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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Chapter Fourteen

Summary and Conclusions

■ This chapter contains an overview of the research presented in this book and summarizes the authors' recommendations in three subject areas. In addition, the chapter lists several areas for further research. The three areas covered in this book are: (1) an empirical survey of CCRCs that describes the various characteristics of existing communities; (2) a financial analysis of CCRCs that includes current financial management practices along with an extensive analysis of how actuarial science can be applied to develop appropriate fees and monitor the long-term financial health of CCRCs; and (3) a legal analysis that first describes the current status of CCRC regulation among the various states and then sets forth the areas where the authors believe that regulation is and is not appropriate.

The following summary cannot possibly serve as an adequate substitute for a thorough reading of each chapter. In many instances, especially in the financial and legal areas, there are no clear-cut answers to the many issues raised and discussed, requiring that the management of CCRCs exercise judgment as to the approaches that should be taken for their community. In those areas where judgment is required, the authors' best judgment is represented in the conclusions and recommendations provided below. The chapters themselves, however, set forth the various points of view so that conscientious readers will be in an excellent position to form their own conclusions.

EMPIRICAL SURVEY

Size of Industry

The study was able to identify 274 communities throughout the United States that met the following definition of a CCRC:

- The facility consists of independent living units and generally has one or more of the following facilities: (1) congregate living, (2) personal care, (3) intermediate nursing care, and (4) skilled nursing care.
- The community guarantees shelter and various health care services to residents under a contract that lasts for more than one year.
- The additional fees for resident health care, if any, are less than the full cost of such services, implying a risk pooling of health care costs among residents.

The study also identified another 120 communities that offered services similar to CCRCs but did not precisely meet the characteristics listed above. For example, a number of communities that would have been classified as CCRCs in prior years have changed their contract so that residents now pay the full cost of any required health care services. These communities are not considered CCRCs as defined by this study.

The survey conducted as a part of this study collected an extensive amount of information on 207 of the 274 identified CCRCs. This represents a response rate of 76 percent, implying that the characteristics summarized here and discussed in detail in Chapters 2 and 3 are quite accurate for the industry as a whole. While it is true that the 24 percent not responding may have a systematic characteristic (for example, they may be predominantly financially distressed communities that did not wish to be examined), the authors believe that little or no such systematic bias exists in the sample.[1]

The 207 communities identified in the study currently serve 55,000 individuals, all of whom are over age 65 and whose ages range predominantly from 75 to 85, the average age being about 81. This is a relatively small fraction of the total number of individuals over 65 in the United States (0.2 percent) and of the number of individuals expected to fall within this age range during the next several decades. Therefore, the authors believe there is a tremendous potential for increasing the number of CCRCs to serve aged Americans. Moreover, as discussed later in this summary, the cost of entering and living in a CCRC appears to be well within the reach of a large number of such individuals.

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[1] One fact leading to this conclusion is that the communities participating only after extensive follow-up efforts showed no characteristics distinctively different from those that participated after the initial contact.

About 20 percent of all CCRCs were formed prior to 1960; 40 percent were built between 1960 and 1970; and the remaining 40 percent were constructed since 1970. The median age of all communities is 14 years; however, numerous communities constructed prior to 1960 have offered continuing care contracts for decades.

Physical Aspects of Communities

The survey results indicated quite a range in the physical characteristics of CCRC facilities. Half of the communities have only a skilled nursing facility in conjunction with their independent living units, while the other half also have a personal care facility. The authors believe that the latter type of configuration, providing a continuum of health care services, is probably the most desirable approach in terms of the quality, appropriateness, and economic efficiency of delivering health care services to CCRC residents.

The number of independent living units per community is uniformly distributed from 50 to 300 units; however, a distinct trend toward a larger number of units exists in newer communities. The authors believe it desirable, from an economic viewpoint, to build CCRCs with at least 250 independent living units. This size provides economies of scale in management and allows the construction of a skilled nursing facility that meets the needs of the population on the one hand while complying with state regulations on the other.

CCRCs are evenly split between garden apartment, or low-rise, structures and high-rise structures. The main determinant of the type of structure is the suburban versus urban location of the facility. None of the analyses suggested that one type is perferable over the other.

