Continuing Care Retirement Communities

An Empirical, Financial, and Legal Analysis

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To our children:
Amanda, Cameron, & Tyler
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Part Three

Legal Analysis

Chapter Twelve

Status of Current Legislation

■ The purpose of this chapter is to provide a descriptive analysis of existing formal legal regulation of continuing care retirement communities. This material will serve as the foundation for the authors' normative analysis. The discussion is divided into three parts, based on three different types of formal legal responses to CCRCs:

Detailed state regulatory schemes: The first part discusses the responses of nine states and at least one organization—detailed regulation of CCRCs.[1]

Limited state regulatory schemes: The second part discusses the responses of at least three states—selected regulation of one or two of the problems of the continuing care retirement community industry susceptible to legal regulation.

Nonregulation: The third part discusses the responses of the remaining thirty-six states, the District of Columbia, and the federal government—virtually total inaction. Included in this part are comments on proposed, but as yet unenacted, legislation and judicial attitudes toward CCRCs.

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[1] The footnotes used throughout this chapter contain references to several state statutes and model acts; however, copies are not included. Appendix F contains information on where the reader can obtain copies of statutes and model acts. In order to summarize this information and to simplify comparisons over state lines, comparative charts are included.

care, and life lease are anything but homogeneous. Various 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, and the financing arrangements between the resident and the community.

Given the diverse characteristics of separate CCRCs, if a state wants to regulate continuing care, it must first determine which type of CCRC it wants to regulate, and then it must draft a definition that ensures that all of these types of communities will be brought under the scope of the statute.

California's definition appears to have avoided most of the typical pitfalls:

> "Life care contract" means a contract to provide to a person for the duration of such person's life or for a term in excess of one year, nursing services, medical services, or health-related services, board and lodging and care as necessary, or any combination of such services for such person in a facility, which is conditioned upon the transfer of property. Such transfer may include a payment of an entrance fee to the provider of such services or the payment of periodic charges for the care and service involved, or both such payments, and includes continuing care agreements.[5]

Note that this definition includes terminable continuing care agreements explicitly, as well as all types of financing arrangements between the resident and the community. Michigan's definition has also apparently caused few problems.[6]

Arizona's definition is similar to California's,[7] but most facilities within Arizona have stopped charging entrance fees altogether, thereby avoiding regulation, raising their periodic fees, and, therefore, moving closer to becoming fee-for-service providers.[8] Maryland's definition[9] and Minnesota's definition[10] appear susceptible to the same problems faced by Arizona, though the statutes are still too new in these states to tell.[11] Similarly, the AAHA definition[12] and the Indiana

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[5] California §1771(i).

[6] Michigan §§554.803(5)–(6).

[7] Arizona §20–1801(5).

[8] Ohio Nursing Home Commission Memorandum from Paul Wallace to Catherine Hawes (October 18, 1978).

[9] Maryland §7(b).

[10] Minnesota §80.D.02(2).

[11] Colorado's statute also appears to be susceptible to this problem. Colorado §12-13-101(6).

[12] AAHA §2(a).

Definitions

Arizona: Contract to provide for a person for life or for a term in excess of one year medical services and board and lodging conditioned on payment of an entrance fee in addition to or in lieu of periodic payments.

California: Contract to provide for a person for life or for a term in excess of one year medical services and board and lodging conditioned on payment of an entrance fee in addition to or in lieu of periodic charges, including continuing care agreements.

Colorado: Care provided under a contract for life of an aged person, including health care, board, and lodging.

Florida: Furnishing of nursing care, shelter, and food upon payment of an entrance fee. Continuing care shall include only life care, care for life, or care for a period of one year or more.

Indiana: Contract to provide for a person for life or for a term in excess of one month medical services, board, and lodging conditioned on payment of an entrance fee in addition to or in lieu of periodic payments.

Maryland: Furnishing for money, care or shelter to an individual over age 60 under a contract which (1) requires 12 or more months of care to another to be paid in advance, (2) provides for care for more than one year, or (3) provides for life care.

Michigan: Three-part definition covering only life care and care for more than one year. Labels the former "life interest" and the latter "long-term lease."

Minnesota: Furnishing to an individual board and lodging together with medical services pursuant to a written agreement effective for the life of the individual or for a period in excess of one year.

Missouri: Furnishing shelter, food, and nursing care to an individual for life or for a term of years. Care for a term of years defined to include care in excess of one year and an agreement for continuing care for an indefinite term.

AAHA: Agreement for the payment of an entrance fee and/or periodic charges in exchange for living accommodations, medical care, and related services, which is effective for the life of the individual or for a period in excess of one year.

definition,[13] because they do not expressly include mutually terminable agreements, might cause problems.

Florida provides an example of the hazards of improper definition of the institutions to be regulated. The earliest Florida legislation applied only to institutions using total-fee-in-advance or assignment-of-all-assets methods of financing[14] and only to contracts for life or for a term of years.[15] In 1978, Florida expanded its definition beyond fixed-fee arrangements[16] by expressly including terminable continuing care contracts within the definition of "care for a term of years."[17] New Florida

[13] Indiana §1.

[14] Fla. Stat. Ann. §651.02(4) (West 1972).

[15] *Id.* §651.02(3). Colorado's statute is similar. Colorado §12–13–101(6).

[16] Fla. Stat. Ann. §§651.011(6), (8) (West Supp. 1978).

[17] *Id.* §651.011(7); *see id.* 651.011(2). This is the model followed by the new Missouri statute and should cause no problems. Missouri §1(1), (2).

legislation, though including the expanded definition of "care for a term of years,"[18] deleted any reference to that phrase in its definition of continuing care.[19] Thus, it was possible that Florida's new statute did not apply to communities offering mutually terminable continuing care contracts that need not last for more than one year. Florida is now amending its statute again, and it is expected that this definitional problem will be resolved.

Two further illustrations of definitional problems can be found in states that apparently tried to prohibit life care arrangements. New York's nursing home regulations prohibit any "residential health-care facility" operator from accepting prepayment for "basic services" for more than three months[20] or from entering into any contract for "life care."[21] This language has been construed to mean that CCRCs are prohibited in New York;[22] yet it may not apply to communities that offer terminable contracts and earmark prepaid entrance fees for capital expenditures rather than basic services. Indeed, at least 11 facilities in New York purport to offer continuing care contracts.[23] Similarly, Pennsylvania's nursing home regulations provide that such facilities "shall not require or permit a patient to assign his assets to the facility in return for a life care guarantee,"[24] yet continuing care retirement communities that use mutually terminable contracts are common in that state.[25]

PREOPENING PROCEDURES: CERTIFICATION

All nine states and the AAHA model act require some sort of preliminary registration and certification by a relevant state authority before

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[18] Florida §651.011(7).

[19] Florida §651.011(2).

[20] N.Y. Code of Rules & Regulations, tit. 10, §730.2(f) (1979); *see id.* §415.1(f), §420.1(f).

[21] *Id.* §730–3(b); *see id.* §414.16(b).

[22] See, e.g., Brown, *An Appraisal of the Nursing Home Enforcement Process,* 17 Arizona L. Rev. 304, 350 (1975).

[23] *See* AAHA, *Directory of Members* 50–61 (1982). These may be contracts that were in existence before promulgation of the present regulations.

[24] 28 Pa. Code §201.38 (1979). The confusion surrounding this regulation arises from the failure to define "life care" and the use of the word *assets* without any modifier. Does it mean *any* assets, thus apparently prohibiting continuing care, or *all* assets, thus apparently prohibiting only assignment-of-all-assets contracts? *See* Jenkins, *Life Care Contracts—Problems?,* Concern. February–March 1976, at 27, 30.

[25] *See* N. Adelman, *Director of Life Care Communities,* 2d ed. (Kennett Square, Pa.: Kendal Crosslands, 1980); and Howard E. Winklevoss and Alwyn V. Powell, *1982 Reference Directory of Continuing Care Retirement Communities* (Philadelphia: Human Services Research, Inc. (1982).

Certification

Provisional certification

Arizona: None.

California: None.

Colorado: None.

Florida: Required application with attachments. Then can collect entrance fees and enter into feasibility study.

Indiana: None.

Maryland: None.

Michigan: None.

Minnesota: None.

Missouri: None.

AAHA: None.

Certification

Arizona: Cannot sell contract without certification.

California: Cannot sell contract without certification.

Colorado: Cannot sell contract without certification.

