Department of Legislative Services

Maryland General Assembly
2014 Session

FISCAL AND POLICY NOTE

Senate Bill 276 (Senator Kelley, *et al.*)
Finance

Continuing Care Retirement Communities - Continuing Care Agreements - Actuarial Studies

This bill distinguishes among three types of continuing care agreements: "extensive agreement," "fee-for-service agreement," and "modified agreement." The bill alters the contents of a renewal application for a continuing care retirement community (CCRC) by modifying the existing requirement that a qualified actuary review actuarial studies for certain types of providers. Studies must be reviewed and submitted every three to five years, depending on the type of continuing care agreement. Specifically, unless otherwise exempted, a provider with extensive or modified agreements must *continue* to submit an actuarial study that is reviewed by a qualified actuary every three years, whereas a provider with only fee-for-service agreements must *now* provide an actuarial study that is reviewed by a qualified actuary every five years.

Fiscal Summary

State Effect: None. The bill increases the Maryland Department of Aging's (MDoA) oversight responsibilities for providers with fee-for-service agreements, but the department advises that the impact is small enough that it can be handled with existing resources.

Local Effect: None.

Small Business Effect: Meaningful. To the extent that a CCRC is a small business, the bill may have a meaningful impact on CCRCs that must now hire a qualified actuary to review actuarial studies.

Analysis

Bill Summary: The bill defines an "extensive agreement" as a continuing care agreement under which the provider promises to provide residential facilities, meals, amenities, and long-term care services in a licensed assisted living program or comprehensive care program. These services must be provided for as long as the subscriber needs the services and without any substantial increase in the subscriber's entrance fee or periodic fees, except for an adjustment to an account for increased operating costs caused by inflation or other factors that are unrelated to the individual subscriber.

A "fee-for-service agreement" is defined as a continuing care agreement that is either:

- an agreement under which the provider promises to provide residential facilities, meals, amenities, and long-term care services in a licensed assisted living program or comprehensive care program for as long as the subscriber needs the services, with these services provided at a per diem, a fee-for-service, or another agreed-on rate that generally reflects the market rates for these services; **or**

- a continuing care agreement that is not an extensive agreement or a modified agreement.

A "modified agreement" means a continuing care agreement:

- under which the provider promises to provide residential facilities, meals, amenities, and a limited amount of long-term care services in a licensed assisted living program or comprehensive care program for as long as the subscriber needs services – without any substantial increase in the subscriber's entrance fees or periodic fees, except for an adjustment to account for increased operating costs caused by inflation or other factors unrelated to the individual subscriber; **and**

- that provides that long-term care services in a licensed assisted living program or comprehensive care program beyond the limited amount of services to be provided (as described above), at a per diem cost, a fee-for-service cost, or another agreed-on rate.

Current Law: Current law requires that every year, within 120 days after the end of a provider's fiscal year, the provider file an application for a renewal certificate of registration to MDoA. The renewal application must contain required notice of certain changes; an audited financial statement for the preceding fiscal year; an operating budget for the current fiscal year; a projected operating budget for the next fiscal year; a cash flow projection for the current fiscal year and the next two fiscal years; and a projection of the life expectancy and the number of residents who will require nursing home care.

Every three years, the renewal application has to include an actuarial study reviewed by a qualified actuary, unless the provider is exempted from this requirement by regulations.

Under *Code of Maryland Regulations* 32.02.01.13E., a continuing care provider offering Type A (extensive or life care) or B (modified) contracts must submit an actuarial study to MDoA with its initial application and with each renewal application every three years. However, a provider offering Type C (fee-for-service) contracts is exempt from these requirements. Each actuarial study must include (1) an actuarial balance sheet for current subscribers; (2) a cohort pricing analysis for a cohort of new subscribers; (3) projected cash and investment balances for a period of 20 years; and (4) supporting detailed documentation, including a projection of future population flows and health care bed needs for 20 years using specified assumptions. MDoA may request this information more frequently to assist in the determination of possible financial difficulty under specified circumstances.

Background: In recent years, concerns have arisen among various stakeholders regarding the administration of continuing care law – particularly as related to the unique nature of the contract between providers and subscribers and the increasing complexity of CCRC corporate structures. In response to these concerns, the Secretary of Aging reconvened the Continuing Care Advisory Committee (CCAC), with membership including subscribers, providers, senior advocates, industry professionals, and representatives from the Maryland Continuing Care Residents Association (MaCCRA), and LifeSpan. After a year of study, CCAC submitted a final report in November 2010 with recommendations on key issues, including (1) financial matters; (2) refinements to existing statutory language and policies; and (3) subscribers' rights.

Initial departmental legislation reflecting CCAC's recommendations did not pass. However, recommendations developed by a small workgroup consisting of representatives from MaCCRA, MDoA, LifeSpan, and the General Assembly were enacted as Chapters 523 and 524 of 2012. Chapters 523 and 524 modified several provisions of law relating to CCRCs, including establishing additional requirements with regard to continuing care agreements, disclosure statements, and grievance procedures; requiring providers to make specified information available to subscribers; modifying requirements for the sale or transfer of a facility; restricting the pledging or encumbering of operating reserve assets; and increasing the operating reserve that a provider must set aside for each facility.

This bill represents a recommendation adopted by CCAC's financial matters subcommittee report, that Type C communities (fee-for-service) should be required to have actuarial studies performed at least every five years.

Additional Information

Prior Introductions: None.

Cross File: HB 271 (Delegate Bromwell, *et al.*) - Health and Government Operations.

Information Source(s): Maryland Department of Aging, Department of Legislative Services

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