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Shortage of Insurance Coverage for Mental Health Care Among Adolescent Patients

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Abstract

Recent efforts to reform behavioral and mental health care policies from the federal and state levels have changed slowly. One notable milestone occurred with the passage of the Affordable Care Act (ACA) in 2010, which mandated that insurance companies, including those operating through the Health Insurance Marketplace, offer coverage for mental health services and substance abuse. This is a step forward in integrating behavioral health into the U.S. care delivery system. In addition, at the State level, California has also implemented policy reforms to address gaps in care. The lack of access for adolescents is especially detrimental during their developmental period, when most mental health disorders first emerge, is concerning. Although recent policy reforms have aimed to expand access and equity, adolescents remain disproportionately underserved compared to other age groups. This is especially concerning given that most lifetime mental health disorders emerge during adolescence, making timely intervention critical to long-term well-being. Yet, many adolescents continue to face significant challenges, including limited provider networks, long wait times, and cost-related barriers. By comparing adolescents with Medi-Cal to those with commercial insurance and to their adult counterparts, this study addresses an urgent gap in understanding how systemic insurance structures may contribute to persistent inequities. The findings aim to inform policy efforts to expand adolescent-appropriate services, ensure insurance accountability, and build a more responsive behavioral health workforce.

Keywords: Adolescents, barriers to mental health care, Medi-Cal, equity in access to mental health care

Introduction

Despite recent efforts to reform behavioral and mental health care policies from the federal and state levels, change remains slow. One notable milestone occurred with the passage of the Affordable Care Act (ACA) in 2010, which mandated that insurance companies, including those operating through the Health Insurance Marketplace, offer coverage for mental health services and substance abuse. This is a step forward in integrating behavioral health into the U.S. care delivery system. In addition, at the State level, California has also implemented policy reforms to address gaps in care. In March 2024, California voters approved Proposition 1, which included a comprehensive initiative designed to modernize and expand the state's mental health infrastructure and resources **[3]**. The new policy, known as the Behavioral Health Services Act and Behavioral Health Bond, replaced the outdated Mental Health Services Act of 2004. The new policy introduced several reforms aimed at increasing the availability and effectiveness of behavioral and mental health care across the state. It also allocated $6.4 billion in funding which is to be invested directly in behavioral and mental health treatment, with a focus on underserved populations **[3]**.

Lack of access for adolescents is especially detrimental during their developmental period, when most mental health disorders first emerge is concerning. According to Solmi et al. (2022), a meta-analysis of 192 global epidemiological studies found that roughly one-third of mental health disorders begin before age 14, nearly half by age 18, and over 60% by age 25, with the most common onset around age 14.5. Due to this, adolescents are within a critical age window for mental health interventions. However, our current behavioral health systems often fail to address these needs swiftly. Early intervention during adolescence can significantly improve long-term outcomes, making it essential to address the structural and system barriers that prevent this population from accessing care. To effectively address these barriers and support early intervention, it is critical that we examine the underlying factors driving those trends **[11]**.

It has also been suggested that social media adds to the increased issue that networking platforms have fundamentally altered how adolescent individuals interact, perceive each other, and navigate and manage social expectations. Social media has become an essential part of everyday life, often shaping identities, social status, and acceptance among peers. It has also led to vastly increased mental health challenges, such as low self-esteem issues, anxiety, and depression. The risk of depression increased by 13% for each hour increase in

social media use and those with the highest levels of social media use were 59.6% more likely to experience symptoms of depression compared to the control group **[7]**.

The adolescent behavioral health workforce is equally responsible for access issues, with few graduate programs offering robust clinical training focused on adolescent mental health. Addressing the needs of this population requires professionals with specialized training in adolescent development and mental health. Alarmingly, this is the expertise that the current health care system lacks in sufficient quality to meet this population's rising demands. There are approximately 14 child and adolescent psychiatrists per 100,000 individuals (American Academy of Child and Adolescent Psychiatry, n.d.). Further exacerbating the workforce instability, the professionals in the field frequently experience high emotional strain, with many exiting due to burnout and compassion fatigue. Providers who regularly experience emotional exhaustion and secondary traumatic stress due to ongoing exposure to client trauma have much higher frequencies of job dissatisfaction and reduced sustainability rates **[9]**.

