Continuing Care at Home: A Cautionary Alert

Many traditional nonprofit Continuing Care Retirement Community (CCRC) organizations are now moving into the Continuing Care at Home (CCaH) business. You may have heard that your own CCRC provider is developing a CCaH program. If so, you should be aware that your entry fee investment may be at risk and that you should be vigilant in questioning all the premises of the CCaH program, especially if they sound too optimistic and too rewarding.

In its purest form, CCaH acts like a long term care insurance company operating without an insurance company license. Long term care insurance pays for long term services and support when and as needed. CCaH does the same. Why does it matter that CCaH programs operate as unlicensed insurance companies? It matters because state laws governing licensed insurance companies have been developed over many years to ensure that they are sustainable and responsible.

The National Association of Insurance Commissioners (NAIC) is an association in which the sole members are the Insurance Commissioners of the 50 states, the five major territories, and the District of Columbia. The NAIC allows the state regulators to pool their resources to provide technical expertise that individual states could not afford on their own. It lifts insurance regulation above political pressures to provide well-reasoned, competent oversight for a critical industry on which Americans rely.

Insurance is a capital-intensive business. In order to make sure that an insurance company can weather an unanticipated risk or the inadvertent underpricing of a line of business, insurance companies are required to demonstrate minimum capital and technical expertise before they are granted a license to solicit business from the public. Insurance and CCaH are trust enterprises that require highly sophisticated enterprise risk management. Absent such a commitment to trust and stewardship, insurance might prey upon an unwary public, accepting funds and then failing to deliver the promised benefits. Because of the stringent licensing requirements, insurance company failures are rare and, when they do occur, the customers are protected from loss by interstate guaranty requirements.
That is not the approach that has developed with CCaH. Some states, such as the Commonwealths of Virginia and Pennsylvania, have approved CCaH programs without requiring that they be licensed as insurers and without requiring that they meet the reserving and enterprise risk management prerequisites required of insurers to protect the public.

Within a CCRC enterprise, the startup capital to get the CCaH program off the ground comes principally from retained earnings gained from fee charges to existing CCRC residents and from resident entry fees. If the net worth of the CCRC organization is negative, i.e. if the book liabilities exceed the assets, as is the case for many tax exempt CCRCs, then the capital funding is a further drain on resident fees that have been diverted for corporate purposes. This diversion of fees further erodes a balance sheet that may already be impaired. These funds should instead be earmarked to provide the benefits promised to entering residents as an inducement for them to pay entry fees and move in. This means that a CCaH program potentially places at risk the future expectations of existing residents who are counting on deferred services if, and as, they become frail and dependent.

Friends Life Care at Home System is one of the oldest, if not the oldest, CCaH and is conservatively structured and managed. It has grown slowly over many years and has learned lessons the hard way during that period; lessons which the management shares with the industry at periodic industry meetings. I attended one such briefing at a LeadingAge meeting in Nashville and I was struck by the complexity of what was shared. CCaH is not an easy business to master. It’s better to learn from those who have gone before than to repeat the mistakes of the past.

A brief overview of the Friends Life Care experience is given by CEO Carol Barbour in an article published on the LeadingAge.org website under the title “Evolution of the Continuing Care at Home Business.” ([Click here to go directly to the article.](http://leadingage.org/articles/evolution-of-the-continuing-care-at-home-business)) As occurred for CCRCs over the past two decades, Ms. Barbour rationalizes a shift away from the full care inclusive model, known by the industry as Type A, to leave more of the long term care risk with the aging members themselves. Ms. Barbour presents this as a response to market pushback against the cost of
full care coverage, and maybe it was, but it also had the effect of reducing enterprise risk at a time when there were troubling financial trends.

The biggest barrier to providing coverage for long term care is the lack of public awareness of what the cost is. Most members of the public imagine that they will avoid the need for care toward the end of life or that they will somehow get along if they ever need it. The reality is much different. The graph below illustrates the level annual cost exposure for long term care services. The escalating cost, which is faced by people who wait to act to cover these costs until they are older, is clear and evident.

![Graph illustrating annual cost exposure for long term care](image.png)

Note the sharp uptick in cost exposure as one enters the 90s and beyond. By age 100 nearly all people need assistance and the proportion increases exponentially thereafter. As more and more people are becoming centenarians, the challenge of paying for the needed care becomes more and more pronounced. For a woman at age 80 the discounted value of those future benefits, i.e. the fund that a person would have to have on hand to cover the expected value of future benefits, allowing for the contingencies of mortality and affliction, and assuming an investment rate of 3%, which is consistent with today’s stagnant interest rate milieu, is roughly $230,000. The cost rises dramatically with increasing age, accelerating steeply in the late 90s.
Most people underestimate this cost exposure, which makes it difficult to persuade people to provide adequately for the contingencies of aging. This tends to be more of a challenge for women than for men because many women provide unpaid care services for their aging husbands, while widows have to rely on others, often paid workers or providers, to meet their care needs as they decline.

