

December 2008 Newsletter

Of the

National Association of County Behavioral Health and Developmental Disability Directors

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Parity Goes Into Effect January 1, 2010: Details on the Law, What's Next, Reactions

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was signed into law on October 3, 2008 after years of advocacy efforts by many partners, including NACBHDD. Rep. Patrick Kennedy (D-RI) has long advocated for the law and in November, along with Senator Ted Kennedy, Senator Pete Domenici, and Rep. Jim Ramstad, he joined President Bush at the White House for a ceremonial signing of the act. In a press release about the event, Patrick Kennedy highlighted the profound meaning and impact of parity for individuals with mental illness and substance use disorders and their families:

For far too long, the stigma of mental illness and addiction has been used as an excuse to deny equitable insurance coverage for those biological disorders. The parity law outlaws this discriminatory practice, effectively opening a new door to treatments that will save lives. [bolding added] I was honored to represent the outstanding mental health and addiction treatment advocacy organizations, and the countless individuals who shared their stories, at today's memorable White House signing. (For the entire press release, click here: [Rep. Patrick Kennedy Press Release: Kennedy Attends White House Signing of Landmark Mental Health Parity Legislation](#)).

The parity law goes into effect on January 1, 2010, and NACBHDD will address questions related to the law as its implementation approaches. In order to address some of the preliminary questions about how the law will be "rolled out" and initial reactions to the law, NACBHDD contacted Rep. Kennedy's office. Kennedy staff member Laurel Havas answered the following preliminary questions about the parity law. Many thanks to Kennedy press secretary Kerrie Bennett for facilitating this exchange.

Parity goes into effect on January 1, 2010. When and how will the regulations be written and "rolled out"?

The Departments of Labor, Treasury, and Health and Human Services will issue regulations implementing the law and must do so no later than one year after enactment, or by October 2009. The Secretaries of the three departments must ensure coordinated implementation and enforcement and avoid duplication of their rules through the execution or revision of an interagency memorandum.

How are insurance companies reacting?

Health insurance companies were in support of the final agreement. The Rhode Island Blue Cross/Blue Shield CEO testified in favor of this legislation.

Can health plans drop mental health coverage in order to avoid the parity law?

This bill doesn't mandate that insurance companies cover the entire diagnostic manual. Part of the compromise of this law was to let employers and insurance companies determine what they would cover, with medical necessity as the determinant of the day. Allowing them this flexibility significantly lessens the concerns that health plans would drop all mental coverage. And as mentioned, the insurance companies were in support of this bill. Further, in states that already had strong mental health parity laws, we have not seen a pattern of companies dropping coverage.

What about plans dropping certain diagnoses from coverage? How will this be monitored?

The law requires the Government Accountability Office to conduct a study within three years of enactment that analyzes specific patterns, rates and trends in coverage and exclusion of mental health and substance use disorders by health insurance and health plans. The study should include specific coverage rates for specific mental health and substance use disorder diagnoses and the impact of covering or excluding them, as well as the effect of regulations on coverage and exclusion trends, and information about which diagnoses are most often covered and excluded. A second report must be submitted two years from the submission of the first. By 2012 and every two years thereafter, the Secretary of Labor must submit a report to Congress regarding the compliance of ERISA group plans with the requirements of the law. The report should include results of audits or surveys on compliance of group health plans and an analysis of the reasons for failures in compliance.

In cooperation with the Secretaries of Health and Human Services and Treasury, the Secretary of Labor must publish and widely disseminate guidance and information about the requirements listed above to group health plans, participants, beneficiaries, applicable state and local regulatory bodies, as well as the National Association of Insurance Commissioners. These Departments must also provide assistance to these recipients and include information in the materials regarding access to such assistance.

Medicaid is the biggest provider of services for NACBHDD's consumers. What does parity mean for Medicaid?

Kennedy's staff directed NACBHDD to the Bazelon Center for Mental Health Law's article "Mental Health and Addiction Parity Enacted" available at <http://www.bazelon.org/newsroom/reporter/2008/10-16-08reporter.htm#1> to answer this question. This information below is quoted directly from that site.

