the medical healthcare payment and delivery system.

I look forward to learning more from the perspectives and understanding of those whose view and experience is different from mine. These are interesting times in the evolving world of alternative and complementary health care options. Thank you once again for your attention to and interest in exploring these issues that are close to the hearts and health of us all.

Linda / Logan [illegible] Recommend to Congress / Phoney Thompson
Expand CPT codes + indicate who can use CPT codes

Melina
Gionnini - Coding provider for level of training, eg.
M.T. learns Rolfing, Feldenkrais, Reiki in educ
training - CMT = 500 hrs
CMT+ = 1200

Level of Expertise
Overhead
Liability
} Set of Cost
RBRB System - Pricing System
Conventional codes

AMA - CPT - not open to change of codes
HCFA PICS - more open to change in Ch codes

→ Produce a huge revenue stream

ICD-IX - Intl - World Healthcare Organization
Support diagnostic tools (for CAM) Practices
Not just acupuncture (cupping, moxabustion, Acupuncture) needling, electroacupuncture

Reimbursement for
Complementary and Alternative Health Services

Testimony of Max Heirich, Ph.D., Professor Emeritus
University of Michigan

EXECUTIVE SUMMARY

Reimbursement policies for complementary and alternative medicine have major implications for the economy, since over forty percent of the American public currently uses CAM products and services. Depending on how policies are crafted, and with what base of evidence, strategies for reimbursement could lower overall costs for health care or escalate costs rapidly. The stakes are high.

Many advocates of Complementary and Alternative Medicine argue that greater use of CAM services and products could improve the health status of the American public and reduce overall costs for care. Anecdotal and observational evidence suggests this could be true. However systematic evidence for or against these claims has not been conclusively gathered or appraised. If the claims are true, encouraging wider use of CAM will be an important public policy objective, because the U.S. spends much more per capita for health services than any other nation, yet ranks far down the list in terms of indicators of the health status of the population. If use of CAM does not improve health in ways that actually lower overall costs for care, however, any reimbursement for these services must be done in ways that do not disrupt risk pools for health insurance premium setting. Otherwise even more Americans will be left with no access to health insurance. Documenting CAM's impact on health improvement and its costs become important tasks, and will be relevant for various possible reimbursement strategies.

Policies regarding payment for CAM services and products can go in three directions. They could emphasize reliance on market mechanisms, as at present, and help encourage current directions of movement. They could mandate reimbursement coverage through insurance for CAM services and products whose clinical effectiveness has been documented or for which there is high public demand. Or they could use the mechanism of tax relief to encourage higher use of CAM services. Each strategy has advantages and disadvantages which are discussed in the body of this document.

Current market mechanisms are working well for a substantial portion of the public. The persons left out tend to have lower education and incomes. Because public taxes pay for much of the health care given low-income populations, increased use of CAM services by these groups not only might improve health but also lower public expenditures. This is only true, however, **if** CAM services actually decrease use of more expensive disease-care services. If this proves true, strategies that make CAM services available to persons with low incomes who lack health insurance will be especially important.

Because needed evidence is not yet in place, policy re: reimbursement for CAM services needs to be developed in stages.

- •Mechanisms need to be developed which will gather, consolidate and disseminate information relevant for coverage and reimbursement policies and decisions.
- •Demonstrations need to be developed which test the impact that different CAM coverage policies and reimbursement methodologies have on use of services by strategic population groups, and that test the impact this has on overall health costs for them.
- •Performance-based tax relief should be introduced that encourages use of health improvement approaches which lower overall disease-care utilization.

Here are a set of proposals that further each of these goals:

PROPOSAL 1: Congress could instruct public agencies (NIH and AHRQ) to gather data both on the clinical effectiveness of various CAM approaches and on the relative costs of more conventional allopathic treatments and of CAM treatments for the same condition. This information, supplemented by other information found in peer-reviewed journals, should be brought together and made available in an easily accessible website, which is updated constantly as new data becomes available. The public agency responsible for this website should be instructed to draw this information to the attention of insurance companies, managed care organizations, HCFA, and the continuing medical education programs of medical schools on an on-going basis.

PROPOSAL 2: The White House Commission and Congress could encourage HCFA to develop a HCFA demonstration project with selected HMOs. This would cover reimbursement for evidence-based CAM procedures as part of comprehensive case management of persons with chronic disease. The demonstrations would occur within Medicare-choice plans and Medicaid managed care plans. Demonstrations should be located in selected HMOs whose physician leadership has demonstrated a commitment to evidence-based medicine, and pursuit of excellence in high quality case management.