Florida: Required for operation.

Indiana: Cannot sell contract without certification.

Maryland: Cannot sell contract without certification.

Michigan: Cannot sell contract without certification.

Minnesota: Cannot sell contract without filing (self-executing statute).

Missouri: Cannot sell contract without certification.

AAHA: Cannot sell contract without certification.

Financial information required

Arizona: Balance sheets, income statements, and projected income statements.

California: Past three years' balance sheets and income statements plus five-year projections.

Colorado: Certified financial statements and projected income statements for at least a five-year period.

Florida: Use of proceeds statements plus balance sheet and income statement. Also, computation of debt service requirement and information on plant equipment and property.

Indiana: Financial statements of the provider prepared in accordance with generally accepted accounting principles.

Maryland: Certified statement of applicant's financial condition.

Michigan: Balance sheet, use of proceeds statement, and feasibility study.

Minnesota: Balance sheet and income statements. Projected income statement for next year.

Missouri: Comprehensive financial statements with specifics varying depending on whether the CCRC is new or old. Also, statement of reserve and escrow provisions.

AAHA: Certified financial statements and income statements. Projected income statements for next year.

Renewals, revocations, etc.

Arizona: Annual filings, but certification valid until revocation.

California: Annual filings, but certification valid until revocation. Independent revocation procedure.

Colorado: Annual renewal procedure. Independent revocation procedure.

Florida: Annual renewal procedure. Independent revocation procedure.

Indiana: Annual filings, but certification valid until revocation. Independent revocation procedure.

Maryland: Annual renewal procedure. Independent revocation procedure.

Michigan: Annual renewal procedure. Independent revocation procedure.

Minnesota: Annual filings, but certification valid until revocation. Independent revocation procedure.

Missouri: Annual renewal procedure. Independent revocation procedure.

AAHA: Annual filings, but certification valid until revocation. Independent revocation procedure.

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the beginning of operations. Failure to comply with these requirements can result in civil or criminal penalties.

This element of regulation involves an attempt by the state to screen "unacceptable" operators out of the continuing care industry. The notion is that, based on some sort of comprehensive application complete with required submissions, the state will be able to determine the financial stability and capacity, the sincerity, and the integrity of a prospective continuing care operator. Prospective certification, coupled with annual monitoring and various enforcement provisions, is the major mechanism by which the states currently regulating in detail supervise the financial stability of the continuing care industry.

Thus, the purpose of such certification is to ensure compliance with whatever standards the governmental agency decides to impose. The key problems are whether the states have isolated proper standards, whether the information they request helps them to evaluate financial stability, and whether the responsible state agency has the time, inclination, or expertise to evaluate that information properly. Given some skepticism about the efficacy of government certification programs, it has been suggested that private accreditation might eventually replace such systems.[26]

As mentioned above, all 10 statutes require that the provider be certified before the execution of any continuing care agreement. Florida requires each provider to apply for a provisional certificate of authority.[27] Florida requires prospective continuing care operators to

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[26] 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. *See* 42 U.S.C. §1395bb (1976). Also, the Council on Developmental Disabilities is a private accreditation program for facilities for the handicapped. A private accreditation program for continuing care retirement communities is in the final planning stages in the New Jersey/Pennsylvania area.

[27] Florida §651.031.

submit advertising, organizational information, construction data, and financial information to the state. The state then issues a provisional certificate that entitles the provider to collect deposits from prospective residents, so long as they are kept in escrow, and to undertake the feasibility study required for permanent certification.[28]

The Arizona, California, Colorado, Indiana, Maryland, Michigan, Minnesota, Missouri, and AAHA statutes simply provide that a continuing care operator may not sell or offer to sell a continuing care contract until a certificate of authority is granted.[29] Applications for certification, complete with the required attachments, are made to the appropriate state departments. The most important attachments are actual and projected financial statements,[30] a copy of the contract to be used,[31] services provided under the contract and charges for services not provided under the contract, and ownership and financial responsibility disclosure statements.[32]

The Colorado, Florida, Maryland, Michigan, and Missouri statutes provide for annual renewal of the certificate of authority after required financial forms are filed and specific statutory requirements are met.[33] The Arizona, California, Indiana, Minnesota, and AAHA certificates are valid until revoked, but annual reports similar to the financial filings in the other states are still required.[34] All the states except Arizona have specific, detailed procedures for revocation and/or suspension of certificates of authority.[35]

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[28] Florida is presently considering amending its provisional certification requirements to mandate submission of a preliminary feasibility study before the proposed community is permitted to collect any deposits.

[29] Arizona §§20–1802–1803; California §1770(a); Colorado §12–13–102(1); Indiana §3(a); Maryland §9; Michigan §554.807; Minnesota §80D.03; Missouri §3; AAHA §3. The amended Minnesota statute is somewhat unique in the continuing care field. It is a completely self-executing legislative scheme. Thus, CCRCs are not *registered* under the act; they are required to file a disclosure statement with the county clerk meeting the requirements of section 80D.04. Similarly, there is no annual report to an administering agency—there is, however, an annual filing required. Finally, the administering agency and court step in only upon violation of a statutory provision.

[30] The states require balance statements, income statements, and statements of use of proceeds in varying combinations.

[31] The provisions that must be in the contract vary from state to state and will be discussed below.

[32] The Arizona, California, Colorado, Missouri, and AAHA statutes are the most advanced in this area. *See* Arizona §20–1802(B); California §1771.8(d)–(e), (h)–(k); Colorado §12–13–102; Missouri §4; AAHA §4(a)–(y).

[33] Colorado §12–13–108; Florida §§651.026(l), (8); Maryland §22; Michigan §§554.821–.822; Missouri §5(2).

[34] Arizona §§20–1803(B), –1807; California §§1782.5, 1783; Indiana §8(a); Minnesota §80D.12; AAHA §7(a).

[35] California §1784; Colorado §12–13–105; Florida §§651.026(8), .105, .114, .125; Maryland §22; Michigan §554.817; Minnesota §80D.12; AAHA §7.

LEGAL REGULATION OF FINANCIAL STATUS

Escrow Provisions

The basic policy behind escrow provisions is the view that an extra protection is needed for the residents' investments. Mandated escrow provisions might be viewed as tacit acknowledgments of the inadequacy, at least in certain instances, of disclosure, certification, and enforcement of other regulatory provisions. A disadvantage of mandated escrow provisions is that such provisions, by definition, direct capital into relatively stagnant bank accounts or other relatively unproductive uses of money, thereby depriving the 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.

It is important to note, therefore, that escrow provisions must represent a delicate balance between these two policies. On the one hand, all of the community's reserves should not be in escrow because, though that maximizes protection of resident investment, it limits the community's capacity to put money to work for the residents. On the other hand, it might be advisable to require some funds to be placed in escrow at some time (for example, when the residents could not monitor the funds themselves), in order to ensure some protection of resident payments.

There are at least three different types of escrow requirements, representing to some extent different views on the outcome of the balancing process between the competing policies suggested above:

Entrance fee and deposit escrow until the resident moves into the community, at which time all funds are released to the operator.

Entrance fee escrow 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, to be kept in escrow.

General fund escrow of varying levels imposed on a perpetual basis by a bonding authority or bank holding a mortgage on the property.[36]

In the first category, Arizona, California, Colorado, Indiana, Michigan, Minnesota, and Missouri all require the maintenance of an escrow account for all entrance fees and deposits received before the resident occupies his or her unit.[37] The AAHA statute authorizes the regulatory

[36] Although this third form of escrow is fairly common, because it is largely a matter of private contract, it need not concern us in this chapter.

[37] Arizona §20–1804; California §1773.5; Colorado §12–13–104; Indiana §6; Michigan §554.810(b); Minnesota §80D.05; Missouri §10. *See also* 22 Cal. Code §84204.

Escrow Provisions

Arizona: Entrance fee escrow until occupancy for new units. Complicated formula for release of funds. Also requires a reserve fund escrow equal to aggregate principal and interest payments due on first mortgage over next 12 months.

California: Entrance fee escrow until occupancy for new units. Simple formula for release of funds. Also requires a reserve fund escrow equal to aggregate interest, principal, and lease payments due over next 12 months if there is no contractual provision for adjusting monthly fees.

Colorado: Entrance fee escrow until occupancy for new units. Complicated formula for release of funds. Also requires a reserve fund escrow equal to 65 percent of all large initial payments. This reserve is to be amortized over the first five years of residence, but at no time is the reserve to fall below 35 percent of the original requirement.

