COMMENTS TO DC DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING ON ESSENTIAL HEALTH BENEFITS AND SELECTION OF A NEW BENCHMARK PLAN

Acupuncture Society of the District of Columbia
May 31, 2015

The Acupuncture Society of DC (ASDC) appreciates the opportunity to provide comments to the DC Department of Insurance, Securities, and Banking (DISB) regarding the DC Health Benefits Exchange Authority's (HBX) selection of a new Affordable Care Act Benchmark Plan for 2017.

Summary of Recommendation

ASDC strongly believes that the HBX should choose a Benchmark Plan that covers acupuncture. Of the ten options for a Benchmark Plan, the following options cover acupuncture:

Option E: Blue Cross Blue Shield FFS Standard Plan
Option F: Blue Cross Blue Shield FFS Basic Plan
Option G: Government Employee Health Association Plan FFS Standard[1]

We urge the HBX to choose one of these three plans, for the following reasons, described in detail below:

- Public demand for acupuncture is increasing;
- Acupuncture meets certain 2013 HBX criteria for Essential Health Benefits (EHBs);
- Acupuncture is medically effective;
- Acupuncture is cost effective;
- Other States require insurance coverage for acupuncture.

Who We Are

The Acupuncture Society of the District of Columbia (ASDC) is a non-profit organization dedicated to educating the public about acupuncture and traditional East Asian medicine; protecting and promoting the integrity of the medicine; and broadening opportunities for practitioners and consumers through education, legislative action, and communication. We are the sole professional organization of practitioners of acupuncture and East Asian medicine in D.C.

[1] The GEHA plan appears to cover acupuncture only if delivered by an MD or DO. It is our understanding that this is impermissible under the ACA Section 2706(a) "Provider Nondiscrimination," which states that health insurance plans "...shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law." If the GEHA plan is selected, this issue must be addressed. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html

Rationale for Recommendation to Choose Option E, F, or G

ASDC recognizes that there are many factors the HBX must consider in selecting a Benchmark Plan. We urge the HBX to consider coverage of acupuncture very high among those factors, for the following reasons.

Public Demand for Acupuncture is Increasing

- Some consumers prefer non-invasive, non-pharmacological interventions when those interventions are safe and effective. Over the last decade or so, ASDC members have observed that physicians are increasingly referring patients for acupuncture treatment, particularly where allopathic interventions have been ineffective, or where the patient does not tolerate the allopathic interventions well.

- Studies have shown that consumer use of acupuncture is on the rise. For example, a 2013 Rand study found a 16 percent increase in the number of users of acupuncture from 2002 to 2008, even though visits to most other CAM practitioners were stable during that period.[2] The NIH estimates that in 2007, almost $12 billion was spent on visits to CAM practitioners, including acupuncturists, which is about 25 percent of total out-of-pocket expenditures on physician visits.[3] A related NIH study found that in 2007, 1.5% of American adults received acupuncture treatment.[4]

Acupuncture Meets Certain 2013 HBX Criteria for an EHB:

- In early 2013, the HBX Standing Advisory Board established a set of criteria for framing their recommendations on selecting EHBs. Criteria #11 was "Address current market needs and future market trends", and Criteria #12 was "Accommodate demographic and taste differences among consumers." Assuming the Board still holds these criteria as important, selecting a Benchmark Plan that covers acupuncture would directly address these criteria.

Acupuncture is Medically Effective

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[2] Davis, Matthew A. *et al,* US Spending on Complementary and Alternative Medicine During 2002--08 Plateaued, Suggesting Role in Reformed Health System, Health Aff January 2013 vol. 32 no. 1 45-52, Exhibit 3. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3644505/

[3] Nahin, R.L., *et al,* Costs of Complementary and Alternative Medicine (CAM) and Frequency of Visits to CAM Practitioners: United States, 2007, *National Health Statistics Reports; no. 18.* Hyattsville, MD: National Center for Health Statistics, 2009. https://nccih.nih.gov/sites/nccam.nih.gov/files/nhsrn18.pdf

[4] Barnes PM, Bloom B, Nahin RL. Complementary and alternative medicine use among adults and children: United States, 2007. Natl Health Stat Report. 2008;(12):1-23 http://www.cdc.gov/nchs/data/nhsr/nhsr012.pdf

- In 2011, the California Health Benefits Review Program (CHBRP), in it's analysis of a bill requiring acupuncture coverage in the State, conducted a literature review of the medical effectiveness of acupuncture. They focused on studies with the strongest research designs that were also recent; they also emphasized studies of musculoskeletal and neurological conditions. Using a "preponderance of the evidence" standard, they identified a range of musculoskeletal and neurological conditions for which acupuncture is effective, including back pain, peripheral joint osteoarthritis, migraine headache, and smoking cessation, among others.[5]

- The 2011 CHBRP study also stated that research studies using "sham acupuncture" as a control "...*may understate the effects of acupuncture* [emphasis added], because there is considerable evidence that sham acupuncture is not an inert placebo."[6]

- Many studies conducted in the US use "sham acupuncture" (i.e., acupuncture that is improperly delivered) as the "no treatment" control. Usually, the results of these studies show that both the properly delivered acupuncture and the improperly delivered (i.e., "sham") acupuncture have a positive effect on the condition being treated, with the properly delivered acupuncture the most effective. The fact that the sham control has some positive effect, however, can result in a statistically insignificant difference between the treatment arm and the control arm, and thus a conclusion is drawn that acupuncture is "ineffective" for that condition. There is increasing concern in the research community that improperly delivered acupuncture ("sham") is *not* the most appropriate experimental control, and is resulting in significant underestimation of acupuncture's medical effectiveness.

