November 12, 2010

The Honorable Gloria Lawlah
Secretary, Maryland Department of Aging
301 West Preston Street
Baltimore Maryland 21201

Dear Secretary Lawlah:

After twelve months work, the Continuing Care Advisory Committee has completed the task you presented to us – analyze and recommend solutions to various continuing care issues raised by the continuing care industry, the Department, and continuing care residents. I am pleased to submit to you the final Report and Recommendations of the Committee, which is enclosed.

In summary, the Committee recommends that the Department consider proposing amendments to the Continuing Care Subtitle in the 2011 General Assembly session primarily in the following areas:

1. Subscriber Rights: strengthening the Disclosure Statement requirements, the internal grievance procedure, the governing body membership requirements; and adding requirements to distribute summaries of minutes and make public the financial statements of some related entities;

2. Refinement of Existing Statutory Language/Policies: clarification of and coordination with the Department of Health and Mental Hygiene's requirements for assisted living, and clarification and tightening of the transfer of ownership and control statutes; and

3. Financial Matters: permitting obligated groups that meet certain standards, and strengthening the requirements for transfers of assets, operating reserves, and actuarial studies.

I know you are aware that the Committee members put in a great deal effort and, I believe, accomplished a great deal. The chairs of the subcommittees, Leslie Fried, Esquire, Rose Matricciani, Esquire, and Dave Bond F.S.A., M.A.A.A. deserve particular gratitude, as does Annette Anselmi, Executive Director of MHHEFA, who lent us her expertise in bond financing. This work could not have been accomplished with the extraordinary contributions in time and expertise of your staff and your attorneys, particularly Debra Roane, Martha Roach, Jeff Myers, and George Hughes.

Finally, I appreciated the opportunity to undertake this interesting and important effort.

Yours truly,

Maureen Mullen Dove

Maureen Mullen Dove, Chair
Continuing Care Advisory Committee

MARYLAND DEPARTMENT OF AGING

REPORT AND
RECOMMENDATIONS TO
GLORIA LAWLAH
SECRETARY OF AGING

2010 CONTINUING CARE ADVISORY COMMITTEE

Maryland Department of Aging

301 West Preston Street

Baltimore Maryland 21201

I. INTRODUCTION

Continuing earlier practice, Secretary Gloria Lawlah in September 2009 invited a group of individuals to constitute a Continuing Care Advisory Committee (the "Committee") with respect to continuing care retirement communities ("CCRCs"). The Committee included representatives of the provider community, the subscriber community, and the senior advocacy community, as well as attorneys, two actuaries and a financial specialist with expertise in continuing care. A list of the Committee members is attached as Exhibit 1.

Before the first meeting, the Maryland Department of Aging (the "Department") distributed an "issues list" it had prepared, along with correspondence from the following suggesting possible issues: the Maryland Continuing Care Residents' Association ("MaCCRA"), LifeSpan and the President of Buckingham's Choice Resident Association, Sam Keiter. (Copies attached as Exhibit 2.)

At the first meeting, October 1, 2009, after Secretary Lawlah greeted the Committee and thanked the members for agreeing to serve, the Committee discussed how to best organize and address the issues presented, and added several additional issues. Members were asked to submit their preferences for sub-committee assignments, in order of priority. Three members agreed to chair the subcommittees. The sub-committees and their chairs were:

1. Financial Matters – Dave Bond, F.S.A., M.A.A.A., Managing Partner, CCRC Actuaries LLC

2. Subscriber Rights – Leslie B. Fried, Esq., Senior Attorney, American Bar Association's Commission on Law and Aging

3. Refinement of Existing Statutory Language/Policies - Rose Matricciani, Esq., Partner, Whiteford, Taylor & Preston LLP

Members of the subcommittees are listed in Exhibit 3. The subcommittees were asked to convene before the next meeting of the Committee to decide their priorities and be prepared to make presentations at that meeting.

II. PRIORITIES

At the second meeting of the Committee, the subcommittees briefly outlined the issues to which they planned to give priority. See Exhibit 4. There were other issues raised, see Exhibit 2, that were not made priorities by the subcommittees.

III. SECRETARY'S REQUEST

On April 15, 2010, Secretary Lawlah sent a letter to the Committee Chair pointing out that several changes to the continuing care law made by the General Assembly in 2009 (*See* Chapter 750 Laws of 2009) to streamline the contract review process seem to have also unintentionally reduced consumer protections. See Exhibit 5. These issues were added to the priorities to be addressed by the Committee.

IV. RECOMMENDATIONS

Each subcommittee discussed and debated, on some occasions with outside resources, the issues listed above. Progress was reported to the Committee throughout the year, which conducted its own discussions of the issues in response to the reports. Beginning in June 2010, each subcommittee made its final recommendations to the Committee, which voted on these recommendations, with the understanding that staff would develop the specific language needed to change the relevant statutes. Thus, the recommendations contained here were, with some fairly minor exceptions, accepted both at the subcommittee and the full committee level.

A. Subscriber Rights Subcommittee

The subcommittee sent 25 recommendations to the Committee. During the meetings of June 22, June 30 and July 7, 2010, the Committee considered these and adopted recommendations concerning the contents of the continuing care agreement, contents of the disclosure statement, subscriber input into the governing body, information to be provided to subscribers regarding the governing body, the internal grievance procedure and marketing materials. During the Committee's discussions, some of the recommendations were separated into additional parts.

These recommendations were adopted at the June 22, 2010 meeting.

1. A copy of the contract shall be provided to potential subscribers, along with the Disclosure Statement and written rules at least two weeks prior to the signing of the contract. (Amend §10-444) (Currently only the Disclosure Statement and written rules are required to be given to potential subscribers before the signing of the contract.)

2. A copy of the Department on Aging's general consumer document on CCRCs shall be provided at least two weeks prior to the signing of the contract.

3. In addition, on the Department's website, there should be a Department checklist of questions and links to different checklists of questions which it is recommended potential subscribers should ask before deciding to reside in a CCRC.

4. Each provider shall include a Table of Contents in the Disclosure Statement.

5. Each provider shall include a corporate structure or organizational chart, as applicable, in the Disclosure Statement.

6. Each provider with a refundable entrance fee shall include in its contract and Disclosure Statement a statement that clearly informs a potential subscriber (1) as to whether the entrance fee refund is secured; and (2) the circumstances under which the entrance fee refund is paid.

7. Each provider shall include a Table of Contents in each CCRC contract.

8. All marketing materials and disclosure statements that advertise a refund of the entrance fees must include a statement or an asterisk that states: "Read the Continuing Care Agreement for conditions that may apply to refunds."

9. Providers shall make the operating budget available to subscribers, upon request, at least 30 days prior to implementation of the budget or budget amendment.

At the June 30, 2010 meeting, the Committee adopted the following recommendations.

10. Each provider shall include with its continuing care agreement a single sheet for the consumer to sign regarding entrance fee refunds, stating that the consumer had received and read the entrance fee refund terms, including appropriate details.

11. If requested by the Department, a provider shall provide to the Department within 15 working days any financial statement prepared in accordance with GAAP of any entity affiliated with the provider to which the Department determines that the provider has directly or indirectly transferred funds in the last five years or plans to transfer funds within the next 12 months. The provider shall also provide, upon request of any subscriber or any prospective subscriber who has paid a deposit, a copy of any financial statement provided within the last three years to the Department pursuant to this provision.

12. A provider's contract and Disclosure Statement will clearly state whether the CCRC is a standalone community or part of a of a larger operation, or whether the funds generated from the resident fees can only be used for purposes of that one community or whether the provider can use funds derived from resident fees for purposes beyond that CCRC facility. If a provider is a standalone community, it must also disclose in its Disclosure Statement any plans to convert its contractual arrangements with future residents so it can use future fees for purposes beyond the CCRC facility.

13. Providers' internal grievance procedures shall provide that subscribers may obtain the assistance and counsel from any person or entity of their choosing, other than unrelated legal counsel, during any stage of the grievance procedure.

14. The internal grievance procedure provision that prohibits the representation of parties during mediation of an internal grievance should be revised to provide the following: The provider and subscriber may be represented by counsel during mediation if both the provider and subscriber agree.

15. The providers' internal grievance procedure shall require that the provider respond in writing regarding its investigation, resolution and decision of the grievance.

16. If a provider has a governing body, at least two of its members shall be subscribers in the community, with staggered terms.

17. If the provider owns or operates more than one community in the state, the governing body membership shall include at least one subscriber from each community.

At its July 7, 2010 meeting, the Committee adopted the following recommendations.

18. Amend the governing body (Board) subscriber nomination process to provide: At a minimum, the governing body (Board) nominating committee shall solicit Board member nominations from all subscribers. All interested subscribers shall submit resumes to the nominating committee. The Board shall select the subscriber board members, who shall be subject to ratification by a majority of the subscribers who vote. The provider's Disclosure Statement shall disclose the process by which subscribers are appointed to the Board.

19. The non-confidential portions of the governing body's minutes of its meetings, or a summary thereof, shall be distributed to subscribers within one month of approval of the governing body's meeting minutes. An approval of a transfer of assets to a related entity is not confidential.

20. Regarding the coordination of benefits of a Type A CCRC community and long-term care insurance policies, the Maryland Department of Aging consumer packets should include a paragraph that encourages policy holders to have their legal or financial advisors review and advise them on the coordination of the CCRC agreement and their long-term care policy.

21. Amend the Disclosure agreement requirements for Type A communities at §10-425(a) to provide: "If an agreement is for a Type A community, an attorney or financial advisor should review any applicable long-term care insurance policy for coverage of services and possible duplication/coordination of benefits."

22. Any changes to the provider's written rules for the community shall be distributed to the current subscribers at least 5 days prior to implementation.

23. Revise and amend §10-425(a)(21) which currently requires that the Disclosure Statement include "a description of the role of any resident association" by adding the following phrase to the end of the sentence "and any MACCRA chapter."

The following recommendations are in response to Secretary Lawlah's request to consider consumer protection issues raised by the 2009 amendments.

24. Revise and amend Section 10-445(a)(1)(v)1 [which currently limits the Department's approval of a provider's continuing care agreement as explained in Exhibit 5] to provide: "If the Department does not approve the agreement, the Department shall notify the provider in writing, including citations to the specific provisions or principles of statutory and common law that the Department determined were not complied with in the agreement."

25. Revise and amend §10-445(a)(ii) and (iv)(1) [which currently limit the Department's follow-up approval authority in the same way], by adding "and other applicable statutory and common law provisions or principles" after "the requirements of this subtitle."

26. Revise and amend §10-445 to add a new 445(d) to provide that "the new 445(d) shall authorize the Department to reexamine continuing care agreements being offered to prospective subscribers, for good cause, at any time."

[N. B. The Refinement Subcommittee made additional recommendations in this regard at Recommendation 3(ii) below.]

B. Refinement of Existing Statutory Language /Policies Subcommittee

At its July 14 and July 29, 2010 meetings, the Committee adopted the following recommendations. (Specific language for some of the recommendations is set out in Exhibit 6.)

1. Assisted Living – Amendment to Health General Article §19-1806 to conform statute to existing practice

2. Assisted Living – Amendment to Health General Article §19-1808 to authorize a CCRC Uniform Disclosure Statement

3. Assisted Living – Amendments to Human Services Article - §10-444 (d) and (e)

(i) Amendments to the "safe harbor" provisions

(ii) Department approval of separate assisted living agreements. [N.B. Separate assisted living and comprehensive care agreements used with Type A and B agreements would be required to be approved by the Department, but separate assisted living and comprehensive care agreements used with Type C agreements would not be required to be approved by the Department.]

