



**REPORT OF THE 2012 – 2013 PARITY FIELD HEARINGS**

**AUGUST 2013**

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## 1. EXECUTIVE SUMMARY

The Mental Health Parity and Addiction Equity Act (MHPAEA) (P.L. 110-343) was signed into law by President Bush on October 3, 2008. The law aims to ensure parity between coverage for mental health/substance use disorders (MH/SUD) and medical/surgical benefits in insurance plans that offer coverage for both benefits.

Interim final regulations (IFR) reflecting the final version of the law were published by the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury in February 2010. In January 2013, the Obama Administration announced final regulations would be released by the end of the year. Parity provisions were also included in the Affordable Care Act and are scheduled to go into effect in 2014.

Modeled after field hearings in 2007 which were successful in helping to enact MHPAEA, in 2012 – 2013, field hearings around the country were organized by the law's lead sponsors, former Congressmen Patrick Kennedy (D-RI) and Jim Ramstad (R-MN). The field hearings were intended to shine a light on problems patients are still facing as they try to access addiction and mental health treatment in the absence of a final rule implementing the law. The hearings also highlighted the unique problems consumers face in finding addiction and mental health services. Testimony on what is working well was also provided.

The field hearings revealed the 2010 IFR fails to provide sufficient regulatory guidance to operationalize the law and final regulations are needed in four key areas:

1. Disclosure and transparency;
2. Scope of service;
3. Non-quantitative treatment limitations; and
4. Medicaid managed care parity.

Additionally, witnesses spoke about the need for greater federal and state enforcement of MHPAEA in order to ensure equitable patient access to mental health and substance use disorder treatment as intended by Congress.

This report is not exhaustive, and its findings are not based in statistics or formal data gathering, but the testimony provided by the witnesses is consistent with the vast number of complaints and appeals submitted by consumers and healthcare providers to the Parity Implementation Coalition, federal regulators and state enforcement offices, as well accounts individuals and organizations in and outside of the mental health and addiction fields have shared around the country with the law's authors, Patrick Kennedy and Jim Ramstad, since the enactment of parity. Moreover, the report is a synthesis of the voices of Americans from every walk of life offering their perspectives on how we as a nation can combat the public health crisis represented by untreated and undertreated mental health and substance use disorders.

## 2. INTRODUCTION

### ***a. History of the Mental Health Parity and Addiction Equity Act***

The Mental Health Parity and Addiction Equity Act (MHPAEA) (Public Law 110-343) was signed into law by President Bush on October 3, 2008. The law aims to ensure parity between coverage for mental health/substance use disorders (MH/SUD) and medical/surgical benefits in insurance plans that offer coverage for both benefits. Enactment of the legislation followed more than a decade of congressional consideration of similar bills. During the 110th Congress, the bipartisan legislation was introduced in the Senate as S. 558 and in the House as H.R. 1424. MHPAEA was the vehicle for the financial rescue legislation, the *Emergency Economic Stabilization Act of 2008*. A bipartisan group of House and Senate members whose lives had been touched by addiction and mental illness championed the legislation, including the late Ted Kennedy, former Senator Pete Domenici, former Rep. Patrick Kennedy, and former Rep. Jim Ramstad. Enactment followed fourteen field hearings around the country, consideration by five congressional committees and floor deliberation in both congressional chambers. The final bill signed into law was truly a compromise and melded the House and Senate versions of the legislation.

### ***b. Legislative and Regulatory History***

MHPAEA applies to private and public sector employers with more than 50 employees, including self-insured and fully insured plans. State and local self-funded plans are allowed to apply for an exemption from the law. MHPAEA does not require employers to offer a MH/SUD benefit, only that if the benefit is offered, it must be on par with medical/surgical benefits covered by the plan. In 2014, under the Affordable Care Act (ACA), new individual and small group plans in and outside of the health insurance exchanges will be required to offer MH/SUD benefits at parity. Individuals covered under the Medicaid expansion authorized by ACA will also receive a benefit that includes mental health and addiction coverage at parity.

In 2009, over 400 comments were submitted in response to a Request for Information (RFI) from the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury.

In February 2010, interim final regulations (IFR) were published by DOL, HHS and Treasury. At their release, Agency officials indicated that final regulations would be issued on Medicaid managed care parity, non-quantitative treatment limits and scope of service following the comment period on the IFR. Over 5,000 comments were submitted in response to the IFR.

In April 2010, three managed behavioral health organizations – Magellan, ValueOptions and Beacon Health - unsuccessfully sued to prevent the IFR from going into effect; and the IFR went into effect for all plans January 1, 2011.

In January 2013, in the wake of the Newtown school shooting tragedy, the Administration released [guidance](#) on the application of MHPAEA to Medicaid managed care organizations and state based exchanges and promised parity final rules would be released by the end of the year as part of the [Administration's effort to combat gun violence](#).

**c. Patriots for Parity Campaign**

Modeled after field hearings in 2007, which provided valuable input on the provisions that would become part of the parity law, in 2012 – 2013 a series of field hearings, the Patriots for Parity Campaign, were organized by the law’s lead sponsors, former Congressmen Patrick Kennedy (D-RI) and Jim Ramstad (R-MN). The field hearings were intended to provide an opportunity for stakeholders to testify about gaps remaining in MHPAEA implementation and where implementation is going well.

Field hearings were held in:

- Atlantic City, New Jersey
- Chevy Chase, Maryland (Washington, DC)
- Chicago, Illinois
- Delray Beach, Florida
- Denver, Colorado
- Hartford, Connecticut
- Kalamazoo, Michigan
- Los Angeles, California
- Providence, Rhode Island
- Seattle, Washington
- St. Paul, Minnesota

The field hearings were supported and organized with the help of the [Parity Implementation Coalition](#) and Coalition members’ local affiliates. Each hearing featured three or more panels of witnesses, including representatives from business and insurance, mental health/addiction and medical treatment providers, state and local government officials, academic experts, veterans, and mental health and addiction



**Patrick Kennedy and Rep. Ted Deutche at the Delray Beach, FL field hearing**

consumers and their family members. Materials, including agendas and summaries of these proceedings may be obtained online at [www.parityispersonal.org](http://www.parityispersonal.org). Those individuals or groups who were unable to provide oral testimony, were able to submit written testimony to be included in the record.

Members of Congress who participated included:

- **California**
  - Rep. Grace Napolitano
  - Rep. Mary Bono
- **Connecticut**
  - Sen. Dick Blumenthal
- **Colorado**
  - Sen. Michael Bennet
  - Rep. Diana DeGette
- **Florida**
  - Rep. Ted Deutche
- **Illinois**
  - Rep. Mike Quigley
  - Rep. Jan Schakowsky
- **Maryland**
  - Rep. Jim Moran
  - Rep. Paul Tonko
  - Rep. Van Hollen
- **Michigan**
  - Sen. Debbie Stabenow
- **Minnesota**
  - Sen. Al Franken
  - Sen. Amy Klobuchar
  - Rep. Betty McCollum
  - Rep. Keith Ellison

This report is not exhaustive, and its findings are not based in statistics or formal data gathering. It is, however, a summary of the voices of Americans from across the country on the need for equitable access for mental health and substance use disorder treatment.

