

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

## Insurable risks for continuing care contracts

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*This three-part series examines the pros and cons of self-insuring versus purchasing third-party insurance for the three risks addressed by designers of continuing care contracts and attempts to quantify the magnitude of the risk assumed by the provider. Part One deals with the healthcare usage risk and Part Two deals with the refund longevity and benevolence aid risks. -Ed.*

Designing the "perfect" continuing care, or lifecare, contract has been a mystery to developers and providers for the past four decades. The objective is to develop a contract that offers minimal financial risk to the provider while maintaining a high market appeal.

For many organizations, the contract design and the provision of services are one and the same. But there is a distinction between the contract provision and the service provision. The contract provision is simply the method designated by management to fund various services offered by the CCRC. The American Association of Homes and Services for the Aging (AAHSA) has defined four healthcare coverage categories of contracts: Types A-extensive, B-modified, C-fee-for-service, and D-monthly rental. These variations are distinguished by the degree of limitation or transference of the risks associated with prepaid healthcare from the community to the resident.

Three types of risk are addressed by designers of continuing care contracts.

**Risk I**, or healthcare usage risk, refers to the actuarial risk for healthcare usage and reflects the extent to which healthcare costs are not covered at the time of usage (incidence) and therefore must be pre-funded and risk-pooled among all participants in such a contract.

**Risk II**, or refund longevity risk, refers to the actuarial risk for longevity and reflects the potential for variation in the timing for contract termination that is associated with minimum refund contracts.

**Risk III**, or benevolence aid risk, refers to the actuarial risk for a resident who outlives his financial resources and reflects the potential support provided by the community to cover monthly fees that are not collectable from contractholders.

Of course, there are additional risks involved in the design of continuing care contracts, such as economic risk for estimating future inflation and interest or fill-up risk for a new start or maintaining occupancy risk in a competitive environment, among others. These are important risks that should be considered, but are not addressed in this article.

### Risk I, Or Healthcare Usage Risk

In designing a continuing care contract, many people view the risk associated with prepaid

healthcare (i.e., institutional assisted living or nursing care) as the prevalent risk. The typical lifecare contract with extensive health care coverage, or Type A, calls for the resident to pay the same monthly fees throughout his stay in the CCRC regardless of the level of care in which he resides. Under the lifecare with an entry fee contract in which residents prepay certain costs, some believe that the risk associated with the long-term care portion is uninsurable or too risky for an "actuarially" small CCRC to undertake. To that extent, they have avoided or have refused to offer the standard lifecare contract and have developed numerous options. However, one risk that has been overlooked is that a portion of the entry fee is also a prepayment for future housing and other costs. Changes to contract provisions that appear to limit healthcare exposure do nothing to address the longevity risk associated with the other costs.

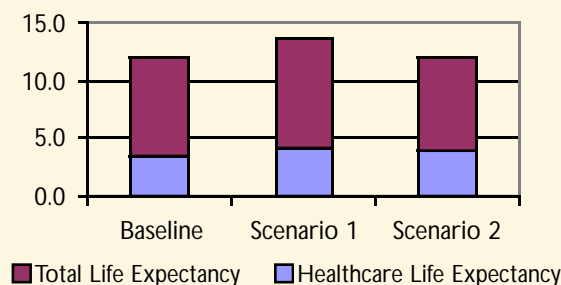
### Minimizing healthcare risks

There are several methods to minimize the healthcare risks, two of which are: (1) self-insurance options to redefine contract provisions; and (2) third-party insurance options to purchase group long-term care insurance coverage. Both methods have minor disadvantages that limit their application as a complete solution for avoiding the healthcare usage risk associated with a lifecare contract. At this point in time, it appears that the self-insurance method of contract redesign in which the amount of prepaid healthcare subsidy is reduced holds a slight advantage over third-party group insurance options that are disappearing rapidly.

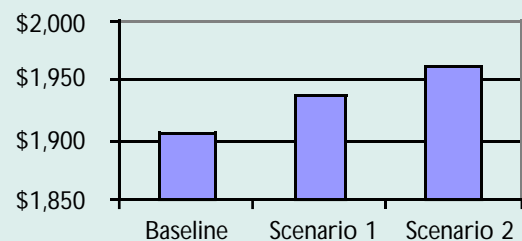
### Type A lifecare contract is viable

Offering a traditional Type A lifecare contract to prospective residents of a CCRC is financially and actuarially viable. Potential variations in the expected healthcare utilization that are related to increased longevity don't pose a significant threat to the long-term financial condition of the CCRC so long as

Life Expectancies and Health Care Lifetime



Monthly Fees to Cover Assumption Variations



monthly fees are effectively increased to match operating costs and management employs a prudent method of health screening upon admission.

### How to quantify the long-term care risk

Notwithstanding other prepaid cost risks, the risk associated with variation in healthcare usage and other costs can be quantified. An actuarial pricing model has been developed that reasonably projects how long a resident will live and where he or she will live in a CCRC. These projections are based on a sample of experience from a database of 80,000 CCRC residents. The typical 79-year female entrant has a 12.0-year life expectancy, of which 29.2% is expected to be spent in either assisted living or nursing.

