Comprehensive Cancer Care: Integrating Complementary & Alternative Therapies
Financing and Insurance: Possibilities and Pitfalls
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Mr. Mayo: Reimbursement is a complex issue, changing frequently based on legislative policy, government regulations, insurance policy limitations and payer requirements. To complicate matters even more, now when evaluating whether to add a complementary service for your patients, it is just as important to know your payer mix economically and to evaluate the following: Place of service, type of service, provider of service (whether it's a physician, an RD, a naturopath), the payer of the service (who is going to pay for this) and then the volume of patients to be served.

What type of progress have we made? Cancer Treatment Centers of America has been involved in this for well over 20 years, so we believe we have some experience. Patients are more involved and demand alternatives. A vast wealth of information is available to everyone on the Internet supporting alternative therapies. There is general acceptance that preventive care is beneficial to the patient and to the payers. Payers are beginning to evaluate across the country medical therapies and treatments which were previously denied. They now realize such treatment may be more cost-effective and patients respond well, a win-win situation for everyone.

There are marketing efforts to connect vitamins and nutrition with medical entities, for instance, Tropicana with the American Heart Association, Florida Citrus Growers with the American Cancer Society. There are marketing efforts to connect foods with preventive

medicine and healthy living, promoting good nutrition. The movement to accept alternative and complementary therapies has taken hold. People look for balance and harmony in their life.

The FDA has approved acupuncture. Washington State, where we have a center, the Seattle Cancer Treatment and Wellness Center, licenses naturopathic physicians as primary care physicians in that state. Washington Blue Cross reimburses through an alternative care IPA for nutrition and dietitian services. In the more traditional sense, bone marrow transplants and high-dose brachytherapy for prostate cancer are increasingly covered by insurance payers.

Drug companies assist providers in getting payment for new drugs, including those of a micronutrient or botanical derivative, leucovorin, FUDR. Leucovorin is a Vitamin B derivative used extensively in the Cancer Treatment Centers of America organization. That is now being paid for and gaining widespread payer acceptance.

Medical records-based software. Technology is being developed which will enable entities to manage data to meet requirements for payers, government entities, compliance issues, medical studies, contract management and a whole host of other areas of outcome concerns. It is extremely important, if you're going to be involved in alternative care, that you have a database of information on what you're doing for your patients, so that even if you're only reporting anecdotal response, you can at least show some examples of the therapeutic value of what you're doing.

What are some of the current obstacles? Medicare does not cover take-home nutritional supplements and drugs. Typically that's a self-pay item for patients. In our organization, regardless of whether the payer pays for it or not, we believe it's important enough in our comprehensive approach to make sure that patients don't suffer from cachexia and malnutrition. If they can't afford it, we give it to them. Some patients are unable to pay for complementary

and alternative therapies. Not only do the insurance companies deny it, but sometimes the patient simply cannot afford to pay for it. There are time delays in obtaining CPT and other codes for treatments and therapies, such as nutrition, yoga, and meditation. There is a lack of documented medical research to support integrated complementary medicine.

This is a cornerstone in Cancer Treatment Centers of America. We document and we publish, good, bad or indifferent, the results of our therapy. There will be some here who say that our studies aren't correct, because, for instance, we did a study on the use of shark cartilage, and published it and presented at the American Society of Clinical Oncology last year. Unfortunately, we used shark cartilage a lot in our organization prior to our study. The study proved that there was no therapeutic value to shark cartilage in most cancers. I'm not saying that it's not a good nutrient. The company that we did the study with finally said it agreed with Cancer Treatment Centers of America's study. We do believe there's therapeutic value in osteopathic diseases.

There is a constant evolving of extensive medical documentation required to support reimbursement of services, while expecting streamlined efficient processes with minimal paper. This is typical of Medicare. They ask for more documentation, or changing documentation. The result is a higher cost to the provider, therefore lower margins. How can we continue to provide this type of care and not be reimbursed for our services?

Mind-body research and other protocols are difficult to fund, and payers are not obligated to cover protocol services. Yoga, meditation, PNI, meaning psychoneuroimmunology, nutrition, acupuncture, massage, research, biological and herbal treatments and therapies are still perceived as non-conventional medical care in the United States. This is slowly changing to some degree,

but believe me, in 20 years of serving cancer patients, it won't be overcome easily. We're making great strides. We'll get there.

What can we do? Get patients and families involved in the process. They can contact state insurance commissioners, attorneys, employers, insurance companies, government officials and community leaders. Verify insurance benefits prior to services, when you have the best chance of having all the parties work together. We've learned this over a period of 20 years. If you verify the insurance benefits up front, get all the parties working together, it's much easier to expect the insurance companies and payers to work with you.

Work together with national organizations (AANP, American Association of Naturopathic Physicians, ACAN, NIH, OAM, NCI, ASCO, ACCC and even the AMA) to overcome obstacles. You've got to get out on their doorstep. Don't expect them to come to you. Go visit them. Tell them what you're doing. Present case studies. Present anecdotal information. If you go to their doorstep they feel much more comfortable. They'll look at your information. Interact with their medical directors. The bottom line is to build and maintain payer relationships.

Go to seminars like this where we all can share in our experiences. Build alliances with health care providers, drug companies, hospitals, and physicians. In our continuum of care, our relationship is not only with alternative care practitioners but also with traditional physicians like our medical director, Dr. R. Michael Williams. Perhaps some of you listened to his presentation. Hospitals. Patients are looking for a continuum of care, not a pillar to post. We know that they're participating in the pillar to post way of receiving therapy today, but that's not what they want. They want it all under one roof, and that's what we try to do in Cancer Treatment Centers of America.

Contain costs. Improve efficiencies. Reduce overhead where feasible. Check into volume discounts and contract purchasing. Invest in information technology. You've got to do it. Invest in maintaining skilled staffing. Hire only the brightest and the best. Don't hire billers and collectors and pay them $5 an hour and expect that you're going to get good work out of them. It isn't going to happen.

I had two case studies. I'm going to use just one of them in the interest of time. This is a CTCA technical and professional case two study. This is a patient with prostate cancer who researched his own disease, as patients typically do, and determined that high-dose rate brachytherapy was the treatment that he wanted. We offer that treatment in our Tulsa facility. His insurance denied it as being experimental. It took nine weeks, but as a result of the combined efforts of the patient and his family, his employer, and the radiation oncologist, we finally got it approved. The patient had it earlier this month and he's doing great. Let's look at the steps that we took to get it approved. It was laborious, but you can't circumvent it. You've got to jump through all the hoops.

Here are the steps that we took. The patient contacted Cancer Treatment Centers of America to request information on the therapy. Our insurance verification staff contacted Blue Cross and confirmed what the patient already was told. High-dose rate brachytherapy was not covered. The patient contacted his employer, family and state insurance commissioner. Our patient accounts staff provided supporting documentation to Blue Cross. The radiation oncologist spoke to Blue Cross's Medical Director. Our oncologist appealed the decision in writing and included several publications, again data, regarding the treatment.

The family sent letters to congressmen and senators in three states. Our patient accounts staff obtained permission from four other patients who had gone through the therapy and had

their insurance companies pay for it, to write letters to Blue Cross. We negotiated a global treatment cost with the employer. The self-insured employer took the matter to their legal department and a decision was reached to instruct Blue Cross to pay for the treatment. It was an arduous task, but the treatment was paid for.

Regretfully, shortly after the treatment started, the patient was notified that his company was downsizing and being sold and switched over to a COBRA plan, which made his wife's plan primary. We took it to his wife's plan and they said, "We'll approve brachytherapy." The end result was good. It was a lot of work. Most would say, "Gosh, that's a lot of work to go through." If you don't go through that you won't get over that hump. You've got to develop the experience. You've got to develop the experience with the payers.

The last thing I'd like to say and leave with you is this important note. Changes in this industry are constant, as all of my colleagues here on the panel will attest to. While it took two months to resolve this issue for the patient, in the end because his primary insurance changed he is not really going to realize any financial benefit from this struggle. However, others facing the same situation in that state, or with the same Blue Cross plan, may. Further, several elected officials have now become aware of the struggles of one man trying to receive less invasive and more cost-effective oncology care than what was previously considered traditional. This small success helped enlighten many. Thank you.

