



State of Wisconsin
2019 - 2020 LEGISLATURE

LRB-0448/1
TJD:amn

2019 BILL

1 **AN ACT** *to repeal* 40.51 (15m), 632.86 and 632.865 (title) and (1); *to renumber*
2 632.865 (2); *to amend* 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.983
3 (1) (intro.), 601.43 (1) (a), 609.83, 616.09 (1) (a) 2. and 628.36 (2m) (e) 1.; and *to*
4 **create** 628.36 (2m) (a) 2s., 632.861 and chapter 649 of the statutes; **relating**
5 **to:** registration and regulation of pharmacy benefit managers, drug pricing
6 transparency, granting rule-making authority, and providing a penalty.

Analysis by the Legislative Reference Bureau

This bill generally allows the commissioner of insurance to regulate pharmacy benefit managers by requiring them to register. The bill also establishes certain price transparency requirements and requirements on contracts the pharmacy benefit manager enters into with pharmacies, pharmacists, or health benefit plan sponsors among other requirements.

Registration of pharmacy benefit managers

The bill prohibits a person, except an insurer already regulated by the commissioner, from performing any activities of a pharmacy benefit manager in this state without first registering with the commissioner. Certain pharmacy benefit managers must be licensed by the Pharmacy Examining Board and registered as a pharmacy benefit manager. If the Pharmacy Examining Board revokes the pharmacy or distributor license for such a pharmacy benefit manager, the

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commissioner must revoke the pharmacy benefit manager's registration. An applicant for registration as a pharmacy benefit manager must file an appropriate application and pay any registration fee set by the commissioner. A registration is valid for one year. The commissioner may refuse to register a pharmacy benefit manager for which a previous registration was suspended or revoked.

Under the bill, the commissioner, after a hearing, may suspend or revoke a registration of a pharmacy benefit manager if the registered pharmacy benefit manager, or an officer, director, or employee of a registered pharmacy benefit manager, does any of the actions specified in the bill. The commissioner may promulgate rules necessary to carry out the intent of pharmacy benefit manager registration. The bill also allows the commissioner to use his or her authority that is granted to regulate insurers to similarly regulate pharmacy benefit managers, including the authority to require reports, conduct examinations, and issue orders. The commissioner is required to promulgate certain rules, including rules regarding formulary development, required disclosures, and a standardized medical exceptions approval process, among others.

The bill requires pharmacy benefit managers to provide a reasonably adequate and accessible network of pharmacies. Pharmacy benefit managers are not allowed to include mail-order pharmacies in their calculation of network adequacy. The bill requires pharmacy benefit managers to submit a network adequacy report to the commissioner. The bill also imposes on pharmacy benefit managers a current law requirement on health maintenance organizations, limited service health organizations, and preferred provider plans that provide coverage of pharmaceutical services when performed by one or more selected pharmacists to provide an annual period of at least 30 days during which any pharmacist may elect to participate in the organization or plan under its terms as a selected provider for at least one year.

Pharmacy benefit manager regulation

The bill requires pharmacy benefit managers to refrain from certain actions in their interactions with pharmacists or pharmacies including charging a pharmacist or pharmacy a fee related to the adjudication of a claim, requiring pharmacist or pharmacy accreditation or certification requirements in addition to, more stringent than, or inconsistent with requirements of the pharmacy examining board, reimbursing a pharmacist or pharmacy less than the amount reimbursed to an affiliate of the pharmacy benefit manager for the same services, failing to make payments for services properly provided by a pharmacist or pharmacy before the termination of the pharmacist or pharmacy from the network, and restricting or limiting a pharmacy or pharmacist from disclosing information to a governmental official or law enforcement that is investigating a complaint or conducting a review. The bill requires a pharmacy benefit manager to disclose to a health benefit plan sponsor any activity, policy, or practice that presents a conflict of interest and, if the pharmacy benefit manager makes a formulary substitution to a higher cost drug, the cost of the drug and any benefit that accrues to the pharmacy benefit manager related to the substitution. A pharmacy benefit manager is prohibited in the bill from retroactively denying a pharmacist's or pharmacy's claim unless the original claim was fraudulent, the payment of the original claim was incorrect because it had

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already been paid, or the pharmacy services were not rendered by the pharmacist or pharmacy. The bill requires every pharmacy benefit manager to submit annual transparency reports containing information specified in the bill to the commissioner and to certain committees of the legislature.

