Title

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Authors

Maust, Donovan T
Moniz, Michelle H
Zivin, Kara
et al.

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Attitudes about required coverage of mental health care in a US national sample

Donovan Maust,
University of Michigan - Psychiatry, NCRC 016-217W, Ann Arbor, Michigan 48109

Michelle Moniz,
University of Michigan

Kara Zivin,
University of Michigan Medical School - Psychiatry, Michigan

Helen Christine Kales, and
University of Michigan - Psychiatry, 4250 Plymouth Road, Ann Arbor, Michigan 48109

Matthew M Davis
University of Michigan Medical School - Child Health Evaluation and Research Unit, Division of General Pediatrics, Ann Arbor, Michigan

Donovan Maust: maustd@umich.edu

Abstract

Objective—Recent policy initiatives such as the Affordable Care Act and Mental Health Parity and Addiction Equity Act have expanded coverage of mental health services. However, it is unclear to what extent the public supports mandated insurance coverage of mental health care relative to other specific medical services.

Methods—A cross-sectional, national poll of the US adult population. Respondents (n=2124) were asked whether health plans should be required to provide coverage for mental health care and other types of services. Logistic regression was used to assess the association of respondent characteristics with support for coverage.

Results—78% (95% CI=75–81%) of respondents supported mandated coverage of mental health care. This was higher than the level of support for birth control medications, equivalent to dental/tooth care, but lower than all other medical services.

Implications—True parity for mental health care may be limited if public support lags behind that for other medical services.

INTRODUCTION

National dialogue regarding coverage for mental health treatment has accompanied implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) and the

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Affordable Care Act (ACA) (1, 2). The MHPAEA generally applies to public and private employers with >50 employees and requires that the financial requirements applied to mental health and substance use disorder (MHSUD) benefits be “no more restrictive” than the financial requirements applied to medical and surgical benefits (3). Under the ACA, new insurance policies offered through state exchanges and Medicaid must include 10 essential benefits including MHSUD services (4), which must also meet the parity criteria. These legislative acts have helped expand coverage of mental health services, which will likely mean that rates of treatment will continue to rise (5). In addition to these policy initiatives, recent school and campus shootings such as those in Virginia and Connecticut have brought additional attention to access to mental health care, as the young men involved are suspected to have had mental disorders. The perceived connection between mental illness and violence has lent further urgency to calls for improved access to mental health services.

While policy in this area has evolved, it is less clear to what extent public opinion has changed regarding required mental health coverage by insurance plans. In 1998, this journal published an extensive examination of public support for mental health coverage drawn from surveys conducted between 1989 and 1994 (6). Depending on the survey and specific item phrasing, public support for mental health coverage was generally near 80%, whether phrased as support for mental health care in general or as a comparison to treatment for other medical illness. More recently, Barry and McGinty found that 69% of a national sample supported insurance parity for “mental health and drug and alcohol abuse services” (7). Less is known regarding the extent to which the public presently supports coverage for mental health care relative to other specific medical services. Smith et al. published analyses comparing public willingness to pay to avoid mental illness compared to general medical illness (8). While rating mental illnesses (depression and schizophrenia) as relatively more burdensome than general medical illnesses (diabetes, below-the-knee amputation, partial blindness), respondents were willing to pay 40% less to avoid the mental illnesses, suggesting lower willingness to allocate resources for treatment of mental illness.

The history of ACA implementation highlights the importance of public support for policy. Since the legislation’s passing, the ACA has enjoyed a relatively low level of public support, with a larger share of respondents viewing it unfavorably than favorably in national polling (9). This lack of a favorable public attitude has created an environment that has helped sustain political and judicial challenges to the legislation, which would likely be less common if the ACA had significant public support. Therefore, successful implementation of the MHPAEA and essential-benefit provisions of the ACA would benefit from robust public support.

As part of a national survey, we explored factors associated with public support that insurers be required to provide coverage for a variety of medical services including mental health care. As personal experience of mental illness is known to influence support (10), we tested whether prior receipt of care would moderate the association of other characteristics with required support.

METHODS

The sample (n=2124) is from wave 20 of the C.S. Mott Children's Hospital National Poll on Children's Health, fielded November 2013. The survey population is drawn from the KnowledgePanel® (GfK Custom Research North America), a nationally representative online panel established through probability sampling of the civilian, noninstitutionalized US population aged ≥18 years (see Appendix for comparison of survey respondent and US population demographics). Unselected volunteers are not able to join the KnowledgePanel®. Panel members are provided a computer and internet access if they do not already have these. Respondents accrue points upon survey completion, which may be redeemed for small cash awards. The recruitment rate for this panel was 13.2%. For additional general NPCH details and published studies, please see (11).