Based on costs from an actual client who offers a lifecare, or Type A contract, the per capita expenses for assisted living are \$82.86 and for nursing care, \$139.53 per day. The resident pays \$62.70 in fees after transfer which results in a 24.3% discount for assisted living and a 55.1% discount for nursing care. The actuarial present value of lifetime costs is approximately \$300,000 and the break-even monthly fees and entry fee are \$1,907 and \$76,586, respectively.

Two identifiable risks associated with this situation are: (1) a resident living longer, and (2) if she lives longer, her expected healthcare lifetime increases as a percentage of her new, total lifetime. Figure 1 shows the variation expected

total and healthcare lifetimes for two scenarios. Figure 2 shows the equivalent monthly fees for the two scenarios.

For scenario one, it is assumed that the resident would live 14% longer, i.e., 13.7 years instead of 12.0 years, but her expected lifetime in healthcare remains approximately the same (29.9% of total lifetime versus 29.2%). The breakeven fees are essentially the same, at \$1,937 (a 1.6% increase) for the monthly fee and the same entry fee at \$76,586.

For scenario two, we assumed that the resident will have the same 12.0-year life expectancy, but her healthcare usage will increase from 29% to 33% of her total lifetime. The breakeven monthly fees are \$1,961 (a 2.8% increase) and the entry fee remains the same at \$76,586. It should be noted that recent research by academicians at Duke University Center for Demographic Studies indicates that the rate of chronic disability (which would lead to institutional care) is declining for the general population so a trend of a 14% increase in the healthcare lifetime is extremely unlikely.

What both these projections show is that even for significant changes in longevity of future healthcare lifetimes, fairly modest monthly fee adjustments are needed to compensate for such changes in a lifetime contract. These projections also emphasize the need to annually

monitor the actuarial and financial condition of a CCRC so that changes in experience can be reflected immediately in relatively modest fee adjustments. If not, more significant adjustments may be needed at a later date.

It is important to note that no facility has gone bankrupt or faced a severe financial crisis because of runaway healthcare utilization. The major financial problems to date are more directly related to occupancy problems or other non-actuarial management issues. ■

*Part Two of Insurable Risks For Continuing Care Contracts in the next issue of D&O FORUM will explore the potential of protecting your CCRC against health care risk using self-insurance or third-party insurance. Part Three will deal with Risk II, refund longevity risk and Risk III, benevolence aid risk.*



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### Financing Facts, Continued from pg. 4

would include the annual amount of capital expenditures needed to replace and provide for upgrades to the community in order to keep it operational and marketable.

With the major cash expense and annual cash outlays determined, focus should be paid to the sources of annual cash flow. As the initial market study revealed the range of marketable fees, this range can be utilized to approximate a marketable fee schedule for the independent living and health care units. The fees for each unit type can then be extrapolated, given a reasonable occupancy assumption for the number of units expected to be built, to determine annual cash flow from monthly fees and entrance fees. Additional cash flow sources to be calculated should include interest income from cash on hand and other miscellaneous income from items such as employee meals, salon, convenience store and activity fees. If the fee structure includes a refundable entrance fee, annual cash flow should include an estimate of refunds paid.

All the primary components needed to determine projected cash flow would now be in hand. The annual cash sources from monthly fees, entrance fees and other income should be sufficient to cover the annual cash operating expenses, capital expenditures and principal and interest payments on permanent financing. Likely there will be the need for several iterations of adjusting the fee levels, facility size and/or services and amenities offered before the cash sources are sufficient to cover all the cash uses and provide for the maintenance of the ratios required by the permanent lender (i.e. debt service coverage ratio, cash to debt, operating ratio) and a cash reserve cushion. As the development progresses and plans evolve, the cash flow should be adjusted accordingly to see the impact of changes on the financial feasibility of the community. ■

### Management Issues, Continued from pg. 2

the Golden Rule: do unto others as you would have them do unto you. As a result, we do things differently at Good Shepherd.

#### Replace the chain of command with a chain of hands

At Good Shepherd, the *Chain of Command* has been replaced with a *Chain of Hands* working together to strive for excellence. Proactively investing in changing management thinking and staff empowerment can make a world of difference to any organization. It is based on an honored concept so old that it is new again: the Golden Rule.

Mary Ann Kehoe serves on the Wisconsin Association of Homes & Services for the Aging (WAHSA) Board of Directors and the American Association of Homes & Services for the Aging (AAHSA) Health Committee and has testified before the Senate Aging Committee. Good Shepherd Services cofounded the first longterm care provider alliance in the nation to focus on providing cost-effective quality through management paradigm shift, staff empowerment and the establishment of care resource teams. Because of her dedication to ensuring quality care in an era of healthcare cost containment, Ms. Kehoe received WAHSA's Distinguished Service Award in 1997 and AAHSA's Meritorious Service Award in 1998.