CONNECTICUT
Health Strategy

Financial Impact of Formulary Change Restrictions on Health Plans in Connecticut

State of Connecticut

Office of Health Strategy

Report pursuant to Conn. Gen. Stat. §38a-477jj(e)

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Executive Summary

Pursuant to C.G.S. 38a-477jj, the Office of Health Strategy (OHS) conducted a study of the financial impact of "frozen formulary" laws in Connecticut, which are laws that prohibit some health insurers from changing a formulary during a plan year. OHS estimates that the impact of "frozen formulary" laws in Connecticut ranges from 62 cents per member per month (PMPM) to 97 cents PMPM. Existing research estimates the aggregate impact to the commercial market is between aggregate $10 million and $18 million per year.[1]

The financial impact on Connecticut health plans of frozen formulary laws must be weighed against consumer protection concerns raised by advocates. Health plans, including the state employee health plan, require the flexibility to adapt to changing markets. At the same time, consumers deserve stable and predictable prescription drug coverage to plan for medical expenses.

Connecticut's "frozen formulary" law includes exceptions that allow for some flexibility. Health plans change formularies every plan year in response to new prescription drugs or changes in prescription drug rebates. Connecticut health carriers are not required to report on the number or impact of mid-year formulary changes. How often Connecticut health plans and employers not subject to the "frozen formulary" laws change their formulary mid-plan year is subsequently unclear.

Connecticut may want to consider additional flexibility to better align health plans with prescription drug rebate incentives and reduce the cost impact of the "frozen formulary" laws for health plans and consumers. Changes to increase flexibility should only be considered in concert with consumer protections.

[1] https://www.pcmanet.org/wp-content/uploads/2021/02/Milliman_Frozen-Formulary-Report_FINAL.pdf

Introduction

A formulary is a list of prescription drugs that a health insurance plan will cover. In practice, a formulary sorts covered prescription drugs into cost sharing tiers, with drugs in higher tiers requiring more out-of-pocket patient costs and/or additional utilization reviews (such as step therapy or prior authorization). Sometimes, a formulary will change in the middle of a plan year to accommodate new prescription drugs, new drug rebates, or other market conditions. A "frozen formulary" law is a law that prohibits health insurers from changing a formulary during a plan year (i.e., it freezes the current formulary for the duration of the plan year).

Broadly, health insurers argue that flexible formularies - which can add, remove, or re-tier prescription drugs - save both consumers and health insurers money. By incentivizing consumers to use drugs with lower out-of-pocket costs, formularies can decrease a patient's cost sharing obligation. Accordingly, formularies also decrease utilization of drugs with a higher net price, potentially bringing down the overall spending on pharmaceuticals. The ability to change formularies based on market forces can be an important cost saving tool.

Consumer advocates generally argue that frozen formulary laws protect consumers from unnecessary medical changes and costs during a plan year. Many consumers select a health plan based on what medications are covered and the associated cost-sharing. For an insurer to change that coverage, while a consumer is unable to change their plan, can upend a consumer's ability to plan their medical care and expenses.

To address both these concerns, C.G.S. 38a-477jj generally prohibits certain health carriers (e.g., health insurers and HMOs) from: (1) removing a prescription drug from a formulary or (2) moving a prescription drug to a higher cost-sharing tier during a plan year. However, the law allows a health carrier to remove a prescription drug from a formulary under certain conditions, as described below. It also requires OHS to study the financial impact of these formulary restrictions on qualified health plans offered and sold in Connecticut, including health insurance plans offered through Access Health CT, the state's health insurance exchange.

Formularies

Formularies are often created with the help of pharmacy benefit managers (PBMS), which are organizations that help health plans manage their prescription drug costs.

Sixty-two percent (62%) of employers and health plans rely on a PBM's standard national formulary that excludes certain drugs according to a recent survey of health plans and employers across the country.[2] A formulary may exclude a drug for numerous reasons, including that higher rebate or lower priced options to treat the same conditions are available. Only 11% of those surveyed used a standard formulary with no exclusions, while almost a quarter (24%) created a custom formulary for their organization.

