

Summary of the Results of the 2010 Connecticut Legislative Session

I. Snapshot of the population based on CT Long-Term Care Needs Assessment (UConn, 2007):

a. Myth-defying financial constraints

Rebutting the myth that older adults in Connecticut are economically secure, the Elder Economic Security Standard Index for Connecticut (2009, UMass Gerontology Institute, Wider Opportunities for Women, the Atlantic Philanthropies), illustrates that older adult residents of **suburban** Connecticut towns:

- require the following annual income to meet basic living expenses:
 - for an individual who owns his or her home free and clear: \$23,460
 - for an individual who rents an apartment: \$25,092
 - for a couple who owns their home free and clear: \$34,024
 - for a couple who rents an apartment: \$35,656
- can cover only 56-60% of an individual's basic living expenses with the average Social Security benefit (\$13,972 for New Haven County in 2008)
- can cover only 41-44% of an individual's basic living expenses on an income equal to 100% of the FPL
- will likely lose a significant amount of income upon the death of a spouse, but will see living expenses reduced by only 30%

b. High incidence of disability and functional impairment

10% of Connecticut adults age 21-64 and 35% of Connecticut adults age 65 and older has a disability. Among those age 65 and older, 26% have a physical disability, 15% have a mobility-related disability, 14% have a sensory disability, and 9% have cognitive impairment.

c. Majority live in private homes and indicate preference to remain there, with or without supports

- o 77% live in own home or condo
- o overwhelming majority not only prefer to remain at home, but expect to do so

d. Little planning for long-term care needs and misconceptions about sources of payment

i. When asked how they plan to pay for LTC:

1. leading reply is "savings or investments"
2. followed by Medicare
3. followed, unsurprisingly, but disturbingly, by "don't know"

ii. With respect to ability to pay:

1. 23% can pay nothing toward cost of LTC
2. 32% could pay less than \$10,000 per year
3. 23% could pay between \$10,000 and \$25,000 per year
4. 22% could pay over \$25,000 per year

iii. Few have long-term care insurance.

Only 18% of respondents have LTC insurance

iv. Long-term care is extremely costly

1. average 2009 private pay rate in a nursing facility:
\$341/day (\$124,400) annually [Connecticut Office of Policy and Management]
2. home care rates

v. People are inadequately served

of those currently in need of LTC, 37% report that they are unable to get all needed services and most reported reason for this: "lack of affordability"

vi. Not all about HCBS!!

While Assessment projected that by 2030, need for HCBS will increase by 28%, need for nursing facility services is also projected to increase by 43%.

