LEGISLATIVE RESEARCH COMMISSION

LIFE CARE ARRANGEMENTS

REPORT TO THE 1987 GENERAL ASSEMBLY OF NORTH CAROLINA

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TABLE OF CONTENTS

STATE OF NORTH CAROLINA

LEGISLATIVE RESEARCH COMMISSION

STATE LEGISLATIVE BUILDING

RALEIGH 27611

December 15, 1986

TO THE MEMBERS OF THE 1987 GENERAL ASSEMBLY:

The Legislative Research Commission herewith reports to the 1987 General Assembly on the matter of life care arrangements. The report is made pursuant to Chapter 790 of the 1985 Session Laws.

This report was prepared by the Legislative Research Commission's Committee on Life Care Arrangements and is transmitted by the Legislative Research Commission for your consideration.

Respectfully submitted,

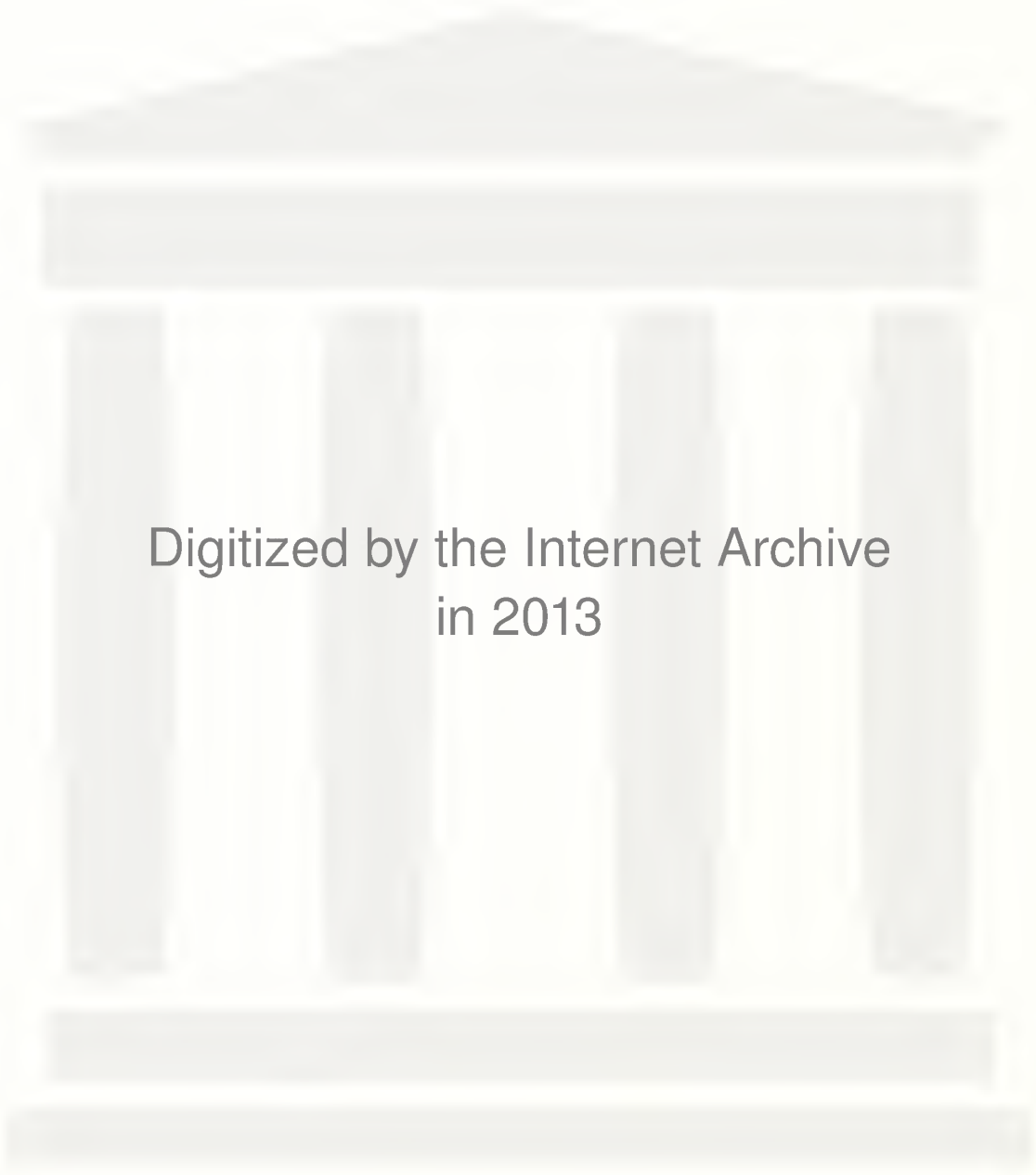
Liston B. Ramsey

J. J. (Monk) Harrington

Co-Chairmen

Legislative Research Commission

INTRODUCTION



The Legislative Research Commission, created by Article 6B of the General Assembly Statutes Chapter 120, is authorized pursuant to the direction of the General Assembly "to make or cause to be made such studies of and investigations into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" and "to report to the General Assembly the results of the studies made," which reports "may be accompanied by the recommendations of the Commission and bills suggested to effectuate the recmmendations." G.S. 120-30.17. The Commission is chaired by the Speaker of the House and the President Pro Tempore of the Senate, and consists of five representatives and five senators, who are appointed respectively by the Cochairmen. G.S. 120-30.10(a). (See Appendix A for a list of the Commission members.)

Pursuant to G.S. 120-30.10(b) and (c), the Commission Cochairmen appointed study committees consisting of legislators and public members to conduct the studies. Each member of the Legislative Research Commission was delegated the responsibility of overseeing one group of studies and causing the findings and recommendations of the various committees to be reported to the Commission. In addition, one senator and one representative from each study committee were designated Cochair.

By Senate Bill 636 (1985 Session Laws, Chapter 790), the Legislative Research Commission was authorized to study life care arrangements. In order to accomplish these tasks, Senator Ollie Harris as a member of the Legislative Research Comission was appointed to coordinate the Study of Life Care Arrangements. Senator James D. Speed and Representative Charles D. Woodard were appointed to cochair the Committee. The other members appointed were Senators Wanda Hunt and Franklin A. Williams, Sr; and Representatives J. Fred Bowman, Ann Duncan, Herman C. Gist, and Richard Wright; and public members Ms. Gail Hardy-Russ and Ms. Anne H. Williams. The Legislative Services Office provided staff assistance to the Committee for this study.

The minutes of the Committee meetings reflect the statements and discussions of each meeting. All of this information is included in the Committee files.

BACKGROUND

A fact of present and future life in the United States is that the elderly represent the fastest growing segment of the population - a segment that is about to explode. This is creating an unprecedented "age bulge" in the population. Consider the numbers: at the turn of the century, one person in 25 was 65 or older; today the ratio is one in nine; by the year 2030, one person in five will be at least 65.

In North Carolina the numbers are equally dramatic. In the September issue of North Carolina Insight devoted to aging issues, it is stated that in 1970, 8.1 percent of the 5.1 million North Carolinians -412,000 - were 65 or over. By 1980, the portion had grown to 10.2 percent(603,000). Projections for the future indicate a continued increase - to 12.2 percent in 1990 and 15 percent in the year 2000.

The North Carolina Insight also says that in 1980 North Carolina ranked only 36th among the 50 states in the percentage of its population 65 or over. But the rate of growth in the number of elderly persons in the state was high. From 1970 to 1980 the number of persons 65 or over in the State increased by 45.7 percent, ranking North Carolina eighth nationwide. Some analysts believe this increase is due largely to an in-migration of retired persons.