PROPOSAL 3: The White House Commission and Congress could encourage one or more of the Fortune Top 50 companies to collaborate with HCFA by creating its own demonstration project, examining the feasibility of using this approach with a broad-based employee population and testing the impact on overall medical costs.

PROPOSAL 4: Congress could amend the tax laws to allow performance-based tax credits to businesses which provide disease-prevention and health-improvement programs to their employees. As part of this legislation, Congress could encourage work-site wellness programs to include relevant complementary and alternative health ingredients as part of these wellness services.

PROPOSAL 5: The White House Commission and Congress could encourage HCFA to set up an additional five-year demonstration project which reimburses Medicare enrollees within a single state or area of a state for costs of services provided by certified CAM practitioners or for herbs and supplements. There would be a cap on reimbursements equivalent to current proposals for prescription drug relief. The project would compare

total Medicare costs for that demonstration area with costs incurred by an equivalent Medicare population of similar size, elsewhere.

The body of this document discusses the advantages and disadvantages of various strategies for reimbursing CAM costs, and their implications for population groups now left out of CAM services. It suggests why reimbursement issues should be approached in stages. It then discusses each of the proposals outlined above in greater detail.

Appendices discuss the following topics:
- planning principles that can be useful for approaching CAM reimbursement issues
- concerns raised by complementary and alternative practitioners and their clients
- use of CAM reimbursement within Medical Savings Accounts and current health policy questions about MSAs

REIMBURSEMENT FOR COMPLEMENTARY AND ALTERNATIVE HEALTH CARE SERVICES

Many advocates of Complementary and Alternative Medicine argue that greater use of CAM services and products could improve the health status of the American public and reduce overall costs for care. Anecdotal and observational evidence suggests this might be true. However conclusive, systematic evidence for or against these claims has not been gathered or appraised. Skeptics note that over forty percent of the population now is using complementary and alternative medicine, but costs for disease care continue to rise quite rapidly.

If claims of advocates are true, encouraging wider use of CAM will be an important public policy objective. The U.S. spends much more per capita for health services than any other nation, yet ranks far down the list in terms of indicators of the health status of the population. If the skeptics are correct, however, and use of CAM does not improve health in ways that actually lower overall costs for care, any reimbursement for these services must be done in ways that do not disrupt risk pools for health insurance premium setting. Otherwise even more Americans will be left with no access to health insurance.

There has been a growing market for CAM services and products, with nearly half of the U.S. population now using them, spending approximately $27 billion in 1997. This marked a forty-five percent increase over expenditures seven years earlier. National surveys estimate that there were approximately twice as many visits to CAM practitioners as to all primary care doctors that same year. It is estimated that about forty-two percent of the public currently use CAM services or products. This interest on the part of the public makes it clear that any coverage or reimbursement policies for CAM services and products will have major implications for health costs in the nation.

The insurance market is responding to this new market by offering riders to existing policies. These cover CAM services for an additional premium fee. Some capitated managed care plans, as well, are now offering a range of CAM services for which there is a high patient demand and/or demonstrated cost savings.

Because CAM coverage and reimbursement policies will have such major implications for the economy, documenting CAM's impact on health improvement, its cost, and its larger impact on health spending become important tasks. This documentation will be relevant for various possible reimbursement strategies.

It will be a long time before most CAM products and services receive definitive evaluation of their effectiveness. However if use of CAM services or products lowers other medical expenditures, it would be appropriate to encourage their use by offering tax relief to purchasers of these products or services. If use of CAM approaches does not lower other health costs, however, tax relief might be popular but would diminish public revenues without compensatory gains for the public.

Policies regarding payment for CAM services and products can go in three directions. They could emphasize **reliance on market mechanisms**, as at present, and help encourage current directions of movement. They could **mandate reimbursement coverage through insurance** for CAM services and products whose clinical effectiveness has been documented or for which there is high public demand. Or they could use the mechanism of **tax relief** to encourage higher use of CAM services. Each strategy has advantages and disadvantages.

Reliance on the Market: The private insurance market is already responding to market demand by offering policies that include reimbursement for CAM services. At least 18 insurance companies currently offer (or recently have offered) riders to cover some CAM treatment options for an additional premium fee. About 70% of Blue Cross/Blue Shield plans report they are exploring this option. The most commonly covered CAM services are for chiropractic, acupuncture, naturopathy, massage, traditional Chinese medicine, stress management/meditation training, homeopathy, and herbal medicine. Insurers report that their interest in CAM came in response to market demand from individuals and from businesses that purchase health insurance for their employees. Fee-for-service health insurance plans allow self-referral for treatments desired. Some managed care plans also allow self-referral, for a higher premium or co-pay cost, to services a consumer wishes to use. Given the high interest in CAM services and products seen within the public today, that trend is likely to continue.

