The Future Life Plan Contracts: Cafeteria –Style LTC Coverage

Will Combining CCRC and CCaH Concepts Lead to a Larger Market Share by Reducing Fees and Creating Flexibility Contract Design to Match Prospect Desires?

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Premise

Industry insider: Can combining a CCRC contract with CCaH options create positive synergy for both products?

For CCRC aka Life Plan Community, they can offer

(a) customers flexibility in selecting their level of prepaid health care coverage that matches their budget, risk propensity, and

(b) provide a cafeteria style of long-term care options while minimizing adverse selection.

For CCaH programs, the CCRC resident market provides

(a) an available, larger census base to share overhead costs that should reduce start-up stabilization losses, and

(b) care coordination approach is expected to reduce institutional usage and compatible with aggressively adopting aging-in-place

Exploring the Opportunity

1. Identify current challenges for CCaH
2. Compare current practice CCaH options pros and cons
3. Early Admission Type C ? And moving toward Type A
4. Type B CCaH; a $0 membership plan
5. CCRC + CCaH; morphing Type C into Type A
6. Provider reactions

Are CCaHs at a Watershed Moment?

1. Less than 5,000 CCaH members nationwide
2. Slow enrollment velocity for developing programs
3. Resistance to paying up-front membership fees
4. Relatively high “overhead” leads to significant “stabilization” losses
5. High costs to educate marketplace re: product value
6. Some states limit number of CCaH contracts sold

Current CCaH and Related Options

1. Legacy; Type A, CCaH contract
   - Substantial membership fee plus monthly fee
   - Copayments with utilization that vary by type of benefit
   - Daily and lifetime caps—optional
2. Newer, more LTCi-like; Type B, CCaH contract
   - $0, membership fees
   - Lifetime caps—required
3. Trending alternative; Early Admission (Advantage) contract
   - Available to confirmed CCRC waiting list
   - Expected conversion to a CCRC contract

Case Example #1: Early Admission

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Why an Early Admission (Advantage) Program?

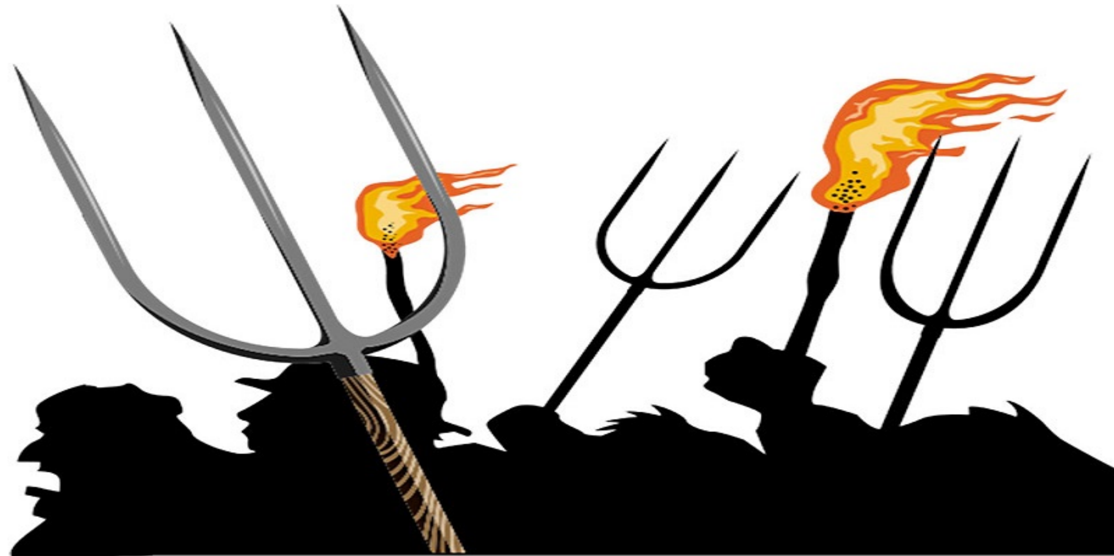
- Extensively reviewed CCaH programs and program concepts over 3-year period; Type C contract models almost nonexistent.
- Concerned with potential overhead costs and "insurance" nature of full CCaH concept.
- Desired to provide "assurance" vs. "insurance".
- Significance of why our residents chose a Type C Life Plan Community to start with.
- Current regulatory environment in North Carolina.

