CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Executive Summary
Analysis of Assembly Bill 72: Health Care Coverage: Acupuncture

A Report to the 2011-2012 California Legislature
March 18, 2011

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Health Care Coverage: Acupuncture

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 72

The California Assembly Committee on Health requested on January 14, 2011, 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) 72, a bill that would require coverage of services provided by acupuncturists. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.[1]

Analysis of AB 72

Approximately 21.9 million Californians (59%) have health insurance that may be subject to a health benefit mandate law passed at the state level.[2] Of the rest of the state's population, a portion is uninsured (and so has no health insurance subject to any benefit mandate) and another portion has health insurance subject to other state law or only to federal laws.

Uniquely, California has a bifurcated system of regulation for health insurance subject to state-level benefit mandates. The California Department of Managed Health Care (DMHC)[3] regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers[4], which offer benefit coverage to their enrollees through health insurance policies.

DMHC-regulated plans and CDI-regulated policies sold in the group markets would be subject to AB 72. Therefore, the mandate would affect the health insurance of approximately 15.1 million Californians (40%).

AB 72 is a mandate to reimburse for acupuncture care—that is, it 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.[5] Although acupuncture can be used to treat dental pain, the bill

[1] CHBRP's authorizing statute is available at http://www.chbrp.org/documents/authorizing_statute.pdf.
[2] CHBRP's estimates are available at http://www.chbrp.org/other_publications/index.php.
[3] The DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code, Section 1340.
[4] The CDI licenses "disability insurers." Disability insurers may offer forms of insurance that are not health insurance. This report considers only the impact of the benefit mandate on health insurance policies, as defined in Insurance Code, Section 106(b) or subdivision (a) of Section 10198.6.
[5] Health care service plans, commonly referred to as health maintenance organizations, are regulated and licensed by the California Department of Managed Health Care (DMHC), as provided in the Knox-Keene Health Care Services Plan Act of 1975. The Knox-Keene Health Care Services Plan Act is codified in the California Health and Safety Code. Health insurance policies are regulated by the California Department of Insurance and are subject to the California Insurance Code.

mandate does not apply to specialized health care plans, such as dental plans. The bill amends Section 1373.10 of the Health and Safety Code and Section 10127.3 of the Insurance Code, and it expands a current mandate to offer coverage into a mandate to provide coverage, and removes exceptions. The bill also 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. Further, the bill would apply to group contracts or policies, while the market for individually purchased health insurance would not be affected by this bill. And finally, the bill stipulates that the coverage for acupuncture shall be under terms and conditions as may be agreed upon by the health plan and group contractholder or health insurer and group policyholder.

A number of other states have had legislative activity around coverage for acupuncture. The State of Washington has had mandated coverage of acupuncture since 1994 when a law was passed that mandated coverage for all licensed health care practitioners for all in-state based insurance. The other states that have some sort of acupuncture/provider access mandate include Florida, Maine, Montana, Nevada, New Mexico, Oregon, Rhode Island, Texas, Virginia, and Washington State.

Medical Effectiveness

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

The search was limited to studies published in English from May 2007 to the present. The time frame for the search was truncated because CHBRP conducted a search of the literature published through May 2007 on the effectiveness of acupuncture for a report it issued in June 2007 on AB 54, an identical bill regarding coverage for acupuncture. The studies identified for the prior review are also included in this report.

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 ramdomized controlled trials (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 and limit the ability to reliably assess the 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 traditional[6] acupuncture points); (3) acupuncture versus other treatments; and (4) acupuncture plus other treatments versus other treatments alone (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 (i.e., sham acupuncture may also induce a physiological response).

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 back pain, peripheral joint osteoarthritis, migraine headache, and tension-type headache.

- The preponderance of evidence suggests that needle acupuncture *may increase* abstinence from smoking relative to no treatment.

- There is *insufficient evidence* to determine whether needle acupuncture is an effective treatment for neck pain.

Needle acupuncture versus sham acupuncture

- The preponderance of evidence suggests that needle acupuncture is *more effective* than sham acupuncture for treatment of temporomandibular joint dysfunction, postoperative nausea and vomiting, and tension-type headaches (reduction in frequency).

- The preponderance of evidence suggests that needle acupuncture is *not more effective* than sham acupuncture for treatment of neck pain, rheumatoid arthritis, migraine headaches, stroke, alcohol dependence, cocaine addiction, and smoking cessation.

