SB 124-FN - VERSION ADOPTED BY BOTH BODIES

03/20/2025 0790s
06/26/2025 2904EBA

2025 SESSION

25-0968
05/08

SENATE BILL ***124-FN***

AN ACT relative to continuing care retirement communities.

SPONSORS: Sen. Ricciardi, Dist 9; Sen. Pearl, Dist 17

COMMITTEE: Health and Human Services

ANALYSIS

This bill recodifies RSA 420-D, relative to continuing care communities. The bill expands certificate of authority requirements, annual reporting requirements, and life care contract requirements. The bill revises escrow requirements for entrance fees and specifies the notice required prior to contract cancellation by either party. The bill includes a bill of rights for continuing care community residents. The bill also requires the provider to notify the insurance department of the intended sale or transfer of the community and may require the provider to submit a financial plan to the insurance department to demonstrate solvency.

The bill is a request of the insurance department.

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Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

SB 124-FN - VERSION ADOPTED BY BOTH BODIES

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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Five

AN ACT relative to continuing care retirement communities.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Statement of Purpose and Findings.

I. The general court recognizes that continuing care communities are an alternative to serve the long term residential, social, and health care needs of many senior citizens. The general court further finds:

(a) That an increasing number of senior citizens spend their life savings in facilities that offer to care and residency for them for the remainder of their lives;

(b) That offering care instead of a cash return, is a type of insurance often called a "single premium policy" or a "single payment annuity";

(c) That individual payments to these facilities are often large, usually from $50,000 to $750,000 and thus may constitute their entire life savings;

(d) That an owner of such facility often invests from $15,000,000 to $200,000,000, depending on the number of residents;

(e) That failure or inability of a facility to operate long term can easily eradicate the life savings of a resident and render such residents financially unable to provide for themselves in their old age and force them to become dependent on public welfare and lose their place to live;

(f) That inadequate operation of such facilities is contrary to the best interests of the residents and the state of New Hampshire and therefore regulation of this industry is necessary to reduce the possibility that a facility fails or provides inadequate care to our seniors; and

(g) Recently, a continuing care resident community filed for chapter 11 bankruptcy in New Hampshire. Other continuing care resident communities have filed for bankruptcy across the country, and the proceedings illustrate the need for laws to be updated to provide more protection for the residents of continuing care resident communities in the event of an insolvency or bankruptcy. In the event of bankruptcy, residents could lose the right to occupy the facility and to receive a refund of any remaining entrance fee when due, leaving them without funds and without a home.

II. The general court, in an effort to protect New Hampshire's senior citizens, hereby establishes regulation of such continuing care facilities.

2 Continuing Care Resident Communities. RSA 420-D is repealed and reenacted to read as follows:

420-D:1 Definitions.

In this chapter:

I.(a) “Advertising” means and includes the publication or dissemination of any information, offering for sale, or for the purpose of causing or inducing any other person to enter into a continuing care contract in a continuing care community, including the contract to be used and any photographs or drawings or artist's representation of physical conditions or facilities existing or to exist by means of any:

(1) Newspaper or periodical;

(2) Radio or television broadcast;

(3) Written, printed or photographic matter;

(4) Billboards or signs;

(5) Display of model facilities or units;

(6) Material used in connection with the disposition or offer of the facility by radio, television, telephone or any other electronic means including the Internet; or

(7) Material used by a provider or their agents to induce prospective residents to visit the facility, particularly gift certificates which require the holders of such certificates to attend or submit to a sales presentation by providers or their agents.

(b) "Advertising" shall not include stockholder communications, such as annual reports, interim financial reports, proxy materials, certification statements, securities prospectuses, applications for listing securities on stock exchanges, and the like, and any and all communications addressed and relating to the account of any person who has previously executed a continuing care contract.

II. "Affiliate" means any person, corporation, limited liability company, business trust, non-profit, partnership, unincorporated association, or other legal entity that directly or indirectly owns or controls, or is owned or controlled by, or is under common ownership or control with, a provider. With respect to a non-profit entity, affiliate status is determined solely by control and not by ownership.

III. “Certificate of authority” means the certificate issued by the commissioner licensing the provider to operate a continuing care community.

IV. “Commissioner” means the commissioner of the insurance department.

V. “Company level officer” includes an executive director, chief executive officer, president, controlling administrator/manager, chief financial officer, director, trustee, managing or general partner, any person having a 5 percent or greater equity or beneficial interest in the continuing care community or any other person identified by the commissioner as having significant responsibility over the finances or operations of the continuing care community or any company level officer of an affiliate.

VI. “Continuing care” or “life care” means furnishing or promising to furnish to a person, services that shall include boarding or lodging, or both, and may include services for assisted living, independent living, nursing, or memory care pursuant to a continuing care contract. Services may

be limited to food or lodging or both as long as the continuing care contract exceeds one year, the entrance fee is more than $10,000, and the age minimum is met if a continuing care retirement community. Continuing care contracts may provide for additional periodic charges for services and include contracts where the resident does not immediately move into the facility; provided that a continuing care contract shall not include services provided by a relative.

VII. “Continuing care contract” means a contract that includes a promise by a provider made in exchange for an entrance fee or the payment of periodic charges, or both, in exchange for the provider providing one or more elements of continuing care to a resident for the duration of his or her life or for a specified term in excess of one year, provided that the entrance fee exceeds $10,000. A continuing care contract includes a life care contract if the contract provides health and/or life services at the facility in addition to room and/or board.

VIII. “Continuing care retirement community" or "CCRC" means a continuing care community, located within the state of New Hampshire, that provides services pursuant to a continuing care contract in a retirement setting, which may include age minimums, assisted living services, memory care, nursing care, and/or independent living.

IX. “Control” means:

(a) With respect to a non-profit entity, the power to elect a majority or more of the governing body of the entity; and

(b) With respect to any entity the power to influence the financial management or policies of the entity, including but not limited to the exercise of approval rights over the budgets of the entity.

X. “Department” means the insurance department.

XI. “Disclosure statement” means the statement prepared by the provider and delivered to the resident before execution of the contract as more particularly described in RSA 420-D:4 and any amendments to the statement.

XII. “Entity” means any form of enterprise of any kind, including a not-for-profit entity.

XIII. “Entrance fee” means an initial or deferred payment, agreed upon in the continuing care contract, of a sum, usually a lump sum, in cash or in kind, to a provider in return for acceptance as a resident for the purposes of ensuring care or related services and may be limited to lodging and/or board. This definition shall not apply to the payment of a sum which is less than the total of periodic payments for one year or $10,000 or if the care is from a relative or someone who is not in the business of providing continuing care.

XIV. “Facility” means any place or accommodation where a provider provides a resident with care or related services, whether or not the place or accommodation is constructed, owned, leased, rented or otherwise contracted by the provider.

XV. “License” means that the provider has obtained a certificate of authority from the commissioner to enter into continuing care contracts and operate a facility.

XVI. "Life care contract" means a continuing care contract that includes a promise by the provider to pay for services at one or more levels of care as provided in the continuing care contract, unless the continuing care contract expressly excludes some or all of such services. Services may include independent living, assisted care, nursing care, and memory care to the extent not covered by public or private insurance benefits.

XVII. "Owner" means the owner of the facility's real and personal property, or if there are multiple places of operation and multiple owners, all of the real estate and personal property. The owner may or may not be an affiliate of the provider, or the provider itself. The owner may be a landlord. The owner must consent to the operation of a continuing care community at the facility as part of the application process.

XVIII. "Periodic payments" or "monthly care fees" mean those payments in addition to the entrance fee made by a resident to a provider for continuing care during the entire period that the continuing care contract is in effect.

XIX. "Person" means any natural person, corporation, limited liability company, non-profit or any other type of entity.

XX. "Provider" means any person that provides continuing care pursuant to a continuing care contract, including a life care contract.

XXI. "Relative" means a person related to the resident by consanguinity or marriage up to and including the third degree, including step-relatives or who is not in the business of providing continuing care.

XXII. "Resident" means a person who meets the age requirements, if any, and enters into a continuing care contract, including a life care contract, with the provider. The resident may have contracted to occupy a specific unit. Resident shall include, in appropriate circumstances, the estate or trust of the resident if the resident has died.

XXIII. "Solicit" means all actions by a person or provider seeking to have individuals enter into a continuing care contract. This includes, but is not limited to, mail, telephone, personal contacts, Internet contacts, and advertisements.

XXIV. "Unit" means a room, apartment, cottage, or other area within a facility set aside for the exclusive use or control of one or 2 residents. However, the resident may be moved to other units during their stay at a CCRC as provided in the life care contract.

420-D:2 Certificate of Authority.

I. No person or provider may solicit funds other than non-binding deposit fees of not more than $1,000, accept payments of any kind, or otherwise engage in providing any form of continuing care without acquiring and maintaining a certificate of authority issued by the commissioner pursuant to this chapter. An application for a certificate shall include the proposed disclosure statement and form contract required under RSA 420-D:4 and, in addition to any other state or federal licensure or certification which may be required, a statement indicating that all of the

statutory requirements have been met. The commissioner shall take prompt action on requests for a certificate and shall, within a reasonable time, issue a certificate of authority or a written rejection. If the commissioner rejects an application, the commissioner may do so outright or state the conditions which must be met before a certificate shall be issued. The applicant may request reconsideration and shall be granted a hearing in accordance with rules adopted by the commissioner pursuant to RSA 541-A. Certificates issued under this section shall continue in effect until revoked by the commissioner or until sale or transfer of control to another provider.

