Continuing Care Retirement Communities

An Empirical, Financial, and Legal Analysis

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1984
Published for the
Pension Research Council
Wharton School
University of Pennsylvania
by
RICHARD D. IRWIN, INC. Homewood, Illinois 60430

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

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of the
Wharton School
University of Pennsylvania

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ISBN 0-256-03125-8
Library of Congress Catalog Card No. 83–81175

Printed in the United States of America

1 2 3 4 5 6 7 8 9 0 M P 1 0 9 8 7 6 5 4

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.

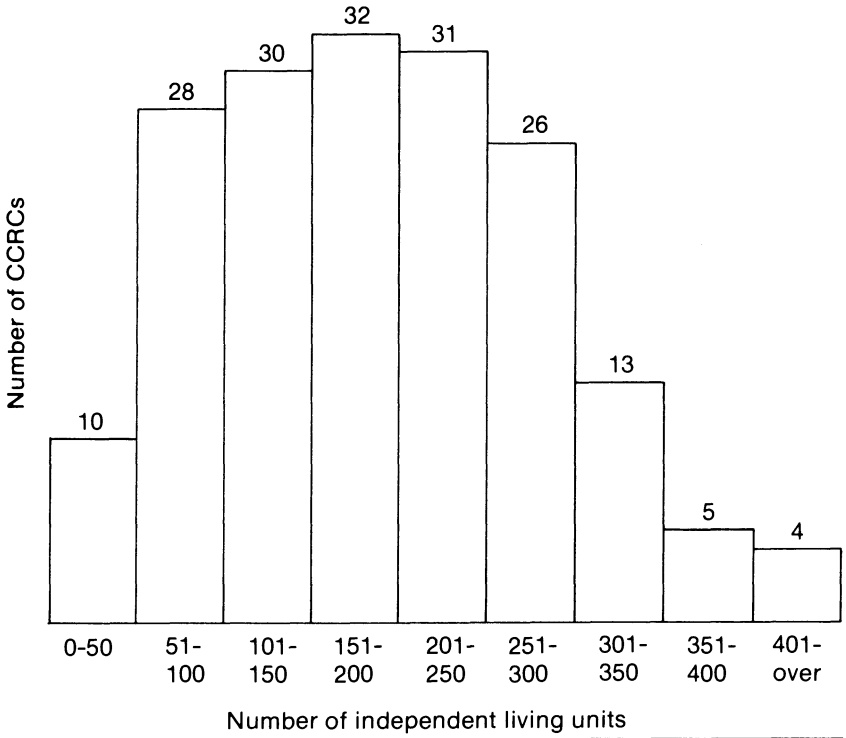
Two models or styles of physical plant design are predominant among CCRCs. The first, designated the *garden* or *campus* style, is represented by 44.4 percent of CCRCs. These have six or more buildings laid out in a campus setting, presumably in suburban locations or on generous portions of city land.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



