



October 2, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Lisa M. Gomez
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20002

The Honorable Douglas W. O'Donnell
Deputy Commissioner for Services and Enforcement
Internal Revenue Service
U.S. Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20224

**Re: 0938-AU93
1210-AC11
1545-BQ29
Requirements Related to the Mental Health Parity and Addiction Equity Act**

Dear Secretary Becerra, Assistant Secretary Gomez, and Deputy Commissioner O'Donnell:

Psychotherapy Action Network appreciates the opportunity to comment on the Department of Health and Human Services, Employee Benefits Security Administration, and the Internal Revenue Service's (the "Departments") proposed rule, Requirements Related to the Mental Health Parity and Addiction Equity Act (hereinafter "2023 Proposed Rule").

Psychotherapy Action Network (PsiAN) advocates for awareness, policies and access to psychotherapies that create lasting change through our network of over 5500 individual members and 90 strategic partner organizations. We aim to educate the public, policymakers, and mental health professionals regarding the robust evidence

base¹ for therapies of depth, insight, and relationship and their place among options readily accessible within our mental health system. We are deeply invested in Rules that accomplish the full compliance of insurance companies with parity, which importantly allows for appropriate coverage of evidence-based depth therapy.

We strongly support the 2023 Proposed Rule's overarching goal to increase access to mental health and substance use disorder (MH/SUD) treatment by addressing treatment limitations that place a greater burden on participants/beneficiaries' access to MH/SUD treatment than to medical/surgical (M/S) treatment.

PsiAN fully supports the comments submitted by the Kennedy Forum regarding the 2023 Proposed Rule. Our comments here are meant to support and expand on theirs with the experiences of our members, most of whom are in solo or group private practice and provide therapies that are often longer term or more intensive, addressing chronic conditions and complex underlying personality dynamics, which the evidence base shows is what leads to lasting change. These therapies don't fit the shorter-term focus and economic model of insurance companies and are often challenged, seemingly, for this reason. Profit-based entities evaluate cost effectiveness on quarterly or at most on an annual basis, not capturing the economic benefits over the longer term, which include documented savings in medical expenditures over the longer term².

Thus, the burdens of parity violations have fallen particularly heavily on beneficiaries who require longer term, more intensive forms of treatment to achieve mental wellness, as well as on the clinicians who provide these services.

In particular, we share the Kennedy Forum's emphasis on required NQTL analysis and on eliminating proposed exceptions:

We are especially supportive of the statement of the purpose of the regulations and law and the corresponding requirement that plans analyze the impact of a nonquantitative treatment limitation (NQTL) on access to MH/SUD services as part of the comparative analysis. We further support the data collection and reporting requirements of the rule, especially with respect to the comparative analyses of NQTLs and network composition, as such requirements are essential to ensure compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) given the longstanding history of practices to disparately limit access to MH/SUD services.

¹ Leichsenring, F., Abbass, A., Heim, N., Keefe, J.R., Kisely, S., Luyten, P., Rabung, S. and Steinert, C. (2023), The status of psychodynamic psychotherapy as an empirically supported treatment for common mental disorders – an umbrella review based on updated criteria. *World Psychiatry*, 22: 286-304. <https://doi.org/10.1002/wps.21104>. Additional documentation of evidence base available upon request.

² Lazar, S. G. (ed). (2010). *Psychotherapy is worth it: A comprehensive review of its cost-effectiveness*. American Psychiatric Association Publishing.

To fully realize the promise of the 2023 Proposed Rule's many extraordinarily strong provisions, however, the Departments must eliminate the proposed exceptions relating to "independent professional medical or clinical standards" and "fraud, waste, and abuse." To be clear, we strongly support requirements for plans/issuers to follow independent professional medical/clinical standards (generally accepted standards of care) and believe it is critical to combat fraud, waste and abuse to safeguard the health and well-being of consumers. However, as structured, the proposed exceptions threaten to swallow significant parts of the 2023 Proposed Rule, potentially making its promise of increased access to MH/SUD services by combatting discriminatory treatment limitations illusory. Furthermore, we believe that these exceptions are not firmly based in MHPAEA's statutory text and that the underlying legitimate issues are most appropriately and effectively addressed within the existing (and proposed) NQTL rules.

As clinicians dealing directly with insurance companies, we are all too familiar with policy and administrative obstacles to MH/SUD treatment which are not grounded in generally accepted standards of care (*Wit v United Behavioral Health*³) or are administratively burdensome, or both. As noted in the examples below, we have to deal extensively with NQTLs which interfere with access and with ongoing treatment. Further, we don't trust the insurance industry not to exploit an "exceptions" rule to continue to create obstacles, gutting the appropriately strong provisions of the Proposed Rules and leaving us in the same position we are in now.

In order to respond substantively to this call for comments, we asked our members to submit examples of the experiences they have had with insurance companies which have interfered with their ability to provide quality care and with patients' access to quality care. Their responses fall into four categories: consequences to patients of in-network limitations, consequences to providers of in-network limitations, TPA issues, and treatment denials. We are including them here as they were submitted to us in order to provide you an unambiguous picture of what it is like to negotiate our current healthcare system from our perspective. While we can't be certain that they are all parity violations, we are certain that they are actions which interfere with access to quality mental health care. Indeed, the fact that we cannot determine which are parity violations makes an important point about how crucial these Rules are to accessing care and constructing a mental health system that doesn't exacerbate the problems it sets out to treat. Without adequate Rules, the burden of identifying and challenging parity violations depends upon beneficiaries and clinicians **knowing** when their rights have been violated and making legal complaints when insurance companies are unresponsive, a responsibility that rightly belongs instead to insurers and regulators.