The geographic distribution of CCRCs throughout the United States follows the distribution of aged individuals, with one important exception. The exception is the state of New York, where CCRCs as defined in this study are not permitted under law. Based on the research findings contained in this book that CCRCs are not only financially viable but also within the financial reach of a large number of aged individuals, the authors believe strongly that the laws in New York should be changed to accommodate CCRCs. Fifty percent of the CCRCs are located in the following states, listed in order of the number of communities per state: California, Florida, Pennsylvania, Ohio, and Illinois.

Fee Levels. The average entry fee for CCRCs as of December 1981 was $35,000, with $2,000 being added for the second of two individuals sharing an apartment. The average entry fee per square foot of independent living unit is $60. The range in entry fees is fairly wide, with 80 percent of all communities having entry fees falling in the range of $13,000 to $65,000.

The average monthly fee among CCRCs as of December 1981 was $550, with 80 percent of such fees falling in the range of $300 to $900 per month. The increase in monthly fees for a second person living in an apartment unit was found to be $250, an increment much greater, percentagewise, than the corresponding increment in entry fees.

Although a convincing actuarial argument can be made that entry fees and monthly fees should vary by such factors as the resident's entry age, sex, and health status, CCRCs tend to vary fees by the apartment type that the resident selects and by whether a second person is involved. This implies that the management of such communities are socializing not only health care expenses but also the expenses associated with other factors that affect the cost of providing future shelter and health care throughout the lifetimes of residents.

The fee ranges charged by CCRCs appear to be within the financial grasp of a large number of individuals over age 70. This is an important finding, since it suggests that CCRCs are not exclusively for the wealthy aged individuals in the United States.

Interestingly, 75 percent of CCRCs provide financial aid to residents whose financial resources become depleted. Although most CCRCs reserve the right to terminate the contracts of individuals who lack the financial resources to pay their monthly service fee, the survey did not find one instance where this had occurred. This reinforces the point that CCRCs are affordable by a large number of aged individuals in the United States. Even in cases where an individual's longevity coupled with inflation-related increases in monthly fees causes financial difficulties, such institutions are able to continue, through financial assistance, the care that the individual expected upon entering the community.

CCRCs are evenly split on the issue of offering partial entry fee refunds at the death of the resident. With respect to the half that provide such refunds, the methods used in determining the dollar amount vary significantly, there being no common approach among the communities.

Services Provided. CCRCs are evenly divided between those that offer an extensive health care guarantee and those that offer a limited guarantee. The differences between the two are as follows:

Extensive guarantee: Residents pay the same monthly service fee while in the health care center as they paid while living in their apartment unit (or, if the monthly fee differs, the health care monthly fee is less than 80 percent of the per diem rate for such services).

Limited guarantee: Residents pay the per diem rate while in the health care center; however, the higher fees do not begin until after a specified period of health care center residency, such as 180 days.

Thus, contrary to the belief that once an individual enters a CCRC, health care services are a free good, the basic insurance principle of "co-pay" is widely used among CCRCs. Surprisingly, however, the data indicated *less* health care utilization among residents in CCRCs with extensive health care guarantees. Perhaps this can be explained by the fact that the management of such CCRCs has a greater financial incentive to monitor and manage health care utilization. This is an area deserving of additional research, since the results are at odds with the general belief that the lower the cost of health care services, the more such services will be used.

With respect to the number of meals offered under continuing care contracts, again communities were found to be evenly split between those offering three meals per day as a part of the basic fee structure and those offering one meal with residents paying additionally if more than one meal per day is prepared for them by the community. However, there is a trend among newer communities to include only one meal, thus giving residents more freedom in structuring services to best meet their needs.

Affiliation and Management. Virtually all CCRCs are nonprofit organizations with religious affiliations. One third of the communities purchase management services from an outside organization, generally a for-profit organization, while the remaining two thirds are self-managed.

FINANCIAL ANALYSIS

The financial analysis of CCRCs comprises eight chapters in this book, Chapters 4 through 11. Chapter 4 provides an overview of the subject matter; Chapter 5 discusses the types of actuarial assumptions required to perform appropriate financial analyses of CCRCs; Chapter 6 describes how the future resident population of a CCRC can be projected with confidence, a process that represents the first step in financially analyzing the future of a CCRC; Chapter 7 discusses the actuarial theory for establishing appropriate fees for new entrants to a community; Chapter 8 provides a methodology to assist management in selecting the appropriate annual fee increases that are required to maintain the long-term financial soundness of the community; Chapter 9 illustrates the cash flow of a CCRC over a 20-year period and shows why conventional accounting procedures are not adequate for financially monitoring such communities; Chapter 10 gives an overview of the fundamentals with respect to financial statements in general and as they are typically applied to CCRCs; and Chapter 11 discusses the modifications that need to be made to traditional accounting statements so that the management of CCRCs has the proper information for

maintaining their long-term financial success. An overview of the findings and recommendations presented in these eight chapters is given below.

