Continuing Care Retirement Communities and At Home Programs, exposure draft #,
http://www.actuarialstandardsboard.org/wp-content/uploads/2020/11/ASOP-No.-3_exposure-draft_november-2020.pdf

Comment Deadline: [February 1, 2021]

Sample response to Exposure Draft

Instructions: Please review the exposure draft, and give the ASB the benefit or your recommendations by completing this comment template. Please fill out the tables within the section below, adding rows as necessary. Sample for completing the template provided at the following link:

Each completed comment template received by the comment deadline will receive consideration by the drafting committee and the ASB. The ASB accepts comments by email. Please send to comments@actuary.org and include the phrase 'ASB COMMENTS' in the subject line. Please note: Any email not containing this exact phrase in the subject line will be deleted by our system's spam filter.

The ASB posts all signed comments received to its website to encourage transparency and dialogue. Comments received after the deadline may not be considered. Anonymous comments will not be considered by the ASB nor posted to the website. Comments will be posted in the order that they are received. The ASB disclaims any responsibility for the content of the comments, which are solely the responsibility of those who submit them.

I. Identification:

Name of Commentator / Company
AV Powell, ASA/A.V. Powell & Associates, LLC

II. ASB Questions (If Any). Responses to any transmittal memorandum questions should be entered below.

Question No.	Commentator Response

III. Specific Recommendations:

Section # (e.g. 3.2.a)	Commentator Recommendation (Please provide recommended wording for any suggested changes)	Commentator Rationale (Support for the recommendation)
1.2	The existing ASOP contains examples of services covered by the ASOP. This language was removed, and I believe it should have been left in.	Examples of services covered by the ASOP provide a good overall summary for those readers who may not be as familiar as the actuaries who practice in this field.
3.6.4	Include allocation of expenses across various levels of care and within each level of care	Add language similar to the language added in this regard for section 3.6.5.
4.1	Exclude new reference to ASOP #7.	ASOP #7 pertains to actuarial analysis for life, health, and P&C insurers, so I do not see the relevance to this reference.
4.2	In the statement where the actuary "should disclose the implications of the deficiency and management's plan to address the unmet condition", add back the "if known" statement at the end of this sentence.	The actuary cannot describe management's plans to address the shortfall if management has not made this clear to the actuary.

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IV. General Recommendations (If Any):

Commentator Recommendation (Identify relevant sections when possible)	Commentator Rationale (Support for the recommendation)
I think that the committee missed the strategic opportunity for the actuarial profession to provide guidance on the still developing industry of Continuing Care at Home by providing valuable guidance to all stakeholders, i.e., Board, management, residents, and regulators, for measuring the true economic status of this long-term care like product.	Having consulted in the CCRC industry for over 40 years and the CCaH industry for more than 20 years, I know that many organizations view their GAAP prepared financial statements as the final arbiter for measuring solvency and accessing their financial performance; and nothing could be more misleading. It can be mathematically proven based on the current ASC 606 that advance fee income recognition significantly overstates financial performance for both CCRCs and CCaHs. Moreover, actuarial reports incorporate corrections to this overstatement that is necessary for stakeholders to receive and understand the true economic position. The current draft does nothing to address these realities, which essentially perpetuates a false sense of success for this product that contains insurance-like contingencies. Both CCRCs and CCaHs are similar to annuities, defined benefit pension plans, and single premium life insurance in terms of their financial characteristics and we as actuaries should know that GAAP techniques are not likely to be appropriate for evaluating financial status and solvency. Notwithstanding the current objectives of ASOPs, I think that it's a travesty for the profession not to address the misleading information and terminology (obligation to provide future services) that results from applying current accounting conventions to create GAAP financial statements for these products. I feel that this revision does not reflect the best capabilities of profession given the current state of actuarial knowledge about these products in 2021 versus the early 1980s when actuarial science was initially applied to CCRCs because it does not identify the rationale for the application of actuarial techniques to evaluate this concept.
The exposure draft adds some new definitions for Continuing Care At Home programs, but fell short of providing additional definitions and guidance for the differences between At Home programs and Continuing Care Retirement Communities	Continuing Care At Home programs have unique features that could be defined such as Benefit Costs, Daily and Lifetime Maximum Benefits, alternative types of care levels, allocation of overhead expenses, to name a few. I believe that the Continuing Care at Home concept would best be addressed by a separate, or companion standard, for reasons stated in my July 10, 2019, letter to the committee. It is attached for reference.

V. Signature:

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Commentator Signature	Date
AV Powell, ASA	02/01/2021

A.V. POWELL & ASSOCIATES LLC
ACTUARIAL INNOVATORS

July 10, 2019

Mr. David Bond, MAAA, FSA, FCA
Chair, ASB Committee for Revisions to ASOP#3
% Continuing Care Actuaries
415 Main Street
Reisterstown, MD 21138

RE: Suggestion for actuarial standards related to Continuing Care at Home (CCaH) entities

Dear Mr. Bond:

I am writing this letter to share my opinion after a conversation with my colleague, Ms. Molly Shaw, a member of the active ASOP#3 task force that you chair. It is my understanding that you are considering the addition of CCaHs to be covered by this standard of practice. It is my recommendation that in lieu of adding CCaHs to the existing CCRC aka Life Plan Communities standard that you recommend that the Actuarial Standards Board develop a new standard that exclusively covers CCaHs. My rationale for this recommendation is provided in the paragraphs that follow a brief statement about my background and experience with both CCRCs and CCaHs.

