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Actuarial Aspects Of Alternative Care

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Instructor: LEE ERIC LAUNER
Recorder: LEE ERIC LAUNER

Summary: During this session you gain knowledge of the SOA activity regarding alternative care and you learn about the issues of alternative care:
- *A description of the history, demand, and activity of alternative care in the U.S. during the 1990s*
- *A description of the SOA Committee on Alternative Care*

Mr. Lee Eric Launer: About two years ago, it became reasonably apparent to us that it was going to be a significant business opportunity to be involved in alternative care from a consulting perspective. In addition to that, I personally, and some of the people that work with me are advocates of alternative care. And I'm not going to bore you with the history, but myself, my wife, some of the family members we know, who have used conventional care for a number of years, were somewhat disheartened by it. And I'll give you one example.

My wife is an asthmatic. And for a number of years, almost five years running, she had total medical bills of about five thousand dollars on average per year. And quite honestly, paying that, she still wasn't better. She was taking steroids. There are a number of additional medical problems. And then, through a friend, we got involved with an alternative care physician, who was a physician, but knew some alternative care modalities, and that had significant, significant effect on her. And using kind of, what I call, integrative medicine, the combination of alternative and conventional care, she really got much better. The medical bills went down to a couple of hundred dollars a year. And while she still has some asthmatic conditions, she really feels much better than she did. She's off all pharmacological products, as an example.

That led our family to find out more information about alternative care. And to some degree, for that reason, I am personally an advocate of it, and one of the

reasons that I kind of moved the practice into being involved in alternative care. It's one of the reasons why, and I'll mention this a little bit later, why I started the SOA Committee On Alternative Care.

Before I even begin, another thing I have to do is kind of describe an alternative care environment. As an example, here, is kind of a conventional setting. I have now spoken around the world about twenty-five times on alternative care, and I almost have to give you the environment so you'll understand the difference between conventional and alternative care. And I'm not going to do any of these things, so don't be frightened.

In many situations, an alternative care session will begin with meditation. The speaker will come up and, for the first ten minutes, kind of calm everyone with meditation. I've been to sessions where, amazingly, in the middle, they break for yoga sessions. An instructor comes in for a ten minute session and there are either yoga or tai chi exercises. I've been in sessions where they actually sell and give out vitamins, enzymes, things that are within the alternative care framework. I've even been to a meeting where, at the end of the meeting, we all walked around and hugged each other.

And it's almost like I want everyone to know that, as I talk of alternative care, I was just going to be, hopefully, rather professional and rather academic and scientific. That's not really the world that alternative care has been born in. It's only that I wanted to give you that context in terms of as we go through the discussion.

While I will, to some degree, talk about the actuarial aspects and talk about some of the analytical components of alternative care, I really would like to spend a significant portion of the time talking about alternative care in general. What is it? What are the definitions? I wanted to find some things. What really is the demand? What's the demand right now of individuals in the U.S. for alternative care? And what's the activity? So it's almost like I'm probably going to spend the first forty-five minutes going over what's going on right now. And then after that, I'll talk a little bit about the SOA Committee.

Now, as far as questions, I think it's probably easier, as I speak, if there are burning questions, raise your hand and I'll answer them then. If it's not a burning question, we'll take those at the end.

But one of the things I should also say is what I mentioned before. I'm an advocate of alternative care. Anything that either we do from a consulting environment, anything, clearly, in the SOA is going to have to be a very rigorous, scientific study. We'll go into the questions. As actuaries always are, we're going to make sure

things are statistically significant. So even though I'm going to describe later the committee members, many of whom, in fact, are advocates, it's clearly going to be done within the context of a rigorous, scientific, academic type world.

The basic definition of alternative care is: a set of health care practices including preventive, diagnostic, and therapeutic techniques that are considered to be an adjunct to conventional medicine. Typically, these are not taught in medical school. Typically, they're not practiced by conventional health care physicians. And quite honestly, in many cases, conventional physicians feel very uncomfortable with some of these modalities. The types of care that are typically within the framework of alternative care; chiropractic, though, in the last couple of years, clearly, that's much more in the conventional frame; acupuncture; acupressure; herbs; homeopathic remedies. Any type of psychological impact, which is biofeedback, a number of things also within that realm.

