

ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672
6408 SENATE LABOR & COMMERCE

812

Draft: Dec. 5, 1989

Eliminates Prior Stays on Home Health Care Benefit, pp. 6-7

LONG-TERM CARE INSURANCE MODEL ACT
PROPOSED AMENDMENTS

Table of Contents

Section 1.	Purpose
Section 2.	Scope
Section 3.	Short Title
Section 4.	Definitions
Section 5.	Extraterritorial Jurisdiction - Group Long-Term Care Insurance
Section 6.	Disclosure and Performance Standards for Long-Term Care Insurance
Section 7.	Administrative Procedures
Section 8.	Severability
Section 9.	Effective Date

Section 1. Purpose

The purpose of this Act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Comment: The purpose clause evidences legislative intent to protect the public while recognizing the need to permit flexibility and innovation with respect to long-term care insurance coverage.

Comment: The Task Force recognizes the viability of a long-term care product funded through a life insurance vehicle, and this Act is not intended to prohibit approval of this product. Section 4 now specifically addresses this product. However, states must examine their existing statutes to determine whether amendments to other code sections such as the definition of life insurance and accident and health reserve standards and further revisions are necessary to authorize approval of the product.

Section 2. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and

intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

Note: See Section 6I.

Comment: This section makes clear that entities subject to the Act must continue to comply with other applicable insurance legislation not in conflict with this Act.

Section 3. Short Title

This Act may be known and cited as the "Long-Term Care Insurance Act."

Section 4. Definitions

Unless the context requires otherwise, the definitions in this section apply throughout this Act.

- A. "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.
- B. "Applicant" means:
- (1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits, and
 - (2) In the case of a group long-term care insurance policy, the proposed certificate holder.

- C. "Certificate" means, for the purposes of this Act, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.
- D. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Where the word "Commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

- E. "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:
 - (1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or
 - (2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:
 - (a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and
 - (b) Has been maintained in good faith for purposes other than obtaining insurance; or
 - (3) An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the Commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and by-laws which provide that:
 - (a) The association or associations hold regular meetings not less than annually to further purposes of the members;
 - (b) Except for credit unions, the association or associations collect dues or solicit contributions from members; and
 - (c) The members have voting privileges and representation on the governing board and committees.

Thirty days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

- (4) A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the Commissioner that:
 - (a) The issuance of the group policy is not contrary to the best interest of the public;
 - (b) The issuance of the group policy would result in economies of acquisition or administration; and
 - (c) The benefits are reasonable in relation to the premiums charged.

F. "Policy" means, for the purposes of this Act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Drafting Note: This Act is intended to apply to the specified group and individual policies, contracts, and certificates whether issued by insurers; fraternal benefit societies; non-profit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization. In order to include such organizations, each state should identify them in accordance with its statutory terminology or by specific statutory citation. Depending upon state law, insurance department jurisdiction and other factors, separate legislation may be required. In any event, the legislation should provide that the particular terminology used by these plans and organizations may be substituted for, or added to, the corresponding terms used in this Act. The term "regulations" should be replaced by the terms "rules and regulations" or "rules" as may be appropriate under state law.

The definition of "long-term care insurance" under this Act is designed to allow maximum flexibility in benefit scope, intensity and level, while assuring that the purchaser's reasonable expectations for a long-term care insurance policy are met. The Act is intended to permit long-term care insurance policies to cover either diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, or any combination thereof, and not to mandate coverage for each of these types of services. Pursuant to the definition, long-term care insurance may be either a group or individual insurance policy or a rider to such a policy, e.g., life or accident and sickness. The language in the definition concerning "other than an acute care unit of a hospital" is intended to allow payment of benefits when a portion of a hospital has been designated for, and duly licensed or certified as a long-term care provider or swing bed.

Section 5. Extraterritorial Jurisdiction - Group Long-Term Care Insurance

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in Section 4E(4), unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

Drafting Note: By limiting extraterritorial jurisdiction to "discretionary groups," it is not the drafters' intention that jurisdiction over other health policies should be limited in this manner.

Section 6. Disclosure and Performance Standards for Long-Term Care Insurance

- A. The Commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

Comment: This subsection permits the adoption of regulations establishing disclosure standards, renewability and eligibility terms and conditions, and other performance requirements for long-term care insurance. Regulations under this subsection should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual long-term care insurance policies.

- B. No long-term care insurance policy may:

- (1) Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or
- (2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or
- (3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

- C. Preexisting condition:

- (1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in

Section 4E(1) shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

- (2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.
- (3) The Commissioner may extend the limitation periods set forth in Sections 6C(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.
- (4) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6C(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6C(2).

D. Prior hospitalization/institutionalization:

- (1) No long-term care insurance policy may be delivered or issued for delivery in this state if such policy:
 - (a) Conditions eligibility for any benefits on a prior hospitalization requirement; or
 - (b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or
 - (c) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.
- (2) (a) A long-term care insurance policy containing any ~~limitations or conditions for eligibility other than those prohibited -- above -- in -- Paragraph -- (1)~~ post-confinement.

post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

(a) -- ~~A long-term care insurance policy containing a benefit advertised, marketed or offered as a home health care or home care benefit may not condition receipt of benefits on a prior institutionalization requirement.~~

(b) A long-term care insurance policy or rider which conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days ~~for which benefits are paid.~~

Drafting Note: The amendment to the section is primarily intended to require immediate and clear disclosure where a long-term care insurance policy or rider conditions eligibility for non-institutional benefits on prior receipt of institutional care.

(2) No long-term care insurance policy or rider which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty days after discharge from the institution.

Drafting Note: The Dec. 1988 amendment to this section will eliminated the three-day prior hospitalization screen for new long-term care insurance policies. Some states may wish to consider a "dual-option" alternative to the total prohibition against the prior hospitalization screen, based on the state's particular demographic, geographic and market characteristics. If so, the following provision is such an alternative: "No long-term care insurance policy which conditions the eligibility of benefits on prior hospitalization may be delivered or issued for delivery in this State unless the insurer or other entity offering that policy also offers a long-term care insurance policy which does not condition eligibility of benefits on such a requirement."

Editors Note: Section 6D(2) is language from the original model act which did not prohibit prior institutionalization. The drafters intended that Section 6D(2) would be eliminated after adoption of the amendments to this section which prohibit prior institutionalization. States should examine their Section 6 carefully during the process of adoption or amendment of this Act.

E. The Commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

F. Right to return - free look:

Long-term care insurance applicants shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined Section 4(E)1 of this Act, the applicant is not satisfied for any reason.

G. (1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(a) The Commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(b) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(2) The outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contain governing contractual provisions;

- (e) A description of the terms under which the policy or certificate may be returned and premium refunded; and
- (f) A brief description of the relationship of cost of care and benefits.

H. A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state shall include:

- (1) A description of the principal benefits and coverage provided in the policy;
- (2) A statement of the principal exclusions, reductions and limitations contained in the policy; and
- (3) A statement that the group master policy determines governing contractual provisions.

Comment: The above provisions are deemed appropriate due to the particular nature of long-term care insurance, and are consistent with group insurance laws. Specific standards would be contained in regulations implementing this Act.

I. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

- (1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;
- (2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;
- (3) Any exclusions, reductions and limitations on benefits of long-term care; and
- (4) If applicable to the policy type, the summary shall also include:
 - (a) A disclosure of the effects of exercising other rights under the policy;
 - (b) A disclosure of guarantees related to long-term care costs of insurance charges, and

(c) Current and projected maximum lifetime benefits.

J. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

- (1) Any long-term care benefits paid out during the month;
- (2) An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and
- (3) The amount of long-term care benefits existing or remaining.

K. Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this Act.

Section 8. Administrative Procedures

Regulations adopted pursuant to this Act shall be in accordance with the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

Section 9. Severability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 10. Effective Date

This Act shall be effective [insert date].

Legislative History (all references are to the Proceedings of the NAIC).

1987 Proc. I 11, 19, 655, 677-680, 700 (adopted).
1988 Proc. II 15, 23, 632-633, 727, 730-734 (amended and reprinted).
1988 Proc. I 9, 20-21, 629-630, 652, 661-665 (amended and reprinted).
1989 Proc. I 9, 24-25, 703, 754-755, 789-793 (amended).
1989 Proc. II (amended and reprinted).

drafts@misc@ltcact3

STATE LEGISLATION ON LONG-TERM CARE INSURANCE
(as of March 1989)

NAIC MODEL BILL	LEG/REG MORE STRINGENT THAN MODEL BILL	OTHER	LEGISLATION PENDING	AMENDMENTS PENDING
Arizona	California	Colorado	Arkansas <i>Passed</i>	Arizona
Florida	Connecticut	Kentucky	Delaware	California
Georgia	Maine	New York	Hawaii*	Connecticut
Hawaii*	Minnesota		Maryland	Florida
Idaho	Washington	<u>3 STATES</u>	Massachusetts	Georgia
Illinois	Wisconsin		Michigan	Iowa
Indiana			Montana	Kansas
Iowa	<u>6 STATES</u>		New Hampshire	Maine
Kansas			New Jersey	Missouri
Nebraska			New Mexico	Nebraska
Nevada			Oregon	North Dakota
North Carolina			Pennsylvania	Oklahoma
North Dakota			South Dakota	Tennessee
Ohio			Utah	
Oklahoma			Vermont	<u>13 STATES</u>
Rhode Island				
South Carolina			<u>15 STATES</u>	
Tennessee				
Virginia				
Wyoming				
<u>20 STATES</u>				

*Inadvertently repealed in 1988; has been re-introduced in 1989.

Long-term Care Insurance

Many people want to know how to buy insurance coverage that will protect them from the potentially catastrophic expenses related to long-term care. However, most people do not know what their chances are of ever needing long-term care services, how expensive these services can be or whether their present health insurance coverage will take care of them.

What Is Long-term Care?

Long-term care refers to the kind of help that you might need should you develop a chronic illness or disability that makes it impossible for you to care for yourself. You may never need lengthy care in a nursing home, but it's possible that some day you will need help at home with daily activities such as dressing, bathing, or walking.

To meet a range of long-term care needs, there are many kinds of long-term care services in addition to the care associated with lengthy stays in a nursing home or health care you may need at home. Other services include: adult day care; respite care (which helps family members cope with caring for older persons at home); care given in senior citizens or congregate housing; aide or chore services; and friendly visiting services.

Some or all of these services may be available where you live now or plan to retire. However, this issue of **Consumer Notes** deals mainly with the two kinds of long-term care covered by private long-term care insurance policies that are currently available: nursing home and home health care.

In addition, it will help you gauge whether long-term care insurance policies can help you meet future expenses related to chronic illness or disability.

Medicare and Long-term Care

The fact is that neither Medicare nor private Medicare supplement insurance (or the health insurance you have through your employer) will pay for most long-term care expenses.

Medicare supplement (Medigap) insurance is private insurance that is designed to help cover some of the gaps in Medicare coverage. It will not cover long-term care costs. Some retirees are covered by their group health plan which complements Medicare, but these plans generally do not cover long-term care either.

Although you may have Medicare as well as other health insurance, you will be covered for expenses related to only a limited amount of skilled nursing care. Skilled nursing care refers to the kind of daily nursing and rehabilitative care that can be performed only by, or under the supervision of skilled medical personnel. The care received must also be based on a doctor's orders.

This means you will not be covered if you need the kind of extended, intermediate or custodial care associated with long-term nursing home stays or if you need prolonged home health care on a daily basis.

Intermediate care refers to occasional nursing and rehabilitative care that must be based on a doctor's orders and can only be performed by, or under the supervision of skilled medical personnel. Custodial care is care that is primarily for the purpose of meeting personal needs such as help in walking, bathing, dressing, eating or taking medicine. It can usually be provided by someone without professional medical skills or training.

Home health care may include care received at home such as part-time skilled nursing care, speech therapy, physical or occupational

therapy, part-time services of home health aides or help from homemakers or choreworkers.

At present, there are a limited number of long-term care insurance products available that do cover these kinds of expenses. However, insurance companies are developing more products as the demand for this kind of coverage increases.

Will You Need Long-term Care?

By the year 1990, about 7.7 million Americans over age 65 will likely need some form of long-term care.

But those aged 85 or older are the most at risk for needing long-term care services. In fact, statistics show that, at any given time, 22 percent of those aged 85 or older are in a nursing home.

At the same time, it is estimated that two out of five people aged 65 or older risk entering a nursing home. More than half of those will need to stay 90 days or fewer; yet about 40 percent will need to stay on average 2½ years. Only a small number ever stay over five years.

While you may never need nursing home care, home health care or other long-term care services, you still may wish to consider purchasing insurance that covers many of these services because of the risks posed by the need for long-term care and the costs involved.

Insurance, by definition, is a way for you to share the costs of possible economic loss by contracting with an insurance company to assume the risk of such a loss in exchange for a premium.

How Expensive Is Long-term Care?

Long-term care can be very expensive. In 1986, a year in a nursing home cost an average of \$20,000 to \$30,000 (the cost often depending on the area in which the

home is located) or about \$2,000 per month. At the most expensive nursing homes, the annual cost could be as much as \$50,000.

Home health care provided on an unskilled basis (help with grooming or dressing) by a home health aide three times a week for a year can easily cost \$440 a month or \$5,300 a year. Skilled nursing home care visits can cost even more with three visits per week for a year running as much as \$680 a month or \$8,200 a year.

It's difficult to know what kind of care you may need or what the costs will be, but knowing you will be responsible for the majority of expenses, you can begin to consider what kind of insurance coverage you need to buy.

Who Pays for Long-term Care?

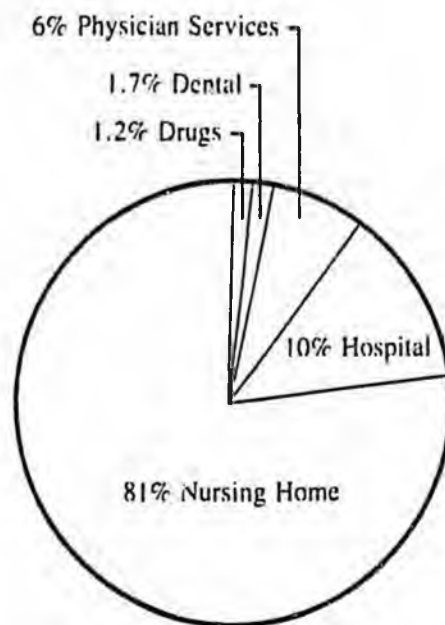
In 1987, over half of nursing home care expenses alone were paid out-of-pocket by individuals or families. Medicare paid for less than two percent of the nation's \$41.6 billion annual nursing home bill and private insurance paid even less.

In fact, Medicare will only help pay for:

- Skilled nursing care up to 100 days, and your admission to a facility must be within 30 days of a three-day hospital stay. A physician must show that your admission is necessary.*
- Part-time skilled home health care (but only if you are homebound, a physician certifies the care is necessary and provides a treatment plan and the agency is Medicare participating). This is a very limited benefit and does not cover services you may need on a daily basis over an extended period of time.*

The other primary payer of nursing home care expenses (over 42 percent) is Medicaid, the government program that is meant to pro-

Elderly Out-Of-Pocket Expenses over \$2,000 Per Year



vide help with medical expenses to the poor. To qualify for Medicaid, you (or your family) either must already be "poor" or literally impoverish yourself—by spending virtually all of your assets (except your house). That happens to about one half of the people who enter nursing homes as "private-pay" patients. A recent study showed that those who pay for nursing home care out of their own pockets are often impoverished within six months to a year. They then must turn to Medicaid (public assistance) to pay part or all of their expenses.

For those over the age of 60, expenses for some home care services, such as Meals on Wheels, homemaker and home health aides, are available on a limited basis under the Federal Older Americans Act. If you need such services, contact the local Area Agency on Aging, listed in your telephone directory, for more information about eligibility requirements. Area Agencies on Aging are not direct providers of services, but they do operate an information and referral service to help older adults identify and access needed assistance within their communities.

What Kind of Insurance Is Available?

You can buy private insurance that helps to cover major expenses for long-term care. (See the "Who Offers Long-term Care Insurance" section for where to write about available policies.) There are a limited number of policies on the market today, but at least one is available in each state. These policies help pay expenses that may pose the highest risk to you.

Almost all available policies are "indemnity" policies, meaning they pay a set amount (usually a certain dollar figure per day) for care in a nursing home or for home health care. No policy, however, provides blanket coverage for all expenses and most policies on the market today do not automatically adjust for inflation. This means a policy's benefits are not necessarily tied to future increases in the costs of long-term care.

Each policy is priced differently. In 1986, costs ranged from about \$100 a year in premiums to more than \$2,500, depending on several factors:

Age—In general, the younger you are when you buy a policy, the lower the premium will be.

Elimination or Deductible Periods—These periods are defined as the number of days you must be confined in a facility or the number of home care visits you must have received before policy benefits begin. Usually, the longer the elimination or deductible period is, the lower the premium will be.

Amount Paid and Duration of Benefits—These vary from policy to policy, but in general, the more money the policy will pay or the longer the benefit period is, the more you will pay for the policy. For example, a policy that pays \$100 a day for up to five years of nursing home care will cost more than a policy that pays \$50 a day for three years.

What Kind of Care Is Provided?

Long-term care policies may pay for skilled, intermediate or custodial care in a nursing home. Each policy

*Legislation currently pending in Congress is expected to change Medicare's present skilled nursing care and home health care benefits. All Medicare beneficiaries will be receiving details from insurers and the federal government once the law goes into effect.

may define these levels of care differently and the definitions are not the same as Medicare's.

Some policies require you to be hospitalized first before covering nursing home care, and many require that you receive skilled or intermediate care before they will pay for custodial care expenses.

Policies generally pay only for expenses in facilities that:

- Are licensed by the state and participate in Medicaid and/or Medicare; and
- Meet the policy's definition of skilled, intermediate or custodial care.

This is why it's very important for you to find out the kinds of nursing homes in the area in which you live or plan to receive care before you buy a policy. Check the nursing homes in your area to make sure they fit policy definitions. If they don't, you may not be eligible for benefits.

Also, policies often cover home health care services such as skilled or non-skilled nursing care, and homemaker and home health aides. Some policies, however, require a prior nursing home or hospital stay before they will cover home health care benefits.

What Kinds of Limits Are There?

All policies contain limitations and exclusions in addition to age, elimination or deductible periods, or the amount and duration of benefits. Others you should study before making a purchase are:

Pre-existing conditions—When you apply for long-term care insurance, you may be asked questions about the previous and current state of your health. This is because an insurance company generally requires that a certain period of time pass before the policy pays for care related to a health problem you may have had when you applied. Such health problems are called pre-existing conditions. At this time, most companies use a six-month pre-existing condition limitation period. In some cases, you may be denied

coverage because of your health status.

Eligibility—After a certain age, you will be unable to buy a policy. Each company sets its own age limit—usually around age 79. Most policies are only available to those over the age of 55. It's possible that both age limits may change in the future, as new policies are developed and sold.

Renewability—This policy provision is normally found on the first page of the policy. It tells you under what circumstances the policy can be cancelled by the insurance company or how premiums can be raised. Most policies are guaranteed renewable and cannot be cancelled.

Exclusions—Policies may not pay for long-term care related to mental or nervous conditions, alcoholism, mental retardation, or certain other health conditions or situations. However, Alzheimer's disease, and other organic disorders, leading causes of nursing home admissions, are generally covered.

What Kinds of Questions Should You Ask?

Before you consider buying long-term care insurance, you should determine what kinds of resources you have or plan to have to take care of your long-term care needs. For example, do you have savings, life insurance, or a pension that would help pay for them? Would other family members help you, if necessary, or would you qualify for community services that are income-related?

Be sure to read policies you are considering carefully and compare them. Don't be afraid to ask an insurance agent about anything that doesn't seem clear in the policy. There is no one solution for everyone in planning for the future, but your financial plans should include consideration of your long-term care needs.

The following questions will help you compare and evaluate policies you may wish to consider. Use them as a basis for discussion with an insurance agent or for asking ques-

tions about promotional literature you may receive in the mail.

What Does Long-term Care Cost?

1. What kinds of nursing homes are there in your area and how much do they charge per month for:
 - skilled nursing care?
 - intermediate nursing care?
 - custodial/personal care?
2. What do home health care agencies in your area charge per month for:
 - unskilled care?
 - skilled care?

How Much Does the Policy Pay?

3. What is the maximum amount the policy will pay for:
 - skilled nursing care?
 - intermediate nursing care?
 - custodial nursing care?
 - home health care?

How Much Does the Policy Cost?

4. How much will the policy cost you over time (i.e., 1, 5, 10, or 15 years)?
5. Can the company raise your premium over time or under other circumstances? If so, what are the circumstances?

What Are the Benefits?

6. Does the policy provide benefits for:
 - skilled nursing care?
 - intermediate care?
 - custodial care?
 - home health care?
7. How long will the policy pay benefits for:
 - skilled nursing care?
 - intermediate nursing care?
 - custodial nursing care?
 - home health care?
 - all of the above services?
8. Does the policy cover Alzheimer's disease if you developed it after you purchased the policy?
9. Does the policy provide benefits if you need care away from the area in which you live or if you move to another state?
10. Will the policy provide benefits if you have similar coverage with another policy?

What are the Limits?

11. What is the elimination or deductible period before benefits begin for:
 - nursing home care?
 - home health care?
12. What is the pre-existing condition limitation period?
13. Can the company cancel or refuse to renew the policy? If there are conditions, what are they?
14. a. Is a prior hospital stay required before the policy will pay for:
 - skilled nursing care?
 - intermediate nursing care?
 - custodial nursing care?b. Is a prior skilled nursing home stay required before the policy will pay for:
 - intermediate care?
 - custodial care?c. Is a prior nursing home stay required before the policy will pay for:
 - home health care?
15. Are there other limitations or exclusions that concern you? If so, what are they?

Who Offers Long-term Care Insurance?

There are policies available now in every state and many companies are in the process of developing policies.

You may wish to contact your state insurance department or insurance agent for more information. To obtain a list of private insurers offering products in your state, write to:

Health Insurance Association of America
Information Services
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599

Additional Reading

Publications about long-term care, health care coverage, and other subjects of interest to older Americans are available free or at a low cost from the following organizations:

American Association of Homes for the Aging
1129 20th Street, N.W.
Washington, D.C. 20036
Telephone: 202/296-5960

Brochures describing continuing care communities.

