Innovative Finance and Claims Management

Monday March 27, 2017

10:45 – 12:00

PRODUCER AND SPEAKERS

- Carol Barbour, CEO & President,
  Friends Life Care Partners

- Vincent Bodnar, Chief Actuary, LTCG

- Eileen J. Tell, ET Consulting

Continuing Care at Home (CCaH)

Carol Barbour, CEO & President
Friends Life Care Partners

AGENDA

- Overview of Continuing Care At Home (CCaH)
  - History
  - Description
  - Pricing models
- Finance & Claims Management
- CCaH and LTCI: A Comparison
- Results

About the Concept

"Continuing Care at Home"

"Life Care at Home"

"CCRC without Walls"

Origin of the Idea

"How can we bring the promises and guarantees of a Continuing Care Retirement Community to people who prefer to remain in their own homes?"

Donald L. Moon, Executive Director

Foulkeways at Gwynedd

Circa 1982

Demonstration Phase

1982 to 1990

$2.5+ million grant funding

- Commonwealth Fund
- Robert Wood Johnson Foundation
- Pew Charitable Trust

Groundwork for Initial Site Development

Grant funding supported:

- Ground-setting research
- Pilot sites

Ground-setting Research

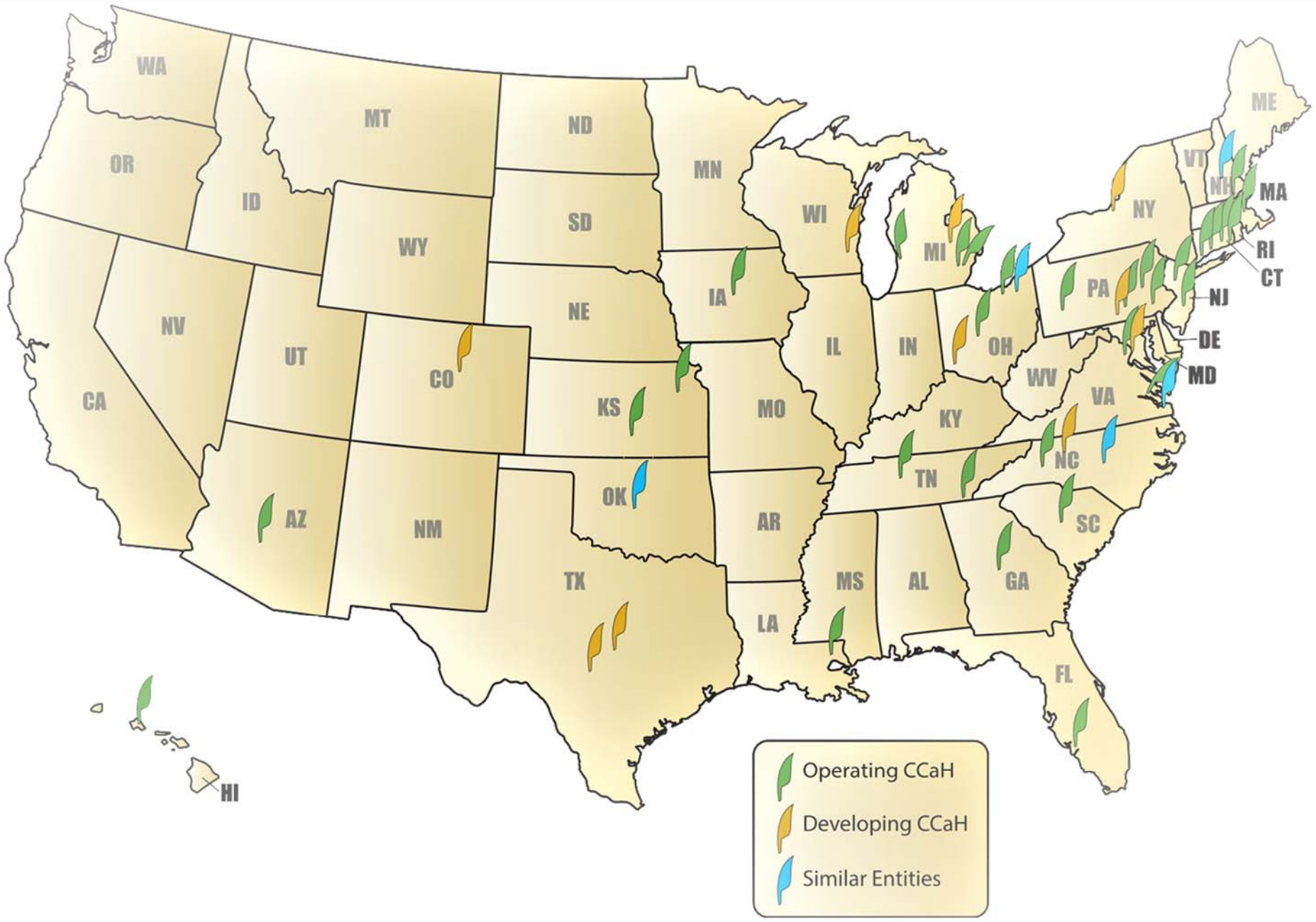
- Brandeis University conducts 4-year, two phase study in partnership with Advisory Team including CCRC leadership, pricing actuaries, LTCI academics and others.
- Research phase funding from Pew Charitable Trust and the Robert Wood Johnson
  - Phase I: Benefit design, pricing analysis and consumer market testing;
  - Phase II: RFP for pilot sites

