

ACCESSING ASSISTIVE TECHNOLOGY

Chapter 3

Private Health Benefit Plans

From a 17-Chapter Manual
Available by Chapter and in Manual Form

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Written by:

Disability Rights California

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ACCESSING ASSISTIVE TECHNOLOGY

TABLE OF CONTENTS

Chapter 1 Introduction and Overview

Chapter 2 Advocacy Skills

Chapter 3 Private Health Benefit Plans

Chapter 4 Regional Centers

Chapter 5 California Children's Services

Chapter 6 Reasonable Accommodation in Employment

Chapter 7 Vocational Rehabilitation (Including Loan Programs)

Chapter 8 Social Security Work Incentives

Chapter 9 Special Education

Chapter 10 Medi-Cal

Chapter 11 Medicare

Chapter 12 Veteran's Administration

Chapter 13 Right to Assistive Technology from Public Entities

Chapter 14 Right to Assistive Technology from Private Businesses

Chapter 15 Right to Assistive Technology in Higher Education

Chapter 16 The Protections of The Lemon Law for Buyers of Assistive Technology

Chapter 17 Resource Guide (with Table of Contents)

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ACCESSING ASSISTIVE TECHNOLOGY

Chapter 3

PRIVATE HEALTH BENEFIT PLANS

Table of Contents

Question

1. What evidence do I need to document my need for an assistive technology device?
[*](#)
2. My employer is self-insured. What laws does a self-insured company have to follow? [*](#)
3. What does ERISA require a plan to do when it receives a claim? [*](#)
4. What should happen under ERISA if I appeal a denial by my plan? [*](#)
5. Can a health benefit plan deny a claim because the policy states it is the provider of last resort? [*](#)
6. Can a health benefit plan deny coverage or a benefit because of my disability? [*](#)
7. Are there alternatives if I am rejected by a health plan because of a pre-existing condition? [*](#)
8. Can I appeal if a health benefit plan rejects my request for assistive technology? [*](#)
9. Do I have a right to continue my health benefit plan after I leave my job? [*](#)
10. How would I know if I qualify for COBRA? [*](#)
11. What are COBRA's election rights? [*](#)

Chapter 3

PRIVATE HEALTH BENEFIT PLANS

Private health benefit plans have no legal requirement to cover assistive technology. Whether a private health benefit plan will buy assistive technology for its beneficiaries depends on the terms of the policy.

Most health benefit plans are employment benefits. Your employer negotiates the plan and makes it available to you. You probably think of your health benefit plan as a contract between you (the employee) and the provider (the insurance company). The provider's responsibilities and your rights depend on the benefits set out in the policy.

Sometimes you have a choice of plans. If access to assistive technology is a concern, you should review each plan's benefits carefully to see which plan gives you the best benefits for the cost.

1. What evidence do I need to document my need for an assistive technology device?

Your health benefit plan should set out the process for requesting assistive technology. It should also set out what supporting information you need to submit. Many HMO plans say that your primary care doctor must refer you to a specialist - such as an orthopedist, physical therapist or speech therapist. The specialist will then prescribe the equipment. It is important to follow the process and document your need for the technology as required. In some cases, you should ask for a referral to a rehabilitation center, where you will probably get the most thorough and accurate evaluation.

Health benefit plans will only buy technology services and equipment that are *medically necessary*. Your plan should define *medically necessary*. The definition of *medically necessary* usually says that the requested service or equipment must cure or alleviate a medical condition, reduce pain, or help maintain or obtain more normal function. A wheelchair is medically necessary if you need it to become more independent. A speech device is medically necessary if you need it to communicate with other people consistent with your potential.

Supporting evidence, such as letters or reports from physicians or other professionals, should explain:

- Your impairment;
- Your functional ability without the equipment;
- How the requested device will reduce the impact of your disability;
- How the *medically necessary* definition in the policy is satisfied;

- How other requirements are met;
- Under which covered service(s) the requested device should be provided; and, if possible
- Where in other cases, the plan has previously provided the requested device or equipment.

Some plans may claim that the requested equipment is for education or convenience, but is not medically necessary. However, the fact that you will use an item in school, or for recreation, or to make your life easier, does not make it medically unnecessary. Arguments for the equipment should discuss how it will reduce the impact of your disability, regardless of where you use it.

