

COMPLEMENTARY AND ALTERNATIVE MEDICINE: THE ROAD LESS TRAVELED?

Background

Complementary and alternative medicine (CAM) covers a wide range of medical approaches, therapies, and philosophies that, in general, have been rejected or neglected by physicians in the United States in the age of modern medicine. As its name suggests, CAM therapies can either be used in conjunction with (“complementary”), or instead of (“alternative”) more conventional treatments.

Signs of a new openness to CAM have begun appearing in recent years: more research is being done on various CAM practices; a growing number of medical schools are teaching CAM courses; more private insurance plans are beginning to recognize the utility of some forms of CAM and are offering coverage in conjunction with conventional treatments; federal programs are examining CAM treatments; state governments are passing legislation on access to CAM and the scope of practice of its practitioners; and media coverage of CAM is becoming more prominent.

Popular forms of CAM treatments include, but are not limited to, the following:¹

- **Acupuncture:** Uses thin, hollow needles inserted into specific “reflex points” to relieve pain and to treat conditions.
- **Homeopathy:** Uses very small and diluted doses of natural, yet frequently poisonous, substances to produce symptoms similar to that of the illness in order to stimulate the immune system and restore health, in the belief that “like cures like.”
- **Naturopathy:** Uses a variety of nontoxic therapies to help the body heal itself, including such methods as clinical nutrition, herbal medicine, aromatherapy, massage, homeopathy, and stress-reduction techniques.
- **Herbal therapies:** Involves ingestion of various plant-derived preparations to counteract pain and illness, to prevent sickness, and to maintain vitality.²
- **Nutritional supplements:** Involves ingestion of various products, such as vitamins and minerals, usually in combinations and high doses, for therapeutic and preventive purposes.³
- **Chiropractic services:** Adjusts the spine to treat pain and improve general health.⁴
- **Massage therapy:** Uses manual massage to enhance relaxation, elevate mood, decrease pain, and heighten immune response.

CAM can also include practices such as biofeedback, exercise/movement, meditation, tai chi, spiritual healing, ayurvedic medicine, hydrotherapy, lifestyle diet, relaxation, imagery, reiki, folk remedies, hypnosis, enzyme therapy, the Dr. Dean Ornish Program for Reversing Heart Disease®,⁵ Christian Science healing, yoga, and art/music therapy. CAM therapies are given many labels: unconventional, holistic, and integrative are a few examples.

It is important to note that definitions of CAM usually exclude therapies that are already used in conventional medical treatment and recommendations (i.e., exercise to treat hypertension).⁶ CAM also does not include mainstream therapies such as podiatry, ophthalmology, or midwifery. In this *Issue Brief*,⁷ we adhere to this common delimitation of CAM.

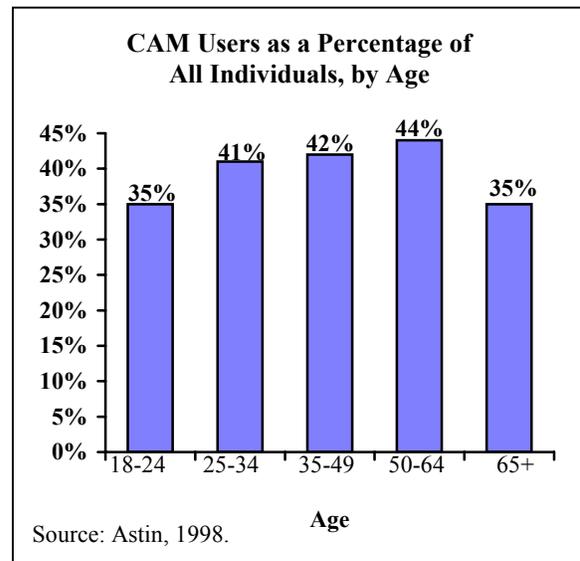
Many CAM therapies can be classified as preventive medicine. Preventive medicine is any medical practice that focuses on preventing illness, including such activities as diet, health counseling, diagnostic procedures, hygiene, and health education.⁸ Furthermore, several types of CAM practices fall under the definition of self-care. It is estimated that more than 80 percent of health care is self-care, which includes following a healthy lifestyle, focusing on disease prevention, and managing some health concerns without professional guidance.⁹

Profile of CAM Users

Researchers have investigated the characteristics of persons who use CAM. Higher levels of education and poorer overall health were among the top five variables that predict use of CAM therapies. Other predictors included cultural values, having had an experience that changed an individual's outlook on life and health, and having a holistic view of health (an idea that health requires harmony of mind, body, and spirit). A person's gender, ethnicity, and negative attitudes toward—or unsatisfactory experiences with—conventional medicine were not found to be factors that predicted the likelihood of CAM usage.¹⁰

The largest group of CAM users is the pre-baby boom generation: individuals ages 50–64.¹¹ However, other data show that individuals age 65 and over are joining the ranks of CAM users in increasing numbers. Research shows that middle-aged and older Americans have driven much of the current market expansion, including those seeking general health improvement, pain management, and relief for conditions they believe are not effectively treated by conventional medicine.¹²

While there does not appear to be a significant relationship between the type of CAM therapy an individual seeks and the particular health condition from which he or she suffers, CAM treatments are frequently used to treat certain health problems. These problems can include anxiety, back problems, chronic pain, and urinary tract disorders.