Current law requires pharmacy benefit managers to agree in their contracts to make certain disclosures regarding prescription drug reimbursement, including updating maximum allowable cost pricing information for prescribed drugs or devices at least every seven business days, reimbursing pharmacies or pharmacists subject to the updated maximum allowable cost pricing, and modifying information in the maximum allowable cost information in a timely fashion. Pharmacy benefit managers currently must also include in each contract with a pharmacy a process to appeal, investigate, and resolve pricing disputes in accordance with the specifics in current law. These current law requirements are unchanged by the bill.

Audits of pharmacists or pharmacies

The bill sets requirements on a pharmacy benefit manager, insurer, defined network plan, such as a health maintenance organization, or a third-party payer that is conducting an audit of pharmacist or pharmacy records, including requiring at least two weeks' notice of an audit that is on the premises of a pharmacist or pharmacy, refraining from conducting the audit within the first seven days of the month unless the pharmacist or pharmacy consents, limiting the audit to claims submitted no more than two years before the date of the audit, establishing a written appeals process allowing for appeals of preliminary and final reports and mediation by either party, and allowing a pharmacist or pharmacy to use health care provider records to validate records and any prescription that complies with the pharmacy examining board requirements to validate claims. The bill requires an entity that has conducted an audit of a pharmacist or pharmacy to comply with certain timing requirements for delivery of the preliminary and final reports and for allowing a pharmacist or pharmacy to address any discrepancies and requires the entity to refrain from using extrapolation in calculating the recoupments or penalties from an audit among other requirements in the bill. If an audit identifies a clerical or record-keeping error, the pharmacy benefit manager or entity must prove that the pharmacist or pharmacy intended to commit fraud or that the error resulted in actual financial harm before requesting recoupment from the pharmacist or pharmacy based on the error. A pharmacy benefit manager or other entity conducting an audit may not pay an auditor based on a percentage of the amount recovered in an audit.

Allowing disclosures to consumers

This bill prohibits a health insurance policy, referred to in the statutes as a disability insurance policy, or a governmental self-insured health plan from including in a contract for pharmacy services, or allowing a pharmacy benefit manager or another entity to include in a contract for pharmacy services, a provision that prohibits or penalizes a pharmacist's disclosure to an individual purchasing a prescribed drug or device of the cost of a prescribed drug or device, a less expensive therapeutically equivalent drug or device, or a less expensive method of purchasing the drug or device.

BILL***Cost sharing limitation, choice of provider, and drug substitution***

The bill sets a limitation on the amount of cost sharing that a person who is covered under a health insurance policy or self-insured governmental health plan must pay at the point of sale for a prescription drug as specified in the bill. A policy or plan or a pharmacy benefit manager may not require a person covered under the policy or plan to pay an increased amount of cost sharing for a newly prescribed drug or device if the policy, plan, or pharmacy benefit manager requested the substitution of the original drug and if the newly prescribed drug or device is therapeutically equivalent to the originally prescribed drug or device. The bill requires health insurance policies, self-insured governmental health plans, and pharmacy benefits managers to develop a procedure to ensure that a policy or plan does not deny coverage to an insured or plan participant during a plan year or subject the insured or plan participant to new exclusions, limitations, deductibles, copayments, or coinsurance if the prescribed drug or device was covered under the policy or plan for the insured or plan participant when the insured or plan participant either enrolled in coverage or renewed coverage and if the prescribing health care provider states that the prescribed drug or device is more suitable for the insured's or plan participant's condition than alternative drugs or devices that are covered under the policy or plan. An insurer, self-insured governmental health plan, or pharmacy benefit manager may not require or penalize a person who is covered under a health insurance policy or plan to use or for not using a specific retail, specific mail order pharmacy, or other specific pharmacy within the policy's or plan's provider network.

