Continuing Care Retirement Communities

An Empirical, Financial, and Legal Analysis

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Continuing Care Retirement Communities

An Empirical, Financial, and Legal Analysis

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To our children:
Amanda, Cameron, & Tyler
and
Thandi & Sibongile

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PENSION RESEARCH COUNCIL

PURPOSE OF THE COUNCIL

The Pension Research Council was formed in 1952 in response to an urgent need for a better understanding of the private pension mechanism. It is composed of nationally recognized pension experts representing leadership in every phase of private pensions. It sponsors academic research into the problems and issues surrounding the private pension institution and publishes the findings in a series of books and monographs. The studies are conducted by mature scholars drawn from both the academic and business spheres.

Foreword

Those familiar with the interests and past activities of the Pension Research Council may be surprised that it is publishing a book on continuing care retirement communities. Over the years, the Council has been concerned principally with the actuarial and financial soundness of pension plans and the protection of the rights of individuals who look to them as a source of old-age financial support. In other words, the Council has traditionally sponsored research with the underlying purpose of strengthening those mechanisms designed to provide the financial resources needed for a secure old age. In contrast, this book is concerned with a relatively recent institutional arrangement that seeks to provide old-age security and health care *in kind.*

Almost from the moment The Commonwealth Fund and the Robert Wood Johnson Foundation approved a grant to the Wharton School to study continuing care retirement communities, the Council expressed an interest in reviewing the findings of the study, with a view toward its publication. The sponsors of the project had the same concerns about this new institution that the Pension Research Council has about the pension institution—its ability to deliver the benefits and services promised. The nature of the arrangement raises questions about its actuarial soundness, financial stability, and protection of members' rights.

The author of this Foreword participated in the study in an oversight capacity and was in a position to judge the quality of the research involved. The project director, Dr. Howard E. Winklevoss, a member of the Wharton School faculty and the Council, kept the Council fully apprised of developments and of progress being made on the project. The final draft of the report was reviewed by members of the Council—and by the project's advisory committee—who recommended publication by the Council, if permissable. The project sponsors (The Commonwealth Fund and the Robert Wood Johnson Foundation) suggested several guidelines for selecting an entity to publish the study results but left the choice to the dean of the Wharton School. On the basis of his knowledge of and confidence in the Pension Research Council, Dean Donald C. Carroll designated the Council to publish the study.

The Council is proud to publish the results of this pioneering study. The study and its recommendations should be a constructive influence on the future growth of this new social organism, embodying an innovative approach to old-age financial security.

The Council extends its congratulations to The Commonwealth Fund and the Robert Wood Johnson Foundation for conceiving this project, and it expresses its profound gratitude to them for making the necessary financial resources available.

Funds for the publication of this volume were drawn from the Ralph H. Blanchard Memorial Endowment of the Pension Research Council. Mr. Blanchard was one of the founders of the organization now known as the National Health and Welfare Mutual Life Insurance Association, which provides pension and insurance facilities for the staffs of social welfare agencies. Mr. Blanchard served as president of the organization for 14 years, and at the time of his death in 1972 he was honorary president. The Memorial Endowment was established and funded by the NHW Mutual Life Insurance Association to perpetuate the memory of Mr. Blanchard and to further the social goals to which he was so deeply committed. The subject matter of this study epitomizes the concern for the elderly that occupied the thoughts and energy of Mr. Blanchard throughout his life.

It should be understood, of course, that the statements made and the views expressed in this volume are solely the responsibility of the authors and should not be attributed to the funding agencies.

Dan M. McGill

Preface

Today there are about 275 continuing care retirement communities (CCRCs) in the United States where some 90,000 elderly people (average age about 80) live independently in their own apartments but have the opportunity for eating together, group recreation, and other activities that comes from being part of an organized community. Most important, in addition to having immediately available a variety of health and social services which they can call on according to their desires and needs, the residents have a virtual guarantee that they will be adequately taken care of no matter what happens to their health. The fear of someday being a burden on relatives or friends or of finding oneself helpless among uncaring strangers is effectively removed.

It is this health care guarantee that principally distinguishes CCRCs from other retirement communities. CCRCs provide insurance against the cost of long-term care, and supplement coverage of acute health care costs paid for largely by Medicare and private insurance. Their unique feature is that they provide this otherwise unobtainable full insurance in combination with independent living arrangements that the resident can enjoy as long as health permits.

CCRCs are intended to be fully self-supporting, and therein lies the origin of this book. The study is the first detailed analysis of the actuarial, financial, and legal issues involved in keeping existing CCRCs financially sound and providing for the formation of new communities in ways that protect the rights of residents while assuring the perpetuation of the community.

CCRCs provide essentially a new form of insurance, but until now this type of insurance has not been subjected to rigorous examination. It is fortunate that such an examination has begun, and it is to be hoped that this book will be followed quickly by other work in the field. The members of the Advisory Committee who worked closely with the research team believe that the CCRC field may be on the threshold of a major expansion, principally because for the first time large numbers of older Americans will be able to meet the cost.

The financing method combines a sizable entrance fee (average $35,000 single and $39,000 couple at the time of the study) with a monthly payment which is adjusted from time to time for inflation and occasionally other factors (average $600 single and $850 couple). About 70 percent of older people now own their homes, and in many cases they have enough equity in those homes to meet the required entrance fees. And inflation-proof Social Security plus some additional income from private pensions and investments can form a basis for meeting the monthly fee for many older people, although undoubtedly considerably less than a majority.

It is true that many who can afford CCRCs will nevertheless prefer other retirement arrangements, but for a considerable number the full health insurance, including long-term care, combined with independent living in a community setting will make CCRCs attractive.

On behalf of the other 12 members of the Advisory Committee, I wish to commend the research team—Howard E. Winklevoss, Ph.D., project director; Alwyn V. Powell, MAAA; David L. Cohen, Esq.; Ann Trueblood-Raper; and Amy R. Karash—for their efforts to address the comments and suggestions of the Advisory Committee throughout the past 18 months and for diligently pursuing the research which has produced this book. We also wish to thank Dr. Dan M. McGill, who served the study as consultant to the research team and as chairman of the Wharton School Insurance Department and the Pension Research Council.

It is our hope that the book will be useful to public policymakers, to corporations and foundations with an interest in older people and their health, to the financial community, and to potential sponsors of CCRCs.

The Robert Wood Johnson Foundation of Princeton and The Commonwealth Fund of New York City provided financial support for the work of the research team and the Advisory Committee. We are grateful for their backing and hope that the philanthropic community will continue to support important research on CCRCs and related topics.

Robert M. Ball

Chairman of the Advisory Committee
Continuing Care Retirement Community Study

Authors' Preface

Nearly four years have passed since we completed our first comprehensive actuarial study of a continuing care retirement community (CCRC). At that time, the application of actuarial science to set fees in this growing field was nonexistent. Most of the assumptions and methodologies used to set fees and establish financing were not based on scientific analysis but instead were rules of thumb or anecdotal approaches. Moreover, the literature about the industry dealt with social and health-related issues, and rarely with the financial issues associated with operating a facility.

To some degree, the limited financial sophistication was due to the newness of the concept and a misconception regarding its true nature. Many of the early marketing efforts concentrated on the real estate component of the services provided. The central theme of providing a way to finance long-term health care needs privately was a secondary and rarely emphasized issue. Actuaries and other financial analysts were basically unaware of this industry prior to publicity about the financial distress of some communities that made national headlines in the late 1970s. Even then, there was considerable controversy over the correct pricing methodologies and the appropriate types of contractual guarantees. It was even suggested that the continuing care financing arrangement to ensure lifetime health care for small groups of elderly was not viable, or was possible only with fees that were prohibitively expensive.

Recognizing that the service goals of the continuing care concept may be one answer to the growing needs of the independent elderly for housing and health care, the Robert Wood Johnson Foundation and The Commonwealth Fund solicited proposals to conduct research to address the question of financial viability for the concept. In April 1981, they agreed to fund jointly a research grant to the Wharton School of the University of Pennsylvania, with Howard E. Winklevoss, Ph.D., and Alwyn V. Powell, MAAA, as the primary investigators. So that the research would be timely, the authors decided to concentrate on the following three areas: (1) a definition and survey of the general characteristics of the CCRC industry, (2) a detailed development and explanation of the actuarial principles underlying the pricing and long-term financial characteristics of CCRCs, and (3) a discussion of the legal issues arising from the continuing care contract with suggestions for their legislative treatment.

This book is the culmination of 18 months of research. Its primary objectives are to set forth normative guidelines for pricing and evaluating continuing care retirement communities and to provide a reference that will assist legislators in assessing the advantages and disadvan-

tages of various components of continuing care regulation. This book is not designed as a "how-to" book on the financial operation of CCRCs; rather, it is intended to provide the management and board members of CCRCs with a broad understanding of the financial intricacies of their communities. Furthermore, this book provides guidelines to analysts who wish to conduct similar research by explaining in detail the methodologies developed during the course of the study.

Chapter 1 presents an overview of the industry's growth and explains why the industry is worthy of research; the rest of the book is divided into three parts, corresponding to the study's three research topics. Part One consists of Chapters 2 and 3, which summarize the empirical findings of the survey of 207 CCRCs (75 percent of the defined universe). Part Two consists of Chapters 4 through 11, which will interest those readers whose concerns embrace financial issues. These chapters develop the actuarial methodology proposed for evaluating the long-term financial condition of a CCRC. The results of applying this methodology to six existing CCRCs are discussed in each of the chapters. Part Three consists of Chapters 12 and 13. Chapter 12 discusses relevant legal issues and how they are treated by existing legislation. Chapter 13 presents the authors' recommendations for state-level legislation on each of these issues. Finally, Chapter 14 summarizes the significant research findings and recommendations and suggests a number of areas that merit further research. The appendixes contain technical explanations of the methodologies developed by the authors.

We would like to offer thanks to the members of the study's Advisory Committee, who reviewed all preliminary drafts of the book and attended 11 days of seminars to guide the research staff in the conduct of the study. Other valuable advice was contributed by members of the review panel, which consisted of providers of continuing care and legal experts practicing in the field; the members of both groups are listed on the following pages. Several members of the Pension Research Council also offered their comments prior to publication, and Dr. Dan M. McGill, chairman of the Pension Research Council, is owed special thanks for his review of the book and for his helpful guidance throughout the study.

Our collaborators made important contributions to this volume. They include Ann Trueblood-Raper, consultant in gerontology, who wrote Chapters 2 and 3; David L. Cohen, Esq., associate at Ballard, Spahr, Andrews & Ingersoll, who researched and wrote Chapters 12 and 13; Dr. Robert A. Zelten, associate professor of insurance and health care systems, who contributed to Chapter 10; and Mitchell Leon, public relations consultant, who contributed to Chapter 1.

We are grateful to the American Association of Homes for the Aging for its assistance in developing our 24-page survey instrument, for

encouraging its members to complete the instrument, and for its helpful comments and support.

The authors are particularly indebted to the following staff members, whose collective contributions were essential for the timely completion of this project: Robert Goodrich; Roger W. Hallowell; Joseph Marant; Jayaram Muthuswamy; and Catherine C. Singer. We extend our special thanks to Amy R. Karash, our administrator, who planned the logistics associated with the survey questionnaire, word-processed and edited innumerable versions of the book, and provided day-to-day support from the inception of the study.