Why an Early Admission (Advantage) Program?

- Inherent marketing and occupancy risks to existing CCRC if we don't offer due to increasing competition in our market space.
- Allows our residents to have more "Boomer control" of the decision when they would like to make a move on campus and assures they can have access to services when needed – all about choice.
- Possible unintended consequences at conversion to CCRC contracts if we made Early Advantage a Life Care contract.

Why an Early Admission (Advantage) Program?

- Our existing Type C residents opposed guaranteeing healthcare in a Life Care model for new residents not living on campus – occupancy/capacity risks as well as perceived financial risks seen as deal breakers: “We do not have guaranteed healthcare, why should they?”



How Does it Work?

- Prospective EA residents must be on our Ready List or join it first – cues them for potential move-in at a later date.
- Same financial screening as non-EA applicants.
- Everyone gets a priority number. The higher the number, the longer the wait for home availability.
- Must execute an "Early Advantage Agreement" to enter program. When resident desires to move to campus, must execute "R & C Agreement Following Early Advantage".
- Entry fee is amortized over 25 months; if resident moves in, then entire amount is credited toward current entry fee.

What is Included?

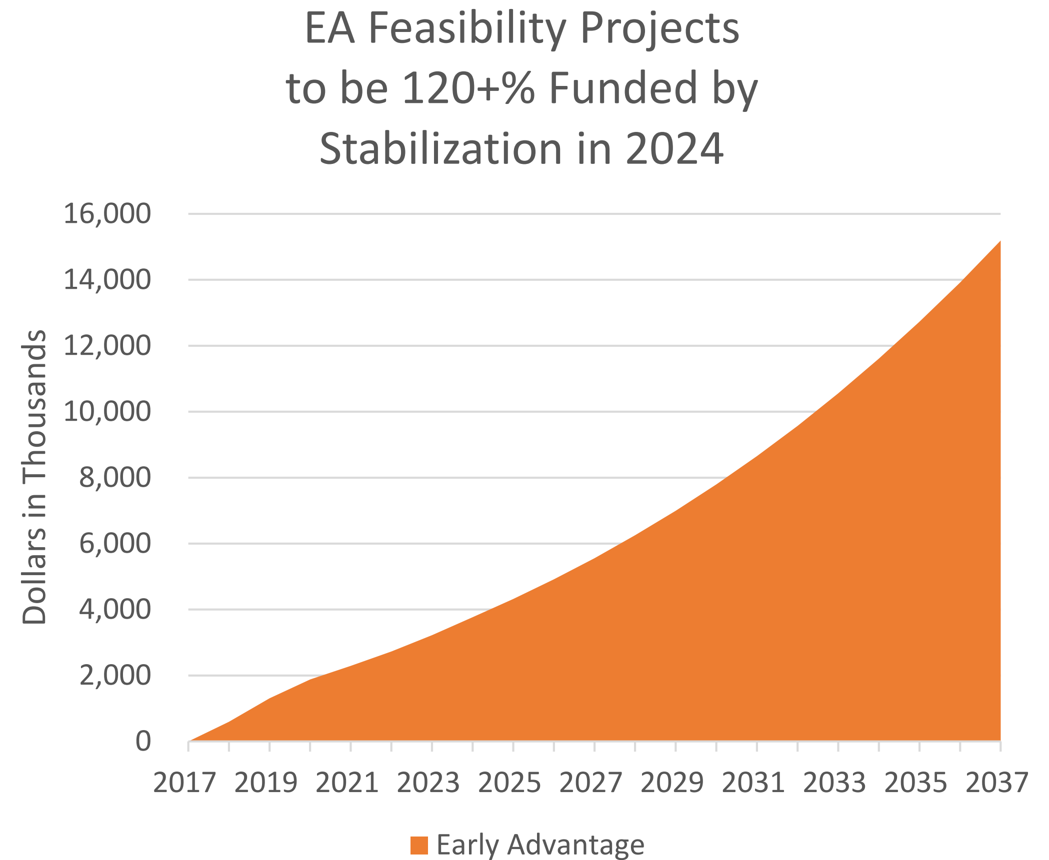
- Priority access to Assisted Living, Memory Care, and Skilled Nursing when needed.
- Five (5) free days in Skilled Care per year up to ten (10) lifetime total days while in the EA program.
- Access to on-site primary care medical practice.
- Care Coordination including annual in-home visit.
- Two medical transportation trips per month at no charge.
- Access to all amenities on campus as if they lived on campus.
- All other fee-for-service items available to on campus residents.