And then after that, there are a number of more esoteric type techniques, which fall within the framework of alternative care, and mostly because these type of providers want to be labeled alternative care, which is now acceptable, but really is somewhat far out. Aromatherapy, as an example. Gems, color therapy, things that made actuarial—many individual analytically based, but difficult time dealing with. But yet, still within the overall definition needs to be at least recognized.

A couple of other basic definitions. Holistic, that many people probably know. Holistic really means kind of a combination of things; mind, body, soul, putting the entire thing together. A real theme of alternative care. Prevention and wellness, certainly, is a very important aspect of alternative care. Self-care. You hear many holistic alternative care physicians talk about self-care. Without a doubt, one of the basic tenets of it is to have individuals responsible for their own health. Natural. You'll hear lots of advertisements, books talking about natural. Natural, obviously, means it's botanical. It's plant. It's air. It's something which is not chemically pharmacologically oriented. The definition of integrative care is the combination of alternative and conventional care put together in one cohesive, coordinated package where the two are kind of synthesized. The two work together.

Finally, I'll be talking about health focused lifestyles. It's just a definition; a set of practices that individuals will use which typically will focus themselves and other family members on health care typically relating to exercise, diet, avocations, driving. Just all of the aspects relating to an individual being more focused on their health.

Some synonyms. You hear lots of different words used all meaning roughly the same. Alternative is saying, "Unconventional, unorthodox." Many of the

conventional physicians like the word complementary because, to some degree, it makes them feel the alternative care world is complementary to what they're doing.

Unproven, and actually my favorite, quacker. Quacker, I should spend a moment on, because in much of the work that we've done, one of the most significant things that needs to be overcome is conventional physicians feeling that much of what is done with an alternative is really quacker. It is unproven, and really should have no place in medical science. And while that may be a bit harsh for some of the techniques, quite honestly, some of the things that are within alternative care, that are kind of the esoteric layout, there's a very real reason to deal with that. So it's something that when dealing with alternative care, those items which are less than even conventionally in alternative care, needs to be recognized and understood.

Again, I defined a few of these a moment ago, but I would like to talk a little bit about the themes, the basic themes of alternative care. Typically, mind, body and spirit. In other words, when an individual comes into a practitioner's office, it's not only dealing with the body. It's really, really what the mind is dealing with the spirit. It's really dealing with the context of the whole human being.

And in this way, when an individual is seen by a physician, the first visit, very often, is an hour-and-a-half or two hours; really learning about the entire individual as opposed to what might be in our capacitative world of a fifteen minute visit in and out, and kind of all of the inherent problems associated with that. Again, natural modalities, without a doubt. When someone speaks of an herb or a homeopathic remedy, there's no doubt that natural, as I defined it before, it a critical component of that.

As I mentioned before, a very important theme of alternative care is self-care, educating the patient about themselves, really giving the person responsibility for their own health. Without a doubt, prevention and awareness of not having the symptoms, not having the disease is a really critical component of alternative care.

Health focused lifestyles. Most individuals, and this becomes a difficult actuarial problem when we try to figure out individuals who are going to be taking alternative care what their ultimate claim cost is. Most individuals who go into using alternative care typically do so because their style of living is somewhat different, and—from the way we think of it, their health styles are somewhat different. And for that reason, differentiating the cost between those individuals who use alternative care and those individuals who use conventional care becomes that much more difficult.

I should spend a moment on spirituality and prayer. I'm not going to, in any way, get into any type of religious discussion. But there's no doubt that spirituality and

prayer are very significant components of alternative care. I'll mention it later, but there are a number of organizations now, hospitals, HMOs that literally put in various spirituality, various prayer mechanisms that they believe, whether it's true or not, we don't know, actually help the healing process.

I'm involved in one study right now, which actually is looking at the difference between those individuals who pray and those individuals who don't. And again, I'm not going to discuss this in too much depth, but that's a very significant component of the overall context of alternative care.

We've heard the National Institute of Health approved for certain things. The fundamental theory of acupuncture is to take these undetectable energies throughout the body and balance them. And the needles that are placed in the body are supposed to balance the energy throughout the body, therefore, relieving the illness, relieving the symptoms. So this entire field of energy medicine is a very significant one within the context of alternative care.

