New Directions in Life Care: An Industry in Transition

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THE GREATEST CHALLENGE TO THE HEALTH CARE system will be the provision of long-term care and support services for the rapidly increasing elderly population. Our current approach to financing long-term care is not adequately meeting today's needs and shows no sign of being able to respond to the future long-term care needs of dramatically increasing numbers of disabled and chronically ill elderly. State policy makers are restricting the growth of nursing home beds and tightening reimbursement policies in order to arrest the growth in nursing home expenditures, which have been doubling every five years and which account for nearly half of all Medicaid costs. At the same time, the Medicare program is drawing a clearer line between what it will pay for (i.e., acute care) and what it will not cover (i.e., chronic care). With the growing recognition among the elderly of the limitations of current coverage and their financial exposure to catastrophic long-term care costs, insurers, providers, and individuals are searching for private-sector solutions to provide economic and physical security for the growing elderly population.

One option currently offering such protection is the continuing care retirement community (CCRC). As of 1986, about 700 CCRCs provide retirement security, health care, and financial protection to a small but growing number of elderly. CCRCs, also known as life

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care retirement communities, have provided housing, health care, social activities, and meals to the general elderly for over twenty years. While there are many variations, a typical CCRC has approximately 200 independent-living apartments and two or three levels of on-site health care, such as personal care and intermediate or skilled nursing care, on either a campus or in a high-rise complex. CCRCs offer "long-term contracts which typically guarantee shelter, health care, and various other social services for the rest of the resident's life, through the same risk-sharing principles on which commercial insurance policies are based" (Winklevoss and Powell 1984).

What is important about CCRCs is that they provide a viable model for comprehensive long-term care protection. In fact, one of the few comprehensive and financially stable long-term care insurance products available today is offered by a portion of life care communities. About one-third of these communities provide unlimited coverage for long-term nursing home care on a pooled-risk basis funded from residents' entry and monthly fees. In this way, they insure against long-term care costs so that no one in the community has a catastrophic expenditure or spends down their assets and goes on Medicaid.

This is in contrast to the prevailing long-term care insurance industry approach which provides very limited indemnity benefits for primarily skilled care. (Notable exceptions which are developing to broaden the scope of services and financial protection available within "long term care insurance" include the social health maintenance organizations (SHMOs) and a new joint offering of Group Health Cooperative of Puget Sound and Metropolitan Life Insurance.) CCRCs demonstrate that risk-pooling for all long-term care can be accomplished successfully with relatively small populations (e.g., between 200 and 300 residents) if adequate prefunding exists. Thus, CCRCs can fill an important void in current long-term care financing.

Life care is a rapidly growing industry with twice as many CCRCs in the planning and development stages as currently exist (Traska 1985). Those searching for viable private-market solutions may be initially heartened by this growth. But it is troubling that, along with this growth, the life care industry may be losing one of its most important distinguishing features—the pooling of risk for unlimited long-term care. At a time when other actors in the long-term care field are looking eagerly toward various models of risk-pooling and

long-term care insurance, the life care industry, which first embraced these concepts, seems to be moving in the opposite direction. Newer communities emphasize lifestyle and housing while offering little or, in some cases, no opportunity for insuring long-term care costs. Long-term care risk is being shifted quite evidently from the community as a whole to individual residents. More and more communities require residents to pay on a fee-for-service basis for needed care although they may still guarantee access to the nursing facility when needed. Some of these "fee-for-service" communities have low entrance fees or no entrance fees. Many other new communities establish extremely high entry fees designed fully to cover lifetime housing costs. In this way, the sponsor need not assume the risk that residents will survive in the community longer than expected.

As a result of these changes, today's CCRCs offer inadequate insurance for long-term care, are affordable to a smaller and more affluent segment of the elderly than was true in the past, or both. If nursing home costs in the CCRC are paid by residents on a private fee-for-service basis, then having wealthier residents assures that few, if any, will be unable to pay the full nursing home rates or will spend down to Medicaid. If this industry trend continues, fewer elderly will have access to the kind of physical independence, financial protection, and health security available in CCRCs. Also, as CCRCs continue largely to attract the wealthier elderly, fewer private-pay patients will be available to offer cross-subsidies to the Medicaid population in nursing homes in the general community. Given the inadequacy of Medicaid rates to cover nursing home costs in most states, this trend could further constrain the financial well-being of nursing homes, which could have serious implications for the appropriateness and quality of the care they provide.

What accounts for the recent increase in new communities that do not offer all-inclusive life care contracts? Is the industry moving away from long-term care insurance because it is a difficult concept for small populations? Or are these changes motivated by changes in community sponsors, by elderly consumers, by changes in the marketplace, or by some dynamic interactions of these factors? The life care industry today is characterized by a multitude of new and varied sponsors. The rapid growth in the number of new communities comes from new sponsors in the industry more than from the expansion of

current participants. Analyzing the motives and capabilities of these new industry players will be important to an understanding of life care's new directions.