This widespread popular denial about the true cost of end of life care has made it difficult for insurers and CCRCs to provide for this contingency. Long term care insurance has proven difficult to sell and the premiums have turned out to be inadequate forcing many insurance companies out of the long term care insurance market and leading to the bankruptcy of Conseco Senior Health Insurance Company and Penn Treaty Network America Insurance Co., both of which specialized in long term care insurance, and which required other long term care insurance to seek white knight companies to take over their failing business.

Cost ignorance and denial has also impacted CCRCs since many prospective residents underestimate the added value of a full care inclusive (Type A) contract. This allows many less mission directed providers to shift the long term care risk onto their residents while charging rates that allow them to be more profitable than are those providers which try to fully meet residents’ care needs on a shared cost basis.
As one would expect, this lack of market awareness of the true cost exposure for long term care affects CCaH programs just as much as it has long term care insurance, though the CCaH movement is still too new for the challenges to be as evident as they are now for long term care insurance offered by licensed insurance companies.

This lack of value awareness (“value” in the sense that prospective customers will reject the cost as too high since they can’t accept that it is what it is) has made it nearly impossible to market in volume to the universal need for coverage. Friends Life Care’s CEO, Carol Barbour, when asked what her strongest competitor is, doesn’t cite the long term care insurance industry. She states succinctly that her biggest rival to creating market demand is denial.

The current interest in CCaH among CCRC providers seems to be a push by consultants, who curry fee income by providing guidance to prospective CCaH providers, combined with a desire by provider enterprises to increase cash flow without the investment in buildings required for the residential CCRC approach. It’s conventional wisdom in the senior housing industry that market feasibility studies almost always provide the response that the clients want and expect, i.e. the market will support the project. When projects are later slow to fill up, there is always some rationale that avoids citing an incorrect market assessment. Rationalizing excuses for slow occupancy range from poor economic conditions to water main breaks.

The same optimism at the behest of hopeful clients is likely to occur with CCaH. Consultants – whether accountants, actuaries, or others – provide what appear to be plausible projections. They show positive results, though they are delivered with cautions that experience may evolve more adversely than what is projected. The projections, however, are only as meaningful as the assumptions that comprise them. Those assumptions are prognostications of future experience, and crystal balling the future is always a difficult undertaking.

Such forward looking projections are made all the more difficult when the presence of the coverage is likely to change behaviors in a way that can increase the projected costs leaving a financial shortfall. That’s a roundabout way of saying that people who have long term care insurance are more likely to use their coverage to pay for assistance than to rely for help on unpaid volunteer family members and friends.
The experience with long term care insurance demonstrates that CCaH, which is much the same, is a risky business. The proponents of CCaH argue that it is different because of the centrality of the Care Coordinator who serves as a gatekeeper to ensure that care is provided at the lowest possible cost and only as needed. This is a similar role to that of gatekeeper physicians in managed care health insurance plans.

The risky nature of CCaH raises a question concerning what level of contingency margin for potential adverse deviations is needed to ensure a soundly operated program. That’s the stuff with which licensed insurance companies grapple all the time – and under strict regulatory supervision – and even insurance companies often get into financial straits as did the Penn Treaty and Conseco insurance companies and others as mentioned above.

Consider how CCaH programs would differ if they were required to qualify as licensed insurance companies.

1. Insurance companies are required to meet strict minimum capital, i.e. positive Net Worth, requirements. As a general rule, the riskier the business undertaking the higher the minimum capital required. This is to ensure that the enterprise will have sufficient funds to weather adverse experience if the initial projections prove to be overly optimistic. CCaH enterprises have no such requirements and can operate as bootstrap businesses funded by cash received in trust from resident entry fees and from retained earnings accumulated from resident loyalty.

2. Insurance companies are not permitted to continue operating with an impaired balance sheet (or even with an impaired capital position relative to minimum capital requirements). CCaH programs have no such constraint and can continue to operate without significant regulatory intervention until cash from entry fees and other sources is exhausted, forcing the provider organization to seek bankruptcy restructuring. CCaH participants, like CCRC residents, have the lowest standing, together with trade creditors such as food suppliers, in bankruptcy negotiations which may take place after most of the residents’ entry fee investments have been exhausted and lost. By any standard, people who pay entry fees should have first claim on those funds to meet their later
needs, so providers who use entry fees for speculative business undertakings are jeopardizing the reasonable expectations of the customers they serve.

3. Insurance companies participate in guaranty programs which ensure that when an insurance company fails the policyholders are protected and do not lose the value in their insurance contracts. CCaH participants like CCRC residents have no such protection and can lose their entire investment as well as the ongoing promise of future benefits.

4. Insurance companies are required to complete rigorous annual (and quarterly) financial reporting documentation geared toward customer protections as opposed to the “going concern” theory of Generally Accepted Accounting Principles (GAAP). CCaH programs’ financials reflect GAAP theories which consider enterprise health rather than consumer interests.

5. Insurance companies are subject to rigorous periodic examinations on a zone basis in which several states pool resources to fund highly capable examiners who are accountable to the regulatory authority and who scrutinize the company’s representations, statutory conformance, and ability to meet its obligations toward customers. CCaH businesses are audited by GAAP auditors who are paid by, and accountable for retention to, the management of the CCaH enterprise and its Board.

