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Opportunities in Continuing Care Retirement Communities

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Moderator: GARY L. BRACE
Panelists: GARY L. BRACE
BILL YOST†
Recorder: COURTNEY R. WHITE

Summary: *This session discusses continuing care retirement communities. What opportunities exist? What role does the actuary play?*

Mr. Gary L. Brace: I am from the Atlanta Office of Milliman & Robertson. This is slated as a small panel discussion comprised of two people, Bill Yost and myself.

Bill is the chief financial officer of The Kendall Corporation, which is a not-for-profit multisite continuing care retirement community (CCRC) organization in suburban Philadelphia, sponsored by the Quaker Organization. Bill has, I believe he said, eight or so facilities, depending on how you count some of the start-ups, and some of those that are in the developmental stage.

I'll speak on the general aspects of CCRCs, including the delivery mechanism and the attributes of the resident, and how the financing works and so forth. Then Bill is going to talk about some of the particulars related to some of the products that are offered in the industry. He'll also be talking a little bit about how a CCRC starts from conception to when the residents first enter the facility, in terms of going through the development stage, giving the seed money, and getting the bond issue. And if they are doing external financing, to give a feel that you all need to have a good understanding of what a CCRC is all about.

I think we actuaries want to put everything in a certain mathematical box, and those of you who are familiar with CCRCs probably recognize that it is a different kind of box altogether. It is kind of a combination of health insurance, life insurance pensions, mathematics, real estate, and a number of different disciplines and sciences that are rolled into one. This discussion is geared toward people with no experience, so we are trying to make sure everybody is up to the same level, but at the same time I want to make sure we cover some intermediate-to-advanced topics as well.

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†Mr. Yost, not a member of the sponsoring organizations, is Chief Financial Officer at The Kendall Corporation in Kennett Square, PA.

In terms of the learning objective of the session, it is really threefold: (1) to make sure that everyone has a good understanding of the CCRC delivery mechanism and all the facts that are associated with it; (2) to understand why CCRC residents represent an opportunity for life and health insurance companies; and (3) to learn of some of the specific products that Bill will be talking about that are currently available or even some that could be available and maybe aren't right now.

The topics we are going to be talking about are: (1) a brief overview of the CCRC delivery mechanism; (2) the retirement housing market in general and specifically hybridization of that market; (3) the fee structure and how these things are financed by the resident; (4) the type of assumptions that we as actuaries use in the development of the pricing and tax flows for these entities; (5) risks such as budget and marketing risks; and (6) some of the other types of things that aren't as readily apparent for people new to the industry, at least from the actuary side, i.e., the opportunities that exist because of the resident attributes and characteristics, insurance products, and the developments and the future of the industry.

In terms of the delivery mechanism, how it works is the residents enter independent living, where everyone is pretty ambulatory. They go through both a medical and financial screening process. The medical-screening process is much like the underwriting process that a long-term-care (LTC) carrier would do, but frankly less rigorous. They would have a physician possibly interview the person and have them answer a few questions in terms of how long and how ambulatory they are. Frankly, and Bill can disagree, this is a lot less rigorous than the typical LTC carrier's process.

The financial screening is done to make sure that the residents don't run out of money six years into their residency in the facility. Because even though facilities have what they might call a benevolent fund to front people running out of money, it puts the facility in a really awkward situation in terms of how to deal with this resident, because they're obviously not going to kick him or her out. But at the same time, they don't want to keep drawing upon certain funds that are set aside.

Typically, all the levels of care are in one campus. The people come in when they are fairly ambulatory and living independently. If they need to have a higher level of care, because of higher dependency, they will move to assisted living. Then further on, they move to skilled care. There are different types of models that we'll talk about, where maybe there may or may not be certain levels of care on the same campus, but I think the commonality here is that in the CCRC, per se, all the residents are guaranteed access to these levels of care.

Sometimes if they don't have the skilled nursing facility on-site, there may be a place down the road where residents can get guaranteed access, but at least they have in the contract that they would get, say, priority mission, so it speaks to that.

The transfer to the higher levels of care are based on the resident's need and facility requirements. The trend now is to keep residents in particular levels of care maybe

a little bit longer than they had in the past because of the home-health agencies that some of these facilities own or at least have relationships with. In general, the trend is to keep people in the level of care for quite a bit longer, but, at the same time, they have to walk a fine line. For example, if you're a prospective resident coming into the facility and you take the tour into the dining hall and see people in walkers and so forth, it may not be as attractive to the 78-year-old who still plays golf 3 times a week. You have this balance between the level of dependency of the people in independent living and the need to keep people ambulatory.

These facilities typically require a Medicare supplement. While they don't say Type C in the requirements, that is pretty much what it turns out to be so that they have the Part A and B coverage at least paid for—not necessarily the drugs but the basic program coverage. The financing for residents would typically be a combination of entry and monthly fees. There is a variation between what the mix of entry and monthly fees will be, but they do pay some combination of that.

The contract is typically what you would call a wide-lease contract, where the person gets these services for as long as he or she is in the facility, but doesn't necessarily own the unit per se. They would be entitled to housing, whether it be independent, assisted, or skilled-care, and would get at least one meal a day. Some of these facilities offer two or three, but one is probably the most common in independent housing. When they transfer to the assisted and skilled, they may get the three meals a day because in skilled care they wouldn't have the ability to make their own food; in assisted living they may or may not. They would have laundry and a linen service. The facility might have a van for transportation to provide the opportunity to attend certain events, maybe a play or a concert. CCRCs have social events. This sounds almost trite or something, but they have bridge games, craft events, and different things happening around the facility, because one of the attractions of the CCRC is the ability to meet other people who are active like yourself and keep active and do things like you would ordinarily but have that security of living in a facility.

