benefits as OPM deems necessary or desirable. For example, immunizations for children, mammography screenings, those kinds of things.

Once contract negotiations are completed, consumers are given extensive benefits information. OPM publishes an FEHB guide each year. The individual health plans develop, in conjunction with us, plan brochures, which are distributed widely. And, finally, our website at this point is a very important source of information. It not only includes the guide and the plan brochures, but also links to a decision support tool and has access to all kinds of information that is useful in helping our consumers make an informed choice.

In April of 2001, we issued our annual call letter, which gives policy guidance to the plans. We do this every year. That policy guidance tells the plans what we will be looking for in the negotiation cycle for the following contract year.

In that call letter, we stated, "Where there is demonstrated medical effectiveness and consistent with your overall strategy for benefit design, we encourage you to consider services such as chiropractic,

acupuncture, biofeedback, and others that are being used increasingly for pain management and as alternative treatments.

We did that for a number of reasons. For one thing, we have been hearing from our customers that there is increased interest in coverage for alternative and complementary services. This program, the Federal Employees Health Benefits Program, it is considered the national model of a consumer choice program. So, we listen very carefully to what consumers tell us. To the degree that their requests are reasonable and that they make sense, that they are affordable, that they can be accommodated within the statutory and regulatory framework of the program, we encourage our carriers to listen, as well, to those consumer interests and frame their benefit proposals accordingly.

So, that is what we did in our call letter this year. This was the first time that we specifically addressed the issue of alternative and complementary medicine.

Rates are set by negotiation between OPM and the carriers. We have two different rating

methodologies. The fee-for-service plans and a small number of the HMOs are what we call experience rated. The vast majority of the HMOs are community rated. Regardless of the rating methodology, all the enrollees within a plan pay the same premium. It varies by self only or self and family type of contract, and some plans have both a high and a standard option. But, wherever you live in the country, if you are enrolled in a fee-for-service plan and whether you are an active employee or a retiree, you will pay the same premium for that plan. The HMOs, of course, are geographically based.

As I said earlier, the contribution formula is set in statute. We typically refer to it as the fair-share formula. It consists of the weighted average of all the plans in the program. We take the weighted average of all the plans and there is a cap so that the contribution to any given plan's premium cannot exceed 75 percent. The government share is then 72 percent of that weighted average premium. The balance is paid by the employee or retiree, and the agencies actually collect the premiums for us by payroll deduction and remit them to OPM. We, in turn, remit them to the carriers.

Our contracting cycle goes like this: the annual time line of our activities, February, March, we review and accept or deny new plan applications, and the program, by law, is open at this time only to HMOs. The way the statute is written, we can't admit new fee-for-service plans. We can readmit plans that were once in the program and then dropped out.

June to August, we negotiate benefits and rates for the next contract year. June to September, we collaborate with the carriers on plan brochure language. November to December, there is a four to five week annual open season period.

OPM designs and contributes to the design of the guides and distributes the open-season guides. We provide agencies with open-season guidance through benefits administration letters. We provide plan information and links to comparative information and decision tools on the FEHB website. That website is www.opm.gov/insure. It has become a very significant way of communicating with our enrollees.

I can tell you that during those opening weeks of the open season, even though we rent additional server

capability, we are overwhelmed and typically the servers basically are at maximum capacity.

The agencies make the guides and brochure information available to employees. They conduct health fairs. They counsel employees and process enrollment changes.

Year-round, OPM monitors plan performance, responds to customer concerns, resolves disputed claims, monitors industry trends, consults with carriers, and develops guidelines for the next contract year.

If I had to make an analogy in terms of how we operate, we consider ourselves and function very much like any other large employer health benefits plan, which means, and you probably noted in my presentation, that there are some fairly significant differences in the way we function as opposed to the way HCFA functions, HCFA being a national entitlement program.

MS. CHANG: Excuse me, you have about three minutes. I just wanted to let you know.

MS. BLOCK: So, basically, if you were to think of who we are and how we operate, we are very similar in many ways to, say, a large employer like GM. We are a

major purchaser. We are the largest purchaser, really, in the health insurance market, but we are an employer-based health insurance plan, and our model is a market model, featuring consumer choice.

Panel Discussion

DR. GORDON: Thank you very much. That was also extremely clear.

I have a question first for Dr. Whyte while other people are formulating questions. One of the striking things about your presentation is the opening that has now been extended to Dean Ornish and Herb Benson's programs. How did that come about? How was the choice made to make it a study, rather than a covered benefit for everyone? And what lessons can you share with us?

DR. WHYTE: Well, maybe I can provide some general information. Dr. Ornish might want to talk about his own experience. What I can tell you in terms of why it was decided to do under a demonstration authority, and I didn't talk much about demos, but basically our demo authority relates to when devices or services may not already exist in a benefit category or there are perhaps

some statutory restrictions relating to scope of services or other issues relating to that, it was the feeling of the senior leadership at HCFA that Dr. Ornish's program did not fall into a specific benefit category.

So, although there might have been some services that could have been covered, that the constellation of benefits that Dr. Ornish offered did not have a discrete benefit category. There was also the feeling on some people's part that additional data in the Medicare population was necessary.

So, what was decided to do was a demonstration project so we would be able to provide for all these services that may not have been able to have been covered under the present structure. So, that is how Dr. Ornish's program got covered. Basically, it was determined through HCFA.

Dr. Benson's program was actually mandated by congressional action under the Benefits Improvement Protection Act, known as BIPA. So, that is how those two programs were designed. One was more executive. One was more a congressional action.

DR. GORDON: And did the congressional action

mandate the demonstration, or was that a HCFA decision?

DR. WHYTE: It mandated the demonstration with 1,800 patients, similar to Dr. Ornish's, as well as some other time frames and things of that nature.

DR. GORDON: Thank you. Any general lessons, as we think about complementary and alternative medicine?

DR. WHYTE: Sure. I think it is important to keep in mind that there is demonstration authority, but, as Steve, Maureen, and I talked about, there is not a lot of money to do demonstration projects, and most of the demos that we do, basically, are congressionally-mandated.

I wouldn't necessarily discourage you from going that approach. I think it is something that you should carefully about. In the overall context of the coverage policy, you could look to see where there is the greatest data on a particular service and go through the national coverage process, is one route. Then you could think of things like the Dean Ornish program, similar types of services where there is a lot of data and that looks very encouraging, but perhaps may not be able to be covered under existing benefit categories and think of a

demonstration authority and that approach.

So, that would be my counsel, that you look at the spectrum of opportunities available, but I wouldn't put all your cards in a demonstration approach, because the options are very limited.

DR. GORDON: So, Congress could have said, in talking about the Benson program, that they wanted national coverage?

DR. WHYTE: Congress could have said that we want to create a benefit program for either the Dean Ornish program or something like the Dean Ornish program, and then that is scored by the Congressional Budget Office. I think that is an approach that people can take. Again, Dr. Ornish might want to talk about his experience, but I would think you all can appreciate that it is difficult to get Congress to create new benefit categories.

Something that people might want to think about is how could the service be provided in already existing benefit categories. There is the issue of, perhaps, the incident two provision. I looked at today's time as an opportunity to speak broadly and I don't want to go into

all the specifics of what is covered under an incident two provision, because I look at today as a dialogue that we can continue to have information. So, that is one approach to use, look at already existing benefit categories.

But, certainly Congress can mandate the benefit and say, you are going to cover a lifestyle modification program.

DR. GORDON: In looking at already existing benefit categories, are there some that are applicable to complementary and alternative medicine that you would see?

DR. WHYTE: That is a hard question to answer, because there is a wide range of complementary and alternative medicine benefits. So, not knowing particularly what you are thinking about, it is hard to guess. But what I would imagine is that there probably are certain benefits that could be provided. Acupuncture is something that we don't cover, but we have had a lot of discussions at HCFA as to whether or not it could fall into a benefit category.

Most things probably could fall into a benefit

category, but what is going to get caught up in is who is eligible to provide those services. As some of the other speakers have talked to about, when the Medicare program was established, most of the services are provided by physicians. I believe that many of your services are provided both by physicians, as well as other types of providers.

So, you need to think about that, because you may end up getting a service provided, but the type of person that you would want to be able to provide those services would not be able to be paid for under the Medicare program. I can provide the specific statutory language to Steve and Maureen about what Medicare defines as a physician. It is more than just an M.D. or a D.O. There are other people that fall into it, but I think most of the providers to which you would refer are not covered by that language.

DR. GORDON: I have Tieraona and Joe Dean.I wondered if you wanted to add anything to this discussion, at this point?

DR. ORNISH: No. I just wanted to say I thought the presentations were very clear, and I could

add a lot some other time, but it would take much too long at this point. But, again, I wanted just to say how much I appreciate you both coming and how clear and useful. If I had heard your presentation six and a half years ago, my experiences with HCFA would have been much easier.

[Laughter.]

DR. GORDON: Thank you. Tieraona, and Joe, and Tom.

DR. DOG: I think a lot of what we keep hearing is that the research needs to be there and that for some things it may be premature and for other things we have got adequate research. I think we would all agree with that. I had a question, though, that confused me just a little. If you had lobbyists and somebody got somebody in Congress to really say, gosh, we need to cover this, and it was mandated, if there is not the evidence there, do you have the right to veto Congress? Do you hear my question? Can something come in and we end up mandating it without the body of evidence there because we have got powerful lobbyists who have said we want to pay for it, we want to have it covered?