Actuarial Assumptions. Several types of actuarial assumptions are required in performing financial analyses of CCRCs, two of the more important ones being mortality rates and morbidity rates. One of the recommendations of the study is that the CCRC industry must begin to develop a national data base for use in developing community-specific rates. Although it is true that mortality and morbidity experience varies among communities, a national data base would provide the basis for monitoring each community's experience and would also provide valuable information to individuals who are planning a new facility.[2]

As a part of this study, the mortality and morbidity experience of seven communities was studied. This data base, which consists of 25,000 life years (where one life year represents an individual living in a community for one year), indicates that the life expectancy of CCRC residents is significantly longer than the life expectancy of individuals of the same age in the general population. In fact, the life expectancy of CCRC residents is comparable to the life expectancy of individuals who purchase annuities from insurance companies. Overall, the life expectancy of both groups is about 20 percent greater than that of the general population. The greater life expectancy of CCRC residents could, in fact, be due to the same reason as that of annuitants—namely, such individuals tend to be in good health at the start of the contract. However, some individuals believe that additional factors may be associated with the greater life expectancy of CCRC residents, such as ready access to good health care, closeness to one's spouse if a resident is transferred to the health care center, the communal spirit among residents, and the opportunity to remain quite active in various recreational activities. Whether such factors make a difference in the life expectancy of CCRC residents must be studied in future research.

The data base also suggests that potential savings may be associated with the lower hospital utilization of CCRC residents as compared to that of the general population. Although the data base was too thin to draw definitive conclusions, this finding could have important implications relating to the cost of delivering health care to older Americans, and the authors suggest that this is a rich subject for further research.

The final point with respect to actuarial assumptions concerns the manner in which such assumptions are being used by those performing financial analyses of CCRCs versus the manner in which such assumptions should be used. One serious mistake in applying actuarial as-

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[2] The insurance industry has pooled the experience of large companies in developing mortality rates for many years. The authors are suggesting that this same degree of cooperation would be beneficial to the life care industry as well.

sumptions is to use life expectancies for amortizing lump-sum entry fees into the community's income stream. This subject will be mentioned again at a later point in this summary.

A second serious mistake is that financial planners do not distinguish between mortality rates applicable while the individual is living in an apartment and the corresponding (and higher) mortality rates applicable while the individual is living in the health care center. While it is true that the overall mortality rates of CCRC residents follow those of an annuitant mortality table, the table itself is of little value in performing financial analyses. The annuitant mortality table must be decomposed into two tables, with lower rates applicable to apartment lives and higher rates applicable to health care center lives. This split in rates is important because the cost of caring for individuals differs significantly depending on their living status. Applying one table to all residents means that death rates for apartment dwellers will be too high (implying that projected apartment turnover rates and hence projected entry fee income will be overstated) and death rates for health care center residents will be too low (implying that the projected cost of health care will be too high). This misapplication can cause serious errors in the financial analyses of CCRCs.

Population Projections

In order to perform a financial analysis of a CCRC, whether a new or existing community, it is necessary to project the resident population on a year-by-year basis for a period of years into the future, calculating each year the expected number of apartment releases, the number of individuals expected to be transferred to the health care center, and so forth. Among the significant deficiencies observed in the industry are that existing communities, by and large, do not engage in this type of projection and that the projection period associated with financial feasibility studies for developing communities is generally limited to five or seven years. The authors recommend that all communities engage in such forecasts periodically and that such forecasts extend for a period of 20 years or more, especially for new communities, whose expected health care utilization is expected to be lower than the ultimate expected utilization during their maturation (the first 10 to 15 years of operation).

