Mental Health Parity in Arkansas • July 2015

Much of the recent focus on healthcare access in Arkansas has been on providing financial access to coverage through insurance affordability programs under federal and state law. The viability of these programs—particularly the Arkansas Health Care Independence Program funded with Medicaid dollars—is dependent on the ability to provide cost-effective care. While health policy organizations, including the Arkansas Center for Health Improvement, have noted the potential for access issues related to the primary and specialty care provider workforce following a major coverage expansion, limited attention has been given to access to mental health and substance use disorder services. Access to these services has been bolstered by a series of federal and state laws that require insurance companies to cover mental health and substance use disorder services the same as other medical services ("parity"). However, additional work is needed to ensure equitable access for individuals with these needs as the state invests in expanded coverage, particularly given that failure to ensure access has secondary effects such as increased incarceration and reduced workplace productivity. This issue brief describes federal and Arkansas parity laws, the extension of parity requirements under the Affordable Care Act, and issues concerning access and parity in Arkansas.

INTRODUCTION

A recent report by Mental Health America describes the extent of mental health needs and access to mental health services in the United States.[1] The report documents successes and failures of both federal and state initiatives aimed at improving mental health. It tracks adult and youth dependence or abuse of illicit drugs or alcohol and ranks Arkansas high for prevalence of mental health illness. Arkansas ranked 43rd among states in the report, indicating a high prevalence of mental illness and a low rate of access to care. The report found that 19.81 percent of Arkansas adults have a mental illness and 12.86 percent of Arkansas children have emotional, behavioral, or developmental issues. Recognizing the prevalence of these issues, particularly among those involved with the criminal justice system—half of incarcerated individuals have mental health problems[2]—Arkansas passed legislation in 2015 to create the Behavioral Health Treatment Access Legislative Task Force.[3]

Part of the access issue has been addressed by new or improved state and federal parity laws. Parity means that equal standards are applied to both mental health and substance use disorder care compared to other healthcare services. For example, a plan cannot limit outpatient mental health treatment visits more strictly than outpatient medical treatment visits. Mental health parity is a politically divisive issue where advocates have viewed parity requirements as a way to ensure fairness and improved access while opponents focus on potentially increased costs. Figures 1 and 2 describe federal and state laws that prohibit health plans from denying or discriminating between coverage for mental illness and other health disorders are described in detail in this issue brief.

FIGURE 1: FEDERAL LAWS

Mental Health Parity Act (MHPA). In 1996, Congress passed the MHPA, which required group health plans that offered mental health benefits to apply the same lifetime and annual expenditure limits as coverage for other medical services. Rather than comply with the law, some employers and insurers opted to drop mental health benefits altogether. The law did not address cost sharing or utilization limits, and insurers began to restrict these benefits. In addition, the MHPA did not cover substance use disorders.

Mental Health Party and Addiction Equity Act (MHPAEA). In 2008, Congress passed the MHPAEA, which expanded MHPA requirements. Additional protections include equivalent mental health and substance use disorder benefits with respect to beneficiary financial exposure and treatment limits. However, the law still did not require health plans to offer mental health and substance use disorder benefits. Under the MHPAEA, patients only have to meet a single deductible for medical and mental health expenses.

FIGURE 2: ARKANSAS LAWS

Arkansas Mental Health Parity Act of 2009 (AR MHPA). Under the AR MHPA, health plans that provide benefits for the diagnosis and treatment of mental illness must do so on the same terms as for the treatment of other medical illnesses and conditions. Parity of covered benefits includes frequency, dollar amount of coverage, and beneficiary financial exposure. Parity is not required for preventive care treatments. It also does not prohibit carve-out arrangements, plan management provisions similar to those used for other medical conditions, separate but equal cost-sharing features, or lifetime and annual dollar limits as applicable to other medical services. An insurer may obtain an exemption due to increased costs after six months of compliance.

Minimum benefits for mental illness.[4] Insurers and hospital and medical service corporations providing hospitalization or medical benefits for mental illness cannot impose limits on benefits that differ from benefits for other medical conditions or illnesses regarding deductible amounts, lifetime maximum payments, payments per outpatient visit, or payments per day of partial hospitalization. However, the copayment requirements for these services may differ from the copayment requirements of other medical conditions.

Treatment of alcohol and drug dependency.[5] Every insurer, hospital and medical service corporation, and health maintenance organization offering accident and health insurance in this state must offer benefits for the necessary care and treatment of alcohol and other drug dependency at parity with other physical illness, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors.

