INSURANCE

Budget Summary						FTE Position Summary				
				2023-25 Change Over Base Year Doubled					2024-25 Over 2022-23	
	2022-23	Governor					Governor			
Fund	Adjusted Base	2023-24	2024-25	Amount	%	2022-23	2023-24	2024-25	Number	%
GPR	$34,233,200	$23,715,900	$59,464,900	$14,714,400	21.5%	0.00	10.00	10.00	10.00	0.0%
FED	165,766,800	208,266,500	171,800,000	48,532,900	14.6	0.00	0.00	0.00	0.00	0.0
PR	20,513,900	24,014,400	28,216,100	11,202,700	27.3	124.15	151.65	151.65	27.50	22.2
SEG	62,997,400	63,048,200	63,048,200	101,600	0.1	10.68	10.68	10.68	0.00	0.0
TOTAL	$283,511,300	$319,045,000	$322,529,200	$74,551,600	13.1%	134.83	172.33	172.33	37.50	27.8%

Budget Change Items

Agency Operations and Current Programs

1. STANDARD BUDGET ADJUSTMENTS

PR	- $169,600
SEG	101,600
Total	- $68,000

Governor: Reduce funding by $34,000 (-$84,800 PR and $50,800 SEG) annually to reflect the following standard budget adjustments: (a) -$277,500 PR annually for turnover reduction; (b) $259,300 PR and $53,500 SEG annually for full funding of continuing position salaries and fringe benefits; and (c) -$66,600 PR and -$2,700 SEG annually for full funding of lease and directed move costs.

2. FINANCIAL AND MARKET REGULATION POSITIONS

	Funding	Positions
PR	$1,631,900	10.00

Governor: Provide $699,400 in 2023-24 and $932,500 in 2024-25 and 10.0 positions, beginning in 2023-24, to address increased workload and responsibilities relating to OCI's supervision of the insurance industry. Of the funding and positions that would be provided, 5.0 positions would be assigned to the Division of Market Regulation, which regulates the market conduct of insurance companies and agents to ensure compliance with insurance laws and rules. This includes investigating consumer complaints, providing consumer information, issuing agent licenses, and reviewing company underwriting and rating practices. The other 5.0 positions would be assigned to the Division of Financial Regulation, which oversees company licensing, financial analysis and examinations, and the solvency of insurers licensed to do business in Wisconsin. This includes conducting regular financial

examinations of companies and issuing company licenses.

3. RESTORE FUNDING FOR AGENCY OPERATIONS

PR	$1,404,600

Governor: Provide $702,300 for OCI administrative functions, reflecting the net effect of the following two changes: (a) provide an increase of $2,222,600 annually in OCI's general program operations appropriation; and (b) delete the interagency and intra-agency operations appropriation, along with base funding in that appropriation of $1,520,300 annually.

The 2021-23 budget (Act 58) created an interagency and intra-agency PR appropriation in OCI for general program operations and made a non-recurring transfer of $1,520,300 in each year of the biennium to that appropriation from the unencumbered revenue balance in OCI's PR appropriation for general program operations. In addition, Act 58 reduced funding in the general program operations appropriation by $2,222,600 annually. The result of these changes was a net reduction in program operations funding, in both appropriations combined, of $702,300. This item would delete the interagency and intra-agency appropriation created by Act 58 and reverse the net funding reduction that resulted from that act.

[Bill Section: 279]

4. WISCONSIN HEALTHCARE STABILITY PLAN

GPR	$11,467,100
FED	48,532,900
Total	$60,000,000

Governor: Provide $30,000,000 (-$12,499,700 GPR and $42,499,700 FED) in 2023-24 and $30,000,000 ($23,966,800 GPR and $6,033,200 FED) in 2024-25 to reflect estimated increases in total reinsurance payments under the Wisconsin healthcare stability plan (WHSP), from the base of $200,000,000 annually to $230,000,000 annually.

The following table shows the appropriation base and estimated funding for reinsurance payments in the 2023-25 biennium with these adjustments.

		Change to Base		Total Funding	
	Base	2023-24	2024-25	2023-24	2024-25
GPR	$34,233,200	-$12,499,700	$23,966,800	$21,733,500	$58,200,000
FED	165,766,800	42,499,700	6,033,200	208,266,500	171,800,000
Total	$200,000,000	$30,000,000	$30,000,000	$230,000,000	$230,000,000

WHSP is a state-operated reinsurance program, supported with state and federal funding, that is intended to reduce premiums for health insurance policies sold in the individual market. Reinsurance payments reimburse insurers for a portion of the total annual claims for individuals with high costs. Each year, OCI establishes reinsurance payment parameters based on a total expenditure target. The 2021-23 budget act increased the statutory target from $200,000,000 to $230,000,000, beginning for the 2022 insurance plan year. Since the 2022 plan year reinsurance payments will be made in state fiscal year 2023-24, this item adjusts the GPR and FED

appropriations to equal anticipated expenditures.

The reinsurance payments for the 2022 plan year will be made in 2023-24 with a combination of federal funds received for that plan year ($181,902,400) and federal funds received for the 2021 plan year, but not needed for 2021 reinsurance payments ($26,364,100). Since the federal funding for 2021 exceeded the total amount of reinsurance payments, the excess funding will be carried over to offset the state cost of making the 2022 payments. The Administration estimates that federal funds for the 2023 plan year will total $171,800,000, so the bill would increase GPR funding in 2024-25 to equal the difference between the available federal funding and the anticipated reinsurance payment total.

5. WISCONSIN HEALTHCARE STABILITY PLAN -- PROGRAM MANAGER POSITION

	Funding	Positions
PR	$249,400	1.00

Governor: Provide $106,900 in 2023-24 and $142,500 in 2024-25 and 1.0 position, beginning in 2023-24, to establish a designated program manager for the Wisconsin healthcare stability plan program. According to the Administration, the program manager would oversee contract management, data analysis, and strategy development for the program.

6. WISCONSIN HEALTH CARE STABILITY PLAN -- ADJUSTMENT OF TOTAL ANNUAL REINSURANCE PAYMENT

Governor: Specify that, beginning for plan year 2025, the annual maximum amount of reinsurance payments under the Wisconsin healthcare stability plan shall be the maximum amount for the prior year, adjusted to reflect the percentage increase, if any, in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. Department of Labor, for the 12-month period ending on December 31 of the year before the year in which the amount is determined.

Require OCI to determine the annual adjustment for a particular year in January of the previous year and publish the new maximum each year in the Wisconsin Administrative Register. The Joint Committee on Finance would retain the authority to increase the maximum payment by more than the amount of this adjustment under s. 13.10 of the statutes upon request by OCI. Clarify that the current statutory maximum payment of $230,000,000 applies to plan years 2022, 2023, and 2024 and that the program shall be administered in accordance with any extensions of the federal waiver that was approved by the Department of Health and Human Services on July 29, 2018.

[Bill Sections: 3047 thru 3049]

7. BOARD ON AGING AND LONG-TERM CARE HELPLINE FUNDING TRANSFER

PR	$148,700

Governor: Provide $71,800 in 2023-24 and $76,900 in 2024-25 to reflect a reestimate of

the amount of insurance fee revenue that will be needed to fund telephone counseling services provided by the Board on Aging and Long-Term Care (BOALTC) for individuals seeking information on Medicare supplemental insurance policies ("Medigap" policies), Medicare Part D policies (policies that cover prescription drugs), and SeniorCare.

The BOALTC Helpline provides free one-on-one insurance counseling services to state residents over the age of 60. The Helpline is supported from two sources -- federal funds the state receives under the state health insurance assistance program (SHIP) and state insurance fee revenue budgeted as part of OCI's general program operations appropriation that OCI transfers to BOALTC. The BOALTC budget request includes funding to increase administrative support for the Helpline. OCI's request would provide the expenditure authority for making the Helpline transfer in an amount that equals BOALTC's proposed funding increase for the Helpline.

8. EQUITY OFFICER POSITION

	Funding	Positions
PR	$83,600	0.50

Governor: Provide $36,600 in 2023-24 and $47,000 in 2024-25 and 0.5 position, beginning in 2023-24, to create an agency equity officer position. The agency equity officer would be responsible for collaborating with the chief equity officer in the Department of Administration and with other agency equity officers to identify opportunities to advance equity in government operations. [See "Administration -- General Agency Provisions."]

Drug Costs and Pricing

1. OFFICE OF PRESCRIPTION DRUG AFFORDABILITY

	Funding	Positions
PR	$3,854,100	16.00

Governor: Provide $1,968,300 in 2023-24 and $1,885,800 in 2024-25, and 16.0 positions, beginning in 2023-24, to administer new initiatives related to prescription drug supply chain regulation and consumer assistance in a new Office of Prescription Drug Affordability within OCI. Specify that all moneys received from the regulation of pharmacy benefit management brokers, pharmacy benefit management consultants, pharmacy services administration organizations, and pharmaceutical representatives shall be credited to OCI's program revenue appropriation for general program operations.

Of the funding provided by the bill, $500,000 in 2023-24 would be one-time financing for implementation costs associated with the Office, while the remainder, $1,468,300 in 2023-24 and $1,885,800, would be for salary, fringe benefit, and supplies costs associated with the positions. The positions would include five insurance examiners, four policy initiatives advisors, two attorneys, an insurance program manager, two insurance administrators, and two operations program associates. The prescription drug affordability initiatives are summarized in subsequent

items in this section.

[Bill Section: 278]

2. PRESCRIPTION DRUG AFFORDABILITY BOARD

Governor: Establish a Prescription Drug Affordability Review Board, attached to the Officer of the Commissioner of Insurance for the purpose of budgeting, program coordination and related management functions, but with independence with respect to exercise its powers, duties and functions prescribed by law, including rule making, licensing and regulation, and operational planning within its area of program responsibility. Specify that the provisions of this item take effect on the first day of the seventh month beginning after the effective date of the bill.