Relationship to SCHIP and Medicaid The parity law applies to State Children's Health Insurance Program (SCHIP) plans and to Medicaid managed care plans, as required under the Balanced Budget Act of 1997 (Public Law 105-33). However, some SCHIP plans could still provide substantially less mental health coverage than medical/surgical. This will occur if a state chooses not to include mental health services in the SCHIP plan, as allowable under SCHIP law. <http://www.bazelon.org/pdf/ParityLawandSCHIP.pdf>

How does parity impact existing state parity laws?

The existing MHPA law of 1996 only prohibited health plans from offering lower annual or lifetime benefits for mental health coverage than for physical health coverage. Most plans came into compliance by imposing additional treatment limits or cost-sharing for mental health care, both of which remained legal under the old law. This new law closes this massive loophole by requiring most health plans which cover mental health to no longer be able to require patients to pay 50% coinsurance for mental health outpatient services when other outpatient services require only 20% in cost sharing, or cap psychiatric inpatient stays at 30 days while allowing unlimited stays for treatment of other conditions. Further, while many states had parity laws on the books, ERISA plans were not covered under these laws, and this federal legislation brings ERISA plans into the fold. State laws that are less stringent than the new federal parity law will also be overridden. This is a tremendous improvement in coverage because more than 100 million Americans will now have access to mental health benefits on par with their physical health.

In addition, the following information from the Bazelon Center at

<http://www.bazelon.org/newsroom/reporter/2008/10-16-08reporter.htm#1> may be helpful in understanding the federal parity law and state parity laws.

Status of State Parity Laws

State parity laws have limited reach because they cannot apply to ERISA plans. This new parity law does apply to ERISA plans and will not supersede state parity laws that provide stronger protections and rights for individuals with respect to their mental health or substance abuse coverage. This is accomplished by applying the preemption rule in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA," Public Law 104-191).

The impact of the federal parity statute depends on an analysis of whether the particular provision of the State law is more or less stringent than the federal parity statute.

This provision works, for example, like this:

- State laws that address mental health coverage in plans that are not affected by the federal law (that is, individual health insurance plans or plans of employers with fewer than 50 employees) will remain in force.
- State laws that mandate coverage for mental health services in health plans but require only a limited benefit will be overridden. Plans covered by that state law will have to provide mental health benefits (under the state law), and provide them at parity as defined in the federal law;
- State laws that mandate parity for certain specific mental health diagnoses will be overridden. Diagnoses covered under these state mandates will be those defined by the health plans, as under the federal law;
- State laws only requiring that *if* a plan includes mental health benefits it must include a specified minimum level of benefits will be overridden by the new federal law (within the constraints in the law, summarized here—such as size of employer, parity benefits only if the plan includes mental health coverage, etc.).

It will be important for consumers to contact their state insurance commissioner's office for information on the specifics of their own state's parity law. A chart of the state parity laws as of 2007 can be found at <http://www.bazelon.org/issues/insurance>.

Resources for additional parity information

Bazelon Center for Mental Health Law's article "Mental Health and Addiction Parity Enacted" is available at <http://www.bazelon.org/newsroom/reporter/2008/10-16-08reporter.htm#1>.

Information on SCHIP and Medicaid managed care and parity: <http://www.bazelon.org/pdf/ParityLawandSCHIP.pdf>.

Chart of state parity laws as of 2007: <http://www.bazelon.org/pdf/ParityLawandSCHIP.pdf>.

For Consumers: The National Alliance for Mental Illness (NAMI) will provide information online about how parity will affect coverage for consumers and families. See www.nami.org in the coming weeks.

More on the ADA Amendments Act of 2008 as January 1, 2009 Implementation Approaches

For the October *Newsletter*, NACBHDD spoke with Chai Feldblum, JD, Professor of Law and Director of the Federal Legislation and Administrative Clinic at Georgetown University, about the **ADA Amendments Act of 2008 (ADAAA)**, signed into law by President Bush on September 25, 2008 (eighteen years after the original ADA), and effective January 1, 2009. Feldblum calls the ADAAA “an incredibly important piece of legislation” for NACBHDD and the individuals NACBHDD serves. She described the ADAAA as “revitalizing” the original ADA because “[o]ver time, Supreme Court decisions whittled away at the definition of disability, narrowing the protections available to citizens and eroding the intent of the law.”

