


10-1-1988

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Recommended Citation

Groves, Harry E. (1988) "The Law of Continuing Care Facilities in North Carolina," *North Carolina Central Law Review*: Vol. 17 : No. 2, Article 3.

Available at: <https://archives.law.nccu.edu/nclcr/vol17/iss2/3>

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THE LAW OF CONTINUING CARE FACILITIES IN NORTH CAROLINA

HARRY E. GROVES*

With effect from January 1, 1988, the North Carolina legislature added to Chapter 131E *Health Care Facilities and Services* a new Article 12, "Disclosure and Contract Requirements for Continuing Care Facilities." This new legislation recognized a fast-growing industry in North Carolina¹ and the need for legislative intervention to protect the rights of the aged residents of these facilities.

"Continuing Care Facilities" is one of a number of synonyms for the same entities. In some states they are called "Life Care Facilities,"² in others "Continuing Care Retirement Communities."³ The characteristic which they have in common is that they offer to persons of retirement age a home with the availability, normally within the structures of the facility, of comprehensive medical care. The facilities are not designed for the poor. The entry fee, which purchases a life estate in particular quarters, often exceeds one hundred thousand dollars and the monthly service charge frequently exceeds seven hundred dollars per person. The purchase agreement varies with the facilities as do the services offered for the monthly fee. In some the purchase price for the life estate is forfeited on the death or departure of the resident. In others the purchase price, or some part of it, may be recovered by the resident on departure or by his/her estate upon the resident's death. The quarters purchased may be a separate house, an attached house or an apartment, depending upon the facility.⁴

The monthly fee purchases health care, usually with certain limitations. A resident may receive all routine out-patient medical care on the premises. In the event of short-term illnesses he will normally have avail-

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1. Development in North Carolina reflects that in the nation, the American Association of Homes for the Aging's "Guidelines for Regulation of Continuing Care Retirement Communities," dated May, 1987, reports on page 1 that there are now approximately 600 continuing care retirement communities, a figure which has doubled in the past ten years and is expected to more than double again in the current decade.

2. *E.g.*, Ariz. Rev. Stat. Ann. § 20-1801 (Supp. 1987); Ill. Ann. Stat. ch. 111-1/2 ¶ 4160 (Smith-Hurd Supp. 1988).

3. *E.g.*, Me. Rev. Stat. Ann. tit. 24-A, § 6202(2) (Supp. 1988).

4. See WINKLEVOSS & POWELL, *Continuing Care Retirement Communities: An Empirical, Financial, and Legal Analysis*, 1984, WHARTON SCH. 11.

able on premises a clinic with full nursing services. Operations are generally not performed in the clinic but are usually paid for by the facility, utilizing the resident's medicare eligibility and any other insurance of the resident, with the facility paying any excess costs. Stays in the clinic, without additional cost to the resident, may be limited to a number of days per year, e.g., thirty. For stays of greater length, the resident may be charged a daily rate comparable to that of nursing homes. Residents often pay for their medications. In some facilities the contract of life care may exclude communicable diseases and/or serious mental conditions, such as Alzheimer's disease.

The monthly fee also normally provides for one meal a day. The living units have their own separate kitchens as in any apartment or house. Other meals may be purchased in the facility's dining room. Maid service is usually a part of the contract and a variety of other services may be offered, such as recreational events, transportation to stores and places of recreation, etc.

In addition to being able to afford entry and therefore ranging from the middle class to wealthy, residents share other characteristics. They are, of course, elderly. While entry in the sixties is usually permitted, observation reveals that the majority of residents are in their seventies and above. Most people do not normally elect to leave their homes for communal living until infirmity of body or ill health makes independent living infeasible. Many of the residents will have found that the act of severing community ties, selling of a loved residence and disposing of many of the furnishings and other possessions for which there is no room in the new and smaller residence has been traumatic. For many these painful acts have followed upon the loss of a mate. Often the surviving spouse is not the one who has handled the business affairs of the family. Thus while this is a class of people who have known independence and some affluence, they can be expected to number many who need the protection that only the state can afford. An aged person, perhaps traumatized by the loss of a mate, often not in good health, may be only theoretically in a position of bargaining equality with a Continuing Care provider.

Continuing care facilities are a rapid growth industry and not just in the sunbelt states, although California and Florida have, as might be expected, had some of the longest experience of regulation in this field.⁵ Currently, statutes in some form addressed to these matters are found in twenty-six states, with many of the enactments being quite recent.

The North Carolina statute is a disclosure, not a licensing, statute. This contrasts with a number of states, including some with the longest

5. Florida, for example, began to regulate the industry in 1953. See PATRUCCO, *Florida's Continuing Care Contracts*, 61 FLA. B. J. 29 (1987).

experience with these facilities. In Arizona a permit to enter into life care contracts must be secured from the Department of Insurance.⁶ A similar requirement is found in the laws of Colorado,⁷ Florida,⁸ Maine,⁹ Missouri,¹⁰ Pennsylvania,¹¹ Texas,¹² Virginia,¹³ Wisconsin,¹⁴ and New Hampshire.¹⁵ In Vermont, it is the Department of Banking and Insurance.¹⁶ Kansas, which does not require a license, does require the filing with the state insurance commissioner of an annual disclosure statement and audit.¹⁷ The logic of close supervision, including licensing, by a state's Department of Insurance is compelling. What residents think and hope that they are purchasing with the substantial initial expenditure and monthly fee is in reality a new type of insurance, guaranteeing their maintenance for life. For many, the initial purchase represents the surrender of substantially all of their capital assets, often derived from the sale of their home. For many the financial collapse of a continuing care facility would be even more devastating than the failure of a life insurance company. Failure of the latter might merely deprive heirs of an expectation. Failure of a continuing care facility could result in impoverishment in old age.

Some other states which do not place licensing authority in a department of insurance do require a permit of some other agency of government. In California it is the Department of Social Services,¹⁸ in Illinois the Department of Public Health,¹⁹ in Indiana the Securities Commission,²⁰ in Connecticut and Maryland the Department of Aging,²¹ in Louisiana and Michigan Department of Commerce,²² and in New Jersey the Department of Community Affairs.²³ It is apparent from their titles that all of these licensing agencies have a reasonable nexus to the subject matter of continuing care communities. The comprehensiveness of the supervision inherent in the licensing of all these agencies will be discussed *infra*.

