State of Wisconsin
2025 - 2026 LEGISLATURE

LRB-0277/1
EKL:cdc

2025 ASSEMBLY BILL 720

December 3, 2025 - Introduced by Representatives KURTZ, KAUFERT, KITCHENS, ANDRACA, BEHNKE, DONOVAN, GREEN, KNODL, KREIBICH, KRUG, MOSES, MURSAU, O'CONNOR, RODRIGUEZ and SUBECK, cosponsored by Senators TESTIN, DASSLER-ALFHEIM, HABUSH SINYKIN, JAMES, KEYESKI and PFAFF. Referred to Committee on Health, Aging and Long-Term Care.

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g) and 185.983 (1) (intro.); ***to create*** 609.825 and 632.851 of the statutes; **relating to:** coverage and reimbursement of emergency ambulance services under health insurance policies and plans.

Analysis by the Legislative Reference Bureau

This bill makes several changes to the coverage and reimbursement of emergency ambulance services under health insurance policies and plans.

Under the bill, defined network plans, preferred provider plans, and self-insured governmental plans that provide coverage of emergency medical services are required to cover emergency ambulance services provided by an ambulance service provider that is not a participating provider at one of the following rates, according to this order of priority:

1. A rate that is mutually agreed upon by the plan and the ambulance service provider.

2. A rate that is set or approved by a local governmental entity in the jurisdiction in which the emergency ambulance services originated.

3. A rate that is 350 percent of the Medicare program's published rate for the services in the same geographic area or a rate that is equivalent to the rate billed by the ambulance service provider for the services, whichever is less.

The bill provides that an ambulance service provider that is reimbursed at the applicable rate may not charge an enrollee an additional amount for the emergency ambulance services except for any cost-sharing responsibility, such as a copayment, coinsurance, or deductible. The bill also prohibits the plan from imposing a cost-sharing amount on an enrollee that is greater than the amount that would have applied had the ambulance service provider been a participating provider.

The bill further requires that a health insurance policy or self-insured governmental health plan respond to claims for covered emergency ambulance services within 30 days by remitting payment directly to the ambulance service provider or by notifying the provider of any defect with the claim. The bill also provides that the policy or plan must remit payment for the transportation of a patient by ambulance (including transport from one facility to another to receive services not available at the first) as a medically necessary emergency ambulance service at a rate as described above if the ambulance service provider includes with its claim for payment a medical necessity certification statement signed by an individual who meets criteria established by federal regulations.

For further information see the state fiscal estimate, which will be printed as an appendix to 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, 632.729, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.851, 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 board under sub. (7) shall comply with ss. 631.95, 632.722, 632.729, 632.746 (1) to

(8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.851, 632.853, 632.855, 632.861, 632.867, 632.885, 632.89, and 632.895 (11) to (17).

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

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.722, 632.729, 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.851, 632.853, 632.855, 632.861, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

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

120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.722, 632.729, 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.851, 632.853, 632.855, 632.861, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

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

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.722, 632.729, 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.851, 632.853, 632.855, 632.861, 632.867, 632.87 (2) to (6), 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. 609.825 of the statutes is created to read:

609.825 Coverage of emergency ambulance services. (1) In this section:

(a) "Ambulance service provider" has the meaning given in s. 256.01 (3).

(b) "Self-insured governmental plan" means a self-insured health plan of the state or a county, city, village, town, or school district that has a network of participating providers and imposes on enrollees in the self-insured health plan different requirements for using providers that are not participating providers.

(2) A defined network plan, preferred provider plan, or self-insured governmental plan that provides coverage of emergency medical services shall cover emergency ambulance services provided by an ambulance service provider that is not a participating provider at a rate that is the following, in the following order of priority:

(a) A rate that is mutually agreed upon by the defined network plan, preferred provider plan, or self-insured governmental plan and the ambulance service provider.

(b) A rate that is set or approved by a local governmental entity in the jurisdiction in which the emergency ambulance services originated.

(c) A rate that is 350 percent of the current published rate for the provided emergency ambulance services established by the federal centers for medicare and medicaid services under title XVIII of the federal social security act, 42 USC 1395 et seq., in the same geographic area or a rate that is equivalent to the rate billed by

the ambulance service provider for emergency ambulance services provided, whichever is less.

(3) No defined network plan, preferred provider plan, or self-insured governmental plan may impose a cost-sharing amount on an enrollee for emergency ambulance services provided by an ambulance service provider that is not a participating provider at a rate that is greater than the requirements that would apply if the emergency ambulance services were provided by a participating ambulance service provider.

(4) No ambulance service provider that receives reimbursement under this section may bill an enrollee for any additional amount for emergency ambulance services except for any copayment, coinsurance, deductible, or other cost-sharing responsibilities required to be paid by the enrollee.

(5) For purposes of this section, "emergency ambulance services" does not include air ambulance services.

SECTION 7. 632.851 of the statutes is created to read:

632.851 Reimbursement of emergency ambulance services. (1) In this section:

(a) "Ambulance service provider" has the meaning given in s. 256.01 (3).

(b) "Clean claim" means a claim that has no defect of impropriety, including a lack of required substantiating documentation or any particular circumstance that requires special treatment that prevents timely payment from being made on the claim.

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

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

(2) (a) A disability insurance policy or self-insured health plan shall, within 30 days after receipt of a clean claim for covered emergency ambulance services, promptly remit payment for covered emergency ambulance services directly to the ambulance service provider. No disability insurance policy or self-insured health plan may send payment for covered emergency ambulance services to an enrollee.

(b) A disability insurance policy or self-insured health plan shall respond to a claim for covered emergency ambulance services that is not a clean claim by sending a notice, within 30 days after receipt of the claim, acknowledging the date of receipt of the claim and informing the ambulance service provider of one of the following:

1. That the disability insurance policy or self-insured health plan is declining to pay all or part of the claim, including the specific reason or reasons for the denial.

2. That additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is required.

(3) A disability insurance policy or self-insured health plan shall remit payment for the transportation of any patient by ambulance, including transport from one facility to another to receive services not available at the originating facility, as a medically necessary emergency ambulance service in the amount described under s. 609.825 (2) if the ambulance service provider includes with its claim for payment a medical necessity certification statement signed and dated by an individual who meets the criteria under 42 CFR 410.40 (a) (i) to (iii).

SECTION 8. Initial applicability.

(1) For policies and plans containing provisions inconsistent with this act, this

act first applies to policy or plan years beginning on the effective date of this subsection, except as provided in sub. (2).

(2) For policies and plans that are affected by a collective bargaining agreement containing provisions inconsistent with this act, this act first applies to policy or plan years beginning on the effective date of this subsection or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

SECTION 9. Effective date.

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

(END)