One of the concerns parents of children with hypoxic-ischemic encephalopathy often have is how they will pay for their child's medical and therapeutic care. In some cases, health insurance is there to cover the cost of a child's care. Insurance companies calculate how much a group of people will – on average – cost to take care of, and then the companies spread the costs out among a pool of people to keep costs lower for everyone. Some insurance is supplied by a private company, while other insurance is provided through government programs, such as SCHIP, Medicare and Medicaid.

A child with HIE is likely to need specialized, team-based services throughout their lifetime, with care provided by numerous parties, such as neurologists, nutritionists, and physical therapists, just to name a few. Because of this, insurance plans for the child must be robust in order to prevent undue strain on the family's finances. What kind of coverage a child will need can vary significantly, but there are a few common threads that parents should consider:

- Is preventive care a priority?
- Is major medical coverage a priority?
- Is dental, vision or prescription coverage needed?
- Does the parent's' workplace offer coverage? What kind?
- Is the child eligible for government coverage?
- Do the parents belong to any special groups that can get them insurance discounts?
- What is better: an indemnity or managed care plan?
    - If a managed care plan is picked, what kind of coverage: HMO, PPO, or POS?

Jump To:

Things to Take Into Account When Picking an Insurance Provider

- Licensure*:* Most insurance in the U.S. is provided by private companies. The government steps in to help seniors, those with disabilities, and low-income people defray the cost of healthcare as care costs can often exceed income for these groups. Insurance companies must be licensed and follow certain regulations. Insurance should be bought *only* from companies that are licensed and accredited; to check accreditation, see the National Association of Insurance Commissioners (NAIC)'s website.
- Comprehensive Coverage: Different insurance plans provide different coverage for certain services. Comprehensive coverage tends to provide primary care and preventive care; other types of services (such as dental and prescription coverage) can be added on or requested separately.
- Service Limitations: Different insurance policies can set limits (caps) or maximums that they may pay out for a given time period, or else set limitations on the number of appointments, procedures, treatment types, or medication costs. Check limits, restrictions, requirements and exclusions such as the following:

    - Covered service limits (caps)

  - Per-charge limits (caps)
  - Annual limits (caps)
  - Lifetime payout limits (caps)
  - Exclusions
  - Medication restrictions
  - In-network only coverage
  - Restrictions on number of doctor visits
  - Pre-existing condition clauses
  - Therapy and treatment restrictions
  - Yearly and lifetime maximums
- In-Network vs. Out-of-Network Care: Does the insurance only cover in-network providers? If so, are the child's existing providers in-network or out-of-network? Does the plan require the child be assigned to a primary care doctor?
- Preauthorization: Preauthorization requires an extensive amount of paperwork, but may allow parents a better idea of what out-of-pocket expenses will look like.
- Monthly premiums: Fewer policy limitations mean higher premiums, but in the long term they save money on major medical procedures.
- Indemnity vs. Managed Care Plans: Indemnity plans

Indemnity vs. Managed Care

Different types of plans provide different coverage; the type of plan that is best suited to a person's needs can vary significantly based on how much care they need, whether the care is specialized, how often they need care, and their financial situation. Generally, when flexibility is important and cost isn't an issue, indemnity plans may be recommended. When finances are a significant factor, managed care plans may be better, as they help minimize cost.

Indemnity Care

Indemnity care is a plan that is best for people who prioritize flexibility and for whom cost is not an issue. Indemnity plans don't have a 'network' of providers, so parents can choose to get their child care from any provider. However, this flexibility comes with higher costs – indemnity plans reimburse policyholders for care, but the amount they reimburse can vary. Some companies reimburse for 'actual charges,' (the full cost of a particular service or procedure), others only reimburse a certain percentage of costs (often 80%, leaving the family to pay 20%), which other plans use an indemnity system where the insurer pays out a specific sum per day for a certain (maximum) number of days. Indemnity care plans tend to have more out-of-pocket charges (such as deductibles and copayments) and often have caps placed on the amount paid out over a lifetime.

Managed Care

Managed care is divided into one of three categories: health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service plans (POS). All three of these types of plans involve a network of preferred physicians and service providers. Individuals who select these plans are usually given incentives to pick providers within that network in the form of lower costs.

HMOs

In an HMO, individuals must choose care from physicians and facilities within a specific network, and charges for out-of-network care tend to be significantly steeper. HMO members pay a monthly fixed fee. In exchange for this fee, services are provided on a prepaid basis. HMOs tend to have fewer out-of-pocket costs but have a network of healthcare providers that individuals must select from to receive covered care.

