CONTINUING-CARE COMMUNITIES FOR THE ELDERLY: POTENTIAL PITFALLS AND PROPOSED REGULATION

In 1977, 23.5 million people—one in every nine persons in the United States—were sixty-five years of age or older. By 2010, when the “baby boom” children are only beginning to reach age sixty-five, the number of elderly persons in this country is expected to be thirty-four million. That number is expected to reach fifty-two million by 2030, at which time the proportion of our populace over sixty-five should peak at somewhere between fourteen and twenty-two percent.

Even now, the provision of adequate medical care and housing for the elderly is one of the nation’s most pressing social problems. To date, the primary institutional solution has been the nursing home: more than 1.3 million elderly people were living in nursing

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1 NATIONAL CLEARING HOUSE ON AGING, ADMINISTRATION ON AGING, OFFICE OF HUMAN DEVELOPMENT SERVICES, DEP’T OF HEALTH, EDUCATION, AND WELFARE, FACTS ABOUT OLDER AMERICANS 1978, DHEW PUB. NO. (OHDS) 79-20006 (1978) [hereinafter cited as FACTS ABOUT OLDER AMERICANS].

2 Throughout this Comment, “elderly” will be used to refer to people who are 65 years of age or older.


4 The phrase “nursing home” will be used in this Comment as a generic term encompassing all those institutions that fall within any of the half dozen definitions used by the federal government. Among those included in the general federal classification for statistical purposes are: (1) Nursing care homes, whose primary function is nursing care; (2) Personal care homes with nursing, in which personal care is the primary function and some nursing is provided; (3) Personal care homes without nursing, whose sole function is personal care; and (4) Domiciliary care homes, in which domiciliary care is the primary function but the home has responsibility for providing some personal care. NATIONAL CENTER FOR HEALTH STATISTICS, OFFICE OF HEALTH RESEARCH, STATISTICS, AND TECHNOLOGY, PUBLIC HEALTH SERVICE, DEP’T OF HEALTH, EDUCATION, AND WELFARE, HEALTH RESOURCES STATISTICS: HEALTH MANPOWER AND HEALTH FACILITIES 298 (1976-1977) [hereinafter cited as HEALTH RESOURCES STATISTICS]. For purposes of Medicare and Medicaid programs, the government certifies skilled nursing facilities, for people who need constant professional medical attention; for purposes of Medicaid only, it certifies intermediate care facilities, for people who need less extensive medical supervision. Id. 299-300. See NATIONAL CENTER FOR HEALTH STATISTICS, OFFICE OF HEALTH RESEARCH, STATISTICS, AND TECHNOLOGY, PUBLIC HEALTH SERVICE, DEP’T OF HEALTH, EDUCATION, AND WELFARE, THE NATIONAL NURSING HOME SURVEY: 1977
homes in 1977 at a cost in excess of nine billion dollars. Up to now, too, academicians and government policymakers have focused their studies of the housing and medical needs of the elderly on nursing homes and conventional housing. An increasingly popular alternative, a combination housing and nursing-care institution known as the continuing-care community, has received scant attention.

The continuing-care community provides residential accommodations for the elderly, and, when necessary, nursing care in a specialized facility on the premises. In exchange for this lifetime


"The growth of the industry has been impressive. Between 1960 and 1970, nursing home facilities increased by 140 percent, beds by 232 percent, patients by 210 percent, employees by 405 percent, and expenditures for care by 465 percent. Measured from 1960 through 1973, expenditures increased almost 1,400 percent." Senate Special Comm. on Aging, Subcomm. on Long-Term Care, 94th Cong., 1st Sess., Nursing Home Care in the United States: Failure in Public Policy XIII (Comm. Print 1975) [hereinafter cited as 1975 Senate Report]. And one House of Representatives subcommittee found that "the rate of public spending for nursing home care has increased virtually faster than for any other health service," at an annual rate of more than 23% from 1967 through 1976. House Comm. on Interstate and Foreign Commerce, Subcomm. on Oversight and Investigations, 95th Cong., 1st Sess., Report on Fraud and Abuse in Nursing Homes: Pharmaceutical Kickback Arrangements 1-2 (Comm. Print 1977) [hereinafter cited as Report on Fraud and Abuse in Nursing Homes].

Although the 1.3 million people living in nursing homes represent only five percent of the elderly population, the fact that by 1974 there were more nursing-home beds in the United States than general hospital and surgical beds demonstrates the importance of the problems of long-term institutionalization of the elderly. 1975 Senate Report, supra note 4, at XII.


9 Although the contemplated term of the continuing-care contract is the life of the resident, each party has certain limited rights of termination. See note 13 infra.
service, the resident makes a substantial capital contribution to the
community and pays a relatively fixed monthly fee. This arrange-
ment, a modern variation on well-established charitable and often
church-sponsored institutions,\textsuperscript{10} offers a form of social insurance to
the elderly: it preserves residential independence and removes the
spectre of costly, and often premature, long-term institutionalization.\textsuperscript{11}

This Comment will first describe the modern-form continuing-
care community and the reasons for its growth and increasing popu-

larit. It will then, in part II, focus on those aspects of continuing
care that present significant public-policy concerns and demonstrate
the need for some form of government regulation. Finally, in part
III, the Comment will review the possible governmental responses,
including the current, and largely inadequate, state efforts at regu-
lration. In conjunction with that review, it will suggest a three-
phase regulatory scheme designed to protect the interests of the
elderly without inhibiting the development of continuing care.

Because the modern form of continuing care is a relatively
new development, information about its practical application is not
abundant, nor is there any single sophisticated model that may be
called modern-form continuing care. Therefore, on the basis of
available information and the opinions of people who have had
experience in running continuing-care communities, this Comment
will present a general picture of the institution. Even the broad
survey that is now possible reveals the compelling social advantages
of continuing care and the major potential dangers associated with
it. Especially because more and more people can be expected to
entrust their savings and social well-being to continuing-care com-
munities, it is not too early to suggest the likely targets and broad
outlines of a comprehensive scheme of regulation. At issue is not
merely the financial success of entrepreneurs in a free market, but
the welfare of countless thousands of people who may have staked
all they own on those entrepreneurs' vision of security in old age.

I. THE CONTINUING-CARE PHENOMENON

A. What Is a Modern-Form Continuing-Care Community?

In brief, a modern-form continuing-care community\textsuperscript{12} is a
financially self-sufficient residential community for the elderly that

\textsuperscript{10} See note 14 infra.
\textsuperscript{11} See notes 38-44 infra & accompanying text.
\textsuperscript{12} The chief distinction between the "modern form" and its continuing-care
predecessors is the mode of financing the community. See note 14 infra & accom-
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offers medical and nursing services in specialized facilities on the premises. Its distinguishing feature—and the basis of its existence and operations—is a lifetime contract between the community and each resident that defines each party's financial and service obligations. The resident pays a lump-sum "accommodation fee" prior to occupancy and a monthly fee thereafter.

It should be noted that the literature, statutes, and case law on this subject refer to continuing care, life care, perpetual care, residence and care, and life lease, often interchangeably, and often with the result of no small degree of confusion. Important distinctions between the terms will be explained as necessary throughout this Comment. The description that follows in the text sets out the fundamental definitional features of modern-form continuing care.

Several examples of modern-form continuing-care contracts are on file with the University of Pennsylvania Law Review. This Comment refers to the continuing-care contract as a "lifetime" contract in accordance with the expectations of the parties. In fact, in contrast to the traditional life-care contract, see note 14 infra, which binds at least the provider for the life of the resident, the continuing-care contract may be terminated by either the resident or the community, see notes 108-10 infra & accompanying text.

American Association of Homes for the Aging, Continuing Care Homes 1 (1976). Fees vary greatly from community to community and within communities. Entrance fees range from $15,000 to $75,000, depending on the offerings of the particular community, the size of the residential unit, and the type and relative proportions of expenses that the entrance and monthly fees are designed to cover. Monthly fees may run between $350 and $1500, depending on the same factors. Interview with Lloyd W. Lewis, Executive Director of Kendal-Crosslands, in Kennett Square, Pa. (Dec. 3, 1979) (notes on file with the University of Pennsylvania Law Review) [hereinafter cited as Interview with Lewis].

See N. Adelmann, Directory of Life Care Communities (1978).

Most continuing-care communities use one of three methods of financing. The accommodation-fee-plus-monthly-payments method, in its modern form, is a flexible one in which, as recommended here, entrance fees are used to cover capital expenditures of the community and monthly fees are tied to current operating costs. See text following notes 56 & 61 infra. Not all communities that use the accommodation-fee-plus-monthly-payments method use it in its modern form. See, e.g., text accompanying note 88 infra.

Another financing arrangement, now largely of historical interest only, see Letter from Thomas M. Jenkins, Judge of the Superior Court, County of San Mateo, California, to the author (Nov. 26, 1979) (on file with the University of Pennsylvania Law Review), has been used primarily by church-affiliated providers. Based on the sectarian convent tradition according to which the novice "donated" all her possessions for the support of the convent, C. Townsend, Old Age: The Last Segregation 92 (1971), it requires the resident to assign all his present and after-acquired assets to the community in exchange for an irrevocable promise of lifetime care. In this manner, the residents pay what they can afford, and the total cost for each resident is only incidentally related to the cost of care. Use of this method always entails the threat of financial disaster because the community assumes the risks of projecting indeterminate costs and life expectancies: the resident must be supported for life regardless of the size of his original contribution. American Association of Homes for the Aging, supra, at 3. See notes 76-81 infra & accompanying text.

This assignment-of-all-assets arrangement has been sharply criticized because of the economic hazards to the community, the psychological damage caused by depriving people of all their assets, and the incidence of large "contributions" without commensurate benefit. Jenkins, Life Care Contracts—A Viable Option?, Concern, Dec. 1975-Jan. 1976, at 35.

The third arrangement is known as the total-fee-in-advance contract, under which the resident pays a predetermined amount when he enters the facility. The
The typical contract provides that upon the death of the resident—whether one day, one year, or a decade after occupancy—the entrance fee vests in the community, regardless of the value of services received by the resident. The required monthly fee, although based on community operating costs and thus subject to change, does not increase as a result of a resident's transfer from his residential cottage (where he is largely self-sufficient) to the nursing facility (where full nursing care is provided); it is the same for all residents with comparable housing units. This rate structure is considered by some experts to be the most crucial element of continuing care because it transforms the contract into a form of insurance against the high costs of long-term institutionalization.

The continuing-care community is a unique response to the needs of the elderly, but it draws on features of several other housing and nursing institutions. Like a retirement village, it provides individual units for its residents in an age-segregated environment, but the continuing-care residents have no ownership rights in those units. The community offers nursing care on the premises, just like a traditional nursing home, but unlike in the latter, entry into the community nursing facility entails no increase in the resident's cost of living.
Continuing-care and life-care arrangements are becoming increasingly popular in the United States. In 1976 there were an estimated three hundred communities. By early 1979 that figure had doubled to approximately six hundred—eighty of which were sufficiently similar to one community's definition of continuing care to be included in the industry's first directory of continuing-care communities. Another twenty-five to thirty modern-form continuing-care communities were in relatively advanced stages of planning in 1979; thirty to fifty more were in the early planning stages. This dramatic growth is attributable to two primary advantages for elderly, middle-class people: the sociological advantage of independent living without the burdens of ownership and the economic or insurance advantage of relatively fixed fees regardless of the level of services received. The significance of these advantages is discussed in the following section.

B. Why Continuing Care?

Continuing care is particularly well suited for two groups of elderly, middle-class people: those who live independently but need occasional medical or nursing care, and those in nursing homes who do not need full-time care. This section will survey the demographic and economic underpinnings of the popularity of continuing care.

The proportion of elderly people in the United States, already large, will continue to grow steadily until at least 2030. During most of that time, the average age of the elderly population is also expected to increase dramatically. A major factor in these fore-

there is no direct correlation between an individual's fees and his admittance into the nursing facility.

21 See notes 12-14 supra.

22 Frankel, Life Care Communities: Housing for Both the Active and Infirm Elderly, J. PROP. MANAGEMENT, Mar.-Apr. 1979, at 82. Based on an estimated average size of 350 residents, Interview with Lewis, supra note 14, life-care and continuing-care communities thus had approximately 210,000 residents in 1979.

23 This figure includes only communities that intended to offer a "pure" form of continuing care, as determined by seven criteria: (1) lifetime contract; (2) medical and nursing care on the premises; (3) accommodation-plus-monthly-fee financing; (4) financial self-sufficiency; (5) adjustable monthly fees; (6) nonprofit; and (7) designed for people healthy at entrance. See N. ADELLE, supra note 14, at 4.

24 Id. 93; Interview with Lewis, supra note 14.

25 See notes 40-44 infra & accompanying text.

26 See notes 1 & 3 supra & accompanying text. Predictions such as this are relatively safe because everyone who will be at least 65 years old some time in the next 65 years is now living.

27 In 1976, 38% of elderly people were age 75 or older. In 2000, this proportion will reach 45% before falling back to 38% by 2020. Demographics of Aging,
casts is the general increase in life expectancy in this country: a child born in 1976 was expected to live seventy-three years, twenty-six years longer than was a child born in 1900. Although the life expectancy of persons over age seventy-five is also increasing, approximately eighty percent of the overall increase is attributable to a reduction in mortality among people seventy years old or younger.

The demand for housing and nursing care among the elderly is closely related to age, health, and financial status. Since the


28 Facts About Older Americans, supra note 1.

29 In 1976 a 75-year-old had a life expectancy of 10.1 years and an 80-year-old a life expectancy of 7.9 years. The comparable figures in 1900 were 7.08 and 5.30, respectively. National Center for Health Statistics, Public Health Service, Dept of Health, Education, and Welfare, Facts of Life and Death, DHEW Pub. No. (PHS) 79-1222, at 6 (1978). This statistic is most important to a continuing-care operator because life expectancy at time of entry is a key variable used in the setting of rates. See notes 76-79 infra & accompanying text.


31 See Domestic Consequences of U.S. Population Change, supra note 3, at 62. For instance, in 1974, 12 of every 1,000 people between the ages of 65 and 74 were residents of nursing homes, compared to 237 of every 1,000 people over age 85. Demographics of Aging, supra note 7, at 127 (statement of Mary Grace Kovar). In general, people over age 65 require twice the health care that those under that age do. M. Mendelson, Tender Loving Greed 35 (1974).

