

The Public Sector and Mental Health Parity: Time for Inclusion

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Abstract

Background: In the United States, there is an uneasy division of responsibility for financing mental health care. For most illnesses, employer-sponsored health insurance and the large federal health insurance programs (Medicare, Medicaid) cover the costs of care. However, most employer-sponsored plans and Medicare provide only limited coverage for treatment of mental illness.

A possible cause and result of this limited coverage in mental health is that states, and in some cases local (county) governments, finance a separate system of mental health care. This separate 'public mental health system' provides a 'safety net' of care for indigent individuals needing mental health care. However, there are potential negative consequences of maintaining separate systems. Continuity of treatment between systems may be impaired, and costs may be higher due to duplicate administrative costs. Maintaining a separate system managed by government may exacerbate the stigma associated with mental illness treatment. Most significantly, since eligibility for care may be linked to poverty status, and since having a serious mental illness may preclude regaining private coverage, maintaining a separate system may contribute to the poverty rate among persons with mental illnesses.

Aims of the paper: These potential problems have not been widely considered, perhaps because other problems and controversies in mental health care have captured our attention. In particular, controversies over deinstitutionalization in mental health have dominated the policy debate, especially when linked to related problems. These have included conflicts over authority and financial responsibility among federal, state and local governments, sensationalized media coverage of incidents involving people with mental illness, problems with siting community facilities, concern about mental illness among prisoners and the like. However, with the substantial reform of public mental health care in some states and localities, it is now possible to consider the implications of public and private integration. This paper considers such an approach.

Methods: This paper addresses the question of public and private integration, considering the state of Ohio as a case study. Ohio is a large state (population 11.2 million) and shares demographic, cultural and political characteristics with many other states. Ohio's successful experience implementing community mental health reform makes it a good candidate to use in evaluating issues in the potential integration of insurance-paid and public mental health care.

Results: The analysis indicates that the resources now used in Ohio's public system may be sufficient to support insurance financing of inpatient and ambulatory mental health treatment (the types of health care usually paid by insurance) while maintaining supportive services (e.g. housing, crisis care) as a residual safety net.

Discussion: At the current time, these resources are in state and local mental health budgets, and in the Medicaid program that finances health care for low income and disabled individuals. The analysis indicates that the aggregate level of resources expended on inpatient and ambulatory mental health treatment are substantially greater than expenditures for such care in an insurance plan for Ohio State employees. A substantial **limitation** of the analysis is that it is not possible to compare the need for care in a relatively healthy employed population versus a poor and disabled population.

Conclusions: The paper concludes that there are substantial structural, economic and social problems associated with the 'two-tiered' system of commercial/employer-paid insurance and public mental health care in the United States. Examining data from one state's public system, the paper further concludes that it might be feasible to finance a single system of acute and ambulatory mental health benefits, if public resources were redeployed and private contributions were continued.

Implications for policy and research: Given the substantial problems associated with the two-tiered American approach to mental health care, further consideration and analyses of the feasibility of public and private integration are suggested. Given the complexity of this effort, much more sophisticated analysis is needed. However, given the possibility that sufficient resources may now be available to accomplish integration, further work is suggested. © 1998 John Wiley & Sons, Ltd.

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Introduction

This paper will reflect on one facet of the issue of 'nondiscriminatory' or 'parity' insurance coverage for the treatment of mental illness—that is, insurance with coverage patterns, cost sharing and limits that are comparable to coverage for treatment of other illnesses. The focus of the discussion will be on the status and problems of the public mental health system, which exists in part because such private coverage is not available. The state-coordinated public mental health system is a taxpayer-financed and publicly managed health system which is unique in health care, since no other disorder-specific system exists, and since care for other illnesses is covered by commercial health insurance. I will try to illustrate the scope of the public system, how it has been reformed, and the relationship

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between commercially paid and public care, and opportunities that may now exist for public–private integration.

Mental illness is essentially the only category of illness where a substantial tax-financed and publicly managed service system exists in parallel to insurance paid private care. This public system is substantial, with over \$25b annually in state and Medicaid expenditures for mental health care, and, by historical accident or default, the dual system of publicly financed and commercially paid mental health care has become both useful and counterproductive (useful because a public safety net is essential in the absence of commercial coverage, and counterproductive in the sense that the availability of a public system may help rationalize limits on private responsibility). This paper will illustrate these issues, with particular reference to Ohio's mental health system. Since Ohio's state employees have access to a well structured and non-discriminatory behavioural healthcare insurance plan,¹ and since the Ohio public system is well regarded, the juxtaposition of these approaches is instructive.

The Unusual Division of Responsibility for Mental Health Funding

The American health care system is dominated by employer-financed group health insurance and the massive Medicare and Medicaid programs. More recently, managed care has become a dominant force or trend across each of these areas. What is generally not appreciated is that the public mental health system is far older than any of these dominant health care programs or approaches. The public mental health system was born in the asylums that were founded in most existing states in the middle of the 19th century. Many of these early hospitals were built in response to the vigorous and effective advocacy of Dorothea Dix, a retired Boston school teacher who had visited every state legislature east of the Mississippi, and convinced most of them to build a state hospital, by the early 1850s.

The dominant mainstream healthcare approaches are all of more recent origin. The first prepaid health insurance plan in the United States was started at Baylor University in 1929. Medicare and Medicaid were created as part of President Johnson's 'Great Society' agenda of the mid 1960s. The federal Health Maintenance Organization legislation—an initiative of President Nixon's—was enacted in 1973. Thus, all of the mainstream health programs were initiated at a time when state hospitals had existed for many years. In a sense, covering mental illness in these newer approaches was not really essential from an insurance point of view, because a kind of safety net for mental health care already existed, and certainly many other problems (the stigma of mental illness, views that mental health problems were not illnesses at all, doubt about the effectiveness of treatments and fears about costs) militated against inclusion of mental health treatment in health insurance plans.