With HMOs:

- Individuals must select a designated primary care physician
- Referrals for specialized care must be obtained through the primary care physician
    - The specialists typically must also be in-network.
- Preauthorization is usually needed
- Limited referral to outside medical specialists
- Out-of-pocket costs typically lower than PPOs
- Typically don’t have deductibles or plan limits
- Minimal co-pays
- Less paperwork
- Emphasis on preventive care

PPOs

With PPOs, individuals do *not* prepay for services. Instead, they pay for services rendered. When a service is provided, the individual pays a co-pay. Then the medical provider sends a bill to the insurance company, which pays a set amount towards the total cost of the service. Amounts not covered are paid by the individual. PPOs tend to be more expensive than HMOs (with higher copays and deductibles) but offer more flexibility in choosing care providers.

PPO plans:

- Provide incentives for in-network care
- Allow out-of-network care at a higher cost to the individual
- Do *not* require a designated primary care physician
- Do *not* require referrals for specialized care
- Do *not* require preauthorization for most procedures
- Are more likely to have deductibles and coverage limits

POS Plans

POS plans usually have no deductible and a small co-payment when used in-network. To take advantage of a POS plan, an individual has to select an in-network primary care physician who refers the individual to specialty care. Under a POS plan, out-of-network care *is* subject to a deductible and copayments are between 30-40% of total cost of care. POS plans combine aspects of both HMOs and PPOs. POS plans tend to cost somewhere in between the costs of an HMO and a PPO.

- Like an HMO, POS plans require a designated primary care provider.

  - Unlike an HMO, primary care providers can refer out-of-network (though the individual will be paying the higher costs of out-of-network care).
- Like a PPO, POS plans are more flexible in terms of selecting in-network vs. out-of-network care.
- There is less paperwork in-network but more paperwork out-of-network.

Non-Private Insurance Options

Some individuals don't have the option of getting insurance coverage through their employer and may have financial difficulties. For individuals who qualify based on income, there are programs that may help parents secure insurance care for their children, including the Children's Health Insurance Program, Medicaid and Medicaid Waivers. Available options can vary from state to state.

- Children's Health Insurance Plan (CHIP): CHIP is a program specifically designed to help individuals who don't qualify for Medicaid due to income but still have trouble affording private health insurance. Because the program is managed by the U.S. Department of Health and Human Services on a federal level, and by individual state service departments on a local level, coverage premiums, cost and coverage can vary significantly.
- Medicaid: Medicaid is a program administered on the state level according to federal guidelines, and is specifically targeted towards helping low-income families secure health insurance. Before getting care, parents must check that the service provider accepts Medicaid: covered services are paid directly to the hospital or service provider, and the family pays the rest. If the provider doesn't accept Medicaid, the family is on the hook for the entire amount.
- Medicaid Waivers: Medicaid waivers are designed to help keep vulnerable populations out of nursing homes or residential facilities by helping pay for home care services. 44 states have Medicaid waiver programs. The guidelines surrounding these are very complex; it is a good idea to get help from organizations that specifically can help with interpreting

guidelines and ensuring provided care is covered by these waivers. To qualify for a waiver, an individual must first qualify for Medicaid or CHIP. After an application is submitted, there is typically a visit by a caseworker (who completes an Individual Support Plan, or ISP, as well as a documentation review and other evaluations), and – once services are underway – periodic re-evaluations to confirm continued need.

- Medicare: Individuals with disabilities who are often eligible for Medicaid may potentially be eligible for Medicare. While the program primarily focuses on providing insurance coverage for the elderly, it can also defray the cost of care for certain populations with disabilities as well.

Children's Health Insurance Plan (CHIP)

The Children's Health Insurance Plan (CHIP) (also known as the State Children's Health Insurance Program, or SCHIP) is designed to help families that don't make enough money to buy private health insurance but make more than the cutoffs for Medicaid. As the costs of medical care continue to rise, CHIP becomes a crucial way for families to help cover the cost of special-needs care.

The program is jointly administered via the federal government and through individual states, so application procedures and requirements can vary. Some children can get coverage via a hybrid of CHIP and Medicaid. Generally, program eligibility depends on two things: the family's income, and whether there are children in the household. Other eligibility requirements include:

- Child must be 19 or younger
- The child must live in the state they are applying for CHIP in
- Family must not have any other kind of health insurance (or know they will be losing it

shortly)
- Family must not be eligible for Medicare or employer insurance

Coverage may also begin if a woman is pregnant and meets income limits, even before the child is born. Some states have a tiered CHIP system, which divides the applicant pool into two halves: some applicants are eligible for free CHIP, and others are eligible for low-cost CHIP. Those in the low-cost CHIP program pay a low fee each month (usually less than $50) to stay enrolled. It is also important to note that some states require parents to renew benefits once they are in the program; how often this occurs varies state-to-state.