Finally, and most important, we are grateful to our wives, Carol and Keitumetse, whose encouragement and acceptance of additional responsibilities during the course of the study enabled us to devote our time to the research and writing of this book.

Naturally, the authors remain solely responsible for any conceptual or technical errors that may remain.

Howard E. Winklevoss

Alwyn V. Powell

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Contents

List of Tables

List of Figures

Chapter One
Introduction

■ Of all the challenges facing American society, none is more dramatic than the one created by the unprecedented "age bulge" in the population. The number of Americans aged 60 and over has increased nearly sevenfold so far this century. Moreover, the number of Americans aged 65 and over is expected to approach 50 million by the year 2025, nearly double the current figure of 26 million.

The elderly now account for 11.6 percent of the population. However, projections by the Census Bureau are that the elderly will account for 13.1 percent of the population in the year 2000 and 21.7 percent in 2050.

The aging of the American population has understandably been the focus of attention and concern, and has accounted for a major portion of the government's health care and income security dollars in recent years. At the same time, health service delivery planners, providers of care, advocates for the elderly, and the philanthropic community active in health affairs have been instrumental in drawing attention to the need for well-conceived living and health care arrangements for the growing number of older Americans.

That concern and need are being expressed against the backdrop of a remarkable economic and social accomplishment which has taken place over the past four decades—the provision of nearly universal Social Security benefits for Americans over 65. At this time, nearly 95 percent of people over 65 are eligible to receive monthly Social Security benefits indexed to climb at the rate of inflation. In 1982, an estimated $156 billion in Social Security benefits was paid out to 36 million

Americans. An estimated 25 percent of those over 65 are eligible for private pensions which supplement their Social Security benefits.

As the economic well-being of most members of the older American community has continued to improve, much more attention has been paid to the need for a broad range of shelter and care options.

In many cases, the ideal option is a combination of community-based medical and nonmedical assistance which permits the elderly person to remain in his or her own home. In other cases, the alternative of living in the homes of other family members or moving to a nursing home may be preferable or necessary. However, for a growing number of retired Americans, a practical and attractive solution to the problem of where to live with maximum independence and readily available social and medical services has been the continuing care retirement community.

Continuing care retirement communities provide lifetime residence to people after retirement. These communities offer long-term contracts which typically guarantee shelter, health care, and various other social services for the rest of the resident's life, through the same risk-sharing principles on which commercial insurance policies are based. Retirement homes founded on the continuing care concept have been in existence, in varying forms, for over half a century, but they have been a growing phenomenon since the 1960s.[1]

During the past two decades, the demand for continuing care accommodations has increased markedly. Retirees are attracted to the notion of having both independence and security together in a campus-like setting. The homes encourage residents to lead full, active lives as long as possible, yet offer access to various kinds of assistance, including full-time nursing care, when needed.

This study was undertaken in recognition of the fact that in order to provide the quality services they wish to offer, it is incumbent upon retirement facilities to have the soundest financial management. Although sound financial management is the primary subject of this book, it is first useful to place in perspective the issues associated with retirement living and the reasons why it is a subject of growing importance.

ECONOMIC ISSUES

As Joseph Pechman, director of economic studies at the Brookings Institution, has described the situation:

> Twenty or thirty years ago the elderly were a disadvantaged group in the population. As a result of public policies, primarily Social Security, they

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[1] Aldersly, Inc., also known as the Danish Home, in San Raphael, California, has been in continuous operation as a continuing care retirement community since 1921.

> have improved their relative status compared with the nonelderly to the point where, right now, on the average, the elderly are as well off as the nonelderly. That's a great national achievement.[2]

According to data from the Social Security Administration, 26 percent of the elderly derive at least 90 percent of their income from Social Security and two thirds of the elderly derive at least half of their income from Social Security.[3]

The changes now being considered in the scope and direction of government activities threaten the very tangible accomplishments of the last several decades in providing a base of economic, health, and social supports for America's elderly.

Many states have increased taxes and/or reduced spending in an attempt to trim their multimillion-dollar shortfalls. Expansion of public services and programs under these conditions has become ever more difficult, even as demands have risen.

The federal government is currently spending over $210 billion in major programs for the elderly, with Social Security accounting for three quarters of that amount and Medicare, the health program for the elderly, accounting for another $50 billion.

Estimates of the federal deficit for 1983 range upwards of $200 billion. Unemployment rates of 10 percent and high interest rates, as well as inflation of 14 percent in the nation's health care bill, have brought calls for reductions in the rate of growth in the economic security and health programs. Our national commitment to the continued economic and social well-being of our elderly is being sorely tested.

In addition to the need for continuing public support, there is a need to identify private sources of financing for retirement living, sources that allow the elderly themselves, as a group, to use the resources available to them to help finance their later years affordably. The continuing care retirement community, with its exclusive reliance on private financing, is one of the attractive options being developed to meet this need.

THE CHALLENGE OF AN AGING SOCIETY

Retirement living is an issue of extreme importance to an increasing number of Americans, especially as more workers retire before age 65 and as life expectancy continues to grow. Labor force participation over the past three decades has been tending toward earlier retirement; rates of labor force participation for men over age 65 are now less than half the rates in 1950.

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[2] *New York Times,* December 19, 1982, p. 4.

[3] Ibid.

Between 1980 and 2030, the total population is expected to grow by 40 percent. In contrast, the number of people over 65 will double. The over-75 group is growing at an even faster rate. Currently, 38 percent of the elderly are 74 years of age or older. By 2030, this figure will increase to 45 percent. Those aged 85 and older now number about 2 million. By 2030, this figure will triple to 6 million.[4] This demographic upheaval will create an unprecedented demand for services, especially long-term care services.

There will continue to be large numbers of older people who cannot afford their retirement years, though in general the next elderly generation will be wealthier than any before it. The number of elderly persons living in poverty, according to Census Bureau estimates, dropped from 35.2 percent in 1959 to 25.3 percent in 1969 to 14.6 percent in 1974. Since then, the figure has remained within the 14–16 percent range.

America's current system of housing and long-term care is being deeply affected by the speed with which these societal changes are occurring. The elderly are demanding high-quality services. They are better educated, longer living, more active, and better off financially than any elderly group before them. They are giving providers of housing and health care new challenges to guarantee not only shelter and services but also creative avenues for their interests and a new definition of quality of life.

CHOICES IN SHELTER AND SERVICES

Most older people want to live independently for as long as possible, but until fairly recently, few options were available to those older persons who could not, or did not wish to, maintain their own homes. Increasingly, the available options have not been limited to private residence at one extreme and institutional care at the other. More than a matter of preference, however, the choice of where to live is often complicated by the presence or absence of a spouse, the proximity of adult children, and questions of health needs, income limitations, and housing supply. The available options may include renting an apartment or space in a private home, sharing living quarters, or living with or near relatives. More independent but impaired elderly may take advantage of home health or other in-home support services, where available. In some areas, adult day care and respite care help families keep elderly relatives at home. Federal housing projects combined with rental assistance offer affordable shelter to some low-income persons, but support for these programs has been reduced. Congregate

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[4] Health Care Financing Administration, *Long-Term Care Background and Future Directions* (Washington, D.C., 1981).

living arrangements offer independent living accommodations and such non-medical amenities as meals and housekeeping. Other alternatives exist as well, though most are not yet available on a wide scale.

A number of relatively new alternatives to existing federal and state programs have developed. Among these are communities that offer rental housing, communities that offer housing and guaranteed access to health care at a daily rate, and the aforementioned continuing care retirement communities, which treat housing and services as an integral set of concerns.

As the elderly population grows, and pressures for housing and services mount accordingly, more imaginative, cost-effective approaches to traditional forms of care will be needed, combining private, community, and voluntary commitments with available government resources to meet the growing demand.

FINANCING OF LONG-TERM CARE

Public demand on the future direction of long-term care and the means to finance that demand often focus on alternatives to institutional settings for the provision of care. Yet the existing health care system provides far greater support for institutional and medically oriented care than for any of these alternatives.

The complexity and fragmentation of federal and state programs, moreover, make it difficult for elderly persons to get the services they need in order to remain at home. In addition, certain elderly persons will always require the ongoing medical care, nursing services, continual supervision, and assistance with daily living that institutions, chiefly nursing homes, provide.

Although only 5 percent of the elderly, about 1.3 million persons, live in nursing homes today, that number is expected to increase by more than 50 percent in the next 20 years. The great majority of nursing home residents are over 75, female, and single, widowed, or divorced. It is estimated that about 20 percent of people over 65 may be in a nursing home at some point during the remainder of their lives.

Medicaid, the federal health program for the poor, is the principal public funding mechanism for care in nursing homes. Government funds paid for nearly 70 percent of nursing home costs in 1979, with private payments accounting for the rest.[5] At the current rate of increase, the total cost of nursing care will triple by 1990, from the current $25 billion to more than $75 billion. The actual annual national nursing home bill should be much lower than this projection, however. States are taking steps to reduce the growth of nursing home beds and

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[5] Health Care Financing Administration, unpublished data.

to increase the availability of skilled nursing care in the home and other community settings.

The high costs, as much as $18,000 to $20,000 a year, quickly deplete the savings of many persons who enter nursing homes on a private-paying basis. Only a small percentage of nursing home residents can afford to be private payors for an extended period of time. The rest often turn to Medicaid, which accounts for 87 percent of government expenditures for nursing home care. However, Medicaid is a means-tested welfare program, and federal and state governments are taking steps to restrict its growth. Medicare, which accounts for less than 4 percent of government expenditures for nursing home care, pays very little because of a 100-day limit on benefits and, currently, a prior hospitalization requirement.

At present, only about 1 percent of nursing home payments are made by third parties. However, insurance companies are beginning to recognize a potentially expanded role for themselves in the provision of long-term care. Insurers are testing the market for long-term health care insurance policies and analyzing the financial risks associated with such coverage. Another insurance option is the formation of residential communities into risk-sharing groups, spreading the potential health care liability over a number of individuals. An existing example of this self-insurance approach is the continuing care retirement community (CCRC), the subject of this book.

CCRCs, which combine the insurance principle of risk pooling, private capital, and a management system, are likely to become an increasingly important option for financially self-sufficient retirees as greater emphasis is placed on developing private financing alternatives to address pressing needs.

HISTORY AND GROWTH OF CCRCs

The continuing care retirement community represents a further step in the evolution of public and private involvement in caring for the aged, including the provision of pension or assistance programs under governmental and private sector auspices.

The concept of continuing care is the result of the cross-pollination of related ideas and disciplines, many of which have their roots in the social programs of England, Germany, and the Scandinavian countries.

Among the precursors of the CCRC were the medieval guilds, which were the beginnings of premodern times of attempts by self-reliant people, through prior contributions, to insure themselves against losses arising from death, injury, and old age. Mutual aid societies and the English friendly societies were organized for such purposes.

As immigration to the United States increased during the 18th and 19th centuries, the English, Welsh, Irish, Scottish, Germans, French, Swiss, Jews, Belgians, Italians, Dutch, and Scandinavians organized mutual aid societies.

