Attachment F to CCRC Finances Guide

Florida Statutes 651 – Layman's Terms

CONTINUING CARE RETIREMENT COMMUNITIES IN FLORIDA – A REGULATORY OVERVIEW.

This summary of information is made available to local chapters of the Florida Life Care Residents Association (FLiCRA). It is intended to furnish chapters and their members with an overview of the provisions of Chapter 651, Florida Statutes that govern continuing care facilities, continuing care contracts and residents' rights.

Over the past several years, a major revision of Chapter 651 was undertaken to better protect residents by providing objective financial metrics and greater disclosure to residents as well as clarifying the enforcement tools available to the Office of Insurance Regulation. This summary has been updated to include the many changes to Chapter 651 that were enacted in House Bill 1033 in 2019.

It is FLiCRA's hope that this plain language overview will assist CCRC residents and prospect residents in addressing their relationships with their communities. This document is not intended to be an exhaustive description of the total law or administrative rules.

Readers should be aware that the provisions of Chapter 651 in this overview describe the minimum standards that are set in law. A "provider" who owns or operates the "facility" or "CCRC" may choose to include additional levels of services or a higher level of protection than current Florida law requires.

Continuing care contracts and providers are regulated by the State of Florida namely the Florida Office of Insurance Regulation (OIR). This overview of Chapter 651, Florida Statutes outlines provisions related to the protection of CCRC residents and the financial oversite of continuing care providers. Additional legal references are presented where appropriate.

A. LICENSE REQUIREMENT & APPLICABLE STATUTES. Before beginning operations as a continuing care provider or issuing continuing care contracts, a prospective provider must apply for and receive a license known as a "Certificate of Authority" from the State of Florida. There are detailed and comprehensive plan requirements regarding the financial security of the facility that must be met by a provider before a license, called a Certificate of Authority (COA) to operate a CCRC may be issued. Continuing care contracts and providers are regulated in Florida under Chapter 651, Florida Statutes.

Chapter 651 is administered by the Florida Office of Insurance Regulation (OIR). (Sections 651.013 and 651.015)

In addition to the requirements of Chapter 651, continuing care providers are subject to the provisions of Parts I, II and III of Chapter 400, Florida Statutes, related to Nursing Home and Related Health Care Facilities. Continuing care contracts are regulated as a "specialty insurance product" since residents generally pay certain amounts of money in advance to receive future skilled nursing or assisted living benefits and care at a later time.

Continuing Care Providers are also subject to Part VI of Chapter 624, Florida Statutes. This section of Florida relates to administrative supervision whereby under certain circumstances the Florida Department of Financial Services can take over interim control of a licensed CCRC.

The primary legal authority is found in these statutes as adopted by the legislature. However, the various state agencies that are charged with carrying out the regulation are also given specifically delegated legislative authority to adopt administrative rules to implement the statutory system.

B. FACILITIES. Continuing Care Retirement Communities (CCRCs) are defined as providers of continuing care and their contracts, operations, and the facilities are subject to the statutes above. It is mandatory that every resident of a CCRC be furnished a continuing care contract (residency agreement) which provides a complete and detailed description of all costs and services which are part of the agreement between residents and the provider. While Chapter 651 includes a listing of residents rights in § 651.083, it is the continuing care contract that is the primary document defining a resident's rights with respect to day-to-day life and activities in a CCRC community.

C. CONTRACTS. "Continuing care" or "care" means furnishing pursuant to a contract, shelter and either nursing care or personal services upon payment of an entrance fee. (Section 651.011 F.S.). Residents and the providers sign the contract. Providers agree to furnish continuing care to residents during the resident's lifetime, subject to the terms and conditions of the contract. The contract may be for any duration of time upon which the resident and facility agree. Section 651.055, Florida Statutes requires that, at a minimum, each contract shall:

1. Specify in detail all services to be furnished under the contract and the services that are available at extra charge.
2. Describe the terms and conditions under which the contract can be cancelled by the provider and the resident and the conditions under which the entrance fee or a portion of it will be refunded if the contract is cancelled.
3. Describe the health and financial condition required for a person to be accepted as a resident.
4. Describe the circumstances under which the resident will be permitted to

remain in the facility if the resident is unable to pay the charges required by the contract.

