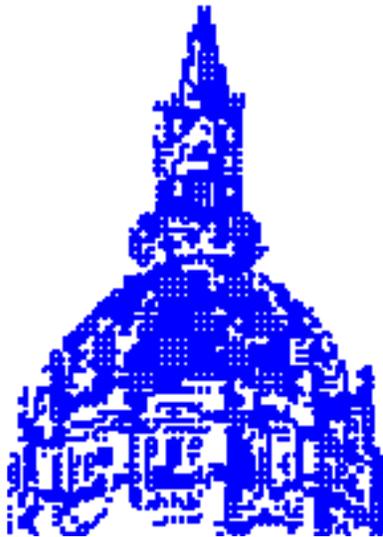


Office of Legislative Research
Connecticut General Assembly



OLR ACTS AFFECTING

Seniors



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NOTICE TO READERS

This report provides brief highlights of new laws (public acts) affecting seniors enacted during the 2005 regular and June special sessions. At the end of each summary we indicate the public act (PA) number. A number of the changes were made as part of several large acts that are commonly known as “the budget act” (PA 05-251, formerly HB 6940), the “DSS/DPH Implementer” (PA 05-280, formerly HB 7000), the “OPM Implementer” (PA 05-3, June Special Session, formerly HB 7502), and the “transportation bonding act” (PA 05-4, June Special Session, formerly SB 2000).

Not all provisions of the acts are included here. Complete summaries of all 2005 public acts will be available in the fall when OLR’s *Public Act Summary* book is published; some are already on OLR’s webpage: <http://www.cga.ct.gov/olr/OLRPASumsER.asp>

Readers are encouraged to obtain the full text of acts that interest them from the Connecticut State Library, the House Clerk’s Office, or the General Assembly’s website: <http://www.cga.ct.gov/>

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PRESCRIPTION DRUGS

State Response To Federal Medicare Part D Prescription Plans

A new state law makes a number of changes in prescription coverage for the Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE) and dually eligible Medicare-Medicaid participants in response to the upcoming permanent federal Medicare Part D prescription program. These changes will affect participants once the federal program starts in January 2006.

Federal Part D allows Medicare beneficiaries to enroll in private prescription plans that must offer at least a specified "standard" benefit package. People with low incomes and assets and those eligible for both Medicare and Medicaid (the "dually eligible") will receive extra federal help with deductibles, premiums, copays, and coverage. The plans only cover prescription drugs designated or treated as "Medicare Part D covered drugs" and, to some extent, they can choose which of these they will put on their formularies.

ConnPACE. PA 05-280 requires ConnPACE participants to (1) enroll in a Part D plan (enrollment can begin in

November but benefits start in January); (2) disclose their income and assets to the Department of Social Services (DSS) to determine their eligibility for the extra federal help; and (3) appoint the DSS commissioner as their authorized representative to enroll them in a plan if they do not choose one in time and represent them in Part D appeals.

It coordinates ConnPACE benefits with Part D so that participants do not pay more than ConnPACE's \$30 annual registration fee and \$16.25 per-prescription copayment for drugs that are (1) preferred drugs on their plan's formulary or (2) not designated a Part D covered drug. ConnPACE participants may pay less than the \$16.25 copay if their federal copays are lower. But they may have to pay the difference between DSS's payment and the price of a drug that is on the formulary but not a preferred drug. DSS generally will pay nothing for Part D covered drugs that are not on a plan's formulary. But under a federal exception procedure, if the client or DSS appeals and wins, the plans and DSS could treat and pay for drugs not on the formulary as though they were on it.

DSS will pay ConnPACE participants' Part D monthly premiums. It will cover drugs to the same extent as otherwise during the federal deductible period and the gap in the

“standard” benefit. The standard benefit, after a \$250 annual deductible, pays 75% of the drug costs up to \$2,250 and then pays nothing (the gap) until total drug costs reach \$5,100, after which it generally pays 95%.

Medicare-Medicaid Dually Eligible. Consistent with the federal law, dual eligibles will no longer receive Medicaid benefits for Part D covered drugs, even if they are not on the plan’s formulary. For drugs on a formulary, Medicare copays for this group will be \$1 to \$5 depending on income and drug type (generic, preferred, or other). Participants will not have to pay premiums or deductibles and will not be subject to the coverage gap. Medicaid continues to cover their drugs that are not Part D covered drugs. Dually eligible nursing home residents will not have copays.