32 In 1976, chronic ailments limited the abilities of 39% of the elderly to work or keep house; only seven percent of people under 65 were so limited. People over 65 are more likely to visit a doctor or hospital, do so more frequently, and stay longer in the hospital. Thus, it is not surprising that the per capita cost of health care for elderly people in 1976 was $1,521, nearly three times the $547 for those younger than 65. Facts About Older Americans, supra note 1.

33 The typical person over 65 is in a precarious financial position. The median income of families headed by an elderly person in 1969 ($4,885) was only half the median income for all families in the United States ($9,596). Older persons not living in families had a median income of only $1,813 for the year. Bureau of the Census, Dept of Commerce, We the American Elderly 12 (1973). For many elderly people, this income is fixed, and, although perhaps sufficient to meet usual day-to-day expenses, cannot cover the costs of long-term institutionalization. Jenkins, supra note 14, at 35, 36.

Of the 20 million persons 65 and older in 1970, 4.8 million had incomes below the poverty level. Two million more could not afford the cost of necessary medical care. Only two million of these seven million were receiving aid under federal old-age assistance programs. Fewer than half the elderly people who were eligible actually received Medicaid, which is available only to qualified needy individuals. For many, the co-insurance and deductible features of Medicaid are often oppressive. C. Townsend, supra note 14, at 19-20.

For those elderly persons who fail to qualify for Medicaid, there is no governmental assistance for intermediate nursing care. See note 4 supra; Report on Fraud and Abuse in Nursing Homes, supra note 4, at 7-12. Coverage for long-term institutionalization is sharply limited under Medicare to 100 days per "benefit period." A benefit period begins upon entry to a hospital or nursing home and terminates after the individual has been out of the institution for 60 consecutive days. This benefit is available only after the patient has been hospitalized for at
early part of this century, middle-class elderly people have tended to live independently for as long as possible and then, as their health and financial condition deteriorated, to move to an apartment or room in a retirement home or the home of an adult child, and then to an institution. But because of the shortage of appropriate housing, the general increase in mobility of the population, the rise of the two-worker family, and, perhaps most important, the enactment of Medicare and Medicaid programs, that historical pattern is showing signs of changing.

In 1980, more and more people who are at all financially and physically able to do so are holding on to their houses or apartments longer. Many others, faced with failing health and dwindling financial resources, find they must move to nursing homes before long-term institutionalization is really necessary or desirable. In fact, it has been estimated that 2.4 million elderly people who are not in need of long-term institutionalization do need some form of housing/nursing-service plan to avoid a premature move to nursing homes. And surveys in three states have indicated that from fifty-three to as much as ninety percent of residents of long-term nursing facilities did not require such extensive care. As the overall number and average age of elderly people increase, these two groups can be expected to grow as well.

Continuing-care communities offer such people significant advantages over their present situations and over other forms of con-

34 Domestic Consequences of U.S. Population Change, supra note 3, at 62.
35 See Health Resources Statistics, supra note 4, at 327; Demographics of Aging, supra note 7, at 12 (testimony of Tamara Hareven), 15 (testimony of Beth J. Soldo), 21 (testimony of Tamara Hareven); Phila. Inquirer, Dec. 16, 1979, § L, at 1, col. 1.
36 This trend has manifested itself primarily in three ways: (1) a shift in the institutionalized population from mental and other inappropriate facilities to nursing homes; (2) a decline in the number of multigenerational households; and (3) a decline in the incidence of strangers living in others' households. Domestic Consequences of U.S. Population Change, supra note 3, at 62-63; see Demographics of Aging, supra note 7, at 217-20 (statement of Beth J. Soldo). See generally M. Mendelson, supra note 31, at 34-39; W. Thomas, Nursing Homes and Public Policy (1969); C. Townsend, supra note 14.
37 Carp, The Concept and Role of Congregate Housing for Older People, in Congregate Housing for Older People 3, 6 (W. Donahue, M. Thompson, & D. Curren eds. 1977).
38 M. Mendelson, supra note 31, at 40-41. The three states were Michigan, New York, and Ohio.
39 See note 36 supra.
aggregate housing arrangements. Unlike any nursing home, condominium, or retirement village, the communities preserve the incidents of independent living, without the burdens of ownership and without sacrificing affordable and readily available nursing care. The most significant advantage of continuing care for the middle class, however, lies in the structure and amount of residents' payments: a substantial entrance fee plus moderate and relatively fixed monthly payments. Because most elderly people own their own homes and may have other capital assets such as stocks and bonds, they have the means to raise sufficient cash for the entrance fee. In return for liquidating what may be their entire financial bases, they are guaranteed lifetime housing and nursing care at relatively fixed rates that correspond to what for many are fixed incomes. This arrangement not only offers the long-term security many elderly people lack, but also ensures that long-term nursing care will be within their financial means—and without unnecessary loss of independence or unnecessary institutionalization.

See N. ADELHAEDE, supra note 14, at 4; Frankel, supra note 22, at 82-84. It is not inconceivable that, in addition, the continuing-care contract may create enforceable standards for quality of care. See Brown, An Appraisal of the Nursing Home Enforcement Process, 17 Am. L. Rev. 304, 350-51 (1975). But see C. TOWNSEND, supra note 14, at 93-94.

Eighty-two percent of elderly heads of households and 59% of elderly persons living alone own their own homes. The median value of the housing units owned by elderly people in 1976 was over $25,000. FACTS ABOUT OLDER AMERICANS, supra note 1.

See notes 16-20 & 33 supra & accompanying text. Some numbers, based on those in papers filed in a New Jersey suit by heirs of a resident, may help illustrate this relationship. See Defendant's Memorandum in Support of Motion for Summary Judgment at 6-7, exh. D, Smith v. Estaugh, No. 75-1996 (D.N.J. Oct. 13, 1976). Before entering the community, the resident converted his house, stocks, and bonds into $73,000 in cash. He had annual interest income of $6,000, social security income of $2,700, and pension income of $5,500, a total of just over $14,000 a year. He paid an entrance fee of $15,000 to the community out of the cash derived from his capital assets; his monthly fee was $300. When the resident had to move into the community's nursing facility, he continued to pay $300 per month. The monthly rate at an equivalent skilled nursing facility would have been $1,500. Thus, whereas the resident could easily afford the costs of continuing care, entrance into an independent skilled nursing facility would have threatened to consume his capital assets.

The continuing-care form allows spreading of costs and cross-subsidization. The spreading is achieved when residents do not live as long as expected: their prepaid funds may be used to pay the costs of caring for residents who live longer than expected and who might run out of money. Cross-subsidization among residents occurs because people who buy more spacious or luxurious housing units pay higher fees for the same care than do people who buy smaller units.

S. DE BEAUVOR, THE COMING OF AGE 699 (P. O'Brian transl. 1970). Elderly middle-class people who neither qualify for Medicaid nor have health insurance to finance long-term institutionalization have good reason to feel less than secure. See note 33 supra & accompanying text.

See note 33 supra.
The correspondence between the structure of continuing-care communities and the financial and social needs of the elderly has led some housing experts to predict that these communities will supplant "retirement" condominium housing to a large extent and take over a "substantial portion" of the market in housing for the elderly.\textsuperscript{45}

II. The Basis for Regulation

The need for specific regulation tailored to continuing care arises from the distinctive financial and contractual nature of the institution. This part will attempt to elaborate the basic justifications for such regulation. As will be seen in the references to the dramatic bankruptcy of Pacific Homes, these justifications are by no means merely hypothetical.\textsuperscript{48}

A few general considerations should be noted first. The model of continuing care described in the preceding part is just that—a model. But, for a variety of reasons discussed below, even good intentions may not ensure that the reality of continuing care conforms to this Comment's paradigmatic well-run community. Because even apparently minor miscalculations or variations from that model can be catastrophic, the need for regulation is even more pressing in such nonconforming communities.

Moreover, proprietary operators are entering the continuing-care field in ever-increasing numbers.\textsuperscript{47} The development of the flexible modern-form financing method has mitigated some of the risks that traditionally have made life care the province of charitable organizations.\textsuperscript{48} But, as has been demonstrated in the case of nursing homes,\textsuperscript{49} the mechanisms of a free market are inadequate to ensure that high-quality nursing care will be provided.\textsuperscript{50}

\textsuperscript{45} Frankel, supra note 22, at 84; Demographics of Aging, supra note 7, at 60 (statement of Dr. Donald Cowgill); Address by Gerard V. Carey, Chairman of Life Services Corp., remarks noted in The Bulletin, Jan. 27, 1980, § H, at 2, col. 6 (Philadelphia).

\textsuperscript{46} See notes 85-96 infra & accompanying text.

\textsuperscript{47} See Frankel, supra note 22, at 82.

\textsuperscript{48} See note 14 supra.


\textsuperscript{50} Id. For this reason, a Federal Trade Commission program advisor has argued that current regulation of nursing homes is inadequate. Elizabeth A. Taylor, Address Before the American Association of Homes for the Aging's 7th Annual Government Affairs Workshop, in Washington, D.C. (March 30, 1979) (copy on file with the University of Pennsylvania Law Review) [hereinafter cited as Taylor, Address].
A. Financing Continuing Care

The intricacies of initial and year-to-year financing of a continuing-care community pose the most significant challenge to the operators and the greatest threat to the welfare of the residents. The following explanation of alternative ways to finance a continuing-care community is offered in an attempt to illustrate the challenge and lay the foundation for the discussions of fraud and mismanagement in the next two sections.

Initial financing may be obtained in one of two ways. The community can issue bonds to finance the purchase of land and construction of facilities, or it can borrow money and mortgage its property. When bonds are used, construction costs not covered by the bond issue and interest and principal payments on the bonds are financed primarily through entrance fees, which are set accordingly. Operating costs and the remaining portion of the capital debt are then met with the revenue from future entrance fees and from monthly fees, which are based on the health and projected life expectancy of the average resident. The faster an institution retires its bonds, of course, the greater the initial financial burden on the first residents.

Ideally, mortgage financing should work in a similar fashion, with entrance fees set to cover the difference between the cost of the project and the amount of the permanent mortgage. Again, because excessive reliance on the initial residents' payments would be unfair, the permanent mortgage is often used to cover between thirty and sixty percent of the project cost.

The long-term financial success of any continuing-care community is critically dependent on the turnover of residents. Permanent transfer of a resident to the nursing facility frees a residential unit which can be used to generate a new entrance fee. And the death of a resident frees the remainder of his entrance payment for unrestricted use by the community. Obviously, if the resident

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52 See Interview with Lewis, supra note 14.

53 A permanent move to the nursing facility is made when the community and the resident decide it is in the resident's best interest. Even if a permanent transfer is agreed upon, the resident retains his contractual right to a housing unit should he recover.

54 The status of a resident's entrance payment both before and after his death—including any right to a refund—is a matter of contract. See note 15 supra; notes 111 & 127-30 infra & accompanying text. The idea that a resident's payment may
had not yet made a permanent move to the nursing facility, his
death means a new resident may be admitted—and a new entrance
fee paid. In fact, all communities fix their fees on the basis of an
assumed rate of turnover. In the early years, therefore, and in
any other year when turnover is lower than expected, the commu-
nity will have a shortfall in revenues. For this reason, well-run
communities voluntarily establish significant cash or other liquid
reserves which may be drawn on to counteract a shortfall.

Communities may rely to differing extents on the accommodation
(or entrance) and monthly fees to pay operating expenses. Some prefer large accommodation fees and lower monthly fees; they
put significant portions of the accommodation fees in reserve, to be
"earned" each year and used with the monthly fees. Others place
primary reliance on monthly fees for operating revenues. Both
entrance and monthly fees may be altered over time, but the better
—and more difficult—practice is to keep them relatively level. Keep-
ing fees level eliminates the potential unfairness to early residents
described above and avoids disruption of residents' financial plans.
(For instance, a community with a high entrance fee and a relatively
low monthly charge may attract residents with substantial fixed
assets and low expected income; one with a low entrance fee and
higher monthly fees may attract people without a ready source of
cash but with higher expected income. In the former case, a change
to significantly higher monthly fees could cause serious difficulties
for residents.)

Fee-setting decisions turn on a number of factors. The high
entrance fee emphasizes the insurance aspects of continuing care; the high monthly fee, on the other hand, offers the community the
advantage of greater financial flexibility. If a community using the
former approach miscalculates the entrance fee for its first residents,
it will face the possibility of having to increase monthly fees sub-
stantially, and, because its residents are likely to have only moderate

\[^{55}\] An assumed annual turnover rate of eight percent is commonly used. See Interview with Lewis, supra note 14.

\[^{56}\] See Kendal-Crosslands Annual Report for the Year April 1, 1978 to March 31, 1979, at 7-9; Interview with Hartman, supra note 51.

\[^{57}\] See note 14 supra.

\[^{58}\] See text accompanying notes 51-52 supra; notes 33 & 42 supra. Keeping fees relatively level is in the community's interest as well: residents' financial troubles can easily become revenue problems for the community as a whole.

\[^{59}\] See notes 18 & 42 supra & accompanying text.
income, financial collapse may ensue. A miscalculation in any one year by a community with low entrance fees, however, is more easily overcome through reliance on cash reserves in the short run and slightly increased monthly fees in the long run.

Communities must also take account of the relation between the size of the entrance fee and their estimate of the community's turnover rate. Because higher entrance fees are more likely to be paid only by people who expect to live longer, mortality estimates must be adjusted accordingly—which may force a community to raise the initial fee even more to cover expenses over the longer term.

A final complicating factor is that, in general, monthly fees will be higher in absolute terms in communities with low entrance fees, and one of the hallmarks of modern-form continuing care is a monthly payment affordable by people with only moderate income.

The fee-setting decision of a community is thus complex and critical. A rough rule of thumb that strikes a balance between “insurance” and low monthly fees on the one hand and financial stability on the other hand is that the provider (1) should set its entrance fees to cover capital expenditures, debt service, and depreciation and (2) should attempt to match its adjustable monthly fees to its estimated operating expenses.

B. Potential for Fraud

One significant consequence of the entrance-fee financing discussed above is that a continuing-care provider may have as much as seven to twelve million dollars at its disposal before the community's doors ever open. Even after operations are underway, entrance prepayments continue to come in. Those entrance fees are not merely investors' spare dollars, but substantial down payments on security in old age. The possibility that care providers will have control of sums of this size and character fairly cries out for protective regulation.