In this article, we describe current industry changes and identify the factors behind these trends. Industry changes of interest include sponsorship, service emphasis, financial arrangements, and the extent of risk-sharing and insurance. We explore whether the move away from full long-term care insurance is based on the experience that these risks are, in fact, not insurable or whether other factors are responsible. We speculate on whether current trends will continue and identify forces that may come into play to reshape the industry. We also discuss why state and federal policy makers should be concerned about these industry directions and suggest possible strategies to encourage the development of affordable full-guarantee life care communities.

Overview of a Diverse Life Care Industry

A wide diversity of entities call themselves "retirement communities." They vary significantly in terms of the services provided, the costs and extent of the contract, sponsorship, financing, and other aspects. This section provides a "snapshot" of today's life care industry. Because we are looking at essentially a "moving target," a more illuminating industry profile, presented in a subsequent section, examines changes over time.

Today's CCRCs are modern variations on early church-sponsored programs. Although the median age of all CCRCs is 19 years (American Association of Homes for the Aging 1987), the concepts embodied in life care go back centuries. The earliest models of today's life care communities were church-run homes that cared for aging ministers without families. Over time, nonprofit church-affiliated groups also began to provide services to a broader population of elderly congregation members who had no families. The chief distinctions between today's CCRCs and their predecessors are the scope of services provided, the type of sponsor and its relationship to the resident group, the mode of financing, and the extent of diversity that characterizes the industry.

Basic Features of the Industry

Estimates of the current number of CCRCs vary because of a lack of consensus as to what types of retirement facilities should be considered a CCRC (Pies 1984). The most recent estimate is that there are 700 communities (American Association of Homes for the Aging 1987), although other sources have identified anywhere from 600 to 900 communities (Topolnicki 1985). About two-thirds of all CCRCs are located in the north-central and southern regions of the United States. With the exception of New York State (which continues to prohibit the prefunding of long-term care), the five states with the largest elderly populations also have the greatest number of all CCRCs. These are California, Florida, Pennsylvania, Ohio, and Illinois, which together have almost one-half of the nation's CCRCs (American Association of Homes for the Aging 1987; Winklevoss and Powell 1984).

CCRCs enroll primarily healthy elderly residents who are capable of independent living. Most communities employ health entrance screens based on individual interviews or a personal physician's assessment of the applicant's ability to function independently. The average age of CCRC residents is 81 years, and the majority of residents are single (73 percent) and female (76 percent) (American Association of Homes for the Aging 1987).

Nearly all CCRCs are operated by nonprofit organizations (97 percent) and many are affiliated with a religious organization (87 percent). As of 1981, only about 1 percent of all CCRCs were identified as having proprietary sponsors (Winklevoss and Powell 1984). Nearly two-thirds of all CCRCs were affiliated, however, with another organization. Most often, this affiliation was with a management firm. Nonprofits account for 94 percent of affiliations, while proprietaries represent a still small but more significant share of these affiliations (6 percent) than is true for primary sponsorship (Winklevoss and Powell 1984).

Services, Costs, and Pricing

The specific services provided in CCRCs vary, but can usually be classified into three types: health care services; supportive and preventive health care; and nonmedical services such as meals, housekeeping, recreation, and transportation. Communities differ in the amount and

type of services provided, in whether an additional fee is charged for various services, and in the design and amenity features of the community. For example, CCRCs can be high-rise apartments in urban/suburban locations, or garden-apartment style communities on rural campuses. They can be plushly decorated with amenities such as fireplaces, swimming pools, or health clubs, or more modestly appointed with few amenities.

Perhaps the most significant variations among CCRCs are in the extensiveness of the health care guarantees they provide. About one-third of all CCRCs offer all-inclusive contracts, where unlimited long-term nursing care is provided for little or no substantial increase in monthly payments. Another third of CCRCs provide residents with modified contracts where only a specified amount of long-term nursing care is provided for little or no substantial increase in monthly fees. Beyond the specified amount of care, residents pay either a discounted rate or the full per diem rates for nursing home care. Finally, just under one-third of all CCRCs are operated on a strictly fee-for-service basis. While access to nursing care is guaranteed, residents who require care pay full per diem rates (American Association of Homes for the Aging 1987). Communities with extensive guarantees are also more likely to offer a more comprehensive package of health care services than communities with more limited guarantees.

The significant variation in CCRC fees is due in part to differences in the services and guarantees, although location, age, and style of the community also influence price. In 1981, median entry and monthly fees were $35,000 and $600, respectively. Typical of the rate and nature of change in the life care industry, these 1981 cost figures are not very representative of today's fees. As of 1986, median entry and monthly fees for a two-bedroom unit were $65,000 and $808, respectively (American Association of Homes for the Aging 1987). CCRCs with entry fees above $150,000 and monthly charges above $1,500, however, are not uncommon today. This increase is a function of increased development, construction, financing, and marketing costs as well as changes in the style, services, and pricing arrangements for today's CCRCs.