This aging of the population has understandably been the focus of attention and concern and has accounted for a major portion of the governments health care and income security dollars

in recent years. At the same time, health service delivery planners and advocates for the elderly have been instrumental in drawing attention to the need for well-conceived living and health care arrangements for this growing number of older Americans.

Most older persons want to live independently for as long as possible; but until recently, few options were available to those older persons who could not, or did not wish to, maintain their own homes. America's current system of housing and long-term care is being deeply affected by the speed with which societal changes are occurring. The elderly are demanding high quality services. They are better educated, longer living, more active and better off financially than any elderly group before them. They are giving the providers of housing and health care new challenges to guarantee not only shelter and services but also creative avenues for their interests and new definition of quality of life.

State policymakers are now recognizing that adequate long-term care means more than nursing home care; it involves a coordinated system of health care, social services and housing. One approach gaining in popularity is the continuing care retirement community (CCRC), sometimes referred to as the life care community. This alternative to the nursing home and other forms of long-term care is increasingly attractive to many elderly because it guarantees them lifetime care as well as housing and other services. Proponents of the concept also envision CCRC's as

affordable for a large proportion of the aging population despite the widespread view that it is a viable option only for the well-to-do. A new comprehensive study of CCRCs, prepared for the Wharton School of the University of Pennsylvania, concludes that the majority of elderly citizens have the financial means to pay for life care.

The very nature of the continuing care arrangement, however, brings with it serious financial risk, not only for the community and its developers, but especially for the residents. For this reason State regulation may be needed to insure careful financial planning of the CCRCs and to protect the financial security of their elderly residents. The concept of continuing care was developed to meet the elderly's need for an independent way of life and to give them the security of guaranteed, affordable health care and other services. Continuing care is generally regarded as a social and health insurance plan for the aging.

Life care facilities or continuing care retirement communities vary widely in their financing arrangements on the type of housing available and in the range of services provided. Consequently, a variety of definitions exists. Similar to other kinds of nursing homes and congregate housing for the elderly, they provide independent living units, such as apartments or cottages, and they offer various social, recreational, maintenance, and health care services, usually on the premises.

In exchange for these services, residents pay a substantial fee.

But the distinguishing feature of the CCRC is the continuing care or life care contract. Under terms of the contract, which lasts for more than one year or for life, the community promises to provide housing, health care and various services, and the resident agrees to pay, in advance, certain fees to help cover the cost of these services. Although the fees cover the cost of housing, these payments do not give the resident any ownership rights.

The earlier life care communities rquired residents to turn over all of their assets in return for lifetime shelter and services. Today most communities require payment of an entrance fee and a monthly service charge. According to the Wharton School study, the average entrance fee in 1981 was $35,000, with 80% in the range of $13,000 and $65,000; the monthly fee averaged $550, with most communities charging between $300 and $900. CCRCs usually vary their monthly fees on the basis of the type of housing selected and the number of occupants in each unit.

As with any type of insurance plan, the advanced funding for future services provides the financial foundation of CCRCs. The community pools the revenues it collects from residents, including entrance fees, monthly fees and private insurance payments. Although residents selecting similar units will pay similar fees, the cost of providing services to them will vary since some will live longer than others and some will require more

nursing care. In principle, the excess costs incurred by these residents will be covered by the reserved pool of funds received from others who need fewer services.

Life care communities are generally selective in admitting elderly individuals. Residents usually have to be a certain minimum age, have a minimum level of assets, have no preexisting serious health problems, and be covered by Medicare and private insurance plans. The result of this selective admissions policy is that CCRC residents tend to be healthier and wealthier than the elderly in the general population.

Although a number of communities were established before the 1960s, most of them have been constructed in the last 20 years. Today there are about 300 CCRCs in the United States according to the Wharton School. Other groups using less rigid definitions, have estimated as many as 600. Estimates of the number of persons housed in CCRCs range from 55,000 to 100,000. The North Carolina Association of Non-Profit Homes for the Aged lists 21 in North Carolina.

The first communities were organized and sponsored by religious and charitable organizations. Today the majority are owned by nonprofit corporations, still, mostly church-related groups. Only about 5 to 10% of CCRCs are owned by for profit institutions. But as many as a third of the communities sponsored by not-for-profit groups are being managed by outside proprietary companies the Federal Commission reports.

In recent years high interest rates have slowed the development of CCRCs. Not only has it been difficult for developers to raise the necessary capital for construction, but potential occupants have had trouble selling their houses to obtain money for the entrance fees. But with declining interest rates and increased real estate sales, the number of new communities is expected to grow rapidly in the decade ahead. The Philadelphia accounting firm, Laventhol & Horwarth, predicts that an additional 1,000 to 1,500 communities will be in operaion by 1990.

Even with the predicted growth of the life care industry, only about 2% of the elderly people are expected to reside in CCRCs by 1990. But proponents of life care see the communities as an attractive option for an even larger share of the growing elderly population. They offer certain advantages that other long-term care arrangements cannot provide. Life care represents an alternative to institutionalization for older people who can no longer maintain their own homes for both health and financial reasons, but who do not want or need the extensive care provided in a nursing home. Unlike nursing homes and other retirement communities, CCRCs give their aging residents the assurance they can live independently as long as possible and they can receive nursing care and support services as long as needed.

Another benefit of CCRCs is that the quality of care may be better than in other types of long-term care facilities.

Studies have shown that the residents of life care communities live 20% longer than the elderly population at large. They also tend to use health care resources less than the residents of comparable facilities. These favorable health status factors may be attributed to the availability of prepaid health care and other community services; they may also be influenced by the self-selection process, which reflects the better health and higher income of those choosing CCRCs.

The major advantage of CCRC's, however, is that it is affordable to many elderly Americans, contrary to the widespread notion that only the wealthy can afford the fees. The range of fees charged by CCRCs is "within the financial grasp of the majority of individuals over age 70," the authors of the Wharton School study concluded. This may be especially true for the older communities that have paid off most of their debts and can therefore charge lower fees.

Since most elderly own their own homes, they can usually raise enough cash from selling their houses to pay the entrance fees. Social Security and private benefits are generally sufficient to cover the fixed monthly service charges. In approximately 54% of the communities the monthly payment remains the same when the resident is transferred to the nursing facility. The monthly rate at a comparable nursing home outside the community could be considerably higher.

Another reason for the expected increase in the number of

CCRCs is that the expanding elderly population, with its financial assets, offers new business opportunities for the proprietary institutions. Although most CCRCs are owned and operated by nonprofit groups, an increasing number are under the management of for-profit corporations. In addition, more and more proprietary firms are becoming interested in developing life care communities because of the opportunities for profits and income tax savings.

As pointed out by Laventhol & Horwath in its 1982 report on the continuing care industry, land sales, developers' charges, construction contracts, marketing fees and management contracts can all produce profits, and depreciation of real estate investments can result in tax benefits. Among those for-profit concerns looking into the opportunities to be found in the life care business are architects, construction firms and real estate developers, as well as proprietary nursing homes and hospitals, the accounting firm said.

While the CCRC's promise financial and social security for many elderly Americans, they also pose significant financial risks. Some experts estimate that at least 10 to 20% of existing CCRCs have experienced financial difficulty or are in danger of developing serious fiscal problems in the future.

The danger lies in the considerable potential for mismanagement and fraud inherent in the unique contractual relationship between the life care community and its residents. If a community runs into financial difficulty, because of poor

financial planning or fraud, it may not be able to fulfill its commitment to the residents. The residents, having already fulfilled their part of the bargain by committing much, if not all, of their assets to the commmunity, may be left with nothing; no shelter, no health care and no money.

