

# Medicaid Access in Brief: Children's Use of Behavioral Health Services

Untreated mental health conditions in children can disrupt development and affect school readiness and overall well-being, and these conditions can worsen later in life (NIHCM 2005). Additionally, substance use disorders that occur in adolescence can interfere with normal brain maturation, leading to a possible loss of intelligence and impairment of memory or thinking ability (NIDA 2014).

Children enrolled in Medicaid or the State Children's Health Insurance Program (CHIP) are disproportionately affected by behavioral health disorders such as anxiety disorder, depression, autism spectrum disorder, attention deficit disorder, and attention deficit hyperactivity disorder (ADHD) (MACPAC 2015). Other prevalent diagnoses among children enrolled in Medicaid or CHIP include behavioral or conduct problems and substance use disorders (MACPAC 2015).

Medicaid programs are required, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, to cover behavioral health services for children when medically necessary. However, many factors affect a child's access to behavioral health services, including benefit design, provider availability and location, and the perceived stigma associated with seeking care for behavioral health conditions (Child Trends 2013).

This issue brief compares access to behavioral health services for children with Medicaid or CHIP coverage with access for children who are privately insured and uninsured. Using respondent-reported data from the National Health Interview Survey (NHIS), we find that children enrolled in Medicaid or CHIP are more likely to see a mental health professional or general doctor for an emotional or behavioral problem than their privately insured counterparts. In addition, older children are more likely to receive behavioral health care than younger children, and white non-Hispanic children are more likely to receive behavioral health care than Hispanic and black non-Hispanic children.

We also look at the experience of children with household incomes above and below 138 percent of the federal poverty level (FPL) because low income is associated with worse access to care overall as well as with higher rates of both behavioral and medical diagnoses (NCHS 2015).<sup>1</sup> Among children with household incomes at or below 138 percent FPL, source of health care coverage does not affect the likelihood of seeing a mental health professional. However, among children with household incomes above 138 percent FPL, children enrolled in Medicaid or CHIP see mental health professionals at a higher rate than their privately insured counterparts. Finally, we find that children with special health care needs enrolled in Medicaid or CHIP access behavioral health services at higher rates than their privately insured counterparts.<sup>2</sup>



The measures used in this analysis (which are described in the methods section), do not account for differences in need among children or potential differences in the quality of the services received. Although some children use more behavioral health services than others, rates of use do not necessarily correlate with need. However, low utilization rates by some population subgroups may be an indicator of unmet need.

## Children’s Access to Behavioral Health Care by Insurance Status

### Age

Regardless of age, children enrolled in Medicaid or CHIP were more likely to see a mental health professional or doctor for an emotional or behavioral problem than their privately insured counterparts (Table 1). However, older children were more likely to receive behavioral health care regardless of insurance type.<sup>3</sup> These findings are consistent with studies showing that older children are more likely to be identified as having behavioral health conditions such as ADHD, behavioral or conduct disorders, and depression, and to have higher suicide rates than younger children (CDC 2013). Thus, higher use mirrors prevalence of diagnosed behavioral health disorders.

**TABLE 1.** Percentage of Children Age 0–18 Who Accessed Selected Behavioral Health Services, by Age Group, 2007 and 2014

Age and insurance status	2007		2014	
	Seen or talked to mental health professional, in past 12 months	Seen or talked to general doctor for emotional or behavioral problems, in past 12 months	Seen or talked to mental health professional, in past 12 months	Seen or talked to doctor for emotional or behavioral problems, in past 12 months
<b>Children age 5–11</b>				
Medicaid/CHIP	9.2%	8.2%	10.9%	9.9%
Private	6.4*	4.7*	6.8*	4.9*
<b>Children age 12–18</b>				
Medicaid/CHIP	13.2	9.4	14.0	9.4
Private	8.9*	6.0*	8.3*	5.1*

**Notes:** Mental health professionals in this question included psychiatrists, psychologists, psychiatric nurses, and clinical social workers.

\* Difference from Medicaid/CHIP is statistically significant at the 0.05 level.