6. Ariz. Rev. Stat. Ann. § 20-1801 (Supp. 1987).

7. Colo. Rev. Stat. § 12-13-101 (1985).

8. Fla. Stat. Ann. § 651.021 (West 1984 & Supp. 1988).

9. Me. Rev. Stat. Ann. tit. 24-A, § 6202(2) (Supp. 1988).

10. Mo. Ann. Stat. § 376.905 (Vernon Supp. 1988).

11. 40 Pa. Cons. Stat. Ann. § 3204 (Purdon Supp. 1988).

12. Tex. Rev. Stat. Ann. art. 726 § 4 (Vernon 1987).

13. Va. Code Ann. § 38.2-4901 (1986).

14. Wis. Stat. Ann. § 647.02 (West Supp. 1988).

15. N.H. Rev. St. Ann. § 420-D:2 (Supp. 1988).

16. Vt. Stat. Ann. tit. 8, § 8001 (Supp. 1988).

17. Kan. Stat. Ann. § 16-1104 (Supp. 1987).

18. Cal. Health and Safety Code, § 1770 (West 1988).

19. Ill. Ann. Stat., ch. 111-1/2 ¶ 4160-2 (Smith-Hurd Supp. 1988).

20. Ind. Code Ann. § 23-2-4-3 (Burns Supp. 1988).

21. Conn. Gen. Stat. Ann. § 17-537 (West Supp. 1988); Md. Ann. Art. 70B § 8 (Supp. 1987).

22. La. Rev. Stat. Ann. § 2174 (West 1987); Mich. Stat. Ann. J § 14.1301(8) (Calahan 1987).

23. N.J. Stat. Ann. § 52:27D-333 (West Supp. 1987).

It will be seen from the above two paragraphs that of the twenty-six states that have legislated on continuing care communities, nineteen do not permit a provider to enter into the business except with the permission of the state. The remaining seven states, of which North Carolina is one, require only disclosure by the provider of certain relevant information [discussed in detail *infra*].

All of the license states also require disclosure, demanding varying degrees of detail. In every case disclosure is required to the state.²⁴ In ten, specific disclosure is also required to both prospective purchasers and current residents.²⁵ Five licensing states that require disclosure to prospective purchasers make no similar provisions for residents.²⁶ Neither Michigan nor Florida orders disclosure by the provider to either prospective purchasers or residents; but in Michigan the disclosure documents filed with the bureau are open to public inspection²⁷ and persons may secure photostatic copies of them.²⁸ In Florida the act requires that records of all cost and inspection reports filed with or issued by any government agency be maintained as public information and be available upon request.²⁹ The statute of Maryland requires that the State Office on Aging publicize the availability of the disclosure information and make it available to all interested persons.³⁰

The theory for the requirement of disclosure as to prospective purchasers is, of course, that if they have detailed information about the assets, liabilities, operating income and expenses, and the personal and professional history of major persons connected with the provider, they can make an informed decision as to entry into a contract with the provider.

24. Ariz. Rev. Stat. Ann. § 20-1802 (1987); Cal. Health and Safety Code § 1771.4 to 1771.8 (West Supp. 1988); Colo. Rev. Stat. § 12-13-102 (1985); Conn. Gen. Stat. § 17-536 (1988); Fla. Stat. Ann. § 651.022 (West 1988); Ill. Ann. Stat. Ch. 111-1/2 ¶ 4160-4 (Smith-Hurd Supp. 1987); Ind. Code Ann. § 23-2-4-4 (Burns 1984); La. Rev. Stat. Ann. § 51:2174(B) (West Supp. 1988); Me. Rev. Stat. Ann. tit. 24-A, § 6203 (Supp. 1987); Md. Ann. Code art. 70B § 10 (Supp. 1987); Mich. Stat. Ann. § 14.1301(8) (Calahan 1987); Mo. Stat. §§ 376.915 and 376.920 (Vernon Supp. 1988); N.H. Rev. Stat. Ann. § 420-D:4; N.J. Stat. Ann. § 52-27D-333 (West Supp. 1987); Pa. Stat. Ann. tit. 40 § 3207(b) (Purdon Supp. 1987); Tex. Rev. Stat. Ann. art. 726 § 5(a)(1) (Vernon 1987); Va. Code Ann. § 38.1-956 (1985); Vt. Stat. Ann. tit. 8, § 8010 (Supp. 1988); Wis. Stat. Ann. § 647.02 (West 1987).

25. Colo. Rev. Stat. § 12-13-108 (1985); Conn. Gen. Stat. Ann. §§ 17-537 and 17-543 (West 1988); Ind. Code Ann. § 23-2-4-7 (Burns 1984); La. Rev. Stat. Ann. § 51:2176(B) (West 1988); Me. Rev. Stat. Ann. tit. 24-A, § 6206 (1978); Mo. Ann. Stat. § 376.930 (Vernon 1988); N.J. Stat. Ann. 52:27D-336 and 337 (West 1987); 40 Pa. Cons. Stat. Ann. § 3207(c) (Purdon 1987); Va. Code Ann. § 38.1-958 and 959 (1985); Vt. Stat. Ann. tit. 8, § 8010 (Supp. 1988); Wis. Stat. Ann. § 647.04(b) (West 1987).

26. Ariz. Rev. Stat. Ann. § 20-1812 (Supp. 1987); Cal. Health and Safety Code § 1779 (West Supp. 1988); Ill. Ann. Stat. ch. 111-1/2 ¶ 4160 (Smith-Hurd 1987); Tex. Health & Safety Ann. § 726 (Vernon 1987); Vt. Stat. Ann. tit. 8, § 8010 (Supp. 1988).

27. Mich. Stat. Ann. § 14.1301(40) (Calaghan 1987).

28. *Id.* at § 14.1301(41).

29. Fla. Stat. Ann. § 651.091 (West 1984).

30. Md. Ann. Code art. 70B § 10(f) (Supp. 1987).

The limited options available in many states to one who has already entered into a life contract may well account for the failure of some statutes to require disclosure to current residents.

Most of the disclosure-only states require that the disclosure information be filed with some state agency. In North Carolina that agency is the Division of Family Services of the Department of Human Resources;³¹ in Connecticut it is the Department on Aging;³² in Kansas, as noted above, it is the State Insurance Commission; in New Mexico the State Agency on Aging;³³ in Rhode Island the Department of Health.³⁴ In Minnesota the disclosure statement must be filed in the office of the county recorder of the county in which the facility is or will be located.³⁵ Two of the disclosure states, Massachusetts and Oregon, do not require a public filing of a disclosure statement.

