Strategies to Expand Health Insurance Coverage of Acupuncture

An Analysis of Policy Alternatives for Massachusetts

Presented to:

The Acupuncture and Oriental Medicine Society of Massachusetts

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Executive Summary

The Problem:

Complementary and Alternative Medicine (CAM), also known as integrative therapies,[1] has gained enormous popularity in the United States. Despite high consumer demand, most of these treatments are not covered by private or public health insurance plans. This creates disparity in care along economic lines for acupuncturists, current acupuncture consumers, and prospective consumers who cannot afford to pay for acupuncture out-of-pocket. While the lack of insurance coverage for integrative therapies is a national issue, it makes the most sense to initiate change at the state level since states have historically served as safe and fertile grounds to experiment with incremental changes in health policy.

This policy brief focuses on ways to expand private health insurance coverage of acupuncture in Massachusetts, a state that has historically been a leader in health reform. We choose acupuncture because it is a popular type of CAM and is already covered by many insurance companies across the nation. There is also extensive evidence that acupuncture is safe and effective, and can save insurers money in the long term, especially for patients with chronic disease.[2] We explore different options for coverage using a recent bill as a starting point for discussion and making certain that all stakeholders are involved in the outcome. Our recommendations are directed to the Acupuncture and Oriental Medicine Society of Massachusetts (AOMSM), the professional association for acupuncturists in the Commonwealth.

Background and Findings:

In Massachusetts, it is up to the discretion of private insurers as to whether or not they cover acupuncture treatments. The three largest insurance companies in the state (Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan)[3] cover acupuncture as a medical benefit if an employer adds it as a rider in a group plan, although very few employers choose to do so since that would increase premiums. Riders are not available for individual plans. All three insurers offer their members a discount off of the provider's usual and customary charge for acupuncture regardless of plan type. These discounts only apply to licensed acupuncturists who participate in the plan's provider network.

There have been two attempts to pass legislation that would mandate insurance parity for licensed acupuncturists in Massachusetts. Both bills died in committee indicating that a new legislative strategy is needed. Other states have been more successful on this front. We analyze best practices in Washington, Florida, and New York which stand out in their level of innovation. Experiences from these states speak to the cost effectiveness of acupuncture, but more research needs to be conducted to see how those savings might apply to Massachusetts. Acupuncture is a relatively safe modality and research on its efficacy is promising, but inconclusive.

The political environment in Massachusetts is necessarily cautious about any legislation that requires spending without reducing costs. This is especially true in the case of health care. Governor Deval Patrick has made a strong commitment to controlling spending, demonstrated by his filing of health care payment reform legislation in May 2011. This has proven to be an obstacle for the passage of acupuncture legislation in Massachusetts. In order for future

legislation to be successful, acupuncture advocates need to impress upon the Legislature that this modality is a viable cost-containment tool.

Key stakeholders who are affected by changes in acupuncture coverage include: acupuncturists, insurance companies, consumers and physicians. Expanding coverage of acupuncture raises conflicts between key values that impact these stakeholders such as: cost effectiveness vs. parity, allopathic medicine vs. acupuncture, and fairness to acupuncturists and acupuncture consumers vs. potentially raising premiums for those who do not care about acupuncture.

Policy Alternatives:

The following policy alternatives for expanding health insurance coverage of acupuncture in Massachusetts are included in this policy brief: 1) maintenance of the status quo of allowing insurance companies to decide whether they want to cover acupuncture 2) passage of a statewide insurance mandate similar to H.R. 3519; and 3) a grassroots campaign to educate stakeholders about the need for insurance coverage under the condition that federal funding for comparative effectiveness research is used to investigate whether acupuncture should be covered in the long term. For each alternative, we discuss benefits and supporters as well as drawbacks and opposition.

Criteria for Evaluation:

In order to evaluate the first two policy alternatives we use the criteria of **equity** and **feasibility**. These are used as benchmarks for comparison and standards against which programs are assessed. Economic efficiency or cost effectiveness is also an important criterion, but because the evidence is inconclusive in this area, we hold off on using it as a tool for deciding which alternative should be adapted. Alternative #3 seeks to address the need for more research on cost as well as the need to educate legislators and the public. This policy alternative assumes that there is enough data from other states (especially Washington) to justify the investment of public dollars to study acupuncture in Massachusetts, but more research needs to be done locally to warrant an insurance mandate.

We find that policy alternative #1 ranks very high on feasibility because nothing new needs to be passed or implemented; however, it ranks very low on equity. While alternative #2 is equitable, it ranks very low on feasibility given that a new insurance mandate would potentially increase costs in an environment where all stakeholders are focused on finding ways to reduce spending. We do not evaluate alternative #3 on the basis of equity because the purpose of this alternative is not to achieve equity on its own, but rather to make it feasible for a more equitable option such as alternative #2 to be passed.

Policy Recommendations:

Based on our analysis, we recommend that AOMSM immediately begin laying the groundwork to make alternative #3 a reality. This alternative provides an equitable solution to getting alternative #2 (our preferred option) passed. We also recommend that alternative #3 be used as a template for professional associations representing other types of integrative therapies whose practitioners and users seek insurance coverage.

Introduction:

Complementary and Alternative Medicine (CAM), also known as integrative therapies,[4] has gained enormous popularity in the United States. The 2007 National Health Interview Survey revealed that 38 percent of adults and 12 percent of children use integrative therapies.[5] Despite high consumer demand, most of these treatments are not covered by private or public health insurance plans.[6] According to the National Center for Complementary and Alternative Medicine (NCCAM), 83 million adults spend $33.9 billion out-of-pocket on integrative therapies. These costs comprise 11.2 percent of total out-of-pocket expenditures on health care, surpassing expenditures for conventional treatments by primary care physicians.[7] The lack of insurance coverage causes integrative therapies to be less affordable and accessible for millions of Americans who could benefit from these services as a form of wellness and disease prevention. Numerous studies show that acupuncture can effectively treat symptoms from conditions such as migraine,[8] cancer pain,[9] fibromyalgia,[10] and chronic pain in elderly patients[11] among others. Acupuncture has also been linked to changes in brain activity.[12] There is no existing related legislation at the federal level and Washington is the only state that requires comprehensive coverage of integrative therapies by private insurance plans.[13] (See Appendix A for detailed definitions of "CAM" and "acupuncture").

