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CONTROLLING THE COSTS OF ALTERNATIVE MEDICINE

Lior J. Strahilevitz*

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I. THE RISE OF ALTERNATIVE MEDICINE IN THE UNITED STATES

In 1993, the *New England Journal of Medicine* published a study reporting widespread utilization of unconventional medical therapies by all major demographic groups in society.¹ The study's findings shocked many in the medical establishment. It revealed that in 1990, over a third of all Americans used alternative therapies and that the annual price tag for visits to alternative medicine providers was an estimated \$11.7 billion.² Americans made more visits to providers of unconventional therapy than they did to primary care physicians.³ Perhaps most troubling to the medical profession, however, were the following findings: 89% of those who saw a provider of unconventional therapy did so without recommendations from their physicians, and 70% never informed their treating physicians that they had used alternative medicine.⁴ By 1997, according to a follow-up study, alternative medicine had racked up even more impressive gains: Over 42% of the population had used at least one form of alternative medicine, and the industry had grown to \$21.2 billion in annual sales.⁵

While many alternative therapies are still viewed with great skepticism by the medical profession and the public-at-large, some treatments are clearly more respectable than others.⁶ The relatively reputable modalities have been subjected to double-blind testing,

1. See generally, David M. Eisenberg et al., *Unconventional Medicine in the United States—Prevalence, Costs, and Patterns of Use*, 328 *NEW ENG. J. MED.* 246 (1993) [hereinafter 1993 Eisenberg Study].

2. See *id.* at 250.

3. See *id.*

4. See *id.* at 249, 251. For a discussion of the problems associated with this dynamic, see generally Liz Dunn & Bonita L. Perry, *Where Your Patients Are*, 24 *PRIMARY CARE* 715 (1997).

5. See David M. Eisenberg et al., *Trends in Alternative Medicine Use in the United States: Results of a Follow-up National Survey 1990-1997*, at 280 *JAMA* 1569, 1571, 1573 (1998) [hereinafter 1998 Eisenberg Study].

6. Perhaps among the least respectable are aromatherapy, crystal healing, energy healing, and folk remedies.

while more dubious treatments are backed by nothing more than scattered testimonials. Thus it is misleading to characterize "alternative medicine" as a monolith. Still, contrasting alternative medicine's generally holistic method with orthodox medicine's basically scientific method, is a useful way of introducing the public policy issues that are discussed herein. After this introductory material has been presented, I will consider in turn two of the most prominent alternative modalities, chiropractic and acupuncture, in my discussion of the overutilization of alternative health care.⁷

The overutilization⁸ of alternative health care is the central topic of this Article. More specifically, I am concerned with excessive care that is funded by third-party payers, rather than care that is paid for

7. I have chosen to focus on these two therapies for six reasons: First, unlike users of many of the alternative therapies discussed in the *New England Journal of Medicine* article, see 1993 Eisenberg Study, *supra* note 1, the vast majority of patients who use chiropractic and acupuncture do so under the care of a professional alternative care provider. See *id.* at 248 tbl.2. Therefore, treatment costs are relatively high, see *id.* at 250 tbl.4 (reporting a "[m]ean charge per visit to provider" to be \$27.00), and the use of the therapy is likely to be more consistent and controlled. Second, the empirical data assessing the effectiveness of these two techniques is relatively well-developed. See generally, Kathleen M. Boozang, *Western Medicine Opens the Door to Alternative Medicine*, 24 AM. J.L. & MED. 185 (1998). Third, they are among the alternative therapies most widely utilized (chiropractic easily ranks first). See *id.*; Michael H. Cohen, *A Fixed Star in Health Care Reform: The Emerging Paradigm of Holistic Healing*, 27 ARIZ. ST. L.J. 79, 110-11 (1995) [hereinafter *A Fixed Star*]; 1998 Eisenberg Study, *supra* note 4, at 151-72 (listing chiropractic and acupuncture therapies as among the most popular today). Fourth, they are among the few techniques and professions that have been the subject of state regulatory efforts. See Michael H. Cohen, *Holistic Health Care: Including Alternative and Complementary Medicine in Insurance and Regulatory Schemes*, 38 ARIZ. L. REV. 83, 91-92 (1996) [hereinafter *Holistic Health Care*] (noting that chiropractors are licensed in all 50 states and the District of Columbia and that acupuncturists are licensed in about half the states). Fifth, they present an interesting contrast, in that chiropractic has largely entrenched itself in the medical mainstream, see Boozang *supra* at 196, while acupuncture appears ready to follow suit. See *Panel Makes Point About Acupuncture*, 89 J. NAT'L CANCER INST. 1751 (1997), available in LEXIS, Genmed Library, ALLJNL File (reporting that a National Institute of Health panel of experts found acupuncture an "effective treatment" for postoperative pain and for nausea associated with chemotherapy and pregnancy, and encouraged private and public insurers to include coverage for acupuncture treatments). Finally, and perhaps most importantly, my argument that overutilization is more likely to be patient-driven in the chiropractic realm and provider-driven in the acupuncture realm, see *infra* Part III.D., suggests differing policy outcomes and hints at a useful typology that can be used to categorize other forms of alternative medical treatment.

8. Defining overutilization in the context of this Article is of critical import, and yet the term defies a simple definition. I will refer to overutilization and overconsumption interchangeably, to mean the provision of treatment that is not medically necessary and/or whose costs do not justify the expenditure. Obviously, these latter terms require definition as well, and the context in which I use those terms should emerge from the discussion that follows. See *infra* Parts II.C and III.D. See generally Ruth E. Malone, *Whither the Almshouse? Overutilization and the Role of the Emergency Department*, 23 J. HEALTH POL. POL'Y & L. 795 (1998) (discussing the problem of overutilization in the hospital emergency room context).

out-of-pocket by patients.⁹ Currently, chiropractors and acupuncturists claim (not implausibly) that their methods are less expensive per patient than conventional therapies.¹⁰ But even if alternative therapies are cheaper, that does not eliminate the need to contain their costs. I argue that because these treatments historically were not reimbursable by insurers, utilization of these services was rarely excessive. Now that is changing, as most states have required some chiropractic coverage¹¹ and many states are considering doing the same for acupuncture.¹² This expanded coverage is likely to exacerbate the problem of overutilization significantly. Moreover, because the medical necessity of chiropractic and acupuncture often defy objective verification, relying on independent utilization review or jury determinations of whether care is "reasonable and necessary" may be ineffective in controlling costs.

Unfortunately, to date, no empirical study has been done regarding the overutilization of alternative medicine in the United States. This Article does not purport to engage in such an analysis. But this Article does, for the first time, gather evidence of overutilization from the existing medical and public health literature, and combine it with reports of apparent overutilization from case law and other litigation. The data I compile suggests that as access to alternative modalities, such as acupuncture, is greatly expanded in the coming years, alternative health care overutilization is likely to develop into an expensive problem.¹³ This Article therefore discusses various approaches to alternative medicine cost containment—both for insurers, and for courts that are called upon to determine whether to reimburse plaintiffs for alternative medical care expenses in tort suits.

9. Except in cases where patients are misinformed about the amount of medical care they require, it is my view that their out-of-pocket purchase of excessive medical care is not a pressing public policy issue. Cf. Robert M. Veatch & Carol Mason Spicer, *Medically Futile Care: The Role of the Physician in Setting Limits*, 18 AM. J.L. & MED. 15, 33 (1992).

For those non-life-saving services that are not sufficiently reasonable to generate an entitlement and are not independently prohibited, we see no reason why private, voluntary choices should not prevail. Both patients and providers should be able to agree to provide such debatable services within the constraints of the law, provided that public resources are not consumed in doing so.

Id.

10. Although, as I shall later argue, the crucial cost comparison might not be between an acupuncturist and an orthopedic surgeon—of which the acupuncturist would usually get the better—but between an acupuncturist and a bottle of pain medication or an exercise regimen—in which case the cost savings of acupuncture would disappear. See *infra* Part III.D.

11. See *infra* Part II.B.

12. See *infra* Part III.B.

13. See *infra* Part IV.

Part I of this Article describes and analyzes the explosive growth of alternative medicine since the 1960s. It argues that the rise of alternative medicine was part of a larger anti-scientific movement within American society. Part I then argues that alternative medicine is in the midst of an access expansion phase that is likely to continue for many years.

Part II focuses on chiropractic, by far the most widely used alternative modality. It notes that chiropractic has become a respected complementary medical therapy in the past few decades, and has now entrenched itself in the medical mainstream. The Article then describes two types of chiropractic overutilization: the use of chiropractic to treat conditions for which the technique is not demonstrably beneficial, and the excessive treatment of bona fide medical conditions. In the past, state regulators have focused on preventing the former, but devoted little attention to the latter (probably more serious) form of overutilization. This form of overutilization is particularly likely to occur because chiropractic treatments are often relatively pleasurable for the patient, and because chiropractors, like other holistic healers, are not trained to view patients' complaints skeptically. Part II then discusses how standard elements of the managed care approach to cost containment can be modified to control chiropractic costs. Part II concludes by pointing out the unique challenges in deterring overutilization in the context of tort litigation, and discusses strategies for reform.

Part III addresses cost containment issues surrounding acupuncture therapy. Unlike chiropractic, acupuncture stands at the threshold of integration into the mainstream of American medicine. Recently, many insurers have begun providing coverage for acupuncture benefits, and some states are considering legislation that would encourage or require health plans to expand access. These benefits would reimburse insured patients for "reasonable and necessary" acupuncture treatments. Unfortunately, the few instances in which courts have been called upon to decide what acupuncture benefits are reasonable and necessary illustrate the difficulties of making such determinations. Part III argues that leaving these decisions in juries' hands is likely to produce particularly inconsistent, disjointed policy outcomes that will do little to mitigate the problem of overutilization.

Part IV concludes with a discussion of the larger, philosophical issues that must frame any intelligent societal discussion about the tradeoffs involved in covering alternative therapies. It discusses common themes that emerge from the preceding comparison of chiroprac-

tic and acupuncture. Finally, it suggests that the most important element of any regulatory approach to new, alternative therapies may be a dose of patience, so that regulations will be crafted based on the long-term effectiveness of each new modality, rather than on the lure of anticipated short-term financial gains.

A. *More Than Just a Fad: A Large and Growing Industry*

Prior to the 1960s, alternative medicine as we now know it was practiced mostly at the fringes of society. While the image of traveling charlatans peddling miracle cures was firmly engrained in American film and literature, post-war America was a nation in which only the naïve or uneducated were duped by such schemes. New, scientific medical procedures were all the rage, and the impressive successes of the polio and small pox vaccines had convinced many that American medical science could defeat even the most daunting diseases.¹⁴

The 1960s ushered in an era in which a large segment of society began to question the authority of society's dominant social and political institutions. The medical profession was one of the many social institutions to weather an attack from the counterculture.¹⁵ The counterculture quarreled with the drug-based therapies that physicians frequently prescribed, and began exploring the relative merits of third world healing techniques.¹⁶ Many in the counterculture embraced the holistic perspective of these "primitive" therapies.¹⁷ In contrast to the American medical specialist, who often seemed to tune out the person and focus solely on whatever body part was malfunctioning,¹⁸ the holistic therapist tried to place the individual in a broader health context.¹⁹ For holistic healers, the patient's life circumstances, relations with other people, stress level, and overall emotional well-being all required examination and treatment if the individual, rather than the individual body part or system, was to be healed.²⁰ In contrast to the often cold, detached bedside manner of

14. See *infra* text accompanying note 41.

15. See, e.g., THEODORE ROSZAK, *THE MAKING OF A COUNTER-CULTURE* 259 (1969).

16. See KRISTINE BEYERMAN ALSTER, *THE HOLISTIC HEALTH MOVEMENT* 38-39 (1989).

17. *Id.*

18. See Lauren A. Greenberg, Comment, *In God We Trust: Faith Healing Subject to Liability*, 14 J. CONTEMP. HEALTH L. & POL'Y 451, 456 (1998).

19. See Carl B. Meyer, *Science and Law: The Quest for the Neutral Expert Witness: A View from the Trenches*, 12 J. NAT. RESOURCES & ENVTL. L. 35, 48 (1997) (explaining the holistic view of overall health maintenance).

20. See Ronald A. Chez & Wayne B. Jonas, *The Challenge of Complementary and Alternative Medicine*, 177 AM. J. OBSTETRICS & GYNECOLOGY 1156 (1997) (explaining common philosophies of alternative medicine that tend to promote wellness of mind, body, and spirit).

the elite medical specialist, the holistic alternative therapist was trained to lavish unconditional positive regard upon the patient.

B. *The Holistic Approach*

While a number of prominent medical doctors embraced some tenets of the holistic healing philosophy, the "Holistic Health Movement" was much more closely associated with alternative medicine.²¹ Alternative therapies, such as chiropractic, acupuncture, reflexology, herbal medicine, massage therapy, and naturopathy were all predicated upon a holistic approach.²² A central aspect of the holistic healing ideology was its emphasis on the patient's own role in healing.²³ Conventional medicine envisioned a passive patient being healed by an active doctor. Medical doctors removed the tumor, prescribed the drug, or set the cast that would save the patient from her medical ailment.²⁴ Holistic alternative therapies derided such approaches that emphasized the doctor's heroic role.²⁵

Practitioners of alternative medicine saw health as the product of a partnership between a patient and a health care provider.²⁶ Healers offered guidance, more than answers. Holistic healers could not determine that a patient was healthy by looking at a chart, rather, the patient was not well until the patient felt well.²⁷ In the minds of many holistic alternative healers, there was no such thing as a psychosomatic condition.²⁸ When a patient came forward with a dubious complaint of a physical ailment, it was met with "personal attention, existential support, and reassurance that (probably unknowingly) motivated the visit in the first place," rather than the "counter-suggestion" most likely to relieve the complaint.²⁹

21. See Greenberg, *supra* note 18, at 451.

22. See Cohen, *A Fixed Star*, *supra* note 7, at 88-97 (exploring the nature and types of holistic healing).

23. See *id.* at 119.

24. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 45-99 (1982) (discussing conventional medicine's history and development).

25. See *id.* at 47.

26. See Cohen, *A Fixed Star*, *supra* note 7, at 88.

27. See Cohen, *Holistic Health Care*, *supra* note 7, at 101-03 (discussing the distinction holistic medicine makes between healing and curing).

28. See Barry Beyerstein, *Alternative Medicine: Where's the Evidence?*, 88 *CANADIAN J. PUB. HEALTH* 149, 150 (1997) (stating that alternative healers attribute all conditions, including psychosomatic ones to "psychospiritual causes," including "energy imbalances, environmental sensitivities, or nutritional deficiencies").

29. *Id.*; see also Boozang, *supra* note 7, at 199 ("Thus to a great extent, it seems that patients seek out alternative practitioners for the humaneness that conventional care wants.").

The goals of the holistic health movement also coincided with those of the young (but powerful) consumer rights movement. The consumer rights movement glorified individual rights and the decentralization of economic power.³⁰ The individual consumer was to be given as much information as feasible.³¹ She could then choose among a large number of alternatives, rather than having her decisions constrained by monopolistic producers. This emphasis on the consumer as an active chooser of products, when applied to the health care context, implied a greater role for patients in their treatment decisions.³² Patients were to be given better information—a goal that was furthered by the expansion of informed consent protections, for example—and more options—a goal that seemed to be best served by allowing patients to opt for new, promising treatments. Both movements shared a common nemesis, the medical establishment. Not surprisingly then, the consumer rights and holistic health movements entered into a fruitful political alliance.³³

The rising popularity of the holistic approach in the 1960s was also reinforced by the rise of moral relativism as an intellectual critique.³⁴ The relativists, in denying the existence of objective standards of verification,³⁵ discounted the use of what had been the central evaluative tool of medical science—the double blind clinical trial.³⁶ This approach allowed them to place the claims of alternative therapies—based mostly on anecdotal reports of successful treatment—on equal moral and intellectual footing with proven, successful medical therapies.³⁷ Moral relativism thus lent alternative practitioners newfound

30. See J.A. ENGLISH-LUECK, *HEALTH IN THE NEW AGE: A STUDY IN CALIFORNIA HOLISTIC PRACTICES* 149 (1990).

31. See *id.*

32. See *id.*

33. See *id.*

34. See Beyerstein, *supra* note 28, at 149. For a recent spirited debate on the continuing importance and utility of moral relativist theory, compare Richard Posner, *The Problematics of Moral and Legal Theory*, 111 HARV. L. REV. 1637 (1998), with Ronald Dworkin, *Darwin's New Bulldog*, 111 HARV. L. REV. 1718 (1998).

35. See Beyerstein, *supra* note 28, at 149 (noting that the rejection of such standards is "epitomized in the New Age catchphrase 'you create your own reality'").

36. See David G. Warren, Book Review, 18 J. LEGAL MED. 257, 260-61 (1997) (reviewing JULIE STONE & JOAN MATTHEWS, *COMPLEMENTARY MEDICINE AND THE LAW* (1996)); Nancy M.P. King, *Experimental Treatment: Oxymoron or Aspiration?*, HASTINGS CENTER REP., July-Aug. 1996, at 12 (discussing the incongruity of using such standardized tests for "experimental" treatments). Indeed, advocates of acupuncture therapy attending a National Institute of Health (N.I.H.) panel's hearings on acupuncture's effectiveness questioned the applicability of such trials to acupuncture therapies. See Rick Weiss, *NIH Panel Endorses Acupuncture Therapy*, WASH. POST, Nov. 6, 1997, at A1.

37. See Beyerstein, *supra* note 28, at 149.

respectability. Moreover, those who ascribed to a relativistic worldview provided alternative therapists with an enthusiastic patient pool that could support their fledgling practices.³⁸

C. Early Regulatory Responses

As these therapies grew in popularity during the 1960s and 1970s, state governments adopted strategies designed to contain alternative medicine.³⁹ During this time period, government's basic philosophical orientation, and that of the populace as a whole, remained scientific in nature. On the heels of the great American scientific successes of the era (e.g., the Apollo program), public confidence in science's ability to wipe out diseases remained high.⁴⁰ Seen in this light, alternative therapies were unscientific intrusions upon the medical sphere. The public had to be protected from this quackery, at least until the alternative remedies could prove their effectiveness in double-blind clinical trials. If a promising new drug or medical device had to jump over significant regulatory hurdles before it became available to the public at large, then it was ludicrous to allow alternative medicines, with their much weaker claims of effectiveness, on to the market.⁴¹

Consistent with this approach, many states prosecuted alternative medicine providers for illegally practicing medicine⁴² or for health care fraud.⁴³ Others began licensing alternative practitioners, but tightly regulated the types of procedures they could perform.⁴⁴ These

38. Cf. John A. Astin, *Why Patients Use Alternative Medicine: Results of a National Survey*, 279 JAMA 1548, 1552 (1998) (finding that users of alternative medicine tend to be "classified in a value subculture as cultural creatives," are likely to have experienced "some type of transformational experience that has changed their worldview in some significant way," and to hold "a philosophical orientation toward health that can be described as holistic").

39. See *infra* text accompanying notes 43-46.

40. See D. DUTTON, *WORSE THAN THE DISEASE: PITFALLS OF MEDICAL SCIENCE* 21 (1988) (noting that 73% of Americans expressed "a great deal of confidence" in medicine in 1966).

41. See Gina Kolata, *The Herbal Potions That Make Science Sick*, N.Y. TIMES, Nov. 15, 1998, at WK4.

42. For an interesting summary of the litigation arising from such prosecutions see William H. Danne, Jr., *Acupuncture as Illegal Practice of Medicine*, 72 A.L.R.3d 1257 (1977).

