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Complementary and Alternative Medicine (CAM) and Managed Health-care: Setting an Agenda

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The managed health-care industry in the United States can be considered one of the most revolutionary of its time. In its short, 10-year history, it now covers 75% of the insured American working population, providing an alternative to higher-priced traditional fee-for-service insurance (*The Economist,* 1998). It may also be one of the most reviled of industries. From its earliest days, it has been criticized for cutting costs to the point of impairing quality. Today, the industry continues to fill American newspaper headlines. It is a major subject of attention, affecting employers, consumers, providers, and investors alike. There is hardly any stakeholder that has not been affected by the radical shifts that have accompanied the founding of this industry.

Over the past months, a new twist on the news has emerged. Starting in a significant way in January 1997 (Stern, 1997) major managed care companies are introducing a new benefit to help attract new customers and appease wary investors: complementary and alternative medicine (CAM).

This new association could have important implications for both the managed care and the CAM industries. It begs such questions as "Could CAM help improve the reputation and business success of managed care?" and "Could, in turn, the CAM industry win renewed growth and acceptance in the allopathic medical community given its association with managed care?"

Since the trend toward integrating CAM with managed care is in its infancy, we need more time to determine the effects that this relationship will have on its stakeholders. Meanwhile, in order to provide a critical perspective on the issue, we must look at the available background on the market: (1) industry definition; (2) the significance of this trend; (3) dominant stakeholders and their motivations/reservations; (4) the customer; and (5) the apparent success factors.

Further analysis is necessary to prepare for industry shifts that this integration may engender, such as the types of research that are emphasized, or the level of interest in CAM by the allopathic medical community. Specifically, it would be advantageous to identify and track several key indicators, including trends toward entering or exiting the market, and how different stakeholders are reacting to this new service. This article provides background on the major issues and debates occurring in the lay- and professional press in these areas, and then identifies several key questions to guide a future investigation of the growing dialogue between CAM and managed care.

The Genesis of a New Relationship

The Managed Care Industry: A Negative Image

Managed care is currently a regular feature of newspaper headlines in the U.S. The consensus is almost exclusively negative: voters, corporations, investors, providers, pharmacists, almost every stakeholder, is dissatisfied with managed care, as reflected in several key headlines, listed below:

- *The New York Times* (May 17, 1998): "Voters' Anger at HMO's Plays at Hot Political Issue" (Kilborn, 1998)
- *The Wall Street Journal* (May 19, 1998): "Big Companies Fight Health-Plan Rates" (White, 1998)
- *The Economist* (March 7, 1998): "Health Care in America: Your Money or Your Life" (The Economist, 1998)
- *Investor's Business Daily* (May 4,1998) "Has Managed Care Hurt Quality?" (Litvin, 1998)

Insurers are caught in a cost dilemma: on the one hand, they have been accused of excessive cost-control, leading to a dangerous loss of quality; on the other, this year marks the end of a three-year price freeze, causing them criticism for cost-increases (Goch, 1997).

There are numerous illustrations of dissatisfaction with cost-control and the resulting quality implications. Among the most notable, in December of last year, 2,300 Massachusetts physicians signed a manifesto in the *Journal of the American Medical Association.* Here, they expressed their despair at being pressured by the managed care industry, "as though we were dealing with industrial commodities, rather than afflicted human beings...many are offered bonuses for minimizing care" (Glasser, 1998).

The cost-cutting may not be over, given recent business developments After removing "the fat" (Stranger, 1998) from the health-care system for several years, further cost-savings are unlikely. As a result, for the first time in the recent past, insurers are asking for price increases. According to a recent study on health-care costs by A. Foster Higgins, a 10% rise in health-care costs is predicted for 1998 (Goch, 1997). In May, in an article entitled "Big Companies Fight Health-Plan Rates," *The Wall Street Journal* reported that AT&T Corp., is experiencing proposed rate increases averaging about 8%, while Kaiser Permanente is demanding a 12% price rise from a large state agency (White, 1998).

The "Cure?"

Among many tactics being explored by managed care companies to address this situation, one stands out; they are beginning to introduce alternative medicine to their programs. This is a significant marketing decision potentially helping to reduce health-care costs, while providing an additional "service" to rebelling consumers who, according to medical economist Regina Herzlinger of Harvard Business School, are demanding fundamental change in health-care delivery (Herzlinger, 1997).