Current Status

- Total of 67 contracts since opening in May 2017 (49 in 2017 and 18 in 2018, with 14 more scheduled to close).
- Male = 32, Female = 35.
- Total of 64 active contracts; two have moved in and one has died. Will have total of 78 total contracts by August.
- Total revenue in 2017 = $98,175; allocated expenses of $94, 437.
- Total projected revenue in 2018 = $475,000; at full capacity, expect ~$750,000 per year or 110 contracts.
- Important to note that we have not added any additional staffing thus far so the revenue is all gravy

Financial Considerations for EA Program

1. Monthly fee = $575
2. Membership = $13,500
3. Average enrollment age = 75
4. Maximum enrollment age = 84



Discussion & Reaction to EA Program Option

Case Example #2: Type B CCaH

1. Mimicking concepts incorporated in LTCi
   - Maximum daily benefit
   - Maximum lifetime benefit; dollars or years
   - Optional features such as inflation protection or eliminating period
   - Membership fee paid over time—not up front
   - Are varying copayments a consideration?
2. Most popular/prevalent CCaH contract sold to date
3. Pioneered by

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LTCi “Expensive” at Older Ages

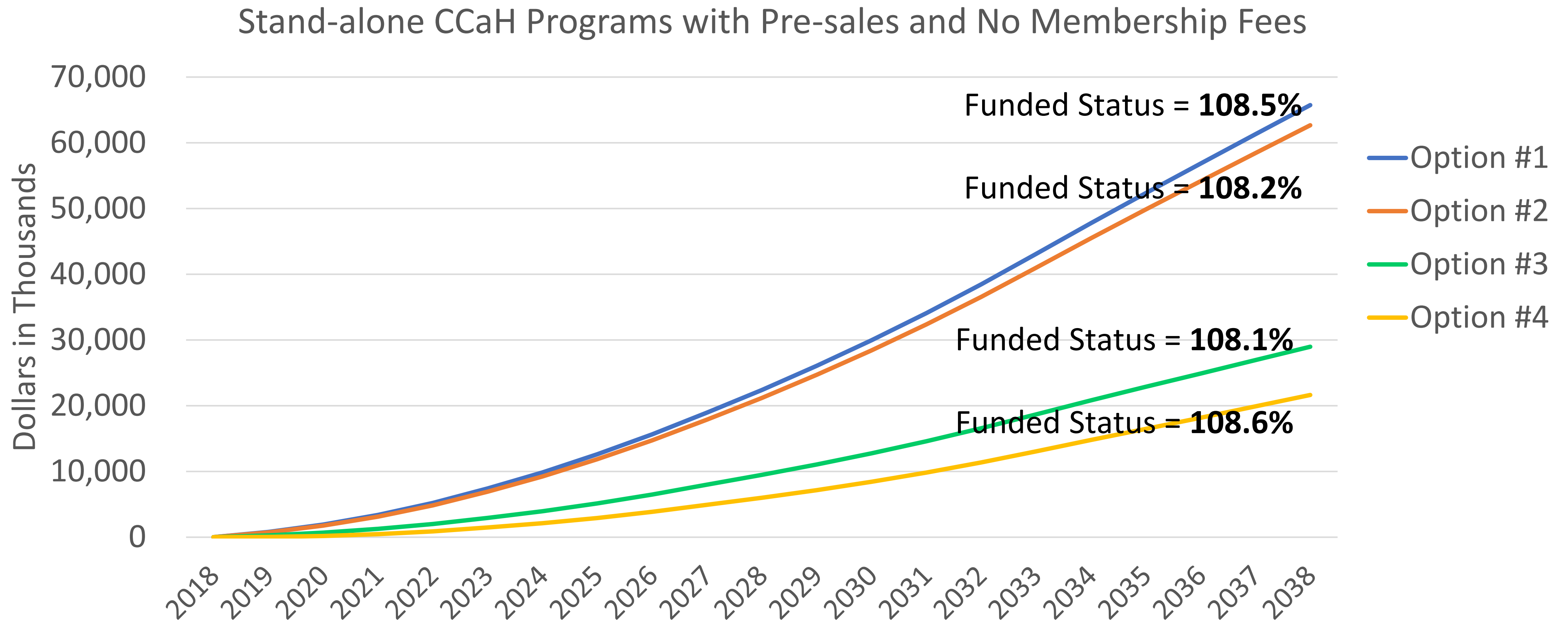
{Illustration not intended to reflect current Type B}