The increase in immigration also gave rise to a religious revival movement, especially in the cities where many immigrants congregated. As a social historian has written of this period:

> In a healthy parish the families could help one another over many everyday emergencies, and parish acquaintance was the foundation of many mutual-benefit societies like those federated into the German Central Verein (1855) and the Irish Catholic Benefit Union (1869). But the resources of parish families and their priest were limited, and the benefit associations were mostly interested in helping their contributing members. Very soon the bishop had to think about a second, institutional line of defense against need. So were founded a variety of charities, all of them conceived to supplement the home. Hospitals were for the sick poor who could not be treated at home; some were for "incurables," but in any case the treatment was likely to fail, leaving the family without a breadwinner or his wife. Hence the orphanage and a home for the aged.[6]

During this same period, the county poorhouse or township poor farm, which reflected the growth of public responsibility for the indigent aged, became part of the American landscape.

Subsequently, but before the development of compulsory old-age insurance systems, some consideration was given to the establishment of industrial pension systems for aging workers and state-administered old-age assistance laws.

> The early years of the depression focused public attention upon the plight of the needy aged, many of whom would never have been in the relief category if it had not been for the loss of savings through bank failures, deterioration of investments, and unemployment. Old-age assistance promised a more humane care of aged dependent persons than commitment to the poorhouse. By 1935, old-age assistance legislation had been provided by the laws of twenty-eight states and two territories.[7]

At the same time that states were struggling to provide for elderly residents who met certain residence and financial qualifications, church groups and other private organizations were developing community-based homes for their aging members.

A 1929 Bureau of Labor Statistics survey of homes for the aged found that religious or private organizations operated 80 percent of the

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[6] James Leiby, *A History of Social Welfare and Social Work in the United States* (New York: Columbia University Press, 1978), pp. 80–81.

[7] Earl L. Muntz, *Growth and Trends in Social Security* (New York: National Industrial Conference Board, 1949), p. 66.

homes for which data were obtained. Many of these homes would not be recognized as continuing care retirement communities by today's standards, but they embodied many of the same principles used by religious and community groups to develop housing and medical care arrangements for the elderly.

Often, churches did not have pensions for their ministers and missionaries and felt that it was their responsibility to provide for the housing and care of these people on their retirement. Two communities quite similar to continuing care retirement communities were established for these purposes: Pilgrim Place in Claremont, California, begun in 1915; and Penney Retirement Community in Penney Farms, Florida, begun in 1925 by James Cash Penney. In the 1929 Bureau of Labor Statistics survey, 16 of 26 national church groups reported having a pension or relief fund for aged ministers.[8]

Most of the communities included in this study that offered continuing care contracts to residents prior to 1934 were originally homes for the aging (and sometimes children) sponsored by the United Methodists in Oregon, the Presbyterians, the United Church of Christ, and private foundations.

Pacific Homes Corporation also belongs in this category. According to information distributed by United Methodist Communications in 1979, Pacific Homes has its roots in the German Methodist Conference that established a home for retired ministers at a campground, now the site of Kingsley Manor, in Hollywood in 1912. In 1928, the German Conference merged with the Southern California Conference of the Methodist Episcopal Church, and in 1929 the Pacific Old Peoples Home was incorporated as a California nonprofit corporation. Kingsley Manor was the only property operated by the corporation until 1949. Presumably the success and ambiance of these communities for ministers and missionaries had appeal and application to the wider church population and the growing number of people who retired to southern California.

From 1949 to 1964,

> six additional properties were acquired by the corporation which came to be known as Pacific Homes Corporation. Pacific Homes historically operated its business on the basis of prepaid life-care contracts which essentially promised residents lifetime care, including comprehensive health care services. Residents paid an "accommodations fee" to cover the cost of the residence and a "life care fee" designed to cover the cost of health care. In later years, Pacific Homes also entered into continuing

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[8] Florence E. Parker, Estelle M. Stewart, and Mary Conymgton, compilers, *Care of Aged Persons in the United States* (New York: Arno Press, 1976), p. 110. Originally published by the U.S. Department of Labor in 1929.

care agreements which included an accommodations fee and a monthly care fee.[9]

The funding of CCRCs through a one-time life care fee has proven to be an unstable situation, and all CCRCs now utilize a combination of an entry fee and a monthly maintenance fee.

Several other communities have offered continuing care contracts for over 30 years, including Brethren Hillcrest Homes in La Verne, California (1947): Dorothy Love Retirement Community in Sidney, Ohio (1922); and Park Vista Presbyterian Home in Youngstown, Ohio (1947). The Heritage in San Francisco, California, founded by the San Francisco Ladies' Protection and Relief Society in 1853, has offered continuing care contracts since 1955.

Homes for the aging which provided care and services to their residents under a policy of receiving all present and future assets in return for a lifetime of total care ("asset turnover" or "total care") gradually changed to a more marketable payment schedule based on actual costs.

In the first decades of the 20th century the principles of insuring oneself against accident, sickness, and for one's retirement began to take hold in the United States. These developments were instrumental in paving the way for the growth of CCRCs as an affordable option for retired persons.

This period also saw progress in the establishment of pensions for various categories of retired workers, primarily civil servants, veterans, and railroad workers and industrial workers to a lesser extent. It was the Depression which impelled American political and social leaders to consider the idea of old-age insurance more seriously. Great pressure developed on government in the early 1930s to enact a program of economic security for citizens in their old age. Efforts to add compulsory national health insurance to the program which eventually became known as Social Security were dropped because of intense opposition from physicians.

Throughout the period of debate over the extent of public responsibility for older citizens, including the level of financial support provided, the concept of CCRCs, frequently sponsored by religious organizations and supported by contributions from residents to the extent of their financial resources, continued to grow.

The existence of pensions for a larger number of retired workers made it possible for many of them to enter continuing care retirement communities over the years. A religious revival occurred in the United States between 1940 and 1960, as church membership rose from 49

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[9] Edwin H. Maynard, *A Summary of Events* (United Methodist Communications, 1979).

percent to 69 percent of the population, and this period coincided with an expansion in the number of CCRCs.

In the 1950s, such church groups as the Northern California Presbyterians, the United Church of Christ, and the American Baptists, sought an alternative to the traditional "home," which was neither attractive nor suitable for the growing numbers of fairly independent, financially secure people living along the Pacific Coast and in the Bay area of California.

During this period, churches in Oregon organized and established several CCRCs, including Willamette View Manor in Portland, sponsored by the United Methodists in Oregon in 1955, and Rogue Valley Manor in Medford, sponsored jointly by the Episcopal, Presbyterian, and Methodist churches.

In 1954, the National Retired Teachers Association built Grey Gables in Ojai, California, and operated it as a CCRC. Villa Gardens in Pasadena, California, was established for teachers by the California Teachers Association in 1927. Although neither of these communities currently offers continuing care contracts, both remain operating retirement communities.

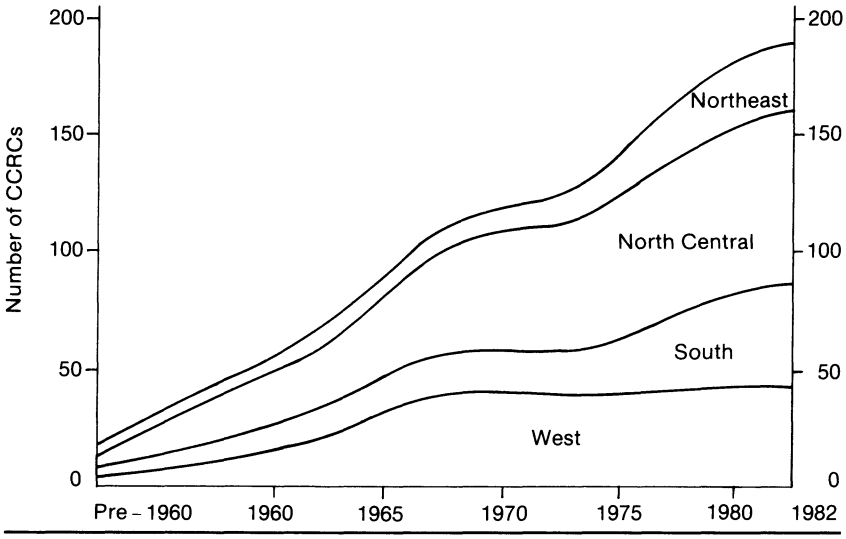
The federal government also influenced the growth and development of continuing care in the late 1950s and early 1960s. In 1959, the National Housing Act created the Section 231 program, providing federal mortgage insurance to aid in the development of new or substantially rehabilitated rental housing for elderly individuals. A number of CCRCs built in the early 1960s, among them the two communities known as The Sequoias, were constructed with Section 231 federally insured mortgages. In 1964, however, the program rules were revised to exclude the use of Section 231 in conjunction with "founder's fees" or any type of admission payment.

Nearly all CCRCs are owned and operated by nonprofit organizations, many sponsored or affiliated with a religious body. Nearly 300 CCRCs were identified in the United States by the empirical study reported in this volume.

Although continuing care retirement communities have existed for many decades, their median age is only 14 years, where age means the number of years since the community first offered a continuing care contract to a resident.

A distinct regional pattern emerges in comparing opening dates of communities by regional location, as illustrated in Figure 1–1. Crosstabulation of these two factors shows that the oldest communities were built primarily in the North Central region and in the West. Steady growth in CCRCs has occurred throughout the past two decades in the North Central area, while the Western region experienced explosive growth between 1960 and 1969 with less growth in recent years. The largest number of communities opened between 1970 and 1979 were in

FIGURE 1–1
Opening Dates by Regional Location



the Northeastern region. The South is the site of most recent growth; most of the new communities (73 percent of those opened in 1980 and 1982) are located in the Sun Belt.

CHARACTERISTICS OF CCRCs

CCRCs are organizations established to provide housing and services, including health care, to people of retirement age. These communities typically offer independent living in a campus-like setting, which may also contain health care facilities such as congregate living, personal care, and intermediate nursing care or skilled nursing care. The communities offer residents the guarantee of shelter and various health care services, usually for life.

CCRCs have an average of 165 independent living units and two or three other levels of on-site care, in either a campus or high-rise design. The physical facilities of CCRCs vary in style and structure and may feature studios, one- and two-bedroom apartments, high- or low-rise buildings, or duplexes. Some communities offer only skilled nursing care, to which residents transfer when they are no longer able to maintain their apartments independently. Others also have intermediate care facilities, consisting of congregate living and/or personal care units. Some offer home nursing programs or other optional health care services such as physical, occupational, or speech therapy. Many com-

munities have built their levels of care in phases, some by original plan and others by converting or extending an existing facility.

Communities tend to build independent living units (ILU) first and skilled nursing units later. The study data showed that many communities have added personal care facilities (PCF) recently or have started with PCFs and added ILUs.

Most communities have a menu of social activities available to residents. Communities vary in size from under 50 to over 2,000 residents, but they typically house between 200 and 500—a population large enough to provide healthy social interaction without being overwhelming. The average resident population is 245. The average age of residents in independent living units is 80.2 years and that of residents in intermediate nursing care units is 85.4 years. Most CCRCs have active resident associations.

To enter a CCRC, residents usually meet a minimum age requirement (often 62 years) and are able to pay a relatively large one-time entry fee and an additional monthly fee, both of which can vary greatly, depending on region and the economic climate. Entry fees are usually dependent upon the size of the living unit occupied, and some portion of the fee is usually refunded if the resident vacates within a given period. The monthly fee may increase if inflation causes living costs to rise, but the fee will not increase by the full amount of any health care costs the resident might incur. In many cases, there is no additional charge for health care.