To this point, we want to stress the Kennedy Forum's point that insurance companies must be held responsible for initiating the reprocessing of claims which have been affected by noncompliant NQTL:

³ [Wit vs. United Behavioral Health \(n.d.\). UNITED STATES DISTRICT COURT NORTHERN DISTRICT OF CALIFORNIA, FINDINGS OF FACT AND CONCLUSIONS OF LAW, Judge Joseph Spero.](#)

We strongly support the addition of new requirements relating to plans/issuers' NQTL comparative analyses that they are required to conduct under amendments to MHPAEA enacted as part of the CAA, 2021. These detailed requirements are necessary to ensure there is clarity on what plans/issuers' analyses must contain and to hold plans accountable for following these requirements.

We also appreciate language relating to providing participants/beneficiaries with information summarizing changes the plan/issuer "has made as part of its corrective action plan following the initial determination of noncompliance, including an explanation of any opportunity for a participant or beneficiary to have a claim for benefits reprocessed." **The framing of the notice as an "opportunity" for a participant/beneficiary to have a claim for benefits reprocessed is misguided and places the burden on participants/beneficiaries in an inappropriate manner. The participant/beneficiary is not well placed to know they may have been impacted by noncompliant NQTL and to navigate a likely complicated path (that the proposal leaves unidentified) to pursue remedies. Instead, we strongly urge the Departments to place an affirmative obligation on plans/issuers, as part of the corrective action plan, to identify affected participants/beneficiaries, reprocess any claims, notify those who they determine have been impacted by the non-compliant NQTL.** [emphasis added] We commend the Departments for appropriately shifting the burden away from consumers throughout this proposed rule, and we urge a consistent approach here.

1. Consequences to patients of in-network limitations

This is a sampling of the kinds of problems that members have dealt with for many years. Because we are usually only in the position of having to turn away patients when we are inaccurately listed as in-network, we don't always know how their search for help is resolved. Our own market research with the public, [Going beneath the surface: What People Want from Therapy](#), finds that many people believe their insurance doesn't cover mental health services, and we wonder if these experiences contribute to that perception. In any case, network limitations, through inaccuracy or inadequacy, unquestionably contribute to feelings of helplessness and hopelessness for which many people seek help and should be seen as exacerbating the need for services.

Inaccurate networks

- *The client called their insurance company and was told that behavioral health benefits were covered by Magellan and was sent a list of in-network providers. Come to find out that not only do they not use Magellan to cover behavioral health, but the list of providers was not an accurate accounting of who was in their network (Lisa Tamar Provorny, LCPC 180011361, Illinois, BCBS, BlueCare Direct HMO).*
- *I have been repeatedly listed as participating in the plans on the Affordable Care Act marketplace. I am not, and have never been in that plan (JoAnn Brown, LCSW 149010958, Illinois).*

- *Our providers were listed as accepting HMOs, Medicare, and Medicaid when they were onboarded with Aetna and we only accept PPOs. I ended up having to send Aetna a fax to get them to remove these "products" from the provider directory. It seems like it's the default to have providers listed as accepting all plans because that wasn't part of the network participation request that I completed on behalf of our providers (Lisa Lipscomb, Illinois, Aetna).*
- *I have had many instances of potential patients calling unable to find an in-network provider. Although I had left BC/BS I was still listed as a provider. I could not provide them with referrals as the number of colleagues I have who take insurance is limited (Betsy Spanbock, NY State Social Work R078596-1, New York, BCBS).*

Inadequate networks

- *I no longer accept Medicare except in MA. This is due to paperwork, payments, clawbacks, and other administrative demands. Every week I get one or more calls asking for appointments from a NYC resident confused by the one-state only listing in Psychology Today. These are all people I would gladly see. And, I no longer have colleagues to whom to refer them because they are full up or not taking medicare either (Judith Rosenberger, MA. PY-PR (psychology provider) 2038, Massachusetts).*
- *I was told Blue Cross was not accepting any new providers (Julianne Curabba, LCSW 077328, New York, BCBS).*
- *Illinois- UHC. UHC does not contract with enough providers to allow clients to access services within their area. The admission standards are too complicated and the reimbursement rate does not cover costs to provide the services (Julie Midgley, Illinois, UHC).*
- *One of my clients waited for two years to find a therapist who accepts her insurance (Kaiser-Beacon at the time) and had an opening. In California, insurance companies are supposed to ensure access to mental health treatment within 10 business days, but this is not happening. The clients who experience the greatest difficulty finding a therapist are those with the lowest-paying "carve-out" HMO plans: Magellan and Beacon/Carelon (Robin Furner, CA MFT 44794, California, Beacon/Carelon; Magellan).*
- *A 10 year old child showed symptoms of anxiety including tic, withdrawn behavior, stutter and increased avoidance. Kaiser set him up with a therapist who couldn't see him for months and then the parent was told she had to schedule the next appointment in the system as quickly as possible to "get a spot" with the provider. The very earliest possible was three weeks away at a different day and time for a psychotherapy appointment for a child. We know that this limited frequency is very unlikely to benefit anyone, let alone children, especially at the beginning of treatment (Kiera Boyle-Toledo, MD 07049, Maryland, Kaiser Permanente).*
- *I was unable to find a provider for my daughter (4 years old) for mental health with an opening within 6 months. Most providers on the list didn't actually work with children (Alyssa Wermers, CSW.09923857, Colorado, Kaiser).*
- *Client was a current client at our agency and obtained coverage with BCBS. The provider the client was involved with was not credentialed with BCBS yet. The process to become credentialed with BCBS is very long and there were not other providers available in the area to provide the service. It also is disruptive to*