While the lack of insurance coverage for integrative therapies is a national issue, it makes the most sense to initiate change at the state level since states have historically served as safe and fertile grounds to experiment with incremental changes in health policy. Massachusetts is an ideal candidate for testing the political feasibility of coverage given that the Commonwealth has historically been a leader in health reform, serving as an example for other states and for the federal government. Because integrative therapies vary in the level of research on their efficacy,

it is most prudent to propose legislation that addresses a single therapy rather than attempting to address all types simultaneously. This policy brief focuses on acupuncture because it is one of the most popular types of CAM and is already covered by many insurance companies across the nation. Research suggests that acupuncture is safe and effective and can save insurers money in the long term, especially for patients with chronic disease.[14] The scope of this brief is limited to private insurance because the process of seeking coverage for medical services under Medicare and Medicaid involves a different group of stakeholders.

The political climate in Massachusetts is focused on cost containment due to the weak economy and the challenges associated with providing subsidized health insurance for low income residents under the Commonwealth's individual insurance mandate. In recent years, the acupuncture community has come together to lobby for reform and has initiated two bills that would have required acupuncture to be covered by private insurers. The bills did not pass, but the acupuncture community is continuing to fight for coverage. There are 1,111 licensed acupuncturists in Massachusetts, 1,012 of whom are actively seeing patients,[15] yet insurance companies have major limitations on coverage for these services. Data from Washington State shows that coverage of integrative therapies, including acupuncture, has been cost-effective since passage of their mandate in 1996. Yet, each year, advocacy groups for integrative therapies in Washington must fight to protect this legislation indicating that the insurance industry was not on board to begin with.[16]

We explore three policy alternatives for consideration by the Acupuncture and Oriental Medicine Society of Massachusetts (AOMSM), the professional association for acupuncturists in the Commonwealth: 1) maintenance of the status quo of allowing insurance companies to decide whether they want to cover acupuncture 2) passage of a statewide insurance mandate similar to

H.R. 3519, the most recent AOMSM-sponsored bill; and 3) a grassroots campaign to educate stakeholders about the need for insurance coverage under the condition that federal funding for comparative effectiveness research is used to investigate whether acupuncture should be covered in the long term. The first two alternatives are evaluated using the criteria of equity and feasibility. We then propose and ultimately recommend policy alternative #3 because it provides an equitable solution to getting alternative #2 (our preferred option) passed.

Background and Overview of Current Knowledge:

Literature on Safety and Efficacy:

Many studies have been done on the safety and efficacy of acupuncture. According to three separate overviews of meta-analyses and systematic reviews, serious adverse events are rare and acupuncture is a relatively safe modality.[17] [18] [19] One of these meta-analyses found that the incidence of minor adverse events may be considerable, but as another review of 57 systematic reviews points out, serious complications from acupuncture are usually caused by malpractice of acupuncturists.[20] Therefore, acupuncture is generally safe as long as it is performed by an appropriately trained practitioner. Adverse events from allopathic modalities are much more common, occurring in anywhere from 3 to 20% of hospitalized patients.[21]

Research on the efficacy of acupuncture is very promising, but inconclusive. For example, a review of three studies (looking at 204 participants) by Cochrane Summaries™ found mixed results about whether acupuncture can relieve pain in cancer patients. One high quality study showed that auricular acupuncture (in the ears) reduced cancer pain compared to acupuncture at non-acupoints. Of the two lower quality studies, one showed that acupuncture was more effective than medication and the second study showed it was more effective. Yet,

both of the latter two studies were poorly designed and the study reports lacked detail. Due to small sample sizes, methodological constraints, a lack of protocol, and different types of patients, the Cochrane review concluded that there is insufficient evidence to judge whether acupuncture is effective in treating cancer pain in adults.[22] These conclusions indicate a need for better designed trials of acupuncture or revision of what constitutes appropriate design.

Acupuncture has been shown to be effective in treating a wide range of other conditions as well. Functional magnetic resonance imaging (FMRI) studies have shown that acupuncture changes brain activity and link it to changes in neurotransmitter activity.[23] A randomized controlled trial on the efficacy of acupuncture in treating migraine attacks found that there was a statistically significant difference in pain, relapse, and aggravation within 24 hours after treatment among the treatment and control groups.[24] A meta-analysis of seven randomized, quasi-randomized, and cohort studies of fibromyalgia patients who used acupuncture found that acupuncture is more effective than sham (fake) acupuncture (a control) for relieving pain, increasing thresholds, improving global ratings, and reducing morning stiffness; however, of the seven studies, only one was of high methodologic quality and the duration of benefits is unknown. This analysis suggests that additional high quality randomized trials are needed in order to provide more robust data on effectiveness.[25]

Acupuncture Usage:

According to the 2007 National Health Interview Survey, an estimated 3.1 million U.S. adults (1 percent of the population) and 150,000 children had used acupuncture during the previous year. Between 2002 and 2007, acupuncture use among U.S. adults increased by 1 million people.[26] During the past five years, these numbers have continued to rise. While state

level data for Massachusetts is not available, one can infer that usage is robust given the number of licensed acupuncturists in the Commonwealth. Pathways for Wellness, the largest non-profit acupuncture clinic in Massachusetts and one of the largest in the nation, provides more than 15,000 treatments per year to more than 1,600 patients. Thanks to its "Share the Care" model, Pathways is able to provide free or low cost treatments to about two thirds of its patients, but each week the clinic has a waiting list of 20 patients and does not have the resources to serve them.[27] Massachusetts is also home to the New England School of Acupuncture (NESA) in Newton, Massachusetts, the oldest acupuncture school in the country[28] which grants approximately 60 Masters in Acupuncture and Masters in Acupuncture and Oriental Medicine degrees each year.[29]

Status of Acupuncture Coverage in Massachusetts:

In Massachusetts, it is up to the discretion of private insurers as to whether or not they cover acupuncture treatments. Interviews with representatives of the three largest insurance companies in the state (Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan)[30] reveal that acupuncture is only covered as a medical benefit if an employer adds it as a rider in a group plan, although very few employers choose to do so since that would increase premiums. Riders are not available for individual plans. All three insurers offer their members a discount off of the provider's usual and customary charge for acupuncture regardless of plan type. These discounts only apply to licensed acupuncturists who participate in the plan's provider network. Blue Cross Blue Shield offers 10-30 percent discounts[31] under its "value added program;"[32] Harvard Pilgrim offers a 25 percent discount[33] for services rendered by acupuncturists who participate in American WholeHealth Networks™, "a national practitioner network for members of participating plans and employer groups;"[34] and Tufts offers a 25

percent discount[35] for acupuncturists who participate in Choose Healthy Networks™.[36] Insurance companies in neighboring New Hampshire have similar policies.[37] These discounts only help patients who can afford to pay out-of-pocket anywhere from 75-90 percent of the usual rate for acupuncture which can vary depending on the type of acupuncture and purpose of the visit. Costs for services vary based on the type of acupuncture being performed. For example, Pathways for Wellness charges $85 for an hour long individual appointment and $25-$45 for a community style session where several patients receive treatment simultaneously. Homecare and hospice visits can cost as much as $175.[38]

Related Legislation and Research on Cost Effectiveness in Other States:

During the past two decades, acupuncture advocates across the country have fought for expanded insurance coverage on the basis of equity, cost-effectiveness, and the potential for improved health outcomes through integrated care. In 1997 alone, 137 laws were enacted in 41 states affecting the finance and practice of CAM services, including acupuncture.[39] In 1998, another 98 laws were passed in 39 states.[40] Under its Every Category of Provider (ECOP) law, passed in 1996, Washington is the only state that requires comprehensive coverage of CAM by private insurance plans;[41] however, other states have also taken leadership roles in making CAM more accessible. We analyze best practices in Washington, Florida, and New York that stand out in their level of innovation and can reassure health care leaders in Massachusetts that coverage of acupuncture will help our bottom line.

Washington:

Data on Washington since passage of its ECOP law shows that coverage of CAM, including acupuncture has been very cost effective in this state. In a comparison of health care

expenditures among users and non-users of CAM in Washington, researchers found that among patients with fibromyalgia, back pain, and menopause symptoms, CAM patients had higher outpatient expenditures that were offset by lower inpatient and imaging expenditures. The largest difference was seen in patients with the heaviest disease burdens among whom CAM users averaged $1420 less than non-users. This was a statistically significant difference ($p<0.001$). Overall, those who used CAM had lower expenditures than those who did not.[42] Given the estimated $356 lower expenditure for each CAM user, the researchers expected an overall $9.4 million difference in expenditures for a group of 26,466 CAM patients compared to a similar group of non-CAM users of equal size.[43] One weakness of the research in Washington is most studies look at CAM as a whole and include, but are not limited to acupuncture. Therefore, it can be difficult to determine how much of the results are directly attributable to one modality over another. Despite these shortcomings, the findings in Washington provide substantial support for the cost effectiveness of covering acupuncture under health insurance plans in Massachusetts.

Research on the behavior of health insurance companies in Washington eight years after passage of their mandate shows that while CAM utilization has increased, CAM expenditures are still such a small percentage of the premium dollar that the increase has not forced companies to take any major actions in response to providing additional coverage.[44] In a political and economic climate where health care costs continue to rise and cost containment is at the top of most policymakers' and business leaders' agendas, insurance coverage of CAM is a viable way for insurers to save money in the long run even if it requires an investment upfront.

Florida:

In 2002, Florida passed a budget bill authorizing the creation of an integrative therapies pilot project to study the effects of massage and acupuncture in Medicaid Provider Access System (MediPass) beneficiaries with chronic pain conditions residing in three counties in the Tampa, Florida area.[45] The project went into effect in 2004 and was administered by Florida's Agency for Health Care Administration and by Alternative Medicine Integration of Florida (AMI), LLC, an independent research and consulting firm. AMI collected physical and mental health information from two groups of beneficiaries- an "eligible, but not managed" group of 494 beneficiaries (11,446 case months) who were eligible to participate in the pilot, but did not receive any CAM services or management during the study, and a "managed" group of 185 eligible beneficiaries (4,284 case months) who did receive these services.[46]

Initial findings from Florida's pilot project reveal that low-income, high utilizing Medicaid beneficiaries can be managed successfully and at a cost-savings through an integrated care approach.[47] By December 2006, mental function among the managed group had increased by 19 percent, physical function by 15 percent, and 88 percent said that the program treatment had helped to reduce their level of pain. Per member per month (PMPM) costs in the managed group were reduced by 9 percent while costs for the non-managed group increased by 15 percent compared to usual care.[48] (See Tables 1 and 2 in Appendix B). Because of these promising results, the pilot was reauthorized in 2007 for an additional three years and the number of managed patients was increased to 500. The pilot does have certain limitations including the relatively short duration of longitudinal data and the fact that the control group was not randomly selected in terms of their pre-study attitudes toward CAM.[49] Similar to the research in Washington, the managed group was treated with both acupuncture and massage, so it is difficult

to discern how much each therapy individually contributed to the results. Still, Florida's experience warrants consideration by health care leaders in Massachusetts since it demonstrates that acupuncture can improve health outcomes and is cost effective when used to treat pain.

New York:

Research in New York has focused on the degree to which acupuncture can be used as a substitute for, or a complement to, conventional medical services.[50] In a one year study conducted between 2002 and 2003 by Bonafede and colleagues, researchers analyzed claims data of a large insurance company in New York that insures over 80 percent of a midsize metropolitan market. There was an identical 50 percent copayment for acupuncture across all five managed care plans. Patients sought acupuncture for conditions ranging from musculoskeletal disorders (88 percent) to infectious diseases (12.7 percent). The study revealed that acupuncture is a "viable substitute for some medical services such as primary care, all outpatient services, pathology services, all surgery, and some pharmaceuticals…a finding [that is of] importance to insurers, health care practitioners, and policy makers."[51] According to the authors, insurance-covered acupuncture users are sicker than insurance-covered non-acupuncture users and had higher member and plan expenditures and prescription expenditures.[52] Still, expenditures on acupuncture may be offset by reductions in other health care utilization; therefore, reluctance by insurance companies to not cover acupuncture is unfounded.[53] The results of the New York study show that acupuncture can save patients and insurers money by reducing the need for allopathic services.

