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# ISSUE BRIEF

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## Mental Health Coverage Parity: Separating Wheat from Chaff

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A discussion featuring

**William Goldman, M.D.**  
*Senior Vice President for Behavioral  
Health Sciences*  
United Behavioral Health  
San Francisco

**Richard G. Frank, Ph.D.**  
*Professor of Health Economics*  
Department of Health Care Policy  
Harvard Medical School  
Boston

as well as other experts, advocates, and interested parties

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George  
Washington  
University  
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## Mental Health Coverage Parity

For some mental health advocates, first the glad tidings: “The day of mandated mental health coverage parity is nigh!” Next, the dose of realism: in the era of managed care, the parity proposals before Congress may not do very much to improve access to mental health services.

As mental health advocates continue campaigning to mandate parity in coverage of mental health services at both the state and federal level, changes in the marketplace seem to have blunted the impact of these laws. Mental health parity laws typically attempt to open up access to mental health services by pushing back demand-side controls on utilization. Over the past decade, however, employers and insurers have instituted supply-side cost controls (also known as managed care), such as utilization review, case management, financial incentives for providers, mental health budget caps, determinations of medical necessity, and other methods. Because most Americans with mental health coverage receive it under some sort of managed care regimen, achieving parity in coverage levels for lifetime and annual dollar limits, outpatient visits, and hospital days can be achieved at a modest cost. The cost of pushing back these demand-side cost controls is often low because management techniques now employed to control costs operate independently of them. While mental health parity laws may lead to better financial protection for a small number of very sick people, supply-side management techniques have assured that spending patterns for the larger population are controlled.

Yet managed mental health strategies, which are applied to most Americans’ health benefits, whether they realize it or not, raise a series of new issues that policymakers need to consider alongside parity in benefit design. As managed care dramatically lowers the cost of inpatient and outpatient mental health services paid for by health plans, economists still do not well understand how managed behavioral health programs may have affected spending on psychotropic drugs and general medical care. Questions also have arisen about the impact of managed behavioral health care on quality and access to care. Just as they did in the old and more costly indemnity insurance system, policymakers are now struggling to understand what the appropriate level of spending should be for mental

health services under managed care. And they have little data to help them.

At this Forum meeting, participants will explore the apparent “disconnect” between political battles over mandating parity in benefit design and developments in the marketplace. Beginning with a discussion of the cost and market effects of parity laws, the focus will then turn to public policy issues raised by managed mental health care, including concerns about access to care, quality of care, and consumer protection.

### PARITY LAWS

#### The Mental Health Parity Act of 1996

The parity bills now before Congress would build on the Mental Health Parity Act of 1996, which became effective January 1, 1998, and sunsets September 30, 2001. Often criticized for containing so many exceptions as to be ineffectual, the 1996 law prohibits employers and insurers from imposing annual or lifetime dollar limits on coverage for mental health benefits that are more restrictive than those applied to medical benefits.<sup>1</sup> A scaled-down version of a full parity bill sponsored by Sens. Pete Domenici (R-N.Mex.) and Paul Wellstone (D-Minn.), the law exempts the plans of employers with 50 or fewer employees. Also exempted are group plans that experience an increase in health benefit costs of 1 percent or more because of the

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##### Analyst/Writer:

Karl Polzer

##### National Health Policy Forum

2021 K Street, NW, Suite 800

Washington, DC 20052

202/872-1390

202/862-9837 (fax)

nHPF@gwu.edu (e-mail)

www.nHPF.org (Web site)

**Judith Miller Jones**, Director

**Karen Matherlee**, Co-Director

**Michele Black**, Publications Director

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requirements. Employers not exempted can avoid the cost impact of the parity legislation by redesigning benefit packages. For example, they may increase employee cost sharing or limits on inpatient or outpatient visits or they may implement managed care programs. The law does not require employers to offer mental health coverage. So they may drop mental health benefits (or their entire health benefit package, for that matter), if parity mandates are perceived as too onerous.

