STATE OF WISCONSIN

Frequently Asked Questions on Mandated Coverage for Autism Services

OFFICE OF THE COMMISSIONER OF INSURANCE PI-234 (R 12/2016)

What is the autism mandate?

Section 632.895 (12m) (c) 1., Wis. Stat., requires insurers to cover certain treatments for individuals with autism spectrum disorders. Specifically, it requires health insurers to provide coverage of at least $50,000 for intensive-level services per year for up to 4 years adjusted annually by the Consumer Price Index (CPI). Insurers are also required to provide coverage of at least $25,000 per year for nonintensive-level services adjusted annually by the CPI.

Each December, the Office of the Commissioner of Insurance (OCI) includes in this publication the adjusted coverage amount for intensive and nonintensive services in accordance with s. 632.895 (12m) (c) 1., Wis. Stat., and s. Ins 3.36 (12), Wis. Adm. Code. For calendar year 2017, insurers must provide coverage of at least $60,158 for intensive-level services and $30,079 for nonintensive-level services. The adjusted coverage amounts are effective for newly issued policies or on the first date of a modified, extended or renewed policy or certificate after January 1, 2017.

What health care coverage does the mandate apply to?

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 that provides coverage to dependents.

The statute does NOT apply to:
- Disability (health) insurance policies that cover 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.
- If your employer has a self-funded health benefit plan that is subject to federal jurisdiction, the mandate does not apply.
- Group health plans issued in another state that cover employees in Wisconsin unless at least 25% of the employees covered under the plan reside in Wisconsin.

If you are not sure whether the mandate applies to you, please contact your insurance company or health plan.

What is the scope of the mandate?

If the health insurance policy was issued in Wisconsin, then the policy must include coverage for autism treatment that complies with the mandate. A policy bought in Wisconsin must still comply with the mandate even if the insured moves out of Wisconsin. However, if a resident of another state buys a policy outside of Wisconsin, that policy does not need to comply with the mandate.

How do I get health care services covered under the mandate?

1. Determine whether the mandate applies to your plan or policy.
2. Determine whether your child qualifies. To qualify, your child needs a primary diagnosis of an autism spectrum disorder. Your child must also be older than 2 years of age and younger than 9 years of age for intensive-level services.

3. Your child must have a prescription from a physician to receive treatment.
4. The treatments must be provided by a qualified provider. Contact your insurance company for listings of qualified providers.

What services does the autism mandate require insurers to cover?

The autism mandate provides coverage for intensive-level services and nonintensive-level services.

Intensive-Level Services

Intensive-level services must be evidence-based, behavioral therapies provided to a child between the ages of 2 and 9 by a qualified health care provider. Because the evidence on autism treatments is frequently updated, please consult your insurer if you have specific questions about what services are covered.

NonIntensive-Level Services

Nonintensive-level services must be evidence-based therapies. Similar to intensive-level services, please consult your insurer if you have specific questions about what services are covered. A person with an autism spectrum disorder does not need to have previously received intensive-level services to qualify for nonintensive-level services and there are no age limitations for receipt of services.

Age Requirements

The mandate provides coverage for a child's intensive-level services starting on his or her 2nd birthday; however, a child may not begin receiving intensive-level services after their 9th birthday. There are no age requirements for nonintensive-level services. The table below summarizes the differences between intensive- and nonintensive-level services.

	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 2 years old Must *begin* before 9 years old	None
Time Limit	Up to 4 years cumulative years	No limit
Minimum Treatment Hours	On average, 20 hours per week	None

*Annually adjusted by CPI and posted to the OCI Web site.

How is "behavioral therapy" defined?

"Behavioral" means interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors.

"Therapy" means services, treatments, and strategies prescribed by a treating physician and provided by a qualified provider to improve the insured's condition or to achieve social, cognitive, communicative, self-care or behavioral goals that are clearly defined within the insured's treatment plan.

Are any of my child's other health care services covered by the mandate?

No. Only services relating to the individual's autism spectrum disorder are covered by this mandate. These services must also meet the definition of either "intensive-level services" or "nonintensive-level services."

When does insurance coverage for intensive-level treatment end?

Intensive-level services end when any of the following occur:

- The child has received a cumulative 4 years of intensive-level services.
- The child receives services, on average, less than 20 hours a week. (The average number of hours a week is calculated over a 6-month period.)
- It is determined by the supervising professional, after consulting with a physician, that less treatment is medically appropriate.

How do I transition between intensive- and nonintensive-level services?