Have I mentioned that they will have access to health care? Sometimes the residents may have to pay more after entry to assisted or skilled, but at least they have guaranteed access. The fee structure is a combination of monthly and entry fees while we, as actuaries, tend to want to compartmentalize the uses of the entry and monthly fees, there is still a blurring there that at least in the aggregate we hope that the entire expenses, and that would include the operating expenses and, of course, the capital expenses associated with the fixed assets, are provided for by the revenue stream.

I think people typically view the entry fees as supporting the capital expenses. Some of the fixed assets and monthly fees may be more than the operating expenses as far as the debt service goes, and Bill will get more into this, but the facilities will typically sell bonds in order to finance the facility so for a brand-new facility that may cost nowadays anywhere from $90 to $120 million or so of financing by bonds, by 30 years these bonds need to be paid off by the monthly

and entry fees. Meeting this debt service is an extremely important aspect of the liquidity and the financial solvency of these facilities.

In terms of ballpark numbers, a typical entry fee may run $150,000–200,000 or so for a contract that just has very minimal refund provisions and $1,500 or so for 1 bedroom. If you have a larger unit, maybe a 2-bedroom or a cottage unit that may be 2,300–400 square feet, that entry fee may go up to $250,000–275,000 or something like that. The monthly fee would go up to maybe $2,200–400.

The second-person fee is roughly one-half of the first-person fee. What it turns out to be is that you are paying for any type of prefunded health care, plus the linen service, meals, and variable expenses, if you will, that are associated with this second person. The second-person fee might average between $600 and $750 a month. As I mentioned before, depending on the contract (we'll talk about the health guarantees in a minute), they may or may not have to pay additional expenses. If you are paying $1,500 per month as a resident for a 1-bedroom unit, of say, 750 square feet, when you transfer to assisted and then maybe even into skilled, your monthly fee will not increase. Obviously the expenses go up; because of that shortfall, you have to determine what portion or how much of the entry fee is going to be used for prefunding, so to speak, that health care or even what portion of the monthly fee is going to be prefunded.

One of the tasks that actuaries do, and I'm probably jumping ahead a little bit here, is to look for tax-deductibility of the resident's medical expenses entitled to when he or she entered the facility. Because out of the $150,000, maybe $25,000 could be viewed as prefunded health care and then used by the resident for his or her income-tax deductions, and then on the monthly fees, maybe $150-250, depending on how you view it, can be used as that portion of prefunded health care.

Again, this is where I guess the art meets the science, as actuarial science, when you are looking at the combination of monthly and entry fees. All you are looking at is the grand total; the present value of the revenue is enough to meet the present value of the expenses, plus any contingency amounts you may have, so how you allocate the expenses between entry fees and monthly fees is somewhat arbitrary. When you are determining reasons for what portion is monthly fee, it needs to be a reasonable division between the two.

The retirement housing market is, in reality, different from the fixed definition that I have outlined so far. You could have facilities that are pure rental facilities, which have no entry fees at all. The person coming in pays maybe $2,500 a month instead of the $1,500 that we talked about, and then he or she will be offered guaranteed access to health care. But instead of paying that same amount after he or she transfers, he or she may have to pay quite a bit more. If he or she transfers to assisted, he may have to pay $3,500 a month or maybe as much as $4,000 a month. Then when he or she transfers to skilled care, that person has to pay even more after that, so you could structure that. There are pros and cons.

And one of the issues that you are dealing with is that for a typical start-up facility, there are just an enormous number of expenses that need to be supplied. The facility typically finds entry fees attractive because it will get $30–40 million in entry fees in the first 2 or 3 years of operation, so it will usually use that $30 million. I don't mean to steal Bill's thunder here, but they'll use that $30 million, which the facility calls sweep-down-the-bond payment. In other words, pay out some of the proceeds so that the facility has less debt outstanding so that it looks better for credit-rating purposes and so forth. You know while I'm painting a conceptual picture here of the mathematics of this, there is really sort of a not-quite-amorphous, but really a continuum in terms of the arrangements you could have.

We've talked about the entry-fee community, and the standard monthly entry-fee structure cooperative arrangements where the resident actually owns the facility and you see this in areas where real-estate appreciation was a lot greater—people could roll over their sold house into a facility and not use their onetime exemption. I guess that's dated now because tax laws have changed and we don't get hit anymore.

In terms of level of care, there is a mixing and blending of the levels of care as well. While we've talked about independent living, you'll also see what might be a step, maybe half a step, toward assisted living, where they'll call it residential living or an adult-care living facility. Different states have different licenser requirements, but again, if it's that kind of in-between level where the people may still be driving or they may still be pretty ambulatory but want that security more than just having a cottage, they may be detached from the main building; they want to have a little more community and then again a little more dependency and a little more reliance upon the entity there.

There are a number of free-standing assisted living facilities out there. They may or may not have an entity associated with it. Probably more often than not, you see it as a pure rental, but again it is a hybrid of models that you typically see, and obviously you see that with the free-standing nursing home.

The trends in the retirement-housing market are primarily focused around the blending we talked about, of facilities with different levels of care, but with the assisted living—a boom that started in the early 1990s. The industry, somewhat belatedly, recognized that there was a real need to fill, what I call the in-between need, because a lot of the residents who were coming in while they were still fairly ambulatory couldn't pass the medical-screening process that the facility went through and they really didn't want to live in the skilled-care or in the assisted-living section of the CCRC. It is an in-between field group and primarily fueled by a lot of the forefathers, the developers who were out there and really were quite successful. But what has happened, though, is that everybody jumped on the bandwagon and now there is quite a bit of overbuilding. The Marriott's, Sunrises, and whatever other company is in assisted living, have really oversaturated the market now and there are lots of facilities that aren't filled to the extent they could be.