Legislative History of Acupuncture Coverage in Massachusetts:

Consumer demand for acupuncture is at an all-time high, yet acupuncture is not unanimously covered by private health insurers in Massachusetts. This creates disparity in care along economic lines for acupuncturists, current acupuncture consumers, and prospective consumers who cannot afford to pay for acupuncture out-of-pocket. There have been two attempts to pass legislation that would mandate insurance parity for licensed acupuncturists in the state. Both bills died in committee indicating that a new legislative strategy is needed. Neither bill specified the means through which acupuncture would be covered (i.e. if providers could bill insurers directly and charge patients a co-pay or if the patient needed to pay upfront and submit a bill for reimbursement of the allowable amount). This lack of clarity could be one reason why repeated attempts at achieving coverage have been unsuccessful.

The first acupuncture- related legislation in Massachusetts dates back to 2008 when Richard Ruth, L.Ac. spoke with his state representative, William Pignatelli (D-Lenox) about sponsoring a bill that would mandate insurance coverage for the services of licensed acupuncturists in the state. The bill, H4111, An Act Providing for Medical Coverage of Acupuncture, was filed on February 6, 2009 and co-sponsored by two other state legislators. The bill also gained support from the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), the American Association of Acupuncture and Oriental Medicine (AAAOM), and the New England School of Acupuncture, as well as acupuncture patients and practitioners. [54] The bill died in committee in April 2010 and was accompanied by a study order [55] indicating that more research needed to be completed before the bill could be brought before the full Assembly. Pignatelli said that the bill died because "it was a late file bill and the committee did not understand the concept of acupuncture." Yet, an article in

Acupuncture Today placed the responsibility on a lack of cohesion and agreement within the acupuncture community itself.[56] Naomi F. Alson, co-chair of the Insurance Committee (then Legislative Committee) for AOMSM stated that her organization was working on its own parity bill when Ruth initiated H.R. 4111 without consulting anyone. AOMSM held a meeting and formed an insurance committee, but did not endorse the bill. Alson believes it would have been better if this had been more carefully thought through.[57]

Near the end of 2010, Pignatelli filed another bill, H.R. 3519, An Act Relative to Insurance Coverage for Acupuncture. The bill had nineteen co-sponsors and was referred to the Committee on Financial Services on January 24, 2011. This time the Senate concurred and a hearing took place on September 21, 2011.[58] Reflecting on her testimony at the hearing, Demie Stathoplos, Executive Director of Pathways for Wellness commented that many of the legislators still did not understand the concept of acupuncture as a modality. One of the committee members commented that "it sounds like you are saying acupuncture is "magic- that it helps with pain, immune system, allergies, digestion, everything."[59] In March 2012, H.R. 3519 died in committee and was accompanied by a study order along with fifty other bills. Advocates are now in the process of deciding how to proceed from here.

Assessment of Political Environment in Massachusetts:

The political environment in Massachusetts is necessarily cautious toward any legislation that requires spending without reducing costs. This is especially true in the case of health care. As of 2010, over 98 percent of Massachusetts residents have health insurance compared to 93.6 percent when the individual mandate was passed in 2006.[60] Yet, in order to provide coverage for all residents, the Commonwealth has to subsidize coverage for those who cannot afford it.

Spending in subsidized health care programs has grown by double digits since 2008 and now consumes over 35 percent of the state budget.[61] The state health exchanges in the federal Affordable Care Act are based on Massachusetts' example; therefore, the Commonwealth is under intense pressure and scrutiny as the rest of the nation watches to see if we can insure our residents while containing costs. Governor Deval Patrick has made a strong commitment to control spending, demonstrated by his filing of health care payment reform legislation in May 2011.[62] Cost savings for acupuncture generally result in savings down the road (as a result of decreased demand for other services). In order for future legislation to be successful, acupuncture advocates need to impress upon the Legislature that this modality is a viable cost-containment tool.

Key Issues:

Research Methods:

One possible reason why studies about the efficacy of acupuncture and other CAM modalities are inconclusive is that placebo-controlled randomized trials, the gold standard for testing pharmaceutical agents, may not be the best way to evaluate non-allopathic therapies. CAM practitioners argue that these methods discount the synergetic effects of treatments that cannot be split up into parts to be investigated separately. They claim that the total effect adds up to more than the sum of its parts. In the case of acupuncture, studying only the specific effects of inserting a needle into a patient overlooks other potentially important aspects of the intervention initiated by the acupuncturist. If CAM is to be given justice, a better strategy is to extend the research focus to all aspects of the treatment approach. [63] Comparative effectiveness research

offers a means of achieving that goal since it compares the treatment under investigation to the standard treatment instead of to a placebo.

Accountable Care Organizations (ACO's) and Medical Homes:

On January 1, 2012, Accountable Care Organizations (ACO's) became effective as part of the Affordable Care Act (ACA). The ACA defines ACO's as "a group of suppliers and providers of services (i.e. hospitals, physicians, and others involved in patient care) that work together to coordinate care for Medicare patients who are not in a Medicare Advantage private plan."[64] The Medicare Shared Savings Program will reward ACO's that lower growth in healthcare costs while meeting performance standards.[65] Patient-Centered Medical Homes (PCMH's) are a type of ACO that has received special attention in Massachusetts. Governor Patrick's PCMH Initiative involves implementing and evaluating the model in 45 primary practices across Massachusetts with the goal of converting all primary care practices to PCMH's by 2015.[66] Integrative therapies including acupuncture are well positioned to become an important component of PCMH's because these models emphasize whole-person oriented care.[67]

Stakeholders and Assumptions:

Key stakeholders who are affected by changes in acupuncture coverage include: acupuncturists, insurance companies, consumers and physicians. We briefly discuss each of these groups below.