About 37 percent of patients who seek CAM treatments cite chronic pain as their main complaint. Other frequent complaints that prompt visits to CAM providers include addictive problems (25%), arthritis (25%), and headaches (24%).¹³ Almost half of people age 65 and older who suffer from arthritis use some type of CAM.¹⁴

According to a 1999 Harris Poll, more than 68 percent of adults use the Internet to find health information. Some of the most frequently trafficked sites contain information about CAM. Some of the demographics of Internet users are similar to those of CAM users (e.g., educated adults, high earners, older Americans).¹⁵

Utilization of CAM

Dr. David Eisenberg published the most comprehensive study of the use of alternative therapies in a 1993 edition of the *New England Journal of Medicine*. In 1998, he and his research team authored a follow-up national survey that appeared in the *Journal of the American Medical Association (JAMA)*. The more recent study compares 1990 and 1997 data. Overall, 42 percent of survey respondents reported using some form of CAM in 1997, compared with 34 percent of adults in 1990. Eighty-three million people sought CAM in 1997, up from 60 million just seven years earlier.¹⁶

Visits to chiropractors and massage therapists accounted for just under half of all visits to CAM practitioners. A study of persons age 65 and older showed that herbal medicine was the most frequently used CAM therapy in that age group; the study reported use by almost one quarter of respondents.¹⁷ Of the adults who visited CAM practitioners in 1997, 42 percent sought treatment for an existing illness, while the remainder sought to prevent future illness or maintain their vitality.¹⁸

In 1998, another national study found that the majority of individuals who used CAM therapies did so as complementary to, rather than as an alternative to, conventional treatments.¹⁹ Various other surveys indicate that more than half of CAM users notice a decrease in their visits to conventional doctors, and a similar percentage say that CAM treatments have diminished their use of prescription drugs.²⁰

The supply of CAM practitioners reflects individuals' demand for these treatments. In 1997, there were 64,400 licensed CAM practitioners in chiropractic, acupuncture, and naturopathy.²¹ About 52,000 of these providers alone were practicing in chiropractic medicine, the third largest group of primary care practitioners in the United States. Of the estimated 10,000 accredited acupuncturists in the United States, 1,000 are medical doctors. Additionally, 300 naturopathic physicians graduate from the three U.S. schools of naturopathy every year.²² The total number of CAM practitioners is projected to nearly double by the year 2005, and nearly triple by the year 2015 (a growth of 150 percent over 20 years).²³

Federal Government Research on CAM

In 1992, a Congressional mandate established the Office of Alternative Medicine (OAM) as a small entity within the National Institutes of Health (NIH). The Omnibus Appropriations Act of 1998 renamed the office the National Center for Complementary and Alternative Medicine (NCCAM), and elevated its status to one of NIH's 25 centers. The NCCAM provides the public with reliable

information on the safety and efficacy of various CAM treatments. The Center's main purposes are to identify, investigate, and evaluate CAM. The annual budget for the Center continues to increase each year, from \$20 million in 1998 to almost \$70 million in 2000.²⁴

The NCCAM and its predecessor, the OAM, have released certain consensus statements based on findings from panels they have convened. In 1995, NIH issued a consensus statement endorsing various types of behavioral and relaxation approaches (e.g., meditation, biofeedback, and hypnosis) as effective treatments for chronic pain and insomnia. Another consensus statement, about the usefulness of acupuncture for postoperative pain and the nausea and vomiting caused by chemotherapy, was released in 1997. This statement also judged acupuncture to be effective in treating conditions such as lower back pain, addiction, asthma, and stroke rehabilitation.²⁵

The NCCAM funds and conducts various research studies about the effectiveness of different CAM practices. Examples of currently funded projects include scientific research on the neuroprotective activity of ginseng compounds; the effect of massage on infants born to HIV-positive mothers; the extent to which individuals with disabilities use CAM; and the CAM training, attitudes, and practice patterns of primary-care physicians.²⁶