This view of divided health insurance and public sector responsibilities for mental health care as a major problem is not yet widely held. In part, this is because the depth of

the problems and controversy in public mental health systems has been so great that it was not possible to focus on this issue. And certainly these problems—institutional abuses, deinstitutionalization, homelessness and neglect—were so serious that they demanded attention. However, it may now be that conditions in better funded and better managed public systems have improved to the point where structural reform within these systems is no longer the overriding problem.

In a succinct analysis, Morrissey and Goldman² described the Community Support Program (CSP) promoted by the National Institute of Mental Health³ as a fourth generation or wave of reform in America's public mental health system. It was a fundamentally different kind of reform, according to Morrissey and Goldman, because it conceptualized serious mental illness as a long-term and potentially disabling condition, rather than as an acute problem. Thus, CSP promoted a new model based on community treatment and support, rather than advancing a different approach to short-term treatment. The earlier eras of reform, they point out, each had featured a particular kind of facility (the asylum, the psychopathic hospital and the community mental health center), all oriented to a new kind of short-term care.

A Case Study: Reform of Ohio's Public Mental Health System

Ohio's public mental health system has existed through each of these eras, and in fact embraced each of them fervently. A number of state hospitals were constructed in the 19th century, and by the 1950s these facilities housed well over 20 000 patients. Like state hospitals generally, these facilities were founded with the moral treatment vision of relatively brief restorative treatment. However, the intractability of serious mental illness, the unintended weakening of local responsibility that the hospitals begat and the absence of effective treatments turned the hospitals into long-term care institutions.

In the middle of the 20th century, Ohio built a number of short-term 'receiving hospitals' that were modeled some what on the psychopathic hospital approach. These smaller facilities were also intended to stabilize acute illness through brief treatment, and they sometimes succeeded. At other times, these newer facilities lived up to their designation, and received people into a career of long-term hospitalization by transferring them to the older long-stay hospitals if brief treatment was not effective.

Ohio also enthusiastically embraced the community mental health movement, in two ways that would each become significant elements of its current system. The first was the development of many community mental health centers (CMHCs). These programs, while to some extent perhaps susceptible to later criticism for not focusing on persons with the most serious mental illnesses, did develop a strong community mental health infrastructure. The services that the CMHCs provided to their communities also helped build local support for mental health, that would be important

later when locally voted mental health levies became a significant funding source in Ohio.

The second community mental health initiative in Ohio in the 1960s was passage of legislation in 1968 modeled after the 1963 federal Community Mental Health Centers Act. The legislation created community mental health boards at the county or multi-county level, with broad community planning responsibilities and the authority to manage the limited state funding available for community mental health care. Like the CMHCs, the boards were an infrastructure—in this case for planning, funding, administration and local support—that would become even more important in the next wave of reform.

Ohio's Community Support Approach

The federal mental health leadership embodied in the small but effective Community Support Program fit very well with an emerging Ohio commitment to substantial mental health reform in the 1980s. Well described elsewhere,^{4,5} this reform was carried forward by the transformational leadership of state director Pam Hyde, with the strong support of Governor Richard Celeste. The reform effort featured values change, development of effective consumer and family advocacy groups, promotion of CSP services such as supported housing and case management and mobilization of political support.

Ohio also took advantage of other federal reforms intended to facilitate development of community services. Dedicated federal mental health funding had slowed with President Nixon's resistance to the CMHC program, and the just-enacted Community Mental Health Systems Act was all but eliminated under President Reagan's New Federalism approach. However, as chronicled by Koyanagi and Goldman,⁶ many of the changes in federal programs recommended by President Carter's Commission on Mental Health were enacted. Importantly, these changes (principally reforms in Social Security, housing programs and Medicaid) were all generally oriented to facilitating a CSP approach. Thus, Ohio—like many other states—developed programs to facilitate consumers' access to Social Security benefits, supported development of local housing programs that could take advantage of federal housing support and used the new Medicaid options to help fund case management and other community services.

Ohio's Mental Health Act of 1988

These reform initiatives were capped by legislative passage of Am. S. B. 156, a comprehensive rewrite of Ohio's mental health law. This legislation enhanced consumer and family participation and required establishment of a community support system in every board area. However, the political and practical genius of the measure was its blending of the philosophical and programmatic aspects of community mental health reform with the politics and mechanics of local control. This was feasible and significant given Ohio's strong cultural and political tradition of local leadership.

This move also anticipated the subsequent national trend toward 'devolution', transferring responsibility for government programs from the federal to state and local levels. The practical significance of the reform was the integration of clinical responsibility with administrative and resource control at the level of a single entity—the local board. Thus, the legislation was a further step toward the CSP model.

During a six-year phase-in period, resources formerly committed from the state budget to state hospital care were transferred to the local boards. Local systems could continue to use these resources to purchase state hospital care, or could develop alternative community support programs. The local system was placed 'at risk' for state hospital care—except for forensic patients, who remained a state responsibility while hospitalized. The legislation also carried a mandate that every local area would develop and maintain a community support system. The state commitment laws were also revised under the legislation, so that involuntary commitments were made to the board, rather than the hospital. Thus, the board gained control over utilization of hospital services, as well as resources.