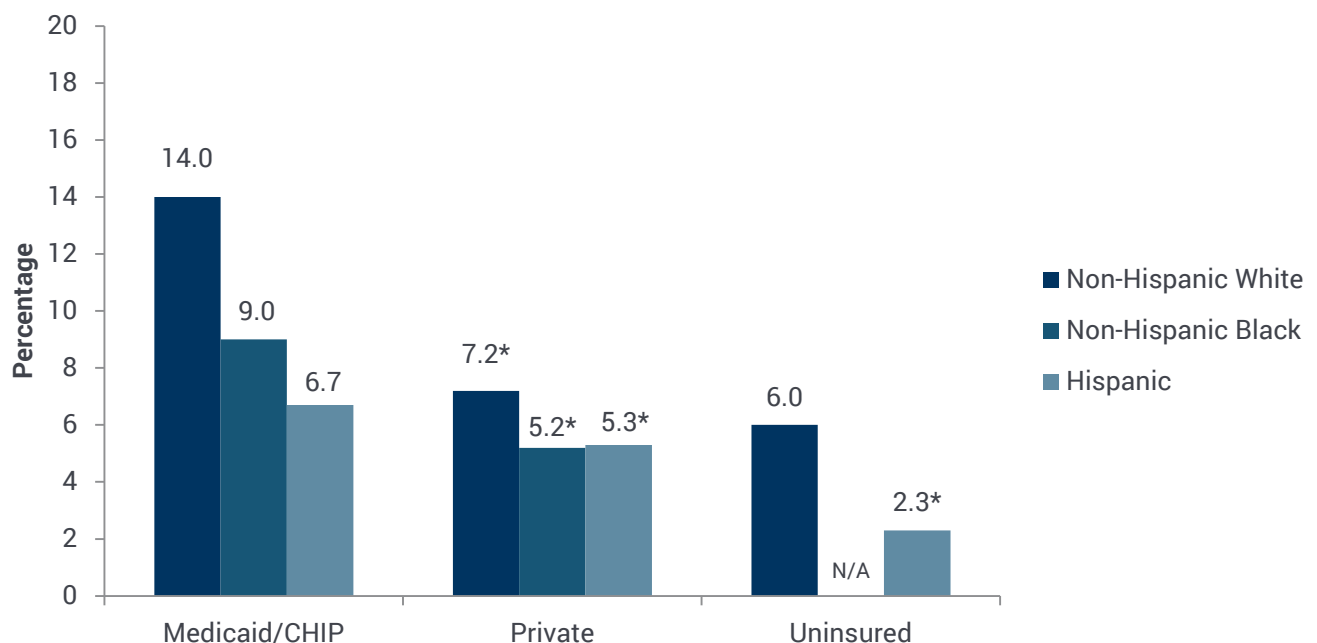
**Source:** MACPAC 2015 analysis of National Health Interview Survey, 2007 and 2014.



## Race and ethnicity

Regardless of race and ethnicity, children enrolled in Medicaid or CHIP saw mental health professionals at higher rates than privately insured children or uninsured children (Figure 1). Additionally, within each insurance type, white non-Hispanic children received behavioral health care at higher rates than Hispanic and black non-Hispanic children. White non-Hispanic children are in fact diagnosed with behavioral health disorders such as ADHD and autism or autism spectrum disorder at higher rates, and they commit suicide at higher rates, than Hispanic and black non-Hispanic children (CDC 2013). Hispanic and white non-Hispanic children are more likely to have an alcohol or illicit drug use disorder than black non-Hispanic children, but black non-Hispanic children are more likely to be diagnosed with a behavioral or conduct problem (CDC 2013).

**FIGURE 1.** Percentage of Children Age 0–18 Who Saw or Talked to a Mental Health Professional in the Past 12 Months, by Race and Ethnicity and Insurance Status, 2012–2014



**Notes:** N/A indicates that estimate is unreliable because it has a relative standard error of more than 30 percent.

\* Difference from white non-Hispanic, within insurance status, is statistically significant at the 0.05 level.

**Source:** MACPAC 2015 analysis of National Health Interview Survey, 2012–2014.

## Income level

Among children with household incomes at or below 138 percent FPL, there was no significant difference in the percentage of children who saw a mental health professional in the past 12 months between those with Medicaid or CHIP coverage and those with private insurance (Table 2). However, among children with incomes above 138 percent FPL, those enrolled in Medicaid or CHIP saw a mental health professional at a higher rate than their privately insured counterparts. Regardless of source of coverage, children with lower



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household incomes are more likely to be diagnosed with behavioral health disorders (e.g., ADHD), a behavioral or conduct problem, or anxiety than with higher household incomes (CDC 2013).

