State of Wisconsin
2025 - 2026 LEGISLATURE

LRBb0738/1
ALL:all

# ASSEMBLY AMENDMENT 16,

# TO ASSEMBLY SUBSTITUTE AMENDMENT 2,

# TO ASSEMBLY BILL 50

July 2, 2025 - Offered by Representatives TAYLOR, ANDERSON, ANDRACA, ARNEY, BARE, BILLINGS, BROWN, CLANCY, CRUZ, DESANTO, DESMIDT, DOYLE, EMERSON, FITZGERALD, GOODWIN, HAYWOOD, HONG, HYSELL, J. JACOBSON, JOERS, JOHNSON, KIRSCH, MADISON, MAYADEV, MCCARVILLE, MCGUIRE, MIRESSE, MOORE OMOKUNDE, NEUBAUER, PALMERI, PHELPS, PRADO, RIVERA-WAGNER, ROE, SHEEHAN, SINICKI, SNODGRASS, SPAUDE, STROUD, STUBBS, SUBECK, TENORIO, UDELL and VINING.

At the locations indicated, amend the substitute amendment as follows:

**1.** At the appropriate places, insert all of the following:

"**SECTION 9149. Nonstatutory provisions; Wisconsin Economic Development Corporation.**

(1) ACCELERATE WISCONSIN. Notwithstanding the cap on expenditures specified in s. 20.192 (1) (a), in fiscal year 2025-26, the amount the Wisconsin Economic Development Corporation may expend from the appropriation under s. 20.192 (1) (a) is increased by $10,000,000 for the purpose of supporting a business accelerator program to be administered in cooperation with the University of Wisconsin System and aimed at developing research, including research from the University of Wisconsin System, into new startup businesses. As part of the

program, the Wisconsin Economic Development Corporation may award grants directly to businesses to assist in their growth and development and may award grants to or in support of business incubators.".

**2.** At the appropriate places, insert all of the following:

"**SECTION 1.** 77.54 (30) (a) 2. of the statutes is amended to read:

77.54 **(30)** (a) 2. Electricity and natural gas sold ~~during the months of November, December, January, February, March and April~~ for residential use.

**SECTION 9437. Effective dates; Revenue.**

(1) SALES TAX EXEMPTION FOR RESIDENTIAL ELECTRICITY AND NATURAL GAS. The treatment of s. 77.54 (30) (a) 2. takes effect on the first day of the 3rd month beginning after publication.".

**3.** At the appropriate places, insert all of the following:

"**SECTION 2.** 77.51 (9rm) of the statutes is created to read:

77.51 **(9rm)** "Over-the-counter-drug" means a drug that contains a label that identifies the product as a drug as required by 21 CFR 201.66, including a label that includes any of the following:

(a) A drug facts panel.

(b) A statement of the active ingredients with a list of those ingredients contained in the compound, substance, or preparation.

**SECTION 3.** 77.54 (14) (g) of the statutes is created to read:

77.54 **(14)** (g) Over-the-counter-drugs.

**SECTION 9437. Effective dates; Revenue.**

(1) OVER-THE-COUNTER DRUGS. The treatment of ss. 77.51 (9rm) and 77.54 (14) (g) takes effect on the first day of the 3rd month beginning after publication.".

**4.** At the appropriate places, insert all of the following:

"**SECTION 4.** 77.54 (56) (a) of the statutes is repealed.

**SECTION 5.** 77.54 (56) (ad) of the statutes is created to read:

77.54 **(56)** (ad) 1. The sales price from the sale of and the storage, use, or other consumption of a solar power system or wind energy system that produces usable electrical or heat energy directly from the sun or wind, if the system is capable of continuously producing at least 200 watts of alternating current or 600 British thermal units. A solar power system or wind energy system described under this subdivision includes tangible personal property sold with the system that is used primarily to store or facilitate the storage of the electrical or heat energy produced by the system, but does not include an uninterruptible power source that is designed primarily for computers. The exemption under this subdivision does not apply to tangible personal property designed for any use other than for a solar power system or wind energy system described in this subdivision.

2. The sales price from the sale of and the storage, use, or other consumption of a waste energy system that produces usable electrical or heat energy directly from gas generated from anaerobic digestion of animal manure and other agricultural waste if the system is capable of continuously producing at least 200 watts of alternating current or 600 British thermal units. A system described under this subdivision includes tangible personal property sold with the system that is used primarily to store or facilitate the storage of the electrical or heat

energy produced by the system, but does not include an uninterruptible power source that is designed primarily for computers. The exemption under this subdivision does not apply to tangible personal property designed for any use other than for a waste energy system described in this subdivision.

**SECTION 6.** 77.54 (56) (b) of the statutes is amended to read:

77.54 **(56)** (b) Except for the sale of electricity or energy that is exempt from taxation under sub. (30), ~~beginning on July 1, 2011,~~ the sales price from the sale of and the storage, use, or other consumption of electricity or heat energy produced by a ~~product~~ system described under par. ~~(a)~~ (ad).

**SECTION 9437. Effective dates; Revenue.**

(1) ENERGY SYSTEMS. The treatment of s. 77.54 (56) (a), (ad), and (b) takes effect on the first day of the 3rd month beginning after publication.".

**5.** At the appropriate places, insert all of the following:

"**SECTION 7.** 20.835 (1) (a) of the statutes is created to read:

20.835 **(1)** (a) *Property tax freeze incentive payments.* A sum sufficient to make the payments under s. 79.06.

**SECTION 8.** 79.015 of the statutes is amended to read:

**79.015 Statement of estimated payments.** The department of revenue, on or before September 15 of each year, shall provide to each municipality and county a statement of estimated payments to be made in the next calendar year to the municipality or county under ss. 79.035, 79.036, 79.037, 79.038, 79.039, 79.04, and 79.05 and shall provide a statement of estimated payments to be made to the

municipality or county under s. 79.06 if the municipality or county is eligible for a payment under s. 79.06 in the next calendar year.

**SECTION 9.** 79.06 of the statutes is created to read:

**79.06 Property tax freeze incentive payments. (1)** In this section, "political subdivision" means a city, village, town, or county.

**(2)** (a) A political subdivision is eligible for a payment under sub. (3) if its property tax levy in a year is less than or equal to its property tax levy in the immediately preceding year.

(b) For purposes of determining eligibility under par. (a), a political subdivision's property tax levy excludes all of the following expenditures made by the political subdivision:

1. Expenditures related to annexation or service consolidation.

2. Unreimbursed emergency expenditures.

**(3)** (a) Beginning in 2026, each political subdivision that is eligible under sub. (2) on the basis of its property tax levy imposed in the immediately preceding December shall receive a payment calculated as follows:

1. Multiply the political subdivision's property tax levy for the year of the payment by 0.03.

2. If the political subdivision received a payment under this subsection in the immediately preceding year, multiply the amount of the payment by 1.03.

3. Add the amounts determined under subds. 1. and 2.

(b) For purposes of calculating the amount of a payment under par. (a), a political subdivision's property tax levy excludes all expenditures excluded under sub. (2) (b).

(c) The department of revenue shall certify the amount of the payment due each taxing jurisdiction under par. (a) to the department of administration, and the department of administration shall make the payment on or before the first Monday in May.

**(4)** The department of revenue may promulgate rules to implement this section.".

**6.** At the appropriate places, insert all of the following:

"**SECTION 9219. Fiscal changes; Health Services.**

(1) HOME-DELIVERED MEALS. In the schedule under s. 20.005 (3) for the appropriation to the department of health services under s. 20.435 (1) (dh), the dollar amount for fiscal year 2025-26 is increased by $10,475,600 and the dollar amount for fiscal year 2026-27 is increased by $11,248,800 to increase the funding available for home-delivered meals under s. 46.80 (5) (a).".

**7.** At the appropriate places, insert all of the following:

"**SECTION 9219. Fiscal changes; Health Services.**

(1) WISCAREGIVER CAREERS. In the schedule under s. 20.005 (3) for the appropriation to the department of health services under s. 20.435 (4) (bm), the dollar amount for fiscal year 2025-26 is increased by $2,180,200 to support the WisCaregiver Careers program. In the schedule under s. 20.005 (3) for the appropriation to the department of health services under s. 20.435 (4) (bm), the dollar amount for fiscal year 2026-27 is increased by $2,163,700 to support the WisCaregiver Careers program.".

**8.** At the appropriate places, insert all of the following:

"**SECTION 9219. Fiscal changes; Health Services.**

(1) AGING AND DISABILITY RESOURCE CENTERS AND TRIBAL RESOURCE SPECIALISTS. In the schedule under s. 20.005 (3) for the appropriation to the department of health services under s. 20.435 (4) (b), the dollar amount for fiscal year 2025-26 is increased by $1,615,200 and the dollar amount for fiscal year 2026-27 is increased by $3,230,500 to increase base allocations for aging and disability resource centers and tribal aging and disability resource specialists.".

**9.** At the appropriate places, insert all of the following:

"**SECTION 9219. Fiscal changes; Health Services.**

(1) ADULT PROTECTIVE SERVICES. In the schedule under s. 20.005 (3) for the appropriation to the department of health services under s. 20.435 (7) (b), the dollar amount for fiscal year 2025-26 is increased by $2,569,800 and the dollar amount for fiscal year 2026-27 is increased by $5,089,700 to increase funding for adult protective services and to increase the authorized FTE positions for the department by 1.0 GPR position beginning in fiscal year 2025-26 to facilitate tribal nation adult protective services coordination.".

**10.** At the appropriate places, insert all of the following:

"**SECTION 9219. Fiscal changes; Health Services.**

(1) HOME AND COMMUNITY BASED SERVICES. In the schedule under s. 20.005 (3) for the appropriation to the department of health services under s. 20.435 (4) (bd), the dollar amount for fiscal year 2025-26 is increased by $2,596,300 and the dollar amount for fiscal year 2026-27 is increased by $2,608,100 to provide ongoing funding for all of the following:

(a) Aging and disability resource centers information technology projects focused on client-tracking and a searchable public-facing provider directory, as well as a centralized, statewide toll-free phone number and reception service to connect people with their local aging and disability resource center.

(b) The No Wrong Door - Supporting Kids Together Wisconsin initiative, through which parents with children who are disabled can access services and referrals from a single toll-free phone line and website.

(c) The resident and assisted living facility assessment tool, which allows for data collection and reporting relating to resident acuity and other factors.".

**11.** At the appropriate places, insert all of the following:

"**SECTION 9219. Fiscal changes; Health Services.**

(1) SUPPLEMENTAL SECURITY INCOME STATE BENEFIT INCREASE. In the schedule under s. 20.005 (3) for the appropriation to the department of health services under s. 20.435 (4) (ed), the dollar amount for fiscal year 2025-26 is increased by $714,000 and the dollar amount for fiscal year 2026-27 is increased by $14,933,500 to increase monthly state supplements to the federal supplemental security income case benefit from $83.78 to $100 per month for the standard state supplement, and from $179.77 per month to $214.57 for "exceptional expense" state supplements.".

