Policy Priority: Mental Health Parity

According to the latest (2023) data from the Centers for Disease Control and Prevention (CDC), suicide is the 11th leading cause of death in the United States – that year alone, 49,316 people in the U.S. died by suicide (CDC, 2025). A 2020 CDC report found that from 1999 through 2018 the suicide rate increased 35%, with a significant increasing trend after 2006. From 1999 to 2006, the suicide rate increased on average approximately 1% per year. From 2006-2018, however, the rate increased by 2% per year (Hedegaard, Curtin, & Warner, 2020). While these statistics point to a serious public health problem, we do know that many suicides can be prevented, and there are steps we can all take to help support individuals at risk in seeking help.

Suicide and suicide attempts have a devastating impact on individuals, families, and communities across the country. Upwards of 90% of individuals who ultimately die by suicide were living with a diagnosable mental health condition at the time of their death, although these conditions often go undiagnosed or untreated. Illnesses like depression, anxiety, and substance problems, especially when unaddressed, can increase risk for suicide.

Assessment and treatment for mental health conditions can save lives, but only if individuals at risk can afford to obtain said care. This is why parity in insurance coverage for mental health is critical. “Parity” means that insurance coverage for mental health and substance use disorder treatments (collectively referred to as behavioral health services) should be no more restrictive than coverage for other medical conditions.

Mental health and substance use disorders affect millions of Americans across all demographics and communities. According to the most recent 2025 report from Mental Health America (MHA), in the year prior, 23.4% of U.S. adults experienced a mental illness, equivalent to over 60 million people, over 14 million adults (5.5%) reported having serious thoughts of suicide, and 17.7% of adults, equivalent to over 40 million people, reported having a substance use disorder(MHA, 2025). In 2022 alone, 107,941 Americans died from a drug overdose, an age-adjusted increase of 50% compared to 2019 (Spencer, Garnett, & Miniño, 2024).

The MHA report sheds light on the severity of the problems surrounding access to care: In 2022-2023 combined data, 1 in 4 adults with a mental illness in the U.S. reported an unmet need for mental health treatment in the year prior. In 2022-2023, 9.2% of adults with mental illness in the U.S. were uninsured. totaling over 5 million people, and 9.6% of adults with mental illness had private health insurance that did not cover mental health treatment, totaling nearly 3 million people. In 2023, in the year prior, 26.58% of adults who reported experiencing 14 or more mentally unhealthy days each month were not able to see a doctor due to costs – a 2% increase over 2022 and a 4% increase over 2021 (MHA, 2025).

Federal Overview of Mental Health Parity: Disparities between insurance for behavioral health and general medical services were first addressed by Congress through passage of the

Mental Health Parity Act of 1996 (see P.L. 104-204). Several policy updates have occurred since, resulting in two major pieces of legislation with significant implications for parity:

- The **Mental Health Parity and Addiction Equity Act (MHPAEA,** see P.L. 110-343) was enacted in 2008. MHPAEA does not require that insurance plans offer mental health and substance use disorder benefits; however, for those that do, benefits must be the same as those offered for other medical and surgical services. To fully comply, plans must provide comparable types of care and equal treatment and financial services in their coverage. The parity statute applies to large-group plans (employer-funded plans with more than 50 insured employees); Medicaid managed-care plans; and CHIP (the Children's Health Insurance Program).
- The **Patient Protection and Affordable Care Act (ACA**, see P.L. 111-148) was enacted in 2010 and enhanced the parity law. ACA extended MHPAEA's protections to small-group plans (employer plans with 50 or fewer employees); individual market plans; Medicaid Alternative Benefit Plans (Medicaid expansion benefit); and plans offered through the health insurance exchanges. The Affordable Care Act was a turning point for behavioral health care access in the United States and included multiple regulations that significantly expanded coverage. **Two of the most impactful provisions of the ACA (1) established ten categories of essential health benefits and (2) expanded Medicaid eligibility to participating states:**
    - The ACA further strengthens coverage under small-group and individual plans by including behavioral health services among a list of **essential health benefits** they are required to provide. While large-group employer plans are exempt from the requirement, their coverage has tended to include generous mental health and addiction treatment benefits pre- and post-ACA. All plan types must not place annual or lifetime caps on any of the essential health benefits they do provide (Norris, 2018).
    - Before the ACA, only members of certain groups qualified for Medicaid coverage and the definitions for each category or group varied state to state by factors such as income level, household size, and family status, creating a complex patchwork of eligibility rules. The ACA **extended Medicaid eligibility** to all adults with incomes up to 138 percent of the federal poverty level, filling substantial gaps in coverage for many populations including low-income Americans with mental health and substance use conditions, who have been the single largest beneficiaries of the Medicaid expansion. Medicaid is the nation's single largest payer of mental health services, accounting for 25% of all mental health spending in the U.S. (Blue & Rosenberg, 2017). In 2015, despite only covering 14% of total adults, Medicaid covered 21% of adults with mental illness, 26% of adults with serious mental illness (SMI), and 17% of adults with substance use disorder (Kaiser Family Foundation, 2017). Overall, approximately 29% of persons who receive health insurance coverage through the Medicaid expansion