DR. WHYTE: I thought of some flip things to say, so I'm glad we have a little delay.

What I would say is that if Congress in its wisdom mandates that a benefit be provided by the Medicare program, it is provided.

DR. DOG: It is mandated.

DR. WHYTE: That us correct.

DR. GORDON: Thank you.

Joe?

DR. FINS: That was sort of my question. I was wondering about any precedent, when there has been a national coverage decision, when Congress has then decided to cover a benefit.

A related question that goes to your first response to the issue of a demonstration project. Does your office have, and your division more generally, have the resources not to fund projects, but to assess the new technologies, the new interventions? Do you folks need a more robust budget to accommodate this growing area in the health-care marketplace?

DR. WHYTE: Perhaps I will answer the second question first. The Secretary has been very successful

in getting greater resources and funding for HCFA to perform its numerous responsibilities that Congress mandates us to do.

In terms of assessments, we are doing assessments continually, that is primarily what the coverage and analysis group does, primarily assess new technologies. So, the answer to your question would be that is typically what we do.

DR. FINS: You said a therapy is a therapy is a therapy, so you are saying there is nothing new under the sun here with respect to the CAM interventions or the methodologies that would require additional coverage?

DR. WHYTE: Sure. Now, what I will tell you, on our website, we list what the pending determinations are, as well as completed determinations. In general, presently of the 19 pending determinations, there aren't currently any what you would consider complementary and alternative medicine policies.

In terms of our completed determinations, there is completed determination on acupuncture, which was request to review the non-coverage policy which was denied. Then there is a treatment on biofeedback, which

is primarily used for urinary incontinence, and I'm not completely sure you would consider that complementary and alternative medicine, but we do have now a national coverage policy on that therapy, whereas before it was carrier discretion.

Just quickly in reference to an intervention is an intervention is an intervention, what I can tell you is when we look at therapies in our division, I don't take the approach that this is complementary and alternative. I think that is something that would be productive for everyone to move away from and just focus on, what is the body of literature that supports this therapy.

DR. FINS: Just to follow up the question about the national non-coverage decision that might have been overruled -- not overruled -- but funded by Congress.

DR. WHYTE: Off the top of my head, I cannot think of one. What Congress usually does, is, when it creates the benefit categories, it is usually for preventive medicine benefits, or it is usually for some type of prescription drug benefit, such as an RLA [ph] in a cancer benefit, RLA in medics, things of that nature.

DR. GORDON: Just a clarification. When you say Congress, you mean the House of Representatives?

DR. WHYTE: No, I mean Congress, the House and the Senate.

DR. GORDON: Both houses, okay.

Tom?

MR. CHAPPELL: Ms. Block, I would like to ask you more about your recent experience with the expansion of benefits into the complementary and alternative medicine field.

It appears to me that your consumers are driving these benefits. Is that correct?

MS. BLOCK: I would say that consumer interest is playing a very big role in our efforts to expand these benefits, yes.

MR. CHAPPELL: And the employer-sponsored styled services are responding to that demand?

MS. BLOCK: Well, yes, although I don't want to mislead you. The response so far has been fairly limited. What is offered under the packages that are currently available is fairly limited, with the same kinds of issues that Dr. Whyte spoke about.

The health plans typically, and we are dealing primarily with traditional insurance companies, at least on the fee-for-service side, they do exactly the same kind of thing as you would see in the Medicare program, in that, they may elect to cover a service, but that service will only be covered by someone that they define as a covered provider.

So there is the issue of, the service may be covered, but not all providers of that service would be covered. We have hoped to see some expansion of those definitions of coverage provider, but it is an iterative process.

Some of our plans currently are not covering alternative or complementary services under their FEHB benefit package, but are covering them as an alternative benefit, which for the past 10 years we have enabled our plans to offer. We have in every plan brochure, we have what we call the non-FEHB page.

In that process, plans can offer as a supplementary package to their enrollees other benefits which are not part of the FEHB program, they are not covered under the FEHB premium. There is an additional

premium for those services, but people who enroll in the plan may then elect to enroll in that supplementary package.

Blue Cross Blue Shield, for instance, our largest plan, has what they call their affinity benefit package, and that includes some of the alternative and complementary services.

So it is a very gradual process. I don't know what we are going to see in the proposals for 2001, because we haven't gotten them yet. We will see when they come in, to what degree the insurance carriers have responded to our call letter guidance.

I can tell you that I think this is going to happen. It is going to happen over time. I don't think it is going to happen terribly quickly. We are not going to see rapid transition. We are going to see a very gradual process as the insurance industry really responds to the consumer interest, because the way our program operates, we don't legislate benefits. We try to avoid mandating benefits, to the greatest degree possible.

Speaking of process, and in my previous meetings this has been my suggestion, the best way to get

things covered in the Federal Employees Health Benefits Program is to work directly with the insurance carriers.

To the degree that they are hearing from their customers, they should respond within the context of their overall benefit package, their competitive position in terms of benefits and rates.

So it is not a simple thing, because any changes that they make, they will consider very carefully in terms of how they look in their market, what their rate looks like as compared to their competitors, and what their benefit package looks like.

To the degree that they can offer something in that benefit package that they think will be attractive to consumers, they are interested in doing that. So it is very much a competitive market orientation.

MR. CHAPPELL: Thank you. That is a very helpful description. I am just wondering if you could identify the most obvious barriers to the insurers' process of change here.

MS. BLOCK: I think the most obvious barrier is resistance to change. We really are dealing with traditional insurance companies that have a traditional

perspective.

I guess the second most significant barrier is the rate impact. We are looking, and it is no secret at this point, we are looking at very significant premium increases for 2002. We are very concerned about them.

The President, in fact, in his budget, has talked about the premium increases in the Federal Employees program over the last several years.

Our premium increases, by the way, are very much in keeping with the private sector. It is not that ours are our out of line. It is just an industry trend. Premiums are going up for everyone. We expect them to go up significantly in 2002.

So, practically speaking, the insurance carriers are going to be looking at their benefit package in the context of those rate increases and how those rate increases are going to affect their market share.

DR. GORDON: Joe Pizzorno, and then Wayne, and anyone else. Joe?

MR. PIZZORNO: In Washington state, where we have chiropractors and acupuncturists licensed as primary care providers, and naturopathic doctors as primary care

physicians, we have a state mandate requiring that every category of provider be included in all insurance programs.

Does that include the federal employees? For example, somebody in Seattle who works for federal, can they go and see a naturopathic doctor or chiropractor for their primary care? And, if not, what has to be done to change that?

MS. BLOCK: Well, this is the situation in terms of state mandates. We have language in our statute that enables us to preempt state mandates, and the reason for that is our national fee-for-service plans. We wanted to be sure, and the Congress wanted to be sure, going all the way back in time, that everybody who elected one of those national plans got the same benefit package and paid the same rate.

If we didn't do that, we would have a situation where people would be paying the same premium, because we have a national premium, and getting a different benefit package, depending on the state that they lived in. So it has been our practice always to preempt state mandates for the national plans.

On the other hand, for the HMOs, we do not preempt state mandates, although we could. Our philosophy there is we want our enrollees in a given geographic area to have the same benefits as anybody else living in that state.

So the HMOs that are domiciled in Washington state have to follow the state mandates, which means that federal employees and retirees who enroll in those plans get the same benefits as any other resident of the state of Washington, but those people who enroll in a fee-for-service plan do not.

DR. GORDON: Wayne?

DR. JONAS: Thank you both for very nice presentations. Most of my questions have been answered. I have a question, really, for Dr. Whyte.

My sense is that you are largely reactive, in the sense that individuals have to come forward and say, we would like to have this covered, and provide the documentation for it. Then you take it in through your process. Is that correct?

DR. WHYTE: That is basically correct. We do have internal requests, but we are moving more towards

being responsive. At the same time, we are also working with people before that request comes forward.

So it is not truly reactive. In many ways, we are working with interested parties.

DR. JONAS: Right, but you don't go out and say, here are some things that can improve quality of care, reduce costs, enhance quality of life; we are going to see if we can identify whether there is adequate evidence to provide this as a benefit. Is that correct?

DR. WHYTE: I think the approach that we have used --

DR. JONAS: Both Benson's came to you, through different mechanisms, obviously.

DR. WHYTE: That is correct, but I think what we have done over the past few years, and what we are continuing to try to do, really, is to outreach to interested parties.

So what I would say is part of the coverage process, we are going to a lot of national meetings of beneficiaries, of device manufacturers, of physician and other groups to talk about our coverage process. So, in a sense, what we are saying is, here is our process and

we know you all believe that there are certain things that should be covered, so, here is our process; work with us to try to bring that about.

A good example is last Friday, several people from HCFA went to the American Medical Association to meet with various clinical specialty societies, but we also met with the National Health Leadership Council, which is a wide range of providers and beneficiaries and other groups to say, what are the top 10 coverage ideas that you have that you think HCFA should be doing.

So we are not necessarily going out and telling people what they should request, but what we are saying is, as we would do here today, we know you are all interested in certain therapies to be covered under the Medicare program; here is our process, here is how we can work together, here is what we would look for, and then if you want to bring it about, this is how we do it.

DR. JONAS: Are there individuals on either of your advisory committees that you would consider, or, would be considered, broad experts in a variety of complementary medicine approaches that sit on those committees at this time?

DR. WHYTE: Well, we have a 100 members of our advisory committee, and I can't think off the top of my head what every one does, but I know we have a wide range of disciplines, including at least one chiropractor. Every one is not a physician. There are a lot of other providers. But I think it goes to your question, the point that I would make is, again, it goes to let's move away from the labels and let's talk about the field of health services research and how you look at data.

