

HOUSE No. 491

The Commonwealth of Massachusetts

PRESENTED BY:

Jennifer E. Benson

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to transparency and access in healthcare.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Jennifer E. Benson</i>	<i>37th Middlesex</i>	<i>1/18/2017</i>
<i>Joseph A. Boncore</i>	<i>First Suffolk and Middlesex</i>	<i>1/19/2017</i>
<i>José F. Tosado</i>	<i>9th Hampden</i>	
<i>Denise Provost</i>	<i>27th Middlesex</i>	
<i>Jason M. Lewis</i>	<i>Fifth Middlesex</i>	
<i>Kenneth I. Gordon</i>	<i>21st Middlesex</i>	
<i>Juana B. Matias</i>	<i>16th Essex</i>	
<i>Michael S. Day</i>	<i>31st Middlesex</i>	
<i>Michael O. Moore</i>	<i>Second Worcester</i>	
<i>Bruce E. Tarr</i>	<i>First Essex and Middlesex</i>	

HOUSE No. 491

By Ms. Benson of Lunenburg, a petition (accompanied by bill, House, No. 491) of Jennifer E. Benson and others relative to transparency and access in healthcare. Financial Services.

The Commonwealth of Massachusetts

**In the One Hundred and Ninetieth General Court
(2017-2018)**

An Act relative to transparency and access in healthcare.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. The General Laws are hereby amended by inserting after Chapter 111O the
2 following Chapter:-

3 CHAPTER 111P.

4 TRANSPARENCY BY DRUG MANUFACTURERS

5 Section 1. Definitions.

6 In this chapter, unless the context requires otherwise, the following words shall have the
7 following meanings:-

8 “Department,” the department of public health.

9 “Manufacturer,” any entity that is engaged in the production, preparation, propagation,
10 compounding, conversion or processing of prescription drugs, either directly or indirectly, by
11 extraction from substances of natural origin, or independently by means of chemical synthesis or

12 by a combination of extraction and chemical synthesis, or any entity engaged in the packaging,
13 repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that a
14 “manufacturer” shall not include a wholesale drug distributor or a retail pharmacist registered
15 under section 24 of chapter 112.

16 “Prescription Drug,” a drug as defined in 21 U.S.C. section 321(g)(1) and approved by
17 the Federal Food and Drug Administration for the treatment of disease in humans.

18 “Therapeutic category,” the category that includes the prescription drug in the most
19 recently published U.S. Pharmacopeia Medicare Model Guidelines.

20 Section 2. Manufacturer transparency

21 Each manufacturer of a prescription drug that is sold or marketed in the commonwealth,
22 and that has experienced a wholesale acquisition cost increase of 15 per cent or more over a 12
23 month period, shall file with the department the following information:

24 (a) With respect to the prescription drug,

25 (1) the current wholesale acquisition cost;

26 (2) the amount of the most recent increase in the wholesale acquisition cost expressed as
27 a percentage; and

28 (3) the five-year history of any increases in the wholesale acquisition cost expressed as a
29 percentage and the month and year each such increase took effect.

30 (b) With respect to the manufacturer,

31 (1) total costs paid for research and development in the prescription drug's therapeutic
32 category;

33 (2) estimated costs incurred relating to research and development of new products,
34 processes or services, including the costs of research and development of new products or
35 services that were acquired or obtained via a license;

36 (3) research and development costs as a percentage of revenue;

37 (4) estimated total annual revenues for prescription drugs sold in North America; and

38 (5) if the manufacturer sells or markets in the commonwealth four or more prescription
39 drugs covered or purchased by MassHealth pursuant to chapter 118E, total rebates, discounts or
40 other price concessions paid to the commonwealth for such drugs in the aggregate and without
41 disclosure of any information that is likely to compromise its financial, competitive or
42 proprietary nature.

