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Support

My name is Courtney Bergan. I am a graduate student at the University of Maryland School of Social Work. I also have a professional background in neuroscience research, having co-authored several publications on neuropsychiatric disorders.

I am here to voice my support for senate bill 484, which protects consumers from incurring high out of pocket costs when their insurer fails to provide access to appropriate in-network behavioral health services.

My insurance carrier does not have an adequate behavioral health provider network; therefore, I have been unable to access appropriate in-network care for my mental health condition. I have now encountered this situation with two different private health insurers in the state, just within the past year. I struggle with a complex mental health condition that requires treatment from a provider who has specialized training and experience in treating my condition, much like complicated medical conditions that require care from a specific specialist or subspecialist. Unfortunately, few providers possess this expertise, and even fewer take insurance as a result of reimbursement rates that are not commensurate with the complexity of the care required for the effective treatment of my condition.

Last year I spent four months contacting more than 60 providers of varying credentials, desperately trying to locate a provider within the CareFirst network who had the availability, willingness, and expertise necessary to assume my care. I even utilized CareFirst's Intake and Assessment service to attempt to locate a provider, however, CareFirst admitted to "exhausting their list" of in-network providers and advised me to seek care utilizing my out-of-network benefits.

Since I was unable to obtain in-network care, I began seeing a non-contracted specialist who agreed to request a single case agreement with my insurer. Within hours of initiating this request, CareFirst denied it because they then authorized me to see my psychologist at my in-network cost-sharing, making a single case agreement "unnecessary." Under this authorization, CareFirst refused to negotiate a reimbursement rate with my provider, offering my provider a rate that was less than the Medicare reimbursement for the service and wouldn't even approximate her costs for providing my care. When my provider expressed concern about the reimbursement rate, she was instructed by CareFirst that she should just balance bill me the remainder of her fee. Utilizing this authorization would ultimately have cost me more than if I were to have utilized my out-of-network benefits to obtain that same care. Under either scenario, obtaining appropriate mental health care would have been well beyond my means, despite having adequate insurance coverage. After providing testimony before this committee

on a similar bill last year, CareFirst finally approved the single case agreement that had initially been requested nearly two months earlier. Under the terms of the single case agreement, CareFirst agreed to negotiate a fair reimbursement rate with my provider, so the service was only subject to my in-network copay.

However, any relief I received following CareFirst's approval of my single case agreement was short-lived, as I was notified by my school last June that our student health insurance coverage would be changing to United Healthcare, causing me to lose the single case agreement I fought so hard to obtain. Prior to the commencement of my coverage with United Healthcare, I contacted the broker for the plan to request assistance in negotiating a single case agreement with United Healthcare and my current psychologist, as well as to request assistance in locating a psychiatrist on the plan. Since I could not access appropriate outpatient mental health care and I couldn't even locate a psychiatrist who would oversee the prescribing of my medications, I ended up spending four months in the hospital until my insurer agreed to cover appropriate outpatient care that was only available outside of their provider network.

As a result of this delay in agreeing to pay for appropriate outpatient care, I will now be graduating from my MSW program a year later than scheduled. Not only that, the delay in providing me access to appropriate outpatient care posed additional costs to Maryland taxpayers, since Maryland Medical Assistance is my secondary insurer, and Medical Assistance ended up paying the hospital costs that were not covered by my primary insurer. Neither I nor the state should be paying for my insurers' failure to comply with state law.

Insurers need to be held accountable when they fail to comply with the network adequacy regulations defined under state law. While I recognize that legislators and regulators are working with carriers to expand their networks, based on the past 2 years of network adequacy reports, no insurer has demonstrated compliance with the network adequacy regulations. Consumers can't wait for their insurers to comply with state law. Without immediate protections for consumers who are forced to utilize non-contracted behavioral health providers due to inadequate insurance networks, carriers have no incentive to expand their networks or take network adequacy exceptions seriously. Carriers can simply tell providers to balance bill their patients if they aren't happy with the reimbursement rate offered by the insurer, shifting insurance carriers' financial responsibility onto patients. Fining insurers for failing to meet network adequacy standards won't solve this problem, as it does nothing to ease consumers' urgent needs to access behavioral health services. We need to ensure consumers are provided affordable access to the behavioral health services they are paying for and are entitled to receive through their insurance coverage.

I strongly support senate bill 484, so consumers aren't paying for their insurers' failure to provide adequate behavioral health networks.

Encl: Media coverage of my story: *Bloomberg Businessweek.* "As Suicides Rise, Insurers Find Ways to Deny Mental Health Coverage."

