



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

EXECUTIVE SUMMARY
Analysis of Assembly Bill 54:
Health Care Coverage: Acupuncture

A Report to the 2007–2008 California Legislature
June 22, 2007



The California Health Benefits Review Program (CHBRP) responds to requests from the State Legislature to provide independent analyses of the medical, financial, and public health impacts of proposed health insurance benefit mandates and proposed repeals of health insurance benefit mandates. CHBRP was established in 2002, to implement the provisions of Assembly Bill 1996 (California Health and Safety Code, Section 127660, et seq.) and was reauthorized by Senate Bill 1704 in 2006 (Chapter 684, Statutes of 2006). The statute defines a health insurance benefit mandate as a requirement that a health insurer or managed care health plan (1) permit covered individuals to obtain health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or (3) offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

A small analytic staff in the University of California's Office of the President supports a task force of faculty from several campuses of the University of California, as well as Loma Linda University, the University of Southern California, and Stanford University, to complete each analysis within a 60-day period, usually before the Legislature begins formal consideration of a mandate bill. A certified, independent actuary helps estimate the financial impacts, and a strict conflict-of-interest policy ensures that the analyses are undertaken without financial or other interests that could bias the results. A National Advisory Council, drawn from experts from outside the state of California and designed to provide balanced representation among groups with an interest in health insurance benefit mandates, reviews draft studies to ensure their quality before they are transmitted to the Legislature. Each report summarizes scientific evidence relevant to the proposed mandate, or proposed mandate repeal, but does not make recommendations, deferring policy decision making to the Legislature. The State funds this work through a small annual assessment of health plans and insurers in California. All CHBRP reports and information about current requests from the California Legislature are available at the CHBRP Web site, www.chbrp.org.

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 54 (Health Care Coverage: Acupuncture)

The California Assembly Committee on Health requested on March 12, 2007, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 54. In response to this request, CHBRP undertook this analysis pursuant to the provisions of Senate Bill 1704 (Chapter 684, Statutes of 2006) as chaptered in Section 127600, et seq. of the California Health and Safety Code.

AB 54 is a provider mandate—that is, the bill requires coverage for treatments delivered by a particular profession, in this case, acupuncturists. It applies to every health care service plan that provides coverage for hospital, medical, or surgical expenses and to every issuer of health insurance, and would amend Section 1373.10 of the Health and Safety Code and Section 10127.3 of the Insurance Code. The bill:

- Expands a current mandate to offer coverage into a mandate to provide coverage, and removes certain exceptions.
- Mandates coverage for expenses incurred as a result of treatment by holders of a license to practice acupuncture, as defined by Section 4938 of the Business and Professions code.
- Applies to *group* contracts or policies. The market for individually purchased health insurance is not affected by this bill.
- The coverage shall be under terms and conditions as may be agreed upon by the health plan and group contractholder or health insurer and group policyholder.

The practice of acupuncture involves the stimulation of the body by the precise placement of thin, solid-metal needles in the skin. It has been practiced for centuries in China as a method of promoting overall health and well-being, and has become more available in the United States, especially in California, since the early 1970s.

The impact of AB 54 is contingent on the determination of acceptable terms and conditions by California regulatory agencies. The proposed benefit is also subject to future changes in the Business and Professions code and determinations of scope of practice. According to the California Acupuncture Board, the scope of practice for a licensed acupuncturist includes not only acupuncture (needling), but also other treatments such as massage, moxibustion, and cupping, and the prescription of herbs as dietary supplements.

Because the mandate is not restricted to particular conditions or diseases, CHBRP necessarily limits the analysis of the bill's impact, which CHBRP does in two ways. First, CHBRP does not evaluate treatments other than acupuncture (needling) for this report. Based on the CHBRP current coverage survey, current coverage for acupuncture does not include herbs used as dietary

supplements. CHBRP assumes the terms of coverage with regard to herbal supplements will remain the same postmandate. Second, the mandate would apply to all enrollees; however, CHBRP has made the simplifying assumption to exclude persons under age 18 years due to their low utilization of acupuncture services and the lack of medical literature on its effectiveness in the under-age-18 population.

Medical Effectiveness

Numerous studies of the effectiveness of acupuncture have been conducted. CHBRP's analysis focuses on the strongest and most current evidence of the effectiveness of acupuncture. It emphasizes evidence regarding musculoskeletal and neurological conditions, because they are the types of conditions for which persons in the United States most frequently use acupuncture.