The Results of Reform

It is now possible to assess the results of reform in Ohio's public system over the long term, based both on a review of patterns of care and resources and on research results. At the broadest level, it is clear that Ohio's public system has been transformed from one balanced between hospital and community care to one that strongly emphasizes community support. **Figure 1** illustrates the reduction in state hospital usage and staffing that has taken place since the 1988 legislation. The reduction in levels of Ohio state hospital use between 1989 and 1995 was more rapid than in any of the 10 largest states.^{7,8} The reduction in state hospital staffing between 1988 and 1997 was about 60% (over 3700 positions), with about 600 staff moved to provide community services and the other positions permanently eliminated from the state payroll via attrition, early retirement incentives and layoffs.

The Ohio reforms demanded dramatic reductions in state hospital costs, as levels of hospital use decreased. To address this, a statewide but regionally managed planning process was conducted (with the participation of hospital and community staff, consumers and family members, union representatives and managers), leading to a statewide plan for hospital 'rightsizing'.⁹ This plan led to the planned closure and consolidation of numerous hospitals, as illustrated in **Figure 2**.

In general, local responsibility and state and local plans emphasized the use of hospitals only for various kinds of 'high-acuity' service requiring the clinical resources and controlled setting of a hospital. Community care emphasized community support and treatment. As a result, reductions in state hospital use, as illustrated in **Figure 3**, were concentrated in longer-stay patients for whom community supports were substituted for institutional care. This pattern

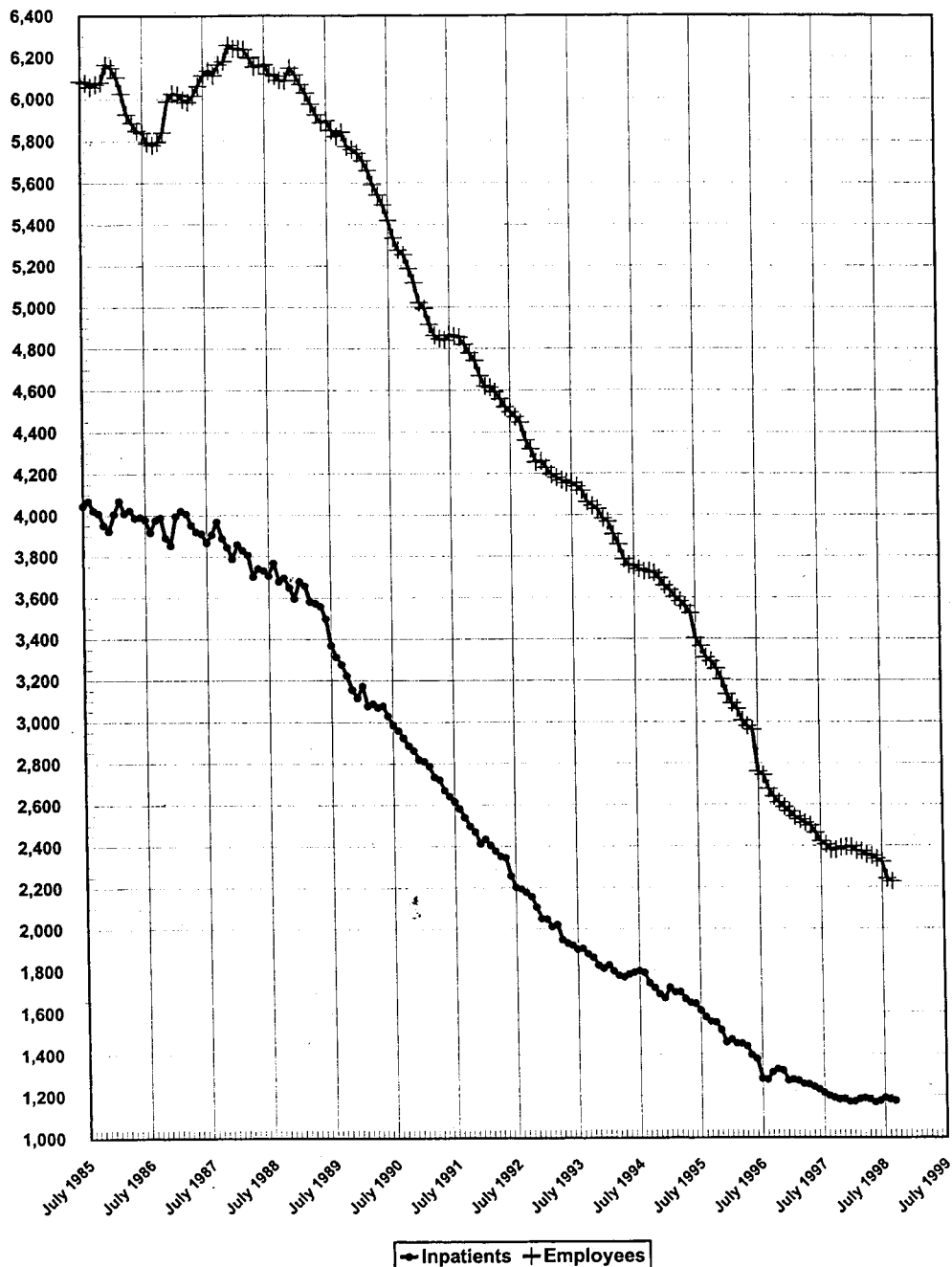


Figure 1. Department of Mental Health inpatients and employees

seems appropriate to us; there is no research evidence and little clinical rationale for long hospital stays.

