



Substitute House Bill No. 5113

Public Act No. 10-127

AN ACT CONCERNING BILLING FOR SERVICES COVERED BY LONG-TERM CARE INSURANCE BY MANAGED RESIDENTIAL COMMUNITIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 19a-694 of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

(a) All managed residential communities operating in the state shall:

(1) Provide a written residency agreement to each resident in accordance with section 19a-700;

(2) Afford residents the ability to access services provided by an assisted living services agency. Such services shall be provided in accordance with a service plan developed in accordance with section 19a-699;

(3) Upon the request of a resident, arrange, in conjunction with the assisted living services agency, for the provision of ancillary medical services on behalf of a resident, including physician and dental services, pharmacy services, restorative physical therapies, podiatry services, hospice care and home health agency services, provided the

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ancillary medical services are not administered by employees of the managed residential community, unless the resident chooses to receive such services;

(4) Provide a formally established security program for the protection and safety of residents that is designed to protect residents from intruders;

(5) Afford residents the rights and privileges guaranteed under title 47a; [and]

(6) Comply with the provisions of subsection (c) of section 19-13-D105 of the regulations of Connecticut state agencies; and

(7) Assist a resident who has a long-term care insurance policy with preparing and submitting claims for benefits to the insurer, provided such resident has executed a written authorization requesting and directing the insurer to (A) disclose information to the managed residential community relevant to such resident's eligibility for an insurance benefit or payment, and (B) provide a copy of the acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to such resident.

(b) No managed residential community shall control or manage the financial affairs or personal property of any resident, except as provided for in subdivision (7) of subsection (a) of this section.

Sec. 2. Subsection (a) of section 38a-501 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

(a) (1) As used in this section, "long-term care policy" means any individual health insurance policy, delivered or issued for delivery to any resident of this state on or after July 1, 1986, which is designed to

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provide, within the terms and conditions of the policy, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after an elimination period [(1)] (A) not to exceed one hundred days of confinement, or [(2)] (B) of over one hundred days but not to exceed two years of confinement, provided such period is covered by an irrevocable trust in an amount estimated to be sufficient to furnish coverage to the grantor of the trust for the duration of the elimination period. Such trust shall create an unconditional duty to pay the full amount held in trust exclusively to cover the costs of confinement during the elimination period, subject only to taxes and any trustee's charges allowed by law. Payment shall be made directly to the provider. The duty of the trustee may be enforced by the state, the grantor or any person acting on behalf of the grantor. A long-term care policy shall provide benefits for confinement in a nursing home or confinement in the insured's own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional capacity. "Long-term care policy" shall not include any such policy which is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(2) (A) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state may refuse to accept or make reimbursement pursuant to a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693, in accordance with subdivision (7) of

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subsection (a) of section 19a-694, as amended by this act, solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(B) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state shall, upon receipt of a written authorization executed by the insured, (i) disclose information to a managed residential community for the purpose of determining such insured's eligibility for an insurance benefit or payment, and (ii) provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to the insured.

Sec. 3. Subsection (a) of section 38a-528 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

(a) (1) As used in this section, "long-term care policy" means any group health insurance policy or certificate delivered or issued for delivery to any resident of this state on or after July 1, 1986, which is designed to provide, within the terms and conditions of the policy or certificate, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after a reasonable elimination period. A long-term care policy shall provide benefits for confinement in a nursing home or confinement in the insured's own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional capacity. "Long-term care policy" shall not include any such policy or certificate which is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage,

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hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(2) (A) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state may refuse to accept or make reimbursement pursuant to a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693, in accordance with subdivision (7) of subsection (a) of section 19a-694, as amended by this act, solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(B) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state shall, upon receipt of a written authorization executed by the insured, (i) disclose information to a managed residential community for the purpose of determining such insured's eligibility for an insurance benefit or payment, and (ii) provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to the insured.

Approved June 7, 2010