(PA 05-280, effective July 1, 2005).

ConnPACE Replacement Prescriptions Copay

New legislation subjects replacement prescriptions to the usual ConnPACE copay (generally up to \$16.25). Last year, PA 04-104 allowed ConnPACE participants to obtain replacements for lost, destroyed, or stolen prescription drugs up to twice a year and exempted them from the copay requirement. This act continues the authority for the program to provide

replacements, but removes the copay exemption for them. DSS had not yet implemented the exemption.

(PA 05-280, effective July 1, 2005)

Prior Authorization (PA) for Prescription Drugs in DSS Drug Assistance Programs

The act changes the frequency of PA in DSS’ Medicaid, State-Administered General Assistance (SAGA) and ConnPACE drug assistance programs. It makes PA for a brand name drug valid for one year from the date the prescription is first filled. And it eliminates DSS’s authority to require PA for drugs costing \$500 or more for a 30-day supply.

By law, DSS must generally require PA for brand name drugs when a chemically-equivalent substitute is available and for early refills of drugs covered by its drug assistance programs cover. Under prior law, PA was required only for the initial prescription. But the PA plan, which prior law established but the act eliminates, was developed to carry out PA and applied a more narrow interpretation. It essentially said that PA lasted for the lifetime of the therapy unless another chemically equivalent generic was subsequently approved by the Food and Drug Administration. And for non-maintenance drugs, the plan required PA every six months. Prescriptions for less than a 15-day supply are never subject to PA.

(**PA 05-280**, effective on passage, but July 1, 2005 for the one-year PA validity)

Preferred Drug Lists

The act allows, rather than requires, DSS to adopt preferred drug lists for Medicaid, ConnPACE, and SAGA in consultation with the Medicaid Pharmaceutical and Therapeutics Committee. It also removes “Medicaid” from the committee’s name to be consistent with its broader responsibilities and requires the committee to include physicians with broader experience serving recipients of medical assistance, instead of just the Medicaid program. Prescriptions for drugs not on the lists need PA except for mental health-related and antiretroviral drugs. The act specifies that this exemption applies to classes of antiretroviral drugs. PA for a drug not on the preferred drug list, if granted, will be valid for one year from the date the prescription is first filled. (**PA 05-280**, effective July 1, 2005)

Pharmacy Outreach Program

This act establishes the Pharmacy Outreach Program administered by participating manufacturers. The program is to (1) help qualified state residents obtain reduced or no-cost medicine from participating manufacturers and (2) educate residents about programs

available in Connecticut relating to such medicine, through, among other means, a statewide toll-free telephone number. The act requires DSS to oversee the program. (The program is not aimed specifically at seniors but may be of interest to them.) (**PA 05-269**, effective on passage)

Prescription Drug Reimportation Study

The act sets up a working group to study whether the state should contract for development of a prescription drug purchasing program or enter into an existing program that allows Connecticut residents to purchase drugs through pharmacies in Canada or other countries. The group includes the public health, consumer protection, and DSS commissioners; the Public Health Committee chairmen; the attorney general, an Office of Policy and Management (OPM) representative, and any other person the health commissioner and Public Health Committee chairmen deem necessary. Its reporting deadline is January 1, 2006. The study must assess various safety, quality, affordability, and legal issues, as well as examine and make recommendations concerning the parameters of a request for proposal to implement such a program. (**PA 05-280**, effective upon passage; **PA 05-3**, June Special Session, effective July 1, 2005)

DEPARTMENT ON AGING REESTABLISHMENT

This act reestablishes a Department on Aging on January 1, 2007. Connecticut had such a department from 1969 to 1993, when it was disbanded and most of its functions were merged into DSS. The act also creates a task force to make further recommendations on revising the statutes to implement the change.

(PA 05-280, effective January 1, 2007 for creation of the department and July 1, 2005 for the task force)

COMMISSION ON AGING MOVE

Another act moves the independent Commission on Aging to the legislative branch for administrative purposes only. It was previously located in DSS for such purposes. The commission advocates for elderly people, conducts public hearings, issues various reports, disseminates information, and makes recommendations on elderly issues. The legislature established the commission in 1993 when it disbanded the former Department on Aging and folded its program functions into the Division of Elderly Services in DSS.