Florida: Entrance fee escrow required until certification and obtaining of long-term financing. Also requires a reserve fund escrow equal to aggregate of one half of the principal interest and lease payment due over the next fiscal year.

Indiana: Entrance fee escrow until occupancy for new units. Complicated formula for release of funds.

Maryland: Entrance fee escrow required until certification.

Michigan: Entrance fee escrow until occupancy for new units. Special provision authorizing state to require an escrow of a reasonable amount when financial conditions become precarious.

Minnesota: Entrance fee escrow until occupancy for new units. Complicated formula for release of funds. Also requires a reserve fund escrow equal to aggregate of principal and interest payments on first mortgage due over next 12 months.

Missouri: Entrance fee escrow until occupancy of new units. Complicated formula for release of funds. Also requires a reserve fund escrow equal to 50 percent of any entrance fee paid by the first occupant of the unit. This reserve is to be amortized and "earned" at the rate of 1 percent each month. But the reserve never can fall below 150 percent of the annual long-term debt, principal, and interest payments of the provider.

AAHA: Authorizes the department to require an entrance fee escrow until occupancy. Complicated formula for release of funds.

department to require an entrance fee escrow but does not mandate it.[38] Adopting a slightly different balance, Florida and Maryland require an escrowing of entrance fees and deposits until the operator is certified.[39] Michigan falls even further down the scale by granting the Corporations and Securities Bureau the discretion to require an escrow deposit of a "reasonable amount when the facility's economic condition is precarious."[40]

Arizona, California, Colorado, Florida, Minnesota, and Missouri all mandate some type of reserve fund escrow, as well as the entrance fee

[38] AAHA §6.

[39] Florida §651.031(4), (6); Maryland §11(c)–(d). Florida's requirement also mandates maintenance of escrow until long-term financing has been attained.

[40] Michigan §554.816.

escrow described above.[41] This kind of escrow requirement is of the second type noted above, and will be discussed in more detail in the next section.

Release of funds from the escrow account can be either very simple or extremely complicated. For example, California's entrance fee escrow is released when the facility is 50 percent completed and 50 percent subscribed to.[42] But the Arizona, Colorado, Indiana, Minnesota, Missouri, and AAHA statutes have 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.[43]

Reserve Funds

Six statutes—all of the statutes with the exception of Indiana's,[44] Maryland's, Michigan's, and AAHA's—mandate the maintenance of financial reserves. The major policy argument in favor of reserves is that, at least in theory, the maintenance of "adequate" reserves provides a financial buffer to help the CCRC survive through difficult financial times. In particular, adequate reserves protect communities from the low rates of turnover typical early in their existence, from actuarial miscalculations and aberrations, and from subsequent unexpectedly low turnover or unpredictably high inflation rates or costs.

On the other hand, arguments exist against mandatory reserve funds. Good financial and actuarial planning should go a long way toward obviating the need for such requirements. Again, as with escrow provisions and depending on investment limitations imposed on reserve funds, mandating reserve funds might well prejudice the future financial stability of the community by preventing funds from being put to their optimal use. Finally, even assuming the desirability of requir-

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[41] Arizona §20–1806; California §1774.4; Colorado §12–13–107; Florida §651.035; Minnesota §80D.06; Missouri §7.

[42] California §1773.5.

[43] Arizona §20–1804(A)(2); Colorado §12–13–104; Indiana §6; Minnesota §80D.05; Missouri §10; AAHA §6.

[44] Indiana's statute contains unique provisions in place of a reserve requirement. Sections 13 through 18 of the Indiana statute establish a Retirement Home Guarantee Fund, a concept first suggested in Comment, *Continuing Care Retirement Communities for the Elderly: Potential Pitfalls and Proposed Regulation,* 128 U. Pa. L. Rev. 883 (1980). The purpose of the fund is to protect the interests of the residents if the CCRC goes into bankruptcy. A $100 fee is assessed on each CCRC resident entering into a continuing care contract. Indiana §13. That fund is then available for distribution to residents of CCRCs upon the meeting of certain conditions. Indiana §16. There are a number of exemptions from participation in the fund, including the tax-exempt status of the provider. Indiana §19.

Reserve Funds

Size

Arizona: Total of interest and principal payments due over the following year on account of any first mortgage or other long-term financing of the facility.

California: Total of interest, principal, and rental payments due during the next year (same as Arizona plus rental payments). Also, a requirement that reserve be sufficient to cover the obligations assumed under continuing care agreements, as calculated through the use of state-approved mortality tables.

Colorado: 65 percent of the amount of any advance payment made by all residents. Straight-line amortization over a five-year period. At no time can reserve fall below 30 percent of the original requirement.

Florida: Amount equal to one half of the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage or other long-term financing on the facility, including taxes and insurance and leasehold payments.

Indiana: None. Has a Retirement Home Guarantee Fund instead.

Maryland: None.

Michigan: None.

Minnesota: Amount equal to the total of all principal and interest payments due during the next 12 months on account of any first mortgage or on account of any other long-term financing of the facility.

Missouri: Requires a reserve fund escrow equal to 50 percent of any entrance fee paid by the first occupant of the unit. This reserve is to be amortized and "earned" at the rate of 1 percent each month. But the reserve never can fall below 150 percent of the annual long-term debt, principal, and interest payments of the provider. In addition, each CCRC must establish a reserve equal to at least 5 percent of the facility's total balance of contractually obligated move-out refunds at the close of each fiscal year.

AAHA: None.

Investment limitations

Arizona: Must be placed in "escrow," but the principal of escrow account may be "invested," apparently without limitation, with the earnings and up to one sixth of the principal payable to the provider. Principal released to the provider must be repaid within two years.

California: The former reserve requirement must be placed in escrow, but the funds can be invested with the same limitations as apply to the second type of reserve. These limitations allow investments in bank deposits, first mortgages, approved bonds and stocks, real estate, and furniture and equipment of the community. Twenty-five percent must be in cash and listed bonds and stocks. If the community has at least half of its contracts on a monthly basis, only 5 percent need be in these liquid investments.

Colorado: Reserves must be held in bank accounts, first mortgages, real estate, or furniture of the community. At least 10 percent must be in bank accounts and listed bonds or stocks.

Florida: Subject to general investment limitations imposed on insurance companies with provision for emergency release of funds to the provider.

Indiana: None. Has a Retirement Home Guarantee Fund instead.

Maryland: None.

Michigan: None.

Minnesota: Must be placed in "escrow," but the principal of the escrow may be "invested," apparently without limitation, with the income and one twelfth of the principal payable to the provider.

Missouri: Must be placed in "escrow," but can be held in federal government or other marketable securities, deposits, or accounts insured by the federal government.

AAHA: None.

ing reserve funds, the calculation of a uniform level of reserves to be applied to all CCRCs might well be difficult.

Thus, as with the policy debate covering escrow provisions, the decision whether to adopt reserve requirements involves balancing sharply competing policies. This balancing takes place on two different levels in the reserve debates. First, one must determine the level of reserves that is necessary or desirable. Second, one must determine the investment limitations to be placed on whatever level of reserves is selected.

As noted above, Arizona, California, Colorado, Florida, and Minnesota all have some form of reserve requirements.[45] Each of these statutes has varying requirements covering both the size of the reserve and investment regulation. These distinctions are presented in tabular form in the accompanying chart and need not be repeated here. However, the following two general points should be noted. First, with respect to the size of the mandated reserves, the statutes typically tend to look to the basic commitments of the community over a 12-month period. This approach is not universal, but, as the recent Florida amendments make clear, it is a growing trend. The other type of approach would involve setting reserves based on net worth requirements established by the state. Such reserve requirements necessarily rest on the assumption that the liquidation value of the facility's real estate and equipment counts as part of the reserve. Second, with respect to investment limitations, the lower the level of required reserves in any statute, the stricter the limitations on investment tend to be.

Bonding Requirements

Before discussing the policy arguments underlying a bonding requirement in the continuing care industry, it is necessary to distinguish between two types of bonds. The first, referred to herein as a *fidelity* bond (or fidelity insurance), is obtained by the community in order to cover losses due to the dishonesty or negligence of employees handling money of the residents. 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.

The policy arguments that need to be discussed here apply basically to the second form of bonding requirements. Bonds (or insurance) covering the fidelity of employees are common in all industries in which the money of third parties is routinely handled by employees.

