PREPARING FOR THE BOOMERS

Jill Rosenblum and Tony Bloemer of Milliman talk to *Captive Review* about the growing insurance demands facing the nursing home industry

Social Security and Medicare solvency has long been a concern as baby boomers reach retirement age. An equally important and often ignored topic is how baby boomer needs will impact the nursing home industry and whether it is prepared to address its casualty insurance exposures.

According to the US Census Bureau, the number of people aged over 65 is expected to double to more than 88 million by 2050. A related concern for the eldest segment of this population is post-retirement medical needs. The population over age 85—those most likely to require nursing home care—is expected to triple, from six million to 18 million, in that same time frame. This inevitable trend will significantly increase the need for nursing home facilities. The US Census Bureau projects that the number of people requiring nursing facilities, alternative residential care places, or home healthcare services will increase from 15 million in 2000 to 27 million by 2050.

In order to provide excellent patient care at a reasonable price, all aspects of operational and financial management need to be revisited. What may in the past have made the most sense may no longer constitute best practices in the changing environment, including the management of casualty insurance risk.

Many of the largest nursing home systems have already reviewed trade-offs between various risk financing alternatives, including self-insurance vehicles. In this article, we will explore the key questions all nursing home management should ask.

What are my insurance options?

A nursing home or nursing home system has several options for managing casualty risk. The first is to purchase traditional guaranteed cost coverage from an insurance company. This option makes the most sense for individual nursing homes not large enough for pooled risks to offset the random nature of claims. Often this is the only vehicle that has ever been considered because it was originally the only option; thus the decision was never revisited as the home or system grew larger. Alternatively, a nursing home with more substantial exposure (discussed below) has the option to retain some of that risk, either through a large-deductible programme or by establishing a captive.

Written by
Tony Bloemer

Tony Bloemer is a principal and consulting actuary in the Chicago Casualty practice of Milliman. He joined the firm in 1998. Tony is a fellow of the Casualty Actuarial Society and a member of the American Academy of Actuaries. Tony's area of expertise is property and casualty insurance, including loss reserving and ratemaking.

Written by
Jill Rosenblum

Jill Rosenblum is an associate actuary in the Chicago Casualty practice of Milliman. She joined the firm in 2009. Jill's area of expertise is property and casualty insurance, including loss reserving and ratemaking. Jill has extensive experience in commercial lines, including workers' compensation, professional liability, general liability, auto liability, and extended warranties (service contracts).

Am I big enough to self-insure?

According to the US Centers for Disease Control and Prevention, the average nursing home houses approximately 88 residents. Generally speaking, a single 88-bed nursing home is not big enough to take on much risk or start a captive. For a larger nursing home or system, the decision to retain risk is dependent on the financial stability and risk appetite of the insured. A well-capitalised nursing home system should consider a large-deductible plan and based on its annual insurance expense could consider forming a captive. Several concerns specific to nursing homes, such as the large variance of claim costs by state and the impact of Medicaid residents on claim frequency and severity, are important to consider when assessing the overall size of the programme and the ability to self-insure. An annual insurance expense of $500,000 across all casualty coverages is a rough starting point when considering a large-deductible programme or formation of a traditional single-parent captive. Forming an 831(b) captive, popular as of late, can be considered if the annual insurance expense is less than $1.2m.

What are the advantages and disadvantages of retaining risk?

Purchasing insurance provides financial stability in the short term but is less cost-effective in the long term. It is no surprise that insurance companies charge more than the expected cost of claims in order to generate a profit. Most small insureds are willing to pay the insurer a profit margin in order to stabilise their own results. However, when an insured becomes large enough to absorb some

of its own volatility, it makes sense to start retaining some risk to keep the insurer's embedded profit in-house. An easy way to do this is by taking on a large deductible. With the baby boomer generation on the long-term care horizon, now is a great time for nursing home systems in particular to reassess their insurance programme.

What are the differences between a captive and large-deductible programme?