5. Provide that the contract may be cancelled upon giving notice of cancellation of at least 30 days by the provider or the resident. The contract must provide for refunding of a portion of the entrance fee during the applicable term. When the resident has no membership or ownership in the facility, the refund is prorated with the facility retaining 2% per month of residency and a 4% processing fee. This means that unless a facility chooses to provide a more liberal refund policy in the residency agreement, the statute does not require that residents be given a refund after four years.
6. State the terms under which a contract is cancelled by the death of the resident. Most facility contracts provide for the entrance fee to be prorated similar to paragraph 5.
7. Describe the policies, which may lead to a change in monthly charges for goods or services. A notice of at least 60 days in advance of the change(s) must be provided to the residents in the community.
8. Each continuing care contract shall be approved by the OIR before it may be used by a facility.
9. Additional requirements and details are set out in Section 651.055, Florida Statutes.
10. The Initial Entrance Fee represents an initial payment of money to assure the resident the opportunity to reside in a facility. The fee is a prepayment for future services and serves as a form of prepaid insurance. This is another example of why, Florida law regulates continuing care contracts as a “specialty insurance product”. The Internal Revenue Code considers the fee as a below market loan to the facility. Income tax must be paid on the interest at the federal rate on the unearned amount in excess of the exemption which is around $130,000, even though the facility may pay no interest. (126 U.S.C., Section 7872(c) and (g), Section. 651.011(13)).

D. **MONTHLY MAINTENANCE FEE**. This is the amount paid by residents for the services furnished by the provider. At a quarterly meeting prior to increasing the monthly fee, the designated representative of the facility must provide the reasons, by department cost centers, for any increase in the fee that exceeds the most recently published Consumer Price Index. The statute does not place a cap or limitation on the amount of any increase in the monthly maintenance fee, and does not place any restrictions on fee increases. (Section 651.085(4)).

E. **PROVIDER FINANCIAL MATTERS.** One of the most significant changes in the 2019 rewrite of Chapter 651 designed to better protect CCRC residents’ financial interests was the introduction of specific financial metrics which trigger a specific defined regulatory response from the Office of Insurance Regulation (OIR). Prior to the 2019 rewrite, determining the appropriate regulatory response to a provider’s specific financial circumstances required a judgement call on the part of OIR staff. While CCRCs in Florida have a strong track record of long term financial stability, the introduction of objective financial metrics reduces uncertainty. The new provisions of

law ensure both providers and residents have a clearer picture of regulatory response based on certain metrics.

1. Minimum Liquid Reserves for the Protection of Residents Chapter 651 requires each provider to maintain financial reserves to cover the regular ongoing expenses that are commonly applicable to the financial management; daily operation, and facilities management of a continuing care community. These reserves are required to be maintained in escrow to help ensure the financial stability of the community and are collectively referred to as Minimum Liquid Reserves (MLR). As described in more detail below, the three required reserves that make up the MLR are the Debt Service Reserve, Operating Reserve, and the Renewal and Replacement Reserve. (Section 651.035).

2. Debt Service Reserve Each provider is required to maintain in escrow a Debt Service Reserve sufficient to cover the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage loan or other long-term financing of the facility, including property taxes. (Section 651.035(1)(a)).

3. Operating Reserve Each provider is required to maintain in escrow an Operating Reserve in an amount equal to 15 percent of the total operating expenses in the most recent annual report filed with the Office of Insurance Regulation. (Section 651.035(1)(c)).

4. Renewal and Replacement Reserve Each provider is required to maintain Renewal and Replacement Reserves in escrow in an amount equal to 15% of the total accumulated depreciation on the annual audited financial statement, capped at 15% of the average operating expenses. (Sec. 651.035(1)(d)). Each fiscal year, subject to written permission from the Office of Insurance Regulation a provider may withdraw up to 33% of the total renewal and replacement reserve to fund capital items or major repairs. The provider must begin refunding the reserve account in equal monthly payments, which will repay the funds withdrawn within 36 months. (Section 651.035(6)(b)).

7. Monitoring and Reporting As part of the regular reporting requirements, providers must report their MLR balances to OIR. Any shortfalls below required minimum balances can trigger increased reporting or lead to regulatory action by OIR.

