EXPLAINER

Mental Health Parity Laws

October 2025

California Health Benefits Review Program (CHBRP)
University of California

Access to behavioral health services can be challenging for patients due to a variety of factors, including shortages in the behavioral health workforce, high out-of-pocket costs, coverage gaps, and more (HRSA, 2024). Prior to the passage of the Mental Health Parity Act of 1996, these services were even more difficult to access because health plans and insurers were not required to cover mental health care.[1]

One important safeguard for consumers is the Mental Health Parity and Addiction Equity Act (MHPAEA), a federal law intended to ensure health plans and insurers that provide behavioral health benefits impose the same limitations for these benefits as they do medical and surgical benefits. When analyzing proposed state legislation related to behavioral health coverage, the California Health Benefits Review Program (CHBRP) considers how federal parity requirements, as well as state parity laws such as the California Mental Health Parity Act, may influence access to care and insurance coverage. This explainer provides an overview of the MHPAEA, California's Mental Health Parity Act, their areas of overlap, and how these policies affect coverage, provider access, and utilization management for Californians enrolled in state-regulated health plans and policies.[2]

What is the Mental Health Parity and Addiction Equity Act?

The MHPAEA, also known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, requires parity between behavioral health benefits – which encompass mental health and substance use disorder (MH/SUD) benefits – and medical/surgical (physical) benefits in terms of cost sharing, treatment limitations, and other access standards when such behavioral health[3] benefits are offered. While the MHPAEA does not require plans and policies to offer behavioral health benefits, any offered benefits must be equivalent to physical benefits in terms of financial requirements (e.g., copayments, deductibles, out-of-pocket maximums) and treatment limitations (e.g., visit caps, prior authorization, medical necessity criteria).

There are three kinds of limits required by the MHPAEA. The first are *financial requirements*. Health plans and policies cannot impose greater financial requirements, such as deductibles and cost sharing, for behavioral health benefits than

[1] The Mental Health Parity Act of 1996 was the first federal mandate on large group health plans that prohibited annual or lifetime dollar limits on mental health benefits that were less favorable than limits on medical/surgical benefits (CMS, 2024).
[2] In California, the Department of Managed Health Care regulates health care service plans and the California Department of Insurance regulates health insurance policies.
[3] CHBRP uses the term "behavioral health" in reference to mental health / substance use disorders (MH/SUD).

they do for other benefits. The second are *quantitative treatment limits (QTLs)*. QTLs are coverage limits that insurers apply to the number of visits or days of treatment a patient is entitled to cannot be stricter for behavioral health benefits than they are for other benefits. And the third are *non-quantitative treatment limits (NQTLs)*. These are limits that a health plan or policy may place on the scope or duration of behavioral health benefits, which under the MHPAEA cannot be stricter than they are for other benefits. Some commonly applied NQTLs include medical management standards, formulary (approved drug list) designs, prior authorization, and provider credentialing and reimbursement.

Plans That Must Comply with MHPAEA

The MHPAEA generally applies to both grandfathered[4] and nongrandfathered large-group health plans and policies (CMS, 2025). The number of employees that constitute a large group health plan or policy is determined at the state level. In California, plans and policies of 101+ employees are considered large group and therefore directly subject to the MHPAEA. Additionally, the MHPAEA was extended by the Affordable Care Act of 2010 to apply to individual health insurance coverage (CMS, 2025). While small group plans and policies, defined as 1-100 employees in California, are not directly subject to the MHPAEA, nongrandfathered small group plans and policies must comply with certain parity requirements through the Affordable Care Act's essential health benefits mandate. Generally, public health plans such as Medicare, Medicaid, and the Children's Health Insurance Program are not subject to the requirements of the MHPAEA (CMS, 2025). Self-insured plans for State and local government employees may opt out of MHPAEA requirements with certain administrative procedures. Additionally, retiree-only plans are also not required to comply with the MHPAEA (DOL, 2024).