Mental health disorders in children and adolescents are known to be highly prevalent, yet undertreated due to not seeking or accessing the help that is crucial to addressing this gap. According to Radez et.al. (2020), almost one in seven young people meet diagnostic criteria for mental health disorders and the author further notes that untreated mental health disorders in children and adolescents are related to adverse health, academic and social outcomes, higher levels of drug abuse, self-harm and suicidal behavior and often persist in adulthood. Almost all studies (96%) reported barriers related to young people's individual factors, such as limited mental health knowledge and broader perceptions of help-seeking. The second most reported theme (92%) was related to social factors, for example, perceived social stigma and embarrassment.

The third theme captured was young people's perceptions of the therapeutic relationship with professionals (68%) including perceived confidentiality and the ability to trust an unknown person. The fourth theme was related to systemic and structural barriers and facilitators (58%), such as financial costs associated with mental health services, logistical barriers, and the availability of professional help. The findings highlight the complex array of internal and external factors that determine whether young people seek and access help for mental health difficulties. In addition to making effective support more available, targeted evidence-based interventions are required to reduce perceived public stigma and improve young people's knowledge of mental health problems and available support, including what to expect from professionals and services **[10]**.

Purpose of Research

Children and adolescent mental health are major public health concerns in the U.S. and 20% of U.S. children have a reported mental health condition, while an estimated 40% will be diagnosed with one by age 18. Despite these concerns, little is known about major factors associated with access to mental health services among children and adolescents **[8]**. In California, the Behavioral Health Services Act (SB 326) directs HCAI to implement a comprehensive behavioral health workforce initiative to build and support a robust and diverse behavioral health workforce capable of providing high-quality, holistic services to all Californians **[2].** Therefore, the purpose of this research is to evaluate the persistent barriers that adolescents in California face when accessing behavioral and mental health services, with particular attention to disparities based on insurance type.

Although recent policy reforms have aimed to expand access and equity, adolescents remain disproportionately underserved compared to other age groups. This is especially concerning given that most lifetime mental health disorders emerge during adolescence, making timely intervention critical to long-term well-being. Yet, many adolescents continue to face significant challenges, including limited provider networks, long wait times, and cost-related barriers. By comparing adolescents with Medi-Cal to those with commercial insurance and to their adult counterparts, this study addresses an urgent gap in understanding how systemic insurance structures may contribute to persistent inequities. The findings aim to inform policy efforts to expand adolescent-appropriate services, ensure insurance accountability, and build a more responsive behavioral health workforce.

Problem Statement

According to WHO (2025), globally, one in seven 10-19-year-olds experiences a mental disorder accounting for 15% of the global burden of disease in this age group. Depression, anxiety and behavioral disorders are among the leading causes of illness and disability in the adolescent group. Adolescents in California face persistent and multifaceted barriers to accessing timely and effective behavioral and mental health services. Among these barriers that affect access to mental health care are systemic challenges that surround low reimbursement rates for mental health care services. Despite programs that are aimed at achieving parity in behavioral and mental health insurance benefits, reimbursement rates remain inadequate and reimbursement for behavioral and mental health services continues to fail to meet reimbursement rates equivalent to those of medical-surgical services **[6]**.

Emotional disorders are common among adolescents. Anxiety disorders (which may involve panic or excessive worry) are the most prevalent in this age group and are more common among older than among younger adolescents. It is estimated that 4.1% of 10–14-year-olds and 5.3% of 15–19-year-olds experience an anxiety disorder **[13]**. Depression is estimated to occur among 1.3% of adolescents aged 10–14 years and 3.4% of 15–19-year-olds. Depression and anxiety share some of the same symptoms, including rapid and unexpected changes in mood. Anxiety and depressive disorders can

profoundly affect school attendance and schoolwork. Social withdrawal can exacerbate isolation and loneliness. Depression can lead to suicide **[13]**. Compounding this issue are burdensome administrative requirements, such as obtaining prior authorizations for therapy along with undergoing utilization review. These procedures can delay care initiation, disrupt therapeutic continuity, and discourage families from pursuing care entirely. Additionally, while many commercial insurance plans provide some mental health coverage, they often shift significant financial burdens onto members through high out-of-pocket costs.

Research Significance

California Mental Health Parity Act, as amended in 2020, requires all state-regulated commercial health plans and insurers to provide full coverage for the treatment of all mental health conditions and substance use disorders. Both state and federal laws require health plans to provide treatment for mental health and substance use disorder conditions. Most recently amended in 2020; California's Mental Health Parity Act requires commercial health plans and insurers to provide full coverage for the treatment of all mental health conditions and substance use disorders. It also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) require commercial health plans that offer mental health and substance use benefits to do so in a manner comparable to medical and surgical benefits. MHPAEA prevents health plans that provide mental health or substance use benefits from placing limits on those benefits that are less favorable than the limits placed on medical/surgical benefits. More specifically, health plans must ensure that financial requirements, such as copayments, coinsurance, deductibles, and treatment limitations, such as the number and frequency of visits, which are applied to mental health or substance use disorder benefits, are not more restrictive than the predominant requirements applied to most of the medical and surgical benefits **[1]**.

