



Policy brief

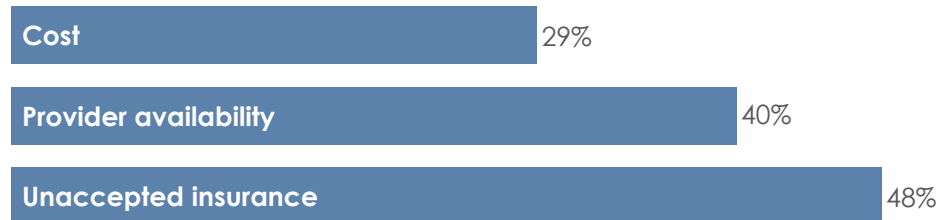
4 Insurance coverage and affordability of mental healthcare for Ohio children and youth

Many young Ohioans experience mental health challenges, and families often have difficulty navigating the mental healthcare and insurance systems. For some families in Ohio, having a health insurance plan is not enough to overcome barriers to access. Figure 1 displays the most common barriers children with unmet mental healthcare needs have when accessing care, including that nearly half had issues with providers not accepting their insurance.

3 Key findings for policymakers

- 1 **Mental healthcare can be expensive.** Costs can accumulate even if a family has insurance due to coverage gaps, high patient cost responsibilities and the need to see a provider who is not in their health plan's network.
- 2 **Mental health provider shortages across Ohio can be worsened due to insurance practices** such as low provider reimbursement rates, administrative burdens and insurers not covering certain mental health provider types.
- 3 **Children in need of mental health treatment have access to different services and supports based on insurance type.** Some children with commercial insurance do not have access to certain mental health services or models of care.

Figure 1. **Reasons for unmet mental healthcare need among Ohio children, ages 0-18, 2023**



Note: Questions were asked of parents/caregivers who reported that their child did not receive needed mental health treatment. They were also asked about transportation and several other factors, and could have answered "yes" to more than one of these barriers.

Source: HPIO analysis of the Ohio Medicaid Assessment Survey

HPIO's Child and Youth Mental Health policy brief series

- released December 2024 **Brief 1** **Mental health conditions among Ohio children and youth** presents prevalence data
- released July 2025 **Brief 2** **Factors contributing to child and youth mental health struggles** explores the impacts of smartphones and social media; housing instability and homelessness; and children's services and/or foster care system involvement
- released December 2025 **Brief 3** **Access to mental healthcare for Ohio children and youth** analyzes treatment capacity across Ohio
- This brief ▶ Brief 4** Examines health insurance coverage, cost of care and how they influence access to mental health services

Building on HPIO’s [Access to mental healthcare for Ohio children and youth](#), this brief examines how the cost of mental healthcare and aspects of insurance coverage can affect mental healthcare access for young Ohioans. Specifically, the brief describes:

- Costs and affordability of mental healthcare services
- Provider availability
- Insurance coverage limitations

Accessing needed mental health treatment is important, especially for children, because mental health conditions often continue into adulthood.¹ However, policymakers and employers must also consider cost implications when making decisions involving insurance coverage. It is possible that policy decisions to improve access to care will increase insurance premiums or costs of other healthcare services.² Policymakers must also balance the upfront costs of prevention and early care with the long-term costs of complications from untreated mental health conditions.³

▶ Health insurance among Ohio children and youth

Figure 2. **Health insurance status and type among Ohio children, ages 0-18, 2023**



Source: HPIO analysis of Ohio Medicaid Assessment Survey data

In 2023, 96% of Ohio children under age 18 had some form of health insurance, as displayed in figure 2. However, having insurance does not always mean that a child can access treatment. For example, some insurance plans are not required to cover mental health services. In 2022-2023, 5.3% of Ohio youth, ages 12-17, had commercial (i.e., private) insurance that did not cover treatment for mental or emotional problems.⁴ HPIO’s [Mental Health Parity policy explainer](#) provides more information about laws prohibiting insurers from making access to behavioral healthcare more restrictive than medical or surgical care.

In addition, even with insurance, out-of-pocket costs for mental health services can be unaffordable for many families. Commercial health insurance plans often include an annual deductible, an amount of money the patient must pay out of pocket before insurance starts to pay (often followed by co-payments or co-insurance⁵). In 2021-2023, 93% of Ohio private sector employees with employer-sponsored health insurance had a deductible.⁶ Approximately 60% of these employees had a high-deductible health plan (HDHP)⁷, which means that they have a higher annual deductible than traditional health plans, but monthly premiums are generally lower. The average deductible for families with HDHPs was \$5,384 in 2021-2023.⁸

Regulation of commercial health insurance in Ohio

Regulation of commercial health insurance is split between the state and federal governments. The Ohio Department of Insurance (ODI), the state’s insurance regulatory agency, does not regulate all private health insurance plans operating in the state. As of 2026, ODI estimated that it had jurisdiction over 11% of Ohio’s health insurance market.⁹

Self-insured plans, in which the employer assumes financial responsibility for employees’ health benefits by paying for claims directly, are regulated at the federal level by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA). Self-insured plans represented 38% of the Ohio health insurance market in 2022.¹⁰

Although self-insured, the state employee health insurance plans are regulated by ODI (as specified in the Ohio Revised Code). The Ohio Department of Administrative Services manages these plans, which includes making decisions regarding benefits offerings and provider contracting.