- The evidence of the effectiveness of needle acupuncture relative to sham acupuncture is *ambiguous*[7] for treatment of fibromyalgia, peripheral joint osteoarthritis, and shoulder pain.

- There is *insufficient evidence* to determine whether needle acupuncture is more effective than sham acupuncture for treatment of epilepsy, chemotherapy-induced nausea and vomiting, lateral elbow pain, and vascular dementia.

[6] For the purposes of this report CHBRP refers to traditional acupuncture points as those points along the meridian, or path, in which "qi" is believed to flow according to Traditional Chinese Medicine.
[7] The evidence is presented as "ambiguous/conflicting" if none of the studies of an outcome have strong research designs and/or if their findings vary widely with regard to the direction, statistical significance, and clinical significance/size of the effect.

Needle acupuncture versus other treatments

- The preponderance of evidence suggests that acupuncture is *more effective* than other treatments for back pain (immediately post-treatment only), peripheral joint osteoarthritis pain (when compared to osteoarthritis education), and for migraine headaches (reduction in frequency but not in intensity).

- The preponderance of evidence suggests that needle acupuncture is *as effective as* other treatments for postoperative nausea and vomiting.

- The evidence of the effectiveness of needle acupuncture relative to other treatments is *ambiguous* for shoulder pain and smoking cessation.

- There is *insufficient evidence* to determine whether needle acupuncture is more effective than other treatments for alcohol dependence, epilepsy, lateral elbow pain, and tension-type headaches.

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

- The preponderance of evidence suggests that needle acupuncture is an *effective* adjuvant treatment for back pain, chemotherapy-induced nausea and vomiting and an *effective* adjuvant to exercise for treatment of shoulder pain.

- The preponderance of evidence suggests that needle acupuncture is *not an effective* adjuvant treatment for peripheral joint osteoarthritis, rheumatoid arthritis, and cocaine dependence.

Benefit Coverage, Utilization, and Cost Impacts

AB 72 would require Knox-Keene licensed health plans and 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 72 if it were to pass into law.

- According to CHBRP's estimates, there are 21.9 million (Table 1) insured Californians currently enrolled in health plans subject to the California Health and Safety Code or insured by health insurance policies subject to the California Insurance Code and, therefore, subject to AB 72. The affected population includes 14.4 million adults aged 18 years and older.

- Currently, 87.2% of insured Californians subject to the mandate have coverage for acupuncture. This mandate impacts those who currently do not have coverage (12.8%). Privately insured individuals with acupuncture coverage generally have benefit limits, including a maximum number of annual visits. In addition, cost-sharing requirements vary by health plan.

- Before July 2009, Medi-Cal Managed Care Plans provided acupuncture services at no charge to members, but with a limit of two visits per month. In July 2009 the coverage was reduced and Medi-Cal currently provides acupuncture benefits to a low number of enrollees, which includes persons who live in a licensed nursing home, pregnant women, people who were ordered a course of acupuncture treatment prior to July 2009, and children (who have a very low rate of acupuncture utilization). Based on DHCS interpretation, Medi-Cal Managed Care would not be subject to this bill.

- 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 was higher than the 2002 national average (1.1%) according to the 2002 National Health Interview Survey (NHIS) data. The CHIS-CAM has not been repeated since 2002 so more recent data on California-specific utilization is not available. Consequently, using other sources and estimates, CHBRP estimates that the utilization in California has risen at a rate consistent with the Western region, resulting in an increased baseline utilization of 3.1% in 2007.

- It is estimated that there would be a negligible change in utilization due to the mandate as both the 2002 and 2007 NHIS surveys showed only small differences in utilization of alternative medical systems between the privately insured and the uninsured (2002: 3.0% and 3.1% respectively, 2007: 3.9% and 4.0% respectively). Cultural acceptance of acupuncture may be a more important factor in utilization than financial barriers.

- Total net annual expenditures are estimated to increase by $7.45 million or 0.0078%.

- There is an estimated increase in premiums of $54.9 million. Total premiums for private employers purchasing group health insurance are estimated to increase by $31.7 million, or 0.0601%, and enrollee contributions toward premiums for group insurance are estimated to increase by $11.5 million, or 0.0757%.

- Total employer premium expenditures for CalPERS HMOs are estimated to increase by $11.7 million, or 0.3380%. Of the amount CalPERS would pay in additional total premium, about 58% or $6.8 million would be the cost borne by the General Fund for CalPERS HMO members who are state employees or their dependents.