### **3. FINDINGS**

#### ***a. Need for Equalizing Benefits is Critical***

The locations and settings of the field hearings varied greatly. Some were in metropolitan areas, others in suburban enclaves. Locations for the hearings ranged from an art museum to a public library to a community center. There were hearings in lower-income and affluent areas. A dominant impression across sites; however, was a need for non-discriminatory access to care and gratitude for the opportunity to be heard. Most hearings were full to capacity or overflowing. A number of hearings ran 30, 45, even 60 minutes over their allotted time. People battling mental illnesses and addictive disorders, and those in the field, have so often received short shrift from policymakers that they seemed grateful just for the fact that Members of Congress were coming to hear their stories.

Over and over, witnesses described how hard it was for them to access mental health and/or addiction treatment for themselves or a loved one and navigate their way through the insurance process. “I cannot fathom anyone newly sober, a chronic relapser, or someone whose meds aren’t balanced yet trying to deal and do what I have done in preparing this appeal,” said Ann Price in Maryland.<sup>i</sup> Dafna Michaelson echoed that frustration in Denver: “My story is the story of a mother struggling to get her son the right treatment for a depression that started making itself known when he was just 6 years old and told me in no uncertain terms that the noise from the other children was so loud that he wanted to rip out all of his hair and skin until he died.”<sup>iii</sup>

When people are denied access to the care they or their family members need, even though they have insurance and pay their premiums like everybody else, they feel like second-class

citizens. They see the parity law as more than a way to reduce barriers to care. They see it as a civil rights law that declares that they are entitled to the same opportunities as everyone else. Lisa Sonnenberg, who was the Mrs. Illinois title holder, said aptly, “Depression does not discriminate. It affects the rich, poor, young and old, and even beauty queens.”<sup>iii</sup>

The business community also expressed its support for parity with the Chicagoland Chamber of Commerce, stating that it “supports the intent and goals of MHPAEA” and “although increasing access to treatment will have a direct benefit to employers, the real benefit lies in the improved quality of life that it will afford to our employees and their families.”<sup>iv</sup>



**Members of Congress and witnesses at the Chevy Chase, MD field hearing**

Members of Congress expressed their support for the full implementation of MHPAEA. In Chicago, in offering to help her constituents get their plan to cover services, Rep. Schakowsky (D-IL) quipped that “cajoling insurance companies is my hobby.”<sup>v</sup> In Chevy Chase, MD, Rep. Van Hollen (D-VA) said, “Drawing on the bipartisan and universal support for the law when we passed it in 2008 in Congress, at the federal agencies and among

advocates and the business community alike, we are here tonight to invoke that same sense of cooperation to see the law fully implemented.”<sup>vi</sup>

### ***b. Access to Treatment is a Life or Death Issue***

The field hearings offered stark reminders of the difference access to treatment makes. Over and over witnesses testified about how unchecked mental illnesses and substance use disorders ravaged people of all backgrounds and all walks of life.

In Florida, Beth Ann Middlebrook with the Watershed Addiction Treatment Programs testified, “Here are emails informing us of someone who has died from addiction just within the last 3 months, these are just those people that we have been made aware of. This is a thank you from a parent, husband and child of a patient who died, thanking us for our efforts, but letting us know she didn’t make it. Her insurance didn’t cover any residential treatment. When people don’t get the treatment they need, when people must fail-first at lower levels of care, they often don’t make it back.”<sup>vii</sup>

Dr. Wendy Oliver-Pyatt with the Oliver Pyatt Treatment Centers echoed Middlebrook’s testimony and read two letters from family members whose friend and loved one had died. Dr. Oliver-Pyatt explained the first letter was from, “a friend of a 20-year-old girl who died in her sleep of a heart attack, not sick enough to require residential treatment according to her insurance company. The second letter is from the mother of a student who ended her own life. She lacked coverage for the services she desperately needed.”<sup>viii</sup>

Witnesses also told the stories of the harm done to their lives by the lack of adequate treatment. In Chicago, Danielle Moles said her life would be vastly different if her insurer had approved inpatient treatment for her eating disorder four years earlier. She described the physical and mental toll her untreated disorder took on her body and estimated she spent over \$100,000 on behavioral treatment costs and her insurance carriers had been billed over \$500,000 in related medical costs, a total she believed could have been halved if she had received residential treatment when it was first indicated as medically necessary.

In Los Angeles, attorney Lisa Kantor told the story of a young woman whose insurer denied coverage because according to the insurance company she was not 'purging enough' to warrant inpatient treatment for her bulimia. Kantor said, "Imagine that one night you get a call from your daughter who tells you that she binged and she can't purge and her stomach hurts like never before. You tell your daughter to go to the emergency room. Your daughter later calls to tell you the doctor discharged her after telling her to 'go home and deal with the consequences of your behavior.' Then imagine your daughter being life-flighted to a different hospital only a few hours later because it turns out the pain she was experiencing was from her stomach having ruptured after she binged. Imagine sitting by your daughter's side as she cries, telling you that she knows she is going to die. And then imagine burying your 19 year old daughter after she dies from septic shock. The insurance company paid for all of the emergency services for Leslie that night, but would not pay for treatment of her eating disorder, the very disease that killed her."<sup>xix</sup>

In Florida, patient Lori Jo Baach testified about being stable for years until her employer changed insurance carriers and the new carrier began denying coverage for three of her medications to treat her schizophrenia. Unable to pay the out-of-pocket, she began getting one of her medications from a Patients Assistance Program and the other two from a Canadian pharmacy. Baach asked, "what is the purpose of paying high premiums for health care coverage if the carrier doesn't cover your lifesaving needs?"<sup>xx</sup>

### ***c. Providing Access to Treatment Works and Saves Money***

Witnesses also spoke about the life-saving benefits of treatment for mental and substance use disorders. The Chicagoland Chamber of Commerce wrote, "Equitable access to behavioral health care means that employees who are struggling with mental health disorders will receive the treatment they need to remain employed or return to the workforce after a period of treatment. It is a "win-win" situation for both parties."<sup>xxi</sup>



**Mrs. Illinois Lisa Sonnenberg testifying at the Chicago field hearing**

In Illinois, Lisa Sonnenberg testified that access to treatment through her husband's insurance for depression and premenstrual dysphoric disorder enabled her to function as a wife and mother and accomplish winning the title of Mrs. Illinois.

