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MEMORANDUM

DATE: November 18, 2011

TO: Ms. Sharon L. Summers, DMMA
Planning & Policy Development Unit

FROM: Wendy Strauss, ^{WS/KIT} Vice-Chairperson
State Council for Persons with Disabilities

RE: 15 DE Reg. 621 [DMMA Proposed LTC Insurance Partnership Program]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA's) proposal to adopt a State Plan amendment to implement a "Qualified Long-Term Care Insurance Partnership Program" ("QLTCIP"). The proposed regulation was published as 15 DE Reg. 621 in the November 1, 2011 issue of the Register of Regulations.

The program is authorized by federal law to provide an incentive to individuals to purchase a qualifying long-term care insurance. Under this scheme, an individual with a QLTCIP policy can enroll in Medicaid without having to exhaust policy benefits. The policy would then pay the authorized policy amount towards long-term care and Medicaid could cover the balance. *Id.* Both nursing home and home-health services would be eligible. There is no "grandfather" provision, i.e., this program is available only to individuals purchasing a QLTCIP policy after November 1, 2011 in Delaware or another state with a QLTCIP. Individuals taking advantage of this program qualify for a disregard of resources in an amount equal to LTC insurance benefits paid. Participating insurers would be required to report benefits paid under covered policies.

SCPD endorses the concept of implementing this federal option. However, the Council would like to also remind DMMA of concerns shared with the Department in the attached August 23, 2010 memo. See also attached Dept of Insurance commentary at 14 DE Reg. 316 (October 1, 2010). In a nutshell, the Department of Insurance allows LTC insurers to offer highly-constrictive policies which: 1) only authorize nursing home payments if an insured has limits in 3 ADLs; 2) ignore limits in IADLs; and 3) allow only ½ benefit payments for individuals opting for home health care versus institutional care. Delaware Medicaid covers both home health and nursing home services based on a deficit in 1 ADL. Effective April 2012, the DSHP Plus

program will authorize home health services based on a deficit in 1 ADL and authorize nursing home coverage based on a deficit in 2 ADLs. Thus, Medicaid will be paying for both nursing home and home health services with 0 contribution by insurers since the “disability” threshold triggering insurance payment is higher. The “bottom line” is that DMMA may not realize anticipated cost savings, i.e., the expectation “that long-term care insurance policies will initially be paying for services rather than Medicaid.” At p. 622, Fiscal Impact Statement.

DMMA would be well advised to collaborate with the Department of Insurance to ensure that qualifying QLTCIP policies provide nursing home benefits based on more liberal standards than limits in 3 ADLs. Moreover, the DSHP Plus program is attempting to promote home health services versus nursing home services by establishing a higher requirement for nursing home eligibility (limits in 2 ADLs) than home health care (limit of 1 ADL). This incentive is undermined by insurance policies which pay only ½ benefits for home health services. DMMA should consult the Department of Insurance to assess prospects for requiring a QLTCIP policy to pay equal benefits for home health and nursing facility care.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our position or observations on the proposed regulation.

cc: The Honorable Matthew Denn
The Honorable Karen Weldin Stewart
The Honorable Rita Landgraf
Ms. Rosanne Mahaney
Mr. William Love
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traveling, doing housework, using the telephone, and taking medications (Fillenbaum et al., 1978). Recent research suggests that there is a hierarchical relationship between some IADL items and ADL items, with IADL disabilities representing less severe dysfunction (Spector, Katz, and Fullton, 1987).

Another domain, related to ADLs and IADLs, is cognitive ability. Persons with Alzheimer's disease and related dementias are prime examples of individuals with cognitive impairment. Cognitive impairment and ADL status are correlated but are separate dimensions of functioning (Fillenbaum et al., 1978). Not all persons with substantial cognitive impairment have ADL dysfunctions. DSAAPD assesses individuals for cognitive and mental health issues. These findings are documented and a risk category for mental health is assigned. Individuals presenting with a need for ADL assistance resulting from a primary or secondary diagnosis of mental illness, mental retardation or a related developmental disability are screened and referred for services in accordance with that process determination.

Because ADLs do not cover all domains of disability, estimates of the need for long-term care services that rely solely on ADL measures will miss a substantial proportion of the disabled population.

SCPD also encourages the Department to consider use of the International Classification of Functioning, Disability and Health (ICF), which is a classification of health and health-related domains (see attached information). These domains are classified from body, individual and societal perspectives by means of two lists: a list of body functions and structure, and a list of domains of activity and participation. Since an individual's functioning and disability occurs in a context, the ICF also includes a list of environmental factors. The ICF puts the notions of 'health' and 'disability' in a new light. It acknowledges that every human being can experience a decrement in health and thereby experience some degree of disability. Disability is not something that only happens to a minority of humanity. The ICF thus 'mainstreams' the experience of disability and recognizes it as a universal human experience. By shifting the focus from cause to impact, it places all health conditions on an equal footing allowing them to be compared using a common metric – the ruler of health and disability. Furthermore, ICF takes into account the social aspects of disability and does not see disability only as a 'medical' or 'biological' dysfunction.

Second, §12.2 provides a disincentive for home-based care. It recites, in pertinent part, as follows:

12.2. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate.

It would be preferable to prompt insurers to offer the same dollar coverage for home-based services. Otherwise, the regulation effectively encourages nursing home placement since home care would be supported by only half the amount of payments that could be made to a nursing home.

Third, §30.1 authorizes compensation to an agent selling long-term care policies of 35% of the total of premiums paid from all the selling agent's policies each policy year. Reasonable persons might view this as "gouging" the elderly and near-elderly. Such excessive compensation likewise artificially raises premiums well beyond the insurer's risk of pay-outs.

Fourth, in §4.0, definition of "Benefit Trigger", second sentence, "purposed" should be "purposes".

Fifth, in §5.0, the definition of "bathing" is as follows:

"Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

This definition is difficult to understand. For example, if an insured can dab his/her body with a damp sponge outside of a tub or shower, does the insured have the ability to "bathe"? The use of the term "or" is disjunctive and suggests that there is no bathing deficit if someone can rub his/her body with a sponge outside of a tub or shower. This is a perversion of the normal view of bathing.

Sixth, in §5.0, the definition of "continence" is as follows:

"Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function.

The definition is "odd". The first part appears to define "continence". The second part appears to define "incontinence", i.e., lack of bowel and bladder control.

Seventh, in §5.0, definition of "home health care services", there is a lack of "people-first" language, and, indeed, use of pejorative language - "ill, disabled, or infirm persons". For example, the term "infirm" is outdated and pejorative. It is considered an insulting term which should be avoided in contemporary regulations. The Guidelines for Reporting and Writing About People with Disabilities, 5th edition, recites as follows:

PUT PEOPLE FIRST, not their disability...Crippled, deformed, suffers from, victim of, the retarded, infirm, the deaf and dumb, etc. are never acceptable under any circumstances.

Eighth, in §5.0, the definition of "mental or nervous disorder" is as follows:

"Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disorder.

According to Wikipedia, the term “neurosis” “is no longer part of mainstream psychiatric terminology”. Indeed, it does even appear in the index to the DSM-IV. However, the more important aspect of this definition is the authorization for insurers to discriminate against applicants with “mental or nervous disorders”. While §6.2 bars policy limits and exclusions based on type of illness, treatment, or medical condition, §6.2.2 incredibly has an exception for “mental or nervous disorders”. Thus, insurers are authorized to discriminate in policy limits and coverage based on an extremely broad definition of “mental or nervous disorder”. Likewise, §6.2.3 authorizes discrimination based on alcoholism and drug addiction. Sections 6.2.2 and 6.2.3 should be stricken in their entirety. Both State and federal public policy promote parity in health insurance and discourage discrimination based on mental illness and substance abuse dependency. See, e.g. Title 18 Del.C. §3343, which recites as follows: (N)o carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan.” For a similar federal perspective, see attached article, SAMHSA News, “Parity: Landmark Legislation Takes Effect. What are the Implications for Millions of Americans?” (January/February, 2010).

