



WISCONSIN: Frequently Asked Questions About the Autism Insurance Reform Law

1. What does the Wisconsin autism insurance reform law do?

Broadly speaking, the law does two main things:

1. It requires private health insurance companies to provide coverage for the diagnosis and treatment of autism spectrum disorder of at least \$50,000 for intensive-level services per year for a minimum of 4 years;
2. After the four-year intensive-level service period has expired, it requires private health insurance companies to provide coverage of at least \$25,000 annually for non-intensive-level services.

The specific terms and provisions of this law are described in more detail in this FAQ document.

2. When does the law requiring insurance companies to cover services for children with autism spectrum disorder go into effect?

The new autism insurance reform law went into effect November 1, 2009.

3. Once the Autism Insurance Act goes into effect, will my employer-provided health insurance be required to cover my child's autism services?

Yes. The Wisconsin's autism insurance reform law applies to fully-funded individual and group health plans and to state, county, city, town, village, and school district health plans provided to public employees.

4. What happens if we get our insurance through a "small group" employer (50 or fewer) or through an employer that self-insures?

If you get your insurance through a small group employer, your provider will be required to cover your child's autism services. The new law is not applicable to employers who operate self-funded health plans

5. What treatments are considered "intensive-level services" and are subject to the \$50,000 minimum included in the first four years?

The statute defines "intensive-level services" as any evidence-based behavioral therapy used to treat the cognitive, social, and behavioral deficits in individuals diagnosed with ASD. These therapies include any that are directly based on, and related to, the diagnosed individual's therapeutic goals and skills as prescribed by his or her physician.

The treatment plan must include at least 20 hours per week over a consecutive six-month period to be included as intensive-level services. These services include Applied Behavior Analysis (ABA).

6. What treatments are considered “nonintensive-level services” and are subject to the \$25,000 minimum following the first four years?

Nonintensive-level services include evidence-based therapy following intensive-level services. These services are specifically designed to sustain and maximize gains made during the intensive-level services or, for individuals not receiving intensive-level services, evidence-based therapy that will improve the individual’s condition.

7. Are there limits on what our private insurance is going to be required to cover?

Insurance companies are required to provide a minimum of \$50,000 per year for intensive level therapy to children aged 2 to 9 for a minimum of 4 years. Treatment may only be subject to a minimum of 30-35 hours of care per week. Following the minimum 4 years, a minimum of \$25,000 per year must be provided for nonintensive-level services. Beginning in 2011, the minimums will be adjusted upwards annually to account for inflation. Insurers are not required to cover acupuncture, animal-based therapy, auditory integration training, chelation therapy, child care fees, cranial sacral therapy, custodial or respite care, hyperbaric oxygen therapy, or special diets or supplements.

8. What coverage is mandated by the law?

The Wisconsin mandate requires that evidence-based therapy for individuals with autism spectrum disorders when provided by qualified providers. Services include those labeled nonintensive-level services and intensive level-services as defined above.

9. Is applied behavioral analysis (ABA) covered?

Yes. ABA is included in the intensive level services. As previously mentioned, coverage for intensive level services are subject to the \$50,000 minimum limit over a period of four years.

10. Will all of the Autism Spectrum diagnoses be covered, or just those diagnoses with the keyword of "autism?"

The statute covers autistic disorder, Asperger’s Syndrome, and Pervasive Development Disorder (Not Otherwise Specified).

11. Will Behavioral Specialist Consultation, Mobile Therapy, and Therapeutic Staff Support be covered under the mandate?

Behavioral Specialist Consultation, Mobile Therapy, and Therapeutic Staff Support are all covered services under the mandate as long as they fall under the definition of "evidence-based therapy."

12. Is Case Management covered?

Case Management is not a mandated service under the mandate.

13. What services are considered "evidence-based therapy"?

Evidence-based means therapy that is based on medical and scientific evidence and is considered an effective treatment or strategy.

14. Who is considered a qualified provider for purposes of prescribing and providing therapy?

The mandate requires the therapy to be prescribed by a physician and provided by a psychiatrist, psychologist, licensed clinical social worker, outpatient mental health clinic, occupational therapist or speech therapist, or a paraprofessional working under the supervision of a qualified psychiatrist, psychologist or licensed clinical social worker. These providers are required to meet certain training requirements to become qualified.

