What is the autism mandate?
Wisconsin law requires health insurers to cover certain treatments for individuals with autism spectrum disorders. Specifically, coverage of at least $50,000 is required for intensive-level services per year for up to four years and at least $25,000 for nonintensive-level services, adjusted annually by the Consumer Price Index (CPI). (s 632.895 (12m) (c) 1, Wis. Stat.)

For 2019, insurers must provide coverage of at least $62,221 for intensive-level services and $31,110 for nonintensive-level services. Each December, the Office of the Commissioner of Insurance (OCI) publishes the adjusted coverage amounts effective for the following year.

Does this mandate apply to all health care coverage?
The statute applies to:
• Group and individual disability (health) insurance policies.
• Self-insured health plans sponsored by the state, county, city, town, village, or school district providing coverage to dependents.

The statute does NOT apply to:
• Disability (health) insurance policies covering only certain specified diseases such as cancer.
• A health care plan offered by a limited service health organization or preferred provider plan that is not also a defined network plan.
• A long-term care insurance policy.
• A Medicare replacement policy or a Medicare supplement policy.
• A self-funded health benefit plan from an employer that’s subject to federal jurisdiction.

How do I get services covered?
To qualify, your child
• Needs a primary diagnosis of an autism spectrum disorder,
• Must be between the ages of 2 and 9 years old for intensive-level services, and
• Must have a prescription from a physician to receive treatment.
Treatments must be provided by a qualified provider. Contact your insurance company for listings of qualified providers.

What services are covered?
Intensive-Level Services
Intensive-level services must be evidence-based, behavioral therapies provided by a qualified health care provider. Evidence on autism treatments is frequently updated, so check with your insurer to find out which services are covered.

NonIntensive-Level Services
Nonintensive-level services must also be evidence-based therapies. Similar to intensive-level services, check with your insurer about which services are covered.

Is there an age requirement?
Intensive-level services are covered starting on a child’s 2nd birthday until his 9th birthday.

There are no age requirements for nonintensive-level services. The table below summarizes the differences between intensive- and nonintensive-level services.

Are any of my child’s other health care services covered by the mandate?
No. This mandate only applies to services relating to autism spectrum disorder. The services must also meet the definition of either “intensive-level services” or “nonintensive-level services.”

When does insurance coverage for intensive-level treatment end?
Coverage ends when:
• The child has received a cumulative 4 years of intensive-level services.

<table>
<thead>
<tr>
<th>Intensive-Level Services</th>
<th>Nonintensive-Level Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Benefit*</td>
<td>At least $50,000 for services provided</td>
</tr>
<tr>
<td>Age Requirement</td>
<td>Must begin after 2 years old</td>
</tr>
<tr>
<td></td>
<td>Must begin before 9 years old</td>
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<tr>
<td>Time Limit</td>
<td>Up to 4 years of cumulative years</td>
</tr>
<tr>
<td>Minimum Treatment Hours</td>
<td>On average, 20 hours per week</td>
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</tbody>
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*A ANNually adjusted by CPI and posted to the OCI website.
• The child receives services, on average, less than 20 hours a week. The average is calculated over a 6-month period.
• The supervising professional consults with a physician and determines less treatment is medically appropriate.

How do I transition between intensive- and nonintensive-level services?
Your insurer will notify you your coverage has changed once the intensive-level phase has ended. The notification must state the reason for the change. Once your child begins nonintensive-level services, he or she cannot resume intensive-level services later.

Can an adult with autism be covered on their parent’s insurance?
If a child is diagnosed with an autism spectrum disorder before turning 18 years old and the condition qualifies as a handicap, the child may remain on the parent’s insurance. If the parent changes employers and the child is older than 18 but younger than 26, the child should be eligible for coverage under their parents’ insurance until his or her 26th birthday.

I’ve already paid for some intensive-level treatment for my child. How much more is she eligible for?
Coverage for intensive-level services may last up to 4 years total. This includes treatment time paid for by previous insurers. If a child previously received on average more than 20 hours of treatment per week, the time counts against the 4 years of intensive-level services mandated by the statute.

If my child has to stop intensive treatment temporarily, can he restart?
Intensive-level treatments may be delayed if the child has a significant medical condition or surgery. Treatment may also be delayed if there is a catastrophic event preventing treatment. Notify your insurer when these situations happen.

What if I disagree with my insurance company about the medical necessity of treatment under the mandate?
An insurance company cannot deny a claim under the mandate due to medical necessity. The insurer can deny a claim if it believes the treatment is not supported by evidence. If you receive a denial for this reason, you can dispute the denial through the insurer’s grievance process and an independent review process.

Is the diagnosis of autism covered under the mandate?
Health insurance covers the cost of autism testing, though copayments and deductibles may apply. These costs do not come out of the funds required under the mandate for that year.

Do I have to use providers in my health insurance plan?
Yes, if your plan requires you to use in-network plan providers for coverage. If your plan permits you to see out-of-network providers for other conditions, they must also accept claims from out-of-network providers for autism treatments. Remember, your plan may have different copayments or deductibles for out-of-network providers, so it may be more affordable to find an in-network provider.

Does the mandate require coverage if I choose an out-of-network provider?
No. You may be able to obtain out-of-network care through a referral from an in-network physician subject to approval by the insurer, but you may be responsible for higher deductibles and copayments for non-network providers. Check with your insurer.

Do I have to get prior authorization from my health insurer for autism services?
Generally, no, but it may be beneficial so your insurer can determine the most affordable way to provide services. If your plan requires prior authorization for similar outpatient services, then you may be required to have autism services prior authorized, too. Health maintenance organizations (HMOs) require prior authorization to receive services from out-of-network providers.

Are there deductibles or any other fees for my child to receive treatment?
The mandate requires certain insurance companies reimburse at least $62,221 for intensive-level services and $31,110 for nonintensive-level services. Reimbursement means the insurance company is responsible for paying the provider of the services. Payment will be made after services are performed and a claim is submitted to the insurer. The insurer is not required to pay more than the amount mandated by the statute although the policy may provide more coverage.

An insurance company may apply deductibles, coinsurance, or copay that generally apply to other conditions covered under the policy or plan. These amounts are considered part of the coverage you receive. The insurer cannot limit the number of treatment visits for therapies.

If a family faces a large financial burden because of high deductibles, copays, or coinsurance, can a provider reduce or waive the fees?
The mandate does not require a provider waive fees. Generally, providers are prohibited from reducing fees unless the total fee would impose an undue financial hardship on the individual insured.

Is the amount my family spends on out-of-network providers counted toward meeting our deductible for other services?
Consult your insurer to find out how they allocate out-of-pocket costs between different types of services in your health plan.

The purpose of this publication is to summarize the statute and rule requiring health insurers to provide coverage for treatment of autism spectrum disorders.

Statute: www.legis.state.wi.us/statutes/Stat0632.pdf
Rule: oci.wi.gov/Documents/Regulation/0336fn10.pdf

Contact your health insurance plan administrator to find out if your group coverage is fully insured or self-funded.
Contact your insurer to resolve questions regarding your coverage. To address a dispute, follow your insurer’s grievance process. If the conflict is not resolved to your satisfaction, you can file a complaint with OCI. Visit ociaccess.oci.wi.gov/complaints/public/ or call (800) 263-8517.

This publication is intended only as a guide. It is a summary and is not intended as an OCI directive nor to interpret or address technical legal questions. Although efforts have been made to ensure this publication is current and accurate, information is subject to change on a regular basis without prior notice.