The potential for financial management problems exists because of the complicated financing required to develop, construct and operate a life care community. Without careful planning and application of sound actuarial principles, a community may be doomed to failure.

Crucial to CCRCs financial solvency is its ability to calculate accurately the residents' fees, which are used to cover current and future capital and operating costs. CCRC managers must protect the costs of future health care services for the residents and then establish a pricing policy to fund that obligation, Howard Winklevoss, principal author of the Wharton School study, pointed out. They must also anticipate the costs of renovating and replacing the physical plant. Possibilities for making innocent errors during the price setting process abound.

Mistakes are often made in projecting the resident population in the years ahead, estimating the number of deaths and the number of transfers to the nursing facility. When a resident moves to the nursing facility, the vacated apartment becomes available to a new resident, who will pay a new entrance fee. When a resident dies, the community now has limited access to any

remaining entrance fee. This reliance on turnover is a concern to some critics of the life care concept who see it as a disincentive to care for residents. But turnover of residents is essential to financial success and is the basis of establishing fees. Failure to use morbidity and mortality tables that adjust for the healthier CCRC population can result in an overestimation of the turnover rate and the setting of lower fees and consequently, lower revenues than expected.

Another problem is failure to maintain adequate reserves. Reserve funds are needed to protect against lower turnover in the beginning and unpredictably low turnover rate in the future, as well as unforeseen capital and operating costs, high inflation rates, and the inability of residents to meet payments. Some communities may be tempted to overspend in the early years when their operating costs are low and their revenues high from the accumulation of entrance fees, attorney David Cohen, a collaborating author of the Wharton School study pointed out. Later, when the health of the residents declines, costs will increase as additional nursing care is required. The community then may not have sufficient funds in store to cover these subsequent costs because of excessive spending earlier.

A third common error is a reluctance to raise the monthly fees to make up for earlier miscalculations in the rate structure, Cohen wrote in a 1980 University of Pennsylvania Law Review article. Sometimes a community that initially charged high entry

and low monthly fees may find it necessary to raise the charge in order to increase revenues. Residents on fixed incomes, however, may not be able to afford the higher fees. In the past some CCRCs have prohibited or limited increases in a residents monthly payments. But if a financially distressed community "either cannot or will not raise its monthly fees quickly enough to make ends meet, the result is financial disaster", Cohen concluded.

The potential for fraud in the life care industry exists merely because of the community's receipt of large entrance fee payments - perhaps totaling millions of dollars in the early years of operation, before expenses mount up. During this period, a fraudulent operator could divert this money to his own use rather than setting it aside to pay for the future costs of caring for the community's residents. When the time comes to provide skilled nursing care to the residents, there may not be enough money to pay for it.

The best known example of mismanagement is the 1977 case of Pacific Homes, a chain of life care facilities sponsored by the Methodist Church. Pacific Homes declared bankruptcy after incurring a deficit of $27 million. This financial dilemma was the result of the diversion of substantial cash prepayments from community residents for "expansion, speculative investments and payment of current operating losses," said the report of the bankruptcy trustees. In order to pay for the care of the residents whose funds had already been spent, the corporation had

to sell more life care contracts. "The scheme continued so long as enough new people could be induced to enter into the contracts," the report concluded. Nearly 2,000 elderly people were affected by the bankruptcy.

In addition to the financial risks inherent in a life care contract, residents may be at risk because of a community's failure to provide full disclosure of its financial status. In some cases the information given to a prospective resident may not be adequate for a reasonable judgement about whether to enter into a contract. In other cases, including examples uncovered during federal investigations, the information about the community's financial condition may be intentionally misleading. One common deception found was false representation about religious affiliation, leading potential residents to believe wrongly that some church entity would bail out the community in the event of financial difficulty.

Because of this potential for mismanagement and fraud, most observers believe that some form of regulation is needed to ensure the financial viability of life care communities and to protect the welfare of the residents. Rather than a federal law for life care communities, state legislation is generally regarded as the most appropriate way to regulate the industry. The Wharton School study concluded that it would be better to encourage a variety of state legislative programs than to enact a broad federal statute since CCRCs are still relatively new and differ

widely from region to region. So far ten states have adopted comprehensive legislation and about six have programs aimed at only one aspect of the industry. In a few other states, legislation is under consideration.

COMMITTEE PROCEEDINGS

Some initial work had already proceeded the deliberations of the Committee on Life Care Arrangements. In past years the Division on Aging had begun to be concerned about the large number of inquiries from out-of-state groups interested in establishing CCRC's in North Carolina. These inquiries seemed to suggest a fertile market in this State. Questions arose about what kind of protection was available for our citizens in helping them to determine those CCRC's that were financially stable and appropriate for those elderly persons who wished to choose this kind of living arrangement. Even though North Carolina has excellent proceedures for protection of consumers through the Attorney General's office, this protection sometimes comes after a problem has arisen. There was even some concern about lack of standards from attorneys that wished to advise their clients concerning the soundness of a particular community. The reputation of all the existing CCRC's in North Carolina has been excellent and they have served a need in this state for many years. Would this reputation hold with the growth of the industry in this state? Therefore these concerns were referred to the Legislative Research Commission's Committee on Aging.

The 1983-85 Committee on Aging held several hearings and

investigated the matter in the months directly preceeding the 1985 Session and was convinced that regulation of life care facilities "is necessary and appropriate for North Carolina". A certification bill was included in their report to the 1985 Session. The recommendation further stated "although the Committee supports the general concepts contained within the bill, it recommends further refinement." With these words of caution, the bill was not introduced into the 1985 Session but a separate Study on Life Care Arrangements was authorized under the Legislative Research Commission to report its findings to the 1987 General Assembly.

The Legislative Research Commissions Committee on Life Care Arrangements held four meetings during the course of its deliberations . These meetings were held on Oct. 17, 1985; February 11, 1986; March 18, 1986; and December 18, 1986.

The Committee learned very quickly that it was faced with a complex task and had limited time to study the issues. It had before it the bill that had been developed by the Study Commission on Aging. Therefore the Committee began its invesigations by studying the basic concepts of life care communities so that it could make some solid and practical recommendations about whether North Carolina should regulate life care and what form this regulation should take.

Continuing care facilities in North Carolina have typically been owned and operated by not-for-profit organizations,

sometimes affiliated with a religious or other charitable group. They offer the resident the right to occupy an apartment, cottage or other residential unit for the remainder of the resident's life and the right to receive a number of services such as building and grounds maintenance, housekeeping services and local transportation, social and recreational programs, food services to the extent desired, security arrangements and emergency medical care. The primary characteristic which distinguishes a continuing care community from a more ordinary retirement living arrangement is the provision of a health care facility.

More often than not, a major financial commitment is required of a prospective resident of a continuing care community in the form of a payment by the resident of an initial entry fee or occupancy charge, often $25,000 to $75,000 or more depending upon accommodations selected, with periodic charges.

Therefore a CCRC includes the following elements:

1. independent living units;
2. a range of health care and social services which may include intermediate or skilled nursing care usually available on the premises;
3. some type of prepayment, generally an entrance fee and/or monthly fees and
4. offers a contract that lasts for more than one year or for life and that describes the service obligations of the community and the financial

obligations of the resident.

Much of the above information was gleaned from an excellent source, Continuing Care Retirement Communities; An Emperical Financial and Legal Analysis by Howard E. Winklevoss and Alwyn V. Powell.

