Dear Chairman Nosse and Members of the House Committee on Behavioral Health and Health Care:

My name is Jennifer Besst and I am a Licensed Marriage & Family Therapist. I have been a therapist for over 15 years and in solo private practice since 2016 in Tigard, Oregon. I have enjoyed the freedom and flexibility of being a small business owner which allows me to provide high quality, client first, personalized therapeutic services to Oregonians, most of whom prefer to maintain small and local relationships with their healthcare providers. Many of my clients also prefer to use their health insurance coverage to help cover the cost of their mental health treatment and would like to maintain freedom of choice in who they select as their provider, rather than being forced to select less personalized care via telehealth apps that typically only offer short term treatment or larger behavioral health programs that can only offer infrequent or group therapy services in order to maintain profit.

I have maintained a balance in my practice to meet these needs by staying contracted with commercial insurance plans while still making sure I can afford to stay in solo practice. Many of my colleagues end up removing themselves from insurance panels once their practices become full and after years of advanced experience and training because they have weighed the benefit vs risk of staying paneled and decided that the risk is too great. Unfortunately, this means that Oregonians have to choose between paying out of pocket for their therapy or limiting their choice of clinician to those who happen to be in network with their plan, which often changes year to year. The vast majority of therapists I talk to who leave insurance panels tell me they've been forced to do so because of the fear and risk of insurance audits, recoupments, and low reimbursement rates. They tell me that out of these three factors, if the first two were resolved they'd likely stay paneled even if reimbursement rates were not ideal. This is highly concerning on many levels; it means that there is a power imbalance and a paucity in checks and balances in the system. Many programs in our state have been focused on a push towards access to care, and rightly so, as we have been in a mental health crisis since the Covid pandemic. However, we have failed to adequately protect the workers who would be tasked with providing this care. We can make sure that Oregonians have "access to care", but if we don't protect those who need to provide it, then it will end up being just another policy push for show in order to check off a box.

For these reasons, I am in full support of HB2029. Several states already have limitations on how far back insurance companies can recoup payments. For example, California has a 365 day limit. I recently attempted to negotiate a redline in an insurance contract I was being offered to add specific language for a 365 day limit and was denied, even though this is a completely reasonable request and it is also the timeframe insurance companies use to cite how far back we as providers are allowed to bill for services. This is an unfair standard; why are insurance companies allowed to put a limit in our contract for how far back we can bill for services, but they are allowed to recoup money indefinitely?

I have personally been subjected to this unfair standard in situations when clients have been double covered by two insurance companies and were unaware that one company was the primary policy. The majority of consumers are not knowledgeable about the intricacies of insurance coverage, and further, when they present for mental health treatment they are often in emotional distress or crisis. Many do not know enough to tell me when there is another policy and even if I check and double check this, things get missed or policies get added or changed mid-year for various reasons. When something like this is discovered mid-treatment it is not a simple fix for a solo provider like me, especially if I am in network with one insurance company and not the other. Typically, calling an insurance company means waiting on hold for an hour or longer, sometimes being hung up on, or facing a confusing phone tree that doesn't actually end in speaking with a live human. For those of us who see a majority of insurance clients, this means scrambling to call on our lunch break multiple days in a row and then in many circumstances finding out that it will be "30-45 business days" for a response on the issue, which doesn't even mean a resolution. Meanwhile, the insurance company is sending letters saying that they are going to withhold payment from all future sessions until the recoupment is paid off. This is not a situation of "fraud" or "waste"; this is a simple fix that can be corrected between the two insurance companies without having to hold up payment and ultimately care for their members.

In one such circumstance I dealt with personally, I was told to resubmit the claims to the primary insurance company, of which I was not even in network with, wait for a denial, and then resubmit to the secondary company. In this case, the primary insurance plan did not have "out of network" coverage, so there was a full guarantee that they would deny 100%. Further, this is not an overnight process; some companies take over a month to process claims, and often if I am not in network with a company I am not even set up to process claims with them directly or they won't respond at all. In addition, we are typically not allowed to then bill the client, because most insurance contracts include language that prohibits this. After the lengthy process of attempting to resolve issues like this, facing delays after months and months, some providers then find themselves outside of that 365 day period for claims submission and simply give up and pay the money back even though services were rendered.

In the vast majority of cases, things go smoothly and insurance billing is straightforward, but for a solo provider even one recoupment of thousands of dollars can be detrimental. In addition, as we advance in AI technology, my concern is that insurance companies will be able to train technology to look for even the smallest errors on claims (such as one digit being wrong in a zipcode) and justify this as a reason to recoup money. The response an insurance company would give to this might be "the provider can correct the zipcode and resubmit"; however, it is not always that simple and becomes increasingly complicated when they are claims from years prior. There absolutely needs to be a limit on this look back period. See this news story about a lawsuit in California on this very topic:

https://www.healthcaredive.com/news/cigna-lawsuit-algorithm-claims-denials-california/688857/

In addition, the auditing process continues to exist in a shroud of mystery. The insurance companies will say they are committed to transparency and fairness of this process and do so to make sure their members' dollars are being spent wisely. This is misleading at best and a lie at worst. If an insurance company truly wanted to be transparent about their documentation standards, then they would give us a clear progress note and treatment plan template with checkboxes of all the required information they need. I would happily fill out such a form after every session if it was provided to me. Instead, what happens is a therapist gets audited and told that they are missing specific details in their notes such as:

- "Start/stop times missing in the body of the note" - even in cases when the electronic health record has automatically logged this information on the top of the note
- "Location of the therapist" - even though the place of service and address is noted on the claim form already
- "No direct client quotes" - even though there is substantial information about reported symptoms and problems throughout the rest of the note
- "Too many checkboxes and not enough narrative" - without clear direction on what the correct balance is
- "No justification for why the session was 53+ minutes" - even though the standard therapy session for decades has been 1 hour.

Most of us have learned these details from other therapists who have been audited, not from anything the insurance company has posted on their website or released in a policy, and it is certainly not anywhere in the insurance contract itself. We are left wondering if our notes will pass an audit or not, and year after year, we find out about more excessive details that we need to make sure are in our notes. For example, I just learned that at least one insurance company told a clinician during an audit that they need to add in language that stated a "*synchronous* audio/visual telehealth platform" was used. We were already adding in information about the telehealth session such as location of client, client consents to telehealth, HIPAA compliant platform used, etc…when will it end? Again, if they want this level of detail then why don't they just give us an updated note template to complete every year?

Whether it is malicious or not, they continue to benefit from leaving us in an uncertain state because they are not restricted from continuing to find ways to justify not paying for services based on small errors. In California currently, the Department of Managed Healthcare is currently investigating four commercial health plans for various reasons, one of which being concerns about unfair and unclear utilization reviews for behavioral health services. It is an unfair and at times abusive practice that can be remediated by this passing this bill.

Thank you for your time in reading and your attention on this matter.

Sincerely,

Jennifer Besst, LMFT