Pilot Sites

Grant funding supported:

- Regulatory approval process
- Pre-sales
- Service provider network setup
- Initial operations

GROWTH of CCaH



CCaH Industry Profile

- Total – 31 operational plans
- 5-10 under development
- All are not-for-profit
- 30 affiliated w/CCRC; 1 free standing

CCaH Model

- √ Where will I turn if I need long term care?
- √ How will I pay for long term care services if I need them?

Covered Services

- Care Coordination
  - Health & wellness
  - Home care
  - Delivered meals
  - Remote monitoring technology
  - Home accessibility
  - Adult day care
  - Referral services
  - Coordination of benefits and community resources
  - Assisted Living Facility/Nursing Home (optional)
  - Portability

Different Types of Plans

- Home Care & Institutional Care (ALF/NH)
- Home Care only
- Limited Plans/Compromised Health
- Care Coordination Only

Pricing Models

- Based on Type A & Type B CCRC pricing
- Based on LTCI pricing

CCaH Pricing: Type A

Key features:

- One-time entrance fee ($15k-$50k+)
- Ongoing monthly fee ($400-$1400/month subject to increase)
- Most comprehensive contract
- Unlimited lifetime benefit
- Minimal or no copayments

CCaH Pricing: Type A (continued)

Key Features:

- Fees based on age at enrollment
- Annual increases in monthly fee
- Household status discount
- Monthly fee waived if member in ALF/NH
- Refund provisions:
  - Entry fee – 2% declining
  - Monthly fee - none
- Continuing Care Agreement
- Member Assistance Fund

CCaH Pricing: Type B

Key Features:

- Same as type A except member pays predetermined percentage of care costs (up to 50%)

CCaH Pricing: Based LTCI Pricing Model

- Member selects benefit levels
  - Daily and lifetime limits
  - Cost of living adjustments
  - Private pay period
- Entrance fee paid over time
  - Typically 5 years
- Average annual fee: $2,500-$3,000
- Average entrance fee: $2,500-$3,000

CCaH Pricing: Based LTCI Pricing Model (continued)

- Fees based on age and health at time of enrollment
- Fees guaranteed for 5 years
- Household status discounts
- Annual fee waived if member in ALF/NH
- Refund provisions: none
- Continuing Care Agreement
- Member Assistance Fund

Regulatory Oversight

Typically the same as for CCRC:

- Annual audit
- Disclosure statement
- Actuarial study
- Reserves

Membership

Estimates of Nationwide CCaH Membership by Pricing Model

Type A/B	LTCI Pricing
≈800 members	≈2500 members

Next Steps

Projected Growth

- 37% of Ziegler's 150 CCRCs indicated plans to develop CCaH (2015)
- Membership growth of Type A & Type B plans slow
- Membership growth in LTCI pricing model plans more robust

What sets CCaH Apart?