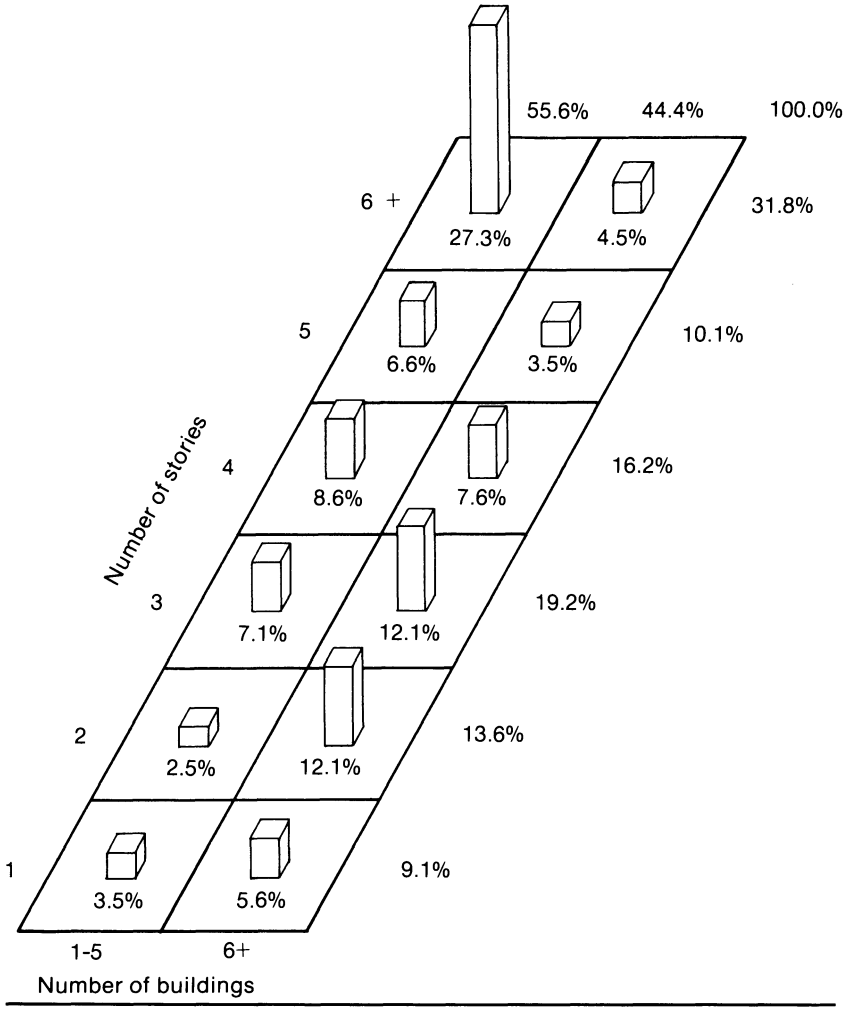
munity reported ever asking a resident to leave because of his or her inability to pay fees (unless this occurred through willful and intentional dissipation of funds).

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

[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.

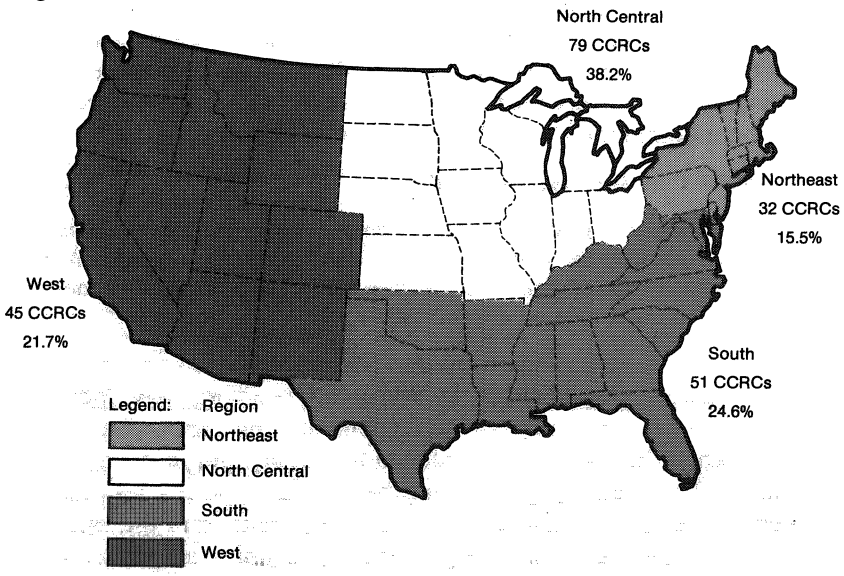
CCRCs are in this group. The second group, classified as offering a *limited* health care guarantee, includes all communities in which residents receiving nursing care are charged the rate that is paid on a per diem basis by individuals not holding contracts (i.e., paying on a fee-for-service basis) 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="4"></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."

---

[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. ■