So, I'm primarily interested in, when I help staff the committees, let's find people who are objective, who know how to analyze the literature. I still agree with you that we need to have these other interests just to sensitize people to the topics, but I wouldn't want to move to a field where we are kind of then counting, say, on our advisory committee and other groups how many of these people are alternative medicine or complementary medicine, because I think it takes away from what you are all trying to do.

I think that something that Dr. Ornish has often talked about is let's not necessarily refer to this as alternative, this is a therapeutic intervention, and

let's judge it on those merits.

So, again, that is what I would encourage you to do. I would encourage you to apply to the advisory panel because you feel you can bring some other interests, but you are primarily going to be objective and look at the literature.

DR. JONAS: I applaud you on your evidence-based approach to this. I think that in God we trust, but everyone else should show data, as the saying goes. And actually my question is specifically related to that issue, because, as you may or may not know, a number of complementary medicine practices, especially traditional medical practices, are not based on nor do they have the same assumptions of diagnosis and therapy that currently the evidence approach you take and the benefit categories that you have fall into.

So it is more than simply sensitizing individuals to the topic, it is really understanding how do these alternative diagnostic and therapeutic categories fit into an evidence-based module, and how might evidence be collected on those.

So I think it directly relates to making sure

that we provide good evidence-based medicine. If you are going to make a decision about orthopedic surgery, hip replacement or something, you want to make sure that you have someone who has true expertise on that and not have your pediatricians doing it or something like that.

I think a very similar idea falls into these. It really is directly related to making sure you provide good evidence.

DR. WHYTE: Can I just make two comments on that? The two things that I would say on that is, one, people will often come to us and talk to us about that you cover this therapy and there is no evidence based on that, so why aren't you covering our service.

I would caution you not to go down that route, because what we are saying is that this is a new process and there may be some things that do not have an evidence base that we cover, but we are going to go back at some point and look at those. We have a new process, and I would focus on, that every therapy that comes under review is going to have to have an evidence base.

The part where I disagree with you a little, and I might not have heard you correctly, is what I would

say again is, there are already established principles of health services research, and those should be applied universally. I wouldn't necessarily change those for alternative medicine strategies. I think an example is thermography used for detecting breast masses. Several people have come to talk to us about thermography.

At the end of the day, what we are always going to say is, what is the evidence base, what does the literature say. We can't get into the argument, well, you already cover such and such, or, you are being discriminatory. I really would say that we have to apply the same standards universally and we really shouldn't make any exceptions.

DR. GORDON: George?

DR. BERNIER: I would like to ask Ms. Block, you had indicated that there was going to be probably a pretty dramatic increase in the cost of the Federal Employees program.

If you assume that the budget isn't going to cover that, then the presumption would have to be that the new cost will be entirely undertaken by the employees?

MS. BLOCK: No. The formula is consistent. The government will bear 72 percent of that increase.

DR. BERNIER: So that is sort of guaranteed?

MS. BLOCK: Yes. That is guaranteed, no matter what. The government share is 72 percent. The employee's share is approximately 28 percent.

I just want to make clear that when I say we are anticipating a significant rate increase, this is not unique to the Federal Employee Health Benefits program. I think that all employers are going to be facing similar significant rate increases this year. It is where the industry trend is.

DR. BERNIER: And they don't have the federal government behind them.

MS. BLOCK: No. We go through cycles, apparently, in terms of health insurance premiums. What we are seeing again is a rise in premium costs. Various employers will deal with it in various ways. There is a lot of talk about defined benefit and so on.

From our perspective, we have also been asked by the President to look at ways of controlling costs in the Federal Employee Health Benefits program, and we will

be doing that in conjunction with the Office of Management and Budget, and the Administration.

DR. BERNIER: Thank you.

DR. GORDON: I have a brief question for you, Ms. Block. What has the response been to the call letter?

MS. BLOCK: Well, we haven't gotten the formal proposals yet. They are due on May 31st. In terms of this particular issue, I have not heard a great deal. So we are kind of on a wait-and-see basis. As those proposals come in, we will get a better sense of what the various plans are going to do about it.

What they do is, between April and May 31st, the carriers are working on designing their benefit proposal and their rate proposal, and they don't talk to us a great deal until those proposals come in.

So on June 1st, I will have a better idea.

DR. GORDON: I would certainly like to know.

The other question relates to, you made a suggestion that local carriers were the ones who, to a significant degree, determine what is going to be covered. Do you have any thoughts about how to

communicate with them, how both federal employees and we, as a commission, might communicate with them?

MS. BLOCK: Well, federal employees do every day. They are very vocal. It is a very vocal group, I can tell you. So I know that federal employees are out there telling carriers what their interests are.

In terms of the Commission, we will be happy to provide you with a list of carrier contacts. We have done that in the past. It is simply a one-to-one approach, contacting the carriers. They are usually receptive to talking with people. They certainly would be receptive to talking with you. It is an opportunity to present your views.

So if you would like, we would be happy to provide such a list. We have about 240 plans participating in the program at this point.

DR. GORDON: The question I have is, apparently the call letter doesn't allow the health plans to charge additional premiums for some of these services. Is that true?

MS. BLOCK: We have required that benefit proposals be cost-neutral for many years now, and that is

not just true this year, it has been true for some time. As premiums go up, we ask the carriers balance their benefits proposals so that they are cost-neutral. So yes, that is true.

DR. GORDON: I see. So the issue is, in a sense, if you want to keep the premium the same and you want to add these CAM therapies, to formulate some way to add them, and either take away or reduce costs somewhere else.

MS. BLOCK: Well, the rate-setting process is a pretty complicated process. The premiums are never going to be the same, because we are looking at ever-increasing costs, but in terms of the actuarial value of the benefits, we would ask that the proposal some how balance off actuarial value so that the added benefit, in and of itself, isn't adding to the premium cost.

That is not a terribly difficult thing to do as you are developing a rate proposal and a benefit package.

DR. GORDON: Joe, you had a quick question? Then we have to close.

DR. FINS: Yes. I think it is an important point. The balancing that you are talking about,

creating a global budget in a sense, even though premiums may creep up, is that there has to be a kind of balancing. I think it gets back to what Dr. Whyte was saying, it has to demonstrate efficacy that is comparable or better than what is there to replace. It is kind of like drug formulary in a sort of crude way. I think it was helpful to hear it from you, as well.

DR. GORDON: Thank you both. I feel like my mind is clearer than it was before you began. Thank you for being very clear and succinct.

MS. BLOCK: Thank you for having us.

DR. GORDON: We are going to take a 15-minute break now. We will come back and hear about state and national perspectives.

[Recess.]

Panel Session III: State and National Perspectives

DR. GORDON: This panel is on state and national perspectives. The first speaker will be Joy Johnson Wilson.

Presenter: Joy Johnson Wilson

MS. WILSON: Thank you, Mr. Chairman, and members of the Commission. It is a pleasure to be here

today to talk to you about state legislative and regulatory initiatives related to complementary and alternative medicine.

My name is Joy Johnson Wilson, and I am a Federal Affairs Counsel and Director of the Health Committee at the National Conference of State Legislatures.

There isn't much written about what states are doing in this area. I think that history is yet to be written, but there is some activity. I think in many ways the state regulation of this area is something of a moving target, because what is complementary or alternative today is likely to be a traditional and standard treatment tomorrow.

So, as the different providers and the treatments that they provide progress, oftentimes those become standard treatments and are treated like traditional providers.

So, when you look at how states are treating complementary and alternative medicines, I would say that to the extent that they are on the radar screen of the state legislature, they are often treated like more

traditional providers, in that the state legislation associated with them and regulations tend to focus on licensure, scope of practice, educational or accreditation requirements, reimbursement issues, insurance coverage, and disciplinary and malpractice concerns.

One are that I thought was kind of interesting is the whole area of health freedom laws that have been enacted in 12 states. These laws, at least initially, started out as protections for providers that were providing alternative or non-traditional therapies. Oftentimes these mostly physicians were subject to disciplinary action by the governing board of their practice for providing treatments that were not recognized by the board. These laws were instituted to protect those providers from disciplinary actions by those boards.

More recently, those laws have been also pointed to the patient, to provide the patient with access to alternative and complementary treatments. There has been an effort to balance the willingness to let providers and patients experiment a little and yet

provide the protections that are necessary for the patient.

So, the new laws have consent requirements, informed consent. They have documentation requirements. They oftentimes have the physician make an assessment of a patient's availability for treatments that are conventional and non-conventional, and then have a discussion about what might be the most appropriate treatment for that patient.

So, there is a balancing act between allowing treatments that may not be recognized by the governing board for the physicians or other health care providers, providing patients with a full access, a full range of treatments, while at the same time trying to ensure that there is protection for those consumers, that they know what they are getting into when they participate.

The most recent law actually became law I think last week. That was in Florida. It does have practice guidelines written within the law that speaks to informed consent and also speaks directly to the right of the patient to avail themselves of these alternative treatments.

There are two states that have extensive regulations on health freedom. That is Texas and Nevada. One of the interesting things I found out when doing the research for this presentation is that Texas has a provision in its constitution that says that you cannot give preference to certain schools of medical thought. This has led to some case law, which has led to supporting statute and regulations that are very supportive of alternative treatments and therapies. But also the regulation in Texas has extensive guidelines regarding informed consent and patient assessment and documentation.