The next trend in retirement housing is hybrid models. What you see is a lot of facilities out there with varying types of guarantees. You will see different types of health-care units. Instead of a contract offering that you can only say that you are able to pay the same monthly fee after you transfer, they say, "Well, we'll give you so many days free per year and then you have to pay per diem, or we'll allow you to pay 80% of the ongoing per diem or usual per diem in the assisted or skilled care." There are various types of mixing and matching.

I guess my point here is to make you all aware that while we have our mathematical framework for CCRC, there is a real variation in both the funding mechanism and in the delivery mechanism. Because of the growth in assisted living, there has been some change in demographics. Some people argue that maybe there is an older population now in some of the traditional settings.

I think that if you look at the actual configuration of these facilities, if you look at the high-rises in particular, you would see that older people tend to go there more because it has a little more security. You see the campus style in more of the rural parts or maybe on the outskirts of town, where you have detached cottages or a separate wing where maybe there's a covered walkway between a certain building and a main building. You see people there who may be a little younger, maybe a little bit in better health, so again it's just blending in the industry.

There are at least five types of assumptions that you would use in developing the actuarial analysis. The first assumption would be obviously the actuarial assumption. Look at the actual mortality rate and transfer and withdrawal rates and where these residents are in each level of care. Not only do we develop these assumptions for an ultimate population, but we also look at the selection factor, because, again, through this underwriting or through this medical-screening process you're going to get people who in the first two, three, or four years exhibit better mortality and transfer patterns than they would once the residents have been there five years or longer. You have the economic assumptions of inflation, and earning rates on free surplus that you have to input into your analysis.

Also, there are the demographic assumptions, and this is the composition of the residents. The average age of the residents or the distribution of age whether or not they are single, coupled, and so forth, and all that becomes extremely critical, because, as you know, at the age of the resident we're looking at, which is an average age of anywhere from 78 to 80, the deterioration in the health status as a resident ages is extremely large, especially compared to somebody even 10 years younger. If you have an average age of 78, you're going to have many different projections than if you have an average age of 76 or even 82, so that becomes important in determining or developing these population projections.

The marketing assumptions primarily have to do with the fill-up pattern of the new facility. Typically, you will see a new facility fill anywhere from 18 to 30 months; probably 24 months is the most common. If a facility tells you it can fill up in less than 18 months, then probably you need to be a little bit concerned the facility probably doesn't have realistic projections. Typically, you would see a facility at full

occupancy at 95% of all the units being occupied because of the people on an ongoing basis who may be transferring or passing away. It may take a little while to fill that unit because you have to repaint, maybe put new carpeting or whatnot in there, so there is always a lag time, even if you do have residents on a waiting list.

The operational assumptions include primarily the budget, what we call the bond sizing or how the facility is going to use the bond proceeds. For a new facility, out of our $90 million that we talked about earlier, let's say $55 million of that might go actually to developing the building, or $60 million. Then you would need some money for working capital and some to pay off the developer and then a small piece for the actuaries. The operational assumptions are rarely developed by the actuary; typically they are developed by people like Bill Yost.

The bond sizing would be developed by the investment banker. Again, there are a number of players in this market, such as investment bankers, feasibility consultants, and developers. You have a whole raft of people who are coming from the insurance industry you might not be as familiar with.

In terms of the actuarial support that we provide to the industry, for the most part the industry operates on a cash-basis mentality. We as actuaries have developed a framework using present values and an approach to analyzing these fixed assets around the CCRC delivery model so that we can make sure that in the aggregate, again the present value, the revenue is enough to cover the present-valued expenses. But when push comes to shove with these facilities, we'll operate on the cash-flow basis. And as long as they're throwing off enough cash to meet their debt service, then they are pretty much active. As I mentioned, the framework that the actuaries have developed around this includes the evaluation of resident revenue, the operating expenses, and, of course, the fixed assets, which is probably a whole lecture in itself. But it is a way to kind of atomize or break up the consumption of the fixed assets into the consumption not only by the current generation of residents but also by the future generation of residents and to make sure that each generation of residents is paying its fair share of these consumable assets.

The work that actuaries do is primarily geared toward resident population projections, which show the residents as they go to higher levels of care and the number of units that turn over in each year in independent living. Then you have a whole batch of new residents coming into the facility who bring, of course, entry fees. The turnover projections are called population projections and become an important aspect of the feasibility work that actuaries do, or say, that Bill will do, or a Big Six accounting firm would do. The risks associated with the development of the facility are really multifold.

The health-care risks are driven from the health-care guarantee, as it is called in the resident contract. The health-care guarantee is a definition used to describe the level of fees paid after a transfer to a higher level of care. As I mentioned, the resident might pay after he or she transfers that same $1,500, or he or she may pay a discounted per diem if the assistant living is $90 or so a day. Maybe that

resident receives a discounted fee of only $70-75 a day, or it could be a percentage. He or she could pay a discounted arrangement or the whole full-blown per diem, which is the entire $90. But, again, depending on this, he or she might have a number of what the industry calls free days, where each year, perhaps for the first 10 or 14 days, the residents get to pay their fee that they pay back in independent living, so they pay the $1,500 and then after that they could pay the full-blown per diem. There are a variety of options.

Typically, in all these contract revisions or regional variations, there is not necessarily any trend that you see in the industry in terms of a facility moving away from or toward risk. It really varies by parts of the country. Up in Bill's neck of the woods, in Pennsylvania, the type of contract you typically see has the full-blown health-care guarantee, where the residents will pay the same monthly fee after they transfer. When they die or if they withdraw, their estate or resident will get back a large portion of that entry fee, which is known as a refund provision.