II. Facilities which reported to or were under the supervision of the director of charitable trusts of the department of justice under RSA 7:19 through RSA 7:32-a on January 1, 1989, shall be exempt from the provisions of this chapter. However, any such facility may elect by a one-time irrevocable election to be subject to the provisions of this chapter by filing an application for a permanent certificate of authority with the commissioner.

III. The application for certification shall contain the following documents and information:

(a) An irrevocable appointment of the department to receive service of any lawful process in any noncriminal proceeding arising under this statute against the provider or the provider's agents.

(b) The states or other jurisdictions, including the federal government, in which an application for certification or similar documents for the subject facility have been or will be filed and any order, judgment, or decree entered in connection therewith by the regulatory authorities in each of the jurisdictions or by any court or administrative body thereof.

(c) The names and business addresses of the company level officers and directors to include a biographical affidavit form provided by the department.

(d) Copies of the articles of incorporation or agreement, with all amendments thereto, if the provider is a corporation; copies of all instruments by which the trust is created or declared, if the provider is a trust; copies of the articles of partnership or association and all other organization papers if the provider is organized under another form. In the event the provider is not the owner of the property upon which the facility is or is to be constructed, the above documents shall be submitted for both the provider and an affiliated owner.

(e) A legal description by metes and bounds or other acceptable means of the lands to be certified, and the relationship of such lands to existing streets, roads and other improvements, together with a map showing the proposed or actual facility and showing the dimensions of the living units as available, except for living units that are completed and available for inspection. The map shall be drawn to scale, signed and sealed by a licensed professional engineer or land surveyor, if available to the applicant.

(f) Copies of the deed or other instrument, including any real property lease, establishing title or leasehold interest of the provider and/or owner and a title search, title report, or title certificate or binder or policy issued by a licensed title insurance company.

(g) A statement concerning any litigation, orders, judgments, or decrees which might affect the provider or owner.

(h) A statement that the continuing care contracts will be offered to the public and entered into without regard to marital status, sexual orientation, sex, race, creed, or national origin or, if not, any legally permissible restrictions on purchase that will apply.

(i) A statement of the present conditions of physical access to the facility, and the existence of any material adverse conditions that affect the facility, that are known, should be known, or are readily ascertainable.

(j) Copies of all contracts, agreements, and any "bill of rights" which the resident may be required to execute or review.

(k) In the event there is or will be a blanket encumbrance or encumbrances affecting the facility or a portion thereof, a copy of the document creating it and a statement of the consequences upon a resident of a failure of the person bound to fulfill the obligations under the instrument or instruments and the manner in which the interest of the resident is to be protected in the event of such eventuality. The provider shall update the department as blanket encumbrances are created or re-financed.

(l) One copy of the proposed disclosure statement with associated biographical affidavits.

(m) A current financial statement of the provider and any related predecessor, parent or subsidiary company, and any current profit and loss statement and balance sheet, whether audited by an independent public accountant or not.

(n) A statement concerning any adjudication of bankruptcy during the last 5 years against the provider, its predecessor, parent or subsidiary company, and any principal owning more than 10 percent of the interests in the facility at the time of the filing of the application for certification. This requirement shall not extend to limited partners or those whose interests are solely those of investors.

(o) Copies of all easements and restrictions, whether of record or not.

(p) A statement as to the status of compliance with all the requirements of all laws, ordinances, and regulations of governmental agencies having jurisdiction over the construction, permitting, and licensing of the facility, including but not limited to any permits required by the department of environmental services together with copies of all necessary federal, state, county, and municipal approvals.

(q) A statement that neither the provider nor any of its officers or principals have ever been convicted of a felony or charged with a misdemeanor involving embezzlement, theft, larceny, or mail fraud, or charged with any violation of any corporate securities laws in this state or a foreign jurisdiction, and that the provider has never been subject to any permanent injunction or final administrative order restraining a false or misleading promotional plan involving continuing care

facility disposition or if so, copies of all pleadings and orders in regard thereto. If there is an action or conviction the commissioner shall determine whether to disqualify the relevant party.

(r) A projected annual budget for the facility for the next 5 years, or such lesser time as the department allows, together with a financial feasibility study prepared according to generally accepted accounting principles, as established by the American Institute of Certified Public Accountants, which study shall include an opinion letter as to the financial feasibility of the facility.

(s) Copies of market studies, if any, prepared on the behalf of the provider, concerning the feasibility of the project.

(t) An affidavit, signed by the provider, that the contents of the application are true and accurate and made in good faith.

(u) A disaster recovery plan.

(v) Certification that the applicant's IT platform meets applicable health information security regulations and standards, including those pertaining to cybersecurity.

(w) Such additional information as the department may require in individual cases after review of an application for certification to assure full and fair disclosure.

420-D:3 Renewal and Amendment of Certificate of Authority.

I. Certificates of authority shall continue in effect until revoked by the commissioner. Certificates are non-transferable to another provider or affiliate either directly or through a change in control. All transfers shall be approved by the commissioner. The commissioner shall establish a fee for applications for certificates of authority by rules adopted under RSA 541-A. The provider shall report to the department within 30 days any material changes in the information or documents contained in the application for certification, with a request for an amendment to the application. The department shall process and review any amendments, determine how they affect the certificate of authority, and take appropriate action pursuant to this chapter and rules adopted thereunder.

II. The department shall retain copies of all certified applications and any amendments and make non-proprietary non-confidential materials reasonably available to the public during ordinary business hours.

420-D:3-a Continuing Care at Home Contracts.

I. A provider may contract to provide continuing care to a resident who remains at home and does not move immediately into a facility if the provider:

(a) Holds a certificate of authority issued under this chapter to provide continuing care.

(b) Owns and operates a facility located in New Hampshire where the resident has the right to receive board, lodging, or both, and other services.

(c) Obtains written approval from the commissioner that the proposal to offer continuing care contracts to residents who do not move immediately into the facility will not place the provider in an unsound financial condition and will not be injurious or hazardous to any resident contracting with the provider for continuing care.

(d) Otherwise complies with all requirements of this chapter.

(e) Provides a copy of the form contract for approval by the department at least 30 days before it is executed by a resident.

II. Any provider that issues contracts under this section shall:

(a) Be in good standing with the commissioner, and not subject to action pursuant to RSA 420-D:5.

(b) Be responsible for all services the provider provides to the resident in the resident's home pursuant to the continuing care contract and shall exercise direct control and oversight over any individual or entity providing those services.

(c) Have procedures to ensure that any third-party providing services to the resident in the resident's home pursuant to the contract is trustworthy and certified, licensed, or otherwise qualified under state law to provide those services.

(d) Require clinical re-assessment of the resident prior to the resident moving into the facility to identify the appropriate accommodation for the resident within the continuum of care at the option of the provider.

III. The provider and any person employed by the provider that assists in delivery of services to the resident in the resident's home shall have a business location within the state of New Hampshire, shall hold appropriate licenses, and shall be available to address complaints, questions, and concerns of residents.

420-D:4 Disclosure Statement.

I. A disclosure statement shall be approved by the department prior to delivery to any prospective resident. Each provider shall provide each prospective resident with a current disclosure statement and a current continuing care contract, which have previously been approved by the commissioner. A disclosure statement shall not be deemed current unless it contains all amendments filed and is approved by the department. When a provider files an amended disclosure statement, the provider shall redline the changes from the prior approved statement when submitting it to the department. The provider shall amend the disclosure statement if there is any change in management or ownership that requires the execution of a new affidavit supporting the disclosure statement or other material change. The provider shall have 30 days to submit an amended disclosure statement to the department for review if there is a material change. The disclosure statement shall include, in conspicuous large type, the statements below. The statements in the disclosure statement and contract shall be in plain and understandable English. The disclosure statement shall disclose fully and accurately state the characteristics of the CCRC, and the interests offered and shall make known to prospective residents all unusual and material circumstances and features affecting the CCRC and provider.

II. The disclosure statement shall be provided to the prospective resident at least 24 hours before consenting to any contract and before the initial transfer of funds, and shall include, at a minimum, the following information:

(a) The name of the provider's organization and whether it is foreign or domestic, for profit or not-for-profit, and whether it is a partnership, corporation, limited liability company, or other type of organization including non-profit entities, including all affiliates.

(b) The name and a brief description of all company-level officers, who shall fill out a biographical affidavit in accordance with the disclosure statement. The affidavit shall include:

(1) Name, address, and, if applicable, amount of ownership.

(2) Responsibility and relationship to the facility.

(3) Previous experience with similar facilities.

(4) Previous business experience.

(5) Any felony convictions against such person in any jurisdiction.

(6) Any court orders or injunctive relief against such person.

(7) Relationships with other nursing homes or like communities.

(8) Previous bankruptcies, insolvencies or financial actions against such person.

(9) Relationship with any supplier or potential supplier of services.

(10) Supplies or materials of any kind contributed or sold to the provider.

(c) The disclosure statement shall also include:

(1) If the provider is not the owner, the name and address of the owner; whether or not it is an affiliate; and the name and address of all affiliates.

(2) The provider's relationship with any religious, charitable, or nonprofit organization and the extent of such organization's financial responsibilities to the provider or to residents.

(3) Whether the provider claims to be nonprofit or tax exempt.

(4) The location and description of the facility and, if it is proposed or incomplete, the estimated completion date, status of construction, and any contingencies on that completion date.

(5) The services to be provided by the facility under basic contract and those at extra cost.