The act adds the chairmen and ranking members of the Select Committee on Aging as *ex officio* non-voting commission members and six new voting

members, appointed by legislative leaders. It also:

1. requires the commission's chairperson to be elected from among its members instead of selected by the governor;
2. requires the commission to meet regularly with state agency representatives to review and comment on their policies and procedures concerning the elderly;
3. requires the commission to review and comment on the budget of DSS's Unit on Aging instead of its Division of Elderly Services (which was recently subsumed under a larger Bureau of Aging, Community, and Social Work Services); and
4. allows the commission to enter into contracts.

(PA 05-77, effective July 1, 2005)

LONG-TERM CARE POLICY

Long-Term Care Policy Statement

This act requires the state's long-term care plan and policy, developed by the Long-Term Care Planning Committee, to provide that people who need long-term care can choose to receive it in the least restrictive, appropriate setting. This is consistent with a 1999 U.S. Supreme Court decision that ruled states cannot discriminate against people with disabilities by offering them long-

term care services only in institutions when they could be served in the community, given state resources and other citizens' long-term care needs (*Olmstead v. L.C.* , 119 S. Ct. 2176).

The interagency Long-Term Care Planning Committee, created in 1998, studies issues related to long-term care for the elderly and people with disabilities. The committee must issue a long-term care plan every three years; it completed the most recent one in 2004. By law, the plan is a guide for state agencies' programs serving people who need long-term care. (**PA 05-14**, effective October 1, 2005)

Duties of a Conservator Who Places A Ward In A Long-Term Care Institution

This act requires a conservator to file a report with the probate court that appointed him when he determines it is necessary to place his ward in a long-term care institution (a skilled nursing facility or intermediate care facility). The report must state:

1. the basis for the conservator's decision;
2. what community resources have been considered, including those offered through area aging agencies; the departments of Social Services, Mental Health and Addiction Services,

and Mental Retardation; the Office of Protection and Advocacy for Persons with Disabilities; independent living centers; residential care homes; and congregate or subsidized housing; and

3. why the ward's physical, mental, and psychosocial needs cannot be met in a less restrictive and more integrated environment.

The act requires the conservator to place the ward before filing the report if the placement results from the ward's discharge from a hospital or if irreparable injury to his mental or physical health or financial or legal affairs would result from filing the report before placement. In these circumstances, the conservator must (1) file the report within five days after making the placement and (2) include a statement about the hospital discharge or a description of the irreparable injury that placement averted. In other circumstances, the conservator must file the report before making the placement.

In either case, the act requires notice and an opportunity for a hearing within 30 days (the court can also hold such a hearing even without a request). If the court then decides the ward's needs can be met in a less restrictive and more integrated setting within his resources, either through his estate or private or public assistance, it

must order him placed and maintained in such a setting. (PA 05-155, effective October 1, 2005)

Temporary Conservators

Another act limits temporary conservators' powers. It restricts the probate court's authority to appoint them and requires it to hold a hearing within 72 hours of making an ex parte (without advance notice and a hearing) appointment.

Restricting Power To Relocate Ward. The act allows temporary conservators to relocate their wards only after attending a court hearing and obtaining a court ruling that the relocation is necessary, except for nursing home placements. They may place wards in nursing homes when necessary, under generally the same conditions and with the same reporting requirements described above for permanent conservators.

Conditions of Appointment. By law, interested parties may apply to the probate court, accompanied by medical documentation, to place people unable to take care of their own financial or health care needs under conservatorship. Temporary conservators are appointed in cases involving potential irreparable harm. The act adds a condition that the risk of irreparable harm must be immediate. It requires the probate court to limit the temporary conservator's powers

to the circumstances that gave rise to the application and to make specific findings to justify these limitations. In doing so, it must consider (1) the present and previously expressed wishes of the ward; (2) previous appointments of attorneys-in-fact, health care agents, or other fiduciaries; (3) other support services available to the ward; and (4) other relevant evidence. Temporary conservators serve for up to 60 days or until a permanent conservator is appointed, whichever occurs first.

Ex Parte Appointments. By law, probate courts may appoint a temporary conservator without prior notice to the ward and without appointing him legal counsel (ex parte). The act restricts this procedure to situations where the court decides the delay resulting from giving notice and appointing the counsel would cause immediate and irreparable injury to the ward's physical health or financial or legal affairs. On the appointment decree, the court must specifically state the injury that formed the basis for its decision and give reasons why it did not require a hearing with appointed counsel.