8. Resident Protection Waivers Are Not Valid The statutory protections for residents contained in Chapter 651 cannot be waived by any residency agreement or contract.

   Any such purported waiver in a resident care contract is invalid. (Sec.

651.065).

F. **RESIDENTS' BILL OF RIGHTS.** Chapter 651 includes a specific provision regarding Residents' Rights. (Sec. 651.083). Providers are required to provide a copy of the Residents' Bill of Rights in
Sec. 651.083 to each resident at or before the resident's admission to the facility.

In addition to the CCRC Residents' Rights provided in Chapter 651, Section 400.022 sets forth rights for residents of nursing home facilities, which are required to be provided to each resident prior to admission.

G. **DISMISSAL OF A RESIDENT.** Dismissals are very rare and may only be for just cause. If a facility terminates a resident for just cause, any unearned entrance fee must be refunded. Termination of contract holders for the purpose of decertifying a facility from Chapter 651 is not just cause. Inability to pay monthly maintenance fees is not a just cause until the entire unearned entrance fee, plus any Medicare benefits, is earned by the facility. If the entrance fees are exhausted within 90 days from the date of failure to pay, the facility may not require the resident to leave within the 90 days, during which time the resident shall pay a reduced fee based on current income. (Sec. 651.061).

H. **RESIDENTS' COUNCIL AND RESIDENT ORGANIZATIONS.** Residents have the right to create local residents' organizations, the right to be represented by an individual of their choosing, and the right to engage in concerted activities for the purpose of keeping informed on the operation of the facility or for the purpose of mutual interest, aid or protection. The statute specifically provides for the establishment of a residents' council. The provider may not restrict a resident's access to the residents' council. A residents' council may be called whatever the residents choose. The council, board, organization, association, or whatever it may be called, is not authorized to require residents to pay dues or qualify for membership in any way other than by being a resident. In addition, residents may belong to FLiCRA and its local chapter. Since payment of dues is part of being a member of FLiCRA, the local chapter of FLiCRA Is not a substitute for a residents' council. The residents' council designates a resident to represent them before the governing body of the provider. The designated representative is invited to attend and participate in the portion of any meeting of the provider's full governing body at which any changes to resident fees or services are expected to be discussed. (Secs. 651.085(2) & (3)).

I. **CONTRACTS FOR ADMINISTRATIVE, MANAGERIAL, OR VENDOR SERVICES.** A facility may contract with other entities for administration, management, or other vendor services. However, the office may review the contract. If the OIR determines that the fees are unreasonably high in relation to the service provided, OIR may order the provider to cancel the contract. (Sec. 651.1151)

J. **QUARTERLY RESIDENT MEETINGS.** The governing body of a provider, or its designated representative, is required to hold quarterly meetings with the residents for

the purpose of free discussion of subjects, including income, expenditures, financial trends and any challenges or issues facing the provider or residents, as well as changes in policy, programs, and services. At the request of the residents' council, a member of the governing body such as a board member, owner or designated representative of the provider shall attend the quarterly meetings. Providers must report to the Office of Insurance Regulation the dates on which the quarterly meetings were held in its annual report. Residents shall be given at least 7-day notice of each quarterly meeting. (Sec. 651.085).

K. **CERTIFICATE OF AUTHORITY**. No person may engage in the business of providing continuing care or issuing continuing care contracts without a certificate of authority issued by the Florida Office of Insurance Regulation. The Certificate of Authority shall be valid for as long as the OIR determines that the provider continues to meet the requirements of the statutes. If the provider fails to meet the requirements of the statutes, the OIR may notify the provider of any deficiencies and require the provider to submit a corrective action plan. OIR may notify the Continuing Care Advisory Council to assist the provider in formulating, or OIR in evaluating, a remedial plan.

The OIR in its discretion may suspend or revoke the Certificate of Authority if one or more of the following grounds exist:

1. Failure of the provider to continue to meet the requirements of the authority granted in the certificate (license).
2. Material misstatements, misrepresentation, or fraud in obtaining the authority.
3. Demonstrated lack of fitness or trustworthiness.
4. Fraudulent or dishonest practices of management in the conduct of business.
5. Misappropriation, conversion or withholding of moneys.
6. Failure to comply with, or violation of an OIR order or rule, or a violation of Chapter 651.
7. Failure to maintain Minimum Liquid Reserves in escrow as required.
8. Failure to file annual reports.
9. Failure by the provider to meet the requirements of the statutes for disclosure of information to residents concerning the facility, refusal by the provider to produce its accounts, records, and files for examination of its financial condition or failure to honor its continuing care contracts.
10. The provider meets the definition of impaired or insolvent.

