Finding a therapist who takes your insurance can be nearly impossible. Here's why

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By
Annie Waldman; Maya Miller; Max Blau; Duaa Eldeib; Rhitu Chatterjee

Top row, from left: Marsinah Ramirez Buchan, Philip Bender, Elizabeth Fisher. Bottom row, from left: Rosanne Marmor, Kendra F. Dunlap, and Carter J. Carter.
Tony Luong for ProPublica

Carter J. Carter became a therapist to help young people struggling with their mental health. Rosanne Marmor wanted to support survivors of trauma. Kendra F. Dunlap aspired to serve people of color.

They studied, honed their skills and opened practices, joining health insurance networks that put them within reach of people who couldn't afford to pay for sessions out of pocket.

So did more than 500 other psychologists, psychiatrists and therapists who shared their experiences with ProPublica.

This story comes from ProPublica, a nonprofit newsroom that investigates abuses of power. Sign up to receive their biggest stories as soon as they're published.
Audio reporting by NPR's Rhitu Chatterjee.

But one after another, they confronted a system set up to squeeze them out.

Although federal law requires insurers to provide the same access to mental and physical health care, these companies have been caught, time and again, shortchanging customers with mental illness — restricting coverage and delaying or denying treatment.
These patients — whose disorders can be chronic and costly — are bad for business, industry insiders told ProPublica.
"The way to look at mental health care from an insurance perspective is: I don't want to attract those people. I am never going to make money on them," said Ron Howrigon, a consultant who used to manage contracts with providers for major insurers. "One way to get rid of those people or not get them is to not have a great network."

Teen with life-threatening depression finally found hope. Then insurance cut her off

There are nowhere near enough available therapists in insurance networks to serve all of the people seeking care. And although almost all Americans are insured, about half of people with mental illness are unable to access treatment.
The consequences can be devastating.
To understand the forces that drive even the most well-intentioned therapists from insurance networks, ProPublica plunged into a problem most often explored in statistics and one-off perspectives. Reporters spoke to hundreds of providers in nearly all 50 states, from rural communities to big cities.

The interviews underscore how the nation's insurers — quietly, and with minimal pushback from lawmakers and regulators — have assumed an outsize role in mental health care.

It is often the insurers, not the therapists, that determine who can get treatment, what kind they can get and for how long. More than a dozen therapists said insurers urged them to reduce care when their patients were on the brink of harm, including suicide.
All the while, mental health providers struggled to stay in business as insurers withheld reimbursements that sometimes came months late. Some spent hours a week chasing down the meager payments, listening to hold music and sending faxes into the abyss.

Several insurers told ProPublica that they are committed to ensuring access to mental health providers, emphasizing that their plans are in compliance with state and federal laws. Insurers also said they have practices in place to make sure reimbursement rates reflect market value and to support and retain providers, for which they continually recruit.

Mental health care is hard to find, especially for people with Medicare or Medicaid

Therapists have tried to stick it out.

They have forgone denied payments. They have taken second jobs. They have sought therapy for their own support.

But the hundreds who spoke with ProPublica said they each faced a moment in which they decided they had to leave the network.

Why I left the network: Because insurers interfered with my patient's care

For Melissa Todd, that moment came after she was pressured to limit the care of a patient in crisis.

A psychologist from Eugene, Oregon, Todd was treating a young woman with a history of trauma whose father had died unexpectedly.

When the patient came to Todd, she was often unable to sleep more than an hour or two for days on end. "She described it to me as maddening," said Todd, who recognized an array of symptoms that fit a diagnosis of bipolar disorder.

Melissa Todd in her office in Eugene, Oregon.

Tony Luong for ProPublica

Todd helped her devise safety plans when she felt suicidal and was available after hours, even in the middle of the night.

“I was giving her almost daily updates,” the patient told ProPublica, “because that was what I realized I needed to do if I wanted to survive.” (Her name is being withheld to protect her privacy.)

Longstanding practice guidelines recommend that providers consider a combination of therapy and medication when treating patients with bipolar disorder, so Todd sought a psychiatrist who could manage the young woman’s prescription. Although the patient was covered by UnitedHealthcare, America’s largest insurer, Todd was unable to find anyone who had openings. Her patient had to pay hundreds of dollars for out-of-network psychiatry sessions.

