

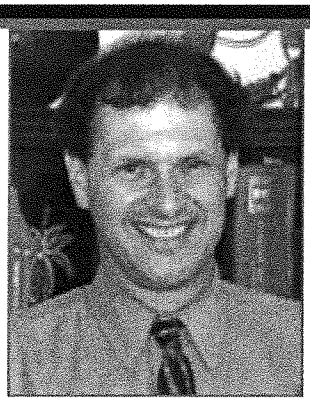
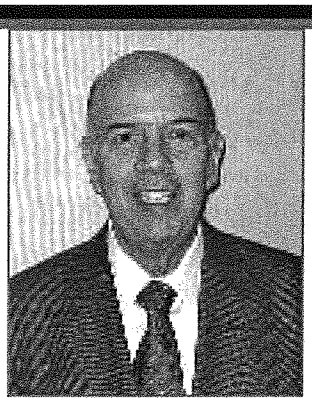

NJPA Harnessing The Power Of The Insurance Complaint Registry: Putting Our Data To Work!

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The focus of the current article is to present a descriptive summary of the qualitative data collected through the NJPA Insurance Complaint Registry (ICR) from 2008 through 2011. The authors also discuss the history and background of NJPA's activism against insurance company abuses, along with providing a summary of the 1998 NJPA article published in *Professional Psychology: Research and Practice* that surveyed NJPA members about insurance abuses.

History & Background of NJPA Activism Against Insurance Company Abuses

The New Jersey Psychological Association (NJPA) has a long and increasingly active commitment to advocacy for the profession of psychology and for the patients (consumers) psychologists serve. Among its most notable advocacy efforts, NJPA has taken a courageous stand against insurance company abuses by pursuing bold legal actions to protect patient privacy and provider autonomy on behalf of our members and all psychologists in New Jersey. In 2009, NJPA filed suit against Horizon Healthcare Services of NJ, Magellan Health Services, its subcontractor, and the State of New Jersey (collectively, "defendants").

The New Jersey State Health Benefits Program (SHBP), covering almost 9% of the state's population, has come under attack by Horizon, Magellan, and the NJ Department of Pensions and Benefits. The plan officially changed on April 1, 2008 and was represented to the unions and public employees as having "no change(s) from the previous plan NJ Plus." This has proved to be untrue.

Until 2008, a public employee had the option to enroll in one of three plans: a traditional plan, a hybrid PPO, and an HMO. Interestingly, 77% of the 830,000 eligible enrollees and their families chose the traditional and hybrid (NJ Plus) plans, with only 23% enrolling in the HMO option. Subsequently, on April 1, 2008, new plans titled "NJ Direct 10" and "Direct 15" were introduced. With the advent of these plans, in addition to traditional case management, extremely aggressive telephonic reviews were instituted, pressuring psychologists to provide extensive, private health information in order to obtain authorization to continue (medically necessary) treatment.

NJPA believed that the defendants routinely violated the New Jersey Psychology Licensing Law that covers patient confidentiality. It is also believed that the defendants violated their own plan documents and the HIPAA Privacy Rule by regularly asking psychologists to release more than the "minimum necessary" information to process claims. The US Department of Health & Human Services was due to amend that provision in August 2010 to let the party releasing the information (in this case, the psychologist rather than the insurers) determine what constitutes the minimum necessary information to release. Unfortunately, to date, no national definition of "minimal necessary" has been provided. However, NJPA believes that provisions in the state psychology licensing law define the minimum necessary information required to process claims, as this has been the standard in NJ since the law passed in 1985.

Horizon/Magellan and the State of NJ declared "war"– on patients' freedom to choose out of network psychologists, on patient privacy, and on minimally necessary information to determine medical necessity–by instituting overly aggressive case management, and telephonic reviews on all plans and all providers. NJPA has been determined to put an end to these abuses. We believe a positive result of our lawsuit could provide a nationwide model for: 1) *how to apply the new HIPAA minimum necessary rule and/or state privacy provisions to the context of health insurers seeking information to determine medical necessity for outpatient mental health treatment;* and 2) *how to resolve the issue of aggressive telephonic interviews and other utilization*

review by insurers that we understand has been a significant problem nationwide since the mental health parity legislation went into effect. Both of these issues significantly affect consumer access to mental health care, as well as limiting psychologist professional autonomy to care for their patients.

