The Interface Between Continuing-Care Retirement Communities and Long-Term-Care Insurance

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Executive Summary

- Financial advisers help clients plan for age-related risks such as a potential need for long-term care, where this care might be obtained, and how it will be funded
- Options in this planning space include continuing-care retirement communities (CCRCs) and long-term-care insurance (LTCI)
- Perhaps lesser known are the connections between CCRCs and LTCI, and why it is necessary to consider them in concert when planning
- This paper provides information to help financial planners broach long-term-care risks with clients to determine appropriate steps for helping them plan for care later in life

Responsible financial planners help clients identify risks and develop the best strategies to address them. As planners help clients consider the financial risks of aging, there should be a plan for the risk of needing an extended period of care and the associated uncertainties: how long care might be needed, where the care can be obtained, and how it will be funded. Continuing-care retirement communities (CCRCs) and long-term-care insurance (LTCI) both evolved as a response to these concerns. Because they evolved independently, it is important to identify how long-term-care insurance interfaces with continuing-care retirement communities in order to plan most effectively. Decisions regarding both CCRCs and LTCI are better made when taken in concert.

CCRCs address the risk of lack of access to long-term care. By definition, a continuing-care retirement community is a facility that provides "a continuum of housing, services, and health care, centrally planned, located, and administered."[1] Typically, individuals who enter a CCRC in good health will be in "independent living." If or when they need assistance with activities of daily living as defined by the American Physical Therapist Association (APTA), or supervision for cognitive impairment, they have access to a level called "assisted living." If residents are seriously disabled, they have access to "skilled nursing care."

LTCI does not address the risk of lacking access to a long-term-care facility, but it can provide financial resources to address the costs associated with assisted living or skilled nursing care upon policy triggering events.

Understanding the Risks

Clients are more likely to make decisions they will not regret when they understand the extent of the risks they face. They may wish to accept risk personally or transfer a portion of the risk, but it is appropriate that they see the larger picture.

Financial risks associated with a need for extended health care are considerable. *USA Today* notes, "Longevity risk is the big unknown. Today, 1.9 million Americans live beyond 90 years of age. It is projected that by 2050, the number will exceed 9 million. People outliving their money is a significant, and growing, risk."[2] According to the U.S. Department of Health and Human Services, people "will likely have a 40 percent chance of entering a nursing home. About 10 percent of the people who enter a nursing home will stay

there five years or more."[3] The *2011 Sourcebook for Long-Term Care Insurance Information* lists the average annual cost of an assisted living arrangement as $38,250.[4] An individual who cannot be completely independent and needs assistance for six years would spend, on average, more than $200,000 for care during that time.

The cost of skilled care is even more dramatic. The average annual cost of care in nursing homes is $73,000 for semi-private and $82,125 for private rooms. A six-year stay could cost almost half a million dollars.[5] Illness or disability can completely exhaust an individual's or a family's resources. Risk increases when a spouse is involved. One spouse may require long-term care for such an extended time that the family's wealth is exhausted and the surviving spouse is left without funds. Some clients want to protect themselves or their spouse from the risk of indigence; others want to protect assets for their heirs or charitable causes. These people may want to transfer risk, whereas other clients may be willing to accept the risk that their money won't provide for their care throughout their life.

Few clients are complete risk avoiders or complete risk acceptors. Understanding how either of the two extremes would deal with risk regarding CCRCs and LTCI helps define a range; clients can locate their comfort zone within that range to make appropriate choices. Addressing the two extremes helps clients think through where CCRCs and LTCI can be used together.

CCRCs and Risk

CCRCs are unique entities. Although any facility that provides a full continuum of care (with the exception of hospitalization) can be called a CCRC, there are tremendous differences in price, quality, amenities, bundling of amenities, and contractual arrangements. It is worth noting, though, that broad divisions among CCRCs are based, to a great extent, on the risk the CCRC is willing to assume for extra cost of advanced care.