In Los Angeles, Keris Myrick testified that treatment for her schizoaffective disorder allowed her to achieve recovery and work as a CEO of a non-profit organization. She said parity "allowed





### **Minnesota parity field hearing**

the health care and insurance playing field to be leveled. I no longer fight with the insurance company as none of my psychiatric care has been terminated. As a matter of fact, I am able to see my psychiatrist when needed rather than having to parcel out the measly 20 visits a year that I was permitted prior to the implementation of parity.”<sup>xii</sup>

Also in Chicago, Phyllis and Molly Foxworth talked about getting treatment for Molly after Molly attempted suicide. The Foxworth’s insurance paid the majority of the \$94,000 in medical bills for Molly’s treatment (the Foxworths paid \$8,600) and Molly stated, “Without the care I received, I would not be standing here in front of you this evening as a productive and healthy member of society.”<sup>xiii</sup>

In Denver, veteran Frank Ruiz also put a face on the power of treatment and recovery. Ruiz, who suffered from Post-Traumatic Stress Disorder (PTSD) and traumatic brain injury from his military service, assaulted the arresting officer during his arrest for his third DUI. After that last DUI, he received treatment and said today he is, “over two years sober, freshly on the Dean’s List with a 4.0 and applying to medical schools this summer.”<sup>xiv</sup>

Dr. Tom McLellan, CEO of the Treatment Research Institute, testified in Chicago, “Serious addictions can be treated effectively, with recovery an expectable outcome, but like other chronic illnesses, there is no cure.”<sup>xv</sup>

Scientific advances have further improved the ability to treat these diseases. McLellan stated “science has provided new medications, therapies and other services that have been shown to be effective in preventing and treating substance use disorders.”<sup>xvi</sup>

#### ***d. Insurance Discrimination is Costly***

Opponents of fully equalizing mental health and substance use disorder benefits on par with other medical benefits often argue that such a move is too expensive. Testimony at the field hearings repeatedly illustrated that, in fact, the opposite is true. Leaving addiction and mental illness untreated is vastly more costly to individuals, families, employers and society at large.

In Los Angeles, firefighter Kevin Kinnon spoke about his struggles to get treatment for his son, Connor, after Connor attempted suicide. Kinnon stated, “The simple truth in the matter is that it became quite clear that a mental illness is costly and in the eyes of the insurance industry it is treated as so.”<sup>xvii</sup>

However, the costs of untreated mental illness and substance use disorders are felt far more extensively throughout society. Dr. McLellan noted that untreated addiction costs employers \$100 billion annually in productivity loss and medical costs and that 70% of emergency room visits are attributable to an underlying untreated substance use disorder. In Denver, District Attorney Morrissey testified, “When we fail to competently and systematically provide for these individuals a far greater percentage become offenders putting their families, our communities and themselves at increased risk.”<sup>xviii</sup>

In Los Angeles, Dr. Suzette Glasner-Edwards, a Research Psychologist at UCLA's Integrated Substance Abuse Programs, testified about the burden that treating addiction places on the public sector. She stated, "The Medicaid system absorbs a disproportionate share of the healthcare costs associated with SUD. Whereas 9% of the general population has an SUD, nearly 13% of the population that qualifies for Medicaid because of a disability has an SUD, and Medicaid patients with SUDs have medical costs that are about twice as high as those who do not."<sup>xxix</sup>

Witnesses also testified about the cost savings associated with treatment. Dr. Daviss, Chair of the Department of Psychiatry at Baltimore Washington Medical Center, noted that a study found coordinated depression treatment for patients age 60 or older yielded \$3,363 in savings per patient for an investment of \$522 a patient.<sup>xx</sup>

Dr. Oliver-Pyatt testified that Minnesota changed its laws after 21 year old Anna Westin committed suicide after her residential care was denied and said, "the result is that people in Minnesota are getting care that not only saves lives but also improves quality of life while saving insurance companies millions of dollars previously paid for the revolving door to the hospital where the patient ends up after fainting, or to the infertility doctor when they cannot have a baby due to their low body fat."<sup>xxxi</sup>

Additionally, witnesses noted that the cost of parity is low. A 2011 Milliman analysis of 'typical' employer plans (including more than 21 million lives) found MH/SUD benefits represent 2% of total health care premiums and most employers provide addiction and mental health benefits for an average premium of \$7.00 per member per month.<sup>xxii</sup>

#### ***e. The Promise of Parity is Too Often Not Realized***

Following the enactment of MHPAEA in 2008, many consumers believed that if they or their family members required treatment, it would be covered by their insurance company. However, at the field hearings witnesses across the country reported health plans continue to impede access to treatment, which they attributed, at least in part, to the lack of final regulations implementing MHPAEA.

In Maryland, Dr. Daviss testified, "I am frustrated and even embarrassed that such a powerful law – one that places the health of our brains on the same level of importance as the health of our heart, our kidneys, our skin – still lacks the final regulations to add teeth to its requirements four years after being signed into law."<sup>xxiii</sup>

A report summarizing the October 17, 2012 parity field hearing in Connecticut cited that, "Since the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, at least one carrier's administration of the MH/SU benefit has become even stricter. While the Office of the Health Care Advocate's (OHA) overall reversal rates on appeal of insurance denials is 85%, with respect to mental health and substance use conditions, our reversal rate is closer to 60%."<sup>xxiv</sup>

Also in Maryland, University of Maryland Law Professor Ellen Weber testified about the lack of parity compliance. She stated, "In six investigations conducted eighteen months after the effective date of the Interim Final Rule, we identified plans that had either not conducted the required parity analysis or not caught all of the violations in their plans. Our investigations uncovered violations of cost-sharing requirements for outpatient mental health and substance use disorder treatment, preauthorization standards and other non-quantitative treatment limitations, such as exclusions for court-ordered substance use disorder treatment."<sup>xxv</sup>

In Connecticut, Dr. Eric Arzubi, Co-Chair of the Keep the Promise Coalition and Fellow at the Yale Child Study Center, testified, "It is not uncommon for private insurers to deny coverage for

inpatient hospitalization or a partial hospital program, even for a patient who is at risk for committing suicide. By denying first and asking questions later, insurance companies often hurt patients and their families in what are often the most difficult times of their lives.”<sup>xxvi</sup>

Barriers to treatment that were most often reported during the field hearings included lack of transparency and disclosure, exclusions of entire levels of care, medical management that is more stringent on the behavioral health benefit than the medical benefit covered by the plan and non-quantitative treatment limits.

Please find below a discussion of these barriers in more detail.