**12.** At the appropriate places, insert all of the following:

"**SECTION 10.** 71.54 (1) (g) (intro.) of the statutes is amended to read:

71.54 **(1)** (g) *2012 ~~and thereafter~~ to 2025*. (intro.) The amount of any claim

filed in 2012 ~~and thereafter~~ to 2025 and based on property taxes accrued or rent constituting property taxes accrued during the previous year is limited as follows:

**SECTION 11.** 71.54 (1) (g) 4. of the statutes is amended to read:

71.54 **(1)** (g) 4. ~~Except as provided in subds. 5. and 7., for~~ For claims filed in 2018 and thereafter and based on property taxes accrued or rent constituting property taxes accrued during the previous year, no credit may be allowed under this paragraph if the claimant has no earned income in the taxable year to which the claim relates unless the claimant is disabled and provides the proof required under subd. 6. or the claimant or the claimant's spouse is over the age of 61 at the close of the year to which the claim relates.

**SECTION 12.** 71.54 (1) (g) 5. of the statutes is repealed.

**SECTION 13.** 71.54 (1) (g) 6. (intro.) of the statutes is amended to read:

71.54 **(1)** (g) 6. (intro.) ~~With regard to a claimant who is disabled, the~~ A claimant who is disabled shall provide with his or her return proof that his or her disability is in effect for the taxable year to which the claim relates. Proof of disability may be demonstrated by any of the following:

**SECTION 14.** 71.54 (1) (g) 7. of the statutes is repealed.

**SECTION 15.** 71.54 (1) (h) of the statutes is created to read:

71.54 **(1)** (h) *2026 and thereafter.* Subject to sub. (2m), the amount of any claim filed in 2026 and thereafter and based on property taxes accrued or rent constituting property taxes accrued during the previous year is limited as follows:

1. If the household income was $19,000 or less in the year to which the claim relates, the claim is limited to 80 percent of the property taxes accrued or rent

constituting property taxes accrued or both in that year on the claimant's homestead.

2. If the household income was more than $19,000 in the year to which the claim relates, the claim is limited to 80 percent of the amount by which the property taxes accrued or rent constituting property taxes accrued or both in that year on the claimant's homestead exceeds 7.891 percent of the household income exceeding $19,000.

3. No credit may be allowed if the household income exceeds $37,500.

4. Notwithstanding the time limitations described in par. (g) (intro.), the provisions of par. (g) 4. apply to claims filed under this paragraph.

**SECTION 16.** 71.54 (2) (b) 4. of the statutes is amended to read:

71.54 **(2)** (b) 4. In calendar years 2011 ~~or any subsequent calendar year~~ to 2024, $1,460.

**SECTION 17.** 71.54 (2) (b) 5. of the statutes is created to read:

71.54 **(2)** (b) 5. Subject to sub. (2m), in calendar year 2025 or any subsequent calendar year, $1,460.

**SECTION 18.** 71.54 (2m) of the statutes is amended to read:

71.54 **(2m)** INDEXING FOR INFLATION; ~~2010~~ 2026 AND THEREAFTER. (a) For calendar years beginning after December 31, ~~2009, and before January 1, 2011~~ 2025, the dollar amounts of the threshold income under sub. (1) ~~(f)~~ (h) 1. and 2., the maximum household income under sub. (1) ~~(f)~~ (h) 3., and the maximum property taxes under sub. (2) (b) ~~3.~~ 5. shall be increased each year by a percentage equal to the percentage change between the U.S. consumer price index for all urban

consumers, U.S. city average, ~~for the 12-month average of the U.S. consumer price index~~ for the month of August of ~~the year before~~ the previous year ~~through the month of July of the previous year~~ and the U.S. consumer price index for all urban consumers, U.S. city average, ~~for the 12-month average of the U.S. consumer price index~~ for August ~~2007 through July 2008~~ 2024, as determined by the federal department of labor, except that the adjustment may occur only if the percentage is a positive number. Each amount that is revised under this paragraph shall be rounded to the nearest multiple of $10 if the revised amount is not a multiple of $10 or, if the revised amount is a multiple of $5, such an amount shall be increased to the next higher multiple of $10. The department of revenue shall annually adjust the changes in dollar amounts required under this paragraph and incorporate the changes into the income tax forms and instructions.

(b) The department of revenue shall annually adjust the slope under sub. (1) ~~(f)~~ (h) 2. ~~such~~ so that, as a claimant's income increases from the threshold income as ~~calculated~~ adjusted under par. (a)~~,~~ to an amount that exceeds the maximum household income as ~~calculated~~ adjusted under par. (a), the credit that may be claimed is reduced to $0, and the department of revenue shall incorporate the changes into the income tax forms and instructions.

**SECTION 9337. Initial applicability; Revenue.**

(1) HOMESTEAD TAX CREDIT. The treatment of s. 71.54 (1) (h) first applies to claims filed for taxable years beginning after December 31, 2024.".

**13.** At the appropriate places, insert all of the following:

"**SECTION 9123. Nonstatutory provisions; Insurance.**

(1) PRESCRIPTION DRUG PURCHASING ENTITY. During the 2025-27 fiscal biennium, the office of the commissioner of insurance shall conduct a study on the viability of creating or implementing a state prescription drug purchasing entity.".

**14.** At the appropriate places, insert all of the following:

"**SECTION 19.** 601.41 (14) of the statutes is created to read:

601.41 **(14)** VALUE-BASED DIABETES MEDICATION PILOT PROJECT. The commissioner shall develop a pilot project to direct a pharmacy benefit manager, as defined in s. 632.865 (1) (c), and a pharmaceutical manufacturer to create a value-based, sole-source arrangement to reduce the costs of prescription medication used to treat diabetes. The commissioner may promulgate rules to implement this subsection.".

**15.** At the appropriate places, insert all of the following:

"**SECTION 20.** 632.868 of the statutes is created to read:

**632.868 Insulin safety net programs. (1)** DEFINITIONS. In this section:

(a) "Manufacturer" means a person engaged in the manufacturing of insulin that is self-administered on an outpatient basis.

(b) "Navigator" has the meaning given in s. 628.90 (3).

(c) "Patient assistance program" means a program established by a manufacturer under sub. (3) (a).

(d) "Pharmacy" means an entity licensed under s. 450.06 or 450.065.

(e) "Urgent need of insulin" means having less than a 7-day supply of insulin readily available for use and needing insulin in order to avoid the likelihood of suffering a significant health consequence.

(f) "Urgent need safety net program" means a program established by a manufacturer under sub. (2) (a).

**(2)** URGENT NEED SAFETY NET PROGRAM. (a) *Establishment of program*. No later than July 1, 2026, each manufacturer shall establish an urgent need safety net program to make insulin available in accordance with this subsection to individuals who meet the eligibility requirements under par. (b).

(b) *Eligible individual.* An individual is eligible to receive insulin under an urgent need safety net program if all of the following conditions are met:

1. The individual is in urgent need of insulin.

2. The individual is a resident of this state.

3. The individual is not receiving public assistance under ch. 49.

4. The individual is not enrolled in prescription drug coverage through an individual or group health plan that limits the total cost sharing amount, including copayments, deductibles, and coinsurance, that an enrollee is required to pay for a 30-day supply of insulin to no more than $75, regardless of the type or amount of insulin prescribed.

5. The individual has not received insulin under an urgent need safety net program within the previous 12 months, except as allowed under par. (d).

(c) *Provision of insulin under an urgent need safety net program*. 1. In order to receive insulin under an urgent need safety net program, an individual who meets the eligibility requirements under par. (b) shall provide a pharmacy with all of the following:

a. A completed application, on a form prescribed by the commissioner that

includes an attestation by the individual, or the individual's parent or legal guardian if the individual is under the age of 18, that the individual meets all of the eligibility requirements under par. (b).

b. A valid insulin prescription.

c. A valid Wisconsin driver's license or state identification card. If the individual is under the age of 18, the individual's parent or legal guardian shall meet this requirement.

2. Upon receipt of the information described in subd. 1. a. to c., the pharmacist shall dispense a 30-day supply of the prescribed insulin to the individual. The pharmacy shall also provide the individual with the information sheet described in sub. (8) (b) 2. and the list of navigators described in sub. (8) (c). The pharmacy may collect a copayment, not to exceed $35, from the individual to cover the pharmacy's costs of processing and dispensing the insulin. The pharmacy shall notify the health care practitioner who issued the prescription no later than 72 hours after the insulin is dispensed.

3. A pharmacy that dispenses insulin under subd. 2. may submit to the manufacturer, or the manufacturer's vendor, a claim for payment that is in accordance with the national council for prescription drug programs' standards for electronic claims processing, except that no claim may be submitted if the manufacturer agrees to send the pharmacy a replacement of the same insulin in the amount dispensed. If the pharmacy submits an electronic claim, the manufacturer or vendor shall reimburse the pharmacy in an amount that covers the pharmacy's acquisition cost.

4. A pharmacy that dispenses insulin under subd. 2. shall retain a copy of the application form described in subd. 1. a.

(d) *Eligibility of certain individuals*. An individual who has applied for public assistance under ch. 49 but for whom a determination of eligibility has not been made or whose coverage has not become effective or an individual who has an appeal pending under sub. (3) (c) 4. may access insulin under this subsection if the individual is in urgent need of insulin. To access a 30-day supply of insulin, the individual shall attest to the pharmacy that the individual is described in this paragraph and comply with par. (c) 1.

**(3)** PATIENT ASSISTANCE PROGRAM. (a) *Establishment of program*. No later than July 1, 2026, each manufacturer shall establish a patient assistance program to make insulin available in accordance with this subsection to individuals who meet the eligibility requirements under par. (b). Under the patient assistance program, the manufacturer shall do all of the following:

1. Provide the commissioner with information regarding the patient assistance program, including contact information for individuals to call for assistance in accessing the patient assistance program.

2. Provide a hotline for individuals to call or access between 8 a.m. and 10 p.m. on weekdays and between 10 a.m. and 6 p.m. on Saturdays.

3. List the eligibility requirements under par. (b) on the manufacturer's website.

4. Maintain the privacy of all information received from an individual applying for or participating in the patient assistance program and not sell, share,

or disseminate the information unless required under this section or authorized, in writing, by the individual.

(b) *Eligible individual*. An individual shall be eligible to receive insulin under a patient assistance program if all of the following conditions are met:

1. The individual is a resident of this state.

2. The individual, or the individual's parent or legal guardian if the individual is under the age of 18, has a valid Wisconsin driver's license or state identification card.

3. The individual has a valid insulin prescription.

4. The family income of the individual does not exceed 400 percent of the poverty line as defined and revised annually under 42 USC 9902 (2) for a family the size of the individual's family.

5. The individual is not receiving public assistance under ch. 49.

6. The individual is not eligible to receive health care through a federally funded program or receive prescription drug benefits through the U.S. department of veterans affairs, except that this subdivision does not apply to an individual who is enrolled in a policy under Part D of Medicare under 42 USC 1395w-101 et seq. if the individual has spent at least $1,000 on prescription drugs in the current calendar year.

7. The individual is not enrolled in prescription drug coverage through an individual or group health plan that limits the total cost sharing amount, including copayments, deductibles, and coinsurance, that an enrollee is required to pay for a

30-day supply of insulin to no more than $75, regardless of the type or amount of insulin needed.

(c) *Application for patient assistance program*. 1. An individual may apply to participate in a patient assistance program by filing an application with the manufacturer that established the patient assistance program, the individual's health care practitioner if the practitioner participates in the patient assistance program, or a navigator included on the list under sub. (8) (c). A health care practitioner or navigator shall immediately submit the application to the manufacturer. Upon receipt of an application, the manufacturer shall determine the individual's eligibility under par. (b) and, except as provided in subd. 2., notify the individual of the determination no later than 10 days after receipt of the application.