Mr. Pacala: Good afternoon. My name is Mark Pacala. I'm the President of American WholeHealth. We are an outpatient-oriented provider of integrated medical services, predominantly to chronically debilitated patients, but we also are very active in prevention and general wellness. Unlike Cancer Treatment Centers of America, that's been doing integrative

medicine for a long time, and unlike Medtronic, Oxford, or ASHP, that have been around for quite a number of years, we're a very new company. We're two years old. We bring two perspectives. One, we're constantly in the fund-raising, finding equity mode. Two, we're struggling with predominantly a self-pay orientation, and how we bridge financing or funding for our care.

I'll provide an overview of our company history, so you'll understand where we've come from and how we manage reimbursement in our environment. As I said, we're two years old. We were founded in the middle of 1996. We are a private company. We have five integrated clinics today, and I'll talk about our model in just a minute. Our centers are in Chicago, Boston, Greater Washington, DC, and Denver, Colorado. We are running approximately 12 to 15 million dollars in annualized revenue, so we're obviously quite small.

We are venture capital, private equity backed. We have seven private equity investors, all institutional, and we've raised around 26 million dollars in private equity. We are now into the debt markets, and we've just closed on a revolving credit facility between five and 10 million. We're starting to get a little bit more traditional financing in our capital structure, but we're still predominantly private equity backed.

Our strategy is to roll out regionally. That's why we've got four markets. That's as many markets as we plan to be in for the near future. We hope to have 30 to 50 of these centers over the next four to five years. That's our game plan. But we're going to have hopefully 30 to 50 of these centers in eight to 10 cities, as opposed to 30 to 50 of these centers in 30 to 50 cities. We get a lot of scale economies, as Bob does with his consumer marketing, as well as to operate the business.

What makes us different? You're probably asking, "Who are you guys? Integrative clinics, holistic centers have been around for a long time. Why are you different?" We've worked very hard at our clinical practitioner skill base to deliver true integrated management, true case management. So many integrative delivery systems for so many medical establishments, in our experience, give lip service to case management. We really do it, because our product is all about bringing the best of conventional and alternative medicine together to treat the patient through this collaborative team. We have a number of our doctors, physicians, at the conference this weekend. I encourage you all to seek out one of our physicians and understand what our model is all about, because it truly is collaborative.

The second feature of our company that's different is our unrelenting focus on patient service, on the customer coming first. The customer has gotten distorted in the health care world. Many of our brethren conventional establishments view the customer as the health plan. We are trying to turn that on ear and make the health care experience a much more service-oriented, hospitality-centered, customer-comes-first environment. If you can this afternoon or on Monday walk into our Bethesda, Maryland center, hopefully you'll feel like you're walking into a place that really cares about you.

What's our model? We have a core line of business. We are branching out, but our core business is approximately 10,000 square feet of retail oriented, upscale medical facility. We employ the vast majority of our clinical team. A typical model is we have four to five board certified physicians or docs who anchor the practice. They serve as the quarterbacks of the clinical team. Those physicians are surrounded by a bevy of other clinical practitioners, about 15 or 20 other practitioners on a full time basis at one of our centers. So we have around 20 health care professionals treating patients.

We refer to the other services that we provide as the big five. We have more, but the big five services we provide are acupuncture, chiropractic, bodywork (multiple types), nutritional services and behavioral health. We find that when you combine the biochemistry of the body with the biomechanics and the psychology of the mind and the spirit, you can then begin to get at the core root of people's difficulties and start the healing process. We aim to bring all of those specialties under one roof.

Let's go to the purpose of this discussion, which is reimbursement. Today we're running around 15 million dollars in annualized revenue. Almost half of our revenue comes from third party-payment plans. The other half comes from self-pay. We have a significant amount of self-pay, patient pay, in our revenue mix. All of our physicians are in some way, shape or form on medical plan panels. We do not take any capitation today, but we encourage all of our doctors to remain on some sort of contracted, predominantly discount fee-for-service mechanism, at rates and with contracts that we considerable favorable or beneficial.

When we enter a new market, we don't just sign up willy nilly with all the health plans. We are very selective. Some of our other clinical practitioners are also on those plans. Chiropractic services are often reimbursed today. Selectively, acupuncture gets reimbursed. Obviously behavioral health for the most part gets reimbursed. We attempt to get as much third party coverage as we can, the same way as Bob's team.

I don't think we've gone to the lengths that you went through for your cancer patient, but we work very closely with our patients and with their insurance plans to get as much coverage as possible. The patient understands, upon registration with us, that if the coverage is just not there, they are ultimately responsible for payment. You know what? In some cases it's an obstacle,

but most of the time people really do care and are willing to pay for their wellness. That's one of the founding philosophies of our organization.

We do get third party coverage for some of the alternative services on a physician incident to services basis. We can code and reimburse on that basis selectively. Today, as I'm sure you'll hear from these gentlemen, there's very little broad-scale coverage of alternative care. But you can do it on a selective basis like Bob does. Some plans (like Kaiser or Mutual of Omaha) have carved out either certain diagnoses or certain modalities and will reimburse for that. It is very plan and market specific.

Our understanding of where reimbursement is in the continuum is that it's obviously at the very early stage. In our view, very simplistically, we see three stages of reimbursement in the market. Stage one is what we call access. I'll come back to that. Stage two is using a rider, with use restrictions. James Dillard will be able to help us understand this in a few minutes. Stage three is a covered benefit, a fully incorporated covered benefit.

We see rapid growth of stage one, of access products. They are all over the place, either on a self-funded basis or insurance companies looking for a way to differentiate themselves in the marketplace. We are constantly being approached by insurance plans or IPA-type networks that want our centers to participate in those access oriented programs. The patient is primarily still paying, but is accessing a network with credentials.

Stage two is when you have a rider. An insurance plan is covering certain diseases or modalities via a rider, probably with use restrictions. You saw that early on in vision care or in chiropractic. We're just beginning to see that now, but I expect over the next three to five years those stage two riders to really take off.

Stage three, which is a fully incorporated covered benefit, is a number of years away in most markets. In Washington State it's not, because they had a state mandate. But in many markets those covered benefits are just not there yet. Regardless of all that, through patient education and through creative contracting, and then through doggone plain old perseverance, you can get your reimbursement. It's coming. It's not coming as fast as we like, but it is coming. Thanks.

Mr. George: My name is Bill George. I'm Chairman and CEO of Medtronic, which is a company that specializes in cardiovascular and neurological medicine. You may ask why I'm here. The real reason I'm here is to support my wife who was a panelist yesterday, but Jim also asked me to talk as an employer.

We have, cover and insure about 50,000 covered lives among our employees and their families. Our clear goal as an employer is to insure healthy and productive employees both on and off the job, not just to get the lowest cost in our insurance programs. The mission of our company, which was written by our founder 38 years ago, is to restore people to full life and health. We feel that very passionately, and that full life and health can only come through fully integrated life, which involves mind, body, heart and spirit, not just providing highly technical, advanced technology solutions to their issues.

In fact our founder, who retired a number of years ago, has set up a whole life healing center on the Big Island of Hawaii. He is now 73 years old, and he's bringing together the best of Eastern and Western medicine from around the world. He has found some outstanding allopathic physicians as well as eastern physicians representing all of the disciplines which he offers in his center there. He's extremely excited about it as are a lot of other people.

Just so you know my perspective and my bias, I'm also Chair-elect of Allina Health System, Vice Chair at the present time. We have over a million covered lives in our health plan, so we get a chance to look at it from that perspective every day. Finally and most importantly, I've learned the most in the last two years being a support person for my wife, who is recovering from breast cancer. I have seen up close and personal how her recovery has been greatly enhanced by a complete integrated healing plan, which in her case she put together herself. I learned more from that experience than all the rest of the others combined.

The key to obtaining financing is an integrated healing plan. When you talk about alternative plans, it just sounds experimental. You're not going to get coverage from government or health plans. It sounds out of the mainstream, and it sounds, worst of all (I've heard many people speak this way), as if it's in opposition to proven therapies. Complementary therapy sounds better, but I like the word integrated. My thesis is that an integrated healing plan which combines the best healing therapies of all types tailored to the specific patient can, should and must be financed by health plans (whether they be government or private plans), employers and individuals.

Let me repeat that, because I do come to you as an advocate for this approach. An integrated healing plan, which combines the best healing therapies of all types and is tailored specifically to the individual patient, should, will and must be financed by health plans, employers and individuals.

