



2015 SENATE BILL 650

January 27, 2016 - Introduced by Senators ROTH, RINGHAND and LASEE, cosponsored by Representatives BERNIER, MACCO, HORLACHER, A. OTT, KREMER, T. LARSON, THIESFELDT, E. BROOKS, TITTL and KULP. Referred to Committee on Insurance, Housing, and Trade.

1 **AN ACT** *to repeal* 632.87 (3) (a) 1., 632.87 (3) (a) 2. and 632.87 (3) (b) 3.; *to*
2 *renumber* 632.857; *to renumber and amend* 632.87 (3) (a) (intro.); *to amend*
3 632.87 (3) (c); and *to create* 632.857 (2), 632.87 (3) (ac), 632.87 (3) (am) 1.,
4 632.87 (3) (am) 2., 632.87 (3) (b) 3m. and 632.87 (3) (d) of the statutes; **relating**
5 **to:** nondiscriminatory insurance coverage of chiropractic services, providing an
6 exemption from emergency rule procedures, granting rule-making authority,
7 and providing a penalty.

Analysis by the Legislative Reference Bureau

Summary

This bill makes a number of changes to requirements for and prohibitions on health insurers with respect to coverage of chiropractic services and requires health insurers to file annual reports on their compliance with the requirements and prohibitions.

Policy prohibitions on excluding, restricting, or denying coverage

Under the bill, a health insurance policy may not restrict or deny coverage for the diagnosis and treatment of a condition or complaint by a chiropractor acting within the scope of his or her license and may not exclude, restrict, or deny coverage of items or services provided by a chiropractor acting within the scope of his or her

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license if the policy covers the diagnosis and treatment of the condition or complaint by a physician and the same items or services provided by a physician. This prohibition applies even if different nomenclature or codes are used to describe the condition or complaint or items or services.

Under current law, a policy is already prohibited from excluding coverage for the diagnosis and treatment of a condition or complaint by a chiropractor if the diagnosis and treatment of the condition or complaint are covered when provided by a physician, even if different nomenclature is used to describe the condition or complaint. Current law explicitly states that this prohibition does not preclude the application of deductibles or coinsurance to chiropractic and physician charges on an equal basis or the application of cost containment or quality assurance measures to chiropractic services in a manner that is consistent with cost containment or quality assurance measures that generally apply to physician services. The bill removes this statement of what is not precluded and provides that the new prohibition against excluding, restricting, or denying coverage of chiropractic services prohibits a policy, among other things, from applying cost containment measures or quality assurance or performance measures unequally to chiropractors and primary care physicians with respect to items or services that may be provided by chiropractors and primary care physicians and from requiring an insured to pay a higher copayment or coinsurance amount for services provided by a chiropractor than the copayment or coinsurance amount that the insured must pay for the same or similar services provided by a primary care physician.

Insurer requirement to provide timely access

Current law prohibits an insurer, under a health insurance policy that covers chiropractic services, from doing a number of things, including establishing underwriting standards that are more restrictive for chiropractic care than for care provided by other health care providers. The bill removes this prohibition and replaces it with another related to access to chiropractic services. The bill prohibits an insurer from establishing or maintaining a policy or provider network that fails to do either of the following: 1) provide insureds with reasonable and timely access to chiropractic care or 2) apply the same standards to chiropractors that are applied to primary care physicians to ensure that insureds receive the same reasonable and timely access to chiropractors that they receive to primary care physicians, including such standards as geographic accessibility, waiting times, and provider-to-insured ratios.

Insurer report

Finally, the bill requires every health insurer annually to file a report with the Office of the Commissioner of Insurance (OCI) that demonstrates the insurer's compliance in the previous year with the requirements and prohibitions related to equality of coverage between chiropractors and primary care physicians. OCI must promulgate rules for the content and format of the report and must make the filed reports publicly available on OCI's Internet site. The bill also authorizes OCI to impose on an insurer that fails to file a report when due a forfeiture of \$1,000 per day for each day the report is overdue.