Three types of literature were reviewed:

- Reports by the National Institutes of Health (NIH) in 1997 and by the Institute of Medicine (IOM) in 2005 that assessed evidence of the effectiveness of acupuncture;
- Meta-analyses and systematic reviews of randomized controlled trials (RCTs) published since the literature review for the IOM report was conducted in March 2004; and
- Large, well-designed RCTs on select musculoskeletal and neurological conditions that were published after the literature synthesized in the meta-analyses and systematic reviews.

This literature review analyzes evidence of the effectiveness of needling, a practice unique to acupuncture that is typically covered by health plans that provide acupuncture benefits. Studies of both manual acupuncture and electroacupuncture needling are included.

Many of the RCTs included in the meta-analyses and systematic reviews that CHBRP assessed are of low quality. In many cases, the sample sizes are too small to provide conclusive evidence of the effectiveness of acupuncture. Only recently have researchers begun conducting large, well-designed RCTs on acupuncture.

This report summarizes findings from RCTs that studied four types of comparisons: (1) acupuncture versus no treatment; (2) acupuncture versus sham acupuncture (i.e., needling or pricking points on the body that are not acupuncture points); (3) acupuncture versus other treatments; and (4) acupuncture plus other treatments versus other treatments (i.e., acupuncture as an adjuvant treatment). Findings from studies that compare acupuncture to no treatment are included as well as studies that compare acupuncture to sham acupuncture, because experts disagree as to which type of study is best. Studies that compare acupuncture to no treatment probably overstate the effects of acupuncture, because they do not control for placebo effects, such as patients' and providers' expectations regarding treatment. For this reason, researchers often attempt to control for placebo effects by comparing acupuncture to sham acupuncture. However, such studies may understate the effects of acupuncture, because there is considerable evidence that sham acupuncture is not an inert placebo.

Needle acupuncture versus no treatment

- The preponderance of evidence suggests that needle acupuncture is *more effective* than no treatment in reducing pain and improving the functioning of persons with chronic low back pain, neck disorders, osteoarthritis of the knee, temporomandibular joint dysfunction, and chronic headache.
- The evidence suggests that needle acupuncture *may increase* abstinence from smoking relative to no treatment.

Needle acupuncture versus sham acupuncture

- The preponderance of evidence suggests that needle acupuncture is *more effective* than sham acupuncture for treatment of lateral elbow pain, neck disorders, osteoarthritis of the knee, and postoperative nausea and vomiting.
- The preponderance of evidence suggests that needle acupuncture is *not more effective* than sham acupuncture for treatment in facilitating recovery from cocaine addiction and smoking cessation.
- The evidence of the effectiveness of needle acupuncture relative to sham acupuncture for treatment of chronic low back pain, shoulder pain, and headache is *ambiguous*.
- There is *insufficient evidence* to determine whether needle acupuncture is more effective than sham acupuncture for treatment of acute low back pain, osteoarthritis of the hip and thumb, rheumatoid arthritis, temporomandibular joint dysfunction, epilepsy, vascular dementia, and chemotherapy-induced nausea and vomiting.

Needle acupuncture versus other treatments

- The preponderance of evidence suggests that needle acupuncture is *more effective* than medication or education for osteoarthritis of the knee, more effective than physical therapy for pelvic pain associated with pregnancy, and more effective than medication for chronic headache.
- The preponderance of evidence suggests that needle acupuncture is *as effective as* other treatments for temporomandibular joint dysfunction, smoking cessation, and postoperative nausea and vomiting.
- The evidence of the effectiveness of needle acupuncture relative to other treatments for lateral elbow pain is *ambiguous*.
- There is *insufficient evidence* to determine whether needle acupuncture is more effective than other treatments for acute and chronic low back pain, pelvic pain, neck disorders, osteoarthritis of the hip, and shoulder pain.