AFFORDABLE CARE ACT

The Affordable Care Act (ACA) extends the reach of federal mental health parity requirements by applying the MHPAEA to qualified health plans (QHPs), Medicaid alternative benefit plans (ABPs), and plans offered outside the health insurance marketplace.[7] The ACA also mandates that mental health and substance use disorder coverage be provided as essential health benefits (EHBs). Since 2014, all non-grandfathered individual and small group plans as well as Medicaid ABPs must cover EHBs. Federal rules clarified that mental health and substance use disorder benefits must be included in all classifications—inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs—that medical and surgical benefits are provided.[8] Parity also applies to all plan standards, including geographic limits, facility-type limits, and network adequacy.[9]

The Centers for Medicare and Medicaid Services (CMS) recently published proposed rules applying MHPAEA to Medicaid ABPs. The proposed rules require that both Medicaid managed care and fee-for-service (FFS) ABPs meet the parity standard with respect to beneficiary financial exposure and treatment limitations.[10] However, requirements relating to annual and lifetime dollar expenditures on benefits and access to out-of-network providers do not apply to ABPs offered only through FFS delivery systems.

The ACA also provides increased access to healthcare coverage by expanding Medicaid eligibility to low-income individuals. Arkansas utilized an alternative approach to Medicaid expansion by using Medicaid dollars to provide premium assistance for individuals to purchase private QHPs in the health insurance marketplace. QHPs cover the same benefits and services provided by the Arkansas Medicaid ABP. Arkansas relies upon the private QHPs to meet parity requirements, with compliance for parity within QHPs monitored by the Arkansas Insurance Department through the plan certification process.

According to a survey by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA):[6]

- ***Of the estimated 18 million adults potentially eligible for Medicaid, at least 2.5 million have substance use disorders***
- ***Of the 19 million uninsured adults who are eligible for subsidized insurance, an estimated 2.8 million have substance use disorders***

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POTENTIAL PARITY ISSUES

Enhanced parity requirements and expanded healthcare coverage have strengthened access to mental health and substance use services, but issues still remain. In Arkansas, there is likely to be high demand for these services. Figures 3, 4, and 5 show the prevalence of serious mental illness, psychological distress, and substance use disorders among newly covered Arkansans relative to the nation as a whole.[11] Expanded coverage is expected to increase the number of individuals being screened for mental illness and substance use disorders in the primary care setting, resulting in an increased demand for these services.[12] According to preliminary analysis by the Arkansas Center for Health Improvement, of expansion enrollees who were identified during enrollment as having exceptional health care needs, greater than half reported a previous diagnosis of depressive disorder.