4. Assisted Living –Require that the new CCRC Uniform Disclosure Statement be given to the CCRC consumer both (i) with marketing materials prior to entering into a continuing care agreement for an independent living unit and (ii) within the 30 days prior to admission to assisted living.

5. Repeal the Continuing Care additional assisted living "safe harbor" disclosure requirements at §10-425(c) of the Continuing Care Subtitle, with the exception of the explanation of the assisted living program's complaint or grievance procedure

6. Clarify and tighten the transfer of ownership or control statutes by:

(i) amending HSA §10-432

(ii) amending HSA §10-436

(iii) creating a new HSA §10-442

[N.B. (i) tightens the language in HSA §10-432 to prohibit a provider from transferring ownership of a facility without Department approval; (ii) makes clear that a provider does not have to go through both the §10-432 transfer of ownership or control approval process and the §10-436 transfer of assets approval process for the same transaction; and (iii) is intended to clarify that providers still remain subject to the fraudulent conveyance laws.]

C. Financial Matters Subcommittee

At its July 29 and August 4, 2010 meetings, the Committee adopted the following recommendations.

1. Transfer of Assets

A. The threshold for requiring Department approval should be lowered from 10% of total assets to 5% of total assets.

B. The "safe harbor" standards should be revised so the Department will be required to approve transfers over 5% of total assets **only** if it is demonstrated the provider will be able to attain **all three** of the following financial ratios by the end of the third year after the transfer:

- 180 days cash on hand ("DCOH")
- Operating ratio of 1.0
- Debt service coverage of 1.25 (unchanged)

C. The Disclosure Statement shall include disclosure of all net transfers between providers and affiliated entities during each of the past ten years. The same information shall be provided to current subscribers in an annual statement.

2. Operating Reserves

A. The basic operating reserve requirement at §10-420 should be increased from the current 15% of net operating expenses (i.e. roughly 55 DCOH) to 25% of net operating expenses, (i.e. roughly 90 DCOH) effective as of three years from the effective date of the statute. [N.B. In order to allow CCRC's time to accumulate the funds.]

B. Except (i) as otherwise required by contractual obligations undertaken prior to the effective date of the new legislation (tentatively, October 1, 2011) and (ii) as otherwise provided in this provision, the assets held by the provider as its operating reserve may not be hypothecated, pledged as collateral, or otherwise encumbered by the provider in any manner. A provider may encumber assets held in its operating reserve as part of a general security pledge of assets or similar collateralization that is part of the provider's long-term capital debt covenants and is included in the provider's long-term debt indenture or similar instrument, if the funds in the operating reserve are available to the provider to pay operating expenses without substantial restrictions or limitations.

C. Except as in B above, the reserve must be met with unrestricted cash and investments and cannot be met with a line of credit.

D. The operating reserve may be used to meet other bond covenants in order to prevent "stacking" requirements on the provider, i.e., it can be used to meet other liquidity standards.

3. Actuarial Study

Type C communities should be required to have actuarial studies performed every five years. [N.B. Types A and B are required to have actuarial studies every three years.] See Exhibit 7, *Ziegler Capital Markets Z-News*, 7/30/10, "Actuarial Risks Are Not Limited to Type A and B Contracts."

4. Removal of Assets from the State/Obligated Groups across State Lines

Removal of Assets from the State

A. HSA §10-440, Removal of Records and Assets from the State should be amended, so that obligated groups that cross state lines are permitted, provided that the obligated groups meet certain standards (see below), in order to provide safeguards to the subscribers of Maryland CCRCs.

Obligated Group Standards

B. An obligated group may not add or delete a member unless the entire group after the transaction can collectively meet the following requirements:

1. 180 days cash on hand, unless the provider is joining an existing obligated group with an existing DCOH requirement less than 180 days in its bond documents, in which case the obligated group DCOH requirement in the existing bond documents would apply, provided that in no case could the DCOH requirement be less than 120 DCOH;

2. 1.20 debt service coverage ratio;

3 a start-up CCRC cannot enter an obligated group until it has reached a stabilized occupancy, defined as 85% for one full fiscal year, and is in compliance with its covenants.;

4. the existing group is in compliance with all bond covenants;

5. the existing ratings of the group will not be unfavorably impacted;

6. annual audits of the obligated group, in addition to the annual audits for the Maryland CCRC, will be submitted to the Department; and

7. certificates of compliance with the bond documents of the obligated group are submitted to the Department.

C. A Maryland CCRC in an obligated group shall be required to maintain 180 DCOH, except where the Maryland CCRC joined an existing obligated group with an existing DCOH requirement less than 180 days, in which case the Maryland CCRC shall be required to maintain the overall DCOH requirement in the existing bond documents, provided that in no event could the DCOH maintenance requirement for the Maryland CCRC be less than 120 DCOH. [N.B. in a default context, the Maryland CCRC could still be forced to aid the out-of-state facilities, even if doing so caused the DCOH of the Maryland provider to go below the 120 to 180 DCOH requirement.]

D. If the Department determines that it is in the interests of a Maryland CCRC and its subscribers to join an obligated group even though the standards in B and C are not met, the Department may waive any requirement of B and C.

E. MDoA shall establish the procedures under which a CCRC will apply for approval to join or develop an obligated group, including the information to be provided to MDoA and determining which procedures should be adopted by statute versus by regulation.

F. MDoA shall have access to any management studies undertaken pursuant to bond documents by an obligated group with a Maryland provider or a Maryland provider that belongs to an obligated group.

G. The General Assembly may want to investigate the possibility of encouraging the development of an Interstate Compact on CCRCs, similar to that on Insurance, so that, in the long term, there will be some assurance that all or most states regulate CCRCs with appropriate stringency and Maryland subscribers are better safeguarded if the Maryland provider joins an obligated group or otherwise agrees to be liable for the debt of out-of-state CCRC facilities.

5. Entrance Fee Refunds

A. The Disclosure Statement shall include a statement of the number of contractual refunds owed in the last three fiscal years that the provider did not pay when due.

B. The Disclosure Statement shall also include a statement of the number of contractual refunds unpaid a year or more after the resident(s) has/have departed the community, by death or otherwise, as of the close of the most recent fiscal year. The statement shall explain the reasons(s) they remain unpaid, e.g. no successor resident.

6. Guarantee Fund

The issue of a guarantee fund for the CCRC industry should be included in the agenda for the next Advisory Committee, particularly if the CCRC industry expands in Maryland.

D. Additional Motions from Committee Members

The Committee met on August 12, 2010 to permit review of the complete package of recommendations and the internal consistency of the recommendations. Prior to that meeting, additional motions were put forth by individual Committee members and were distributed to the full Committee prior to the meeting. Two additional recommendations were adopted.

Standards for Referral to Financial Review Committee

A study of reasonable financial standards that would require a referral to the Financial Review Committee should be included in the agenda of the next Continuing Care Advisory Committee.

Corporate Parent Financial Information

A provider with a corporate parent shall provide any subscriber or potential subscriber who requests it the most recent financial statement of that parent.

V. CONCLUSION

Continuing care is a unique industry involving aspects of the health care, insurance, hospitality, food services, and housing industries. Achieving the proper regulatory balance is not an easy task. While Maryland's present statutes and regulations are good, we believe the adoption of our recommendations will make them better. We thank you for the opportunity to provide input on Maryland's continuing care regulatory system and look forward to helping you implement our recommendations if you agree with them.

LIST OF EXHIBITS

Exhibit 1 – List of Committee Members

Exhibit 2 – Preliminary List of Issues for CCAC

Exhibit 3 – Subcommittee Member Roster

Exhibit 4 – Subcommittees' Priority Issues

Exhibit 5 -- Secretary Lawlah's April 15, 2010 Letter to Maureen Dove

Exhibit 6 – Specific Statutory Changes Recommended by the Refinement Subcommittee

Exhibit 7 – Ziegler Capital Markets Z-News, August 4, 2010

CONTINUING CARE ADVISORY COMMITTEE

Maureen Mullen Dove, Esquire, *Chair* **Former Deputy Attorney General of Maryland** 713 Winans Way Baltimore, Maryland 21229 (410) 233-7845 mmdove@aol.com	**Arnold Eppel** **Executive Director** **Atrium Village** 4730 Atrium Court Owings Mills, Maryland 21117 (410) 363-0330 aeppel@seniorlifestyle.com
Annette Anselmi, **Executive Director** **Maryland Health and Higher Educational Facilities Authority** 401 East Pratt Street, Suite 1224 Baltimore, Maryland 21202 (410) 837-6220 (Office) (410) 685-1611 (Fax) aanselmi@mhhefa.org	**Jason Alan Frank, Esquire** **Frank, Frank & Scherr** 1400 Front Avenue Suite 200 Lutherville, Maryland 21093-5365 (410) 337-8900 (Office) (410) 337-0031 (Fax) jfrank@frankelderlaw.com
Dwight K. Bartlett, III, F.S.A. **Ginger Cove Resident & Board Member** **Bartlett Consulting Services, Inc.** 2211 River Crescent Drive Annapolis, MD 21401-7718 (410) 266-5759 Dkb3fsa@verizon.net	**Leslie B. Fried, Senior Attorney, American Bar Association's Commission on Law and Aging & Maplewood Park Place Board Member** 740 15th Street, N.W. 8th Floor Washington, D.C. 20005-1022 (202) 662-8684 fried@staff.abanet.org
Dave Bond, F.S.A., M.A.A.A. **Managing Partner of CCRC Actuaries** 415 Main Street Reisterstown, Maryland 21136 (410) 833-4220 dave.bond@ccrcactuaries.com	**Henry M. Greenberg** **Associate State Director, Advocacy** **AARP Maryland** 200 Saint Paul Place Suite 2510 Baltimore, Maryland 21202 (410) 818-9271 hgreenberg@aarp.org
Barbara Marx Brocato **Barbara Marx Brocato & Associates** 18 Pinkney Street Annapolis, Maryland 21401 (410) 269-1503 (Office) (410) 269-5021 (Fax) barbara@bmbassoc.com	**Yolanda V. Johnson** **Executive Director** **Glen Meadows Retirement Community** 11630 Glen Arm Road Glen Arm, Maryland 21057-9403 (410) 319-5122 (Office) (410) 592-9824 (Fax) yjohnson@presbyterianseniorliving.org

