

ImproveHealthCare.org

Mental Health Parity: The Case of Diego Garcia

Case Author

Rifaquat Rahman

MD Candidate (2013), Harvard Medical School

Mentor

Niels Rosenquist, MD, PhD

Department of Psychiatry, MGH

Department of Health Care Policy, HMS

August 16, 2010



Background

Introduction to Mental Health Care

The National Alliance on Mental Illness (NAMI) defines mental illness as “medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others, and daily functioning.”¹ Serious mental illnesses include major depression, bipolar disorder, schizophrenia, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder, and borderline personality disorder. Approximately one in four adults in the United States, 57.7 million total, experiences a mental health disorder in a given year, and mental illness costs society over 100 billion dollars in lost productivity per year.^{2,3} The Bzelon Center for Mental Health Law estimates that fewer than half of those in the US with mental disorders receive treatment for their ailment.⁴

Any discussion on mental health care parity must start with a discussion of how mental health care relates to general medical care as a whole. Most physicians would agree that mental health is just as important as physical health, and both aspects are very closely integrated and crucial to one’s overall well-being. There are several characteristics of mental illnesses that support the notion that they should be considered just as important and urgent as physical ailments: there is a biological basis underlying the disease, they cause pain and suffering, and there are therapies that can usually treat the diseases.⁵ According to NAMI, 70%–90% of individuals can have a significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments and support.⁶

Despite the abovementioned similarities, it is also crucial to understand the key differences that set mental health apart from conventional medical diseases. There is seemingly always an extra level of ambiguity in the steps related to diagnosis and treatment of mental illnesses. Furthermore, there is a long-lasting stigma associated with mental illness that still persists in modern society. This is compounded by the fact that mental illness is strongly associated with lower socioeconomic status. These key differences are some of the justifications used and establish a very sharp division between mental health and physical health. Based upon this division, mental health care has evolved on a very different path from physical health through the years.⁷

The End of the Asylum Model of Care

Throughout the history of the United States, there has been a tension between those favoring the care of the mentally ill through hospitalization (ostensibly for patient safety) and those who support the rights of the mentally ill to live out in the community. In the early 1900s, the state-funded asylum system became unfavorable due to harsh conditions and continued ineffectiveness in caring for and supporting the mentally ill.⁸ In 1965, the Community Mental Health Center Movement was promoted with the philosophy that mental health care would be best delivered in the community.^{9,10,11} Deinstitutionalization refers to “the policy of moving severely mentally ill people out of large, state institutions and then closing part or all of those institutions.”¹² Thus, the deinstitutionalization movement of mentally ill patients coincided with the creation of many federally funded community mental health centers across the country.¹³ This represented a shift from long-term care to management of acute episodes, which emphasized outpatient services rather than inpatient care.^{14,15}

Health Insurance and Mental Health Care

As coverage of general medical and surgical care expanded greatly through the 1960s, the coverage of mental health care remained very limited.^{16,17,18} Prior to deinstitutionalization, the states covered most of the costs of mental health care through asylums, and there was little incentive for private insurers to cover mental health care.¹⁹ Deinstitutionalization led to a shift of much of the costs away from the states. Thus, in a relatively short time scale, Medicaid, Medicare and private health insurance came to be the primary sources of support for the mentally ill.²⁰ Another major change in health care came from the development of highly effective medications such as Lithium, Chlorpromazine, and tricyclic antidepressants, all of which served to significantly reduce the symptoms of the mentally ill.²¹ The emergence of these new treatments with established scientific validity brought an added urgency to the need for having mental health services covered by insurance companies, since effective treatments now existed for many common mental illnesses.

The familiar concepts of moral hazard and adverse selection have been very important in shaping coverage of mental health care, especially in relation to physical health issues.²² Moral hazard refers to how our behavior changes when we are protected from the consequences of our actions by insurance.^{23,24,25} The RAND Health Insurance Experiment (HIE) in the 1970s demonstrated how cost sharing can dramatically decrease one's utilization of health services (i.e., supporting the notion of moral hazard).^{26,27} One of the key findings of the RAND study is that different services respond to cost sharing differently. Another way to describe this phenomenon is to think of the situation in terms of elasticity. For a service that is relatively elastic, an increase in cost sharing can dramatically lower demand for the service. For an inelastic service, an increase in cost sharing does not dramatically lower demand for the service.²⁸ The RAND HIE and similar work discovered that ambulatory mental health services are particularly elastic and therefore quite responsive to cost sharing.^{29,30,31} The coverage of psychotherapy was particularly scrutinized because it was considered to be a relatively discretionary treatment with only a few objective endpoints.³² If the patient did not share in the costs associated with receiving psychotherapy, the RAND HIE indicated that overutilization would occur.³³ Furthermore, the RAND study suggested that individuals decrease their use of psychotherapy services at approximately double the rate of other medical services when faced with extensive cost sharing; the implication of this finding is that the relative value of psychotherapy sessions was significantly less than that of other health-related services.^{34,35,36}

