AMERICAN BANKRUPTCY INSTITUTE

2022 Winter Leadership Conference

Look Before You Leap: Lessons Learned from CCRC (Life Plan Community) Bankruptcies

Richard P. Carmody, Moderator
Adams and Reese LLP; Birmingham, Ala.

James S. Feltman
Kroll, LLC; Miami

David E. Gordon
Polsinelli; Atlanta

Demetra L. Liggins
McGuireWoods LLP; Houston

Felicia Gerber Perlman
McDermott Will & Emery; Chicago

CONCURRENT SESSION

2022

Look Before You Leap

Lessons Learned From CCRC (Life Plan Communities) Bankruptcies

Moderator: Richard Carmody

Panelists:

- Demetra Liggins
- David Gordon
- James Feltman
- Felicia Gerber Perlman

Senior Living Options:

- Independent Living
  - Age In Place
  - 55+ Community
  - CCRC
  - Senior Co-housing
  - Senior Home Sharing
- Assistance Services
  - Skilled Nursing Homes
  - Rehab Care
  - Assisted Living
  - Memory Care
  - Hospice

*CCRCs combine Independent Living with Assistance Services (usually on same campus) so couples can remain in proximity to each other despite health changes.

What are CCRCs (Also called Life Plan Communities)?

- CCRCs offer housing, meals, transportation, activities, and provide a continuum of care including assisted living and nursing home care, usually in one location, and usually for the individual's lifetime. Increasingly, CCRCs have health clinics, wellness programs, and specialized dementia care services.
- Non-Profit (many religious organization sponsors).
  For-Profit (many subsidiaries of hospitality and healthcare companies).
- Regulated (75% states) and unregulated (25% states).
- Average size mmm residents

Personal Considerations

Common Reasons to Consider a CCRC

- Highly Subjective – Priority Access to care is very important.
- Peace of mind that comes from meeting one's long term care needs in a single setting.
- No longer maintaining a house.
- Proximity of family.
- Relieves concern of being a burden on friends and family.
- Couples can age together in a community or on a campus.

CCRC Community Culture

- More institutional environment.
- Relatively homogeneous population.
- Everyone is eventually "aging out."

Location, Facility Characteristics & Ownership

- Near or with friends. Near family?
- Age of the facility.
- Downsizing. "Your kids don't want your stuff."
- Non-profit or for-profit?
- Quality of management.

CCRC Affordability

Can You Afford a CCRC?

- Entrance Fees
  - One time, upfront. Usually at or above median house values in the area
- Monthly Fees
  - Variable depending on levels of amenities and care required and type of contract. Indexed to inflation. Compare to homeowner expenses.
- Adequacy of Income Analysis
  - CCRC will fully vet each applicant's financial disclosures. Also calculate an actuarial age (life expectancy).

Continuing Care Contracts

What is a Continuing Care Contract?

- Promise of Care for a Period of at Least One Year or More.
- Offers independent living and continuum of care.
- Tend to protect the provider.
- Usually not subject to negotiation.

Key Elements of Continuing Care Contract

- Disqualifying Conditions
  - Start at independent living.
  - Pre-existing health conditions.
  - Upper age limit.
- Contract Termination
  - Trial period?
  - Prohibit divestment of assets?
  - "For good and sufficient cause?"

Key Elements of Continuing Care Contract (cont.)

- Refundable Entrance Fees
  - Subject to negotiation
  - Paid to heirs
- Ownership
  - Unusual
- Improvements to Independent Units
  - Require approval
  - Become CCRC property

Basic Contract Types – "Type A"

- Life Care Contract
  - Care for life for a fee
  - Most expensive option
  - Non refundable
  - CCRC assumes risk
  - No longer prevalent

Basic Contract Types – "Type B"

- Modified Contracts
  - Entrance fees, monthly fees, guarantee of access to higher levels of care
  - Potential refunds
  - There might be options for full, partial or proportional refunds of entrance fees
  - Less costly upfront
  - Future risk sharing

Basic Contract Types – "Type C"

- Fee-for-Service Contract
  - Entrance fees, monthly fees, guarantee of access to higher levels of care
  - Potential refunds
  - Prevailing market rate for more care
  - The resident assumes the

Assessing the Availability/ Quality of Services and Care

Quality of Care Concerns

- Ask about the years of experience and the track record of ownership / management in operating both independent living units and higher levels of care
  - e.g. – assisted living and nursing homes
  - Check all levels of care

Independent Units

- Housekeeping
- Food plans and food variety
- Quality and meal schedules
- Transportation
- Recreational and activity costs
- Accessibility features
- Options/restrictions for receiving assisted living services in independent units, and associated costs
- Incidence of relocation to higher levels of care
- Consequences of one spouse in assisted living

Assisted Living

- Availability when needed
- On-site
- Dementia and hospice care
- Emergency evacuation
- Qualifications and training of staff
- Ratio of staff to residents at each shifts

Nursing Home & Primary care

- Experience of managers
- Turnover rates
- Acceptance of innovation

Evaluating Administrative Practices

Atmosphere of Respect

- Not patronizing
- Accepting of constructive criticism
- Rapport with administrators

Residents' Self-Determination & Independence

- Are you consulted on decisions affecting your level of care?
- Ask residents about:
  - How decisions are made
  - How residents' input is sought by administration
  - How decisions are communicated to residents
- Is there a functioning resident association?
- Can residents air grievances?

Administration's Transparency & Experience

- Process for informing residents of fee increases?
- Experience of administration in aging services?

Plans for Renovation / New Construction

Renovation / New Construction

- Can affect enjoyment of the independent living residence or otherwise disrupt the campus.
- For older complexes, find out about their history of renovations and if any renovations or new additions are planned in the next 3 to 5 years.

Renovation / New Construction (cont.)

- For new CCRCs, find out at what stage the assisted living and nursing home care levels are planned to be in place, as you are buying into a continuum of care. Will appropriate care levels be available when you might need them?
- How will monthly rates be affected over the next 3 to 5 years?
- How will common areas be improved?

Financial Soundness

Financial Soundness of the CCRC

- Providers should share audited financial statements and different forms indicating their financial soundness prior to the signing of a contract.
- Review these documents well in advance of contract signing.

Occupancy Rates

- Occupancy rates should not on average go below 90%
- Occupancy rates are the single most important indicator of the CCRCs fiscal viability because high occupancy generates entrance fees, and amortized fees are used for maintaining moderate annual rate increases and providing funds for facility reserve funds.

Operating Income & Expenses

- Expenses should not exceed operating income as a historical pattern.
- Relying on investment income to cover operating expenses might be a vulnerable position, especially in volatile economic times.
- Check the philosophy of investment, risk monitoring procedures, and actual performance for funds invested by the corporation.

Assets, Liabilities, Reserves & Legal Obligations

- CCRCs should maintain an excess of assets over liabilities.
- Is the CCRC deeply indebted?
- Contingency funds should cover at least 6 months of operating expenses.
- Are the reserves adequate?
- Has the CCRC been sued, and, if so, why?

Size of Corporation

- Smaller entities may be more vulnerable.
- Are there any plans for future mergers with other CCRCs?
- For multi-facility entities, consider overall strength and performance record.
- Can they, or have they, shifted funds between entities?

Actuaries

- Does the CCRC rely on actuaries to price contracts, conduct regular studies, and certify satisfactory actuarial balance? These matters affect financial viability.

Additional Resources

- https://www.wsj.com/articles/caregiving-costs-expensive-11645282825
- https://www.kiplinger.com/article/retirement/t037-c000-s004-ccrcs-raise-financial-questions-for-retirees.html
- https://thechesapeake.org/blog/top-10-questions-to-ask-a-retirement-community/

Additional Resources

- https://mylifesite.net/blog/post/key-questions-the-ultimate-ccrc-checklist/
- https://mylifesite.net/blog/post/8-questions-to-consider-before-you-decide-to-age-in-place/
- http://www.canhr.org/publications/PDFs/CCRCGuide.pdf

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Birmingham, AL

CCRCs from an Economic and Financial Perspective

ABI Winter Leadership Conference December 9th-12th, 2022 in Palm Springs, California

December 9, 2022

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COVID Effect on Mortality Figures

COVID increased the mortality rate in the U.S. as seen in the below instances where actual deaths surpassed predicted deaths.

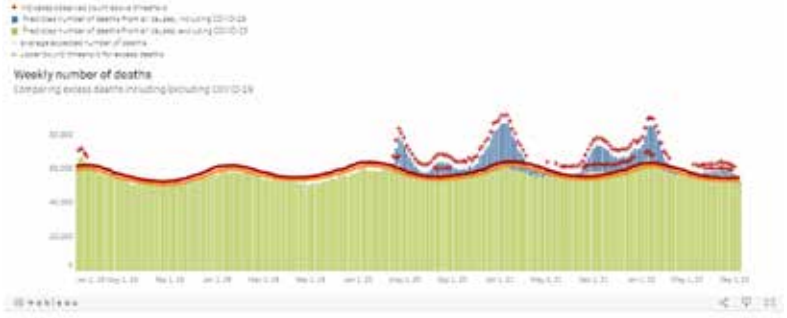


Figure Notes:

Source(s): "Age Distribution in the U.S. from 2010 to 2020". *Statista*. 2 February 2022. (https://www.statista.com/statistics/270000/age-distribution-in-the-united-states/)

CCRC Macro & Market State

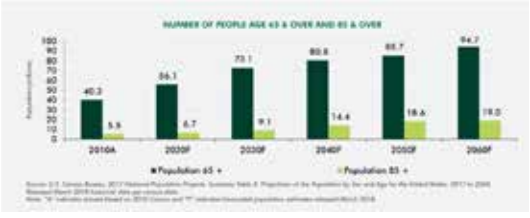
Macro Outlook

The COVID-19 pandemic burned many CCRCs from a financial point of view, particularly due to rapid drops in occupancy rates from to illness within facilities across the country. More recently, and primarily attributable to an aging population and a nearing cessation to COVID, senior-care facilities have begun to make a financial come-back. However, persisting problems (such as inflation and the tight labor market) have continued to cut into CCRC financial performance.

- According to data from the Bureau of Labor Statistics, more than 400,000 long-term care employees have left the workforce since the beginning of the pandemic.
- Senior living occupancy grew 90 bps to 81.4% for 2Q2022, "representing the fourth consecutive quarter for consensus growth in the industry." Still, occupancy rates are far below pre-pandemic levels, when independent living and assisted living were occupied at 84.7% and 89.6% respectively.
- Angela Olea RN, CEO of Assisted Living Locators has noted that everyday until 2030, 10,000 Baby Boomers will turn 65 and 7/10 of them will require long-term care services at some point. Angela continued that "Long-term care expenses at assisted living facilities and nursing homes are climbing … as the industry struggles to meet the soaring demand from an aging population."
- The senior living industry is one that experts have pointed to as being one of the best equipped to survive a recession. This is due to the industry having needs-base demand and the fact that recessions tend to stabilize staffing.

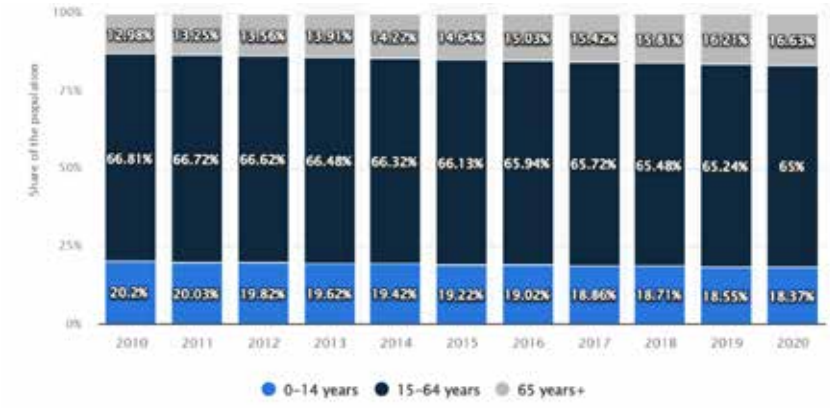
Source(s): "Q22021 Senior Housing Market Insight". *CBRE*. Q22021.
Andrews, Nick. "Senior Living Occupancy Hits 81.4% in Fourth-Straight Quarter of Growth". *Senior Housing News*. 7 July 2022..
"Inflation, Long Term Care Costs On the Rise, Assisted Living Locators Urges Adult Children to Plan Ahead". *PR Newswire*. *3 May 2022*.
Zorn, Alex. "How Rising Inflation is Eroding Margins as the Nursing Home Industry Readies for Possible Recession". *Skilled Nursing News*. 27 June 2022.

- While recognizing that the COVID-19 pandemic has upended the Senior Living industry, CBRE believes the outlook for senior-living facilities is robust. Reasons for that outlook include:
  i. Increasing demand as the U.S. 85+ population is forecasted to grow 177% to 18.5MM by 2050.
  ii. Increasing demand for need-based care (as the average lifespan increases and medical issues become more complex).
  iii. Increasing generational undersupply, currently citing just over two million institutional units/beds in the top 140 Metro Areas.



U.S. Age Trends

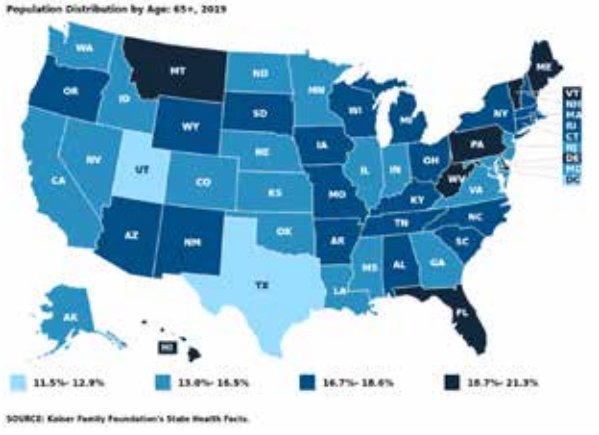
The 65+ population in the U.S. witnessed a 2.96% CAGR from 2008 to 2019, compared with a 0.27% CAGR for the rest of the population.



Source(s): "Age Distribution in the U.S. from 2010 to 2020". *Statista*. 2 February 2022. (https://www.statista.com/statistics/270000/age-distribution-in-the-united-states/)

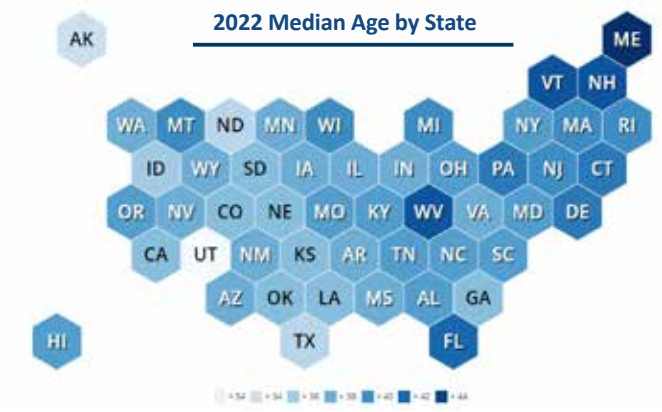
U.S. Age Geography

The below map details those states that had high relative 65+ populations in 2019.



