Publication Date: **September 26, 2009**
Effective Dates: **September 26, 2009 through February 22, 2010**

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE CREATING A RULE

To create Ins 3.36, Wis. Adm. Code,

Relating to treatment of autism spectrum disorders and affecting small business.

FINDING OF EMERGENCY

The Commissioner of Insurance pursuant to s. 632.895 (12m) (f) 2., Stats., need not find that an emergency exists nor provide evidence that promulgating a rule is necessary for the preservation of the public peace, health, safety or welfare.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

   ss. 600.01, 628.34 (12), 632.895 (12m) Stats.

2. **Statutory authority:**

   ss. 600.01 (2), 601.41 (3), 601.42, 628.34 (12), Stats.

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

The statutes all relate to the commissioner's authority to promulgate rules regulating the business of insurance as it relates to disability insurance products. Specifically, s. 632.895 (12m) (f), Wis. Stats., requires the commissioner to define "intensive-level services," "nonintensive-level services," "paraprofessional," and "qualified" for purposes of providing services under this subsection. The statute further authorizes that the commissioner may promulgate rules governing the interpretation or administration of this subsection.

4. **Related statutes or rules:**

There are no other statutes or rules that mandate services for autism spectrum disorders. This rule creates a new section to implement the newly created mandate pursuant to 2009 Wis. Act 28.

5. **The plain language analysis and summary of the proposed rule:**

Under 2009 Wisconsin Act 28, the Commissioner is required pursuant to s. 632.895 (12m), Stats., to define four terms: intensive level services, non-intensive level services, qualified, and paraprofessionals; and may draft rules that relate to the interpretation or administration of section.

To ensure clear understanding of current provider qualifications and treatment options for autism spectrum disorders the Commissioner established the Autism Working Group. The work group was charged with advising the Commissioner on definitions for the four required terms and making recommendations on how the statute should be implemented. The group was composed of parents, providers, insurers, and advocates. Administrators of the Waiver program at the Department of Health services also participated. The group met every other week beginning June 23rd, 2009 until September 10th, 2009

The Waiver program was used as a baseline to discuss the implementation of the new mandate. Current literature on autism spectrum disorders and information from other states was presented to the working for review and consideration. Because the research and literature in the realm of autism treatments is rapidly evolving, the working group recommended defining "evidence-based" and "behavioral" rather than creating a list of approved therapies that could readily become outdated.

The proposed rule includes definitions of intensive level behavioral therapy and non-intensive level therapy. Based upon current research, the rule limits intensive level services to children aged 2 to 9 as this period of time has shown to be the optimum time for gains for individuals diagnosed with autism spectrum disorders. Building from the waiver program, the working group developed a comprehensive regulation.

The proposed rule contains criteria necessary for one to be considered qualified provider, qualified professional, qualified therapist and qualified paraprofessional. The criteria include a combination of educational, professional and specific training with individuals diagnosed with autism spectrum disorders and for qualified paraprofessionals specific requirements for supervised implementation of a treatment plan for the insured. The rule includes provisions to permit individuals who are currently providing services through the department's waiver program to be deemed qualified for up to two years and permit insurers and self-funded plans to contract with these individuals who are experienced but may not met the "qualified" requirements.

The rule also handles several administrative concerns. It allows insurers to deny claims they believe to be fraudulent, exclude travel time from the required hours of treatment and allocated dollars for treatment and permits dispute resolution through independent review organizations.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

Autism Treatment Acceleration Act of 2009 (S. 819, H.R. 2413) was proposed in May. If passed, Section 12 will require all insurance companies across the country to provide coverage for evidence-based, medically-necessary autism treatments and therapies. If passed a comparison of final federal requirements and state law and regulation will need to be reviewed.

Additionally, the ''Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008'' (29 U.S.C. 1185a), requires for group health plans that offer both medical and surgical benefits and mental health or substance use disorder benefits to ensure financial and treatment limitations are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan. Further the federal law does not permit separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. Federal guidance is due this fall on the Mental Health Equity Act of 2008. Wisconsin's law is broader than the federal act but will need to be reviewed when the federal regulations are finally promulgated and effective.