Of course, no insurance company or third-party payer is agreeing to provide an open-pocket book for unlimited use of CAM services. Many, however, seem open to offering health insurance policies that include CAM Insurance Riders—optional extra coverage for an additional premium fee. Riders provide a simple solution to offering CAM insurance coverage without raising the basic premium cost for other health insurance. Employers who want CAM coverage for their employers can opt to pay the rider's additional cost; most, however, seem more likely to make this an optional choice for employees who choose to pay this additional cost, themselves. This market-driven strategy will continue, and needs little advocacy from this commission.

Mandatory insurance coverage: In an ideal world, CAM approaches that have been clinically evaluated and validated would be approved for insurance reimbursement, with the understanding that insurers thereafter would choose to reimburse for the treatment strategy that does the best job at the lowest cost. Unfortunately insurance reimbursement does not work that way in practice. Instead, any and all procedures that get "approved" for treating patients with a particular diagnostic code gets reimbursed. Thus many procedures can be used at the same time to treat a single episode or condition, and all will be reimbursed. Because of this, adding CAM treatments to the "approved" list for insurance reimbursement is likely to escalate their use--but without necessarily lowering the use of other, expensive treatments. Simply making CAM treatments and products eligible for insurance reimbursement, thus, could inadvertently replicate the cost dynamic that occurred shortly after Medicare legislation was enacted, when costs for health care grew by 400% in about five years.

Tax relief: Greater use of CAM approaches could be encouraged through tax relief to businesses that purchase health insurance for their employees, to individual consumers of CAM products and services, or to providers who offer *pro bono* or sliding-scale services to people with low incomes. Tax relief to businesses could be performance-based: to be eligible, businesses would have to document that a substantial portion of their work group is participating actively in efforts to improve their health, and that health risks are being reduced. There is now good documentation that lowering health risks in an employee population leads to decreased medical expenditures within three to five years.

Tax relief to individuals could be accomplished by making CAM expenditures eligible for inclusion as itemized medical expenses on IRS 1040 form A. (Acupuncture now qualifies as an itemizable medical expense.) Alternatively, or in addition, CAM expenditures could be made eligible for inclusion in discretionary payroll deduction accounts using pre-tax dollars set aside for use for health care [e.g., 125 Trusts or 105 Trusts].

(Making complementary or alternative medical expenses eligible for IRS itemized deductions might be preferable, unless the law is—or could be--modified to allow unused payroll deductions to be rolled over from year to year, or else be returned to the employee as end-of-year wage adjustments. Otherwise an employee is tempted to "use up" the full amount deducted, rather than lose it.)

If either or both of these methods were used, Congress might want to set a cap on total expenditures of this kind that were tax deductible. This would limit potential cost to the government, in lost tax revenue. It would also keep in place the principle of having individual citizens determine what helps them most, avoiding the creation of a complex system of government decisions about which treatments to allow and which to disallow.

Finally, tax relief could be used to encourage more health care providers to offer *pro bono* or sliding-scale services to persons with low incomes, by making such services eligible for inclusion on IRS 1040 Form A as charitable contributions.

All of the tax relief approaches open the possibility of severely diminishing public revenue. If compensatory savings occur in other health expenditures, and if caps were set on the amount of tax relief available, the loss in tax revenue might be worthwhile. Some method of discouraging fraud would be needed, however.

Evaluation of the three reimbursement strategies: Reliance on market mechanisms creates the least disruption of present obligations incurred by public and private payers. However reliance on market mechanisms is unlikely to increase poorer people's access to these services, because low-income families lack the discretionary income necessary to purchase additional services not covered by regular health insurance. (This would be as true for payment from Medical Savings Accounts as for other market mechanisms, unless the poor received subsidized accounts.)

Mandating public and private insurance coverage would definitely increase use of all CAM services covered, for all income levels of the population. (If experience with psychotherapy and with allopathic medicine more generally provides any guide, mandating insurance coverage is also likely to increase prices charged for the various CAM services.)

