

Research & Policy Brief

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Rural Adults Face “Parity” Problems & Other Barriers to Appropriate Mental Health Care

Overview

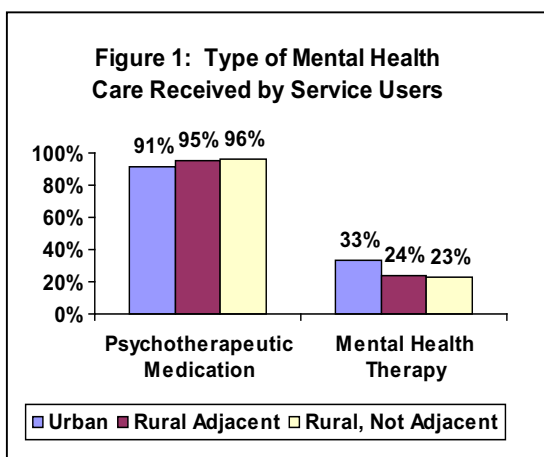
The insufficient supply of mental health professionals in rural areas, and its impact on access to services for rural residents, has been well documented.¹ Less attention has been paid to whether financial barriers limit the use of mental health services in rural areas. Rural residents are more likely to be uninsured² and “underinsured”³ and these factors may make mental health care more unaffordable for them.

To make mental health treatment more accessible and affordable, Congress has recently passed, and President Bush has signed into law, mental health parity legislation that prohibits health insurance plans from setting lower limits on treatment or higher co-payments for mental health services than for other medical care. The effects of these policy changes in rural areas, however, will be limited by the exclusion of employers with less than 50 workers.

This study uses the 2003-2004 panels of the Medical Expenditure Panel Survey (MEPS) to assess rural residents’ access to mental health services by examining their mental health service use and the cost sharing (out-of-pocket costs) that they face when seeking mental health care. We compare patterns of service use and spending for adults aged 18-64 in rural counties bordering urban counties (adjacent counties), and more remote rural counties (non-adjacent), to those of their urban counterparts.

Rural Adults More Likely to Use Mental Health Prescription Medications

Rural residents are more likely than urban residents to report fair or poor mental health status (8% versus 6%). About 18% of rural adults, and 16% of urban adults, received some type of mental health service over the course of the year. This higher rate of service in rural areas is driven by greater use of mental health medications (17% versus 14% for urban).



Although on the surface this suggests that rural adults may not be at an access disadvantage, there is a distinct rural-urban difference in the pattern of mental health use.

As Figure 1 shows, rural residents are more likely than urban to get mental health treatment in the form of medication, and less likely to get any psychotherapy. When they receive therapy, rural patients average two visits fewer per year (7 vs. 9 visits for urban).

Fast Facts

- 8% percent of rural adults say they are in “fair” or “poor” mental health, versus 6% of urban adults.
- Among those using mental health services, rural residents are more likely than urban residents to use medication but not therapy. Practice guidelines for quality mental health treatment recommend that medications be given in *combination* with therapy.
- Both rural and urban adults have greater cost sharing for their mental health care (40% of costs) than for their total health care use (30%). The percentages do not differ by residence.
- However, rural residents may be at greater risk of forgoing mental health care due to costs.

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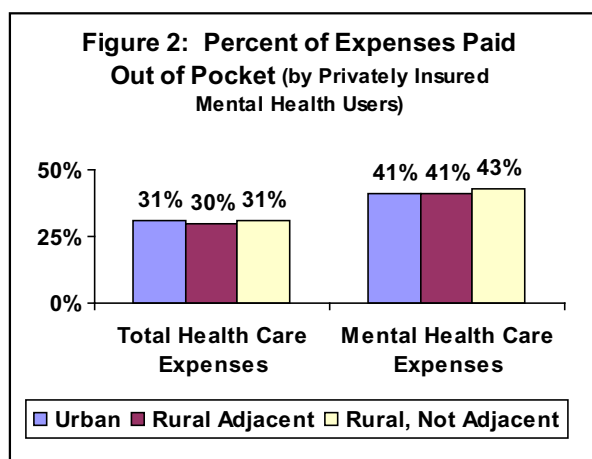
This brief is based on a longer study by the authors.

For more information about this study, contact Erika Ziller at (207) 780-4615 or eziller@usm.maine.edu

This greater use of medication over therapy for rural residents may reflect greater reliance on primary care providers for mental health treatment.⁴ Because they are not trained to provide psychotherapy, and because many rural communities lack a mental health provider, rural physicians may lack options other than medication for their rural patients with mental distress. However, practice guidelines recommend that psychotherapeutic medications be used in conjunction with counseling. While most adults taking mental health medications fall short of this recommendation, rural residents (particularly those not adjacent to urban areas) appear to have poorer access to appropriate mental health care.

“Parity” is a Rural and Urban Problem among the Privately Insured

The ultimate goal of mental health “parity” is to achieve equity in the way insurance plans treat mental and physical ailments. Supporting other research, our findings indicate that the recently enacted Wellstone-Domenici Mental Health Parity bill was a needed step toward achieving this goal. In 2003 and 2004, both rural and urban residents with private insurance paid a larger share of their mental health than total health care bills themselves (about 41% versus 31%, Figure 2).



Rural Residents May Forgo Needed Mental Health Care Despite Insurance Coverage

Although the difference in cost sharing between mental and total health care was essentially the same for rural and urban residents that *used mental health services*, further analysis suggested that those in rural areas are at greater risk of foregoing mental health care altogether.

We found that cost sharing for physical health care is much higher for those that did *not use* mental health services versus those that did, suggesting that mental health users tend to have richer health benefits. In some cases this may be because individuals with mental health problems are buying more comprehensive plans, but for others greater cost sharing for care generally may limit mental health service use. This difference was somewhat more pronounced in rural areas and may indicate that the problem of rural “underinsurance” is impeding entry into the mental health service system for some.

Among the privately insured with fair or poor mental health, rural residents, the “near-poor,” and those with higher cost sharing for physical health are less likely to get any mental health care. This supports the conclusion that financial barriers to mental health care persist among the privately insured, and that rural residents are at particular risk. However, this apparent poorer access in rural areas persists when these financial factors are controlled for, indicating that rural residents face non-financial barriers to mental health care as well.

Policy Implications

These findings suggest that a multi-level approach is essential for meeting the mental health service needs of rural residents. While new parity legislation may benefit both rural and urban residents, it is unlikely to fully eliminate rural-urban differences in mental health access and service use. Instead, an approach that focuses on reducing underinsurance for all health services among rural residents may help to reduce unmet rural needs among the privately insured. At the same time, policy and other changes are needed to address the well-documented and long-standing problems of mental health provider supply, reimbursement, and stigma affecting the availability and accessibility of rural mental health services.

Endnotes

- ¹U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. DHHS, SAMHSA, NIH, NIMH.
- ²Ziller, E.C., Coburn, A.F., Loux, S.L., Hoffman, C., & McBride, T.D. (2003). *Health insurance coverage in rural America: A chartbook*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
- ³Ziller, E.C., Coburn, A.F., & Yousefian, A.E. (2006, Nov/Dec.). Out-of-pocket health spending and the rural underinsured. *Health Affairs*, 25(6), 1688-1699.
- ⁴Lambert, D., & Agger, M.S. (1995, September). Access of rural AFDC Medicaid beneficiaries to mental health services. *Health Care Financing Review*, 17(1), 133-145.