The Complementary & Alternative Medicine (CAM) Industry: Coming of Age

"We have come a long way," says John J. Kao, Editor-in-Chief of *The American Journal of Chinese Medicine,* in a recent editorial. He sites as evidence the study by David Eisenberg of Harvard Medical School, which describes the level of out-of-pocket spending on CAM as well as the large consumer market for CAM products and services. At the same time, he speaks from the perspective of the 25 years that *The American Journal of Chinese Medicine* has tracked the industry. He says, "It has been an eventful path from that fateful [beginning, in the early 1970's] to the present year, reminding us of how long an 'overnight' shift in perspective can sometimes take" (Kao, 1997).

Other recent positive trends sited in the press, include:

- Increasing number of American medical schools offering courses in alternative medicine, now about 50% of the total (Eisenberg, 1998)
- The 1997 Acupuncture Consensus Conference outcome, and the National Institutes of Health endorsement of medical acupuncture (Green, 1998)
- The recent reimbursement of CAM by major insurance carriers (Kao, 1997; Miller, 1997)

The following factors are frequently cited as obstacles to the complete integration of CAM with conventional medicine:

- Insufficient research published using standards regarding effectiveness that would be persuasive to the western medical community
- A lag in the understanding, and perhaps willingness of the medical community to embrace aspects of CAM that may already have sufficient research behind them
- A lack of regulations and consistency of regulations across governing bodies regarding standards of practice, licensure, etc.

Another "Cure?"

Going forward, CAM's association with the managed care industry may or may not help address these factors and advance the progress it has already made toward becoming fully integrated into the conventional health-care system.

The Issues to Analyze

In order to understand the future implications of this new collaboration on managed care and CAM, we must watch the market over the coming months, while understanding the market forces shaping this new "industry," which include:

1) Industry definition
2) Significance of this trend
3) Dominant stakeholders and their motivations/reservations
4) The customer
5) The apparent success factors

Market Forces Shaping the CAM Reimbursement Industry

l) Industry Definition

Defining the "CAM reimbursement industry" as an industry by terms such as its size or the market share of its significant stakeholders is a challenge. The field is young and therefore evolving rapidly, and tracking data is scarce.

Nevertheless, the following is an attempt to define the "CAM reimbursement industry."

This can be defined as an emerging industry with a few key players, including CAM reimbursement specialty firms, HMOs and other health plans experimenting with CAM. The range of services varies from simply offering members discounts on CAM services to offering a dedicated network of providers, whose services are fully reimbursable.

2) Significance of This Trend

In December 1995, an early picture of this industry was provided by *Business & Health,* which surveyed purchasers regarding their benefits offerings. Results indicated that 38% of employers offered their employees a chiropractic benefit, and that 12% offered coverage for other aspects of CAM (Weeks, 1997).

By September 1997, about 40 insurers were covering some aspect of CAM. The larger stakeholders include Prudential (Stern, 1997), Kaiser Permanente, Aetna U.S. Healthcare and the Federal Government CHAMPUS program (La Puma, 1998).

Though the trend has been tracked since at least 1995, the definitive step was reportedly initiated by Oxford Health Plan in January 1997 (La Puma, 1998). Oxford was touted as "the first major health plan to offer [a] comprehensive alternative medicine rider through a credentialed network...of more than 1,500 providers... setting a precedent that other insurers may follow" (Stern, 1997).

Subsequently, the next major HMO to follow Oxford's lead was Blue Shield of California, who began offering their 1.6 million subscribers access to CAM in January 1998 (La Puma, 1998). In terms of the total market, a survey by Landmark Healthcare in Sacramento, CA, which polled HMOs in 13 states in 1996, indicates that 58% of HMOs plan to offer alternative therapies by 1999 (Stern 1997).

When analyzing the extent of this trend, we must also consider major differences in the level of coverage offered by different players. According to Clifford Derr, CEO of Acupuncture Plus, much of the coverage is not true "insurance." Instead, players like Blue Shield in California, he says, only offer discounts on services. Even those who offer reimbursement do so to such a limited extent that it can hardly be considered true care, he adds (Derr, 1998). Jerome McAndrews, in an interview with *Business & Health,* points out that the level of coverage offered by managed care firms does not reflect the level of care that legislators have granted certain CAM practices (Weeks, 1997).

3) Dominant Players and Their Motivation /Reservations

The dominant players

Dominant insurers/managed care companies offering some kind of CAM benefit include Prudential (the number-1 insurer in the US), Aetna, Blue Shield, Kaiser, and Oxford (the 84th largest insurer in the US) (Stroup, 1998). In addition to the major insurers who have made commitments to CAM, there is a category of "stand-alone" CAM practices, who, while usually smaller, offer alternative medicine exclusively either directly to corporations or to insurers. The leader in this subcategory (Dierauf, 1998) is American Specialty Health Plan (ASHP), who is reported to have 2.7 million subscribers. ASHP contracts with 1200 practitioners in acupuncture and chiropractic medicine. Other significant specialty players, include Consensus Health, with 1.3 million subscribers and 550 providers, Landmark with 300,000 subscribers and Acupuncture Plus with less than 100,000 subscribers and contracting with about 300 providers (Dierauf, 1998).