7. Comparison of similar rules in adjacent states as found by OCI:

Illinois: Public Act 95-1005 requires private insurers cover autism benefits for children under 21 years of age. No rule-making accompanied this law, however, the statute does include Applied Behavioral Analysis, intervention, and modification as a part of the covered behavioral treatments. The law is subject to pre-existing condition limitations. It is also subject to denials based on medical necessity.

Iowa: A bill, SF 1 was introduced in the Iowa legislature this year but did not pass. There are no other similar laws or rules in Iowa.

Michigan: Two bills - HB 4183 and 4176 - requiring autism coverage, have passed the Michigan House; however, they are not expected to reach a vote this year. There are no other similar laws or rules in Michigan.

Minnesota: A bill, SF 695 was introduced in the Minnesota legislature this year but did not pass. There are no other similar laws or rules in Minnesota.

8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

The Commissioner created an advisory Autism Working Group to assist in the development of workable definitions of "intensive" and "nonintensive" level services; "qualified" providers and "paraprofessionals." The advisory working group was comprised of providers, insurers, advocates, parents of autistic children and representatives from the Department of Health Services familiar with the Medicaid waiver program for autism services. The working group met seven times between June 23 and September 10, 2009. This proposed rule reflects the advisory working group's recommendations.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

There are no insurers offering disability insurance or state or local governmental self-funded entities that meet the definition of a small business.

10. See the attached Private Sector Fiscal Analysis.

See attached.

11. A description of the Effect on Small Business:

This rule will have little or no effect on small businesses

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: **http://oci.wi.gov/ocirules.htm**

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

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Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Ins 3.36 is created to read:

Ins 3.36 **(1) APPLICABILITY.** This section applies to disability insurance policies as defined in s. 632.895 (1) (a), Stats., except as provided in s. 632.895 (12m) (e), Stats., and self-insured health plans sponsored by the state, county, city, town, village, or school district that provides coverage to dependents issued or renewed on or after November 1, 2009 or the date the policies or plans are established, extended, modified, or renewed on or after November 1, 2009 for collectively bargained agreements containing provisions for health plans or policies.

(3) DEFINITIONS. In addition to the definitions in s. 632.895 (12m) (a), Stats., in this section:

(a) "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.

(b) "Department" means the Wisconsin Department of Health Services.

(c) "Evidence-based" means therapy that is based upon medical and scientific evidence as defined at s. 632.835 (3m) (b) 1., 2., and 2.a., Stats., and s. Ins 18.10 (4), and is determined to be an efficacious treatment or strategy.

(d) "Efficacious treatment" or "efficacious strategy" means treatment or strategies designed to address cognitive, social or behavioral conditions associated with autism spectrum disorders; to sustain and maximize gains made during intensive-level services; or to improve an individual with autism spectrum disorder's condition.

(e) "Intensive-level service" means evidence-based behavioral therapies that are directly based on, and related to, an insured's therapeutic goals and skills as prescribed by a physician familiar with the insured.

(f) "Provider" means a state-licensed psychiatrist, psychologist, or a social worker certified or licensed to practice psychotherapy.

(g) "Qualified paraprofessional" means an individual working under the active supervision of a qualified supervising provider and who complies with all of the following:

1. Attains at least 18 years of age.

2. Obtains a high school diploma

3. Completes a criminal background check.

4. Obtains at least 20 hours of training that includes subjects related to autism, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid.

5. Obtains at least 10 hours of training in the use of behavioral evidence-based therapy including the direct application of training techniques with an individual who has autism spectrum disorder present.

6. Receives regular, scheduled oversight by a qualified provider in implementing the treatment plan for the insured.

(h) "Qualified provider" means an individual acting within the scope of a currently valid state-issued license for psychiatry or psychology or a social worker licensed or certified to practice psychotherapy and who has completed at least 2080 hours that includes all of the following:

1. Fifteen hundred hours supervised training involving direct 1:1 work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models.