- the client to change providers, particularly in the Behavioral Health field. The client had to suspend their services until the current provider was able to complete the lengthy credentialing process (Julie Midgley, Illinois, BCBS).*
- United Healthcare is closed in Illinois for Supervision privileges. Therefore we cannot allow associate level clinicians, LPC and LSW, who are earning hours towards full-licensure to see patients. This dramatically affects the offerings of clinicians and patients can provide to United Healthcare policy holders. We have tried for over a decade to get supervision privileges and have been denied stating they have enough providers in our area. Also, BCBS HMO Sites by my area will not allow us to join their network unless you are on the Northshore Hospital staff. We are constantly turning patients away. We have applied and the network is closed. Has been since 2012 when we opened (Brianne and Michael Clatch, Clinical Psychologists, Illinois, UHC).*
 - In Colorado I have contacted United about supervisory billing and submitted the information they requested from me about my practice. It's been over 2 months and still no response from them that this is allowed. In Colorado, they are the only major insurer that does not allow this for mental health (yet incident-to-billing is allowed for medical with all insurers) (Alyssa Wermers, CSW.09923857, Colorado, Kaiser).*
 - BCBS, Aetna, Evernorth, Optum (Illinois). We receive little guidance from insurers on supervisory billing. While all four of the insurers we are contracted with (ILBLS, United/Optum, Cigna/Evernorth & Aetna) allow supervisory billing, the instructions as to how to submit claims are opaque (Lisa Lipscomb, Illinois, BCBS, Aetna, Evernorth, Optum).*

Difficulty making reliable referrals

- I practice in Long Branch, New Jersey and am in most networks. I get more requests for my services than I can handle. I turn away more potential patients and I am sure that the networks are not adequate enough for them to get the services they seek. Most of the patients are from New Jersey and most have Horizon Blue Cross/ Blue Shield. I tell them to have the insurer find them a treating professional (Russell M. Holstein, NJ psychologist 35SI00094100, New Jersey, BCBS).*
- Carefirst Blue Cross and Blue Shield of Maryland: I have a full practice and try to keep a list of BCBS providers so that when prospective patients contact me I'm able to make referrals. Since the beginning of Covid, I have been unable to find other providers to refer anyone to, or have to refer patients to wait lists for other providers (Joseph Schap, Maryland LCPC LC4722, Maryland, Carefirst BCBS of Maryland).*
- I have received over 8 inquiries, just this week, from patients needing a provider through Anthem in Colorado. I am currently full (and experiencing in network difficulties with the company) and therefore unable to see them. These patients are reporting to me that they cannot find anyone who is available and in network for them (Alyssa Wermers, CSW.09923857, Anthem, Colorado).*
- I have not had success in finding a qualified in-network provider to whom to refer a patient in three years--in any state, for any network. The system is completely gridlocked, from where I'm sitting. This is also true at the inpatient level; I supervise clinicians working on acute short-term inpatient psychiatric units that have been boarding psychiatric patients for years on end because they simply*

- have no placement to which to send them (Carter J Carter, MA LICSW 119527, Massachusetts, BCBS).*
- *I have been unable to find referrals for various patients with United Health or Cigna seeking psychotherapy or psychiatry services (Libby Bachhuber, LCSW Illinois 149.016084, Illinois, UHC).*

Changes in coverage mid-treatment

- *I have had two patients whose healthcare coverage switched from BCBS PPO to United Healthcare PPO. I am not in-network for UHC. They asked me for referrals and I had a very difficult time finding any. Each patient considered seeing me less than their respective situations would have warranted in order to keep the continuity of care, with me.*

From another perspective, my own insurance (through my husband) switched from BCBS PPO to UMR, a subsidiary of UHC. He showed me an email from HR stating that people were now allowed a year to stay with their current BCBS PPO in-network therapists. The HR email was a little oblique and dodgy, saying only that they understood the concerns and that nobody had to switch immediately. However, my suspicion is that (a) people wanted to keep their current therapists and (b) there aren't enough United therapists available (Betsy Nettleton, 071007496 Clinical Psychology, Illinois, UHC).

- *The number one issue I have seen is when patients' insurance carriers change during an on-going treatment and this change affects whether or not they can afford to see their established provider because their cost-share changes. For example, I have a patient whose employer changed the employees' healthcare insurance. In this case they moved from the Blue Cross Blue Shield of Illinois network to a provider network under UnitedHealthcare. I am not in-network to the general UnitedHealthcare/Optum mental health network. I am in-network to a university healthcare plan that is also run by UnitedHealthcare. Over the ten years that I have been in this network under UnitedHealth, I have only had one raise, and that raise was 5% and it went into effect this past month. Let me repeat: I have had no raises for ten years. After ten years in the network, I have gotten one raise, and that raise was for five percent. I quite simply cannot afford to be in-network with UnitedHealthcare. The patient whose employer changed their healthcare insurance is being financially constrained to find an in-network provider because the insurance is not covering care with me as an out-of-network provider (John Garver, LCSW 149015206, Illinois, BCBS, UHC, Aetna, Cigna).*

2. Consequences to providers of in-network limitations

Inadequate networks are directly the result of low reimbursement rates, alongside burdensome NQTLs. Despite the enormous increase in healthcare expenditure, therapist reimbursement rates have remained flat for literally decades. In many urban areas, therapists report that they aren't able to cover their business and living expenses if they accept in-network fees. Our members who provide longer term, intensive treatment also have higher educational expenditures, often completing many years of post-graduate training programs. The system doesn't recognize this additional expertise in any way, let alone with higher reimbursement rates.

With the vastly increased demand for mental health services during and since the pandemic, the marketplace still isn't operating to raise rates, even to meet inflation. For example, in the private insurance marketplace (BCBS-Illinois), payments to clinicians have remained constant for over the last 10 years. This effectively amounts to a pay cut, exactly the opposite of what supply-demand variables indicate.

We concur with the Kennedy Forum's comment on the discriminatory history of mental health reimbursement rates:

For example, plans commonly justify discriminatory reimbursement rates by citing the Medicare Fee Schedule. Of course, Medicare is not subject to MHPAEA and has long undervalued MH/SUD services. The Centers for Medicare & Medicaid Services (CMS) has recognized this [undervaluation](#) in recently proposed updates to the reimbursement rate for psychotherapy in the Medicare Physician Fee Schedule (PFS), but they acknowledge that they still need to develop systemic solutions to longstanding process limitations. In the meantime, MH and SUD clinicians account for [almost half](#) of the total providers who opt out of Medicare, with [low reimbursement rates](#) cited as a key factor affecting provider willingness to accept insurance and join networks. Given how frequently the Medicare Fee Schedule is used to justify discriminatory MH/SUD reimbursement, we urge the Departments to specify that utilizing the Medicare PFS to justify reimbursement rates will fall within the proposed prohibition of (c)(4)(ii) (B).