This research discusses and illustrates the problem of random deviations associated with projecting a population of only a few hundred individuals. Even if the underlying mortality and morbidity assumptions are precisely correct, a deterministic projection of the population will not reveal the likely variations in rates of death and morbidity, and the impact of these variations on the financial health of the community. Compounding this problem is the fact that the underlying rates them-

selves may be somewhat off the true rates. These two difficulties poses a significant barrier to adequate financial planning with respect to CCRCs. Therefore, two of the major conclusions of this research are: (1) that multiple projections must be made using various sets of pessimistic and optimistic rates in order to assess the implications of making an error in the underlying assumptions (i.e., a sensitivity analysis must be performed) and (2) that the projection must incorporate stochastic (or Monte Carlo) methodology. Under stochastic methodology, the population projection includes random deviations. Thus, estimates can be made of the best and worst financial events that are likely to occur, enabling management to plan accordingly.

The simulations presented in connection with the population projection analysis showed that it takes 15 years or more for a new CCRC to reach maturity, where maturity is defined by such statistics as a relative stable year-to-year average age of residents, a relatively constant number of residents living in the health care center on a permanent basis, a relatively stable apartment turnover rate (ignoring random deviations), and so forth. Thus, long-term projections are critical to the proper financial planning and management of CCRCs.

The simulations revealed some interesting statistics in addition to the data on the length of time it takes for a new CCRC to reach a mature state. For example, the density ratio (i.e., the ratio of apartment residents to the number of apartment units) is likely to decrease to some ultimate level from the ratio at the time the community is first opened. The initial density ratio, of course, is dependent on the number of couples in the start-up resident population. Similarly, the ultimate density ratio is dependent on the number of couples assumed to enter in future years and on the community's policy with regard to the transfer of an individual to a smaller apartment unit upon the death or permanent transfer of his or her spouse. Depending on the pricing structure of the community, the density ratio can have an important financial impact.

The simulations also showed, for the set of assumptions used, that the expected period of time spent in the health care center for all entrants will average two to three years. Moreover, since only half of the entrants will ever reside permanently in the health care center, this statistic implies that the average length of stay for those who do transfer is four to six years. Given this tenure, and given the high cost of caring for an individual in the health care center, it is essential that management take such data into account in developing fees. The research also found that a significant role in determining the community's health care costs is played by both management policies and the community's health care delivery system (i.e., whether there is only a skilled nursing facility as opposed to a continuum of care possibly represented by a home nursing program, a personal care facility, an

intermediate care facility, and a skilled nursing facility). Those communities that strive to avoid transfers to the skilled nursing facility until this is absolutely necessary have lower health care costs but also have lower apartment release rates (and hence lower entry fee revenues), and vice versa. Since these factors are important, it is essential that the population methodology, along with the underlying actuarial assumptions, reflect both management policies and the community's health care program.

Finally, over the years a number of rules of thumb have been developed regarding such important items as apartment turnover rates, health care utilization, and density ratios. This research has found that, at best, these rules are not very good in performing financial analyses of CCRCs. There are too many differences among communities, such as differences in management policies, in health requirements for new entrants, and in health care programs, for such rules to be relied on when financially analyzing a community. Therefore, the authors strongly recommend against relying on such rules of thumb in establishing fees and/or projecting the population of a CCRC.

New Entrant Pricing

The actuarial theory for establishing fees for new entrants to a CCRC is set forth in Chapter 7. As a precursor to developing fees, however, the authors introduce what is undoubtedly a new concept to the CCRC industry, the concept of an actuarial liability for new entrants. This actuarial liability is equal to the present value of all future expenses expected to be incurred on behalf of the individual throughout his or her lifetime in the community. For example, the actuarial liability for an age-75 female entrant, given the hypothetical community and the hypothetical set of assumptions used in the research, was calculated to be $150,000. Put another way, if this amount were paid by each such individual at entry (a pricing policy *not* being recommended by the authors), then along with interest earnings on the unused balance it would be sufficient to pay all of the expected expenses for the individual (provided that all of the assumptions were realized).

The actuarial liability for an individual is dependent on four sets of factors: (1) *demographic factors,* such as the entrant's age, sex, and health status; (2) *contractual factors,* such as the community's death refund provision and the extensiveness of its health care guarantee; (3) *accounting factors,* such as the manner in which the cost of fixed assets (e.g., building and furniture) is allocated over time and the manner in which operating expenses are allocated (e.g., on a per capita versus a square footage basis); and (4) *economic factors,* such as future inflation and interest rates. Although many of these factors are technical, the point is that each individual entering the community has an

associated actuarial liability depending on a large number of factors, and it is this liability which is the basis for determining fees.