Exhibit 1

Danna Kauffman **Sr. Vice President of Public Policy** **LifeSpan Network** 10280 Old Columbia Road # 220 Columbia, Maryland 21046 (410) 381-1176 (Work) dkauffman@lifespan-network.org	**Tinna Quigley** **Director of Government Relations** **& Policy Development** **Maryland Insurance Administration** 200 Saint Paul Place, Suite 2700 Baltimore, Maryland 21202 (410) 468-2013 tquigley@mdinsurance.state.md.us
Samuel C. Keiter, **Buckingham's Choice Resident &** **Association President (BCRA)** 7082 Upland Ridge Drive Adamstown, Maryland 21710 (301) 644-1426 samck@edurostream.com	**William A. Root** **Asbury Methodist Village Resident &** **MACCRA President** 419 Russell Avenue, No. 214 Gaithersburg, Maryland 20877 (301) 987-6418 wroot@aol.com
Senator Delores G. Kelley **District 10, Baltimore County** 302 James Senate Office Bldg. 11 Bladen St. Annapolis, Maryland 21401 (410) 841-3606 Delores.Kelley@senate.state.md.us	**Stuart P. Rosenthal** **Chair, Maryland Commission on Aging** **Publisher, The Beacon** **President, North American Mature Publishers Association** 1220 Arcola Avenue Silver Spring, Maryland 20902 (301) 754-0470 (Home) (301) 949-9766 (Work) stuart@TheBeaconNewspapers.com
Donna Mason **Executive Director** **Riderwood Village Retirement Community** 3150 Gracefield Road Silver Spring, Maryland 20904 (301) 572-8301 (Office) (301) 572-8489 (Fax) Dmason@erickson.com	**Anthony R. Sarmiento** **President and Executive Director** **Senior Service America Inc.** 8403 Colesville Road, Suite 1200 Silver Spring, Maryland 20910 (301) 578-8469 (Office) tsarmiento@ssa-i.org
Rose Matricciani, Esquire **Whiteford, Taylor & Preston, LLP** Seven Saint Paul Street Baltimore, Maryland 21202-1626 (410) 347-9476 (Office) (410) 234-2355 (Fax) matricciani@wtplaw.com	**Donna Taylor, NHA** **Executive Vice President for Operations** EMA 576 Johnsville Road Eldersburg, MD 21784 (410) 970-2050 (Office) taylord@emaseniorcare.org
Ted Meyerson, President **United Seniors of Maryland** 13412 Green Hill Court Highland, Maryland 20777 (301) 854-2971 tedmeyerson@verizon.net	

Preliminary List of Issues for the Continuing Care Advisory Committee
August 2009

1. Transfer of Assets

Should changes be made in the statutes and regulations regarding transfers of assets? (Human Services Article ("HSA") §§10-436—438 and COMAR 32.02.01.23:)

Given that a hypothetical provider may have "total assets" of $100 Million (consisting mostly of mortgaged real estate) but "total net assets" of only $10 Million and liquid assets of only $5 Million, should the statutes continue to permit the provider to transfer or give away 10% of its "total assets" annually without Department approval, or should the statutory benchmark for requiring Department approval be set at a much lower level? For example, should the benchmark for requiring Department approval be something like transfers in a one-year period of the greater of 10% of "total net assets" or 1% of annual operating expenses?

For transfers above the statutory benchmark for Department approval (currently 10% of total assets), should the COMAR 32.02.01.23E standard mandating Department approval of transfers be raised to a safer level?

2. Changes in Ownership and Control

Should the provisions at HSA §10-432 be clarified as to when the statutes regarding changes in ownership and control apply? (Providers and the Department have found it difficult to determine when these laws apply.)

3. Removal of Assets from the State

Should HSA §10-440, regarding removal of assets from the State, be revised to reflect modern banking and financial practices?

Should the statute be amended to specifically prohibit Maryland CCRC assets and facilities from being mortgaged or encumbered for the benefit of out-of-state facilities?

4. Escrow Requirements for the Development of New Units

Should the escrow requirements for new development be clarified? (HSA §§10-410, 10-412(f) and 10-444(b)(21).) Should the statute specifically require Department approval as well as certain certifications by the provider to the escrow agent in order to obtain a release of funds from escrow?

5. Operating Reserve Requirement

Maryland law requires providers to maintain approximately two months of cash operating expenses in liquid assets as an operating reserve. (HSA §§10-420-422 and COMAR

Exhibit 2

32.02.01.20). The intent of this law was to try to ensure there will be some monies available to support the operations should the community experience a cash shortfall. The law does not require this account to be escrowed nor does it prohibit the account from being pledged as collateral for a loan. The Department has encountered two problems with this law as it is written.

First, if the CCRC gets into financial trouble, the lender may take any pledged liquid collateral. In one Maryland community experiencing significant financial difficulty, the lender did exactly this and the community was left with very little cash to provide services to its subscribers.

Second, it is misleading to consumers because they assume this account is available to help the community in times of financial difficulty when it may have been pledged to a lender that may take it upon default.

6. Entrance Fee Refunds

Refundable contracts are frequently chosen by subscribers entering CCRCs. These contracts offer varying degrees of refundability (50%, 90%, 100% etc.). Generally, there are contractual conditions that must be met for a subscriber to be eligible for a refund to include termination of the contract (usually met by the death of the subscriber) and receipt of an entrance fee for the independent living unit the subscriber lived in. Once these conditions are met, refunds will be due within a short timeframe (i.e. 60 days). In cases where a subscriber is permanently moved to a higher level of care, the independent living unit is resold and the new entrance fee received goes into the operating cash of the CCRC. When the subscriber dies several years later, contractually they are due a refund.

When a community is experiencing cash flow difficulties, although they have received an entrance fee, they may have used the new entrance fee for other CCRC needs and may not have the monies available to repay the entrance fee as contractually required.

7. Assisted Living Laws Related to CCRCs

Should changes be made in the assisted living laws related to CCRCs (since the assisted living laws were originally passed in 1996, there have been ongoing difficulties in coordinating the relationship between the assisted living and continuing care laws)?

Should comprehensive changes be made, should the assisted living disclosure statement laws be amended, and/or should the Department of Health and Mental Hygiene be asked to change its HSA §10-444(e)(2)(iv) list of assisted living services? (HSA §§10-425(c) and 10-444(e) and Health General Article §19-1806(e)(2).)

William A. Root, President
Maryland Continuing Care Residents' Association
419 Russell Avenue #214, Gaithersburg MD 20877
Tel. 301987 6418; email waroot@aol.com

September 4, 2009

Debra Roane, Chief, Continuing Care, Department of Aging
301 West Preston Street Suite 1007, Baltimore MD 21201-2374

Dear Debra:

Thank you for your letter of August 27 re Continuing Care Advisory Committee.

Two of the issues on the Department's preliminary list and MaCCRA's top priority issue on defining "financial difficulty" mention regulations as well as legislation. The Secretary's announcement of the decision to convene a CCAC referred only to a review of legislation. The CCAC must recognize the relevance of regulations to legislative issues for which regulations are needed to add substance. However, it is suggested that the CCAC postpone time-consuming deliberation concerning regulatory details until after agreement is reached on the related legislative changes.

MaCCRA proposes the following issues for consideration by the Committee:

1. Definition of "financial difficulty": This is MaCCRA's first priority. There are now no effective objective standards for determining when a financial difficulty exists. That is the case whether review takes place in connection with renewal of a certificate of registration, transfer of ownership, or transfer of assets. The financial standards for transfer of assets established per 10-438(d)(1) are ineffective. This is because, under the regulations, only one of three standards need be met; under the law's escape clause in 10-438(d)(3), none need be met; other standards should also be considered; and the standards should also apply to certificate renewal and transfer of ownership. A finding of "financial difficulty" defined in this manner should not require counter-productive publicity, such as the requirement in 10-467(c)(1). That should be required only on the basis of a finding of an undefined "imminent risk of financial failure."

2. Grievance procedure: The following constitutes MaCCRA's second priority. A panel of subscribers to assist a grievant should be authorized. This panel could be designated by the subscriber association established pursuant to 10-444(b)(15). The law should require that resolution of a grievance by a provider be in writing.

3. Other issues: The following additional issues are MaCCRA's third priority. They are not listed in a priority order within this third priority. At the head of the list are variations of the issues on the Department's preliminary list. Those listed thereafter are in the order

where they first appear in the law.

a. Transfer of assets (DoA #1): MaCCRA suggests the threshold for required Department approval be changed from 10% of total assets to 10% of liquid assets or 10% of unimproved land or 10% of other real property.

b. Changes in Ownership and Control (DoA #2): MaCCRA suggests that the definition of "provider" include any entity with ultimate authority or right to control a CCRC in Maryland.

c. Entrance Fee Refunds (DoA #6): It is proposed that the possibility that monies may not be available for entrance fee refunds because of subordination to bond holder claims be addressed under MaCCRA's first priority on definition of financial difficulty.

d. Long-term financing 10-412(c)(1)(vii) and 10-425(a)(11): The law's requirement for a commitment to long-term financing should take into consideration the availability of entrance fees to cover capital costs. The disclosed description of such financing should include a projection of the adequacy of funds to pay refunds of entrance fees in addition to pay debt principal when due.

e. Timely and comprehensive disclosure 10-425(a)(10, 15, and 21): Financial statements should be disclosed no later than four months after the end of the fiscal year and should include those pertaining to all entities of a multi-site provider having authority to transfer funds from one entity to another. The requirement to disclose a renewal and replacement fund should recognize the relevance of amortized entrance fees as revenue and depreciation as expenditure on financial statements. The requirement to disclose a resident association should include a subscriber association established per10-444(b)(15).

f. Subscriber input 10-427(a)(1, 3, 4): The governing body should include at least two subscribers as members in order to provide continuity. These members should present recommendations to the governing body from the association established pursuant to 10-444(b)(15) and inform that association of non-confidential actions of the governing body. These members should be selected by an election of subscribers organized by that association unless there is no such association or it chooses not to organize an election. The governing body should be required to confer with that association if there is one.

g. Appeals 10-435(c), 10-438(d): Subscriber representatives chosen by subscribers should be permitted to appeal decisions by the Department re transfers of ownership or of assets.

h. Use of fees 10-444(b)(22): Fees collected from a subscriber should be used only for services to be provided to that subscriber.

Sincerely,

William A. Root

LIFESPAN NETWORK

September 24, 2009

SENT VIA EMAIL

The Honorable Gloria L. Lawlah
301 West Preston Street
Suite 1007
Baltimore, Maryland 21201

Dear Secretary Lawlah:

On behalf of our continuing care retirement community (CCRC) members, LifeSpan Network appreciates the opportunity to submit our recommendations for topics that should be considered by the newly-formed Continuing Care Advisory Committee. As in all other businesses, the impact of the nation's financial crisis has challenged the continuing care retirement industry over the last year. Declining housing valuations and investment portfolios have manifested in lower occupancy levels as seniors delay the decision to enter a CCRC. A weakened credit market has also limited access to capital. However, as the financial crisis continues to abate, the demand for services will increase along with the growing senior population.[1] Maryland must be able to meet the demands and service needs of our retiring baby boomers.

During this time, Maryland must ensure that the regulatory environment provides CCRCs with the needed flexibility to respond to the fiscal climate and changing marketplace, including the ability to keep costs down and compete with communities in neighboring states, as well as improve their existing campuses. Maryland does not want to create a scenario where the regulatory climate makes it more affordable for either seniors to choose a CCRC in another state or CCRCs to make the decision to build in other states or that the improvement and expansion of existing communities is stymied. In keeping Maryland competitive with other states and fostering strong CCRCs here, we should also look at ways to maintain efficiencies in State government and save costs, both to the State and to the communities. We believe that these goals can be achieved without overly-

[1] As you know, Maryland's 65 and over population is the fastest growing segment of Maryland's population, far exceeding growth in other age groups. By 2030, the over 65 population is expected to more than double, reaching approximately 1.3 million individuals. Since CCRCs serve a population comprised of individuals commencing at age 60, Maryland's CCRCs will serve a vital role in providing necessary housing and health care services to this growing population.

restricting the business practices of CCRCs while at the same time maintaining consumer protections and the quality of services offered.

