

Arizona State University

Gilded Pastures

An Explanation of the Background, History, and Legislation of Risks Pertaining to Continuing
Care Retirement Communities

Julie Tang

Dr. Jelena Milovanovic, ACIA, AIAA, Ph.D.

Dr. Matthew J. Hassett, Ph.D.

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1. Introduction

In recent decades, the world has seen medical advances that have pushed the boundaries of human life expectancy to unprecedented territory. The life expectancy at birth of a baby born in 1900 was not yet 50; today, a new born in the United States will likely live to 78 years of age (Leonhardt). This new vertical growth in our increasingly top-heavy population pyramid will have economic as well as social ramifications never before seen by the financial and healthcare systems. In 2010, an estimated 524 million people were aged 65 or older - 8 percent of the world's population. By 2050, this number is expected to nearly triple to about 1.5 billion, representing 16 percent of the world's population ("Humanity's Aging"). In America, the number of seniors is estimated to reach roughly 20.5% of the U.S. population (Vincent 230). With over one in five Americans projected to be a senior in 2050, the aging populace will not only strain the healthcare care system, but also impact every one close to a senior friend or family member. Among people who are 65 or older, about 68% will be impaired in at least two acts of daily living (eating, bathing, toileting, transferring, dressing, and continence) or dementia (Family Caregiver Alliance). The need to understand solutions that address the issue of senior care is more pressing than ever.

This research explores one particular option for seniors, guardians, or children of seniors, seeking stability and security in their golden years: the continuing care retirement community (CCRC). The CCRC industry offers comprehensive well-being in exchange for a pretty penny, thus serving only the wealthiest of seniors. With such a financial and social impact on its inhabitants, investors, and surrounding communities, a majority of states regulate CCRC operations to help prevent potential mismanagement and control risk to residents. In addition to providing an option to address a concern that will affect everyone one day, the CCRC industry

commands attention with its impressive growth over the last two decades. In 1991, about 800 CCRCs were tallied in the United States; as of 2009, about 1900 individual CCRCs were registered (Sanders; United States). Today, over half a million seniors, or roughly 2% of the senior population, live in these residential complexes (“Continuing Care Retirement Community – Definition and History”).

2. Background

According to the American Association of Homes and Services for the Aging (AAHSA), a CCRC is "an organization that offers a full range of housing, residential services, and health care" through various arrangements of services and facilities that provide on-site medical and social services that serve all of its older residents, especially as their needs change over time (Sanders). A CCRC typically categorizes and provides care in three demarcated levels, detailed as follows.

2.1. Levels of Care

Potential applicants must initially qualify for independent living before entering a CCRC contract. CCRCs must maintain a healthy, asset-rich base of new residents to keep their facility financially solvent and costs stable. To do this, a CCRC's admission criteria consider the applicant's income, mental and physical health, age, gender, and marital status. Some may review mental and physical examinations completed by a doctor approved or selected by the CCRC (Sanders). Only after careful review does a CCRC accept an applicant.

When a new resident enters into a CCRC contract, s/he is placed in the most basic level of care, and moves into an independent living unit within the CCRC campus. This unit is usually an apartment or house relatively removed from the more service-saturated centers of the campus.

An independent living unit provides a sense of independence for older adults who are still able to do the basic chores of everyday life, but may occasionally need some help from others (Sanders). From independent living, residents may sometimes move back and forth between the next level of care, assisted living.

The next level of care, assisted living, provides aid to residents with chronic care needs. Residents in assisted living may need help with some essential self-care such as bathing, dressing, or taking medications, but do not require 24-hour skilled nursing care. Usually, the requirement to qualify is impairment in two or more of the six “Activities of Daily Living” (ADL), but in some cases the inability to walk alone puts a resident in assisted living care (“CCRCs”). Residents who are otherwise independent but are recovering from a temporarily disabling ailment may transition back into independent living as their health improves. However, as their needs increase, they may eventually transition from assisted living into skilled nursing care.

The most severe level of care is skilled nursing. This level of care encompasses short-term as well as long-term skilled nursing services (Sanders). As a resident recovers from a severe ailment or becomes incapacitated by degenerative illness such as dementia, s/he will likely be placed under round-the-clock skilled and licensed nursing care in a CCRC. Each “bed” in skilled nursing facilities can be used for one of three distinct categories of nursing care: hospital rehabilitation covered by Medicare, hospital rehabilitation covered by the CCRC, and nursing home care (“CCRCs”). Independent living, assisted living, and skilled nursing constitute the complete continuum of care that the CCRC offers retirees who want to ensure that their needs are met as they naturally require greater levels of care and involvement.