Mental healthcare costs

Summary

Healthcare for mental health issues can be expensive, and as many mental health conditions are chronic, they often require ongoing treatment. Costs of care and prescription drugs can accumulate quickly with or without insurance. Costs can be especially high when a child needing treatment:

- Sees a provider who has not contracted with the family's insurance plan (called an out-of-network provider)
- Does not have health insurance or the family's insurance plan does not cover a needed service, both of which would require the family to pay the full cost of care
- Has a high-deductible health plan, which requires the family to pay the majority of care costs until meeting a certain amount (i.e., deductible)

It is more common for patients to receive care from out-of-network providers for behavioral health services than for medical or surgical services (as displayed on page 5). This can have considerable cost implications.

There are various sources of public funding for mental health prevention and treatment for Ohio youth in addition to insurance reimbursement and patients' out-of-pocket payments. Some include federal grants, state funding and local levies.

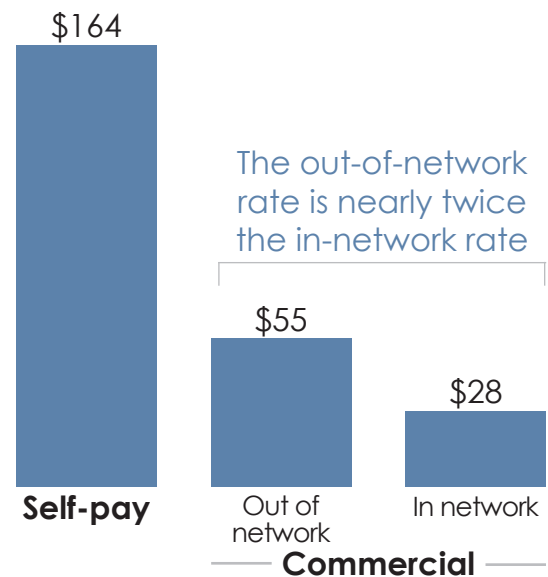
Healthcare, including healthcare for mental health issues, can be expensive, and families can struggle to meet the ongoing costs of care. Seeing a provider who has contracted with the family's insurance plan, known as an in-network provider, can make care more affordable.

As displayed in figure 3, the average out-of-pocket cost for an individual 60-minute therapy appointment with an in-network provider was \$28 in 2021 for an Ohioan with commercial insurance. Seeing an out-of-network provider was nearly twice the cost. A 60-minute therapy appointment would cost \$164 for someone without health insurance or someone who chooses to pay without insurance (i.e., self-pay).

These costs can add up quickly. For example, if a child needs to receive treatment from an out-of-network provider for therapy once a week (i.e., four times a month), the family would pay an average of \$220 per month.

HDHPs generally have higher out-of-pocket costs than traditional health plans.¹¹ For example, the cost of therapy for someone with an HDHP may be closer to the self-pay amount but somewhat discounted for in-network providers based on negotiations between the insurer and provider.¹²

Figure 3. **Average out-of-pocket cost for an individual 60-minute psychotherapy visit, 2021**



Note: Data used for this analysis was primarily for large group commercial insurance members.

Source: Analysis of Milliman's Consolidated Health Cost Guidelines Database as reported in Access across America: State-by-state insights into the accessibility of care for mental health and substance use disorders. December 2023

Mental health service cost examples

As a point of reference, figure 4 contains OhioGuidestone's charges for various services for someone without insurance or whose insurance plan does not cover the services. OhioGuidestone is the state's largest community behavioral health provider that is not a federally qualified health center.

Figure 4. OhioGuidestone approximate charges for select services

Therapeutic Behavioral Services <ul style="list-style-type: none"> • Involves care coordination, treatment planning, evidence-based symptom management, daily functioning support and crisis prevention • Provided by licensed clinicians and qualified mental health specialists • Can be a stand-alone service or in conjunction with psychotherapy 	\$142 (per hour)
Group Psychotherapy	\$41 (per hour)
Day Treatment Group (i.e., partial hospitalization) <ul style="list-style-type: none"> • Intensive, structured program to stabilize a mental health condition • Several hours per day, multiple times per week without requiring overnight stays • Often used as a step down from inpatient care 	\$206 (per day, which is 2.5 hours of services)

Note: These costs do not take into consideration commercial plan variations, co-pays, deductibles or sliding fee eligibility. OhioGuidestone reported that all services listed are typically not covered or are inconsistently covered by commercial insurance.

