unconventional workplace perks.

In this environment, ancillary programs become more important. Many health insurance carriers, as you have already heard, are beginning to add discount programs for vitamins, herbs, alternative care, such as acupuncture and massage therapy.

Employees themselves want more corporate support for non-conventional treatment options. According to an article by Dr. Michael Steinberg in the February Issue of "Baltimore Health Quest," complementary and alternative medicine is the fastest growing sector of the health care industry. The public's desire and demand for something more than pills and shots for the treatment of symptoms is fueling the demand for corporate support for these types of services.

The interconnection of the mind and body on the overall health of an individual is well documented. Financial difficulties, marital problems, substance abuse, the list goes on. All of these have a direct impact on the health and productivity of our workers. The costs of illness to employers are far greater than the cost of health insurance claims. It includes lost

time, lower productivity and mortality among workers.

It is in our interest as employers to promote the health and well-being of our employees and their families.

As alternative therapies have become more popular, employees now expect their health plans to cover them. This leaves the employer with the dilemma of wanting to provide additional wellness benefits, but fearful of endorsing unproven therapies. Just a few years ago, most plans limited benefits for chiropractic care. Now it is generally covered at the same rate as any other health service. The change was driven by employee demand and the recognition of the benefits of chiropractic probably in treating lower back pain. There was an acceptance, I believe, by the AMA that it was proven that this was effective.

CACI has chosen to promote healthy lifestyles by providing informational materials, encouraging wellness by including benefits for such things as well baby care, mammograms, annual physicals, providing a confidential employee assistance program, and by adding a separate, voluntary program which provides discounts for

complementary and alternative medicine.

Adding discount programs, either through the insurance carrier or as a stand-alone program, is one way that we can currently add value to our program without adding cost. It may seem intuitive that if employees take advantage of complementary and alternative therapies, it will ultimately reduce their usage of the traditional health care system and thereby reduce employer costs.

Once again, this could be a two-edged sword. If employees eschew traditional medicine in favor of alternative therapies, there is always the possibility that they will ignore serious health issues that could lead to the need for more expensive treatment later.

It is a universal dilemma and one with which I am keenly familiar. Recently, in the local area, a consortium has been formed of employers like mine, and that is primarily government contractors, who are meeting regularly to explore the possibility of creating a group buying cooperative for pharmacy services and to discuss other employee benefit issues in general.

These are companies who are competing for the

same labor in the same market and yet are actively seeking to share knowledge to improve not only our delivery of health and welfare benefits, but to explore ways to alleviate some of the administrative burden of doing so.

I think that means I am supposed to stop talking.

Panel Discussion

DR. GORDON: Thank you. I am sure the questions will give all three of you much more chance.

Dean?

DR. ORNISH: There are so many questions I would like to ask, but in deference to the Chair's desire to limit it to one, I will address it to Kathy King.

As Commissioners, our charge is to come up with public policy recommendations regarding complementary and alternative medicine policy. We met when you were Chief of Staff at HCFA. As someone who has been on both sides of the equation, Chief of Staff at HCFA and now a vice president at the Washington Business Group, one of the leading organizations in its field, you have talked about what is out there.

I am just personally curious to know, because of the rich experience that you have had, what do you think should be out there? In other words, what do you think our recommendation should be, from a policy standpoint?

Should we be saying, well, the public wants it, so everything should be covered? Should it only be those things that have scientific proof should be covered? In which case, it kind of loses the distinction if it is considered alternative or complementary, because once it has got scientific proof, it tends to become mainstream. Just personally, speaking for yourself, what are your views?

MS. KING: Speaking for myself, I think there are a couple of issues, and I think there is a long continuum between when therapies emerge or when they emerge sort of into the mainstream as ideas that people think about until they become totally accepted into the mainstream.

I guess I think that the best course of action now is to do more research on sort of the clinical effectiveness, and also I think that people will be

interested in the cost effectiveness. Major purchasers will clearly be interested in both.

I think no one wants to pay for a service that they think is not safe or effective, especially if there is a potential for something to go wrong.

DR. ORNISH: So, would you say that our recommendation should be that we should say that coverage, whether it is HCFA or group plans from corporations or individual coverage, should it be limited only to those things that have been already proven to be scientifically safe and effective, cost effective?

MS. KING: I think that depends on whether there is a potential for harm and what that might be in sort of assessing that.

DR. ORNISH: Meaning what?

MS. KING: Well, for example, some nutritional supplements are on the market -- and I am really just speaking not from my own personal experience -- that are not regulated by the FDA that I think have the potential to do harm, or at least there are reports in the popular press, things like ephedra, which can have the potential for harm.

DR. ORNISH: So you are saying that if there is a potential for benefit, even if it isn't yet proven to be medically effective or cost effective, it should still be covered? Because those are the kind of questions that we are going to have to make recommendations for. You have got such extensive experience, I would be particularly interested in what you think.

MS. KING: If there is a strong potential for benefit and there are some treatments that are not as widely accepted in U.S. culture as they are in other cultures but have long histories of proven effectiveness, then I think I would probably lean more towards those types of things.

There are some treatments that just plain make people feel better. I can think of like massage therapy for one. What can be the harm in that? And certainly it is used to treat specific health problems, but also people use it in a much more holistic form just to feel better and feel more vital.

DR. ORNISH: This is my last question. Does that mean that you would recommend that business groups cover massage just as a general feel-good thing or only

for specific conditions or not at all? Just as an example.

MS. KING: I think that is a clinical question that I'm not really capable of. That is not my area of expertise to answer. I'm not in the position of recommending, me personally, to business what they should and should not be covering. But I think they take a number of things into consideration. They take the clinical effectiveness. They take the cost effectiveness. And also in a tight labor market, they think about what benefits are demanded by employees and what it takes to keep them competitive in the labor market.

As opposed to, I think, on the public sector side, it is a question of how do they stay competitive as an employer.

DR. ORNISH: I see. Thank you. I appreciate it.

DR. GORDON: George, and then Wayne.

MR. DEVRIES: This will be a question for all three. Quick survey in terms of the reasons employers would offer CAM benefits versus why would they not offer

them? We have heard the need for clinical efficacy and safety, as well as employee retention, but from your perspective, and again this helps us understand what the foundational issues are in creating the foundation for the delivery of CAM benefits, what do you think are a couple key issues on why an employer would or would not offer a CAM benefit?

MS. MACPHERSON: Well, I think one of the reasons that an employer would offer it is because employees are looking for it. They are asking for it. That is what happened with chiropractic care. I ran benefit programs where chiropractic was severely limited 10 years ago, but there was such employee demand for it, that now a lot of those limits have been taken off in those big plans.

It is covered either on a limited basis, or maybe at a different co-pay, but it is still, pretty generally, covered in health plans. I could see the same thing happening, I think, with acupuncture. It is probably going to be the next one.

As far as why we wouldn't do it, I think the main reason would be if we felt that there was any

liability connected with doing it. If we felt that by offering this, we were promoting it in any way.

Employers have got two things going on in their minds most of the time, attract employees, keep employees, give them what they want, but watch out as far as promoting anything, because they can turn around and sue you. This is a very litigious society, and more employers are being sued every day over their health plans or lack thereof or the restrictions in their health plans.

So, I think as employees, though, become more educated, and you were talking about web access, as they become more educated, they have to become consumers of health care, just like the employer is. At some point, I think we are going to have to offer some of these things to employees and say, it is your choice, we are offering them, we are making them available to you, but it is your choice as to what you use.

I think, too, that we would be pretty careful on some of these. Right now, as I said, at my company, we are offering a discount program. Blue Cross is offering a discount program. Sigma offers a discount

program. So it is already in health plans. So it is there, and it is up to the employee, I think, to decide if it is right for them or not.

MS. KING: I think one of the things that employers think about, and it is sort of an elusive concept, but, what is their image or brand. You see it especially, I think, in the high-tech market, although that is a really volatile market these days. Sometimes employers offer services or benefits because of the image that it gives them and their ability to attract and retain employees.

So in some labor markets, offering more alternative medicine treatments could be seen as a benefit that would help them get certain kinds of workers, especially if they are competing in a very tight labor market. I think that is one factor that they would think about.

MR. SAWYER: Expanding on Kathy's idea, I think we have a tendency in the employee benefits world to paint all employers as if we are talking about one pejorative group, and each one of them is totally individually separate. They have separate cultures,

separate employee issues, separate issues with respect to how paternalistic they are toward their employees.

So I would encourage you to begin to think about those issues as you think about these comments. Just giving you a quick example, many of the employers that I personally worked with through the years, many of them you can almost kind of array them on a continuum from those that have low turnover and a high paternalism toward their employees, toward those that have a very high degree of employee turnover and very low paternalism toward their employees.

For example, you see a lot of the major companies, well, let me use public sector employers as an example, where you have the average employee, for example, in the U.S. that works for a public sector employer, works for them more than 10 years. In the private sector, that drops dramatically to about I believe two and a half years, if my memory serves me correctly here. So, you have a very different picture of how the employer relates to a public sector employee as opposed to a private sector employer who is going to have an employee maybe work for them two and a half years.

You also have the issue of turnover that I mentioned. For example in the hotel and retail, services area, it is not uncommon to see 150 percent turnover in employees every year, where that wouldn't be tolerated in many other types of industries.

So that is what I see, from my vantage point as a consultant, is that we see each employer being very unique and that you really have to understand the context of how they apply benefits philosophy within the context of their corporate culture.

DR. JONAS: Since your last statement, maybe this is a non-answerable question, but just from your own groups that you have worked with, it sounds like there is, from what I hear, there is a high demand for some of these types of services. When they actually get employed and they are available, to what extent do they actually use them?

