

Fact Sheet on Mandated Benefits in Health Insurance Policies

OFFICE OF THE COMMISSIONER OF INSURANCE

PI-019 (R 06/2017)

Health insurance policies sold in Wisconsin often include "mandated benefits." These are benefits an insurer must include in certain types of health insurance policies. Most mandated benefits apply to health insurance sold to both groups and to individuals. However, mandated benefits for maternity coverage and mental health parity only apply to group insurance.

HMOs are regulated as insurance companies and are generally subject to the mandated benefits. HMOs organized as cooperative health plans are not subject to mandates for grandchildren, handicapped children, diabetes, home health care, kidney disease, maternity coverage, or skilled nursing facility.

Professional Health Care Services

- **Chiropractors**—Health insurance must cover services provided by a chiropractor if the policy would provide coverage for the same services if performed by a physician or osteopath. The insurer may not require the insured to be referred to a chiropractor by a physician to receive benefits. [s. 632.87 (3), Wis. Stat.]
- **Dentists**—Health insurance must provide coverage for diagnosis or treatment of a condition or complaint performed by a licensed dentist if the policy covers diagnosis and treatment of the condition if performed by any other health care provider. [s. 632.87 (4), Wis. Stat.]
- **Nonphysician Providers**—Insurers may not refuse to pay for services by certain nonphysician providers if the service is covered by the policy and the professional is licensed to provide the service, unless the policy specifically excludes any coverage by that nonphysician provider. [s. 632.87 (1), Wis. Stat.]

- **Nurse Practitioners**—Health insurance providing coverage for Papanicolaou (PAP) tests, pelvic examinations, and associated laboratory work if performed by a physician must also provide coverage for these services when performed by a nurse practitioner acting within the scope of his or her license. [s. 632.87 (5), Wis. Stat.]
- **Optometrists**—Insurers may not exclude coverage for services provided by an optometrist if the contract covers the same service when it is provided by another health care provider. Insurers may exclude all vision care services and procedures from coverage. [s. 632.87 (2) and (2m), Wis. Stat.]

Covered Persons

- **Adopted Children**—Health insurance providing coverage for dependent children must cover adopted children and children placed for adoption on the same terms and conditions as natural children. Policies may not exclude or limit coverage of a disease or physical condition of the child because the disease or condition existed before coverage under the policy began. [s. 632.896, Wis. Stat.]
- **Dependents**—Health insurance providing dependent coverage of children must provide coverage to an adult child of the applicant or insured if the child is under the age of 26.

Coverage must also be provided to an adult child regardless of age if the child was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education. [s. 632.885, Wis. Stat.]

- **Grandchildren**—Health insurance providing coverage for any child of the insured shall provide the same coverage for all children of that child until that child reaches the age of 18. [s. 632.895 (5m), Wis. Stat.]
- **Handicapped Children**—Health insurance covering dependent children must provide an extension of coverage when a child reaches the age limit for a dependent child while the child continues to be both incapable of self-sustaining employment because of a mental retardation or physical handicap and is chiefly dependent upon the insured person for support and maintenance. Insurers can require notice of continued dependence after a child reaches the maximum age under the policy. [s. 632.88, Wis. Stat.]
- **Newborn Infants**—Health insurance must provide coverage from the moment of birth for a newborn child of the insured. The newborn shall receive the same coverage the policy provides for any children covered or eligible for coverage under the policy. Coverage for newborn children must include functional repair and restoration of congenital defects and birth abnormalities as an injury or sickness under the policy.

Policies may require notification of a child's birth and payment of any required premiums be furnished to the insurer within 60 days after the date of birth. Insurers may refuse to continue coverage beyond the 60-day period if such notification is not received unless within one year after the birth of the child the insured makes all past due payments with interest at the rate of 5 1/2% per annum. [s. 632.895 (5), Wis. Stat.]

- **Student on Medical Leave**—Health insurance providing coverage for a person as a dependent of the insured because the person is a full-time student shall continue to provide dependent coverage for the person if, due to a medically necessary leave of absence, he or she ceases to be a full-time student.

A student is required to submit documentation and certification from the person's attending physician stating the medical necessity of the leave of absence. [s. 632.895 (15), Wis. Stat.]

Mandatory Benefits

- **Autism Spectrum Disorder**—Health insurance is required to provide coverage for the treatment of autism spectrum disorders which includes autism disorder, Asperger's syndrome, and pervasive developmental disorder not otherwise specified. Coverage must be provided for evidence-based treatment of autism spectrum disorders if the treatment is prescribed by a physician and provided by qualified providers. Treatment of autism spectrum disorders is considered mental health treatment not habilitative treatment.

Coverage may be subject to deductibles, co-insurance, or copayments generally applied to other conditions covered by the policy or plan. The coverage may not be subject to limitations or exclusions, including limitations on the number of treatment visits.

Additional information can be found in the *Frequently Asked Questions on Mandated Coverage for Autism Services* at oci.wi.gov/Documents/Consumers/PI-234.pdf.