As we explained in a previous *Journal* article,[6] there are five major CCRC classifications with different levels of risk:

- **Type A, Full Risk.** The resident pays for health-care benefits with the entrance fee and the monthly fees. Monthly fees don't increase for a higher level of care. The facility assumes the risk of the additional costs of advanced care. This is called a life-care contract. Additional services and inflation may result in higher monthly fees, but the base monthly fee does not increase as the resident moves to the higher level of care.
- **Type B, Partial Risk.** The facility assumes some risk, but its risk is contractually limited. There may be a discount for higher levels of care or a specified period when higher levels don't incur a fee increase.
- **Type C, Fee for Service.** Residents pay an entrance fee and monthly fees. When moving to a higher level of care, they pay current market rates and may pay an additional entrance fee. The facility assumes no financial risk.
- **Type D, Fee for Service.** Residents do not pay an entrance fee. They pay monthly fees at market rates as they require higher levels of care. The facility assumes no financial risk.
- **Equity Models.** Residents pay an initial fee deemed an acquisition cost for their dwelling unit. They pay monthly fees. When they move to a higher level of care, the facility "resells" their unit, and the resident receives the initial investment back. If the CCRC doesn't sell the unit or sells it for less than the original cost, the client bears the loss as well as the financial risk associated with care.

Risk Avoiders

A risk avoider seeks ways to transfer risk. Clients may need reminding that insurance companies and CCRCs expect payment for accepting that risk. Shifting all risk may be prohibitively expensive, so even very risk-averse clients will have to think through their choices.

The risk of needing a location for assisted living or skilled care can be addressed by paying an application fee to be put on the waiting list for a CCRC. The application fee is often around $1,000, though any cost estimates for CCRCs are dependent on location, amenities, and other variables.

The risk of being without adequate funding to cover long-term-care needs is more complex. There is no way to foretell longevity. Further, there is no way to tell the amount of time that will be required for any given level of care.

A risk avoider may prefer a CCRC to other options for the security of knowing that care is available on site. A couple may consider a CCRC because they like knowing that although they may be in different levels of care, they still can interact daily. An extreme risk avoider will gravitate toward a Type A CCRC because of the relative predictability of costs. And if they can afford it and they qualify, risk avoiders will almost certainly want to acquire LTCI.

Risk Acceptors

Clients who are true risk acceptors are unlikely to acquire LTCI. It requires an immediate outflow of cash without an immediate benefit, and there is no guaranteed future benefit. Lifestyle guru Andrew Weil, M.D., has nicely identified the desire of most of us for our last years. We want a healthy, involved lifestyle that ends with a "short, precipitous decline."[7] Risk

acceptors may indeed gamble on that outcome. Risk acceptors will use savings or income to pay for care as needed.

If risk acceptors are interested in CCRCs, it will be for their amenities or companionship. On that basis, risk acceptors may be indifferent to the type of CCRC, or they may prefer the fee-for-service model because they pay only for the services they use, as they use them. They accept the risk of the potential increased step-up in future monthly cost to avoid immediate expenditures.

It is critical for the planner and the client to understand the extreme variety among CCRCs. The amenities and financial stability of CCRCs vary greatly. Even the risk classification is challenged, because some CCRCs now offer either the full-risk option or the fee-for-service option at the same facility for different prices.

Eight Decisions Around LTCI

Long-term-care insurance (LTCI) came into existence specifically to address the financial risks associated with the need for long-term care. Although some medical policies include coverage for short-term rehabilitation and short-term skilled nursing costs, many long-term-care costs are not medical. Much long-term care is nonskilled, or custodial. It is a maintenance level of care: supervision needed for cognitive impairment or assistance with activities of daily living such as bathing, dressing, eating, continence, toileting, and transferring (getting in and out of a bed or chair). These activities do not require skilled medical providers and are not usually covered by health insurance or by Medicare.

Long-term-care insurance allows the insured to transfer the financial risks discussed above to the extent of the amount of coverage contractually defined. It is clearly a risk management tool. Though it addresses a different risk, LTCI is analogous to disability insurance. When it is obvious that someone needs the insurance, it is too late to acquire it. When a person decides to acquire it, there are multiple decisions to be made about the contract. Most important, everyone involved in the transaction hopes it will not have to be used.