43 Section 3. Filings; publication

44 (a) Manufacturers shall file the information required under section two on a form
45 prescribed by the department no later than 90 days after the effective date of the most recent
46 wholesale acquisition cost increase for the prescription drug. Any documentary materials or data
47 whatsoever made or received by any member or employee of the department and consisting of,
48 or to the extent that such materials or data consist of, trade secrets or confidential or proprietary
49 information of the manufacturer that may be submitted under this chapter, whether or not so
50 designated by the manufacturer, shall not be deemed a public record of the department and
51 specifically shall not be subject to the provisions of section 10 of chapter 66. The provisions of

52 section 1927(b)(3)(D) of the Social Security Act shall apply to an employee or consultant of the
53 department in the same manner that such provisions apply to the Secretary of the Department of
54 Health and Human Services and the Secretary of the Department of Veteran’s Affairs.

55 (b) The department shall publish on its website no later than June 30 of each year the
56 information submitted by manufacturers under this chapter during the preceding year in a
57 manner that does not compromise its financial, competitive or proprietary nature.

58 SECTION 2. The General Laws are hereby amended by inserting after Chapter 175L the
59 following Chapter:-

60 CHAPTER 175M.

61 TRANSPARENCY BY PHARMACY BENEFIT MANAGERS

62 Section 1. Definitions.

63 In this chapter, unless the context requires otherwise, the following words shall have the
64 following meanings:-

65 "Commissioner," the commissioner of insurance or his designee.

66 “Covered entity,” a health insurer, health benefit plan, or health maintenance
67 organization; a non-profit hospital or medical service corporation; a health program administered
68 by the commonwealth; or an employer, labor union, or other group of persons organized in the
69 commonwealth that provide health coverage to covered individuals who are employed or reside
70 in the commonwealth, but not including any self-funded plan that is exempt from state regulation
71 pursuant to federal law.

72 “Covered individual,” a member, participant, enrollee, contract holder, policy holder, or
73 beneficiary of a covered entity who is provided health coverage by the covered entity.

74 “Pharmacy benefits management," the procurement of prescription drugs at a negotiated
75 rate for dispensation within the commonwealth, or the administration or management of
76 prescription drug benefits provided by a covered entity for the benefit of covered individuals.

77 "Pharmacy benefits manager," an entity that performs pharmacy benefits management,
78 including a person or entity acting for a pharmacy benefits manager in a contractual or
79 employment relationship in the performance of pharmacy benefits management for a covered
80 entity.

81 Section 2. Pharmacy benefits manager transparency

82 (a) Each pharmacy benefits manager under contract with a covered entity shall report to
83 the covered entity and to the commissioner no later than June 30 of each year the following
84 information for the preceding calendar year relative to such contract:

85 (1) The percentage of prescriptions for which a generic drug was available and dispensed
86 by pharmacy type (generic dispensing rate);

87 (2) The aggregate amount and the type of rebates, discounts or price concessions
88 (excluding bona fide service fees, which include but are not limited to distribution service fees,
89 inventory management fees, product stocking allowances, and fees associated with
90 administrative services agreements and patient care programs (such as medication compliance
91 programs and patient education programs) that the pharmacy benefits manager negotiated and
92 that were attributable to patient utilization under the covered entity’s plan;

93 (3) The aggregate amount of the rebates, discounts or price concessions (excluding bona
94 fide service fees, which include but are not limited to distribution service fees, inventory
95 management fees, product stocking allowances, and fees associated with administrative services
96 agreements and patient care programs (such as medication compliance programs and patient
97 education programs)) that the pharmacy benefit manager negotiated and that were passed
98 through to the covered entity and the total number of prescriptions that were dispensed; and

99 (4) The aggregate amount of the difference between the amount the covered entity paid to
100 the pharmacy benefits manager and the amount that the pharmacy benefits manager paid retail
101 pharmacies and mail order pharmacies, and the total number of prescriptions that were
102 dispensed.

103 (b) Information submitted under this chapter shall be confidential and shall not be
104 disclosed to any person by the commissioner or the covered entity receiving the information.
105 Such information shall not be deemed a public record of the commissioner and specifically shall
106 not be subject to the provisions of section 10 of chapter 66.

107 Section 3. Publication

108 No later than June 30 of each year, the commissioner shall issue a report to be published
109 on the commissioner's website aggregating the information received by all pharmacy benefit
110 managers under this chapter for the preceding year, provided that this information shall not be
111 disclosed in a form that discloses the identity of a specific pharmacy benefit manager, a covered
112 entity, prices charged for prescription drugs or any associate rebates, discounts or price
113 concessions, or any information that identifies a drug product or drug manufacturer.

