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Correspondence Memorandum

Date: November 15, 2021

To: Group Insurance Board

From: Tarna Hunter, Legislative Liaison

Subject: Legislative Update

This memo is for informational purposes only. No Board action is required.

Enacted into Law

2021 Wisconsin Act 9 requires pharmacy benefit managers to be licensed with the Commissioner of Insurance or to have an employee benefit plan manager license. It establishes certain requirements for pharmacy benefit managers and certain health plans regarding interactions with pharmacies and pharmacists. The provisions in the law regulating disclosures to consumers, cost sharing limitations and drug substitutions are already performed under the State of Wisconsin Group Health Insurance Program (GHIP) and therefore would have no impact on the program.

Co-Sponsorship Memos

LRB-4440 prohibits an insurer offering a health benefit plan, a pharmacy benefit manager, or an agent of the insurer or pharmacy benefit, from:

- Refusing to authorize, approve, or pay a participating provider for providing a covered clinician-administered drug and related services to an enrollee, policyholder, or insured.
- Condition, deny, restrict, refuse to authorize or approve, or reduce payment to a participating provider for a covered clinician-administered drug and related services when all criteria for medical necessity are met because the provider obtains the drug from an entity that is not selected by the plan.
- Prohibit health benefit plan designs that prevent participating providers from receiving reimbursement for a covered clinician-administered drug and any related services at an applicable rate as specified in the contract.

- Impose coverage or benefit limits, or require an enrollee, policyholder, or insured to pay an additional fee, higher copay or coinsurance, second copay or

Reviewed and approved by Pamela Henning, Assistant Deputy Secretary Electronically Signed 11/15/2021
Pamela L Henning

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coinsurance, or penalty when obtaining a clinician administered drug from an authorized health care provider or pharmacy.

- Require an enrollee, policyholder, or insured to pay an additional fee, higher copay or coinsurance, second copay or coinsurance, or other form of a price increase for a clinician-administered drug when the drug is not dispensed by a pharmacy or acquired from an entity that is selected by the plan
- Interfere with an enrollee's, policyholder's, or insured's right to choose to obtain a clinician-administered drug from a participating provider or pharmacy of choice.
- Limit or exclude coverage for a clinician-administered drug when not dispensed by a pharmacy or acquired from an entity selected by the plan when the drug would otherwise be covered.
- Require a pharmacy to dispense a clinician-administered drug directly to an enrollee, policyholder, insured, or the insured's agent with the intention that the individual will transport the drug to a health care provider for administration.
- Require or encourage the dispensing of a clinician-administered drug to an enrollee, policyholder, or insured in a manner that is inconsistent with the federal Drug Supply Chain Security Act.
- Require that a clinician-administered drug be dispensed or administered to an enrollee, policyholder, or insured in the residence of the enrollee, policyholder, or insured or require the use of an infusion site external to the office or clinic of the enrollee's, policyholder's, or insured's provider.

Introduced State Legislation

2021 SB 693 requires health insurance policies and self-insured governmental health plans to cover diagnosis of and treatment for infertility and standard fertility preservation services. Coverage must include at least four completed egg retrievals with unlimited embryo transfers in accordance with certain guidelines and single embryo transfer is allowed when recommended and medically appropriate.

2021 SB 693 was introduced by Sen. Roys and referred to the Senate Committee on Insurance, Licensing and Forestry.

2021 SB 559 and **2021 AB 571** allows healthcare providers to provide discounts to an individual covered under a health insurance policy if the discount satisfies the following:

- The health care provider offers the discount for prompt payment without regard to the reason for the individual seeking the product or service;
- The amount of the discount bears a reasonable relationship to the amount that the health care provider avoids in collection costs by prompt payment;
- The health care provider notifies the issuer of the health insurance policy of the prompt payment discount policy but, unless required by law, does not publicly advertise the discount; and
- The health care provider does not shift the cost of the discount to any other payer or, except as allowed.

2021 SB 559 was introduced by Sen. Feyen and referred to the Senate Committee on Health. 2021 AB 571 was introduced by Rep. Snyder and referred to the Assembly Committee on Health.

On October 12, 2021, a public hearing was held on SB 559.

2021 SB 546 and **2021 AB 552** prohibit health insurance policies and governmental self-insured health plans that cover insulin and impose cost sharing on prescription drugs from imposing cost sharing on insulin in an amount that exceeds $50 for a one-month supply.

2021 SB 546 was introduced by Sen. Ringhand and referred to the Senate Committee on Insurance, Licensing and Forestry. 2021 AB 552 was introduced by Rep. Anderson and referred to the Assembly Committee on Insurance.

2021 SB 549 and **2021 AB 553** provide that a PBM owes a fiduciary duty to a plan sponsor. The bill also requires that a PBM annually disclose the following information to the plan sponsor:

- The indirect profit received by the PBM from owning a pharmacy or service provider.
- Any payments made to a consultant or broker who works on behalf of the plan sponsor.
- From the amounts received from drug manufacturers, the amounts retained by the PBM that are related to the plan sponsor's claims or bona fide service fees.
- The amounts received from network pharmacies and the amount retained by the PBM.

2021 SB 549 was introduced by Sen. Erpenbach and referred to the Senate Committee on Health. 2021 AB 553 was introduced by Rep. Subeck and referred to the Assembly Committee on Health.

2021 SB 40 and **2021 AB 34** includes the following requirements and limitations on health insurance coverage in the event the federal Patient Protection and Affordable Care Act no longer preempts state law on the topic.

- Health plans must accept every individual in this state who applies for coverage, regardless of whether any individual or employee has a preexisting condition.
- A health plan offered on the individual or small employer market or a self-insured governmental health plan may not vary premium rates for a specific plan on any basis except age, tobacco use, area in the state, and whether the plan covers an individual or a family.
- A health benefit plan or a self-insured governmental health plan may not impose a preexisting condition exclusion.

- A health benefit plan or a self-insured governmental health plan is prohibited from imposing an annual or lifetime limit on the dollar value of benefits under the plan.
- The Affordable Care Act exempts certain plans from complying with the act's provisions. Similarly, any health benefit plan that is exempt from a provision of the Affordable Care Act is exempt from complying with the corresponding provision of this bill.

2021 SB 40 was introduced by Sen. Jacque and referred to the Senate Committee on Insurance, Licensing and Forestry. 2021 AB 34 was introduced by Rep. Magnafici and referred to the Assembly Committee on Insurance.

On March 16, 2021, the Assembly passed 2021 AB 34 (92-0). The Senate has not taken action on the bill.

I will be available at the November 17, 2021, Board meeting to answer any questions.