U.S. Age Geography Cont'd

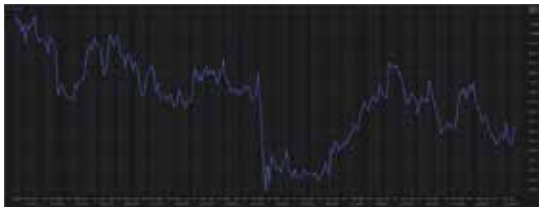
The dark colored states below will require robust assisted-living infrastructure if that is not already the case. Florida's expansive state regulations regarding the senior-living industry are detailed in later slides.



Source(s): *World Population Review*. (https://worldpopulationreview.com/state-rankings/median-age-by-state)

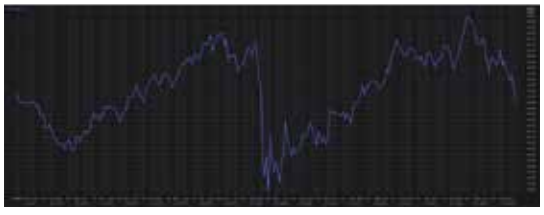
Public Equity

5-Yr Price Performance of Brookdale (NASDAQ:BKD)



- Owner and operator of senior living communities across the U.S. which include independent living, assisted living, memory care, and CCRCs.

5-Yr Price Performance of Largest Sector REIT welltower

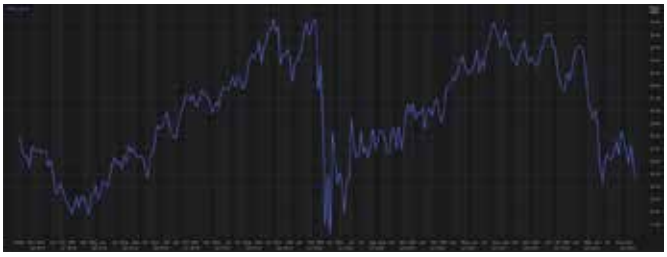


- Welltower invests in senior housing, post-acute communities, and outpatient medical properties, in the U.S., Canada, and the U.K.

Source(s): Refinitiv, Bloomberg, and S&P

Public Equity Cont'd

5-Yr Price Performance of Second-Largest Sector REIT



- Healthpeak holds and has developed over $20Bn of real estate assets in the segments of life sciences, medical offices, and CCRCs across the U.S.

It is obvious to say that the industry took a massive blow in the wake of, and during the worst of, the Coronavirus pandemic. And, as shown through recent price trends, the market is again beginning to look more negatively upon these senior care facility assets. Healthpeak is currently trading at a 2.2x 2Q22 P/BV and 19.5x LTM EV/EBITDA; Welltower is at a 1.8x P/BV and 24.7x LTM EV/EBITDA; and Brookdale is trading at 1.9x P/BV and 27.6x LTM EV/EBITDA. For comparison, the 2Q22 P/BV of the SPX was 3.4x, which shows that the market was valued higher per dollar of BVE than were these senior care facility assets.

Source(s): Refinitiv, Bloomberg, and S&P

Analyst Commentary

RBC on (NASDAQ:BKD) as of 8.9.2022 … CP of $5, PT of $8, and "Sector Perform"

- "BKD has made great strides in recruiting and retention (5x more net hires than 4Q21)."
  - "… we expect the new hires to continue to drive-down contract labor utilization and overtime."
- Management notes confidence in their ability to increase 2023 rates for both new and in-place residents.
- Strong occupancy momentum expected to continue into 3Q22.
  - "Given strong demand and BKD's disciplined operating model, we believe the company should be well positioned to achieved operating leverage and margin expansion as occupancy returns and the labor backdrop stabilizes."

RBC Estimates

FY Dec	2020A	2021E	2022E	2023E
EBITDA, Adj	383.6	338.5	280.2	304.5
Prev			242.5	307.1
AFFO/Sh Diluted	0.13	(1.54)	(0.74)	(0.13)
Prev			(0.92)	(0.04)
Revenue	3,540.2	2,756.3	2,893.4	2,989.9
Prev			2,773.8	2,971.8

BofA on (NASDAQ:BKD) as of 8.9.2022 … CP of $5, PT of $5, and "Underperform"

- "BKD is confident that the occupancy gains and sequential improvement in labor costs will drive a sizeable increase in EBITDA from 1H to 2H."
- "The Company noted that the decline in contract labor utilization has been slower than initially expected … in addition, BKD is seeing an increase in overtime usage. This is partially due to the increase in COVID cases which results in more employees out on quarantine. Turnover remains high vs pre-pandemic levels and the company noted coverage and retention bonuses are elevated."

RBC on (NYSE:WELL) as of 8.19.2022 … CP of $80, PT of $96, and "Outperform"

- "We are lowering our FFO estimates to $3.41/share (down $0.07/share) in 2022, $3.90/share (down $0.15/share) in 2023, and $4.60/share (down $0.12/share) in 2024. Our lower outlook is largely driven by higher debt and equity costs along with near-term expense pressures holding back better seniors housing growth."
- "Management specifically noted in COVID outbreaks in June [2022] disrupted move-ins and resulted in higher usage of agency labor."
- "… expect post-COVID metrics to meaningfully exceed pre-COVID metrics."

RBC Estimates

FY Dec	2021A	2022E	2023E	2024E
FFO/Sh, Rpt Diluted	3.21	3.41	3.90	4.60
Prev		3.48	4.05	4.72
$/Rpt FFO	24.9x	23.4x	20.5x	17.4x
AFFO/Sh, Diluted	2.88	2.97	3.51	4.24
Prev		3.10	3.73	4.43
P/AFFO	27.9x	26.9x	22.8x	18.9x

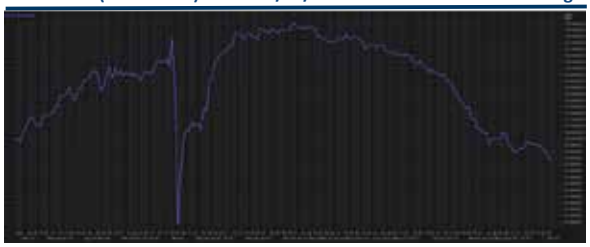
Source(s): Hendrix, Ben and Murray, Michael, CFA of RBC. "Occupancy Expected to Accelerate in 3Q22". *Refinitiv*. 9 August 2022.
Gajuk, Joanna and Fischbeck, Kevin, CFA of BofA. "Takes From the Call – Contract Labor Declining Slower than Expected". *Refinitiv*. 9 August 2022. Carroll, Michael, CFA and Heffern, Brad, CFA of RBC. "SHO Portfolio Still Delivering Solid Growth Despite Near-Term Challenges; Target to $96/share". *Refinitiv*. 19 August 2022.

Public Debt

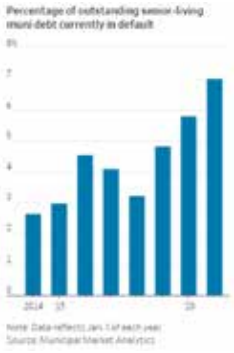
The demand is strong for muni-bonds sold by senior-care facilities despite record default rates, pandemic-related revenue losses, and labor shortages.

- Senior-care facilities (nursing homes, assisted-living, and CCRCs) are permitted by federal law to sell tax-exempt debt (municipal) because they are perceived to have a public benefit.
- ~8% of the $41Bn in outstanding senior-care facility bonds were in default as of December 2021: the most since tracking began in 2009.
  - —The industry now accounts for almost one-quarter of defaulted debt in the muni market.
- Senior-care facilities sold $7.4Bn in new bonds in 2021—21% more than they had in 2019.
- According to David Hammer, head of muni-bond portfolio management at PIMCO, "the operations have not fully recovered, even though, in some places, bond prices have."

Welltower (NYSE:WELL) 3.625% 3/15/24 950MM Notes 3-Yr Price Range



Source(s): Gillers, Heather. "Retirement Communities Lose Residents, Attract Muni Investors". *WSJ*. 4 January 2022.



Cases of Distress

- Business cases of distress in this sector are especially precarious and have a truncated time-line due to the reality that the residents of these facilities are in often fragile, vulnerable states that require the utmost care. This is irrespective of the personal cases where people become buried by debt issued to fund their, or a relative's care.

Personal Anecdote

CCRCs are notoriously expensive, and the current macroeconomic factors (inflation) has augmented this reality. Most facilities charge an entry fee which varies widely in range (from $40,000 to greater than $2MM), of which the average is $402,000, according to AARP. Once residents move-in, there are monthly service fees. The average monthly service fee in the third quarter of 2021 was $3,555, according to AARP. It is easy to imagine how average Americans how pummeled by these fees. Americans are left with few options, as the at-home cost of caregiving is rarely any cheaper. In 2019, AARP's own caregiving expert filed personal bankruptcy after becoming awash with the costs of elderly care.

- Caregiving is becoming more expensive because of increasing life expectancy and labor costs.
  - —The median annual cost of in-home care increased to $54,912 in 2020, an 18.5% increase from 2016. By comparing this in-home cost with the average $3,555 monthly service fee above and roughly spreading the average entrance fee, one can see how the cost of in-home care is approximate to that of facility care.
- Amy Goyer, AARP's "Caregiving Expert", had to leave her personal life and career behind to care for her aging parents.
  - —Goyer initially put her parents up in a CCRC where monthly fees were $4,000 for the two of them. Her parents had long-term care insurance, Social Security, and her father had a pension, which were able to cover the monthly fees. But personal-care services, "including someone to help her mother bathe and dress", were additional and had to be covered by Goyer.
  - —When 24hr care was needed, Goyer moved her parents to her home and hired caregivers to watch them while she worked. As her parents' savings went to zero, Goyer began to rely on credit cards and borrowed money from friends.
  - —In the last two years of his life, her father's medical and in-home care expenses topped $10,000 per month.
  - —Eventually, Goyer's credit card debt reached $120,000 and she was left with no other option but to file bankruptcy.
  - —"*If it can happen to me, it could happen to anyone*," warned Goyer of the financial vortex that elderly care became.

Source(s): "How Continuing Care Retirement Communities Work". *AARP*. 27 January 2022.
Ansberry, Clare. "Caring for Older Relatives Is So Expensive That Even AARP's Expert Filed for Bankruptcy". *WSJ*. 20 February 2022.

Business Anecdote

Christian Care Centers, a faith-based Texas non-profit, filed for Ch. 11 (No. 22-80000) in the Northern District of Texas on May 23, 2022, with plans to sell itself within court.

Case Background & About the Debtor

- According to the declaration of CRO Mark Shapiro (dkt#3), the Debtors have three campuses in Northern Texas that provide a combined 412 independent living units, 152 assisted living units, and 119 skilled nursing units.
- The Debtors received a $4.5MM loan under the Paycheck Protection Program which was forgiven in June 2021.
- At petition, the Debtors had $85,000 cash on hand, which excludes restricted funds to cover the contingent liabilities of Resident Entrance Fee repayments.
- At petition, the Debtor had approximately $60.8MM in assets and $64.5MM in liabilities with trade payables of approximately $2.6MM.
- The Debtor's capital structure at petition consisted of two series of tax-exempt revenue bonds, i.e., municipal bonds.
- The financial difficulties that the Debtor experienced pre-covid were only exacerbated by the pandemic which ultimately caused the slide into bankruptcy. Specifically, the pandemic caused a significant decline in campus occupancy rate and increased care requirements led to a surge in operating costs.
- An auction was set to be heard on July 14, 2022, but the only qualified bid was that of the Stalking Horse, and for that reason, no auction was conducted.

Source(s): Chutchian, Maria. "Texas-Based Senior Living Facility Enters Bankruptcy to Sell Assets". *Reuters*. 23 May 2022.
Declaration of Mark Shapiro, Debtors' Chief Restructuring Officer, In Support of Debtors' Chapter 11 Petitions and Emergency First Day Pleadings. No. 22-80000, dkt#3. 23 May 2022.

Appendix

Industry Regulations

Because CCRCs essentially depend upon Medicare and Medicaid redemptions, it is imperative that the facilities meet the requirements of these government programs. The bulk of these requirements revolve around certifying that elderly care meets some level of adequacy, while some are aimed at improving the working environment for the facility staff. CCRCs and other like-operations are highly scrutinized by regulators. For instance, the CMS inspects the granularities of the cleanliness and safety of the facilities, the ways in which the staff assists patients in daily care and will inspect the facilities' ability to prevent accidents/hazards/disease. In addition to these federal regulators, facilities must comport with state regulators.

Table 4 | US Skilled Nursing Facilities Regulations

Organization or Legislation	Regulatory Actions
Centers for Medicare & Medicaid Services (CMS)	Inspects nursing facilities to see if they meet government standards Places facilities that do not meet standards into the Special Focus Facility (SFF) initiative in an attempt to encourage suitable improvement; facilities that do not achieve improvement in the set amount of time risk funding termination
Patient Protection & Affordable Care Act (ACA)	Requires CMS to maintain a national system to collect and report payroll data on direct care staffing Requires background checks on all job applicants who will potentially have access to residents or recipients of long-term care services
Nursing Home Transparency & Improvement Act	Requires nursing facilities to clearly identify owners, managers, and the organizational structure of the facility, including how funds are spent
National Partnership to Improve Dementia Care in Nursing Homes	Sets yearly targets for the reduction of the use of antipsychotic medications in nursing facilities
US Drug Enforcement Administration (DEA)	Limits who can lawfully deliver controlled substances for disposal to three groups: the ultimate users, those entitled to dispose of the decedent's property, and long-term care facilities on behalf of their residents
US Occupational Safety & Health Administration (OSHA)	Inspects nursing facilities with high worker injury rates in an attempt to reduce the physical and mental stress of workers

Source: The Freedonia Group

Source(s): "Skilled Nursing Facilities: U.S.". *Freedonia Reports*. October 2021.

Florida Regulations

Florida has one of the eldest populations in the U.S. and elderly care is consequently a key sector to its economy. State regulation, specifically through the Florida Office of Insurance Regulation (FLOIR), regarding the finances of these care providers is continual and adaptive as the state seeks to keep all facilities in firm financial health. Florida, along with the rest of the country, aims to avoid any systemic distress in the assisted living industry.

Financial & Operating Requirements

- The laws that encapsulate the CCRC industry in Florida (§651 of the FL Statutes) speak to the remedial steps that must occur if a CCRC (the "provider") is to become *impaired*. Per the state definitions outlined in §651.011 of the FL Statutes, "impaired" means that either of the following has occurred:
  1. A provider has failed to maintain its Minimum Liquid Reserve Requirement (MLRR) as detailed under §651.035, unless the provider has received prior written approval from the office for withdrawal pursuant to §651.035 and is compliant with the approved payment schedule; or
  2. Having begun Jan. 1, 2021:
     a. For a provider with mortgage financing from a third-party lender or a public bond issue, the provider's DSCR ratio is less than one **AND** the days cash on hand is less than 90; or
     b. For a provider without mortgage financing from a third-party lender or public bond issue, the provider's days cash on hand is less than 90.
- If a provider is deemed impaired, the governing body (the "office") must:
  1. Require the provider to prepare and submit a corrective action plan or, if applicable, a revised corrective action plan;
  2. Perform an examination pursuant to §651.105, as the office considers necessary, of the assets, liabilities, and operations of the provider, including a review of the corrective action plan. Examinations pursuant to §651.105 are discussed on the next slide; and
  3. After the examination, issue a corrective order, if necessary, specifying any corrective actions that the office determines requisite.
     a. The office may use members of the Continuing Care Advisory Council, individually or as a group, or may retain actuaries, investment experts, and other consultants to review a provider's corrective action plan or revised corrective action plan; examine or analyze the assets, liabilities, and operations of a provider; and formulate the corrective order with respect to the provider. The cost of which must be borne by the affected provider.
- An impairment is sufficient grounds for the office to be appointed as receiver, except when the office's remedial rights are suspended pursuant to §651.114(11)(a). When the remedial rights are suspended, the provider must make available to the office copies of any corrective action plan approved by the third-party lender or trustee to cure the impairment and any related required report.