(6) All locations where services are to be provided, if different from the main facility.

(7) If the CCRC contract does not provide for assisted living, skilled nursing care, or nursing home care, the contract shall state this prominently, on the first page of the contract and in at least 14-point bold capital letters. This statement shall be preceded by the following caption: "THIS CONTRACT DOES NOT PROVIDE YOU WITH ANY RIGHT TO RECEIVE THE FOLLOWING CARE"

(8) All entrance fees and periodic payments that are required of residents and a description of all policies and conditions for refund or return of these fees and payments.

(9) A description of the provider policy and procedures for receiving advance deposits, also known as "wait list deposits", by prospective residents desiring future occupancy at the facility and how those deposits will be maintained prior to final signing of the continuing care contract, in bank accounts, investment accounts, or escrow accounts if required by this statute and including any interest payment provisions.

(10) A description of the provider policy and procedures for receiving and maintaining entrance fees prior to and during the continuing care contract signing process, in bank accounts, investment accounts, or escrow accounts if required by this statute and including any interest payment provisions.

(11) When and how periodic payments may be charged by the provider.

(12) Provisions of the provider for reserve funding, escrows, and trusts and investment of these funds.

(13) Financial statements audited by a certified public accountant including, if the facility is in operation, a balance sheet and an income statement for the 2 complete and immediately preceding years. This requirement may be waived by the commissioner in his or her sole discretion.

(14) A description of the company's affiliates and structure, and if a non-profit, a discussion of the charitable purpose of the non-profit and the need in certain instances for money to be used for advancement of the charitable purpose.

(15) A description of the provider policy and procedures for receiving advance deposits or "wait list deposits" by prospective residents desiring future occupancy at the facility and how those deposits will be maintained prior to final signing of the continuing care contract, in bank accounts, investment accounts, or escrow accounts if required by this chapter and including any interest payment provisions.

(16) A description of the provider policy and procedures for receiving and maintaining entrance fees prior to and during the continuing care contract signing process, in bank accounts, investment accounts, or escrow accounts if required by this chapter and including any interest payment provisions.

(d) If the facility has not yet begun operating:

(1) All expected costs or obligations for a 5-year period.

(2) Full description of all mortgages or long-term financing and an analysis of the occupancy rates necessary to pay them together with an analysis showing the number of contracts necessary to make start-up feasible.

(3) Estimated entrance fee income prior to operation.

(4) Estimated start-up losses and reserves to be covered by entrance fees.

(5) Projection of estimated annual income from periodic payments for 5 years.

(6) Resident mortality and morbidity assumptions.

(7) Analysis of facilities expected to compete with the proposed facility and a demographic analysis of the elderly population expected to support the facility.

(8) All periodic payments a resident will be expected to pay.

(9) Assumptions and bases for estimating occupancy rates.

(10) All expected subsidies, private or government, including Medicaid and Medicare, and the effect if these subsidies are not received.

(11) Projected annual operating expenses for 5 years.

(12) Estimated capital and equipment replacement expenditures for the current year and the next 5 years. In specific cases, the commissioner may, if he or she deems necessary, require a longer period of projection of the estimated capital and operating expenses.

(13) All assets pledged as collateral including any pledged to an affiliate.

(14) Annual payments on long term financing.

(15) Any other commitments over $50,000 to make payments to another party for any purpose including any affiliate.

(e) The disclosure statement shall contain any other information deemed necessary by the commissioner, including relevant information from affiliates if their organizational documents or financial documents are deemed relevant by the commissioner.

III. The disclosure statement shall be in the following form:

(a) A front cover shall contain the name and address of the provider, the name and location of the CCRC, the effective date of the disclosure statement which shall be the date of certification by the department and shall contain the following statement in 10-point bold face type:

NOTICE TO PURCHASERS

THIS DISCLOSURE STATEMENT IS FOR INFORMATIONAL PURPOSES ONLY. PURCHASERS SHOULD ASCERTAIN FOR THEMSELVES THAT THE UNIT OFFERED MEETS THEIR PERSONAL REQUIREMENTS. THE NEW HAMPSHIRE DEPARTMENT OF INSURANCE AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS NEITHER APPROVED NOR DISAPPROVED THE MERITS OF THIS DISCLOSURE STATEMENT. BE SURE TO READ CAREFULLY ALL DOCUMENTS BEFORE YOU SIGN THEM.

(b) The disclosure statement and the contract shall each state on the cover or top of the first page in bold print the following:

THIS MATTER INVOLVES A SUBSTANTIAL FINANCIAL PAYMENT AND A LEGALLY BINDING CONTRACT. IT DOES NOT INVOLVE THE PURCHASE OR LEASE OF REAL ESTATE. IN EVALUATING THE DISCLOSURE STATEMENT AND THE CONTRACT PRIOR TO ANY COMMITMENT, IT IS RECOMMENDED THAT YOU CONSULT WITH AN ATTORNEY AND FINANCIAL ADVISOR OF YOUR CHOICE, IF YOU SO ELECT, WHO CAN REVIEW THESE DOCUMENTS WITH YOU. THIS ARRANGEMENT CARRIES WITH IT SOME RISK. MAKE

SURE TO HAVE YOUR LAWYER AND FINANCIAL ADVISOR REVIEW THE CONTRACT AND DISCLOSURE STATEMENT WITH YOU.

(c) A reasonably detailed table of contents showing the subject matter of the various sections, subsections, or documents contained in the disclosure statement and the page number on which each appears shall be added at the front of the disclosure statement.

IV. The provider shall attach a copy of an example of a standard continuing care contract used by the provider as an exhibit to each disclosure statement.

V. In bold type in the disclosure statement: "You have the right to cancel the continuing care contract within 15 days after signing without obligation, except for certain described services and charges outlined in the continuing care contract. You will receive a full refund of your entrance fee less only disclosed charges during the 15-day rescission period to be paid within 45 days of request of written notice of rescission.

420-D:4-a Rescission of Contract.

Every continuing care contract shall contain the following notice in 10-point bold face type or larger, directly above the space provided before the signature of the resident:

NOTICE TO THE RESIDENT: YOU HAVE THE RIGHT TO CANCEL THIS CONTRACT OR AGREEMENT BY SENDING OR DELIVERING WRITTEN NOTICE OF CANCELLATION TO THE PROVIDER BY MIDNIGHT OF THE 15TH CALENDAR DAY FOLLOWING THE DAY ON WHICH IT WAS EXECUTED BY BOTH PARTIES. SUCH CANCELLATION IS WITHOUT PENALTY, AND ALL DEPOSITS MADE BY YOU SHALL BE PROMPTLY REFUNDED, EXCEPT FOR THE APPLICATION FEE AND FOR EXPENSES INCURRED BY THE PROVIDER AT THE RESIDENT'S SPECIFIC REQUEST, PROVIDED THAT SUCH EXPENSES ARE ITEMIZED AND SUPPORTED BY APPROPRIATE DOCUMENTATION.

AFTER THIS 15-DAY CANCELLATION PERIOD, YOU HAVE THE RIGHT TO CANCEL THIS CONTRACT FOR ANY REASON ANYTIME BY 90 DAYS WRITTEN NOTICE. IF YOU CANCEL THE CONTRACT IN THIS MANNER, YOU MAY BE ENTITLED TO A FULL OR PARTIAL REFUND OF YOUR ENTRANCE FEE, AS PROVIDED ELSEWHERE IN THE CONTRACT. HOWEVER, YOU MAY HAVE TO WAIT FOR RE-PAYMENT OF ANY FUNDS OWED TO YOU BY THE PROVIDER UNTIL YOUR UNIT IS UNDER CONTRACT AND THE RESCISSION PERIOD HAS PASSED FOR THE FUTURE RESIDENT.

420-D:5 Revocation or Suspension of Certificate of Authority; Liens.

I. The commissioner may revoke, deny, or suspend a certificate of authority upon notice and hearing, which hearing notice may be waived if there are exigent circumstances requiring the commissioner to act without a hearing such hearing to be held as soon as possible after action is taken by the commissioner, if the commissioner finds that any of the following conditions exist:

(a) Violation by a provider of any provisions of this chapter or any rule of the department or the department of health and human services, and/or repeated failure to correct violations of this statute, rule or other applicable law.

(b) Failure to continue to meet the requirements of the certificate of authority.

(c) Lack of any qualifications necessary for approval of or to maintain the certificate of authority.

(d) Failure to file a disclosure statement under RSA 420-D:4 or failure to provide an approved disclosure statement to a prospective resident before the transfer of funds, as provided by RSA 420-D:4. Failure to file and get approval for an amended disclosure statement as required by RSA 420-D:4.

(e) Fraud or misrepresentation of a material fact in the disclosure statement or any application or amendment.

(f) Failure to comply with a cease-and-desist order under RSA 420-D:21.

(g) Misappropriation, conversion, or wrongful withholding of money from residents or anyone conducting business with the provider.

(h) A demonstrated lack of fitness or trustworthiness including violations of state or federal laws.

(i) Failure to make a new application for certificate of authority in accordance with RSA 420-D:13 when there is a sale, transfer of ownership, or transfer of control.

(j) Such unsound financial condition or any other practice which may be hazardous or injurious to residents or to the general public including violation of the liquid reserve requirement of RSA 420-D:8.

(k) Failure to maintain a complete written accounting of all entrance fees paid by each resident or prospective resident by the provider and to keep such funds in a separate bank account entitled “entrance fees”, if required, until they may be released as provided in this statute.