2. My employer is self-insured. What laws does a self-insured company have to follow?

The *Employee's Retirement Income Security Act (ERISA)*, a federal law, covers employer-provided health plans. Your employer must give you information about the health plan. The information must explain benefits and requirements in plain language. 29 U.S.C. §§ 1001, 1021, 1024. The plan administrator must respond to requests for information within 30 days.

29 U.S.C. § 1132(c). The plain language version of the policy is usually a booklet called a *summary of benefits* or *summary plan description*. Employers often do not show employees the actual benefit plan, but your employer must show it to you if you ask to see it.

Some summary booklets do not set out clear lists of covered services and limitations. They may not have adequate information about prior approval requirements, co-payments, or deductibles. It is important to read the summary booklet or plan carefully. If the summary booklet conflicts with the actual plan, the plan provisions control.

Most plans do not list specific devices or equipment as plan benefits. You can argue that necessary assistive technology is a benefit if the plan covers *durable medical equipment*, *prosthetic devices*, or equipment associated with physical or occupational therapy. You could also argue that the plan covers *augmentative and assistive communication devices* under these categories or as equipment associated with speech therapy services.

3. What does ERISA require a plan to do when it receives a claim?

ERISA requires your plan to decide on your claim within a specified timeline. How quickly it must decide depends on the type of the claim.

- For *urgent care*, the plan must decide within 72 hours. Urgent care is care related to a condition for which a "prudent layperson" would believe that not getting immediate care seriously jeopardizes that person's life, health, or ability to regain maximum function. Urgent care also includes care for which a physician knowledgeable about the patient's condition thinks that treatment is needed to alleviate severe pain. Your claim for urgent care cannot be denied solely because you did not get prior authorization from the plan before getting medical attention.
- For *concurrent care*, the plan has to notify you sufficiently in advance of a reduction or termination of benefits so that you can appeal the decision. Concurrent care is care for which the plan has approved an ongoing course of treatment over a time period or a certain number of visits.
- *Pre-service claims* are those for which you must get prior approval in order for the plan to pay for the care. The plan has to decide within 15 days of getting your request. In some cases, the plan may give itself an additional 15 days (for a total of 30), but only if it tells you in advance that it is going to do this and it explains the reasons.
- *Post-service claims* are those you make after getting medical care. For these, the plan must decide within 30 days of getting the claim. In some cases, the plan may give itself an additional 15 days (for a total of 45), but only if it tells you in advance that it is going to do this and it explains the reasons.

Under any of these situations, the plan can have more time within limits to decide if it needs more information from you.

If the claim is denied, either completely or partially, the plan must explain in writing or electronically (e.g., e-mail) why the claim was denied and it must point out specific provisions in the plan documents that justify the denial of the claim. The health plan must also tell you what information can be provided in order for it to approve the claim. Finally, the health plan must tell you about the appeal rights.

On request, the plan must also give you a free copy of whatever medical protocol or internal document it used in denying the claim. Similarly, if the plan denies the claim based on medical necessity or experimental status, you can request that the plan provide an explanation of how it reached that conclusion from the scientific evidence.

If the plan fails to approve the claim within the allotted time frame, the claim is considered denied, and you can then move on to the next level and request a review.

4. What should happen under ERISA if I appeal a denial by my plan?

Health plans are required to give the denied claim a *full and fair review* if you appeal a denial of benefits. The plan can require that you make a written request within 180

days of receiving written notification of the denial. In addition, the plan must let you submit written comments on the denied claim, and the plan has to provide access to any documents it has that relate to the claim. Plans may adopt appeal process that may involve one or two levels of review. Using a two-level appeal process cannot extend the total time an appeal can take. Once the plan receives your request for a review, the plan must follow the following time limits in making its decision and notifying you of its determination.

- For *urgent care*, the plan must complete the review within 72 hours.
- For *concurrent care*, the plan must complete the review within 24 hours, provided that that you requests the review at least 24 hours before the concurrent care ends.
- For *pre-service claims*, the plan has 30 days to complete the review if there is only one appeal level. If the plan has two appeal levels, the plan has 15 days to make its decision at each level. If the plan needs to extend the time for the review, it has to notify you in advance and explain why it needs to extend the time.
- For *post-service claims*, the plan has 60 days if there is only one appeal level. If the plan has two appeal levels, then it has 30 days to make its decision at each level. Again, if the plan needs to extend the time for the review, it has to notify you in advance and explain why it needs to extend the time.

Reviews must be performed by plan officials other than the people who originally rejected the claim. In addition, the medical experts with whom the plan consults cannot be the experts who were involved in the prior denial of the claim.