Benefits and Disadvantages of Life Care

Perhaps the most important benefits of life care for its residents are the access to high-quality health care and financial protection against

catastrophic long-term care costs. The lifetime guarantee of access and insurance for nursing home care is an important advantage not currently available to the elderly through any other option. (Certainly, other types of long-term care insurance products could be designed to provide both access and financial protection similar to that found in CCRCs, and some emerging products move closer to the life care model in this regard than prevailing products.)

The CCRC's emphasis on maintaining independent living is also of importance. CCRCs offer residents an opportunity to remain "vital" and part of a social network. While there are reports of longer life expectancy and less hospitalization among CCRC residents compared with the general elderly population, no scientific studies have been done to test this hypothesis.

Still, most elderly do not join a CCRC. One disadvantage of joining a CCRC is having to move from the family home. Surveys indicate that the elderly prefer to remain in their own homes and that most do not prefer age-segregated living (Tell et al. 1986). For many, the campus lifestyle is a disadvantage, since it may restrict independence or privacy. Finally, the cost puts CCRCs beyond the reach of the vast majority of elderly. One source estimates that less than 10 percent of all elderly can afford them (Cohen et al. 1987).

An Industry in Transition

Life care is a rapidly growing industry. Current predictions suggest that by 1999 there will be 1,500 CCRCs (Traska 1985) with nearly 450,000 elderly residents, or about 1.3 percent of all persons over the age of 65, compared with only 0.4 percent at present. While these numbers in absolute terms are quite small, they reflect an increase of over 200 percent in the CCRC market.

This recent growth has fostered significant industry change. There are important differences between today's life care communities and the CCRCs of the 1960s and before. Key features of the life care model which have changed include: who is served; who bears long-term care risks; the extent of financial obligation that residents face; and the ability of the CCRC model to meet the long-term care needs of a rapidly increasing elderly population.

An Overview of Industry Change: Three Vignettes

Three brief vignettes of a "typical" CCRC of the 1960s, 1970s, and 1980s provide a "flow analysis" to illustrate important changes over time that will enhance our understanding of today's industry configuration. These vignettes are oversimplified to illustrate key changes in the industry.

A 1960 CCRC. A community of the 1960s was most likely initiated, owned, and operated by a religious group to provide retirement security and health care to a small group (about 250) of elderly residents. Most often, these earliest residents were retired professionals from education, religion, or health care, and others of moderate but not modest means.

Community sponsors bore the risk of long-term care for their residents, offering full guarantees for nursing care. The CCRC of this vintage offered a balance of medical care services, preventive/supportive services, and physical plant services. Compared to today's communities, the 1960 CCRC was more likely to include: therapy for psychiatric disorders, special-duty nursing, referrals to specialists, private rooms in the nursing center, dental care, and a community physician. In part, these services may have been emphasized in the 1960 communities because they predate the Medicare program which later covered many of these services. Additionally, in this pre-Medicaid era, community sponsors may have felt a keener sense of social responsibility to protect and provide for their residents.

Communities of this era employed a variety of sources to finance construction. Many of the pre-1960 CCRCs evolved from homes established through individual bequests and endowments which were used as seed money for new facilities. Other sources of financing included FHA-insured mortgages (for those built in the early part of the decade), conventional mortgages, and, to some extent, entry fees. These sources were used alone and in combination with each other.

CCRCs established in the 1960s were less likely to offer a refund upon death of a resident (42 percent). As a result, more modest entry fees could be charged. Today's typical entry/monthly fees for a community established in the 1960s are about $35,000 and $600, although factors other than the age of a community influence its price.

A 1970 CCRC. A CCRC of the 1970s was more likely to see the involvement of multiple sponsors, although the majority were still

initiated, owned, and operated by a religious group or other nonprofit sponsor. These communities were larger, with an average of 300 to 400 residents. Residents were drawn largely from retired professional groups, although a broader spectrum of elderly became aware of and interested in CCRCs. These communities were still largely oriented toward highly educated elderly of at least moderate means.

In this era, we see the beginnings of a shift in risk-bearing from the sponsor to individual residents, in the form of monthly fees which are allowed to increase over time to offset errors in actuarial or financial projections on the part of the sponsor, although residents bore this risk as a community. From this shift, CCRCs may have become a little less affordable to some elderly because only those with sufficient wealth to accommodate unknown increases in monthly fees could assuredly afford this option.

The 1970 CCRC continued to offer a balance of medical, supportive, and physical plant services comparable to those offered in earlier communities, although more emphasis was placed on housing features. These CCRCs were a little more "upscale" in design and were more likely to include parking, transportation, kitchen appliances, and personal laundries.

Communities of the 1970s were financed primarily through conventional mortgages in combination with other financing, most often entry fees and, in the latter part of the decade, with tax-exempt bonds. CCRCs established in the 1970s were somewhat more likely to offer a refund upon death of a resident (60 percent). Today's typical entry/monthly fees for a community established in the 1970s are about $60,000 and $900. (Again, other important factors influencing price include extensiveness of guarantee, location, mode of financing, and construction costs.)