(l) Dissemination of false or misleading advertising material.

(m) Failure to timely file quarterly or annual reports in accordance with RSA 420-D:7 and 420-D:7-a.

(n) Failure to maintain sufficient funds in escrow accounts if required.

(o) Failure to report any intended change in control or change or default in any blanket financing applicable to the facility.

(p) Failure to provide notice of a change in the owner.

II. In addition to other remedies, if necessary to protect the interests of the residents, the commissioner may record a lien in accordance with RSA 420-D:9 on the real and personal property of the provider and/or owner and shall take any other action necessary to protect the residents of the facility. Filing such lien shall not require prior court approval.

420-D:6 Appeal. Any person aggrieved by the action of the commissioner or the commissioner of the department of health and human services in revoking, suspending, or refusing to grant or reissue a certificate has the right to a hearing and appeal in accordance with the provisions of RSA 541.

420-D:7 Annual Reports.

I. Annually, 120 days after the end of each fiscal year, a provider shall submit a report to the commissioner relative to the financial condition of the provider together with any other information required by the commissioner. The commissioner may require more frequent reports of any provider, if the commissioner deems it necessary for proper review.

II. The report required under this section shall be in such form as the commissioner shall prescribe and shall include, but not be limited to, the following information:

(a) The most recent disclosure statement approved by the commissioner as required under RSA 420-D:4. If there are changes to the disclosure statement since the commissioner approved it, they must be submitted to the commissioner for approval.

(b) An annual financial statement with an explanation of the differences between previous financial estimates and actual figures for the year.

(c) An estimated financial statement for the new fiscal year with an estimate in case of major changes expected during the year. The commissioner shall adopt rules under RSA 541-A relative to the definition of major changes.

(d) Financial statements audited by an independent certified public accountant (the requirement of audited financial statements may be waived by the commissioner for cause), which shall contain for 2 or more annual periods, at a minimum, the following information:

(1) A statement of financial position.

(2) A statement of operations.

(3) A statement of changes in net assets.

(4) A statement of cash flows.

(5) The accountant's opinion.

(e) All notes to the financial statements considered customary or necessary to full disclosure and adequate understanding of the financial statements, the financial condition of the facility, and the operation.

(f) Calculation of liquid reserves as defined in RSA 420-D:8, certified by the accountant.

(g) Management disclosure and analysis providing a summary of the provider's prior year business operations and activities based upon, strengths, weaknesses, opportunities and threats.

(h) Financial ratio table in 3 categories, margin, liquidity and capital structure, as follows:

(1) Capital expenditures as a percentage of depreciation ratio (CED).

(2) Unrestricted cash and investments to long-term debt ratio (CD).

(3) Days cash on hand ratio (DCOH).

(4) Debt service coverage ratio (DSCR).

(5) Debt service coverage ratio - revenue basis (DSCR-RB).

(6) Net operating margin (NOM).

(7) Operating ratio (OR).

(i) An actuarial report and statement of actuarial opinion for the first full fiscal year wherein the CCRC has been occupied by one or more residents and for every 5 years thereafter including a balance sheet and statement of operations, prepared in accordance with the "Actuarial Standard of Practice No. 3, Practices Relating to Continuing Care Retirement Communities" adopted July 1994 by the American Academy of Actuaries' Actuarial Standards Board.

(1) The statement of actuarial opinion shall indicate whether the data and assumptions used are appropriate, whether the methods employed are consistent with sound actuarial principles and practices and whether provisions have been made for all actuarial liabilities and related statement items which ought to be established.

(2) The actuarial opinion shall also contain appropriate comment on the CCRCs perceived ability to operate the CCRC as a going concern and the impact of any actuarial deficit. If the actuary is unable to form a needed opinion, or if the opinion is adverse or qualified, the statement of actuarial opinion shall specifically state the reason. The actuarial opinion shall be rendered by a qualified actuary as defined in Ins 901.02.

(3) The commissioner shall not require submission of an actuarial report from any facility which does not offer a contract in which all or part of the risk of uncertain future health care costs is borne by the facility and not the resident.

(j) Such other reasonable data, financial statements, and pertinent information as the Commissioner may request.

(k) Any projects that the provider, owner (related to the CCRC facility) or affiliate is considering which will have an impact on the facility or its finances in future years shall also be disclosed. Any proprietary material shall remain confidential.

III. The annual statement shall be sworn to in writing by the principal officer or chief financial officer of the provider as follows:

(a) If an individual owner, by the owner;

(b) If a limited liability company, by the manager;

(c) If a partnership, by all the partners;

(d) If an unincorporated association, by all its members or by all its officers and directors;

(e) If a trust or non-profit, by a trustee and the president; or

(f) If a corporation, by the president and the secretary.

420-D:7-a Quarterly Financial Calculations.

I. The following financial statements shall be submitted quarterly by the 45th day after the end of the quarter as follows:

(a) Capital Expenditures as a Percentage of Depreciation Ratio (CED).

(b) Unrestricted Cash and Investments to Long-Term Debt Ratio (CD).

(c) Days Cash on Hand Ratio (DCOH).

(d) Debt Service Coverage Ratio (DSCR).

(e) Debt Service Coverage Ratio - Revenue Basis (DSCR-RB).

(f) Net Operating Margin (NOM).

(g) Operating Ratio (OR).

II. In addition, the provider shall calculate and submit a liquid reserve calculation for each quarter and a detail of current occupancy by category of residency and representation that they are in compliance with all material loan covenants.

III. The quarterly statements shall be signed and attested to by the provider's chief financial officer or if there is no chief financial officer, a company level officer.

420-D:8 Liquid Reserves.

I. Each provider shall establish and maintain liquid reserves in an amount equal to or exceeding:

(a) The total of all principal and interest due during the next 12 months on account of any long-term financing of the provider or facility in qualifying assets,"qualified assets"; and in addition;

(b) Sixty days reserve for operating expenses held in qualified assets to be incurred during the following 12-month period.

II. A provider shall satisfy its liquid reserve obligation with qualified assets.

(a) Qualified assets are:

(1) Cash.

(2) Cash equivalents.

(3) Investment securities.

(4) Equity securities, including mutual funds.

(5) Lines of credit and letters of credit that meet the requirements of this paragraph. The line of credit or letter of credit shall be issued by a state or federally chartered financial institution approved by the department or whose long-term debt is rated in the top three long-term debt rating categories by either Moody's Investors Service, Standard and Poor's Corporation, or a recognized securities rating agency acceptable to the department. The line of credit or letter of credit shall obligate the financial institution to furnish credit to the provider.

(A) The terms of the line of credit or letter of credit shall at a minimum provide both of the following:

(i) The department's approval shall be obtained by the provider and communicated in writing to the financial institution before any modification.

(ii) The financial institution shall fund the letter of credit, or the provider shall draw on the line of credit, no later than 4 business days following written instructions from the department that, in the sole judgment of the department, funding of the provider's minimum liquid reserve is required.

(B) The provider shall provide written notice to the department at least 14 days before the expiration of the line of credit or letter of credit if the term has not been extended or renewed by that time. The notice shall describe the qualified assets the provider will use to satisfy the liquid reserve requirement when the line of credit or letter of credit expires.

(C) A provider may satisfy all or a portion of its liquid reserve requirement with the available and unused portion of a qualifying line of credit or letter of credit. For purposes of satisfying all or a portion of a provider's debt service reserve requirement described above, restricted assets that are segregated or held in a separate account or escrow as a debt service reserve under the terms of the provider's long-term debt instruments are qualified assets, subject to all of the following conditions:

(1) The assets are restricted by the debt instrument so that they may be used only to pay principal, interest, or operating expense reserves, whichever is applicable.

(2) The provider furnishes to the department a copy of the agreement under which the restricted assets are held and certifies that it is a correct and complete copy. The provider, escrow holder, or other entity holding the assets must agree to provide to the department any information the department may request concerning the debt service reserve it holds.

(3) The market value, or guaranteed value, if applicable, of the restricted assets, up to the amount the provider must hold as a debt reserve will be included as part of the provider's liquid reserve.

(4) The restricted assets will not reduce or count towards the amount the provider must hold in its liquid reserve for operating expenses and the liquid reserve for operating expenses shall not count towards the long-term debt reserve.

(5) No qualified asset may be liened or encumbered by any secured or attaching creditor, except that a qualified asset may be encumbered by a long-term lender with a blanket lien on all assets as long as the qualified asset meets the requirements of this section.

(c) Sixty days net operating expenses shall be calculated by dividing the provider's cash operating expenses during the immediately preceding fiscal year by 365 and multiplying that quotient by 60.

(1) "Net operating expenses" includes all expenses except the following:

(A) The interest and credit enhancement expenses factored into the provider's calculation of its long-term debt reserve obligation.

(B) Depreciation or amortization expenses.

(C) Cash on hand.

(D) Extraordinary expenses that the department determines may be excluded by the provider. A provider shall apply in writing for a determination by the department and shall provide supporting documentation prepared in accordance with generally accepted accounting principles.

(2) A provider that has been in operation for less than 12 months shall calculate its net operating expenses by using its actual expenses for the months it has operated and, for the remaining months, the projected net operating expense amounts it submitted to the department as part of its application for a certificate of authority.

420-D:9 Limitations on Transfer and Lien Rights.

