



2025 ASSEMBLY BILL 184

April 15, 2025 - Introduced by Representatives FRANKLIN, BEHNKE, BRILL, JOHNSON, KAUFERT, KREIBICH, SUBECK, MURSAU and UDELL, cosponsored by Senators JACQUE, NASS, RATCLIFF and SPREITZER. Referred to Committee on Insurance.

1 **AN ACT** *to amend* 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g) and 185.983
2 (1) (intro.); *to create* 609.847 and 632.728 of the statutes; **relating to:**
3 coverage of individuals with preexisting conditions and benefit limits under
4 health plans.

Analysis by the Legislative Reference Bureau

This bill generally sets certain requirements and limitations on health insurance coverage in the event the federal Patient Protection and Affordable Care Act no longer preempts state law on the topic. Currently, the Affordable Care Act generally allows premium rates to be based only on individual or family coverage, rating area, age, and tobacco use; requires group and individual health insurance policies to accept every employer and individual that applies for coverage, known as guaranteed issue, and renew health insurance coverage at the option of the sponsor or individual; and prohibits health insurance policies from imposing preexisting condition exclusions. If those requirements and limitations of the Affordable Care Act become no longer enforceable or no longer preempt state law, all of the following apply under the bill:

1. Every individual health benefit plan must accept every individual in this state who applies for coverage and every group health benefit plan must accept every employer in this state that applies for coverage, regardless of whether any

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individual or employee has a preexisting condition. A health benefit plan may restrict enrollment in coverage to open or special enrollment periods, and the commissioner of insurance must ensure a statewide 45-day open enrollment period allowing individuals, including individuals who do not have coverage, to enroll in coverage. Health benefit plans must provide special enrollment periods for certain qualifying events described in federal law.

2. A health benefit plan offered on the individual or small employer market or a self-insured governmental health plan may not vary premium rates for a specific plan on any basis except age, tobacco use, area in the state, and whether the plan covers an individual or a family.

3. A health benefit plan or a self-insured governmental health plan may not impose a preexisting condition exclusion. A preexisting condition exclusion is defined in the bill as a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date of enrollment for coverage.

4. A health benefit plan or a self-insured governmental health plan is prohibited from imposing an annual or lifetime limit on the dollar value of benefits under the plan.

The Affordable Care Act exempts certain plans from complying with the act's provisions. Similarly, any health benefit plan that is exempt from a provision of the Affordable Care Act is exempt from complying with the corresponding provision of this bill.

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

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes is amended to read:

40.51 (8) Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.722, 632.728, 632.729, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.861, 632.867, 632.87 (3) to (6), 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 2. 40.51 (8m) of the statutes is amended to read:

40.51 (8m) Every health care coverage plan offered by the group insurance

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1 board under sub. (7) shall comply with ss. 631.95, 632.722, 632.728, 632.729,
2 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85,
3 632.853, 632.855, 632.861, 632.867, 632.885, 632.89, and 632.895 (11) to (17).

4 **SECTION 3.** 66.0137 (4) of the statutes is amended to read:

5 66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city,
6 or a village provides health care benefits under its home rule power, or if a town
7 provides health care benefits, to its officers and employees on a self-insured basis,
8 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),
9 632.722, 632.728, 632.729, 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798,
10 632.85, 632.853, 632.855, 632.861, 632.867, 632.87 (4) to (6), 632.885, 632.89,
11 632.895 (9) to (17), 632.896, and 767.513 (4).

12 **SECTION 4.** 120.13 (2) (g) of the statutes is amended to read:

13 120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.
14 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.722, 632.728, 632.729, 632.746 (10) (a)
15 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.861, 632.867,
16 632.87 (4) to (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

17 **SECTION 5.** 185.983 (1) (intro.) of the statutes is amended to read:

18 185.983 (1) (intro.) Every voluntary nonprofit health care plan operated by a
19 cooperative association organized under s. 185.981 shall be exempt from chs. 600 to
20 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44,
21 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93,
22 631.95, 632.72 (2), 632.722, 632.728, 632.729, 632.745 to 632.749, 632.775, 632.79,
23 632.795, 632.798, 632.85, 632.853, 632.855, 632.861, 632.867, 632.87 (2) to (6),

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632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 6. 609.847 of the statutes is created to read:

609.847 Preexisting condition discrimination prohibited; benefit limits. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.728.

