MENTAL HEALTH PARITY IN ARKANSAS

Introduction

Policymakers increasingly have been focusing on mental health coverage, particularly as the mental health crisis intensified during the COVID-19 pandemic. The pandemic created unprecedented challenges, significantly impacting the mental well-being of individuals and families nationally and in Arkansas. In response to this escalating crisis, access to mental health services has been bolstered by a series of federal and state laws that require insurance companies to cover mental health and substance use disorder (MH/SUD) services in the same way as other medical services ("parity").

Background

The Substance Abuse and Mental Health Services Administration reports mental health status among youth and adults and tracks changes in the prevalence of mental health issues and access to mental health care.[1] In 2021, about 23% of Arkansas adults had a mental illness. Seventeen percent of adults received treatment, and 16% had a substance use disorder. Eighteen percent of Arkansas youth had at least one major depressive episode, and 7% of youth had a substance use disorder.

MENTAL HEALTH IN ARKANSAS: 2021

23%
OF ADULTS HAD A MENTAL ILLNESS

17%
OF ADULTS RECEIVED TREATMENT

16%
OF ADULTS HAD A SUBSTANCE USE DISORDER

18%
OF YOUTH HAD AT LEAST ONE MAJOR DEPRESSIVE EPISODE

7%
OF YOUTH HAD A SUBSTANCE USE DISORDER

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Parity laws aim to ensure that mental health care receives the same level of consideration and has the same level of accessibility as other healthcare services. For example, under parity laws a plan cannot limit outpatient mental health treatment visits more strictly than outpatient visits for other types of medical treatment.

While there is a general recognition of the importance of mental health care and its impact on overall well-being, mental health parity can be a politically divisive issue, particularly as it relates to the cost of implementation and the scope of mental health parity laws.

This explainer describes federal and Arkansas parity laws and highlights ongoing efforts to achieve comprehensive and equitable mental health support for all residents of the state.

Coverage Before Federal and State Action

Before federal and state action, insurers often provided less coverage for MH/SUD treatment compared to treatment for other medical conditions. Inpatient care for mental illnesses, for example, was commonly limited to a maximum 30 days per year, compared to unlimited days for other medical services.[2] Although most employer-sponsored plans covered some outpatient mental health care, two-thirds of these plans applied limitations including a maximum dollar amount per year (usually $1,000) and a maximum number of days per year (most often 50 days) for mental health services but not for other care. Only one-fifth of plans applied the same coinsurance rate to outpatient mental health care as they applied other types of care. Plans typically paid 50% for mental health care, in contrast to 80% for other services. Historically, these disparities were influenced by skepticism on the part of insurers about mental health diagnoses and treatment.[3] A 1999 surgeon general's report countered these views and supported mental health parity.[4] Advocacy efforts, state-level initiatives, and mounting evidence demonstrating the adverse impacts of inadequate mental health coverage influenced federal intervention to advance mental health parity.

Federal Laws

Mental Health Parity Act

In 1996, Congress passed the Mental Health Parity Act (MHPA), requiring large employer-sponsored health plans that offered mental health benefits to apply the same lifetime and annual expenditure limits to mental health coverage as they applied to coverage for other

medical services.[5] However, the MHPA had some limitations. First, it was limited to large employer-sponsored health plans,[a] meaning that other types of coverage, including Medicare and Medicaid, were unregulated. Second, it did not require large employer-sponsored health plans to offer mental health benefits. Third, it did not address cost-sharing requirements or utilization limits, and, as a result, insurers began to disincentivize utilization through higher cost sharing and strict visit limits. Finally, the MHPA did not cover substance use disorders, leaving a gap in addressing the critical issue of addiction treatment.

Mental Health Parity and Addiction Equity Act

Recognizing the need for broader and more comprehensive protections, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008. This law significantly expanded upon the requirements set by the MHPA and addressed many of its shortcomings.

The MHPAEA required group health plans to offer MH/SUD benefits that were equivalent to other medical benefits in all respects, meaning that coverage for MH/SUD benefits should be no more restrictive or financially burdensome than coverage for other medical services. Under the law, patients had a single deductible for both medical and mental health expenses, streamlining the process and reducing potential disparities in cost sharing.

Affordable Care Act

The Affordable Care Act (ACA) extended the reach of federal mental health parity requirements by applying the MHPAEA to qualified health plans (QHPs) in the Health Insurance Marketplace, plans offered outside the Health Insurance Marketplace, and Medicaid expansion coverage and alternative benefit plans (ABPs).[6] The ACA also mandated that MH/SUD coverage be provided as essential health benefits, which are 10 categories of benefits that plans must offer. Since 2014, all non-grandfathered individual and small group plans, as well as Medicaid expansion plans and ABPs, must cover essential health benefits.

In 2013, the Departments of Treasury, Health and Human Services, and Labor issued final rules clarifying that MH/SUD benefits must be included in all benefits classifications — inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs — for which medical and surgical benefits are provided.[7] Parity also

[a] A “large employer” is defined as one with more than 50 employees.

applies to all plan standards, including geographic limits, facility-type limits, and network adequacy.[8] In 2016, the Centers for Medicare and Medicaid Services issued final rules for the application of the MHPAEA to Medicaid beneficiaries receiving services through managed care organizations, ABPs, or the Children's Health Insurance Program.[9]

NON-ELDERLY ADULT MEDICAID POPULATION IN THE US: 2020

40%

HAD A MENTAL HEALTH OR SUBSTANCE USE DISORDER[10]

The ACA also provided increased access to healthcare coverage by expanding Medicaid eligibility to low-income adults. Arkansas's approach to Medicaid expansion uses Medicaid dollars to provide premium assistance for individuals to purchase coverage through QHPs. QHPs cover the same benefits and services provided by the Arkansas Medicaid ABP.