The ADAAA directs the Equal Employment Opportunity Commission (EEOC) to revise its regulations to be consistent with the amendments of the Act. In the next few months, the EEOC will issue regulations that expand on the language in the law. The C-C-D Task Force, a group of disability advocacy representatives, worked with representatives from the business community to draft the language in the ADAAA, and these negotiators met with the EEOC to insure that the regulations reflect the intent of the ADAAA. The EEOC met with the negotiators (those involved in drafting the actual language for the ADAAA) of the law to read through the old regulations and improve on them to reflect the changed language in the ADAAA. This month NACBHDD spoke with **Emily Benfer**, Supervising Attorney / Teaching Fellow at the Federal Legislation and Administrative Clinic at Georgetown, a colleague of Feldblum’s who is actively involved with the Consortium for Citizens with Disabilities (CCD) Task Force and a member of the Georgetown legal staff involved in representing the Epilepsy Foundation in the ADA Amendments process, about what happens next with the ADAAA and the related regulations as we approach the law going into effect on January 1. She discussed some key concerns in the law as it relates to the regulations.

- **“Substantially limits.”** Over the years, the Supreme Court has issued rulings that held an individual to a higher threshold for meeting the concept of a disability substantially limiting a major life function. As Benfer described it, one of the central concerns in “revitalizing” the ADA is to ensure that qualifying as disabled not be so difficult. A rule of construction in the ADAAA requires that the term “substantially limits” be defined consistent with the findings and purposes of the statute. The findings and purposes use terms like “broad scope of protection” and reject past cases that required a “greater degree of limitation than necessary.” With the lower threshold, it will allow more people to receive coverage.

The purposes also direct the EEOC to revise regulations that define the term “substantially limits” to create a higher threshold. In the past, the regulations from the EEOC defined “substantially limits” as “severely restricts,” and as a result, the Supreme Court focused on a higher threshold for defining a disability that substantially limits a major life activity. This resulted in the exclusion of many people from protection. If the EEOC relies on the plain meaning of the ADAAA in its new regulations, it should correct this problem.

- **Major bodily functions.** The ADAAA expands the definition of “major life activities” to include the term “major bodily functions.” This should make it easier for people with behavioral health concerns to meet the definition of disability. A person with behavioral health concerns such as PTSD or depression would be substantially limited in the major bodily function of the brain, and as a result, would qualify as disabled and be entitled to protection under the Act.

Benfer points out that an important clarification in the ADAAA has been to make sure that an individual needs to be substantially limited in only one major life activity or bodily function, and individuals need not go into other areas in which they may be limited in order to prove that they have a disability. These changes should all be reflected in the new regulations.

- **Mitigating measures.** Over the years, one way in which the Supreme Court limited the definition of disability and narrowed the number of people covered under the ADA was by ruling that mitigating measures, such as medication or devices, were to be taken into account when determining if a person was substantially limited in a major life activity.

Benfer noted that this is a very important area of change for individuals with behavioral health concerns. The article, “[ADA Amendments Act of 2008](#),” by Chai Feldblum, Kevin Barry, and Emily Benfer cites the case of Michael McMullin, a career law enforcement officer in Wyoming who was fired from his job because a physician determined that his clinical depression and use of medication disqualified him from his job. He challenged his firing under the ADA, and his employer claimed that he was not “disabled” under the ADA because he had successfully managed his condition for over 15 years, and the court agreed. This change is an important one that the negotiators will be addressing to make sure it is included in the regulations. As the chart “Comparison of the ADA (as construed by the courts) and the ADA, As Amended” states:

The ADAAA provides that the ameliorative effects of mitigating measures should not be considered in determining whether an individual has an impairment that substantially limits a major life activity. An exception is made for “ordinary eyeglasses or contact lenses,” which may be taken into account.