II. An incongruity between expansion and contraction

		Re-Balancing	Retracting												
Capsule		In the interest of achieving cost savings and respecting consumer preference, shifting of resources from historical emphasis on institutional settings to home and community-based services.	Due to budget constraints, pull back of more expansive aspects of its long-term care coverage and imposition of increased cost-sharing obligations.												
Access to services															
	Eligibility requirements	<p>Expansion of Medicare Cost-Sharing Programs:</p> <p>effective 10/1/09, dramatic expansion in eligibility criteria for the Medicare Cost Sharing Programs (CT calls this Medicare Savings Plan Plus):</p> <table border="1"> <thead> <tr> <th>Program</th> <th>Income Limits (singles and couples)</th> <th>Covers</th> </tr> </thead> <tbody> <tr> <td>QMB</td> <td>\$1,778.91 (s) / \$2,393.55 (c)</td> <td>Part A prem. Part B prem. Deducts Co-pays</td> </tr> <tr> <td>SLMB</td> <td>\$1,959.51 (s) / \$2,636.55 (c)</td> <td>Part B prem.</td> </tr> <tr> <td>ALMB</td> <td>\$2,091.67 (s) / \$2,816.67 (c)</td> <td>Part B prem.</td> </tr> </tbody> </table> <p>Effective 10/1/09, no asset limits; effective 1/1/10, no estate recovery. A benefit that is associated with eligibility is Medicare D Low-Income Subsidy (LIS) coverage.</p>	Program	Income Limits (singles and couples)	Covers	QMB	\$1,778.91 (s) / \$2,393.55 (c)	Part A prem. Part B prem. Deducts Co-pays	SLMB	\$1,959.51 (s) / \$2,636.55 (c)	Part B prem.	ALMB	\$2,091.67 (s) / \$2,816.67 (c)	Part B prem.	<p>New constraints on accessing ConnPACE:</p> <p>A provision of 2009 law limits enrollment in ConnPACE to an annual enrollment period - individuals may now enroll in ConnPACE only 1) within 31 days of turning age 65 or becoming eligible for SSDI or SSI benefits on the basis of disability; or 2) during an open enrollment period that coincides with the annual Part D open enrollment period (November 15 - December 31)[Section 33 of Public Act 09-5, effective 10/13/09]</p>
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		Re-Balancing	Retracting
Access to services (cont.)			
	Eligibility (cont.)	<p>Automatic Grant of Maximum CSPA:</p> <p>A 2010 law requires the Commissioner of DSS to amend the Medicaid state plan to require that the community spouse receive the <u>maximum</u> CSPA. [P.A. 73, Section 1, effective 5/27/10] In 2010, the maximum CSPA is \$109,560. DSS has interpreted this as applying to eligibility determinations occurring from May, 2010 forward, and has provided the following examples:</p> <ul style="list-style-type: none"> • if the spousal assets as of the date of institutionalization (DOI) are \$100,000, the CSPA will be \$100,000; • if the spousal assets as of the DOI are \$200,000, the CSPA will be \$109,560. <p>Treatment of RAM/HEC Proceeds:</p> <p>Another section of that same law requires that proceeds of a RAM or other home equity loan not be treated as income or assets for purposes of eligibility if the funds are kept in a segregated account and the Medicaid recipient does not transfer funds for less than Fair Market Value. [P.A. 73, Section 2, effective 5/27/10]</p>	

		Re-Balancing	Retracting
Access to services (cont.)			
		<p>Special Needs Trusts/Residential Care Homes:</p> <p>Public Act 09-73, effective 7/1/09, permits certain individuals who live in residential care homes and New Horizons, Inc. (Farmington) to divert excess income, which otherwise might render them ineligible for SSABD benefits by reason of a non-exempt transfer, into a (d)(4) special needs trust. In order to qualify:</p> <ul style="list-style-type: none"> • the individual must have income that is greater than 300% of the maximum Supplemental Security Income benefit (in 2010, \$2,022 per month) but less than the private monthly rate for room and board in the residential care home; • the trust must solely be funded with this excess income; and • the trust language must provide for recovery by the State at the individual's death of the SSABD funds expended. 	

		Re-Balancing	Retracting
Access to services (cont.)			
		<p>Part D Payments Under Health Care Reform:</p> <p>A section of the biennial budget enacted by the Connecticut legislature in 2010 holds harmless recipients of state and local programs from being found income ineligible due to payments received under the auspices of the federal health care reform law, and ensures that such payments will not be counted as assets in the month of receipt and for two subsequent months. [Public Act 10-179, Section 36, effective 5/7/10]</p>	
	Application process	<p>DSS's Proposed Improvements:</p> <ul style="list-style-type: none"> • MI/MR screening process • document scanning • universal application for benefits across departments of the State 	<p>Failure to Meet Standard of Promptness:</p> <p>There are significant concerns about exacerbation of failure to meet standard of promptness in review of applications due to retirement of many DSS line staff and managers in regional offices.</p>
	Availability	<p>CHCPE Open Admission:</p> <p>The CHCPE is open to intake on a rolling basis, and the 2010 funding level is expected to continue to support open admission.</p>	<p>Waiver/Pilot Waitlists:</p> <ul style="list-style-type: none"> • no new funding for ABI or PCA waivers • no new funding for assisted living pilots

