State of Wisconsin
2023 - 2024 LEGISLATURE

LRB-1933/1
KRP:klm

2023 ASSEMBLY BILL 103

March 14, 2023 - Introduced by Representatives TITTL, ARMSTRONG, SUBECK, BEHNKE, KRUG, MURPHY, MURSAU, ROZAR, SCHRAA, C. ANDERSON, J. ANDERSON, BALDEH, BARE, BROOKS, CABRERA, DRAKE, GREEN, GUNDRUM, JACOBSON, JOERS, O'CONNOR, OHNSTAD, RATCLIFF, RODRIGUEZ, SCHMIDT, SCHUTT, SHANKLAND, SINICKI, SPIROS, STUBBS, WICHGERS, CLANCY and MADISON, cosponsored by Senators JACQUE, WANGGAARD, CARPENTER, JAMES, CABRAL-GUEVARA, L. JOHNSON, LARSON, QUINN, ROYS and TAYLOR. Referred to Committee on Health, Aging and Long-Term Care.

AUTHORS SUBJECT TO CHANGE

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.) and 609.83; and ***to create*** 632.862 of the statutes; **relating to:** application of prescription drug payments to health insurance cost-sharing requirements.

Analysis by the Legislative Reference Bureau

Health insurance policies and plans often apply deductibles and out-of-pocket maximum amounts to the benefits covered by the policy or plan. A deductible is an amount that an enrollee in a policy or plan must pay out of pocket before attaining the full benefits of the policy or plan. An out-of-pocket maximum amount is a limit specified by a policy or plan on the amount that an enrollee pays, and, once that limit is reached, the policy or plan covers the benefit entirely. This bill generally requires health insurance policies that offer prescription drug benefits, self-insured health plans, and pharmacy benefit managers acting on behalf of policies or plans to apply amounts paid by or on behalf of an individual covered under the policy or plan for brand name prescription drugs to any cost-sharing requirement or to any calculation of an out-of-pocket maximum amount of the policy or plan. Health insurance policies are referred to in the bill as disability insurance policies.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.729, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.861, 632.862, 632.867, 632.87 (3) to (6), 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 2. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.729, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.861, 632.862, 632.867, 632.885, 632.89, and 632.895 (11) to (17).

SECTION 3. 66.0137 (4) of the statutes is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.729, 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.861, 632.862, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 4. 120.13 (2) (g) of the statutes is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.729, 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.861, 632.862, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 5. 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.729, 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.861, 632.862, 632.867, 632.87 (2) to (6), 632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 6. 609.83 of the statutes is amended to read:

609.83 Coverage of drugs and devices; application of payments. Limited service health organizations, preferred provider plans, and defined network plans are subject to ss. 632.853, 632.861, 632.862, and 632.895 (16t) and (16v).

SECTION 7. 632.862 of the statutes is created to read:

632.862 Application of prescription drug payments. (1) DEFINITIONS. In this section:

(a) "Brand name" has the meaning given in s. 450.12 (1) (a).

(b) "Brand name drug" means any of the following:

1. A prescription drug that contains a brand name and that has no medically appropriate generic equivalent.

2. A prescription drug that contains a brand name and that has a medically appropriate generic equivalent but to which the enrollee or other covered individual has obtained access through any of the following:

a. Prior authorization.

b. A step therapy protocol.

c. The exceptions and appeals process of the disability insurance policy, self–insured health plan, or pharmacy benefit manager.

(c) "Cost–sharing requirement" means a deductible, copayment, or coinsurance.

(d) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(e) "Generic equivalent" means a drug product equivalent, as defined in s. 450.13 (1e), that is nationally available.

(f) "Pharmacy benefit manager" has the meaning given in s. 632.865 (1) (c).

(g) "Self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) APPLICATION OF PAYMENTS. Except as provided in sub. (4), a disability insurance policy that offers a prescription drug benefit, a self–insured health plan, or a pharmacy benefit manager acting on behalf of a disability insurance policy or self–insured health plan shall apply to any cost–sharing requirement or to any calculation of an out–of–pocket maximum amount of the disability insurance policy or self–insured health plan, including the annual limitations on cost sharing established under 42 USC 18022 (c) and 42 USC 300gg–6 (b), any amounts paid by an enrollee or other individual covered under the disability insurance policy or self–insured health plan, or by any person on behalf of the enrollee or individual, for brand name drugs that are covered under the disability insurance policy or self–insured health plan.

(3) CALCULATION OF COST–SHARING ANNUAL LIMITATIONS. For purposes of calculating an enrollee's contribution to the annual limitation on cost sharing under 42 USC 18022 (c) and 42 USC 300gg–6 (b), a disability insurance policy that offers a prescription drug benefit, a self–insured health plan, or a pharmacy benefit manager acting on behalf of a disability insurance policy or self–insured health plan

shall include expenditures for any item or service covered under the disability insurance policy or self–insured health plan if the item or service is included within a category of essential health benefits, as described in 42 USC 18022 (b) (1), and regardless of whether the disability insurance policy, self–insured health plan, or pharmacy benefit manager classifies the item or service as an essential health benefit.

(4) EXCEPTION; HIGH DEDUCTIBLE HEALTH PLANS. If applying the requirement under sub. (2) to payments made by or on behalf of an enrollee or other individual covered under a high deductible health plan, as defined under 26 USC 223 (c) (2), would result in the enrollee failing to meet the definition of an eligible individual under 26 USC 223 (c) (1), the disability insurance policy, self–insured health plan, or pharmacy benefit manager shall begin applying the requirement under sub. (2) to the disability insurance policy or self–insured health plan's deductible after the enrollee has satisfied the minimum deductible requirement under 26 USC 223 (c) (2) (A) (i). This subsection does not apply to any amounts paid for items or services that are preventive care, as described in 26 USC 223 (c) (2) (C).

SECTION 8. Initial applicability.

(1) (a) For policies and plans containing provisions inconsistent with this act, the act first applies to policy or plan years beginning on January 1 of the year following the year in which this paragraph takes effect, except as provided in par. (b).

(b) For policies or plans that are affected by a collective bargaining agreement containing provisions inconsistent with this act, this act first applies to policy or plan years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

SECTION 9. Effective date.

(1) This act takes effect on the first day of the 4th month beginning after publication.

(END)