Act 329 of the 1987 Regular Session

Act 329 SB405

"AN ACT REGULATING CONTINUING CARE FACILITIES; IMPOSING DUTIES UPON THE INSURANCE COMMISSIONER; REGULATING DISCLOSURE STATEMENTS; REGULATING FINANCIAL RESERVES; REQUIRING ESCROWS; PROVIDING FOR THE RIGHT TO INVESTIGATE AND SUBPOENA, CEASE AND DESIST ORDERS AND AUDITS; IMPOSING REGULATIONS; AND FOR OTHER PURPOSES."

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. SHORT TITLE. This Act shall be known and may be cited as the Continuing Care Provider Regulation Act.

SECTION 2. PURPOSE. The General Assembly recognizes that Continuing Care communities have become an important and necessary alternative for the long term residential, social and health maintenance needs for many of the State's elderly citizens.

The General Assembly recognizes the need for full disclosure of important facts to an appropriate regulatory agency of the State. Accordingly, the General Assembly has determined that Continuing Care facilities should be regulated in accordance with the provisions of this Act. The provisions of this Act apply equally to for-profit and not-for-profit provider organizations. The provisions of this Act shall be the minimum requirements to be imposed upon any person, association or organization offering or providing Continuing Care as set forth in this Act, provided this Act shall not apply to facilities duly authorized and licensed by the State of Arkansas as long term care facilities providing nursing care.

SECTION 3. DEFINITIONS. The following words and phrases when used in this Act shall have the meanings given to them in this Section unless the context clearly indicates otherwise:

(a) "Commissioner." The Insurance Commissioner of this State.

(b) "Continuing Care." The furnishing of independent Living Units to and either:

(i) furnishing Nursing Care or Personal Care Services pursuant to an agreement (whether such Nursing Care or Personal Care Services are provided in the Facility or in another setting designated by the agreement for Continuing Care) to, or

(ii) requiring the payment of an Entrance Fee by an individual not related by consanguinity or affinity to the Provider furnishing such Living Unit. Payments may be made by an Entrance Fee alone, an Entrance Fee and periodic payments or by payment of fees for services. Agreements to provide "Continuing Care" shall include agreements to provide care for any duration including agreements that are terminable by either party. "Continuing Care" shall not include "Life Care" as defined below.

(c) "Department." The Insurance Department of this State.

(d) "Entrance Fee." An initial or deferred transfer to a Provider of a sum of money or other property made or promised to be made as full or partial consideration for acceptance of a specified individual as a Resident in a Facility which exceeds six (6) months rental of the Living Unit. An accommodation fee, admission fee, or other fee of similar form and application shall be considered to be an Entrance Fee.

(e) "Facility." A place which provides Continuing Care.

(f) "Life Care." Continuing Care as defined above, except that no additional charges are made for Nursing Care or Personal Care Services beyond those charged all Residents of the Facility who are not receiving Nursing Care or Personal Care Services.

(g) "Living Unit." A room, apartment, cottage or other area within a Facility set aside for the exclusive use or control of one or more identified individuals.

(h) "Nursing Care." Those services pertaining to the curative, restorative and preventive aspects of nursing services that are performed by or under the supervision of a registered or licensed nurse. Nursing care does not include general health service such as nutritional counseling, exercise programs or other preventive medicine techniques.

(i) "Personal Care Services." Assistance with meals, dressing, movement, bathing or other personal needs of maintenance, or other direct supervision and oversight of the physical and mental well being of a person. Personal Care Services does not include general health services such as nutritional counseling, exercise programs, or other preventive medicine techniques.

(j) "Provider." The owner or operator, whether a natural person, partnership or other incorporated association, trust or corporation whose owner or operator undertakes to provide Continuing Care for a fee, whether fixed or variable, for the period of care, payable in lump sum or lump sum and monthly maintenance charges or in installments.

(k) "Refund Reserve." The actuarially determined annual refund amount required to be maintained by a Continuing Care Provider for service of its refund amounts during the next fiscal year of the Facility.