Making the costs for CAM reimbursable to consumers through tax relief is unlikely to increase access to CAM services by the poor: people with low discretionary income cannot afford to pay these expenses out-of-pocket and wait for tax refunds to reimburse them many months later. Tax relief could be offered to providers, by letting *pro bono* CAM (or other health) services given to persons with incomes at poverty level qualify as charitable contributions for itemized deductions on IRS 1040 Form A. This *might* increase provision of services to persons with low income. (It might also create fraudulent claims, however, which could lead to types of surveillance and prosecution of health care providers by IRS that would be objectionable.) Performance-based tax relief to businesses which substantially reduced health risks among their employee population might lead to greater use of CAM services among both low and higher income groups, while also lowering overall health expenditures.

Rather than spend a great deal of time discussing how to get wider private insurance coverage, this White House Commission on Complementary and Alternative Medicine Policy might wish to address these questions:

- How can we document and disseminate findings about clinical impact and costs for CAM approaches?
- How can we discover the implications of making CAM approaches more available in terms of the impact this has on costs for disease care utilization?
- What level of CAM coverage and reimbursement is appropriate for recipients of publicly funded health care (i.e., for enrollees in Medicare, Medicare, and the States' Children's Health Insurance Program [SCHIP] for low-income families who are not eligible for Medicaid)?
- How can we make CAM services and products accessible to persons with low income who cannot pay these costs out-of-pocket and who are not eligible for Medicaid, Medicare of the SCHIP program?

Because needed evidence is not yet in place, policy re: reimbursement for CAM services needs to be developed in stages.

- Mechanisms need to be developed which will gather, consolidate and disseminate information relevant for coverage and reimbursement policies and decisions.
- Demonstrations need to be developed that test the impact of different CAM coverage policies and reimbursement methodologies on use of services by strategic population groups, and that test the impact this has on overall health costs for them.
- Performance-based tax relief should be introduced that encourages use of health improvement approaches which lower overall disease-care utilization.

Here are a set of proposals that further each of these goals:

PROPOSAL 1: Congress could instruct public agencies (NIH and AHRQ) to gather data both on the clinical effectiveness of various CAM approaches and on the relative costs of more conventional allopathic treatments and of CAM treatments for the same condition. This information, supplemented by other information found in peer-reviewed journals, should be brought together and made available in an easily accessible website, which is updated constantly as new data becomes available. The public agency responsible for this website should be instructed to draw this information to the attention of insurance companies, managed care organizations, HCFA, and the continuing medical education programs of medical schools on an on-going basis.

Discussion: Dynamics currently under way within the insurance market are likely to increase availability of insurance coverage for CAM approaches that have a clinically demonstrated effectiveness, as well as those for which there is a high market demand. NIH clinical trials are one important source of evidence, as are peer-review studies not only of clinical trials but of population-based health changes and of costs for medical care found among those who use a wider range of CAM approaches. Equally important will be the systematic gathering of evidence about the costs of CAM treatment strategies that are being assessed in clinical trials. If this information were gathered in one website, which was constantly up-dated, individual consumers, health insurers, and health care providers would have available the range of information needed to make intelligent choices.

The creation of such a website would be important. Equally important, however, would be the development of procedures which draw this information to the attention of insurers, and to the attention of health care providers who will be counseling patients about the most advantageous uses of complementary and alternative options.

PROPOSAL 2: The White House Commission and Congress could encourage HCFA to develop a HCFA demonstration project with selected HMOs. This would cover reimbursement for evidence-based CAM procedures as part of comprehensive case management of persons with chronic disease. The demonstrations would occur within Medicare-choice plans and Medicaid managed care plans. Demonstrations should be located in selected HMOs whose physician leadership has demonstrated a commitment to evidence-based medicine, and pursuit of excellence in high quality case management. + CAM Leadership present

Discussion: Rather than advocating that insurance coverage for CAM treatments be "mandated" at either the state or federal level, it might be more strategic to advocate for the development of CAM demonstration projects within HCFA that would be relevant for publicly funded health services.

HCFA already has proposed, or is developing, two CAM evaluation studies. One involves use of Herb Benson's relaxation technique, the other uses the Dean Ornish program for cardiovascular rehabilitation. It will be useful to discover the relevance of these programs for use with Medicare, Medicaid, and States' Children's Health Insurance

Program (SCHIP) populations. This is a good beginning. The proposal stated above would extend evaluation to a wider group of CAM approaches and would see how they work in the context of high-quality managed care.

If we want to encourage cost-effective health care, we need to develop ways to help the consuming public discover the most advantageous combination of CAM approaches to use for their particular situations. A number of businesses that have wanted employees to make a wise choice of disease-care options have developed programs that provide non-coercive counseling and information about various treatment options they may be considering. Employees value these programs and businesses discover they save money, because most people prefer the least invasive options for dealing with health problems, and choose options wisely. True managed care, which respects the desires and needs of the patients rather than simply acting as a gate-keeper, could provide similar services in relation to integrating CAM approaches with traditional care.