In addition to other remedies, the commissioner may file a lien on all real and personal property of a provider if the commissioner deems it necessary to protect the interests of the residents. Such lien shall be effective for the period determined necessary by the commissioner and may be renewed if the circumstances warrant it. A lien shall only be foreclosed to protect the entrance fees of residents, their health or safety, and the proceeds shall be distributed in a manner to satisfy any continuing care contracts in effect at that time. The commissioner does not need a court proceeding to file a lien.

420-D:10 Entrance Fee Escrow Account.

I. If required, a separate dedicated account for all entrance fees shall be established and approved by the commissioner before a certificate of authority under this chapter shall be issued. The entrance fee account shall hold all entrance fees required by this section which shall not be disbursed except as provided in this section. This account shall not be subject to liens of any creditors, shall not be encumbered, and shall be maintained separately from other accounts. Funds shall be held in escrow, if required, and only released as provided in paragraph III. Entrance fees shall be paid by the resident at the time the continuing care contract is executed unless otherwise agreed to by the parties. Entrance fees paid by residents before occupancy of a facility living unit or by residents under a contract issued, and which total over $1,000 and are not exempt as provided below shall be placed in the entrance fee account. All entrance fees that are not exempt as provided below shall be placed in the entrance fee account on the first working day after receipt. Interest on such fees shall be paid at the current market rate as established by the commissioner until the funds are released to the provider or returned to the resident or prospective resident as provided in paragraph III. In all cases, residents shall have 15 days after execution of the contract by both parties to move out, if a resident has moved in, and to cancel the contract and receive a refund. If entrance fees are paid to a provider over time, these rules shall apply to that portion of the fee that is paid when a refund or transfer of unit is requested.

II. The provider shall maintain at all times a written accounting of entrance fees and all bank statements of the entrance fee account. Upon request by the commissioner, the provider shall provide sum totals of all entrance fees paid by each resident, as well as any transactions with residents or prospective residents from the entrance fee account. If an entrance fee is paid by a non-resident, that person shall be named in the list maintained by the provider. It shall be the resident or non-resident's obligation to keep the address information held by the provider current.

III. Release of escrowed amounts or determination no escrow is needed shall be made as follows:

(a) For living units that have been previously occupied:

(1) If occupancy is greater than 80 percent for independent living, the days cash on hand is more than 100 days, and there is no violation of RSA 420-D or material loan covenants, there is no entrance fee escrow requirement.

(2) If occupancy is less than or equal to 80 percent for independent living and/or cash on hand is less than 100 days when the new resident and the provider both sign the contract, and 15 days have passed without the new resident canceling the continuing care contract, the entrance fee paid by the new resident may be paid to the provider. Until that time it shall be placed in the entrance fee escrow account.

(3) For other violations of subparagraph (1), entrance fee funds shall be placed in an escrow account and released only when the violation is remedied or other arrangements are made with the commissioner.

(4) Any funds due to the resident previously occupying the unit of the resident, or the resident's estate, trust, or other designee, pursuant to the previous resident's contract shall be refunded within 45 days of the lapse of the cancellation period. If termination occurs during the cancellation period, the prospective resident shall be entitled to a refund within 45 days written notice of rescission, and the former resident may not be paid, at the latest, until a new resident is obtained and the new cancellation period expires plus 45 days. Refund payments after the cancellation period may be reduced as provided in the continuing care contract by fees and costs incurred by the former resident. A contract shall not be deemed canceled under this provision or RSA 420-D:10-a unless the resident moves out or does not move in.

(b) For living units not previously occupied, other than expansions or additions of units when the 15-day cancellation period has passed, payment may be made to the provider from the entrance fee account, provided that subparagraph (1), (2), (3) or (6) is satisfied. Otherwise, the entrance fee shall be held in the entrance fee escrow account until subparagraph (1), (2), (3) or (6) is satisfied and the cancellation period has expired, whichever is later. If termination occurs during the cancellation period, then the requirements of subparagraph (1), (2), (3) or (6) shall not apply and the resident shall be entitled to a refund within 45 days written notice of rescission.

(1) The aggregate entrance fees received or receivable are equal to 50 percent of total entrance fees due at full occupancy, except that any entrance fee payments that are less than 35 percent of the amount due from a resident shall not be counted.

(2) When entrance fees plus proceeds of any first mortgage or other long term loan or capital infusion plus funds on hand equal 50 percent of the total cost of the facility.

(3) When a permanent mortgage has been received and all conditions have been satisfied other than completing construction and closing purchase.

(4) For a resident that has not moved into the facility, 15 days after the contract is fully executed by all parties.

(5) Notwithstanding anything to the contrary in this section and as long as the provider is in compliance with this chapter, a provider shall be permitted to take non-binding deposits to secure a unit prior to the payment of the entrance fee. Such payment shall be known as a "wait list deposit." Any wait list deposit shall be credited against the entrance fee when it is paid, or it shall be refunded if requested prior to payment of the entrance fee.

(6) Otherwise, at the discretion of the commissioner for good cause after request by the provider on notice to the resident.

(c)(1) If a wait list deposit exceeds 10 percent of the entrance fee per resident unit, any amounts more than 10 percent of the entrance fee shall be escrowed. Amounts below or equal to 10 percent of the entrance fee need not be escrowed, as long as the provider has at least 80 percent occupancy for independent living occupancy and 100 days cash on hand, and is otherwise in compliance with RSA 420-D and its material loan covenants. All wait list deposits shall be refundable. A maintenance fee may be charged of up to $1,500, as may be adjusted from time to time by the commissioner. The wait list agreement shall be provided to the department annually and the resident shall be given an estimate of when the resident will be reached on the wait list at the time the resident executes the wait list agreement. A resident shall also be told that their payment will not be escrowed if the payment is being placed in a non-escrow account. Deposits existing as of the effective date of this chapter are exempt. However, the provider shall contact all prospective residents on any wait list within one year of the effective date of this chapter to determine whether they are due any refund of existing deposits, and thereafter every 3 years.

(2) For any deposits made when a unit becomes available, which shall be known as "hold fees", the hold fees shall be applied towards the resident's entrance fee when paid and shall be refundable during the rescission period.

(3) Any fees expended by the provider for upgrades to a unit may be non-refundable, at the option of the provider, if the resident cancels the contract.

(d) If the funds deposited pursuant to this section in an escrow account are not released to the provider under the conditions enumerated in paragraph III within 5 years of the escrow date, unless the prospective resident has previously requested a refund, then the funds shall be returned

to the resident or prospective resident. The commissioner may extend this period for 2 additional years upon written application by the provider.

(e) The escrow provisions for an operating entity under this section shall not apply to nonrefundable application fees that do not exceed one month's periodic payments for services rendered by the provider.

(f) If approved by the commissioner, a provider may post a bond, negotiable securities, or a letter of credit with the commissioner in lieu of escrow. The institution providing a bond or a letter of credit shall meet all requirements of and have the full approval of the commissioner. The amount of the bond, negotiable securities, or letters of credit shall be in the same amount as if the funds received from residents or prospective residents had been placed in escrow.

(g) An escrow agent shall return funds to the person, or to the estate of the person if deceased, who paid the entrance fee, if a request is made to the provider. A request to return funds to any other person shall be approved by the commissioner.

420-D:10-a Termination Outside the Rescission Period.

I.(a) A contract may only be terminated by the provider for the following reasons:

(1) It is necessary for the resident's welfare;

(2) The resident's health has improved sufficiently so that they no longer need the services provided;

(3) The health or safety of the resident or other residents is endangered by the resident's continued presence in the CCRC; or

(4) Nonpayment of periodic payments or other required fees or other violation of the contract.

(b) If a provider seeks to terminate a contract, it must provide the resident with 60 days' notice. If a contract is terminated outside the cancellation period either by the provider for just cause or after 90 days written notice by the resident, then any refund that may be due shall be paid no later than 45 days after a new resident signs a written contract for the unit and the 15-day cancellation period passes without cancellation. The landlord-tenant laws shall apply to any eviction for purposes of removal of a hold over resident in a non-licensed unit, and for no other purpose. For hold over residents residing in units licensed under RSA 151, the transfer or discharge provisions under RSA 151:21,V and RSA 151:26 shall apply.

II. A contract may be terminated by either the provider or resident under exigent circumstances, such as that the resident presents a danger to himself or others, upon reasonable notice under the situation. In determining exigent circumstances, the parties may rely upon a written finding of the provider's medical director or the resident's physician or medical provider. Each party shall have the right to obtain a second medical assessment at their own expense prior to the resident's removal from the community or the filing of an action for termination in a court of competent jurisdiction.

420-D:11 Pledging Assets.

As long as the provider is in compliance with New Hampshire law and subject to the approval requirement of section RSA 420-D:2, unencumbered assets of a facility may be pledged as collateral. Notice shall be given to the commissioner of any additional liens.

420-D:12 Contracts With Residents.

I. Each continuing care contract, and any amendments, between a provider and a resident shall be approved by the commissioner and shall:

(a) Be written in plain, non-technical language.

(b) Cover only one resident, or 2 if jointly liable and shall include the total amount paid by the resident, or on behalf of the resident, to the provider as an entrance fee. If securities or real or personal property are transferred to the provider instead of cash, the provider shall describe the securities, property, or other goods transferred and the market value of securities or the professional appraised value of property or goods as of the date they were tendered.

(c) State specifically and in full detail all services and goods to be provided to the resident including the location where services and goods will be provided, the duration of such services, and how often they are to be provided. The contract shall also describe which services or goods are included in the continuing care agreement, or life care agreement, and which services or goods will be made available by the provider at an extra cost to the resident.