The range of entry fees and monthly fees in CCRCs is quite broad, reflecting a wide variation in services, guarantees, and the effects of inflation. This study found that average entry and monthly fees are comparatively moderate and that the potential universe of CCRC residents is much larger than had been previously thought. For one person, the average entry fee is $34,689 and the average monthly fee is $562. For a couple, the average fees rise to $38,682 and $815, respectively.

These figures support the proposition that CCRCs are within the financial reach of many middle-income individuals, especially elderly homeowners with substantial equity in their private residences and persons with inflation-indexed retirement pensions.

Approximately 70 percent of couples over 65 and 35 percent of single persons over 65 own their homes, and 80 percent of the homes are owned outright. However, housing expenses for older persons have doubled in the past decade as the costs of energy, real estate taxes, insurance, and maintenance have increased, and these costs now represent about 42 percent of the income of older homeowners.[10] Selling one's home can, for many Americans of retirement age, create

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[10] American Association of Retired Persons, *Report on 1981 White House Conference on Aging* (Washington, D.C., 1981).

all or the major part of the lump-sum payment necessary to enter a CCRC.

The growth of retirement systems, including pensions for retired private and public employees and inflation-indexed Social Security benefits, which alone can provide a couple $1,000 per month, is likely to make the CCRC a more viable option for increasing numbers of retirees. And it appears that the CCRC's self-pay approach will become more attractive as the financial burdens of home ownership begin to outweigh the advantages.

In short, then, CCRCs can offer a significant number of elderly people of varying economic means a contract for lifetime health insurance, virtually assuring them of financial security for the remainder of their lifetimes. CCRCs represent an important alternative to nursing homes and other long-term care facilities in that they reverse the trend of alienation experienced by many isolated older people by providing an opportunity for social interaction with peers, a variety of activities, physical security, and a continuum of nursing care as it is required—features which reverse the trend of alienation suffered by people confined to freestanding nursing homes.

Illness and death rates are lower for CCRC residents than for the general population, and there are undoubtedly several reasons for this. For example, healthy individuals may be more willing to pay a larger entry fee; middle- and upper-income individuals may have had better health care earlier in life; and the entry requirements of many communities preclude the acceptance of nonhealthy individuals. A number of studies have confirmed that good housing and adequate health care are conducive to long life, and it may be that the communal spirit and variety of activities offered by a CCRC may foster a lower incidence of illness and an increased life expectancy among residents.

The CCRC is able to offer the attractive package of independent living and health care because it is based on an insurance concept to fund its health care liability. A portion of the entry fees and monthly fees paid by residents is utilized by the community to pay health care expenses; since only a relatively small proportion of the community's residents require health care at any one time, these fees represent an insurance premium paid by the entire community for health care which will be used currently only by a small group. In addition, some portion of fees is often set aside to provide subsidies for residents who cannot continue to pay their monthly fee. It is almost unheard of for a resident to be evicted from a community because of an inability to pay fees due to uncontrollable circumstances.

Since every CCRC resident is guaranteed health care whenever he or she needs it, management must generate a continuing influx of new entrants to fund the community's health care liability. This strong commitment to the lifelong security of CCRC residents typifies the inten-

sity of management's responsibility to maintain the financial well-being of the community itself through health care reserves, and represents the critical distinction between continuing care retirement communities and other arrangements, which operate strictly on a month-to-month, or rental, basis.

One of the unique aspects of initiating a CCRC is the substantial inflow of funds from the lump-sum entry fees paid by the initial group of residents. For example, a community with 300 residents would collect $9 million if the average entry fee were $30,000. The usual arrangement is to use these funds to finance a portion of the facility and to secure an additional amount in the form of a mortgage or bond issue to finance the remainder. Monthly fees are often set to cover operating expenses, with mortgage payments being supported by the resale of apartments when individuals either die or are permanently transferred to the health care center.

Potential Problems

This financing arrangement and pricing methodology appear relatively simple, but a number of precautions must be taken to assure a community's financial stability. Double-digit inflation in recent years has spelled financial trouble for some CCRCs and required them to take corrective action to cover their unfunded liabilities. A crucial element in the financing structure is the turnover or resale of apartments, since the funds obtained in this way are often needed to meet the community's debt service. However, because of the small number of residents, random deviations can cause the number of deaths and/or the number of residents who transfer permanently to the health care center to vary significantly from year to year. If only a few apartments are released in a given period of time, significant cash flow problems can develop—due to an "unlucky" deviation in mortality and morbidity rates. Yet another factor that can cause CCRCs to experience lower than expected turnover is the low mortality and morbidity associated with CCRC residents. Thus, apartment turnover rates may be considerably lower than anticipated from published mortality tables.

If a community avoids these first problems, there is another, more subtle one. From a health care utilization standpoint, a new community requires 10 to 15 years to mature before its health care center becomes fully occupied (that is, mature). Unless the CCRC management establishes a health care reserve in anticipation of this eventuality, monthly fees will have to be increased by a rate greater than inflation, a rate that residents may find unpalatable or unaffordable.

Because the CCRC depends so heavily on the group insurance concept to fund its health care liability, it seems natural that the industry should develop actuarially based guidelines to assure that its reserving

methodologies are appropriate. Until now, however, the accounting and actuarial professions have not developed the appropriate methodology for determining health care reserve requirements for CCRCs. The newness of the industry and the lack of a perceived need on the part of many CCRC managers are the primary reasons for the lack of development in this area. Moreover, boards of directors of nonprofit organizations are generally reluctant to allow revenues to exceed expenses in a manner that would allow the accumulation of a health care reserve (even if they knew its correct value) because such a pricing structure gives the appearance of a "profit" at the residents' expense.

Another barrier to actuarially based pricing structures is that the first community in an area to introduce actuarially based prices may become uncompetitive with respect to other communities in its area. Thus, the tendency to set prices according to the fees set by other communities is a problem that must be solved in future years.

In addition to the health care reserve, a CCRC, like many other business organizations, should hold reserves for the continual modernization and refurbishment of the facility and for its eventual replacement. This is a particularly difficult problem in an inflationary environment, because such future expenditures require that substantial sums be accumulated.

A third area in which reserves are required is the financial aid liability associated with residents who currently, or in the future, cannot meet their monthly fees. Although continuing care contracts generally reserve the right to expel individuals who cannot meet monthly fees, as a practical matter this is seldom, if ever, done. Many communities attempt to solicit contributions from the surrounding area to support such individuals; but this may not be a sufficient solution in uncertain economic times when high levels of inflation may cause more and more residents to fall short of funds.

A final note should be made on the contribution of high, and, especially, varying inflation to the unsatisfactory financial status of some communities. The prepayment of any future cost that cannot be predicted with confidence naturally increases the probability of financial difficulty. During the last decade, inflation has been particularly damaging with respect to the prepayment aspects of continuing care, and it is necessary for CCRCs to develop methods to deal with this problem in the future.

Legislation has been enacted at the state level to attempt to control the financial management of CCRCs, but so far only 10 states have statutes regulating any aspect of continuing care communities. In those states that have developed some continuing care regulation, the methodology and underlying assumptions associated with the laws appear inadequate. Mortality assumptions included in such legislation are not appropriate for CCRCs, since they assume higher death rates than

actually occur. In addition, the "small group" problem is not addressed and the inflation problem faced by communities accepting prepayment is not dealt with in regulations.

OVERVIEW OF CHAPTERS

This book is divided into three parts: (1) an empirical survey of CCRCs that describes in detail the various characteristics of existing communities; (2) a financial analysis of CCRCs that examines current financial management practices and discusses extensively the ways in which actuarial science can be applied to developing appropriate fees and ensuring the long-term financial health of CCRCs; and (3) a legal analysis that first describes the current status of CCRC regulation and then examines those areas where the authors believe regulation is appropriate or inappropriate.

The empirical analysis is presented in Chapters 2 and 3. These chapters analyze the results obtained from a 24-page survey instrument that was completed by more than 200 CCRCs. Several characteristics are discussed, including institutional definition; geographic location; organization, affiliation, and tax status; contract provisions; fees; refunds; resident population; health care utilization; services and special features; management and financial policies; capital financing; and reserves.

The financial analysis follows in the next eight chapters. Chapter 4 discusses the appropriateness of applying actuarial science to the evaluation of the long-term financial status of CCRCs. Several pricing methodologies are described, and the cash flow implications of each approach are illustrated for a hypothetical nonprofit community offering an extensive health care guarantee (i.e., the resident continues to pay the same monthly fee after permanent transfer to the health care center). Only one approach to fee-setting, the closed-group method, is used in the remaining analysis, but the alternative methods are compared with the closed-group approach for five characteristics.

Chapter 5 sets forth the assumptions required for financial analyses of CCRCs and presents a methodology for developing these assumptions. This methodology is applied to several actual communities, and the results of the studies are summarized.

The actuarial model used to translate the actuarial assumptions into projections of future population flows is described in Chapter 6. Population flows are used to determine several statistics useful in financial analyses, such as apartment turnover and apartment density ratio (number of residents in apartments to total number of apartments). Also, these flows generate information regarding nonfinancial planning issues, such as the ultimate health care capacity requirements. Since the underlying assumptions regarding new entrants will vary, the

model is used to illustrate the consequences of changes in entry age distributions and health care transfer policies for future population flows. Chapter 6 also contains the results of applying the population projection methodology to actual communities.

Chapter 7 introduces the discussion on actuarial pricing, describing the closed-group methodology for determining the actuarial costs of offering continuing care contracts to new entrants. These costs are the basis for developing fees that are actuarially adequate and equitable (i.e., that reflect differentials according to age, sex, apartment type, number of occupants, and so forth). Moreover, the actuarial costs are also the basis by which management can set fees that are *actuarially adequate in aggregate* for a group of entrants, even though individual fees may not themselves meet this goal.

The actuarial adequacy of fees for a group of entrants must be monitored over time. If experience differs from the underlying assumptions, then fees must be adjusted to maintain actuarial balance. The actuarial valuation methodology, presented in Chapter 8, is the basic tool used for such monitoring. In addition to determining whether the community is in overall actuarial balance, the actuarial valuation generates information regarding fee adjustments that should be made to keep the community in actuarial balance and information on the reserves (in terms of liquid and fixed assets) that should be held in order to provide for the future liabilities associated with current residents. Illustrative cases are presented at the end of this chapter.

Chapter 9 presents an illustration of the cash flows for a community maintaining actuarially adequate fees and discusses how the new entrant pricing and valuation methodologies, combined with cash flow projections, can be used to assess the financial health of a community at a given point in time. These methodologies are applied to six actual communities to determine their long-term financial position.

Chapter 10 contains an introduction to external financial statements for CCRCs. This chapter describes the objectives of various types of financial statements and the generally accepted accounting principles by which they are prepared. The limitations of using these statements for making management financial decisions are also pointed out. If the reader is familiar with such statements, this chapter may be omitted.

The last chapter in this part, Chapter 11, contains the authors' recommendations for modifying statements of generally accepted accounting principles (GAAP) to bring them closer to the community's actuarial position. These recommendations cover the amortization of entry fees, expensing fixed assets, and establishing fund accounting for health care reserves. Several illustrations are presented to compare current practices with such modifications.

The legal analysis is covered in Chapters 12 and 13. Chapter 12 presents a comprehensive overview of the regulatory status of CCRCs as of June 1982. This chapter describes the components of regulation in

eight states with detailed statutes as well as two model acts prepared by interested groups. The elements of regulation in those states with less comprehensive legislation and the impact of attempts at federal regulation are also examined.

