

MEETING ALL THE NEEDS OF THE SPECIAL EDUCATION STUDENT

*A Survey of Programs and Funding Sources Other than
the Individuals with Disabilities Education Act*

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I. Introduction

- A. In most states, your special education system serves children with disabilities between ages five and 21.
- B. Additionally, younger children with disabilities are often served by early intervention programs (birth through age two) and preschool special education programs (ages three to five).
- C. The special education system in your state can fund a wide range of services and assistive technology (AT).¹
- D. In some cases, however, a particular service or AT device may not be easily obtainable through the special education system. This may be for any number of reasons:
 - 1. The service or item may not meet the Individuals with Disabilities Education Act's (IDEA's) definition of special education or related services. E.g., in most cases a physician's services or other traditional medical interventions are not available for special education funding.
 - 2. The item in question may not be required to ensure that the student benefits from his or her education. See *Board of Ed. of the Hendrick Hudson Sch. Dist. v. Rowley*, 458 U.S. 176 (1982).
 - 3. Despite your strong legal arguments, the school district may not agree that the item(s) in question are their obligation.
 - 4. Since the school district continues to "own" the item(s) purchased with its special education funds, the student cannot retain the item(s) upon graduation.

II. A Special Education Advocate Must be Aware of a Wide Range of Programs and Funding Sources

- A. The most common sources of funding for services and AT are the following:
 - 1. Medicaid - including the Early Prevention, Diagnosis, Screening and Treatment (EPSDT) program for children under 21.

¹ See *Funding of Assistive Technology - The Public School's Special Education System as a Funding Source: The Cutting Edge* (June 1999)(49 pages, copies available through the National AT Advocacy Project, see title page).

2. Medicaid waivers
 3. Medicare - for children over 18 who receive Social Security Disability Insurance
 4. Vocational rehabilitation services - including, in many states, the separate services of a state agency serving persons who are blind
 5. The new Ticket to Work and Self Sufficiency - to become available in some states in 2001
 6. Private insurance contracts
- B. The most common sources of cash benefits include:
1. Supplemental Security Income (SSI)
 2. Social Security, including Social Security Disability Insurance
 3. State and local welfare programs, including the federally-funded Temporary Assistance to Needy Families (TANF) and state-funded General Assistance programs.
- C. Advocates should also become familiar with a wide range of state and local funding sources, and private charities which may help to meet the special needs of children with disabilities.
- D. What will the advocate need to know about these non-IDEA sources of funding and cash assistance?
1. At a minimum, you should become familiar with the general eligibility criteria of each program, how one applies, and what services they cover.
 2. In many cases, you can obtain written informational materials about the various programs that you can hand out or mail to individual clients. Alternatively, your agency may want to develop its own resource materials about alternative programs.

III. Medicaid

- A. Medicaid, also known as Medical Assistance, is a cooperative federal-state program authorized by Title XIX of the Social Security Act. 42 U.S.C. §§ 1396 *et seq.*

1. Medicaid is a health insurance program, designed to serve persons with limited income and resources.
2. Administration of Medicaid will occur at the state level, with the state Medicaid agency often delegating decision making either to other state agencies, or to county or local Medicaid units.

B. Distinguish from Medicare

Medicare, a federal health insurance program authorized by Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*, is most frequently associated with the receipt of Social Security benefits.

C. How Does a Child with a Disability Qualify for Medicaid?

1. Recipients of SSI Will Automatically Qualify for Medicaid in 39 States. 42 U.S.C. § 1396a(a)(10)(A)(i).²
 - a. If the SSI check is as little as \$1, Medicaid eligibility is automatic.
 - b. In 11 states, known as section 209(b) states, Medicaid eligibility is not automatic for SSI recipients. These states use their own Medicaid eligibility criteria which differs from SSI eligibility criteria. *Id.* § 1396a(f).
 - c. The states which exercise the 209(b) option include: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. SSA Program Operations Manual System (POMS) SI 01715.020.
2. Establishing eligibility through the “medically needy” or “spend down” program.
 - a. This is an option exercised by approximately two thirds of the states.
 - b. Medically needy individuals are those who would qualify for Medicaid, including individuals who are disabled, but have income or resources

²**Transition planning tip:** Children with severe disabilities will qualify for SSI (and automatic Medicaid in 39 states) at age 18 without regard to parental income and resources. This source of cash benefits and health insurance should ease the transition into adult life.

above limits set by their state. 42 U.S.C. § 1396a(a)(10)(C).