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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.** 632.857 of the statutes is renumbered 632.857 (1).

2 **SECTION 2.** 632.857 (2) of the statutes is created to read:

3 632.857 (2) Sections 632.87 (3) (b) 1. and 632.875, rather than this section,
4 apply if the restriction or termination of coverage relates to treatment of a condition
5 or complaint by a chiropractor acting within the scope of his or her license.

6 **SECTION 3.** 632.87 (3) (a) (intro.) of the statutes is renumbered 632.87 (3) (am)
7 (intro.) and amended to read:

8 632.87 (3) (am) (intro.) No policy, plan, or contract may exclude, restrict, or
9 deny coverage for diagnosis and treatment of a condition or complaint by a licensed
10 chiropractor, or exclude, restrict, or deny coverage for items or services provided by
11 a chiropractor, acting within the scope of the chiropractor's professional license, if the
12 policy, plan, or contract covers diagnosis and treatment of the condition or complaint
13 by a licensed physician ~~or osteopath~~, or covers the same items or services provided
14 by a physician, even if different nomenclature is or codes are used to describe the
15 condition or complaint or items or services. Examination by or referral from a
16 physician shall not be a condition precedent for receipt of chiropractic care under this
17 paragraph. This paragraph ~~does not~~ prohibits, among other things, all of the
18 following:

19 **SECTION 4.** 632.87 (3) (a) 1. of the statutes is repealed.

20 **SECTION 5.** 632.87 (3) (a) 2. of the statutes is repealed.

21 **SECTION 6.** 632.87 (3) (ac) of the statutes is created to read:

SENATE BILL 650**SECTION 6**

1 632.87 (3) (ac) In this subsection:

2 1. “Chiropractor” means a chiropractor licensed under ch. 446.

3 2. “Cost containment measure” means any mechanism, strategy, or program
4 used by an insurer to reduce a benefit payment or costs under a health care policy,
5 plan, or contract. “Cost containment measure” includes such practices as patient
6 cost-sharing, utilization management, reimbursement adjustment, and limits on
7 the number of visits.

8 3. “Patient cost-sharing” means the amount an insured pays out-of-pocket for
9 health care items or services, including deductibles, copayments, and coinsurance.

10 4. “Physician” means a physician licensed under subch. II of ch. 448.

11 5. “Primary care physician” has the meaning given in s. 609.01 (4m).

12 6. “Quality or performance measure” means a specific qualitative or
13 quantitative indicator that measures health outcomes; processes; structures;
14 patient experience, access, or safety; or other results for an individual patient or a
15 defined population of patients.

16 **SECTION 7.** 632.87 (3) (am) 1. of the statutes is created to read:

17 632.87 (3) (am) 1. Applying cost containment measures or quality or
18 performance measures to chiropractors on an unequal basis compared to primary
19 care physicians with respect to items or services that may be provided by both
20 physicians and chiropractors acting within the scopes of their respective professional
21 licenses, even if different nomenclature or codes are used to describe or identify the
22 items or services.

23 **SECTION 8.** 632.87 (3) (am) 2. of the statutes is created to read:

24 632.87 (3) (am) 2. Imposing a copayment or coinsurance amount on an insured
25 for services provided by a chiropractor that is greater than the copayment or

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1 coinsurance amount imposed on an insured for the same or similar services provided
2 by a primary care physician.

3 **SECTION 9.** 632.87 (3) (b) 3. of the statutes is repealed.

4 **SECTION 10.** 632.87 (3) (b) 3m. of the statutes is created to read:

5 632.87 (3) (b) 3m. Establish or maintain a policy, plan, contract, or provider
6 network that fails to do any of the following:

7 a. Provide insureds with reasonable and timely access to care provided by
8 chiropractors.