Once the actuarial liability has been determined for an individual or a group of individuals, the next step is to decide what portion of the liability is to be paid by entry fees and what portion is to be paid by monthly fees. Theoretically, the mix between the two can range from 100 percent entry fees to 100 percent monthly fees; however, neither extreme is recommended by the authors. For reasons detailed in Chapter 7, the authors believe that entry fees should not exceed 30 to 40 percent of the actuarial liability.

Another approach to determining the entry fee/monthly fee mix is to assume that entry fees cover capital costs, while monthly fees cover all other costs. This generally results in an entry fee that does not exceed 40 percent of the actuarial liability, and such an approach supposedly has appeal to prospective residents. There is nothing sacrosanct about this approach (sometimes called the real estate/actuarial approach to setting fees), since it is simply one of an infinite number of ways to split the actuarial liability between entry fees and monthly fees.

Assuming that the actuarial liability and the mix between entry fees and monthly fees have been determined, it is still necessary for management to decide whether fees will reflect all of the factors that affect the actuarial liability itself. In other words, since the actuarial liability is higher for females and younger entrants, for example, should fees also be higher for such individuals? Similarly, since the actuarial liability differs by the type of apartment and by the number of individuals entering the apartment (i.e., single versus couple), should fees differ by these factors as well? Management must decide which of these dimensions the fee structure should reflect. Most CCRCs have fees that differ by apartment type and by the number of individuals occupying an apartment. This type of pricing structure, therefore, socializes the cost of numerous dimensions, a management policy that is perfectly acceptable, provided that the overall fee structure is equal to or greater than the overall actuarial liability of the new entrants. The authors have no recommendation regarding the distribution of costs among residents as long as the actuarial test is met.

Finally, with respect to the development of fees for new entrants, the authors set forth two objectives that appear to be reasonable and desirable for CCRCs:

Group equity: Fees for a group of entrants should be self-supporting, implying that the fees associated with future groups should not be required to pay for the services used by prior groups.

Inflation-constrained increases in monthly fees: The annual increases in monthly fees should not exceed the community's internal inflation exposure, implying that the increased cost of greater

health care utilization during the community's maturation period must be advance-funded.

The authors recognize that some CCRC managements may not share these objectives, in which case the pricing structure of their communities could differ significantly from the structure that logically follows from the objectives.

Actuarial Valuations

An actuarial valuation involves the application of actuarial science to determining whether a community's aggregate assets (current assets plus prospective fees) are equal to its aggregate liabilities (current liabilities plus prospective costs for all residents). If such an equality exists, then the current fee structure is adequate, whereas if the asset-liability relationship is not equal, then fees should be changed to bring about the balance. One of the most important recommendations of this research is that CCRCs, and especially new CCRCs, should have an actuarial valuation performed periodically, such as annually or every two or three years. In addition to determining whether a community's assets are in balance with its liabilities, an actuarial valuation provides information on how fees should be adjusted from year to year to achieve and maintain such a balance. In other words, even if a community is in actuarial balance currently, random deviations during the following year will inevitably cause the balance to be altered. An actuarial valuation informs management of the financial implications of such deviations and provides guidance on the fee changes that should be made to restore the balance.

An actuarial valuation does not, however, provide management with information on the proper level of liquid assets, or working capital. However, this research clearly demonstrates that a community with an actuarially based fee structure will inevitably generate far more liquid assets than the minimums that various accounting techniques (or cash management techniques) would suggest. The fact that a community with actuarially based fees will generate significant amounts of cash, all of which is required to meet the long-term health care liability and other future commitments of the community, reinforces the need for actuarial valuations. This is the case because the managements of nonprofit organizations are often reluctant to allow such funds to build up and/or because residents object to fee increases when sizable amounts of funds are on hand. An actuarial valuation not only determines the total amount of assets that a community must have but allocates such assets to various liabilities, such as the health care liability, thereby showing management and residents that such funds are *not* redundant and that fees should continue to increase with the community's inflation experience.

If an actuarial valuation of a community shows an unfunded actuarial liability (i.e., aggregate assets are less than aggregate liabilities), management has several options for funding it, such as a one-time percentage increase in fees over and above the current year's inflation increase, a temporary percentage increase over and above inflation for a period of years, or a flat dollar surcharge on fees for a period of time. The only requirement is that the additional increase in fees pay off the unfunded liability either in the current year or over a period of years. The authors recommend that such unfunded liabilities be funded over as short a period as possible, subject to marketing constraints and the ability of residents to pay the increased fees.