Board Membership

Specify that the Board shall be composed of the following members: (a) the Commissioner of Insurance or his or her designee; (b) two members appointed for four-year terms who represent the pharmaceutical drug industry, including pharmaceutical drug manufacturers and wholesalers, at least one of whom is a licensed pharmacist; (c) two members appointed for four-year terms who represent the health insurance industry, including insurers and pharmacy benefit managers; (d) two members appointed for four-year terms who represent the health care industry, including hospitals, physicians, pharmacies, and pharmacists, at least one of whom shall be a licensed practitioner; and (e) two members appointed for four-year terms who represent the interests of the public.

Specify that, notwithstanding the terms established for the Board members, two of the initial members shall be appointed for terms expiring on May 1, 2025, two members with terms expiring on May 1, 2026, two members with terms expiring on May 1 2027, and two members with terms expiring on May 1, 2028.

Specify that, other than the two Board members selected to represent the pharmaceutical drug industry, no member appointed to the Board may be an employee of, a board member of, or a consultant to, a drug manufacturer or trade association for drug manufacturers. Specify that 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.

Purpose, Powers and Duties, Meeting Requirements, and Conflicts of Interest

Purpose. Specify that the purpose of the Prescription Drug Affordability Review Board is to protect state residents, the state, local governments, health plans, healthcare providers, pharmacies licensed in Wisconsin, and other stakeholders of the healthcare system in Wisconsin from the high costs of prescription drug products.

Meeting Requirements. Require the Board to meet in open session at least four times per year to review prescription drug product pricing information, except that the chair may cancel or postpone a meeting if there is no business to transact. Require the Board, to the extent practicable,

to 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 Wisconsin; and (c) accessing other available pricing information.

Powers and Duties. Specify that the Board may: (a) promulgate rules for the administration of its statutory duties; or (b) enter into a contract with an independent third party for any service necessary to carry out the powers and duties of the Board. Specify that, 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.

Require the Board to provide public notice of each Board meeting at least two weeks prior to the meeting and to make the materials for each meeting publicly available at least one week prior to the meeting. Require the Board to provide an opportunity for public comment at each open meeting and to provide the public with the opportunity to provide written comments on pending decisions of the Board. Specify that 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. Specify that the Board may allow expert testimony at any meeting, including when the Board meets in closed session. Require the Board to establish and maintain a website to provide public notices, make meeting materials available, and to disclose any conflicts of interest of Board members.

Conflicts of Interest. Require a member of the Board to recuse himself or herself from a decision relating to a prescription drug product if the member or an immediate family member has received or could receive any of the following: (a) 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; (b) 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.

Specify that a conflict of interest 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 final decision resulting from a review of a prescription drug product. Specify that any conflict of interest shall be disclosed no later than five days after the conflict is identified, except that, if the conflict is identified within five days of an open meeting of the Board, the conflict shall be disclosed prior to the meeting. Require the Board to disclose a conflict of interest on the Board's website unless the chair of the Board recuses the member from a final decision resulting from a review of the prescription drug product. Specify that the disclosure shall include the type, nature, and magnitude of the interests of the member involved.

Prohibit any member of the Board or a third party contractor from accepting 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.

Drug Cost Affordability Review

Require the Board to identify any 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 (CPI), has a launch wholesale acquisition cost of at least $30,000 per year or course of treatment, or whose wholesale acquisition cost increased at least $3,000 during a 12-month period; (b) 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; (c) a generic drug that has a wholesale acquisition cost, as adjusted annually to reflect adjustments to the CPI, that meets all of the following conditions: (i) 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 U.S. Food and Drug Administration (FDA), a supply lasting a patient for fewer than 30 days based on the recommended dosage approved for labeling by the FDA, or one unit of the drug if the labeling approved by the FDA does not recommend a finite dosage; or (ii) 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; or (d) other prescription drug products, including drugs to address public health emergencies, that may create affordability challenges for the healthcare system and patients in Wisconsin.

Require the Board, after identifying prescription drugs that meet the above conditions, to 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. Specify that the information to conduct an affordability review 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 Wisconsin, market competition and context, projected revenue, and the estimated value or cost-effectiveness of the prescription drug product. Specify that the failure of a manufacturer to provide the Board with information for an affordability review does not affect the authority of the Board to conduct the review.

Drug Affordability Challenge and Upper Payment Limit

Require the Board, when conducting an affordability review of a prescription drug product, to determine whether use of the prescription drug product that is fully consistent with the labeling approved by the FDA or standard medical practice has led or will lead to an affordability challenge for the healthcare system in Wisconsin, including high out-of-pocket costs for patients. Require the Board, to the extent practicable, in determining whether a prescription drug product has led or will lead to an affordability challenge, to consider all of the following factors: (a) the wholesale acquisition cost for the prescription drug product; (b) the average monetary price concession, discount, or rebate the manufacturer provides, or is expected to provide, to health plans as reported by manufacturers and health plans, expressed as a percent 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 percent of the wholesale acquisition cost; (d) the price at which therapeutic alternatives to the prescription drug product have been sold; (e) the average monetary concession, discount, or rebate the manufacturer provides or is expected to provide to health plan payors and pharmacy benefit managers for therapeutic alternatives; (f) the costs to health plans based on

patient access consistent with labeled indications by the FDA 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; (j) the average patient copay or other cost sharing for the prescription drug product; (k) any information a manufacturer chooses to provide; and (l) any other factors as determined by the Board by rule.

Require the Board, if it determines that the use of a prescription drug product has led or will lead to an affordability challenge, to establish an upper payment limit for the prescription drug product after considering all of the following: (a) the cost of administering the drug; (b) the cost of delivering the drug to consumers; and (c) other relevant administrative costs related to the drug.

Require the Board, with respect to drugs that the Board determines had a price increase in excess of the 12-month thresholds, to solicit information from the manufacturer regarding the price increase. Require the Board to establish an upper payment limit for a drug 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. Specify that the limit shall be the cost to consumers prior to the price increase.

Specify that the upper payment limit established by the Board shall apply to all purchases and payor reimbursements of the prescription drug product dispensed or administered to individuals in Wisconsin in person, by mail, or by other means, and is applicable to state sponsored and state regulated health plans and health programs. Specify that a plan subject to the federal Employee Retirement Income Security Act of 1974 (ERISA) or Medicare Part D may choose to reimburse more than the upper payment limit. Specify that a provider who dispenses and administers a prescription drug product to an individual in Wisconsin may not bill a payor more than the upper payment limit to the patient, regardless of whether a plan subject to ERISA or Medicare Part D chooses to reimburse the provider above the upper payment limit.

Other Provisions

Specify that information submitted to the Board shall be open to public inspection only as provided under the state's open records laws (sections 19.31 to 19.39 of the statutes).

Specify that these provisions may not be construed to prevent a manufacturer from marketing a prescription drug product approved by the FDA while the prescription drug product is under review by the Board.

Specify that 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. Require the Board to hear the appeal and make a final decision no later than 60 days after the appeal is requested. Specify that a person aggrieved by a final decision of the Board may petition for judicial review in a court of competent jurisdiction.

Definitions

Establish the following definitions used in these provisions: (a) "biologic" means a drug that is produced or distributed in accordance with a biologics license application approved under federal law; (b) "biosimilar" means a drug that is produced or distributed in accordance with a biologics license application approved under federal law; (c) "brand name drug" means a drug that is produced or distributed in accordance with an original new drug application approved under federal law, other than an authorized generic drug; (d) "financial benefit" includes an honorarium, fee, stock, the value of the stock holdings of a member of the board or any immediate family member, and any direct financial benefit deriving from the finding of a drug cost affordability review; (e) "generic drug" means any of the following: (i) a retail drug that is marketed or distributed in accordance with an abbreviated new drug application; (ii) an authorized generic drug, as defined under federal regulations; (iii) a drug that entered the market prior to 1962 and was not originally marketed under a new drug application; (f) "immediate family member" means a spouse, grandparent, parent, sibling, child, stepchild, or grandchild of spouse of a grandparent, parent, sibling, child, stepchild, or grandchild; (g) "manufacturer" means an entity that does all of the following: (i) engages in the manufacture of a drug product or enters into a lease with another manufacturer to market and distribute a prescription drug product under the entity's own name; or (ii) sets or changes the wholesale acquisition cost of the prescription drug product; (h) "pharmacy benefit manager" mean an entity doing business in Wisconsin that contracts to administer or manage prescription drug benefits on behalf of any insurer or other entity that provides prescription drug benefits to state residents; and (i) "prescription drug product" means a brand name drug, a generic drug, a biologic, or a biosimilar.

[Bill Sections: 64, 76, 3042 thru 3045, 9123(1), and 9423(1)]

3. GENERIC PRESCRIPTION DRUG IMPORTATION PROGRAM

Governor: Require the Insurance Commissioner, in consultation with persons interested in the sale and pricing of prescription drugs and appropriate officials and agencies of the federal government, to design and implement a prescription drug importation program for the benefit of, and that generates savings for, Wisconsin residents.

Program Requirements. Specify that the program must satisfy all the following: (a) OCI must 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 must comply with all relevant requirements under federal law; (c) the program must import drugs from Canadian suppliers regulated under any appropriate Canadian or provincial laws; (d) the program must have a process to sample the purity, chemical composition, and potency of imported prescription drugs; (e) the program must import only prescription drugs for which importation creates substantial savings, are not brand-name, and have fewer than four competitor prescription drugs in the United States; and (f) OCI must ensure that prescription drugs imported under the program are not distributed, dispensed, or sold outside of Wisconsin.