		Re-Balancing	Retracting
Scope/mode of services		<p>Self-Directed Care:</p> <p>In 2009, the legislature authorized DSS to include personal care assistants as a covered service of the CHCPE. This service and assistive technology were included in DSS' recent submission to CMS of a request for 5-year renewal of the CHCPE waiver. Coverage is expected to be effective on or about July 1, 2010.</p>	<p>Vision Coverage:</p> <p>Under deficit mitigation measures, DSS medical assistance programs will now cover no more than one pair of replacement glasses per year. [P.A. 10-3, Section 28]</p>
Cost-sharing		<p>Historically, the legislature has rejected calls for Medicaid co-payments for medical services and prescription drugs. In 2006, a comprehensive package of prescription drug protections to "wrap-around" Medicare D benefits was enacted.</p>	<p>Retraction of Coverage of Out-of-Pocket Costs for Rx:</p> <p>Significant retraction of "wrap-around" coverage to Medicare D benefits:</p> <ul style="list-style-type: none"> • participants now pay up to \$15 in Medicare D co-payments per month • annual enrollment fee to participate in ConnPACE was increased from \$30 to \$45 • DSS now pays plan premiums only up to the benchmark - \$34.40/month • in 2010 session, the Medicare Supplemental Needs Fund, which provided failsafe coverage of non-formulary drugs, was eliminated

		Re-Balancing	Retracting
<p>Cost-sharing (cont.)</p>		<p>In past years, Connecticut used a uniform cost-sharing method (“applied income”) for all participants of the CHCPE.</p>	<p>Cost Sharing for Participants of State-Funded Tiers of CHCPE:</p> <p>Effective January 1, 2010, participants of the <u>state-funded tiers</u> of the CHCPE were required to make co-payments as follows: except for individuals who reside in an affordable assisted living demonstration project, 1) each participant whose income is at or below 200% of the FPL (in 2010, \$1,806 per month) is required make a co-payment equal to 15% of the value of his or her care plan; and 2) each participant whose income exceeds 200% of the FPL is required to make a co-payment of 15% of the value of his or her care plan, and also to continue to pay any applicable applied income obligations. Individuals who fail to make the required co-payment are considered ineligible for services, and are discontinued without prejudice from the program. [Section 66 of Public Act 09-5, effective 10/13/09]</p> <p><i>Effective July 1, 2010, the co-payment percentage will be reduced from 15 to 6% of the value of each participant's care plan.</i></p>

Key Elements of Federal Health Care Reform for Older Adults and Individuals with Disabilities:

The Patient Protection and Affordable Care Act (PPACA)¹,

- **Medicare Covered Services:**
 - Effective January 1, 2011, deductibles and co-insurance will be eliminated for all Medicare preventative services.
 - Medicare will cover an annual “wellness” visit for all beneficiaries.

- **Medicare Part D:**
 - In 2010, individuals whose true out-of-pocket (TROOP) costs for prescription drugs are great enough to reach the coverage gap will qualify for a tax-free rebate check of \$250. **Please note:** individuals who qualify for the Medicare D Low-Income Subsidy (LIS or “extra help”), and those in qualified retiree health plans, will not receive rebate checks.
 - In 2011, beneficiaries who reach the coverage gap will receive a fifty percent (50%) discount on all name-brand drugs purchased during the coverage gap, and will also receive discounts on generic drugs (participants will be required to pay 93%, as opposed to 100%, of drug costs).
 - From 2012 through 2020, discounts on prescription drugs purchased during the coverage gap will gradually increase according to a schedule until, in 2020, beneficiaries will be responsible for paying on 25% of those costs.

- **Community Living Assistance Services and Supports (CLASS)**
 - voluntary, public long-term care insurance program
 - expected to be initiated in 2011; five-year vesting period
 - financed via payroll tax (for working individuals)
 - estimated average monthly premium = \$123
 - opt-out
 - premiums will be graduated on an age basis
 - for those who meet functional criteria (e.g. impairments in activities of daily living):

¹ P.L. 111-148 (signed March 23, 2010)