Needle acupuncture plus other treatments versus other treatments (i.e., acupuncture needling used as an adjuvant treatment)

- The preponderance of evidence suggests that needle acupuncture is an *effective* adjuvant treatment for chronic low back pain, pelvic pain, stroke, and chemotherapy-induced vomiting.
- The preponderance of evidence suggests that needle acupuncture is *not an effective* adjuvant treatment for facilitating recovery from cocaine addiction and for smoking cessation.
- The evidence of the effectiveness of needle acupuncture as an adjuvant treatment for fibromyalgia and osteoarthritis is *ambiguous*.
- There is *insufficient evidence* to determine whether needle acupuncture is an effective adjuvant treatment for shoulder pain.

Utilization, Cost, and Coverage Impacts

AB 54 would require Knox-Keene licensed health care service plan contracts and insurance policies sold in the group market to provide coverage for acupuncture services. This section presents the current, or baseline, costs and coverage related to acupuncture (needling) for adults, and then details the estimated utilization, cost, and coverage impacts of AB 54 if it were to pass into law.

- According to CHBRP's estimates, there are 17.95 million insured Californians currently enrolled in group health plans regulated under the Knox-Keene Act or insured by group health insurance policies regulated under the California Insurance Code and, therefore, subject to AB 54. The affected population includes 12.10 million adults aged 18 years and older.
- Currently, 86.3% of insured Californians subject to the mandate have coverage for acupuncture. This mandate impacts those who currently do not have coverage (13.7%). Privately insured individuals with acupuncture coverage generally have benefit limits, including a maximum number of annual visits (e.g., 20 visits). In addition, cost-sharing requirements vary by health plan. Most health plans also require referrals from primary care providers. Some health plans limit acupuncture services to the management of neuromusculoskeletal disorders, nausea, and pain.
- About half (50.8%) of those covered under health plans purchased by California Public Employees' Retirement System (CalPERS) do not have coverage for acupuncture. Medi-Cal provides acupuncture benefits at no charge to the members, but the benefit is limited to two visits per month. Healthy Families members are also currently covered for 20 acupuncture visits per year with a \$5 copay per visit.

- Approximately 2.4% of Californians used acupuncture treatments in 2002, according to the 2003 California Health Interview Survey Complementary and Alternative Medicine Supplement (CHIS-CAM). This utilization is higher than the national average (1.1%) or even the average in the western region of the United States (1.9%), according to 2002 National Health Interview Survey data. CHBRP estimates that there would be a negligible change in utilization due to the mandate. Cultural acceptance of acupuncture may be a more important determinant factor in utilization than financial barriers.
- Total net annual expenditures are estimated to increase by \$2.45 million or 0.004%, mainly due to the administrative costs associated with providing coverage for persons who do not currently have it. There is an estimated increase in premiums of \$16.93 million (\$10.94 million for the portion of group insurance premiums paid by private employers, \$2.68 million by CalPERS employers, and \$3.31 million for the portion of group insurance and CalPERS premiums paid by enrollees) and a net increase in member copayments of \$3.06 million, offset by a reduction in *out-of-pocket* expenditures of \$17.55 million among those whose utilizations of acupuncture services are not currently covered by insurance.
- Increases in insurance premiums vary by market segment. Increases as measured by percentage change in per member per month (PMPM) premiums are estimated to range from 0.007% to 0.102% for the various group markets (Table 4). Increases as measured by PMPM premiums are estimated to range from \$0.03 to \$0.33. It is estimated that the premium will increase by \$0.33 PMPM for CalPERS. In the large-group market, the increase in premiums is estimated to range from \$0.03 to \$0.07 PMPM. For members with small-group insurance policies, health insurance premiums are estimated to increase by approximately \$0.08 to \$0.11 PMPM.
- Based on a few studies mostly conducted in European countries, acupuncture has been shown to be cost effective in treating patients with chronic neck pain, back pain, and migraine headache.

Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 54

	Before Mandate	After Mandate	Increase/ Decrease	Percentage Change After Mandate
Coverage				
Number of individuals subject to the mandate	12,095,000	12,095,000	0	0.000%
Percentage of individuals with coverage	86.3%	100.0%	13.7%	15.890%
Number of individuals with coverage	10,436,600	12,095,000	1,658,400	15.890%
Utilization				
Total number of acupuncture visits covered by insurance	1,492,227	1,729,343	237,117	15.890%
Total number of acupuncture visits paid directly out of pocket annually	237,117	0	-237,117	-100%
Total number of acupuncture visits annually	1,729,343	1,729,343	0	0%
Average cost of an acupuncture visit	\$74.00	\$74.00	0	0%
Expenditures				
Premium expenditures by private employers for group insurance	43,944,936,000	43,955,880,000	10,944,000	0.025%
Premium expenditures for individually purchased insurance	—	—	0	0.000%
CalPERS employer expenditures	2,631,085,000	2,633,766,000	2,681,000	0.102%
Medi-Cal state expenditures ^(a)	4,015,964,000	4,015,964,000	0	0.000%
Healthy Families state expenditures	—	—	0	0.000%
Premium expenditures by employees with group insurance or CalPERS	11,468,688,000	11,471,994,000	3,306,000	0.029%
Member copayments	4,096,879,000	4,099,940,000	3,061,000	0.075%
Out-of pocket expenditures for noncovered services ^(b)	17,547,000	—	(17,547,000)	-100.000%
Total annual expenditures	66,175,099,000	66,177,544,000	2,445,000	0.004%

Source: California Health Benefits Review Program, 2007.

Notes: The population includes employees and dependents covered by employer-sponsored insurance (including CalPERS), or public health insurance provided by a health plan subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975. All population figures include enrollees aged 18–64 years and enrollees 65 years or older covered by employer-sponsored insurance. Member contributions to premiums include employee contributions to employer-sponsored health insurance and member contributions to public health insurance.

Key: CalPERS = California Public Employees' Retirement System.

(a) Medi-Cal state expenditures for members under 65 years of age include expenditures for Major Risk Medical Insurance Program (MRMIP) and Access for Infants and Mothers (AIM) program.

(b) The expenditures for acupuncture services paid by members who currently do not have acupuncture benefits.

Public Health Impacts

- Three common conditions for which acupuncture is used include: (1) lower back pain, (2) neck pain, and (3) migraine or severe headaches. In 2002, over one-third of the insured adult population aged 18–64 years in the United States reported having at least one of these three conditions in the past 3 months. Only a small fraction of the population currently uses acupuncture for these conditions or for one of the many other health conditions for which acupuncture is utilized.
- The primary health outcomes associated with acupuncture treatment for musculoskeletal and neurological disorders are reduced pain and improved functionality. Although acupuncture needling has been found to be effective for some conditions, AB 54 is not expected to result in an overall increase in utilization in the short term and thus is not expected to have any measurable impact on community health in the 1-year time frame used in this analysis. It is possible that in the longer term, passage of AB 54, along with a potential increase in cultural acceptance of acupuncture as a treatment option, will contribute to an increase in utilization of acupuncture and, therefore, improved health outcomes for persons who do not respond to other treatments.
- Women report higher prevalence of lower back pain, neck pain, and migraines or severe headache. Additionally, women report higher utilization of acupuncture. Although AB 54 is not estimated to result in an overall increase in acupuncture treatment, it is expected that more women will financially benefit from insurance coverage of acupuncture compared to men.
- Although Asians do not have higher prevalence rates for lower back pain, neck pain, and migraines or severe headaches, Asians report the highest utilization of acupuncture and, therefore, more Asians are expected to financially benefit from AB 54 compared to other racial and ethnic groups.
- Acupuncture is used for some health conditions and behaviors associated with premature death, such as smoking cessation and other drug addictions. The medical effectiveness analysis, however, did not find that acupuncture was an effective treatment for these conditions. Therefore, AB 54 is not expected to result in a reduction of premature death.
- No research was found on the economic costs associated with neck pain; however, both lower back pain and migraines have been found to be associated with high economic costs, comparable to those of heart disease, depression, and diabetes. Since there is no expected overall increase in use of acupuncture due to AB 54, there is no expected reduction in economic loss associated with conditions related to acupuncture use in a 1-year time period. However, it is possible that in the longer term, passage of AB 54, along with a potential increase in cultural acceptance of acupuncture as a treatment option, will contribute to an increase in utilization of acupuncture and therefore may reduce economic costs associated with these conditions.

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CHBRP gratefully acknowledges all of these contributions but assumes full responsibility for all of the report and its contents. Please direct any questions concerning this report to:

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A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses and three private universities in California. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The CHBRP **staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others.

As required by the CHBRP authorizing legislation, UC contracts with a certified actuary, Milliman Inc. (Milliman), to assist in assessing the financial impact of each benefit mandate bill. Milliman also helped with the initial development of CHBRP methods for assessing that impact.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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