

Have You Read Your Insurance Policy Lately?

by Frank Stewart

Probably not. Hardly anyone does. However, if you don't have the prosthesis, wheelchair or other medical equipment you need, it's probably because of insurance problems

Understanding the various types of healthcare coverage is difficult even for healthcare professionals. So how can the average person sort through it all to determine which type of insurance coverage best fits his or her needs.

Prosthetic care can range from several hundred dollars for a basic prosthetic device to over \$50,000 for a state-of-the-art prosthesis. It is up to you (perhaps with your prosthetist's help) to make sure you are maximizing your insurance premium dollar. The following information will help you get started.

Some Basic Terms

- **Coinurance** – This is the portion of the covered medical expenses you will pay. For example, if your policy states that the insurer will pay 80 percent of your prosthetic needs and your prosthetic needs are \$1,000, then the coinsurance, the amount you will pay, will be 20 percent, or \$200. However, there are also other things to watch out for when determining how much you will actually pay.

- **Maximum annual out of pocket** – This represents the most you will have to pay in a single year. It can range



from \$500 to \$5,000 and may or may not include your deductible expense. If you have a year in which you have a lot of work done, say for a cost of \$30,000, and your coinsurance is 20 percent, then you would expect to pay \$6,000 ($\$30,000 \times .20$) out of pocket. However, if your annual maximum out of pocket is \$2,000, then that (and perhaps your deductible) is all you will have to pay.

- **Deductible** – This is the amount of covered expense you will pay each calendar year before your insurance company pays anything. It may be \$100, \$500, \$1,000 or perhaps nothing at all. Generally, the higher the deductible, the lower your insurance premiums will be. Your deductible may influence when you upgrade or replace your prosthetic device. For example, you may wish to get all of your work done in one calendar year to “save” your deductible expense the following year.

- **Yearly Maximum** – Some insurers will put a yearly maximum on the amount of prosthetic reimbursements they will provide. This is a red flag for prosthetic users! Some of the new high-tech knees alone cost more than \$30,000. If you were considering using such a device, a \$1,500 yearly maximum would put almost all the cost burden on you.

- **Lifetime Limits** – Like the yearly maximum, this will also limit what an insurance company will pay over the course of your life. Young amputees in particular should look closely at lifetime limits. Your lifetime prosthetic needs could run well into six digits.

- **Medical Necessity** – Many insurers will use this ill-defined term to determine if any coverage at all will be provided to you. They might argue that a prosthesis is not medically necessary

for an individual who has experienced limb loss.

Types of Insurance

You will need to understand the differences and similarities of the following types of plans as you look to meet your insurance needs.

- **Fee-for-Service Plans** – With this type of coverage, you can visit the prosthetist, physical therapist, doctor or hospital of your choice. After you or your doctor submits a claim, you will be reimbursed for a portion of the covered medical expenses. The covered expenses are only those listed in your benefits summary (you should, therefore, make sure that the plan has coverage for artificial limbs). You will normally be charged a coinsurance fee (generally 20 percent of the cost) and deductibles (\$100 to \$300 annually) as your part of the payment.

The catch with fee-for-service plans comes when the fees charged by the provider are greater than what the insurance company calls “reasonable and customary” charges. Although “reasonable and customary” charges are usually based on prevailing costs in the area, the charges from your doctor or prosthetist could, in fact, exceed this amount. When they do, you will not only pay the coinsurance and deductibles, but you will also be responsible for all the costs above what is considered “reasonable and customary.”

With fee-for-service plans, it is best to look closely at lifetime limits. For people with limb loss, looking for a policy with at least

\$1 million in lifetime benefits is a good idea.

- **Managed Care Plans** – There are three types of managed care plans: health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service plans (POS).

HMOs are generally designed to keep the cost of medical care down by setting fees that providers can charge for certain procedures or services. You still may have coinsurance and deductibles, but the fees will never exceed what is considered “reasonable and customary.” You may also be charged a nominal fee for office visits called a copayment (usually \$10 to \$20). However, if you belong to an HMO, you generally must receive your medical care through the plan and can’t always choose your own doctors, prosthetists, physical therapists or hospitals.

If you already have a prosthetist, or if you have one in mind, be sure to check with your HMO benefits specialist to see if he or she is on the preferred provider list. With most HMOs, you will

coordinate your medical work through a primary care physician on the HMO’s list of preferred providers.