- c. Since Medicaid eligibility workers often do not explain the spend down program to applicants or recipients, it is important that you:
 - (1) Find out if your state offers this option; and
 - (2) Take steps to educate yourself on how it works.
 - (3) At a minimum, you should keep up to date on your state's medically needy eligibility levels for various sized families.

3. How does the spend down work?

- a. Each state will set its own medically needy income level based on family size.
 - (1) For example, New York has set its medically needy level at \$600 per month for a household of one.
 - (2) All individuals meeting the federal (i.e., SSI) definition of disability, who have incomes and resources below the medically needy level, automatically qualify for Medicaid.

Note: A state must establish a uniform set of income and resource rules for determining income for the medically needy. The rules (or “methodologies”) used in determining eligibility for persons who are blind or disabled can be no more restrictive than those employed by the SSI program.

- b. Individuals with income above the medically needy level do not automatically qualify for Medicaid.
 - (1) They must first meet a “spend down” or “share of cost” test.
 - (2) The spend down is the amount by which the individual's income exceeds the medically needy level after subtracting allowable deductions.
 - (3) Consider this example: In New York, a single adult with a disability receives a monthly SSDI check of \$720. Since this

exceeds the state's medically needy level of \$600, the Medicaid agency will disregard the first \$20 as an unearned income exclusion and the individual will face a \$100 spend down (i.e., their countable income exceeds the medically needy level by \$100).

- (4) The spend down acts like a deductible or insurance premium that must be paid or incurred before the insurance program, i.e., Medicaid, begins coverage.

4. What bills or expenses will be counted toward the spend down?

Nearly any medical expense that is paid or incurred can be used to meet a Medicaid spend down requirement, even if it is for goods or services not covered by your state plan. However, the Medicaid applicant/recipient will need to keep good records. The following is a list of typical expenses that may be used:

- a. Health insurance premiums and co-payments
- b. Doctor bills
- c. Mental health bills (including a psychiatrist's services and mental health counseling services)
- d. Dental bills
- e. Home health care
- f. Prescriptions drugs
- g. Eyeglasses and optometry bills
- h. Over-the-counter drugs or purchases related to health care

D. Why is Medicaid Important to Children with Disabilities?

- 1. Medicaid is typically the only or primary health insurance plan for children with disabilities who have limited income.
- 2. For those advocates dealing with older students, who will soon transition out of the special education system, a lack of adequate health insurance is often cited as a

primary barrier to both the ability to live independently in the community and the ability to succeed in employment.

- E. Under Medicaid, a state is required to provide all federally “required services.” A state may also choose to provide any number of “optional services.”
- F. Under EPSDT, children under age 21 qualify for all “required” and “optional” Medicaid services.
 - 1. This ensures that any of the expensive services, potentially covered by Medicaid for adults (i.e., older than 21), will be covered for the child when such services are medically necessary. 42 U.S.C. § 1396d(r)(5).
 - 2. For example, the following services, many of which are optional, tend to be those that are both the most expensive and not usually covered through employer-funded health insurance programs. All of these would be available to Medicaid-eligible children under EPSDT:
 - a. *Inpatient hospital care* - a required service
 - b. *Home health care services* - importantly, this required service includes “medical supplies and equipment,” the category typically used to fund a wide range of assistive technology
 - c. *Private duty nursing* - this very expensive optional service is seldom available on an ongoing basis through traditional health insurance plans.
 - d. *Physical therapy; occupational therapy; speech, hearing and language therapy* - each of these optional services can be expensive and, when needed on an ongoing basis, is not available through many traditional private insurance plans. Under each of these categories, funding is available for necessary equipment and supplies, providing potential funding for expensive assistive technology.
 - e. *Prosthetic devices* - this optional service category has also been used to fund expensive assistive technology, i.e., to the extent that the device replaces or replaces the functioning of a non-functioning part of the body.
 - f. *Intermediate care facilities* - these very expensive residential programs, which are optional Medicaid service categories, enable many persons with disabilities to move from institutions into more community-

based living environments.