- per diem benefit (estimated average = \$75; approximately \$27,000 per year)
- individual makes decisions about how to use the benefit (nursing facility care, home and community-based services, respite, home modification)
- in contrast to private long-term care insurance:
 - no medical underwriting
 - premiums will not relate to health status
 - lifetime benefit (no durational limitation)
 - however, as of now:
 - no COLA protection
 - no lapse protection
- **Money Follows the Person (MFP):**
 - extends the MFP Demonstration Program through 2016, continuing the enhanced Federal Medical Assistance Payment (FMAP);
 - reduces the minimum qualifying stay in an institution from six (6) to three (3) months

Revised Uniform Anatomical Gifts Act:

In 2010, the Connecticut legislature enacted the Revised Uniform Anatomical Gifts Act.²

An anatomical gift authorizes the donation of all or part of a human body to take effect upon the donor's death for purposes of transplantation, therapy, research or education.

Execution requirements. To make an anatomical gift, an individual must be:

- at least 18 years old;
- a minor who is emancipated, age eligible for a driver's license (age 16 ½), or eligible for a Department of Motor Vehicles identification card;
- parents of unemancipated minors, on the minors' behalf; or
- a donor's:
 - guardian, who is defined as a person appointed by the court to make decisions concerning support, care, education, health or welfare of the individual, but not a guardian ad litem; or
 - agent, who is defined as the attorney-in-fact authorized by a power of attorney to make health care decisions or an individual who is expressly authorized to do so, on his or her behalf.³

Gifts may be made:

- by authorizing a donor designation in a donor registry;
- by will;
- during a terminal illness, by any form of communication addressed to at least two adults, at least one of whom must be a disinterested witness;
- by document of gift signed by donor;
- by execution of record:
 - donor card;
 - other record signed by the donor or another person making the gift; or
 - by authorizing a statement or symbol indicating that the donor has made an anatomical gift to be included on a donor registry.⁴

If an individual is unable to sign, the execution of record may be signed by another person at the direction of the donor or other individual authorized to make an anatomical gift, but must be witnessed by at least two adults, at least one of whom must be a disinterested witness, who have:

- signed at the request of the donor or other person authorized to make a gift; and
- stated that it is signed and witnessed as required.⁵

² 2010 Conn. Pub. Acts 123, effective October 1, 2010

³ 2010 Conn. Pub. Acts 123, Section 4

⁴ 2010 Conn. Pub. Acts 123, Section 5

⁵ 2010 Conn. Pub. Acts 123, Section 11

A disinterested witness is:

- a person other than the spouse, child, parent, sibling, grandchild, grandparent, or guardian (within the meaning of the Revised Uniform Anatomical Gift Act) of an individual who makes, amends, revokes or refuses to make an anatomical gift; or
- another person who has “exhibited special care and concern” for the individual.⁶

Recipients of anatomical gifts can include:

- a hospital;
- a medical or dental school;
- a college or university;
- an organ procurement organization; or
- another person qualified to perform research or education;
- a named beneficiary; or
- eye and tissue banks.⁷

A recipient is not considered to be a disinterested witness.⁸

Refusal. A refusal is defined as a record that expressly states an intent to bar other individuals from making an anatomical gift of a body or body part.⁹ An individual may, by the following means, refuse to make an anatomical gift:

- by a record signed by:
 - the individual; or
 - an individual acting at the direction of the individual if he or she is physically unable to sign;
- by will, whether or not the will is probated or invalidated;
- during a terminal illness, by any form of communication to at least two people, one of whom must be disinterested, who have:
 - signed at the individual’s request; and
 - stated that the record is signed and witnessed as required.¹⁰

In the absence of an explicit refusal to make a gift, a revocation of an anatomical gift does not constitute a refusal nor does it bar an authorized person from make a gift either before or after the individual’s death.