The authors' recommendations in Chapter 13 are based on the assumption that they will be applied in a state statute. In several areas, our best judgment was used, combined with consultation from our Advisory Committee and other interested parties. This chapter is intended to be used as a framework from which legislators might draft reasonable and useful statutes that would avoid the errors of prior efforts. It is not intended to be an absolute guideline for all states to follow.

Chapter 14 contains a summary of the findings of this research and suggests other areas for future research. ■

Part One

Empirical Analysis

Chapter Two

An Empirical Survey of CCRCs I

■ The results of a massive data collection effort undertaken to define the characteristics of continuing care retirement communities are presented in this and the following chapter. It provides a nationwide "snapshot" of the industry, a picture unavailable prior to this study. This general overview should be useful to state legislators, current and potential sponsors, developers of CCRCs, researchers and academicians in related fields of study, prospective residents of CCRCs, and other individuals interested in continuing care retirement communities.

In an effort to contact every continuing care retirement community in operation or under construction, a mailing list was compiled utilizing a number of sources, including the *Directory of Members, 1981* of the American Association of Homes for the Aging, the *Directory of Life Care Communities* compiled by Nora Adelmann and published by Kendal-Crosslands (1980 edition), and the *1980 Directory of California Association of Homes for the Aging*. In addition, specialists in the industry and executive directors of state associations of nonprofit homes for the aging were consulted. Six hundred communities of one type or another were initially identified for questioning as to whether they met the description of a CCRC as defined in this study (see next section, "Institutional Definition").

A self-administered survey questionnaire, designed to gather information from each community on such characteristics as organizational structure, fee schedules, management and financial policies, resident census, services, and contract provisions, was mailed to the 600 communities, following a pretest by a 24-member review panel and appropriate questionnaire revisions.

Extensive follow-up measures were taken to collect completed surveys from all communities. A second mailing was sent to nonrespon-

dents. Nonrespondent community administrators were called and urged to return the survey. In some cases, nonrespondent communities were surveyed by telephone to ascertain whether or not they did, in fact, offer continuing care as defined by the study. This effort reduced the nonresponse list by eliminating the communities that did not meet the criteria.

A total of 274 continuing care retirement communities currently operating or under construction were identified positively; of these, survey questionnaires were obtained from 207 communities, a response rate of over 76 percent. A list of all 274 communities identified as of December 31, 1981, is included in Appendix A. It was determined that, in addition to these communities, over 120 of the original universe list of 600 were offering services similar to continuing care but not meeting the study's strict definition of continuing care.

The characteristics of these communities are discussed in this chapter. Several independent variables are used in the analysis:

1. *Community age:* The year in which continuing care contracts were first offered by the community.
2. *Resident population size:* The number of residents holding continuing care contracts.
3. *Nursing care ratio:* The percentage of all continuing care residents receiving nursing care.
4. *Health care ratio:* The percentage of all continuing care residents receiving health care (which includes nursing and personal care).
5. *Region:* Geographic location.
6. *Health care guarantee:* The extent to which fees charged to contractholders for nursing care are less than the daily rate charged those without continuing care contracts.
7. *Fees:* Total expected combined entry and monthly fees over a typical resident's expected lifetime in the community.

Definitions of each of these variables can be found at the beginning of the appropriate section.

INSTITUTIONAL DEFINITION

A precise definition of continuing care was difficult to formulate, since the industry is virtually embryonic. Many communities offer comparable packages of services but call themselves by different names, often depending on regional custom. Conversely, many communities that claim to provide continuing care in fact offer a distinctly separate menu of services. As a result, some communities that describe themselves as CCRCs, as well as communities that "look like" CCRCs but do not meet the study's definition, are not included in the analysis.

For purposes of this study, a continuing care retirement community is defined by its *contract,* the legal agreement between the individual (resident) and the organization (community) established to provide housing, services, and health care; by the *type of accommodations* available; and by the way *fees* are paid by the resident. By definition, a continuing care contract (1) remains in effect for more than one year, (2) guarantees the resident access to nursing care whenever needed, and (3) covers fees paid by the resident for some or all nursing care, which is on a less than fee-for-service basis. All 207 communities (the number that returned completed questionnaires) included in the data base as well as the 67 communities not in the data base meet the following definition.

CCRC Definition

A continuing care retirement community is an organization established to provide housing and services, including health care, to people of retirement age. At a minimum, the community meets each of the following criteria:

Campus consists, at least, of independent living units; it may also contain health care facilities such as congregate living, personal care, and intermediate or skilled nursing care.

Community offers a contract that lasts for more than one year and guarantees shelter and various health care services.

Fees for health care services are less than the full cost of such services and have been partly prepaid by the resident.

While all the CCRCs in the data base (n = 207) meet this functional definition, they use different terms in describing themselves. About half (50 percent)[1] describe themselves as "retirement communities," "retirement residences," "retirement villages," or "retirement centers"; another quarter refer to themselves as "life care communities"; and 13 percent use the expression "continuing care retirement community." A few are self-described as "total care retirement," "life care retirement residence," "independent living," "long-term health care," or "home for the aging." The question asked and the tabulated responses are given below:

Phrase most often used to describe facility	
Retirement community	45.4%
Life care community	24.2
Continuing care retirement community	13.0
Other	10.1
Home for the aging	3.5
Life/continuing care community	1.4
Continuing care community	1.9
Nursing home	0.5
	100.0%

[1] This includes the 45.4 percent that checked "Retirement Community" plus half of the 10 percent responses checking "Other."

Types of Housing

Most CCRCs have a combination of independent living and health care units. For almost half of the communities (46.9 percent), this combination includes independent living and nursing care levels only, while another 40.1 percent have personal care. A small group of CCRCs (3.4 percent) do not have nursing care units but do have personal care units and independent living. Very few communities have only independent living units. Those communities that do not have an on-site health care center are defined as CCRCs if they have formal arrangements with an outside health care facility to provide services for their continuing care contractholders.

Facilities	
Independent living and nursing care only	46.9%
Independent living, personal care, and nursing care	40.1
Independent living and personal care only	3.4
Independent living only	2.9
No response	6.7
	100.0%

The median number of independent living units per community is 165, with a fairly even distribution between 50 and 300 units. The median number of ILUs has been increasing over time, from 110 for communities constructed before 1960 to 217 for communities built after 1970. Only four communities were found to have more than 400 units. Figure 2–1 shows the distribution of independent living units for all communities.

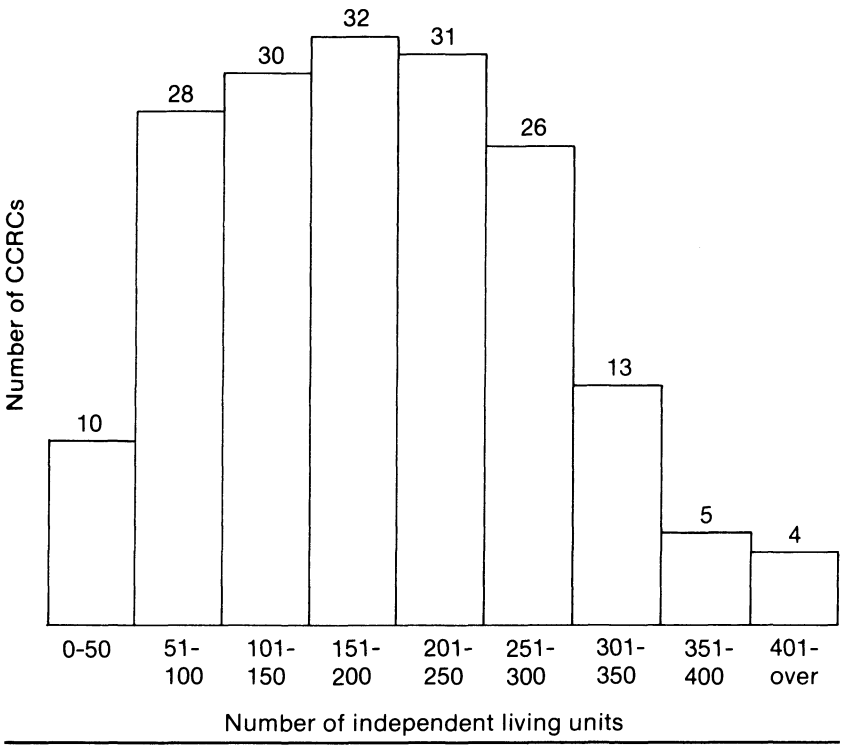
Two models or styles of physical plant design are predominant among CCRCs. The first, designated the *garden* or *campus* style, is represented by 44.4 percent of CCRCs. These have six or more buildings laid out in a campus setting, presumably in suburban locations or on generous portions of city land. Typically, the buildings are one-story or low-rise structures.

The second model, referred to as *high rise,* is typical of at least 27 percent of CCRCs with less than five buildings and six or more stories per building. Such high-rise communities are found in urban locations or among newer communities built on expensive land. Figure 2–2 shows the distribution of CCRCs by the number of buildings and the maximum number of stories.

Contract

One of the distinctive features of a CCRC is that both the resident and the community organization make a long-term commitment. In fact, when asked how long their contract actually remains in effect, 94.2 percent of CCRCs responded, "For the resident's lifetime." No com-

FIGURE 2–1
Distribution of Number of Independent Living Units



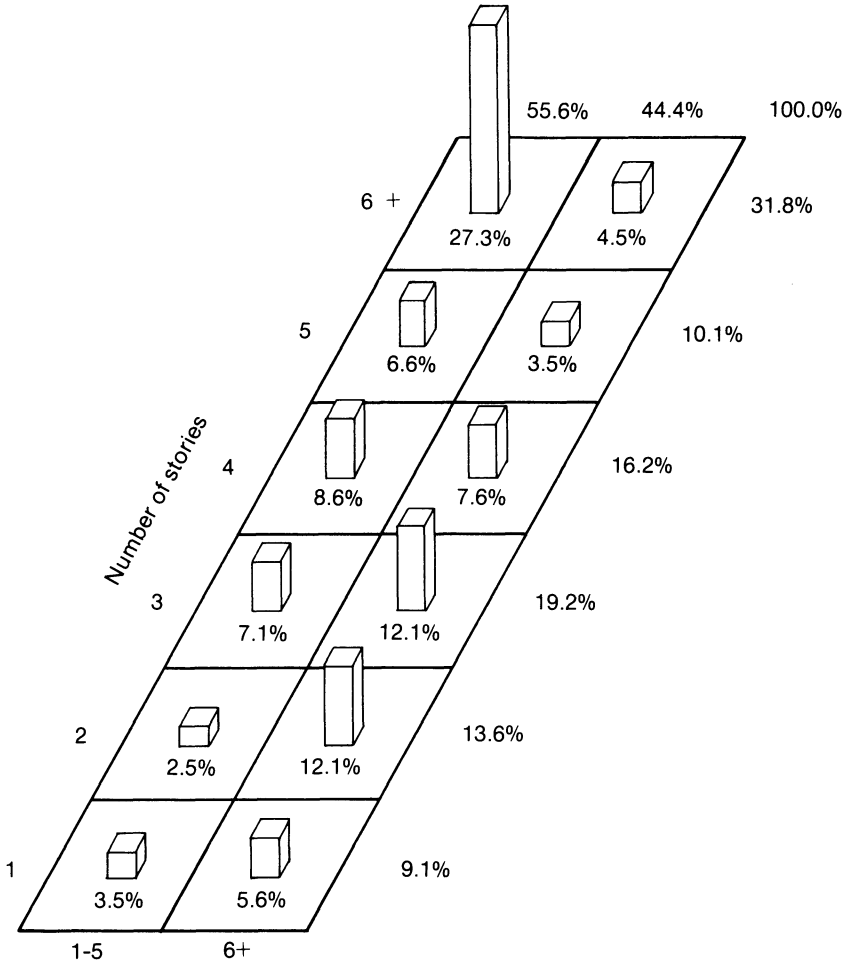
munity reported ever asking a resident to leave because of his or her inability to pay fees (unless this occurred through willful and intentional dissipation of funds).