I think that is the trend that you will see in the years coming, in terms of states looking at these kinds of laws.

In terms of alternative providers, and I did not actually consider chiropractic an alternative provider, because I have seen quite a bit of activity in that area since I have been at NCSL, but chiropractic and acupuncture are two areas where they have moved almost from the alternative to the mainstream. You see that reflected in the kinds of legislation that is enacted in

these two areas. Most of it has to do with scope of practice, reimbursement, and actually they get into the nitty-gritty of how many visits and how many visits will be reimbursed. So, I think these are treated more like traditional treatments in terms of legislation.

Forty-five states have universal licensure and reimbursement equity for chiropractors and thirty-five states either have licensure, certification, or registration for acupuncture. So, clearly these are treatments and providers that are being treated more like mainstream, traditional health care providers.

Massage therapy, I think, is well on its way to becoming treated more like chiropractic and acupuncture. We have 29 states and the District of Columbia that license or regulate massage therapists. Again, when you look at the legislation, most of it has to do with scope of practice, almost entirely scope of practice, and some of it is who would regulate them and credentialing.

Finally, in terms of emerging alternative treatments and providers, homeopathy, we are seeing a little bit of legislation in that area, mostly regarding the establishments of boards to regulate the practice.

Naturopathy, we have 11 states that license those health care providers. Very new, in my view, and there are others that might know more about this, nutritional providers came up a few times. I don't know, I suspect maybe this is renaming something, because most of it has to do with dieticians, maybe it is renaming some things that were being done before and giving it a new title and maybe expanding scope of practice. Most of the nutritional providers are linked to credentialing for dieticians and talk about various kinds of nutritional therapies that those individuals can provide.

So, again, most of what you see in terms of introduced legislation, and there is certainly a lot more introduced legislation than there is enacted in this area, is pretty traditional stuff, regarding scope of practice, whether or not there is insurance coverage.

For chiropractic and acupuncture, they are more mainstream, there is a lot more discussion about reimbursement issues and whether if you are not a physician whether you have to operate under the supervision of a physician, so the direct access issue comes up. But, certainly in the newer areas, it is more

credentialing than anything else.

I'm going to stop there. Thank you very much. I would be happy to answer questions.

DR. GORDON: Great. Thank you very much.

Merilyn Francis.

Presenter: Merilyn Francis, R.N., M.P.P

MS. FRANCIS: Good morning. My name is Merilyn Francis, and I am the Director of Quality Management and Health Services Research for the American Association of Health Plans.

AAHP is a member organization, representing over 1,000 HMOs, preferred provider organizations, and other similar network health care entities.

We thank you for the opportunity to speak here today in front of this Commission. Let's start with some general comments. Over the past 20 years, consumer demand and the availability of complementary and alternative medicine have steadily increased. Health plans made decisions on benefit coverage based on the demand and availability of specific services and their clinical efficacy, safety, and potential cost effectiveness.

The two critical challenges health plans face when deciding which CAM therapies to offer their benefit packages are the lack of licensing and practice standards for certain disciplines and a paucity of research on efficacy.

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

Chiropractic medicine, for example, has licensure requirements in all 50 states, while the other therapies mentioned have requirements in almost half the states. These standards, along with research evidence, allow health plans to set their credentialing, performance measurement, and quality improvement programs as they do for their allopathic medicine programs. These three factors are central to health plans' quality agendas.

In other cases, health plans may offer optional riders for other CAM therapies, such as herbal therapy,

reflexology, and yoga that do not have clearly defined standards or a body of research evidence, but the level of interest and demand by members and/or purchasers is high. In these instances, members may be offered discounts or services at a contracted rate without primary care referral if the member uses the health plan network of alternative practitioners.

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

Evidence-based care. Health plans have supported the use of evidence-based care in allopathic medicine. The development and use of evidence to determine the most appropriate care has been advanced by the efforts of the Agency for Health Care Quality and Research and other research organizations.

These efforts were further supported by the recent Institute of Medicine report, "Crossing the Quality Chasm," which offers that "Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place."

Before CAM therapies can become more integrated into allopathic health care systems, the evidence to support safety and efficacy must be developed. The body of scientific knowledge on effectiveness and appropriate standards of care is spare or absent from many of the centuries-old systems of CAM, such as Ayurvedic medicine, as well as newer therapies, such as light therapy.

Current research efforts by the National Center for Complementary and Alternative Medicine and other research organizations are making headway in developing this body of knowledge. This is an important step in determining the effectiveness, efficacy, and safety in using CAM for specific medical conditions.

Further, the knowledge gained from these research activities will support the development of practice standards that are essential for accountability

and meaningful monitoring and evaluation of quality.

The difference in philosophies between CAM and allopathic medicine makes it both difficult to fit CAM into the health care structure that is dominant in the United States and yet attractive to patients and professionals desiring a holistic approach to care.

Where alternative practitioners view health as a balance between mind, body, and spirit, the allopathic practitioner views health as the absence of disease. The rigorous evaluation of balance between mind, body, and spirit for evidence-based care is difficult at best. For this reason, supportive research on CAM therapies is crucial.

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

practices is a valuable effort.

Evidence-based care is only part of the picture. Professionals delivering that care should have the appropriate skills and training, as documented through education, licensure and/or other types of certification. The credentialing process is used to verify that health care professionals have the necessary skills and ability to provide safe, high-quality care.

Further, the process is used to determine if the provider has had any quality problems, such as malpractice suits, legal actions, or professional sanctions against him. Accreditation programs developed by organizations, such as the National Committee for Quality Assurance, NCQA, the Joint Commission for Accreditation of Health Care Organizations, JCAHCO, have been beneficial in standardizing and increasing the effectiveness of the credentialing process.

While the credentialing process used by health plans and other health care entities is not foolproof, it is the best tool health plans and consumers have to determine the baseline ability of a health care professional to practice their discipline.

The education and licensing requirement for physicians, nurses, and other mainstream health care professionals practicing conventional medicine are well known and clear. Requirements for certain CAM professionals, such as chiropractors, acupuncturists, and massage therapists are also well defined. However, there are many complementary and alternative medicine disciplines that do not have clear standards for defining a qualified practitioner.

This is an obstacle for determining the options of CAM providers and therapies to be included in health plan benefit packages.

Education and training to become a practitioner of CAM therapies vary widely from a few weekends of training to several years of education plus a fellowship, leading to certification and/or licensure. If there is no state licensing or other certification process, what methodology should be used to assess the practitioner's baseline qualifications for performing their therapies.

Some health plans use advisory boards to facilitate the process for defining qualifications necessary where there is little guidance found in the

form of certification or licensing standards from the profession or through state regulation.

In general, health plans offering complementary and alternative medicine to their enrollees use methods that parallel those that are used for their allopathic providers where possible. These include review of practitioner databanks and other types of data to determine if there are sanctions or legal actions documented, the number of years the practitioner has been in practice, education, fellowships, and residencies, and the extent of the program attended, and a site visit to assess and make sure that the office is appropriate and equipped for the type of therapies that the practitioner has said they were going to provide.

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

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

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

Standards of Practice. Defined standards for the level of education and training, combined with scientific evidence of care, provide a framework for developing standards of practice. Health plans are held accountable by governments, purchasers, and other accrediting organizations for ensuring that their systems and processes of support practice standards. Health plans hold their providers accountable for using accepted standards of practice.

The baseline thing I would like to say, though, is that in order for health plans to make their benefit decisions and also meet their quality agendas, it is important for there to be a good a system of credentialing, evidence that services provided are efficacious and also safe, and the third is standards of practice so they measure quality.

DR. GORDON: Thank you. Thank you very much. We appreciate that. The rest of the testimony is there

in the written testimony.

Alan Korn.

Presenter: Alan Korn, M.D.

DR. KORN: Mr. Chairman and members of the Commission, I am Alan Korn, the Senior Vice President for Clinical Fairs and Chief Medical Officer for the Blue Cross and Blue Shield Association. I sincerely appreciate the opportunity to speak today on behalf of the Blues about health insurance perspectives on complementary and alternative medicine.

The Association is a national coordinating body of 45 independent Blue Cross and Blue Shield plans that provide health care coverage to one in four, or more than 80 million, Americans. All plans are members of the Association, which licenses the plans to use the Blue Cross and Blue Shield name and trademark.

Blue Cross and Blue Shield plans constitute the largest, most experienced provider of health care coverage in the country, but each plan is an autonomous organization that operates independently in its own local service area, where it has the flexibility to respond to local market demands and health care needs.

Over the past several years, health plans have become increasingly interested in complementary and alternative medicine due to strong public demand. Published studies, in fact, suggest that more than 600 million visits are made annually to such providers, more than the total number of visits to all primary care physicians. Recent surveys conducted by the Association indicate that about a third of responding Blue plans, especially HMOs and PPOs, accommodate member demand for acupuncture services, while 8 percent accommodate naturopathy and 7 percent homeopathy. PPOs are more likely to accommodate homeopathy and 18 percent reported doing so.

I would like to clarify that the Association does not consider chiropractic services to be complementary or alternative for the purpose of this statement. I believe that chiropractic has become a stakeholder in the politically dominate health system of the United States. The NIH Office of Alternative Medicine defines complementary and alternative medicine as healing resources outside the politically dominant system.

Why are Blue's plans offering these benefits at this time? Well, there are three main reasons for providing a discount network or contractual benefit for CAM services. The first and most prevalent reason is to respond to competitive pressures by visibly meeting consumer demand.