State hospital rightsizing, in turn, led to dramatic increases in state funding for community mental health services. Increased state funding was met—in fact exceeded—by increased levels of local contributions. This reflects the ability of boards in Ohio to seek local levy support for mental health services, and continued strong support of mental health by local communities. In addition, local programs used increased state and local funds to help generate increased Medicaid reimbursement. **Figure 4** illustrates these funding trends.

The changes in service patterns which have taken place

in Ohio's public system during the past decade are too complex to be described here in detail. However, several broad trends can be summarized. The number of people cared for in Ohio's community system has increased, and the proportion of people cared for who meet criteria as 'severely mentally disabled' adults (SMD) or 'severely emotionally disturbed' children and adolescents (SED) has increased. **Figure 5** illustrates these trends. (The population of Ohio has remained essentially the same at about 11 million people during this time.)

The changes in patterns of services for individuals are very complex. In general, these trends involve a move toward more intensity of services for individuals identified

FIGURE 2

ODMH Hospitals Overview

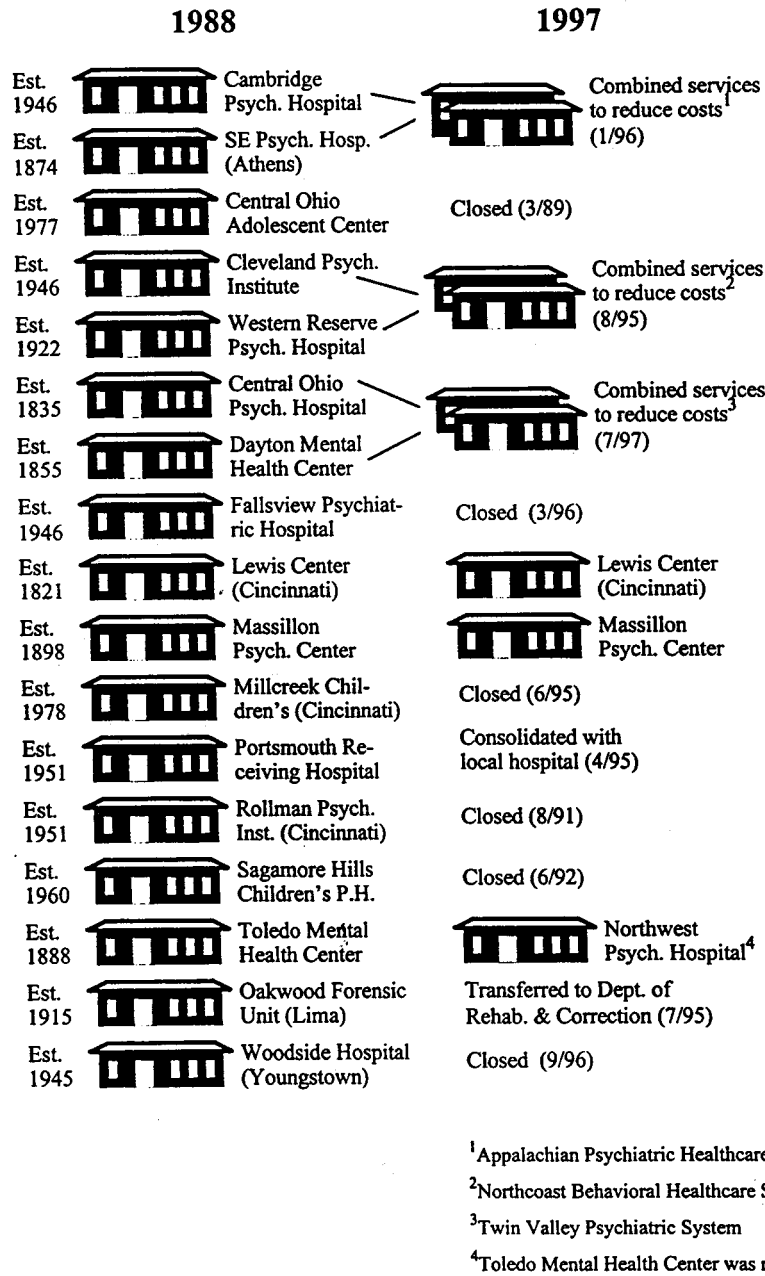


Figure 2. ODMH hospitals overview

as 'SMD' and 'SED'.¹⁰ Additionally, our evaluation of patterns has seen several broad trends. First, about half of all individuals identified as 'SMD' and 'SED' receive relatively low levels of services—about one professional contact per month.¹¹ Additionally, the evidence suggests that a smaller group of about 10% of individuals classified as 'SMD' receive a rich and diverse package of services, and that there is considerable variability in individuals' service use patterns over time. These patterns may surprise readers who expect community care systems to provide

more consistently intensive care to most persons, but we believe these patterns are typical of community care systems rather than an exception. Finally, there are trends over time in patterns of services, for example with fewer individuals receiving only medication management and more receiving a mix of medical and other community support services. In terms of consumer-specific outcomes, a cohort study of SMD adults suggests that consumer outcomes are improving over time.¹²

