What's the Perfect Continuing Care Contract for Your Organization?

INSURABLE RISKS FOR CONTINUING CARE CONTRACTS:

Refund Longevity Risks

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Part One of this three-part series dealt with the health care usage risk. Here, Part Two examines the pros and cons of protecting your CCRC against health care usage risk by using self-insurance or third-party insurance. -Ed.

Two methods are commonly used to minimize or transfer the health care usage risk for a life-care contract. One involves contract redesign and the facility continues to self-insure the health care usage risk. The other involves group long-term care insurance and transfers a portion or all of the health care usage risk to a third party.

Self-insurance methods to minimize health care risks

During the past twenty years, CCRC managers have developed numerous alternatives to restrict or eliminate the apparent health care risk while still attempting to meet market desire. At the extreme is a strictly rental contact (Type D using the trade association's terminology) in which monthly fees are set to cover all operating and capital expenses. Other variations typically limit the number of days of free (no additional charge) health care or charge a higher percentage of the per diem for those transfers. Examples are 5 or 15 days per year, or 30 days per lifetime, or 10% discount on all health care days, and so forth. One recent trend that we have observed is the use of an elimination period for residents who want to move into a Type A facility, but already own individual long-term care insurance. For this type of contract, the resident is responsible for 100% of the per diem rates for the first "n" days, or elimination period, of health care usage. For usage in excess of the n-days, the resident pays the same monthly fee or a substantially discounted health care guarantee.

These variations limit the exposure to subsidized health care and in some geographic markets contracts with these limits are attractive. However, by limiting the health care exposure, the facility is increasing its benevolent aid risk (see next issue) because residents are now more likely to deplete their financial resources under a limited health care risk contract, even though it may appear to be cheaper at the time of admission. Or, the providers severely limit the "financially qualified" market for their community by raising the financial requirements. Moreover, some residents prefer the total insurance that a life-care contact offers so that – no matter how long they live or how much health care they use – they can be assured that they won't be a financial burden to their heirs. This market desire has not diminished for many prospective residents during the past 30 years of CCRC operations. Hence, limited health care guarantee contracts (Types B and C) are not necessarily a panacea for dealing with the health care usage risk.

Third-party insurance methods for minimizing health care risks

About a decade ago, group long-term insurance for CCRCs first became commercially available. The promise of such insurance was that it would place the health care risk with professional insurers who are in the business of accepting such risks. Also, it was felt that the costs of funding this risk (and therefore monthly fees charged to residents) would be less because insurers would be able to spread over a much larger experience base than the typical CCRC.

This concept is fallacious in that both parties are using the same assumptions about future health care utilization: the expected costs that both a large insurer and a single CCRC would incur are the same and therefore both should charge roughly equivalent pure premiums just to cover expected benefits. The expectation is that the insurer's premiums would be less under the situation where both priced their products to include a "ruin" or contingency premium for adverse experience. In that case, the insurer might have an advantage because its ruin premium could be smaller since variation for the large group is expected to be less than for a small group due to the law of large numbers. This ruin premium pricing does not occur in real life for CCRCs.

Third-party long-term care insurance not readily accepted by not-for-profits

Third-party insurers might also have been helpful to new facilities by providing them with guidelines on admission and transfers between levels of care. Unfortunately, or fortunately, third-party long-term care insurance products weren't readily accepted by the not-for-profit retirement housing industry for a variety of reasons.

- First, there was resistance among providers because they could not readily identify the benefits to them. In a for-profit setting, the obvious benefit was the tax advantage for the monthly fees that would otherwise be considered as income and taxable. This is not the case for not-for-profit CCRCs.

- Second, the insurers did not demonstrate unique knowledge of admission policies or transfer protocols for the industry so there was some challenge in achieving the right fit with the policy and existing not-for-profit CCRC practices.

- Third, the first generation of products focused on institutional nursing care and overlooked the need from providers for assisted living and home health care. This situation has been addressed for the most part by second- and third-generation long-term care products that are now offered by the group insurers.

- And fourth, the rapid growth of individual long-term care insurance posed significant competition to the group products for prospective CCRC residents.