Care Coordination

- Care Coordinators become the trusted partner of members as they age
- They are coaches, educators, caretakers, surrogate family members, health care professionals and gatekeepers
- Involvement begins on Day 1 of enrollment

Member Distribution

Current Status of Members

Member Category	Percentage
Well members	72.4%
At risk members	20.1%
Care at home	6.0%
Assisted living facility	0.9%
Skilled nursing facility	0.6%

Care Coordination Team

- Multi-disciplinary
- Wellness, At-risk and Care Coordinators
- Objectivity & consistency
- Data tracking
- Contact schedule
- Highly personalized approach

Care Coordination

- Multiple assessment tools (combination of standardized tools and proprietary assessments)
- Technology to record clinical and financial data

Well Members – Wellness Initiative

- *Goal: help members stay healthy*
- Proactive, research-based initiatives designed to help members improve and extend mental and physical health and resilience of members
- Assessment tool: Vitalize 360 (formerly COLLAGE)

Vitalize 360

- Innovative, award-winning, person-directed approach to wellness coaching
- Scientifically grounded assessment system
- Ability to benchmark results

Addressing Needs of Members at Risk

Evidence-Based Prevention Programs

- *Goal: prevent or delay change in health*
- Fall Risk Reduction Program
- Cognitive Assessment/Memory Enhancement Program
- Medication Management Program
- Stroke Prevention Program

Fall Risk Reduction Program

- Annually assess members beginning at the age of 70, using a specially-designed tool
- Coordinate physical and occupational therapy for in-home strength and balance training
- Perform Home Safety Evaluations and arrange for environmental adaptations as necessary
- Screen and refer for assistance with Medication Management
- Install wireless sensor-based emergency response and activity monitoring system

Members In Care

- *Goals*
  - *Provide quality care and oversight*
  - *Return to independence if possible*
- Assessments to determine type and amount of care needed
- Arrangements for care delivery
- Payment for care up to limits established by member
- Oversight of care delivery

Monitor and Maintain Quality

- Service Provider Network Quality Credentialing
- Member Satisfaction Surveys
- Concern/complaint log and tracking
- Direct feedback from members

Database

- Medical history
- Medications
- Environmental factors
- Lifestyle factors
- Care plans
- Assessment tools
- Member billing
- Provider payment

CCaH & LTCI: A Comparison

Care Coordination	CCaH	LTCI
Face to face	Yes	Sometimes
Telephonic	Yes	Yes
Begins Day 1	Yes	Sometimes
In-claim only	No	Usually
Service Provider Network	Yes	Sometimes
IBNR	Minimal	Yes