When higher levels of review and reporting requirements and network restrictions on covered services are added to low reimbursement rates, therapists' unreimbursed administrative workload increases to unmanageable levels.

Low reimbursement rates

- *I simply don't take insurance except B/C B/S of Kansas to avoid all the trouble. Pts then don't see me (David S Blakely MD, Kansas 20864, Kansas).*
- *I joined BC/BS as an in network provider when I first began my practice and they reimbursed me \$80 a session at the time. I left the panel after about a year because the reimbursement would not allow me to continue providing services and meet my financial needs. My fee is about 4 x that amount with more than 10 years experience at this point, and I will never go back. On top of this, the amount of time I had to spend with discussing plans with the insurance company was not worth the shameful reimbursement they offered (Justin Donofrio, LCSW 084439-1, New York, Premera, BC/BS, Aetna, United, Cigna).*
- *In New York state, because of paltry in-network reimbursements for the area, most experienced therapists are unable to sustain a business while taking insurance. If they do take insurance, they often are required to see an exorbitant number of clients to make it financially feasible. For this reason, most therapists I know do not work with in network plans. This also creates a dearth of good therapists for patients that have to use their healthcare benefits for mental health. The cost of living in New York City specifically makes taking in network insurance an impossibility for most providers. I have had friends and clients that have had*

- to wait, sometimes years, before finding a provider who was on their plan (Justin Donofrio, LCSW 084439-1, New York, Premera, BC/BS, Aetna, United, Cigna).
- We have a major shortage of psychiatrists who take any insurance. Most of them want people to pay out of pocket. As a result, patients who are very depressed, even with suicidal ideation, are waiting weeks to get an appointment. I would be happy even if insurance companies added nurse practitioners who could prescribe. I am a provider originally for GHI which paid \$40 with a co-payment of \$15 making a total reimbursement of \$55. They were taken over by Emblem. I think total reimbursement was \$65, with the usual \$15 copayment. Then Beacon took over and reduced the reimbursement to \$55 with no warning. Now Corleone took over with reimbursement the same, \$55. So there has been no increase in reimbursement for the last 20 years and Beacon dropped the short time there was an increase to \$65 back to \$55 with no communication to providers. This is a shameful treatment of providers. The amount of reimbursement should be increased and providers should be notified (Blake Osborne, LCSW 149-007272, Illinois).
 - In Illinois, BlueCross/BlueShield, UnitedHealthcare/Optum, Cigna, and Aetna all pay significantly lower (\$30-\$40 per hour lower) than the Medicare rate for the same services. They claim to do so due to the high number of providers in this area. The result of this is that many providers do not accept in-network benefits at all -- forcing insured individuals to use out-of-network benefits to find care, which is much more expensive for the patient (Jacob Hogan, LCSW 149021212, Illinois, BCBS, UHC, Cigna, Aetna).
 - BCBS Illinois - I am in-network with BCBS PPO. The amount BCBS pays me requires me to write off \$100/session. BCBS reimburses so far under market rates, it's crystal clear why there is an access problem. If supply-demand operated here as it does in every other market, then therapists would have no problem taking insurance. (Linda Michaels, PsyD, Illinois 071.008703, BCBS).
 - Completed the entire network paneling process with CareFirst BlueCross BlueShield in Washington, DC. The fee schedule was withheld until I received a contract to sign. The fees for the two codes I bill most often (90834 and 90837; \$77.40 and \$109.97) were too low for me to consider joining the network. I am also paneled with DC Medicaid and CareFirst's fees are significantly lower than either Medicaid or Medicare fees (Sean Penny, LPC - PRC15438, Washington, DC, CareFirst BCBS).
 - New York, Blue Cross Blue Shield. The low reimbursement rate is the reason I am ending my contract with the network. I have been an in network provider for 11 years and never once has the insurance company increased my reimbursement rate. It is despicable. Cost of living has certainly gone up and there has been no increase to account for that or inflation. I have no desire to remain in network with an insurance company that paid little 11 years ago and continues to still pay that amount in 2023 (Jessica Moskowitz, Jessica Rodas 079548, New York, BCBS).
 - I was in network with BC/BS for a number of years. I had to end my affiliation because the rates of reimbursement were so low that they did not even cover an hour of my rent. It is impossible to accept their rates. I cannot make a living. In addition, when I submit for out of network reimbursement I have had BC/BS and Cigna refer to some billing agency to "negotiate" a rate. While these rates are better, one is given less than a week to respond and if you don't respond you or