Although there have been no known instances of fraudulent diversions of entrance fees, examples of fraud in nursing-home operations offer instructive examples of the great potential for

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60 See notes 85-96 infra & accompanying text.
61 See note 33 supra; notes 40-44 supra & accompanying text.
62 See notes 51-52 supra & accompanying text.
63 See notes 14 & 22 supra.
64 Once a community retires its initial capital debt, the entrance payments it accumulates for repair and reconstruction are beyond even the nominal control of any outside entity—absent state regulation.
Residents of any kind of nursing facility are not likely to be capable of keeping tabs on management, and so are particularly vulnerable to fraud. And, unlike nursing-home residents, continuing-care residents are likely to have a difficult time leaving the facility for another one.

Annual revenues of nursing homes totaled approximately five hundred million dollars in 1960. By 1978, revenues had increased to a staggering fourteen billion dollars—a three thousand percent increase. The presence of such sums has spawned a great many fraudulent practices: kickback schemes, self-dealing, complicated sale/leaseback transactions to raise government reimbursement levels, and padding of bills are among the more commonly documented nursing-home frauds.

Two more sophisticated and even more profitable schemes—stock-market and mortgage manipulations—are used to generate

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65 The analogy to nursing homes is especially significant in light of the growing presence of proprietary operators in the continuing-care field. See notes 47-50 supra & accompanying text; see also note 90 infra.
66 See note 49 supra & accompanying text.
67 Taylor, Address, supra note 50. The federal and state governments provide more than 70% of nursing-home revenue. Id.
68 Id. Nursing-home providers not only have little incentive to select suppliers with the lowest prices (because they pass on these expenses to the residents or the government) but also may find it in their best interest to deal with high-price retailers who agree to kick back a portion of the inflated price to the unscrupulous provider. Id.
69 See M. MENDELSON, supra note 31; C. TOWNSEND, supra note 14, at 96-99. Self-dealing allows a provider-retailer to inflate the costs of ancillary services and products. One new phenomenon in the nursing-home industry is the rise of the vertically integrated chain operator. See C. TOWNSEND, supra note 14, at 96-99. Such chain operators own not only several nursing homes but also pharmaceutical companies, management firms, and equipment manufacturing companies, all of which sell their goods and services to the nursing homes at excessive prices. See generally M. MENDELSON, supra note 31. This practice is especially effective when the nursing homes are "nonprofit" because it allows the operator to shift "profits" out of the nursing homes to his own profit-making businesses. See note 183 infra.
70 The Federal Trade Commission has documented several examples of this type of fraud. One nursing-home chain recently purchased its own pharmacy. The prices for its drugs immediately shot up 40%. Another group of nursing-home investors sold used equipment to the homes they owned at prices more than twice book value and 86% above cost. And one nursing home reportedly had entered into management contracts with investors or outsiders "which offer little in the way of services." Taylor, Address, supra note 50.
71 M. MENDELSON, supra note 31, at 105-15; Taylor, Address, supra note 50. In one popular scheme, the owner sells his nursing home to his own company, which then leases it back to the operator at an exorbitant rent. Medicaid and Medicare reimbursements—whether based on the cost-plus or flat-rate method, see 42 C.F.R. §§ 405.401-.455, 447.250-371 (1979)—will then rise accordingly, even though there has been no real change in the home's financial position. The Federal Trade Commission has documented one sale/leaseback scheme in which a nursing home doubled its rental rates. Taylor, Address, supra note 50.
72 Padding of bills has been estimated to cost almost $800 million per year in the Medicaid program alone. M. MENDELSON, supra note 31, at 79-80.
large amounts of unencumbered cash that may be used for the operator's own purposes.\textsuperscript{72} In the former, the operator lures investors with the prospect of a share in government-subsidized profits.\textsuperscript{73} In the latter, operators have been known to borrow against future revenues guaranteed by the government at interest rates of up to forty percent.\textsuperscript{74}

The continuing-care provider need not resort to such schemes to generate cash—the residents themselves provide it through their entrance payments, and usually without any form of government supervision. When this money is siphoned off for the operator's own use, the losers are not the investors and the government, but residents of the community, who are left with diminished resources for vital services. If the dissipation of cash reserves leads to the collapse of the community—as it undoubtedly must \textsuperscript{75}—those people could be left without money, housing, or needed medical care.

\textbf{C. Potential for Mismanagement}

The unique financial dynamics of a continuing-care community make it particularly vulnerable to quite innocent miscalculations. Because the possibility of such errors is far from remote, and because the resultant danger to residents is the same as, if not worse than, that posed by fraud, regulation should be designed to safeguard against the following types of critical mistakes.

First, mistaken demographic predictions can be disastrous for a community: its entire rate structure is based on revenue projections that assume a predetermined turnover of residents.\textsuperscript{76} Miscalculations of turnover rate occur through failure to predict changes in mortality rates accurately and/or through use of inappropriate mortality tables. The inherent fallibility of mortality predictions has been made quite clear in just the last decade by an unforeseen one-year increase in the life expectancy of people over age sixty-five.\textsuperscript{77} But some communities have also made the wholly avoidable

\textsuperscript{72}For examples of such diversion of funds, see M. MENDELSON, \textit{supra} note 31, at 48-49, 157, 159, 169.
\textsuperscript{73}See id. 157-59.
\textsuperscript{74}See id. 29, 48-49.
\textsuperscript{75}See notes 89-91 infra & accompanying text.
\textsuperscript{76}See notes 55-56 \textit{supra} & accompanying text. This is not a problem for traditional nursing homes because each patient (or the government) pays his own way each month. There is no dependency on prepaid fees.
\textsuperscript{77}Dominic Consequences of U.S. Population Change, \textit{supra} note 3, at 66.
error of using life insurance, or general, mortality tables instead of annuity, or adjusted, tables. The adjusted tables reflect mortality rates among people who tend to be healthier and wealthier—and so likely to live longer—than the average American described in the general tables. Use of the latter is less likely to yield the appropriately conservative estimate of mortality among the middle-class population of a continuing-care community. It is more likely to lead to overestimation of the turnover rate and establishment of lower fees than are conducive to long-term financial stability.

Second, no sound actuarial method has yet been developed for evaluating simple health-risk factors inherent in continuing care. When a continuing-care community opens its doors, its population is relatively healthy and its current costs of health care are known, and relatively low. In such circumstances, the accumulation of large entrance-fee funds may create what is called "cash-flow euphoria." But the temptation to overspend in the early years must be overcome because, as the years pass, nursing costs will increase unpredictably; as the health of the population deteriorates further, even more—and more expensive—nursing services must be provided. Moreover, the incomes of the residents may be eroded over time, limiting the ability of the community to compensate through increases in the monthly fee. Avoidance of the temptation to overspend may not be left to chance; some mandatory protections are necessary to protect the resident population.

Third, and related to both of the previous factors, is the possibility of excessive reliance on entrance fees for operating revenue

78 See Interview with Hartman, supra note 51.

79 Id., Interview with Dr. Michael Teitelbaum, Program Officer, The Ford Foundation, in New York, N.Y. (Dec. 6, 1979) (notes on file with the University of Pennsylvania Law Review). General mortality tables are based on past mortality rates; in a time of increasing life expectancy, therefore, they are very conservative—and their use is profitable for life insurance companies. But use of general tables would be disastrous for annuity companies or continuing-care communities, which have to pay as long as a person lives, not when he dies. Id.


81 See notes 58-60 supra & accompanying text. Dr. Donald Cowgill has concluded that:

[All of these risks indicate that planning in such places must be very careful and because there is risk not only of miscalculation but of intentional fraud, they must be regulated not only to guarantee quality of service but also sound financial management. Furthermore, it seems to me that the risk factors here are comparable to pension funds, and there is a need for governmental guarantees of the same kind that were instituted about a year ago for pension funds.

Demographics of Aging, supra note 7, at 60 (statement of Dr. Donald Cowgill).
coupled with an inability and/or an unwillingness to raise monthly rates at the first signs of financial trouble. This possibility is most pronounced in communities that still use assignment-of-all-assets or total-fee-in-advance financing.\(^8\) It is also a problem for communities with contracts that provide that the monthly fee may not be raised at all during the life of the resident\(^8\) or that expressly limit the rate of increase.\(^8\) When financial difficulties strike a continuing-care community—either as a result of fraud, inaccurate actuarial projections, or submission to cash-flow euphoria—and it either cannot or will not raise its monthly fees quickly enough to make ends meet, the result is financial disaster.

D. The Pacific Homes Bankruptcy: A Case in Point

Information about continuing-care communities that have failed is generally scarce,\(^8\) but one of the most spectacular failures of a life-care community, the Pacific Homes bankruptcy, is quite well-documented.\(^8\) A brief examination of Pacific Homes’s financial troubles will illustrate the theories of the preceding sections of this Comment; it is especially instructive because Pacific Homes is a California corporation operating communities primarily in California and Arizona, states which extensively regulate continuing-care communities.\(^87\)

\(^{82}\) See note 14 supra.


\(^{84}\) Jenkins, supra note 54, at 29. Restrictions on increases in monthly fees may also be imposed by state legislation. Id.

\(^{85}\) For example, inadequate information exists to analyze the failures of the John Knox Retirement Village in Missouri, Baptist homes in Michigan and Florida, Presbyterian homes in New Jersey, a community operated by a synod of the Lutheran Church in Indiana, and the Cope United Methodist and the Brethren’s homes in Ohio. See Letter from Toba Feldman, Assistant Attorney General of the State of Ohio, to the author (Dec. 11, 1979) (on file with the University of Pennsylvania Law Review); Letter from Gregg A. Johnson, Esq. to the author (Nov. 30, 1979) (on file with the University of Pennsylvania Law Review). See also Montgomery, Predators Find Elderly Are Often Easy Prey For Array of Rip-Offs, Wall St. J., Nov. 9, 1979, at 1, col. 6, at 28, col. 3.


\(^{87}\) See part III C infra.
Most of the Pacific Homes contracts with residents were either total-fee-in-advance, assignment-of-all-assets, or accommodation-fee-plus-fixed-monthly-fee. When operating costs began to outstrip revenues as a result of inflation, the deteriorating health of residents, and unexpectedly low mortality rates, the inflexibility of the rate structure forced Pacific Homes into financial chaos and, finally, bankruptcy. As early as 1950, the corporation began to draw on its accumulated cash reserves to make up annual operating deficits. As a result, by 1954 those reserves dropped below the level considered sufficient by Pacific Homes's own accountants and that required by California law. In later years, the company resorted to borrowing from institutions and individuals.

Pacific Homes's most dangerous response to its difficulties, however, was expansion. Because of the importance of entrance fees to communities with inflexible fee structures, the inherent temptation to cure financial ills by generating new entrance fees is all but irresistible. Short of killing off residents, the only way to generate entrance fees is to expand and take in new residents. But expansion without a change in rate structure only leads to increased operating costs and larger deficits, creating the need for ever-further expansion to produce even more funds. Like any "Ponzi scheme," such a financial structure must eventually collapse of its own weight. In 1977, this is precisely what happened to Pacific Homes.

88 See note 14 supra.

89 PACIFIC HOMES BANKRUPTCY REPORT, supra note 83, at 1-3, passim. See Interview with Hartman, supra note 51; notes 76-84 supra & accompanying text.

90 An indication that continuing-care operations are no less vulnerable to fraud than traditional nursing homes, see notes 65-74 supra & accompanying text, is the apparently intentional cover-up of these financial machinations by Pacific Homes. PACIFIC HOMES BANKRUPTCY REPORT, supra note 83, at 16-17, 24, 33, 36, 44-45, 47, 49-51. In addition, the trustee in bankruptcy alleged that the operator of Pacific Homes fraudulently and negligently used life-care funds for ill-advised and only marginally related investments in much the same way as its counterparts in traditional nursing homes have done. Id.

91 Id. 18-21, 33, passim. See notes 194-95 infra & accompanying text.

92 PACIFIC HOMES BANKRUPTCY REPORT, supra note 83, at 18-21, 40-41, 47-49, 53-55.

93 Id. 24, 29-31, passim.

94 See notes 14, 59-60, & 82-84 supra & accompanying text.

95 For a discussion of continuing-care operators' disincentive to care for residents in times of community financial trouble, see note 142 infra & accompanying text.

96 A "Ponzi" scheme is a fundamental type of fraud. It is based on taking money from investors on the promise of repaying huge returns and then paying off early investors with funds taken in from more recent investors. The scheme eventually collapses when not enough new investors are found to cover payments due. PACIFIC HOMES BANKRUPTCY REPORT, supra note 83, at 1 n.1.
The Pacific Homes demise is but one example of the many ways in which fraud or simple errors in judgment can be disastrous for a continuing-care community and its residents—people who may have pauperized themselves to secure what they expected to be lifetime care. The lesson is clear: if hundreds of thousands of our nation's elderly citizens contract for lifetime care, and if risks intrinsic in continuing-care operations make financial collapse a real possibility, then government must protect the operators against themselves in order to safeguard the welfare of their residents. Just what form that protection should take is the subject of the following part.

III. THE FORM AND SUBSTANCE OF THE REGULATORY RESPONSE

The overriding purpose of any government regulation of continuing-care communities must be to ensure their financial integrity: financial failure poses the greatest threat to the financial and social well-being of the residents. In particular, regulation must provide the safeguards that individual residents cannot against fraudulent dissipation of entrance fees, miscalculations of life expectancy and resident-turnover rates, poor financial planning, excessive reliance on rigid entrance-fee financing, and Ponzi-scheme expansion.

Having identified the potential dangers inherent in continuing-care operations, this Comment now turns to an exploration of the possible regulatory responses. This part, divided for convenience according to the degree of regulatory intrusiveness, addresses three related questions: (1) What have the federal and state governments already done? (2) What alternative courses of action are open to them? (3) What are the essential elements of an economical and efficient regulatory scheme?