American Association of Retired Persons
Health Advocacy Services
1909 K Street, N.W.
Washington, D.C. 20049
Telephone: 202/872-4700

Brochures about long-term care, home care, housing options, health care, and health maintenance organizations.

American Health Care Association
1200 15th Street, N.W.
Washington, D.C. 20005
Telephone: 202/833-2050
Brochures about long-term care facilities.

Council of Better Business Bureaus
1515 Wilson Boulevard
Arlington, VA 22209
Telephone: 703/276-0100

Brochures about home care and long-term care facilities.

Health Insurance Association of America
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599
Health Insurance Hotline 1-800-423-8000

Brochures about health insurance, in general, and how private health insurance works with Medicare.
Health insurance hotline.

National Consumers League
Suite 516
815 15th Street, N.W.
Washington, D.C. 20005
Telephone: 202/639-8140

Brochures about life care communities, home health care, hospice care, ambulatory care, and health maintenance organizations.

The National Council on the Aging, Inc.
West Wing 100
600 Maryland Avenue, S.W.
Washington, D.C. 20024
Telephone: 202/479-1200

Brochures about long-term care and Medicaid, Medicare, community resources, housing options and long-distance caregiving.

State Insurance Departments

Some have consumer education programs for older Americans about a range of insurance-related topics, including Medicare, Medicaid, Medigap, and long-term care insurance. Contact the department in your state for further information.

Social Security District Office

Several brochures, including *Your Medicare Handbook*, as well as information on Medicaid and other government programs for the elderly. To find the office nearest you, check the government listings in your telephone directory.

Other Consumer Notes include:

- A326 *Choosing Financial Advisers*
- C326 *Staying Well, Your Responsibility*
- D326 *Group Health Insurance Continuation*
- E326 *IRAs: An Investment in Your Future*
- F326 *Medicare Supplement Insurance*
- G326 *Help for the Working Caregiver*
- H326 *Checklist for Change: Financial Planning for Life's Transitions*

All issues of Consumer Notes may be obtained free-of-charge in single or bulk quantities by writing to the following address. Please be sure to include the name and booklet number of the issues you are ordering.

American Council of Life Insurance

Health Insurance Association of America
Company Services
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599

LONG TERM CARE EDUCATION COALITION

WHAT IS LONG-TERM CARE? *Why You Need to Know*

This is the first in a series of newsletters produced by the Coalition for Long-term Care Education. The Coalition is comprised of a variety of organizations, cooperating in this endeavor to respond to the need for educational information on the subject of long-term care. This issue introduces the concept of long-term care and explains why it should be of concern to you. Subsequent issues will be produced periodically on such topics as long-term care options, paying for long-term care, what to look for when selecting long-term care services, and others.

There's a great deal of talk these days about "the graying of America" and something called "the long-term care issue."

What's it all about? Why should you care?

America is getting older. More and more of us are moving into our senior years. And our life expectancy is increasing.

In the year 2000, about 35 million Americans will be aged 65 and over—more than twice the number in 1960. Since 1960, the population aged 65 and over has grown more than twice as fast as the U.S. population in general. The number of Americans aged 80 and over totals almost six million today; in the year 2030, that number is expected to have almost tripled.

These statistics tell the story behind the phrase, "the graying of America."

This growth in the elderly population will be reflected, among other things, in an increased demand for long-term care services. But what is "long-term care" and why do you need to know about it?

The Challenge of Living Longer

We Americans are healthier than ever—and living longer. And because so many Americans will live into their eighties and nineties—perhaps even to age 100—we all need to do some looking ahead.

While many millions of "young-old" Americans lead healthy, active lives, others are not so fortunate. Two out of five persons aged 65 and over risk needing nursing home care. By the year 1990, about 7.7 million Americans over age 65 are expected to need some form of long-term

care. And as we get into our eighties, the chances increase considerably that we will face health problems or frailty. Statistics show that, at any given time, 22 percent of those aged 85 or older are in a nursing home.

Many of us are concerned that our health might deteriorate as we get older and we worry about our financial ability to handle disability or illness. Still, few of us make preparations that would help us handle these situations. Why? Partially it has to do with widespread misunderstanding about long-term care and how it is paid for.

Getting the Facts Straight

Many Americans deny their own possible future need for long-term care, associate long-term care only with nursing homes and believe that Medicare will pay for most long-term care services—all misconceptions.

The purpose of this newsletter is to help clear up some of the confusion for you about long-term care—to help you learn about the issue and to prepare yourself and other family members for a possible need for long-term care services.

What Is Long-term Care?

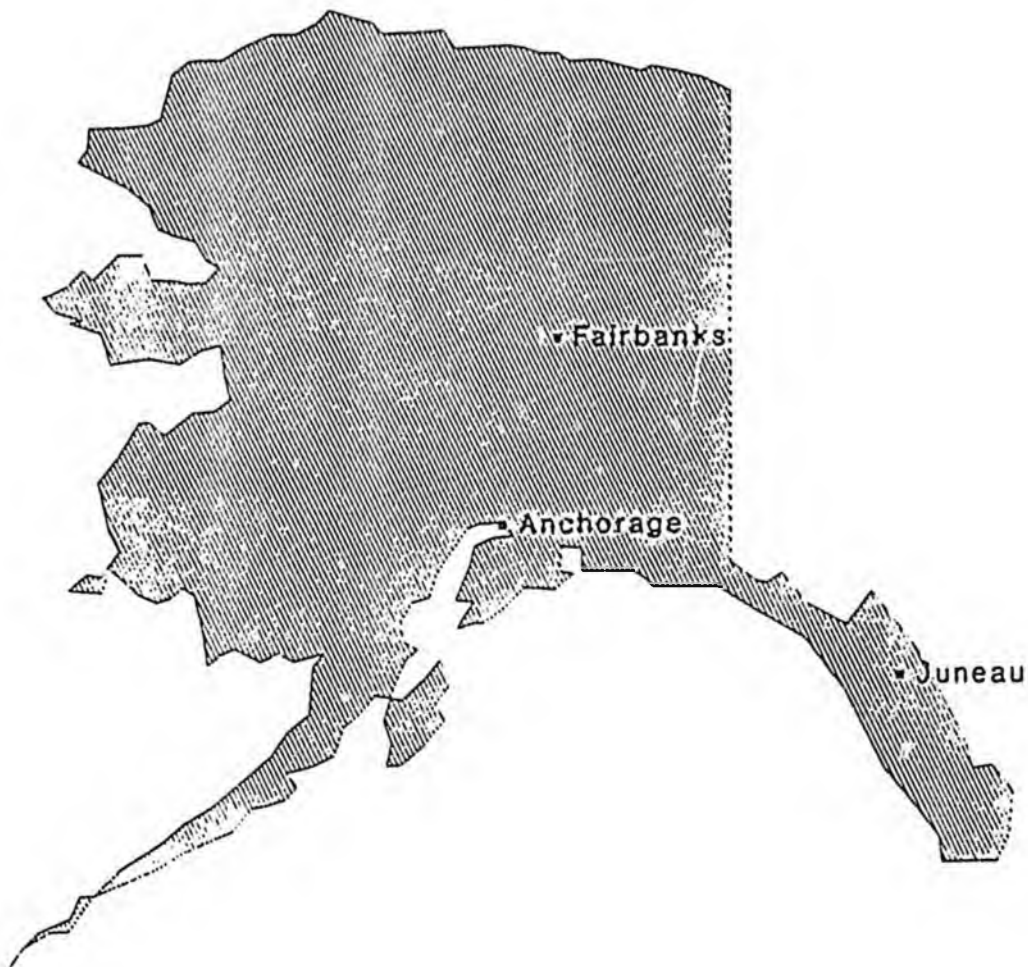
Simply stated, long-term care refers to a person's need for a wide range of medical, nursing, and social services over a prolonged period of time. This is generally called "chronic" care, as distinct from more intensive medical treatment for a short-term illness called "acute" care. The need for long-term care can result from chronic illness or disability or from a sudden accident or stroke.

Long-term care does NOT take place only in a nursing home, nor is it needed only by the elderly. Care might be provided to people of any age in the home, in community facilities, or in nursing homes. Relatives, friends and neighbors, and those working for community services often provide assistance with the normal activities of daily living such as eating, bathing, and dressing. Or, those who need care could be living in a community for senior citizens which might meet all of their health and social needs—commonly known as a continuing care community.

If you do not have these support systems or if you need skilled nursing or rehabilitative care on a daily basis, you may find your only option to be an institution such as a nursing home.

STATE PROFILE: ALASKA

DATA RELEVANT TO HEALTH INSURANCE COVERAGE



Health Insurance Association of America

State Profile: Alaska
Data Relevant to Health Insurance Coverage

Resident Population, 1988, Total U.S. (X 1,000) (a).....245,807
State Total Resident Population, 1988 (X 1,000).....513
State Percent of U.S.Total,1988.....0.208%

<u>EMPLOYMENT</u> (b)	<u>STATE</u>	<u>Nat'l</u> <u>Avg.</u>
Percent Unemployed (1987).....	10.8%	6.2%
Percent of Civilian Employment Participation		
For Males (1987).....	80.4%	76.2%
For Females (1987).....	64.3%	56.0%

Percent of State Total* Employed by Industry (1987)	<u>STATE</u>	<u>Nat'l</u> <u>Avg.</u>
Construction (avg 27.7% nationally unin, 1986).....	5.23%	4.88%
Wholesale and Retail Trade (20.7%).....	19.52%	23.83%
Services (17.4%).....	20.00%	23.64%
Transportation and Public Utilities (10.8%).....	8.57%	5.26%
Manufacturing (9.1%).....	6.66%	18.63%
Finance, Insurance, and Real Estate (8.1%).....	5.23%	6.40%
Government (7.2%).....	31.42%	16.63%

*Total includes mining which is not a part of industry figures.

<u>INCOME</u> (c)	<u>STATE</u>	<u>Avg.</u> <u>State</u>
Total Personal Income in Current Dollars (1987, billions).....	\$9.6	\$73.8
-As Percent of U.S. Total (1987).....	0.3%	
Personal Income Per Capita	<u>STATE</u>	<u>Nat'l</u> <u>Avg.</u>
-In Current Dollars (1987).....	\$18,230	\$15,481
-Rank, out of 50 States (1987).....	4	
-Rank, out of 50 States (1980).....	1	
-In Constant 1982 Dollars (1987).....	\$15,255	\$12,955
Poverty Rate (Mid-1980s) (d).....	10.4%	14.0%

-
- a.) Source: U.S. Bureau of the Census, July 1, 1988.
b.) Source: U.S. Bureau of Labor Statistics, "Geographic Profile of Employment and Unemployment," annual; and "Employment and Earnings," monthly (compiled from data supplied by cooperating State agencies).
c.) Source: U.S. Bureau of Economic Analysis, "Survey of Current Business," August issues; and unpublished data.
d.) Source: Tabulations by Plotnick, Robert D., and Danziger, Sheldon, "Poverty Rates by State in the Mid-1980s: An Update," Focus, Institute for Research on Poverty, Univ. of Wisconsin, Madison, Vol II, No.3, Fall 1988. Data based on 1985, 1986, and 1987 Current Population Surveys.

State Profile: Alaska

<u>HEALTH INSURANCE COVERAGE (e)</u>		Nat'l
	STATE	Avg.
Insurance Coverage (Nonelderly 1986)		
Total Privately Insured.....	71.6%	73.5%
Total Publicly Insured.....	Number too small	12.0%
No Coverage.....	21.5%	17.8%
<u>EXPENDITURES</u>		<u>Avg.</u>
State Government Expenditures (1986) (f)	STATE	State
Total (Millions of Dollars).....	\$3,888	\$7,382
Total Per Capita.....	\$7,309	\$1,566
Rank Per Capita, of 50 States.....	1	
Gross State Product (1986, Millions) (c).....	\$19,575	\$82,190
<u>MEDICAID AND MEDICARE</u>		<u>Avg.</u>
Medicare (1987) (g)	STATE	State
Enrollment (X1,000) (g).....	20	622.3
Payments (Millions of Dollars) (g).....	\$48	\$1,570
Medicaid (1987) (h)		
Recipients (X1,000) (h).....	28	388
Ratio of Recipients to Poverty Population.....	0.52	0.67
Nonelderly Recipients (X1,000) (h).....	25	344.6
Payments (Millions of Dollars) (h).....	\$77	\$877
Percent State Share of Medicaid (Oct. '87-Sept. '88)		
(i).....	50.00%	39.55%
Percent Federal Financial Participation Of Medicaid		
(Oct. '87-Sept. '88) (i).....	50.00%	60.44%
Percent of Total State Expenditures		
For Medicaid FY 1989 (j).....	3.5%	10.8%
For Medicaid FY 1988 (j).....	3.1%	10.4%
For Medicaid FY 1987 (j).....	2.3%	10.2%
Medicaid-type Program for Non-welfare		
Adults, Ages 18-64 (1988) (k).....	General Relief-Medical	

e.) Source: Employment Benefit Research Institute tabulations of 1987 Current Population Survey. Adds to more than 100% because some individuals have both public and private coverage.		
f.) Source: U.S. Bureau of the Census, "State Government Finances," series GF, No. 3, "Census of Governments," 1977, 1982, Vol. 6., No. 4.		
g.) Source: U.S. Health Care Financing Administration, unpublished data. (Enrollees as of July 1, 1987.)		
h.) Source: U.S. Health Care Financing Administration, July 1988, unpublished data. (Recipients at any time during year.)		
i.) Source: Adapted from Commerce Clearing House 1987; <u>Federal Register</u> 52 (April 15, 1987) 72:12253-4.		
j.) Source: National Association of State Budget Officers, "State Expenditure Report," 1989.		
k.) Source: Lipson, Debra, "Recently Adopted State Initiatives For The Uninsured," Intergovernmental Health Policy Project, The George Washington University, February, 1989.		

State Profile: Alaska

	<u>STATE</u>	<u>Avg. State</u>
Aged Individual, Eligibility Level (SSI) (l).....	\$8,196	\$4,877
Percent of Poverty (\$7,480).....	109.6%	80.8%
AFDC Family of 3, Eligibility Level (m).....	\$9,708	\$4,942
Percent of Poverty (\$10,060).....	77.2%	48.6%
Medically Needy Family of 3, Eligibility (m)..	Not Covered	\$6,165
Percent of Poverty (\$10,060).....	Not Covered	61.0%
Pregnant Women Family of 3, Eligibility (m).....	\$12,580	\$14,617
Percent of Poverty (\$10,060).....	100.0%	144.1%
All Children in Poverty Covered up to Age (m).....	2	

	<u>STATE</u>	<u>Avg. State</u>
Medicaid Maximum Payments (n)		
For Brief Follow-up Visit (o).....	\$28.41	\$12.43
As Percent of (1984) Medicare (n).....	115.0%	67.0%
For Appendectomy (o).....	N/A	\$337.9
As Percent of (1984) Medicare (n).....	N/A	60.6%
Limitation on Number of Physician Visits (1986) (p)		
Office Visits.....	none	
Combination of Visits.....	none	

HOSPITAL COSTS

	<u>STATE</u>	<u>Nat'l Avg.</u>
Uncompensated Care, 1985 (In Millions) (q)		
Number of Hospitals Surveyed.....	18	112
Survey Response Rate.....	72.2%	58.8%
Total Patient Gross Revenues.....	\$242	\$3,201
Total Expenses.....	\$219	\$2,558
Uncompensated Dollars (Charge Based).....	\$11	\$186
As Percent of Charges.....	4.50%	5.84%
Uncompensated Dollars (Cost Based).....	\$10	\$144
As Percent of Costs.....	4.55%	5.65%

l.) Source: Social Security Administration, "Characteristics of State Assistance Programs for SSI Recipients," January 1989.

m.) Source: National Governors' Assoc, July 1989; and Children's Defense Fund, Sept. 1989.

n.) Source: Congressional Research Service analysis of Medicaid data from U.S. Dept. of Health and Human Services. H.C.F.A., Analysis of State Medicaid Program Characteristics, 1986, Table 56, August 1987; Medicare Directory, HCFA, 1984.

o.) Source: See footnote (m) plus statewide average maximum as reported to HCFA.

p.) Source: National Governors' Association, State Medicaid Program Information Center, 1986, A Catalogue of State Medicaid Program changes, p.2.

q.) Source: AHA 1985 Annual Survey of Hospitals. Includes estimated data. Copyright 1987.

HIAA

Health Insurance Association of America

L THE CONSUMER'S GUIDE TO
LONG-TERM
CARE
INSURANCE

Selecting the health insurance that's right for you can be very complicated. There can be confusing words, exclusions and differing costs for various coverages to understand.

Recently there has been yet another form of insurance introduced to the American people. It is long-term care insurance. While many people think that Medicare insurance will cover the cost of long-term care, such as care in nursing homes, it actually pays for such coverage only in certain cases. Even if you have purchased private supplemental insurance, sometimes called Medigap, it does not cover long-term care either. Because there has been limited insurance for this care in the past, people have had to pay for their own care with their own resources or become impoverished in the process and qualify for Medicaid.

This booklet will explain what long-term care is and how long-term care insurance works. It also provides a handy checklist you can use to compare policies before you buy.

You owe it to yourself to examine carefully all aspects relating to this coverage and its cost. Many of the different types of policies available will be suitable for you and will meet your needs. Some may be suitable for others, but may not be suitable for you. This booklet will tell you in plain language most of what you need to know.



What is long-term care?

Long-term care is the kind of assistance you could need if you ever have a chronic illness or disability that lasts a long time and you are unable to care for yourself. Long-term care does not refer only to nursing home care. It can be provided in your own home if you need help with activities such as bathing, walking or doing chores.

There is a range of services available in the community to meet long-term care needs besides the nursing home. These services include: visiting nurses, home health aides, friendly visiting, meals on wheels, chore services and respite care that is available for caregivers who need an occasional break from daily responsibilities.

Some or all of these services may be available in your community. You may want to check with the Area Agency on Aging, listed in the telephone book, for help in locating these types of long-term care services.

Long-term care refers to more than nursing home care.

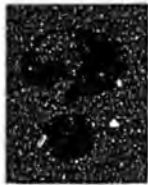


What are the chances that you will need long-term care?

By 2000, more than 8 million Americans aged 65 or more probably will need some form of long-term care due to disability or chronic illness. Most people can be cared for at home. Family and friends are the sole caregivers for 70 percent of these elderly.

Those aged 85 or older are the most at risk for needing long-term care. In fact, statistics show that, at any given time, 22 percent of those age 85 and older are in a nursing home. One study showed that in 1985, 2.3 million people who were 65 years old and older spent at least part of a year in a nursing home. An additional 4 million elderly people received care in their homes.

At the same time, it is estimated that two out of five people aged 65 or more risk entering a nursing home. Half of them will need to stay about six months or less; and half will need to stay an average of 2.5 years. Only a small number stay longer than 5 years.



What are the costs associated with long-term care?

Long-term care can be very expensive. Recent figures indicate that a year in a nursing home costs an average of \$25,000. Depending on where you live it could cost more than that.

Home-based care (help with dressing, bathing, household chores) provided by an aide just three times a week for a year can easily cost \$440 each month, or \$5,300 a year. If you require someone to assist you in administering oxygen or medication, for example, skilled nursing visits can cost even more with three visits per week for a year running as much as \$8,200 per year.



Who pays for it?

Neither Medicare nor private Medicare supplemental insurance (or the health insurance you may have through your employer) will pay for most long-term care expenses. Medicare supplemental insurance (Medigap) is private insurance that is designed to help cover some of the gaps in Medicare coverage—but not long-term care. Even the new Catastrophic Care Amendments to Medicare do not cover long-term care. Many people think that this new expansion of Medicare insurance will cover the cost of nursing home care or home health care, but it actually pays for such coverage only in extremely limited circumstances.

*Medicare
pays for
nursing
home
care in
limited
situations.*

*People can
lose most
of their
assets after
entering
a nursing
home.*

Medicare will help pay for long-term care under these conditions only:

- Skilled nursing care is covered for up to 150 days per calendar year. You must meet restrictive eligibility criteria and a physician must show that nursing home admission is necessary. Under the new law, in 1989 there is a \$25.50 copayment per day for the first through the eighth day of a nursing home confinement. After the eighth day there is no copayment required.
- Part-time skilled home health care is covered but only for short-term unstable conditions. You must be homebound and certified by a doctor that care is necessary. Also, the home health agency must participate in Medicare. The new law allows more frequent use of the benefits under limited circumstances.

Your care will not be covered if what you need is custodial care, or if you need prolonged home health care on a daily basis. (See Glossary for definition of intermediate care and custodial care.)

It is not surprising then that Medicare pays for less than 2 percent of the nation's annual nursing home bill. Medicare supplemental policies generally do not cover services in addition to Medicare, but rather are designed to pay the costs Medicare does not cover such as hospital deductibles or physician copayments. More than half of nursing home care expenses are paid out-of-pocket by individuals and their families.

Medicaid is a major payer of nursing home care, accounting for 42 percent of all payments to these facilities. Medicaid is a federal-state welfare program meant to provide help with medical expenses to the aged, blind and disabled poor. Many people who begin paying for nursing home care out of their own pockets are often impoverished soon after entering a nursing home. They then turn to Medicaid to pay part or all of their nursing homes expenses.

Recent changes to Medicaid allow your spouse to keep at least \$786 per month and at least \$12,000 in assets in 1989, if you should

become Medicaid-eligible for nursing home care. These amounts will increase annually.

It is difficult to know what kind of care you may need or what the costs will be. But knowing that you will be responsible for the majority of expenses, you need to know what kind of insurance coverage you should consider. The rest of this booklet describes features of private insurance policies and provides a convenient work sheet you may use in evaluating insurance policies.



What kind of insurance is available?

Long-term care insurance is a relatively new type of private insurance. More than 100 companies offer private long-term care insurance today and that number is rising as more insurance companies seek to fill this growing need.