Source: Provided by OhioGuidestone in March 2026

▶ Prescription drugs

Prescription drugs are a common part of mental health treatment plans, and their costs can also accumulate quickly. When a person or family experiences difficulty paying for medications, they may choose to split pills, delay refills or discontinue medications, which can have negative effects.¹³

Insurers use practices, such as those listed below, to ensure the clinical appropriateness of medications and to contain costs:

- Step therapy — Requiring patients to try lower-cost drugs before brand-name or specialty drugs
- Prior authorization — Requiring the insurer to approve the healthcare provider's prescription before dispensing
- Multi-tier formularies — List of drugs that the insurer will cover and at what rate; specialty drugs are often put on a higher tier, requiring patients to pay a larger share of the cost

However, these practices can cause delays and serve as barriers to obtaining affordable medications.¹⁴

Funding for mental health treatment for children in Ohio

In addition to provider reimbursement from insurers, including Medicaid and private insurers, and patient payments, there are various other streams of public funding for mental health prevention and treatment services for Ohio youth:

- **Federal grants** from several agencies within the U.S. Department of Health and Human Services (e.g., Substance Abuse and Mental Health Services Administration and the Administration for Children and Families) to states, health facilities, non-profit organizations and other partners to support behavioral health.¹⁵
- **Disadvantaged Pupil Impact Aid and Student Wellness and Success Funds**, allocated by the Ohio Department of Education and Workforce using a funding formula established by state law, are used to support student academic success, health and wellness, including mental health.¹⁶

Funding (cont.)

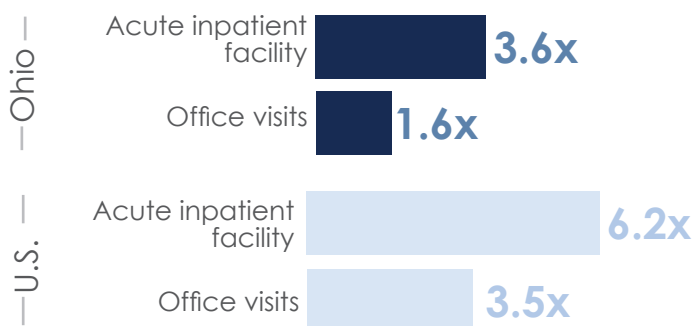
- **Allocations to the Alcohol, Drug and Mental Health (ADAMH) Boards** via the Department of Behavioral Health (DBH) from sources such as the General Revenue Fund, Dedicated Purpose funds and federal awards.¹⁷ DBH has [Community Funding Program Guidelines](#) outlining allowable uses of certain funding streams and eligibility requirements, among other information.¹⁸
- **ADAMH Board levies** (i.e., property taxes), via authority granted by the state, can be used by the Boards for a variety of purposes, including supplementing the general fund to make appropriations for human, health or social services.¹⁹ As of 2021, 78 counties had an ADAMH levy.²⁰ Ohio is considering several changes to property taxes, including eliminating them entirely, which would limit or prevent Boards from issuing levies in the future and could considerably reduce their ability to fund mental health treatment.

▶ Out-of-network utilization

It is more common for patients to receive care from out-of-network providers for behavioral health services than for medical or surgical services (see figure 5). However, these differences are not as extensive in Ohio as in the overall U.S. As described previously, seeing out-of-network providers is more expensive.

A child may need to see an out-of-network provider when no in-network providers have availability or in-network providers' offices are too far away.

Figure 5. **Ratio of out-of-network utilization for medical/surgical to behavioral health, by provider type, Ohio, 2021**



In 2021, an Ohio patient was 1.6 times more likely to see an out-of-network provider for a behavioral health office visit and 3.6 times more likely to go to an out-of-network provider for inpatient behavioral healthcare. However, these disparities are worse in the overall U.S.

Source: Behavioral Health Parity - Pervasive Disparities in Access to In-Network Care, April 2024



Provider availability

Summary

There are critical mental health provider shortages across the state. Several factors, described below, can worsen access gaps:

1. There are some mental healthcare provider types for which many commercial plans will not reimburse. This decreases the number of providers available to children with commercial insurance.
2. Behavioral health clinicians in Ohio are reimbursed an average of 18% less than medical or surgical clinicians. Further, commercial insurance reimbursement rates are generally lower than Ohio Medicaid rates.
3. Administrative burdens, such as credentialing and billing complexity and navigating care denials, can strain provider capacity and lead to burnout. These factors, in addition to low reimbursement rates, lead some providers to not accept insurance and instead require patients to self-pay, which is out of reach for many families.