Additionally, in March 2000, President Clinton established a White House Commission on Complementary and Alternative Medicine Policy within the Department of Health and Human Services. The commission's responsibility is to make legislative and administrative recommendations to the president about how public policy can maximize the benefits of CAM for Americans. These recommendations encompass education, research, access to information, and access to care. The commission will complete its responsibilities in 2002, unless extended by the President.²⁷

CAM and Medical Education

CAM has been gaining support among medical schools and its students. In 1997, the Group on Educational Affairs of the Association of American Medical Colleges announced the formation of the Special Interest Group on Alternative and Complementary Medicine.²⁸ This action was in response to the recommendations of a Blue Ribbon Panel of experts in medical and nursing education convened by the OAM in 1996. The panel assessed the state of CAM education, and made the following recommendations:²⁹

- (1) Medical and nursing education should include information about complementary practices;
- (2) Medical and nursing education about each complementary practice should include information about the discipline's philosophy/spiritual paradigm, scientific foundation, educational preparation, practice, and evidence of efficacy and safety; and
- (3) National centers of excellence should continue to be developed to foster collaboration among complementary practitioners, nurses, and physicians and to promote synergy among education, research, and clinical practice.

Perhaps related to the convening of the Blue Ribbon Panel, there was a notable increase in CAM instruction between the 1996–1997 and 1997–1998 academic years. Between those years, the number of schools requiring courses in CAM topics increased by almost 40 percent. A 1998 study revealed that, in 1997–1998, 64 percent of medical schools surveyed offered one or more courses in CAM, or included CAM topics in required courses. Two-thirds of schools that offered CAM had only one class, and the remaining third offered two or more.³⁰

Of the schools that included curricula (i.e., syllabi, course descriptions) for their courses with their survey responses, 77 percent of the

CAM courses featured a practitioner lecture or demonstration.³¹ This format is intended to help the students more fully comprehend the CAM practice, and to provide them with an opportunity to ask questions or test their own technique.

Students have played major roles in getting such classes implemented at some medical and nursing schools. For example, student interest groups at University of California, Davis, School of Medicine and Stanford University School of Medicine organized a yearly seminar series.³²

CAM and Practitioners of Conventional Medicine

The interest in CAM has also spread to professionals practicing conventional medicine. In 1995, the American Medical Association (AMA) House of Delegates adopted “a position of encouraging its members, as individuals and as groups, to become better informed regarding alternative (complementary) medicine and to participate in appropriate studies of it...”³³

Physicians with sufficient knowledge of CAM are more likely to be able to advise patients regarding likely effects—both positive and negative—as well as make referrals to CAM therapies.³⁴ Nonetheless, medical literature about CAM is limited. In 1998, Medical Economics Company published the first *Physician's Desk Reference for Herbal Medicines*.³⁵ Physicians' associations are looking for reliable, scientific evaluations of CAM therapies to aid physicians in clinical encounters.³⁶

Several studies have indicated that a growing number of physicians have become more open to CAM in the last decade. Approximately half of physicians surveyed in 19 separate studies believe in the efficacy of chiropractic (53%), acupuncture (51%), and massage therapy (48%). Fewer physicians believe that homeopathy (26%) and herbal remedies (13%) are effective.³⁷ Over 70 percent express interest in learning more about these particular CAM practices.³⁸

Over half of the doctors surveyed would encourage patients to try CAM therapies,³⁹ and a similar percentage is willing to refer their patients for CAM treatment. The therapies with the highest referral rates are acupuncture (43%), chiropractic (40%), and massage therapy (21%).⁴⁰ Thirty percent of physicians believe that appropriate use of CAM could provide more cost-effective care than conventional medicine.⁴¹

About 13 percent of U.S. hospitals offer CAM therapies, including institutions such as Cedars-Sinai Medical Center in Los Angeles and the University of Pittsburgh Medical Center. Higher percentages of large and inner city hospitals provide CAM services.⁴²

In recent years, integrative medicine clinics, which integrate conventional and CAM approaches, have surfaced. Examples of integrative medicine clinics include George Washington University Medical Center for Integrative Medicine in Washington, D.C., Jefferson's Center for Integrative Medicine in Philadelphia, and the new Beth Israel Center for Health and Healing in New York.⁴³

Proponents of such clinics assert that such an approach is more time and cost-efficient than a conventional medical clinic, and that it promotes a holistic philosophy of healing mind, body, and spirit. However, these clinics require collaboration with conventional medical institutions in order to become part of the routine referral system of physicians. Such collaboration is sometimes difficult, as it requires the cooperation of both conventional providers and insurers, and creates needs for internal business and marketing resources.⁴⁴

