



# House of Representatives

\General  
Assembly

**File No. 569**

*January Session, 2009*

Substitute House Bill No. 6540

*House of Representatives, April 8, 2009*

The Committee on Public Health reported through REP. RITTER of the 38th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

## ***AN ACT CONCERNING PRESCRIPTION EYE DROP REFILLS.***

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

1 Section 1. (NEW) (*Effective January 1, 2010*) (a) As used in this  
2 section, "health insurance policy" means any individual health  
3 insurance policy or benefit plan that is delivered, issued for delivery,  
4 renewed, amended or continued in this state by an insurer, health care  
5 center, hospital service corporation, medical service corporation,  
6 fraternal benefit society or governmental entity that provides medical  
7 benefits to Medicaid, HUSKY Plan, Charter Oak Plan, ConnPACE or  
8 state-administered general assistance recipients.

9 (b) Each individual health insurance policy providing coverage of  
10 the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
11 38a-469 of the general statutes delivered, issued for delivery, amended,  
12 renewed or continued in this state on or after January 1, 2010, that  
13 provides coverage for prescription eye drops, shall not deny coverage  
14 for a renewal of prescription eye drops when (1) the renewal is

15 requested by the insured less than thirty days from the later of (A) the  
 16 date the original prescription was distributed to the insured, or (B) the  
 17 date the last renewal of such prescription was distributed to the  
 18 insured, and (2) the prescribing physician indicates on the original  
 19 prescription that additional quantities are needed and the renewal  
 20 requested by the insured does not exceed the number of additional  
 21 quantities needed.

22 Sec. 2. (NEW) (*Effective January 1, 2010*) (a) As used in this section,  
 23 "health insurance policy" means any group health insurance policy or  
 24 benefit plan that is delivered, issued for delivery, renewed, amended  
 25 or continued in this state by an insurer, health care center, hospital  
 26 service corporation, medical service corporation, fraternal benefit  
 27 society or governmental entity that provides medical benefits to  
 28 Medicaid, HUSKY Plan, Charter Oak Plan, ConnPACE or state-  
 29 administered general assistance recipients.

30 (b) Each group health insurance policy providing coverage of the  
 31 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-  
 32 469 of the general statutes delivered, issued for delivery, amended,  
 33 renewed or continued in this state on or after January 1, 2010, that  
 34 provides coverage for prescription eye drops, shall not deny coverage  
 35 for a renewal of prescription eye drops when (1) the renewal is  
 36 requested by the insured less than thirty days from the later of (A) the  
 37 date the original prescription was distributed to the insured, or (B) the  
 38 date the last renewal of such prescription was distributed to the  
 39 insured, and (2) the prescribing physician indicates on the original  
 40 prescription that additional quantities are needed and the renewal  
 41 requested by the insured does not exceed the number of additional  
 42 quantities needed.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2010</i>	New section
Sec. 2	<i>January 1, 2010</i>	New section

*AGE*      *Joint Favorable C/R*

PH

*PH*      *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

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**OFA Fiscal Note**

**State Impact:**

Agency Affected	Fund-Effect	FY 10 \$	FY 11 \$
Department of Social Services	GF - Cost	Minimal	Minimal

**Municipal Impact:** Potential Cost – STATE MANDATE

**Explanation**

The bill mandates coverage for prescription eye drops. There are no anticipated costs to the state health plans since the state plans currently allow participants to obtain up to 3 months of maintenance eye drops at one time. In instances requiring additional medication, there is an administrative process by which pharmacists can work with state providers to manually override a prescription denial.

The bill’s provisions may increase costs to certain fully insured municipal plans that currently do not provide the coverage mandated. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

This bill makes changes to the prescription eye drop refill policy under the Department of Social Services’ (DSS) medical programs. The language of the bill appears to override the current DSS prior authorization procedure. To the extent that this increases utilization of prescription eye drops under the DSS medical programs, additional state costs will result. These costs are expected to be minimal.

**The Out Years**

The annualized ongoing fiscal impact identified above would

continue into the future subject to inflation.

*Sources: Office of the State Comptroller, Municipal Employees Health Insurance Plan (MEHIP) Schedule of Benefits, State Employee Health Plan Subscriber Agreement.*

**OLR Bill Analysis****sHB 6540*****AN ACT CONCERNING PRESCRIPTION EYE DROP REFILLS.*****SUMMARY:**

This bill prohibits certain health insurance policies that provide prescription eye drop coverage from denying coverage for prescription renewals when (1) the refill is requested by the insured less than 30 days from either (a) the date the original prescription was given to the insured or (b) the last date the prescription refill was given to the insured, whichever is later and (2) the prescribing physician indicates on the original prescription that additional quantities are needed and the refill requested by the insured does not exceed this amount.

The bill applies only to an individual policy or benefit plan that provides medical benefits to Medicaid, HUSKY Plan, Charter Oak Health Plan, ConnPACE, or state-administered general assistances recipients. (It is unclear how this requirement will be implemented or enforced, as these plans are not under the Insurance Department's jurisdiction.)

**APPLICABILITY**

The bill applies to individual and group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services that are delivered, issued, renewed, amended, or continued in the state on or after January 1, 2010 by a:

1. insurer;
2. health care center (i.e., HMO)
3. hospital or medical service corporation;

4. fraternal benefit society; or
5. government entity covering Medicaid, HUSKY Plan, Charter Oak Health Plan, ConnPACE, or state-administered general assistance recipients.

(The bill does not appear to apply to federally qualified health centers, which provide services under the state's medical assistance programs.)

EFFECTIVE DATE: January 1, 2010

## **BACKGROUND**

### ***Prescription Refills Under DSS Programs***

DSS currently requires medical assistance beneficiaries requesting early refills (refills requested within 30 days of the original prescription or last refill) to obtain prior authorization. This authorization is generally initiated by a pharmacist and acted upon immediately, except for refills of controlled drugs that require physician intervention.

## **COMMITTEE ACTION**

Select Committee on Aging

Joint Favorable Change of Reference  
Yea 11 Nay 0 (03/05/2009)

Public Health Committee

Joint Favorable Substitute  
Yea 30 Nay 0 (03/23/2009)