Ensuring that insurance plans have adequate and accurate provider networks is important for assuring affordable access to care. Policies can be implemented to improve network adequacy and accuracy.

As described in HPIO's [Access to mental healthcare for Ohio children and youth](#) brief, there are critical mental health provider shortages across the state. The challenges described in this section can worsen the access gaps caused by these shortages, including several policies and practices that influence the extent to which providers participate in insurance networks.

▶ Provider reimbursement eligibility

There are various types of mental health providers permitted to deliver services in Ohio, and a child's care may involve more than one provider type. In addition to psychiatrists, psychologists, therapists, social workers and primary care practitioners, care teams may include the following provider types:

- **Qualified mental health specialists (QMHSs)** are non-licensed individuals who have received training or education in mental health and/or substance use disorder (SUD) and recovery skills. They work under supervision of a licensed practitioner. There are currently no credentials in Ohio for these practitioners, but there is legislation pending in the 136th General Assembly [[House Bill \(HB 718\)](#)] to create a credential. Credentials demonstrate that a provider has met state-required standards of training and expertise.²¹
- **Peer recovery specialists** have lived experience with behavioral health challenges and receive training to help others impacted by similar challenges. There are [three types of certification available in Ohio](#): Adult, family and youth/young adult.

All of these provider types are eligible for reimbursement from Ohio Medicaid, at least for certain services.

However, many commercial plans do not reimburse for services from QMHSs, peer recovery specialists or independently licensed practitioners.²² Psychologists, therapists and social workers are dependently licensed if they have completed required graduate education (generally a master's degree) but are still practicing under supervision. To become independently licensed, they must have practiced for several years with a supervisor and passed an examination.

In 2022, the Ohio Department of Insurance commissioned NovaRest Actuarial Consulting to conduct a [behavioral health benefits study](#). It showed that 14 of 20 surveyed commercial insurers (70%) reported they do not explicitly cover services provided by non-licensed mental health and SUD professionals. Most of the insurers that contracted with non-licensed providers (five of six) were also Medicaid managed care organizations (MCOs),²³ and these providers would likely be in their Medicaid networks.

Commercial insurers cite quality concerns as a primary reason for limiting contracting to only licensed independent providers. Other possible reasons may include additional administrative complexity (e.g., tracking supervision) and controlling for legal and fraud risk.²⁴

According to Ohio providers serving on HPIO's **Child Mental Health Advisory Group**, when commercial plans do cover them, dependently licensed practitioners are reimbursed at a lower rate or are required to have a supervisor physically onsite when services are provided.²⁵ These practices limit the number of available providers for commercial enrollees and may preclude them from certain supports and care models.

▶ Provider reimbursement rates

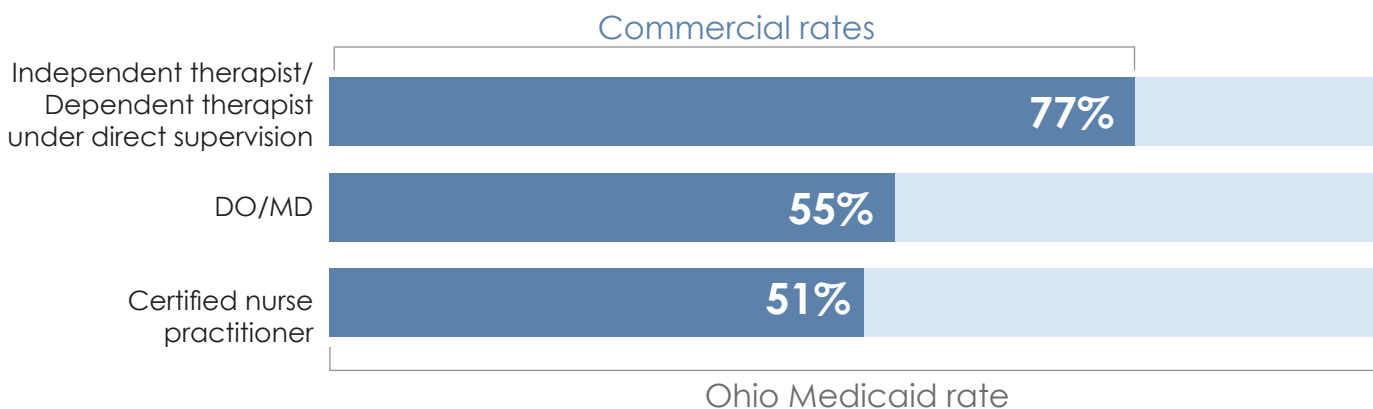
An analysis by RTI International that compared commercial reimbursement rates using Medicare fee-for-service rates as a common benchmark found that behavioral health clinicians in Ohio are reimbursed an average of 18% less than medical or surgical clinicians for an office visit.²⁶

Experts²⁷ interviewed by the U.S. Government Accountability Office (GAO) point to low reimbursement rates as a primary factor contributing to providers not joining insurance networks.²⁸ Some providers choose not to accept insurance and instead require patients to self-pay, which is out of reach for many families. In a 2024 survey conducted by the American Psychological Association, one-third (34%) of psychologists in the U.S. reported not being in-network with any insurance types.²⁹ Most of these providers (82%) cited insufficient reimbursement rates as a barrier to participating in insurance networks. Administrative issues and concerns about payment reliability (e.g., payment delays or refund demands) were the next most common reasons.

