State of Wisconsin
2023 - 2024 LEGISLATURE

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2023 ASSEMBLY BILL 773

December 8, 2023 - Introduced by Representatives SCHRAA, ROZAR, TITTL, CONLEY, DITTRICH, DONOVAN, EDMING, GOEBEN, GOYKE, GUNDRUM, JACOBSON, MAGNAFICI, MURSAU, NOVAK, O'CONNOR, OLDENBURG, PALMERI, SNYDER, TUSLER, WICHGERS and RETTINGER, cosponsored by Senators FELZKOWSKI, QUINN, JAMES, PFAFF and TAYLOR. Referred to Committee on Health, Aging and Long-Term Care.

AUTHORS SUBJECT TO CHANGE

AN ACT ***to repeal*** 632.865 (2) and 632.865 (5) (e); ***to renumber*** 632.865 (4); ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.83, 632.861 (4) (a), 632.865 (1) (ae) and 632.865 (6) (c) 3.; and ***to create*** 632.861 (1m), 632.861 (3g), 632.861 (3r), 632.861 (4) (e), 632.862, 632.865 (1) (ab) and (ac), 632.865 (1) (an), (aq), and (at), 632.865 (1) (bm), 632.865 (1) (cg) and (cr), 632.865 (2d), 632.865 (2h), 632.865 (2p), 632.865 (2t), 632.865 (4) (b), 632.865 (5d), (5h), (5p) and (5t), 632.865 (6) (bm), 632.865 (6) (c) 3m., 632.865 (6g), 632.865 (6r) and 632.865 (8) of the statutes; **relating to:** regulation of pharmacy benefit managers, fiduciary and disclosure requirements on pharmacy benefit managers, and application of prescription drug payments to health insurance cost-sharing requirements.

Analysis by the Legislative Reference Bureau

This bill makes several changes to the regulation of pharmacy benefit managers and their interactions with pharmacies and pharmacists. Under current law, pharmacy benefit managers are generally required to be licensed as a pharmacy benefit manager or an employee benefit plan administrator by the commissioner of

insurance. A pharmacy benefit manager is an entity that contracts to administer or manage prescription drug benefits on behalf of an insurer, a cooperative, or another entity that provides prescription drug benefits to Wisconsin residents. Major provisions of the bill are summarized below.

Pharmacy benefit manager regulation

The bill requires a pharmacy benefit manager to pay a pharmacy or pharmacist a professional dispensing fee at a rate not less than is paid by the state under the Medical Assistance program for each pharmaceutical product that the pharmacy or pharmacist dispenses to an individual. The professional dispensing fee is required to be paid in addition to the amount the pharmacy benefit manager reimburses the pharmacy or pharmacist for the cost of the pharmaceutical product that the pharmacy or pharmacist dispenses. The Medical Assistance program is a joint state and federal program that provides health services to individuals who have limited financial resources.

The bill prohibits a pharmacy benefit manager from assessing, charging, or collecting from a pharmacy or pharmacist any form of remuneration that passes from the pharmacy or pharmacist to the pharmacy benefit manager including claim–processing fees, performance–based fees, network–participation fees, or accreditation fees.

Further, under the bill, a pharmacy benefit manager may not use any certification or accreditation requirement as a determinant of pharmacy network participation that is inconsistent with, more stringent than, or in addition to the federal requirements for licensure as a pharmacy and the requirements for licensure as a pharmacy provided under state law.

The bill requires a pharmacy benefit manager to allow a participant or beneficiary of a pharmacy benefits plan or program that the pharmacy benefit manager serves to use any pharmacy or pharmacist in this state that is licensed to dispense the pharmaceutical product that the participant or beneficiary seeks to obtain if the pharmacy or pharmacist accepts the same terms and conditions that the pharmacy benefit manager establishes for at least one of the networks of pharmacies or pharmacists that the pharmacy benefit manager has established to serve individuals in the state. A pharmacy benefit manager may establish a preferred network of pharmacies or pharmacists and a nonpreferred network of pharmacies or pharmacists, however, under the bill, a pharmacy benefit manager may not prohibit a pharmacy or pharmacist from participating in either type of network provided that the pharmacy or pharmacist is licensed by this state and the federal government and accepts the same terms and conditions that the pharmacy benefit manager establishes for other pharmacies or pharmacists participating in the network that the pharmacy or pharmacist wants to join. Under the bill, a pharmacy benefit manager may not charge a participant or beneficiary of a pharmacy benefits plan or program that the pharmacy benefit manager serves a different copayment obligation or additional fee, or provide any inducement or financial incentive, for the participant or beneficiary to use a pharmacy or pharmacist in a particular network of pharmacies or pharmacists that the pharmacy benefit manager has established to serve individuals in the state. Further, the bill prohibits a pharmacy benefit

manager, 3rd–party payer, or health benefit plan from excluding a pharmacy or pharmacist from its network because the pharmacy or pharmacist serves less than a certain portion of the population of the state or serves a population living with certain health conditions.