2.2. Contracts and Fees

While three levels of care are clearly delineated and offered, residents do have to make a choice about how they will pay for their care. A CCRC most commonly offers three main types of contracts with different payment structures.

The most expensive contract is the Type A contract, also known as the “Life Care” or “Extensive” contract. On top of housing and amenities, this agreement grants the resident unlimited long-term care and health maintenance services not covered by Medicare without substantial increases in periodic – typically monthly – payments. In this contract, the CCRC bears full financial risk of the health and long-term care expenses associated with the resident. In other words, if the resident requires very intensive and expensive care very quickly, the CCRC will pay out its substantially greater obligation while the resident sees no major increased expenses outside of the monthly fees delineated in his or her contract. This type of contract usually requires an up-front entrance fee, accompanied by a continued, periodic fee which is significantly higher than those outlined in the other two contracts.

The second type of contract, Type B, requires a comparable entrance fee, but a lower periodic payment that continues throughout the lifetime of the resident. Also known as the “Modified” contract, the Type B contract grants housing and amenities, as well as a limited, specified amount of assisted living, health services, and skilled nursing care. Contractual limits to care are usually defined as a number of days each year or a discounted rate at which the residents are charged for these services (Breeding). In the former arrangement, if the contractual number of days are used up, additional services and care are accessible at additional service fees or increased monthly fees (Breeding). Thus, the risk of health expenses is shared between the

resident and the CCRC. If the resident remains in fantastic health for a long period of time, s/he may underutilize the health service facilities, and pay the extra premium for very little return while the CCRC pays nothing extra for the risk. If the resident's health deteriorates rapidly and quickly, s/he may also require more care than the specified amount. In this case, the resident will also have to pay a great deal of medical expenses while the CCRC bears only the contractual limit of care.

The third type of contract, Type C or "fee-for-service," the resident bears all of the morbidity risk. Residents with a fee-for-service contract pay the lowest entrance fee and lowest monthly fee. However, all care services are out-of-pocket for the individual and not part of the CCRC's obligation. If the resident needs to be moved into assisted living or skilled nursing facilities, s/he may see a substantial increase to the monthly fee that is higher than the monthly fee of a similar resident with an extensive contract (Breeding). The resident still enjoys the comfort and ease of staying within the same environment and social community while moving through different levels of care. This makes a CCRC particularly attractive as an alternative to a potential trauma associated with moving to and from different health care environments to which seniors would otherwise be subjected outside of a CCRC arrangement. Under all three main contracts, entrance fees are refundable under certain circumstances by law while monthly fees are not. However, two far less common fee arrangements can also be found in the industry: the rental fee and the equity purchase.

The rental fee structure has only a monthly fee that can be substantially higher than a fee structure with an up-front fee. In the rental arrangement, the resident may opt out at any time without entitlement to a refund of the monthly fee, as there is no prepayment of future anticipated health services (Zebolsky). This payment follows a pay-as-you-go fee structure, does

not assume the resident will remain at the facility for life, and does not guarantee any services to the resident (Breeding). Thus, any healthcare the resident may require may become very costly as assisted living, skilled nursing, and other health services are charged at market value (Breeding). This arrangement is very rare and often arises as a measure against low occupancy at a CCRC (Zebolsky).

An equity purchase model often makes residents themselves the owners of the CCRC. Residents, instead of an escrowed entrance fee, pay to own an equity share, a unit, or membership, of the community (Zebolsky). This purchase does not follow the same statutes as a refundable entrance fee payment found in Type A, B, or C contracts. The resident's ownership of the independent living unit or membership in the CCRC can be resold by either the resident or the resident's estate only to applicants who meet health criteria and are approved to live in an independent living unit. Health services under the equity model are at additional fee, which can vary from a monthly prepayment to separate fees-for-service (Zebolsky). With this variability in payment structures to suit differing needs of incoming residents, it follows that CCRCs vary tremendously from one another.