(d) State the conditions upon which the provider may terminate the continuing care agreement and remove the resident from the unit and the conditions upon which a resident may terminate the continuing care agreement. A statement of the unearned portion of the entrance fee to be returned under each condition shall also be included.

(e) Describe conditions required for a person to continue as a resident.

(f) Describe any conditions under which a resident delinquent in his or her periodic payments may remain in his or her unit and on the premises and if there is a specific time limit after which the resident must vacate the unit and the entire premises.

(g) State the entrance fees and periodic payment changes that may occur if a resident marries or if a spouse joins a unit. The continuing care agreement shall also state the fee changes that may occur if either one of the 2 people who occupy the same living unit dies or otherwise leaves the unit.

(h) Describe the terms and conditions under which a provider or a resident may cancel a continuing care agreement. The contract shall also state that a minimum of 60 days' notice to the resident to terminate shall be given, or that if there are exigent circumstances, only reasonable notice shall be required.

(i) Describe in clear detail all the terms under which a continuing care contract is canceled upon the departure or death of a resident.

(j) State how the entrance fees are earned as of the death of a resident after occupancy, and what portion, if any, shall be paid to the estate of the resident, and the formula for calculating such amounts.

(k) Describe the conditions under which periodic payments may change. The continuing care contract shall state that a 60-day notice is required before a change in periodic payments shall take effect, except those periodic payments required by federal or state assistance programs.

(l) State that periodic payments for care paid in a lump sum shall not be changed during the period covered, unless the resident is receiving federal or state assistance and the change is mandated by those programs.

(m) Provide a rescission period of the first 15 days during which a prospective resident may cancel the continuing care contract after both parties execute it and that the refund will be reduced by any payments due under the continuing care contract.

(n) Describe under what conditions a resident may be transferred to another living unit or another part of the facility together with the financial adjustments to be made as a result of such changes.

(o) Except for contracts described under RSA 420-D:3-a, provide for full refund, except any initial non-refundable application fee of less than one month's periodic payment, if, before occupancy, death occurs or if there is a medically certified incapacity preventing move in.

(p) Provide for a separate written disaster recovery plan, which shall be made available to all residents.

(q) Explain whether the CCRC provides assisted living, skilled nursing care, or nursing home care or accepts Medicaid or Medicare as a source of payment for these services.

II.(a) No continuing care contract issued pursuant to this section shall allow unilateral dismissal of a resident prior to the end of the contractual period or life of the resident, except for just cause as provided in the contract or if exigent circumstances exist. In such cases, the minimum refund shall be the unearned portion of the entrance fee in the contract with the resident, less any outstanding charges. The resident may cancel the continuing care contract on 90 days' notice for any reason. After cancellation, any refund due under any contract shall be subject to RSA 420-D:10-a.

(b) The commissioner or his designee may investigate and may intervene prior to a dismissal if requested by the resident, at the discretion of the commissioner. If the commissioner finds that a resident is being or has been unjustly dismissed, the commissioner may issue a cease-and-desist order prohibiting the provider from dismissing the resident.

420-D:12-a Continuing Care Community Residents' Bill of Rights.

I. The provider shall adopt the following bill of rights for residents of an independent living unit in a CCRC and shall provide a copy of the bill of rights to each resident prior to their purchase of such unit. The bill of rights shall be prominently displayed at one or more locations at the facility so that residents can view them at any time.

II. The bill of rights shall be as follows:

RESIDENT BILL OF RIGHTS

Residents in New Hampshire continuing care retirement communities (CCRCs) have a broad range of rights. This CCRC "residents' bill of rights" applies only to residents in independent living units. The residents' bill of rights does not modify or replace other rights of residents provided by RSA 420-D and regulations promulgated thereunder, the continuing care contract, or, to the extent applicable, federal or state laws and regulations, including but not limited to those governing: residential care facilities for the elderly; residential care and health facilities licensed under RSA 151; and nursing care facilities.

I. Respect, Individuality, and Environment.

(a) The resident shall be treated respectfully by the facility, and the facility shall foster an environment that supports the self-determination and independence of the resident to the extent possible in a community setting.

(b) The resident shall be entitled to the beneficial use and enjoyment of the resident's unit and any common areas of the facility, in a safe and well-maintained environment, subject only to the reasonable rules and regulations of the provider and the terms of the continuing care contract.

(c) The resident shall have the right to participate, or decline to participate, in all activities offered by the provider and for which resident qualifies to participate. The activities shall offer opportunities to contribute to the individual physical, intellectual, and social needs of the resident body in general.

II. Right of Association; Service on Governing Board.

(a) All residents shall have the right to form a resident association or council and to elect a governing body of the resident association to advocate on their behalf and to organize and conduct activities on their behalf, separate from those offered by the provider. The resident association governing body may establish committees to perform duties on its behalf. The resident association and its governing body and committees has no governance or management authority, rights, or powers with respect to the CCRC and will act only in an advisory capacity when interacting with the provider.

(b) The resident shall have the right to at least 14 days' prior notice of and the right to attend all meetings between the governing body of the resident association, or the residents if a resident association does not exist, and the provider's management executive and other administrative staff. The provider shall schedule at least one such meeting annually for a general discussion of, and to receive resident input regarding, income, expenditures, and financial trends, proposed changes in policies, programs, and services, and other matters of concern to residents generally.

(c) The resident shall have the right to voice concerns to the provider's administration through the resident association, or directly if a resident association does not exist, and to request

the provider's administration to share such concerns with the governing body of the provider, if applicable. The provider's administration shall respond to such concerns as promptly as possible.

(d) The resident shall have the right to join and participate in the resident association and any other independent resident groups without hindrance or retaliation by the provider.

(e) The provider shall reserve at least one seat on its governing body or board for a qualified resident, known as the resident trustee, to serve with or without voting rights, as determined by the board. The provider shall seek input from the resident association regarding resident trustee nominees, although the resident trustee nominees will be selected and evaluated according to the nominating process observed for all board members. Each resident trustee nominee shall satisfy the qualifications established by the board for all of its members. Qualified resident trustees shall be elected by the board and shall be bound by the same fiduciary duties to the provider as other board members. If there are no qualified resident trustee nominees, then that seat on the board shall remain vacant until a qualified resident trustee is elected. If the board governs more than one provider, then the mandatory resident trustee position shall rotate among those providers on a term-by-term basis.

III. Right to Information.

(a) The resident shall have the right to request from any regulatory agency any non-proprietary and non-confidential information filed with it by the provider and which information is subject to public disclosure under RSA 91-A, the New Hampshire right-to-know law.

(b) The resident shall have the right to be notified by the provider of any material citations issued by a regulatory agency against the provider, and to obtain a copy of any such citations upon request to the provider or to the regulatory agency, as applicable.

IV. Contract, Statutory Rights, and Communications with Provider.

(a) The resident shall have the right to receive a continuing care contract meeting the requirements of RSA 420-D:12 and that establishes the mutual rights and obligations of the resident and the provider.

(b) In addition to those required under this residents' bill of rights, the resident shall be entitled to all of the rights and notices required under the continuing care contract and RSA 420-D as it may be amended.

(c) The resident shall have the right to effective channels of communication with provider administration and staff, and to request through the resident association, or directly if a resident association does not exist, that certain communications be shared with the governing body of the provider as applicable.

(d) The resident shall have the right to receive communications from the provider in plain and understandable language. The communications, including notices required under RSA 420-D, may be provided by the provider through electronic means if the resident is alerted that the

communications will be provided in that manner and the resident has ready access the communications by electronic means.

V. Notice of Rights; Complaints; Enforcement of Rights.

(a) The resident shall have the right to receive this residents' bill of rights before or at the time of signing the continuing care contract, and the provider shall post notice in a prominent place in the facility or on its website or intranet site advising residents that a copy of the residents' bill of rights is available upon request.

(b) The resident shall have the right to exercise his or her rights under the residents' bill of rights without impediment or retaliation by the provider.

(c) The resident shall have the right to file a complaint with the department alleging a violation of this residents' bill of rights. The provider shall post notice in a prominent place in the facility or on its website or intranet site advising residents as to how to file such complaints.

(d) The resident has the right to make complaints to or contact other public agencies and elected officials without retaliation.

420-D:13 Transfer or Sale of Interest or Control.

I. A provider shall notify the commissioner prior to the proposed sale or transfer to a third party of a material portion of the provider's assets or beneficial interests, or of a proposed transfer of control of the provider. For purposes of this section, "material portion of the provider's assets and or interests" means any assets of the provider worth greater in the aggregate more than 10 percent of any interests of the provider's total assets or 50 percent or more of the beneficial interests. The notification shall specify the amount of assets or interests involved in the transfer, the type of transfer, and to whom. The proposed transfer shall be approved by the commissioner before such transfer can be made and become effective. The commissioner may refuse to approve such transfers until full disclosure has been made, to his or her satisfaction, of the terms and conditions of the transfer and the commissioner has determined that such transfer (i) will be to a qualified provider to whom a certificate of authority will be issued under the statute; (ii) will not negatively impact the financial stability of the CCRC; and (iii) will not diminish services or protections given to current and future residents, whose interests are paramount. Notwithstanding the above, if a provider is in violation of RSA 420-D or its material loan covenants, the provider shall notify the department of any transfer of assets or interests out of the ordinary course of business in any amount and the department shall, at its option, approve or deny the sale or transfer. If the transfer involves a transfer of ownership of more than 5 percent of the outstanding ownership interests, a new biographical affidavit shall be provided to the department.