2. If necessary to determine the individual's eligibility under par. (b), the manufacturer may request additional information from an individual who has filed an application under subd. 1. no later than 5 days after receipt of the application. Upon receipt of the additional information, the manufacturer shall determine the individual's eligibility under par. (b) and notify the individual of the determination no later than 3 days after receipt of the requested information.

3. Except as provided in subd. 5., if the manufacturer determines under subd. 1. or 2. that the individual is eligible for the patient assistance program, the manufacturer shall provide the individual with a statement of eligibility. The statement of eligibility shall be valid for 12 months and may be renewed upon a

determination by the manufacturer that the individual continues to meet the eligibility requirements under par. (b).

4. If the manufacturer determines under subd. 1. or 2. that the individual is not eligible for the patient assistance program, the manufacturer shall provide the reason for the determination in the notification under subd. 1. or 2. The individual may appeal the determination by filing an appeal with the commissioner that shall include all of the information provided to the manufacturer under subds. 1. and 2. The commissioner shall establish procedures for deciding appeals under this subdivision. The commissioner shall issue a decision no later than 10 days after the appeal is filed, and the commissioner's decision shall be final. If the commissioner determines that the individual meets the eligibility requirements under par. (b), the manufacturer shall provide the individual with the statement of eligibility described in subd. 3.

5. In the case of an individual who has prescription drug coverage through an individual or group health plan, if the manufacturer determines under subd. 1. or 2. that the individual is eligible for the patient assistance program but also determines that the individual's insulin needs are better addressed through the use of the manufacturer's copayment assistance program rather than the patient assistance program, the manufacturer shall inform the individual of the determination and provide the individual with the necessary coupons to submit to a pharmacy. The individual may not be required to pay more than the copayment amount specified in par. (d) 2.

(d) *Provision of insulin under a patient assistance program*. 1. Upon receipt

from an individual of the eligibility statement described in par. (c) 3. and a valid insulin prescription, a pharmacy shall submit an order containing the name of the insulin and daily dosage amount to the manufacturer. The pharmacy shall include with the order the pharmacy's name, shipping address, office telephone number, fax number, email address, and contact name, as well as any days or times when deliveries are not accepted by the pharmacy.

2. Upon receipt of an order meeting the requirements under subd. 1., the manufacturer shall send the pharmacy a 90-day supply of insulin, or lesser amount if requested in the order, at no charge to the individual or pharmacy. The pharmacy shall dispense the insulin to the individual associated with the order. The insulin shall be dispensed at no charge to the individual, except that the pharmacy may collect a copayment from the individual to cover the pharmacy's costs for processing and dispensing in an amount not to exceed $50 for each 90-day supply of insulin. The pharmacy may not seek reimbursement from the manufacturer or a 3rd-party payer.

3. The pharmacy may submit a reorder to the manufacturer if the individual's eligibility statement described in par. (c) 3. has not expired. The reorder shall be treated as an order for purposes of subd. 2.

4. Notwithstanding subds. 2. and 3., a manufacturer may send the insulin directly to the individual if the manufacturer provides a mail-order service option, in which case the pharmacy may not collect a copayment from the individual.

**(4)** EXCEPTIONS. (a) This section does not apply to a manufacturer that shows

to the commissioner's satisfaction that the manufacturer's annual gross revenue from insulin sales in this state does not exceed $2,000,000.

(b) A manufacturer may not be required to make an insulin product available under sub. (2) or (3) if the wholesale acquisition cost of the insulin product does not exceed $8, as adjusted annually based on the U.S. consumer price index for all urban consumers, U.S. city average, per milliliter or the applicable national council for prescription drug programs' plan billing unit.

**(5)** CONFIDENTIALITY. All medical information solicited or obtained by any person under this section shall be subject to the applicable provisions of state law relating to confidentiality of medical information, including s. 610.70.

**(6)** REIMBURSEMENT PROHIBITION. No person, including a manufacturer, pharmacy, pharmacist, or 3rd-party administrator, as part of participating in an urgent need safety net program or patient assistance program may request or seek, or cause another person to request or seek, any reimbursement or other compensation for which payment may be made in whole or in part under a federal health care program, as defined in 42 USC 1320a-7b (f).

**(7)** REPORTS. (a) Annually, no later than March 1, each manufacturer shall report to the commissioner all of the following information for the previous calendar year:

1. The number of individuals who received insulin under the manufacturer's urgent need safety net program.

2. The number of individuals who sought assistance under the

manufacturer's patient assistance program and the number of individuals who were determined to be ineligible under sub. (3) (c) 4.

3. The wholesale acquisition cost of the insulin provided by the manufacturer through the urgent need safety net program and patient assistance program.

(b) Annually, no later than April 1, the commissioner shall submit to the governor and the chief clerk of each house of the legislature, for distribution to the legislature under s. 13.172 (2), a report on the urgent need safety net programs and patient assistance programs that includes all of the following:

1. The information provided to the commissioner under par. (a).

2. The penalties assessed under sub. (9) during the previous calendar year, including the name of the manufacturer and amount of the penalty.

**(8)** ADDITIONAL RESPONSIBILITIES OF COMMISSIONER. (a) *Application form*. The commissioner shall make the application form described in sub. (2) (c) 1. a. available on the office's website and shall make the form available to pharmacies and health care providers who prescribe or dispense insulin, hospital emergency departments, urgent care clinics, and community health clinics.

(b) *Public outreach*. 1. The commissioner shall conduct public outreach to create awareness of the urgent need safety net programs and patient assistance programs.

2. The commissioner shall develop and make available on the office's website an information sheet that contains all of the following information:

a. A description of how to access insulin through an urgent need safety net program.

b. A description of how to access insulin through a patient assistance program.

c. Information on how to contact a navigator for assistance in accessing insulin through an urgent need safety net program or patient assistance program.

d. Information on how to contact the commissioner if a manufacturer determines that an individual is not eligible for a patient assistance program.

e. A notification that an individual may contact the commissioner for more information or assistance in accessing ongoing affordable insulin options.

(c) *Navigators*. The commissioner shall develop a training program to provide navigators with information and the resources necessary to assist individuals in accessing appropriate long-term insulin options. The commissioner shall compile a list of navigators that have completed the training program and are available to assist individuals in accessing affordable insulin coverage options. The list shall be made available on the office's website and to pharmacies and health care practitioners who dispense and prescribe insulin.

(d) *Satisfaction surveys*. 1. The commissioner shall develop and conduct a satisfaction survey of individuals who have accessed insulin through urgent need safety net programs and patient assistance programs. The survey shall ask whether the individual is still in need of a long-term solution for affordable insulin and shall include questions about the individual's satisfaction with all of the following, if applicable:

a. Accessibility to urgent-need insulin.

b. Adequacy of the information sheet and list of navigators received from the pharmacy.

c. Helpfulness of a navigator.

d. Ease of access in applying for a patient assistance program and receiving insulin from the pharmacy under the patient assistance program.

2. The commissioner shall develop and conduct a satisfaction survey of pharmacies that have dispensed insulin through urgent need safety net programs and patient assistance programs. The survey shall include questions about the pharmacy's satisfaction with all of the following, if applicable:

a. Timeliness of reimbursement from manufacturers for insulin dispensed by the pharmacy under urgent need safety net programs.

b. Ease in submitting insulin orders to manufacturers.

c. Timeliness of receiving insulin orders from manufacturers.

3. The commissioner may contract with a nonprofit entity to develop and conduct the surveys under subds. 1. and 2. and to evaluate the survey results.

4. No later than July 1, 2028, the commissioner shall submit to the governor and the chief clerk of each house of the legislature, for distribution to the legislature under s. 13.172 (2), a report on the results of the surveys under subds. 1. and 2.

**(9)** PENALTY. A manufacturer that violates this section may be required to forfeit not more than $200,000 per month of violation, with the maximum forfeiture increasing to $400,000 per month if the manufacturer continues to be in violation after 6 months and increasing to $600,000 per month if the manufacturer continues to be in violation after one year.".

**16.** At the appropriate places, insert all of the following:

"**SECTION 21.** 609.83 of the statutes is amended to read:

**609.83 Coverage of drugs and devices.** Limited service health organizations, preferred provider plans, and defined network plans are subject to ss. 632.853, 632.861, and 632.895 (6) (b), (16t), and (16v).

**SECTION 22.** 632.895 (6) (title) of the statutes is amended to read:

632.895 **(6)** (title) EQUIPMENT AND SUPPLIES FOR TREATMENT OF DIABETES; INSULIN.

**SECTION 23.** 632.895 (6) of the statutes is renumbered 632.895 (6) (a) and amended to read:

632.895 **(6)** (a) Every disability insurance policy ~~which~~ that provides coverage of expenses incurred for treatment of diabetes shall provide coverage for expenses incurred by the installation and use of an insulin infusion pump, coverage for all other equipment and supplies, including insulin or any other prescription medication, used in the treatment of diabetes, and coverage of diabetic self-management education programs. ~~Coverage~~ Except as provided in par. (b), coverage required under this subsection shall be subject to the same exclusions, limitations, deductibles, and coinsurance provisions of the policy as other covered expenses, except that insulin infusion pump coverage may be limited to the purchase of one pump per year and the insurer may require the insured to use a pump for 30 days before purchase.

**SECTION 24.** 632.895 (6) (b) of the statutes is created to read:

632.895 **(6)** (b) 1. In this paragraph:

a. "Cost sharing" means the total of any deductible, copayment, or coinsurance amounts imposed on a person covered under a disability insurance policy or self-insured health plan.

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

2. Every disability insurance policy and self-insured health plan that covers insulin and imposes cost sharing on prescription drugs may not impose cost sharing on insulin in an amount that exceeds $35 for a one-month supply of insulin.

3. Nothing in this paragraph prohibits a disability insurance policy or self-insured health plan from imposing cost sharing on insulin in an amount less than the amount specified under subd. 2. Nothing in this paragraph requires a disability insurance policy or self-insured health plan to impose any cost sharing on insulin.

**SECTION 9423. Effective dates; Insurance.**

(1) COST-SHARING CAP ON INSULIN. The treatment of ss. 609.83 and 632.895 (6) (title), the renumbering and amendment of s. 632.895 (6), and the creation of s. 632.895 (6) (b) take effect on the first day of the 4th month beginning after publication.".

**17.** At the appropriate places, insert all of the following:

"**SECTION 25.** 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), 632.722, 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 26.** 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, 632.722, 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 27.** 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), 632.722, 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 28.** 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), 632.722, 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 29.** 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), 632.722, 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 30.** 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 31.** 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 generic equivalent.

2. A prescription drug that contains a brand name and has a generic equivalent but for which the enrollee has received prior authorization from the insurer offering the disability insurance policy or self-insured health plan or authorization from a physician to obtain the prescription drug under the disability insurance policy or self-insured health plan.

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

(d) "Prescription drug" has the meaning given in s. 450.01 (20).

(e) "Self-insured health plan" means a self-insured health plan of the state or a county, city, village, town, or school district.

**(2)** APPLICATION OF DISCOUNTS. A disability insurance policy that offers a prescription drug benefit or a self-insured health plan shall apply to any calculation of an out-of-pocket maximum amount and to any deductible of the disability insurance policy or self-insured health plan for an enrollee the amount that any discount provided by the manufacturer of a brand name drug reduces the cost sharing amount charged to the enrollee for that brand name drug.