Source(s): The 2021 Florida State Statutes, Title XXXVII, §651.034, "Financial & Operating Requirements for Providers".

Florida Regulations Cont'd

Examination

- The office may at any time (at least once every three years), examine the business of any provider engaged in the execution of care contracts or engaged in the performance of obligations under such contracts. The written report of each examination must be filed with the office and such report constitutes a public record. The representative or examiner designated by the office may at any time examine the records and affairs and inspect the physical property of any provider, whether in connection with a formal examination or not. Relatedly, any duly authorized officer, employee, or agent of the office may, upon presentation of proper identification, have access to, and examine, any records, with or without advance notice.
- The office must notify the provider and the executive officer of the governing body of the provider in writing of all deficiencies in its compliance and shall set a reasonable length of time for compliance by the provider. Additionally, the office shall require corrective action or request a corrective action plan from the provider which plan must demonstrate a good faith attempt to remedy the deficiencies by a specified date. If the provider fails to comply within the established timeframe, the office may initiate action against the provider in accordance with the provisions of this chapter.
- All providers are required to respond to written correspondence from the office and provide data, financial statements, and pertinent information as requested by the office. The office has standing to petition a circuit court for mandatory injunctive relief to compel access to and require the provider to produce the documents, data, records, and other information requested by the office.
- Unless a provider is impaired (as defined in the preceding slide) or is subject to a "regulatory action level event" (as defined in §651.011: DSCR<1.2, and/or Days Cash on Hand<100, and/or Occupancy Rate<80%), any parent, subsidiary, or affiliate is not subject to examination by the office as part of a routine examination. But if a provider or facility relies upon a contractual or financial relationship with a parent, subsidiary, or affiliate, the office may examine to the extent necessary to ascertain the financial condition of the provider.

To some, the examinations and dominant position held by the office may seem intrusive and stringent. The position conferred to the office makes clear the gravity with which the state considers the protection of residents, albeit indirectly through the close monitoring of providers' financial health.

Source(s): The 2021 Florida State Statutes, Title XXXVII, §651.105, "Examination".

Florida Regulations Cont'd

Minimum Liquid Reserve requirement (MLRR)

- The MLR requirement consists of the following reserves which must be maintained in escrow, as detailed in §651.035:
  1. **Debt Service Reserve:** Each provider must reserve the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage loan or other long-term financing of the facility, to include property taxes and leasehold payments. If a provider does not have a mortgage loan or other financing on the facility, the provider must make monthly escrow deposits equivalent to one-twelfth of the annual property tax liability as indicated in the most recent tax notice provided.
  2. **Operating Reserve:** Each provider must maintain an unencumbered reserve equal to 30% of the total operating expenses projected for the first 12 months of operation. After that initial 12 months, the reserve lowers to 15% of total operating expenses, where operating expenses are calculated annually by averaging the total operating expenses reported in the three most recent annual financial reports filed pursuant to §651.026.
  3. **Renewal & Replacement Reserve:** Each provider shall maintain a reserve equal to 15% of the total accumulated depreciation based on the annual financial reports filed pursuant to §651.026, not to exceed the value of the Operating Reserve. For a provider who does not own any of its facilities and so depreciation is not a component of the financial reports, the Renewal & Replacement Reserve is to equal the Operating Reserve.
- A provider can satisfy the MLR through a clean, unconditional letter of credit equal in dollar value to the MLRR. This letter of credit must be issued by a financial institution participating in the Florida Treasury Certificate of Deposit Program. Additionally, both the financial institution and the letter of credit must each meet several further requirements outlined in §651.035. Even after meeting all the requirements to use a letter of credit in lieu of an MLRR, a provider using a letter of credit must nonetheless maintain an operating cash reserve equal to two months' operating expenses determined via the annual financial reports filed pursuant to §651.026.
- Pursuant to §625, the office may order the immediate transfer of up to 100% of the MLRR funds to the custody of the office if it is determined that the provider is impaired or insolvent, as a defined in §651.011.

Source(s): The 2021 Florida State Statutes, Title XXXVII, §651.035, "Minimum Liquid Reserve Requirements".

MLRR Calculation Expert

Below is an excerpt for the required annual operating reserve calculation that can be found in the Florida Office of Insurance Regulation's MLRR document required to be filled-out annually be each CCRC in the state. The MLRR document is meant to be annexed to each CCRC's Annual Financial Report.

Facility Name: Enable Calculations

If the Facility has operated **less than 12 months**, the annual operating reserve is calculated below:

(13) x (.30) x (15) / (16) = (17)

13. Net Operating Expenses (Line 12D)
14. Operating Reserve Factor (.30)
15. CCRC Residents (Line 5A)
16. Total Residents (Lines 5A + 5B)
17. Total Operating Reserve

CALCULATION: _____ X .30 X _____ / _____ = _____

If the Facility has operated for **12 or more months**, the annual operating reserve is calculated below:

(18) x (.15) x (20) / (21) = (22)

18. Net Operating Expenses (Line 12D)
19. Operating Reserve Factor (.15)
20. CCRC Residents (Line 5A)
21. Total Residents (Lines 5A + 5B)
22. Total Operating Reserve

CALCULATION: _____ X .15 X _____ / _____ = _____

Source(s): Florida Office of Insurance Regulation. "Minimum Liquid Reserve Requirement (MLRR) Calculation". (https://www.floir.com/siteDocuments/OIR-A3-477.pdf)

Actuarial Issues

Specifically when considering the structure of Type A contracts, the majority of CCRCs implicitly include a multitude of long-term care obligations. The issue with these implied insurance contracts is that they were not actuarily underwritten and CCRCs generally do not keep enough reserves on hand to cover these contractual obligations. Rather than establishing appropriate actuarial reserves, CCRCs rely on the cash-flows derived from entry fees and access to the tax-exempt (muni) bond market. With that, many CCRCs are "actuarily insolvent" and exposed to high risk in the face of market-based disruptions to their fee structures.

- Bondholders of these facilities typically have first liens on the assets, so the residents become the most vulnerable class of unsecured creditors.
- According to the Commission on Accreditation of Rehabilitation Facilities (CARF), the bottom 25% of operators issuing Type A contracts:

i. Are unable to cover more than 23% of debt service from ongoing operating revenue;

ii. Have negative operating cash flow before entry fees; and

iii. Have either little or no equity cushion in their capital structures

- Further increasing the cash flow risk of CCRCs is how many operators have created "refundable entry fee plans", albeit for higher sticker prices than non-refundable fees. These refundable fees increase current cash flow for a delayed potential liability. These unsecured promises are generally fulfilled only after death or departure from the facility, and no cash exchanges hands until a new resident takes the prior's position and replaces the prior's entry fee.
- Regulators have historically been far more focused on quality of care within these facilities over the financing structures and financial health.
- As discussed in prior slides, Florida has taken steps to address the risks by having adopted legislation in 2017 that requires operators to hold actuarial reserves that aim to match future incurred liabilities. Other states have followed suit and have begun to adopt similar legislation.
- In the absence of equity cushions or actuarial reserves, state regulators will require cash reserves (measured by days cash on hand) or a "cushion ratio" equal to unrestricted cash on hand divided by annual debt service.

Source(s): Barker, Peter. "The Looming Crisis in CCRCs". *TopTal.com.*

SOCIETY OF ACTUARIES

Managing the Impact of Long-Term Care Needs and
Expense on Retirement Security Monograph

Improving Retirement by Integrating Family, Friends, Housing and Support: Lessons Learned from Personal Experience

By Anna M. Rappaport

Actuaries
Risk is Opportunity.℠

Improving Retirement by Integrating Family, Friends, Housing and Support: Lessons Learned from Personal Experience

By Anna M. Rappaport, FSA, MAAA

Introduction

As we get older and develop limitations or illnesses, we probably will need support and/or care from other people. Such help may come from family and friends at home or from professional caregivers, often in a senior residence. This paper provides insights about choices made with regard to housing and supportive services based on personal experience and discussions with my family and friends. It is focused primarily on choices made that included a senior residence and support outside of the home. My perspective in this paper is that of a consumer and not one of an expert.[i]

The first story is about my mother, who had Parkinson's disease and moved from her own home into independent living, then assisted living and ultimately a nursing home. The second story mainly involves a friend interested in a continuing care retirement community (CCRC) and my attempts to investigate and understand CCRC issues on her behalf.[ii] Also added into the second story are experiences from friends who are CCRC residents or have parents in such facilities, and who have actuarial or retirement planning backgrounds. The third story is about people who live in a community whose residents are committed to helping each other. All the stories offered some insights, most of which were not obvious to me, and which so far as I know, are often not easy to find in the literature.

Further insights listed here are based on additional discussions with friends and on thinking through the issues.

The First Story—Where Is the Best Place to Be?

My mother had Parkinson's disease, with a long period of decline in physical and mental ability. The last few years while in the nursing home, she couldn't write or speak understandably, so communication was very difficult, and she couldn't walk at all. Her four children worked cooperatively to help her during the later stages of her Parkinson's disease.[iii] Some of my insights are as follows:

- The ability to use the telephone unaided was highly important. When the phone was no longer available as a means of communication, it made a huge difference in her quality of life. When the ability to communicate on the telephone without help was limited, that was also important. Steps along the way included: could no longer use answering machine, could only use phone with big buttons, could only call pre-programmed numbers (up to three) on big button phone, could not have much of a conversation, and could not talk at all even when phone brought to her. Limitations in operating the phone may involve inability to pick up or hang up the phone, poor vision and cognition. I had not thought about this until we experienced it. Difficulties in using phones may be greater with cell phones.[iv] Others have had told me the phone is truly a lifeline, especially for a woman, and that it can require hands-on assistance.

- Managing medication was very difficult, and was a consideration in the type of help needed. Specific facilities and types of helpers offer different capabilities for managing medication. Even where help is provided, the family needs to provide oversight over management of medication.[v]
- The availability of family was extremely important at later stages, particularly when my mother was in assisted living and a nursing home. Earlier, access to friends and activities important to her were a top priority, particularly since she could regularly talk to the family on the phone. The ability to move to a different geographic area near those people she wanted to be near or who could help was very valuable. Because the family was so geographically dispersed, no one location would have been ideal through all the stages. This is different from many other situations.[vi]
- My mother moved from her own single-family home to an independent living facility, then to assisted living and finally to the nursing home. My view is that each of these facilities proved very helpful and provided appropriate support when she was there, and that it was valuable to be able to move.[vii]
- We couldn't predict exactly when the next stage would occur. What is a very good situation at one point may not work at all at another. (We experienced only changes in personal situation, not changes in facilities, but they can occur also.)
- My mother was able to maintain as much independence as she could handle.
- In managing her money, my mother made an interesting transition from full independence to turning over management to family members with an investment advisor. She had noticed some difficulty doing math (which can be tied to the Parkinson's disease). During the transition period, she asked the accountant's assistant to check over her payment of bills, which they did periodically. The next step was that she put them in a pile and they paid them together. Next she put them in a pile, and the helper paid them for her. This enabled her to do as much as she could for quite a while. It is valuable for people to do as much as they can, and to be able to accomplish tasks of importance to them.
- While each facility involved considerable expense, what mattered was the added cost relative to what she had previously spent. Since she sold her home at the time of the first move, she no longer had the costs associated with that home.
- Each situation is different, and there are no uniformly right answers.

This story is heavily influenced by the experiences of my family.[viii] The accompanying exhibits outline the transitions in my mother's living and support arrangements along with changes in her capability and activities. Exhibit I on transitions identifies each transition, the triggers for the transition, and how the decision was made. Exhibit II discusses mobility and communication issues. Exhibit III discusses activities, financial management, and support services including preparation of meals.

Exhibit I
Transitions to Different Living Arrangements

Transition	Triggers for Making Transition	How Decision Was Made	Comments
From suburban single-family home to independent living community	Mother was concerned about being trapped in the winter, yard and house care, and generally managing. No family members were nearby to help.	Both my parents were in a study group that looked into the range of available options. They selected the option they preferred after visits to various choices and group discussions about different options. Mother wanted to stay near her prior home and contacts, in a community with only monthly charges, leaving complete flexibility to change later.	Facility chosen had a two-year waiting list. My parents' names were put on the waiting list with the expectation that they would decide when their names were reached. My mother was widowed shortly before her name came up. My parents didn't like the idea of a large upfront payment and inflexibility regarding future moves.
From independent living to assisted living	A key final trigger was inability to manage her medication. She had a number of meds, which had to be taken in different combinations four times a day. The reasons for staying in the location near her prior home were ability to maintain her contacts and participation in various groups and activities. However, she was no longer participating in such activities or seeing the former contacts by the time she moved. My mother was diagnosed with Parkinson's disease while in independent living.	Accountant expressed concerns that she was not managing well and needed support from the family. Decision was made to explore the area near her son and daughter. A consultant known to a family member was engaged to suggest alternatives based on her situation and resources. After selecting three options, she visited them all and worked with the consultant to think through issues. My mother made the decisions to move and where to go.	This move included a location change. During her years in independent living, my mother gradually needed more help. Ultimately someone came to help her twice a day for a short period. Other support from her accountant's office gave much of the help family members often provide. Within two weeks after the move, my mother said she was very grateful and did not know how she would have managed in the old situation.
To a special assisted living unit that could handle dementia	Two events signaled the need for a change: problems with a two-burner stove-top and going downstairs with a walker.	Assisted living facility said the change was required. No further decision was needed as she stayed at the same place.	Special unit offered a higher level of care, and was also locked so that individuals could not leave without an escort.
From special assisted living to nursing home	Problems increased as she became more paralyzed and less able to communicate. Assisted living facility indicated that the change was required.	All four children conferred, and my brother recommended a nursing home at a new location. Decision was made by the	This move included a change to a new location. The brother at that location was available to oversee care and visit nearly every day.