My experience with gyms, for example, and those type of benefits is that you have people who really like them and they want them there, but when you actually put them in, there is a very small percentage that actually come in and make use of them. Do you have some

experience with that or some data on that?

MS. MACPHERSON: Well, this is my first year with this particular program. We have now completed about one year. Out of 4,600 employees -- I wish I could give you the right number, but it is not a high percentage that actually signed up for the alternative care voluntary program.

Now, what I am waiting to see is what kind of usage we are going to get from the piece that our insurer is offering, where they are offering this discount program, and you can get on the Internet and access some of these services, and order herbs and vitamins and things like that. I would be interested in seeing that. That is something that has just recently been put into our insurance program.

I didn't see a huge response, but it is also the program that we picked. I think it is a relatively new network -- it is being expanded -- so I think I have got to give it a little bit more time.

DR. JONAS: What kind of services are actually offered under that?

MS. MACPHERSON: Acupuncture, massage therapy,

aromatherapy, some of the even more exotic alternative medicines. They are not really medicine. I think I saw a regression therapist listed in there. So it pretty much covers the gamut.

MS. KING: We don't have any specific data on use of CAM therapies, but I think if you look at mainstream medicine, 80 percent of the costs are generated by 20 percent of the people. So, across the board, you don't have a lot of people using the health care system in any given year.

So I think when you are comparing it, if you can get data, you would want to compare it against that sort of benchmark, how does it look different than how people use traditional medical services.

DR. JONAS: I agree. You would have to look at a percentage. Also, the definition of what is included in the package makes a huge difference. We hear the standard 40 percent rule, but that includes things that you buy over the counter, off the shelf, self-care types of things. Actual professional visits, like an acupuncturist or a massage therapist, or perhaps a chiropractor, are considerably less, 5, 10 percent in

many surveys.

DR. GORDON: George Bernier, then Charlotte, and then me.

DR. BERNIER: I have a question for Ms. King.

At the end of your remarks, you gave a series of examples of programs that have used CAM as a benefit. Was there any take-home message about that, or was it just saying it is an eclectic selection?

MS. KING: If there is a take-home message, I think it is that, going back to Tom's point, the employer world is really varied, and employers are different in what they think is important, but I think they are driven by the same sort of underlying principles in terms of what they want out of the workforce and what the workforce is demanding of them.

DR. BERNIER: Thank you.

DR. GORDON: Charlotte.

MS. KERR: This goes back to both. People are demanding. You, for example, in your creativity, have offered -- and this goes somewhat to my bias of what I think health is, but I saw a special on Sass, the shoe company. I believe it is in North Carolina.

They went on to suggest that what they provided for people were things like getting your dry cleaning picked up at work, and they deliver it to you, rides back and forth to work, subsidized nutritional lunches, child care right there so the father could take the children at lunch, sports, and building community.

They listed -- I keep getting the number wrong because I can't believe it -- but I believe it was billions of dollars they were saving, and they had people testifying how they took $20-, $30,000 cuts.

Are you all starting to see that? And, is anybody doing it, and then doing longitudinal studies and seeing the outcomes of that?

We have spent some considerable time here talking about complementary medicine not necessarily being modalities delivered.

MS. MACPHERSON: Well, I see a lot of literature about it. A lot of people are trying to sell it to me, concierge services, things like that, because people don't have any time any more.

I think there is quite a bit of it, probably, in this area because of the high tech industry around

here, but I don't see it in my particular piece of the industry being offered.

MS. KING: Certainly, some of the members of the Business Group offer things like that. For example, General Mills, which is located in Minnesota, they have a wide range of things, but they have a Smart Card that employees can use in the cafeteria. So when they go to the cafeteria, it all gets racked up at the end of the month. They have a gas station on the premises so you can get your car tuned up or your tires rotated, or whatever.

Part of the reason, I think, that employers do that, and I think I, personally, would distinguish those from health treatments, is because the less time that employees take away from the work day to do things like that, the more productive they are.

So from the employer side, it really goes to a productivity issue, not a health issue.

MS. KERR: I just want to say I don't know if I agree with that. I totally understand what you are saying. My own health index would go up if I didn't have to take my car 50 miles.

Also, this is an example to me of a creative way of dealing with the nursing shortage. I can tell you right now, as a nurse, if somebody was getting my dry cleaning, and the whole caboodle, you would retain me real fast.

MR. SAWYER: If I may just offer a comment? I am, by way of introduction, a health psychologist by background, which may not be typical of benefits consultants generally, but it is certainly my experience that in both my clinical days and my consulting days with employers, that you can't take health out of the context of a person's total life. I think that is right on target from what we are hearing.

In looking at the trends that I see emerging for the future, I see a rather rapid uptake in interest in linking health and productivity issues amongst the thought leadership of employers today. Certainly, not all of them are there, but we are certainly seeing a wealth of information start to emerge now in looking at how we can actually map various health-related benefit issues, and in a broader sense of health, the stress, if I might say, for workers today, and how those things link

to productivity and to health costs.

There is certainly a wide range and growing literature on that topic, and one that I would encourage you to take a look at, if you haven't, because it is certainly going to be an important field over the next decade or so, in my view.

DR. GORDON: Dean?

DR. ORNISH: This is also for Kathy.

When you were at HCFA, one of the major concerns that I found in my dialogues with HCFA was the concern that if they started covering anything other than devices and drugs, and things that they already cover -- not drugs, but devices and procedures and such, that there would be this real problem with fraud and abuse, if they cover any alternative program, they are going to have to cover every alternative program, that everybody is going to hang out a shingle and say, well, I have got whatever program and so you should cover it. They kept talking about a Pandora's box, those kinds of things.

How does that differ in the business community and in group insurance plans that you have talked with, and why is that less of a problem for them? Or, is it

less of a problem for them?

MS. KING: I think some of the issue in Medicare is that Medicare is such a large purchaser that it moves markets. Medicare alone can dramatically change a market. There is no employer that I know of, certainly none who are members of the Business Group, who have 38 million employees. They don't have the same ability.

In Medicare, as you know, there are huge controversies over what should be covered and who should be allowed to provide it because it is such a major market. I think employers, even very large, multi-national employers, are just not playing on that scale.

DR. ORNISH: But clearly, even though the scale is going to be different, the issue would be similar, though. Does this issue even come up with them? And, if so, how do they address it?

DR. KING: It is not an issue that I have heard raised, keeping in mind I have been with the Business Group six months. That could come up.

I also think that public sector programs are subject to much more scrutiny than private employer plans, so they are held to a different standard and there

are hearings and all those kinds of things. I think that is part of what goes on, too.

MR. CHAPPELL: If we are not using these services in the employer groups, there is a need for more education to know what the value is, and it is just helpful to hear the reality of use, of once the benefit is offered, because we need to be concerned about education as much as anything else in our policy-making thought process.

I know that employer programs need to be concerned with wellness as an educational matter, as well as a benefit matter.

DR. GORDON: One question I have is one of the issues that has been coming up consistently is the whole issue of what are the cost benefits or cost effectiveness of different complementary therapies or different comprehensive therapies.

I'm wondering if you have any data or any of you know of any data as the employee benefits plans shift, are you tracking cost savings? Are you tracking the differences in productivity? Are you tracking differences in health status?

MR. SAWYER: I will give that one a go. My experience is that employers are just tiptoeing into that water, as we speak. I have not personally seen what I would think of as good evaluation research in that area on any scale. What I have seen is largely anecdotal studies about employer XYZ doing a study on a specific therapy with a specific back condition, for example. I haven't seen the kind of rigorous studies that need to be done, obviously. So anecdotal research is the current state, in my opinion, that needs to change quite a bit.

One of the other challenges is that, as we look at the bigger picture of productivity in the workplace, I think these kinds of CAM issues take on a totally different perspective. So, to the degree, I think, that we can encourage focus on productivity, rather than looking at just the direct medical cost offset, but on a broader scale look at the productivity cost offset, which from our studies in Mercer indicate that they are about four times larger than the direct medical cost offset, by the way, that there can be a broader picture of what the true cost of having workers that perhaps be better enabled to be productive had they had access to these

kinds of therapies.

DR. GORDON: Let me just throw out something. I would like to hear from the other two of you, as well.

If there were grants, whether it was from NIH or CDC, or somewhere, HCFA, to large employers particularly to do these kinds of studies, do you think that people you represent would welcome this kind of approach?

MR. SAWYER: I, again, will answer very quickly. I think, very quickly, affirmative yes. I personally know of several employers that I have spoken to a great deal in my consulting work about these very issues. The biggest barrier is the lack of funding.

Employers in today's economy, I would say, are reluctant to spend money in order to save money later. They are much more interested in having other groups fund those kinds of studies and then look at being a buyer rather than then being the guinea pig, if I might say it the way.

MS. KING: I agree.

MS. MACPHERSON: I would agree with that.

DR. GORDON: Any other thought? Do you think

that employers who you work for or represent would be open to this kind of study and would be interested in it?

MS. MACPHERSON: I think they would be interested in the results. I don't know how far they would go in participating, I have no idea.

How about your's?

MS. KING: I don't think that there are any standard measures now of employee health and productivity, and the Business Group has formed a council recently of leading disability managers, and disability is probably a misnomer here, because they are really in charge of all absence management in the workplace. So, that is something that they are really interested in doing is developing a standard set of measures by which you can measure health and productivity in the workplace.

I think there are a number of leading employers who would be interested in these kinds of studies.

DR. GORDON: Thank you. Any other questions at this point? Go ahead, Effie.