The Committee next began an analysis of the bill referred to it by the Study Commission on Aging which had proposed a comprehensive regulatory scheme based on the form and content from statutes from ten other states. Regardless of whether one prefers comprehensive regulation, selective regulation, or no regulation at all the experience of the states that have adopted comprehensive regulation proved a valuable data base from which to work.

From the study of the state statutes and the book by Winklevoss and Powell, certain elements of regulation were common to all. They included:

1. definition of the entity to be regulated
2. certification;
3. legal regulation of financial status;
4. legal regulation of resident relationships with the community; and
5. administration of the statute. (For further information, see Appendix B).

The Committee also spent one meeting getting a first hand view of how one CCRC in North Carolina operates by visiting Carol

Woods outside of Chapel Hill. The community was gracious enough to provide the Committee with a tour of the facility. An open discussion with the residents and management was held on various aspects of the continuing care concept in this one community.

COMMITTEE FINDINGS AND RECOMMENDATIONS

RECOMMENDATION. THE STATE OF NORTH CAROLINA SHOULD GIVE ADDED PROTECTION TO ITS OLDER CITIZENS BY REGULATING BY STATE STATUTE CONTINUING CARE RETIREMENT COMMUNITIES (See Appendix C)

Because of potential for mismanagement and fraud, the Committee believes that some form of regulation is needed to ensure the financial viability of life care communities and to protect the welfare of the residents. The Committee also believes that this regulation is the responsibility of State Government.

The weight of the evidence suggest that there are certain basic hazards which create the potential for financial difficulties for some CCRC's and include:

1. excessive vacancies resulting from inadequate marketing or the failure of management to live up to its commitments to previous residents;
2. burdensome debt structures;
3. Poor long range financial planning; and
4. inflexible occupancy agreements restricting periodic fee adjustments in response to inflationary effects on community costs and residents' income.

The Committee believes that any state action should meet certain goals for the protection of those older citizens involved in CCRC's. Those goals are:

1. Insuring that complete and adequate facility and financial planning, including the initial years

of operation has taken place prior to the receipt of funds from prospective residents;

2. Preventing the use of entrance fees deposited in advance until the public acceptance and initial feasibility of a project is assured;
3. requiring complete disclusure of the terms and conditions of any proposed contract for continuing care services; the background, resources and financial program of the provider of the services; and the exact commitments of the provider, including lack of commitments, if any in certain major areas which may become crucial to a prospective resident at a later date; and
4. minimizing regulatory prescription of standards for the accommodations, services and financing methods of a continuing care facility and its program, while still protecting the rights, assets and freedom of choice of existing and prospective residents.

The Committee believes the best method for meeting the above goals is a scheme of nonintrusive governmental regulations designed to provide minimum economic safeguards for residents and to enhance the functioning of normal market mechanisms through consumer education. The proposed bill included as Appendix C and offered to the 1987 General Assembly for its consideration is

unique because it relies on mandatory public disclosure to protect the consumers' interest rather than a regulatory process such as licensing or certification.

The Committee believes that this self-executing mechanism offers several distinct advantages over a more obtrusive regulatory approach. The most obvious advantage is that this model does not require the creation and expense of implementing a regulatory bureaucracy to administer the system. There is little support for the assumption that the presence of a "watchdog" agency overseeing these projects increases protection to consumers or prevents abuses. First, having a staff review applications or disclosure statements offers no assurance that a dishonest sponsor has not submitted false or misleading information to the regulatory agency. Fraud and abuse in the banking and insurance industries occur despite heavy regulation under both state and federal oversight. Secondly most regulatory agencies would probably lack both the number of staff and staff with the knowledge or experience in accounting and acturial science needed to evaluate complex and highly specialized continuing care projects.

One of the main assumptions of the proposed bill is that the most critical evaluators of CCRC's are competitors in the market, since they not only have the staff and expertise to thoroughly assess a proposed CCRC but also have a strong vested interest in keeping the fraudulent developer or poorly concerned

projects out of the market. The consumer is also a critical evaluator. In a competitive market with full disclosure he will usually make a good and informed decision based on his own needs and wants. The typical purchaser of a CCRC contract is also a very knowledgeable and sophisticated consumer with the ability and inclination to seek expert advice from attorneys and financial planners before making this type of major decision.

The specific provisions of the proposed act, and the reasons for their inclusion are as follows:

G.S. 131E.215 defines the various terms used in the act. The most important of the definitions is "continuing care" which delineates the acts coverage and incorporates the concepts of lodging, health, medical or nursing services and a period expected to exceed one year. This definition is used in order to avoid inadvertent coverage of arrangements such as nursing homes or college dormitories, which may include room board and health services but do not normally operate with multi-year contracts, or cooperative housing or long term residential leases, which might include use of dining facilities but would not ordinarily include health-related services. "Entrance fee" is also included and applies only if it exceeds twenty thousand dollars.

G.S. 131E.216 is the primary operative section of the act. It prohibits a provider from making a contract to provide continuing care until a disclosure statement outlining the provider's program has been made a public record and until any

escrows required by the act have been established.

G.S. 131E.217 specifies the content of a disclosure statement required to be delivered to the prospective resident or other person contracting for continuing care accommodations.This approach allows the provider to design its program as it deems best while also developing a major document which performs the functions of informing a prospective resident of exactly what the obligations of the respective parties under a continuing care contract are; forcing the provider itself to develop a thorough and realistic financial plan for development and operation of the community; presenting an objective basis for thorough evaluation of the project by the attorneys, accountants, bankers or other financial advisors who in most cases are retained by prospective residents; and making a written record of the promises and commitments then being made by the provider. Based on the information and any independent advice thus made available, the prospective resident is able to make an informed and considered decision.

Subdivisions (1), (2), (3) and (4) of subsection (a) of G.S. 131E.217 require a description of the identity, background and experience of the persons sponsoring and operating the community, so a prospective resident will know with whom he or she is dealing. The information required by the subdivision (3) is also to be provided about a facility's manager to enable a thorough analysis of records and interrelationships of all parties

whose conduct might affect the success of the project. Subdivisions (5) and (6) provide for a description of the facility and the services to be rendered, including disclosure of the items available only at extra cost and the extent to which facilities already exist or are merely proposed. Subdivision (7) requires a complete discussion of the various fees a resident will be expected to pay and includes disclosure of the providers policies in the event of certain contingencies which the prospective resident may not previously have considered. Paragraph e. of this subdivision also requires disclosure of the historical experience of the provider or manager in raising periodic rates at other facilities, so that the resident can evaluate the probability and relative size of potential periodic rate increases for his or her own accommodations. Subdivision (8) complements the discussion of individual fees by requiring a discussion of the effects of changing health and financial circumstances on the residents' status at the facility.

Subdivisions (9) through (13) focus on the overall financial planning for the facility as a whole. Adequate but not excessive reserve funding is critical to a CCRC, which will normally rely on a continuous cycle of entrance fees, especially during the facility's early years when the initial bulk of such fees is received before the turnover rate becomes stabilized. Subdivision (9) of the disclosure statement requirements provides for a general discussion of this reserve funding, including the

manner in which it will be invested. This is supplemented by subdivision (12) information in the case of new facilities, showing the estimated construction and start-up costs, initial sources of funds and amounts designated for reserve funding. The financial statements required by subdivision (13) will be of little importance in the case of a new facility which has not commenced operations, but they will become increasingly relevant as experience is obtained and a comparison can be made between actual results and corresponding earlier pro forma projections.

