MENTAL HEALTH/SUD PARITY: HISTORY AND POLICY

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INTRODUCTION

According to data from the Centers for Disease Control and Prevention, 80,112 Americans died of a drug overdose in the 12-month period ending in December 2024.[1] In 2022, the most recent year for which there is data, 49,449 Americans died by suicide,[2] at least 46 percent of whom had a known, but untreated, mental illness at the time of death.[3] Treatment for mental health conditions and substance use disorders (SUD) can save lives, but historically, people with mental health and SUD issues have faced unique obstacles in accessing that treatment through health insurance coverage. Mental health and SUD benefits often required burdensome additional cost or benefit caps that did not exist for physical health benefits. Mental health and SUD parity aims to ensure that health insurance coverage for mental health and SUD benefits is not more restrictive than that for medical/surgical benefits for physical health conditions and that covered patients do not face greater burdens in accessing mental health and SUD benefits than physical health benefits.

In this fact sheet, the Legislative Analysis and Public Policy Association examines the obstacles that have historically restricted many Americans' access to mental health and SUD care, as well as policymakers' efforts to establish parity at the state and federal levels.

HISTORICAL DISPARITIES IN COVERAGE

For many years, people with mental health and substance use disorders have been less likely to have health insurance than the general population.[4] Before the implementation of pro-parity legislation in the United States starting in 1996, even those who had insurance discovered that treatment for mental health and SUD conditions were not covered equally when compared to treatment for physical health conditions.[5] Many policies did not include any mental health or SUD benefits. Of those that did, many subjected those benefits to harsh "qualitative treatment limitations" (QTLs), such as annual or lifetime service limits or higher out-of-pocket costs, and "nonquantitative treatment limitations" (NQTLs), such as preauthorization requirements or "medical necessity" criteria that the insured needed to meet before coverage was approved.[6] Such limitations were either not applied to medical/surgical benefits or were much less restrictive for patients.

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[1] F.B. Ahmad, et al., *Provisional Drug Overdose Death Counts*, NAT'L CTR. FOR HEALTH STAT., CTRS. FOR DISEASE CONTROL & PREVENTION (2025), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

[2] *Suicide Data and Statistics*, NAT'L CTR. FOR INJURY PREVENTION & CONTROL, CTRS. FOR DISEASE CONTROL & PREVENTION (last reviewed Nov. 29, 2023), https://www.cdc.gov/suicide/suicide-data-statistics.html.

[3] Deborah M. Stone, et al., *Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015*, MORBIDITY & MORTALITY WEEKLY REP. (June 8, 2018), https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a1.htm?s_cid=mm6722a1.

[4] Julia Dickson-Gomez, et al., *Insurance barriers to substance use disorder treatment after passage of mental health and addiction parity laws and the affordable care act: A qualitative analysis*, 3 DRUG AND ALCOHOL DEPENDENCE REPTS (June 2022), https://www.sciencedirect.com/science/article/pii/S2772724622000294; Kathleen Rowan, et al., *Access and Cost Barriers to Mental Health Care by Insurance Status, 1999 to 2010*, HEALTH AFFAIRS (October 2013), https://pmc.ncbi.nlm.nih.gov/articles/PMC4236908/.

[5] *See* JoAnn Volk, et al., *A Review of State Efforts to Enforce Mental Health Parity: Lessons for Policymakers and Regulators*, GEORGETOWN U. HEALTH POLICY INST., CTR. ON HEALTH INSURANCE REFORMS (Oct 2022), https://mamh-web.files.svdcdn.com/production/files/MHParity_review.pdf?dm=1666014628..

[6] *Policy Priority: Mental Health Parity*, AMERICAN FOUNDATION FOR SUICIDE PREVENTION (January 9, 2023), https://www.datocms-assets.com/12810/1677181553-afsp-mental-health-parity-issue-brief.pdf; Dickson-Gomez, et al., *supra* note 4.