The second important concept behind the economics of insurance that must be examined with regard to coverage of mental health services is adverse selection. Studies have repeatedly shown that insurance plans with slightly better benefits have significantly higher overall utilization of services.³⁷ Incentives related to adverse selection are particularly strong with regard to mental health care. Many mental health and addictive disorders are chronic in nature, and insurance companies have historically tried to reduce the chance that the mentally ill will choose their health plans. Evidence indicates that people with mental illness seek plans with better benefits. Further supporting the logic used by health insurers, evidence suggests that people with a history of mental illness tend to have higher overall health spending.^{38,39} Thus, insurance companies have a financial incentive to try to limit benefits for mental health care and discourage people suffering from mental illnesses to join their risk pools.^{40,41}

As already alluded to, the problems of moral hazard and adverse selection were supported by many research studies in the 1970s. Five independent studies after the RAND HIE again reinforced the justification of using higher cost sharing for psychiatric services such as psychotherapy.⁴² Another piece of evidence came from the study of two nationally available Federal Employee Health Benefits Program health plans in the 1960s that offered generous mental health care benefits. These plans

quickly lost significant amounts of money as “needier” populations enrolled into the generous benefit plans (i.e., adverse selection).^{43,44} These federal employee health plans with generous mental health care benefits were briskly scaled back within a decade due to the large financial losses.^{45,46}

Based on this large body of evidence, insurance companies reacted by placing increasingly stringent limits on mental health care that were not placed on physical health illnesses. Coverage of outpatient mental health services has often included extra copayments, higher deductibles, and limits of usage.

Carve-out contracts represent a key strategy that emerged to improve the cost effectiveness of mental health care. A carve-out “allows a unique set of managed care techniques to be applied to a subset of particularly costly or complex benefits.”⁴⁷ Carve-out companies are contracted by health insurance companies as a way to become more efficient in a particular subset of care (i.e., mental health). The carve-out firm can become very specialized and use its expertise to create networks of providers at lower reimbursement rates while remaining as cost efficient as possible.^{48,49,50} Several observational studies have shown that there can be substantial reductions in mental health care costs while improving access to care via the usage of carve-out contracts.⁵¹ The effects of the use of carve-out contracts on the quality of care delivered, however, are not fully understood.^{52,53} The most commonly cited problem with carve-outs is that they promote fragmentation of care due to their inherent specialized nature.⁵⁴ Nonetheless, the use of carve-outs has continued to grow, as the enrollment in a managed behavioral health program went from 70 million in 1993 to 164 million in 2002.⁵⁵

Achieving Parity in the Insurance Coverage of Mental Health Care

Since the 1950s, advocates for the mentally ill have espoused the need to eliminate the differences in the health care coverage of mental health and physical health.⁵⁶ The argument for parity primarily focused around the concept of fairness; advocates argued that a lack of parity in coverage of mental health amounted to discrimination against the mentally ill.^{57,58,59,60}

By 1995, 89% of health insurance plans had inpatient mental health limits, while 96% had outpatient mental health limits.⁶¹ In a largely symbolic gesture, the Mental Health Parity Act of 1996 was enacted to prohibit insurers from placing annual or lifetime dollar limits on the coverage for mental illnesses.^{62,63} While it was a step in the direction of true parity, the law did not apply to other benefit limits such as special annual inpatient day limits, outpatient visit limitations, or higher cost sharing.⁶⁴ These left glaring loopholes that allowed for continued disparities in the coverage of mental health in relation to general health coverage.^{65,66} The following table compares the coverage of mental health services relative to other health services for a typical employer-sponsored plan in 2000:

Table 1: Limitations of Mental Health Coverage after 1996 Mental Health Parity Act⁶⁷

Feature	Mental Health	Medical and Surgical
Lifetime dollar limit	\$1 million combined with medical and surgical	\$1 million combined with mental health
Hospital day limit	30 days	Unlimited
Outpatient office visit limit	20 visits	Unlimited
Outpatient office visit coinsurance	50%	20%

Source: Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited. General Accounting Office, 2000.

As advocates of the mentally ill made stronger efforts to bring parity in coverage, opponents continued to cite previous research as evidence that such parity would be unsustainable. The cited research, however, represented work in the 1970s and early 1980s, before managed care evolved into a dominant force in the US health care system. Managed care reduces inpatient admissions, inpatient lengths of stay, and total spending in the health sector, so there was reason to believe that it could blunt the issues thought to be promoted by parity in coverage of mental health services.⁶⁸ A second generation of research was done in the late 1990s to study mental health care coverage in the context of managed care. This new wave of research aimed to examine the effects of implementing parity on total mental health spending and consumers' out-of-pocket spending.⁶⁹ Unlike the previous generation of research, this new work concluded that there would not be a large increase in mental health spending in response to parity.^{70,71,72} Furthermore, the studies speculated that there should also be significant decreases in the out-of-pocket spending by consumers.⁷³ In essence, the growing tide of evidence suggested that bringing parity to the coverage of mental health care would “not break the bank.”^{74,75,76,77,78}