(If the White House Commission adopts this proposal, it may want to commend HCFA's current initiative when proposing this additional project.)

PROPOSAL 3: The White House Commission and Congress could encourage one or more of the Fortune Top 50 companies to collaborate with HCFA by creating its own demonstration project, examining the feasibility of using this approach with a broad-based employee population and testing the impact on overall medical costs.

and FEBHP

Discussion: HCFA's policies for Medicare reimbursement often become the models for reimbursement decisions by businesses and private insurers. If one of the Fortune Top 50 companies would agree to cooperate with the HCFA demonstrations, mounting a comparable program in the private insurance market, this could test applicability of the approach among other population groups and speed cost-effective utilization of CAM approaches among the wider public.

PROPOSAL 4: Congress could amend the tax laws to allow performance-based tax credits to businesses which provide disease-prevention and health-improvement programs to their employees. As part of this legislation, Congress could encourage work-site wellness programs to include relevant complementary and alternative health ingredients as part of these wellness services.

Discussion: Chronic diseases, such as heart problems, cancer, arthritis, diabetes, emphysema, and cirrhosis of the liver, develop over time, as particular organ system lose their youthful vitality and cease to function efficiently. While genetics may determine which organ system is susceptible to degeneration, health behaviors strongly influence the speed at which this occurs, if it does. There is now clinical evidence that this degenerative process can be reversed in heart disease through such CAM approaches as changes in nutrition, behavior, and methods for dealing with stress. Since many of the same, modifiable behaviors affect premature aging of each of these organ systems, public policy might well encourage reimbursement procedures that encourage active health improvement.

There is now good documentation that properly organized work-site wellness programs can lead to substantial lowering of health risks in an employee population, and over a period of three to five years can produce striking drops in utilization of disease-care services. Encouraging inclusion of CAM approaches in work-site wellness programs, and subsidizing their introduction during the period before cost-savings accrue, might be an effective public investment that lowers over-all health care spending.

To qualify for tax credits, programs should show that a substantial proportion of the employees are involved in active efforts to improve health and should show measurable reductions in health-risks among this workforce. (The most effective programs now get about forty percent of employees with health risks actively working on health improvement. This substantially lowers disease care utilization. Tax credits for work-site wellness programs should go to those companies most likely to actually reduce overall health care costs.) Performance-based tax credits for work-site wellness programs could help produce a new standard of excellence for such programs, as well as decrease spending for disease care.

PROPOSAL 5: The White House Commission and Congress could encourage HCFA to set up an additional five-year demonstration project which reimburses Medicare enrollees within a single state or area of a state for costs of services provided by certified CAM practitioners or for herbs and supplements. There would be a cap on reimbursements equivalent to current proposals for prescription drug relief. The project would compare total Medicare costs for that demonstration area with costs incurred by an equivalent Medicare population of similar size, elsewhere.

Discussion: This project could test the impact on health costs for the elderly of reimbursing for CAM services and products, within a capped limit. Results could be relevant for broader Medicare reform as well as for possible tax relief for a broader group of the public, either through IRS 1040 Form A medical expense deductions for CAM services and products or through pre-tax flexible medical accounts.

The reexamination and possible restructuring of Medicare offers opportunity to explore greater use of CAM options among our aging population. There is strong public pressure for prescription drug coverage for Medicare enrollees, and strong resistance to this from pharmaceutical companies who fear that federal subsidy will lead to price controls over the cost of drugs. That policy debate might get restructured to explore which coverage options produce the greatest health improvement at the lowest cost. Trading CAM coverage for pharmaceutical coverage, for example, might lead to more effective health assistance to the aging population, and to lower use of many disease-oriented services in the long run. Since the argument that greater use of complementary and alternative health services will lead to lower disease care utilization has not been persuasively demonstrated, however, it would be prudent to encourage demonstration projects that can evaluate this potential, before advocating inclusion as general entitlements for the older public. Considerable public support might be generated for efforts to make CAM

services and herbs available, as a trade-off for prescription drug coverage. This, in turn, might bring pharmaceutical interests and those of the elderly more nearly together.