DR. CHOW: Thank you. I am interested in your comment about, if there is proof that it could help. Are there no statistics about when expending $1 on

prevention, you are saving 15- to $35? Where does CAM come into this? Do you have statistics on that?

I know there are statistics. I don't have it off the top of my head right now, but about 15 years ago it was $1 saves you $3. Now it has gone up to 15- to $30.

MS. KING: I think the data on savings for preventive care vary by type, but those data are mostly collected in the scientific community, not by employers. I think there are things funded by the NIH or academic health centers, rather than research that is done by employers specific to their communities.

DR. CHOW: I think these are in private businesses, major businesses that some of these statistics have come out from, not funded by government.

MS. KING: I'm sorry, I'm not familiar with them.

MS. MACPHERSON: I have heard the statistics, but I don't know where they came from, but I have heard those, yes. I believe that more wellness issues are something that employers could be helping their employees with, just by providing more information. Not all of

them do it. There are different ways of delivering it, too.

DR. CHOW: Because part of the concept of CAM is to prevent disease and not just using CAM as a treatment for disease, it is promoting health, as well.

I'm sorry I can't provide that.

DR. GORDON: Buford?

MR. ROLIN: Thank you. Do you have a recommendation, either of you, how we might encourage or come up with any type of recommendation for employers to consider these alternatives that you have suggested? I notice that you have all given some excellent examples of what is happening, but do you have a specific recommendation for us?

MR. SAWYER: I will venture into that briefly here.

I think one of the kind of key discussion points that has come out through a lot of the testimony that I have heard today is being able to look at CAM benefits that can be packaged, as it were, within the benefit package where providers can be licensed or there is clinically safe and effective treatment.

I would, maybe, suggest that for those therapies that don't fit that kind of packaging, if you will, I am wondering if some sort of, what I would call, a fund that is something like an FSA account, might be looked at, or some other kind of direct contribution by employers for those kinds of therapies that don't fit that kind of packaging, where there is an account with a maximum and a co-pay that can be drawn upon.

I think that kind of approach may offer at least one possibility for allowing employees to access therapies where there may be more limits, per se, since there are not going to be licensed providers, there is not going to be some of the liability concerns that we have talked about.

But, something like that, where information can be packaged around that, that can give employees access to that kind of information.

MS. MACPHERSON: Excuse me, but are you talking about the employer providing? When you said FSA, that is usually employee money.

MS. SAWYER: Right. Correct.

MS. KING: Pre-tax.

MS. MACPHERSON: Yes, pre-tax.

MR. SAWYER: I think there are various ways to establish that. It could be either employee or employer money, or a mix of both, but certainly a funding arrangement with some sort of a cap to it might be one possible way to get at that.

MS. MACPHERSON: Anything you make pre-tax, incidentally, is always popular.

MR. SAWYER: Yes.

MS. MACPHERSON: So, if that came under health benefits and qualified for pre-tax benefits, I think you would see more usage, too.

People want to do it. As with many things, employees want things. They just don't necessarily want to pay for it all, or they don't want to pay the entire cost, but in some cases, they will. As they are with our voluntary program, they pick up the entire cost and it is a post-tax benefit.

DR. GORDON: Charlotte?

MS. KERR: Really just a closing comment. You responded to what I said before about the future and the psychology. I guess what I want to say in response to

what you just said of what you heard and might take away, I want to ask you not to forget what we just said about things like building the community, the dry cleaning, because the lack of community, the lack of third place, I believe that that is going to show up.

We know social alienation, from social epidemiology, indicates more of the incidence of TB than exposure to the organism, and I think that can apply to so many things. So I want to say, please, hold onto this other piece. We are not just talking about modalities, delivery of acupuncture, or some therapy.

The other thing is, just to think about including, for example, CAM practitioners at your decision-making or advisory level, cross-conversations with other disciplines. Bring in the surgeons, bring in the acupuncturists, bring in the whatever, in terms of your visioning for the future of what you want to give the employees. Thank you.

DR. GORDON: Thank you all very much. We appreciate your testimony.

MS. KING: Thank you for inviting us.

MS. MACPHERSON: Yes, thank you very much.

Panel Session V: Health Plan Perspectives

MS. CHANG: Panel Session V will be on health plan perspectives. If Rick Gallion, Dr. John Kelly, and John Weeks could come to the table, please. Thank you.

Presenter: Rick Gallion

MR. GALLION: Good afternoon. My name is Rick Gallion. I am Director of Complementary and Alternative Medicine for Blue Cross and Blue Shield of South Carolina.

I guess you can tell by my title that I have a unique role for an insurance company. My actual job at Blue Cross and Blue Shield of South Carolina is to figure out how complementary therapies fit into our traditional health insurance programs.

I thank you for the opportunity to come before you today. I think you have a very important mission. I think that your work in directing the public policy on CAM initiatives is crucial to the future of our health care.

Whenever I talk about complementary medicine, it is very difficult for me to separate Rick Gallion the

insurance executive from Rick Gallion the advocate for complementary and alternative medicine. I think you will see from my comments that I am a big advocate, but I will try to keep my comments more in line with the insurance companies' perspectives.

What I want to talk to you about in the next few minutes is why Blue Cross and Blue Shield of South Carolina got involved with complementary medicine. I want to talk to you about the three phases of our Natural Blue Program and a little bit about benefit structures and reimbursement methodologies that we are either using or are considering and a couple of comments on future recommendations that your panel can consider in developing your position statements.

First of all, with regards to my comments on why we got involved with CAM. We are the largest insurance company in South Carolina, having 1.3 million customers. We are a consumer-driven company. We listen to our customers. Suffice it to say that a lot of people in South Carolina spend a lot of money on complementary and alternative medicines.

A research paper was done, a joint venture

between one of our hospitals and our university, the University of South Carolina and the Palmetto-Richland Memorial Hospital, very similar to the Eisenberg study that said that over 44 percent of South Carolinians use some type of alternative medicine. Over 52 percent in their lifetime. And 65 percent of these people surveyed say that it is either very effective or effective.

So it is far more than just a trend. People are convinced that CAM therapies work and are willing to pay a lot of money out of pocket to have access to those therapies.

Americans are seeking different, non-invasive approaches to health care. They are interested in living longer and having a better quality of life. The baby boomers are spending a lot of money on wanting to be healthy in their later years of life.

Why did Blue Cross get involved? We feel obligated as the largest insurance company in South Carolina to provide educational assistance to those employees and employers and citizens of the state who are interested in exploring complementary medicine.

We are also very interested in warning them

about the possible interactions with drugs and possible side effects with various things that they can do to their bodies. But the big reason is that we wanted to be different in the marketplace. We wanted to show Blue Cross and Blue Shield of South Carolina is a progressive, forward-thinking company, thinking outside of the box and adding access rather than denying access to health insurance. We are the industry leader and we like being first.

Our goal is to attract more people to our health plan as a result of our progressive approach to considering alternative therapies, and, again, an interest in providing more options that help to promote better health and wellness. The other thing is, thinking about this, we said, these are the reasons why do it, now tell me why not do it.

In considering CAM, some of the things that we thought about is whether we should build the network on our own or should we outsource it. When we thought about adding this program, we said, well, you know, we don't really know how to credential providers, we don't really know what the liability issues are, so we had to decide

whether to build or to outsource it.

We decided to subcontract the network development activities to a company called American Specialty Health, which is an experienced company and has a lot of experience and offer these programs around the country.

The other question that we had is what practitioners should we include in our program. There are hundreds of different practitioners and programs that fit under the category of complementary and alternative medicine. We had to figure out which ones to focus on and why.

The other big thing is what should be the credentialing criteria for those that we decided to focus on. The other point is what is the cost of doing this versus the benefit that we will receive out of doing it. One other issue is do we attract healthy people, which we hope, to our program as a result of implementing CAM programs or do we attract people who are sick, who have not had good experience with the traditional medical model and who is looking for complementary medicine as a last resort. All these things are thoughts that we had

to deal with in considering our program.

The three phases of our program, you have heard discussions about the discounted fee-for-service program, the affinity discount networks. We were one of the first in the country and the first in South Carolina do develop what we call our Natural Blue Program, and I like that name. It is a neat name, isn't it? We were the first. Many Blue Cross Blue Shield plans around the country have adopted that name, but we were the first. If I keep saying we were the first, please excuse me, but we were first in doing a lot of things.

The Natural Blue Holistic Health Choices Program is basically a discounted program, including chiropractors, acupuncturists, massage therapists, and fitness centers, and soon we will be adding registered dieticians to our program.

The other neat thing that we did to improve educational opportunities for our customers is to develop a web-linking agreement to a company who knows a lot more about complementary medicine than we do, where we provide a resource for education where they can look up herbs and nutriceuticals and different forms of alternative

therapies and find out what the research says. We provided a web-link through our website, southcarolinablues.com to healthyroads.com through American Specialty.

The one thing that I want to emphasize here to you, as an insurance company, we realize that everything that everything "natural" is not necessarily safe and we need to inform or customers and the general public of what is out there that may not be in their best interests. That is phase one.

Phase two, and what we are working, on as we speak, is to develop a benefit rider, which we are going to offer to our current customers under one of our HMO products, HMO Blue.

This rider, which will start in June, we are going to be offering direct access to CAM providers, chiropractors, acupuncturists, and massage therapists under a co-pay model where the patient pays a certain amount of money and there is a medical necessity guideline, a maximum number of visits.

My point is these benefit riders are going to be based on the same medical necessity and utilization

and review requirements as our other programs.

The reimbursement model is going to be we are going to pay a company to do this for us, we are going to pay on a per-member per-month basis. They assume the risk. They pay the provider on a fee-for-service type of program. That is phase two, the benefit rider.