Almost all policies now available are called indemnity policies, meaning they pay a set amount, usually a fixed dollar amount per day for nursing home or home health care. No policy, however, provides full coverage for all expenses. In addition, many policies do not increase the indemnity amount as the cost of care increases over time. Several newer policies do offer increased benefits over time to allow for increased costs.

Long-term care coverage also is offered as part of individual life insurance policies. Under this arrangement, a certain percentage of the policy's death benefit is paid for each month the policyholder requires long-term care.

Each policy is priced differently. In 1987, individual policy premiums ranged from about \$250 a year in premiums to more than \$2,500 depending on several factors:

Age

The younger you are when you buy a policy, the lower the premium. Most policies are sold on an entry-age level basis, so that the premium should

*Private
long-term
care
insurance
can fill
a growing
need.*

*Policies
can cover
round-the-
clock care
and help
with
daily
activities.*

remain at that level and not increase with age, unless there is an increase for everyone that has the same kind of insurance.

Elimination or deductible periods

These are defined as the number of days you must be confined in a facility or the number of home care visits you must receive before policy benefits begin. For example, if the policy you select has an elimination period of 20 days for nursing home care or home health visits, your policy will begin paying you benefits on the 21st day. Usually the longer the elimination or deductible period, the lower the premium.

Indemnity value and duration of benefits

These vary from policy to policy, but in general the more money the policy will pay or the longer the benefit period, the more the policy costs. For example, a policy that pays \$100 a day for up to five years of nursing home care will cost more than a policy that pays \$50 a day for three years.



What kind of coverage is provided?

Long-term care policies usually pay for skilled, intermediate or custodial care in a nursing home. Generally, skilled care refers to round-the-clock treatment by a registered nurse under a doctor's supervision. Intermediate care refers to occasional nursing and rehabilitative care under the supervision of skilled medical personnel. Custodial care primarily meets personal care needs in activities of daily living such as help in bathing or eating that can be provided by someone without professional medical skills.

Most policies will pay for expenses in facilities that are licensed by the state to provide skilled and intermediate care and participate in Medicaid and Medicare, and meet the policy's definition of skilled, intermediate or custodial care.

Many long-term care policies require hospitalization before covering any portion of a

nursing home stay. This is increasingly not the case, however. A few require that the policyholder receive skilled or intermediate care before they will pay for custodial care or allow that custodial care be covered only if it is provided in a skilled or intermediate nursing home.

Also, policies usually cover home health care services such as skilled or nonskilled nursing care and homemaker and home health aides, although many policies require a prior nursing home or hospital stay before they will cover home health care benefits. This, too, is changing. Newer policies do not base benefit eligibility for nursing home or home health care benefits on a prior hospitalization requirement.

Therefore, it is very important to make sure the coverage you seek is provided in the policy. Also, make sure you understand the conditions under which your policy will pay for nursing home or home health care.



What kinds of limits are there?

All policies contain limitations and exclusions in addition to age, elimination or deductible periods, and the amount and duration of benefits. The purpose of these provisions is to help maintain reasonable premiums that would cover anticipated costs should that become necessary.

Other limitations for consideration are:

Preexisting conditions

An insurance company generally requires that a certain period of time passes before the policy pays for care related to a health problem you may have already had when you became eligible for coverage. Such health problems are called preexisting conditions. At this time, most companies use a six-month preexisting condition limitation period. (For these policies, if you need to use long-term care benefits within six months

*Make sure
the
benefits
you want
are
covered.*

(Continued on page 10)

Long-Term Care Policy Checklist

The following checklist will help you compare policies you may be considering.

Policy A Name: _____

Policy B Name: _____

	Policy A	Policy B
<p>1. What services are covered?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skilled care <input type="checkbox"/> Intermediate care <input type="checkbox"/> Custodial care <input type="checkbox"/> Home health care <input type="checkbox"/> Other care 		
<p>2. How much does the policy pay per day for:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skilled care <input type="checkbox"/> Intermediate care <input type="checkbox"/> Custodial care <input type="checkbox"/> Home health care <input type="checkbox"/> Other care 		
<p>3. Does the policy offer a means for increasing benefits to account for expected future costs? If so, how?</p> <p>Is there an additional premium?</p>		
<p>4. Does the policy have a maximum lifetime benefit? If so, what is it?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nursing home <input type="checkbox"/> Home health 		

5. Does the policy have a maximum length of coverage per "spell of illness" of maximum benefit period? If so, what is it?

- Nursing home
- Home health

6. How long do I have to wait before preexisting conditions are covered?

7. Is Alzheimer's disease covered?

8. How many days is the elimination or deductible period before benefits begin?

9. Does this policy require:

- Physician certification of need
- A functional assessment
- A prior hospital stay for:
 - Nursing home care
 - Home health care
- A prior nursing home stay for home health care
- Other

10. Can the policy be cancelled?

11. Will the policy cover you if you move to another area?

12. What is the age range for enrollment?

13. What does the policy cost?

- per month
- per year

of the effective date of coverage due to a preexisting condition, you may be denied coverage.

Eligibility

For most individual policies, you will be unable to buy a policy after a certain age. Each company sets its own age limit, usually around age 79. Most policies are available only to those over the age of 50. These age limitations refer only to the ability to purchase long-term care insurance, not to the age you are when you use the benefits.

Renewability

Most policies sold on an individual basis are guaranteed renewable and cannot be cancelled. This renewability provision normally is found on the first page of the policy and tells under what conditions the policy can be cancelled and under what conditions premiums may be raised.

Exclusions

Policies may not pay for long-term care related to inorganic mental or nervous conditions, alcoholism, mental retardation, or certain other health conditions or situations. Alzheimer's disease and other related cognitive impairments, leading causes for nursing home admissions, generally are covered. Check policy provisions carefully to determine what exclusions apply.

Don't be afraid to ask an insurance agent if something is unclear.



What should you look for in a long-term care policy?

Be sure to read policies you are considering carefully and compare them. Ask for a summary of the policies' benefits or a disclosure form outlining the policies' features. Don't be afraid to ask your insurance agent about anything unclear. There is no single solution for everyone, but your financial plans should include consideration of your long-term care needs.

Glossary

The following definitions of commonly used long-term care terms are meant to provide a general definition of each term but may differ somewhat from those found in long-term care policies, in Medicare or by actual nursing homes.

■ **Conditionally renewable**—An insurance company agrees to continue to insure a policyholder as long as it continues to insure all people in the state holding the same kind of policy.

■ **Coinsurance**—A percentage of allowed expenses that an insured person is required to pay, e.g., 20 percent of "reasonable" charges under Medicare.

■ **Custodial care**—Care that is primarily for meeting personal needs such as help in bathing, dressing, eating or taking medicine. It can be provided by someone without professional medical skills or training but must be according to doctor's orders.

■ **Deductible or elimination period**—This amount is the initial sum that must be paid for services covered under an insurance plan before benefits are paid by the insurance company. It is usually expressed in terms of days in long-term care insurance policies (e.g., 20 days).

■ **Disclosure form**—A description of benefits, exclusions and provisions of a policy that facilitates understanding of the plan and comparison among plans.

■ **Exclusion**—Any condition or medical expense for which the policy will not pay.

■ **Guaranteed renewable**—An insurance company agrees to insure a policyholder for life as long as the premium is paid and for a fixed premium unless there is an across-the-board rate increase.

■ **Home health care**—Care received at home such as part-time skilled nursing care, speech therapy, physical or occupational therapy, part-time services of home health aides or help from homemakers or choreworkers.

- **Individual insurance**—Insurance underwritten and sold on an individual basis.
- **Intermediate care**—Occasional nursing and rehabilitative care that can be performed by, or under the supervision of, skilled medical personnel only. Care must be based on doctor's orders.
- **Intermediate care facility**—A nursing home that is licensed by the state and one that may be certified by Medicaid to provide intermediate care. It may provide custodial care as well.
- **Medicaid**—A joint federal-state program that provides payment for health care services to those with low incomes or with very high medical bills relative to income and assets. It provides benefits for long-term nursing home care once income and assets have been "spent down" to eligibility levels. It also provides some home health services.
- **Medicare**—The federal program providing people aged 65 and older, some disabled persons and those with end-stage renal disease with hospital and medical insurance. Active employees covered under their employers' plans do not qualify. It provides only very limited benefits for nursing home and home health services under narrowly defined circumstances.
- **Medigap**—Medicare supplemental insurance is private insurance that supplements or fills in many of the gaps in Medicare coverage, such as deductibles and coinsurance amounts. It does not, however, provide benefits for long-term care.
- **Preexisting condition exclusion**—An exclusion of benefits for medical conditions that a policyholder had before applying for health or long-term care insurance.
- **Skilled nursing care**—Daily nursing and rehabilitative care that can be performed only by, or under the supervision of, skilled medical personnel. Care must be based on doctor's orders.
- **Skilled nursing facility**—A nursing home that is licensed by the state and one that may be certified by Medicare and/or Medicaid to provide skilled care. It also may provide intermediate and custodial care.

Questions we hear most often



What does long-term care insurance cover?

Generally, today's policies cover skilled, intermediate and custodial care in state-licensed nursing homes. They also cover home health services provided by state-licensed and/or Medicare certified home health agencies.



How much do policies pay?

Almost all policies pay a fixed amount per day, or an indemnity, that is independent of a particular nursing home or home health agency rate. Policyholders are usually offered a choice of indemnity amounts ranging from \$40 to more than \$100 per day. Generally, the higher the indemnity, the higher the premium. In most cases, the indemnity for home health care is 50 percent of the nursing home rate.



What about five years from now, when costs probably will rise?

The cost of nursing home care varies widely and depends on factors such as geographic location, and staffing and personnel requirements. The average cost of a year in a nursing home is \$25,000 and rising steadily.

Most policies currently do not automatically adjust the benefit amount upward to account for higher costs expected in the future. Make sure you understand whether the policy you are examining offers protection against future, increasing costs. If the policy does offer protection, make sure you understand how the provision works. While these types of policies are more expensive, more companies are offering them.

Do these policies cover Alzheimer's disease?

Policies generally cover Alzheimer's disease specifically or "organic mental and nervous disorders," which generally include Alzheimer's disease and related disorders.

What are the real chances of entering a nursing home?

A Brandeis University study indicates that persons aged 65 or more face a 40 percent chance of entering a nursing home for any length of time. For those who do, 40 percent will stay three months or less.

What do policies cost?

Policy premiums are based on the age of the purchaser. The premium remains at one level for as long as you own the policy, although premiums can be increased if they are raised for all individuals who hold a policy just like yours. Premiums, in general, cannot be increased because of your age or if your health deteriorates. At age 50, a policy offering a \$60 per day nursing home indemnity and a 20-day deductible period costs around \$500 per year, at age 65, about \$675 and at age 79 or 80, about \$2,100 per year.

How does the preexisting condition limitation work?

Preexisting conditions are conditions that warranted medical attention prior to the policy's effective date. Benefits for preexisting conditions will be paid if you require long-term care after buying the policy, usually after a period of six months. What this means is that if you buy a policy and need services for a preexisting condition within six months of purchase, it will not pay. If everyone who already needed long-term care purchased a policy, premiums would not be affordable for healthy persons.

 **What else do I need to know?**

Insurance policies are legal contracts; make sure you understand what you are buying. If you are not satisfied with an agent's answers, ask for a phone number or an address of someone you can contact in the company itself. Good agents want you to know what you are buying. Community consumer organizations such as the Better Business Bureau, which is listed in your telephone book, might also help answer your questions.

 **Who offers long-term care insurance?**

You may obtain a list of all companies offering long-term care policies by writing to:

Health Insurance Association of America
P.O. Box 41455
Washington, DC 20018

Additional Reading

Additional publications about health care coverage and long-term care are available from other organizations.

American Association of Homes for the Aging

Suite 400
1129 20th Street, N.W.
Washington, DC 20036
Telephone: 202/296-5960

Brochures describing continuing care retirement communities.

American Association of Retired Persons Health Advocacy Services

1909 K Street, N.W.
Washington, DC 20049
Telephone: 202/872-4700

Booklets and pamphlets on long-term care choices for older Americans.

American Health Care Association

1202 L Street, N.W.
Washington, DC 20005
Telephone: 202/842-4444

Various pamphlets about long-term care facilities.

Council of Better Business Bureaus

Suite 800
4200 Wilson Boulevard
Arlington, VA 22203
Telephone: 703/276-0100

Written materials on home care and nursing homes.

National Consumers League

Suite 516
815 15th Street, N.W.
Washington, DC 20005
Telephone: 202/639-8140

Consumer's guide to life care communities has health and ambulatory fact sheets on Medicare.



Health Insurance Association of America
1025 Connecticut Avenue, NW
Washington, DC 20036-3998
(202) 223-7780

What Legislators Need to Know About Long-Term Care Insurance



National Conference
of State Legislatures



Foundation for
State Legislatures



What Legislators Need to Know About Long-Term Care Insurance was written by David Landes, health care program manager, National Conference of State Legislatures (NCSL).

Persons who provided information and who also reviewed drafts were:

Gary Claxton, Ron Hagen, Gail Kirby, Bette Mullen, and Jane Tilly, American Association of Retired Persons; Carroll Wendland, Ph.D. and Glen Duncan, Beverly Foundation; Cynthia Fuller, Florida Department of Insurance/Treasurer; Alice Clamp, John Mathews, Shirley Nagelschmidt, Susan Van Gelder, and Karen Williams, Health Insurance Association of America; Kim Bellard, Prudential Insurance Company of America; Linda Schofield, Traveler's Insurance Company; and Martha King, Bob Pierce, and Candace Romig, National Conference of State Legislatures.

Others who provided special assistance include:

S. David Childers, Arizona Department of Insurance; John Coniff, Washington legislative staff; Ginny Felice, Massachusetts Special Commission on Elderly Health Care; Senator Helen Garrett, Kentucky; Lawrence Kirsch, Consumer Health Advocates, Inc.; Larry Lane, InSpeech, Inc.; Senator Eric Petty, Minnesota; Roy Ray, Texas State Board of Insurance; Lloyd Rice, Illinois Department of Insurance; Harlan Tanaka, Hawaii Insurance Commissioner's Office; David Walker, Washington Insurance Examiners Office.

Special thanks to Joanne Ourada for typing the manuscript and Sharon Schwoch for editing it.

Preparation of *What Legislators Need to Know About Long-Term Care Insurance* was sponsored by the Beverly Foundation, the Health Insurance Association of America, and the American Association of Retired Persons Women's Initiative. The National Conference of State Legislatures is solely responsible for its content.

May 1987

Introduction

Long-term care insurance is an emerging private financing mechanism for long-term care services—those services required due to a chronic illness or a condition lasting over a prolonged period of time. Currently, through the Medicaid program, government payment for long-term care is available only for the poor. Individuals not qualifying for Medicaid generally use their own assets until they are exhausted. State governments are searching for ways to reduce the burden of Medicaid expenses and to halt the financial drain on individuals. Long-term care insurance and other private financing mechanisms for long-term care represent a group of possible solutions to the problem.

State governments are also responsible for insurance regulation and consumer protection. Having begun to assess the need for regulation of long-term care insurance, states are finding that such regulation raises some difficult issues. Because long-term care insurance is relatively new, insurers consider it a financially risky

venture. Some state attempts to protect consumers and regulate the insurance market raise the possibility that insurers may withdraw from the state rather than operate under conditions of increased financial risk. Each state must balance the need to protect consumers against the possibility of losing any potential benefits of long-term care insurance. States also may want to take action promoting the purchase of long-term care insurance.

This booklet discusses the potential importance to states of long-term care insurance, describes general policy characteristics, and summarizes state actions to both regulate and promote long-term care insurance. It is intended as a resource for both legislators and others involved in long-term care financing and public policy formulation.

What Are Long-Term Care Question and Long-Term Care One: Insurance?

Long-Term Care

Long-term care refers to a broad spectrum of medical and support services provided to persons who have lost some or all capacity to function on their own due to chronic illness or condition and who are expected to need such services over a prolonged period of time.¹

As used in this booklet, *long-term care* does not include short-term rehabilitative care, whether provided in nursing homes, other institutional settings such as extended care or rehabilitation units of acute care hospitals, or individuals' own homes. In contrast to acute care, long-term care typically requires less technical and intensive medical treatment. Nurses, nurses aides, rehabilitation and other specialists, and persons providing homemaker services play key roles. Physicians are less prominent than in acute care.

There are three different levels of long-term care:

- *Skilled nursing care* – nursing and rehabilitative services given by skilled health personnel on a daily basis, under orders of a physician;
- *Intermediate care* – the same as skilled nursing care, except that procedures may be performed on an occasional basis; and
- *Custodial/personal care* – assistance in activities of daily living that can be provided by persons without medical skills.²

Although there is general agreement on the existence of the three levels of care, insurers, government officials, and other groups all define the three levels differently.

All three levels of long-term care can be provided in nursing homes or in patients' own homes. The cost for each type of care, however, may vary by the setting. In 1984, approximately 20 percent of persons receiving long-term care resided in nursing homes, with the remainder living at home. Of those in their own homes, 75 percent were maintained solely through the efforts of unpaid caregivers such as family, friends, and volunteer community workers.³

The elderly (over age 65) population, the primary users of long-term care services, will increase in the future. By the year 2000, the number of elderly (over age 65) persons will have increased by 37 percent over the number in 1980.⁴ As a percentage of total population, the elderly will increase from 11.3 percent in 1980 to 13.1 percent by 2000.⁵ Increasing longevity will swell the over-85 age group, those elderly most likely to need long-term care. The number of persons over age 85 in the year 2000 will be 129 percent higher than the number of persons in the same age group in 1980.⁶ It is estimated that on any given day in 1978 22 percent of those over 85 resided in nursing homes, compared with 7 percent of the age 75 to 84 population and only 2 percent of the age 65 to 74 population.⁷

The need for long-term care services will reflect the growth in the elderly population. The number of elderly persons with limitations of activity due to chronic conditions is projected to increase 38 percent between 1978 and 2003, assuming current mortality rates.⁸ Should mortality rates

continue to decline, the increase could be as high as 64 percent.⁹ Nursing home utilization is projected to rise by between 62 percent and 125 percent in the same time period, depending on whether mortality rates remain constant or decline.¹⁰

Long-Term Care Insurance

Long-term care insurance is insurance intended to cover long-term care services. The definition of long-term care used in this publication excludes short-term rehabilitative or acute care services. Consequently, the definition of long-term care insurance excludes insurance intended primarily to cover short-term care, such as Medicare supplemental insurance covering Medicare deductible and coinsurance payments. (See Question Four for a complete discussion of the Medicare nursing home benefit.) Existing long-term care insurance policies cover long-term care services exclusively, but long-term care insurance eventually may be sold as part of a more comprehensive health or life insurance package.

Policies now on the market have the following general characteristics:

- Coverage for nursing home care (almost always skilled nursing care, sometimes intermediate or custodial level care) and sometimes for home health care services. Benefits are paid up to a specified maximum number of days, home visits, or dollars, and often are contingent on a prior stay in a nursing home or hospital.
- Indemnity benefit payments. Policyholders receive a specified amount of money per day or per home visit, regardless of the actual expenses incurred. Policyholders then are responsible for paying providers of care, making up the difference between insurance receipts
- Benefit or coverage limitations. Long-term care required for certain conditions, such as alcoholism or mental illness, may be excluded entirely from coverage. Care for other medical conditions diagnosed or treated before the policy is purchased ("pre-existing conditions"), such as heart disease or stroke, may be covered only after a waiting period of between three months and one year. Policyholders generally pay for a minimum number of nursing home days or home health visits before benefit payments can begin ("elimination periods").

and charges incurred out of their own funds. Some policies escalate the amount of the indemnity payment each year the policy is in force, charging a higher premium for this option.

Should current policies achieve satisfactory results, insurers can be expected to broaden their offerings to include policies with wider coverage and fewer exclusions and limitations.

Estimates of the number of insurers offering long-term care policies range as high as 35.¹¹ At least one policy is available in every state. Between 130,000¹² and 200,000¹³ policies are estimated to be in effect.

Long-term care insurance helps consumers pay for long-term care by spreading the risks and the costs over large numbers of persons. There also exist two types of asset accumulation programs (not discussed further in this publication) that help consumers generate funds to pay for long-term care services by themselves:

- Asset accumulation programs targeted to health care. These include life insurance with pre-death long-term care benefits and "individual medical accounts" ("medical IRAs") that allow individuals to save their own money to pay for future health care expenditures. These are largely proposals at this time. Only one state, Colorado, has enacted legislation recognizing individual medical accounts,¹⁴ and no insurers currently offer life insurance with long-term care benefits.

- Asset accumulation programs not targeted to health. These include life insurance cash value savings, pension accumulations, and reverse annuity/mortgage programs that allow individuals to convert their equity in real property or other assets into monthly income. These programs supply unrestricted income that individuals may use for any purpose, including health care. All are widely available except for reverse annuities/mortgages, which are available only in certain states and localities.

Accumulated assets also could be used to purchase long-term care insurance rather than long-term care services directly.

Question Two: Why Is Long-Term Care Insurance an Important Issue for State Legislators?

Long-term care insurance has the potential to reduce state Medicaid expenditures by decreasing the number of persons who are forced to rely on Medicaid to pay their nursing home and home health care costs. A major study of private financing of long-term care, conducted by ICF Incorporated for the U.S. Department of Health and Human Services, estimated that long-term care insurance could reduce Medicaid nursing home expenditures by between \$3 billion and \$9 billion annually over a 35-year period (depending on the

assumptions used to estimate how many persons would purchase long-term care insurance).¹⁵ These dollar amounts represent reductions of between 8 and 23 percent in annual Medicaid nursing home expenditures.¹⁶ Another study, done by The Brookings Institution using different assumptions, estimated a maximum average 5 percent reduction in Medicaid expenditures in the years 2016 to 2020.¹⁷ Reductions might increase, however, in subsequent years.

Medicaid expenditures are one of the fastest growing components of state budgets. Between 1975 and 1981, state-only Medicaid costs increased from 5.6 percent of all state expenditures to 7.7 percent.¹⁸ Long-term care expenditures are a significant component of Medicaid expenditures. Nursing home care is the second largest expense in the national Medicaid budget after hospital care, accounting for 37 percent of total state-funded Medicaid expenditures in 1985.¹⁹ Between 1980 and 1985, total Medicaid nursing home expenditures increased from \$9.8 billion to \$14.7 billion, a 10 percent annual increase, growing faster than any other part of the Medicaid budget except hospital care.²⁰ The predicted increase in the over-65 population and the especially large increase in the over-85 population are expected to accelerate the rise in Medicaid expenditures.