In a limited-choice question, CCRCs checked the phrase that best described the contract they currently offer to new residents. A fairly even split between "life care" and "continuing care" is evident, while a few communities use such expressions as "life lease," "fee for service," and "rental":

Describe current contract	
Life care	39.6%
Continuing care	34.8
Other	14.0
Life lease	7.8
Fee-for-service	2.4
Rental	1.4
	100.0%

The various names for these functionally similar contracts reflect regional and historical differences within the field. "Life care" is more

FIGURE 2–2
Frequency Block Chart



prevalent in the Northeastern section of the country, particularly in Pennsylvania. Communities in the West, represented mainly by those in California, are more likely to use "continuing care" because this term is included in the definition contained in the California regulation (California Health and Safety Code) as a result of the negative connotation of "life care" or "total care" associated with an older type of home for the aging which required an entrant to turn over all assets to the home for "care for life." Current continuing care contracts are mutually terminable (can be terminated by the resident or the community) and thus quite different from traditional life care in this sense.

Beyond this historical variance within the field over terminology, the distinction between "life care" and "continuing care" is not meaningful. All 274 communities identified by the study meet the definition of a continuing care retirement community and are increasingly recognized by this term.

Health Care Guarantee

The third definitional criterion of a CCRC concerns the fee schedule (entry and monthly fees) and cost allocation for health care provided under the terms of the continuing care contract. On this point, there is virtual unanimity among the CCRCs studied with respect to the *guarantee of access* to nursing care:

Do currently offered contracts guarantee an independent living unit and access to nursing care whenever needed?	
Yes	97.6%
No	0.5
No response	1.9

However, some communities offer contracts covering almost all health care costs incurred in the health care center, while others have contracts that cover only a limited portion.[2] To distinguish between these two types, a variable called the *health care guarantee* was created, based on a community's response to several questions.

Health Care Guarantee Definition

The health care guarantee is the degree to which costs for nursing care are covered by the continuing care contract and are shared among all residents ("pooled risk") so that fees paid by an individual resident are less than those paid on a fee-for-service basis.

Communities were categorized into two groups based on their health care guarantee. Communities in which all residents pay the same monthly fee for temporary or permanent nursing care as they were charged when they were in an independent living unit *or* communities in which all residents pay the same basic rate, typically less than 80 percent of per diem rates (even if this is different from the rate they were charged while in an independent living unit), are classified as offering an *extensive* health care guarantee. Fifty-four percent of

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[2] Almost all hospital, as opposed to health care center, costs are covered under Medicare Part A, and a considerable amount of physicians' costs is covered under Medicare Part B. If the community requires insurance supplementary to Medicare, that combination covers all hospital costs and most physicians' costs, leaving the costs of nursing care to the community.

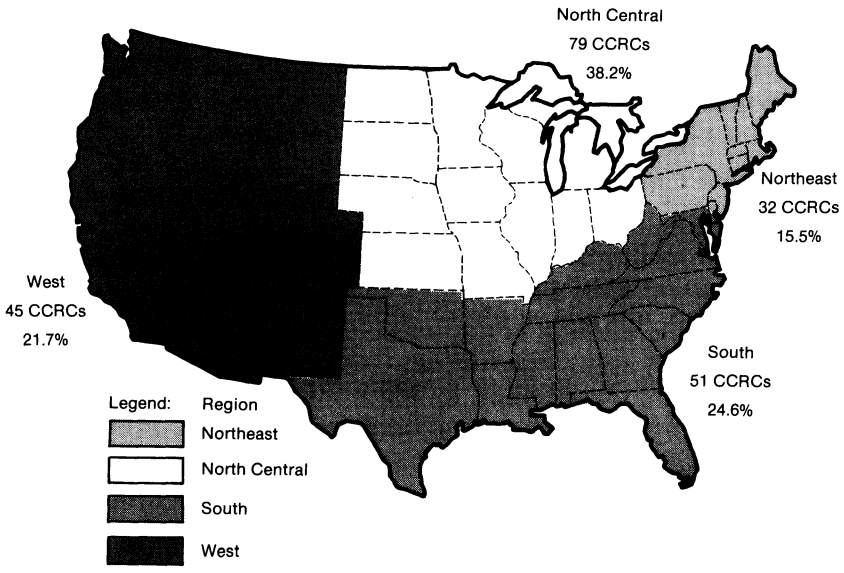
CCRCs are in this group. The second group, classified as offering a *limited* health care guarantee, includes all communities in which residents receiving nursing care are charged the rate that is paid on a per diem basis by individuals not holding contracts (i.e., paying on a fee-for-service basis) after a specified length of stay that typically ranges from 10 to 180 days. The various plans and fee schedules used by communities in this category are discussed in more detail at a later point in this chapter. Forty-four percent of CCRCs are in this group.[3]

GEOGRAPHIC LOCATION

Continuing care retirement communities are found throughout the country, although some states have relatively large numbers, while other states have none. Figure 2–3 shows the distribution of the 274 CCRCs identified by the study.

The states with more than 1 million elderly people also have the most CCRCs, with one notable exception. New York, which has the

FIGURE 2–3
Regional Distribution



[3] In some cases, judgment had to be used in classifying the community; the basic distinction between limited and extensive guarantees was preserved to the extent made possible by a community's responses. Two percent of the communities remained unclassified.

second largest elderly population among the states, does not permit the operation of CCRCs.[4] In rank order, the other states are California with 36 CCRCs, Florida with 33, Pennsylvania with 31, Ohio with 22, and Illinois with 16.

In order to facilitate data analysis, the 50 states and the District of Columbia were grouped into four regions, as follows:

Northeast			
Connecticut	New Hampshire	New York	Rhode Island
Maine	New Jersey	Pennsylvania	Vermont
Massachusetts			
North Central			
Illinois	Kansas	Missouri	Ohio
Indiana	Michigan	Nebraska	South Dakota
Iowa	Minnesota	North Dakota	Wisconsin
South			
Alabama	Georgia	Mississippi	Tennessee
Arkansas	Kentucky	North Carolina	Texas
Delaware	Louisiana	Oklahoma	Virginia
District of Columbia	Maryland	South Carolina	West Virginia
Florida			
West			
Alaska	Hawaii	Nevada	Utah
Arizona	Idaho	New Mexico	Washington
California	Montana	Oregon	Wyoming
Colorado			

The distribution of CCRCs among these four regions is shown in Figure 2–3.

Several of the factors and characteristics presented in the following sections are analyzed according to these regional groupings to determine whether they vary by geographic location. In reviewing such figures, however, one should keep in mind that (1) Pennsylvania, (2) Florida and Virginia, and (3) California dominate the Northeastern, Southern, and Western groups, respectively. CCRCs in the North Central region are more evenly distributed: Ohio, Illinois, Iowa, Kansas, and Missouri each have more than 10 CCRCs.

ORGANIZATION, AFFILIATION, AND TAX STATUS

All but a few continuing care retirement communities (97.1 percent) have nonprofit federal income tax status. Only two proprietary communities have been identified by the study. More than 93 percent (93.2

[4] New York's nursing home regulations prohibit any residential health care facility operator from accepting prepayment for basic services for more than a three-month period.

percent) own their buildings, 2.9 percent lease them, and 1 percent both own and lease buildings.

The concept of "sponsorship" and the legal relationship between a community and its "sponsoring" body have been scrutinized and defined in recent court cases, and the sponsoring organization's financial responsibility—implied or real—has been under particular review. As a result, changes in sponsoring philosophy and practice are being made by many organizations providing continuing care. With this in mind, several questions about CCRCs' affiliations were included in the survey questionnaire.

About two thirds of all CCRCs are affiliated with another institution, typically a nonprofit, religious organization. Only a few are affiliated with proprietary organizations. One third of the communities are independent. Figure 2–4 displays the tax and affiliation characteristics of all the CCRCs studied.

FIGURE 2–4
Tax Status and Sponsorship of Continuing Care Retirement Communities

<table>
<tr><td colspan="4">All communities (100%)</td></tr>
<tr><td colspan="3">Nonprofit status (97%)</td><td>*</td></tr>
<tr><td colspan="2">Affiliated with another organization (63%)</td><td>Independent (36%)</td><td>†</td></tr>
<tr><td colspan="2">Nonprofit sponsor or affiliation (59%)</td><td>‡</td><td></td></tr>
<tr><td>Sponsor appoints controlling share of board members (35%)</td><td>Sponsor does not appoint controlling share of board (28%)</td><td colspan="2" rowspan="5"></td></tr>
<tr><td>Owned by sponsor (25%)</td><td>Not owned by sponsor (38%)</td></tr>
<tr><td>Managed by sponsor (24%)</td><td>Not managed by sponsor (39%)</td></tr>
<tr><td>Sponsor financially responsible (24%)</td><td>Sponsor not financially responsible (39%)</td></tr>
</table>

* 1% = proprietary; 2% = no response.
† 1% = no response.
‡ 4% = affiliated with proprietary organization.

Considering for the moment only those CCRCs that are affiliated with another organization (n = 131), one sees that almost all of the "parent" organizations are nonprofit, religious bodies:

Federal income tax status of affiliated organization (n = 131)	
Nonprofit	92.3%
Profit	6.9
No response	0.8

If nonprofit, type of affiliated organization (n = 122)	
Religious	89.3%
Foundation	0.8
Other	9.9

In more than half (56.2 percent) of communities with an affiliation (n = 131), the affiliated "parent" organization appoints a controlling share of the board of directors or trustees; it also may reserve the right to approve major program changes and/or indebtedness by the community organization. Another group of respondents have a more distant relationship, characterized as historical or philosophical, with their affiliated organizations. Almost 40 percent of communities with an affiliation are owned by, managed by, and/or financially responsible to their parent organization. The concept and fact of sponsorship and affiliation are not the same for all communities; indeed, the entire spectrum of affiliation from distant, historical ties to a close, symbiotic relationship is evidenced among CCRCs nationwide.

Relationship between community and affiliated organization (n = 131)	
Owned by	39.2%*
Managed by	37.7
Financially responsible for	38.5
Appoints controlling share of board membership	56.2

* Percentages sum to more than 100 percent since responses are not mutually exclusive.

In some states, nonprofit CCRCs are seeking exemption from real estate taxes; in other states they are already exempt. Survey data provide a profile of these exempt communities:

Community exempt from state real estate taxes	
Yes	65.2%
No	27.1
N/A	1.0
No response	6.7

Smaller communities and communities that offer limited health care guarantees are more likely to have tax-exempt status.