Health plans my differentiate themselves in the competitive market and appeal to different segments of the population by offering these very popular programs. A second reason is compliance with state-mandated coverages. And a third reason for health plans to offer a program is the potential for the use of these services to theoretically reduce health care costs through emphasis on health maintenance, leading to improved health status and lower use of other services and/or serving as an alternative to higher cost services.

CAM services typically have lower per-unit charges than conventional biomedical services, but existing data, however, suggests that these services are often adjunctive rather than substitutive for conventional care.

Health plans interested in offering these

programs must consider a number of important issues and design options. The Association has made no recommendations to Blue plans on providing benefits for these services. These can be integrated into insured benefits by being added to basic benefits or by being offered as a separate rider with an additional premium.

Alternatively, improved access to these services can be achieved a value-added program that does not entail an additional premium. Value-added programs may provide access to a credentialed network of CAM providers at a discount. Members would self-refer and pay for the discounted services out of pocket. This is not news to you.

Integrating CAM benefits into existing insured medical benefit coverage confronts several difficult obstacles. Integration would require applying the same contractual definitions and exclusions to complementary and alternative medicine that apply to conventional biomedical services.

In our litigious environment, contract provisions and policy must be first clinically, then legally defensible, and applied consistently. Health

plans use two contract provisions in adjudicating benefits included within the benefit contract.

They determine first that the service in question is investigational. If not, the health plan would then determine the service to be medically necessary that is appropriate for the patient's conditions.

Blue Cross and Blue Shield plans typically define investigational services as those that have not been shown through clinical evidence to improve health outcomes when compared to alternatives.

Health plans have made great strides in applying evidence-based standards to coverage determinations. Health plans try to make decisions based on scientific evidence or, if necessary, on well-documented expert consensus, which is generally based on soon-to-be-published studies or published studies with small numbers of patients, but not by anecdotal evidence.

My written statement refers to the TEC criteria used by some plans to define investigational. TEC being the Technology Evaluation Center, which is housed in the Blue Cross and Blue Shield Association building.

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

Clinical trials for most CAM therapies would be difficult to validate because therapies are often individualized to subjective complaints. Elimination of bias from protocols and outcome measures could be difficult, if not impossible, due to the customization of therapy and the subjectivity of results.

At this time adequate, non-anecdotal outcomes data for many CAM therapies are unavailable. Such evidence would be welcomed by those who would consistently apply them in adjudication processes.

The next step in the benefits adjudication process evaluates the medical necessity and appropriateness of the service for an individual patient's condition. To make medical assessment and determinations, health plans refer to criteria that delineate indications for particular services and

modalities.

These criteria may be developed by professional organizations, government bodies, such as NIH or AHRQ, academic centers, or even consulting organizations, but clinical evidence, expert consensus, and utilization data are the foundations of medical necessity criteria.

Developing patient selection and appropriateness criteria for CAM services may prove difficult due to the disparate philosophies of such disciplines that are involved in CAM therapy and the disparity of practitioners and to whether specific categories of services will be intended for preventive, which is often included in contracts, or for the treatment of diagnosis and specific conditions or disorders.

If health plans opt to integrate these services into basic health care benefits, they may need to employ different standards for medical necessity determinations than they employ for traditional biomedical services, undermining the plan's coverage adjudication process. For example, the program completed 17 different independent clinical effectiveness analyses of positron

emission tomography, or PET scans, since 1989, involving central nervous system cancers and various cardiac indications. Based on those analyses, only seven indications met the criteria.

To conduct a comparable analysis of indications for acupuncture, for example, it would be necessary to evaluate the location and number of each needle and degree of patient-reported pain relief for each placement. The issues, remember, for a health plan will always be how many do we pay for and for how long and for each condition. This analysis for multiple different massage therapy modalities would be even more difficult.

Reliance on a separate rider with a separate premium component could eliminate this potential conflict. A separate rider could specify a designated number of visits, an annual dollar limit, and/or a selected provider network.

Separate riders that will carry a separate premium are also much easier to price, since the number of visits, et cetera, are controlled by the definition. Health plans currently lack the data on the local use of such providers and how these services either substitute

or add to traditional types of care.

Discount networks do not require benefit adjudication, as well, and I think you will understand how they work.

I would also like, parenthetically, to address one further issue before concluding my remarks, and that is coding. Coding poses a potential issue for reimbursement of these services. Under HIPAA, only nationally-recognized code sets may be submitted and processed electronically.

CPT codes for medical and surgical services are one of the recognized code sets for HIPAA. Certain CAM services, specifically acupuncture and massage, do have CPT codes. It is unclear, however, whether CPT would recognize additional CAM services for code development. Under HIPAA, unlike the past, health plans can no longer develop local codes for identifying and reimbursing such services. The coding issue for CAM service requires further analysis.

To conclude, I would like to say that health plans are exploring these programs due to strong member interest, including in the basic benefits may undermine

health plan evidence-based kinds of adjudication processes.

More research is urgently needed to evaluate the effectiveness of these services in improving health outcomes. It will also be important to study how CAM care relates and supports conventional biomedical services. Can CAM substitute appropriately for some biomedical services or will they always be additive?

The impact of CAM services on improving health and moderating health care costs must be studied and proven to be of value based on clinical evidence. Such studies must use metrics that will withstand the legal and professional scrutiny to which plans are subject prior to their inclusion of CAM in actuarial-driven health care products.

Thank you for your attention.

Panel Discussion

DR. GORDON: Thank you very much. Thank you all three. That gives us a very nice overview.

Questions from the Commissioners? George?

MR. DEVRIES: Dr. Korn, thank you very much for your overview of how Blue Cross Blue Shield is

approaching CAM benefits.

In particular, you described the possibility of supplemental benefit riders, and in particular, I want to touch on one issue related to a Blue Cross Blue Shield plan covering CAM as a benefit, even as a supplemental benefit rider.

Really, it is the issue of licensure of providers, in that the access to providers is critical and yet we have, as we have also heard from American Association of Health Plans and from other organizations presenting this morning, that there is a disparity, shall we say, in licensure in states across the country. In particular, you take something like acupuncture where it may not be licensed in all states, or naturopathy, for example, where doctors of naturopathy are licensed in only 11 states.

I guess my question would be, what would be the Blue Cross Blue Shield Association's position on covering as a benefit, CAM as a benefit, supplemental benefit rider working with covering services from licensed providers versus non-licensed providers in the importance that those providers have a licensing statute in that

state and are able to be licensed.

DR. KORN: Thank you. That is an outstanding question. I deferred discussion of licensure to my colleague, because we had to talk fast to get our little piece in.

First of all, the Association, we independently license 45 plan, who structure their own benefit plans within their individual markets. We don't disseminate a model.

I would venture a guess, however, that given the legal environment in which health plans exist today, the risk of sanctioning a group of providers that aren't licensed would be very high, because any harm would obviously be focused right on the health plan for steering or directing a patient to a preferred provider of services that we really have no metric to measure either competence or outcomes.

So although that decision will be made 45 times, I think 45 legal departments, having reviewed it, would probably be very cautious about offering unlicensed networks to members on any preferred basis.

MR. DEVRIES: Thank you.

DR. GORDON: Other questions or comments?

Charlotte, go ahead.

MS. KERR: I didn't quite say yes, but there was something I wanted to say in my eyes.

Dr. Korn, I thought all the presentations were excellent. I wanted to say there were particular insights into your presentation I was curious about.

One, in terms of the trials for CAM therapies, that the traditional research models may not apply, you also seemed to identify this whole difficulty on a conceptual level of the biomedical model and complementary and alternative therapies. How is it that the Blues kind of have evolved to this knowing? Have you had input on your advisory levels and decision-making levels by complementary and alternative therapy practitioners?

DR. KORN: We do. We have discussions regularly with both state and national organizations about such therapies. Our issue isn't whether there is a demand or even fairly good word of mouth on some of these.

We are in a spotlight. We are in many

spotlights. We are in, obviously, the media spotlight, physicians obviously are very interested in what we are doing, and non-physicians as well, as are trial lawyers.

So the one thing we have to do is maintain a set of business practices which are consistent, defensible, and quite open, and increasingly we are doing that. It is a challenge.

I think the creative responses are to say, well, we would offer the chiro here, we won't warrant that we know much about some of these individuals, but for a set premium there is this set of services that are reimbursed that we will not warrant that there is anything that we can judge as being better or less good than something else.

And so, I think it is a very creative way of dealing with it, given the tough environment we are in, or all together these value-added networks where discounts are offered and it is out-of-pocket. The evidence is what we really, really want, peer-reviewed evidence that stands up to the kind of scrutiny that we are held to all the time.

That sort of cuts both ways. Just a bit of

anecdote here. You are all aware of the very terrible problems we face here in this country with respect to autologous bone marrow transplantation for victims of breast cancer, over a decade. Without the evidence, we eventually began paying the claims for all of the reasons that I am sure you understand and appreciate. Having done so, we are now being sued by patients who thought we should have known better and not allowed them to have unproven treatment.

So, given the environment, we have got to be extraordinarily cautious about all such matters. My plea is, show me the evidence, please.

DR. GORDON: I have a follow-up question to that. The example about acupuncture having to justify each point as an analogy to using scans, diagnostic techniques, it seems to me that one could also just simply do outcome studies in which the choice of points was optional. It is really the method that is being used, rather than the specific points. Does that make sense?

