



Senate

General Assembly

File No. 45

January Session, 2011

Substitute Senate Bill No. 879

Senate, March 8, 2011

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING PRESCRIPTION EYE DROPS AND DEPENDENTS' DENTAL COVERAGE.

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

1 Section 1. Section 38a-492m of the general statutes is repealed and
2 the following is substituted in lieu thereof (*Effective January 1, 2012*):

3 Each individual health insurance policy providing coverage of the
4 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
5 469 delivered, issued for delivery, amended, renewed or continued in
6 this state [on or after January 1, 2010,] that provides coverage for
7 prescription eye drops, shall not deny coverage for: [a]

8 (1) A renewal of prescription eye drops when [(1)] (A) the renewal is
9 requested by the insured less than thirty days from the later of [(A)] (i)
10 the date the original prescription was distributed to the insured, or
11 [(B)] (ii) the date the last renewal of such prescription was distributed
12 to the insured, and [(2)] (B) the prescribing physician indicates on the
13 original prescription that additional quantities are needed and the

14 renewal requested by the insured does not exceed the number of
15 additional quantities needed; and

16 (2) One additional bottle of prescription eye drops when (A) such
17 bottle is requested by the insured or the prescribing physician at the
18 time the original prescription is filled, and (B) the prescribing
19 physician indicates on the original prescription that such additional
20 bottle is needed by the insured for use in a day care center or school.
21 Such additional bottle shall be limited to one every three months.

22 Sec. 2. Section 38a-518l of the general statutes is repealed and the
23 following is substituted in lieu thereof (*Effective January 1, 2012*):

24 Each group health insurance policy providing coverage of the type
25 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
26 delivered, issued for delivery, amended, renewed or continued in this
27 state [on or after January 1, 2010,] that provides coverage for
28 prescription eye drops, shall not deny coverage for: [a]

29 (1) A renewal of prescription eye drops when [(1)] (A) the renewal is
30 requested by the insured less than thirty days from the later of [(A)] (i)
31 the date the original prescription was distributed to the insured, or
32 [(B)] (ii) the date the last renewal of such prescription was distributed
33 to the insured, and [(2)] (B) the prescribing physician indicates on the
34 original prescription that additional quantities are needed and the
35 renewal requested by the insured does not exceed the number of
36 additional quantities needed; and

37 (2) One additional bottle of prescription eye drops when (A) such
38 bottle is requested by the insured or the prescribing physician at the
39 time the original prescription is filled, and (B) the prescribing
40 physician indicates on the original prescription that such additional
41 bottle is needed by the insured for use in a day care center or school.
42 Such additional bottle shall be limited to one every three months.

43 Sec. 3. (NEW) (*Effective January 1, 2012*) Each individual health
44 insurance policy providing coverage of the type specified in

45 subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the
 46 general statutes delivered, issued for delivery, amended, renewed or
 47 continued in this state that includes coverage for dental care services
 48 shall provide that coverage of a child for dental care services shall
 49 terminate no earlier than the policy anniversary date on or after the
 50 date on which the child attains the age of twenty-six. Each such policy
 51 shall cover a stepchild on the same basis as a biological child.

52 Sec. 4. (NEW) (*Effective January 1, 2012*) Each group health insurance
 53 policy providing coverage of the type specified in subdivisions (1), (2),
 54 (4), (11), (12) and (16) of section 38a-469 of the general statutes
 55 delivered, issued for delivery, amended, renewed or continued in this
 56 state that includes coverage for dental care services shall provide that
 57 coverage of a child for dental care services shall terminate no earlier
 58 than the policy anniversary date on or after the date on which the child
 59 attains the age of twenty-six. Each such policy shall cover a stepchild
 60 on the same basis as a biological child.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2012</i>	38a-492m
Sec. 2	<i>January 1, 2012</i>	38a-518l
Sec. 3	<i>January 1, 2012</i>	New section
Sec. 4	<i>January 1, 2012</i>	New section

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 12 \$	FY 13 \$
State Comptroller - Fringe Benefits	GF & TF - Cost	None	\$456,000- \$798,000

Note: GF=General Fund , TF = Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 12 \$	FY 13 \$
Various Municipalities	STATE MANDATE - Cost	Potential	Potential

Explanation

Sections 1-3 results in no fiscal impact to the state because the state employee and retiree health 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.

