Continuing Care Retirement Communities

An Empirical, Financial, and Legal Analysis

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To our children:
Amanda, Cameron, & Tyler
and
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Chapter Thirteen

Evaluation of Legislative Options

■ Chapter 12 reported on the formal legal positions of the states and the federal government vis-à-vis the continuing care industry. It contained a comprehensive review of existing legislation, court decisions, administrative regulations (where available), proposed legislation, and draft model statutes. Every attempt was made to keep the presentation contained in that chapter as neutral as possible; it was the authors' intent that no value judgments be drawn in that initial analysis.

In sharp contrast to the material in Chapter 12, this chapter draws many value judgments. These judgments are the views of the authors, reached after thorough collaboration with many persons familiar with and experienced in the continuing care field.

It will be readily apparent that this study has not proposed its own suggested model legislation. It was the authors' judgment that the typical state legislature considering implementation of legislation regulating the continuing care industry is blessed with an abundance of legislative options. Chapters 12 and 13 are designed to inform the typical state legislator—not to confuse him or confront him with additional complicating statutory language. Thus, it is the authors' hope that these chapters can serve as a catalyst for discussion in this area.

Foremost among our judgments is the conclusion that legislation at the state level will be appropriate in many states. The rationale underlying this conclusion cannot be explained in general terms; rather, the conclusion can be justified only through analysis of the value judgments drawn with respect to each element of regulation. It should not be surprising, therefore, that this chapter is again organized according to the various elements of regulation identified in the previous chapter.

This chapter contains a series of value-laden conclusions as to whether each of the identified elements of regulation has any place in state legislation. Some of these conclusions are based on no more than the authors' analysis of competing policy considerations. Others are based on more traditional types of legal analysis. Whenever appropriate, the authors have drawn on the study's results and based the conclusions on current practice in the continuing care industry.

It has been the authors' experience that each element of regulation fits relatively neatly into one of three categories:

1. First, some elements of regulation definitely belong in any state statute regulating the continuing care industry.
2. Second, some elements of regulation present much closer questions based on one's value judgments and analyses. In these cases, it was felt that some states might want to adopt such sections, while other states might prefer not to or might prefer alternatively phrased sections.
3. Third, certain elements of regulation should not be included in any enlightened state statutory scheme.

This chapter, therefore, contains an analytic commentary on which elements of regulation the authors have concluded to be appropriate in state legislative schemes. Reasonable persons can differ over the conclusions and opinions expressed in this chapter. It is for this reason that we have provided the underlying analysis for our conclusions as well as alternative proposed statutory provisions. In the final analysis, of course, each individual state must decide what form, if any, its legislative regulation of the continuing care industry will take.

One value judgment is implicit in all that follows. As noted above, the authors have concluded that legislation at the *state* level is appropriate. We have chosen this option in full recognition of the reality that, in order to comprehensively regulate the continuing care industry nationwide, it requires 51 independent legislative enactments, whereas an option involving *federal* legislation would involve the legislative action of only one Congress.

We made this choice for three reasons. First, because of the detail required and the nature of the subject matter, the type of regulation envisioned appears more suited to state administration than to federal supervision. Second, CCRCs are still relatively new, and, at least at present, it would be advantageous to encourage the variety of legislative programs that would develop at the decentralized state level. Third, a jurisdictional problem exists whenever the federal government attempts to regulate essentially local institutions.

This last point can best be explained by reference to H.R. 4170, the federal legislation introduced in 1977 by Representatives William Cohen and Gladys Spellman. That legislation regulated only "federally assisted continuing care institutions," which was defined to include

communities that offered long-term care to the elderly and engaged in interstate commerce, received Medicaid or Medicare reimbursement, or were constructed with federal assistance. It is the authors' judgment that too many communities might structure their organization so that they would not fit within this definition and would thereby be exempted from regulation should only a federal statute be enacted. This conclusion is reinforced by the history of the continuing care industry in Arizona and Florida, detailed in Chapter 12, where certain communities structured themselves so as to fall outside the definition of the regulated entity in the statutes of those two states and, therefore, escaped regulation.

DEFINITION OF ENTITY TO BE REGULATED

Based on the first comprehensive survey of continuing care retirement communities, it is known that the institutions variously referred to as life care, continuing care, living care, perpetual care, residence and care, and life lease are anything but homogeneous. Communities differ significantly in substance, depending on the respective termination rights of the community and the resident, the amount of services and medical care covered under the contract at no or a nominal extra charge, the length of the contract, and the financing arrangements between the resident and the community. Given the diverse characteristics of separate CCRCs, it is absolutely essential to draft a definition to ensure that all types of CCRCs will be brought within the scope of the statute.

Given the authors' conclusion that legislation will be appropriate for adoption in many states, it should not be surprising that we consider the definitional section of the CCRC statute to be an absolute necessity—that is, the definitional element of regulation clearly falls within the first category described in the introduction. A proper definition should include all contracts that last for more than one year or for the life of the resident (including mutually terminable continuing care contracts); that provide (either on-site or contractually) shelter and various health care services; that provide for either a payment of an entrance fee or periodic payments, or a combination of the two; and that are not completely based on a fee-for-service theory of payment (i.e., if there is *any* prepayment). In this way, the problems experienced in Arizona, Florida, New York, and Pennsylvania, which were discussed in the preceding chapter, can perhaps be avoided.

PREOPENING PROCEDURES: CERTIFICATION

This element of regulation involves an attempt by the legislating authority to screen "unacceptable" operators from the continuing care

industry. The theory behind certification requirements is that some sort of comprehensive application process, complete with required submissions, will enable the regulatory agency to determine the financial stability, capacity, sincerity, and integrity of prospective and existing continuing care operators. Such prospective certification, coupled with annual monitoring and various enforcement provisions, is the major mechanism used to supervise the financial stability of the continuing care industry by the states that have adopted comprehensive statutes.