Ohio providers on HPIO's **Child Mental Health Advisory Group** report that commercial reimbursement rates for behavioral health services are generally lower than Ohio Medicaid rates.³⁰ For example, OhioGuidestone shared the reimbursement data displayed in figure 6. OhioGuidestone representatives stated that even though Medicaid rates are above commercial reimbursement rates, most still do not cover the organization's costs to provide care.

Figure 6. Commercial insurance reimbursement rates received by OhioGuidestone as a percentage of Ohio Medicaid rates, March 2026

Average revenue received from commercial insurers as a percentage of revenue received from Ohio Medicaid for OhioGuidestone's most common behavioral health services, by licensure type



Note: OhioGuidestone calculated revenue across licensure types by using the reimbursement rates across the most common procedural codes (30, 60 and 90-minute psychotherapy and diagnostic evaluations for the therapist licensures; and established patient with moderate complexity, CPT 99214, for DO/MD/CNP). For commercial insurance revenue, negotiated rates from the top three commercial insurers were weighted based on fiscal year (FY) 2025 revenue volume. The procedural codes were also weighted based on their FY 2025 revenue percentages.

Source: Provided by OhioGuidestone in April 2026

▶ Administrative factors

In addition to low reimbursement rates, other factors contribute to providers' decisions regarding contracting with insurers, such as³¹:

- **Complex credentialing processes:** Different credentialing requirements and processes among insurance plans can be time-consuming and cumbersome.
- **Billing complexity:** Benefits and coverage can vary greatly from one insurance plan to the next. Navigating this complexity can strain provider capacity. Some must hire additional staff to navigate billing and care denials, as described below.³²
- **Utilization management practices** (e.g., prior authorization, step therapy requirements, post-service claim reviews): These techniques can delay or limit patient care, and managing care denials can contribute to provider burnout and administrative burden.³³ Additionally, post-service denials (i.e., an insurer denying a claim after the service was provided) can result in claw-backs (i.e., requirements for providers to collect and pay money back to the insurance companies). These can be especially burdensome for smaller providers.³⁴

In addition to limiting access to care, the time spent managing these administrative challenges also represents additional costs to the mental healthcare system.

A 2020 GAO study found that increases in state Medicaid reimbursement rates for SUD treatment increased provider supply, and states with larger increases saw more gains.³⁵ However, research has not consistently shown increases in provider supply due to reimbursement increases. Several studies found that perceived costs associated with administrative factors temper the effectiveness of reimbursement increases on provider participation in insurance networks.³⁶

▶ Network adequacy

Network adequacy refers to an insurance plan having sufficient numbers and types of providers to ensure enrollees can access care within a reasonable amount of time.

Ohio Medicaid has network adequacy requirements in its agreements with MCOs that are partially federally required. These include standards related to time and distance to reach a provider, timing for appointment availability and the number of providers per county. The MCOs are also required to continually monitor network adequacy and take corrective action when needed.³⁷

There are also federal network adequacy requirements for health insurance plans sold on the federal health insurance marketplace, and the large national insurance plan accreditation bodies, such as the National Committee for Quality Assurance (NCQA), issue **guidance** for maintaining adequate networks. However, Ohio is one of only a few states without network adequacy requirements for commercial plans under state jurisdiction, with the exception of health maintenance organizations (HMOs). HMO plans generally only cover care from in-network providers; providers outside their networks are usually not covered, except for emergencies.³⁸ There is legislation pending in the 136th Ohio General Assembly (**HB 219**) to adopt network adequacy standards for all ODI-regulated plans.