**SECTION 9323. Initial applicability; Insurance.**

(1) APPLICATION OF MANUFACTURER DISCOUNTS.

(a) For policies and plans containing provisions inconsistent with the treatment of ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.83, and 632.862, the treatment of ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.83, and 632.862 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 the treatment of ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.83, and 632.862, the treatment of ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.83, and 632.862 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 9423. Effective dates; Insurance.**

(1) APPLICATION OF MANUFACTURER DISCOUNTS. The treatment of ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.83, and 632.862 and SECTION 9323 (1) take effect on the first day of the 4th month beginning after publication.".

**18.** At the appropriate places, insert all of the following:

"**SECTION 9216. Fiscal changes; Administration.**

(1) BOARD ON AGING AND LONG-TERM CARE MEDIGAP HELPLINE. In the schedule under s. 20.005 (3) for the appropriation to the board on aging and long-term care under s. 20.432 (1) (kb), the dollar amount for fiscal year 2025-26 is increased by $100,600 and the dollar amount for fiscal year 2026-27 is increased by $122,000 to support telephone counseling services provided under s. 16.009 (2) (j) for individuals seeing information on medicare supplemental insurance policies.".

**19.** At the appropriate places, insert all of the following:

"**SECTION 32.** 609.712 of the statutes is created to read:

**609.712 Essential health benefits; preventive services.** Defined network plans and preferred provider plans are subject to s. 632.895 (13m) and (14m).

**SECTION 33.** 609.847 of the statutes is created to read:

**609.847 Preexisting condition discrimination and certain benefit limits prohibited.** Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.728.

**SECTION 34.** 625.12 (1) (a) of the statutes is amended to read:

625.12 **(1)** (a) Past and prospective loss and expense experience within and outside of this state, except as provided in s. 632.728.

**SECTION 35.** 625.12 (1) (e) of the statutes is amended to read:

625.12 **(1)** (e) Subject to ~~s.~~ ss. 632.365 and 632.728, all other relevant factors, including the judgment of technical personnel.

**SECTION 36.** 625.12 (2) of the statutes is amended to read:

625.12 **(2)** CLASSIFICATION. Except as provided in ~~s.~~ ss. 632.728 and 632.729, risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that no classifications may be based on race, color, creed or national origin, and classifications in automobile insurance may not be based on physical condition or developmental disability as defined in s. 51.01 (5). Subject to ss. 632.365, 632.728, and 632.729, rates thus produced may be modified for individual risks in accordance with rating plans or schedules that establish reasonable standards for measuring probable variations in hazards, expenses, or both. Rates may also be modified for individual risks under s. 625.13 (2).

**SECTION 37.** 625.15 (1) of the statutes is amended to read:

625.15 **(1)** RATE MAKING. ~~An~~ Except as provided in s. 632.728, an insurer may itself establish rates and supplementary rate information for one or more market segments based on the factors in s. 625.12 and, if the rates are for motor vehicle liability insurance, subject to s. 632.365, or the insurer may use rates and supplementary rate information prepared by a rate service organization, with average expense factors determined by the rate service organization or with such

modification for its own expense and loss experience as the credibility of that experience allows.

**SECTION 38.** 628.34 (3) (a) of the statutes is amended to read:

628.34 **(3)** (a) No insurer may unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved, subject to ss. 632.365, 632.728, 632.729, 632.746, and 632.748. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket or franchise policy, and terms are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.

**SECTION 39.** 632.728 of the statutes is created to read:

**632.728 Coverage of persons with preexisting conditions; guaranteed issue; benefit limits. (1)** DEFINITIONS. In this section:

(a) "Cost sharing" includes deductibles, coinsurance, copayments, or similar charges.

(b) "Health benefit plan" has the meaning given in s. 632.745 (11).

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

**(2)** GUARANTEED ISSUE. (a) Every individual health benefit plan shall accept every individual in this state who, and every group health benefit plan shall accept every employer in this state that, applies for coverage, regardless of the sexual orientation, the gender identity, or any preexisting condition of any individual or employee who will be covered by the plan. A health benefit plan may restrict

enrollment in coverage described in this paragraph to open or special enrollment periods.

(b) The commissioner shall establish a statewide open enrollment period that is no shorter than 30 days, during which every individual health benefit plan shall allow individuals, including individuals who do not have coverage, to enroll in coverage.

**(3)** PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS. (a) An individual health benefit plan or a self-insured health plan may not establish rules for the eligibility of any individual to enroll, or for the continued eligibility of any individual to remain enrolled, under the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

1. Health status.

2. Medical condition, including both physical and mental illnesses.

3. Claims experience.

4. Receipt of health care.

5. Medical history.

6. Genetic information.

7. Evidence of insurability, including conditions arising out of acts of domestic violence.

8. Disability.

(b) An insurer offering an individual health benefit plan or a self-insured health plan may not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay, on the basis of any health status-

related factor under par. (a) with respect to the individual or a dependent of the individual, a premium or contribution or a deductible, copayment, or coinsurance amount that is greater than the premium or contribution or deductible, copayment, or coinsurance amount, respectively, for an otherwise similarly situated individual enrolled under the plan.

(c) Nothing in this subsection prevents an insurer offering an individual health benefit plan or a self-insured health plan from establishing premium discounts or rebates or modifying otherwise applicable cost sharing in return for adherence to programs of health promotion and disease prevention.

**(4)** PREMIUM RATE VARIATION. A health benefit plan offered on the individual or small employer market or a self-insured health plan may vary premium rates for a specific plan based only on the following considerations:

(a) Whether the policy or plan covers an individual or a family.

(b) Rating area in the state, as established by the commissioner.

(c) Age, except that the rate may not vary by more than 3 to 1 for adults over the age groups and the age bands shall be consistent with recommendations of the National Association of Insurance Commissioners.

(d) Tobacco use, except that the rate may not vary by more than 1.5 to 1.

**(5)** STATEWIDE RISK POOL. An insurer offering a health benefit plan may not segregate enrollees into risk pools other than a single statewide risk pool for the individual market and a single statewide risk pool for the small employer market or a single statewide risk pool that combines the individual and small employer markets.

**(6)** ANNUAL AND LIFETIME LIMITS. An individual or group health benefit plan or a self-insured health plan may not establish any of the following:

(a) Lifetime limits on the dollar value of benefits for an enrollee or a dependent of an enrollee under the plan.

(b) Annual limits on the dollar value of benefits for an enrollee or a dependent of an enrollee under the plan.

**(7)** COST SHARING MAXIMUM. A health benefit plan offered on the individual or small employer market may not require an enrollee under the plan to pay more in cost sharing than the maximum amount calculated under 42 USC 18022 (c), including the annual indexing of the limits.

**(8)** MEDICAL LOSS RATIO. (a) In this subsection, "medical loss ratio" means the proportion, expressed as a percentage, of premium revenues spent by a health benefit plan on clinical services and quality improvement.

(b) A health benefit plan on the individual or small employer market shall have a medical loss ratio of at least 80 percent.

(c) A group health benefit plan other than one described under par. (b) shall have a medical loss ratio of at least 85 percent.

**(9)** ACTUARIAL VALUES OF PLAN TIERS. Any health benefit plan offered on the individual or small employer market shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to at least 60 percent of the full actuarial value of the benefits provided under the plan.

**SECTION 40.** 632.746 (1) (a) of the statutes is renumbered 632.746 (1) and amended to read:

632.746 **(1)** ~~Subject to subs. (2) and (3), an~~ An insurer that offers a group health benefit plan may~~, with respect to a participant or beneficiary under the plan,~~ not impose a preexisting condition exclusion ~~only if the exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the participant's or beneficiary's enrollment date under the plan~~ on a participant or beneficiary under the plan.

**SECTION 41.** 632.746 (1) (b) of the statutes is repealed.

**SECTION 42.** 632.746 (2) (a) of the statutes is amended to read:

632.746 **(2)** (a) An insurer offering a group health benefit plan may not ~~treat~~ impose a preexisting condition exclusion based on genetic information ~~as a preexisting condition under sub. (1) without a diagnosis of a condition related to the information~~.

**SECTION 43.** 632.746 (2) (c), (d) and (e) of the statutes are repealed.

**SECTION 44.** 632.746 (3) (a) of the statutes is repealed.

**SECTION 45.** 632.746 (3) (d) 1. of the statutes is renumbered 632.746 (3) (d).

**SECTION 46.** 632.746 (3) (d) 2. and 3. of the statutes are repealed.

**SECTION 47.** 632.746 (5) of the statutes is repealed.

**SECTION 48.** 632.746 (8) (a) (intro.) of the statutes is amended to read:

632.746 **(8)** (a) (intro.) A health maintenance organization that offers a group health benefit plan ~~and that does not impose any preexisting condition exclusion under sub. (1)~~ with respect to a particular coverage option may impose an affiliation period for that coverage option, but only if all of the following apply:

**SECTION 49.** 632.748 (2) of the statutes is amended to read:

632.748 **(2)** An insurer offering a group health benefit plan may not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay, on the basis of any health status-related factor with respect to the individual or a dependent of the individual, a premium or contribution or a deductible, copayment, or coinsurance amount that is greater than the premium or contribution or deductible, copayment, or coinsurance amount, respectively, for ~~a~~ an otherwise similarly situated individual enrolled under the plan.

**SECTION 50.** 632.76 (2) (a) and (ac) 1. and 2. of the statutes are amended to read:

632.76 **(2)** (a) No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss. This paragraph does not apply to a group health benefit plan, as defined in s. 632.745 (9), which is subject to s. 632.746, a disability insurance policy, as defined in s. 632.895 (1) (a), or a self-insured health plan, as defined in s. 632.85 (1) (c).

(ac) 1. ~~Notwithstanding par. (a), no~~ No claim or loss incurred or disability commencing ~~after 12 months from the date of issue of~~ under an individual disability insurance policy, as defined in s. 632.895 (1) (a), may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of

coverage~~, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of the loss~~.

2. ~~Except as provided in subd. 3., an~~ An individual disability insurance policy, as defined in s. 632.895 (1) (a), other than a short-term policy subject to s. 632.7495 (4) and (5), may not define a preexisting condition more restrictively than a condition that was present before the date of enrollment for the coverage, whether physical or mental, regardless of the cause of the condition, ~~for which~~ and regardless of whether medical advice, diagnosis, care, or treatment was recommended or received ~~within 12 months before the effective date of coverage~~.

**SECTION 51.** 632.795 (4) (a) of the statutes is amended to read:

632.795 **(4)** (a) An insurer subject to sub. (2) shall provide coverage under the same policy form and for the same premium as it originally offered in the most recent enrollment period, subject only to the medical underwriting used in that enrollment period. Unless otherwise prescribed by rule, the insurer may apply deductibles, ~~preexisting condition limitations,~~ waiting periods, or other limits only to the extent that they would have been applicable had coverage been extended at the time of the most recent enrollment period and with credit for the satisfaction or partial satisfaction of similar provisions under the liquidated insurer's policy or plan. The insurer may exclude coverage of claims that are payable by a solvent insurer under insolvency coverage required by the commissioner or by the insurance regulator of another jurisdiction. Coverage shall be effective on the date that the liquidated insurer's coverage terminates.