Before major federal parity legislation was enacted in 2008, increasing numbers of Americans had mental health and SUD coverage in theory, but their ability to use those benefits was limited. The number of employer-provided health insurance plans offering mental health or SUD benefits gradually increased, but annual and lifetime service caps on those benefits simultaneously became more restrictive.[7] A 2003 study found that among workers whose employer-sponsored health insurance covered mental health or SUD benefits, 74 percent had an annual cap on their number of outpatient visits, 64 percent had a cap on the number of days in inpatient care, and 22 percent had higher cost sharing for mental health/SUD benefits than for medical/surgical benefits.[8]

LEGISLATIVE AND REGULATORY EFFORTS TO SUPPORT PARITY

The first federal legislation to encourage parity was the Mental Health Parity Act of 1996.[9] Under this law, annual or lifetime limits on mental health benefits (not including SUD benefits) could not be lower than such limits for medical/surgical benefits. Insurers were still permitted to require increased cost-sharing or caps on days of care of number of doctor visits, however. In 2008, in a more comprehensive effort toward establishing mental health and SUD parity, the U.S. Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).[10] Compared to levels of protection at the time, it was a modest improvement. The MHPAEA did not mandate that insurance plans must provide mental health and SUD coverage; it only required that those plans already offering mental health and SUD benefits must provide those benefits without imposing financial requirements, QTLs, or NQTLs that are more restrictive than those applied to medical/surgical benefits.[11] The MHPAEA, as enacted, only applied to group health plans sponsored by large employers (employers with more than 50 employees) and Medicaid managed care plans, though amendments in the years since have expanded its protections.[12]

One such major expansion occurred in 2010, with the passage of the Affordable Care Act (ACA)[13] which extended parity requirements to a wider variety of health insurance plans, including individual and small group health insurance, and mandated that all covered plans must provide mental health and SUD benefits as part of a package of essential health benefits. New mandated coverage for preventative care encompassed preventative screenings for mental health conditions and SUD. After the MHPAEA's enactment in 2008, most health benefit plans eliminated impermissible financial requirements and QTLs on mental health and SUD benefits, and studies have indicated that its parity protections are positively associated with increased utilization of mental health and SUD services.[14]

Additional federal legislation has further expanded the federal government's role in enforcing parity requirements. The Consolidated Appropriations Act of 2021[15] imposed a requirement for companies issuing health insurance plans to conduct comparative analyses of NQTLs that they apply to mental health or SUD benefits and make these analyses available to state officials and to the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury, upon request. These analyses demonstrate issuers' justification for any NQTL for mental health or SUD benefits, specifically and meticulously demonstrating how each is no more restrictive than those for medical/surgical benefits. The 2021 legislation further established a process for the departments to evaluate insurance plans' compliance with federal parity requirements more generally.

The federal departments have also collaborated to enact administrative regulations to implement the MHPAEA and its amendments. The most recent final rules went into effect in the fall of 2024. These new regulations amended the procedures that insurance issuers must follow for their comparative analyses of NQTLs, specifically by clarifying

[7] Colleen Barry, *et al*, *A political history of federal mental health and addiction insurance parity*. THE MILBANK QUARTERLY, vol. 88,3 (2010).
[8] Colleen Barry, *et al*, *Design Of Mental Health Benefits: Still Unequal After All These Years*. HEALTH AFFAIRS. (September 1, 2003).
[9] Mental Health Parity Act of 1996, Pub. L. No. 104–204, 110 Stat. 2945 (1996).
[10] Emergency Economic Stabilization Act of 2008, Pub. L. No. 110–343, 122 Stat. 3765 (2008).
[11] Dickson-Gomez, et al., *supra* note 4.
[12] Emergency Economic Stabilization Act of 2008, *supra* note 10.
[13] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010).
[14] Norah Mulvaney-Day, et al., *Mental Health Parity and Addiction Equity Act and the Use of Outpatient Behavioral Health Services in the United States, 2005-2016*, 109(S3) AM. J. PUBLIC HEALTH (June 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6595520/.
[15] Consolidated Appropriations Act of 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020).

which information must be included in each analysis, authorizing applicable state or federal authorities to request additional data from the issuers, and requiring issuers to provide comparative analyses to plan members and beneficiaries in a timely manner.[16] The regulations further prohibit plans or issuers from using discriminatory information, evidence, sources, or standards that systematically disfavor or are specifically designed to disfavor access to mental health or SUD benefits. Finally, the new rules sunset the option for certain self-funded non-federal governmental health insurance plans issued after December 2022 to opt out of MHPAEA compliance.[17]

Compliance with federal parity law has been a consistent challenge. One year after the passage of the 2021 MHPAEA amendments, the federal departments overseeing the law reported to Congress that none of the comparative analyses requested from health insurers contained sufficient information to meet the MHPAEA's requirements.[18] Independent studies have indicated that disparate treatment limits continue to exist in health benefit plans in violation of federal parity requirements.[19] State insurance commissions play a crucial role in encouraging enforcement, as they have broad authority to regulate health insurance within their borders. Enforcement actions vary significantly among the states, however: another study found that effective state-level parity enforcement was dependent on the priorities of specific governors, insurance commissioners, and legislatures, with minimal enforcement in states that did not have any parity champions.[20] This is particularly true in states in which state officials have the constitutional or statutory authority to enforce parity regulations but do not have an affirmative duty to take enforcement actions.