The major motivations/reservations of industry players

Among major reasons that managed care companies and insurers begin offering CAM benefits, include those cited by Kenneth Pelletier, MD, PhD, of the Stanford Center for Research in Disease Prevention. During a recent presentation at his ground-breaking research on reimbursement of CAM by managed care, insurance carriers, and hospital providers, Pelletier (1998) cited motivations that include:

a) High market-demand
b) Attentiveness to a healthier, better-educated cohort
c) Cost-efficiencies
d) Effectiveness/quality care
e) Growing state-mandated coverage of CAM

For the most part, there is agreement in the popular press regarding these motivations. However, controversy continues, as outlined below.

a) Market-demand

According to Pelletier, "This movement is not driven by any association or agenda or gov-

ernment agency. It is like water, people are just becoming aware [of alternative medicine] and demanding [it]. This is a grass-roots industry, [a] patient-driven movement....In this case, the Industry is playing catchup with [market] demand" (Pelletier, 1998). He also points out that offering alternative therapies, based on indigenous cultures from around the world, is seen as a means of attracting new ethnic populations that may feel dissatisfaction under the health-care generally available to them in the U.S.

Pelletier's findings and these comments correspond with many citations in the literature regarding consumer demand. Indeed, Oxford initiated its CAM program after surveying its members. The results showed that 75% of its members were interested in alternative medicine; and 33% had seen an alternative medicine provider in the last two (2) years (Stern, 1997). Similarly, in the Landmark Healthcare study, 70% of HMOs surveyed in 1996 reported an increase in the number of requests for alternative medicine from their members (Goch, 1997).

Other large insurers experimenting with alternative medicine, such as Prudential, however, do not report the same level of demand. According to Devi Heine, spokesperson for Newark-based Prudential Insurance Company of America, "We have not seen a large demand from groups or individual members for alternative treatments. If the utilization of services and the frequency are examined, it is extremely low. What we have found is a fascination in the press, but there is very little interest among our members." Prudential, with 25 health plans across the country, covers several forms of alternative medicine, but only for chronic pain management (Goch, 1997).

b) Attracting a healthier cohort

An alternative medicine program may attract healthier members to a plan. Insurers might surmise that this related to the results of Eisenberg's 1990 usage study published in *The New England Journal of Medicine* (Eisenberg, 1993). Eisenberg indicated that the alternative medicine sector consisted largely of young adults, aged 20-49, who were better educated, and had higher incomes than other groups.

According to Pelletier, "This is the biggest reason that insurers are interested in alternative medicine: they want this cohort. So far, this seems to be bearing itself out" (Pelletier 1998).

Some are critical of insurers for using alternative medicine to pre-select a potentially lower-risk cohort. In his article in *Harper's Magazine,* March 1998, Ronald J. Glasser, M.D., accuses insurers of de-emphasizing more critical care in order to cut costs. He says, "Managed-care companies actually seek to hide their competencies.... Were a company to become known for treating complicated or expensive disease, it would run the real risk of attracting the attention of the very sick....In less than five years, managed care has managed to eliminate from the public-policy debate any and all words that describe suffering and disease...the industry defends itself against...criticism with...warm and fuzzy fairy tales that the public apparently still chooses to believe." "One of these," asserts Glasser (1998), "is alternative medicine. [Alternative medicine] is the panacea of the 1990's, and the health plans promote the wonders of [nontraditional forms of care] in order to obscure the real purpose of medicine, which is the treatment of illness and the relief of suffering."

c) Cost-efficiencies

Many believe that aspects of alternative medicine, such as behavior change, do indeed reduce health costs. According to Susan J. Blumental, deputy assistant secretary for women's health, of the US Public Health Service, "If I were to tell you we had discovered a new medical intervention that could decrease premature deaths in this country by one half and could cut chronic disability by two thirds and acute disability by one third, not to mention substantially reducing health-care costs, everyone would say, 'What is this new technology? What is this new drug?' The truth is, it is low-cost behavioral intervention that can decrease the risk of these illnesses" (Stern, 1996).

Pelletier, however, has found that while prevention is commonly considered an integral part of CAM, the majority of insurers represented in his sample "do not offer CAM coverage to enhance wellness or prevent disease. Rather, like conventional therapies, CAM therapies are covered only if treatment is medically necessary for a specific diagnosis." He explains that while the popular media give the impression that an increasing number of insurers are offering coverage of CAM, the current status of CAM coverage is actually quite limited in scope (Pelletier, 1997).