Specify that the program must ensure all of the following: (a) participation by any pharmacy

or health care provider in the program is voluntary; (b) any pharmacy or health care provider participating in the program has the appropriate license or other credential in Wisconsin; and (c) 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.

Specify that the program must 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.

Requirements Relating to Health Plans and Health Insurance Policies. Specify that the program must ensure that any health plan or health insurance policy participating in the program does all of the following: (a) maintains a formulary and claims payment system with current information on prescription drugs imported under the program; (b) 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; and (c) demonstrates to OCI or a state agency designated by OCI how premiums under the policy or plan are affected by savings on prescription drugs imported under the program.

Additional Restrictions Relating to Importation. Specify that the program must ensure that: (a) any wholesale distributor importing prescription drugs under the program must limit its profit margin to the amount established by OCI or a state agency designated by OCI; (b) the program may not import any generic prescription drug that would violate federal patent laws on branded products in the United States; and (c) the program complies, to the extent practical and feasible, with tracking and tracing requirements specified in federal regulations.

Program Finance. Specify that the program must establish a fee or other mechanism to finance the program that does not jeopardize significant savings to Wisconsin residents.

Audit Function. Provide that the program must have an audit function that ensures all of the following: (a) OCI has a sound methodology to determine the most cost-effective prescription drugs to include in the importation program; (b) OCI has a process in place to select Canadian suppliers that are high quality, high performing, and in full compliance with Canadian laws; (c) prescription drugs imported under the program are pure, unadulterated, potent, and safe; (d) the program is complying with the requirements specified under this item; (e) the program is adequately financed to support administrative functions of the program while generating cost savings to Wisconsin residents; (f) the program does not put Wisconsin residents at a higher risk than if the program did not exist; and (g) the program is projected to continue to provide substantial cost savings to Wisconsin residents.

Anti-Competitive Behavior. Require OCI, in consultation with the Attorney General, to identify the potential for, and monitor anticompetitive behavior in industries affected by the program.

Program Approval. Require OCI to submit a report on the design of the program to the Joint Committee on Finance for approval no later than the first day of the seventh month beginning after the effective date of the bill. Within 14 days of approval by the Committee, require OCI to submit the plan to the U.S. Department of Health and Human Services (DHHS) for certification. Provide

that OCI may not submit the program to DHHS for certification unless it is first approved by the Committee.

Program Implementation. Upon certification of the program by DHHS, require OCI to begin implementing the program so that the program is fully operational within 180 days of certification.

Require OCI to do all of the following to implement the program: (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; (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 Wisconsin residents 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 described above with a timeline to complete each audit function every two years; and (h) conduct any other activities determined by OCI to be important to successful implementation of the program.

Authorize OCI to promulgate any administrative rules necessary to implement the program.

Report. Require OCI, by January 1 and July 1 of each year, to submit to the Joint Committee on Finance a report including all of the following: (a) a list of prescription drugs included in the program; (b) the number of pharmacies, health care providers, and health plans and health insurance policies participating in the program; (c) the estimated amount of savings to Wisconsin residents, health plans and health insurance policies, and employers resulting from the implementation of the program reported from the date of the previous report and from the date the program was fully operational; and (d) findings of any audit functions completed since the date of the previous report. Require OCI to submit the first report by the next January 1 or July 1, whichever is earliest, that is at least 180 days after the date of the prescription drug importation program is operational. Require OCI to include in the first three reports it submits information on the implementation of the audit functions specified in this item.

[Bill Sections: 3040 and 9123(2)]

4. INSULIN SAFETY NET PROGRAMS

Governor: Require insulin manufacturers to create an urgent need safety net program and a patient assistance program, as described below, for certain persons who are insulin-dependent. For the purposes of this provision, define a manufacturer as a person engaged in the manufacturing of insulin that is self-administered on an outpatient basis.

Urgent Need Safety Net Program

Require each manufacturer, no later than July 1, 2024, to establish an urgent need safety net program to make insulin available to individuals who meet the requirements outlined below. Define "urgent need of insulin" to mean having less than a seven day supply of insulin readily available for use and needing insulin in order to avoid the likelihood of suffering a significant health consequence.

Eligibility. Specify that an individual shall be eligible to receive insulin under the program if all of the following conditions are met: (a) the individual is in urgent need of insulin; (b) the individual is a Wisconsin resident; (c) the individual is not receiving public assistance under Chapter 49 of the statutes (including Wisconsin Works, Wisconsin Shares, Medical Assistance, SeniorCare, FoodShare, and Supplemental Security Income supplemental payments); (d) 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; (e) the individual, with certain exceptions (described below), has not received insulin under an urgent need safety net program within the previous 12 months.

Specify that a person may be eligible to receive insulin under an urgent need safety net program despite previously receiving insulin under a program within the previous 12 months if the individual: (a) has applied for assistance under Chapter 49, but for whom a determination of eligibility has not been made or whose coverage has not become effective; or (b) has applied for assistance under, and has been determined ineligible for, a patient assistance program (created under this item and described below), but has filed an appeal with OCI and is awaiting a determination on that appeal. Specify that to receive a 30-day supply of insulin under this exception, an individual must attest that either of these conditions applies and that he or she meets the other eligibility criteria for assistance.

Application. Specify that, in order to receive insulin under an urgent need safety net program, an eligible individual shall provide a pharmacy with all of the following: (a) a completed application, on a form prescribed by OCI that shall include 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; (b) a valid insulin prescription; and (c) a valid Wisconsin driver's license or state identification card, or, if the individual is under the age of 18, the driver's license or identification card of the individual's parent or legal guardian.

Require OCI to make the application for the urgent need safety net program available on its website and to 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.

Pharmacy Duties. Require a pharmacist, upon receipt of an application for assistance under an urgent need safety net program, to dispense a 30-day supply of the prescribed insulin to the individual. Specify that 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. Require the pharmacy, in addition, to do the following: (a) notify the health care practitioner who issued the

prescription no later than 72 hours after the insulin is dispensed; (b) provide the individual with an information sheet about the insulin assistances programs and a list of licensed health insurance navigators; and (c) retain a copy of the application form.

Specify that a pharmacy that dispenses insulin under an urgent need safety net program 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. Specify that 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.

Define a pharmacy, for the purposes of this provision, to include a licensed pharmacy located in Wisconsin, or a pharmacy located in a different state that is licensed to ship, mail, or deliver prescriptions to persons in Wisconsin.

Patient Assistance Program

Require each manufacturer, no later than July 1, 2024, to establish a patient assistance program to make insulin available to individuals who meet the requirements outlined below. Require each manufacturer to do the following: (a) provide OCI with information regarding the program, including contact information for individuals to call for assistance in accessing the program; (b) 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; (c) list the eligibility requirements for the program on the manufacturer's website; and (d) maintain the privacy of all information received from an individual applying for or participating in the program and not sell, share, or disseminate the information unless required under the program or authorized, in writing, by the individual.

Eligibility. Specify that an individual shall be eligible to receive insulin under a patient assistance program if all of the following conditions are met: (a) the individual is a Wisconsin resident; (b) 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; (c) the individual has a valid insulin prescription; (d) the family income of the individual does not exceed 400 percent of the poverty line for a family the size of the individual's family; (d) the individual is not receiving public assistance under Chapter 49; (e) 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 if the individual is enrolled in a Medicare Part D plan and has spent at least $1,000 on prescription drugs in the current calendar year; and (f) 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.

Application and Determination. Specify that an individual may apply to participate in a patient assistance program by filing an application with the manufacturer who established the program, the individual's health care practitioners if the practitioner participates in the program, or a health insurance navigator. Require a health care practitioner or navigator to immediately submit

the application to the manufacturer. Require the manufacturer to determine the individual's eligibility for the program and notify the individual of the determination no later than ten days after receipt of the application. Specify that, if necessary to determine the individual's eligibility, the manufacturer may request additional information from an individual who has filed an application no later than five days after receipt of the application and, upon receipt of the additional information, shall determine the individual's eligibility for the program and notify the individual of the determination no later than three days later.

Require the manufacturer, if it determines that the individual is not eligible, to provide the reason for the determination. Specify that the individual may appeal the determination by filing an appeal with OCI that shall include all of the information provided to the manufacturer. Require OCI to issue a decision no later than 10 days after the appeal is filed, and specify that OCI's decision shall be final. Require the manufacturer to provide the individual with the statement of eligibility if OCI determines that the individual meets the eligibility requirements. Require OCI to establish procedures for deciding appeals.

Specify that if a manufacturer determines that an individual who has prescription drug coverage through an individual or group health plan and who 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. Specify that he individual may not be required to pay more than the copayment of $50 for each 90 day supply of insulin under this provision.

Pharmacy and Manufacturer Duties. Require any pharmacy, upon receipt from an individual of the eligibility statement under a patient assistance program, as well as a valid insulin prescription, to submit an order containing the name of the insulin and daily dosage amount to the manufacturer. Specify that the order shall also include the pharmacy's name, shipping address, office telephone number, fax number, electronic mail address, and contact name, as well as any days or times when deliveries are not accepted by the pharmacy.

Require the manufacturer, upon receipt of the order, to 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. Require the pharmacy to dispense the insulin to the individual associated with the order and specify that 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. Specify that the pharmacy may not seek reimbursement from the manufacturer or a 3rd-party payer. Specify that the pharmacy may submit a reorder to the manufacturer if the individual's eligibility statement has not expired and the reorder shall be treated as an original order by the manufacturer.

Specify that 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.