Upon joining KnowledgePanel®, respondents provide basic demographic information including gender, age, race/ethnicity, educational level, annual income, and insurance status. For this survey, respondents were asked if they think that all US health plans should be required to include coverage for the following services: mental health care; dental/tooth care; birth control medications; preventive services such as mammograms and colonoscopies; preventive screening tests for diabetes or high cholesterol; or recommended vaccinations. In addition, they were asked if they had received medical care in the past three years for depressed mood. The survey completion rate (2124/3504, 61%) was determined using RR1 of the American Association for Public Opinion Research and is consistent with other national household-based surveys (12).

The proportion of respondents that supported each type of service was determined and then compared using an adjusted Wald test. Descriptive statistics were calculated for all items among those who supported mental health care coverage, with logistic regression used to determine associations between single demographic characteristics and support. We used a final regression model to test for interactions between having received prior care for depression and the other demographic characteristics. All analyses used post-stratification sampling weights to draw national inferences and were performed in Stata version 13 (StataCorp); a 2-sided $p<0.05$ was considered statistically significant. The University of Michigan Medical School institutional review board declared this study exempt because respondent data were de-identified.

RESULTS

There were 316 respondents aged 18 to 29 (21%); 930 aged 30–44 (26%); 681 aged 45–59 (27%); and 197 aged ≥60 (26%). Respondents were 52% female. They self-identified as 67% non-Hispanic white, 14% Hispanic, 12% non-Hispanic black, and 8% non-Hispanic other race. 78% of respondents (95% CI=75–81%) supported coverage for mental health care. This was higher than support for birth control medications (66%; CI=63–70%, $p<0.001$) and equivalent to dental care (76%; CI=73–79%, $p=0.12$). The level of support for mental health care was lower than for preventive screening tests for diabetes or cholesterol (85%; CI=82–87%, $p<0.001$), vaccinations (86%; CI=83–88%, $p<0.001$), or preventive services such as mammograms and colonoscopies (86%; CI=84–89%, $p<0.001$).

Results of the unadjusted and adjusted logistic regressions are presented in Table 1. In the multivariable model, support for coverage of mental health care was significantly higher among women, older respondents, non-Hispanic black respondents, and those with private insurance. Having received prior medical care for depressed mood was most strongly associated with supporting mandatory coverage.

The final regression model tested for an interaction between having previously received care for depressed mood and each of the other demographic characteristics. In contrast to the strong association between prior care and support of coverage among non-Hispanic white respondents (reference), support among the Hispanic and non-Hispanic other groups was less associated with prior care (p=.001 and p=.003, respectively). Likewise, in contrast to the association between prior care and support of coverage among those in the lowest annual income group (reference), there was little effect of prior care on support among those reporting annual income great than $100,000 (p=.03).

DISCUSSION

Three-quarters of respondents in this national survey supported mandated mental health coverage in health plans, though support was slightly lower than for more standard medical services. In the adjusted models, support was strongest among respondents who previously received medical care for depressed mood and the oldest age group (≥60 years old). Female and non-Hispanic black respondents were almost more likely to support mandatory mental health coverage. Prior history of treatment for depressed mood a pronounced effect among nearly every demographic group except for respondents that identified as Hispanic and non-Hispanic other, along with those at the highest income level, where support was not moderated by prior care.

Through implementation of the MHPAEA and the ACA, insurance coverage for mental health services has expanded recently. However, since Hanson's synthesis (6) of the issue nearly two decades ago, there have been few updates on the level and nature of public support. In Barry and McGinty's recently-published analyses using the same survey research firm ((7), they found that 69% favored insurance parity, a lower level than the respondents in this sample. Of note, however, respondents in that poll were asked whether they supported coverage for "mental health and drug and alcohol abuse services," and coverage for substance abuse problems generally garners less support (6). In addition, this survey enumerated specific medical services for comparison, which may also account for the differential findings as respondents could compare mental health care to specific services (e.g., vaccination) as opposed to "medical care" generally.

Previous work suggests that non-white and older patients are less likely to receive any mental health treatment (13) and are also less likely to receive treatment in specialty mental health settings (14, 15). It may seem counterintuitive that support for a service would be strongest among those groups less likely to be recipients, but perhaps these groups have encountered obstacles accessing mental health care and are therefore strongly in support of guaranteed coverage. In addition, as older adults have more years of accumulated life experience, it is more likely that they have dealt with mental health problems, either their

own or those of friends or families, and therefore might be more likely to support required coverage. And, consistent with prior work (7, 10), prior personal experience of care was most strongly associated with support for mental health care coverage. The respondents least likely to support mental health coverage were males, in the youngest age group, and white. This lower level of support suggests that these respondents may perceive limited advantages to coverage, despite the fact that they could need and may potentially benefit from such services.

Our findings are limited by their cross-sectional nature, which may not capture evolving perspectives on the issue of mandated mental health care coverage. Another potential limitation is the response rate, although non-response bias should be minimized through post-stratification weighting.

