

Insurance Coverage and Natural Medicine

Some insurance companies offer plans to employers that limit on how much money the insured can spend on alternative care. Other insurance plans limit how many visits you may make to a type of provider (for example only 12 acupuncture visits). Another thing that might occur is a separate deductible for alternative medicine.

To better understand your insurance benefits, some insurance terms and experiences you should familiarize yourself with include:

In-Network: this term refers to providers of medical service (doctors, clinics, hospitals, laboratories) that are signed up with the insurance company. There is generally an application and approval process. The providers are then termed “in-network” or “preferred providers” by the insurance companies. The preferred providers generally agree to accept lower rates of reimbursement decided upon by the insurance companies.

Out-of-Network: this means that a provider such as a doctor or lab, is not a preferred provider with your plan. Coverage depends upon your individual plan and may range from zero to partial. Some plans will provide significant coverage once you pay an out-of-network deductible, i.e. a certain amount of the initial out-of-network doctors bills.

Annual deductible: many plans have this feature, which means that every calendar year you must pay a certain initial portion of your medical bills before the insurance company will cover anything. In some plans the deductible is small, requiring you to pay the first \$200-500 of each year’s medical bills. Catastrophic plans have higher deductibles such as \$1,000-5,000 yearly. Once your yearly deductible is paid then the insurance company will begin paying for some or all of your medical bills. When the calendar year is up, you are responsible for the annual deductible again.

Benefits: this is a term that refers to what you get coverage for. In other words, if your plan will pay for acupuncture, your insurance company will say that you have acupuncture “benefits.” The term is also used when referring to amounts of coverage that you have. For example, if your insurance company will only pay for \$500 worth of alternative medicine it is said that “your benefits have been exhausted” when you have used this amount up.

Co-pay: this is an dollar amount that the insurance company requires you to pay each time you visit the doctor. Co-pays generally range from \$15-35 these days and are paid at the time of the doctor visit. Co-pays are often higher for emergency room visits compared to doctor’s visits.

Co-insurance: Co-insurance is usually a percentage of the medical charges (doctor’s or lab charges for example) that the insurance company makes the patient pay. The Co-

insurance is separate from the Co-pay. This is confusing to some people especially if they also have both a co-pay and co-insurance, or if they used to have 100% coverage in the past. Few plans cover 100% now, and it is becoming more common for insurance plans to require patients pay a co-pay at the time of the doctor visit, and then pay a portion of the remainder of the doctor's bills at a later date (co-insurance).

Explanation of Benefits: this is a statement that the insurance company sends to the patient and to the doctor. Also called an EOB, this statement is sometimes quite clear and other times confusing. It shows the doctor's or clinic's charges for the various procedures or services provided to the patient. If your doctor is a preferred provider (i.e. "signed up with") that insurance company, then the doctor's payments are usually "adjusted" (i.e. lowered) in the next column. The next column of the EOB usually will show how much money the insurance company is going to pay the doctor and how much money they expect the patient to pay the doctor. They usually call this the "patient responsibility." The EOB will sometimes indicate why the patient owes the money (i.e. that the patient's portion is applied to the deductible, or that it is co-insurance). Increasingly, the percentages that the patients are responsible for is increasing.

Delay in doctor's billing: some people are confused when they receive a bill from a doctor months after the visit. They feel that too much time has passed and that there must be a mistake. Of course, a mistake is always possible, but the reason for the delay is usually this: the doctor sees the patient and sends a bill to the insurance companies. This bill is called a HCFA form and contains codes for the procedures, the diagnoses and the doctor's charges. The insurance companies can take 30 days or even months to pay the doctor for her charges. When the insurance company pays the doctor, it sends an EOB to the doctor and the patient. If the EOB indicates that the patient is responsible for a portion of the doctor's charges, then the doctor's office will generate a bill for the patient. Since many small doctor's offices send out bills only once per month, it may take a while before a patient receives the bill from the doctor. Be aware, that you should receive an EOB from the insurance company explaining what you owe and that the decisions about what you owe are generally made by the insurance company and not the doctor's office.

Primary Care Provider (PCP): some insurance plans, typically HMO's require you to have a main doctor responsible for coordinating your medical care and deciding which specialists you can see (i.e. referring you to specialists). On some plans, you can actually chose a Naturopathic Physician (ND) as your primary care doctor. I have many patients under the Regence HMO plans who use me as their PCP. I then refer them on to see other providers such as medical doctors when they require it. Insurance plans called PPO's do not require a PCP and you can self-refer to most specialists covered by your insurance.

Referrals: this is also common on HMO's and is a term for the special permission needed from your PCP and your insurance company for you to see certain doctors and

specialists. Many plans require a referral to see an alternative care provider. If you need a referral to see a specialist or alternative care provider, it is best to get that referral before you visit the specialist. Otherwise, your insurance company may not accept the doctor's charges and may hold you responsible for the entire bill. To get a referral you generally have to schedule a visit/examination with your PCP, explain your condition or symptoms and ask if you may have a referral to the specialist. Most referrals, once requested by the PCP and approved by the insurance company are confirmed with a form sent by the insurance company to the specialist, the PCP and the patient. Rarely, an insurance company will change its mind about a referral that they made and hold the specialist or patient responsible for the charges.

Preventive Medicine: this refers to medical services that are not targeted at a specific disease. It includes care designed for screening an apparently healthy person for disease (for example, yearly physical exams, screening blood work, and PAP smears) or for discussing how to avoid disease or improve health to "optimal," such as with dietary or lifestyle counseling. Often services for weight loss and quitting smoking are considered preventive medicine. You may want to find out how much preventive medicine your insurance plan will cover because insurance plans often consider a lot of what naturopathic doctors do as "preventative."

Medical necessity: this term refers to specific medical "need" or "appropriateness" of the procedure provided by the doctor. It is up to the insurance company ultimately to decide what is medically necessary and what is not, though the doctor of course has some say in this. However, some alternative medicine and preventative medicine is not considered "medically necessary" by insurance companies and therefore is the financial responsibility of the patient. I try to inform patients when I think care I provide or services I suggest are not covered or not considered medically necessary, but I do not always know when an insurance company will decide that something should not be covered.

Prescription referrals: some referrals do not need to be pre-approved by the insurance company, but a doctor must prescribe the visit or treatment. For example, some plans will pay for you to see a massage therapist with a prescription from a doctor. However, the prescription for massage must be medically necessary, in other words, it must be prescribed for a specific health problem typically thought to respond to massage. Insurance companies generally will not pay for massage for relaxation.

Flexible Spending Account: these accounts are usually set up by the patient's employer. Both the patient and employer can make contributions to the account. The contributions are protected from taxes. The patient brings receipts from her medical expenses (co-pays, coinsurance, medicines, deductibles, often things like eye glasses, and sometimes prescribed supplements and out of network lab bills) and she is reimbursed from the fund by the administrator of the fund. Any money left in the flex spending account at the end of the year is lost to the patient, so you should try to determine how

much you think you will spend in advance of setting up the account each year.

Health Savings Accounts: these accounts can be set up by the patient and/or his employer. The money in these accounts can be less than or equal to the patient's annual deductible and is used to pay for medical expenses (deductibles, medications, etc) incurred by the patient each year. The money withdrawn from the HSA is exempted from income taxes. Any money left unused in the HSA at the year's end can be rolled into an Individual Retirement Account and therefore is not lost to the patient.

We hope this information we provided helps you to understand your insurance coverage. You are the one who is responsible for your coverage so arming yourself with knowledge is the best plan!