Since real estate taxes are under the jurisdiction of state governments, it is not surprising that exemption from state real estate tax varies by region.

Regional location by percentage exempt from state real estate taxes

Region	Percent CCRCs exempt
Northeast*	50.0%
North Central	72.7
South	63.6
West†	88.1

* Represented primarily by Pennsylvania, which does not exempt CCRCs from its real estate tax.

† Represented primarily by California, which exempts CCRCs from its real estate tax.

CONTRACT PROVISIONS

All communities included in the data base, by definition, offer contracts that remain in effect for more than one year. In fact, almost all of the CCRCs (94.2 percent) stated that their continuing care contracts remain in effect for the resident's lifetime (1.4 percent have contracts that last for one year only, and 4.4 percent have contracts specifying some other duration).

Over half of the communities studied offer one contract, but a sizable minority (40.1 percent) offer more than one contract type, complicating the pricing, accounting, and financial management of these communities. Most of these communities (n = 83) have two or three types of contracts.

If multiple contracts are offered, how many contract types are held? (n = 83)

Two contract types	42.2%
Three contract types	28.9
Four contract types	6.0
Five contract types	6.0
More than five contract types	9.6
No response	7.3

In a large majority of CCRCs (80.9 percent), nearly all residents (over 90 percent) hold continuing care contracts. Facilities are either totally identified as continuing care retirement communities, or they offer a continuum of services on another basis entirely; few facilities combine residents holding contracts with residents of independent living units paying on some other basis. (In 13.3 percent of CCRCs, 90 percent or less of the resident population holds contracts; 5.8 percent did not respond.)

Probationary Period

More than half (54.6 percent) of the communities have contracts that provide for an adjustment or probationary period during which the

community can terminate a contract by giving written notice to a resident. Communities in the Western and Northeastern regions are more likely to have such a probationary period than are those in the other two regions. There is a slight trend away from providing a probationary period in the contracts offered by newer communities.

Contract Termination Policies

Many contracts held by residents of CCRCs are archaic and not well defined, though the contracts offered by newer communities tend to be clearer and more specific. In particular, the conditions surrounding termination of a contract between community and resident are spelled out more carefully in the new contracts.

Contracts can be terminated by most CCRCs (72.9 percent) *if a resident cannot be cared for* in the community's facilities (e.g., if care for mental illness or skilled nursing care is needed where the community does not provide such); 23.2 percent cannot terminate contracts under this condition (3.9 percent no response).

As shown in Table 2–1, communities are much less likely to terminate a contract because of a *resident's inability to pay the fees*. This is

TABLE 2–1
Contract Termination by Community Age Due to Inability to Pay Fees

	Percent CCRCs	
Community age	Able to terminate contract	Unable to terminate contract
Pre-1960	29.4%	70.6%
1960–69	33.3	66.7
1970–79	43.8	56.2
1980–post	66.7	33.3
All years	40.2	59.8

due in part to IRS regulations relating to their nonprofit tax status and in part to the moral commitment of continuing care providers. The majority of CCRCs (96.1 percent) have contracts that do not allow them to ask residents to leave if they run out of money under any conditions or only on the condition that the resident has willfully dissipated his or her financial resources. Moreover, only 1 percent of all communities indicated that a resident had ever been asked to leave because of lack of funds. There is a trend toward including a "willful dissipation" provision in the contracts being offered by communities built since 1980, as the data below illustrate. The section on "Financial Aid" shows how communities and their resident populations deal with this potentially difficult situation.

FEES

Two different types of fees are paid by residents of continuing care retirement communities: an *entry fee* (a lump-sum payment, also called a "founder's fee" or an "accommodation fee") and a *monthly fee*. In addition, communities have developed a variety of fee schedules to accommodate residents who want continuing care contracts for personal care or nursing care, married couples who need different levels of service, and to meet other situations arising out of the aging process which demand a flexible, human approach in providing a continuum of care. These schedules are addressed under the heading "Health Care Fees."

An indication of the complexity of fee schedules among CCRCs is the response to the question "Do you allow residents to choose from a variety of entry fee and/or monthly fee combinations for residence in a particular apartment type?" Forty percent said yes; 60 percent said no.

Entry Fees

In most communities (91.8 percent), entry fees are established and paid according to the size and type of living unit. Entry fees depend on the entrant's age in only 7.7 percent of CCRCs. The practice of basing fees on the unit size (real estate basis) rather than an entrant's age or physical condition (actuarial basis) persists despite industry-wide agreement that the product is the intangible, insurance-like concept of continuing care and not the living unit itself.

Although the range of entry fees charged by communities is broad, reflecting a wide variation in services and guarantees and the effects of inflation, the *average* fee is moderate, refuting critics' claims that continuing care is only for the rich. The median differential between the entry fees charged a single individual and the entry fees charged for two persons in one unit is only 16 percent (see Table 2–2). In fact, few communities vary the entry fee for more than one person in a particular apartment.

TABLE 2–2
Range of Entry Fees

	One-person fees (n = 1,028)	Two-person fees (n = 845)
Minimum	$ 1,000	$ 1,000
10th percentile	13,700	15,680
25th percentile	20,500	24,400
Median	32,500	38,000
75th percentile	49,500	55,000
90th percentile	66,675	72,250
Maximum	178,000	178,000
Average	$ 34,689	$ 38,582

Entry fees tend to vary by region. North Central communities typically have lower entry fees; Southern communities have entry fees slightly higher than the average. Entry fees are related, of course, to construction and financing costs, which are higher for new communities, most of which are located in the Southern region. As these costs have escalated in recent years, the entry fee charged per square foot has also increased (see Table 2–3).

TABLE 2–3
Entry Fees—Charges per Square Foot

Range of charges	
10th percentile	$29
25th percentile	42
50th percentile	56
75th percentile	69
90th percentile	81
Average charge	$60
Construction before 1975	55
Construction after 1975	70

Entry fees are higher in CCRCs with larger resident populations and in CCRCs offering an extensive health care guarantee, as shown in Table 2–4.

TABLE 2–4
Summary Table: CCRC Entry Fees for One-Bedroom Unit
(n = 285)

	Percent of all units	Less than $20,000	$20,001–$30,000	$30,001–$40,000	$40,001–$50,000	$50,001 and over
Region						
Northeast	15.4%	0.0%	9.3%	18.0%	26.2%	18.0%
North Central	35.4	59.6	53.4	34.4	20.0	18.0
South	30.6	24.6	14.0	32.8	38.4	40.0
West	18.6	15.8	23.3	14.8	15.4	24.0
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Resident population						
200 and less	40.7%	49.1%	41.9%	52.5%	27.7%	30.0%
201 to 300	22.5	31.6	30.2	21.3	9.2	28.0
301 and more	36.8	19.3	27.9	26.2	63.1	42.0
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Health care guarantee						
Extensive	58.9%	24.6%	37.2%	57.4%	84.6%	84.0%
Limited	41.1	75.4	62.8	42.6	15.4	16.0
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Entry Fee Increases

Since entry fees are present payments for future services, they must be calculated carefully and, in times of high inflation, adjusted frequently. They are constrained, however, by the market and, in some cases, by the policy or tradition of a sponsoring organization. According to the data, entry fees are increased once a year by a little over half of CCRCs (54.1 percent). Few communities (4.3 percent) increase fees more often than annually or on a regular, biannual basis (8.7 percent). A relatively large number of communities (24.2 percent) increase fees on some other basis, such as "as needed," depending on the market demand, costs, or new construction. Some communities adjust fees for each new resident, and a few increase fees monthly, quarterly, or "to meet state requirements." Eight communities indicated that entry fees had never been changed or had changed only once in the past 5–18 years.

For the period June 30, 1980, to July 2, 1981, the average increase in entry fees was 12 percent. As the following data show, the range of percentage increases varied from 0 percent to over 30 percent. The median is slightly below the average at 10 percent:

Approximate percentage increase in entry fees from June 30, 1980, to July 2, 1981:	
No response and 0%	37.2%
1–10%	40.1
11–20%	20.3
21–30%	1.9
Over 30%	0.5

Amortization of Entry Fees

About one third (35.6 percent) of communities amortize entry fees into their financial statements based on the *individual life expectancy of each resident;* another third (32 percent) amortize entry fees within a specified number of years;[5] and 11.9 percent amortize entry fees based on the average expected lifetime of a *group of residents*. A variety of schedules are followed by 9.8 percent of CCRCs, yet another example of the complexity and dissimilarity of continuing care communities. (No response was received from 10.7 percent.)

Illustrative examples of methods used by communities to amortize entry fees are:

"According to the Colorado State Law regulating reserve requirements."

"Treated as nonoperating income for capital use as needed."

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[5] Typically tied to a community's entry fee refund schedule. Within 5 years (11.9 percent), within 10 years (13.9 percent), and more than 10 years (6.2 percent).

"Received upon death of resident."

"At time of payment."

"Not amortized—considered as a gift."

"Earn 1 percent a month or over nine years."

Monthly Fees

Monthly fees vary depending upon the size and type of dwelling unit, the number of occupants, and the number of meals included. A wide range of monthly fees are charged among CCRCs, as demonstrated in Table 2–5. These figures support the proposition that fees charged by CCRCs can be afforded by middle-income individuals.

TABLE 2–5
Range of Monthly Fees

	One person (n = 1,052)	Two persons (n = 853)
Minimum	$ 70	$ 70
10th percentile	320	349
25th percentile	453	610
Median	580	835
75th percentile	742	1,075
90th percentile	900	1,312
Maximum	2,762	3,026
Average	$ 562	$ 815

Monthly fees in half of the communities (50.3 percent) include three meals per day, while in 44.4 percent such fees include just one meal per day. Only 5.3 percent of CCRCs base their monthly fees on two meals per day.

The cross-tabulations presented in Table 2–6 were performed to determine whether monthly fees vary by geographic region, size of resident population, or health care guarantee. They show that monthly fees (for a one-bedroom unit) are associated with region and health care guarantee and are somewhat related to size of resident population. Monthly fees are lower in the North Central region, where entry fees are also lower than average. Communities in the Northeast have higher monthly fees, but they also tend to provide more services, as discussed later. Understandably, communities offering extensive health care guarantees have higher monthly fees than those with limited guarantees.

Monthly Fee Increases

Asked if current continuing care contracts limited the amount of increase allowed in monthly fees, 72.5 percent of CCRC respondents

TABLE 2–6
Summary Table:
CCRCs Monthly Fees for One-Bedroom Unit
(n = 285)

	Percent of all units	$500 and under	$501–$700	$701 and over
Region				
Northeast	15.4%	10.5%	3.0%	33.3%
North Central	35.4	54.8	30.3	22.6
South	30.6	26.3	36.4	28.6
West	18.6	8.4	30.3	15.5
	100.0%	100.0%	100.0%	100.0%
Resident population				
200 and less	40.7%	40.0%	46.5%	33.3%
201 to 300	22.5	30.5	26.3	10.8
301 and more	36.8	29.5	27.2	55.9
	100.0%	100.0%	100.0%	100.0%
Health care guarantee				
Extensive	58.9%	48.4%	60.6%	67.9%
Limited	41.1	51.6	39.4	32.1
	100.0%	100.0%	100.0%	100.0%

answered no, 25.1 percent answered yes, and 2.4 percent did not respond. Of those who replied affirmatively, most made statements like the following:

"The limit depends upon Social Security increases."

"Is determined by an independent auditor."