The present, near-exclusive reliance on Medicaid and private financing for long-term care raises additional public policy concerns about access to care and family impoverishment. In 1985, payments out of personal funds accounted for 53 percent of all long-term care services purchased in nursing homes while Medicaid covered 42 percent.²¹ Medicaid recipients may find it difficult to gain admission to Medicaid-certified nursing homes because their operators prefer patients who pay privately, generally at rates higher than those Medicaid pays. This is especially true for patients requiring intensive and technically difficult care and in states where bed supply has been strictly controlled by certificate of need programs.

Medicaid recipients are excluded entirely from nursing homes that choose not to be Medicaid certified. Medicaid emphasizes institutional long-term care, and many state programs provide only limited home health care. Finally, the pressure on legislatures to reduce state budgets makes Medicaid recipients vulnerable to future benefit cuts.

Private-pay patients incur nursing home charges that average \$67 per day, or nearly \$25,000 annually.²² Many exhaust their resources. One study, using computer simulations, estimated that between 40 and 72 percent of the persons entering nursing homes as private-pay patients would spend down to Medicaid eligibility levels within six months of admission.²³ Between 55 percent and 82 percent would do so within one year of admission.²⁴ For elderly couples with one spouse in a nursing home, the depletion of assets for long-term care also impairs the remaining spouse's ability to live independently. This problem of spousal impoverishment has been of special concern to state legislators, and states have begun searching for ways to limit the amount of assets that must be spent before becoming eligible for Medicaid.

Question Three: What Types of Long-Term Care Insurance Policies Are Available?

Long-term care insurance is a relatively new phenomenon, and policy offerings will be refined continually over the next few years. While policies on the market differ in a number of ways, they share some general features.

Benefits

Nursing Home Care

Coverage for nursing home care is the principal component of almost all long-term care insurance policies. Generally, a specified dollar amount per day is paid for a maximum number of days (most frequently three or five years) in a state-licensed nursing home. Some policies impose lifetime maximum limits on total days of care paid for or total reimbursement dollar amounts or both. Almost all policies cover skilled nursing care. Some also cover intermediate or custodial level care. Benefit payments often differ by type of facility or level of care.

Most policies include provisions designed to reduce induced demand – the tendency of policyholders to use more services because insurance pays some or all of the costs. These provisions may require, for example, that covered nursing home care be preceded by a minimum length of stay in a hospital (usually three days), or that care be certified by a physician as "medically necessary." Elimination or deductible periods before benefit payments begin serve a similar purpose. Policyholders are discouraged from unnecessary

nursing home use, since they must pay the initial charges themselves until benefit payments begin. Elimination periods also screen out nursing home stays intended more for short-term rehabilitation or posthospital recovery.

Adverse selection – the tendency of high-risk or already-ill persons to seek insurance – is reduced by applicant screening, which all insurers writing individual policies have the right to do. Many policies exclude coverage for alcoholism, mental retardation, or mental illness not of organic origin. For insurers, these exclusions represent high-risk coverages since they are difficult to define in an insurance policy and use of services is difficult to manage effectively. Other pre-existing conditions (conditions diagnosed or treated prior to purchase of the insurance), such as a recent stroke or diagnosed Alzheimer's disease – the existence of which could encourage already-sick individuals to seek insurance, generally are covered only after a waiting period, typically six months.

Home Health Care

Some policies cover home health care. Home health coverage is not universal because insurers are less able to protect themselves against adverse selection and induced demand. There is no general agreement on the services included in home health care and the need for such care is more difficult to judge objectively. Policies covering home health care differ in the scope of covered services. Some cover only those services provided by licensed health care personnel: rehabilitation services such as physical, speech, and occupational therapy; and nursing services

such as injections, wound dressing, and intravenous fluid administration. Policies with broader coverage also may include personal care services intended to assist with activities of daily living: bathing, routine physical exercise, walking, eating, and monitoring of medication use.

All policies limit the number of home health visits or days of home health care covered. Most policies include provisions to guard against adverse selection and induced demand similar to those applied to nursing home benefits. Use of home health benefits may be contingent on a prior nursing home stay, for example.

Payment Mechanisms and Premiums

Individuals who have purchased long-term care insurance have done so at about the same time they perceived the need—in middle to late life. Policies typically have a minimum age of 55 or 60.²⁵ If clients would purchase at a younger age, insurers could reduce annual premiums since they would have a longer payment period to build up funds to pay benefits. However, since even elderly individuals often do not see the need to purchase long-term care insurance (see Question Four), purchase by younger individuals does not appear likely without employer-sponsorship or changes in public attitudes.

Long-term care insurance premiums vary depending on the policyholder's age. "Level premium" policies have premiums that are determined by the policyholder's age at the time of purchase and remain the same as long as the policy remains in effect. "Graduated premium" policies increase the annual premium as the policyholder ages. Premiums for these policies are lower for younger individuals than those of the level premium policies but are higher for older persons. In addition to age, scope of covered services, the length of elimination periods before benefits can begin, the length of time benefits will be paid, and the amount of the daily benefit payment all influence the premium amount. Insurers often reserve the right to increase

premiums for whole classes of policyholders based on changes in benefit utilization. A comparison of nine relatively comprehensive policies published in March 1986 showed that monthly premiums ranged from \$28 to \$37 at age 55 to from \$106 to \$148 at age 75.²⁶

Most long-term care policies are sold on an individual, rather than a group, basis. Experts generally agree that premiums would decrease with a shift to group long-term care insurance. Group insurance covers larger numbers of persons allowing insurers to spread the risks more broadly and offering greater protection from adverse selection. Most group insurance, however, is employer based, and numerous obstacles exist to offering long-term care insurance as a component of employers' benefit packages.²⁷ Younger employees generally are not interested in long-term care insurance, preferring more immediately useful benefits such as longer vacations. Court decisions and existing legislation may restrict an employer's ability to alter benefits of current retirees, limiting the freedom to reallocate funds to new benefits for active workers. Tax laws do not provide favorable tax treatment for the expenses of pre-funding retiree health benefits such as long-term care insurance. Finally, accounting standards soon may require companies to show unfunded retiree health benefits as balance sheet liabilities. Long-term care insurance benefits for retirees ultimately could cost much more than expected given the difficulty of accurately estimating future expenses of providing such care. Despite these obstacles, some employers are considering long-term care insurance benefits for employees.

Combining Long-Term Care Insurance with Other Forms of Insurance

While existing long-term care insurance policies cover long-term care exclusively, there is no reason why long-term care insurance could not be part of a broader life or health insurance policy. An experimental program offering both acute care and long-term care services on a capitated basis is being tested in four locations (Long Beach, California; Portland, Oregon; Minneapolis, Minnesota; and Brooklyn, New York), with technical assistance paid for by the U.S. Department of Health and Human Services. Labeled "social" health maintenance organizations (S/HMOs), these are traditional medical HMOs that also provide long-term care (nursing home, home health) and social services (homemaker and case management services) to Medicare beneficiaries for limited amounts of time. S/HMOs combine insurance and service provision in a single entity. Since S/HMOs must provide all necessary services for a set monthly fee, they have a strong incentive to provide services in the most cost-effective manner. This could mean substituting less expensive nursing home care for hospital care, and home care for nursing home care, wherever possible. The S/HMO structure also should help control induced demand. Since the S/HMO controls access to care, it should be able to manage and coordinate service use and reduce inappropriate utilization. Since these experimental programs only began operation in 1985, it is too early to judge their success. Should they succeed, however, capitated systems will offer another mechanism for combining long-term care financing and services with acute care and Medicare supplemental benefits in a managed care environment.

Life care communities, in which persons are guaranteed a lifetime residence and long-term care services in return for an initial payment and continuing monthly fees, are a form of long-term care insurance. Some life care communities provide nursing home and home health services using their own employees; others contract with outside entities for the provision of services. In 1984, between 55,000 and 100,000 persons nationwide were believed to reside in life care communities.²³

Long-term care insurance also could be incorporated into a life insurance policy. Policyholders generally would begin paying premiums at a younger age than current long-term care insurance purchasers. Policy benefits would be similar to those available under existing life insurance policies, except that a long-term care insurance coverage option would be available at the time the policyholder chose to begin benefit payments. A number of insurers are developing such policies. A first step in this area is the Office of Personnel Management's recent proposal that certain older federal employees be allowed to convert a portion of their life insurance to long-term care insurance.

Question Four: What Are the Barriers to the Expansion of Long-Term Care Insurance?

Barriers to the expansion of long-term care insurance exist both among potential purchasers and among insurers. Elderly consumers often do not see a need for long-term care insurance or believe they already are covered in the event they need to use long-term care services. At the same time, many insurers view long-term care insurance as risky and potentially unprofitable, given the nature of the product and the absence of historical experience on which to calculate premiums. Governmental actions (discussed in Question Five) also have influenced the availability of long-term care insurance.

Consumer Disinterest Toward Long-Term Care Insurance

Among the over-55 population, the rate of purchase of long-term care insurance is low. Of a potential market of approximately 50 million persons over age 55 in 1985, only 0.3 to 0.4 percent had such coverage. If long-term care insurance is to become a viable financing mechanism for long-term care, the reasons for this low rate of purchase must be understood.

Market research data do much to explain consumers' low level of interest. The findings of two surveys are especially relevant: the Long-Term Care Insurance Survey, a 1982 six-state survey of 1,403 elderly persons done by the National Center for Health Services Research; and the American Association of Retired Persons (AARP) Survey of 1,009 AARP members nationwide, done by the Gallup Organization in 1984.²⁹

The research data indicate that many of the beliefs and expectations of the elderly that discourage purchase of long-term care insurance are incorrect. A common misconception concerns the probability of needing long-term care services in later

life. Long-Term Care Insurance Survey results indicate that older persons may underestimate the likelihood of needing nursing home care. While 24 percent of the respondents believed that the average person in their age group was "very likely" to require long-term care in the future, only 15 percent believed it "very likely" that they themselves would ever need long-term care.³⁰ By contrast, some researchers estimate the likelihood the average person age 65-69 will ever use at least one day of nursing home care to range from 31 percent for men to 52 percent for women.³¹

Survey results also show that the elderly are not thoroughly familiar with existing insurance benefits, believing that Medicare will pay for most long-term care services. Among respondents to the AARP Survey who believed they would need long-term care, 79 percent believed Medicare would pay all or part of their nursing home charges.³² In fact, Medicare coverage criteria are very stringent: no more than 100 days of skilled nursing care in a Medicare-certified skilled nursing facility following a three-day minimum hospital stay, and then only when a physician certifies that the patient requires skilled nursing care. Consequently, the average covered nursing home length of stay for Medicare patients in 1980 was less than 30 days, compared with an average length of stay for all patients of 456 days.³³ Medicare pays in full only the first 20 days of nursing home care; the beneficiary must pay the first \$65 (in 1987) in charges for each of the remaining 80 days. As a result, Medicare's role in long-term care delivery is insignificant. Medicare accounted for only 2 percent of total payments to nursing homes in 1985.³⁴ Only about 30 percent of

all licensed nursing homes in the United States were certified to accept Medicare patients in that year.⁴⁵

Additional data confirm the relative lack of knowledge about insurance coverage. Only 33 percent of the Long-Term Care Survey respondents were considered to have "solid" knowledge of their Medicare benefits, based on answers to a set of six Medicare-related questions.⁴⁶ AARP Survey respondents overestimated their insurance coverage for long-term care; 35 percent believed their insurance policies covered long-term care, when in fact they did not.⁴⁷

Underlying attitudes toward long-term care also may play a role in consumers' reactions to long-term care insurance. A more psychologically oriented study found that individuals viewed contingency planning for long-term care as "an overwhelming, solutionless problem."⁴⁸ Study participants felt they were unable to plan for the future because they had little control over future events and because they had little credible information about the costs of long-term care and ways to meet those costs.

Some have argued that the availability of Medicaid may discourage the purchase of long-term care insurance since older persons willing to "go on welfare" will not buy the insurance. There are contradictory findings on attitudes toward welfare. The AARP Survey showed that 62 percent of the respondents considered it acceptable for someone (not necessarily themselves) to accept Medicaid benefits when all other assets had been exhausted.⁴⁹ This attitude was more common among younger respondents. Only 19 percent of the elderly in the Long-Term Care Insurance Survey, however, indicated that the availability of Medicaid would prevent them from purchasing long-term care insurance.⁴⁰

A 1984 study of 1,000 members of the "prime life" generation, those age 50 to 64, showed disparate attitudes about responsibility for payment of nursing care after

age 65. While 35 percent of the respondents believed individuals had that responsibility, 31 percent believed the responsibility rested with government. Twenty percent indicated that responsibility should be shared.⁴¹

Another consumer-related deterrent to the growth of long-term care insurance has been the relatively high cost of premiums compared with the average income of the elderly population. Many of the elderly have relatively low incomes, leaving little after costs of food and shelter have been met. What discretionary funds are available for health care usually go for Medigap insurance and noncovered items such as pharmaceuticals and eyeglasses. Thus, some elders may not have enough income to pay long-term care insurance premiums.

Insurer Disinterest in Long-Term Care Insurance

Until recently, there was relatively little interest in long-term care insurance among insurance companies and few policies were available. Insurers generally regarded long-term care by its very nature to be an uninsurable risk, for a number of reasons:

- Individuals' future use of long-term care services is difficult to predict because the factors that influence such use are difficult to measure and quantify. Medical and physical conditions alone do not determine use of long-term care services. Of two persons with the same level of physical or medical disability, only one actually may seek formal long-term care services. Personal preference, availability of family and other social support networks, financial status, and other variables all influence a person's decision to seek long-term care services. Insurers cannot measure these factors accurately and thus find it difficult to calculate the risk of individuals' using long-term care and to determine appropriate premiums.
- Long-term care itself is difficult to define for insurance purposes. Should routine help with bathing

and dressing at home be considered long-term care services? What about nursing home care provided during a three-month recovery from a broken hip? Lack of a clear definition of long-term care makes it difficult to calculate risks to the insurer accurately.

- Adverse selection is more difficult to control in the case of long-term care because of the difficulty of predicting who will use long-term care services. The lower cost of insurance compared with the actual cost of health care, however, can be maintained only if adverse selection is controlled and a relatively small proportion of policyholders actually use benefits. Insurers' failure to limit adverse selection may result in financial losses since long-term care is relatively expensive and also may force premiums up to unaffordable levels.
- Induced demand increases the use of long-term care services. This problem would be most severe for noninstitutional services, where judging appropriateness of services is most difficult. As with adverse selection, uncontrolled induced demand would result in greater than expected utilization of services and possible financial losses for insurers.
- Establishing policy coverages and corresponding premiums in the present for benefits that may be paid far in the future can be risky without reliable historical data. An individual purchasing a policy at age 55 may not collect benefits until age 75 or 80. Future changes in circumstances, such as use of more nursing home care and less home health care, can have a large negative impact on insurers in the future.

Indeed, one of the greatest barriers to insurer participation has been the lack of reliable data on which to base product development and premium-setting decisions. Two types of data in particular are lacking: data on the need for, and use of, long-term care services in the population as a whole, especially in an

insured environment; and studies of attitudes and desires of the elderly population.

The first type of data—information on the use of nursing home and home health services by various population groups over time—is needed for pricing long-term care insurance products. Insurers also need more information on the factors that cause persons in need to seek long-term care services so they can calculate the risks of service use accurately and price the premiums accordingly. Such data are not readily available now.

The potential value of the second type of data is illustrated by the AARP Survey. In that survey, 77 percent of the respondents said they would prefer a long-term care plan covering home health care to one covering nursing home care.⁴² Yet, home health care benefits are not universal. Such studies are indispensable if products acceptable to the buying public are to be brought to the market.

Reducing Barriers to Long-Term Care Insurance

A number of steps must be taken if these barriers among consumers and insurers are to be reduced. Education and information programs will be needed to increase consumers' awareness and understanding of current long-term care financing mechanisms and the potential role of long-term care insurance. Among insurers, recent events already have stimulated interest in the long-term care insurance concept. Insurance companies have recognized the older population as a potentially profitable new market due to its increasing numbers and affluence (see Question Seven). Insurers are beginning to recognize that while long-term care may be a difficult risk to insure, there may be ways to counteract adverse selection, induced demand, and other uncertainties that threaten the financial viability of long-term care insurance. Finally, insurance companies and government will need to begin collecting the necessary market research and utilization data. The end result should be policies constructed and priced to better meet the expressed needs of consumers.

Question Five: What Have States Done to Regulate the Sale and Content of Long-Term Care Insurance Policies?

To date, few states have enacted laws regarding the sale or content of long-term care insurance policies specifically. Several others have seen some legislative activity but no significant enactments. Still others have initiated studies in the legislative or executive branches to make recommendations regarding long-term care insurance. States with studies in progress or completed are Alaska,³³ Arizona,⁴⁴ California, Connecticut, Florida, Georgia,⁴⁵ Hawaii,⁴⁶ Massachusetts,⁴⁷ North Carolina, Texas, and Virginia (citations are given for completed studies only).

The states have primary responsibility for overseeing most activities in the insurance market. The McCarran-Ferguson Act of 1944 affirms the primacy of the states in regulating the insurance industry and limits federal government activity. Generally, state regulation is performed by agencies of the executive branch using statutorily delegated authority to promulgate necessary rules and regulations.

Consumer protection has been the driving force behind state actions to regulate long-term care insurance. State regulation has focused on two areas: the manner in which policies are sold to consumers and the financial attributes of policies and insurers ("performance-based" aspects of the insurance policies); and the specific provisions contained in the policies being sold ("product-based" aspects).

The National Association of Insurance Commissioners (NAIC) recently published a Long-Term Care Insurance Model Act intended to serve as a basis for state regulation of long-term care insurance. The model act relies on both performance-based and product-based regulation.⁴⁸

The following discussion of state regulatory actions is not intended to be a complete listing. Rather, it describes sample enactments and proposals representing approaches to long-term care insurance regulation. Provisions of the model act also are discussed.

Regulating Performance-Based Aspects of Long-Term Care Insurance

Insurance regulators in all states are empowered to promulgate regulations protecting purchasers of insurance. As a result, numerous performance-based requirements intended to protect all purchasers, including those who buy long-term care insurance, already exist. These generally cover:

- Authorization of insurance companies to sell insurance in a state;
- Licensure of insurance salesmen;
- Approval of specific policy wording and format for understandability;
- Disclosure of policy benefits and limitations;
- Specification of conditions under which buyers may return previously purchased insurance (termed "free look" provisions);
- Review of advertising and marketing materials;

- Required notification of rate changes;
- Imposition of financial solvency and reserve requirements to assure that insurance companies can meet future obligations to policyholders.

In addition to these generic consumer protections, some states have enacted or proposed specific measures applicable to long-term care insurance. A common action, derived from existing insurance regulation, is the establishment of minimum loss ratios for policies. A loss ratio is the proportion of premium income from a particular type of policy projected to be ultimately paid back to policyholders in the form of benefits. The lower the loss ratio, the more premium income the insurance company retains for operating expenses and profit. Establishment of a minimum loss ratio attempts to assure that premiums will be fairly and reasonably related to the cost of benefits by making certain that a minimum portion of every premium dollar received will be paid out in benefits. Connecticut and Minnesota have established minimum loss ratios for long-term care insurance by statute: 55 percent and 60 percent, respectively, for individual policies, and 60 percent and 65 percent, respectively, for group policies. Maine and Washington have elected to give authority to insurance regulators to set minimum loss ratios by regulation.⁴⁹ The model act allows regulators to prescribe minimum loss ratios as long as they are specifically for long-term care insurance.

Minimum loss ratios have been opposed by the insurance industry because the proposed ratios generally are higher than the industry believes is warranted, given the level of risk and uncertainty in pricing involved. Because long-term care insurance is relatively new, insurers argue, there is no experience on which to base judgments about appropriate loss ratios. Also, imposition of unreasonable loss ratio requirements during the next 10 to 20 years of long-term care insurance "start up" could prevent insurers from building up the reserves necessary to pay future claims. Low loss ratios will occur because the majority of today's purchasers will not begin to claim benefits until 10 or 20 years

from now, and insurers will be collecting premiums in anticipation of future benefit payments but paying relatively little in benefits. Insurers claim that the result would be long-term financial losses and that they might have to withdraw from the market rather than run the risk of selling potentially unprofitable policies.

Limiting insurers' ability to cancel policies has been another common legislative action. Minnesota and Washington prohibit cancellation of policies except in the case of nonpayment. South Dakota has considered, but not passed, similar legislation. The model act prohibits cancellation of policies for reasons of age or health status.⁵⁰ Advocates of noncancellation provisions argue that it is unfair to allow policyholders to pay premiums for years only to have the policies cancelled in later life when benefits are most likely to be paid.

In another type of consumer protection action, Washington prohibits sale of long-term care insurance policies to persons already receiving Medicaid assistance. This action was taken in an effort to stop the unethical practice of knowingly selling insurance policies to persons who do not need them.

Regulating Product-Based Aspects of Long-Term Care Insurance

As with performance-based regulation, the goal of product-based regulation has been consumer protection. Product-based regulation has caused more controversy, however, than performance-based regulation because its potential impact on market development and on the financial condition of insurers is greater.

Product-based regulation has focused on requiring minimum benefits for long-term care insurance policies and prohibiting inclusion of certain provisions. Examples of minimum benefit provisions either approved, or considered but not approved, include:

- Minimum daily payments for nursing home or home care.

In Minnesota, the statutorily prescribed minimums are \$40 to \$60 per day for nursing home care and \$20 to \$25 per day for home care.⁵¹ Other unsuccessful state proposals would have tied the minimum payments to other indicators. New Jersey would have required that the daily home care benefit equal 75 percent of the daily nursing home benefit.⁵² Kansas would have mandated that the daily nursing home benefit be no less than 75 percent of actual charges.⁵³

- Coverage of specific services.