Prescription drugs that are covered are sorted into cost sharing tiers. Prescription drugs in a lower cost sharing tier have a lower copay, coinsurance, or other out of pocket cost for the consumers. Accordingly, drugs in a higher cost sharing tier have higher patient obligations. The average copay for a 30-day supply of a Tier 1 prescription drug is $10, increasing to $65 for a Tier 4 drug.[3]

Approximately 90% of employers and health plans surveyed use at least three tiers, with the majority of those using three or four. Only 9% of those surveyed used one or two tiers.[4]

Health plans change formularies every plan year in response to new prescription drugs or changes in prescription drug rebates. Connecticut health carriers are not required to report on the number or impact of mid-year formulary changes. How often Connecticut health plans and employers change their formulary mid-plan year is therefore unclear. [5]

Allowable Formulary Changes

Connecticut's prohibition on formulary changes incorporates several important exceptions. Specifically, a health carrier may always add new prescription drugs and may remove or tier shift a prescription drug under certain circumstances.

Removing a Prescription Drug

Under state law, a health carrier can remove a prescription drug from a formulary if the U.S. Food and Drug Administration (FDA) questions the drug's clinical safety or approves it for over-the-counter use.

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[2] https://www.psgconsults.com/industry-report/2023-trends-in-benefit-design-report/, p. 43

[3] https://www.psgconsults.com/industry-report/2023-trends-in-benefit-design-report/, p. 34

[4] https://www.psgconsults.com/industry-report/2023-trends-in-benefit-design-report/, p. 32

[5] Rates of mid year formulary changes are difficult to ascertain. As one example, In 2021, Express Scripts noted that the mid-year formulary change impacted .6% of members and .8% of total drug spend. https://www.psgconsults.com/blog/upcoming-2021-midyear-express-scripts-formulary-changes/

Shifting a Prescription Drug to a Higher Cost Sharing Tier

State law allows carriers to move a drug to a higher cost-sharing tier if the drug is available in-network for $40 or less per prescription per month in any tier.

State law also allows shifting a prescription drug to a higher cost-sharing tier if the carrier adds a lower cost generic equivalent and provides consumers with 90 days' notice.

Applicability of the Law

C.G.S. 38a-477jj applies to insurers, HMOs, hospital or medical service corporations, fraternal benefit societies, or other entities that deliver fully-insured individual or group health insurance policies in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services. However, it does not apply to a grandfathered health plan, which is a plan that existed on March 23, 2010, and has not made significant coverage changes since. The law additionally does not apply to self-insured benefit plans because of the federal Employee Retirement Income Security Act (ERISA).

In practice, the Connecticut state employee health plan, which is self-insured, voluntarily follows many state health insurance laws. However, the state employee health plan allows formulary changes under certain circumstances, which are discussed in more detail below (see below).

State Employee Health Plan

The state employee health plan uses formulary changes to align PBM rebate contracts, which are often on a calendar year basis, with the health plan year, which runs from July 1 to June 30. Without mid-year formulary changes, the state employee health plan would not be able to incorporate changes in rebate contracts (which generally occur January 1) until the plan year renewed six months later. The result would be lost rebate savings to the plan.

Original Proposed Study Design

Methodological Challenges

OHS originally designed a study to assess the impact of carriers' formulary decisions. The proposal would have requested carriers to complete a survey detailing their mid plan-year formulary changes, including impacted drugs and associated prices and rebates, that:

1. were made from 2019 to 2021, before state law restricted these changes; and
2. would have been made in 2022 and 2023, absent state law.

OHS planned to compare historical mid-year formulary changes to the hypothetical changes. This data could be used to:

1. ascertain the amount and financial impact of mid-year formulary changes historically being made;
2. assess the savings, if any, of these historical changes;
3. determine whether the reported measures of the changes payors would have made align with or differ from historical mid-year formulary change patterns; and
4. provide additional data points for assessing financial impact.

OHS proposed a survey template with this information and requested carrier feedback. The carriers, through the Connecticut Association of Health Plans, stated that the methodology must also consider member mix, client changes, plan selection variation, changes in renewal dates, as well as the proprietary nature of unit costs to provide meaningful comparative data. The carriers informed OHS that responding to a survey capturing all of this data would be too onerous to complete.