The fact that a permit or license is not required by a state does not necessarily mean that the state exercises no control over the provider. Even the non-filing state of Oregon permits a purchaser to rescind the contract of purchase within six years if the seller fails to supply the prospective purchasers with the mandated disclosure statement, makes an untrue statement of a material fact or fails to state a necessary material fact. The statute further makes personally jointly and severally liable to the purchaser every person who directly or indirectly controls the seller. Curiously, members of the board of directors are excluded from liability by the statute.³⁶ Oregon does not prescribe any of the terms of the contract. Massachusetts, a non-filing state, does prescribe terms of the contract and gives the resident the right of rescision and full refund of the entrance fee if the contract violates any of the mandated provisions.³⁷

With one exception, Connecticut, it is the pattern in the disclosure-only filing states that the agency with which the disclosure statement is filed exercises no direct supervision over the provider. Kansas neither supervises the provider nor addresses the question of any civil liability; the statute does state that a provider who fails to comply with the provisions of the act, shall be fined not more than \$500 upon conviction.³⁸ The statute is silent as to the machinery of enforcement of the criminal penalty. It should be noted that the Kansas statute consists of only one printed page. The more detailed statutes of Minnesota and New Mexico appear to have provided some of the model for the North Carolina stat-

31. N.C. Gen. Stat. § 131E-216 (1987).

32. Conn. Gen. Stat. § 17-536 (West 1988).

33. N.M. Stat. Ann. § 24-17-7 (1986).

34. R.I. Gen. Laws § 23-59-1 (1985).

35. Minn. Stat. Ann. § 80D.03 (West 1986).

36. Ore. Rev. Stat. § 105.835 (1983).

37. Mass. Gen. Laws Ann. ch. 93, § 76 (West 1984).

38. Kan. Stat. Ann. § 16-1105 (Supp. 1987).

ute. The New Mexico statute makes civilly liable a provider who has not delivered to the prospective purchaser a disclosure statement or whose statement misstates or omits a material fact. The purchaser is entitled to damages and a return of all fees, less the reasonable value of care and lodging. The purchaser may also be awarded court costs and reasonable attorney fees. The purchaser has one year after discovery of the conduct to bring an action.³⁹ The New Mexico statute specifically places some enforcement authority in the Attorney General. He may, upon reasonable belief of violations of the act, bring an act in the name of the state alleging the violations. He may seek temporary or permanent injunctive relief and restitution, and if the court finds a willful violation of the Continuing Care Act, it may assess a civil penalty not to exceed five thousand dollars per violation.⁴⁰

The Minnesota statute is the most comprehensive of the disclosure-only filing states which place no supervisory authority in the filing agency. The civil remedies provided for are similar to those in the New Mexico statute.⁴¹ Unlike the New Mexico statute, the Minnesota law makes violation of its provisions a criminal act, subject to a \$20,000 fine and one year imprisonment.⁴² An important feature of the Minnesota law is that every resident is given a lien on the real and personal property of the provider or facility, to secure the obligations of the provider pursuant to existing and future contracts of continuing care. The lien is effective for ten years and may be foreclosed upon the liquidation of the facility on the insolvency or bankruptcy of the provider, and in that event the proceeds shall be used in full or partial satisfaction of obligations of the provider pursuant to contracts for continuing care then in effect.⁴³

In North Carolina, as stated earlier, the Division of Facility Services of the Department of Human Resources, with which the disclosure statements must be filed, is a depository only, with no powers of supervision over a provider. The civil liability stated in the law is like that of New Mexico, except that the statute of limitations is three years from the date of the execution of the contract.⁴⁴ Willful violation of the statute is a misdemeanor and can result in a fine of not more than ten thousand dollars, imprisonment for one year, or both.⁴⁵ The Attorney General is empowered to make public or private investigations within or outside the state of violations or possible violations.⁴⁶ Whenever it appears to either

39. N.M. Stat. Ann. § 24-17-9 (1978 and Supp. 1986).

40. *Id.* at § 24-17-10.

41. Minn. Stat. Ann. § 80D.13 (West 1986).

42. *Id.* at § 80D.16.

43. *Id.* at § 80D.08.

44. N.C. Gen. Stat. § 131E-221 (1988).

45. *Id.* at § 131E-224.

46. *Id.* at § 131E-222.

the Attorney General or any district attorney, upon complaint or otherwise, that any person has engaged or is about to engage in a violation of the statute, that officer may seek a restraining order or a temporary or permanent injunction. A court may also appoint a receiver or conservator for the provider or the provider's assets.⁴⁷

The disclosure provisions⁴⁸ of the North Carolina statute are comprehensive and compare favorably with those of any other state. The provider, prior to entering into a contract with a prospective resident, must file with the Division a current disclosure statement.⁴⁹ This same statement must be provided the prospective resident prior to, or at the time of, entering into a contract with or accepting money or other property from or on behalf of the prospective resident.⁵⁰

The disclosure statement must identify the provider by name and business address and indicate whether the provider is a partnership, corporation or some other type of legal entity.⁵¹ It must also include the names and business addresses of the officers, directors, trustees, managing or general partners as well as any person having a ten percent or greater equity or beneficial interest in the provider and any person who will be managing the facility on a day-to-day basis, and a description of these persons' interests in or occupations with the provider.⁵²

The disclosure statement requires quite detailed information on all the persons identified in the preceding paragraph. This includes a description of their business experience in the operation or management of similar facilities.⁵³ It requires the disclosure of the name and address of any legal entity which will provide goods, leases or services to the provider of a value of or greater than five hundred dollars in a year and in which any of the identified persons have a ten percent or greater interest or which entity has a ten percent or greater interest in the person. The goods, leases or services must be described and their probable or anticipated costs indicated or a statement that the cost cannot presently be estimated.⁵⁴

The legal history of the above-indicated persons must be supplied for each person who has (1) been convicted of a felony or pleaded *nolo contendere* to a felony charge, or been held liable or enjoined in a civil action by final judgment, if the felony or civil judgment involved fraud, embezzlement, fraudulent conversion, or misappropriation of property; or (2) is

47. *Id.* at § 131E-223.

48. *Id.* at § 131E-217.

49. *Id.* at § 131E-216.

50. *Id.* at § 131E-217(a).

51. *Id.* at § 131E-217(a)(1).

52. *Id.* at § 131E-217(a)(2).

53. *Id.* at § 131E-217(a)(3)(a).