[s. 632.895 (12m), Wis. Stat., and s. Ins 3.36, Wis. Adm. Code]

- **Breast Reconstruction**—Health insurance providing coverage for a mastectomy is required to provide coverage of breast reconstruction of the affected tissue incident to a mastectomy. [s. 632.895 (13), Wis. Stat.]
- **Coverage of Certain Health Care Costs in Cancer Clinical Trials**—Health insurance is required to provide coverage of routine medical services for the treatment of cancer provided to an insured in a cancer clinical trial if the services would be covered under the policy if the insured were not enrolled in a cancer clinical trial. The coverage is subject to all terms, conditions and restrictions applying to other coverage under the policy, including the treatment and services performed by participating and nonparticipating providers. Health insurance is not required to cover the cost of the treatment or drug the clinical trial is studying. [s. 632.87 (6), Wis. Stat.]
- **Hearing Aids and Cochlear Implants**—Health insurance is required to provide coverage for hearing aids, cochlear implants, and related

treatment prescribed by a physician or by a licensed audiologist for children under 18 years of age. The child must be certified as deaf or hearing impaired. The cost of hearing aids is not required to exceed the cost of one hearing aid per ear per child more than once every three years.

Coverage may be subject to any cost-sharing provisions, limitations, or exclusions, other than preexisting condition exclusion, applying generally under the health insurance policy. [s. 632.895 (16), Wis. Stat.]

- **Contraceptive Coverage**—Health insurance providing coverage for outpatient health care services, preventive treatments and services, or prescription drugs and devices is required to also provide coverage for contraceptives prescribed by a health care provider, and outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive if covered for any other drug benefits under the policy or plan. Coverage may only be subject to the exclusions, limitations, or cost-sharing provisions applying generally to the coverage of outpatient health care services, preventive treatment and services, or prescription drugs and devices provided under the policy. [s. 632.895 (17), Wis. Stat.]
- **Colorectal Cancer Screening**—Health insurance covering any diagnostic or surgical procedures is required to cover colorectal cancer examinations and laboratory tests for any insured who is 50 years of age or older or any insured who is under 50 years of age and at high risk for colorectal cancer. The insurer may use the most current guidelines issued by the U.S. Preventive Services Task Force, the National Cancer Institute, or the American Cancer Society in determining which screening tests and procedures to cover. [s. 632.895 (16m), Wis. Stat., and s. Ins 3.35, Wis. Adm. Code]
- **Facility Charges and Anesthetics for Dental Care**—Health insurance is required to cover hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care for a child under the age of 5, an individual who has a chronic disability, or an individual who has a medical condition requiring hospitalization or general anesthesia for dental

care. This requirement does not apply to dental-only plans. [s. 632.895 (12), Wis. Stat.]

- **Diabetes**—Health insurance covering expenses for the treatment of diabetes shall provide coverage for insulin infusion pumps, other equipment and supplies, including insulin and other prescription medication, and diabetic self-management education programs. Insurers may apply the same exclusions, limitations, deductibles and coinsurance provisions applying to other covered expenses. Coverage may be limited to the purchase of one pump per year, and the insured may be required to use the pump 30 days before purchase. [s. 632.895 (6), Wis. Stat.]
- **Genetic Testing**—Health insurers are prohibited from:
 - Requiring an individual or a member of the individual's family to obtain a genetic test using DNA from the person's blood to determine the presence of a genetic disease or disorder.
 - Requiring an individual to reveal if he or she or a member of the family has had a genetic test and revealing the results of that test.
 - Requiring or requesting a health care provider to reveal either an individual or family member had a genetic test or the results of a genetic test.
 - Conditioning coverage on whether a person or member of a person's family has had a genetic test.
 - Basing premium rates or other aspects of insurance coverage on whether a person or a person's family member has had a genetic test and revealing the results of the test. [s. 631.89, Wis. Stat.]
- **Drugs for Treatment of HIV Infection**—Health insurance providing coverage of prescription medicine shall provide coverage for each drug prescribed by the insured's physician for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection and is approved by the Federal Food and Drug Administration, including each investigational new drug that is in or has completed a phase 3 clinical investigation. If the drug is an investigational new drug, it must be prescribed and administered in accordance with the treatment protocol approved for the investigational new drug. Coverage of these drugs may be subject

to any copayments and deductibles the health insurance policy applies generally to other prescription medication covered by the policy. [s. 632.895 (9), Wis. Stat.]

- **Home Health Care**—Health insurance providing benefits for inpatient hospital care must provide coverage for the usual and customary fees for at least 40 home health care visits per year. Home health care may include intermittent home nursing care, home health aide services, various types of therapy, medical supplies, medication prescribed under the home care plan, and nutrition counseling. If two or more insurers jointly provide health insurance coverage to an insured under two or more policies, home health care coverage is required under only one of the policies.

Coverage may be limited to cases where hospitalization or skilled nursing confinement would be necessary if home care were not provided and the necessary care cannot be provided by the patient's family without undue hardship. Only state-licensed or Medicare-certified home health agencies or certified rehabilitation agencies must be covered. [s. 632.895 (2), Wis. Stat.]

