AB 507 (see companion bill SB 475)

Prior authorization for coverage of physical therapy, occupational therapy, speech therapy, chiropractic services, and other services under health plans.

SB 475 (see companion bill AB 507)

Prior authorization for coverage of physical therapy, occupational therapy, speech therapy, chiropractic services, and other services under health plans.

AB 748 (see companion bill SB 719)

Cost-sharing cap on insulin
This bill prohibits every health insurance policy and governmental self-insured health plan that cover insulin and impose cost sharing on prescription drugs from imposing cost sharing on insulin in an amount that exceeds $35 for a one-month supply. Current law requires every health insurance policy that provides
coverage of expenses incurred for treatment of diabetes to provide coverage for specified expenses and items, including

insulin. The required coverage under current law for certain diabetes treatments other than insulin infusion pumps is subject to the same exclusions, limitations, deductibles, and coinsurance provisions of the policy as other covered expenses. The bill's cost-sharing limitation on insulin supersedes the specification that the exclusions, limitations, deductibles, and coinsurance are the same as for other coverage.

Fiduciary and disclosure requirements for pharmacy benefit managers

The bill imposes fiduciary and disclosure requirements on pharmacy benefit managers. Pharmacy benefit managers contract with health plans that provide prescription drug benefits to administer those benefits for the plans. They also have contracts with pharmacies and pay the pharmacies for providing the drugs to the plan beneficiaries.

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

by the pharmacy benefit manager.
Reimbursements for certain 340B program entities
The bill prohibits any person from reimbursing certain entities that participate in the federal drug pricing program, known as the 340B program, for a drug subject to an agreement under the program at a rate lower than that paid for the same drug to pharmacies that have a similar prescription volume. The bill also prohibits a person from imposing any fee, charge back, or other adjustment on the basis of the entity's participation in the 340B program. The entities covered by the prohibitions under the bill are federally qualified health centers, critical access hospitals, and grantees under the federal Ryan White HIV/AIDS program, as well as these entities' pharmacies and any pharmacy with which any of the entities have contracted to dispense drugs through the 340B program.

AB 541 (see companion bill SB 515)

This bill provides that no mental health care provider may be required to be licensed, registered, certified, or otherwise approved to practice in this state to provide mental health services by telehealth to patients located in this state if the mental health care provider satisfies certain conditions,

including: 1) the mental
health care provider is licensed, registered, certified, or otherwise approved to
practice in the state that the provider is physically present in when providing
telehealth services; 2) the mental health care provider may provide telehealth
services in this state within the scope of his or her license, registration, certification,
or approval from the state from which the mental health care provider is providing
telehealth services; and 3) the mental health care provider informs the patient
whether the provider is licensed in this state, what state he or she is providing
telehealth services from, what states in which he or she is licensed, registered,
certified, or otherwise approved to practice, and which regulatory boards the patient
may contact to file a complaint. Under the bill, “mental health care provider” means
a physician, physician assistant, psychologist, registered professional nurse,
counselor, therapist, or social worker who, by education, training, and experience, is
qualified to provide mental health services to patients.

SB 515 (see companion bill AB 541)

This bill provides that no mental health care provider may be required to be

licensed, registered, certified, or otherwise approved to practice in this state to provide mental health services by telehealth to patients located in this state if the mental health care provider satisfies certain conditions, including: 1) the mental health care provider is licensed, registered, certified, or otherwise approved to practice in the state that the provider is physically present in when providing telehealth services; 2) the mental health care provider may provide telehealth services in this state within the scope of his or her license, registration, certification, or approval from the state from which the mental health care provider is providing telehealth services; and 3) the mental health care provider informs the patient whether the provider is licensed in this state, what state he or she is providing telehealth services from, what states in which he or she is licensed, registered, certified, or otherwise approved to practice, and which regulatory boards the patient may contact to file a complaint. Under the bill, “mental health care provider” means a physician, physician assistant, psychologist, registered professional nurse, counselor, therapist, or social worker who, by education, training, and experience, is qualified to provide mental health services to patients.