This proposal may contain a health insurance mandate requiring a social and financial impact report under s. 601.423, stats.

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:

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

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1 40.51 **(8m)** Every health care coverage plan offered by the group insurance
2 board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,
3 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.861, 632.867,
4 632.885, 632.89, and 632.895 (11) to (17).

5 **SECTION 3.** 40.51 (15m) of the statutes is repealed.

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

7 66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
8 a village provides health care benefits under its home rule power, or if a town
9 provides health care benefits, to its officers and employees on a self-insured basis,
10 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),
11 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.861,
12 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513
13 (4).

14 **SECTION 5.** 120.13 (2) (g) of the statutes is amended to read:

15 120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss.
16 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
17 632.798, 632.85, 632.853, 632.855, 632.861, 632.867, 632.87 (4) to (6), 632.885,
18 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

19 **SECTION 6.** 185.983 (1) (intro.) of the statutes is amended to read:

20 185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a
21 cooperative association organized under s. 185.981 shall be exempt from chs. 600 to
22 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44,
23 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93,
24 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85,
25 632.853, 632.855, 632.861, 632.867, 632.87 (2) to (6), 632.885, 632.89, 632.895 (5) and

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1 (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but
2 the sponsoring association shall:

3 **SECTION 7.** 601.43 (1) (a) of the statutes is amended to read:

4 601.43 (1) (a) *Insurers, other licensees and other persons subject to regulation.*

5 Whenever the commissioner deems it necessary in order to inform himself or herself
6 about any matter related to the enforcement of chs. 600 to 647 and 649, the
7 commissioner may examine the affairs and condition of any licensee ~~or~~ permittee,
8 or registrant under chs. 600 to 647 and 649 or applicant for a license ~~or~~ permit, or
9 registration of any person or organization of persons doing or in process of organizing
10 to do an insurance business in this state, and of any advisory organization serving
11 any of the foregoing in this state.

12 **SECTION 8.** 609.83 of the statutes is amended to read:

13 **609.83 Coverage of drugs and devices.** Limited service health
14 organizations, preferred provider plans, and defined network plans are subject to ss.
15 632.853, 632.861, and 632.895 (16t).

16 **SECTION 9.** 616.09 (1) (a) 2. of the statutes is amended to read:

17 616.09 (1) (a) 2. Plans authorized under s. 616.06 are subject to s. 610.21, 1977
18 stats., s. 610.55, 1977 stats., s. 610.57, 1977 stats., and ss. 628.34 to 628.39, 1977
19 stats., to chs. 600, 601, 620, 625, 627 and 645, to ss. 632.72, 632.755, ~~632.86~~ 632.861
20 and 632.87 and to this subchapter except s. 616.08.

21 **SECTION 10.** 628.36 (2m) (a) 2s. of the statutes is created to read:

22 628.36 (2m) (a) 2s. "Pharmacy benefit manager" has the meaning given in s.
23 649.01 (6).

24 **SECTION 11.** 628.36 (2m) (e) 1. of the statutes is amended to read:

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1 628.36 **(2m)** (e) 1. A health maintenance organization, limited service health
2 organization ~~or~~, preferred provider plan, or pharmacy benefit manager that provides
3 or administers coverage of pharmaceutical services when performed by one or more
4 pharmacists who are selected by the organization ~~or~~, plan, or pharmacy benefit
5 manager but who are not full-time salaried employees or partners of the
6 organization ~~or~~, plan, or pharmacy benefit manager shall provide an annual period
7 of at least 30 days during which any pharmacist registered under ch. 450 may elect
8 to participate in the health maintenance organization, limited service health
9 organization ~~or~~, preferred provider plan, or coverage administered by a pharmacy
10 benefit manager under its terms as a selected provider for at least one year.

11 **SECTION 12.** 632.86 of the statutes is repealed.