**SECTION 52.** 632.895 (8) (d) of the statutes is amended to read:

632.895 **(8)** (d) Coverage is required under this subsection despite whether the woman shows any symptoms of breast cancer. Except as provided in pars. (b), (c), and (e), coverage under this subsection may only be subject to exclusions and limitations, including ~~deductibles, copayments and~~ restrictions on excessive charges, that are applied to other radiological examinations covered under the disability insurance policy. Coverage under this subsection may not be subject to any deductibles, copayments, or coinsurance.

**SECTION 53.** 632.895 (13m) of the statutes is created to read:

632.895 **(13m)** PREVENTIVE SERVICES. (a) In this section, "self-insured health plan" has the meaning given in s. 632.85 (1) (c).

(b) Every disability insurance policy, except any disability insurance policy that is described in s. 632.745 (11) (b) 1. to 12., and every self-insured health plan shall provide coverage for all of the following preventive services:

1. Mammography in accordance with sub. (8).

2. Genetic breast cancer screening and counseling and preventive medication for adult women at high risk for breast cancer.

3. Papanicolaou test for cancer screening for women 21 years of age or older with an intact cervix.

4. Human papillomavirus testing for women who have attained the age of 30 years but have not attained the age of 66 years.

5. Colorectal cancer screening in accordance with sub. (16m).

6. Annual tomography for lung cancer screening for adults who have attained

the age of 55 years but have not attained the age of 80 years and who have health histories demonstrating a risk for lung cancer.

7. Skin cancer screening for individuals who have attained the age of 10 years but have not attained the age of 22 years.

8. Counseling for skin cancer prevention for adults who have attained the age of 18 years but have not attained the age of 25 years.

9. Abdominal aortic aneurysm screening for men who have attained the age of 65 years but have not attained the age of 75 years and who have ever smoked.

10. Hypertension screening for adults and blood pressure testing for adults, for children under the age of 3 years who are at high risk for hypertension, and for children 3 years of age or older.

11. Lipid disorder screening for minors 2 years of age or older, adults 20 years of age or older at high risk for lipid disorders, and all men 35 years of age or older.

12. Aspirin therapy for cardiovascular health for adults who have attained the age of 55 years but have not attained the age of 80 years and for men who have attained the age of 45 years but have not attained the age of 55 years.

13. Behavioral counseling for cardiovascular health for adults who are overweight or obese and who have risk factors for cardiovascular disease.

14. Type II diabetes screening for adults with elevated blood pressure.

15. Depression screening for minors 11 years of age or older and for adults when follow-up supports are available.

16. Hepatitis B screening for minors at high risk for infection and adults at high risk for infection.

17. Hepatitis C screening for adults at high risk for infection and onetime hepatitis C screening for adults born in any year from 1945 to 1965.

18. Obesity screening and management for all minors and adults with a body mass index indicating obesity, counseling and behavioral interventions for obese minors who are 6 years of age or older, and referral for intervention for obesity for adults with a body mass index of 30 kilograms per square meter or higher.

19. Osteoporosis screening for all women 65 years of age or older and for women at high risk for osteoporosis under the age of 65 years.

20. Immunizations in accordance with sub. (14).

21. Anemia screening for individuals 6 months of age or older and iron supplements for individuals at high risk for anemia who have attained the age of 6 months but have not attained the age of 12 months.

22. Fluoride varnish for prevention of tooth decay for minors at the age of eruption of their primary teeth.

23. Fluoride supplements for prevention of tooth decay for minors 6 months of age or older who do not have fluoride in their water source.

24. Gonorrhea prophylaxis treatment for newborns.

25. Health history and physical exams for prenatal visits and for minors.

26. Length and weight measurements for newborns and height and weight measurements for minors.

27. Head circumference and weight-for-length measurements for newborns and minors who have not attained the age of 3 years.

28. Body mass index for minors 2 years of age or older.

29. Blood pressure measurements for minors 3 years of age or older and a blood pressure risk assessment at birth.

30. Risk assessment and referral for oral health issues for minors who have attained the age of 6 months but have not attained the age of 7 years.

31. Blood screening for newborns and minors who have not attained the age of 2 months.

32. Screening for critical congenital health defects for newborns.

33. Lead screenings in accordance with sub. (10).

34. Metabolic and hemoglobin screening and screening for phenylketonuria, sickle cell anemia, and congenital hypothyroidism for minors including newborns.

35. Tuberculin skin test based on risk assessment for minors one month of age or older.

36. Tobacco counseling and cessation interventions for individuals who are 5 years of age or older.

37. Vision and hearing screening and assessment for minors including newborns.

38. Sexually transmitted infection and human immunodeficiency virus counseling for sexually active minors.

39. Risk assessment for sexually transmitted infection for minors who are 10 years of age or older and screening for sexually transmitted infection for minors who are 16 years of age or older.

40. Alcohol misuse screening and counseling for minors 11 years of age or older.

41. Autism screening for minors who have attained the age of 18 months but have not attained the age of 25 months.

42. Developmental screening and surveillance for minors including newborns.

43. Psychosocial and behavioral assessment for minors including newborns.

44. Alcohol misuse screening and counseling for pregnant adults and a risk assessment for all adults.

45. Fall prevention and counseling and preventive medication for fall prevention for community-dwelling adults 65 years of age or older.

46. Screening and counseling for intimate partner violence for adult women.

47. Well-woman visits for women who have attained the age of 18 years but have not attained the age of 65 years and well-woman visits for recommended preventive services, preconception care, and prenatal care.

48. Counseling on, consultations with a trained provider on, and equipment rental for breastfeeding for pregnant and lactating women.

49. Folic acid supplement for adult women with reproductive capacity.

50. Iron deficiency anemia screening for pregnant and lactating women.

51. Preeclampsia preventive medicine for pregnant adult women at high risk for preeclampsia.

52. Low-dose aspirin after 12 weeks of gestation for pregnant women at high risk for miscarriage, preeclampsia, or clotting disorders.

53. Screenings for hepatitis B and bacteriuria for pregnant women.

54. Screening for gonorrhea for pregnant and sexually active females 24 years

of age or younger and females older than 24 years of age who are at risk for infection.

55. Screening for chlamydia for pregnant and sexually active females 24 years of age and younger and females older than 24 years of age who are at risk for infection.

56. Screening for syphilis for pregnant women and adults who are at high risk for infection.

57. Human immunodeficiency virus screening for adults who have attained the age of 15 years but have not attained the age of 66 years and individuals at high risk of infection who are younger than 15 years of age or older than 65 years of age.

58. All contraceptives and services in accordance with sub. (17).

59. Any services not already specified under this paragraph having an A or B rating in current recommendations from the U.S. preventive services task force.

60. Any preventive services not already specified under this paragraph that are recommended by the federal health resources and services administration's Bright Futures project.

61. Any immunizations, not already specified under sub. (14), that are recommended and determined to be for routine use by the federal advisory committee on immunization practices.

(c) Subject to par. (d), no disability insurance policy, except any disability insurance policy that is described in s. 632.745 (11) (b) 1. to 12., and no self-insured health plan may subject the coverage of any of the preventive services under par. (b) to any deductibles, copayments, or coinsurance under the policy or plan.

(d) 1. If an office visit and a preventive service specified under par. (b) are billed separately by the health care provider, the disability insurance policy or self-insured health plan may apply deductibles to and impose copayments or coinsurance on the office visit but not on the preventive service.

2. If the primary reason for an office visit is not to obtain a preventive service specified under par. (b), the disability insurance policy or self-insured health plan may apply deductibles to and impose copayments or coinsurance on the office visit.

3. Except as otherwise provided in this subdivision, if a preventive service specified under par. (b) is provided by a health care provider that is outside the disability insurance policy's or self-insured health plan's network of providers, the policy or plan may apply deductibles to and impose copayments or coinsurance on the office visit and the preventive service. If a preventive service specified under par. (b) is provided by a health care provider that is outside the disability insurance policy's or self-insured health plan's network of providers because there is no available health care provider in the policy's or plan's network of providers that provides the preventive service, the policy or plan may not apply deductibles to or impose copayments or coinsurance on the preventive service.

4. If more than one well-woman visit described under par. (b) 47. is necessary to provide all necessary preventive services as determined by a qualified health care provider and in accordance with applicable recommendations for preventive services, the disability insurance policy or self-insured health plan may not apply a deductible to or impose a copayment or coinsurance on any such well-woman visit.

**SECTION 54.** 632.895 (14) (a) 1. i. and j. of the statutes are amended to read:

632.895 **(14)** (a) 1. i. Hepatitis A and B.

j. Varicella and herpes zoster.

**SECTION 55.** 632.895 (14) (a) 1. k. to o. of the statutes are created to read:

632.895 **(14)** (a) 1. k. Human papillomavirus.

L. Meningococcal meningitis.

m. Pneumococcal pneumonia.

n. Influenza.

o. Rotavirus.

**SECTION 56.** 632.895 (14) (b) of the statutes is amended to read:

632.895 **(14)** (b) Except as provided in par. (d), every disability insurance policy, and every self-insured health plan of the state or a county, city, town, village, or school district, ~~that provides coverage for a dependent of the insured~~ shall provide coverage of appropriate and necessary immunizations~~, from birth to the age of 6 years,~~ for an insured or plan participant, including a dependent ~~who is a child~~ of the insured or plan participant.

**SECTION 57.** 632.895 (14) (c) of the statutes is amended to read:

632.895 **(14)** (c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. ~~This paragraph applies to a defined network plan, as defined in s. 609.01 (1b), only with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.~~

**SECTION 58.** 632.895 (14) (d) 3. of the statutes is amended to read:

632.895 **(14)** (d) 3. A health care plan offered by a limited service health

organization, as defined in s. 609.01 (3)~~, or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b)~~.

**SECTION 59.** 632.895 (14m) of the statutes is created to read:

632.895 **(14m)** ESSENTIAL HEALTH BENEFITS. (a) In this subsection, "self-insured health plan" has the meaning given in s. 632.85 (1) (c).

(b) On a date specified by the commissioner, by rule, every disability insurance policy, except as provided in par. (g), and every self-insured health plan shall provide coverage for essential health benefits as determined by the commissioner, by rule, subject to par. (c).

(c) In determining the essential health benefits for which coverage is required under par. (b), the commissioner shall do all of the following:

1. Include benefits, items, and services in, at least, all of the following categories:

a. Ambulatory patient services.

b. Emergency services.

c. Hospitalization.

d. Maternity and newborn care.

e. Mental health and substance use disorder services, including behavioral health treatment.

f. Prescription drugs.

g. Rehabilitative and habilitative services and devices.

h. Laboratory services.

i. Preventive and wellness services and chronic disease management.

j. Pediatric services, including oral and vision care.

2. Conduct a survey of employer-sponsored coverage to determine benefits typically covered by employers and ensure that the scope of essential health benefits for which coverage is required under this subsection is equal to the scope of benefits covered under a typical disability insurance policy offered by an employer to its employees.

3. Ensure that essential health benefits reflect a balance among the categories described in subd. 1. such that benefits are not unduly weighted toward one category.

4. Ensure that essential health benefit coverage is provided with no or limited cost-sharing requirements.

5. Require that disability insurance policies and self-insured health plans do not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.

