Using Insurance to Pay for Mental Health Care

Why Don't I Participate With Insurance Plans?

Non -mental health professionals who know me are surprised that I have chosen to limit my services to people who can afford to pay me without using their insurance benefits, so I thought I should explain why this is the case.

It is because I believe that everyone should have the access to good, full-service, confidential mental health care that I am unable to participate in a system which profits by limiting care and stockpiling potentially harmful information about people who would come to me for help. Most people are unaware of the how active the insurance companies are in gathering and cataloging confidential information, directing healthcare decisions and limiting care.

For example, if I was on a health insurance panel, you would have to allow me to tell the insurance company about your problem and give it a psychiatric diagnosis. The insurance company would have to be permitted to be told about the treatment I am recommending, about your progress during treatment, and about how you are doing in many areas of your life (functions at work, in your family, and in activities of daily living). All of this information then becomes part of the insurance company's records, and some of it is included in your permanent medical record at the Medical Information Bureau, a national data bank that is not open to the public including you. The information will be examined when you apply for life or health insurance, and it may be considered when you apply for employment, credit or loans, a security clearance, or other things in the future. You will have to release this information, or you may not get the insurance, job, loan, or clearance.

All insurance carriers claim to keep the information they receive confidential, and there are federal laws about its release. The laws and ethics that apply to me are much stricter than the rules that apply at present to insurance companies. There have been reports in the media about many significant and damaging breaches of confidentiality by insurance companies.

During intervals throughout your treatment with me, more information would be requested by the insurance company to determine whether treatment will continue to be authorized. Even if we send all the forms and information to the insurance company on time, there may be long delays before any decisions are made. This creates stressful uncertainty and may alter our earlier assumptions about the costs and nature of your treatment. I would be waiting while the company

decides how much and what kind of treatment can be provided and reluctant to start new therapies or begin addressing new concerns.

As you can imagine, this is very disruptive to treatment planning and goal-setting. The insurance company can suddenly refuse to pay for any of your treatment, or for any treatment by me. Or, it may pay only a very small part of the treatment's cost, and it can prevent me from charging you directly for further treatment we would agree to. Finally, it can set limits on the kinds of treatments you can receive. These limited treatments may not be the most appropriate for you or in your long-term best interest. The insurance company will approve treatment aimed at improving the specific symptoms (behaviors, feelings) that brought you into treatment, but it may not approve treatments directed at the source of the symptoms, for instance underlying childhood trauma.

Insurance companies favor treatment with medication (rather than holistic approaches) because medication is less expensive. For this reason, an insurance company may insist on treatment with medication, whether you or I think this is appropriate.

When it does authorize our treatment, the insurance company is likely to limit the number of times we can meet. Your insurance policy probably has a maximum number of appointments allowed for outpatient psychotherapy or psychiatric medication management (usually per year, though there may be a lifetime limit as well), but it does not have to let you use all of those. It may not agree to more sessions, even if I believe those are needed to fully relieve your problems, or if I believe that under-treating your problems may prolong your distress or lead to relapses (worsening or backsliding).

If the insurance company denies payment before either of us is satisfied about our progress, we would also need to consider other treatment choices, and they may not be the ones we would prefer. We can appeal the insurance company's decisions on payment and number of sessions, but we can only do so within the insurance company itself. We cannot appeal to other professionals, to your employer, or through the courts. This state does not have laws regulating insurance companies —that is, laws about the skills or qualifications of their staff members, about access to medical and psychological records by employers and others, or about the appeals process.

You should know that contracts between clinicians and insurance companies and employer's contracts with a particular insurance company often prevent us from taking legal actions against the insurance company if things go badly because of its decision. Additionally, if I had a contract

with an insurance company, it could prevent me from discussing with you treatment options for which the insurance company will not pay for.

I hope this helps and gives you more information to help you decide whether to use insurance or not. I wish you the best of luck and health along your journey!