- the patient are only reimbursed at a ridiculous "usual and customary" rate (Betsy Spanbock, NY State Social Work R078596-1, New York, BCBS).
- Time and time again insurance companies, most often BCBS, have paid me very low rates which has me contemplating leaving their network. The only reason I have yet to do so is because a very large number of people in my area have BCBS and I want to be able to help as many clients as possible. However, it is becoming increasingly difficult to manage when my own finances struggle, and I am not being valued at all by the insurer (Marena Passarelli, OR LPC #C5559/WA LMHC #LH61032464, Oregon/Washington, BCBS).
 - BCBS has two different PPO networks, one is called "Blue Choice" and that had reimbursement rates that were lower than its other BCBS PPO network. I did not join the plan with lower reimbursement, although it is becoming more prevalent because it is the only PPO available from BCBS on the state's insurance marketplace/exchange/"Obamacare" for individuals and families. I have patients who are therefore unable purchase a healthcare plan for themselves on the exchange to which I am in-network. While they might offer an out-of-network benefit, the deductible is so large (well over \$10K) that they effectively have no help defraying cost for their care from the insurance carrier (John Garver, LCSW 149015206, Illinois, BCBS).
 - I was paneled with Cigna and then ended the contract because of ridiculously low rates. I am in the process of ending my contract with United and Oxford because of low rates. Oxford delays payment. I am often not paid for six weeks after a session. United is a little better but not much. I will, in the next year, remove myself from all panels because of the low rates and hoops insurance companies make me and my patients go through to get paid. Private practitioners do not have the time (we aren't drs that can see multiple people in an hour. One patient per hour, and because of the deep emotional work we provide, most of us agree that 6 patients a day is the max) nor the income, to hire office staff to deal with it all. I pay upwards of \$700 a month to a billing company. That would be ok if I was making at least \$150 per session, but I am not. So, I plan to move to self pay clients only, so I can make at least \$150 per 53 minute session and not have the burden and expense of billing (Julianne Curabba, LCSW 077328, New York, BCBS).
 - I attempted to join the Cigna/Evernorth network earlier this year in Colorado. The first rates they offered me were well-below any other insurance company. We negotiated 2 times after, and they still remained below a rate that was sustainable to keep a practice open. I chose not to go in-network with them (Alyssa Wermers, CSW.09923857, Colorado, Cigna/Evernorth).
 - JCFS Chicago determined not to pursue becoming in-network with Cigna as it was determined that the reimbursement was too low to make sense for us as an agency (Scott Cupper, Illinois, Cigna).
 - Cigna now Evernorth has extremely low reimbursement rates compared to other top level insurance providers. Humana has low insurance reimbursement rates and we tried to join, however the rates are too low for us to afford paying our therapists (Brianna and Michael Clatch, Clinical Psychologists, Illinois, Cigna/Evernorth).
 - I will not join Cigna because of low rates (Libby Bachhuber, LCSW- Illinois 149.016084, Illinois, Cigna/Evernorth).

- *Illinois- United Health Care. We have had numerous clients come seeking services with UHC. We are currently out of network. We have explored the possibility of becoming in network with UHC but the requirements are too intense and the coverage of behavioral health services is very limited and not consistent across plans. We have consulted with several other behavioral health providers who have expressed the same (Julie Midgley, Illinois, UHC).*
- *Aetna reimbursement for couples/ family treatment is extremely low and is making me consider not seeing patients with this insurance who need these services (Libby Bachhuber, LCSW- Illinois 149.016084, Illinois, Aetna).*
- *Recently, most of the out of network plans I work with have found a loophole to prevent paying for presumed covered mental health services. With a good portion of my current client roster, the plans listed above (Premera, BC/BS, Aetna, United, Cigna with Premera being the worst offender) reimburse based on the in network Medicare rate. This rate is an in network estimate negotiated by Medicare. In NY State that rate is \$125. They then say they will reimburse a percentage of that amount. SO even if they reimburse say, 140% of the Medicare rate, it does not come close to what most therapists charge as their full fee. Therefore, a consumer buys this plan through their employer, pays more monthly for the OON coverage, and is told they will get back 60 or 70 percent of the provider fee. That's what they are shown during open enrollment. If you call these insurers they will give you the run around but refuse to provide the accurate coverage, which can only be determined after you submit a claim. Once you dig deeper you can find the fine print in 100 page documents that are unavailable to most employees, unless asked for, which shows this Medicare language. It essentially makes their benefits then useless for mental health services. I have successfully appealed United personally but only after I got my HR dept involved about 5 years ago. Now, there is no hope for even an appeal. My clients are simply being denied coverage after multiple appeals, and their employers are none the wiser. It's a scam on a massive scale (Justin Donofrio, LCSW 084439-1, New York, Premera, BCBS, Aetna, United, Cigna).*
- *I have never taken insurance in my private practice because I've been told that I won't even be allowed to know the reimbursement rates until after I contract with the insurance company. This occurred in Massachusetts. In Massachusetts I was also listed as an in network provider with Aetna in my private practice due to a hospital affiliation years ago and received numerous calls from patients who could not find child therapy providers in-network. (Kiera Boyle-Toledo, MD 07049, Maryland)*

TPA issues

TPAs create further administrative burdens for providers, reduce transparency, and seem to offer additional ways around parity because they aren't currently held to the same standards as the companies they process claims for, introducing another administrative level at which parity violations can take place.

- *South Carolina. EBMS, 3rd party administrator for Cigna member processed claims inaccurately for a whole year of claims. Issues included wrong contracted reimbursement rates, processing as out of network, wrong copay amounts. Numerous calls and even conference calls between myself and Cigna to resolve the issues did not address all the issues. Multiple appeals and a request for a*