Therefore, in reviewing the topic lists submitted by both the Department of Aging and the Maryland Association of Continuing Care Residents, we believe that the two lists are inclusive of topics that are appropriate for discussion. LifeSpan would like to add the following issues:

- The use of consultants in the initial and renewal application process to determine whether greater efficiencies could be achieved;
- The public information laws for CCRCs and whether they differ from the public information laws for other business and if changes would be appropriate;
- The ability of a CCRC to discharge a resident when it has been determined that the resident poses a risk to the health and safety of other individuals, including staff;
- A review of the regulations and statute to determine consistency and uniformity between the two.

Again, LifeSpan appreciates the opportunity to participate on the Continuing Care Advisory Committee. We look forward to a robust discussion on the submitted topics. If you have any questions, please do not hesitate to contact Danna Kauffman at dkauffman@lifespan-network.org or at 410-279-5572. Thank you.

Sincerely,

Danna J. Kauffman

Danna Kauffman
Sr. Vice President of Public Policy

7082 Upland Ridge Drive
Adamstown, MD 21710
September 25, 2009

Debra A. Roane, Chief, Continuing Care
Maryland Department of Aging
301 West Preston Street, Suite 1007
Baltimore, MD 21201-2374

Re: Continuing Care Advisory Committee

Dear Ms. Roane:

Thank you for your letter of August 27 and the enclosed preliminary list of issues. I look forward to meeting with you again on October 1.

Changed Face Of The Industry: I believe that above all the CCAC should consider what changes in existing law are needed in the light of the shift in the industry from independent CCRCs to CCRC families. The objectives should be to ensure that the purposes of the existing legislation are still being attained and to protect the residents ("subscribers") at each CCRC. We all know, from experience with for-profit multi-site corporations (GM, for example), that what management thinks is good for the corporation may be disastrous for a particular site, its workers (and/or residents), and the surrounding community.

Possible specifics include:

A clause specifying that those who control a provider are bound by requirements placed by law on the provider: There should be no possibility that a provider could avoid those requirements on the excuse that its parent, or other controller, had so ordained.

Tightened Requirements for Transfers of Assets: The corporate parents of CCRC families take pride in treating the family as a single unit. Thus they may be tempted to use one subsidiary to fund others. While some forms of this, e.g., loans with adequate protections from one subsidiary to another, or even to the parent, may be acceptable, large-scale transfers of assets are not. And under existing law large-scale transfers of assets, especially liquid assets over a period of a few years, are entirely possible.

Disclosure of the Parent's, and Entire Family's, Finances: Again, the move toward treating the family as a single unit requires such disclosure in order to have a complete picture. Otherwise the interested resident is in the position of the blind man trying to discern an elephant on the basis of feeling one part of its body. The need is further increased by the fact that the parent provides services to each subsidiary under non-arms-length agreements. Currently, while those services amount to a significant proportion of total expenses (often 15%, more of cash expenses), no breakdown of the charge is available.

Definition of "Possible Financial Difficulty":

Current law provides for findings of financial difficulty at three levels, "possible financial difficulty", "financial difficulty", and "financial difficulty with a significant risk of financial failure". Though the Department may refer a finding of "possible financial difficulty" to the Financial Review Committee for advice on whether or not to proceed to a more serious finding, it apparently has the authority to proceed to a more serious finding without seeking the Financial Review Committee's advice.

None of the three levels is defined, but the problem is at the first stage. This should be a sort of early warning system, intended to alert the provider that its finances at minimum need a closer look, and perhaps begin Financial Review Committee consideration. But without any definition of "possible financial difficulty", the tendency is to put off pulling the alarm until the situation is truly serious, and perhaps irretrievable. Once "possible financial difficulty" has been determined, the Department and/or the Committee can look more closely at the situation, taking special situations into account and looking at various tests as a single constellation, to determine whether or not a finding of "financial difficulty" or even "risk of financial failure" is warranted. One possible definition for "possible financial difficulty" would be Days Cash on Hand < 150 days (per CARF's 2004 edition), OR Total Excess Margin Ratio </= zero, OR Current Debt Service Coverage Ratio < 1.25 OR Maximum Debt Service Coverage Ratio < 1.10, OR it appears that available funds may not be sufficient to cover entrance fee refunds when due.

Removal of Assets from the State:

In addition to the considerations mentioned in the Department's list, It is important to ensure that CCRC assets are not removed from the State without Department approval simply by using the CCRC's parent (or other related entity) as a conduit.

You will have noticed some additional overlap between this list and the Department's. In addition, I strongly support including both Operating Reserve Requirement and Entrance Fee Refunds on the Committee's agenda.

I look forward to the Committee's discussions.

Sincerely,

Sam Keiter

Samuel C. Keiter
President
Buckingham's Choice Residents' Association

Continuing Care Advisory Committee

Subcommittee Member Roster

Financial Matters Subcommittee

Chair – David Bond
MDoA Staff – Debra Roane

Members
Annette Anselmi
Dwight Bartlett
Yolanda Johnson
Danna Kauffman
Senator Delores Kelley
William Root

Subscriber Rights Subcommittee

Chair – Leslie Fried
MDoA Staff – Marty Roach

Members:
Barbara Brocato
Jason Frank
Sam Keiter
Donna Mason
Ted Meyerson
Stuart Rosenthal
Donna Taylor

Refinement of Existing Statutory Language/Policies Subcommittee

Chair - Rose Matricciani
MDoA Staff – George Hughes

Members:
Arnold Eppel
Henry Greenberg
Tinna Quigley
Anthony Sarmiento

Exhibit 3

2009 Continuing Care Advisory Committee, Subcommittees' Priority Issues:

A. Financial Matters Subcommittee

1. Transfer of Assets

The laws and regulations addressing asset transfers under 10% of total assets and over 10% of total assets will be reviewed, including: notifications to the Department of transfers; the 10% of total assets law; and the "safe harbor" regulations.

2. Removal of Assets from the State

The subcommittee will consider whether the law prohibiting removal of assets from the State except in very narrow circumstances should be changed and whether to allow the creation of obligated groups across state lines.

3. Operating Reserve Requirement

The current operating reserve requirement is only 55 days cash on hand and because it can be pledged or liened, it may not be available for residents in case of a default. The subcommittee will consider the appropriate size of the reserve, whether pledging the reserve should be prohibited, or if it is allowed, whether the fact that it is pledged should be disclosed.

4. Entrance Fee Refunds

Generally, if the contract offers an entrance fee refund, the refund does not have to be paid until the subscriber's unit has been reoccupied and a new entrance fee has been received. Where a subscriber has permanently moved to a higher level of care and a new entrance fee has been received for the subscriber's previous unit, the subcommittee will consider whether a portion of the new entrance fee should be placed in escrow so that it is available to refund to the resident when the resident dies and the refund is due. The broader discussion included refunds based on occupancy rates and passage of time.

5. Requirement of Actuarial Studies for Type C Contract Communities.

Under current regulation, communities offering Type A and B contracts are required to have an actuarial study conducted and submitted to the Department every three years. Type C communities are exempt from this requirement. The subcommittee will consider whether the actuarial study requirement should be extended to Type C communities. The subcommittee chair, Dave Bond, recused himself from all discussion of this subject,

Exhibit 4

since his company performs actuarial studies for CCRC's and he believes he may have a conflict of interest.

B. Refinement of Existing Statutory Language/Policies Subcommittee

The subcommittee decided to concentrate its efforts in two areas.

1. Changes of Ownership and Control

The subcommittee felt that the change of ownership/control statute at HSA § 10-432 is a priority issue that should be addressed. There are broad issues as to whether factual situations that fit within the four corners of the statute are also subject to additional statutes, including the transfer of asset statutes (§§10-436—438) and fraudulent conveyance laws. There are also internal issues within the statutes, such as (i) whether transfers of facility ownership are too lightly regulated, (ii) whether changes in ownership and control are too unclearly regulated, and (iii) whether the statutes should be clarified as to when they apply, including the scope of the reorganization exception at §10-432(a). The issue of those who control the provider taking money out of the provider seems to be a transfer of assets issue that will be addressed by the Financial Subcommittee, so this subcommittee will not.

2. Assisted Living Laws Related to CCRCs

There are tough and long-standing issues related to assisted living programs at continuing care facilities and the subcommittee will need to involve others in the discussions to resolve them successfully, but these issues currently cause much confusion to providers. Historic and still evolving problems involving the relationship between the assisted living and continuing care laws include (i) the new OHCQ Uniform Disclosure Statement requirements, (ii) conflicts between the Uniform Disclosure Statement list of services and DHMH's HSA §10-444(e)(2)(iv) list of services, (iii) difficulties in complying with HSA §10-444(e), including various problems in using the HSA §10-444(e)(2)(iv) list of services, and (iv) the appropriateness of the additional disclosure requirements in HSA §10-425(c).

The ideal approach may be to have a special set of rules for Assisted Living ("AL") contract terms and disclosure statements at CCRCs. Given that DHMH regulates AL, the subcommittee will need to request that DHMH agree to work together on these issues.

C. Subscriber Rights Subcommittee

1. Timely and Comprehensive Disclosure of Financial Information, including Information on Related Entities

This topic will be addressed, along with the issues of "Notice" and "Required Information in Marketing Materials."

2. Grievance Procedures

The issues to be considered will be (1) whether a panel of subscribers should be set up at each CCRC to help residents file their grievances; and (2) whether the provider should be required to issue grievance decisions in writing.

3. Subscriber Input

This subject concerns subscribers' input on the provider's governing body or board of directors, and information that should be provided about board meetings. The subcommittee will consider whether:

(a) the Board of Directors or governing body should include two of the provider's subscribers, with staggered terms;

(b) the subscriber Board Members should be obligated to inform the subscribers' association of non-confidential actions of the governing body;

(c) the subscriber Board Members should be elected by the subscribers' association, if there is one; and

(d) the governing body should be required to distribute written minutes to the subscribers.

4. Coordination of Benefits with Long-Term Care Insurance at Type A Communities

Because Type A communities provide much the same benefits as long-term care insurance, prospective residents should be advised to consider this, perhaps through disclosure during marketing.

5. Subscriber Appeals

Should residents have standing to appeal a decision of the MDoA on a proposed sale or transfer of assets of the provider?

6. Resident Discharge Requirements

One of the four reasons for which a subscriber may be involuntarily discharged is when the health status or behavior of the resident is a danger to the subscriber or other subscribers. The subcommittee will consider whether this should be expanded to include staff members and employees, and perhaps others.

7. Maryland Continuing Care Residents Association

The subcommittee will discuss a concern that some communities do not permit MaCCRA to have a meeting room and to place notices of upcoming meetings throughout the community.

Martin O'Malley
Governor

Anthony G. Brown
Lt. Governor

Gloria Lawlah
Secretary

MARYLAND DEPARTMENT OF AGING

Choice, Independence and Dignity for Older Marylanders

April 15, 2010

Maureen Mullen Dove, Esquire, Chair
Continuing Care Advisory Committee
713 Winans Way
Baltimore, Maryland 21229

Dear Ms. Dove:

On behalf of the Maryland Department of Aging, I want to again thank you and the other members of the Continuing Care Advisory Committee for your service to the State of Maryland. I know that the Committee is working hard on a number of issues of importance to continuing care providers and seniors. However, I respectfully request that the Committee also consider the additional issues outlined below, which have become apparent to the Department over the last nine months.