Ninth, in §6.1.1, second sentence, delete the colon and do not capitalize “(t)hat”.

Tenth, §6.1.6.2 contains a mandatory disclosure to be provided to insureds in bold print. However, the following “disclosure” would not be understood by the ordinary policyholder:

Insurers will be allowed a carry forward of the initially disclosed maximum premium increase, but said carry forward is lost within twenty-four (24) months if not utilized.

This mandatory disclosure will be unintelligible to consumers. In addition, as a general proposition, SCPD encourages the Department to simplify disclosures provided to applicants. Other states (e.g. New York) require insurance documentation to be written at a “lay person” level.

Eleventh, §6.2.6 is unclear. It is common for persons in need of care to be relocated close to other relatives who may live some distance from the home/domicile of the insured, perhaps in another state. This section is unclear on whether the insurer could deny services based on such relocation, especially if the insured’s home/domicile is not immediately sold. Consider how the following text should be interpreted:

No territorial limits are permissible, except that nothing herein shall preclude limiting benefits...to specific providers within a particular geographic area. Moreover, nothing herein shall prohibit the limitation of services to a particular geographical area when the insured elects to receive services within that specific geographical area. For purposes of this clause, the location of receipt of services must be within 50 miles of the domicile of the insured at the time of entry therein or that area, including the nearest three nursing

homes, whichever distance is greater.

It would be preferable to simply disallow territorial limitations, at least within the United States.

Twelfth, there is a "typo" in §8.2.5.1, i.e., "proemium" should be "premium".

Thirteenth, §22.0 contains a model outline of coverage to be shared with applicants. Par. 15 directs applicants to an undefined "State Senior Health Insurance Assistance Program". SCPD suspects this may be the ElderInfo program referenced in §24.1.6. It would be preferable to include more specific information in the Par.15 notice. For the same reason, more specificity should be included in Appendix C, "Things You Should Know Before You Buy Long-Term Care Insurance", which refers generically to the "state's insurance counseling program" and the "department of aging". Delaware does not have a department of aging.

Fourteenth, SCPD recommends that there be an acknowledgement in writing of receipt by the consumer regarding disclosures which the Department of Insurance mandates be shared with the applicant.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or recommendations on the proposed regulation.

cc: The Honorable Jack Markell
The Honorable Matthew Denn
The Honorable Rita Landgraf
Ms. Rosanne Mahaney, DMMA
Mr. William Love, DSAAPD
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Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

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ORIGINAL RESEARCH
ON IADL'S. NOW
UPDATED in 1990 + by
to include COGNITIVE
functions.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (IADL)

M.P. Lawton & E.M. Brody

A. Ability to use telephone

- | | |
|---------------------------------------------------------------------------|---|
| 1. Operates telephone on own initiative; looks up and dials numbers, etc. | 1 |
| 2. Dials a few well-known numbers | 1 |
| 3. Answers telephone but does not dial | 1 |
| 4. Does not use telephone at all. | 0 |

B. Shopping

- | | |
|---------------------------------------------------|---|
| 1. Takes care of all shopping needs independently | 1 |
| 2. Shops independently for small purchases | 0 |
| 3. Needs to be accompanied on any shopping trip. | 0 |
| 4. Completely unable to shop. | 0 |

C. Food Preparation

- | | |
|--------------------------------------------------------------------------------------------|---|
| 1. Plans, prepares and serves adequate meals independently | 1 |
| 2. Prepares adequate meals if supplied with ingredients | 0 |
| 3. Heats, serves and prepares meals or prepares meals but does not maintain adequate diet. | 0 |
| 4. Needs to have meals prepared and served. | 0 |

D. Housekeeping

- | | |
|------------------------------------------------------------------------------------------|---|
| 1. Maintains house alone or with occasional assistance (e.g. "heavy work domestic help") | 1 |
| 2. Performs light daily tasks such as dish-washing, bed making | 1 |
| 3. Performs light daily tasks but cannot maintain acceptable level of cleanliness. | 1 |
| 4. Needs help with all home maintenance tasks. | 1 |
| 5. Does not participate in any housekeeping tasks. | 0 |

E. Laundry

- | | |
|-------------------------------------------------|---|
| 1. Does personal laundry completely | 1 |
| 2. Launders small items; rinses stockings, etc. | 1 |
| 3. All laundry must be done by others. | 0 |

F. Mode of Transportation

- | | |
|------------------------------------------------------------------------------------|---|
| 1. Travels independently on public transportation or drives own car. | 1 |
| 2. Arranges own travel via taxi, but does not otherwise use public transportation. | 1 |
| 3. Travels on public transportation when accompanied by another. | 1 |
| 4. Travel limited to taxi or automobile with assistance of another. | 0 |
| 5. Does not travel at all. | 0 |

G. Responsibility for own medications

- | | |
|----------------------------------------------------------------------------------|---|
| 1. Is responsible for taking medication in correct dosages at correct time. | 1 |
| 2. Takes responsibility if medication is prepared in advance in separate dosage. | 0 |
| 3. Is not capable of dispensing own medication. | 0 |

H. Ability to Handle Finances

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------|---|
| 1. Manages financial matters independently (budgets, writes checks, pays rent, bills goes to bank), collects and keeps track of income. | 1 |
| 2. Manages day-to-day purchases, but needs help with banking, major purchases, etc. | 1 |
| 3. Incapable if handling money. | 0 |

Source: Lawton, M.P., and Brody, E.M. "Assessment of older people: Self-maintaining and instrumental activities of daily living." *Gerontologist* 9:179-186, (1969).

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**Towards
a
Common Language
for
Functioning, Disability and Health
ICF**



**World Health Organization
Geneva
2002**

**Towards a
Common Language
for
Functioning, Disability and Health:**

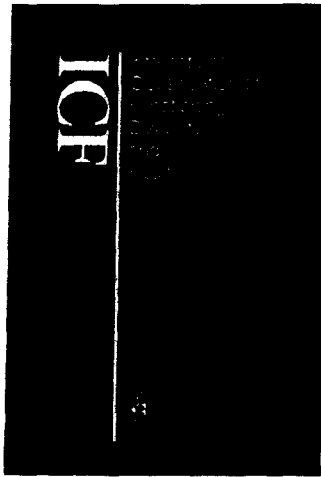
ICF

**The International Classification
of Functioning, Disability and Health**

Introduction	2
ICF and the WHO Family of Classifications	3
The need for ICF	4
How will WHO use ICE	5
How can ICF be used?	6
The Model of ICF	9
Concepts of functioning and disability	10
The qualifiers	11
Underlying principles of ICF	14
The Domains of ICF	15
Conclusion	19
The World-Wide ICF Network	20

INTRODUCTION

The *International Classification of Functioning, Disability and Health*, known more commonly as ICF, provides a standard language and framework for the description of health and health-related states. Like the first version published by the World Health Organization for trial purposes in 1980, ICF is a multi-purpose classification intended for a wide range of uses in different sectors. It is a classification of health and health-related domains -- domains that help us to describe changes in body function and structure, what a person with a health condition can do in a standard environment (their level of capacity), as well as what they actually do in their usual environment (their level of performance). These domains are classified from body, individual and societal perspectives by means of two lists: a list of body functions and structure, and a list of domains of activity and participation. In ICF, the term *functioning* refers to all body functions, activities and participation, while *disability* is similarly an umbrella term for impairments, activity limitations and participation restrictions. ICF also lists environmental factors that interact with all these components.