Once the intensive-level phase has ended, your insurer will notify you that your coverage has changed. The notification must say the reason for the change in coverage. Once your child begins nonintensive-level services, he or she cannot resume intensive-level services later.

When does an adult with autism need to transition from their parent's insurance?

If a child is diagnosed with an autism spectrum disorder prior to turning 18 years of age and the child's condition qualifies as a handicapping condition, the child may remain on the parent's insurance provided the parents are able to provide the insurer sufficient supporting documentation. If the parents change employers and a child with an autism spectrum disorder is over 18 years of age but less than 26 years of age, then the child should be eligible for coverage under their parent's insurance until the child's 26th birthday.

My child has already received intensive-level treatment paid for by my family. How much intensive-level treatment will my child be eligible for?

Coverage for intensive-level services may last up to 4 years total. If a child previously received, on average, more than 20 hours of treatment per week, that time counts against the 4 years of intensive-level services mandated by the statute. This includes treatment time paid for by the family, other states, or covered by previous insurers.

My child receives intensive services through the mandate and needs to have surgery. They won't be able to participate in intensive treatment for a month. Can they re-start intensive treatment?

Yes. 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 that prevents treatment. You need to notify your insurer when these situations happen.

What happens 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?

The cost of testing to reach a diagnosis must be covered by an insurer; however, it does not come out of the funds required under the mandate for that year. Other portions of the policy typically cover the cost of diagnosis but may also include copayments or deductibles.

Do I have to use providers in my health insurance plan?

Yes, if your plan requires that you use plan providers for coverage. Some plans permit you to receive services from out-of-network providers. If your plan permits you to see out-of-network providers for other conditions in your policy,

they must also accept claims from out-of-network providers for autism treatments. Remember that your plan may have different copayments or deductibles for out-of-network providers than for in-network providers. If the plan uses only in-network providers, they may require that you use only their providers.

You may want to consult your insurer to consider finding an in-network provider. In-network providers may be more affordable.

I would like to have my child receive treatment from a provider who is not in my insurer's network of providers. Does the mandate require coverage in this situation?

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. However, as noted in the question above, you may be responsible for higher deductibles and copayments for non-network providers. If you have a dispute with your insurer about coverage, you should follow your insurer's grievance process. If the conflict is not resolved to your satisfaction or if you prefer, you may file a complaint with the Office of the Commissioner of Insurance. An online complaint form is available at https://ociaccess.oci.wi.gov/complaints/public/.

Do I have to get autism services prior authorized by my health insurer?

Generally, no. However, if your plan requires prior authorization for all services, then you must have services prior authorized. For health maintenance organizations (HMOs), you need prior authorization to receive services from out-of-network providers.

It may be beneficial to get prior authorization from your insurer because they can determine the most affordable way to provide services. It is also helpful to receive assurance that the treatment will be covered.

How does payment work? Do I need to pay a deductible or other fee for my child to receive treatment?

The mandate requires certain insurance companies reimburse at least $60,158 for intensive-level services and $30,079 for nonintensive-level services. Reimbursement means the insurance company is responsible for paying the provider of services for providing intensive- or nonintensive-level 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 copays that generally apply to other conditions covered under the policy or plan. The amount of the deductible, coinsurance or copays you (the consumer) pay is considered part of the coverage you receive. The insurer may not 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 to families?

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.

Will insurance companies count the amount we spend on out-of-network providers toward meeting our deductible for other services?

Please 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 document is to summarize the statute and rule requiring health insurers to provide coverage for treatment of autism spectrum disorders. Please revisit the OCI Web site as these frequently asked questions may be revised and additional questions and answers added in the future for guidance and clarity.

The statute containing the autism mandate is available at http://www.legis.state.wi.us/statutes/Stat0632.pdf.

The rule is available at https://oci.wi.gov/Documents/Regulation/0336fn10.pdf.

You should contact your plan administrator to find out if your group coverage is fully insured or self-funded. You should also contact your insurer's customer service department to resolve questions regarding your coverage. If you are unable to get a satisfactory response from your insurance company, you can file a complaint with OCI. OCI has an online complaint form available at https://ociaccess.oci.wi.gov/complaints/public/ or you can call 1 800-263-8517 to request that a complaint form be mailed to you.

If you have questions regarding this publication, please contact ocicomplaints@wisconsin.gov.

Disclaimer: 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 that this publication is current and accurate, information is subject to change on a regular basis without prior notice.

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

OCI's Web Site:
oci.wi.gov