2.3. Societal Impact

Today, anywhere from 5.8 to 7 million Americans (family, friends, and neighbors) provide care to a senior over the age of 65 who is unable to complete activities of daily living (Family Caregiver Alliance). This figure grows staggeringly to 43.5 million informal caregivers providing care for those over age 50 (Alzheimer's Disease). The impact of caring for a disabled senior reaches every part of the caregiver's life. The income and benefits forfeited by a caregiver over a lifetime are estimated to total around \$283,716 for men and \$324,044 for women, who are

more likely to spend considerably more time providing care for their loved one (Family Caregiver Alliance). The ubiquitous impacts of informal senior care do not only impact the caregiver's financial and emotional reserves, but also stress the relationships between family and friends as a result. These various strains on the well-being of individuals, both caring and being cared for friends and family, can all be addressed to some degree by the operations of a CCRC.

3. Risks

3.1. CCRC Risks

Care expenses pose the largest risk for both the CCRC and its residents. These include memory, long-term, nursing, as well as other forms of care offered by the facility.

For a CCRC, there are several pitfalls that may lead to bankruptcy. Typically, residents' entrance fees are used to pay off long term debt and maintain and/or upgrade facilities, while monthly fees go toward the facility's operating expenses and care services ("CCRCs"). This cash flow structure is highly dependent on acquiring enough capital from large "buy-in" fees, usually indicated by sufficient levels of occupancy in the facility. Facilities that fail to reach and maintain sufficient occupancy could have done so by either failing to conduct an accurate feasibility study on factors such as location, demographics, and competition prior to commencing the project; garnering a bad reputation for any number of reasons; or over-expanding once established. The outcome of a bankruptcy can range from changes in management, reduction of services offered, to restructuring of the facility ("CCRC Bankruptcy: A Much Discussed Rare Event"). While no resident has ever been forced to leave a CCRC due to its bankruptcy since the Great Recession, s/he can experience adverse impacts such as reduction in quality of service or anxiety.

Historically, CCRCs have seen difficulties with regards to bankruptcy. In the 90s, CCRCs saw bankruptcy rates as low as 0.3% (Conover). This auspiciously low rate is punctuated by two distinct periods of hardship for the industry in the mid-70s and in the late 2000s to early 2010s following the Great Recession.

In the mid-70s, the lack of governing statutes surrounding the CCRC industry attracted the attention of dishonest firms, leading to approximately forty bankruptcies that ravaged the industry into the 80s due to fraud and mismanagement (United States). Since these bankruptcies, tighter state legislation across the United States has guarded against fraud and mismanagement.

One high-profile case in recent years was the Erickson Retirement Communities bankruptcy. In late 2009, Erickson Retirement Communities, owning 20 individual CCRCs across the country, claimed over \$1 billion in assets and liabilities in the largest retirement housing bankruptcy filed in American history, after 15 years of growth and success (“CCRC Industry Pioneer Succumbs to Bankruptcy”). The expensive growth of this company saw occupancy levels take a deep dive: seniors, suddenly unable to sell their homes to come up with entrance fees, did not come through the door. While this incident may make CCRCs appear tenuous for retirees looking for a safe investment, the CCRC industry saw 12 bankruptcies out of nearly 2,000 facilities since the onset of the Great Recession in 2007, faring better than most other real estate sectors during that time period (“CCRC Bankruptcy: A Much Discussed Rare Event”). This optimistic perspective seems to indicate that the state regulations set in place from the 80s had successfully guided the CCRC toward a more financially robust and secure future. Additionally, fair treatment of residents has been the foremost objective in times of bankruptcy, as negative word-of-mouth and a bad reputation would only further contribute to a financial ruin

of a CCRC. Going forward, the industry should remain vigilant in anticipating potential drivers of low occupancy rates and adapt their operations to assist in preventing bankruptcy.

Another red flag for CCRCs is the overuse of rental agreement contracts. While this form of contract is a temporary solution to low occupancy rates, too many rental agreements may be a cause for concern. Regular monthly payments can help contribute to operating expenses, but they lack the scale of entrance fees on which facilities rely to finance large debts and capital (Hassett). Facilities that fail to meet necessary occupancy levels cannot simply use rental agreements as a “Band-Aid” solution to their larger financial obligations.

3.2. Consumer Risks

For the consumer, a CCRC contract can tie up almost all of his or her assets. Entrance fees range from around \$100,000 to highs of over \$1,000,000, while monthly fees can vary from \$3,000 to over \$5,000 (“About Continuing Care Retirement Communities”). As a result, residents are justified in being concerned about the guarantee of services in times of need. From the resident’s perspective, the solvency of the CCRC, and the ability to pay monthly fees, are the two largest risks when committing to a CCRC.