Age 78 (* means 4% COLA for daily cap)	Federal LTCi estimate SOURCE: ltcfeds.com Premium Calculator tool	AVP CCaH Illustration 5% Pricing Margin including admin & marketing	AVP CCaH Illustration 10% pricing margin excluding admin & marketing
3 year benefit period; $450* daily benefit cap; max lifetime benefits ≈ $490K	$ 1,510	$1,623	$1,435
5 year benefit period; $450* daily benefit cap; max lifetime benefits ≈ $820K	2,123	1,881	1,705
Unlimited benefit period, $450* daily benefit cap; no max lifetime	2,781	2,130	1,964

Actuarial Tools Can Be Used to Price CCaH Contract to Meet Prospect's Budget

Age 78 (* means 4% COLA)	Max daily = $450*; Unlimited lifetime; 0% Hmcare copay	Max daily = $450*; Unlimited lifetime; 90% Hmcare copay	Max daily = $450*; 3-yr lifetime limit; 90% Hmcare copay	Max daily = $450*; 3-yr lifetime limit; 90% Hmcare copay
Entry Fee	**Option #1** $0	**Option #2** $0	**Option #3** $0	**Option #4** $0
Monthly fee ILU	$1,360	$1,310 Δ = **(3.7%)**	$1,000 Δ = **(26.5%)**	$820 Δ = **(39.7%)**
Monthly fee w/Homecare	1,360	1,376 + 90% copay	1,114 + 90% copay	820 + 90% copay
Monthly fee ALU	1,360	1,310	1,114	3,900 ≈ 43% copay
Monthly fee SNF	1,360	1,310	1,114	3,900 ≈ 28% copay

Pro Forma Cash Flows and GAAP Misleading?



Case Example #3: Cafeteria-Style Options

Advantages for CCaH

1. Shortens time to reach critical mass
2. Improves program credibility
3. Reduces stabilization losses by sharing CCaH overhead with CCRC
4. Possible synergy between care coordinator and marketing staff

Advantages for CCRCs

1. Allows Type C to create look-alike Type A contracts and vice versa
2. Unbundling fees creates lower price points for CCRC admission
3. Provides flexible health admission criteria with potential to minimize adverse selection?
4. Facilitates move-into CCRC
5. Increase consumer satisfaction with contract options

Case Example Overview

1. Mature CCRC that offers Type A and C contracts
   - Over 250 ILUs and 140 heath care beds
   - Stabilized CCaH membership = 400 over 15 years
   - *100 members pre-sold before starting operations*
2. Per diem rates in 2018
   - Home health aides = $25/hour
   - ALU = $298/day
   - SNF = $464/day
3. CCaH administrative costs
   - Care coordinator = $146/member/mouth
   - Marketing cost per contract closed = $5,139