Patient-Provider Communication about CAM

Research indicates that communication between patients and physicians about CAM use remains a problem. Eisenberg, et al. (1998) indicate that less than 40 percent of CAM use was disclosed to physicians in both 1990 and 1997.⁴⁵ Astin, et al. (2000) indicate that a similar percentage of persons age 65 and older

discussed their CAM use with their physician.⁴⁶ A May 2000 survey of *Consumer Reports* readers found only a little more than half of respondents using CAM told their physicians about it.⁴⁷

Patients' use of CAM is often more widespread than physicians believe. For instance, in a study of prostate cancer patients undergoing radiation therapy, doctors predicted that 4 percent used some type of CAM therapy. However, almost 40 percent of the patients reported use of CAM practices such as herbal remedies, massage therapy, and chiropractic.⁴⁸

There are several reasons why individuals may not wish to disclose their CAM use to their physicians. They may believe that their physicians would not approve, understand, or be able to provide any more information about CAM modalities. Alternatively, some people may not think of CAM use as medical treatment, and therefore would not consider it information their physician needs to know.

This communication gap can cause problems. For example, health care professionals may have difficulty supporting many of their patients in making informed, safe, and appropriate choices if the professionals are unaware which patients are using CAM therapies and the extent of their usage. Indeed, such lack of information could hinder their ability to treat their patients effectively.

Even more problematic, patients who fail to inform their physicians about CAM therapies they are using could actually be jeopardizing their health. A common yet inaccurate assumption is that if a therapy is natural, then it must be safe. One particular concern is patients' concurrent use of herbal remedies and prescription medications. Several studies show that particular herbal remedies can diminish or even alter the effects of some prescription drugs.⁴⁹ Furthermore, such interactions can be life-threatening. Anesthesiologists disclose that individuals using herbal products can experience significant changes in heart rate or blood pressure. These conditions can be dangerous for patients undergoing surgery.⁵⁰

CAM and Health Care Spending

Spending on CAM is substantial and has grown over time. Conservative estimates show that total spending on CAM *practitioner* services was around \$21.2 billion in 1997, an increase of 45 percent over 1990 levels.⁵¹ The majority (58%) of this amount was paid out-of-pocket in 1997, a slightly larger percentage than in 1990 (49%) (see table). In contrast, only 16 percent of spending on conventional practitioner services was spent out-of-pocket in 1997.

Americans spent a total of \$27 billion out-of-pocket when other CAM expenses (e.g., nutritional supplements, CAM books) are included. By comparison, out-of-pocket spending on *conventional* physician services in 1997 was \$34.1 billion.⁵² One of the fastest growing components of out-of-pocket spending on CAM was for high-dose vitamins, which more than tripled to \$3.3 billion between 1990 and 1997.⁵³ The market for herbal therapies is growing at a rate of approximately 20 percent per year.⁵⁴

Expenditure	1997 (Billions of Dollars)	1990 (Billions of Dollars)
Total CAM practitioner services ^a	21.2	14.6
Total conventional practitioner services ^b	217.6	146.3
Out-of-pocket CAM practitioner services ^a	12.2	7.2
Out-of-pocket conventional practitioner services ^b	34.1	32.2
% of CAM practitioner services paid out-of-pocket ^c	58%	49%
% of conventional practitioner services paid out-of-pocket ^c	16%	22%

Note: Projections are based on conservative estimates of practitioner fees and product costs.
^a Eisenberg et al., 1998
^b HCFA National Health Expenditure Projections
^c AARP PPI analysis based on these data

Private Insurance Coverage of CAM

Insurers—both insurance companies and employers—have begun to voluntarily cover different types of CAM. Studies show that anywhere from one-half to two-thirds of insurers offer coverage of at least one type of CAM in one or more of their insurance products. Chiropractic is the most common type of CAM to be covered, although many insurers do not classify it as a CAM therapy. A 1999 International Foundation of Employee Benefit Plans (IFEBC) study reported that 86 percent of employers cover chiropractic, while other surveys show at least one-third do so. A 1998 Mercer/Foster Higgins survey of employer-sponsored plans found that 59 percent of point-of-service (POS) plans cover chiropractic, while about 45 percent of health maintenance organizations (HMOs) cover it. Acupuncture is the second most common form of CAM covered, with one study reporting coverage by 31 percent of employers. Coverage of other therapies is less prevalent. No more than 19 percent of insurers overall cover biofeedback, homeopathy, or massage.⁵⁵

Coverage can vary dramatically from one plan to another. Many insurance companies that cover CAM therapies tend to impose high deductibles and copayments or coinsurance, as well as strict limits on the number of visits or total dollar coverage.⁵⁶ Insurers generally provide CAM coverage only if the treatment is deemed “medically necessary” for a specific diagnosis. Each individual insurer usually defines “medically necessary,” although recently some states have passed legislation to establish statewide definitions.⁵⁷