either have a mental health condition, a substance use condition, or both (Blue & Rosenberg, 2017).

- The **Consolidated Appropriations Act, 2021,** enacted at the end of 2020 (,see P.L. 116-260), included important parity provisions to empower the U.S. Department of Labor (DOL) and state insurance commissioners to better enforce existing federal parity laws by **requiring health plans to perform comparative parity analyses and make those analyses available to the DOL or a state insurance regulator upon request**. It also requires that the DOL request analysis whenever it receives a complaint, that plan members are informed of noncompliance when the DOL deems a plan noncompliant with MHPAEA and the plan does not remedy violations within 45 days, and that the DOL send an annual report to Congress that identifies plans that are out of compliance.

    - The **Consolidated Appropriations Act, 2023,** enacted at the end of 2022 (see P.L.117-328), included two important provisions relating to mental health parity. It eliminated an existing opt-out which allowed non-federal governmental health insurance plans to avoid compliance with mental health parity requirements. Eliminating this opt-out **ensures that state and local governmental health insurance plans will be required to cover mental health just as they cover physical health.**

    - The **Consolidated Appropriations Act, 2023** also authorized $10 million to be appropriated in annual federal funding for Fiscal Years 2023 through 2027 to **assist states in enforcing mental health parity requirements.**

- In September of 2024, the Department of Labor, the Department of Health and Human Services, and the Department of the Treasury finalized a **new federal rule to help enforce mental health parity requirements**. The final rule clarifies existing requirements for insurance providers; reinforces that limits on insurance coverage for mental health and substance use cannot be more restrictive than limits applied to other medical/surgical benefits in the same classification; and requires insurers to take action to address existing disparities between mental health and substance use coverage and coverage for other medical/surgical benefits. The new rule implemented the sunset provision to prohibit non-federal government entities from opting out of compliance with MHPAEA mental health parity requirements. This rule included other new steps to promote mental health parity compliance by insurers.

State Overview of Mental Health Parity: Most states have laws in place that require some level of parity and/or compliance with the federal parity law. Still, 28.2% of adults with a mental illness actively seeking services report they are not able to get the treatment they need (MHA, 2025). Many patients across the country continue to face several systemic barriers to care such as lack of insurance or adequate insurance; lack of available treatment providers or treatment types; and insufficient finances to cover out-of-pocket costs (copays, uncovered treatment types, or when providers don't take insurance).

In many states, treatment limitations like inpatient or outpatient day limits and annual or lifetime maximums for mental health and substance use disorder care are now a thing of the past. Yet, plans are still proving to be more restrictive and offer different terms and conditions in the area of "non-quantitative treatment limitations," or NQTLs. Defined as any limitation that is not expressed numerically, NQTLs can include prior authorization or "fail first" requirements, medical necessity criteria, network provider standards, geographic restrictions, prescription formulary designs, and network tier designs.

Prior to the Consolidated Appropriations Act, the enforcement and oversight of parity laws had largely become the responsibility of the states, requiring collaboration between state lawmakers and regulators. As a result of the 2021 Act's provisions, for states without reporting requirements, their insurance commissioner can now request analyses and is entitled to receive them without any new state law. However, it is still preferable that these states introduce and enact parity legislation to force annual and proactive reporting, though state legislators can simply reference relevant federal provisions in bill language, providing for an easier pathway.