(Secs. 651.021,651.0235, 651.108, and 651.114).

L. **INSOLVENCY OF PROVIDER**. Insolvency means the condition in which the provider is unable to pay its obligations as they come due in the normal course of business.

If the financial condition of the provider is such that if not corrected insolvency would result, the OIR may direct the provider to file a corrective plan with the OIR. If none is filed, the OIR may specify a plan and direct the provider to implement the plan. Also, the

OIR may place a facility in administrative supervision pursuant to the statutes pertaining to insurance companies.

If the OIR finds that sufficient grounds exist for rehabilitation, conservation, reorganization, seizure, or summary process of an insurer, it may seek a court order. If a court order is entered against a provider, the OIR is vested with the powers and duties it has in regards to delinquency proceedings of insurance companies.

When the OIR has been appointed a receiver of a provider by the court, the court is authorized to enjoin a creditor from disposing of collateral in order to protect the life, health, or welfare of the residents, or if necessary, to provide sufficient time to relocate the residents. No injunction shall last for more than 12 months. (Sec. 651.116).

In the event of receivership or liquidation proceedings against a provider, all continuing care contracts executed by a provider shall be deemed preferred claims against all assets owned by the provider. Provider bankruptcy is very rare. However, this is a key provision that was included in the statute at FLiCRA's urging and has proven instrumental in two instances as the courts referred to this provision to protect the residents' interests and used this provision as a basis for exercising its discretion to treat resident claims on a par with the claims of secured creditors. (Sec. 651.071).

M. **ASSISTANCE TO RESIDENTS UPON CLOSURE DUE TO LIQUIDATION OF PROVIDER**. If an order of liquidation has been entered against a provider, the Department of Health shall determine whether any residents are eligible for assistance by that department. The department shall develop a plan of relocation for residents requesting assistance, and shall counsel residents regarding such eligibility and relocation. If a facility closes and ceases to operate as a result of liquidation and residents are forced to relocate, the Office of Insurance Regulation shall become a creditor of the facility for the purpose of providing moving expenses for displaced residents and other care or services as is made possible by the unsecured assets of the facility. Moving expenses include cost of transportation, packing and relocating personal belongings.

If the unencumbered assets and voluntary contributions of other providers are insufficient to cover moving costs, the department may levy pro rata assessments on the reserves of other providers, which for any particular provider may not in the aggregate for any 12-month period exceed 1% of the unencumbered portion of its reserves, provided that payment of such a contribution or assessment does not violate a bond or loan covenant. (Secs. 651.117 and 651.119)

N. **REQUEST FOR INSPECTIONS**. Any person who believes a provider is in violation of any provision of Chapter 651 may request the OIR to inspect the records and financial affairs of a provider by providing OIR with the specifics of the alleged violation in a signed complaint. A copy of the complaint or any record made available to the provider shall not disclose the name of the complainant, unless the complainant specifically requests their name be disclosed. A provider may not discriminate or retaliate in any manner against a resident who has filed a complaint with the OIR. (Sec. 651.111).

O. DISCLOSURE REQUIREMENTS - AVAILABILITY, DISTRIBUTION AND POSTING OF REPORTS AND RECORDS. The 2019 revision of Chapter 651 includes greatly enhanced disclosure requirements and provides residents full access to a broad array of provider information. Any cost and inspection reports that have been filed with, or issued by, any governmental agency within 5 years and all annual statements that have been filed with the OIR are public information and are available upon request. (Sec. 651.091).