Why is that? This clearly offers the highest possibility of restoration to a healthy productive life for the patient. As an employer, it's the surest return to productivity. We have to look at that. That's why I say we can't just look at the costs. We want our employees fully healthy and back on the job as soon as possible, and only in this integrated approach can you

insure that. Finally, and study after study is showing this now, it's the most cost-effective for the health system. If you start talking about individual therapies, you really have to look at the total cost of the patient to the system. This is the most cost-effective approach.

What is it? An integrated healing plan is an individualized plan developed by the patient, physician and case manager. Patient participation in developing the plan is absolutely critical. Obviously the patient is the one that has to carry out the plan. Each patient should participate in the financing of the plan. There's no free lunch, and I don't believe we should say everything, 100%, is covered. Everyone, unless they have no resources at all, should participate to some extent.

Let's face it. A lot of the therapies are very low cost. I've meditated for 24 years, and that doesn't cost anything, other than maybe a quick session of instruction that might cost $100 or something like that. More importantly than that, psychologically, people support what they help create. It's extremely important that patients not look at their physicians as God but as a partner to help them in their healing. It's important that they develop the plan together and they have ownership for that plan. All the doctors I know complain about people not complying with what they ask them to do. Part of the reason is that they aren't a full participant in developing the plan.

What should be included? I'm pretty liberal about this, but I do believe that all the traditional surgical and adjuvant therapies should. Nutrition and dietary counseling is a must. It's harder to get than you would believe, to find good, solid counseling for dietary and nutritional reasons. Herbal medications, vitamins, which are part and parcel of the approved plans, massage, physical therapy, exercise therapy, all should be an integral part of the plan. It can include acupuncture if indicated.

I feel a stress reduction plan is an integral part of an integrated healing plan, including relaxation therapy, meditation, guided imagery, yoga, biofeedback, energy work, whatever the patient, the case manager and her physician work out. All those things, in one form or another, could be or should be reimbursed. Social support, whether through support groups, spiritual healing opportunities, should be an integral part of this, as well as psychological counseling.

Obviously we need a well-defined base of educational, informational tools, and we need to teach people how to use and access these tools. The Internet has about anything we could possibly want on it today. So many people need to be educated. When they're in the greatest period of stress in their life, it's hard, but they need to be educated, or with a loved one, to know how to access these tools. Again, all these things should be paid for with a patient sharing formula, if it's part of an approved plan.

That plan has to include a timetable and regular checkpoints, so that there is an end point, after which maybe the patient has learned enough about these things to carry on on her own. We're seeing leading plans like Medica in our area, and cancer centers like the Virginia Piper Cancer Institute, moving in the direction of covering these things as well as developing such plans.

I have a few watch outs in thinking about this. This always gets my physician friends angry, but I do think you have to watch out for the tyranny of the drug model, the double blind, randomized, trial. How many more studies do we need to prove that exercise is good for healing? How many do we need to prove that a low fat diet is good for healing? Trying to do some of these things with double blind randomized control is virtually impossible. We're doing subsets.

Yes, of course, if you want to look at various herbal medications you can use a placebo for that kind of study. But when you get into a lot of these social support areas (and we are participating in several studies), I can tell you that they're virtually impossible to do on a double blind randomized basis. You can do them on a control basis, and the kind of studies we're funding are more controlled trials, but even then it's very difficult knowing how to handle the control group. One should never trivialize that. If it is a true randomized study, you have trouble getting physicians. They won't admit it, but there is a bias in selection for the trials and who goes into the trial. They don't want to put a patient into no therapy at all if they believe the patient needs it.

We have to watch out for unapproved excesses by patients, providers and their physicians. That can kill programs like this. We have to look out for unapproved treatments that are too far outside of what is a sound treatment. Most important of all, we need careful supervision through good centers and through a case manager, not just a physician. Physicians don't have time to carry this out. In our particular case we're funding a healing coach at the cancer institute to work with patients in developing these plans.

We do need more controlled studies to prove the cost-effectiveness and clinical benefits as well as the quality of life impact. It's not just mortality. There's a bias in a lot of federal studies to look just at mortality. Quality of life is extremely important, and well-being, as we've heard in every aspect of this conference.

I predict that cancer centers which offer an integrated healing plan and health plans which pay for them are going to be in ascendancy, and those that do not are going to find themselves losing patients and losing covered lives. We're already seeing this happening today. Patient power is on the rise. It is the new wave in medicine. It is the counterpoint to the

excesses of managed care. As has been pointed out by Bob Mayo and Mark, sometimes it's hard to get funding, but we all have to work towards that end.

Furthermore, I believe that oncologists who are not in touch with their patients and in tune with the latest healing therapies are going to find themselves losing patients. All the choice plans are going up, in terms of health plans, and all the closed panel plans are tending downward right now, because patients are choosing to have choice. They're going to choose oncologists who are going to offer them and be sensitive to their whole needs, not just their traditional allopathic needs. I really believe this is the wave of the future. It's going to take, as you've heard from previous speakers, a lot of work to get it done, so let's get on with doing it. Thank you.

Dr. Dillard: I'm James Dillard. I was an acupuncturist and chiropractor before I went to medical school. I trained originally in Los Angeles in chiropractic and acupuncture. I'm the Medical Director for Oxford Health Plans' Alternative Medicine Program. Has anyone heard of Oxford Health Plans? I'm going to be passing a hat later, so if you have any spare change.... Actually, we just got 700 million dollars of capital infusion. We're one of the best capitalized companies in the country right now, so we're okay. The alternative medicine program at Oxford is more than okay. It started in January 1997.

This particular managed care company decided to do this because of personal connections. Our CEO's wife, Catherine Wiggins, was very interested in this. She had worked in the offices of naturopathic physicians in Connecticut, and got Steve involved in this. Steve was looking around for someone to build an alternative medicine delivery system at Oxford. He found my partner, Hassan Rifaat, who is a Harvard graduate and a graduate of UVA Medical

School. He came in and built the program and brought me in, first as the chairman of the chiropractic advisory board and then as the first medical director of the program in October 1996.

It's not a completely unique program. There are other programs around the country that have tried to do this. You're going to be hearing from Dr. Doug Metz in a few minutes. We currently have two million lives insured. We did a survey in 1996 to find out whether or not our membership would be interested in having this kind of a program. It was very similar to the survey that Dr. Eisenberg did at Harvard. We found exactly the same number. One third of Oxford members were already using alternative and complementary techniques.

We took the survey a step further. We asked if they would be interested in having their health plan embrace or deliver alternative or complementary services. 75% of our membership said yes, they would, and they would be willing to pay extra for it. We also went one other step. We asked the benefits administrators of our large employee groups if they would be interested in having this as an aspect of the diversity of offerings to their employees. 85% of benefits administrators told us they were interested in having this option available to their large employee groups. So this became a no-brainer for the company.

We moved forward. We chose six provider types initially. How did we choose these six? We took the top six off the list. The provider types are chiropractic, acupuncture, naturopathic physicians in states in which they are licensed to practice (they are licensed to practice in New Hampshire and Connecticut but not in New York and New Jersey), massage therapists, yoga instructors and diet and nutrition counselors. These are more alternatively oriented diet and nutrition counselors, with a minimum of a master's degree. Many of them are

also RDs, but not just a hospital based RD. This was our original list of six provider types and they are the provider types we have now.

I'm going to talk briefly about access. We have three routes of access to our alternative medicine services. One is through what we call the contracted rate, or what some people may refer to as a discounted fee-for-service. We use that access type for all of our provider types, and specifically for massage therapy, yoga instructors, and diet and nutrition counselors. You can also go to one of our network acupuncturists and pay the Oxford contracted rate as well. That covers all our provider types and it's available to all two million members in the plan.

We also have standard benefits for chiropractic. Chiropractic is the third largest health provider type in the United States. There are 55,000 chiropractors. They are licensed in all 50 states. When many people they talk about alternative and complementary medicine, as David Eisenberg says, there's this elephant in the room that nobody is talking about, and that is the profession of chiropractic. It is the single largest delivery provider type of complementary and alternative services in the country. It's very important for us to understand that.

We have direct benefits. One of the first things we did was say that all of our chiropractors are specialists, just like a neurologist. You get a referral from the primary care physician, and you go see the chiropractor. We will manage the care. They'll send us a care plan and we'll make sure the care is clinically appropriate. That was a major step that we took with that provider type.

