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

My name is Jill Cain, and I am a Licensed Professional Counselor (LPC) in Wilsonville, Oregon. I have been a therapist for over 20 years, including my time in California as a Licensed Marriage and Family Therapist. In 2018, I founded a solo private practice here in Oregon as a sole proprietor. I am writing ***in support of HB 4028***, which would limit how insurers and Coordinated Care Organizations (CCOs) can audit behavioral health claims and do more to regulate their medical management practices that are often designed to deny or delay payment of claims.

I strongly support HB 4028 because it would establish reasonable limitations on insurance audits, which currently burden mental health providers and reduce access to care. This bill goes a long way in trying to help tip the balance of power for us as independent practitioners who make up the backbone of the behavioral health providers here in Oregon. We do not have legal consultants, huge billing departments, and staff dedicated to dealing with the many issues that arise and feel vulnerable to the tactics used by these huge companies backed by teams of lawyers and billing experts who continually are changing the rules of the game.

When I opened my counseling practice in 2018, I contracted with several major commercial insurance companies to help as many Oregonians as possible by allowing them to utilize their mental health benefits to access my services.

However, after dealing with these insurers and the amount of time and effort it took to navigate unclear expectations, confusing billing and documentation requirements, and endless minutes spent on hold, I realized I would have to opt out of working with some of them. After receiving conflicting information from various customer service representatives and experiencing limited provider support resources, I became increasingly frustrated with the complexity of managing insurance contracts. As a small business owner, I realized this was not sustainable, so I slowly began dropping some of my insurance contracts.

For the sake of my current insured clients, I remain in-network with a few of these major insurers. However, it has become extremely taxing—both financially and emotionally. The hours I've wasted on the phone and trying to resolve issues with unpaid or incorrectly processed claims have been maddening and frustrating. As a result, I've had to hire professional billing services to help me stay compliant and navigate the ever-changing requirements, policies, and procedures.

In early 2024, I received a letter from a major insurer stating that some of my claims had been paid incorrectly. They stated the insurer had made an overpayment. These were claims from the previous year, and they demanded that I immediately pay back the money they claimed I owed. The letter gave me 30 days to appeal the decision or pay the money back right away. I was surprised, concerned, and confused by the letter. So, I called to try to understand what had happened. Initially, after speaking with a representative, I was told the situation was likely an error because they had, in fact, paid me correctly as an in-network provider. The representative

assured me they would reprocess the claims, and I could disregard the letter. I assumed perhaps the reimbursement rates had changed, so I didn't worry much further.

Unfortunately, this was not the end of it. I then received similar letters for other dates of service, stating they had been processed incorrectly, and I would need to refund the payments. It was overwhelming to receive these letters, and I eventually hired extra billing help to assist in investigating the situation. I simply couldn't afford to waste more hours on the phone when I had clients to see. This took well over a year to get resolved. The insurer would simply withdraw money from my checking account to recoup the payments they made in error. While I understand I may have been overpaid for this particular client, the ongoing situation was extremely stressful and was tedious to resolve.

All that said, in my experience—and from what I have heard from other providers—these audits are often financially motivated and do not uncover insurance fraud or poor quality of care. Typically, they uncover billing or clerical errors. In my case and many others, the issue has been the insurer's mistake, and they've subsequently attempted to "claw back" payments that were made for services provided appropriately. This bill would limit the degree to which large, profit-driven companies could recoup payments for services properly rendered and would establish fair practices for doing so.

Mental health providers like me do not have the profit margins to repay large sums of money owed for claims from previous years, nor do we have the time to battle insurers over payments. The financial risk is stressful, and my colleagues and I are faced with the choice of either stopping work with insurance companies or closing our practices altogether. So many of my friends and family have commented to me that they can't find a therapist or have to wait to see one for months. I don't think it is always a problem of a shortage of therapists. There are usually plenty of providers I can refer to that are private pay but not many who are willing to accept the insurance that clients wish to utilize. This also does not bode well for attracting new, quality providers to the field. At a time when Oregon is seeking to increase access to mental health care, these tactics used by insurance companies are having a negative effect on care availability and are leading to high rates of burnout and compassion fatigue for providers.

Please help ensure that reasonable time limits, clear guidelines, and procedures for audits—like those already implemented in other states—are put into effect to protect providers.

Thank you for supporting House Bill 4028.

Sincerely,
Jill Cain, LPC
Licensed Professional Counselor