Continuing Care Retirement Communities

An Empirical, Financial, and Legal Analysis

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To our children:
Amanda, Cameron, & Tyler
and
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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

[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

[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.

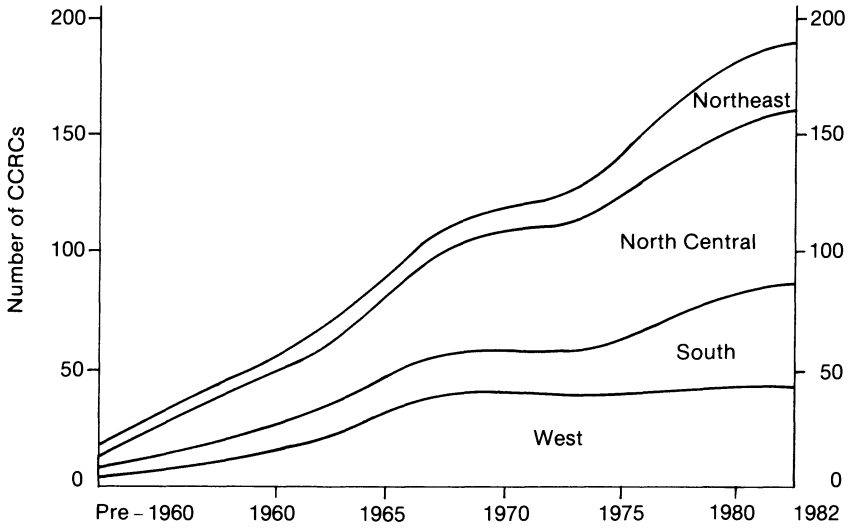
The federal government also influenced the growth and development of continuing care in the late 1950s and early 1960s. In 1959, the National Housing Act created the Section 231 program, providing federal mortgage insurance to aid in the development of new or substantially rehabilitated rental housing 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. Cross-tabulation 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. ■