

Mental Health Parity

By

Donna Sisler

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1999-2000 Undergraduate Research Fellow

Regional Research Institute
West Virginia University
Morgantown, WV 26506-6825

Mentor: Dr. Roger Lohmann, Professor

Division of Social Work
College of Arts and Sciences
West Virginia University
Morgantown, WV 26506

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Abstract: In 1996, the federal government passed the Mental Health Parity Act. This limited attempt to mandate a degree of parity, or equality, between physical and mental health coverage took effect on January 1, 1998. In the four years since passage of the federal parity act, states adopted their own parity laws, which may be more or less restrictive than the federal law. This new form of coverage has left states generally lacking benefit data prior to parity implementation. Therefore, they can not assess the impact of parity on access, adequacy and quality of mental health/substance abuse services. As West Virginia considers passage of parity legislation, it is important to gather baseline data that can serve as a point of reference for comparison if parity is enacted. This research provides facts, impressions, interpretations and other subjective information in order to get a more complete picture of how passage of the parity act may impact the delivery of mental health services to clients.

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Mental Health Parity

Introduction

As the health insurance industry emerged for physical diseases, mental conditions were either handled as public concerns (and costs) through state hospitals or as private (primarily family) matters. Gradually, however, “changes in treatment systems and their financing,...development of new pharmacological and counseling therapies” (Burnam and Escarce, 1999) and a better understanding of the causes of mental illness brought about a change in attitudes. These and other factors contributed in the 1970s to a massive de-institutionalization in the United States during which millions of formerly institutionalized mental patients were moved back into the community. Moreover, changes in commitment laws and enforcement made it permanently more difficult to move those and future patients into institutions. De-institutionalization also completely changed the economics of mental health for millions of families. Previously, public care also meant public support. De-institutionalization initially placed the costs associated with mental health treatment on the individual. Gradually, insurance providers began including mental health coverage alongside existing physical health coverage, partly because there existed a rationale that insurance coverage could reduce the risk for financial losses from mental problems and conditions. Insurance companies, however, set annual and lifetime dollar limits and limits on visits and hospital stays for mental health lower than that for physical illnesses. They set deductibles and co-payments for mental health visits higher. Recently, in an attempt to address these disparities, a few states passed various forms of parity legislation. Leaving the issue entirely to state initiative, however, will likely produce a variety of regulations and various levels of

intervention. Thus, in 1996, the federal government passed the Mental Health Parity Act. This limited attempt to mandate a degree of parity between physical and mental health coverage took effect on January 1, 1998. It equalizes aggregate annual and lifetime dollar limits on benefits between mental health and physical health coverage, while leaving limits on visits and hospital stays up to the insurer. Alcohol and drug abuse, commonly known together as substance abuse, falls somewhere between physical and mental illness. Recently, however, it was added to the long list of mental health conditions. Therefore, when we talk about extending parity to insurance and coverage for mental illnesses, it seems natural to include substance abuse. The Mental Health Parity Act, however, excluded substance abuse as a part of mental health. Employers and insurers feared, based on statistics from the 1980s, that its inclusion would raise premiums to unacceptable highs (Sturm et al., 1999).

In the four years since passage of the federal parity act, thirty states have adopted some form of parity legislation (APA. 2000). These state mandated parity laws, enacted under managed care, may be more or less restrictive than the federal law. Some states include substance abuse under mental health coverage with equal limits on visits and hospital stays while others do not.

Four years after passage of the Parity Act, it is still early in the game for mental health insurance coverage. Many matters still need to be addressed and issues resolved on a state-by-state basis. As West Virginia considers passage of parity legislation, it too must make many decisions, such as which diagnoses should be covered. They also will want to explore the impact parity might have on Medicaid.

