Section 5: Private Health Insurance

Program Purpose

During the 1930s the first Blue Cross organizations were founded, nonprofit groups formed by doctors and hospitals providing insurance against costly hospital stays. During the 1960s the federal government instituted Medicare and Medicaid, health care programs for individuals who were elderly, disabled, or had low incomes.

Those who were not covered by an employer or a federal program could buy health insurance for themselves and their families from private insurance companies—provided they could afford the regular premium payments required for coverage.

Although health insurance plans vary greatly in terms of coverage provided, there are some essential elements. Individuals enroll in a plan either on their own or through their employer.

- **Policy**- A legal document or contract issued by the insurance company and agreed upon by the individual or employer, outlines the conditions and terms of the insurance benefits and costs.
- **Premium**-The amount you pay each month for the insurance policy
- **Deductible**- This is the amount an individual must pay out of pocket before the insurance company starts covering costs.
- **Co-pay**- A percentage payment of the overall cost, may also be required.
- **Coinsurance** – The percentage you pay after you meet the deductible.
- **Stop-loss provision**- The maximum amount of co-payment required.
- **Policy limit**- The maximum coverage an insurance company will provide either for specific kinds of care or overall care. This can be annual or over the course of a lifetime.
- **Exclusions**- Services and/or items not covered by the policy.
- **Dependent**-A person who can be covered under the insurance policy. For example, a child or a spouse.
- **Pre-authorization** – Services can require a pre-approval from your insurance before the service and/or item is provided.

There are other forms of insurance which cover medical costs, including assistive technology:

- **Disability Income** - Insurance that individuals can purchase to provide income if they become unable to work due to injury or illness. The main goal of this coverage is to help the individual return to work.
- **Vision Insurance** – In addition to a health insurance policy. Vision insurance can cover examinations, glasses, and/or contact lenses.
- **Liability** - Coverage that protects against injuries or damages resulting from negligence, typically carried by businesses and sometimes by individuals, such as homeowners.
- **Workers' Compensation** - Employer-provided insurance, required by state law, that provides benefits to employees who are injured or become ill as a result of their work.

Eligibility

Individuals become eligible for health insurance in three ways:

- **Direct Purchase**- Buying insurance directly from an insurance company, either individually or as part of a small group. The policyholder is responsible for paying premiums, deductibles, and co-payments.
- **Employer-Sponsored Coverage** – Receiving health insurance through an employer that offers health care benefits to its employees.
- **Federal Program Eligibility** – Qualifying for health insurance coverage by meeting the eligibility requirements of federal programs.

Services Provided

Laws mandating what must be provided by insurance companies are primarily enacted at the state level rather than federal.

Depending on the policy obtained, health insurance can vary widely. Examples of some of the health care services covered by insurance:

- Doctor and hospital care
- Dental
- Durable medical equipment
- Long-term care
- Mental health
- Outpatient care

- Prescription drugs
- Preventive care
- Surgery
- Therapies
- Vision care, etc.

Assistive Technology Covered

Insurance coverage for assistive technology varies depending on the individual policy. The amount paid and the specific items covered are determined by the terms of the insurance plan. While specific devices are rarely listed, some insurance policies may identify items or categories that are excluded from coverage.

To obtain assistive technology through insurance, it is essential to demonstrate medical necessity. Documentation should clearly show that the device or equipment:

- Significantly improves the individual's medical condition, or
- Helps reduce additional health care costs.

In most cases, a physician must prescribe the device, and therapists or other qualified professionals must prepare a written justification supporting the request.

Insurance companies do not always consider improved functional abilities as sufficient justification for coverage. For example, the rationale for a leg brace for a child may focus on maintaining bone strength rather than improving walking stability.

Assessing Assistive Technology

To receive payment from an insurance company for assistive technology, the individual must file a claim. A claim is a notice that the service or device has been received and a request for payment in accordance with the insurance policy.

The following guidelines outline what should be included when filing a claim:

1. **Cover Letter**
    a. Explain why the equipment is needed.
    b. Summarize existing coverage under the policy that supports payment for the device.
    c. Include a brief summary of all supporting information provided.
2. **Required Forms**
    a. Complete all insurance company forms thoroughly and accurately.
    b. Medical Documentation

   c. Physician's prescription and/or letter of medical necessity.
   d. In some cases, a supporting letter from a therapist.
   e. Any relevant medical reports or documentation.
3. **Vendor Information**
   a. Bids or quotes from multiple vendors may be required.
4. **Record Keeping**
   a. Always keep copies of all submitted documents.
   b. Allow at least 30 days for a response after filing a claim.
   c. If no response is received, contact the insurance company to follow up.
   d. Keep a detailed record of any conversations with insurance representatives, including names, dates, and discussion points.
   e. If any promises are made, send a written confirmation to the representative.

Tip: Therapists and vendors often have significant experience with the claims process, and their assistance can be invaluable.

Problems Obtaining Assistive Technology

Health insurance policies are highly flexible because there are few strict federal regulations and, in many cases, limited state laws governing coverage. This allows insurance companies considerable discretion in determining what their policies include.

- **Assistive Technology Coverage-** Policies rarely specify which assistive technology devices are covered, so it is important to clearly explain the rationale for the equipment when requesting coverage.
- **Preexisting Conditions-** Many insurance plans do not cover preexisting conditions, which can prevent individuals from obtaining equipment related to an existing disability.
- **Employer-Sponsored Plans-** Many consumers receive insurance through employer group plans, which often offer little choice in coverage options.
- **Policy Limits-** Lifetime limits or caps may restrict the total amount an insurance company will pay, which can affect the assistive technology a consumer can access.
- **Equipment Ownership-** Insurance companies may choose to rent or lease equipment instead of purchasing it outright. In these cases, the equipment does not become the property of the consumer, and the company typically selects the least expensive option.
- **Affordability-** Many people cannot afford the required premiums, making health insurance—and coverage for assistive technology—unavailable to them.

Application Process

- **Employer-Sponsored Insurance**- If you receive health insurance through your employer, you may need to complete application forms provided by your employer or personnel office.
- **Individual Insurance-**
    - Research insurance companies available in your state.
    - Consider key factors when choosing a health care plan, such as coverage, costs, and benefits.
- **Resources**- The Kansas Insurance Department provides a free guide, Health Insurance in Kansas, which explains insurance terms, types of coverage, and important questions to ask about your plan.
- **Application Process-**
    - Once you have gathered information and selected a plan, complete the application with the chosen insurance provider.
    - Be Informed
    - Understanding your options and coverage protects you from being without health insurance when it is needed most.

Appeals Process

The appeal process can vary depending on the insurance company. Some insurers require specific forms to be completed. When filing an appeal, include the following:

- **Appeal Letter**
    - Explain why you believe the denial of funding was incorrect.
    - Clearly state why the policy should cover the device.
    - Review the deadlines and instructions for filing an appeal letter.
- **Supporting Information**
    - Demonstrate the medical need for the equipment.
    - Understand and reference the reason the coverage was denied.

If the claim is still denied and you believe the decision is unjustified, contact the Office of the Insurance Commissioner for assistance.