In 1991, published in 1993, Dr. David Eisenberg from Harvard, a researcher, very well respected within the medical community, ran a study on alternative care, and it's kind of become the quintessential study. This was published in *The New England Journal of Medicine*, and it really showed, for the first time, what people intuitively thought was happening, and that was a very significant portion of the U.S. population who were using alternative care techniques. There were about one-third of the individuals who were using alternative care techniques on a consistent basis, and it was almost 50% of the population that was at least using it periodically. So a very significant amount was being used. Fifteen billion dollars was the estimate in terms of what was being spent, and about two-thirds of that, $10 billion was out of pocket. The only things that were really being covered was the chiropractic care, and a few other very minor coverages. But the vast majority of it was not covered. Therefore, individuals were going on their own seeking these services, and utilizing these services with their own dollars.

Amazingly, 70% of the individuals who were using alternative care were also using conventional care, and they were not telling their doctor. Almost 90% of the individuals who were using both were not telling their conventional physician. And this was really something which was a very significant point because conventional physicians really needed to know. They needed to know if there were potentially certain herbs, and certain homeopathic remedies, and certain other things that the alternative care physician could have given the patient. It was really very, very

important for the conventional physician to know. There could have been counter-indications, as an example. And it was the first time people recognized the

incredible amount of overlap there was, and that conventional physicians didn't even know this was happening.

This study was being updated for 1997. And, in fact, the SOA is working with David Eisenberg and researchers at Harvard to update the study in 1997. We have added some more analytical questions. There were about 25 questions originally. We've added about five analytical type questions so we can get more information on utilization and cost in the things that we typically need as actuaries. The study should probably be available late 1998. And what we, the Society, are going to do, we're not only going to help him publish the study, but we're going to have access to the data. So we can have our own research, which we will, of course, do, analyze the study, get information, and then put it in more of a context, hopefully, that we're used to being able to do to help place an alternative care product.

In the 1991 study, published in 1993, the profile of the individual was fairly young. From my context, fairly young. Twenty-five to thirty-nine, both men and women utilized alternative care. Salary was typically greater $35,000. You have to think about in 1991 dollars. Mostly college educated and from all areas; rural, suburban. So it was a fairly reasonable cross-section, but yet it was the more educated, the higher paid, the baby–boomer generation that was using it more. And the typical thought process was the younger are not that sick, the younger typically are not within the health focused lifestyle. And the older are much more set in their ways. So, therefore, it kind of was the middle of the age spectrum that was, in fact, utilizing these services.

Now what was used mostly? Vitamins, nutritional supplements. And certainly here, it was not just the occasional individual who was taking a vitamin or a nutritional supplement. Without a doubt, it was those individuals who had been prescribed by a physician to take this on a consistent basis. Exercise, aerobics. Again, individuals who were doing this in an organized fashion, having been advocated by a physician.

Those of you who either read books, see magazines, go into a health food store, or in fact, even go into your conventional drug store see that there's a tremendous market now for herbs, homeopathic remedies, for things that individuals actually take what they believe to be true and natural significantly supplements, and significantly helps them from a health perspective. Certainly, a significant amount of activity in Yoga and tai chi and in meditation.

I've now spoken a little bit about what the demand in the marketplace, as from Eisenberg's study. I'm going to talk a little closer to our world in terms of what actually is going on. What's the activity in the marketplace? There are

approximately 50 HMOs. And I say HMOs loosely. I really mean health care systems in the broadest context that have some type of alternative or integrative care plan now. Our projection is, by 1999, relatively soon, it's going to be approximately 100. And by the year 2000, again, relatively soon, it's going to be approximately 200. Almost every health care system will have some kind of alternative care program.

In fact, much of what we do at Coopers & Lybrand, in the last couple of years, is to really help insurers put in alternative care programs. And it's very interesting. It's somewhat similar, in many aspects, to putting in a conventional care program with the complicating factor, of course, alternative care is different in context, as I've been describing. It's developing networks of acupuncturists, chiropractors, and homeopathists, and those individuals as opposed to cardiovascular surgeons, and all other kind of subspecialties we normally think of.

It's putting in a credentialling system. Now credentially, again, being much more complicated, as you might expect, has more credentials, someone who sells herbs, as an example. But yet, still a credentialling criteria, and credentialling practitioners just the way we typically do.

And then you can just think of all the other things that need to be done in developing kind of a conventional plan; the actuarial pricing, the plan design, quality assurance programs, utilization review. All of those things need to be put in by the insurer or the HMO, the health care system. But again, now it's in the context of alternative care.