The Issue

This new form of coverage has left states generally lacking benefit data prior to parity implementation. Therefore, they can not assess the impact of parity on access, adequacy and quality of mental health/substance abuse services. Thus, one major challenge involves gathering together facts, impressions, interpretations and other subjective information in order to get a more complete picture of how passage of the parity act may impact the delivery of mental health services to clients. As West Virginia considers passage of parity legislation, it is important to gather this kind of baseline data that can serve as a point of reference for comparison if parity is enacted. In order to understand the current pattern of mental health coverage under managed care in West Virginia, we must begin by asking how mental health coverage compares to physical health coverage in West Virginia. Next, we must explore substance abuse issues in relation to insurance coverage. One of the many effects of down-sizing the state mental hospital system was to dump large parts of the problem of substance abuse back onto the very local and county jail system against which Dorothea Dix had campaigned in the early 19th century. Thus, to the extent that mental health parity is an issue, the issue of parity between substance abuse and other mental health treatment as well as physical health treatment is a major identifiable special concern within that broader issue. Therefore, we must determine if substance abuse is included in mental health coverage under managed care in West Virginia.

Definitions:

For the purpose of this research it is important to define substance abuse, managed care, behavioral health services, behavioral health coverage, and parity.

“Substance abuse refers to behavioral, emotional and life-style problems associated with illegal or excessive use of controlled substances such as alcohol or narcotics or other pharmacological agents. Substance abuse treatment refers to programs or services offered by mental health or behavioral health service providers and directed specifically at the behavioral, emotional or life-style aspects of substance abusers, and their caregivers or significant others. Substance abuse treatment is ordinarily offered by behavioral health specialists in the 'behavioral health professions' of social work, psychology, nursing and psychiatry. Substance abuse treatment does not extend to specifically medical treatment by physicians, surgeons or other medical specialists of physical diseases which may be associated with substance abusing behavior or life-styles, such as cirrhosis of the liver, tuberculosis, malnutrition, or brain lesions.” (Lohmann, personal communication, November 29, 1999)

“Managed care is a simple phrase for an amazing variety of changes in contemporary health care financing. Often it refers to movement away from simple fee-for-service systems and doctor-patient relationships toward capitation and other financing schemes and large scale industrial medicine. Despite the controversial nature of managed care in behavioral health, most experts predict that managed care systems are or will soon be characteristic of child welfare and other service systems in the near future, due to factors such as the frustrations of policy makers with rising caseloads, over utilization of high-cost services, insufficient availability of low-cost services, over-treatment and clients remaining in care too long, out-of-control costs and the apparent impossibility of assuring positive outcomes. Advocates of managed care claim that it will enable more accurate matching of appropriate care with individual need, assure higher quality of care

and improve patient/client outcomes, and provide cost controls and predictability. Critics argue that managed care substitutes accounting and managerial judgement for professional determinations of service providers and introduces a business/profit orientation which puts institutional bottom lines above patient well-being.” (Lohmann, personal communication, November 29, 1999)

“Behavioral health services are defined as any professional services, including substance abuse services (as defined), offered within a behavioral health center, clinic, or private practice by one or more behavioral health professionals.” (Lohmann, personal communication, November 29, 1999)

“Behavioral health coverage refers to the inclusion of payments for behavioral health services among the portfolio of benefits included in any health insurance policy in effect in the state of West Virginia and offered by Medicare, Medicaid, PEIA, Blue Cross-Blue Shield, or any other health insurance or benefit provider in the state.” (Lohmann, personal communication, November 29, 1999)

“Parity means equality. In the case of MHPA, it means equality in value with regard to annual and lifetime dollar limits on benefits. Sometimes it requires computation to compare values because plans have more than one dollar limit for medical/surgical benefits.” (HIPAA, 1998)

Importance

Mental health has been an important and controversial issue since the days of Dorothea Dix and her struggle to improve the treatment of the mentally ill in institutions. Still today, this controversy leads to many questions. Do the mentally ill deserve government support? If so, how much and for what illnesses? Can the mentally ill be

cured or are we throwing our money away on treatment? With an increase in managed care, we ask if coverage should be included for mental illness. Again we ask how much and for what illnesses? Today, many are beginning to realize the importance of proper treatment for mental illnesses. We can attribute a change in attitude to several factors. For example, “scientific findings of biological causes for several serious psychiatric diseases, and” (Sturm, Pacula, 1999) more effective treatments impact our feelings about mental health. Also, with an increase in consumer pressure and the growth of managed care to control costs, improving coverage for mental health seems more possible than ever before. As we move into this new realm of increased coverage for mental health treatment, evaluating effectiveness becomes crucial for the well being of mentally ill clients. In order to evaluate the success or failure of mental health coverage under managed care, we must understand the current situation. Then we can use that baseline information to determine if coverage has truly increased, and whether it is adequate or at least improved from coverage prior to parity implementation. We can determine if substance abuse clients are receiving more or less coverage under the new parity legislation. We can determine if visits are more limited under managed care, and if so, whether clients are staying well or getting worse because of this change. These important issues must be addressed if parity is implemented in West Virginia to ensure the well being of the mentally ill.