Appendices discuss the following topics:
•planning principles that can be useful for approaching CAM reimbursement issues
•concerns raised by complementary and alternative practitioners and their clients
•use of CAM reimbursement within Medical Savings Accounts and current health policy questions about MSAs

Note: Help with preparing this document has come from a variety of sources. I appreciate having had access to peer-reviewed journal studies by David Eisenberg on use of CAM by the American public, and studies by Ken Pelletier and associates re: inclusion of CAM coverage by insurance companies. James Fries and Lawrence Crapo's discussion of the processes by which chronic diseases develop (*Vitality and Aging*) has been similarly helpful. Recommendations, suggestions of useful studies, and critiques of earlier drafts of this report have come from the following people:
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Barbara Sloat (Biologist, Health Practitioner and Adjunct Lecturer, University of Michigan Medical School)
Barry Sloat (Health Benefits manager for Ford Motor Company)
Dale Sugars (Chair of the Michigan Senate's Health Policy Committee), and
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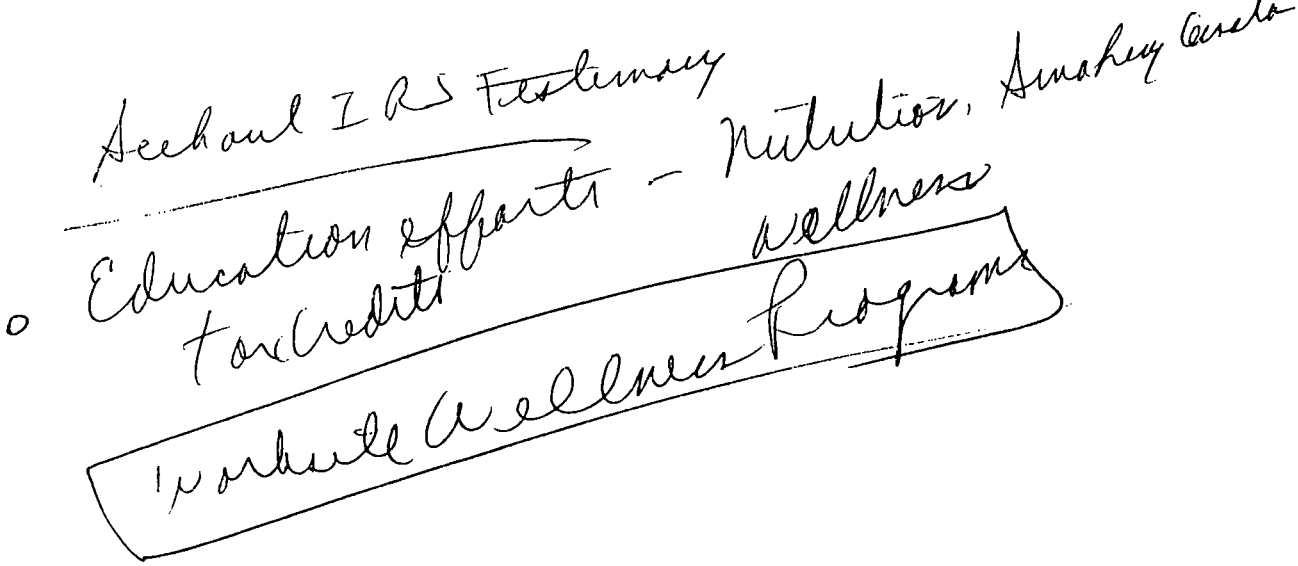

Appendix 1

Four Principles for Planning CAM Reimbursement Policy and Why They Matter

Four principles should be protected when making recommendations about reimbursement for complementary and alternative health services.

Principle 1: CAM methods that have been clinically demonstrated to be effective for dealing with a specific medical problem at the same or lower cost than methods currently covered by health insurance should be eligible for insurance reimbursement.

Some CAM practitioners argue that this principle holds CAM methods to a higher standard than is imposed on traditional medicine: most traditional treatments for which reimbursement is now given have not been subjected to the kind of scrutiny for clinical effectiveness that NIH now gives the CAM approaches it studies. This is true. The first principle, as stated, however, is consistent with moves being made toward evidence-based medicine. By keeping to this higher standard, it lessens the likelihood that overall health insurance costs will rise because CAM treatments are included.

Principle 2: Coverage and reimbursement policies should encourage the public to use CAM services and products that have the potential to actively improve their health, whether or not these have been clinically assessed. However because many CAM services and products have not had rigorous assessment of their clinical effectiveness, most probably should not be reimbursed through health insurance coverage. Other reimbursement methods, including tax relief, could be used.

In addition to CAM health services, a variety of wellness-oriented disease prevention efforts also have the potential to improve health and lower use of disease-care services. Hopefully, the White House Commission will encourage greater use of all of these approaches. We need to make sure that the over-all cost for health insurance does not rise, however. It is important to include for insurance reimbursement only those additional services that demonstrate an ability to lower use of other disease-care services. For funding other CAM treatments and approaches whose ability to lower over-all health-care spending have not yet been demonstrated, tax relief seems preferable to reimbursement through insurance.