In response to the new wave of research, there were several new initiatives experimenting with mental health parity. A new federal initiative towards parity was instilled in 2001 for federal employees, and it constituted the most comprehensive parity policy enacted up until that time.⁷⁹ The policy for federal employees resulted in a significant reduction in out-of-pocket spending for mental health care, but there was neither change in inpatient admissions nor significant increase in total costs.^{80,81} While there is still much debate as to how different managed care tools are effective in reducing costs, the use of carve-out contracts are thought to be an important factor.⁸² And while there have been many different estimates on the change in premiums that would occur due to parity, the Congressional Budget Office estimated an average increase of 0.9% of premiums.⁸³ In response to the growing tide of sentiment in favor of parity for the coverage of mental health services, many states adopted parity laws for the coverage of mental health care. Study of the mental health coverage in these states, such as California, indicated that there could indeed be small improvements in the access to mental health services without dramatic cost increases when parity was implemented in the context of managed care.^{84,85,86} Further bolstering the conclusions of the newer generation of research, momentum built up for a federal law to instill parity in mental health coverage on a federal level.

In the fall of 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act was enacted into law.^{87,88,89} To comply with this law, health insurers will be required to provide comparable levels of coverage for mental health and physical health; this will end the longstanding practice of charging disproportionately high co-pays and stringent restrictions on mental health care services.^{90,91} This law has brought parity in the coverage of mental health benefits for over 113 million people, 82 million of whom are self-insured individuals who were not covered by many of the state parity laws already in place.⁹² The federal parity law also extends to Medicaid managed care plans and Medicare, which gives many of the poor and elderly parity in mental health coverage.⁹³ It is important to realize that not much is known about the effects of parity on the quality of mental health care provided, but preliminary research results show higher performance on important measures of quality.⁹⁴

There are, however, a few shortcomings of the law, which should be noted. If an insurer provides coverage for mental health services, they must do so at an equal level to medical and surgical coverage, but they may still choose simply not to offer coverage for mental health care in the first place.^{95,96,97,98} Also, the federal law applies only to insurance plans for employers with over 50

employees, and it does not mandate the coverage of any specific diseases. Thus, the diseases covered by a given health plan remain at the discretion of the insurer.^{99,100,101,102} Nonetheless, the law represents a momentous achievement for everyone involved in mental health care.

Moving Forward

Moving beyond parity in coverage, mental health care in the United States still has much room for improvement. Parity does not represent a panacea to the many issues related to mental health care.^{103,104} The persistent stigma and nonscientific distinction between mental and physical illness must continue to erode.¹⁰⁵ The care for lower-income people with mental illness continues to be a low-priority social activity, and this will need to change if there is to be further improvement in the conditions of the chronically mentally ill.^{106,107,108} Furthermore, educational efforts must be promoted to ensure that mental health is valued as a critical component of general overall health and well-being.¹⁰⁹ Alarming, individuals living with serious mental illness face a much increased risk of having chronic medical conditions; adults living with serious mental illness die 25 years earlier than other Americans, mostly as a result of treatable medical conditions.¹¹⁰ Such a statistic only further emphasizes the need to continue efforts to increase health care access for the mentally ill. Finally, it is also important to remember that one of the managed care techniques used to reduce admissions and costs is setting stringent criteria for what constitutes a “medical necessity.” While there is a reasonable economic rationale for this approach, it will be important to gauge the use of this criterion to make sure it is not too stringent so that those in need of help are not discouraged from seeking it.^{111,112}

Part Ia

Originally from Colombia, Diego Garcia had moved to New York City with his family when he was 15 years old. Diego's first couple of years in a tough neighborhood in the Bronx were very difficult, made worse by his mother's "mental problems" and subsequent drug use. Diego did not adapt well, and he dropped out of high school within two years of enrollment. Exhibiting increasingly aberrant behavior, he was diagnosed with schizophrenia and a seizure disorder in his later teenage years.

Despite having a translator present, the psychiatrist, who originally made the diagnosis, found it difficult to explain the disease to Diego's Spanish-speaking family. Although the family recognized the term "esquizofrenia" (the Spanish translation of schizophrenia), the medical team struggled to explain the disease, since it was a complex condition with variability in presentation, duration, and outcome.

Following diagnosis, Diego did not immediately seek care. The culture in his mother's native Colombia traditionally relied on family support to treat mental illnesses. Coming from the Caqueta Department, a Colombian province wrought with persistent armed conflict and governmental neglect, mental illness was stigmatized, and most people did not seek professional help.^{113, 114} According to Doctors Without Borders, Caqueta had only one mental health program and one psychiatrist serving a population of hundreds of thousands of residents.¹¹⁵ In this setting, it was not surprising that Diego's family did not seek out care and kept him at home. The mother's own illness, however, made it impossible to care for Diego, and he quickly fell through the cracks of the system, alternating between living on the street, in homeless shelters, and in hospitals for short visits when his symptoms worsened.