43. Cf. DEP'T HEALTH & HUM. SERVS., OFFICE OF THE INSPECTOR GENERAL, SEMI-ANNUAL REPORT 7-8 (Oct. 1, 1993-Mar. 31, 1994) (visited Jan. 28, 1999) <<http://www.hhs.gov/progorg/org/semann/sar0394.hhs>> (describing the Medicare fraud conviction of a Connecticut couple who managed an acupuncture center and billed acupuncture treatments as physical therapy performed by physicians); James G. Sheehan, Dep't of Health & Hum. Servs., *Office of the Inspector General: Health Care Financing Administration Projects*, available in Westlaw, 1045 PLI/CORP 747, 923 (1998) (describing the prosecution of a physician accused of taking kickbacks from a marketer of alternative medical blood tests).

44. For example, California began regulating acupuncturists as early as 1975. See *Health Net to Offer Acupuncture, Massage Therapy, Acupressure Benefit*, BUSINESS WIRE, Sep. 9, 1997,

practitioners were prohibited from engaging in doctor-like activities.⁴⁵ In this climate, in which there was still little hard evidence of alternative medicine's effectiveness, courts were confronted with questions regarding whether alternative therapies were still "experimental treatments" subject to health insurance policy exclusions,⁴⁶ and how to evaluate claims of malpractice against alternative practitioners.⁴⁷ Creating sensible legal rules for the alternative health care field proved intrinsically difficult, as medical "technologies" were constantly being re-evaluated, and the number of practitioners was growing so rapidly.

D. *The Future of Alternative Medicine*

Despite this containment policy, by the late 1980s and 1990s many suspected that alternative medicine had won an unshakable foothold in American society. Everyone seemed to know someone who had used acupuncture, biofeedback, or chiropractic, but no systematic study of utilization had been performed in the United States.⁴⁸ Finally, in the 1993 *New England Journal of Medicine* article, researchers revealed that fully 34 percent of the American public had

at 6 (Fact Sheet), available in Westlaw, Bus.Wire Plus. In 1982 the state created the Acupuncture Committee, a state agency that "licenses and regulates acupuncturists in California." *Id.* Florida and Massachusetts, among other states, have adopted a similar regulatory regime. See 64 FLA. ADMIN. CODE ANN. r. 64B1-3.001 to 3.010 (1997); MASS. REGS. CODE tit. 243, §§ 5.01 to 5.10 (1997).

45. See, e.g., *State v. Van Wyk*, 320 N.W.2d 599, 605 (Iowa 1982) (rejecting due process and equal protection challenges to the state's tight restrictions on the types of services chiropractors are allowed to provide).

46. See, e.g., *Andrews v. Ballard*, 498 F. Supp. 1038, 1053 (S.D. Tex. 1980). See generally J. Gregory Lahr, *What Is the Method to Their "Madness?" Experimental Treatment Exclusions in Health Insurance Policies*, 13 J. CONTEMP. HEALTH L. & POL'Y 613 (1997) (describing the decisional framework in which courts decide what constitutes an experimental treatment).

47. See Cohen, *Holistic Health Care supra* note 7, at 140-44 (discussing the appropriate standard of care in such circumstances and the duty of such practitioners to refer patients with serious medical needs to physicians). See generally David M. Studdert et al., *Medical Malpractice Implications of Alternative Medicine*, 280 JAMA 1610 (1998) (concluding that alternative medicine practitioners are sued for malpractice less frequently than physicians).

48. A Belgian researcher had, in 1987, published data showing that alternative medicine was popular throughout Western Europe. See G. SERMEUS, *ALTERNATIVE MEDICINE IN EUROPE: A QUANTITATIVE COMPARISON OF THE USE AND KNOWLEDGE OF ALTERNATIVE MEDICINE AND PATIENT PROFILES IN NINE EUROPEAN COUNTRIES* (1987), cited in URSULA SHARMA, *COMPLEMENTARY MEDICINE TODAY: PRACTITIONERS AND PATIENTS* 16-17 tbl. 2 (1992). For a comprehensive discussion of coverage disputes involving alternative medicine treatments under the German health care system, see Timothy Stoltzfus Jost, *Health Care Rationing in the Courts: A Comparative Study*, 21 HASTINGS INT'L & COMP. L. REV. 639, 663-69 (1998). For data on Australia, where levels of utilization are higher than in either Europe or the United States, see A.H. MacLennan et al., *Prevalence and Cost of Alternative Medicine in Australia*, 347 LANCET 569 (1996).

used a form of alternative medicine during 1990.⁴⁹ A 1998 follow-up study showed that utilization rates climbed even higher during the 1990s, such that more than 42% of the population had used some form of alternative medicine by 1997.⁵⁰

A similar study on alternative medicine utilization was recently published in the *Journal of Pain and Symptom Management*.⁵¹ That study asked respondents whether they had seen a professional for treatment in chiropractic, therapeutic massage, relaxation techniques, or acupuncture during 1994.⁵² It found that almost twenty-five million Americans, or 9.4% of the U.S. population, had done so.⁵³ When data from the 1998 Eisenberg Study is thrown into the mix, to account for visits to practitioners of imagery, herbal medicine, energy healing, biofeedback, hypnosis, homeopathy, megavitamins, commercial and lifestyle diets, folk remedies, self-help groups and spiritual healing by others, we arrive at a number closer to thirty-nine million.⁵⁴

49. See 1993 Eisenberg Study, *supra* note 1, at 248 tbl.2. The 34% figure included a number of therapies that might not fit in everyone's definition of alternative medicine. For example, lifestyle diets, self-help groups, commercial diets, and relaxation techniques were included. See *id.* Alternative treatments such as prayer or exercise, however, were not included. See *id.* One useful aspect of the study is that it polled respondents to see whether they had seen a professional provider of these alternative therapies. See *id.* at 247. Thus, while 13% of all Americans had used relaxation techniques in the past twelve months, only 9% of those had seen a "relaxation provider." See *id.* at 248 tbl.2. In contrast, 91% of those who used acupuncture and 70% of those who used chiropractic saw professional providers of these therapies. See *id.*

50. See 1998 Eisenberg Study, *supra* note 5, at 1569; see also Astin, *supra* note 38, at 1550 (finding that 40% of respondents reported using some form of alternative health care during 1997).

51. See generally, L. Clark Paramore, *Use of Alternative Therapies: Estimates from the 1994 Robert Wood Johnson Foundation National Access to Care Survey*, 13 J. PAIN & SYMPTOM MGMT. 83 (1997). In the most recent follow-up study, researchers found that 40% of American survey respondents had used an alternative medical treatment in the past year. See Astin, *supra* note 38, at 1550.

52. The Paramore study revealed strikingly similar results to the *New England Journal of Medicine* study, once the adjustment for patients seeing a provider was made. Compare 1993 Eisenberg Study, *supra* note 1, at 248 tbl.2, with Paramore, *supra* note 51, at 85 tbl.1.

53. See Paramore *supra* note 52, at 85 tbl.1. Of this group, 5.6% of users had seen professionals in more than one of these modalities during the previous year. Calculated from *id.* at 85 tbl.1.

54. See 1998 Eisenberg Study, *supra* note 5, at 1571-72 & tbl.2. The NIH Office of Alternative Medicine (OAM) defines alternative medical practices as those "that lack 'sufficient documentation in the U.S. for safety and effectiveness against specific diseases and conditions,' are not 'generally taught in U.S. medical schools[,] and]. . . are not 'generally reimbursable by health insurance providers.'" See Paramore, *supra* note 51, at 83-84 (citations omitted). This criteria would include treatments such as commercial weight loss programs and self-help groups under the rubric of alternative medicines. Indeed, although the inclusion of these therapies conflicts with what most people understand alternative therapies to include, it is difficult to design a criteria that excludes these therapies while including imagery and acupuncture. For instance, if we adopt a criteria such as "holds itself out as a substitute for a conventional medical proce-

After the publication of the 1993 Eisenberg Study, a number of researchers set out to assess the efficacy of alternative therapies.⁵⁵ A great deal of the funding for this research came from the newly created National Institutes of Health (NIH) Office of Alternative Medicine (OAM). The OAM was created in 1992 to "investigate and validate . . . unconventional medical practices."⁵⁶ The Office was established against the will of the NIH, at the insistence of Senator Tom Harkin, a true believer in the powers of alternative medicine.⁵⁷ Some of the projects funded by the OAM have been so outlandish as to provoke ridicule.⁵⁸ Conversely, reasonable commentators have pointed out that a million dollars spent debunking the supposed curative value of magnets placed on the human body may ultimately lead to significant long-term consumer savings.⁵⁹ In any event, funding flowed in from non-NIH sources as well, resulting in the publication of some reputable evaluative studies.⁶⁰

dure," then we would certainly include commercial weight loss programs—a substitute for liposuction, and self-help groups—a substitute for psychiatric care. For purposes of this Article, I will refer to alternative treatments as those that are holistic in nature and lack rigorous scientific proof of their effectiveness in treating specific diseases and conditions.

55. See Paramore, *supra* note 51, at 83-84 (discussing the rise in research studies since the 1993 Eisenberg Study).

56. Leon Jaroff, *Bee Pollen Bureaucracy*, N.Y. TIMES, Oct. 6, 1997 at 19.

57. See, e.g., Daniel S. Greenberg, Editorial, *Wrong Prescription for Alternative Medicine*, BALTIMORE SUN, Nov. 12, 1998, at 19A, available in 1998 WL 4992817.

58. See, e.g., Jaroff, *supra* note 56, at 19. Daniel Greenberg summarizes the criticism:

Assigned to study such remedies, the office has so far produced a gusher of outrage, but little medical information, though it has doled out several million dollars to researchers

Budget season brings out the critics of the office. It's more like "witchcraft than medicine," says D. Allan Bromley, who boned up on quackery as an adviser to the Reagan White House and as President Bush's science adviser. Its activities range from the "barely plausible to the totally preposterous," says Robert Park, who monitors Washington for the American Physical Society. "There is no reason to have this office," Maxine Singer, president of the prestigious Carnegie Institution of Washington, told Chemical & Engineering News.

Daniel S. Greenberg, *Orthodox Medicine Slights the Off-Beat*, SACRAMENTO BEE, Aug. 11, 1997, at B5, available in 1997 WL 3300989.

59. See, e.g., James D. Livingston, *Magnetic Therapy: Plausible Attraction?*, SKEPTICAL INQUIRER, July 1, 1998, at 25, available in 1998 WL 17318166.

60. See, e.g., Jeffrey Balon et al., *A Comparison of Active and Simulated Chiropractic Manipulation as Adjunctive Treatment for Childhood Asthma*, 339 NEW ENG. J. MED. 1013 (1998); Francesco Cardini & Huang Weixin, *Moxibustion for Correction of Breech Presentation: A Randomized Controlled Trial*, 280 JAMA 1580 (1998); Jennifer Jacobs, *Treatment of Acute Childhood Diarrhea with Homeopathic Medicine: A Randomized Clinical Trial in Nicaragua*, 93 PEDIATRICS 719 (1994); Pierre L. LeBars et al., *A Placebo-Controlled, Double-blind, Randomized Trial of an Extract of Ginkgo Biloba for Dementia*, 278 JAMA 1327 (1997); Malcolm H. Pope et al., *A Prospective Randomized Three-Week Trial of Spinal Manipulation, Transcutaneous Muscle Stimulation, Massage and Corset in the Treatment of Subacute Low Back Pain*, 19 SPINE 2571 (1994); David Reilly et al., *Is Evidence for Homeopathy Reproducible?*, 344 LANCET 1601

At present, it appears that alternative medicine will continue to grow in popularity. In addition to the enhanced respectability of modalities such as chiropractic and acupuncture, discussed in this Article,⁶¹ several trends bode well for alternative medicine. First, the continued trend towards cost containment in the health care industry has prompted Health Maintenance Organizations (HMOs) and other insurers to explore lower cost alternatives to hospitalization and conventional medical care.⁶² Second, schools of alternative medicines are projecting a doubling of the number of chiropractic practitioners, and a tripling of oriental medicine and naturopathy practitioners by the year 2010,⁶³ and are adjusting class sizes to meet this demand.⁶⁴ This increased supply of alternative physicians is likely to spread to parts of the country currently unserved by alternative practitioners,⁶⁵ which may well generate further increases in demand. Third, as baby boomers age and begin developing more chronic medical conditions, their per capita demand for alternative medical care will likely increase.⁶⁶ Half of all baby boomers currently use alternative therapies, giving them the highest utilization rate of any cohort.⁶⁷ Fourth, as the

(1994); Wallace Sampson, *The Pharmacology of Chelation Therapy*, 1 SCI. REV. ALTERNATIVE MED. 23 (1997); Gerald R. Weis, *Chiropractic Referrals Reduce Neuromusculoskeletal Health Care Costs*, 23 J. HEALTH CARE FIN. 88 (1996). See generally, Jeffrey S. Levin, *Quantitative Methods in Research on Complementary and Alternative Medicine*, 35 MEDICAL CARE 1079 (1997) (discussing the need for greater methodological rigor in assessing alternative therapies).

61. See *infra* Parts II.A and III.A.

62. See Mike Schwartz, *By Popular Demand*, PRESS-ENTERPRISE, Oct. 7, 1997 at D1, available in 1997 WL 13969308.

63. See Richard A. Cooper & Sandi J. Stoflet, *Trends in the Education and Practice of Alternative Medicine Clinicians*, 15 HEALTH AFFAIRS 226, 233 (1996).

64. See *id.* at 232-33; see also Miriam S. Wetzel et al., *Courses Involving Complementary and Alternative Medicine at US Medical Schools*, 280 JAMA 784 (1998) (describing medical schools' recent efforts to expand the availability of elective alternative-medicine related courses).

65. Currently, alternative medicine is noticeably more popular in the West than the South, and somewhat more popular in the West than the Northeast and Midwest. The Midwest, however, which was the birthplace of chiropractic, has the highest rates of chiropractic utilization. See Paramore, *supra* note 51, at 86 tbl.2.

66. See *NIH Clinical Research: Hearings Before the Senate Labor and Human Resources Subcomm. on Public Health and Safety*, 105th Cong. 1997 (statement of David M. Eisenberg), available in 1997 WL 14152181 (explaining that the "baby boom" generation, now 30-55 years of age, is likely to utilize more alternative medical services in the future).

67. See *id.* While it is possible that middle-aged people generally are more likely to take advantage of alternative care and that utilization will decline as the baby boomers age, I have a strong suspicion that this is not the case. Because the boomers were socialized during an era in which the counter-culture was at its peak, I suspect that the counter-culture's residual acceptance of alternative medicine will color the boomers' lifelong utilization. For compelling data suggesting that age cohorts' perceptions of social phenomena and their subsequent political views later in life are shaped during their young adulthood, see generally M. KENT JENNINGS & RICHARD NIEMI, *GENERATIONS AND POLITICS: A PANEL STUDY OF YOUNG ADULTS AND*

number of Asian Americans in the United States increases, the demand for so-called "Eastern" medical care is likely to rise.⁶⁸ Fifth, society's expectations for longevity and health seem to rise at a pace that exceeds even the pace of scientific medical breakthroughs. As people's demands for conventional medicine become less and less realistic, they will be more likely to feel that conventional medicine has let them down.⁶⁹ Finally, and perhaps most importantly, the public currently seems less confident in medical science than during previous eras.⁷⁰ This sentiment is part of an anti-scientific ethos that is becoming pervasive in modern American society.⁷¹ Some of the central tenets of the holistic health movement in the 1960s have become engrained in the popular psyche and, somewhat surprisingly, in the practices of mainstream, conventional medicine.⁷² The confluence of

THEIR PARENTS (1981). Since there are no systematic surveys of Americans' utilization of alternative medicine prior to 1990, only time will tell.

68. See Cooper & Stoflet, *supra* note 63 at 233 (indicating that the number of alternative medical practitioners will increase dramatically by the year 2010); see also Christine E. Drivdahl & William F. Miser, *The Use of Alternative Health Care by a Family Practice Population*, 11 J. AM. BD. FAM. PRAC. 193, 196 (1998) (finding that Asian Americans had higher levels of alternative medicine use than any other group). Two of the three states with the highest concentration of practitioners of "oriental medicine," and presumably the highest percentage of residents who use Eastern medicine, are Hawaii (23%) and California (10.8%), both of which have very large Asian American populations. See *id.* at 231 ex. 3. The third state—New Mexico (16.7%)—has a very extensive legal licensing and quality control regime for Asian medicine. See WORKSHOP ON ALTERNATIVE MED., ALTERNATIVE MEDICINE: EXPANDING MEDICAL HORIZONS at xvi (1992). While a walk through almost any urban Chinatown will confirm that Chinese immigrants often visit providers of Chinese medicine, it is by no means clear that second- and third-generation Asian Americans would use these therapists at significantly higher rates than the rest of the population. To the best of my knowledge, no study addressing this question has been performed.

69. Cf. ALSTER, *supra* note 16, at 184 (describing the ways in which alternative medicine has capitalized on the failures of conventional medicine).

70. See DUTTON, *supra* note 40, at 21 (noting that the proportion of Americans expressing "a great deal of confidence" in medical science fell from 73% in 1966 to 32% in 1982).

71. See, e.g., Paul Forman, *Assailing the Seasons*, 276 SCIENCE 750 (1997) (reviewing PAUL R. GROSS ET AL., *THE FLIGHT FROM SCIENCE AND REASON* (1996)); John Yemma, *Science v. Fiction*, BOSTON GLOBE, Apr. 13, 1997 at 13 (describing how the media reflects the increase of non-science based phenomenon in our culture, and the trend toward anti-scientific thinking). Cf. PAUL R. GROSS & NORMAN LEVITT, *HIGHER SUPERSTITION: THE ACADEMIC LEFT AND ITS QUARRELS WITH SCIENCE* (1994) (discussing the anti-scientific bent of much of the academy); Jean-Claude Ellena, *Other Cultures-Other Fragrances*, DRUG & COSMETIC INDUSTRY, Mar. 1996, at 26, 30 (discussing how the anti-scientific, New Age bent has influenced the fragrance industry, of all things, spawning lines of perfumes "that promise to enhance the wearer's mental and physical well-being").

72. For example, the use of relaxation techniques, diet monitoring, anti-oxidant vitamins, and various forms of stress management are basically holistic in outlook in that they treat the totality of the person. Strong medical evidence has shown that these treatments can be effective as part of treatment strategies for various medical. See, e.g., G. Bassotti & W.E. Whitehead, *Bi-feedback, Relaxation Training, and Cognitive Behaviour Modification as Treatment for Lower Functional Gastrointestinal Disorders*, 90 QJM 545 (1997) (concluding that relaxation training

these factors strongly suggests that levels of unconventional medicine utilization will continue to rise in the near future.