Tucked in an appropriations bill, the 1996 parity act utilizes a regulatory structure Congress had established a few months earlier in the Health Insurance Portability and Accountability Act (HIPAA).<sup>2</sup> Under this structure, states have the option of enforcing federal mandates directed at insurers and are not preempted from adding regulations that are consistent with the federal floor. Unless states pass enabling legislation and actively enforce the law, enforcement duties fall on DHHS' Health Care Financing Administration. While 45 states have assumed enforcement responsibility for HIPAA's main provisions, only about one-third have done so for the mental health parity requirements for insurers, in part because the requirements themselves are generally perceived as ineffectual, according to several state regulators.<sup>3</sup>

More than 20 states have passed mental health parity laws, ranging from measures that simply mirror the federal statute to those that impose far stricter requirements. So far this year, governors in six states have signed legislation expanding private-sector mental health coverage.<sup>4</sup> These state laws cannot be applied to self-insured, private-sector health plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) but may apply to insurers providing services to ERISA plans. There is a great deal of variability among the state parity laws. Many of the more recent measures establish coverage parity for mental conditions with a biological basis. Some state laws apply only to certain populations (state employees, for example).

### **Costs of Parity**

While opponents of the 1996 Domenici-Wellstone full parity proposal claimed that it would cause health plan premium increases ranging from 3.0 percent to 11.4 percent, these estimates were generated on models assuming utilization in an environment with a low penetration of managed care. The Congressional Budget Office estimated that premiums would increase about 4 percent under the Domenici-Wellstone full parity bill and 0.16 percent under the limited parity measure that Congress eventually enacted.

Recent analyses show that the cost estimates of full parity may have been overblown because of both the ability of managed care to reduce mental health benefit costs and the penetration of managed care in the marketplace. Examining 1995 and 1996 claims data from 24 managed care carve-out plans offering "unlimited" mental health coverage with minimal co-payments (full parity), Roland Sturm of RAND found that overall costs increased only by about \$1 per enrollee per year and concluded that assumptions used in the 1996 debates over parity overstated actual managed care costs by a factor of 4 to 8.<sup>5</sup> In the plans studied, costs were reduced by lower rates of hospitalization, a relative shift to outpatient care, and lower payments per service.

Last year, a National Advisory Mental Health Council (NAMHC) work group simulated the costs of moving to full parity using a model developed by the Hay Group.<sup>6</sup> Incorporating some of the more recent findings about the impact of managed care on costs, the model predicts that if an indemnity or PPO plan moved to full parity (absent a managed-care carve out) mental health costs would more than double, rising from \$8 per member per month (PMPM) to \$17 PMPM. Implementing full parity in a managed care carve-out would increase costs from \$4 PMPM to \$5 PMPM, or about 25 percent, according to the simulation. Because full parity would raise costs substantially in an unmanaged environment, such a mandate gives health plan sponsors and insurers a strong incentive to implement managed mental health care if they have not done so already. The model predicts that simultaneous implementation of full parity and managed care would reduce costs from \$8 PMPM to \$5 PMPM.

NAMHC reported that implementation of parity may accelerate the trend toward management of mental health services. Some employer and insurer groups argue that, by doing this, the parity mandates in effect remove from the marketplace a benefit option that many people may prefer. Employers and insurers are generally opposed to benefit mandates at either the state or federal level.

### **More Parity on the Way**

In May, the Clinton administration announced plans to make health insurance coverage for mental illnesses and substance abuse comparable to that for physical ailments for more than 9.5 million federal employees, annuitants, and family members covered by the Federal Employees Health Benefits program (which is not subject to the 1996 parity law). The previous month,

bills were introduced in both the House and Senate that would widen the 1996 parity requirements applying to other employers and to insurers.

Legislation introduced by Reps. Marge Roukema (R-N.J.), Peter DeFazio (D-Ore.), and Bob Wise (D-W.Va.) would provide full parity for coverage of mental health and addiction services. The Mental Health and Substance Abuse Parity Amendments of 1999 (H.R. 1515) would prohibit group and individual health plans from imposing treatment limitations or financial requirements on the coverage of mental health benefits and on the coverage of substance abuse and chemical dependency benefits if similar limitations or requirements were not imposed on medical and surgical benefits. The bill would prohibit plans from imposing limits on the frequency of treatments, number of visits, or the scope and duration of treatment for mental health benefits if similar limitations were not imposed on medical and surgical benefits. It would also prohibit plans from imposing copayments, deductibles, out-of-network charges, out-of-pocket contributions or fees, annual limits, and lifetime aggregate limits for mental health benefits if similar requirements were not imposed on medical and surgical benefits. The bill, however, would not stop a group health plan from negotiating separate reimbursement rates, establishing different service delivery systems for different benefits, or from managing the provision of benefits through the use of pre-admission screening, prior authorization of services, and other such mechanisms.