Principle 3: Legislation re: reimbursement should involve as little regulation of health service providers or insurance providers as is possible while still protecting the public.

Use of this principle helps protect the integrity of health professionals who provide either conventional medicine or complementary or alternative services. It also helps protect the integrity of the market. Protection of the public is a more complex problem. One would like to guarantee that providers have been well trained, are competent, and use appropriate ethical standards. Oversight by the professional organizations within each CAM modality, through certification and recertification, is likely to be more effective

than state or national licensing would be for insuring that high standards of practice are established and maintained.

Health policy planners seem to be united in recommending an additional principle to use when considering reimbursement proposals of any kind:

Principle 4: Risk pools now used for health insurance premium-setting must be preserved, so that the cost of health insurance for those who need it most does not rise. We should not recommend options that would let the healthy get insurance at low cost, while driving up the costs for people who have more serious medical problems.

The number of Americans with no health insurance continues to rise, in large part because the price of health insurance has been increasing because costs for high tech medicine and for prescription drugs continue to rise. As is well known, many smaller businesses and private individuals can no longer afford to pay for health insurance. This problem of higher costs for health insurance will be exacerbated still further if new services are covered that do not lower the use of expensive disease services. CAM treatments that have a demonstrated effectiveness and that also lower use of more expensive disease-care would be appropriate additions to insurance coverage. Those that do not lower over-all expenses for disease care would not.

With current medical costs rising dramatically, payers for health claims can be expected to oppose any incursion of additional cost obligations that do not guarantee similar or greater savings elsewhere. Some third party payers, in fact, argue passionately that CAM services should not become part of benefit packages at all. They note that any health benefit for which reimbursement is guaranteed tends to get used highly, and that each time another health benefit gets covered, its use increases far more than any previously seen need for it would have predicted. These payers tend to favor the current move toward "defined benefit" packages that set a fixed limit on what a third party payer will pay, and that then give the individual employee freedom to choose what to use within those limits. With the sharp rise in cost for health insurance this year, employers can be expected to oppose adding additional "guaranteed benefits" to insurance coverage.

The Congressional Budget Office, which will evaluate the financial implications of any proposals introduced into Congress, also is likely to point negatively to any additional on-going costs for public agencies, unless clear savings of a comparable amount are also involved. Those political realities make it wise to avoid proposals that could increase the total cost for health insurance. These, then, are practical, political reasons why this fourth recommended principle for health policy planning should provide an active criterion to use when choosing among proposals.

But, as members of the Commission are aware, there is also a more humanitarian reason why the total costs for health insurance should not rise because of our proposals: As health insurance costs rise, fewer and fewer Americans have health insurance. Small businesses cannot afford it. And half of all Americans now work in companies that have twenty or less employees.

It will be important to avoid reimbursement options that might take the healthy out of current insurance pools, so that only sicker people are left in an insurance pool. If that happens, the cost of insurance for the less healthy population will rise even more, and the people who most need insurance to pay for their disease care will be less likely to have it.

Access to health insurance does not guarantee better health, however: for example, 89% of Michigan residents are covered for disease care either through Medicare, Medicaid or private health insurance. Nonetheless Michigan has the fourth worst health ranking in the nation in terms of cardiovascular disease. Michigan's rates of smoking, obesity, and uncontrolled hypertension are unusually high. Health behaviors, as well as access to disease-care services, determine health outcomes.

For these reasons, we must actively encourage use of approaches that improve health, while avoiding reimbursement policies that might take the healthy out of insurance risk pools.

Appendix 2

Concerns of Complementary and Alternative Practitioners and of the Consuming Public That Will be Important to Address

Reimbursement proposals endorsed by this White House Commission should honor the present concerns of those who provide complementary and alternative services and of the people who use them. Here are some frequently voiced concerns of complementary and alternative health care providers.

Some providers want to increase the market for complementary and alternative medicine, by having payment arrangements that make more people able to afford their services. Those with a social vision also want to make sure that poorer Americans will have as much access to complementary and alternative services as other Americans.

