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S Glied, C W Hoven, R E Moore, A B Garrett and D A Regier

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Children’s Access To Mental Health Care: Does Insurance Matter?

A major National Institute of Mental Health study provides an unusual opportunity to better understand the relationship between mental health coverage and use of services for children.

by Sherry Glied, Christina W. Hoven, Robert E. Moore, A. Bowen Garrett, and Darrel A. Regier

ABSTRACT: Using data from a 1992 community survey of children and their parents (or guardians), we found major gaps in mental health insurance coverage. Interestingly, private insurance had no statistically significant effect on use of mental health services. Youth without insurance coverage and those with public insurance had higher rates of serious emotional disorder than did those with private insurance. The analysis is based on the National Institute of Mental Health’s Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) study, conducted in three mainland U.S. sites and in Puerto Rico.

An estimated 20 percent of American children and adolescents—almost eleven million—have a serious and diagnosable emotional or behavioral disorder.¹ Most youth with mental health disorders, however, do not receive specialty mental health services.² Nor do these children and adolescents receive treatment for their psychiatric problems from general medical practitioners.³ One reason for the mismatch between mental health problems and service use may be a lack of mental health insurance coverage.

We evaluate this mismatch using data from the 1992 National Institute of Mental Health (NIMH) Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) study. We examine rates of mental health insurance coverage among children and adolescents, the match between mental health insurance coverage and needs, and the relationship between insurance coverage and mental health service use. Few studies to date have combined infor-
information on both the need for mental health services (based on a
structured psychiatric assessment as well as information on service
use from parents and children) together with information about
insurance coverage in the general population.

The MECA Study

The MECA study was conducted between 1989 and 1992 in four
geographic areas in the United States: (1) Hamden, East Haven, and
West Haven, Connecticut (n = 314); (2) DeKalb, Rockdale, and
Henry Counties, Georgia (n = 299); (3) Westchester County, New
York (n = 360); and (4) San Juan, Puerto Rico (n = 312). Sampling
methods and interview procedures are described elsewhere. The
data presented here are from the final field trial conducted in 1992.
Our analysis excludes data for Puerto Rico because the distribution
of income lies so far below that for the other three sites. (Median
income for the Puerto Rico site is about $13,000, compared with
about $50,000 for the other MECA sites.)

The target population included all youths ages nine to seventeen
who resided in randomly selected housing units in defined geo-
graphic areas (census tracts). Excluding Puerto Rico, the survey
population totaled 6,514 household units; overall, 19 percent con-
tained at least one eligible youth. Lay interviewers conducted simul-
taneous structured direct interviews with both an adult caretaker,
usually the biological mother (90–95 percent across all sites), and a
child selected at random in households with more than one age-
eligible youth. Interviews were completed for 81 percent of eligible
youth/caretaker pairs. Each site’s sample is representative of an area
within an urban area (n = 973). The samples also are ethnically and
culturally diverse (approximately 75 percent white, 20 percent Afri-
can American, and 5 percent Hispanic), include approximately
equal numbers of girls (47 percent) and boys (53 percent), and have
an equal distribution across the sampled age span.

The MECA sample is not representative of children and youth in
the nation as a whole. More MECA children live in two-parent
families than the U.S. average, have higher family incomes and more
employer-provided health insurance than average, and are less often
uninsured. Nonetheless, this survey provides some important les-
sons about mental health insurance in the United States.

The interviewers asked an extensive series of questions and col-
lected data on a range of measures of mental health status, service
use, and socioeconomic variables. NIMH’s Diagnostic Interview
Schedule for Children (DISC, version 2.3) was used to assess six-
month prevalence of most major child and adolescent psychiatric
disorders, including major depression, generalized anxiety disorder,
and attention deficit/hyperactivity disorder.\textsuperscript{5} The Non-Clinician Child Global Assessment Scale (NC-CGAS), based on an assessment made by a lay interviewer, was used to estimate functional impairment during the preceding six months.\textsuperscript{6}

In the analyses that follow, we coded a child as having a serious emotional disorder if the child met criteria for any psychiatric disorder other than simple phobia and had an NC-CGAS score less than 69. Parents also were asked about a child’s use of mental health and other services in a variety of settings, including offices of mental health professionals, psychiatric outpatient departments, schools, the justice system, social service systems, and inpatient hospitals.\textsuperscript{7} We examine the use of services in any setting and separately in mental health specialty offices and psychiatric outpatient facilities, schools, offices of general medical providers, and inpatient facilities during the twelve months preceding the interview.