There are five main insurance models ordinarily used to cover CAM therapies.⁵⁸ Often, an employer or insurer will offer more than one model, depending on the insurance product. Therefore, the models are not mutually exclusive:

- **Integrated CAM Services:** (66% of employers that provide CAM coverage.) A covered benefit where the insurer offers CAM services as part of its core benefit

package, often through affiliation with a network of CAM providers.⁵⁹

- **CAM Rider:** (7% of employers that provide CAM coverage.) A covered benefit where the insurer offers CAM services as a non-core rider on a standard plan, often through affiliation with a network of CAM providers. Members can access these services by paying an increased premium.
- **Combination/Other:** (27% of employers that provide CAM coverage.) A covered benefit where the insurer offers CAM services through some type of combination of CAM rider, contracted rate, wellness plan, or other form of coverage.
- **Contracted Rate:** (4% of employers that provide CAM coverage.) An insurer-negotiated arrangement involving a network of CAM providers who offer their services at contracted rates that are less than the rates for non-members.
- **Wellness Program:** (3% of employers that provide CAM coverage.) Comprehensive programs including stress management and CAM treatments, as well as nutrition, exercise, and smoking cessation therapies.

A survey of employees conducted by the American Compensation Association shows that 37 percent of employers who offer CAM coverage do so through a preferred provider organization (PPO) only, while 27 percent offer CAM benefits as part of all their insurance products. CAM coverage through indemnity plans, POS plans, and HMOs is less common. Less than 10 percent of insurers contract directly with CAM providers, while the majority contract indirectly through CAM provider networks.⁶⁰

Major private plans offering coverage to some subscribers include Aetna, Allstate, American Western Life Insurance Company, Blue Cross/Blue Shield, Kaiser Permanente, Mutual of Omaha, Oxford Health Plans, Prudential, and State Farm.⁶¹

Established in January 1997, Oxford became the first major health care plan in this country to offer comprehensive coverage for a range of CAM services. Its AltMed network of more than 2,000 alternative providers includes licensed practitioners of acupuncture, chiropractic, naturopathy, and other specialties (e.g., nutrition, yoga, massage therapy). All of these services are available for an additional 3 percent premium.⁶²

Some integrative clinics have begun to contract with insurers. For example, in early 2000, Oxford Health Plans in Connecticut announced its new contract with the Integrative Medicine Center at Griffin Hospital in Derby. However, the majority of integrative clinics do not deal with insurers at this time.⁶³

A few self-insured companies, which represent 33 percent of the private employment-based market, directly cover CAM practices in their health plans. For example, Microsoft employees have a plan option that includes unlimited access to naturopaths and chiropractors.⁶⁴ Starkey Laboratories, Inc. has a full-time Rolfer (a practitioner trained in a type of deep-tissue massage therapy) on site at its Eden Prairie, Minnesota office. The company's self-insured health plan also covers chiropractic and acupuncture without an employee copayment.⁶⁵

Several studies report that market demand, consumer interest, potential for more effective medical care, and state mandates are among the most important reasons why insurers or employers would offer CAM coverage.⁶⁶ However, CAM coverage is limited due to lack of utilization or cost data, lack of proof of clinical efficacy, and regulatory concerns.⁶⁷

Costs of Private Insurance Coverage of CAM

The costs of providing insurance coverage for CAM therapies vary widely. Insurers that offer CAM as part of a core benefit incur the highest costs, as much as \$9.00 per member per month.⁶⁸ CAM riders carry additional monthly premiums of around \$1.50 to \$4.00 (1% to 4% more), while access to a discounted CAM

network is only \$0.15 to \$0.30 per enrollee.⁶⁹ Wellness programs are often offered to employees at little or no cost.

There have been few studies on the cost-effectiveness of CAM treatments. One study indicates insurers' uncertainty about whether CAM coverage would increase or reduce health care costs. A 1999 nationwide survey of HMOs conducted by Landmark Healthcare (a California managed care company) found that 49 percent of HMOs surveyed believed that offering CAM benefits would add to their total health care costs. However, 21 percent believed it would reduce their costs, and 30 percent reported that it would have no impact.⁷⁰

Since relatively little is known about the cost-effectiveness of alternative medicine in general, many insurers are cautious about voluntarily offering the same levels of coverage for alternative medicine as they have for conventional medicine.⁷¹ Proponents and opponents within the health field differ in their views on whether or not CAM adds to the cost of health care.