A 1980 CCRC. There are more differences in today's CCRCs than there are similarities with the earliest models. The four major industry changes evident in this decade are: a dramatic increase in the diversity of life care sponsors and developers, including greater proprietary involvement; significantly higher, but refundable, entry fees; rental models with no entry fee; and fee-for-service health care models. A greater burden of the risk is now placed on individual residents.

While nonprofit sponsors still predominate (94 percent compared to 97 percent in pre-1980), for-profit groups, alone or in partnership with nonprofit entities are more frequently involved in CCRC de-

velopment and operation. Similarly, while religion-affiliated sponsor groups dominated the scene in the 1960s and early 1970s, development firms, real-estate investors, insurers, bankers, and nursing home and hotel chains are becoming increasingly visible in the life care industry.

The trend toward larger communities continues in the 1980s, with an average of over 300 residents. Residents are increasingly being drawn from professionally diverse groups of elderly within a relatively small proximity of the community (about 25 to 50 miles). Today's CCRC entrants are much more affluent than residents of earlier communities, since entry and monthly fees are substantially greater.

Many of these newest communities emphasize physical plant, amenities, and lifestyle over insurance and the extensiveness of the health care benefits. As mentioned, they are less likely to include therapy for psychiatric disorders, special-duty nursing, referrals to specialists, private rooms in the nursing center, dental care, home health care, coverage for out-of-area care, and a community physician. In this decade, a new model emerges that offers health care on a fee-for-service basis only, and which may offer apartments on a rental basis, with no entry fee. The 1980 communities continue the trend evident in the earlier decade of an emphasis on features like parking, transportation, kitchen appliances, personal laundry, swimming pools, and other amenities. In terms of decor, service features, and setting, these communities can be described as "plush" compared to the more modest communities of earlier decades.

Today's communities are financed primarily through tax-exempt revenue bonds and entry fees. These communities are much more likely to offer a refund upon death (80 to 95 percent), although generally it is contingent upon reoccupancy of the apartment unit. As a result, entry fees have soared. Entry fees may reach or exceed $250,000, and monthly fees typically run between $1,000 and $2,000. It is estimated that the 90 percent refund provision prevalent today increases the entry fee by at least 50 percent (Lublin 1986) and possibly by as much as 80 to 100 percent.

Factors Influencing Industry Trends Away from Full Insurance

Many forces have been involved in shaping the changing direction of the life care industry to its present form, which is characterized by

great diversity, greater affluence, and less focus on health insurance. This section offers some explanations for these changes and discusses how they have influenced the industry.

Concern with the Insurability of Long-term Care

The move away from fully insured life care models may be caused by a growing belief that long-term care risk is not insurable. The market for private long-term care insurance has been slow to develop for many reasons, including the lack of data on which to project lifetime resource use and concerns of insurance-induced demand.

Experience has shown, however, that long-term care risks can be shared across a relatively small elderly cohort, as has been done in many life care communities, some of which have been operating successfully for over 20 years. Of the approximately 40 community failures to date, few, if any, can be attributed to long-term care costs in an experience-rated system. The most widely publicized life care failures occurred in California in the 1970s. While these failures were somewhat related to unexpected increases in long-term care expenses, they emerged largely from the fact that the communities offered contracts that limited the amount of increase in monthly fees that could be applied to cover increased costs. If the communities had had the flexibility in their contracts to increase monthly fees, these failures might not have occurred. Certainly, problems in marketing and poor management will continue to pose a threat to the success of CCRCs. But the guarantee to cover lifetime long-term care costs need not be a reason for a community to fail.

The performance of the vast majority of successful CCRCs illustrates in practice what we observe in theory, that long-term care is an ideal candidate for risk-sharing. This is because extended nursing home care has a small chance of occurring for any one individual, but when it does its costs are significant. Specifically, a 65-year-old faces only a 13 percent probability of facing a nursing home liability in excess of $40,000 and only a 9 percent probability of incurring over $100,000 in nursing home costs over a lifetime. But even one year in a nursing home (about $25,000) represents a catastrophic expense for between 60 to 80 percent of all elderly.

The ability to insure effectively long-term care in the CCRC depends upon three factors: (1) the prefunding of future nursing home costs, where residents enter healthy and pay into the nursing home reserve

fund for some time before they draw out of the fund; (2) the reasonably accurate prediction of economic trends and expected mortality and morbidity for an entry cohort, along with experience adjustments; and (3) the fact that nursing home use is a very skewed distribution, with only a small proportion of residents using the majority of resources. Specifically, only about 15 percent of all elderly use 90 percent of all nursing home resources, while the vast majority of elderly consume very little nursing care in their lifetimes (Cohen, Tell, and Wallack 1986a). This means that while the costs of nursing home care are catastrophic for an individual they are affordable to a group.

The CCRC's ability to predict accurately morbidity, mortality, and economic trends is especially crucial. If forecasts of financial trends and expected utilization are not correct, the risk pool may not be able to fund the health care liability. Establishing monthly fees that can be increased over time to adjust for increases in costs and utilization has strengthened the industry. Other methods of protecting against community failures include: screening new entrants for health status, using more conservative actuarial assumptions, building larger communities to minimize risk, and carefully managing nursing home use.