54. *Id.* at § 131E-217(a)(3)(b).

subject to a currently effective injunctive or restrictive court order, or within the past five years, has had any State or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department, if the order or action arose out of or related to the business activity of health care including foster care facilities, nursing homes, retirement homes, homes for the aged in North Carolina or in another state with a similar law.⁵⁵

The provider must indicate the nature and extent of the involvement of any religious, charitable, or other nonprofit organization, if any, with which the provider is affiliated.⁵⁶ The property of the facility existing and proposed must be described, to include projected construction.⁵⁷ The services to be provided must be detailed.⁵⁸ A detailed description of all fees must be stated.⁵⁹

Requirements as to the health and financial condition required both for admission and continued residence must be spelled out.⁶⁰

Provisions as to reserve funding or security must be provided. This information must disclose the establishment of escrow accounts, trusts, or reserve funds, together with the manner in which these funds will be invested, and the names and experience of any individuals in the direct employment of the provider who will make the investment decisions.⁶¹ Certified financial statements of the provider must be given.⁶²

Operators of facilities established after January 1, 1988, must provide a summary report of an actuary, updated every five years, that estimates the capacity of the provider to meet its contract obligations to residents. Facilities established prior to January 1, 1988 do not need to meet this obligation until January 1, 1993.⁶³

If operation of the facility has not commenced, there must be a statement of the anticipated source and application of the funds used or to be used in the purchase or construction of the facility.⁶⁴ Pro forma annual income statements for the facility must be provided.⁶⁵ The estimated number of residents of the facility must be stated.⁶⁶

As is generally true in all the states, a copy of the standard form of contract for continuing care used by the provider must be attached to

55. *Id.* at § 131E-217(a)(3)(c).

56. *Id.* at § 131E-217(a)(4).

57. *Id.* at § 131E-217(a)(5).

58. *Id.* at § 131E-217(a)(b).

59. *Id.* at § 131E-217(a)(7).

60. *Id.* at § 131E-217(a)(8).

61. *Id.* at § 131E-217(a)(9).

62. *Id.* at § 131E-217(a)(10).

63. *Id.* at § 131E-217(a)(11).

64. *Id.* at § 131E-217(a)(12).

65. *Id.* at § 131E-217(a)(13).

66. *Id.* at § 131E-217(a)(14).

each disclosure statement.⁶⁷ Terms which must be included in the contract are specified. The contract may contain additional terms. The required terms include a right to rescind within thirty days of the execution of the contract or receipt of the disclosure statement, whichever is later,⁶⁸ automatic cancellation if the resident dies prior to occupying a living unit in the facility or is precluded on account of illness, injury or incapacity from occupying a living unit in the facility.⁶⁹ "Living unit" is defined by the statute as "a room, apartment, cottage, or other area within a facility set aside for the exclusive use or control of one or more identified residents."⁷⁰ The contract must spell out the total consideration,⁷¹ services to be provided,⁷² procedures to be followed if a change of accommodation becomes necessary for the health or safety of the resident or the general and economic welfare of the residents,⁷³ policies to be implemented if the resident cannot pay the periodic fees,⁷⁴ refund terms,⁷⁵ the policy regarding increasing the periodic fees,⁷⁶ description of the living quarters,⁷⁷ any religious or charitable affiliations of the provider and the extent, if any, to which the affiliate organization will be responsible for the financial and contractual obligations of the provider,⁷⁸ any property rights of the resident,⁷⁹ the policy, if any, regarding fee adjustments if the resident is voluntarily absent from the facility,⁸⁰ and any requirement that the resident apply for Medicaid, public assistance or any public benefit program.⁸¹

The North Carolina law also requires the filing of what is called an "annual disclosure statement revision." This statement is to be filed within 150 days following the end of the provider's fiscal year and is to make current the information demanded in G.S. 131E-217. The revised disclosure statement must be made available to all residents of the facility.⁸²

The fourth substantive requirement of the North Carolina statute seeks to protect the investment of the resident prior to his moving into

67. *Id.* at § 131E-217(c).

68. *Id.* at § 131E-218(a)(1).

69. *Id.* at § 131E-218(a)(2).

70. *Id.* at § 131E-215(5).

71. *Id.* at § 131E-218(b)(1).

72. *Id.* at § 131E-218(b)(2).

73. *Id.* at § 131E-218(b)(3).

74. *Id.* at § 131E-218(b)(4).

75. *Id.* at § 131E-218(b)(5).

76. *Id.* at § 131E-218(b)(6).

77. *Id.* at § 131E-218(b)(7).

78. *Id.* at § 131E-218(b)(8).

79. *Id.* at § 131E-218(b)(9).

80. *Id.* at § 131E-218(b)(10).

81. *Id.* at § 131E-218(b)(11).

82. *Id.* at § 131E-219.

the facility. The provider must place the resident's purchase payment in an escrow account with the sum to be released to the provider when the living unit becomes available to the resident.⁸³ If the facility is new, the entrance fee is not released to the provider until the aggregate entrance fees received or receivable, plus the anticipated proceeds of any long-term financing commitment are equal to not less than ninety percent of the cost of constructing or purchasing, equipping and furnishing the facility plus not less than ninety percent of the funds estimated in the statement of anticipated source and application of funds submitted by the provider as part of the required disclosure statement.⁸⁴

It is thus apparent that the philosophy underlying the North Carolina statute is basically that of protecting the prospective purchaser by enabling him to make an informed opinion of the financial and managerial capacity of the provider, prior to making his investment. The protection offered to the resident past the thirty-day grace period of the contract to withdraw is minimal, essentially limited to the right to receive the annual disclosure statement revision.

The property interest of the resident in the real estate of the quarters for which he has paid is unique. It is infinitely less than that of an owner of a condominium or a cooperative, with which it is sometimes mistakenly compared. The typical resident of a continuing care community purchases a bare estate for life. He cannot devise it, sell it, hypothecate it or rent it. By the usual adhesion contract offered him, he has no role in management. It may thus be seen that the resident has no options and none of the attributes of real or personal property ownership, except the right of occupancy.⁸⁵ If management is failing, he cannot replace it; he has no way of limiting or reducing his losses. Moreover, the provider, with whom the resident contracts, may not even be the owner of the real estate, which may be owned by a separate non-profit or profit entity with which the provider has a contractual relationship.

It is the recognition of the extremely vulnerable position of these aged, often infirm, residents that has prompted the majority of states legislating on this subject to afford protective measures beyond those of the North Carolina statute. The disclosure-only states proceed on the presumption that the relationship between provider and resident, being contractual, it is for the resident not only to assess in the first instance prior to entering upon the contract the fiscal and managerial capabilities of the provider but then to take his chances that his future is secure to the date of his death, however long that may be.

83. *Id.* at § 131E-220(a)(1).

84. *Id.* at § 131E-220(a)(2).

85. It was noted earlier that some providers, for a much higher initial purchase price, may offer a resident a partial or total refund of the entrance fee, if he chooses to leave the facility. Many providers offer no such option.