ICF is WHO's framework for health and disability. It is the conceptual basis for the definition, measurement and policy formulations for health and disability. It is a universal classification of disability *and* health for use in health and health-related sectors. ICF therefore looks like a simple health classification, but it can be used for a number of purposes. The most important is as a planning and policy tool for decision-makers.

ICF is named as it is because of its stress is on health and functioning , rather than on disability. Previously, disability began where health ended; once you were disabled, you were in a separate category. We want to get away from this kind of thinking. We want to make ICF a tool for measuring functioning in society, no matter what the reason for one's impairments. So it becomes a much more versatile tool with a much broader area of use than a traditional classification of health and disability.

This is a radical shift. From emphasizing people's disabilities, we now focus on their level of health.

ICF puts the notions of 'health' and 'disability' in a new light. It acknowledges that every human being can experience a decrement in health and thereby experience some disability. This is not something that happens to only a minority of humanity. ICF thus 'mainstreams' the experience of disability and recognises it as a universal human experience. By shifting the focus from cause to impact it places all health conditions on an equal footing allowing them to be compared using a common metric – the ruler of health and disability.

THE WHO FAMILY OF INTERNATIONAL CLASSIFICATIONS

ICF belongs to the WHO family of international classifications, the best known member of which is the ICD-10 (the *International Statistical Classification of Diseases and Related Health Problems*). ICD-10 gives users an etiological framework for the classification, by diagnosis, of diseases, disorders and other health conditions. By contrast, ICF classifies functioning and disability associated with health conditions. The ICD-10 and ICF are therefore complementary, and users are encouraged to use them together to create a broader and more meaningful picture of the experience of health of individuals and populations. Information on mortality (provided by ICD-10) and information about health and health-related outcomes (provided by ICF) can be combined in summary measures of population health.

In short, ICD-10 is mainly used to classify causes of death, but ICF classifies health.

WHO Family of International Classifications

development.

There is also an increased recognition among social planners and service agencies that reductions in the incidence and severity of disability in a population can be brought about both by enhancing the functional capacity of the person and by improving performance by modifying features of the social and physical environment. To analyze the impact of these different interventions, we need a way of classifying domains of areas of life as well as the environmental factors that improve performance. ICF allows us to record this information.

HOW WILL WHO USE ICF?

WHO must provide tools that our Member States can use to improve their health policies, achieve better health for their population and to ensure that their health systems are as cost effective and fair as possible. We provide tools that are based on the best science and which represent the basic core values on which the Organization bases its work: equity, inclusion and the aim of all to achieve a life where each person can exploit his or her opportunities to the fullest possible degree.

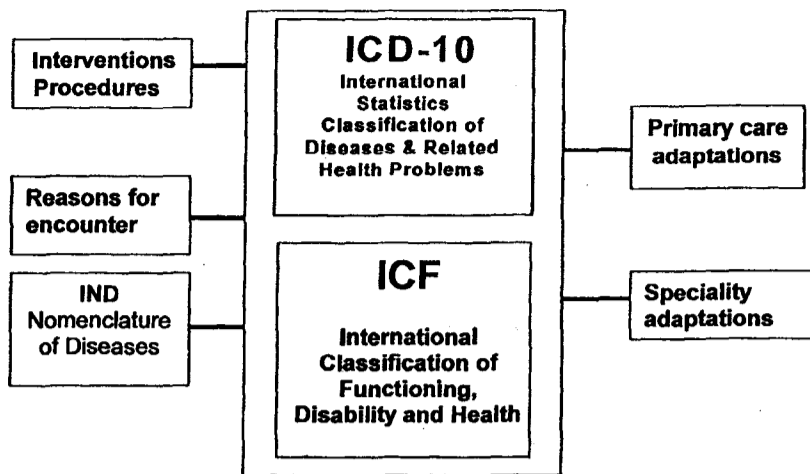
Last year, the 191 Member States of the World Health Organization agreed to adopt ICF as the basis for the scientific standardization of data on health and disability world-wide. ICF directly contributes to WHO's efforts to establish a comprehensive population health measurement framework. We would like to go beyond the old, traditional mortality and morbidity measures by including measures of functional domains of health.

WHO uses a multi-dimensional health measure as the basis for health systems performance assessment. The health goal of a health system is measured on the basis of ICF. In this way, WHO can assist Member States in enhancing the performance of their health systems. With better functioning health systems, health levels across the population are raised and everyone benefits.

The ICF is key example of such a tool. ICF is a scientific tool for consistent, internationally comparable information about the experience of health and disability. As such, it also provides the basis for WHO overall approach to health.

HOW CAN ICF BE USED?

Because of its flexible framework, the detail and completeness of its classifications and the fact that each domain is operationally defined, with inclusions and exclusions, it is expected that ICF, like its predecessor, will be



THE NEED FOR ICF

Studies show that diagnosis alone does not predict service needs, length of hospitalization, level of care or functional outcomes. Nor is the presence of a disease or disorder an accurate predictor of receipt of disability benefits, work performance, return to work potential, or likelihood of social integration. This means that if we use a medical classification of diagnoses alone we will not have the information we need for health planning and management purposes. What we lack is data about levels of functioning and disability. ICF makes it possible to collect those vital data in a consistent and internationally comparable manner.

For basic public health purposes, including the determine the overall health of populations, the prevalence and incidence of non-fatal health outcomes, and to measure health care needs and the performance and effectiveness of health care systems, we need reliable and comparable data on the health of individuals and populations. ICF provides the framework and classification system for these purposes.

For some time, there has been a shift in the focus from hospital-based acute care to community-based long-term services for chronic conditions. Social welfare agencies have noticed a marked increased in demand for disability benefits. These trends have underscored the need for reliable and valid disability statistics. ICF provides the basis for identifying kinds and levels of disability which provides the foundations for country-level disability data to inform policy

used for a myriad of uses to answer a wide range of questions involving clinical, research and policy development issues. (For specific examples of the uses of ICF in the area of service provision, and the kinds of practical issues that can be addressed, see the box below.)

ICF Applications Service Provision

At the individual level

- For the assessment of individuals: What is the person's level of functioning?
- For individual treatment planning: What treatments or interventions can maximize functioning?
- For the evaluation of treatment and other interventions: What are the outcomes of the treatment? How useful were the interventions?
- For communication among physicians, nurses, physiotherapists, occupational therapists and other health workers, social service workers and community agencies
- For self-evaluation by consumers: How would I rate my capacity in mobility or communication?

At the institutional level...

- For educational and training purposes
- For resource planning and development: What health care and other services will be needed?
- For quality improvement: How well do we serve our clients? What basic indicators for quality assurance are valid and reliable?
- For management and outcome evaluation: How useful are the services we are providing?
- For managed care models of health care delivery: How cost-effective are the services we provide? How can the service be improved for better outcomes at a lower cost?

At the social level...