2. Supervised experience with all of the following:

a. Working with families as the primary provider and ensuring treatment compliance.

b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.

c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.

d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.

e. Designing and implementing progressive treatment programs for individuals with autism spectrum disorders.

3. Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

(i) "Qualified professional" means an individual working under the supervision of an outpatient mental health clinic who is a licensed treatment professional as defined in s. DHS 35.03 (9g), and who has completed at least 2080 hours including all of the following:

1. Fifteen hundred hours supervised training involving direct 1:1 work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models.

2. Supervised experience with all of the following:

a. Working with families as part of a treatment team and ensuring treatment compliance.

b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.

c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.

d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.

3. Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

(j) "Qualified supervising provider" means a qualified provider that is a currently valid state-licensed psychiatrist, psychologist or a social worker licensed or certified as a psychotherapist and the qualified provider has completed at least 4160 hours of experience as a supervisor of less experienced providers, professionals and paraprofessionals.

(k) "Qualified therapist" means a speech-language pathologist or occupational therapist acting within the scope of a currently valid state issued licensed and who has completed at least 1200 hours of training including all of the following:

1. Seven hundred fifty hours supervised training involving direct 1:1 work with individuals, including pediatric individuals, with autism spectrum disorders using evidence-based, efficacious therapy models.

2. Supervised experience with all of the following:

a. Working with families as the direct speech or occupational therapist and ensuring treatment compliance.

b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.

c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.

d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in language ability and adaptive and social interaction skills.

(L) "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.

(m) "Therapist" means a state-licensed speech-language pathologist or occupational therapist acting within the scope of a currently valid state license.

(n) "Waiver program" means services provided by the department through the Medicaid Home and Community-Based Services as granted by the Centers for Medicare & Medicaid Services.

3.36 (3) Verified diagnosis. Insurers and self-insured health plans shall provide coverage for services to an insured that who a primary verified diagnosis of autism spectrum disorder when made by a provider skilled in testing and in the use of empirically validated tools specific for autism spectrum disorders.

(a) Insurers and self-insured health plans shall accept as valid and provide coverage of the diagnostic testing in addition to the benefit mandated by s. 632.895 (12m), Stats. For the diagnosis to be valid for autism spectrum disorder, the testing tools shall be appropriate to the presenting characteristics and age of the insured and be empirically validated for autism spectrum disorders to provide evidence that the insured meets the criteria for autism spectrum disorder in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Insurers and self-insured health plans may require confirmation of a primary diagnosis through completion of empirically validated tools or tests from each of the following categories: intelligence, parent report, language skills, adaptive behavior, and direct observation of the child.

(b) An insurer and a self-insured health plan may require an insured to obtain a second opinion from a provider experienced in the use of empirically validated tools specific for autism spectrum disorders that is mutually agreeable to the insured or the insured's parent or authorized representative and to the insurer or self-insured health plan. An insurer and a self-insured health plan shall cover the cost of the second opinion and the cost of the second opinion shall be in addition to the benefit mandated by s. 632.895 (12m), Stats.

(c) Insurers and self-insured health plans may require that the assessment include both a standardized parent interview regarding current concerns and behavioral history as well as direct, structured observation of social and communicative behavior and play. The diagnostic evaluation should also assess those factors that are not specific to an autism spectrum disorders including degree of language impairment, cognitive functioning, and the presence of nonspecific behavioral disorders.

3.36 (4) Intensive-level Services. (a) Insurers and self-insured health plans shall provide coverage for evidence-based behavioral intensive-level therapy for an insured with a verified diagnosis of autism spectrum disorder, the majority of which shall be provided to the insured when the parent or legal guardian is present and engaged and all of the prescribed therapy is consistent with all of the following requirements:

1. Based upon a treatment plan developed by a qualified provider that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment, and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the insured be present and engaged in the intervention.

2. Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals.

3. Provided in an environment most conducive to achieving the goals of the insured's treatment plan.

4. Included training and consultation, participation in team meetings and active involvement of the insured's family and treatment team for implementation of the therapeutic goals developed by the team.