Converting Type C to Type A; Example #1

Age 78 (* means 4% COLA)	CCRC Type C @ 10% Margin	$464 SNF per diem; Unlimited lifetime; 100% Hmcare copy	CCRC Type C + CCaH Membership Fee	CCRC Type A @ 10% Margin
Entry Fee	$156,449	+ $129,348	$285,797	$339,449
Monthly fee ILU	$3,903	+ $0	= $3,903	$3,903
Monthly fee w/Homecare	3,903 w/100% copay	+ 0 w/100% copay	= 3,903 w/100% copay	3,903 w/100% copay
Monthly fee ALU	9,074	3,900 ≈ 43% copay	→ 3,900 ≈ 43% copay	3,903 ≈ 43% copay
Monthly fee SNF	14,099	3,900 ≈ 28% copay	→ 3,900 ≈ 28% copay	3,903 ≈ 28% copay

Converting Type C to Type A; Example #2

Age 78 (* means 4% COLA)	CCRC Type C @ 10% Margin	$464 SNF per diem; Unlimited lifetime; 100% Hmcare copy	CCRC Type C + CCaH Membership Fee	CCRC Type A @ 10% Margin
Entry Fee	$232,592	+ $71,303	$303,895	$339,449
Monthly fee ILU	3,044	+ 500	= 3,544	3,903
Monthly fee w/Homecare	3,044 w/100% copay	+ 0 w/100% copay	3,544 w/100% copay	3,903 w/100% copay
Monthly fee ALU	9,074	3,900 ≈ 43% copay	→ 3,900 ≈ 43% copay	3,903 ≈ 43% copay
Monthly fee SNF	14,099	3,900 ≈ 28% copay	→ 3,900 ≈ 28% copay	3,903 ≈ 28% copay

Cafeteria-Style Can Be Done, but…

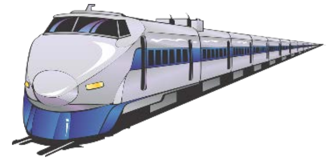
1. Possible disconnect with utilization assumptions
2. Complicated sales process
3. Education associated with a new concept
4. Legal and organizational structure issues
5. Bond covenant constraints or obstacles

Actuarial Caveats re: CCaH Contracts

1. Actuarial science provides a toolbox to derive unlimited options
2. Actuarial science can quantify risks associated with options
3. This toolbox doesn't contain insights into what the market desires
4. One can infer that CCaH utilization will follow LTCi, but
5. Limited available data on CCaH experience at the present time
6. *Industry has an opportunity to invest in its future growth and mitigate risk management concerns by collaborating in research that may validate the effectiveness of their unique care management practices*

Future Challenges & Opportunities

1. What CCaH offerings will younger prospects value?
2. Do baby boomers desire more flexible choices?
3. Can CCaH be branded as the best LTCi option?
4. Is the $0 membership fee model the new wave?
5. Will enrolling CCRC residents in your CCaH program be the to minimize stabilization losses and spur program growth?



6. How should the nonforfeiture provisions of CCaH be promoted in light of its additional risk?
7. Who is going to commit to on-going data collection and analysis?

About Kevin McLeod

Mr. McLeod has served as the President and Chief Executive Officer of Carolina Meadows Senior Communities and Services. He led the corporate restructuring efforts to create this Parent Corporation for the CCRC Carolina Meadows, Inc., a Home Care agency, and a management and development firm. Mr. McLeod has been an officer with Carolina Meadows entities since 1998 when he served as their CFO. He is a licensed CPA and serves as a financial and administrative accreditation surveyor with CARF, and he is a director for LeadingAge North Carolina and has served as a Board Chair.

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About AV Powell

AV Powell is an actuary who has consulting in consulting the senior living industry for more than nearly 40 years. Mr. Powell has published articles and one book on the actuarial techniques to price and quantify solvency for continuing care contracts. He chaired the first the American Academy of Actuaries committee on CCRCs that led to the development of Actuarial Standards of Practice No. 3 for CCRCs and participated in the grant that lead to the development of the first Continuing Care at Home program. He is a member of the American Academy of Actuaries (MAAA) and an Associate of the Society of Actuaries (ASA).

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