The projections, detailed requirements which are spelled out in subdivisions (11) and (12) of subsection (a), are probably the most critical portion of the entire disclosure statement and the proposed act itself, since it is here that the provider is forced to refine and disclose its future planning and assumptions.

An advance period of five years in (13) was chosen to give early warning of potential difficulties while not extending the time frame to a point where projections become mere guesses. Projections in (13) required to be made for the period include turnover and occupancy rates, increases in operating expenses and charges to residents, and anticipated future placements and additions. Simple cash flow analysis can promote a false sense of security in as much as they can mask a serious long-term financial problem whereas the actuarial methodology rquired in subdivision (11) is designed to uncover such problems. By requiring detailed advanced planning of the nature required by

(11) and (13) subject to review by prospective residents and their advisors, and disclosures, once operations commences, of the accuracy of previous projections it is hoped that the provider itself will see and react to early warning signals presaging financial difficulty in time to take appropriate corrective action.

G.S. 131E.219 rquires the disclosure statement, including the pro forma projections, to be updated at least annually. After the initial filing, the annual revision must also include a discussion of any changes made in the financial projections, as well as any differences between the past projections and the actual results of the operations. In this way, the provider's planning will be based on the most current information available, the reviewer will be able to compose and evaluate the accuracy of the estimates and projections made in the past, and both the provider and the reader will be able to focus on the reasons, if any, that past projections did not compare with actual results.

The dual purposes of this requirement are to encourage thorough financial planning on a long-range basis, and to draw attention to any discrepancies between pro forma estimates and actual results of operations, thereby giving early warning of possible financial difficulties.

Two major abuses are addressed in G.S. 131E.218. Paragraph (1) of Subdivision (a) provides for a 30 day waiting period during which the person entering the contract for

continuing care with the provider may rescind the agreement. This provides time for a considered view of the information contained in the disclosure statement, and using a rescession period rather than an advance delivery requirement reduces continued sales pressure while eliminating attempts to avoid the waiting period due to real or induced concern about specified accomodation availability. Paragraph (2) provides for a refund of all fees paid on behalf of a proposed resident, less a reasonable service charge and the amount of costs already incurred by the facility in adapting a standard living unit to the needs or desires of a particular resident if the resident becomes unable to enter the continuing care community on account of death or illness. For further protection of the consumer, subdivision (b) requires the inclusion of eleven items that must be addressed in the contract. Inclusion of these eleven points is a relatively unintrusive way to ensure that the agreement reached and signed between the CCRC and the resident contains some basic protection for the resident and approximates a contract that would be reached between negotiators of equal bargaining strength.

G.S. 131E.220 addresses the issue of entrance fee escrow provisions. The basic view underlying escrow provisions is that some extra protection is needed for the residents' investment beyond disclosure. There are two types of problems that entrance fee escrow requirements could help to ameliorate. First, an unscrupulous operator could commit fraud by absconding with the

residents entrance fees. The likelihood of this type of fraud is greatest before the resident occupies his or her unit - therefore the use of entrance fee escrow. Second, in the case of a new CCRC, the use of an entrance fee escrow is one mechanism to ensure that the community is in a position to meet the expectations of the promoter. A primary assumption made by the developer of any community is that the operator of a new community can attract a certain number of residents at a certain price to "buy in" to that facility. By forcing a CCRC to hold its entrance fees in escrow until a certain percentage of its capacity is subscribed to, one can statutorily ensure the accuracy of this critical assumption. G.S. 131.220 establishes the requirement for an escrow account with a bank, a trust company, or another entity agreed upon by the provider and resident. Subdivisions (1) and (2) outline the mechanism by which these funds can be released. The proposed act makes it much easier to have the escrowed funds released in a previously occupied facility . For a unit not previously occupied subdivision (2) outlines the three requirements that the provider must meet before the escrowed funds can be released by the escrow agent.

There are circumstances where civil and criminal penalties may be appropriate and these are covered fairly broadly in G.S. 131E.121 through G.S. 131E.124 of the proposed act.

Potential civil liability, in particular is a major incentive for the accuracy and completeness of disclosure

statements prepared in accordance with G.S. 131E.217. G.S. 131E.121 therefore creates a civil liability, in favor of the payor, against the provider entering a contract to provide continuing care if a disclosure statement which complies with G.S. 131E.217 is not delivered or if a delivered disclosure statement contains materially false or inadequate information. Subdivision (b) of G.S. 131E.221 does provide a proceedure for the provider to remove any contingent liabilities by making a rescession offer, thus encouraging attempts to straighten out possible errors, particularly those made inadvertently, but which nevertheless might have affected a decision to contract. G.S. 131E.224 adds a criminal penalty in the case of willful violations of the proposed act, while G.S. 131E.122 and G.S. 131E.123 give certain investigatory and cease and desist powers which may be desirable in enforcing the provisions of the act.

In summary, the proposed continuing care legislation provides comprehensive guidelines to protect existing continuing care beneficiaries as well as prospective residents through its emphasis on full disclosure, adequate planning, restricted use of initial funds, and early warning of financial difficulty. At the same time, the proposed act is flexible enough to accomodate varing programs, facilities, and financing concepts necessary for continuing care programs to become available to the greatest possible number of people. The self-enforcing nature of the act, with its emphasis on financial program review and warnings by

private parties, civil liabilities, and the general involvement of persons in addition to the provider and the state, also serves to carry out its purposes without the creation of additional bureaucratic mechanisms with their attendent costs.

APPENDICES

APPENDIX A

LEGISLATIVE RESEARCH COMMISSION

Senator J. J. Harrington, Cochairman
Senator Henson P. Barnes
Senator A. D. Guy
Senator Ollie Harris
Senator Lura Tally
Senator Robert D. Warren

Representative Liston B. Ramsey, Cochairman
Representative Christopher S. Barker, Jr.
Representative John T. Church
Representative Bruce Ethridge
Representative Aaron Fussell
Representative Barney Paul Woodard

Elements of Life Care Regulation

I. Definition of Entity to be Regulated

A. There are diverse characteristics of individual Continuing Care Retirement Communities. These communities differ significally in substance depending on the respective termination rights of the community and the resident, the amount of service and medical care covered under the contract at no or nominal extra charge, the length of the contract, and the financing arrangements between the resident and the community. Experts suggest that a definition should include:

1. all contracts that last for more than one year or for the life of the resident. (including mutually terminable continuing care contracts)

2. the provision (either on-site or contractually) of shelter and various health care services

3. either a payment of an enhance fee or periodic payments or a combination of the two

B. Examples:

1. California.
2. Florida.
3. AAHA.

II. Preopening Procedures'. Certification

The theory behind certification requirements is that some sort of comprehensive application process will enable the regulatory agency to determine the financial stability, capacity, sincerity, and integrity of prospective and existing continuing care operators. Legislative provisions on certification may contain two independent types of provisions to include:

A. Provisional certificates to be applied only to new prospective operators who have not yet acquired the necessary facilities or land or who have not yet begun construction. Such operators may be required to submit advertising, organizational information, a statement of proposed location and size and at least a preliminary feasibility study demonstrating the future validity of the facility. A provisional certificate would entitle the applicant to collect deposits from prospective residents, to pursue contractual commitments with contractors and to start out on the path toward permanent certification. Example. Florida.

B. Permanent Certification. This would include CCRC presently operating in the state as well as all those new communities with provisional certificates (if required). All states that regulate CCRC's require certification. There is usually certain information required for certification such as a copy of the contract being used by the community, ownership

and financial responsibility disclosure statements and a series of actual and projected financial statements.