Then, six months into treatment, UnitedHealthcare began to question whether therapy was even necessary.

Todd walked an insurance reviewer through the details of her patient’s fragile state. Even when the woman had periods of calm, Todd said, she knew the disorder was unpredictable. She worried her patient could attempt suicide if care was cut off at the wrong time.

The reviewers responded that the patient needed to be actively experiencing severe symptoms to continue with treatment and suggested that the therapy wasn’t working.

“I felt all this pressure to say the right thing to be able to keep giving my client what she needed,” Todd said.

In the end, the reviewers demanded a date when therapy would no longer be needed.

Todd left the network so she could treat her patient without interference. The patient could afford to pay out-of-pocket because of a small settlement after her father’s sudden death. People are more than twice as likely to pay their full bill out of pocket for visits to mental health providers than primary care physicians, according to a ProPublica analysis of federal survey data.
While United did not respond to questions about Todd’s experience, spokesperson Tony Marusic said the insurance company is “committed to ensuring members have access to care that is consistent with the terms of their health plans.”

Like Todd, many providers told ProPublica that insurers frequently interfere with patient care. In addition to cutting off therapy, they are pressuring providers to cap the length of their sessions to 45 minutes, even when the patients require more time. Therapists told us that they have seen their patients sink deeper into depression, suffer worsening panic attacks and wind up in emergency rooms after insurers refused to cover treatment.

ProPublica interviewed 44 providers who said they left networks after insurers questioned the necessity of care.

Why I left the network: Because of the dysfunction

Last summer, Daniel Clark, a psychologist from New York, tested a college student for attention deficit hyperactivity disorder. According to the student's plan, Cigna was supposed to cover nearly all of the evaluation, which cost more than $1,400. But the company refused to do so and told Clark to bill the patient. Clark told his patient not to pay until he contested the claim.

When Clark first called Cigna, a customer service representative told him the insurer had made a mistake. But the company didn't immediately correct the error, so Clark faxed an appeal. He figured it would be quicker than sending it via snail mail — which, in the year 2023, remained his only other way to contest a coverage decision.

Daniel Clark in his office in New York City.
Tony Luong for ProPublica

When he heard nothing in response, he called again and repeated the story to a new customer service rep, who said the claim was still being worked on. Clark kept making calls — from his office, his car, his home — but gave up logging them when he hit 20. Just last month, more than a year after seeing the patient and what he estimates were 45 calls, Cigna

finally paid Clark. With the amount of time he spent on customer service lines, he calculates he has lost more than $5,000 that he could have earned seeing additional patients.

Anneliese Hanson, a former Cigna manager, told ProPublica that the poor customer service can be traced, in part, to a decision several years ago to outsource these calls to the Philippines. A therapist who was hired as a manager at Cigna, Hanson worked in the behavioral health department during that transition. She said overseas employees lack access to the full claims system and often are unfamiliar with complex medical terminology in English.

After leaving the insurance industry in 2022, Hanson opened her own private therapy practice. She has experienced firsthand waiting more than two hours on hold and searching in vain for relevant addresses and fax numbers. The byzantine process isn't an accident, she has concluded.

"The idea is if you make it so frustrating for providers to follow up on claim denials, they're just going to give up and the insurance company is not going to have to pay out," Hanson said.

Cigna did not respond to ProPublica's questions.

ProPublica spoke with more than 100 providers who left insurance networks after getting tangled in red tape.

In 2022, Connecticut therapist Donna Nicolino was treating a Ukrainian woman for posttraumatic stress. Her condition worsened after Russia invaded her home country, which threatened her family's safety and led to the death of her friend's son.

Just before the conflict began, New York-based Healthfirst denied nearly a dozen of Nicolino's therapy claims.

Donna Nicolino in her office in Willimantic, Connecticut.
Tony Luong for ProPublica

"Documentation does not support services billed," a notice stated. Her claims lacked a physician's signature, according to the insurer, and did not include sufficient information to identify the patient or proof of consent for telehealth.