DR. KORN: Yes. Yes, it would. As we get into the details, we would want to be certain that unlike

certain other disciplines, there is not a fee associated with each needle.

DR. GORDON: There is not, what, I'm sorry?

DR. KORN: There is not a fee associated with each needle, because other disciplines have done that.

DR. GORDON: Are some people charging a fee for each needle?

DR. KORN: Well, not necessarily the needle, but people bill very creatively, and that is a question we would absolutely have to deal with before very long.

DR. GORDON: I think what you are saying, though, is that outcome studies are regarded as good evidence by you.

DR. KORN: Yes, that's right. If we don't, in every circumstance, have an ideal randomized, clinical trial, good observational studies are a pretty good substitute, if we can get them well done.

DR. GORDON: I had a more general question, and maybe all three of you might respond to it. This relates to one of the perspectives of complementary and alternative medicine.

Many of these traditional systems of healing

that we are talking about are very much focused on health promotion as well as disease prevention. I am wondering what you are thinking about in the health plans or at the state level for including this kind of approach, which potentially has tremendous cost savings. Some of them have already been demonstrated in some papers, Dr. David Sobel's work, for example, on mind-body therapies and cost savings.

I am wondering where you are in considering some of these, really, more global or more holistic approaches for coverage and consideration?

MS. WILSON: That is hard to say, because I think that in each state exactly how a legislature comes to address any given therapy varies. Sometimes it is because the school that certifies or educates that particular provider is located in that state. Sometimes it is because a key member of the legislature has availed him- or herself of the treatment that they have found effective, and it was not reimbursed under their plan.

So there could be any number of reasons why a legislature considers a treatment or a provider. Sometimes it is because the providers are organized in a

way that they have made an effective presentation to the legislature and, on a demonstration basis or operating under the supervision of an already licensed practitioner, get an opportunity to show whether or not their therapy is effective or not. So it is kind of hard to say.

In general, legislatures are very interested in effective treatment. One example I can give is acupuncture for detoxification for chemical dependency. This is an area that seems to have a fairly high degree of interest in the state legislatures because of the lack of effectiveness, or certainly the challenges that have been found in other treatment modes for chemical dependency. So, in some respects, it is, well, these other things haven't worked, this seems to have worked in some cases, let's give it a try. So I think it is eclectic, and it really depends, on a state-by-state basis, what is going on in that state and how it comes to the legislature.

MS. FRANCIS: Yes. I think that from health plan to health plan it would vary on how it may be incorporated into their benefit packages.

Health plans, managed care, one of their basic themes is prevention and health promotion, but yet we still, as I said before, looking at the evidence and looking at qualified providers, some health plans do offer at discounts wellness and prevention therapies such as yoga and membership to health clubs, stress and relaxation, those types of therapies that do help with prevention and health promotion. But it would vary from plan to plan.

DR. GORDON: I'm sorry, it is very what?

MS. FRANCIS: I said it would vary from plan to plan and state to state, though.

DR. KORN: It is a complicated world, Mr. Chairman.

I would agree with Merilyn with respect to large health plans, large employers, and HMOs. And 18 percent of our 80 million are enrolled in HMOs. Half of our enrolled lives at Blue Cross and Blue Shield are small businesses, beauty shops, print stores, mom-and-pop operations, and individual families. And to make health insurance affordable, they often pick and choose benefits, including only those that protect their members

from catastrophic events.

Generally, the kinds of things that we would call lifestyle or wellness are thought to be individual responsibilities, not collective responsibilities. That is an important market. The risk of putting too much into the benefit plan is that we make them uninsured. That is the Blues. That is a good part of what we still do.

The other issue in some large accounts is, even the with double-digit prescription drug costs, every emerging new technology, they have to draw the line somewhere. Nobody would argue that these kinds of services are important. We all ought to. I guess the argument has to be is it something that we want our friends and neighbors to pay for through premiums or is it something that we should assume is personal responsibility.

The easy answer is let someone else pay. The truth is probably somewhere in the middle. So, although I would agree that these are important considerations and down the road may be associated with long-term savings, the insurance market is an annual by decision that we

have to live in year in and year out, and we are faced with a great number of upward cost pressures right now that you are all aware of, reading the newspapers, et cetera. So it is a very complex world.

DR. GORDON: Thank you. Joe?

MR. PIZZORNO: Dr. Korn, you made a very provocative statement that I would like you to address further. You said you do not consider chiropractic part of CAM anymore, that is part of the dominant health care system at this point. Why do you think that and what was the transition that chiropractic went through?

DR. KORN: The chiropractors have gone through a very painful transition and one that I would wish none of you would have to do. It is obviously a very complex topic that I will try to summarize at a very, very high level.

What we have observed over the past many years, four or five really, and we have really actually come to understand quite clearly through some direct discussions with the American Chiropractic Association, is the profession has evolved in a way that we find to be quite intriguing.

They have now adopted in large measure a collaborative model of care, in which what the chiropractic community offers is merged with what the allopathic and osteopathic communities offer. And you have a unique opportunity we see here in blending all of the science often rendered by physicians, who sort of stand behind a medical record, it gets between them and the patient, and another body of physicians, and that is how chiropractors are defined in most states, who really are very expert in hands-on care, nutritional counseling, lifestyle things.

What we have observed, the data would suggest that with that kind of an approach, patients are far more likely to change their behavior, to not smoke, to lose weight, to exercise, to eat properly than being told to do so by someone sitting on the other side of the desk, writing a progress note in a allopathic office.

So, we could talk a great deal more about it, but we have become impressed with the contribution that that model of care has in the global picture. Again, that is overlaid on a long history and many other things, but that is why, at this point, it probably makes sense

to put them outside of the CAM circle.

DR. GORDON: Okay. I have Wayne, George Bernier, Bill, and Tom.

DR. JONAS: I would like to ask you all to reflect on what impact the current IOM report on crossing the quality chasm, that I think at least two of you mentioned, is going to have, if any, on health care benefits, payment, associations, et cetera.

What I heard you just describe, Dr. Korn, is that chiropractors appear to have developed a relationship with their patients that is more motivational, perhaps more continuous, customizes the care, perhaps more individually than what we currently have, and puts the individual kind of in control of the situation. Of the 10 rules that IOM listed, the first three, and I assume these are in some kind of priority order, is that care is based on a continuous healing relationship, not just office visits; care is customized and individualized according to patient needs and values; and the patient is the source of the control. I think evidence-based medicine is number five on that issue.

I couldn't think of any better first three

principles in terms of what I would like to see in health care, and I'm wondering if many complementary practitioners aren't, in their own little world, providing these kinds of characteristics, and part of the public response is that they like that better and they are willing to pay for it and do it even outside the health care system?

How is this going to impact on our current system and reimbursement? Are any of these principles going to be able to be implemented? Is payment going to be able to be aligned with some of these principles in some way? Will it require restructuring of how we think of health and disease?

The first one, is about healing relationships. That is the first time I have ever heard that, really, as the top priority. I am just wondering if any of you could reflect on if and how this might impact the reimbursement payment system?

MS. FRANCIS: Well, I think it is probably a little too early to tell in some ways how it is going to impact, but the six aims that the IOM report does put forth as far as how to increase the quality of the health

care system and to redesign health processes throughout the health care system have to be taken together and not necessarily in isolation.

Each of those principles on their own are important, but along with the healing relationships and the patient-centered care is the issue of safety and evidence-based and access and things like that.

I think that as the entire health care system moves towards having better relationships, having more coordination of care, really looking at the evidence of care, then what may happen and should happen is some care that is not as optimal as it should be may be retooled and made more effective. But as far as reimbursement, I think that is probably far down on the list right now, only because there is some of these other macro issues that need to be dealt with and worked on beforehand.

DR. GORDON: Go on.

DR. KORN: Healing relationships are probably the most important factor in patient compliance and ultimate success, once you get beyond the biochemistry and the drug or whatever.

Now, once a health plan establishes a network,

and of course the Blues contract with 90 percent of doctors in the country, they are stable. Occasionally doctors die, new doctors come into the system, and occasionally they are drummed out for one reason or another, but they are very stable networks. Why then don't we have healing relationships?

The average turnover in a health plan is 19 percent a year. Every January that happens, so that your ability to stay with a patient longer than three or four years is very low. Why? Price. People shop on price annually.

So, we have a very difficult problem now in maintaining healing relationships in a competitive business environment.

Now, in terms of reimbursement, I think there is an opportunity to really differentially reimburse for outstanding outcomes, but a health plan can't do that all by itself. If you were to tell me as an accreditor or a purchaser that I want you to figure out who your best doctors are, what am I going to do? I'm going to create a bell-shaped curve, aren't I? And I will reward the two standard deviations way over on the far right side of the

curve and maybe ding the people on the left a little bit, but for 94 percent of the doctors in my network, nothing will have changed.

So, to really find quality and reward it meaningfully, we are reaching out, for example, to the American Academy of Family Physicians and saying, you define quality, make it meaningful, and when you find it, do whatever you can using peer pressure to get everybody into that top quartile, let's move that curve over. When we do that, we think the quality will be there, and when we do enhance reimbursement for those who do those things that count there will be some assurance that the payback will be rather short-term rather than long, because we only have two or three years to make it back. That patient is going to change health plans.

So, we have a lot to do. Quality isn't something that health plans can do to a doctor or a patient. We have been living in a world in which that was the operative assumption, whether it is an accreditor or an employer. Quality and good outcomes are something that health plans have to do with doctors, and that means we need to re-earn your trust and we need to get to work.

