

# Practitioner Support

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## Understanding Health Insurance Structure and Reimbursement

Gail Cox, Co-Chair Healing Touch Professional Association Insurance Initiative Committee

Probably the most frequent question received in our HTPA Member e-mail is: "Can our clients get Health Insurance Reimbursement for their Healing Touch sessions?" As a result of our sincere desire to answer that question (as best HTPA can), we formed an Insurance Initiative Committee and are offering this second article (see Energy Magazine issue [Jan/Feb 2014](#) for the first article). Our goal in offering these articles is to provide background information to educate you about the multi-layered insurance system.

Understanding Health Insurance structure and reimbursement is complicated so let's break it down. In essence, some of the five types of insurance are HEALTHCARE PROVIDERS and are as follows:

1. **Managed Care Organization (MCO)** is a negotiated plan between insurance companies and employers. Its goal is to closely monitor costs of healthcare providers' treatment of

specific disorders. It requires pre-certification approval for hospitalizations, length of stay, and treatments and requires referral to specialists by either a case manager or primary physician.

There are three subcategories -

**Preferred Provider Organization (PPO)**  
**Health Maintenance Organization (HMO)**  
**Private Organization Services (POS)**

**PPOs** are prepaid managed care. They provide discounted rates, co-payments and treatment from a Preferred Provider Network (physicians, hospitals, clinics, pharmacies, etc).

**HMOs** are also prepaid managed care that offer services for a fixed rate for small deductibles and co-pays or no out of pocket cost. Policy holders can only see authorized providers. With prior authorization, the preferred providers may cover the entire amount or may pay only a percentage.

**POSs** consist of nationwide group plans which combine the best of traditional and PPO/HMO insurance. Providing a full range of coverage for both in and out patient care.

2. **Major Medical (MM)** is private insurance for hospital and medical care. There are deductibles, coverage limits, percentages and the plans vary. There are two subcategories **Self Insurance (SI)** and **Indemnity Insurance (II)**.

**SI** is offered by employers with sufficient capital to insure its employees without contracting with commercial carriers for medical care. The biggest example of this is Kaiser Permanente, a healthcare conglomerate of hospitals, clinics, physicians and pharmacies, which provides health care coverage to its employees and now contracts to other employers throughout the United States. They are not an insurance company and therefore not regulated by a state's Insurance Commissioners.

**II** - a fee for service - usually covers 20% of unpaid claims.

3. **Personal Injury Protection (PIP)** is a policy to protect and cover an insured person or persons when injured in an auto accident.

4. **Workman's Compensation (WC)**, which varies state by state, is designed to pay employees injured while working to cover loss of wages, medical care and disability.



5. **Medicare and Medicaid**, are federally and state funded policies that cover medical care and hospitalization. Currently patients can opt for private PPO or HMO plans.

PPO's and HMO's have preferred providers or "in network," which means that the insurance companies have negotiated for a considerably reduced fee of it's "standard" fee to physicians, hospitals, clinics, therapists, laboratories and pharmacies. These reduced fees are then passed on to the patient. For example, my father's hip replacement, which would regularly cost \$120,000, cost my parents \$40,000. When seeing a non-preferred provider, who is out of network, the member will have to pay a percentage which could be up to 100%. You need to have a very good reason for seeing an out of network provider and have coverage approved. "*He's been my doctor for 20 years*" is not an acceptable reason.

How are policies made? Employers and the insurance/healthcare providers meet and choose benefits the policy will cover. The decisions are based on coverage and cost to both the employer and employees and what would be

beneficial to all. Most employers will offer several plans to give the employee the ability to make a cost/benefit choice. Increasingly employers are including plans that include integrative and preventive medicine for education and self care, such as weight loss, exercise programs, and diet plans.

Although healthcare coverage is complicated, providers are interested in your health and in keeping costs down. Stay tuned as our HTPA Insurance Initiative Committee continues to delve into the Health Insurance structure and reimbursement maze. We will be bringing you progress reports as we gain insights into how to get Healing Touch sessions, as well as, other modalities reimbursed. If you have information about this, we welcome your stories. Let's communicate!

Please e-mail [info@HTProfessionalAssociation.com](mailto:info@HTProfessionalAssociation.com). Also, look at the Energy Magazine archives for previous articles about this subject – some include sample invoices for you to develop to give to your clients to submit for reimbursement for services they have received.