We are considering, as we speak, a core benefit model that we are thinking about either putting out under our individual products or as a part of our HMO Blue product, just as a core benefit, again providing direct access, under the same model that I just described where it is a capitated model. We pay a per-member per-month. The company that we subcontract with pays the provider on a fee-for-service basis.

My closing comments. I wish I had 45 minutes to talk about this, but I only 10, so I'm going to summarize my closing comments and my recommendations to you in the next couple of minutes.

I see insurance companies as having a great opportunity to be partners in this initiative of integrating complementary medicine. We have an opportunity to participate in studies to define the

safety standards, to determine medical necessity guidelines, to figure out where the line is drawn between medical necessity and prevention, and to put a price tag on how much prevention is and how much is saved through preventive initiatives.

We have an opportunity to participate in initiatives that answer questions like does it work, how does it work, does it control costs, does it improve the quality of life. Some of the recommendations that I would like to make to you is that when considering CAM and what to do with it, talk to people who use it. We have a vast research body called the general public.

When I introduced Natural Blue, before I did anything, I talked to the practitioner who were using these various forms of therapies and talked to them about the research that they had. I sat in chiropractor's offices, I sat with acupuncturists, I have sat with massage therapists.

I go to a chiropractor, by the way. I had massage therapy last Friday. So, I am a believer in this and I encourage you to talk to the people who are most affected by what your recommendations are.

Finally, employers are looking for lower cost alternatives to offer under their insurance plans which help people and improve their quality of life and to return to their work, their jobs, a lot quicker.

My time is up, so I am going to quit. I thank you.

DR. GORDON: Thank you.

John Kelly.

Presenter: John Kelly, M.D.

DR. KELLY: Mr. Chairman, I am John Kelly. I am Director of Physician Relations for Aetna. On behalf of Aetna, I would like to commend the Commission for this important work.

Aetna is the largest health benefits company in the United States. We provide health benefits and other health-related services, such as pharmacy and dental insurance, to approximately 19 million Americans. Aetna offers a wide variety of health insurance products, including traditional, PPO, HMO, pharmacy, and dental products.

Insurance benefits and the costs of health insurance vary by product type, benefit design,

administrative requirements, financing mechanisms, other factors such as state-specific requirements and individual contract design. As I go through this presentation, I'm going to particularly emphasize the issue of individual contract design.

Members receive a certificate of coverage that specifies what benefits are covered and what services are excluded. A typical certificate of coverage might specify outpatient benefits, inpatient benefits, optional benefits, other riders, deductibles, co-insurance, and exclusions.

Typically, unless specifically stated otherwise in the certificate of coverage, services must be medically necessary for services to be covered. The certificate of coverage would include information regarding how medical necessity is determined. For example, a typical certificate might specify that medically necessary services are services that are appropriate and consistent with the diagnosis in accordance with acceptable medical standards.

Then additional information would be provided, indicating that in determining if a service is medically

necessary we consider the information on the member's health status, reports in peer-reviewed medical literature, reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data, professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment, the opinion of health professionals in the generally recognized health specialty involved, the opinion of the attending physicians, and other relevant information.

A typical certificate of coverage might also specify specific exclusions. For example, the certificate might state that charges and expenses are not covered for services or supplies not medically necessary.

Aetna does not generally provide coverage for complementary and alternative medical services, as these services would not typically meet Aetna's definition of medical necessity. I will add that members have not typically sought to purchase and employers have not typically sought to provide access to coverage for complementary and alternative medical services.

However, if the certificate of coverage explicitly states that coverage for specific complementary and alternative medical services is included, coverage for those services would be provided according to the terms of the certificate of coverage.

Aetna's coverage policy bulletins are used as a guide when determining health care coverage for our members. Coverage policy bulletins are written on specific clinical issues, especially addressing new technologies, new treatment approaches and procedures, but also addressing more traditional approaches.

All of our coverage policy bulletins are available through the open Internet at www.aetna.com. So, they are widely available to those who are members and those who are not.

The coverage policy bulletin is used as a tool to be interpreted in conjunction with the member-specific benefit plan and after consultation with the treating physician. Actual coverage decisions are made on a case-by-case basis.

In the event that a member disagrees with the coverage determination, Aetna provides its members with

the right to appeal the decision. In addition, a member may have an opportunity for an independent external review of coverage denials based on medical necessity when the service in question costs more than a specific dollar amount.

Although insurance coverage, and that means where either the employer, employee, or member actually has arranged for payment mechanisms, although insurance coverage for complementary and alternative medicine is not generally provided to Aetna members, Aetna offers our members reduced rates on alternative therapies and products, including visits to acupuncturists, massage therapists, and nutritional counselors through a program called Natural Alternatives. We have been doing this for a number of years.

Natural Alternatives program participants can also save on vitamins, herbal supplements, books, and other health-related products. This program is, again, described on our website, available for anybody to look to.

As far as this particular program is concerned, Aetna has not evaluated and makes no guarantee regarding

the quality of Natural Alternatives' providers or vendors. Providers or vendors offering reduced rates under this program have not been credentialed or reviewed for quality. We do not have any responsibility to pay or reimburse participants for reduced-rate services received through this program. So if a member chooses to access those services, they pay for them themselves.

Aetna also provides educational information on the subject of complementary and alternative medicine through the Internet to Aetna members and to anyone else who has access to the Internet. This information is available at www.intelihealth.com. Intelihealth includes articles on alternative medicine and alternative medical therapies, as well as commentaries on complementary and alternative medicine from physicians and other experts from the Harvard Medical School.

Intelihealth's "Ask the Doc" provides questions and answers on the topic of alternative health. Intelihealth also provides access to literature searches on complementary and alternative medicine. It also provides information on related resources, such as the National Institutes of Health's National Center for

Complementary and Alternative Medicine and the Alternative Medicine Foundation. We believe that this site is particularly widely used. We have literally millions of individuals who access Intelihealth on a monthly basis. This is certainly one of the popular areas on that.

Aetna does not promote or discourage specific forms of therapy, but Aetna does encourage its members to consult their physician for the advice and care appropriate for their specific medical needs.

Because of the many important and complex issues related to complementary and alternative medicine, Aetna strongly encourages research, especially outcome research regarding complementary and alternative medicine.

Such research will increase our knowledge regarding what works and what doesn't and assist our efforts to identify optimal ways to provide access to health care services, improve quality, and use resources efficiently. Such research will assist health plan efforts to develop and implement effective insurance mechanisms.

I would, again, like to thank you for the opportunity to meet with you, and I wish you success in your important work. Thank you.

DR. GORDON: Thank you.

John Weeks.

Presenter: John Weeks

MR. WEEKS: Thank you, Dr. Gordon and Commissioners, for this opportunity to speak with you. I am not a representative of a plan here. I have been involved as a consultant with a number of health plans and health care organizations. They have been trying to figure out their way into this field.

For the last five years, I have written a newsletter that is kind of an industry letter on what is going on. So I have been following closely the variety of ways that employers and managed care firms, insurers, have attempted to respond to the consumer's need.

My comments, I have written in much more length, and I will have a chance to talk about it here. I wanted to say that it is going to go back and forth, somewhat, between health plan and employers, because as you work in the health plan market, you will hear health

plans say, we respond to employers, and you will hear employers say, well, we are able to do what the health plans offer. So there is kind of chicken-and-egg thing that goes on there.

In the coverage, as you present it to health plans is, are there cost offsets. If there are cost offsets, we can look at this in core benefits. If there are not, we have to look at it as a value-add. We have been talking about this today.

From the employer perspective, the question broadens. You are looking there at health and productivity and you are looking at a much wider set of outcomes. The industry that is involved in this field, by and large, thinks that integrated medicine and complementary medicine is likely to show best the broader set of outcomes.

When you look at things like health and productivity, you are beginning to capture the kinds of things that consumers experience and talked about in building the grassroots movement.

Now, if you are telling Aunt Louise that she ought to try this, it is because you have had a good

outcome yourself. The employer tends to be like the consumer, like an athlete, what I care about is results; that is what is going to get me there. So there is an alignment there between the consumer and the employer.

Really, the fundamental question is, are we paying for the CAM therapies, providers, and approaches at the optimal time and optimal level to maximize the health and well-being of the human beings we are here to serve, and the corollary, are we asking the questions that will allow us to answer that question.

I am going to share with you some observations, then some suggestions. My observations begin on page 2 of my testimony.

First, a fundamental one, which perhaps goes without saying, that we are not going to have optimum integration unless we have optimal reimbursement. Physicians won't recommend therapies that aren't covered, often regardless if they think they are valuable. They just don't want to put their patients through that transition from a reimbursed practice to a non-reimbursed practice. It is a problem that shows up frequently in the integrative clinic environments that are hospital-

funded.

We won't be able to reach major sections of our population if we don't figure out, in the public health arena, for middle class, the working poor, how to cover these things. They just can't pay cash out their pocket, even if they are the most appropriate therapies. So we cannot integrate well unless we answer these questions.

The second major point I would like to make is that most of our reimbursement models, right now, in complementary and alternative medicine are essentially in quarantine. What we have done is we have set up reimbursement strategies, essentially based on their fear-based models.

When chiropractic first came in, as with mental health, it came into practice based on mandates, often. A structure was set up that actually said, well, we don't know about the cost, so let's have separate money. We are not good at managing this internally, so let's outsource the management. We know that our conventional providers are not comfortable with a lot of these therapies, so let's not involve them. Let's create direct access.

In all those ways, we have set up a structure that is a separate economy. It is not integrated. Even when covered, the patient can perceive it as integrated because now their insurance company is involved, but it is fundamentally not. There are some incentive structures in there that keep us from getting answers to these fundamental questions. With policy makers, what you need to do is figure out, okay, how can we get through those structural barriers to answering our questions.