In 2007, and prior to the introduction of the new plans, NJPA attempted to negotiate with Horizon, the NJ Department of Treasury, and Magellan, requesting they discontinue this "cost ineffective" case management, and violation of patients' rights to privacy, all to no avail. In fact, these egregious behaviors began to increase in both frequency and aggressiveness. In a final attempt to address these unlawful behaviors, NJPA met with key New Jersey legislators and requested that the state regulatory board, the NJ Board of Psychological Examiners, intervene. The Board chose to recommend that psychologists in NJ obtain their own attorney and follow their attorney's advice with regard to these violations by insurance companies. The legislature that was dealing with New Jersey's severe fiscal crisis at the time and did not appear likely to take on this issue in the foreseeable future.

In a misguided attempt at cost containment, the defendants decided to unduly pressure enrollees to choose in-network providers only. Some of the tactics employed included providing inaccurate information to patients, violating their rights to privacy, and restricting access to out-of-network providers. In an attempt to assess these tactics and their impact, NJPA developed an online "Insurance Complaint Registry (ICR)" allowing providers and consumers to cite and document their experiences regarding these egregious behaviors. There are currently over 200 complaint entries by providers and nearly 100 complaint entries by consumers, each denoting multiple incidences of negative experiences with insurance companies that illustrate how these tactics restrict access, deny necessary care, and withhold approved payments. The current descriptive summary will demonstrate how varied and egregious some of these practices have been. Left with no other choice, NJPA, in consultation with the American Psychological Association Practice Organization (APAPO), outside counsel, and the association's leadership, decided to file suit against Horizon BC/BS of NJ, Magellan (its subcontractor), and the State of New Jersey. In December 2009, NJPA retained Andrew Friedman, Esq. of Bonnett, Fairbourne, Friedman, and Balint, PC of Phoenix, Arizona, to represent the association in this legal matter. In the initial lawsuit filed in 2009, plaintiffs, NJPA and Dr. Barry Helfmann (NJPA Director of Professional Affairs), filed a complaint in NJ state court, in Trenton, against Horizon and Magellan and the State Health Benefits Commission (SHBC), seeking a declaratory judgment that the defendants' practice of conditioning treatment authorization on the disclosure of confidential information and communications between psychologists and their patients, in and of itself, violates the Psychology Licensing Act, as well as forces treating psychologists to violate the Licensing Act by disclosing protected information.

In October 2010, NJPA and Dr. Helfmann filed an amended complaint adding another claim seeking a declaratory judgment that defendants breached the terms of the NJ Direct Plan provisions that provide the defendants will comply with state and federal privacy laws and will only request protected information to the minimum extent necessary to make authorization decisions. Soon after, Horizon/Magellan filed a motion to dismiss the case, arguing that NJPA and Dr. Helfmann did not have standing to bring the suit. Unfortunately, the court agreed with the defendants' claim that the plaintiffs did not have standing to bring the case since neither has a contractual relationship with the defendants, and ultimately issued a ruling dismissing the complaint. The court noted that the issues raised by NJPA's complaint were important, and suggested that a case challenging these practices may be more appropriately brought by patients who have been harmed by Horizon's and Magellan's policies.