Proponents of CAM coverage suggest that insurers offering such services will keep long-term costs down by deterring more serious illnesses, because many CAM therapies focus on preventive care. Proponents also believe that it lowers costs as people move from procedures that are more expensive to less expensive alternative medicine treatments.⁷²

Opponents assert that CAM insurance coverage would lead to more practitioner visits—both conventional and CAM. They argue that persons who have never tried CAM treatments would be more likely to do so, and persons who had used such treatments only sparingly would have incentives to use more services. These increased visits would consequently lead to higher costs for both the insurers and the members. Critics contend that these costs may not level off in the long run.⁷³

Indirect Private Insurance Coverage of CAM

Another way some employers indirectly

cover CAM therapies is through flexible spending accounts (FSAs). An FSA is a pre-tax account that can cover any service not covered by a third-party payer, provided the service is deemed medically necessary. The Internal Revenue Service (IRS) maintains a list of services that qualify for these tax deductions. Contributors who use these services are reimbursed from their FSA funds. Currently, contributors can be reimbursed for acupuncture and chiropractic services. FSAs cannot be used for any other CAM therapies at this time.⁷⁴

Reimbursement through a medical savings account (MSA) is controlled by the same IRS list of services. An MSA is a type of insurance plan that combines a pre-tax savings account with a high-deductible health insurance policy.⁷⁵ Therefore, like FSA contributors, MSA users can be reimbursed for acupuncture and chiropractic, but not any other CAM practices.

Federal Insurance Coverage of CAM

Medicare

The federal Medicare program currently offers limited coverage of alternative medicine. Only certain chiropractic services and Christian Science nursing facilities are covered treatments.⁷⁶ However, the Health Care Financing Administration (HCFA), the agency that administers Medicare, has started to evaluate several treatments. First, in response to recent findings, Medicare announced it would test the Dr. Dean Ornish Program for Reversing Heart Disease®. Medicare will soon begin a demonstration entitled the Medicare Lifestyle Modification Program, in which Medicare will pay for the Ornish program at selected sites for beneficiaries who meet strict clinical eligibility requirements. Currently, five sites have been authorized to receive Medicare funding for one year.⁷⁷

Medicare also decided to evaluate the cost-effectiveness of adding an acupuncture benefit after NIH released its consensus statement in 1997. As of July 2000, the Medicare national coverage policy states that the program will not provide reimbursement for acupuncture “until

the pending scientific assessment of the technique has been completed and its efficacy has been established.^{77,78}

Additionally, the program is currently considering a national coverage policy to approve biofeedback for the treatment of urinary incontinence. Medicare presently covers biofeedback for muscle re-education and pathological muscle abnormalities only if conventional treatments have not been successful.⁷⁹

Some Medicare+Choice plans provide further coverage for chiropractic services beyond what is already included under traditional Medicare. For example, UHP Healthcare in southern California covers up to 25 routine chiropractic visits each year, with a \$5 copayment.⁸⁰ Recent Medicare+Choice data show that the percentage of basic plans offering supplemental chiropractic benefits decreased between 1999 and 2000. In 2000, less than 9 percent of basic plans covered chiropractic care beyond Medicare.⁸¹

Federal Institutions

The U.S. Department of Defense (DoD) and the Veterans Health Administration (VHA) of the U.S. Department of Veterans Affairs have evaluated chiropractic for possible inclusion in their health care systems.

The DoD Chiropractic Health Care Demonstration Program, which was mandated by Congress in 1994 to assess the implementation of chiropractic medicine in the military, was recently completed.⁸² Legislation recommending that chiropractic become a permanent part of the military health care system is currently on the Senate calendar in Section 737 of the DoD Authorization Act for Fiscal Year 2001. If passed, all major military treatment facilities would be required to implement chiropractic services by October 2001.⁸³

With the passage of the Veterans Millennium Health Care and Benefits Act on November 30, 1999, the VHA began to establish

policy regarding the role of chiropractic in the care of veterans. A VHA directive issued in May 2000 stated that VHA centers and clinics may offer chiropractic spinal manipulation for musculoskeletal problems of the spine. It also indicated that the need for chiropractic services is likely to be affected by local and regional factors (e.g., the availability of practitioners; urban or rural setting). Consequently, coverage decisions on frequency, duration, and cost per visit will not be made on a national level but instead at local VHA network or medical center levels.⁸⁴ The VHA has also covered acupuncture for several years for a variety of conditions, including detoxification for chemical dependence.⁸⁵

State Insurance Coverage of CAM

In response to the expanding popularity of CAM therapies, more state lawmakers are taking an active role in guaranteeing that CAM practitioners are regulated to provide effective and safe health care treatments. A majority of states have considered bills in the past few years that related to licensure, reimbursement, scope of practice, and access to CAM providers. In 1997, 137 laws were enacted in 41 states, and in 1998, 91 laws were enacted in 39 states.⁸⁶