Alternative medicine today is somewhere in the middle of a dramatic expansion phase. Expanding access to alternative therapies is now an important goal of a large number of private insurers, health maintenance organizations, legislators, patients and, of course, alternative medicine practitioners. This orientation towards increasing access and availability contrasts sharply with the trend in the rest of the health care sector, where cost containment is the primary goal.⁷³ Interestingly, however, these two trends are not at odds. Advocates of cost containment are promoting alternative medicine as a means of reducing health care expenditures.⁷⁴

As insurers expand access to alternative care, many seem determined to prevent a cost escalation of the sort that occurred for orthodox medicine during the 1970s and 1980s. Accordingly, they are adapting to alternative medicine the same techniques that were developed to contain the costs of conventional medicine. Among these techniques, utilization review appears to be ill-suited to alternative medicine.⁷⁵ However, tools such as treatment limitations,⁷⁶ capitation⁷⁷ and cost sharing⁷⁸ promise to keep costs under control effectively. In contrast, in tort litigation, where such cost containment

may be useful in treatment of irritable bowel syndrome (IBS)); Zachary T. Bloomgarden, *Antioxidants and Diabetes*, 20 *DIABETES CARE* 670 (1997) (discussing evidence suggesting that the use of antioxidant vitamins may be effective in treating diabetes); James A. Blumenthal et al., *Stress Management and Exercise Training in Cardiac Patients with Myocardial Ischemia: Effects on Prognosis and Evaluation of Mechanisms*, *ARCHIVES INTERNAL MED.* 2213 (1997) (concluding that using stress-management techniques can lower the risk of heart disease); Peter J. Keel et al., *Comparison of Integrates Group Therapy and Group Relaxation Training for Fibromyalgia*, 14 *CLINICAL J. PAIN* 232 (1998) (finding that relaxation techniques can help reduce chronic pain); Dean Ornish et al., *Intensive Lifestyle Changes for Reversal of Coronary Heart Disease*, 280 *JAMA* 2001 (1998) (discussing the benefits that diet changes and stress management can create for heart disease patients). Accordingly, these techniques are widely prescribed by medical doctors as an integral part of treatment.

73. See Brian P. Battaglia, *The Shift Toward Managed Care and Emerging Liability Claims Arising from Utilization Management and Financial Incentive Arrangements Between Health Care Providers and Payers*, 19 *U. ARK. LITTLE ROCK L.J.* 155, 155 (1997) (noting the critical role cost containment plays in a managed healthcare system).

74. Cf. Joanne P. Cavanaugh, *Holistic Medicine Acceptance Growing*, *BALTIMORE SUN*, July 29, 1997, at C7, available in 1997 WL 5522342 (discussing the availability of alternative medicine at six Baltimore Hospitals as "low-tech, low-cost treatment[s]").

75. See *infra* Part II.C.3.

76. See *infra* Part II.C.1.

77. See *infra* Part II.C.4.

78. See *infra* Part II.C.5.

mechanisms do not exist, and the potential for bill padding is greater, overutilization is likely to become a very serious problem.⁷⁹

II. CHALLENGES IN CONTROLLING THE COSTS OF CHIROPRACTIC CARE

A. *Chiropractic Enters the Mainstream*

Chiropractic involves "detecting and correcting by manual or mechanical means structural imbalance, distortion, or subluxations in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, malalignment or subluxation of or in the vertebral column."⁸⁰ Chiropractors generally manipulate the spine and other body parts to improve skeletal and muscular alignment in the body. Approximately three quarters of those who visit chiropractors do so for a specific medical condition,⁸¹ often ailments involving the lumbar and cervical regions of the neuromusculoskeletal system.⁸²

In the last two decades chiropractic care has become firmly rooted in the American health care system.⁸³ Twenty-two million Americans now receive chiropractic care each year, double the number of a decade ago.⁸⁴ These patients make an average of thirteen visits to chiropractors per year.⁸⁵ Between 1980 and 1988, chiropractic expenditures grew from one billion to four billion dollars.⁸⁶ Not surprisingly, then, the number of chiropractors in the United States rose from 13,000 in 1970 to 50,000 by 1994.⁸⁷ That number is projected to reach 100,000 by 2010.⁸⁸

79. See *infra* Part II.D.

80. N.Y. EDUC. LAW § 6551 (Consol. 1997) (providing a statutory definition of chiropractic).

81. See Paramore, *supra* note 51, at 88 tbl.4.

82. See Miron Stano & Monica Smith, *Chiropractic and Medical Costs of Low Back Care*, 34 MED. CARE 191, 192 (1996).

83. See Paul G. Shekelle, *What Role for Chiropractic in Health Care?*, 339 NEW ENG. J. MED. 1074, 1074 (1998) ("In the last decade of the 20th century, chiropractic has begun to shed its status as a marginal or deviant approach to care and is becoming more mainstream.").

84. See Cavanaugh, *supra* note 75, at C7.

85. See Stano & Smith, *supra* note 82, at 191. Of these, approximately 17.6 million actually visit a chiropractic professional. See Paramore, *supra* note 51, at 85 tbl. 1. See also Eric L. Hurwitz et al., *Use of Chiropractic Services from 1985 through 1991 in the United States and Canada*, 88 AM. J. PUB. HEALTH 771, 773-74 (1998) (finding that patients with lower back pain made an average of 14 visits to a chiropractor per episode of care, and that patients with other conditions made an average of 9 visits).

86. See Stano & Smith, *supra* note 82, at 192.

87. See Cooper & Stoflet, *supra* note 63, at 228.

88. See *id.* at 233.

While the American Medical Association (AMA) was for many years sharply critical of the purported benefits of chiropractic,⁸⁹ that criticism waned somewhat in the 1970s. As the medical profession and public became increasingly convinced that chiropractic care could provide patients with some relief from back pain, stiffness, and acute malalignment,⁹⁰ the prestige and incomes of chiropractors increased.⁹¹ While chiropractors still lack the stature and income of medical doctors, chiropractic is now regarded as a credible treatment by most doctors and state governments.⁹² Although few (and maybe no) reliable clinical studies demonstrate the effectiveness of chiropractic techniques,⁹³ some recent studies showing that chiropractors can treat chronic back pain patients at less expense than medical doctors,⁹⁴ and

89. See Walter I. Wardell, *Orthodox and Unorthodox Practitioners: Changing Relationships and the Future Status of Chiropractors*, in MARGINAL MEDICINE 61, 70 (Roy Wallis & Peter Morley eds., 1976); see also *Wilk v. American Med. Ass'n*, 895 F.2d 352, 370 (7th Cir. 1990) (describing the conflict between the American Medical Association (AMA) and chiropractors that ultimately resulted in anti-trust litigation against the physicians); HOWARD WOLINSKY & TOM BRUNE, *THE SERPENT ON THE STAFF: THE UNHEALTHY POLITICS OF THE AMERICAN MEDICAL ASSOCIATION* 121-43 (1994) (describing the AMA's tactics in repeatedly attempting to discredit chiropractic care in an effort to protect doctors' livelihood).

90. See DESMOND PANTANOWITZ, *ALTERNATIVE MEDICINE: A DOCTOR'S PERSPECTIVE* 48 (1994).

91. See *id.* at 67, 69.

92. Currently, all fifty states license chiropractors. See Daniel S. Greenberg, *A Light on Quack Medicine*, WASH. POST, Aug. 10, 1997 at C7, available in 1997 WL 12880652.

93. See E. Ernst & W.J.J. Assendelft, *Chiropractic for Low Back Pain: We Don't Know Whether It Does More Good than Harm*, BRIT. MED. J., July 18, 1998, at 160, 160

A recent systematic review restricted to chiropractic manipulation included only eight randomised controlled trials, all of which were methodologically flawed and 'did not provide convincing evidence for the effectiveness of chiropractic for acute or chronic [low back pain].' Consequently, we can conclude only that the effectiveness of chiropractic as a treatment for low back pain has not been established beyond reasonable doubt.

Id. (citing W.J.J. Assendelft et al., *The Effectiveness of Chiropractic for Treatment of Low Back Pain: An Update and Attempt at Statistical Pooling*, 19 J. MANIPULATIVE PHYSIOLOGICAL THERAPY 499 (1996)); Rebecca Berg, Note, *HMO Exclusion of Chiropractors*, 66 S. CAL. L. REV. 807, 823-24 (1993) and sources cited therein (discussing the Rand Corporation's review of published research on spinal manipulation and noting the small quantity of such research).

94. See Monica Smith & Miron Stano, *Costs and Recurrences of Chiropractic and Medical Episodes of Low-Back Care*, 20 J. MANIPULATIVE & PHYSIOLOGICAL THERAPEUTICS 5, 9 (1997). But see Timothy S. Carey et al., *The Outcomes and Costs of Care for Acute Low Back Pain Among Patients Seen by Primary Care Practitioners, Chiropractors, and Orthopedic Surgeons*, 333 NEW ENG. J. MED. 913, 915-16 (1995) ("Chiropractors and orthopedists had the highest charges. The chiropractors' charges were high because of the use of radiographs and the large number of office visits, which more than made up for the low charge per visit."); Daniel C. Cherkin et al., *A Comparison of Physical Therapy, Chiropractic Manipulation, and Provision of an Educational Booklet for the Treatment of Patients with Low Back Pain*, 339 NEW ENG. J. MED. 1021, 1026 (1998) ("[T]he total time spent with either a chiropractor or a physical therapist was similar . . . as was the total cost of the treatments . . ."); Ernst & Assendelft, *supra* note 93, at

with arguably better results⁹⁵ have buoyed chiropractors' spirits. That said, the evidence is still too inconclusive for one to conclude credibly that chiropractic actually works or is cost-effective.⁹⁶

B. State Regulation of Chiropractors

States have long regulated the practice of chiropractic care.⁹⁷ Typically, state regulations define precisely the types of services in which chiropractors can and cannot engage.⁹⁸ These regulations are

160 ("There are few conclusive economic evaluations, but most of the rigorous studies do not suggest that chiropractic saves money.").

95. See Carey et al., *supra* note 94, at 916 ("The higher level of satisfaction among the patients who saw chiropractors persisted after adjustment for the number of visits and the use of radiography. The strongest correlates of satisfaction were the patient's responses to questions . . . of the provider's history taking, examination, and explanation of the problem during the visit."); Stano & Smith, *supra* note 82, at 193, 201 (reporting that patients expressed a higher degree of satisfaction with chiropractic care than with treatment by family physicians, and that patients were more likely to leave the care of family practitioners in favor of chiropractors than the reverse). Of course, patient satisfaction is only one way of measuring treatment success. Chiropractic does not perform as well when assessed in terms of more objective assessments, such as the amount of follow-up care requested after treatment ended. See Carey et al., *supra* note 94, at 917; Cherkin et al., *supra* note 94, at 1025.

96. See Carey et al., *supra* note 94, at 916-17. "Several studies have reported improved outcomes among patients undergoing spinal manipulation, as compared with those receiving medical treatments. Our study did not confirm these results." *Id.* at 916 (citations omitted); see also Cherkin et al., *supra* note 94, at 1028 ("Thus, although chiropractic manipulation and physical therapy may slightly reduce symptoms, their main benefit . . . appears to be increased satisfaction with care."); *id.* at 1026 ("We found that patients who received chiropractic manipulation or physical therapy had only marginally better outcomes than those who received only an educational booklet."); Ernst & Assendelft, *supra* note 93, at 160; Shekelle, *supra* note 83, at 1074 ("Because these data on direct costs are compatible with observational data, I conclude that chiropractic care for low back pain, at least as practiced in the United States, costs more than the usual supportive medical care delivered by health maintenance organizations." (citations omitted)).

97. See, e.g., CAL. BUS. & PROF. CODE § 1000.7 (West 1997) (stating the practices authorized); N.Y. EDUC. LAW § 6551 (Consol. 1998) (providing a definition of chiropractic practice).

98. For example, the New York statute is characteristically explicit and exhaustive:

A license to practice chiropractic shall not permit the holder thereof to treat for any infectious diseases such as pneumonia, any communicable diseases listed in the sanitary code of the state of New York, any of the cardio-vascular-renal or cardio-pulmonary diseases, any surgical condition of the abdomen such as acute appendicitis, or diabetes, or any benign or malignant neoplasms; to operate; to reduce fractures or dislocations; to prescribe, administer, dispense or use in his practice drugs or medicines; or to use diagnostic or therapeutic methods involving chemical or biological means except diagnostic services performed by clinical laboratories which services shall be approved by the board as appropriate to the practice of chiropractic; or to utilize electrical devices except those devices approved by the board as being appropriate to the practice of chiropractic. Nothing herein shall be construed to prohibit a licensed chiropractor who has successfully completed a registered doctoral program in chiropractic, which contains courses of study in nutrition satisfactory to the department, from using nutritional counseling, including the dispensing of food concentrates, food extracts, vitamins, minerals, and other nutritional supplements approved by the board as being appropriate to, and as a part of, his or her practice of chiropractic. Nothing herein shall be construed to

often more explicit than the regulations governing medical conduct.⁹⁹ As a result, medical doctors possess a greater degree of flexibility and discretion. Physicians are prohibited from engaging in “unprofessional conduct,” but, with a few exceptions,¹⁰⁰ state statutes do not go into much detail describing such conduct. Rather, the professions themselves are expected to self-regulate,¹⁰¹ and the courts are expected to correct problems of malpractice. In short, unlike doctors who have a broad grant of authority to heal the sick and a few activities proscribed, chiropractors face narrow authority and rather legal consequential prohibitions within that authority.

The most commonly offered explanation for this disparate regulatory burden—the overwhelming political might of the medical establishment¹⁰²—has a kernel of truth to it. However, a more satisfying explanation focuses on an unfortunate tendency of some chiropractors (and holistic healers generally) to over-reach.¹⁰³ Some chiropractors believe that the spinal column controls the functions of the entire body and that by manipulating the spine, one can heal a patient’s ulcers or tonsillitis.¹⁰⁴ These chiropractors can then convince their more

prohibit an individual who is not subject to regulation in this state as a licensed chiropractor from engaging in nutritional counseling.

N.Y. EDUC. LAW § 6551(3).

99. See Berg, *supra* note 93, at 817-18.

100. See, e.g., N.Y. EDUC. LAW. § 6530(41),(44) (Consol. 1998) (prohibiting a few activities, such as “[k]nowingly or willfully performing a complete or partial autopsy on a deceased person without lawful authority,” or activities that “promote explicit physical sexual contact between group members during [therapy] sessions.”).

101. See Einer Elhauge, *The Limited Regulatory Potential of Medical Technology Assessment*, 82 VA. L. REV. 1525, 1537 (1996).

102. See, e.g., Cohen, *A Fixed Star*, *supra* note 7, at 144-47.

103. Specifically, a little less than ten percent of all treatments by chiropractors were for nonmusculoskeletal symptoms. See Hurwitz et al., *supra* note 85, at 775; see also R.L. Plamondon, *Summary of 1994 ACA Annual Statistical Survey*, 32 J. AM. CHIROPRACTIC ASSOC. 57 (1995) (reporting that 10 to 15 percent of treatments fall into that category). In this paragraph I discuss ideological motivations behind chiropractic overreaching. However, the fact that chiropractors’ training is notably less rigorous than physicians’ training, see Susan M. Hobson, Note, *The Standard of Admissibility of a Physician’s Expert Testimony in a Chiropractic Malpractice Action*, 64 IND. L.J. 737, 750 (1989), provides an independent reason to suspect that overreaching might be a particularly prominent problem among chiropractors.

104. See PANTANOWITZ, *supra* note 90, at 47-48. As Victor Turow noted:

Among the 50,000 licensed chiropractors in the United States, the minority view advocates chiropractic strictly for musculoskeletal conditions. Chiropractors . . . are treating children for otitis media, asthma, various musculoskeletal disorders, gastrointestinal symptoms (including constipation and infant colic), enuresis, attention deficit disorders, allergies, and even epilepsy. Many chiropractors offer “comprehensive family health care,” including checkups and preventive manipulations. Many oppose childhood immunization, offering spinal adjustment as an alternative means of health maintenance.

Victor D. Turow, *Chiropractic for Children*, 151 ARCHIVES PEDIATRICS & ADOLESCENT MED. 527, 528 (1997) (citations omitted); see also Boozang, *supra* note 7, at 197 (“[C]hiropractors

naïve patients that chiropractic is a cure-all, and that they should forego conventional medical care in favor of continued chiropractic therapies.¹⁰⁵ Chiropractic patients are particularly susceptible to such suggestions, because they generally “have lower education levels than non-users.”¹⁰⁶ Because some “true believer” holistic chiropractors¹⁰⁷ embrace a world view as much as an occupation,¹⁰⁸ they are prone to dismiss conventional medical care as harmful, and doctors as misguided elites.¹⁰⁹ As chiropractors gain the trust of their patients by producing positive health outcomes for them, patients are more likely to view their chiropractors as primary care providers.¹¹⁰ This dynamic may be only mildly harmful in the case of colds and warts, but it might

resist any attempts to limit their practice to back care, applying their therapies to other ailments for which scientific support remains insufficient.”). In truth, there is some evidence that chiropractic care can reduce stress and, as a result, help treat diseases such as hypertension. See John P. Crawford et al., *The Management of Hypertensive Disease: A Review of Spinal Manipulation and the Efficacy of Conservative Therapies*, J. MANIPULATIVE PHYSIOLOGICAL THERAPY, Mar. 1986, at 27. Even this evidence, however, strongly cautions that chiropractic is to be used as a complementary therapy in coordination with diet, exercise, and medication. See *id.* at 27; see also Geoffrey Bove & Niels Nilsson, *Spinal Manipulation in the Treatment of Episodic Tension-Type Headache: A Randomized Controlled Trial*, 280 JAMA 1576, 1579 (1998) (concluding that spinal manipulation does not help prevent or relieve episodic tension-type headaches).

105. For an example of such a situation in the case law, see *Strohm v. Hertz Corp.*, 685 So.2d 37, 38 (Fla. Dist. Ct. App. 1996) (stating that the plaintiff held “a deep belief in chiropractic as evidenced by his testimony that he has sought chiropractic treatment for himself and his children for a broad range of maladies ranging from colds to warts to bed wetting.”).

106. Paramore, *supra* note 51, at 84. *But cf.*, Regis Blais et al., *How Different Are Users and Non-Users of Alternative Medicine?*, CANADIAN J. OF PUB. HEALTH, May-June 1997, at 159, 161 (describing Quebec’s users of alternative medicine as “more likely to be well-off, better educated and young adults”).

107. *Chiropractic Manipulation*, HARV. WOMEN’S HEALTH WATCH, Dec. 1995, at 4, 5. See Oliver Fultz, *Chiropractic: What Can It Do for You?*, AM. HEALTH, Apr. 1992, at 41 (noting that “original” chiropractic theory is preoccupied with the spine as the major factor in health and disease”). It is important to underscore that the majority of chiropractors no longer eschew conventional medicine. Over the past few decades, many chiropractors have rejected holistic healing’s innate skepticism about the value of the scientific method. At the same time, chiropractic programs do not provide graduates with research opportunities, so many chiropractors lack experience with the methods of conventional medical science. See Alan H. Adams, & Meridel Gatterman, *The State of the Art of Research on Chiropractic Education*, 20 J. MANIPULATIVE & PHYSIOLOGICAL THERAPUTICS 179 (1997); John Q. Zhang, *Research Attitudes Among Chiropractic College Students*, 19 J. MANIPULATIVE & PHYSIOLOGICAL THERAPUTICS 446 (1996).

108. See generally ALSTER, *supra* note 16, at 46-72 (describing and discussing “holistic health therapies [as] largely a compendium of practices designed to move the person toward wholeness,” which “Western medicine has not always served . . . well”).

109. See *id.*; see also ENGLISH-LUECK, *supra* note 30, at 150-51 (discussing how the holistic healer has traditionally seen himself as “at odds with the [medical] establishment”).

110. See Blais, *supra* note 106, at 161-62.

be catastrophic for patients with serious medical needs whose chiropractors do not refer them to conventional medicine professionals.¹¹¹

C. Controlling Chiropractic Consumption

Prescribing chiropractic care for symptoms that it is unlikely to heal is the one form of overconsumption that has garnered much attention from the states.¹¹² But chiropractors can encourage overconsumption of their services in other, more subtle ways. Indeed, I will argue that the chief cause of overutilization—one that has received less attention from state legislators—is the overtreatment of patients suffering from medical conditions for which some chiropractic care may be justified.