12 **SECTION 13.** 632.861 of the statutes is created to read:

13 **632.861 Prescription drug charges; choice of provider. (1) DEFINITIONS.**

14 In this section:

15 (a) “Disability insurance policy” has the meaning given in s. 632.895 (1) (a).

16 (b) “Pharmacist” has the meaning given in s. 450.01 (15).

17 (c) “Pharmacy benefit manager” has the meaning given in s. 649.01 (6).

18 (d) “Prescribed drug or device” has the meaning given in s. 450.01 (18).

19 (e) “Prescription drug benefit” has the meaning given in s. 649.01 (8).

20 (f) “Self-insured health plan” has the meaning given in s. 632.85 (1) (c).

21 **(2) ALLOWING DISCLOSURES.** No disability insurance policy or self-insured
22 health plan that provides a prescription drug benefit may include in a contract for
23 pharmacy services, or allow a pharmacy benefit manager or another entity to include
24 in a contract for pharmacy services, a provision that prohibits or penalizes, including
25 by increased utilization review, reduced reimbursement, or other financial

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1 disincentives, a disclosure of any of the following by a pharmacist to an individual
2 purchasing a prescribed drug or device:

3 (a) The cost of the prescribed drug or device to the individual.

4 (b) The availability of any therapeutically equivalent alternative prescribed
5 drugs or devices or alternative methods of purchasing the prescribed drug or device,
6 including paying cash, that are less expensive to the individual.

7 **(3) COST SHARING LIMITATION.** An insurer, self-insured health plan, or a
8 pharmacy benefit manager may not require a person who is covered under a
9 disability insurance policy or self-insured health plan to pay at the point of sale for
10 a covered prescription drug an amount greater than the lowest of all of the following
11 amounts:

12 (a) The applicable copayment for the prescription drug.

13 (b) The allowable claim amount for the prescription drug.

14 (c) The amount a person who is covered under the disability insurance policy
15 or plan would pay for the prescription drug if the person purchased the prescription
16 drug without using a disability insurance policy or any other source of prescription
17 drug benefits or discounts.

18 (d) The amount the pharmacist or pharmacy is reimbursed for the prescription
19 drug from the pharmacy benefit manager or insurer.

20 **(4) CHOICE OF PROVIDER; PENALTY PROHIBITED.** An insurer, self-insured health
21 plan, or pharmacy benefit manager is prohibited from requiring or penalizing a
22 person who is covered under a disability insurance policy or self-insured health plan
23 to use or for not using a specific retail, specific mail order, or other specific pharmacy
24 provider within the network of pharmacy providers under the policy or plan. A

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1 prohibited penalty under this subsection includes an increase in premium,
2 deductible, copayment, or coinsurance.

3 **(5) DRUG SUBSTITUTION.** (a) A disability insurance policy that offers a
4 prescription drug benefit or self-insured health plan or a pharmacy benefit manager
5 acting on behalf of a disability insurance policy or self-insured health plan may not
6 require a person covered under the policy or plan to pay an increased cost-sharing
7 amount for a newly prescribed drug or device if the substitution for the originally
8 prescribed drug or device is suggested by the policy, plan, or pharmacy benefit
9 manager and if the newly prescribed drug or device is therapeutically equivalent to
10 the originally prescribed drug or device being substituted.

11 (b) Every disability insurance policy that offers a prescription drug benefit,
12 self-insured health plan, and pharmacy benefit manager shall develop a procedure
13 to ensure that a policy or plan does not deny coverage to an insured or plan
14 participant during a plan year or subject the insured or plan participant to new
15 exclusions, limitations, deductibles, copayments, or coinsurance under a
16 circumstance that satisfies all of the following:

17 1. The prescribed drug or device was covered under the policy or plan for the
18 insured or plan participant when the insured or plan participant either enrolled in
19 coverage or renewed coverage, whichever is later.

20 2. A health care provider who prescribed the prescribed drug or device states,
21 in writing, that the prescribed drug or device is more suitable for the insured's or plan
22 participant's condition than alternative drugs or devices that are covered under the
23 policy or plan.