If the claim is denied on review, the plan must tell you: the specific reasons for the denial; reference plan provisions; how to get free copies of any additional information related to the claim (such as medical protocols or how the scientific evidence supported the medical necessity decision), and information about any non-binding arbitration that the plan may offer. Finally, the plan must let you know that you have the right to file an action in federal court. If the plan does not process a review within the allotted time, the claim is considered denied, and you are able to pursue the matter in federal court.

5. Can a health benefit plan deny a claim because the policy states it is the provider of last resort?

Many health benefit plans do not cover benefits that are the responsibility of another entity - including government programs such as Medi-Cal. Your response to a denial of benefits will depend on which program the plan thinks should provide the

requested device. If you are eligible for Medi-Cal, California Children's Services or regional center services, by law you must use your health plan benefits first. Your plan cannot contradict this law.

School districts, however, cannot make you use health benefits to get a device that your child is entitled to through special education. If the school district refuses to provide the device, you will need to decide whether to appeal the denial or ask your health plan to provide the device. (See Chapter 9 on the Right to Assistive Technology through Special Education.) If you decide to ask your health plan to provide the device, you will need a letter of denial from the school district. The health plan should not insist that you appeal the school district's denial prior to providing the requested equipment.

6. Can a health benefit plan deny coverage or a benefit because of my disability?

Health benefit plans often try to deny coverage for a "pre-existing condition." Under some circumstances, this may be discrimination. Both the Americans with Disabilities Act (ADA) and California law say that a benefit plan **may not**, solely because of a physical or mental impairment:

- Refuse to insure, or refuse to continue to insure;
- Limit the amount, extent, or kind of coverage available; or
- Charge a different rate for the same coverage.

42 U.S.C. § 12201, *et seq.*; Cal. Insurance Code § 10144.

These laws provide an exception if the benefit plan bases its refusal, limitation, or higher rate on:

- Available statistics; or
- Actual experience; or
- Reasonable projections.

The benefit plan must show, using real facts and statistics, that the disability leads to higher health care costs. Otherwise, the plan cannot justify treating people with disabilities differently.

It may be possible for you to challenge a denial of coverage. In many cases, the benefit plan has no data that your disability will, in fact, result in higher overall costs.

If you have a pre-existing disability, the plan can deny coverage of the costs associated with that disability. However, treatment for illness or injuries not related to the pre-existing condition should still be a plan benefit.

The benefit plan cannot make distinctions based on a perception of disability in general, or of your disability. If the plan covers power wheelchairs, refusal to pay for

a power wheelchair for people with mental retardation would be discrimination. Even if the plan thinks that no one with mental retardation has the ability to learn to operate it, many people with mental retardation can learn to use a power wheelchair. The plan may only deny purchase of a power wheelchair after proving that your disability, in fact, makes it impossible for you to learn to operate a power chair safely.

It is not discrimination, however, for a plan to exclude specific benefits, even if the exclusion would have a greater impact on people with disabilities. Thus, a plan can clearly state that it does not cover assistive communication devices as long as it applies the limitation consistently.

In *Carparts Distribution Center Inc. v. Automotive Wholesalers of New England Inc.*, 37 F.3d 12 (1st Cir. 1994), a federal court found that employer-provided health benefit plans might be considered employers under the ADA. In that case, they would be subject to stricter anti-discrimination mandates than health benefit providers in other contexts.

7. Are there alternatives if I am rejected by a health plan because of a pre-existing condition?

If your disability does result in a non-discriminatory denial of benefits, an alternative in California may be to enroll in the California Major Risk Medical Insurance Program (MR-MIP). This state-administered program provides coverage for people who, usually because of a pre-existing condition, cannot qualify for other health benefits. MR-MIP applicants cannot be eligible for Medi-Cal or for continuation of benefits under the Consolidated Omnibus Reconciliation Act (COBRA). (See Question 7.) Private health benefit plans provide benefits. You or your employer would pay for premiums at a regular competitive rate; the state would then pay the excess premium. State funding for this program comes from tobacco tax funds. Limited funding limits the number of people who can participate. There is usually a waiting list. To find out more about MR-MIP, write or call MR-MIP, 818 K Street, Suite 200, Sacramento, CA 95814; (916) 324-4695.