The bill provides that a pharmacy benefit manager may neither prohibit a pharmacy or pharmacist that dispenses a pharmaceutical product from, nor penalize a pharmacy or pharmacist that dispenses a pharmaceutical product for, informing an individual about the cost of the pharmaceutical product, the amount in reimbursement that the pharmacy or pharmacist receives for dispensing the pharmaceutical product, or any difference between the cost to the individual under the individual's pharmacy benefits plan or program and the cost to the individual if the individual purchases the pharmaceutical product without making a claim for benefits under the individual's pharmacy benefits plan or program.

The bill prohibits any pharmacy benefit manager or any insurer or self–insured health plan from requiring or penalizing a person who is covered under a health insurance policy or plan for using or for not using a specific retail, mail–order, or other pharmacy provider within the network of pharmacy providers under the policy or plan. Prohibited penalties include an increase in premium, deductible, copayment, or coinsurance.

Pharmaceutical product reimbursements

The bill provides that a pharmacy benefit manager that uses a maximum allowable cost list must include all of the following information on the list: 1) the average acquisition cost of each pharmaceutical product and the cost of the pharmaceutical product set forth in the national average drug acquisition cost data published by the federal centers for medicare and medicaid services; 2) the average manufacturer price of each pharmaceutical product; 3) the average wholesale price of each pharmaceutical product; 4) the brand effective rate or generic effective rate for each pharmaceutical product; 5) any applicable discount indexing; 6) the federal upper limit for each pharmaceutical product published by the federal centers for medicare and medicaid services; 7) the wholesale acquisition cost of each pharmaceutical product; and 8) any other terms that are used to establish the maximum allowable costs.

The bill provides that a pharmacy benefit manager may place or continue a particular pharmaceutical product on a maximum allowable cost list only if the pharmaceutical product 1) is listed as a drug product equivalent or is rated by a nationally recognized reference as "not rated" or "not available"; 2) is available for purchase by all pharmacies and pharmacists in the state from national or regional pharmaceutical wholesalers operating in the state; and 3) has not been determined by the drug manufacturer to be obsolete. Further, the bill provides that any pharmacy benefit manager that uses a maximum allowable cost list must provide access to the maximum allowable cost list to each pharmacy or pharmacist subject to the maximum allowable cost list, update the maximum allowable cost list on a timely basis, provide a process for a pharmacy or pharmacist subject to the maximum allowable cost list to receive notification of an update to the maximum allowable cost list, and update the maximum allowable cost list no later than seven days after the

pharmacy acquisition cost of the pharmaceutical product increases by 10 percent or more from at least 60 percent of the pharmaceutical wholesalers doing business in the state or there is a change in the methodology on which the maximum allowable cost list is based or in the value of a variable involved in the methodology. A maximum allowable cost list is a list of pharmaceutical products that sets forth the maximum amount that a pharmacy benefit manager will pay to a pharmacy or pharmacist for dispensing a pharmaceutical product. A maximum allowable cost list may directly establish maximum costs or may set forth a method for how the maximum costs are calculated.

The bill further provides that a pharmacy benefit manager that uses a maximum allowable cost list must provide a process for a pharmacy or pharmacist to appeal and resolve disputes regarding claims that the maximum payment amount for a pharmaceutical product is below the pharmacy acquisition cost. A pharmacy benefit manager that receives an appeal from or on behalf of a pharmacy or pharmacist under this bill is required to resolve the appeal and notify the pharmacy or pharmacist of the pharmacy benefit manager's determination no later than seven business days after the appeal is received. If the pharmacy benefit manager grants the relief requested in the appeal, the bill requires the pharmacy benefit manager to make the requested change in the maximum allowable cost, allow the pharmacy or pharmacist to reverse and rebill the relevant claim, provide to the pharmacy or pharmacist the national drug code number published in a directory by the federal Food and Drug Administration on which the increase or change is based, and make the change effective for each similarly situated pharmacy or pharmacist subject to the maximum allowable cost list. If the pharmacy benefit manager denies the relief requested in the appeal, the bill requires the pharmacy benefit manager to provide the pharmacy or pharmacist a reason for the denial, the national drug code number published in a directory by the FDA for the pharmaceutical product to which the claim relates, and the name of a national or regional wholesaler that has the pharmaceutical product currently in stock at a price below the amount specified in the pharmacy benefit manager's maximum allowable cost list.

The bill provides that a pharmacy benefit manager may not deny a pharmacy's or pharmacist's appeal if the relief requested in the appeal relates to the maximum allowable cost for a pharmaceutical product that is not available for the pharmacy or pharmacist to purchase at a cost that is below the pharmacy acquisition cost from the pharmaceutical wholesaler from which the pharmacy or pharmacist purchases the majority of pharmaceutical products for resale. If a pharmaceutical product is not available for a pharmacy or pharmacist to purchase at a cost that is below the pharmacy acquisition cost from the pharmaceutical wholesaler from which the pharmacy or pharmacist purchases the majority of pharmaceutical products for resale, the pharmacy benefit manager must revise the maximum allowable cost list to increase the maximum allowable cost for the pharmaceutical product to an amount equal to or greater than the pharmacy's or pharmacist's pharmacy acquisition cost and allow the pharmacy or pharmacist to reverse and rebill each claim affected by the pharmacy's or pharmacist's inability to procure the

pharmaceutical product at a cost that is equal to or less than the maximum allowable cost that was the subject of the pharmacy's or pharmacist's appeal.