24 **SECTION 14.** 632.865 (title) and (1) of the statutes are repealed.

25 **SECTION 15.** 632.865 (2) of the statutes is renumbered 649.30 (1).

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1 **649.05 Registration of pharmacy benefit managers. (1)** (a) Except as
2 provided in par. (b), no person may perform any activities of a pharmacy benefit
3 manager in this state without first registering with the commissioner under this
4 chapter.

5 (b) A pharmacy benefit manager that is an insurer with a current certificate
6 of authority issued under s. 601.04 is not required to register under this section.

7 (c) 1. Any pharmacy benefit manager that is required to obtain a license under
8 s. 450.06, 450.065, or 450.071 shall also register under this chapter.

9 2. If the pharmacy examining board revokes a license that had been granted
10 under s. 450.06, 450.065, or 450.071 to a registrant, the registrant shall notify the
11 commissioner of the revocation. The commissioner shall revoke the registration
12 under this chapter.

13 **(2)** An applicant for registration as a pharmacy benefit manager shall do all
14 of the following:

15 (a) File with the commissioner an application on a form that the commissioner
16 provides.

17 (b) Pay any registration fee set by the commissioner.

18 **(3)** The commissioner shall register any pharmacy benefit manager that meets
19 the requirements of this chapter and any requirements the commissioner requires
20 of applicants. Registration under this section is valid for one year unless registration
21 is suspended or revoked. The commissioner may refuse to register any pharmacy
22 benefit manager for which a previous registration was suspended or revoked.

23 **649.10 Powers and duties of the commissioner. (1)** The commissioner
24 may do any of the following:

25 (a) Promulgate rules necessary to carry out the intent of this chapter.

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1 (b) Use authority granted under ss. 601.41, 601.42, 601.43, 601.44, 601.61,
2 601.62, 601.63, and 601.64 to enforce this chapter, s. 628.36, and ch. 632 as it relates
3 to pharmacy benefit managers.

4 (2) The commissioner shall promulgate rules regarding all of the following
5 using as a model the prescription drug benefit management model act of the National
6 Association of Insurance Commissioners for the 2nd quarter of 2018 to the extent the
7 model act does not conflict with this chapter or ch. 632:

8 (a) Requirements for the development and maintenance of prescription drug
9 formularies and other pharmacy benefit manager procedures, except that the
10 commissioner may not allow a health benefit plan, self-insured health plan, or
11 pharmacy benefit manager to require a consumer to obtain a prescription drug at a
12 mail order pharmacy because the prescription drug requires special handling,
13 provider coordination, or patient education.

14 (b) Information that the pharmacy benefit manager is required to provide to
15 a person who is covered or who seeks to be covered under a health benefit plan or
16 self-insured health plan, a prescriber of prescription drugs, or a pharmacist or
17 pharmacy.

18 (c) Requirements and procedures for a medical exceptions approval process
19 that is standardized among pharmacy benefit managers.

20 (d) Requirements for nondiscrimination in prescription drug benefit design.

21 (e) Requirements for record keeping and reporting by a pharmacy benefit
22 manager.

23 (f) Responsibilities for the pharmacy benefit manager in oversight and
24 contracting.

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1 (g) Required disclosures by a health benefit plan or self-insured health plan
2 or a pharmacy benefit manager.

3 **649.20 Suspension or revocation of registration; penalty.** (1) The
4 commissioner, after a hearing, may suspend or revoke the registration of a
5 registrant, if the registrant or an officer, director, or employee of the registrant does
6 any of the following:

7 (a) Knowingly makes or causes to be made a false statement or
8 misrepresentation of a material fact in an application for registration under s.
9 649.05.

10 (b) Obtains or attempts to obtain a registration under s. 649.05 through
11 misrepresentation or fraud.

12 (c) Misappropriates or converts for the registrant's own use or improperly
13 withholds insurance premiums or contributions held in a fiduciary capacity, except
14 for any interest earnings received by the pharmacy benefit manager and disclosed
15 to the pharmacist, pharmacy, or health benefit plan sponsor with which the
16 pharmacy benefit manager has a contract to provide services.