- **Child Immunizations**—Health insurance providing coverage for a dependent of an insured must provide coverage of appropriate and necessary immunizations for children under 6 years of age. The coverage may not be subject to any deductibles, copayments or coinsurance under the policy or plan, except a managed care plan is prohibited from applying such cost-sharing only with respect to services provided by network providers. [s. 632.895 (14), Wis. Stat.]
- **Kidney Disease**—Health insurance covering hospital expenses must provide for inpatient and outpatient treatment of kidney disease, including dialysis, transplantation, and donor-related services. The coverage is not required to duplicate Medicare benefits and may be subject to the same limitations applying to other covered health conditions. [s. 632.895 (4), Wis. Stat.]
- **Lead Screening**—Health insurance is required to provide coverage for blood lead tests for children under 6 years of age, according to

screening protocols established by the Department of Health Services. [s. 632.895 (10), Wis. Stat.]

- **Mammography**—Health insurance must provide women between the ages of 45 and 49 two examinations by low-dose mammography. Insurers may refuse to provide coverage for an examination by low-dose mammography for a woman aged 45 to 49 if she has had such an examination within the previous two years. Insurers may apply any mammogram obtained during that age period, even if obtained prior to coverage under the policy, toward the two mandated examinations. Women who are age 50 to 65 must be covered for annual mammograms.

Coverage is required regardless of whether the woman shows any symptoms. Policies may not apply exclusions or limitations not applying to other radiological examinations covered under the policy. [s. 632.895 (8), Wis. Stat.]

- **Maternity Coverage**—If a group health policy provides maternity coverage for anyone covered under the policy, it must provide coverage for all persons covered under the policy. Insurers may not apply exclusions and limitations to the mandated maternity coverage not applying to other maternity coverage provided under the policy. [s. 632.895 (7), Wis. Stat.]
- **Mental Health Parity**—Group health insurance providing coverage for inpatient hospital treatment or outpatient treatment must provide coverage of inpatient hospital services, outpatient services, and transitional treatment arrangements for the treatment of nervous and mental disorders and substance use disorders.

Coverage may be subject to any exclusions and limitations; deductibles; copayments; coinsurance and out-of-pocket expenses that generally apply to other conditions covered by the plan. Coverage may also include visit and other treatment limitations when the restrictions applied are similar to substantially all other coverage under the plan. Any overall deductible amount or out-of-pocket limit for the plan must include expenses incurred for the treatment of nervous and mental disorders and substance use disorders.

Federal law may provide additional coverage under provisions included in the Patient Protection and Affordable Care Act (PPACA) and Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. [s. 632.89, Wis. Stat.]

A Fact Sheet on Mandated Benefits for the Treatment of Nervous and Mental Disorders or Substance Use Disorders is available at oci.wi.gov/Documents/Consumers/PI-008.pdf.

- **Oral and Injected Chemotherapy**—Health insurance covering injected or intravenous chemotherapy and oral chemotherapy are prohibited from requiring a higher copayment, deductible, or coinsurance amount for oral chemotherapy than they require for injected or intravenous chemotherapy. For high-deductible health plans, the limitation applies only after the insured deductible has been satisfied.

Health plans limiting copayments paid by covered individuals to no more than \$100 for a 30-day supply of an oral chemotherapy medication are considered to comply with this mandate. Annually on January 1, health plans may adjust the \$100 limit by an amount not exceeding the percentage increase in the U.S. consumer price index for all urban consumers, U.S. city average, as determined by the U.S. Department of Labor. [s. 632.867, Wis. Stat.]

- **Skilled Nursing Care**—Health insurance covering hospital expenses must cover at least 30 days of skilled nursing care to patients who enter a licensed skilled nursing facility within 24 hours after discharge from a hospital. Coverage may be limited to care that is medically necessary as certified by the attending physician every 7 days and for the same condition treated in the hospital. Skilled nursing care is narrowly defined. Many people in nursing homes are not receiving skilled care. [s. 632.895 (3), Wis. Stat.]
- **TMJ Disorders**—Health insurance providing coverage of any diagnostic or surgical procedure involving a bone, joint, muscle, or tissue are required to provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular (TMJ)

disorders. Plans are permitted to impose a prior authorization requirement on surgical or nonsurgical TMJ services, but not diagnosis. [s. 632.895 (11), Wis. Stat.]

For Additional Information:

State and local government self-funded health plans are not generally subject to Wisconsin insurance law. However, various self-funded Wisconsin government health plans are subject to some of the mandated benefits. If you are covered by a self-funded state or local government plan, check with your employer or the plans administrator for additional information.

For information regarding mandated benefits in Medicare supplement insurance, refer to the *Wisconsin Guide to Health Insurance for People with Medicare*, available on our web site at oci.wi.gov/Documents/Consumers/PI-002.pdf.

Also, please note the Affordable Care Act requires individual health insurance and small group insurance to include “essential health benefits” in their policies. Information on the federal law may be found at www.healthcare.gov.

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, contact OCI.

To file a complaint online or to print a complaint form:

[OCI's Web Site](http://oci.wi.gov)

oci.wi.gov

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(608) 266-0103 (In Madison)

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