As noted earlier, all statutes reviewed in the preparation of the study contain relatively extensive registration and certification provisions. Failure to comply with these provisions can result in the imposition of civil and/or criminal penalties. Similarly, there is some current discussion of the possibility of developing local, state, regional, or national self-accreditation programs. For example, seven communities in Pennsylvania, New Jersey, and Maryland have been attempting to establish such an accreditation program.[1] Such self-accreditation programs have worked efficiently to varying degrees with hospitals, nursing homes, mental hospitals, and schools.[2] Governmental reliance on a private accreditation system would not be unprecedented. For purposes of Medicare certification, the federal government usually requires no more of hospitals than that they meet standards set by the Joint Commission on Accreditation of Hospitals.[3]

It is the conclusion of the authors that certification requirements should be classified within the first category of regulatory elements discussed in the introduction—that is, they should definitely be adopted by all states implementing continuing care legislation. Yet, this conclusion is tempered by a unique twist that, to the authors' knowledge, has not been proposed in any other analysis to date. We urge that all legislation provide a mechanism whereby the administrator of the responsible agency in each state shall approve private self-accreditation programs that meet certain specified standards—some of which are provided in the uniform legislation and some of which must be developed through regulatory processes. Once a self-accreditation program has been approved by the administrator, all CCRCs that receive accreditation from that program should be exempted, in large part,

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[1] *See Kendal-Crosslands Annual Report for the Year April 1, 1978 to March 31,* at 6, 1979.

[2] *See* National Center for Health Statistics, Office of Health Research, Statistics, and Technology, Public Health Service, Department of Health, Education, and Welfare, *Health Resources Statistics: Health Manpower and Health Facilities,* 300 (1976–77).

[3] *See* 42 U.S.C. §1385bb (1976). In the JCAH, there are four organizations with arguably conflicting goals and interests that offset one another's parochial interests in the setting of policy, while all members of a CCRC self-accreditation program would have homogeneous views. But the analogy still has substantial value.

from the statutory certification procedures.[4] Finally, the legislation should require reapproval of each accreditation program at periodic intervals, such as every five years.

Legislative provisions on certification should contain two independent types of provisions. First, they should include provisional certification procedures to be applied only to new prospective operators who have not yet acquired the necessary facilities or land or who have not yet begun construction of a CCRC. Such operators should be required to submit advertising, organizational information, a statement of proposed location and size, and at least a preliminary feasibility study demonstrating the future viability of the facility. After review of these submissions, the responsible agency should have the authority to issue a provisional certificate that entitles the applicant to collect deposits from prospective residents, to pursue contractual commitments with contractors, and to start out on the path toward permanent certification. It is the authors' opinion that, definitionally, the exemption discussed above for members of approved self-accreditation programs cannot apply to this type of provisional certification (as a prospective provider could not yet be a member of any approved accreditation program).

Second, all CCRCs presently operating in each state, as well as all new communities following the provisional certification procedure, should be required to apply for and receive permanent certification in order to sell or offer to sell continuing care contracts. Applications for certification should be developed by the responsible administering agency. A number of attachments to the application should be required, including a copy of the contract being used by the community, ownership and financial responsibility disclosure statements, a copy of the disclosure statement required for distribution to residents elsewhere in the statute, and a series of actual and projected financial statements.

The authors take the position that once a certificate of authority to operate is issued by the administering agency, it should remain perpetually valid, subject to the revocation procedures provided for elsewhere in the statute. Notwithstanding this conclusion, we would require the filing of annual reports, consisting of current financial statements as well as notification of any changes from information on file with the administering agency. We believe that, in this way, all the benefits of certification could be achieved while minimizing the admin-

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[4] This option in CCRC legislation is modeled after the similar exemption procedures discussed above in the federal Medicare program. The major differences between this accreditation exemption and the JCAH program are that our exemption is not complete, as is JCAH accreditation, and that our accreditation program need not be national in scope, as is JCAH accreditation. The same type of exemption is discussed elsewhere in this chapter as well *See, e.g.,* pp. 275–78.

istrative burdens. Finally, members of approved self-accreditation programs should be required to file these annual reports with the responsible administering agency. This requirement is included to ensure that there is one central repository for all relevant information on each CCRC operating in any state.

LEGAL REGULATION OF FINANCIAL STATUS

Escrow Provisions

The basic view underlying escrow provisions is that some extra protection is needed for the residents' investment beyond disclosure, certification, and enforcement of other regulatory provisions—at least in certain instances. The objection to mandated escrow provisions is that, by definition, they direct capital into relatively stagnant bank accounts or other relatively unproductive uses of money, thereby depriving residents of the full value of their money, in that some part of their investment is not working as efficiently for them as it might.

Two basic approaches to escrow requirements could be used. The first approach would be to require an entrance fee and deposit escrow until the resident moves into the community, or until some other point in time, at which point all funds are released to the operator. The second approach would be to require general escrow funds of varying levels on a perpetual (or sometimes more limited) basis. This second requirement is typically imposed by a bonding authority or bank holding a mortgage or lien on the property.[5]

The Arizona, California, Michigan, and Minnesota statutes all require the maintenance of an escrow account for all entrance fees and deposits received before the resident occupies his or her unit. The AAHA statute authorizes the regulatory department to require an entrance fee escrow, but does not mandate it. Florida and Michigan require an escrowing of entrance fees and deposits only until the operator is certified. Finally, Michigan grants the administering agency the discretion to require an escrow deposit of a "reasonable amount when the facility's economic condition is precarious."

The existing state statutes approach in varying ways the issue of when funds should be released from the escrow account. For example, California's statute permits the entrance fee escrow to be released when the facility is 50 percent completed and 50 percent subscribed. The Arizona, Minnesota, and AAHA statutes, however, have more

[5] Chapter 12 also discussed the notion of an entrance fee escrow, which is an account maintained even after residence is established because of a legal or self-imposed standard requiring a certain amount of funds, ranging from relatively small amounts to the full value of all resident payments to the community. This type of fund escrow, classified herein as a reserve fund escrow, is discussed in the "Reserve Funds" section of this chapter.

complicated formulae governing release of the escrow funds, depending on whether the unit is new or old and, if new, depending on the stage of construction or financing.[6]

Against this background, the authors have reached the judgment that some type of escrow provision is a mandatory element of regulation. In reaching this result, which is not viewed as punitive, we found it helpful to isolate three different types of problems that entrance fee escrow requirements could arguably ameliorate:

First, a totally unscrupulous operator could commit fraud by absconding with the residents' entrance fees. Of course, this type of fraud could theoretically occur at any point in the life of a CCRC. It is the authors' judgment, however, reflected in the balance that we have struck between competing policies, that the likelihood of this type of fraud is greatest before the resident occupies his or her unit. Additionally, special protections might be advisable in the case of an operator who has not yet constructed his facility, but is collecting entrance fees.