5. Commenced after an insured is two years of age and before the insured is nine years of age.

6. The insured is directly observed by the qualified provider at least once every two months.

(b) Four cumulative years. Insurers and self-insured health plans shall provide up to four years of intensive-level services. Insurers and self-insured health plans may credit against the required four years of intensive-level services any previous intensive-level services the insured received regardless of payor. Insurers and self-insured health plans may require documentation including medical records and treatment plans to verify any evidenced-based behavioral therapy the insured received for autism spectrum disorders that was provided to the insured prior to the insured attaining nine years of age. Insurers and self-insured health plans may consider any evidence-based behavioral therapy that was provided to the insured for an average of 20 or more hours per week over a continuous six-month period to be intensive-level services.

(c) Travel. Insurers and self-insured health plans shall not include coverage of travel time for qualified providers, supervising providers, professionals, therapists or paraprofessionals when calculating the number of hours of care provided per week and are not required to separately reimburse for travel time.

(d) Progress assessment. Insurers and self-insured health plans shall require that progress be assessed and documented throughout the course of treatment. Insurers and self-insured health plans may request and review the insured's treatment plan and the summary of progress on a periodic basis.

3.36 (5) Nonintensive-Level Services. (a) Insurers and self-insured health plans must provide coverage for an insured with a verified diagnosis of autism spectrum disorder for nonintensive-level services that are evidence-based and that are provided to an insured by a qualified provider, professional, therapist or paraprofessional in either of following conditions:

1. After the completion of intensive-level services and designed to sustain and maximize gains made during intensive-level services treatment.

2. To an insured who has not and will not receive intensive-level services but for whom nonintensive-level services will improve the insured's condition.

(b) Insurers and self-insured health plans shall provide coverage for evidence-based therapy that is consistent with all of the following requirements:

1. Based upon a treatment plan developed by a qualified provider, supervising provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the insured be present and engaged in the intervention.

2. Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals

3. Provided in an environment most conducive to achieving the goals of the insured's treatment plan.

4. Included training and consultation, participation in team meetings and active involvement of the insured's family in order to implement the therapeutic goals developed by the team.

5. Provided supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team.

(c) Services. Insurers and self-insured health plans shall provide coverage for nonintensive-level services that may include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified paraprofessionals, or qualified therapists.

(d) Progress assessment. Insurers and self-insured health plans shall require that progress be assessed and documented throughout the course of treatment. Insurers and self-insured health plans may request and review the insured's treatment plan and the summary of progress on a periodic basis.

(e) Travel. Insurers and self-insured health plans shall not include coverage of travel time by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals when calculating the number of hours of care provided per week and are not required to separately reimburse for travel time.

3.36 (5) Transition to nonintensive-level services. (a) Insurers and self-insured plans shall provide notice to the insured or the insured's authorized representative regarding change in an insured's level of treatment. The notice shall indicate the reason for transition that may include any of the following:

1. The insured has received four cumulative years of intensive-level services.

2. The insured no longer requires intensive-level services as supported by documentation from a qualified provider or supervising provider.

3. The insured no longer receives evidence-based behavioral therapy for at least 20 hours over a six-month period of time.

(b) Insurers and self-insured plans may require an insured or an insured's authorized representative to timely notify the insurer or self-insured plan if the insured requires and qualifies for intensive-level services but the insured or the insured's family or care giver is unable to receive intensive-level services for an extended period of time. The insured or the insured's authorized representative shall indicate the specific reason or reasons the insured or the insured's family or care giver are unable to comply with an intensive-level service treatment plan. Reasons for requesting intensive-level services be interrupted for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event or any other reason the insurer or self-insured plan determines to be acceptable.

(c) Insurers and self-insured plans may not deny intensive-level services to an insured for failing to maintain at least 20 hours per week of evidence-based behavioral therapy over a six-month period when the insured or the insured's authorized representative complied with par. (b) or the insured or the insured's authorized representative can document that the insured failed to maintain at least 20 hours per week of evidence-based behavioral therapy due to waiting for waiver program services.