While H.R. 1515's provisions would apply to individuals diagnosed with any mental illness or substance abuse disorder, it would not require a group health plan to provide any specific mental health benefits. It would eliminate the sunset provision in the 1996 parity law and end the current exemption for employers who show that their health insurance premiums rose more than 1 percent as a result of complying with the parity act.

Domenici and Wellstone have introduced the Mental Health Equitable Treatment Act (S. 796), which would prohibit group health plans from setting arbitrary day and visit limits on services for all mental disorders. It would provide full parity, including equal co-payments, deductibles, and other out-of-pocket costs, but only for specified, severe, "biologically based" mental illnesses. It does not address parity for addictive disorders. As would H.R. 1515, S. 796 would remove the 2001 parity sunset provision and the 1 percent cost exemption. It would also expand the scope of the 1996 parity mandate by including small businesses with 25 or more employees (the 1996 law applies to firms with 50 or more workers).

Some mental health advocates have objected to the distinction that S. 796 makes between biologically based mental illnesses and those seen as having other causes.<sup>7</sup> The bill would exclude many childhood disorders, anxiety disorders, and mild-to-moderate depressive disorders, as well as Tourette Syndrome and bulimia. Illnesses categorized as eligible for full parity would be schizophrenia, bipolar disorder, major depression, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder, autism, and other severe and disabling biologically based mental disorders, such as anorexia nervosa and attention deficit/hyperactivity disorder. As of this writing the Congressional Budget Office had yet to develop cost estimates of the impact on premiums of either bill.

### **Economics behind Parity**

While mental health parity is coming to legislative fruition in an age of widespread managed mental health care, it is a political response to an uneven benefit design that some economists argue was justified in the era of fee-for-service medicine financed by indemnity insurance. In markets for most types of goods and services, each consumer must pay the full cost of what he or she is buying. In the case of items financed by health insurance, individuals consume services without the same incentive to control their spending because a third party is paying the bills. (Political economists call this phenomenon "moral hazard." The "excess" spending resulting from third-party payment is eventually shared by everyone in the insured group, thereby reducing everyone's welfare.)

To control spending caused by the moral hazard phenomenon, health plan administrators and insurers often impose costs, such as co-payments or co-insurance, that are triggered by consumption. Because the moral hazard problem is greater for many types of mental health services than for many types of general medical care, an argument can be made that higher co-insurance levels are warranted for mental health care.<sup>8</sup> (The RAND Health Insurance Experiment reported responses to reduced cost sharing were nearly twice as large for mental health care as those in general medical care.) Applying higher dollar or day limits to mental health benefits, however, is not as justifiable as a means to control moral hazard.

Another reason that an health insurer may restrict mental health benefits is to protect itself from adverse selection—that is, to prevent the plan from attracting a disproportionate number of sick people who will drive up premium costs, thereby hurting the firm's ability to

compete. An argument has been advanced that the threat of adverse selection creates an incentive to offer too little mental health coverage and that public policymakers are justified in limiting cost-sharing techniques applied to mental health benefits. Richard Frank, Chris Koyanagi, and Thomas McGuire summarize the policy dilemma brought on by the underlying economics well: “A long-standing problem for policymakers has been to determine whether restricted benefits for mental health are there for a ‘good reason’ (moral hazard) or a ‘bad reason’ (adverse selection). There is ample evidence that both have been at work.”<sup>9</sup>

Advocates of parity argue that unequal benefit limits should be eliminated. There is evidence of a widening gap between coverage for physical and mental illness.<sup>10</sup> According to the Hay Group, 57 percent of plans surveyed had day limits on inpatient psychiatric care in 1997, up from 38 percent in 1988. In 1997, 48 percent had outpatient visit limits, up from 26 percent in 1988. The Hay Group also estimated that behavioral health care benefits dropped from 6.1 percent of total benefit costs in 1988 to 3.1 percent in 1997.<sup>11</sup>

Despite the detected increase in demand-side controls, much of the drop in mental health benefit spending is probably due to the impact of managed care. By 1998, managed behavioral health firms reported a total enrollment of up to 162 million Americans (30 percent more than in 1996).<sup>12</sup> The publication *Open Minds* surveyed the industry with regard to enrollment in five types of programs and found

- 36.6 million people in stand-alone behavioral health utilization review programs (costing about \$1.50 PMPM).
- 31.4 million people in stand-alone employee assistance programs (EAPs) (costing about \$2.50 PMPM).
- 16.9 million people in integrated managed behavioral health/EAP programs (costing about \$4.00 PMPM).
- 32.2 million people in non-risk-based behavioral health network programs (costing about \$1.00 PMPM).
- 45.1 million people in risk-based networks (costing about \$5.85 PMPM).