Strong state parity reporting bills are still essential to ensure federal and state laws are uniformly implemented by requiring (1) insurers and health plans to submit annual parity compliance analyses to state regulatory agencies, and (2) state regulators to implement and report on enforcement activities, such as market conduct examination and parity compliance audits. (*To learn more about coverage disparities between addiction and mental health vs. physical health within your state, see the 2024 RTI International study "Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue," an update to the 2019 Milliman Report.)*

Current State Parity Oversight & Reporting Laws (as of September 2025):

- **26 states and DC** have laws (1) requiring a state authority to enact regulations, submit reports, take enforcement actions, and/or otherwise enforce statutory parity requirements on health insurers and (2) requiring health insurance companies to demonstrate compliance with such laws through annual reports: Alabama, Arizona, California, Colorado, Connecticut, DC, Delaware, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, Tennessee, Washington, West Virginia, and Wisconsin.
- An additional **12 states** have laws requiring a state authority to enact regulations, submit reports, take enforcement actions, and/or otherwise enforce statutory parity requirements on health insurers only: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, DC, Delaware, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

For more details about state laws, see the Legislative Analysis and Public Policy Association's *Mental Health and Substance Use Disorder Insurance Parity: Summary of State Laws*.

Current Advocacy Efforts: AFSP understands that assessment and treatment for mental health conditions can save lives, but only if individuals at risk can afford to obtain said care, making parity in insurance coverage for mental health critical. AFSP also acknowledges that insurers have succeeded in implementing major parts of parity law and that there has been a great deal of progress over the last decade. However, plans are often not in compliance with some of the more complex components and continue to apply managed care practices in ways that are more restrictive for mental health and substance use disorder treatment than for other types of medical treatment.

AFSP urges the enforcement and oversight of parity laws, recognizing that this still requires oversight and responsibility from the states and collaboration between state lawmakers and regulators. Currently, AFSP is working with partners like the Kennedy Forum to support the passage of comprehensive state-level parity reporting legislation to ensure federal and state laws are uniformly implemented in all 50 states.

AFSP's Public Policy Team in Washington, D.C. (advocacy@afsp.org) maintains connections with legislators and stakeholders in many of the states that have adopted parity reporting laws and can connect interested legislators and stakeholders to those individuals upon request.

Resources:

To learn more about the policy and advocacy work being done around mental health care in America, visit the Kennedy Forum where you can find the latest parity resources including toolkits, policy briefs, videos, and more.

The Kennedy Forum and National Alliance on Mental Illness (NAMI) published *The Health Insurance Appeals Guide: A Consumer Guide for Filing Mental Health and Substance Use Disorder (MH/SUD) Appeals* in April 2021. Written by leading health insurance experts to help educate individuals about their appeal rights and explain the steps in the appeals process, the Guide includes important information that consumers, providers, and other stakeholders need to know when filing appeals for denials of MH/SUD treatment and related services.

The American Psychiatric Association has created State Model Parity-Implementation Legislation Adapted to All 50 states and the District of Columbia. The legislation is designed to require transparency and accountability from insurers and state regulators. Each state has legislation that is tailored specifically for that state's terminology and formatting.

Parity at 10 was a three-year campaign launched in November, 2017 that worked to unite local and national advocates in ten states to pursue full enforcement of the Parity Act. The campaign aimed to establish effective models for robust enforcement of the Parity Act and disseminate those models across the country.

In April of 2022 the Substance Abuse and Mental Health Administration (SAMHSA) published "Understanding Parity: A Guide to Resources for Families and Caregivers," "Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits," and "The Essential Aspects of Parity: A Training Tool for Policymakers." The three guides were designed in conjunction with the Department of Labor and the Department of Treasury to inform individuals of their insurance benefits under the MHPAEA and to help families, caregivers, state insurance regulators, and behavioral health staff better understand parity laws.