3.36 (6) Notice to Insureds. Insurers and self-insured plans shall provide written notice regarding claims submitted and processed for the treatment of autism spectrum disorders to the insured or insured's parents or authorized representative and include the total amount expended to date for the current policy year. The notice may be included with the explanation of benefits form or in a separate communication provided on a periodic basis during the course of treatment.

3.36 (7) Research that is the basis for efficacious treatment or efficacious strategies.

(a) Research designs that are sufficient to demonstrate that a treatment or strategy when used solely or in combination with other treatments or strategies, is effective in addressing the cognitive, social, and behavioral challenges associated with autism spectrum disorders demonstrates significant improvement must include at least one of the following:

1. Two or more high quality experimental or quasi-experimental group design studies that meet all of the following criteria:

a. A clearly defined population for whom inclusion criteria have been delineated in a reliable, valid manner.

b. Outcome measures with established reliability and construct validity.

c. Independent evaluators who are not aware of the particular treatment utilized.

2. Five or more single subject design studies that meet all of the following criteria:

a. Studies must have been published in a peer-reviewed scientific or medical journal.

b. Studies must have been conducted by three different researchers or research groups in three different geographical locations.

c. The body of studies must have included 20 or more participants.

3. One high quality randomized or quasi-experimental group design study that meets all of the criteria in subpar. 1 and three high quality single subject design studies that meet all of the criteria in subpar. 2.

3.36 (9) Disputes. **(a)** An insurer's or a self-insured health plan's determination regarding diagnosis and level of service may be considered an adverse determination if the insured disagrees with the determination. The insured or the insured's authorized representative may file a grievance in accordance with s. Ins 18.03. The insured or the insured's authorized representative may seek independent review of the adverse determination in accordance with s. Ins 18.11.

3.36 (10) Non-required coverage. (a) Services. Insurers and self-insured health plans are not required to cover any of the following:

1. Acupuncture.

2. Animal-based therapy including hippotherapy.

3. Auditory integration training.

4. Chelation therapy.

5. Child care fees.

6. Cranial sacral therapy.

7. Custodial or respite care.

8. Hyperbaric oxygen therapy.

9. Special diets or supplements.

(b) Drug and devices. Insurers and self-insured health plans shall not provide coverage for pharmaceuticals or durable medical equipment through s. 632.895 (12m), Stat. Coverage of pharmaceuticals and durable medical equipment shall be covered in compliance with the terms of the insured's policy.

(c) Fraudulent claims. Insurers and self-insured health plans shall not be required to pay claims that have been determined to be fraudulent.

(d) Parents of children diagnosed with autism spectrum disorders. Insurers and self-insured health plans shall not be required to pay for treatment rendered by parents or legal guardians who are otherwise qualified providers, supervising providers, therapists, professionals or paraprofessional for treatment rendered to their own children.

3.36 (11) Locations for Services. (a) Insurers and self-insured health plans shall cover treatments, therapies and services to an insured diagnosed with autism spectrum disorders in locations including the provider's office or clinic, or in a setting conducive to the acquisition of the target skill. Treatments may be provided in schools when they are related to the goals of the treatment plan and do not duplicate services provided by a school.

(b) Insurers and self-insured health plans are not required to cover therapy, treatment or services when provided to an insured who is residing in a residential treatment center, inpatient treatment or day treatment facility.

(c) Insurers and self-insured health plans are not required to cover the cost for the facility or location or for the use of a facility or location when treatment, therapy or services are provided outside an insured's home.

3.36 (12) Annual publication CPI adjustment. The commissioner shall publish to the office of the commissioner of insurance website on or before December 1 of each year beginning December 1, 2011, the consumer price index for urban consumers as determined by the U.S. Department of Labor and publish the adjusted dollar amount in accordance with s. 632.895 (12m) (c) 1., Stats. The adjusted dollar amount published each December shall be used by insurers and self-insured health plans when complying with s. 632.895 (12m), Stats., effective the following January 1 for newly issued policies or on the first date of a modified, extended or renewed policy or certificate after January 1.