What CHIP covers varies state-to-state, but typically physician appointments, hospitalization, ER services, preventive care, dental, hearing, and vision care, diagnostic services, immunizations and medications are covered. When a child receives medical care under CHIP, the precise process of what happens can vary. In some states, families are expected to pay copays, while in others, there are copays in addition to a monthly premium.

Typically, families can apply online for CHIP via the Insurance Marketplace online, by mail, or in person at the state Human Services office. Parents should prepare pay stubs, tax forms, Social Security numbers, rental leases/mortgage documents, and utility bills in anticipation of a caseworker visit as well. If a family is denied, parents can ask for a decision reversal. Usually, the mailed document that explains the denial will provide a phone number parents can call to find out how to have the decision reversed. Usually, this involves writing and sending a letter to the state's Human Services department requesting a review. This must be usually done within 30 days of the date on the denial letter. The letter should include the following:

- Why the applicant thinks the decision was incorrect
- A copy of the denial letter
- Any additional information the application thinks will help their case
    - This can include information that was accidentally not included in the initial

determination, as well as any new information that supports the application.

Medicaid

Medicaid is a health insurance program for low-income individuals and families. It helps cover the cost of essential health services for individuals who cannot pay for medical care out-of-pocket, and is the largest source of health service funding for low-income Americans. Some children with disabilities qualify for Medicaid, as they may have reduced incomes due to unemployment or underemployment.

Medicaid does not pay benefits directly to individuals, instead directly paying health service providers who accept the program. It is the responsibility of individuals enrolled in the program to pay for non-covered services and small copays. Because the program is administered on both the state and federal level, there can be significant variation in what is and is not covered under the program, income requirements, and other eligibility requirements.

Typically, Medicaid covers at least some portion of the following services:

- Hospital stays
- Nursing care
- Outpatient medical clinic care
- Hospital care
- Physician visits
- Prescription medications
- Chiropractic services
- Dental care
- Mental health services
- Home care

- Durable medical equipment
- Ambulance transport
- Vision
- Therapeutic services (occupational, physical, speech/language pathology, etc.)

In some cases, services that aren't initially covered by Medicaid (such as certain home care services) may be covered if an individual is granted a Medicaid waiver. It is also worth noting that a related program exists to assist children with disabilities, called the Fee-for-Service program. The program reimburses schools that provide children with disabilities with certain services, helping the school district pay for needed services.

Eligibility for Medicaid is primarily determined by income and other qualifying conditions. Individuals must be U.S. citizens or legal residents, live at or below the poverty level, live in the state they are applying for assistance in, and meet state-specific requirements regarding assets, income, marital status and age. Children with disabilities can often be eligible for Medicaid, even if their parents aren't. This is often the case if the child still lives with the parents, and if true in some certain cases even when the child does not. In some cases, individuals with significant disabilities who meet income and asset guidelines automatically qualify for Medicaid if their family receives certain other benefits (such as TANF or SSI).

When an individual is enrolled in Medicaid, the individual is enrolled in a privately-managed health plan. Individuals over the age of 65, *or those with disabilities,* however, are enrolled in 'fee for service' Medicaid, which means they must seek care from a provider who accepts Medicaid in order to have the program cover the cost of their medical care. In both cases, enrollees must follow their plan's guidelines and pay co-pays and/or deductibles just as they would with regular private insurance.

To apply for Medicaid, consult your state's Department of Human Services. As with many other assistance programs, individuals may apply online, in person or have an application mailed to them. After the initial application, they may need to meet with a caseworker to go over important financial and medical paperwork. Parents of children with disabilities should

be aware that Medicaid may send their application to a Disability Determination Service to determine whether the child is eligible according to that state's disability definitions. Medicaid will also send a document to their child's physician called a 'Certification for Disabled Children Living at Home' to obtain medical evidence of the child's diagnosis.

Parents will get a written notification of an application's status. If an application is denied, it is possible to get a hearing (called a 'Medicaid Fair Hearing') within 45 days to get a redetermination of the application. Most disputes are resolved before this point, however.

Medicare

Medicare is one of the U.S.'s national health insurance programs, and is administered by the Centers for Medicare and Medicaid Services (CMS). While the program primarily focuses on helping older individuals over the age of 65, the program also accommodates some individuals with disabilities, such as those caused by hypoxic-ischemic encephalopathy (HIE). Unlike some other health insurance programs, Medicare is *not* tied to prior work history.