If you go down to central Florida, you see contracts where they may have a minimal refund provision and different health-care provisions, where they may get 14 free days per year and they pay 80% of the per diem thereafter. In North Carolina, around the Raleigh-Durham area, you see these structures where all the monthly fees, regardless of the unit type, are identical and it is the entry fees that only vary. There are these regional pockets of competition that really dictate the type the contract you see. While there may be national trends, I guess I would really dismiss that and say that there are more regional trends much the same as managed care.

The level of risk determined by any type of health-care guarantee is really the amount of prefunding that is included in the contract. Obviously, if you have a contract where the resident pays the same monthly fee after the transfer, there is going to be a lot more reliance upon either the entry or the monthly fee to make up that shortfall. The prefunding is that much greater. On the other hand, if they are paying the full per diem, there is going to be absolutely no prefunding, so you don't need to worry about the accuracy of the entry fee, obviously, and that case could lead to future prefunding. I guess some of the good news about the health-care risk is even if you have a fee structure that pays the same monthly fee, after the transfer there is a relative slowness of the results turning down, because you are not going to see a large number of people necessarily transfer all at once, unless the facility has done a really poor job in the medical-screening process.

If you estimate that there are six people per year transferring to skilled care and there are eight, it is not the end of the world because you are going to have time to adjust your fee structure. And while you may have a slight subsidy after adjusting the fee structure, you're still going to recover. The flip side to that, where things really turn sour, is the refunds. The refund provision has to do with the amount of the entry fee that the estate gets back after a resident either dies or withdraws.

There is a whole range of refund provisions. The first could be what is known as the declining refund, which on a monthly basis declines at 2% a month down to

zero. Over a 50-month period, if you withdrew in month 1, you would get a 98% refund, at month 2 a 96% refund, and so forth. Or if you died in those same months, your estate would get that declining scale. That is a very common type of provision.

An equally common refund provision would have a floor of perhaps 50%. It would decline at 2% per month down to floor of 50%. Or it could have a floor of 90% or a maximum floor of 100%, so it stays constant. Again, this is subject to the regional product consideration, but the risk here is the mispricing risk because it is a lot larger dollar amount.

If we're talking about an entry fee that is maybe $150,000 for a declining refund, that may be $275,000 for a 100% refundable contract. If you misestimate the number of people who are going to be withdrawing or dying, it could really wreak havoc on the cash status and the financial liability of the facility. If you look back at some of the case studies for the failures or financial hardships of these facilities, you see a lot more problems associated with refunds than you do with the health-care part, because, again, the health care is so slow to materialize that you have a chance to react, whereas with refund it is instantaneous and you find yourself up a creek quickly.

The other thing that I didn't mention here, in terms of the types of risks that you might have, are nonactuarial risks. You can still be cognizant of those marketing risks or the fill-up pattern, operational risks, or budget risks. There are a lot of facilities that would misestimate the ability to get maybe the second generation of residents, or maybe they can get their facility to 75-80% full, but can't fill all the way up to that 95%. There is a real risk there because these facilities are so heavy in terms of their fixed assets and expenses that they'll break even.

From the work I've done, occupancy is maybe in the low 80% range. If you don't get that 83-84% occupancy, there's no chance of breaking even on a cash-flow basis. To repeat, occupancy is extremely critical and it is beyond the purview of actuaries, but nevertheless you have to be aware of that and at least look at the reasonableness of the assumption and make sure that they are not in an oversaturated market because of other facilities or rental communities in the area.

The other aspects that we see sometimes bringing hardships to facilities are the operational and budget assumptions. Someone may have assumed a certain pattern of FTDS to operate their nursing or to do the administrative or marketing fees, and they find out they need several more people than they assumed. There are a number of reasons they could get into budget concerns, but that's probably more likely to happen than maybe misestimating something on an actuarial basis and having that same kind of corresponding financial impact.

The opportunities that exist in the market for these residents lie around the fact that these residents really represent a super-select population at an advanced age. What we have here are people buying annuities at ages 78-80, so not only are we medically screening these people to make sure that they are healthy, but these

people are self-selecting themselves, because, obviously, you are not going to want to plunk down an entry fee of $150,000-200,000 if you think you are going to die tomorrow; that's not to be flippant, but that is exactly the case. What we have then is a bunch of residents at age 78-80 who are in much better health than the general population.

From the Floor: I was wondering what screening you do for the medical-end portion.

Mr. Brace: Do you want to handle that question, Bill?

Mr. Bill Yost: For the medical underwriting we typically would have a fairly simple health form, a physical-type form, where the residents' physician would fill it out. Then the prospective residents would come in for a series of interviews with a multidisciplinary team at the community, including social service workers, so they can kind of check their cognitive functioning.

The prospective residents would meet with our geriatric nurse practitioner who would review the physical information form that their physician completed and do another mini physical. They would meet with perhaps some of our physical or occupational therapists, if they have any kind of issues in that area. Our screening is at a minimum on the social service side and the health side. If we start to see some issues we will have them meet with additional people. I would say probably 80-90% of the people who apply get approved; there are very few who don't get accepted into the community.

Mr. Brace: What do you all know as a higher percentage that would be approved for LTC policies? If we look at the comparative health status of a CCRC facility versus a general population, you'll see that the CCRC residents clearly have a lower mortality rate than the general population. The rates, and we'll use both transfer and mortality rates here, are really indicative of a healthier lifestyle that a lot of the residents had before they came into this facility, because these residents are really higher in terms of socioeconomic status than the general population, and that is really reflected in their health status.

There is some evidence that the effect of the lifestyle after residing in the facility also improved the health status, but I know that there have been two studies done that I've looked into, and both researchers threw up their hands, saying that there is not enough statistical significance in the results to say whether or not just living in this facility itself improves health status.