Figure 1. Types of Health Insurance and Subjectivity to the MHPAEA Mandate

Type of Health Insurance	Subject to the Mandate?
Grandfathered Large Group Health Plans and Policies	✓
Nongrandfathered Large Group Health Plans and Policies	✓
Grandfathered Small Group Health Plans and Policies	✗
Nongrandfathered Small Group Health Plans and Policies *	*
Individual Health Insurance Coverage	✓
Public Health Plans (Medicare, Medicaid, and the Children's Health Insurance Program)	✗
Self-Insured Governmental Plans	✗
Retiree-Only Plans	✗

Source: California Health Benefits Review Program, 2025.
*Nongrandfathered small group health plans and policies are not subject to the MHPAEA, but they must comply with some of its requirements, according to the Affordable Care Act.

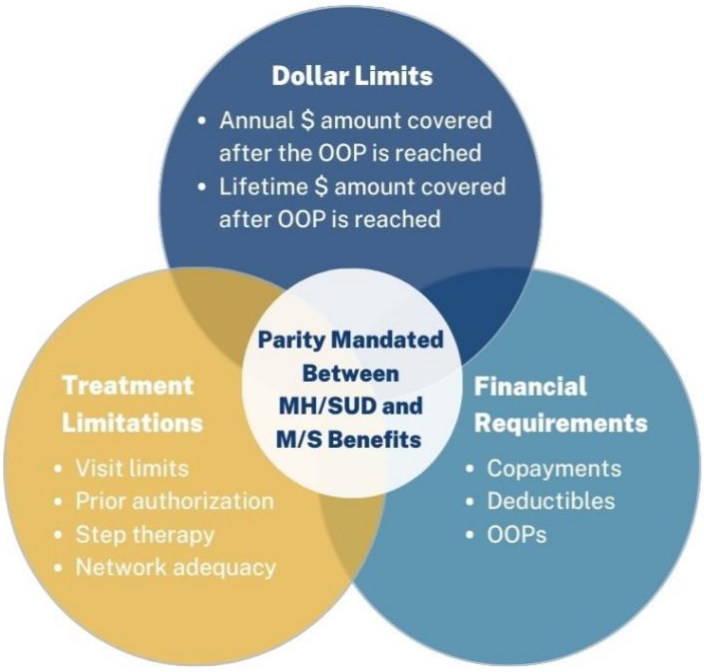
[4] A grandfathered plan or policy is one that existed before the Affordable Care Act was enacted on March 23, 2010.

Benefits and Services Subject to MHPAEA

If a plan or policy is subject to the MHPAEA, it must provide behavioral health benefits on equal terms with medical and surgical benefits. The six classifications of benefits in the MHPAEA are (DOL, 2024):

- **Inpatient, in-network care:** treatment where the patient is formally admitted to a healthcare facility that has a specific contract with their insurer.
- **Inpatient, out-of-network care:** treatment where the patient is formally admitted to a healthcare facility that does not have a specific contract with their insurer.
- **Outpatient, in-network care:** treatment without admission to a healthcare facility from a provider that has a specific contract with a patient's insurer.
- **Outpatient, out-of-network care:** treatment without admission to a healthcare facility from a provider that does not have a specific contract with a patient's insurer.
- **Emergency care:** treatment received as part of an emergency room visit or other unforeseen treatments.
- **Prescription drugs:** All benefits related to the coverage of prescription pharmaceuticals.

Figure 2: Types of Parity Required Under the MHPAEA



Source: California Health Benefits Review Program, 2025.
Key: M/S = medical/surgical; MH/SUD = mental health/substance use disorder; OOP = out-of-pocket maximum.

Although health plans and policies are not required to cover behavioral health benefits by the MHPAEA, health plans and policies that do cover behavioral health benefits must, per the MHPAEA, provide them in any classification in which they provide medical or surgical benefits. Intensive outpatient programs, partial hospitalization, residential treatment, and emergency mental health services must also be covered at the same level as their medical and surgical counterparts when offered by a health plan or policy under the MHPAEA.

As shown in Figure 2, parity also applies to the financial aspects of coverage, including copayments, deductibles, out-of-pocket maximums, and annual/lifetime dollar limits, which must not be more restrictive for behavioral health treatment than for medical care (CMS, 2025). The MHPAEA mandates that both QTLs and NQTLs[5] cannot be applied to behavioral health benefits unless they are comparable to limitations imposed on medical or surgical benefits, as shown in Figure 2 (CMS, 2025). Further, the clinical criteria used to determine whether care is approved or denied must be comparable across behavioral health and physical services. Importantly, health plans and policies are required to make available, upon request, the standards they use to determine medical necessity for behavioral health services and an explanation when coverage is denied.