- **Episodic impairment.** When determining whether someone with an episodic impairment meets the definition of a disability, the impairment must be considered in its active state. Benfer says that the EEOC originally wrote the regulation related to episodic impairment correctly; however, she emphasized that it has been reaffirmed by Congress and will need to be kept in the regulations. Post-Traumatic Stress Disorder (PTSD) will be considered a disability if in its active state it substantially limits a major life activity or bodily function.
- **Eliminating language around the major life activity of working.** Benfer explained that, in writing the regulations, it will be important for the EEOC to eliminate language around the major life activity of working, as the courts overemphasized the emphasis on working, so that decisions were inconsistent and created an impossible hurdle for individuals to overcome to prove that they were disabled. Most plaintiffs will be able to prove that a major bodily function or major life activity is substantially limited, and the only time when the standard of working should be used is when no other major bodily function or major life activity is limited. Benfer says these situations will be rare, and she cited the example of a chemist who must wear gloves in the work place, but is allergic to standard latex gloves.
- **Proving a perceived or actual impairment.** Another area that Benfer and advocates are hoping that the EEOC will emphasize is that under the third prong of the law, the bar has been lowered and an individual only needs to prove that there is a perceived or actual impairment and that there was an adverse action that

was not transitory or minor. As Benfer says, this change really points to the anti-discriminatory nature of the law. “The [Health, Education, and Labor] Committee understood that mistaken beliefs are just as disabling as actual impairments. This finally sends a message that we are all equal and all have the right to access employment.”

Public comment will be invited when the regulations are released. Although the date for the release of the regulations is not yet known, they will be released in the *Federal Register* as a proposed rule and there will be a period for public comment. While most abuses of the ADA occurred in the area of employment, the CCD Rights Task Force is also making recommendations to the Department of Justice, the Department of Labor, the Department of Education, and the Department of Transportation on changes in disability law in those areas.

Resources

The **ArchiveADA website**, a comprehensive, online archive on the ADA and ADAAA developed by the Federal Legislation and Administrative Clinic at Georgetown University, can be accessed at www.archiveada.org. The Archive contains an article, “[ADA Amendments Act of 2008](#),” authored by Chai Feldblum, Kevin Barry, and Emily Benfer, that contains a history and summary of the ADA and ADAAA.

To access a comparison chart that summarizes the major changes in the law, see:
<http://nacbhdd.org/content/ComparisonofADAandADAAA10-17-08final.pdf>

Report on NACBHDD’s October Board of Directors Meeting

NACBHDD’s October Board meeting was held October 30 and 31 in Austin, Texas in conjunction with the Texas state association, the Texas Council of Community MH/MR Centers, Inc. The Texas state association is a new member of NACBHDD, and NACBHDD is pleased to have a strong partnership with them. NACBHDD Board Chair Leon Evans described the meeting as a “great interaction with 37 mental health authorities in Texas.” Evans reported on the following important issues covered at the Board meeting.

- **Membership Campaign.** The 2009 Membership Campaign is underway, and all members should have received the new membership information brochure and a pre-populated invoice of their county or counties. *(Any member who has not yet received these materials should contact Melissa Stein at 202-942-9275.)*

Most of NACBHDD’s revenue comes from dues paying members. The larger the membership, the stronger the organization and the greater NACBHDD’s ability to educate elected and appointed officials about the essential work of county-based, public behavioral health and developmental disability systems. Evans expressed the Board’s appreciation to Pat Fleming, Co-Chair of the Membership Committee, and the whole Membership Committee for their hard work. He noted that while “the organization sells itself” when people know about it,

“...[too many] people don’t know about us. A goal is to make sure to get the information about the organization out there. Our mission and outcomes have been great. We are different from other organizations; we are really linked to county officials and county government, whose mission it is to make sure counties get the best value – which is linked to cost and outcome. We work for citizens directly, both those who need our services and those taxpayers who pay for them. It strengthens our relationship with all the other organizations we work with. We provide the public perspective no one else provides.”