I was at a press conference at a trade association meeting three or four years ago when a Greenwood, Pennsylvania congressman and some other industry leaders wanted me, as the representative to the trade association, to say, "Yes indeed we have statistical evidence that it really does improve the health status," and I said, "I can't say that." I would have liked to have said that, but we have no statistical evidence to prove that.

From the Floor: Can you tell us what specific conditions are included in the CCRC underwriting that are not included in LTC insurance?

Mr. Yost: I'll start and Gary can maybe add to that. I think typically a CCRC underwriting would be less stringent than what you would see from tong term care insurance or even a life insurance plan. We generally don't screen for cancer. Cancer is not a big problem in CCRC, particularly when people are paying nonrefundable entry fees. Where you are going to refund money, cancer should really become much more important. We're looking more to the cogent side so that when we see health issues, where somebody may not be able to live independently for a period of time, that's our bigger concern. The likelihood is that the cancer patient will spend more time in the nursing facility and be quite different from the rest of the population, and that's the primary thing that we are searching for in the health screening.

Mr. Brace: I guess I would agree. I am considerably less familiar with the LTC underwriting process, but what I have seen is that the facility is going to be a little more liberal. The facility is also going to be under more pressure, especially for a new facility, to bring people in. Depending upon the market the facility is operating in, a newer facility that is having to scrape up or get residents from a wide geographic range may be more apt to bring in people who would be a little less healthy than an established facility.

I need to move along a little bit to give Bill a chance to talk. If we look at comparative statistics in Table 1, where the life expectancies of a 75-year-old female entering an independent living unit are compared to the general population, it is 14.4 years over 12 years, which is quite a bit longer life expectancy, really, all the way down through the various stages. I guess what is significant here is that the percentage, between the resident entering the facility and the general population, tends to grow as the resident who comes into the facility ages, because this is a super-select population that we are dealing with. This population is in better health, is of a higher socioeconomic class, and has a higher level of education. These people are saying, "We are going to buy this annuity at age 85."

TABLE 1
COMPARATIVE HEALTH STATUS OF CCRC RESIDENTS
VERSUS GENERAL POPULATION

- Comparative Statistics - Life Expectancy at Entry

Age	ILU	SNF	General Population
75 Female	14.4	6.4	12.0
80 Female	11.3	5.8	9.0
85 Female	8.8	4.9	6.4
• Percentage difference between ILU life expectancy and general population widens with increasing age			

There is a facility executive director who tells a funny story up in Pennsylvania. A resident to whom he was talking was inquiring about the services that they offered.

The prospective resident asked if they had garbage service, where someone would come to the house and take the garbage out. The executive director said, "Well, no ma'am, I apologize we don't." She said, "Well, I've never taken the garbage out in my life, and I'm not going to start now." That gives you an idea of the kind of residents who are getting into these facilities.

Back in the late 1980s and early 1990s one particular carrier pushed LTC products that would really wrap around the health-care guarantee offered by these facilities. The results were disappointing for this one carrier. Other carriers had gotten into this market because the industry felt, at least in my view, sort of insulated from the risks and they didn't really feel the need to cover that health-care risk because of the deep-pocket potential of the sponsors and the affiliation some of these facilities had. These carriers really didn't see the urgency or the need necessarily.

A lot of the for-profit entities sell instead to need and still feel the need for the LTC product to be wrapped-around. My perception is that it has probably been a little disappointing. I think the market now is finally maturing and that a lot of the business managers from these facilities now do see the LTC risk, and are maybe a little more aware of this risk. I think if you all were to talk to financial managers, you might be a little disappointed in terms of their profitability situation or their attitude toward this risk.

One aspect of life insurance coverage that I thought might be used for a refundable portion of the entry fee would be to insure that extra portion of the entry fee. In my example of the $150,000 nonrefundable fee, if we were going to give them all the money back, then we need to add an additional amount to pay for that and maybe pay $275,000 in total. Well, you could use a life insurance policy to fund that. And the reason that's attractive is because the CCRCs, because of their restrictions in the bond documents, are not able to invest anything very liberally. They are typically held to CDs or something like that where they may be only offered for maybe 5-6% investment income, whereas the insurance companies, even though they have statutory restrictions, are able to invest in longer-term investments; so they are able to use that investment income from the entry fees to really leverage off of that.

Some of the developments that we're seeing now, and this is probably a little bit dated at this point, is the managed care initiative by the CCRC because, again, these residents represent the super-select population.

A lot of the Medicare Risk HMOs in the last two years are looking to enroll residents in their risk contracts. And depending upon the institutional status of these residents, the Medicare Risk HMOs may get a higher level of payment for this, but it represents, again, probably a better-than-average group of residents that these HMOs can get. The other thing that we are seeing that is probably in its warning gate now, unfortunately, is the alignment of CCRC with other post-acute entities to contract with these HMOs and offer the full service post-acute contract for these Medicare Risk HMOs, where they are able to offer everything from the rehab to

sub-acute to home-health to SNF to adult day care—the whole gambit as the patient transitions out of the acute state.

Finally, we've talked about the LTC insurance and the life insurance for these refundable contracts. That, again, seems like it would be a viable product.

Mr. Yost: I thought I'd give you a little bit of background about what The Kendall Corporation is and then talk specifically about some of the contracts that we offer to our residents. I will talk from both the service and entry-fee sides, because they are different.

The Kendall Corporation was formed in 1971, just outside of Philadelphia. Philadelphia, for some reason, has a large concentration of retirement communities. I think there are close to 40 retirement communities in the Philadelphia area. There are pockets in Florida where you will find a concentration as large as there is in Philadelphia. The early community started out as a religious, not-for-profit organization offering a fully exclusive contract.