**TABLE 2.** Percentage of Children Age 0–18 Who Accessed Selected Behavioral Health Services, by Income Level and Insurance Status, 2007–2009 and 2012–2014

Insurance status	2007–2009		2012–2014	
	Seen or talked to mental health professional, in past 12 months	Seen or talked to general doctor for emotional or behavioral problems, in past 12 months	Seen or talked to mental health professional, in past 12 months	Seen or talked to doctor for emotional or behavioral problems, in past 12 months
<b>All income levels</b>				
Medicaid/CHIP	9.1%	6.7%	9.7%	7.3%
Private	6.4*	4.0*	6.5*	3.7*
Uninsured	4.0*	3.2*	4.0*	3.0*
<b>≤ 138% FPL</b>				
Medicaid/CHIP	8.6	6.7	9.1	7.6
Private	7.4	6.4	7.2	3.7*
Uninsured	3.7*	N/A	3.5*	N/A
<b>&gt; 138% FPL</b>				
Medicaid/CHIP	9.9	6.8	11.1	6.5
Private	6.3*	3.9*	6.4*	3.7*
Uninsured	4.2*	3.6*	4.3*	3.6*

**Notes:** FPL is federal poverty level. N/A indicates that estimate is unreliable because it has a relative standard error of more than 30 percent. Mental health professionals in this question included psychiatrists, psychologists, psychiatric nurses, and clinical social workers.

\* Difference from Medicaid/CHIP, within income category, is statistically significant at the 0.05 level.

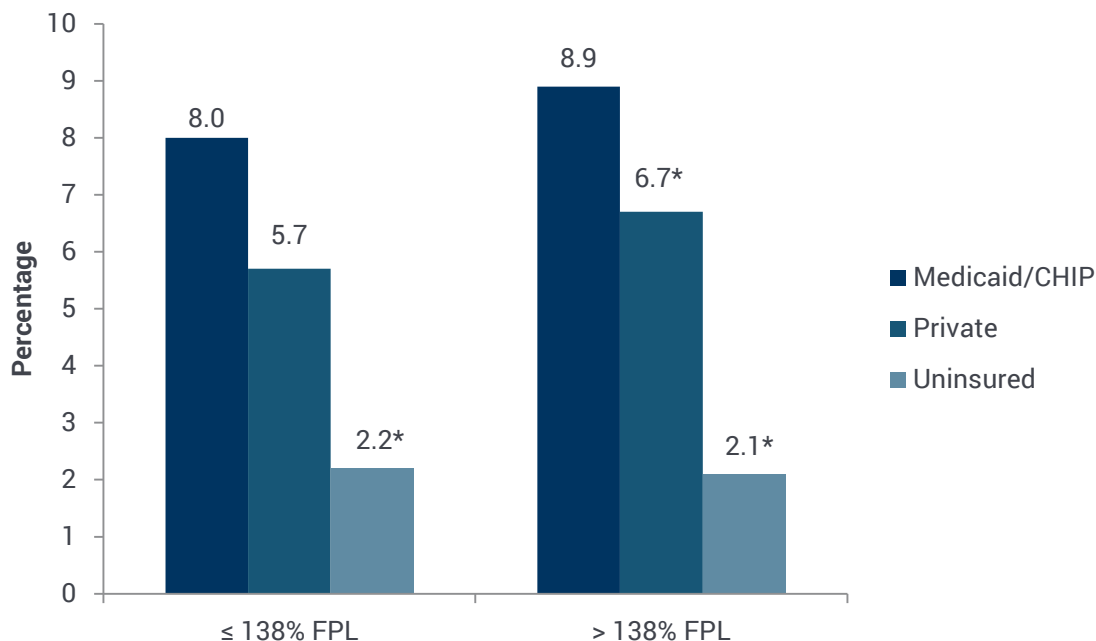
**Source:** MACPAC 2015 analysis of National Health Interview Survey, 2007–2009 and 2012–2014.