In terms of reliability of services, a CCRC intends to continually fulfill its contractual obligations to its residents. A facility’s ability to obtain new buy-ins and remain in business depends utterly on its local reputation and good standing. To further maintain the quality and pleasantness of residents’ experience, many CCRCs provide a guaranteed bill of rights to residents. Rights in their contract are often required to include but are not limited to comprehensive disclosures as well as some rights to board representation in the management of the facility’s operations and planning (“Continuing Care Retirement Community Resident

Contract Checklist”). Thus, CCRCs take both statutory as well as elective precautions to help ensure that residents’ needs are satisfied and that they are empowered in their financial and personal decisions. Some checks for gaining a perspective on the financial health of a facility before buying-in include speaking to current residents, reviewing audited financial documents, and visiting the campus in-person (“About Continuing Care Retirement Communities”).

Medicare, the federal program aiding elderly and disabled individuals, covers some skilled nursing care while predominantly covering many of the medical expenses of residents. Medicaid, the joint federal-state healthcare financing aid for certain low-income Americans, covers nursing home care for eligible individuals, but is usually not a large factor in the CCRC industry (United States of America). Managed care plans from Medicare can cover only a portion of the care services available to a resident at a CCRC. Private and government long-term care areas of CCRCs and Medicare and Medicaid can synergistically provide residents of CCRCs with greater assistance in paying for care.

Acknowledging the financial benefits of eligibility in government assistance programs, an increasing number of CCRCs require residents to have Medicare A and B coverage. These government aid plans can help cover certain eligible services including physician visits, nursing care, and hospitalization, as medical services and expenses unrelated to care are typically not provided for in a CCRC contract (Sanders). As of the 90s, over 80% of CCRCs accept either Medicare or Medicaid, and 49% accept both as third-party service payments (Sanders). On top of Medicare and Medicaid, some CCRCs can require residents to enroll in Medigap or apply for Social Security Income to further reduce their risk of running through their assets while living in the community (Jong). As of 2005, amended Medicare and Medicaid laws require CCRC residents to “spend down” their resources to be eligible for Medicaid nursing-care payments

(Deficit Reduction Act of 2005). Couples impacted by this law could potentially see access to savings drastically limited for the healthier spouse. Another consideration for residents is the medical expense tax deduction by IRS Ruling 76-481 for the money spent on entrance and monthly fees (Begley). Facility management should calculate and provide the tax-deductible amount for residents annually. Governmental funding of residents' health care services, despite its potential limitations on individuals who have more assets to "spend down," provides welcome help to many residents with increasingly expensive and uncertain care needs.

In summary, the risks faced by residents vary greatly from the risks faced by CCRC facilities. Basic medical expenses, as well as additional care expenses outside of the CCRC contract, remain the responsibility of the resident. The risk to a CCRC, however, is the cost associated with providing care to the elderly who suffer from Parkinson's disease, dementia, and Alzheimer's disease which are not covered by Medicare.

4. Regulation

4.1. Legislature

Currently, the United States federal government does not regulate CCRCs in full, only the nursing homes (Begley). Regulations for this industry therefore only exist at the state level, varying from state to state. State regulation of CCRCs has developed over time, motivated by shortfalls in the mid-70s. Currently, thirty-eight states have enacted laws through various state divisions such as insurance, financial services, aging or elder services, or social services which apply to CCRCs (United States of America). State regulation typically requires full disclosure of the CCRC's financial standing, contractual obligations, and ownership of the facilities; full disclosure of the rights of residents; full disclosure of costs to the residents; minimum standards

concerning financial status of facilities for financial solvency; and that the facility has obtained a Certificate of Authority to offer continuing care (Begley).

While statutes and standards differ from state to state, Florida exemplifies a strictly regulated state for CCRCs, compared to the less regulated state of Arizona. In a document for the United States Senate Special Committee on Aging regarding the CCRC industry, the Insurance Commissioner of the Florida Office of Insurance Kevin McCarty shared his state's strict regulations, which include two feasibility studies. A prospective provider must submit two separate, independent feasibility studies before obtaining a Certificate of Authority to operate: once before collecting 100% escrowed deposits on entry fees, and once more by an independent consultant only after deposits have been collected for over half the living units, and secure financing to complete the project has been proven (United States). The purpose of these feasibility studies is to curtail reckless overexpansion of CCRCs into locations with little demand or means for such a facility. Only after the Certificate of Authority is obtained can the provider begin construction of the CCRC campus, using no more than 25% of future residents' entrance fees (United States). The residents' funds are barred from the prospective provider to help protect the residents' right to obtain a refund of their entrance fee should they change their mind or the CCRC fails during the construction stage. The remaining 75% of the collected deposits and entrance fees are held in escrow until the CCRC provides proof that construction is complete, at least 70% of units have been paid in full, statutory reserve requirements have been fulfilled, and an independent consultant has verified no material changes have occurred since the feasibility study (United States). These final checks help ensure that the facility is fully operational and competently managed before residents' funds are put at complete risk. These guidelines in Florida aim to prevent the victimization of seniors by poor planning in the early