When the court makes an ex parte appointment, the act requires it to hold a hearing within 72 hours, excluding weekends and holidays, with appropriate hearing notice. After the hearing, the act requires, rather than allows, the court to confirm or revoke the

conservator's appointment. It also permits the court to modify the conservator's assigned duties, responsibilities, or powers.
(PA 05-154, effective on passage)

MEDICAID CHANGES

Repeal of Medicaid Long-Term Care Transfer of Assets Waiver Request

The act repeals a 2000 law that directed the DSS commissioner to seek a federal Medicaid waiver to allow her to make the start date later for long-term care asset transfer penalties and other provisions related to the waiver. DSS submitted the waiver request in 2002, but it was never approved and the governor announced recently that she would withdraw the request.

These penalties apply when people transfer assets for less than fair market value solely to qualify for Medicaid long-term care within 36 months before applying. Under federal law, the penalty period (i.e., period of Medicaid ineligibility) starts from the date the asset is transferred. Under the 2000 law, if the waiver had been approved, the penalty period would have started on the date the applicant was determined otherwise eligible for Medicaid.

The act also repeals provisions related to the waiver that would have allowed the commissioner to (1) increase the

look-back period for home property transfers from three years to five years and (2) establish asset thresholds below which DSS would not scrutinize transfers.
(PA 05-209, effective on passage; PA 05-280, effective on passage)

Prior Authorization for Chronic Disease Hospital Stays

This act requires the DSS commissioner to establish PA procedures for admissions and lengths of stay for Medicaid-eligible individuals who might require care in chronic disease hospitals.
(PA 05-209, effective July 1, 2005)

Disease Management Program

The same act permits, instead of requires, the DSS commissioner to design a care enhancement and disease management initiative for high-cost Medicaid recipients and implement it if she determines that it will be cost-effective. The commissioner has not yet implemented a program.
(PA 05-209, effective July 1, 2005)

NURSING HOMES

Nursing Home Provider Tax

The act imposes a provider tax (also called a “nursing home resident user fee”) on the state’s

nursing homes. It directs the DSS commissioner to file an amendment to the Medicaid State Plan to implement the fee and seek a federal Medicaid waiver to enable her to exempt continuing care retirement communities from the fee and charge certain homes a lower fee.

It increases rates the state pays in FY 06 to nursing homes, intermediate care facilities for people with mental retardation (ICF-MR), home health care agencies, home care agencies, personal care attendants, assisted living services agencies, residential care homes, and various private providers in DMHAS, DMR, Judicial Department, and DCF grant funded programs — all contingent on the nursing home fee's implementation and the availability of federal Medicaid matching funds.

(**PA 05-251**, effective July 1, 2005; **PA 05-280**, effective July 1, 2005)

Fire Sprinklers in Nursing Homes

This act extends the deadline for nursing homes to install automatic fire extinguishing systems, expands reporting requirements, and adds employee fire training requirements. Under prior law, each nursing home had to have such a system approved by the state fire marshal on each floor by July 1, 2005. The act extends the deadline to July 31, 2006,

specifies that the system should be complete, and requires it to be installed throughout the home instead of on each floor. It requires the Connecticut Health and Educational Facilities Authority (CHEFA) to create and administer a loan program to help pay for the installation cost. (**PA 05-187**, effective on passage, except the CHEFA requirements take effect July 1, 2005; **PA 05-272**, effective on passage)

Strike Contingency Plans

By law, when a health care institution receives a strike notice from a labor organization representing its employees, the institution must file a strike contingency plan with the Department of Public Health (DPH) commissioner. This act requires the plan to be filed no later than five days before the scheduled strike, rather than immediately after receiving a strike notice.

The act allows the commissioner to issue a summary order to any nursing home failing to file a contingency plan by the deadline. The order must require the home to immediately file a plan complying with the act and DPH regulations. A home can be subject to a civil penalty of up to \$10,000 for each day of noncompliance.

