From: [redacted]
To: EBSA MHPAEA Request for Comments
Subject: Comment for Mental Health Parity Act
Date: Wednesday, July 26, 2023 4:49:01 PM

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Hello,

In light of comments being open for the parity act, please find my comments below.

- Compensation: I am a licensed clinician in two states. In which, I do not practice in direct care NOR am I on insurance panels providing direct care because of money and livable earnings. My first year as a clinician working full time as an intern, I made 19k in a year of full time client work. That is below the poverty level. Needless to say, as soon as I got my license and could leave direct care - I did. The wages are not liveable, you are a contracted worker who also has to then find their own benefits, and you cannot advocate for higher rates based on experience and expertise. In addition, supervisory rates are extremely high and required for licensure. Why aren't there staffed, salaried supervisors for new clinicians? No money.
- Documentation/Rate: Private pay clinicians charge anywhere from 100-300 per hour. And as a clinician I gladly paid my personal therapist out of pocket (and out of network) because I knew that I wanted to get a clinician that was right for me, and support someone in my field who didn't have to fit in the constraints of insurance requirements and documentation. When you are treating clients with insurance you need to ensure that all the things you are doing are billable - note, assessments, treatment planning. But what is not billable is thinking about the treatment plans, coming up with creative solutions, training, so many other things. The amount of documentation for a client seems more like justification as opposed to truly tracking growth and improvement organically.
- Quality of Care: I believe that since rates are so low, clinicians are spread very thin, clients are not receiving the best care (generally) because a lot of great clinicians leave the field if they don't have someone else to pay their bills. If you have overburdened and underfunded care professionals, it doesn't take much to know that the care provided won't be of the highest quality...
- "Justifying Care": Insurance companies will pay based on their arbitrary requirements. People go to therapy for MANY reasons, and sometimes they just need some support or insight. Not EVERYONE is impaired in their ADLs in a moderate-severe way. If they don't have a clinically significant problem/diagnosis, their care will not be covered by insurance. In addition, sometimes care needs to go longer than the arbitrary 3-6-9 months - and clinicians need to constantly document that their clients are impaired (which wont even guarantee continued approvals OR payment after service). This in itself is a barrier to those struggling with non-clinically significant issues to receive mental health care.
- Employment Environment: Compared to hospitals (which providers are salaried employees) clinicians are contract workers who regularly have to work in multiple clinics to get an appropriate "full" caseload. You regularly work alone, and with minimal to no support within

your working environment it is no surprise that burnout happens at an alarming rate. Not to mention if you're a clinician who has to drive to clients homes to provide sessions - which is an additional liability.
- Caseload: to earn a liveable wage, clinicians have to see upwards of 35 clients. 35 clients which all require separate documentation, planning and coordination. if you were to bill for those 35 hours of client work - let's say you took 10 minutes per client to plan and think of a creative way to help them - this adds up to an additional 5.83 hours a week - totalling to roughly 41 hours. Along with unpaid professional development and training, you can easily work more than 50 hours in a week as a clinician, and your compensation will not add up to the hours worked.
- Continuing Education Requirements: Continuing education is a requirement for the healthcare field - all which have to be paid out of pocket (unless you're one of the lucky FEW that can get it reimbursed). If you want to specialize in a new population or condition - well that will take client (billable) hours away. So you only do what is required, instead of doing what would benefit you and your clients most.
- Utilization Review (UR) Clinicians: In addition to all of this, if you are a clinician that has worked in the field and wants to transition to utilization review - good luck. The field is only available to those who have connections, and insurance companies very readily deny applicants who don't have prior UR experience. I would think someone who has worked in direct care, who has seen clients in a clinical setting, that has technology skills would be able to be employed in utilization review - but these candidates are not the preference.

In closing, insurance companies are taking advantage of clinicians. There is a lack of oversight that is causing clinicians to not want to be on panels (not take insurance), leave the field for better pay and support, clients who are not moderately or severely impaired cannot be provided care (based on insurance), and lack of financial security/livable wage. There are more and more cases of insurance taking back retroactively compensated sessions - and as a clinician I personally won't be on any insurance panels providing direct care until I can be sure that I am adequately compensated, don't have to over-justify why clients need therapy, and will not be at risk of poverty to provide care to the community.

I do hope that this changes in my lifetime. Thank you for your time.

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