OHS believes the original survey methodology would provide worthwhile results and contribute to policy development. However, the agency would require additional authority to compel CT carriers to provide the data necessary. As an alternative, OHS utilized existing research to approximate the impact of frozen formulary laws on Connecticut health plans.

Existing Research

A 2021 report prepared by Milliman, "Estimated Cost of Potential 'Frozen Formulary' Legislation," estimated that frozen formulary laws have a $10 million to $18 million impact per year on fully insured commercial health plans in Connecticut, as reproduced in Table 1 below:

Table 1: Estimated Financial Impact of Frozen Formulary Laws in Connecticut, 2021-2025, in millions

Year	2021	2022	2023	2024	2025	Total
Estimated Financial Impact	$10	$12	$14	$16	$18	$70

*Source: Milliman, "Estimated Cost of Potential 'Frozen Formulary' Legislation," Appendix I

Connecticut law differs from Milliman's methodological assumptions in two important ways. First, Milliman's methodology assumes that health plans would be prohibited from 'negative' formulary changes to existing brand name drugs (i.e., moving a drug to a higher cost-sharing tier) if a new generic or brand medication were launched (see Figure 1, p. 3). In contrast, Connecticut law allows a 'negative' formulary change if (1) the drug is available for $40 or less per month or (2) following 90 days' notice, if an equivalent generic is added. Second, Milliman assumes a July 1 average launch date. This assumption means that a plan would have to wait about six months to implement a change and yield savings from a less costly new drug. In Connecticut, if a generic is added to a formulary a carrier only needs to provide 90 days' notice.

OHS Member Calculation Design

OHS utilizes Milliman's estimates of total savings in the fully insured market as the high end of expected financial impact. OHS approximates that Milliman's estimates represent the high end of the financial impact on health plans in Connecticut from frozen formulary laws because the two exceptions to the law described above provide greater flexibility for formulary changes than Milliman uses in their study.

OHS then uses the All Payer Claims Database (APCD) to determine the number of members in the fully insured commercial pharmaceutical market for the given year. OHS restricts its analysis to calendar years 2021-2023 for which precise APCD member month data is available, although Milliman estimates the impact from 2021-2025. The per person, per month savings is calculated by dividing the estimated savings by the members in the non-state, commercial market and then by 12 months, which shows the per member, per month cost of these laws.

Results

The estimated financial impact of Connecticut's frozen formulary legislation averages 78 cents per member per month, and ranges from 62 cents PMPM in 2021 to 97 cents PMPM in 2023. Table 2 below shows the estimated financial impact from Milliman's report; the number of members in the non-state employee commercial pharmacy membership from the APCD; and the per member, per month cost calculation.

Table 2: Estimated PMPM Impact of Frozen Formulary Laws in Connecticut

Year	2021	2022	2023
Estimated Financial Impact	$10,000,000	$12,000,000	$14,000,000
Members	1,350,929	1,267,977	1,204,727
PMPM Impact	$0.62	$0.79	$0.97

*Sources: Estimated Financial Impact, Milliman, https://www.pcmanet.org/wp-content/uploads/2021/02/Milliman_Frozen-Formulary-Report_FINAL.pdf, Appendix I; Member Months, All Payers Claims Database, Non-state Employee Commercial Prescription Drug Market, Extract 6012 Cost Driver Analytical File

Limitations

There are two important limitations to OHS's calculations. The first is that by using a third party Milliman study, OHS is unable to validate results using data from Connecticut health carriers. The results of this study would be significantly enhanced with health carrier participation.

Second, the data underlying Milliman's aggregate savings estimates, retrieved from public sources, may not align with the data OHS uses to calculate member months, impacting the estimates' accuracy.

Recommendations

OHS estimates that the aggregate estimates of the impact of frozen formulary laws on the Connecticut fully insured market is up to $70 million over five years. However, OHS finds that the financial impact of frozen formulary laws to be relatively minimal on a per member, per month basis and needs to be weighed against consumer protection concerns raised by advocates. OHS also finds instances when mid-year formulary changes provide savings to plan sponsors, for example with the state employee health plan. OHS acknowledges that the methodology as proposed by stakeholders, including the Connecticut Association of Health Plans would require additional resources.