

Frequently Asked Questions on Mandated Coverage for Autism Services

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. (s 632.895(12m)(c)1, Wis. Stat.)

For 2025, insurers must provide coverage of at least \$72,008 for intensive-level services and \$36,003 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.
- Group health plans issued in another state covering employees in Wisconsin, unless at least 25% of the employees covered under the plan reside in Wisconsin.

Ask your insurance company or health plan if the mandate applies to you.

Does the mandate apply to Wisconsin residents only?

If the health insurance policy was issued in Wisconsin, then the policy must include coverage for autism treatment complying with the mandate. The mandate applies to a policy bought in Wisconsin even if the insured moves out of Wisconsin.

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 two and nine years old for intensive-level services, and

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- 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. Like intensive-level services, you should check with your insurer about which services are covered.

A person with an autism spectrum disorder is NOT required to receive intensive-level services to qualify for nonintensive-level services. There is no age limit for receipt of services.

Is there an age requirement?

Intensive-level services are covered starting on a child's second birthday until their ninth birthday.

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

Is behavioral therapy covered?

Yes. Wisconsin's autism mandate requires health insurers to cover behavioral analyst services and behavioral therapy. This treatment refers to interactive approaches aimed at building skills that help the child reduce problem behaviors. It is also used to improve communication, social, self-care, and learning skills.

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 four years of intensive-level services.
- The child receives services, on average, less than 20 hours a week. The average is calculated over a six-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 that 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, they 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 disability, 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 parent's insurance until the child's 26th birthday.

I've already paid for some intensive-level treatment for my child. How much more are they eligible for?

Coverage for intensive-level services may last up to four years in total. This includes treatment time paid for by the family, other states, or covered by previous insurers. If a child previously received on average more than 20 hours of treatment per week, the time counts against the four years of intensive-level services mandated by the statute.

If my child must stop intensive treatment temporarily, can they 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 to reimburse at least \$72,008 for intensive-level services and \$36,003 for nonintensive-level services.

Reimbursement means the insurance company is responsible for paying the provider of the services. Payment is 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 a policy may provide more coverage.

An insurance company may apply deductibles, [coinsurance](#), or copays 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 to 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.

	Intensive-Level Services	Nonintensive-Level Services
Annual Benefit*	At least \$50,000 for services provided	At least \$25,000 for services provided
Age Requirement	Must begin after two years old Must begin before nine years old	None
Time Limit	Up to four years of cumulative years	No limit
Minimum Treatment Hours	On average, 20 hours per week	None

**Annually adjusted by Consumer Price Index and posted to the OCI website.*

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

Statute: legis.state.wi.us/statutes/Stat0632.pdf

Rule: oci.wi.gov/Documents/Regulation/0336fn10.pdf

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