[5] QTLs are based on numerical values, such as limits on the amount of visits a year a plan or policy will cover. In contrast, NQTLs are not easily quantified and, as an example, can include geographical limitations on where treatment can be provided.

2024 Final MHPAEA Rules and Key Updates

The 2024 final rules for the MHPAEA were issued by the Departments of Labor, Health and Human Services, and the Treasury. According to the authors, the intent of the final rules is to strengthen enforcement, reduce administrative hurdles, and improve access to behavioral health care. These updates reinforce that access to behavioral health care cannot be more restrictive than access to medical/surgical benefits (EBSA, 2024). The rules also clarify that NQTLs, such as prior authorization – also known as pre-authorization – requirements or network adequacy standards, must be applied in a way that is no more stringent for behavioral health services than for medical or surgical care. To ensure compliance, the rules require insurers to monitor and analyze data to identify disparities in access caused by NQTLs[6] and take corrective action when necessary (EBSA, 2024). On May 15, 2025, the federal Departments of Labor, Health and Human Services (HHS), and the Treasury announced that they will revisit the 2024 MHPAEA final rules following litigation by the ERISA Industry Committee challenging the ruling and a directive under Executive Order 14219 to review potentially burdensome regulations (EBSA, 2025). While the authors of the 2024 final rules reconsider the rules (to revise or rescind), they will not be enforced for an indefinite amount of time, though the MHPAEA's core statutory protections remain in effect.

State Parity Laws

States may enforce their own parity laws so long as they are inclusive of existing federal rules. For example, health plans and policies must cover behavioral health benefits if state law mandates it, even though federal parity does not require coverage, only parity. Federal law overrides state laws only if state law impacts parity between behavioral health and physical health benefits.

California Law

Enacted in 1999 and amended in 2024, California's Mental Health Parity Act[7] goes beyond the scope of the federal MHPAEA. Importantly, California law requires all state-regulated health plans and policies to provide behavioral health treatment at all levels of care (e.g., inpatient, outpatient, residential, partial hospitalization, intensive outpatient). The federal MHPAEA, in contrast, does not mandate that plans and policies provide behavioral health disorder benefits, but only regulates parity when they are covered. California law also adds network adequacy rules to the existing requirements of the MHPAEA: if in-network care isn't available, the plan or policy must cover out-of-network care at in-network costs.

Conclusion

Understanding federal laws like the MHPAEA is essential when crafting and evaluating state-level legislation, as the two often interact and overlap. While the MHPAEA sets a federal baseline by requiring parity when behavioral health benefits are offered, state laws can expand upon these protections by mandating coverage for specific conditions or applying broader protections, provided they do not undermine federal law. Policymakers must consider both federal and state requirements to avoid conflicts, ensure compliance, and effectively expand access to behavioral health services. CHBRP evaluates the potential overlap between proposed legislation and existing requirements under both the MHPAEA and California's behavioral health parity laws. It is important to note that the 2024 final rules of the MHPAEA are not currently being enforced. Federal agencies have paused enforcement of the 2024 MHPAEA final rules while they review them in light of litigation and regulatory directives, but core MHPAEA protections still apply.

[6] Additionally, under the Consolidated Appropriations Act of 2021, insurers must conduct and document comparative analyses demonstrating that their NQTLs meet parity requirements, though these reports are not required to be publicly available. These rules also explicitly prohibit the use of standards that systematically disadvantage behavioral health care.
[7] See California Health & Safety Code §1374.72 and Insurance Code §10144.5

About the California Health Benefits Review Program (CHBRP)

Drawing on the experience and assistance of multi-disciplinary faculty, researchers, and analysts based at the University of California, CHBRP provides the California Legislature with timely, independent, and rigorous evidence-based analyses of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g., mandates to cover a test, treatment, or service, such as continuous glucose monitors). For more about CHBRP's 60-day analysis process, see the resource Academic Rigor on a Legislature's Timeline.

To read any of the 200+ bill analyses CHBRP has completed, see the Completed Analysis page on CHBRP's website. In addition to analysis of introduced legislation, CHBRP produces other publications including several annually updated resources, as well as issue briefs and explainers.

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