HB 282

Department of Legislative Services

Maryland General Assembly
2015 Session

FISCAL AND POLICY NOTE

House Bill 282 (Delegate Bromwell, *et al.*)
Health and Government Operations

Continuing Care Retirement Communities - Continuing Care Agreements - Actuarial Studies

This bill makes various changes to the law applicable to continuing care retirement communities (CCRCs). The bill distinguishes among three types of continuing care agreements: "extensive agreement," "modified agreement," and "fee-for-service agreement." The contents of a renewal CCRC application are modified in regards to submission of an actuarial study reviewed by a qualified actuary. Providers with extensive or modified agreements must submit an actuarial study every three years, and providers with only fee-for-service agreements must do so 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: None. None of the CCRCs operating in the State (that do not currently submit actuarial studies) is a small business.

Analysis

Bill Summary:

Actuarial Studies

Actuarial studies must be reviewed and submitted every three to five years with the renewal application, 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.

Definitions of Agreements

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

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.

Current Law: Every year, within 120 days after the end of a provider's fiscal year, a provider must file an application for a renewal certificate of registration to MDoA. The renewal application must contain (1) required notice of certain changes; (2) an audited financial statement for the preceding fiscal year; (3) an operating budget for the current fiscal year; (4) a projected operating budget for the next fiscal year; (5) a cash flow projection for the current fiscal year and the next two fiscal years; (6) 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 the Code of Maryland Regulations, 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.

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.

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.

MDoA advises that 24 of the 38 CCRCs currently in Maryland operate with only fee-for-service agreements and become subject to the requirement to submit an actuarial study every five years with their renewal applications. (Another such CCRC is planned but has not yet been approved.) MDoA further advises that such studies cost approximately $20,000.

Additional Information

Prior Introductions: SB 276 of 2014 was heard in the Senate Finance Committee, but no further action was taken. Its cross file, HB 271, received an unfavorable report from the House Health and Government Operations Committee.

Cross File: SB 91 (Senator Kelley, *et al.*) - Finance.

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

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