Literature Review

In review of previous work on this subject matter, several issues rise to the surface. It is important to understand the ways in which the growth of managed care has brought about major changes in mental health benefits. Managed care forged an increase

in subcontracting out of benefits, known as carve-outs (Jensen, 1998, Burnam, 1999, Goldman, 1998). Also, prior estimates of costs incurred under parity implementation, based as they were on fee-for service, are largely invalid since managed care now dominates the market for mental health treatment. (NIMH, 1998).

Parity is another important issue that must be considered. Enactment of the Mental Health Parity Act increased activity by states on parity legislation. Some of these state laws replicate the federal mandate, while others do not. Parity legislation is not the only federal statute to enter into this question however. Under the Employee Retirement Income Security Act of 1974 (ERISA), states can not regulate self-insured health plans. They can, however, regulate third-party insurers. Therefore, even with the federal mandate many people lack parity benefits at the state level. This issue is discussed further in Sturm and Pacula (1999).

When considering parity, cost always becomes a concern. Studies of mental health parity implemented under fee-for service generally showed an increase in cost, while states that implemented managed care and parity at the same time experienced a significant reduction in costs (NIMH, 1998). Under managed care, gatekeepers have the potential to keep costs down. These reports of lower costs coupled with widespread growth in managed care lessened the risk of implementing parity (Burnam, Escarce, 1999). Therefore, decision-makers may have been more willing to pass parity legislation based on this information.

Because it is an important part of the problem and because of the acute, short-term nature of much substance abuse treatment, coverage for substance abuse must be considered when looking at parity and mental health. Currently, a push to create a

Substance Abuse Treatment Parity Act (SATPA) is underway at the federal level. The general effect of this legislation would be to extend the notion of mental health parity to substance abuse treatment, except that suggestions for the SAPTA extend beyond requirements under the MHPA. The SATPA stipulated that no limitations be required regarding visits, financial requirements, additional deductibles, co-insurance, cost-sharing or lifetime dollar limits. The proposed act states that substance abuse treatment would be limited only to the extent that medical care is limited. For example, if a health plan imposes medical visit limits, then substance abuse treatment can be limited in the same way. Also, each insurance plan can define its own array of mental health benefits. Under the SATPA, however, each plan that includes substance abuse coverage must offer a basic level of benefits. In other words, any plan that offers substance abuse coverage must offer inpatient and outpatient treatment, non-hospital residential treatment, and prevention services at the very least. (NIAAA, 1998).

Lack of data prior to parity remains an issue. As many states implement parity, they find it difficult to assess its impact. Most studies thus far have focused on “well-funded plans” (NIMH, 1998). These studies have limited our understanding. Additional information is needed on the impact parity has on access and quality of care (NIMH, 1998, Goldman, McCullough, Sturm, 1998). In order to evaluate a new process, we must have data from the prior one.

For many, access and quality of service are more important than financial costs. Is it possible that implementation of parity in West Virginia might impact upon these issues? At the same time, many fear the federal Mental Health Parity Act of 1996 is too limited (Burman, 1999, Findlay, 1999). It may turn out to be the case that the parity

legislation will have little impact upon mental health treatment generally and substance abuse treatment specifically. These are some of the reasons why The National Institute of Mental Health (1998) suggests that additional research is needed in this area.

Methodology: What

In order to further understand the impact of parity on substance abuse, other mental health and physical health treatment, an exploratory study of existing conditions in West Virginia was undertaken. It involved interviewing a number of key informants with open-ended questions addressing the current state of mental health coverage, specifically in regards to substance abuse and the impact parity is likely to have if enacted at the state level. It also includes questions regarding failure to pass a parity bill in the 2000 legislative session.

