Considerations of Health Insurance and Money In Psychotherapy

In recent years, there were significant changes to the health insurance industry, and many of these changes had particular impact on the use of insurance in psychotherapy. National and state legislation around "parity" (equal level of benefit) in physical and mental health care ensured that psychological care and substance abuse treatment were more widely offered under health care plans. Coverage offered through the Affordable Care Act (ACA) also expanded the number of individuals who had access to medical and psychological treatment.

Yet there is now uncertainty about the future of ACA, and other trends in public policies suggest more obstacles to accessing health care. Acceptance of health care insurance is also becoming an issue, particularly in more affluent neighborhoods. Many mental health providers are following the lead of physicians and dentists in choosing to become "fee for service" practitioners.

Therapists in the fee for service model do not accept traditional health insurance plans or Medicare, and their fees are generally much higher than insurance plans typically reimburse. As a client, you pay the costs of treatment in the fee for service paradigm. If you have a plan with out of network benefits, you may be able to recover a portion of those treatment costs by submitting a claim to your insurance company.

There are many reasons why some therapists choose a fee for service practice. They often opt to have a fee for service policy when rates of reimbursement from insurance plans do not keep up with the costs of operating a private practice. Rents are rising rapidly, in addition to other business costs. Psychotherapists are also sometimes concerned about intrusive oversight imposed by insurance companies. Finally, many practitioners want immediate payment for their services. Getting reimbursement for services from insurance companies involves extra time for claims submission.

Other therapist, however, continue to participate in insurance plans. For some, it is a philosophical commitment to the notion of equal opportunity for quality care, while for others, it is simply pragmatic. Psychotherapist who accept insurance coverage benefit from client referrals from insurance plans. Their marketing costs may be lower, and the steady volume of clients helps to offset the reduced hourly rate they receive from the insurance coverage.

As a client, there are a variety of factors to weigh in determining whether to use insurance coverage or pay for services. Affordability is the first factor. Many clients can only afford the cost of psychotherapy by utilizing their health care coverage. Other clients believe that they should benefit from their coverage whether or not they have the means to cover treatment on a fee for service basis. In either scenario, insurance coverage ensures that treatment is an affordable option.

Another decision factor pertains to privacy protections. While all psychotherapists are required to maintain certain records, the use of insurance increases the number of parties who have

access to treatment information. Under the provisions of health insurance plans, psychotherapists must provide a diagnosis to establish the "medically necessity" of treatment, and they agree to the possible oversight of treatment through periodic review.

If clients have individual as opposed to group health insurance coverage, the information insurance plans collect may be reported to the Medical Information Bank (MIB). The MIB is a storehouse of medical information compiled from insurance utilization, online websites, medical and fitness devices, and other entities. Healthcare information collected is translated into a coded form and retained for up to seven years. The MIB is used by insurance plans to provide data for future underwriting purposes, such as future health or life insurance policies.

A final consideration with respect to insurance usage involves ethical practices with regard to billing. For psychotherapists, the decision to accept insurance requires that they comply with the agreements in their insurance contracts. Unfortunately, some therapists sidestep this obligation in a variety of ways.

In some instances, therapists suggest that they have only a limited number of slots available for insurance subscribers, and insist that clients pay their full rate when those limited hours are taken. Some therapists may indicate that they have immediate availability for self-pay clients and a waiting list for those utilizing insurance. Therapists may also bill for a significantly longer session than the actual meeting time. Finally, some accept the compensation from the insurance plan while charging a significantly higher fee than the one authorized by the health plan. This is sometimes known as "balance billing".

All of these practices are in conflict with the insurance contracts that they have signed with insurance carriers. Generally, these contracts obligate therapist to accept subscribers when they have availability unless other clinical circumstances apply, and they do not allow psychotherapists to bill clients for fees above the "usual and customary" rate of the plan. In a number of instances, psychotherapists have had their licenses suspended or revoked by their respective boards, but the practices continue.

An exception to this contractual obligation may exist when a subscriber has insurance coverage but elects not to use it for psychotherapy. Often this is for privacy reasons. As a consumer, it is important to understand the implications of using insurance, and the applicable ethical and professional standards around fees. A good standard of practice provides for transparency around billing and insurance issues. When these standards are not observed by a therapist, know that better alternatives are available and proceed with caution.

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