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SECRETARY

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## Correspondence Memorandum

**Date:** April 11, 2022  
**To:** Group Insurance Board  
**From:** Tarna Hunter, Government Relations Director  
Office of the Secretary  
**Subject:** Legislative Update

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

The 2021 Regular Session of the Wisconsin Legislature ended when the State Senate adjourned on March 9. Two bills were passed by the Legislature that affect programs overseen by the Board.

### 2021 Session – Enacted 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. 2021 Act 9 took effect on January 1, 2022.

**2021 Wisconsin Act 245** makes the following remedial changes recommended by ETF. The changes clarify current law or codify current practice. These technical changes may require minor modifications to procedures and forms for members and employers but do not make substantive changes. 2021 Act 245 took effect on April 10, 2022.

1. Annuity Option – Joint Survivorship
2. Outdated Qualified Domestic Relations Order Section
3. Other Governmental Service Purchase – Change “participant” to “participating employee”
4. Clarifying that a Member Cannot be Receiving a Disability Annuity and be Considered a Participating Employee
5. Employee Reimbursement Accounts – Aligning State Statutes with Federal Law

Reviewed and approved by Pamela Henning, Assistant Deputy  
Secretary  
Electronically Signed 04/11/2022

*Pamela L. Henning*

Board	Mtg Date	Item #
GIB	5.18.22	10E

6. Correct Outdated References to Director of the Office of State Employment Relations
7. Federal SECURE Act changes to Required Minimum Distributions (RMD) and Required Beginning Date (RBD)

### **Other Proposed Legislation**

The following bills were introduced this session but were not passed by the full Legislature. The bills are likely “dead” and – except in the unlikely event they are considered in a special or extraordinary session – will need to be reintroduced next session if the Legislature intends to take action on them.

[2021 SB 753](#) and [2021 AB 718](#) prohibit 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 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.

2021 SB 753 was introduced by Sen. Darling and referred to the Senate Committee on Insurance, Licensing and Forestry. 2021 AB 718 was introduced by Rep. Kurtz and referred to the Assembly Committee on Health.

On January 20, 2022, a public hearing was held on SB 753. On February 16, 2022, a public hearing was held on AB 718.

[2021 SB 693](#) and [2021 AB 747](#) require 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 AB 747 was introduced by Rep. Emerson and referred to the Assembly Committee on Insurance.

[2021 SB 559](#) and [2021 AB 571](#) allow 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. On January 11, 2022, a public hearing was held on AB 571.

[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 pharmacy benefit manager (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](#) include 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.

Staff will be available at the May 18, 2022, Board meeting to answer any questions.