Methodology: How

This exploratory research was carried out through interviews with key informants familiar with mental health, substance abuse managed care and insurance coverage in West Virginia. These key informants were chosen based on their knowledge of health care policy, mental health services and insurance laws. These individuals understood the current status of mental health coverage and had a vision of what would work best in regards to mental health parity legislation in West Virginia. Six (listed below) specific key informants were interviewed. These interviews were conducted and tape-recorded either face to face or by telephone. The questions were open-ended. Through the use of snowball sampling, no further interviewees were identified.

Careful selection of the initial group of key informant interviewees was crucial because the quality of information gathered from key informant interviews depended on the knowledge and objectivity of that individual.

Interview protocol involved contact via telephone or e-mail to discuss the purpose of the interview and ask permission to tape record the session. Whenever possible, the interviews were conducted in person, but this was not always possible due to travel distances involved, busy schedules, etc.

Rather than beginning with a specific, fixed total number of individuals to interview, the project proceeded using a well-established qualitative research criterion called "theoretical saturation". (Glaser and Strauss, 1967) From an economic standpoint, this might also be called a "value added" approach. That is, interviews were conducted only as long as new material and new insights continued to surface in each interview. When the facts, opinions, and statements made by interviewees added little and tended only to confirm what was previously established, the process of interviewing was terminated.

The tape recorded interviews were transcribed and the information sorted for evaluation.

Data Presentation:

In order to explore issues regarding mental health parity in West Virginia, I interviewed two individuals involved in the 2000 legislative process, one substance abuse specialist, 2 insurance representatives, and one behavioral health administrator. (See Appendix A) I also attended a Senate Judiciary Hearing called by Senator Kessler.

In general, all agree that treatment for mental illnesses is important, but opinions vary on definitions and implementation of coverage. Difficulties arise in defining mental illness. Do you include substance abuse and alcoholism? Do you include diagnoses outside of those listed in DSM IV? Do you cover all of the diagnoses listed in DSM IV or just serious mental illnesses? If you choose serious mental illnesses, what does that include? Concern arose that the state would go bankrupt over coverage for what many felt were frivolous items such as caffeine addiction, sibling rivalry, anxiety of test taking, etc. These are some of the issues that arose regarding definition during the past legislative session. Also, once mental illness is defined, it must be determined which of those illnesses should be covered. Sixty days was not enough to come to agreement and alleviate fears over these very important questions. Therefore, lobbyists are working with the insurance industry now, to come to an agreement prior to the next legislative session.

Not only were there questions about definitions of mental illness, but also how broadly the coverage should be based. Should it cover group insurance and individual insurance? Should it cover the state's Public Employees Insurance Agency (PEIA)? Should it be implemented across the board or only under managed care? Even though a push existed to implement under managed care, many of these issues remain unanswered.

Another issue was qualification of clinicians, doctors, social workers, etc. Do you only cover visits to licensed practitioners? Some say that practitioners wanted a practice bill rather than an insurance coverage bill. Others feared clinicians and therapists offices would pop up on every street corner to get a piece of the action. Some feel that when you open the field to other practitioners and increase access to services, you may cause costs to rise. Others wanted any willing provider to have the ability to provide services. The bill introduced this year, included language requiring licensure and regulation. Most agree that it should remain as stated.

Most interviewees agree that we must be careful not to compare “apples to oranges” when addressing mental health parity facts. For example, facts and figures regarding parity implemented under managed care is very different from parity implemented under fee for service plans. Through the interviews and during the Senate Judiciary Hearing, this issue came to light. Differing figures on increase of costs in other states were thrown out as fact, but reasons for those differences were often not fully addressed. Also, the figures may have been based on a bill that was somewhat different from the one being proposed here. Some states implemented full parity while others did not. Implementation of parity under managed care seems to keep costs down, while implementation under fee for service causes an increase. In an attempt to address this issue in the state legislature, legislators agreed to put a 2 percent cap on premium increases, but did not make it clear whether or not it would be implemented under managed care even though that was suggested in the interim committee. Also, there are differing assumptions on this matter. Some believe it will be implemented under

managed care, and some believe it will be implemented “across the board” (H. Clark, personal communication, April, 2000).