114 SECTION 3. Chapter 175 of the General Laws is hereby amended by inserting after
115 section 110M the following section:-

116 Section 110N. (a) A health insurance plan that issues any policy, contract, agreement,
117 plan or certificate of insurance, delivered or renewed within the commonwealth on or after
118 January 1, 2019, shall:

119 (1) Post the formulary for the health plan on its web site in a manner that is accessible
120 and searchable by enrollees, potential enrollees, and providers;

121 (2) Update the formulary posted pursuant to subsection (a)(1) no later than twenty-four
122 hours after making a change to the formulary;

123 (3) Use a standard template developed by the commissioner pursuant to subsection (d) to
124 display the formulary or formularies for each product offered by the plan; and

125 (4) Include on any published formulary for the plan, including but not limited to the
126 formulary posted pursuant to subsection (a)(1), the following:

127 (i) Any utilization management edits -- including prior authorization, step therapy edits,
128 quantity limits, or other requirements -- for each specific drug included in the formulary;

129 (ii) If the plan uses a tier-based formulary, the plan shall specify for each drug listed on
130 the formulary the specific tier the drug occupies and list the specific co-payments for each tier in
131 the evidence of coverage;

132 (iii) For prescription drugs covered under the plan's medical benefit and typically
133 administered by a provider, plans must disclose to enrollees and potential enrollees all covered
134 drugs and any cost-sharing imposed on such drugs. This information can be provided to the

135 consumer as part of the plan's formulary posted pursuant to subsection (a)(1) or via a toll free
136 number that is staffed at least during normal business hours;

137 (iv) For each prescription drug included on the formulary under clause (ii) or (iii) that is
138 subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

139 (A) disclose the dollar amount of the enrollee's cost-sharing, or

140 (B) provide a dollar amount range of cost sharing for a potential enrollee of each specific
141 drug included on the formulary, as follows:

142 (a) Under one hundred dollars: \$;

143 (b) One hundred dollars to two hundred fifty dollars: \$\$;

144 (c) Two hundred fifty-one dollars to five hundred dollars: \$\$\$; and

145 (d) Five hundred dollars to one thousand dollars: \$\$\$\$.

146 (e) Over one thousand dollars: \$\$\$\$\$

147 (v) If the carrier allows the option for mail order pharmacy, the carrier separately must
148 list the range of cost-sharing for a potential enrollee if the potential enrollee purchases the drug
149 through a mail order facility utilizing the same ranges as provided in paragraph (4)(iv)(B).

150 (vi) A description of how medications will specifically be included in or excluded from
151 the deductible, including a description of out-of-pocket costs that may not apply to the deductible
152 for a medication.

153 (b) Each carrier offering or renewing a health insurance contract on or after January 1,
154 2019, must make available to current and potential enrollees the information mandated under this
155 section. The information must be available prior to the beginning of the open enrollment period
156 and must be done via a public website and through a toll free number that is posted on the
157 carrier's website.

158 (c) Each carrier offering or renewing a health plan on or after January 1, 2019, must, no
159 later than thirty days after the offer or renewal date, attest to the commissioner that the carrier
160 has satisfied the requirements of this section.

161 (d) The commissioner may develop a standard formulary template for use by carriers for
162 compliance with this section.

163 (e) For purposes of this section, "formulary" means the complete list of drugs preferred
164 for use and eligible for coverage under the health plan.

165 SECTION 4. Chapter 176A of the General Laws is hereby amended by inserting after
166 section 8KK the following section:-

167 Section 8LL. (a) A corporation under contract with a subscriber for an individual or
168 group hospital service plan delivered or issued or renewed within the commonwealth on or after
169 January 1, 2019, shall:

170 (1) Post the formulary for the health plan on the carrier's web site in a manner that is
171 accessible and searchable by enrollees, potential enrollees, and providers;

172 (2) Update the formulary posted pursuant to subsection (a)(1) no later than twenty-four
173 hours after making a change to the formulary;

174 (3) Use a standard template developed by the commissioner pursuant to subsection (d) to
175 display the formulary or formularies for each product offered by the plan and

176 (4) Include on any published formulary for the plan, including but not limited to the
177 formulary posted pursuant to subsection (a)(1), the following:

178 (i) Any utilization management edits -- including prior authorization, step therapy edits,
179 quantity limits, or other requirements -- for each specific drug included in the formulary;

180 (ii) If the plan uses a tier-based formulary, the plan shall specify for each drug listed on
181 the formulary the specific tier the drug occupies and list the specific co-payments for each tier in
182 the evidence of coverage;

183 (iii) For prescription drugs covered under the plan's medical benefit and typically
184 administered by a provider, plans must disclose to enrollees and potential enrollees, all covered
185 drugs and any cost-sharing imposed on such drugs. This information can be provided to the
186 consumer as part of the plan's formulary posted pursuant to subsection (a)(1) or via a toll free
187 number that is staffed at least during normal business hours;

188 (iv) For each prescription drug included on the formulary under clause (ii) or (iii) that is
189 subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

190 (A) disclose the dollar amount of the enrollee's cost-sharing, or

191 (B) provide a dollar amount range of cost sharing for a potential enrollee of each specific
192 drug included on the formulary, as follows:

193 (a) Under one hundred dollars: \$;

194 (b) One hundred dollars to two hundred fifty dollars: \$\$;

195 (c) Two hundred fifty-one dollars to five hundred dollars: \$\$\$; and

196 (d) Five hundred dollars to one thousand dollars: \$\$\$\$.

197 (e) Over one thousand dollars: \$\$\$\$\$

198 (v) If the carrier allows the option for mail order pharmacy, the carrier separately must
199 list the range of cost-sharing for a potential enrollee if the potential enrollee purchases the drug
200 through a mail order facility utilizing the same ranges as provided in paragraph (4)(iv)(B).

201 (vi) A description of how medications will specifically be included in or excluded from
202 the deductible, including a description of out-of-pocket costs that may not apply to the deductible
203 for a medication

204 (b) Each carrier offering or renewing a health plan on or after January 1, 2019, must
205 make available to current and potential enrollees the information mandated under this section.
206 The information must be available prior to the beginning of the open enrollment period and must
207 be done via a public website and through a toll free number that is posted on the carrier's
208 website.

209 (c) Each carrier offering or renewing a health plan on or after January 1, 2019, must, no
210 later than thirty days after the offer or renewal date, attest to the commissioner that the carrier
211 has satisfied the requirements of this section.

212 (d) The commissioner may develop a standard formulary template for use by carriers for
213 compliance with this section.

214 (e) For purposes of this section, "formulary" means the complete list of drugs preferred
215 for use and eligible for coverage under the health plan.

216 SECTION 5. Chapter 176B of the General Laws is hereby amended by inserting after
217 section 4KK the following section:-

218 Section 4LL. (a) Any subscription certificate under an individual or group medical
219 service agreement delivered, issued or renewed within the commonwealth on or after January 1,
220 2019, shall:

221 (1) Post the formulary for the health plan on the carrier's web site in a manner that is
222 accessible and searchable by enrollees, potential enrollees, and providers;

223 (2) Update the formulary posted pursuant to subsection (a)(1) no later than twenty-four
224 hours after making a change to the formulary;

225 (3) Use a standard template developed by the commissioner pursuant to subsection (d) to
226 display the formulary or formularies for each product offered by the plan and

227 (4) Include on any published formulary for the plan, including but not limited to the
228 formulary posted pursuant to subsection(a)(1), the following:

229 (i) Any utilization management edits -- including prior authorization, step therapy edits,
230 quantity limits, or other requirements -- for each specific drug included in the formulary;

231 (ii) If the plan uses a tier-based formulary, the plan shall specify for each drug listed on
232 the formulary the specific tier the drug occupies and list the specific co-payments for each tier in
233 the evidence of coverage;

234 (iii) For prescription drugs covered under the plan's medical benefit and typically
235 administered by a provider, plans must disclose to enrollees and potential enrollees, all covered
236 drugs and any cost-sharing imposed on such drugs. This information can be provided to the
237 consumer as part of the plan's formulary posted pursuant to subsection (a)(1) or via a toll free
238 number that is staffed at least during normal business hours;

239 (iv) For each prescription drug included on the formulary under clause (ii) or (iii) that is
240 subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

241 (A) disclose the dollar amount of the enrollee's cost-sharing, or

242 (B) provide a dollar amount range of cost sharing for a potential enrollee of each specific
243 drug included on the formulary, as follows:

244 (a) Under one hundred dollars: \$;

245 (b) One hundred dollars to two hundred fifty dollars: \$\$;

246 (c) Two hundred fifty-one dollars to five hundred dollars: \$\$\$; and

247 (d) Five hundred dollars to one thousand dollars: \$\$\$\$.