There are insurance mandates in 41 states for insurance equality which can be circumvented to a larger or lesser degree. We just had a law passed in the State of New York that is a very strong insurance mandate. Oxford Health Plans is the only health plan in the State of New York that is currently not being sued by the chiropractic professional organizations,

because we were, before the law came out, in full compliance with the law. That's something we're proud of and plan to continue.

So we have the contracted rate, we have standard benefits and we have an alternative medicine rider, which we offer to our groups only, not individuals. For about three to four percent of your premium dollars you can have direct access to acupuncture, chiropractic and naturopathy without a primary care physician's referral. There are other enhanced benefits with that too. That insurance product has sold very well. We've sold approximately twice as much of that alternative medicine rider as we had originally projected.

In terms of cancer therapy, as a plan and as a design for delivering alternative and complementary medicine services, we did not want to embrace a single disease type, in other words a disease management program for cancer. Rather we wanted to increase the access of our membership to these different provider types so that those providers can help them with whatever disease they may have. Our naturopaths, our acupuncturists can help Oxford members create integrative programs. This is all done by provider type, which we think is, at least for now, a simpler way to embrace this.

We have over 3,000 complementary and alternative practitioners in network. It's a pretty big network. We're doing very well. You may know that some companies have come out with very aggressive benefit structures and have had some serious problems. One company in the Midwest was paying for many different modalities and some of the other presenters have made reference to this. They were paying for massage therapy, botanicals, vitamins and a bunch of other things. They found within a year's time that their claims were three times their revenues, which unfortunately is not a good way to do business. We wanted to try to avoid that.

One reference I'll give you is to Ken Pelletier's paper in the *American Journal of Health Promotion* in November of last year, which summarizes what would be at that time the insurance companies and integrative centers in hospitals. Follow-up through the Stanford Center is going to be occurring on that. Ken Pelletier from the Stanford OAM Center is the primary author. I'm not going to say anything else, because I want to leave time for your questions. This is where you really learn something. I'll look forward to those in a moment. Thank you very much.

Mr. Martinez: My name is Tony Martinez. I'm an attorney and lobbyist in the area of health care law, food and drug law. I've been working in this area now for approximately eight years. I know most of you are here because you want to know why therapies aren't getting covered, what we need to do to break the log jam and what have been the experiences of people navigating through the system of insurance.

I'll acknowledge several people who are here at this conference who you can speak to in some of these areas. A colleague of mine, Alan Dumoff, is an attorney who is an expert in this area. Linda Bedell Logan has done some great things in the State of Maine and other states to help improve the insurance laws. Tamara Stuchlak, who has the Alternative Medicine Network here in the Washington area, is helping bridge the gap that's still out there with the lack of coverage.

I have five basic points that everyone needs to appreciate, principles to guide themselves by through the process, particularly if you're a patient faced with cancer and you're in an HMO or an insurance plan that doesn't seem to be very friendly or supportive. 1) An educated consumer is the best patient. This means you take the time to read the contract that your health provider has given to you via your employer, or if you're self-employed. Make sure you read

and understand what your benefits are. Understand and learn how to deal with appeals and grievance procedures. Familiarize yourself, so that should you need to exercise those options you're not starting at ground zero but you at least have some information. Also that will hopefully get you to be a better shopper. If you see that the plan is deficient in certain areas you can certainly approach your employers and tell them to shop around or ask for better coverage.

2) An active participatory patient gets better treatment. You cannot sit back. As my colleague here said, the doctor is not God. Take responsibility for your health, take care and responsibility for your medical treatment. Educate yourself. This is where family and friends can be a great resource. I know this firsthand through my father's own struggle dealing with three different types of cancer. Thank God he's alive. I'm going to go into how we dealt with this in the last five minutes of my talk, because he's also in an HMO.

3) All insurance plans are not created equal. Be a shopper. If you think plans are deficient or lacking in things, start demanding and speak up. Vocalize, get other employees together, start asking for better coverage. The bottom line also is to understand that treatments, particularly alternative and complementary treatments, are not reimbursed because they are not approved. Approval is the golden key that opens the door to getting reimbursement. Unfortunately, complementary and alternative medicine has many barriers to approval, which is another whole discussion.

It's something that everyone needs to be actively involved in. I speak from a political standpoint. We need to be looking at how we can speed the approval process, but also at the same time as a society increase new drug and therapy discoveries. That is something that we are not doing. The level of discovery in this country since the early 1960's has decreased dramatically, and the barriers and the costs have gone up more and more. You're not going to

get rid of the FDA. You've got to engage the Food and Drug Administration. We need to look as a society and begin to ask how are we going to motivate and incentivize research into complementary and alternative medicine and get them approved so that insurance companies will be willing to reimburse for them.

4) Learn how to appeal adverse insurance decisions. Certainly find out. If you have problems, the legal profession is out there to assist people to get relief and to get remedies from unfair treatment. Oftentimes an attorney can serve a very useful purpose. When a company realizes that they may be in for a legal fight over a particular treatment they may be a little bit more willing to come to a more acceptable solution to your particular situation.

5) Get involved to modify laws to improve access and get alternative and complementary treatments approved and also to protect your right to sue. Some of you may not even know that you're in some plans where you have limited or given up your rights to seek legal redress in the courts. It's very important to understand what your rights are and make sure that you protect your rights.

I got involved in this area from a personal standpoint through my father, who is 71 years old and is also an attorney. In December 1994 he was diagnosed with lung cancer, and in the early part of 1995 was also diagnosed with prostate cancer. We were a little bit at our wit's end. My father obviously was very concerned. He was also in an HMO, HIP of New York. We tried to deal with this step by step.

With the prostate cancer my father and I immediately began to review the medical literature to see what were the best therapies. We found that the brachytherapy using palladium seed implants had excellent results. The cost of the treatment is about $10,000. The HIP was willing to give my father the radioactive iodine seed implant, which had a cost of $4,000, but the

research wasn't as impressive or as expansive as for the palladium. We built a case. We prepared the information. I said, "Dad, go in there with this information. Here's the argument." He went in there and got the HIP to pay for the palladium seed implant. He got treatment. My father is fine. That was taken care of.

Also during the process with the prostate cancer, and also having a lung cancer diagnosis, they had they pushed off the prostate cancer treatment. They said, "Let's deal with the lung cancer first." In discussion with other doctors and friends of ours we realized that with surgery and other treatments, you can't leave one cancer alone. You've got to do something about it or at least keep it in check. So my father asked for hormone therapy just as a treatment for the time being, while he was focusing on dealing with the lung cancer.

Originally the doctor was a little bit reluctant to give my father the Lupron, but again, we got assertive. We said it doesn't make any sense. He's going to have all this surgery. Cancer is a crazy disease. We want to at least keep the prostate cancer in check. The oncologist said okay, and they gave my father the Lupron. He dealt with treating his lung cancer, and he had surgery.

When he completed the surgery to remove the tumor, we then were faced with looking at what the other options were. We discovered how poor the numbers of approved treatments were available for lung cancer. I had looked at the studies based on the recommendations that the oncologist made for radiation and chemotherapy. I was not impressed with the data. I also showed my father. As a patient, I got him the drug label information for the drugs that they wanted to give him. After he read them, he said, "Absolutely no way am I going to take that. I'd have better odds playing the lottery." We engaged a cancer treatment information service called Can Help. We sent my father's medical records and they sent us back a report providing

information on every known therapy from conventional to alternative for my father's particular type of cancer, on a worldwide basis.

We discovered that there was a vaccine immunotherapy at Ottawa General Hospital in Canada. I drove my dad up to Ottawa. He got treated with two injections of this material that's made from lung cancer cells. My father was stabilized and did not have any chemotherapy or radiation. Last year when my father had his regular checkups, they found a small nodule again in the lung. He had that removed surgically and he's been using some alternative herbal and botanical treatments to keep the cancer in check.

My father learned as a cancer survivor you sometimes can never get rid of the cancer completely. You're in a process of keeping cancer under control in your body so that you have a quality of life and pretty much a regular life. The whole lesson that we got out of this is that you have to take responsibility for your own care and educate yourself with the medical literature. Ask questions and engage your oncologist. My father's oncologist was amazed when we told him about the vaccine immunotherapy. He had never even heard of this. When we showed him the information, the oncologist said, "Why not?" You're certainly not going to undergo the terrible side effects that you'd be undergoing with the drugs that they were going to recommend. Even though we had to pay for the costs involved out of pocket, it was still important that my father had an option.