An individual can revoke his or her refusal by:

- codicil to a will;

⁶ 2010 Conn. Pub. Acts 123, Section 2

⁷ 2010 Conn. Pub. Acts 123, Section 2

⁸ 2010 Conn. Pub. Acts 123, Section 5

⁹ 2010 Conn. Pub. Acts 123, Section 2

¹⁰ 2010 Conn. Pub. Acts 123, Section 7

- signing a written document;
- orally expressing such a wish to two or more adults;
- making an inconsistent document of gift; or
- destroying the refusal.¹¹

Unless a refusal is revoked, or there is express contrary indication of wishes, a refusal to make an anatomical gift bars all other persons from making an anatomical gift.¹²

Operative condition and search requirements. An anatomical gift becomes operative upon death. A document of gift need not be delivered during the donor’s lifetime to be effective.¹³ A gift that has not been revoked before death is irrevocable and requires no additional consents or concurrences from any other person. An anatomical gift that was made by will becomes effective irrespective of whether a will has been probated, and invalidation of a will does not invalidate the gift.¹⁴ If the gift has been made by imprint on driver’s license, revocation, suspension, expiration or cancellation of the license does not invalidate the gift.¹⁵

The law requires the following to conduct a reasonable search of an individual who is reasonably believed by them to be dead or near death to attempt to locate a document of gift, other indication of donor statute, or other indication of refusal; to send any document that is located to the hospital; and subjects to administrative sanction for failure to do so:

- law enforcement officers, firefighters, paramedics and other emergency responders; and
- if no other source of information is available, the hospital as soon as is practical after the individual’s arrival.¹⁶

The law also requires organ procurement organizations to which an individual who is at or near death is referred by a hospital to make a reasonable search of Department of Motor Vehicle (DMV) records and any donor registry for the geographical area in which the individual lives.¹⁷

Further, any person who is in possession of a document of gift or refusal must permit an individual who is authorized to make or object to the making of a gift to review and copy the document.¹⁸

Unless otherwise precluded by law (e.g. by reason of a donor’s unrevoked refusal), and with certain exceptions based on a hierarchy of class that is addressed below, any member of the following classes of people, listed in order of priority, who is reasonably available may make an anatomical gift of a decedent’s body or part for purpose of transplantation, therapy, research or education:

¹¹ 2010 Conn. Pub. Acts 123, Section 7

¹² 2010 Conn. Pub. Acts 123, Section 7

¹³ 2010 Conn. Pub. Acts 123, Section 13

¹⁴ 2010 Conn. Pub. Acts 123, Section 5

¹⁵ 2010 Conn. Pub. Acts 123, Section 5

¹⁶ 2010 Conn. Pub. Acts 123, Section 12

¹⁷ 2010 Conn. Pub. Acts 123, Section 14

¹⁸ 2010 Conn. Pub. Acts 123, Section 13

- an agent of the decedent, as defined above;
- the spouse of the decedent;
- a person designated by the decedent under C.G.S.A. § 1-56r;
- adult children of the decedent;
- parents of the decedent;
- adult siblings of the decedent;
- adult grandchildren of the decedent;
- grandparents of the decedent;
- an adult who exhibited special care and concern for the decedent;
- the person(s) who were acting as guardians or conservator of the person of the decedent at the time of death; and
- any other person who has legal authority to dispose of the decedent's body.¹⁹

If there is more than one member of a class who is an agent, person designed under C.G.S.A. § 1-56r, adult child, parent, adult sibling, adult grandchildren, grandparent, guardian or conservator of the decedent, and a member knows of no objection, an anatomical gift may be made by any member of the class. If a member of the class, or an individual who has legal authority to dispose of the decedent's body, knows of an objection by another member of the class, the gift may only be made by a majority of the members of the class.²⁰

Any of the above referenced persons may make an anatomical gift:

- by document of gift signed by the person making the gift; or
- by oral communication that is electronically recorded or is contemporaneously reduced to a record and is signed by the individual who receives the oral communication.²¹

Revocation/amendment requirements. Where a gift has been made by document of gift, it may be revoked by:

- a record signed by:
 - the donor;
 - another person authorized by the donor;
 - a person acting at the direction of the donor or another person authorized by the donor, if they are unable to sign, signed by a minimum of two witnesses who state that the document has been signed and witnessed as required;
- a subsequently executed document of gift that amends or revokes all or a portion of a previously executed anatomical gift, either expressly or by inconsistency;
- by destruction or cancellation of document of gift or portion of document of gift, with the intention to revoke; or