(The publication notes that the same person could be counted in more than one category if different vendors reported that they provided different services for the same group of insured people.) Generating a total annual

revenue of more than \$4 billion, the managed behavioral health industry is dominated by a few players. In 1998, three firms accounted for more than 60 percent of total market share. In addition, managed behavioral health programs operated internally by health maintenance organizations covered 14.3 million people and had revenues exceeding \$380 million, the survey found.

While employers and insurers strive to cut mental health costs, a case can be made that financing treatment of depression and other mental disorders can increase worker productivity and improve corporate financial performance. Up to 10 percent of all adults experience clinical depression each year, costing the nation a total of \$44 billion, according to estimates in a recent report by the Washington Business Group on Health.<sup>13</sup> Of this total cost, 28 percent is associated with direct health expenditures, 55 percent with absenteeism and reduced productivity, and 17 percent with premature mortality costs. The report also concluded that clinical depression, which is concentrated among people aged 25 to 44, can be effectively treated in more than 80 percent of cases with medication and psychotherapy or a combination of the two approaches.

Estimates of the cost savings achieved by managed mental health programs are open to question in several ways. First, such programs typically are not responsible for managing drug costs. Data used to analyze such programs’ performance usually do not include the cost of drugs, and drug costs have been rising rapidly in recent years. One economist interviewed for this paper said that he recently examined a set of contracts showing capitation rates of about \$3.50 PMPM for mental health services and \$3.75 PMPM for psychotropic drugs. It is not known to what degree pharmaceutical spending or general medical spending for that matter has changed, if at all, in response to the shrinkage in benefit costs for inpatient and outpatient mental health services. In order to understand trends in total mental health costs, an analyst would have to examine at least three factors: mental health carve-out costs, drug costs, and the cost of mental health services rendered in a general medical setting.

## MANAGED CARE ISSUES

Some experts say that achieving parity in benefit design has only symbolic importance. Others say it is important in widening the parameters within which managed care techniques are applied. And, of course, it is important to protect very ill people from financial ruin. Yet, while managed care has allowed parity in benefit

design to be achievable, it has also compromised the impact of parity. The salient question seems to be, How good is your managed mental health care? To answer this question, there are few answers and little data.

Managed behavioral health care tools include capitation, financial incentives to providers, the size and composition of provider networks, utilization review, and case management. For such strategies to succeed, much depends on the philosophies and motive of management, the quality of the professionals involved, and the coherence of incentive structures.<sup>14</sup> According to an executive in one of the largest managed behavioral health firms, the major firms in this field use the general strategy of moving patients from inpatient settings to outpatient settings where appropriate and managing the use of medications. Case management (concurrent review to determine medical necessity) by these firms is much more intensive than management techniques applied to most general medical illnesses. The quality of care hinges in part on how much money is allocated by plan administrators toward mental health benefits. If capitation rates are negotiated or budgets are set too low, quality will diminish.

A case study of the state of Ohio's experience in adopting full parity for alcohol, drug, and mental health benefits for state employees found that switching from unmanaged indemnity care to a managed care carve-out was followed by a 75 percent drop in inpatient days and a 40 percent drop in outpatient visits, despite the increase in allowable benefits.<sup>15</sup> Implementation of managed care by far overwhelmed the impact of benefit parity. But the authors pointed out that, "unfortunately, that does not answer the question of which level of service intensity meets the criterion of appropriateness." They also expressed concern that cost competition might reduce care below acceptable limits. In this instance, the state of Ohio took the rare precaution of including minimum utilization standards in its managed care contract (for example, stipulating a minimum of 500 outpatient visits be provided per 1,000 lives). Yet contractual standards such as these raise many issues, including the possibility of rigidifying inefficient treatment patterns. The authors of the Ohio case study note that the scientific information needed to set utilization standards is not yet available.