- In 2012, the American Association of Acupuncture and Oriental Medicine (AAAOM) summarized medical effectiveness and cost effectiveness research on acupuncture. Acupuncture was shown to be highly effective for a number of medical conditions, including management of chronic pain, increasing conception rates in infertile couples, reducing chemotherapy induced nausea and vomiting, and treatment of migraine headaches, among others.[7]

- A 2012 study in JAMA Internal Medicine concluded that acupuncture is effective in treating at least four chronic pain conditions (back and neck pain, osteoarthritis, chronic headache, and shoulder pain), and is a reasonable referral option.[8]

Acupuncture is Cost Effective

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[5] California Health Benefits Review Program, Analysis of Assembly Bill 72: Health Care Coverage: Acupuncture, March 18, 2011, pages 6-8. http://chbrp.ucop.edu/index.php?action=read&bill_id=111&doc_type=3

[6] Ibid., page 7. http://chbrp.ucop.edu/index.php?action=read&bill_id=111&doc_type=3

[7] American Association of Acupuncture and Oriental Medicine (AAAOM) Position Statement in Support of the Designation of Acupuncture as an Essential Health Benefit Service, January 27, 2012 https://c.ymcdn.com/sites/www.aaaomonline.org/resource/resmgr/EHB/AAAOM_EHB_Position_Paper-FIN.pdf

[8] Vickers, Andrew J. et.al., Acupuncture for Chronic Pain: Individual Patient Data Meta-Analysis, Arch Intern Med. 2012;172(19):1444-1453. http://archinte.jamanetwork.com/article.aspx?articleid=1357513

- The AAAOM study cited above concluded that, while additional research is needed, "existing evidence suggests cost savings in the use of acupuncture for treating some common health problems."[9] For example, a Danish study showed some acupuncture patients are able to avoid knee surgery, at a savings of $9000 per patient.[10]

- The 2011 CHBRP study concluded that studies on cost effectiveness of acupuncture have found acupuncture to be cost effective for a wide range of conditions, including allergic rhinitis, chronic headache, neck pain, dysmenorrhea, low back pain, and carpal tunnel syndrome[11].

- The same CHBRP study cited a 2008 study that 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."[12] When medically appropriate, if a condition is treated with acupuncture (vs. with prescription drugs or surgery), the cost of treatment can be much lower. Additionally, the fact that enrollees who had used acupuncture services utilized several medical services less frequently than the mean implies that acupuncture may help promote wellness and resilience.

- The Rand study cited above concluded that integrating some CAM services into standard care might help accountable care organizations reduce costs, increase satisfaction, and meet accountable care goals, because CAM interventions are typically less costly than allopathic interventions, and because of the relatively high patient satisfaction with CAM services.[13]

Other States Require Insurance Coverage of Acupuncture

According to the 2011 CHBRP report, at least ten states (Washington, Florida, Maine, Montana, Nevada, New Mexico, Oregon, Rhode Island, Texas, and Virginia) had some form of requirement for access to acupuncture***[14]***.

Five states (Arkansas, California, Maryland, New Mexico, and Washington) consider acupuncture an Essential Health Benefit for the purposes of the Affordable Care Act***[15]***.

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[9] American Association of Acupuncture and Oriental Medicine, *op.cit.* *https://c.ymcdn.com/sites/www.aaaomonline.org/resource/resmgr/EHB/AAAOM_EHB_Position_Paper-FIN.pdf*

[10] Christensen, B.V. et. al, Acupuncture treatment of severe knee osteoarthrosis: A long-term study, Acta Anaesthesiol Scand. 1992 Aug;36(6):519-25. http://www.ncbi.nlm.nih.gov/pubmed/1514335

[11] California Health Benefits Review Program, *op. cit.*, pages 10, and 43-44. http://chbrp.ucop.edu/index.php?action=read&bill_id=111&doc_type=3

[12] California Health Benefits Review Program, *op. cit*., page 43. http://chbrp.ucop.edu/index.php?action=read&bill_id=111&doc_type=3

[13] Davis, Matthew A., *op. cit.,* Discussion http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3644505/

[14] California Health Benefits Review Program, Analysis of Assembly Bill 72: Health Care Coverage: Acupuncture, March 18, 2011, page 19. http://chbrp.ucop.edu/index.php?action=read&bill_id=111&doc_type=3

ASDC hopes to see the District of Columbia counted among these States in the near future.

[15] University of Pennsylvania Leonard Davis Institute of Health Economics, Essential Health Benefits: 50 State Variations on a Theme, October 2014 http://ldi.upenn.edu/uploads/media_items/essential-health-benefits-50-state-variations.original.pdf