And for good reason; insurers are uncertain of the cost-effectiveness of CAM. While many insurers believe that CAM may be less costly, Pelletier is quick to point out that no data proves this yet. In his paper (Pelletier, 1997), he says, "...until there is clear scientific proof of the efficacy of particular CAM therapies, each insurance company is left to decide for itself whether the effectiveness may exceed the costs of covering a particular therapy." However, this data my be forthcoming. Pelletier, for example, has published several papers on the cost-effectiveness of behavior modification/prevention programs (Pelletier, 1993; 1991). He suggests that it would not be difficult to verify the cost-effectiveness of other forms of alternative medicine, and reassures us that this type of data is expected in the near future (Pelletier, 1998).

d) Effectiveness/Quality of care

While some say that CAM is potentially more effective in treating certain conditions (i.e. arthritis and ear infections) that cannot be treated well by allopathic medicine, the jury on "effectiveness" still seems to be out.

Joan Faro, MD, of the New York management consulting firm APM Inc., justifies effectiveness in a broad sense by saying, "anything that enhances the outcome is what we should be valuing. Anything that provides a benefit to the patient, perceived or otherwise, is going to change risk and reduce cost" (Ziegler, 1997). Her point of view reflects a perspective that is not uncommon. The consensus in some circles, notes Richard Burgess of the University of Utah department of physiology, and active researcher in CAM, does not appear to be in mechanisms nor even in outcomes, but in pure belief (Burgess, 1998).

Despite the view shared by Faro and others that perception is a justifiable measure of effectiveness, business-minded insurers are not satisfied. Uncertainty regarding efficaciousness is a reason that many insurers today consider alternative medicine to be a risky business. "Most of us are still waiting for science to show safety and effectiveness," says

Richard Coorsh, spokesperson for the Health Insurance Association of America, a trade group in Washington, D.C. (Stern, 1996). For this reason, it is the medical community, according to *Life Insurance News,* that influences an insurer's decision to cover for a particular modality: "Most health insurance companies think conservatively...and maintain it's not up to them to decide safety or efficacy. They hold the medical community responsible for determining a treatment's worth, and deciding whether it's legitimate enough to be covered" (Stem. 1996).

Some worry that many of the major programs do not adhere to a quality standard that could support positive outcome studies. According to Derr of Acupuncture Plus, quality of care depends on the quality of the policy being offered. He describes his program as the industry "gold standard," providing customers with access to what his group considers an ample and sufficient level of care, offering the largest number of visits to acupuncturists compared with other programs, and choice among a substantial network of highly qualified, and compensated, providers. Many of the larger programs do not offer this level of quality because the consumer can not yet determine what they truly need, he explains. For many of these larger firms, CAM is simply a marketing tool, and not seen as a real way to offer quality care and therefore cannot positively impact the health of the end-consumer and their healthcare expenditures (Derr, 1998).

Licensing

Another quality hurdle for alternative medicine is the issue of licensing. According to *Healthcare Financial Management,* "[the] sticky question of alternative medicine practitioners' professional credentials and licenses...must be addressed" (La Puma, 1998). Among the common top 14 therapies, only three (3) (chiropractic, osteopathy, and physical therapy) are designated as having "licensed practitioners" by all 50 states, with each state having its own criteria for distributing and maintaining professional licensure. Otherwise, there is wide variation across the U.S. in recognizing CAM professions as worthy of licensure. For some therapies, such as massage therapy, nutritionists/dieticians, and chiropractic care, up to half of the states in the U.S. do license. On the other end of the spectrum, only three (3) states license for homeopathic medicine, and no state licenses Ayurvedic medicine, biofeedback, or herbal medicine (Pelletier, 1997).

e) Growing state-mandated coverage of CAM

Managed care companies and insurers often respond to legal pressure to begin offering CAM coverage. Today, 41 states mandate coverage for chiropractors and for acupuncturists (Pelletier, 1997). In the future, state mandates are expected to grow, especially with examples such as those set by the state of Washington. In January 1996, Washington State became the first state to mandate that health insurers cover all forms of alternative medicine for treating illness (*The Economist,* 1996). While this is an extreme case, leading to continual vacillation as to whether this law will remain in effect in Washington or be instituted in other states, it points to a future scenario that insurance companies and HMOs consider when making strategic decisions regarding their businesses.

4) The customer

Consumer demographics

While there is little public data on the CAM insurance consumer, per se, we can use the Eisenberg study to glean a basic understanding of the consumer for all CAM products and services, and assume some degree of comparability with the characteristics for the CAM insurance consumer.