With respect to year-to-year random deviations, two methods for dealing with the corresponding change in the unfunded liability are discussed. One method is to adjust fees each year to fully account for the deviations. The other method is to build up a buffer or contingency fund, against which unfavorable deviations are charged and favorable deviations are credited. Under this approach, the size of the fund can be evaluated periodically and adjusted to the proper level if it has grown too small or too large. Either approach is acceptable from the authors' viewpoint.

Case Study Results

All of the actuarial techniques developed in the study were applied to six CCRC case studies. The communities that participated in this portion of the study were not selected on a random basis; therefore, it is *not* possible to generalize from the results. Nevertheless, it was interesting to discover that the fees charged by five of the six communities placed them in reasonable actuarial balance. The fees for these communities fell in the following ranges:

Weighted average entry fee range: $25,000–$55,000.

Weighted average monthly fee range: $400–$800.

Given the fact that these fee ranges produce reasonable actuarial balances, it appears that CCRCs are well within the financial grasp of a large number of Americans over age 65 and that the CCRC concept is financially viable.

One of the communities studied was found to be in severe financial distress; however, it was later learned that imprudent practices by previous management contributed to this situation. Therefore, it was not possible to tell whether the current pricing structure of the community would have supported the community's continuation if these practices had not occurred.

Financial Management Statements

As noted previously, the cash flow of an actuarially priced community will generally be quite strong. The problems associated with a CCRC accumulating significant amounts of cash were also mentioned. Moreover, accounting statements prepared according to generally acceptable accounting practices (GAAP) were found to contribute to this problem because such statements do not reflect the future long-term liability of the community. Generally speaking, the authors found three areas where GAAP statements could be modified to better represent the financial picture of a CCRC:

Entry fee earnings: The current practice is to earn entry fees over the life expectancy of an individual or a group of individuals. This approach was found to bring too much money into the community's income statement too fast. Therefore, the authors recommend that entry fees should be earned over an individual's lifetime on an increasing-dollar basis, an approach that better matches revenues with expenses.

Expensing fixed assets: Expensing fixed assets according to a cost-based depreciation schedule charges too little for such assets in an inflationary environment. Therefore, the authors recommend that such statements should be based on a replacement-basis depreciation method.

Health care fund accounting: Most accounting statements commingle the apartment side of the CCRC with the health care center side. This adds confusion and often masks the true financial picture of the community. Therefore, the authors recommend that fund accounting be employed to generate separate statements, one for apartment cost center revenues and expenses and another for health care cost center revenues and expenses.

LEGAL ANALYSIS

The legal analysis of CCRCs is presented in Chapters 12 and 13 of this book. An overview of that material is given in the following subsections.

Current Regulation

The study contains a descriptive analysis of existing formal legal regulation of CCRCs. This material serves as a foundation for the study's analysis. For analytical purposes, the study divided its discussion of

the current regulatory status of the continuing care industry into three parts:

Detailed state regulatory schemes: The study first discussed the responses of nine states and at least one organization—detailed regulation of CCRCs. The issues covered in this analysis include the definition of communities to be regulated, government certification/private accreditation, regulation of financial status, protection of residents' rights, and the legal structure of the community.

Limited state regulatory schemes: The study also discussed the responses of at least three states—selected regulation of one or two of the problems of the continuing care industry most susceptible to legal regulation.

Nonregulation: The third division of the study discussed the responses of the remaining 36 states, the District of Columbia, and the federal government—virtually total nonregulation. Included in this discussion are comments on proposed, but as yet unenacted, legislation and judicial attitudes toward CCRCs.

Evaluation of Legislative Options

The core of the study's legal analysis of CCRCs is presented in Chapter 13. That chapter contains the study's conclusions, underlying analysis, and recommendations for future legislative action concerning the continuing care industry.

The full contours and rationale underlying all the judgments reached by the study in its legal analysis cannot be explained in general terms; rather, the conclusions can be justified only through analysis of the value judgments drawn with respect to each element of regulation. As a result, both chapters of the legal analysis are organized according to the various elements of regulation identified by the study. Some of the highlights of the study's conclusions and recommendations are as follows:

Type of legislation: Foremost among the judgments drawn by the study is its judgment that legislation at the state, rather than federal, level will be appropriate in many states. The most substantial justification underlying this judgment is the study's view that, because CCRCs are still relatively new, it would be advantageous to encourage the variety of legislative programs that would develop at the decentralized state level.