For most mid-size nursing home systems, a typical large deductible might initially be $100,000 or $250,000 per occurrence. There are advantages to having a large-deductible programme as compared to a captive. Generally, expenses are less and start-up is easier. To start a large deductible programme, an insured can simply request a quote from its insurance company at various deductibles. The insurer will typically require a letter of credit to secure the deductible advance but not much else. Because retained risk can be substantial, a regular analysis by an independent actuary is recommended and may be required for GAAP compliance.

A major reason to form a captive is increased control over the claims process. The potential negative publicity of a trial may put an insured nursing home at odds with its carrier regarding settlement of a claim. With a guaranteed cost or large-deductible policy, the claims process and right to settle are generally controlled by the insurance company. With a captive, the right to settle is controlled by the nursing home.

Another major advantage of a captive is expense acceleration for tax purposes. Generally under a large deductible programme, the insured (parent) can only expense losses as they are paid whereas establishing a captive allows the parent to expense the total incurred losses (paid losses plus case reserves). This represents a significant timing difference as the average payment lag is three to five years for nursing home professional liability claims.

How do I choose an optimal retention level?

The selection of an optimal retention level is dependent on the financial stability and risk appetite of the insured. Most sophisticated insureds have actuaries model the expected value and variability of losses at various retention levels. As the claim environment for the industry rapidly changes it is important to seek out an actuary with expertise specific to nursing homes. Being aware of future trends such as the expected increase in both frequency and severity for nursing homes as opposed to hospital professional liability in general can have a big impact on the accuracy of estimates. A simplified actuary report risk/return chart is shown in below which details annual (one-year) values. As can be seen over the long term represented by the expected level, the nursing home is better off establishing the captive and retaining $1m per occurrence. However, in a single adverse year (90th percentile), the insured would lose money in the short term by forming a captive. Ultimately, the insured has to make a cost/benefit decision on giving away long term profit to stabilise short term results.

What coverages can I put in my captive?

Most nursing homes begin captives with professional/general liability coverage. This is usually one of the largest insurance expenses and generally has sufficient frequency to be modelled. After a few successful years, other lines of coverage can incrementally be added. Workers' compensation is another major expense for nursing homes that has recently been added to some captives. Additional lines which can be incorporated include: employment practices liability, director and officer (D&O) liability, auto liability, property, and in a recent trend medical benefits. One of the major advantages of forming a captive is the ability to pool the various coverages required by the parent.

Where do I go from here?

In the current soft insurance market, nursing home management may be tempted to fall into a false sense of hesitancy with regard to the self-insurance decision. However, now is the time to act for a nursing home that wants to be able to make the appropriate decisions at the right time. As mentioned above, much needs to be done in terms of feasibility studies and actuarial analyses before an informed decision about risk financing alternatives can be made or a captive can be formed. As seen in the early 2000s hard market, the cost of insurance can quickly increase and a company that isn't prepared in advance may miss out on the opportunity for savings.

To explore your options, we encourage you to reach out to an actuary with sufficient nursing home experience and complete a risk/return analysis for your nursing home or system. From there your actuary can assist through the process based on what makes the most sense for the unique needs of your programme. Among other things this may involve consulting with tax professionals, legal counsel and potential captive managers to begin a feasibility study.

DATA | SIMPLIFIED RISK/RETURN CHART

	Expected Level (Long-Term Average)				90th Percentile (Adverse One-Year Period)			
	Discounted Retained Losses	Commercial Premium	Total Cost	Savings / (Cost)	Discounted Retained Losses	Commercial Premium	Total Cost	Savings / (Cost)
Guaranteed Cost Coverage	$0	$4m	$4m	$0	$0	$4,00,000	$4m	$0
$250,000 per Occurrence Large Deductible Policy	$2m	$1.7m	$3.7m	$300,000	$2.5m	$1.7m	$4.2m	($200,000)
$1m per Occurrence Captive Retained	$2.8m	$700,000	$3.5m	$500,000	$3.7m	$700,000	$4.4m	($400,000)