A. Inaction and Prohibition

It should be clear by this point that a policy of either prohibition or total nonregulation of continuing-care communities is unacceptable. Yet the federal government has done little more than show its awareness of continuing care, and forty states and the District of Columbia have made no attempt to regulate the industry at all. Two states have apparently attempted without success to prohibit continuing care.97

97 See notes 165-71 infra & accompanying text.
1. The Federal Government

With the exception of standard Medicare and Medicaid certification regulation for nursing facilities in continuing-care communities, the federal presence in the field is virtually nonexistent. Several congressional committees have expressed interest in the problems of continuing care, but none has yet addressed them. In 1977, Representatives William Cohen and Gladys Spellman introduced legislation that would have required continuing-care providers subject to federal jurisdiction to disclose financial information to all current and prospective residents and to maintain minimum cash reserves. The bill died without a day of hearings at the end of the Ninety-Fifth Congress and has not been reintroduced.

The Federal Trade Commission, the Securities and Exchange Commission, the Administration on Aging, the National Institute on Aging, and the Department of Housing and Urban Development have all also expressed interest in continuing care—also without

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98 See note 4 supra.

99 Compare Demographics of Aging, supra note 7, at 60 (problems of continuing care highlighted by Dr. Donald Cowgill) with Domestic Consequences of U.S. Population Change, supra note 3 (in which the subject was ignored). See Laurence F. Lane, Director for Public Policy, American Association of Homes for the Aging, Presentation at Continuing Care Seminar, Valley Forge, Pa. (June 12, 1979) (proceedings on file with the University of Pennsylvania Law Review); Letter from E. Bentley Lipscomb, Staff Director, Senate Special Committee on Aging, to the author (Dec. 14, 1979) (on file with the University of Pennsylvania Law Review).

100 H.R. 4170, 95th Cong., 1st Sess. (1977). The bill provided that no federally assisted continuing-care institution could require any prepayment of fees except under a written contract that met the bill's requirements. Id. § 2(a). The term "federally assisted continuing care institution" was defined to include communities that offered long-term care to the elderly and either engaged in interstate commerce, received Medicaid or Medicare reimbursement, or were constructed with federal assistance. Id. § 2(b).

The bill required that the contract between the community 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, including a requirement that termination be allowable on 90 days' notice; and (6) provide for an annual audit. Id. §§ 3, 4.

The bill provided that each community had to maintain "financial reserves sufficient to meet its obligations" without any further definition. Id. § 5(a). Payments to facilities under construction would have to have been held in escrow. Id. § 5(b). The bill also permitted the Secretary of Health, Education, and Welfare to waive its terms in states that had regulations at least as stringent as those in the bill. Id. § 8.

For a full discussion of provisions such as those in H.R. 4170, see part IIIC infra.

101 Laurence F. Lane, Director for Public Policy, American Association of Homes for the Aging, Presentation at Continuing Care Seminar, Valley Forge, Pa. (June 12, 1979) (proceedings on file with the University of Pennsylvania Law Review).
tangible result. For example, the Federal Trade Commission has concluded that continuing-care institutions are sufficiently different from traditional nursing homes to justify their exclusion from the scope of a current investigation of nursing homes. Whether a separate investigation of continuing care will be conducted is not yet known.

At best, federal inattention to continuing care has had a neutral impact; at worst, it has actually contributed to the problems of continuing care.

2. State Inaction and Reliance on the Judiciary

The dearth of state regulation noted above clearly is not a result of lack of interest in the problems of the elderly: all fifty states and the District of Columbia require the licensing of traditional nursing homes. In fact, the fifty-four state agencies charged with regulation of nursing homes constitute the largest contingent of such agencies in the entire field of health-care regulation.

Abdication of responsibility for continuing care by state legislative and executive branches has forced many states' courts into the business of regulation. But judicial oversight through private litigation is not the answer to the problems of continuing care. Private litigation, by its nature, tends to occur after the damage has been done—damage that in the case of continuing care will often be irreparable. No judicial mechanism exists to head off the dangers discussed in this Comment. More particularly, the state courts have shown, and at times declared, themselves incapable of taking a broad view of continuing care in individual cases.

The bulk of the litigation involving continuing-care communities has focused on the relatively narrow issues of contract termi-
nation and refunds. Through a narrow focus on the case-by-case equities involved, and often with reference to vague notions of public policy, state courts have only added to the financial uncertainties of continuing care. Although the results of litigation have been, in general, predictable, the inherent unpredictability of cases in equity and the dearth of clear statements of law in the courts' opinions have had two effects: potential plaintiffs are encouraged to litigate the particular facts of their grievances, and communities are prevented from planning intelligently—instead, they must devote a wasteful amount of resources to countering the threat of costly litigation. 107

This latter problem is not merely one of inconvenience. Continuing-care providers resemble public utilities in the manner in which increased costs are passed on directly to consumers of the service. Increases in litigation costs therefore only increase the cost of continuing care. Similarly, residents' fees must increase to protect the communities against the possibility of court-ordered refunds.

Contract-termination and refund suits may be divided for analytical purposes into suits by residents, which generally are successful, and suits by heirs of residents, which generally are not. A brief review of each category will serve to introduce the case law and illustrate the inadequacy of the judicial response to the problems of continuing care.

a. Suits by Residents

Many continuing-care agreements allow either party to terminate the contract immediately and without cause within a certain probationary period, 108 allow the resident to terminate the contract upon specified notice at any time, 109 and allow the community to

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107 At least one new continuing-care community, fearful of expensive and time-consuming litigation, has drafted a contract that provides for refund of one-half the entrance fee if the resident dies within one year of taking occupancy. Interview with Hartman, supra note 51. And at least one existing community is considering altering its contracts to provide the same refunds on death that occur on withdrawal from the community. Interview with Allen R. Hunt, Esq., Chairman of the Board of Directors, Kendal-Crosslands, Philadelphia, Pa. (Dec. 4, 1979) (notes on file with the University of Pennsylvania Law Review). Both of these refund schemes simply increase residents' entrance and monthly fees and effectively transfer wealth from the resident population to heirs.

108 "There shall be a probationary period of three months of residence . . . which shall be considered a period of adjustment. During this period, either Community or Resident may terminate this agreement . . . ." Crosslands Corp., Residence and Care Agreement, ¶ 6(a), appended to Complaint, Mears v. Crosslands Corp., No. 175 (Pa. C.P., Chester County, Oct. 3, 1979). See Jenkins, supra note 15, at 21.

109 Resident has the right at any time prior to death, so long as Resident is then in good general health and not suffering from any illness, to terminate this agreement by delivering to Community written notice of his
terminate the contract upon specified notice for good cause.\footnote{110} Most modern-form continuing-care agreements explicitly provide that upon termination of the contract during the probationary period, the resident is entitled to a full refund of all monies and property transferred to the community less the reasonable cost of his care.\footnote{111} Even in the absence of specific contractual terms to this effect, the courts have tended to order full refunds.\footnote{112}

In general, courts have simply treated the continuing-care agreements as more or less typical contracts. For example, communities have not been able to rewrite the terms of fixed-rate con-

\footnote{110} Community reserves the right to terminate this agreement for any cause which, in the judgment of Community, shall be good and sufficient, as evidenced by any one or more of the following: failure on the part of Resident to abide by the rules adopted by Community; the making of any material misrepresentation or omission in connection with application papers; a breach by Resident of any of the terms of this agreement . . . ; or if Resident's continued presence has become seriously disruptive to or a threat to the safety of the other residents, or a threat to the safety of Resident himself. In such case the Community shall serve upon Resident written notice of termination specified to be effective on a date not less than thirty (30) days nor later than one hundred twenty (120) days after the date of notice.


In practice, communities have found it "almost impossible to evict a resident except for the most 'grievous' conduct." Garrett M. Heher, Esq., Presentation at the Continuing Care Seminar, in Valley Forge, Pa. (June 12, 1979) (proceedings on file with the \textit{University of Pennsylvania Law Review}). \textit{But cf.} Onderdonk v. Presbyterian Homes, Inc., 171 N.J. Super. 529, 410 A.2d 252 (App. Div. 1979) (contract not a lease; therefore no statutory damages for retaliatory eviction).

\footnote{111} For termination, notice of which was given during the three month period of adjustment, Resident is entitled to a full refund of the Entry Fee, less any costs, actually incurred by Community, of redecorating Resident's apartment . . . , and less any cost to Community of maintaining Resident in Community's skilled nursing facility or in a hospital or other special care facility, and of providing any medical care, which cost shall be based upon the prevailing charges made by the Community normally for such services.


tracts to take account of inflation. But in cases involving contracts that provide that monthly fees may be increased by the community, resident challenges to even significant increases in fees have been rebuffed by the courts. Most courts have also accepted the common modern-form contract provision disavowing any property interest of the resident either in his unit or in the community's plant or equipment.

Except perhaps in the rare cases of termination by the community, which must be for "good cause," contract enforcement of this sort does not require the courts even to address any community problems that may underlie suits by residents. Nor do the individual remedies granted necessarily have any beneficial effect on either the community or the remaining residents.

b. Suits by Heirs

In contrast to the relative solicitude shown by courts to resident plaintiffs, heirs of residents have almost uniformly been rebuffed in their attempts to secure refunds of entrance fees or other property transferred for prepayment of services. Most often, plaintiff heirs have raised, and the courts have rejected, three related arguments: that when the resident died shortly after paying a substantial sum of money to the community for his care, the contract as performed...
was unconscionable\textsuperscript{117} or voidable for lack or insufficiency of consideration;\textsuperscript{118} and that because the termination rights of the community created only a limited promise to provide care, the arrangement lacked mutuality.\textsuperscript{119} The courts have also rejected heirs' arguments based on lack of capacity to contract;\textsuperscript{120} fraud or undue influence;\textsuperscript{121} and illegality as a gambling or wagering contract,\textsuperscript{2} as an assignment of a possibility,\textsuperscript{23} as a testamentary disposition,\textsuperscript{124} as an unregulated life-insurance contract,\textsuperscript{125} or as a contract of adhesion.\textsuperscript{126}

The timing of residents' deaths has often provided the heirs' only hope of success in refund suits, but the case law is not uniform. For instance, in cases of residents dying during the probationary period, heirs have been granted refunds.\textsuperscript{127} But in cases involving


\textsuperscript{120}E.g., \textit{In re Heim's Estate}, 166 Misc. 931, 3 N.Y.S.2d 134 (Sur. Ct., Kings County), aff'd, 255 A.D. 1007, 8 N.Y.S.2d 574 (1938). \textit{But see Estate of Ballard} v. Clay County, 355 S.W.2d 894 (Mo. 1962).

\textsuperscript{121}E.g., Borgeson v. Fairhaven Christian Home, 1 Ill. App. 3d 323, 272 N.E.2d 496 (1971); General German Aged People's Home v. Hammerbacker, 64 Md. 595, 3 A. 678 (1886); Old Men's Home v. Lee's Estate, 191 Miss. 679, 4 So. 2d 235 (1941).


\textsuperscript{126}See, e.g., \textit{id}.

\textsuperscript{127}E.g., Christenson v. Board of Charities, 253 Ill. App. 380 (1929); Evangelical Lutheran St. Stephan's Congregation v. Bishop, 213 Ill. App. 137 (1919); First Nat'l Bank v. Methodist Home for the Aged, 181 Kan. 100, 309 P.2d 389 (1957); Farrand v. Redington Memorial Home, 270 A.2d 871 (Me. 1970);
residents who died after the probationary period, and after having given notice of termination, but before actually leaving the community, heirs have been denied refunds.\textsuperscript{128} When residents have died outside the community after removal to hospitals for extended care, the courts have split, but the better view has been that the community was entitled to the entrance fee.\textsuperscript{129} Finally, communities have been allowed to keep the fees of residents who died while on voluntary leave.\textsuperscript{130}

The most revealing aspect of cases involving residents' heirs has been the courts' generally poor articulation of the grounds for decision. More often than not, the courts resort to ill-defined notions of public policy.\textsuperscript{131} In fact, some of the cases most frequently cited by judges are those in which the courts made explicit a public policy in favor of institutions that care for the elderly—in particular, continuing-care communities.\textsuperscript{132}

This Comment certainly does not take issue with such a policy; rather, it disagrees with reliance on the judiciary to implement the policy. The courts are simply incapable of creating a coherent legal framework for continuing care by deciding individual cases. First, the major problems of continuing-care operations discussed


\textsuperscript{130} E.g., In re Heim's Estate, 166 Misc. 931, 3 N.Y.S.2d 134 (Sur. Ct., Kings County), aff'd, 255 A.D. 1007, 8 N.Y.S.2d 574 (1938).

\textsuperscript{131} Although the courts have not made clear the basis of this policy, justifiable grounds do exist for a general policy of favoring residents and ruling against heirs. When heirs sue for refunds, they do not usually question the quality of the community's performance; rather, they argue that the quantity was not sufficient to warrant retention of the full entrance fee. Dissatisfaction with the quality of performance is more likely to underlie suits by residents. Moreover, residents' suits often are intended to disgorge from the communities sums essential to the future maintenance of the plaintiffs, whereas suits by heirs may be viewed as attempts to augment estates knowingly and intentionally diminished by the decedents when they entered the communities.

\textsuperscript{132} E.g., Wilson v. Dexter, 135 Ind. App. 247, 192 N.E.2d 469 (1963); Dodge v. New Hampshire Centennial Home for Aged, 95 N.H. 472, 67 A.2d 10 (1949); Fidelity Union Trust Co. v. Reeves, 96 N.J. Eq. 400, 125 A. 582 (1924), aff'd, 98 N.J. Eq. 412, 129 A. 922 (1923).
in this Comment are neither presented to the courts nor susceptible to judicial solution. Second, by substituting ad hoc and narrow policy analysis for legal analysis, the courts only end up injecting yet another element of uncertainty into an already precarious financial structure. Summing up the problem quite nicely, one New Jersey court has said: "[T]he necessary balance between the needs and responsibilities of elderly residents and the management of a retirement community can best be achieved by a comprehensive legislative program, and not by ad hoc court remedies which effectually restructure the parties' agreement." The following sections discuss the options for that legislative program that lie between inaction and outright prohibition.

B. Intermediate Regulation

Two intermediate possibilities must be analyzed before extensive regulation is discussed. The first is selective, specific regulation of the most egregious problems of continuing care, an attempt to eliminate the worst dangers without imposing a full-scale regulatory apparatus on the industry. The second, based on recognition of the fact that the distinctive problems of continuing care are financial, separates the financing from the provision of services by shifting the responsibility for money management to a third-party payor in the already heavily regulated insurance industry. Although each of these responses has some merit, neither is adequate to achieve the full protection of continuing-care residents.