Eisenberg's findings indicate that CAM usage is significantly higher among those in the 25-49 year-old-range (38%), than among those were much younger or older. Also, he pointed out that usage was more rare among blacks (23%) than among all other racial groups. In addition, use was more common among those with some college education (44%) than among those without (27%). Further, usage was more common on the west coast (44%) vs. the rest of the United States (31%), with the overall average across the country being about one in three (34%) (Eisenberg, 1993).

Consumer motivations

Among reasons for consumer demand for CAM cited by Pelletier of Stanford is a desire to supplement conventional medicine with other choices (Pelletier, 1998). The reasons they are attracted to CAM include:

- A perception of the limits of the biomedical model & a belief that CAM better-addresses chronic disease management/prevention by focusing on life-style factors critical to prevention
- A perception that CAM will necessitate fewer medications
- A greater awareness of medical practices from around the world, due to travel and increased exposure to other cultures within the U.S.
- Some firsthand experience with the benefits of CAM

Pelletier and James Dillard, MD, Medical Director, Oxford Alternative Medicine, both emphasize that CAM is not considered an alternative to conventional medical care. (Many feared this may be the case after the Eisenberg (1993) study demonstrated that consumers often sought CAM treatments without notifying their physicians.) According to Pelletier, "[Consumers] are not negative regarding conventional medicine. It is not an antagonism, nor a polarization, it is just that it is not enough" (Pelletier, 1998). Dillard (1998) notes that alternative practices are not really used as an "alternative" to conventional medicine, but as a "complement," stating, "People who use [our CAM services] do so in an additive fashion."

The level of consumer demand for CAM reimbursement

We must distinguish between an interest in CAM in general and a penchant for purchasing CAM insurance. While the above arguments verify a consumer interest in CAM, we must

address CAM reimbursement specifically. One of the inferences one could make from the Eisenberg study is that since 70% of payments were made out-of-pocket, consumers were price-insensitive when it came to CAM. Further, Eisenberg's study (1993) indicated that "there were no significant differences according to insurance status." He found that the majority of respondents (55%) paid the total costs of their visits. Specifically, third-party payment was more likely when paying for herbal therapists (83%), biofeedback (40%), chiropractors (39%), and megavitamin therapy (30%). While this may be because much less was available in terms of CAM reimbursement when the study was conducted in 1990, we must alert ourselves to the possibility that consumers may be willing to pay for quality CAM care out-of-pocket.

Herzlinger of Harvard might agree. In her book, "*Market Driven Health Care*," she suggests that the success of health sectors such as CAM may be precisely because they *are not* reimbursed. She suggests that coverage of certain health services results in inefficiencies, a reduction in "customer-service," and a decline in consumer-benefits. ''When people pay only partly out of their own pockets, as is common in the U.S., the services are inconvenient and consumer-oriented information is largely unavailable...[w]hen no health-care services are paid for directly by consumers, inconvenience and obscurity reach new heights, as demonstrated by the long queues for care in countries where healthcare is paid for by the government." She says. In her book, she implies that the CAM industry may be more effective in informing patients, precisely because consumers tend to pay directly for their health. She sites several health services that are largely not reimbursed, and which have become highly successful businesses, she argues, as a result: eyeglasses, contact lenses, calcium supplements, and aerobics videos (Herzlinger, 1997).

5) *The Apparent Success Factors*

The success or failure of players in an industry is determined by their ability to realize and react to market conditions using a particular "winning" strategy. Today, we can point to two areas that will be critical going forward: (a) cost-control; and (b) customer service. However, there is a strong debate around the interpretation of these "key success factors." Only time will tell which interpretation of these factors will be achieve optimal results.

a) Cost-control

The cost-control debate revolves around whether cost-effectiveness can be demonstrated to exist inherently in CAM, or whether costs should simply be managed such that they are contained. In essence, it is about determining cost-effectiveness vs. managing costs.

Determining cost-effectiveness

According to Janice Stanger, Ph.D., a senior human resources and benefits consultant at William M. Mercer, Incorporated, a corporate benefits management company, stakeholders "have to position their services as 'cost-effective.'" After hearing author and CAM thought leader Andrew Weil speak on the use of CAM to control health-care costs, she began exploring the potential of Mercers' developing CAM coverage as a subspecialty. She says that

while the payback for wellness programs (exercise, diet, stress-control) is often "way downstream," employers are looking for services that promise the "quick payback." "If [insurers] could show that acupuncture [for example] could offer quick payback," she explains, they could legitimize themselves to their buying customer, the corporation. Otherwise, CAM reimbursement will be much less viable from a business perspective, says Stanger (1998).

