State of Wisconsin
2025 - 2026 LEGISLATURE

LRB-6417/1
EKL:cjs

2025 BILL

AN ACT ***to amend*** 15.01 (6), 20.145 (1) (g) 1. and 601.45 (1); ***to create*** 15.732, 601.25 and 601.455 of the statutes; **relating to:** insurer claims denial practices and auditing, creating the Office of the Public Intervenor, granting rule-making authority, and making an appropriation.

Analysis by the Legislative Reference Bureau

This bill imposes upon insurers certain requirements for health insurance claims processing and denials. These include requirements to process claims within a reasonable time frame that prevents an undue delay in care, to provide a detailed explanation of a claim denial, and to disclose whether the insurer uses artificial intelligence or algorithmic decision-making in processing claims.

The bill also prohibits certain actions by an insurer with respect to health insurance claims. Prohibited actions under the bill include using vague or misleading terms to deny a claim, stalling review of a claim to avoid timely payment, allowing non-physician personnel to determine whether care is medically necessary, mandating prior approval for routine or urgent procedures in a manner that causes harmful delays, or requiring an insured to fail a cheaper treatment before approving coverage for necessary care.

The bill directs insurers to annually publish a report about their claim denials for health insurance policies and their use of artificial intelligence or algorithmic decision-making in processing claims for health insurance policies. The bill also

directs the commissioner of insurance to maintain a public database of insurers' health insurance claim denial rates and the outcomes of independent reviews of adverse actions under health insurance policies.

In addition, the bill authorizes the commissioner of insurance to audit insurers that deny health insurance claims with such frequency as to indicate a general business practice. Under the bill, the commissioner may collect any relevant information from an insurer necessary to conduct an audit; contract with a third party to conduct an audit; order an insurer to comply with a corrective action plan based on the findings of an audit; and impose forfeitures or sanctions on an insurer that fails to comply with a corrective action plan. The bill also requires insurers to provide a written response to any adverse findings of an audit.

Finally, the bill creates the Office of the Public Intervenor attached to the Office of the Commissioner of Insurance. Under the bill, the Office of the Public Intervenor assists individuals with claims, policies, appeals, and other legal actions related to pursuing insurance coverage for medical procedures, prescription medications, and other health care services. The bill provides that, in addition to the rights insureds have under current law to request an independent review of certain adverse actions under a health insurance policy, insureds also have the right to request from the Office of the Public Intervenor a review of any health insurance claim denial. The bill authorizes the Office of the Public Intervenor to levy an assessment on insurance providers based upon their premium volume for health insurance policies written in the state.

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. 15.01 (6) of the statutes is amended to read:

15.01 **(6)** "Division," "bureau," "section," and "unit" means the subunits of a department or an independent agency, whether specifically created by law or created by the head of the department or the independent agency for the more economic and efficient administration and operation of the programs assigned to the department or independent agency. The office of credit unions in the department of financial institutions, the office of the inspector general in the department of children and families, the office of the inspector general in the department of health services, <u>the office of the public intervenor in the office of the</u>

commissioner of insurance, and the office of children's mental health in the department of health services have the meaning of "division" under this subsection. The office of the long-term care ombudsman under the board on aging and long-term care and the office of educational accountability and the office of literacy in the department of public instruction have the meaning of "bureau" under this subsection.

SECTION 2. 15.732 of the statutes is created to read:

15.732 Same; attached office. (1) OFFICE OF THE PUBLIC INTERVENOR. There is created an office of the public intervenor which is attached to the office of the commissioner of insurance under s. 15.03.

SECTION 3. 20.145 (1) (g) 1. of the statutes is amended to read:

20.145 **(1)** (g) 1. All moneys received under ss. 601.25 (2), 601.31, 601.32, 601.42 (7), 601.45, and 601.47 and by the commissioner for expenses related to insurance company restructurings, except for restructurings specified in par. (h).

SECTION 4. 601.25 of the statutes is created to read:

601.25 Office of the public intervenor. (1) The office of the public intervenor shall assist individuals with insurance claims, policies, appeals, and other legal actions to pursue insurance coverage for medical procedures, prescription medications, and other health care services.

(2) The office of the public intervenor may levy an assessment on each insurer that is authorized to engage in the business of insurance in this state. The assessment levied under this subsection shall be based on the insurer's premium volume for disability insurance policies, as defined in s. 632.895 (1) (a), written in this state.

(3) The commissioner may provide by rule for the governance, duties, and administration of the office of the public intervenor.

SECTION 5. 601.45 (1) of the statutes is amended to read:

601.45 **(1)** COSTS TO BE PAID BY EXAMINEES. The reasonable costs of examinations and audits under ss. 601.43, 601.44, 601.455, and 601.83 (5) (f) shall be paid by examinees except as provided in sub. (4), either on the basis of a system of billing for actual salaries and expenses of examiners and other apportionable expenses, including office overhead, or by a system of regular annual billings to cover the costs relating to a group of companies, or a combination of such systems, as the commissioner may by rule prescribe. Additional funding, if any, shall be governed by s. 601.32. The commissioner shall schedule annual hearings under s. 601.41 (5) to review current problems in the area of examinations.

SECTION 6. 601.455 of the statutes is created to read:

601.455 Fair claims processing, health insurance transparency, and claim denial rate audits. (1) DEFINITIONS. In this section:

(a) "Claim denial" means the refusal by an insurer to provide payment under a disability insurance policy for a service, treatment, or medication recommended by a health care provider. "Claim denial" includes the prospective refusal to pay for a service, treatment, or medication when a disability insurance policy requires advance approval before a prescribed medical service, treatment, or medication is provided.