The notion of surety bonds insuring the financial stability of a CCRC is more novel and controversial. Theoretically, bonds, like reserves, can provide a financial buffer to aid the community through difficult financial times or to protect it against unfavorable actuarial experience.

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[45] Arizona §20–1806; California §§1774.4, 1775; Colorado §12–13–107; Florida §651.035; Minnesota §80D.06; Missouri §7.

Bonding Requirements

Arizona: None.

California: Agency may require a bond in any reasonable amount when necessary to protect the residents. Fidelity bond also required.

Colorado: None.

Florida: None.

Indiana: A community may replace entrance fee escrow requirement with a letter of credit.

Maryland: None.

Michigan: Agency may require a bond in any reasonable amount when necessary to protect the residents.

Minnesota: None.

Missouri: None.

AAHA: A community may replace entrance fee escrow requirement with a surety bond.

Theoretically, bonds are even better than reserves in that they provide this buffer without tying up funds in unproductive uses such as bank accounts. But surety bonds, even if obtainable, would probably be extremely expensive. Finally, as with reserves, administrative problems are involved in determining the size of a surety bond for individual communities.

The California, Indiana, Michigan, and AAHA statutes all require, or authorize the administering agency to require, the filing of fidelity or surety bonds under certain circumstances. California and Michigan authorize the administering agency to require a surety bond in any reasonable amount necessary to protect the residents of the community.[46] California also requires the bonding of agents and employees who handle substantial sums of money.[47] The AAHA and Indiana statutes allow a community the option of securing a surety bond or a letter of credit in lieu of maintaining its entrance fee escrow.[48] Finally, and worthy of note, Florida and Colorado have removed their old surety bond requirements in their new statutes.

Fee Regulation

An intrusive form of regulation is direct setting of fees by the state, or supervision of fee-setting by the state. Such fee regulation might be

[46] California §§1773, 1773.5; Michigan §554.816.

[47] California §1774.

[48] AAHA §6(e); Indiana §11.

modeled after the detailed regulation of rates commonplace in the insurance industry.[49]

The assumption behind direct fee regulation is that one cannot "trust" operators to charge the "correct" fees. They might charge too much, thus gouging the residents. Or they might charge too little, thus guaranteeing financial collapse of the community in time. Therefore, the argument runs, the state should regulate the setting of fees in order to ensure the "proper" fee and maximum protection.

There are some serious contrary policies. First, even assuming the validity of the assumptions, the administrative problems involved in fee-setting are substantial. Second, and more telling, in terms of its objectivity and motivation, the state may be no better suited to set fees than continuing care operators, and possibly far worse suited.

None of the statutes under discussion has any fee-setting provisions.

LEGAL REGULATION OF RELATIONSHIPS BETWEEN RESIDENTS AND THE COMMUNITY

Financial Disclosure to Residents

The basic assumption behind full disclosure to prospective and current residents is that, by making such disclosure, the community informs all residents and the state about the past, present, and future financial condition of the facility, thereby rendering the residents better able to protect themselves without any additional regulatory intrusions. Further, it is assumed that full disclosure protects the community from making mistakes because of the premise that the state administering agency now possesses complete information. Proponents of full disclosure, therefore, may be heard to say that "we should let the market work" by equalizing bargaining power and that such equalization occurs through the providing of information.

Problems exist, however, with relying on disclosure as the only form of regulation. Even giving information might not equalize bargaining power between residents and operators—the information must be comprehensible. Because, by its nature, financial information is complex, disclosure of only raw financial data may not be 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 equalize bargaining power. Thus, the efficacy of disclosure is linked to the validity of the assump-

[49] *See* R. Keeton, *Basic Text on Insurance Law,* 557–67 (1971).

Financial Disclosure to Residents

Arizona: Furnish copy of latest annual report to prospective residents before signing of contract.

California: Furnish financial statements to prospective residents before signing of contract.

Colorado: Furnish copy of latest annual report to prospective residents before signing of contract.

Florida: Allows public inspection of reports filed with the state. Must post a summary of latest examination report and latest annual report in facility. Disclosure of same to prospective residents.

Indiana: Allows public inspection of reports filed with the state. Furnish copy of latest annual report to prospective residents before signing of contract.

Maryland: Allows public inspection of filings.

Michigan: Allows public inspection of filings.

Minnesota: Detailed financial disclosure to prospective residents before signing of contract.

Missouri: Furnish copy of latest annual report to prospective residents before signing of contract. Annual disclosure.

AAHA: Detailed financial disclosure to prospective residents before signing of contract. Annual disclosure.

tion that lack of information is the sole or a major cause of the disparity in bargaining power.

All 10 statutes have included some form of disclosure within their detailed regulatory schemes. The disclosure provisions can be divided into three basic types:

Florida, Indiana, Maryland, Michigan, and Minnesota allow general public inspection, on request, of financial statements and annual reports filed with the administering agency.[50] Such a right is available to prospective residents, current residents, and the general public.

Arizona, California, Colorado, Florida, Indiana, Minnesota, Missouri, and AAHA require that continuing care providers furnish copies of specified disclosure material of varying content to all prospective residents or their advisers before the execution of the contract.[51] Of these statutes, the Minnesota and AAHA lists of required disclosure are the most comprehensive, including such

[50] Florida §651.091(1); Indiana §7(b); Maryland §10(f); Michigan §554.840; Minnesota §80D.04. Actually, because the Minnesota statute is completely self-executing, the disclosure material is filed with the county recorder and is available for public inspection in that office.

[51] Arizona §20–1802(G); California §1779.3(a); Colorado §12–13–102(7); Florida §651.091(4); Indiana §7(a); Minnesota §80D.04; Missouri §4(8); AAHA §4.

information as identity and background of the provider; identity of the manager; description and location of the property and facility; description of all services, fees, and health and financial conditions required for acceptance and termination; certified financial statements; and future income statements.

The Florida, Missouri, and AAHA statutes provide for annual disclosure statements to current residents.[52]

Given its disclosure orientation, the AAHA statute is a model of what a disclosure statute should be. The authors commend sections 4 and 5 of that statute to the reader, especially the breadth of the disclosure, the requirement for narrative descriptions in addition to raw financial data, and the requirement that the disclosure form be on file with the state. In this regard, the Minnesota provision on understandability of the disclosure statement is also pertinent.[53]

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 content of agreements (e.g., fees, refunds, and termination provisions), the state can, in a relatively unintrusive way, mandate that the agreement reached and signed between the community and the resident contain some basic protections for the resident and approximate 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 contract litigation surrounding continuing care.

Contrary policy arguments against regulation of the form and contents of continuing care agreements include (1) the potential administrative difficulties, and (2) the possibility that state regulation 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.

The discussion of how the 10 statutes under consideration deal with this element of regulation will be divided into several parts. Two initial comments are necessary. First, the AAHA, Indiana, and Minnesota statutes are the only statutes that do not regulate the form or contents of the continuing care agreement, although certain aspects of content

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[52] Florida §651.091(3); Missouri §4(8); AAHA §5.

[53] Minnesota §80D.04(4).

are addressed in the disclosure form provisions.[54] Second, four of the statutes require that the community's contract be submitted to and approved by the responsible regulatory agency.[55]

Increasing Certainty. Two sections of the Florida statute that may forestall litigation require that the contract contain a provision governing increases in fees[56] and that no resident be permitted to waive his statutory rights.[57] California, Colorado, Florida, and Maryland all have general, albeit detailed, requirements that clauses be included covering the rates of the community, the manner in which rates can be changed, the cost and duration of the services to be provided, and the health and financial conditions each resident must meet to remain in the community.[58]

Refunds. Refund provisions vary substantially. Only Florida, Maryland, Michigan, and Minnesota specifically require that the contract grant a right of full refund to a resident who dies before taking occupancy.[59] More generally, the Florida statute requires that all refund terms be clearly stated in the contract,[60] adding that the contingency of death after occupancy must be addressed.[61] California's refund regulation requires only a refund of entrance payments, less a reasonable processing fee and the reasonable value of services provided, within 10 days of cancellation,[62] but it does not attempt to deal with the contingency of death.[63] Maryland's statute mandates coverage of refunds and the contingency of death.[64]

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[54] AAHA §4; Indiana §4; Minnesota §80D.04. The Missouri statute also contains substantial regulation of the contract form in its disclosure provisions. *See* Missouri §4.