I'm also pleased to know from reading a biotechnology company's market letters that a number of companies are developing vaccines for treating cancer. Hopefully they will reach the market. I asked the doctor in Ottawa why this vaccine was not available. He said it's because of our FDA. It's because of the drug approval process. It is so costly to get a cancer drug approved in this country, that even if you get it approved, the average person would not be able to afford it.

Insurance companies have hard economic decisions to make about how they're going to pay for some of these treatments that are so expensive. There's a lot of work to be done. The most important thing is to take responsibility, get educated, be proactive, be assertive and keep the fight for complementary and alternative medicines. There are treatments here that are just waiting to reach the whole mainstream of people. I'm glad to be a part of that effort. Thank you.

One more thing, just as a point of information. The medical use of marijuana and laetrile are not tax-deductible. The IRS passed a regulation a year ago deliberately stating that. A U.S. citizen cannot deduct the cost of medical marijuana or laetrile. That's FYI. My dad is fine.

Dr. Metz: Thank you. Good afternoon everyone. That's an interesting way to end a presentation. It's certainly something of interest to all of us, being in these positions to answer some of the questions that we hear from patients, or employers, or insurance companies, or whomever it is in this milieu.

I want to mention a couple of challenges before I get into talking a little bit about the company that I work for and who I am. One of the challenges that we face, and something that has been brought to my attention at the last four conferences that I have spoken at, relates to an issue that Mr. George raised. That is that the people who need health care reimbursement are not the people who choose the reimbursement system or package which is covering the services that they need to have covered. We all understand what a complex issue that creates for all of us. I always put this back to folks this way. I'm going to take $100 out of your pocket and give it to somebody else to decide how to spend that money either on your behalf or somebody else's behalf.

With all these parties involved in the reimbursement system, part of the challenge is just the way it's concocted, and the way it has developed. Certainly insurance companies, and I am one, or managed care companies, build products that meet the market's expectations. If the market wants a purple widget, then I as an insurance company am going to sell a purple widget. Otherwise I'm not going to be in business.

One of the challenges that we all share is that as we take our political action and our energy out to try to resolve some of these issues, we need to enlighten more of the colleagues of our employer here who spoke today. Employers are asking for, they're the ones that are actually paying for the services. They need to be educated about why they need to pay and buy the services of health plans that cover this stuff. If the employers are a little tight and a little concerned about whether this is effective and why they should cover it, then they're not going to take their hard-earned bottom line and buy insurance benefits for all their employees that cover any of this stuff, despite how great it sounds. It's certainly an education piece that we all have. It's something that I enjoy. It's probably the most exciting piece of what I have done in the last 12 years, being one of the very first chiropractors to get into the insurance industry back in the late 80's as a full time employee, medical director.

One other thing I'd like to begin with in my long introductory comments is a recent conversation with one of the largest employee consultant companies in the country. Do you know who those are? I won't mention who this one is, but they are Mercer and Towers Perrin and Johnson Higgins and the like. The chief medical vice president responsible for quality in this organization said, "When you come and meet with me, make sure you bring me information about cost-effectiveness. I really don't care much about the clinical effectiveness, because I can't sell this to employers unless it's going to be cost-effective."

I'm actually meeting with this person in two weeks to explain why they should talk to their employers about complementary care. This is an interesting bias. Cost-effectiveness is important, and it has been addressed by some of our panelists today. The challenge is that some of the programs that we're talking about through a conference like this are more cost-effective and some of them may not be. The issue is, why isn't the patient the issue, whether it's cost-effective or not, if there's research? This is certainly another issue of education that we all need to work on, especially at the highest levels of the decision-makers in this financial industry.

American Specialty Health Plans is the company I work for. I'm the Vice President for Health Services, and am responsible for all the clinical decision-making in the organization. I want to give you an idea of how another company addresses this issue of reimbursing complementary care, and a couple of comments about how we deal with cancer patients specifically. We're based in California. We primarily provide rider products, as was discussed earlier by Mark Pacala, the second tier typically of integration of these things. We provide primarily rider products for chiropractic and acupuncture to about four million lives in the State of California. Those are managed lives.

We also provide another four to six million lives with discount access programs. These are direct access benefit riders, so the patient in our system does not have to go to the medical doctor to see their chiropractor or acupuncturist. Interestingly, although that works well in California in managed care and it sells well, it flies right in the face of what we've just talked about all weekend long, about integration. It's my biggest issue. One of the hardest things I fight with on the clinical side is making sure that the patient doesn't leave the system to get care and that there are people talking to each other. We'll talk about a couple of the systems we've developed within the rider model that make that possible, because it really is possible.

In addition, we provide coverage for about 700,000 lives in core benefits for Medicare. Interestingly enough, Medicare does not cover acupuncture, for example. However, we sold approximately four months ago our first Medicare rider which covers acupuncture. There are now approximately 20,000 lives, 20,000 people in California who we cover for acupuncture as a Medicare benefit. That's growing. I think it will be big news come next year based on our new contracting plans for this year.

How do we deal with the issue of cancer management in our program? I'm not going to talk a lot about chiropractic. That's my specialty. That's where I got into this, but there's not a lot that would be said for chiropractic necessarily in the management of a cancer patient. However, there is in our system the ability for the chiropractor to be reimbursed if he diagnoses the primary cancer, and if that doctor, chiropractic, for example, sees a patient in a collaborative manner with a medical doctor and does massage therapy or mobilization procedures in a patient who might be post-surgical and having some complications or sequelae from that surgery.

Of interest to me in this is our acupuncture model. We have developed our model to cover conditions that are primarily defined in the core western research, and specifically the NIH study that recently came out. That identifies the potential conditions of pain syndromes. We cover treatment with acupuncture of pain syndromes relative to cancer and other life-threatening illnesses, as well as nausea and vomiting related to chemotherapy. In addition to acupuncture we also have a formulary of 140 traditional Chinese herbs that we actually cover and pay for on the recommendation of licensed acupuncturists.

Our system is built on a network of 600 licensed acupuncturists who have credentials through a system very similar to that defined by NCQA for medical doctors. It makes it easy in California, because acupuncture has a very well defined law and scope of practice in that state.

In other states it's a little tougher to credential acupuncturists because the regulatory milieu is not quite as stringent.

Here's what we've done to help bridge the gap in those situations where, for example, a patient is coming to one of our acupuncturists for let's say treatment of nausea relative to chemotherapy. In order for the treatment to be paid, the acupuncturist submits to us a treatment plan. This is a simple two-page document that defines the patient's clinical findings, their diagnosis, and we use ICD9 diagnoses and the CPT procedures that they're going to use. Upon receipt of that in our office a licensed acupuncturist reviews it.

In that particular case, because the patient is co-managed with the medical doctor, we actually call and contact the PCP, and get the PCP talking with the acupuncturist about the care that's going on. One of the biggest concerns that the buyers of this product have is that the oncology treatment, drugs for example, may have contraindicated effects when mixed with herbal treatments. We don't know that for sure, but that's something that two professionals need to talk about and consider. That's one methodology where we got the medical doctor and the acupuncturist talking together on behalf of the patient to insure that the best appropriate care can be delivered.

In addition, we're working with one of our health plan customers so that every time we have information from an acupuncturist in the field who wants to prescribe herbs, we actually send that patient's name and ID number to them and they download to us the last 120 days of fill date information on pharmacy data. This enables our acupuncturist to compare the pharmacy protocol with the herbs being taken, to evaluate drug interactions. Secondly, it enables us to evaluate whether or not the patient may have a condition for which they're receiving medical care that they had not told the acupuncturist about, which you can tell from the prescription data.

Any of you here who are clinicians know that oftentimes patients are really concerned about telling their MD about the acupuncturist, and they're concerned about telling the acupuncturist about their MD. What we're trying to do is get the two of them talking together so that the patient is not harmed and is benefited in that way. Obviously it's a lot of oversight and a lot to do. If I had all my docs in one place like some of these gentlemen here do, it would make it easier to communicate. But in a network-based managed care model, this is an example of how we have developed a system that integrates even though it's a rider. We have the various professionals talking to each other.

One nice thing about this is that because of our treatment plan requests (our providers hate it because they have to send in information every time they want to treat a patient), I can track outcomes, clinical outcomes, cost outcomes, utilization outcomes, relative to the various treatments. We are actually working with Kaiser, Health Plan of the Redwoods, and Health Net, as examples, to do concurrent quality improvement studies to evaluate the outcomes of patients who seek care only in the medical system and compare that against patients who seek care in the medical system and in the acupuncture, chiropractic rider system. That information is being developed. Hopefully in the next six to eight months we'll have some information that we can begin to publish on this.