Acupuncturists:

For many years, acupuncturists in Massachusetts have been divided over support of insurance coverage for their services. Some acupuncturists argue that they are discriminated

against by existing policies since many insurers do not recognize them as credentialed health care professionals even though acupuncturists must complete a minimum of 1,095 hours of instruction in acupuncture related courses at an accredited school in order to be licensed in Massachusetts.[68] These acupuncturists believe that if insurers covered acupuncture as a medical benefit, they would be legitimized in the eyes of consumers and the broader medical community. Coverage of acupuncture would also make it easier for acupuncturists to attract consumers since their services would be more affordable. Others fear that insurance reimbursement will drive down the amount that clinicians are reimbursed for acupuncture by insurance companies. As Alson notes, they also do not want to deal with the paperwork burden of billing insurance companies or providing documentation in accordance with "medical necessity" criteria in order to be reimbursed.[69] In order for insurance coverage to be a viable option, the acupuncture community needs to come together in its support of such a related legislative initiative.

Insurance Companies:

Historically, insurance companies have resisted government regulation, especially mandated benefits. Insurers do not want to lose money as a result of increasing their risk pool or expanding coverage without charging higher premiums. In 2007, the Massachusetts Association of Health Plans (MAHP) outlined a seventeen point proposal "designed to improve the affordability and quality of the health care system in the Commonwealth." Among these points were "establish a moratorium on mandated benefits" (#11) and "comparative effectiveness studies of medical services" (#15). In its 2010 annual report, MAHP noted that both of these points "still need work."[70] MAHP reinforced its commitment to mandated benefit reform by listing it as a key component of its 2011-2012 legislative agenda. MAHP defines mandated benefit reform as "impos[ing] a moratorium on new mandated benefits, allow[ing] consumers

and employers to choose mandate-free and mandate-lite products, and requir[ing] an analysis of the cost of new mandated benefits on municipalities and small businesses."[71] Given the Massachusetts insurance industry's commitment to restricting mandated benefits, it is not surprising that previous attempts to mandate acupuncture coverage have been unsuccessful here. If insurers are to support efforts to expand coverage of acupuncture, the acupuncture community must make the argument that investment in acupuncture will save money on chronic disease in the long run and back this up with studies using comparative effectiveness research.

Consumers:

Consumers of acupuncture want affordable coverage of complementary medicine and will benefit from and support any type of expansions in insurance coverage of acupuncture. Depending on the insurance company and the type of reform that is passed, consumers would either pay a co-pay for acupuncture or they might pay upfront for the service and submit a bill to their insurance company for reimbursement. Assuming that insurance companies were to tier acupuncturists along measures of quality the way they currently tier physicians, consumers would be able to compare the value of different acupuncturists. Insurance coverage of acupuncture would have positive implications for consumers in terms of safety regulations as well. In contrast, health care consumers who do not use or believe in acupuncture will oppose expanded coverage of this service. These consumers will resist the prospect of higher insurance premiums to compensate for a mandated benefit they will not use.

Physicians:

Physicians are also likely to be divided in their support of expanded coverage for acupuncture. Physicians who believe in complementary medicine and regularly refer their

patients to acupuncturists will support coverage because it will benefit their patients. According to Stathoplos, "many doctors are anxious to have acupuncture covered because their patients are clamoring for it, and because healthcare providers are some of the most frequent users of acupuncture, they know it works, and want to be able to prescribe it."[72] Other physicians may resent the idea of non-MDs receiving equal reimbursement for services. Even some physicians who support acupuncture may see a bill such as H.R. 1593 as a way of opening the door for coverage of other types of CAM they do not support. In July 2011, the Massachusetts Medical Society testified against passage of Senate Bill 1104, An Act to Expand the Scope of Acupuncture to Treat Drug Addiction" on the grounds that the bill went beyond the treatment of addiction to include "pain management and palliative care, and acupuncture anesthesia." The Society took the position that acupuncture was not safe to treat these conditions.[73]

Policy Alternatives:

This section proposes three policy alternatives to be considered by the acupuncture community to address the lack of insurance coverage for acupuncture in Massachusetts. These include: 1) maintenance of the status quo of allowing insurance companies to decide whether they want to cover acupuncture 2) passage of a statewide insurance mandate similar to H.R. 3519; and 3) a grassroots campaign to educate stakeholders about the need for insurance coverage under the condition that federal funding for comparative effectiveness research is used to investigate whether acupuncture should be covered in the long term. For each alternative, we discuss benefits and supporters as well as drawbacks and opposition.

Criteria for Evaluation:

In order to evaluate the first two policy alternatives proposed in this brief we use the criteria of **equity** and **feasibility**. These are used as benchmarks for comparison and standards against which programs are assessed. Economic efficiency or cost effectiveness is also an important criterion, but because the evidence is inconclusive in this area, we hold off on using it as a tool for deciding which alternative should be adapted. Alternative #3 seeks to address the need for more research on cost as well as the need to educate legislators and the public.

Equity:

Equity is "the study of who gets what, when, and how."[74] Technically, all Massachusetts residents have *equal opportunity* to acupuncture, but not everyone has *equal access*. As long as acupuncture is not covered by health insurance plans, only consumers with discretionary income can afford these services. Professional equity is relevant to acupuncturists because as licensed health care professionals, they are not currently acknowledged as such by insurance companies. This directly influences the demand for acupuncture services.

Feasibility:

To determine which policy alternative has the greatest chance of being successfully passed and implemented, we use John Kingdom's agenda setting model. Kingdom identifies "three streams or dynamic processes that must be moving at the same time" for any major policy to occur. These include the *problem stream*, *political stream*, and the *policy stream*. The most important stream for feasibility is the *political stream*, "the sense among those with the power to act that the timing for action is right in relation to public sentiment and consistency with other policy objectives."[75] The feasibility of expanding insurance coverage for acupuncture in

Massachusetts is very closely related to economic efficiency since cost containment is a major priority for most stakeholders.

Policy Alternative #1- Maintenance of the Status Quo:

The first alternative is to take no action and maintain the status quo of not covering acupuncture under private health insurance plans in Massachusetts. Please refer to the "Status of Acupuncture in Massachusetts" section of this brief for details about current policies.