The bill prohibits a pharmacy benefit manager from reimbursing a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmaceutical product. Under the bill, a pharmacy benefit manager affiliate is a pharmacy or pharmacist that is an affiliate of a pharmacy benefit manager.

Finally, the bill allows a pharmacy or pharmacist to decline to provide a pharmaceutical product to an individual or pharmacy benefit manager if, as a result of a maximum allowable cost list, the pharmacy or pharmacist would be paid less than the pharmacy acquisition cost of the pharmacy or pharmacist providing the pharmaceutical product.

Drug formularies

This bill makes several changes with respect to drug formularies. Under current law, a disability insurance policy that offers a prescription drug benefit, a self–insured health plan that offers a prescription drug benefit, or a pharmacy benefit manager acting on behalf of a disability insurance policy or self–insured health plan must provide to an enrollee advanced written notice of a formulary change that removes a prescription drug from the formulary of the policy or plan or that reassigns a prescription drug to a benefit tier for the policy or plan that has a higher deductible, copayment, or coinsurance. The advanced written notice of a formulary change must be provided no fewer than 30 days before the expected date of the removal or reassignment.

This bill provides that a disability insurance policy or self–insured health plan that provides a prescription drug benefit shall make the formulary and all drug costs associated with the formulary available to plan sponsors and individuals prior to selection or enrollment. Further, the bill provides that no disability insurance policy, self–insured health plan, or pharmacy benefit manager acting on behalf of a disability insurance policy or self–insured health plan may remove a prescription drug from the formulary except at the time of coverage renewal. Finally, the bill provides that advanced written notice of a formulary change must be provided no fewer than 90 days before the expected date of the removal or reassignment of a prescription drug on the formulary.

Pharmacy networks

Under the bill, if an enrollee utilizes a pharmacy or pharmacist in a preferred network of pharmacies or pharmacists, no disability insurance policy or self–insured health plan that provides a prescription drug benefit or pharmacy benefit manager that provides services under a contract with a policy or plan may require the enrollee to pay any amount or impose on the enrollee any condition that would not be required if the enrollee utilized a different pharmacy or pharmacist in the same preferred network. Further, the bill provides that any disability insurance policy or self–insured health plan that provides a prescription drug benefit, or any pharmacy benefit manager that provides services under a contract with a policy or plan, that has established a preferred network of pharmacies or pharmacists must reimburse each pharmacy or pharmacist in the same network at the same rates.

Audits of pharmacists and pharmacies

This bill makes several changes to audits of pharmacists and pharmacies. The bill requires an entity that conducts audits of pharmacists and pharmacies to ensure that each pharmacist or pharmacy audited by the entity is audited under the same standards and parameters as other similarly situated pharmacists or pharmacies audited by the entity, that the entity randomizes the prescriptions that the entity audits and the entity audits the same number of prescriptions in each prescription benefit tier, and that each audit of a prescription reimbursed under Part D of the federal Medicare program is conducted separately from audits of prescriptions reimbursed under other policies or plans. The bill prohibits any pharmacy benefit manager from recouping reimbursements made to a pharmacist or pharmacy for errors that involve no actual financial harm to an enrollee, policy, or plan unless the error is the result of the pharmacist or pharmacy failing to comply with a formal corrective action plan. The bill further prohibits any pharmacy benefit manager from using extrapolation in calculating reimbursements that it may recoup, and instead requires a pharmacy benefit manager to base the finding of errors for which reimbursements will be recouped on an actual error in reimbursement and not a projection of the number of patients served having a similar diagnosis or on a projection of the number of similar orders or refills for similar prescription drugs. The bill requires that a pharmacy benefit manager that recoups any reimbursements made to a pharmacist or pharmacy for an error that was the cause of financial harm must return the recouped reimbursement to the individual or the policy or plan sponsor who was harmed by the error.

Pharmacy benefit manager fiduciary and disclosure requirements

The bill provides that a pharmacy benefit manager owes a fiduciary duty to a health benefit plan sponsor. The bill also requires that a pharmacy benefit manager annually disclose all of the following information to the health benefit plan sponsor:

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

2. Any payments made to a consultant or broker who works on behalf of the plan sponsor.

3. From the amounts received from drug manufacturers, the amounts retained by the pharmacy benefit manager that are related to the plan sponsor's claims or bona fide service fees.

4. The amounts received from network pharmacies and pharmacists and the amount retained by the pharmacy benefit manager.

Discriminatory reimbursement of 340B entities

The bill prohibits a pharmacy benefit manager from taking certain actions with respect to 340B covered entities, pharmacies and pharmacists contracted with 340B covered entities, and patients who obtain prescription drugs from 340B covered entities. The 340B drug pricing program is a federal program that requires pharmaceutical manufacturers that participate in the federal Medicaid program to sell outpatient drugs at discounted prices to certain health care organizations that provide health care for uninsured and low–income patients. Entities that are eligible for discounted prices under the 340B drug pricing program include

federally–qualified health centers, critical access hospitals, and certain public and nonprofit disproportionate share hospitals. The bill prohibits pharmacy benefit managers from doing any of the following:

1. Refusing to reimburse a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity for dispensing 340B drugs.

2. Imposing requirements or restrictions on 340B covered entities or pharmacies or pharmacists contracted with 340B covered entities that are not imposed on other entities, pharmacies, or pharmacists.