Our particular organization, as Gary mentioned, is Quaker-based. A majority on our board of directors have to be members of the religious Society of Friends, and that has been an excellent marketing tool when talking with new residents. Our organization consists of the parent corporation, and we have separate not-for-profit organizations which own and operate each of our CCRCs. We have about eight CCRCs in five different states.

The first ones were right outside of Philadelphia. We have about 2,400 –500 residents we serve today. About 1,300 are in residence units, 350 in nursing units, and 240 in assisted-living units. We have about three projects under various stages of development, from the initial concept to getting ready to go to financing.

I thought maybe I'd just give you a quick rundown of how a CCRC gets started and its time frame, because it is longer than you might suspect. I am going over the project that we developed in Ithaca, New York. It was the first CCRC offering full continuing care under one basic fee set up under the New York law, and it opened in 1995. We started talking to the people in Ithaca back in 1988. They came to Kendall and told us they'd like a Kendall community to be built in Ithaca. Within a year or two we formed a small group of local people from Ithaca who were interested in seeing this community built, as well as some members of our board, and we incorporated a new entity and began the process.

The first hurdle is finding what we call the seed or adventure capital to start these things. It takes anywhere from $2 to $4 million to get from the idea to what we call permanent financing. That seed money has been financed in a number of different ways. At Ithaca, we had two universities, Cornell and Ithaca College, that put up large loans. The local bank and hospital also invested. And when I say invested, they put up the money fully at risk for a reasonable return of 15-20% on their money if the project proceeded. If it didn't, they took all the risks. Our

corporate office is not in a position to prefund that kind of start-up risk, so we do deferral of all our costs for the whole project.

The next step, once that seed money is secured, takes about two to four years. Gary touched on pieces of this, but this is where we hired the architect and started designing the project and getting zoning approvals. It takes a tremendous amount of time and work getting those things done. In fact, it's probably becoming the most difficult thing that we are doing these days. We began our marketing effort, talked to the local residents, and saw what types of service program they would like. We'll design the type of entry-fee product based on the local real-estate market. If we see a depressed real-estate market, we'll try to lower the entrance fee, but then raise the monthly fees if the area can afford that. During this phase, we'll also be doing our actuarial projections, making sure this thing is priced properly. Our financial feasibility studies will be used then for the financing.

When we break ground and do our permanent financing, we'll have anywhere from 60 to 70% of the units presold; our organization takes large deposits, anywhere from 25 to 50%, on the entry fee. I think the industry norm is closer to 10% deposit prior to financing.

The financing structure is often a combination of tax-exempt bonds for usually about half of the financing. Then it's a long-term, 30-year bond. The other half can either be a construction loan or short-term bonds that get taken out. When the entry fees are paid, as people move in and pay their entry fees, part of the debt is reduced. Construction takes about two years. Ithaca cost, I think, $60 million and $30 million of that was construction.

On that particular project, we built 200 residential units, ranging in size from 500–600 square-foot studio units to 2-bedroom dens, which were around1,300–400 square feet. There are 35 beds in nursing care and about 36 beds in assisted living. Then there is also a community center, which in this particular project, I think, was around 40,000 square feet, and that included the dining area, fitness centers, therapy areas, and auditorium. We provide a lot of common space for the residents to figure out what they want to do. We don't have an activities structure that plans the daily activities for the residents. The residents plan it themselves.

They have a wonderful library, woodshops, and other kinds of craft rooms. One of the area's residences has been turned into a computer lab. In another of our communities, a woman came in who was very interested in reading. She set up a couple of rooms and now there must be 30 spaces in this room. At any time of day, you'll walk in there, it could be 11 P.M. or 8 A.M., and you'll see some activity in those various spaces. From the first time we started talking with the people at Ithaca, it took about six years to get this project open and that is not unusual.

A typical service package that we offer in all communities has four different types of contracts. They include meals, housekeeping, maintenance, and utilities. Our communities have a strong belief that therapy, such as physical or occupational, is important to keep people active. If we can keep our residents active, we can keep

them out of the health center. They are happier to be out of the health center, plus the cost of providing a service is less with fewer people residing in our health center. Most communities have therapy available, but it may or may not be included in the basic fee.

Pharmacy. Our traditional contracts and what we call a Type A contract, which is a full inclusive contract, cover all the pharmacy costs of a resident. Our newer versions of a Type A contract do not include pharmacies. We're seeing many more people who have pharmacy benefits from their previous employer, as well as Medigap coverage for pharmacy. Skilled nursing traditionally will be provided for an unlimited period of time at the same basic fee as the person paid for his or her apartment. The same thing will be provided for assisted living.

Excess costs. These are fairly unusual, and probably in the Philadelphia area you are going to find this. We are responsible for excess costs incurred by the residents in the areas of hospitalization, physician services, specialists, and surgical costs. There are some additional risks that our particular fee states that many today do not. That is an area in our revised contract that we are not including anymore. We're finding that people's Medicare coverage and coinsurance are covering that, so there's no need for us to duplicate that.

We've built a project in Virginia. The competition there in our particular area is not what you would call a Type A community. A limited nursing care contract is what is known in our industry as a Type B contract. The residents still have the meals and therapies, but we are not covering pharmacy, although it is available on-site. Nursing care is provided off-site. We do include about 60 days of coverage, but we are not covering excess costs.

In the last two to three years we found a number of people coming to us who have LTC insurance, and this is the issue we have been trying to figure out how to handle. Our contract covers everything that most LTC plans cover. When you think about an LTC plan, you're going to pay *x* amount per day, depending on the level of care; our contract is already doing that.