(l) "Resident." An individual entitled to receive Continuing Care in a Facility.

(m) "Solicit." All actions of a Provider in seeking to have individuals residing in this State pay an application fee and enter into a Continuing Care agreement by any means such as, but not limited to, personal, telephone or mail communication or any other communication directed to and received by any individual in this State and any advertisements in any media distributed or communicated by any means to individuals in this State.

SECTION 4. DISCLOSURE STATEMENT. (a) No later than sixty (60) days prior to the first solicitation of a contract to provide Continuing Care, the Provider shall deliver an initial disclosure statement to the Department which shall contain all of the following information:

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

(2) The names and business addresses of the officers, directors, trustees, managing or general partners, and any person having a ten percent (10%) or greater equity or beneficial interest in or of the Provider, and a description of such person's interest in or occupation with the provider.

(3) A statement as to whether the Provider or any of its officers, directors, trustees, partners, managers or affiliates, within ten (10) years prior to the date of application:

(i) was convicted of a felony, a crime that if committed in Arkansas would be a felony or any crime having to do with the provision of Continuing Care or providing of licensed nursing home care;

(ii) has been held liable or enjoined in a civil action by final judgment if the civil action involved fraud, embezzlement, fraudulent conversion or misappropriation of property;

(iii) had a prior discharge in bankruptcy or was found insolvent in any court action; or

(iv) had any state or federal licenses or permits suspended or revoked or had any state, federal of industry self-regulatory agency commence an action against him and the result of such action.

(4) A statement as to:

(i) Whether the Provider is or ever has been affiliated with a religious, charitable or other nonprofit organization.

(ii) The nature of the affiliation, if any.

(iii) The extent to which the affiliate organization will be responsible for the financial and contract obligations of the Provider.

(iv) The provision of the Federal Internal Revenue Code, if any, under which the Provider or affiliate is exempt from the payment of income tax.

(5) The location and description of the physical property or properties of the Facility, existing or proposed, and to the extent proposed, the estimated completion date or dates whether or not construction has begun, and the contingencies subject to which construction may be deferred.

(6) The services provided or proposed to be provided under contracts for Continuing Care at the Facility, including the extent to which medical care is furnished. The disclosure statement shall clearly state which services are included in basic contracts for Continuing Care and which services are made available at or by the Facility at extra charge.

(7) A description of all fees required of Residents, including the Entrance Fee and periodic charges, if any. The description shall include the manner by which the Provider may adjust periodic charges or other recurring fees and the limitations on such adjustments, if any.

(8) A balance sheet of the Provider, reviewed by a certified public accountant, and certified to by the Provider, as of the end of the two most recent fiscal years.

(9) A calculation of the actuarially required Refund Reserve showing the alternative bases upon which the calculation is made.

(10) A copy of the standard form or forms of contract used by the Provider which contain the minimum requirements of this Act for Continuing Care contracts shall be attached as an exhibit to each disclosure statement.

(b) The Provider shall file with the Department annually within four (4) months following the end of the Provider's fiscal year, an annual disclosure statement which shall contain the information required by this Act for the initial disclosure statement.

(c) The Department shall review the filed disclosure document for the following:

(i) the completeness of the filing, and

(ii) the manner and method of computing the Reserve.

(d) The Commissioner shall notify a Provider of any deficiency in the filing within sixty (60) days from the date of filing. If the Provider is notified of deficiencies in the filing, reasonable time shall be allowed to the Provider to correct the deficiencies.

(e) No Provider may offer Continuing Care contracts to the public during the initial sixty (60) day filing period or during the period allowed to correct deficiencies noted by the Commissioner.

(f) All disclosure statements shall be made available at the Facility and the office of the Commissioner for inspection by the citizens of this State upon request. Each Resident of a Facility shall be informed of the availability of the statement annually.