The Department was recently requested to report to the Public Health & Long-Term Care Subcommittee of the House Health and Government Operations Committee on the implementation of Chapter 750 of the Laws of 2009 (House Bill 952). A copy of the "enacted" portion of that chapter is enclosed (for environmental purposes we have not included the 75 pages of the original bill that were stricken), along with a copy of my written submission to the Subcommittee. As you will see from the written submission, several changes made by Chapter 750 to streamline the contract review process seem to have also unintentionally reduced consumer protections. Accordingly, as I indicated to the Public Health & Long-Term Care Subcommittee, I am requesting the Continuing Care Advisory Committee to consider whether there are consumer protection issues arising from Chapter 750 that need to be addressed, while bearing in mind the importance of prompt review of submissions of continuing care agreements.

While the CCAC's plate is full, it would be greatly appreciated if the CCAC would consider this request.

Sincerely,

Gloria Lawlah
Secretary of Aging

Enclosures
cc: James W. Hubbard, Chair, Public Health & Long-Term Care Subcommittee
Danna Kaufman, LifeSpan
Debra A. Roane, Chief, Continuing Care
Jeffrey H. Myers, Assistant Attorney General

Exhibit 5

CHAPTER 750

(House Bill 952)

AN ACT concerning

Continuing Care ~~– Department of Aging and Maryland Insurance Administration – Transfer of Oversight~~ Agreements and Related Agreements

~~FOR the purpose of transferring oversight of continuing care from the Department of Aging to the Maryland Insurance Administration; requiring the Administration, in consultation with certain groups, to conduct a certain review and to provide a certain report to the General Assembly on or before a certain date; making certain stylistic and technical changes; requiring the publisher of the Annotated Code of Maryland to make certain corrective changes; providing for the effective date of certain provisions of this Act; providing for the termination of certain provisions of this Act; and generally relating to the oversight of continuing care.~~

FOR the purpose of requiring the Department of Aging to review and approve or disapprove certain continuing care agreements and any other related agreements within a certain number of days; authorizing the Department to submit comments to or request additional information from a provider who has submitted certain agreements to the Department; providing for the suspension of a certain review period; requiring the Department to provide a certain written notice to certain providers if the Department does not approve a certain agreement; providing for a certain appeal under certain circumstances; requiring the Department to limit its review of certain modifications to certain agreements in a certain manner; providing that certain providers are not required to submit certain agreements or requests for modification to the Department for approval; and generally relating to the oversight of continuing care.

BY repealing and reenacting, with amendments,
Article – Human Services
Section 10–445
Annotated Code of Maryland
(2007 Volume and 2008 Supplement)

~~BY transferring~~
~~Article – Human Services~~
~~Section 10–401 through 10–405 and the part "Part I. Definitions; General Provisions"; 10–407 through 10–416 and the part "Part II. Continuing Care in a Retirement Community – Certificates of Registration"; 10–419 through 10–429 and the part "Part III. Providers"; 10–432 through 10–441 and the part "Part IV. Facilities and Assets"; 10–444 through~~

~~10-450 and the part "Part V. Continuing Care Agreements"; 10-453 through 10-460 and the part "Part VI. Continuing Care at Home"; 10-463 through 10-469 and the part "Part VII. Financial Review"; 10-472 through 10-493 and the part "Part VIII. Delinquency Proceedings"; and 10-496 through 10-499 and the part "Part IX. Prohibited Acts; Penalties; Remedies", and the subtitle "Subtitle 4. Continuing Care", respectively~~

~~Annotated Code of Maryland~~

~~(2007 Volume and 2008 Supplement)~~

~~to be~~

~~Article - Insurance~~

~~Section 30-101 through 30-105 and the subtitle "Subtitle 1. Definitions; General Provisions"; 30-201 through 30-210 and the subtitle "Subtitle 2. Continuing Care in a Retirement Community - Certificates of Registration"; 30-301 through 30-311 and the subtitle "Subtitle 3. Providers"; 30-401 through 30-410 and the subtitle "Subtitle 4. Facilities and Assets"; 30-501 through 30-507 and the subtitle "Subtitle 5. Continuing Care Agreements"; 30-601 through 30-608 and the subtitle "Subtitle 6. Continuing Care at Home"; 30-701 through 30-707 and the subtitle "Subtitle 7. Financial Review"; 30-801 through 30-822 and the subtitle "Subtitle 8. Delinquency Proceedings"; and 30-901 through 30-904 and the "Subtitle 9. Prohibited Acts; Penalties; Remedies", and the title "Title 30. Continuing Care", respectively~~

~~Annotated Code of Maryland~~

~~(2006 Replacement Volume and 2008 Supplement)~~

~~BY repealing and reenacting, with amendments,~~

~~Article - Insurance~~

~~Section 30-101, 30-102, 30-103, 30-105, 30-201, 30-202, 30-203, 30-204, 30-205, 30-206, 30-207, 30-208, 30-209, 30-210, 30-302, 30-303, 30-304, 30-305, 30-306, 30-307, 30-309, 30-311, 30-401, 30-402, 30-403, 30-404, 30-405, 30-406, 30-407, 30-409, 30-410, 30-501, 30-502, 30-503, 30-601, 30-602, 30-603, 30-604, 30-605, 30-606, 30-607, 30-608, 30-701, 30-702, 30-703, 30-704, 30-705, 30-706, 30-707, 30-801, 30-802, 30-803, 30-804, 30-805, 30-806, 30-807, 30-808, 30-809, 30-810, 30-813, 30-814, 30-816, 30-817, 30-818, 30-819, 30-820, 30-821, 30-822, 30-901, 30-902, 30-903, and 30-904~~

~~Annotated Code of Maryland~~

~~(2006 Replacement Volume and 2008 Supplement)~~

~~(As enacted by Section 1 of this Act)~~

~~BY repealing and reenacting, with amendments,~~

~~Article - Insurance~~

~~Section 30-102~~

~~Annotated Code of Maryland~~

~~(2006 Replacement Volume and 2008 Supplement)~~

~~(As enacted by Chapter 503 of the Acts of the General Assembly of 2007 and Section 1 of this Act)~~

~~SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 10-401 through 10-405 and the part "Part I. Definitions; General Provisions"; 10-407 through 10-416 and the part "Part II. Continuing Care in a Retirement Community – Certificates of Registration"; 10-419 through 10-429 and the part "Part III. Providers"; 10-432 through 10-441 and the part "Part IV. Facilities and Assets"; 10-444 through 10-450 and the part "Part V. Continuing Care Agreements"; 10-453 through 10-460 and the part "Part VI. Continuing Care at Home"; 10-463 through 10-469 and the part "Part VII. Financial Review"; 10-472 through 10-493 and the part "Part VIII. Delinquency Proceedings"; and 10-496 through 10-499 and the part "Part IX. Prohibited Acts; Penalties; Remedies", and the subtitle "Subtitle 4. Continuing Care", respectively, of Article – Human Services of the Annotated Code of Maryland be transferred to be Section(s) 30-101 through 30-105 and the subtitle "Subtitle 1. Definitions; General Provisions"; 30-201 through 30-210 and the subtitle "Subtitle 2. Continuing Care in a Retirement Community – Certificates of Registration"; 30-301 through 30-311 and the subtitle "Subtitle 3. Providers"; 30-401 through 30-410 and the subtitle "Subtitle 4. Facilities and Assets"; 30-501 through 30-507 and the subtitle "Subtitle 5. Continuing Care Agreements"; 30-601 through 30-608 and the subtitle "Subtitle 6. Continuing Care at Home"; 30-701 through 30-707 and the subtitle "Subtitle 7. Financial Review"; 30-801 through 30-822 and the subtitle "Subtitle 8. Delinquency Proceedings"; 30-901 through 30-904 and the subtitle "Subtitle 9. Prohibited Acts; Penalties; Remedies"; and the title "Title 30. Continuing Care", respectively, of Article – Insurance of the Annotated Code of Maryland.~~

SECTION ~~2. AND BE IT FURTHER ENACTED~~ 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – ~~Insurance~~ Human Services

10–445.

(a) (1) (I) If a provider's feasibility study has been approved under § 10–409 of this subtitle, the Department [shall decide whether to approve a continuing care agreement within 180 days after receipt of a complete agreement], **WITHIN 120 DAYS AFTER RECEIPT OF A CONTINUING CARE AGREEMENT OR ANY OTHER RELATED AGREEMENT SUBMITTED BY A PROVIDER, SHALL DETERMINE WHETHER THE AGREEMENT COMPLIES WITH THE REQUIREMENTS OF THIS SUBTITLE.**

(II) AT ANY TIME DURING THE REVIEW PROCESS, THE DEPARTMENT MAY SUBMIT COMMENTS TO OR REQUEST ADDITIONAL INFORMATION FROM THE PROVIDER TO DETERMINE WHETHER THE AGREEMENT COMPLIES WITH THE REQUIREMENTS OF THIS SUBTITLE.

(III) IF THE DEPARTMENT SUBMITS COMMENTS OR A REQUEST FOR ADDITIONAL INFORMATION UNDER SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE 120–DAY REVIEW PERIOD UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH IS SUSPENDED.

(IV) ON RECEIPT OF ANY REQUESTED INFORMATION OR MODIFICATIONS TO THE AGREEMENT NECESSITATED BY THE DEPARTMENT'S COMMENTS UNDER SUBPARAGRAPH (III) OF THIS PARAGRAPH, THE DEPARTMENT, WITHIN THE NUMBER OF DAYS REMAINING IN THE 120–DAY REVIEW PERIOD, SHALL:

1. COMPLETE ITS REVIEW TO DETERMINE WHETHER THE AGREEMENT MEETS THE REQUIREMENTS OF THIS SUBTITLE; AND

2. APPROVE OR DISAPPROVE THE AGREEMENT.

(V) 1. IF THE DEPARTMENT DOES NOT APPROVE THE AGREEMENT, THE DEPARTMENT SHALL NOTIFY THE PROVIDER IN WRITING, INCLUDING CITATIONS TO THE SPECIFIC PROVISIONS OF LAW THAT THE DEPARTMENT DETERMINED WERE NOT COMPLIED WITH IN THE AGREEMENT.

2. A PROVIDER MAY APPEAL THE DISAPPROVAL OF AN AGREEMENT UNDER SUBPARAGRAPH (IV) OF THIS PARAGRAPH UNDER THE PROVISIONS OF TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE.

(2) If the Department does not act within [180] 120 days, the agreement is deemed approved.

(b) The provider shall maintain the continuing care agreement at the facility and make it available for inspection by the Department of Health and Mental Hygiene under Title 19, Subtitle 18, of the Health – General Article AND TITLE 10, SUBTITLE 3 OF THE HEALTH – GENERAL ARTICLE.

(C) IF A PROVIDER IS SEEKING APPROVAL FOR A MODIFICATION TO AN APPROVED CONTINUING CARE AGREEMENT OR OTHER RELATED AGREEMENT, THE DEPARTMENT SHALL LIMIT ITS REVIEW TO:

(1) THE SECTION OF THE AGREEMENT BEING MODIFIED AND ANY SECTIONS DIRECTLY AFFECTED BY THE MODIFICATION; AND

(2) ANY SECTION OF THE AGREEMENT THAT MAY HAVE BEEN AFFECTED BY A CHANGE IN THE LAW OR A REGULATION THAT WAS ENACTED AFTER THE DEPARTMENT APPROVED THE AGREEMENT.