While providers and advocates are generally supportive of such legislation,³⁹ insurers cite behavioral health workforce shortages as a barrier to building provider networks.⁴⁰

NovaRes's analysis for ODI found that Ohio Medicaid MCOs had more mental health and substance use disorder providers in their networks than commercial insurers. However, when enrollment was considered, the difference in the number of providers per 1,000 members was not as large.⁴¹

Network accuracy

Commercial insurers and Medicaid MCOs are required to maintain accurate provider directories, a list of all in-network providers, for their members.⁴² These directories, however, can quickly become outdated. Providers may change practices, may not be accepting new patients, may not accept a specific plan, or their information may otherwise be incorrect. These unavailable providers, also called ghost providers, make it harder for patients to get the care they need.⁴³

A **recent review by the Office of Inspector General for the Department of Health and Human Services** found that a third of Medicaid plans reviewed had inactive behavioral health providers listed in their network.⁴⁴ In **an amended rule** published in 2024, CMS is requiring states to implement secret shopper surveys to determine compliance with network adequacy and accuracy requirements for Medicaid and Children's Health Insurance Program (CHIP) managed care plans.⁴⁵ States will have to establish criteria for secret shopper surveys by July 2027 and implement them beginning on or after July 2028.⁴⁶



Insurance coverage limitations

Summary

Sometimes, the mental healthcare that a child can receive depends on what their insurance plan will cover. Otherwise, the family must pay the full cost out-of-pocket. Insurance plans will sometimes not cover a service at all, only allow a certain amount of care (e.g., a certain number of visits or days of care) or not pay for care that is provided in a certain setting (e.g., in a school or a home). Further, insurance companies use utilization management practices (e.g., prior authorization), which may result in decisions to deny coverage for care requested for a patient. This concept was central to federal mental health parity laws.

All of these practices are in place to keep costs down, and some guard against wasteful spending. However, they may also delay care or restrict access to care. Policymakers must weigh these tradeoffs, while also considering that addressing mental health conditions in lower-intensity settings and early, such as during childhood, can keep them from worsening.

When a family has health insurance, the care they can receive generally depends on what is covered under their insurance plan, unless they can pay the full cost of services that are not covered. Widespread concerns about more restrictive insurance coverage for mental health and SUD treatment than for medical and surgical care led to policy action at both the state and federal levels to improve mental health parity. This has occurred over the past 30 years. The most influential federal parity law, the Mental Health Parity and Addiction Equity Act (MHPAEA), was passed in 2008. Ohio passed legislation to align state law with MHPAEA in 2021.

There is evidence that mental health benefits legislation, which includes mental health parity requirements, increases access to mental healthcare and decreases patient costs.⁴⁷ However, current mental health parity requirements are very complex and difficult to enforce, and non-compliance findings are common.⁴⁸ HPIO's [Mental Health Parity Policy Explainer](#) provides more information.

▶ Non-covered services and limits on care

Some mental health services are not covered by certain insurance plans. Additionally, there are often limitations on the amount of care allowed by insurance, such as a set number of therapy sessions or days of inpatient care.

For example, provider partners that served on HPIO's Child Mental Health Advisory Group shared their observation that commercial plans rarely cover:

- Therapeutic behavioral health support*
- Case management
- Intensive home-based treatment*
- Behavioral health nursing*
- Crisis services/mobile response
- Peer recovery services

*Coverage of these services was analyzed in [NovaRest's study conducted for ODI](#). NovaRest found that although the majority of surveyed commercial insurers said the services were covered, they may have been covered by a different code or in a different site of service. Regardless, utilization of these services was very low among commercially-insured enrollees.⁴⁹

Medicaid coverage

As shown in figure 2 on page 2, 45% of Ohio children have Medicaid insurance. Within Medicaid, the federally required Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit establishes standards to ensure that children and youth under the age of 21 have access to a comprehensive set of medically necessary services, including a robust continuum of behavioral health services.⁵⁰ EPSDT is designed to guarantee that vulnerable populations receive early detection and treatment for health problems. Ohio's EPSDT program is called **Healthchek**.

Because of EPSDT, children and youth with Medicaid generally have a more robust and comprehensive set of mental health benefits compared to children with private commercial insurance. Under EPSDT, children have access to regular health and developmental screenings, in addition to screenings outside of the designated schedule if a new medical need is suspected.⁵¹ States must then provide coverage for any medically necessary treatment needed to "correct or ameliorate a child's physical and mental health conditions."⁵² This includes any service that a child needs if it is coverable under federal Medicaid law, even if the state typically does not offer the service.⁵³

Due to the growing behavioral health crisis among youth, the Centers for Medicare & Medicaid Services (CMS) released a **State Medicaid & CHIP Toolkit for Children's Behavioral Health Services and the EPSDT Requirements** in early 2026. It contains new guidance and strategies for developing and supporting an effective behavioral healthcare delivery system for children.⁵⁴

However, considerable funding losses are anticipated for the Ohio Medicaid program in the coming years due to policy changes in the 2025 federal reconciliation bill, **HR 1**. Ohio policymakers will need to make important decisions to address changes to how Medicaid is financed. In response to HR 1, some states are considering decreasing provider reimbursement rates, removing coverage for optional services that the state currently offers, or restricting Medicaid eligibility for certain populations. These decisions could negatively impact mental healthcare access for Ohio children. However, Ohio policymakers have other options to mitigate some of the impact of HR 1 changes without cutting expenditures. More information is available in HPIO's policy explainer **Changes to Medicaid Financing in Ohio**.