9 b. Apply the same standards to chiropractors, in the same manner and using
10 the same methodology, such as provider-to-insured ratios, waiting times, and
11 geographic accessibility standards, that are applied to primary care physicians to
12 ensure that insureds receive the same reasonable and timely access to chiropractors
13 that insureds receive to primary care physicians.

14 **SECTION 11.** 632.87 (3) (c) of the statutes is amended to read:

15 632.87 (3) (c) An exclusion or a restriction that violates par. (am) or (b) is void
16 in its entirety.

17 **SECTION 12.** 632.87 (3) (d) of the statutes is created to read:

18 632.87 (3) (d) Every insurer that provides health care coverage under a policy,
19 plan, or contract shall annually, no later than February 1, file a report with the
20 commissioner that demonstrates the insurer's compliance in the previous year with
21 pars. (am) and (b). The commissioner shall prescribe by rule the manner of filing and
22 the content and format of the report under this paragraph and shall make the filed
23 reports available to the public on the office's Internet site. If an insurer that is
24 required to file a report under this paragraph does not file the report by the time

SENATE BILL 650**SECTION 12**

1 required under this paragraph, the commissioner may impose a forfeiture against
2 the insurer of up to \$1,000 per day for each day the report is overdue.

3 **SECTION 13. Nonstatutory provisions.**

4 (1) EMERGENCY RULE FOR INSURER REPORTS. Using the procedure under section
5 227.24 of the statutes, the commissioner of insurance may promulgate the rule
6 required under section 632.87 (3) (d) of the statutes, as created by this act, for the
7 period before the effective date of the permanent rule promulgated under section
8 632.87 (3) (d) of the statutes, as created by this act, but not to exceed the period
9 authorized under section 227.24 (1) (c) of the statutes, subject to extension under
10 section 227.24 (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b), and
11 (3) of the statutes, the commissioner is not required to provide evidence that
12 promulgating a rule under this subsection as an emergency rule is necessary for the
13 preservation of the public peace, health, safety, or welfare and is not required to
14 provide a finding of emergency for a rule promulgated under this subsection.

15 **SECTION 14. Initial applicability.**

16 (1) POLICY, PLAN, OR CONTRACT PROVISIONS. The treatment of section 632.87 (3)
17 (a) (intro.), 1., and 2., (ac), (am) 1. and 2., and (b) 3. and 3m. of the statutes first applies
18 to all of the following:

19 (a) Except as provided in paragraphs (b) and (c), policies, plans, or contracts
20 that are newly issued or renewed, and self-insured governmental or school district
21 health plans that are newly established, extended, modified, or renewed, on the
22 effective date of this paragraph.

23 (b) Policies, plans, or contracts covering employees who are affected by a
24 collective bargaining agreement containing provisions inconsistent with the

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1 treatment of those sections that are newly issued or renewed on the earlier of the
2 following:

- 3 1. The day on which the collective bargaining agreement expires.
- 4 2. The day on which the collective bargaining agreement is extended, modified,
5 or renewed.

6 (c) Self-insured governmental or school district health plans covering
7 employees who are affected by a collective bargaining agreement containing
8 provisions inconsistent with the treatment of those sections that are newly
9 established, extended, modified, or renewed on the earlier of the following:

- 10 1. The day on which the collective bargaining agreement expires.
- 11 2. The day on which the collective bargaining agreement is extended, modified,
12 or renewed.

13 (2) INSURER REPORTS. The treatment of section 632.87 (3) (d) of the statutes first
14 applies to reports that are due in the year beginning after the effective date of this
15 subsection.

16 (3) VOID EXCLUSIONS OR RESTRICTIONS. The treatment of section 632.87 (3) (c) of
17 the statutes first applies to exclusions or restrictions under policies, plans, or
18 contracts that are newly issued or renewed, and self-insured governmental or school
19 district health plans that are newly established, extended, modified, or renewed, on
20 the effective date of this subsection.

21 (END)