In deciding whether and where to make a move, one should consider several important issues:

- Anytime one needs to locate a new facility, there is a question of finding a new facility, whether it meets current needs, and whether a unit is available. Availability depends on both meeting the requirements for the facility and whether it is full or has space currently available. One of my contacts also found that it was very difficult to evaluate facilities, and expressed the hope that a *Consumer Reports* type of rating could be found. Issues include quality, fit to needs, and affordability. The websites I located that help one find facilities have information supplied by the facilities, not objective third-party ratings.
- One advantage of being in a CCRC is that one does not need to find a new location for the next steps, and it should have space available when needed. The later transitions are probably much easier, but can be troublesome if there is disagreement about what support is needed. However, depending on the type of CCRC contract and on personal financial resources, transitions could also be difficult within a CCRC. While some CCRC contracts do not increase fees with higher levels of care, others do increase fees to much higher levels with greater levels of care.
- People with and without family support have different issues. Those without families need to work particularly hard to find a suitable support system. A CCRC might be especially valuable for them if it's a viable choice.
- Anytime one moves, the transition requires an adjustment. The transition is often easier if there are familiar people and/or surroundings.
- Moving is stressful. A stronger person may be better able to handle the stress. That argues for moving earlier and less often.
- The transition to assisted living or to a nursing home can be very difficult if a suitable facility is not available at the time needed.
- Different situations can make a particular place desirable and feasible. Every situation is different.
- For many people, financial issues are critical. People with modest financial resources and those covered by Medicaid have a much more limited choice of options and facilities.

Exhibit II
Communication and Mobility Issues at Different Stages

Stage	Communication and Technology	Mobility and Transportation	Comments
Lived in single family home—retired	Used computer for writing, family history and other applications. Regularly used telephone and answering machine (no cell phone).	Walked regularly with husband (until last few months) in a nearby park, usually four to five days per week. This was a major morning activity. Drove or used public transportation and drove to train station.	Husband died shortly before she left the single-family home. This was the early 1990s. Today, the Internet and email would have been used for communication.
Independent living community	Could use computer for word processing and a few applications initially, but later could no longer use computer. My mother never used email. Very good oral communication skills. Responded to phone messages left on answering machine, but became less capable of using machine over time—big problems by time she moved away. Hands were getting crippled and handwriting getting worse.	Had no problems initially. Walked a mile or a little longer in the neighborhood regularly and walked to local shops. Drove a car at time of move, but gave up car within a few years. Transportation was provided for shopping and various activities. Used taxis as needed.	Remember that this was about 20 years ago. Today some facilities have computers available to residents for email and Internet service. Computers can be set up for easy use and impaired vision.[ix] Phone response was a huge issue. It was very important when she could no longer answer phone messages.
Assisted living	Needed special phone with three buttons and could primarily call those numbers. Did not have ability to respond to phone messages. Later, she could not write and had difficulty with speech.	Could take short walks without help (about 1/4 mile). After a time, needed a walker. Could go out in car if someone took her. Went out quite a lot at first. More limited later on.	Gradually lost ability to operate television set.
Higher-level assisted living	Could not make phone calls. Could respond to calls if called to phone, but had difficulty with speech so it was nearly impossible to understand her. Could not write at all.	On a very limited basis, could go out in car if someone took her. Had a walker. Could barely walk prior to move to nursing home.	Could not operate television set. At this stage, probably would qualify for benefits under a typical long-term care policy.

Stage	Communication and Technology	Mobility and Transportation	Comments
Nursing home	Could not converse much at all. Mostly could nod yes or no. Couldn't talk on phone or write.	In wheelchair, needed someone else to push it. Could not walk. Did not go out except into garden at the nursing home.	

Exhibit III
Money Management, Support and Activities at Different Stages

Stage	Money Management[x]	Activities	Support and Meal Arrangements
Lived in single family home—retired	Managed independently with advice from accountant; active in equity investments; covered by pensions and bought income annuity in addition.	Walked regularly every morning, participated in study groups, went to symphony, had many friends.	Cooked regularly while husband present; cooked much less after he was deceased.
Independent living community	Accountant/adviser provided quite a lot of help. Gradually shifted from personal management of investments to investment advisor. Gradually shifted from personal payment of bills to getting help from accountant's staff. At first the staff checked over her payments, later they handled together with her, and finally bills were put in a stack and paid by accountant's staff.	Continued to attend study groups (and people picked her up when she no longer drove) for quite a long time. Continued to read German weekly with a friend. Played bridge several times a week. Participated in organized armchair exercise classes. Went to symphony and other performances and museums. Served on residents' council. Made new friends and kept in touch with old ones. Later, participation in these activities declined. Family visited several times a year.	One meal provided daily. Apartment cleaned weekly. Access to washing machines on each floor. Transportation provided to shopping, activities, etc. Cooked other meals in apartment. Shopping was nearby and van service was provided, but could walk to shops and often did. Accountant's assistant came weekly to help with bills, correspondence etc. Later on, someone came for a short while in the morning and afternoon to help with personal care.
Assisted living	Family members who were joint trustees took over all bill paying and daily money management. They interfaced with investment adviser who handled investments.	Participated in exercise program and some activities. Made some new friends. Local family visited often and other family did periodically. Took short walks.	Assistance with medication, bathing, dressing. All meals provided. Apartment cleaned. Laundry service provided.
Higher-level assisted living	Same as above.	Much more limited participation in different activities.	Assistance with medication, bathing, dressing. All meals provided. Help with moving around.
Nursing home	Same as above.	Observed limited activities, didn't participate. Could not walk at all. Daily visits from local family member.	Could not walk, could not communicate well. Needed assistance with all activities of daily living.

Costs vary for different options that provide support and/or care. *HelpGuide.org* provides a current comparison of costs and estimates independent living monthly costs at $1,500 to $3,500,

assisted living at $2,500 to $4,000, and nursing homes at $4,000 to $8,000 (*HelpGuide.org* 2014). They also compare some of these options. The GAO analyzed 2009 costs for one person for rental options at several CCRCs that also offered a rental program. They found monthly independent living fees of $900 to $2,700, assisting living costs of $4,700 to $6,500, and nursing home costs of $8,100 to $10,700 (GAO, 2010). Exhibit IV draws on their analysis and some of my experience.

When making any decision about facilities, it is important to read the fine print, especially on services provided, extra services available and costs. For example, one of my friends reported that her mother had extra costs for food when a special diet was required in the nursing home. Also, what are the contractual limits on cost increases? And what have monthly fees been over the last few years?

Exhibit IV

Comparison of Senior Housing Options

Feature or service	Independent Living	Assisted Living	Nursing Home
Meals per day	Depends on meal plans offered and chosen; common to have one meal per day provided.	3+ meals	3+ meals
Medication management	None	Yes. Cost of meds may be an extra charge. May have to use a specified pharmacy.	Yes
Personal care	No	Yes, with limitations; can have extra charges for more care.	Yes[xi]
Offer activities for residents	Yes, often fairly extensive. May include attendance at outside events, day trips.	Yes, but likely more limited. May include shopping and more limited outside trips.	Yes, but very limited and geared to capability of residents.
Mobility assistance	No, but facility likely is designed to accommodate people with limited mobility	Yes	Yes
Housekeeping	Varies, likely to be laundry facilities	Yes, laundry service may also be offered. Family may prefer to launder the resident's own clothes at home.[xii]	Yes[xiii]
On-site nurses	No	Yes	Yes
Transportation	Mostly yes to shopping and various activities.	Mostly yes.	Occupants probably do not go out much if at all.
Alzheimer's/dementia care	No	Varies, there may be special units.	Varies

Age 55+ Communities—Age 55+ communities are very different from facilities within the scope of this paper but are worth noting here briefly, as these communities can be an attractive alternative for some active people over 55. There are many such communities. Well-known examples are The Villages in Florida, Sun City in Arizona and Leisure World in several states. Housing costs in age 55+ communities

are usually no higher, and maybe lower, than in otherwise comparable communities in the geographic area. The types and cost of housing vary widely. Some of them have connections to or agreements with housing options that offer more support.

My experience is that middle-income age 55+ active communities have extensive facilities for activities and some have extensive activity programs. In some middle-income communities, the activities are largely volunteer-run, with little or no charge to participants. Communities with many 55+ residents but which are not 55+ communities may have similar activities. The community offers the facility, and the residents design and run their activities in large part. The activities may include exercise programs, card games, potlucks and other food functions, tennis, pickle ball, shuffleboard, petanque or bocce, etc.

The Second Story—Is Moving to a Continuing Care Retirement Community (CCRC) a Good Idea?

A few years ago, a friend asked for help in deciding about moving into a CCRC. This story is based on what I learned in the process of exploring the issues, and from research and conversations with others including friends who live in CCRCs. I started by searching the literature for a good paper on how to evaluate a CCRC from the viewpoint of the individual, and at the end of the day, I did not find anything very helpful.

I talked about the issues to actuaries who had considered them or done financial work for CCRCs, to people living in a CCRC, and to planners. For one CCRC, I also inspected the documents, visited the facility, and talked with the marketing staff. The experience left me on a quest for better information, feeling that potential CCRC users lacked the data needed to make an informed judgment, especially regarding a CCRC's financial sustainability and the rights of a resident.[xiv]

I have three friends in CCRCs in different parts of the country, all very satisfied to be where they are. One has been in the CCRC for 16 years, one for eight years, and one for less than two years. One of them commented that aging in place is generally preferable, but the CCRC is a great option for their situation. His wife is legally blind and he's had heart problems, so it was a good move for them. The second friend had a wife with multiple sclerosis, and he had been warned that ultimately she might totally lose mobility. The third friend had experienced many challenges in caring for her parents, and she did not want to experience the same challenges herself. She and her husband decided that moving to a CCRC was a better choice for them.

The community I looked at and another one I visited since had very nice facilities and good activities. Both seemed to have a lifestyle that fit many people well, making them appear to be very good choices when one is ready and willing to be in a senior community. But CCRCs have certain characteristics that complicate the decision process, especially from a financial and timing viewpoint. Unlike other assisted living and long-term care facilities, one must apply to move into a CCRC while still in good health, and there is an admissions process.[xv] Moving while still in good health also enables people to build a support system of their peers at their new home. But these incentives to move to a CCRC sooner rather than later may conflict with the preference of many retirees to age in place in their own home as long as possible.

From a family viewpoint, there may be other issues. If the family is spread out geographically or not very accessible, a CCRC can be particularly valuable. But it may not match well if different family members are very available to help regularly during different years. In addition, a "blended family," where one or both spouses have their own children, may wish to keep some of their money separate, and thus not fit neatly into standard CCRC financial rules that assume spouses pool their money.

The long-term care to be provided by a CCRC will be very valuable for some people but not for others. A cost for the long-term care is built into both the entrance fee and monthly payments, but it is not easily separated out. The fact that health care costs are built into CCRC costs means that part of the cost may be tax-deductible if it can be identified.

CCRCs offer several types of contracts:

- **Type A: Life Care or Extensive Contract:** This is the most expensive option initially, but it offers unlimited assisted living, medical treatment and skilled nursing care without additional charges. This option requires substantial entrance fees and monthly charges that do not increase substantially as residents move through different levels of care.
- **Type B: Modified Contract:** This contract offers a set of services for a certain length of time. For example, a resident may receive 30, 60 or 90 days of assisted living or nursing care before there are higher charges for such care. When that time has expired, services are repriced, generally at higher monthly fees. Entrance fees and initial monthly charges are generally lower than under Type A contracts.
- **Type C: Fee-for-Service Contract:** This has the lowest initial fees for independent living, but costs for assisted living and skilled nursing will be charged at market rates. Entrance fees are still required. The risk of long-term costs remains with the resident.
- **Type D: Rental:** These contracts generally require no entrance fees, but guarantee access to CCRC services and health care. These are essentially pay-as-you-go for the resident. The monthly fees charged vary based on the size of the living unit and services and care provided. (GAO, 2010)

I understand that some CCRC contracts include a requirement for long-term care insurance, with different methods of integrating long-term care insurance benefits with the contract. The contract should be carefully reviewed on this point. Some CCRCs may simply require that the insurance proceeds be assigned to the facility.

The CCRC I looked at required a large entrance fee, with two options—either it was non-refundable after an initial period or it was higher but was 80 percent refundable on death or exit at any time. The monthly payments were much higher than one would pay for rent. People who moved into the CCRC would be eligible to receive assisted living or nursing services at the same monthly cost as the cost for independent living in a regular apartment. This is like the Type A contract described above.

One of my friends commented that moving into the CCRC was the best investment he ever made. He was able to pay $210,000 as an entrance fee for a unit that met his needs nearly 10 years ago,

with a monthly charge of $3,200 for the couple.[xvi] This was a Type A contract. The monthly charge included a meal allowance (often one meal a day per person), cleaning and laundry service, basic cable and other essentials. About 40 percent of the monthly payments was tax-deductible as health expenses. He was able to sell his house for more than the buy-in price, so that added to his other assets. The ongoing cost of his prior home included taxes, utility payments, yard service and maintenance, so the financial transition was not a problem. He moved before 2007 when housing prices dropped. The transition became more difficult for many people after the drop in housing prices.

The financial transition can vary widely, depending on the equity and ongoing costs for one's housing before making the move. It is much easier if the prior housing can be sold with money left over after buying into the CCRC, and much harder if there is no prior home ownership or equity. The ongoing costs associated with the prior house may include mortgage payments or rent, taxes, insurance, some utilities and other maintenance costs. Such ongoing costs may be greater or less than the monthly cost for the CCRC. There are huge variations in housing values, taxes, whether people have mortgages, etc. My friend's situation was entirely different from the other situation I looked at where the equity in the existing home was less than half the buy-in price and the monthly expenses in the existing housing were also modest. In the second situation, the CCRC was not affordable.

A new Internet search provides some insight about current CCRC costs. The AARP's website indicates that entrance fees range from $100,000 to $1,000,000 (AARP 2010). They define the fee as an upfront sum to pre-pay for care as well to provide the facility money to operate. Their website indicates monthly charges from $3,000 to $5,000, which might be more for couples. AARP notes that there may be additional fees for services not included in the basic package. My research a few years ago indicated that monthly fees in a CCRC even after the entrance fee could be as high or higher than the costs for assisted living or nursing home care for one person. (Of course, the CCRC costs may cover two people.) Monthly charges usually are increased periodically. The GAO found 2009 entrance fees for eight CCRCs for Type A contracts ranging from $160,000 to $600,000 for one person, and monthly charges for one person of $2,500 to $5,400 (GAO, 2010). Exhibit V shows examples of minimum entrance fees and monthly charges for CCRCs.

Exhibit V
Sample Costs for CCRCs

Facility	Minimum Entrance Fee	Minimum Monthly Fee	Comments
Clare—Chicago, Illinois	$253,500	$2,723	Offers 1-3 bedroom units; managed by Life Care Services
Sagewood—Phoenix, Arizona	$323,000	$2,748	Owned and managed by Life Care Services
Admiral on the Lake—Chicago, Illinois	$371,000	$2,405	Offers 1-3 bedroom units and townhomes, affiliated with Kendal

Source: Data from *SeniorHomes.Com* in March 2014

Data from the public disclosure statement of a North Carolina CCRC offer more insight into entrance and monthly fees in one community. This is an example in a smaller city with a population of about 50,000 in the 2010 census, and it is not necessarily representative of other communities. This CCRC offers both Type A and Type C contracts. Based on the disclosure statement, the 2013 entrance fee for a life contract for a one-bedroom apartment with a 90 percent refund ranges from $318,720 to $338,320. With a declining refund, the entrance fee is $185,300 to $196,700. This varies based on size of unit and floor plan. These amounts are increased if there is a second person by $46,100 for the 90 percent refund plan, and $26,800 if there is a declining refund. When there is a declining refund, the entrance fee is amortized 2 percent per month. The monthly fees are from $2,445 to $2,674 for one person, and $1,094 is added for a second person. Fees are considerably higher for larger homes. For a three-bedroom garden home, the entrance fee for one person is $469,220 with a 90 percent refund and $272,800 with the declining refund. The monthly fee for one person is $3,594. The fees for an additional person are the same regardless of unit size. Under this type of contract, the monthly fee for someone in assisted living or nursing care is $3,360 per month (The Village at Brookwood, 2013).