My background and experiences with CCRCs and CCaHs. From 1985 to 1991, I was chair of the AAA Committee on CCRCs that promulgated the first ASOP#3 that was adopted by the Interim Actuarial Standards Board as well as co-author of the textbook Continuing Care Retirement Communities: An Empirical, Financial, and Legal Analysis. Also, in the 1980s I was the actuary for 3 of the 4 pilot CCaHs (fka Life Care Without Walls) that were developed as part of a grant funded by the Robert Wood Johnson Foundation. The late Hal Barney was the actuary for the fourth site. The objective of this grant was to evaluate the feasibility of the CCaH concept by quantifying the actuarial risks associated with providing the long-term care benefits that are imbedded in a continuing care contract, i.e., home care, assisted living care, memory care, and nursing care, to individuals who would otherwise qualify for admission to a CCRCs in their own homes. The CCaH concept was an innovative attempt to combine the best attributes of two trending options for seniors to finance their potential health care care needs; removing the high cost shelter and board components of CCRCs to create a more affordable product and applying managed care techniques with use of care coordinators to LTCi to reduce long-term care costs.

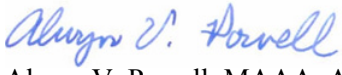
Overview of CCaH industry. The current industry consists of slightly more than 30 entities. All are non-profit, self-insured organizations and all but one was created under the aegis of a parent CCRC. As of June 2019, we estimate that the industry serves slightly less than 5,000 contractholders nationwide, and the oldest six CCaHs serve nearly 80% of that estimate. Many CCaHs are under the regulatory auspices of the insurance department because CCRCs are regulated as such in their state. Others are regulated by the Department or Office on Aging or Health Services. Since CCaH are treated as an extension of a CCRC for regulatory purposes, this allows their development to occur without having to meet certain capital reserve requirements. Given their actuarially small size and limited financial resources of their sponsors, one might argue that there is more than a nominal risk with such an approach. In some states there are limits to the number of CCaH contracts that can be sold by one entity. At least one state is involved in rate, i.e., monthly fee and membership (up-front) fee, control.

Rationale for the development of a separate ASOP. Even though CCaH was conceived by separating a component of benefits that were part of a CCRC contract and in most states a CCaH contract can only be offered by a CCRC, my reasons for recommending a separate actuarial standard are:

1. Notwithstanding the observation that ASOP#3 defines a somewhat universal criteria for actuarial soundness, or satisfactory actuarial balance, in my opinion the benefit structure of the typical CCaH contract is closer to a long-term care insurance contract than a continuing care contract with options that allow the enrollee to select from:
    a. Lifetime care benefits
    b. Daily care benefits
    c. Copayments
    d. COLA options
    e. Portability (this provision does not commonly exist in CCRC contracts)
2. The continual replacement of deceased or withdrawn CCRC contractholders with new entrants is an essential element for their continued operation and solvency. For a CCaH plan, once a minimum membership threshold is achieved, the solvency of that block of business is independent of new members. This means that the solvency measure is simply the actuarial analysis of the closed-book of contracts augmented by cash flow testing and the periodic confirmation of product pricing.
3. A CCRC relies heavily on its fixed asset reserves to achieve solvency because it is an inherent part of their benefit structure. This also creates some nuances in providing an actuarial opinion for satisfactory actuarial balance as it relates to whether or not book or appraisal value is used for fixed assets (which by the way is an issue that might be addressed in ASOP#3). For a CCaH plan, the fixed asset component of reserves would be de minimus, if any, and doesn't factor into the measurement of solvency for a CCaH.
4. Despite my belief that there is a valid argument for CCaHs to be handled in an actuarial manner that is similar to long-term care insurance and apply ASOP#18, I would suggest that this is an opportunity for our actuarial profession to take the lead in providing guidance to maintain solvency for an innovative and relatively young product as we did for CCRCs with ASOP#3. Developing CCaHs have avoided the strenuous capital reserve requirements that are associated with other insurance products by being regulated a CCRC as well as the implicit assumption that the parent CCRC will make good on their contractual obligations. This accommodation (or advantage) is probably essential for the industry to grow and I'm not suggesting that it should be changed. Instead I believe that as actuaries in defining our actuarial standards can create useful reports for clients to better understand those risks. Given the insignificant size of the industry at this time, this is the perfect opportunity for actuaries to demonstrate the relevance of our expertise by helping to create a viable industry based on actuarial tools that protect the public good. Also, it would allow regulatory statutes to refer to a specific ASOP as the measure of solvency.

In closing, I would be willing to elaborate on my reasoning if requested, and, repeating myself this is another unique opportunity for our profession to demonstrate its value. If you don't agree that a separate standard is an appropriate recommendation, perhaps you might consider bifurcating the existing standard into ASOP#3A for CCRCs and ASOP#3B and for CCaHs.

Sincerely,



Alwyn V. Powell, MAAA, ASA

cc: Ms. Kathy Riley, MAAA, FSA, FCA, EA, Chairperson, ASB
Mr. Rick Lassow, MAAA, FSA, Chairperson, ASB Health Committee
Members of the ASOP#3 Task Force
Ms. Erica Kennedy, ASB Liaison

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