- No change is estimated for MRMIB Plan premiums[8] and Medi-Cal Managed Care Plan premiums as this mandate would not apply to these programs.[9]

- Prior to the mandate, enrollees without coverage for acupuncture incurred an estimated $67.4 million in out-of-pocket expenses. Postmandate, that $67.4 million in out-of-pocket expenses would be shifted to health plans and insurers. However, enrollees would incur an additional $20.0 million in copayments for the newly covered benefits.

[8] MRMIB plans would not be considered "group plans." Personal communication with J. Symkowick, MRMIB, February 2011.

[9] DHCS does not consider Medi-Cal Managed Care plans, "group plans" because beneficiaries do not contract with Medi-Cal managed care plans. Personal communication with C. Macklin, DHCS, March 2011.

- 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 0.0010% to 0.0834% for the various group markets (Table 6). Increases as measured by PMPM premiums are estimated to range from $0.0034 to $0.2924. In the large-group market, the increase in premiums is estimated to range from $0.0658 in CDI large-group plans to $0.2533 PMPM in DMHC large-group plans. For members with small-group insurance policies, health insurance premiums are estimated to increase by approximately $0.0034 in CDI to $0.2924 PMPM in DMHC small-group plans. For CalPERS, the estimated increase is $1.47 PMPM. It is estimated that there would be no increase in the premiums for MRMIB Plans and Medi-Cal Managed Care Plans since the agencies have stated that AB 72 would not apply to their programs.

- The majority of cost effectiveness studies on acupuncture have been conducted in Europe, predominantly the UK, Germany, and Denmark. These studies have found that acupuncture is cost effective in treating patients with allergic rhinitis, chronic headache, chronic neck pain, dysmenorrhea, low back pain, musculoskeletal system disorders, and osteoarthritis. A small number of U.S.-based studies exist. In a general adult population, it has been concluded that acupuncture is cost-effective in improving substance abuse and may be cost saving in the treatment of carpal tunnel syndrome. A 2008 study used managed claims care data in a cross sectional study of the influence of acupuncture utilization on the utilization of other healthcare services in a U.S. setting. The authors found that enrollees that had utilized acupuncture services were statistically less likely to use primary care, all outpatient services, pathology services, all surgery, and gastrointestinal.

Public Health Impacts

- The CHBRP *Public Health Impacts* analysis addresses three common conditions for which acupuncture is used: low back pain, neck pain, and migraine or severe headache. Only a small fraction of the population uses acupuncture for these or other conditions.

- 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 72 is not expected to result in an overall increase in utilization in the short term, and thus is not expected to have measurable impact on the public's health in the 1-year time frame used in this analysis. It is possible that in the longer term, passage of AB 72, along with a potential increase in cultural acceptance of acupuncture as a treatment option, would 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 low back pain, neck pain, and migraines or severe headache. Additionally, women report slightly higher utilization of acupuncture. Although AB 72 is not estimated to result in an overall increase in acupuncture treatment, it is expected that more women would financially benefit from insurance coverage of acupuncture compared to men.

- Although Asians do not have higher prevalence rates for low back pain, neck pain, and migraines or severe headache, they report the highest utilization of acupuncture. Therefore, Asians are expected to benefit financially from AB 72 more than other racial and ethnic groups until and unless rates in other ethnic groups come to approximate those of Asians.

- Acupuncture needling is used for some health conditions and behaviors associated with premature death, such as smoking and drug addiction. The evidence presented in the *Medical Effectiveness* section indicates that acupuncture needling may increase abstinence from smoking compared to no treatment. However, the evidence also shows that acupuncture needling is not an effective adjuvant treatment for smoking cessation or drug addiction and is not a more effective treatment compared to sham acupuncture needling. Therefore, CHBRP estimates that AB 72 would have no measureable impact on premature death.

- No research was found addressing economic costs associated with neck pain; however, both low 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 measurable increase in the use of acupuncture due to AB 72, 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 72, along with a potential increase in cultural acceptance of acupuncture as a treatment option, would contribute to an increase in utilization of acupuncture and therefore may reduce economic costs associated with these conditions.