An obvious point of beginning for a state that would extend protection to this growing group of citizens beyond the limited range of the North Carolina statute is to require a license or permit to engage in the business of a continuing care provider. While North Carolina's disclosure-only statute places the entire burden on the prospective purchaser of evaluating the financial and managerial capacities of the provider, the licensing states share this burden. Although many of the licensing states are careful to include a disclaimer in their license that its issuance does not constitute approval, recommendation or endorsement of the provider,⁸⁶ nevertheless the agency customarily makes a close initial analysis of the financial and other capabilities of the provider⁸⁷ and may deny the application for a license.⁸⁸ In Colorado the commissioner of insurance makes a determination of the financial soundness of the provider.⁸⁹

Any discussion with residents of a continuing care community will reveal that their concerns fall in only three categories. The first, and overriding one, is the continued financial stability of the provider. Second, and closely related to the first, is that services be maintained at the promised level. The third is that management be responsive to their various concerns. Licensing states have addressed all of these issues. Indeed, an examination of their statutes reveals that in addition to the issues addressed in the North Carolina disclosure statute, the three mentioned subjects are the only substantive ones found in the licensing statutes, which may, of course, deal with them in various ways.

It was noted earlier that the North Carolina statute requires that the resident's purchase payment be placed in escrow until a living-unit becomes available to him. And the North Carolina statute seeks to ensure, at the beginning of the facility's operations, that it be financially sound. All but three of the states⁹⁰ require some evidence of the financial soundness of the enterprise prior to opening. A smaller number, eleven,⁹¹ require, in the case of an on-going facility, that the resident's entrance fee be placed in escrow until he takes up residence.

A number of statutes also seek to ensure financial stability after the opening of the facility. A common provision applicable when the provider owns the real estate is a requirement that an amount be kept in

86. *E.g.*, Tex. Rev. Stat. Ann. art. 726, § 16 (Vernon 1987).

87. *E.g.*, Fla. Stat. Ann. § 651.023 (West 1984 & Supp. 1988).

88. *E.g.*, Colo. Rev. Stat. § 12-13-103 (1985).

89. *Id.*

90. The states Kansas, New Mexico, and Oregon do not require any evidence of financial soundness prior to opening.

91. Ariz. Rev. Stat. Ann. § 20-1804 (Supp. 1987); Colo. Rev. Stat. § 12-13-104 (1985); Conn. Gen. Stat. Ann. § 17-539 (West 1988); Ind. Code Ann. § 23-2-4-10 (Burns Supp. 1987); La. Rev. Stat. § 51:2177 (West Supp. 1988); Mo. Stat. § 376.940 (Vernon Supp. & 1988); N.J. Stat. Ann. § 52:27D-342 (West Supp. 1987); N.H. Rev. Stat. Ann. § 420-D:10 (Supp. 1988); N.M. Stat. § 24-17-6 (1986); N.C. Gen. Stat. § 131E-220 (1988); Pa. Stat. Ann. tit. 40, § 3212 (Purdon Supp. 1988).

escrow which equals the aggregate principal and interest payments due during the next twelve months on account of any first mortgage or other long-term financing arrangement.⁹² Connecticut includes rental or lease payments for one year to the enumeration of principal and interest payments.⁹³ California has a twelve-month requirement similar to that of Connecticut.⁹⁴ Florida has a twelve-month reserve provision for mortgage and leasehold payments.⁹⁵

Many of the states require an operating reserve for expenses other than those connected with mortgage or rental payments. There is great variance among the states as to these provisions. The Connecticut requirement is the most modest. It mandates maintenance of an escrow sum equal to the cost of operations of the facility for a one-month period.⁹⁶ The New Hampshire requirement is two months.⁹⁷

California has a provision that may be compared to that of Arizona, noted *supra*.⁹⁸ For this security requirement the base measurement of coverage is the obligation assumed under all continuing care agreements and the reserve must be in an amount not less than the sum computed in accordance with the standard of valuation based upon a modern mortality table selected by the Department of Insurance.⁹⁹ The Colorado reserve requirement specifies that the reserves shall be equivalent to sixty-five percent of the amount of any advance deposit, entrance fee, or other lump-sum initial payment made by each resident of the facility. The deposit shall then be amortized for the purposes of these reserves over the first five-year period of each such resident's residency, on a straight-line basis, but at no time during the period of an agreement shall the reserves be less than thirty percent of the original reserve requirement.¹⁰⁰

There are other devices that some of the states have used to seek to protect the investment of the residents. Until 1982 California gave the State Department of Social Services power to require a bond of any applicant for a certificate of authority to operate a continuing care facility. The bond was for the use and benefit of all persons who may have been injured or aggrieved by the failure of the provider to perform its obligations. The provision permitted any injured or aggrieved person to bring

92. *E.g.*, Ariz. Rev. Stat. Ann. § 20-1806 (Supp. 1987); N.H. Rev. Stat. Ann. § 420-D:8 (Supp. 1988); N.J. Stat. Ann. § 52:27D-339 (West & Supp. 1988); Pa. Stat. Ann. tit. 40 § 3204 (Purdon Supp. 1987); Tex. Rev. Stat. Ann. art. 726 § 9 (Vernon 1987); Vt. Stat. Ann. tit. 8, § 8009 (Supp. 1988); Ill. Ann. Stat. ch. 111-1/2 ¶ 4160-7 (Smith-Hurd Supp. 1988), substitutes six months for twelve.

93. Conn. Gen. Stat. Ann. § 17-540(a) (West Supp. 1988).

94. Cal. Health & Safety Code § 1774-4 (West Supp. 1988).

95. Fla. Stat. Ann. § 651.035(1) (West 1984 & Supp. 1988).

96. Conn. Gen. Stat. Ann. § 17-540(a) (West Supp. 1988).

97. N.H. Rev. Stat. Ann. § 420-D:8 (Supp. 1988).

98. See *infra*, note 91.

99. Cal. Health & Safety Code § 1775 (West Supp. 1988).

100. Colo. Rev. Stat. § 12-13-107(1) (1985).

suit on the bond in his own name and without an assignment.¹⁰¹

Indiana has a unique approach to the security question. It has established a retirement home guaranty fund. Each contracting party to a continuing care agreement is assessed a fee of one hundred dollars, which is collected by the provider and forwarded to the securities commissioner, who sends the money on to the state treasurer. Here the fund, with any income from it, is held in trust. In the event of the bankruptcy or termination of a home, a distribution is made from the fund, up to one-half its aggregate amount, to the living residents affected by the bankruptcy or termination. The amount is prorated to each resident in a sum calculated to compensate his loss. A board of directors, established to administer the fund, is composed of one provider, two residents, one person with expertise in insurance and one with expertise in banking and finance. The board is appointed by the governor. The securities commissioner is an ex-officio member of the board.¹⁰²