Licensure is the most prestigious recognition for CAM practitioners. Other forms of recognition, such as certification or registration, do not provide the same autonomy or access to reimbursement.⁸⁷

Chiropractors have attained universal licensure and reimbursement equity in all 50 states and the District of Columbia, and have CPT codes exclusively for chiropractic services. Forty-seven states have established separate professional chiropractic boards.⁸⁸ Forty states and the District of Columbia recognize acupuncturists either through licensure, certification, or registration,⁸⁹ and another three allow the practice of acupuncture under physician supervision. Ten states have separate acupuncture boards. Additionally, 11 states recognize naturopaths as licensed health care providers, while 5 have separate naturopathy boards.⁹⁰ Further, 29 states and the District of

Columbia currently license or regulate massage therapists,⁹¹ and 3 states license homeopaths.⁹²

Additionally, 10 states have “health freedom” laws that protect patients’ rights to use CAM under the guidance of licensed physicians. For example, a section of the Texas administrative code reads: “...(P)hysicians should be allowed a reasonable and responsible degree of latitude in the kinds of therapies they offer their patients. ...(P)atients have a right to seek integrative or complementary therapies.”⁹³

Chiropractors, acupuncturists, and naturopaths are also permitted to prescribe and dispense minerals, herbal remedies, and food supplements in most of the states where they are licensed. State-licensed naturopaths have the authority to dispense non-controlled prescription drugs.⁹⁴ The FDA, under the Federal Food Drug and Cosmetic Act, regulates the manufacture and sale of homeopathic medicines,⁹⁵ most of which are available without a prescription.

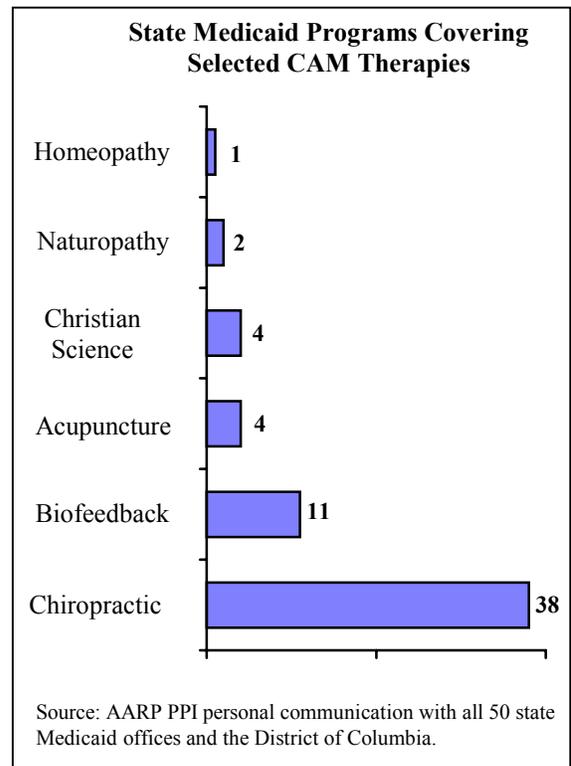
Medicaid

State Medicaid programs can receive federal funding to provide optional services in addition to the mandatory services set by federal law. One optional service is medical care provided by state-licensed practitioners, within the scope of their practice, as defined by state law. Medicaid may offer these services to the categorically needy, and to the medically needy.⁹⁶

As of July 2000, a full three-quarters of state Medicaid programs surveyed cover chiropractic, and another fifth cover biofeedback. Medicaid coverage of other types of CAM is much less prevalent (see chart).⁹⁷

State Mandates

Some states have issued mandates relating to CAM. For example, since 1998, New York has required insurers to cover up to 15 chiropractic visits per year. New York was the third state to require that insurers cover increase costs and drive large companies to leave the commercial insurance market and, instead, self-



insure.⁹⁸ Altogether, 41 states reportedly require private insurers to offer chiropractic services, either as a rider or mandated as a benefit. Additionally, eight states currently mandate that insurers offer acupuncturists, three states mandate coverage of naturopaths, and Florida mandates coverage of massage therapists.⁹⁹ Moreover, jurisdictions such as the state of Oregon and the city of Miami have mandated acupuncture treatment for chemically dependent offenders.¹⁰⁰ Overall, state mandates increased by 20 percent between 1990 and 1998.¹⁰¹

Of all 50 states, the state of Washington has had the most extensive mandate. An “every-category” law was passed in 1993 and initially was scheduled to take effect on January 1, 1996. Under this mandate, insurance policies would have been required to provide coverage for treatments and services by every category of health care provider. The law applies to all providers who are licensed, registered, or certified by the state of Washington. The health conditions covered by each plan have not changed, but the type of provider from which an individual seeks treatment may have changed.