This problem is particularly daunting because both chiropractors and patients may have an incentive to overutilize. Chiropractors' motivation for overtreatment is fairly obvious: the prospect of financial gain. For many patients who enjoy visiting chiropractors, however, overutilization is likely to occur when a third party is covering the costs of treatment. Deep tissue massage is often a mainstay of chiropractic practice, and many patients are likely to find such massages quite pleasurable.¹¹³ Chiropractic treatments can be very beneficial in

111. See Beyerstein, *supra* note 28, at 150. Cf. *Boyle v. Revici*, 961 F.2d 1060, 1062 n.1 (2d Cir. 1992) (noting that "Boyle [had] introduced evidence that Dr. Revici [an alternative medicine practitioner, but not a chiropractor] actively discouraged Zyjewski [a cancer patient] from obtaining conventional medical care, even when she gravely needed it and it had become evident that his treatment was not succeeding."); *Charell v. Gonzalez*, 660 N.Y.S.2d 665, 666 (Sup. Ct. 1997) (involving a uterine cancer patient who testified that her alternative medicine provider "dissuaded her from having chemotherapy or radiation, and recommended treatment through his protocol of a special diet, including six coffee enemas a day"), *vacated in part* by 673 N.Y.S.2d 685 (App. Div. 1998). To address this problem, some states have created statutory or common law duties to refer. See, e.g., *Rosenberg v. Cahill*, 492 A.2d 371, 378 (N.J. 1985) (holding that the standard of care for chiropractors includes referring the patient to a medical doctor when a conventional mode of treatment is indicated); *Mostrom v. Pettibon*, 607 P.2d 864, 867 (Wash. Ct. App. 1980) (requiring alternative practitioners to refer those medical problems that they could not reasonably expect to solve to physicians). For a discussion of the duty to refer in the chiropractic context, see Cohen, *Holistic Health Care*, *supra* note 7, at 144. Such a duty requires the referral of those ailments that a reasonable chiropractor should realize required the care of a physician. See *id.*

112. A critical premise underlying this Article—the idea that a society with scarce resources must allocate medical resources to those who can benefit the most from assistance, and to those willing to pay the most for premium assistance—has been discussed in great detail elsewhere. For a particularly insightful discussion, see generally David C. Hadorn, *Emerging Parallels in the American Health Care and Legal-Judicial Systems*, 18 AM J.L. & MED. 73 (1992). See also Peter Franks et al., *Gatekeeping Revisited—Protecting Patients from Overtreatment*, 327 NEW ENG. J. MED. 424, 424-25 (1992) (discussing the dangers of overtreatment).

113. See Craig Liebenson, *Active Muscular Relaxation Techniques*, 12 J. MANIPULATIVE & PHYSIOLOGICAL THERAPUTICS 446 (1989); Hurwitz et al., *supra* note 85, at 773 (reporting that

reducing stress.¹¹⁴ As a result, patients may (consciously or subconsciously) continue treatments so as to obtain the real benefits of a weekly or bi-weekly massage, even after they have been healed of the ailment for which they originally sought a chiropractor's care.¹¹⁵

Health insurance policies, workers' compensation statutes, and Medicaid regulations generally require third party insurance providers to cover all medical care that is "reasonable and necessary" or "medically necessary."¹¹⁶ As one can readily imagine, coverage disputes over these terms have often engendered litigation. As a result, a few courts have already confronted the chiropractic overconsumption problem. For example, in *Perun v. Utica Mutual Insurance Company*,¹¹⁷ a New Jersey court considered a case in which the plaintiff sought reimbursement for chiropractic care stemming from an automobile collision in 1986.¹¹⁸ The problem was that in 1994, when the case was adjudicated, the plaintiff was still making weekly visits to the chiropractor as part of an "annual wellness contract."¹¹⁹ Finding that the ongoing chiropractic treatments were "disproportionately expensive, excessive and in large part for Perun's personal comfort," the court upheld the denial of benefits.¹²⁰ The court was undoubtedly guided by its strong suspicions that the care was not addressing the lingering effects of the car accident, but the plaintiff's "general aging

79% of chiropractic low back pain patients received treatment with massage, hot packs, physical therapy, mobilization or other nonthrust therapies); see also N.I. Gluck, *Passive Care and Active Rehabilitation in a Patient with Failed Back Surgery Syndrome*, 20 J. MANIPULATIVE & PHYSIOLOGICAL THERAPUTICS 41, 41-47 (1996) (describing massage as an element of passive chiropractic care); Pope et al., *supra* note 60, 2571 (discussing manipulation and massage, the two techniques used by chiropractors, as having a lower study drop-out rate than other modalities). But see Siegrist v. Iwuagwa, 494 S.E.2d 180, 181-83 (Ga. Ct. App. 1997) *cert. denied*, 119 S.Ct. 344 (1998) (holding that Georgia law prohibits those chiropractors who use massage as a modality from billing patients for that massage treatment). In fact, massage therapy has established itself as a popular form of alternative medicine. Of course, massage therapy utilizes almost exclusively massage technique in treatment, while chiropractors use massage as a complement to their primary manipulations, which consist of low amplitude, high velocity thrusts to the spinal nerves. See PANTANOWITZ *supra* note 90, at 46-47; see also *infra* text accompanying note 183 (describing other elements of comprehensive chiropractic care).

114. See Crawford, *supra* note 104, at 27.

115. In such cases, perhaps the only factor mitigating a patient's tendency to overconsume chiropractic care will be the time sacrifices associated with frequent visits to a chiropractor.

116. See, e.g., *Beal v. Doe*, 432 U.S. 438, 444 (1977) (holding that state Medicaid programs must operate with reasonable standards to facilitate the goal of providing necessary medical treatment to those who cannot afford it).

117. 655 A.2d 99 (N.J. Super. 1994).

118. See *id.* at 100.

119. *Id.* at 101.

120. *Id.* at 107.

condition."¹²¹ Thus, the court concluded: "The fact that one may temporarily feel better from continued chiropractic treatment, which includes massage, does not make the treatment necessary."¹²² In a number of other cases, concerns that plaintiffs were milking soft tissue injuries for years of free chiropractic care helped lead courts to similar conclusions.¹²³

Chiropractors' tendency to provide patients with unnecessary treatments is borne out by more than just scattered examples from published cases. Most tellingly, one study found that more than fifty-seven percent of chiropractors' cervical spine manipulations were inappropriate.¹²⁴ Another commentator has observed that "[c]hiropractic care provides no benefit for many ailments, and in some cases may exacerbate the patient's problem."¹²⁵ Systematic comparisons of chiropractic and orthopedic care reveal that chiropractors tend to treat patients many more times than conventional practitioners.¹²⁶ Indeed, in a large number of cases, physicians treat pain episodes in one day, and no further care is needed.¹²⁷ In contrast, chiropractors frequently saw patients many times for the same episodes.¹²⁸ Moreover, a separate study found that chiropractic care is noticeably more sensi-

121. *Id.* at 102.

122. *Id.*

123. *See, e.g.*, *Otani v. State Farm Fire & Cas. Co.*, 927 F. Supp. 1330, 1336-38 (D. Haw. 1996) (involving continued passive care more than a year post-accident); *State Farm Mut. Ins. Co. v. Hill*, 883 S.W.2d 867, 867 (Ark. Ct. App. 1994) (involving 117 treatments during a single year); *Florek v. Kennedy*, 618 N.E.2d 760, 763-64 (Ill. App. Ct. 1993) (describing a plaintiff who sought care from several different doctors, consisting of her own physician, a chiropractor, an orthopedist, and two naprapaths); *Elkins v. N.J. Mfrs. Ins.*, 583 A.2d 409, 412-413 (N.J. Sup. Ct. App. Div. 1990) (involving a patient who sought continuous chiropractic care for 7 years following an accident); *see also Clair v. Glades County Bd. Of Commissioners*, 635 So.2d 84, 85 (Fla. Dist. Ct. App. 1994) (citing finding by administrative commission that where chiropractor had furnished palliative treatment for soft tissue injury for a lengthy period of time, commission refused to pay more for therapy), *rev'd on other grounds*, 649 So.2d 224 (Fla. 1995); *Whitlock v. Mitchell*, 1992 WL 682593, *1 (T.D. Cal. Jury) (reporting on a jury trial in which plaintiff's chiropractor testified that 99 treatments were "reasonable and necessary" treatment for pain resulting from rear-end collision).

124. *See Samuel Homola, Finding a Good Chiropractor*, 7 ARCHIVES FAM. MED. 20, 22 (1998).

125. Boozang, *supra* note 7, at 197 n.71 and sources cited therein.

126. *See Carey et al.*, *supra* note 94, at 915-16; *Cherkin et al.*, *supra* note 94, at 1026; *Smith & Stano*, *supra* note 94, at 9.

127. *See Stano & Smith*, *supra* note 82, at 198. Still, chiropractic care still may be cheaper in the aggregate (and, again, only in the short run) because physicians charge so much more when they do treat patients extensively. *See generally id.*

128. *See, e.g.*, *Fultz*, *supra* note 107, at 42 (recounting how one chiropractor advised a patient "to begin the adjustments immediately, with visits three times a week for the first eight to 10 weeks, then twice a week for at least the next eight weeks, for a total of perhaps 50 visits . . .").

tive to cost sharing (i.e., the use of copayments and deductibles) than overall health care expenditures.¹²⁹ The elasticity of demand for chiropractic care might mean that it is frequently not necessary for those who have access to its benefits, but rather an attractive perk.¹³⁰ Once consumers are forced to shoulder even a quarter of the costs of chiropractic care out of pocket, utilization declines dramatically.¹³¹ Little wonder then that one in four visits to a chiropractor is made by a patient who reports that he is not suffering from a specific medical condition.¹³²

1. Treatment Limitations

To mitigate the problem of chiropractic overconsumption, some states have established bright line rules limiting the number of chiropractic treatments that will be reimbursed by Medicaid or state mandated insurance plans. This approach has the advantage of simplicity and low administrative costs. For example, under Florida's Workers' Compensation law,¹³³ employers are responsible for furnishing medically necessary treatment to injured employees. Florida provides that, "[m]edically necessary treatment, care, and attendance does not include chiropractic services in excess of eighteen treatments or rendered eight weeks beyond the date of initial chiropractic treatment, whichever comes first, unless the carrier authorizes additional treatment or the employee is catastrophically injured."¹³⁴ The statute establishes a clear default rule that guards against the type of extended chiropractic overconsumption that was at issue in *Perun*.¹³⁵ Under the

129. See Paul G. Shekelle et al., *The Effect of Cost Sharing on the Use of Chiropractic Services*, 34 MED. CARE 863, 869 (1996). For studies of other areas of health care finding much less significant impacts of cost sharing on utilization, see Shou-Hsia Cheng & Tung-Liang Chiang, *The Effect of Universal Health Insurance on Health Care Utilization in Taiwan: Results From a Natural Experiment*, 278 JAMA 89 (1997); Richard E. Johnson et al., *The Effect of Increased Prescription Drug Cost-Sharing on Medical Care Utilization and Expenses of Elderly Health Maintenance Organization Members*, 35 MED. CARE 1119 (1997); Scott A. Kupor et al., *The Effect of Copayments and Income on the Utilization of Medical Care by Subscribers to Japan's National Health Insurance System*, 25 INT'L J. HEALTH SERVICES 295 (1995). Cost sharing is described in fuller detail *infra* Part II.C.5.

130. Perhaps some of this heightened elasticity also stems from the fact that chiropractic patients come from relatively lower socio-economic backgrounds than orthodox medicine patients. See Paramore, *supra* note 51, at 84.

131. See Shekelle et al., *supra* note 129, at 868.

132. See Paramore, *supra* note 51, at 88 tbl.4.

133. See FLA. STAT. ANN. § 440.13(2)(a) (West Supp. 1999).

134. *Id.*

135. See *infra* notes 118-123 and accompanying text. The average user of chiropractic has 13 treatments a year. See 1993 Eisenberg study, *supra* note 1, at 248 tbl.2. Therefore, the Florida statutory default maximum of 18 treatments seems to be a reasonable way of scrutinizing poten-

statute, the burden is on the claimant to convince the insurance carrier that he either has some special medical condition that justifies extended medical care, or that he has been catastrophically injured.¹³⁶ Several other states have adopted similar bright-line limitations.¹³⁷ Some states have even completely refused to allow the reimbursement of chiropractic services under state medical assistance programs,¹³⁸ presumably on the grounds that in a world of scarce medical resources, means-tested programs should cover only emergency medical care.

While the treatment limitations approach is easy to apply, it is an incomplete solution to the problem of overconsumption. Under Florida's scheme, chiropractors recognize that they can treat any patient, even one with minor ailments, eighteen times without facing departmental scrutiny.¹³⁹ While most chiropractors presumably would not knowingly pad bills, one tenet of holistic health care that is firmly engrained in chiropractic is the notion that the patient is not well until the patient believes she is well.¹⁴⁰ When the patient is enjoying the

tially overconsumptive claims. This data, however, should be taken with a grain of salt because the distribution of treatment around the average is critically important. If the utilization "curve" is fairly normal with a low standard deviation, then setting a treatment limit of 18 would only remove the suspicious high tail end of the distribution. On the other hand, if the curve has a bipolar shape, with a large number of patients seeing a chiropractor a few times and a large number seeing a chiropractor 30 or 40 times, then setting a cut-off point at 18 would be more controversial.

136. See § 440.13(2)(2); see also *Dynair Servs., Inc. v. L'Herisson*, 690 So.2d 659, 660 (Fla. Dist. Ct. App. 1997) (reversing a claim award because the claimant did not fall into one of two statutory exceptions).

137. See, e.g., NEB. REV. STAT. § 68-1019.02(1) (1996) (limiting reimbursement under Medical Assistance program to "eighteen treatments in a five-month period," with one visit per month for stabilization of care); FLA. ADMIN. CODE ANN. r. 59G-4.040 (1997) (limiting payment for chiropractic services for adults to one visit per day and twenty-four visits during a calendar year under Medicaid); N.J. ADMIN. CODE tit. 13 § 75-1.7(j) (limiting coverage to thirty treatments under state Victims of Crime Compensation program); 25 TEX. ADMIN. CODE § 29.403 (West 1997) (limiting coverage to 12 visits under Medicaid); 28 TEX. ADMIN. CODE § 26.27(R)(36) (West 1997) (excluding chiropractic care from coverage under the Small Employer Health Insurance Availability Act); WIS. ADMIN. CODE § 107.15(3)(a)(1) (1997) (requiring authorization for chiropractic treatment in excess of 20 visits under Medical Assistance Program). Many other states accomplish the same purpose through fee schedules for chiropractic care.

138. See, e.g., UTAH ADMIN. CODE R420-1-6(1)(k) (1997) (excluding chiropractic care from state medical assistance program).

139. Cf. PETER A. BELL & JEFFREY O'CONNELL, *ACCIDENTAL JUSTICE: THE DILEMMAS OF TORT LAW* 165 (1997) (noting that in states that require a minimum threshold for aggregate medical bills in order to allow a cause of action under tort, medical bills are often inflated to a dollar figure just above that threshold).

140. See Beyerstein, *supra* note 28, at 150; see also STONE & MATTHEWS, *supra* note 36, at 187-88 (1996) (describing the subjective, patient-centered focus of alternative medicine).

treatments or has the telltale signs of hypochondria, a chiropractor may be especially tempted to see eighteen treatments as a minimum, as well as a maximum. Moreover, chiropractors have no rigorous scientific evidence about the optimal number of treatments for a given condition.¹⁴¹ Thus, even if they wanted to be more scientific in prescribing a treatment program, chiropractors have only their own experience to use as a guide.

Consistent with their general practices of limiting medical treatments, health maintenance organizations that cover chiropractic care also typically cap the number of chiropractic visits a patient can make in a year. For example, depending upon the price of the health plan, the annual limitations of one California HMO range from twenty to fifty per year.¹⁴² Many HMOs also employ utilization review, which when applied to chiropractic care requires treatment and cost oversight by independent chiropractors, and requires member chiropractors to justify treatment beyond initial consultations.¹⁴³ Because independent review is of questionable worth in the chiropractic context,¹⁴⁴ this technique may only be marginally effective in containing costs.

2. Penalizing Overtreatment

To address overconsumption, some states have enacted regulations penalizing chiropractors who bill for unnecessary treatments. States that have these provisions make them generally applicable to health professionals.¹⁴⁵ Florida, however, has crafted a regulation designed specifically to deal with exploitative behavior by chiroprac-

141. See Shekelle, *supra* note 83, at 1074-75 ("Since the number of spinal manipulations needed to achieve the maximal therapeutic effect is unknown, chiropractors may be able to deliver fewer treatments and still achieve the same results.").

142. See *American Specialty Health Plans Becomes California's First Acupuncture HMO*, BUSINESS WIRE, Dec. 2, 1997, available in LEXIS BusFin Library, Bwire File [hereinafter *American Specialty*].

143. See *infra* Part II.C.3.

144. See *infra* notes 149-153 and accompanying text.

145. See, e.g., N.Y. EDUC LAW § 6530 (Consol. 1998) (prohibiting professionals from "exercising undue influence on the patient, including the promotion of the sale of services . . . or drugs in such manner as to exploit the patient for the financial gain of the [practitioner] or a third party"). See generally Pamela H. Bucy, *Health Care Reform and Fraud by Health Care Providers*, 38 VILL. L. REV. 1003 (1993) (discussing the difficulties encountered in prosecuting fraud cases against doctors); Mary DuBois Krohn, Comment, *The False Claims Act and Managed Care: Blowing the Whistle on Underutilization*, 28 CUMB. L. REV. 443, 459-63 (1997-98) (arguing that efforts to enforce the federal False Claims Act have discouraged overutilization).

tors.¹⁴⁶ That regulation defines overutilization as instances in which “[t]he written chiropractic records . . . do not justify or substantiate the quantity or number of chiropractic services, practices rendered, or goods or appliances sold by a chiropractic physician to a patient.”¹⁴⁷ The regulation also prohibits the blatant problem of double billing.¹⁴⁸

Enforcing a law like Florida’s will no doubt be challenging, given the nature of chiropractic. It is very difficult to achieve consensus among chiropractors as to whether a procedure should have been performed.¹⁴⁹ Many chiropractors, consistent with the holistic method, believe that effective chiropractic care must be individually tailored to each patient. To a chiropractor, diagnosis and treatment involves talking to the patient, touching the patient, and observing the patient’s mannerisms.¹⁵⁰ Medical records are a poor means to convey such information to a far-removed board. As a result, a patient would have little difficulty proving that at least a respectable minority of chiropractors would affirm the necessity of a given treatment.¹⁵¹ What’s more, the probability of obtaining convictions in health care fraud cases is often quite low.¹⁵² Given the low cost of each chiropractic treatment (relative to unnecessary conventional medical treatments) and the flexibility of the legal standard, it is likely that even a criminal statute crafted specifically to deal with the problem of chiropractic overutilization will fail to adequately deter overuse. Health care fraud investigators will perhaps focus on a few egregious instances of overbilling, but, at the margin, a significant amount of overutilization will occur.

3. Utilization Review

Utilization review is a system whereby independent evaluators examine a physician’s treatment of a patient *ex post* to determine

146. See, e.g., FLA. ADMIN. CODE ANN. tit. 64, r. § B2-17.005 (1998) (“Exploitation of Patients for Financial Gain”); see also N.J. ADMIN. CODE tit. 13, § 44E-2.13 (1997) (containing similar provisions regarding overutilization and excess fees).