General Provisions

Exempted Manufacturers. Specify that the program requirements established under this item do not apply to a manufacturer to which either of the following apply: (a) the manufacturer shows to OCI's satisfaction that the manufacturer's annual gross revenue from insulin sales in Wisconsin does not exceed $2,000,000; or (b) the wholesale acquisition cost of the insulin product from the manufacturer 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.

Reimbursement Prohibition. Specify that no person, including a manufacturer, pharmacy, pharmacist, or third-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.

Confidentiality. Specify that all medical information solicited or obtained by any person under these provisions shall be subject to the applicable provisions of state law relating to confidentiality of medical information.

Penalties. Specify that a manufacturer that fails to comply with these provisions may be assessed a penalty of up to $200,000 per month of noncompliance, with the maximum penalty increasing to $400,000 per month if the manufacturer continues to be in noncompliance after six months and increasing to $600,000 per month if the manufacturer continues to be in noncompliance after one year.

Program Reports

Satisfaction Surveys. Require OCI to develop and conduct a satisfaction survey of individuals who have accessed insulin through urgent need safety net programs and patient assistance programs. Specify that the survey ask whether the individual is still in need of a long-term solution for affordable insulin and 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; and (d) ease of access in applying for a patient assistance program and receiving insulin from the pharmacy under the program.

Require OCI to develop and conduct a satisfaction survey of pharmacies that have dispensed insulin through urgent need safety net programs and patient assistance programs. Specify that the survey 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; and (c) timeliness of receiving insulin orders from manufacturers.

Authorize OCI to contract with a nonprofit entity to develop and conduct these surveys and to evaluate the survey results. Require OCI, no later than July 1, 2026, to submit to the Governor and the Chief Clerk of each house of the Legislature a report on the results of the surveys.

Manufacturer Assistance Data. Require each manufacturer, on an annual basis no later than March 1, to report to OCI all of the following information for the previous calendar year: (a) the number of individuals who received insulin under the manufacturer's urgent need safety net program; (b) 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; and (c) the wholesale acquisition cost of the insulin provided by the manufacturer through the urgent need safety net program and patient assistance program.

Require OCI, on an annual basis no later than April 1, to submit to the Governor and the Chief Clerk of each house of the Legislature a report on the urgent need safety net programs and patient assistance programs that includes all of the following: (a) the program participation data provided to OCI by manufacturers; and (b) the penalties assessed to manufacturers during the previous calendar year for violations of program requirements, including the name of the manufacturer and amount of the penalty.

Other Provisions

OCI Duties. Require OCI to conduct public outreach to create awareness of the urgent need safety net programs and patient assistance programs and to develop and make available on its 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 OCI if a manufacturer determines that an individual is not eligible for a patient assistance program; and (e) a notification that an individual may contact OCI for more information or assistance in accessing ongoing affordable insulin options.

Require OCI to develop a training program to provide navigators with information and the resources necessary to assist individuals in accessing appropriate long-term insulin options and to compile a list of navigators who have completed the training program and are available to assist individuals in accessing affordable insulin coverage options. Specify that the list shall be made available on the OCI website and to pharmacies and health care practitioners who dispense and prescribe insulin.

[Bill Section: 3090]

5. INSULIN COPAYMENT CAP

Governor: Prohibit health insurance policies and governmental self-insured health plans that cover insulin and that impose cost sharing on prescription drugs (deductible, copayment, or coinsurance) from imposing cost sharing on insulin in an amount that exceeds $35 for a one-month supply of insulin. Specify that this provision does not prohibit an insurance policy or plan from imposing cost sharing on insulin in an amount less than $35 and does not require a policy or plan from imposing cost sharing on insulin. Specify that this provision would take effect on the first day of the fourth month beginning after the effective date of the bill.

[Bill Sections: 3058, 3096 thru 3098, and 9423(3)]

6. VALUE-BASED DIABETES MEDICATION PILOT PROGRAM

Governor: Require OCI to develop a pilot program to direct a pharmacy benefit manager and a pharmaceutical manufacturer to create a value-based, sole-source arrangement to reduce the costs of prescription medication used to treat diabetes. Authorize OCI to promulgate administrative rules to implement this provision.

[Bill Section: 3039]

7. APPLICABILITY OF MANUFACTURER BRAND NAME DRUG REBATES TO DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

Governor: Specify that health insurance policies that offer a drug benefit and any governmental self-insured health plans must count toward an enrollee's annual deductible and out-of-pocket maximum the amount by which any manufacturer drug discount reduces the cost sharing amount charged to the enrollee for certain prescription drugs. Specify that this provision would apply to brand name drugs that have no generic equivalent or to brand name drugs that have a generic equivalent but for which the enrollee has received prior authorization from the insurer, plan, or a physician to obtain the brand name drug.

Specify that this provision applies on January 1 of the year following the effective date of the bill to policies and plans containing provisions inconsistent with the provision, except that for policies and plans that are affected by a collective bargaining agreement that are inconsistent with the provision, the provision applies to policy or plan years beginning after the effective date of the bill or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

Generally, only the actual amount spent on a prescription drug by the consumer (after any manufacturer discount) is counted toward the consumer's deductible and out-of-pocket maximum for an insurance policy or benefit plan. This item would increase the amount applied to the deductible and out-of-pocket spending by the amount which the discount reduces the consumer's cost, which would allow some individuals to reach these plan thresholds earlier than they otherwise would.

[Bill Sections: 727, 728, 1177, 2219, 2402, 3058, 3086, and 9323(5)]

8. DRUG REIMBURSEMENT FOR CERTAIN ENTITIES UNDER FEDERAL 340B DRUG DISCOUNT PROGRAM

Governor: Provide that no person, including a pharmacy benefit manager and third-party payer, may do any of the following, with respect to reimbursement of drugs for certain entities (specified below) that participate under the federal 340B drug discount program:

- Reimburse the entity for a drug that is subject to a price discount agreement under the 340B program at a rate lower than that paid for the same drug to pharmacies that are not eligible entities under 340B and are similar in prescription volume to the covered 340B covered entity; or

- Assess a covered entity any fee, charge back, or other adjustment based on the entity's participation in 340B.

Specify that this provision would apply to the following 340B entities: federally qualified health centers, critical access hospitals, and grantees under the Ryan White HIV/AIDS program, as well as any pharmacy of these entities of pharmacy contracted with these entities to dispense drugs through the 340B program. Authorize OCI to promulgate rules to implement these provisions and to establish a minimum reimbursement rate for any entities participating in 340B.

The federal 340B program requires drug manufacturers to limit the price for outpatient drugs dispensed to patients of certain covered entities. Generally, entities eligible for discounted drugs under the program include nonprofit health care organizations such as federally-qualified health centers, hospitals, and clinics that serve a disproportionate share of low-income patients. Under this item, third-party payers, such as pharmacy benefit managers, insurers, or self-insured benefit plans would be required to pay certain 340B entities the same amount for drugs as they pay to other entities that are not eligible 340B entities. To the extent that these payers are currently reimbursing these 340B entities at a lower rate (reflecting the lower acquisition price for the drug), this item has the effect of shifting the benefit of the 340B program discounts from the payer to the 340B entity.

[Bill Section: 3091]

9. LICENSURE OF PHARMACEUTICAL REPRESENTATIVES

Governor: Specify that, beginning on the first day of the twelfth month beginning after the effective date of the bill, no individual may act as a pharmaceutical representative in Wisconsin without a license issued by OCI. Define a pharmaceutical representative as an individual who markets or promotes pharmaceuticals to health care professionals on behalf of a pharmaceutical manufacturer for compensation. Define, for the purpose of this provision, a pharmaceutical as a medication that may legally be dispensed only with a valid prescription from a health care professional. Define a health care professional as a physician or other health care practitioner who is licensed to provide health care services or to prescribe pharmaceutical or biologic products.

Specify that, in order to obtain a license, an individual shall apply in the form and manner prescribed by OCI. Establish a fee for a pharmaceutical representative license in an amount set by OCI by administrative rule. Specify that the term of a pharmaceutical representative license is one year and is renewable. Require any pharmaceutical representative to display his or her license during each visit with a health care professional.

Specify that any individual that violates provisions pertaining to pharmaceutical licensure shall be fined not less than $1,000 nor more than $3,000 for each offense, and specify that each day the violation continues constitutes a separate offense. Authorize OCI to suspend or revoke the license of a pharmaceutical representative who violates these provisions and specify that a suspended or revoked license may not be reinstated until all violations related to the suspension or revocation have been remedied and all assessed penalties and fees have been paid.

Require OCI to promulgate an administrative rule to implement the licensure provisions,

including rules that require pharmaceutical representatives to complete continuing education coursework as a condition of licensure, and including the amount of the license fee.

[Bill Sections: 3037 and 3087]

10. LICENSURE OF PHARMACY BENEFIT MANAGEMENT BROKERS AND CONSULTANTS

Governor: Specify that, beginning on the first day of the twelfth month beginning after the effective date of the bill, no individual may serve as a pharmacy benefit management broker or consultant or as any other individual who procures the services of a pharmacy benefit manager on behalf of a client without a license. Authorize OCI to promulgate rules to establish criteria and procedures for initial licensure and renewal of licensure to implement these requirements and specify that the fee for issuing and renewing the license shall be established by administrative rule.

[Bill Sections: 3036 and 3066]

11. LICENSURE OF PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS

Governor: Specify that, beginning on the first day of the twelfth month beginning after the effective date of the bill, no person may operate as a pharmacy services administrative organization in Wisconsin without a license issued by OCI.