Benefits and Supporters:

The primary benefit of maintaining the status quo is that insurance premiums will not need to universally increase to pay for coverage of an additional service that not all consumers will use. Based on the data for other states that we discussed above, one could argue that the upfront costs of a mandate would be offset by long term savings, but because exact numbers are not available, insurers are likely to support alternative #1. Physicians and consumers who do not use or believe in acupuncture will also support the status quo. Finally, some acupuncturists will support alternative #1 because they do not want to deal with the paperwork burden associated with accepting insurance. Even if these acupuncturists choose to not accept insurance, they will be competing against colleagues who do.

Drawbacks and Opposition:

The major drawback of maintaining the status quo is that acupuncture will continue to be unaffordable for many Massachusetts residents. Current and prospective acupuncture consumers, and acupuncturists who would like to be able to accept insurance will oppose alternative #1. Although they may not acknowledge it, insurance companies also stand to lose under the status

quo in the form of more expensive medical claims that could have been prevented if acupuncture had been within reach of more beneficiaries. Physicians who regularly refer their patients to acupuncturists will oppose alternative #1 because limits on access to key wellness services translate into less healthy patients.

Policy Alternative #2- Pass an Insurance Mandate:

The second alternative is to lobby the Massachusetts Legislature to pass a bill similar to H.R. 3519 that would require a statewide mandate for coverage of acupuncture by private health insurers. Since the two bills discussed earlier in the "Background" section of this policy brief were unsuccessful, we recommend that a new bill include several improvements to clarify some points that were left open to interpretation in the old legislation.

First, the mechanism through which acupuncture is to be covered needs to be more clearly specified. H.R. 3519 simply states that all individual or group health insurance policies shall provide benefits for acupuncture diagnostic techniques, acupuncture services, and acupuncture therapies provided that the care is provided by a licensed acupuncturist.[76] There is no indication as to whether the consumer will only be responsible for a co-payment (similar to what one would pay for a specialist visit under most insurance plans) or if the consumer is expected to pay upfront for the entire service and submit a bill to their insurance company for reimbursement.

Second, the new bill should state whether acupuncturists need to join insurance networks in order for their services to be covered. In the case of allopathic medicine, consumers who receive their health insurance through a health maintenance organization (HMO) can only receive benefits through in-network providers. In contrast, consumers with a preferred provider

network (PPO) plan can see providers outside their network, but must pay more for these services. Some acupuncturists may resist the idea of participating in an insurance network, but we believe that the bill should allow for this so that consumers have the option of making a co-payment instead of being reimbursed later.

Third, the new bill needs to specify that acupuncture is to be covered only for documented medical reasons. This will alleviate any concerns on the part of insurers and cost-conscious consumers that insurance companies could reimburse acupuncturists for services that are not medically necessary for a given patient. H.R. 3519 does not speak to this issue at all.

Finally, the new bill should incorporate a means of ensuring accountability for acupuncturists. We recommend that the bill authorize creation of an online portal similar to "Physician Profiles"[77] through the Massachusetts Board of Registration in Medicine, where consumers can look up information on any acupuncturist in the Commonwealth. Currently, consumers can look up any physician's contact information, accepted insurance plans, education and training, board certifications, professional publications and malpractice information. This should be easy to implement since acupuncturists are already licensed by the Board.

Benefits and Supporters:

The most significant benefit of a statewide insurance mandate is that acupuncture will be reimbursed fairly. Consumers who use acupuncture will be strong supporters of a mandate because acupuncture will now be more affordable, and for many people, accessible for the first time. Acupuncturists who plan to accept insurance under the mandate will support the legislation because they will no longer need to turn away patients who cannot afford to pay. This may be especially helpful for acupuncturists who are in the early years of building their practices or

work in areas that are economically disadvantaged. A mandate will benefit the acupuncture community as a whole since the profession will be legitimized in the eyes of skeptics.

Insurance companies may not initially support a mandate, but they will benefit from the legislation. By forcing all insurance companies to cover acupuncture, the companies will not need to compete with each other over coverage of acupuncture as a "wellness benefit." Instead, they stand to gain from having healthier beneficiaries and overtime, a lower risk pool. As the data from Washington shows, the potential savings of covering acupuncture in Massachusetts are considerable.

Drawbacks and Opposition:

The primary drawback of a mandate is that even if insurers save money in the long run, higher premiums may be necessary in the short term to cover immediate costs in a state where cost containment is already a major issue. The exact amount premiums would need to increase by is unknown; hence, the need for more studies using comparative effectiveness research. Some acupuncturists may oppose a mandate on the grounds that the "allowable amount" they would be reimbursed by insurers is likely to be less than the real cost of the service. Yet, these acupuncturists can choose to not accept insurance and utilize a self-pay option the way some allopathic practitioners do.

Evaluation of Policy Alternatives #1 and #2:

Equity:

Policy alternative #1 ranks very low on equity. Under the status quo, acupuncturists will continue to be discriminated against and acupuncture will be unaffordable for many consumers,

especially vulnerable populations, who could benefit from these services. Alternative #2 ranks very high on equity. A statewide mandate would make acupuncture affordable to anyone with private health insurance who can afford a co-payment for a specialist visit.

Feasibility:

Policy alternative #1 ranks very high on feasibility because nothing new needs to be passed or implemented. While alternative #2 is equitable, it ranks very low on feasibility given that a new insurance mandate would potentially increase costs in an environment where all stakeholders are focused on finding ways to reduce spending.

The Need for a Third Alternative:

The fact that the last two acupuncture-related bills were referred for further study indicates that the acupuncture community needs a new advocacy strategy. The current political environment requires that more research must be conducted on cost effectiveness and legislators must be educated about acupuncture as a health care modality. Even with the improvements we recommend to H.R. 3519, the chances of such a bill passing at the time of this writing are slim to none. As Table 3 demonstrates below, our preferred alternative is not politically feasible and the status quo is unacceptable. This brings us to our third alternative which seeks to address these shortcomings.