This research is essential for deepening understanding of the structural barriers, specifically insurance related limitations and provider shortages, afflicting the adolescent population. As rates of psychological distress and unmet mental health needs continue to rise among youth, it is essential to examine the effectiveness of recent policy reforms and identify where gaps in access persist. By focusing on both insurance type and provider availability, this study offers a nuanced analysis of the real-world challenges adolescents face within a fragmented care system. Importantly, the study contributes empirical evidence on how different insurance models, specifically Medi-Cal versus commercial insurance, influence access to care for adolescents compared to adults. These findings can help inform future policy reforms aimed at improving mental health equity across insurance types, especially for populations that are already developmentally vulnerable.

Conceptual Framework of Research

The Behavioral Model for Vulnerable Populations (BMVP) which is an extension of Andersen's Behavioral Model of Health Services Use and accounts for the unique challenges faced by underserved populations influence this research. This model organizes health service utilization into three different domains, which include predisposing factors, enabling factors, and need factors **[5]**. For this research, predisposing factors include the highly specific developmental vulnerabilities that adolescents have, such as social pressures, identity issues, peer acceptance, and social stigmas. These factors shape how adolescents perceive themselves and their mental health along with their willingness to accept help. Need factors are represented by the rising prevalence of anxiety, depression, suicidal ideation, and other behavioral health conditions among adolescents, raising concerns for a growing demand for specialized care.

The focus of this research is mainly on the enabling factors that influence whether individuals can access care once a need is established. These factors include insurance and provider availability. Adolescent patients with commercial insurance are disproportionately burdened by narrow networks and higher costs of care, while the overall shortage of adolescent-trained providers exacerbates access further. By using the BMVP framework to examine these structural and systemic barriers, this research identifies how policy and insurance design can influence adolescent access to behavioral and mental health services. Additionally, this model can be used to demonstrate the need for an expansion in the mental health workforce and advance the equity of adolescent behavioral health care **[5]**.

Research Methodology, Design and Dataset

The California Health Interview Survey (CHIS) is the largest state-level health survey in the United States, conducted by the UCLA Center for Health Policy Research. It gathers data through a dual-mode collection strategy that includes random-digit-dial (RDD) telephone interviews and online surveys. The 2023 CHIS was administered in English, Spanish, Chinese (Mandarin and Cantonese), Korean, and Vietnamese, enhancing inclusivity and representativeness. The survey's comprehensive design, including oversampling of underrepresented populations and detailed measures on dental access and insurance coverage, makes it highly suitable for studying oral health disparities. Its complex, multistage sampling methodology enables general estimates across California's diverse demographic and geographic groups.

This Research utilizes a comprehensive dataset that offers critical insights into the behavioral and mental health status of individuals across the state of California. The 2023 adolescent dataset included

responses from 1,045 participants, while the 2023 adult dataset comprised data from 23,697 participants. CHIS is known for being one of the largest state health surveys in the nation and is designed to collect population-level data and provide valuable information on a wide range of health-related issues, including access to and utilization of mental health services, perceived barriers to care, and the prevalence of mental health conditions among individuals. For this research, CHIS was particularly essential in identifying disparities and inequities that adolescent individuals face related to insurance and provider availability compared to those of adults. The survey utilizes random sampling and collects responses through both telephone and web-based questionnaire modalities. The survey is also offered in several languages to ensure an accurate representation of the state's population is obtained **[12]**.

Statistical Analysis

For the statistical analysis conducted for this research, IBM SPSS Statistics software was used to explore the relationships between key variables within the 2023 California Health Interview Survey (CHIS) datasets. The analysis focused on variables related to access to behavioral and mental health services, type of health insurance, and age group. Prior to conducting statistical tests, the datasets were carefully combed. Respondents who skipped relevant questions or whose responses were marked as "inapplicable" were excluded to enhance the accuracy and reliability of the findings. As a result, the final sample sizes were adjusted to 947 adolescent respondents for the first hypothesis (insurance type comparison), and 22,639 respondents, 968 adolescents and 21,655 adults, for the second hypothesis (age group comparison) **[12]**.