There are a lot more things we could all say, but I would like to conclude with one personal comment. I appreciated the comment of our attorney on the panel who said that all insurance companies are not created equal. From a personal side, I can be thankful for that. Two years ago next month I was operated on for a brain tumor. When I was diagnosed in my HMO it was interesting that there was no specialist in that HMO, no surgical specialist, who does this kind of surgery. They referred me out of the plan and actually paid fee-for-service for a

high level, best in the country specialist. As was encouraged by many of the panelists, as we look around, as we encourage our friends, colleagues, and ourselves, certainly we can speak with our choices in the type of insurance and funding that we purchase.

Mr. Carlson: I want to commend the speakers for staying on track and being disciplined. They've all had a lot of experience and have probably a lot more they could have said, but we did want to give the audience an opportunity with the time we had left. I will forewarn the panel that at the end I'll reserve about one minute for each of you for a final comment before we close, if you want to get a jump on thinking about that now. What I ask you in the audience to do is to make these questions, preferably, rather than comments. There is a difference. If you want to direct your question to any one panelist, do so. If you want to make it an open question for one or more, do that as well. Speak as loudly as you can. There is a microphone here. I'll try to referee this process and keep us moving right along.

Participant: Let's say the patient has chronic pain syndrome, and the acupuncturist sends in the plan of care saying that in their educated opinion it would be appropriate for this patient to have 15 treatments of acupuncture before they would reach maximum medical improvement. Do you in fact always make a counter offer? Or how often do you make a counter offer, and say it's inappropriate to have 12 treatments? Or it's more important to have eight? And how does that skew the data coming out of the insurance company when insurance companies tend to come down (this is my experience anyway) from what the practitioner in his or her educated opinion feels is appropriate? How does that skew the data in the long run, when 12 visits did in fact

resolve that patient's care, but the insurance company only paid for eight, and the last four visits were paid out of pocket and weren't included in that data? Am I making that clear?

Panelist: Perfectly. That's a very good question. I'll give you the managed care party line.

Mr. Martinez: She didn't introduce herself. That's Linda Bedell Logan, one of the people I mentioned. Alan Dumoff is also here in the audience.

Dr. Metz: I'll mention a couple of issues real briefly. When we receive a treatment plan from our acupuncturists, they give us an ICD9 code, like chronic fatigue syndrome, that we use for claim payment. However, all case management is done based on TCM findings, chi deficiency, blood stagnation, whatever. The decisions that are made within the health plan are made by licensed acupuncturists. If an appeal is overturned, for example, a request for 15 visits is brought and it is decided that we feel eight visits is ... *(The remainder of Dr. Metz's comment was not recorded.)*

Dr. Dillard: We had a research program with David Eisenberg's group at Harvard which was based upon a direct survey of our practitioners and our members at the time of the office visit. That data is much cleaner data than what you're going to get from claims data or from care plan submission data. Claims data and care plan submission data is necessary for companies, but if you really want to know what's going on you have to use very exquisitely designed research tools. That distinction has to be kept in mind.

Participant: My question is directed at Doug and James. I'm wondering what initiatives, if any, your organizations take in fostering education between your different care providers so that they have a good understanding of what each does, so that they can truly provide integrated service?

Dr. Metz: I'll give you a start. We have not done a lot. Until a year ago, our company was not integrative. We were chiropractic only for 10 years. We have begun to educate the medical community in California through a very small, drop-in-the-bucket start. This is not an advertisement by the way. In September of this year we are holding a conference in conjunction with Stanford University to present complementary care, how to do it, research, how to integrate, how to talk to each other and how to share information, for about 500-600 medical doctors from across the state who are plan participants in many of our customers. That's how we're beginning to do that process. Dr. Dillard may have other ways that they've done it as well.

Mr. Mayo: Not from an insurance standpoint, certainly, but certainly from a provider standpoint, I'd like to say that Cancer Treatment Centers of America has been providing integrated care for almost 20 years, long before the perils of dealing with insurance companies came into play. Even as we work through those perils, what we have always stayed true to in terms of our philosophy is know what your customer wants and is prepared to pay for. If your customer can't pay for it, find a way to provide it.

In our organization (unlike people who are less integrated by nature of the fact that they deal with networks or they are insurance providers), we can provide those comprehensive

services, because in a truly integrated approach one of the disciplines can make up for the cost of another discipline that isn't provided. For instance, in a truly integrated approach, if they're receiving some traditional therapy, we can provide the nutritional support, the psychological support and the spiritual support without charging for them because there's enough profitability in the traditional side to make up for those that they aren't getting.

Panelist: There's one other source I want to give you for the public. Former congressman Berkley Bedell has set up an alternative medicine foundation, and the purpose of it is to go out there and collect and gather information about these treatments so that any member of the public and insurance companies can get access to information and experiences that are going on out there. He's here at this conference. I suggest that you approach him and engage him if you have more questions, if you're interested.

Dr. Dillard: Regarding education let me give you a quick answer. We have education programs that are run regionally in each of our areas. We have network providers come in and speak to employee groups to tell them more about what a massage therapist is, what an acupuncturist is, what you can get out of the yoga class. That's a grass roots effort using our providers, using our employee groups, that goes on every day at Oxford at the level of the work site.

We also had a big conference early last October. We had David Eisenberg. We had Scott Haldeman, an MD, DC and PhD speak on chiropractic. We had Tiffany Field from the University of Miami talk about massage therapy. We had Bill Prensky, the chair of our

acupuncture board. That was for our primary care physicians, so this is the sort of thing we've done.

Let me say one thing about integration that's going to be a slightly different story. When we first built this program, we wanted our providers to send reports to the primary care physicians. We wanted to create actual structures for sending information back and forth, sharing of data between the primary care physicians and the CAM providers. We found out that not only did the primary care physicians not want those reports, because they were afraid of the legal exposure for having those reports in their files, but also our members didn't want us to tell their primary care physician that they were seeing an acupuncturist. This was the overwhelming response.

So when we all talk about integration, we have to remember that it doesn't necessarily fit into the nice models that people talk about in conferences. There are real people out there who have their own ideas about what they want, and ultimately they will drive the system. They should drive the system. It's our job to respond to that. That's what we had to do at Oxford.

Participant: This is for Doug and Jim, and also Robert Mayo, all of you really. This is a question I brought up in the consumer advocacy session. I'm 68 years old. I'm on Medicare and right now AARP Medigap policy. The feeling I have is that if I were to show up with a life-threatening disease like cancer, I would not be able to get the kind of care, although I'm paying a large share of my budget, because I'm poor, for that Medigap insurance. Would any of you be able to suggest what you think I could do as an alternative, as a Washington, DC resident, who would like to have a policy that covers alternative therapy?

Would it be one of those HMOs? If I were to show up with cancer and go to your organization, Cancer Care – I did get some materials from you before, because of a friend of mine. What you just said frightened me a little. I would have to consent to have conventional therapy, which I might not believe in. I might think chemo and radiation and all of those things are toxic, dangerous and don't really help. From some of the things I've been hearing at this conference, they don't really improve survival rates. What if I didn't want those? What if I wanted to try Coenzyme Q_{10}, let's say, and just Coenzyme Q_{10} at the higher doses and see what that would do? Would I be able to go to your center and get that, if I have no money, if I'm really dirt poor? That's the question.

Mr. Mayo: The answer is yes, you would be able to. You'd be primarily treated on an outpatient basis. As you all know, Dr. Patrick Quillin is the director of our nutritional programs for Cancer Treatment Centers of America. He obviously believes in the use of Coenzyme Q_{10} and a number of what we think to be not only adjunctive but therapeutic nutritional interventions. Those would be provided to you on an outpatient basis. You would get the nutritional counseling, and you would get all of the other adjunctive services as well.

Some of them would be self-pay items and others would be covered by third party reimbursement. Some may be even covered by Medicare. Think of our Medicare this way, when you're talking to your legislators. Medicare is the only program in the government that is treated the way it is. Let's take food stamps for example. If a person goes to the grocery store and puts $50 worth of groceries in their basket and they go to the check out stand and they only have $25 worth of food stamps, what do you think is going to happen to them? Do you think the

grocery store guy is going to give them the $50 worth of food? No. He's going to ask them to either come up with $25 or put $25 worth of groceries back on the shelves.

