



# Senate

General Assembly

**File No. 795**

January Session, 2011

Substitute Senate Bill No. 879

*Senate, May 11, 2011*

The Committee on Appropriations reported through SEN. HARP of the 10th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

***AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR  
PRESCRIPTION EYE DROPS.***

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 Section 38a-492m of the general statutes is repealed and  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 Section 38a-518l of the general statutes is repealed and the  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.

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

**APP**      *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:** None, See Below for Out-Years

**Municipal Impact:**

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

**Explanation**

The bill 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.

The bill 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 after January 1, 2012. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

Many municipal health plans are recognized as “grandfathered” health plans under the Patient Protection and Affordable Care Act (PPACA)<sup>1</sup>. It is unclear what effect the adoption of certain health

<sup>1</sup> 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)

mandates will have on the grandfathered status of grandfathered municipal plans PPACA<sup>2</sup>.

### ***The Out Years***

The annualized ongoing fiscal impact identified above would 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.

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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](http://www.healthcare.gov))

<sup>2</sup> 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](http://www.healthcare.gov))

**OLR Bill Analysis****sSB 879*****AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR PRESCRIPTION EYE DROPS.*****SUMMARY:**

This bill 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.

The bill applies 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. Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

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 after 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

**BACKGROUND*****Legislative History***

On April 27, the Senate referred the bill (File 45) to the Appropriations Committee, which favorably reported a substitute eliminating the bill's provisions requiring 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.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 11 Nay 7 (02/17/2011)

Appropriations Committee

Joint Favorable Substitute

Yea 35 Nay 19 (05/04/2011)