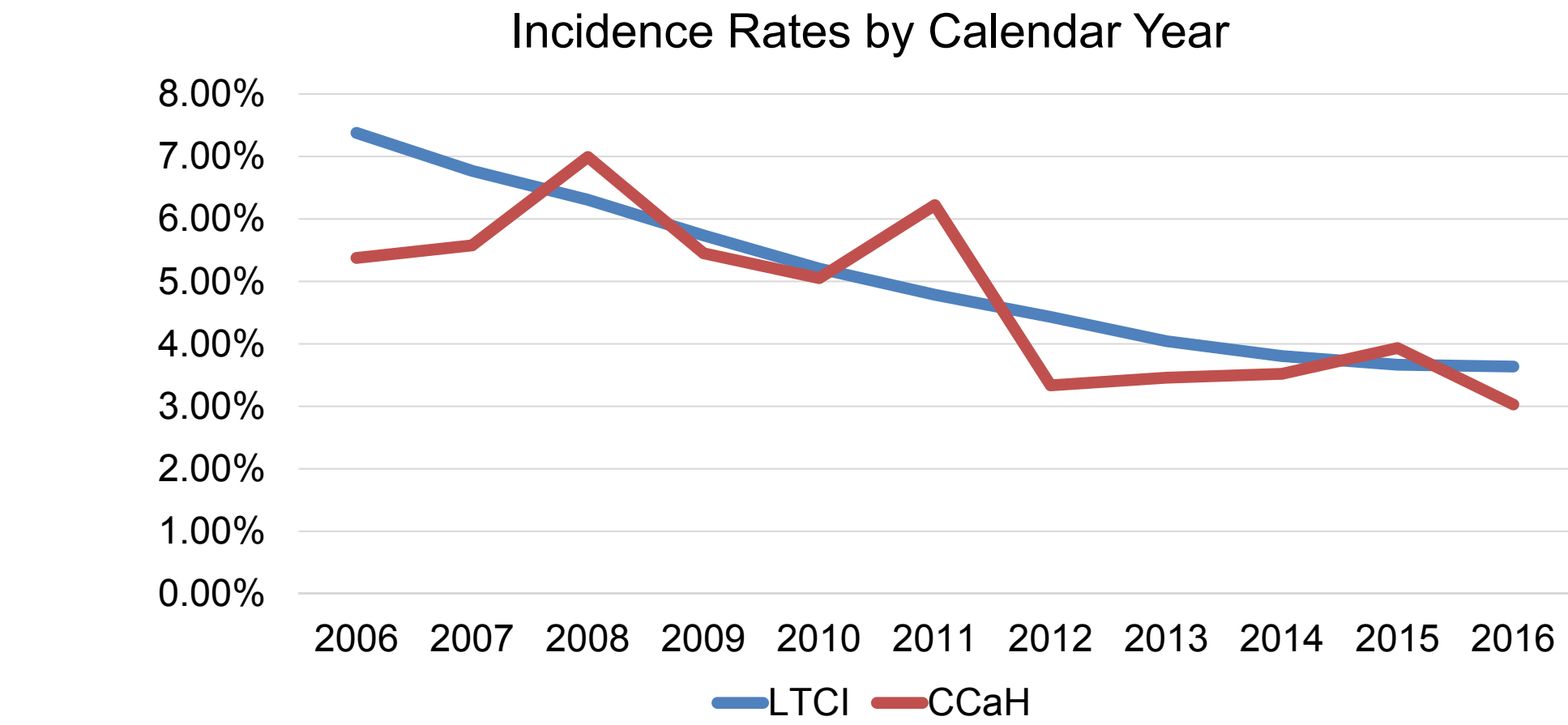
Costs of CCaH vs. LTCI

Vincent Bodnar, Chief Actuary, LTCG

Cost / Benefit Analyses

- Does the CCaH model produce different “claims” experience than observed with LTCI?
- How much does the CCaH model cost to execute compared to LTCI?
- Does the net effect result in savings?