17 (d) Commits fraudulent, coercive, or dishonest practices in the transaction of
18 business as a pharmacy benefit manager.

19 (e) Uses, or knowingly permits the use of, any advertisement, promotion,
20 solicitation, representation, proposal, or offer that is untrue, deceptive, or
21 misleading.

22 (f) Has a license or registration suspended, revoked, or not renewed in any
23 other state, district, territory, or province that impacts business conducted in this
24 state.

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1 (g) Knowingly violates a requirement of this chapter or ch. 632 or a rule
2 promulgated under this chapter or ch. 632.

3 (2) Any person who performs the activities of a pharmacy benefit manager in
4 this state without a valid registration under s. 649.05 is subject to a forfeiture of \$500
5 for each day of violation.

6 **649.30 Pricing transparency; prohibitions; contracts.**

7 (2) PROHIBITIONS. A pharmacy benefit manager or a representative of a
8 pharmacy benefit manager may not do any of the following:

9 (a) Unless approved by the commissioner, charge a pharmacist or pharmacy a
10 fee related to the adjudication of a claim, including a fee for receiving and processing
11 a pharmacy claim, developing or managing claims processing services in a pharmacy
12 benefit manager network, or participating in a pharmacy benefit manager network.

13 (b) Unless approved by the commissioner after consulting with the pharmacy
14 examining board, require pharmacist or pharmacy accreditation standards or
15 certification requirements in addition to, more stringent than, or inconsistent with
16 any requirements of the pharmacy examining board.

17 (c) Reimburse a pharmacy or pharmacist in this state an amount less than the
18 amount that the pharmacy benefit manager reimburses an affiliate of the pharmacy
19 benefit manager for providing the same services. To comply with this paragraph, the
20 pharmacy benefit manager shall compare the amounts calculated on a per-unit
21 basis using the same generic product identifier or generic code number.

22 (d) After termination of a pharmacy or pharmacist from a pharmacy benefit
23 network, fail to make payments to a pharmacist or pharmacy for services that were
24 properly rendered and provided before termination.

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1 (e) Prohibit, restrict, or limit a pharmacy or pharmacist from disclosing
2 information to the commissioner, law enforcement, or a state or federal
3 governmental official that is investigating or examining a complaint or conducting
4 a review of a pharmacy benefit manager's compliance with the requirements under
5 this section.

6 **(3) CONFLICT OF INTEREST; BUSINESS PRACTICES.** (a) If a pharmacy benefit
7 manager makes a formulary substitution in which the substitute drug costs more
8 than the originally prescribed drug, the pharmacy benefit manager shall disclose to
9 the health benefit plan sponsor the cost of the drugs and any benefit that accrues,
10 directly or indirectly, to the pharmacy benefit manager related to the substitution.

11 (b) A pharmacy benefit manager may not require that a pharmacy or
12 pharmacist enter into one contract in order to enter into another contract.

13 (c) A pharmacy benefit manager shall notify a health benefit plan sponsor in
14 writing of any activity, policy, or practice of the pharmacy benefit manager that
15 presents a conflict of interest, directly or indirectly, with any requirement of this
16 section.

17 **(4) RETROACTIVE CLAIM REDUCTION.** A pharmacy benefit manager may not
18 retroactively deny or reduce a pharmacist's or pharmacy's claim after adjudication
19 of the claim unless any of the following is true:

20 (a) The original claim was submitted fraudulently.

21 (b) The payment for the original claim was incorrect because the pharmacy or
22 pharmacist had already been paid for the pharmacy services.

23 (c) The pharmacy services were not rendered by the pharmacist or pharmacy.

24 **649.35 Audits of pharmacies or pharmacists.** (1) **DEFINITION.** In this
25 section, "entity" means a defined network plan, as defined in s. 609.01 (1b), insurer,

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1 3rd-party payer, or pharmacy benefit manager or a person acting on behalf of a
2 defined network plan, insurer, 3rd-party payer, or pharmacy benefit manager.

