SENATE No. 1163

The Commonwealth of Massachusetts

PRESENTED BY:

Joseph A. Boncore

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: | |
|--------------------|-----------------------------|--|
| Joseph A. Boncore | First Suffolk and Middlesex | |
| Jennifer E. Benson | 37th Middlesex | |

SENATE No. 1163

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.

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 1110 the |
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| 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 |
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| 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

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

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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 |
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| 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 |
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| 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 utilization93 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.

(b) Information submitted under this chapter shall be confidential and shall not be
disclosed to any person by the commissioner or the covered entity receiving the information.
Such information shall not be deemed a public record of the commissioner and specifically shall
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 |
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| 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 |
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| 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). |

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

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

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

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

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

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

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

| 171 | (1) Post the formulary for the health plan on the carrier's web site in a manner that is |
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| 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: |
| 101 | (A) displays the dollar amount of the annollog's cost sharing or |

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 |
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| 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 |
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| 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: |

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

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

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

(iv) For each prescription drug included on the formulary under clause (ii) or (iii) that is
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

(B) provide a dollar amount range of cost sharing for a potential enrollee of each specific
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: \$\$\$\$

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

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

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

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

264 (d) The commissioner may develop a standard formulary template for use by carriers for265 compliance with this section.

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

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

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

- (1) Post the formulary for the health plan on the carrier's web site in a manner that isaccessible and searchable by enrollees, potential enrollees, and providers;
- (2) Update the formulary posted pursuant to subsection (a)(1) no later than twenty-four
 hours after making a change to the formulary;
- (3) Use a standard template developed by the commissioner pursuant to subsection (d) todisplay the formulary or formularies for each product offered by the plan and
- (4) Include on any published formulary for the plan, including but not limited to theformulary posted pursuant to subsection (a)(1), the following:
- (i) Any utilization management edits -- including prior authorization, step therapy edits,
 quantity limits, or other requirements -- for each specific drug included in the formulary;
- (ii) If the plan uses a tier-based formulary, the plan shall specify for each drug listed on
 the formulary the specific tier the drug occupies and list the specific co-payments for each tier in
 the evidence of coverage;
- (iii) For prescription drugs covered under the plans medical benefit and typically administered by a provider, plans must disclose to enrollees and potential enrollees, all covered drugs and any cost-sharing imposed on such drugs. This information can be provided to the consumer as part of the plan's formulary posted pursuant to subsection (a)(1) or via a toll free 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 |
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| 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 |

and must be done via a public website and through a toll free number that is posted on thecarrier'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 for315 compliance with this section.

316 (e) For purposes of this section, "formulary" means the complete list of drugs preferred317 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)to328 display the formulary or formularies for each product offered by the plan and

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

- (i) Any utilization management edits -- including prior authorization, step therapy edits,
 quantity limits, or other requirements -- for each specific drug included in the formulary;
- (ii) If the plan uses a tier-based formulary, the plan shall specify for each drug listed on
 the formulary the specific tier the drug occupies and list the specific co-payments for each tier in
 the evidence of coverage;

(iii) For prescription drugs covered under the plan's medical benefit and typically
administered by a provider, plans must disclose to enrollees and potential enrollees, all covered
drugs and any cost-sharing imposed on such drugs. This information can be provided to the
consumer as part of the plan's formulary posted pursuant to subsection (a)(1) or via a toll free
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: \$\$\$\$

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

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

(b) Each carrier offering or renewing a health insurance contract on or after January 1,
2019, must make available to current and potential enrollees the information mandated under this
section. The information must be available prior to the beginning of the open enrollment period
and must be done via a public website and through a toll free number that is posted on the
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 for366 compliance with this section.

367 (e) For purposes of this section, "formulary" means the complete list of drugs preferred368 for use and eligible for coverage under the health plan.