8. Can I appeal if a health benefit plan rejects my request for assistive technology?

Almost all health benefit plans provide for an internal appeal. If you are persistent, you can get a decision reversed-especially if you can provide more documentation of medical necessity or information that the health benefit plan has purchased similar devices in the past. The appeal is often informal. It consists of explaining the need and justification for the device in writing, with copies of supportive documents. Since the plan sets health benefit policies, and does not negotiate them with the beneficiary, a court will usually resolve ambiguities in favor of the beneficiary. Pointing out parts of

the policy or summary plan description that could be interpreted to cover assistive technology may help you convincing a plan to provide assistive technology, even if the policy does not specifically mention the device or equipment.

If the policy has a provision for arbitration, you must follow it. In arbitration, you and the plan present your arguments to a third party who will decide which of you is correct.

The **California Department of Insurance** has a toll-free consumer information and complaint line: (800) 927-4357. The Department of Insurance will investigate complaints against insurance companies-such as failure to provide plan benefits or refusal to insure because of a pre-existing condition where there is not a sound basis for denial. If the Department of Insurance finds in your favor, it will order the insurance company to provide benefits or insurance.

The **Department of Managed Care (DMC)** governs Health Maintenance Organizations (HMOs). If an HMO provides your plan, you can file a complaint with DMC by calling at (916) 445-7205 or (800) 400-0815. DMC will investigate complaints concerning an HMO's failure provide agreed-upon benefits. It will order the HMO to take corrective action if it finds that the complaint is justified.

The **Equal Employment Opportunity Commission (EEOC)** will look into complaints against an employer-provided health plan alleging discrimination in violation of the ADA. Your complaint would be against your employer, not the health benefit plan provider. See Chapter 6, Reasonable Accommodation in Employment, for instructions in filing an EEOC complaint.

Finally, **ERISA** says that you can bring claims against an employer-provided health plan in federal court. You may claim that the health benefit plan is not providing services as required under the policy, or that the plan or the employer did not follow required procedures. For example, you could bring an action for failure to provide a clear summary plan description or a clear and complete description of why a requested benefit was denied. 29 U.S.C. §§ 1001, 1021, 1024.

A court can order provision of the requested device if it finds that it is a plan benefit. Some courts have ordered provision of benefits for failure to provide a clear summary plan description under the theory that ambiguities are resolved against the benefit plan provider.

9. Do I have a right to continue my health benefit plan after I leave my job?

Under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act), you have the right to continue your health benefit plan for 29 months if you have a Social-Security-eligible disability. Coverage must continue for 18 months for people who do

not have a disability. You must pay the benefit premiums at the group rate paid by your employer.

10. How would I know if I qualify for COBRA?

You generally qualify to continue health coverage under COBRA if you are covered by a group health plan on the day before a specified *qualifying event*. So you could be an employee, the employee's spouse and dependent child, and in certain cases, a retired employee, the retired employee's spouse and dependent child.

"Qualifying events" are certain types of events that would cause you to lose health coverage. The type of qualifying event will determine who can qualify and for how long. A plan, at its discretion, may provide longer periods of continuation coverage.

The types of qualifying events for employees are:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction in the number of hours of employment
- The types of qualifying events for spouses are:
 - Termination of the employee's employment for any reason other than "gross misconduct;"
 - Reduction in the hours worked by the employee;
 - The employee becoming entitled to receive Medicare;
 - Divorce or legal separation from the employee;
 - Death of the employee.
- The types of qualifying events for dependent children are:
 - Termination of employee's employment for any reason other than "gross misconduct;"
 - Reduction in the hours worked by the employee;
 - Loss of "dependent child" status under the plan rules;
 - The employee becoming entitled to receive Medicare;
 - Divorce or legal separation of the employee;
 - Death of the employee.

PERIODS OF COVERAGE

Qualifying Events	Beneficiary	Coverage
Termination	Employee	18 months

Reduced hours	Spouse	↓
	Dependent child	↓
Employee entitled to Medicare	Spouse	36 months
	Dependent child	↓
Divorce or legal separation	Spouse	↓
Death of covered employee	Spouse	↓
	Dependent child	↓
Loss of "dependent child" status	Dependent child	36 months

11. What are COBRA's election rights?

If you qualify, you have 60 days to elect whether or not to continue health coverage under COBRA. This period starts from (1) the date you lost your health coverage; **or** (2) the date the notice to elect COBRA coverage was sent to you, whichever date is **later**. COBRA coverage is retroactive if you elect and pay for it within the period.

If you are the employee, you or your spouse can elect COBRA for anyone who qualifies. Each qualifying person can also elect COBRA independently. You can always elect for your minor child or someone for whom you are a legal guard