- g. *Personal care services* - this optional service is what allows many individuals with disabilities to live independently in the community.
- h. *Clinic services* - to the extent that this optional category and other optional categories (e.g., *case management services*) are available to provide community-based mental health treatment, this allows persons with mental illness diagnoses to avoid the need for more segregated inpatient treatment.

IV. Medicare

- A. Medicare, a federal health insurance program authorized by Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*, is most frequently associated with the receipt of Social Security benefits. *Id.*³
- B. Adults with disabilities can establish eligibility in three ways:
 - 1. After 24 months of eligibility for Social Security Disability Insurance (SSDI) benefits;
 - 2. After 24 months of eligibility for Railroad Retirement disability benefits [*Id.* § 426(b)]; or
 - 3. If suffering from kidney disease and not receiving SSDI benefits, upon entering end stage renal disease or developing an impairment that requires regular dialysis or kidney transplantation to maintain life. *Id.* §§ 426-1, 1395c, 1395rr; 42 C.F.R. § 406.13(b).

³The National AT Advocacy Project (see address, phone, web site, and email information on title page) has produced or collected a wealth of information related to Medicare as a funding source for AT, including two comprehensive booklets: *Medicare, Managed Care and AAC Devices: Funding Augmentative and Alternative Communication (AAC) Devices Through Medicare - The Decision Making and Appeals Process for HMO and Other Medicare+Choice Participants*; and *Medicare and AAC Devices* (December 1999, 23 pages; previously distributed to P&As); *Funding of Augmentative and Alternative Communication (AAC) Devices Through Medicare, the Decision Making and Appeals Process for Non-HMO Participants* (April 1999, 19 pages; previously distributed to P&As). Both publications are available through the National AT Advocacy Project or the project's web site, www.nls.org.

- C. Medicare is, for a majority of persons with disabilities, an inferior health insurance plan compared to Medicaid. Compared to most state Medicaid programs:
1. Medicare provides much more limited home health care benefits.
 2. Medicare provides more limited coverage of community-based care.
 3. Medicare currently provides no coverage for prescription drugs for persons living in the community. (Depending on what happens in Congress this year, some form of prescription coverage could be added to Medicare.)
 4. Typically, Medicare provides more limited coverage for the wide range of assistive technology devices than Medicaid.
 5. Medicare requires payment of premiums (for Part B coverage), deductibles and co-payments that are typically not required by Medicaid.
 - a. A state's Medicaid agency may, subject to income eligibility requirements, pay for the Part B premiums, deductibles and co-payments.
 - b. This is generally done under the Qualified Medicare Beneficiaries program or the Selected Low-Income Medicare Beneficiaries program.

V. The Social Security and SSI Disability Benefit Programs

- A. The Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs permeate the lives of persons with disabilities.
1. A majority of children on the special education advocate's caseload are current SSDI or SSI recipients, or can expect to be recipients as young adults.
 2. The advocate should have a working knowledge of these programs which are both administered through the Social Security Administration.
- B. SSDI
1. SSDI is an insurance program.
 2. To qualify, one must meet an earnings or "insured status" test, i.e., a wage earner

must have put money into the Social Security trust fund.