Decision 1: When to Acquire. The age for purchasing long-term-care insurance has dropped over the past 10 years. Currently, the average age is approximately 58.[8] The younger the purchaser, the lower the monthly premiums. Insuring after age 60 means significantly higher premiums.

Medical underwriting is part of the application process. Note that underwriting for long-term-care insurance differs from underwriting for life insurance; life insurance underwrites for mortality, whereas long-term-care insurance underwrites for morbidity. Someone who has experienced cancer may find it difficult to obtain medical or life insurance but may be able to obtain long-term-care insurance, though the rate will be higher than for someone with no history of health concerns. Some people with chronic diseases will be uninsurable for LTCI. The longer the delay in acquiring LTCI, the greater the risk for being uninsurable or having to pay more because of the rating system that assesses greater premium cost for those whose health warrants it.

Decision 2: A Reimbursement Model or a Cash Model. A reimbursement policy is like medical insurance. The client submits a reimbursement claim for payments made for services received. The services must meet the policy's guidelines. Payment is made strictly for services that have been provided and documented.

Cash policies pay the holder a set amount when the contractual definition of need is met. The recipient may then use the cash as he or she chooses.

Reimbursement policies are more affordable, more available, and more popular. Cash policies are more expensive, but they offer the flexibility to use the money to receive in-home aid from any provider, including family members, after the holder is certified by a health-care provider as chronically ill. A reimbursement policy is based on the health-care provider's charges; a cash policy pays directly to the policy holder.

Decision 3: Length of the Elimination Period. The elimination period is the equivalent of the deductible in an auto or health policy except it is measured in days instead of dollars. It is the period between a health-care provider's assessment that there is a need for assistance with the activities of daily living and the date the policy begins to pay for that assistance. Options range from 0–365 days depending upon the insurance carrier and on regulations in specific states. The shorter the elimination period, the higher the premium cost.

Having the elimination period calculated on calendar days instead of service days is best. When the elimination period is based on calendar days, the countdown to the benefit period begins when the health-care provider certifies need and it continues for the specified number of calendar days. When the elimination period is based on service days, only the days when the policy holder is actually receiving qualified services (as defined by the policy) count. This usually means that days when family members provide care are not counted.

Today all major insurance carriers offer a "one-time elimination period." This means that once the elimination period has been met, there will not be another elimination period, even if the policyholder returns to independent living for an extended time before returning to assisted living.

Decision 4: Option of Home Health Care. Most LTCI policies written today

are comprehensive policies that cover services at home, in adult day care, in assisted living, and in a nursing facility. This includes care at CCRCs. For care received at home, most policies require a licensed or certified caregiver; a few will pay unlicensed caregivers but will not pay immediate family members unless it is a cash policy.

Financial planners may be working with clients who acquired LTCI 20 or more years ago, and those policies may be structured differently than policies written today. Knowing the specifics of the client's policy is necessary for effective planning.

Decision 5: Monthly Benefit. This is a decision that directly addresses the maximum amount the policy will pay in today's dollars. The average rate for home care is currently $4,623 per month (assuming eight hours per day at approximately $19 per hour). Home-care costs vary with the number of hours of assistance received. The average rate for skilled-nursing-facility care is $6,844 per month for a private room. The median rate for assisted living in a one-bedroom unit is $31,875 per year.[9]

The cost in the individual's geographical area is the most important one. Inquiries to local facilities help establish the level of benefit most appropriate. Note that it is not necessary to insure for the full cost of care. Some opt to shift only a portion of the risk to the insurance carrier, recognizing that costs above the insured amount will be borne by the individual receiving care. In short, have clients consider obtaining what they can afford, even if they can't get what they prefer.

Decision 6: Inflation Rider. After clients establish the daily benefit to acquire, they need to determine whether they are interested in an inflation rider to address inevitable increases in health-care costs. If they decide to forego the rider, they will simply receive the originally purchased benefit payout. They are assuming full risk of inflation. If they decide to pay extra for an inflation rider, they must next decide between a simple calculation of the increase versus a compound calculation. Historically, annual increases in medical costs exceed 4.5 percent, even when inflation is low. In 2012, they are expected to be 8.5 percent.[10]

Decision 7: Benefit Period. The insured can set a benefit period of a specific number of years or an unlimited period. Logically, the longer the potential benefit period lasts, the higher the premium. In a reimbursement policy, the benefit period determines the pool of benefits. If the full daily or monthly benefit amount is not used, the benefit period will be extended until the available funds are depleted. For example, if an individual purchased a policy paying $5,000 per month (in today's dollars) for a four-year benefit period, the pool of money available is $240,000 ($5,000 x 48 months). If only $2,500 per month is used, that pool would last 96 months.