► Utilization management

Utilization management includes practices in which insurers review whether requested treatment is medically necessary or whether there is a less expensive option to try first. Prior authorization, step therapy requirements and post-service claim reviews are a few examples. These methods are forms of non-quantitative treatment limitations (NQTs). They control costs but can also play a role in ensuring quality and appropriateness of care, especially when based on evidence-based criteria and combined with case management and care coordination.⁵⁵ However, they can also delay care or lead to families needing to pay out of pocket for services.⁵⁶

By law, consumers can appeal insurance denials through their insurance company. If the complaint is not resolved, the consumer can contact the **ODI Customer Services Division** for assistance and/or to file a complaint.

NQTs were a primary focus of MHPAEA, the 2008 federal mental health parity law. The law sought to ensure that insurers do not use NQTs to restrict mental healthcare more often than medical or surgical care. However, NQTs are often identified by insurers and policy experts as the most difficult piece of the parity law with which to comply.⁵⁷ More information on mental health parity laws can be found in HPIO's **Mental Health Parity Policy Explainer**.

The **NovaRest analysis** conducted for ODI showed similar rates of prior authorizations between Medicaid MCOs and commercial plans in all areas of mental healthcare except intensive outpatient services. Commercial plans require prior authorization for these services more often.⁵⁸

Some states require insurers to use generally accepted standards of care (described in the box below) when making these decisions. Ohio Medicaid requires its MCOs to use the American Society of Addiction Medicine evidence-based guidelines when making decisions related to SUD care but does not have a similar requirement for mental health.

Generally Accepted Standards of Care (GASC) provide guidelines for what care patients should receive and when, based on available evidence. They are often created and endorsed by health experts and medical societies or associations. Insurers do not always use GASC when conducting utilization reviews and making determinations on whether mental healthcare is medically necessary.⁵⁹ According to the Kennedy Forum, insurers sometimes “rely on for-profit, proprietary, and non-transparent criteria in practice.”

Nineteen states have implemented guidelines mandating the use of GASC for mental health and/or SUD decisions.⁶⁰ This also adds more transparency for consumers.

To be compliant with federal parity laws, if an insurer relies on medical societies for medical and surgical determinations, they must do the same for behavioral health.

▶ Settings of care

Some commercial insurance plans do not reimburse for services provided to patients in certain non-medical settings, such as schools and in homes. For example, commercial insurers may view treatment at schools as a way to advance educational goals, which would make it a responsibility of the education system.⁶¹

However, schools are a common location for children to access mental health services. This can reduce stigma and circumvent common barriers, such as transportation and navigating parent/caregiver work schedules.⁶² As mentioned in HPIO’s **Access to Mental Healthcare for Ohio Children and Youth** brief, during the 2024-2025 school year, community behavioral health providers partnered to provide services in 82% of school buildings throughout Ohio.⁶³ Ohio Medicaid does reimburse for services in schools for some enrolled children and for short-term intensive home-based treatment for children enrolled in **OhioRISE**.



Implications and considerations for Ohio

In addition to the mental health provider shortages across the state⁶⁴, some insurance practices, such as those described in this brief, can restrict access to care. Access to needed mental healthcare ensures conditions do not worsen. Untreated mental health conditions generally end up costing more to treat.

At the same time, ensuring care is appropriate and medically necessary, such as through prior authorizations, can be important. Insurance decisions such as narrower benefit design and provider networks both contribute to lower commercial insurance premiums. Policymakers and employers must weigh all of these factors when considering insurance-related policy changes.

A final consideration is about behavioral health safety net providers, such as federally qualified health centers, community mental health centers and free clinics, which are important sources of care access when people have insurance gaps and affordability challenges. These entities generally provide care for free or on a sliding fee schedule. However, capacity is limited, as they generally rely primarily on government funding. Care access available through ADAMH Board funding could be further constrained if Ohio chooses to eliminate property taxes. Additional funding for these entities could mitigate gaps in coverage for some Ohio families.



Relevant policy initiatives and legislation of the 136th Ohio General Assembly

In 2023, Governor DeWine created the **Mental Health Insurance Assistance Office** at the Ohio Department of Insurance (ODI) to help Ohioans navigate their mental health insurance benefits. The Office offers resources for consumers and employers. They also have several responsibilities related to mental health parity:

- Review information submitted by all Ohio insurance plans to ensure compliance with applicable mental health parity laws
- Investigate and track consumer and provider complaints related to potential parity violations (In 2025, 20 complaints were investigated.⁶⁵)
- Collaborate with the Ohio Department of Behavioral Health (DBH) to create an annual **mental health parity report** to be shared with the Governor and General Assembly, outlining the departments' efforts around mental health parity

In 2023, ODI began convening a mental health insurance working group comprised of representatives from state agencies, providers, health plans and consumer advocates. The group explored possible changes related to mental health insurance. Work of this group informed the development of legislation introduced in early 2026, **HB 724**, to require health plans to cover an annual behavioral health wellness visit.