Define a pharmacy services administrative organization (PSAO) as an entity operating in Wisconsin that does all of the following: (a) contracts with an independent pharmacy to conduct business on the pharmacy's behalf with a third-party payer; and (b) provides at least one administrative service to an independent pharmacy and enters into a contract with a third-party payer or pharmacy benefit manager on behalf of the pharmacy. Define, for the purposes of this provision, an administrative service to mean any of the following: (a) assisting with claims; (b) assisting with audits; (c) providing centralized payment; (d) performing certification in a specialized care program; (e) providing compliance support; (f) setting flat fees for generic drugs; (g) assisting with store layout; (h) managing inventory; (i) providing marketing support; (j) providing management and analysis of payment and drug dispensing data; or (k) providing resources for retail cash cards. Define an independent pharmacy to mean a pharmacy operating in Wisconsin that is licensed and is under common ownership with no more than two other pharmacies. Define a third-party payer as an entity, including a plan sponsor, health maintenance organization, or insurer, operating in Wisconsin that pays or insures health, medical, or prescription drug expenses on behalf of beneficiaries.

Specify that the application for a PSAO license shall contain the following: (a) the name, address, telephone number, and federal employer identification number of the applicant; (b) the name, business address, and telephone number of a contact person for the applicant; (c) the license fee; (d) evidence of financial responsibility of at least $1,000,000; and (e) any other information required by OCI. Specify that the term of the PSAO license is two years from the date of issuance.

Require any PSAO to disclose to OCI the extent of any ownership or control of the PSAO by an entity that does any of the following: (a) provides pharmacy services; (b) provides prescription drug or device services; or (c) manufactures, sells, or distributes prescription drugs, biologicals, or medical devices. Require any PSAO to notify OCI in writing within five days of any material change in its ownership or control relating to such an entity.

Authorize OCI to promulgate rules to administer these provisions and specify that the fee for issuing and renewing a PSAO license shall be established by administrative rule.

[Bill Sections: 3038 and 3088]

12. FIDUCIARY DUTY AND DISCLOSURE REQUIREMENTS OF PHARMACY BENEFIT MANAGERS

Governor: Specify that a pharmacy benefit manager (PBM) under contract with a health benefit plan sponsor owes a fiduciary duty to the plan sponsor to act according to plan sponsor's instructions and in the best interests of the plan sponsor.

Require the PBM to annually provide to the health benefit plan sponsor, no later than the date, and using the method prescribed, by OCI by rule, all of the following information from the previous calendar year: (a) the indirect profit received by the PBM from owning any interest in a pharmacy or service provider; (b) any payment made by the PBM to a consultant or broker who works on behalf of the plan sponsor; (c) from the amounts received from all drug manufacturers, the amounts retained by the PBM, and not passed through to the plan sponsor, that are related to the plan sponsor's claims or bona fide service fees; and (d) the amounts, including pharmacy access and audit recovery fees, received from all pharmacies that are in the PBM's network or have a contract to be in the network and, from these amounts, the amount retained by the PBM and not passed through to the plan sponsor.

[Bill Section: 3089]

13. PRESCRIPTION DRUG PURCHASING ENTITY STUDY

Governor: Require OCI to conduct a study on the viability of creating or implementing a state prescription drug purchasing entity during the 2023-25 biennium. As described in the final report of the Governor's 2020 Task Force on Reducing Prescription Drug Prices, a drug purchasing entity would pool state agency and local government purchasers of prescription drugs to leverage greater purchasing power in negotiations with drug manufacturers, with the intent of securing lower drug prices.

[Bill Section: 9123(4)]

Health Insurance

1. STATE-BASED HEALTH INSURANCE EXCHANGE

	Funding	Positions
GPR	$2,247,300	10.00
PR	3,000,000	0.00
Total	$5,247,300	10.00

Governor: Provide $982,400 GPR in 2023-24 and $4,264,900 ($1,264,900 GPR and $3,000,000 PR) in 2024-25, and 10.0 GPR positions, beginning in 2023-24, to develop and implement a state-based health insurance exchange, as described below. Modify OCI's PR appropriation for general program operations to specify that it may be used for costs related to operating the exchange and to specify that the appropriation account would receive revenues collected from exchange user fees charged to participating insurers. Create an annual GPR-funded general program operations appropriation to support the GPR positions that would be provided under this item.

Require OCI to: (a) establish and operate an exchange that is at first a state-based exchange on the federal platform and then subsequently transitions to a state-based exchange without the federal platform; and (b) develop procedures to address the transition from the state-based exchange on the federal platform to the state-based exchange without the federal platform, including the circumstances that must be met in order for the transition to occur.

Define the terms "exchange," "state-based exchange on the federal platform," and "state-based exchange without the federal platform" by reference to federal regulations for the establishment of state-based and state-federal exchanges.

Require OCI to impose a user fee, as authorized under federal regulations, on each insurer that offers a health plan through the state-based exchange on the federal platform or the state-based exchange without the federal platform. Specify that the user fee must be applied at one of the following rates on the total monthly premiums charged by an insurer for each policy under the plan where enrollment is through the exchange: (a) for any plan year for which OCI operates a state-based exchange on the federal platform, the rate is 0.5%; (b) for the first two plan years for which OCI operates a state-based exchange without the federal platform, the rate shall equal the user fee rate established by the federal government for the federal health insurance exchange; (c) beginning with the third plan year for which OCI operates a state-based exchange without the federal platform, the rate would be set by OCI by rule.

Specify that OCI may enter into any agreement with the federal government necessary to facilitate the implementation of these provisions, and may promulgate administrative rules to implement these provisions.

The state-based insurance exchange would, for Wisconsin residents and individual market insurance plans, perform the functions currently performed by an insurance exchange established by the federal government under provisions of the federal Patient Protection and Affordable Care Act (ACA). These functions include providing a website for the comparison of individual market health insurance policies and to facilitate selection and enrollment, reviewing plans to ensure compliance with ACA requirements, determining eligibility of individuals for federal premium tax

credits and cost-sharing reductions, providing funding for outreach and enrollment assistance activities, and collecting user fees from participating insurers to support the costs of the exchange. Under this item, the state-based exchange would initially utilize the federal exchange technology platform, but would eventually be transitioned to a fully state-based exchange. The Administration indicates that the intent would be to move to a state-based exchange on the federal platform for plan year 2025 and then a fully state-based exchange for 2026.

The positions established by this item would include six policy initiatives advisors, an insurance examiner, an insurance program manager, and two operations program associates.

[Bill Sections: 275 thru 277 and 3041]

2. PUBLIC OPTION HEALTH INSURANCE PLAN

GPR	$1,000,000
PR	1,000,000
Total	$2,000,000

Governor: Provide $1,000,000 GPR in 2023-24 and $1,000,000 PR in 2024-25 to fund the development and operation of a public option health insurance plan. Modify OCI's general program operations PR appropriation to include the development and operation of a public option health insurance plan as an eligible use. Specify that OCI may spend not more than $1,000,000 in 2023-24 for the development of the public option health plan from the GPR appropriation for state operations (created under a separate item, summarized above).

[Bill Sections: 275, 276, and 9123(3)]

3. HEALTH INSURANCE AND COVERAGE REQUIREMENTS

Governor: Modify statutory provisions related to health insurance and health benefit plan regulations, as they relate to issuance and renewal of policies, premiums, cost sharing, and coverage requirements, as described below.

Guaranteed Issue and Renewal of Policies. Require every individual health benefit plan and every group health benefit plan to accept every individual and every employer, as applicable, that applies for coverage, regardless of sexual orientation, gender identity, or whether or not any employee or individual has a preexisting condition. Specify that a health benefit plan may restrict enrollment in coverage to open or special enrollment periods. Require OCI to establish a statewide open enrollment period of no shorter than 30 days for every individual health benefit plan to allow individuals, including individuals who do not have coverage, to enroll in coverage.

Prohibit Preexisting Condition Exclusions. Prohibit an insurer that offers a group health benefit plan or an individual insurance policy from imposing a preexisting condition exclusion (the denial or reduction of a claim related to a condition that existed prior to the effective date of coverage). Modify related statutory definitions and provisions that place limits on preexisting condition exclusions to reflect the change to a general prohibition against the practice.

Prohibit Discrimination Based on Health Status -- Enrollment, Premiums and Cost Sharing. Prohibit an individual health benefit plan or a government self-insured plan from establishing rules

for the eligibility of any individual to enroll, or the continued eligibility to remain enrolled in a plan based on any of the following: (a) health status; (b) medical condition, including both physical and mental illnesses; (c) claims experience; (d) receipt of health care; (e) medical history; (f) genetic information; (g) evidence of insurability, including conditions arising out of acts of domestic violence; or (h) disability.

Prohibit an insurer offering an individual health benefit plan or a self-insured plan from requiring any individual, as a condition of enrollment or continued enrollment under the plan, to pay, on the basis of any health status-related factor listed above, 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 that required for a similarly situated individual enrolled under the plan.

Specify that these restrictions do not prevent an insurer from 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.

Modify a current law provision, applicable to group health benefit plans, from charging different premiums to similarly-situated individuals based on any health status-related factor, to also prohibit charging a different deductible, copayment, or coinsurance amount to similarly-situated individuals based on health status.

Restrictions on Premium Rate Variation. Specify that a health benefit plan offered on the individual or small employer market (between two and 50 employees) or a government 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) the rating area in the state, as established by OCI; (c) age, except that the rate may not vary by more than three-to-one for adults over the age groups and the age bands shall be consistent with recommendations of the National Association of Insurance Commissioners; and (d) tobacco use, except that the rate may not vary by more than 1.5-to-one.

Statewide Risk Pool. Specify that 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.

Prohibit Annual and Lifetime Limits. Prohibit an individual or group health benefit plan or a government self-insured health plan from establishing lifetime or annual limits on the dollar value of benefits for an enroll or a dependent of an enrollee under the plan.