1. Selective Regulation

As used here, selective regulation is an attempt by a legislature to isolate one or two problematic aspects of continuing care and to regulate those features only. Experience with this form of regulation has not been entirely satisfactory.

Illinois, Connecticut, and Oregon each have chosen to regulate a single aspect of the continuing-care institution. Connecticut and Illinois statutorily limit the eligibility of life-care residents to receive public assistance or Medicaid. They thereby

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134 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).


effectively counter whatever incentive federal Medicaid regulations create to use large entrance-fee contracts.\textsuperscript{137} Oregon's statute obviates the need for some refund litigation by requiring that any cash fees or transfers of property made prior to or during the first six months of occupancy must be refunded to any resident who withdraws from the facility within six months of occupancy.\textsuperscript{138}

None of these state responses is clearly wrong, but all are inadequate even to solve the limited problems they address. The Connecticut and Illinois statutes eliminate the incentive for operators to use high entrance fees, but potentially penalize an otherwise eligible Medicaid recipient who has entered into a life-care contract. And the Oregon law deals with only part of the problem of suits for refunds: because death is not considered "withdrawal," heirs of a resident who died within six months of occupancy may still litigate their claim to a refund.\textsuperscript{139} Finally, and most important, although each of these states has focused on a cause of financial instability in continuing-care institutions, each has chosen one cause

\textsuperscript{137} See note 105 supra. In Connecticut, see Conn. Gen. Stat. Ann. § 17-116 (West 1975), 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. But see Rowland v. Maher, 176 Conn. 57, 404 A.2d 894 (1978) (related statute, Conn. Gen. Stat. Ann. § 17-109(e) (West 1958), held unconstitutional as contrary to federal policy that only legitimate ground for withholding Medicaid is actual availability of assets). See also Buckner v. Maher, 424 F. Supp. 366 (D. Conn. 1976) (three-judge court), aff'd, 434 U.S. 898 (1977). The Rowland court also stated that § 17-116 was unconstitutional to the extent that it "deprives a person holding a life contract of medical assistance on any ground other than actual availability of assets." 176 Conn. at 63, 404 A.2d at 898.

Under Ill. Ann. Stat. ch. 23, § 3-1.5 (Smith-Hurd 1971), 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. The rules of the Illinois Department of Public Aid explain that "[a] resident who 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." Ill. Dept. of Public Aid Rules and Regulations, art. 8, rule 8.03.02, cited in Cornue v. Department of Pub. Aid, 64 Ill. 2d 78, 81, 354 N.E.2d 359, 361 (1976). The difference between the statute and the rule is quite significant: the statute seems to say that any life-care resident who lived longer than expected would be eligible for aid because his entrance fee would have been "wholly consumed"; the regulation explicitly negates this interpretation.

The Illinois Supreme Court has upheld both the statute and regulation. Cornue v. Department of Pub. Aid, 64 Ill. 2d 78, 354 N.E.2d 359 (1976), reversing Cornue v. Weaver, 29 Ill. App. 3d 546, 331 N.E.2d 148 (1975). 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 regulation and did not involve consideration of federal constitutional limits.

\textsuperscript{138} Or. Rev. Stat. § 91.690 (1977); see notes 108-33 supra & accompanying text.

\textsuperscript{139} See notes 127-30 supra & accompanying text.
to the exclusion of all others. That is the most that can be accomplished by selective regulation, and it is not enough: were a community to go bankrupt, it would be small solace indeed that the cause of its failure was not one of those regulated by the state.

2. Third-Party Money Management

The second intermediate response is to separate provision of services from financing of services. Under such an approach, the prospective resident would purchase a continuing-care contract from a third party, most likely an insurance company, and the community would enter into a service contract with the resident and a payment contract with the financing agent. The resident would pay an initial lump sum, as in the standard modern-form arrangement, and promise to pay monthly fees to the insurance company. The insurance company would agree to pay the provider for the cost of the resident's care in either the residential or nursing facilities. Although the resident's move to the nursing facility would increase the amount the insurance company would pay to the community, the resident's monthly premium would not change. The advantages of independence and insurance found in modern-form continuing-care arrangements would thus be fully preserved.

The argument in favor of this response is as follows: Financially, continuing care resembles a reverse form of life insurance similar to an annuity plan. Rather than create an entirely new regulatory mechanism, we should recognize this characteristic of continuing care for what it is and place responsibility for the institution's money management in a third party (the insurance company) whose financial practices are already comprehensively regulated. Such a step would have the incidental advantage of spreading the risk of individual continuing-care communities and minimizing the high risk of starting a new community. The key advantage of this form of financing, however, seems to be its capacity to minimize the disincentive to care that the continuing-care form produces. This disincentive results from the community's need to generate new entrance fees through turnover of residents when mortality-rate projections—upon which fees are based—prove erro-


\[^{141}\text{The greatest financial risk to a community's survival arises during its first years in operation. See notes 55-56 supra & accompanying text. Financing by insurance companies, which presumably would cover many residents in different communities at different stages of development, would reduce this risk.}\]
Use of a third-party payor, the argument runs, would remove the incentive to cut costs from the community administrators who control the quality of care. Thus, third-party financing seems to preserve the advantages of continuing care while eliminating some of the disadvantages.

But such a system entails serious administrative problems. For example, given the tremendous disparity in both entrance and monthly fees between communities, an insurer would have to devise and administer different rate schedules for each community with which it did business. Also, fee increases would be more difficult to implement because the party that must ultimately collect the increase, the insurer, is one step removed from the decision to increase rates.  

To be sure, neither of these objections alone is sufficiently substantial to merit rejection of the proposal. But the solution to these problems—collaboration between insurers and providers to match premiums and costs—undercuts the argument that third-party financing will minimize the disincentive to care. It also creates the

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142 Because the community bases its fees on actuarial projections, its financial stability may be threatened if residents—in the aggregate—do not die at predicted rates. See notes 55 & 76 supra & accompanying text. For example, assume a total-fee-in-advance community in which the fee is set at $10,000 per year of life expectancy. If everyone lives, on the average, six months beyond that life expectancy, the community will go bankrupt. Faced with the threat of bankruptcy, the community has an incentive to "kill off" its residents—and a corresponding disincentive to care for them: the sooner everyone dies, the more money the community has at its disposal from the entrance fees paid by the deceased residents, and the sooner the community can solicit new residents and new entrance fees.

No one expects continuing-care communities to murder their residents, but the special needs of elderly people can lead to the same result if affirmative steps are not taken to enrich their lives. For instance, if the residents are not happy, they will not have as strong a desire to live. See 1975 Senate Report, supra note 4, at X-XII; C. Townsend, supra note 14, at 104-10. The disincentive to care is most often confronted and most likely to be harmful in deciding whether to spend additional dollars on better-qualified staff, meals, and interior decoration and atmosphere. Such expenditures increase not only costs in the current fiscal year, but also long-run costs to the extent the average lifetime of residents is lengthened as a result of the improvements. See generally 1975 Senate Report, supra note 4, at XVII-XX; C. Townsend, supra note 14, at 122-32.

The disincentive to care is far more acute in communities that use assignment-of-all-assets or total-fee-in-advance contracts, or otherwise rely excessively on entrance fees. To the extent the community draws on monthly payments to finance care, the disincentive is minimized because of the community's ability to raise fees when actuarial projections prove wrong. But when all fees are either prepaid or fixed, turnover of residents—one way or another—is the only solution to revenue problems.

143 See note 14 supra.

144 Note also that this financing arrangement would increase the cost of continuing-care service: the financial middleman would certainly—and not unreasonably—expect to be paid for its services.
problem of essentially cost-based reimbursement for continuing care. When continuing-care communities decide they need more revenue, they need not approach the resident population directly. Similarly, when residents object to the rate increases, their complaints will go to the insurance company, which is one step removed from the decision to spend. Such a system, in short, would reduce the incentives that now exist for legitimate cost cutting and would result in higher prices for the consumer.\footnote{Although the analogy is incomplete, useful reference may be had to the effect on hospital costs of domination of financing by third-party payors. The third-party payors of hospital costs are private insurers and the government. When hospitals seek to increase their charges, they simply inform the third-party payors. Any cost increases are passed on to the consumer in the form of higher premiums or taxes.}

Finally, the purported minimization of the disincentive to care is simply not an advantage of third-party money management over modern-form community financing. In a modern-form community, an individual's basic monthly payment covers more than the cost of his housing, but less than the cost of his care in the nursing facility. Because his fee does not change when he is transferred to the nursing facility, the community has an interest in keeping the resident healthy and out of the nursing facility. Only in communities that do not use modern-form financing and do not rely primarily on monthly fees to cover operating costs does a resident's unexpected longevity cost the community money.\footnote{Costs inevitably increase in such a system as a result of the breakdown of incentives to behave in an economically efficient manner. Hospitals have less incentive to economize to the extent they pass on costs to the third-party payors. The Staff of Senate Comm. on Finance, 96th Cong., 1st Sess., Background Materials Relating to S. 505 and Other Health Care Cost Containment Proposals 1 (Comm. Print 1979). Similarly, continuing-care communities would lose much of their current incentive to economize if third parties paid their costs. Moreover, the third-party-insurance payors, whether governmental or private, lack the means and incentives to monitor provider costs and efficiency meaningfully. Hearings on Inflation of Health Care Costs, 1976, Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare, 94th Cong., 2d Sess. 32-33, 110-11, 795 (1976) (statements of Dr. Theodore Cooper, Leonard Woodcock, & Morton D. Miller). There is no reason to believe this observation would not apply as well to continuing care.} The sensible regulatory response, therefore, is not the indirect third-party-payor approach—which has its own problems—but the direct regulation of certain financial practices of continuing-care providers. The effect of such regulation on quality of care would be enhanced by two nonfinancial factors: the professional ethics of community doctors and nurses.\footnote{Every doctor takes the "Hippocratic Oath," as follows in part: "I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. . . . I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman. . . ."}
and the existence of residents' committees to help set and monitor community policies.\textsuperscript{148}

\section*{C. Extensive Regulation}

This Comment's preference for some form of regulation of continuing care has been expressed from the outset. The analysis and critique of regulatory programs ranging from inaction to prohibition of continuing care bring us to the threshold of the proper response to the problems sketched in part II—extensive regulation.

Arizona,\textsuperscript{149} California,\textsuperscript{150} Colorado,\textsuperscript{151} Florida,\textsuperscript{152} and Michigan\textsuperscript{153} have responded to the potential and actual problems of continuing care with statutory schemes that may fairly be characterized as extensive regulation. This Comment now breaks down these five states' legislation into eleven constituent parts and describes each state's approach to each type of provision.

The analysis of each regulatory component is followed by an evaluative discussion that concludes with a judgment whether such a provision should be adopted and, if so, when. The philosophy upon which these judgments are based is as follows: A first stage of regulation should be designed to improve the functioning of the market in continuing-care services through consumer education. Because of the high stakes and some inherent market imperfections, some minimum financial safeguards should also be provided at this stage. Slightly more intrusive, and therefore more expensive, proposed regulatory devices should be reserved for a second stage of regulation, to be implemented only if necessary. A proposed third stage—a last resort—would involve the state governments in direct fee regulation such as is currently imposed only in the most heavily regulated industries.

\begin{itemize}
\item Nurses are also subject to a strict code of ethics:
\item Inasmuch as the nurse's primary commitment is to the patient's care and safety, she must be alert to, and take appropriate action regarding, any instances of incompetent, unethical, or illegal practice by any member of the health care team, or any action on the part of others that is prejudicial to the patient's best interests.
\item See notes 237-40 infra \& accompanying text.
\item \textit{Mich. Comp. Laws Ann. §§ 554.801-.844 (Supp. 1979).}
\end{itemize}
Thus, this Comment strives to develop the most unintrusive regulatory scheme possible, given the significant public interests at stake. As will be seen, some components of the current state programs are not necessary at any level of regulation; most others are not necessary in the first stage. Some possibly necessary devices, explored in a separate section, have not yet been adopted by any state.

In general, it may be said that no one state, and not even all five states taken together, have successfully come to grips with the problems of continuing care. Some have not even been able to devise an adequate definition of the institutions they wish to regulate. All the state systems fail to tread the delicate line between requirements sufficiently comprehensive to prevent or at least warn of financial disaster and regulations sufficiently manageable to minimize the costs of compliance. The net result has been a general lack of enforcement.\(^{154}\)

These problems aside, the current state efforts fall critically short in several particulars. None of these five states prohibits assignment-of-all-assets or total-fee-in-advance contracts. None attempts to regulate the setting of fees—or to prohibit excessive reliance on entrance fees—to ensure at least minimum financial security for residents. And no state takes account of the full range of case law in its regulation of the contents of continuing-care agreements, thus leaving resolution of many questions to costly and inefficient litigation.

The prospect for continuing care is not attractive. The United States is faced with the existence and probable growth of institutions that offer a novel and desirable means of providing housing and medical care for the elderly. Because of the dynamics of continuing care and the lack of sufficient governmental protection, many of these institutions may fail, creating enormous pressures on government to prohibit continuing-care operations\(^{155}\) or to overregulate them to the point of extinction.\(^{156}\) The policymaker's task, there-

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154 The Pacific Homes failure, see notes 85-96 supra & accompanying text, provides a perfect example. From at least 1954, Pacific Homes's reserve funds were maintained below California's statutory minimum level. From at least 1965, the annual reports of Pacific Homes to the state disclosed this violation of the statute. It was not until seven years later that the state recorded a lien on behalf of all residents. Pacific Homes's authority to enter into life-care contracts was never revoked. And the state later subordinated the residents' lien to further borrowings. Pacific Homes Bankruptcy Report, supra note 83, at 52-53.

155 New York and Pennsylvania seem to have attempted this. See notes 165-71 infra & accompanying text.

156 This seems to have happened in Arizona. See notes 158-59 infra & accompanying text.
fore, is to fashion a workable, minimally intrusive regulatory program to protect the continuing-care industry from its own intrinsic failings. This Comment now considers the elements of such a program.