The Type C fee-for-service contract is available with a declining or 50 percent refund. For the larger one-bedroom apartment, the declining refund entrance fee for one person is $185,000 with life care, and $109,200 for the Type C fee-for-service contract. The monthly charge for one person drops from $2,445 per month to $1,893 per month. The additional charge for a second person drops from $1,092 per month to $485. With the Type C contract, the cost for assisted living is $4,443 per person per month; for memory support, it is $5,749 per month; and for skilled nursing, it is $7,995 per month. (The Village at Brookwood, 2013). These assisted living costs are higher than costs cited earlier based on data from *Helpguide.org*, and the nursing home costs are at the high end of the range.

Data from the public disclosure statement of a Maryland CCRC offers added insight into entrance and monthly fees in another community. This is one example in a relatively high-cost area, and it is not necessarily representative of other communities. This CCRC uses a Type C contract. Based on the disclosure statement, 100 percent refundable independent living entrance fees for one-bedroom apartments ranged from $474,000 to $597,000. For a three-bedroom, three-bath unit, the fee was $1,095,000. For the declining balance plan, the fees for the one-bedroom apartment types ranged from $227,520 to $286,560, and for the three-bedroom apartment, it was $525,000. Fees shown are for one person, and there is an additional $39,500 entrance fee for the second person for a 100 percent refundable contract, and $18,960 for the declining balance contract. The independent living monthly fees for single occupancy for a one-bedroom unit range from $2,517 to $3,151, and for three bedrooms it is $3,957. For double occupancy, add an additional $1,022 (Kings Farm, 2011).

Assisted living in a large two-room suite is $7,522 per month for one person in Level 1, $8,852 in Level 2 and $9,608 in Level 3. For a second person, it is an additional $4,247 in Level 1, $5,577 in Level 2 and $6,333 in Level 3. The monthly fee for a private room in the Comprehensive Care residence (nursing home) is $12,015 (Kings Farm, 2011). With a Type C contract, the fees change as the individual moves to a higher level of care. Fees can be increased. Residents in the community have priority with regard to entry to assisted living and comprehensive care. These assisted living and nursing home costs are much

higher than costs cited earlier based on data from *Helpguide.org*. The GAO found 2009 Type C fee-for-service entrance fees of $100,000 to $500,000 for a sample of CCRCs. For these Type C contracts, the independent living costs were $1,300 to $4,300 per month for one person; the assisted living expenses were $3,700 to $5,800 per month; and the nursing care monthly fees were $8,100 to $10,000 (GAO, 2010). The two communities and the communities studied by the GAO have significantly different cost levels, and there is no assurance that the same services are included. The two specific examples are provided to illustrate with more detail cost levels currently or recently in effect.

The costs are such that CCRCs are accessible only to the more affluent part of the population, i.e., less than 25 percent of the population can afford a CCRC according to a Society of Actuaries study.[xvii]

Neither the AARP data nor *SeniorHomes.com* data identified contract type. A 2013 survey from Zeigler provides insights as to which of the types of contracts are most popular (Zeigler, 2013a). Responses were received from 180 not-for-profit senior living facilities. In response to the question, "At your community, what is the predominant contract type?" 38 percent responded Extensive (Type A), 14 percent responded Modified (Type B), 35 percent responded Fee-for-service (Type C), and 13 percent responded Rental (Type D).[xviii]

At an independent living facility, my impression is that the monthly charge covers a combination of rent, meals provided and other services including transportation, activities, limited maid service to the units, etc. I call these services "senior services." At a CCRC, the monthly charge is higher (but somewhat dependent on the buy-in amount). I view this charge as a combination of rent, "senior services" and pre-payment for long-term care, if such pre-payment is included.

In my exploration of whether a CCRC worked well for a household, there was a discussion of what costs the CCRC charge replaces. The CCRC charge includes replacement for housing expenses including most utilities if the prior residence was sold or if the household moved out of a rental unit where they had similar expenses. There is likely to be a reduction in food costs, and for many people, transportation cost. However, there is no change in health care costs including doctor bills, drug costs and insurance premiums.

CCRC contracts vary regarding whether any of the original entrance fee is refundable if someone leaves. SeniorHomes.com is a website designed to help people find options in their local areas. It also includes general information about CCRC costs, but the ranges are lower than on the AARP website. The definitions and contract types are similar. SeniorHomes.com also provides a list of 10 considerations in choosing a CCRC. While they mention financial status, there is little focus on the risks involved. The box below builds from their list and adds other points from my research.

Considerations in Choosing a CCRC

1. **Contract Type(s)—**Does the contract suit your needs? Do you understand the provisions? What is covered? What if any refund is available if you leave? Under what conditions can they force you to leave?
2. **Your Costs—**What are regular costs and how might they increase? What costs are extra and how are they billed to you? What happens if you do not have funds to make payments? What happens if costs increase more rapidly than expected? Can you afford the costs currently and in the long term?
3. **Health Care Services—**What professional services are provided and what is covered? How will services coordinate with your health coverage and long-term care insurance? Do you accept the physician(s) available at the facility?
4. **CCRC's Financial Status—**What do current statements say and what factors could cause problems? Have you access to a business model or financial projection that goes beyond your expected lifetime? If there are bonds, when do they need to be refinanced, and is this a potential problem? What risks are lurking in the background, and what are their implications? What are your options and obligations if the facility goes bankrupt? What happens to residents if the facility is bankrupt?
5. **Regulation[xix]—**What agencies regulate the facility? What protection does the regulation offer to consumers?
6. **Information Sharing—**What information is shared with residents? How often are financial statements made available? How are changes in services and facility updates communicated to residents?
7. **Safety & Security—**Do they adequately provide for safety and security?
8. **Record of Complaints—**How many complaints have there been? Is a record available? Were they satisfactorily resolved?
9. **Quality of Care—**What can you learn about the quality of care? Do you have any information about the experience of current residents?
10. **Accreditation—**Are they accredited? What organization has accredited the facility? What is the rating?
11. **Lifestyle—**What types of activities are there? What types of people? How do you feel about the food service? Do visiting options work for family and friends?
12. **Exit Strategy—**Do you have an exit strategy if things do not work out? (This is not mentioned in any literature that I was able to find.)

More is said about questions to ask when choosing to move to any senior housing that includes support services below.

What happens if a CCRC resident has financial problems? One challenge I encountered in my exploration was that the "story" provided by the CCRC advocates including residents and marketing people differed from the contract. It seems that the CCRC I looked at operates with some benevolent practices, but the contract was much stricter. Apparently some not-for-profit CCRCs have charity funds for residents who need help. The first issue of concern was what happened if you could not afford to make regular payments. Some of the websites I reviewed also refer to these charity funds. The story presented was that if you had not been "foolish" in spending your money, you would not be thrown out, and the CCRC would carry you. The contract simply said you needed to leave if you could not make

payments. Apparently there was a charity fund that could carry a few people, but the contractual right asking people to leave remained. It appears likely that the number of people needing help and the size of the charity fund would be considered together to see when the contractual provision would apply. I also heard from a planner that religiously operated CCRCs might carry people. The contract I reviewed also had a provision saying you could be asked to leave if you had a condition so that they could not care for you. That provision gave you no additional right to get your money back.[xx] A disclosure statement for another CCRC described the existence of a support fund and stated firmly that the CCRC had total discretion with regard to providing financial support (The Village at Brookwood, 2013).

As an actuary and someone who had worked on insurance policies as well as pension plans, I considered the contract provisions critically important. I located a questionnaire from the National Senior Law Center[xxi] that raises the issues noted above. However, in a conversation with another very senior planner, she indicated that she had not previously focused on the importance of CCRC contracts and reviewing them carefully. I believe that many people who enter CCRCs are not aware of the contractual provisions and their potential pitfalls, and that some planners may also be unaware of them.

What happens if the CCRC has financial problems? One question seldom discussed is what happens if a CCRC gets into financial trouble or bankruptcy. Next Avenue, a PBS production, reported in 2012 that eight CCRCs have become bankrupt and 12 more were in trouble.[xxii] They also reported that in most of these cases, the individuals were able to continue without losing their investments with a new organization that took over operation of the CCRC. However, some situations experienced increases in prices and declines in service. A search has yielded several other articles about problems, but there does not seem to be any good consolidated survey. A paper from Grant Thornton provides insights into business strategies and corrective actions when CCRCs get into trouble (Grant Thornton, 2012). Reducing expenses (and services) is one of those strategies. I also find that some CCRCs have been sold or changed management companies—this seems more likely in the event of problems.

If a CCRC has been undercharging for services, the owner can increase fees, cut services or do a combination of both. One may hope that changes would be gradual. The issue of financial trouble or change in management is a real one. One of my friends reported that the CCRC they are in went bankrupt and was taken over by a new company. Another friend reported that the assisted living facility where her parents are has changed hands three times in one year, and that virtually the entire staff turned over during that year.

In the absence of government regulation of CCRCs regarding long-term solvency, consumers need useful financial evaluation, and we have not seen that. For example, it might be helpful if seniors had access to transparent financial data and ratings for all CCRCs from an independent source, somewhat like Best's ratings of life insurance companies, but this seems unlikely to happen.

One independent nonprofit organization, the Commission on Accreditation of Rehabilitation Facilities (CARF), accredits a relatively small number of CCRCs—about 1 in 6 nationwide. This is a step in the right direction, and "financial strength" is one of the many qualities needed to gain such accreditation. But it falls short of the ideal because CARF doesn't report on most CCRCs, their

accreditation report doesn't discuss long-range finances, and CARF has a potential conflict as they're paid by the CCRC applying for accreditation.

The Third Story—Anecdotes from Communities and Friends

I have observed friends and people around me offering support for others, sometimes a great deal of support over a long period of time. This can work very well, but it can collapse if the person needs more support than the caregiver offers or if something happens to the caregiver. In one case, a couple avoided doing much travel for a number of years so they could care for a friend—not a parent or close family member. They checked on her daily, brought her some meals in later years, took her to the doctor and for errands, etc. They inherited her house, but I do not think they were paid for the care in any other way. In another case, I observed a neighbor calling daily on another neighbor who was crippled and unable to care for herself. The neighbors did her weekly grocery shopping and many other things to help. In both these cases, if more support was needed, the individuals would probably have had to go to assisted living (or maybe even nursing homes).

My aunt offers another story of help and support from others. She lived in a high rise in New York City for many years among a small network of friends, who offered each other various types of help when needed. As she aged, her network got smaller as people died and moved away, and ultimately she had much less support. Her children were in different locations, and when she needed more regular help, she ultimately moved to independent living near one of her children and then to a nursing home. Her network was like an informal version of the Village Movement today. The Village Movement involves neighborhood organizations where older people band together to help each other, often on a volunteer basis. This type of organization helps people stay in their homes longer, but it is not a substitute for regular care.

One other aspect of my aunt's story provides an interesting twist on volunteering. My aunt fell and broke her hip while still in her apartment and nowhere near family. For many, many years she had volunteered in a neighborhood hospital. She was brought there by ambulance. One of the hospital administrators, who had known about her volunteer work for years, oversaw her care and kept in contact with the family. Her contacts from the years of volunteering became a support network.

I have friends living in senior communities, including both independent living with some higher-level care options available, and in CCRCs. One friend decided to move when her home of 40+ years got too difficult to manage. She had been widowed nearly 10 years earlier, but was finding that coping with stairs, home maintenance and snow was too much. She was able to find a community a few blocks away, allowing her to continue all her prior activities in her old neighborhood. Another friend observed that if you move into a new CCRC or community, you can build up a new support network there. I believe it is possible to build up support networks within any type of community where people are in close contact and where some are healthy and active.

One of my friends greatly appreciates the value of the CCRC when individuals have limited mobility, and even more so after an adverse event. His wife who had severe mobility issues was able to

live a very good independent life in the CCRC for a number of years. She then suffered a fracture. After the fracture she had to be moved from bed to wheelchair with a lifter, and then stay in the wheelchair. She also needed diaper changes at that point. Because they resided in a CCRC and had a Type A contract, she could be moved to their excellent skilled nursing facility. Medicare would not have paid for her skilled nursing, so there would have been very large expenses without the CCRC. She may need skilled nursing for a long time.

People I know have decided what facility to use for many different reasons, including recommendations from friends, nearness to family, whether or not the facility allowed residents to bring in outside help, and other issues as indicated in the table above.

My friends also reported challenges in managing the health care of residents. Facilities varied with regard to the type and quality of professional care provided on-site. Sometimes it was very inconvenient or impractical to take residents out for medical care—this is a consideration in evaluation. It is very possible that there will be a change in physicians when an individual enters assisted living or a nursing home. Later it may be difficult to change physicians if the resident is not satisfied with one on-site.

Related Research Findings

The 2013 Society of Actuaries Risks and Process of Retirement Survey explored several issues that are central to the discussion in this paper: likely caregivers in retirement, likelihood of staying in one's home, and expected reasons for leaving your current home (Society of Actuaries 2013). The survey looks at two samples, retirees and pre-retirees. Respondents are between ages 45 and 80. Retirees have retired from a primary occupation. Exhibit VI shows that the most likely caregiver is a spouse or partner, especially for a man. The second most likely caregiver is a child or stepchild, especially for a woman. Results are not separated by marital status, except there are separate results from the sample of retired widows.

Exhibit VI
Likely Caregivers in Retirement *

	Pre-Retirees		Retirees		Retired Widows
	Male	**Female**	**Male**	**Female**	
Your spouse/partner	63%	44%	67%	51%	NA
A child or stepchild	31	45	30	35	49%
A paid caregiver in your home	15	15	17	25	34
A paid caregiver in a facility	8	10	11	9	17
Another family member	8	8	7	8	11
A friend	4	5	2	3	6
Don't know	10	10	6	11	14
***** Responses to question: "Suppose you, yourself needed caregiving (in retirement). Who do you think would realistically be most likely to provide the care you needed?"					

Source: Society of Actuaries 2013

Exhibit VII shows that most people prefer to stay in their homes. Other data show that 18 percent of pre-retirees, 36 percent of retirees and 40 percent of retired widows had already modified their home or moved to a new home to make it more suitable as they aged.

Exhibit VII
Importance of Keeping Primary Home in Retirement *
(percentages of those who own homes)

	Pre-Retirees		Retirees	
Reason for wanting to keep primary home	**Very important**	**Somewhat important**	**Very important**	**Somewhat important**
Stay in a place that time has made comfortable and familiar	42%	36%	55%	30%
Use the money from your home as an emergency fund, if necessary	24	38	20	36
Leave your home as an inheritance to your children or other family members	23	23	24	24
* Responses to question: "How important is it for you (and your spouse) to keep your primary home so that you can . . ."				

Source: Society of Actuaries 2013

The funds from a home could be used as an emergency fund through selling and downsizing, through selling and renting, or through use of a reverse mortgage. The home can be used as an inheritance designed to reward family or others who have provided care. The survey did not explore this issue further. It is unclear from the national experience so far under what circumstances reverse mortgages would be a good idea.