[55] *See* California §1778; Colorado §12–13–113(2); Florida §651.026(5); Maryland §§10(a)(b), 10(d)(2). Indiana, Minnesota, and Missouri require submission of contracts, but not approval. *See* Indiana §4; Minnesota §80D.04(1); Missouri §4. Again, because of the self-executing nature of Minnesota's statute, the "submission" of the contract is to the county clerk for recording.

[56] Florida §651.055(1)(i). *See also* Maryland §§13(8)–(9).

[57] Florida §651.065.

[58] California §1779; Colorado §12–13–114; Florida §651.055; Maryland §13. The California guidelines for fee increases are generalized. Further, they authorize CCRC changes in fee policy with prior state agency approval. *See* 22 Cal. Code §84331.

[59] Florida §651.055(5); Maryland §80D.04(3); Michigan §554.810(a); Minnesota §80D.04(3)(b).

[60] Florida §651.055(1)(g). Refunds must be made within 120 days and must be on a pro rata basis with no more than 2 percent per month of residence deducted from the entrance fee.

[61] *Id.* §651.055(1)(h). The contract may provide for retention of the entrance fee by the community on the resident's death and must provide for the contingency of the death of one resident in a two-resident apartment.

[62] California §1779.8(a).

[63] *Id.* §1779.8. *See also* Michigan §§554.810(i),(e).

[64] Maryland §§13(6)–(7).

Resident Termination Rights. Regulation of resident termination rights is also diverse. Arizona, California, Florida, and Missouri mandate a 7-day cooling-off period before occupancy, during which the resident may cancel the contract with no penalty;[65] Minnesota has a similar 10-day cooling-off period;[66] and Colorado has added a new 60-day cooling-off period.[67] In Florida, after the initial 7-day period, the resident must be permitted to withdraw on 30 days' notice.[68] Arizona and Minnesota have no comparable provision. California allows cancellation of the contract without notice or cause by either party within the first 90 days; thereafter, 90 days' notice is required from the party that wishes to terminate.[69] Michigan does not limit resident termination rights, but the amount of refund varies with the time of cancellation.[70]

Dismissal. California and Colorado permit contracts that provide for dismissal of residents with or without cause; in the event of such a dismissal, however, they mandate a refund of the difference between the amount paid by the resident and the cost of his care.[71] Florida's strict regulation allows dismissal of residents by the community on 30 days' notice,[72] but only for a good cause.[73] Maryland allows the cancellation of the agreement on 60 days' notice, but only for good cause.[74] Michigan's statute is somewhat unique: it provides that residents dismissed without good cause are entitled to immediate refunds specified in the contract, but that continuing care providers may mitigate potential damage suits by placing these residents in adequate alternative facilities.[75] Unless the provider supplies alternative accommodations, however, it must give 30 days' notice before cancellation.[76] The Colorado and Missouri statutes simply require that the contract contain the terms under which either the provider or the resident may terminate the contract.[77]

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[65] Arizona §20–1802; California §1779.8(a)–(b); Florida §655.055(2); Missouri §4(7). *See* California §1779(f); Michigan §554.819.

[66] Minnesota §80D.04(3)(a).

[67] Colorado §12–13–102(5).

[68] Florida §651.055(1)(g). *See* Maryland §16.

[69] California §1779(d)–(f). California also requires each contract to be accompanied by a notice explaining all rights of cancellation. *Id.* §1779(e)–(f).

[70] Michigan §554.810(c)–(d). *See id.* §554.810(e).

[71] California §1780; Colorado §12–13–105. The Colorado statute authorizes tax-exempt CCRCs to make refunds on other bases if such schedules are set forth in the contract. Colorado §12–13–105(2).

[72] Florida §651.055(1)(g).

[73] *Id.* §651.061. Good cause will not be found simply because of an inability to pay monthly fees, at least until the entrance fees have been exhausted as well.

[74] Maryland §15.

[75] Michigan §554.810(2).

[76] *Id.* §554.810(3).

[77] Colorado §12–13–102(2); Missouri §4(4)(13).

Contract Regulation

Submission to state

Arizona: No.
California: Submit and approve.
Colorado: Submit and approve.
Florida: Submit and approve.
Indiana: Submit only.
Maryland: Submit only.
Michigan: No.
Minnesota: Submit only.
Missouri: Submit only.
AAHA: No.

Detailed requirements

Arizona: No.
California: Yes.
Colorado: Yes.
Florida: Yes.
Indiana: No.
Maryland: Yes.
Michigan: No.
Minnesota: No.
Missouri: No.
AAHA: No.

Refunds

Arizona: Not addressed.
California: Must have refund of admission fee less reasonable expenses within 10 days of cancellation. Does not deal with contingency of death.
Colorado: Must have refund of difference between amount paid in and amount used for care of the resident. Special provision for tax-exempt CCRCs.
Florida: Full refund if resident dies before occupancy. All refund provisions must be stated in contract. Must be within 120 days and on a pro rata basis. Contingency of death must be addressed.
Indiana: Not addressed.
Maryland: Full refund if resident dies before occupancy. All refund provisions must be stated in contract. Contingency of death must be addressed.
Michigan: Full refund if resident dies before occupancy.
Minnesota: Full refund if resident dies before occupancy.
Missouri: Not addressed.
AAHA: Not addressed.

Rights of Self-Organization

The policy behind giving residents the right to self-organization is that, at its core, the community is for the residents. By giving them a voice and a role in its governance, one is, in effect, charging the residents with partial responsibility for ensuring that the community functions

Rights of Self-Organization

Arizona: None.

California: Regulations grant right to form a residents' association.

Colorado: None.

Florida: Right of self-organization, plus required quarterly meetings between management and residents.

Indiana: None.

Maryland: None.

Michigan: One resident as advisory member of board of directors.

Minnesota: None.

Missouri: One resident as member of board of directors.

AAHA: None.

smoothly and efficiently. Like disclosure, therefore, this element of regulation is designed to put in the hands of the residents the power and information to safeguard their own interests.

There are some contrary attitudes. One reason given for opposing this type of regulatory provision is that, if the residents' role in the governance of the community is such that they gain effective control of the community's operations, the facility's tax-exempt status might be in jeopardy. Our survey, however, has disclosed no examples of this potential problem.

A second objection to granting residents rights of self-organization applies only to the issue of whether it should be mandatory that residents sit on the facility's board of directors. It is contended 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 might 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).

Only the Florida, Michigan, and Missouri statutes recognize any right to resident self-organization.[78] Michigan simply requires that one resident serve as an advisory member on the facility's board of directors.[79] Missouri's new statute requires that at least one member of each facility's board of directors be a regular paying resident of the CCRC.[80] Florida grants residents the right of self-organization, the right to be

[78] California's new regulation for residential facilities for the elderly grants residents the right to form a residents' association. *See* 22 Cal. Code §87614.

[79] Michigan §554.812.

[80] Missouri §8.

represented by individuals of their own choosing, and the right to engage in concerted activity for the purpose of keeping informed or for mutual aid or protection.[81] Florida also requires quarterly meetings (if requested by residents) between management and residents to discuss income, expenditures, financial problems, and proposed changes in policies or services.[82]

Advertising Regulation

Another attempt to cut down on misinformation on the part of residents, is direct regulation of the form and contents of advertising by CCRCs. Indeed, advertising regulation is a basic antifraud protection common in many industries. The purpose of such regulation is to ensure that any advertising put out by a continuing care operator does not intentionally or negligently mislead a prospective resident. Among the bases for objections to this policy are a general reluctance to meddle in what is basically a private matter, as well as the argument that existing truth-in-advertising rules and regulations already adequately cover this element of regulation. There is also an administrative cost involved that some say is not worth the incidental benefit gained.

California, Florida, Maryland, and Michigan all mandate that a copy of all advertising and promotional literature be filed with the state before publication or dissemination.[83] In Colorado and Florida, the mention of any other organization in the literature or advertising must be accompanied by a statement of the extent of that organization's financial responsibility for the community.[84] The California, Indiana, and Missouri statutes require only that the statement of financial responsibility be filed with the proper agency.[85] The Michigan legislation grants the administering agency the discretion to promulgate regulations governing the form and contents of advertising.[86] Maryland prohibits distribution of "prohibited" advertising, but does not define that term.[87]

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[81] Florida §651.081.

[82] *Id.* §651.085.