I believe, in the last five years, where we really had active look at the broader CAM approaches, we have begun to see some evidence mounting that there is a good deal of potential here. If you look at the employer interest in coverage -- you have heard some of it here -- this word "potential" comes up. There is a potential, the perceived potential.

Sixty-three percent of the large employers in a Price Waterhouse Cooper study say that they believe that these services could be cost effective. You will see, if you look at my second chart, the Motivations, you will see this belief that we can have some savings and

productivity, belief that we can have savings in other areas. However, the data is not there.

If you look at cost offsets, we now have a series of studies, mainly produced through the CAM networks, who are delivering most of these services, that show that consumers, when asked, will have very high satisfaction, very high, 90 percent plus, perception of helpfulness, and 50 to 65 percent perception that there are at least some diminished use of conventional services and conventional drugs.

What this means, again, is that we are creating an interesting postulate for exploration. There appears to be value here. Are we looking at it?

I think you have gathered, from some of your questions, that employers aren't much looking at it yet. In two studies that I am aware of, the response was that zero employers were looking at it seriously. We have not seen a data set developing inside health plans on their experience. Even at things like utilization, a core question here is not actually offset, but how much is it going to cost us, period, if we include acupuncture in the benefit.

There are those who say that actual utilization data like that is more important to some plans than is efficacy data. In an environment where you have a perception of cost offset, you have very high satisfaction, and you have low utilization, there you have an environment which is a very robust environment for beginning to look at the impact of these therapies on cost.

The data that has emerged, and I speak from Washington State, I was involved with a study there that looked at Primera Blue Cross and group health utilization. It is a fascinating paradox that while satisfaction is very high, perception of helpfulness is high, the utilization is minuscule.

Primera Blue Cross' outside actuary guessed that there would be a 10 percent increase, perhaps, in premium. It was 1 percent, and that includes the cost of outsourcing to the network. In a managed plan under group health, it was less than 1 percent. It was actually half of Primera's.

Again, I mention this to you, that it looks like if a plan gets started by actually approaching a

continuous quality improvement approach, it will have a chance to begin to measure the value before the utilization goes up and becomes problematic at a straight dollar level.

So we have goal where there is a potential of a great amount of value. There is not a heck of a lot of risk, but we are not, at this time, actually creating the information which will allow us to move forward. I should say that the kinds of things that are going on in the community are, there are a robust number and variety of explorations.

We have places where Regence Blue Cross in Washington has got naturopathic physicians as primary care provider gatekeepers. We have no analysis of this data yet. We have integrative clinics inside hospitals, which are working to work in a disease management environment. There is no money to look at what the cost is of those kinds of interventions. We have employers, like right out here, T. Rowe Price has had an acupuncture benefit on the books for the last four years that they have been promoting.

The list goes on of the kinds of things in the

field that are not being analyzed. So, where do we go. My recommendations, which begin on page 19, are four. One, is that we simply need to vastly expand the allotment of federal research and development dollars which directly focus on the interrelated practical questions of third party payment and delivery.

We need to fund demonstration projects. There is a lot being demonstrated, there are a lot of ideas people are concocting that we need to be looking at. We are not looking at them. We will have no learning curve unless we are.

Is that the end of the minute?

DR. GORDON: Yes. We will come back. I am sure people will have questions.

Let's begin with questions.

Panel Discussion

MR. CHAPPELL: Thank you all very much.

Dr. Kelly, I began my young career in Hartford, in the Group Department. The year that the dental product was introduced, and I sold more dental insurance than anyone in the country. So I have a long appreciation and respect for Aetna's background and

commitment to excellence. I know you bring that kind of commitment today. On top of that, your market share, it is quite impressive.

Do you think Aetna would be interested in partnering to penetrate some of these barriers that exist with physicians, with inexperienced practitioners who don't have quite the same experience to know how to develop the evidence-based tests?

The case is clear in the consumer ranks that there is a desire for more of this product, and certainly you would like to transition Natural Alternatives into something that didn't carry a disclaimer.

So, don't you think Aetna would be just a wonderful example of a company that would like to partner and help pioneer some of these breakthroughs?

DR. KELLY: I appreciate the question. I think, as you know, and as the other commissioners may be aware, Aetna has a long tradition of participating in research, developing new products. We fund out some of the research ourselves, and over the last four years, have contributed over $15 million of our own money and brought in another $15 million to fund outcomes research

that we have provided to a number of academic institutions around the country.

In fact, that group is getting together today and tomorrow to design and focus on our next research area. So we have a long tradition of that. We also have a long tradition of collecting and analyzing data to try to evaluate how our members are receiving services and where their health care can be improved.

So part of the reason why I emphasized the Commission encouraging the need for additional research, is that it is really through the kind of research that would emerge from those kinds of efforts that we would have the kind of information that would help us better understand the value of particular services, and then help identify and develop the kind of benefits packages that we could make available to our various members for their consideration.

DR. GORDON: I want to come back, John Weeks, to a recommendation that you were making, a theme that runs through your recommendations, and ask you and the other panelists about health services research.

What kind of research would each of you like to

see done that would help to move ahead the integration of CAM approaches into coverage for everyone?

MR. WEEKS: It is astonishing how simple are some of the kinds of things that people don't know that are getting away, like fundamental utilization. If you offer these services in a certain benefit structure to a given population, how much of it is used. This is a major barrier. It is just a big question mark. So I think that is a core thing.

I believe the richest environment for health services research is to approach this from the kinds of questions that an employer is asking. After all, it is the employer that is going to purchase, and if the employer is saying, does this influence absenteeism; does it influence productivity; does this influence ability to get back to work; does this influence the amount of time I spend at work negotiating my health care benefits.

You see all kinds of questions that are of use to the employer in this global cost of health. I think it is valuable, in part, because it actually agrees with the assertions of the CAM community when this conversation began. It is a global sort of intervention

holism, and it is useful to capture global outcomes.

So I would definitely push things in that direction.

DR. GORDON: Dr. Kelly?

DR. KELLY: Something I think that would be tremendously helpful would be some sort of taxonomy of CAM. I think that there are a whole array of services that go under that broad umbrella, but I think it is just a mistake to think they are all equal. So I think some sort of taxonomy in which we could see what the different CAM services are first.

Second of all, for those different services, many already have a fairly substantial research base; others don't. So it would be very helpful to have access to what research has already been published around tied to that particular taxonomy.

Then third, I think that the research needs, then, are going to vary, depending upon the specific services. So the kind of research that would be, perhaps, helpful in certain areas might be very, very different than other areas.

So I think that a process something like that,

which is what has occurred in some other aspects of health services research, would be tremendously helpful.

DR. GORDON: Could you give an example, or a couple of examples, of the latter?

DR. KELLY: Sure. Several of my colleagues have focused on the issue of chiropractic. There is a tremendous degree of literature now which has emerged around that. I just think it is a mistake to characterize chiropractic in the same environment as, perhaps, as some very non-traditional services that we read about.

And so, I think that to provide access to the information regarding each of those categories and what kind of research would be helpful. Again, as all of the Commissioners are very familiar, even in traditional medicine, what was at times seen as being strange or new, or highly unconventional, over time, with the proper research, is seen as being very effective and very valuable.

So I think that this is really the key. We don't talk about medical care all in a big lump, either. We talk about what is appropriate for a diabetic or a

patient with cardiac disease, what works on the preventive side. Every one of these services needs to be and should be evaluated.

So I would suggest a long-term research strategy around CAM would be tremendously helpful.

DR. GORDON: Rick Gallion.

MR. GALLION: We have been approached, on a few occasions, to participate in research initiatives in South Carolina, and in each situation, we have responded favorably.

One of the initiatives was through the Medical University of South Carolina, Complementary and Alternative Medicine Program, headed by acupuncturist Gary Nessler, who is applying for a grant, an NIH grant, to do some research on acupuncture. We wrote a letter saying, yes, we will support you in any way we can with your initiative.

We also wrote a letter of intent to work with the University of South Carolina on a research initiative dealing with complementary medicines and various forms of arthritis, rheumatoid arthritis, osteoarthritis, fibromyalgia.

So we welcome the opportunities to participate. We have the database and the customers, and the diagnosis data to be effective in assisting with research.

DR. GORDON: Thank you.

Tieraona, George, Joe, and Charlotte.

DR. LOW DOG: Any of you can answer this, but I think, John, you had been talking about the initiatives that have been going on in Washington and utilization and that. I guess my question revolves around consumers want this. And then, are employers wondering if there is increased productivity and fewer absentee workers.

Do you we have the data yet that that is the case, that if you go get a massage, you go to the chiropractor, you miss work less often, or that you are more productive at work? Is the data there, or is this still preliminary, that we are anticipating this is going to be true?

MR. WEEKS: The data that is there is the perception of the users, and the perception of the users will say yes.

I think that what the employer panelist stated earlier, that there is not yet real agreement on the

appropriate metrics for measuring presenteeism and absenteeism in the large employer market. I think it has a place, just helping to move that conversation through some funding.

A lot of people have identified the questions, but we need to get together and figure out, okay, where are we going to start. We have identified what the questions are; we need to figure out what way our approach is going to be.

MR. GALLION: If I may respond to that. One of these things that really interests me is chiropractic, because at one time I didn't understand chiropractic and really didn't understand how it worked to help people.

I did some research of my own to find out if there was any research out there to substantiate the services of chiropractic. I can't remember the study, but the name of the person was Jarvis or something, and his study suggested that chiropractic is a lower-cost alternative to traditional allopathic treatment of low-back pain, and there were some very interesting statistics on how quickly people return to work as a result of chiropractic care versus the traditional

medical model.