1. Definition of Continuing Care

As several states have found, defining the types of institutions to which their regulations will apply is not easy. California's definition seems to have avoided the most dangerous pitfalls by defining "life care contract" to include terminable continuing-care agreements. Arizona uses a similar definition, but most facilities within that state have stopped charging entrance fees altogether, thereby escaping regulation, and have instead raised their monthly fees, thus moving one step closer to becoming fee-for-service providers. The first Florida legislation applied only to institutions using the total-fee-in-advance or assignment-of-all-assets methods of financing and only to contracts for life or for a term of years. Because the statute did not apply to communities that charged both an entrance fee and monthly fees or to those that offered continuing care with mutual rights of termination, the regulations soon became obsolete. Florida has solved these problems by expanding the scope of its new statute beyond fixed-fee arrangements and by explicitly including continuing care in the definition of "care for a term of years."

Two further illustrations of definitional problems come from states that may have attempted to prohibit life-care arrangements.

159 Ohio Nursing Home Commission Memorandum from Paul Wallace to Catherine Hawes (Oct. 18, 1978) (copy on file with the University of Pennsylvania Law Review). Although the statute has been in effect since January 1, 1978, only two facilities in the state are currently regulated under it. Id. Evasion of this sort is a risk in any regulatory scheme, and there is not much to be done about it. Regulations should not force providers out of the continuing-care market, but they must be drafted tightly enough to have some effect.
162 See Comment, Florida's Life Care Law: Revitalizing a Dormant Statute to Protect the Elderly, 28 U. Fla. L. Rev. 1016, 1019-20 (1976). This omission was far worse than the Arizona loophole because the principal danger of continuing care—large advance payments which can be fraudulently or negligently dissipated by the provider—exists even when entrance-fee-plus-monthly-fee terminable contracts are used.
New York's nursing home regulations prohibit any "residential health care facility" operator from accepting prepayment for "basic services" for more than three months\(^{165}\) or from entering into any contract or agreement for "life care."\(^{166}\) This language has been understood to mean that continuing-care communities are prohibited in New York;\(^{167}\) yet it arguably does not apply to communities that offer mutually terminable contracts\(^{168}\) and earmark prepaid entrance fees for capital expenditures rather than "basic services."\(^{169}\) Similarly, Pennsylvania's nursing home regulations provide that "Skilled Nursing and Intermediate Care Facilities shall not require or permit a patient to assign his assets to the facility in return for a life care guarantee,"\(^{170}\) yet continuing-care communities that use mutually terminable contracts are flourishing in that state.\(^{171}\)

An essential element of a first-level regulatory program is a precise definition of the subject of regulation. The definitions of life care found in Florida, Arizona, and California can serve as models of statutory language. Further, in order to protect the financial feasibility of continuing care, assignment-of-all-assets and total-fee-in-advance contracts must be strictly prohibited.

2. Certification Provisions

All five states require that the provider be certified prior to the execution of any continuing-care agreements. Colorado and Florida both require provisional certificates of authority.\(^{172}\) The

\(^{165}\) N.Y. Code of Rules and Regulations tit. 10, § 730.2(f) (1979); see id. §§ 415.1(f), 420.1(f).

\(^{166}\) Id. § 730.3(b); see id. § 414.16(b).

\(^{167}\) See, e.g., Brown, supra note 40, at 350.

\(^{168}\) See notes 12-13 supra.

\(^{169}\) See text following notes 56 & 61 supra. In fact, at least 13 facilities in New York purport to offer continuing-care contracts. AMERICAN ASSOCIATION OF HOMES FOR THE AGING, DIRECTORY OF MEMBERS 44-52 (1979). Ironically, the only form of continuing care that seems to be allowed in New York is particularly stable financially. See notes 59-60 supra & accompanying text. Given the wording of the regulations, it is not likely that this result was intended.

\(^{170}\) 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 more: does it mean any assets, thus apparently prohibiting continuing care, or all assets, thus apparently prohibiting only assignment-of-all-assets contracts? See Jenkins, supra note 54, at 27.


\(^{172}\) Colorado's provision is quite general, and the purposes of the provisional certificate are unclear. COLO. REV. STAT. § 12-13-104(1) (1978). Florida's require-
Arizona, California, and Michigan 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.\textsuperscript{7} Applications for certification, accompanied by the required attachments,\textsuperscript{174} are made to the appropriate state departments.\textsuperscript{175} The most important attachments are actual and projected financial statements,\textsuperscript{176} a copy of the contract to be used,\textsuperscript{177} and ownership and financial-responsibility disclosure statements.\textsuperscript{178} Michigan also prohibits proprietary operators from entering into "pure" life-care agreements.\textsuperscript{179} The Colorado, Florida, and Michigan statutes provide for annual renewal of the certificate of authority after required financial forms apply only to new operators who have not yet acquired the necessary facilities or land or begun construction of the continuing-care facility. Such operators must submit advertising, organizational information, and a statement of proposed location and size to the state. The state then issues a provisional certificate that entitles the provider to collect deposits from prospective residents, as long as they are kept in escrow, and to undertake the feasibility study required for permanent certification. \textit{Fla. Stat. Ann.} § 651.031 (West Supp. 1978).


\textsuperscript{175} The statutes in Arizona and Florida are administered by the state departments of insurance. California's is administered by the State Department of Social Services. Michigan vests control in the Corporation and Securities Bureau of the Department of Commerce. Colorado established a Board of Examiners of Life Care Institutions in the Division of Registrations of the Department of Regulatory Agencies.


\textsuperscript{177} The provisions that must be included in the contract vary from state to state. See notes 244-62 infra & accompanying text.

\textsuperscript{178} The Arizona and California statutes are the most advanced in this area. \textit{Ariz. Rev. Stat. Ann.} § 20-1802(B) (Supp. 1979); \textit{Cal. Health & Safety Code} § 1771.8(d)-(e), (h)-(k) (West 1979). They require the applicant to disclose the true corporate and individual owners of the facility; any entity, including a parent or other affiliate, holding more than a 10% interest in the applicant; any affiliation of the applicant with a nonprofit, religious, or charitable institution and the extent of that institution's financial responsibility for the applicant; and any civil or criminal action against the applicant, a principal, or a corporate affiliate.

are filed and specific statutory requirements met. Arizona's and California's certificates are valid until revoked, but annual reports similar to the financial filings in the other states are still required. All the states except Arizona have procedures for revocation and/or suspension of certificates of authority.

Certification requirements should be imposed only as part of the second stage of regulation. The cost of such requirements to the state and the community simply may not be justified by their limited impact on the problems of continuing care. If a certification scheme is adopted, however, it should require both provisional and permanent certification; the former, particularly when used to mandate feasibility studies, encourages well-planned projects. A strong emphasis on true ownership disclosure to the administering agency and the public would also be a good idea.

The administering agency should be a department of insurance or similar bureau because the issues involved are primarily financial, not medical. No analogue to Michigan's exclusion of proprietary operators is either desirable or feasible. Finally, an annual renewal requirement is not necessary or desirable; it only increases paperwork. The California and Michigan approach of using per-


182 The Florida Department of Insurance is empowered to refuse to renew the certificate or to seek court assistance in enforcing the act. Fla. Stat. Ann. §§ 651.026(8), .105, .114, .125 (West Supp. 1978). The Department of Social Services in California may suspend, limit, or revoke a certificate because of (1) failure to maintain minimum reserves; (2) failure to file an annual report; (3) failure to maintain the reserve fund escrow account at the proper level; (4) failure to abide by a limitation imposed by the Department; or (5) violation of any rules or regulations of the Department. Cal. Health & Safety Code § 1784 (West 1979). Colorado allows revocation or suspension for violation of any section of the statute or failure to meet reserve requirements. Colo. Rev. Stat. § 12-13-105 (1978). Michigan offers the most comprehensive regulation, providing that the Corporation and Securities Bureau can seek suspension or revocation of a provider's registration if it finds that such an action would be in the public interest and that one of eight enumerated problems exist, including fraudulent or illegal practices, unreasonable financial risk, or any violation of the act. Mich. Comp. Laws Ann. § 554.817 (Supp. 1979).

183 Such a provision, based on the notion that profit-seeking has an adverse effect on the quality of care, attempts to eliminate the opportunity to profit from continuing-care operations. A policy of excluding proprietary operators would not effectively achieve this aim. First, the policy is too broad in that it would exclude desirable proprietary operators from the industry. Second, it is too narrow in that it could be easily circumvented. A person who wishes to operate a continuing-care community for profit can establish a nonprofit "front" that will, in effect, distribute "profits" to him through contracts with companies he owns or controls—specifically, a management services company hired to run the community. This arrangement breaks the "nondistribution constraint" traditionally associated with nonprofit organizations. See generally Hansmann, supra note 49, at 838. Compare notes 68-71 supra & accompanying text.
petual certificates subject to revocation or suspension and requiring annual reporting and auditing is adequate.\textsuperscript{184}


Arizona, California, Florida, and Michigan all have statutory escrow provisions to deal with the problems of fraudulent diversion of entrance fees prior to occupancy\textsuperscript{185} and the inability to pay off long-term capital debt as it becomes due.\textsuperscript{186} Arizona and Michigan require that prepaid monies be placed in escrow at least until the resident occupies the unit; \textsuperscript{187} Florida's escrow requirement applies only until the authorization certificate is issued.\textsuperscript{188} Michigan also grants the Corporation and Securities Bureau the discretion to require an escrow deposit of a "reasonable" amount when the facility's economic condition is precarious.\textsuperscript{189}

A requirement like Arizona's that all entrance fees paid to the community prior to occupancy be held in escrow is an essential element of a first-level regulatory program. The existence of such an escrow account minimizes the possibility of fraudulent or negligent dissipation of uncommitted funds. In contrast, a mandatory escrow account for entrance fees paid after occupancy serves no useful purpose. Required maintenance of adequate reserves in safe and relatively liquid investments is satisfactory.

4. Reserve Requirements

To protect the continuing-care community against unexpectedly low rates of turnover early in its existence\textsuperscript{190} or miscalculations

\textsuperscript{184} Admittedly, current annual audit requirements have not met with spectacular success. The Pacific Homes collapse could have been less severe had the California state authorities properly performed their duties under the statute. \textit{See note 86 supra; note 91 supra} & accompanying text. State implementation of federal Medicaid auditing requirements also has been remarkably lax. From 1966 to 1975, 20 states did not conduct a single audit of a Medicaid-eligible long-term facility. \textit{1976 House Report, supra note 6, at 29-31.}

\textsuperscript{185} \textit{See notes 62-63 & 75 supra} & accompanying text.

\textsuperscript{186} \textit{See text following note 61 supra.}

\textsuperscript{187} \textit{Ariz. Rev. Stat. Ann.} § 20-1804 (Supp. 1979); \textit{Mich. Comp. Laws Ann.} § 554.810(b) (Supp. 1979). Arizona's statute has a complex formula for determining when the entrance fees deposited in escrow may be released. If the fee is for a unit that is currently occupied, it will be released when the unit becomes available for occupancy by the payor. If the fee is for a new unit, it is released when three requirements are satisfied: (1) construction is substantially complete and an occupancy permit issued; (2) commitment has been secured for long-term financing; and (3) aggregate entrance fees added to proceeds from long-term financing total 90% of the total cost of the facility plus 90% of the money necessary to fund start-up losses. \textit{Ariz. Rev. Stat. Ann.} § 20-1804(A)(2) (Supp. 1979).


\textsuperscript{190} \textit{See text following note 55 supra.}
CONTINUING-CARE COMMUNITIES

in mortality rates, as well as to ensure a minimum level of financial stability, all five states except Michigan mandate the maintenance of financial reserves. Two features of these reserve requirements will be analyzed here: the required size of the reserves and investment limitations on reserve funds.

Arizona requires establishment of a reserve fund that equals the total of the principal and interest payments due over the following year "on account of any first mortgage or other long-term financing of the facility." California's basic requirement is similar, but increases the minimum level of the reserve fund by the amount of any rental payments due during the year. California has an additional requirement, also in force in Florida, that reserves be sufficient to cover the obligations assumed under continuing-care agreements, as calculated through the use of state-approved mortality tables. Colorado's reserve calculation is slightly more complicated but is designed to achieve the same result. Colorado, Florida, which, unlike Arizona, do not require placement of reserve funds in escrow, do regulate the type of investments for which the funds may be used. Because the California and Colorado reserves are set very high in order to approximate total current obligations, the reserves may include not only traditional investment "safeties" such as cash deposited in banks, approved stocks and bonds, and specified investments in property and mutual funds, but also high percentages of the net equity in buildings and equipment used to service the resident population. Florida al-

191 See notes 76-79 supra & accompanying text.

192 The theory behind the reserve requirements is that communities should have a certain level of cash or near-cash reserves available to pay debts as they become due. But even reserves, unless astronomical, cannot help a community with severe financial problems over the long run. At best, continued inadequacy of reserves can serve as a warning of impending financial collapse. See note 91 supra & accompanying text.


195 Cal. Health & Safety Code § 1775 (West 1979); Fla. Stat. Ann. § 651.035(1) (West Supp. 1978). This reserve requirement is not as onerous as it might seem because the reserves may include such items as the equity in the property and equipment of the facility.


allows the Department of Insurance discretion to set the level of the reserves that may be held in cash, stocks, and bonds on the one hand and property and equipment used for the care of residents on the other hand. 198

A simple-formula reserve requirement should be included in the first-level regulatory scheme. The amount of the reserve should be equal to at least eighteen months' principal and interest payments on the mortgage or bonds plus eighteen months' projected operating expenses. The reserves need not be held in escrow, but they should be liquid (cash and approved stocks and bonds). There is no sense in including the value of the community's real estate in the reserve because the property could not be liquidated to pay bills without depriving the residents of a place to live. Reserve levels should be monitored through annual audits. In addition, investment limitations should be strictly defined and enforced for all funds of the community, even those in excess of the reserve requirements.