3. Both the wage earner and person with a disability who was dependent upon a wage earner may be eligible for SSDI benefits.
 - a. Many of the children you work with may qualify for SSDI benefits as young adults (i.e., at age 18 or older) on the Social Security earnings record of a parent who retires, becomes disabled or dies. These benefits, officially named Child's Insurance Benefits, are most commonly referred to as Disabled Adult Child's (DAC)Benefits.
 - b. Children under age 18 (in some cases up to age 19) may qualify for Social Security benefits without establishing disability if their parent is already retired, disabled or deceased.
 - c. The size of a recipient's benefit check will vary based on the level of earnings of the parent and the number of dependents collecting against the account. In some cases DAC benefits may exceed \$800 per month.
4. As noted in section IV, above, an SSDI recipient will qualify for Medicare after 24 months of eligibility.⁴
5. Because it is an insurance program, current income will not affect the amount of one's SSDI check. Earnings in excess of \$700 per month, however, may result in a finding that the person is not disabled.⁵

C. SSI

1. SSI, a welfare or needs-based program for the aged, blind or disabled, is authorized by Title XVI of the Social Security Act. 42 U.S.C. §§ 1381 *et seq.*;

⁴**Transition Planning Tip:** Children with severe disabilities will qualify for SSDI (and Medicare after 24 months of eligibility) as early as age 18 if a parent is retired, disabled or deceased. Similar to our comment about SSI and Medicaid, above, this source of cash benefits and health insurance should ease the transition into adult life (particularly if a prescription plan is added to Medicare).

⁵For information on the effect of wages on SSDI and related issues, see FUNDING OF ASSISTIVE TECHNOLOGY: *Work Incentives for Persons with Disabilities Under the Social Security and SSI Programs; Using the Work Incentives to Fund AT and Make Work a Reality* (December 1999, 55 pages; previously distributed to P&As). This publications is available through the National AT Advocacy Project or the project's web site, www.nls.org.

20 C.F.R. pt. 416

2. To qualify for SSI, a child or adult must have limited income and resources. *See* 20 C.F.R. §§ 416.1100 *et seq.* (regarding SSI's income rules); §§ 416.1201 *et seq.* (regarding SSI's resource rules).
 - a. Up until age 18, the SSI program will count the income and resources of the parent who lives with the child.
 - b. At age 18, the child is eligible for SSI without regard to the parent's income.
3. SSI can be a person's only form of income or it can supplement other income such as Social Security benefits or wages.
4. Because SSI is a needs-based program, the amount of one's income is always relevant in determining the amount of the monthly SSI check.
5. Under section 1619(a), however, once a person has been approved for SSI, the amount of earnings will never affect the determination of whether that person continues to be disabled. This is one way in which SSI and SSDI are different.⁶
6. As explained in section V.C, above, a child or adult who receives any amount of SSI benefits will be automatically eligible for Medicaid in 39 states.
7. How much will the individual receive in SSI benefits?
 - a. This will be based on a federal benefit rate (FBR) of \$512 in 2000 plus an optional state supplement.
 - b. After determining your state's SSI rate (FBR + state supplement, if any), subtract an individual's countable income to determine their monthly SSI check.

VI. Vocational Rehabilitation Services

- A. Each state will have a state vocational rehabilitation (VR) agency. About 30 states also have a separate agency which serves only individuals who are legally blind.

⁶See note 5, above.

1. Congress, pursuant to Title I of the Rehabilitation Act, gives money to states to provide VR services to persons with disabilities. 29 U.S.C. §§ 701 *et seq.*; 34 C.F.R. Part 361.⁷
 2. VR agencies can fund a wide range of goods and services, including “rehabilitation technology” (i.e., AT), that are connected to a person’s vocational goal.
 3. Congress has stated that VR services are to empower individuals to maximize employability, economic self-sufficiency, independence and integration into the work place and the community through “comprehensive and coordinated state-of-the-art programs.” *Id.* § 701(b)(1)(emphasis added).
- B. The services available through each state’s VR system can play a critical role in assisting people with disabilities to enter the work force.
1. Special education students and their families should be made aware of the VR agency and the services it provides as early as age 14 (i.e., whenever the transition planning process begins within the special education system).
 2. Although most state VR agencies will not begin funding and delivering services until the child or young adult has completed the public school program, the involvement of the VR agency in planning should begin much earlier.
- C. Who is eligible for VR agency services?
1. To receive services, an individual must be disabled and require VR services “to prepare for, secure, retain or regain employment.” *Id.* § 722(a)(1).
 2. Therefore, any service an individual is to receive from the VR system must be connected to an ultimate employment goal.
 - a. Employability had been defined, prior to 1998, as full or part-time