3. Reimbursing a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity for a 340B drug at a rate lower than the amount paid for the same drug to pharmacies or pharmacists that are not 340B covered entities or pharmacies or pharmacists contracted with a 340B covered entity.

4. Restricting the access of a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity to a 3rd–party payer's pharmacy network solely because the 340B covered entity or the pharmacy or pharmacist contracted with a 340B covered entity participates in the 340B drug pricing program.

5. Requiring a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity to contract with a specific pharmacy or pharmacist or health benefit plan in order to access a 3rd–party payer's pharmacy network.

6. Restricting the methods by which a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity may dispense or deliver 340B drugs.

Application of prescription drug payments

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

Prohibited retaliation

The bill prohibits a pharmacy benefit manager from retaliating against a pharmacy or pharmacist for reporting an alleged violation of certain laws applicable to pharmacy benefit managers or for exercising certain rights or remedies. Retaliation includes terminating or refusing to renew a contract with a pharmacy or pharmacist, subjecting a pharmacy or pharmacist to increased audits, or failing to promptly pay a pharmacy or pharmacist any money that the pharmacy benefit manager owes to the pharmacy or pharmacist. The bill provides that a pharmacy or pharmacist may bring an action in court for injunctive relief if a pharmacy benefit manager is retaliating against the pharmacy or pharmacist as provided in the bill.

In addition to equitable relief, the court may award a pharmacy or pharmacist that prevails in such an action reasonable attorney fees and costs.

For further information see the state fiscal estimate, which will be printed as an appendix to this bill.

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 7. 632.861 (1m) of the statutes is created to read:

632.861 **(1m)** REQUIRED DISCLOSURES. A disability insurance policy or self–insured health plan that provides a prescription drug benefit shall make the formulary and all drug costs associated with the formulary available to plan sponsors and individuals prior to selection or enrollment.

SECTION 8. 632.861 (3g) of the statutes is created to read:

632.861 **(3g)** CHOICE OF PROVIDER; PENALTY PROHIBITED. No insurer, self–insured health plan, or pharmacy benefit manager may require, or penalize a person who is

covered under a disability insurance policy or self–insured health plan for using or for not using, a specific retail, specific mail–order, or other specific pharmacy provider within the network of pharmacy providers under the policy or plan. A prohibited penalty under this subsection includes an increase in premium, deductible, copayment, or coinsurance.

SECTION 9. 632.861 (3r) of the statutes is created to read:

632.861 **(3r)** PHARMACY NETWORKS. (a) If an enrollee utilizes a pharmacy or pharmacist in a preferred network of pharmacies or pharmacists, no disability insurance policy or self–insured health plan that provides a prescription drug benefit or pharmacy benefit manager that provides services under a contract with a policy or plan may require the enrollee to pay any amount or impose on the enrollee any condition that would not be required if the enrollee utilized a different pharmacy or pharmacist in the same preferred network.

(b) Any disability insurance policy or self–insured health plan that provides a prescription drug benefit, or any pharmacy benefit manager that provides services under a contract with a policy or plan, that has established a preferred network of pharmacies or pharmacists shall reimburse each pharmacy or pharmacist in the same network at the same rates.

SECTION 10. 632.861 (4) (a) of the statutes is amended to read:

632.861 **(4)** (a) Except as provided in par. (b) and subject to par. (e), a disability insurance policy that offers a prescription drug benefit, a self–insured health plan that offers a prescription drug benefit, or a pharmacy benefit manager acting on behalf of a disability insurance policy or self–insured health plan shall provide to an enrollee advanced written notice of a formulary change that removes a prescription drug from the formulary of the policy or plan or that reassigns a prescription drug

to a benefit tier for the policy or plan that has a higher deductible, copayment, or coinsurance. The advanced written notice of a formulary change under this paragraph shall be provided no fewer than ~~30~~ 90 days before the expected date of the removal or reassignment and shall include information on the procedure for the enrollee to request an exception to the formulary change. The policy, plan, or pharmacy benefit manager is required to provide the advanced written notice under this paragraph only to those enrollees in the policy or plan who are using the drug at the time the notification must be sent according to available claims history.

SECTION 11. 632.861 (4) (e) of the statutes is created to read:

632.861 **(4)** (e) No disability insurance policy, self–insured health plan, or pharmacy benefit manager acting on behalf of a disability insurance policy or self–insured health plan may remove a prescription drug from the formulary except at the time of coverage renewal.

SECTION 12. 632.862 of the statutes is created to read:

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

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

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

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

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

a. Prior authorization.

b. A step therapy protocol.