One thing that I am working on at Blue Cross Blue Shield of South Carolina, because some of our accounts actually cover chiropractic services, and I want to track, is, if someone chooses the traditional medical model and goes to their family physician, and uses prescription drugs and, perhaps, physical therapy, how much does that cost versus someone who goes the chiropractic route who goes for manipulations to reduce the pain.

The reason why this interested me on a personal note, my wife had low-back pain, and I kind of did my own experiments with my wife to try out alternative medicines to see what works. She went the traditional route, to her family physician, back and forth. She was on the drugs that gave her side effects. She didn't like it. She went to the physical therapy. It helped, but it didn't cure her.

She called me one day, begging for relief, what am I going to do. I said, why don't you try a chiropractor. It was just so amazing to me, because I went with her, and after two visits, her pain was gone.

In my mind, as a health care executive, I am saying, my company is spending all of these dollars where there is no relief given, and then after two visits to this other provider, what is wrong with this picture.

I had to throw that in, I'm sorry.

DR. GORDON: Thank you.

George DeVries.

MR. DeVRIES: A question for John.

John, there is research out there demonstrating safety and efficacy of certain complementary health care modalities, even for specific diagnoses, but the challenge is always, when we talk to health plans, there is the, is this a cost addition or a cost offset; how does it factor out.

So I guess, looking at your comments related to research, related to the cost effectiveness, cost offset of CAM, in other words, looking at what it costs under a basic health care package, and then, what is the cost for that basic health care package if you add acupuncture, chiropractic, or massage. The inherent conclusion being, if it is the same or less, that those members who would have gone to a medical provider have sought care from a

complementary health care provider, and there has been cost offset or cost reduction.

To my understanding, conclusive research in this area is not out there yet. Your thoughts.

MR. WEEKS: First, a point of clarification. There is efficacy data. I don't that the data on health and productivity is out there yet.

Part of my job is to search for this data and report it, and I can tell you that I have spoken with executives of most all of the CAM networks, the leading ones in the country, and put this question to them.

Frankly, there is a pretty frequent set of responses. While we have some things in development with some of our good clients, it is hard to actually keep their attention. We may not have been capturing parallel data inside the network with what the plan is capturing. They have other pressures on their information officers. It is hard to get that time and energy.

It cuts both ways. The dollar value is so small, that they don't really want to pay attention compared to the other kinds of major cost issues that they are encountering.

I do know that there are at least five or six, that I have heard of, applications through the new NCCAM Health Services Research Initiative, which you should all be aware of this last year, to begin to analyze the data and move in on the question.

But no, I don't think it is there. It may be there for chiropractic is some areas, certainly not with acupuncture, massage, naturopathic physician services. I was told that there were 80 expressions of interest in 40 applications for the handful of grants they are going to be letting, which shows the level of interest which is out there, and the kind of scurrying to form partnerships with plans that began to take place all over the country.

So if you make the money available, the work will get done, and we will be able to see what we are doing.

MR. DeVRIES: John, what is your perception of the value of this research, long-term, for CAM?

MR. WEEKS: On, strictly, the health plan perspective, it is the necessary information to cross the chasm. This whole movement will only be consumer-driven, which is fine, but it can only get so far. It will not

be integrated well into payment and delivery unless we have this. It was the question that was in front of us in '96 when the conversation really began. It is the same question with the same limited data set right now.

There are those who believe that one good, large health plan study that is robust enough to capture -- for instance, if you look at Connecticut, there have been mandates around chiropractic and naturopathic physician services for at least 15 years. There is a heck of a lot of experience data there. Washington State, with the mandate, we have got five years.

If we went in and looked at that data thoroughly, had the money to go back and track through the old legacy systems, however we could, we could begin to come up with something that is closer to conclusive to move the conversation.

DR. GORDON: One thing I just wanted to remind the Commissioners of is, I believe we have the David Sobel, which provides some of this data for mind-therapy. So I think it is an important beginning in this area, showing the cost benefits of a number of different mind-body approaches.

Joe Pizzorno.

DR. PIZZORNO: John, at your excellent summit last week, there were two presentations that I thought were quite provocative that did provide some data, the ones from Husky Injection Molding and AMI in Chicago.

Could you relate to us what data they gathered, and what the next step is that needs to be taken in order for that data to have the impact it could potentially have?

MR. WEEKS: The AMI data, both of these I mentioned in the paper as a couple of the examples. Actually, I think I have data from both of them in the book of charts in the back.

The AMI is a very unusual product. It is a chiropractic primary care provider for HMO Illinois, in the Chicago area. There are M.D. medical directors, and there is a network of medical doctors around this plan. Their outcomes, at this point -- I need to caveat this because they have only had 300 lives, and it has only been about two years -- but what they have shown is, for to population that have selected these folks, their prescription drug levels are 40 to 60 percent less, their

hospitalizations are 40 to 60 percent less than the conventional medical population, the normative data from HMO Illinois.

Again, we don't know if this was about the selection, the people that selected this product, or if they actually contributed through their benefit structure to actually diminishing the use of the services, but it is interesting. Again, a great postulate, fascinating.

The Husky Injection Molding is in Canada. It is an on-site integrative clinic for an employer that has expanded services to include an acupuncturist, massage therapist, and a naturopathic physician. They also have a network of complementary providers where there is a benefit of 500- to $1,000, depending on the type, and actually, a supplements that is covered, which is extremely unusual.

They have, through their health and productivity markers, looking at the loss of employees, this whole retention issue, their diminished use of other services, the diminished absenteeism and a quicker return to work, they are estimating something on the order of $8 million of savings per year.

Again, there are a lot of questions that a good researcher would want to ask about this data. What it presents is a very interesting postulate.

DR. GORDON: Charlotte.

SISTER KERR: Mr. Gallion, I really wanted to applaud you for listening to the folks of the coastal empire, and we know South Carolina has a great contribution, historically, to this country. I also want you to know I am totally not biased, even though I am from South Carolina.

Having said that, two things. One, I wanted to know when you began to do that survey, because my own experience with being down there was that we were lagging in complementary medicine. So I wanted to know what year you began to do that.

Then the other was, we had some wonderful input in some of our Town Hall [meetings], specifically New York. I wanted to know what ethnic breakdown was there, particularly the African American community, having a particular richness and expectations in traditional medicine, and also the growing Hispanic community.

I am particularly interested to know if you

might have a unique aspect in your survey in terms of traditional medicine in the Sea Islands that might be a whole other contribution to CAM.

MR. GALLION: The year of the survey done by the University of South Carolina, in conjunction with Palmetto-Richland Memorial Hospital, was 1999. I think it started in '98, and the paper was published in 1999.

SISTER KERR: Did you say '88 or '98?

MR. GALLION: '98, 1998.

With regards to the demographics, the ethnic makeup, according to this survey, most of the people in South Carolina who use complementary therapies were Caucasian, more female than male, and people with higher incomes who could afford to pay the out-of-pocket amounts. Surprisingly, the statistics did not reflect a lot of minority utilization of CAM therapies.

With regards to the Sea Islands Initiatives, I don't have anything on that.

I will be happy to give you a copy of that complete research paper, if you would like that.

DR. GORDON: Wayne.

DR. JONAS: First of all, thank you, John, for

collecting this tremendous amount of information. It will take a while to study it, actually, and also, for asking the question on, what is the important, historic role for the White House Commission, where I see that 76 percent strongly agree, and 28 percent mildly agree, that the Commission will be a positive turning point. So let's hope that that occurs.

I have one simple question, and then one policy question.

Dr. Kelly, is there any CAM benefit, recently, that has gotten the approval of this coverage policy basis on an insurance-wide basis, or a company level that has occurred?

DR. KELLY: Well, I made the distinction between what are covered services, and then what are medically necessary services. I think you are supposed to keep them both in mind.

DR. JONAS: I understand.

DR. KELLY: We do have a coverage policy bulletin on chiropractic services, in which we describe which particular chiropractic services we have identified as being medically necessary, and which we have

identified as not being medically necessary, and that is available on the public Internet.

So for those of our members who have access to chiropractic services, and obviously many do; many others don't, then if they do have access, then we would use that coverage policy to determine under which circumstances chiropractic services would be appropriate, and under which other services they would not be.

So I think that a general comment I would make is two-fold. One is, I think research, as has been discussed here a moment ago, is truly necessary but not sufficient. It is an absolute essential. We have got to have the kind of research to help guide us to know what works and what doesn't.

Then obviously, the follow-up is, as we get that kind of information, then plans, such as mine and Rick's and others, can develop benefits design and coverage policies, and make them available.

Then obviously, the third, which is, what will employers and members agree to purchase, or agree to pay for. Clearly, that is the final test of the marketplace.

The one other comment I would make is that, as

we all know, health care costs are going up at a very rapid rate, even though the economy has been generally strong and employers have continued to offer benefits and make benefits available. We have considerable concern that as employers get hit with increasing costs, which are now truly in the double-digit range, nationwide, that they are increasingly shifting those costs to employers. They are looking to their employees. They are looking at ways of, perhaps, thinning their benefit package.

So I think it is important to keep those kinds of issues in mind as well.

DR. JONAS: Other than chiropractic, the evaluation took quite a long time. It sounds like there aren't any other ways of reaching the gold standard of safety checks with an appropriate --[off mike].

Is that correct?

DR. KELLY: I admit that unlike Rick, I am not an expert in complementary and alternative medicine, and clearly, we do have coverage policies on the public Internet regarding chiropractic, but I am not aware of others that are currently on the public Internet. There may be some which are in development, but just not

available at this point.