NJPA and APA attorneys believed that the opinion rendered by the judge was incorrect because of legal precedent in other instances of professional organizations being found to have standing to bring such suits on behalf of their members. Therefore, NJPA filed an appeal of the Court's dismissal order while simultaneously undertaking to identify patients who had been harmed by Magellan/Horizon's policies and who would be willing to be plaintiffs in a new lawsuit. In May 2011, NJPA decided to withdraw the appeal of the dismissal order and, in July 2011, a new lawsuit was filed in NJ state court, in Newark, with two patients joining NJPA as plaintiffs against Horizon and Magellan. Dr. Helfmann was not included as a plaintiff, and the State of New Jersey was also eliminated as a defendant. This current lawsuit seeks a declaration that Horizon and Magellan, in their administration of the SHBP, have violated the Psychological Licensing Act and inflicted harm on these patients by requiring their treating psychologists to disclose confidential information in order to authorize treatment. Further, the lawsuit seeks a declaration that Horizon and Magellan breached their contracts with these patients by asking for information beyond the "minimum extent necessary" to process the claims. This standard is required by HIPAA, and is promised in the SHBP handbook and contract.

In September 2011, the defendants predictably filed a motion to dismiss the new lawsuit, this time claiming that the new complaint is merely a restating of the previous case that has already been decided, and that NJPA still does not have standing to bring the claims. Further, they asserted that the patients involved did not pursue the administrative remedies available to them (pursuing appeals within the SHBP system). This time, NJPA prevailed. After hearing oral arguments on the defendants' Motion to Dismiss, Judge Harriet F. Klein ruled to deny the motion. In another predicted move, the defendants petitioned the appeals court for permission to appeal Judge Klein's decision. NJPA prevailed again, and the Appellate Division issued

a ruling denying the defendants' request to appeal. In a final attempt to reverse the lower court's ruling against their motion to dismiss the case, Horizon/Magellan petitioned the NJ State Supreme Court; unfortunately, in this instance, their view prevailed, and the case was referred back to the Appellate Court to hear arguments requesting leave to appeal. As of the writing of this article, those arguments are scheduled to be heard on January 14, 2013.

Prior NJPA Data Collection Initiatives on Psychologists' Experience with Managed Care

Collecting data and surveying psychologists about their experiences with insurance companies is nothing new in NJPA. In the mid-1990s, in response to increasing concern about the negative impact of managed mental health care on both psychological practice and patient well-being, NJPA engaged in a massive effort to determine the extent of the impact. Estimates by former NJPA Directors of Professional Affairs (DPAs), at that time, indicated that one-third to one-half of the membership had called or written, at one time or another, to complain about the policies and behaviors of managed care companies. Complaints initially centered on lack of access to panel membership and specific contract issues such as "hold harmless" clauses. As managed care assumed control over a larger share of the New Jersey health care market, concerns fell into two domains: (a) *that managed care companies were impinging on the ability to deliver quality psychological services and damaged the integrity of care by limiting access, restricting the number of sessions, and micromanaging treatment;* and (b) *that managed care policies were raising legal and ethical issues related to contracts and demands to violate confidentiality.* A conservative estimate indicated that over the course of a typical week, NJPA received three to four complaint calls from members (excluding repeat callers) about managed care. The calls were primarily related to utilization review and access to care.

In response to a request from Dr. Russ Newman, the former American Psychological Association (APA) Executive Director for Professional Practice, one of the current authors, Dr. Peggy Rothbaum, in partnership with NJPA and APA, coordinated data collection, analysis, and dissemination efforts to assess growing concerns about the negative impact of managed mental health care in New Jersey. The results of this initiative were then published in the journal, *Professional Psychology: Research and Practice.* It was felt that contacts with legislators and other advocacy efforts were enhanced when psychologist advocates could furnish data concerning the impact of insurance and managed care practices on the provision of mental health services. Though it was understood that issues such as reimbursement rates could, at times, appear to be self-serving, to some extent, other concerns, such as the level of knowledge and training of case managers who make utilization decisions or the erosion of confidentiality, clearly and directly affected the well-being of patients.

A survey questionnaire was initiated to capture the scope and extent of NJPA members' concerns about the negative impact of managed care. Specific items were developed on the basis of a pool of concerns and issues raised by association members through contacts with the NJPA DPA and the Committee on Utilization of Professional Services. Other items were added on the basis of the popular and scientific literature. Demographics questions were also included, along with questions about work setting and income, and the effects of managed care on morale, approach to therapy, professional identity, and ethics. Furthermore, the instrument requested specific ratings of potential problems for ten managed care companies operating in New Jersey at the time.

