From: Brooke Halliday
To: EBSA MHPAEA Request for Comments
Subject: Comments on MHPAEA
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Hello

I am attaching parts of a blog post I wrote that addresses some of the questions that were called for comment on.

Many of the questions the government is looking for answers on are related to how many providers should be permitted to join insurance networks and how many providers are needed for a given area. Just for a little context, right now many mental health providers (since that's what I can speak to) are being denied access to joining insurance company networks (being in network with an insurance company means that subscribers can use their insurance benefits that they pay for to see those providers) due to there being "too many providers" in a specific area. To put it bluntly, insurance companies are getting free range to decide what the need is as far as the number of providers for a certain population area (eg: 1 provider to every 100 people). My question for insurance companies and the government is this: *With the technology we have, which increases access to services for people, regardless of their physical location, why are we determining things based on geographical location?* With the effective delivery of therapy virtually in this day and age we can provide quality care to anyone, anywhere. It should be mentioned too that right now, therapists are only able to practice in states in which they are licensed due to licensing boards. But that is a whole separate issue we won't be going into today. Physical location no longer feels relevant if we are ACTUALLY trying to do something about increasing access to services and working towards a resolution of the **mental health crisis** everyone is talking about in this country. In small communities, the odds of having a provider in the town or even within a reasonable driving distance are slim. Not to mention, if a provider lives and works within a small town, it increases the likelihood that a dual relationship which will be formed (which are frowned upon in the mental health world) and decreases clients privacy.

To complicate things further (for those who are not in this field), many providers get in-network with insurance companies when they are working for a bigger organization or larger group practices. When they leave these jobs however, they remain "in network" because the employer they worked for is still in-network. As a result, insurance companies still count these providers as part of their network, even if they are no longer providing services. This of course skews the number of providers that appear in-network and able to serve those in need, making insurance companies believe there are more providers and greater access than their are in reality. Insurance companies are not looking to see which providers are actively submitting claims and serving those in their network. If we can just look at the number of subscribers to an insurance plan and base the number of MH/SUD providers off the total number of people who may one day need support, we are then proactively treating our citizens. It seems simple enough to me when we think of people, rather than profit first.

Which leads me to the next complicating factor with insurance company being able to determine the appropriate therapist to client ratio. When insurance companies are allowed to determine this ratio, they are essentially dictating how much therapists should be working. Most therapists that I know have to base how many clients they see a week off of their financial needs due to the (in my opinion) low payouts from insurance companies to therapists for their services. Amongst the therapists that I have communicated with, most say that if they weren't concerned about their finances, seeing somewhere between 15-20

clients a week (doing 1 hour long sessions) feels sustainable. Keep in mind that therapists are ONLY paid for the time they are sitting face to face with a client even though they have many other obligations such as paperwork, continuing education, coordinating care, etc. But how does this actually look when you lay out the numbers? Let's see. All therapists practice differently and each client has a different treatment plan that best fits their unique situation, but for the sake of this discussion, let's say that a therapist recommends someone to come in every two weeks. Let's use the number of 15 clients a week (because we want QUALITY mental health professionals) times two, so that we are filling a full schedule for two weeks. Thirty. In this scenario, the ratio should be 1 therapist for 30 clients/insurance subscribers. While I may not know what ratio insurance companies are using (because they certainly don't actually TELL providers anything), I would bet BIG money that their ratio is not 30:1.

I want to stop and address for a moment all of the people who look at 15-20 client hours a week and have a negative reaction to that. "Therapists have it easy. They just sit and talk to people." "I work 60 hours at my job!" On and on, I feel like I've heard it all. In this situation we are only looking at client contact hours because that is the only thing that insurance companies pay for. In addition to those 15-20 client hours therapists are writing notes (required by insurance companies), doing treatment plans, connecting with other providers to coordinate care, finding resources for clients, furthering their education, etc. Not only that, those 15-20 hours a week that a therapist is being paid are times where the therapist is required to be 100% focused and dialed in. Engaging in active listening. Remembering the details of a clients life. Integrating their knowledge of humans and psychology with the nuances of each individual client's situation. This is not 15-20 hours of mindlessly sitting at a desk or walking a job site. This is intentional, skilled, and focused work. To keep it in perspective, imagine going into a meeting at work and being unable to zone out because you have to provide a summary after so that someone else can determine if you listened and understood well enough to actually get paid for your time. Now do that 14-19 more times over the course of your week. It's no walk in the park and not as easy as people want to believe it is. Sitting with people through some of the worst moments of their life without turning off your own humanity is not for the faint of heart. If you are still someone that thinks they could do that for 20 hours a week, I challenge you to notice how many times you check your phone during your work day. Or get up and go to the bathroom whenever you please. Or simply get lost in your own thoughts or problems. We therapists don't have those luxuries when we are working.

The next set of questions the government is looking for answer to are the appropriate cost of MH/SUD treatment compared with other types of medical treatment. In my opinion, MH/SUD treatment should be treated/paid similarly to physical therapists, occupational therapists, and chiropractors. Typically, people don't seek out these type of providers until there is a problem. Then, when the problem is resolved or better managed, there is maintenance care that is helpful for preventing relapse. While all of the providers listed use different CPT codes and bill for services differently, if we looked at the average dollar amount billed for any given hour these professionals work, we would better be able to determine what more equal pay would be for those in the MH/SUD field. I'm sure that someone would like to make the argument that physical therapists, chiropractors, etc. are technically "doctors" and therefore should be paid more than masters level therapists. So I will say this, my husband, who is a chiropractor, has about one trimester more of education than I do as a mental health counselor. For some perspective, for me to obtain a doctorate degree (which would then allow me to be called a doctor) I would need to go to school for somewhere between 4-7 MORE years depending on the program. We need to be looking at the amount of education a professional has, not their title, which can be very deceiving. If we are going to treat mental health as the same priority as physical health, we need to determine an average that each professional, based on their education, can earn in an hour and make some decisions from there.

While not asked about this in their call for comment, another power that insurance companies wield over MH/SUD providers that the government (and society as a whole) should acknowledge is the insurance companies ability to clawback previous payments to providers. What this means is that anytime within three years after a service is provided, insurance companies can decide that they overpaid or that there was some other issue and take back their original payments to providers. That means, at any time the insurance company may decide, providers can be saddled with a large bill without any warning. Providers are then responsible for repaying the insurance company, retracting what could be a very substantial part of their income with no way to compensate for it. While some providers may try to pass off this repayment off to clients, often times clients don't remain in therapy for three years so tracking them down for

payment years after the fact is often fruitless.

Lastly, while I know it is typically required of all types of service providers, the need for approved diagnoses to get treatment paid for is maddening. To be frank, life is really hard sometimes. That doesn't mean that someone is mentally ill or is a good match for a mental health diagnosis. For example, divorce or other major life change is an excellent reason to seek out therapy. And while the individual may have some symptoms present associated with the change, providers are then required to pathologize the individual seeking help, even though their reaction might be how we would anticipate any human to react. We are required to give someone a label, just so that the insurance that clients already pay for monthly, will cover mental health services. Insurance companies want only people who meet criteria for things like major depressive disorder, generalized anxiety, or PTSD to be able to get help. They aren't interested in helping someone deal with their grief after a significant loss or the parent looking for ways to manage their own stress while raising children. They do this to try and limit the people who can get mental health care while also continuing to perpetuate mental health stigma that so many people say they want to break.

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