But along with these concerns about actual reimbursement for services, a number CAM practitioners worry that "going mainstream" might reshape CAM practice and relationships in ways that resemble the conventional medical system. Many fear that adding complementary and alternative medicine as guaranteed benefits in insurance plans could lead to loss of their independence and their ability to practice high quality holistic medicine. There has been little *public* discussion of another concern that many complementary and alternative practitioners express privately, i.e., that they will end up being controlled by doctors, by insurance companies, or by state or federal regulators. Many fear that insurance or other reimbursement will put them under pressure to spend less time with patients, to make access to CAM services dependent upon prescription by a medical doctor, or that funding policies could end up making CAM health care simply ancillary to the conventional medical system. These concerns should be taken seriously by the Commission.

The concerns just stated contrast sharply with those of people who feel a responsibility to protect the public from harmful or ineffective services.

Consumers of CAM services seem to be divided on these matters. Some would welcome the security of knowing which CAM services are properly "vouched for", but many fear that licensing would reshape complementary and alternative medicine in the image of conventional medical care. Others want to make sure that reimbursement policies and practices protect CAM services from getting "regulated" (either publicly or privately) in ways that move away from the individualized, time-intensive practice that is the heart of much CAM treatment. Many consumers, however, would welcome relief from out-of-pocket expenses for CAM treatments.

The proposals recommended here are consistent with all of these concerns.

Appendix 3

Conditions under which Medical Savings Accounts Could Pay for CAM and Reasons why Use of MSAs might not work

Paying for CAM products and services from Medical Savings Accounts could be an attractive way to encourage people to use CAM services without involving a great deal of regulation or bureaucratic handling of the costs involved. However it could create an additional risk for the insurance system. The forty percent of the population who now use CAM services might be quite attracted to these MSAs, opting out of conventional insurance programs. Many of these people come from the relatively healthy population. Their low use of disease care services now subsidizes the higher costs incurred for the sicker people who currently join them in insurance pools. If the healthy move to MSAs, insurance costs for the pool of persons who continue to have regular health insurance will go up. As these costs increase, fewer small employers will be able to afford health insurance as an employment benefit, and the proportion of sick people who have no health insurance will increase. Since half of the working public now is employed in small firms, this is an important consideration.

If two protections were added to current legislation authorizing Medical Savings Accounts the risk that health insurance costs for the sicker population will increase could be avoided. First, when group insurance is involved (as for all employees of a given company or purchasing pool), the group could be given a choice. All members of that health insurance pool could have Medical Savings Accounts plus catastrophic health insurance that covers costs beyond a certain threshold. Alternatively the entire pool could continue with conventional health insurance. If this were done, risk pools would be protected and costs for sicker members of the group would be protected.

However, some might see a need to protect the public against using Medical Savings Accounts in ways that did not, in fact, improve their health. A second change in current legislation regarding Medical Savings Accounts could provide some protection against misuse. To be eligible for Medical Savings Accounts, individuals and families might be required to show that they have available and that they use wellness monitoring and guidance services similar to those now being used in some of the better work-site wellness programs. (These work-site programs cost about $150 per year, per person.) The monitoring and guidance services would provide annual assessment of the health status of these subscribers and would provide proactive case management of any disease risks identified during these assessments. Some people could use their work-site wellness program for this purpose. Others might have primary care providers who will provide these proactive services. Still others would need to purchase such services themselves.

Adding this kind of qualification for eligibility to use a Medical Savings Account would protect the public from health deterioration, would actively encourage health improvement efforts, and would not require supervision or regulation of the providers of health improvement services. Instead, as individuals received feedback information

about the success of their health improvement efforts, they would make their own decisions about which services to purchase in the future.

In summary, for CAM products and services to qualify for reimbursement from Medical Savings Accounts without danger to the larger health insurance market, current legislation about Medical Savings Accounts would need to be amended in the following ways:

a. Allow Medical Savings Accounts plus catastrophic health insurance as an option for an entire purchasing pool, rather than for individuals within a current pool. (Persons who purchase insurance outside of outside of risk or purchasing pools, of course, would be eligible to use Medical Savings Accounts as well, if requirement "b" below were met.)
b. Require, as an eligibility qualification for using a Medical Savings Account, that Accounts users have access to health status monitoring and improvement services and that they use them.

These kinds of amendments to Medical Savings Accounts legislation would preserve health insurance risk pools and help protect the users of Medical Savings Accounts from making choices that could damage their health in the long run, thereby further increasing health care costs. However many who advocate most passionately for Medical Savings Accounts are ideologically committed to unrestricted personal choice of services. Making Medical Savings Accounts "safe" for inclusion of CAM reimbursements, thus, might create opposition to the proposal among those who now support Medical Savings Accounts.

Moreover, because the dynamics of risk pools and the health insurance market are not well understood by many members of Congress, recommendations with this degree of complexity probably would not survive the political process.