These results suggest that the overall level of public support for mental health benefits as well as the differential compared to support for other medical services is essentially unchanged since Hanson's analysis of nearly 20 years ago (6). While the majority of Americans continue to support coverage of mental health benefits, it still lags slightly behind that for other medical services. This is in keeping with Smith et al.'s analyses where, while respondents rated mental disorders as burdensome, they were less willing to allocate resources for their prevention (8). In addition, these findings compared to those of Barry and McGinty (7) also suggest that support for mental health services continues to be stronger when substance abuse treatment is not explicitly included. While policy regarding mental health coverage has changed recently, these analyses add to the evidence of little change in public support, which continues to be largely driven by personal experience of mental illness. This may pose a challenge to implementing true parity for care of mental health and substance use disorders.

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eAppendix 1: Demographic characteristics of survey respondents (weighted) compared to 2013 US population characteristics

Demographic Factor	Survey Respondents	US Census[a,b]
Gender		
Male, %	48.3	49.2
Female	51.2	50.8
Age		
18–29	21.1	21.9
30–44	25.6	25.5
45–59	27.4	26.8
60+	25.9	25.9
Race/ethnicity		
NH White	66.5	62.6
NH Black	11.7	13.2
NH Other	7.6	6.7
Hispanic	14.1	17.1

[a] gender and ethnicity proportions are for entire US population, not just those ≥18yo.

[b] Current Population Survey, United States Census Bureau, US Department of Commerce. Population estimates: population and housing unit estimates. http://www.census.gov/popest/index.html.

Table 1

Respondent characteristics associated with support of mandated mental health care coverage in health plans.[a]

	Respondents N=2090[b]				Unadjusted Bivariate Analysis		Adjusted Multivariable Logistic Regression	
	Support		Don't Support					
Demographic Factor	**n**	**%[c]**	**n**	**%[c]**	**OR**	**95% CI**	**OR**	**95% CI**
Gender								
Male	676	74	280	26	1	ref	1	ref
Female	929	82	205	18	**1.54[d]**	**1.09–2.17**	**1.48**	**1.04–2.11**
Age								
18–29	221	70	86	30	1	ref	1	ref
30–44	696	75	218	25	**1.30**	**.82–2.05**	1.16	.72–1.88
45–59	522	80	152	20	**1.71**	**1.05–2.77**	1.53	.93–2.54
60+	166	86	29	14	**2.77**	**1.52–5.04**	**2.34**	**1.26–4.35**
Race/ethnicity								
NH White	1115	77	376	23	1	ref	1	ref
NH Black	181	86	24	14	1.87	.97–3.64	**2.09**	**1.03–4.23**
NH Other	121	75	40	25	.89	.49–1.62	1.02	.52–2.01
Hispanic	188	80	45	20	1.23	.70–2.18	1.63	.89–2.96
Educational Level								
HS or less	545	78	175	22	1	ref	1	ref
Some college	492	81	117	19	1.19	.77–1.84	1.15	.72–1.83
Bachelor's or higher	568	77	193	22	.95	.64–1.39	.99	.63–1.56
Annual Income, $								
<30,000	333	78	101	22	1	ref	1	ref
30, <60,000	407	81	115	19	1.24	.76–2.02	1.10	.65–1.87
60, <100,000	421	78	136	22	1.03	.64–1.64	.89	.49–1.60
>/=100,000	444	76	133	24	.91	.56–1.48	.90	.49–1.67
Insurance Status[e]								

	Respondents N=2090[b]				Unadjusted Bivariate Analysis		Adjusted Multivariable Logistic Regression	
	Support		Don't Support					
Demographic Factor	**n**	**%[c]**	**n**	**%[c]**	**OR**	**95% CI**	**OR**	**95% CI**
No Insurance	179	75	92	35	1	ref	1	ref
Private Insurance	1088	81	314	19	**2.27**	**1.43–3.63**	**2.20**	**1.24–3.88**
Public Insurance	329	81	73	19	**2.35**	**1.32–4.18**	1.64	.89–3.01
Medical Care for depressed mood in past 3 years?[f]								
No	1319	76	36	24	1	ref	1	ref
Yes	251	91	36	9	**3.06**	**1.70–5.50**	**2.89**	**1.58–5.28**

Abbreviations: NH, non-Hispanic; HS, high school; CI, Confidence Interval; OR, odds ratio

[a] Support defined as answering "yes" and don't support as answering "no" or "uncertain" to the survey question.

[b] No response provided by 34 of 2124 (1.6%) respondents.

[c] All percentages are weighted to approximate the US population and are calculated on a per-question basis excluding those who were eligible for each question but did not respond.

[d] Bold font denotes statistically significant findings (p<.05).

[e] N=2075

[f] N=2043

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