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

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

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

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

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

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

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

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

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

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

SECTION 13. 632.865 (1) (ab) and (ac) of the statutes are created to read:

632.865 **(1)** (ab) "340B covered entity" has the meaning given for "covered entity" under 42 USC 256b (a) (4).

(ac) "340B drug" has the meaning given for "covered drug" under 42 USC 256b (b) (2).

SECTION 14. 632.865 (1) (ae) of the statutes is amended to read:

632.865 **(1)** (ae) "Health benefit plan" ~~has the meaning given~~ means a health benefit plan, as defined in s. 632.745 (11), that is not prescription drug coverage

provided under part D of medicare under Title XVIII of the federal Social Security Act, 42 USC 1395 to 1395lll.

SECTION 15. 632.865 (1) (an), (aq), and (at) of the statutes are created to read:

632.865 **(1)** (an) "Maximum allowable cost list" means a list of pharmaceutical products that sets forth the maximum amount a pharmacy benefit manager will pay to a pharmacy or pharmacist for dispensing a pharmaceutical product. The list may directly establish the maximum amounts or set forth a method for how the maximum amounts are calculated.

(aq) "Pharmaceutical product" means a prescription generic drug, prescription brand–name drug, prescription biologic, or other prescription drug, vaccine, or device.

(at) "Pharmaceutical wholesaler" means a person that sells and distributes, directly or indirectly, a pharmaceutical product and that offers to deliver the pharmaceutical product to a pharmacy or pharmacist.

SECTION 16. 632.865 (1) (bm) of the statutes is created to read:

632.865 **(1)** (bm) "Pharmacy acquisition cost" means the amount that a pharmaceutical wholesaler charges a pharmacy or pharmacist for a pharmaceutical product as listed on the pharmacy's or pharmacist's billing invoice.

SECTION 17. 632.865 (1) (cg) and (cr) of the statutes are created to read:

632.865 **(1)** (cg) "Pharmacy benefit manager affiliate" means a pharmacy or pharmacist that is an affiliate of a pharmacy benefit manager.

(cr) "Pharmacy services administrative organization" means an entity that provides contracting and other administrative services to pharmacies or pharmacists to assist them in their interactions with 3rd–party payers, pharmacy benefit managers, pharmaceutical wholesalers, and other entities.

SECTION 18. 632.865 (2) of the statutes is repealed.

SECTION 19. 632.865 (2d) of the statutes is created to read:

632.865 **(2d)** PHARMACEUTICAL PRODUCT REIMBURSEMENTS. (ag) *Contents of maximum allowable cost lists.* A pharmacy benefit manager that uses a maximum allowable cost list shall include all of the following information on the maximum allowable cost list:

1. The average acquisition cost of each pharmaceutical product and the cost of the pharmaceutical product set forth in the national average drug acquisition cost data published by the federal centers for medicare and medicaid services.

2. The average manufacturer price of each pharmaceutical product.

3. The average wholesale price of each pharmaceutical product.

4. The brand effective rate or generic effective rate for each pharmaceutical product.

5. Any applicable discount indexing.

6. The federal upper limit for each pharmaceutical product published by the federal centers for medicare and medicaid services.

7. The wholesale acquisition cost of each pharmaceutical product.

8. Any other terms that are used to establish the maximum allowable costs.

(ar) *Regulation of maximum allowable cost lists.* A pharmacy benefit manager may place or continue a particular pharmaceutical product on a maximum allowable cost list only if all of the following apply to the pharmaceutical product:

1. The pharmaceutical product is listed as a drug product equivalent, as defined in s. 450.13 (1e), or is rated by a nationally recognized reference, such as Medi–Span or Gold Standard Drug Database, as “not rated” or “not available.”

2. The pharmaceutical product is available for purchase by all pharmacies and pharmacists in this state from national or regional pharmaceutical wholesalers operating in this state.

3. The pharmaceutical product has not been determined by the drug manufacturer to be obsolete.

(b) *Access and update obligations.* A pharmacy benefit manager that uses a maximum allowable cost list shall do all of the following:

1. Provide access to the maximum allowable cost list to each pharmacy or pharmacist subject to the maximum allowable cost list.

2. Update the maximum allowable cost list on a timely basis.

3. Update the maximum allowable cost list no later than 7 days after any of the following occurs:

a. The pharmacy acquisition cost of a pharmaceutical product increases by 10 percent or more from at least 60 percent of the pharmaceutical wholesalers doing business in this state.

b. There is a change in the methodology on which the maximum allowable cost list is based or in the value of a variable involved in the methodology.

4. Provide a process for a pharmacy or pharmacist subject to the maximum allowable cost list to receive prompt notification of an update to the maximum allowable cost list.

(c) *Appeal process.* 1. A pharmacy benefit manager that uses a maximum allowable cost list shall provide a process for a pharmacy or pharmacist to appeal and resolve disputes regarding claims that the maximum payment amount for a pharmaceutical product is below the pharmacy acquisition cost.