15. Will the new law require insurance companies to cover the cost of social groups? Must it be prescribed by a physician?

The mandate does not include a "list" of covered services. Rather, the law requires coverage for specific evidence-based therapy. Therefore, coverage under the bill will be determined by the insurance company based on the requirements of the law, whether the treatment is based on medical and scientific evidence, and whether the treatment is prescribed by a physician.

16. May an insurance company be able to question my child's existing autism diagnosis?

No, insurers are required to accept as valid a verified diagnosis of autism spectrum disorder when made by a provider skilled in testing.

17. Will insurance companies be able to deny services if my child is not making "sufficient progress" or has reached a plateau in his/her progress?

No. The law specifically requires coverage of nonintensive-level services to *sustain* and maximize gains made during intensive-level services.

18. If my insurance company denies my child's autism diagnostic or treatment services, where can I go for help?

Families can appeal any denial or partial denial of an autism diagnostic or treatment service to your insurance company and obtain a decision on an expedited basis. If your appeal is denied by the insurance company, your family can appeal for an independent, external review. If the independent external review denies your appeal, you can further appeal to a court of competent jurisdiction.

19. Which providers and services will be eligible for reimbursement under the statute?

Reimbursement is required for any evidence-based service prescribed by a physician that is provided by qualified professionals. Qualified professionals include psychiatrists, psychologists, licensed clinical social workers, an outpatient mental health clinic, occupational therapists or speech therapists, or a paraprofessional working under the supervision of a qualified psychiatrist, psychologist or licensed clinical social worker. These providers are required to meet certain training requirements to become qualified.

20. How can I be sure that the health care provider has the certification or license necessary to diagnose my child's autism disorder and provide services?

Insurers are required to verify the licensure, certification, training or other credentials of a qualified provider, but your family should check with your insurance provider to ensure that your health care provider is sufficiently certified or licensed.

21. Are licensed speech language pathologists eligible to provide services under the bill?

Licensed speech language pathologists are eligible to provide services pursuant to a treatment plan, if they are acting within the scope of a currently valid state issued license and have completed at least 1200 hours of training including work with individuals with autism spectrum disorders. Private insurers may choose to but are not required to contract with other practicing providers.

22. I have a child with a diagnosis of autism and I have commercial insurance. Will Medicaid cover the cost of the copays and deductibles associated with my commercial coverage for autism services?

The mandate has no impact on the rules in Wisconsin's Medicaid program regarding copayments and deductibles. Medicaid will cover copayment, deductible and coinsurance provisions for children with autism exactly as it does today, using the same rules and standards as it does for non-autism related services.

Families should ask themselves two simple questions:

1. Is my child eligible for and enrolled in Medicaid? If the answer is no, Medicaid will not pay for copays or deductibles.

2. Is the service provider enrolled in the Medicaid Program? If the answer is no, Medicaid will not pay the copay because the provider is not part of the Medicaid system. In this case, the family will be responsible for paying the private insurance copay.

If you answer yes to those two questions listed above and are getting your copays covered today, you will continue to get your copays covered under the law. Parents should be aware that they cannot pay the provider and then ask to be reimbursed by the Medicaid program. Providers bill Medicaid directly and Medicaid determines if they are eligible.

23. Will representatives from commercial insurance plans participate in service plan meetings?

The law does not specify whether or not representatives of the commercial insurance policies may participate in service plan meetings. Even so, Insurers shall require that progress be assessed and documented throughout the course of treatment

24. What is “utilization review”?

“Utilization review” refers to techniques used by health carriers to monitor the use of, or to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings. Some examples of techniques used include ambulatory review, prospective review, retrospective review, second opinion, certification, concurrent review, case management or retrospective review. (Source: National Association of Insurance Commissioners)

25. What is “grievance review”?

“Grievance review” refers to a health carrier’s internal processes for the resolution of covered persons’ complaints. The complaints may arise out of a utilization review decision or involve the availability, delivery or quality of health care services; claims payment, handling or reimbursement for health care services; or matters pertaining to the contractual relationship between a covered person or health carrier. Some states may call it an “internal appeal” process. (Source: National Association of Insurance Commissioners)