(D) IF THE PROVIDER EXECUTES A SEPARATE ASSISTED LIVING AGREEMENT OR COMPREHENSIVE CARE AGREEMENT, THE PROVIDER IS NOT REQUIRED TO SUBMIT THE ASSISTED LIVING AGREEMENT OR COMPREHENSIVE CARE AGREEMENT OR ANY REQUESTS FOR MODIFICATIONS TO THE DEPARTMENT FOR APPROVAL.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2009.

~~20-101.~~

~~(a) In this [subtitle] TITLE the following words have the meanings indicated.~~

~~(b) "Assisted living program" has the meaning stated in § 19-1801 of the Health - General Article.~~

~~(c) "Certified financial statement" means a complete audit prepared and certified by an independent certified public accountant.~~

~~(d) "Continuing care" means:~~

~~(1) continuing care in a retirement community; or~~

~~(2) continuing care at home.~~

~~(e) "Continuing care agreement" means an agreement between a provider and a subscriber to provide continuing care.~~

~~(f) (1) "Continuing care at home" means providing medical, nursing, or other health-related services directly or by contractual arrangement:~~

~~(i) to an individual who is at least 60 years of age and not related by blood or marriage to the provider;~~

~~(ii) for the life of the individual or for a period exceeding 1 year; and~~

~~(iii) under a written agreement that requires a transfer of assets or an entrance fee notwithstanding periodic charges.~~

~~(2) "Continuing care at home" includes providing assistance with the physical maintenance of the individual's dwelling.~~

~~(g) "Continuing care in a retirement community" means providing shelter and providing either medical and nursing or other health-related services or making~~

~~streamlining and simplifying the continuing care process. On or before January 1, 2010, the Administration shall report, in accordance with § 2-1246 of the State Government Article, to the Governor and General Assembly on the review and any changes or actions taken as a result of the review.~~

~~SECTION 6. AND BE IT FURTHER ENACTED, That the publisher of the Annotated Code of Maryland, in consultation with and subject to the approval of the Department of Legislative Services, shall correct, with no further action required by the General Assembly, cross-references and terminology rendered incorrect by this Act or by any other Act of the General Assembly of 2009 that affects provisions enacted by this Act. The publisher shall adequately describe such correction in an editor's note following the section affected.~~

~~SECTION 7. AND BE IT FURTHER ENACTED, That Section 4 of this Act shall take effect on the taking effect of the termination provision specified in Section 6 of Chapter 503 of the Acts of the General Assembly of 2007. If that termination provision takes effect, Section 3 of this Act shall be abrogated and of no further force and effect. This Act may not be interpreted to have any effect on that termination provision.~~

~~SECTION 8. AND BE IT FURTHER ENACTED, That, except as provided in Section 7 of this Act, this Act shall take effect October 1, 2009.~~

Enacted under Article II, § 17(c) of the Maryland Constitution, May 31, 2009.

Implementation of HB 952 of 2009: Talking Points

The Department has worked diligently to implement House Bill 952 of 2009.

In the six months since its enactment, the Department has met the new 120 day time period.

However, contract submissions have been down. We believe this is due to the recession, which is affecting the CCRC industry as well the rest of the country.

The Department has undertaken additional efforts to improve the efficiency of the contract approval process, such as providing model pre-approved provisions that can be inserted into existing contracts.

Several changes made by House Bill 952 to streamline the contract review process unintentionally reduced consumer protection. I plan to ask the Continuing Care Advisory Committee to look at this issue.

Implementation of House Bill 952 of 2009

The Department has worked diligently to implement House Bill 952 of 2009. The number of submissions of continuing care agreements slowed in the six months since House Bill 952 became effective. The Department believes this was due to the financial turmoil that has affected the country as well as the continuing care industry. This helped the Department meet the new 120-day contract review deadline in the law. However, if the volume of submissions resumes or increases, we are not sure we will have sufficient resources to keep up. Only about 1/24th of one percent of the amount paid by residents at CCRCs goes toward supporting the Department's regulation of the industry.

In accordance with HB 952, the Department now issues two types of letters for continuing care agreement reviews: (1) comment or request for information letters and (2) final letters. Final letters either approve or disapprove a submission. Disapproval or denial letters cite the specific provision of law that were not met and set forth the provider's appeal rights.

Additional Efforts to Improve the Contract Review Process

Other efforts the Department has made to improve the contract review process include sending a 6 page memo to providers that addressed the 2009 changes in the continuing care laws. The memo included model provisions developed by the Department that providers could use in their continuing care agreements to comply with new statutory grievance requirements without having to submit them to the Department for advance approval. A new 20 page Contract Worksheet was also supplied with the memo. The Worksheet will help streamline future submissions, if providers use it.

In addition, the Department has published proposed changes to its continuing care regulations that should increase the efficiency of the contract review process. The Department also provided a number of sample agreements to LifeSpan last summer for it to use in trying to develop a model agreement, and offered to cooperate with it in that regard. However, we have not heard back from LifeSpan on the model agreement concept.

The Continuing Care Advisory Committee

On a broader front and as you know, last summer I created the latest iteration of the Continuing Care Advisory Committee. The Committee is an ad hoc advisory group that many Department of Aging Secretaries and Office on Aging Directors have used over the years to help develop improvements to the continuing care laws. The Committee is comprised of residents, providers, financing experts, a legislator, consumer advocates, attorneys, and actuaries. The Committee has divided into several smaller working subcommittees, which are studying a variety of issues of importance to the industry. Needless to say, among those issues are financial ones. I have charged the Committee to have its recommendations to me in time to prepare any necessary implementing legislation for the 2011 session of the General Assembly.

Consumer Protection

Several changes made by House Bill 952 to streamline the contract review process also unintentionally reduced consumer protection. I plan to ask the Continuing Care Advisory Committee to look at these issues.

Important Health Care Provisions Cannot Be Reviewed for Compliance With the Continuing Care Law

Due to the passage of House Bill 952, a number of providers are changing their contracting structure so that consumers who need assisted living or comprehensive care will sign a separate agreement that will no longer be subject to Department review. No State regulator is reviewing these agreements for compliance with the continuing care laws. These separate agreements are in substance amendments to the continuing care agreement that are signed when a resident is infirm and needs a higher level of care – a time when the consumer is most vulnerable. The Department has seen serious violations of the continuing care laws with such separate agreements. See Exhibit One.

To give one example, a key law that the Department has found providers tend to violate is the statutory requirement that the consumer may only be discharged from a CCRC for just cause and, in that event, must receive a proportional refund of the entrance fee. There is no such provision in a typical assisted living or comprehensive care agreement. Thus, providers working off of such forms have repeatedly proposed provisions that violate the law restricting a provider's right to terminate. Before HB 952, the Department could stop such illegal provisions from being included in assisted living or comprehensive care agreements. Under the new law, the Department is barred from reviewing them.

To make matters worse, continuing care agreements contain statements such as the following:

> This Agreement may not be amended without the prior approval of the Maryland Department of Aging.

However, under the new statute, "amendments" to a continuing care agreement in the form of a separate assisted living or comprehensive care agreement are not required to be submitted to the Department. Thus, the Department can no longer do the contract review that the continuing care agreements promise. It is wrong to assure consumers that their agreement may not be amended without Department approval when that is not the case.

Some CCRCs have argued that these separate agreements are not an amendment to the continuing care agreement because they are separate documents. However, they all contractually govern the resident's relationship with the provider simultaneously so as a practical matter they are amendments.

The Department Cannot Require That Illegal or Deceptive Language In Existing Contracts Be Corrected.

The laws that govern CCRCs are not just in the continuing care subtitle. They are scattered through numerous statutes and regulations. Therefore, occasionally the Department will see a violation in an agreement it had previously approved. The reviewers are human and do not always catch every problem. The Department is now barred by statute from insisting that these violations be corrected. This creates an unlevel playing field among Maryland providers because the new statute grandfathers some illegal contract provisions.

Human Services Article §10-444(b)(22) requires a continuing care agreement to state that fees collected by a provider under a continuing care agreement may only be used for the purposes set forth in the agreement. Many consumers read this sentence in their agreements and feel comforted by it, because they believe it means that, as in a condominium, the money they pay will be used for their community. However, by inserting legalistic provisions into their agreements stating that funds paid by the consumer may be used by a provider for its "corporate purposes," organizations have been able to shift funds to other facilities, including out-of-state acquisition and development activities, without having made it clear to consumers that that could occur. Or, as residents have complained to the Department, their CCRC is being used as a cash cow, because tens of millions of dollars have been transferred out of state and they are faced with an austerity program and much higher monthly fees. House Bill 952's grandfathering language prevents the Department from insisting that existing language on this key issue be clarified.

Compliance With Just The Continuing Care Subtitle

Many of the laws that govern CCRCs are set forth in places other than the continuing care subtitle. These include CCRC specific Certificate of Need laws in the Health and Mental Hygiene Article, late payment fee statutes, and common law. In considering the issue after last year's session, the Department determined that various statutory wording in the Human Services Article, including the statutory reference to "specific provisions of law," still allowed it to enforce various specific statutes enacted by the legislature. However, the Department has stopped objecting to certain exculpatory clauses that are based on common law, rather than "specific provisions of law" enacted by the legislature. For example, comprehensive care agreements regulated by DHMH are required to state that the provider is not responsible for damage to someone's valuables not caused by the negligent or willful action of the Facility staff. The Department used to require similar limitations on exculpatory clauses in continuing care agreements, based on common law. However, based on the new statute, the Department no longer insists that this be done and has begun approving wording that violates common law -- a distasteful experience.

Summary

In conclusion, the Department's staff worked very hard, including uncompensated overtime, to meet the new requirements of HB 952 of 2009. To date we have met them, although we are not sure we will be able to in the future, which could result in agreements being

"deemed approved." House Bill 952 created some consumer protection issues that I will be asking the Continuing Care Advisory Committee to examine.

EXHIBIT ONE

Nine Problems In A Nursing Home Contract That A CCRC Refused To Fix Because Of HB 952

The Department pointed out in writing nine problems in a CCRC's nursing home agreement. See below. The CCRC responded, "Since House Bill 952 was signed into law, we are withdrawing our request to have the comprehensive care agreement receive Department approval."

The Nine Problems as set forth in the Department's letter to the CCRC:

1. Section 8.10 of the [Continuing Care] Agreement refers to this contract as the "Health Center Admission Agreement." Accordingly, this contract should have that title.

2. The Department reiterates the following Comment XI.5 from its October 31, 2006 letter (note that, due to renumbering, the section numbers are now slightly different):

> It is clear that this document was based on the Department of Health and Mental Hygiene's model agreement. It is understandable that you eliminated the paragraphs dealing with Medicaid since [the CCRC] does not participate in Medicaid. However, you also eliminated the two paragraphs in Section 3.B that begin "If you are no longer able to pay for your care ..." and "If there is a dispute about whether you should be discharged...." While you may want to delete the one mention of Medicaid in those two paragraphs, the rest needs to remain. The same is true of the paragraph in the DHMH Model Agreement that reads, "We do not participate in the Medicaid Program. If, after you are admitted here, you no longer have sufficient funds to remain, we will assist you in finding and transferring you to a facility that participates in the Medicaid Program. If there is any dispute about your transfer or discharge, the notice and other requirements described in Section 4.F will apply."

3. In Section 5.D, the phone numbers for the Office of Health Care Quality belong after its name and address, rather than before. Further, please compare this set of phone numbers for OHCQ with the list in the form discussed in the preceding comment. As you will see, that version includes certain OHCQ phone numbers have been incorrectly deleted from this form.