147. FLA. ADMIN. CODE ANN. tit. 64, § B2-17.005(3)(a) (1998).

148. See *id.* § B2-17.005(3)(b).

149. See STONE & MATTHEWS, *supra* note 36, at 187.

150. See *id.*

151. Nevertheless, some jurisdictions continue to try to force such objective review onto the chiropractic model. See, e.g., *Wolk v. Jaylen Homes, Inc.*, 593 So.2d 1058, 1060 (holding that deauthorization of chiropractic care is appropriate under Florida Workers’ Compensation law only upon a finding of overutilization by an independent chiropractic review board).

152. See Sharon L. Davies & Timothy Stoltzfus Jost, *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse?*, 31 GA. L. REV. 373, 397-98 (1997) (discussing the difficulty of proving intent in health care fraud cases).

whether the services provided were cost effective.¹⁵³ This technique is frequently employed successfully by HMOs and private insurers to constrain costs by reducing the temptation for doctors to conduct unnecessary tests or make unwarranted referrals to specialists.¹⁵⁴ In its most benign form, utilization review entails "educational sessions" in which an insurer keeps a doctor informed about which of his referrals have tended to be less cost effective. But a more insidious dynamic that clearly exists under utilization review involves its use by the insurer as a means to convince a doctor to make fewer costly referrals or risk the loss of initial patient referrals from the insurer or HMO itself.

Utilization review is not a particularly good match for chiropractic or other alternative modalities for reasons related to those discussed above.¹⁵⁵ Chiropractors are simply not conditioned to make judgments about whether a certain treatment was necessary on the basis of the type of information that is available at the utilization review stage. All that can accurately be done by utilization reviewers is to examine the average number of treatments per patients, and assess one chiropractor against a pool of others. But even this will be controversial, and it will not solve the problem of chiropractors' systematic bias in favor of overtreatment.

4. Capitation

Another way to discourage the overconsumption of chiropractic care is for governmental and private health insurers to encourage capitation. Capitation is a prospective payment of a fixed sum for each patient under the care of a selected provider during a specific time period, regardless of the actual costs incurred by the provider in treating the patient.¹⁵⁶ Capitation strongly discourages health care providers from providing patients with unnecessary treatments, because

153. For discussions of utilization review in managed care organizations, see generally Michael A. Dowell, *Avoiding HMO Liability for Utilization Review*, 23 U. TOL. L. REV. 117 (1991); Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 27-29 (1993); and Helene L. Parise, Comment, *The Proper Extension of Tort Liability Principles in the Managed Care Industry*, 64 TEMP. L. REV. 977, 998-1003 (1991).

154. See James S. Cline & Keith A. Rosten, *The Effect of Policy Language on the Containment of Health Care Cost*, 21 TORT & INS. L.J. 120, 129 (1985).

155. See *supra* text accompanying notes 150-153.

156. See MARK V. PAULY ET AL., *PAYING PHYSICIANS: OPTIONS FOR CONTROLLING COST, VOLUME, AND INTENSITY OF SERVICES* 101 (1992). For a more general analysis of legal issues arising out of capitation in the health care system, see David Orentlicher, *Paying Physicians to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 161-62 (1996); Edward P. Richards & Thomas R. McLean, *Physicians in Managed Care: A Multidimensional Analysis of New Trends in Liability and Business Risk*, 18 J. LEGAL MED. 443, 460 (1997); and Andrew

providers are not reimbursed for each procedure they perform. Providers receive the same payment for caring for patient X regardless of whether patient X visits the provider once a week or once a year.¹⁵⁷ Thus, whereas under a fee-for-service arrangement the chiropractor's financial incentive is to maximize the number of sick patients he treats, under a capitation scheme the chiropractor wants to maximize the number of healthy patients who do not require treatment.¹⁵⁸ He will often have an incentive to help convince his patients that their conditions have improved, and that they can cease treatments. To the extent that his patients are suffering from psychosomatic ailments, this encouragement is likely to improve their condition.¹⁵⁹

Some have criticized capitation as an overreaction to over-utilization.¹⁶⁰ To be sure, it is widely acknowledged that health maintenance organizations, which often use a capitation system, sometimes deny members access to medically necessary treatments.¹⁶¹ Undoubtedly, some underutilization will occur where chiropractors are reimbursed at a capitated rate.¹⁶² In the context of chiropractic, however, capitation seems likely to strike a proper balance between over- and underutilization. Chiropractic patients have an incentive to overconsume.¹⁶³ Chiropractors, under capitation, have an incentive to

Ruskin, *Capitation: The Legal Implications of Using Capitation to Affect Physician Decision-Making Processes*, 13 J. CONTEMP. HEALTH L. & POL'Y 391, 398-99 (1997).

157. A very similar dynamic to capitation operates inside many HMOs. Physicians' salaries or bonuses are inversely related to the number of expensive referrals they make and hospitalizations they recommend. See Ezekiel J. Emanuel & Lee Goldman, *Protecting Patient Welfare in Managed Care: Six Safeguards*, 23 J. HEALTH POL. & L. 635, 636-37 (1998).

158. See Davies & Jost, *supra* note 152, at 384.

159. See *supra* text accompanying note 29.

160. Indeed, this is the classic populist critique of HMOs. For a similarly founded, but academic critique of HMOs, see Davies & Jost, *supra* note 152, at 387.

161. See generally Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86 (1989) (concluding that capitated care, relative to a fee-for-service arrangement, may adversely affect the quality of care patients receive). But see Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512 (1994) (finding that managed care organizations do not provide inferior health care); cf. Willard G. Manning et al., *A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services*, 310 NEW ENG. J. MED. 1505, 1509 (1984) (concluding that managed care physicians are practicing a different, less "hospital-intensive" style of care).

162. But see Donald M. Berwick, *Payment by Capitation and Quality of Care*, 335 NEW ENG. J. MED. 1227, 1230 (1996) (finding that the quality of care under capitated medical treatment schemes is as good as or better than the quality of care under a fee-for-service arrangement).

163. See *supra* notes 114-116 and accompanying text.

underprovide.¹⁶⁴ Admittedly, under a capitation arrangement, the more persistent patients would still be likely to receive the most treatment.¹⁶⁵ Moreover, there is a danger that shifting chiropractors' financial incentives may cause them to abandon their nurturing bedside manner, leading patients to return in droves to their medical doctors, which might in turn raise short-term medical costs. Still, it is likely that by introducing an incentive for one party to control chiropractic costs, capitation would represent an improvement over the current system, in which neither doctor nor patient has any such incentive.¹⁶⁶

Capitation, while conceptually similar to the methods of treatment limitations already discussed,¹⁶⁷ is superior in several crucial respects. Treatment limitations control overutilization only by those who have suffered some injury, but not those who occasionally use chiropractic care as part of a general wellness program. Capitation, in contrast, pays chiropractors for preventive care of patients who are eligible for treatment, but who do not in fact obtain treatment. Consequently, capitation encourages health care providers to teach patients behaviors that will keep them away from their providers' offices altogether. Additionally, capitation encourages chiropractors to wean patients off treatment. Further, capitation does not create the problem that often arises under numerical treatment limitations—a chiroprac-

164. Other factors, such as the fear of malpractice liability, ethical obligations to ensure patient wellness, and the desire to maintain a trusting relationship with patients, will partially counteract these financial incentives.

165. Some patients are persistent because they are genuinely suffering pain. Other patients are persistent by nature. Obviously, it is socially desirable for the first group, but not the second group, to receive the most care. The relative size of these two groups in the chiropractic context is an empirical matter upon which future research should focus.

166. It is troubling that such a scheme should require that patients and practitioners have clashing interests. But, with the possible exception of cost sharing, *see infra* Part II.C.5, I am aware of no method of containing costs that would avoid engendering all conflicts between patients and either their physicians or a third party payer. Moreover, as commentators have noted: "conflicts between physicians and patients have existed long before managed care . . . [and] elimination of all conflicts between physicians and patients is neither practical nor legally required." Gail B. Agrawal, *Chicago Hope Meets the Chicago School*, 96 MICH. L. REV. 1793, 1821 (1997) (reviewing MARK A. HALL, *MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS* (1997)). For discussions of whether physicians are the most appropriate agents for controlling costs and rationing health care resources, see generally HALL, *supra*; Ezekiel J. Emanuel & Nancy Neveloff Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 JAMA 323 (1995); David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians*, 275 JAMA 1693 (1996); Ruskin, *supra* note 156; Deborah A. Stone, *The Doctor as Businessman: The Changing Politics of a Cultural Icon*, 22 J. HEALTH POL. POL'Y & L. 533; Robert M. Veatch, *Physicians and Cost Containment: The Ethical Conflict*, 30 JURIMETRICS J. 461, 466-70 (1990); Veatch & Spicer, *supra* note 9, at 29.

167. *See supra* Part II.C.1.

tor who continues treating a patient just because that patient has not exhausted his or her annual quota for treatments. Capitation is, therefore, a more comprehensive means of cost containment than treatment limitations.

5. Cost Sharing

Unlike capitation, which gives practitioners an incentive to control costs,¹⁶⁸ cost sharing gives consumers the incentive.¹⁶⁹ Cost sharing has two basic and familiar forms—copayments and deductibles.¹⁷⁰ Copayments require a patient to pay for a fixed percentage of all medical expenses; with a third-party provider covering the remaining expenses. Deductibles require a patient to pay for the first fixed number of dollars of medical expenses incurred during the relevant coverage period; with a third-party provider paying all expenses above the deductible amount. Often, these two forms of cost sharing are used in tandem, with the health insurer, for example, paying for ninety-five percent of all covered medical expenses in excess of a \$500 deductible. Insurers offering chiropractic benefits utilize cost sharing widely.¹⁷¹

Cost sharing has shown great promise as a way of reducing overutilization in the chiropractic arena. A 1996 study of the effects of cost sharing on chiropractic utilization revealed that if patients were required to pay twenty-five percent of the costs of chiropractic care, their utilization dropped by more than half.¹⁷² Recall that chiropractic care is noticeably more sensitive to price than other forms of medical care.¹⁷³ This makes cost-sharing another promising tool for mitigating

168. It is worth noting for comparative purposes that “physicians’ decisions account for almost 75 percent of all health care spending,” suggesting that the absolute dollar values that can be influenced through a capitated system or other physician incentives is great. Emanuel & Goldman, *supra* note 157, at 636.

169. See Jerry L. Mashaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending*, 11 YALE J. ON REG. 455, 480-81 (1994) (noting consumers are likely to exercise reasonable judgment when involved with a cost-sharing plan); Sana Loue, *An Epidemiological Framework for the Formulation of Health Insurance Policy*, 14 J. LEGAL MED. 523, 545 (1993) (discussing cost-sharing in California’s Medicaid program).

170. See Mashaw & Marmor, *supra* note 136, at 480.

171. See 1998 Eisenberg Study, *supra* note 5, at 1575 (“Even when alternative therapies are covered, they tend to have high deductibles and co-payments and tend to be subject to stringent limits on the number of visits or total dollar coverage.”).

172. See Shekelle et al., *supra* note 129, at 868. There was little difference in utilization levels between those required to pay 25%, 50%, and 95% of their chiropractic bills, suggesting that a cost sharing level of 25% is sufficient to deter overconsumption. See *id.* at 868 tbl.3.

173. See *supra* note 130 and accompanying text.

chiropractic costs.¹⁷⁴ Not surprisingly, cost sharing is a staple of many HMO chiropractic plans.¹⁷⁵

This data simply demonstrates that cost sharing can reduce utilization of chiropractic care. If cost sharing is discouraging patients from seeking necessary chiropractic care, then that is not a desirable outcome. Logically, however, there is strong reason to believe that cost sharing is deterring use of those chiropractic services that are least medically necessary. The majority of chiropractic patients seek treatment because they are suffering from back pain.¹⁷⁶ Patients — as opposed to their health care providers — are in the best position to determine whether they are truly in need of care when their complaint is back pain, as opposed to a more medically obscure condition. Cost sharing forces a patient to “put his money where his pain is,” thus arguably and effectively revealing the degree to which the patient is actually suffering.

Yet, if a patient is seeking chiropractic care because of a desire to increase his pleasure, rather than decrease his pain, such medically unnecessary treatment may not be deterred by cost sharing. After all, if a healthy patient values the deep tissue massage and back-cracking treatments that he gets from a chiropractor at twenty dollars per treatment, and he need only make a ten dollar copayment to get it, he will probably continue to seek such care. To date no rigorous study has sought to discover the percentage of chiropractic patients who fall into this latter category. Unless one believes as an empirical matter that people are willing to pay more for pain-avoiding than pleasure-seeking, the larger the size of the pleasure-seeking group, the less effective cost sharing will be at decreasing overutilization of chiropractic care.

174. Currently, the availability of Medigap policies significantly diminishes the effectiveness of cost sharing under the federal Medicare program. Medigap policies cover all of a patient's copayments and deductibles in exchange for an annual premium. Unless the laws governing Medigap policies are reformed to preclude cost sharing of alternative medicine expenses, any effort to control reimbursable Medicare costs through cost sharing for alternative medicine will be less effective.

175. See, e.g., Morey Stettner, *Health Policies Go Holistic – At a Price*, INVESTOR'S BUS. DAILY, Nov. 4, 1997, at A1.

176. See Hurwitz et al., *supra* note 85, at 772 (finding that 68% of chiropractic “patients sought care for low back pain”). Other forms of pain, especially in the face, neck, and mid-back regions, accounted for the majority of the remaining visits to chiropractors. See *id.* at 773 tbl.2; see also Shekelle, *supra* note 83, at 1075 (concluding that back pain accounts for 40% to 60% of all visits to chiropractors).

D. *The Special Problem of Tort Damages*

When combined with bill-padding incentives already present in the health care industry,¹⁷⁷ the problem of chiropractic overconsumption in tort litigation is far more serious. A tortfeasor is generally held responsible for “reasonable and necessary” medical damages.¹⁷⁸ In negotiating settlements in tort suits, pain and suffering damages are generally calculated as a multiple of medical bills.¹⁷⁹ Bargaining often begins at a multiple of two to ten times the amount of economic damages.¹⁸⁰ For plaintiffs, as well as unscrupulous doctors and chiropractors—who may be in cahoots with plaintiff’s counsel—this convention provides incentives for medical bill padding.¹⁸¹ One check on bill padding, perhaps, has been that medical appointments are often not particularly pleasant for the patient. Chiropractic services, on the other hand, are often enjoyable.¹⁸² Moreover, chiropractic care can encompass informative services such as nutritional counseling, weight management, stress management, prescriptive exercises, ergonomic evaluations, and the like.¹⁸³ In this sense, there is a particularly weak relationship between actual pain and suffering and the crude heuristic of a multiple of chiropractic bills used to measure it.

Finally, chiropractic care is often sought by those seeking to alleviate pain from soft tissue injuries in the back and neck. These types of injuries are particularly susceptible to bill padding.¹⁸⁴ By some estimates, fraud accounts for approximately ten percent of all health care costs.¹⁸⁵ Given the factors discussed above, the rate of chiropractic claim fraud may well be even higher. In litigation, the incentives to

177. See PETER A. BELL & JEFFREY O’CONNELL, *ACCIDENTAL JUSTICE: THE DILEMMAS OF TORT LAW* 163 (1997) (“[T]he current tort system . . . is riddled with corruption. It provides both adversaries, claimant and defendant, with incentives to exaggerate and even cheat – and they do so”).

178. See, e.g., *Kay v. Martin*, 777 S.W.2d 859, 861 (Ark. 1989); *Walters v. Littleton*, 290 S.E.2d 839, 842 (Va. 1982); *Thoreson v. Milwaukee & Suburban Transp. Co.*, 201 N.W.2d 745, 752 (Wis. 1972).

179. See BELL & O’CONNELL, *supra* note 177, at 164.

180. See Mark Geistfeld, *Placing a Price on Pain & Suffering: A Method for Helping Juries Determine Tort Damages for Non-Monetary Injuries*, 83 CAL. L. REV. 773, 787, n.55 (1995).

181. See BELL & O’CONNELL, *supra* note 177, at 164.

182. See *supra* notes 113-115 and accompanying text.

183. See Smith & Stano, *supra* note 94, at 11.

184. In states that have enacted no-fault insurance schemes, which eliminate the availability of pain and suffering damages, medical claims from unverifiable soft tissue pains are much lower than in those states that have not enacted no-fault. See BELL & O’CONNELL, *supra* note 177, at 164.

185. See James F. Blumstein, *The Fraud and Abuse Statute in and Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J. L. & MED. 205, 206 (1996).

overconsume chiropractic care can become overwhelming.¹⁸⁶ It should not be surprising then, that personal injury victims account for a significant percentage of chiropractic patients.¹⁸⁷

As long as parties use a heuristic based on some multiple of medical bills to estimate compensation due, this problem is likely to continue. It is certainly true that it will be difficult for the law to change the engrained practices used by private litigants to settle these kinds of cases. By altering the rules for compensatory damages at trials, however, the state can adjust the relative strengths of the parties' bargaining positions at pre-trial settlement conferences. This development may succeed in forcing parties to modify their settlement strategies.

One way of shifting the balance of power would be to import the copayment concept into the medical damages arena.¹⁸⁸ States could enact laws providing that defendants would never be required to pay more than ninety percent of a plaintiff's chiropractic bills.¹⁸⁹ A statutory limit on the number of visits to chiropractors for which tortfeasors are financially responsible would serve a similar purpose. Such rules would admittedly conflict with the principle that tort damages should attempt to make a victim whole after an injury.¹⁹⁰ Assum-

186. One complication occurs when plaintiffs are covered in HMOs or other health plans. The plaintiff may be subject to the HMO's cost containment mechanisms, which may conflict with the patient's interest in running up her medical bills. With minor inconvenience, however, a plaintiff can seek treatment by a chiropractor not affiliated with the HMO and seek reimbursement for these out-of-pocket medical expenses. Indeed, to the extent that these providers charge higher rates than HMO providers, such expenses will increase the potential size of the plaintiff's pain and suffering award.

187. See Hurwitz et al., *supra* note 85, at 773 tbl.1 (providing data that that the author used to calculate that 146 out of 1397 (10.46%) American chiropractic patients were pressing personal injury claims, not including a similar number who were pressing workers' compensation claims).

188. Workers' Compensation laws have long utilized a similar approach, providing for only partial replacement of lost wages. See Dean M. Hashimoto, *The Future Role of Managed Care and Capitation in Workers' Compensation*, 22 AM. J. L. & MED. 233, 257 (1996).

189. Under such a scheme, a danger would exist that chiropractors and plaintiffs could thwart the rule fairly easily. Chiropractors could simply charge those injured in tort their usual fees, plus an 11% premium. In this way a 90% fee would become a 100% fee. The parties could arrange to waive the premium if the plaintiff were to fail to recover in full. Any state adopting a 90% rule would need to prohibit such contracting in order to maintain the rule's integrity.

190. Of course, aspects of tort reform legislation, such as caps on damage awards or attorneys' fees also arguably violate this compensation principle. See William R. Jones, Jr., *Managed Care and the Tort System: Are We Paying Billions in Phantom Healthcare Charges?*, ARIZ. ATT'Y., Mar. 1996, at 28, 28. An argument, albeit a rather weak one, could be made that a 90% cap on reimbursement does not violate the principle of just compensation: Such a cap could reflect a societal determination that, regardless of the circumstances of a plaintiff's injury, chiropractic treatments are always somewhat enjoyable. As noted previously, perhaps 90% of the benefit from chiropractic care involves treatment of an injury, but an average of 10% results from care

ing injured persons knew of such a rule,¹⁹¹ however, it could act to deter overutilization in an area where the potential for abuse is serious.¹⁹² In the final calculus, such a rule would penalize plaintiffs who use chiropractic reasonably, but would protect defendants against incurring the costs of overutilization.