(g) Each disclosure statement shall clearly state that a prospective or present Resident shall rely solely upon the Provider for the accuracy and completeness of the information contained in the disclosure statement and that

no independent investigation of the accuracy of the information has been conducted by the Commissioner.

SECTION 5. CONTRACT INFORMATION. (a) A Continuing Care contract shall be written in clear and understandable language.

(b) A Continuing Care contract shall, at a minimum:

(i) describe the Facility's admission policies, including age, health status and minimum financial requirements, if any;

(ii) describe the health and financial conditions required for a person to continue to be a Resident;

(iii) describe the circumstances under which the Resident will be permitted to remain in the Facility in the event of possible financial difficulties of the Resident;

(iv) list the total consideration paid, including donations, Entrance Fee, subscription fees, periodic fees and other fees paid or payable; provided, however, that a Provider cannot require a Resident to transfer all his assets to the Provider or community as a condition for providing Continuing Care and the Provider shall reserve his rights to charge periodic fees;

(v) describe in detail all items of service to be received by the Resident such as food, shelter, medical care, Nursing Care, Personal Care Services, and other health services and the time period such services will be provided;

(vi) provide as an addendum to the contract a description of items of service, if any, which are available to the Resident but are not covered in the entrance or monthly fee;

(vii) specify taxes and utilities, if any, that the Resident must pay;

(viii) specify that deposits or Entrance Fees paid by or for a Resident shall be held in trust in a cash escrow pursuant to this Act;

(ix) state the terms under which a Continuing Care contract may be cancelled by the Resident or the Provider and the basis for establishing the amount of refund of the Entrance Fee, if any;

(x) state the terms under which a Continuing Care contract is cancelled by the death of the Resident and the basis for establishing the amount of refund, if any, of the Entrance Fee;

(xi) state when fees will be subject to periodic increases and what the policy for increases will be;

(xii) state the Entrance Fee and periodic fees that will be charged if the Resident marries while living in the Facility, the terms concerning the entry of a spouse to the Facility and the consequences if the spouse does not meet the requirements for entry;

(xiii) state the rules and regulations of the Provider then in effect and state the circumstances under which the Provider claims to be entitled to have access to the Resident's Unit;

(xiv) list the Resident's and Provider's respective rights and obligations as to any real or personal property of the Resident transferred to or placed in the custody of the Provider;

(xv) describe the living quarters purchased by or assigned to the Resident;

(xvi) provide under what conditions, if any, the Resident may assign the use of a unit to another;

(xvii) include the policy and procedure with regard to changes in accommodations due to an increase or decrease in the number of persons occupying an individual unit;

(xviii) state the conditions upon which the Facility may sublet or relet a Resident's unit;

(xix) state, in the event of voluntary absence from the Facility, for an extended period of time by the Resident, what fee adjustments, if any, will be made;

(xx) include the procedures to be followed when the Provider temporarily or permanently changes the Resident's accommodations, either within the Facility or by transfer to a health facility;

(xxi) if the Facility includes a nursing facility, describe the admissions policies and what will occur if a nursing facility bed is not available at the time it is needed;

(xxii) describe, if the Resident is offered a priority for nursing facility admission at a facility that is not owned by the Facility, with which nursing facility the formal arrangement is made and what will occur if a nursing facility bed is not available at the time it is needed;

(xxiii) include the policy and procedures for determining under what circumstances a Resident will be considered incapable of independent living and will require a permanent move to a nursing facility;

(xxiv) specify the types of insurance, if any, the Resident must maintain, including medicare, other health insurance and property insurance;

(xxv) specify the circumstances, if any, under which the Resident will be required to apply for medicaid, public assistance or any other public benefit programs;

(xxvi) state that the Provider has filed a disclosure statement with the Commission and state the contents of the disclosure statement required by paragraph (3) of Section 4 of this Act;

(xxvii) state in bold and conspicuous type the following:

THIS CONTRACT IS GOVERNED BY THE CONTINUING CARE PROVIDER REGULATION ACT. THE PROVIDER HAS FILED A DISCLOSURE DOCUMENT WITH THE INSURANCE COMMISSIONER OF THE STATE OF ARKANSAS PRIOR TO OFFERING THIS CONTRACT. THE INSURANCE COMMISSIONER HAS NOT PASSED UPON THE VALIDITY OF THE INFORMATION FILED BY THE PROVIDER, DOES NOT MAKE ANY RECOMMENDATION WITH RESPECT TO THE FAIRNESS OF THE CHARGES MADE BY THE PROVIDER, HAS NOT CONDUCTED AN INDEPENDENT REVIEW OF THE FINANCIAL STRENGTH OF THE PROVIDER AND DOES NOT WARRANT THE ENFORCEABILITY OF ANY CONTRACT OFFERED BY THE PROVIDER. NO PROSPECTIVE RESIDENT SHOULD RELY UPON THE FACT THAT A FILING HAS BEEN MADE WITH THE COMMISSIONER IN MAKING THEIR DECISION. EACH_PROSPECTIVE_RESIDENT_SHOULD_CONSULT_HIS_OWN_LEGAL_AND_FINANCIAL_ADVISERS_PRIOR_TO ENTERING_INTO_ANY_CONTRACT_WITH_THE_PROVIDER.

SECTION 6. RECESSION PERIOD. For a seven-day period beginning on the date a Provider receives any payment from a prospective Resident, a prospective Resident shall have the right to rescind any contractual obligation into which he has entered and receive a full refund of any monies transferred to the Provider.

SECTION 7. FALSE INFORMATION. (a) No Provider shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public in a newspaper or other publication, or in the form of a notice,

circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement of any sort containing any assertion, representation or statement which is untrue, deceptive or misleading.

(b) No Provider shall file with the Department or make, publish, disseminate, circulate or deliver to any person or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or delivered to any person, or placed before the public, any financial statement which does not accurately state its true financial condition.

SECTION 8. REFUND RESERVES. (a) Each Provider shall establish and maintain liquid Refund Reserves in an amount determined in accordance with this Section. The Refund Reserve shall be equal to or exceeding the actuarially determined annual refund amount as of the financial reporting date. The actuarially determined annual refund amount shall be calculated upon both the actual experience of the Facility and published industry norms. The method which yields the greater sum shall determine the actuarially determined annual refund amount for the purposes of this Section and Section 4(a)(8) hereof.

(b) The Provider may satisfy the liquid reserve requirement by:

(1) Holding the reserve amount in an escrow account with a federally insured financial institution or institutions, located and doing business in this State; or

(2) Purchasing a certificate of deposit from an Arkansas lending institution; or

(3) Investing in bonds, notes, warrants and other evidences of indebtedness which are direct obligations of the United States of America; or

(4) Having the unqualified guaranty of an affiliated organization or individual, as evidenced by a written agreement, whose net worth as reported in its most recent financial statement reviewed by a certified public accountant, and certified by the Provider and filed with the Department, which is equal to five (5) times the reserve amount, or portion of the reserve amount to be satisfied by this method; or

(5) Any combination of the foregoing.

(c) When requested by the Commissioner, the Provider shall furnish all of the information relating to the amount of the reserve and the method used to maintain the reserve amount.

SECTION 9. ENTRANCE FEE ESCROW. (a) The Commissioner shall require that the Provider establish an interest-bearing escrow account with a financial institution authorized to do business in the State. Any Entrance Fees or payments received by the Provider prior to the date the Resident is permitted to occupy the living unit in the Facility shall be placed in the escrow account subject to release at such time as the Living Unit becomes available for occupancy by the new Resident.

(b) If the funds in an escrow account and any interest earned thereon are not released within thirty-six (36) months, or such greater time as may have been specified by the Provider with the consent of the Commissioner, then such funds shall be returned by the escrow agent to the persons who made the payment to the Provider.