Bloomberg Businessweek

As Suicides Rise, Insurers Find Ways to Deny Mental Health Coverage

Red tape and a lack of in-network providers frustrate those seeking treatment.

By
Cynthia Koons
and
John Tozzi

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The U.S. is in the midst of a mental health crisis. In 2017, 47,000 Americans died by suicide and 70,000 from drug overdoses. And 17.3 million adults suffered at least one major depressive episode. The Mental Health Parity and Addiction Equity Act, a landmark law passed more than a decade ago, requires insurers to provide comparable coverage for mental health and medical treatments. Even so, insurers are denying

claims, limiting coverage, and finding other ways to avoid complying with the law.

Americans are taking to the courts to address what they see as an intrinsic unfairness. DeeDee Tillitt joined one lawsuit in 2016, months after she lost her son Max. He'd been an inpatient for three weeks at a treatment center to recover from a heroin addiction and seemed to be making progress. His addiction specialist wanted him to stay. United Behavioral Health, a unit of UnitedHealth Group, the nation's largest insurer, declined to cover a longer stay for Max. Reluctantly, his family brought him home. Ten weeks later, Max was dead of an overdose. He was 21.

DeeDee Tillitt and her son Max, who died of a drug overdose 10 weeks after leaving a treatment center when his insurer declined to cover a longer stay.

COURTESY: DEEDEE TILLITT

Tillitt soon discovered that Max's death wasn't an isolated tragedy. Across the country, people who need mental health and addiction treatment encounter roadblocks to care that could save their lives. United Behavioral Health was already the target of a class action alleging that it improperly denied coverage for such treatment. UnitedHealth's headquarters is in the

Minneapolis suburbs, not far from where Tillitt lived. She says she spent hours on the phone getting passed from one rep to another in her quest to find Max care the insurer would cover. “I felt like, God, could I just drive down to the lobby and scream at them?’ ” she says.

Tillitt became part of the suit against the company in February 2016. In March of this year, a judge found United Behavioral Health liable for breaching fiduciary duty and denying benefits, saying the insurer considered its bottom line “as much or more” than the well-being of its members in developing coverage guidelines. United Behavioral Health says it’s changed its guidelines and that “our policies have and will continue to meet all regulations.” In May the company asked the court to decertify the class, which would mean only the named plaintiffs would be eligible for remedies.

Failures of the mental health system contributed to trends that have lowered U.S. life expectancy over the past three years. From 2008, when Congress passed the parity act, to 2016, the rate at which Americans died by suicide increased 16%. The rate of fatal overdoses jumped 66% in the same period. “The health insurers are not following the federal law requiring parity in the reimbursement for mental health and addiction,” President Trump’s commission on the opioid crisis wrote in its report in November 2017. “They must be held responsible.”

• The Lawmaker

Patrick Kennedy, a former Rhode Island congressman, was the force behind the parity law. In the early hours of May 4, 2006, he crashed his car on Capitol Hill. In a press conference the next day, Kennedy disclosed lifelong trouble with depression and addiction and announced he was going to rehab. Two years later he helped push through legislation to strengthen access to mental health care.

Kennedy helped push the parity act through Congress in 2008, two years after pleading guilty to a DUI.
PHOTOGRAPHER: CHRISTOPHER LEAMAN FOR BLOOMBERG BUSINESSWEEK

The law was problematic from the start. Passed in the midst of the 2008 financial crisis, the parity act was tacked onto the emergency bill that bailed out the U.S.'s failing banks. "We didn't pass the mental health parity legislation because there was this big public outcry, because we had this great march on the mall and we had 100,000 people show up," Kennedy says. "The good news is that we got it passed. The bad news is no one

knew that we got it passed because the underlying bill was secondary to the fact that we were facing a potential Great Depression." Kennedy now works on several initiatives to improve compliance with the law.

In 2010 the Affordable Care Act became law, mandating that commercial health insurance plans offer mental health benefits. Combined with the parity act, federal law appeared to guarantee that Americans would have access to mental health services like never before. And there are signs the laws have helped. A federal report published in February 2019 concluded that the law increased the use of outpatient addiction treatment services and, for those already getting mental health care, the frequency of their visits.

• Ghost Networks

Insurers fought the requirements from the start. The industry formed a group called the Coalition for Parity that sued to block the regulations to implement the law, saying they would be unduly burdensome. A judge dismissed the challenge.