PPOs are much like HMOs, but allow you to go outside of your preferred providers for service. Generally, the premiums are higher than those for HMOs, and, if you do visit a doctor or prosthetist who is outside the plan, your share of the costs will be higher. With PPOs, typically you do not work through a primary care physician.

A POS plan is the same as a PPO (you can see “outside” physicians for additional cost), except you will generally work through a primary care physician.

Questions & Answers

Q: What is the best plan for amputees?

A: Since all insurance policies are different, it’s tough to generalize. However, in most cases you get what you pay for. PPOs typically will cost a little more in premium, but they will allow you to see the prosthetist of your choice and they have very high or no annual or lifetime maximums. PPOs are usually a good



choice of coverage for amputees! HMO policies are inexpensive to buy but they don't always let you see the prosthetist you would like to, and they often impose maximums. POS plans, although they will allow you to go out of plan for service, also often impose low annual and lifetime maximums.

Q: What about pre-existing conditions?

A: Before 1997, it was often difficult to change insurance companies or jobs for fear of losing your insurance coverage for some injury or illness that you already had. However, in 1997, the Health Insurance Portability and Accountability Act (HIPAA) was passed by Congress, changing the way pre-existing conditions are handled by health insurance plans. Now, your insurer can only impose one 12-month waiting period for any pre-existing condition. Furthermore, if you were insured by another company, with no lapse in coverage, your prior insurance will count toward your waiting period.

Q: What if I lose my job?

A: COBRA is a federal law that forces employers with 20 or more employees to continue coverage for you and your dependents for 18 months after you leave your job. For any reason! You must, however, notify your employer within 60 days of leaving your job and be prepared to pay the entire premium for this period. As an amputee, you can get prosthetic coverage as you did while you were working with no pre-existing condition waiting period. Remember, if you find another job during those 18 months and the employer offers a group medical plan, you will still have no penalty for pre-existing conditions. If your current employer has less than 20 employees, COBRA will not apply. You will need to search for insurance coverage, and it may be 12 months before

prosthetic work will be covered. (If you are faced with this situation, try to get any major work done before leaving your job, if possible.)

Q: Can Medicare or Medicaid help with my prosthetic payments?

A: Medicare covers people over 65 who are entitled to Social Security benefits, as well as people under 65 who receive Social Security disability benefits. It will often help pay for a wide range of prosthetic products. You will communicate with your prosthetist, who will communicate with Medicare to determine which prosthetic devices will qualify for reimbursements.

Medicaid is a program sponsored by federal and state agencies that generally covers children from low-income families and disabled individuals who receive federally assisted income. Eligibility varies widely by state; therefore, you should see if you qualify in your state for prosthetic reimbursements.

Q: How do I choose a policy that is best for my prosthetic needs?

A: First, examine the prosthetic coverage offered in each of the plans. You should learn the answers to the following questions:

- Are the doctor and prosthetist that I use or hope to use included in the list of preferred providers (for managed care plans)?
- Are artificial limbs covered in this plan? You may need to look under durable medical equipment (DME), which includes other devices such as wheelchairs and crutches, to determine if prosthetic limbs are covered.
- Is there a yearly limit for prosthetic devices? If they are included in DME, is there an annual limit on DME? Remember, this is usually a red flag.
- What is the coinsurance and yearly deductible for prosthetic limbs?
- Is there a lifetime maximum?

When talking to insurance companies, take notes and write down the name of the person you talk to and the date and time of the call.

Secondly, once you understand the features of the plans, talk to your prosthetist. Insurance companies are constantly changing. The insurance policy may indicate that a prosthetic knee or foot will be covered, but the particular knee or foot you want may be deemed not medically necessary for you and you may be denied coverage. Your prosthetist deals with insurance companies every day, and he or she can give you an idea of which companies are more likely to cover a specific device.

Thirdly, determine which of the plans will be most cost-effective for you. If you and your prosthetist feel you are capable of using state-of-the-art prosthetic equipment, go for the policy that has low coinsurance, no yearly maximums, and high lifetime maximums. If your prosthetic needs are minimal, then you may want to choose a plan that has high annual deductibles and low premiums, without regard to policy limitations. Don't be afraid to sit down with a pencil and paper – your prosthetist should be willing to help you – and see what your out-of-pocket cost will be, based on your needs, for each of the plans offered. ■

About the Author



Frank Stewart received his engineering degree from the University of Massachusetts and spent 29 years in the insurance industry.

An above-knee amputee, he is now an independent manufacturer's sales rep for prosthetics and orthotics.