**Who Has Mental Health Insurance Coverage?**

Fifteen percent of American children lacked health insurance in 1991.\textsuperscript{8} In the MECA data we analyzed, 7.5 percent of adult respondents reported that their child had no health insurance whatsoever, which indicates that this sample is much better insured than the national estimate. Having health insurance, though, is not a guarantee of mental health coverage. About 2.1 percent of those with general health insurance in 1991 lacked mental health protection.\textsuperscript{9}

Although the MECA sample as a whole had better-than-average insurance coverage, there are striking variations in that coverage (Exhibit 1). As expected, private insurance coverage increases with income, whereas Medicaid coverage is concentrated among the poor. More than one-quarter of children in poor families and nearly one-quarter of those in low-income families had no health insurance coverage for mental health services. Most of these children had no insurance at all, but about 2 percent had private health insurance coverage that excluded both inpatient and outpatient mental health (and an additional 2.8 percent lacked insurance for either inpatient or outpatient mental health care). Restrictions of this type on mental health coverage were most commonly reported by poor families. Private health insurance policies that covered poor, low-income, and middle-income children were statistically significantly less likely to include mental health coverage than were the policies that covered high-income children.

**Mental Health Problems And Insurance Coverage**

Children in low-income families have lower rates of insurance for mental health services than other children do. These children,
though, are the very ones with the highest rates of psychiatric disorder and mental health impairment (Exhibit 2). In addition, children in single-parent and other household families are more than twice as likely as children in two-parent families to be classified as having a serious emotional disorder (not shown).

Serious emotional disorder is least prevalent among children with private health insurance coverage (11.6 percent). On the other hand, almost one-third (31.3 percent) of children in the MECA sample who had Medicaid coverage met criteria for serious emotional disorder. Similarly, 18.3 percent of children without insurance coverage met criteria for a serious emotional disorder. The high rates of emotional disorder in the Medicaid and uninsured population suggest that private insurance is bearing only a small share of the burden of mental health illness among youth.

**EXHIBIT 1**  
Availability Of Insurance For Mental Health Coverage, By Poverty Status, 1992 MECA Sample

<table>
<thead>
<tr>
<th>Poverty status</th>
<th>All children</th>
<th>Children with private health insurance</th>
<th>Private insurance including mental health coverage</th>
<th>Public insurance</th>
<th>Uninsured for mental health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor (0–99% of poverty)</td>
<td>109</td>
<td>88.2% b</td>
<td>27.4% b</td>
<td>46.8% b</td>
<td>25.8% b</td>
</tr>
<tr>
<td>Low income (100–199% of poverty)</td>
<td>107</td>
<td>96.1</td>
<td>68.2% b</td>
<td>7.5% b</td>
<td>24.3% b</td>
</tr>
<tr>
<td>Middle income (200–399% of poverty)</td>
<td>355</td>
<td>97.3% b</td>
<td>90.1% b</td>
<td>1.7% b</td>
<td>8.2% b</td>
</tr>
<tr>
<td>High income (400% or more of poverty)</td>
<td>390</td>
<td>99.2% b</td>
<td>97.4% b</td>
<td>0.5% b</td>
<td>2.1% b</td>
</tr>
<tr>
<td>Total</td>
<td>961</td>
<td>97.7%</td>
<td>83.5%</td>
<td>7.0%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ tabulations from the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) study.

- a Insurance includes mental health coverage.
- b Significantly different from high income at the 5 percent level.

Does Insurance Coverage Affect Access To Mental Health Care?

Our results suggest that those children most likely to suffer from serious emotional disorders are those least likely to have private health insurance that covers mental health problems. Yet this lack of insurance coverage does not appear to affect the ability of children and youth to obtain mental health services. MECA children with private health insurance coverage are less likely than their counter-

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**DATA WATCH**

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parts with Medicaid coverage or no coverage at all to receive mental health services in the preceding year. One explanation for this result is that children with private insurance are much less likely than children with Medicaid to need mental health services. For children with emotional disorder (n = 132), the differences among groups are smaller and not significant, but even in this group, private insurance does not improve access relative to no insurance (Exhibit 3).

Children in privately insured families may differ in other ways, such as presence of general health conditions or family composition, from those with Medicaid or no insurance coverage. We adjust for these differences in logistic analyses that control for age, race, sex, family income, family composition, impairment score, number of psychiatric symptoms, type of disorder, MECA site, and general health status. Private insurance has a negative and nonsignificant effect on service use relative to no insurance for all categories of service use. The log odds ratio of overall service use was 0.92 for Medicaid (relative to no insurance) and 0.84 for private insurance (relative to no insurance). Neither odds ratio was statistically significant, nor was the difference between Medicaid and private insurance (odds ratio for private insurance relative to Medicaid, 0.91).

Insurance does not seem to play the same enabling role for children in gaining access to mental health services as it does in the general health sector. Previous research has shown that the poor and near-poor with Medicaid use more mental health services than do

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**EXHIBIT 2**

Prevalence Of Serious Emotional Disorder, By Poverty Status, 1992 MECA Sample

<table>
<thead>
<tr>
<th>Percent having serious emotional disorder</th>
<th>Poor</th>
<th>Low income</th>
<th>Middle income</th>
<th>High income</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>25.7</td>
<td>23.3</td>
<td>11.2</td>
<td>9.7</td>
<td>13.6</td>
</tr>
</tbody>
</table>

SOURCE: Authors' tabulations from the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) study.
NOTES: N = 961. Serious emotional disorder is defined as: (1) meets diagnostic criteria for a psychiatric disorder, and (2) functional impairment as measured by a Child Global Assessment Scale score of 68 or below.