The program tends to pay for approximately 50% of medical care costs individuals may encounter – it's very common for people to carry other insurance in addition to Medicare (such as insurance from their workplace). Because Medicare is not set up to pay for *all* of a person's medical needs, the enrollee is still responsible for paying copays, coinsurances, deductibles, premiums, and services not covered by Medicare. It is worth noting that there is a small but significant population enrolled in *both* Medicare and Medicaid; generally, this happens when a works, their income is low enough to qualify for Medicaid, and they have consistently paid Medicare taxes. Dual enrollees must apply for each program separately.

Most medical care providers accept Medicare, but not all do. Some have opted out entirely (which is rare), while others accept Medicare but charge slightly-higher-than-approved rates.

Parents whose children are on Medicare due to disabilities should check to see if services are covered under Medicare prior to getting those services.

The program is divided into four different sections, each of which provides coverage for different classes of medical services, products or procedures:

- Medicare Part A: Part A is funded by payroll taxes (a subset of payroll taxes called FICA taxes), either split between employee and employer (for full-time employees) or paid entirely by the individual (for self-employed individuals). Part A pays for hospitalization, though additional coverage can be purchased via a deduction from monthly Social Security checks. Most people pay enough Medicare tax from work to have premium-free coverage; individuals that have not can pay a monthly fee instead. Part A premiums can be waived if the individual with disabilities has been a legal resident for at least five years, has paid Medicare taxes at their workplace for at least ten years, and is receiving SSDI payments. Medicare Part A does *not* typically cover prescription drugs.
    - Medicare Part B: Services covered by Medicare Part A include:
        - Hospital care
        - Skilled nursing facility care
        - Nursing home care (as long as custodial care isn't the only care you need)
        - Hospice
        - Home health services
- Medicare Part B: Medicare Part B is medical insurance; in most cases, enrollees participate in *both* Medicare Parts A and B. Individuals enrolled in Medicare Part B pay a monthly premium, and should be aware of deductibles. Once deductibles are met, Medicare will cover 80% of costs, leaving the individual to pay 20%. Medicare Part B does not typically cover prescription drugs.
    - Services covered by Medicare Part B include:

    - Medically necessary services
    - Preventive services
    - Clinical research
    - Ambulance services
    - Durable medical equipment (DME)
    - Mental health (Inpatient, Outpatient or Partial hospitalization)
    - Getting a second opinion before surgery
    - Limited outpatient prescription drugs
- Medicare Part C: Medicare Part C (also known as the Medicare Advantage Plan) is an option available in some (but not all) states that allows services provided under Medicare Part A and B to be provided by a private HMO of the enrollee's choice. If chosen, there is a premium in addition to standard Medicare Part B premiums, as well as rules regarding who is considered an in-network care provider; however, this program often covers certain care (such as dental or vision) that regular Medicare does not. Typically, Medicare part C also includes prescription drug coverage.
- Medicare Part D: Medicare Part D is a prescription drug coverage plan that individuals with Medicare Part A or B can enroll in for an additional premium.

Eligibility for Medicare

Most individuals qualify for Medicare due to being age 65 or older. Individuals with disabilities can still qualify even if they are not yet 65 years old. It is worth noting, however, that before a person can be eligible for Medicare, they must first be deemed eligible to receive SSDI. They must wait two years from the date of becoming SSDI-eligible before applying for Medicare – they become eligible for coverage only after that point (unless they have end-stage renal failure or ALS, which are exceptions). If an application is denied, applicants can request a redetermination, where a Qualified Independent Contractor (QIC) will review the decision over several weeks and return a decision. Individuals who are denied the second time can request a third and final administrative appeal within 60 days of a denial of a second reconsideration.

Related Resources:

- Disability Cost Guide

About the HIE Help Center

The HIE Help Center is run by Reiter & Walsh ABC Law Centers, a medical malpractice firm exclusively handling cases involving HIE and other birth injuries. Our lawyers have over 100 years of combined experience with this type of law, and have been advocating for children with HIE and related disabilities since the firm's inception in 1997.

We are passionate about helping families obtain the compensation necessary to cover their extensive medical bills, loss of wages (if one or both parents have to miss work in order to care for their child), assistive technology, and other necessities.

If you suspect your child's HIE may have been caused by medical negligence, please contact us today to learn more about pursuing a case. We provide free legal consultations, during which we will inform you of your legal options and answer any questions you have. Moreover, you would pay nothing throughout the entire legal process unless we obtain a favorable settlement.

You are also welcome to reach out to us with inquiries that are not related to malpractice. We cannot provide individualized medical advice, but we're happy to track down informational resources for you.