In the Medicare system, they don't even allow you, if you are a Medicare patient, to pay for those items which they will not pay for. That's the fact of life. If our organization is a Medicare subscriber, we cannot allow you to self-pay certain items in our program. The government says you can't do that. That's the difference between how the government treats the program. If there are any practitioners out there, you'll know that I'm telling the absolute truth. It's the only system treated that way.

Mr. Carlson: Are there any further comments on this question? Otherwise I'd like to get three more questions from the audience before we conclude.

Participant: Rick, I wonder what your thoughts are, and anyone else, on the five to ten-year future of HMOs. Since we're talking financing, I haven't heard anything about medical savings accounts. I also wonder what your thoughts are on that.

Mr. Carlson: I'll be very brief. We've been engaged in about a 20-year experience with managed care firms, with HMOs, and a good deal, interestingly enough, has been accomplished. Protocols have been developed, guidelines have been developed and there is arguably less cost in the system than there might have been. But whether you think badly or well of HMOs, or what your philosophical or political position on HMOs may or may not be, the business model that lies beneath them is deeply flawed and it won't survive. The experiment is largely over. The fundamentals – how you pay for, how you deliver care, what patients need, what their demands

are, what providers' needs and requirements are – all remain, but we're going to reshuffle the deck in terms of the organizations that provide that care.

We're moving back powerfully to an insurance model. As of 20 years ago when you got it from Cigna or Prudential or Aetna, within a few more years there will only be five big insurance companies. They'll be very remote and distant from you. They will not be tightly integrated, local neighborhood HMOs. The business model doesn't work. The primary reason is that we put so much proprietary private money into the system that the people who really own the health plans are distant investors. Those distant investors are not making enough money off the model, so the model is so flawed that it has to fall as a business. The change will be brought about not so much because of unrest on the part of members or doctors, but that those who own the HMO simply cannot drive them effectively as businesses any more. That's an unusual comment perhaps.

Mr. Martinez: No I want to jump in. I find those comments very interesting. I think we're headed for some kind of major meltdown transformation in this whole area. I like the model of medical savings accounts because that is at least one area where the individual can have more control and self direction as to what services they're going to access and what they're going to pay for. Ultimately as a society we are going to have to make a choice because of the political debate. Do we go to a nationalized health care system, as some people would like, that would give everybody access? Or are we going to go to a model where people are given greater control over their health care spending dollars? It's going to be interesting to see what's going to come from that.

Mr. Carlson: I'll add a quick footnote, because obviously in a very limited answer from that it could be misleading. You're seeing innovation here. The organizations represented on this panel, including the employer representative, Bill George, are where the innovation is occurring in health care, with these kinds of organizations who are struggling with dealing with your needs and still trying to build businesses at the same time.

There are startups here. They're very entrepreneurial. Oxford had its hard times, but it was the most entrepreneurial, marketing oriented, consumer responsive HMO. It ran into difficulty. It may well survive that difficulty. The organizations you know of as HMOs today probably will not survive. There's a great deal of innovation occurring in the system nevertheless, so it's a complex question.

The bottom line to Bill's question is the business model. You build an HMO, and then you take the only product you have, which is medical care, and you put the risk out into the network where the doctors are. You basically outsource the only product you own. What justification do you have for hanging on to 12 cents on the dollar of the premium if you've outsourced your only product to the network?

The action right now is on the provider side. That constituency has basically begun to take control back in the managed care marketplace. As a result, HMOs are going to have a hard time justifying hanging onto that 12 cents administrative fee, because they don't add value to you. The value is sitting out in the network where the doctors are. The innovation is occurring out there, by and large, not within the health plan.

When I say the business model is flawed, it's largely flawed because you can't make enough money off them, the owners aren't making enough money off them. They can put their money somewhere else. So the capital will flee the market. At the same time, the plans, to try to

hold on to that 12 cents, have got to figure out how they can justify to you the members what they're doing with it. That's a hard case to make. That's a little bit of amplification. It may help.

Participant: Rick, would you say the same thing about the not-for-profit HMOs?

Mr. Carlson: No, where the interesting innovation is occurring is not only with groups like this but in the not-for-profit integrated hospital systems. There's more innovation occurring in that part of the marketplace right now. They're closer to you because they're community hospitals and you're their patients. They're also more receptive to innovation, interestingly enough. Health plans are in a very defensive, reflexive place right now because they're not making enough money.

Participant: Are you taking any risk of service delivery along the lines of capitation?

Mr. Pacala: We're not taking any risks now. We are getting ready to do that if we have to go that way. We're not doing double blind clinical trials but we're doing a functional status assessment, it's an SF36 on everybody. We'll need to partner with some of the other people on this panel to help us get better information, because we do have, along with Bob, a very integrative approach, and we do sort of control a lot of the medical care delivery.

But I echo completely what Rick is saying. You're going to see the risk absorbed somewhere else, but you're going to see total fragmentation and a movement back toward more of a fee-for-service, out of network environment where there's a lot more choice. That choice is

going to involve what Mr. George is saying, patients absorbing more of the cost. It has to be that way. The days of the entitlement mentality are over. In Linda's question, the plan is paying for eight treatments and the patient has to pay for the other four. I think that's a pretty good balance, frankly. That doesn't bother me one bit. That's a great model if he could capture the 12 visits in his outcomes information. Why not have the patient pay a third or 25%?

Mr. Martinez: Mark, right along the same line, to add to that, we need to have the kind of tax laws and laws in place that will foster exactly what the people here on the panel are talking about. We have not reached that point yet. There's a lot of work that has to be done, but it's encouraging that it's going on right now.

Panelist: What you will be seeing in the next few years is that health plans will tell you about pharmacy that you will have a defined contribution, not a defined benefit. In the future what will happen with pharmacy is they'll say, "You have $500 to spend. You have to decide how to spend it. That's all we're going to pay." It's going to shift the financial burden to you. You're going to have to know a whole lot more about medications than you currently do, of the conventional sort as well as the unconventional sort, because it will be your money for $501 and beyond. That's a cost control mechanism, but it's going to happen. It shifts more of the burden to you, as an example.

Participant: I'm a physician who started my professional life as massage therapist. My husband and I have a private practice and we provide holistic medicine. 75% of our folks have cancer. We do an intake that is a biopsychosocial-spiritual intake. We spend an hour-and-a-half,

and we really look at all these as well as follow-up. It is very individualized. It's based on where the patient is at the time. They might need spiritual counseling. They might need some emotional work. They might need nutritional counseling. First of all, with Medicare it's impossible to code this. We've tried to do multiple codes and it's rejected.

Mr. Mayo: Be very careful with coding.

Participant: We understand that, but there's still another paradigm shift that needs to happen if you're a physician or some other practitioner who is really doing a holistic integrative approach, seeing the person as a whole person. You're not just doing one thing. You're doing a lot of education. You're not doing really technical procedures, but you are doing procedures. I'd appreciate any guidance as to how to deal with that.

Mr. Mayo: We've developed some evaluation and management guidelines for physicians that help through the Medicare process. I've got some examples of that for you to take back to your office, that tell you how to deal for the physician, the nutritionist, etc. If you'd like copies of those guidelines I'll give them to you.

Mr. Carlson: Any other comments?

Panelist: One briefly. I think it was addressed from the podium yesterday that our general research study approach homogenizes all patients into this great mob of people. That's how we do outcome studies. We measure 1000 people and see what happens in percentages of

those 1000 people. Our actuarial assumptions are exactly the same. We look at large populations.

The entire system as it's currently created doesn't lend itself to individual care, except at the level of the doctor/patient interface. This goes specifically to the comments that were made by our moderator, that one of the challenges that HMOs and reimbursement systems in general have is that the way the system is going, in dealing with large numbers of people, is different than what many patients are looking for. They know they're not 1000 people. I'm just one person. I want care for one person. I can't imagine that you don't have problems, because the system isn't built to manage that kind of a relationship.

Mr. Mayo: To answer your question specifically, what you just described in your and your husband's practice (this is going to sound like a plug, which it is) is a mini version of what we do, and the reason we do spend an hour with the patient. One of our physicians is in the room here. The only way we get that reimbursed is half of it comes out of the patient's pocket and the other half comes from a third party reimbursement plan. Medicare is the snakiest, most quicksand-laden area there is. We struggle with it on a weekly basis, how to educate the coding issue. It's not all or nothing. It's not all reimburse or not. You've got to engage your patient in their self-funding process.