5. Bond Requirements

The California, Colorado, Florida, and Michigan 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 agencies to require a surety bond in any reasonable amount necessary to protect the residents of the community. 199 California also requires the bonding of agents and employees who handle substantial sums of money. 200 Colorado requires a blanket fidelity bond in an amount to be set based on the "magnitude" of the community's operations. 201 Florida life- and continuing-care providers that fail to satisfy net-worth requirements set by the Department of Insurance must file a surety bond. 202

Although it may be advisable to have a fidelity bond for employees who handle significant sums of money, general performance

202 Fla. Stat. Ann. § 651.021 (West Supp. 1978). Florida's previous statute merely required life-care providers to deposit $75,000 with the Department of Insurance. Fla. Stat. Ann. § 651.09 (West 1972). Under this provision, if a community had gone bankrupt, the residents would have split the $75,000, regardless of their number. But bonds, deposits, or insurance must vary with the size and commitments of the community, thus guaranteeing each resident a minimum amount in the event of bankruptcy. See Comment, supra note 162, at 1023-24.
bonds or deposits with administering agencies are not necessary, nor, as will be seen below, are they the most desirable means of protecting the interests of residents. One exception might be when outside management companies are hired to run communities. In such cases, a bond covering the management company would serve to protect both the residents and the operator. Of course, only the bonding company and operator would be responsible for evaluating the management company's performance; the government would still play no role.

In lieu of the bond provision, states should require continuing-care operators to form mutual guaranty associations. Such a system has been used quite successfully in the insurance industry. All continuing-care communities would be required to join a mutual guaranty program established by state or region. If one community failed, the other members of the association would be required to absorb its residents without the payment of additional entrance fees. In this way, consumers of continuing care would always be guaranteed the full performance of their contracts, although the price of those contracts might have to be slightly higher.

203 Forty-five states and the District of Columbia in 1976 required at least some insurance companies to participate in mutual guaranty associations to guard against the insolvency of an insurer. Hank, Post-Assessment Guaranty Funds: Are They the Ultimate Solution to the Insolvency Problem?, 1976 Ins. L.J. No. 643, at 482, 483. These state plans can be placed into two categories. A post-assessment guaranty association, by far the more common, assesses its members following the insolvency of an insurance company to generate a fund to pay off that company's policyholders as claims become due. E.g., CAL. INSURANCE CODE §§ 1063-1063.13 (West 1972). A pre-assessment guaranty association assesses its members as necessary to generate a fund that may be used to pay off the claims of any company that may become insolvent in the future. E.g., N.Y. INSURANCE LAW § 224 (McKinney 1976).

The success of these guaranty associations is undeniable. Hank, supra, at 484. The National Committee on Insurance Guaranty Funds has stated that 60% to 70% of the claimants of insolvent insurance companies are fully reimbursed on their claims within six to seven months of insolvency. Without the guaranty associations, claimants could expect to recover only 10% to 15% of their claims, and only after seven to nine years. Id.

A continuing-care guaranty association necessarily would be somewhat different. Because continuing-care communities have a continuing obligation to care for their residents, the analogue to the insurance structure in the continuing-care field would be a board of directors with funds at its disposal to operate an insolvent community until all of its residents withdrew or died. Because this is a far more complex task than simply paying off claims as they mature, the continuing-care association would be saddled with far greater administrative problems than its insurance-industry counterpart. For this reason, this Comment proposes that the members of the continuing-care association simply agree to absorb residents of the failing community without the payment of any additional entrance fee. Whether monthly fees would remain the same is a problem that cannot be resolved here.

204 Because in many states the number of communities might not be sufficient to allow establishment of effective statewide mutual guaranty systems, federal action in this area might be desirable. See generally Kaplan, Regulation for Insolvency, 3 Forum 166, 172 (1968).
to cover costs of the system. An ancillary effect of this proposal would be to stimulate the industry to develop a meaningful self-accreditation program to reduce the likelihood of community failures.\textsuperscript{205}


In order to protect residents in the event of liquidation or bankruptcy, and possibly to discourage excessive encumbrance of communities’ property, all statutes but Michigan’s provide for imposition of a lien on property and equipment for the benefit of the residents and/or for a preferred claim in the event of liquidation.

The states use two forms of lien provisions. California and Colorado provide for a lien when necessary to secure performance of the continuing-care agreements.\textsuperscript{206} Arizona, on the other hand, requires that a lien be filed as a condition to receiving a permit for the operation of the facility.\textsuperscript{207} All three states subordinate the lien to prior-recorded liens, and at least Arizona allows the administering agency to subordinate the lien to certain later-recorded liens.\textsuperscript{208}

There are also two forms of preferred-claim provisions. Colorado and Florida give a preference to resident claims, but the priority of duly recorded liens is retained upon liquidation.\textsuperscript{209} California, on the other hand, apparently grants an absolute preference to resident claims in the event of liquidation.\textsuperscript{210}

\textsuperscript{205} Such self-accreditation programs have worked efficiently with hospitals, nursing homes, mental hospitals, and schools. See Health Resources Statistics, supra note 4, at 300; Interview with Lewis, supra note 14. In fact, seven communities in Pennsylvania, New Jersey, and Maryland are already attempting to establish an accreditation program. See Kendal-Crosslands Annual Report for the Year April 1, 1978 to March 31, 1979, at 6.

In addition, two communities in Pennsylvania, which does not regulate continuing care, have attempted individually to eliminate some of the problems of continuing care discussed in this Comment. For example, residents serve on the board of directors at Kendal-Crosslands. Although Kendal is a Quaker-affiliated community, all of its advertising and promotional literature disclaims any financial connection between the community and the Philadelphia Yearly Meeting. Kendal also voluntarily makes complete financial disclosure to residents and prospective residents. Paul’s Run, which has not yet begun operations, plans to place all entrance fees received prior to opening in escrow accounts. Both communities have also established stiff reserve requirements. See id.; Preliminary Official Statement for Paul’s Run Lifecare Community Bond Offering by Philadelphia Authority for Industrial Development (July 27, 1979).

\textsuperscript{206} Cal. Health & Safety Code § 1772 (West 1979); Colo. Rev. Stat. § 12-13-112(2) (1978). The California lien attaches only to real estate; the Colorado lien attaches to both real and personal property of the community.


\textsuperscript{208} Id. § 20-1805(1); Cal. Health & Safety Code § 1772 (West 1979); Colo. Rev. Stat. § 12-13-112(2) (1978).


These provisions seem unnecessary, useless, and possibly even counter-productive. Subordination to mortgages, other long-term debt, and prior-recorded liens seems likely to cut into the residents' rights so significantly as to make the entire exercise futile. Moreover, the uncertainty created by the liens or preferred claims, regardless of their actual legal effect, may raise the cost of borrowing, which increase the community will pass on to the residents.

Finally, reliance on statutory liens recorded by the administering agency for the benefit of residents may well be frustrated by the new Bankruptcy Code. That legislation allows the bankruptcy trustee to avoid any statutory lien 211 that first becomes effective against the debtor (the community), _inter alia_, when its financial condition fails to meet a specified standard 212 or when a third party levies to make the lien effective. 213 If the lien is created through administrative action when necessary for the protection of the residents, both of these provisions are implicated; 214 if the lien is created by administrative action at the time of certification, only the latter applies. 215 But in both cases the lien is suspect: the mutual guaranty association proposed above seems better suited to meet the needs of the residents. 216

7. Advertising Regulation

Primarily in response to the many allegations of false advertising by continuing-care providers, 217 all the states but Arizona regulate the content of continuing-care advertising. Florida and Michigan mandate that a copy of all advertising and promotional literature be filed with the state before publication or distribution. 218 In Colorado and Florida, the mention of any other organization in

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211 A statutory lien is defined as a "lien arising solely by force of a statute on specified circumstances or conditions," 11 U.S.C. § 101(38) (Supp. II 1978), and clearly applies to residents' liens.
212 _Id._ § 545(1)(E).
213 _Id._ § 545(1)(F).
214 This is the case in California and Colorado. _See_ note 206 _supra_ & accompanying text.
215 This is the case in Arizona. _See_ note 207 _supra_ & accompanying text.
216 _See_ notes 203-05 _supra_ & accompanying text.
217 The most prominent example is provided by the Pacific Homes scandal in California. _See_ notes 85-96 _supra_ & accompanying text. Advertising for Pacific Homes communities prominently listed the Methodist Church as a sponsor. _Pacific Homes Bankruptcy Report, supra_ note 83, at 1, 61-62. In fact, the Church has declined to accept financial responsibility for any of the communities, and residents have sued for breach of contract. _Barr v. Methodist Church_, No. 404611 (Cal. Super. Ct., filed July 20, 1979).
the literature or advertising must be accompanied by a statement of the extent of the organization’s financial responsibility for the community.\(^{219}\) California requires only that the statement of financial responsibility be filed with the Department of Social Services.\(^{220}\) The Michigan legislation simply grants the Corporation and Securities Bureau the discretion to promulgate regulations governing the form and content of advertising.\(^{221}\)

Because the proposed first level of regulation is designed in part to enhance the functioning of the market in continuing care through education of consumers, advertising regulation is essential. Misleading advertising, especially that which implies the existence of financial connections between continuing-care communities and unrelated but well-known and respected organizations, should be expressly prohibited. All advertising and promotional literature should be submitted to the administering agency and checked against extensive ownership-disclosure data on file. Any mention of outside organizations in the advertising should be followed, in print at least the same size, by an explanation of the financial connection between that organization and the community. Prior approval of advertising and regulation of its form and content are also necessary components of a first-level regulatory scheme. Mere availability of ownership statements for public inspection is not sufficient.

8. State Investigative, Enforcement, and Rehabilitative Powers

Crucial to any effective regulatory scheme is the ability of the administering agency to determine violations promptly and to remedy them effectively.\(^{222}\) The tools available to state agencies are the powers to investigate, to seek injunctive relief, and to rehabilitate communities in trouble.\(^{223}\)

The investigative powers granted by each of the five states’ statutes are slightly different. In Arizona, continuing-care examiners with the same powers as insurance examiners are authorized

\(^{219}\) COLO. REV. STAT. § 12-13-113 (1978); FLA. STAT. ANN. § 651.095(3) (West Supp. 1978).

\(^{220}\) CAL. HEALTH & SAFETY CODE § 1789 (West Supp. 1980).

\(^{221}\) MICH. COMP. LAWS ANN. § 554.826(1) (Supp. 1979).

\(^{222}\) In a similar regard, as discussed above, all five states require annual renewal of operating certificates and/or submission by providers of comprehensive annual reports to the administering agency. See notes 172-82 supra & accompanying text.

\(^{223}\) Although it is essential that a regulatory scheme have “teeth” in order to be effective, a strong argument can be made that rehabilitative authority is not useful: government does not have the best track record in efficient operation of institutions far less complex than continuing-care communities. See note 236 infra.
to conduct inspections as often as may be necessary.\textsuperscript{224} Michigan grants a limited power to investigate when mandatory records or annual reports are incomplete,\textsuperscript{225} as well as a more structured and general investigative authority to protect against other violations of its statute.\textsuperscript{226} Florida grants a general examination authority to be exercised from "time to time."\textsuperscript{227} Colorado requires both an annual investigation\textsuperscript{228} and an annual audit.\textsuperscript{229} In contrast, California permits the administering agency to conduct inspections at any time\textsuperscript{230} but allows the agency to rely on an annual audit in lieu of inspection.\textsuperscript{231}

Enforcement mechanisms also vary from state to state. Colorado, Florida, and Michigan all authorize injunctive relief against violation or threatened violation of any provision of the legislation.\textsuperscript{232} As an important additional sanction focused specifically upon the performance of administrators, all the states provide either criminal or civil penalties for violation of the legislation by individuals.\textsuperscript{233} Finally, Arizona, California, and Florida authorize the administering agency to assume management of continuing-care facilities in certain specific situations in order to rehabilitate communities in serious financial trouble.\textsuperscript{234}


\textsuperscript{226} Id. § 554.833.


\textsuperscript{229} Id. § 12-13-111.


\textsuperscript{231} Id. § 1782.


The California rehabilitation procedure, probably the most detailed, is triggered when a continuing-care institution does not file its annual report or when the director of 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." Cal. Health & Safety Code § 1790 (West 1979). The facility is first allowed to propose a plan to correct the deficiencies. Id. Next, in case of an emergency that threatens immediate closure of a facility, or if no approved plan is forthcoming, the director may
A comprehensive investigation and enforcement mechanism should be considered only as a component of a second-level regulatory scheme. If the first-level minimum financial requirements and market pressure from educated consumers prove insufficient to force communities to follow sound financial practices, some governmental corrective mechanism may be necessary. In that event, the following scheme would be appropriate. First, full investigative authority should be vested in the administering agency. This power should extend both to on-site inspections and to examinations and financial audits. Second, strong civil and/or criminal penalties should be enacted to ensure continuing-care administrators' compliance with the statutory requirements.

The remedial authority of the administering agency should be somewhat different from that in any of the state schemes described above. No corrective action should be permitted until the non-complying provider is given notice of a violation and an opportunity to correct it. Thereafter, all agency actions should be subject to prior judicial approval.235

The primary corrective mechanisms should be injunctive decrees and the appointment of examiners to supervise compliance with court orders. Such methods would allow the operator to continue to run his facility, a feature of some importance because of his specialized knowledge of that particular community. Use of rehabilitative procedures that displace the operator 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 deal with the serious problems that arise once a community is in financial trouble; indeed, most of the evidence to date supports a contrary conclusion.236

petition a court for appointment of an administrator. Id. § 1790.1. The administrator has broad powers, including total power over all property, equipment, and funds and the power to perform all duties of the original provider. Id. § 1790.4. The statute provides for termination of the intervention when the defect is cured, id. § 1790.5, as well as for liquidation or dissolution of the provider if rehabilitative efforts fail, id. § 1790.6.

235 Requiring the state to make precise showings of noncompliance with the statute prior to judicial intervention will prevent the uncertainty that currently accompanies private continuing-care litigation. See notes 131-33 supra & accompanying text.

236 The corrective mechanisms proposed in this section are analogous to the reorganization provisions of the new bankruptcy code, Bankruptcy Code §§ 101-1330, 11 U.S.C. §§ 101-1330 (Supp. II 1978). A comparison between this Comment's proposal and bankruptcy reorganization requires a brief glimpse of the old bankruptcy procedure, however. The Bankruptcy Act of 1898, 11 U.S.C. §§ 1-1103 (1976), which still has limited application, has three business reorganization chapters: X, XI, and XII. In Chapter X the appointment of a trustee is mandatory.
9. Rights of Self-Organization

In order to combat some of the harms of institutionalization and the disincentive to care which may be present in some continuing-care institutions, Florida and Michigan provide rights of self-organization to the residents of continuing-care communities. Michigan simply requires that one resident serve as an advisory member on the facility's board of directors. Florida's legislation grants residents the right of self-organization, the right to be represented by individuals of their own choosing, and the right to engage in concerted activity for the purpose of keeping informed or for other mutual aid or protection. Florida also requires quarterly meetings between management and residents to discuss income, expenditures, financial problems, and proposed changes in policies or services.

when the bankrupt's liability exceeds $250,000. Id. § 556. In Chapters XI and XII, however, appointment of a trustee is optional, id. §§ 742, 832, and the bankrupt usually remains in control of the business. See D. Epstein & M. Schinfeld, Teaching Materials on Business Reorganization Under the Bankruptcy Code 52 (1980). This disparity results from two apparently irreconcilable policies behind business reorganizations: protection of creditors and the public (the Chapter X policy) and facilitation of an effective reorganization to benefit both creditors and the bankrupt (the Chapters XI and XII policy).