- For eligibility criteria for state entitlements such as social security benefits, disability pensions, workers' compensation and insurance: Are the criteria for eligibility for disability benefits evidence based, appropriate to social goals and justifiable?
- For social policy development, including legislative reviews, model legislation, regulations and guidelines, and definitions for anti-discrimination legislation: Will guaranteeing rights improve functioning at the societal level? Can we measure this improvement and adjust our policy and law accordingly?
- For needs assessments: What are the needs of persons with various levels of disability - impairments, activity limitations and participation restrictions?
- For environmental assessment for universal design, implementation of mandated accessibility, identification of environmental facilitators and barriers, and changes to social policy: How can we make the social and built environment more accessible for all persons, those with and those without disabilities? Can we assess and measure improvement?

Among the other kinds of uses for ICF are these:

Policy development...

In both the health sectors and other sectors that need to take into account the functional status of people, such as social security, employment, education and transportation, there is an important role that ICF can play. It goes without saying that policy development in these sectors requires valid and reliable population data on functional status. Legislative and regulatory definitions of disability need to be consistent and grounded in a single coherent model of the disability creation process. Whether it is devising eligibility criteria for disability pensions, developing regulations for access to assistive technology, or mandating housing or transportation policy that accommodates individuals with mobility, sensory or intellectual disability, ICF can provide the framework for comprehensive and coherent disability-related social policy.

Economic analyses...

Most applications of ICF lend themselves to economic analyses. Determining whether resources are effectively used in health care and other social services requires a consistent and standard classification of health and health-related outcomes that can be costed and compared internationally. We need information on the disability burden of various diseases and health conditions. To ensure that society can effectively prevent limitations on activities and restrictions on participation, it needs to cost the economic impact of functional limitations as compared to the costs of modifying the built and social environment. ICF makes both of these tasks possible.

Research uses...

Generally, ICF assists in scientific research by providing a framework or structure for interdisciplinary research in disability and for making results of research comparable. Traditionally, scientists have measured the outcomes of health conditions by relying on mortality data. More recently, the international concern about health care outcomes has shifted to the assessment of functioning at the level of the whole human being, in day-to-day life. The need here is for universally applicable classification and assessment tools, both for activity levels and overall levels of participation, in basic areas and roles of social life. This is what ICF provides and makes possible.

Intervention studies...

Of particular interest in research are intervention studies that compare the outcomes of interventions on similar populations. ICF can facilitate this kind of research by clearly distinguishing interventions -- and coding outcomes -- in light of the aspect of disability that the intervention addresses. Body level or impairment interventions are primarily medical or rehabilitative, and attempt to prevent or ameliorate limitations in person or societal level functioning by correcting or modifying intrinsic functions or structures of the body. Other rehabilitative treatment strategies and interventions are designed to increase capacity levels. Interventions that focus on the actual performance context of an individual may address either capacity-improvement or else seek environmental modification, either by eliminating environmental barriers or creating environmental facilitators for expanded performance of actions and tasks in daily living.

Uses of Environment Factors...

One of the major innovations in ICF is the presence of an environmental factor classification that makes it possible for the identification of environmental barriers and facilitators for both capacity and performance of actions and tasks in daily living. With this classification scheme, which can be used either on an individual basis or for population wide data collection, it may be possible to create instruments that assess environments in terms of their level of facilitation or barrier-creation for different kinds and levels of disability. With this information in hand, it will then be more practical to develop and implement guidelines for universal design and other environmental regulations that extend the functioning levels of persons with disabilities across the range of life activities.

THE MODEL OF ICF

Two major conceptual models of disability have been proposed. The *medical model* views disability as a feature of the person, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by professionals. Disability, on this model, calls for medical or other treatment or intervention, to 'correct' the problem with the individual.

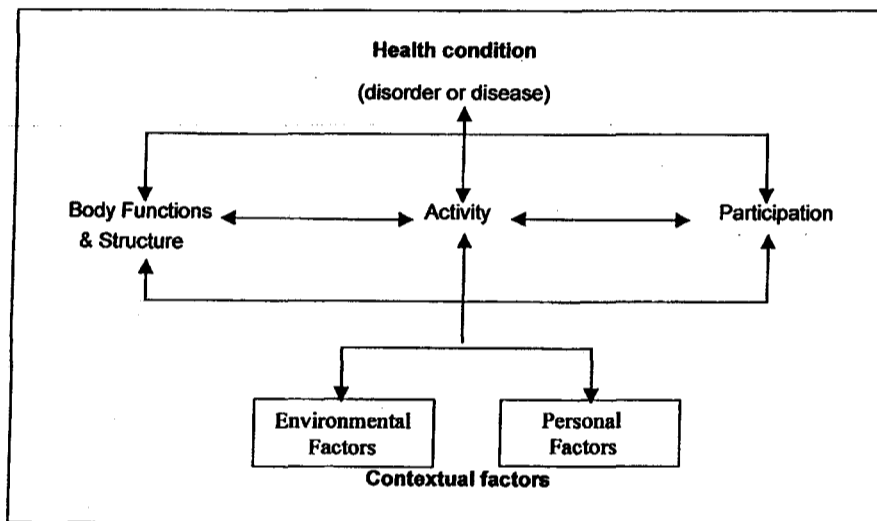
The *social model* of disability, on the other hand, sees disability as a socially-created problem and not at all an attribute of an individual. On the social model, disability demands a political response, since the problem is created by an unaccommodating physical environment brought about by attitudes and other features of the social environment.

On their own, neither model is adequate, although both are partially valid. Disability is a complex phenomena that is both a problem at the level of a person's body, and a complex and primarily social phenomena. Disability is always an interaction between features of the person and features of the overall context in which the person lives, but some aspects of disability are almost entirely internal to the person, while another aspect is almost entirely external. In other words, both medical and social responses are appropriate to the problems associated with disability; we cannot wholly reject either kind of intervention.

A better model of disability, in short, is one that synthesizes what is true in the medical and social models, without making the mistake each makes in reducing the whole, complex notion of disability to one of its aspects.

This more useful model of disability might be called the *biopsychosocial model*. ICF is based on this model, an integration of medical and social. ICF provides, by this synthesis, a coherent view of different perspectives of health: biological, individual and social.

The following diagram is one representation of the model of disability that is the basis for ICF



Concepts of functioning and disability

As the diagram indicates, in ICF disability and functioning are viewed as outcomes of interactions between *health conditions* (diseases, disorders and injuries) and *contextual factors*.

Among contextual factors are external *environmental factors* (for example, social attitudes, architectural characteristics, legal and social structures, as well as climate, terrain and so forth); and internal *personal factors*, which include gender, age, coping styles, social background, education, profession, past and current experience, overall behaviour pattern, character and other factors that influence how disability is experienced by the individual.

The diagram identifies the three levels of human functioning classified by ICF: functioning at the level of body or body part, the whole person, and the whole person in a social context. Disability therefore involves dysfunctioning at one or more of these same levels: impairments, activity limitations and participation restrictions. The formal definitions of these components of ICF are provided in the box below.

Body Functions are physiological functions of body systems (including psychological functions).

Body Structures are anatomical parts of the body such as organs, limbs and their components.

Impairments are problems in body function or structure such as a significant deviation or loss.

Activity is the execution of a task or action by an individual.

Participation is involvement in a life situation.

Activity Limitations are difficulties an individual may have in executing activities.

Participation Restrictions are problems an individual may experience in involvement in life situations.

Environmental Factors make up the physical, social and attitudinal environment in which people live and conduct their lives..

The Qualifiers

The list of domains in ICF becomes a classification when qualifiers are used. Qualifiers record the presence and severity of a problem in functioning at the body, person and societal levels.

For the classifications of body function and structure, the primary qualifier indicates the presence of an impairment and, on a five point scale, the degree of the impairment of function or structure (no impairment, mild, moderate, severe and complete).