stages of a CCRC project. Florida also boasts a number of ongoing statutory requirements for operational CCRCs both new and old.

Florida's general legislation governing CCRCs focuses on four distinct areas to mitigate risk to residents. These areas are verifying that CCRC management is responsible and reputable, ensuring proper disclosure of information to the public, ensuring compliance to licensure requirements, and providing financial oversight (United States). All four prongs of Florida's approach relate strongly to the idea of protecting the resident from financial or personal ruin. The measures outlined in McCarty's document include numerous filings of both the facility and its staff, as well as regular independent audits, reviews, and on-site inspections. Reserve statutes are specific and differentiated among different reserves, and actions taken for CCRCs experiencing a negative financial trend are more stringent and corrective. These ongoing legal requirements of CCRCs in Florida help ensure that residents are continually protected from the risk of financial mismanagement that can lead to the facility's bankruptcy or decline in quality.

Arizona also regulates CCRCs, but to a lesser degree. Before obtaining a Certificate of Authority, prospective providers must also provide a feasibility study demonstrating sufficient funding for the project and the first two months of operation (20 Arizona Rev. Code Sec 20-1802). Under the Arizona Department of Insurance (ADOI), CCRCs are subject to similar regulations as a typical insurance company. The funds of a CCRC may be examined by the director of insurance, legislature, or residents at any time, and any event of insolvency will necessitate submission of all transactions leading to the insolvency to the director of insurance (20 Arizona Rev. Code Sec 20-678). This statute grants the ADOI financial oversight and rights to investigation, discouraging mismanagement leading to insolvency. In addition, Title 20 Sec 20-698 of the Arizona Rev. Code provides that "an independent certified public accountant must

conduct an annual financial audit of the company and submit a financial report” to the ADOI. This is an annual report that follows Statutory Accounting Principles, and further allows for transparency of CCRCs’ financial health.

As an insurance entity providing a variety of long-term care services for fixed contractual fees and rates, a CCRC also requires the addition of an actuarial report. In Arizona, the appointed actuary conducting this study and providing his or her actuarial opinion must not be an executive, and be in good standing with the American Academy of Actuaries (MAAA) and any other professional actuarial organizations with which the individual has been affiliated (20 Arizona Rev. Code Sec 20-696.02). The appointed actuary conducts and submits the results of three distinct analyses, or “tests,” that measure three aspects of financial health of the facility in accordance to the Actuarial Standards of Practice. These are a balance sheet study, which evaluates the viability of supporting only the current residents of the facility until death; a price adequacy study, which evaluates the viability of supporting a completely new cohort of incoming residents using current pricing structures; and a long-term asset and liability analysis of cash flows, which looks at the viability of the whole, operating CCRC as an ongoing concern (Arizona Rev. Code Sec 20-1807). These analyses will be compiled in a memorandum that follows a comprehensive disclosure law that ensures complete transparency of calculations, methods, reserve bases, sources of cash flows, and assumptions (Arizona Rev. Code Sec 20-510). Based on these analyses, the actuary submits an official public opinion on the standing of the CCRC. If the opinion is adverse or qualified, the actuary must issue the explicit reasons for this opinion (Arizona Rev. Code 20-696.03). This extensive review process is conducted every three years, or more often if the facility is experiencing a negative financial trend (Arizona Rev.

Code 20-1807). This analysis is necessary to ensure the financial health of CCRCs going forward.

4.2. Actuarial Standards of Practice

The actuarial analyses applied to CCRCs follow a set of guidelines that help the actuary answer key questions about the financial standing of the facility, the Actuarial Standards of Practice (ASOP). The body that governs the standards for these actuarial analyses is the Actuarial Standards Board. The 3rd ASOP, titled “Continuing Care Retirement Communities,” specifically addresses best practices for actuaries doing work for CCRCs. As stated on the document, the purpose of ASOP No. 3 is to act as a guideline for actuaries to perform analysis on the financial solvency of CCRCs based on “cash flow, pricing, and expense trends and projections” that reveals “whether a CCRC is in sound financial health or ... shaky standing.” The document contains appendices and sections with background, limitations, and other meta-discussions on the ASOP itself.