The success of the long-term care insurance component in life care depends upon an experience-rated approach, rather than simply prefunding lifetime nursing home costs across a cohort. In this context, "experience rating" refers to the establishment of fees based both on actuarial forecasts and historical experience of the community (or similar communities) and monitoring and adjusting those fees based on actual utilization experience. Rates also need to be set such that adequate reserves are established. Thus, the experience on which community rates are based is the lifetime experience of individual residents. A key question then becomes: Is there enough experience in the marketplace to enable CCRCs to experience rate properly? While there seems to be sufficient experience, the significant amount of variation in CCRC nursing home use rates makes it somewhat difficult to interpret and establish accurate prices based on previous experience. While we may know that the life care model works, we are less confident of how the model will perform under varying client and system variables. One approach, therefore, is to be fairly conservative in establishing fees and to continue to analyze the life care experience to facilitate more accurate pricing.

The CCRC experience also suggests that the problem of insurance-

induced demand can be adequately addressed when insurance for long-term care is combined with: appropriate financial incentives to provide cost-effective care, resource constraints, and a managed care approach. Nursing homes are used differently in some CCRCs than in the general population. Although CCRC residents are more likely to enter a nursing home at some point in their lifetime and are also more likely to have repeat nursing home entries, they have much shorter lengths of stay per admission than the general elderly population. Based on an in-depth study of six CCRCs, we find that the mean length of stay per admission in the CCRC is only 179 days, compared with 455 days for the non-CCRC population (Cohen, Tell, and Wallack 1987a). As a result, lifetime costs under an insured system of care, like the CCRC, can be comparable to cost levels for the general elderly population. Considering the enhanced quality and access to care in CCRCs, and the assurance that no one will spend-down their assets, this is a fairly negligible cost difference.

There are several reasons that may explain the different nursing home use patterns in CCRCs, despite the presence of full insurance. The CCRC's fixed nursing home bed supply serves as a resource allocation tool to ensure that care is given where it is most appropriately needed. As evidence of this, one finds that CCRCs that admit noncontract residents to their nursing homes at full per diem rates have lower rates of nursing home use for their residents (Bishop 1988). While the extent to which formal case-management techniques are used in CCRCs has not been documented, many communities employ case managers and rely upon a variety of strategies to prevent or delay the need for institutional care. Clearly, most communities have incentives to keep residents healthy and out of the nursing home and they employ a variety of approaches to that end (e.g., providing routine preventive care, providing in-home health care, encouraging residents to provide informal supports for each other, adapting resident apartments for those with activity limitations or special needs, etc.). Thus, an important factor in the CCRC's ability to manage effectively long-term care costs is the fact that the entity that insures care also provides and manages care.

More research is needed on factors that influence patterns of nursing home use and costs in CCRCs, since there is significant variation in departmental costs across communities, from a low of $2,000 per resident per year to a high of $14,000 (Bishop 1985). While resident

characteristics play some role in determining nursing care use rates (Cohen, Tell, and Wallack 1986b, 1988), "community" variables account for over 50 percent of the observed variation (Bishop 1985). Embodied in these community variables are factors such as resource supply, extensiveness of the guarantee, financial incentives, management policies, and others.

Sponsorship

The most important factors influencing industry change, in particular the trend away from insurance and risk-pooling, are changes in sponsorship, alone and in interaction with changes in the characteristics of the population served. Most CCRCs are operated by nonprofit organizations and/or are affiliated with a religious organization. In the current half of this decade, however, for-profit sponsors and new sponsor types have entered the CCRC industry in increasing numbers, first, as management firms for communities owned by religion-affiliated groups, and second, as primary sponsors. Sponsors relatively new to the industry include hotel, nursing home, and health care chains, hospitals, real estate investors and developers, and even a major cosmetics manufacturer. The proven track record of the model, its popularity with financial and other groups central to its growth, and the rapidly growing market of elderly with sufficient wealth to afford it have attracted new sponsors, including for-profits, to enter the field.

Other factors prompting the entrance of specific new sponsor types include the following: high interest rates and a shortage of investment funds make it difficult for certain entities to initiate new communities; real estate developers have been attracted by the opportunities for high returns on investment and the depreciation and tax benefits of life care; the introduction of reimbursement based on diagnosis-related groups (DRGs) and other hospital cost-containment programs are urging hospitals to look for new markets and new revenue sources; nursing homes are seeking to expand and assure a larger private pay market.

These trends in sponsorship appear to be a key factor shaping other changes in the life care industry, most notably changes in the extent of insurance, the benefit package, and the overall philosophy of life care that has prevailed to date. As mentioned, many newer CCRCs place greater restrictions on coverage, set caps on the amount of

guaranteed nursing care, or limit the number of services under contract. New CCRCs are increasingly offering amenities and enhanced physical plant services rather than health care and supportive services. Finally, there is an increasing interest in rental and fee-for-service options that only guarantee access to a nursing home, not financial protection against long-term care costs. In large part, these changes are associated with the new sponsor types who are more interested in and knowledgeable about the real estate, housing, or health service delivery components of the life care model. Because they have little or no experience with risk-pooling and prepayment for long-term care, they are likely to be frightened by the contingent liabilities represented by full guarantees.