6. Establish essential health benefits in a way that takes into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.

7. Ensure that essential health benefits established under this subsection are not subject to a coverage denial based on an insured's or plan participant's age, expected length of life, present or predicted disability, degree of dependency on medical care, or quality of life.

8. Require that disability insurance policies and self-insured health plans

cover emergency department services that are essential health benefits without imposing any requirement to obtain prior authorization for those services and without limiting coverage for services provided by an emergency services provider that is not in the provider network of a policy or plan in a way that is more restrictive than requirements or limitations that apply to emergency services provided by a provider that is in the provider network of the policy or plan.

9. Require a disability insurance policy or self-insured health plan to apply to emergency department services that are essential health benefits provided by an emergency department provider that is not in the provider network of the policy or plan the same copayment amount or coinsurance rate that applies if those services are provided by a provider that is in the provider network of the policy or plan.

(d) The commissioner shall periodically update, by rule, the essential health benefits under this subsection to address any gaps in access to coverage.

(e) If an essential health benefit is also subject to mandated coverage elsewhere under this section and the coverage requirements are not identical, the disability insurance policy or self-insured health plan shall provide coverage under whichever subsection provides the insured or plan participant with more comprehensive coverage of the medical condition, item, or service.

(f) Nothing in this subsection or rules promulgated under this subsection prohibits a disability insurance policy or a self-insured health plan from providing benefits in excess of the essential health benefit coverage required under this subsection.

(g) This subsection does not apply to any disability insurance policy that is described in s. 632.745 (11) (b) 1. to 12.

**SECTION 60.** 632.895 (16m) (b) of the statutes is amended to read:

632.895 **(16m)** (b) The coverage required under this subsection may be subject to any limitations~~,~~ or exclusions~~, or cost-sharing provisions~~ that apply generally under the disability insurance policy or self-insured health plan. The coverage required under this subsection may not be subject to any deductibles, copayments, or coinsurance.

**SECTION 61.** 632.895 (17) (b) 2. of the statutes is amended to read:

632.895 **(17)** (b) 2. Outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive, ~~if covered for any other drug benefits under the policy or plan~~ sterilization procedures, and patient education and counseling for all females with reproductive capacity.

**SECTION 62.** 632.895 (17) (c) of the statutes is amended to read:

632.895 **(17)** (c) Coverage under par. (b) may be subject only to the exclusions~~,~~ and limitations~~, or cost-sharing provisions~~ that apply generally to the coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices that is provided under the policy or self-insured health plan. A disability insurance policy or self-insured health plan may not apply a deductible or impose a copayment or coinsurance to at least one of each type of contraceptive method approved by the federal food and drug administration for which coverage is required under this subsection. The disability insurance policy or self-insured

health plan may apply reasonable medical management to a method of contraception to limit coverage under this subsection that is provided without being subject to a deductible, copayment, or coinsurance to prescription drugs without a brand name. The disability insurance policy or self-insured health plan may apply a deductible or impose a copayment or coinsurance for coverage of a contraceptive that is prescribed for a medical need if the services for the medical need would otherwise be subject to a deductible, copayment, or coinsurance.

**SECTION 63.** 632.897 (11) (a) of the statutes is amended to read:

632.897 **(11)** (a) Notwithstanding subs. (2) to (10), the commissioner may promulgate rules establishing standards requiring insurers to provide continuation of coverage for any individual covered at any time under a group policy who is a terminated insured or an eligible individual under any federal program that provides for a federal premium subsidy for individuals covered under continuation of coverage under a group policy, including rules governing election or extension of election periods, notice, rates, premiums, premium payment, ~~application of preexisting condition exclusions,~~ election of alternative coverage, and status as an eligible individual, as defined in s. 149.10 (2t), 2011 stats.

**SECTION 9323. Initial applicability; Insurance.**

(1) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH BENEFITS, AND PREVENTIVE SERVICES.

(a) For policies and plans containing provisions inconsistent with these sections, the treatment of ss. 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac)

1. and 2., 632.795 (4) (a), 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c), and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c), and 632.897 (11) (a) 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 and plans that are affected by a collective bargaining agreement containing provisions inconsistent with these sections, the treatment of ss. 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac) 1. and 2., 632.795 (4) (a), 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c), and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c), and 632.897 (11) (a) 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 entered into, extended, modified, or renewed, whichever is later.

**SECTION 9423. Effective dates; Insurance.**

(1) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH BENEFITS, AND PREVENTIVE SERVICES. The treatment of ss. 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac) 1. and 2., 632.795 (4) (a), 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c), and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c), and 632.897 (11) (a) and SECTION 9323 (1) of this act take effect on the first day of the 4th month beginning after publication.".

**20.** At the appropriate places, insert all of the following:

"**SECTION 64.** 20.145 (1) (g) 5. of the statutes is created to read:

20.145 **(1)** (g) 5. All moneys received from the regulation of pharmacy benefit managers, pharmacy benefit management brokers, pharmacy benefit management consultants, pharmacy services administration organizations, and pharmaceutical representatives.".

**21.** At the appropriate places, insert all of the following:

"**SECTION 65.** 15.07 (3) (bm) 7. of the statutes is created to read:

15.07 **(3)** (bm) 7. The prescription drug affordability review board shall meet at least 4 times each year.

**SECTION 66.** 15.735 of the statutes is created to read:

**15.735 Same; attached board. (1)** There is created a prescription drug affordability review board attached to the office of the commissioner of insurance under s. 15.03. The board shall consist of the following members:

(a) The commissioner of insurance or his or her designee.

(b) Two members appointed for 4-year terms who represent the pharmaceutical drug industry, including pharmaceutical drug manufacturers and wholesalers. At least one of the members appointed under this paragraph shall be a licensed pharmacist.

(c) Two members appointed for 4-year terms who represent the health insurance industry, including insurers and pharmacy benefit managers.

(d) Two members appointed for 4-year terms who represent the health care industry, including hospitals, physicians, pharmacies, and pharmacists. At least one of the members appointed under this paragraph shall be a licensed practitioner.

(e) Two members appointed for 4-year terms who represent the interests of the public.

**(2)** A member appointed under sub. (1), except for a member appointed under sub. (1) (b), may not be an employee of, a board member of, or a consultant to a drug manufacturer or trade association for drug manufacturers.

**(3)** Any conflict of interest, including any financial or personal association, that has the potential to bias or has the appearance of biasing an individual's decision in matters related to the board or the conduct of the board's activities shall be considered and disclosed when appointing that individual to the board under sub. (1).

**SECTION 67.** Subchapter VI (title) of chapter 601 [precedes 601.78] of the statutes is created to read:

**CHAPTER 601**

SUBCHAPTER VI

PRESCRIPTION DRUG

AFFORDABILITY REVIEW BOARD

**SECTION 68.** 601.78 of the statutes is created to read:

**601.78 Definitions.** In this subchapter:

**(1)** "Biologic" means a drug that is produced or distributed in accordance with a biologics license application approved under 21 CFR 601.20.

**(2)** "Biosimilar" means a drug that is produced or distributed in accordance with a biologics license application approved under 42 USC 262 (k) (3).

**(3)** "Board" means the prescription drug affordability review board established under s. 15.735 (1).

**(4)** "Brand name drug" means a drug that is produced or distributed in accordance with an original new drug application approved under 21 USC 355 (c), other than an authorized generic drug, as defined in 42 CFR 447.502.

**(5)** "Financial benefit" includes an honorarium, fee, stock, the value of the stock holdings of a member of the board or any immediate family member of the member of the board, and any direct financial benefit deriving from the finding of a review conducted under s. 601.79.

**(6)** "Generic drug" means any of the following:

(a) A retail drug that is marketed or distributed in accordance with an abbreviated new drug application approved under 21 USC 355 (j).

(b) An authorized generic drug, as defined in 42 CFR 447.502.

(c) A drug that entered the market prior to 1962 and was not originally marketed under a new drug application.

**(7)** "Immediate family member" means a spouse, grandparent, parent, sibling, child, stepchild, or grandchild or the spouse of a grandparent, parent, sibling, child, stepchild, or grandchild.

**(8)** "Manufacturer" means an entity that does all of the following:

(a) Engages in the manufacture of a prescription drug product or enters into a lease with another entity to market and distribute a prescription drug product under the entity's own name.

(b) Sets or changes the wholesale acquisition cost of the prescription drug product described in par. (a).

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

**(10)** "Prescription drug product" means a brand name drug, a generic drug, a biologic, or a biosimilar.

**SECTION 69.** 601.785 of the statutes is created to read:

**601.785 Prescription drug affordability review board. (1)** MISSION. The purpose of the board is to protect state residents, the state, local governments, health plans, health care providers, pharmacies licensed in this state, and other stakeholders of the health care system in this state from the high costs of prescription drug products.

**(2)** POWERS AND DUTIES. (a) The board shall do all of the following:

1. Meet in open session at least 4 times per year to review prescription drug product pricing information in the manner described in subd. 2., except that the chairperson may cancel or postpone a meeting if there is no business to transact.

2. To the extent practicable, access and assess pricing information for prescription drug products by doing all of the following:

a. Accessing and assessing information from other states by entering into memoranda of understanding with other states to which manufacturers report pricing information.

b. Assessing spending for specific prescription drug products in this state.

c. Accessing other available pricing information.

(b) The board may do any of the following:

1. Promulgate rules for the administration of this subchapter.

2. Enter into a contract with an independent 3rd party for any service necessary to carry out the powers and duties of the board. Unless written permission is granted by the board, any person with whom the board contracts may not release, publish, or otherwise use any information to which the person has access under the contract.

(c) The board shall establish and maintain a website to provide public notices and make meeting materials available under sub. (3) (a) and to disclose conflicts of interest under sub. (4) (d).

**(3)** MEETING REQUIREMENTS. (a) Pursuant to s. 19.84, the board shall provide public notice of each board meeting at least 2 weeks prior to the meeting and shall make the materials for each meeting publicly available at least one week prior to the meeting.

(b) Notwithstanding s. 19.84 (2), the board shall provide an opportunity for public comment at each open meeting and shall provide the public with the opportunity to provide written comments on pending decisions of the board.

(c) Notwithstanding subch. V of ch. 19, any portion of a meeting of the board concerning proprietary data and information shall be conducted in closed session and shall in all respects remain confidential.

(d) The board may allow expert testimony at any meeting, including when the board meets in closed session.

**(4)** CONFLICTS OF INTEREST. (a) A member of the board shall recuse himself or herself from a decision by the board relating to a prescription drug product if the

member or an immediate family member of the member has received or could receive any of the following:

1. A direct financial benefit deriving from a determination, or a finding of a study or review, by the board relating to the prescription drug product.

2. A financial benefit in excess of $5,000 in a calendar year from any person who owns, manufactures, or provides a prescription drug product to be studied or reviewed by the board.

(b) A conflict of interest under this subsection shall be disclosed by the board when hiring board staff, by the appointing authority when appointing members to the board, and by the board when a member of the board is recused from any decision relating to a review of a prescription drug product.

(c) A conflict of interest under this subsection shall be disclosed no later than 5 days after the conflict is identified, except that, if the conflict is identified within 5 days of an open meeting of the board, the conflict shall be disclosed prior to the meeting.

(d) The board shall disclose a conflict of interest under this subsection on the board's website unless the chairperson of the board recuses the member from a final decision relating to a review of the prescription drug product. The disclosure shall include the type, nature, and magnitude of the interests of the member involved.

