



## INSURANCE FORMULARY AND PROVIDER NETWORK TRANSPARENCY

By: Alexander Reger, Legislative Analyst II

### TERMS AND DEFINITIONS

**Formulary:** A list of prescription drugs that a health care plan will cover.

**Provider Network:** A network of health care providers who contract with an insurer to provide plan members with certain services at prenegotiated rates. In general, visiting a provider within the network results in a lower "in-network" expense for the member.

### ISSUE

This report provides information about the availability of prescription drug formularies and provider network directories for plans offered on a state health insurance exchange. It also addresses the process by which Connecticut insurers may change formularies and provider networks.

### SUMMARY

The federal Affordable Care Act (ACA) defines minimum transparency requirements for all plans offered on a state or federal health insurance exchange (Pub. L. 111-148, as amended by Pub L.

111-152). For instance, the ACA specifically requires an exchange's website to link to provider directories. A proposed U.S. Health and Human Services Department (HHS) rule would require insurers offering health insurance plans on an exchange to publish their formularies on their websites.

In Connecticut, there is no statutory or regulatory requirement governing how insurers (1) may change formularies and provider networks and (2) notify members of changes. In practice, insurers make (1) formularies and provider networks available on their websites and (2) changes to formularies and provider networks 45 to 60 days after providing written notice to members.

Of the 14 jurisdictions that operate state-run health insurance exchanges, California, Washington, and the District of Columbia (D.C.) have adopted more stringent transparency requirements than the ACA requires. For example, California requires insurers to post formularies online and update them monthly.

## **FEDERAL TRANSPARENCY REQUIREMENTS**

### ***ACA and Federal Requirements***

The ACA requires a state exchange to make public on its website a range of information specific to each participating health insurance plan, including:

1. example cost estimates for common benefit scenarios,
2. quality ratings,
3. premium and cost sharing information,
4. provider directories, and
5. any other benefits identified by the HHS secretary.

Formularies are not specifically included in this list ([45 CFR §155.205](#)). However, all qualified health insurance plans offered on an exchange must provide cost sharing transparency information for a specific item or service upon request ([45 CFR §156.220](#)).

In addition, all individual and group health insurance plans (regardless of whether offered on a state exchange) are required to provide a summary of benefits and coverage (SBC) upon request. The SBC must include an Internet address or similar contact information for individuals to obtain a (1) formulary and (2) provider network listing ([45 CFR §147.200](#)).

HHS has recently proposed a rule that would require all plans offered through exchanges to publish a complete, up-to-date formulary and make it easily accessible on the plan's public website through a clearly identifiable link and without requiring an individual to create an account or enter a policy number ([79 Fed. Reg. 70673, proposed Nov. 26 2014 to be codified at 45 CFR 156.122](#)). If adopted, the rule would apply to exchange plans beginning January 1, 2016.

## **CONNECTICUT TRANSPARENCY REQUIREMENTS**

### ***Access Health CT and Connecticut Requirements***

According to Access Health CT, Connecticut's health insurance exchange, drug formularies and provider networks for qualified health plans offered on the exchange are available through Access Health CT's website. Customers can access the information without making an account or providing identifiable data.

According to the Connecticut Insurance Department (CID), formularies and provider networks are also available on all insurers' individual websites.

Additionally, state law requires plans offered through the Connecticut exchange to post general coverage and benefit information on Access Health CT's website ([CGS §38a-1084\(6\)](#)). Also, all plans provided through a managed care organization are required to provide enrollees or potential enrollees with a plan description that includes, among other components, the use of drug formularies ([CGS §38a-478g\(b\)\(5\)](#)).

### ***Changes to Formularies and Provider Networks***

According to CID, there is no Connecticut statute or regulation governing how often plans may change formularies and provider networks. The CID provided information regarding insurers' practices. In general, insurance companies describe formulary changes as either negative or positive for the consumer. In practice, most insurers in Connecticut change formularies (1) negatively between once and twice a year, and (2) positively as needed. In most cases, insurers provide members written notice of any changes 45 to 60 days in advance. But there is at least one major insurer for which changes are only posted online or available through customer service.

### **HEALTH EXCHANGE TRANSPARENCY IN OTHER STATES**

Thirteen states and D.C. currently operate state-run health exchanges similar to Connecticut. (Several additional states operate under a state and federal partnership.) At least three, California, Washington, and D.C., have recently enacted more stringent requirements for formularies than the minimum transparency levels mandated by the ACA. (This is not intended to be an exhaustive listing.)

#### ***California***

California generally requires (1) insurers to post formularies online, including monthly updates; (2) the Departments of Managed Health Care and Insurance to jointly develop and implement a standard formulary template by January 1, 2017; and (3) the California health insurance exchange to include a link to the formularies on its website ([SB 1052, chaptered 9/25/14](#)).

#### ***D.C.***

D.C. requires qualified health plans offered on the exchange to provide to the exchange a drug formulary. In general, the formulary must list the drugs by category and class according to either the District's benchmark plan or the formulary established by the federal Centers for Medicare and Medicaid Services (D.C. Code Ann. § 31-3171.09).

## **Washington**

Washington generally requires all formularies be made public prior to the sale of an insurance plan ([Wash. Rev. Code Ann. § 48.43.510](#)). In addition, the state has recently passed or considered additional measures:

1. SB 6228, effective June 2014, requires all health plans to offer member transparency tools beginning January 1, 2016. The tools must aim for best practices and cover a wide range of cost and quality data, including cost estimates for common diagnostic tests, office visits, and inpatient and outpatient treatments (Wash. Rev. Code Ann. § 48.43.007).
2. The Washington State Office of the Insurance Commissioner (OIC) recently passed a rule ([Insurance Commissioner Matter No. R 2013-22](#)) that requires plans to (1) make provider network information available to consumers and (2) update provider directories monthly (Wash. Admin. Codes §§ [284-43-200](#) & [284-43-204](#)).
3. OIC is currently considering additional rules that, among other things, would require insurers to notify the commissioner within 30 days after a substantial change to its provider network ([Insurance Commissioner Matter No. R 2014-08](#)).

According to the OIC, the process to develop rules increasing formulary transparency has begun, although no drafts have been issued yet.

## **ADDITIONAL INFORMATION**

The National Association of Insurance Commissioners (NAIC) has a model act that generally requires, among other things, insurance companies to (1) post formularies online or make them otherwise publicly available electronically and (2) provide 60 day's notice before changing a formulary (NAIC 22-1). According to NAIC, no state has adopted these specific formulary provisions.

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