Despite these positive signs, it would be premature to

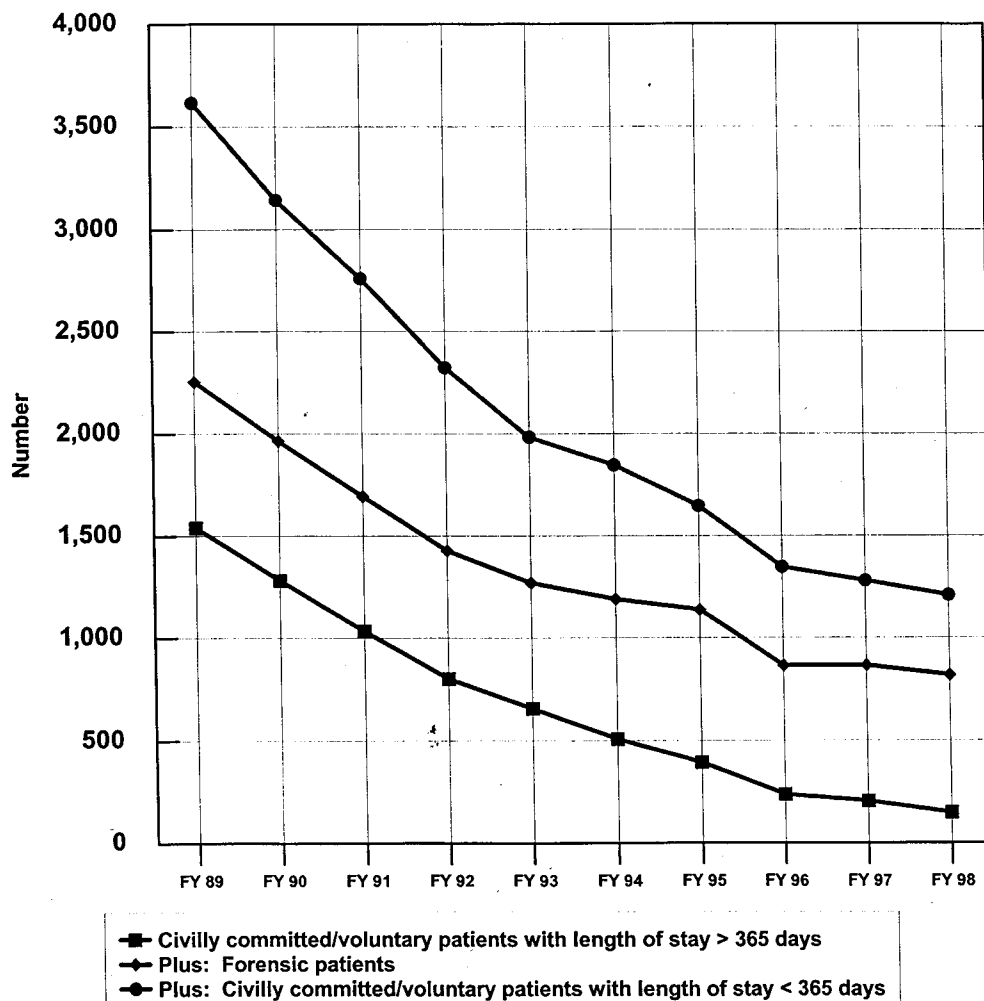


Figure 3. State hospital use by type

conclude that system reform has resulted in clinical success. The links between systems changes, clinical service delivery and consumer outcomes are complex, and there are many intervening and extraneous variables. Further studies dependent on better clinical information are needed to evaluate the clinical consequences of system change.

However, we do conclude that intended reforms in the structure and financing of the system have been substantially completed. **Figure 6** illustrates this, displaying the 'portfolio' of services paid for in FY 1996. **Figure 6** includes about \$125 m in Medicaid fee for service reimbursement for inpatient and office-based care paid directly by the state Medicaid agency to providers. Since this reimbursement mechanism is separate from the local board-managed system, these funds were not reflected in **Figure 4**, which summarizes all funding controlled by the boards—including Medicaid reimbursement for care in clinics and mental health centers—as well as resources for forensic care that remain the responsibility of the Department of Mental Health.

These data illustrate the service portfolio of a system that is now better balanced on several dimensions. Less than 30% of expenditures are now for all categories of inpatient care (short term, long term, forensic). About half of all expenditures are for inpatient and outpatient treatment, and

about half are for other categories of care including housing, community support/case management, rehabilitation and day programs and crisis intervention. These patterns of services were envisioned under the CSP approach, at a time when most resources were spent on inpatient care and community mental health investments emphasized only treatment without considering the need for rehabilitation and support services such as housing.

It would be premature to argue that Ohio's reforms have resulted in a clinically state-of-the-art system, and we cannot definitively conclude that the changes have led to improvements in consumer outcomes. However, it is fair to assert that planned reforms based on the CSP model have been substantially completed. Additionally, available data on consumer outcomes are also positive. Thus, the reformed system represents a better fit with desired or prescribed models, and it appears to be moving toward desired results.

The 'Catch-22' of Reformed Mental Health Care

The description of Ohio's reformed public mental health system does not lead the writer—or, I trust, the reader—to conclude that a perfect system of care has been achieved