#### ***f. Filing Appeals is Complex and Time Consuming***

Witnesses spoke to the tremendous time commitment involved in trying to access benefits and/or file an appeal. Over and over again, patient and family member witnesses said “it shouldn’t have to be this hard” to obtain care. Professor Weber testified that she and her students spent 20 – 30 hours per investigation. In Chicago, attorney Kelly Whelan called the process, “arduous.”<sup>xxvii</sup>

The Connecticut Office of the Healthcare Advocate (OHA) found in their report summarizing the Hartford field hearing that among fully-insured plans, only approximately 5% of all denials are appealed “despite major marketing efforts by OHA and provisions in state legislation and the ACA requiring OHA’s contact information to be included on every denial notice.”<sup>xxviii</sup>

However, OHA found there was a high level of interest among consumers who were aware of the process. OHA stated, “In calendar years 2009, 2010 and 2011, behavioral health appeals were 34%, 43% and 36% of all external appeals, respectively, accepted by the Connecticut Insurance Department.”<sup>xxix</sup>

OHA estimated, “that of the cases related to substance abuse and co-morbidities that OHA takes to appeal, 60% are overturned at external appeal. This trend casts grave doubt on the efficacy of the insurer’s internal mechanisms to adequately review and determine appropriate treatment protocols for their members. It’s important to remember that by the time an appeal reaches external review, the claim has already been reviewed at least twice by the insurer, sometimes three times counting the initial claim review and up to two levels of internal appeal, a process that typically takes several months.”<sup>xxx</sup>

The rates of appeal were similar in Maryland. Brenda Wilson, Associate Commissioner for Life and Health for the Maryland Insurance Administration, testified that, “In 2011, the Appeals and Grievances unit handled 30 complaints dealing with mental illness and substance abuse. The vast majority of the Appeals and Grievance complaints (25) dealt with inpatient denials. The Maryland Insurance Administration reversed the carrier in 16 of the cases, and upheld the carrier in 14 of these cases. This rate of reversal of the 2011 Appeals and Grievances cases for mental health and substance abuse is very similar to the historical reversal rate for all Appeals and Grievances Cases.

The Life and Health Complaint unit deal with all types of complaints involving life and health insurance, including denials of care for mental illness and substance abuse. The Life and Health Complaint unit received 123 complaints dealing with mental health and substance abuse in 2011. Fifty-two of these complaints were reversed in favor of the complainant, 31 upheld the company’s decision, 31 were out of the Maryland Insurance Administration’s jurisdiction for investigation, 7 were returned to the complainant for more information or for failure to exhaust the internal grievance process, 1 was withdrawn by the complainant and 1 remains under investigation today.”<sup>xxxi</sup>

**g. Barriers to Treatment: Lack of Transparency & Disclosure**

One of the barriers multiple witnesses spoke to was the lack of transparency and disclosure by plans, making the filing an appeal of a denied claim very difficult.

Attorney Whelan testified, “Strict requirements for appeals are buried in provider agreements, beneficiary plan documents and provider manuals. In the best case scenario, a beneficiary is able to track down all of the information she needs to file a complaint, has a strong clinical case and makes undeniable arguments based on the regulations. Even then, however, a plan can (and plans frequently do) deny the appeal for lack of medical necessity.”<sup>xxxii</sup>

In Minnesota, Kim S. told her story about trying to get addiction treatment for her son. She stated the plan, Health Partners, said they use the American Society of Addiction Medicine (ASAM) criteria for determining whether to approve levels of care. Kim stated, “When I requested more information about the criteria used to make benefit determinations, my Health Partners advocate told me there were no copies of the ASAM manual on site at Health Partners, no additional information was available and that she was not able to help me. I did my own investigation [and] found the manual on Amazon.com.”<sup>xxxiii</sup>

In Chicago, Dr. Yohanna, Vice Chair of the Department of Psychiatry and Behavioral Neuroscience at the University of Chicago and Past President of the Illinois Psychiatric Society, said the Illinois Psychiatric Society, “has tried, but cannot get insurance companies, self-insured organizations or municipalities to release standards in writing for mental health services or substance use disorders.”<sup>xxxiv</sup>

Also in Chicago, Angela Woods, Manager of Authorizations at Insight Psychological Centers and Inspire Centers, said plans often refuse to disclose their medical necessity criteria by citing length of stay as the reason for a denial despite MHPAEA’s requirement for the plan to disclose the medical necessity criteria upon request.<sup>xxxv</sup>

Professor Weber confirmed the other witnesses’ experiences, testifying, “All information that is required to determine whether a parity violation exists is in the exclusive possession of the plan: cost data to determine whether a financial requirement or treatment limitation meets the ‘substantially all’ or ‘predominant’ standards; the medical necessity standard; all medical management criteria for imposing authorization requirements, step therapy or fail first requirements; and standards for network admission and usual and customary rates.”<sup>xxxvi</sup>

Witnesses also testified the lack of transparency by plans makes it difficult to determine if a plan is compliant with the law. In California, Dr. Forgey, on behalf of the California Academy of Child and Adolescent Psychiatry, testified, “The penetration rates among private-for-profit health plans are not routinely published. Since there has not been any recent evaluation of the current status of mental health parity in California, it is impossible to determine if health plans are in compliance with federal and state statutes. This type of review should be done on an ongoing basis to ensure that children and families are receiving access to services as intended by mental health parity.”<sup>xxxvii</sup>

#### ***h. Barriers to Treatment: Medical Management***

Across the country, consumer witnesses and providers testified that the application of more stringent medical management of behavioral health benefits than comparable medical benefits was a barrier to care. Some of the testimony included:

- In Denver, Dr. Charles Stephens, medical director of Peak Addiction Recovery Center, a thirty day residential addiction treatment facility, testified about his experience as an addiction medicine physician versus when he practiced family medicine. Stephens stated, “As a family medicine physician, my pre-authorizations and concurrent reviews were straightforward and my knowledge of the patient was respected. In addiction medicine, lengths of stay seem to be based more on computer models which subjugate the knowledge of the client’s needs.”<sup>xxxviii</sup>
- In California, Dr. Itai Danovitch with the California Society of Addiction Medicine stated, “There are a seemingly endless number of obstacles that insurers utilize to evade providing mental health and substance use services. Roadblocks we face include vague medical necessity standards, lengthy approval processes that result in attrition, bureaucratic stonewalling of service requests, appeals processes that require an advanced degree to navigate and so on. I encounter these obstacles every day in my work.”<sup>xxxix</sup>
- In Connecticut, the Connecticut Medical Society testified, “We are continually provided with examples by our members of situations in which it appears the underlying mental health status or condition of the patient is completely ignored by the individual assessing the medical care plan modality for the insurer. In fact, we are constantly told of instances where insurers will not authorize continuation of treatment of Connecticut patients unless a traumatic event occurs (because improvement means discharge from inpatient programs). This contradicts all efforts being made to improve the health and well-being of every resident of the state of Connecticut, regardless of medical status or condition.”<sup>xl</sup>