3 **(2) AUDIT PROCEDURE REQUIREMENTS.** An entity conducting an audit of
4 pharmacist or pharmacy records shall do all of the following:

5 (a) If the audit is an audit on the premises of the pharmacist or pharmacy, notify
6 the pharmacist or pharmacy in writing of the audit at least 2 weeks before conducting
7 the audit.

8 (b) Refrain from auditing a pharmacist or pharmacy within the first 7 days of
9 a month unless the pharmacist or pharmacy consents to an audit during that time.

10 (c) If the audit involves clinical or professional judgement, conduct the audit
11 by or in consultation with a pharmacist licensed in this state or the pharmacy
12 examining board.

13 (d) Limit the audit review to claims submitted no more than 2 years before the
14 date of the audit.

15 (e) Audit each pharmacist or pharmacy under the same standards and
16 parameters as other similarly situated pharmacists or pharmacies.

17 (f) Establish a written appeals process that allows appeals of preliminary and
18 final reports and allows for mediation if either party is dissatisfied with the appeal.

19 (g) Allow the pharmacist or pharmacy to use records of a hospital, physician,
20 or other health care provider to validate the pharmacist's or pharmacy's records and
21 use any prescription that complies with requirements of the pharmacy examining
22 board to validate claims in connection with a prescription, refill of a prescription, or
23 change in prescription.

24 **(3) RESULTS OF AUDIT.** (a) An entity that has conducted an audit of a pharmacist
25 or pharmacy shall do all of the following:

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1 1. Deliver to the pharmacist or pharmacy a preliminary report of the audit
2 within 60 days after date of the conclusion of the audit.

3 2. Allow a pharmacist or pharmacy that is the subject of an audit at least 30
4 days after the date the pharmacist or pharmacy receives the preliminary report to
5 provide documentation to address any discrepancy found in the audit.

6 3. Deliver to the pharmacist or pharmacy a final audit report within 90 days of
7 the date the pharmacist or pharmacy receives the preliminary report or the date of
8 the final appeal of the audit, whichever is later.

9 4. Refrain from assessing a recoupment or other penalty on a pharmacist or
10 pharmacy until the appeal process is exhausted and the final report under subd. 3.
11 is delivered to the pharmacist or pharmacy.

12 5. Base a finding of overpayment or underpayment of a claim on the actual
13 overpayment or underpayment and not on a projection based on the number of
14 patients served having a similar diagnosis or on the number of similar orders or
15 refills for similar drugs.

16 6. Exclude dispensing fees from calculations of overpayments.

17 7. Refrain from using extrapolation in calculating the recoupments or penalties
18 for an audit.

19 8. Refrain from charging interest until the final report under subd. 3. has been
20 delivered.

21 (b) If an audit of a pharmacist or pharmacy identifies a clerical or
22 record-keeping error in a required document or record, the pharmacy benefit
23 manager or entity conducting the audit may not request recoupment of funds from
24 the pharmacist or pharmacy based on such an error unless the pharmacy benefit
25 manager or entity proves the pharmacist or pharmacy intended to commit fraud or

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1 unless the error by the pharmacist or pharmacy results in actual financial harm to
2 the pharmacy benefit manager, a health benefit plan, or a consumer.

3 (c) Information obtained in an audit under this section is confidential and may
4 not be shared unless the information is required to be shared under state or federal
5 law. An entity conducting an audit may have access to the previous audit reports on
6 a particular pharmacy conducted by the same entity.

7 (d) Any entity that conducts an audit shall provide to the health benefit plan
8 a copy of the final report of the audit and a disclosure of any recoupment amount
9 assessed as a result of the audit.

10 **(5) PAYMENT OF AUDITORS.** A pharmacy benefit manager or entity conducting an
11 audit may not pay an auditor employed by or contracted with the pharmacy benefit
12 manager or entity based on a percentage of the amount recovered in an audit.