Second, in the case of a new CCRC, the use of an entrance fee escrow is one mechanism to ensure that the community is in a position to meet the expectations of the promoter. A primary assumption made by the developer of any community is that the operator of a new community can attract a certain number of residents at a certain price to "buy in" to that facility. By forcing a CCRC to hold all of its entrance fees in escrow until a certain percentage of its capacity is subscribed to, one can statutorily ensure the accuracy of this crucial assumption.

Third, an escrow requirement could be used to help ensure the financial stability of the CCRC. Thus, it could be argued that any community maintaining a certain level of "cash" would be financially stable and secure.[7]

Balancing all of these considerations has led the authors to the conclusion that two different types of entrance fee escrows should be required by statute. First, all entrance fees, including refundable deposits in excess of 5 percent of the then-existing entrance fee for the

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[6] Arizona's statute provides one example of this type of complex formula. If the entrance fee paid is for a unit that is currently occupied, it will be released when the unit becomes available for occupancy by the payor. If the entrance fee is for a new unit, however, it is released when three requirements are satisfied: (1) construction is substantially complete, and an occupancy permit has been issued; (2) commitment has been secured for long-term financing; and (3) aggregate entrance fees added to the proceeds from long-term financing total 90 percent of the total cost of the facility plus 90 percent of the money necessary to fund start-up losses. Ariz. Rev. Stat. Ann. §20-1804(A)(2) (Supp. 1979).

[7] This is presumably the theory underlying reserve fund escrows. The authors have concluded that it is more appropriate to account for this theory in the "Reserve Funds" section of this chapter.

unit requested, paid to *existing* and *operating* communities for occupied units before the resident takes occupancy, should be held in a cash escrow account.[8] With this type of escrow account, all funds should be released to the community on the day that the unit becomes available for occupancy by the resident.

Second, state legislation should require that entrance fees and refundable deposits paid to *new* communities before their construction or opening be held in a cash escrow account.[9] For the purposes of this section, any escrow required by a bonding authority or bank holding a mortgage on the community or its property, for either construction or permanent financing, should be considered to count against the requirements of the statute. Thus, the statute's escrow requirement should be concurrent with any escrow requirements established as a result of private contract. For funds held in this second type of escrow account, the entrance fee should be released in whole when all of the following conditions are satisfied:

The CCRC becomes 50 percent subscribed through receipt of entrance fees from a sufficient number of residents to fill 50 percent of the community.

Commitments have been secured for both construction and long-term financing. Further, any conditions that must be met to activate those commitments before disbursement of funds thereunder, other than completion of the construction or closing of the purchase of the community, must be satisfied.

Aggregate entrance fees received by or pledged to the provider plus anticipated proceeds from any long-term financing commitment plus funds from other sources in the actual possession of the provider must equal not less than 100 percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the community, plus not less than 100 percent of the funds necessary to fund start-up losses of the community.

The most controversial aspect of this proposed statutory requirement—the release formula for the entrance fee escrow in a new community—represents a delicate balance among the various options discussed above. On the one hand, the proposed approach would make these funds available to the operator as soon as is practicable in a policy sense. On the other hand, in order to protect the residents from

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[8] The term *cash escrow account* should be a defined term in the statute. Essentially, it should include any bank or similar company account specifically identifiable as an account held by the individual for the benefit of the community.

[9] This was an extremely difficult judgment for the authors to reach because of the difficulty it will create for small, church-related providers who may depend on the use of the entrance fees to fund their predevelopment costs. But the risk to residents—and the CCRC industry—and the capability of these providers to generate predevelopment costs by charging nonrefundable deposits tipped the balance. In this way, prospective residents' funds that are, in reality, at economic risk are identified clearly as such.

fraud and to ensure the integrity of the assumptions in the feasibility study, funds would not be released to the provider until it has received substantial commitments from potential residents and from sources of both short- and long-term funds.

The apparent harshness of the third requirement should be ameliorated, at least in part, by the statutory provision that the statute's escrow requirements be concurrent with, and not additional to, any escrow accounts entered into as a result of private contract. Because of the private market protective mechanisms that will come into play, no additional protection appears necessary to residents once the statutory requirements have been satisfied. Thus, the bank or bonding authority releasing funds to the provider under construction or permanent financing commitments should be policing the hopeful operator to protect against fraud. The interest of such entities in seeing the community's construction completed is as powerful as that of the potential residents. Because these lenders or financiers are sufficiently sophisticated to protect the interests of the residents, admittedly for different reasons, no additional statutory protection is necessary at this point.

Reserve Funds

As noted in Chapter 12, the major policy argument in favor of reserves is to ensure that the CCRC can provide the services associated with the deferred liabilities for which it has contracted with its residents. Applications of sound principles of actuarial science to determine liabilities associated with CCRCs, thereby resulting in the establishment of actuarially sound reserves, could be the most significant contribution of this study to the continued viability of the continuing care industry. Thus, the maintenance of actuarially sound reserves by all CCRCs should serve as the best protection residents can expect, both in terms of the sound financial planning that such a practice would bring to the continuing care industry and in terms of the inherent early warning signaling device that such a procedure would produce.[10]

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[10] The Report on the Feasibility of the Trustee's Plan to Reorganize Pacific Homes concludes that "one of the key ingredients to the long term viability of an organization is the maintenance of adequate cash reserves." That report concludes that there should be reserves of two types: operational and future liabilities. The report explains its reasoning as follows:

> Operational reserves are maintained to cover normal operating expenses. These protect against unforeseen drops in occupancy or in slow payment from the residents. This reserve should be at least thirty to forty-five days of cash operating expenses.
>
> Future liability reserves are set up to provide for future replacement of property, plant and equipment, protect against emergency capital expenditures, and maintain reserve against potential future liability due to the contract residents. While there is no widely agreed upon level for this amount, it should probably be at least six months' operating expenses.

For the reasons explained later, the authors accept the report's statements on operational reserves but reject its conclusions on future liability reserves.