Additionally, numerous bills related to insurance coverage of mental health have been introduced in the 136th General Assembly. A few include:

- **HB 219** – To establish network adequacy standards for health insurance plans
- **HB 220** – Addresses health insurance and Medicaid program prior authorization requirements, including provisions that specifically extend protections to mental health and substance use disorder (SUD) treatment, as well as prohibits retroactive denial of prior authorization for mental health or SUD services in certain cases
- **HB 709** – To require private insurers to cover telehealth mental health services
- **HB 718** – To create a qualified mental health credential and change the name of the Chemical Dependency Professionals Board to the Behavioral Health Professionals Board
- **Senate Bill 162** – To shorten the timeframe during which health insurers can recoup payment from a healthcare provider from two years to one

Policy options

There are many actions public and private leaders can take to improve access to mental healthcare for young Ohioans. Examples are below.

Monitor costs of behavioral healthcare

1. Track and publicly report indicators of mental health access and affordability to inform insurance-related policy decisions (e.g., forgone care because of cost, medication nonadherence due to cost), such as through the Ohio Medicaid Assessment Survey.
2. Require insurance plans to collect and submit data such as:
 - In-network and out-of-network utilization
 - Claim denial rates by mental health service type
 - Appointment availability and/or wait times by mental health provider type and specialty
3. Consider broader reforms to address rising healthcare costs including the considerations for policy progress on p. 6 of the [2026 Health Value Dashboard](#). One tool recommended in the Health Value Dashboard was an all-payer claims database (APCD), which was included in [legislation](#) sent to the Governor in June 2026. An APCD aggregates data on healthcare costs and utilization in the state, allowing for analysis of spending trends and supporting potential policy solutions. Policymakers in Ohio should effectively implement the newly-passed APCD and employ it to monitor behavioral health costs and utilization, as other states like [Colorado](#) have done.

Expand provider availability

4. Continue to take action to enhance the behavioral health workforce, such as with the policy options on p. 18 of HPIO's [Access to mental healthcare for Ohio children and youth](#) brief.
5. Adopt behavioral health network accuracy and adequacy standards that reflect the accessibility of services (e.g., requirements for time and distance, appointment wait times, inclusion of key provider types and levels of care) and pair these actions with other initiatives to increase the overall provider supply. To strengthen effectiveness, the Ohio General Assembly can ensure ODI, the Ohio Department of Medicaid (ODM) and the Ohio Department of Administrative Services have the authority and resources to continually enforce the network accuracy and adequacy requirements, such as with regular audits and secret shopper investigations.
6. Reimburse for services of dependently-licensed providers and paraprofessionals such as peer support specialists and qualified behavioral health specialists.
7. Consider prior authorization reforms, such as those adopted by other states and described in this [National Conference of State Legislators' brief](#). For example, some states prohibit prior authorization or step therapy requirements for specific behavioral health services (e.g., New York prohibits prior authorization for minors entering inpatient psychiatric treatment). These decisions should be based on evidence.
8. Consider increasing mental health provider reimbursement rates among commercial plans and maintaining the Ohio Medicaid rate increases that went into effect in 2024.
9. Provide more financial support for safety net providers, such as free clinics, federally qualified health centers (FQHCs) and community behavioral health providers, and monitor care access implications if ADAMH Boards experience funding loss due to property tax policy changes.
10. The Ohio General Assembly can create credentials for qualified mental health specialists, as was introduced in [HB 718](#).

Policy options (cont.)

Consider changes related to insurance limitations and mental health parity

11. Require insurers to use non-proprietary and evidence-informed Generally Accepted Standards of Care (GASC) when making medical necessity determinations for mental health services, as at least seven other states have done. For example, decisionmakers can require use of those outlined in the [Ramstad model legislation](#).
12. Require commercial health plans to remove restrictions on reimbursement of medically necessary mental health services provided in schools (similar to [Jake's law](#) in Arizona).
13. The Ohio General Assembly can revise the Ohio Revised Code language classifying which conditions health plans consider as behavioral health conditions to align with the most current versions of the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM).



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Ohio Child Mental Health Project

Led by the Health Policy Institute of Ohio and informed by a [multi-sector advisory group](#), this project includes a series of policy briefs exploring child and youth mental health in Ohio.

<https://bit.ly/4xqi0aW>



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Notes

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