III. Legal Regulation of Financial Status

A. Escrow Provisions. The basic view underlying escrow provisions is that some extra protection is needed for the residents' investment beyond disclosure, certification and the enforcement of other regulatory provisions. The disadvantage of mandated escrow provisions is that such provisions direct capital into relatively stagnant, bank accounts or other relatively (unproductive uses of money). Release of funds from escrow accounts can be either very simple or extremely complicated. For example, California's entrance fee escrow is released when the facility is 50 percent completed and 50 percent subscribed. But other states such as Arizona, Colorado, Indiana, Minnesota and Missouri have complicated formulas governing release of the escrow funds depending on whether the unit is new or old and if new, depending on the stage of construction or financing.

B. Reserve Funds. One of the basic propositions of CCRC's is that residents expect and are entitled to a basic guarantee that their community will retain the essential financial where with all over the years to provide the services to which it has committed itself contractually without the need to have monthly fees increase faster than inflation. More over

because future inflation constrained monthly fees will fall short of future expenses (because of increased health care utilization as individuals age) the difference must be made up from current assets (or reserves) to work. Six of the nine states with CCRC regulations contain some form of reserve requirements and they tend to regulate both the level of reserves necessary and the investment limitations to be placed on whatever level of reserve is selected. The most typical regulations of size tend to look to the basic commitments of the community over a 12-month period and require that the amount necessary to meet these commitments be held in a cash or quasi-cash reserve.

C. Bonding Requirements. There are two possible types of bonds. The first, a fidelity bond, may be obtained by the community in order to cover losses due to the dishonesty or negligence of employees handling money of the residents. The second, referred to as a surety bond is obtained by the community as a substitute for, or in addition to the reserve requirements. The first type may be left to the individual community. The second has no application for legislation because it does not appear to be obtainable.

D. Fee Regulation. The ultimate in intrusive regulation is direct setting of fees by the state, or supervision of fee-selling by the state. All current existing legislation of other states does not contain fee regulation provisions.

IV. Legal Regulation of Resident Relationships with the Community.

A. Financial Disclosure to Residents. The basic rationale underlying full financial disclosure to both prospective and current residents is that, by making such disclosure, the community informs all residents about the past, present and expected future financial condition of the facility, thereby rendering the residents' better able to protect themselves. Because financial information is complex, disclosure of only raw financial data is probably not effective in equalizing bargaining power. Therefore, the experts suggest that prospective residents should be given a copy of a simplified disclosure form including a clear narrative description of the financial condition of the CCRC to supplement all raw data.

B. Form and Contents of the Contract. The state may, in a relatively unintrusive way, mandate that the agreement reached and signed between the community and the resident contain some basic protections for the resident and approximate a contract that would be reached between negotiators of equal bargaining strength. Further regulation of certain substantive terms has the incidental benefit of reducing uncertainty and, therefore, simplifying much of the contract, litigation surrounding continuing case. The following are provisions which may be addressed by state law:

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

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

The particular living unit contracted for by the applying resident should be disclosed in the contract.

A provision governing dual occupancy of residency units should be included in all contracts. This provision must specify what occurs when one of the two residents dies, withdraws, is dismissed, or needs to be transferred to the health facility.

Provisions governing the reoccupancy of residents' living units as a result of prolonged sickness should be included in the contract.

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

The contract should specify that is creates no property interest of any kind, that it is simply a service agreement.

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

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

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

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

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

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should be a full refund to the resident of all fees paid to the CCRC less reasonable costs.

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

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

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

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

C. Advertising Regulation. Advertising regulation is a basic antifraud protection common in many industries. Many state CCRC statutes contain some form of regulation pertaining to advertising and promotional literature. The argument against regulation is that this state has statutes of general applicability prohibiting the use of fraudulent or misleading

advertising. Some say that the administrative cost involved is not worth the benefit.

D. Rights of Self-Organization. Like disclosure, this element is designed to give residents the power and the information to safeguard their own interests. Three of the states statutes, plus one state's regulations recognize any right to resident self-organization.

V. State Administration of the Statute

A. Responsible Agency.

1. Arizona Dept. of Insurance. No Advisory Council.
2. California - Dept. of Social Services. Eight-member advisory board.
3. Colorado - Dept. of Insurance. No Advisory Council.
4. Florida - Dept. of Insurance, Seven-member advisory council.
5. Indiana - Dept. of Securities.
6. Maryland - Office of Aging. No Advisory Board.
7. Michigan - Corporation and Securities Bureau of the Department of Commerce. No Advisory Board.
8. Minnesota. None.
9. Missouri - Division of Insurance.

B. Investigative, Enforcement, and Rehabilitative Powers. Most of the policy arguments on this element of regulation pertain to the degree of power, and not to the need for some power. No matter what form a regulatory scheme takes, enforcement is essential, and investigation and audit are essential adjuncts to the enforcement power. The policy debates, therefore, center mostly on the scope and nature of the investigative enforcement, and rehabilitative powers that need to be granted.

87W25-LF-1

Public

S.T.: Continuing Care Disclosure Requirements.

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ADEQUATE DISCLOSURE BY CONTINUING CARE FACILITIES.

The General Assembly of North Carolina enacts:

Section 1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"Article 12.

"Disclosure and Contract Requirements for Continuing Care Facilities.

"§ 131E-215. Definitions.--As used in this Article, unless otherwise specified:

(1) 'Continuing care' means the furnishing to an individual other than an individual related by consanguinity or affinity to the person furnishing the care, of lodging together with nursing services, medical services, or other health related services, pursuant to an agreement effective for the life of the individual or for a period in excess of one year.

(2) 'Entrance fee' means an initial or deferred payment of a sum of money exceeding twenty thousand dollars ($20,000) or any other consideration that assures a resident a place in a facility for a term of years or

for life. An accommodation fee, admission fee, or other fee of similar form and application is considered to be an entrance fee if it exceeds twenty thousand dollars ($20,000).

(3) 'Facility' means the place or places in which a provider undertakes to provide continuing care to an individual.

(4) 'Health related services' means, at a minimum, nursing home admission or assistance in the activities of daily living, exclusive of the provision of meals or cleaning services.

(5) 'Living unit' means a room, apartment, cottage, or other area within a facility set aside for the exclusive use or control of one or more identified residents.

(6) 'Provider' means the promoter, developer, or owner of a continuing care retirement community, whether a natural person, partnership, or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, or any other person, that solicits or undertakes to provide continuing care under a continuing care facility contract.

(7) 'Resident' means a purchaser of, a nominee of, or a subscriber to, a continuing care contract.

"§ 131E-216. Pre-contractual statements of record.--No provider may enter into a contract to provide continuing care in

a facility if (i) the contract requires or permits the payment of an entrance fee to any person, and (ii) the facility is, or will be, located in this State unless there has been filed in the office of the Division of Facility Services of the Department of Human Resources:

(1) A current disclosure statement as prescribed by G.S. 131E-217, and

(2) A copy of the agreement establishing the escrow as prescribed by G.S. 131E-220.

"§ 131E-217. Disclosure statement.--(a) At the time of, or prior to, the execution of a contract to provide continuing care, or at the time of, or prior to, the transfer of any money or other property to a provider by or on behalf of a prospective resident, whichever occurs first, the provider shall deliver a current disclosure statement to the person with whom the contract is to be entered into, the text of which shall contain at least:

(1) The name and business address of the provider and a statement of whether the provider is a partnership, corporation, or other type of legal entity.

(2) The names and business addresses of the officers, directors, trustees, managing or general partners, any person having a ten percent (10%) 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.