A second alternative for shifting the balance of power would require juries to consider whether and to what extent claimed chiropractic expenses are "customary."¹⁹³ Some policies explicitly state that insurers are responsible for covering medical treatments that are not only "reasonable and necessary", but "customary" as well. "Customary" generally means that the doctor's charge must be in line with what doctors in the community normally charge,¹⁹⁴ or that the treatment was not so nontraditional as to be non-reimbursable.¹⁹⁵ Neither definition of "customary" would be particularly helpful in combating chiropractic overconsumption. Instead, "customary" might be defined specifically in relation to the level of benefits that government health care plans or private insurers authorize for comparable injuries. For example, if the state's public employee medical insurance schemes allows up to twenty annual visits to a chiropractor for treatment of back pain, and an injured plaintiff makes ninety-nine visits in a year for back pain treatments, such utilization would not be "customary."¹⁹⁶

The third alternative would be to continue the status quo of allowing juries to make these determinations on the basis of what expenses they find to be reasonable. For reasons that I will articulate in my discussion of acupuncture cost containment,¹⁹⁷ I believe that there is little reason to be confident in juries' ability to declare certain costs

directed towards improving a patient's "general wellness." See *supra* text accompanying note 120.

191. Within days of the typical accident, most injured people presumably speak with lawyers about representation. Thus, in many cases, plaintiffs' lawyers would be able to transmit this information to their clients before the client seeks excessive medical care.

192. To be effective, the jury would have to be ignorant of the rule. Otherwise, they could subvert its policy objective by awarding the plaintiff higher damages for pain and suffering, to offset the reduction in chiropractic reimbursement.

193. Questions of whether or not medical expenses are "reasonable and necessary" are questions of fact. See, e.g., *Victim v. Martin*, 326 N.E.2d 12, 16 (Mass. 1975).

194. See *Cline & Rosen*, *supra* note 154, at 124.

195. See *id.* at 131.

196. At first glance, the term "necessary" in policy language might suffice to preclude reimbursement in such a case. One court has even gone so far as to define "necessary" as "general[] and customar[y]." See *Forcier v. State Farm Mut. Auto. Ins. Co.*, 310 N.W.2d 124, 128 (Minn. 1981). In practice, however, courts have defined "necessity" only in terms of whether the provided care meets customary medical practice. See *Clark C. Havighurst, Practice Guidelines for Medical Care: The Policy Rationale*, 34 ST. LOUIS U. L.J. 777, 780 n.10 (1989).

197. See *infra* notes 267-275 and accompanying text.

unreasonable. It is to that general discussion of acupuncture that I shall now turn. In so doing, it will soon become apparent that, although acupuncture and chiropractic have much in common, they differ in important ways and that policymakers and insurance companies seeking to control the modalities' respective costs should understand and account for these differences.

III. INTEGRATING ACUPUNCTURE

A. *Acupuncture Defined and Assessed*

Acupuncture took longer to catch on in the United States than did chiropractic. Though employed by the Chinese for at least 2500 years, few Americans heard of acupuncture prior to 1972, when a *New York Times* reporter, who was in China to cover President Nixon's visit, reported on his experience with the technique.¹⁹⁸ The Chinese healing technique of acupuncture has always been more shrouded in mystery than chiropractic. Simply put, for most Americans, inserting needles into the human body is a reason to stay away from a doctor, not go to one.¹⁹⁹

Illinois defines acupuncture as a method of "stimulation of . . . points on or immediately below the surface of the body by the insertion of . . . needles . . . with or without the application of heat, electronic stimulation, or manual pressure to prevent or modify the perception of pain . . ." ²⁰⁰ If done properly, the insertion can be relatively painless. The needles are inserted at key points on the body, which are thought to correlate with meridians, through which the body's energy, which acupuncturists refer to as Qi, flows.²⁰¹ Acupuncturists claim that by manipulating this Qi, they can cure patients of a host of ailments.²⁰² While there is little reliable evidence showing that needles inserted at true needle points do a better job of mitigating chronic pain than needles inserted randomly in the body,²⁰³ true nee-

198. See Office of Alternative Medicine, News Release, *NIH Panel Issues Consensus Statement on Acupuncture* (visited Nov. 5, 1997) <<http://www.opd.od.nih.gov>>.

199. See Laeth Nasir, *Acupuncture in a University Hospital: Implications for Inpatient Consulting Service*, 7 ARCHIVES FAM. MED. 593, 594 (1998) ("Most hospitalized patients offered acupuncture . . . have initially refused it or have been openly skeptical of its efficacy. They are understandably very apprehensive before the first treatment.").

200. See ILL. COMP. STAT. ch. 225 § 2/10 (West 1997). For other statutory definitions of acupuncture, see, for example, FLA. ADMIN. CODE ANN. r. 64B1-3.001 (1997); MASS. REGS. CODE tit. 243, § 5.01 (1997); WASH. ADMIN. CODE § 246-918-310 (1997).

201. See FELIX MANN, SCIENTIFIC ASPECTS OF ACUPUNCTURE 3-40 (2d ed. 1983).

202. See *id.*

203. See GABRIEL STUX & BRUCE POMERANZ, BASICS OF ACUPUNCTURE 28-30 (3d ed. 1995); Judith C. Shlay et al., *Acupuncture and Amitriptyline for Pain Due to HIV-Related Periph-*

dle points sometimes seem to outperform sham points in treating acute pain.²⁰⁴ Acupuncture advocates argue that the insertion of the needles stimulates a release of endorphins and, specifically, cerebral serotonin.²⁰⁵ The release of these biochemicals is associated with higher levels of happiness and lower levels of stress.²⁰⁶

Acupuncture is firmly poised to follow chiropractic into the mainstream of American medicine. Acupuncture's respectability made a major leap forward in 1982, when the California legislature professionalized the practice of acupuncture.²⁰⁷ Since then, acupuncture's rise in the United States has been steady: One million Americans saw professional acupuncturists during 1994²⁰⁸ and an estimated fifteen million have been treated by acupuncturists at least once.²⁰⁹ And, a recent report appears ready to dramatically accelerate the increasing public acceptance of the modality.

In November of 1997, the National Institutes of Health's Office of Alternative Medicine released a report concluding that there was "sufficient evidence of acupuncture's value to expand its use into conventional medicine."²¹⁰ The NIH panel found clear evidence that acupuncture is an effective treatment for some patients suffering from postoperative and chemotherapy nausea and vomiting, nausea of pregnancy, and postoperative dental pain.²¹¹ The panel also concluded that acupuncture may be an effective complementary therapy for the treatment of substance addiction, stroke, headaches, menstrual cramps, tennis elbow, general muscle pain, low back pain, carpal tun-

eral Neuropathy: A Randomized Controlled Trial, 280 JAMA 1590 (1998) (concluding that a randomized, placebo-controlled trial of acupuncture revealed it to be no more effective than a placebo in relieving chronic pain resulting from nerve damage).

204. See *Stux & Pomeranz*, *supra* note 203, at 28-30.

205. See Allen Chen, *An Introduction to Sequential Electric Acupuncture (SEA) in the Treatment of Stress Related Physical and Mental Disorders*, 17 ACUPUNCTURE & ELECTRO-THERAPEUTIC RES. INT. J. 273 (1992).

206. See generally Chawki Benkelfat et al., *Mood-lowering Effect of Tryptophan Depletion: Enhanced Susceptibility in Young Men at Generic Risk for Major Affective Disorders*, 51 ARCHIVES GEN. PSYCHIATRY 687 (1994). Even some of alternative medicine's harshest critics concede that acupuncture, by raising endorphin levels, or through pain convergence mechanisms, can relieve pain. See, e.g., PANTANOWITZ, *supra* note 90, at 40-42.

207. See *Health Net to Offer Acupuncture, Massage Therapy, Acupressure Benefit*, BUSINESS WIRE, Sept. 9, 1997 available in LEXIS BusFin Library, Bwire File (discussing the creation in 1982 of the Acupuncture Committee, the State agency under the Department of Consumer Affairs and the Medical Board of California that regulates acupuncturists.)

208. See *Paramore*, *supra* note 51, at 85 tbl.1.

209. See *Weiss*, *supra* note 36, at A16.

210. NIH CONSENSUS DEVELOPMENT PANEL ON ACUPUNCTURE, *reprinted in* 280 JAMA 1518, 1522 (1998) [hereinafter *Consensus Statement*].

211. See *id.*

nel syndrome, and asthma.²¹² Although the report noted that acupuncture's impact was unclear and that more controlled studies were necessary to evaluate its effectiveness,²¹³ the media hailed the report as a wholehearted endorsement of the technique.²¹⁴

B. *The Response to Acupuncture's Growing Acceptance*

In the months following the release of the NIH Report, several insurance carriers announced that they would soon offer acupuncture to those enrolled in their health plans.²¹⁵ Although very few states require health insurers to provide enrollees with acupuncture reimbursement,²¹⁶ a number of insurance carriers are now announcing plans to voluntarily expand coverage to include acupuncture care.²¹⁷ Indeed, in some areas, insurers and hospitals are seeking a competitive advantage by aggressively advertising their acupuncture benefits.²¹⁸ The attitude of many insurers seems to be "provide benefits first, evaluate effectiveness later."²¹⁹ If a major insurer in a geographic

212. *See id.*

213. *See id.* at 1521-22.

214. *See, e.g.,* Weiss, *supra* note 36, at A16.

215. *See, e.g., Alternatives Can Be the Right Medicine*, TAMPA TRIB., Dec. 6, 1997, at 7, available in 1997 WL 13846296 (discussing a survey indicating that half of responding HMOs cover or would soon cover alternative therapies) [hereinafter *Alternatives*]; *American Specialty*, *supra* note 142. Many health carriers had been planning on extending coverage to acupuncture therapies even before the NIH report and saw the announcement of the panel's findings as a convenient occasion for doing so. *Cf. Schwartz, supra* note 62, at D1.

216. *See* Barbara Carton, *Health Insurers Embrace Eye-of-Newt Therapy*, WALL ST. J., Jan. 30, 1995, at B1 (indicating that only six states require acupuncture coverage).

217. *See, e.g.,* Schwartz, *supra* note 62, at D1; Stettner, *supra* note 175, at A1. *See also* 1998 Eisenberg study *supra* note 5, at 1569 (noting that between 1990 and 1997 the percentage of patients who paid for all their costs of alternative treatment out of pocket declined from 64% to 58.3%); Angela A. Mickelson et al., *Managed Care Potpourri IV: Where Oh Where is Complementary/Alternative Care?*, 19 WHITTIER L. REV. 119, 125 (1997) ("Insurance executives are starting to approach holistic practitioners, begging to be enlightened.").

218. *See, e.g.,* Mickelson et al., *supra* note 217, at 130; Cavanaugh, *supra* note 74, at C7 (discussing competition for alternative medical benefits among Baltimore health care providers); Mary Leonard, *'Boutique Medicine' Is Not for Everybody*, BOSTON GLOBE, July 6, 1997, at C1 (reporting that Oxford Health Plans "began offering managed-care coverage for alternative medicine—including acupuncture, homeopathy, chiropractics, yoga, and massage therapy—after surveys showed that one-third of all subscribers used and liked those services.").

219. This rush to increase coverage has set up a particularly curious and troubling dynamic. Health insurers are known for being painstakingly cautious in expanding coverage to experimental medical treatments; experimental treatments (such as new drugs) typically must succeed in clinical trials, clinical investigations, and randomized trials before they will be approved by the Food and Drug Administration (FDA) for distribution. *See* Lahr, *supra* note 46, at 620-23. Only then will a therapy categorically become reimbursable. *See id.* Acupuncture techniques have never been through such a rigorous evaluative process – even the NIH report was based on two days public hearings about acupuncture's effectiveness. Moreover, the FDA's approval of acu-

area has expanded access to acupuncture benefits, others have immediately followed suit, to avoid losing market share.²²⁰

In the meantime, acupuncture seems an attractive short-term health care alternative. Visits to acupuncturists generally are much less expensive²²¹ than visits to physicians.²²² While it is by no means clear that acupuncture is therapeutic in the long-run,²²³ or that acupuncturists will be restrained from dramatically overbilling third party payers,²²⁴ this cost differential makes acupuncture coverage a financially attractive short-term option. As a result of these expanded

puncture needles as Class II medical devices, merely means that the FDA concluded that the needles could be used safely and that establishing minimal manufacturing and labeling standards would be desirable. See *Medical Treatment: Hearings Before the Senate Comm. on Labor and Human Resources*, 105th Cong. (1996) (statement of Jerold Mande, Exec. Asst. to Comm'r of FDA), available in 1996 WL 10830242. High consumer demand for acupuncture is perhaps the most important reason for distinguishing it from experimental, but scientifically oriented medical techniques. See Boozang, *supra* note 7, at 201 (suggesting that the "pressure to integrate an unproven [alternative medicine] treatment into conventional treatment is more likely to come from patients"). As a result, acupuncture is covered by insurance whereas a very promising treatment that has yet to pass through the final stages of FDA approval may be excluded from reimbursement as an experimental treatment. For example, in *Smith v. Office of Civilian Health & Med. Programs of the Uniformed Servs.*, 97 F.3d 950 (7th Cir. 1996), cert. dismissed, 117 S. Ct. 1027 (1997), the court upheld the government's decision to deny a breast cancer patient coverage for high-dose chemotherapy with peripheral stem cell rescue because of its experimental nature. And yet, the few scientific evaluations of acupuncture that have been undertaken show that its use as a treatment for stroke patients, for example, is supported by relatively weak scientific evidence of long term benefits. See, e.g., Young-Hue Yu et al., *The Effect of Acupuncture on Spinal Motor Neuron Excitability in Stroke Patients*, 56 CHIN. MED. J. 258, 261-62 (1995).

220. See Stettner, *supra* note 175, at A1.

221. See *Alternatives*, *supra* note 215. An initial session with an acupuncturist costs approximately \$60 to \$110, and \$30 to \$80 thereafter for follow-up sessions. See *id.*

222. It is worth noting that the relevant cost comparison might not be between acupuncturists and physicians, but between acupuncturists and pain medication or pain mitigating devices. See *infra* text accompanying notes 302-308.

223. The potential long-run costs of acupuncture are quite high. If acupuncture is prescribed for medical conditions that it cannot effectively treat, it may delay patients from seeking conventional cures for those conditions. These delays can be extremely costly for health insurers and can cost patients their lives.

224. For an example of litigation involving an allegation of fraudulent billing and RICO violations by an acupuncturist allegedly bilking an insurer, see generally the unreported case of *Empire Blue Cross & Blue Shield v. Tsoi*, No. 95 Civ. 7058(KTD), 1998 WL 157058 (S.D.N.Y. Apr. 2, 1998). A recent report from the Office of the Inspector General describes more instances of fraud by acupuncturists. See, e.g., Sheehan, *supra* note 43, at 916-17 (describing a prosecution against the owners and operators of six acupuncture clinics in Florida that billed Medicare for more than \$1.8 million in fraudulent claims, and resulted in several guilty pleas or sentences, the harshest of which involved a fine of almost a million dollars and a 31 month term of imprisonment); *id.* at 929 (describing the conviction of two doctors who performed acupuncture, but billed Medicare for other (reimbursable) services, and their respective 30 and 27 month jail sentences and \$300,000 fines).

third-party commitments to cover acupuncture, utilization is expected to rise dramatically.²²⁵

Rather than let market forces determine acupuncture reimbursement policy as more information becomes available, many states have recently enacted or are currently considering legislation that would encourage or even require health insurers and health care providers to offer expanded access to acupuncturists.²²⁶ Rhode Island has just enacted a law that requires health insurance providers to include acupuncture benefits as a policy option.²²⁷ The requirement applies to insurance policies offering limited benefit insurance policies, such as disability income, long term care, accident only, or Medicare supplement insurance.²²⁸ Virginia recently enacted a similar piece of legislation.²²⁹ Virginia is also considering a bill that would bar insurers from imposing copayments on acupuncture services where it does not impose copayments on other medical or surgical procedures in the same class or category.²³⁰ Because, as I will argue,²³¹ copayments probably will not prove effective in preventing acupuncture overconsumption, the legislation is unlikely to engender wasteful spending in the short run. In the long run, however, if the "no discrimination in copayments" concept is extended to other forms of alternative medicine,

225. See 1998 Eisenberg Study, *supra* note 5, at 1575 ("Because the demand for health care (and presumably alternative therapies) is sensitive to how much patients must pay out-of-pocket, current use is likely to underrepresent utilization patterns if insurance coverage for alternative therapies increases in the future.").

226. As with alternative medicine generally, most previous governmental endeavors relating to acupuncture have focused on constraining its practice. See, e.g., ALASKA ADMIN. CODE tit. 7, § 48.050(3) (Supp. 1998) (categorizing acupuncture as "experimental procedures and services that are not in accordance with customary standards of medical practice," and excluding it from coverage under the state's public assistance program); FLA. ADMIN. CODE ANN. r. 64B2-17.0003(3) (1997) (prohibiting the use of acupuncture "in treating any of the following diseases or conditions: Cancer, Leukemia, Tuberculosis, Syphilis, Gonorrhea, Hepatitis, Anthrax, Diphtheria, Hansen's Disease, Hookworm Disease, Malaria, Rabies, Typhoid Fever, Typhus Fever, and AIDS"); IND. ADMIN. CODE tit. 405, r. 5-29-1(8)(A) (Supp. 1998) (excluding acupuncture treatments from reimbursement under Medicaid). *But see* MASS. REGS. CODE tit. 130, § 418.406(C)(3)(a) (1997) (authorizing reimbursement for outpatient acupuncture services as part of a substance abuse treatment program); N.Y. COMP. CODES R. & REGS. tit. 14, § 830.5 (1995) (containing similar provisions). Washington state has already enacted a law that requires HMOs and health plans to cover acupuncture, as well as massage therapy and other forms of natural health care. See WASH. REV. CODE § 48.43.045 (1998); Melanie K. Curtice, Comment, *Every Category of Provider: Hindsight Is 20/20 Vision*, 21 SEATTLE U. L. REV. 317, 318 (1997) (discussing Washington's requirement for alternative healthcare coverage in early 1996).

227. See S.B. 622, 1999-2000 Leg. Sess. (R.I. 1999).

228. See *id.*

229. See H.B. 1234, 1998 Sess. (Va. 1998).

230. See H.B. 1383, 1998 Va. Sess.

231. See *infra* Part III.D.

such as chiropractic or massage therapy, insurance companies may find that they have lost their most potent tool in preventing wasteful expenditures.²³² New York is considering more sweeping legislation, which would mandate that an insurance policy reimburse a patient for any acupuncture treatment that would be within the lawful scope of a physician or dentist's practice, when that procedure is performed by a licensed acupuncturist.²³³ Among other things, this dubious legislation would therefore bar insurance companies from using reimbursement policies to steer patients toward physician acupuncturists, and away from acupuncturists lacking M.D.s. Finally, North Carolina is considering radical legislation that would require insurers to reimburse patients for any acupuncturist-provided service "rendered in connection with a condition or complaint that is within the scope of practice a" physician.²³⁴ These legislative efforts are indicative of a trend in state governments to make acupuncture a third-party expense, as opposed to an out-of-pocket expense, for health care consumers.