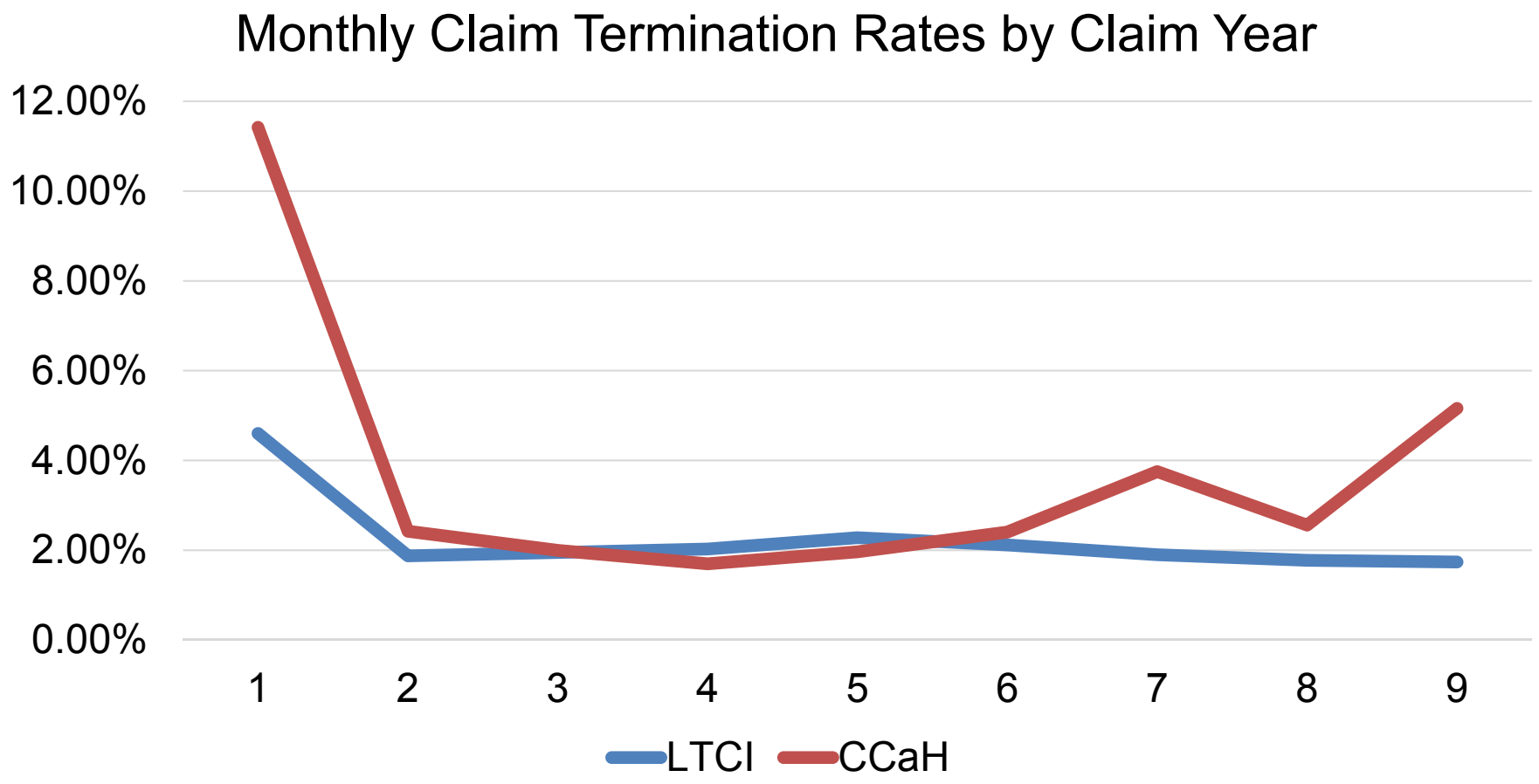
Experience Analysis: Frequency of Claim



CCaH incidence rates are similar to LTCI.

LTCI: 2001-2011 SOA Long Term Care Intercompany Experience Study
The study does not include claims under $200