The act requires the commissioner to adopt regulations (1) establishing strike contingency plan requirements,

including requiring the plan to document that the institution has arranged for adequate staffing and security, food, pharmaceuticals, and other essential supplies and services to meet patients' needs if there is a strike and (2) for imposing the civil penalty on a nursing home. (**PA 05-172**, effective October 1, 2005)

HOME AND COMMUNITY-BASED CARE

Asset Cap Increase For State-Funded Home Care Program

Starting April 1, 2007, asset limits will increase for seniors in the state-funded side of the Connecticut Home Care Program for Elders (CHCPE). These limits are currently \$19,020 for an individual and \$28,530 for a couple, which respectively, represent 100% and 150% of the minimum federal "community spouse protected amount" (CSPA) of assets that a Medicaid-eligible nursing home resident's spouse living in the community can keep.

The act increases these caps to 150% and 200% of the CSPA. The increase would result in new asset limits of \$28,530 for single people and \$38,040 for married couples if it were in effect in 2005. But since the federal government adjusts the CSPAs annually for inflation, the limits will likely be somewhat higher by 2007, when the change takes effect.

The CHCPE provides home- and community-based care to seniors age 65 and over who would otherwise be at risk of going to a nursing home, meet certain financial conditions, and have incomes too high for regular Medicaid in the community. The program has a Medicaid waiver-funded portion and a solely state-funded portion with different asset limits.

(**PA 05-280**, effective July 1, 2005)

Elderly Personal Care Assistance Pilots Consolidation and Expansion

This act increases, from 100 to 150, the number of seniors who may participate in the state-funded Personal Care Assistance (PCA) pilot program created in 2004, but not yet implemented. And it repeals a PCA pilot established in 2000 for seniors either (1) transitioning off the state's Medicaid waiver PCA program for younger adults with disabilities or (2) eligible for CHCPE but unable to access adequate home care services. (The DSS commissioner had administratively expanded that pilot from 50 to 100 people in 2004.) People in the repealed pilot will become part of the new, less restrictive, 150-person pilot.

Under the new pilot, participants will still have to be age 65 or older and meet the CHCPE eligibility requirements. But the program will not be restricted to those aging out of

the Medicaid program for younger disabled people or otherwise unable to find adequate home care. And family members other than spouses will be allowed to serve as the PCA. The commissioner must determine that such services are cost-effective.
(PA-209, effective on passage)

Home Health Services Prior Authorization

The act requires the DSS commissioner to establish PA procedures in the Medicaid program for home health services involving more than two weekly skilled nursing visits. PA will not be required more than once a month unless there are changes.
(PA 05-280, effective July 1, 2005)

Nursing Oversight of Patients Receiving Home Health Care

New legislation directs that any state regulations defining minimum service quality standards for home health care agencies and homemaker-home health aide agencies require a registered nurse (RN) to visit and assess each patient receiving homemaker-home health aide services at least once every 60 days, consistent with federal guidelines. The RN must complete the assessment while the aide is providing services in the patient's home. Current state regulations require a more frequent assessment (at least

every four weeks), but do not specify that the assessment must be done by an RN, or that it must be done at the home while the aide is there.
(PA 05-64, effective on passage)

Nursing Home Diversion or Discharge Medicaid Waiver

The act requires the DSS and Department of Mental Health and Addiction Services (DMHAS) commissioners to convene a task force by July 1, 2005 to develop a feasibility plan to obtain a federal waiver to create a Medicaid-financed home and community-based pilot program to help adults with severe and persistent psychiatric disabilities who are diverted or discharged from nursing homes. The program can include housing assistance. The task force must report to the governor and General Assembly by January 1, 2006.
(PA 05-280, effective on passage)

TRANSPORTATION

Municipal Dial-a-Ride Grants

New legislation provides \$5 million out of transportation strategy bonds in both FY 06 and FY 07 for the municipal demand responsive (dial-a-ride) matching grant program for and those age 60 and over and the disabled, which was established by the legislature in 1999 but never implemented for lack of funding. The program will allocate matching grants to

municipalities based on a formula with two equal factors: the municipality's relative share of the state's elderly population and its size compared to the total area of the state. Municipalities must apply for the grants through a regional planning organization or transit district and must collaborate on service design to determine how to use the funding most effectively. (PA 05-4, June Special Session, effective July 1, 2005).