Approximately a year ago, one of the homeless shelters that Diego often visited had set him up with a psychiatrist, Dr. Rafael Ibanez, a few blocks away from the shelter. Although Dr. Ibanez had trouble eliciting much of a response from Diego during the first few visits, he built a rapport with Diego over time, and Diego would regularly attend his appointments. Initially, Dr. Ibanez was hesitant to prescribe an antipsychotic. Dr. Ibanez had recently read about the CATIE trial examining the effectiveness of antipsychotics; the study had found that the majority of patients interrupted or discontinued taking their antipsychotic medications within 18 months of initiation.¹¹⁶ This did not surprise Dr. Ibanez, because he had witnessed many patients over the years stopping their medications for a host of reasons, including numerous uncomfortable side effects, disorganized behavior, and harsh living situations that interrupted their daily routine. He also considered potentially trying Risperidone's depot formulation, which could last up to two weeks a dose (and is the standard of care in many parts of Europe), but it wasn't covered by Diego's health insurance. Encouraged by Diego's dedication to their appointments, Dr. Ibanez eventually decided to prescribe Clozapine to reduce his severe psychotic episodes.

As per the FDA-mandated black box labeling on Clozapine, there was a significant chance of agranulocytosis, especially during the patient's first year of therapy. To monitor for this, Diego

regularly went to the local clinic to have his Clozapine levels and white blood cell count checked.¹¹⁷ Diego finally seemed to be getting better control of his illness with less episodes of psychosis after having the drug prescribed by Dr. Ibanez, who he continued to see regularly in conjunction with his medication.

Discussion Questions

- Why do cultural differences seem to be especially important to consider when treating the mentally ill?
- What are some of the added complexities in the treatment of psychiatric patients? Consider the patient population and the types of medications used to treat them.

Part Ib: November 15, 2005

Diego came to the Sunnyside Falls Adult Home with high hopes. Sunnyside Falls had been around for some time by the time Diego was sent there. Adult homes for the mentally ill were founded after the deinstitutionalization of state psychiatric hospitals in the mid 1900s. They are mostly for-profit residencies that were proposed as a “decent alternative” to the misery found in state psychiatric hospitals after deinstitutionalization.¹¹⁸ The state paid the adult homes to feed, shelter, and supervise the residents via daily sums taken from each resident’s monthly Social Security disability check. By offering the support needed to obtain jobs, receive better care, and join society as productive contributors, these adults homes were intended to serve as bridges for the mentally ill to start new, independent lives.¹¹⁹

While he had initially hoped that moving into Sunnyside Falls would provide some much-needed stability in his living situation after years of moving between hospitals and shelters, Diego quickly discovered a different reality upon entering the home. Unfortunately, at the time many of New York City’s adult homes repeatedly failed inspections and had been noted to provide wretched living situations for the mentally ill.^{120,121,122} Chronically understaffed and poorly maintained, it was apparent that this was not an ideal place for rehabilitation.^{123,124} The most shocking aspect of the adult home was the prevalence of loan-sharking, prostitution, and unchecked violence among residents.¹²⁵ Despite the fact that the home was for the mentally ill, most of the workers did not have any mental health training. Furthermore, most of the staff was not bilingual and, since budget cuts had decimated the professional translator services, Diego had trouble communicating with them in his broken English.

Without any better alternative, Diego stayed in the home with an optimistic attitude, eager to make the best of the situation. With the involvement of Dr. Ibanez, he took his medications and regularly went to the clinic to have his blood count carefully monitored. At Sunnyside Falls, Diego learned to stay mostly in his room to avoid dangerous residents who would prey on the frail ones. The most chaotic days would occur once a month when all the residents would receive a monthly allowance from the adult home administration; pandemonium would ensue as in-house loan sharks would attempt to collect debts, and new funds were used to buy contraband.¹²⁶

Discussion Questions

- What motivated the movement known as deinstitutionalization?
- What are the advantages and disadvantages to having *privately owned* adult homes to take care of the mentally ill?

Part IIa: July 16, 2006

Diego was one of the few people at the adult home who attempted to gain employment, although he had been incapable of keeping a job in the past due to his struggles with mental illness. He was doing well with the help of Dr. Ibanez, who he continued to see on a regular basis. Despite Diego's positive progress, Dr. Ibanez had recently learned of a change in the coverage provided by Diego's insurance company. According to the guidelines, Diego had nearly reached the limit on the amount of outpatient visits for the year. Knowing his family would not be able to pay for the services without insurance coverage, Diego stopped seeing Dr. Ibanez in the hopes that he would be able to maintain his stable condition on his own.

Soon thereafter, Diego became more and more inconsistent in taking his Clozapine. Although Clozapine was an antipsychotic drug that could be used to treat very severely mentally ill patients, it had very dangerous side effects, including agranulocytosis, increased seizures, and myocarditis. Vigilant monitoring was required for anyone taking such a powerful medication. Soon after he became less adherent, Diego began to suffer more seizures, and his fluctuating intake of Clozapine led to a mild dystonia.