Residents expect and are entitled to a basic guarantee that their community will retain the essential financial wherewithal over the years to provide the services to which it has committed itself contractually, without the need to have monthly fees increase faster than inflation. This would appear to be a desirable goal of a CCRC, as discussed in Chapters 7 and 8. The goal implies that the community's current assets plus the present value of future inflation-constrained monthly fees must be at least as large as the community's current liabilities plus the present value of future expenses. Moreover, because future inflation-constrained monthly fees will fall short of future expenses (because of increased health care utilization as individuals age), the difference must be made up from current assets (or reserves) for the concept to work. Thus, the basic contractual guarantee can be provided only through the maintenance of sound actuarial reserves.

As will be recalled from a review of Chapter 12, the existing statutes tend to regulate both the level of reserves necessary or desirable and the investment limitations to be placed on whatever level of reserves is selected. Six of the 10 statutes studied contained some form of reserve requirements. The most typical regulations of size tend to look to the basic commitments of the community over a 12-month period and require that the amount necessary to meet those commitments be held in a cash or quasi-cash reserve. California also has a general requirement that the reserve be sufficient to cover the obligations assumed under continuing care contracts, as calculated through the use of state-approved mortality tables. Colorado requires that 65 percent of the amount of any advance payments made by all residents be held in a reserve to be drawn upon on a straight-line basis over a five-year period. Finally, with respect to investment limitations, the lower the level of required reserves in any statute, the stricter the limitations on investment tend to be.

The authors do not consider it advisable to specify in the cold type of this book the appropriate level of reserves for all communities, as has been done in other analyses of actual and proposed legislative schemes. It is our expectation that the discussions in this book will prompt the actuarial, continuing care, and accounting professions to research, test, and develop meaningful methodologies for evaluating the long-term financial soundness of individual CCRCs. Although these issues are explored in Chapters 7 and 8 along with a methodology for evaluating a community's actuarial position, no specific recommendation for legislative language is made here on the theory that something of this significance must await substantial additional field research.

Notwithstanding the lack of a specific recommendation, the authors feel strongly that mandating actuarially sound reserves is the best long-term legislative solution. We are simply reluctant to make a definitive prescription as to actuarial reserves and liquid asset requirements at

this stage of the research, because of the risk that such a standard would be either too harsh or too weak, given the limited scope of this study.

Bonding Requirements

As was pointed out in Chapter 12, it is necessary to distinguish between two types of bonds. The first, referred to herein as a *fidelity bond,* is obtained by the CCRC in order to cover losses owing to the dishonesty or negligence of employees handling residents' money. The second, referred to as a *surety bond,* is obtained by the community as a substitute for, or in addition to, the reserve requirements just discussed.

Current practice in the continuing care industry is relatively consistent and easy to discern. Although only the California statute requires a fidelity bond for agents and employees who handle substantial sums of money, bonds covering the fidelity of employees are common in all industries in which the money of third parties is routinely handled by employees, including the CCRC industry. Ironically, although several state statutes require, or authorize the administering agency to require, the filing of surety bonds under certain circumstances, the authors are not aware of a single instance in which a CCRC obtained a surety bond to ensure its financial stability.

The authors have reached a mixed conclusion on this element of regulation. With respect to fidelity bonds, we are unpersuaded that it is necessary for states to include a statutory provision mandating all CCRC operators to obtain fidelity bonds for their employees. Recognizing, however, that certain states might feel more comfortable with such a provision, we have classified this element of regulation in category two as an optional section. With respect to surety bonds, however, we have concluded that no such provision is advisable in any state regulatory scheme. This element of regulation therefore falls within category three.

This conclusion was based on a number of considerations. First, surety bonds would not appear to be obtainable given the current experience. Second, even if obtainable, surety bonds would probably be prohibitively expensive. Third, the surety bond might have a poor incentive effect on the community's management; in short, it is arguably better to run a community well than to rely on a surety bond. Fourth, there are difficult administrative problems involved in determining the size of a surety bond for individual communities. Finally, the entire theory of reserves is that communities maintaining an actuarially sound reserve will have no need for further intrusive regulation of economic and financial status. Imposing a bonding requirement in addition to the reserve requirement would be superfluous.

Fee Regulation

The ultimate in intrusive regulation is direct setting of fees by the state, or supervision of fee-setting by the state. Such fee regulation might be modeled after the extensive regulation of rates commonplace in the insurance industry.

It is the authors' firm conclusion that no such fee regulation provision is appropriate in any state legislative scheme. Not surprisingly, all current existing and proposed pieces of legislation concur in this judgment, and do not contain fee regulation provisions. This element of regulation has, therefore, been placed in the third category noted in the introduction.

The appropriate setting of fees by CCRC operators is both complicated and essential to the welfare of the residents. It is recognized that operators might set fees too high, thereby gouging the residents, or that they might set fees too low, thereby attracting residents away from financially stable communities and ensuring the collapse of their own communities. And the frequent comparisons that have been made between the continuing care industry and the insurance industry are also noted. But the solution to this complex and crucial problem is not, and never will be, fee regulation by the state. Simply stated, there is no evidence that the state is any better suited for the fee-setting function than are CCRC operators. Indeed, the high administrative costs involved in such an apparatus would appear to disqualify the states automatically.

The search for solutions to the problem of correct fee-setting has led the authors to a more obvious answer. The fastest and most efficient way in which to improve the setting of fees for CCRCs is to improve the information base upon which such decisions are made. An improved information base, coupled with appropriate consultations with knowledgeable experts, will do more to improve the reliability of fee-setting decisions than will any state involvement in the fee-setting procedure. The goal of improving the information on which CCRC operators base their decisions was, of course, a major consideration in the decision to go forward with this research.

LEGAL REGULATION OF RESIDENT RELATIONSHIPS WITH THE COMMUNITY

Financial Disclosure to Residents

The basic rationale underlying full financial disclosure to both prospective and current residents is that, by making such disclosure, the community informs all residents about the past, present, and expected future financial condition of the facility, thereby rendering the resi-

dents better able to protect themselves without any additional regulatory intrusions. Thus, financial disclosure equalizes bargaining power between otherwise "ignorant" residents and "sophisticated" providers. The notion is that residents will not move into financially precarious CCRCs and will agitate to improve such communities once they reside there. For this reason, CCRCs will not risk allowing their financial condition to deteriorate, because this can lead to total collapse arising from a refusal of residents to move in.