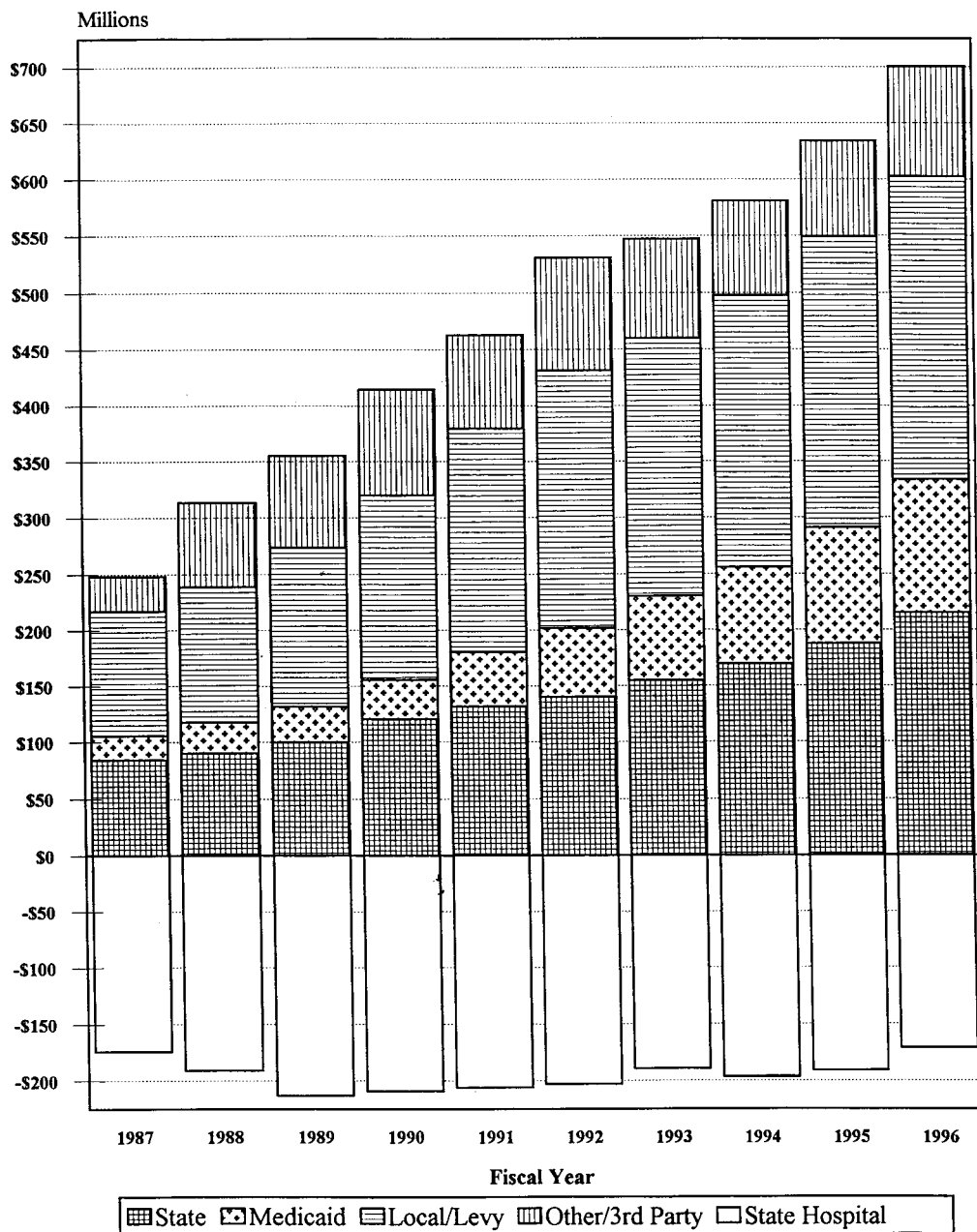


Figure 4. State of Ohio community mental health funding

Clients served (1000's) in Community Care

	Children	Children and Adults identified as "Severely Mentally Disabled" (SMD)	Children and Adults not identified as SMD
FY 93	60.8	57.6	162.3
FY 96	68.8	69.4	177.4
Change	+12.8%	+20.5%	+9.3%