⁷On February 28, 2000, the federal Rehabilitation Services Administration issued proposed regulations to implement the 1998 amendments to Title I of the Rehabilitation Act. Those regulations are summarized in the article, “U.S. Department of Education Issues Proposed Vocational Rehabilitation Regulations,” the lead article of the February-March 2000 issue of *AT Advocate*, the newsletter of the National AT Advocacy Project. Copies of this issue can be obtained from the AT Advocacy Project (see title page) or from the project’s web site, www.nls.org.

competitive employment to the greatest extent practicable, supported employment or other employment consistent with the individual's strengths, abilities, interests and informed choice. 34 C.F.R. § 361.5(b)(15).

- b. The 1998 amendments to the Rehabilitation Act added self-employment, telecommuting and business ownership as successful employment outcomes. 29 U.S.C § 705(11)(C).

D. What services are available to an eligible person?

- 1. VR services are defined to include “any goods or services to render an individual with a disability employable.”
- 2. Services states must provide include [29 USC 723(a); 34 CFR 361.48(a)]:
 - a. The assessment to determine eligibility and needs, including, if appropriate, by someone skilled in rehabilitation technology.
 - b. Counseling, guidance and job placement services and, if appropriate, referrals to the services provided by WIA providers.
 - c. Vocational and other training, including higher education and the purchase of tools, materials and books.
 - d. Diagnosis and treatment of physical or mental impairments to reduce or eliminate impediments to employment, to the extent financial support is not available from other sources, including health insurance or other comparable benefits. This may include:
 - (1) corrective surgery;
 - (2) therapeutic treatment;
 - (3) necessary hospitalization;
 - (4) prosthetic and orthotic devices;
 - (5) eyeglasses and visual services;
 - (6) services for individuals with end-stage renal disease, including

dialysis, transplants and artificial kidneys; and

- (7) diagnosis and treatment for mental or emotional disorders.
- e. Maintenance for additional costs incurred during rehabilitation. In *Scott v. Parham*, 422 F.Supp. 111 (N.D. Ga. 1976), the Court struck down a limitation on maintenance to only those receiving VR services outside of the home or home community because it failed to account for the individualization requirements of Title I of the Rehabilitation Act.
 - f. “Transportation, including adequate training in the use of public transportation vehicles and systems, that is provided in connection with the provision of any other service described in this section and needed by the individual to achieve an employment outcome (emphasis added).” Under the regulations, transportation is defined as “travel and related expenses that are necessary to enable an applicant or eligible individual to participate in a [VR] service.” 34 C.F.R. 361.5(b)(49). A note, following the regulation, specifically states that “[t]he purchase and repair of vehicles, including vans” is an example of an expense that would meet the definition of transportation. *Id.*, Note.
 - g. Personal assistance services while receiving VR services.
 - h. Interpreter services for individuals who are deaf, and readers, rehabilitation teaching, and orientation and mobility services for individuals who are blind.
 - i. Occupational licenses, tools, equipment, initial stocks and supplies.
 - j. Technical assistance for those who are pursuing telecommuting, self-employment or small business operation.
 - k. Rehabilitation technology (i.e., assistive technology), including vehicular modification, telecommunications, sensory, and other technological aids and devices.
 - l. Transition services for students with disabilities to facilitate the achievement of the employment outcome identified in the Individualized Plan for Employment.
 - m. Supported employment.

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- n. Services to the family to assist an individual with a disability to achieve an employment outcome.
 - o. Post-employment services necessary to assist an individual to retain, regain or advance in employment.

