The Benefits and Pitfalls of Third Party (Insurance) Coverage

by William K. McDonald

Some Background and Considerations

Many people have become accustomed to having their medical insurance cover mental health problems as well. And this is coverage is generally a positive development by the insurance industry. [1]

Also, insurance carriers across the board are increasingly aware that short-term coverage for mental health problems in the long run reduces monies spent for more expensive future medical treatments. Research has indicated this correlation for many years. So it is an economic benefit for insurance carriers to offer limited mental health coverage.

I am a HealthPlus of Michigan Provider, and their Behavioral Health Provider Manual (edition 3/15/06, p5) gives a succinct summary of their Treatment Philosophy by spelling out the following treatment goals:

> "Treatment goals are focused on problem resolution with the patient and the patient is
>
> encouraged to anticipate achieving these goals *in a reasonable time frame*. HealthPlus believes in a treatment process of *brief, solution-focused therapy using cognitive behavioral therapy as a means of reducing* ***acute symptoms*** [their emphasis]." [italic emphasis mine] [2]

However, the kind and amount of mental health coverage generally is limited. Most carriers will allow up to twenty outpatient mental health visits per year. Their philosophy is based on a model of outpatient treatment called "**brief therapy**" for the short-term alleviation of acute symptoms. This is informally called "talk therapy." This is often in conjunction with the prescribing of psychotropic medication (an example would be a mood-altering drug for depression or anxiety). Current research quoted by HealthPlus indicates that maximal results are usually obtained by a combination of "talk therapy" and medication. If only one is to be chosen, the slight winner is "talk therapy."

> Due to the great influence of insurance carriers on the medical and mental health delivery systems in our culture, the "brief therapy" model now generally dominates the "therapy" field.

A second model, though actually much more predominant in actual practice, is the **"medication management**" model. Here a patient who has been placed on psychotropic medication, meets with his or her service provider (usually a physician or psychiatrist) to monitor medication issues. A frequent assumption of this model is that medication then becomes a permanent lifestyle for the patient.

Philosophically, I can be critical of this model. However, books like Solomon's The Noonday Demon[3], remind me of the great amount of human suffering that has been alleviated or at least modified by the judicious use of psychotropic medication, and the psychiatrists who struggle sometimes heroically to find the resources and combinations that will work for their suffering

patients. That specific book impressed me greatly.

> Let me also speak to another favorable aspect of the "brief therapy" vision. In the Summer of 2006, George Albee died. He was a former president of the American Psychological Association and a manor architect of the *community mental health movement* in the '60s and '70's. His simple thesis was that many serious psychological problems, especially among the more vulnerable of our population, could be prevented by the availability of strong social support mechanisms and agencies. Unfortunately, with the Ronald Regan victory in 1980, this vision of tackling mental health problems by making communities stronger was summarily abolished, and relegated to the memory of sixties-style idealism. The "brief therapy" model of the insurance industry is a meager replacement for Albee's ideals, but it's at least better than nothing. And the remnant of any community mental health structure even today is itself a lost child in the all-consuming world of homeland security and war in Iraq.[4]

Acute mental health problems that require *inpatient* or partial hospital services, are geared toward short-term hospital care, followed up by one or both outpatient models, "brief therapy" and "medication management."

For reasons primarily of economic management, insurance carriers are not as supportive of longer-term psychotherapy or analysis. These modes are more geared toward working with more deep-set character or personality issues, and with the maturing or higher personality development of an individual.

> The greater happiness or well-being that comes from a pill can come through the *medical* system. The greater happiness or well-being that comes from the deep maturing of the personality comes from the therapeutic services of the private mental health sector - that is, generally outside the *medical model*.

One philosophical (and sometimes practical) disadvantage of mental health insurance coverage is that I, the therapist, have to gear my work to the satisfaction of the insurance carrier's policies. (If you have an immature or "just average" therapist, that's a benefit.) It means there's a "third party" involved, monitoring the relationship between me and my client. However, the outcome of good therapy and personality development is often to become free of "third parties" in our heads (or in our lives or lifestyles or relationships).

There is another (important for some) specific benefit of *not* making use of insurance benefits. In spite of recent increases in the security of confidential information, one's *diagnosis* (which is necessary for insurance reimbursement) is not fully protected as confidential information.

The best therapy operates from a balanced contract between me and my client. I give my client something of value (wise attention and direction), and he or she in turn gives me something of value (an income and professional satisfaction). That balance is itself representative of the outcome - a well-balanced life.

I strive to structure what I do so it models the outcomes I believe in - to walk my talk, and that

you can more fully enjoy *life lived to the fullest*.

Fenton, Michigan

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Endnotes:

1. Not that many years ago, much of the psychiatric and psychological community of Genesee County came to Flint in the first place to reap the generous benefits of "General Motors Blue Cross." What was often called *"Generous Motors"* became the golden door to a guaranteed professional income.

2. I do appreciate being a provider for HealthPlus of Michigan especially because they are more generous than most insurance carriers or HMOs in allowing and supporting my own decisions about patient mental health care, within their general guidelines concerning the number of sessions authorized, and as long as I regularly provide them with appropriate progress information. They generally consider it appropriate for an initial number of sessions to be on a weekly basis, then move toward bi-weekly and/or monthly sessions.

3. Andrew Solomon, The Noonday Demon - An Atlas of Depression. (New York: Scribner, 2001), 576 pages. I appreciated this book, both for it's encyclopedic breadth of the history and developing understanding of depression, as well as the author's sharing of his own suffering and journey toward hope and healing.

4. Wray Herbert, "The Passing of a Visionary" in Psychotherapy Networker, Sept/Oct 2006, p 17f.