The goal of the survey was to allow the data to serve as information that could be utilized by consumers and advocates as a preliminary "report card" of the sort being called for by policymakers and the health care industry, though, in this case, for specifically evaluating managed mental health companies from the provider perspective. It was also hoped that individual psychologists might also use the data to make informed decisions about dealing with certain managed care companies, as well as simply to keep informed about potential problems or strengths of companies. The data could also be used by legislators, employers, and consumers to highlight those managed mental health care companies whose policies incorporate essential components of care, such as protection of patient confidentiality. Ultimately, it was hoped that such report cards tapping multiple concern dimensions from multiple constituencies (such as providers, consumers, and employers) would also be used as a part of managed care companies' quality assurance plans and to make recommendations as part of the regulatory process. In 1998, the New Jersey State Department of Health had established initiatives using consumer-based data for information purposes, and NJPA was included in those discussions. The results of the 1998 study indicated that not all managed care companies are equally problematic from the perspective of NJPA providers (see Rothbaum, et al., 1998 for details on the study methodology and its results). The NJPA data set served as a basis for bringing provider concerns into the process.

Of particular note, although it was only a single item on the questionnaire, was the alarming finding that NJPA psychologists were feeling increased pressure from managed care companies to compromise their ethical principles, particularly in the area of protecting patients' confidentiality. This finding foreshadowed what was to come later–increasingly aggressive and intrusive case management practices that became "abusive" of both patients' and providers' rights–and what became the basis for NJPA's legal action initiatives.

Current NJPA Data Gathering Initiatives: Insurance Complaint Registry (ICR)

More than a decade has passed since NJPA's collaboration on the 1998 article reporting on managed mental health care. Since then, not only have the issues revealed by that study not im-

proved, but they have actually become worse and more numerous, affecting even greater numbers of patients utilizing mental health services and the psychologists attempting to provide quality mental health care. In an effort to collect current data on the experience of patients and providers impacted by certain behaviors of insurance carriers, and to provider ongoing support for NJPA's legal action initiatives against such abuses, the Association, with the assistance of Dr. Jeffrey Axelbank, developed the Insurance Complaint Registry (ICR). The ICR currently utilizes a "Survey Monkey" <www.surveymonkey.com> platform, but was previously developed and distributed through a different survey mechanism. For the purposes of the current descriptive summary, the data are categorized and presented collectively.

To register a complaint in the ICR, a psychologist or a consumer can go to the NJPA website <www.psychologynj.org>, or "Speak Your Mind NJ" <www.speakyourmindnj.org>, a website established by NJPA, and endorsed by with other mental health providers, consumer groups, and individuals to improve access to mental health services and to protect patient privacy. Speak Your Mind NJ also serves as a cornerstone for educating and alerting New Jersey residents, mental health professionals, employers, and policy makers to the current crisis in the access and delivery of mental health services in NJ. Visitors are invited to learn more about the issues, get involved in advocating for easier access to outpatient mental health services, and make donations to help protect patients' privacy. They are also invited to help NJPA by "telling their story" about the consequences of insurance companies' mismanagement of care on the ICR. Interested parties can also view press releases and the latest news coverage, in addition to sending letters to government officials to stop these harmful practices.

The current study aimed to review and summarize all of the narrative complaint entries in the ICR, after names were removed to protect confidentiality. In general, it was found that most entries (entered by provider or patient) invariably contained multiple discrete complaints about various abuses by insurance companies. Therefore, while developing a formal rating system and training raters to score and assign each narrative complaint into categories was initially considered, it soon became apparent that the description of complaints are so varied (and, in some cases, so egregious) that quantifying and collapsing entries into only a few discrete categories would run the risk of diluting the impact of the data and make for a very complex coding system. Further, since the purpose of the ICR was not an attempt to create a statistically valid and reliable instrument to capture insurance company abuses, it does not easily lend itself to coding. It was felt that having respondents describe their experiences with open-ended comments would allow NJPA to collect anecdotal patient and provider experiences of insurance company abuses that have negatively impacted on the provision of mental health services and help support advocacy efforts to change these practices. To that end, the authors believed that performing a descriptive summary of the complaints by those aggrieved would be a more appropriate first step in utilizing this data.