This Comment proposes that courts be required to apply a similar standard in continuing-care rehabilitation proceedings. The chances for successful rehabilitation are greatly enhanced if the continuing-care provider remains in possession. Like the debtor going through reorganization, the provider is more familiar with his business. If he remains, there will be no period of adjustment while the outside trustee familiarizes himself with the unique features of the particular facility. Finally, the cost of such an outside trustee is saved. See id. 233, reprinted in [1978] U.S. Code Cong. & Ad. News 5963, 6192.

As does the new bankruptcy code, see 11 U.S.C. § 1104(a)(1) (Supp. II 1978), this Comment's proposal envisions 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 for resorting to the drastic remedy of appointing an outside trustee. Finally, this Comment's middle-ground solution of having the court appoint an examiner to investigate and supervise the affairs of a continuing-care provider mirrors the provisions and policy of the new Bankruptcy Code. Id. § 1104(b). See H.R. Rep. No. 95-595, 95th Cong., 2d Sess. 234, reprinted in [1978] U.S. Code Cong. & Ad. News 5963, 6193-94.

237 See note 7 supra; note 142 supra & accompanying text.
240 Id. § 651.085.
The right of residents to organize and participate in community governance is an essential element of a first-level regulatory system. Unlike some of the other components of the first-level program, the purpose of granting residents this right is not primarily educational. The existence of a residents' committee and the presence of at least one resident with full voting powers on the community's board of directors are essential checks against fiscal mismanagement and undesirable reductions in quality of care. Moreover, a residents' committee with a real voice in community governance preserves for residents a self-esteem and sense of control over their own lives that is often lost upon institutionalization.

10. Financial Disclosure to Residents

In order to mitigate some of the problems inherent in consumer bargaining for nursing-care services, all five states have enacted financial-disclosure requirements that fall into two basic categories: (1) Florida and Michigan allow general public inspection, on request, of financial statements and annual reports filed with the administering agency; (2) Arizona, California, Colorado, and Florida require that continuing-care providers furnish copies of disclosure material to all residents and to prospective residents or their advisors prior to the execution of the contract.

Complete financial disclosure to prospective and actual residents is one of the most important components of this Comment's proposed first-level regulatory system. It allows prospective and current residents and their advisors to evaluate fully the financial position of a continuing-care community. In conjunction with industry-accreditation programs, full disclosure is the best non-coercive mechanism available to ensure compliance with minimum financial safeguards. Communities that do not measure up to industry standards will simply not be able to attract residents.

The form and content of disclosure is critical. States should require use of a standard form that elicits a complete summary of the community's current and long-range financial picture. This form should include space for a clear narrative description of the financial condition of the community to supplement any raw data supplied. The form should be completed and submitted to the

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241 See notes 49-50 supra & accompanying text.  
administering agency for approval once a year. All prospective 
residents should be given a copy of this form as a matter of course 
before signing a continuing-care contract. Current residents should 
be provided with copies of the form annually and on request. 
Finally, the residents and their advisors 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 in-
spection should be clearly and conspicuously stated on the dis-
closure form.

11. Regulation of the Contents of the Agreement

Another method of consumer protection utilized by the states 
is direct regulation of certain terms of the continuing-care agree-
ment. An important result of some of this regulation is a reduction 
in litigation and, consequently, in the cost of continuing care.244 Only three states require that the community's contract be sub-
mitted to and approved by the responsible regulatory agency.245

Two sections of the Florida statute that forestall litigation re-
quire that the contract contain a provision governing increases in 
fees 246 and that no resident be permitted to waive his statutory 
rights.247 California, Colorado, and Florida all have general re-
quirements that clauses be included concerning the rates of the 
community, the manner in which rates may be changed, the cost 
and duration of services to be provided, and the health and finan-
cial conditions each resident must meet to remain in the com-

Refund provisions vary. Only Florida and Michigan specifi-
cally require that the contract grant a right of full refund to a 
resident who dies before taking occupancy.249 More generally, the 
Florida statute requires that all refund terms be clearly stated in 
the contract,250 adding that the contingency of death after occupancy

244 Requirements that contracts contain express terms on fee setting, termina-
tion rights, and refund rights would forestall, or at least simplify, most of the 
continuing-care litigation that now occurs. See notes 108-30 supra & accompanying 
text.

245 See CAL. HEALTH & SAFETY CODE § 1778 (West 1979 & Supp. 1980); 
COLO. REV. STAT. § 12-13-106(2) (1978); FLA. STAT. ANN. § 651.026(5) (West 


247 Id. § 651.065.

248 CAL. HEALTH & SAFETY CODE § 1779 (West Supp. 1980); COLO. REV. 

249 FLA. STAT. ANN. § 651.055(3) (West Supp. 1978); MICH. COMP. LAWS 
ANN. § 554.810(a) (Supp. 1979).

250 FLA. STAT. ANN. § 651.055(1)(g) (West Supp. 1978).
must be addressed.\textsuperscript{251} California's refund regulation is insufficient: the statute requires a refund of entrance payments, less a reasonable processing fee and the reasonable value of services provided, within ten days of cancellation,\textsuperscript{252} but it does not attempt to deal with the contingency of death.\textsuperscript{253}

Regulation of residents' termination rights is also diverse. Arizona, California, and Florida mandate a seven-day "cooling off" period prior to occupancy, during which the resident may cancel the contract with no penalty.\textsuperscript{254} In Florida, after the initial seven-day period, the resident must be permitted to withdraw on thirty days' notice.\textsuperscript{255} Arizona has no similar provision. California allows cancellation of the contract without notice or cause by either party within the first ninety days; thereafter ninety days' notice is required from the party that wishes to terminate the contract.\textsuperscript{256} Michigan does not limit the residents' right of cancellation, although the refund allowed varies with the time of cancellation.\textsuperscript{257}

Finally, 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.\textsuperscript{258} Florida's strict regulation allows dismissal of residents by the community upon thirty days' notice,\textsuperscript{259} but only for good cause.\textsuperscript{260} Michigan's statute has a novel feature: it provides that residents dismissed without good cause are entitled to immediate refunds as specified in the contract, but that continuing-care providers may mitigate potential damage awards by placing those residents in adequate alternative facilities.\textsuperscript{261} Unless the terminating provider sup-

\textsuperscript{251} Id. § 651.055(1)(h). The contract may provide for retention of the entrance payment by the community upon the resident's death. \textit{Id.}
\textsuperscript{252} CAL. HEALTH & SAFETY CODE § 1779.8(a) (West Supp. 1980).
\textsuperscript{253} Id. § 1779.8. \textit{See also} MICH. COMP. LAWS ANN. § 554.810(e), (e) (Supp. 1979).
\textsuperscript{255} FLA. STAT. ANN. § 651.055(1)(g) (West Supp. 1978).
\textsuperscript{256} CAL. HEALTH & SAFETY CODE § 1779(d)-(f) (West Supp. 1980). California also requires that each contract be accompanied by a notice explaining all rights of cancellation. \textit{Id.} § 1779(e)-(f). \textit{See also id.} § 1779.8(b).
\textsuperscript{257} MICH. COMP. LAWS ANN. § 554.810(e)-(d) (Supp. 1979). \textit{See id.} § 554.810(e).
\textsuperscript{258} CAL. HEALTH & SAFETY CODE § 1780 (West 1979); COLO. REV. STAT. § 12-13-108(1) (1978).
\textsuperscript{259} FLA. STAT. ANN. § 651.055(1)(g) (West Supp. 1978).
\textsuperscript{260} Id. § 651.061.
\textsuperscript{261} MICH. COMP. LAWS ANN. § 554.810(2) (Supp. 1979).
plies alternative accommodations, however, it must give thirty days' notice before cancellation.\textsuperscript{262}

Although this Comment's first-level regulatory philosophy of minimal intrusion is violated to some degree by the comprehensive regulation of contract terms, such regulation is essential to the success of the overall scheme, and is also relatively inexpensive. This Comment proposes the following regulations for contracts and contract terms:

(a) The community's contract form must be approved by the administering agency.

(b) The contract should specify that it creates no property interest of any kind; it is simply a service agreement.

(c) The value of all assets transferred to the community, the initial amount of the monthly fees, and the manner of changing monthly fees should all be stated in the contract.

(d) Provisions limiting the permissible increase in monthly fees should be prohibited.

(e) The contract should list all services to be provided and any surcharges that may be levied.

(f) Any health or financial condition of a resident that can allow the community to terminate the contract must be set forth in detail.

(g) All rights of cancellation by the resident should be conspicuously stated in the contract. The requirement of a seven-day cooling-off period is an excellent provision. In addition, some probationary period of at least thirty days should be allowed. The contract should clearly explain any rights of cancellation thereafter, but those rights should be mutual.

(h) Similarly, the community's rights of dismissal must be clearly stated in the contract. This Comment favors a good-cause limitation on the dismissal power of the community; perhaps, also, the resident committee should be consulted prior to the dismissal of any resident for any reason. Residents should also be protected against eviction in retaliation for complaints against the community.

(i) The refund provisions should be clearly stated in the text of the contract (possibly in boldface type). Upon dismissal of a resident, the community should be required to refund the entire entrance payment less the costs of care not actually covered by the

\textsuperscript{262} Id. § 554.810(3).
monthly fees. Authorization of refund formulas that are not cost-based (such as one that allows the community to retain two percent of the entrance fee for each month of occupancy) conceivably could allow the community to profit by a dismissal. But for cases of resident withdrawal, a formula based on either actual cost or an acceptable percentage per month of occupancy seems perfectly proper.

(j) The statute must also require that the contract specify what refund, if any, will be granted upon the death of the resident.263

12. Miscellaneous

Three additional proposals do not fit neatly into any of the categories previously discussed. The first two are essential to an effective first-level program; the third is harsh and should be adopted only if third-level measures prove necessary.

First, the regulatory legislation should mandate a study of the operation of continuing-care communities under whatever form of regulation is adopted. An independent commission of private citizens, experts, and policymakers should be formed to gauge the effect of the legislation both on the financial stability of individual continuing-care communities and on the continuing-care industry as a whole. A comprehensive report with specific recommendations for further or less regulation should be produced within a specified number of years. This proposal makes the suggested first-level regulation just that, a first step, representing one set of thoughts about the absolutely essential steps that must be taken to preserve an important institution. Five or ten years later, the legislature will be able to step back and look at its handiwork with a great deal more information than exists today.

Second, the legislation should attempt to limit continuing-care communities' reliance on entrance fees to cover operating expenses. This may be done in one of two ways. The statute could provide an arbitrary figure, say seventy percent, and require that monthly fees be set to fund at least that percentage of present operating costs. Or, the statute could mandate that the continuing-care in-

263 The contract could provide for no refund of entrance payments, a fixed refund, or a variable refund based on a schedule such as the following:

<table>
<thead>
<tr>
<th>Time of Death</th>
<th>Refund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before occupancy</td>
<td>Full</td>
</tr>
<tr>
<td>Within 90 days of occupancy</td>
<td>Full, less expenses</td>
</tr>
<tr>
<td>After 90 days of occupancy</td>
<td>No refund</td>
</tr>
<tr>
<td>After 90 days of occupancy and after notice of termination given but before departure</td>
<td>Community retains two percent of entrance fee per month of occupancy prior to death</td>
</tr>
</tbody>
</table>
Industry develop an accreditation program that included a similar requirement. Under the latter approach, the government would have no need to regulate the financing of any community that met the accreditation standards. This Comment strongly favors this approach because of the continuing-care providers’ higher level of expertise and greater familiarity with some of the factors that might influence the choice of a particular percentage.

Third, and only as part of a third-level regulatory program, the states might consider regulation of fee setting, perhaps along the lines of fee regulation in the insurance industry. In the continuing-care industry, the adequacy of fees is as much a problem as the excessiveness of fees. Both problems could be dealt with through direct or indirect regulation. Comprehensive fee regulation is the ultimate in government interference, however, and should be imposed only as a last resort.

IV. CONCLUSION

This Comment has attempted to describe and analyze the little-discussed institution of continuing care. In response to a number of intrinsic failings and weaknesses in the institution and the current regulatory vacuum, five different approaches to regulation have been considered.

In an effort to avoid the trap of treating regulation as a panacea, this Comment’s suggested initial resolution of continuing-care problems is a scheme of nonintrusive governmental regulation designed (1) to provide minimum economic safeguards for residents and (2) to enhance the functioning of normal market mechanisms through consumer education. The basic financial protection is provided through the proposed reserve and escrow requirements, minimum regulation of financing methods, and mandatory mutual guaranty associations. Consumer education is to be achieved through proposals for advertising regulation, contract-term regulation, and full disclosure of community finances and practices. Finally, a study commission required to report on the effect of these proposals will serve as a bridge between this first-level regulation and a second, possibly more intrusive phase.

264 Government reliance on a private accreditation system would not be unprecedented. For purposes of Medicaid certification, the federal government usually requires no more of hospitals than that they meet standards set by the Joint Commission on Accreditation of Hospitals. 42 U.S.C. § 1395bb (1976).

265 For a general review of fee regulation in the insurance industry, see R. Keeton, supra note 140, at 557-67.
In the event the first-level regulation fails to stabilize the continuing-care industry, more burdensome devices, such as certification requirements and authorization of the use of investigative and injunctive powers, are proposed. Should even these measures prove insufficient, the third-level direct fee regulation could be imposed.

The proposals set forth in this Comment are realistic responses to what are considered manageable problems of an institution of great importance to our nation's elderly people. Their goal is to guarantee that continuing-care communities can offer care that is truly continuing.