6. Insurance companies are required to hold statutorily defined minimum actuarial reserves calculated to ensure that there is good and sufficient provision for the company’s contract obligations on a reasonably conservative basis. CCaH GAAP allows the amortization of entry fees over the life expectancy of the participants which assigns all investment earnings on the entry fees to the enterprise without giving value to the participants.

7. Insurance companies are required to be conservative in their investments reflecting the stewardship and trust obligations that they undertake when they enter into multi-year contracts with policyholders. CCaH programs like CCRCs are able to invest aggressively,
which can place entry fee investments, in particular, at risk. Moreover, some CCaH managements view entry fees as free cash and overlook the deferred obligations to the contracting participants, aside from the GAAP amortization, that induced the payment of the entry fees.

While there are other constraints on insurance companies, this listing is sufficient to make clear that CCaH programs offer nowhere near the protections that come with licensed insurance companies and that they should, therefore, be viewed as far riskier than the comparable long term care insurance contracts with which the insurance industry has long struggled.

Let’s examine Friends Life Care at Home (FLCaH) since it has been in business so long and, thus, can provide a sense of what new programs are likely to encounter. FLCaH has a record of dealing with the ups and downs of the CCaH business including both prosperous and challenging economic conditions.

The following shows the trend of both Net Worth, i.e. the balance sheet excess of assets over liabilities, and of Net Gain, i.e. the profit (or loss) for the core CCaH operations.

Note particularly the greater volatility of Net Worth compared with CCaH operations. This is attributable to the volatility of the FLCaH investment portfolio and does not reflect the exigencies of the core CCaH business. Although the investment portfolio shows volatility,
investment results have contributed more to the growth of Net Worth than have operating results. Since the mission is to provide the CCaH benefits, it is striking that the enterprise has been more successful as an investment company than as an operating company.

Membership growth has been elusive. The business perception was that pricing was a challenge so FLCaH shifted from a full care inclusive approach to a modified cost sharing approach in the hope of attracting more participation. FLCaH also discovered that adverse selection was such that they limited enrollment to those age 40 to 81 at the time of enrollment. Adverse selection occurs when a person enrolls in a program, knowing that they have a covered condition, and intending to use the services beyond the allowance that the provider included in the pricing. The consequence of these changes has resulted in a modest increase in participation as seen in the chart below.

Despite these gains, however, FLCaH has not had the success that one might expect given the market potential in the home Delaware Valley market. In 2013, the most recent year for which Form 990 data are available from public sources, FLCaH had just 2,359 members compared with a population of 706,648 in the target 65 to 84 age segment for the Philadelphia-Camden-Wilmington Metropolitan Statistical Area defined by the U. S. Census Bureau.
Reflecting the strategic decision to try to keep pricing affordable by limiting benefits, revenue per member has tailed off after increasing in the early years to stay current with the costs of full care inclusive protections. Note that the baseline is $300 for the chart.

Overall program revenues have been comparable to what moderately sized CCRCs typically realize. FLCaH program revenue peaked just short of $13 Million in 2011. By way of comparison, Genworth Financial, Inc., the largest surviving long term care insurance company, has premiums of over $3 Billion a year for that coverage line.
Overall, the FLCaH experience suggests that, while CCaH may be an attractive offering for participants, it is not the cash-generating, bootstrap-financed undertaking that some providers may have been led to believe that it represents. Since CCaH has all the enterprise risk exposures of an insurance company, but without the regulatory safeguards applicable to licensed insurance companies, residents of sponsoring CCRC enterprises and prospective participants in such programs should be wary, especially if the program places entry fee investments at risk.

There is a place where CCaH programs are appropriate without conditions. Once people are committed to your CCRC and are waiting on your waiting list, it’s perfectly appropriate to extend to them some of the benefits of residency in return for an appropriate fee. That can also serve to cement the relationship and to smooth the transition into residency. NaCCRA has a Model Law for CCaH programs which relates to exactly this kind of appropriate ancillary CCaH program. You can find the Model Law at [http://www.naccra.com/advocacy/model-laws/](http://www.naccra.com/advocacy/model-laws/). But for most people considering a CCaH program, or reflecting on a CCaH program under development by their CCRC provider, caution is the watchword. Be vigilant. Ask questions. And don’t allow yourself to be put off by questionable explanation and rationalizations.

**Afterword:** How to pay for long term care is a major challenge confronting our nation, especially as the demographic bulge of the post-World-War-II birth surge moves through into advanced old age. America also has a cost crisis with our healthcare delivery which particularly affects older people. Our cost for medical care is 40% to 50% higher than most other countries with which we trade which places our jobs at a competitive disadvantage.

High healthcare costs have also placed in jeopardy the social insurance programs, Medicare and Medicaid, on which many older Americans rely. It will be important for our nation’s leaders to devise a constructive, integrated, and comprehensive approach to healthcare soon so that long term care needs can be merged with overall health maintenance to reduce costs and to improve the quality of life for older people. Howard Gleckman is a respected authority on these issues and his views can be found in a fascinating talk which you can view by clicking anywhere on this Afterword.
Jack Cumming, an actuary and insurance expert, is NaCCRA's Director of Research.