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Testimony of Jennifer B. Warkentin, Ph.D.

In support of H. 1078 and S. 589, An Act to limit retroactive denials of health insurance claims for mental health and substance abuse services

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The Massachusetts Psychological Association (MPA) strongly supports H.1078 and S.589, *An Act to limit retroactive denials of health insurance claims for mental health and substance abuse services.* Ensuring access to timely quality behavioral health services is an important factor in improving patient care and decreasing overall healthcare costs. However, it is common practice for health plans in Massachusetts to carve out the management of those services to for-profit corporations- a practice that is not found in any other healthcare specialty. These for-profit companies tend to employ predatory and unfair business practices to increase the company's profits, and one of the consequences is that behavioral health providers have the lowest rates of participation in health plan networks. The Attorney General's 2015 Report on Healthcare Cost Trends Analysis highlighted these issues as well, noting that the way in which behavioral health services are managed directly undermines access, and undercuts attempts to decease overall healthcare expenditures. The unfair business practice of retracting funds, often referred to as "clawbacks," plays a large role in providers leaving networks because it creates a constant threat to a provider's financial security.

The relationship between these managed behavioral health corporations and behavioral health providers is inherently unequal. These health plans typically require providers to submit claims for all services within 60 or 90 days, and refuse to pay any claims submitted after that time period, regardless of the reason for late submission. In contrast, there is no limitation on when health plans can retract payments for claims, even if several years have passed since the service was provided, and or for reasons that had nothing to do with fraud or mistakes by the provider. In my work as the Director of Professional Affairs for MPA, I am often contacted by psychologists who have experienced a retraction of payments due to the corporation's mistake of paying for certain services that the corporation later learns they were not in fact responsible for. These corporations can conduct audits of their records at any time and look for any instance when another plan should have been the primary payer, and retract those funds. Essentially, the corporation verified coverage for a member at the time of service and only later discovered that it was a mistake. To retract those funds from a provider, who verified coverage at the time of service and who has no way of accessing the necessary information to discover such a mistake, is a classic example of unfair business practices. I am also aware that some corporations have retracted funds due to instituting policy changes that are retroactively applied to services already rendered. Again, in this situation the provider has done his or her due diligence and followed the corporation's policies at the time of service, but the money is still retracted.

For the vast majority of these retractions, it is too late to then submit claims to the health plan deemed responsible, if that was the issue. If a provider tries to bill the member for the amount that was retracted, assuming they can find the person, that member understandably becomes angry and frustrated, and potentially more distrusting of healthcare providers. As such, providers have little to no recourse to challenge the retraction, so most have little choice but to accept the financial loss. Furthermore, instead of sending a bill to the provider for the retraction, many corporations simply deduct the amount owed from whatever current claims are being paid out to the provider for clients unrelated to the retraction. So with little to no notice or warning, a provider will stop receiving payment for the services they are currently rendering, for however long it takes to pay back the retraction. The result of this practice is that providers experience a constant threat to the financial viability of their practice, and there is no way for them to control when or if such retractions take place.

This practice is devastating to behavioral health providers who, as the Attorney General's report describes, are already paid at "historically low" rates. Providers often find themselves forced to choose between preserving the viability of their business and their desire to offer services to all members covered by health plans in Massachusetts. The constant fear of a retraction also takes its toll over time and leads many providers to leave health plan networks, especially since they have no way of preventing or anticipating these situations. It is no wonder that the best trained behavioral health providers refuse to participate in health plan networks more than any other health specialty, and psychologists are leaving the healthcare system at alarmingly high rates. These practices, and the resulting impact on providers, highlight the reality that there is nowhere else in all of the healthcare system in which specialists refuse to participate in health plan networks more than behavioral health. Thus, these business practices undermine access to appropriate behavioral health services for fully insured consumers, as the Attorney General's report describes, and thus undermine access to services that could help reduce overall healthcare expenditures in many cases.

House bill 1078 and Senate bill 589 will not prevent health plans from retracting funds in a timely manner. They will not prevent health plans from retracting payment for fraudulent billing, nor will they prevent them from retracting claims by seeking judicial intervention if there is legal cause. These bills will simply set a 12 month limit on how long health plans have to retract these funds paid to providers in cases other than fraud or other legitimate legal actions. Even this 12 month limit is still 4-6 times longer than the typical 60 to 90 day limit providers have to submit claims.

To help fully insured consumers have fair access to behavioral health services by having a sufficient number of providers in their health plan's network, we urge you to move favorably on House 1078 and Senate 589, An Act to limit retroactive denials for mental health and substance abuse services.

Respectfully,
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