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

(c) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (p).

(2) CLAIMS PROCESSING. (a) Insurers shall process each claim for a disability

insurance policy within a time frame that is reasonable and prevents an undue delay in an insured's care, taking into account the medical urgency of the claim.

(b) If an insurer determines additional information is needed to process a claim for a disability insurance policy, the insurer shall request the information from the insured within 5 business days of making the determination and shall provide at least 15 days for the insured to respond.

(c) All claim denials shall include all of the following:

1. A specific and detailed explanation of the reason for the denial that cites the exact medical or policy basis for the denial.

2. A copy of or a publicly accessible link to any policy, coverage rules, clinical guidelines, or medical evidence relied upon in making the denial decision, with specific citation to the provision justifying the denial.

3. Additional documentation, medical rationale, or criteria that must be met or provided for approval of the claim, including alternative options available under the policy.

(d) If an insurer uses artificial intelligence or algorithmic decision-making in processing a claim for a disability insurance policy, the insurer must notify the insured in writing of that fact. The notice shall include all of the following:

1. A disclosure that artificial intelligence or algorithmic decision-making was used at any stage in reviewing the claim, even if a human later reviewed the outcome.

2. A detailed explanation of how the artificial intelligence or algorithmic decision-making reached its decision, including any factors the artificial intelligence or algorithmic decision-making weighed.

3. A contact point for requesting a human review of the claim if the claim was denied.

(3) INDEPENDENT REVIEW OF DENIALS. In addition to an insured's right to an independent review under s. 632.835, as applicable, insureds have the right to request a review by the office of the public intervenor of any claim denial.

(4) PROHIBITED PRACTICES. An insurer may not do any of the following with respect to a disability insurance policy:

(a) Use vague or misleading policy terms to justify a claim denial.

(b) Fail to provide a specific and comprehensible reason for a claim denial.

(c) Cancel coverage under the policy after a claim is submitted due to alleged misstatements on the policy application.

(d) Deny a claim based on hidden or ambiguous exclusions in a disability insurance policy.

(e) Stall review of a claim to avoid timely payment.

(f) Reject a claim without reviewing all relevant medical records or consulting qualified experts.

(g) Fail to properly review or respond to an insured's appeal in a timely manner.

(h) Allow non-physician personnel to determine whether care is medically necessary.

(i) Apply different medical necessity criteria based on financial interests rather than patient needs.

(j) Disregard a treating health care provider's medical assessment without a valid clinical reason.

(k) Mandate prior approval for routine or urgent procedures in a manner that causes harmful delays.

(L) For a disability insurance policy that provides coverage of emergency medical services, refuse to cover emergency medical services provided by out-of-network providers.

(m) List a health care provider as in-network on a provider directory and then deny a claim by stating the health care provider is out-of-network.

(n) Deny coverage based on age, gender, disability, or a chronic condition rather than medical necessity.

(o) Apply stricter standards in reviewing claims related to mental health conditions than claims related to physical health conditions.

(p) Perform a blanket denial of claims for high-cost conditions without an individualized review of each claim.

(r) Reclassify a claim to a lower-cost treatment to reduce insurer payout.

(s) Require an insured to fail a cheaper treatment before approving coverage for necessary care.

(t) Manipulate cost-sharing rules to shift higher costs to insureds.

(5) TRANSPARENCY AND REPORTING. (a) Beginning on January 1, 2027, an insurer shall annually publish a report detailing the insurer's claim denial rates, reasons for claim denials, and the outcome of any appeal of a claim denial for the previous year for all disability insurance policies under which the insurer provides coverage.

(b) The commissioner shall maintain a public database of insurers' claim denial rates and the outcomes of independent reviews under s. 632.835.

(c) Beginning on January 1, 2027, an insurer that uses artificial intelligence or algorithmic decision-making in claims processing shall annually publish a report detailing all of the following for the previous year for all disability insurance policies under which the insurer provides coverage:

1. The percentage of claims submitted to the insurer that were reviewed by artificial intelligence or algorithmic decision-making.

2. The claim denial rate of claims reviewed by artificial intelligence or algorithmic decision-making compared to the claim denial rate of claims reviewed by humans.

3. The steps the insurer takes to ensure fairness and accuracy in decisions made by artificial intelligence or algorithmic decision-making.

(6) CLAIM DENIAL RATE AUDITS. (a) The commissioner may conduct an audit of an insurer if the insurer's claim denials are of such frequency as to indicate a general business practice. This paragraph is supplemental to and does not limit any other powers or duties of the commissioner.

(b) The commissioner may collect any relevant information from an insurer that is necessary to conduct an audit under par. (a).

(c) The commissioner may contract with a 3rd party to conduct an audit under par. (a).

(d) The commissioner may, based on the findings of an audit under par. (a), order the insurer who is the subject of the audit to comply with a corrective action plan approved by the commissioner. The commissioner shall specify in any corrective action plan under this paragraph the deadline by which an insurer must be in compliance with the corrective action plan.

(e) An insurer who is the subject of an audit under par. (a) shall provide a written response to any adverse findings of the audit.

(f) If an insurer fails to comply with a corrective action plan under par. (d) by the deadline specified by the commissioner, the commissioner may order the insurer to pay a forfeiture pursuant to s. 601.64 (3).

(7) FORFEITURES. A violation of this section that results in a harmful delay in an insured's care or an adverse health outcome for an insured shall be subject to a civil forfeiture of $10,000 per occurrence, in addition to any other penalties provided in s. 601.64 (3) or other law.

(END)