- formal independent review resolved some of the reimbursement issues, but not all. Hours went into appeals, the patient incurred undue stress, and I lost money I was due as I just gave up. Incompetency, intentional mistakes, intentional fraud, who knows? I will not take any new clients who have EBMS managing claims (Christine Dowling, Social Work SC6852, South Carolina, EBMS - third party administrator for Cigna, Humana).*
- Third-party Administrator Issues. Cigna/Evernorth (Illinois). The guidelines around claims submission when a client has insurance through Cigna that is managed by a TPA are confusing. We have to submit claims directly to UPMC, a Cigna TPA, but with Allegiance we have to submit them to Cigna. We have no way of tracking claims digitally except through our practice management software because the Evernorth provider online portal, which is what behavioral health providers have to use, does not give claim information for TPAs (neither UPMC nor Allegiance). We don't have digital access to ERAs. We're unable to access TPA online portals. I tried to sign-up with UPMC and Allegiance but their systems won't let me because we are not contracted with them directly (Lisa Lipscomb, Illinois, Cigna/Evernorth).*
 - I use my UMR (via UHC) out-of-network benefits, and these are rendered through a third party, "Data iSight," which decides the rates based on their own metrics and not what was stated in my benefits handbook for OON care (Betsy Nettleton, 071007496 Clinical Psychology, Illinois, UHC).*
 - I have stopped accepting 3rd party payments, which sadly have mostly been college students because of the enormous difficulty faced to get paid. One company automatically signed me up for a debit card with my payments that wasn't accepted anywhere and the only way I could get a paper check was to call them and go through a ridiculous process. To get direct payments required a letter notarized by my bank. Another one, every six weeks would deny payments. After much time, between my patient and I, we learned that after two years of tx, Aetna's third party payor (Columbia's teachers college) decided she needed to see someone at the college. Thankfully, I am located outside of their treatment area and we were able to continue working together. I still continue to have payment issues. Most recently it took 2 escalations over 3 months before receiving my \$98. This could have greatly impacted this highly anxious (panic attacks), depressed, struggling interpersonally college student. At the very least it increased her anxiety for a few weeks while we figured out what was going on. Shame on them! (Julianne Curabba, LCSW 077328, New York).*
 - A patient had Cigna as their insurance but it was administered by Allied Benefit. When the company laid off much of its staff, including the patient, they offered a severance package that included paying for COBRA. The confluence of Cigna, Allied, COBRA, the old employer's HR department, and a Union created a mistake where for three months the patient's claims were not being covered because Allied and Cigna believed that the patient was "not covered" by the insurance carrier during the time period specified. This was factually incorrect. The number of phone calls about this issue took hours from both the patient and the provider. On multiple instances representatives at the TPA claimed it had not received the claims although they had been sent by fax and by electronic portal MULTIPLE TIMES successfully. The TPA would also assert that they would need 30 days to process the claim after submission. When follow-up happened they would allege they had not received them, or if they did see that the claims came*

- in and acknowledge that there was another response that resulted in further delay. It would call and they would actually acknowledge receiving them but they had not resolved the issue of verifying coverage. They then made the claim that the claims were submitted outside of a certain number of months and that this would result in further delay and re-processing. It is unclear exactly what the problem was, but the claims were submitted initially, at least five times by electronic portal after they were rejected/not covered, and sent by fax three times. At the end of July 2023 a check was finally written to cover claims from April, May and June of 2022 (John Garver, LCSW 149015206, Illinois, Cigna).*
- *One particular practice struck me as exceptionally cynical and legally dubious. Whenever I worked out-of-network with a patient with Tufts insurance, I would get a call from a third-party company inquiring about my claims. They would call and say that they had received them, and that they would be willing to issue payment right away, but at only 1/3 to 1/2 the rate I had actually billed; if I wanted the full fee to which I was entitled, I would need to wait weeks for the claim to pay out. In essence, they were holding the reimbursement to which my patient and I were entitled hostage, lowballing me by capitalizing on my need to get paid in a timely way. I never accepted these extortionate offers as a matter of principle, but the result is that it would take me months to get paid for a standard service, which was a real financial hardship (Carter J Carter, MA LICSW 119527, Massachusetts).*

3. Treatment denials

Our members report treatment denials which follow from medical necessity standards which violate parity and aren't consistent across insurance providers. Often, there is little to no transparency as to the clinical reason treatment is being denied, or the reason for repeated reviews of some cases and not others. Reviewers may not have a background in mental health and rarely are aware of the evidence base for longer term treatment. The administrative burden on the provider to resolve these issues is large and unfairly placed on them, as is the impact on patients whose treatment is disrupted or ended. The Proposed Rule specifically notes exclusions of autism and eating disorders. (c)(2)(ii)(C) We provide examples of other exclusions as well.

There is also a significant issue with length of treatment sessions. 90837, individual psychotherapy for 53-60 minutes, is reimbursed at a more than proportionally higher rate than 90834, individual psychotherapy for 45-52 minutes. The 90837 length is a useful and often recommended length of time for clinical reasons. Some insurance doesn't cover 90837 at all; others only cover it for certain diagnoses, without reference to an independent standard of care they are employing; and many review 90837 at a much higher rate than 90834, again for no clinically verifiable reason, costing the clinician more administrative time, interfering with the treatment, and creating anxiety in the patient that they will lose access to their care.

Service exclusions

- *Patient inability to seek treatment due to exclusions of diagnosis, UHC is enabling employers to exclude behavioral disorders, impulse control and personality disorders as well as excluding services for Sexual/gender Identity. This is predominantly happening in Kansas but I am finding it in Washington too. Also, UHC enables employers to allow exclusions for behavior/impulse disorders,*

- learning disabilities (often ADHD is denied for although it's not a learning disability) and exclusion for personality disorders. Cigna/Evernorth does not provide Mental health benefits on their website and or their benefits are not documented vs what is actual after billing claims (Sandra Stanford, Kansas & WA State, UHC/UMR plans).*
- Illinois- UHC. We have a long term client who has stopped services due to consistent denials for the service. The client has repeatedly contacted the insurance company as have we. The insurance company has not provided any accessible resources to the client and has not acknowledged that there is not a provider available. The client's anxiety has increased and is no longer receiving treatment (Julie Midgley, Illinois, UHC).*
 - United 90837 - I am out of network with United, and both the patient and myself called United to verify that 90837 would be accepted. United verified this to us, and then once the claims were submitted, denied them all. The patient then called United numerous times herself, and she and I called United together – using up valuable treatment time waiting on hold for them. A different United rep told us that the first agent was wrong, and that 90837 is only allowed for diagnoses of PTSD and borderline personality disorder. I asked for their clinical rationale for this restriction, and the rep had no response. Not only did this whole experience – which took months until UBH provided accurate information about their own policy – greatly interfere with the treatment and wasted valuable time that should have been spent treating the patient, it also terrified the patient that she would have to choose either to stop therapy altogether or go into debt to pay for it. (Linda Michaels, PsyD, Illinois 071.008703, BCBS).*
 - I have had two different patients tell me, separately, with UnitedHealthcare plans, that when they submitted their claims for reimbursement they were told by representatives of the plans/networks that they do not have coverage for mental healthcare and that they were responsible for the full cost (John Garver, LCSW 149015206, Illinois, UHC).*
 - Coverage exclusion for autism and eating disorders - I specialize in eating disorders, and have experienced BCBS refusing to admit my clients to a higher level of care when I have deemed it necessary for them to attend either increased sessions per week, or a higher level care facility (Marena Passarelli, OR LPC #C5559/WA LMHC #LH61032464, Oregon/Washington BCBS).*
 - Illinois- BCBS. We receive denials from BCBS for services provided without information on why the service is being denied. When we research the service provided it is unclear to us as a provider why the service is denied and we do not believe that it should have been denied. This in turn leads to numerous calls to determine the issue and rebilling. There are instances where the client will receive denial information and we have received nothing from the insurance provider (Julie Midgley, Illinois, UHC).*
 - As a provider who specializes in treating personality disorders, I am out-of-network because the insurers are so hostile to the evidence-based approaches for treating these disorders that I can only work in an evidence-based fashion out of network. They insist on empirically-supported treatments, but only when this means brief therapy that is cheap for them to reimburse; when the evidence clearly requires long-term and frequent treatment by a well-paid specialist, they balk and refuse. Because the patients I am referring often have personality disorders that require specialist care such as this, I have never in seven years of*