[83] Florida §651.095; Maryland §10(a)(10); Michigan §554.82b(2). California's requirements appear only in its regulations. *See* 22 Cal. Code §84555.

[84] Colorado §12–13–116; Florida §651.095(3).

[85] California §1789; Indiana §4(8); Missouri §4(4)(8). The California regulations, however, require submission of advertising material to the administering agency. *See* 22 Cal. Code §84555.

[86] Michigan §554.826(1).

[87] Maryland §18(b).

Advertising Regulation

Arizona: None.

California: If any third party is mentioned, must file a statement of its financial responsibility with the state. Violation is a misdemeanor and can lead to revocation of certificate. Regulations require filing.

Colorado: If any third party is mentioned, must include statement of its financial responsibility for the community. Violation is a misdemeanor.

Florida: Filing. If any third party is mentioned, must include statement of its financial responsibility for the community.

Indiana: A statement of financial responsibility by any affiliated charitable organization must be on file with the state.

Maryland: "Prohibited" advertising must not be distributed; term not defined.

Michigan: Filing. Agency can promulgate regulations on contents.

Minnesota: None.

Missouri: A statement of financial responsibility by any affiliated charitable organization must be on file with the state.

AAHA: None.

Lien Provisions and Preferred Claims

This element of regulation, the last in this section, differs qualitatively from the other elements discussed above. While the four preceding elements of regulation are designed to equalize the informational position of residents and providers, this element is designed to provide a modicum of financial protection for the residents should the community fail.

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 in liquidation proceedings.

Thus, the policy of giving liens and preferred claims to residents is that they shield residents from total financial loss. An incidental benefit of giving residents such an interest in the property of the community, is that doing so might limit excessive encumbrances on the property by subordinating subsequent creditors' claims to the interests of the residents.

There are several contrary policies. First, the residents' liens will invariably be subordinated to existing encumbrances such as first mortgages. Such encumbrances are usually the largest obligations of a CCRC, thereby cutting dramatically into the residents' rights. Second, the existence of residents' liens or preferred claims inevitably increases the cost of borrowing to communities by lowering the priority

Lien Provisions and Preferred Claims

Arizona: Lien as a precondition to certification. Subordinated to prior recorded encumbrances and may be subordinated to later recorded encumbrances.

California: Liens where necessary to secure performance of the continuing care contract. Subordinated to prior recorded liens.

Colorado: Liens as a precondition to certification. Subordinated to prior recorded liens and may be subordinated to later recorded liens.

Florida: Preferred claim to residents on liquidation, but prior recorded liens retain their priority.

Indiana: None.

Maryland: None.

Michigan: None.

Minnesota: Lien comes into existence when facility begins operation. No subordination at all.

Missouri: None.

AAHA: None.

of subsequent creditors. Third, such residents' interests may make certain borrowing impossible, thus limiting communities' expansion plans. Finally, under the new bankruptcy code, liens and preferred claims may well be invalid as statutory liens. That legislation allows the bankruptcy trustee to avoid any statutory lien[88] that first becomes effective against the debtor (the community), *inter alia,* when its financial condition fails to meet a specified standard[89] or when a third party levies to make the lien effective.[90] If a lien is created through administrative action when necessary for the protection of the residents, both of these provisions are implicated;[91] if a lien is created by administrative action at the time of certification, only the latter applies.[92] In both cases, however, the lien is suspect and would defeat the major purpose of the provision.

The statutes at issue here use two types of lien provisions. The California statute provides for a lien when necessary to secure performance of the continuing care agreements.[93] The Arizona and Colorado statutes, on the other hand, require that a lien be filed as a condition to certification.[94] Minnesota's self-executing statute provides that a lien

[88] A statutory lien is defined as a "lien arising solely by force of a statute on specified circumstances or conditions." *See* 11 U.S.C. §101 (38) (Supp. II 1978).

[89] *Id.* §545(1)(E).

[90] *Id.* §545(1)(F).

[91] This is the case in California and Colorado.

[92] This is the case in Arizona and Minnesota.

[93] California §1772. The California lien attaches only to real estate.

[94] Arizona §20–1805; Colorado §12–13–106.

Responsible Agency

Arizona: Department of Insurance. No advisory council.

California: Department of Social Services. Eight-member advisory board.

Colorado: Department of Insurance. No advisory board.

Florida: Department of Insurance. Seven-member advisory council.

Indiana: Department of Securities.

Maryland: Office of Aging. No advisory board.

Michigan: Corporation and Securities Bureau of the Department of Commerce. No advisory board.

Minnesota: None.

Missouri: Division of Insurance.

AAHA: Left to option of states. No advisory board.

exists on all real personal property of the CCRC from the time the facility is first occupied by a resident.[95] All of these states except Minnesota subordinate the lien to first-mortgage liens,[96] and Arizona and Colorado allow the administering agency to subordinate the lien to certain later recorded liens.

There are also two forms of preferred-claim provisions. Florida gives a preference to resident claims, but the priority of duly recorded liens is retained on liquidation.[97] California, on the other hand, apparently grants an absolute preference to resident claims in the event of liquidation.[98]

STATE ADMINISTRATION OF THE STATUTE

Responsible Agency

At a policy level, not much can be said about this particular issue. Basically, the goal is to ensure that the responsible agency has both the expertise and the interest to administer whatever regulatory program one develops. Many of the statutes resort to advisory councils to aid the appropriate agency in administering the program. Of significance is Minnesota's approach to this issue. Because that state's statute is wholly self-executing, there is no need for any day-to-day administer-

[95] Minnesota §80D.08.

[96] This is probably a drafting error by the Minnesota legislature. Unless the residents' lien is subordinated to first-mortgage liens, no bank will give any mortgage and no investment bank will underwrite any bond. The deletion of the provision explicitly subordinating the residents' lien in this manner is probably an oversight.

[97] Florida §651.071.

[98] California §1777.

ing agency. This appears to be a unique approach in the continuing care field, and the Minnesota experience should, therefore, be interesting to observe.

The attached chart depicts the way in which the 10 statutes have dealt with the issue.

Investigative, Enforcement, and Rehabilitative Powers

Most of the policy arguments on this element of regulation pertain to the degree of power, and not to the need for some power. No matter what form a regulatory scheme takes, and regardless of whether it is by government or private sources, enforcement is essential. And investigation and audit are essential adjuncts to the enforcement power.[99] The policy debates, therefore, center mostly on the scope of the investigative, enforcement, and rehabilitative powers that need to be granted, and, more specifically, on the nature of the enforcement and rehabilitative powers that need to be granted. These arguments are mostly apparent and self-explanatory and therefore need not be explored here.

Investigation. The investigative powers granted by each of the statutes are slightly different. In Arizona, continuing care examiners with the same power as that of insurance examiners are authorized to conduct inspections as often as may be necessary.[100] Michigan grants a limited power to investigate when mandatory records or annual reports are incomplete,[101] as well as a more structured and general investigative authority to protect against other violations of its statute.[102] Indiana, Maryland, and AAHA all authorize this latter general investigative power, including a subpoena power.[103] Florida grants a general examination authority to be exercised from "time to time."[104] Colorado authorizes the administering agency to conduct an examination as often as it deems necessary for the protection of the residents.[105] In contrast, California permits the administering agency to conduct inspections at any time[106] but allows the agency to rely on an annual audit

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[99] The Missouri legislature apparently disagrees, as that state's recent legislation contains no enforcement power. This is particularly curious because of the statutory authorization to revoke certificates of authority. *See* Missouri §5(2). One cannot help but speculate about how, without investigative and enforcement powers, the administering agency will revoke a certificate of authority to operate.

[100] Arizona §20–1809.

[101] Michigan §554.823.

[102] *Id.* §554.833.

[103] Indiana §22; Maryland §71; AAHA §9.

[104] Florida §651.105(1).

[105] Colorado §12–13–110.

[106] California §1781.

in lieu of inspection.[107] Because the Minnesota statute is wholly self-executing, there is no administering agency and therefore no investigating authority.