Seed Money for Elderly Community-Based Regional Transportation Systems

Another act requires DSS, as its budget permits, to provide \$25,000 grants each in FY 06 to up to four towns with populations of at least 25,000 or nonprofit organizations located in them. The grants are seed money for planning and developing financially self-sustaining, community-based regional transportation systems that, through a combination of private donations and user fees, provide rides in passenger cars for seniors who can no longer drive. Before receiving the grant, the town or entity must show that it has raised at least \$25,000 in matching private funds. The town must work cooperatively to develop the system with the regional planning agency of which it is a member.

Under the act, a grantee must, to the extent practicable, model its community-based system on the "ITNAmerica" model. ITNAmerica is a national nonprofit organization planning to replicate in other locations a model first developed by the Independent Transportation Network (ITN) in the Portland, Maine, area. ITN obtains its operating funds through memberships in the organization; riders' fares; and support from individuals, community businesses, and private foundations. It uses a combination of volunteers and paid drivers to provide on-demand, unrestricted transportation to seniors in passenger automobiles. (PA 05-280, effective on passage)

HOUSING

Elderly And Disabled Housing Issues

New legislation addresses concerns about elderly and non-elderly disabled people living in state-assisted elderly housing projects. It requires (1) state social service agencies to assist local housing authorities to identify and access their services and (2) several agencies to develop plans detailing their outreach efforts, available services, and crisis intervention activities. The act also requires a comprehensive assessment of rental assistance needs for state-assisted elderly and disabled

housing projects and a comprehensive inventory of all state and federally assisted housing in the state.

It also requires a number of reports to legislative committees, including one by February 1, 2006 from the Department of Economic Development (DECD) to the Legislative Program Review and Investigations Committee. The report must describe DECD's progress in a number of areas, such as revising the elderly and disabled housing operating manual, providing specified training to housing authorities, addressing security issues, reassessing resident service coordinators' qualifications and duties at these housing projects, and planning for a statewide manager position for the resident service coordinator program in elderly and disabled housing. **(PA 05-239**, effective upon passage, except the requirement for the assisted housing inventory takes effect July 1, 2005.)

Resident Service Coordinators' Training and Responsibilities

This act expands and redefines the responsibilities of resident service coordinators (RSCs) in state-assisted elderly housing projects. The act adds to RSCs' responsibilities the requirements that they (1) organize meetings and plan activities to promote residents' socialization; (2) help orient new residents; and (3) establish and

maintain relationships with community service providers, including linking residents to appropriate services. It also requires them to (1) facilitate conflict resolution between residents, including between elderly and younger disabled residents, and (2) assist in problem solving. DECD will convene monthly in-service training and information sharing meetings for them that cover information on the health care needs of seniors and people with disabilities, mediation and conflict resolution, and local and regional service resources.

Supportive Housing

Another act requires the Department of Mental Health and Addiction Services (DMHAS) commissioner to provide for up to 500 additional units of affordable, supportive housing for people with mental illness. Such housing would be an alternative for people with mental illness or substance abuse problems who otherwise qualify for elderly housing. These units are a second, "Next Steps," phase of the Supportive Housing Initiative. The first phase was instituted in 2001 to create 650 units.

Like the first phase, the Next Steps Initiative is funded through mortgages, tax credits, and grants from the Connecticut Housing Finance Authority and DECD; DSS rent subsidies; and

grants from various state agencies for support services.

Under the act, Next Steps housing is for:

1. people or families affected by psychiatric disabilities, chemical dependency, or both who are homeless or at risk of homelessness;
2. families who are eligible for TFA;
3. 18- to 23-year olds who are homeless or at risk of homelessness because they are transitioning out of foster care or other residential programs; and
4. community-supervised offenders with serious mental health needs who are under Judicial Branch or the Correction Department jurisdiction.

All of the units developed under the act must be permanent and can house individuals and families with or without special needs.

(PA 05-280, effective July 1, 2005, PA 05-3, June Special Session, effective July 1, 2005)

CASH ASSISTANCE

State Supplement Program (SSP)

New legislation continues the current freeze on benefit payments for the State Supplement Program (SSP) for FYs 06 and 07, but, in calculating benefits, allows the pass-through of the annual federal Supplemental Security

Income (SSI) cost-of-living (COLA) increase starting January 1, 2006. It does this by raising the SSP unearned income disregard (for example, \$183 for people living in the community) by the federal COLA amount.