E. Comparable Services Requirement [29 USC 721(a)(8)]

- 1. Generally, services are not available through a state VR agency until a determination has been made that comparable services and benefits are not available under any other program.
 - a. For example, if personal assistance services are available through Medicaid, similar services will not be approved through the state VR agency.
- 2. A state VR agency cannot require a prior determination regarding the availability of similar benefits and services if consideration of the similar benefit would interrupt or delay [29 U.S.C. 721(a)(8)(A)(i)]:
 - a. The progress of an individual toward achieving the employment outcome;
 - b. An immediate job placement; or
 - c. Services to an individual at extreme medical risk.
- 3. The following services are not subject to the comparable benefits requirement [29 USC 721(a)(8)(A)(i)]:
 - a. Assessment to determine eligibility and needs;
 - b. Counseling, guidance, referral and work-related placement, job retention and follow-along services;
 - c. Rehabilitation technology services, including assistive technology devices and services.

- F. Must an individual meet financial need criteria?
1. For basic eligibility the answer is no. However, a state is permitted to establish a financial needs test for the majority of services it provides.
 2. There is no requirement that a state consider financial need when providing VR services. 34 C.F.R. § 361.54(a).
 - a. However, if a state VR agency chooses to establish a financial needs test, it must establish written policies which govern the determination of financial need and which identify the specific VR services that will be subject to the financial needs test. *Id.* § 361.54(b)(2).
 - b. Any financial needs test must take into account the individual's disability-related expenses. *Id.* § 361.54(b)(2)(v)(B).
 - c. The level of the individual's participation must not be so high as to "effectively deny the individual a necessary service." *Id.* § 362.54(b)(2)(v)(C).
 3. The following services must be provided without regard to financial need: (1) diagnostic services; (2) counseling, guidance and referral services; and (3) job placement. *Id.* § 361.54(b)(3).

VII. The Ticket to Work and Self Sufficiency

- A. This is one of the key components of the Ticket to Work and Work Incentives Improvement Act of 1999.
1. It establishes what might be viewed as an alternative program to the traditional state VR agency programs.
- B. Key dates for Ticket provisions
1. The effective date is January 1, 2001, with phase in at sites throughout the country. Full implementation is required in every state not later than January 1, 2004.
 2. Graduated implementation of ticket program
 - a. The Social Security Administration (SSA) is required to implement the ticket program in phase-in sites throughout the country.

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- b. The purpose of the phase-in is to ensure, prior to full implementation, the development of referral processes, payment systems, and other processes.
 3. Full implementation is required in every state “as soon as practicable” but not later than three years after the January 1, 2001 implementation date.
 4. SSA must enact regulations to carry out the ticket provisions “not later than 1 year after enactment” of the Act (i.e., not later than December 17, 2000).
 - C. Establishment of program [section 101]
 1. SSA will issue tickets to SSDI or SSI beneficiaries “to obtain employment services, vocational rehabilitation services, or other support services from an employment network which is of the beneficiary’s choice and which is willing to provide such services to such beneficiary.”
 2. A state vocational rehabilitation (VR) agency, administering a state VR plan under Title I of the Rehabilitation Act (29 U.S.C. § 720 *et seq.*), may elect to participate in the Program as an employment network.
 - a. If the state VR agency elects to become an employment network, the services it provides under the program shall be governed by Title I of the Rehabilitation Act. Thus, the current mandates under federal law and regulations, including all of the due process appeal procedures that currently govern a state VR agency (see Chapter 10), would apply to tickets administered by the state VR agency.
 - D. Dispute resolution
 1. SSA is required to create a mechanism for resolving disputes between beneficiaries and employment networks, between program managers and employment networks, and between program managers and providers of services.
 2. A special concern here is that the law does not mandate an opportunity for a due process hearing, similar to the hearing authorized under Title I of the Rehabilitation Act, for a beneficiary who wishes to challenge a decision regarding the denial of services under the Ticket program. The law provides only that SSA “shall afford

a party to such a dispute a reasonable opportunity for a full and fair review of the matter in dispute.”

3. Advocates anxiously await SSA’s enactment of regulations on dispute resolution. Those regulations are expected to come out in proposed form (i.e., published in the Federal Register, with public comment invited) during the first half of 2000.

E. What services are available under a Ticket?

“Services provided under the Program may include case management, work incentives planning, supported employment, career planning, career plan development, vocational assessment, job training, placement, follow-up services, and such other services as may be specified by [SSA] under the Program.”