The law states that insurance companies give all categories of providers equal treatment.¹⁰²

In 1997, the Federal District Court for the Western District of Washington issued an injunction against the state, blocking the implementation of the law. The court agreed with the twelve insurers in the state who challenged the law on grounds that it was preempted by the Employee Retiree Income Security Act of 1974 (ERISA).¹⁰³ However, in 1998, the Court of Appeals for the Ninth Circuit reversed the district court's decision, finding that the law was not preempted under ERISA, because, among other reasons, it specifically excluded from coverage employer-sponsored and self-funded plans.¹⁰⁴

In 1999, the U.S. Supreme Court declined to review the challenges raised by the insurance industry. After the federal district court asked the Supreme Court of Washington to answer questions concerning coverage under this law, in January 2000, the supreme court ruled that the law extended to all forms of health care plans, not just to managed care plans.¹⁰⁵ According to the office of the Washington State Insurance Commissioner, the law—although popular with consumers—has been a constant challenge for the state, and difficult to enforce.¹⁰⁶

Washington state's alternative medicine experience could ultimately provide useful information to other states. The Office of the Insurance Commissioner reports that the law has not been a major financial burden for the insurers who voluntarily complied before it took effect.¹⁰⁷ However, the use of Washington state's mandated alternative medicine benefits has not been in effect long enough to provide analysts with meaningful cost-benefit data. Consequently, no cost-effectiveness studies have been completed there.

Media Coverage of CAM

News, reviews, anecdotes, and advertisements about CAM appear in a number of media sources. Some of the nation's top-selling newspapers have printed a number of stories about CAM. For example, in the past

two years *The New York Times* has published over 90 articles, and the *Washington Post* nearly 70. For instance, in January 2000, *The New York Times* ran a special report on the front page entitled "Folk Cures on Trial: Alternative Care Gains a Foothold."¹⁰⁸

Additionally, in recent years mainstream magazines have run major stories on CAM, among them *Time*, *Newsweek*, and *Consumer Reports*; one example is the May 2000 *Consumer Reports* survey on "The Mainstreaming of Alternative Medicine."¹⁰⁹ Scientific journals have also been publishing research on various therapies. The *Journal of the American Medical Association (JAMA)* devoted its November 11, 1998 edition to CAM. The 10 other AMA journals published more than 80 articles that month. The *New England Journal of Medicine* has had 35 features on CAM in the past several years. For instance, the June 2000 edition featured a sounding board article entitled "Should Physicians Prescribe Religious Activities?"¹¹⁰ In addition, various CAM-related specialty magazines emerged in the late 1990s, including consumer magazines (such as *Spectrum* and *Alternative Medicine*) and scientific journals (such as *Explore Magazine*).¹¹¹

Television advertising for CAM services and products has shown a marked increase in the past few years. Commercials for health plans that offer coverage of CAM, CAM practitioners in private practice, and various CAM products (e.g., herbal medicines) have started appearing across the country. These commercials have aired in cities on both coasts including New York City and Seattle, Washington, as well as Midwest cities like Wichita, Kansas; Toledo, Ohio; and Flint, Michigan.¹¹²

Conclusions

This *Issue Brief* has provided a broad overview of CAM. As discussed, CAM has grown in popularity over the last decade. Millions of Americans of varying age, income, and health status use one or more CAM treatments, and pay for the majority of these

expenses out-of-pocket. Acceptance of CAM has also grown in parts of the medical community (e.g., more medical schools are including course options; more insurers are voluntarily offering coverage), and news about CAM is appearing in periodicals and on television. Despite this growth in popularity, many remain skeptical about CAM.

This skepticism has varied repercussions. First, a general lack of communication between patients and providers regarding CAM usage persists. Second, although growing, the body of medical literature about CAM is limited. Third, there have been very few studies completed on the cost-effectiveness of particular CAM treatments.

For health and safety reasons, it is important that improved communication among physicians and patients about CAM treatment usage take place in the health care community, regardless of one's opinions of CAM. Continued physician education on CAM topics, as well as common terminology in referencing CAM, perhaps could facilitate this communication. Additionally, more comprehensive clinical studies and cost-effectiveness analyses of CAM practices are needed. Such information can catalyze conversations among the medical community, federal and state governments, and insurance providers regarding the potential value—both clinical and financial—of these treatments.

Because CAM can take so many forms, it is difficult to generalize about the usefulness and effectiveness of CAM as a whole. As education about and research on various types of CAM practices continue, it should become easier for all of those involved to identify and evaluate those treatments that effectively complement conventional medicine.

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