Children enrolled in Medicaid or CHIP were prescribed medication for mental difficulties at a higher rate than privately insured children of the same household income level, consistent with findings that these children had more provider visits (Figure 2).<sup>4</sup> Among children enrolled in Medicaid or CHIP, the highest proportion of psychotropic medication users are those eligible on the basis of disability, followed by children eligible on the basis of child welfare assistance, such as foster care (MACPAC 2015). When used appropriately, psychotropic medications are a part of current evidence-based mental illness treatment (Seixas et al. 2012, Smith et al. 2007). However, overprescribing of psychotropic medications has been a



concern due to evidence about short- and long-term safety and efficacy of these medications in children (GAO 2012).

**FIGURE 2.** Percentage of Children Age 0–18 Prescribed Medication for Mental Difficulties in the Past 6 Months, by Income Level and Insurance Status, 2013



**Notes:** FPL is federal poverty level. Mental difficulties was the term used in the National Health Interview Survey (NHIS) to describe difficulties with emotions, concentration, behavior, or being able to get along with others.

\* Difference from Medicaid/CHIP, within income category, is statistically significant at the 0.05 level.

**Source:** MACPAC 2015 analysis of NHIS, 2013.

Regardless of income, uninsured children reported more problems affording mental health care than children enrolled in Medicaid or CHIP, although from 2007–2009 to 2012–2014, uninsured children with incomes above 138 percent FPL saw a decrease in these problems (Table 3). Overall, such problems were rare across income and insurance categories.

**TABLE 3.** Percentage of Children Age 0–18 Who Reported They Were Unable to Afford Mental Health Care or Counseling, by Income Level and Insurance Status, 2007–2009 and 2012–2014

Income and insurance status	2007–2009	2012–2014
<b>All income levels</b>		
Medicaid/CHIP	1.1%	0.9%
Private	0.7*	0.7
Uninsured	3.4*	2.0*
<b>≤ 138% FPL</b>		
Medicaid/CHIP	1.1	0.9
Private	N/A	N/A
Uninsured	3.9*	3.6*
<b>&gt; 138% FPL</b>		
Medicaid/CHIP	0.9	1.0
Private	0.7	0.7
Uninsured	3.1*	0.8

**Notes:** FPL is federal poverty level. N/A indicates that estimate is unreliable because it has a relative standard error of more than 30 percent.

\* Difference from Medicaid/CHIP, within income category, is statistically significant at the 0.05 level.

**Source:** MACPAC 2015 analysis of National Health Interview Survey, 2007–2009 and 2012–2014.

## Special health care needs

Children with special health care needs include those who have or are at increased risk for developing a chronic behavioral condition, including those with other conditions who may or may not need behavioral health care services in addition to ongoing medical care (Ganz and Tendulkar 2006). More than one-third of children with a special health care need have a mental health issue that requires treatment (CHIRI 2009).

Regardless of source of coverage, children with special health care needs use behavioral health services at higher rates than those without special health care needs (Table 4). However, many families of children with special health care needs do not perceive that their children needed mental health services, possibly due to the amount of time and attention paid to these children’s other health needs (CHIRI 2009).

Among children with special health care needs, those enrolled in Medicaid or CHIP accessed behavioral health care at higher rates than their privately insured counterparts in 2014 (Table 4). This may reflect the better coverage due to EPSDT. In 2014, among children without special health care needs, there was no



significant difference between the percentages of Medicaid-enrolled and privately insured children who saw a mental health professional or talked to a doctor about emotional problems.

**TABLE 4.** Percentage of Children Age 0–18 Who Accessed Selected Behavioral Health Care, by Special Health Care Needs and Insurance Status, 2007 and 2014

Child characteristics and insurance status	2007		2014	
	Seen or talked to mental health professional, in past 12 months	Seen or talked to general doctor for emotional or behavioral problem, in past 12 months	Seen or talked to mental health professional, in past 12 months	Seen or talked to doctor for emotional or behavioral problem, in past 12 months
<b>Children with special health care needs</b>				
Medicaid/CHIP	32.5%	20.6%	34.8%	24.8%
Private	30.3	19.2	28.2*	16.5*
<b>Children without special health care needs</b>				
Medicaid/CHIP	1.7	1.7	3.4	2.6
Private	2.9*	1.9	3.1	1.8

**Notes:** Mental health professionals in this question included psychiatrists, psychologists, psychiatric nurses, and clinical social workers.

\* Difference from Medicaid/CHIP, within each special health care needs category, is statistically significant at the 0.05 level.

**Source:** MACPAC 2015 analysis of National Health Interview Survey, 2007 and 2014.

## Data and Methods

All differences discussed in the text of this brief are computed using Z-tests and are significant at the 0.05 level.