Discussion Questions

- Why were such strict limits placed on usage of mental health care by insurance companies relative to other forms of care?
- Why are moral hazard and adverse selection thought to be a greater issue with people who are mentally ill?
- What role should the physician play in helping a patient understand his or her insurance coverage?

Part IIb: August 27, 2006

Diego's mental health deteriorated rapidly through August. There were warning signs, as he lost his appetite and his mood and temperament shifted for the worst, but there was no support staff to identify and correct these issues. Diego tried to stay in his bed to avoid injury during the seizures he increasingly suffered from, but his intake of Clozapine became even more sporadic during this time. After weeks of gradual worsening, Diego had a severe psychotic episode on a Saturday night that could not be ignored by the staff. He was immediately sent to the emergency room.

In the ER, Diego could be seen mumbling incoherently, and he reacted angrily to any approach. The hospital staff was unable to get much of a story out of him. Diego repeatedly screamed out violent intentions in Spanish with a startling hostility. Terrified by seemingly unprovoked rage, hospital security was called, and the nurses avoided any engagement with Diego. It did not help that Diego had struck a nurse in the same hospital many years ago; such episodes were rarely forgotten by the older nurses who were still in the ER.

The psychiatrist on call was summoned to deal with the behavioral emergency. Dr. Martinez had been on call for 20 hours and had an unusually busy night with more of a patient load than usual. Yawning and having trouble keeping his eyes fully open, he slowly walked to the emergency room to answer the call. Luckily, he was one of the few psychiatrists on the hospital staff that could fully communicate to his patients in English or Spanish.

Observing Diego in his psychotic state, Dr. Martinez realized that Diego was a danger to himself and others. He needed to be admitted to the hospital for observation. Dr. Martinez grumbled to himself as he pondered his plan of action. He was almost done with his day's shift, but his concern for Diego was undoubtedly going to disrupt his plans for leaving the hospital in a timely manner.

As Dr. Martinez knew all too well, there were several obstacles to getting Diego admitted for the care that he desperately needed. First, he would need to obtain precertification through Diego's insurance company. Dr. Martinez had come to abhor this aspect of his work: He would have to wait on the phone and then explain his rationale for wanting to admit Diego.^{127,128} A cold, emotionless voice on the other end of the line would then listen and render a decision. Far too often, Dr. Martinez had to resort to arguing his case vehemently to an insurance company representative who would not readily agree that there was a "medical necessity" to hospitalize a patient.

The second obstacle would be to find a hospital bed for Diego. Beds for psychiatric patients were often in short supply, especially on the weekends. The hospital attempted to avoid "giving away" too many beds for psychiatric patients, especially considering the low reimbursement rates for psychiatry.¹²⁹ Dr. Martinez was well trained on this issue, and he figured he would be able to find a bed for Diego. Dr. Martinez took a deep breath and picked up the phone to start the potentially long process of getting Diego's insurance company to comply with his recommendation for hospitalization.

Discussion Questions

- What steps can the emergency department take to better prepare itself for behavioral emergencies?
- For what purpose does an insurance company employ a precertification process for admitting psychiatric patients?
- What are important things to consider in defining “medical necessity” for psychiatric cases?
- What are possible solutions to the general lack of beds for psychiatric patients in many areas of the country?

Part IIc: September 1, 2006

Diego was stabilized and kept under observation, to be released a few days later. Dr. Martinez was hoping to recommend Diego for psychotherapy sessions, but he noted that Diego had already used up his allotment of outpatient services. Diego would not have any additional outpatient mental health services covered for the rest of the year, and it was unlikely that his family would be able to cover the costs without help from insurance. Dr. Martinez made sure to tell Diego and the Sunnyside Falls administration that they should bring him back to the emergency room if his behavior ever became aberrant in any fashion.

Discussion Questions

- What are the consequences of having the emergency room serve as a stopgap in this manner?
- What steps could be taken to alleviate this burden on the emergency room?

Part III: February 8, 2007

In the following months, Diego had fewer psychotic episodes. Due to the poor maintenance of the stairway in his residence, however, he suffered a painful fall that caused several broken bones, including a few broken ribs, a dislocated shoulder, and a sore neck.

Taking spinal precautions, EMS personnel carefully transported Diego to the same hospital emergency department. This time, however, there was minimal delay in getting admitted to the hospital. The emergency department physician assessed Diego, and he was briskly admitted in order to obtain the appropriate care. He was soon discharged and assigned physical therapy sessions at a nearby rehabilitation center.

Discussion Questions

- Why is the care of Diego so drastically different when he has a medical/surgical problem as opposed to a mental issue?
- Are the differences justifiable?

Epilogue

Since the enactment of the 2008 mental health parity law, Diego has had much greater coverage for outpatient care, and he quickly reconnected with Dr. Ibanez. This allowed him to regularly undergo counseling sessions, which he found to be very helpful. Dr. Ibanez also worked with him to find the prescription antipsychotic that gave him the best effect. Given his improved access to outpatient care and improved medication adherence, Diego suffered much fewer severe psychotic episodes. His family also started to have some financial relief, since the coinsurance for these helpful outpatient visits for Diego are on track to be lowered to match the coinsurance of other services by the year 2014.