Pelletier of Stanford believes it is possible to demonstrate the cost-effectiveness of CAM as he did in the case of health promotion programs, which were the subject of two seminal literature reviews published in *The American Journal of Health Promotion* in 1991 and 1993. In the 1993 review, he defends the literature against continual skepticism by stating, "When anyone cavalierly dismisses 48 studies with the glib dismissal of 'there is no evidence,' they are simply ignorant of more than 13 years of increasingly sophisticated research with documentation of both health and cost outcomes" (Pelletier, 1993).

Managing costs

Some are not willing to wait for cost-effectiveness data. Dillard of Oxford is not as easily swayed by the cost-benefits argument of Andrew Weil as Stanger. Referring to Weil's comment that "we will see tremendous cost-benefits down-the-road," Dillard comments, "I've heard him say this many, many times. He's saying, 'I think this is going to work.' If I were a hospital administrator, I'm [would not be] so sure" (Dillard, 1998).

It is for this reason that Oxford decided to use a different approach, focusing on "cost-management" over "demonstrating intrinsic cost-efficiencies." "This is difficult to study," says Dillard. "It is difficult to get reliable information. We could wait, but people are already voting with their feet and their wallets. For that reason, it makes sense for the health delivery system to attempt to integrate it in as cost-effective a fashion as possible." It is not that CAM is inherently cost-effective, but that programs must be "intelligently designed," according to Dillard (1998).

In order to insure cost-effectiveness from a fiscal standpoint, Oxford "looked at bad examples, and came up with a big, cautious program....The reason we have been as successful as we are [is that]...we are the leanest-and-meanest in this country." Dillard points to the dangers of uncontrolled costs. "Look at American Western Life. [They] came out with an aggressive program, paying for herbal medicine, massage....Guess what? Their claims were three times their revenues, [and] the company blew up as a result." Heeding this example, Oxford's program emphasizes simplicity, "You can get a lot out of a minimal investment This is where we are working," says Dillard (1998).

b) Customer service

For customer service, the debate concerns whether to address inherent "needs" among patients of CAM care, versus simply giving them what they "want." In sum, it is about addressing "needs" vs. "wants."

Addressing "needs"

Derr of Acupuncture Plus is using the "needs" strategy. Offering one of the more compre-

hensive programs on the market, Acupuncture Plus provides customers with a full level of service, which they believe will be effective in actually treating medical claims with acupuncture. The problem with this strategy is that "[r]ight now, the consumer is not really demanding it. [They] haven't figured out what they want. Consumers just want an alternative." In order to fill the gap between the premium service that Acupuncture Plus provides and the market, which seems to be buying based largely on price, Acupuncture Plus is counting on education. "There is a lag between demand and knowing what they want, [and] we are addressing this," says Derr (1998).

Addressing "wants"

Oxford uses the opposite approach, addressing consumer "wants," rather than being guided by a fixed idea of what the consumer "needs." Dillard believes that the problem with many CAM insurance programs is the "fixed agendas that exist in the alternative medicine world." The goal at Oxford is to serve the customer (Dillard, 1998).

"It gets down to an issue of marketing," says Dillard. Oxford successfully used its new alternative medicine package to grow from 1.4 million to over 2 million subscribers since they introduced CAM, because, he says, "Oxford markets our program well." Their marketing strategy focuses on customer service. "We respect the wishes and choices and intuition of the patient. There is tremendous value in respecting the internal healing model of the patient. [Ask] 'what do they think will make them better?"' Regardless, says Dillard, "The patient will only change so much [and] this is the wisdom of having it be patient-driven. Unless you are certain," says Dillard, implying that the research does not, and perhaps will not, allow this assertion, "you are wasting their [time, and] your time." To secure their future in the marketplace, Dillard emphasizes letting the program evolve with customer demand, rather than "educating" the consumer about what is good for them (Dillard, 1998).

Market Trends to Monitor Going Forward

In order to determine the impact that the new collaboration between managed care and CAM will have on these two industries, we must watch the market over the coming months, focusing on several pivotal issues, including:

1. Is the Trend Toward Entering or Exiting This Market?

- After Oxford Health Plans' pioneering step into CAM in January 1997, do we see other major players following their lead and entering the market in a significant way? What types of programs do they offer? How do we "rank" the level of service they offer? What is their success rate in terms of incremental sales attributable to CAM?
- What happens to the smaller, specialty firms? Do they offer a level of service that competes with larger players that lack focus on CAM? Will they compete with the larger players, become suppliers, or be absorbed by them?

2. How Do Different Stakeholders React to This New Service?

- Are employers convinced that there is a cost-benefit? Can employers determine a means of evaluating the different CAM options that competitors offer?
- Are consumers satisfied with the level of care they receive? Can they distinguish between the options offered by different players in the market?
- Are CAM practitioners content with their level of compensation?
- Does the medical community help enable the success of CAM by referring as necessary and/or becoming licensed CAM practitioners?

