

**SENATE . . . . . No. 1163**

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**The Commonwealth of Massachusetts**

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PRESENTED BY:

***Joseph A. Boncore***

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*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.**

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PETITION OF:

NAME:

DISTRICT/ADDRESS:

*Joseph A. Boncore*

*First Suffolk and Middlesex*

*Jennifer E. Benson*

*37th Middlesex*

**SENATE . . . . . No. 1163**

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By Mr. Boncore, a petition (accompanied by bill, Senate, No. 1163) of Joseph A. Boncore and Jennifer E. Benson for legislation relative to transparency and access in healthcare. Public Health.

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**The Commonwealth of Massachusetts**

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**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  
27 as a percentage; and

28 (3) the five-year history of any increases in the wholesale acquisition cost expressed  
29 as a 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  
32 therapeutic 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  
39 prescription drugs covered or purchased by MassHealth pursuant to chapter 118E, total rebates,  
40 discounts or other price concessions paid to the commonwealth for such drugs in the aggregate  
41 and without disclosure of any information that is likely to compromise its financial, competitive  
42 or 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  
83 to 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  
86 dispensed 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

92 the pharmacy benefits manager negotiated and that were attributable to patient utilization  
93 under the covered entity's plan;

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

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

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

### 108 Section 3. Publication

109 No later than June 30 of each year, the commissioner shall issue a report to be published  
110 on the commissioner's website aggregating the information received by all pharmacy benefit  
111 managers under this chapter for the preceding year, provided that this information shall not be  
112 disclosed in a form that discloses the identity of a specific pharmacy benefit manager, a covered

113 entity, prices charged for prescription drugs or any associate rebates, discounts or price  
114 concessions, or any information that identifies a drug product or drug manufacturer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

219 Section 4LL. (a) Any subscription certificate under an individual or group medical  
220 service agreement delivered, issued or renewed within the commonwealth on or after January 1,  
221 2019, shall:

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

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

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

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

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

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

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

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

242 (A) disclose the dollar amount of the enrollee’s cost-sharing, or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

306 (b) Each carrier offering or renewing a health insurance contract on or after January 1,  
307 2019, must make available to current and potential enrollees the information mandated under this  
308 section. The information must be available prior to the beginning of the open enrollment period

309 and must be done via a public website and through a toll free number that is posted on the  
310 carrier's website.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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