DR. JONAS: The other question is, it sounds like there is general agreement that there needs to be more data, and there needs to be more data about some specific items in complementary medicine. There is willingness and interest in collecting that data, and there is the capability to collect that data.

Can you make some suggestions for us, is there anything that we can do from a federal policy perspective to try to catalyze this? And this is for all three of you.

DR. KELLY: Just a quick comment. Clearly, it is possible to do research if there are data available. For example, a plan like my own, we do have information regarding encounters and services that have been provided or received if it is a service which has been paid for in one way or another.

If the service has not been paid for, if it has been paid for by an entirely mechanism, a plan may not have access to that information directly, although there are other indirect ways to get it, through surveys and other kinds of mechanisms.

So I think that there is a very strong appetite within, certainly, an organization like mine, to encourage collection of useful data to help answer some of these important questions.

DR. JONAS: I am asking specifically for a policy. Is there something we can do that could catalyze this interest, which is obviously there and shared by a number of groups? Is there anything that could motivate individuals to begin to collect and assess the impact of these types of services?

MR. GALLION: I would like to comment on that. With my advocate hat on, just for a second, how much data is enough? How much do you need to, really, make a policy decision?

Now, if I could reverse that and put on my insurance executive hat -- well, let me go to my advocate hat one more time. We are not talking about brain surgery. We are not talking about heart transplants and kidney transplants. We are talking about holistic approaches to medicine. We are helping people to look at prevention, and eating better, and exercise, and managing their stress. We are talking about hands-on approaches

to treating people. We are not talking about very complicated medical procedures.

The answer to your question. My recommendation, from a policy standpoint is, in order for this to work, you have to have physicians involved and get their support and their interest in at least participating in research. There will not be an integrative process unless the traditional medical doctor, who is a scientist, has faith in the outcomes of what he prescribes to his patients.

I think if there is enough interest, starting with physician education, to get him interested enough to do research, then we can get involved with a lot of clinical outcomes measurements.

MR. WEEKS: I would like to respond, if I could. Two approaches, I think. One is through AHRQ instead of NCCAM that you set up a fund that you know is X million dollars a year, which goes towards research addressing the health services around payment and delivery.

The delivery issues are important in understanding the payment issues. If you don't create

the integration, you don't create the right referrals. You have got to be working on those. So I think that there needs to be a place where you know there is a good deal of money available that people can be applying for year in and year out.

The other approach I would suggest that I think policy can support is convening the roundtables to get the CAM network executives, the health plan executives, and the representatives of the provider groups together to agree on questions and data that they are going to capture. This actually grew out of the summit network, in the managed care breakout, is, let's agree on what we want to capture; let's all go out and capture it; let's find a third party where we can send the data; and let's then go out and capture it.

There is a problem right now with the data sets, in that, everybody's information systems are different. We need to create the meetings to figure out what we want to do.

DR. GORDON: We have time for one last question. Tieraona is going to have the chance. One thing that I do want to remind everybody of is that we

are going to be looking at health services research more tomorrow and the next day. So we will have an opportunity to go into some of these questions in depth.

DR. LOW DOG: I had just a quick question. One was that it was interesting that chiropractic and acupuncture were covered before registered dieticians, since we talked very much about the role of nutrition, and that, actually, there is a tremendous volume of data about the role of nutrition in disease. So it was interesting to me that that came on, and I am glad. I applaud that you are doing it.

I guess my question is to Aetna. Are registered dieticians covered for most conditions under your plan? I have heard from dieticians that often they are not covered, and that they have been fighting for coverage. That doesn't even seem complementary and alternative to me, working with a largely diabetic population in New Mexico. It just seems like that is just fundamental health care. Yet, we can't even get coverage for that.

So a comment from either one of you. I am curious why it is just now coming onboard, though I am

glad it is, and if you all cover it.

DR. KELLY: I did not come here today, specifically to describe our coverage of dietetic services. I would certainly be happy to get the Commission information regarding that. Obviously, we have, literally, hundreds of thousands of diabetics in our networks, and so we have huge interest in making sure that they have the appropriate information.

I think there is a separate issue, though, about how one actually contracts for having particular services provided, and how one actually gets those paid for. Those are the issues where research identifies the value of certain services.

Then there is a second issue of how health plans actually decide to design benefit structures and arrange for payment, what the health plan pays for, what the insurer pays, what the member pays for, the amounts. Those are some of the more challenging issues.

DR. GORDON: We are really at the end of out time. Thank you all three very much. We really appreciate it.

[Applause.]

DR. GORDON: We will be taking a 15-minute break, and then we will be back for the next panel.

[Recess.]

Panel VI: Special Populations: Minorities, Uninsured and Underinsured

DR. GORDON: This is a panel on Special Populations: Minorities, Uninsured, and Underinsured. We will begin with Nathan Stinson.

Presenter: Nathan Stinson, M.D., Ph.D., M.P.H.

DR. STINSON: Thank you very much. I am Nathan Stinson. I am the deputy assistant secretary for Minority Health in the U.S. Department of Health and Human Services, and I want to thank the Commission for the opportunity to talk about some of the issues around complementary and alternative medicine as it affects racial and ethnic groups in this country.

The Office of Minority Health was created by the U.S. Department Health and Human Services in 1986. The creation of the office was in response to a 1985 report of the Secretary's Task Force on Black and Minority Health. The report analyzed the continuing disparity in health status experienced by African

Americans and other minorities when compared to the population as a whole, as it was reported in 1983 in "Health USA."

The Office of Minority Health advises the Secretary on public health issues, programmatic activities and policy, as it affects African Americans, Latinos, American Indians, Alaskan Natives, Asian American, Native Hawaiian, and Pacific Islanders.

OMH, by nature of where it sits in the Department of Health and Human Services, plays several key roles that are crucial in the Department's ability to address the needs of racial and ethnic groups in this nation. First of all, it plays a role in the development and implementation of health policy as it affects all the agencies in the Department of Health and Human Services.

In addition, the Office of Minority Health receives a direct line-item appropriation from Congress, which allows the Office of Minority Health to directly award grants and contracts to state, local, and community-based organizations to implement programmatic activities around racial and ethnic groups.

What the Office of Minority Health strives to

do is to plug some of the gaps and to get resources to organizations for activities that may not fit squarely within some of the categorical programs within the Department of Health and Human Services and any of the particular agencies.

In addition, the Office of Minority Health operates a resource center, a resource center in the context that it is far more than a clearinghouse where individuals can request publications or documents related to racial and ethnic groups, but where it is more of a minority health portal where individuals who have a broad range of interests in any of the racial and ethnic groups in this nation can contact our resource center. We will provide them with documents. We will do literature search. We will even match them up with academic researchers who have an particular interest in the area of minority health.

So the Office of Minority Health was established based on a clear need. It was based on the realization that there have been health disparities and an unequal burden of illness in racial and ethnic groups in this country for decades, for decades, for decades,

and that it was important to have some type of focus, some type of organizational entity that could perform several different functions, but most importantly, to try to help be some of the glue as the disparate organizational units in the Department implements its varied programs across the board to assure that all the different programs considered and took into account the needs of racial and ethnic groups, as they implemented their programs.

It is clearly our belief, as this nation continues to become more and more diverse, that attention to the health care needs of populations that have an unequal burden is something that is necessary for this nation to remain vital and to remain strong.

One of the important implementation activities of the Department over the past year and a half has been the kickoff of Health People 2010, which we believe is a blueprint for the improvement of the nation as a whole. Healthy People 2010 has two goals, one having to do with a long and healthy life, and the second one is elimination of health disparities.

For the first time in the Healthy People

process, we have established single goals, single targets, for all the different populations. Many of you who are familiar with Healthy People 2000, there were different targets for each of the different racial and ethnic groups.

When we talked about the process for the next decade, we made a very deliberate decision that there should be only one target, because setting different targets, meaning that we were willing to accept a certain level of disparity, and that is absolutely the wrong message that we really need to project to the nation as a whole.

So clearly, one of the departures from the previous Healthy People implementation was the setting of a single goal and single targets. The target, wherever possible, would be better than the best, so that all groups have room for improvement over this next decade.

The second thing that we did is, during the monitoring and the mid-course evaluations, how the nation is doing with health disparities will be part of all of the objective reviews and not grouped into together, as was done in Healthy People 2002, where they had a review

of African Americans and Hispanics, and only looked at it from a population point of view.

There may be those reviews also, but when we talk about diabetes, when we talk about asthma, part of that discussion has to be, how are we doing as far as any disparities that exist. We think that focusing on the needs of special populations all through the process is something that will be necessary to make the progress that we need.

So that is a little background on the Office of Minority Health, how we got established and the vital role that we play in Healthy People 2010, and also the advisory capacity that we have in the Department.

The fundamental question I want to tackle today: Is there a role for complementary and alternative medicine in efforts to eliminate disparity? From our view, the answer is a resounding yes.

As defined by the National Institutes of Health, Center for Complementary Medicine, complementary medicine covers a broad range of healing philosophies, approaches and therapies. Generally, it is defined as those treatments and health care practices not taught

widely in medical schools, not generally used in hospitals, not usually reimbursed by medical insurance companies.

When we have looked at some of the studies that have been conducted on the use of CAM by race and ethnicity, there has been a diversity of opinions and a diversity of results. AHRQ's Medical Expenditure Panel Survey have found the use of CAM medical providers to be lower for Hispanics and African Americans than for whites. The use of chiropractors was also found by the Rand Health Insurance Experiment to be higher for whites than for racial and ethnic minorities.