We have found that we're located in a lot of college towns and we are seeing many more applicants who have long-term-care coverage. TIAA CREF provides definite annuity products for many universities. It is really active with marketing LTC benefits, as well as other companies, so we're finding people on our waiting list who say, "I have some amount of coverage. I don't what to buy superfluous coverage." We have developed a limited contract which allows the resident to maintain the LTC policy, and we tried a couple different ideas on this contract. First, we tried to customize this, where we input the benefits participants had in their policy and we would compute how much of a discount we could give them.

What we couldn't really figure out was, would the policy pay for the level of care that the resident had been using? When our resident transfers to assisted living or to skilled nursing, he or she may not trigger benefits under the common LTC policy.

What we have done is take a little different approach; we're covering the first 100 days of nursing care under the resident's basic fee, then the resident has a choice.

Right now we are offering one-, three-, or five-year periods. And we call this an exclusion period, where the residents will pay the daily rate for nursing care during that time. Ideally, what's going to happen is that they are going to use the LTC benefits to make up the difference. While we are in the exclusion period, the residents will return to the monthly fee from the apartment they last resided in.

But we are worried that either someone's benefits will be exhausted in their LTC policy, or we're not running into a lot of people who have unlimited benefits. A lot of people have bought specific contracts and probably some of you know more about what they bought than I do. We decided to give an entry-fee discount to this particular product rather than a monthly fee discount, but it is the price either way.

Here's an example of how it works. The nursing care is about $5,500 a month in our average facility; that is the per diem rate for somebody coming in off the street. Our average residents pay $2,500 a month in their monthly fee, so the additional cost for that 1-, 3-, or 5-year period is about $3,000 a month, so an LTC policy with the benefit of $100 a day the residents would break even.

We have been marketing this for about a year in 2 of our communities and sold probably 15 contracts. Table 2 gives you an idea of the kind of discounts we can give people for this particular product. For a 1-year exclusion period, we can give an entry-fee discount of about $21,000. If we convert that on a monthly fee basis, it could be about $175 per month. We found in some test proofs with people on a waiting list that the entry-fee discount was the preferred method to discount this particular product. If we go up to 3 years, we have about a $35,000 discount. In 5 years the discount only goes to about $40,000, because the average length of time in nursing care is probably around a 2.5- to 3.5-year period.

TABLE 2
LONG-TERM-CARE INSURANCE
- Discount Offered

Exclusion Period	Entry Fee or	Monthly Fee
1 year	$21,000	$175
3 Year	$35,000	$275

That's the way we, as an organization, tend to deal with LTC insurance. For somebody who is 65 years old and has purchased his or her LTC coverage, they are probably better off taking our discount and working through the elimination period. For somebody 75 years old, he or she can't buy the policy and make money with what is offered.

Our average resident moves in at age 75, and we want to make sure that our discounts are a little bit less than what they can buy a policy for at age 75, because we would rather have them in our insurance plan if possible. But as the LTC industry evolves, and we're beginning to see this, more and more people have this

coverage purchased at a younger age. If there is a way we can still get them into the community, that is our goal. You don't want to limit our market and not be available to people who own LTC insurance.

The last thing I want to cover is a couple of entry-fee plans. The first item is the monthly fee for services. Basically, there are three common entry-fee plans that we see today, and there are variations on all of these. The first is a 2% declining refund, no refund after 50 months, and I would say probably 40-50% of the retirement community in the U.S. today offers that type of plan.

You'll also find that communities may offer an age-rated refundable plan. Gary talked a little about how life insurance could be used for this. But someone would pay an additional premium to get a permanent refund. We have a plan that we offer that if you want a refund of 50% of your total fees, the additional premium is about 15% on a 65-year-old and 45% for an 85-year-old. That really is just a single life policy if you think about it.

The next plan that we are offering is what we call a combination plan. We divided the fee into two components. This is really marketing-driven, and it is a little bit of semantics, I think. What we have is what we call health-care and residential portions. The health-care portion declines at a rate of 2% a month, or it becomes immediately nonrefundable depending on what state you are in. Certain states make us have a refund provision; other states do not regulate this.

The residential portion declines to some level but retains a permanent refund. For example, the residential portion declines at a rate of 2% a month for 25 months so that there is a 50% permanent refund in the contract. This is a hybrid year. We are seeing a proliferation of different contract options and entry-fee options in the industry.

This, in particular, is what we are starting to see in New York. There are only, I think, three CCRCs operating in New York today, but there are about six or eight on the drawing board and this is a very common plan in New York. Finally, the LTC insurance discount, which we described, is a way to bring additional people into the pool and move into the community.

Richard Coglata, GE Financial Insurance: You mentioned that the industry operates on a cash basis and that is a little scary, but what I was thinking about is there is a lot of debt financing going on tax-exempt bonds, so it would seem that a lot of the fiscal and actuarial discipline would bear on the holders of those bonds and the structuring of the bonds. I have some questions on that.

First, regarding the collateral behind those bonds, is real estate put up for collateral? Second, are the bonds publicly placed or privately placed? Third, do the bankers employ actuaries and the underwriting process? Fourth, what is the overall size of that debt-bond market and the CCRC market in general? I have no idea how big this thing is in aggregate.

Mr. Yost: Those are good questions. Typically for the collateral, for the community, there is a lien on all the revenues, as well as the physical assets, so the entire facility is really put up. State regulations get mixed up in this because the purchasers of the bonds or the provider of the financing will have to deal with this specific state's regulation in terms of resident's rights and means, so that does differ in some states.

These bonds are generally publicly placed. Most start up for time in communities unless they are part of a group where there is a group guarantee that they are not part of investment-rate activities. We issue what is known as "junk" bonds. There are, as you know, high-grade or high-interest-rate, tax-exempt bonds, and generally a project will refinance within five to ten years. Whether at some advance refunding or at the ten-year call date, there will be a permanent refunding because by then the financial model has gotten much stronger.