The social objectives of life care sponsor organizations have also changed as new sponsor groups have entered the market and as more diverse population groups have been attracted to CCRCs. These changes have affected sponsors' willingness and need to assume a significant portion of long-term care risks. The earliest CCRC sponsors were religion-oriented groups that offered guaranteed life care as a social service to a relatively homogeneous population group with which they had a strong affiliation. They established the community largely out of a social responsibility to their membership group, or some extension thereof. For this reason, they were more likely to feel obligated to provide lifelong care and were more committed for the long run in serving this group. Newer sponsors are less likely to be religion-affiliated organizations and are likely to serve a more socially diverse population and one with which they are not closely affiliated. Thus, they may be less interested in the social goals of financial protection and health security. They are entering life care primarily as a business, made more attractive by meeting a social need for good residential environments and independence for the elderly. It is troublesome, but perhaps accurate, that *not* providing insurance with its attendant costs may make today's communities more attractive to the elderly than the earlier models which included insurance. In recent years, the improved financial status of the elderly, the availability of a Medicaid safety net, and the misperception that Medicare or private supplemental health insurance policies will protect against long-term care costs may also have enabled sponsors to shift their focus away from a social obligation to protect and provide for residents to more of a service-provision perspective.

Life Care Industry's Growth and Challenges

In this section the factors facilitating industry growth and current and future challenges to the industry are summarized.

Industry Growth

The industry has shown consistent growth, indicating an ability to attract financiers, sponsors, and, most important, residents. Factors that have influenced the rate and nature of growth within the industry include: demographic trends, availability of financing, trends in nursing home bed supply and long-term care costs, and regulatory initiatives.

The most rapid period of expansion in the industry, excluding the current boom, occurred during the 1960s. Nearly one-half of all retirement communities in existence by 1980 were opened during this period, although the definition of a retirement community for inclusion in this statistic is fairly broad (Marans et al. 1983). In the 1950s and early 1960s, the federal government encouraged the growth of CCRCs by providing federal mortgage insurance to aid in the development of new or rehabilitated rental housing for the elderly.

In recent years, the growth and popularity of CCRCs have been encouraged by many factors including: the lack of viable alternatives for retirement security for the elderly; demographic trends, in particular greater life expectancies which mean more elderly are living to the point where they anticipate requiring health care and assisted living; changing family dynamics which limit the extent of family care available to aging parents; and an improved financial climate for the elderly which enables more of them to be able to afford a CCRC.

Industry Challenges

The CCRC industry, however, has not been without its difficulties. Specific challenges that the industry has had or can expect to address include difficulties obtaining financing and marketing problems.

One industry challenge is the ability to obtain adequate capital and financing for development. A CCRC is an extremely costly undertaking. For example, a typical CCRC with 250 units and 75 nursing care beds will cost from $30 to $60 million in development costs. Obtaining financing has been especially difficult for the more traditional (nonprofit)

life care sponsors and this may partly explain the shift in new sponsor types to include more for-profits, developers, real estate groups, and others that are more heavily endowed and who may be in a better position to capitalize a new CCRC development.

Many different forms of financing have been and are being used. Based on a 1981 survey, CCRCs employed the following construction financing methods, often in combination with each other (totals exceed 100 percent): conventional mortgages (54 percent), entry fees (34 percent), gifts and donations (30 percent), tax-exempt revenue bonds (16 percent), FHA-insured mortgages (15 percent), other sources (11 percent), private taxable bonds (5 percent), and public taxable bonds (2 percent) (Winklevoss and Powell 1984).

Changes in mortgage markets, the economic climate, and the regulatory environment have influenced the sources of CCRC construction financing used over time. The oldest CCRCs (pre-1960) relied largely upon entry fees and, to some extent, upon conventional mortgages in combination with entry fees or gifts and donations. Most communities developed in the early 1960s were able to obtain FHA-insured mortgages. New regulations in 1964 prohibited the use of this source by many CCRCs, who then turned to conventional mortgage lenders. The newest nonprofit communities rely upon tax-exempt revenue bonds alone or in combination with other sources. Industrial revenue bonds are another current financing route.

A final area of challenge to the industry pertains to marketing. Only a very small percentage of the elderly can afford to or desire to live in CCRCs. One recent study indicates that only about 5 to 8 percent of all elderly can afford CCRCs (Cohen et al. 1987). While this is a small percentage of the elderly in relative terms, it would still allow for substantial growth in an industry that currently serves less than 150,000 residents. A more important market constraint may be the preference of most elderly to spend their retirement years in their own homes. Based on a telephone survey of over 2,000 elderly, the vast majority of elderly (86 percent) prefer to remain in their own homes and only 7 percent state an interest in living in a CCRC (Tell et al. 1986). Presumably, only some subset of this small group would also be able to afford one.