The survey also asked respondents about 10 possible reasons they might want to move from their homes. Most respondents chose more than one reason, and of course the trigger for moving will

depend on circumstances at the time. The preferred reason for moving among pre-retirees and retirees was dealing with a situation that had become difficult. Among retired widows, the top reasons were different, with more emphasis on reducing expenses and improving their living conditions.

Exhibit VIII

Reasons for Leaving Current Home *

	Pre-Retirees	Retirees	Retired Widows
Reduced responsibility for upkeep and maintenance	77%	74%	63%
Health or physical disability	76	78	58
Changed needs if you lose your spouse/partner	75	78	NA
Reduced housing expenses	75	61	71
More suitable layout	70	60	70
Better climate	61	45	76
Better access to services/transportation/support	56	52	70
Being closer to family	59	51	63
Better access to friends or activities	52	42	69
Tapping into the equity in your home	47	38	77
* Responses to question: "Which of the following do you think might be reasons why you eventually leave your current home?"			

Source: Society of Actuaries 2013

Interesting Questions and What I Learned

Should I Move and Where Should I Go?

As indicated by the research, for many people, the first choice is staying where they are—they do not want to move. For others, moving is a dream because they want to live in a warmer climate, near family, or at a place where they can do their hobby more.

As also indicated by the research, there are many possible reasons for moving. Sometimes there is little choice. Stairs are a problem in some cases. In others, it is just much easier to move. When people move, there are many considerations as discussed below. Support can be integrated with housing—one of the major topics of this paper. When support is needed, one of the big decisions is whether an option should be chosen that integrates support with housing. The decision will be based on needs, preferences and resources—a very personal decision. The Society of Actuaries Decision Brief Where to Live in Retirement provides information about considerations.

Location is a very important issue, and climate can be a huge consideration. Some people get to really dislike ice and snow. For people with mobility or balance issues, ice and snow can be treacherous and mean that they feel trapped. People with certain health problems just ache in cold. Some people

move or become snowbirds because of cold weather. This can become a big issue if the family is no longer nearby after a move. In some cases people ultimately go back to be near the family, particularly if they need more help.

Where support is needed, that will be a consideration in staying or moving. The majority of support is provided in the home, on an informal basis, by family and friends. There are also a variety of market and community-based services that can be obtained to supplement informal support. Caregivers can be hired to come into the home. The CMS publication, Your Guide to Choosing a Nursing Home or Other Long-Term Care, outlines such services and how to find information about them (Centers for Medicare and Medicaid Services, 2013).

Are Senior Communities a Good Place to Live?

For many people, yes. Age 55+ communities and communities with more seniors but without support services are often lower cost than housing in many urban areas. For people who are social and like the activities involved, they may have a very good quality of life. The community does not need to be high-end for a good quality of life, and for people who like to volunteer, middle-market communities may be very good. Communities with support services come at a considerable price and mean giving up one's independent home for living in a community. Senior communities vary in what they have to offer. Some offer independent housing units (like townhouses) as well as units in apartment buildings. Some offer only apartment buildings. They may offer activities, meals, security, transportation to selected areas, some housekeeping, and some care. Those that offer activities, meals, transportation, etc. may have a lot of structure. Some people like such structure and others do not. One of the people I talked with reported that a family member became increasingly unhappy with the structure in the community where she was.

Some communities with a lot of seniors and some apartment buildings may be viewed as naturally occurring retirement communities. The activities and support networks found in some retirement communities may be found there as well, but probably not to the same extent.

The people surrounding one in a senior community are all elderly. Active living housing communities for 55+ may include a wide range of ages, with many younger seniors. But independent living, assisted living, and nursing facilities generally have much older populations and more women. What is a good choice depends a great deal on personal circumstances, support systems including individual current and expected future needs, as well as desires, resources and match of personal style to degree of structure.

Are People Happy in Senior Communities?

My mother and I had several conversations about this when she was in an independent living facility. Our conclusion was that most of the people who had made their own decisions to be there were quite happy, but it was a very different story for people whose family members had decided they should

be there. The people who were there because of someone else's choice were much more likely to be unhappy and to be women living alone.

Couples where one person needs help may be quite happy to be in a place where that person can get the help yet they can stay together. The match of activities and the other people in the community to personal preferences are important.

What Financial and Other Issues Should Be Considered?

When moving to any type of senior housing that includes support services, there are a variety of questions to be asked with regard to the financial structure, nature and quality of support, lifestyle, and fit of the community. Earlier in the paper, considerations in evaluating CCRCs were discussed. This is a broader list of questions, and they have been grouped.

Questions with regard to location, lifestyle and personal fit

- Why might I want to move, and would such a move address my issues?
- How much will I need to downsize and will I be comfortable in the living space?
- How will I feel living so close to many people?
- Why is a supported environment a better choice than a rental apartment or a condominium?
- What other options are available? How do I compare them?
- Where do I want to live?
- What are the location and surroundings like?
- What family and support system do I have, and does this move help me utilize the support system I need today?
- Does the location have good transportation for me?
- Does the location fit my preferences about climate and lifestyle?
- Are the people who reside there people I would like to be with? Are they interesting and would they make stimulating companions?
- Will I be able to have the pets that are important to me?
- Which of my prior activities can I continue?
- Do the activities and opportunities for outside activities fit my needs and preferences?
- Is there access to religious activities that fit my preferences?
- What will I need to give up to move there? How much will I have to downsize?

Questions about health care and services

- What support services are included in the regular fees?
- What additional services can be provided and what will they cost?
- Can the facility provide the services that I expect to need?
- Is moving to this location compatible with getting the medical care I need? Can I still access my doctors? If not, am I satisfied with what is available in the local area? What is available on-site or nearby?

- If the arrangement includes assisted living and skilled nursing, are there adequate beds? What will happen if a bed is needed and not available on-site?
- Are home health and physical therapy services available on-site? Are they Medicare-approved? Are they competitive**?**
- If I need more assistance in the future, what options are there without a major move?
- Are the services provided compatible with my objectives?

Questions about ability to stay in facility if situation changes

- If I want to leave, is there a good exit strategy?
- Will there be financial problems if I decide I wish to leave?
- Under what financial and other circumstances (if any) can a resident be asked to leave?
- Is there a trial period during which most of the entrance fee may be refunded? How would the refund be determined?

Questions about quality and stability of facility

- What information do I have about quality and about complaints?
- What do I know about the staff? How much staff turnover is there?
- What is the financial condition of the facility? Are there "backers" who can provide added funds if needed?
- Are there any potential problems with debt refinancing?
- What is the current occupancy in the facility and how does that affect its finances?

Questions about regular charges

- Are the costs, financial arrangements and contract acceptable?
- What is the monthly charge?
- What is covered by the monthly charge, and what are the additional charges for extra services?
- How often does the monthly charge increase, and what is known about likely increases? What is the history of the charge over the last five years?
- Are there any circumstances where help may be provided for people who are no longer able to make payments? How likely is it that help will be available when needed?
- Is there a requirement to maintain long-term care insurance? If so, how is it integrated into the arrangement?

Questions about entrance fees

- Is there an entrance fee and how much is it?
- If there is an entrance fee, how much is returned on leaving while alive, and are there conditions attached?
- If there is an entrance fee, how much is returned on death?
- If there is an entrance fee, how financially stable is the organization, and what would happen if it got into financial problems?

General questions

- If additional help is needed, can a helper be brought in? Are there limits on using outside helpers?
- What happens when one member of a couple dies?
- What food service is provided, how is the food, and what are the arrangements with regard to food? Do they fit my needs and preferences?

When considering these questions, one should expect to make trade-offs.

What Are Some of the Risks in a Senior Community with an Entrance Fee?

I spent many years involved with actuarial work, first for insurance companies, then for pension plans. My traditional view was that if a single premium financial security arrangement is sold, then actuarial reserves should be set aside to pay future benefits. I learned that there is an entirely different custom in CCRCs and other housing communities, and reserves are entirely different from those set up for single premium annuities and life insurance policies.[xxiii] The entrance fees can be used to meet current financial obligations, and one of the key issues with regard to future success is to have adequate occupancy.

I also was accustomed to state regulation of insurance, and learned that there is no similar regulation of these entities. They are subject to different types of regulation.

For CCRCs that provide a promise of future care, part of the buy-in is like a single premium long-term care insurance policy. One of the key issues is how many people need care and what level of care. The cost of care is also a key lever. From the viewpoint of the individual, if care is not satisfactory or available as needed, that also becomes a major problem.

Not-for-profit CCRCs may be financed through tax-exempt bonds and any communities can have debt. Interest rates are very low today, and they can easily rise in the future. The debt service—both interest and principal repayments—flows through to the costs financed out of buy-in amounts and monthly payments received. If there were significant changes in interest payments at the time of a loan refinancing, that could be a big problem. It could be a huge problem if a loan could not be refinanced.

Experience with long-term care insurance in the last few years has indicated that costs have far exceeded expectations. Carriers have exited the market, and, in addition, premiums have increased much more than anticipated.

My discussions with professionals who have worked with CCRCs have not calmed my concerns. One person questioned whether many CCRCs will be viable in the future, and whether the model will work. Another indicated that there are problems looming for these organizations that often they may not expect. Some of the references listed reinforce my concerns. Clearly some CCRCs have had problems, and in some of these situations, residents have had trouble. It is unclear to me how often that has occurred.

One of my friends pointed out that some facilities that include a nursing home which must accept Medicaid patients potentially face certain challenges. Governmental budget difficulties are such that reimbursements are likely to stay below costs, and may even drop relative to costs. That can lead to higher costs for other patients, or a decline in service.

Is It Important to Be in a Place that Offers Multiple Levels of Support and Care?

It can be very convenient and helpful if you do not have to "figure it out" when you or a family member happens to need care. The transition may also be much easier if family members live in the same area. Often family members are heavily involved in figuring it out. For people without family support, it can be more helpful if it has been figured out in advance. (However, it is always possible to have conflict with the facility over what is appropriate care at a given time.)

A support system is extremely valuable and important when you need help, even if care is provided professionally. When family members or the support system are dispersed, it may be important for the individual needing more care to move. It also may be that the personal choices made early in life, particularly earlier in retirement, have people in a place that is not optimal for the support needed later. For example, my mother retired and lived many years in the location where she spent the years before retirement, with many connections and activities there. However, as she gradually became sicker and frailer, she disconnected from those activities and it became much more important to live near children who could offer support. Moving twice, once when she went to assisted living and again when she went to the nursing home, meant that she was near the best support system at the time. In that case, being able to select the appropriate facility and moving was very valuable.

I also have become aware of people who needed help and moved to be near or with family members who could help them. I also know many parents who moved to be nearer adult children and grandchildren, not generally because of care needs at the time.

My opinion is that a local support system at the place where one gets care or help is extremely important. Even if care is provided on a fully paid basis, it is still important for one to have an advocate for their needs and care. It obviously becomes much more important where family or friends are providing care.

Is It Smart to Move into a Senior Community or Facility that Requires an Entrance Fee?

There are many independent living 55+ communities where one can buy a house that can be resold the same as any other house. This is a decision related to buying a house and that house should be considered as any other housing option. In such situations, houses are sold based on market value. The house is an asset if owned at death.

Other senior communities require an entrance fee, which can be non-refundable or partly refundable if an individual moves. There may be further conditions on the refund, such as the resale of the unit. There might be some residual value at death or there might not. They also have monthly fees that are much higher than the monthly fee would be in a condominium or the rent would be in an

apartment. My assessment with regard to these options is that they may offer a very good "lifestyle choice" and good care and support. My view is that a household who wishes to make such a choice should have a viable alternative and exit strategy if needed. This may be a very good choice when the household has enough resources to move out if the community goes bankrupt or if it becomes important to move for other reasons. However, if making this choice completely locks one in, then I question the choice.

The situation is further complicated because the monthly charges in the communities increase periodically (normally annually), and there is no guarantee with regard to future increases. Someone who does not have the resources to pay the monthly fees in the future could be forced to leave the community, and in that process forfeit some or all of the entrance fee plus the value of any health care pre-payments included in monthly charges already paid (i.e., actuarial reserves that theoretically should be set aside). In the community I looked at, there was a fund to help people who later were in need, but the contract said that people could be asked to leave. The research I did several years ago and recently shows only limited awareness of these issues. The Kiplinger article (Laise, 2013) and the National Senior Law Center article (National Senior Law Center, 2009) raise the issues. The experts I informally talked with pointed out the fund would provide a solution only if few people needed help. If there were more, and if economic conditions became difficult, then the provisions of the contract might be enforced and people without resources would be asked to leave.[xxiv] In such a case, a planner told me she thought that religiously based communities were less likely to stick to the contract.

My experience with pension plans and retiree health benefits indicates that large organizations can change their philosophy and how they deal with people mid-stream. The uncertainty about future monthly charges is another important reason to have resources to fall back on in the event living in the facility does not work out. In summary, this issue suggests to me a need for caution.

What Other Issues Came Up in My Research?

Various community-based services exist to help people who want to age in place, although I do not have experience with them. Senior centers, senior day care and meals-on-wheels are three examples. Area agencies on aging are probably a good resource to locate services in a specific area. Some employee assistance programs may also offer help. Religious organizations and churches also offer facilities and services for the aged or homebound.

Elder care consultants with local experience can be very helpful in dealing with most of the problems discussed here, and sometimes can pay for themselves by helping reduce other costs. When the problem is not urgent, a local support group can be useful for studying and comparing alternatives at no cost. To find such a consultant or group, one can use personal referrals or search online.

Another issue that came up is that family members involved in caregiving and helping to manage care may also be involved in helping people deal with their stuff. One of the people I interviewed indicated that her parents had a great deal of stuff. A lot of work was needed to sort and figure out what to do before their house could be sold. This was happening at the same time that her parents needed care, help with doctor's appointments, oversight of assisted living issues, etc.

Although I did not find good comparative information for consumers, I did find several locator websites that directed me to facilities in a given area. I also found a report on the top 100 not-for-profit systems, aimed more at investors (Zeigler, 2013b).

Conclusions

Housing is the largest expense in retirement. Housing that integrates with support is more expensive. Location is critical in determining access to family, friends, activities of interest, and support. This paper explains some insights gained from personal experience as well as research to help people make better choices. My summary of key insights is as follows:

- There are very good options for the affluent. Options are much more limited for those with little money.
- Be very careful about paying entrance fees. They involve risks that may not be clear at the time of making the payment.
- Entering a CCRC often means making a major financial commitment without having all the facts.
- Decisions about housing and support choices are very important.
- Be prepared for the potential of a next move. Even if one believes that a choice will be good for the rest of their lives, and even if multiple levels of care are provided, there may still be circumstances where another move is very desirable.
- The best choice brings together considerations of preferences, support needs, access to family and friends, resources, quality of the particular arrangement, and location.
- The market is evolving. Individual facilities change over time. The needs of each individual also change over time.
- Many people will not have the resources to support their ideal choice and must make trade-offs.
- Moving to housing that builds in support services often involves major downsizing and reductions in living space.
- Access to family and others who can provide support is often very important. If one is expecting help from family, it is important that all parties have the same expectations and that they are realistic.
- Inability to communicate by telephone changes the options that are viable. There is a huge variation in people's ability to communicate and the media they can use. Communication ability changes over time.
- Managing medication can be a huge issue, and can create problems for those who can't handle it well.
- Be prepared for multiple transitions to be needed at unexpected times.
- People need better resources to help evaluate options. There is no well-established process for evaluating all the issues, and some issues are difficult to understand.[xxv]
- Staff and staff turnover are important factors in evaluating alternatives.
- Some of the potential challenges are hard to predict.