248 (e) Over one thousand dollars: \$\$\$\$\$

249 (v) If the carrier allows the option for mail order pharmacy, the carrier separately must
250 list the range of cost-sharing for a potential enrollee if the potential enrollee purchases the drug
251 through a mail order facility utilizing the same ranges as provided in paragraph (4)(iv)(B).

252 (vi) A description of how medications will specifically be included in or excluded from
253 the deductible, including a description of out-of-pocket costs that may not apply to the deductible
254 for a medication

255 (b) Each carrier offering or renewing a health insurance contract on or after January 1,
256 2019, must make available to current and potential enrollees the information mandated under this
257 section. The information must be available prior to the beginning of the open enrollment period
258 and must be done via a public website and through a toll free number that is posted on the
259 carrier's website.

260 (c) Each carrier offering or renewing a health plan on or after January 1, 2019, must, no
261 later than thirty days after the offer or renewal date, attest to the commissioner that the carrier
262 has satisfied the requirements of this section.

263 (d) The commissioner may develop a standard formulary template for use by carriers for
264 compliance with this section.

265 (e) For purposes of this section, "formulary" means the complete list of drugs preferred
266 for use and eligible for coverage under the health plan.

267 SECTION 6. Chapter 176G of the General Laws is hereby amended by inserting after
268 section 4CC the following section:-

269 Section 4DD. (a) Any carrier issuing an individual or group health maintenance contract
270 on or after January 1, 2019, shall:

271 (1) Post the formulary for the health plan on the carrier's web site in a manner that is
272 accessible and searchable by enrollees, potential enrollees, and providers;

273 (2) Update the formulary posted pursuant to subsection (a)(1) no later than twenty-four
274 hours after making a change to the formulary;

275 (3) Use a standard template developed by the commissioner pursuant to subsection (d) to
276 display the formulary or formularies for each product offered by the plan and

277 (4) Include on any published formulary for the plan, including but not limited to the
278 formulary posted pursuant to subsection (a)(1), the following:

279 (i) Any utilization management edits -- including prior authorization, step therapy edits,
280 quantity limits, or other requirements -- for each specific drug included in the formulary;

281 (ii) If the plan uses a tier-based formulary, the plan shall specify for each drug listed on
282 the formulary the specific tier the drug occupies and list the specific co-payments for each tier in
283 the evidence of coverage;

284 (iii) For prescription drugs covered under the plans medical benefit and typically
285 administered by a provider, plans must disclose to enrollees and potential enrollees, all covered
286 drugs and any cost-sharing imposed on such drugs. This information can be provided to the
287 consumer as part of the plan's formulary posted pursuant to subsection (a)(1) or via a toll free
288 number that is staffed at least during normal business hours;

289 (iv) For each prescription drug included on the formulary under clause (ii) or (iii) that is
290 subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

291 (A) disclose the dollar amount of the enrollee's cost-sharing, or

292 (B) provide a dollar amount range of cost sharing for a potential enrollee of each specific
293 drug included on the formulary, as follows:

294 (a) Under one hundred dollars: \$;

295 (b) One hundred dollars to two hundred fifty dollars: \$\$;

296 (c) Two hundred fifty-one dollars to five hundred dollars: \$\$\$; and

297 (d) Five hundred dollars to one thousand dollars: \$\$\$\$.

298 (e) Over one thousand dollars: \$\$\$\$\$

299 (v) If the carrier allows the option for mail order pharmacy, the carrier separately must
300 list the range of cost-sharing for a potential enrollee if the potential enrollee purchases the drug
301 through a mail order facility utilizing the same ranges as provided in paragraph (4)(iv)(B).