Within the 50 HMOs that sell alternative care now, you might expect there are some that really discuss it, that really have the program from a very limited basis. All they really want to do, truthfully,— this is the value judgement they made, is to have the ability to say they sell alternative care. So they may have a very limited acupuncture program, as an example. And then they can say, "Well, our insurer that has alternative care."

Then there are some where they have a very full integrated total system, which kind of puts the entire thing together. So they will have an alternative, a conventional care program put together, and then, what I call, integrated in one overall comprehensive package. There are really only a couple of those in the U.S. right now.

I'll take a moment to mention, there's one in Arizona that actually has a program where they have a conventional physician, and they have a few alternative care physicians evaluate the patient on intake. The patient comes in, they're evaluated

in this kind of integrative, collaborative way. And as this actually happens, they make a treatment plan, a clinical protocol for that individual, which is then utilized over some number of weeks or months of the program.

There are a number of hospitals, a number of conventional hospitals that have alternative care programs. And I'll mention one because it's an interesting thing. It's in Connecticut. The chief executive officer, about five years ago, had a life-changing event by having found that he had heart disease, went through some coronary problems and, as you might expect, had bypass surgery and decided from that one event that he was going to change his hospital around. He not only decided he wanted to have an adjunct of alternative care, he wanted to change the building physically. And he actually changed the building.

First, the hospital was now built in concentric circles. Let's say, you're visiting a patient. When you first come in, it's almost like coming into a hotel. One of the first outside circles is more like a hotel setting. The second one is where the patients are. But even where the patients are, all of the things that you'd normally think of in a hospital—and I'm not sure how many of you are like I am, when you walk in, you can get a little queasy, all the scary stuff, like actuarial lingo. Well, that's all in the middle concentric circle. So as you're walking in, it's really something to make people, to make children, in particular, feel extremely comfortable within this hospital.

Now in the hospital, not only do you get all the conventional tertiary type things that we're familiar with, but there's praying. They have individuals that they hire that pray for the patients, the physicians, the surgery that's going to happen. That's if you want it. You, as a patient, can have that or not have not. There's meditation for those who want it. As opposed to putting on the television and getting Days of Our Lives, you can turn to channel seven and get meditation, if you want. There's vegetarian cooking, if you want it. There are a number of things; herbs, a self-education library there with all—they have 500 different books on this topic. And it's really a wonderful setting. And everyone can avail themselves of this specifically, but, clearly, it's something where you're taking this next step to open up this hospital. And there are a few other hospitals in the U.S. that are just beginning this type of process.

Significant now are teaching and research. Throughout the U.S. now, there are about 28 different medical schools that actually are assigned to teach alternative care. I'm participating in a couple programs to educate conventional physicians on alternative care. The National Institute of Health, a couple of years ago, approved $7 million for research in alternative care.

And there are a number of schools around the country such as Harvard, Stanford, and the University of Maryland, that have specific programs where they are evaluating specific techniques. They're evaluating things like homeopathic remedies on asthma, evaluating chiropractic care on low back pain, evaluating a program on reversing heart disease. They're trying to get clinical trials on the things that are taught within alternative care journals.

Another activity in the marketplace would be legal issues. As you might expect, from an insurer's perspective, there is just a host of legal issues related to malpractice, credentialling, and patients suing. There are legal companies now which are, in fact, going into only the business of alternative care. They are hiring individuals and doing work in advance to get themselves set up for what they believe is going to be an incredible amount of liability in the future to help insurers, to help physicians deal with all of these litigation issues.

The last item is data. There is not a lot of data. In a couple of minutes, I'm going to get to the SOA study. We're trying for the first time to get data around these things, to see if what individuals say is true or. In other words, what we've always been told is, "It's cheaper, patients are more satisfied, and outcomes are better." We don't know if that's true right now.

One company that we work with wanted to integrate two networks. They wanted to have their conventional practitioners, the ones who we understand, that we know from our world. They wanted to add to them licensed practitioners of complementary medicine, and they specifically want to emphasize prevention. They wanted to emphasize wellness and self-care. This is kind of the first step. Ultimately, they would like to have a program similar to the one that I mentioned before where conventional alternative care is put together in one overall context.