* Significantly different from high income at the 5 percent level.
those without any insurance, but, like our results, these studies have found that both groups are at least as likely to use services as are those with private insurance coverage.\textsuperscript{10}

The principal reason for this result lies in the structure of the mental health service system. State and local governments finance more than 25 percent of all mental health expenses in addition to their contribution to the 19 percent of mental health expenses funded through Medicaid.\textsuperscript{11} Furthermore, many mental health services, especially services for children, are provided through state and locally financed nonmental health service systems. The most important single provider of services for children, for example, is the school system. In the MECA sample almost one in ten children surveyed and more than one-quarter of children with disorder reported receiving mental health–related services in schools. Children also receive services from other publicly funded service systems, such as child welfare agencies. This complement of direct, publicly funded services may reduce the role of insurance in assuring access to diagnostic and treatment services for children with mental health problems.

Indeed, even children with private or Medicaid insurance often use services that insurance does not cover. As Exhibit 4 shows, among children who had used any mental health services in the prior twelve months, MECA parents reported that insurance paid for about half of the services. Among those who had used office-based or outpatient services in the prior twelve months, insurance

### Exhibit 3

Children’s Mental Health Service Use In Prior Year, By Insurance Status, 1992 MECA Sample

<table>
<thead>
<tr>
<th>Insurance status</th>
<th>Any use</th>
<th>Any office</th>
<th>Any school</th>
<th>Any medical</th>
<th>Any inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>All children (N = 973)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private mental health insurance</td>
<td>16.1\textsuperscript{a}</td>
<td>6.0%</td>
<td>8.7%</td>
<td>3.2%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Public insurance</td>
<td>28.4</td>
<td>9.0%</td>
<td>17.9%</td>
<td>3.0%</td>
<td>1.5%</td>
</tr>
<tr>
<td>No mental health insurance</td>
<td>20.4</td>
<td>6.5%</td>
<td>12.9%</td>
<td>4.3%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

| Children with serious emotional disorder (n = 132) |         |            |            |             |               |
| Private mental health insurance       | 55.3    | 26.6%      | 34.0%      | 20.2%       | 4.3%          |
| Public insurance                      | 47.6    | 14.3%      | 28.6%      | 4.8%        | 4.8%          |
| No mental health insurance            | 70.6    | 35.3%      | 47.1%      | 11.8%       | 5.9%          |

Source: Authors’ tabulations from the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) study.

Note: Overall service use also includes counselors, religious counseling, and other types of service use.\textsuperscript{a} Significantly different from public insurance at the 5 percent level.
EXHIBIT 4
Insurance Payment For Mental Health Services Among Service Users, 1992 MECA Sample

<table>
<thead>
<tr>
<th></th>
<th>All service users (N = 169)</th>
<th>Children who had used office or outpatient services (n = 61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any mental health insurance</td>
<td>49.7%*(a)</td>
<td>62.3%*(a)</td>
</tr>
<tr>
<td>Private mental health insurance</td>
<td>54.2%*</td>
<td>67.3%*</td>
</tr>
<tr>
<td>Public insurance</td>
<td>63.2</td>
<td>83.3</td>
</tr>
<tr>
<td>Uninsured</td>
<td>5.3*</td>
<td>0.0</td>
</tr>
</tbody>
</table>

SOURCE: Authors’ tabulations from the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) study.
NOTE: Percentage reporting that insurance paid for at least one service.
* Significantly different from 100 percent at the 5 percent level.

paid for fewer than two-thirds of the services—much less than might be expected. Many office and outpatient services provided to children with private mental health coverage or Medicaid were not paid by insurance. The exceptional importance of public funders in this area reduces the role of private insurance as an enabling factor.

It is important to recognize that the MECA data do not allow us to measure the quality or nature of services provided to children with problems. Although insurance may not provide better access to services generally, we cannot say whether insurance provides access to better services.

Conclusions

Our results about the insignificant role of insurance in the child mental health system in 1992 have important implications for understanding the potential and limitations of the recent shift to managed mental health care. Simply shifting Medicaid dollars into managed care may have little effect on total costs or service coordination for children, because so many services are provided in settings that are not covered by insurance. Shifting both Medicaid and state mental health funding into managed care, while providing more opportunities for care management and cost reduction for Medicaid children, also may reduce services to uninsured and privately insured children who currently use the public mental health system. Reductions in the public mental health system may increase the burden on schools, child welfare agencies, and other providers of mental health services to children.
Data analysis was funded by National Institute of Mental Health (NIMH) Grant no. R01 MH52698-01. The authors thank Maritza Rubio-Stipec, Philip Leaf, Sherryl Goodman, and all of the MECA collaborators at NIMH, Emory University, Yale University, Columbia University, and the University of Puerto Rico for the use of these data. Computer support for this study was provided by NIMH Mental Health Clinical Research Center Grant no. MH30906.

NOTES


11. EBRI, Sources of Health Insurance.