#### ***i. Barriers to Treatment: Lack of Clarity in Non-Quantitative Treatment Limits***

Many witnesses spoke about how non-quantitative treatment limits (NQTLs) are used by plans as barriers to treatment. In Denver, Steve Melek, an actuary with Milliman, stated, “NQTLs can be broadly defined as any type of medical management technique that is used to manage or limit the benefits. MHPAEA requires that a plan not apply these management techniques in a non-comparable or more stringent manner to each classification of MH/SUD benefits than how they are applied to each classification of medical/surgical benefits. Examples of NQTLs include the determination of medical necessity, fail first requirements, the use of utilization management techniques, and the determination of provider reimbursement levels.”<sup>xli</sup>

In Chicago, attorney Whelan explained, “the regulations do not provide any objective test by which to measure whether NQTLs are applied in a way that is ‘comparable to’ and ‘no more stringently than.’ Accordingly, it is almost impossible to translate this standard into meaningful requirements for plans to which we can hold them accountable. Moreover, the regulations provide that ‘clinically appropriate standards of care’ may permit a difference in the application of an NQTL. The result is that we have an amorphous test for determining whether an NQTL is prohibited and an exception to the standard which is big enough to eclipse the standard itself.”<sup>xlii</sup>

In Florida, Beth Ann Middlebrook with the Watershed Addiction Treatment Programs testified, “these are limitations on treatment that don’t have a numerical value (such as number of days, or a dollar figure directly attached to them), these other types of treatment limitations are still being used in an unequal way.”<sup>xliii</sup>

In Maryland, Dr. Daviss also testified about NQTLs as barriers to care – he said obtaining pre-authorization for patients he sees in the emergency department who need to be admitted for psychiatric treatment is significantly more difficult than for patients his colleagues admit for medical/surgical treatment, with staff spending 30 to 50 minutes on the phone with insurers to obtain authorization for psychiatric hospitalization. Daviss stated, “When I walk down the hall and ask the staff in the main ER about their experiences for authorizations to treat other people in medical crisis, they invariably say that, at most, they are on the phone for two minutes and only need to provide name, insurance number and reason for hospitalization. They do not get the third degree.”<sup>xliiv</sup>

Whelan echoed Dr. Daviss’ remarks, stating “we regularly hear from our clients that patients show up at their doors in urgent need of residential treatment for potentially deadly disorders – much in the same way that patients show up at emergency rooms with chest pain in urgent need of cardiac surgery and follow-up inpatient care. However, our patients face onerous medical necessity pre-authorization requirements that a cardiac patient doesn’t. These pre-authorization requirements can include waiting periods of up to 14 days. Just like a cardiac patient, our patients could be dead in 14 days.”<sup>xliiv</sup>

In Chicago, Dr. Daniel Yohanna testified, “there are still serious limitations being placed on clinicians through preauthorization and various forms of treatment reviews. Clinicians are in the dark and usually unaware of these standards being used to make these decisions and they do not know if the limitations are any more stringent than limitations for other medical or surgical care.”<sup>xlivi</sup>

Please find below a discussion of some of these NQTLs in more detail.

### *Network Adequacy*

One form of NQTL witnesses spoke about as a barrier to treatment is network adequacy. “On the outpatient side, network adequacy is probably the biggest barrier to access to care” Dr. Daviss testified. He added, “The insurance networks do not maintain a large enough network of physicians who specialize in psychiatry. This bottleneck makes it hard for patients to initiate treatment. The insurance companies may have decreased or eliminated the need to obtain outpatient treatment authorizations, but the loophole here is that if there are not enough psychiatrists in the network who can actually see the patients needing care, then many patients go without. This effectively limits the number of claims a payer must pay out. This is a non-quantitative treatment limit that is more restrictive on the mental health and addictions side than on the physical health side.”<sup>xliivii</sup>

In Florida, regulatory attorney Irvin “Sam” Muszynski testified on behalf of the American Psychiatric Association (APA) and the Parity Implementation Coalition (PIC) about Florida Blue Cross Blue Shield’s (FLBCBS) termination of the majority of its mental health and substance use disorder provider contracts.

Muszynski stated that in July of 2011 FLBCBS announced it was terminating the majority of the behavioral health contracts and engaging New Directions to contract with providers under new terms and conditions. Specifically, the new conditions changed the terms of participation in the network and reduced reimbursement rates by 20 - 45% (certain practitioners were not affected because they participate through a university system, hospital system, or multi-specialty clinic).

“By operation of the Parity Law and its implementing regulations, the terms and conditions (including reimbursement rates) of provider participation in a health plan’s network are considered non-quantitative treatment limitations (NQTLs). They are subject to the regulatory test for same, which basically states that NQTLs for MH/SUD must be comparable and applied equally as those applied to medical/surgical benefits,” he stated.<sup>xlviii</sup>

Unable to confirm that FLBCBS had made the same changes to medical providers covered by the plan, APA and the PIC began to pursue the matter further. Muszynski said that between August and December 2011 numerous correspondence was sent to the Florida Department of Insurance, FLBCCS and the federal regulators regarding whether FLBCBS was acting in compliance with MHPAEA. Muszynski testified that the Florida Department of Insurance said it had no jurisdiction and would take no action; FLBCBS said the allegations of wrongdoing were false and declined to provide requested documentation; and the federal regulators did not respond. Subsequently, at a meeting with FLBCBS and New Directions, the APA and PIC learned federal regulators did make an inquiry with FLBCBS regarding the matter.

As of the field hearing, there was no resolution of the matter and Muszynski stated, “We do not think that the intent and spirit of the law and regulations contemplated insurers being able to circumvent the law by decimating their provider networks and precluding access by health plan beneficiaries on reasonable terms.”<sup>xlix</sup>

Witnesses also testified about “phantom networks,” a phenomenon where plans list providers in their networks who are not really available to treat patients, are no longer in existence, or have long since ceased being an in-network provider.