The analysis began with the use of descriptive statistics to summarize the distribution of variables, including frequencies and standard deviations, providing an overview of respondent characteristics and patterns of care access. To examine the relationship between categorical variables, a Chi-Square Test of Independence was performed to determine whether statistically significant associations existed between adolescent insurance type, age groups, and access to care. Cramér's V coefficients were also calculated to assess the strength of the associations. Lastly, logistic regression was used to estimate the odds of adolescents or adults experiencing unmet mental health care needs based on their insurance type and age group, allowing for a more comprehensive and predictive understanding of these variables. This combination of methods provided insight into the barriers faced by adolescents in accessing behavioral and mental health services. A detailed summary of statistical analysis and research design can be seen below in **Table 1.**

Table 1: Summary of Statistical Analysis and Research Design

Hypothesis	Dependent Variable	Independent Variable	Statistical Test
Adolescent individuals in California with employment-based and privately purchased insurance face greater barriers to access to behavioral and mental health care than those with Medi-Cal.	Access to Behavioral/Mental Health Services	Insurance Type	Descriptive, Chi Square w/ Cramer's V
Adolescents in California experience more significant barriers to accessing behavioral and mental health services compared to adults.	Access to Behavioral/Mental Health Services	Age Group	Descriptive, Chi Square w/ Cramer's V, Logistic Regression.

Independent and Dependent Variables

The dependent variable in this research is access to behavioral and mental health care, which was examined across both hypotheses. Two independent variables are used as part of this analysis. For the first hypothesis, the independent variable is the type of health insurance held by the adolescent participant, which was categorized as either Medi-Cal, employment-based commercial insurance, or privately purchased commercial insurance through the health insurance marketplace. For the second hypothesis, the independent variable is the age group of the participants, comparing both adolescents and adults to assess differences in access to care between populations.

Research Hypotheses

This study hypothesizes that adolescents in California face significant barriers to accessing behavioral and mental health services with disparities that are shaped by both insurance type and age. Specifically, adolescents covered under employment-based or privately purchased insurance policies are expected to encounter greater challenges in obtaining necessary care compared to those enrolled with Medi-Cal. These such as higher out-of-pocket costs, limited provider networks, challenges may stem from factors and slower policy adaptations within commercial insurance plans relative to public coverage. Furthermore, adolescents as a population are expected to face more frequent and severe access barriers than adults,

due to an insufficient number of trained providers specializing in adolescent care highlighting a critical gap in the delivery of services for younger populations.

Analysis and Findings

The analysis aimed to explore disparities in access to behavioral and mental health care among adolescents in California and the focus is on insurance and provider availability. Descriptive statistics showed that 7.1% of respondents' participants (n=968) reported delaying or forgoing needed mental health care. Key findings:

- Most of the adolescent respondents were insured through employment-based plans (64.5%),
- Followed by Medi-Cal (31.8%), and
- Private purchase insurance (3.7%).

To examine whether insurance type significantly influenced access, a Chi-Square test for Independence variable revealed that no statistically significant association between insurance type and delays in care (χ^2 (2) = 1.798, p = 0.407, Cramér's V of 0.044); indicating a very weak effect. These results suggest that insurance type did not significantly predict delays in adolescent behavioral and mental health care with this sample.

When comparing adolescents to adults, only 7.1% of adolescents had delayed care versus 10.0% of adults, initially suggesting that adults were more likely to report unmet needs. However, when examining respondents who attested to experiencing psychological distress in the previous 12 months, disparities became much more apparent. Among adolescents who experienced psychological distress (31.8% of the sample), 45 out of 69 (65.2%) respondents had delayed care representing which shows a statistically significant association at (χ^2 (1) = 38.203, p = < 0.001, Cramér's V = 0.199). Interestingly, when examining the adults that attested to psychological distress in the last 12 months (2.89% of the sample), 625 out of 1531 (40.8%) respondents also had delays in care, resulting in a significant association (χ^2 (1) = 688.300, p = < 0.001, Cramér's V = 0.178). Logistic regression confirmed this relationship that adolescent individuals who experienced psychological distress were 4.53 times more likely to have delayed care (OR = 4.534, 95% CI [2.707, 7.595], p < .001). Similarly, adults who experienced psychological distress were 3.75 times more likely to have delayed care (OR = 3.746, 95% CI [3.375, 4.158], p < .001). These findings indicate that, although insurance type was not a significant predictor of access barriers, adolescents in need of behavioral and mental health care were more likely to experience delays in receiving services compared to adults, emphasizing a critical age-related disparity in access to services.