2. A pharmacy benefit manager required to provide an appeal process under subd. 1. shall do all of the following:

a. Provide a dedicated telephone number and email address or website that a pharmacy or pharmacist may use to submit an appeal.

b. Allow a pharmacy or pharmacist to submit an appeal directly on the pharmacy's or pharmacist's own behalf.

c. Allow a pharmacy services administrative organization to submit an appeal on behalf of a pharmacy or pharmacist.

d. Provide at least 7 business days after a customer transaction for a pharmacy or pharmacist to submit an appeal under this paragraph concerning a pharmaceutical product involved in the transaction.

3. A pharmacy benefit manager that receives an appeal from or on behalf of a pharmacy or pharmacist under this paragraph shall resolve the appeal and notify the pharmacy or pharmacist of the pharmacy benefit manager's determination no later than 7 business days after the appeal is received by doing any of the following:

a. If the pharmacy benefit manager grants the relief requested in the appeal, the pharmacy benefit manager shall make the requested change in the maximum allowable cost; allow the pharmacy or pharmacist to reverse and rebill the relevant claim; provide to the pharmacy or pharmacist the national drug code number published in a directory by the federal food and drug administration on which the increase or change is based; and make the change effective for each similarly situated pharmacy or pharmacist subject to the maximum allowable cost list.

b. If the pharmacy benefit manager denies the relief requested in the appeal, the pharmacy benefit manager shall provide to the pharmacy or pharmacist a reason for the denial, the national drug code number published in a directory by the federal

food and drug administration for the pharmaceutical product to which the claim relates, and the name of a national or regional pharmaceutical wholesaler operating in this state that has the pharmaceutical product currently in stock at a price below the amount specified in the pharmacy benefit manager's maximum allowable cost list.

4. Notwithstanding subd. 3. b., a pharmacy benefit manager may not deny a pharmacy's or pharmacist's appeal under this paragraph if the relief requested in the appeal relates to the maximum allowable cost for a pharmaceutical product that is not available for the pharmacy or pharmacist to purchase at a cost that is below the pharmacy acquisition cost from the pharmaceutical wholesaler from which the pharmacy or pharmacist purchases the majority of pharmaceutical products for resale. If this subdivision applies, the pharmacy benefit manager shall revise the maximum allowable cost list to increase the maximum allowable cost for the pharmaceutical product to an amount equal to or greater than the pharmacy's or pharmacist's pharmacy acquisition cost and allow the pharmacy or pharmacist to reverse and rebill each claim affected by the pharmacy's or pharmacist's inability to procure the pharmaceutical product at a cost that is equal to or less than the maximum allowable cost that was the subject of the pharmacy's or pharmacist's appeal.

(d) *Affiliated reimbursements.* A pharmacy benefit manager may not reimburse a pharmacy or pharmacist in this state an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmaceutical product. The reimbursement amount shall be calculated on a per unit basis based on the same generic product identifier or generic code number, if applicable.

(e) *Declining to dispense.* A pharmacy or pharmacist may decline to provide a pharmaceutical product to an individual or pharmacy benefit manager if, as a result of the applicable maximum allowable cost list, the pharmacy or pharmacist would be paid less than the pharmacy acquisition cost of the pharmacy or pharmacist providing the pharmaceutical product.

SECTION 20. 632.865 (2h) of the statutes is created to read:

632.865 **(2h)** PROFESSIONAL DISPENSING FEES. A pharmacy benefit manager shall pay a pharmacy or pharmacist a professional dispensing fee at a rate not less than is paid by this state under the medical assistance program under subch. IV of ch. 49 for each pharmaceutical product that the pharmacy or pharmacist dispenses to an individual. The fee shall be calculated on a per unit basis based on the same generic product identifier or generic code number, if applicable. The pharmacy benefit manager shall pay the professional dispensing fee in addition to the amount the pharmacy benefit manager reimburses the pharmacy or pharmacist for the cost of the pharmaceutical product that the pharmacy or pharmacist dispenses to the individual.

SECTION 21. 632.865 (2p) of the statutes is created to read:

632.865 **(2p)** PHARMACY BENEFIT MANAGER–IMPOSED FEES PROHIBITED. A pharmacy benefit manager may not assess, charge, or collect any form of remuneration that passes from a pharmacy or pharmacist to the pharmacy benefit manager, including claim–processing fees, performance–based fees, network–participation fees, or accreditation fees.

SECTION 22. 632.865 (2t) of the statutes is created to read:

632.865 **(2t)** FIDUCIARY DUTY AND DISCLOSURES TO HEALTH BENEFIT PLAN SPONSORS. (a) A pharmacy benefit manager owes a fiduciary duty to the health benefit plan

sponsor to act according to the health benefit plan sponsor's instructions and in the best interests of the health benefit plan sponsor.

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

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

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

3. From the amounts received from all drug manufacturers, the amounts retained by the pharmacy benefit manager, and not passed through to the health benefit plan sponsor, that are related to the health benefit plan sponsor's claims or bona fide service fees.

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

SECTION 23. 632.865 (4) of the statutes is renumbered 632.865 (4) (a).