(e) A member of the board or a 3rd-party contractor may not accept any gift or donation of services or property that indicates a potential conflict of interest or has the appearance of biasing the work of the board.

**SECTION 70.** 601.79 of the statutes is created to read:

**601.79 Drug cost affordability review. (1)** IDENTIFICATION OF DRUGS. The board shall identify prescription drug products that are any of the following:

(a) A brand name drug or biologic that, as adjusted annually to reflect adjustments to the U.S. consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, has a launch wholesale acquisition cost of at least $30,000 per year or course of treatment.

(b) A brand name drug or biologic that, as adjusted annually to reflect adjustments to the U.S. consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, has a wholesale acquisition cost that has increased by at least $3,000 during a 12-month period.

(c) A biosimilar that has a launch wholesale acquisition cost that is not at least 15 percent lower than the referenced brand biologic at the time the biosimilar is launched.

(d) A generic drug that has a wholesale acquisition cost, as adjusted annually to reflect adjustments to the U.S. consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, that meets all of the following conditions:

1. Is at least $100 for a supply lasting a patient for a period of 30 consecutive days based on the recommended dosage approved for labeling by the federal food and drug administration, a supply lasting a patient for a period of fewer than 30 days based on the recommended dosage approved for labeling by the federal food and drug administration, or one unit of the drug if the labeling approved by the federal food and drug administration does not recommend a finite dosage.

2. Increased by at least 200 percent during the preceding 12-month period, as determined by the difference between the resulting wholesale acquisition cost and the average of the wholesale acquisition cost reported over the preceding 12 months.

(e) Other prescription drug products, including drugs to address public health emergencies, that may create affordability challenges for the health care system and patients in this state.

**(2)** AFFORDABILITY REVIEW. (a) After identifying prescription drug products under sub. (1), the board shall determine whether to conduct an affordability review for each identified prescription drug product by seeking stakeholder input about the prescription drug product and considering the average patient cost share of the prescription drug product.

(b) The information used to conduct an affordability review under par. (a) may include any document and research related to the manufacturer's selection of the introductory price or price increase of the prescription drug product, including life cycle management, net average price in this state, market competition and context, projected revenue, and the estimated value or cost-effectiveness of the prescription drug product.

(c) The failure of a manufacturer to provide the board with information for an affordability review under par. (b) does not affect the authority of the board to conduct the review.

**(3)** AFFORDABILITY CHALLENGE. When conducting an affordability review of a prescription drug product under sub. (2), the board shall determine whether use of

the prescription drug product that is fully consistent with the labeling approved by the federal food and drug administration or standard medical practice has led or will lead to an affordability challenge for the health care system in this state, including high out-of-pocket costs for patients. To the extent practicable, in determining whether a prescription drug product has led or will lead to an affordability challenge, the board shall consider all of the following factors:

(a) The wholesale acquisition cost for the prescription drug product sold in this state.

(b) The average monetary price concession, discount, or rebate the manufacturer provides, or is expected to provide, to health plans in this state as reported by manufacturers and health plans, expressed as a percentage of the wholesale acquisition cost for the prescription drug product under review.

(c) The total amount of the price concessions, discounts, and rebates the manufacturer provides to each pharmacy benefit manager for the prescription drug product under review, as reported by the manufacturer and pharmacy benefit manager and expressed as a percentage of the wholesale acquisition cost.

(d) The price at which therapeutic alternatives to the prescription drug product have been sold in this state.

(e) The average monetary concession, discount, or rebate the manufacturer provides or is expected to provide to health plan payors and pharmacy benefit managers in this state for therapeutic alternatives to the prescription drug product.

(f) The costs to health plans based on patient access consistent with labeled

indications by the federal food and drug administration and recognized standard medical practice.

(g) The impact on patient access resulting from the cost of the prescription drug product relative to insurance benefit design.

(h) The current or expected dollar value of drug-specific patient access programs that are supported by the manufacturer.

(i) The relative financial impacts to health, medical, or social services costs that can be quantified and compared to baseline effects of existing therapeutic alternatives to the prescription drug product.

(j) The average patient copay or other cost sharing for the prescription drug product in this state.

(k) Any information a manufacturer chooses to provide.

(L) Any other factors as determined by the board by rule.

**(4)** UPPER PAYMENT LIMIT. (a) If the board determines under sub. (3) that use of a prescription drug product has led or will lead to an affordability challenge, the board shall establish an upper payment limit for the prescription drug product after considering all of the following:

1. The cost of administering the drug.

2. The cost of delivering the drug to consumers.

3. Other relevant administrative costs related to the drug.

(b) For a prescription drug product identified in sub. (1) (b) or (d) 2., the board shall solicit information from the manufacturer regarding the price increase. To the extent that the price increase is not a result of the need for increased

manufacturing capacity or other effort to improve patient access during a public health emergency, the board shall establish an upper payment limit under par. (a) that is equal to the cost to consumers prior to the price increase.

(c) 1. The upper payment limit established under this subsection shall apply to all purchases and payor reimbursements of the prescription drug product dispensed or administered to individuals in this state in person, by mail, or by other means.

2. Notwithstanding subd. 1., while state-sponsored and state-regulated health plans and health programs shall limit drug reimbursements and drug payment to no more than the upper payment limit established under this subsection, a plan subject to the Employee Retirement Income Security Act of 1974 or Part D of Medicare under 42 USC 1395w-101 et seq. may choose to reimburse more than the upper payment limit. A provider who dispenses and administers a prescription drug product in this state to an individual in this state may not bill a payor more than the upper payment limit to the patient regardless of whether a plan subject to the Employee Retirement Income Security Act of 1974 or Part D of Medicare under 42 USC 1395w-101 et seq. chooses to reimburse the provider above the upper payment limit.

**(5)** PUBLIC INSPECTION. Information submitted to the board under this section shall be open to public inspection only as provided under ss. 19.31 to 19.39.

**(6)** NO PROHIBITION ON MARKETING. Nothing in this section may be construed to prevent a manufacturer from marketing a prescription drug product approved by

the federal food and drug administration while the prescription drug product is under review by the board.

**(7)** APPEALS. A person aggrieved by a decision of the board may request an appeal of the decision no later than 30 days after the board makes the determination. The board shall hear the appeal and make a final decision no later than 60 days after the appeal is requested. A person aggrieved by a final decision of the board may petition for judicial review in a court of competent jurisdiction.

**SECTION 9123. Nonstatutory provisions; Insurance.**

(1) STAGGERED TERMS FOR PRESCRIPTION DRUG AFFORDABILITY REVIEW BOARD. Notwithstanding the length of terms specified for the members of the prescription drug affordability review board under s. 15.735 (1) (b) to (e), 2 of the initial members shall be appointed for terms expiring on May 1, 2027; 2 of the initial members shall be appointed for terms expiring on May 1, 2028; 2 of the initial members shall be appointed for terms expiring on May 1, 2029; and 2 of the initial members shall be appointed for terms expiring on May 1, 2030.

**SECTION 9423. Effective dates; Insurance.**

(1) PRESCRIPTION DRUG AFFORDABILITY REVIEW BOARD. The treatment of ss. 15.07 (3) (bm) 7., 15.735, 601.78, 601.785, and 601.79 and subch. VI (title) of ch. 601 and SECTION 9123 (1) of this act take effect on the first day of the 7th month beginning after publication.".

**22.** At the appropriate places, insert all of the following:

"**SECTION 71.** 632.869 of the statutes is created to read:

**632.869 Reimbursement to federal drug pricing program participants. (1)** In this section:

(a) "Covered entity" means an entity described in 42 USC 256b (a) (4) (A), (D), (E), (J), or (N) that participates in the federal drug pricing program under 42 USC 256b, a pharmacy of the entity, or a pharmacy contracted with the entity to dispense drugs purchased through the federal drug pricing program under 42 USC 256b.

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

**(2)** No person, including a pharmacy benefit manager or 3rd-party payer, may do any of the following:

(a) Reimburse a covered entity for a drug that is subject to an agreement under 42 USC 256b at a rate lower than that paid for the same drug to pharmacies that are not covered entities and have a similar prescription volume to that of the covered entity.

(b) Assess a covered entity any fee, charge back, or other adjustment on the basis of the covered entity's participation in the federal drug pricing program under 42 USC 256b.

**(3)** The commissioner may promulgate rules to implement this section and to establish minimum reimbursement rates for covered entities and any other entity described under 42 USC 256b (a) (4).".

**23.** At the appropriate places, insert all of the following:

"**SECTION 72.** 601.31 (1) (nw) of the statutes is created to read:

601.31 **(1)** (nw) For issuing or renewing a license as a pharmacy services

administrative organization under s. 632.864, an amount to be set by the commissioner by rule.

**SECTION 73.** 632.864 of the statutes is created to read:

**632.864 Pharmacy services administrative organizations**. **(1)** DEFINITIONS. In this section:

(a) "Administrative service" means any of the following:

1. Assisting with claims.

2. Assisting with audits.

3. Providing centralized payment.

4. Performing certification in a specialized care program.

5. Providing compliance support.

6. Setting flat fees for generic drugs.

7. Assisting with store layout.

8. Managing inventory.

9. Providing marketing support.

10. Providing management and analysis of payment and drug dispensing data.

11. Providing resources for retail cash cards.

(b) "Independent pharmacy" means a pharmacy operating in this state that is licensed under s. 450.06 or 450.065 and is under common ownership with no more than 2 other pharmacies.

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

(d) "Pharmacy services administrative organization" means an entity operating in this state that does all of the following:

1. Contracts with an independent pharmacy to conduct business with a 3rd-party payer on the independent pharmacy's behalf.

2. Provides at least one administrative service to an independent pharmacy and negotiates and enters into a contract with a 3rd-party payer or pharmacy benefit manager on behalf of the independent pharmacy.

(e) "Third-party payer" means an entity, including a plan sponsor, health maintenance organization, or insurer, operating in this state that pays or insures health, medical, or prescription drug expenses on behalf of beneficiaries.

**(2)** LICENSURE. (a) Beginning on the first day of the 12th month beginning after the effective date of this paragraph .... [LRB inserts date], no person may operate as a pharmacy services administrative organization without being licensed by the commissioner as a pharmacy services administrative organization under this subsection. In order to obtain a license under this paragraph, the person shall apply to the commissioner in the form and manner prescribed by the commissioner. The application for licensure under this paragraph shall include all of the following:

1. The name, address, telephone number, and federal employer identification number of the applicant.

2. The name, business address, and telephone number of a contact person for the applicant.

3. The fee under s. 601.31 (1) (nw).

4. Evidence of financial responsibility of at least $1,000,000.

5. Any other information required by the commissioner.

(b) The term of a license issued under par. (a) shall be 2 years from the date of issuance.

(c) A license issued under par. (a) may be renewed. Renewal applications shall be submitted to the commissioner on a form provided by the commissioner and shall include all the items described in par. (a) 1. to 5. A renewal application under this paragraph may not be submitted more than 90 days prior to the end of the term of the license being renewed.

**(3)** DISCLOSURE TO THE COMMISSIONER. (a) A pharmacy services administrative organization licensed under sub. (2) shall disclose to the commissioner the extent of any ownership or control of the pharmacy services administrative organization by an entity that does any of the following:

1. Provides pharmacy services.

2. Provides prescription drug or device services.

3. Manufactures, sells, or distributes prescription drugs, biologicals, or medical devices.

(b) A pharmacy services administrative organization licensed under sub. (2) shall notify the commissioner in writing within 5 days of any material change in its ownership or control relating to an entity described in par. (a).