While mental health coverage mandates are in part designed to overcome the paucity of benefits offered due to insurer concerns about adverse selection, the selection problem comes back in spades in the context of managed care. Managed behavioral health firms carrying financial risk to provide care have ample

means at their disposal to discourage the sickest patients from joining or remaining in a health plan. This raises the issue of whether capitation rates should be adjusted for the severity of illness and how such a system might be operated. Even if effective risk-adjustment mechanisms were developed, the incentive to select favorable risk would remain, especially in instances where insurers were competing with one another or where capitation rates were relatively low.

Some mental health providers, analysts, and advocates also question whether tight management of acute mental health services by employers and insurers may ultimately shift the cost of treating the sickest patients to the public sector. A related concern is that seriously ill people might be denied care by a health plan but still not qualify for public-sector coverage, leaving them uninsured.

There is evidence that responsibility for financing mental health and substance abuse services has been shifting from the private to the public sector. From 1986 to 1996, funding from public sources increased from about 49 percent to 54 percent of total spending for mental health, alcohol, and other drug abuse treatment.<sup>16</sup> Over that decade, Medicaid, Medicare, and other federal programs became slightly more important as sources of financing for these kinds of treatments, while the share of funding from private insurance remained relatively constant (about 25 to 26 percent). Treatment financed by out-of-pocket sources decreased from 23 percent in 1986 to 16 percent 10 years later. (In 1996, mental health, alcohol, and other drug abuse treatment cost a total of about \$79 billion. Of the approximately \$36.3 billion in private sector spending, \$20.9 billion is estimated to have come from private insurers, \$12.7 billion from individuals, and \$2.8 billion from other private sources. Of the estimated \$43 billion in public expenditures, Medicare accounted for \$10.7 billion, Medicaid programs \$14.4 billion, other state and local programs \$14.8 billion, and other federal government programs \$3 billion.)

NAMHC's 1998 report concluded that benefit parity alone does not guarantee improved access to mental health care because of the strong counteracting effect of management, noting that the "proportion of individuals receiving mental health treatment varies considerably across managed behavioral health plans—both before and after the introduction of parity benefits."<sup>17</sup> The report also expressed concern about variability in quality in managed mental health care but noted that there is some evidence that access and quality can be maintained or improved under managed care. That evidence is preliminary and further research is needed to assess treatment outcomes, it concluded.

Managed care strategies have sparked provider complaints about very sick people being discharged prematurely from inpatient settings, thereby driving up readmission rates. Providers also note that many health plans have formularies that exclude some of the most expensive breakthrough psychiatric drugs:

For family members with schizophrenia or employees with bipolar illness, new antipsychotic medications such as risperidone, olanzepine or quetiapine may be excluded because of cost despite the fact that they have fewer side effects than earlier drugs and are more effective in preventing relapse,

wrote Steven S. Sharfstein and Sally Satel in a recent *Wall Street Journal* commentary.<sup>18</sup>

Mental health advocates support several policy interventions to ensure access to mental service in the managed care context. These include making sure that mental health services capitation rates are high enough to provide appropriate levels of care.<sup>19</sup> Other measures include standardized benefits based on parity, public release of comparative information on plan performance, practice guidelines, effective and timely grievance and appeals mechanisms, and risk-adjusted payment.<sup>20</sup>

## THE FORUM SESSION

After several short presentations by the featured speakers, the discussion will open up to include a panel of experts, advocates, and interested parties.

### Issue Questions

Among the issues to be discussed at this Forum meeting are the following:

- What has been the effect of requiring parity for mental health benefits? Have the passage of parity laws and the prospects of more parity legislation speeded up the shift to managed mental health care?
- What problems do parity laws solve and what problems do they create?
- What are the principal mechanisms that employers and insurers use to manage mental health costs in today's marketplace? What is known about the ability of such strategies to control overall mental health and health care costs?
- In the era of managed mental health care, what new issues have emerged for public policymakers?
- Are managed care techniques applied in a different way or more intensely to mental health services than to other types of medical care?

- What are the prospects that Congress may pass a full parity bill this year? How might such legislation address the parity issue with respect to managed care?

### Speakers

**William Goldman, M.D.**, is senior vice president for behavioral health sciences at United Behavioral Health in San Francisco. He is also a clinical professor of psychiatry at the University of California, San Francisco. Dr. Goldman is currently a member (and immediate past chair) of the American Psychiatric Association Council on Economic Affairs. He also serves on the UCLA/RAND Research Center on Managed Care for Psychiatric Disorders Advisory Board; the NIMH National Worksite Program Research Advisory Group; and the NIMH Parity Workgroup. Previously, Dr. Goldman served as medical director for several managed care organizations as well as director of mental health, drug, and alcoholism services for the City and County of San Francisco and as Massachusetts Commissioner of Mental Health and Mental Retardation.