302 (vi) A description of how medications will specifically be included in or excluded from
303 the deductible, including a description of out-of-pocket costs that may not apply to the deductible
304 for a medication

305 (b) Each carrier offering or renewing a health insurance contract on or after January 1,
306 2019, must make available to current and potential enrollees the information mandated under this
307 section. The information must be available prior to the beginning of the open enrollment period
308 and must be done via a public website and through a toll free number that is posted on the
309 carrier's website.

310 (c) Each carrier offering or renewing a health plan on or after January 1, 2019, must, no
311 later than thirty days after the offer or renewal date, attest to the commissioner that the carrier
312 has satisfied the requirements of this section.

313 (d) The commissioner may develop a standard formulary template for use by carriers for
314 compliance with this section.

315 (e) For purposes of this section, "formulary" means the complete list of drugs preferred
316 for use and eligible for coverage under the health plan.

317 SECTION 7. Chapter 32A of the General Laws is hereby amended by inserting after
318 section 27 the following section:-

319 Section 28. (a) Any coverage offered by the commission to any active or retired
320 employee of the commonwealth who is insured under the group insurance commission on or
321 after January 1, 2019, shall:

322 (1) Post the formulary for the health plan on the carrier's web site in a manner that is
323 accessible and searchable by enrollees, potential enrollees, and providers;

324 (2) Update the formulary posted pursuant to subsection (a)(1) no later than twenty-four
325 hours after making a change to the formulary;

326 (3) Use a standard template developed by the commissioner pursuant to subsection (d) to
327 display the formulary or formularies for each product offered by the plan and

328 (4) Include on any published formulary for the plan, including but not limited to the
329 formulary posted pursuant to subsection (a)(1), the following:

330 (i) Any utilization management edits -- including prior authorization, step therapy edits,
331 quantity limits, or other requirements -- for each specific drug included in the formulary;

332 (ii) If the plan uses a tier-based formulary, the plan shall specify for each drug listed on
333 the formulary the specific tier the drug occupies and list the specific co-payments for each tier in
334 the evidence of coverage;

335 (iii) For prescription drugs covered under the plan's medical benefit and typically
336 administered by a provider, plans must disclose to enrollees and potential enrollees, all covered
337 drugs and any cost-sharing imposed on such drugs. This information can be provided to the
338 consumer as part of the plan's formulary posted pursuant to subsection (a)(1) or via a toll free
339 number that is staffed at least during normal business hours;

340 (iv) For each prescription drug included on the formulary under clause (ii) or (iii) that is
341 subject to a coinsurance and dispensed at an in-network pharmacy the plan must:

342 (A) disclose the dollar amount of the enrollee's cost-sharing, or

343 (B) provide a dollar amount range of cost sharing for a potential enrollee of each specific
344 drug included on the formulary, as follows:

345 (a) Under one hundred dollars: \$;

346 (b) One hundred dollars to two hundred fifty dollars: \$\$;

347 (c) Two hundred fifty-one dollars to five hundred dollars: \$\$\$; and

348 (d) Five hundred dollars to one thousand dollars: \$\$\$\$.

349 (e) Over one thousand dollars: \$\$\$\$\$

350 (v) If the carrier allows the option for mail order pharmacy, the carrier separately must
351 list the range of cost-sharing for a potential enrollee if the potential enrollee purchases the drug
352 through a mail order facility utilizing the same ranges as provided in paragraph (4)(iv)(B).

353 (vi) A description of how medications will specifically be included in or excluded from
354 the deductible, including a description of out-of-pocket costs that may not apply to the deductible
355 for a medication.

356 (b) Each carrier offering or renewing a health insurance contract on or after January 1,
357 2019, must make available to current and potential enrollees the information mandated under this
358 section. The information must be available prior to the beginning of the open enrollment period
359 and must be done via a public website and through a toll free number that is posted on the
360 carrier's website.

361 (c) Each carrier offering or renewing a health plan on or after January 1, 2019, must, no
362 later than thirty days after the offer or renewal date, attest to the commissioner that the carrier
363 has satisfied the requirements of this section.

364 (d) The commissioner may develop a standard formulary template for use by carriers for
365 compliance with this section.

366 (e) For purposes of this section, "formulary" means the complete list of drugs preferred
367 for use and eligible for coverage under the health plan.