Data consisted of ICR responses from participants who responded between November 7, 2008 and September 16, 2011 (though data collection remains ongoing). There were a total of 301 entries from 215 provider respondents and 86 consumer respondents. In total, a majority of the complaint entries, 51%, were related to Horizon Blue Cross Blue Shield (BCBS) NJ Direct, 18% to other BCBS insurance plans, 5% to Cigna, 4% to Aetna, 3% to Oxford, 2% to United Healthcare, and 18% to "other" insurance plans. Each entry included a narrative description of complaints being made about insurance companies that led to difficulties with mental health treatment. Though in some cases, entries listed only a single complaint, the vast majority of entries described multiple complaints (at times up to six) about actions by the insurance company that led to negative experiences. Consequently, each entry was qualitatively analyzed for any and all complaints described therein, yielding a total of 150 discrete varieties of complaints that were then clustered into seven general categories of complaints. The categories were as follows: *"Denying Coverage for Treatment"; "Difficulties With Treatment Authorization"; "Negative Impact on Patient"; Network Issues"; "Insurance Company Provided Misinformation or Was Unresponsive to Inquiries"; "Payment Difficulties Due to Insurance Company Errors" (See chart on following page).*

It is important to note that while a quantitative/statistical analysis of this data is beyond the scope of the current article, in many cases, there were numerous occurrences of the various complaint types listed within each category. For example, F4 "paying the patient instead of the provider," A3 "reducing sessions," or A10 "denying pre-authorized claims" were mentioned across numerous complaints registered, as were an exhaustive list of many others. In a future article, we will present more quantitative data with specific examples of narrative descriptions of complaints. (See chart on next page that outlines the variety of complaints made, by category.)

Lack of access to mental health services is a serious problem in New Jersey. For those who are able to access mental health services, it is also clear that various tactics of insurance carriers present many hurdles to obtaining appropriate care. The ICR data confirmed that insurance companies frequently delay or deny authorization of outpatient mental health services, make it difficult for patients and providers to obtain appropriate information, make persistent errors resulting in payments delays or other problems, and most importantly, and perform intrusive clinical reviews that require providers to disclose confidential patient information that negatively impact patients, among other abusive case management practices.

This data is just a sample of some of the difficulties experienced by psychologist providers (and patients) as they try to navigate the increasingly complex and ever-changing policies of health insurance–insurance that was purchased for the purpose of accessing care when it is needed.

A. Denying Coverage for Treatment	B. Difficulties with Treatment Authorization
1. Unresponsive to claims even if they admit they received them	1. Repetitious
2. No notification of problems with claims	2. Contradictory
3. Reducing sessions	3. Delays
4. Cutting back sessions in direct reaction to appeal	4. "Automatic" review demand
5. Demanding that a "wellness assessment" that violates the Peer Review Law	5. Pressure on patient to make an immediate decision about provider choice or coverage will be denied
6. Refusing hospital/facility admission	6. Ignoring previously given authorization
7. Not covering psychological evaluations	7. Overlapping authorizations (which reduces the allowable sessions)
8. Not covering autism or PDD	8. No notification of authorization
9. Using "preexisting condition" or "potential preexisting condition" as a reason not to pay	9. Sudden authorization/procedure policy changes with no warning
10. Denying pre-authorized claims	10. Over-authorization
11. No peer for a "peer review"	11. Reduction of sessions after refusal to violate Peer Review Law
12. Refusing to cover something "not biologically based"	12. Magellan/Horizon confusion about authorization
13. Denying claims	13. No preauthorization given
14. Denial for substance abuse	14. Conflicting authorization between Horizon and Magellan
15. Denial for dual diagnosis	15. Demanding authorization when none is required
16. Violation or threat to violate Peer Review Law as a reason to deny treatment	16. Refusing to accept an appeal
17. Denying treatment because DOB or gender was not provided	17. Saying that they can change the requirements any time for no reason
18. Denying more twice a week treatment	18. Changes in maximum allowable sessions with no notice
19. "Lost claims"	19. Requiring a TRF and then rejecting it and not paying
20. Limiting sessions when unlimited access is allowed by policy	20. Retroactive disapproval of already authorized sessions
21. Coverage severely limited	21. Multiple appeals
22. Requests to reduce sessions	22. Authorization decision based on only diagnosis

