AB 114 (see companion bill SB 100)

Registration and regulation of pharmacy benefit managers, drug pricing transparency, granting rule-making authority, and providing a penalty. The bill requires pharmacy benefit managers to provide a reasonably adequate and accessible network of pharmacies. The bill requires pharmacy benefit managers to submit a network adequacy report to the commissioner.

AB 26 (see companion bill SB 28)

Direct primary care agreements. Bill exempts valid direct primary care agreements from the application of insurance law. A valid direct primary care agreement includes: 1) allows either party to terminate the agreement upon written notice and specifies the terms for termination and the subscription fee; 2) describes and quantifies the specific primary care services that are provided under the agreement; 3) specifies the duration of the agreement; 4) prominently states that the agreement is not health insurance and may not satisfy insurance coverage requirements under federal law; 5) prohibits the provider and patient from billing an insurer or any other third party on a fee-for-service basis for the primary care services included in the subscription fee under the agreement; 6) prominently states that the individual patient, or employer if applicable, is responsible for paying the provider for all services that are not included in the subscription fee under the agreement; and 7) prominently states that the patient is urged to consult with any health insurance carrier the patient has before entering the agreement, that some services provided under the agreement may be covered by any health insurance the patient has, and that direct primary care fees may not be credited toward deductibles or out-of-pocket maximum amounts under any health insurance the patient has.

AB 329 (see companion bill SB 313)

Billing practices for certain health care providers and granting rule-making authority. This bill creates disclosure, notice, billing, and mediation requirements for the situation in which an enrollee in a defined network plan or preferred provider plan may receive services from a

health care provider that is not in the plan's network. If an enrollee of a defined network plan or preferred provider plan receives emergency services from an out-of-network provider, then the plan must reimburse the provider at the usual and customary rate or at a rate agreed to between the provider and the plan and may not require the enrollee to pay more than the enrollee would have paid if the provider was in the plan's network.

AB 62

Manufacturer and insurer disclosure of prescription drug costs. The bill requires that a manufacturer of a prescription drug whose wholesale acquisition cost exceeds $40 notify certain purchasers of the drug, including the state, health insurers, and pharmacy benefit managers doing business in Wisconsin, when the cost for a course of therapy increases by more than 16 percent. The bill requires that an insurer issuing health insurance coverage in this state annually file a report with OCI that identifies which of the plan's covered drugs have the highest prescription rates and costs and, for large group plans, provides information about the relationship between prescription drug costs and premium rates.

SB 100 (see companion bill AB 114)

Registration and regulation of pharmacy benefit managers, drug pricing transparency, granting rule-making authority, and providing a penalty. The bill requires pharmacy benefit managers to provide a reasonably adequate and accessible network of pharmacies. The bill requires pharmacy benefit managers to submit a network adequacy report to the commissioner.

SB 26 (see companion bill AB 24)

Step therapy protocols for prescription drug coverage and requiring the exercise of rule-making authority. Sets specifications on the development and use of and exceptions to step therapy protocols for prescription drug coverage. When establishing a step therapy protocol, an insurer, pharmacy benefit manager, or utilization review organization must use clinical review criteria based on clinical practice guidelines that meet certain criteria specified in the bill, including development and endorsement of the guidelines either by a multidisciplinary panel of experts that manages conflicts of interest among its members or, in the absence of a multidisciplinary panel, based on peer reviewed publications. The bill requires the insurer, pharmacy benefit manager, or utilization review organization to consider the needs of atypical patient populations and diagnoses when establishing the clinical review criteria.

SB 28 (see companion bill AB 26)

Direct primary care agreements. Bill exempts valid direct primary care agreements from the application of insurance law. A valid direct primary care agreement includes: 1) allows either party to terminate the agreement upon written notice and specifies the terms for termination and the subscription fee; 2) describes and quantifies the specific primary care services that are provided under the agreement; 3) specifies the duration of the agreement; 4) prominently states that the agreement is not health insurance and may not satisfy insurance coverage requirements under federal law; 5) prohibits the provider and patient from billing an insurer or any other third party on a fee-for-service basis for the primary care services included in the subscription fee under the agreement; 6) prominently states that the individual patient, or employer if applicable, is responsible for paying the provider for all services that are not included in the subscription fee under the agreement; and 7) prominently states that the patient is urged to consult with any health insurance carrier the patient has before entering the agreement, that some services provided under the agreement may be covered by any health insurance the patient has, and that direct primary care fees may not be credited toward deductibles or out-of-pocket maximum amounts under any health insurance the patient has.

SB 313 (see companion bill AB 329)

Billing practices for certain health care providers and granting rule-making authority. This bill creates disclosure, notice, billing, and mediation requirements for the situation in which an enrollee in a defined network plan or preferred provider plan may receive services from a health care provider that is not in the plan's network. If an enrollee of a defined network plan or preferred provider plan receives emergency services from an out-of-network provider, then the plan must reimburse the provider at the usual and customary rate or at a rate
agreed to between the provider and the plan and may not require the enrollee to pay more than the enrollee would have paid if the provider was in the plan's network.

SB 37

Coverage of preventive services, essential health benefits, and individuals with preexisting conditions; rating; and benefit limits under health plans. This bill requires certain health plans to guarantee access to coverage; prohibits plans from imposing preexisting condition exclusions; prohibits plans from setting premiums or cost-sharing amounts based on a health status-related factors;
prohibits plans from setting lifetime or annual limits on benefits; requires plans to cover certain essential health benefits; and requires coverage of certain preventive
services by plans without a cost-sharing contribution by an enrollee.

Wis. Stat. § 146.68. Grant for Colposcopies and Other Services: Miscellaneous Health Provisions

From the appropriation account under s. 20.435 (1) (dg), the department shall provide $75,000 in each fiscal year to an entity that satisfies the following criteria to provide colposcopic examinations and to provide services to medical assistance recipients or persons who are eligible for medical assistance.