"Is set by a specified table included in the contract."

"Is dependent upon operating costs less endowment earnings."

"Is limited to a total of five increases."

"Limit determined by legislation."

Communities offering contracts limiting the amount of increase in monthly fees do not vary by size, health care ratio, or type of financing, but they do vary somewhat by region. North Central communities are least likely and Western communities are most likely to specify limits. Older communities are slightly more likely to specify limits on monthly fees.

A majority of communities (64.7 percent) give 1–30 days' notice prior to an increase in monthly fees; 18.4 percent give 46–60 days' notice; and the remaining respondents give more than 60 days' notice (12.1 percent did not respond). Whether limited or not, monthly fees are increased once a year by 83.1 percent of CCRCs, twice a year by

4.8 percent, and as needed or on some other schedule by the remaining CCRCs.

The distribution by percentage increase in monthly fees during the period June 30, 1980, to July 2, 1981, is given below. It indicates that a fairly large number (42.5 percent) experienced increases of between 11 and 20 percent. The average increase, however, was 10.4 percent (n = 176), in line with inflation for the same period.

Approximate percentage increase in monthly fees from June 30, 1980, to July 2, 1981	
No response and 0%	15.1%
1–10%	39.6
11–20%	42.5
21–30%	1.4
Over 30%	1.4

Health Care Fees

Fee schedules for health care in continuing care retirement communities are complex and nonstandard. There are almost as many schedules as there are communities, especially when one considers that many communities have more than one fee schedule. Some CCRCs also offer continuing care contracts to individuals entering directly into their personal care (29 percent) or nursing care (34 percent) facilities.

Communities in the data base were categorized as offering either limited or extensive health care guarantees to residents, depending upon the communities' responses to several questions on temporary and permanent nursing care utilization fees. A CCRC was categorized as offering an *extensive* guarantee if its plan was similar to any one of the following:

1. A resident's monthly fee for temporary and/or permanent nursing care is the same as the monthly rate for his or her apartment.
2. A resident's monthly fee for nursing care is equal to that paid for the smallest independent living unit.
3. All residents pay the same rate for nursing care (e.g., middle of fee range) regardless of the type of independent living unit occupied previously.

All other communities were categorized as offering a limited health care guarantee. Examples of limited guarantee fees for temporary utilization are:

> "Same monthly fee plus an additional charge for skilled nursing care but less than daily rate."

"Monthly fee for apartment is reduced and pay daily SNF (skilled nursing facility) rate."

"Discount on SNF fees for first 10 years of residency."

"Monthly fee plus 40 percent of difference between regular monthly fee and current SNF daily rate for first 180 days; thereafter, 80 percent of difference between monthly fee and current SNF daily rate."

Some of the fee schedules or formulas for permanent health care are as unique as those for temporary health care. These include:

"Basic rate minus rebate of 1/66 of membership fee per month."

"Special continuing care contract with outside nursing home; resident pays monthly fee plus costs above $800 to nursing home."

"Pay SNF rate minus 1/60 of entry fee per month forever."

"Credits remaining on the apartment [prorated schedule for earning fee][6] are used up at the prevailing rate before the resident has to pay.

Rates charged by CCRCs to individuals receiving nursing care who *do not* have continuing care contracts (called "outside admissions" in this report) range from a median of $36 for personal care to a median of $50 for skilled nursing care. The numbers of units by levels of care used by outside admissions to CCRCs are presented in Table 2–7. During the period June 30, 1980, to July 2, 1981, the rates for these units were raised 1–10 percent by 21.3 percent of CCRCs, 11–20 percent by 23.7 percent of CCRCs, and over 20 percent by 4.9 percent of CCRCs. The remaining 50.1 percent either did not raise their rates during this period or did not respond.

TABLE 2–7
Level of Care, Number of Beds, and Fees for Outside Admissions

Level of care	Number of beds (total CCRCs)	Median semiprivate rates
Personal care	3,146 (n = 75)	$36 (n = 18)
Intermediate care	4,048 (n = 77)	42 (n = 43)
Skilled nursing care	8,269 (n = 132)	50 (n = 100)
Other	519 (n = 11)	— —

Double-Occupancy Fees

One of the attractions of a continuing care retirement community for married couples is the security of knowing that a continuum of care is

[6] Explanation added.

provided, so that if one spouse needs health care sooner than the other, they can still be physically near each other. Thus, fee schedules must account for this fairly frequent occurrence. But not all communities approach this situation in the same way.

In most communities (72.5%), the surviving member of a double-occupancy unit can continue to reside in the unit *alone* by paying the monthly fee rate for a single person. Some communities require the survivor to pay 1½ times the single-person fee (4.8 percent) or the two-person fee (4.8 percent) or to move to a smaller unit (2.4 percent). An additional 12.6 percent have some other plan, and 2.9 percent did not respond.

If one member of a double-occupancy couple must move permanently to the health care center, in 59.4 percent of CCRCs the other member can remain in the independent unit alone by paying the single-person fee. In 14 percent of CCRCs, the remaining member is required to pay the two-person fee. This response may indicate that the question was misinterpreted to mean the total fees paid by the couple, in which case the response is the same as that described first (i.e., single-person fee). Almost one fifth (16.4 percent) of CCRCs have some other payment schedule which covers this situation.

When one spouse is in ILU and the other is in HCC, does HCC resident pay the same fee as he or she did prior to:	
Temporary transfer	
Yes	48.8%
No	43.5
Yes and no	0.5
N/A	1.9
No response	5.3
Permanent transfer	
Yes	35.7%
No	58.5
Yes and no	0.5
N/A	1.4
No response	3.9

Financial Aid

Financial aid is available to residents in about three quarters (73.4 percent) of all communities, a considerable number.[7] In many of these communities, residents raise or contribute part or all of the funds available to residents who "outlive their financial resources."

Although one might expect to find financial aid more widely available in communities with older resident populations and higher per-

[7] Financial aid is not available in 20.3 percent of CCRCs; 6.3 percent did not respond.

centages of residents receiving health care, this is not the case. These factors were determined to be not significantly related to the financial aid available in any particular community.

More important, one might expect financial aid to be more widely available to residents of communities with limited health care guarantees, since these residents have less assurance of medical cost coverage than do residents in communities with extensive guarantees. Table 2–8, however, shows no significant difference between these two types of communities with respect to financial aid.

TABLE 2–8
Financial Aid by Health Care Guarantee

Aid available	Extensive	Limited
Yes	80.4%	76.1%
No	19.6	23.9

The availability of financial aid is related significantly to the level of monthly fees charged by a community, but not to the entry fees charged. Communities with monthly fees in the $401–$600 range and in the range above $701 typically have financial aid for residents. CCRCs with monthly fees in the $601–$700 range are less likely to have financial aid than are those with monthly fees at the low end of the scale, implying that they have higher financial requirements at admission and/or that they are relatively new and their residents have not yet experienced financial problems.

REFUNDS

The subject of entry fee refunds paid by continuing care retirement communities is one which has been debated and studied for many years. Some community organizations believe there is a moral commitment to return any unused fees to a person or the estate, while others return very little money, if any, basing their policy on the belief that residents accept the insurance, or "pooled risk," concept underlying continuing care. Several questions were asked in the empirical survey to identify trends among CCRCs with respect to refunding policies. Three areas were addressed: refunds upon death, refunds upon withdrawal, and refunds made when the community terminates a contract.

Refunds upon Death

Communities are divided evenly on the policy of providing entry fee refunds upon the death of a resident: 48.8 percent give refunds; 46.9

percent do not (2.4 percent = not applicable; 1.9 percent = no response). Of the CCRCs that do give refunds, most (78.2 percent) base the refund on the death of the second member of a couple, and only 8.9 percent base it on the death of the first member (1.0 percent base it on the death of both, and 11.9 percent did not respond).

Among the communities following a policy of refunds upon death, there is little agreement on the period after which the refund is not provided, as the following data illustrate:

Length of death refund provision (after which there is no refund) (n = 101)	
1–90 days	20.9%
91–180 days	10.9
181–270 days	0.0
271–365 days	19.8
1 year, 1 day–2 years	9.9
2 years, 1 day–3 years	9.9
3 years, 1 day–4 years	3.0
4 years, 1 day–5 years	9.8
Over 5 years	6.9
No response	8.9

Newer communities, particularly those built since 1980, tend to provide refunds upon the death of a resident, but these communities make the refund contingent upon reoccupancy of the living unit. Table 2–9 shows the progression of this trend over time.

Regional differences exist with respect to policies on refunds made to a resident's estate; CCRCs in the Northeast are most likely and those in the West are least likely to offer refunds upon death. Policies on death refunds are not related to the level of fees charged by CCRCs.

The refund policies described by communities on the survey questionnaire are so heterogeneous that they almost defy categorization, though it can be stated that a majority follow a prorated schedule over the refund period. A sample of these policies is presented to illustrate this point:

"100 percent of total entry fee upon death."

"Community retains 1/12 of fee per month of occupancy."

"First year 75 percent; second year 50 percent; third year 25 percent."

"All but 10 percent is refunded."

"One third is refunded."

"Prorated based on 5½-year refund schedule."

"80 percent less sum used for skilled nursing care is refunded."

"4 percent deducted for first and second months; 2 percent a month thereafter."

"50 percent refunded."

TABLE 2-9
Summary: Refund Provisions

Refund type and condition	Community age					Region			
	Total	Pre-1960	1960–1969	1970–1979	1980–post	NE	NC	S	W
Upon death	48.8%	38.7%	42.1%	59.7%	78.6%	73.3%	55.8%	56.3%	20.9%
Contingent upon reoccupancy*	37.6	10.0	20.9	34.9	46.2	47.7	26.0	28.1	8.7
Upon withdrawal	89.0	87.1	96.1	92.5	85.7	96.7	87.0	93.8	100.0
Contingent upon reoccupancy*	44.8	22.2	40.8	54.8	64.3	53.3	49.2	46.7	30.2
Upon termination									
Contingent upon reoccupancy†	23.2	14.8	16.7	47.4	28.6	39.3	35.0	28.6	9.8

* The values in these rows are based on the number of CCRCs that responded positively to refund condition. For example, 18.3 percent (0.488 × 0.376) of all CCRCs (n = 207) hold entry fee refunds in the event of death until the unit is reoccupied.

† These percentages are based on n = 207.

"First two months, full refund; thereafter, 10 percent a month is deducted."

"2 percent a month is deducted."

"1/60 per month deducted until year 2."

"1/180 per month with a minimum of 36/180 deducted."

"Prorated over 10-year period" and so on.

"4 percent of fee plus 1 percent per year per person plus 2 percent per month."

"8⅓ percent per month."

"1⅔ percent per month for period not used."

Refunds upon Termination by Community

Most communities (70 percent) apply the same or similar provisions to refunds upon withdrawal as are applied to refunds when the community terminates a continuing care contract. But some communities (12.6 percent) follow yet another refund schedule; 3.9 percent apply the "refund upon death" provision; 2.9 percent base their refunds on state requirements; and 10.6 percent did not respond.

One of the ways a community can reduce its exposure or risk in refunding entry fees, or portions thereof, is to make the refund contingent upon reoccupancy of the independent living unit by a new resident. Indeed, there is a trend among newer communities to follow such a policy. The data presented in Table 2–9 show that approximately 45 percent of CCRCs opened since 1970 currently have such a requirement. ■