They're going to have the two parallel networks: conventional practitioners, who are called allopathetic and osteopathic physicians, and complementary practitioners, licensed chiropractors, homeopathic; Ayuvedic medicine, which is Indian medicine. Other licensed practitioners include nutritional counselors, massage therapists, acupuncturists, and naturopaths. As you see, these specifically are practitioners. The ones that are listed under complementary practitioners that can, in fact, be licensed, licensed somewhere in the U.S.

So when this HMO went through a credentialling process putting together an overall program, they felt that they wanted only to have those individuals who had some state license as opposed to a number of practitioners, as I mentioned, for whom there's no state license. And that's a significant differentiation for an insurer or a health care system to put into effect.

A very important part of this HMO's program was, again, conventional wellness and self-care. They wanted to have an integrative system. They wanted to put into context one patient going in for an individual assessment and coming up with that individual's medical history, and putting that on line. All the practitioners in the system would be able to view that when an individual patient comes in to their office. So right now, they're devising a system to deal with that. As you might expect, significant data, significant computer, and a significant system technology are needed.

Another thing they wanted to do was educate everyone. What is really integrative medicine? They're having various sessions, similar to this, but in more detail, so patients can come in and hear, what is alternative care? What's conventional care? How do the two interact? They're also having sessions for conventional physicians so they can understand about alternative care, and vice versa.

A 24-hour help line will also be there. Is anyone familiar with demand management? In demand management, an individual calls up seven days a week, 24-hours a day. It's not just information on conventional care, but finding out information about alternative care as well. If an individual calls up with a problem, he or she is told to do something conventionally, but also can be alternatively. They can be referred to a number of these different providers and practitioners, as I mentioned before.

They're also having basic wellness programs. At their site, various nights throughout the week, they have exercise programs, yoga, tai chi, and meditation. The patients within the system have the ability to go there and get that, if that's something they want. In addition to that, not only do they have these on various nights of the week, they have a referral system. If an individual wants to have one of these programs and they're willing to pay for it themselves, they have a discount program, having made deals with various health clubs and exercise programs in the area.

This one system wants actuaries to maintain the data. We're helping them develop their system, and we're helping them to get enough information. After a year or two of the program, they're going to have information in terms of what was the utilization and the cost so they can really assess if this was an overall beneficial program or not.

Let me spend a few moments on the SOA Committee on Alternative Care structure. When we were going into alternative care, it seemed critical for actuaries to be able to get enough information to price the plan. And we felt that we would start a committee to get data for the first time in alternative care. The committee is

comprised of, right now, ten people. There are five actuaries and five physicians. Of the five physicians, three of the physicians are "alternative care", and two are conventional.

The committee has met a number of times over the last two years. Quite honestly, it's very slow. It takes a very long time to gather data; mostly because not that much data that we normally can utilize even exists. The belief of some of the committee members was that alternative care appears to produce lower cost. There are some data, but much of it is anecdotal.

To some degree, it needs a recognized source, like the SOA, to help. Anything that the committee does needs to be extremely academic, rigorous, and scientific. As always, we're going to be cautious, as we are as a society, in publishing any information. While there may be some committee members including myself, who are advocates of alternative care, the data will show what's real and what's not real. And we have to be very rigorous in doing that.

Now in that context, we set up some criteria to address the question, "How do we need to make sure that the data that we put together is extremely scientific?" This is a broad context, but we've spent a lot of time talking about the data source, and making sure that the data source is recent, large enough, and has clean data. The methodologies to extract the data sampling, as an example, need to be very conventional, and not alternative, if you will. These are conventional extraction methods.

The computations, similarly, need to be comparable. They need to be statistically significant, as we know what those words mean. We need to report this. We need to have discussions on this in a very objective professional way. And we spent a lot of time talking about how we are going to have a study that meets all these criteria.

We have three goals in the committee. The first is to assemble all of the existing data in one source. The second is to, on some sample basis, evaluate the statistical validity of the data. And the third is, by far, the most important, to develop data for the future. Let's prospectively, for the first time, have data that we, as actuaries, and others can use. Public policy can be formed based upon this.

As an aside, I've gotten a number of phone calls from different states and different legislators asking us if we have any available data at the moment. Right now, we do not have that much data that are in the format that can be used to make that a policy issue on alternative care in their state.

The state of Washington has opened up all of their individuals in the state to be able

to get alternative care. And they were looking to Coopers & Lybrand or the Society to help them with data. And at the moment when they called, we didn't have any information.