Figure 3: Prevalence of Serious Mental Illness among Adults Ages 18–64

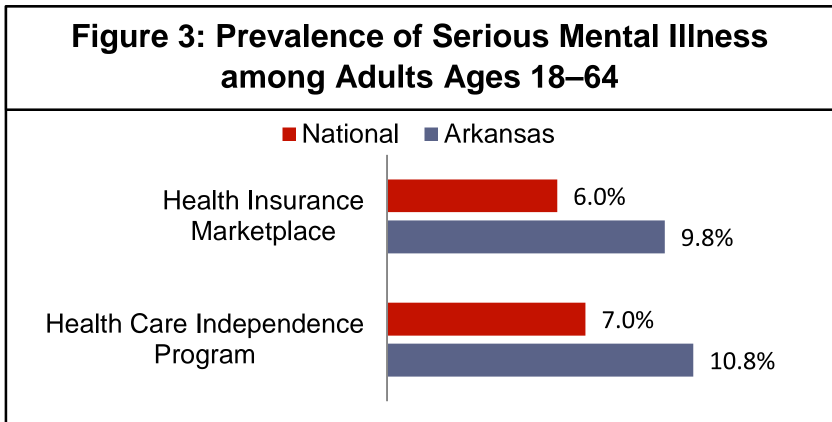


Figure 4: Prevalence of Serious Psychological Distress among Adults Ages 18–64

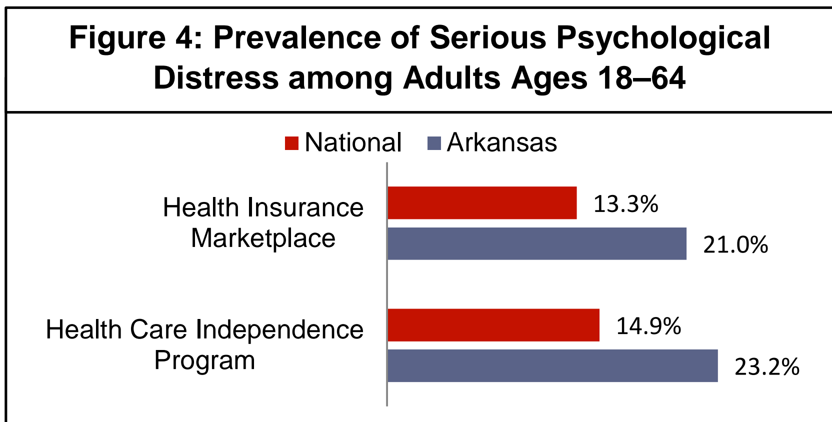
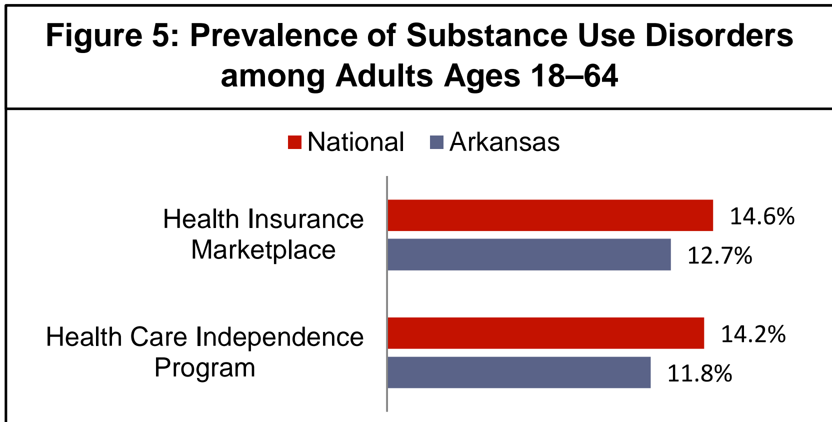


Figure 5: Prevalence of Substance Use Disorders among Adults Ages 18–64



Will private QHP networks be able to respond to the service demand at parity for the Health Insurance Marketplace and Health Care Independence Program populations? Will non-quantitative treatment limits such as provider network admission standards, prescription drug formulary design, and step-therapy requirements otherwise limit consumer access? New plan certification requirements including network adequacy standards that are aimed at assessing the availability of providers for these types of services should serve as a safeguard, but readily available data are currently limited to assess plan responsiveness and ensure parity. Local advocates have reported emerging issues related to QHP network access to these types of services in testimony before the Arkansas General Assembly's Behavioral Health Treatment Access Legislative Task Force, particularly for individuals gaining access to coverage upon release from prison.[13]

Ascertaining the mental health and substance use disorder workforce is a challenge due to the many classifications of providers that deliver these services, the lack of recognized certifications, and the lack of a standardized approach to survey workforce data. Without a standardized approach that accounts for the many ways to receive mental health and substance use disorder treatment, it is difficult to uniformly identify workforce shortages. However, some organizations have identified shortages in the major professions working in the field.

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According to the Health Resources and Services Administration (HRSA), Arkansas has 43 Mental Health Care Health Professional Shortage Areas (HPSAs),[i] resulting in only 63.3 percent of the need met.[14] The Provider Availability Index, a tool created by Advocates for Human Potential, for substance use disorder (SUD) is 24.4 in Arkansas, meaning that there are 24.4 providers for every 1,000 individuals needing substance use disorder treatment, ranking Arkansas below the national average of 32.[6] Previous workforce assessments in other clinical areas have found significant geographic variations with shortages accentuated in some rural areas in the state.[15]

CONCLUSION

Federal and state mental health parity laws have expanded coverage to mental illness and substance use disorder; however, service limitations and access issues still remain. Without a sufficient workforce to support an increase in demand, individuals will still have challenges obtaining care. Assessing emerging data will be critical to understanding if access and parity issues persist as regulators, insurers, and consumers adjust to the changing healthcare landscape. Opportunities to address mental health and substance use disorder needs of Arkansas citizens through required parity in benefits presents an opportunity to not only improve health but also address criminal justice issues and workforce productivity affected by these conditions.

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[i] Mental Health HPSAs are based on a psychiatrist-to-population ratio and are designations that apply to areas, groups, or facilities with unmet healthcare needs. Federal regulations stipulate that in order to be considered as having a shortage of providers, an area must have a population-to-provider ratio of at least 30,000 to 1 (20,000 to 1 if there are unusually high needs in the community).
http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsaoverview.html

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