Conversely, there have been other studies, Walsco and others, that found that, on an overall basis, race and ethnicity were not always predictors of the use of alternative medicine practitioners among clinic attendees. But we have also found that in some of the other studies, in particular populations, some of the studies relating to Mexican Americans and other groups, there has been a higher percentage of use of complementary and alternative medicine providers.

I mention those points because I think it is

really important that when we are talking about the role and influence of CAM with racial and ethnic groups, that we don't over generalize, and that we really do have to look at not only population specifics but also look at what type of therapy, what type of interventions are we specifying at that point in time.

One of the clear issues that we have seen when we look at the role of complementary and alternative medicine, and the special population, is, of course, an issue of funding, an issue of how the services are going to be paid for by the health care system.

As many of you know, many of the racial and ethnic groups have a very high percentage of uninsurance and underinsurance. Some of the procedures that are currently paid for by insurance and Medicare organizations are also some of the procedures that aren't the most commonly used by some of the organizations.

DR. GORDON: We have the testimony. We will come back and be asking you some questions, but we have to ask you to come to a conclusion now. Thank you.

DR. STINSON: Okay. I think the last point I want to make is that there are really three issues for

us:

Number one, the funding, how are the services going to be paid; Number two, the importance that all patients who are utilizing alternative medicine share that information with other providers that they may come into contact with in the health care system.

Number three, the education of health care providers in knowing some of the potential adverse effects of some of the different procedures, meaning, what type of chemicals are in some of the most commonly used remedies; and Number four, how do we work with health care providers to destigmatize individuals who may use complementary and alternative medicine, either before or after they have interacted with the traditional health care system.

Thank you.

DR. GORDON: Thank you very much.

Doriane Miller.

Presenter: Doriane Miller, M.D.

DR. MILLER: Thank you, Mr. Chairman and Commissioners. I am happy to have the opportunity to talk this afternoon about some of the issues that affect

the underinsured, and also uninsured, regarding CAM services.

In the interest of time, you have copies of my testimony in your handouts. I would like to address the question that you have posed to this panel: Are minorities, the uninsured and underinsured more vulnerable to questionable CAM practices. I think that this will be a very good setup for the testimony I will provide you with tomorrow regarding research challenges.

As we see shifts in the demographics of our population, with increased immigration from Asia, Latin America and the Caribbean, people are bringing more traditional health beliefs and practices that include the use of CAM. In addition, some minority groups that are U.S.-born, particularly African Americans, have folk health remedies that have been passed on from generation to generation for treatment of a certain ailment.

I spent many years working in a low-income, inner city clinic in San Francisco where the percentage of uninsured was about 70 percent. Many of my patients were first and second generation migrants from Texas and Louisiana. For some of my older patients, even though

they were U.S.-born, English for them was a second language because they were raised speaking French-Creole.

When some of these patients ran out of money to buy medicine for treatment for their high blood pressure, they turned to drinking garlic juice instead of purchasing a prescribed diuretic or beta blocker.

Clinically, I used this information as a sign that my patients were concerned about their health, and tried to provide them with counsel regarding the effectiveness of their chosen folk remedy where evidence existed, but I also worked even harder to get them the traditional prescribed medicines needed at low or no cost.

To the extent that CAM is a part of one's health beliefs system, these populations may use CAM in conjunction with the use of traditional medical treatments. For those people who lack access to folk remedies for a medication, thinking that treatments are equivalent, this may be of issue.

Lack of widespread knowledge of the efficacy of CAM exists for people of all socioeconomic groups. However, low-income people may be more vulnerable due to

a lack of money to pay for traditional prescribed services. In addition to providing that type of counsel for my patients, we also arranged for services in an integrative medical practice with the American College of Traditional Chinese Medicine on site that was funded through Ryan White monies.

Lack of insurance coverage is a very complex problem. We have over 42 million uninsured in the country, with many people underinsured or having very basic coverage. Skeptics might conclude that this is not a promising time to expand health insurance coverage, and in particular, it may be a very difficult time to increase the coverage of CAM services within those health benefits packages.

The fact that the Congress is evenly split at this point between two parties could force some partisans to seek common ground. The Robert Wood Johnson Foundation has been committed to reducing the number of uninsured since its founding more than 25 years ago. We have invested hundreds of millions of dollars in solving this problem, and will continue to do so.

More than 42 million people in the U.S. lack

basic health insurance. Until the issue of basic health insurance is addressed, the prospects for expansion of CAM coverage may be very poor for the underinsured and uninsured.

Thank you.

DR. GORDON: Thank you. You were very brief, and we will come back and ask for your advice about how to bring this about. Thanks very much.

Daniel Hawkins.

Presenter: Daniel Hawkins

MR. HAWKINS: Good afternoon, Mr. Chair and members of the Commission. My name is Dan Hawkins. I am vice president for Federal and State Affairs, effectively public policy, for the National Association of Community Health Centers.

I thank you very much for the opportunity to dialogue with the Commission this afternoon on health centers, what they are, where they are, who they serve, what services they provide, and their interaction with complementary and alternative medicine across the country.

I have provided a PowerPoint presentation, on

somewhat short notice, for the Commission. I will try to expand briefly upon that in my remarks, and then in the question-and-answer period.

Although health centers have been around for just 35 years -- they celebrated their 35th anniversary just last year -- like so many providers of care to low-income, inner city, rural, and underserved populations, people of color as well, they have a long origin in history that goes back many, many decades prior to that, in particular, for health centers beginning at the turn of the century, with the last great wave of immigration that brought about the development of hospital-based dispensaries, milk clinics, and other systems of care.

However, community health centers as we know them today really have their most recent fundamental origins outside of mainstream health care. I believe that it is because they were founded outside of mainstream health care that they were actually able to be born in the first place, and to survive and thrive over the last 35 years, because they were not squashed by the opposition of organized medicine, as other efforts to provide acute and diagnostic care, and care for chronic

conditions, in underserved populations had been.

They were founded as part of the war on poverty in the civil rights movement of the mid 60s. They were founded to serve a dual purpose, to be agents of care in communities with too little of the same, but also to be agents of change, to truly change the way health care was organized and delivered to populations that had too long stayed outside of the mainstream of health care.

Through unique public and private partnerships with resources provided at the federal level, and increasingly today at the state and local level, by public sources to private, community-owned and -operated organizations to provide care to the communities.

Health centers today, as we know them, embody four fundamental characteristics, and those are what I call the pillars of the health center program, the core elements. They are located in high-need areas, areas designated as medically underserved, or serving populations that are medically underserved, assuring the targeting of those resources on areas of relatively greater need.

They must provide comprehensive primary and

preventive care services, not just medical care but truly care that goes beyond that, including services that facilitate access to care, like outreach and transportation, multilingual and translation services, and services that make effective the health care services that the individuals receive in the health centers, such as health and nutrition education, and other important services as well.

They are open to everyone, and the open-door policy is a critical defining factor for health centers, with services made affordable based on ability to pay. Finally, as I indicated, they are owned and operated by the communities they serve. Thus, at least, much like Winston Churchill said about democracy, it may be the worst system we know of, except for all the others; the best possible mechanism that has been found to try to make sure that these health centers are responsive to the needs of the people and communities they serve.

Today, health centers are the major health care providers. They are what I call the family doctor and health care home for 12 million Americans. Only 4 percent of the population, but within that 4 percent of

the population, they are the family doctor and health care home for one out of every ten uninsured Americans, one of every eight Medicaid recipients, one out of every six low-income children, one out of every five low-income births in this country, one out of every ten rural Americans, and almost 8 million, one out of every ten, people of color in this country, 3 million of whom speak a language other than English in the home.

Health centers have grown pretty dramatically, particularly in the last decade. Now, of the 12 million people that they serve, as you can see from the graph and chart, the uninsured still remain the single largest group of people they serve, more than 40 percent of the population, almost 5 million people.

Studies, over the years, have identified health centers as providing excellent quality care; more effective, more frequent and common use of preventative care; lower infant deaths and lower low-birth weight births for individuals served by health centers when compared with the same type of population served by other providers; higher cost effectiveness; lower rates of referrals and hospitalization; shorter lengths of stay;

substantial savings, on average 30 percent for Medicaid recipients that use health centers compared to other providers, including managed care organizations; and significant community impact, being major employers in the community; helping to stimulate the economy of the often economically devastated inner city and rural communities in which they are located; also, helping to develop community leaders in those communities.

Health centers rely heavily on public support. Public support represents four-fifths of a typical health center's operating budget, even though the federal grant they receive that is the core element of their operation is now, today, only a quarter of their operating budget. In fact, Medicaid is the single largest source of income to health centers today.

They also receive other important forms of support. Dr. Stinson was involved in helping to implement the extension of coverage under the federal Tort Claims Act in lieu of $50 million in wasted malpractice insurance coverage to cover what was, on average, 3- to $4 million in malpractice-related costs for health centers over the years, thus enabling them to

serve an additional half million people with no extra increase in funding or support from other sources, as well as participation in the Vaccines for Children Program, Medicaid enrollment worker outstationing, and exemption from federal, state, and in many cases, local taxes.

The health centers respond to that because they do, obviously, face their accountability requirements by having a patient mix that is unique among most ambulatory care providers, matched only by free clinics and other community clinics, and public hospital emergency room and outpatient department operations, for the portion of their populations that are either publicly insured or totally uninsured.

In fact, with only 6,500 physicians, 1 percent of the practicing physicians in this country, health centers provide one-fifth of all ambulatory care for the uninsured in America. They face many of the same challenges that other safety net providers face, including significant growth in the numbers of uninsured Americans; the continuing effects of welfare reform, now that we are about approach the outer limits of the