Previously, SSP payments were reduced by whatever SSI COLAs beneficiaries received. The SSP program, run by DSS, generally supplements cash assistance received under the SSI program. The amount of state aid is based on the person's total needs, using DSS standards. This amount is then compared to the individual's income, and the difference after deductions are taken is the benefit.

(PA 05-243, effective on passage; PA 05-280, effective July 1, 2005.)

INSURANCE

Nutmeg Health Partnership Insurance Plan Study

This act requires the Insurance and Real Estate Committee to study creation of a "Nutmeg Health Partnership Insurance Plan," a public-private partnership to (1) increase the number of residents with health insurance, (2) provide broader health care access, and (3) make health care more affordable. By February 1, 2006, the committee must develop a plan to achieve these goals and report to the General Assembly on its details and legislation to implement it. This program is not specifically

aimed at seniors, but it could help seniors who are not yet eligible for Medicare (age 65). (**PA 05-280**, effective July 1, 2005)

Medicare Supplement Policies

This act revises state Medicare supplement policy requirements to reflect changes that take effect January 1, 2006 as a result of the 2003 federal law that creates Medicare Part D prescription drug coverage for seniors.

A Medicare supplement policy (also referred to as “Medigap”) is a health insurance policy that covers some of the health care costs that Medicare does not cover. Currently, there are 10 standard Medicare supplement policies called plans “A” through “J.” Plan A covers only basic benefits. Plans B through J offer additional benefits, with Plan J offering the most. The federal law creates two new plans: K and L. Plan K will cover 50% of the cost-sharing required under Medicare Parts A and B and limit out-of-pocket expenses to \$4,000, adjusted annually for inflation. Plan L will cover 75% of the cost-sharing and limit out-of-pocket expenses to \$2,000. The state act makes conforming changes.

The federal law also prohibits private insurers from selling new Medicare supplement plans with drug coverage (plans H, I, or J) after January 1, 2006. If a person enrolls in such a Medicare supplement policy by

December 31, 2005, he can keep it with the drug coverage if he does not enroll in Part D. If he enrolls in Part D, he can keep the supplement policy but without the drug coverage.

PA 05-20 prohibits an insurer from considering a person’s age, gender, claim history, or medical condition when deciding to accept or reject an application for coverage under a Medicare supplement policy, except for plans H, I, and J issued before January 2006, which can consider claims history and medical condition.

It also removes insurers’ authority to consider claims history and medical condition when setting rates for plans H, I, and J. In effect, this requires “community rating” for all Medicare supplement plans, since the others already had to use this method. (Community rating uses a uniform rate for all enrollees, regardless of their claims history or medical condition.)

(**PA 05-20**, effective July 1, 2005)

Protecting Seniors In Annuity Transactions

This act requires the insurance commissioner to adopt regulations to establish (1) standards for selling to, or exchanging annuities with, senior consumers (age 65 or older) and (2) procedures for making annuity sales or exchange recommendations to them. In the case of a purchase

by more than one person, the purchaser is considered a senior consumer if one of them is age 65 or older.

By law, “annuities” are agreements to make periodic payments where all or some of the payments depend on a person’s continued life or a specified number of years. (PA 05-57, effective on passage)

Coverage for Comprehensive Breast Ultrasounds

This act requires individual and group health insurance policies to cover a physician-recommended comprehensive ultrasound screening of an entire breast or breasts for a woman classified in certain categories on the American College of Radiology’s Breast Imaging Reporting and Database System (BI-RADS), subject to any policy provisions applicable to other covered services.

(PA 05-69 effective October 1, 2005)

A related act requires the Department of Public Health to review when breast cancer screening should be done using comprehensive ultrasound screening or mammogram examination and make best practices recommendations by January 1, 2006.

(PA 05-272, effective October 1, 2005)

Extended Reporting Period Coverage Under Medical Malpractice Insurance Policies

This act requires that under certain circumstances, professional liability insurance policies issued on a claims-made basis provide coverage for prior acts and unlimited extended reporting period coverage without additional charge to insured.

The requirement applies if, while an insured is covered under the policy, (1) the insurer stops offering the policy in Connecticut for any reason and the insured is over the age of 55 and has been insured by the insurer for the seven consecutive years immediately preceding the discontinuance or (2) the insured dies, becomes permanently disabled and unable to carry out his or her practice, or retires permanently from practice.