(3) The following information on all persons named in response to subdivision (2) of this section:

a. a description of the business experience of this person, if any, in the operation or management of similar facilities;

b. the name and address of any professional service, firm, association, trust, partnership, or corporation in which this person has, or which has in this person, a ten percent (10%) or greater interest and which it is presently intended shall or may provide goods, leases, or services to the facility, or to residents of the facility, of an aggregate value of five hundred dollars ($500) or more within any year, including a description of the goods, leases, or services and the probable or anticipated cost thereof to the facility, provider, or residents or a statement that this cost cannot presently be estimated; and

c. a description of any matter in which the person (i) has 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 action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property; or (ii) is subject to a currently effective injunctive or restrictive court order, or within the past five years, 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 business activity of health care, including actions affecting a license to operate a foster care facility, nursing home, retirement home, home for the aged, or facility, subject to this Article or a similar law in another state.

(4) A statement as to whether the provider is, or is affiliated with, a religious, charitable, or other nonprofit organization, the extent of the affiliation, if any, the extent to which the affiliate organization will be responsible for the financial and contract obligations of the provider, and the provision of the Federal Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of income tax.

(5) The location and description of the physical property or properties of the facility, existing or proposed, and to the extent proposed, the estimated completion

date or dates, whether construction has begun, and the contingencies subject to which construction may be deferred.

(6) The services provided or proposed to be provided pursuant to contracts for continuing care at the facility, including the extent to which medical care is furnished, and a clear statement of which services are included for specified basic fees for continuing care and which services are made available at or by the facility at extra charge.

(7) A description of all fees required of residents, including the entrance fee and periodic charges, if any. The description shall include:

a. a statement of the fees that will be charged if the resident marries while at the facility, and a statement of the terms concerning the entry of a spouse to the facility and the consequences if the spouse does not meet the requirements for entry;

b. the circumstances under which the resident will be permitted to remain in the facility in the event of possible financial difficulties of the resident;

c. the terms and conditions under which a contract for continuing care at the facility may be canceled by the provider or by the resident, and the conditions, if any, under which all or any portion of the entrance fee will be refunded in

the event of cancellation of the contract by the provider or by the resident or in the event of the death of the resident prior to or following occupancy of a living unit;

d. the conditions under which a living unit occupied by a resident may be made available by the facility to a different or new resident other than on the death of the prior resident; and

e. the manner by which the provider may adjust periodic charges or other recurring fees and the limitations on these adjustments, if any; and, if the facility is already in operation, or if the provider or manager operates one or more similar continuing care locations within this state, tables shall be included showing the frequency and average dollar amount of each increase in periodic charges, or other recurring fees at each facility or location for the previous five years, or such shorter period as the facility or location may have been operated by the provider or manager.

(8) The health and financial conditions required for an individual to be accepted as a resident and to continue as a resident once accepted, including the effect of any change in the health or financial condition of a person between the date of entering a contract for continuing care and the date or initial occupancy of a living unit by that person.

(9) The provisions that have been made or will be made, if any, to provide reserve funding or security to enable the provider to perform its obligations fully under contracts to provide continuing care at the facility, including 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.

(10) Certified financial statements of the provider, including (i) a balance sheet as of the end of the most recent fiscal year and (ii) income statements for the three most recent fiscal years of the provider or such shorter period of time as the provider shall have been in existence. If the provider's fiscal year ended more than 120 days prior to the date the disclosure statement is recorded, interim financial statements as of a date not more than 90 days prior to the date of recording the statement shall be included, but need not be certified.

(11) A summary of a report of an actuary, updated every 5 years, that estimates the capacity of the provider to meet its contract obligation to the residents.

Disclosure statements of continuing Care Facilities established prior to January 1, 1988, do not need an actuary report or summary until January 1, 1993.

(12) If operation of the facility has not yet commenced, a statement of the anticipated source and application of the funds used or to be used in the purchase or construction of the facility, including:

a. an estimate of the cost of purchasing or constructing and equipping the facility including such related costs as financing expense, legal expense, land costs, occupancy development costs, and all other similar costs the provider expects to incur or become obligated for prior to the commencement of operations;

b. a description of any mortgage loan or other long-term financing intended to be used for the financing of the facility, including the anticipated terms and costs of this financing;

c. an estimate of the total entrance fees to be received from, or on behalf of, residents at, or prior to, commencement of operation of the facility; and

d. an estimate of the funds, if any, that are anticipated to be necessary to fund start-up losses and provide reserve funds to assure full performance of the obligations of the provider under contracts for the provision of continuing care.

(13) Pro forma annual income statements for the facility for a period of not less than five fiscal years, including:

a. a beginning cash balance consistent with the certified income statement required by subdivision (10) of this section or, if operation of the facility has not commenced, consistent with the statement of anticipated source and application of funds required by subdivision (12);

b. anticipated earnings on cash reserves, if any;

c. estimates of net receipts from entrance fees, other than entrance fees included in the statement of source and application of funds required by subdivision (12) less estimated entrance fee refunds, if any, and including a description of the actuarial basis and method of calculation for the projection of entrance fee receipts;

d. an estimate of gifts or bequests, if any, that are to be relied on to meet operating expenses;

e. a projection of estimated income from fees and charges other than entrance fees, showing individual rates presently anticipated to be charged and including a description of the assumptions used for calculating the estimated occupancy rate of the facility and the effect on the income of the facility of government subsidies for health care services, if any, to be provided pursuant to the contracts for continuing care;

f. a projection of estimated operating expenses of

the facility, including a description of the assumptions used in calculating the expenses, and separate allowances, if any, for the replacement of equipment and furnishings and anticipated major structural repairs or additions; and

g. an estimate of annual payments of principal and interest required by any mortgage loan or other long-term financing arrangement relating to the facility.

(14) The estimated number of residents of the facility to be provided services by the provider pursuant to the contract for continuing care.

(15) Any other material information concerning the facility or the provider as the provider wishes to include.

(b) The cover page of the disclosure statement shall state, in a prominent location and in boldface type, the date of the disclosure statement, the last date through which that disclosure statement may be delivered if not earlier revised, and that the delivery of the disclosure statement to a contracting party before the execution of a contract for the provision of continuing care is required by this Article but that the disclosure statement has not been reviewed or approved by any government agency or representative to ensure accuracy or completeness of the information set out.

(c) A copy of the standard form of contract for continuing care used by the provider shall be attached to each disclosure statement.

"§ 131E-218. Contract for continuing care; specifications.--(a) Each contract for continuing care shall provide that:

(1) The party contracting with the provider may rescind the contract within 30 days following the later of the execution of the contract or the receipt of a disclosure statement that meets the requirements of this section, in which event any money or property transferred to the provider, other than periodic charges specified in the contract and applicable only to the period a living unit was actually occupied by the resident, shall be returned in full, and the resident to whom the contract pertains is not required to move into the facility before the expiration of the 30-day period; and

(2) If a resident dies before occupying a living unit in the facility, or if, on account of illness, injury, or incapacity, a resident would be precluded from occupying a living unit in the facility under the terms of the contract for continuing care, the contract is automatically canceled and the resident or legal representative of the resident shall receive a refund of all money or property transferred to the provider, less (i) those non-standard costs specifically incurred by the provider or facility at the request of the resident and described in the contract or an addendum thereto signed by the resident, and (ii) a reasonable

service charge, if set out in the contract, not to exceed the greater of one thousand dollars ($1,000) or two percent (2%) of the entrance fee.