F. Individual Work Plans (IWP)

1. Services are to be provided under IWPs.
2. An IWP must include:
 - a. A statement of the vocational goal developed with the beneficiary, including, as appropriate, goals for earnings and job advancement;
 - b. A statement of necessary services and supports;
 - c. A statement of any terms and conditions related to the provision of such services and supports; and
 - d. A statement of understanding regarding the beneficiary’s rights under the Program (such as the right to retrieve a ticket if the beneficiary is dissatisfied with the services being provided by the employment network) and remedies available to the individual, including information on the availability of Protection and Advocacy services to resolve disputes.
3. Beneficiaries can amend the IWP as circumstances dictate.
4. An IWP is effective upon written approval by both the beneficiary (or his/her representative) and a representative of the employment network.

VIII. Private Insurance⁸

A. Introduction

1. Why is private health insurance important?
 - a. Covers very high percentage of each state's population
 - b. Insurance policies have been used to fund many AT devices and other expensive services.
 - c. As managed care moves more into Medicaid and Medicare, advocates will be dealing with private insurers more and more.
2. The analysis of coverage for any item or service under a health insurance policy breaks down to three questions:
 - a. Is the child or adult in question covered by the insurance policy?
 - b. Is the item being sought one that is covered by the policy?
 - c. Is the item being sought medically necessary?
 - d. If the answer to each of these questions is yes, the item or service in question will be covered, subject to any policy limits, co-payments and deductibles.

B. Rules Governing Interpretation of Insurance Contracts: Some General Guidelines

1. We have not attempted to review the statutory and case law of the 50 states to look for rules governing the interpretation of health insurance contracts.
 - a. However, you need to become familiar with your relevant state law.

⁸Readers who want a more detailed discussion of private insurance may wish to review our two-part newsletter feature, "Private Insurance Contracts and Assistive Technology: Parts I and II," featured in the February-March 1998 and April-May 1998 issues of *AT Advocate*. These and all other back issues of the newsletter are available through the National AT Advocacy Project or the project's website, www.nls.org.

- b. In New York, for example:
 - (1) Health insurance is governed by the state Insurance Law and Public Health Law.
 - (2) There is a strong body of case law which often favors the beneficiary over the insurer.
 - (3) A specific statutory provision sets the statute of limitations for suing on a health insurance contract. Another statutory provision allows the parties to a contract to agree on a shorter statute of limitations.

- 2. A good starting point for analysis is the *Restatement of Contracts, 2nd*. Although the *Restatement* is not law, it has been regularly cited with approval by the courts.

- 3. How New York case law treats the subject:
 - a. Where the language in an insurance policy is clear, that language determines what is available under the policy. *IBM World Trade Corp. v. Granite State Ins. Co.*, 455 N.Y.S.2d 914, 917-18 (Sup. Ct., N.Y. County 1982).

 - b. The meaning of that language must be found in the “common sense and common speech of the average person,” or the meaning which would be given by the average man. *Stainless, Inc. v. Employers’ Fire Ins. Co.*, 418 N.Y.S.2d 76, 79 (Appellate Div., 1st Dept. 1979), affirmed 428 N.Y.S.2d 675.

 - c. The general rule is that insurance contracts must be liberally construed, with ambiguities in the policy language resolved in favor of the insured (i.e., the beneficiary). *Westchester Resco Co., L.P. v. New England Reninsurance Corp.*, 818 F.2d 2, 3 (2nd Cir. 1987); *Stainless, Inc., supra*, 418 N.Y.S. 2d at 79; *Government Empire Ins. Co. v. Kligler*, 42 N.Y.2d 863, 397 N.Y.S.2d 777 (1977)(a decision from New York’s Court of Appeals); *Restatement of Contracts, 2nd*, § 206 & comment a.

- C. Is the service or item in question covered by the policy?

To give this inquiry context, we will consider whether a particular AT device can be funded.