### Data sources

Data for this report come from the National Health Interview Survey (NHIS) and the Household Component of the Medical Expenditures Panel Survey (MEPS-HC). NHIS data were collected continuously throughout the year for the Centers for Disease Control and Prevention’s National Center for Health Statistics by interviewers from the U.S. Census Bureau. The NHIS collects information about the health and health care of the U.S. civilian non-institutionalized population. Interviews are conducted at respondents’ homes, and follow-up interviews may be conducted by phone. The MEPS-HC is a nationally representative longitudinal survey that collects detailed information on health care utilization and expenditures, health insurance, and health status, as well as on a wide variety of social, demographic, and economic characteristics for the U.S. civilian non-institutionalized population. For more information on the NHIS, see



[http://www.cdc.gov/nchs/nhis/about\\_nhis.htm](http://www.cdc.gov/nchs/nhis/about_nhis.htm). For more information on the MEPS-HC see [http://www.meps.ahrq.gov/mepsweb/about\\_meps/survey\\_back.jsp](http://www.meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp).

## Insurance coverage

The following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, uninsured for the past 12 months. Not separately shown are the estimates for those covered by any type of military health plan or other government-sponsored program. Coverage source is defined as of the time of the survey interview. Because an individual may have multiple coverage sources and because sources of coverage may change over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this brief. Private health insurance coverage excludes plans that cover only one type of service, such as accident or dental insurance. The Medicaid or CHIP category also includes persons covered by other state-sponsored health plans. Medicaid and CHIP coverage are combined because it was determined through validation processes that respondents could not accurately distinguish between the two programs. Individuals were defined as uninsured if they did not have any private health insurance, Medicaid, CHIP, Medicare, state- or other government-sponsored health plan, or military plan during the past year. Individuals were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accident or dental coverage only.

## Children with special health care needs

In both the NHIS and the MEPS, children with special health care needs are identified through a series of questions that ask about the need for or use of medicines prescribed by a doctor; the need for or use of more medical care, mental health, or education services than is usual for most children; being limited in or prevented from doing things most children can do; the need for or use of special therapy such as physical, occupational, or speech therapy; and the need for or use of treatment or counseling for emotional, developmental, or behavioral problems. Parents or other respondents who responded yes to any of the initial questions in the sequence were then asked to respond to up to two follow-up questions about whether the health consequence was attributable to a medical, behavioral, or other health condition lasting or expected to last at least 12 months. Children with positive responses to all of the follow-up questions for at least one of the five health consequences were identified as having a special health care need.

## Access questions

Three of the questions analyzed were chosen as indicators of how much behavioral health care was received by children of differing insurance types and income levels and by children with special health care needs. An additional question focused on barriers to accessing behavioral health care. Point estimates were calculated using sample weights, and corresponding variances accounted for the complex sample design of the NHIS. All estimates shown in this report have a relative standard error of less than or equal to 30 percent.





## Endnotes

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<sup>1</sup> The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) set the mandatory income eligibility threshold for all children at 138 percent FPL; prior to the ACA, the mandatory eligibility levels for children in Medicaid differed by age—states were required to cover infants and children age 1–5 in Medicaid up to 133 percent FPL and children age 6–18 up to 100 percent FPL. Despite being eligible, some children do not enroll and remain uninsured. In 2012, an estimated 2.4 million uninsured children (45.1 percent of uninsured children) were eligible for public coverage and had income under 138 percent FPL (Kenney et al. 2015). The ACA set a single income eligibility disregard equal to 5 percentage points of the FPL. For this reason, eligibility is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL. The federal poverty level in 2014 for a family of four was \$23,850, and the income threshold for 138 percent of FPL was \$32,913 (ASPE 2014).

<sup>2</sup> Children with special health care needs are children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally (Bethell et al. 2008).

<sup>3</sup> Making a behavioral health diagnosis in a young child can be challenging because these children often cannot express their thoughts and feelings in the same way as older children and adults. Additionally, because children are constantly changing and growing, diagnosis and treatment should be viewed with these changes in mind (NIMH 2009). Because of these difficulties, few children under age five in our sample had a behavioral health diagnosis, and thus the age group was excluded from our analysis.