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Anna Rappaport, FSA, MAAA
Anna Rappaport is an actuary, consultant, author and speaker, and is a nationally and internationally recognized expert on the impact of change on retirement systems and workforce issues. She serves on the board of the Women's Institute for a Secure Retirement (WISER), and the Advisory Board of the Pension Research Council. She is a member of the GAO's Retirement Security Advisory Panel. Anna is a past-president of the Society of Actuaries and chairs its Committee on Post-Retirement Needs and Risks. She formed Anna Rappaport Consulting in 2005 after retiring from Mercer Human Resource consulting at the end of 2004 after 28 years with the firm. Anna served on the ERISA Advisory Council from 2010 to 2012. She earned her fellowship in the Society of Actuaries in 1963 and was honored as a 50-year fellow in 2013. Anna has an MBA from the University of Chicago's Booth School of Business. She can be reached at *anna@annarappaport.com*. For more information about Anna Rappaport, see www.annarappaport.com.

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Zeigler. 2013b. Zeigler LeadingAge Ziegler 100. The Nation's 100 Largest Not-for-Profit Multi-Site Senior Living Organizations. (ISBN 1-930599-13-7). Chicago, Illinois.

[i] While the majority of Americans receive care and support at home provided largely by family and friends, these stories are about people who chose to use a senior residence where there is support and/or care provided. The majority of people prefer to stay at home, but a move may be needed if there is not a family caregiver available, or if the amount of care needed is too intensive.

[ii] A CCRC is a retirement community that provides lifetime housing, social activities, and increased levels of care as one ages. It is part independent living, part assisted living and part skilled nursing care, accommodating residents' changing needs. It normally requires an entrance fee and monthly charges.

[iii] She did not live near any of her four children, who lived in three different states.

[iv] Technology has changed since the experiences with my mother, and will change more. It is important to check on the most recent technology as assistive devices have improved and new options may emerge. Computers have various options available to make them easier to use.

[v] Two stories were shared with me. In one case, a parent's medication was changed while they were in the hospital, but when they returned to the assisted living facility, the facility was not properly informed of the change, creating problems with the patient receiving the wrong drugs. In another case, an individual had difficulty in coordinating their parent's insurance with the medications provided by the nursing home. The nursing home had its own ideas about which drugs it wanted to use.

[vi] A friend who is a CCRC resident commented that many of the newer residents in his CCRC first had moved to the area to be near family and then to the CCRC.

[vii] It should be noted that ability to move to a facility depends on meeting their entrance requirements, availability of space, and financial issues. Many of the facilities have requirements with regard to health status and support needed. Some facilities have waiting lists. Individuals relying on Medicaid have much more restricted access to care. Some facilities require people to leave if their care needs grow and exceed what can be provided.

[viii] This is written from recollections and some notes made in the past. Not all facts have been checked and ages are approximate. Some additional information is added based on comments and experiences of friends who reviewed the draft. Story is structured to bring out key learnings with regard to care.

[ix] Individuals will vary as to whether they continue to use computers. Of five friends I have who are living in senior facilities, four are regular email users. One does not use computers at all. One of the four is having increasing difficulty with computer use, probably due to cognition issues.

[x] Whenever there is support for money management, there is the potential for fraud. Care should be taken in choosing who will offer help in money management. Checks and balances are helpful. In our family, financial management was split between an investment adviser and two siblings who periodically discussed the result, and the results were also under scrutiny from the tax adviser. We were fortunate that this was not an issue for us. Fraud and scams can be a problem with outside caregivers who come into the home, with vendors who sell services, with advisers, and with family members. A lot of diligence is needed.

[xi] One person reported that nursing homes vary as to whether they would permit the family to provide personal care supplies including diapers and special food. While they had experience with one that permitted them to bring such supplies, another did not. The second nursing home supplied them but charged a very high price.

[xii] Two of my contacts reported doing a family member's laundry at home, and that others also did this.

[xiii] While laundry service is provided in some facilities, some of my friends reported that personal clothing often was lost or damaged, so they chose to launder personal clothing at home.

[xiv] The Commission on Accreditation of Rehabilitation Facilities (CARF) offers a Consumer Guide to Understanding Financial Performance & Reporting in a Continuing Care Retirement Community. In my view this guide does not deal with some of the longer-term issues that can create financial challenges.

[xv] The admissions process typically includes both financial and health underwriting. The facility wants to be sure that the individual has adequate financial resources so that they can be expected to pay charges as due. They also want to be sure that the individual is unlikely to need long-term care too quickly.

[xvi] Unpublished data supplied by a friend.
[xvii] The Society of Actuaries study Segmenting the Middle Market-Phase II, has defined middle affluent Americans as the population segment in the top 25 percent but below the top 15 percent, based on wealth data from the 2010 Survey of Consumer Finances. Median middle affluent couples may be able to afford minimum CCRC entrance fees, but median single middle affluent individuals would not be able to afford these fees.
[xviii] Zeigler CFO Hotline: Resident Monthly Fee Increases, 2013, based on an October 2013 poll. This is a survey of not-for-profit senior housing to discover fee increases. Zeigler is a financial and investment banking firm with a leading presence in the not-for-profit senior housing market.
[xix]The GAO report referenced in this paper includes information about the number of CCRCs by state, and the state agency used to regulate CCRCs. Regulatory patterns include insurance regulation, public health regulation, secretary of state regulation, social services regulation, human services regulation, health regulation, finance regulation, consumer affairs and elder affairs regulation, and no regulation. The number of CCRCs by state vary from 1 to 189 (GAO, 2010). The GAO also found major variation in the stringency of regulation by state. Of eight states analyzed in more detail, three required regular actuarial valuations.
[xx] The disclosure statement for one CCRC in North Carolina included this language: "*Provider declares that it is the intent of The Village to permit a Resident to continue to reside at The Village if the Resident is no longer capable of paying the prevailing fees and charges of The Village as a result of financial reversal occurring after occupancy, provided such reverses, in Provider's judgment, are not the result of willful or unreasonable dissipation of the Resident's assets. In the event of such circumstances, Provider will give careful consideration to subsidizing the fees and charges payable by the Resident so long as such subsidy can be made without impairing the ability of Provider to operate on a sound financial basis. Any determination by Provider with regard to the granting of financial assistance shall be within the sole discretion of Provider*." (The Village at Brookwood, 2013, Disclosure Statement page 24).
[xxi] Questions to Consider When Evaluating Continuing Care Contracts, National Senior Citizens Law Center, http://www.nsclc.org/index.php/questions-to-consider-when-evaluating-continuing-care-contracts/, 2009.

[xxii] Shaky Finances of Continuing Care Retirement Communities. http://www.nextavenue.org/article/2012-01/shaky-finances-continuing-care-retirement-communities, Next Avenue, PBS, 2013.

[xxiii] I do not have information about typical reserve practices, or regulatory requirements. My understanding is that they vary by jurisdiction and that they are much less strict than the types of requirements applied to insurance products and companies.
[xxiv] See earlier endnote that includes language from one CCRC disclosure on support for those in need.
[xxv] The LeadingAge Zeigler report of the top 100 systems offers information about the major systems and their characteristics and also about accreditation and bond ratings. It is helpful for investors looking at financial information but is not designed to help consumers understand if there is a fit. The Commission on Accreditation of Rehabilitation Facilities offers the Consumer Guide to Understanding Financial Performance & Reporting in Continuing Care Retirement Communities: http://www.carf.org/financialperformanceccrcs/.

SOCIETY OF ACTUARIES

Aging and Retirement

Are CCRCs and Senior Housing Communities a Good Choice?

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COVID-19 and Risk in Arrangements for Senior Housing and Support

AUTHOR Anna Rappaport, FSA, MAAA

Anna Rappaport Consulting
Anna.rappaport@gmail.com

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COVID-19 and Risk in Arrangements for Senior Housing and Support

Introduction

Two recent Society of Actuaries reports, *Impact of COVID-19 on Retirement Risks* and *Impact of COVID-19 on Senior Housing and Support Choices* , provide a discussion of issues related to senior housing, support, and retirement risks. They include substantial content related to long-term care facilities, Continuing Care Retirement Communities (CCRC's), and other housing, focused specifically on COVID-19 issues. These SOA reports were informed by an on-line conversation with a wide range of retirement professionals. The prior reports do not explore in-depth the financial risks and resulting trade-offs involved in some of these housing choices. This essay supplements these reports with a further exploration of senior housing financial risks including regulation issues, due diligence, and other related issues.

I first become interested in risk and due diligence issues related to senior housing nearly ten years ago when a family member asked me for help in evaluating a CCRC near his home. That, together with personal experience dealing with my mother's long-term care needs, and conversations with many colleagues, led me to write the paper[1] *Improving Retirement by Integrating Family, Friends, Housing and Support*. Since I wrote the paper, I have identified two useful resources for consumers to understand the financial and contract arrangements for these types of housing.[2]

I found information about the benefits and security provided in these senior communities, but without much explanation of the trade-offs and risks.[3] The COVID-19 conversation offered new perspectives. Recently, there has been an explosion of news about COVID-19 and nursing homes, pointing to the number of senior communities where there are deaths from COVID-19, and sometimes large clusters of deaths. This is a problem in the U.S., Canada, and globally. The on-line discussion focused on addressing the challenges through risk mitigation strategies and techniques. This essay deals with issues of risk and disclosure and it draws on the research from my 2014 paper, the general literature on this topic, and the COVID-19 conversation. My repeated focus on this topic over the last ten years reinforces the need for

[1] Rappaport, Anna, Improving Retirement by Integrating Family, Friends, Housing and Support, 2014 https://www.soa.org/globalassets/assets/files/resources/essays-monographs/managing-impact-ltc/mono-2014-ltc-manage-rappaport.pdf.

[2] Breedling, Brad, "What's the Deal with Retirement Communities?", 2017 and CARF, International, "Consumer Guide to Understanding Financial Performance and Reporting in Continuing Care Retirement Communities", 2016. The National Continuing Care Residents Association also has some consumer information which is only available to members.

[3] The 2010 GAO Report, Continuing Care Retirement Communities Can Provide Benefits, but Not Without Some Risk, is an exception and it focuses on risks to various parties.

better information about the trade-offs and risks, so that the decisions to enter senior housing with a significant entrance fee can be made on an informed basis.

A Wide Variety of Housing Options and Financial Arrangements for Seniors

There is a wide range of housing options for seniors designed to provide different packages of services, levels of support and costs. Some arrangements integrate support and care and offer multiple levels of care. Some require an upfront payment at time of entrance which provides for prepayment of care and a monthly payment. This essay is focused on arrangements that provide for some upfront payment vs. a purely month-to-month payment for the services received. Such arrangements that provide multiple levels of care are called Continuing Care Retirement Communities or CCRC's. They have many variations in what is offered and the related financial arrangements, and the individual entering the community may have a choice of different financial arrangements.

The senior housing options that appeal to independent seniors and those with modest support needs often provide many features that help their residents have a good quality of life, provide opportunities for social engagement, and make day-to-day living easier for them. Those that offer the combination of independent living and access to care also may make it much easier to secure care when needed which gives people a sense of security about their future care needs. Many residents love these communities and they are particularly appealing to those without family to care for them. There are, however, additional costs and financial risks involved with these arrangements, and these are often not well understood. COVID-19 did not change the costs or financial risks found in these communities, but it has brought a new set of risks into focus.

Costs vary widely. According to Kiplinger's, as of January 2018, the entrance fees for CCRC's ranged from under $100,000 to more than a million. The monthly fees averaged $3,266 nationwide and ranged from about $2,000 to $7,000.[4] They vary by geographic area, community, size and type of unit and type of contract. Some contracts provide for life care, some for limited long-term care, and some do not cover any long-term care. Some offer partial refunds of the entry fee on death or leaving the arrangement, and some do not.

My research on CCRC's indicates that there are several types of contracts:

- Type A: Life Care or Extensive Contract: This is the most expensive option initially. It provides for prepayment for unlimited assisted living and skilled nursing care without additional monthly charges at the point support is needed. This option requires substantial entrance fees and monthly charges that do not increase substantially as residents move through different levels of care. In these contracts, the entrance fee includes substantial prepayment for long-term care. My understanding is that there are fewer of these contracts available today.
- Type B: Modified Contract: These contracts include prepayment for long-term care services for a certain length of time. For example, a resident may receive 30, 60 or 90 days of assisted living or nursing care before there are higher charges for such care. When that time period of services has ended, services are repriced, generally through higher monthly fees. Entrance fees and initial

[4] Esswein, Pat Mertz and Eileen Ambrose, "How to Shop for a Continuing Care Retirement Community", Kiplinger's, January 2018.

monthly charges are generally lower than under Type A contracts, and they offer much less prepayment for long-term care.

- **Type C: Fee-for-Service Contract:** This type of contract has the lowest initial fees for independent living, and costs for assisted living and skilled nursing are charged at rates determined by factors such as market level and individual provider contracts when these services are used. Entrance fees are still required but are lower. The risk of long-term care costs remains with the resident since there is no prepayment for long-term care.
- **Type D: Rental:** These contracts generally require no entrance fees but offer access to CCRC services and health care. These are essentially pay-as-you-go for the resident. The monthly fees charged vary based on the size of the living unit and the services and care provided.

The monthly charges are increased each year. Kiplinger's says to plan on increases of 4% to 6% annually while in independent living and more if you are receiving assisted living or skilled nursing services within a CCRC.[5]

There are a variety of different arrangements used with regard to the return of entrance fees.[6] Some contracts provide for the return of a fixed percentage of the entrance fee on death or leaving, some a reducing percentage depending on how long the resident has lived there, and some do not return any of the entrance fee. Some CCRC's may not, depending on the State, be legally required to maintain a refund reserve fund, and in some circumstances where all or a portion of the entrance fee is to be returned, there may be a requirement for the unit to be occupied by a new owner who has paid an entrance fee for the unit before the previous owner's entry fee is returned.[7]

Charity Funds and Contract Provisions

Not-for-profit CCRC's often maintain a charity fund to assist residents who have depleted assets and need assistance.[8] Some have endowments to help their finances. However, in normal economic times, the need for support should be minimal because residents are screened financially before they enter.[9] In an article in Kiplinger's, it was stated that CCRC's typically look for entrants to have total assets that are twice the amount of the entrance fee and monthly income from sources such as Social Security, annuities and pensions (but not asset drawdown) to be one and one-half to two times the monthly fee.[10] In "*What's the Deal with Retirement Communities*?" there is some discussion about charity funds. There was no data provided.