3. How Does CAM Impact the Reputation of Managed Care?

- Do managed care sales grow as a direct result of CAM programs?
- Are cost-control techniques reproducible?
- Can managed care continue to offer CAM in light of recent cost-cutting pressures?
- Will CAM be perceived as a benefit or as a means of preventing the customer from receiving "true" medical care?

4. How Does Managed Care Impact the Reputation of CAM?

- Does managed care help CAM gain legitimacy/distribution or does it taint CAM with its negative service image?
- Do managed care companies with CAM respect a level of quality that meets CAM stakeholder "standards?"
- Does interest by "big business" promote new rigor in research regarding effectiveness and cost-benefits?
- Are CAM practitioners willing to work under the often strict, cost-conscious guidelines of managed care?

Harbingers of a Changing Paradigm

Currently, we have early signals regarding the impact that CAM will have on managed care and that managed care will have on CAM.

How Does CAM Impact the Reputation of Managed Care?

a) Do managed care sales grow as a direct result of the CAM programs?

Some, such as Oxford, report increasing sales (from 1.4 million to 2 million subscribers), according to Dillard (1998) due to their CAM program. It is difficult to understand whether these subscribers are directly purchasing the new CAM program, or whether they opt for Oxford for other reasons. Going forward, it will be important to monitor sales attributable directly to CAM plans. Further, we must understand the extent of the commitment subscrib-

ers have made to the new service: have they paid up front, or are they merely being offered the option to pay downstream?

b) Are cost-control techniques reproducible?

Companies such as American Western Life, while reportedly increasing sales, experienced claims that far exceeded revenues (Dillard, 1998). If other companies emulate the strict cost-control/marketing strategies of Oxford, they too may be successful in increasing sales while maintaining a healthy profit margin using CAM.

c) Can managed care continue to offer CAM in light of recent cost-cutting pressures?

While HMOs are offering CAM programs to attract new participants, there is speculation that "mounting cost pressures may force the health plans to separate the wheat from the chaff among the new offerings" (Wojcik, 1998). Until this spring, managed care costs have been controlled, rising at 0.5% per year in the mid-1990's, vs a 13.6% per year rise in the late 1980's and early 1990's (*The Economist,* 1998). Since this spring, however, dropping profits, mergers and the consumer uprising against cost-cutting may cause managed care companies to react by increasing pricing, as many have begun to do (White, 1998). Already, ballooning costs have forced at least one large managed care CAM program out of the market (Dillard, 1998). According to health-care strategist Gary Meller, MD, it would not be surprising to witness the same fate at Oxford. He reminds us of the recent headline news of their financial difficulties. "When someone finally gets control [of financial matters], [extras, like CAM] may disappear" (Meller, 1998).

d) Will CAM be perceived as a "benefit" or as a means of preventing the customer from receiving "true" medical care?

Some argue that CAM may be a way of steering patients away from more effective and higher cost care (Glasser, 1998; Schwartz, 1996). However, there appears to be more evidence that CAM will be perceived as a benefit, despite the fact that it is often available at a lower cost.

There are numerous examples of treatment forms that happen to be less costly, yet more effective, especially in the area of prevention. According to Tom Houston, MD, Director of Preventive Medicine at the American Medical Association, influenza and flu vaccines for the elderly fall into this category. He emphasizes that one cannot accuse insurers of being parsimonious simply because they invest in prevention. Further, Houston reminds us that CAM is not always less expensive than conventional medicine, citing a study indicating that chiropractic treatments could demand higher costs than other forms of medical care to treat the same issue (Houston, 1998).

Otherwise, there is already a strong consumer perception that CAM is a true benefit, as demonstrated by the Eisenberg study (1993). This grass-roots belief in the inherent value of CAM will surely fuel a positive regard toward insurers that offer CAM as an option for their customers.

How Does Managed Care Impact the Reputation of CAM?

a) Does managed care help CAM gain legitimacy/distribution or does it taint CAM with its negative service image?

It is widely believed that CAM coverage will have a positive effect on the CAM industry, both in terms of legitimizing this industry, in addition to allowing growth. According to Jerry Kantor, principal of Convergent Medical Systems, a firm consulting to the managed care industry, "Reimbursement is destiny. Nothing in medicine is perceived as entirely legitimate until it's reimbursed. Acupuncturists suspect that, for the profession, mandated third-party reimbursement would be more validating than a Nobel Prize award to an acupuncturist" (Goch, 1997).