Clients can also purchase a shared-benefit rider. A couple can buy a benefit period that can be allocated between the couple as the need arises. For example, an eight-year benefit period could result in one spouse receiving benefits for two years and the other for six, or any combination. This option provides an additional level of flexibility.

Decision 8: Waiver of Premium. When the policyholder is receiving the benefits of the policy, all leading carriers waive premiums as part of the base policy. Some offer a waiver of premium as an option for the second spouse when the first is on claim.

The individual preparing to acquire LTCI needs to be aware of each of the preceding options/riders and be prepared to make choices. Note, however, that new products and options are being created as the need for LTCI increases. Many carriers give the option of an accelerated payment plan for the policy, allowing the purchaser to have a fully paid policy in 10 years (another option is to prorate the premiums to the age of 65), with no further premiums due. Examples of relatively new products include combination life/LTCI policies and annuity/LTCI products.

Interfaces

Neither LTCI nor CCRCs were created with the other in mind. However, clients who want the option of a CCRC to be confident they will have access to long-term care may be the same clients who will consider LTCI to cover financial risks. From the perspective of the CCRC, individuals who have LTCI reduce their risk of not being able to meet monthly fees. In some cases, ownership of an LTCI policy may increase the likelihood of acceptance to CCRCs for individuals whose financial resources are borderline. (Clients should understand that CCRC residents not receiving any qualifying care are not eligible for insurance benefits. Policyholders qualify for LTCI benefits when medical providers certify that they need a given level of assistance—either substantial supervision because of a cognitive impairment or assistance with two out of six activities of daily living, listed above.)

Because a fee-for-service CCRC does not offer any financial protection, a person entering any type (C, D, equity, and, to the contractual extent, B) has the same financial risks as a person not entering a CCRC. Their need for insurance is no different. CCRCs cover availability of care; LTCI covers financial risk. The client can choose one or both, independently.

The confounding combination is the interface between a Type A, full-risk facility, and LTCI. Clients who decide to enter a full-risk facility are prepaying for long-term care as part of the entrance fee and monthly base fees. If they have acquired LTCI prior to considering the type of CCRC, they may ask, "Am I paying for the same thing twice? Is it worth it to continue my long-term-care coverage?"

Type A and LTCI: Preplanning

Though some financial risk is covered by LTCI and Type A CCRCs, it does not follow that an individual considering a Type A facility would automatically forego LTCI. The first risk a client should consider is the chance that long-term care may be needed when it is not possible to access a CCRC. Many CCRCs have a minimum age requirement. Some may require that a new resident be able to first live in independent living, not enter directly into an assisted living area or skilled nursing section. Thus a person who suffers a debilitating injury or illness prior to moving to the CCRC may no longer be a candidate for entry. In a situation where illness or injury drains resources, the individual would not qualify for a CCRC from a financial perspective. These individuals would benefit from owning an LTCI policy because it would give them options for care in other settings.

In addition to the possibility of needing care before qualifying for a CCRC or needing care and not qualifying financially, there can be a situation in which an individual cannot enter a CCRC at the time planned. It is not unheard of for a given CCRC to have a waiting list extending several years. There are situations in which an applicant is accepted for entrance but cannot be admitted until an opening occurs. Should there be a situation that requires chronic care (either at home or in a facility) prior to the resident's admission, LTCI would be useful to cover the expenses.

It is also reasonable for clients to change their minds about moving into a particular CCRC—possibly deciding to move closer to other family members. Again, having LTCI in place enables them to keep their options open.