Kentucky requires that skilled, intermediate, and custodial care all be covered by at least one policy offered by each insurer. A number of states have proposed that specific services be covered, such as respite care ("short-term" long-term care intended to give family members a break from attending elderly relatives at home) and home care. Maryland indirectly addresses long-term care coverage by requiring health insurers to offer optional coverage for Alzheimer's disease, the later stages of which require long-term care, and any other care required by the elderly and mandated by the insurance commissioner.⁵⁴

- Minimum numbers of nursing home days or home care visits.

Kansas and New Jersey considered, but did not pass, such provisions. Kansas proposed a two-year minimum for nursing home benefits; New Jersey, a three-year minimum.

Some states have enacted, or have considered but not enacted, prohibitions on certain policy provisions. These include:

- Prohibiting deductible or copayment amounts above specified levels.

Minnesota limits copayments to 20 percent of actual charges. Kentucky requires insurers to offer at least one policy with copayments no more than 25 percent of actual charges.

- Prohibiting exclusion from coverage of pre-existing conditions for longer than specified maximum times.

Generally, medical conditions that were diagnosed or treated within a specified time immediately prior to commencement of the policy are excluded from coverage for a specified time period immediately following commencement of the policy. Washington law specifies that only medical conditions that were diagnosed or treated within one year prior to policy commencement can be excluded, and then only during the first six months following commencement. The model act uses standards of "two years before commencement-two years after commencement" for policyholders under age 65 and "six months before commencement-six months after commencement" for older policyholders. An unsuccessful South Dakota proposal would have limited the definition of pre-existing conditions to only those for which treatment was received within six months prior to the effective date of the policy. This proposal would have prohibited exclusion of coverage for conditions present but not treated in the six-month period.

- Prohibiting the requirement of a prior stay in a hospital as a condition of nursing home benefit payments.

Kentucky has enacted this prohibition and also proscribes requiring prior care at the skilled nursing level as a condition of

payment of benefits for intermediate level nursing home care.⁵⁵ Kansas and New Jersey considered, but did not enact, such a provision.⁵⁶

The practices targeted by these prohibitions are those used by insurance companies to protect themselves from adverse selection and induced demand. The public, however, sometimes sees them as ways of unfairly preventing policyholders from claiming benefits to which they are entitled.

States that have acted to regulate the content of long-term care insurance policies have taken a variety of approaches in allocating responsibility between the legislative and executive branches of government. Kentucky, Minnesota, and Washington have enacted relatively extensive and specific statutes, leaving less discretion to regulators.⁵⁷ On the other hand, Maine statutes delegate all regulatory authority to regulators.⁵⁸ Some states, such as Arkansas and Wisconsin, have enacted no statutes, but insurance regulators have used existing authority to promulgate long-term care insurance regulations.

Regulation of policy content has been controversial. Proponents argue that the state is obligated to protect consumers from the sale of insurance policies that do not provide meaningful benefits. The elderly, the primary target of long-term care insurance marketing, are particularly vulnerable to deceptive and misleading sales practices. They are not always well informed about the long-term care delivery and financing system or its associated costs. The highly publicized fraud and abuse associated with Medigap policies are cited as a reminder of what can happen when states fail to safeguard the interests of the elderly population. For all these reasons, proponents claim, it is necessary to set minimum benefit levels and prohibit certain provisions, thus preventing the sale of inadequate policies that do not provide the coverage for which consumers believe they have paid.

Opponents of product-based regulation claim that state prescription of policy content limits the flexibility of insurers to adapt their offerings to changing market conditions. Persons desiring relatively low benefit levels or only one kind of coverage, such as nursing home or home health care, will be forced to pay higher premiums for coverage they do not want. Low-income persons may have to do without insurance entirely because they cannot afford the higher premiums insurers must charge for the state-mandated minimum benefits. A second argument is that development of long-term care insurance currently entails excessive financial risk and that imposition of minimum benefit levels and other regulatory requirements will discourage insurance companies fearful of future financial losses. The end result will not be consumer protection but nonavailability, or limited availability, of long-term care insurance.

The States' Experience with Long-Term Care Insurance Regulation

The experience of states that have attempted to regulate long-term care insurance indicates that insurers are highly sensitive to some statutory or regulatory requirements that pose potential financial risks. In general, the insurance industry has supported performance-based regulation. The Industry Advisory Committee on Long-Term Care of the National Association of Insurance Commissioners supported a position of "regulatory flexibility," but with consumer protection safeguards.

Most problems have arisen when states have acted to regulate policy content. An extreme example occurred in Wisconsin. The insurance commissioner, motivated by complaints from policyholders failing to receive benefits to which they believed they were entitled, decided that existing regulations did not protect consumers

sufficiently. He concluded that the most effective way to reduce the number of complaints was to require all policies to provide a minimum level of benefits and to prohibit certain policy provisions limiting benefits. Consequently, the commissioner issued a relatively stringent set of regulations that, among other things, prohibited use of a prior hospital stay as a precondition for payment of nursing home benefits and required insurers to pay for all days of care certified only as "necessary," rather than as "medically necessary." To the insurers, this meant paying benefits for long-term care services that might be necessary for nonmedical reasons, such as social isolation, in addition to those services required due to illness or accident. These requirements increased the likelihood of induced demand since the need for long-term care due to nonmedical factors is difficult to judge objectively or to predict with any reliability. The result was that all but one insurer discontinued sales of long-term care policies in the state, and this insurer did not market this policy actively. The state now has promulgated a revised set of regulations.

Whether Wisconsin and other states are better off with more stringent regulations and fewer insurers or more liberal regulations and more insurers, is a question for each to decide individually. Wisconsin policymakers apparently concluded at the time that it was preferable to have a small number of "good" policies available rather than a large number of policies that did not meet policyholders' expectations. In other states, the opposite may be the case. What the Wisconsin experience demonstrates is that states face difficult tradeoffs in considering proposals to regulate long-term care insurance.

States must balance consumer protection against insurers' avoidance of markets where they perceive inordinate financial risk. State studies of long-term care insurance have emphasized finding a middle ground where consumers are adequately protected and insurers still are willing to offer a variety of coverage. The Arizona and Georgia study commissions recommended no restrictions on long-term care insurers beyond already-existing consumer protections. Although the Massachusetts study called for minimum benefits, they were similar to those already offered in many existing policies. The authors also suggested requiring some policy features but avoided conditions they considered especially onerous to insurers, attempting to leave them free to experiment with new policy features. The National Association of Insurance Commissioners has published a model act intended to balance the interests of consumers and insurers.⁵⁹ The model act approach has the advantage of assuring uniformity of both performance-based and product-based requirements from state to state.

Federal Support of State Efforts

Despite lack of direct involvement with insurance, the federal government is interested in long-term care insurance. There have been numerous suggestions for extension of Medicare coverage to long-term care, and long-term care insurance is a potential private sector substitute. Also, budgetary reductions in Medicaid could result from widespread acceptance of long-term care insurance. The federal government has supported a number of research efforts and feasibility studies on long-term care insurance. The recently passed Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA, Section 9601) established the Task Force on Long-Term Health Care Policies to develop recommendations regarding consumer protection, consumer education, and promotion of long-term care insurance. The task force's report will be completed by August 1987.

Question Six: What Have States Done to Encourage the Sale of Long-Term Care Insurance?

States have taken little concrete action to encourage purchase of long-term care insurance. State actions that have been taken have been of two types: requiring insurers to offer long-term care insurance, and encouraging market development through incentives and consumer education. State actions involving requirements have mandated that all insurers offering health insurance also offer coverage for some long-term care services, either as a standard benefit or as an option. Kentucky requires all insurers—individual and group insurers, HMOs, and Blue Cross plans—issuing health policies to make available at least one long-term care policy.⁶⁰ Unsuccessful bills in Kansas, Massachusetts, and New Jersey have contained similar requirements. While this kind of requirement may increase the number of insurers offering long-term care coverage, policies offered might not be appealing to consumers. Critics argue that most insurers, fearing financial losses in long-term care insurance, will design unattractive policies with limited benefits and high premiums. Others may withdraw from the state. The upshot would be only a small increase in the number of policies sold and public dissatisfaction with long-term care insurance.

Other states have focused on encouraging long-term care insurance. New York has sought to promote policy availability by giving the superintendent of insurance power to "modify or suspend" certain statutory or regulatory requirements for experimental long-term care insurance policies.⁶¹ Other states have taken more specific actions. These include:

- **Preferential Tax Treatment for Long-Term Care Insurance Premiums**
Tax incentives to encourage particular actions are a common

strategy in many situations. In 1986, Colorado enacted an income tax deduction for long-term care insurance premium payments for policies meeting specified minimum benefit criteria.⁶² An unsuccessful Hawaii proposal would have allowed a tax credit equal to twice the amount of long-term care insurance premiums.⁶³ Tax incentives were rejected by Arizona's study commission, however, which argued they might hinder development of other incentive programs that would accomplish the same objective without reducing state tax revenues. No action has been taken at the federal level to give preferential treatment to premium expenses on federal income taxes.

- **Premium Tax Reductions for Companies Selling Long-Term Care Insurance Policies**
Reductions in premium taxes for long-term care insurance policies could encourage purchasers if part of the savings were passed on in the form of lower premiums. Lower taxes on long-term care insurance premium income also would encourage insurers to sell more long-term care policies since the premium income would be taxed at a lower rate. Colorado has been the only state to take this step, enacting a one percentage point tax reduction on long-term care insurance premium income.

■ Consumer Education About Long-Term Care Insurance

Consumer education programs on long-term care insurance are a frequently mentioned market development strategy. Such programs encourage wise buying and address consumer misconceptions about long-term care and its costs. Long-term care insurance studies in Arizona and Georgia have emphasized the importance of consumer education. The Washington state Insurance Commissioner's Office has established a separate senior citizens' program unit to oversee the state-sponsored Senior Health Insurance Benefit Advisors (SHIBA) program. Working through trained elderly volunteers, the SHIBA program conducts public meetings and media campaigns to educate elderly consumers about a range of insurance-related topics, including long-term care insurance. Topics covered include Medicare and Medicaid eligibility and program benefits, as well as comparison of available long-term care insurance policies. SHIBA also publishes a number of consumer guides for the elderly.

Additional materials from which states might draw in formulating consumer education programs are also available. A report prepared for the Massachusetts insurance commissioner contains a draft "Guide to Long-Term Care Insurance" describing Medicare and Medicaid benefits, materials to aid prospective purchasers in evaluating the adequacy of benefits, and a proposed disclosure statement to be given to purchasers explaining policies in uniform language.⁶⁵ The report done for the National Association of Insurance Commis-

sioners by an advisory committee of insurance industry representatives also contains a model consumer education booklet.⁶⁵ The booklet discusses topics similar to those covered by the Washington program. It also has a list of "Questions to Ask [About Long-Term Care Insurance]" and a glossary of long-term care terms. The American Association of Retired Persons also has prepared a consumer's guide to long-term care entitled "Making Wise Decisions For Long-Term Care."⁶⁶

■ Removing Barriers to Long-Term Care Insurance Availability

State laws written prior to the advent of long-term care insurance sometimes create unintentional barriers. Failure to define long-term care insurance as a separate category of insurance may cause it to be considered a form of disability, Medigap, or other supplemental insurance. The result may be the application of inappropriate regulatory criteria and discouragement of interested insurers. Minnesota prohibited sale to Medicare beneficiaries of all health or accident insurance except Medigap policies in an attempt to eliminate the sale of duplicative insurance policies to the same person. This prohibition made the sale of long-term care policies effectively illegal, however, an obstacle that was removed recently.

In some states, statutory definitions of group insurance may not include the insurance offered by HMOs and Blue Cross plans, making it impossible for them to offer long-term care insurance on a group basis. The public, however, may best be served by a wider selection of policies.

Legislators may want to review state statutes and reconsider those that restrict development of long-term care insurance. An unsuccessful

South Carolina proposal would have required the Department of Insurance to conduct a review of state regulations to be sure none discouraged long-term care insurance. The Arizona study commission conducted such a review and concluded that no additional laws or statutory revisions were necessary to encourage long-term care insurance. Review of the NAIC model act also may be useful in this regard.⁶⁷

■ **State Catastrophic Coverage for Long-Term Care Insurance Purchasers**

While not yet introduced as legislation, a proposal from the Massachusetts Special Commission on Elderly Health Care is noteworthy.⁶⁸ Under the proposal, the state would agree to assume financial responsibility for persons who purchase Medigap and long-term care insurance with specified minimum benefits, but who exhaust their benefits while receiving long-term care. No asset "spend-down" or other financial requirements would be imposed. Consumers would be encouraged to purchase long-term care insurance since they would be guaranteed future state protection without having to spend down their own funds when their insurance benefits ended. The state would benefit from substitution of private insurance coverage for Medicaid and postponement of Medicaid responsibility for payment. Whether this program is to be implemented through Medicaid or through some other program will depend on interpretation of existing Medicaid program regulations. The advantages and disadvantages of

such a plan in terms of access, quality of care, and cost to both consumers and the state are yet to be explored fully. A successful program of this nature, however, might hasten the spread of long-term care insurance by creating a large customer base and stimulating market entry by more insurers.

■ **State Participation as a Long-Term Care Insurer**

States could act as insurers when private insurance is not widely available. An unsuccessful California proposal would have created a Long-Term Care Association within state government to issue a long-term care insurance policy offering benefits specified in the statute.⁶⁹ The policy was intended specifically to supplement policies already available to consumers. It would have covered intermediate, personal, and home care, but not skilled nursing care, which generally is covered by policies now on the market.

■ **Long-Term Care Insurance Benefits for State Employees**

An additional proposal is for states to purchase long-term care insurance for their own employees and retirees. As pointed out in Question Three, however, legal and practical obstacles must be overcome if employers, including the states, are to offer long-term care insurance.

Question What Is the Future of Long-Term Care Insurance?

Long-term care insurance has a definite role to play in financing long-term care. The demand for long-term care services will increase in the coming years, and government and personal funds alone may be inadequate to pay the costs. A range of new funding mechanisms will be necessary, and long-term care insurance is important among these. Although it has achieved wide visibility only recently, there is growing interest on the part of insurers, consumers, and government. All three groups have incentives to promote its use, but all three groups must take action if long-term care insurance is to play a significant, meaningful part in the nation's long-term care financing scheme.

Insurers

Insurers see a new market for insurance in the growing over-55 age group. Between 30 and 40 companies currently offer long-term care insurance policies. Many more are developing policies for introduction in the next few years. Over 20 Blue Cross plans also are considering offering long-term care coverages. All this activity clearly indicates that insurer interest in long-term care insurance will continue to grow.

But the increased interest among insurers is accompanied by widespread uncertainty about the ultimate financial viability of long-term care insurance. Long-term care is difficult to insure by its very nature. There is little agreement on exactly what constitutes long-term care or on the definitions of the three levels of care. The probability that persons will use long-term care ser-

vices is not easily calculated, and adverse selection and induced demand are difficult to control. In addition to the inherent difficulties in insuring long-term care, there exist little historical data on which to calculate risks and price premiums. All these factors increase insurers' financial risks.

Insurers temper their interest with words of caution:

Long-term care insurance is in an embryonic state of development and as yet, it is not known which policy designs might work best. Established carriers are entering this market but products are in an evolutionary stage. The challenge of insurers is to establish benefit levels and premium charges in products which minimize insurance induced demand for services and adverse selection, which avoid stimulating increased provider charges, and which provide meaningful benefits to consumers.⁷⁹

Consumers

Existing long-term care financing alternatives do not always meet the needs of consumers well, so they have been motivated to seek other ways of financing long-term care. Individuals needing such care now must become Medicaid recipients immediately, or they must deplete most or all of their own assets on long-term care expenditures. Medicaid, however, provides little financial support for those desiring home health care, and consumer choice in selection of a nursing home is restricted. Those who must spend down their own funds suffer the loss of self-esteem accompanying the loss of self-sufficiency. Noninstitutionalized spouses may become impoverished paying the expenses of spouses receiving long-term care.

The lack of interest in long-term care insurance up to now may mean that the financial and other burdens of long-term care are not evident to consumers. Potential purchasers may be underestimating the risks of needing long-term care and may not be completely knowledgeable about the limitations of Medicare and Medigap insurance policies. Effective consumer education programs gradually might diffuse these misconceptions and help potential policyholders better assess the risk of needing long-term care and the role private insurance might play. Consumers need specific information regarding available long-term care financing options, planning for future needs, and the costs of long-term care. Long-term care insurance cannot reach its full potential without educated and aware consumers.

Affordability is also an obstacle to consumer acceptance. While the cost of long-term care insurance always will be too costly for many of the elderly, studies indicate that a larger proportion of the future elderly population will be able to afford long-term care insurance as it is presently sold. One study predicts that the proportion of elderly households with annual real incomes greater than \$20,000 will increase from 21 percent in 1980 to 31 percent in 1995.⁷¹

One solution to the affordability problem is purchase of long-term care insurance at an earlier age, when premiums are lower. A second possible solution may be group insurance, which offers lower premiums because risk is spread over a larger number of persons and adverse selection is reduced. Life insurance and similar capital accumulation vehicles incorporating long-term care insurance options, should they appear on the market, also might be less expensive than currently available exclusively long-term care policies because the premium payments would be spread over a longer time period of time. Barriers to consumer acceptance must be overcome, however, for these more inclusive options to be effective.

The need for consumer protection in long-term care insurance is a recurring theme. Consumer groups, legislators, and govern-

ment leaders alike have emphasized the importance of insuring that policyholders receive benefits commensurate with premiums paid, and that consumers fully understand the policies they purchase. The question here is what measures are needed to insure that consumers are protected adequately. AARP, speaking on behalf of its members, has taken the following position:

[States] should encourage the development of a range of private, long-term care insurance products by eliminating legal and regulatory barriers that impede this development. At the same time, states should protect consumers' interests by such actions as prohibiting fraudulent advertising, developing a buyer's guide, and providing public education about long-term care insurance.⁷²

State Government

To governments, long-term care insurance offers the possibility of reduced Medicaid expenditures. This option is especially attractive in a time of declining federal financial support and resistance to tax increases. Long-term care insurance alone will not solve the problem of increasing Medicaid budgets, however. Researchers estimate that, at most, a 23 percent maximum decrease in total annual Medicaid expenditures can be expected because of long-term care insurance. Others estimate the impact to be as low as 5 percent annually, on average. Thus, a need always will exist for public funding of long-term care. Long-term care insurance is only one of a number of private and public financing mechanisms that must be developed to create a more accessible, flexible, and efficient long-term care financing system.

At the same time that government seeks to promote the purchase of long-term care insurance, it also must act to assure fair and principled marketing of these policies. Government actions to protect consumers

may focus on the manner in which policies are sold (such as disclosure provisions and "free looks") or their contents. Because the content-related requirements may influence the financial viability of policies, insurers have objected to many of these measures. In some cases, insurers have left states rather than sell policies, leaving little insurance available. State legislatures will have to reconcile the requirements of consumer protection and insurer encouragement, finding a solution that meets each state's unique needs.

The preamble to Georgia Senate Resolution 314 of 1983, creating the Senate Private Long-Term Care Insurance Study Committee, sums up the states' perspective on long-term care insurance:

- it is projected that one-tenth of the population of Georgia will be age 65 or over by the end of 1985; and
- it is a public policy goal of this state that every senior citizen should have access to quality care; and
- Medicare covers only a maximum of 100 days of care in a skilled nursing facility, provides no coverage for intermediate facility care, and only limited coverage of home health services; and
- most Medigap policies only pay for the deductibles and coinsurance required by Medicare for skilled nursing facility care between the twenty-first and one hundredth day; and

. . . coverage for comprehensive long-term care services and home health services is offered on a limited basis by only a few companies; and

. . . long-term expenses may have devastating financial consequences for senior citizens, often forcing them to liquidate assets and exhaust savings until they become eligible for benefits under the Georgia Medical Assistance program; and

. . . the lack of availability of private insurance for long-term care has resulted in tax supported programs having to bear more than their share of the costs of nursing home services; and

. . . the health care marketplace is in a state of uncertainty and transition regarding Medicare and coverage for comprehensive long-term care.

States must be concerned about the needs of the growing elderly population and seek ways to meet the financial demands of long-term care. The states' own resources may not be enough, and long-term care insurance should be investigated as one possible alternative.