Section 4 results in a fiscal impact to the state which could range from approximately \$456,000 to \$798,000 annually, depending on the number of participants¹. The costs would not start to accrue to the state until FY 13 when the state enters into a new contract. The state dental plan currently provides coverage for qualified dependents up to age 19. Pursuant to CGS Sec. 38a-554(a) step-children are required to be covered the same as biological children. Unlike the state employee

¹ The estimated increased cost assumes an increase of \$689.28 a year to the state's dental plan premium share for plan members who shift between coverage groups. The costs assume a 45% shift in coverage from either individual to 2 or individual to a family plan.

health plan, the state dental plan is fully insured and therefore would adopt the mandate as specified in the bill.

The bill's prescription provisions may increase costs to certain fully insured municipal plans that currently do not provide the coverage mandated. The bill's dental coverage requirements will increase costs to certain fully insured, free-standing, dental policies². The coverage requirements may result in increased premium costs when municipalities enter into new health and dental insurance contracts after January 1, 2012. Due to federal law, municipalities with self-insured health plans and dental plans are exempt from state health insurance benefit mandates.

The state employee health plan and many municipal health plans are recognized as "grandfathered" health plans under the Patient Protection and Affordability Act (PPACA)³. It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of the state employee health plan or grandfathered municipal plans PPACA⁴.

The Out Years

The annualized ongoing fiscal impact identified above would

² Under Connecticut law if dental insurance is combined in the same policy as health insurance or as a rider to the health policy qualified dependents are currently covered up to age 26. If the dental policy is a free-standing policy, then the policy is not subject to the continuation requirements.

³ Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010. Pursuant to the PPACA, all health plans, including those with grandfathered status are required to provide the following as of September 23, 2010: 1) No lifetime limits on coverage, 2) No rescissions of coverage when individual gets sick or has previously made an unintentional error on an application, and 3) Extension of parents' coverage to young adults until age 26. (www.healthcare.gov)

⁴ According to the PPACA, compared to the plans' policies as of March 23, 2010, grandfathered plans who make any of the following changes within a certain margin may lose their grandfathered status: 1) Significantly cut or reduce benefits, 2) Raise co-insurance charges, 3) Significantly raise co-payment charges, 4) Significantly raise deductibles, 5) Significantly lower employer contributions, and 5) Add or tighten annual limits on what insurer pays. (www.healthcare.gov)

continue into the future subject to inflation.

The federal health care reform act requires that, effective January 1, 2014, all states must establish a health benefit exchange, which will offer qualified plans that must include a federally defined essential benefits package. While states are allowed to mandate benefits in excess of the basic package, the federal law appears to require the state to pay the cost of any such additional mandated benefits. The extent of these costs will depend on the mandates included in the federal essential benefit package, which have not yet been determined. However, neither the agency nor mechanism for the state to pay these costs has been established.

OLR Bill Analysis**sSB 879*****AN ACT CONCERNING PRESCRIPTION EYE DROPS AND DEPENDENTS' DENTAL COVERAGE.*****SUMMARY:**

This bill requires a child's dental care benefits under certain individual or group health insurance policies to continue at least until the policy anniversary date on or after the date the child turns age 26. (Current law does not specify an age although in practice, most plans terminate dental coverage at age 19.) It requires these policies to cover stepchildren on the same basis as biological children.

The bill also sets conditions under which certain health insurance policies that provide prescription eye drop benefits must cover one additional bottle of drops. A policy must do this when (1) it is requested by the insured or the prescribing physician when the original prescription is filled and (2) the physician indicates on the original prescription that the insured needs an additional bottle for use in a day care setting or school. The bill limits coverage of the additional bottle to one every three months.

Current law requires these insurers to provide coverage for prescription eye drop renewals when (1) the refill is requested by the insured less than 30 days from either the (a) date the original prescription was given to the insured or (b) 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.

EFFECTIVE DATE: January 1, 2012

BILL'S APPLICABILITY

The bill's dental and eye drop provisions apply to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. Its dental care provision also applies to single service ancillary health coverage plans, including dental, vision, and prescription drug plans.

Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

BACKGROUND

Extended Health Insurance Coverage For Children

Current law prohibits a child's medical benefits under an individual health insurance policy from ending before the policy anniversary date on or after the date the child (1) marries; (2) ends Connecticut residency, unless he or she is (a) under age 19 or (b) a full-time student at an accredited college; (3) gets coverage under his or her employer's group health plan; or (4) turns age 26.

Group comprehensive plans must extend eligibility to unmarried children under age 26 and offer continuation of coverage to the end of the month in which the child meets the criteria for losing coverage under an individual policy.

According to the Insurance Department, if dental, vision, or prescription drug coverage is combined with the medical benefits in a policy, the law also applies to those benefits. But, if such coverage is issued in a policy separate from the medical benefits, the law does not apply to those benefits.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 11 Nay 7 (02/17/2011)