C. Miscellaneous Actions Resulting in Negative Impact on Patient	D. Network Issues
1. Recommended a particular type of psychotherapy	1. Not allowing use of out of network benefits
2. Pressure to take medication instead of psychotherapy	2. Saying someone is in-network when they aren't
3. Saying that a patient can manage without a therapist	3. Directing a patient to in-network providers
4. Threatening the patient	4. Making providers prove that they are out-of-network
5. Having unqualified people make decisions about psychological evaluations	5. Saying that an in-network provider is out-of-network
6. Confidential information stolen by a Magellan employee	6. Refusal to allow in-network provider disenrollment
7. Ridiculing patient on the phone	7. Treat out-of-network providers like in-network providers
8. Patient harm	8. Terminating the contract too soon in contradiction of their own policy
9. Calling the police or threatening to call the police	9. Penalizing out-of-network providers/limiting sessions for out-of-network
10. Suggestions to hospitalize the patient if more sessions are required	10. List of in-network providers lead to dead ends
11. Overhearing comments made by insurance company employees	11. Magellan/Horizon confusion about network status
12. Being insulted	12. Refusing to acknowledge out-of-network providers/status
	13. Refusal to approve as in-network provider
	14. Suggesting that a patient see a "coach" rather than a psychologist
	15. Discrimination against doctoral level providers, steering to Master's level clinician
	16. Saying a provider "isn't qualified"

E. Insurance company provided misinformation or was unresponsive to inquiries	
1. Incorrect information given i.e. incorrect address for bill submissions and appeals, explanations incorrect, misleading, or inaccurate	23. Failure to process/reprocess information
2. Refusing to provide policies in writing	24. Taking too much time to process claims
3. Refusing to help or answer questions	25. Saying something was not received when there was proof that it was received
4. Prolonged time on the phone	26. Requiring a "0" in a certain box
5. Requiring additional phone calls/multiple phone reviews	27. Requiring "paid in full" to be written, even if it was not yet paid
6. No follow-up from the insurance company	28. Claiming not to have an NPI/TIN that they previously had
7. Lying about "peer" credentials or not providing a "peer"	29. Claiming that there had been a change of address of provider when that did not occur
8. Conflicting with insurance company's own requirements	30. Giving misinformation about laws
9. Claiming incorrect information i.e. wrong date, code, etc. or that information was missing when this was not the case	31. Saying "Magellan law rules"
10. Excessive paperwork; additional faxes and emails required	32. Making false claims or promises
11. Refusing to provide written information to back up demands or statements	33. Violation or threat to violate Peer Review Law, demanding personal information beyond the limits of Peer Review Law during telephonic review
12. Unable to get information on the Internet	34. Not able to reach a representative/not returning calls
13. Claiming something was the responsibility of the provider when it was clearly the responsibility of the insurance company	35. No suggestion about how to proceed
14. Making accusations against the provider	36. Demanding retroactive paperwork
15. Claiming it is the wrong form when it was the one provided by the insurance company	37. Providing conflicting information/rationales for decision-making
16. Claiming paperwork was "lost"	38. Having no one to talk to about a particular issue
17. Asking for license update when it was already sent	39. Changes without prior notification
18. Taking months to provide a review	40. Contradictory requirements, stating conflicting reasons for determinations
19. Requiring multiple processing/reprocessing of information followed by denial	41. Refusing to accept complaints
20. Stating "Your tax id is incompatible with the office's specialty"	42. Disconnect/hang up
21. Stating "The provider's name, address, and/or Tax ID number do not agree with the information on file"	43. Mismatch between lists on Internet and Magellan lists
22. Failure to send information about claims	44. Error in mailing out information