Certification: The study concluded that certification requirements should be adopted by all states implementing continuing care legislation. This conclusion is tempered by the study's recommenda-

tion that each state approve private self-accreditation programs that meet certain specified standards and, once these programs have been approved, perform the accreditation function for the state.

Escrow: For existing communities, the study recommends that legislation require all entrance fees, including refundable deposits in excess of 5 percent of the then existing entrance fee for the unit requested, to be held in a cash escrow account to be released to the community on the day that the unit becomes available for occupancy by the resident. For new communities, the study recommends that state legislation require all entrance fees and refundable deposits to be held in a cash escrow account until the CCRC becomes 50 percent subscribed, commitment has been secured for both construction and long-term financing, and aggregate entrance fees received by or pledged to the provider plus anticipated proceeds from financing equal not less than 100 percent of the aggregate cost of construction or of purchasing, equipping, and furnishing the community plus not less than 100 percent of the funds necessary to fund start-up losses of the community.

Reserve funds: Although the study makes no specific recommendation at the present time on reserves, the authors feel strongly that mandating actuarially sound reserves is the best long-term legislative solution. More research is necessary on this issue, however. At the very least, periodical actuarial reviews should be required.

Financial disclosure: The study recommends that all states regulating the continuing care industry mandate financial disclosure to residents. The study's recommendation is both for a complete disclosure form to be filed with the state and for a simplified disclosure form, including a clear narrative description of the financial condition of the community, to be supplied to all prospective and current residents.

Contract regulation: The study concluded that both the form and the content of the continuing care contract should be regulated by the state. The state, however, should not regulate the precise wording of continuing care contracts; rather, the optimal statute would simply mandate the subject areas that each continuing care contract should cover.

Advertising regulation: Although the study concedes that this is a close question, the authors have concluded that some form of advertising regulation is an essential component in any legislation of the continuing care industry. Misleading advertising, therefore, should be expressly forbidden. In addition, the study would require that all advertising, promotional, and solicitation literature be submitted to the administering agency for approval. Failure of

the agency to respond within 14 days should be statutorily deemed to be approval of the literature.

There is a need to develop and further test various methodologies for determining whether fees are set to maintain long-term financial viability; however, the fee-setting mechanisms should avoid the disadvantages of trying to apply a simple mechanistic formula to all cases.

Among the other recommendations made by the study were expanding and strengthening preconstruction requirements to protect bondholders' interests and establishing a formal disclosure criterion to minimize possible abuse through conflict of interest among management and board members.

AREAS FOR FUTURE RESEARCH

During the two years of study leading to this book, it became clear that there were a number of issues related to continuing care that required additional research and evaluation.

Although these issues were outside the scope of the study, the authors and members of the Advisory Committee feel strongly that consideration should be given to such issues, which include the following:

How large is the demand for continuing care, and how widely can the continuing care concept be applied successfully?

Do CCRCs help to prolong life, and if so, what specific factors produce this longer life expectancy? Based solely on a review of life expectancies in this study, CCRC entrants tend to live longer than the general population.

Contrary to the general belief that more health care services are used when the cost is lower, the study data indicated *less* health care utilization among residents of CCRCs. Why?

Comparative studies are needed to determine not only what differences exist in the cost of health care but also what is being bought with the health care dollar: physician usage, usage of skilled nurses and of nurse practitioners, drugs, laboratory tests, and additional recognized services such as podiatry and dental care. Data are also needed on health care expenditures by CCRC residents compared to expenditures by comparable groups living outside CCRCs.

Does the immediate availability of health services in a CCRC produce better health among residents?

What are the economies of scale in a CCRC?

There is a definite need for development of a national, or regional, data base from which guidelines can be drawn in selecting the assumptions to be used for financial analyses of CCRCs. Development of CCRC mortality rates is especially needed because it is impossible to reflect the financial consequences of a continuing care contract with accuracy using only life expectancies and mortality rates.

How will CCRCs be affected by federal and state tax laws?

What bioethical and legal questions will arise as a result of the increasing age of CCRC residents?

Is discrimination on the basis of age, race, or religious affiliation being practiced by any CCRCs?

Who will determine the allocation of decreasing resources?

What are the legal impacts of Medicare and Medicaid decisions? ■