(b) Each contract shall include provisions that specify the following:

(1) The total consideration to be paid;

(2) Services to be provided;

(3) The procedures the provider shall follow to change the resident's accommodation if necessary for the protection of the health or safety of the resident or the general and economic welfare of the residents;

(4) The policies to be implemented if the resident cannot pay the periodic fees;

(5) The terms governing the refund of any portion of the entrance fee in the event of discharge by the provider or cancellation by the resident;

(6) The policy regarding increasing the periodic fees;

(7) The description of the living quarters;

(8) 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;

(9) Any property rights of the resident;

(10) The policy, if any, regarding fee adjustments if the resident is voluntarily absent from the facility; and

(11) Any requirement, if any, that the resident apply

for Medicaid, public assistance, or any public benefit program.

"§ 131E-219. Annual disclosure statement revision.--Within the 150 days following the end of each fiscal year of the provider, the provider shall have filed in the Division of Facility Services of the Department of Human Resources, located a revised disclosure statement setting forth current information required pursuant to G.S. 131E-217. The provider shall also make this revised disclosure statement available to all the residents of the facility. This revised disclosure statement shall include a narrative describing any material differences between (i) the pro forma income statements filed in response to G.S. 131-217 as a part of the disclosure statement recorded most immediately subsequent to the start of the provider's most recently completed fiscal year and (ii) the actual results of operations during that fiscal year together with the revised pro forma income statements being filed as a part of the revised disclosure statement. A provider may also revise its disclosure statement and have the revised disclosure statement recorded at any other time if, in the opinion of the provider, revision is necessary to prevent an otherwise current disclosure statement from containing a material misstatement of fact or omitting a material fact required to be stated therein. Only the most recently recorded disclosure statement, with respect to a facility, and in any event, only a disclosure statement dated within one year plus 150 days prior to the date of delivery, shall be considered current for purposes of this Article or delivered pursuant to G.S. 131E-217.

"§ 131-220. Escrow, collection of deposits.--(a) A provider shall establish an escrow account with (i) a bank, (ii) a trust company, or (iii) another person or entity agreed upon by the provider and the resident. The terms of this escrow account shall provide that the total amount of any entrance fee received by the provider prior to the date the resident is permitted to occupy a living unit in the facility be placed in this escrow account. These funds may be released only as follows:

(1) If the entrance fee applies to a living unit that has been previously occupied in the facility, the entrance fee shall be released to the provider when the living unit becomes available for occupancy by the new resident;

(2) If the entrance fee applies to a living unit which has not previously been occupied by any resident, the entrance fee shall be released to the provider when the escrow agent is satisfied that:

a. Construction or purchase of the living unit has been completed and an occupancy permit, if applicable, covering the living unit has been issued by the local government having authority to issue such permits;

b. A commitment has been received by the provider for any permanent mortgage loan or other long-term financing, and any conditions of the commitment prior to disbursement of funds thereunder have been substantially satisfied; and

c. Aggregate entrance fees received or receivable by the provider pursuant to binding continuing care retirement community contracts, plus the anticipated proceeds of any first mortgage loan or other long-term financing commitment are equal to not less than ninety percent (90%) of the aggregate cost of constructing or purchasing, equipping and furnishing the facility plus not less than ninety percent (90%) of the funds estimated in the statement of anticipated source and application of funds submitted by the provider as part of the certification application, to be necessary to fund start-up losses and assure full performance of the obligations of the provider pursuant to continuing care retirement community contracts.

(b) Upon receipt by the escrow agent of a request by the provider for the release of these escrow funds, the escrow agent shall approve release of the funds within five working days unless the escrow agent finds that the requirements of subsection (a) of this section have not been met and notifies the provider of the basis for this finding. The request for release of the escrow funds shall be accompanied by any documentation the fiduciary requires.

(c) If the provider fails to meet the requirements for release of funds held in this escrow account within a time period the escrow agent considers reasonable, these funds shall be returned by the escrow agent to the persons who have made payment

to the provider. The escrow agent shall notify the provider of the length of this time period when the provider requests release of the funds.

(d) An entrance fee held in escrow may be returned by the escrow agent to the person who made payment to the provider at any time upon receipt by the escrow agent of notice from the provider that this person is entitled to a refund of the entrance fee.

"§ 131E-221. Civil liability.--A provider who enters into a contract for continuing care at a facility without having first delivered a disclosure statement meeting the requirements of G.S. 131E-217 to the person contracting for this continuing care, or enters into a contract for continuing care at a facility with a person who has relied on a disclosure statement that omits to state a material fact required to be stated therein or necessary in order to make the statements made therein, in light of the circumstances under which they are made, not misleading, shall be liable to the person contracting for this continuing care for actual damages and repayment of all fees paid to the provider, facility, or person violating this Article, less the reasonable value of care and lodging provided to the resident by or on whose behalf the contract for continuing care was entered into prior to discovery of the violation, misstatement, or omission or the time the violation, misstatement, or omission should reasonably have been discovered, together with interest thereon at the legal rate for judgments, and court costs and reasonable attorney fees.

(a) Liability under this Section exists regardless of

whether the provider or person liable had actual knowledge of the misstatement or omission.

(b) A person may not file or maintain an action under this Section if the person, before filing the action, received a written offer of a refund of all amounts paid the provider, facility, or person violating this Article together with interest at the rate established monthly by the Commissioner of Banks pursuant to G.S. 24-1.1(3), less the current contractual value of care and lodging provided prior to receipt of the offer, and if the offer recited the provisions of this section and the recipient of the offer failed to accept it within 30 days of actual receipt.

(c) An action may not be maintained to enforce a liability created under this Article unless brought before the expiration of three years after the execution of the contract for continuing care that gave rise to the violation.

(d) This Article may not limit a liability that may exist by virtue of any other statute or under common law if this Article were not in effect.

"§ 131E-222. Investigations and subpoenas.--The attorney general may make such public or private investigations within or outside of this state as necessary to determine whether any person has violated or is about to violate any provision of this Article or to aid in the enforcement of this Article or to verify statements contained in any disclosure statement filed or delivered hereunder.

(a) For the purpose of any investigation or proceeding under this Article, the attorney general may require or permit any person to file a statement in writing, under oath or otherwise, as to any of the facts and circumstances concerning the matter to be investigated.

(b) For the purpose of any investigation or proceeding under this Article, the attorney general or a designee thereof has all the powers given to him for consumer protection. He may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence, and require the production of any books, papers, correspondence, memoranda, agreements or other documents or records deemed relevant or material to the inquiry, all of which may be enforced in any court of this state which has appropriate jurisdiction.

"§ 131E-223. Cease and desist orders and injunctions.--Whenever it appears to the attorney general or any district attorney, upon complaint or otherwise, that any person has engaged or is about to engage in any act or practice constituting a violation of any provision of this Article or any order hereunder, this officer may bring an action in any court which has appropriate jurisdiction to enjoin the acts or practices and to enforce compliance with this Article or any order hereunder. Upon a proper showing, a permanent or temporary injunction or restraining order shall be granted and a receiver or conservator may be appointed for the defendant or the defendant's assets.

"§ 131E-224. Criminal penalties.--Any person who willfully and knowingly violates any provision of this Article is guilty of a misdemeanor and shall, upon conviction, be fined not more than ten thousand dollars ($10,000) or imprisoned not more than one year, or both. The attorney general or the district attorney may institute the appropriate criminal proceedings under this Article. Nothing in this Article limits the power of the State to punish any person for any conduct that constitutes a crime under any other statute."

Sec. 2. This act shall become effective January 1, 1988.