Parity policymaking is active at the state level. All U.S. states, the District of Columbia, and Guam have some type of statute on the books providing parity protections, though these cover a broad spectrum of comprehensiveness. Some essentially echo the federal parity standards under MHPAEA, while others implement robust enforcement systems with protections that go beyond federal requirements. For more information, see LAPPA's Mental Health and Substance Use Disorder Insurance Parity: Summary of State Laws. In January 2025, LAPPA released its Model Mental Health and Substance Use Disorder Parity Act, proposing a system that would: (1) enshrine parity protections in state law; (2) impose reporting requirements on companies issuing health insurance plans in a state; and (3) specifically require that state insurance commissioners investigate violations of parity law and impose corrective actions when appropriate. Such legislation would empower more vigorous enforcement of federal parity law at the state level and create additional protections that go beyond federal minimums, preventing new restrictions on mental health and SUD coverage and providing a pathway for more Americans to get the treatment they need.

CONCLUSION

Health insurance parity for mental health and SUD benefits is an important means for connecting more Americans to life-saving treatment. Since the enactment of the MHPAEA, studies have indicated that the law has resulted in greater utilization of mental health and SUD services and a significant drop in QTLs in health insurance plans.[21] Federal and state policy has gradually expanded parity protections over decades, but this area of law is not static. Enforcement of existing parity law can change with new regulators, and at both the federal and state levels, new statutes, regulations, or enforcement priorities can take effect at any time. Any changes in parity policy will have an enormous impact on Americans' access to care for years to come.

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[16] 45 C.F.R. § 146.136.
[17] 45 C.F.R. § 146.180.
[18] *Id.*
[19] *See* Mulvaney-Day, et al., *supra* note 14, and Volk, et al., *supra* note **Error! Bookmark not defined.**.
[20] Rachel Presskreischer, et al., *Factors Affecting State-Level Enforcement of the Federal Mental Health Parity and Addiction Equity Act: A Cross-Case Analysis of Four States*, 48 J. HEALTH POLIT. POLICY LAW (Feb. 1, 2023), https://doi.org/10.1215/03616878-10171062.
[21] Jessica M. Harwood, et al., *The Mental Health Parity and Addiction Equity Act Evaluation Study: Impact on Specialty Behavioral Health Care Utilization and Spending Among Carve-In Enrollees,* MEDICAL CARE, 55(2) (February 2017), https://pmc.ncbi.nlm.nih.gov/articles/PMC5233645/; Amber G. Thalmayer, et al., *The Mental Health Parity and Addiction Equity Act (MHPAEA) Evaluation Study: Impact on Quantitative Treatment Limits (QTLs),* PSYCHIATRIC SERVICES, 68(5) (December 2016), https://pmc.ncbi.nlm.nih.gov/articles/PMC5411313/.

RESOURCES

"The Mental Health Parity and Addiction Equity Act (MHPAEA)," *Centers for Medicare & Medicaid Services*, 2024, https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity.

"Mental Health and Substance Use Disorder Parity," U.S. Department of Labor, Employee Benefits Security Administration, last accessed June 2025, https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

"Mental health & substance abuse coverage," *Healthcare.gov*, last accessed June 2025, https://www.healthcare.gov/coverage/mental-health-substance-abuse-coverage/.

"What is Parity?" The Kennedy Forum, last accessed June 2025, https://www.thekennedyforum.org/focus-areas/coverage-parity/parity/.

ABOUT THE LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

The Legislative Analysis and Public Policy Association (LAPPA) is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

LAPPA produces model laws on critical issues as well as comparative analyses, publications, educational brochures, and other tools that can be used by national, state, and local public health and public safety practitioners who want the latest comprehensive information on law and policy. Examples of topics on which LAPPA has assisted stakeholders include naloxone access, treatment in emergency settings, Medicaid Section 1115 demonstration waivers, medication for addiction treatment in correctional settings, collateral consequences of conviction, syringe services programs, and the health information disclosure provisions of HIPAA and 42 C.F.R. Part 2.

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