Underlying the remainder of this chapter, which suggests the advisability of a comprehensive statute going beyond disclosure, is the judgment that problems exist with relying solely on disclosure to protect resident rights. Just giving information might not equalize bargaining power between residents and providers—the information must also be comprehensible. Because, by its nature, financial information is complex, disclosure of only raw financial data is probably not effective in its major goal of equalizing bargaining power. Further, if, because of age or educational background, residents are inherently weaker bargaining partners than operators, disclosure will not necessarily equalize bargaining power. Thus, the efficacy of disclosure is linked to the validity of the assumption that lack of information is the sole or major cause of the disparity in bargaining power.

Finally, the assumption that operators will not allow their facilities to deteriorate for fear of not attracting new residents requires close examination. Even if this were the case in most communities, the size and unrecoverable nature of each resident's investment in a CCRC might give rise to a more substantial obligation on the part of the state to safeguard the continued viability of CCRCs. In short, the authors have reached the judgment that disclosure is a necessary, but not sufficient, component of a regulatory scheme.

The current practice of CCRCs with respect to the disclosure element of regulation suggests that comprehensive disclosure requirements will not impose additional expensive burdens on most CCRCs. All 10 statutes analyzed in Chapter 12 include some form of disclosure within their extensive regulatory schemes. The disclosure provisions in these statutes were divided into three general types:

- Those that allow general public inspection, on request, of financial statements and annual reports filed with the administering agency. Such a right is available to prospective residents, current residents, and the general public.
- Those that require CCRC providers to furnish copies of specified disclosure material of varying content to all prospective residents or their advisers before execution of the contract.
- Those that require CCRC providers to furnish annual disclosure statements to current residents.

As part of this research, a sample of representative CCRCs was assessed as to the extent of disclosure to residents at this time.[11] These communities were surveyed with a seven-question questionnaire that yielded the following results:

98 percent of the CCRCs surveyed formally disclosed some information to their residents.

CCRCs currently use diverse methods to disclose this information:

a. 90 percent disclose information at residents' meetings.
b. 88 percent disclose information in writing.
c. 81 percent disclose information through resident representatives.
d. 60 percent disclose information through regular newsletters.
e. 45 percent disclose information in a specialized disclosure statement.
f. 24 percent disclose information through other means, usually more informal than the above-noted methods.

The nature of the material disclosed to residents by CCRCs is also quite diverse:

a. 88 percent of the communities surveyed disclose financial statements to residents. Of these, 70 percent disclose those statements annually, 16 percent quarterly, and 11 percent monthly.
b. 100 percent of the communities surveyed disclose planned changes in fees to the residents. Of these, 60 percent disclose this information at least a month before the planned change, 29 percent at least two months before, and 7 percent on an annual basis.
c. 90 percent of the communities surveyed disclosed planned changes in services to their residents. Of these, 66 percent disclose these changes at least a month beforehand, 32 percent at least two months beforehand, and 3 percent on some other basis.

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[11] Our sample community profile included 50 CCRCs with the following diverse characteristics:

Fifteen were constructed before 1970.
Fifteen were smaller than 300 residents.
Five were from the Northeast.
Twelve were from the North Central.
Seven were from the South.
Six were from the West.
Seventeen offered unlimited health care guarantees.
Thirteen offered limited health care guarantees.
Seventeen were in regulated states.
Thirty-seven were in nonregulated states.

d. 71 percent of the communities in our sample disclose planned changes in community size to their residents. A clear majority of these communities make this disclosure as far in advance as is practicable; only 17 percent of these communities have any specified time within which they disclose planned changes.

e. 83 percent of the communities surveyed disclose planned changes in construction to their residents. Again, as with planned changes in community size, the overwhelming majority disclose the plans as far in advance as is practicable.

52 percent of the CCRCs in our sample provide a narrative describing the financial condition of the community to residents. Of these, 77 percent provide the narrative annually, 5 percent quarterly, and 9 percent monthly.

Only 17 percent of the CCRCs surveyed disclosed to residents the salaries of their administrators, and only 12 percent disclosed any compensation paid to board members as a result of their service on the board.[12]

A clear majority of the CCRCs surveyed provide residents with background information on their owners (71 percent), administrators (88 percent), and members of the board (76 percent).

31 percent of the CCRCs in our sample disclosed to their residents information on the ownership interest of any owner, administrator, or member of the board in any company that did business with the particular community (e.g., management consulting companies).[13]

In sum, if the survey of CCRCs and existing statutes is any test at all, financial disclosure to residents is something that virtually every person associated with the continuing care industry can agree on. The authors are no exception. We have made the judgment that the financial disclosure element of regulation is an essential part of legislation.

The form and contents of disclosure are critical. States should require the use of a disclosure form that provides a complete summary of the CCRC's current and long-range financial picture. The form should be completed and submitted to the administering agency annually. All prospective residents should be given a copy of a simplified disclosure form including a clear narrative description of the financial condition of

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[12] Fifty-five percent of the CCRCs surveyed, however, noted that the board members were not paid.

[13] This somewhat low figure is partially explained by the fact that 36 percent of the CCRCs surveyed marked this question "not applicable" or appeared to misunderstand the nature of the information requested by the question.

the CCRC to supplement all raw data supplied as a matter of course before execution of a continuing care contract. Current residents should be provided with copies of the simplified form annually and on request. Finally, residents and their advisers should be permitted access to the community's full financial and income statements, as well as to reports of any feasibility studies conducted. This right of inspection should be stated clearly and conspicuously on the simplified disclosure form.

The subject matter that the authors recommend be disclosed to the regulating agency draws heavily on the AAHA Model Continuing Care Provider Registration and Disclosure Act and includes the following:

- The name, business address, and corporate form of the provider.
- The names of the individual owners, including the names of all officers, directors, trustees, or managing partners of the provider.
- With respect to any individual named above, as well as with respect to any proposed manager of the community, a description of the business experience of the person, the identity of any other business in which the person has a substantial ownership interest with which the community would do business, and a statement of any crime or civil fraud committed by such person.[14]
- If the CCRC is to be or is operated by a management services company, full disclosure as to all persons affiliated with that management services company as above.
- Statement of the experience of the provider in operating CCRCs.
- Statement as to any affiliation with a religious, charitable, or other nonprofit organization, as well as an explanation of the extent of that organization's financial responsibility for the CCRC's operations.
- Statement of the location and description of the properties of the provider relating to the CCRC.
- Certified financial statements of the provider.
- If operation of the CCRC has not yet begun, statement of the anticipated source and application of funds used or to be used in the purchase and construction of the CCRC.
- A pro forma income statement for the CCRC for the next fiscal year.
- A copy of the simplified disclosure form discussed elsewhere in this section.