In Maryland, Daviss stated, “If you pay for a plan that has 40 doctors listed in their online provider directory, you expect that you can see most of those 40 doctors. If the truth was that there are only 4 who can actually see you, then this is false advertising. It is a form of treatment limitation that seems to be applied particularly to behavioral health much more than to primary care.”<sup>i</sup>

In California, Dr. Marcy Forgey reported the same phenomenon. Dr. Forgey testified, “Network provider lists provided by insurance companies are frequently out of date. Families will sometimes have to call 30 – 40 providers before they can find one that is actually taking new patients. They may not be able to find a provider at all or are matched with one who does not have the skill set they require. Waiting lists for mental health treatment may be months long for a provider in network or families may have to drive long distances to access care.”<sup>ii</sup>

### *Fail First*

Witnesses testified about the use of “fail first” criteria, a non-quantitative treatment limit, by plans more stringently on behavioral benefits than medical benefits as a tool to deny care. For example:

- In Maryland, dentist Paul Berger spoke about being forced to hand over his credit card while going through detoxification after his health plan denied his residential addiction treatment because he had not “failed first” at a lower level of care.<sup>iii</sup>
- In Connecticut, on behalf of the the Health Assistance Intervention Education Network (HAVEN), Maureen Sullivan Dinnan testified, “Too often, we hear that the patient will not be allowed a residential treatment, partial hospitalization program or even an intensive outpatient program, as the patient has not failed at a lower level of care.”<sup>iiii</sup>
- In Denver, Dr. Elizabeth Cookson testified on behalf of the Colorado Coalition for the Homeless and the Colorado Psychiatric Society. She offered a composite patient as an example of the burden placed on patients as a result of fail first policies. Cookson

stated, “Jane’ had been successfully treated for depression in the past, and had a recurrent episode when her hours were cut at work and she began having financial problems. Although she had a history of response to a particular antidepressant, her employer-sponsored health plan had a ‘fail first’ formulary for antidepressants – it would not pay for the drug which she had previously responded unless she previously had two documented failures on other medications.

As she went through those medication trials, Jane’s depression worsened, her work performance suffered, and she was fired. She did not have the money to continue her insurance through COBRA, nor did she have the funds to pay her rent. After staying with friends and family for several months, and becoming more and more depressed, she made a suicide attempt.

After this, friends and family would no longer take her in, and she became homeless. While staying at a local shelter, she started treatment with the Colorado Coalition for the Homeless. We were able to get the specific antidepressant she needed through a Patient Assistant Program and she began to improve.”<sup>liv</sup>

***j. Barriers to Treatment: Scope of Service***

Many witnesses testified about plan limits or exclusions on certain types of treatment. Actuary Steve Melek stated, “Another issue that is not well defined within MHPAEA is the scope of services that are required to be included for covered mental health conditions and substance use disorders. The IFR is clear that a plan must provide MH/SUD benefits in every class where medical/surgical benefits are provided. What is not clear is how broad these benefits need to be. For example, is providing inpatient detoxification benefits for substance use disorder sufficient to meet parity requirements without covering inpatient rehabilitation benefits for the same disorder? Can a plan exclude benefits for residential treatment services entirely, both those provided in hospitals and non-hospitals and still be parity compliant? Can a plan limit the types of behavioral healthcare providers that it will include in covered outpatient benefits.”<sup>lv</sup>

In Michigan, Mark Reinstein, on behalf of the Mental Health Association in Michigan and Michigan Partners for Parity, echoed Melek’s call for more clarity in a final rule. Reinstein stated, “Without additional regulatory clarity on scope of services, confusion and varying interpretations will remain for service beneficiaries, families, providers, employers and insurers. Additionally, the trend that’s been seen in actual service reductions for intensive care needs will worsen.”<sup>lvi</sup>

In a letter to the Department of Labor, Sen. Blumenthal stated the lack of guidance on scope of service is resulting in Connecticut plan participants being denied “essential services, treatments and benefits.”<sup>lvii</sup> Blumenthal added, “In the absence of federal regulations that make Congressional intent clear, plans have increasingly excluded coverage for residential life-saving eating disorder and addiction treatment.”<sup>lviii</sup>

Middlebrook testified in Florida, “We also face a real challenge over the scope of services that are covered under a parity plan. On the medical side, almost all plans cover the full continuum – a patient goes from ICU, to a regular hospital bed, then is transferred to a skilled nursing facility, then to outpatient therapy. But on the substance abuse side, many plans exclude residential treatment and day treatment from coverage. Some plans even exclude inpatient rehabilitation, leaving a patient to go straight from detox into an outpatient setting. This skeleton benefit is not what parity was meant to achieve.”<sup>lix</sup>

In Los Angeles, John Schwarzlose, President and CEO of the Betty Ford Center, echoed other witnesses’ testimony, stating that since parity was enacted, two Members of Congress have



gone to the Center and both were surprised to discover their insurance would not cover residential treatment.<sup>ix</sup>

In Maryland, Raymond Crowel, Chief of Behavioral health and Crisis Services for Montgomery County, provided an example of a patient for whom scope of service is important. Crowel stated, “Roger H., a 50 year old, requested treatment for opiate addiction from one of our outpatient programs. After a thorough assessment of his condition, our team concluded that Roger needed additional services including psychiatric consultation and 24-hour crisis support. They contacted the managed care organization (MCO) to request authorization for intensive outpatient services. The MCO denied these services because they were not medically necessary, forcing an appeal and a delay in accessing services that might have resulted in a relapse. Roger was fortunate in that the clinic director decided to provide intensive treatment out of pocket rather than risk losing him to the streets. He was also fortunate in that his MCO elected to include intensive services as a benefit. This is not universally true of MCO’s in the state.”<sup>xi</sup>

#### ***k. Barrier to Treatment: State Confusion & Lack of Enforcement***

##### *State Confusion*

Witnesses testified about confusion in the states over state and federal responsibilities for enforcing the law.

In a letter included in the record from the Connecticut field hearing, Sen. Blumenthal (D-CT) wrote, “Specifically, I understand that there is substantive variability in states’ understanding of their role in implementation and enforcement of MHPAEA and the IFR. Many states are declaring that they do not have the authority to enforce MHPAEA or the IFR and cannot act on any complaints regarding potential violations of the Parity Law or Rules.”<sup>xii</sup> Blumenthal added, “In the absence of guidance, states’ confusion is limiting patient access to the benefits promised to them under the Parity Law. Right now, in certain states, patients in fully insured plans have no ability to seek enforcement of MHPAEA and the IFR.”<sup>xiii</sup>

Attorney Muszynski’s testimony about the situation in Florida echoed Sen. Blumenthal’s letter; he said the Florida Department of Insurance said it had no jurisdiction and took no action.