13 **(6) APPLICABILITY.** This section does not apply to an investigative audit that is
14 initiated as a result of a credible allegation of fraud or willful misrepresentation.

15 **649.40 Transparency reports.** (1) Beginning on June 1, 2020, and annually
16 thereafter, every pharmacy benefit manager shall submit to the commissioner, the
17 joint committee on finance, and, under s. 13.172 (3), each standing committee of the
18 legislature with jurisdiction over insurance a report that contains all of the following
19 information from the previous calendar year:

20 (a) The aggregate amount of all rebates that the pharmacy benefit manager
21 received from all pharmaceutical manufacturers by each health benefit plan sponsor
22 and for all health benefit plan sponsors combined.

23 (b) The aggregate administrative fee amount that the pharmacy benefit
24 manager received from all pharmaceutical manufacturers by each health benefit
25 plan sponsor and for all health benefit plan sponsors combined.

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1 (c) The aggregate rebate amount that the pharmacy benefit manager received
2 from all pharmaceutical manufacturers but retained and did not pass through to
3 health benefit plan sponsors and the percentage of the aggregate rebate amount that
4 is retained rebates.

5 (2) The commissioner shall publish, within 60 days of receiving the report
6 under sub. (1), on the office's Internet site information from the transparency report
7 submitted under sub. (1). The commissioner shall publish the report information in
8 a manner that does not disclose any trade secrets.

9 **649.45 Network adequacy.** A pharmacy benefit manager shall do all of the
10 following:

11 (1) Provide a reasonably adequate and accessible pharmacy network for
12 providing prescribed drugs or devices for a health benefit plan that allows convenient
13 patient access to pharmacies within a reasonable distance from a plan participant's
14 residence. A pharmacy benefit manager may not include any mail-order pharmacy
15 in its calculations of network adequacy under this subsection.

16 (2) Submit to the commissioner, at the time and in the manner required by the
17 commissioner, a pharmacy benefit manager network adequacy report describing the
18 pharmacy benefit manager network and accessibility to the network for health
19 benefit plan participants.

20 **SECTION 17. Nonstatutory provisions.**

21 (1) PHARMACY BENEFIT MANAGER; COMPLIANCE DATE. Notwithstanding s. 649.05,
22 a pharmacy benefit manager is not required to register under s. 649.05 or to comply
23 with ch. 649 until the date that is 180 days after the date of the promulgation of rules
24 by the commissioner of insurance under s. 649.10, unless the commissioner specifies
25 a different date on which registration or compliance is required.

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1 (2) RULEMAKING; RECONCILIATION WITH STEP THERAPY BILL. If 2019 Assembly Bill
2 24 or 2019 Senate Bill 26 is enacted and contains criteria for when a medical
3 exception to a step therapy protocol must be granted, notwithstanding the
4 requirement in s. 649.10 (2) to base rules on the prescription drug benefit
5 management model act of the National Association of Insurance Commissioners for
6 the 2nd quarter of 2018, the commissioner of insurance shall incorporate in rules
7 promulgated under s. 649.10 (2) (c) criteria for granting a medical exception that are
8 identical to the criteria for granting a medical exception in 2019 Assembly Bill 24 or
9 2019 Senate Bill 26. The commissioner of insurance may incorporate in rules
10 promulgated under s. 649.10 (2) (c) requirements and procedures for a medical
11 exceptions process that do not conflict with 2019 Assembly Bill 24 or 2019 Senate Bill
12 26. If 2019 Assembly Bill 24 or 2019 Senate Bill 26 is not enacted in the 2019
13 legislative session, this subsection is void.

SECTION 18. Initial applicability.

14 (1) For policies and plans containing provisions inconsistent with this act, this
15 act first applies to policy or plan years beginning on January 1 of the year following
16 the year in which this subsection takes effect.

17 (2) This act first applies to contracts with a pharmacy or pharmacist that are
18 entered into, modified, or renewed on the effective date of this subsection.

SECTION 19. Effective date.

19 (1) This act takes effect on the first day of the 4th month beginning after
20 publication.

21
22
23 (END)