While state legislatures have been the major proponent of extending acupuncture coverage,²³⁵ Congress is currently considering a bill that would expand coverage at the federal level. The House legislation would cover reasonable acupuncture services under Medicare Part B and the Federal Employees Health Benefits Program.²³⁶ Needless to say, the stakes of such legislation are enormous. But the legislation has won only a handful of co-sponsors — perhaps because the costs extending such coverage are so uncertain.²³⁷

The problem with this access-expanding legislation is that the lack of information about the effectiveness of acupuncture therapies remains. Acupuncture has never been proven to be an effective treatment for many of the conditions for which acupuncturists often treat patients.²³⁸ At the same time, many acupuncturists are taught that ac-

232. See *supra* notes 179-183.

233. See A.B. 2434, 222d Leg., 1999-2000 N.Y. Sess.

234. H.B. 678, 1999 N.C. Sess.

235. States are preempted from regulating many aspects of the private health insurance market by the Employee Retirement Income Security Act of 1974 (ERISA). However, under that statute's saving clause, "regulation regarding the substantive terms of insurance contracts" is not pre-empted. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 742-43 (1985). Accordingly, a Washington district court's decision to invalidate that state's law requiring insurers to cover alternative therapies because of ERISA was reversed. See *Washington Physicians Serv. Ass'n v. Gregoire*, 967 F. Supp. 424, 430 (W.D. Wash. 1997), *rev'd* 147 F.3d 1039 (9th Cir. 1998).

236. See H.R. 1890, 106th Cong. (1999).

237. Only ten members of the House have co-sponsored the legislation, eight of whom are from California or Oregon. See 1999 CQ US HR 1890 Summary.

238. Even for ailments such as acute pain, the NIH report's conclusion that acupuncture helps sufferers of acute pain is controversial. See, e.g., L. Grabow, *Controlled Study of the Anal-*

upuncture can cure a host of ailments, ranging from herpes²³⁹ to hypertension²⁴⁰ and hiccups.²⁴¹ Since the "reasonable and necessary" inquiry often hinges on the judgment of the treating health care provider,²⁴² patients are likely to be reimbursed for many questionable treatments if legislation like that proposed in North Carolina²⁴³ is adopted.

C. *The Difficulty of Defining "Reasonable and Necessary" in the Acupuncture Context*

Even with the trend towards private insurers expanding coverage and legislative efforts to require expanded coverage, the majority of Americans' health insurance policies do not explicitly cover acupuncture. The policies, however, often do cover all "reasonable and necessary" medical care. Using this language, insured patients may seek to force their insurers to reimburse them for acupuncture treatments.

In the scattered instances in which courts have been asked to review whether acupuncture expenses were "reasonable and necessary," the courts have been quite deferential to the treating physicians. In *Lindsey v. Urban*,²⁴⁴ for example, a Florida appeals court overturned a lower court ruling that an acupuncturist was a health care provider whose services had to be reimbursed under the state's Workers' Compensation statute.²⁴⁵ Although the patient "enjoyed dramatic improvement" while under the acupuncturist's care, and despite the patient's psychiatrist's testimony that the treatment was, in retrospect, "psychiatrically beneficial," the insurer was not required to provide reimbursement for the period in which treatment was not explicitly

getic Effectivity of Acupuncture, 44 ARZNEIMITTEL-FORSCHUNG 554, 554-58 (1994) (concluding that the analgesic effect of acupuncture is no better than that of a placebo).

239. See SUNG J. LIAO ET AL., PRINCIPLES AND PRACTICE OF CONTEMPORARY ACUPUNCTURE 336-39 (1994). The Liao textbook is endorsed by the American Academy of Acupuncture.

240. See *id.* at 344.

241. See *id.* at 346. Liao and his coauthors also claim that acupuncture can be an effective treatment for, among other things, asthma, eczema, acne, psoriasis, and nicotine addiction. See *id.* at 330-51.

242. See, e.g., *Sarchett v. Blue Shield of Cal.*, 729 P.2d 267, 270-71 (Cal. 1987) (defining "medically necessary" services as those deemed reasonable by the treating physician); *Florida Mining & Materials v. Calderon*, 625 So.2d 951, 952 (Fla. Dist. Ct. App. 1993) (addressing whether a claimant's treating physician had "recommended chiropractic treatment"); *Southwest Office Supply v. Smith*, No. 0387-94-3, 1994 WL 410869, at *1 (Va. Ct. App. 1994) (holding employer responsibility for an employee's medical expenses depends on whether the employee's physician made a referral to obtain acupuncture treatment).

243. See *supra* text accompanying note 241.

244. 559 So.2d 734 (Fla. Dist. Ct. App. 1990).

245. See *id.* at 735-36.

authorized by a medical doctor.²⁴⁶ Thus, even if acupuncture is later found to be “reasonable and necessary,” the insurer need not reimburse until a physician authorizes the necessity of the treatment.²⁴⁷ Similarly, a Virginia appeals court, in an unreported decision, held that where a treating physician had referred a patient to an acupuncturist and the patient’s condition had improved, such treatments were “reasonable and necessary.”²⁴⁸ The same court, in a separate, but also unreported decision, gave “great weight” to the treating physician when that doctor had recommended a discontinuation of treatment, even though the patient’s acupuncturist had recommended a continuation, and the patient had been “experiencing some relief after fifteen years of severe pain.”²⁴⁹ All three cases turned on the wording of the Workers’ Compensation statutes at issue, which made the judgment of the treating physicians critical elements in the determination of whether a treatment was “reasonable and necessary.” To be sure, if state legislatures do amend these statutes to include acupuncturists within the scope of qualified health care providers who may bill for their services, then the courts would presumably be just as deferential to acupuncturist’s assessment of medical necessity. Indeed, House Bill 1890²⁵⁰ would require such deference in the Medicare context.

The dearth of reported cases discussing the scope of “reasonable and necessary” medical expenses as applied to acupuncture treatments has left juries with great discretion in awarding medical expenses.²⁵¹ A survey of California jury verdicts and case settlements in *Trial Digest*²⁵² and *LRP Publications*²⁵³ reveals that as more Americans use acupuncture, juries are increasingly likely to be called upon to make such determinations. As is often the case with jury judgments, they vary widely.²⁵⁴

246. *Id.* at 735.

247. *Id.* at 736.

248. See *Southwest Office Supply v. Smith*, No. 0387-94-3, 1994 WL 410869, at *1 (Va. Ct. App. 1994).

249. *Slota v. Eastern Airlines*, No. 0048-97-4, 1997 WL 275350, at *1 (Va. Ct. App. 1997).

250. See *supra* note 244 and accompanying text.

251. The determination of what constitutes “reasonable and necessary” medical damages is almost always a matter on which the trier of fact has great discretion—whether the damages cover acupuncture services or conventional medical services. See *supra* note 193.

252. TRIAL DIGEST, available in Westlaw database.

253. LRP PUB., available in Westlaw database.

254. In presenting this jury data I want to emphasize its significant limitations. This data is compiled from reports that usually originate with one side’s counsel. Thus, the reports may well represent the bias of one party or contain convenient inaccuracies.

The Orange County Superior Court case of *Lander v. Cunningham*,²⁵⁵ involved damages from a fender bender. The plaintiff allegedly sustained injuries as a result of a five mile per hour collision.²⁵⁶ The plaintiff claimed \$28,000 in medical specials, including a whopping \$17,400 for acupuncture treatments.²⁵⁷ The jury apparently felt the acupuncture claims to be "unreasonable."²⁵⁸ Accordingly, it only awarded the plaintiff medical costs for the first two months of treatment.²⁵⁹ This adjustment resulted in a substantial reduction in the plaintiff's award.

Just one year earlier, a Los Angeles County jury in *Lawrence v. Toys 'R' Us*²⁶⁰ was much less skeptical of the plaintiff's alternative medical needs. While the plaintiff had been shopping at a Toys 'R' Us store, "five to seven cartons of toys fell from approximately [fifteen] feet, hitting her on the head."²⁶¹ She claimed that as a result, she suffered from "severe head, neck and back pain with radiating symptoms into her arms and legs, TMJ, dizziness and numerous other problems."²⁶² Within a little over a year, her chiropractor reported that she was 85% better.²⁶³ The plaintiff, however, did not agree.²⁶⁴ In addition to \$20,000 in expenses for chiropractic care and acupuncture, the plaintiff "sought out over thirty health care providers and had spent over \$40,000 on holistic and nutritional treatments, including trips to Germany and the Bahamas searching for an answer"²⁶⁵ to her health dilemma. A sympathetic jury awarded the plaintiff \$400,000,²⁶⁶ rejecting the defendant's arguments that the health care expenses were unreasonable.

A survey of other jury decisions shows that the great disparity in verdicts suggested by a comparison of *Lander* and *Lawrence* is wide-

255. No. 734590, 15 TRIALS DIG.2D 111, available in 1995 WL 817762, at *1 (O.C. Super. Ct. Dec. 8, 1995).

256. See *id.*

257. See *id.*

258. See *id.* at *2.

259. See *id.*

260. No. NWC 54053, 3 TRIALS DIG.2D 77, available in 1994 WL 846033, at *1 (L.A. Super. Ct. July 8, 1994).

261. *Id.*

262. *Id.* TMJ is the abbreviation for the condition called temporal mandibular joint dysfunction. See Paul I. Weiner, *Stress and Mental Disorder: New Responsibilities for Employers Under the ADA*, 586 PLI/LIT 453, 457, available in Westlaw database (June 1998).

263. See 1994 WL 846033, at *1-*2.

264. See *id.*

265. *Id.* at *2.

266. See *id.* at *1.

spread.²⁶⁷ Several factors probably account for this variation in damage awards for acupuncture expenses.²⁶⁸ First, the composition of the jury probably makes a great deal of difference in determining the size of the award. Approximately fifteen million Americans have tried acupuncture at some point in their lives.²⁶⁹ Their perceptions of whether such treatments are “reasonable and necessary” are likely to be framed by their own experience (or the experiences of family and friends) with the procedure. This factor may trump another conceivable explanation for the variation, the relative credibility of the experts’ testimony. Many of the jury trials cited earlier likely involved acupuncturists testifying as expert witnesses for the plaintiffs and physicians testifying as expert witnesses for the defendants. Most jurors are perhaps more likely to see physicians’ testimony as credible, given physicians’ often impressive credentials,²⁷⁰ and acupuncturists’ often relatively unimpressive resumes.²⁷¹ Jurors who have used acupuncture in the past, however, may have formed negative impressions of the medical-scientific establishment,²⁷² and may be more trusting of an acupuncturist’s testimony. Finally, in most cases, the acupuncturists themselves will be more familiar with acupuncture techniques than the treating physicians often called as defense witnesses. Jurors may conclude that the physicians have little basis upon which to evaluate the effectiveness of acupuncture. Though acupuncturists will be able to point to few controlled studies demonstrating the effectiveness of

267. See, e.g., *Huang v. Baker-Fusco*, No. 621629, 8 TRIALS DIG. 167, available in 1991 WL 632690, at *1 (S.D. Super. Ct. Dec. 19, 1991) (reporting a jury award of \$5000 for special damages after plaintiff claimed \$7265 in past medical and \$2500 in future medical expenses for acupuncture treatment); *Klimas v. Moffo*, No. 65544 (JVR), available in 1990 WL 467151, at *1 (M.C. Super. Ct. Nov. 1990) (reporting a jury award of \$59,000, likely including full compensation for \$9006 in acupuncture treatments, and thereby rejecting defendant’s contention that “acupuncture was an unaccepted treatment” for the alleviation of pain); *Maakestad-Landrie v. Mullan*, No. 148016 (JVR), available in 1994 WL 797127, at *1 (P. Super. Ct. Sept. 1993) (reporting a complete award for plaintiff on \$6342 in chiropractic and acupuncture expenses); *Park v. Hedwig*, No. 136216 (JVR), available in 1994 WL 604493, at *1 (S. Super. Ct. July, 1994) (reporting a jury award of all \$4273 in claimed acupuncture care).

268. Admittedly, this variation may have less to do with the composition of particular juries and more to do with the strengths and weaknesses of the plaintiffs’ cases. Because of the nature of my surveying technique, it is impossible to rule out the explanation that juries correctly determined the level of “necessary” medical treatment in each of the cases before them and awarded high or low damages accordingly. This portion of my argument, therefore, should be taken with a grain—or perhaps even a pinch—of salt.

269. See *supra* text accompanying note 209.

270. But see *supra* note 40.

271. See *Cooper & Stoflet*, *supra* note 63, at 229 (noting that admission standards at colleges of Oriental Medicine tend to be noticeably lower than even those at chiropractic and naturopathic colleges).

272. See *supra* note 71 and accompanying text.

acupuncture, they might still appear more knowledgeable about the treatments at issue. Although there is a community of acupuncture critics—physicians who have thoroughly reviewed the literature and concluded that its benefits are minor²⁷³—the damages at issue in these cases often are insufficient to justify a defendant's payment of these witnesses' fees.

As the availability of acupuncture increases in the coming years, the jury pool will contain a greater percentage of individuals who are sympathetic to plaintiffs' claims for reimbursement. It is certainly true that some portion of the individuals who use an acupuncturist's services are likely to be disappointed by the outcomes. On the other hand, when awarding "reasonable and necessary" medical damages, jurors generally consider such damages using an *ex ante* approach. As long as the patient used reasonable care in selecting a physician, the patient is generally entitled to recover from the wrongdoer to the full extent of injury.²⁷⁴ It will not be a question of whether, in retrospect, the medical treatments were necessary,²⁷⁵ but whether, by putting themselves in the patient's shoes, the jurors could have reasonably chosen an acupuncturist as their health care provider. It seems likely that jurors who have previously used acupuncture will be more likely to view others' choices to do so as entirely reasonable behavior.²⁷⁶

Jurors' incomplete perspectives create another serious problem with allowing juries to make determinations about what medical benefits should be reimbursed by third parties. Jurors are presented with coverage disputes in which an individual is seeking a plausibly beneficial medical treatment. They are never confronted with the big picture, allocative decisions that insurers and HMOs must make about how to cover the most cost effective treatments, given scarce medical

273. See e.g., Grabow, *supra* note 238, at 554.

274. See RESTATEMENT (SECOND) OF TORTS § 457, illus. 1 (1965); see also *O'Quinn v. Alston*, 104 So. 653, 655-56 (Ala. 1925) (holding that where treating surgeon amputated finger, it was error to ask defense expert whether amputation was necessary); *Whitaker v. Kruse*, 495 N.E.2d 223, 226 (Ind. Ct. App. 1986) (holding that plaintiff could recover expenses of unnecessary surgery); *Cline & Rosten*, *supra* note 154, at 123-24 (arguing that most juries are likely to view all charges by an injured person's doctor as inherently "reasonable").

275. Indeed, courts have held that "necessary" in this context merely means "causally related to the tortfeasor's negligence." *Ponder v. Cartmell*, 784 S.W.2d 758, 761 (Ark. 1990) (citing *Bell v. Stafford*, 680 S.W.2d 700 (Ark. 1985)).

276. The life experiences and backgrounds of jurors prior to entering the courtroom can often have a significant effect on their perceptions of a case's facts, and, ultimately, on trial outcomes. Cf. Reid Hastie & Nancy Pennington, *The O.J. Simpson Stories: Behavioral Scientists' Reflections on The People of the State of California v. Orenthal James Simpson*, 67 U. COLO. L. REV. 957, 972-74 (1996) (concluding the African Americans' life experiences make them more sympathetic than whites to allegations of police brutality and misconduct).

resources.²⁷⁷ Because jurors have limited exposure to the tradeoffs that are present whenever an insurer is required to cover a questionable therapy, they will focus only on whether the treatment might be beneficial. As Einer Elhauge argues, any health care regime that is committed to funding all medically beneficial care, rather than just care that is cost effective or more beneficial than the alternatives, will produce “unending cost escalation.”²⁷⁸ Where juries play a major role in coverage disputes or assessing tort damages, such escalation indeed seems likely.

D. Cost Containment Strategies: A Comparison with Chiropractic

In several respects, the acupuncture and chiropractic markets are similar. As a result, some of the same hypotheses proposed in the previous part of this Article can be applied to acupuncture as well. With both modalities, it will be difficult to achieve consensus among practitioners as to whether a given treatment was medically necessary. Thus, as with chiropractic, utilization review may be an inefficient way of reducing costs,²⁷⁹ and criminal prosecutions for acupuncturists who encourage overconsumption are unlikely to be efficient.²⁸⁰ Similarly, the strategies that are likely to address chiropractic bill padding in tort litigation will probably prove equally effective for acupuncture overutilization.²⁸¹

The differences between the chiropractic and acupuncture markets, however, are most interesting. Acupuncture's nature as a modality has important implications for how best to contain its costs. The modality's characteristics demonstrate that a cookie-cutter approach to alternative medicine cost containment will generate efficiency losses for society.²⁸²

277. Cf. Elhauge, *supra* note 101, at 1550-65 (arguing that courts have required insurers and HMOs to cover all medically beneficial care, and rejected defendants' arguments that because the costs of a given treatment outweigh its benefits, the treatment need not be provided).

278. *Id.* at 1536-47, 1567.

279. Cf. *supra* note 150-155 and accompanying text.

280. Cf. *supra* text accompanying notes 149-152.

281. Cf. *supra* Part II.D. Note, however, that because acupuncture is less inherently pleasurable than chiropractic care, there is less justification for importing the co-payment concept into tort litigation involving acupuncture. Cf. *supra* note.

282. Although this Article intentionally focuses on chiropractic and acupuncture, the methodology developed is broadly applicable to other therapies as well. Some modalities, such as massage therapy, are similar to chiropractic in that the temptation to overutilize is likely to be particularly strong among both patients and providers. Others, like naturopathy, are more similar to acupuncture, in that providers will be the primary cause of overutilization. It follows that policymakers seeking to control the costs of those emerging modalities may wish to pay close attention to my discussion of acupuncture and chiropractic.

There are three important ways in which acupuncture differs from chiropractic: First, unlike chiropractic, acupuncture treatment is not particularly pleasant, its purported beneficial effects on serotonin levels notwithstanding.²⁸³ Although not as painful as most accidental insertions of needles into the skin, the procedure results in mild pain in some people.²⁸⁴ Perhaps for this reason, 95% of those who saw an acupuncturist in 1994 did so because of a specific medical condition, a noticeably higher percentage than chiropractic's 77%.²⁸⁵ Second, users of acupuncture tend to be well-educated, relative to the rest of the population.²⁸⁶ This represents a noticeably higher level of education than users of chiropractic care.²⁸⁷ Assuming that increased education is correlated with increased sophistication as consumers of health care, we can assume that acupuncture patients will be relatively unlikely to be duped by their practitioners.²⁸⁸ Third, however, practitioners of acupuncture tend to be trained at less competitive institutions than other health care providers.²⁸⁹ *Ceteris paribus*, this suggests a relatively low level of practitioner competence, in the aggregate.

The picture that emerges from the acupuncture market is that consumers have few incentives to overconsume acupuncture care, but practitioners may be likely to encourage overutilization. From this it follows that efforts to control costs may be more successful if containment focuses on the practitioners, who are likely to be the source of the overbilling.²⁹⁰ For that reason, methods that reduce physician incentives to overtreat patients, such as capitation or limits on the number of treatments reimbursed by insurance, are likely to be effective. Co-payments, by the same logic, will probably be less useful in discouraging overconsumption.