To attempt to ensure that a provider remains fiscally sound, some states take steps in addition to mandating reserves. In many states, the licensing authority has the power to make periodic examinations and audits of the provider.¹⁰³ Florida even gives to any interested party the right to request an inspection of the records and related financial affairs of a provider.¹⁰⁴ The licensing agency may promulgate rules and regulations to effectuate its purposes.¹⁰⁵ Maine requires a provider to conform its investment strategy to the standards adopted by the superintendent of insurance.¹⁰⁶

An additional protection for residents afforded by nine states is to give them a lien on the provider's property. Arizona's statute states that the director of the department of insurance shall, as a condition to granting a permit to an applicant record with the county recorder of any county a notice of lien against the facility's land and improvements on behalf of all residents who enter into life care contracts with the applicant to secure performance of the provider's obligations to residents pursuant to life care contracts. From the time of such recording there exists a lien for an amount equal to the reasonable value of services to be performed under a life care contract in favor of each resident on the land and improvements

101. Cal. Health & Safety Code § 1773 (West 1979), repealed by c. 840 p. 3168 § 2 (West Supp. 1988).

102. Ind. Code Ann. § 23-2-4-13 to 23-2-4-18 (Burns 1984).

103. See e.g., Ariz. Rev. Stat. Ann. § 20-1809 (Supp. 1987); Cal. Health & Safety Code § 1782 (West 1979); Colo. Rev. Stat. § 12-13-110 (1985); Fla. Stat. Ann. § 651.105 (West 1984); Me. Rev. Stat. Ann. tit. 24-A, § 6222 (Supp. 1988); Pa. Stat. Ann. tit. 40, § 3218 (Purdon Supp. 1987); Tex. Rev. Stat. Ann. art. 726 § 16 (Vernon 1987).

104. Fla. Stat. Ann. § 651.111 (West 1984).

105. See e.g., Ariz. Rev. Stat. Ann. § 20-1810 (Supp. 1987); Cal. Health & Safety Code § 1781 (West 1979).

106. Me. Rev. Stat. Ann. tit. 24-A, § 6219 (Supp. 1987).

of the facility's properties owned by the provider. The liens provided for are preferred to all encumbrances attaching subsequently to the time the lien is recorded and are preferred to all unrecorded encumbrances. The lien may be foreclosed by civil action.¹⁰⁷ Quite similar language is found in the statute of Colorado.¹⁰⁸ In Pennsylvania filing of the lien is not a condition of granting the license. Rather, the commissioner of insurance may at any time he determines it to be in the best interests of residents, file a lien on both the real and personal property of the provider to secure the obligations of the provider pursuant to existing and future contracts of continuing care.¹⁰⁹ The New Hampshire provision is similar, without the reference to existing and future contracts.¹¹⁰ The Pennsylvania lien may, however, be foreclosed only upon the liquidation, insolvency or bankruptcy of the provider. It is subordinate to a first mortgage on the real property.¹¹¹ New Jersey has a similar provision.¹¹² In Florida,¹¹³ Texas,¹¹⁴ and Minnesota¹¹⁵ the lien attaches as a matter of law without recordation. In all three the lien attaches to both real and personal property of the provider and in all three enforcement of the lien only arises upon the liquidation, insolvency or bankruptcy of the provider. In both Florida and Texas the lien is subordinate to first mortgages on the real property. The Minnesota statute does not describe the lien as subordinate. The language of the California statute differs from that of any of the other states. It says that when necessary to secure the performance of all obligations of the certificate holder to one who has transferred or promised to transfer money or property to the provider pursuant to a life contract, the State Department of Social Services may record with the recorder of any county a notice of lien on behalf of the transferors. From the time of recording, there exists a lien on all real property of the provider, not otherwise exempt, and located within the county of recording. The filing of a bond can effectuate release of the lien.¹¹⁶ Vermont's provision is like that of New Jersey.¹¹⁷

In 1987 Florida amended its law to provide that all funds deposited in an escrow account shall generally not be subject to any liens or charges by the escrow agent or judgments, garnishments, or creditors' claims

107. Ariz. Rev. Stat. Ann. § 20-1805 (Supp. 1987).

108. Colo. Rev. Stat. § 12-13-106 (1987).

109. 40 Pa. Cons. Stat. Ann. § 3211 (Purdon Supp. 1988).

110. N.H. Rev. Stat. Ann. § 420-D:9 (Supp. 1988).

111. 40 Pa. Cons. Stat. Ann. § 3211 (Purdon Supp. 1988).

112. N.J. Stat. Ann. § 52:27D-341 (West Supp. 1987).

113. Fla. Stat. Ann. § 651.071 (West Supp. 1987).

114. Tex. Rev. Stat. Ann. art. 726, § 10 (Vernon 1987).

115. Minn. Stat. Ann. § 80D.08 (West 1986).

116. Cal. Health & Safety Code § 1772 (West Supp. 1988). 1988 Supp. with amendment deleted this sentence from the statute. Lien can be released by proof of complete performance of all obligations of transferors or if state department deems the lien no longer necessary to secure performance.

117. Vt. Stat. Ann. tit. 8, § 8004 (Supp. 1988).

against the provider or facility.¹¹⁸

The ultimate fear of residents is the insolvency of the provider. There have, in fact, been a number of examples around the country to justify these fears.¹¹⁹ The laws of a number of the states provide for state intervention before insolvency has occurred, when the provider appears to be in financial difficulty. In Arizona the director of insurance can apply, through the attorney general, to the superior court for an order directing him to assume management and possession of the provider's facility in an attempt at financial rehabilitation.¹²⁰ In Colorado the commissioner of insurance has the same remedial powers as in the instances of insurance company delinquencies.¹²¹ In these and other states, action by the state agency may be triggered by the report of an escrow agent, auditor or any other source of information satisfactory to the state authority. In Minnesota any resident or association of residents may apply to a state district court or to federal bankruptcy court, if it has taken jurisdiction over the provider, for an order directing the appointment of a trustee to attempt to rehabilitate the provider.¹²² A resident may also petition for the appointment of a receiver in Wisconsin.¹²³ Provisions for the state to assume authority to attempt to rehabilitate a failing provider can also be found in California,¹²⁴ Connecticut,¹²⁵ Indiana,¹²⁶ New Hampshire,¹²⁷ New Jersey,¹²⁸ Pennsylvania¹²⁹ and Texas,¹³⁰ and Vermont.¹³¹

Of course, rehabilitation may not be successful. All of the above-named states, except Indiana and New Jersey, provide for liquidation of the provider with the statutory provision usually appearing in the same section setting out the conditions for the attempt at rehabilitation. Some of these states have particular provisions seeking to protect the residents. California states that obligations pursuant to life care agreements executed by a provider shall be deemed a preferred claim against all assets owned by the provider in the event of liquidation.¹³² Florida states that these are preferred claims but are subordinate to certain statutorily de-

118. Fla. Stat. Ann. § 651.033(d) (West Supp. 1987).

119. See, e.g., Fisher, *Continuing Care Retirement Communities: A Promise Falling Short*, 8 Geo. Mason L. Rev. 47 (1985).