3.36 (14) Verification of qualified provider, supervising provider, therapist, professional and paraprofessional. (a) Insurers and self-insured health plans are required to verify the licensure, certification and all training or other credentials of a qualified provider, qualified supervising provider and qualified therapist.

(b) Insurers and self-insured health plans shall require the qualified provider or certified outpatient mental health clinics employing or contracting for the services of qualified professionals or qualified paraprofessionals to verify the qualified professional's or qualified paraprofessional's credentials and to document that the qualified professional or qualified paraprofessional has not been convicted of a felony or any crime involving maltreatment of a child in any jurisdiction. Insurers and self-insured health plans may receive documentation from the qualified providers or certified outpatient mental health clinics upon request and may require periodic review and verification.

(c) A provider, therapist, paraprofessional or professional working under the supervision of a certified outpatient mental health clinic that is approved by the Department and has a signed Medicaid provider agreement to provide services through the waiver program to individuals with autism spectrum disorders prior to November 1, 2009 shall be deemed to be a qualified provider, therapist or professional through October 31, 2011. Beginning November 1, 2011 any provider, supervising provider, therapist, paraprofessional or professional must comply with the applicable requirements to be considered a qualified provider, supervising provider, therapist or professional.

(d) An insurer or self-insured health plans may elect to contract with certain providers, therapists, paraprofessionals and professionals that do not meet all of the requirements necessary to be considered qualified providers, therapists, paraprofessionals or professionals, but are approved by the Department and have a signed Medicaid provider agreement to provide services through the waiver program to individuals with autism spectrum disorders and meet any criteria established y the insurer or self-insured health plan. The insurer and self-insured health plans must have a verifiable and established process for rendering its determination for otherwise qualified providers, therapists and professionals.

SECTION 2. These changes first apply to policies issued or renewed on or after November 1, 2009.

SECTION 3. This section may be enforced under ss. 601.41, 601.64, 601.65, 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 4. These emergency rule changes will take effect as provided in s. 227.24(1)(c), Stats.

Dated at Madison, Wisconsin, this _____ day of _____, 2009.

_____

Sean Dilweg
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for Section Ins 3.36 relating to autism spectrum disorders treatment and affecting small business

This rule change will have no significant effect on the private sector regulated by OCI.

Division of Executive Budget and Finance
DOA-2047 (R10/2000)

Wisconsin Department of Administration

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 336**

Subject

autism spectrum disorders treatment and affecting small business

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):

Annualized Costs:	**Annualized Fiscal impact on State funds from:**	
	Increased Costs	**Decreased Costs**
A. State Costs by Category State Operations - Salaries and Fringes	**$ 0**	**$ -0**
(FTE Position Changes)	(**0** FTE)	(**-0** FTE)
State Operations - Other Costs	**0**	**-0**
Local Assistance	**0**	**-0**
Aids to Individuals or Organizations	**0**	**-0**
TOTAL State Costs by Category	**$ 0**	**$ -0**
B. State Costs by Source of Funds	**Increased Costs**	**Decreased Costs**
GPR	**$ 0**	**$ -0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
C. State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	**Increased Rev.**	**Decreased Rev.**
GPR Taxes	**$ 0**	**$ -0**

GPR Earned	**0**	**-0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
TOTAL State Revenues	**$ 0 None**	**$ -0 None**

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ **None 0**	$ **None 0**
NET CHANGE IN REVENUES	$ **None 0**	$ **None 0**

Prepared by: Julie E. Walsh	**Telephone No.** (608) 264-8101	**Agency** Insurance
Authorized Signature:	**Telephone No.**	**Date (mm/dd/ccyy)**

Division of Executive Budget and Finance
DOA-2048 (R10/2000)

Wisconsin Department of Administration

FISCAL ESTIMATE

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **INS 336**

Subject

autism spectrum disorders treatment and affecting small business

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues

☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues

☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected:
   ☐ Towns ☐ Villages ☐ Cities
   ☐ Counties ☐ Others _____
   ☐ School Districts

Fund Sources Affected

☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications **None**		
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