private practice been able to find an in-network provider to refer to when I needed to refer out. People with personality disorders constitute roughly 10% of the general US population. These are people with debilitating mental illnesses who require extensive specialist outpatient care, specialist care that also has the effect of keeping them out of the ER and psychiatric units which have been shown to be counterproductive for their treatment even as they cost exorbitant amounts of money for no benefit. The way they are treated--or, more to the point, not treated--by insurance companies strikes me as a clear violation of their rights, and of the contracts they enter into with the companies (Carter J Carter, MA LICSW 119527, Massachusetts).

Code exclusions

- *I am in-network to a university health plan under UnitedHealthcare and I am only allowed to bill CPT code 90834 (John Garver, LCSW 149015206, Illinois, BCBS, UHC, Aetna, Cigna).*
- *UnitedHealthcare/Optum has unilaterally put into place a different standard of care that forces providers to use 45-minute billing codes instead of 60-minute codes which are the standard with other payers. This results in certain clients having shorter sessions for the same copay than other insurance companies (Jacob Hogan, LCSW 149021212, Illinois).*
- *CA United/Optum - I have never been audited when I use the lower-paying 45 minute CPT code but I frequently get audited when I use the higher paying 53 minute code. I do longer sessions with all my clients, but sometimes choose the lower paying code with United/Optum clients just to avoid the audit hassles (Robin Furner, CA MFT 44794, California, Beacon/Carelon; Magellan).*
- *Any time I attempted to use 90837 with BCBS, the case would get reviewed; it seemed predatory, and designed to discourage me from billing for the service I actually rendered. Like most other providers I know, I moved to billing 90834, even though the service I was rendering was a 60-minute session rather than a 45-minute one. Every time I saw a patient twice a week--for example, because they had borderline personality disorder and benefited from more frequent outpatient treatment to stave off hospitalizations and do the difficult work of changing their personality structure--the case would be reviewed. Mainly, they were denied. The logic of these denials was Kafka-esque. If I saw the patient twice a week, the reviewer would conclude that they were either A. not sick enough for this, and decide to only reimburse for once weekly, or B. that they were too sick for outpatient, and relentlessly question why I was not moving them up to a higher level of care. To my knowledge, I never had a case reviewed by a mental health provider; they were always generalist nurses or physicians with no specialized knowledge of mental health treatment or current evidence-based practices; when I tried to provide them with academic studies attesting to the efficacy of my approach, they were ignored, even as they demanded "evidence-based practice." Memorably, in one case, the reviewer was a semi-retired general practitioner who knew absolutely nothing about the treatment of borderline personality disorder, my specialty, and denied my twice weekly treatment on grounds that made no sense, even after I demonstrated that my approach was evidence-based (Carter J Carter, MA LICSW 119527, Massachusetts, BCBS).*

Multiple same-day service exclusions

- *BCBS (Illinois). Unlike other healthcare services, for example, physical therapy, BCBS won't pay for more than one mental health service (e.g., individual therapy 90837 and group therapy 90853) on the same day without unique documentation for each encounter every time there are multiple services performed the same day. I contacted BCBS about the issue and they wouldn't advise on CPT codes or modifiers. However, even when using the correct codes and modifiers, each encounter requires unique documentation. When we have submitted claims with two same-day services, BCBS only pays for the service that costs less (Lisa Lipscomb, Illinois, BCBS).*
- *"Multiple same-day services not covered or only partially covered (e.g., individual and group therapy performed the same day and only 1 service is covered)." This is a serious issue in my program. We treat severe mental illness in a wrap-around program: we offer groups, case management, therapy, and psychiatry. Patients are frequently hospitalized and discharged, requiring appts with their psychiatrist within 5 days. This billing issue always creates problems because then patients either have to miss group or individual therapy, or we have to forgo billing for one of these services, which ultimately harms our capacity to build out the program further. In general this rule limits how comprehensive and ambitious of a program we can be (Daniel Hoffman, LCSW 095046, New York, multiple medicaid managed care plans).*
- *It is a regular occurrence that when a patient has a psychiatry appointment and a therapy session scheduled on the same day, whichever is billed last will be denied. I now warn patients that they cannot schedule both appointments on the same day and be assured that the claims will both be paid (JoAnn Brown, LCSW IL 149010958, Illinois, BCBS).*
- *CPT codes for family and individual therapy not being covered on the same day caused significant problems scheduling family sessions when I worked in a hospital DBT program for teens. Many families cannot schedule two separate sessions a week and being able to do them back-to-back would increase family involvement and accessibility of treatment (Kiera Boyle-Toledo, MD 07049, Maryland, Kaiser Permanente).*
- *Family and individual therapy provided on the same day, with a modifier 59 on the individual therapy line are no longer being paid by BCBS (Alysa Slay, 071-004845, Illinois, BCBS).*
- *Illinois - We cannot bill a group session on the same day as an individual therapy session. We cannot bill a psychiatry visit on the same day as a therapy session. This is inconvenient for the patient to have to come back to our center on multiple days just because of insurance limitations (Brianne and Michael Clatch, Clinical Psychologists, Illinois, UHC).*
- *South Carolina, Humana. Saw a client who was in crisis. Assessed and sent to inpatient psychiatric hospital, further assessed and admitted that same day. I submitted CPT code 90839. I was denied payment as considered a duplication of services. I guess the hospital filed before me. I've refiled with 90837 which is not accurate and lower reimbursement rate. Waiting on outcome (Christine Dowling, Social Work SC6852, South Carolina, EBMS - third party administrator for Cigna, Humana).*