Figure 5. Clients served (1000s) in community care

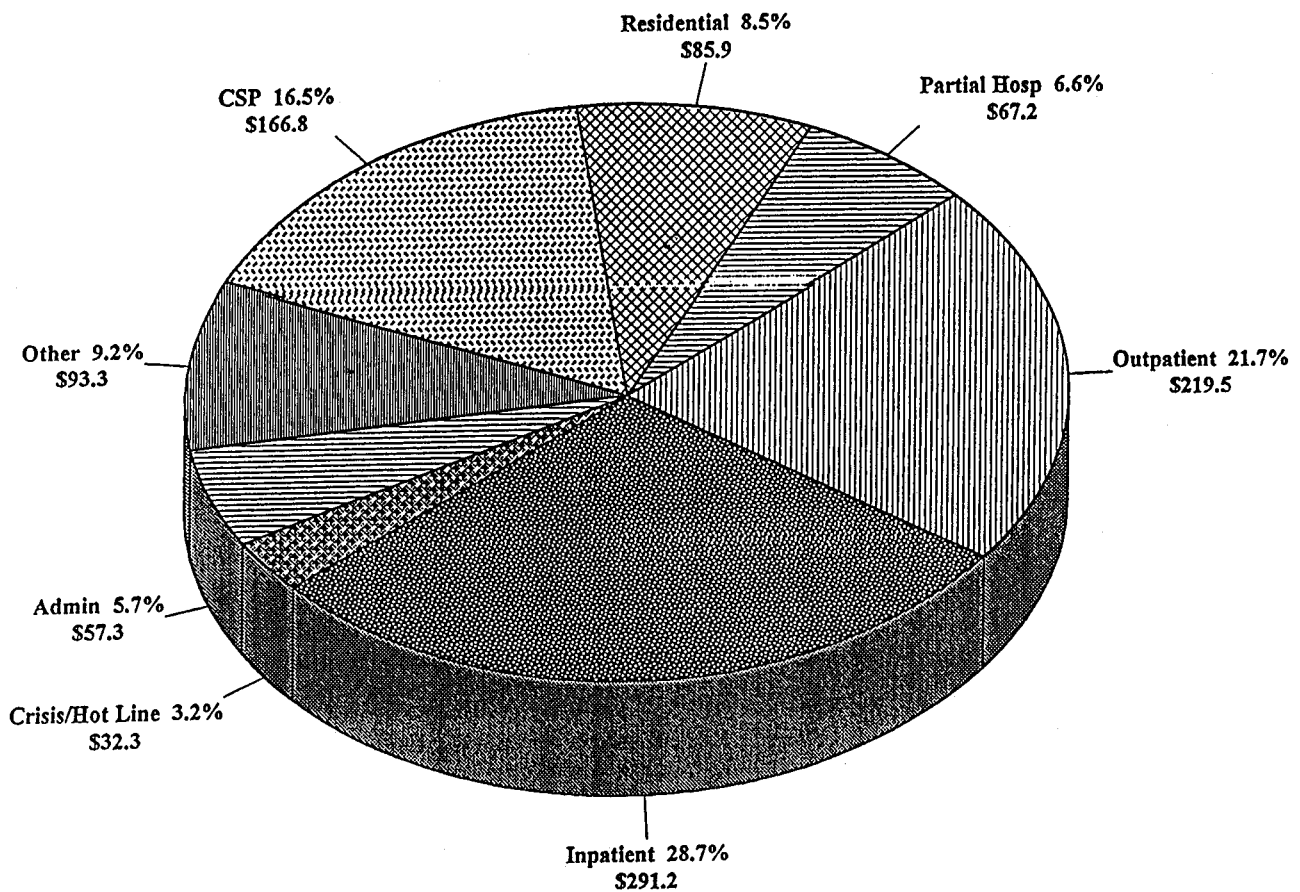


Figure 6. State of Ohio total public mental health resource portfolio—FY 1996 (\$1013.5 million)

in Ohio. We are painfully aware that systems reform does not automatically lead to clinical improvements and better outcomes (see, e.g. Lehman *et al.*,¹³ Bickman¹⁴). Furthermore, it is increasingly clear that practitioners' conformance with research validated treatment methods is generally poor.^{15,16} Therefore, we believe that one overriding need and challenge in Ohio is to improve practice and the quality of care within a structurally reformed system.

At the same time, it is increasingly apparent that the division between the private (commercially paid) and public (state coordinated) mental health systems in the United States is now a limiting factor in reform. The two-tiered mental health system has no analogue in health care. It stratifies individuals based on insurance coverage. People who have commercial health insurance with a benefit that is adequate to meet their needs (and those who have not yet needed to use coverage) remain in the private/commercially insured sector. Those who have exhausted their benefits or are uninsured are transferred to the public sector. Because of the limits on mental health coverage in the vast majority of commercial health plans (limited benefits, higher copayments for mental health than other visits, annual or lifetime limits on the number of visits or the amount of care that is covered by the plan etc), private coverage is typically 'shallow'. Therefore, people with a serious and persistent mental illness are likely to lose their coverage and turn to public sector care. The problem of losing

coverage is compounded by the age of onset of serious mental illness. Disabling mental illness often strikes in early adulthood, as people transition off their parents' health coverage or begin employment, with less generous coverage. Thus, the dominant United States pattern of employer-based coverage with weak mental health benefits is very problematic when it comes to care for serious and persistent mental illness. The public mental health system functions as a safety net, which 'catches' and cares for people who have been extruded from the commercial insurance paid sector.

Addressing the gross structural problems of the public mental health system (excessive institutionalization followed by precipitous deinstitutionalization) has occupied and dominated mental health policy for the past generation. As the Ohio case study illustrates, these structural public sector reforms are largely completed in a number of states. The fact that many of the structural problems in the public system have been resolved now brings deeper problems into focus. The public system is largely means tested. Many consumers depend on Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) for living expenses. Eligibility for these programs leads to Medicaid eligibility. Since Medicaid has become a dominant source of financing for the public system, both providers and consumers depend on it. For individuals, the cost of Medicaid-covered medications alone may run to hundreds of dollars monthly. For provider agencies, Medicaid billings

may cover 40% of their budget, so there is little incentive to encourage their consumers to get well enough to lose coverage. These 'benefits' may now create significant disincentives to recovery and to economic well being.

The structure of commercial health insurance thus interacts with Medicaid and SSI/SSDI to perpetuate poverty. It is extremely difficult for someone to go off Medicaid and acquire adequate commercial coverage during their recovery, mostly because benefits are often inadequate to cover needed care, and because of limits on coverage of pre-existing conditions. In an era of increased cost pressures on health plans, there are strong pressures for plans to not enroll high-cost individuals formerly cared for in the public sector.

These disincentives do not exist so powerfully with respect to most other illnesses, where all care is provided in a single—albeit multiply financed—system. In mental health, current financing arrangements act to deprive people of insurance coverage if and when they truly need it and then transfer their care to a public system that is largely financed through poverty-related entitlement programs. These same arrangements tend to prevent individuals who are recovering from serious illnesses from achieving economic independence, and from reentering the arena of privately financed care. It is a classic 'Catch-22'. The public system is needed because private care is inadequate—but the existence of the public system makes it unnecessary to expand private coverage. The consequences are problematic for consumers, and result in increased costs because of duplication of effort. Because of the high proportion of mental health care financed by government—in particular state and local governments—the inefficiencies of the two-tiered system result in higher government expenditures.

Figure 6 reveals that total expenditures in Ohio's public mental health system are about \$1 billion annually. About half of this cost is borne by state government, while the other half of the cost is divided approximately equally between federal and local governments. Thus, Ohio's public system costs taxpayers over \$1 b annually—and Ohio is not among the most costly state systems.