II. If the commissioner approves a sale or transfer under this section, the commissioner shall cancel the existing certificate of authority and require that an application for a certificate of authority be submitted by the new provider within 30 days, unless the provider is already licensed, in which case a new certificate shall not be required.

III. Unless a new provider assumes all of the continuing care obligations under the continuing care contracts of the selling provider at the close of the sale or transfer, the selling provider shall set up a trust fund, secure a performance bond, or establish some other mechanism satisfactory to the commissioner to ensure the fulfillment of all its continuing care contract obligations.

IV. The provider shall give written notice to residents 120 days prior to the sale or transfer of a CCRC, unless there are exigent circumstances to shorten the notice period, with specifics of the sale or transfer and options available to the residents. The provider shall confirm that each resident has been provided notice.

420-D:14 Waiver Prohibited. Contracts entered into prior to the date the provider receives the certificate of authority are valid and binding for those providers offering or providing continuing care on January 1, 1989; except that a resident or a prospective resident who has signed a contract prior to that date may request that his or her contract with the provider be changed to conform with the provisions of this chapter. However, any changes made to such contracts after the date that rules adopted by the commissioner in accordance with RSA 420-D:17 take effect shall conform to all provisions of this chapter and such rules.

420-D:15 Right to Organize and to Obtain Outside Consultation.

I. In addition to and as part of the bill of rights, all residents shall have the right to self-organize, the right to be represented by an individual of their own choice, and the right to engage in concerted activities for their own purposes. Residents shall have the right both individually and severally to obtain outside advice and consultation of their own choosing on any matter, including, but not limited to, medical, legal, and financial matters.

II. A provider shall be available for meetings at least annually with residents or their representative. The meetings shall be for the purpose of providing a forum for free and open discussion of any point. If requested, the manager of a facility shall be present at such meetings, and the residents' organization may also request that an owner, partner, director, or other official of the provider operating the facility be present. Residents shall be given at least 2 weeks' notice of each such meeting.

420-D:15-a Unsound Financial Condition.

I. The department may require a provider to submit a financial plan, if either of the following applies:

(a) A provider fails to file a complete annual report.

(b) The department has reason to believe that the provider is insolvent, is in imminent danger of becoming insolvent, is in a financially unsound or unsafe condition, or that its condition is such that it may otherwise be unable to fully perform its obligations pursuant to continuing care contracts in the discretion of the commissioner.

II. A provider shall submit its financial plan to the department within 60 days following the date of the department's request. The financial plan shall explain how and when the provider will rectify the problems and deficiencies identified by the department.

III. The department shall approve or disapprove the plan within 30 days of its receipt.

IV. If the plan is approved, the provider shall immediately implement the plan.

V. If the plan is disapproved, or if it is determined that the plan is not being fully implemented, the department may consult with its financial consultants to develop a corrective action plan at the provider's expense or require the provider to obtain new or additional management capability approved by the department to remedy its deficiencies. Unless there are exigent circumstances, a reasonable period, as determined by the department, shall be allowed for the reorganized management to develop a plan which, subject to the approval of the department, shall reasonably assure that the provider will meet its responsibilities under the law.

420-D:16 Rehabilitation, Liquidation, or Bankruptcy.

I. The commissioner may, if it is in the best interest of the residents, petition a court of competent jurisdiction to appoint a trustee to rehabilitate or liquidate a facility. Such rehabilitation or liquidation shall occur only if the commissioner finds, after proper notice and hearing, any of the following:

(a) That a provider is insolvent or bankrupt or in danger of becoming insolvent or bankrupt.

(b) That a provider has failed to maintain required liquid reserves under RSA 420-D:8.

(c) That any part of the reserve fund escrow amount under RSA 420-D:10 has been or is about to be released in violation of RSA 420-D:10.

(d) That a provider has been or is about to become unable to meet the cash flow or income projections for the period.

(e) That the certificate of authority has been suspended or revoked.

(f) That the provider named in a certificate has conducted a transfer or sale described under RSA 420-D:13 without prior notification and approval by the commissioner.

II.(a) A rehabilitation order shall authorize the commissioner, or the trustee, to:

(1) Take possession of the property of the provider, including all facilities owned by the provider within the state;

(2) To operate the facility, directly or through a manager, including the employment or discharge of any facility employees as the commissioner or trustee may determine necessary; and

(3) To manage the facility and take other measures the court may direct as necessary.

(b) The commissioner, trustee, provider, or the court on its own motion may petition for removal of a rehabilitation order and return the management of the facility to the provider, if the provider demonstrates that the objectives of the original order have been met and that no further

jeopardy to the residents exists. A rehabilitation order shall contain an automatic stay, staying any collection actions by a secured or unsecured creditor against the receivership estate. Relief from the stay may be requested by a party in interest in the receivership proceedings.

III. If attempts to rehabilitate the facility fail, the commissioner may apply to the court for an order to liquidate. A liquidation order shall not require a prior rehabilitation order. An order to liquidate shall automatically revoke the certificate of authority for all facilities of the provider and shall include an order to liquidate all facilities owned by such provider.

IV. In applying for an order to rehabilitate or liquidate, the commissioner shall consider the best interests of the residents who have contracted for continuing care at the facility. The proceeds, if any, of liquidation shall be paid to other providers as full or partial entrance fees refunds for the affected residents who will need to move or shall otherwise be paid to the residents of the facility being liquidated. Except as provided in paragraph V, in the event of state court liquidation, all continuing care contracts with a provider shall be deemed preferred claims against the assets of the provider. A preferred claim shall be paid ahead of operating expenses, but behind secured debt. Providers shall be obligated to place residents in other qualified facilities as part of any liquidation.

V. A provider may avoid a rehabilitation order by posting a bond in an amount which is satisfactory to the commissioner. The bond shall be from a maker in this state who is acceptable to the commissioner and shall be in favor of the commissioner on behalf of those entitled to refunds or damages. It shall be in an amount sufficient to cover any refunds due to the residents plus other amounts as determined necessary by the commissioner in order to protect the residents. Nothing in this chapter shall be construed to impair the priority, with respect to the lien property, of mortgages, security agreements, lease agreements, or installment sales agreements on property not otherwise encumbered which have been entered into by a provider with an issuer of bonds or notes and bonds which are secured by a resolution, ordinance, or indenture of trust if such mortgages or agreements were duly recorded at least 4 months prior to the institution of liquidation proceedings.

VI. In the event of a federal bankruptcy court proceeding, the department and the department of health and human services may appear in the proceeding as a party in interest to protect the interests of the residents and the state of New Hampshire.

420-D:16-a Notice of Cancellation of a Continuing Care Contract.

I. Each resident may, upon 90-days' written notice, cancel the resident's continuing care agreement for any reason.

II. Each resident shall be provided at least 60-days' written notice from the provider if the resident's continuing care contract is being canceled for just cause. Notification may be waived if the provider can demonstrate exigent circumstances for terminating the continuing care contract on shorter notice. The resident may challenge the facility's notice of continuing care agreement cancellation by requesting a hearing with the provider or with the provider's representatives. Any notice of cancellation by the provider shall include the following:

(a) Specific factual representations constituting just cause, if any;

(b) Notice of the resident's right to challenge the provider's notice of cancellation by requesting a hearing; and

(c) Notice of the resident's right to a prompt full or partial refund of the resident's entrance fee to the extent provided in the continuing care contract or as provided by law.

III. The notice may be waived if the resident is a present danger to themselves or others.

420-D:16-b Refunds.

I. Upon cancellation of the continuing care contract by either the resident or the provider, the resident shall have the right to receive a refund of the amount of any unearned entrance fee as provided in the continuing care contract or as otherwise provided by law. The amount of the entrance fee and the method of determining the amount of the refundable deposit shall be set forth in a clear and conspicuous manner in the continuing care contract.

(a) When a resident permanently vacates the facility, or, in the case of 2 residents occupying the same residence, when both vacate at the same time, the provider shall provide to the resident or residents or the legal representative of the resident's estate, whichever is applicable, a refund of the unearned or guaranteed refundable entrance fee amount, as set forth in the contract, subject to the waiting periods contained in RSA 420:D-10-a.

(b) Any unpaid fees or charges incurred by the resident including unpaid monthly service fees, as well as the amount of any charitable assistance that the facility has provided to the resident, may be deducted from the remaining balance of the refund of the entrance fee.

(c) Any remaining amount due the resident shall be payable within 45 days from the date of the end of the cancellation period or the date the entrance fee from the new resident is received by the provider, whichever is later.

II. When an entrance fee deposit is refundable, it shall be paid to either the resident, the resident's named beneficiary, or the legal representative of the resident's estate, whichever is applicable, except for beneficiary assignments made irrevocable by the resident. A resident shall have the right to change, in writing, the named beneficiary for the entrance fee refund at any time.

III. Payment of the refundable entrance fee shall be subject to any other state and federal laws except that the first $120,000, or $240,000 for a couple, of the funds shall be exempt from attachment by creditors if the original entrance fee was payable from the proceeds of a house sold by the resident in New Hampshire.

420-D:17 Rulemaking. The commissioner may adopt rules pursuant to RSA 541-A to implement this chapter.