120. Ariz. Rev. Stat. Ann. § 20-1808(C) (Supp. 1987).

121. Colo. Rev. Stat. § 12-13-109 (1985).

122. Minn. Stat. Ann. § 80D.11(1) (1985).

123. Wis. Stat. Ann. § 647.06 (West Supp. 1987).

124. Cal. Health & Safety Code § 1785 (West 1979).

125. Conn. Gen. Stat. Ann. § 17-547 (West Supp. 1988).

126. Ind. Stat. Ann. § 23-2-4-21 (Burns 1984).

127. N.H. Rev. Stat. Ann. § 420-D:16 (Supp. 1988).

128. N.J. Stat. Ann. § 52:27D-346 (West Supp. 1987).

129. 40 Pa. Cons. Stat. Ann. § 3216 (Purdon Supp. 1988).

130. Tex. Rev. Stat. Ann. art. 726 § 12 (Vernon 1987).

131. Vt. Stat. Ann. tit. 8, § 8004 (Supp. 1988).

132. Cal. Health and Safety Code, § 1777 (West 1979).

financed priority and secured claims.¹³³ The New Hampshire provision is similar.¹³⁴ Pennsylvania states that the commissioner of insurance shall give due consideration to the welfare of the residents and to this end the proceeds of any lien obtained by the commissioner pursuant to the act may be used in full or partial payment of entrance fees, used on behalf of residents of a facility being liquidated or paid to other facilities operated by providers.¹³⁵ The Texas statute provides that upon liquidation, the court shall consider the manner in which the welfare of persons who have previously contracted with the provider for continuing care at the facility may be best served. In furtherance of this objective, the proceeds of any lien imposed by the act may be used in full or partial payment of entrance fees to other facilities.¹³⁶ The New Hampshire statute tracks the Texas language.¹³⁷

It is, of course, possible that a provider might elect to sell its interest in the facility, an act which could be to the decided disadvantage of residents. The issues of their relationship to, and the obligations of, the new provider can be exceedingly problematic. Eight of the states have addressed this possibility. The Virginia statute states that no provider and no person or entity owning a provider shall sell or transfer, directly or indirectly, more than fifty percent of the ownership of the provider or of a continuing care facility without giving the Insurance Commission written notice of the sale or transfer at least thirty days prior to the consummation of the sale or transfer.¹³⁸ California states that a holder of a certificate of authority who wishes to sell or transfer ownership of a facility that has life care residents to another party, shall first obtain approval from the State Department of Social Services.¹³⁹ The Pennsylvania provision is comparable.¹⁴⁰ The Maine provision states that any provider desiring to sell or transfer ownership of a continuing care facility shall notify the Superintendent of Insurance and the acquiring interest shall obtain the Superintendent's advance approval of the sale or transfer.¹⁴¹ The New Hampshire¹⁴² and Vermont¹⁴³ provisions are similar. The certificate of authority is nontransferable. In Maine the new owner must apply for a new certificate of authority to continue to provide continuing

133. Fla. Stat. Ann. § 651.071 (West Supp. 1988). *But see* text at note 113.

134. N.H. Rev. Stat. Ann. § 420-D:16 (Supp. 1988).

135. 40 Pa. Cons. Stat. Ann. § 3216 (Purdon Supp. 1988).

136. Tex. Rev. Stat. Ann. art. 726 § 12 (Vernon 1987).

137. N.H. Rev. Stat. Ann. § 420-D:16 (Supp. 1988).

138. Va. Code Ann. § 38.2-4906 (1986).

139. Cal. Health & Safety Code § 1787 (West 1979).

140. 40 Pa. Cons. Stat. Ann. § 3206 (Purdon Supp. 1988).

141. Me. Rev. Stat. Ann. tit. 24-A, § 6216 (Supp. 1987).

142. N.H. Rev. Stat. Ann. § 420-D:13 (Supp. 1988).

143. Vt. Stat. Ann. tit. 8, § 8003 (Supp. 1988).

care at the facility.¹⁴⁴ Colorado provides that no certificate of authority shall be transferable; and no provider shall sell or transfer ownership of the facility, or enter into a contract with a third-party service provider for management of the facility, unless the commissioner of insurance approves such transfer or contract.¹⁴⁵ The Rhode Island provision is similar to that of Virginia, except that notice is to the Department of Health. The statute also adds a proviso that the department must be notified of any change in the provider's chief executive officer or managing firm.¹⁴⁶

While concern about the continuing fiscal stability of the provider is by far the most important to the resident, there is also a natural concern that the facility provide the promised services and amenities. To this end, it is vital that the resident be heard by management. One not infrequently encounters an unexpected reticence, even fear, on the part of many residents to confront management. It is not the purpose of this paper to attempt a psychological analysis of these fears. Reason suggests that they are related to age, physical infirmity, ill health, a feeling of aloneness and vulnerability that afflicts many who have severed ties with friends, church, community, property and perhaps family to move to the facility. Some state statutes have taken cognizance of these facts. The need may seem odd in a nation governed by the First Amendment to the United States Constitution, but eight states have seen the value of providing to residents a specific right of self-organization. The Vermont¹⁴⁷ and Pennsylvania¹⁴⁸ statutes provide that residents shall have the right of self-organization. The Virginia statute adds that no retaliatory conduct shall be permitted against any resident for membership or participation in a residents' organization.¹⁴⁹ The Rhode Island provision is similar.¹⁵⁰ New Jersey adds to the Virginia language that there shall be no retaliation for the resident's lawful efforts to secure or enforce his rights under the continuing care agreement, the laws of the state or of the United States, or for the resident's good faith complaint to a governmental authority of the provider's alleged violation of any state regulation or law.¹⁵¹ Louisiana not only states the right of self-organization but adds that the resident has a right to be represented by an individual of his own choosing.¹⁵² The New Hampshire Statute is similar.¹⁵³

In recognition of the fact that management may not convey residents'

144. Me. Rev. Stat. Ann. tit 24-A, § 6216 (Supp. 1987).

145. Colo. Rev. Stat. § 12-13-103(4) (1985).

146. R.I. Gen. Laws § 23-59-7 (Supp. 1985).

147. Vt. Stat. Ann. tit. 8, § 8011 (Supp. 1988).

148. 40 Pa. Cons. Stat. Ann. § 3215(a) (Purdon Supp. 1988).