In the case of the Activity and Participation list of domains, two important qualifiers are provided. Together, these qualifiers enable the user to code essential information about disability and health.

The *Performance qualifier* describes what an individual does in his or her current environment. Since the current environment always includes the overall societal context, performance can also be understood as "involvement in a life situation" or "the lived experience" of people in their actual context. (The 'current environment' will be understood to include assistive devices or personal assistance, whenever the individual actually uses them to perform actions or tasks.)

The *Capacity qualifier* describes an individual's ability to execute a task or an action. This construct indicates the highest probable level of functioning of a person in a given domain at a given moment.

When a person has a capacity problem associated with a health condition, therefore, that incapacity is a part of their state of health. To assess the full ability of the individual, one would need to have a "*standardized environment*" to neutralize the varying impact of different environments on the ability of the individual. In practice, there are many possible environments that we could use for this purpose.

That is, a standardized environment might be: (a) an actual environment commonly used for capacity assessment in test settings; or (b) an assumed environment thought to have an uniform impact; or (c) an environment with precisely defined parameters based on extensive scientific research. Whatever it is in practice, this environment can be called 'uniform' or 'standard' environment. The capacity construct therefore reflects the environmentally-adjusted ability of the individual in a specified domain. The Capacity qualifier assumes a 'naked person' assessment, that is, the person's capacity without personal assistance or

the use of assistive devices. For assessment purposes, this environmental adjustment has to be the same for all persons in all countries to allow for international comparisons. For precision and international comparability, features of the uniform or standard environment can be coded using the Environmental Factors classification.

For a disability and health classification it is important that users be able to express these domains by means both of a performance and a capacity construct, even if, in particular cases for special uses only one of the two constructs are employed. ICF provides a single list of Activities and Participation which users can, for their needs and purposes, employ either by

- A) designating some domains as Activities and others as Participation and *not allowing overlap*;
- B) making this designation but *allowing overlap* in particular cases;
- C) designating *detailed* (third- or fourth-level) categories within a domain as Activities and *broad* (second-level) categories in the domain as Participation;
- D) *designating all domains* as potentially both Activity and Participation, and employing the qualifiers to distinguish the information that is required and collected.

(The approach described in D) is WHO's default approach and ICF country data submitted to WHO will be assumed to reflect this approach.)

Having access to both performance and capacity data enables ICF user to determine the 'gap' between capacity and performance. If capacity is less than performance, then the person's current environment has enabled him or her to perform better than what data about capacity would predict: the environment has facilitated performance. On the other hand, if capacity is greater than performance, then some aspect of the environment is a barrier to performance.

The distinction between environmental 'barriers' and 'facilitators', as well as the extent to which an environmental factor acts in one way or another, is captured by the qualifier for coding Environmental Factors.

Finally, an additional qualifier is available to supplement this information. Both the Capacity and Performance qualifiers can further be used with and without assistive devices or personal assistance. While neither devices nor personal assistance alter the impairments, they may remove limitations on functioning in

specific domains. This type of coding is particularly useful to identify how much the functioning of the individual would be limited without the assistive devices. The constructs and the operation of the qualifiers is set out in the next chart:

Construct	First qualifier	Second qualifier
Body Functions (b)	Generic qualifier with the negative scale used to indicate the extent or magnitude of an impairment <i>Example: b175.3 to indicate a severe impairment in specific mental functions of language</i>	None
Body Structure (s)	Generic qualifier with the negative scale used to indicate the extent or magnitude of an impairment <i>Example: s730.3 to indicate a severe impairment of the upper extremity</i>	Used to indicate the nature of the change in the respective body structure <ul style="list-style-type: none"> 0 no change in structure 1 total absence 2 partial absence 3 additional part 4 aberrant dimensions 5 discontinuity 6 deviating position 7 qualitative changes in structure, including accumulation of fluid 8 not specified 9 not applicable <i>Example: s7300.32 to indicate the partial absence of the upper extremity</i>
Activity & Participation (d)	PERFORMANCE Generic qualifier <u>Problem in the person's current environment</u> <i>Example: a5101.1 to indicate mild difficulty with bathing the whole body with the use of assistive devices that are available to the person in his or her current environment</i>	CAPACITY Generic qualifier <u>Limitation without assistance</u> <i>Example: a5101.2 to indicate moderate difficulty with bathing the whole body and implies that there is moderate difficulty without the use of assistive devices or personal help</i>
Environmental Factors (e)	Generic qualifier, with negative and positive scale to denote extent of barriers and facilitators respectively <i>Example: e145.2 to indicate that products for education are a moderate barrier. Conversely, e145+2 would indicate that products for education are a moderate facilitator</i>	None

Underlying principles of ICF

There are general principles that underlay the conception of ICF as a health classification of functioning and disability, and are closely linked to the biopsychosocial model of disability. These principles are essential components of

the model of ICF and guided the revision process.

UNIVERSALITY

A classification of functioning and disability should be applicable to all people irrespective of health condition. Therefore, ICF is about all people. It concerns everyone's functioning. Thus, it should not become a tool for labeling persons with disabilities as a separate group.

PARITY

There should not be, explicitly or implicitly, a distinction between different health conditions as 'mental' and 'physical' that affect the structure of content of a classification of functioning and disability. In other words, disability must not be differentiated by etiology.

NEUTRALITY

Wherever possible, domain names should be worded in neutral language so that the classification can express both positive and negative aspects of each aspect of functioning and disability.

ENVIRONMENTAL FACTORS

In order to complete the social model of disability, ICF includes Contextual Factors, in which environmental factors are listed. These factors range from physical factors such as climate and terrain, to social attitudes, institutions, and laws. Interaction with environmental factors is an essential aspect of the scientific understanding of the phenomena included under the umbrella terms 'functioning and disability'.

THE DOMAINS OF ICF

The domains of ICF are arranged in a hierarchy (Chapter, second, third and fourth level domains), which is reflected in the coding:

Level	Example	Coding
Chapter	Chapter 2: Sensory Functions and Pain	b2
Second level	Seeing Functions	b210
Third level	Quality of vision	b2102
Fourth level	Colour vision	b21021

The follow chart sets out the complete list of chapters in the ICF:

Body	
Function: Mental Functions Sensory Functions and Pain Voice and Speech Functions Functions of the Cardiovascular, Haematological, Immunological and Respiratory Systems Functions of the Digestive, Metabolic, Endocrine Systems Genitourinary and Reproductive Functions Neuromusculoskeletal and Movement-Related Functions Functions of the Skin and Related Structures	Structure: Structure of the Nervous System The Eye, Ear and Related Structures Structures Involved in Voice and Speech Structure of the Cardiovascular, Immunological and Respiratory Systems Structures Related to the Digestive, Metabolic and Endocrine Systems Structure Related to Genitourinary and Reproductive Systems Structure Related to Movement Skin and Related Structures
Activities and Participation	
Learning and Applying Knowledge General Tasks and Demands Communication Mobility Self Care Domestic Life Interpersonal Interactions and Relationships Major Life Areas Community, Social and Civic Life	
Environmental Factors	
Products and Technology Natural Environment and Human-Made Changes to Environment Support and Relationships Attitudes Services, Systems and Policies	

The following chart gives some possible examples of disabilities that may be associated with the three levels of functioning linked to a health condition.