Opportunities for Public and Private Integration

During most of the past 30 years, the deep and obvious problems within the public mental health system (e.g. institutional abuses, the problems associated with deinstitutionalization) were the focus of public attention and mental health reforms. A broader view that envisioned inclusion of mental health care and coverage within a single reformed health system was not timely, and perhaps not even appropriate. The public system demanded reform, and there was not much support for including mental health in health insurance and health care plans. Much has changed.

As we approach the 21st century, although nondiscriminatory mental health benefits are the exception rather than the rule, many health plans (including the plan for Ohio state employees) have demonstrated that providing such benefits in a cost controlled manner is possible. The Congress has

enacted legislation (the Health Insurance Portability Act) which takes step toward equality of mental health benefits, and about 20 states have enacted even more vigorous 'parity' legislation. In many states such as Ohio, the public system is reformed, and it is increasingly apparent that the gulf between the public system and private coverage is a critical problem, which keeps many thousands of people from productive lives and economic independence. Additionally, the tax resources needed to sustain this system are substantial.

The improvements in public systems and the resources devoted to them may create an opportunity for the previously impossible integration of public and private mental health care such as that proposed in President Clinton's ill fated Health Security Act. A broad review of Ohio data illustrates the potential financial feasibility of such an approach. A review of **Figure 5** suggests that about \$500 m annually is spent on inpatient and outpatient care (the kinds of care, for treatments of other conditions, that are usually covered by health insurance) in Ohio's public system. Roughly an equal amount is spent in Ohio on a broad array of community support and rehabilitative services, generally targeted at the disabling consequences of serious mental illness. Typically, such disability-oriented, long-term rehabilitative services—again, for any illness—are not covered by commercial health insurance plans.

Might it be possible to use all or a portion of the funds now spent on hospital and outpatient care in Ohio's public system to purchase coverage for these same services, and might it be possible to design this coverage so that consumers need not stay poor as a condition of eligibility? Such an arrangement could rely on subsidized commercial plans (e.g. the plan for state employees) or a focused expansion of Medicaid to specifically cover acute and outpatient mental health care. Under this approach, would it be possible to maintain but redefine components of the local public mental health system to provide rehabilitation, and other community support services? The recently enacted federal legislation providing for a Children's Health Insurance Program (CHIP) for children in families with incomes up to 200% of poverty suggests a possible framework for such an approach.

A full examination of the feasibility of such an approach is beyond the scope of this paper. However, one threshold issue that can be superficially assessed is the financial feasibility of this approach. One gross test of such an approach is to review the adequacy of current funding to support such an 'acute and outpatient' benefit. A closer review finds that not all of the resources devoted to inpatient care would be available for use in such a program. Roughly \$70 m of state hospital expenditures are devoted to care of forensic patients, and presumably these services should remain a state responsibility. Another proportion of state hospital inpatient care (estimated at \$70 m annually) is devoted to intermediate and long-stay treatment (over 30 days). For the purposes of this analysis, this non-acute care is considered rehabilitation rather than health care. These adjustments mean that about \$140 million in publicly paid acute hospital care, and a total of about \$360 m in publicly paid inpatient and outpatient care was provided in Ohio in

1996. These are the resources that could be considered available for purchase of insurance coverage for these same services. About \$650 m would remain to finance a locally managed safety net of rehabilitation, community support and forensic services under this analysis.

A superficial assessment of the economic feasibility of this approach follows. There are about 1.2 million Medicaid eligible individuals in Ohio, and about 1.4 million uninsured persons. If the \$360 million now used for direct purchase of public inpatient/outpatient services were used to purchase coverage for these services, about \$11.50 would be available per person per month for these services alone. This is a generous amount, about three times higher than the cost of the parity coverage provided to Ohio state employees.¹ In a crude way, the comparison suggests that the approach may be financially feasible. The resources that would be involved in a new plan are now used to finance the care that would be covered. Additionally, current expenditures on a *per capita* basis are substantially greater than expenditures in a plan providing comparable coverage. The level of need or financial risk to a plan represented by an uninsured population is almost certainly greater than in the state employee population. However, the state employee plan has broader benefits (including, for example, residential or day treatment services), and current Medicaid services are not subject to managed care. These factors argue for the financial feasibility of the approach.

Of course, this simple analysis does not demonstrate that providing coverage is possible. It is not certain whether this level of funding would be adequate to meet needs for acute inpatient and outpatient care—even if this care were well managed and if Ohio's locally managed community support system were retained to provide these services. There are numerous potential implementation problems (many of them identified in debate about the new federal Children's Health Insurance Program). These include how to get people enrolled, and how to prevent coverage under the new plan from 'crowding out' private coverage that now exists (by making it feasible for employers to reduce or terminate current coverage, because a new safety net exists). Other potential problems include the difficulties in managing care for such a population, and the complexities in reforming federal entitlement programs. Implementing such a program (whether through state purchase of coverage, a targeted expansion of Medicaid, or expanding the state employee program) would also involve complex political, legal and regulatory reform at the state, federal and local levels. It would require developing 'parity' coverage for those with health insurance, so cost shifting would be minimized. In short, it would be an exceedingly complex endeavor.

Nonetheless, it is time to be exploring the feasibility of such approaches. The completion of structural reform in the public system in states like Ohio makes the issue of

public/private integration timely—and perhaps necessary. The juxtaposition of a \$1 billion public system for those who have exhausted their insurance with a well managed, parity benefit program for employees of the same state is both ironic and instructive. It is time for more rigorous economic and policy analyses of proposals that consider both non-discriminatory mental health insurance benefits and the blending of public sector and private responsibilities.

Acknowledgements

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