Additionally, under Section 651.091 each CCRC is required to:

1. Display its certificate of Authority in a conspicuous place inside the facility.
2. Prominently post in an area accessible to all residents a concise summary of the last examination report issued by the OIR. Each CCRC must inform residents of the manner in which a full annual report as filed with OIR may also be obtained.
3. Prominently post in an area accessible to all residents a notice containing the Division of Consumer Services website and the toll-free consumer helpline and OIR's website and telephone number with a statement that the Consumer Services or OIR may be contacted for the submission of inquiries and complaints with respect to potential provider violations of Chapter 651.
4. Provide notice to the president or chair of the residents' council of a final examination report or the initiation of any legal or administrative proceeding by the office or the department and include a copy of the document within 10 business days of issuance.
5. Prominently post in an area accessible to all residents a summary of the last annual statement, indicating where in the facility the full annual statement may be inspected. The CCRC is also required to post a listing of any proposed changes in policies, programs or services.
6. Provide a copy of the full annual statement and the most recent third-party financial audit to the president of the residents' council within 30 days of filing with OIR.
7. Deliver the information about any increase in the monthly maintenance fee as described in Section 651.085(4), and the reasons for any increase that exceeds the most recent Consumer Price Index, in writing to the president or chair of the residents' council.
8. Deliver to the president or chair of the residents' council a summary of entrance fees collected and refunds made during the time period covered in the annual report and the refund balances due at the end of the report period.
9. If required by OIR to file quarterly, the CCRC must deliver to the president or chair of the residents' council a copy of each quarterly statement within 30 days of filing.
10. Upon request, deliver to the president or chair of the residents' council a copy of any newly approved continuing care or continuing care at-home contract within 30 days of approval.
11. Deliver any notice of change in ownership to the president or chair of the

residents' council within 10 business days of filing with OIR.

12. Make master plans and any plans for expansion or phased development available for review as they are approved by the provider's governing board, and provide notice of changes to the president or chair of the residents' council within 3 business days.
13. Notify the residents' council of any plans to obtain new financing, additional financing, or refinancing for the facility at least 30 days before the closing date of the financing or refinancing transaction. (Sec. 651.019)

P. **ANNUAL REPORTS**. Annually, on or before May 1, each CCRC must file an annual report and other information and data showing its condition as of the last day of the preceding calendar year as well as the following financial information:

1. Financial statements audited by an independent certified public accountant which shall contain full information for the appropriate time that the facility has been in existence.
2. A detailed listing of assets maintained in the liquid reserves for bond payments, for operation expenses and for renewal and replacement of capital items.
3. A schedule giving additional information relating to property, plant, and equipment having an original cost of $25,000 to show cost, book value, appraised value and net equity of appraised value over encumbrances.
4. The level of participation in Medicare and Medicaid programs.
5. A statement of all fees required to be paid by residents, including the entrance fee and monthly fee, and the proposed application of the proceeds of the entrance fee by the provider, and the plan by which the amount of the entrance fee is determined if the entrance fee is not the same in all cases.
6. Any change or increase in fees for basic services and for services available at additional costs to the residents.
7. If the provider has more than one facility, or has other operations, it shall submit a balance sheet, statement of income and expenses, statement of equity or fund balances, and statement of cash flows for each for each facility licensed under Chapter 651 as supplemental information to the audited financial report.
8. The management's calculation of the provider's debt service coverage ratio, occupancy, and days cash on hand for the current reporting period.

Q. **EXAMINATION AND INSPECTIONS**. The OIR may at any time, and shall at least once every 3 years, examine the business of any provider in the same manner as is provided for examination of insurance companies pursuant to Section 624.316 and 624.318, Florida Statutes. The final written report of the examination shall be filed with OIR and is a public record. (Sec. 651.105).

R. **CONFLICT RESOLUTION.** Any resident injured by a violation of Chapter 651, Florida Statutes, may bring an action for recovery of damages plus reasonable attorney's fees.

The statute requires that OIR adopt rules for alternative procedures for resolution of disputes between residents and providers. Current Florida law provides a non-binding mediation process and a binding arbitration process when mediation fails to resolve a dispute. The process for mediation and arbitration is established by the OIR in administrative rule.

This concludes the summary of Chapter 651, Florida Statutes. That cited chapters and the Florida Administrative Rules that interpret the statutes may be amended from time to time. The Florida Life Care Residents Association monitors legislative and administrative rule changes and provides updates on a continuing basis.

The original document has been substantially revised by FLiCRA's staff including the association's inside general counsel to reflect significant changes signed into law by the Governor in June 2019.