Nicolino was perplexed: Her notes didn't require a doctor's signature. Her records detailed the patient's progress and included a signed consent.

Nicolino shared photos of her handwritten notes, and her patient called to attest that the therapy sessions had actually occurred. But Healthfirst continued to deny the claims and didn't clarify why.

Nicolino saw her patient, often for free, as she tried to overturn the denials. She worried that the stress of dealing with insurance was aggravating her patient's trauma.

But after nearly a year, Nicolino couldn't go on with the instability and left the network. The patient, unable to cover the costs, had to end treatment.

"She was making some progress," Nicolino said, "and we had to just pull the plug."

Healthfirst spokesperson Maria Ramirez did not respond to questions about Nicolino's payment issues, but she said as a general matter, the insurer has "processes to verify that claims accurately reflect the services provided and are coded with accuracy and completeness."

Why I left the network: Because it was financially unsustainable

Many providers just couldn't make ends meet as in-network therapists.

Reimbursements rates are largely stagnant and notoriously low. Therapists on average earn about $98 for a 45-minute session from commercial insurers, whereas their out-of-network colleagues can earn more than double that amount. Dozens of providers told ProPublica their reimbursement rates have barely shifted in years.

The overhead of running a private practice can also be substantial: malpractice and health insurance, billing and administrative services, office rent and utilities. Insurers pay only for time in session, not the documenting of notes or chasing down of payments.

The reimbursement rates for mental health clinicians are also lower than what insurers pay medical providers for similar services. Take two in-network clinicians: If you spend an office visit talking about depression with your psychiatrist and then have the same conversation with a physician assistant, an insurer could pay the physician assistant nearly 20% more than the psychiatrist, despite their medical school training. This is according to rates set by Medicare, which insurers look to when setting their own rates. Despite federal rules requiring equitable access to care, there are no requirements to even out provider reimbursements.

Providers could join forces to fight for better pay, but antitrust laws and insurer contracts forbid them from collectively setting fees, which limits them talking to one another about how much they make.

Many did not share their pay rates with ProPublica, afraid that they would break a law or lead insurers to claw back payments.

More than 130 providers said they left insurance networks because of low reimbursement rates.

Almost every state has a law that requires insurers to quickly reimburse for treatment claims, but the strength and enforcement of those laws varies greatly. Providers said they sometimes had to wait years to get paid.

Companies can also take back money even if they are the ones who made a mistake. Many states generally limit an insurer from clawing back payments more than two years after a claim is paid. But about 10 states have no restrictions.

Nearly 60 providers told ProPublica that they left networks after insurers delayed payments or tried to claw them back.

After nearly a decade of providing therapy for children with severe autism, psychologist Anna DiNoto learned Premera Blue Cross was taking back more than $11,000 in payments for services she already delivered.

The company alleged that her large Washington-based practice sometimes used incorrect billing codes and kept notes that were not detailed enough to justify the treatment provided.

Anna DiNoto in her office in Monroe, Washington.
Tony Luong for ProPublica

Instead of having providers correct isolated errors like forgetting to log start and stop times for sessions, it placed the entire practice on a prepayment audit: For months, payments weren't made because a reviewer had to first deem the documentation adequate.

“We just kept being told that our notes weren’t good and we needed to spend less and less time with our patients,” she said.

After taking out loans to pay staff, DiNoto and her business partner informed patients they would soon be unable to provide services. By the end, she estimated the insurance company had failed to pay them $1.5 million.

“And they also stole my heart,” she said. “I felt like I was gonna have a heart attack every day.”

A Premera spokesperson said that the company was “transparent, responsive, and made every effort to ensure our responses were clear and straightforward.” The process of recouping money, the spokesperson said, ensures “proper fund use to support access to quality, affordable care.”
DiNoto, who took pride in having helped children who couldn’t walk or talk to be able to move and communicate, said her patients were left with little recourse. Several families went months without being able to find another provider. Some never did.

Desperate parents called her as their kids regressed; one went back to punching walls and running away from home.

When she informed Premera she was leaving the network, she received an email that surprised her almost as much as the audit.

Premera asked her to stay.

But she had made up her mind: She was done.

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