Indeed, analyzing the history of reimbursement in the US, there is evidence of reimbursement leading to a wider market for particular forms of care. Houston points to several examples where a modality/technology was not widely used until insurance companies started paying for it: coronary bypass grafting, as well as CAT scanning and MRI. "Utilization went up because people saw that it could be paid for, got training, and began using [the technology]...Suddenly, there was a CAT scanner on every corner...because it was paid for" (Houston, 1998). Stranger of Mercer agrees, "When a new benefit clearly addresses customer needs,...a framework is in place...[and] if the conditions are right, [the] benefit can grow quickly" (Stanger, 1998). The National Association of Insurance Commissioners has data that support the positive effect that reimbursement can have on impacting access to certain health programs (Stroup, 1998).

Conversely, Herzlinger's argument that coverage leads to a reduction in quality and "customer service" provides an important reminder of the potential negative impact that managed care could have on CAM. Quality must meet consumer expectations and must be balanced with cost-control only to the extent that customers do not notice a drop in service. Otherwise, her theory warns us that CAM programs could be attacked like the managed care industry is in the news today (Herzlinger, 1997).

b) Do managed care companies with CAM respect a level of quality that meets CAM industry "standards?"

CAM "standards" cannot be quantified because of the wide range of opinions, and state laws regarding what these may be. However, the following are arguments that question the quality of programs offered by many providers. These may be used to help establish benchmarks with which to measure of the level of service being offered by the different stakeholders today.

- Some large providers, such as Blue Shield, while advertising CAM programs, simply offer discounts on services, rather than actually reimbursing for CAM services (Derr, 1998)
- The providers that do offer reimbursement often do not offer what some consider to be "sufficient" service, limiting usage to a minimal number of visits,

often with under-compensated providers (Dierauf, 1998)

- The packages whose CAM network consists only of MD's are suspect because MD's can obtain CAM licensure with a minimal level of training (by correspondence), whereas the licensing processes for non-MD's in some states, such as California, demand rigorous training (Bernie, 1998)

c) Does interest by "big business" promote new rigor in research regarding effectiveness and cost-benefits?

It appears that the introduction of a management mindset to the CAM world will have a positive effect on stimulating increased research. Among business-scientific research collaboration that have been discussed publicly are an Oxford-Harvard Mind-Body Institute study, and collaboration between Stanford University and a consortium of U.S. corporations.

d) Are CAM practitioners willing to work under the often strict, cost-conscious guidelines of managed care?

Already, conventional medical doctors have attempted to flee the strict cost-cutting mandates of managed care, as indicated by the Massachusetts physicians' manifesto in the *Journal of the American Medical Association.* (GIasser, 1998). In CAM, we may already be witnessing a trend in this direction. According to Kurt Hegetschweiler of Pacific Coast Chiropractic, and panelist at the World Whole Health Forum, there has been a 25% reduction in the number of chiropractors under managed care contracts, due to dissatisfaction with compensation (Hegetschweiler 1998). Derr of Acupuncture Plus believes this is only the beginning. He sites the low fees paid by his competitor, American Specialty Health Plan (about $30 for a one-hour acupuncture treatment, vs. about $45 by Acupuncture Plus) as a force that will cause a "revolt" among CAM practitioners (Derr, 1998).

Conclusion

The new CAM reimbursement industry is still in its infancy. The announcement by Oxford Health Plans to start offering CAM services to its group purchases in 1997 is considered a watershed event that made CAM reimbursement a recognizable movement. Since then, other major firms have experimented with the service, and there is a great deal of speculation about the impact that CAM reimbursement could have on the health-care industry in the future. Since CAM-managed care collaboration is so new and is evolving quickly, at this point it is difficult to predict the true success of this service and the strategies by which certain players, if any, will succeed. Instead, there are questions and issues to monitor, going forward.

Using the information available at this point, we might speculate that CAM will improve the appeal of managed care and lead to increased sales and acceptance of CAM. However, due to current and impending cost-cutting pressures, we may see insurers offer only those CAM services that can be demonstrated as "cost-effective." Research money

will tend to support investigations of cost-efficiencies, rather than studies that focus outcomes or mechanisms. The results of this research may allow some CAM practices, such as acupuncture to become more fully integrated into conventional medicine. Other CAM practices may not stand up to the tests of cost-effectiveness and providing "immediate" results, and be left by the wayside. The distinction between what practices are reimbursable and what are not may become the new dividing line between what is considered "alternative" and "conventional" medicine (Kantor, 1998; Meller, 1998).

In order to prepare for inevitable industry shifts, and to understand the flow in research findings and other changes that will result, further analysis is necessary. It will be important for members of the CAM and managed care communities alike to track market developments over the coming months in a manner suggested by the framework presented in this article.

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