The ASOP No. 3 enumerates three different business scenarios which must be analyzed, and specifies the methodologies and type of analyses for each scenario. The text describes projection of population movements for all three tests mentioned before, taking into account factors such as mortality, morbidity, and withdrawal. The actuarial balance sheet, the first examination to be conducted, is an estimate of the present values of all liabilities and assets associated with the current group of residents – including third party payments, investments, physical capital, depreciations, refunds, and long-term debt and obligations. The cohort pricing analysis is the second scenario an appointed actuary must evaluate. The guidelines for the actuary conducting the cohort pricing analysis prescribes methods for calculating actuarial

present values associated with a completely new cohort of residents brought in with the current fee structure. If the present value is positive, then it may be concluded that the CCRC is pricing its contracts adequately and sustainably. For the last scenario, all cash flows for the CCRC are projected to a future point in time, past which there is no material difference according to the judgement of the actuary. This scenario tests the viability of the facility as an ongoing concern. Acceptable methods of calculations and assumptions are addressed, establishing standards for making and defending these assumptions for the purposes of the prescribed scenarios. The document serves as a guideline for all actuaries to follow when analyzing the ongoing financial concern of a continuing care operation. Simply prescribing these three scenarios, however, would uphold a somewhat one-sided and weak standard of professional ethics.

The ASOP No.3 closes this gap by requiring complete disclosure of analytical methods and assumptions employed by the actuary conducting the analysis. In addition, the actuary is required to give feedback based on the results of the scenario testing. If the projected liabilities are not met or exceeded by the projected assets, the actuary should not only give an adverse or qualified opinion with exact reasons, but also propose a plan on how to manage and remedy the current financial situation of the CCRC (“Continuing Care Retirement Communities”). The acuity of the three tested scenarios engages the consultant role of an actuary to add value to a CCRC that a typical financial audit otherwise does not. Further stipulations include that any issues that came up “in any step in the analysis process, be it assumptions, legislature, proposed plans, results of any sensitivity tests” must be disclosed in the submitted studies. While few facilities are periodically issued an official actuarial opinion, the CCRCs in states where actuarial opinion is issued, statutorily or voluntarily, have a powerful measure of financial standing with which to manage themselves.

5. Unaddressed Risk

State government entities as well as professional actuarial committees oversee the industry's financial health, but this is an ongoing and improvable system. While all facilities may undergo periodic independent inspections following statutory and actuarial standards, facilities with concerning financial patterns are subject to more stringent and corrective courses of action. These regulatory structures currently in place address much of the industry's current risks regarding low occupancy and possible mismanagement, but there will always be unavoidable risks that can bankrupt a CCRC.

While no one since the Great Recession has been forced to leave a CCRC due to bankruptcy, residents still suffer adverse effects from economic downturn. Senator Herb Kohl, during a meeting with the Senate Special Committee on Aging, revealed that low occupancy rates and economic hardship for a CCRC means residents will experience "increase in the monthly fees, a reduction in the services and amenities provided, or both," (United States of America). Alicia Cackley, Director of the Financial Markets and Community Investment team of the U.S. Government Accountability Office, has expressed similar concerns about residents facing the risk of considerable increases in monthly fees during economic downturn (United States of America). It appears that when all facets of the economy are suffering, particularly real estate markets and investment portfolios, there is a certain amount of risk that cannot be prevented for both a CCRC and its residents. However, this risk of jumps in costs for senior health services would likely exist regardless of whether a resident has placed his/her trust and assets in a CCRC for his or her care needs. Other options for long-term care, such as nursing homes or home health services, similarly experience hikes in service costs or serious shortages in

nursing labor due to recession and budget cuts (Alameddine). Thus, CCRCs are not a perfect and invincible financial choice of retirees. Looking toward the future, regulators and potential residents alike should continue to stay vigilant in identifying and preparing for the constant evolution and growth of the CCRC industry. With a history of change and innovation, the industry continues to shift and develop even today.

6. Expert Opinions

Six experts were surveyed for their expertise with CCRCs and other forms of senior care and planning, addressing questions about solutions to current issues in the future of the continuing care model. Their combined experience forms a uniquely balanced set of perspectives from many angles of the CCRC industry.