HEALTH CONDITION	IMPAIRMENT	ACTIVITY LIMITATION	PARTICIPATION RESTRICTION
Leprosy	Loss of sensation of extremities	Difficulties in grasping objects	Stigma of leprosy leads to unemployment
Panic Disorder	Anxiety	Not capable of going out alone	People's reactions leads to no social relationships
Spinal Injury	Paralysis	Incapable of using public transportation	Lack of accommodations in public transportation leads to no participation in religious activities
Juvenile diabetes	Pancreatic dysfunction	None (impairment controlled by medication)	Does not go to school because of stereotypes about disease
Vitiligo	Facial disfigurement	None	No participation in social relations owing to fears of contagion
Person who formally had a mental health problem and was treated for a psychotic disorder	None	None	Denied employment because of employer's prejudice

The next chart indicates how the different levels of disability are linked to three different levels of intervention.

	Intervention	Prevention
HEALTH CONDITION	Medical treatment/care Medication	Health promotion Nutrition Immunization
IMPAIRMENT	Medical treatment/care Medication Surgery	Prevention of the development of further activity limitations
ACTIVITY LIMITATION	Assistive devices Personal assistance Rehabilitation therapy	Preventive rehabilitation Prevention of the development of participation restrictions
PARTICIPATION RESTRICTION	Accommodations Public education Anti-discrimination law Universal design	Environmental change Employment strategies Accessible services Universal design Lobbying for change

CONCLUSION

ICF offers an international, scientific tool for the paradigm shift from the purely medical model to an integrated biopsychosocial model of human functioning and disability. It is a valuable tool in research into disability, in all its dimensions -- impairments at the body and body part level, person level activity limitations, and societal level restrictions of participation. ICF also provides the conceptual model and classification required for instruments to assess the social and built environment.

ICF will be an essential basis for the standardization of data concerning all aspects of human functioning and disability around the world.

ICF will be used by persons with disabilities and professionals alike to evaluate health care settings that deal with chronic illness and disability, such as rehabilitation centres, nursing homes, psychiatric institutions, and community services.

ICF will be useful for persons with all forms of disabilities, not only for identifying their health care and rehabilitative needs, but also in identifying and measuring the effect of the physical and social environment on the disadvantages that they experience in their lives.

From the viewpoint of health economics, ICF will help monitor and explain health care and other disability costs. Measuring functioning and disabilities will make it possible to quantify the productivity loss and its impact on the lives of the people in each society. The classification will also be of great use in the evaluation of intervention programmes.

In some of the developed countries, ICF and its model of disability have been introduced into legislation and social policy, across sectors. It is expected that ICF will become the world standard for disability data and social policy modeling and will be introduced in the legislation of many more countries around the globe.

In sum, ICF is WHO's framework for health and disability. It is the conceptual basis for the definition, measurement and policy formulations for health and disability. It is a universal classification of disability *and* health for use in health and health-related sectors.

THE WORLD-WIDE ICF NETWORK

For further information about ICF, and its application to regions or countries, contact the following organizations, agencies, and NGOs who form part of ICF collaborating network.

Collaborating Centers:

- Australia:** Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601, Australia
Contact: Ros Madden.
- Canada:** Canadian Institute for Health Information, 377 Dalhousie Street, Suite 200, Ottawa Ontario K1N9N8, Canada
Contact: Janice Miller.
- France:** Centre technique national d'Etudes et de Recherches sur les Handicaps et les Inadaptations (CTNERHI), 236 bis, rue de Tolbiac, 75013 Paris, France
Contact: Catherine Barral.
- Japan:** Japan College of Social Work, 3-1-30 Takeoka, Kiyosehi, Tokyo 204, Japan
Contact: Hisao Sato.
- The Netherlands:** Center for Standardization of Informatics in Health Care (CSIZ), Driebergseweg 3, 3708 JA Zeist, The Netherlands, Contacts: Willem Hirs and Marijke W. de Kleijn de Vrankrijker.
- Nordic countries:** Department of Public Health and Caring Sciences, Uppsala Science Park, SE Uppsala Sweden
Contact: Björn Smedby.
- United Kingdom:** NHS Information Authority, Coding and Classification, Woodgate, Loughborough, Leics LE11 2TG, United Kingdom. Contact: Ann Harding, Jane Millar
- USA:** National Center for Health Statistics, Room 850, 6525 Belcrest Road, Hyattsville MD 20782, USA
Contact: Paul Placek.

Networks:

La Red de Habla Hispana en Discapacidades (The Spanish Network). Co-ordinator: Jose Luis Vazquez-Barquero, Unidad de Investigacion en Psiquiatria Clinical y Social Hospital Universitario "Marques de Valdecilla", Avda. Valdecilla s/n, Santander 39008 Spain.

The Council of Europe Committee of Experts for the Application of ICDH, Council of Europe, F-67075, Strasbourg, France. Contact: Lauri Sivonen.

Participating Non Governmental Organizations:

Disabled Peoples International, 11 Belgrave Road, London SW1V 1RB, United Kingdom. Contact: Rachel Hürst.

European Disability Forum, Square Ambiorix, 32 Bte 2/A, B-1000, Bruxelles, Belgium. Contact: Frank Mulcahy.

European Regional Council for the World Federation of Mental Health (ERCWFM), Blvd Clovis N.7, 1000 Brussels, Belgium. Contact: John Henderson.

Inclusion International, 13D Chemin de Levant, F-01210, Ferney-Voltaire, France. Contact: Nancy Breitenbach

Rehabilitation International, 25 E. 21st Street, New York, NY 10010, USA. Contact: Judith Hollenweger, Chairman RI Education Commission, Institute of Special Education, University of Zurich, Hirschengraben 48, 8001 Zurich, Switzerland.

For further information contact:

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Tap the potential of the ICF home page
<http://www.who.int/classification/icf>

- Read the introduction to the ICF
- Download the ICF Introduction in PDF format for printing.
- Download the order form for ICF Publications
- Consult the training materials and Beginner's Guide
- Keep up with the latest developments in the ICF
- Register yourself for receiving news or information via e-mail.

Parity: HHS Secretary Sebelius Speaks

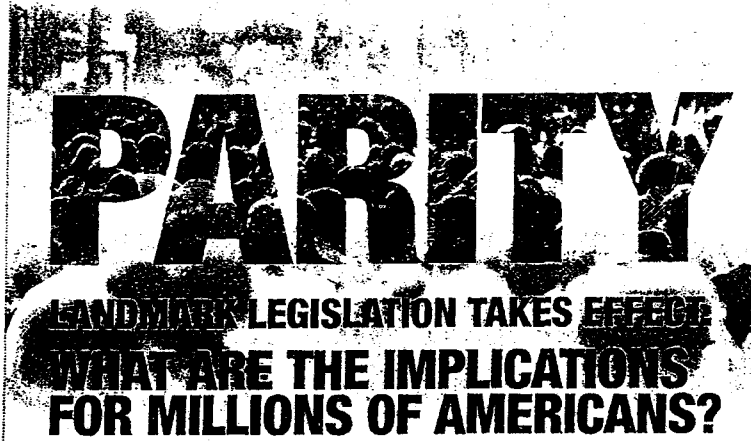
Editor's Note: U.S. Department of Health and Human Services Secretary Kathleen Sebelius delivered comments about parity in Towson, MD, at Sheppard Pratt, an organization that provides care for consumers of mental health services. The Secretary also discussed parity and other topics during a recent visit to SAMHSA. (See page 2.)

"We need to understand what we mean when we say 'parity.' What we're really talking about is 'parity in reimbursement by private health insurance plans that cover mental health and substance abuse services.'

That is significant, but it's just a starting point. A broader definition of parity encompasses investments in prevention, investments in health care delivery reform, investments in support services like housing that can affect behavioral health outcomes, and investments in treatment and service system research.