1. Analysis of what is covered starts with reviewing the provisions of the insurance policy or contract.
 - a. In private health insurance policies, AT is commonly referred to as durable medical equipment (DME).
 - b. DME is usually not available in what is commonly termed a "basic" plan, the least costly of group plans.
 - c. DME is provided, in most cases, in what is labeled a "major medical" plan which is often an adjunct or a rider to a basic plan.
 - (1) Major medical riders often cover items such as hospital stays, diagnostic testing and DME.
2. In addition to the DME clause, AT might be covered by a clause which addresses prosthetics, orthopedic appliances, medical supplies, or vision services and equipment.
3. One should review the entire policy and all the riders in search of any language that can be relied upon to fund AT.
4. You also need to look for "exclusions," i.e., provisions that specifically mention items that are not covered.
 - a. It is common for a policy to list various types of DME or other AT categories that the insurer will not cover.
 - b. Examples of items which are commonly excluded from coverage are:
 - (1) Air conditioners
 - (2) Prosthetic devices
 - (3) Hearing aids
 - (4) Computer-assisted communication devices

- (5) Humidifiers
- (6) Items characterized as athletic equipment
- (7) Orthotics - shoe inserts
- (8) Eyeglasses
- (9) Equipment characterized as experimental

5. Look for policy limits and co-payment requirements

- a. Even if a DME clause or a similar clause would appear to cover an item, the policy may specifically limit the funding that is available.
- b. Some policies contain provisions that place a dollar limit on what will be spent on a particular item.
 - (1) For example, one policy we reviewed had a \$1,500 limit on DME coverage.
- c. It is also common for insurers to require a co-payment for the purchase of DME.
 - (1) E.g., one major New York insurer sets it at 20 percent while another New York insurer sets it at 50 percent.
 - (2) An insurer with a 50 percent co-payment requirement would pay \$5,000 towards the purchase of a \$10,000 power wheelchair while the insured or beneficiary would be responsible for payment of the remaining \$5,000.

6. DME definitions

- a. Each policy will contain its own definition of DME.
- b. Most often the definition is similar to the following:
 - (1) Is able to withstand use by more than one person;
 - (2) Is primarily and customarily used to serve a medical purpose;

- (3) Is not useful in the absence of illness or injury.
 - c. Some policies also include a statement that the DME is for use in the home.
 - d. Any part of this definition can give rise to disputes over what is covered.
 - (1) For example, many insurance companies interpret the statement, "is able to withstand use by more than one person," to exclude anything but standard equipment.
 - (a) Therefore, some insurers have refused to fund customized wheelchairs by invoking that clause. They may limit payment to the normal cost for a standard wheelchair, which is usually far less than the cost of the customized wheelchair.
 - (b) That coupled with the co-payment requirement may make the particular wheelchair or other piece of DME unaffordable.
 - (c) It is an unresolved question whether that clause, or the restrictive interpretation of it, violates the American with Disabilities Act (see Steve Mendelsohn's handout).
- D. Is the assistive technology device in question medically necessary?
 - 1. Like Medicaid and Medicare, private insurance policies generally contain language stating that they will only pay for DME that is "medically necessary."
 - a. How that term is defined is determined by the individual insurance contract.
 - b. Most policies use language such as the following in defining medical necessity:
 - (1) Is consistent with the symptoms or diagnosis and treatment of a condition, disease, ailment or injury;
 - (2) Is in accordance with standards of good medical practice;

- (3) Is not for the insured's convenience.
2. It is important that you check your state laws governing insurance to determine whether they provide any guidance or mandates to the insurance company for making these determinations.
3. Representative New York laws
 - a. In New York, determinations of medical necessity are made by a utilization review agent for the insurer.
 - b. Effective April 1, 1997, an insurer must appoint a medical director who is a licensed physician and who must oversee and supervise the utilization review process. N.Y. Insurance Law § 4902(a)(1).
 - (1) This process is the equivalent of the prior approval process which most states follow under Medicaid.
 - c. New York law also requires that the utilization review agent must also develop written policies and procedures that govern all aspects of the utilization review process. He or she must maintain and make available to insurance policy beneficiaries and health care providers a written description of such procedures including procedures to appeal an adverse determination. N.Y. Insurance Law § 4902(a)(2).