LeadingAge New York

September 2, 2025

The Honorable Kathy Hochul
Governor
NYS State Capitol
Albany, NY 12224

Re: A.1464-A (Paulin)/S.4585 (Cleare)

Dear Governor Hochul,

LeadingAge New York and its not-for-profit, mission-driven members write to you today in support of A.1464-A (Paulin)/S.4585 (Cleare). This legislation would modify Articles 46 and 46-A of the Public Health Law to eliminate various barriers to the development, expansion, and efficient operation of Continuing Care Retirement Communities (CCRCs) in New York State while preserving vitally important resident protections. It would consolidate authority for the approval and operation of CCRCs into the Department of Health (DOH). The bill would also allow the state to update, through regulation, the limit on priority reservation fee deposits. This fully refundable fee is currently capped by statute at $2,000, a number that hasn't changed since 1991. The ability for the Department of Health to update this cap would help ensure that the deposit amount reflects current market conditions and is indicative of a genuine interest in the community. We urge that this reasonable and rational bill be signed into law.

Article 46 was first enacted in New York in 1989, and Article 46-A (which allows for fee-for-service CCRCs) was added in 2004. Over the last 30 years, the number of CCRCs and similar communities has grown dramatically across the nation, including in neighboring states. However, there are only *12* CCRCs in New York State. The requirements of Articles 46 and 46-A have created an environment in which it is prohibitively expensive and administratively burdensome to start or expand a CCRC, and extremely difficult for current CCRCs to operate efficiently and make their services more affordable. CCRCs are regulated by two State agencies [DOH and the Department of Financial Services (DFS)], and in certain cases by a third entity, the Office of the Attorney General. This level of oversight is burdensome, time-consuming, creates conflicts and duplication, and adds significantly to the cost of developing and operating CCRCs.

This oversight structure may have made sense 36 years ago, when the model was new and DOH lacked experience with insurance programs. However, since that time, DOH has developed extensive expertise in financial oversight of insurance products – the only DFS role in relation to CCRCs. This has resulted in considerable duplication of functions that slows processes and makes it difficult for CCRCs to respond nimbly to the changing conditions in the healthcare, financial, and retirement community markets. Delays in these processes can slow projects and initiatives that would improve the quality of life of CCRC residents and/or the financial position of the community.

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In addition to the state agencies, under the current structure, the CCRC Council must provide final approval of establishment and most operational changes in CCRCs. However, the Council has faced persistent challenges due to high turnover, frequent vacancies, and limited familiarity with the program among new members. By statute, only one member of the Council may be an operator or board member of a CCRC, further limiting its expertise. The Council often struggles to reach a quorum, leading to frequent cancellations of its already infrequent meetings—a problem that began before the pandemic and continues today. At the most recent Council meeting *in May of 2023*, another member retired adding to the number of vacant seats. These ongoing vacancies and infrequent meetings severely hinder the Council's ability to fulfill its statutory responsibilities, causing critical projects to stall when quorum cannot be met.

Not only does the cumbersome multiple agency oversight and Council approval cause delays that result in increased costs for existing CCRCs and their residents, but it also discourages providers who might otherwise pursue this model of care from proceeding. We believe this is a significant contributing factor to New York's lack of CCRCs compared to neighboring states: Pennsylvania (292), New Jersey (26), and Massachusetts (31).

This legislation would address these problems by streamlining provisions of Articles 46 and 46-A that mandate multiple agency involvement to consolidate oversight in DOH and make it clear that other agencies are involved in a limited, consultative role. It would also limit the CCRC Council to an advisory role, as is customary in most of New York's health-related councils.

CCRCs not only offer a desirable setting for healthy aging, they are also are a proven economic driver for local communities. Further, the CCRC is a private-pay model. At a time when the state faces significant budgetary pressures, we should be seeking to grow programs that do not rely on Medicaid dollars. Permitting more efficient oversight of New York's CCRCs may encourage the growth of this model in New York, reduce older adults' dependence on publicly-funded long-term care services, and prevent New Yorkers from moving to other states in search of these integrated, high-quality services.

For these reasons, LeadingAge New York strongly supports A.1464-A (Paulin)/S.4585 (Cleare) and urges you to sign it into law.

Sincerely,

Sebrina Barrett
President & CEO
LeadingAge New York