And it's this fuller version of parity that we should be striving for. Parity establishes the principle that, as a society,

continued on page 3



On January 1, 2010, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 went into effect, with interim final regulations issued on January 29 (see page 4). What will the law do for people with mental health and substance abuse disorders and their families?

Passed as part of the stimulus package, the law ends discrimination against consumers of mental health and substance abuse treatment services in many health insurance plans. That means it gives consumers better access to the care they need.

"The passage of this landmark legislation was the culmination of years of work by consumers, providers, advocates, and others," said SAMHSA Administrator Pamela S. Hyde, J.D. "This historic occasion marks the beginning of improved coverage for an estimated 113 million Americans."

ENDING UNEQUAL TREATMENT

In the past, health plans have often treated mental health and substance abuse treatment services differently than they have medical and surgical benefits. The new parity law ends that practice in group health plans offered by employers with more than 50 employees.

Now plans that offer both physical and mental health benefits must treat the two similarly, explained Kevin D. Hennessy, Ph.D., the Science to Service Coordinator in SAMHSA's Office of Policy, Program, and Budget.

continued on page 2

IN THIS ISSUE

Parity Interim Final Regulations Released	4
PBS's <i>This Emotional Life</i> Launches Campaign of Hope	5
Resources To Prevent Underage Drinking	6
Suicide Prevention on Campus	8
Treatment Update	10
Violent Behaviors Among Teen Girls	11



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Welcoming HHS Secretary Sebelius

On January 19, 2010, U.S. Department of Health and Human Services Secretary Kathleen Sebelius visited SAMHSA to learn more about the Agency's priority programs and initiatives (see photos). "Our efforts can only be successful with much collaboration with many partners, throughout the Government and the private sector," she said.



First row, left photo: Administrator Pamela S. Hyde (right) and Secretary Sebelius (left). First row, right photo: Dr. Eric Broderick (left) describes some of SAMHSA's current initiatives. Second row, left photo: Frances M. Harding (right), Director, SAMHSA's Center for Substance Abuse Prevention, listens to a question from the Secretary. Second row, right photo: Dr. H. Westley Clark (right), Director, SAMHSA's Center for Substance Abuse Treatment, talks with the Secretary and *Recovery Month's* Ivette Torres (left). Third row, left photo: A. Kathryn Power (right), Director, SAMHSA's Center for Mental Health Services, and Anne Mathews-Younes (left).

PARITY UPDATE <<p.1

"Historically, access to care has been low," said Dr. Hennessy, noting that financial concerns are one of the primary obstacles to receiving care. SAMHSA's 2008 National Survey on Drug Use and Health, for example, found that by far the biggest barrier to people receiving the treatment they needed was lack of health coverage and inability to pay. "Now those financial reasons should be less of a barrier," said Dr. Hennessy.

The law focuses primarily on two areas: financial requirements and treatment limitations.

Financial requirements, such as copayments, deductibles, and out-of-pocket limits, must be the same for both mental health and substance abuse services, and medical and surgical services.

Similarly, the number of visits allowed, duration of treatment, and other treatment limitations can't be more restrictive for mental health and substance abuse services.

Regulations released in January 2010 flesh out the details of the law's implementation. The regulations were crafted by the Centers for Medicare & Medicaid Services within the U.S. Department of Health and Human Services, the Internal Revenue Service within the U.S. Department of the Treasury, and the Employee Benefits Security Administration within the U.S. Department of Labor, which are responsible for enforcing different aspects of the law.

SAMHSA's staff helped analyze more than 400 public comments after the law was passed. SAMHSA also helped identify key issues to include in the regulations and draft the document's language. "We played an important behind-the-scenes role," said Dr. Hennessy.

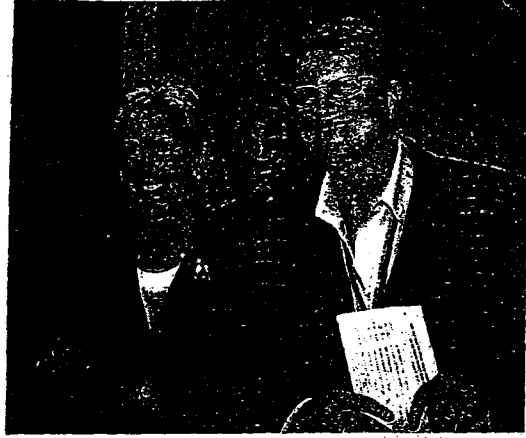
"SAMHSA is committed to making sure that everybody knows how

we have just as much of an obligation and interest in treating diseases of the brain as we do diseases that affect the rest of the body.

Thanks to the [parity law], millions of Americans with mental illness and substance abuse disorders will get the care they need."

To read the Secretary's complete speech presented in Towson, MD, in December 2009, visit <http://www.hhs.gov/secretary/speeches/sp20091215a.html>.

HHS Secretary Sebelius (left) is introduced to SAMHSA staff by SAMHSA Administrator Pamela S. Hyde (right) during her visit to the Agency. HHS Deputy Secretary Bill Corr (center) also attended. "The work you at SAMHSA are doing is critical to the health of this Nation. Roll up your sleeves because we've only just begun," the Secretary said.



parity can help people with substance abuse issues get the help they need more than ever before," said H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment (CSAT).

UNDERSTANDING THE REGULATIONS

One important element of the regulations is that parity needs to be "operationalized" in six classes of benefits, explained Dr. Hennessy. Covered plans must ensure parity of financial requirements and treatment limitations within inpatient/in-network services, inpatient/out-of-network services, outpatient/in-network services, outpatient/out-of-network services, emergency care, and prescription drug coverage.

"Insurers need to offer mental health and substance abuse benefits in any of the classes they're offering medical and surgical benefits," Dr. Hennessy explained. "For example, they can't just offer inpatient mental health services when on the medical and surgical side, they're offering inpatient, outpatient, prescription drug, and emergency care."

Another key part of the regulations is the area of "non-quantitative"

treatment limitations. Insurers use various techniques to manage costs. They may require beneficiaries to get pre-approval before receiving certain types of treatment, for instance. Or they might require beneficiaries to try a less intensive type of treatment before allowing them to move up to a more intensive level of services.

According to the new regulations, insurers cannot apply these utilization management techniques differently for mental health and substance abuse services than they do for medical and surgical benefits.

The regulations also clarify that the parity law applies to Medicaid managed care plans and the State Children's Health Insurance Program. While the parity law doesn't apply to Medicare patients, the recent Medicare Improvements for Patients and Providers Act brings parity to copayments for outpatient mental health services.

Of course, the parity law doesn't affect everyone. "Small employers are essentially exempt," said Dr. Hennessy, noting that the law doesn't cover employers with 50 or fewer employees. And while the law mandates parity in plans that offer mental health and

substance abuse services, it doesn't require plans to offer those services.

NEXT STEPS

Just passing the law isn't enough, emphasized Jeffrey A. Buck, Ph.D., Chief of the Survey, Analysis, and Financing Branch in the Division of State and Community Systems Development at SAMHSA's Center for Mental Health Services (CMHS).

"Passage of the law doesn't get you there," said Dr. Buck. "There are things you need to do after a law like this is passed to make sure it's truly effective."

Recent research by Dr. Buck and others shows why that's so. Published in the journal *Psychiatric Services* in December 2009, the study looked at what happened in California after the state implemented its own parity law in 2000. (See "Parity Law: Lessons Learned from California" *SAMHSA News*, November/December 2009.) The research showed that 44 percent of the consumers in the study weren't familiar with the law, even though most of them had diagnoses covered by it.