(c) Nothing in this Section shall require the escrow of any nonrefundable application fees charged to prospective Residents.

(d) An Entrance Fee held in escrow may be returned by the escrow agent at any time to the person or persons who paid the fee to the Provider upon receipt by the escrow agent of notice from the Provider that such person is entitled to a refund of the Entrance Fee.

SECTION 10. STATUTORY LIEN. In the event of the bankruptcy or receivership of the Provider resulting from the financial difficulties of the Provider, the Residents of the Facility shall have a statutory lien on the real and personal property of the Facility which shall be subordinate to liens of record prior to the date of a filing of a petition in bankruptcy or petition for receivership but which shall be superior to all other creditors.

SECTION 11. INVESTIGATIONS AND EXAMINATIONS.

(a) The Department may conduct any investigation or examination as deemed necessary by the Commissioner in response to a written complaint filed by a resident or prospective resident, or if it appears from the filings required by this Act that the solvency of the facility is in question, or to determine whether any provision of this Act or any rule or order has been violated.

(b) The Commissioner may conduct any investigation in person or direct any Department employee to act on his behalf. For any on-site investigation, the expenses incurred, including compensation of any Department examiner, shall be paid by the Facility being investigated. For the purposes of this Section the provisions of Section 35 of Act 148 of 1959, as amended, shall apply.

(c) If, after an initial investigation, it appears that the Facility may be insolvent, the Commissioner may conduct a financial examination. The Commissioner may utilize Department examiners or he may retain independent certified public accountants to conduct the examination. Each facility being examined shall pay the Department the expenses incurred pursuant to Section 35 of Act 148 of 1959, as amended. The cost of any retained accountants shall not be in excess of the amount that could be charged for Department examiners.

(d) When the services of an actuary are deemed necessary in any investigation or examination, the Commissioner may retain an independent actuary with such expenses being paid by the facility.

(e) The Commissioner or any officer designated by the Commissioner may administer oaths and affirmations, issue subpoenas, hear testimony, and take evidence in reference to any investigation or examination conducted pursuant to this Act.

SECTION 12. CEASE AND DESIST ORDERS; INJUNCTIONS. Whenever it appears to the Commissioner that any person has engaged in, or is about to engage in, any act or practice constituting a violation of any provision of this Act or any rule or order hereunder, the Commissioner may:

(a) Issue an order directed at any such person requiring such person to cease and desist from engaging in such act or practice; and/or

(b) Bring an action in any court which has appropriate jurisdiction to enjoin the acts or practices and to enforce compliance with this Act or any rule or order hereunder. Upon a proper showing, a permanent or temporary injunction, restraining order, or writ of mandamus shall be granted.

SECTION 13. REGULATIONS. The Commissioner shall have the authority to adopt, amend or repeal such rules and regulations as are reasonably necessary for the enforcement of the provisions of this Act.

SECTION 14. TRANSITION RULE. All Continuing Care providers who are offering Continuing Care contracts to the citizens of this State on the effective date of this Act shall be granted a period of six (6) months within which to file the initial disclosure document as required by this Act. During the

six (6) month period, the Provider may continue to offer Continuing Care contracts to the citizens of this State. However, if upon filing of the disclosure document with the Commissioner there are deficiencies noted in the filing and reasonable time is allowed for the correction of those deficiencies, no contracts may be offered by the Provider until such deficiencies are cured.

SECTION 15. REPEALER. All laws and parts of laws in conflict with this Act are hereby repealed.

SECTION 16. SEVERABILITY. If any portion of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are declared to be severable.

SECTION 17. EMERGENCY. It is hereby found that the possibility of new Providers commencing business in this State in the absence of any regulation of Continuing Care Facilities poses an economic threat to the citizens of this State, and it is, therefore, declared that an emergency exists, and this Act being necessary to protect the citizens of this State who are contemplating entering into Continuing Care contracts, shall take effect and be in force from and after its passage and approval.

APPROVED: 3/19/87