1. Cole Marvin: Marvin is the CEO of Friendship Village, a CCRC founded in 1980, and Board Chairman for LeadingAge of Arizona.
2. Gregory T. Zebolsky: Zebolsky performs “comprehensive actuarial studies for CCRCs, including population projections, actuarial balance sheet, cash flow projections, and actuarial pricing analysis,” and is an expert on CCRCs and long-term care insurance.
3. Anna Rappaport: Rappaport, former president of the SOA, and “internationally recognized expert on the impact of change on retirement systems and workforce issues,” she also served 15 years chairing the “[SOA] Committee on Post-Retirement Needs and Risks,” (Rappaport).

4. John Cutler: Cutler served as Project Oversight Group chair for the “Diverse Risks in Retirement” project by the SOA Committee on Post Retirement Needs and Risks (Cutler).
5. Faye Albert: Albert served as the chair of the CCRC Project Oversight Group in 1989.
6. Matthew Hassett: Hassett is a current CCRC resident, retired professor, and former actuary.

Overall, experts shared a common frustration in the significant variance from state to state with regards to CCRC regulation – or the lack thereof. Establishing a consistent system of oversight and regulation of CCRCs has thus far proved difficult. To emphasize this point, Zebolsky explained further discrepancies in CCRC legislation: even among the states with such laws, some may only have initial requirements for a new CCRC project, such as feasibility studies. Far fewer states have ongoing regulations, such as annual actuarial reports, that monitor the facilities going forward (Zebolsky). In fact, only seven states require a formal periodic actuarial opinion (“Actuarial Opinions”) to be submitted by CCRCs. Ongoing regulations for CCRCs are crucial for overseeing continuing care facilities as on-going concerns that must remain solvent and able to fulfill obligations indefinitely after their founding. While mandating periodic actuarial reports may not resolve all of the industry’s risk of bankruptcy, it can greatly help facilities better manage performance in order to prevent it.

This lack of universally adopted regulations poses is also an issue for the vulnerable senior population. The array of complex laws has yet to be translated into simple yet actionable language in each state. In effect, these state laws often remain inaccessible for most prospective and current residents who may struggle to understand their legal protections, and the standards to

which their facilities are held accountable. Rappaport emphasized that it would be better for the consumer if, as for life insurance providers, there were a minimum set of requirements upheld by all states or federal legislation enacted for all CCRCs in the United States (Rappaport). A common CCRC law would be easier to translate into understandable and accessible language such that potential residents and CCRCs alike would be able to make more informed financial decisions. However, the path to realizing this goal may see pushback from the industry itself. Many CCRC establishments, having a much more complex product to offer than long-term care, do not see themselves as selling “insurance,” and thus do not believe they should be regulated as such.

In addition to noticing nationwide inconsistency, several experts indicated that some risks remain unaddressed altogether by legislation. A specific concern for Cutler was the lack of reliable “protection for residents in the event of personal bankruptcy,” (Cutler). To recall, a number of CCRCs choose to offer a benevolence fund for residents who do exhaust their assets. However, as this is not a statutory requirement, this cannot be assumed for any given CCRC and most residents do not have this sort of fund as a protection. Albert agrees that “legislation was not effective in protecting the CCRC residents” during her involvement with CCRCs (Albert). In her experience, while the churches associated with many CCRCs would contribute money “to keep the facilities financially sound” when institutions faced bankruptcy; residents, faced with personal bankruptcy, could not expect to receive the same grace from the institution (Albert). One potential remedy for this risk, offered by Cutler, is to require CCRCs to set up a fund to “carry” residents in case of personal bankruptcy instead of leaving it as an elective service (Cutler).

In terms of the effectiveness of the Actuarial Standards of Practice for CCRCs in protecting residents and facilities, experts surveyed shared a few similar suggestions. Rappaport brought up the stringent actuarial reserving standards that apply to products such as single premium whole life insurance, which also feature a large up-front payment, suggesting that CCRCs may benefit from similar actuarial reserving guidelines, prescribed by the ASOP or otherwise (Rappaport). Another possible consideration for the ASOPs is stress testing. Currently, it is not a requirement to perform sensitivity or stress tests either “when facilities are first opening their doors,” or throughout their operation (Cutler). With independent actuarial reports of CCRCs, actuarial judgement is employed in selecting the most likely scenario with which to perform actuarial analyses. While this approach balances efficiency and accuracy, it may be prudent for actuaries to also test the CCRC under other possible assumptions and scenarios and explain troubling findings, if any. Hassett echoed an interest in determining which scenarios could theoretically “bring a place down,” even if the facility appears to be presently solvent (Hassett). These opinions indicate possible additions to the ASOP no. 3 that may improve and elevate standards for actuarial projections, and analyses of CCRCs.