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[14] This last element will be confidential and not subject to public inspection.

The simplified disclosure form distributed annually to all residents and to prospective residents must contain at least the following information:

Simplified financial statements of the CCRC for the past year.

Simple narrative statement explaining the financial position of the CCRC.

The names of the individual owners, including the names of all officers, directors, trustees, or managing partners of the provider.

With respect to any individual named above, as well as with respect to any proposed manager of the community, a description of the business experience of the person, and the identity of any other business in which the person has a substantial ownership interest with which the community would do business.

If the CCRC is to be or is operated by a management services company, full disclosure as to all persons affiliated with that management services company as above.

Form and Contents of the Contract

A regulatory provision governing the contents of the continuing care agreement would, like regulations mandating full disclosure, attempt to equalize bargaining power between providers and prospective residents. By regulating the form of contracts (e.g., size of print and plain English requirements) and the contents of agreements (e.g., fees, refunds, and termination rights), the state can, in a relatively unintrusive way, ensure that the agreement reached and signed between the CCRC and the resident contains some basic protection for the resident and approximates a contract that would be reached between negotiators of equal bargaining strength. Further, regulation of certain substantive terms has the incidental benefit of reducing uncertainty and, therefore, simplifying much of the litigation surrounding continuing care.

Arguments that the form and contents of continuing care agreements should not be regulated in any way are rarely encountered. There are certainly potential administrative difficulties, and the possibility exists that state regulations in this area would have to be quite complete for fear that certain communities would include in their contract only the provisions required by the statute. Most significantly, and with some justification, there has been an increasing resistance to state legislation that, in effect, provides a standard form contract that each CCRC is forced to adopt.

Chapter 12 detailed quite extensively the method by which each of the statutes analyzed dealt with this element of regulation. Seven of the 10 statutes under consideration regulated the form and/or the contents

of continuing care contracts to some extent. The form of each statute varies considerably.

The authors selected 25 CCRCs to serve as a sample of current practice vis-à-vis continuing care contract forms.[15] The following represents a breakdown of the percentage of continuing care retirement communities from the sample whose contracts contain provisions on the following list of items:

		Percent
I.	*Fees and accommodations*	
	A. Size and payment schedule for entrance fees and monthly fees	100%
	B. Provision governing increases in monthly fees	84
	C. Health and financial conditions required to gain entrance to the community and to stay in the community	76
	D. Type of accommodations	72
	E. Provision covering the contingency of two residents in any one unit	60
	F. Provision governing how long the resident can keep his or her individual unit upon transfer to a health center	80
	G. Services provided and surcharges	100
	H. Provision noting that no property interest is granted by the contract; only an agreement for services	52
II.	*Refunds*	
	A. General provision on refunds	80
	B. More specific refund terms	
	1. For death or withdrawal before occupancy	32
	2. Probationary refund	48
	3. Refund upon withdrawal of resident at any time	88
	4. Address contingency of death after occupancy	80
	5. Timing of refund	48
III.	*Termination rights*	
	A. Preoccupancy cooling-off period	36
	B. Probationary period termination provision	48
	C. Resident cancellation rights	92
	D. Community's rights of dismissal	84
	E. Provision governing the contingency of inability to pay	68
	F. Provision mandating that the residents preserve assets	44

As a result of the study, an analysis of the current statutory provisions, and current practice in both regulated and unregulated jurisdictions, the authors have reached the following conclusions with respect to the form and contents of the continuing care contract element of regulation. First, we conclude that provisions governing the form and

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[15] The characteristics of this 25-community sample are as follows:

Eleven were constructed before 1970.
Eleven had fewer than 300 residents.
Five were from the Northeast.
Eight were from the North Central.
Six were from the South.
Six were from the West.
Thirteen offered an unlimited health care guarantee.
Twelve offered a limited health care guarantee.
Eight were in regulated states.
Seventeen were in nonregulated states.

contents of CCRC contracts fit within the first set of regulations described in the introduction to this chapter—that is, that they are an absolutely essential element of regulation in all states.

Second, the state legislation should impose a "plain English" requirement on all contracts for continuing care providers. Such provisions can be modeled after similar provisions found in several pieces of consumer protection legislation enacted at both the federal and state levels over the past 5 to 10 years.

Third, the state legislation should require that all new CCRC contract forms be approved by the responsible administering agency. Thirty days following submission of the contract to the administering agency, the form of the contract should be deemed approved even if the CCRC has received no word from the agency. The legislation should also require existing CCRC contracts to be submitted to the responsible administering agency. The agency approval requirement, however, should apply only to future continuing care contracts; that is, existing contractual agreements should be "grandfathered."

Fourth, any contract that attempts to limit the permissible increases in monthly fees should be prohibited. Any continuing care contract submitted to the administering agency containing such a provision should be automatically rejected.

Finally, although the state legislation should not generally impose particular word-for-word provisions on continuing care contracts, it should require all continuing care contracts to contain provisions dealing with the following issues:

- The value of all assets transferred to the CCRC, the initial amount of the monthly fees, and the manner of changing monthly fees should all be stated in the contract.
- Any health or financial condition of a resident that can allow the community to terminate the contract of a resident should be set forth in detail.
- The particular living unit contracted for by the applying resident should be disclosed in the contract.
- A provision governing dual occupancy of residency units should be included in all contracts. This provision must specify what occurs when one of the two residents dies, withdraws, is dismissed, or needs to be transferred to the health facility.
- Provisions governing the reoccupancy of residents' living units as a result of prolonged sickness should be included in the contract.
- The contract should list all services to be provided and any surcharges that may be levied.
- The contract should specify that it creates no property interest of any kind, that it is simply a service agreement.

The refund provisions should be clearly stated in the text of the contract, either in boldface type or in type larger than the rest of the body of the contract. Full refunds, less a nominal processing fee, should be mandated in the case of death or withdrawal before the resident takes occupancy of the unit. The refund policies of the community on either withdrawal by the resident or dismissal by the CCRC should be stated explicitly. As a recommended, but not required, provision, the state legislation might contain a section providing for a probationary refund. Finally, the contingency of death after occupancy should be addressed explicitly in each continuing care contract.

