

Gender differences in cost barriers to mental health care among insured adults: findings from Integrated Health Interview Series, 1998-2010.

Although health insurance reduces financial barriers to care, it does not necessarily eliminate such barriers. Many individuals still perceive cost to be a barrier to mental health care. The past few years have seen dramatic changes in the delivery of mental health care. On the one hand, parity legislations means that health plans that offer mental health benefits are required to offer them on par with general medical care benefits. This may potentially reduce barriers to mental health treatment. On the other hand, the number of individuals with managed care plans for mental health continues to increase and such plans may set limits on services or use a number of administrative means to lower utilization, thereby potentially increasing barriers to access (Merrick et al, 2008).

Findings from this study can help address current concerns regarding the inadequacy of most private health insurance plans in providing mental health care. Private insurance plans are the benchmark for the Essential Benefit Package (ESB) in the Patient Protection and Affordable Care Act. The scale of the problem of cost barriers among those with private suggests reevaluating the use of private plans as the standard for mental health care. Newly covered individuals receiving services through private insurance may face an unmet need for care if they are forced to pay out of pocket for services not covered by private plans or if plan limitations do not meet their needs. Understanding who is at risk for cost barriers to care now will improve the chances of new enrollees receiving adequate care.

Cost barriers may be more of an issue in access to mental health care for women than men due to their lower socioeconomic status and occupational class. These affect the quality of health insurance plan benefits available. Women are also more likely to seek mental health services, creating a greater number that face cost barriers. Further, once in treatment, women are 70 percent more likely to drop out of outpatient treatment for depression, though it is unclear why (Olfson et al., 2009). Cost barriers may be one potential explanation. Cost barriers may also partially explain gender differences in patterns of use of services. For example, lower use of specialty services among women may be related to higher copays for specialty services.

Previous studies have documented that gender differences in cost barriers to medical care due to occupational class, income and education (Long, Stockely and Shulman, 2009; Salganicoff and Wyn, 1999), but most research has examined barriers to care in the public sector. It is important to look at barriers to care in the private sector, as it accounts for 42 percent of the total expenditure on mental health (with public sector paying for 58 percent) (Mark, et al., 2011). The extent of class, education and income, alongside other possible predictors (such as health status) among those with private insurance has not been examined. Further, changes in the cost barriers for mental health care between men and women over time have also not been examined.

This study expands upon a previous study which examined trends treatment and cost barriers to care using National Health Interview Survey data (Mojitbai, 2005). Mojitbai found that while access to mental health services increased between 1997 and 2002, the proportion of persons in need who reported not being able to afford mental health care increased from about 15 percent to 20 percent (Mojitbai, 2005). The author also reported that women are more likely than men to report cost barriers to access, but did not explore the reasons for this gender difference, and concluded that without wide-reaching improvements in health insurance coverage, barriers would increase in the overall population. This study provides the opportunity to examine the growth in cost barriers to care between men and women.

Our study focuses on the working age (age 18 to 64) population with private insurance, as we are interested in employment-related coverage. We also examine difference in access to mental health treatment within a sub-group, the most severe cases (scores above 19 on the Kessler -6 scale). Need is greatest among those with the most severe problems, and this group is more likely to be affected by co-pays and benefit limits compared to less severe forms. We believe that for those with severe problems, there are severe consequences from any unmet need for care in this population (McVeigh and Wunsch-Hitzig, 2006).

Methods:

Data for this study come from the Integrated Health Interview Series, which was created from National Health Interview Survey data to facilitate trend analysis of the health of the U.S. population. While the NHIS is conducted annually, around 70 percent of studies using NHIS data only examine one year of data. The NHIS captures a rich profile of its respondents which allows us to incorporate demographic characteristics of race and ethnicity and many additional factors, including health status, usual source of care, and characteristics of the insurance plan and occupational category.

We begin by examining trends, from 1998 to 2010, in gender differences in the percentage of respondents who perceived a cost barrier to getting mental health care in the past year among working age adults (19-64) who have private insurance. We describe trends for those with any psychological distress, as measured through the Kessler-6 scale, which quantifies non-specific psychological distress (SPD). The questions in the scale ask respondents about sadness, nervousness, hopelessness, restlessness and worthlessness and effort for activities in the past 30 days. Table 1 shows trend in the proportion of privately insured men and women with any psychological distress, who experienced a cost barrier in the past year.

Survey year	Women		Men	
	Mean Cost Barrier	95% CI	Mean Cost Barrier	95% CI
1998 (n=1,286)	0.066	[0.047,0.085]	0.056	[0.035,0.078]
1999 (n=1,122)	0.088	[0.066,0.109]	0.037	[0.017,0.056]
2000 (n=1,240)	0.1	[0.078,0.122]	0.053	[0.030,0.077]
2001 (n=1,553)	0.071	[0.054,0.088]	0.054	[0.037,0.072]
2002 (n=1,125)	0.094	[0.073,0.116]	0.061	[0.034,0.087]
2003 (n=1,150)	0.112	[0.086,0.138]	0.069	[0.043,0.095]
2004 (n=1,169)	0.113	[0.089,0.138]	0.095	[0.070,0.121]
2005 (n=1,171)	0.12	[0.093,0.148]	0.098	[0.060,0.137]
2006 (n=851)	0.127	[0.091,0.164]	0.08	[0.037,0.122]
2007 (n=704)	0.17	[0.127,0.214]	0.082	[0.042,0.123]
2008 (n=801)	0.128	[0.094,0.161]	0.089	[0.048,0.129]
2009 (n=928)	0.123	[0.085,0.162]	0.073	[0.046,0.099]

In our second analysis, we include the predictors of cost barriers among those with any PD who have private insurance. Cost barriers to care vary by sociodemographic characteristics and

health status and we therefore included age, occupation, marital status, race, income, family size, and education in our models. As most private insurance is obtained from employers and benefit design varies by employer type, we also include a variable to capture firm size as a proxy for the scope of private coverage under group insurance plans. We then examine how gender differences in cost barriers have varied over time and what factors have moderated barriers to care over time. Below are the unadjusted odds of a cost barrier.

Unadjusted Odds of A Cost Barrier to Mental Health Care Among Individuals On Private Insurance				
Ref year =1998	Women		men	
Cost Barriers	OR	SE	OR	SE
1999	1.36	0.205	0.64	0.344
2000	1.18*	0.195	0.95	0.296
2001	1.08	0.202	0.97	0.252
2002	1.47	0.208	1.08	0.304
2003	1.79**	0.198	1.27	0.286
2004	1.80**	0.208	1.77*	0.261
2005	1.93**	0.209	1.82*	0.305
2006	2.05**	0.231	1.45	0.359
2007	2.89**	0.223	1.49	0.341
2008	2.05**	0.222	1.63	0.327
2009	1.97**	0.241	1.31	0.284
**p<.05, *p<.10				

In a final analysis, we use a decomposition framework to separate any disparities in cost barriers into observed and unobserved components between men and women (Shen and Long, 2006). We decompose the male-female difference in probabilities of experiencing a cost barrier into one part which is due to differences in observed characteristics of men and women, such as income and insurance coverage, and another part which is due to differences in unobserved factors (a single "unexplained" component). The "unexplained" component may reflect preferences for seeking care or perception of the financial impact of expenditures.