4. In the second paragraph of Section 5.F, the language the Department suggested in its October 31, 2006 letter required that the notification be given 60 days in advance, not 30 days in advance. The current provision providing for only 30 days notice to discharge violates the requirement for 60 days' notice to discharge in HSA §10-448. This can be corrected by changing the phrase "by letter 30 days in advance" to read "by letter 60 days in advance."

5. In Section 7, the titles listed for the various exhibits do not match those set forth on the exhibits themselves. Please make them the same. In addition, please put the numbers of the exhibits on the first page of the exhibits and number the pages of the exhibits. Further, what is labeled in Section 7 as Exhibit 1.A is missing. Instead, [the CCRC] submitted two copies of what is labeled in Section 7 as Exhibit 1.B. Please include Exhibit 1.A with your next submission. The current inconsistent and confusing approach as to the exhibits is not in a form acceptable to the Department and thus violates HSA §10-444(b) and (d).

6. The various exhibits have numerous differences from the DHMH model nursing home agreement. The Department is used to seeing wording in the various exhibits that tracks that of the DHMH model agreement, especially given COMAR 10.07.09.06 which provides that if DHMH has approved a model contract, a nursing facility shall include "within its contract, at a minimum, all of the provisions of the model contract." [The CCRC] has not done that.

7. Exhibit 2 is confusing because, unlike the rest of the agreement and its exhibits, it suddenly repeatedly uses the term "[Garden Court[." What is [Garden Court]? Is it the comprehensive care facility or the comprehensive care and assisted living facility? Please make clear to the reader what is being referred to. Similarly, Exhibit 4 suddenly refers simply to the "Facility." Please use consistent terminology.

8. Exhibit 3 begins with a statement that it "has been determined that your stay or a portion of your stay in the Health Center will be covered under Medicare Part A." That is not a true statement for many subscribers. Please redo the wording in accordance with the DHMH model agreement.

9. Exhibit 4 is much shorter and very different from Exhibit 4 to the DHMH model agreement, which is entitled "Policies and Procedures Concerning Your Personal Funds and Your Personal Property." Please redo it to conform to Exhibit 4 of the DHMH model agreement.

Specific Statutory Changes Recommended by Refinement of Existing Statutory Language/Policies Subcommittee

1. Assisted Living - Amendment to Health General Article to Conform Statute to Existing Practice. The following is a proposed amendment to the Health General Article:

§19–1806.

(a) (1) In this section the following words have the meanings indicated.

(2) "Continuing care" has the meaning stated in § 10–401 of the Human Services Article.

(3) "Continuing care agreement" has the meaning stated in § 10–401 of the Human Services Article.

(b) This section applies to assisted living programs that offer assisted living program services as part of a continuum of care in accordance with a continuing care agreement that does not require a subscriber to execute a separate assisted living agreement to receive those services.

(c) (1) An assisted living program subject to this section that meets the requirements of Title 10, Subtitle 4 of the Human Services Article with regard to assisted living is not required to execute a separate assisted living resident agreement that is in addition to the continuing care agreement.

(2) For purposes of paragraph (1) of this subsection, if a separate assisted living resident agreement is not utilized, references to a resident agreement in any regulations adopted under this subtitle shall mean the continuing care agreement.

(d) A continuing care agreement that contains a provision to provide assisted living program services and does not require a subscriber to execute a separate assisted living agreement to receive those services is not required to contain general or specific contract provisions, except as required under Title 10, Subtitle 4 of the Human Services Article, that apply to assisted living programs that are not subject to this section.

~~(e) (1) In addition to subsection (c) of this section, an assisted living program subject to this section is not required to provide a disclosure statement relating to its assisted living program separate from any disclosure statement required by Title 10, Subtitle 4 of the Human Services Article for continuing care.~~

~~(2) Any disclosure statement required to be provided to a resident under Title 10, Subtitle 4 of the Human Services Article shall include information that is required to be disclosed by an assisted living program in accordance with this subtitle.~~(f) A transfer of a resident from an assisted living program subject to this section to another assisted living or continuing care arrangement governed by the same continuing care agreement may not be considered a relocation or discharge from the assisted living program for purposes of triggering any regulatory requirements adopted under this subtitle for matters relating to notice, financial accounting, or refunds.

Exhibit 6

2. Assisted Living - Amendment to Health General Article to Authorize CCRC Uniform Disclosure Statement. The following is a proposed amendment to the Health General Article:

§19–1808.

(a) The Department, in consultation with the Maryland Health Care Commission and stakeholders, including advocates, consumers, and providers of assisted living services, shall develop a standard assisted living program services disclosure statement. The Department, in consultation with the Department of Aging, shall also adopt a standard version of the assisted living program services disclosure statement for use for assisted living that is included in continuing care, as defined in §10-401 of the Human Services Article.

(b) The purpose of the assisted living program services disclosure statement is to inform potential consumers about the services provided by an assisted living program in order to assist a consumer in choosing the most appropriate assisted living program.

(c) (1) An assisted living program, as part of the application for licensure, shall file with the Office of Health Care Quality the assisted living program services disclosure statement developed by the Department.

(2) If an assisted living program changes the services reported on the assisted living program services disclosure statement, the assisted living program shall file with the Office of Health Care Quality an amended assisted living program services disclosure statement within 30 days of the change in services.

(d) (1) If an individual requests a copy of an assisted living program's services disclosure statement, the assisted living program shall provide a copy of the services disclosure statement to the individual making the request.

(2) An assisted living program shall provide a copy of the services disclosure statement to individuals as part of the program's marketing materials.

3. Assisted Living – Amendments to Human Services Article §10-444(e). The following are proposed amendments to the Human Services Article:

Human Services Article, §10-444(e):

(e) (1) This subsection applies if:

(i) a provider's continuing care agreement includes a provision to provide assisted living program services; and

(ii) the provider does not execute a separate assisted living agreement.

(2) In addition to any other requirement of this section, the continuing care agreement shall include the following provisions concerning the assisted living program:

(i) a statement of the level of care that the assisted living program is licensed to offer;

(ii) a description of the procedures to be followed by the provider for notifying the subscriber of the initial assisted living level of care the subscriber needs if the subscriber transfers to an assisted living program;

(iii) a statement indicating the options available to a subscriber if the subscriber's level of care, after admission to an assisted living program, exceeds the level of care for which the provider is licensed;

~~(iv) based on a sample list of assisted living program services that the Department of Health and Mental Hygiene maintains, a statement of which services are provided by the assisted living program and which services are not;~~

(iv) a statement of the obligations of the provider and the subscriber or the subscriber's agent for handling the subscriber's finances;

(v) a statement of the obligations of the provider and the subscriber or the subscriber's agent for ~~handling the subscriber's finances;(vi) a statement of the obligations of the provider and the subscriber or the subscriber's agent for~~ disposition of the subscriber's property on the subscriber's discharge or death; and

(~~vii~~vi) ~~the applicable~~ rate structure and payment provisions covering:

1. all rates to be charged to the subscriber, including:
   A. service packages;
   B. fee-for-service rates; and
   C. any other nonservice-related charges;
2. criteria to be used for imposing additional charges to provide additional services, if the subscriber's service and care needs change;
3. payment arrangements and fees, if known, for third-party services not covered by the continuing care agreement, but arranged for by the subscriber, the subscriber's agent, or the assisted living program;
4. identification of the persons responsible to pay all fees and charges and a clear indication of whether the person's responsibility is or is not limited to the extent of the subscriber's funds;
5. a provision for notice at least 45 days before any rate increase, except for an increase necessitated by a change in the subscriber's medical condition; and
6. fair and reasonable billing and payment policies.

Human Services Article §10-445(d):

(d) If the continuing care agreement is not an extensive agreement or modified agreement, as defined in §10-447 of this subtitle, and the provider uses a separate assisted living agreement:

(1) the provider is not required to submit the assisted living agreement or any requests for modifications to the Department for approval; and

(2) the provider shall state in its continuing care agreement that, if the subscriber wishes to transfer to assisted living, the subscriber will be required to sign an additional separate agreement for assisted living services that will not be reviewed or approved by the Maryland Department of Aging for compliance with legal requirements or coordination with the continuing care agreement.

(e) If the continuing care agreement is not an extensive agreement or modified agreement, as defined in §10-447 of this subtitle, and the provider uses a separate comprehensive care agreement:

(1) the provider is not required to submit the comprehensive care agreement or any requests for modifications to the Department for approval; and

~~(d) If the provider executes a separate assisted living agreement or comprehensive care agreement, the provider is not required to submit the assisted living agreement or comprehensive care agreement or any requests for modifications to the Department for approval.~~

(2) the provider shall state in its continuing care agreement that, if the subscriber wishes to transfer to comprehensive care, the subscriber will be required to sign an additional separate agreement for comprehensive care services that will not be reviewed or approved by the Maryland Department of Aging for compliance with legal requirements or coordination with the continuing care agreement.

4. Clarifying and Tightening the Transfer of Ownership and Control Statutes. The following are proposed amendments to the Human Services Article:

§10–432.

(a) (1) ~~This~~Subsection (b)(2) of this section ~~and §§10-433 through 10-435 of this subtitle do~~ does not apply to ~~a transfer of ownership of a facility, or~~ a transfer of ownership or control of a person that owns or controls a facility, if:

(i) the transfer is part of a business reorganization; and

(ii) the same person or persons holding the right to control or a majority of ownership ~~or right to control~~ before the business reorganization will retain, directly or indirectly, ~~a majority of ownership or~~the right to control or a majority of ownership, respectively, after the business reorganization.

(2) The provider shall notify the Department and the facility's subscribers 30 days before any reorganization described in paragraph (1) of this subsection.

(b) Unless the Department approves the sale or transfer in accordance with §§ 10-433 through 10-435 of this subtitle,

(1) excluding the grant of a mortgage or deed of trust to an unrelated third party, a provider that holds a preliminary, initial, or renewal certificate of registration ~~or~~may not sell or

otherwise transfer, directly or indirectly, ownership of a facility or any ownership interest in a facility; and

(2) a person with an ownership interest in or a right to control the provider, through governing body appointments or contractual or similar arrangements, may not sell or otherwise transfer, directly or indirectly:

~~(1)~~, the right to control or more than 50% of the ~~provider's ownership of a facility; or(2) more than 50% of the ownership of or right to control~~ownership of a person that owns or controls a facility.

(c) Any series of sales or other transfers described in subsection (b) of this section that occur in a 12-month period shall be aggregated for purposes of this section and §§ 10-433 through 10-435 of this subtitle.

§10–436.

(a) This section does not apply to:

(1) a transaction undertaken under a contractual obligation in effect on October 1, 1996;

(2) a transaction made in the ordinary course of business of operating a facility;

(3) a refund under a contract entered into in the ordinary course of business;

(4) a transfer of cash, securities, or other investment property in connection with an ordinary investment transaction;

(5) a grant of a mortgage, deed of trust, or security interest to an unrelated third party;

(6) a transaction involving an easement, right-of-way, road widening, or similar conveyance for the benefit of a public body or a utility;

(7) a transaction made for an expansion or renovation;

(8) a transaction to which §10-432 applies; or

(~~8~~9) any other sale, transfer, or other disposition exempted by the Department by regulation.