420-D:18 Dividends and Transfers. A provider shall obtain prior approval from the commissioner before declaring and distributing any dividends, if a for-profit entity, or, except as noted below, transferring any cash, dividends, or any other funds or assets of the provider to an affiliate of any entity. Notwithstanding this paragraph, if the provider has more than 80 percent

occupancy of its independent living units, more than 100 days cash on hand, and the provider is otherwise in compliance with RSA 420-D and its material loan covenants, the provider shall not need commissioner approval for a transfer if the transfer is less than 10 percent of the provider's total assets for any consecutive 12-month period. A transfer of assets shall include a management or management-type fee that is not associated with providing goods and services by the affiliate. All management contracts between the provider and an affiliate shall be disclosed to the commissioner, and the commissioner shall have 30 days to object.

420-D:19 Civil Liability.

I. In the following circumstances, a provider or his agent shall be liable for damages, entrance fees with any accrued interest, and attorneys' fees, plus any other fees paid in advance of receipt of services:

(a) If the provider or agent enters into contracts for continuing care for a facility that does not have a certificate of authority under this chapter;

(b) If the provider did not deliver a disclosure statement before entering into a contract; or

(c) If a disclosure statement is misleading and induces acceptance of a contract for continuing care or induces payment of any money or transfer of anything of value by a resident or prospective resident.

II. Negligent misrepresentation or omission shall not preclude recovery under this section.

III. The provider, upon written approval of the commissioner, may make a good faith offer to refund all fees and costs listed in paragraph I. Failure of a resident or prospective resident to accept such an offer within 60 days shall preclude further action by such resident or prospective resident.

IV. Any action brought pursuant to this section shall be in accordance with applicable state law and shall not limit the liability of the provider under other state laws. A private party shall not be liable by implication unless expressly permitted under this chapter.

420-D:20 Temporary and Permanent Closures.

I. Temporary and permanent closures shall be reported to the department and the department of health and human services as soon as the provider determines one is necessary, but no later than 120 before such closure is scheduled to occur. The provider must submit a written plan to both departments for any such closure that, at a minimum, shall include the following:

(a) The reasons for the temporary or permanent closure.

(b) What will happen to each resident. The provider shall either provide for the refund of any remaining entrance fee to the resident through immediately available funds or shall provide an alternative facility for the resident to occupy, with a transfer of remaining funds to the new provider. The residents shall have the choice to move to the alternate facility, to have the remaining portion of their entrance fee refunded through immediately available funds, or to enter into a

mutually agreeable alternative resolution with the provider. If the provider is incapable of satisfying this subparagraph, they must explain why in any plan.

II. Following the submission of the written plan, the provider shall act diligently to resolve any liquidation or solvency issues and shall keep the departments informed of any changes in information or status.

III. In connection with any proposed temporary closure of the facility or any portion thereof for a period lasting 9 months or more but less than 18 months, the provider shall:

(a) If the provider is relocating residents affected by the temporary closure to another portion of the facility or to another provider's facility, ensure that the residents receive comparable levels of care, services, and living accommodations during the relocation.

(b) Provide residents with at least 60 days' prior notice of the temporary closure, containing information about the date of relocation, replacement units, any change in monthly fees, time for inspection by residents of the replacement unit, and the estimated date of return to the resident's unit.

(c) Hold a meeting with residents at least 30 days in advance of the temporary closure, and at least 7 days after notice provided pursuant to subparagraph (b), to discuss all aspects of the relocation.

(d) Notify residents 60, 30, and 7 days prior to the scheduled return of the residents to the units originally vacated due to the temporary closure. The notice shall present a relocation plan to the unit originally vacated, if refurbished, or, if the unit originally vacated has been replaced, to another unit at the facility comparable in services, size, features, and amenities and without a further increase in monthly service fees beyond those established in the continuing care contract. The relocation plan shall detail the process and timelines by which the residents may select replacement units.

III. Except in the case of the reduction or elimination of units that are not independent living units, the provider shall, with respect to any permanent closure of the facility:

(a) Provide residents with at least 120 days' prior notice of a permanent closure, unless exigent circumstances require a shorter notice period.

(b) Prepare a relocation plan and provide written notice to residents of the components of the plan at least 90 days prior to the permanent closure, unless exigent circumstances require a shorter notice period. If the permanent closure is within the control of the provider and unless there are circumstances preventing the provider from acting, the relocation plan shall provide residents with at least one of the following options:

(1) Relocation to another CCRC owned or operated by the provider;

(2) Relocation to a CCRC not owned or operated by the provider, subject to the terms of the continuing care contract offered by the other CCRC provider;

(3) Monetary compensation equal to the amount of the refundable portion of the entrance fee due under the terms of the continuing care contract, if any; or

(4) An alternative, mutually agreed upon by the provider and the resident.

420-D:21 Complaints, Investigations, Violations, Enforcement.

I. Any person may, at any time, file a complaint with the department concerning any matter governed by RSA 420-D. The complaint may be written or oral. The department may also institute an investigation on its own initiative for just cause.

II. If the department determines or has cause to believe that a person has engaged in any act or practice which constitutes a violation of RSA 420-D, the department may take any or all of the following actions, or any other action consistent with this statute, as appropriate:

(a) Issue a temporary cease and desist order in writing and including a finding of fact, upon the determination by the department that the public interest will be irreparably harmed by delay in issuing an order. The temporary order shall include a provision that, upon written request made within 5 business days following issuance of the order, a hearing will be held within 10 days of the request to determine whether or not the temporary cease and desist order shall become permanent. Unless exigent circumstances exist, the department shall schedule a hearing before a cease and desist order is issued. A copy of any temporary or permanent cease and desist order shall be sent to the person by certified mail and e-mail;

(b) Issue any order requiring such action that in the judgment of the department will carry out the purposes of RSA 420-D;

(c) Bring an action in the superior court to enjoin the act or practice and to enforce compliance with RSA 420-D if it appears that a person has engaged or is about to engage in an act or practice constituting a violation of a provision of this chapter or a rule or order of the department. Upon a proper showing, the court may grant a permanent or temporary injunction, restraining order, or writ of mandamus, and may appoint a receiver or conservator for the defendant or the defendant's assets. The commissioner shall not be required to post a bond; and

(d) Levy and collect civil penalties for a violation of any provision or provisions of RSA 420-D or other law, or any rule adopted pursuant thereto or order issued thereunder, and compromise and settle any claim for a penalty in such amount in the discretion of the commissioner as is appropriate and equitable under the circumstances of the violation. Each day during which a violation continues after the effective date of a notice to terminate issued by the commissioner shall constitute an additional, separate, and distinct violation. If an administrative order levying a civil penalty is not satisfied within 30 days of its issuance, the commissioner may sue for and recover the penalty with costs in a summary proceeding as provided by applicable law.

III. For the purposes of actions that the department may take under paragraph II, the following shall have the same effect as a violation:

(a) Directly, or through an agent or employee, knowingly engaging in false, deceptive, or misleading advertising or promotional or sales methods to offer or dispose of a unit;

(b) Making any material change in the plan of disposition of the continuing care retirement community subsequent to the issuance of a certificate of authority and without obtaining prior approval from the department;

(c) Disposing of any unit or interest in a continuing care retirement community if the provisions of this chapter have not been satisfied or

(d) Violating any lawful order or rule of the department.

420-D:22 Investigation. The commissioner may make such investigations as he or she deems necessary both within and outside the state in accordance with applicable law.

420-D:23 Records and Assets to be Kept Within State.

I. All records and assets of a provider shall be established and kept in the state of New Hampshire and shall not be removed from this state by a provider or his or her agent unless agreed to in writing by the commissioner prior to such removal. The commissioner shall consent to such removal only if the provider submits satisfactory evidence that the removal will facilitate a more economical operation and will not diminish the service or protection given to the residents remaining in this state. The commissioner may order the return of the records and assets if such return is in the best interests of the residents or of the state. Records in remote locations that are readily accessible electronically shall be considered to be “in the state”.

II. All providers and affiliates shall comply with the privacy rules contained in Ins 3000 and any federal rules.

420-D:24 Examinations. The commissioner or the commissioner's agent shall examine the books and records of a provider subject to this chapter at least once every 5 years, or more frequently as the commissioner deems necessary to assure the accuracy of reports, taking into consideration other independent audits required under this chapter. The provider shall keep records for at least 5 years.

420-D:25 Fees. The commissioner shall charge providers subject to this chapter a fee for services rendered to them by the department of insurance. The fees shall be established and adopted by rule under RSA 541-A and shall be sufficient to cover the costs of administering this chapter.

420-D:26 Criminal Penalties. Any person, partnership, association, corporation, limited liability company, affiliate, or non-profit, including state, county, or local governmental units, or any division, department, board, or agency thereof who intentionally violates any provision of RSA 420-D or who fraudulently establishes, conducts, manages, or operates any CCRC without first obtaining a certificate as provided in this chapter, or who knowingly violates any rule adopted under this chapter, shall be guilty of a misdemeanor if a natural person, or guilty of a felony if any other person. Nothing in this section shall preclude any other action at law against such person.

420-D:27 Severability. If any provision of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provisions or application, and to this end the provisions of this chapter are severable.

3 Effective Date. This act shall take effect January 1, 2026.

LBA
25-0968
3/24/25

SB 124-FN- FISCAL NOTE
AS AMENDED BY THE SENATE (AMENDMENT #2025-0790s)

AN ACT relative to continuing care retirement communities.

FISCAL IMPACT:

The Office of Legislative Budget Assistant states this bill, as amended by the Senate, has no fiscal impact on state, county and local expenditures or revenue.

AGENCIES CONTACTED:

Insurance Department