When I first focused on CCRC's in trying to help a family member who was exploring a community, the charity fund was an important feature of the security "promised." I was told that the CCRC was offering a promise of life care and that they would take care of the residents if they acted prudently and ran out of

[5] Laise, Eleanor, "Risks and Rewards of Moving to a CCRC", Kiplinger's, January 1, 2013
[6] Breedling, Brad, "What's the Deal with Retirement Communities?", 2017
[7] One of the things I learned in the conversations I had about CCRC's was that some of them used all or part of the entrance fees to meet to current expenses and that they were not generally set aside to pay future long-term care expenses. This led to financial difficulty if occupancy dropped.
[8] Revenue Ruling 72-124 bans nonprofit "Homes for the Aged" from evicting residents for inability to pay fees (on pain of losing their tax exemption) unless they are able to establish that the resident squandered funds.
[9] Laise, Eleanor, "Risks and Rewards of Moving to a CCRC," Kiplinger's, January 1, 2013. For a discussion of the charity funds, see "Differences Between For-Profit and Not-for-Profit CCRC's", Oct, 2018, https://www.kendal.org/news/differences-between-for-profit-and-not-for-profit-CCRC's/. This information is provided on the Kendal website. Kendal is an operator of Not-for-Profit CCRC's.
[10] Esswein, Pat Mertz and Eileen Ambrose, "How to Shop for a Continuing Care Retirement Community", Kiplinger's, January 2018.

money. The sales people promoted this security, but there was no mention of the charity fund in the contract, which said that the CCRC could ask a resident to leave if they did not pay the monthly fees. In exploring this topic, I found from several sources the existence of discretionary charity funds, at least in some not-for-profit CCRC's. There does not seem to be an established resident right to such funds or detail about the funds. In the event of an adverse economic climate, these funds might not be adequate at a time when many more people may need them. The economic downturn accompanying COVID-19 could well lead to such situations in some CCRC's.

Understanding the Financial Situation and Due Diligence

The recent on-line discussion touched several times on the financial arrangements in this type of housing and raised concern about residents understanding them. The discussion also served as a strong reminder that due diligence is difficult, written material often lacks details, and that there are financial and other risks connected with these arrangements.

"What's the Deal with Retirement Communities?" includes a discussion of some of the things to look for in doing due diligence. This is particularly important when there is an entrance fee. The book mentioned focusing on both financial viability of the community and the quality of the health care provided. It is also important to focus on the fit to personal needs and lifestyle. Quantitative measures suggested for review are occupancy level, financial ratios, the actuarial report and debt covenants. Qualitative indicators recommended to be reviewed include leadership, track record, accreditation, debt ratings, length of wait list, types of contracts and future plans. Health-related measures suggested to review include CMS ratings, record of complaints, and staff turnover. This resource was written before the COVID-19 outbreak so I would add reviewing their experience with managing specific COVID-19 challenges including maintaining proper staffing, controlling public exposure, and inventory of protective equipment for viral and bacterial exposure. They also suggest onsite observation and talking to persons associated with the community.

Some of the risks my research and the conversation identified include the following:

- Change in operating environment due to an epidemic or pandemic such as COVID-19, making the community no longer attractive or safe to live in
- Risks of infections spreading quickly and easily in communities
- Bankruptcy, although some communities have emerged from bankruptcy
- Discretionary action by the management of the community – which may or may not be in compliance with the contract
- More people needing long-term care than there is space and budget for
- Drop in occupancy rates leading to the need to raise fees; my understanding is that a portion of entrance fees may be used to meet current expenses
- Costs rising so that monthly fees become unaffordable to residents without access to a charity fund
- Difficult economic situations leading to residents being no longer able to afford units and/or potential new residents being unable to afford the entrance fee
- Unrealistic expectations about the availability of a charity fund
- Inability to refinance loans and bonds on a satisfactory basis
- Residents can be asked to leave if the CCRC feels that they can't take care of them
- Inadequate definition and recognition of residents' rights
- Aging facilities leading to growing maintenance costs

My observation is that while there is a great need for due diligence, I have been unable to locate a well-laid out and accepted process that covers all of the financial and other risks.

Regulation and Safety of Senior Housing, Assisted Living and CCRCs

The regulation of CCRC's is mixed, with most states having some regulation and some not having any at all. The type and strength of the regulation also varies greatly.[11]

Regulation potentially should extend to financial stability, health care standards and participant rights.[12]

While CCRC's are not regulated in all states, they are accredited by CARF International.[13] All nursing homes[14] that participate in Medicare or Medicaid programs are subject to Federal oversight. This includes nursing homes that are part of a CCRC.[15]

Type A and B contracts include features which are somewhat analogous to insurance contracts but are not regulated as insurance products. My understanding is that many of the state insurance departments have not acted on the regulation of the finances and contracts of these businesses. We can compare the portion of the entry fee used to prepay for future care to an insured life annuity, which is quite heavily regulated to ensure its long-term stability. There appears to be no parallel regulation. The regulation of the life annuity focuses on both the financial stability of the insurance organization and the rights of and benefits promised to the purchaser.

In "What's the Deal with Retirement Communities?", Brad Breeding commented that he was not able to locate research indicating that CCRC's in states with regulation performed better financially those in states without regulation. The GAO report indicated that regulators, participant representatives, and industry participants held different views on the effectiveness of state financial oversight of CCRCs.[16] It should be pointed out that even if the CCRC is not regulated, the health care providers serving the CCRC will probably be subject to state regulation.

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[11] Breedling, Brad, "Regulation of Continuing Care Retirement Communities Explained". https://www.mylifesite.net/blog/post/how-continuing-care-retirement-communities-CCRC's-are-regulated/

[12] The GAO report, GAO-10-611 provides insights into state regulation based a sample of states for which they reviewed regulation. The report also provides a map of all of the states showing whether they have state regulation and which department regulates the CCRCs as of 2009. The report indicates that 38 states had some regulation of CCRCs, and 12 plus the District of Columbia did not. That report also shows the number of CCRCs as of 2009 by state. See Figure 2 on page 17 of the GAO report for this data. Insurance departments are involved in about 1/3 of the states.

[13] CARF provides a list of accredited CCRC's http://www.carf.org/ccrcListing.aspx. CARF also offers a Consumer Guide for Evaluating CCRC's. CARF is an international organization that accredits are a variety of types of health and service facilities. It was founded in 1966 as the Commission on Accreditation of Rehabilitation Facilities. The GAO report discussed the CARF accreditation as of 2010 and indicated that some of the people that they had talked indicated that the accreditation reflected best practices and that it included a focus on long-term financial stability.

[14] Other health care components of the CCRC also may be subject to state regulation even if the CCRC overall is not regulated.

[15] GAO-10-611

[16] GAO-10-611.

The Importance of Sound Decisions

CCRC decisions have a major impact on finances and quality of life. These decisions can turn out to be very positive and result in a satisfying quality of life. On the other hand, things can also go seriously wrong. It seems clear that due diligence is challenging, and few people know all of the issues and how to evaluate them.

The SOA on-line conversation also included some personal advice given by some of the individuals to others:

"Don't go to a CCRC that requires a large down payment that you can't afford to lose. I strongly prefer month-to-month contracts that you can get out of at any time."

"Take the time to shop and read the fine print. It took my wife and I many days to do the due diligence for her mother. We must have investigated 20 places and visited 10 before settling on a residential care facility for the elderly. It was time well spent."

My advice is that CCRC's are often a very good choice for receiving care and having a good life, but at a cost and with risks. My advice is don't enter into an arrangement that you can't change later if things go wrong. You need to have enough resources so that you have an exit strategy if a choice does not work out later. Know the circumstances under which the CCRC can terminate the contract and understand the financial consequences and what portion of the entry fees will be refunded and how if you terminate the contract.

The comments in this section represent the opinions of three individuals and there is no consensus on these points. They are not an opinion of the Society of Actuaries or any committee of the SOA.

Conclusion

Seniors and their families make choices about where and how to age and how to get help. Some involve going to communities which offer a lot of support but require entry fees. The new resident may have a choice of payment options. All of this involves trade-offs and risks that are complex and difficult to understand.

COVID-19 could change the view that these organizations are safe and very desirable places to age. While infectious diseases have long been a risk, COVID-19 presents extreme risk to the residents of these communities, and it brings a spotlight to the related issues. The variation in the way different communities have responded indicates that residents may face very different situations. Such communities remain an important option for seniors, but they involve a complex set of risks and require thoughtful consideration of the trade-offs before they are selected.

More consumer protection and disclosure would help consumers make more informed choices.

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Society of Actuaries
475 N. Martingale Road, Suite 600
Schaumburg, Illinois 60173
www.SOA.org

Faculty

Richard P. Carmody is a principal bankruptcy lawyer in the Birmingham, Ala., office of Adams and Reese LLP and has practiced law for more than 45 years. He specializes in insolvency law (C&I) and secured lending, and has a network of referral sources that he has developed throughout his career. Mr. Carmody is one of the firm's principal bankruptcy attorneys, representing clients in difficult financial matters. He also provides counsel to lenders for complex commercial transactions and internal policies. In 1992, Mr. Carmody became the first lawyer in Alabama to become Board Certified in Business Bankruptcy Law by the American Board of Certification. On the state level, he helped establish and served as the first chair of the Alabama State Bar section on bankruptcy and commercial law, and he was a member of the Alabama Law Institute's committees for revision of the UCC (Articles 3, 4, 4A, 5 and 9). Mr. Carmody is a founding member of ABI, and he established and co-chaired its Ethics Committee from 1999-2005. Additionally, he served as vice chair of the ABI's 2013 Task Force for Ethical Standards and was honored as ABI's Committee Member of the Year in 2012. Currently, he serves on ABI's Veterans Task Force. Mr. Carmody was inducted as a Fellow in the American College of Bankruptcy in 1999 and serves as a director of the College Foundation and as a member of its *pro bono* committee. He is a frequent writer and lecturer on bankruptcy and commercial law topics, and in 2017, the Alabama State Bar presented him with the Albert L. Vreeland Pro Bono Award. Mr. Carmody received his B.A. in finance in 1964 from the University of Illinois and his J.D. in 1975 from Vanderbilt University School of Law.

James S. Feltman, CPA is a managing director in the Restructuring practice of Kroll, LLC in Miami, where his practice is focused on providing fiduciary, advisory consulting and expert witness testimony in the areas of insolvency, restructuring, money laundering, Ponzi schemes, asset-tracing and recovery, accounting and financial statement reporting issues, causes of action against officers, directors and third parties, securities fraud, misrepresentation, and hedging and trading in complex securities schemes. He has more than 30 years of experience in a broad range of litigation, forensic and investigative services, and he has led cross-border forensic and investigative engagements on behalf of U.S. and foreign government agencies and is an established expert in determining the underlying fact pattern, establishing liability and determining damages in myriad engagements. Mr. Feltman has served as an appointed fiduciary with a branch of the U.S. Department of Justice for nearly 30 years. He also has been appointed as an advisor by both federal (U.S. district and U.S. bankruptcy) and state courts, served as an arbitrator and mediator, and has been appointed as a monitor by the U.S. Federal Trade Commission (FTC). Recently, he was named a Top 25 Consultant in the "Excellence in Client Service" category for 2015 by *Consulting Magazine*. Prior to joining Kroll, Mr. Feltman had more than 20 years of experience with Big 4 accounting firms, and was previously a partner at Mesirow Financial, Arthur Andersen LLP and KPMG LLP. He received his B.A. from the University of Wisconsin, Madison and his M.P.S. from Cornell University.

David E. Gordon is a shareholder with Polsinelli PC in Atlanta and leads Polsinelli's national distressed health care practice. He counsels on business bankruptcies and insolvencies with a distinct focus on health care industry restructuring. Mr. Gordon has represented health care providers, REITs, hospitals, lenders, landlords, health care systems, skilled-nursing and assisted-living facilities, purchasers of distressed assets, secured and unsecured creditors, committees, trustees and other parties-

in-interest in chapter 11 reorganization proceedings, receiverships and workouts throughout the U.S. His transactional experience includes representing purchasers in § 363 sales and representing various parties in problem loan workouts, bridge loans and other financings, forbearance agreements and other distressed transactions. Prior to joining Polsinelli, Mr. Gordon taught as an adjunct professor of law at the Emory University School of Law for more than seven years. He received his B.A. in 2003 from Georgetown University and his J.D. with honors in 2006 from Emory University School of Law.

Demetra L. Liggins is a partner with McGuireWoods in Houston and has nearly 20 years of experience in business finance and restructurings for a variety of large and small public and private companies. Ms. Liggins has led many representations of bankruptcy clients, working on both in-court and out-of-court restructurings. She works with her clients to purchase and sell assets in distressed situations, secure financing, and negotiate structure and implement cash-collateral orders and debtor-in-possession financing agreements. Her clients include health care systems, retail corporations, financial institutions, oil and gas companies, partnerships and private-equity funds, among others. Ms. Liggins is a frequent speaker on bankruptcy and finance-related topics, in addition to speaking on career goals, branding, and mentorship to minority and female audiences ranging from established professionals to students. She has been actively involved in numerous organizations, including serving as Southern Regional director and a former Fellow of the Leadership Council on Legal Diversity; past Houston Network chair of the International Women's Insolvency & Restructuring Confederation (IWIRC); a member of the Women's Business Alliance, Greater Houston Partnership; a member and former chair of the Bankruptcy Section of the Houston Bar Association; a member of the Cumberland Law School Advisory Board; a member of the Women's Energy Network; and a Fellow of the American College of Bankruptcy, American Bar Foundation, Houston Young Lawyers Foundation and Texas Bar Foundation. She has been listed in *The Best Lawyers in America*, *Texas Super Lawyers* and *Texas Rising Stars* by Thomson Reuters, as a Law Firm Rainmaker by *Diversity & the Bar*, and to Houston's "Top Lawyers" by *H Texas* magazine. She has also been featured in *Law360*'s Minority Powerbroker Q&A series. She also was honored in 2020 by the Houston Association for Women Attorneys Premier Women in Law and for the 2019 Texas Minority Counsel Lifetime Achievement Award. Ms. Liggins received her B.S. in business administration *cum laude* from Christian Brothers University in 1997 and her J.D. *cum laude* from the Cumberland School of Law at Samford University in 2000.

Felicia Gerber Perlman is a partner in the Chicago office of McDermott Will & Emery, where she focuses her practice on complex business reorganizations, debt restructurings and insolvency matters. She also is the global co-head of the firm's Restructuring and Insolvency Practice Group. Ms. Perlman advises debtors, creditors, lenders, investors, sellers, purchasers and other parties-in-interest in all stages of restructuring transactions, from chapter 11 reorganizations to out-of-court negotiations, workouts and acquisitions. She frequently presents on bankruptcy topics and is featured in several notable publications. Ms. Perlman is a frequent speaker and has been recognized in *Turnarounds & Workouts* as one of the nation's "Outstanding Young Bankruptcy Lawyers," and she has repeatedly has been selected for inclusion in *Chambers USA: America's Leading Lawyers* for Business and *The Best Lawyers in America*. In addition, she received the 2017 Flex Success Award from The Diversity & Flexibility Alliance for her commitment and success in creating and working in a flexible environment. She also was named by *Crain's Custom Media* as one of Chicago's Notable Women Lawyers in 2018. Ms. Perlman has been a member of the boards of directors of the Women in Law Empowerment Forum and the Chicago Coalition of Women's Initiatives in Law

Firms, and she is a Fellow in the American College of Bankruptcy. She received her B.A. and B.S.E. in 1989 from the University of Pennsylvania's Wharton Business School, and her J.D. in 1992 from Northwestern University Pritzker School of Law.