149. Va. Code Ann. § 38.1-965(A)(1985).

150. R.I. Gen. Laws § 23-59-11(A) (Supp. 1985).

151. N.J. Stat. Ann. § 52:270-345 (Supp. 1988).

152. La. Rev. Stat. Ann. § 51:2180 (West Supp. 1988).

153. N.H. Rev. Stat. Ann. § 420-D:15 (Supp. 1988).

concerns to the governing body, several states command the board of directors of the provider to hold quarterly meetings with the residents. Such a provision is found in Florida, which further commands a free discussion including, but not limited to, income, expenditures, financial trends and problems of the facility and policies, programs and services.¹⁵⁴ To give added meaning to these meetings, in Florida any interested party may request an inspection of the records and related financial affairs of the provider.¹⁵⁵ New Jersey provides for quarterly meetings with residents,¹⁵⁶ as does Pennsylvania,¹⁵⁷ Virginia,¹⁵⁸ and Rhode Island.¹⁵⁹ Louisiana requires that the board of directors meet annually with the residents.¹⁶⁰ Missouri requires that one member of the board of directors of the provider be a resident.¹⁶¹ Michigan requires that one member of the board be a resident and further requires that he be elected by the other residents. However, his role is advisory only.¹⁶² Michigan also requires that any dispute between a resident and the facility be submitted to binding arbitration.¹⁶³

Minnesota has, perhaps, the most detailed statement of residents' associational rights, although not all the rights listed in other statutes are included. The residents' right to form an association is stated. If so requested by the residents' association, the provider must present its annual budget to the association for comment before its adoption; and the provider must give the association monthly statements of current income and expense showing year-to-date relationship for a deviation from the budget. The association or its representatives may comment on, or raise questions about, the monthly statement to the provider.¹⁶⁴

Nearly all states mandate a right of rescission of the contract, often reciprocal, within a brief time after its making. The North Carolina thirty day period is typical.¹⁶⁵ Maine gives the resident one year to rescind.¹⁶⁶ Florida gives either party the right of cancellation anytime upon thirty days notice.¹⁶⁷ Minnesota gives the resident only the right to terminate at any time, without the payment of any fees for termination. The statute states that the terms and provisions for reimbursement must

154. Fla. Stat. Ann. § 651.085 (West 1984).

155. *Id.* at § 651.111.

156. N.J. Stat. Ann. § 52:27D-345 (Supp. 1988).

157. 40 Pa. Cons. Stat. Ann. § 3215(b) (Purdon Supp. 1988).

158. Va. Code Ann. § 38.1-965(B) (1985).

159. R.I. Gen. Laws § 23.59-11(B) (Supp. 1985).

160. La. Rev. Stat. Ann. § 51:2181 (West Supp. 1988).

161. Mo. Ann. Stat. § 376-950 (Vernon Supp. 1988).

162. Mich. Comp. Laws Ann. § 554-812 (West 1988).

163. *Id.* at § 554-811.

164. Minn. Stat. Ann. § 80D.20 (West 1986).

165. N.C. Gen. Stat. § 131E-218(a)(1) (Supp. 1987).

166. Me. Rev. Stat. Ann. tit. 24-A, § 6210 (Supp. 1987).

167. Fla. Stat. Ann. § 651.055(1)(g) (West 1984).

be stated in the residency agreement, but the statute does not mandate its terms.¹⁶⁸

Finally, six states, perhaps in recognition of the complexity, not to say gravity, of many of the issues surrounding continuing care communities have created boards or committees to advise the state concerning them. California has a Committee on Life Care Contracts of the State Social Services Advisory Board composed of eight members. These include three representatives of nonprofit providers, a business person with five years experience managing health care facilities, a certified public accountant, an actuary and a senior citizen.¹⁶⁹ Florida has a Continuing Care Advisory Council to the Department of Insurance. Its nine members are appointed by the governor. Three of them are administrators of continuing care facilities, one is a business person whose expertise is in management, one is a certified public accountant, one an attorney, one a member of the financial community and two are residents.¹⁷⁰ The Connecticut statute mandates an advisory committee and suggests, but does not require, particular qualifications in the advisors; nor does it prescribe the size of the committee.¹⁷¹ The Maryland statute, recognizing that at some point many of the residents may need a guardian, which by the entrance contract may be the provider, created a Guardianship Advisory Board. It is appointed by the Director on Aging. The size of the Board is not prescribed, but one member must be an attorney, one a physician and one who is neither an attorney nor physician.¹⁷² Louisiana created a Continuing Care Advisory Council, whose seven members include two experienced administrators of providers, one representative each of the business and financial communities, a certified public accountant, an attorney and a resident.¹⁷³ The New Hampshire Advisory Council of nine members, has two administrators of facilities, a representative from the business community and one from the financial community, a certified public accountant, a lawyer, and three public members, all appointed by the governor. There are also three ex-officio members: the insurance commissioner, the director of the division of elderly and adult services, and the ombudsman.¹⁷⁴

CONCLUSION

North Carolina's enactment of a disclosure type of continuing care statute is certainly a step towards protection of the rights of residents of

168. Minn. Stat. Ann. § 80D.07 (West 1986).

169. Cal. Health & Safety Code § 1791 (West 1979).

170. Fla. Stat. Ann. § 651.121 (West 1984).

171. Conn. Gen. Stat. Ann. § 17-550 (West 1988).

172. Md. Ann. Code art. 70B § 24 (1988).

173. La. Rev. Stat. Ann. § 51:2187 (West Supp. 1988).

174. N.H. Rev. Stat. Ann., § 420-D:19 (Supp. 1988).

continuing care communities. It provides considerable help in enabling a prospective resident to make an informed decision prior to entering into a contract with a provider. But by limiting the statute only to disclosure, North Carolina does not join the main stream of the majority of states with legislation in this field. North Carolina's statute places the total burden of attempting to protect his investment and his future on the prospective resident, aged, often infirm. North Carolina, unlike a majority of the states, gives almost no protection to the resident. It does not surround what is, in effect, a contract of insurance with the protections long recognized as essential in this field. It offers no aid to residents who are, by definition, with each passing day, less able to cope with the vagaries and vicissitudes of life.