Authorization, Audits & Reviews

- *While in network repeated utilization reviews were conducted with no understanding of patients needing long term treatment (Betsy Spanbock, NY State Social Work R078596-1, New York, BCBS).*
- *I had to appeal and then appeal again to Kaiser (this process took over a month) before they would cover out of network for the therapist I found. The first time, they sent me the same providers I had already called. So in the 2nd appeal, I had to outline all of the barriers they facilitated (Alyssa Wermers, CSW.09923857, Colorado, Kaiser).*
- *Regarding a patient with dissociative identity disorder and PTSD diagnoses whom I see 2 times per week -- he has United Health Care. This insurance company (which I am in network with) has responded to my submitted claims with 1) multiple treatment reviews (which I've never had for any other patient); 2) claim denials accompanied by requests for more documentation; 3) once I submit the requested documentation, on two occasions the "appeal" was denied because of a technicality, ie an apparently new rule about documentation that I was not aware of but that is buried in their information for providers. (In those cases, there is nothing about the content of the note itself that was "wrong", it was the way I indicated the date or the place of service.) At that point, there was no way to submit a further appeal, so I simply was not reimbursed for my services (Libby Bachhuber, LCSW Illinois 149.016084, Illinois, UHC).*
- *Burdensome reviews were a constant feature of my time on the BCBS panel. It was clear to me that they reviewed any case of mine that exceeded once weekly 90834. This seemed designed to discourage me for billing anything other than that. The reviews were time-consuming in the extreme, requiring me to spend hours on hold, hours during which I was not being paid. The result is that they made it so much more expensive (i.e. via hours of unpaid admin work) to do anything besides once weekly 90834 that I was really discouraged from making choices that were better for patient care, such as seeing patients with severe personality disorders more frequently and for slightly longer sessions (Carter J Carter, MA LICSW 119527, Massachusetts, BCBS).*
- *Denials of appeals, which may entail entire records of 40+ pages for long term patients or complex cases, are automatic without explanation. The statement that you can appeal the appeal denial is useless because there is no indication of reason for denial. Most patients give up. More \$ for insurance companies. Let me add parenthetically that my 92 year old husband was denied long term care coverage for which we had paid in for 25+ years. Appeal made to an "outside consultant" who never saw or spoke to him but confirmed the denial without explanation. Our PC physician wrote forcefully about the 12 conditions for which he is being treated now and her 20 year relationship with him during which these developed. VOILA, the denial was reversed. Point being: the outside consultant was a sham Judith Rosenberger, MA. PY-PR (psychology provider) 2038, Massachusetts.*
- *Illinois We do not receive EOB/responses for claims submitted to BCBS HMO (OON clients) (Alysa Slay, 071-004845, Illinois, BCBS HMO).*
- *I have had a client whose insurance is BCBS but it is administered by a union. The union has required multiple reviews where the client and therapist felt intruded upon in order to "justify" "giving" more sessions under "medical necessity reviews." This created much administrative work for the therapist and*

financial precariousness for the patient and the therapist, increasing everyone's anxiety and frustration while the patient was being treated for an anxiety disorder (John Garver, LCSW 149015206, Illinois, BCBS).

Telehealth

- *CA Beacon/Carelon - I have concerns about their continued policy of covering telehealth co-pays while not covering co-pays for in-person appts. This policy made sense at the start of the pandemic, but not now. Clients with significant mental health symptoms are preferring telehealth appointments just to save money. Clinically, in-person sessions are superior, especially when symptoms become more acute (Robin Furner, CA MFT 44794, California, Beacon/Carelon; Magellan).*
- *Kaiser - They are continuing to do IOP programs via telehealth for clients with serious mental illness and/or serious addiction. There is no reason for this in 2023 and I strongly believe that clients with more severe mental health and/or addiction symptoms will get much better quality care with in-person mental health services (Robin Furner, CA MFT 44794, California, Beacon/Carelon; Magellan).*
- *In 2023 (in Arizona) I requested an 'out of panel' agreement from AZ-BCBS for a former client to work with me. They sent a letter indicating they approved this. As I began submitting claims I was never reimbursed, and took "twenty five hours of my own time" to navigate their system. I learned that "if you submit a claim with an error on it, or with a duplicate previously filed claim, we are instructed to shred it." I encountered dozens of support employees who knew little to nothing about how their system worked. I was told that "after COVID only telehealth through our own network is compensated, but they didn't tell the support employees or the providers." I sent dozens of emails that were unanswered. I had to file a formal grievance and submit evidence that I had actually seen their member. Because of the wide-spread nature of their multiple failures, and their remarkably poor telephone support tree, I came to assume that this is a deliberate business model that successfully constrains pay-outs for clinician's work (Carlton F. Clark, LCSW-0011, Arizona, BCBS).*

CONCLUSION

We have included citations of supporting research, including direct links to the research. We direct the Departments to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If the Departments are not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for the opportunity to comment on this important issue. If you have further questions or would like documentation of the examples provided, please contact Janice Muhr, PhD, at Psychotherapy Action Network, jrmuhr@psian.org.

Sincerely,

Psychotherapy Action Network (PsiAN)

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