**Richard G. Frank, Ph.D.**, is professor of health economics in the Department of Health Care Policy at Harvard University Medical School, which he joined in 1994. He also serves as a research associate for the National Bureau of Economic Research. Dr. Frank has served on many national and state governmental agencies. Currently, he is a member of the Substance Abuse and Mental Health Services Administration Advisory Council and the MacArthur Foundation's Mental Health Policy Research Initiative. His primary areas of interest include the economics of health and mental health, the behavior of nonprofit institutions, pharmaceutical pricing, and the financing of health services for vulnerable populations. He is currently conducting studies on managed care design for mental health and substance abuse, risk adjustment of capitation rates, and financial incentives associated with medical group practices.

## ENDNOTES

1. See Richard E. Hegner, "Mental Health Parity: Unresolved Issues Affecting Employers, Consumers, and Insurance Coverage," National Health Policy Forum Issue Brief No. 709, November 13, 1997.
2. For more detail on this regulatory "model" see Karl Polzer, "HIPAA as a Regulatory Model: Early Experiences and Future Prospects," National Health Policy Forum Issue Brief No. 735, April 5, 1999.

3. HCFA is in the process of determining how many states have enacted legislation allowing them to enforce the 1996 federal mental health parity law. While the agency is not actively enforcing the law in the remaining states, it has yet to receive any consumer complaints about violations of the statute, according to a HCFA official.
4. "States expand coverage for mental illness; focus on conditions with biological bias," *State Health Watch*, American Health Consultants, Atlanta, July 1999, 1.
5. Roland Sturm, "How Expensive Is Unlimited Mental Health Care Coverage under Managed Care?" *Journal of the American Medical Association*, 278, no. 18 (November 12, 1997): 1533.
6. National Advisory Mental Health Council, "Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access and Quality," interim report to Congress, U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health, Washington, D.C., April 1998, 17-18.
7. "Action Alert," Judge David L. Bazelon Center for Mental Health Law, April 30, 1999.
8. Richard G. Frank, Chris Koyanagi, and Thomas G. McGuire, "The Politics and Economics of Mental Health 'Parity' Laws," *Health Affairs*, 16, no. 4 (July/August 1997): 110.
9. Frank, Koyanagi, and McGuire, "Politics and Economics," 111.
10. Jeffrey A. Buck, Judith L. Teich, Beth Umland, and Mitchell Stein, "Behavioral Health Benefits in Employer-Sponsored Health Plans, 1997," *Health Affairs*, 18, no. 2 (March/April 1999): 68.
11. These estimates do not include the cost of drugs.
12. John Clary and Monica E. Oss, "Managed Behavioral Health Program Coverage Increases 9%," *Open Minds*, 10, no. 2 (May 1998): 12.
13. Angela Glover Burgess, Isabel Davidoff, and Veronica Vaccaro Goff, "Investing in Workplace Productivity: Innovations in Managing Indirect Mental Health Costs," Washington Business Group on Health/National Institute of Mental Health National Worksite Program, Washington Business Group on Health, Washington, D.C. March 1999, 9.
14. David Mechanic, "Emerging Trends in Mental Health Policy and Practice," *Health Affairs*, 17, no. 6 (November/December 1998): 83.
15. Roland Sturm, William Goldman, and Joyce McCulloch, "Mental Health and Substance Abuse Parity: A Case Study of Ohio's State Employee Program," *Journal of Mental Health Policy and Economics*, 1 (1998): 129-134.
16. Tami Mark, David McKusick, Edward King, Henrick Harwood, and Jim Genuardi, "National Expenditures for Mental Health, Alcohol and Other Drug Abuse Treatment, 1996," U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Rockville, Md.; accessed June 24, 1999, at [www.samhsa.gov/csatsat/idbse/sereport.asp](http://www.samhsa.gov/csatsat/idbse/sereport.asp).
17. National Advisory Mental Health Council, "Parity in Financing Mental Health Services," 5.
18. Steven S. Sharfstein and Sally Satel, "'Parity' Isn't Charity," *Wall Street Journal*, June 11, 1999.
19. Interview with Chris Koyanagi.
20. E. Clarke Ross, "Overcoming Repression in an Era of Managed Care," *NAMI Advocate*, October/November 1998, 13.