The Blue Cross and Blue Shield Association has been reaching out for the past two years, internists, pediatricians, family doctors, and even the AMA, which tomorrow, with us, will announce a major joint initiative after a year and a half of discussion. We will do it together.

MS. WILSON: I just wanted to say that in terms of the impact of the IOM study on state legislation, it doesn't really happen like that too often. Usually they are going to hear from the insurers and they are going to hear from those who want coverage perhaps, or those providers who want to be covered.

The IOM study may be entered into public hearing at some point by one of those parties or another, but the IOM study in and of itself doesn't drive state legislation, and it really depends on how it would be presented at that public hearing and how those legislators receive that information as to how much impact it would have at that level.

DR. JONAS: Yes. I'm wondering if it will have any impact at all. Its goals are so magnanimous, if you will, and also it is targeting system change, as opposed

to what you just described in terms of working with individual practitioners, which is a different matter.

DR. GORDON: George.

MR. BERNIER: I had wanted to ask Dr. Korn how policy decisions get made in a collection of autonomous Blue Cross partners, and then when I heard that there had been a pretty dramatic change in that relationship between those institutions and the chiropractic enterprise, it sounds like maybe there are different kinds of decision making that is being carried out at various times.

Could you give us an idea?

DR. KORN: I will do it very briefly. At the national level, we try to create in infrastructure to ease both the human and financial burdens on all of our plans. We have the Technology Evaluation Center, where we centrally look at new and emerging technologies and new indications for existing technologies.

We also have a Medical Policy Advisory Group. Not everything on earth can undergo a six-month assessment. So we will look at medical literature and, in an advisory way, advise our plans on what medical

policy might be with respect to an issue or a technology or a treatment or a procedure. They are not binding, but the plans typically don't have the resources to do a lot of additional research.

So the compliance rule that we like to use within the Blue system is the 90/90/90 rule, that 90 percent of the plans will probably use 90 percent of the policies 90 percent of the time, and 70 percent is not too bad. We do have a number of national accounts, as well. So there is the expectation that we will be consistent.

On the other hand, we are firmly rooted in local communities. The arrangement that the Texas plan might make with the M.V. Anderson Hospital, for example, would be unique and might not be applicable in Wyoming or in Maine.

So there is autonomy and independence and, again, as I said early in my statement, our plans have the ability to deal with local medical need and market conditions in ways that are unique. We provide, on an advisory basis, an infrastructure that we hope is a cost savings to them.

DR. GORDON: Tom.

MR. CHAPPELL: I have a question for Dr. Korn and for Merilyn Francis, please.

The issue we face is to recommend policy that is integrative with our present system, complementary, separate, and both of you have described the burden that we need to achieve on creating better case for the evidence of efficacy, safety and efficacy of CAM services in your reports.

However, I still would like to know whether you recommend we pursue integrative partnerships with the Blues and the health care plans, which could be through providing menus of different products to groups, or whether you encourage use to accomplish the needs of the consumers through separate routes?

MS. FRANCIS: When you say a separate route, you mean totally not integrated at all with --

MR. CHAPPELL: Well, when I say separate, outside the health plans that your association has for state-of-the-art systems and requirements for evidence-based credentialing and standards and practice?

MS. FRANCIS: I think that it depends on your

goals. For integrating into health plans or integrating into the allopathic health care system, I think there is value in pursuing looking at ways that it can be integrated into the system and working with health plans to see what extent is possible and appropriate for integrating.

It may be, like many other things, that it is a combination of the two. It doesn't necessarily have to be all or none, because, as we have seen as the evidence comes in, certain therapies have integrated pretty well into health plan philosophy and their delivery mechanism.

So, I think that there is partnerships. I think that the more information exchanged the better, so that people can make good decisions.

DR. KORN: I guess the answer has to be a little of each. Where you have pretty good evidence and a group of physicians, providers, or other experts who can be credentialed in some way, okay, integrated. There is a demand for it, and people are willing to pay the premium hit that they would have for it, absolutely.

And where there isn't and there is still a desire for it, then you have these two options, either a

rider or a value-added network, and I would pursue them. That is the quick answer.

The harder answer is distinguishing together through the research that you can help us do, between what people truly need, what can be considered medically necessary and therefore ought to be paid for by their friends and neighbors, and what they simply want. That is one of the core issues that is tearing us apart today as citizens, and insurance happens to be the focus.

I think each and every one of us believes that our major medical policy entitles us to all the care that we want, when in fact it is financed based on an actuarial model that tries to anticipate all the care that we need. Help us, help us, please, distinguish between those through the data that you will produce.

Once we can establish medical necessity -- that is a bad word now. It has been beaten up, and everyone hates it, but in fact, what you need is different from what you want. What you need, other people pay for; what you want, you pay for. Help us figure that out. When you do, it becomes integrated, but it is a journey. We will take it together.

DR. GORDON: We are actually out of time right now. We have a couple of people who haven't asked questions. We have the option of cutting down on our lunch time or letting things go here.

A burning question that needs to be asked at this moment?

[No response.]

DR. GORDON: Okay. Thank you all very much. We hope to continue to be in touch with you and ask for your feedback. Thank you.

[Applause.]

DR. GORDON: We are going to take a one-hour break and we will come back promptly at 1:30.

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

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AFTERNOON SESSION

[1:30 p.m.]

Panel Session IV: Employer Perspectives

DR. GORDON: We will begin with Panel IV, Employer Perspectives. The first speaker will be Tom Sawyer.

Presenter: Tom Sawyer

MR. SAWYER: Thank you, Mr. Chairman and Commissioners. On behalf of William M. Mercer, a global human resource consulting firm, I am please that you invited us to participate and offer some comments today.

The first point I would like to make is that the interest of employers -- and I want to take some liberties with the term "employers," if I may, to also use the term "plan sponsors," since we do have plan sponsors that are not employers, such as the Taft-Hartley Trust and so forth. I think they might take umbrage if we didn't at least make that mention, that I am really discussing this from the standpoint of plan sponsors.

The interest of plan sponsors in alternative and complementary medicine have, in large part, paralleled but lagged behind the interests of consumers

generally. I think this situation is the result of concerns regarding the cost of health care, safety and efficacy of these types of services, potential liability, and lack of involvement in medical issues. Plan sponsors generally would prefer to leave medical issues to the experts and not get directly involved in general terms.

For these reasons, most CAM therapies are paid for by the consumer out of pocket today. Most plan sponsors, although they utilize these services, the consumers that press upon them the need to purchase and add these benefits has been a major reason that employers or plan sponsors have added these benefits.

In looking at plan sponsors, you usually see six types of models that are currently being used in the field of benefits. One type of model is an informational model, where the member receives telephonic or Internet information about CAM issues. A second type of model is the CAM discount programs that you have heard other speakers refer to, where the member receives a pre-negotiated discount from a panel of pre-screened providers.

A third type of plan model is the CAM benefit

account, where a member is given a fixed annual maximum for certain CAM expenses and usually requires a co-pay. A fourth type of model is the CAM indemnity, or PPO, coverage model, where the plan member accesses those CAM services that are covered under the plan and within plan limits.

Another type of model is the CAM rider, which you have heard referred to today, where members access services under an HMO provided plan that also manages utilization and limits the number and kind of conditions that are covered.

Last, but not least, you occasionally will see employers offering on-site CAM services where employees may access certain services on-site, such as massage therapy, at discounted prices.

Primarily because employee demand for such services exists, plan sponsors have increasingly implemented CAM programs into their sponsored PPOs, POS plans, HMOs, and indemnity plans. The main factor in the survey data shows, through a survey done by the International Society of Certified Employee Benefit Specialists, indicated that the primary reason to

implement CAM programs was employee related. Thirty-seven percent of respondents indicated that the main reasons for this have to do with the fact that they desire to please their members and also to give them a competitive edge in attracting and retaining employees.

Twenty-three percent of respondents in this same survey gave a reason related to the potential for improved health or medical care. Thirteen percent stated the need for state-mandated compliance as the primary reason to implement CAM benefits. Another 27 percent did not answer the question.

Since 1998, the firm that I am with, Mercer, has surveyed employees inclusion of CAM benefits through its benchmark Mercer Foster Higgins National survey of employer-sponsored health plans. I have included in your documents, I think, a number of things that you might want to refer to as we talk about what these survey data shows with respect to the results of the 2000 survey by therapeutic modality, region, industry, size of employer, and type of health plan.

My first comment is directed at coverage by modality. The results of the 2000 survey continue to

show the same trend that chiropractic care is by far the most frequently covered alternative therapy. We have heard comments today that that may or may not fit your definition. In our survey data it does fall within the definition that we used in our benchmark survey.

Eight-four percent of PPOs and indemnity plans currently cover this therapy, a slightly higher percent than the previous year. Among HMO plans, 66 percent of employers offered chiropractic care. Of the five modalities that we surveyed, biofeedback was least often covered. As compared to the 1998 survey, the percent of employers offering these modalities has increased somewhat from 3 percent for massage therapy to 21 percent increase for chiropractic, regardless of the type of health plan.

In looking at coverages by region, we do see some regional differences for coverage of the modalities that can be noted. Generally, employers in the northeast and west more frequently offered coverages for CAM therapies, regardless of type of plan offered. One notable exception is the less frequent coverage of chiropractic care in the west for PPO and HMO plans.

In terms of coverages by industry, we found that employers from the government, financial services, service and health care sectors are generally more likely to offer CAM benefit regardless of type of plan.