Moody, Standard & Poors, and Fitch Investor Services today are now waiting for these institutions. We have a five-year-old community. It is a triple B+; we have a nine-year community that is an A-. It is possible to bring them up to investment grade very quickly.

I think the marketing and construction risks are considered so great that initially it is hard to get an investment-grade rating on these. The available marketplace for bonds is tremendous; state tax-exempt bonds funds purchased the bonds as well as individuals on the short-term that are taken out by entry fees. You will see 50-60% of those sold to retail investors and usually institutional investors. The money-market funds and the long-term bond funds will purchase the rest of the bonds.

We also have used bank letters of credit to enhance the bond issue, which will bring the rate down significantly. There are a number of foreign banks that will ensure these deals and provide letters of credit on short-term bonds they like to be taken out with the entry fees from the first generation of move-ins. There are not a lot of domestic banks that get involved in start-up projects, but they do come in later and provide longer-term letters of credit to guarantee the longer-term bond.

It is kind of a mix in terms of what the market is and what is available. Do investment bankers require actuarial studies? Sometimes. We are regulated by the Department of Insurance in every state but one, and they are the ones that are requiring these actuarial studies. The investment bankers love to use that to help sell the bonds.

Richard Coglata: Just a follow-up. I know that the bond market is very large on the demand side. I was thinking of how many CCRC bonds are out there. What is the size of the CCRC market in terms of any metrics?

It was in the billions last year. BC Ziegler was the leading underwriter in the CCRS market and they issued maybe $12 billion. Don't quote me on that number, but there are a lot of bonds outstanding.

The size of the bond market is easily getting into the billions because, again, the average bond issue nowadays is going to be usually in excess of $100 million, so you get to $1 billion pretty darn quick if you are using income of $100 million. You spend the real dollars really quickly.

Mr. Yost: Just let me refine my comments on the notion of early-cash basis. The large number of investment bankers and some letter-of-credit banks that Bill was talking about do use actuaries. I can think of two foreign banks right off the bat. They will use actuaries to show the present-value basis. There is a wide amount of surplus that really by and large is cash-flow driven.

Bill talked about refinancing, whether it is advanced or crossover refunding after five or ten years. Because of that refinancing, the financial structure changes and so the private-defending bankers here may not use actuaries as much because the structure is going to change. Typically, the feasibility study that the institutional or retail investors will look at will be the feasibility work done by the Big Six accounting firms, which is just going to look at projected financial statements for the next five to seven years. And while the actuaries do use population projections that the cash flows are driven up there, I can't think of one official statement that is going to have an actuarial presentation from the present values presented in it.

From the Floor: Is there a difference between the use of the facility care for CCRC versus LTC in short population in terms of the types of services? Would the population be more readily using the care? Just because the facilities are there, would they be more likely to use them?

Mr. Brace: Yes, good question. One of the issues, and I think Bill can talk more about this, is the benefit triggers that are typically used in LTC policies versus maybe the trigger that the facilities use before they try to transfer residents. Unfortunately, the benefit triggers vary across each facility, depending upon the people doing the valuation. Because, after all, this is kind of the last step before death. The resident's family is really reluctant to admit that their relative is going to be transferred to that higher level of care, and that could affect the decision.

Mr. Yost: Unfortunately, sometimes the availability of the bed affects the decision, too. It's kind of a joke at the expense of the actuaries that there are going to be incorrect population projections, because if we project a bunch of capacity in health center, then maybe the transfer policy will be loosened up. If there are fewer beds, we are wrong, because then they transfer more. Or if we say, "Well, you guys watch your transfers. You're going to overshoot the capacity," then, boom, they become really hard-nosed about the transfer and then we are wrong again. Again, you chase your tail, but I think that is a real valued concern that you know there may be a mismatch between what triggers the transfer and the bed availability.

And I think, Gary, I assume that in the community that included all the nursing care at the same fee you are going to see a little higher transfer. I would like to see that study, because of a little higher number of transfers we've noticed in our communities. It is not statistically valid yet, but we have noticed a little more

nursing utilization where they don't pay extra for the nursing care. For those where you do pay extra, it is economically driven as well.

From the Floor: When someone goes into the facility, how long do you hold onto the residence before you sell it?

Mr. Yost: When people transfer from the residential unit, different communities deal with this differently. In our particular communities, if somebody has a likelihood of moving back to their residential unit, we will maintain basically two living spaces for them: one in the health-care area temporarily and their residential unit. If the family, physician, and individual determine that the likelihood is smaller-to-none that they will return, then we will turn over the unit right away. It could be as quick as two or three weeks, but we do involve the family and the resident in that decision. Other communities have hard-and-fast rules on that, but they'll hold it for 30 to 60 days. It just depends.

Just a couple of closing comments. While CCRCs are certainly a fairly common entity and there is opportunity there, they are not really intended to be a broad-based delivery mechanism for LTC insurance because, again, you see the upper crust of society in these facilities.

There have been several attempts to make them more moderately priced facilities around the country. North Carolina looked into this several years ago and was unsuccessful. They can't make it work because of the cost of real estate and construction. All these issues now make it really difficult, and so where 10 years ago you saw bond issues of $50-60 million, a relative pittance, now you are seeing $100-130 million. It is difficult to get an attractively or moderately priced mechanism built into that, so you are seeing the cost of these things going up and up, and, of course, the entry fees and monthly fees, and you are getting this more well-to-do resident in addition to that.

I think some of you probably know the sources of these, but if you are interested, the SOA Study Note, which I wrote back in 1993 or 1994, is a good source. Then the Standard of Practice, but again the standard isn't quite the educational thing that the Society Note is, but it is another source. Also, there is a two-page summary that I wrote in the health section back in 1994, which gives a quick synopsis of what CCRCs are all about relative to actuarial science.