**(4)** RULES. The commissioner may promulgate rules to implement this section.".

**24.** At the appropriate places, insert all of the following:

"**SECTION 74.** 601.31 (1) (nv) of the statutes is created to read:

601.31 **(1)** (nv) For issuing or renewing a license as a pharmaceutical representative under s. 632.863, an amount to be set by the commissioner by rule.

**SECTION 75.** 632.863 of the statutes is created to read:

**632.863 Pharmaceutical representatives. (1)** DEFINITIONS. In this section:

(a) "Health care professional" means a physician or other health care practitioner who is licensed to provide health care services or to prescribe pharmaceutical or biologic products.

(b) "Pharmaceutical" means a medication that may legally be dispensed only with a valid prescription from a health care professional.

(c) "Pharmaceutical representative" means an individual who markets or promotes pharmaceuticals to health care professionals on behalf of a pharmaceutical manufacturer for compensation.

**(2)** LICENSURE. Beginning on the first day of the 12th month beginning after the effective date of this subsection .... [LRB inserts date], no individual may act as a pharmaceutical representative in this state without being licensed by the commissioner as a pharmaceutical representative under this subsection. In order to obtain a license under this subsection, the individual shall apply to the commissioner in the form and manner prescribed by the commissioner and shall pay the fee under s. 601.31 (1) (nv). The term of a license issued under this subsection is one year, and the license is renewable.

**(3)** DISPLAY OF LICENSE. A pharmaceutical representative licensed under sub.

(2) shall display the pharmaceutical representative's license during each visit with a health care professional.

**(4)** ENFORCEMENT. (a) Any individual who violates this section or any rules promulgated under this section shall be fined not less than $1,000 nor more than $3,000 for each offense. Each day of continued violation constitutes a separate offense.

(b) The commissioner may suspend or revoke the license of a pharmaceutical representative who violates this section or any rules promulgated under this section. A suspended or revoked license under this paragraph may not be reinstated until the pharmaceutical representative remedies all violations related to the suspension or revocation and pays all assessed penalties and fees.

**(5)** RULES. The commissioner shall promulgate rules to implement this section, including rules that require pharmaceutical representatives to complete continuing educational coursework as a condition of licensure.".

**25.** At the appropriate places, insert all of the following:

"**SECTION 76.** 601.31 (1) (mv) of the statutes is created to read:

601.31 **(1)** (mv) For initial issuance or renewal of a license as a pharmacy benefit management broker or consultant under s. 628.495, amounts set by the commissioner by rule.

**SECTION 77.** 628.495 of the statutes is created to read:

**628.495 Pharmacy benefit management broker and consultant licenses. (1)** DEFINITION. In this section, "pharmacy benefit manager" has the meaning given in s. 632.865 (1) (c).

**(2)** LICENSE REQUIRED. Beginning on the first day of the 12th month beginning after the effective date of this subsection .... [LRB inserts date], no individual may act as a pharmacy benefit management broker or consultant and no individual may act to procure the services of a pharmacy benefit manager on behalf of a client without being licensed by the commissioner under this section.

**(3)** RULES. The commissioner may promulgate rules to establish criteria and procedures for initial licensure and renewal of licensure and to implement licensure under this section.".

**26.** At the appropriate places, insert all of the following:

"**SECTION 78.** 632.865 (2m) of the statutes is created to read:

632.865 **(2m)** FIDUCIARY DUTY AND DISCLOSURES TO HEALTH BENEFIT PLAN SPONSORS. (a) A pharmacy benefit manager owes a fiduciary duty to the health benefit plan sponsor to act according to the health benefit plan sponsor's instructions and in the best interests of the health benefit plan sponsor.

(b) A pharmacy benefit manager shall annually provide, no later than the date and using the method prescribed by the commissioner by rule, the health benefit plan sponsor all of the following information from the previous calendar year:

1. The indirect profit received by the pharmacy benefit manager from owning any interest in a pharmacy or service provider.

2. Any payment made by the pharmacy benefit manager to a consultant or broker who works on behalf of the health benefit plan sponsor.

3. From the amounts received from all drug manufacturers, the amounts

retained by the pharmacy benefit manager, and not passed through to the health benefit plan sponsor, that are related to the health benefit plan sponsor's claims or bona fide service fees.

4. The amounts, including pharmacy access and audit recovery fees, received from all pharmacies that are in the pharmacy benefit manager's network or have a contract to be in the network and, from these amounts, the amount retained by the pharmacy benefit manager and not passed through to the health benefit plan sponsor.".

**27.** At the appropriate places, insert all of the following:

"**SECTION 79.** 601.575 of the statutes is created to read:

**601.575 Prescription drug importation program. (1)** IMPORTATION PROGRAM REQUIREMENTS. The commissioner, in consultation with persons interested in the sale and pricing of prescription drugs and appropriate officials and agencies of the federal government, shall design and implement a prescription drug importation program for the benefit of residents of this state, that generates savings for residents, and that satisfies all of the following:

(a) The commissioner shall designate a state agency to become a licensed wholesale distributor or to contract with a licensed wholesale distributor and shall seek federal certification and approval to import prescription drugs.

(b) The program shall comply with relevant requirements of 21 USC 384, including safety and cost savings requirements.

(c) The program shall import prescription drugs from Canadian suppliers regulated under any appropriate Canadian or provincial laws.

(d) The program shall have a process to sample the purity, chemical composition, and potency of imported prescription drugs.

(e) The program shall import only those prescription drugs for which importation creates substantial savings for residents of this state and only those prescription drugs that are not brand-name drugs and that have fewer than 4 competitor prescription drugs in the United States.

(f) The commissioner shall ensure that prescription drugs imported under the program are not distributed, dispensed, or sold outside of this state.

(g) The program shall ensure all of the following:

1. Participation by any pharmacy or health care provider in the program is voluntary.

2. Any pharmacy or health care provider participating in the program has the appropriate license or other credential in this state.

3. Any pharmacy or health care provider participating in the program charges a consumer or health plan the actual acquisition cost of the imported prescription drug that is dispensed.

(h) The program shall ensure that a payment by a health plan or health insurance policy for a prescription drug imported under the program reimburses no more than the actual acquisition cost of the imported prescription drug that is dispensed.

(i) The program shall ensure that any health plan or health insurance policy participating in the program does all of the following:

1. Maintains a formulary and claims payment system with current information on prescription drugs imported under the program.

2. Bases cost-sharing amounts for participants or insureds under the plan or policy on no more than the actual acquisition cost of the prescription drug imported under the program that is dispensed to the participant or insured.

3. Demonstrates to the commissioner or a state agency designated by the commissioner how premiums under the plan or policy are affected by savings on prescription drugs imported under the program.

(j) Any wholesale distributor importing prescription drugs under the program shall limit its profit margin to the amount established by the commissioner or a state agency designated by the commissioner.

(k) The program may not import any generic prescription drug that would violate federal patent laws on branded products in the United States.

(L) The program shall comply with tracking and tracing requirements of 21 USC 360eee and 360eee-1, to the extent practical and feasible, before the prescription drug to be imported comes into the possession of this state's wholesale distributor and fully after the prescription drug to be imported is in the possession of this state's wholesale distributor.

(m) The program shall establish a fee or other mechanism to finance the program that does not jeopardize significant savings to residents of this state.

(n) The program shall have an audit function that ensures all of the following:

1. The commissioner has a sound methodology to determine the most cost-effective prescription drugs to include in the program.

2. The commissioner has a process in place to select Canadian suppliers that are high quality, high performing, and in full compliance with Canadian laws.

3. Prescription drugs imported under the program are pure, unadulterated, potent, and safe.

4. The program is complying with the requirements of this subsection.

5. The program is adequately financed to support administrative functions of the program while generating significant cost savings to residents of this state.

6. The program does not put residents of this state at a higher risk than if the program did not exist.

7. The program provides and is projected to continue to provide substantial cost savings to residents of this state.

**(2)** ANTICOMPETITIVE BEHAVIOR. The commissioner, in consultation with the attorney general, shall identify the potential for and monitor anticompetitive behavior in industries affected by a prescription drug importation program.

**(3)** APPROVAL OF PROGRAM DESIGN; CERTIFICATION. No later than the first day of the 7th month beginning after the effective date of this subsection .... [LRB inserts date], the commissioner shall submit to the joint committee on finance a report that includes the design of the prescription drug importation program in accordance with this section. The commissioner may not submit the proposed program to the federal department of health and human services unless the joint committee on finance approves the proposed program. Within 14 days of the date of approval by the joint committee on finance of the proposed program, the

commissioner shall submit to the federal department of health and human services a request for certification of the approved program.

**(4)** IMPLEMENTATION OF CERTIFIED PROGRAM. After the federal department of health and human services certifies the prescription drug importation program submitted under sub. (3), the commissioner shall begin implementation of the program, and the program shall be fully operational by 180 days after the date of certification by the federal department of health and human services. The commissioner shall do all of the following to implement the program to the extent the action is in accordance with other state laws and the certification by the federal department of health and human services:

(a) Become a licensed wholesale distributor, designate another state agency to become a licensed wholesale distributor, or contract with a licensed wholesale distributor.

(b) Contract with one or more Canadian suppliers that meet the criteria in sub. (1) (c) and (n).

(c) Create an outreach and marketing plan to communicate with and provide information to health plans and health insurance policies, employers, pharmacies, health care providers, and residents of this state on participating in the program.

(d) Develop and implement a registration process for health plans and health insurance policies, pharmacies, and health care providers interested in participating in the program.

(e) Create a publicly accessible source for listing prices of prescription drugs imported under the program.

(f) Create, publicize, and implement a method of communication to promptly answer questions from and address the needs of persons affected by the implementation of the program before the program is fully operational.

(g) Establish the audit functions under sub. (1) (n) with a timeline to complete each audit function every 2 years.

(h) Conduct any other activities determined by the commissioner to be important to successful implementation of the program.

**(5)** REPORT. By January 1 and July 1 of each year, the commissioner shall submit to the joint committee on finance a report including all of the following:

(a) A list of prescription drugs included in the prescription drug importation program under this section.

(b) The number of pharmacies, health care providers, and health plans and health insurance policies participating in the prescription drug importation program under this section.

(c) The estimated amount of savings to residents of this state, health plans and health insurance policies, and employers resulting from the implementation of the prescription drug importation program under this section reported from the date of the previous report under this subsection and from the date the program was fully operational.

(d) Findings of any audit functions under sub. (1) (n) completed since the date of the previous report under this subsection.

**(6)** RULEMAKING. The commissioner may promulgate any rules necessary to implement this section.

**SECTION 9123. Nonstatutory provisions; Insurance.**

(1) PRESCRIPTION DRUG IMPORTATION PROGRAM. The commissioner of insurance shall submit the first report required under s. 601.575 (5) by the next January 1 or July 1, whichever is earliest, that is at least 180 days after the date the prescription drug importation program is fully operational under s. 601.575 (4). The commissioner of insurance shall include in the first 3 reports submitted under s. 601.575 (5) information on the implementation of the audit functions under s. 601.575 (1) (n).".

**(END)**