Useful Terms Around Parity & Insurance:

- **Individual Plans**: Insurance plans that people can purchase for themselves.
- **Group Health Plans**: Insurance plans employers offer their employees. Examples include small and large employer plans.
- **Small Employer Plans**: Insurance plans offered by employers with 50 employees or less.
- **Large Employer Plans:** Insurance plans large employers offer their employees. A large employer has 51 or more employees.
- **In-network:** Providers and healthcare facilities that are part of a health insurance plan's network.
- **Out-of-network:** Providers and healthcare facilities that are not part of a health plan's contracted network and can set their own prices for the services they provide.
- **Quantitative Treatment Limitation:** A limitation on treatment that can be measured with numbers. Examples include deductibles, copayment, inpatient visit limitations, and outpatient day limits.
- **Deductible:** The money a person must pay on their own, or out-of-pocket, before the insurance company starts to pay for care.
- **Copayment:** Money that a person with insurance has to pay for services after a deductible has been met. A copayment is a flat dollar amount, like $20 per visit, but may vary by type of doctor you see (for example, a specialist may have a higher dollar amount). For example, if your insurance plan's allowable cost for a doctor's office visit is $100, and your copayment for a doctor visit is $20, if you've paid your deductible, you pay $20, usually at the time of the visit. If you haven't met your deductible, you pay $100, the full allowable amount for the visit.
- **In-patient care:** Services given in a hospital after admission with a written doctor's order.
- **Outpatient care:** Treatment given to a person who can go home after care without being admitted in a hospital or treatment facility.
- **Non-Quantitative Treatment Limitation (NQTL):** A limitation that can't be measured with numbers. Examples include prior authorization, step therapy, medical necessity criteria, network provider standards, geographic restrictions, prescription formulary designs, and network tier designs.
- **Prior Authorization:** Occurs when a patient needs to get pre-approved for coverage of a treatment or medication; an insurance plan may not pay for care if the patient's condition does not meet certain standards.
- **Step Therapy:** A requirement that a patient try a less expensive treatment first before they get approval for the treatment their provider orders.

More definitions in relation to mental health parity can be found here, at ParityTrack.

References:

Blue, Susan C., & Rosenberg, Linda. (2017). *Americans with mental health and substance abuse disorders: The single largest beneficiaries of the Medicaid expansion*. Washington, DC: The National Council for Behavioral Health. Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2017/01/Medicaid-Expansion-Behavioral-Health-UPDATED-1-24-17-1.pdf

Butler, L., Clement, T., & Mauri, A. (2016). *State of parity report.* The Kennedy Forum and The Scattergood Foundation.

Centers for Disease Control and Prevention (CDC). (2025). *National Center for Injury Prevention and Control: WISQARS Leading Causes of Death Reports, National and Regional, 1999-2023*. Retrieved from www.cdc.gov/injury/wisqars.

Legislative Analysis and Public Policy Association. (2025). *Mental health and substance use disorder insurance parity: Summary of state laws*. Retrieved from https://legislativeanalysis.org/mental-health-and-substance-use-disorder-insurance-parity-summary-of-state-laws/

Mark, T. L., & Parish, W. J. (2024). *Behavioral health parity – Pervasive disparities in access to in-network care continue.* RTI International.

Mental Health America (MHA). (2025). *2025 State of Mental Health in America.* Retrieved from www.mhanational.org/issues/state-mental-health-america

Norris, L. (2018). *How Obamacare improved mental health coverage.* Retrieved from https://www.healthinsurance.org/

Palanker, D., Volk, J., Lucia, K., & Thomas, K. (2018). *Mental health parity at risk.* Arlington, VA: National Alliance on Mental Illness

Parsons, J. & Neath, S. (2017). *Minimizing harm: Public health and justice system responses to drug use and the opioid Crisis.* New York, NY: The Vera Institute of Justice.

Silverman, Y. (2018). Mental health parity: Where are we? *Practice Perspectives.* Washington, DC: National Association of Social Workers.

Spencer M., Garnett, M., & Miniño, A. (2024). Drug overdose deaths in the United States, 2002–2022. *NCHS Data Brief, no 491*. Hyattsville, MD: National Center for Health Statistics. Retrieved from https://stacks.cdc.gov/view/cdc/135849

Stone, D. M., Simon, T. R., Fowler, K. A., et al. (2018). Vital signs: Trends in state suicide rates—United States, 1999–2016 and circumstances contributing to suicide—27 states, 2015. *Morbidity and Mortality Weekly Report, 67*, 617–624.

Zur, J., Musumeci, M., & Garfield, R. (2017). *Medicaid's role in financing behavioral health services for low-income individuals*. Washington, DC: Kaiser Family Foundation