Limitations to this Research

One key limitation of this study concerns the differences in verbiage of the CHIS survey questions between adolescent and adult versions. Although the survey aimed to measure comparable data across age groups, slight variations in phrasing may influence how respondents interpreted and answered the questions. This inconsistency could compromise the validity of direct comparisons between adolescent and adult responses. Additionally, the adolescent sample size (n = 968) was significantly smaller than the adult sample size (n = 21,655), which may have impacted the statistical power of the analysis. A smaller sample increases the risk of Type I error in the first hypothesis (rejecting a null hypothesis that is true) or Type II error in the second hypothesis (accepting a hypothesis that is false). These limitations suggest that findings should be interpreted with caution and highlight the importance of future studies to further validate results.

Discussion and Conclusions

This research underscores the persistent and multifaceted barriers that adolescents in California face in accessing behavioral and mental health services. Despite recent policy reforms mandating expanded insurance coverage, limitations persist such as workforce shortages, inadequate reimbursement, and narrow provider networks. These factors continue to hinder timely access to care. Adolescents, as a uniquely vulnerable population, require developmentally appropriate and culturally responsive services that are currently insufficiently available. Addressing these disparities will require coordinated efforts to expand the mental health workforce, reform insurance structures, and enhance regulatory oversight. Without targeted, sustained interventions and further research, the state risks widening the gap in care for a generation already at heightened risk for mental health challenges.

This research did demonstrate significant results when comparing adolescent and adult population access to care. While initial comparisons suggested adults were more likely to report delayed care overall (10.0% vs 7.1% in adolescents), more detailed analysis revealed that adolescents who attested to psychological distress and needed care were significantly more likely to experience unmet mental health needs. Specifically, 65.2% of adolescents experienced delayed care, compared to 40.8% of adults. The magnitude of this association was confirmed further through logistic regression, with adolescents 4.53 times more likely to have delayed care compared to adults that were just 3.75 times more likely. These results likely highlight the well-documented shortage of mental health professionals trained to work with adolescent populations.

While this research did not yield statistically significant differences in adolescents' access to behavioral and mental health care by insurance type, the findings still point to broader systemic issues that warrant further observation. However, with this information we have access to, it can be concluded that other factors may influence access and that coverage alone is not sufficient to determine barriers. Additionally, the lack of statistical significance could be due to limited sample size or overlapping structural challenges. Further research is needed to explore how different insurance models interact

with systemic barriers and to identify targeted reforms that prioritize reducing delays and expanding adolescent-focused behavioral health care statewide.

One area of concern that needs to be explored is the narrow scope of mental health provider networks within both public and private insurance plans. Mental health providers are far less likely to than other medical professionals to participate in insurance networks, often citing low reimbursement rates and burdensome administrative requirements as deterrents. Due to the complexity of care needed for adolescent mental health treatment, service needs are often excluded from standard benefit designs or reimbursed at too low a rate to support provider participation **[14]**. As a result, insufficient access to care remains despite adequate insurance coverage. To address these gaps in care, policymakers need to consider more targeted reformations to incentivize provider participation in adolescent mental health care. These may include increased reimbursement rates for adolescent-specific services and stronger mandates for network adequacy that specifically address the complexities of care that could be needed for adolescent populations.

To combat these network inadequacies, state regulators such as the California Department of Managed Health Care (DMCH) need to play a more central and active role in auditing networks. More recently, the DMHC has increased its scrutiny of commercial insurers in recent years in relation to timely access standards and mental health parity. In 2022, the DMHC enforcement reportedly identified multiple commercial health plans that were failing to provide adequate access to behavioral health services, a violation of the Knox-Knee Act which is California law that helps maintain regulatory standards across health care service plans **[4]**. By strengthening regulatory mechanisms, such as routine audits, public performance reporting, and enforcing timely access to care, adolescents in California may receive equitable behavioral care regardless of their insurance type. The intensive nature of youth behavioral and mental health care services, which often requires family systems engagement, coordination with schools, and specialized developmental training, creates both a high burden of care and high investment levels to provider with entry and retention. As a result, even with adequate insurance coverage, the availability of providers is limited, leading to significant bottlenecks in access to care during critical windows of psychological needs. These findings have critical implications for the mental health workforce and policy design. While expanding insurance coverage may be necessary to further improve access to care, it is insufficient without simultaneous investment in training new adolescent mental health professionals.

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