Cost Sharing Maximum. Specify that a health benefit plan offered on the individual or small employer market may not require an enrollee to pay more in cost sharing (deductibles, coinsurance, copayments, or similar charges) than the maximum amount calculated under provisions of the federal Affordable Care Act, including the annual indexing of the limits.

Medical Loss Ratio. Establish the minimum medical loss ratios for health benefit plans as

follows: (a) 80 percent for a plan on the individual or small employer market; (b) 85 percent for a group health plan not in the small employer market. Define medical loss ratio as the proportion, expressed as a percentage, of premium revenues spent by a health benefit plan on clinical services and quality improvement.

Actuarial Values of Plan Tiers. Require any health benefit plan offered on the individual or small employer market to 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. The actuarial value represents the average cost of the benefits covered by plan over an average population, with the rest covered by enrollee cost sharing.

Essential Health Benefits. Require every health insurance policy (except for specified restricted-benefit policies) and every government self-insured health plan to provide coverage for essential health benefits, as determined by OCI by rule, on a date specified by OCI by rule. Require OCI, in determining the essential health benefits for which coverage is required, to 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; and (j) pediatric services, including oral and vision care.

Require OCI to do the following with respect to essential health benefits: (a) 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 is equal to the scope of benefits covered under a typical insurance policy offered by an employer to its employees; (b) ensure that essential health benefits reflect a balance among the essential health benefit categories such that benefits are not unduly weighted toward one category; (c) ensure that essential health benefit coverage is provided with no or limited cost-sharing requirements; (d) require that 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; (e) 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; (f) ensure that essential health benefits 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; (g) require that insurance policies and government 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; (h) require an insurance policy or government 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; and (i) periodically update, by rule, the essential health benefits to address any gaps in access to coverage.

Specify that if an essential health benefit is also subject to other coverage mandates specified in state statute and the coverage requirements are not identical, the insurance policy or government self-insured health plan shall provide coverage under whichever provision provides the insured or plan participant with more comprehensive coverage of the medical condition, item, or service. Specify that the essential health benefit provisions or rules promulgated under these provisions do not prohibit an insurance policy or a government self-insured health plan from providing benefits in excess of the essential health benefit coverage.

Coverage of Preventive Services and other Mandatory Coverage Requirements. Require every health insurance policy (except for specified restricted-benefit policies) and every government self-insured health plan to provide coverage for the preventive services listed below. These preventive services are generally from the list of services given an "A" or "B" rating by the U.S. Preventive Services Task Force. Under federal regulations developed to implement provisions of the Affordable Care Act, these services must be covered with no cost sharing by insurance policies and health plans.

- Mammography.

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

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

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

- Colorectal cancer screening.

- 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.

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

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

- 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.

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

- Lipid disorder screening for minors two 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.

- 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.

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

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

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

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

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

- 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 six 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.

- 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.

- Immunizations.

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

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

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

- Gonorrhea prophylaxis treatment for newborns.

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

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

- Head circumference and weight-for-length measurements for newborns and minors

who have not attained the age of three years.

- Body mass index for minors two years of age or older.

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

- Risk assessment and referral for oral health issues for minors who have attained the age of six months but have not attained the age of seven years.

- Blood screening for newborns and minors who have not attained the age of two months.

- Screening for critical congenital health defects for newborns.

- Lead screenings.

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

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

- Tobacco counseling and cessation interventions for individuals who are five years of age or older.

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

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

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

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

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

- Developmental screening and surveillance for minors including newborns.

- Psychosocial and behavioral assessment for minors including newborns.

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

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

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

- 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.

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

- Folic acid supplement for adult women with reproductive capacity.

- Iron deficiency anemia screening for pregnant and lactating women.

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

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

- Screenings for hepatitis B and bacteriuria for pregnant women.

- 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.

- 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.

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

- 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.

- All contraceptives and services in accordance with separate statutory provisions.

- Any services not already specified having an A or B rating in current recommendations from the U.S. Preventive Services Task Force.

- Any preventive services not already specified that are recommended by the federal Health Resources and Services Administration's Bright Futures project.

- Any immunizations, not already specified under a separate statutory coverage mandate provision, that are recommended and determined to be for routine use by the federal Advisory Committee on Immunization Practices.

Prohibit insurance policies and government self-insured health plans, with certain exceptions, from subjecting the coverage of any of the listed preventive services to any deductible, copayments, or coinsurance under the policy or plan, and modify various statutory mandatory coverage provisions related to these preventive services to conform to this restriction.

Specify that the insurance policy or plan may apply deductibles to and impose copayments or coinsurance in the following circumstances: (a) if an office visit and a preventive service are billed separately by the health care provider, applicable only on the office visit but not on the preventive service; (b) if the primary reason for an office visit is not to obtain a preventive service, applicable on the office visit; or (c) if a preventive service is provided by a health care provider that is outside the policy's or plan's network of providers, unless the preventive service is provided by an out-of-network provider because there is no available health care provider in the policy's or plan's network of providers that provides the preventive service. Specify that if multiple well-woman visits are required to fulfill all necessary preventive services and are in accordance with clinical recommendations, the insurance policy or health plan may not apply a deductible to or impose a copayment or coinsurance on any of those well-woman visits.

Other Insurance Mandatory Coverage Provisions. Modify a provision that requires health insurance plans and government self-insured plans to cover certain immunizations to add the following immunizations: (a) hepatitis A; (b) herpes zoster; (c) human papillomavirus; (d) meningococcal meningitis; (e) pneumococcal pneumonia; (f) influenza; and (g) rotavirus. Modify the immunization coverage mandate to extend the coverage requirement to any insured or plan participant, rather than just a child from birth to age six who is a child of the insured.

Modify a current law provision that requires health insurance policies and government self-insured plans to cover outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive, if these services are covered for any other drug benefits under the policy or plan, to remove the clause that makes the coverage requirement contingent upon whether these services are coverage for any other drug benefits. Add to the coverage mandate sterilization procedures, and patient education and counseling for all females with reproductive capacity. Specify that an insurance policy or self-insured health plan may not 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. Specify that the insurance policy or health plan may apply reasonable medical management to a method of contraception to limit coverage that is provided without being subject to a deductible, copayment, or coinsurance, to prescription drugs without a brand name. Authorize the insurance policy or health plan to 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.

Initial Applicability. Specify that these provisions first apply to policy or plan years beginning on January 1 of the year following the year of the first day of the fourth month beginning after the bill's general effective date, or, for policies and plans that are affected by a collective bargaining agreement containing provisions that are inconsistent with the bill, to policy or plan years beginning on the day on which the collective bargaining agreement is entered into, extended, modified, or renewed, whichever is later.

Some of the provisions contained in this item are intended to conform state laws to insurance market regulations contained in the federal Affordable Care Act (ACA). Since the ACA preempts state regulations with respect to many insurance market regulations, these provisions have no

effect as long as the ACA is in effect in its present form. If the ACA's insurance market provisions were to not be enforceable, the provisions in this item would maintain some of the ACA's market regulations for the individual and small group policies and for self-insured plans offered by a government entity. [The bill would not affect non-government self-insured plans since federal law preempts state law with respect to these benefit plans.] Specifically, the bill closely matches the ACA's regulations with respect to premium rating rules, guaranteed issue and renewal, prohibition against preexisting condition exclusions, non-discrimination in health care, the essential health benefits, prohibition against lifetime or annual limits, statewide risk pool requirements, maximum out-of-pocket spending, and coverage of preventive services without cost sharing.

[Bill Sections: 727, 728, 1177, 2219, 2402, 3053, 3059, 3061 thru 3065, 3068 thru 3078, 3082, 3085, 3099 thru 3106, 3108 thru 3111, 9323(3), and 9423(4)]

4. SHORT-TERM, LIMITED DURATION HEALTH INSURANCE PLANS

Governor: Establish requirements related to the guaranteed issue, health status discrimination, premium rate variation, and annual and lifetime limits for short-term, limited duration health insurance plans, as described below. Modify a provision in current law that establishes the definition of a short-term, limited duration plan in reference to the duration of the coverage term, as follows: (a) reduce the maximum coverage term of a qualifying plan from 12 months to three months; and (b) reduce the maximum aggregated coverage term for consecutive periods of the policy from 18 months to six months. [This definition is established in a current law provision that creates an exception to a requirement for guaranteed renewal of individual health insurance policies. Consequently, the effect of reducing the maximum term of what qualifies for the short-term plan exemption would be to reduce the scope of exceptions to the guaranteed renewal requirement.]

Guaranteed Issue and Prohibiting Health Status Discrimination. Require that any insurer that offers a short-term, limited duration plan to accept every individual in Wisconsin who applies for coverage whether or not any individual has a preexisting condition. Prohibit an insurer that offers a short-term, limited duration plan from establishing rules for 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: (a) health status; (b) medical condition, including both physical and mental illnesses; (c) claims experience; (d) receipt of health care; (e) medical history; (f) genetic information; (g) evidence of insurability, including conditions arising out of acts of domestic violence; or (h) disability.

Repeal a provision that establishes the conditions under which a short-term, limited duration plan may impose preexisting condition exclusions, and, instead, prohibit such plans from imposing any preexisting condition exclusions.

Prohibit any insurer that offers a short-term, limited duration plan from requiring any individual as a condition of enrollment or continued enrollment under the plan, to pay, on the basis of any of these health status-related factors, 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 similarly situated individual enrolled under the plan.