Both Evans and Executive Director Ellen Witman emphasize that “current members are our best promoters.” The October Board meeting is a good example of this; there were several opportunities to introduce NACBHDD to the Texas directors, including a joint meeting at which NACBHDD Board members Don Polzin (Gulf Bend MH/MR Center, Texas) and Pat Fleming were able to present the benefits of NACBHDD membership to their counterparts. In addition, David Evans, Executive Director, Austin Travis County Mental Health/ Mental Retardation Center, hosted a dinner one evening. As a result, NACBHDD has already welcomed several Texas centers as new members and anticipates that more will follow.

- **Key Contacts.** Although the Board meeting was held a few days before the election, one focus of discussion was how the organization can prepare for the new Administration and newly elected Congressional members – specifically, how NACBHDD can educate the Congress about behavioral health and developmental disability issues and advocate for those issues. “SAMHSA, CMS, and NIMH will all have new leadership, and we want to have input. We’re going to be prepared for the change,” said Evans.

To prepare for this change, NACBHDD is developing a list of “Key Contacts” – a list of NACBHDD members who have strong professional or personal relationships with members of Congress or officials in the Obama administration. These contacts can be an important component of NACBHDD’s advocacy, as they would be able to aid in ensuring that NACBHDD’s message is heard by reaching out to Congressional members or Administration officials at critical times.

A “Key Contact Form” will be sent to members in January. Evans urges members to think about those they know who might be willing to act as key contacts and contact key officials as we move forward in these critical times.

- **Corporate Partners Program.** Evans explained that while the Board discussed the fundamental concerns about the economy, the organization “continues to be more and more financially sound.” To further support and build upon NACBHDD’s mission, the new Corporate Partners Program will be launched in 2009.

Several corporations have supported NACBHDD with donations for programs and conferences. The organization is now asking companies with which it and its members have done business to join as Corporate Partners and to provide annual contributions that will enable NACBHDD to strengthen its ability to represent and serve members. Corporate partners will receive benefits, such as complimentary Conference registration, sponsor recognition in newsletters and other publications, opportunities to meet with the Board, and an opportunity to contribute an article to the newsletter.

Members who know of companies that might be Corporate Partners are encouraged to contact Ellen Witman at 202-942-4296 or ewitman@nacbhd.org for details.

NACBHDD’s IT Committee Prepares to Launch New Initiatives

Although NACBHDD’s first-ever Information Technology Committee is just getting started with its work, the group is already holding monthly conference calls and has several areas of clear focus, including plans to roll out a series of webinars and teleconferences in 2009. IT Committee is co-chaired by Mark Refowitz, Behavioral Health Director, Orange County Health Care Agency, Santa Ana, California, and Patrick Fleming, Director, Salt Lake County Substance Abuse, Salt Lake City, Utah. In a conversation about the Committee, Refowitz said that the resources and knowledge among NACBHDD members on a wide-range of IT issues means there is a “potential for great synergy” in developing NACBHDD’s IT capabilities in a variety of areas critical to members – including billing, electronic health records, long-distance learning, web-based applications that can measure

outcomes, and more. Refowitz, who has co-chaired a California IT committee for nearly nine years, notes that NACBHDD's affiliation with Trilogy Integrated Resources and the Network of Care were the organization's "first sticking of the toe in the water" of the IT potential in the behavioral health care arena, but that the possibility for making the organization's website a valuable resource for the membership is much greater.

Currently, the IT Committee is focusing on:

1. Discussing the impact the IT Committee and the organization can have on federal policy issues, such as electronic health records.
2. Sharing the wealth of information from members across the country via the NACBHDD website -- as a substantial benefit of NACBHDD membership. Refowitz cites the sharing of uniform electronic signature policies and procedures or the sharing of RFPs as examples. As he describes it, NACBHDD "could post a wealth of knowledge on the website as an incredible benefit of membership." In addition, such information sharing is a highly effective cost-saving tool for county behavioral health authorities, with the potential to save "hundreds of thousands of dollars in consultant fees."
3. Developing webinars on topics associated with information technology. Possible topics include open source software, rural teleconferencing, electronic tools that assist in tracking evidence-based practices, and engaging national experts and officials in Information Technology to speak in the webinars.
4. Educating the membership about the ways the website can be used, including the use of the website as an invaluable resource for what is going on in DC and across the country.