Table 3: Policy Alternatives #1 and #2 Against Criteria

	Equity	**Feasibility**
Alternative #1: Status Quo	Very low	Very high
Alternative #2: Insurance Mandate	Very high	Very low

Policy Alternative #3- Pilot Study and Grassroots Campaign:

Our third alternative has two components. First, we recommend that AOMSM seek federal funding from the Patient Centered Outcomes Research Institute (PCORI) to conduct a comparative effectiveness pilot study in Massachusetts that investigates the efficacy and cost effectiveness of acupuncture for different medical conditions. The reason for pursuing such a study is to gather the local data necessary to make alternative #2 feasible in the future. Second, we recommend that AOMSM organize a grassroots campaign to educate stakeholders about the value of acupuncture while the pilot study is in progress. That way, the acupuncture community will be prepared to lobby the Legislature with the new research as soon as the pilot is completed. This policy alternative assumes that there is enough data from other states (especially Washington) to justify the investment of public dollars to study acupuncture in Massachusetts, but at this time, we cannot be specific enough about the "best" use of acupuncture in terms of cost and clinical outcomes) to provide effective care. More research needs to be done locally to warrant an insurance mandate.

About the Pilot Study:

Funding:

In recent years, the federal government has recognized CAM (and specifically acupuncture) as an area worthy of further investment and research using funds for comparative effectiveness research. In June 2009, the Institute of Medicine came out with a report, *Initial National Priorities for Comparative Effectiveness Research*. Among the report's 100 initial priority topics, acupuncture is listed in the third quartile, specifying that the effectiveness of this treatment should be tested for various indications using a cluster randomized trial. Because of

this interest, there is reason to believe that PCORI would respond favorably to a request to fund a pilot study on acupuncture in Massachusetts.

PCORI just concluded its merit reviews for funding requests from 2011 and decisions will not be announced until May 21, 2012. Since last year was the first time PCORI accepted applications, there are no award amounts for past grantees that can be used to determine the amount of funding AOMSM can expect to receive. This summer, AOMSM should review past awards to determine what is reasonable to ask for. The next round of applications will be due in December 2012.[78] See Table 4 in Appendix B for a suggested timeline for implementation of the study.

Design:

In accordance with PCORI's preferences, AOMSM in cooperation with one of the universities in the Boston area is to request funding for a cluster randomized trial where individuals are randomized into groups (i.e. the group is the unit of analysis, not the individual). In cluster randomized trials, it is helpful to look at dichotomous outcomes such as "a treatment was a success or a failure."[79] We recommend that AOMSM look at medical conditions that are likely to improve the most from acupuncture based on existing research. Examples include cancer pain, nausea, fibromyalgia, and migraine. Each condition will constitute a group or "cluster" within the study. Criteria for "success" will be lower medical claims (quantitative data) and improved clinical outcomes (both qualitative and quantitative). The pilot will be a longitudinal study that lasts two years. This allows enough time to study the effect of acupuncture on patients within each "cluster" and to see if cost savings are realized in the form of lower medical claims for these groups.

For the purposes of comparative effectiveness, each cluster will be divided into three groups- a control group that receives the standard allopathic treatment for pain, a control group that receives sham (fake) acupuncture to control for the placebo effect, and a treatment group that receives therapeutic acupuncture. To address one of the weaknesses of the research in Washington and Florida, participants in the Massachusetts study will only receive acupuncture, not other types of CAM that could be considered confounding variables.

Sampling and Recruitment:

Patients are to be recruited from one of the Boston area hospitals that offer acupuncture through an integrative therapies clinic such as the Leonard P. Zakim Center for Integrative Therapies at Dana-Farber Cancer Institute, the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital, or the Osher Clinical Center for Integrative Medical Therapies at Brigham and Women's Hospital. The sample size needs to be representative of the target population (Massachusetts residents) and can be determined during consultation with university researchers who will be responsible for carrying out and evaluating the results of the study. Participants will be randomly selected to control for variables such as race, gender, ethnicity, and income. Patients should be otherwise healthy besides the condition they are receiving treatment for.

Ethical Considerations:

To comply with HIPPA regulations, patients would need to agree to release their relevant health records with the understanding that only aggregate data for each group would be provided to researchers. In the treatment and sham control groups, acupuncture would only be substituted

for conventional pain relievers. For ethical reasons, no group is to be denied chemotherapy or any other curative intervention.

About the Grassroots Campaign:

While the pilot study is in progress, AOMSM is to organize a grassroots public policy campaign to educate the Massachusetts Legislature and the public about the efficacy of acupuncture and the importance of passing an insurance mandate to cover it. We use guidelines from renowned lobbyist Judith Meredith's workbook Real Clout to offer recommendations for designing an effective issue-based campaign. See Table 5 in Appendix B for a suggested timeline for implementation of the campaign.

Developing a Campaign Message:

Developing a campaign message is the first step to mounting a successful public policy campaign, but before a message can be disseminated, the host organization must persuade allies to join its coalition.[80] AOMSM's legislative committee will spearhead this initiative in collaboration with the New England School for Acupuncture (NESA) in Newton, MA, Pathways for Wellness in Boston, and other organizations that share the vision of equal access to acupuncture. Next, the coalition must convince private donors to contribute to the campaign.[81] AOMSM can seek donations from its membership. NESA and Pathways for Wellness have their own donor bases that can be tapped as well. The coalition also must recruit affected constituents into its district-based grassroots network.[82] AOMSM and its coalition partners should create a mailing list of patients who have personally benefited from acupuncture, are willing to share their stories, and volunteer time and/or money to the campaign. Once these tasks have been completed, AOMSM and its partners can disseminate the campaign message through a variety of

vehicles such as outlines of research reports, fact sheets, talking points, and slogans. Bumper stickers, and sound bites.[83]

Building and Sustaining Operational Coalitions:

The second step in developing a campaign is to build and sustain an operational coalition. AOMSM should look for "untraditional allies" in the business community and trade associations. A steering committee should be formed of the major partners who have a high level of commitment to the campaign. Each organization should be able to contribute something unique in the form of cash, grassroots capacity, and/or political capital. The committee should have a democratic structure to ensure that all stakeholders have input.[84] As the campaign progresses, it is important that powerful stakeholders such as insurance companies have a seat at the table. Otherwise, Massachusetts risks falling into the same trap as Washington where acupuncturists continue to fight to keep their law on the books.