We found out in gathering data that, first, we had to categorize the data in a few different ways. We categorized it by specific modalities and population. An example of specific modalities is an individual who has asthma a very specific type procedure as opposed to population at large. We, actuaries need data in terms of either your utilization or cost, or something we can use to price a product. We also categorize it by U.S. versus other countries.

We then categorize it by different types of alternative care. There are six fundamental different types of categories of alternative care. Amazingly, there were thousands of studies on alternative care, almost all of which were, what I call, specific modalities. There were three studies that I don't think we, as actuaries, can necessarily feel really comfortable with using. Yet, as of this moment, that's really all there is.

There's the David Eisenberg study, that I mentioned before, published in 1993 in *The New England Journal of Medicine*. It does show certain information on utilization and cost. It's not, by any means, a definitive study, but there is at least some information there that an actuary can use to price a plan.

Second, there's a study that was published by the Robert Woods Johnson Foundation in 1994 on a subset of the population. It has some utilization data and some cost data that an actuary can use.

Finally, the Province of Manitoba and Saskatchewan published a government-sponsored study in 1993, to show alternative care use in Canada during those years.

All three studies are not perfect and, are well below the standards of what an actuary would feel really comfortable with in pricing a product. But having said that, that's really all there is right now that really can be utilized. We think that the 1997 study by Dr. David Eisenberg will, in fact, be extremely helpful.

The SOA Committee is getting ready to send out to certain selective insurers the ability for them to coordinate with the SOA, and give us the data that they have on alternative care. Jim Connor is working with me on the committee, and he is helping coordinate this for the Society to get insurers involved to help us put together this prospective study.

And one of the reasons that I wanted to mention that specifically is if there are insurers in the room have in place, or who are going to put in place an alternative care program, we would love to have you participate. Clearly, the larger the database, the better, and the more statistically significant it is. That's something where we, as actuaries, can feel more comfortable.

We're certainly hoping, in a couple of years, to publish a more definitive update on utilization on cost of all the things that we typically use to be able to price a product.

These are some measures which we want to develop for insurers that offer alternative care. Some possibilities are quality and clinical measures. What are these measures for patients who use alternative care? And how does that compare to conventional?

If there's a utilization pattern, or there's a health care cost of—a health care cost of $3,500 a year for an individual who uses conventional care, what's that health care cost for the individual who goes to an insurer that uses alternative care? Clearly, there are numerous complications to coming out with a fact like that.

As we all know, there's a significant amount of data available on conventional care, and it comes from insurance companies, the government, data warehouses, and consulting firms. You're fairly familiar with this. We're going to try to take the data on alternative care and compare it to conventional care. But clearly, from an actuarial perspective, there needs to be risk adjustment, health status, and demographics. It needs to be put on a comparable basis so the cohorts of individuals in each of the two categories are comparable.

So if we say, "The health care cost for this group is $3,500, and the health care cost for this group is $3,000," We really need to know that those two groups are the same and that they are comparable. As you might expect, and I won't get into detail, there's just a host of actuarial stuff related to making those two groups the same. That's a fairly challenging thing to do in a rigorous, scientific way.

If there was a way to specifically delineate what the impact on a patient's health was of those stress-related techniques, I think, that would be extremely helpful to the overall study.

The average patient's health care cost for conventional care is $3,500. Let's say that we do ultimately find that those who seek alternative care have a lower health care cost on an age, sex, risk-adjusted basis. Let's say that's $3,000. What are the differentiating factors between conventional and alternative, and if, in fact, we could

define one of the major factors as stress related, a psychological intervention, I think that would be a wonderful amount of knowledge for us to have as actuaries. It would even be a policy issue.

From the Floor: The SOA appears to have been fighting off a pretty ambitious project here in terms of gathering data and creating resources for data. I'm just wondering if we are going to be tapping into work that's done by various organizations in the medical field. The American Medical Association (AMA) has groups working on treatment protocols and outcomes research. Are we making certain, or are we making efforts to try to make certain that any research directed by the medical profession into these areas will give adequate consideration to the potential impacts and nonimpacts of alternative medicine?

Mr. Launer: An excellent question. You said it very well a moment ago. We're trying to utilize and we interact with any data already developed or are being put together at this moment.