Mr. Carlson: I'll take one more question, and then I'd like to ask the panelists after this question each to provide a final comment.

Participant: My question is to Bill George. Bill, I see you as a very enlightened consumer. I emphasize consumer because it's clear that industry is the largest purchaser of health care. I have to congratulate them on one hand (even with all of the HMO problems that we face and the problems of providing care), because it's through what employers demanded that we have the changes coming about, that's allowing an opportunity for us to even be here talking about the potential of integrating into traditional treatment. We as the health care providers didn't change the system. You're also enlightened because of your own personal experiences in the board seats with Allina.

Is there a new purple widget to define, as Doug was mentioning? They'll provide what you want to buy. Do you see, besides a product that says employers need to cost share more, a different product? Another question is as an organization do you calculate the total cost of an employee or a family member's illness to your organization, not just the health insurance premium cost?

Mr. George: We're entirely self-insured. Over the last 10 years we've held our increases in health care costs for our employees to about 3.5% per annum. We do that with a whole variety of mechanisms that are on the preventative side. We do a tremendous amount of prevention, with fitness centers, noontime luncheons, and education sessions. We don't permit anyone to smoke in any parking lot in our company. No one can smoke anywhere on the property. We have to actually ask people to leave the property if they're smoking out in their cars. We're pretty tough about it. We'll pay any amount of money for a smoking cessation class. We'll spend any amount of money you want on diet and nutrition classes if you're prepared to spend your time doing that.

I'm going to use up my final comment now. If Rick is right, and managed care is phasing out as we know it today, and I think he is, I sure hope that the answer is not to go to these big insurance companies. That's an anathema to me. Employers have to take more responsibility and patients have to. We have to spend a lot more time, money and energy educating people (in our case employees, but let's say people) about taking full responsibility for their disease and their life. Why not put $1,000 into something if it's your life? You go out and buy a car for $20,000. Why not put it into your life? We've got to get away from this entitlement mentality. Employers have to start recognizing their responsibility for this whole field and not just abdicate. I do feel there is a lot of creativity in this room. I'd like to see much more direct contracting. That's where I come out.

Mr. Carlson: We'll take that as your final comment. Bob, do you want to start out and we'll go right down with a final comment.

Mr. Mayo: We've got a dual audience here. We've got providers of care and we've got consumers of care. If you're a consumer of care, I suggest that in dealing with the providers you insist on a provider that not only provides a comprehensive integrative approach towards any disease, but also a provider that has taken the lead in developing clinical guidelines and critical pathways for treatment of your specific ailment. The reason I say that is that as a provider who deals with specific ailments, they've really got to know what their treatment plan is going to look like for you. It can't be all over the board. Beware of people who are all over the board with respect to treatment plans, whether it's alternative or integrated. Make sure they have treatment plans in place.

If you are a provider of services, I can tell you that through the development of clinical guidelines, critical pathways (not those that are designed by the NCCN, but those that indicate how you practice medicine), and if you adhere to those guidelines, you'll find it much easier to deal with the payers, because you will have the data that suggests that you're getting results. A lot of alternative care physicians are too consumed with trying to help people to spend time gathering data. But it's critical in terms of reimbursement, if you're going to survive in this arena.

Mr. Pacala: On the specific topic of reimbursement for integrative health services, there's reason for great hope. Forces and momentum are on our side. We are a small company in the private sector and we must deliver a return on capital for our investors. That's a fact of life. So we've got to figure out a way to work with this Byzantine system that's moving slowly, but nevertheless in the right direction. That's why half of our reimbursement is traditional third party-pay and half of it's self-pay.

In every one of your markets, the situation and the conditions are just a little bit different. It will be a checkerboard for any of you to get this stuff covered, whether you're a consumer (like the woman trying to figure out how to get her coverage paid under Medicare), or for any of you who are trying to get reimbursed as a provider. But it is out there if you're creative, and if you push and have real tenacity. Then have a lot of hope and prayer and we'll all get there.

Dr. Dillard: This is an interesting time of crisis and opportunity in health care delivery. Not only do a lot of those traditional third party-paying systems seem to be coming apart

(including my own personal company, which is still with us), but also these innovative consumer driven models are being built. I do believe a lot of shake-out is going to occur.

I don't think that management of care is going to go away. Ultimately there's going to be a need for that, because we're spending approximately 16% of the gross national product on health care. I don't think anybody believes that we're going to be able to take all the need for inspection of appropriateness of services away. I agree that doing that more on a local level makes a lot more sense.

I finalize this by saying I believe that any health care delivery system, be it a hospital, an insurance company, or even a state, local or federal government, that fails to embrace appropriate delivery of CAM services in the next few years will be uncompetitive. I absolutely believe that, and I think that most of the people in this room would agree with that. It's just a matter of who is going to build the most intelligent widget.

Mr. Martinez: Two final comments, one echoing Bill George. We need, again, as a society, to get out of this entitlement mentality, because we actually don't have a choice. That's headed to a melt down with entitlements. Moreover, I'm going to throw out an adage that Adam Smith put out there that may draw some inspiration and motivation for us. That is that the market always works. If you don't like your results, change your incentives. That's what we need to be focusing on so that the marketplace is incentivized, so that we can be delivering the kind of results, creating the kind of results that we'd all like.

Dr. Metz: I appreciate your attention today. Three brief comments. First, to the patients and the advocates in the audience and on the panel, we need to continue to make noise and

educate those who need to know with good education, good clear information. For the providers, an encouragement to stick with it. I started in managed care over 15 years ago and I was looked at with a jaundiced eye. A chiropractor in the medical world, that was really bad. Now we're a novelty, this is kind of neat, and more people are interested. If we continue to help our patients make that noise, more decision-makers will move in a direction that's positive for patients. For the health plan side, an adage that a friend of mine told me many years ago is that good money follows good service. If we continue as industry to provide good, high quality service, then we'll have the business that we need to stay in business.

Mr. Carlson: I'll offer one last comment. It's appropriate to be fair to HMOs a little bit. Our intention when we designed the original HMO legislation and package some 25 years ago is really being manifested by the comments that have been made here. Our clear thinking (which turned out to be wrong) was that if you created organizations that were vertically integrated, and they were sensitive to the needs and demands of their members, they would in fact respond based on those market mechanisms. The model was built with the expectation that you would enlighten and inform and drive demand up. That was what was designed into them originally.

They got held hostage over the last 20 years by other forces. I would remind you also that when the HMO act was passed in 1971, the amount of medical care that consumed the gross domestic product was 5.6%. The notion was that there would be cost containing mechanisms, but we didn't have the alarm and panic factors in place that ensued some 15 or 20 years later which have driven them to become basically managers of cost, not managers of care. As they focused on managing cost, they've completely lost track and lost touch with their members. They don't respond to upward pressure very much at all. They are focused largely as actuarial

organizations. They're simply moving money and paper. They're becoming what they were an antidote to, which is big insurance companies. That's part of the model I think will largely fail.

A comment related to that is that unlike the situation 20 years ago when we believed that members of health plans would have information and drive demand, today the amount of information and the access we have to information is profoundly greater than it was 20 years ago. There's no question that the amount of information people have access to, through the Internet and otherwise, is vastly greater than we could have ever anticipated 20 years ago. That information is wildly variable in its quality, integrity and reliability, but there's a great deal of it.

A lot of the questions that have arisen from this group today were rooted in your access to information which 15 or even five years ago you wouldn't have had access to. However, I would also remind everybody that like money, information is not equally distributed. The net appears to be a wide open frontier, accessible to all. The danger is that it won't be, that it will become bounded, guarded and gated, so the relevant information you may seek to have access to, the so-called high quality reliable information, may come at a price. It will not necessarily be free.

That's good and bad. The good part of it is that the information you have to drive demand is much richer, deeper and wider than it ever was. The concern is that that information is not equally accessible to everybody in our society. If that information is what allows you to negotiate the health care system on your own behalf, let's make real sure that (unlike any other commodity or thing of value or resources) the information itself does not become unevenly and inequitably distributed in our society. Otherwise those who don't have access to reliable information to negotiate their way through the health care system will suffer as they have for economic reasons in the past. They will now suffer for deprivation of information.

We’ll break at this point. You’ve been very attentive. Thank you all for your questions.