Organizing and Mobilizing Grassroots Activists into Action:

Once the campaign's message and operational structure are in place, the coalition can mobilize and expand its base. Each organization's board and staff should be asked to identify local coordinators who can assume leadership roles in different regions of the state. These coordinators need to be briefed on the relevant policy issues so that they can go back home and immediately organize local training sessions.[85] Once local efforts are underway and the acupuncture community is unified as one voice for change, state capitol activities such as lobby days and legislative briefing sessions should be planned[86] in order to pass a new bill similar to the one proposed in policy alternative #2 above, assuming that the results of the pilot study offer promising support that a statewide insurance mandate will be cost effective.

Recommendations:

Table 6 below compares all three policy alternatives against our criteria. We do not evaluate alternative #3 on the basis of equity because the purpose of this alternative is not to achieve equity on its own, but rather to make it feasible for a more equitable option such as alternative #2 to be passed.

Table 6: All Policy Alternatives Against Criteria

	Equity	Feasibility
Alternative #1: Status Quo	Very low	Very high
Alternative #2: Insurance Mandate	Very high	Very low
Alternative #3: Pilot Study and Grassroots Campaign	N/A	Very high

Based on our analysis, we recommend that AOMSM immediately begin laying the groundwork to make alternative #3 a reality. If Massachusetts does not take action on this issue, acupuncture will continue to be out of reach for millions of people. Furthermore, insurance companies (and the Commonwealth) will lose the opportunity to lower costs by making a key form of wellness and disease prevention available to more citizens. We also recommend that alternative #3 be used as a template for professional associations representing other types of integrative therapies whose practitioners and users seek insurance coverage. As stated in the introduction to this brief, the best way to achieve coverage of integrative therapies is to do so incrementally by lobbying for coverage of one modality at a time. As more patients have access to acupuncture and other types of integrative therapies, we will have a healthier Commonwealth and more productive workforce.

Appendix A
Definitions

Complementary and Alternative Medicine (CAM) is difficult to define because the field is so broad and constantly evolving, but the National Center for Complementary and Alternative Medicine (NCCAM) characterizes it as "a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine."[87] For these purposes, conventional (or Western/allopathic) medicine includes medical doctors, doctors of osteopathy, and allied health professionals such as registered nurses, physical therapists, and psychologists. "Complementary medicine" refers to practices such as acupuncture that are often used alongside conventional medicine to relieve pain. In contrast, "alternative medicine" is used as a substitute for conventional medicine. This policy brief refers to the use of acupuncture as a complementary medicine, not an alternative one.

Acupuncture describes a family of procedures that aim to restore and maintain health through the stimulation of specific anatomical points on the body using a variety of techniques. The technique most often studied scientifically involves penetrating the skin with thin, solid, metallic needles that are manipulated by the hands or by electrical stimulation. According to acupuncture and oriental medicine, acupuncture seeks to achieve homeostasis between "yin" and "yang," two opposing and inseparable forces in the body which when properly aligned, enable the body to be in a healthy, balanced state. An imbalance in these forces can result in a blockage of "qi" (vital energy) along pathways called meridians. A skilled acupuncturist can unblock qi by using acupuncture at certain points along the body that connect with those meridians. The number of meridians is thought to range between fourteen and twenty. These channels connect the body in a matrix of at least 2,000 acupuncture points.[88]

A key component of traditional Chinese medicine, acupuncture is one of the oldest healing practices in the world and has been practiced in Asian countries for thousands of years.[89] The first news of acupuncture hit the U.S. mass media in 1971 when *New York Times* reporter James Reston wrote an article that explained how doctors in China used needles to abate his pain after receiving an appendectomy.[90] Today, acupuncture is increasingly popular among physicians, dentists, acupuncturists, and other health professionals who use it to relieve or prevent pain and to treat other conditions.

Appendix B

Tables

Table 1: The Florida Medicaid Integrative Therapies Pilot Project Clinical and Cost Outcomes at a Glance[91]

Measure	Findings
SF-12 Survey Mental Function	16% increase, year 1
	20% increase, year 2
	19% increase, year 3
SF-12 Survey Physical Function	20% increase, year 1
	24% increase, year 2
	15% increase, year 3
"Program treatment providers helped to reduce my levels of pain"	86% yes, year 1
	94% yes, year 2
	88% yes, year 3
Per Member Per Month (PMPM) Costs	9% decrease
PMPM Costs in the population with usual care	15% increase

**The measurement timeframe is different for year 3. Previous SF-12 scores were measured annually, while year 3 scores incorporate those that had been measured at the 6 month mark. This may indicate a correlation between level of overall improvement and total time spent in the Integrative Therapies Program.*

Table 2: PMPM Costs, Pre and Post Intervention Period[92]

	Pre-Intervention PMPM*	Post-Intervention PMPM*
Eligible, Non-managed	$801	$902
Managed	$906	$821

**Actual claims costs incurred for medical and pharmacy services.*

Table 4: Suggested Timeline for Pilot Study	
Action Item	**Deadline**
Review PCORI awards from last year	June 2012
Consult with universities and acupuncture clinics to partner with	June - August 2012
PCORI application for funding due	December 2012
Decide on a university partner and clinic	January 2013
PCORI awards announced	May 2013
Recruitment period for pilot study	June 2013 - November 2013
Surveys designed to collect qualitative data	August 2013
Baseline data collected from participants	December 2013
Pilot study in progress	January 2014 - January 2016
Analysis of results	February 2016 - June 2016

Table 5: Suggested Timeline for Grassroots Campaign		
	Action Item	**Deadline**
Developing a Campaign Message	Recruit allies	June 2012 – October 2012
	Solicit private donors	October 2012 – January 2013
	Dissemination of message	February 2013 – January 2014
Building and Sustaining an Operational Coalition	Look for untraditional allies/form steering committee	January 2014 – June 2015
Organizing/Mobilizing Activists into Action	Identify local coordinators	June 2015
	Lobby legislators	Beginning February 2016

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