We have spoken to the AMA. As I mentioned before, there are five physicians on the Committee. We have one physician who has, in fact, gone to the AMA describing what we're doing, seeing if there are some studies that they have that we could utilize, or even if there's a way that we could interact with them. As you might expect, to some degree, there are some individuals in the AMA who may not be thrilled with alternative care. I won't say we've gotten resistance. That's not true. But to be able to say that we have spoken to every single individual or have every single study which is being done, as you know, is virtually impossible. But we are making efforts to coordinate that. That's an excellent point. That has come up in a number of Committee discussions.

From the Floor: Thank you.

From the Floor: I have a couple of questions. The first is really about short-term and medium-term deliverables from the Committee. It sounds like you found a number of studies. I was wondering if you were thinking of publishing a white paper or some other type of summary of the material that you already had.

Mr. Launer: Yes, we definitely are going to publish something. As you might expect, almost like transitions, it iterates all the time. When we first started this two years ago, our plan was literally this year to publish something. However, as we discovered the incredible amount of data that are out there from certain studies and the incredible sparsity of data from the things that we really utilize, we felt that we should probably wait approximately one more year.

We're still gathering data. As an example, a gentleman just mentioned data from the AMA. But we also would be one year into collecting data from insurance companies' for the future. And if there are even early results on that, we'd love to be able to publish that simultaneously. But the answer on publishing this, is definitely yes. The question really is, when? Instinct will tell me it's at least a year off.

From the Floor: The only thing I'd suggest is, as a Society member, and I'm sure you would want to check with other people on that issue, a comprehensive Society-backed summary of 1,000 articles where the clear indications of successful outcomes would be very helpful and could probably be done on a shorter term basis than a year.

My second thought is that you talked about a number of carriers, HMOs, et cetera that are developing alternative medicine programs ranging from token to substantive programs. I was wondering if, in the data collection process that you're going through, you were going to use those as natural experiments and try to figure out what the outcomes are for those organizations on some type of broad basis.

Mr. Launer: If I understand your question correctly, are we going to utilize those companies that are currently selling alternative care in the overall study? If that's the question, the answer is definitely yes.

From the Floor: The last possible source for you. There is actually a wide variation, for instance, in California, between how all the various medical groups and major organizations ranging from the Unified Medical Group Association to other people, are treating alternative medicine. There may also be some experiments within California that basically have one medical group versus another medical group treating things differently.

The big challenge there was it looked like the target population for this was under 40, and the morbidity changes in that group were very small and very hard to detect at some point.

Mr. Launer: There are a significant number of insurers, HMOs and health systems, mostly in the western part of the country, that are selling alternative care. They tell me they have data. But, quite honestly, when they give me information, it's not data we normally can utilize. It's data that are not statistically significant. Even though it's wonderful to get information, it's really not something an actuary can utilize.

The one thing we, as a Society, don't want to do, and I completely agree, with

trying to publish something in a reasonable period of time, is publishing something that may not be factual, giving credibility to information that is more antidotal than it is valid.

Mr. Bruce E. Palmer: Our company is controlled by physicians, and they're very conservative doctors. While I was listening to this, I was thinking we've had nothing in the way of alternative care. We have allowed chiropractic care on a very limited basis, really a token basis because our doctors are antichiropractic.

But we have had some smokers cessation programs both at the employer site and on our site. We also have weight loss programs and healthy diet programs. We arrange for discounts for health classes at other sites. We have massages on site for employees once a week at a discount cost. We do pay for biofeedback under mental health. Our company pharmacist is definitely interested in alternative medicine as a way to reduce our medical or pharmacy cost. I visited China two-and-a-half years ago, and my understanding is that Chinese doctors get paid based on the wellness of their clients. We pay our doctors based on the sickness of our clients. My belief in everything that I've done is that we get what we pay for, so maybe we need to change our paradigm.

Self-care may be an uphill battle for us. This morning's paper, mentions the shortage of butter fat. We, as a people now, are starting to demand more taste, and the usage of butter fat is going up now.

Fat has decreased in our diet, but now we've gotten tired of that. So I don't know how self-care is going to work. I'm all for it, but, obviously, I have a problem around the waistline result.

Mr. Launer: Traditional Chinese medicine, I think around 900 B.C., did precisely what you were saying. Physicians, at that point in time, were only paid if, in fact, the patient got better. They were not paid one penny if, in fact, the patient either got worse or, clearly, if the patient died.

I think the same way that you do. This might be something we can utilize in America today. We could have a system specifically based upon outcomes research, which clearly says, "You get what you pay for."