##### *Enforcement*

Witnesses also testified about lack of enforcement of MHPAEA. Whelan testified, “perhaps the biggest shortcoming we see with respect to the regulations is that they provide no meaningful enforcement mechanism.”<sup>xiv</sup> She added, “We have even been told that our appeals asserting a violation of parity are ‘too legal,’ signaling that the plans put no stock in parity arguments (and thus have no fear of ramifications with respect to failure to comply with the same).”<sup>xv</sup>

Muszynski expressed concern over lack of transparency around enforcement in Florida, stating “It is very clear from this situation that compliance and enforcement under the federal parity law must be timely. Even if the FLBCBS actions were upheld by regulations, we need to know this. We strongly believe the actions were improper and would need the opportunity to try to appeal the regulators’ decision. In any case, untimely oversight leaves the entire situation in limbo. Patients, the intended beneficiaries of the parity law, are the real losers here.”<sup>xvi</sup>

## 4. CONCLUSIONS

### a. *Final Regulations Should Clarify Barriers to Treatment in the Interim Final Regulations*

To ensure access to non-discriminatory mental health and addiction treatment as intended by Congress, the final regulations must address the above loopholes witnesses testified about at the field hearings. Whelan testified these “loopholes,” lack of clarity or other shortcomings in the law, make it impossible to assert a meaningful challenge to policies that are at odds with parity.”<sup>lxvii</sup>

#### ***Disclosure and Transparency***

Witnesses testified repeatedly about the need to require plans to disclose information to patients and providers and be more transparent. Professor Weber testified, “in addition to the adoption of parity compliance standards by national accreditation bodies, state departments of insurance, the DOL or HHS, as appropriate, must adopt standards that require issuers, carriers or third-party administrators to demonstrate that they have conducted the required parity analysis for all plans (not just products), provide documentation of their analysis to state or federal regulators and make available such documentation to plan members and beneficiaries. In this way, consumers can be assured that plans have done due diligence in analyzing plans for parity compliance and, additionally, have access to basic plan information that will enable them and their representative to evaluate whether a violation exists in particular cases.”<sup>lxviii</sup>

#### ***Non-quantitative Treatment Limits***

Witnesses spoke to the need for the final regulations to provide clarity around NQTLs. Recommendations for the final rule included:

- Whelan testified, “we believe final regulations should provide an objective, quantifiable test for determining whether an NQTL is ‘comparable to’ and/or ‘applied more stringently than.’”<sup>lxix</sup>
- Steve Melek with Milliman recommended the final regulations provide clarity to address confusion in many plans over “whether an NQTL may be applied to the MH/SUD benefit if it does not apply to some minimum level of medical/surgical benefits in the same class.”<sup>lxx</sup>
- Additionally, Melek recommended the final regulations should clarify other areas of confusion that exist for NQTLs. For example, “is it acceptable to make an appointment with a medical specialist such as an allergist within 3 days, but have to wait 3 weeks for an appointment with a psychiatrist? Is it acceptable that medical providers get paid at higher levels than mental health and substance use providers for comparable services? Is it acceptable to require different levels of credentialing between covered physician healthcare providers and behavioral healthcare providers?”<sup>lxxi</sup>
- Dr. Daviss recommended the final regulations address network adequacy and stated that phantom networks and non-quantitative treatment limits “will continue until we have final regulations that specifically address network adequacy and include consequences that are more costly than the financial benefits to having inadequate networks.”<sup>lxxii</sup>

## **Scope of Service**

Witnesses testified that final regulations must address scope of service. As stated by Whelan, “in order to make parity meaningful, final regulations must specify that plans which choose to cover MH/SUD treatment must cover all treatment modalities. Final regulations should further specify that all levels on the continuum of care for MH/SUDs must be assigned to one of the six classifications.”<sup>lxixiii</sup>

Professor Weber also testified that the final rules must address scope of service, stating, “plans have little incentive to cover the full range of services if they know the DOL will not address scope of service complaints pending the promulgation of the final rule. Yet, failure to provide the clinically appropriate level of care harms the patient and ultimately imposes significant costs on the employer and the larger community.”<sup>lxixiv</sup>

In Chicago, Pamela Rodriguez testified on behalf of Treatment Alternatives for Safe Communities and stated, “The full continuum of services should include services that improve functioning and help people achieve rehabilitation and maintain long-term recovery. It should cover services to meet individuals’ multiple needs and should recognize that no single treatment for mental illness and substance use disorders is effective for all individuals. Services must include:

- Outpatient treatment
- Inpatient hospital services
- Intensive outpatient
- Intensive home-based treatment
- Crisis services
- Residential substance use disorder treatment
- Prescription drugs including all medications approved for the treatment of mental illness and substance use disorders
- Care management and
- Recovery support services, including peer support and coaching”<sup>lxixv</sup>

### **b. Parity Must be Actively Implemented and Enforced**

Witnesses made the case at the field hearings for increased federal and state MHPAEA enforcement. Weber stated, “The federal government’s enforcement actions directly influence the level of voluntary compliance by employers and the effectiveness of enforcement efforts by those on the ground. One Maryland treatment provider captured the importance of enforcement, noting that the law determines ‘whether our patients get care and whether we get paid.’”<sup>lxixvi</sup>

Whelan stated, “we believe final regulations should incorporate a requirement for health insurance carriers to demonstrate that they evaluate all plans that they offer and determine that the plans are compliant with parity on an annual basis. The results of these evaluations should be filed with the Department of Labor and made available to insureds on request.”<sup>lxixvii</sup> Whelan also advocated for, “an investment of resources at the federal level to monitor compliance with parity. This should include a way for patients to register complaints about parity violations that will be addressed promptly and in a meaningful way.”<sup>lxixviii</sup>

### **c. Conclusion**

Witnesses throughout the country expressed their commitment to the full implementation and enforcement of MHPAEA so the benefits of the law can be fully enjoyed by patients and family members as intended by Congress. Witnesses testified final regulations must address the gaps in the interim final regulations, including scope of service, transparency and disclosure and non-quantitative treatment limits. Additionally, witnesses asked for more clarity around state and federal enforcement responsibilities.