Potential Effects of the Federal Affordable Care Act

The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (H.R.4872) were enacted in March 2010. These laws—together referred to as the "Affordable Care Act" (ACA)—are expected to dramatically affect the California health insurance market and its regulatory environment, with most changes becoming effective in 2014. How these provisions are implemented in California will largely depend on pending legal actions, funding decisions, regulations to be promulgated by federal agencies, and statutory and regulatory actions to be taken by California state government. The provisions that go into effect during these transitional (2011 to 2013) years would affect the baseline, or current enrollment, expenditures, and premiums. It is important to note that CHBRP's analysis of specific mandate bills typically address the marginal effects of the mandate bill—specifically, how the proposed mandate would impact benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP's estimates of these marginal effects are presented in this report.

Table 1. AB 72 Impacts on Benefit Coverage, Utilization, and Cost, 2011

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,902,000	21,902,000	0	0%
Total enrollees with health insurance subject to AB 72	15,113,000	15,113,000	0	0%
Percentage of enrollees with coverage for the mandated benefit	87.2%	100.0%	12.8%	15%
Number of enrollees with coverage for the mandated benefit	13,171,000	15,113,000	1,942,000	15%
Utilization and Cost				
Coverage similar to mandated levels	3,108,624	3,567,094	458,470	15%
No coverage	458,470	0	(458,470)	-100%
Average per unit cost	$147	$147	0	0%
Expenditures				
Premium expenditures by private employers for group insurance	$52,713,266,000	$52,744,925,000	$31,659,000	0.0601%
Premium expenditures for individually purchased insurance	$6,724,851,000	$6,724,851,000	$0	0.0000%
Premium expenditures by persons with group insurance, CalPERS HMOs, Healthy Families Program, AIM or MRMIP (b)	$15,173,472,000	$15,184,954,000	$11,482,000	0.0757%
CalPERS HMO employer expenditures (c)	$3,465,785,000	$3,477,498,000	$11,713,000	0.3380%
Medi-Cal Managed Care Plans state expenditures	$8,657,688,000	$8,657,688,000	$0	0.0000%
MRMIB Plans state expenditures (d)	$1,050,631,000	$1,050,631,000	$0	0.0000%
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.) (e)	$7,548,415,000	$7,568,403,000	$19,988,000	0.2648%
Enrollee expenses for noncovered benefits (e)	$67,395,000	$0	($67,395,000)	-100%
Total Annual Expenditures	$95,401,503,000	$95,408,950,000	$7,447,000	0.0078%

Source: California Health Benefits Review Program, 2011.

Notes: (a) This population includes persons with privately funded and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans, Healthy Families Program, AIM, MRMIP) health insurance products regulated by the DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-sponsored insurance.

(b) Premium expenditures by enrollees include employee contributions to employer-sponsored health insurance and enrollee contributions for publicly purchased insurance.

(c) Of the increase in CalPERS employer expenditures, about 58% or $6,660,000 would be state expenditures for CalPERS members who are state employees or their dependents.

(d) MRMIB Plan expenditures include expenditures for 874,000 enrollees of the Healthy Families Program, 8,000 enrollees of MRMIP, and 7,000 enrollees of the AIM program.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: AIM=Access for Infants and Mothers; CalPERS HMOs=California Public Employees' Retirement System Health Maintenance Organizations; CDI=California Department of Insurance; DMHC=Department of Managed Health; MRMIB=Managed Risk Medical Insurance Board; MRMIP=Major Risk Medical Insurance Program.

Acknowledgments

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 72. In response to a request from the California Assembly Committee on Health on January 14, 2011, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Edward Yelin, PhD, Janet Coffman, MPP, PhD, and Chris Tonner, MPH, all of the University of California, San Francisco, prepared the medical effectiveness analysis. Stephen L. Clancy, MLS, AHIP, of the University of California, Irvine, conducted the literature search. Joy Melnikow, MD, MPH, Stephen McCurdy, MD, MPH, and Meghan Soulsby, MPH, all of the University of California, Davis, prepared the public health impact analysis. Todd Gilmer, PhD, and Jennifer Lewsey, MS, of the University of California, San Diego, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, of Milliman, provided actuarial analysis. Content expert Richard Hammerschlag, PhD, of Oregon College of Oriental Medicine (Emeritus Dean of Research) and Rosa Schnyer, DAOM, LA, Dipl. OM (NCCAOM) of the University of Texas provided technical assistance with the literature review and expert input on the analytic approach. Garen Corbett, MS, of CHBRP staff prepared the introduction and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Theodore Ganiats, MD, of the University of California, San Diego, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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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California Health Benefits Review Program Committees and Staff

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 CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. 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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