The implications of that research are clear as the national parity law rolls out, said Dr. Hennessy.

continued on page 4

Parity Interim Final Regulations Released, 90 Days for Public Comments

On January 29, 2010, the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury jointly issued interim final rules that will govern how group health plans and group health insurance issuers will put into practice the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Published in the February 2 issue of the *Federal Register* (see the full text at <http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf>), the rules go into effect April 5, 2010.

MAKE YOUR VOICE HEARD

As interim final rules, the regulations are subject to revision. In fact, the Government is actively soliciting input from the public. Comments are due on or before May 3, 2010.

Submit your written comments to any of the addresses below. Please do not submit duplicates.

- **HHS:** Refer to CMS-4140-IPC
By Federal eRulemaking Portal: <http://www.regulations.gov> (Follow the instructions under the "More Search Options" tab.)
By regular mail: Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, Attention: CMS-4140-IPC, P.O. Box 8016, Baltimore, MD 21244-1850

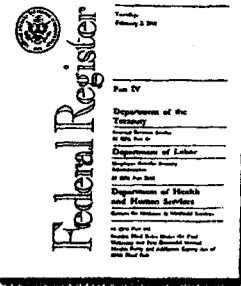
- **Department of Labor:** Refer to RIN 1210-AB30
By Federal eRulemaking Portal: <http://www.regulations.gov> (Follow the instructions for submitting comments.)
By email: E-OHPSA.EBSA@dol.gov
By regular mail: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N-5653, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210, Attention: RIN 1210-AB30

- **Internal Revenue Service:** Refer to REG-120692-09
By Federal eRulemaking Portal: <http://www.regulations.gov> (Follow the instructions for submitting comments.)
By regular mail: CC:PA:LPD:PR (REG-120692-09), Room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044
For instructions on hand delivery, overnight mail, or courier service, please refer to the *Federal Register* document for specific direction.

WHAT OTHERS ARE SAYING

Consumer groups, professional societies, and others applauded the new regulations.

"Parity regulations are an important milestone on the road to ending the unnecessary suffering for millions of



Americans with treatable mental illness and addictions," said Linda Rosenberg, President and Chief Executive Officer of the National Council for Community Behavioral Healthcare. "Now people in need won't have to go without treatment because of discriminatory insurance policies."

Patients are already benefiting, said Kathleen Nordal, Ph.D., Executive Director for Professional Practice at the American Psychological Association. "Since January 1," she said, "patients have seen copayments and co-insurance for psychological services reduced as mental health treatment is covered at parity with physical health care."

A national advocacy group, Faces & Voices of Recovery, called for further advocacy. "Some insurance companies have already put plans in place that fall short of this law's intent, severely restricting patients' access to life-saving care," said Vice Chair Stephen Gumbley. "This needs to change, and we encourage individuals and families covered by these plans to ask them to fully implement policies consistent with this new law."

PARITY UPDATE <p.3

EDUCATING PROVIDERS

The first step is education. "Providers should make sure that they become familiar with the law and its provisions and understand how it will affect the people they are serving," Dr. Hennessy said, noting that providers should review the benefits offered by the insurers that cover their clients.

Providers also have an important role in monitoring whether insurers are following the law according to the regulations.

SAMHSA plans to develop materials and provide technical assistance to help various constituencies understand the law's provisions and the rights and responsibilities of those affected, he added.

"For consumers of mental health services, the parity law can make a difference," said A. Kathryn Power, Director of CMHS. "Whether it's access to counseling, medications, or building awareness about mental health, we are hopeful this law will help create more access to services."

—By Rebecca A. Clay

4007.1 Standards of Need/Payment Standard - GA

This policy applies to all General Assistance applicants and recipients.

1. The Payment Standard is equal to the Standard of Need.
 2. The Division of Social Services determines the Standard of Need.
 3. ~~The Division of Social Services may establish different Standards of Need for children and adults.~~
 4. The Division of Social Services will issue an administrative notice detailing Standard of Need changes at least 30 days prior to an implementation of a Standard of Need change.
54. The Division of Social Services will issue an administrative notice annually detailing the current Standard of Need.

13 DE Reg. 1333 (04/01/10)

(Break in Continuity of Sections)

4009 Determining Financial Eligibility and Grant Amounts in GA

Follow the steps listed below to determine financial eligibility and grant amounts in the GA program. Refer to DSSM 4004.3 for information regarding GA earned income disregards.

1. Subtract \$50.00 from earned income.
2. ~~Subtract payment for dependent care from earned income.~~
3. Compare the sum of remaining earned income plus other income to the applicable GA standard. Deny assistance if income exceeds the standard.
43. If income is less than the standard, subtract income from the applicable GA standard to determine the grant amount. Round remainders by dropping the cents.

DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Sections 311 & 7105 (18 Del.C. §§311, 7105)

18 DE Admin. Code 1404

1404 Long-Term Care Insurance

ORDER

Proposed amendments to Regulation 1404 relating to Long-Term Care Insurance was published in the *Delaware Register of Regulations* on August 1, 2010. The comment period remained open until September 7, 2010. There was no public hearing on proposed amendments to Regulation 1404. Public notice of the proposed amended Regulation 1404 in the *Register of Regulations* was in conformity with Delaware law.

SUMMARY OF THE EVIDENCE AND INFORMATION SUBMITTED

Comments were received from the State Council for Persons with Disabilities (SCPD) and from America's Health Insurance Plans (AHIP). While the major purpose of the proposed amendments are to prohibit post-claim underwriting in long-term care insurance, SCPD did not comment on those proposed changes. SCPD directed its comments to suggested changes in the original Regulation 1404, not the proposed amendments. While the comments are well reasoned and valid, they are directed to updating, modernizing the substantial part of the existing regulation not being amended. What the Department of Insurance advertised as proposed amendments to the regulation is the only subject open for comment. SCPD's observations are well taken and will be considered for future changes to the regulation.

ACLI wrote to express support for the proposed amendment's rescission sections. The ACLI suggested that rather than incorporate some sections of the Model Regulation adopted by the National Association of Insurance Commissioners (NAIC) the Delaware Department of Insurance should adopt the Model Regulation whole. The Department has chosen to adopt sections of the Model Regulation that it feels are needed in this State. The ACLI pointed out errors in terminology that were not changed throughout the document, including the change from the use of "agent" to that of "Producer". Those non-substantive changes are made in the final document. The ACLI also noted sections of the Model Language that should be adopted in the future for purposes of clarity. That advice will be seriously considered in future updates.

FINDINGS OF FACT

Based on Delaware law and the record in this docket, I make the following findings of fact:

The requirements of the proposed amendments to Regulation 1404 best serve the interests of the public and of insurers and comply with Delaware law.

DECISION AND EFFECTIVE DATE

Based on the provisions of 18 Del.C. §§314, 1111 and 29 Del.C. §§10113-10118 and the record in this docket, I hereby adopt amended Regulation 1404 as may more fully and at large appear in the version attached hereto to be effective on October 11, 2010.

TEXT AND CITATION

The text of the proposed Regulation 1404 last appeared in the *Register of Regulations* Vol. 14, Issue 2, pages 92-93.

IT IS SO ORDERED this 8th day of September 2010.

Karen Weldin Stewart, CIR-ML
Insurance Commissioner

1404 Long-Term Care Insurance

***Please Note: Due to the size of the final regulation, it is not being published here. A copy of the regulation is available at:**

<http://regulations.delaware.gov/register/october2010/final/14 DE Reg 316 10-01-10.htm>