Enforcement. Enforcement mechanisms also vary from statute to statute. Colorado, Florida, Indiana, Maryland, Michigan, and AAHA all authorize injunctive relief against violations or threatened violations of any provision of the legislation.[108] Indiana, Michigan, and AAHA also authorize the administering agency to seek a cease and desist order.[109] As an important additional sanction focused specifically on the performance of administrators, all of the statutes except that of AAHA provide either civil or criminal penalties (or both) for violations of the statute by individuals.[110]

Rehabilitation. In what is perhaps the most controversial of these mechanisms, Arizona, California, Colorado, Florida, Indiana, Maryland, and Minnesota all authorize the administering agency to assume the management of continuing care facilities in certain specific situations in order to rehabilitate communities in serious financial trouble.[111]

The California rehabilitation procedure, probably the most detailed, is triggered when a CCRC fails to file its annual report and the Department of Social Services has reason to believe that "the provider is insolvent, is in imminent danger of becoming insolvent, is in a financially unsound or unsafe condition, or that its condition is such that it may otherwise be unable to fully perform its obligations pursuant to life care contracts."[112] The facility is first allowed to propose a plan to correct the deficiencies.[113] Next, in case of an emergency that threatens immediate closure of the facility, or if no approved plan is forthcoming, the administering agency may petition a court for appointment of an administrator.[114] The administrator has broad powers, including total power over all property, equipment, and funds and the power to perform all the duties of the original provider.[115] The statute provides for

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[107] *Id.* §1782.

[108] Colorado §12–13–117(1); Florida §651.125(3); Indiana §23; Maryland §20; Michigan §554.834; AAHA §10.

[109] Indiana §23; Michigan §554.828; AAHA §10.

[110] Arizona §20–1811 (misdemeanor); California §1788 (misdemeanor); Colorado §12–13–117(2) (misdemeanor); Florida §§651.108, 651.125(1), 651.13 (administration fines, felony, and civil penalties); Indiana §9 (misdemeanor); Maryland §18(c) (misdemeanor); Michigan §554.836 (fine and imprisonment); Minnesota §§80D.13, 80D.16 (civil and criminal liability).

[111] Arizona §20–1808; California §§1790–1790.6; Colorado §12–13–109; Florida §651.114; Indiana §21; Maryland §20(b); Minnesota §80D.11.

[112] California §1790.

[113] *Id.*

[114] *Id.* §1790.1.

[115] *Id.* §1790.4.

Investigative, Enforcement, and Rehabilitative Powers

Arizona: Examiners can conduct examinations as needed. Misdemeanor to violate. Rehabilitative authority.

California: Inspections authorized at any time, but annual audit can be relied on instead. Misdemeanor to violate. Rehabilitative authority.

Colorado: Examinations when necessary. Injunctive relief. Misdemeanor to violate. Rehabilitative authority.

Florida: General examination authority. Injunctive relief. Felony and civil penalties for violations. Rehabilitative authority.

Indiana: General investigative authority plus subpoena power. Injunctive relief. Cease and desist orders allowed. Misdemeanor to violate. Rehabilitative authority.

Maryland: General investigative authority. Injunctive relief. Misdemeanor to violate. Rehabilitative authority.

Michigan: Limited power to investigate when records are missing plus general investigative authority. Injunctive relief. Cease and desist orders allowed. Fines and imprisonment for violation.

Minnesota: Self-executing statute. Civil and criminal penalties for violation. Resident-initiated rehabilitation and liquidation procedure.

Missouri: None.

AAHA: General investigative authority plus subpoena power. Injunctive relief. Cease and desist orders allowed. No penalties for violation.

termination of the intrusion when the defect is cured,[116] as well as for liquidation or dissolution of the provider if rehabilitative efforts fail.[117]

The Minnesota statute, owing to its self-executing character, has a unique triggering mechanism for its rehabilitation/liquidation provision. If any CCRC fails to meet its reserve requirements, if any provider has been or will be unable to meet its obligations, or if any provider files for relief from its creditors, then any *resident* can petition a court for an order directing the appointment of a trustee.[118] The court can then appoint a trustee who will attempt to rehabilitate or liquidate the facility.[119] There is no involvement of any state administrative agency at any point in the proceedings.

LIMITED STATE REGULATORY SCHEMES

The second set of state responses after detailed regulation is selective, specific regulation of certain aspects of the continuing care industry. Six states have adopted legislation falling short of detailed regulation

[116] *Id.* §1790.5.

[117] *Id.* §1790.6.

[118] Minnesota §80D.11(1).

[119] *Id.* §80D.11(1), (4).

and, in most cases, isolating one of the more serious problems of continuing care, and attempting to eliminate that problem without imposing a full-scale regulatory program.

MEDICAID AND PUBLIC ASSISTANCE REGULATIONS

Connecticut[120] and Illinois[121] have enacted statutes limiting the eligibility of life care residents to receive public assistance or Medicaid. These statutes are usually implicated in the following situation: Over time, or even immediately after payment of the entrance fee, residents qualify for public assistance because of their reduced net worth and the resultant reduced income stream. They, therefore, apply for Medicaid benefits, often at the behest of the provider, and all such benefits are turned over to the community.

In Connecticut, a life care resident (life care is not defined) is eligible for assistance only if: (1) care under the contract commenced before April 3, 1957; (2) the operator is a charitable institution; (3) the applicant is a resident at the time of application; (4) the consideration paid for the resident's care has been exhausted, assuming a rate of $75 per month; and (5) the income of the provider is insufficient to permit continued performance of the agreement.[122]

Under the Illinois statute, a person maintained in a private institution qualifies for aid only if he has not purchased care or, if he has, only if his payment has been wholly consumed. A regulation of the Illinois Department of Public Aid explains that a "resident that has an agreement for life care . . . shall be considered not in need of public assistance on the basis that he has a resource to meet his needs."[123] The difference between the statute and the regulation is quite significant: the statute appears to say that any life care resident who lives longer than expected will be eligible for aid because the entrance fee would

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[120] Conn. Gen Stat. Ann. §§17–116, 17–316 (West 1958).

[121] Ill. Ann. Stat. ch. 23, §3–1.5 (Smith-Hurd 1971); Ill. Dept of Public Aid Rules & Regulations, art. 8, rule 8.02.02, cited in *Cornue* v. *Department of Pub. Aid,* 64 Ill. 2d 78, 81, 354 N.E.2d 359, 361 (1976).

[122] This statute may ultimately be declared invalid under the supremacy clause of the Constitution. *Rowland* v. *Maher,* 176 Conn. 57, 404 A.2d 894 (1978), held a related statute unconstitutional as contrary to the federal policy that the only legitimate ground for withholding Medicaid is actual unavailability of assets. The court stated in dicta that §17–116 was unconstitutional to the extent that it "deprives a person holding a life care contract of medical assistance on any ground other than actual availability of assets." *Id.* at 63, 404 A.2d at 895.

[123] Ill. Dept. of Public Aid Rules & Regulations, art. 8, rule 8.02.02, cited in *Cornue* v. *Department of Pub. Aid,* 64 Ill. 2d 78, 81, 354 N.E.2d 359, 361 (1976).

have been "wholly consumed"; the regulation explicitly negates this interpretation.[124]

REFUND REGULATIONS

Only one state has chosen to regulate refunds of entrance fees in isolation. Oregon has enacted legislation requiring that any such fees or transfers of property made before or during the first six months of occupancy must be refunded to any resident who withdraws from the facility within the first six months of occupancy.[125] One should note that this statute covers only a small part of the refund problem, as death is not normally considered equivalent to withdrawal, and the statute applies to withdrawal only during the first six months of residence.

PROHIBITION

Although not strictly selective regulation, two state attempts to outlaw the institution of life care are relevant in this regard. As noted above, New York[126] and Pennsylvania[127] have apparently attempted to prohibit the offering of life care contracts. As also noted above, neither effort appears to have been successful owing to definitional difficulties.

PROPRIETARY/NONPROFIT DISTINCTION

As part of its detailed regulatory program, Michigan incidentally prohibits proprietary operators from entering into "pure" life care agreements.[128] To the authors' knowledge, no other state has taken this step.

This provision, based on the notion that profit seeking has an adverse effect on the quality of care and services, attempts to eliminate the opportunity to profit from continuing care operations. Regardless of one's views on the desirability of such a policy, a provision excluding proprietary operators would not effectively advance this aim. First,

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[124] The Illinois Supreme Court upheld both the statute and the regulation in *Cornue*. *See Reynolds* v. *Department of Pub. Aid,* 26 Ill. App. 3d 933, 326 N.E.2d 109 (1975). These decisions, however, were based on construction of the statute and the regulation and did not involve consideration of federal constitutional limitations.