Within the ASOP no. 3, the three prescribed tests are met with ambivalent opinions. It is not uncommon for the Actuarial Balance Sheet test to fail; in fact, there are scenarios that can trigger a deficit in the Actuarial Balance Sheet that do not necessarily mean the facility is struggling financially – such as a recent loss in stocks (Zebolsky). Some experts expressed an interest in whether there can be an adjustment in standards of practice to increase the sensitivity of the Actuarial Balance Sheet to better answer the relevant financial questions. While stress tests could be an interesting and useful tool to provide more financial insight on facilities, the extensive analyses presently required to perform the three prescribed studies provide substantial insight

into and understanding of the financial health of the CCRC from an actuarial perspective (Zebolsky). In addition, there exist numerous risks that can lead to bankruptcy that the actuarial tests cannot test for, such as debt structure and facility reputation (Marvin). In these cases, the prescribed tests still aid management in maintaining adequate levels of surplus that in turn help them survive economic downturns.

Ultimately, change is a slow and arduous process. Legislation that might have a long-term positive impact of facilities in a few years' time can unfortunately cause many to go bankrupt before the savings or benefits can be seen. CCRCs today employ lobbyists as a measure to mitigate legislation, such as new taxes, that could negatively impact facilities' immediate financial health (Marvin). When asked what we, as a society, can do to adapt to our aging population, Rappaport emphasized the importance of "promoting understanding and public dialogue" of post-retirement. With increased awareness of these issues, a more informed public can advocate and help guide the structure of regulations to most thoroughly protect both the consumers and facilities.

7. Emerging Trends

One of the emerging trends in the industry is the "CCRC without walls." In the "CCRC without Walls" model, instead of moving in to an on-campus independent living unit to begin his or her contract at the CCRC, the resident spends the independent living portion of the "stay" in the comfort of his/her own home. Insurance Commissioner McCarty of Florida has noted this trend in the CCRC industry of Florida in response to "the steep drop in the housing market when people are reluctant or unable to sell their homes for market value or what they think their properties are worth," (United States of America). This model also reduces, and in some cases,

eliminates, the entrance fee which bars a portion of seniors from accessing a CCRC. In addition to developing more affordable and flexible models of continuing care, CCRCs are focusing on increasing the variety of services offered to attain additional sources of revenue. CCRCs within the last ten years have begun opening their own home health care agencies on campus, as well as opening their own on-site pharmacies (United States of America). With more sources of revenue, CCRCs are continually improving their financial stability and viability, strengthening their ability to continue caring for residents.

Another trend in the CCRC industry is contracted for-profit management. Katherine C. Pearson, Professor of Law at the Pennsylvania State University specializing in elder, nonprofit, and contract law, stated in a document to the Senate Special Committee on Aging that she perceives a “trend toward non-profit ‘affiliation’ of facilities” wherein non-profit owners increasingly “contract out” “management to for-profit management companies (United States of America). While this shift may seem to undermine the humanitarian roots and philosophy of the CCRC model, it may, in fact, be a step towards improved reliability of services and better outcomes for residents. David Reis, CEO of Senior Care, believes that, of affordable CCRC housing projects that have experienced financial troubles in the last two decades, many had to do with not-so-savvy business management committees, including many members from non-profit – rather than business – backgrounds (Luciano). These recent trends point to the recurring notion that the CCRC industry continues to see new developments and a need for self-improvement.

8. Conclusion

Despite the state-level regulations of CCRCs today, let there be no illusion that long-term care in a CCRC is readily accessible for all seniors seeking peace of mind. They are simply too expensive. Research indicates a troubling pattern of low savings rates and weakening government assistance programs for the elderly (VanDerhei). A greater proportion of seniors, by 2030, will either struggle or be unable to pay for basic expenses related to nursing, home health, and long-term care services (VanDerhei). While CCRCs provide an increasingly comprehensive package of housing, leisure, community, and health services, they are not a one-size-fits-all solution. Regulations by some state governments and the Actuarial Standards Board are in place to protect residents investing their assets in CCRC contracts. While far from perfect, the CCRC industry's presence continues to grow and evolve in the United States.

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