Notes

1. National Association of Insurance Commissioners Advisory Committee on Long-Term Care, *Long-Term Care: An Industry Perspective on Market Development and Consumer Protection* (exposure draft), (Kansas City, Mo., 1986), p. ii.
2. *Ibid.*, p. 155.
3. Pamela Doty, "Family Care of the Elderly: The Role of Public Policy," *Milbank Quarterly* 64, no. 1 (Spring 1986): 35.
4. U.S. Department of Commerce, Bureau of the Census, *Provisional Projections of the Population of States, by Age and Sex: 1890 to 2000*, Current Population Reports, Series P-25, no. 937 (Washington, D.C., August 1983), Table 2, p. 12.
5. *Ibid.*
6. *Ibid.*
7. *Changing Mortality Patterns, Health Services Utilization, and Health Care Expenditures: United States, 1978-2003*, National Center for Health Statistics, Vital and Health Statistics, Analytical and Epidemiological Studies Series 3, no. 23 (Hyattsville, Md., September 1983), Table 8, p. 20.
8. *Ibid.*, based on data in Figure 7, p. 14.
9. *Ibid.*
10. *Changing Mortality Patterns*, based on data in Figure 10, p. 16.
11. Larry Lane, personal communication, September 1986.
12. Health Insurance Association of America, "State of Private Long-Term Care Insurance: Results from a National Survey," *Research and Statistical Bulletin*, no. 5-86 (Washington, D.C., 1986), p. 3.
13. Larry Lane, personal communication, September 1986.
14. 1986 Colo. Sess. Laws, Chap. 76.
15. ICF Incorporated, *Private Financing of Long-Term Care: Current Methods and Resources, Phase I*, Final Report (Washington, D.C., 1985), p. 61.
16. *Ibid.*
17. Josh Weiner, personal communication, February 1986.
18. Marian Gornick, Jay Greenberg, Paul Eggers, and Allen Dobson, "Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures," *Health Care Financing Review*, 1985 Annual Supplement, Table 32, p. 49.
19. Daniel Waldo, Katharine Levit, and Helen Lazenby, "National Health Expenditures, 1985," *Health Care Financing Review* 8, no. 1 (Fall 1986): Table 10, p. 20.
20. *Ibid.*
21. "National Health Expenditures 1985," p. 19.
22. Martha Riche, "Nursing Home Dilemma," *American Demographics* 7, no. 10 (October 1985): 36.
23. U.S. Congress, House Select Committee on Aging, *Twentieth Anniversary of Medicare and Medicaid: Americans Still at Risk*, Committee Print No. 99-538, 99th Congress, 1st Session (Washington, D.C., 1986), based on data contained in Table 2, p. 57.
24. *Ibid.*
25. Health Insurance Association of America, "Results from a National Survey," p. 4.
26. Doris Topolnicki, "When a Nursing Home Becomes Your Poorhouse," *Money* 15, no. 3 (March 1986): 177-182.
27. National Association of Insurance Commissioners, *Long-Term Care: An Industry Perspective*, pp. 72-75, 90-93.
28. Laventhol and Horwath, *Life Care Industry: Fourth Annual Report of the Life Care Industry in the United States* (Philadelphia, Pa., July 1984), p. 84.
Cited in *Life Care Centers: An Alternative Delivery System for the Elderly* (Washington, D.C.: Office of Health Planning, Health Resources and Services Administration, 1986), p. 2.
29. These two studies are described in Mark Meiners and A. K. Tave, "Consumer Interest in Long-Term Care Insurance: A Survey of the Elderly in Six States" (Washington, D.C.: National Center for Health Services Research, 1984); and Towers, Perrin, Foster, and Crosby, *American Association of Retired Persons Long-Term Care Research Study, Executive Summary* (New York, N.Y., 1984).
30. Meiners and Tave, "Consumer Interest," Tables 3 and 5.
31. Marc Cohen, Eileen Tell, and Stanley Wallack, "Lifetime Risks and Costs of Nursing Home Use Among the Elderly," *Medical Care* 24, no. 12 (December 1986): 1167-68.
32. Cyril Brickfield, "Long-Term Care Financing Solutions Are Needed Now," *American Health Care Association Journal* 11, no. 6 (October 1985): 14.
33. Pamela Doty, Korbin Liu, and Joshua Wiener, "An Overview of Long-Term Care," *Health Care Financing Review* 6, no. 3 (Spring 1985): 72.
34. Waldo, Levit, and Lazenby, "National Health Expenditures," p. 19.
35. Data on Medicare-certified beds in *Medicare Program Statistics: Selected State Data, 1978-82* (Baltimore, Md.: Bureau of Data Management and Strategy, Health Care Financing Administration, 1984), p. 28. Total nursing home beds in *Statistical Abstract of the United States* (Washington, D.C.: Bureau of the Census, 1985), Table 178, p. 111.
36. Meiners and Tave, "Consumer Interest," pp. 6-7.
37. Brickfield, "Long-Term Care Financing Solutions," p. 14.
38. Beverly Foundation, *Public Attitudes About Contingency Planning for Long-Term Health Care Needs*, July 1986, p. 7.
39. Towers, Perrin, Foster, and Crosby, *American Association of Retired Persons Long-Term Care Research Study*, p. 4.

40. Meiners and Tave, "Consumer Interest," p. 13.
41. *The Prime Life Generation: A Report Describing the Characteristics and Attitudes of Americans 50 to 64 Years of Age* (n.p.: American Council of Life Insurance and Health Insurance Association of America, n.d.), Table 45, p. 36.
42. Brickfield, "Long-Term Care Financing Solutions," p. 14.
43. Report of the Mini-Cabinet on Long-Term Care to Governor Bill Sheffield, n.d.
44. Report of the Governor's Private Sector Insurance Task Force on Long-Term Care, January 1986.
45. The General Assembly, Report of the Senate Private Long-Term Care Insurance Study Committee (Atlanta, Ga.: December 1985).
46. Report in response to S.R. 76-1983SLH, October 1984.
47. Lawrence Kirsch and Donna Gruverman, *Regulating Long-Term Care Insurance in Massachusetts: Final Report and Recommendations to Insurance Commissioner Peter Hiam* (Boston, Mass.: Consumer Health Advocates, Inc., June 1986).
48. "Long-Term Care Insurance Model Act," National Association of Insurance Commissioners (Kansas City, Mo., 1987).
49. 1985 Me. Laws, Chap. 648; 1986 Wash. Laws, Chap. 170.
50. "Long-Term Care Insurance Model Act," p. 9.
51. 1986 Minn. Laws, Chap. 397.
52. S 746, A 2005, 1986 Session, New Jersey.
53. HB 3064, 1986 Session, Kansas.
54. 1986 Md. Laws, Chap. 633.
55. 1986 Ky. Acts, Chap. 409.
56. Kansas: HB 3064, 1986 Session; New Jersey: S 746, A 2005, 1986 Session.
57. 1986 Ky. Acts, Chap. 409; 1986 Minn. Laws, Chap. 397; 1986 Wash. Laws, Chap. 170.
58. 1986 Me. Laws, Chap. 648.
59. "Long-Term Care Insurance Model Act."
60. 1986 Ky. Acts, Chap. 409.
61. 1986 N.Y. Laws, Chap. 245.
62. 1986 Colo. Sess. Laws, Chap. 246.
63. H.B. 1925, 1986 Session, Hawaii.
64. Kirsch and Gruverman, *Regulating Long-Term Care Insurance in Massachusetts*, pp. 26-40.
65. National Association of Insurance Commissioners, *Long-Term Care: An Industry Perspective*, Appendix C, pp. 145-156.
66. "Making Wise Decisions for Long-Term Care" (Washington, D.C.: American Association of Retired Persons, 1986).
67. "Long-Term Care Insurance Model Act."
68. The Commonwealth of Massachusetts Special Commission on Elderly Health Care, Finance Recommendations (draft) (Boston, Mass., 1986), unnumbered.
69. AB 2583, 1986 Session, California.
70. Testimony Submitted by the Health Insurance Association of America Before the California Assembly Aging and Long-Term Care Committee, Health Insurance Association of America, January 23, 1986, p. 5.
71. "Demographic Forecasts: Elderly Incomes," *American Demographics* 6, no. 11 (November 1984): 50.
72. *1987 Federal and State Legislative Policy* (Washington, D.C.: American Association of Retired Persons, 1987), p. 249.

National Conference of State Legislatures

The National Conference of State Legislatures serves the country's 7,461 state lawmakers and their staffs.

NCSL was created in January 1975 from the merger of three organizations that served or represented state legislatures. NCSL is a nonpartisan organization with three objectives:

- To improve the quality and effectiveness of state legislatures;
- To foster interstate communication and cooperation; and
- To ensure states a strong, cohesive voice in the federal system.

The Conference has an Office of State Services in Denver, Colorado, and an Office of State-Federal Relations in Washington, D.C.

The Foundation for State Legislatures

The Foundation for State Legislatures was established in 1982 to provide a forum for the exchange of views between state legislators and the private sector, and to support the programs and objectives of the National Conference of State Legislatures. It is funded by tax-deductible contributions

from individuals, groups, and corporations. It is governed by a Board of Directors consisting of officers and members of the NCSL Executive Committee and executive officers from the private sector.

The Series on State Health Policy Issues

What Legislators Need to Know is a series of booklets on state health policy issues prepared for legislators. *What Legislators Need to Know About Long-Term Care Insurance* is the fourth in this series. Previous booklets examined uncompensated hospital care, medical malpractice, and health data/cost information programs. Booklets may be ordered from: Marketing Department, National Conference of State Legislatures, 1050 Seventeenth Street, Suite 2100, Denver, Colorado 80265, 303/623-7800.



National Conference of State Legislatures

Earl S. Mackey, Executive Director

**Denver Office
1050 Seventeenth Street, Suite 2100
Denver, Colorado 80265
303/623-7800**

**Washington Office
444 North Capitol Street, N.W., Suite 500
Washington, D.C. 20001
202/624-5400**



S B

316

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY
LEGISLATIVE REFERENCE LIBRARY

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

SB 316

SLC

1/19/90

SB 316: "An Act relating to disciplinary actions of the State Medical Board."

The Department of Commerce and Economic Development is opposed to this proposed legislation.

Upon first review, because the language of the proposed bill basically states what is the general method currently applied in determining professional incompetence, the proposed bill only raised questions concerning the necessity for the legislation. The addition of the proposed sponsor amendment to SB 316, however, clarifies the true intent of the proposed legislation: to deny Alaskans protection from potentially harmful modes of treatment by tying the hands of the State Medical Board and Division of Occupational Licensing (hereinafter "division"), entities whose shared responsibility it is to define and enforce the scope of medical practice in this state.

Presently, when incompetence is alleged by the state against professionals licensed by the division, the state has the burden of establishing that the actions of the professional complained about (i.e., the "respondent" in a discipline case) rise to the level of professional incompetence. It is a heavy burden and difficult to substantiate. In making such a case, the state would not only have to call on experts in the field, it would also have to rely on local, licensed practitioners in the respondent's profession to establish community practice standards for the particular profession involved. Naturally, the respondent would make every effort to represent his or her actions as within acceptable peer norms.

To specifically avoid instances where the state might allege incompetence against a professional where the facts in a case did not support it, the various licensing boards -- together with the division -- have adopted a policy that requires the records in most discipline investigatory case files to be provided to a member of the board in order that that member can provide a professional review of the investigation conducted by the division into the allegations contained in the consumer complaint. The board member reviews the investigatory files and either concurs or disagrees with the division's view of the case and often, given his or her expertise, suggests areas for additional investigation or suggests other matters for consideration in determining whether to close a case or to proceed with the disciplinary process.

The reason for establishing licensing boards with substantial (i.e., majority) board membership from out of the profession which the board regulates is, in fact, to guard against overly enthusiastic state regulators whose investigations might not be as sensitive to community norms and not as fully aware of local practices as appropriate. This system is a part of the various checks and balances found within state government.

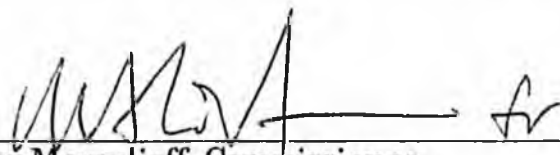
The discipline case review procedures described above apply across all board regulated professional occupations licensed by the division. We questioned at the outset, then, legislation that would amend only those discipline procedures affecting the Medical Board. The proposed sponsor amendment to SB 316 makes it even more clear, however, that the motivation behind this bill is not to clarify discipline procedures for all occupations but to support the concerns of a few within the medical community for the actions of the Medical Board, the very entity established by law to protect Alaskans and ensure quality medical care.

By placing in statute an incredibly restrictive and confusing standard of review, one can see that SB 316 would effectively negate any potential for objective review by the board of certain potentially very controversial modes of diagnosis, therapy or treatment, however harmful the practices might be found to be. This should be unacceptable to consumers and licensed physicians alike.

We draw attention to the laetrile issue of some years back. In that instance, given the controversy, the Legislature in 1976 gave the Medical Board specific authority to formally review the use of laetrile treatments in a public hearing and to publish its findings (see AS 08.64.367). These findings were then binding on the medical profession.

Based on current practices and previous example, we believe sufficient protections already exist in statute and administrative procedure to ensure that any controversial treatment, diagnosis or therapy practiced, regardless of the profession or occupation involved, would be given a thorough public hearing before any action establishing the objective validity of the practices in controversy would be taken by the board involved.

For the reasons stated above, this department opposes passage of SB 316.



Larry Mercurieff, Commissioner
Date: 18/1/90

LM/RPB/dgl6112D
11790d

FISCAL NOTE

REQUEST:

Revision Date: _____
 Title: An Act relating to disciplinary actions of the State Medical Board.
 Sponsor: Senator Rodey
 Requestor: Senate Labor & Commerce

Agency Affected: Commerce & Economic Dev.
 BRU: Occupational Licensing
 Components: All

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS : (Attach a separate page if necessary)

The bill adds a new subsection to disciplinary actions of the State Medical Board requiring the board to make certain considerations when evaluating for professional incompetence. New funding is not required.

Prepared by: Jennifer Strickler, Administrative Officer Phone: 465-2144
 Division: Occupational Licensing Date: 1-12-90
 Approved by Commissioner: Larry Merewieff Date: 1/19/90
 Agency: Commerce and Economic Development

Distribution (by preparer):
 Legislative Finance
 Legislative Sponsor
 Requestor
 Office of Management and Budget
 Impacted Agency(ies)

A M E N D M E N T

OFFERED IN THE SENATE

BY RODEY

TO: SB 316

Page 1, line 20, after "of":

Insert "diagnosis,"

Page 1, line 20, after "therapy":

Insert ","

Page 1, line 20, after "treatment.":

Insert "The board may not find an unconventional, innovative, eclectic, investigational, or experimental mode of diagnosis, therapy, or treatment to be unacceptable solely because it is unconventional, innovative, eclectic, investigational, or experimental."

OMNI MEDICAL CENTER

Robert Jay Rowen, M.D.
Diplomate, American Boards of
Family Practice, Emergency
Medicine, Chelation Therapy

"Biologic Alternatives to
Drugs and Surgery"
907-344-7775

Sandra Deaton, M.D.
Diplomate, American Boards of
Emergency Medicine &
Chelation Therapy

January 16, 1990

Senator Dick Eliason, Chairman
Senate Labor and Commerce Committee
P.O. Box V (MS3200)
Juneau, AK 99811

RE: Senate Bill 316


Dear Senator Eliason:

I am writing you this letter on behalf of myself, my staff, and many patients and Alaskans. Organized medicine has had an ironclad grip on health care delivery in this country. As a results, we have seen skyrocketing health care costs with little return. Insurance rates are going through the roof, malpractice rates likewise, and we have a form of medicine through drugs, surgery, and radiation, which can directly result in injury to people. As a result, physicians seek to protect themselves through tort reform rather than altering their style of medicine. When they do, they often are censured by their colleagues or professional licensing boards. It is a truism that the sixth leading cause of death in this country is iatrogenic disease. That means illness, disease, or injury caused directly by the medical doctor through his or her therapies or procedures.

Senate Bill 316 at last offers freedom for the medical doctor to practice his heart and the latest information on what biologic modes may assist the body rather than continuing the 'party line', which limits itself to the aforementioned 3 therapies. We have not truly had freedom of health care in this country, and I feel there is more openness and pluralism in Eastern Europe in the last few weeks than we have seen in medicine in the last many years. I urge not only your support for SB 316 with Senator Rodey's ammendment to protect unconventional therapies, but also ask for your co-sponsorsh'p. Passage of this Bill will be a dramatic breakthrough in the rights or privacy and personal freedom for the people of this state.

I certainly look forward to hearing from you directly as soon as possible on this Bill.

Sincerely,

 - Please read my enclosed article

Robert Jay Rowen, M.D.

RJR/fdl

P.S. Your health/life may depend on it one day too!

615 E. 82nd Street, Suite 300 • Anchorage, Alaska 99518
Members: American Academy of Advancement in Medicine, American Academy
of Environmental Medicine, American Society of Bariatric Physicians

FORUM

Remaining ill, with bodies that cannot heal

By DR. ROBERT JAY ROWEN

The Daily News has done a laudable job in recent months reporting on the extent of poisoning of the environment and the appalling content of the typical American diet. The health insurance cost crisis has been presented, yet the wisdom to tie it all together continues to be lacking.

Three years ago, the News published a four-part series on modern cardiology extensively reporting on the latest "wonders" of medicine, drugs and bypass surgery. Not a word was written on prevention or nutritional approaches extolled by many "alternative practitioners," but now, years later, articles are published on the reversibility of coronary disease by diet, nutrition and exercise.

Concurrently, articles are finally reaching the lay public about the gross abuse and failure of the \$50,000-plus bypass in America. Yet it and other surgeries continue.

In the '50s and '60s, the fad surgery was tonsillectomy. The

'70s gave us hysterectomy. The '80s -- bypass. Through it all was the maiming radical mastectomy. Skyrocketing insurance costs are often blamed on high technology.

Yet what has all this wizardry given us? Of all the expensive CAT scans, X-rays, MRI's and procedures performed, how many are positive? Or better yet, how many give us information that will actually help the patient instead of creating an intellectual pursuit for the physician and dollars for the industry? In truth, very few.

Treatment is often little better. Aside from costly and dangerous surgery, a quick glance through the bible of medicine, the "Physicians' Desk Reference," reveals that almost every drug used by the doctor is an anti: anti-hypertensive, anti-biotic, ant(i)-acid, anti-histamines, etc.

All of these drugs are designed to interfere with physiologic functions. Physicians are wooed by grand promotions for drugs that are not only costly (and long-term, since they do not cure), but are



often very dangerous. With the possible exception of antibiotics (which don't cure if you don't have an immune system), what other drugs cure any disease?

Are hyperactive children born with a deficiency of Ritalin? What has medicine done to promote or enhance natural healing functions instead of suppressing symptoms? A single nutrient deficiency or excess sugar is known to impair immune function.

Drug treatment of high blood pressure has been going on for years, yet most studies indicate that patients might be better off without the drugs. Further, most hypertensives (and those with high cholesterol) have moderate to severe nutritional deficiencies brought on by the typical American diet, which contributes to the blood pressure and is never ad-

dressed, but is easily, inexpensively and safely treated.

The logic of natural selection suggests that humans have self-healing mechanisms, or we would have died out. Logic further suggests the body must get basic building blocks (nutrients) to repair itself and, further, must avoid toxins or poisons that interfere with normal or repair processes.

It has been standard medical training (mine included) to offer perhaps two hours on these simple truisms and months on drugs and surgical education. Yet published U.S. Drug Administration studies confirm that at least 99 percent of Americans are malnourished in at least one essential nutrient.

The epidemic of malnutrition and chemical contamination in this country parallels the rise in "unexplained illnesses." Insurance pays for the "usual and customary" (expensive drugs, surgery and procedures).

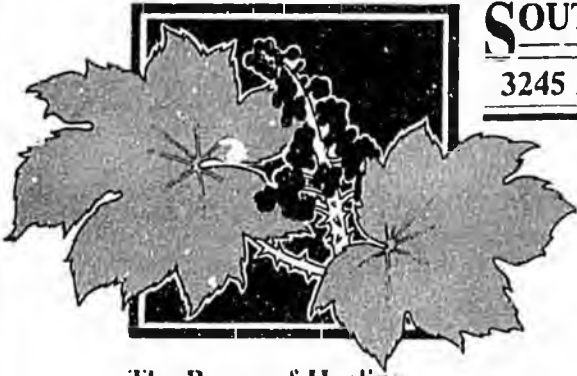
Studies have shown that pa-

tients with metastatic cancer fare worse with their \$15,000 per year average chemical poison program (paid for by insurance and Medicare) than they would if they had done nothing!

Yet a \$10 nutrient that could correct the imbalance creating a disorder and obviate a surgery or illness is not covered. The lay press is full of information on self-help, nutrition and healing from basic science journals that rarely makes it into the mainstream medical journals, which rely heavily on drug promotion. So doctors are kept in the dark.

Until physicians and insurance companies alike give attention to the three basic causes of biologic failures — malnutrition, toxic factors and stress — we will continue to pay more and get less as people remain ill with bodies that cannot heal.

□ Dr. Robert Jay Rowen is an Anchorage physician.



SOUTH EAST ALASKA REGIONAL HEALTH CORPORATION

3245 HOSPITAL DRIVE • JUNEAU, ALASKA 99801 • (907) 463-4000

January 17, 1990

The Power of Healing

Senator Dick Eliason, Chairman
Senate Labor and Commerce Committee
P.O. Box V (MS 3100)
Juneau, AK 99811

Dear Senator Eliason:

I am writing to express my concern about SB 316 with Senator Rodey's amendment to protect unorthodox medicine practices from sanctions by the state Medical Board. This clearly is a giant step backwards in terms of protecting the public from charlatans, quacks and medical incompetents who could then hide under the umbrella of practicing "unorthodox medicine." At a time when we in the medical profession already have a difficult enough time policing our own ranks against incompetents (at least, as partially manifested by some aspects of the malpractice crisis), this bill has the very real potential of hamstringing one of the effective checks we currently have in the medical profession, namely sanctions by the state Medical Board. Don't add to the problem by making it more difficult for the Board to deal with the complex task they already face in weeding out incompetence. Don't let this poorly conceived bit of legislation become law.

Sincerely,

A handwritten signature in cursive script that reads "Randall H. Wiest".

Randall H. Wiest M.D.

cc: Senator Duncan, Representatives Ulmer and Hudson



SENATE LABOR & COMMERCE COMMITTEE

Senator Richard I. (Dick) Eliason, Chairman

Senator Pat Rodey, Vice-Chairman

Senator Jan Farka

Senator Jalmar Kerttula

Senator Jack Coghill

Dick - Re: SB316
med. incompetency

Mel, ^(she is a RN) from Rep Barnes, dropped
off this article on Chelation
Therapy. The articles indicate
the therapy has not demonstrated
scientifically that it helps,
altho some patients say it
does. Amer Heart Ass, Amer
College of Cardiology, Amer
College of Physicians, etc
feel there is no scientific

h acute
s most
tals, or
special
f Santa
veloped
tal pa-
thosc
le hos-
uses in
grams.
h pro-
of the
/ pro-
ls and

Refer to: Craven PC, Morrelli HF: Chelation therapy (Medical Information). West J Med 133:377-378, Mar 1975

Medical Information

Chelation Therapy

PHILIP C. CRAVEN, MD
HOWARD F. MORRELLI, MD
San Francisco

This statement was prepared in response to a request made to the Clinical Pharmacology Service at the University of California, San Francisco to evaluate the potential therapeutic uses and the possible toxicities of chelation therapy. The question arose in regard to the use of ethylene tetraacetic acid (EDTA) in the treatment of atherosclerotic cardiovascular disease.