[125] Or. Rev. Stat. §91.690 (1977).

[126] N.Y. Code of Rules and Regulation, tit. 10, §§730.2(F), 730.3(b) (1979). See id. §§414.16(b), 415.1(F), 420.1(f).

[127] 28 Pa. Code §201.38 (1979).

[128] Michigan §554.805(5).

the policy is too broad in that it would exclude desirable proprietary operators from the industry.[129] Second, it is too narrow in that it could easily be circumvented. A person who wishes to operate a continuing care retirement community for profit can establish a nonprofit "front," thus satisfying the statutory provision. The front could then, in effect, distribute "profits" to the providers through contracts between the nonprofit entity and for-profit entities that the provider owns or controls—most obviously, a management service company hired to run the community.[130] Such legal self-dealing arrangements are extremely effective tools for breaking the "nondistribution constraint" traditionally associated with nonprofit organizations.[131]

REMAINING RESPONSE: NONREGULATION

The third potential state response following detailed and selective regulation is the most common of our three sets of responses. The response of nonregulation has been "adopted" by 36 states, the District of Columbia, and the federal government. Notwithstanding the simplicity of the nonregulation response, some comments are necessary.

THE STATES

It is unfair to say that 36 states have done nothing to regulate CCRCs. Several states have considered or are currently considering legislation to regulate the continuing care industry. Illinois[132] and Massachusetts have considered such legislation in the past; New Jersey[133] and Penn-

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[129] Because of the tax consequences, it is questionable how successful a proprietary CCRC could be. Without the tax advantages in the treatment of receipt of entrance fees, it is unclear whether continuing care is a desirable vehicle for proprietary operators.

[130] *See* Hansmann, *The Role of Nonprofit Enterprises,* 87 Yale L.J. 835, 838 (1980).

[131] *See* Comment, *Continuing Care Communities for the Elderly: Potential Pitfalls and Proposed Regulation,* 118 U. Pa. L. Rev. 883, 896 (1980).

[132] Following preparation of this chapter, a comprehensive statute regulating CCRCs went into effect in Illinois. As a result of timing difficulties, no discussion of that new legislation occurs in this work.

[133] New Jersey has definitely not yet enacted any form of continuing care legislation. On May 14, 1981, however, Assemblyman Snedeker introduced comprehensive legislation concerning the continuing care industry.

The provisions of Bill No. 3359 may be summarized as follows: (1) administering agency is the state Department of Health; (2) standard definition of continuing care, complete with the potential problems discussed in this chapter; (3) requirement that only nonprofit entities may offer continuing care agreements similar to the Michigan provision; (4) general antifraud provision; (5) requires obtaining a certificate of authority before selling any continuing care contract—procedure for certification involves submission of application form complete with typical attachments, including financial data and

sylvania[134] are currently considering such legislation; and discussions are taking place in Ohio that could lead to proposed legislation. Other states have, in all likelihood, considered similar legislation in the past, but the information sources disclosing such matters are scattered and unreliable.

The dearth of state regulation clearly is not a result of lack of interest in the problems of the elderly: all 50 states and the District of Columbia require the licensing of traditional nursing homes. In fact, the 54 state agencies charged with regulation of nursing homes comprise the largest contingent of such agencies in the entire field of health care regulation.[135]

In some states in which the legislature has not acted to regulate continuing care, the state judicial system has been pressed into service. It is important to note, however, that judicial regulation of continuing care is, definitionally, quite different from legislative regulation. Private litigation usually arises after the damage occurs—damage that, in the case of continuing care, may often be irreparable. No judicial

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full disclosure; (6) annual renewal and reporting requirements; (7) independent revocation of registration procedure; (8) detailed regulation of the contents of the continuing care agreement, including a seven-day cooling-off period and mandatory arbitration of disputed claims between residents and the community; (9) one resident must be permitted to sit on each facility's board of directors; (10) filing of a financial plan for the community, which could lead to the discretionary imposition of an escrow or bond requirement; (11) advertising regulation; (12) public inspection of all documents filed including the disclosure statement; (13) full investigative and injunctive powers, including subpoena power and authority to seek cease and desist orders; and (14) civil and criminal liability for violations.

[134] Pennsylvania is actively considering the possibility of enacting some form of legislation regulating the continuing care retirement industry. Early in 1981, the state Senate adopted Senate Resolution No. 32, which established a task force "to investigate nonprofit corporations providing for retirement homes and retirement communities." The task force produced a bill proposed in 1982 which has been amended and introduced as Senate Bill No. 1270 (Session of 1982). The provisions of this bill may be summarized as follows: (1) standard definition of continuing care, complete with the problems discussed in this chapter; (2) complete certification provisions; (3) provisions governing annual disclosure; (4) provisions authorizing revocation of certification of authority; (5) advertising regulation; (6) detailed reserve requirements; (7) reserve fund escrow provision; (8) provision granting residents a subordinated lien; (9) entrance fee escrow provision; (10) regulation of the form and contents of continuing care contracts; (11) provision establishing an advisory council; (12) provision granting residents rights of self-organization; (13) rehabilitation and liquidation procedures; (14) regulation of conflicts of interest on the board of directors; and (15) civil and criminal penalties for violations of the statute.

Finally, the Pennsylvania House has also been considering legislation governing the continuing care field. House Bill No. 2348, introduced on March 22, 1982, can be summarized as follows: (1) an insufficient definition section; (2) administration vested in the Department of Insurance; (3) complete certification provision; (4) disclosure provisions; (5) reserve provision; (6) audits required every three years; (7) civil and criminal penalties; (8) injunctive relief; (9) rehabilitation and liquidation authority; and (10) provision on suspension of registration.

[135] Department of Health, Education, and Welfare, *Health Resources Statistics: Health Manpower and Health Facilities*, 328, 473, 479–80 (1976–77).

mechanism exists to head off the potential dangers of improper financial and actuarial planning that inhere in the process of continuing care.

The bulk of the litigation involving CCRCs has focused on the relatively narrow issues of contract terminations, refunds, and the fee/service structure of community operators. Through a narrow focus on the case-by-case equities, and often with reference to vague notions of public policy, state courts have apparently added to the financial uncertainties of continuing care. Although the results of litigation have been generally predictable, the inherent unpredictability of cases in equity and the dearth of clear statements of law have also had two effects: the potential plaintiffs are encouraged to litigate the particular facts of their grievances, and communities are prevented from planning intelligently. Instead, they must devote a substantial amount of resources to countering the threat of costly litigation.

Continuing care litigation may be divided for analytical purposes into suits by residents, which generally are successful, and suits by heirs of residents, which generally are not. This chapter is not the place to enter into a comparative analysis of the case law.[136] Suffice it to say that, should a state opt to legislate a comprehensive regulatory program, one of the goals of the state might well be a reduction of the litigation uncertainty.

THE FEDERAL GOVERNMENT

With the exception of standard Medicare and Medicaid certification regulations for nursing facilities in CCRC, the federal presence in the field is virtually nonexistent. Several congressional committees and federal agencies have, from time to time, expressed interest in the problems of continuing care, but none has yet addressed them directly.[137]

In 1977, Representatives William Cohen and Gladys Spellman introduced legislation that would have required continuing care providers subject to federal jurisdiction[138] to disclose financial information to all current and prospective residents and to maintain minimum cash reserves.[139] The bill required that the contract between the community

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[136] For a summary discussion of the extensive continuing care case law, see Comment, *Continuing Care Communities for the Elderly: Potential Pitfalls and Proposed Regulation,* 128 U. Pa. L. Rev. 883, 903–09 (1980).

[137] *See id.* 902.

[138] Such communities would have had to have been engaged in interstate commerce, to have received Medicare or Medicaid reimbursement, or to have been constructed with federal assistance.

[139] H.R. 4170, 95th Cong., 1st Sess. (1977). The Cohen/Spellman bill was in response to a proposal introduced by Representative Claude Pepper, which would have prohibited any residential health facility operator from accepting prepayment for basic services for more than three months.

and the resident (1) provide for full written financial disclosure, (2) include a full description of charges and services, (3) make clear that the contract granted no property rights, (4) contain assurances that all fees would be spent on patient care and related expenses, (5) specify termination conditions, and (6) provide for an annual audit. Each community would have been required to maintain financial reserves sufficient to meet its obligations. Payments to facilities under construction would have had to be held in escrow. The bill died at the end of the 95th Congress and has not been reintroduced. ■