Because of these market challenges, communities today are more likely to fail as a result of inadequate marketing than from poor financial management. Recognizing this, lenders in many states now

require at least 50 percent in presales as a precondition to permanent financing. Also, because of the relatively limited market potential of life care as it is currently configured and priced, efforts are under way within the industry to diversify along both product and price lines in order to attract a broader segment of the elderly. A recent survey indicates that the elderly join CCRCs for a wide variety of reasons. Health care is one of the most important reasons, with insurance for and access to quality nursing home care being given nearly equal importance. Many elderly join for financial protection against long-term care costs, while others join primarily for social, recreational, or family reasons. Some join primarily for a more secure living environment (Tell et al. 1987). Being able to respond to different market segments will be an important element of the future marketing success of CCRCs.

Sponsors assert that CCRC consumers prefer an entry fee that is almost fully refundable, even though these fees are substantially higher than nonrefundable fees. In part, the greater involvement of adult children in their parent's financial and retirement planning may be one factor in support of refundable entry fees, since the refund reverts to the resident's estate. Also, more elderly today have the wealth to meet these higher entry fees. There is little available data that support or refute a strong consumer preference for these high but refundable entry fees. Both types of communities (the more traditional with no refunds and the newer model), once established, quickly generate a waiting list. More likely there is great demand for the variety of services offered by CCRCs because of the lack of other long-term care options, so any "good" program will have market appeal.

Policy Implications and Future Directions

How will these and other emerging forces affect the life care industry of tomorrow? What will the industry of the 1990s look like? While there may not be a consensus regarding what the industry will look like, there is certainly a consensus that it will be a prominent and high-stakes industry. One source speculates that within the next 8 to 10 years, life care will become a $46 billion industry. Forecasts suggest a lucrative market in two types of developments: "affluent life care communities that offer prepaid nursing care, and congregate

rental facilities, whose resort-style services usually exclude nursing care" (Lublin 1986). These latter models, however, cannot truly be considered "life care" communities.

Few forecasts suggest a dramatic return to the more modestly priced, fully guaranteed models of the 1960s and 1970s. In all likelihood, the industry will continue to include a diversity of models. The current diversity of models characterizing today's life care industry has both strengths and weaknesses. One of its strengths is that it offers consumers a choice. It provides different products to fill varying and various needs of the elderly. This diversity also affords an opportunity to test the marketability and performance of various approaches. It also brings new talent and financial resources to vitalize the industry. One problem created by all this diversity is that it becomes difficult for consumers to compare and choose between models that pose very different price tags and offer very different benefits. A more serious problem of the current configuration of the industry is that the predominance of limited- or no-guarantee communities does not reduce the elderly's exposure to catastrophic nursing home costs.

There are significant benefits to be realized from expanding the life care model to middle-income and even low-income elderly. These include benefits for individual elderly like financial security, enhanced access to high-quality care, and the ability to maintain independence and delay institutionalization. There is also an important benefit to public payers of long-term care from risk-pooling. The potential benefit to Medicaid from risk-pooling for long-term care is illustrated by the following hypothetical example. Consider a cohort of 100 65-year-olds with median incomes ($13,000) and assets ($12,000). They face about a 0.4 probability in 1985 of entering a nursing home at some point in their lives (Cohen, Tell, and Wallack 1986a). Of these 40 nursing home entrants, only about 20 percent of them will stay in the nursing home long enough to "spend down" their assets (about one year). But these long stayers will spend an average of 2.9 years each in the nursing home, incurring group lifetime nursing home costs totaling about $650,000. About 50 percent of this amount ($325,000) will be paid for by Medicaid. If these 100 elderly were enrolled in a CCRC with risk-pooling for long-term care, no one would spend-down and Medicaid would save $3,250 per enrolled person, or at least about 25 percent of total costs (Cohen, Tell, and Wallack 1987b).

There are various emerging trends that may stimulate interest in developing the more traditional life care options which incorporate all-inclusive health care guarantees and more affordable CCRCs. These two features need not be contradictory. Earlier CCRC models were both affordable and comprehensive in long-term care coverage in part because they did not incorporate a costly refund provision and because they employed a more modest design with fewer amenity features. Important forces prompting the growth of the more traditional life care options are the following:

- A growing awareness among the elderly of their vulnerability to long-term care costs. Surveys indicate that an overwhelming majority of elderly erroneously believe that their long-term care costs will be covered by Medicare or private insurance. Efforts are under way by state policy makers, consumer groups, and insurers to educate the elderly to their virtual lack of protection. As this begins, growing numbers of elderly, including those with more limited means, will seek out meaningful insurance protection.
- The increased reluctance and inability of Medicare and Medicaid to cover long-term care costs. State and federal budgets are already tightly constrained. State policy makers are seeking to encourage private options that can substitute for or prevent the need for public financing.
- Limits to the highly affluent market. Eventually, life care developers and sponsors will also need to reach out to less wealthy elderly who, nonetheless, have significant resources to invest in a life care option. While they may not be able to afford the plush $150,000/$1,500 model CCRC, they could meet more modest entry and monthly fees.
- Greater involvement of insurers in the life care industry. As more entities with insurance expertise take an interest in the life care marketplace, sponsors who are reluctant to assume the risk of providing fully guaranteed life care can team up with these insurance partners to offer models with more than just fee-for-service health care. Like other new entrants to the life care field, insurance companies are just as eager to enter the rapidly growing "mature" market and see health-screened retirement communities and elderly housing as an especially attractive entree to that market since marketing costs and adverse selection are reduced.