It has been our observation that most group CCRC long-term care insurers have left this market or increased premiums significantly such that individual CCRCs have been forced to reconsider whether or not they should continue with the product. One possible explanation for provider dissatisfaction with premium increases is a misunderstanding about the insurance process. Actuaries for the insurer develop premiums to cover expected costs. These expected costs are likely to be similar to what a CCRC would

develop based on its own evaluation. In addition, the insurer typically charges a loading factor to cover its administrative costs, such as rate filings and product approvals and profits. Some may have thought that this loading factor would be less than, or equal to, the savings associated with the insurer in covering a large number of residents, but as previously mentioned, this is a fictitious savings.

A possible third-party insurance product that probably provides the most value to CCRCs is a "stop-loss" product. Under this product, the CCRC self-insures all health care risks on an individual or group basis up to a certain dollar amount or number of days. After this elimination period, the insurance covers the cost for the excess usage. This type of contract option would work best for covering individual residents as opposed to stop loss on aggregate group usage. It would significantly reduce the risk to the CCRC for outliers in utilization. For example, the stop-loss limit could be set at 1,825 days (five years) on an individual basis, and the insurance would cover the difference between health care costs and monthly fees paid for all days over the limit. To date, we are aware of only one company that offers such a policy, but to obtain it the CCRC must first purchase the standard group policy that covers the first day of health care usage. This means that the CCRC can't self-insure that component at a potential savings.

Part Three of Insurable Risks For Continuing Care Contracts in the next issue of D&O FORUM will deal with Beneveloence Aid Risk.

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be the ones satisfying emotional and spiritual as well as physical needs. Our survival will depend more on the ability to create an effective image based on great new ideas, innovations and systems rather than on worrying about whether the accounting system works to perfection, the policy manual defines every eventuality or the change of command is followed.

The consumer has regained control of the marketplace due to the information explosion. They do not depend on your collaterals, brochures and tours for information. With the advent of the Internet and the proliferation of email, marketing moved from monologue to dialogue. From the privacy of their homes, prospects are researching the competition, checking your credentials and seeking the guidance of trusted advisors. Information is and will continue to be the powerful equalizer. Future technology will see to that.

The Next Generation community will become the natural and preferred choice for retirees who want more out of life than just an end to working. Rather than "need oriented," communities must become "life oriented." The culture will engage, enable and inspire community members to use their time and talents to make a better world.

Rather than attracting the need-based consumer of the past using fear and urgency strategies of the past, Next Generation communities can and will attract prominent and influential personalities as members. They will become recognized as "think tanks" and powerful resources for public policy, product research, and opinion formation. The role of the elder as "wisdom keeper" and social stabilizer will be restored and revered as our community members play increasingly prominent roles in local and national issues.

The concept of "positive aging" will take on greater significance as Next Generation community members are recognized as role models for positive living and carry the message personally as they share their talents with and give presentations to younger generations in schools, colleges, churches and clubs.

While the Next Generation community will offer comprehensive health care services, they will be transformed into more interactive personal environments, where community members take a larger role in their own care. Health care will be less isolated from the mainstream of life, and each person will continue to have significant roles consistent with their abilities. Staffing will also become less specialized as nursing, dietary, housekeeping and administrative departmental turf give way to the wisdom of teams. Those teams will be more involved with holistic care and support as "family" members, rather than as program personnel.

As the memorable line from the movie, *Field of Dreams*, proclaimed, "If we build it, they will come." By build we don't mean the buildings, but the sense of community that will grow from a culture based on positive aging. Our greatest marketing resource will be our enthusiastic and articulate community members. Their joy of living and unbridled passion for their communities will create a mushrooming demand for additional communities that will almost market themselves.

Rather than watching the average age of community member increase, we will see it decline. New community structures and contracts become more attractive to younger retirees (or pre-retirees). This will involve much more choice in contract arrangements and variety, including equity as well as larger town-planning concepts that will integrate retail and religious organizations, and smaller communities offering lower price points to serve a broader market.

Next Generation community team members and associates will feel a strong sense of personal satisfaction because they will know that their contributions and efforts have made a difference in the lives of those they serve. Rather than struggling to find help, communities will become preferred employers because of their reputation for valuing, encouraging and recognizing its staff as they set new standards for service.

That is just one vision of the future. But it is a vision that the FORCE and AD&M team is committed to making a reality. If you are curious and open to examining the stereotypes of the past, look a little bit outside the box and join us on our quest to create very special places for future generations of older adults.