Each contract should provide for a preoccupancy cooling-off period of at least seven days following execution of the contract, during which the resident may elect to cancel the contract with a full refund, less some small administrative fee for processing the application.

As an optional, but not required, section, state legislation might include a provision establishing a 90-day probationary period during which either party to the contract may cancel the contract, with or without cause. In such an event, there should be a full refund to the resident of all fees paid to the CCRC less reasonable costs.

All rights of cancellation by the resident should be conspicuously stated in the contract.

Similarly, the CCRCs' rights of dismissal should be clearly stated in the contract. Any state statute should include a good-cause limitation on the dismissal power of the community. Residents should also be protected against eviction and retaliation for complaints against the community.

A provision explaining clearly what can happen to the resident who is unable to continue to afford the monthly payments should be in each continuing care contract.

A provision in which each resident promises to preserve his or her assets to the best of his or her ability should also be mandated by state legislation

Rights of Self-Organization

In order to combat some of the potential harms of institutionalization, as well as the theoretical disincentive to care that may be present in some CCRCs,[16] it has been argued that it is advisable to grant rights of

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[16] *See* Comment, *Continuing-Care Communities for the Elderly: Potential Pitfalls and Proposed Regulation,* 128 U. Pa. L. Rev. 883, 884 n.7, 911–12, 912 n.142 (1980).

self-organization to residents. By giving residents a voice and a role in a community's governance, one is, in effect, charging them with partial responsibility for assuring that the community function smoothly and efficiently. Like disclosure, therefore, this element is designed to give residents the power and the information to safeguard their own interests. Further, residents can often bring great wisdom and insight to the governance of a CCRC.

One objection to this type of regulatory provision is that, if the residents are given a role in the governance of the community that enables them to gain effective control of the community's operations, the facility's tax-exempt status might be in jeopardy. The study, however, has disclosed no examples of this potential problem.

A second potential problem with granting residents rights of self-organization applies only to the issue whether it should be mandatory that residents sit on the CCRC's board of directors. An objection is that residents sitting on a board of directors might be unable to execute their responsibilities properly due to a sense of emotional, rather than administrative and financial, responsibility. For example, residents on a board might hesitate to raise rates or tend to negotiate lower increases because of their concern for the reaction of their fellow residents (because they will continue to live in the community) as well as their own financial self-interest.

The authors find this argument persuasive, and, therefore, no provision mandating a CCRC to have a resident on its board is recommended for any state legislation. Of course, individual communities may wish to place residents on their boards, and legislation should not prohibit this.

The current approach of the various states that regulate the continuing care industry was detailed in Chapter 12. Only three of the statutes, plus one state's regulations, recognize any right to resident self-organization. Notwithstanding this statutory framework, a recently published study[17] found that 70 percent of all nonprofit homes for the aging (including CCRCs) permit some form of resident participation in decision making. Most typically, this participation takes the form of a resident council or association.

The study found that CCRCs with a relatively large number of residents (approximately 150 or more), CCRCs that contain independent living units, and CCRCs that offer several different levels of care are most likely to have resident involvement in aspects of daily operations and long-range planning. Consistent with this finding, the authors concluded that CCRCs also have a relatively high degree of involvement by residents in the decision-making process of the board of directors.

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[17] A. Trueblood-Raper, *Resident Participation in Governance of Homes for the Aging* (1981).

Thus, although only 10 percent of the entire sample permitted residents to sit as fully participating members of their boards of directors, 18 percent of the CCRCs identified by the study have residents on their boards.

The authors have concluded that a statutory provision guaranteeing residents a role in the governance of their individual communities is appropriate. Because CCRCs tend to attract people who are highly educated and have had professional and community experience, an unusual pool of talent, resources, and decision-making skills exists in the typical CCRC resident population. The Trueblood-Raper study concluded that one finds a broad base of resident participation in a typical CCRC: residents serve on numerous committees, produce newsletters, coordinate and sponsor activities and events, and raise funds to serve the community and other charitable purposes. CCRC residents also currently influence decision making in other formal and informal ways.

A regulatory provision on residents' rights to organize would, therefore, be appropriate in any state statute regulating the continuing care industry. But such a provision should not require that any residents serve on the facility's board of directors. A general statement delineating some of the residents' organizational rights should be provided, however, in addition to a provision requiring periodic meetings, but only if requested by the residents, between management and residents to discuss income, expenditures, financial problems, and proposed changes in policies or services. Such provisions will help facilitate the voluntary development of resident councils, committees, and associations.

Advertising Regulation

The primary public policy behind all types of advertising regulation is an attempt to reduce misinformation and minimize the significance of weak bargaining power on the part of residents by ensuring that CCRC advertising and solicitation materials are accurate and not subject to misinterpretation. Advertising regulation is a basic antifraud protection common in many industries.

Seven of the analyzed statutes contain some form of regulation pertaining to advertising and promotional literature. The analysis of current practice in the continuing care industry disclosed no obvious examples of extreme abuse in either advertising or solicitation literature.[18] Yet, the fear is often expressed that an unscrupulous opera-

[18] In the past, there have been several examples of less than model behavior in the distribution of advertising materials by certain providers. For example, Pacific Homes' advertising literature suggested strongly the existence of a financial link between the provider and the United Methodist Church, a connection that the church went all the way to the Supreme Court of the United States to deny.

tor could, through clever advertising suggesting a relationship between the community and some well-known entity, either intentionally or negligently mislead prospective residents.

Although it is a close question, the authors have concluded that some form of advertising regulation is an appropriate component in state legislation of the continuing care industry. We reach this conclusion with full recognition of the reluctance of some to encourage this form of meddlesome government intervention. We also recognize that all CCRCs would be subject to any state statute of general applicability prohibiting the use of fraudulent or misleading advertising. The authors believe, however, that, owing to the subtleties and complexities of continuing care, and the particular skills and interests required to review advertising in a meaningful manner, advertising regulation of the CCRC industry is merited. This conclusion was made easier by the lack of any problems experienced by states that presently regulate CCRC advertising.