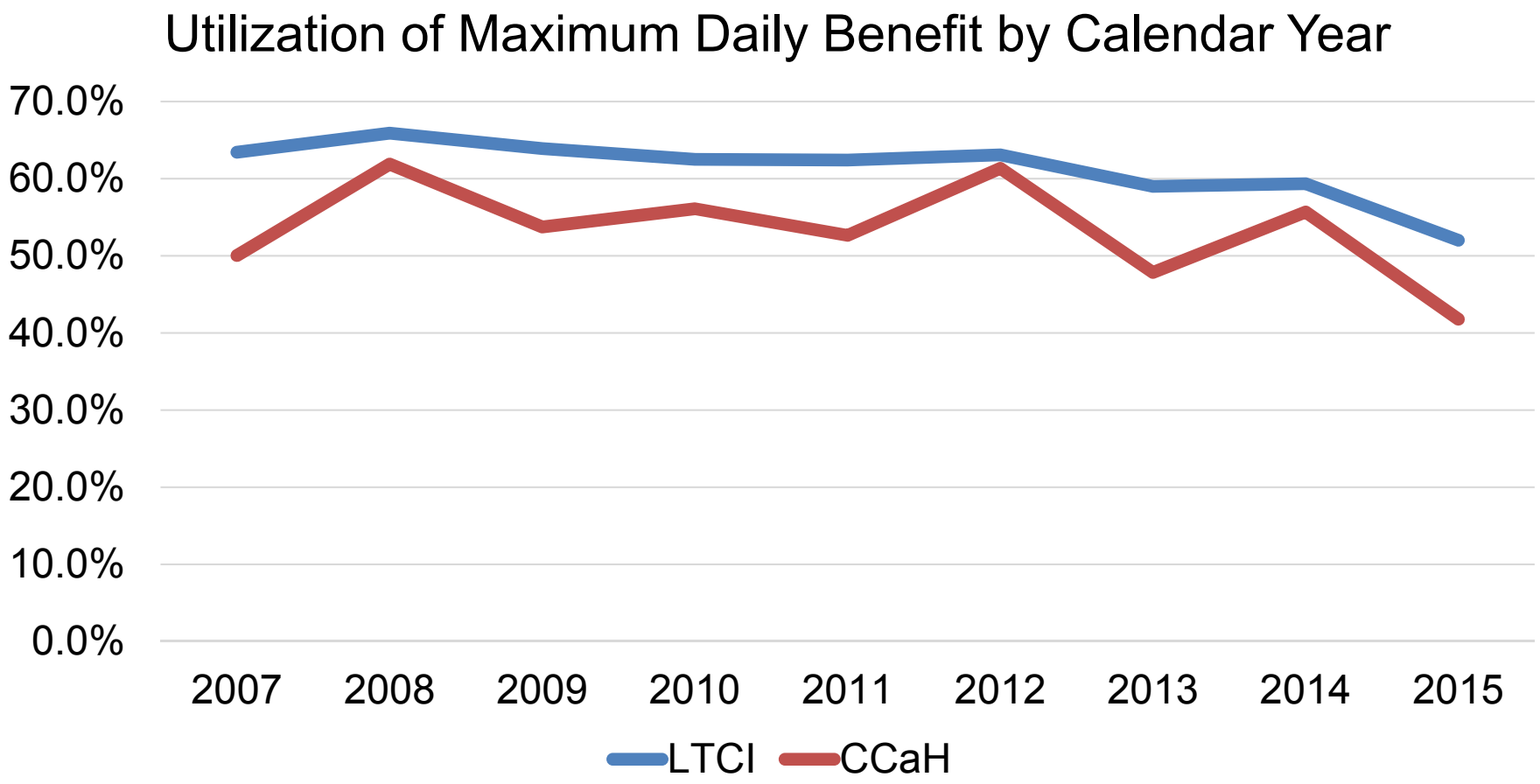
Experience Analysis: Duration of Claim



CCaH claim termination rates are similar to LTCI.

LTCI: 2001-2011 SOA Long Term Care Intercompany Experience Study
The study does not include claims under $200