Action

Sodium edate (Na₂ EDTA or edathamil or versenate) is a complex molecule whose only recognized pharmacologic action is the chelation of certain divalent and trivalent cations (such as calcium, zinc, cadmium, manganese, lead, vanadium and plutonium). Following oral administration, 80 to 95 percent of the dose appears in the feces within 24 hours. After intravenous administration, 95 percent of the dose appears in the urine by 24 hours and less than 0.5 percent remains in the body after 48 hours. The compound is not metabolized and is handled by the kidneys as inulin is, so that alterations in urine flow rate and pH do not affect overall excretion rate of EDTA, although impaired renal function with reduced glomerular filtration will delay excretion.¹

Sodium-EDTA administered parenterally binds serum calcium very rapidly, and administration rates greater than 15 mg per minute produce hypocalcemic tetany. Slower rates do not affect

serum calcium levels, but mobilize bone calcium and induce hypercalcaemia. (Calcium-Na₂ EDTA does not affect plasma or body levels of calcium, but otherwise has the same actions and toxicities as the unchelated form).¹

Accepted Therapeutic Uses and Doses

The single, generally recognized use of EDTA is in the diagnosis and treatment of lead poisoning.¹⁻⁴ Other reported and suggested uses are in the diagnosis of hypoparathyroidism, the treatment of porphyria, scleroderma, hypercholesterolemia, hypercalcaemia, calcific cardiac valvular disease, cardiac arrhythmias and atherosclerotic coronary artery and peripheral vascular disease.^{1,2} Most of these uses are considered "investigational."⁵

Recommended chelation therapy in acute lead intoxication includes the combined parenteral administration of 2,3 dimercaptopropanol (BAL) and Ca EDTA, the latter in doses of 50 to 75 mg per kg of body weight per day for five days, followed by long-term oral therapy with D-penicillamine.⁶ The dose of Ca EDTA should exceed 50 mg per kg of body weight per day only when combined with BAL, and even using the recommended dosage schedule, the following side effects have been observed: fever, hypercalcaemia, proteinuria, microscopic hematuria and large epithelial cells in the urinary sediment. Therefore, frequent urinalyses and determination of serum electrolytes, blood urea nitrogen, calcium, phosphate and alkaline phosphatase are recommended during therapy.⁴ Long-term therapy is considered unwarranted because of potential renal toxicity.⁶

Toxicity

Fatal and nonfatal renal toxicity in humans given large doses of EDTA has been well documented. Reported symptoms include nocturia, frequency and urgency of urination and dysuria. Results of urinalyses have shown albumin, parenchymal cells, granular casts and red and white blood cells. In two fatal cases reported, severe renal tubular damage and widespread engorgement of reticuloendothelial cells were noted at autopsy.^{7,8}

Well-designed experimental studies using rats showed that Ca EDTA caused severe hydropic degeneration of proximal tubules, with casts and epithelial cells in urine, that was clearly dose dependent.⁷ Other tissues were not affected. The ED-50 (the dose required to produce the first histologic evidence of damage in 50 percent of

From the Department of Medicine, University of California, San Francisco.

Reprint requests to: H. F. Morrelli, MD, Department of Medicine, University of California, San Francisco, San Francisco, CA 94143.

roposed
974, 98
spitals.
20:135-
e com-
s com-
n. Am
the pa-
ad lbs

5075613144

5075613144

3:18PM 06-8-90

SENT BY AIR

animals treated daily for 16 days) was 203 mg per kg of body weight per day. Lesions developed in none of the animals given 62.5 mg per kg of body weight per day for 16 days. Neither acidification nor alkalization of the urine affected the development of lesions. These studies form the major basis for the dose recommendations in man: not more than 5 grams (70 mg per kg of body weight) per day for not more than five days, followed by a two-day rest period.

Other toxicities reported include thrombophlebitis (probably related to concentration of the solution); hypocalcemia after rapid administration of disodium EDTA; systemic symptoms of malaise, fatigue, thirst, fever, then myalgia and headache in a characteristic sequence often heralding renal toxicity; histamine-like reactions; glycosuria without a diabetic state; anemia in one case; dermatitis similar to that seen with avitaminosis B, especially B₆,^{9,10} and fatal emboli in a patient with calcium deposits in heart valves.¹¹ Congenital malformations and fetal deaths were consistently observed after administration of EDTA to pregnant rats; these changes were prevented by administration of zinc.¹²

Use in Atherosclerotic Cardiovascular Diseases

In 1955, a case report regarding EDTA therapy in a patient with severe nephrocalcinosis states, on the basis of serial x-ray films of the abdomen, that there was a 50 to 65 percent decrease in renal metastatic calcium following prolonged therapy with intravenously given EDTA totalling 575 grams in 13 months; neither renal function, nor side effects were reported.¹³

The same authors reported dissolution of mitral valve calcification and relief of congestive pulmonary symptoms following EDTA therapy in a patient with rheumatic heart disease, and removal of metastatic calcium from a necrotic sinus tract in a patient previously operated on for thyroid malignancy.¹¹ Extrapolating from these experiences, the authors reported treating 20 patients with progressive angina pectoris with prolonged courses of EDTA (5 grams daily for five days, followed by a two-day rest period, to a total of 75 to 300 grams).¹¹ Results were reported in terms of sub-

jective symptomatic improvement. Also of 17 patients with abnormal findings on electrocardiograms, six were stated to have improved; and electrocardiograms from two patients were displayed, but the improvements were difficult to interpret. One patient died following a convulsion; results of autopsy showed extensive aortic atherosclerosis and it was suspected "that he died from a calcium embolus that had been freed from a large arterial plaque." No other toxicities were apparently monitored nor commented upon.¹¹

Results of a third study, involving ten men with disabling angina pectoris, were also reported in terms of subjective symptomatic improvement and changes noted on electrocardiograms, without mention of toxicities.¹⁴ No well designed, controlled studies with blindly read, objective results have been reported.

Because of the risk of severe renal toxicity, and the lack of objective evidence suggesting therapeutic benefit from EDTA therapy for atherosclerotic disease, such therapy should be regarded as investigational and conducted under carefully controlled conditions in an academic institution by experienced investigators.

REFERENCES

1. Goodman LS, Gilman A: *The Pharmacologic Basis of Therapeutics*. New York City, The Macmillan Co., 1970, p 948
2. *New Drugs Evaluated by AMA Council on Drugs*. Chicago, American Medical Association, 1966, p 419
3. *Physicians' Desk Reference*. 25th Ed. Oradell, NJ, Medical Economics Company, 1974, p 1185
4. Chelating agents in medicine, *In Today's Drugs*. Br Med J 3:270, May 1, 1971
5. Chisolm JJ Jr: Treatment of lead poisoning, *In Modern Treatment*. New York City, Harper & Row Co., Aug 1971, pp 593-611
6. Chisolm JJ Jr: The use of chelating agents in the treatment of acute and chronic lead intoxication in childhood. *J Pediatr* 73: 1-38, Jul 1968
7. Foreman H, Finnegan C, Lushbaugh CC: Nephrotoxic hazard from uncontrolled edthamil calcium diiodium therapy. *JAMA* 160:1042-1046, Mar 24, 1956
8. Dudley HR, Ritchie AC, Schilling A, et al: Pathologic changes associated with use of sodium ethylene diamine tetraacetate in treatment of hypercalcemia: Report of 2 cases with autopsy findings. *N Engl J Med* 252:331-337, Mar 1955
9. Seven MJ: Observations on the toxicity of intravenous chelating agents. *In Seven MJ (Ed): Metal-Binding in Medicine*. Philadelphia, J. B. Lippincott Co., 1960, pp 95-103
10. Foreman H: Toxic side effects of ethylenediaminetetraacetic acid. *J Chronic Dis* 18:319-323, 1963
11. Clarke NE, Clarke CN, Mosher RE: Treatment of angina pectoris with diiodium ethylene diamine tetraacetic acid. *Am J Med Sci* 232:654, 1956
12. Swenerton H, Hurlay LS: Teratogenic effects of a chelating agent and their prevention by zinc. *Science* 173:62-63, Jul 2, 1971
13. Clarke NE, Clarke CN, Mosher RE: The "in vivo" dissolution of metastatic calcium—An approach to atherosclerosis. *Am J Med Sci* 239:142-149, 1955
14. Metzger LE, Ural MB, Kitchell JR: The treatment of coronary artery disease with diiodium EDTA. *In Seven MJ (Ed): Metal-Binding in Medicine*. Philadelphia, J. B. Lippincott Co., 1960, pp 129-136

CORRECTION

**THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**



SENATE LABOR & COMMERCE COMMITTEE

Senator Richard I. (Dick) Eliason, Chairman

Senator Pat Rodey, Vice-Chairman

Senator Jan Falks

Senator Jalmar Kerttula

Senator Jack Coghill

Dick - Re: SB316
med. incompetency

Mel, <sup>(she is a
RN)</sup> from Rep Barnes, dropped
off this article on Chelation
Therapy. The articles indicate
the therapy has not demonstrated
scientifically that it helps,
altho some patients say it
does. Amer Heart Ass, Amer
College of Cardiology, Amer
College of Physicians, etc
feel there is no scientific



SENATE LABOR & COMMERCE COMMITTEE

Senator Richard I. (Dick) Eliason, Chairman

Senator Pat Hodey, Vice-Chairman

Senator Jan Faiks

Senator Jalmar Kerttula

Senator Jack Coghill

evidence to support
the therapy. One article
says the practice is
worse than the laetrille
instances.

BUT still Ak doctor's
can practice this therapy -
SO is there a need
for the bill

Medical Information

Chelation Therapy

PHILIP C. CRAVEN, MD
HOWARD F. MORRELLI, MD
San Francisco

This statement was prepared in response to a request made to the Clinical Pharmacology Service at the University of California, San Francisco to evaluate the potential therapeutic uses and the possible toxicities of chelation therapy. The question arose in regard to the use of ethylene tetraacetic acid (EDTA) in the treatment of atherosclerotic cardiovascular disease.

Action

Disodium edatate (Na₂ EDTA or edathamil or versenate) is a complex molecule whose only recognized pharmacologic action is the chelation of certain divalent and trivalent cations (such as calcium, zinc, cadmium, manganese, lead, vanadium and plutonium). Following oral administration, 80 to 95 percent of the dose appears in the feces within 24 hours. After intravenous administration, 95 percent of the dose appears in the urine by 24 hours and less than 0.5 percent remains in the body after 48 hours. The compound is not metabolized and is handled by the kidneys as inulin is, so that alterations in urine flow rate and pH do not affect overall excretion rate of EDTA, although impaired renal function with reduced glomerular filtration will delay excretion.¹

Disodium-EDTA administered parenterally binds serum calcium very rapidly, and administration rates greater than 15 mg per minute produce hypocalcemic tetany. Slower rates do not affect

serum calcium levels, but mobilize bone calcium and induce hypercalcemia. (Calcium-Na₂ EDTA does not affect plasma or body levels of calcium, but otherwise has the same actions and toxicities as the unchelated form).¹

Accepted Therapeutic Uses and Doses

The single, generally recognized use of EDTA is in the diagnosis and treatment of lead poisoning.¹⁻⁴ Other reported and suggested uses are in the diagnosis of hypoparathyroidism, the treatment of porphyria, scleroderma, hypercholesterolemia, hypercalcemia, calcific cardiac valvular disease, cardiac arrhythmias and atherosclerotic coronary artery and peripheral vascular disease.^{1,5} Most of these uses are considered "investigational."⁶

Recommended chelation therapy in acute lead intoxication includes the combined parenteral administration of 2,3 dimercaptopropanol (BAL) and Ca EDTA, the latter in doses of 50 to 75 mg per kg of body weight per day for five days, followed by long-term oral therapy with D-penicillamine.⁶ The dose of Ca EDTA should exceed 50 mg per kg of body weight per day only when combined with BAL, and even using the recommended dosage schedule, the following side effects have been observed: fever, hypercalcemia, proteinuria, microscopic hematuria and large epithelial cells in the urinary sediment. Therefore, frequent urinalyses and determination of serum electrolytes, blood urea nitrogen, calcium, phosphate and alkaline phosphatase are recommended during therapy.⁴ Long-term therapy is considered unwarranted because of potential renal toxicity.⁴

Toxicity

Fatal and nonfatal renal toxicity in humans given large doses of EDTA has been well documented. Reported symptoms include nocturia, frequency and urgency of urination and dysuria. Results of urinalyses have shown albumin, parenchymal cells, granular casts and red and white blood cells. In two fatal cases reported, severe renal tubular damage and widespread engorgement of reticuloendothelial cells were noted at autopsy.^{7,8}

Well-designed experimental studies using rats showed that Ca EDTA caused severe hydropic degeneration of proximal tubules, with casts and epithelial cells in urine, that was clearly dose dependent.⁹ Other tissues were not affected. The ED-50 (the dose required to produce the first histologic evidence of damage in 50 percent of

From the Department of Medicine, University of California, San Francisco.

Reprint requests to: H. F. Morrelli, MD, Department of Medicine, University of California, San Francisco, San Francisco, CA 94143.

animals treated daily for 16 days) was 203 mg per kg of body weight per day. Lesions developed in none of the animals given 62.5 mg per kg of body weight per day for 16 days. Neither acidification nor alkalization of the urine affected the development of lesions.⁷ These studies form the major basis for the dose recommendations in man: not more than 5 grams (70 mg per kg of body weight) per day for not more than five days, followed by a two-day rest period.

Other toxicities reported include thrombophlebitis (probably related to concentration of the solution); hypocalcemia after rapid administration of disodium EDTA; systemic symptoms of malaise, fatigue, thirst, fever, then myalgia and headache in a characteristic sequence often heralding renal toxicity; histamine-like reactions; glycosuria without a diabetic state; anemia in one case; dermatitis similar to that seen with avitaminosis B, especially B₁₂,^{8,10} and fatal emboli in a patient with calcium deposits in heart valves.¹¹ Congenital malformations and fetal deaths were consistently observed after administration of EDTA to pregnant rats; these changes were prevented by administration of zinc.¹²

Use in Atherosclerotic Cardiovascular Diseases

In 1955, a case report regarding EDTA therapy in a patient with severe nephrocalcinosis states, on the basis of serial x-ray films of the abdomen, that there was a 50 to 65 percent decrease in renal metastatic calcium following prolonged therapy with intravenously given EDTA totalling 575 grams in 13 months; neither renal function, nor side effects were reported.¹³

The same authors reported dissolution of mitral valve calcification and relief of congestive pulmonary symptoms following EDTA therapy in a patient with rheumatic heart disease, and removal of metastatic calcium from a necrotic sinus tract in a patient previously operated on for thyroid malignancy.¹¹ Extrapolating from these experiences, the authors reported treating 20 patients with progressive angina pectoris with prolonged courses of EDTA (5 grams daily for five days, followed by a two-day rest period, to a total of 75 to 300 grams).¹⁴ Results were reported in terms of sub-

jective symptomatic improvement. Also of 17 patients with abnormal findings on electrocardiograms, six were stated to have improved; and electrocardiograms from two patients were displayed, but the improvements were difficult to interpret. One patient died following a convulsion; results of autopsy showed extensive aortic atheromatosis and it was suspected "that he died from a calcium embolus that had been freed from a large arterial plaque." No other toxicities were apparently monitored nor commented upon.¹⁴

Results of a third study, involving ten men with disabling angina pectoris, were also reported in terms of subjective symptomatic improvement and changes noted on electrocardiograms, without mention of toxicities.¹⁶ No well designed, controlled studies with blindly read, objective results have been reported.

Because of the risk of severe renal toxicity, and the lack of objective evidence suggesting therapeutic benefit from EDTA therapy for atherosclerotic disease, such therapy should be regarded as investigational and conducted under carefully controlled conditions in an academic institution by experienced investigators.

REFERENCES

1. Goodman LB, Gilman A: *The Pharmacologic Basis of Therapeutics*. New York City, The Macmillan Co., 1970, p 948
2. *New Drugs Evaluated by AMA Council on Drugs*. Chicago, American Medical Association, 1964, p 489
3. *Physicians' Desk Reference*, 25th Ed. Oradell, NJ, Medical Economics Company, 1974, p 1184
4. Chelating agents in medicine, *In Today's Drugs*. Br Med J 3:270, May 1, 1971
5. Chislem JJ Jr: Treatment of lead poisoning, *In Modern Treatment*. New York City, Harper & Row Co., Aug 1971, pp 593-611
6. Chislem JJ Jr: The use of chelating agents in the treatment of acute and chronic lead intoxication in childhood. *J Pediatr* 73:1-33, Jul 1966
7. Foreman H, Finnagen C, Lushbaugh CC: Nephrotoxic hazard from uncontrolled edothamil calcium disodium therapy. *JAMA* 160:1042-1048, Mar 24, 1954
8. Dudley HR, Ritchie AC, Schilling A, et al: Pathologic changes associated with use of sodium ethylene diamine tetraacetate in treatment of hypercalcemia: Report of 2 cases with autopsy findings. *N Engl J Med* 252:331-337, Mar 1955
9. Savin MJ: Observations on the toxicity of intravenous chelating agents, *In Savin MJ (Ed): Metal-Binding in Medicine*. Philadelphia, J. B. Lippincott Co., 1960, pp 95-103
10. Foreman H: Toxic side effects of ethylenediaminetetraacetic acid. *J Chron Dis* 16:319-323, 1963
11. Clarke NE, Clarke CN, Mosher RE: Treatment of angina pectoris with disodium ethylene diamine tetraacetic acid. *Am J Med Sci* 233:454, 1954
12. Swannerton H, Hurley LS: Teratogenic effects of a chelating agent and their prevention by zinc. *Science* 173:182-83, Jul 2, 1971
13. Clarke NE, Clarke CN, Mosher RE: The "in vivo" dissolution of metastatic calcium—An approach to atherosclerosis. *Am J Med Sci* 239:142-149, 1955
14. Mellor LE, Ural MB, Kitchell JR: The treatment of coronary artery disease with disodium EDTA, *In Savin MJ (Ed): Metal-Binding in Medicine*. Philadelphia, J. B. Lippincott Co., 1960, pp 123-136

...ment by the AMA of particular diagnostic and therapeutic procedures or treatment. DATTA-related inquiries should be submitted to Richard J. Jones, MD, Acting Program Director, American Medical Association, 535 N Dearborn St, Chicago, IL 60610.

CO₂ Laser Treatment of Gynecologic Malignant Neoplasms

Q Is the treatment of vulvar, vaginal, and/or cervical lesions with the CO₂ laser safe and effective? When is it a desirable substitute for either electrocautery or cryocautery?

A The consensus of the Diagnostic and Therapeutic Technology Assessment (DATTA) panelists was that the treatment of appropriately selected cervical, vulvar, and vaginal intraepithelial neoplasia and condyloma acuminatum with the CO₂ laser is a safe and established procedure. This is also the position of the American College of Obstetricians and Gynecologists.

This treatment of early gynecologic malignant neoplasms with CO₂ lasers originated in the early 1970s. The initial investigators found that it was an effective and accurate means of destroying intraepithelial lesions. Careful patient selection was considered critical because of the need for close follow-up.

The DATTA panelists repeatedly stressed the necessity for an adequate preoperative colposcopic workup and biopsy to ensure exclusion of endocervical subepithelial invasion by the neoplastic process. If the results of cytological colposcopic and biopsy examinations are found to be discordant, the use of the CO₂ laser is not indicated.

The procedure of CO₂ laser cautery is recommended when the preservation of normal anatomic function is paramount. For example, in the still sexually active patient, the laser provided the best means of controlled superficial destruction for either vulvar or vaginal lesions because of reduced scar formation and maintenance of the normal architecture of the reproductive tract. Destruction can be limited to the precise boundary of the lesion. Not only is the depth of tissue destruction controlled but healing is rapid, postoperative wound sloughing is minimized, infection and hemorrhage are virtually absent, and colposcopic follow-up is simplified.

Despite the enhanced precision of this technique and the practical advantages noted, no claim can be made that laser surgery is any more effective than either electrocautery or cryocautery in its ability to accomplish destruction of carcinoma in situ. Although it offers a new dimension of precision that is not available with other forms of cautery and permits a better outcome in the treatment of vulvar and vaginal lesions, this is less important in cervical lesions where depth of destruction is not as critical. In addition, the equipment is not yet widely available, it is both expensive and relatively immobile, and

In summary, the use of the CO₂ laser in the treatment of appropriately selected cervical, vulvar, and vaginal epithelial neoplasia and condyloma acuminatum is considered safe and effective.

Chelation Therapy

Q How safe and effective is chelation therapy with edetic acid or its sodium salt for the treatment of atherosclerotic disease?

A There was a consensus among all respondents that chelation therapy with edetic acid or its sodium salt was not an established treatment for atherosclerotic vascular disease.

The original thesis that repeated intravenous infusion of the chelating agent, edetate disodium, was of benefit to patients with coronary artery disease, as manifested by the anginal syndrome, has not been established in a well-designed, controlled trial. Although some uncontrolled studies claim benefits, others have shown no substantial effects from such therapy. There is no supporting evidence that it has any substantial effect on the atherosclerotic plaque. Furthermore, the use of edetic acid, especially in patients with coronary artery disease, is questionable. Chelation of calcium will decrease the levels of ionized calcium and can cause tetany, cardiac arrhythmias, convulsions, and respiratory arrest. It can cause renal tubular necrosis and failure, permanent renal damage, bone marrow aplasia, and prolongation of the prothrombin time.

The majority of respondents believed that the use of chelation therapy was unacceptable or indeterminate for the treatment of atherosclerotic vascular disease. About half as many respondents believed that it could still be considered investigational, if only in the context of a controlled trial under protocol.

The Department of Health and Human Services released a report entitled *EDTA Chelation Therapy for Atherosclerosis* in 1981 (HRST Assessment Report, volume 1, No. 18). It noted that chelation for this use is controversial, that there is no accepted rationale for its effectiveness, and that its safety is questionable. *Medical Letter*, in 1982, reviewed the experience of 10 years and concluded that "there is no acceptable evidence that chelation therapy with EDTA is effective for the treatment of atherosclerosis and the adverse effects of such drugs can be lethal." The American Heart Association also reviewed the data and found no scientific evidence to support the claims of benefit in patients with atherosclerosis. This opinion is shared by the American College of Physicians, The American Academy of Family Physicians, The American Society for Clinical Pharmacology and Therapeutics, the American College of Cardiology, and the American Osteopathic Association.