In the years since, health insurance companies have eliminated many of the explicit policies that violate the law. Benefit plans can no longer set higher out-of-pocket limits on mental health care than on medical care, for example. But patients and their families say insurers use more subtle methods to stint on treatment. Their directories of providers are

padded with clinicians who don't take new patients or are no longer in an insurer's coverage network. They request piles of paperwork before approving treatment. They pay mental health clinicians less than other medical professionals for similar services.

"I found a great number of their providers were no longer practicing, or were dead"

Patients frequently complain of "ghost networks"—insurance directories full of clinicians listed as in-network who aren't contracted with the plan. Brian Dixon, a Fort Worth child psychiatrist, no longer accepts insurance. But Blue Cross and Blue Shield of Texas' directory indicates he's still part of the network. He says he regularly has to tell patients who call his office that he won't take their coverage. "It'll look like they have all these psychiatrists," Dixon says of the network, "but they actually don't." The insurer says it updates its directory based on information received from physicians.

Some practitioners who want to join networks are turned away. Melissa Davies, a psychologist in Defiance County, Ohio, was part of Anthem's network for years when she worked in a larger medical group. But the insurer refused to contract with her after she started a solo practice in 2012, saying the area was saturated, even though Davies is one of only three psychologists

in the county. When Davies examined Anthem's directory, "I found a great number of their providers were no longer practicing, or were dead," she says. Anthem says it works to ensure its network can meet members' needs and is dedicated to adding behavioral health providers.

It all adds up to a wall between people and the help they need, the kind of barrier that would never be tolerated if the illness were diabetes or leukemia. "You have parity coverage on paper," says Angela Kimball, acting chief executive officer of the National Alliance on Mental Illness. "But if you can't find an in-network provider in your coverage, it can become meaningless for you if you can't afford care or find it."

Out of Network, Out of Reach

Data: Milliman, National Alliance on Mental Illness, U.S. Government Accountability Office, Centers for Disease Control and Prevention

• The Advocate

People like Meiram Bendat are trying to hold insurers accountable where government authorities haven't. Bendat, an attorney who originally specialized in child welfare law, decided in the early 2000s to change tack and pursue a doctorate in psychoanalytic science and a master's in clinical psychology. He started seeing patients a few years before the parity law passed. It didn't take long for him to recognize that insurers were denying coverage for patients with persistent mental health

conditions and they might not be in compliance with the parity law.

Bendat's legal practice is dedicated to fighting claims denials for mental health care.
PHOTOGRAPHER: YE RIN MOK FOR BLOOMBERG BUSINESSWEEK

Bendat returned to the legal profession and opened his practice, Psych-Appeal, in Los Angeles. It's dedicated solely to fighting denials of mental health coverage. Because his office is "inundated" with calls, he says, he tries to build class action

suits. Bendat was one of the lead attorneys in the case against United Behavioral Health in which Tillitt participated.

Still, winning legal cases does only so much to change industry practices. The United Behavioral Health suit, for example, won't result in punitive damages for the insurer, because it was brought under a labor law, ERISA, which doesn't allow them. "Basically, there's an incentive for managed-care companies to do the wrong thing, because they know that at the end of the day they don't stand to be punished monetarily," Bendat says.

A 2017 report from Milliman Inc., a consulting firm, found that patients were going out-of-network for behavioral health care significantly more often than for medical and surgical care, which typically means they're paying more. It also found behavioral health providers got lower reimbursements than medical providers—primary care medical doctors made 20% more for a basic office visit, for example, than psychiatrists did.

"I'm so tired of staying silent about this stuff and not speaking out because of the stigma that exists around mental illness"

Higher reimbursements would lead to better access for patients, says Sam Salganik, executive director of the Rhode Island Parent Information Network, which fields parity

complaints on behalf of the state. Because patients can't find providers who take their insurance, many believe they must pay privately for mental health care. That would be unacceptable if that were the case with other health-care services, Salganik says. "Consumers on average are reluctant to go to an out-of-network cardiologist," he says, "and I think that's largely because there's a robust network of in-network cardiologists."

Kate Berry, senior vice president of clinical affairs at America's Health Insurance Plans, a trade group, says a shortage of mental health clinicians and lack of reliable ways to measure quality contribute to the problem. "Our members work very hard day in and day out to ensure there is parity between mental health care and physical health care," she says.

• Absent Enforcers

How can insurers continue to violate the letter and spirit of the law? Partly because the parity act sets ambiguous standards, advocates say, and doesn't have teeth. The federal rules don't say how to measure whether a health plan's network of mental health providers is sufficient, for example, so insurers have discretion over what they deem is an adequate network.