¹ About Mental Illness. National Alliance on Mental Illness, 2010. (Accessed August 3, 2010, at http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm.)

² Mental Illness: Facts and Numbers. National Alliance on Mental Illness, 2007. (Accessed August 4, 2010, at http://www.nami.org/Content/Microsites140/NAMI_Austin/Home130/Advocacy11/Mental-Illness-FactSheet.pdf.)

³ State Action Alert. National Alliance on Mental Illness Policy Research Institute, 2003. (Accessed August 3, 2010 at http://www.nami.org/Template.cfm?Section=policy_research_institute&Template=/ContentManagement/ContentDisplay.cfm&ContentID=6767.)

⁴ Kershaw S. Mental Health Experts Applaud Focus on Parity. *New York Times*, March 30, 2010.

⁵ Rosenquist JN, Barry C. Chapter 68: Managed Care and Psychiatry. *Comprehensive Clinical Psychiatry*. Boston, MA: Mosby Publishing, 2008.

⁶ About Mental Illness. National Alliance on Mental Illness, 2010.

⁷ Rosenquist and Barry.

⁸ Ibid.

⁹ Ibid.

¹⁰ Kaiser Family Foundation. Deinstitutionalization Movement Provides Lessons for Reforming Long-Term Care in the United States. *Psychiatric Services* 2007;58:1383.

¹¹ Torrey EF. *Out of the Shadows: Confronting America's Mental Illness Crisis*. New York: John Wiley & Sons, 1997: Chapters 1, 3, and Appendix.

¹² Ibid.

¹³ Kaiser Family Foundation.

¹⁴ Rosenquist and Barry.

¹⁵ Kaiser Family Foundation.

¹⁶ Rosenquist and Barry.

¹⁷ Tesoriero HW. Health Blog Q&A: Parity for Substance Abuse Care. *Wall Street Journal*, 2007. (Accessed July 14, 2010, at <http://blogs.wsj.com/health/2007/10/24/health-blog-qa-parity-for-substance-abuse-care>.)

¹⁸ Glied SA, Frank RG. Shuffling toward Parity—Bringing Mental Health Care under the Umbrella. *New England Journal of Medicine* 2008;359:113-115.

¹⁹ Frank RG, Koyanagi C, McGuire TG. The Politics and Economics of Mental Health 'Parity' Laws. *Health Affairs* 1997;16:108-119.

²⁰ Mental Illness: Facts and Numbers. National Alliance on Mental Illness, 2007.

²¹ Moncrieff J. *Psychiatric Imperialism: The Medicalisation of Modern Living*. Soundings, 1997. (Accessed August 11, 2010, at <http://www.academyanalyticarts.org/moncrieff.htm>.)

²² Ibid.

-
- ²³ Ibid.
- ²⁴ Horgan CM. The Demand for Ambulatory Mental Health Services. *Health Services Research* 1986;21:321-340.
- ²⁵ Ellis RP, McGuire TG. Cost Sharing and Patterns of Mental Health Care Utilization. *Journal of Human Resources* 1986;21:359-379.
- ²⁶ Donaldson C, Gerard K. Countering moral hazard in public and private health care systems: a review of recent evidence. *Journal of Social Policy* 1989;18:235-251.
- ²⁷ Barry CL, Frank RG, McGuire TG. The Costs of Mental Health Parity: Still an Impediment? *Health Affairs* 2006;25:623-634.
- ²⁸ Tesoriero.
- ²⁹ Horgan. The Demand for Ambulatory Mental Health Services.
- ³⁰ Ellis and McGuire. Cost Sharing and Patterns of Mental Health Care Utilization.
- ³¹ Manning WG, Wells KB, Buchanan JL, Keeler EM, Valdez RB, Newhouse JP. *Effects of Mental Health Insurance: Evidence from the Health Insurance Experiment*. Santa Monica, CA. The RAND Corporation, 1989.
- ³² Rosenquist and Barry. *Comprehensive Clinical Psychiatry*.
- ³³ Manning WG, et al. *Effects of Mental Health Insurance: Evidence from the Health Insurance Experiment*.
- ³⁴ Horgan CM. The Demand for Ambulatory Mental Health Services.
- ³⁵ Ellis and McGuire. Cost Sharing and Patterns of Mental Health Care Utilization.
- ³⁶ Barry CL. The political evolution of mental health parity. *Harvard Review Psychiatry* 2006;14:185-194.
- ³⁷ Frank et al. The Politics and Economics of Mental Health ‘Parity’ Laws.
- ³⁸ Rosenquist and Barry.
- ³⁹ Tesoriero.
- ⁴⁰ Ibid.
- ⁴¹ Frank et al. The Politics and Economics of Mental Health ‘Parity’ Laws.
- ⁴² Barry et al. The Costs of Mental Health Parity.
- ⁴³ Ibid.
- ⁴⁴ Barry. The political evolution of mental health parity.
- ⁴⁵ Rosenquist and Barry.
- ⁴⁶ Barry. The political evolution of mental health parity.
- ⁴⁷ Grazier KL, Eselius LL. Mental Health Carve-Outs: Effects and Implications. *Medical Care Research and Review* 1999;56:33-59.
- ⁴⁸ Rosenquist and Barry.
- ⁴⁹ Grazier and Eselius.
- ⁵⁰ Frank RG, Garfield RL. Managed Behavioral Health Care Carve-Outs: Past Performance and Future Prospects. *Annual Review of Public Health* 2007;28:303-320.
- ⁵¹ Ibid.
- ⁵² Grazier and Eselius.
- ⁵³ Frank and Garfield. Managed Behavioral Health Care Carve-Outs.
- ⁵⁴ Grazier and Eselius.
- ⁵⁵ Oss M, Jardine EL, Pesare MJ. *Open Minds Yearbook of Managed Behavioral Health & Employee Assistance Program Market Share in the United States, 2002-2003*. Gettysburg, PA. Behavioral Health Industry News, Inc., 2003.
- ⁵⁶ Frank et al. The Politics and Economics of Mental Health ‘Parity’ Laws.
- ⁵⁷ Glied and Frank.
- ⁵⁸ Barry et al. The Costs of Mental Health Parity.
- ⁵⁹ Rosenbach ML, Lake TK, Williams SR, Buck JA. Implementation of Mental Health Parity: Lessons From California. *Psychiatric Services* 2009;60:1589-1594.
- ⁶⁰ Study Shows Mental Health Coverage Would Not “Break the Bank.” Yale School of Public Health, 2006. (Accessed July 14, 2010, at <http://opa.yale.edu/news/article.aspx?id=1771>.)