“Claims-made policy” means an insurance policy or a policy endorsement that covers liability for injury or damage the insured is legally obligated to pay arising out of incidents, acts, or omissions, as long as the claim is first made during the policy period or any extended reporting period. The act applies to policies delivered, issued for delivery, or renewed in Connecticut on or after October 1, 2005, to a physician or surgeon, advanced practice registered nurse, physician assistant, or hospital.

(PA 05-103, effective October 1, 2005)

TAXES

Estate, Succession, And Gift Taxes

The budget act eliminates the succession tax and gift taxes immediately instead of over several more years as required by prior law and replaces them with a uniform tax on transfers of Connecticut taxable gifts and estates that exceed a combined lifetime total of \$2 million. Connecticut's prior estate tax was effectively eliminated as of January 1, 2005 by a 2001 federal law.

The new transfer tax applies to:

1. estates of people who die on or after January 1, 2005 if (a) the estate's taxable value exceeds \$2 million and (b) the person was either a Connecticut resident when he died or owned Connecticut real or personal property;
2. gifts above the federal gift tax threshold (currently \$11,000 per year, per recipient) made on or after January 1, 2005 that, in the aggregate over the donor's life, exceed \$2 million; and
3. a person's estate, if the combined value of all the Connecticut taxable gifts he made after January 1, 2005 and his taxable estate exceeds \$2 million.

A qualifying life income interest in property passing to a

surviving spouse is not taxed until the spouse dies. The act requires a Connecticut estate tax return to be filed for all estates, regardless of gross value, if the decedent (1) died on or after January 1, 2005 and (2) was a Connecticut resident or owned real or personal property in the state when he died.

(PA 05-251, effective on passage. The new transfer tax applies to gifts made, and to estates of people who die, on or after January 1, 2005; the gift tax repeal applies to calendar years beginning on or after January 1, 2005; and the succession tax repeal applies to estates of those who die on or after January 1, 2005.)

Maximum Property Tax Credit

The budget act delays a scheduled increase in the maximum property tax credit against the income tax. Instead of increasing to a maximum of \$500 starting with the 2005 tax year, the act maintains the maximum credit at \$350 through the 2005 tax year, and then increases it to \$400.

(PA 05-251, effective on passage and applicable to tax years starting on or after January 1, 2005)

Half of Military Retirement Income Exempt from State Income Tax

The budget act exempts 50% of military retirement income

from state income tax starting with the 2008 tax year. The exemption applies to federal retirement pay for retired members of the U.S. Army, Navy, Air Force, Marines, Coast Guard, and Army and Air National Guard.

(PA 05-251, effective on passage and applicable to income years starting on or after January 1, 2008)

TEACHERS' RETIREMENT BENEFITS

Participants in TRS Health Benefit Plans Required to be Medicare Part A Participants

This act requires those receiving health benefits through plans offered by the Teachers' Retirement Board (TRB) to be enrolled in, rather than just eligible for, Medicare Part A. By law, the TRB must offer one or more health coverage plans to members of the Teachers' Retirement System (TRS) receiving retirement or disability benefits from the system; their spouses or surviving spouses; and to their disabled dependents, if there is no spouse or surviving spouse. Medicare Part A offers coverage for hospital stays and some other services.

(PA 05-98, effective July 1, 2005)

TRS Participation For Teachers and Professionals Employed By Children's Center Successor Organizations

The act allows teachers and other certified professionals who work at the Children's Center's successor organizations to participate in the state TRS and to receive credit for their service with the successor organization. Teaching service at the Children's Center itself is already covered by the TRS.

The Children's Center is a private agency in Hamden that offers residential and day programs for children with combinations of emotional and behavioral problems, learning disabilities, histories of physical or sexual abuse, or substance abuse and family dysfunctions. It operates Whitney Hall School, a state-accredited special education facility.

(PA 05-99, effective July 1, 2005)

MISCELLANEOUS

Hospital Patients' Rights

This act requires hospitals to notify each patient in writing, upon the patient's admission, of his specific rights under the hospital's conditions of participation in Medicare. Notification can be made to his guardian or representative. The notice must also inform the patient on how to complain, including how to contact DPH.

(**PA 05-128**, effective October 1, 2005)

Senior Citizens' Bingo

This act increases, from \$5 to \$20, the maximum value of the prize or prizes that senior citizen organizations may award for senior citizens' recreational bingo.

(**PA 05-11**, effective on passage)

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