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## **Should I use my health insurance to pay for psychotherapy?**

At first glance, you would think the answer is "Of course!" But the issue is a little more complicated, and it is best to be well-informed of the pros and cons before making a decision that has permanent consequences.

The obvious benefit to using your health insurance is that it pays for part, and sometimes nearly all, of your psychotherapy. You pay for your premiums, one way or another, and it is reasonable that you would want to use your insurance whenever possible.

But in this age of computers and databases, the decision gets a little more complicated. The first thing to realize is that medical insurance exists to pay for medical conditions. Therefore, you have to have a diagnosis in order for your insurance to pay for therapy. Diagnoses are listed in the American Psychiatry Association's Diagnostic and Statistical Manual. Some are relatively mild, others more severe. Obviously, your therapist cannot diagnose you with a condition that you do not have. However, many people who come to therapy do fall into diagnostic categories, especially if there is a severe stress going on, or if they have suffered from mild depression for a long time.

Once a diagnosis enters the insurance system, it is there for a long time. This can impact you if you apply for private life or disability insurance, or for private health insurance if you are self-employed. So this is something to consider carefully.

Besides having a psychiatric diagnosis in the system, if you use managed care, then there is no end to the information that may be requested as the clerks at the insurance company determine whether or not you will be authorized for sessions. Many people assume, because their insurance booklet says that they have a certain number of sessions per year, that they will be able to use that many sessions. Not necessarily true. Again, use of insurance benefits is dependent on the medical necessity of the treatment, not on how much you may think it benefits you. Therefore, your therapist must substantiate to the managed care company why continued sessions are medically necessary.

So another drawback to using the insurance is that someone else will be deciding whether or not you should have sessions paid for. Of course, you always have the option of continuing your therapy on a self-pay basis even if the insurance company no

longer will pay for it. This happens more frequently than you may expect, because insurance companies again are focused on medical necessity, not what you may think is benefiting you. So they tend to focus heavily on specific symptoms, and whether they are changing. There is definitely an increased emphasis on using medication if, for instance, depression symptoms do not lift promptly.

All of the above may make you think that therapy will drag on forever, and be tremendously expensive. This is generally not the case. Most clients experience some improvement relatively quickly, and many clients feel satisfied and terminate therapy within 8 to 20 sessions. Once you meet with your therapist and set some goals for treatment, then an estimate can be made of how long it should take to reach those goals. Some clients meet their goals, and finish. Others develop new goals, and choose to continue for a time. Still others like to come in for a while, stop and let the changes they have made take effect, and then return later in a few months for another round of therapy. The choice is yours.

The purpose of this information is not to discourage you from coming to therapy. If cost is a prohibitive factor, you may well decide that the benefits of therapy outweigh any potential problem that may come from using your insurance. As with any other important decision, however, it helps to have as much information as possible at your disposal before making a decision.

Please feel free to discuss these issues with your therapist, either over the telephone, or as part of your initial session. Then be sure to inform your therapist how you would like to handle payment.