(b) (1) A provider that holds a preliminary, initial, or renewal certificate of registration may not sell, transfer, or otherwise dispose of more than 10% of its total assets in any 12-month period unless the Department approves the sale, transfer, or disposition in accordance with §§ 10-437 and 10-438 of this subtitle.

(2) A provider may not sell, transfer, or otherwise dispose of assets equal to or less than 10% of its total assets if the sale, transfer, or disposition is likely, according to standards set by regulation, to have an unreasonably adverse effect on:

(i) the financial stability of the provider; or

(ii) the capacity of the provider to perform its obligations under its continuing care agreements.

(3) Determinations of total assets shall be based on the provider's latest certified financial statements available at the time the sale, transfer, or other disposition is made.

§10–442.

The provisions of Part IV of this subtitle are in addition to, and not in lieu of, other applicable laws.

To view this email as a web page, go here.

Z-NEWS

July 30, 2010

FROM A CREDIT PERSPECTIVE
A mid-year check of upgrade/downgrade trends for senior living borrowers suggests a hint of optimism for 2010. For the first six months of 2010 ... more

MARKET COMMENTARY
Treasury bond prices improved slightly as reports showed the U.S. economy slowed in the second quarter as a scarcity of jobs eroded consumer spending, ... more

FULL NEWSLETTER

CLIENTS SERVED

FEATURED ARTICLE

Z-News readers are well aware of the critical scrutiny of the financial well-being of continuing care retirement communities (CCRCs) recently administered by the Senate Special Committee on Aging and the General Accounting Office; such was highlighted in last week's *Z-News* feature, "From the Desk of Dan Hermann." Featured prominently in the testimonies presented to the Senate Special Committee on Aging at its July 21 hearing is the topic of the actuarial soundness of CCRCs, prompting A.V. Powell, one of the industry's leading actuarial experts, to express his thoughts on the critical role of actuarial-based pricing for entrance fee CCRCs. Ziegler is pleased to present Mr. Powell's comments in their entirety below, not so much as an endorsement of the views expressed, but as a recognition of the importance of the topic and the value of expert insights on so complex a matter. We hope his essay prompts additional thought and discussion.

ACTUARIAL RISKS ARE NOT LIMITED TO TYPE A AND B CONTRACTS

As a student of the CCRC[1] industry, I watched and read with interest the findings of the GAO and the Senate Special Committee on Aging studies. My take on their findings is that the few CCRCs that have had financial difficulties that resulted in bankruptcy are exceptions to the overall risk exposure for residents of CCRCs. This outcome is not surprising based on my 31 years of experience in dealing with 25% of the industry.

However, I was surprised to hear testimony from two witnesses in response to Senator Franken's question[2] about the value and need for actuarial studies for CCRCs. In my opinion, there is a misconception that pervades the industry similar to the misinterpretation of the GAAP calculation for the obligation to provide future services (more on that issue in another article). It is unclear to me why many believe that the application of actuarial science and corresponding mathematics don't apply to Type C entry fee contracts. These statements are interesting especially in light of the fact that the recent bankruptcies were CCRCs that predominately offered Type C contracts and, as a result, were the primary catalysts in the evaluation of the effectiveness of CCRC regulation.

Actuarial science is a statistical tool that generates projections to determine the advance funding of future obligations based on various contingencies, such as mortality, morbidity (health care), and property and casualty. Traditionally, actuarial science is applied to determine

ZIEGLER LINKS

- Market Review >>
- Rate Comparison >>
- RMA Weekly Update >>
- Ziegler Advisor July 2010 >>
- Banker Contacts >>
- Recommended Best Practice Guidelines for Senior Living Borrowers>>

INTEREST RATES

	Current	Change from last wk	52-wk avg
30 Yr MMD	3.97%	3.97%	4.12%
Senior Living 30-Year "A"	5.85%	5.85%	5.91%
Senior Living 30-Year "BBB"	6.25%	6.25%	6.47%
Senior Living Unrated	7.25%	7.35%	8.10%
Senior Living New Campus	8.50%	8.50%	9.06%
SIFMA	0.28%	0.29%	0.27%

FEATURED FINANCINGS

Exhibit 7

pricing for life insurance, annuity (i.e., social security), and long-term care insurance (LTCi) products. If one were to follow the logic touted for CCRCs, then the only application of actuarial techniques would be for LTCi since it covers health care risk.

All entry fee CCRC contracts contain actuarial risks because entry fees are prepaying a component of future costs. Therefore, actuarial analysis is needed to determine whether those organizations are solvent. Type A and B contracts contain components of LTCi, and actuarial analysis is used to estimate health care contingencies. Entry fees for all CCRC contracts include prepayment of a portion of future operating and/or capital costs which corresponds to annuity risk and longevity contingencies. Refund provisions, especially fully refundable entry fees, for all CCRC contracts are identical to whole life insurance and require actuarial analysis to determine mortality contingencies.

In fact, CCRCs have always been trail blazers in offering products for small groups that incorporate actuarial principles---starting with managed care in extensive lifecare contracts before the insurance industry actively began marketing LTCi policies to seniors. More recently, the industry has lead the way with refundable entry fees by offering whole life insurance to seniors who have difficulty purchasing such policies at age 80 or older.

It appears that some confusion occurs with the use of the "fee-for-service" label. This terminology is often associated with Type C entry fee contracts that offer refundable entry fees. Most refundable contracts include a provision that payment of the refund will be withheld until the unit is reoccupied. Also, some contracts allow residents to draw down on their refund if they can't pay the higher monthly fees when they need higher cost health care services.

Neither the timing of the refund payment nor the source of cash for the refund eliminates the actuarial refund liability. If one decides to ignore the actuarial refund liabilities and use the next occupant's entry fee to pay the refund instead of setting aside a portion of the current entry fee to cover the anticipated refund liability, then is it likely that those Type C contracts will be underpriced. This gives the prospective resident a false sense of financial security in regard to the CCRC's overall solvency and ability to make good on its contractual obligations.

In other words, for many residents the promise of refundable entry fees can be empty especially if multiple refund options are offered to new entrants (i.e., there is no guarantee that their unit will be reoccupied by similar refund provisions) or if a CCRC is in a fill-up or low occupancy stage where the ILU is not resold. However, if the CCRC funded the refund liabilities as determined by an actuarial study, then monies would be available to make good on those promises when death or move-out occurs without delay.

Although many in the industry believe that Type C fee-for-service entry fee contracts do not have actuarial risks, this is simply not true. Actuarial risks are a consequence of the refund provisions and residents' potential inability to pay monthly fees. By allowing these Type C contracts to be excluded from the requirements of actuarial funding, it is possible that these contracts will be underpriced leading to a competitive advantage compared with Type A or Type B contracts that are required to meet actuarial funding requirements. This loophole could lead to reducing the number of CCRCs that provide the popular and economically viable Type A and B options. This means that seniors will have fewer continuing care choices including the option to select one of the best long-term care policies available today (the "true" lifecare in Type A extensive contracts).

The only CCRC contract that may not include actuarial risk is a rental, or Type D contract. For these contracts there is no up-front prepayment of costs, and monthly fees are set to cover both operating and capital expenses. But even 100% rental CCRCs can benefit from actuarial analysis to evaluate the liabilities associated with residents outliving their financial resources.

It is a good finding that both the Senate Special Committee on Aging and GAO gave the CCRC industry a clean bill of health. Nevertheless, there is still a need for the industry-wide application of actuarial science to provide

residents, Boards, and management with the necessary information to ensure the solvency of their organization and ability to set fees to provide services promised by continuing care contracts. Actuarial studies prepared in accordance with the Actuarial Standards of Practice No. 3 for CCRCs were designed to and will provide this information for all models of continuing care contracts.

Prepared by Alwyn V. Powell, Consulting Actuary
A.V. Powell & Associates LLC

1 The term CCRC was first coined by Mr. Walter Shur, former Chief Actuary of New York Life Insurance Company, in a Pension Research Council textbook that I co-authored in 1981.

2 Minutes 75 through 82 in the Senate testimony by Mr. David Erickson and Ms. Alicia Cackley.

FINANCIAL RATIOS SPOTLIGHT

Total Excess Margin (TEM): A Review of 2009 CARF-CCAC Financial Ratios and Trend Analysis Results

The Total Excess Margin Ratio (TEM) 'builds' from the NOM and NOM-Adjusted ratios, both of which we've highlighted in previous Z-News. While each of these ratios measures the efficiency of what RESIDENTS are charged against the costs of services delivered to those residents, the Total Excess Margin Ratio measures the broader efficiency of revenues versus expenses. TEM is computed based on total excess revenues over expenses (before any extraordinary items and change in accounting principles). Unrestricted contributions, realized gains/losses on unrestricted investment, and nonoperating funding sources (such as receipts from a parent/affiliate/owner and assets released from restriction for operations and/or PP&E) are included. This difference in an organization's relative performance in relation to other providers for NOM and NOM-A versus its performance for TEM may highlight the degree to which an organization has benefited from contributions and/or these other nonoperating sources.

2009 TEM Ratio Publication Results: Median for single sites, 1.97%; Median for multi sites, 2.27%

The 2010 Financial Ratios and Trends Analysis publication preparation is underway (release scheduled for late September 2010), but, meantime, the 2009 Financial Ratios and Trend Analysis publication is available for purchase from CARF-CCAC (http://www.carf.org/catalog: click on 'Continuing Care Retirement Communities', then 'General CCRC publications')

AOPHA 2010 Annual Conference & Trade Show

Hyatt Regency Columbus
Greater Columbus Convention Center
Columbus, OH
August 31 - September 2, 2010

Ziegler Speaker: Tom Meyers
Session 4C, September 1
8:00-9:30am
Innovative Strategies for Survival in Today's Environment

Ziegler Speaker: Tom Meyers
Session 13C, September 1
9:45-11:15am
New Alternatives for Old Financial Tools: Bank Qualified Debt Today

CCRC "FACTOIDS"

A number of CCRC developers of the past are no longer active today. One of the most prominent developers of the past was Dr. Kenneth Berg. Dr. Berg developed 16 CCRCs through his company Christian Services, Inc. and ultimately, after a merger that created Life Care Services, he helped develop 62 different communities. To test your knowledge of the developments of Christian Services between 1971 and 1976, see page 92 of the ***Ziegler National CCRC Listing & Profile.***

Non-profit Senior Living Ratings Actions

ORGANIZATION	RATING AGENCY	RATING/ OUTLOOK	TYPE OF ACTION	DATE
Abbey Delray South (FL)	Fitch	BBB Stable	Assigned Rating	7/26/10
Claridge Court (KS)	Fitch	BBB+ Stable	Assigned Rating	7/26/10
Friendship Village of South Hills (PA)	Fitch	BBB+ Stable	Assigned Rating	7/26/10
The Waterford (FL)	Fitch	BBB Stable	Assigned Rating	7/26/10
Simpson House (PA)	S&P	BBB- Stable	Affirmed Rating	7/27/10
Masonic Homes (PA)	S&P	A Stable	Affirmed Rating	7/30/10
Westminster Presbyterian Center (SC)	S&P	BBB- Stable	Affirmed Rating	7/30/10

Contact Dan Hermann in Ziegler's Chicago office or the banker in your area with questions or comments about Ziegler.

Contact Kathryn Brod with comments, areas to cover, questions or other: Kbrod@ziegler.com, (410) 884-8302.

Any non-Ziegler sources referenced in this Z-News are believed to be reliable but cannot be guaranteed.