SECTION 24. 632.865 (4) (b) of the statutes is created to read:

632.865 **(4)** (b) A pharmacy benefit manager may not use any certification or accreditation requirement as a determinant of pharmacy network participation that is inconsistent with, more stringent than, or in addition to the federal requirements for licensure as a pharmacy and the requirements for licensure as a pharmacy under s. 450.06 or 450.065.

SECTION 25. 632.865 (5) (e) of the statutes is repealed.

SECTION 26. 632.865 (5d), (5h), (5p) and (5t) of the statutes are created to read:

632.865 **(5d)** DISCRIMINATORY REIMBURSEMENT PROHIBITED. (a) In this subsection, "3rd–party payer" means an entity, other than a patient or health care provider, that reimburses for and manages health care expenses.

(b) A pharmacy benefit manager may not do any of the following:

1. Refuse to reimburse a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity for dispensing 340B drugs.

2. Impose requirements or restrictions on 340B covered entities or pharmacies or pharmacists contracted with 340B covered entities that are not imposed on other entities, pharmacies, or pharmacists.

3. Reimburse a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity for a 340B drug at a rate lower than the amount paid for the same drug to pharmacies or pharmacists that are not 340B covered entities or pharmacies or pharmacists contracted with a 340B covered entity.

4. Assess a fee, charge back, or other adjustment against a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity after a claim has been paid or adjudicated.

5. Restrict the access of a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity to a 3rd–party payer's pharmacy network solely because the 340B covered entity or the pharmacy or pharmacist contracted with a 340B covered entity participates in the 340B drug pricing program under 42 USC 256b.

6. Require a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity to contract with a specific pharmacy or pharmacist or health benefit plan in order to access a 3rd–party payer's pharmacy network.

7. Impose a restriction or an additional charge on a patient who obtains a 340B drug from a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity.

8. Restrict the methods by which a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity may dispense or deliver 340B drugs.

9. Require a 340B covered entity or a pharmacy or pharmacist contracted with a 340B covered entity to share pharmacy bills or invoices with a pharmacy benefit manager, a 3rd–party payer, or a health benefit plan.

(5h) REGULATION OF PHARMACY NETWORKS AND INDIVIDUAL CHOICE. All of the following apply to a pharmacy benefit manager that sells access to networks of pharmacies or pharmacists that operate in this state:

(a) The pharmacy benefit manager shall allow a participant or beneficiary of a pharmacy benefits plan or program that the pharmacy benefit manager serves to use any pharmacy or pharmacist in this state that is licensed to dispense the pharmaceutical product that the participant or beneficiary seeks to obtain, provided that the pharmacy or pharmacist accepts the same terms and conditions that the pharmacy benefit manager has established for at least one of the networks of pharmacies or pharmacists the pharmacy benefit manager has established to serve individuals in this state.

(b) The pharmacy benefit manager may establish a preferred network of pharmacies or pharmacists and a nonpreferred network of pharmacies or

pharmacists, but the pharmacy benefit manager may not prohibit a pharmacy or pharmacist from participating in either type of network in this state, provided that the pharmacy or pharmacist is licensed by this state and the federal government and accepts the same terms and conditions that the pharmacy benefit manager has established for other pharmacies or pharmacists participating in the network that the pharmacy or pharmacist wants to join.

(c) The pharmacy benefit manager may not charge a participant or beneficiary of a pharmacy benefits plan or program that the pharmacy benefit manager serves a different copayment obligation or additional fee, or provide any inducement or financial incentive, for the participant or beneficiary to use a pharmacy or pharmacist in a particular network of pharmacies or pharmacists the pharmacy benefit manager has established to serve individuals in this state.

(5p) GAG CLAUSES PROHIBITED. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist that dispenses a pharmaceutical product from, nor may a pharmacy benefit manager penalize the pharmacy or pharmacist for, informing an individual about the cost of the pharmaceutical product, the amount in reimbursement that the pharmacy or pharmacist receives for dispensing the pharmaceutical product, the cost and clinical efficacy of a less expensive alternative to the pharmaceutical product, or any difference between the cost to the individual under the individual's pharmacy benefits plan or program and the cost to the individual if the individual purchases the pharmaceutical product without making a claim for benefits under the individual's pharmacy benefits plan or program.

(5t) EXCLUSION OF PHARMACIES PROHIBITED. No pharmacy benefit manager, 3rd–party payer, or health benefit plan may exclude a pharmacy or pharmacist from its network because the pharmacy or pharmacist serves less than a certain portion

of the population of the state or serves a population living with certain health conditions.

SECTION 27. 632.865 (6) (bm) of the statutes is created to read:

632.865 **(6)** (bm) *Requirements of audits*. An entity that conducts audits of pharmacists of pharmacies shall ensure all of the following:

1. Each pharmacist or pharmacy audited by the entity is audited under the same standards and parameters as other similarly situated pharmacists or pharmacies audited by the entity.

2. The entity randomizes the prescriptions that the entity audits and the entity audits the same number of prescriptions in each prescription benefit tier.

3. Each audit of a prescription reimbursed under Part D of Medicare under 42 USC 1395w–101 et seq. is conducted separately from audits of prescriptions reimbursed under other policies or plans.