F. Payment difficulties due to insurance company errors	
1. Reducing provider payments	9. Overpaying/Underpaying
2. Fluctuating "Usual, Customary, and Reasonable" (UCR) fees	10. Repeated requests for documentation already submitted
3. Reductions in UCR fees	11. Denying payment for dates not submitted
4. Paying the patient instead of the provider	12. Refusing to reveal allowable charge
5. Slow/delayed payment	13. Applying duplicate deductibles
6. Errors with payment	14. Paying partial claims
7. Refusing/Failing to pay	15. Having to involve collection agency because the insurance company did not pay
8. Sending an "Explanation Of Benefits" (EOBs) and claiming a check was included when it was not	16. Stopping payment resulting in bank fee

Every day, many psychologists struggle with case management practices that have become obstructive and "abusive." These continually threaten appropriate access to mental health services, limit freedom of choice for patients when opting to see out-of-network providers, and ultimately, can cause real harm to patients.

Overall, our results describe the perspectives of psychologists in one state association and provide information about particular issues with some of the managed mental health companies in New Jersey. It would be helpful to have comparative data on psychologists in other states as well as on other types of providers to compare with our findings. Informal discussion with psychologists across the country revealed that data concerning managed mental health care is currently being collected.

Finally, we have what we believe is the first data set that gives provider-based information about specific insurance companies. To further inform consumers, providers, employers and legislators in New Jersey, a potentially helpful next step would be to gather information about the specific policies of each of the insurance companies featured in our survey (e.g., authorization, access, network formation). This information could be useful to better understand the concerns of participants in our survey as well as to aid providers and consumers in selecting an insurance plan where there are meaningful differences across companies. In addition, we hope that other state psychological associations and mental health professions will gather similar information about companies operating in their states for use in addressing problems with managed mental health care.

We believe that the mismanagement of care documented through the ICR harms patients, threatens their privacy, and wastes taxpayer money. We are presenting the data from the Insurance Complaint Registry in an effort to educate the public and policymakers to the deleterious effect these insurance company behaviors are having. Psychologists, consumers, other professionals, and the general public can join our campaign to protect patient rights and demand easier access to mental health services. We urge you to learn more and Speak Your Mind by visiting: <www.SpeakYourMindNJ.org>.

In order to change this trend, we must advocate for appropriate and fair access, for protection of patients' rights, and for provider autonomy in determining the needs of our patients. Entering complaints on ICR that remains an ongoing tool, and filing formal complaints with the NJ Department of Banking and Insurance (DOBI), are simple ways providers can begin to make a difference. Filing complaints work. Most recently, DOBI proposed changes to health insurance company regulations in a number of areas that have been concerning to psychologists for years, including eliminating the phenomenon of "phantom" panels and reducing unfair practices when making changes to provider contracts. In their introduction as to why they are proposing these changes, DOBI specifically stated that it was in response to consumer and provider complaints. For more information on how to file a complaint with DOBI, please visit <http://www.state.nj.us/dobi/consumer.htm> or contact NJPA Central Office. To tackle such pervasive industry practices, we must all do our part. Letting regulatory authorities and decision makers know about these problems can, and does, make a difference. The best way to end insurance company abuses is to report them. Educate others. Help those who cannot protect and advocate for themselves. It is time to "Speak Your Mind, New Jersey."

Lastly, you can also make a difference by getting involved. NJPA's Insurance Committee, chaired by Dr. Jeff Axelbank, is always looking for members who want to assist in addressing insurance issues relevant to psychologists. Now, more than ever, psychologists are being burdened by multiple demands and requirements by insurance companies. We need members to assist us in finding solutions, advocating for change, or even just helping us develop educational materials. Together, we can support one another, advocate for improved access, and make a difference in our patients' lives.

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