Federal Laws That Strengthen Monitoring and Enforcement of the MHPAEA

MHPAEA ENFORCEMENT EFFORTS[11]

The enforcement of parity regulations is essential to ensure that people have access to behavioral health services. The Employee Benefits Security Administration (EBSA) and CMS have made MH/SUD parity a top priority for enforcement.

EBSA, which oversees about 2.5 million private group health plans covering roughly 133 million Americans, is dedicating significant resources to enforce the NQTL requirements of the MHPAEA.

However, despite the increased efforts, both EBSA and CMS face limitations in resources compared to the large number of plans they regulate.

More recent laws have aimed to improve MHPAEA monitoring and enforcement efforts and increase reporting requirements. The 21st Century Cures Act of 2016 was intended to foster stronger collaboration between federal and state agencies, unify efforts to enforce parity requirements, and improve accountability in adhering to the regulations surrounding non-quantitative treatment limitations[b] (NQTLs).[12] Building upon this, the Consolidated Appropriations Act of 2021 further strengthened mental health parity enforcement. The act mandated that health plans conduct comparative analyses of NQTLs and

[b] NQTLs do not set numerical limits, such as numerical or financial limits on visits, but nevertheless can significantly impact the availability of services. Examples of NQTLs include restrictions tied to prescription drug formulary design, requirements for step therapy, prior authorization requirements, and geographic restrictions on facilities. The MHPAEA final regulations state that health insurance issuers cannot apply NQTLs to MH/SUD benefits differently than to medical/surgical benefits within the same classification. The processes, strategies, standards, and other factors used for applying NQTLs to MH/SUD benefits must be comparable to, and no more stringent than, those applied to medical/surgical benefits.

provides that the Departments of Treasury, Health and Human Services, and Labor are required to request these NQTL comparative analysis to provide annual reports to Congress on the outcomes.[13]

SUMMARY OF ARKANSAS LAWS

Arkansas Mental Health Parity Act of 2009 (Ark. Code Ann. §§ 23-99-501 to -511). Under this law, health plans that provide benefits for the diagnosis and treatment of mental illness must do so on the same terms as those provided 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 (Ark. Code Ann. § 23-86-113). Insurers and hospital and medical service corporations providing hospitalization or medical/surgical 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 (Ark. Code Ann. § 23-79-139). Every insurer, hospital and medical service corporation, and health maintenance organization offering accident and health insurance in the state must offer benefits for the necessary care and treatment of alcohol and other drug dependency at parity with benefits provided for other physical illnesses, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors.

Mental Health Parity Initiatives in Arkansas

Recognizing the prevalence of MH/SUD issues, the Arkansas General Assembly passed Act 802 of 2021, which required a study to examine various aspects of mental and behavioral health in the state and aimed to identify potential improvements and policy changes to better address mental health needs. The Mental Health and Behavioral Health Working Group, the legislative group responsible for the final report required under act, met several times in 2022. Though the group did not address parity issues specifically, its recommendations encompass a

comprehensive approach to mental health services and accessibility in the state. MH/SUD parity can play a significant role in the implementation of these recommendations by ensuring that MH/SUD services are treated on par with medical/surgical services and that the proposed enhancements to behavioral health services promote comprehensive and equitable MH/SUD care. The infobox on the previous page describes state laws that prohibit health plans from denying or discriminating between coverage for mental illness and other health disorders.

Potential Access Issues

Improved parity requirements and expanded healthcare coverage have improved access to MH/SUD services. Studies have shown that Medicaid expansion has resulted in increased utilization of medication-assisted treatment for opioid use disorder, increased usage of telehealth for mental health care, and improved availability of comprehensive mental health services.[14] However, access issues remain, including limited provider options, limited availability of services, difficulties in obtaining timely appointments, and geographical barriers.[15]

Assessing the MH/SUD workforce to identify shortages is a challenge due to several factors, including the many classifications of providers that deliver these services, the lack of universally recognized certifications or qualifications because these may vary by state, and the lack of a standardized approach to surveying workforce data that accounts for the many ways to receive MH/SUD treatment. However, some organizations have identified provider shortages. According to the Health Resources and Services Administration (HRSA), Arkansas has 68 mental health professional shortage areas,[c] resulting in only 33.7% of the need being met.[18] Previous workforce assessments in other clinical areas have found significant geographic variations, with the most severe shortages identified in some rural areas in the state.[19]

- In 2021, close to 44 million people ages 12 and older reported needing substance use treatment in the past year; however, only 6.3% reported receiving any.[16]
- Uninsured adults with moderate to severe symptoms of anxiety and/or depression were 36% more likely not to receive mental health care compared to their insured counterparts in 2019.[17]

[c] Mental health professional shortage areas are identified based on a provider-to-population ratio. The designation is applied to areas, groups, or facilities with unmet healthcare needs.

Conclusion

Federal and state mental health parity laws have expanded coverage to MH/SUD; however, service limitations and access issues remain. In the absence of a sufficient workforce to meet increasing demand, individuals will continue to have challenges obtaining care. Assessing emerging data will be critical to understanding whether access and parity issues persist as regulators, insurers, and consumers adjust to the changing healthcare landscape. Addressing the MH/SUD needs of Arkansas citizens through required parity in benefits presents an opportunity not only to improve health but also to address criminal justice issues and workforce productivity affected by these conditions.

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