Type A and LTCI: Entrance

If the client enters a full-risk CCRC and has an LTCI policy, stays healthy over years of residence, then experiences that "brief, precipitous decline," the client will have paid twice for a service never used—he or she will have paid for the policy and for the life-care portion of fees charged at full-risk CCRCs. The risk avoider will benefit from the sense of security, but the risk acceptor will not see a benefit.

However, if the client needs care, the advantage of having insurance is significant. The policy pays for the services identified as long-term care. Those payments from the insurer come to the insured and can be used to pay the charges of the facility. The cash-flow position of the resident is improved by the amount the insurer has provided. Even though base monthly fees don't increase for a higher level of care in Type A, peripheral services will require additional payment. (And cash policies can be used to cover peripherals.)

One of the most important additional costs the resident may opt to incur is the

cost of an upgrade. The CCRC contract provides for living arrangements in assisted living and skilled care. The contract also defines the nature of these living arrangements, which may involve semi-private quarters. For many clients, that arrangement is less than desirable. The cost of a private room may be an add-on to the base monthly fee and be tied to market rates. The additional cash flow from LTCI can be invaluable in providing a single room for privacy. With the waiver of premium, it is possible that the cash flow of an individual covered by LTCI living in a Type A facility will actually be better than his cash flow prior to receiving care. It may also be used to fund the additional cost of one-on-one care if needed within the facility.

So, here are the two extremes. There are those residents of a Type A CCRC who do not benefit financially from continuing enrollment in LTCI because they never require assisted living or skilled care, and there are those who benefit significantly because they experience extended periods of time using care. The client's perceptions of risk and tolerance of risk will color the decision to maintain insurance coverage.

The Psychology of Giving Up an LTCI Policy

The resident who enters a full-risk facility owning an LTCI policy needs to rationally consider advantages to keeping or relinquishing the policy. A problem can be the psychological difficulty of giving up an asset, no matter how intangible it might seem. The policyholder has been making regular payments for a period of time and now must decide between relinquishing the policy and relying on life-care aspects of a Type A or maintaining the policy for the benefits it will provide.

Home insurance, automobile insurance, and disability insurance end when one no longer owns a home, uses an automobile, or has employment income. But with life insurance, health insurance, and LTCI there is no natural end resolving the policyholder's decision. Situations requiring care are still likely. Should the individual give up access to benefits that cover those situations? Even if it is clearly more cost effective to terminate a policy, the emotional aspect of giving up coverage for a need that is increasingly likely with advanced age cannot be ignored.

If the CCRC resident can look at LTCI unemotionally, he or she can make a rational decision. What are the chances the premiums paid after entering the CCRC will be justified by the likely benefits received? If the policyholder focuses on the amount already paid and perceives relinquishing the policy as having made expenditures now guaranteed to have no financial payback, it can be wrenching to cancel the policy. It may make more sense to adjust the coverage by lowering the number of years of coverage or the daily benefit available. These options give some continued coverage and can mitigate the difficult decision of giving up coverage for which one has paid premiums for many years.

The planner should address two areas. First, assure the policyholder that a benefit has been received: protection for events that, fortunately, did not occur. The prior payments are a sunk cost and need to be disregarded. Second, rationally calculate the cost/benefit of continuing the policy, decreasing it, or discontinuing it. The life-care cost at the Type A CCRC should not be considered, as the client has already committed to the facility, and that cost will continue whatever the decision about insurance. What must be considered is the cost of the premiums up to the time of need (assuming a waiver of premium when benefits begin) compared with the benefits from the policy over the prospective time of need.

Conclusion

LTCI and CCRCs came into existence in response to a population living longer than ever who can no longer depend on family for long-term assistance. Although they arose independently, both were designed to meet existing and ongoing needs. Clients should be aware of the risks these two options address and have a plan for dealing with those risks.

The financial planner must remind clients they need to plan *before* risks become realities. Clients who are strong risk acceptors may choose to dismiss either option, but they will have had an opportunity to make that decision in a thoughtful process. Most clients will want to examine the costs and the potential benefits of these options and determine whether they wish to address long-term care risks through them. If clients see them as part of a strategy, they can make a better financial allocation to cover their risks. The sooner clients begin to strategize, the better they will be served.

Endnotes

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