-
- ⁶¹ National Compensation Survey: Employee Benefits in Medium and Large Size Firms, 1995. Bureau of Labor Statistics, 1998. Bulletin no. 2140.
- ⁶² Barry. The political evolution of mental health parity.
- ⁶³ The Mental Health Parity Act of 1996. National Alliance on Mental Illness, 1996. (Accessed August 3, 2010, at http://www.nami.org/Content/ContentGroups/E-News/1996/The_Mental_Health_Parity_Act_of_1996.htm.)
- ⁶⁴ Noel S. Parity in Mental Health Coverage: The Goal of Equal Access to Mental Health Treatment Under the Mental Health Parity Act of 1996 and the Mental Health Equitable Treatment Act of 2001. *Heimline Law Review* 2003;377:378-413.
- ⁶⁵ Study Shows Mental Health Coverage Would Not “Break the Bank.”
- ⁶⁶ Noel.
- ⁶⁷ Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited. General Accounting Office, 2000. (Accessed August 3, 2010, at <http://www.gao.gov/archive/2000/he00095.pdf>.)
- ⁶⁸ Bao Y, Sturm T. Effects of State Mental Health Parity Legislation on Perceived Insurance Coverage, Access to Care, and Mental Health Specialty Care. *Health Services Research* 2004;39:1361-1377.
- ⁶⁹ Barry et al. The Costs of Mental Health Parity.
- ⁷⁰ Bao and Sturm.
- ⁷¹ Ma CA, McGuire TG. Network Incentives in Managed Health Care. *Journal of Economics and Management Strategy* 1998;11:1-35.
- ⁷² Goldman HH, Frank RG, Burnam MA, et al. Behavioral Health Insurance Parity for Federal Employees. *New England Journal of Medicine* 2006;354:1378-1386.
- ⁷³ Ma and McGuire.
- ⁷⁴ Rosenquist and Barry.
- ⁷⁵ Kaiser Family Foundation. Deinstitutionalization Movement Provides Lessons.
- ⁷⁶ Grazier and Eselius.
- ⁷⁷ Frank et al. The Politics and Economics of Mental Health ‘Parity’ Laws.
- ⁷⁸ Noel.
- ⁷⁹ Goldman et al.
- ⁸⁰ Glied and Frank.
- ⁸¹ Goldman et al.
- ⁸² Grazier and Eselius.
- ⁸³ Congressional Budget Office Cost Estimate: S543 Mental Health Equitable Treatment Act of 2001. CBO, 2001.
- ⁸⁴ Rosenbach et al.
- ⁸⁵ Noel.
- ⁸⁶ Barry SH, Barry CL. New Evidence on the Effects of State Mental Health Mandates. *Inquiry* 2008;45:308-322.
- ⁸⁷ Barry CL, Goldman HH, Frank RG, Huskamp HA. Lessons for Healthcare Reform From the Hard-Won Success of Behavioral Health Insurance Parity. *American Journal of Psychiatry* 2009;166:969-971.
- ⁸⁸ Kuehn BM. Congress Passes Mental Health Parity Bill. *JAMA* 2008;300:1868.
- ⁸⁹ The Mental Health Parity and Addiction Equity Act. Centers for Medicare and Medicaid Services, 2010. (Accessed August 1, 2010, at https://www.cms.gov/healthinsreformforconsume/04_thementalhealthparityact.asp.)
- ⁹⁰ Kershaw.
- ⁹¹ Kuehn.
- ⁹² Rosenbach et al.
- ⁹³ Ostrow L, Manderscheid R. Medicare and Mental Health Parity. *Health Affairs* 2009;28:922.
- ⁹⁴ Trivedi A, Swaminathan S, Mor V. Insurance Parity and the Use of Outpatient Mental Health Care following a Psychiatric Hospitalization. *JAMA* 2009;300:2879-2885.
- ⁹⁵ Rosenbach et al.