AB 747 (see companion bill SB 718)

Creating a Prescription Drug Affordability Review Board, funding for an office of prescription drug affordability, crediting certain amounts to the general program operations account of the office of the commissioner of insurance, granting rulemaking authority, and making an appropriation.

AB 746 (see companion bill SB 717)

The bill requires DHS to develop a plan and request federal approval to create a basic health plan that complies with the federal Patient Protection and Affordable Care Act. The basic health plan must cover individuals whose household income does not exceed 200 percent of the federal poverty line. The ACA allows states to create such a basic health program. This bill directs the Office of the Commissioner of Insurance to establish and operate a state-based health insurance exchange, which must also include access to the ability to enroll in the purchase option for BadgerCare.

SB 717 (see companion bill AB

746)

The bill requires DHS to develop a plan and request federal approval to create a basic health plan that complies with the federal Patient Protection and Affordable Care Act. The basic health plan must cover individuals whose household income does not exceed 200 percent of the federal poverty line. The ACA allows states to create such a basic health program. This bill directs the Office of the Commissioner of Insurance to establish and operate a state-based health insurance exchange, which must also include access to the ability to enroll in the purchase option for BadgerCare.

SB 743 (see companion bill AB 784)

This bill requires defined network plans, such as health maintenance
organizations, and certain preferred provider plans and self-insured governmental
plans that cover benefits or services provided in either an emergency department of
a hospital or independent freestanding emergency department to cover emergency
medical services without requiring a prior authorization determination and without
regard to whether the health care provider providing the emergency medical services
is a participating provider or facility. If the emergency medical services for which
coverage is required are provided by a nonparticipating

provider, the plan must 1) not impose a prior authorization requirement or other limitation that is more restrictive than if the service was provided by a participating provider; 2) not impose cost sharing on an enrollee that is greater than the cost sharing required if the service was provided by a participating provider; 3) calculate the cost-sharing amount to be equal to the amount that would have been charged if the service was provided by a participating provider; 4) provide, within 30 days of the provider's or facility's bill, an initial payment or denial notice to the provider or facility and then pay a total amount to the provider or facility that is equal to the amount by which the provider's or facility's rate exceeds the amount it received in cost sharing from the enrollee; and 5) count any cost-sharing payment made by the enrollee for the emergency medical services toward any in-network deductible or out-of-pocket maximum as if the cost-sharing payment was made for services provided by a participating provider or facility. The provider or facility may not bill or hold liable an enrollee of the plan for any amount for the emergency medical service that is more than the cost-sharing amount that is calculated as described in the bill for the emergency medical service.

AB 784 (see companion bill SB 743)

This bill requires defined network plans, such as health maintenance organizations, and certain preferred provider plans and self-insured governmental plans that cover benefits or services provided in either an emergency department of a hospital or independent freestanding emergency department to cover emergency medical services without requiring a prior authorization determination and without regard to whether the health care provider providing the emergency medical services is a participating provider or facility. If the emergency medical services for which coverage is required are provided by a nonparticipating provider, the plan must 1) not impose a prior authorization requirement or other limitation that is more restrictive than if the service was provided by a participating provider; 2) not impose cost sharing on an enrollee that is greater than the cost sharing required if the service was provided by a participating provider; 3) calculate the cost-sharing amount to be equal to the amount that would have been charged if the service was provided by a participating provider; 4) provide, within 30 days of the provider's or facility's bill, an initial payment or denial notice to the provider or facility and then pay a total amount to the provider or facility that is equal to the amount by which

the provider’s or facility’s rate exceeds the amount it received in cost sharing from
the enrollee; and 5) count any cost-sharing payment made by the enrollee for the emergency medical services toward any in-network deductible or out-of-pocket
maximum as if the cost-sharing payment was made for services provided by a
participating provider or facility. The provider or facility may not bill or hold liable
an enrollee of the plan for any amount for the emergency medical service that is more
than the cost-sharing amount that is calculated as described in the bill for the
emergency medical service.