<sup>4</sup> The term mental difficulties was used in the National Health Interview Survey to describe difficulties with emotions, concentration, behavior, or being able to get along with others. This question was asked in 2008–2013 surveys only.

## References

Assistant Secretary for Planning and Evaluation (ASPE). 2014. 2014 Poverty Guidelines. <http://aspe.hhs.gov/2014-poverty-guidelines>.

Bethell, C.D., D. Read, S.J. Blumberg, et al. 2008. What is the prevalence of children with special health care needs? Toward an understanding of variations in findings and methods across three national surveys. *Maternal and Child Health Journal* 12, no. 1: 1–14. <http://www.ncbi.nlm.nih.gov/pubmed/17566855>.

Centers for Disease Control and Prevention (CDC). 2013. Mental health surveillance among children—United States, 2005–2011. *Morbidity and Mortality Weekly Report* 62, no. 2. <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm>.

Child Health Insurance Research Initiative (CHIRI), Agency for Healthcare Research and Quality (AHRQ), David and Lucille Packard Foundation, and Health Resources and Services Administration. 2009. *Mental health needs of low-income children with special health care needs*. AHRQ Publication No. 09-0033. Rockville, MD: AHRQ. <http://www.ahrq.gov/sites/default/files/wysiwyg/cpi/initiatives/chiri/Briefs/brief9/brief9.pdf>.

Child Trends. 2013. *Access to Mental Health Care*. Publication no. 2013-2. Bethesda, MD: Child Trends. <http://www.childtrends.org/contact-us/>.



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Ganz, M.L., and S.A. Tendulkar. 2006. Mental health care services for children with special health care needs and their family members: Prevalence and correlates of unmet needs. *Pediatrics* 117, no. 6: 2138–2148.  
<http://www.ncbi.nlm.nih.gov/pubmed/16740858>.

Kenney, G.M., J.M. Haley, N. Anderson, et al. 2015. Children eligible for Medicaid or CHIP: Who remains uninsured and why? *Academic Pediatrics* 15, no. 3S: S36–S43.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. *Report to Congress on Medicaid and CHIP*. June 2015. Washington, DC: MACPAC. <https://www.macpac.gov/publication/june-2015-report-to-congress-on-medicaid-and-chip/>.

National Center for Health Statistics (NCHS). 2015. *Health, United States, 2014: With special feature on adults aged 55–64*. Hyattsville, MD: NCHS. [http://www.cdc.gov/nchs/data/14.pdf](http://www.cdc.gov/nchs/data/hus/14.pdf).

National Institute for Health Care Management (NIHCM) Foundation. 2005. *Children's mental health: An Overview and key considerations for health system stakeholders*. Washington, DC: NIHCM Foundation. <http://www.nihcm.org/pdf/CMHReport-FINAL.pdf>.

National Institute of Mental Health (NIMH), National Institutes of Health, U.S. Department of Health and Human Services. 2009. *Treatment of children with mental illnesses: Frequently asked questions about the treatment of mental illness in children*. NIH Publication No. 09-4702. Bethesda, MD: NIMH. [http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/nimh-treatment-children-mental-illness-faq\\_34669.pdf](http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/nimh-treatment-children-mental-illness-faq_34669.pdf).

National Institute on Drug Abuse (NIDA), National Institutes of Health (NIH). 2014. *Principles of adolescent substance use disorder treatment: A research-based guide*. NIH Publication No. 14-7953. Bethesda, MD: NIH. [https://teens.drugabuse.gov/sites/default/files/podata\\_1\\_17\\_14\\_0.pdf](https://teens.drugabuse.gov/sites/default/files/podata_1_17_14_0.pdf).

Seixas, M., M. Weiss, and U. Muller. 2012. Systematic review of national and international guidelines on attention-deficit hyperactivity disorder. *Journal of Psychopharmacology* 2, no. 6: 753–765.

Smith, L.A., V. Cornelius, A. Warnock, et al. 2007. Effectiveness of mood stabilizers and antipsychotics in the maintenance of bipolar disorder: A systematic review of randomized controlled trials. *Bipolar Disorders* 9, no. 4: 394–412.

U.S. Government Accountability Office (GAO). 2012. *Children's mental health: Concerns remain about inappropriate services for children in Medicaid and foster care*. Report no. GAO-13-15. Washington, DC: GAO. <http://www.gao.gov/assets/660/650716.pdf>.