SLEEP/WAKE

Now choose from CME I

AMA Video Clinics bring the high quality of your home or office. Each Video Clinic features authorities from the nation's top medical schools. By using these AMA self-study courses, you can save thousands of dollars on yearly CME costs. Unusually inexpensive—there's only a modest amount of travel expenses involved; no travel practice.

To select the topic, time, and place, AMA Video Clinics give you the unmatched convenience of home or office use. You decide when and where to get the CME you need. A complete CME package. Each Video Clinic provides all necessary materials for effective continuing medical education: color videotapes, a detailed study guide, self-assessment tests, and Category 1 credit forms.

SCIENCE NEWS
3-2-85

Chelation Therapy: Charlatans or Saviors?

Hailed as a miracle cure by its proponents and condemned as a fraud by its critics, chelation therapy is being sought by many people, mostly elderly, as a cure for whatever ails them

By DAWN D. BENNETT

Seventy-nine-year-old J. B. Snelson complains little about his health. But the retired veterans hospital ward foreman from Knoxville, Iowa, has one problem: cold feet. Snelson's feet get so cold at night that he can't sleep.

Doctors told Snelson that his cold feet probably were caused by poor circulation, but they seemed unable to help him. Snelson went to the Mayo Clinic in Rochester, Minn., for help, but doctors there told him nothing was wrong with his circulation. They suggested it was just nerves and probably imaginary, he says.

Then Snelson got an ad in the mail for a clinic in a Kansas City, Mo., suburb that offers chelation therapy. The ad said the therapy improves a potpourri of ailments, from poor circulation to heart disease to arthritis. Believing the therapy might speed up his circulation and get more blood to his feet, Snelson decided to take the long bus ride from Knoxville to Kansas City and try the treatment. "Since I tried so many things that didn't work, I thought this would be the salvation, the thing that hit the bull's-eye," he recalls.

Snelson sat in the waiting room of McDonagh Medical Center in Gladstone, Mo., this winter, waiting for his first chelation treatment. A couple from Montana were newcomers, too. They came in the hope that chelation therapy would help improve their breathing and memory. Most of the people waiting were elderly.

The license plates in the parking lot chattered that they came from as far away as Oregon and Ohio seeking a cure for their various ills.

Chelation therapy, touted as a miracle cure by its proponents and denounced as a fraud by its critics, has been used to treat 400,000 people at 1,000 or so clinics across the nation, its proponents say. Food and Drug Administration (FDA) spokesperson Bruce Brown says the estimate should be more conservative, but that the FDA doesn't know the exact count. The agency has asked state health departments to report any chelation therapy being offered in their states.

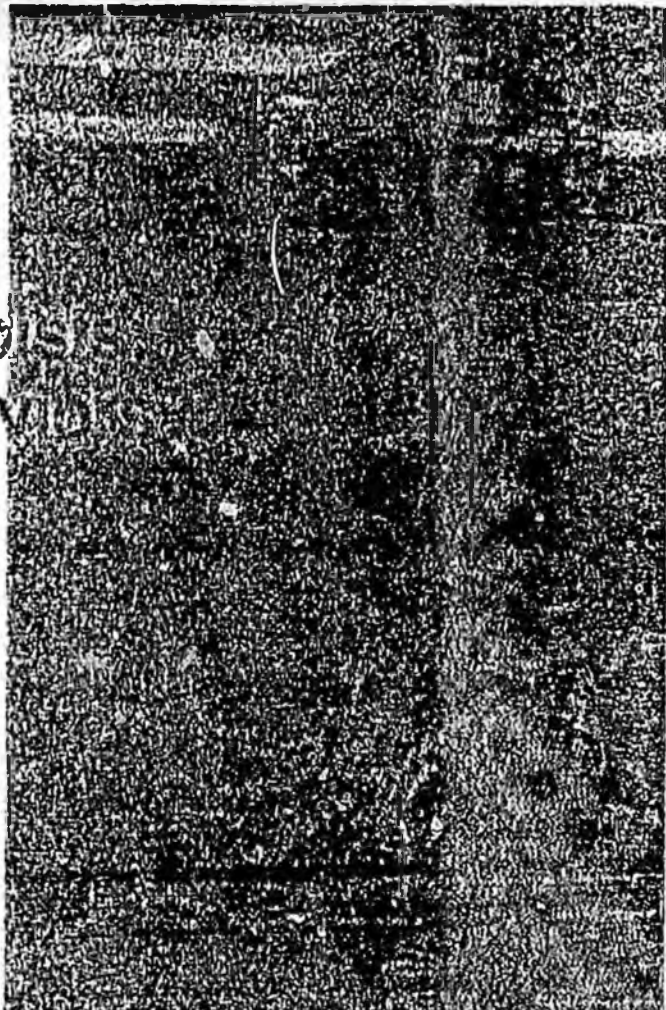
The therapy involves the introduction of a chelating agent, ethylenediamine tetraacetate (EDTA), into a patient's bloodstream for about 20 to 30 four-hour-long sessions. The EDTA purportedly binds to, or chelates, the calcium in atherosclerotic plaques, breaking up the plaques and increasing the diameter of arteries to let blood flow through more easily. The EDTA-calcium complex is then excreted from the body.

Such was the mechanism originally proposed in the mid-1950s to explain how chelation therapy works. But this mechanism, along with the therapy itself, has been discredited by most members of the medical profession, including the American Medical Association, American Heart

Association, American College of Physicians and American Geriatrics Association.

An article in the July 1978 *HARVARD MEDICAL SCHOOL HEALTH LETTER* explains why: "Even if chelation therapy did take calcium out of atherosclerotic plaques, it does not automatically follow that blood flow would improve as a result. The remaining material—cholesterol, excessive smooth muscle tissue and fibrous scar—would still remain to obstruct blood flow."

Such criticism has led chelation therapists to set aside their original mechanism and propose a free-radical mechanism to explain how the therapy works. (Free radicals are atoms or groups of atoms with an unpaired electron, which makes them extremely reactive.) A Jan. 19 *LANCET* editorial lends some credence to the free-radical mechanism: "These chelating agents might help limit tissue damage done by oxygen-derived chemical species, such as superoxide free radicals (O_2^-) and hydrogen peroxide (H_2O_2). These species produce hydroxyl radicals (OH^\cdot) which can cause degradation of DNA and destruction of the endothelial cells lining blood vessels. Both processes have been implicated in aging. Hydroxyl production from O_2^- and H_2O_2 requires iron, the editorial says; thus an agent that removes iron would help prevent the damaging effects of free radicals. Chelating agents do just that.



The editorial mentions desferrioxamine as a chelating agent to help prevent tissue damage from free radicals. It does not mention EDTA, although EDTA is known to chelate iron.

But osteopath Edward McDonagh, founder of the Gladstone clinic and several other clinics throughout the Midwest and South, believes the mechanism holds true for EDTA as well. "Free-radical reactions need metalloenzymes to progress," he says. "Using EDTA to remove the metal is one way of stopping the reactions, and since aging involves the uninhibited production of free radicals, EDTA is one way to help in this regard."

Aside from the fact that a free-radical mechanism is only one of several theories proposed for how aging occurs, the chelation therapists' emphasis on mechanism instead of effectiveness is a sure sign the therapy is a fraud, says William Jarvis, president of the National Council Against Health Fraud in Loma Linda, Calif. Chelation therapists talk about how the therapy works, he says, to make themselves sound more scientific. "Once they start talking mechanism and avoiding the question of safety and effectiveness, that's a tip-off that it's quackery."

Another sign that chelation therapy is a fraud, critics say, is the long list of ailments it is said to help. In his book, *Chelation Can Cure*, McDonagh describes how the therapy can help prevent senility, reverse blindness, treat diabetes, open blocked arteries and exert an anti-aging effect.

Fraudulent or not, chelation therapy is being sought out by many people as an alternative to conventional medical treatments, most notably coronary bypass surgery. "People are being scared by the thought of open-heart surgery into trying a dangerous alternative," says FDA's Brown.

The FDA in 1953 approved EDTA for use in treating heavy metal poisoning, such as lead poisoning, and a rare copper storage disease called Wilson's disease. It did not approve EDTA for the uses proposed by chelation therapists. But because of a loophole in the law regulating use of drugs like EDTA, as long as a practitioner does not mislabel it, the FDA can't stop its use, Brown says. "The product [EDTA] as manufactured and labeled is perfectly fine," he explains. "It's individuals who are violating the law, and the FDA doesn't regulate individuals."

Nonetheless, chelation therapy is generating major lawsuits. Joseph Hoskins of Excelsior Springs, Mo., last year charged McDonagh with negligence and malpractice. Hoskins came to the McDonagh clinic with claudication, a narrowing of leg arteries that causes cramping upon walking. But after receiving chelation treatments, his right leg became gangrenous and had to be amputated. Hoskins's lawyer, James Bartimus of Kansas City, Mo., alleges that McDonagh failed to diagnose Hoskins's

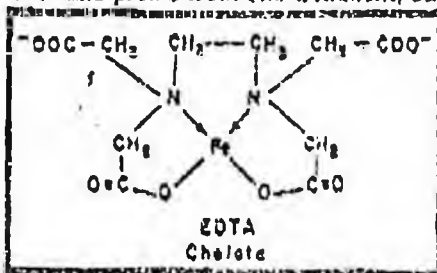


Edward McDonagh believes chelation therapy can help patients for whom conventional therapies have failed. Clinic patients, opposite page, chat or cogitate while being injected with solutions of EDTA.

proper condition and, by giving chelation therapy, masked the condition and delayed proper treatment. Hoskins is seeking more than \$1 million in damages.

McDonagh says that such lawsuits are the exception rather than the rule. Like any medical practitioner, chelation therapists are subject to malpractice suits — but because chelation therapy isn't accepted by many standard practitioners, he says, the suits are magnified. "We've been called charlatans and frauds by standard practitioners, but for 22 years, our only source of income has been satisfied patients."

Patients pay a high price, however, for any satisfaction they get from chelation therapy. A standard course of therapy calls for about \$1,000 for preliminary tests "of doubtful value," according to the HARVARD MEDICAL SCHOOL HEALTH LETTER. The McDonagh Medical Center then charges about \$72 for each EDTA treatment. Materials and labor for each treatment cost chelation clinics less than \$15 (\$5 for one dose of EDTA and \$7.50 for nurse supervision, according to the newsletter's estimates). This leaves about \$55 for overhead and profits from one treatment, but



Claw-shaped EDTA molecules surround and inactivate iron, lead or calcium ions.

most patients require 20 to 30 treatments. Insurance does not cover the therapy, so patients must pay about \$3,000 for one round of testing and treatments. Many patients undergo a second round of treatments.

What's in it for the price? University of Missouri-Columbia biochemist Boyd O'Dell says the most valuable part of the therapy often can be gotten elsewhere for much less or for free. He's referring to the diet and exercise counseling that goes along with the standard chelation treatments. O'Dell believes that such counseling, along with the motivation clinic personnel provide, is probably more important than the EDTA treatments to any success resulting from chelation therapy. "It's a common trick in this business to bring in some things that are really doing some good, such as good diet, exercise and the attention of a doctor who gives the patient some motivation."

Is there anything to lose? Quite a bit, according to many physicians and scientists. Chelation therapy can prevent patients from seeking out conventional treatments that might do them some good, O'Dell says. In some cases, the therapy causes permanent damage. The Oct. 5, 1984 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION recorded the case of a 70-year-old man with renal insufficiency who sought treatment at a chelation therapy center for circulatory problems. He was given 2.5 grams of vitamin C in solution for five hours in preparation for the therapy. The treatment resulted in excessive production of oxalate, which accumulated as kidney stones, requiring that the patient be on dialysis for the rest of his life.

Chelation therapy has been compared to laetrile, the now-discredited cancer therapy, in that it gives people a false sense of security and its promoters a large income. But John Renner, president of the Kansas City (Mo.) Committee Against Nutrition Fraud and Abuse, believes chelation therapy will exceed laetrile "in misery and money." Unlike laetrile, EDTA is legal and approved by the FDA, and is thus more readily accessible, Renner points out. In addition, promoters of laetrile accumulated their income all at once because of the sudden waxing and waning of the treatment, Jarvis says, but promoters of chelation therapy stand to gain much more by building up their incomes over several years.

Like laetrile, chelation therapy seems to be a modern version of patent medicines of old. No longer hawked on the streets, and more sophisticated than herbals and exotic mixtures, chelation therapy nonetheless appeals to those looking for a quick and easy fix to medical problems. "Some of us would like to avoid aging and disease," O'Dell says, "and people are very vulnerable to looking for easy answers. It's difficult for people to see that it's not magic." □

During the days after this infusion, the itch gradually disappeared. Her perception of painful stimuli was reduced and remained unmodified by the treatment.

A 39-year-old woman had a 25-year history of asthma, chronic urticaria, and angioedema. No specific allergy had been shown. Because of frequent episodes of laryngeal obstruction, glucocorticosteroids were administered for more than 10 years. After a similar naloxone infusion, clinical improvement was seen, allowing a discontinuation of the corticosteroids.

In both of these patients, we have been surprised by the sustained clinical improvement that began after the naloxone infusion and persisted for more than 6 months.

Endogenous and exogenous opiates have been used to control itching in man. Itching produced by morphine and butorphanol may have a central mechanism that involves binding to opiate receptors in the central nervous system, mimicking the binding of naturally occurring opioid peptides to these receptors (1, 2). Naloxone, an opiate antagonist, can prevent itching induced by butorphanol (2) and relieve generalized itch in patients with liver diseases (1, 3). Endogenous opiates may also have a role in some diseases of the respiratory system. Asthma induced by chlorpropamide and alcohol is probably mediated by endogenous peptides with opiate-like activity (4). Recently Bar-Or and associates (5) reported a dramatic clinical improvement after naloxone therapy in a patient with high-altitude pulmonary edema. The finding of a high plasma beta-endorphin concentration in this patient suggested that endorphins may play a role in this disorder.

The mechanism of the sustained effectiveness of a single naloxone infusion is uncertain. In the first patient, a disturbance of the opioid peptide system can be suspected and the efficiency of naloxone would be due to its ability to interact with this system. Naloxone may have a positive effect on asthma, chronic urticaria, and angioedema, but future studies with control subjects on placebo are needed to confirm the efficacy of naloxone and to define the role of endogenous opiates in these disorders.

SIMON SMITZ, M.D.

JEAN-JACQUES LEGROS, M.D.

University of Liège; Liège, Belgium

MARC LI MAIRE, PH.D.

Centre National de la Recherche Scientifique; Gif-Sur-Yvette, France

REFERENCES

1. BURKSTEIN JE, SWIRT R. Relief of intractable pruritus with naloxone. *Arch Dermatol.* 1979;115:1366-7.
2. BURKSTEIN JE, GRINZI RA. Butorphanol-induced pruritus antagonized by naloxone. *J Am Acad Dermatol.* 1981;8:227-8.
3. SUMMERHILD JA. Naloxone modulates the perception of itch in man. *Br J Clin Pharmacol.* 1980;10:180-2.
4. LESLIE RDG, BULLAMY D, PYKE DA. Asthma induced by enkephalin. *Br Med J.* 1980;1:116-8.
5. BAR-OR D, MARY JA, GOOD JT. Naloxone, beta-endorphins and high-altitude pulmonary edema. *Ann Intern Med.* 1982;95:684-5.

Iron Deficiency and Pica

TO THE EDITOR: We wish to address some of the points raised by Crosby (1) about iron deficiency and pica in the case we reported (2).

After a full diagnostic work-up to exclude continued blood loss, the patient was started on oral therapy that she continued until her readmission with hypokalemia. Despite the gradual improvement in her hematological values, she continued to crave clay. The answer to the question of whether clay ingestion causes or is a symptom of iron deficiency anemia remains controversial. It is difficult to ignore the work of Minalch and associates (3) who showed both in-vitro and in-vivo interference of clay with iron absorption, or the patient reported by Leming and associates (4) who continued magnesium carbonate pica despite oral iron, parenteral iron, and transfusion therapy.

Although most cases of pica respond to iron therapy (5), there appear to be clear exceptions to this rule as our case and Leming's cases suggest.

JORGE J. GONZALEZ, M.D.

University of North Carolina, Wilmington, NC 28402

REFERENCES

1. CROSBY WI. Clay ingestion and iron deficiency anemia [Letter]. *Ann Intern Med.* 1982;97:456.
2. GONZALEZ JJ, OWENS W, UNDER PC, WEAKE BE, WENZEL PW. Clay ingestion: a rare cause of hypokalemia. *Ann Intern Med.* 1982;97:65-6.
3. MINKICH V, OKUIMOTO A, TAPCON Y, et al. Pica in Turkey. II. The incidence and association with anemia. *Am J Clin Nutr.* 1968;21:78-80.
4. LEMING HD, HUBB DC, MARTIN DJ. Magnesium carbonate pica: an unusual case of iron deficiency. *Ann Intern Med.* 1981;94:600.
5. COLEMAN CA. Picaophagy and iron lack. *JAMA.* 1969;207:1513-16.

Chelation Therapy in Atherosclerosis

TO THE EDITOR: A number of inquiries have been made to the West Virginia University Drug Information Center requesting information on the value of edetate disodium (EDTA) in chelation therapy of atherosclerosis, angina pectoris, and related disorders. The American Academy of Medical Preventives (AAMP) has been distributing information on this subject to the public. We would like to alert physicians and other health professionals to the misleading claims made by this group and clarify the status of EDTA chelation therapy.

The AAMP has suggested that patients with atherosclerotic disease complete a "computer-analyzed" medical history questionnaire, have a "trace mineral analysis" of a hair sample done, and have a series of 30 to 50 infusions of EDTA at a frequency of two to four per week in doses of approximately 3 g per infusion. The cost of each infusion is between \$60 and \$110, and quarterly to yearly follow-up treatments are recommended. The AAMP has provided the public with material extolling the virtues and minimizing the potential risks of this therapy. In addition to claiming that chelation therapy is effective in atherosclerosis and angina pectoris, the AAMP asserts that it can lower blood pressure, normalize 50% to 60% of cardiac arrhythmias, improve diabetic retinopathy, reduce insulin requirements, improve arthritis, heal necrotic ulcers, and eliminate senility. The AAMP maintains that EDTA is inert and has no toxicity. These claims are misleading at best.

Although there were several uncontrolled reports in the 1950s and 1960s suggesting that EDTA may have been beneficial in treating these conditions (1), there have been no prospective controlled studies comparing EDTA to standard treatments, nor is there any objective evidence that EDTA has the ability to cause regression of atherosclerotic plaque or reduce morbidity and mortality in occlusive vascular disorders (2, 3). One study reported that EDTA apparently caused temporary improvement in anginal symptoms, but this effect was short-lived. The authors concluded that chelation therapy was not a useful clinical tool in the treatment of coronary artery disease (4). Severe adverse effects have been reported with EDTA administration including hypocalcemia, tetany, convulsions, cardiac arrhythmias, and respiratory arrest. Edetate disodium has caused acute tubular necrosis and death due to renal failure (5).

Because of the lack of objective evidence of efficacy and the potentially dangerous nature of the treatments, EDTA chelation therapy for atherosclerosis and related disorders must be considered investigational and not without risk. Physicians and other health professionals should advise their patients accordingly.

JAMES G. STEVENSON, PHARM.D.

TIMOTHY R. COVINGTON, PHARM.D.

West Virginia University; Morgantown, WV 26506

REFERENCES

1. CLARK NE, CLARK CN, MUSHKA RE. Treatment of angina pectoris with disodium ethylene diamine tetraacetic acid. *Am J Med Sci.* 1956;230:651-66.
2. SAMPSON A. Chelation therapy for atherosclerosis. *JAMA.* 1972;233:1206-7.
3. CRAVEN PC, MORRILL HF. Chelation therapy. *West J Med.* 1973;123:777-8.
4. KRICHELI JR, PALMON F, AYAN N, MILTZEM IE. The treatment of coronary artery disease with disodium EDTA: a reappraisal. *Am J Cardiol.* 1963;11:301-6.

OMNI MEDICAL CENTER

Robert Jay Rowen, M.D.
Diplomate, American Boards of
Family Practice, Emergency
Medicine, Chelation Therapy

"Biologic Alternatives to
Drugs and Surgery"
907-344-7775

Sandra Denton, M.D.
Diplomate, American Boards of
Emergency Medicine &
Chelation Therapy

February 6, 1990

Representative Ramona Barnes
Alaska State Legislature
P.O. Box V (MS3100)
Juneau, AK 99811

Dear Ramona:

I am writing this letter in response to the letters you have sent out regarding the public opinion messages coming on on SB316, professional incompetence/State Medical Board.

The reason underlying the introduction of this Bill by Senator Rodey is that throughout the country many medical doctors are finding themselves under intense pressure from their medical boards for practicing therapies other than the rigidly-held orthodox viewpoints on medicine, which are largely limited to drugs, radiation, and surgery. Many of these doctors have lost their licenses for practicing such therapies as herbs, nutrition, homeopathy, acupuncture, biologic approaches without having had any patient complaints or injuries to patients. The rationale behind the respective medical boards' decisions was that the physicians were not practicing the "standard, accepted practice" of medicine.

The current Alaska statute gives the Medical Board broad authority in how to interpret what is acceptable. Many patients are finding that drugs, surgery, and radiation just don't cut it or help their problems. Biologic approaches to assist their bodies to heal rather than drugs to suppress symptoms seem to be gaining favor among the masses who are becoming more enlightened by their own reading. At the same time, orthodox medicine is becoming more rigid in tenaciously holding on to its narrow viewpoints on symptom suppression with drugs.

While the Alaska Medical Board, to the best of anyone's knowledge, has not directly moved against physicians for practicing "alternative" or biologic approaches, the possibility does exist. The current make-up of the Board has expressed tolerance. However, medical boards do change with time and so do philosophies. In view of what is happening in other states, many people in this state are concerned that the inquisition could spread into Alaska. It is for that reason that the Bill was introduced. It simply prohibits the Medical Board from being prejudicial against a physician solely on the philosophy of his practice. It certainly would not prevent the Medical Board from censuring a physician who was hurting people. Because of the looseness in interpretation of what is acceptable, it is felt by many people as well as myself that the statute must be tightened up in order to give both physicians and patients the