No other states scaled back on coverage after parity was implemented under managed care. If anything, they expanded the coverage and it has not “broken the bank”(S. Subkoviak, telephone conversation, June, 2000). Some states are seeing a pay-off in the long run due to decreases in payments for physical illnesses. Individuals who may come in complaining of back pain, for example, may have had a battery of tests only to learn they are suffering from depression. If properly diagnosed early on, you would avoid these situations and costs.

Another factor in the failure to pass a mental health parity bill was a split among mental health practitioners within the mental health coalition. Most wanted full parity, but some believed that if they went for a broad-based bill as was introduced last year, they would end up with nothing. Many had difficulty focusing on a more narrow bill. In an attempt to compromise, they pared back to full parity for children only. This worried clinicians who did not treat children. They were not gaining anything from this bill. It also worried those who are against diagnosing children. They didn't want children labeled. This pull from within led children's advocates to take a stance and demand full parity for children or nothing at all. Now, the coalition has learned that often times legislation is passed incrementally. They are learning from the past and beginning to see the benefits of compromise.

Another possible drawback to passage of the bill was a concern that the legislators had not strategized. For example, they met several times to discuss parity, but failed to

include members of the banking and insurance commission until later. Some feel this was poor planning that may have stifled collaboration.

One of the main reasons stated for failure of passage of the bill this past legislative session was the financial concerns of PEIA. PEIA was already in financial trouble and considering removal of certain benefits while this bill asked for additional coverage. Initially, when focus was on a broader bill, PEIA suggested it would cost hundreds of millions of additional dollars to implement mental health parity at the state level. As the bill narrowed, PEIA began to sway in favor of parity, but they still referenced millions of additional dollars. This was enough to cause legislators to move cautiously. There was no time to get a full understanding of this bill and address these serious concerns.

Another reason given for failure involves how society views mental illness. I was told that legislators don't like drunks, so it is doubtful that parity will be offered for substance abuse and alcoholism. Unless we aim for full parity, these illnesses will likely be sacrificed. Also, many see mental illness as a moral issue instead of a health care issue. Unless you are personally involved in it, you are not likely to view it any other way. The idea of stigma is interesting. For example, many never seek treatment for mental illness because of the stigma associated with it. Instead, they may show up when it is too late to treat the illness and therefore costs are high. And everyone agrees that offering parity helps eliminate stigma, because it says it is not your fault. As one interviewee put it, "The problem does not have to be overutilization of mental health coverage, but underutilization" (S. Subkoviak, telephone conversation, June, 2000). Still, fears arose that people would come out of the woodwork if this bill passed.

There were several concerns about implementing parity to any degree at the state level. Many of these concerns arose from lack of specifics within the bill. For example, if the proposed bill had passed, how would the 2 percent cap work? Would it mean that if an agency reaches 2 percent they no longer have to offer coverage for mental illnesses to anybody ever again? Or does it mean they would not have to continue to offer it that year? Also, health insurance costs go up every year without including coverage for mental illness. There is concern that a normal increase in costs could be presented as being due to additional coverage for mental illnesses. It would be important to monitor this. Another concern lies within the definition. If the bill covered only serious mental illnesses, then people would have to be diagnosed as such in order to be covered. This could cause people to delay treatment. Also, covering only serious mental illness is costly. The idea is prevention and early treatment to cut costs. So some are unsure this definition for coverage would work. There is concern that parity will not work unless the bill is narrowly constructed and implemented under managed care. Some believe that substance abuse must be included in the bill, but only in a managed care environment with a focus on outpatient treatment.

There are many hurdles to overcome in implementation of parity in West Virginia, but everyone interviewed could quickly spell out benefits of passage. Simply covering mental illnesses the same as physical illnesses helps eliminate the stigma attached. Stigma was a common thread throughout the senate judiciary hearing. As long as we reimburse for mental illnesses at a different rate than physical illnesses, we are suggesting that the mentally ill person has some degree of responsibility for their illness. It suggests their disease is made-up. T. Johnson suggests that by failing to implement

parity, we impose a strain on the public sector. Often times, those with mental illness may quickly exhaust the limited insurance benefits for treatment for mental illness and, after that, their bank account. If they continue working, they find themselves unable to obtain the services they need. Then, when they quit working, they receive the treatment they need in the public sector. I was told of someone who tried to avoid this situation by maintaining a job in another state which offered parity. The individual believed that by doing this, they could continue working and avoid the stereotype that you can be nothing and do nothing if you have a mental illness (telephone conversation, July, 2000). Also, passage of a parity bill could lead to a decrease in symptoms for mental illness and a decrease in family and individual problems. It could lead to a decrease in work related problems like absenteeism. It leads to more productive citizens. We would see an overall improvement in healthcare and cost savings in the long run. It would be a win-win situation