SECTION 7. 632.728 of the statutes is created to read:

632.728 Coverage of individuals with preexisting conditions; rating; benefit limits. (1) **DEFINITIONS.** In this section:

(a) “Health benefit plan” has the meaning given in s. 632.745 (11).

(b) “Preexisting condition exclusion” means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date of enrollment for coverage.

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

(d) “Small employer” has the meaning given in s. 635.02 (7).

(2) ACCESS TO COVERAGE. Every individual health benefit plan shall accept every individual in this state who applies for coverage and every group health benefit plan shall accept every employer in this state that applies for coverage, regardless of whether any individual or employee has a preexisting condition. A health benefit plan may restrict enrollment in coverage described in this subsection to open or special enrollment periods under sub. (4).

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1 **(3) PREMIUM RATE VARIATION.** A health benefit plan offered on the individual
2 or small employer market or a self-insured health plan may vary premium rates for
3 a specific plan based only on the following considerations:

4 (a) Whether the plan covers an individual or a family.

5 (b) Rating area in the state, as established by the commissioner.

6 (c) Age, except that the rate may not vary by more than 3 to 1 for adults over
7 the age groups and the age bands shall be consistent with recommendations of the
8 National Association of Insurance Commissioners.

9 (d) Tobacco use, except that the rate may not vary by more than 1.5 to 1.

10 **(4) ENROLLMENT PERIODS.** (a) The commissioner shall ensure that every
11 individual health benefit plan has open enrollment during a statewide open
12 enrollment period of no longer than 45 days to allow individuals, including
13 individuals who do not have coverage, to enroll in coverage.

14 (b) Every health benefit plan shall provide special enrollment periods for
15 qualifying events under 26 USC 9801 (f) and 29 USC 1163.

16 **(5) PREEXISTING CONDITION EXCLUSION.** An individual or group health
17 benefit plan or a self-insured health plan may not impose a preexisting condition
18 exclusion for any time on an enrollee or beneficiary under the plan.

19 **(6) ANNUAL AND LIFETIME LIMITS.** An individual or group health benefit plan
20 or a self-insured health plan may not establish any of the following:

21 (a) Lifetime limits on the dollar value of benefits for an enrollee or a
22 dependent of an enrollee under the plan.

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1 (b) Annual limits on the dollar value of benefits for an enrollee or a dependent
2 of an enrollee under the plan.

3 (7) APPLICABILITY. (a) This section applies only if provisions of the federal
4 Patient Protection and Affordable Care Act, P.L. 111-148, as amended, under 42
5 USC 300gg to 300gg-4 and 300gg-11 are no longer enforceable or no longer preempt
6 state law relating to individual or group health insurance policies. If this section
7 applies, this section supersedes any conflicting provision of s. 625.12 (1) or (2),
8 625.15 (1), 628.34 (3), 632.746, 632.76, 632.795 (4) (a), 632.896 (4), or 632.897 (11)
9 (a) or any other conflicting provision in chs. 600 to 655 to the extent this section
10 conflicts with that provision.

11 (b) 1. A health benefit plan that is not required to comply with 42 USC 300gg-
12 1, as amended, as of January 1, 2023, is not required to comply with sub. (2).

13 2. A health benefit plan that is not required to comply with 42 USC 300gg, as
14 amended, as of January 1, 2023, is not required to comply with sub. (3).

15 3. A health benefit plan that is not required to comply with 42 USC 300gg-3,
16 as amended, as of January 1, 2023, is not required to comply with sub. (5).

17 4. A health benefit plan that is not required to comply with 42 USC 300gg-11
18 (a) (1) (A), as amended, as of January 1, 2023, is not required to comply with sub. (6)
19 (a).

20 5. A health benefit plan that is not required to comply with 42 USC 300gg-11
21 (a) (1) (B), as amended, as of January 1, 2023, is not required to comply with sub. (6)
22 (b).

23 (END)