SECTION 28. 632.865 (6) (c) 3. of the statutes is amended to read:

632.865 **(6)** (c) 3. Deliver to the pharmacist or pharmacy a final audit report, which may be delivered electronically, within 90 days of the date the pharmacist or pharmacy receives the preliminary report or the date of the final appeal of the audit, whichever is later. The final audit report under this subdivision shall include specific documentation of any alleged errors and shall include any response provided to the auditor by the pharmacy or pharmacist and consider and address the pharmacy's or pharmacist's response.

SECTION 29. 632.865 (6) (c) 3m. of the statutes is created to read:

632.865 **(6)** (c) 3m. If an entity delivers to the pharmacist or pharmacy a preliminary report of the audit or final audit report that references a billing code,

drug code, or other code associated with audits, the entity shall provide an electronic link to a plain language explanation of the code.

SECTION 30. 632.865 (6g) of the statutes is created to read:

632.865 **(6g)** RECOUPMENT. (a) No pharmacy benefit manager may recoup reimbursement made to a pharmacist or pharmacy for errors that have no actual financial harm to an enrollee, policy, or plan unless the error is the result of the pharmacist or pharmacy failing to comply with a formal corrective action plan.

(b) No pharmacy benefit manager may use extrapolation in calculating reimbursements that it may recoup. The finding of errors for which reimbursement will be recouped shall be based on an actual error in reimbursement and not on a projection of the number of patients served having a similar diagnosis or on a projection of the number of similar orders or refills for similar prescription drugs.

(c) A pharmacy benefit manager that recoups any reimbursement made to a pharmacist or pharmacy for an error that was the cause of financial harm shall return the recouped reimbursement to the individual or the policy or plan sponsor who was harmed by the error.

SECTION 31. 632.865 (6r) of the statutes is created to read:

632.865 **(6r)** QUALITY PROGRAMS. No pharmacy benefit manager may base any criteria of a quality program in a contract between a pharmacy and a pharmacy benefit manager on a factor for which the pharmacy does not have complete and exclusive control.

SECTION 32. 632.865 (8) of the statutes is created to read:

632.865 **(8)** RETALIATION PROHIBITED. (a) In this subsection, "retaliate" includes any of the following actions taken by a pharmacy benefit manager:

1. Terminating or refusing to renew a contract with a pharmacy or pharmacist.

2. Subjecting a pharmacy or pharmacist to increased audits.

3. Failing to promptly pay a pharmacy or pharmacist any money the pharmacy benefit manager owes to the pharmacy or pharmacist.

(b) A pharmacy benefit manager may not retaliate against a pharmacy or pharmacist for reporting an alleged violation of this section or for exercising a right or remedy under this section.

(c) In addition to any other remedies provided by law, a pharmacy or pharmacist may bring an action in court for injunctive relief based on a violation of par. (b). In addition to equitable relief, the court may, notwithstanding s. 814.04 (1), award a pharmacy or pharmacist that prevails in such an action reasonable attorney fees and costs in prosecuting the action.

SECTION 33. Initial applicability.

(1) AFFILIATED REIMBURSEMENTS. Except as provided in sub. (4), the treatment of s. 632.865 (2d) (d) first applies to a reimbursement amount paid for on a claim for reimbursement submitted on the effective date of this subsection.

(2) PROFESSIONAL DISPENSING FEES. Except as provided in sub. (4), the treatment of s. 632.865 (2h) first applies to a pharmaceutical product that is dispensed on the effective date of this subsection.

(3) PHARMACY BENEFIT MANAGER-IMPOSED FEES. Except as provided in sub. (4), the treatment of s. 632.865 (2p) first applies to remuneration collected by a pharmacy benefit manager on the effective date of this subsection.

(4) CONTRACTS. The treatment of ss. 632.861 (1m), (3g), (3r), and (4) (a) and (e) and 632.865 (1) (ab), (ac), (ae), (an), (aq), (at), (bm), (cg), and (cr), (2), (2d), (2h), (2p), (2t), (5) (e), (5d), (5h), (5p), (5t), (6) (bm) and (c) 3. and 3m., (6g), (6r), and (8), the renumbering of s. 632.865 (4), and the creation of s. 632.865 (4) (b) first apply to a

pharmacy benefit manager that is affected by a contract that contains a provisions inconsistent with those treatments on the day on which the contract expires or is extended, modified, or renewed, whichever occurs first.

(5) APPLICATION OF PRESCRIPTION DRUG PAYMENTS.

(a) For policies and plans containing provisions inconsistent with the treatment of s. 632.862, that treatment first applies to policy or plan years beginning on January 1 of the year following the year in which this paragraph takes effect, except as provided in par. (b).

(b) For policies or plans that are affected by a collective bargaining agreement containing provisions inconsistent with the treatment of s. 632.862, that treatment first applies to policy or plan years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

SECTION 34. Effective dates. This act takes effect on the day after publication, except as follows:

(1) APPLICATION OF PRESCRIPTION DRUG PAYMENTS. The treatment of s. 632.862 takes effect on the first day of the 4th month beginning after publication.

(END)