More important, there's no one agency or office responsible for enforcing the rules. The relevant authority may be the U.S. Department of Labor, or the U.S. Department of Health and Human Services, or a state insurance regulator, depending on

the health plan. “It’s hard to define who owns this problem when there’s so many different entities and people responsible for enforcement,” says Lindsey Vuolo, associate director of health law and policy at the nonprofit Center on Addiction.

The Labor Department oversees health plans sponsored by employers, which cover 156 million people. But it’s authorized to act only against specific plans sponsored by particular employers, not against a health insurer that may provide similar benefit plans for hundreds or thousands of companies. Secretary of Labor Alex Acosta told the opioid commission that “he needs the ability to fine violators and to individually investigate insurers, not just employers,” according to the commission’s report. When the department does punish companies for violating the parity law, it doesn’t publicly disclose which companies or insurers aren’t providing adequate coverage. The department didn’t respond to requests for comment.

At the state level, enforcement varies widely, and rarely leads to large financial penalties. In California, with relatively active regulators, the biggest fine over access to mental health care was a $4 million penalty for Kaiser Permanente in 2013. A Kaiser spokesman said the citations didn’t constitute parity violations and the plan wasn’t limiting mental health visits inappropriately.

Aetna, now a unit of CVS Health Corp., settled with the Massachusetts attorney general in December over allegations of

inaccurate network directories and agreed to improve information for consumers. An Aetna spokesman says the company had already fixed one of the issues raised by the attorney general and is moving to "give our members better access to the correct contact information" of in-network clinicians.

In 2015, New York's attorney general settled with Beacon Health Options over allegations of wrongful denials of mental health and substance abuse claims. The company neither admitted nor denied wrongdoing. A spokeswoman says Beacon relies on evidence-based criteria to determine coverage "regardless of cost."

Insurance regulators in Florida, Indiana, and Nevada haven't taken any enforcement actions against insurers over federal parity laws, according to spokespeople.

● The Determined Patient

Courtney Bergan first entered the mental health system when she was in high school after her primary care physician discovered she was cutting herself. She's been through an array of institutions, from a wilderness high school to psychiatric wards and specialist rehab in the quest to find adequate treatment for issues including complex trauma, an eating disorder, and suicidal thoughts.

Bergan struggled to find a provider who would see her at rates she could afford.
PHOTOGRAPHER: CHRISTOPHER LEAMAN FOR BLOOMBERG BUSINESSWEEK

Bergan studied neuroscience, behavior, and biostatistics in college and landed a job at Massachusetts General Hospital doing neuroimaging research for chronic pain disorders. Her insurance was sufficient to cover therapists and hospital stays as needed. She moved to Baltimore in January, in part because she learned that Maryland had better treatment options for her and in part to pursue a dual degree in social work and law at the University of Maryland.

As a student she was eligible to enroll in an insurance plan run by CareFirst. In preparation for the move, she started calling

mental health providers. She contacted more than 50, both in and out of the CareFirst network, before finding one who would agree to see her—and to apply for what's known as a "single-case agreement" to cover her out-of-network at in-network rates. CareFirst denied the single-case agreement the same day Bergan's provider requested it.

Under a Maryland network adequacy law that went into effect at the start of the year, if an insurer can't offer a patient a provider within 10 days and within 10 miles of his or her home in an urban area, it's required to cover an out-of-network provider at an in-network price—but the provider can bill the patient for the difference. In Bergan's case, that meant she was going to have to pay $92 a session out-of-pocket, and she needed to be seen twice a week.

That was still more than she could afford. She reached out to the Mental Health Association of Maryland, which asked her if she'd be willing to testify at a state senate hearing on legislation to lower the out-of-pocket burden for patients like herself. She said she was. The day after her appearance at the state capitol, she was notified that CareFirst had approved her single-case agreement, under which she'll pay $25 a session, for three months. It's just been renewed for six months. CareFirst doesn't dispute her account, but says her testimony didn't influence its decision.

"I'm so tired of staying silent about this stuff and not speaking out because of the stigma that exists around mental

illness," Bergan says. "At every point on the way, I've done what my providers have told me to do, I've followed through on treatments, I've sacrificed. When I go to file my taxes, I realize that 50% of my income is spent on medical expenses. I haven't taken a vacation in my adult life because all of my income is going to my treatment. I shouldn't be ashamed of that. I'm doing what I'm supposed to be doing. It needs to change."

If you or someone you know is having suicidal thoughts, The National Suicide Prevention Lifeline is: 1 (800) 273-8255