- Provider associations and individual nursing homes will support expanded private long-term care insurance, especially those products that cover catastrophic long-term care costs. Given the inadequacy of most state Medicaid nursing home reimbursement rates, the financial well-being of many nursing homes rests with their ability to maintain an adequate private-pay base. Insurance for nursing home care, especially the unlimited coverage that has characterized life care in the past, expands and extends the private-pay base.

From these trends, we also suggest that innovations on the traditional life care model will emerge that bring the benefits of CCRCs to elderly who prefer to remain in their own homes. One such model currently being developed is "life care at home," which incorporates the service-delivery features and risk-pooling aspects of a CCRC but which provides those benefits to elderly in their own homes (Tell, Cohen, and Wallack 1987). This approach reduces program costs significantly and makes life care available and affordable to a broader segment of the elderly population.

These forces have already encouraged some city and state governments to explore ways to offer subsidized or lower-cost CCRCs for mixed-income populations, to expand the long-term care protection inherent in that model, and generate Medicaid savings. Some possible approaches to offering lower-cost life care which would be affordable to moderate-income elders include the following:

- Configuring campus-model CCRCs in a less-costly manner. Research on CCRC cost variations suggests several ways to assemble less-costly CCRCs. The least-costly models have average departmental costs of $2,000 per resident, compared with $14,000 for the most-costly communities. Thus, significant economies in delivering campus life care are possible (Bishop 1985).
- Obtaining public subsidies for poor or near-poor participants to cover either the entry fee or, more likely, to assist in meeting monthly premiums. These subsidies could come from a variety of sources including public housing agencies, Medicaid, Medicare, and welfare programs. Medicaid might also cover a portion of the costs on a sliding-scale basis for those not eligible for Medicaid but at-risk of becoming eligible in the future.

- Establishing a CCRC around subsidized housing would remove housing costs from the program.
- Finally, developing an off-campus life care model like "life care at home", alone, or in conjunction with a campus CCRC, offers the benefits of traditional life care at a substantially lower price.

These approaches should be pursued. Public policy makers can also facilitate the development of affordable full-guarantee life care models by educating consumers to their current vulnerability to long-term care costs to create consumer demand for insurance models of life care and by offering tax incentives for elderly who participate in full-insurance CCRCs. States should also facilitate shared information on long-term care utilization and costs to assist program developers to establish sound insurance programs. Another state role is the development of reinsurance risk pools for CCRCs. Finally, states can encourage sponsors willing to take on long-term care risk through favorable regulatory treatment of communities that incorporate full insurance. While CCRC models with full insurance pose some concerns for states with regard to consumer protection, states can regulate life care along these lines (e.g., full disclosure and reserve requirements) while also facilitating their development through the certificate of need (CON) and licensure process.

Given the current shortage of capital to finance new communities and likely difficulties in staffing an increasing number of new communities, there is likely to be an even greater presence of proprietary chains and multi-institutional sponsors in the industry if growth rates are to continue. To date, many new communities have been able to attain "nonprofit" status and benefit from exclusion from property taxes, receive preferential treatment in certificate of need (CON) and other benefits while offering little or no return to the public in terms of financial protection of the elderly or in affordability. States should give more uniform and closer scrutiny to those communities which receive nonprofit status and should pose certain requirements in exchange for that provision which advance public goals like broadening long-term care protection for the elderly. For example, nonprofit communities with full guarantees could be exempt from CON requirements to facilitate full-insurance life care models that are most likely to generate some savings for Medicaid. In fact, many localities are reexamining property tax exemptions that have been traditionally granted to CCRCs.

States should maintain and expand their involvement in assuring consumer protection by, for example, assuring that a CCRC's financial status be periodically evaluated according to standards set forth by generally accepted actuarial practices and principles, and by simplifying contract language so consumers are fully aware of the benefits and protection they are (and are not) getting in various communities.

Considering even the more modest projections for growth in the life care industry, it is likely that the current diversity of sponsors and services will continue to characterize the industry for at least the immediate future. We have observed the importance of sponsorship in shaping the industry, in terms of the extent of long-term care insurance provided and the financial and pricing arrangements of newer communities. Therefore, it will become increasingly important for state policy makers and consumers to urge, encourage, and enable new sponsors to offer affordable models of life care that provide meaningful financial protection for the elderly.

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