To a greater extent than chiropractic, there is uncertainty about what conditions acupuncture can effectively treat. Therefore, another cost containment approach that states may wish to adopt is limiting reimbursement to those medical conditions for which acupuncture has

283. See *supra* notes 212-213 and accompanying text.

284. See LIAO ET AL., *supra* note 239 at 162-63.

285. See Paramore, *supra* note 51, at 88, tbl.4.

286. See *id.* at 86, tbl.2.

287. See *id.*

288. A countervailing dynamic may exist. Perhaps more-educated people are more likely to worry about various ailments, and rush to see their acupuncturist at the first sign of danger.

289. See Cooper & Stoflet, *supra* note 63, at 229.

290. For illustrative purposes, the facts of *Slota v. Eastern Airlines*, No. 0048-97-4, 1997 WL 275350 (Va. Ct. App. 1997), are revealing. In that case, the acupuncturist insisted that it would take a "minimum of eighty treatments to see significant improvement." *Id.* at *1. Such a prognosis is at odds with a leading text in the field. See LIAO ET AL., *supra* note 239, at 158-59.

been proven an effective treatment.²⁹¹ California's medical assistance program, for example, covers acupuncture, but only to "prevent, modify or alleviate the perception of severe, persistent [or] chronic pain resulting from a generally recognized medical condition."²⁹² Use of acupuncture for nausea-prevention, as an anesthetic, and for the alleviation of pain is supported by relatively convincing evidence.²⁹³

While the California approach might require bureaucracies to constantly update their regulations to keep abreast of new developments in acupuncture effectiveness research, such a bright line rule²⁹⁴ will reduce overbilling. And although overconsumption will occur even if acupuncture reimbursement is limited to pain and nausea relief, the most flagrant overconsumption is likely to occur in areas where acupuncture's benefits are not clear. When treating pain or nausea, a reputable acupuncturist should recognize that if the treatments are not improving the patient's situation within a fixed period of time, say fifteen treatments, treatment should be discontinued.²⁹⁵ Acupuncturists will be able to draw upon their experience with numerous other patients who have responded to treatment more quickly, and recognize that the treatments should end.²⁹⁶ When treating less familiar ailments, there will be a greater temptation to experiment with different needle points, lengths of treatment, and modalities. An acupuncturist who wants to make a name for herself might go to great lengths (and great expense) to develop an innovative treatment for a condition previously thought untreatable.

Even if society wants to encourage such experimentation in acupuncture treatment, there is little justification for requiring private or governmental insurers to fund it. When neither the patient nor practitioner is paying for the experimental treatment, the temptation to overutilize will be far too great. Acupuncture research should be conducted as clinical trials funded by medical research grants, not as case studies funded by unwitting insurers or tortfeasors.

291. By proven I mean that the NIH, FDA, or some similarly reputable body has endorsed its use. Cf. *supra* notes 218-219 and accompanying text (discussing some of many ailments for which acupuncture has been utilized in treatment).

292. See CAL. CODE REGS. tit. 22, § 51308.5 (West 1997).

293. But see *supra* note 210 and accompanying text (suggesting that acupuncture is ineffective in treating chronic pain).

294. Of course, categories such as "nausea prevention" and "pain alleviation" may defy objective definition as well. Upon reflection, perhaps these are more appropriately referred to as "dim line rules."

295. See LIAO ET AL., *supra* note 239.

296. Although "true believer" acupuncturists would reject such an approach as being insufficiently holistic.

In recommending that Medicare and Medicaid expand coverage to include "appropriate" acupuncture therapies,²⁹⁷ the NIH has declined to recommend a specific means of delineating appropriate and inappropriate treatments.²⁹⁸ Surely, the NIH Consensus Statement, which notes that there is insufficient evidence to evaluate acupuncture's effectiveness in treating the vast majority of medical conditions,²⁹⁹ offers little help. The Consensus Statement clearly implies that acupuncture used as a form of pain and nausea relief should be covered.³⁰⁰ It is silent on the issue of whether acupuncture treatments ought to be reimbursed when used to combat stroke, substance addiction, or asthma.³⁰¹

Even if acupuncture coverage were limited to pain and nausea relief, however, serious cost containment issues would arise. If acupuncture is a potential substitute for pain and nausea prescription drugs (which are often not covered—or are only partially covered—by private insurance plans and Medicaid) then reimbursing patients for acupuncture utilization, but not pain killing drugs, provides a subsidy to those who prefer one "modality" over another.³⁰² This will shift consumption away from medication and towards acupuncture. Such a shift might be costly. After all, while it is undoubtedly true that acupuncture treatments are generally less expensive than physician treatments,³⁰³ acupuncture treatments may be more expensive than prescription pain or nausea medication.³⁰⁴ Similarly, transcutaneous electrical nerve stimulation (TENS) has been proven to be a highly effective treatment for chronic pain.³⁰⁵ The data on acupuncture's effectiveness is simply not as strong.³⁰⁶ Yet TENS, because it is self-administered, costs much less than acupuncture.³⁰⁷ Since most of the ailments for which acupuncture's effectiveness has been relatively well established are conditions that can be treated by medication or inex-

297. See *Consensus Statement*, *supra* note 210, at 1521.

298. See *id.* at 1521-22.

299. See *supra* text accompanying notes 212-214.

300. See *Consensus Statement*, *supra* note 210, at 1518.

301. See *id.*

302. Furthermore, it subsidizes a relatively unproven treatment instead of a counterpart whose effectiveness is well established.

303. See *supra* note 228 and accompanying text.

304. Sadly, my medical literature review turned up not a single study comparing the cost-effectiveness of acupuncture to various prescription medications for the treatment of chronic pain or nausea. Clearly this is a topic worthy of rigorous research.

305. See M.I. Johnson et al., *Long Term Use of Transcutaneous Electrical Nerve Stimulation at Newcastle Pain Relief Clinic*, 85 J. R. SOC. MED. 267-68 (1992).

306. See, e.g., Grabow, *supra* note 238, at 554.

307. A TENS unit costs only \$70. See Bucy, *supra* note 145, at 1019.

pensive medical devices, the anticipated cost savings of extending insurance coverage to acupuncture³⁰⁸ benefits may fail to materialize.³⁰⁹

This consideration implicates another area that policy-makers may wish to consider in tort cases. Should "reasonable and necessary" medical care be read to require that the plaintiff seek the most cost effective treatment available?³¹⁰ Presumably not, if the plaintiff tried the cheaper therapies and they failed to improve her condition. But what if a patient suffering from joint pain resulting from a collision has refused TENS therapy and opted for thrice-weekly acupuncture treatments instead? Such a decision may be "reasonable" and entirely "necessary."³¹¹ It may even be "customary," if the injured lives in an area where HMOs and government plans routinely allow covered individuals to choose acupuncture treatments. Yet, allowing the plaintiff to recover fully is almost certainly socially undesirable and might violate a plaintiff's general duty to mitigate damages. When dealing with cases in which the plaintiff has chosen to seek an inferior alternative remedy and has not tried cheaper alternatives, it would be entirely appropriate for courts to award the plaintiff only the projected cost of the less expensive treatment.

IV. CONCLUSION

A. *Are Placebos Medically Necessary?*

Insuring that acupuncture and chiropractic are used to treat bona fide medical conditions presents yet another difficult challenge for policymakers. By way of illustration, let us recall the facts of *Lindsey v. Urban*.³¹² In *Lindsey*, the patient's psychiatrist justified a patient's

308. This comparative cost perspective may also be true with respect to chiropractic, but to a lesser extent. Lower back pain is a condition for which there are few inexpensive treatments.

309. It is worth mentioning that there are chronic pain treatments much more expensive than aspirin, TENS, or acupuncture. For example, sufferers of chronic pain for whom a host of treatments have failed will often be sent to high-tech pain clinics, where the daily bill can run into the thousands of dollars. See generally J.C.D. Wells & J.B. Miles, *Pain Clinics and Pain Clinic Treatments*, 47 BRIT. MED. BULL. 762 (1991).

310. Einer Elhauge's fine article on medical technology assessment presents a compelling affirmative answer to this question. Elhauge argues that cost effectiveness is not a criteria of current health care coverage decisions, that incorporating cost effectiveness into our regime would be much more efficient, and that doing so would require a radical reconstruction of our health care finance system. See generally Elhauge, *supra* note 101, at 1525. My approach seeks an outcome similar to his, but I am more confident in the ability of existing cost control mechanisms, once freed from their legal shackles, to effectively minimize overutilization.

311. Medical necessity is generally defined to mean that the treatment was justified by a medical condition, not that it was the best treatment available. See Havighurst, *supra* note 196, at 780, n.10.

312. 559 So.2d 734 (Fla. Dist. Ct. App. 1990); see *supra* text accompanying notes 254-256.

acupuncture therapy as “psychiatrically valuable.”³¹³ On that basis, the court upheld reimbursement for the patient’s acupuncture as medically necessary.³¹⁴ Should such a benefit be sufficient to justify third party reimbursement? That presents a difficult philosophical question. If acupuncture increases serotonin levels, which in turn raises a patient’s spirits and helps a manic depressive patient cope with life, we are likely to be sympathetic. But many activities might produce identical biochemical benefits: spending time with loved ones, owning a loyal pet, or attending a performance of Beethoven’s Ninth Symphony.³¹⁵ Yet such activities do not strike us as medically necessary. Prozac, on the other hand, which operates directly on the brain’s serotonin levels, is almost certainly “medically necessary” for a depressed patient. The fact is that acupuncture creates benefits for patient health in mysterious ways. Even if there is a logically coherent way to draw a line between Prozac and Beethoven, it is by no means clear on which side of that line acupuncture should fall.

In *Lindsey*, the patient did not appear to have been a manic depressive. She simply suffered from back pain that doctors could never treat to her satisfaction.³¹⁶ Apparently, her psychiatrist’s diagnosis was based mostly on his belief that Urban’s “particular psychiatric makeup” made her the type of person who was likely to feel much better from acupuncture.³¹⁷ Empirical work supports his assessment. Even those clinical studies that have found acupuncture to be no more effective than a placebo have shown that there is a minority of the examined population who are completely satisfied with acupuncture treatments for pain.³¹⁸ There is probably something about this minor-

313. 559 So.2d at 735.

314. *See id.* at 760.

315. Similarly, it may well be that many of the medical benefits of chiropractic and acupuncture flow from its ability to reduce the stress levels of those treated. Reductions in stress have well documented medical benefits. *See generally* David Spiegel et al., *Effect of Psychosocial Treatment on Survival of Patients with Metastatic Breast Cancer*, 14 LANCET 888 (1989); Allen R. Wyler et al., *Magnitude of Life Events and Seriousness of Illness*, 33 PSYCHOSOMATIC MED. 115 (1971). Moreover, as Paul Shekelle notes, chiropractic is not alone among questionable treatments covered by insurers:

Whether the small symptomatic benefit and the enhanced satisfaction of patients, as consistently reported by studies of patients treated by chiropractors, are worth this cost is debatable. Before we judge this approach too harshly, however, we must remember that many existing medical interventions currently paid for by insurance companies provide equally small benefits or even none at all

Shekelle, *supra* note 83, at 1074.

316. *See* 559 So.2d at 735.

317. *Id.*

318. *See* Grabow, *supra* note 238, at 554; M. Thomas et al., *Is Acupuncture an Alternative in Idiopathic Pain Disorder?*, 36 ACTA ANAESTHESIOLOGICA SCANDINAVIC 637 (1992); J. Xiao et

ity's psychiatric makeup that makes them receptive to acupuncture. They might well be just as pleased with sham (placebo) acupuncture.³¹⁹ That is certainly an argument for not requiring insurers to provide them with acupuncture treatments.

On the other hand, it is also an argument for requiring insurers to pay for these patients' placebos! Can that counter-intuitive finding be correct? The placebo effect is known to have a powerful and beneficial effect on the suffering of some humans.³²⁰ Indeed, prior to the advent of informed consent, placebos were widely distributed by doctors as mind medicine.³²¹ For these people, placebos are medically beneficial; perhaps as beneficial as any FDA approved drug. A medical doctor is trained to believe that a treatment that is no better than a placebo is not medically beneficial. But an acupuncturist is not.³²² This represents a fundamental clash between orthodox and alternative philosophies.³²³ If it turns out that double-blind clinical trials cannot verify the effectiveness of acupuncture for vast segments of the population, then society will have to decide whether it has the resources to provide this minority of suffering patients with acupuncture, some cheaper placebo, or nothing but a paternalistic sneer.

al., *Experimental Study on the Influence of Acupuncture and Moxibustion on Interleukin-2 in Patients with Rheumatoid Arthritis*, 17 CHEN TZU YEN CHIU 126 (1992).

319. See Sandra Blakeslee, *Placebos Prove So Powerful Even Experts Are Surprised*, N.Y. TIMES, Oct. 13, 1998, at F1 ("Critics of alternative medicine say its enduring appeal is explained by the placebo effect. When conventional therapies fail to help chronic or poorly understood conditions, the acupuncturist, homeopathist or chiropractor steps into the breach with a potent belief system ready-made to help the suffering patient.").

320. Recent scholarship suggests that the placebo effect is even more powerful than previously thought. See *id.*; Walter A. Brown, *The Placebo Effect*, SCI. AM., Jan. 1998, at 90.

321. See Ted J. Kaptchuck, *Powerful Placebo: The Dark Side of the Randomised Controlled Trial*, 351 LANCET 1722, 1722 (1998).

322. See Kolata, *supra* note 41, at WK4. Indeed, an acupuncture advocate attending the recent NIH Panel discussion about the benefits of acupuncture stated, "[p]eople don't care if it works in a controlled setting. They care if it works for them in the real world." Weiss, *supra* note 36, at A1. For discussions of the conflicts that ensue when patients demand that doctors provide "medically futile" care, see Boozang, *supra* note 7, at 207-08; Nasir, *supra* note 199, at 595; and Veatch & Spicer, *supra* note 9, at 16-19, 28-31.

323. Kathleen Boozang aptly characterizes the fundamental disagreement:

The divisiveness over clinical testing of at least some alternative treatments is so acute that some critics reject the notion that efficacy research is appropriate at all. Some critics say testing would waste scarce research dollars on notions that are scientifically indefensible. Others, however, claim that natural therapies have stood the test of time and need not pass the rigors of scientific medicine, or that testing is impossible because of the unique nature of some forms of alternative medicine.

Boozang, *supra* note 7, at 189-190 (citations omitted).

B. *Alternative Medicine as Long-Term Palliative Care*

How best to ensure that alternative therapies are used to treat bona fide ailments is not the only troubling normative question in the looming public discussion about covering chiropractic and acupuncture. Again, a case will be a useful tool for introducing a policy dilemma. *Elkins v. New Jersey Manufacturer's Insurance Company*³²⁴ arose out of a 1982 automobile accident. The plaintiff, who suffered eye damage as a result of the collision, developed neck pains because she needed to continue working and driving despite the injury.³²⁵ To treat this condition, she underwent weekly acupuncture treatments and therapeutic massages twice a week for a period of at least seven years.³²⁶ Elkins' chiropractor testified that he felt that the treatments were reasonable and necessary pain-relieving services, and that they would need to be continued indefinitely.³²⁷ The court reversed the trial judge's ruling that long-term palliative care was per se medically unnecessary.³²⁸ The court denied her reimbursement, however, because the chiropractor was unable to cure her condition, yet had made no effort to wean her off chiropractic care by teaching her effective home remedies.³²⁹

The *Elkins* fact pattern presents another cost containment problem. Acupuncture and chiropractic can help mitigate pain, but rarely cure conditions. Where patients are truly suffering, and experience temporary relief because of alternative therapies, when, if ever, should reimbursement stop? Again, this is a decision that must be constrained by the level of resources society wishes to devote to health care. The cost containment strategies discussed previously would certainly provide answers. But those answers might seem harsh in dealing with what is arguably not "overconsumption."

C. *Unknown Long-Term Costs of Alternative Medicine*

Finally, any discussion of cost containment for alternative therapies cannot be complete without noting the long-term uncertainty surrounding the human costs of acupuncture and chiropractic. Using double-blind clinical trials to test the effectiveness of alternative medicine is a rather new phenomenon. As such, there is a dearth of

324. 583 A.2d 409 (N.J. Super. Ct. App. Div. 1990).

325. *See id.* at 410.

326. *See id.* at 410-11.

327. *See id.* at 411.

328. *See id.* at 412.

329. *See id.* at 413.

sound research that explores whether foregoing orthodox medical treatments will create health problems for patients later in life. Without such information, it is impossible to weigh the comparative costs and benefits of different modalities accurately. It remains to be seen whether chiropractic and acupuncture are effective therapies, or whether using these alternative techniques is little more than an unconscious decision to defer maintenance until future years. If so, then by embracing acupuncture and chiropractic treatments as a way of reducing health care expenditures in the 1990s, insurers and HMOs will be leaving society with much greater expenses down the road.

This uncertainty suggests that governments should be cautious in expanding the availability of acupuncture and other unproven alternative modalities. Advocates of acupuncture are currently expending a great deal of political energy trying to convince legislatures to mandate expanded coverage. Without greater information from reputable scientific studies showing that acupuncture is effective, legislatures cannot make these types of decisions responsibly. Instead, Congress should continue to fund generously medical research grants given out by the National Center for Complementary and Alternative Medicine (formerly the NIH Office of Alternative Medicine),³³⁰ so that, in a few years, legislatures will have a modicum of information with which to evaluate these new techniques. Similarly, HMOs—which spend relatively little on medical research³³¹—should shift some of their resources from marketing acupuncture benefits to evaluating acupuncture's effectiveness.

D. Summary of Conclusions

This Article is only the first effort in an area that deserves much further academic discourse. The foregoing analysis suggests that alternative medicine overutilization is becoming a serious health care problem in this country. As more and more people gain access to third party reimbursement for alternative modalities, the major existing restraint on utilization—the requirement that patients pay all their costs out-of-pocket—will disappear.

Cost sharing, which requires insured patients to bear some of the costs of their treatment, is obviously only a partial replacement for a

330. In addition to changing the Office's name, Congress recently boosted the Center's funding from \$20 million to \$50 million annually. See Charles Marwick, *Alterations Are Ahead at the OAM*, 280 JAMA 1553, 1553 (1998).

331. See Robert Pear, *Medical Research to Get More Money From Government*, N.Y. TIMES, Jan. 3, 1998 at A1.

system in which patients must foot the entire bill, but an effective replacement nevertheless. Capitation and numerical treatment limitations are also likely to prove promising techniques.

In the tort litigation context, the use of mandated medical cost sharing by plaintiffs or jury instructions that require medical expenses to be "customary" in order for them to be reimbursable will help juries become more effective agents of cost containment. In the process, they will also mitigate the temptation to pad alternative medical bills in cases that are likely to settle.

There are also strategies that can be made applicable to both insurers and courts in tort litigation. For example, rather than focusing on whether a treatment is medically beneficial, the focus should shift to providing payment for the most cost effective treatment. A less ambitious reform would require the patient to opt for a less expensive but equally effective treatment, except in cases where the less expensive treatment had failed to improve the patient's condition. Another promising reform would be to limit reimbursement to cases involving the treatment of an objectively verifiable medical condition where the ability of the modality to effectively treat the condition has been proven.

In opting for such approaches, policymakers must recognize that these types of cost containment are philosophically inconsistent with a fundamental tenet of the holistic healing model. In a world of scarce resources, such a rejection of the holistic model is justified. Holistic evaluation of therapies may provide some people with helpful treatments, but holistic healing cannot address overutilization because it rejects the premise that overutilization even exists. At some point, if health care costs are to be contained, society must say to some patients: "You are well, regardless of what you may believe."