¹⁹ 2010 Conn. Pub. Acts 123, Section 9

²⁰ 2010 Conn. Pub. Acts 123, Section 9

²¹ 2010 Conn. Pub. Acts 123, Section 10

- during a terminal illness, if the gift has been made other than by will, by any form of communication addressed to a minimum of two adults, at least one of whom must be disinterested.²²

If the anatomical gift was made by will, it must be amended or revoked as provided in statute for wills.²³

If the anatomical gift was made by another person, it may be revoked or amended by any reasonably available member of a higher priority class. If more than one other member of a higher priority class is available, the gift may be:

- amended only if a majority of the reasonably available members of the higher priority class agree; or
- revoked only if a majority of the reasonably available members of the higher priority class agree or are evenly divided as to whether to revoke.²⁴

Please note that any such revocation is effective only if the procurement organization, hospital, physician or technician knew of the revocation prior to making an incision in support of removal of a body part, or before invasive procedures have begun to prepare the recipient.²⁵

In the absence of an express, contrary indication by a donor:

- with the exception of a refusal made by an unemancipated minor, a person other than the donor is prohibited from making, amending or revoking an anatomical gift if the donor made or amended an anatomical gift of all or part of his/her body;
- a reasonably available parent of an unemancipated minor may revoke or amend an anatomical gift of the minor's body or part; and
- an anatomical gift of a part is neither a refusal to give another part or a limitation on the donor or another person making a gift of another part at a later time.²⁶

A revocation, either by a donor or another person, of an anatomical gift does not constitute a refusal, nor bar another person from making an anatomical gift of the donor's body or part. If a person other than the donor makes an unrevoked anatomical gift of the donor's body or part, another person may not make, amend, or revoke the gift.

Comity provision. The law provides a comity provision that confirms that an anatomical gift will be considered valid if executed according to the laws of the jurisdiction in which it was executed or where the person making the gift was at the time of execution domiciled, resided or was a national.²⁷

Use of anatomical gifts. The new law contains detailed guidance on how gifts may be used. Generally:

²² 2010 Conn. Pub. Acts 123, Section 9

²³ 2010 Conn. Pub. Acts 123, Section 9

²⁴ 2010 Conn. Pub. Acts 123, Section 10

²⁵ 2010 Conn. Pub. Acts 123, Section 10

²⁶ 2010 Conn. Pub. Acts 123, Section 8

²⁷ 2010 Conn. Pub. Acts 123, Section 19

- if the part is an eye and the gift is for transplantation or therapy, the gift passes to the appropriate eye bank;
- if the part is tissue and the gift is for transplantation or therapy, the gift passes to the appropriate tissue bank;
- if the part is an organ and the gift is for transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian; and
- if the part is an organ, an eye or tissue and the gift is for research or education, the gift passes to the appropriate procurement organization.²⁸

Liability considerations. The law states that knowingly purchasing or selling organs for “valuable consideration”, where removal is intended to occur after the individual’s death, constitutes a class A misdemeanor. The law does, however, permit individuals to charge reasonable amounts to remove, process, preserve, control quality, store, transport, implant and dispose of organs.²⁹

Further, the law subjects any individual who for financial gain intentionally falsifies, forges, conceals, defaces or obliterates a document of gift, amendment, revocation, or refusal to prosecution as a class A misdemeanor.³⁰

Additionally, the law:

- holds harmless from civil, criminal and administrative liability a person who acts in accordance with the Act, or attempts in good faith to do so;
- holds harmless from liability persons making anatomical gifts and donors’ estates for injury or damage that results from making or using the gift;
- excepts from warranties of merchantability and fitness organs, tissues, eyes, human blood and blood plasma, and establishes that they are medical services and not commodities subject to sale or barter; and
- permits a person to rely upon representations made by various individuals authorized to make anatomical gifts in the absence of knowledge that an individual’s representation is untrue.³¹

²⁸2010 Conn. Pub. Acts 123, Section 11

²⁹ 2010 Conn. Pub. Acts 123, Section 16

³⁰ 2010 Conn. Pub. Acts 123, Section 17

³¹ 2010 Conn. Pub. Acts 123, Section 18