Advertising should be a defined term in the statute. That term can be defined so as to include promotional and solicitation literature, media advertisements, and similar material, but so as to exclude such items as community newsletters and routine correspondence to current and prospective residents. Misleading advertising, especially advertising that implies the existence of financial connections between CCRCs and unrelated but well-known and respected organizations, should be expressly prohibited. All advertising, promotional, and solicitation literature should be submitted to the administering agency and checked against the extensive ownership disclosure data already on file. Any mention of outside, but unaffiliated, organizations in the literature should be required to be followed, in print at least the same size, by an explanation of the financial connection between those organizations and the community. Continuing care operators should not be permitted to distribute or print any of the literature submitted to the administering agency for 14 days to permit the agency to review and, if appropriate, reject the proposed literature. Once again, as with the contract form approval process, failure of the agency to respond within 14 days should be statutorily deemed to be approval of the advertising, and distribution can begin.[19]

Lien Provisions and Preferred Claims

Definitionally, a *lien* gives the residents something beyond their contracts to sue on. Most critically, a filed lien gives the residents *priority* over subsequent claimants even if the community goes under 10 years after the filing. A *preferred claim* is, in essence, a special lien used only

[19] The Florida experience with this sort of "deeming" provision appears to have created no problems.

should extend both to on-site inspections and to examinations and financial audits. Second, strong civil and criminal penalties should be included to ensure the compliance of CCRC administrators with the statutory requirements. Third, full subpoena power should be given to the administering agency. Fourth, the basic remedial authority of the administering agency should require that agency to notify the noncomplying provider of its violation and to give the provider an opportunity to correct the violation. The basic tools available to the administering agency should include the authority to impose a cease and desist order or seek injunctive relief in the courts, and the appointment of examiners to supervise compliance with court or agency orders.[21] Such methods permit the operator to continue to run the facility, a feature of some importance because of his specialized knowledge of that particular community.

It is the authors' view that the type of comprehensive statute proposed in this chapter, coupled with this investigative and enforcement scheme, is all that is necessary to ensure proper operation of CCRCs. In the past, however, some states have determined that it is necessary to go further than the proposed provisions noted above and have included a provision permitting the administering agency and the court to appoint an outside person to assume operation of a financially troubled CCRC. It is not beyond the realm of possibility that some states might choose to enact such rehabilitative mechanisms in the future as well.

For the benefit of those states, the authors offer the following comments on what we regard as a limited rehabilitative procedure. The use of rehabilitative procedures that displace the operator from the community should be sharply limited to cases of actual fraud or gross mismanagement, which presumably will be rare. Such restrictions on rehabilitation appear justified by the lack of evidence that a government-appointed administrator would be better able to handle the serious problems that arise once a community is in financial trouble; indeed, most of the commonsense evidence to date supports a contrary conclusion.

Such limited corrective mechanisms are analogous to the reorganization provisions of the new Bankruptcy Code. A comparison between the authors' proposal and bankruptcy reorganization requires a brief glimpse of the old bankruptcy procedure, however. The Bankruptcy Act of 1898, which still has limited application, has three business reorganization chapters: 10, 11, and 12. In chapter 10, the appointment of a trustee is mandatory when the bankrupt's liability exceeds

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[21] The provisions and policies of the new Bankruptcy Code are mirrored in this study's proposal that, on request by the administering agency, a court appoint an examiner to investigate and supervise the affairs of a troubled CCRC provider. *See* 11 U.S.C. §1104(B); H.R. Rep. No. 95–595, 95th Cong., 2d Sess., *reprinted in* (1978) *U.S. Code Cong. & Ad. News,* 5963, 6193–94.

$250,000.[22] In chapters 11 and 12, however, appointment of a trustee is optional,[23] and the bankrupt usually remains in control of the business.[24] This disparity results from two apparently irreconcilable policies behind business reorganizations: protection of creditors and the public (the chapter 10 policy) and facilitation of an effective reorganization to benefit both creditors and the bankrupt (the chapters 11 and 12 policy).

The Bankruptcy Reform Act of 1978 struck a different balance between these two policies. First, all business reorganizations are handled under a new chapter 11. Second, the debtor remains in possession of his business, unless a request for appointment of a trustee is made.[25] "The standard provided in the bill directs the court to order appointment of a trustee only if the protection afforded by a trustee is needed and the costs and expenses of a trustee would not be disproportionately higher than the protection afforded."[26]

The authors propose that courts be required to apply a similar standard in CCRC rehabilitation proceedings. The chances for successful rehabilitation are greatly enhanced if the CCRC provider remains in possession. Like the debtor going through reorganization, the provider is more familiar with his business than an outside trustee would be. If it remains, there will be no period of adjustment while the outside trustee familiarizes itself with the unique features of the particular facility. Finally, the cost of an outside trustee is avoided.[27] Consistent with the new Bankruptcy Code,[28] the authors recommend appointment of a trustee only in the event of fraud or gross mismanagement. But short of this result of regulatory failure, there is no reason to resort to the drastic remedy of appointing an outside trustee.

THE PROPRIETARY/NONPROFIT DISTINCTION

As noted in Chapter 12, a provision barring proprietary operators from offering continuing care contracts appears to be based on the notion that profit seeking has an adverse effect on the quality of care and services. One state (Michigan) appears to have attempted to bar such

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[22] 11 U.S.C. §556 (1976).

[23] *Id.* §§742, 832.

[24] *See* D. Epstein & M. Scheinfeld, *Teaching Materials on Business Reorganization under the Bankruptcy Code,* 52 (1980).

[25] 11 U.S.C. §1104 (Supp. II 1978).

[26] H.R. Rep. No. 95–595, 95th Cong., 2d Sess. 234, *reprinted in* (1978) *U.S. Code Cong. & Ad. News,* 5963, 6193.

[27] *See id.* 233, *reprinted in* (1978) *U.S. Code Cong. & Ad. News,* 5963, 6192.

[28] *See* 11 U.S.C. §1104(A)(1) (Supp. II 1978).

operators from the life care industry; another (Pennsylvania) has considered a move in that direction, at least if one can believe the state legislature's press clippings.

Unfortunately, regardless of one's views on the desirability of such a policy, a provision excluding proprietary operators would not effectively advance this aim. Any proprietary operator who wished to circumvent the statute could establish a nonprofit corporate shell to run the CCRC and distribute the profits to himself by having the nonprofit shell contract with his own proprietary management and services company. The authors believe, therefore, that no provision prohibiting proprietary operators from offering continuing care contracts should be included in any state statute. To the extent that any state is concerned about the fraud, conflict of interest, and self-dealing abuses that it has been argued inhere in such arrangements, the appropriate vehicle with which to regulate such abuses is the state nonprofit corporation law. ■