-
- ⁹⁶ Barry et al. Lessons for Healthcare Reform From the Hard-Won Success.
- ⁹⁷ Kuehn.
- ⁹⁸ Trivedi et al.
- ⁹⁹ Glied and Frank.
- ¹⁰⁰ Kuehn.
- ¹⁰¹ Shern DL, Beronio KK, Harbin HT. After Parity—What’s Next. *Health Affairs* 2009;28:660-662.
- ¹⁰² Federal Parity for Mental Illness and Addictions. National Alliance on Mental Illness, 2009. (Accessed August 3, 2010, at http://www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=94856.)
- ¹⁰³ Ibid.
- ¹⁰⁴ Cunningham PJ. Beyond Parity: Primary Care Physicians’ Perspectives On Access To Mental Health Care. *Health Affairs* 2009;28:w490-w501.
- ¹⁰⁵ Federal Parity for Mental Illness and Addictions.
- ¹⁰⁶ Shern et al.
- ¹⁰⁷ Federal Parity for Mental Illness and Addictions.
- ¹⁰⁸ Cunningham.
- ¹⁰⁹ Shern et al.
- ¹¹⁰ Mental Illnesses: Treatment Saves Money and Makes Sense. National Alliance on Mental Illness, 2007. (Accessed August 4, 2010, at <http://www.nami.org/Template.cfm?Section=Policy&Template=/ContentManagement/ContentDisplay.cfm&ContentID=44613>.)
- ¹¹¹ Benjamin JA. Will parity coverage result in better mental health care? *New England Journal of Medicine* 2010;345:1701-1704.
- ¹¹² Clemens NA. New parity, same old attitude towards psychotherapy? *Journal of Psychiatric Practice* 2010;16:115-119.
- ¹¹³ Three-Time Victims: Colombians Continue to Face Violence, Neglect, and Stigma as a Result of Long-Standing Conflict. Doctors Without Borders, 2010. (Accessed August 14, 2010, at <http://www.doctorswithoutborders.com/press/release.cfm?id=4615&cat=press-release&ref=related-sidebar>.)
- ¹¹⁴ Colombia: Armed Conflict and Mental Health. Doctors Without Borders, 2010. Accessed August 14, 2010, at <http://www.doctorswithoutborders.com/photogallery/gallery.cfm?id=4616&cat=slideshow>.)
- ¹¹⁵ Ibid.
- ¹¹⁶ Liebermann JA, Strupp TS, McEvoy JP, et al. Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia. *New England Journal of Medicine* 2005;353:1209-1223.
- ¹¹⁷ Drug Safety Labeling Changes > Clozaril (clozapine). Food and Drug Administration, 2008. Accessed August 11, 2010, at <http://www.fda.gov/Safety/MedWatch/SafetyInformation/Safety-RelatedDrugLabelingChanges/ucm121329.htm>.)
- ¹¹⁸ Levy CJ. Voiceless, Defenseless And a Source of Cash. *New York Times*, April 30, 2002.
- ¹¹⁹ Levy CJ. Here, Life Is Squalor and Chaos. *New York Times*, April 29, 2002.
- ¹²⁰ Levy. Voiceless, Defenseless And a Source of Cash.
- ¹²¹ Levy. Here, Life Is Squalor and Chaos.
- ¹²² Levy CJ For Mentally Ill, Death and Misery. *New York Times*, April 29, 2002.
- ¹²³ Levy. Here, Life Is Squalor and Chaos.
- ¹²⁴ Levy. For Mentally Ill, Death and Misery.
- ¹²⁵ Levy. Here, Life Is Squalor and Chaos.
- ¹²⁶ Ibid.
- ¹²⁷ Behavioral health precertification list. Aetna, 2010. Accessed August 1, 2010 at <http://www.aetna.com/healthcare-professionals/policies-guidelines/behavioral-health-precertification-list.html>.)

¹²⁸ Precertification and concurrent review for outpatient mental health services. Blue Cross and Blue Shield of Minnesota and Blue Plus, 2010. Accessed August 1, 2010, at http://www.bcbstx.com/provider/pdf/ppo_seci.pdf.)

¹²⁹ Genn A. For the Mentally Ill, a Long Search for a Bed. New York Times, January 26, 2003.