A different type of information was gathered through interviews with the insurance industry. I was unable to obtain everything I wanted, but believe the information I gathered could serve as a beginning for additional research on the current state of insurance in West Virginia. It is as follows:

- The Insurance Commission does not regulate Medicare products, but they do regulate Medicare Supplement (Medigap).
- The insurance industry developed Medigap policy, which supplements charges not covered by the federal government under Medicare.
- There are some HMO's in WV serving Medicare clients, but it is limited

- It is not believed that Medigap could be effected by mental health parity because the Medicare Supplement policy has been structured by the federal government. The Commission's legal division would need to look into it.
- The state allows companies to offer 10 Medigap policies if they choose to.
- According to the Insurance Commission, the bill that was introduced in West Virginia only effected small group policy of 2-50 employees.
- Rate comparisons are available to consumers. To obtain information on mental health benefits you must contact the rates and forms division for the actual policy.
- Some West Virginia managed care plans, both public and private, cover substance abuse and mental health services. To obtain benefit levels you must contact each HMO.
- The commission had seven HMO's licensed in WV as of December, 1999. Three were to merge into one. I was unable to obtain a list of the major Medicare Supplement writers.
- One rate increase request is accepted per year because it takes that long to see if the rates granted are effective.
- The state requires prior approval, so companies can not change their rates until the Commission takes action.
- The process includes making a formal filing with a \$25 check. If the application is complete, the law allows the Commission 60 days to take action, but they generally average less than 30. Rate increases are public record.

- Rate increase requests are generally based on what the federal government does and the actual experience of the company. The Commission looks at the company's loss ratio. If a company takes in one dollar and pays out 90 cents to cover all the bills, they have a 90 percent pure loss ratio. A pay out of 65 cents would probably not warrant an increase.
- Increases are expected every year as the country ages.
- It is not believed that mental illness and substance abuse would be a big factor as it stands now. It probably accounts for less than 5-7 percent.
- Currently, pharmaceuticals are driving health insurance.
- West Virginia does not have a community rating law.

Conclusion:

Even though West Virginia has come a long way in its attempt to mandate parity, there are several issues that must be discussed and choices that must be explored prior to the next legislative session. This exploratory study simply brings issues to light and indicates that future research is clearly needed. For example, West Virginia would benefit from an in-depth study of each previous state that implemented parity. This information would allow legislators to study the effects of implementing varying degrees of parity. Is there a state that implemented parity for serious mental illness only? If so, was it implemented under managed care? What was the impact on the insurance industries? Maybe another state implemented parity for children only. How is that working? This type of information would allow a legislator to choose which plan best suits the needs of their state.

It would be beneficial to know how often diagnosis of a physical illness stemmed from an undiagnosed mental illness. This information might help lobbyists show that early treatment of mental illness could cut costs by eliminating expensive tests and procedures. It would be helpful to know the current costs of serious mental illness compared to other mental illness. Taking it a step further, we should gather information on absenteeism from work in West Virginia due to mental illnesses. This would provide a baseline for comparison if parity were implemented.

Most importantly, we should make sure we understand the current state of insurance coverage in West Virginia so that we can compare costs in an appropriate manner. I attempted to gather information along these lines, but learned that it was difficult to obtain through interviews. I was instructed to contact various agencies and web sites to pull the information together, but failed to accomplish the task for this research. The insurance information, however, is a very integral part of implementation of parity and a study on this alone would be beneficial to legislators and lobbyists.

Appendix A

Mike Adkins, Public Employees Insurance Agency

Mimi Berne, Substance Abuse Specialist, Chestnut Ridge Hospital

Hanley Clark, WV Insurance Commissioner

John Blair Hunter, West Virginia State Senator

Ted Johnson, Director, DHHR, Division of Mental Health & Community

Rehabilitation Services, Office of Behavioral Health Services

Susan Subkoviak, NASW Lobbyist

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