Premium Rate Variation Restrictions. Specify that an insurer that offers a short-term, limited duration plan may vary premium rates for such a plan based only on the following considerations: (a) whether the policy or plan covers an individual or a family; (b) the rating area in the state, as established by OCI; (c) age, except that the rate may not vary by more than three-to-one for adults over the age groups and the age bands shall be consistent with recommendations of the National Association of Insurance Commissioners; and (d) tobacco use, except that the rate may not vary by more than 1.5-to-one.

Annual and Lifetime Limits. Specify that a short-term, limited duration plan may not establish any of the following coverage limits: (a) lifetime limits on the dollar value of benefits for an enrollee or a dependent of an enrollee under the plan; or (b) limits on the dollar value of benefits for an enrollee or a dependent of an enrollee under the plan for the initial or cumulative duration of the plan.

[Bill Sections: 3065, 3079 thru 3081, 3083, and 3084]

5. INSURER NETWORK ADEQUACY STANDARDS

Governor: Authorize OCI to promulgate administrative rules to establish minimum network time and distance standards and minimum network wait-time standards for defined network plans and preferred provider plans. Specify that, in promulgating rules, OCI shall consider standards adopted by the federal Centers for Medicare and Medicaid Services for qualified health plans offered through the federal health insurance exchange.

[Bill Section: 3051]

6. LIMITATIONS ON BALANCE BILLING AND COVERAGE RESTRICTIONS FOR CERTAIN OUT-OF-NETWORK MEDICAL SERVICES

Governor: Establish restrictions and requirements related to provider and insurer billing, applicable to certain services rendered by out-of-network providers or facilities to enrollees of a defined network plan, preferred provider plan, or self-insured governmental plan, as described below. The Administration's intent is to codify, in state law, the provisions of the federal No Surprises Act, which was passed as part of the Consolidated Appropriations Act of 2021. The No Surprises Act prohibits certain medical providers and emergency medical services who are out-of-network for a patient's insurance from billing the patient by an amount that exceeds what the patient would be billed for an in-network provider.

Insurer and Health Benefit Plan Requirements and Restrictions

Emergency Medical Services. Specify that any defined network plan, preferred provider plan, or self-insured governmental plan that covers any benefits or services provided in an emergency department of a hospital or emergency medical services provided in an independent

freestanding emergency department may not, with respect to emergency medical services, require a prior authorization determination and may not deny coverage based on whether or not the health care provider rendering the services is a participating provider or participating emergency facility.

Specify that if the emergency medical services are provided to an enrollee by a provider or in a facility that is not a participating provider or facility (hereafter an "out-of-network provider or facility"), the plan must comply with the following requirements: (a) the services are covered without imposing a prior authorization or coverage limitation that is more restrictive than requirements or limitations that apply to emergency medical services provided by an in-network provider or facility; (b) any cost-sharing requirement imposed on an enrollee for the emergency medical service must be no greater than the requirements that would apply if the emergency medical service were provided by an in-network provider or facility; (c) any cost-sharing amount imposed on an enrollee for the emergency medical service is calculated as if the total amount that would have been charged for the emergency medical service if provided by an in-network provider or facility is equal to the recognized amount for such services, plan or coverage, and year; and (d) the plan counts any cost-sharing payment made by the enrollee toward any in-network deductible or out-of-pocket maximum applied by the plan in the same manner as if the cost-sharing payment was made for an emergency medical service provided by an in-network provider or facility.

Require the plan, if an emergency service is provided to an enrollee by an out-of-network provider or facility, to do all of the following: (a) no later than 30 days after the provider or facility transmits to the plan the bill for emergency medical services, sends to the provider or facility an initial payment or a notice of denial of payment; and (b) pays to the provider or facility a total amount that, incorporating any initial payment, is equal to the amount by which the out-of-network rate exceeds the enrollee cost-sharing amount.

Services Rendered by an Out-of-Network Provider in an In-Network Facility. Specify that for items or services, other than emergency medical services, that are rendered to an enrollee by an out-of-network provider within an in-network facility, the plan must provide coverage for the item or service in accordance with all of the following: (a) the plan may not impose on an enrollee a cost-sharing requirement for the item or service that is greater than the cost-sharing requirement that would have been imposed if the item or service was provided by an in-network provider; (b) any cost-sharing amount imposed on an enrollee for the item or service is calculated as if the total amount that would have been charged for the item or service if provided by an in-network provider is equal to the recognized amount for such item or service, plan or coverage, and year; (c) no later than 30 days after the provider transmits the bill for services, the plan shall send to the provider an initial payment or a notice of denial of payment; (d) the plan shall make a total payment directly to the provider that rendered the item or service to the enrollee that, when added to any initial payment, is equal to the amount by which the out-of-network rate for the item or service exceeds the cost-sharing amount; and (e) the plan counts any cost-sharing payment made by the enrollee for the item or service toward any in-network deductible or out-of-pocket maximum applied by the plan in the same manner as if the cost-sharing payment was made for the item or service when rendered by an in-network provider.

Specify that the terms "recognized amount" and "out-of-network rate," as used in these provisions, have the meaning established by OCI by rule, or, in the absence of a rule, as defined

in the federal No Surprises Act. Define the terms "emergency medical condition" and "emergency medical services" as those terms are defined in the federal No Surprises Act.

Limitations on Provider Billing

Specify that an out-of-network provider of an item or service rendered in an in-network facility may not bill or hold liable an enrollee for any amount for an ancillary item or service that is more than the cost-sharing amount determined as if the service were rendered by an in-network provider for the item or service, whether or not provided by a physician or non-physician practitioner, unless OCI specifies by rule that the provider may balance bill for the specified item or service, if the ancillary item or service is any of the following: (a) related to an emergency medical service; (b) anesthesiology; (c) pathology; (d) radiology; (e) neonatology; (f) an item or service provided by an assistant surgeon, hospitalist, or intensivist; (g) diagnostic service, including a radiology or laboratory service; (h) an item or service provided by a specialty practitioner that OCI specifies by rule; or (i) an item or service provided by an out-of-network provider when there is no in-network provider who can furnish the item or service at the in-network facility.

Prohibit an out-of-network provider of an item or service that is rendered in an in-network facility from billing or holding liable an enrollee for any amount for the item or service that is more than the cost-sharing amount determined as if the services were rendered by an in-network provider for the item or service unless the out-of-network provider provides notice and obtains consent in accordance with all of the following: (a) the notice states that the provider is an out-of-network provider in the enrollee's plan; (b) the notice provides a good faith estimate of the amount that the provider may charge the enrollee for the item or service involved, including notification that the estimate does not constitute a contract with respect to the charges estimated for the item or service; (c) the notice includes a list of the in-network providers at the facility that would be able to render the item or service and notification that the enrollee may be referred to one of those providers; (d) the notice includes information about whether or not prior authorization or other care management limitations may be required before receiving an item or service at the in-network facility; (e) the notice clearly states that consent is optional and that the patient may elect to seek care from an in-network provider; (f) the notice is worded in plain language; (g) the notice is available in languages other than English, as identified by OCI; (h) the enrollee provides consent to the provider to be treated by the out-of-network provider, and the consent acknowledges that the enrollee has been informed that the charge paid by the enrollee may not meet a limitation that the enrollee's plan places on cost sharing, such as an in-network deductible; and (f) a signed copy of the consent is provided to the enrollee.

Specify that, to be considered adequate, the notice and consent described above shall meet one of the following requirements, as applicable: (a) if the enrollee makes an appointment for the item or service at least 72 hours before the day on which the item or service is to be provided, any notice shall be provided to the enrollee at least 72 hours before the day of the appointment at which the item or service is to be provided; or (b) if the enrollee makes an appointment for the item or service less than 72 hours before the day on which the item or service is to be provided, any notice shall be provided to the enrollee on the day that the appointment is made. Specify that the notice and consent may not extend to items or services furnished as a result of unforeseen, urgent medical

needs that arise at the time the item or service is provided. Require the provider to retain any consent provided under these provisions for no less than seven years.

Specify that, beginning no later than January 1, 2024, a health care provider or health care facility shall make available, including posting on a website, to enrollees in defined network plans, preferred provider plans, and self-insured governmental plans notice of the requirements applicable to providers or facilities under the provisions of this item and of any other applicable state law requirements on the provider or facility with respect to charging an enrollee for an item or service if the provider or facility does not have a contractual relationship with the plan, and of information on contacting appropriate state or federal agencies in the event the enrollee believes the provider or facility violates any of these requirements.

Negotiation and Dispute Resolution

Specify that an out-of-network provider or facility that is entitled to receive an initial payment or notice of denial under these provisions may initiate, within 30 days of receiving the initial payment or notice of denial, open negotiations with the defined network plan, preferred provider plan, or self-insured governmental plan to determine a payment amount for the emergency medical service or other item or service for a period that terminates 30 days after initiating open negotiations. Specify that if the open negotiation period terminates without determination of a payment amount, the provider, facility, defined network plan, preferred provider plan, or self-insured governmental plan may initiate, within the four days beginning on the day after the open negotiation period ends, the independent dispute resolution process as specified by OCI.

Specify that if the independent dispute resolution decision maker determines the payment amount, the party to the independent dispute resolution process whose amount was not selected shall pay the fees for the independent dispute resolution, but if the parties to the independent dispute resolution reach a settlement on the payment amount, the parties to the independent dispute resolution shall equally divide the payment for the fees for the independent dispute resolution.

Continuity of Care

Modify statutory provisions related to the billing for and coverage of services rendered to a continuing care enrollee in circumstances in which the status provider of those services changes from in-network to out-of-network provider of facility, as described below. Define, for the purposes of this provision, a "continuing care patient" as an individual who is any of the following: (a) undergoing a course of treatment for a serious and complex condition from a provider or facility; (b) undergoing a course of institutional or inpatient care from a provider or facility; (c) scheduled to undergo nonelective surgery, including receipt of postoperative care, from a provider or facility; (d) pregnant and undergoing a course of treatment for the pregnancy from a provider or facility; or (e) terminally ill and receiving treatment for the illness from a provider or facility. Define a "serious and complex condition" to mean any of the following: (a) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period.

