State of Wisconsin
2025 - 2026 LEGISLATURE

LRB-1559/P4
KMS:cjs&skw

DOA:.....Lessner, BB0348 - Insurer Claims Denial Rate Audits

FOR 2025-2027 BUDGET -- NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

INSURANCE

Health insurance claims

This bill imposes upon insurers certain requirements for health insurance claims processing and denials, including a requirement 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, including 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.

Under current law, insureds may request an independent review of adverse actions under a health insurance policy under certain circumstances. The bill provides that an insured also has the right to request from the Office of the Public Intervenor created under this bill a review of any health insurance claim denial.

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.

Health insurance policies are referred to as disability insurance policies in the bill and under current law.

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. 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 2. 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)