### **Endnotes**

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- <sup>i</sup> Testimony of Ann Price at June 26, 2012 Chevy Chase, MD field hearing
- <sup>ii</sup> Testimony of Dafna Michaelson at January 10, 2013 Denver, CO field hearing
- <sup>iii</sup> Testimony of Lisa Sonnenberg at August 6, 2012 Chicago, IL field hearing
- <sup>iv</sup> Letter signed by Gerald J. Roper on behalf of the Chicagoland Chamber of Commerce to Jim Ramstad and Patrick Kennedy
- <sup>v</sup> Statement of Rep. Jan Schakowsky at August 6, 2012 Chicago, IL field hearing
- <sup>vi</sup> Statement of Rep. Chris Van Hollen at June 26, 2012 Chevy Chase, MD field hearing
- <sup>vii</sup> Testimony of Beth Ann Middlebrook at October 9, 2012 Delray Beach, FL field hearing
- <sup>viii</sup> Testimony of Dr. Wendy Oliver-Pyatt at October 9, 2012 Delray Beach, FL field hearing
- <sup>ix</sup> Testimony of Lisa Kantor at September 18, 2012 Los Angeles, CA field hearing
- <sup>x</sup> Testimony of Lori Jo Baach at October 9, 2012 Delray Beach, FL field hearing
- <sup>xi</sup> Letter signed by Gerald J. Roper on behalf of the Chicagoland Chamber of Commerce to Jim Ramstad and Patrick Kennedy
- <sup>xii</sup> Testimony of Keris Myrick at September 18, 2012 Los Angeles, CA field hearing
- <sup>xiii</sup> Testimony of Molly Foxworth at August 6, 2012 Chicago, IL field hearing
- <sup>xiv</sup> Testimony of Frank Ruiz at January 10, 2013 Denver, CO field hearing
- <sup>xv</sup> Testimony of Dr. Tom McLellan at August 6, 2012 Chicago, IL field hearing
- <sup>xvi</sup> Ibid.
- <sup>xvii</sup> Testimony of Kevin Kinnon at September 18, 2012 Los Angeles, LA field hearing
- <sup>xviii</sup> Testimony of District Attorney Morrissey at January 10, 2013 Denver, CO field hearing
- <sup>xix</sup> Testimony of Suzette Glasner-Edwards at September 18, 2012 Los Angeles, CA field hearing
- <sup>xx</sup> Testimony of Dr. Steve Daviss at June 26, 2012 Chevy Chase, MD field hearing
- <sup>xxi</sup> Testimony of Dr. Wendy Oliver-Pyatt at October 9, 2012 Delray Beach, FL field hearing
- <sup>xxii</sup> Testimony of Dr. Steve Daviss at June 26, 2012 Chevy Chase, MD field hearing
- <sup>xxiii</sup> Ibid.
- <sup>xxiv</sup> Report prepared by the Office of the Connecticut Office of the Healthcare Advocate summarizing October 17, 2012 field hearing findings Available at:  
<http://www.ct.gov/oha/cwp/view.asp?a=2258&q=300588>
- <sup>xxv</sup> Testimony of Ellen Weber at June 26, 2012 Chevy Chase, MD field hearing
- <sup>xxvi</sup> Testimony of Dr. Eric Arzubi at October 17, 2012 Hartford, CT field hearing
- <sup>xxvii</sup> Testimony of Kelly Whelan at August 6, 2012 Chicago, IL field hearing
- <sup>xxviii</sup> Report prepared by the Office of the Connecticut Office of the Healthcare Advocate summarizing October 17, 2012 field hearing findings Available at:  
<http://www.ct.gov/oha/cwp/view.asp?a=2258&q=300588>
- <sup>xxix</sup> Ibid.
- <sup>xxx</sup> Ibid.
- <sup>xxxi</sup> Testimony of Brenda Wilson at June 26, 2012 Chevy Chase, MD field hearing
- <sup>xxxii</sup> Testimony of Kelly Whelan at August 6, 2012 Chicago, IL field hearing
- <sup>xxxiii</sup> Testimony of Kim S. at July 16, 2012 St. Paul, MN field hearing
- <sup>xxxiv</sup> Testimony of Dr. Daniel Yohanna at August 6, 2012 Chicago, IL field hearing
- <sup>xxxv</sup> Testimony of Angela Woods at August 6, 2012 Chicago, IL field hearing

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- xxxvi Testimony of Ellen Weber at June 26, 2012 Chevy Chase, MD field hearing
- xxxvii Testimony of Dr. Marcy Forgey at September 18, 2012 Los Angeles, CA field hearing
- xxxviii Testimony of Dr. Charles Stephens at January 10, 2013 Denver, CO field hearing
- xxxix Testimony of Dr. Itai Danovitch at September 18, 2012 Los Angeles, CA field hearing
- xl Testimony of Connecticut State Medical Society at October 17, 2012 Hartford, Connecticut field hearing
- xli Testimony of Steve Melek at January 10, 2013 Denver, CO field hearing
- xlii Testimony of Kelly Whelan at August 6, 2012 Chicago, IL field hearing
- xliiii Testimony of Beth Ann Middlebrook at October 9, 2012 Delray Beach, FL field hearing
- xliv Testimony of Dr. Steve Daviss at June 26, 2012 Chevy Chase, MD field hearing
- xlv Testimony of Kelly Whelan at August 6, 2012 Chicago, IL field hearing
- xlvi Testimony of Dr. Daniel Yohanna at August 6, 2012 Chicago, IL field hearing
- xlvii Testimony of Dr. Steve Daviss at June 26, 2012 Chevy Chase, MD field hearing
- xlviii Testimony of Irvin “Sam” Muszynski at October 9, 2012 Delray Beach, FL field hearing
- lix Ibid.
- i Testimony of Dr. Steve Daviss at June 16, 2012 Chevy Chase, MD field hearing
- ii Testimony of Dr. Marcy Forgey at September 18, 2012 Los Angeles, CA field hearing
- iii Testimony of Dr. Paul Berger at June 26, 2012 Chevy Chase, MD field hearing
- iiii Testimony of Maureen Sullivan Dinnan at October 17, 2012 Hartford, CT field hearing
- liv Testimony of Dr. Elizabeth Cookson at January 10, 2013 Denver, CO field hearing
- lv Testimony of Steve Melek at January 10, 2013 Denver, CO field hearing
- lvi Testimony of Mark Reinstein at April 26, 2012 Kalamazoo, MI field hearing
- lvii Letter from Sen. Dick Blumenthal to the Department of Labor dated October 17, 2012 and included in October 17, 2012 Connecticut field hearing record
- lviii Ibid.
- lix Testimony of Beth Ann Middlebrook at October 9, 2012 Delray Beach, FL field hearing
- lx Testimony of John Schwarzlose at September 18, 2012 Los Angeles, CA field hearing
- lxi Testimony of Raymond Crowel at June 26, 2012 Chevy Chase, MD field hearing
- lxii Letter from Sen. Dick Blumenthal to HHS Center for Consumer Information and Insurance Oversight dated October 17, 2012 and included in October 9, 2012 Connecticut field hearing record
- lxiii Ibid.
- lxiv Testimony of Kelly Whelan at August 6, 2012 Chicago, IL field hearing
- lxv Ibid.
- lxvi Testimony of Irvin “Sam” Muszynski at October 9, 2012 Delray Beach, FL field hearing
- lxvii Testimony of Kelly Whelan at August 6, 2012 Chicago, IL field hearing
- lxviii Testimony of Ellen Weber at June 26, 2012 Chevy Chase, MD field hearing
- lxix Testimony of Kelly Whelan at August 6, 2012 Chicago, IL field hearing
- lxx Testimony of Steve Melek at January 10, 2013 Denver, CO field hearing
- lxxi Ibid.
- lxxii Testimony of Dr. Steve Daviss at June 26, 2012 Chevy Chase, MD field hearing
- lxxiii Testimony of Kelly Whelan at August 6, 2012 Chicago, IL field hearing
- lxxiv Testimony of Ellen Weber at June 26, 2012 Chevy Chase, MD field hearing
- lxxv Testimony of Pamela Rodriguez at August 6, 2012 Chicago, IL field hearing
- lxxvi Testimony of Ellen Weber at June 26, 2012 Chevy Chase, MD field hearing
- lxxvii Testimony of Kelly Whelan at August 6, 2012 Chicago, IL field hearing
- lxxviii Ibid.