Specify that if an enrollee is a continuing care patient and is obtaining items or services from an in-network provider or facility and the contract between the defined network plan, preferred provider plan, or self-insured governmental plan and the provider or facility is terminated because of a change in the terms of the participation of the provider or facility, or the contract between the plan and the provider or facility is terminated, resulting in a loss of benefits provided under the plan, the plan shall do all of the following: (a) notify each enrollee of the termination of the contract or benefits and of the right for the enrollee to elect to continue transitional care from the provider or facility; (b) provide the enrollee an opportunity to notify the plan of the need for transitional care; and (c) allow the enrollee to elect to continue to have the benefits provided under the plan under the same terms and conditions as would have applied to the item or service if the termination had not occurred for the course of treatment related to the enrollee's status as a continuing care patient beginning on the date on which the notice is provided and ending 90 days after the date on which the notice is provided or the date on which the enrollee is no longer a continuing care patient, whichever is earlier.

Specify that current law continuing care requirements shall not be applied in a manner that limits the enrollee's rights for, or length of, continuing care established under this item. Specify that a defined network plan may not contract or arrange with a participating provider for the provider to provide the notice that the plan is required to provide to enrollees under current law, of termination of the participating provider's participation in the plan's network.

Administrative Rules

Authorize OCI to promulgate any rules necessary to implement these provisions, including specifying the independent dispute resolution process and any modification to the list of those items and services for which a provider may not balance bill. Specify that, in promulgating these rules, OCI may consider any rules promulgated by the federal Department of Health and Human Services pursuant to the federal No Surprises Act.

[Bill Sections: 3050 and 3052]

7. TELEHEALTH COVERAGE PARITY

Governor: Prohibit any health insurance policy, state employee health plan, or governmental self-insured health plan from denying coverage of any treatment or service provided through telehealth on the basis that the treatment or service is provided through telehealth, if that treatment or service is covered by the policy or plan when provided in person. Specify that an insurance policy or health plan may limit coverage of treatments or services provided through telehealth to those treatments or services that are medically necessary. Specify that an insurance policy or health plan may not subject a treatment or services provided through telehealth to any of the following: (a) any greater deductible, copayment, or coinsurance amount than would be applicable if the treatment or service is provided in person; (b) any policy or calendar year or lifetime benefit limit or other maximum limitation that is not imposed on other treatments or services covered by the plan that are not provided through telehealth; (c) prior authorization requirements that are not required for the same treatment or service when provided in person; or (d) unique location requirements. Specify that an insurance policy or health plan that covers a

telehealth treatment or service that has no equivalent in-person treatment or service, such as remote patient monitoring, shall specify in policy or plan materials the coverage of that telehealth treatment or service.

Define "telehealth" as a practice of health care delivery, diagnosis, consultation, treatment, or transfer of medically relevant data by means of audio, video, or data communications that are used either during a patient visit or consultation or are used to transfer medically relevant data about a patient. Specify that the term "telehealth" does not include communications delivered solely by audio-only telephone, facsimile machine, or e-mail unless specified otherwise by rule.

Specify that for policies or plans containing provisions inconsistent with the requirements in this item, the requirements first apply to policy or plan years beginning on January 1 of the year following the effective date of the bill, except that for policies or plans that are affected by a collective bargaining agreement that are inconsistent, the requirement first applies to plan years beginning on the effective date of the bill or on the day on which the collective bargaining agreement is newly established, modified, or renewed, whichever is later.

[Bill Sections: 727, 728, 1177, 2219, 2402, 2921, 3056, 3058, 3065, 3095, and 9323(1)]

8. COVERAGE OF INFERTILITY SERVICES

Governor: Specify that any health insurance policy, including any preferred provider plan or defined network plan, and any government self-insured health plan that provides coverage for medical or hospital expenses shall cover diagnosis of, and treatment for, infertility and standard fertility preservation services. Specify that the coverage, for the purposes of this requirement, must include at least four completed oocyte retrievals with unlimited embryo transfers, in accordance with the guidelines of the American Society for Reproductive Medicine or its successor organization, and that a single embryo transfer may be used when recommended and medically appropriate. Specify that the policy or plan must provide coverage of infertility services to any covered individual under the policy or plan, including any spouse or nonspouse dependent, to the same extent as other pregnancy-related benefits covered under the policy or plan.

Specify that a policy or plan may not do any of the following: (a) impose any exclusions, limitations, or other restrictions on coverage of infertility services based on a covered individual's participation in fertility services provided by or to a third party; (b) impose any exclusion, limitation, or other restriction on coverage of medications that are required to be covered for infertility services that are different from those imposed on any other prescription medications covered under the policy or plan; or (c) impose any exclusion, limitation, cost-sharing requirement, benefit maximum, waiting period, or other restriction on the diagnosis of and treatment for infertility and standard fertility preservation services that is different from an exclusion, limitation, cost-sharing requirement, benefit maximum, waiting period, or other restriction imposed on benefits for services that are covered by the policy or plan and that are not related to infertility.

Specify that these coverage requirements do not apply to coverage that is only accident or disability income insurance, supplemental liability insurance, worker's compensation coverage, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar coverage under which benefits for medical care are secondary or incidental

to other insurance benefits.

Define terms, for the purposes of these provisions ,as follows: (a) "infertility" means a disease, condition, or status characterized by any of the following: (i) the failure to establish a pregnancy or carry a pregnancy to a live birth after regular, unprotected sexual intercourse for, if the woman is under the age of 35, no longer than 12 months or, if the woman is 35 years of age or older, no longer than six months, including any time during those 12 months or six months that the woman has a pregnancy that results in a miscarriage; (ii) an individual's inability to reproduce either as a single individual or with a partner without medical intervention; (iii) a physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing; (b) "diagnosis of and treatment for infertility" means any recommended procedure or medication to treat infertility at the direction of a physician that is consistent with established, published, or approved medical practices or professional guidelines from the American College of Obstetricians and Gynecologists, or its successor organization, or the American Society for Reproductive Medicine, or its successor organization; and (c) "standard fertility preservation service" means a procedure that is consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine or its successor organization, or the American Society of Clinical Oncology or its successor organization, for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

Require OCI, after consulting with the Department of Health Services on appropriate treatment for infertility, to promulgate any rules necessary to implement these requirements. Specify that before the promulgation of rules, policies and plans are considered to be in compliance with the coverage requirements if the coverage conforms to the standards of the American Society for Reproductive Medicine.

Specify that these provisions first apply to policy or plan years beginning on January 1 of the year following the year of the first day of the fourth month beginning after the bill's general effective date, or, for policies and plans that are affected by a collective bargaining agreement containing provisions that are inconsistent with these coverage requirements, to policy or plan years beginning on the day on which the collective bargaining agreement is entered into, extended, modified, or renewed, whichever is later. Specify that for policies and plans that have a term greater than one year and contain provisions inconsistent with these provisions, the coverage requirements first apply to policy or plan years beginning on January 1 of the year following the year in which the policy or plan is extended, modified, or renewed, whichever is later.

[Bill Sections: 3057, 3107, 9323(6), and 9423(6)]

9. COVERAGE OF SUBSTANCE ABUSE COUNSELOR SERVICES

Governor: Specify that no health insurance policy, limited service health organization, preferred provider plan, defined network plan, or government self-insured health plan may exclude coverage for alcoholism or other drug abuse treatment or services provided by a substance abuse counselor within the scope of the substance abuse counselor's education and training if the policy

or plan covers the alcoholism or other drug abuse treatment or services when provided by another health care provider.

Specify that this provision first applies to policy or plan years beginning on January 1 of the year following the year of the first day of the fourth month beginning after the bill's general effective date, or, for policies and plans that are affected by a collective bargaining agreement containing provisions that are inconsistent with the bill, to policy or plan years beginning on the day on which the collective bargaining agreement is entered into, extended, modified, or renewed, whichever is later.

[Bill Sections: 727, 728, 1177, 2219, 2402, 3055, 3094, 9323(2), and 9423(2)]

10. COVERAGE OF BEHAVIORAL HEALTH SERVICES PROVIDED BY A QUALIFIED TREATMENT TRAINEE

Governor: Prohibit any health insurance policy, limited service health organization, preferred provider plan, defined network plan, or government self-insured health plan from excluding coverage for mental health or behavioral health treatment or services provided by a qualified treatment trainee within the scope of the qualified treatment trainee's education and training if the policy or plan covers the mental health or behavioral health treatment or services when provided by another health care provider.

Define "qualified treatment trainee" for the purposes of this provision using a cross reference to a definition of the term in a DHS administrative rule relating to outpatient mental health clinics, in which the term means either: (a) a graduate student who is enrolled in an accredited institution in psychology, counseling, marriage and family therapy, social work, nursing or a closely related field; or (b) a person with a graduate degree from an accredited institution and course work in psychology, counseling, marriage and family therapy, social work, nursing or a closely related field who has not yet completed the supervised practice requirements applicable to the degree.

Specify that this provision first applies to policy or plan years beginning on January 1 of the year following the year of the first day of the fourth month beginning after the bill's general effective date, or, for policies and plans that are affected by a collective bargaining agreement containing provisions that are inconsistent with the bill, to policy or plan years beginning on the day on which the collective bargaining agreement is entered into, extended, modified, or renewed, whichever is later.

[Bill Sections: 727, 728, 1177, 2219, 2402, 3054, 3093, 9323(4), and 9423(5)]