Refowitz is enthusiastic about the IT Committee's work and the web's ability to support NACBHDD members in their mission. He cites the **Inspire Foundation's** work with Johns Hopkins University to bring the **Reach Out!** website, which started in Australia, to the United States as an example of the powerful role information technology can play in behavioral health. The effort, which has already started in California, is described on the website as combining "research-based mental health content, sophisticated youth involvement programs, and savvy marketing and communications to support young people experiencing tough times and struggling with mental health difficulties." (See <http://www.inspireusafoundation.org/about-us.html>).

Members will be emailed information about the upcoming webinars in early 2009.

**HOLD THE DATES: March 9-11, 2009 for
NACBHDD's 2009 Legislative and Policy Conference
and Celebrate NACBHDD's 20th Anniversary as a NACO Affiliate!**

**Hear Representatives from Obama Administration and New Congress
Meet with your Members of Congress on Capitol Hill**

The March 9 – 11, 2009 Legislative and Policy Conference is an historic, not-to-be-missed event! As a new President, new Executive Agency Directors, and a new Congress begin their work you will have the opportunity to hear from representatives of key federal agencies, Congress, national organizations, and other leaders in the fields of behavioral health and developmental disabilities. We will spend time on Capitol Hill and meet with Members of Congress and key Congressional staff.

Make your voice heard. Plan to join us and make your voice heard – this year's conference will offer an exciting opportunity to talk with policymakers, advocates, and colleagues from around the country. Speakers will include representatives from the Obama Administration, as well as members of the new 111th Congress. On Tuesday, March 10, attendees will go to Capitol Hill to take our message to their elected officials and participate

in a Hill Reception that evening. As Congress and the Administration focus on health care reform as a top priority, NACBHDD members will be making sure that the issues of mental health, substance use disorders and developmental disabilities are receiving the attention they deserve. And, given the difficult economic circumstances facing many counties, we will be advocating for a strengthened partnership among federal, state and local governments so that essential services can be maintained.

20th anniversary of NACo affiliation. In addition to this unique opportunity to engage in many discussions critical to our members and those we serve, we will recognize the 20th Anniversary of NACBHDD's affiliate partnership with the National Association of Counties (NACo). On Monday evening, March 9th, there will be a special 20th anniversary reception held to celebrate this milestone.

Location and registration. This year's conference will be held at the Churchill Hotel, which is located on Connecticut Ave., NW, just north of Dupont Circle and across the street from the Washington Hilton Hotel. A conference registration form and hotel registration information will be posted on our website (www.nacbhdd.org) by the end of the year. Please check the website and make your reservations now.

We look forward to seeing many of you in Washington, DC in March.

Look for a Special Edition of the Newsletter on Health Care Reform in January

As NACBHDD Executive Director Ellen Witman noted in a recent ***Memo to Members***, "Health care reform will be high on the list of issues addressed by the Obama Administration right after his Inauguration." NACBHDD is already working with the Campaign for Mental Health Reform, The Mental Health Liaison Group, NACo, and other organizations to ensure that reform includes the critical interests of behavioral health and developmental disabilities that will support recovery, independence, and a life in the community.

The January ***NACBHDD Newsletter*** will be a special edition covering health care reform, with interviews with those involved in the Campaign for Mental Health Reform, the NACo efforts, and experts in the developmental disabilities arena.

In the meantime, NACBHDD is working on principles around behavioral health care reform that will be shared with the membership and submitted to the Obama transition team website: <http://change.gov>. Members are urged to examine videos, press releases, and comments on health care reform on the site and to send President-Elect Obama and his team comments about the importance of behavioral health in health care reform by going to <http://change.gov/page/s/healthcare>. A separate page on developmental disabilities can be found at: http://www.change.org/ideas/view/fully_fund_medicaid_waivers_for_the_developmentally_disabled.

Please send NACBHDD a copy of your comments.

As Witman said in her recent ***Memo to Members***:

It is vitally important that the issues NACBHDD members deal with every day are raised over and over again in the early health care discussions so that it is clear to those developing the Obama policy recommendations that behavioral health and developmental disabilities must be addressed from the outset, not set aside to review later. Behavioral health care and physical health care are integral to each other and must be addressed together.