As a modality, homeopathy coverage is least consistently offered across industry sectors. The retail, manufacturing, and transportation, communication, utility sectors are least likely to offer CAM benefits.

Size of employer. Regardless of health plan type, employers with 20,000 or more employees were likely to offer coverages for acupressure, acupuncture, biofeedback, and chiropractic, while coverage for homeopathy and massage therapy were more inconsistently covered. Employers with fewer than 20,000 employees were more inconsistent in their coverage patterns for these types of therapies.

Coverage by type of health plan. Acupressure, acupuncture, biofeedback, and chiropractic were all more likely to be offered in a PPO or indemnity plan than an HMO plan. POS plans closely parallel PPO plans in patterns of coverage across all modalities. The most significant differences in frequency of coverage occurred

with chiropractic care, where 84 percent of employers offering PPO or indemnity plans offered this modality, while only 66 percent of HMO plans did.

Employer-sponsored HMOs offered no CAM benefits 31 percent of the time, compared with 15 percent of PPO and indemnity plans not offering CAM benefits.

Let's talk about CAM program costs. Costs for CAM programs are low to modest and vary with the type of program offered. Information only, discount, and on-site programs usually are less than $1 per employee per month.

On the other hand, offering broad CAM benefits can cost $10 to $20 per month per employee, depending upon plan design, location, employee demographics, provider contracting, utilization management, and other factors. Most program costs fall between one and $10 per employee per month. Savings from traditional medical claims reduced disability costs and decreased absenteeism and turnover may offset some of these costs. However, it is rare to find well-done evaluation research of this type in actual practice.

Issues with CAM programs that employers face. Employers are faced with several issues when considering

CAM programs for their employees. First and foremost is the management of financial risk.

Second, geographic variation and provider licensure, and availability, and requirements that are different from state to state also present challenges.

Third, there are some tax and compliance issues regarding Section 213 of the Internal Revenue Code. And last, but not least, is certainly the challenge of how to measure the program's effectiveness.

The challenges for the future for the employer include the ability to establish safe, clinically effective treatments that are accessible. Employers are not scientists or providers. As payers they look to the scientific and health delivery community to bring safe, cost-effective treatments to the market, while seeking to integrate them into their rightful place in the spectrum of health care services.

Thank you for your time, and I will be happy to take questions at the appropriate time.

DR. GORDON: Thank you very much.

Kathleen King.

Presenter: Kathleen King

MS. KING: Thank you, members of the Commission. It is a real thrill to be here with you this afternoon. I submitted a longer statement for the record, but I am going to sum up my testimony here.

I am here today on behalf of the Washington Business Group on Health, which is a non-profit association comprised of about 165 major, national, and multi-national employers. The mission of the Business Group is to improve the health and productivity of companies and communities.

The Business Group has a long reputation. It has been around more than 25 years of really being leading edge in its thinking about health benefits in the workplace.

So I want to start off by saying today that employers, especially the members of the Business Group, have a real stake in the health of their workforces, because a healthy workforce is more productive, it is sick less often, has lower workers compensation costs and lower medical costs overall.

Anything that keeps a workforce healthy and continuing to produce is something that the employer

world is in favor of and really supports, and will take a lot of different approaches in terms of thinking about whether things work. That is the premise that employers bring to this, does it keep our workforces healthier. So that is where they come from.

The other thing is, I think that employers are interested in CAM treatments for several reasons. The first one, is because consumers today, employees, are much better informed and want to take charge of their own health care. So they bring something to the table in terms of looking at employee benefits.

The second, is that the health care community overall values prevention and wellness, now more than before, and that is another factor that contributes.

The third thing, is that today's workforce is multicultural and multiracial and has a different set of ideas concerning CAM treatments than the workforce of a generation ago. So that really has an effect on employers.

Employers recognize that they can satisfy some of the demands that employees bring for CAM benefits and that, in most cases, the cost for CAM treatments are

relatively low cost when compared to other traditional medical treatments.

In terms of thinking about how consumers are move involved in their health care, we found that especially with the rise of the Internet that many employees are taking a much more active interest in their health care and they want to get more involved in it and they want to participate more in decision making.

A recent survey by "Modern Healthcare" has found that about 69 percent of respondents said that they wanted health insurance to cover CAM treatments. About 77 percent said they wanted more research devoted to alternative medicine. About half, or 49 percent, and this is not necessarily the same sample here, reported that their health plan covered some type of complementary or alternative medicine treatment.

Another change in the health care community is a trend toward more holistic approaches to health. I don't have to tell you that CAM treatments are much more holistic than many forms of traditional medicine. So that is something also that employees bring to the table.

The third thing is that the workforce grows

increasingly diverse. As some of the early results from the 2000 census indicate, the U.S. population is changing much more rapidly than anyone had anticipated. In addition to people from other cultures, such as people from Eastern cultures, having a faith and practices in things like acupuncture, acupressure, tai chi, those type of treatments are becoming much more broadly disseminated in the culture overall, and that is something that employees bring to the table.

The second thing is that our workforce is aging. The baby boom generation is increasingly interested in things that prolong their health and vitality. As we see the demographic bulge of the baby boom, which peaks about 2020, I think that employers expect to see much more interest in keeping people employed longer and in a healthier state. So they are much more receptive to that.

I think that CAM has become much more accepted in the medical community. It also goes without saying, I think, that employers are interested in more research that shows both the clinical and the cost effectiveness of complementary and alternative medicine treatments.

In my testimony, I have referred to a number of anecdotes that we found of employers covering CAM treatment, but I will leave you to read that.

With that, I will conclude my testimony. Thank you.

DR. GORDON: Thank you.

Next will be Judith MacPherson.

Presenter: Judith MacPherson

MS. MACPHERSON: Good afternoon, ladies and gentlemen. My name is Judy MacPherson. I'm a benefits manager at one of the local companies here in the Washington area, CACI, International, Incorporated, commonly called CACI around the beltway.

We have got close to 5,000 employees. They are a diverse workforce, because we do primarily work for the federal government. We do work for the Justice Department, as well as the Department of Defense. We have sites at about 90 locations around the country and overseas. So, providing a competitive package of health and wellness benefits for these employees is a challenging and increasingly costly undertaking.

What I would like to do is talk to you a little

bit about what it is like to provide employee benefits as an employer.

Since at least the 1800s, employers in this country have had a practical interest in the health of their employees. Industries in remote areas used to provide company doctors to care for their injured or their sick workers. Some of these early employment-based programs covered care for not only the workers, but their families and their community, as well. I know, my father-in-law actually was a doctor in Arizona for a mining company in the '40s. So, it wasn't so long ago that this was a norm.

These programs were often funded by deductions from workers' wages. The concept of prepaid health care began to spread with funding from foundations and hospitals. That eventually led to the formation of Blue Cross. World War II accelerated the growth of employment-based benefits. However, it wasn't until 1954 when the IRS made it very clear that the employer cost of providing health benefits was not taxable to the worker but was still tax deductible to the employer as a business expense that employer-provided health insurance

grew to become the most common source of health insurance in the United States.

Over the past 50 years, the majority of working Americans have looked to employers as the source of their health insurance. In 1999, 66 percent of all Americans were covered by employment-based health plans. What started with manufacturing and grew with the unions, then the Blue Cross system has become an expected entitlement of traditional employment.

Employers who do not offer health benefits or whose health benefits are not up to community standards have greater difficulty attracting and retaining employees. According to a recent survey, 65 percent of workers responding rated employment-based health insurance as their most important employee benefit.

As recently as at mid-80s, health insurance was relatively cheap and easily managed, a benefit for employers to provide to their employees. You made remember, everybody had $100 deductible and an 80/20 coinsurance.

Over the last 10 to 15 years, the industry has changed, to the point that everyone now expects to pay

$10 to go to the doctor and $10 to fill a prescription. Unfortunately, those expectations are becoming no more realistic today than the $100 deductible.

Managed care was touted as the salvation of an increasingly costly system. The fact is that it was simply a stop gap measure, which contained health care costs for several years but reached a saturation point.

We are now at that point where most of the savings that could be squeezed out the health care delivery system have been. In addition, both patients and providers have become frustrated and are demanding more control over how health care dollars are spent.

As an employer, I hear the complaints daily. They range from dissatisfaction with the managed care that is being provided to them to requests for more managed care. Truthfully, most employees want it all. They want a choice of physicians, they don't want to pay extra for it.

I have personally experienced doctors and hospitals dropping out of networks across the country, either because the insurer is paying them too little, too slowly, there is no incentive because the area they are

in there is so little competition that there is no incentive for these physicians to join a managed care network. Some drop out because they don't like being told what they can prescribe.

Personal experience, from the time I was asked to participate in this panel, which was just a little over a week ago, until today, one of the HMOs that I use in the midwest has gone completely out of business, and I'm right in the middle of an open enrollment. So, this is true stuff from the employer's perspective.

Within the last several years, we have seen the cost of providing health benefits begin climbing again. This has been attributed, I'm sure you have heard, to advances in technology, our aging population, the appearance of hundreds of new drugs being marketed directly to consumers.

Pharmacy benefit cost alone to employers has risen 15 to 25 percent in the last three years. In a recent survey of certified employee benefit specialists conducted by Deloitte and Touche and the Society of Certified Employee Benefit Specialists, the key objective driving benefit policy and design is employee attraction

and retention. And the top objective for the year 2000 was to control health and welfare costs. This is the first time in the survey's history that the same issue has been identified as the top priority for two years in a row.

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

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

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