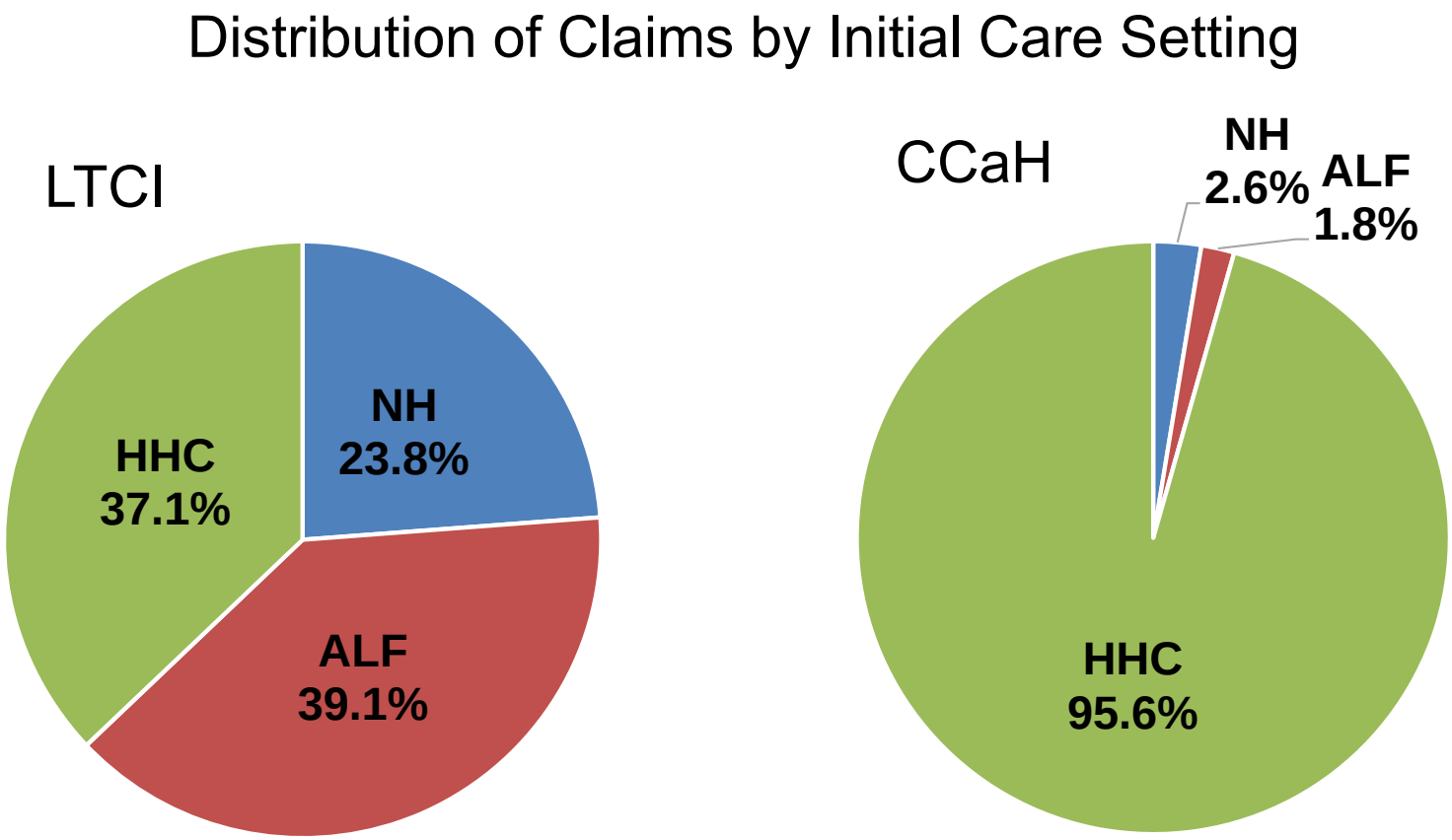
Experience Analysis: Utilization



CCaH utilization rates are consistently lower than LTCI

LTCI: 2001-2011 SOA Long Term Care Intercompany Experience Study
The study does not include claims under $200

Experience Analysis: Care Setting



CCaH heavily weights towards HHC. Further analysis shows that less than 10% of HHC claims transfer to facilities.

LTCI: 2001-2011 SOA Long Term Care Intercompany Experience Study
The study does not include claims under $200

Potential Impact of Care Setting

Illustration of Potential Impact of Distribution Shift

Initial Care Setting	Average Claim Size	LTCI Distribution	CCaH Distribution
Nursing Home	**$100,000**	**23.8%**	**2.6%**
Assisted Living	**$130,000**	**39.1%**	**1.8%**
Home Health Care	**$75,000**	**37.1%**	**95.6%**
Total		**$102,455**	**$76,640**

This example shows a potential claim savings of 25%

Experience Analysis

- Conclusions
  - Similar number of claims generated
  - Similar duration of claim
  - Marginally lower daily benefit utilization
  - Heavy skew towards lower-cost HHC setting
- Net reduction to claim size
  - Amount of reduction will depend on benefit configuration of contract

Expense Comparison

Comparison of Expenses by Business Model

Expense	LTCI	CCaH
Policy admin.	**$120 / year**	**$120 / year**
Claim admin.	**5% of claims**	**13% of claims**
Healthy visits	**None**	**$150 / year**
At-risk visits	**None**	**$1,400 / year**

CCaH is significantly more expensive to administer than LTCI

Example Cost-Benefit Analysis: Age 70

	LTCI	CCaH
Healthy lives	973	973
At-risk lives	16	16
On claim lives	12	12
Total lives	1,000	1,000
New claims	7	7
Average claim size	102,455	76,640
Incurred Claims	751,957	562,490
Policy maintenance	120,000	120,000
Claim administration	37,598	73,124
At-risk visits	0	22,030
Healthy visits	0	145,878
Total expenses	157,598	361,032
Claims + expenses	909,554	923,522

*CCaH model is **2% more** expensive than LTCI.*

Example Cost-Benefit Analysis: Age 80

	LTCI	CCaH
Healthy lives	693	693
At-risk lives	224	224
On claim lives	84	84
Total lives	1,000	1,000
New claims	35	35
Average claim size	102,455	76,640
Incurred Claims	3,585,462	2,682,054
Policy maintenance	120,000	120,000
Claim administration	179,273	348,667
At-risk visits	0	313,434
Healthy visits	0	103,887
Total expenses	299,273	885,988
Claims + expenses	3,884,735	3,568,042

*CCaH model is **8% less** expensive than LTCI.*

Example Cost-Benefit Analysis: Age 90

	LTCI	CCaH
Healthy lives	100	100
At-risk lives	604	604
On claim lives	296	296
Total lives	1,000	1,000
New claims	88	88
Average claim size	102,455	76,640
Incurred Claims	9,040,586	6,762,682
Policy maintenance	120,000	120,000
Claim administration	452,029	879,149
At-risk visits	0	844,965
Healthy visits	0	15,000
Total expenses	572,029	1,859,114
Claims + expenses	9,612,616	8,621,795

*CCaH model is **10% less** expensive than LTCI.*

Conclussions

- Conclusions
  - **At younger ages**, where claims are less frequent, the example **LTCI model is less expensive**.
  - **At older ages** ,here claims are more frequent, the example **CCaH model is less expensive**.

- Concerns and unknowns
  - Would an LTCI population seek or welcome intervention?
  - Is the CCaH model scalable?

QUESTIONS


why
when
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where
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why
QUESTIONS
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