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Mental Health Parity and Coverage in Private Health Insurance: Federal Requirements

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Introduction

Mental health conditions and substance use disorders are common in the United States. According to estimates from the Substance Abuse and Mental Health Services Administration (SAMHSA) derived from the 2021 National Survey on Drug Use and Health, 82.5 million adults in the United States reported having had either a mental health condition or a substance use disorder in 2021. Participation in treatment for these conditions is also common. In 2021, 46.5 million adults reported that they had received mental health treatment and 4 million adults reported that they had received substance use treatment in the past year.¹

Given that most people in the United States have private health insurance,² there is considerable congressional interest in understanding private coverage of mental health and substance use disorder (MH/SUD) benefits, including diagnostic and treatment services. This report explains federal requirements related to coverage of MH/SUD benefits, as well as federal mental health parity requirements, with respect to private health insurance.³

- **Benefit coverage requirements** generally address whether a plan must cover certain health care services or items. The two federal provisions most relevant to private health insurance coverage of MH/SUD benefits are the requirements that (1) certain plans cover a set of essential health benefits (EHB) and (2) most plans cover certain preventive services without cost sharing. For example, per EHB requirements, plans must offer a core package of 10 categories of health benefits, one of which is “mental health and substance use disorder services, including behavioral health treatment.”⁴
- **Mental health parity requirements** do not mandate that plans cover MH/SUD benefits. However, when an applicable plan (i.e., a plan otherwise subject to parity law) *does* cover MH/SUD benefits and medical/surgical (M/S) benefits, parity law generally prohibits the imposition of more restrictive limitations on MH/SUD benefits than on M/S benefits.

This report explains these MH/SUD benefit coverage and parity requirements, as well as the types of private health insurance plans subject to such requirements. It includes a brief review of relevant legislative history—including changes enacted in December 2022—and a discussion and examples of required federal agency activities (e.g., oversight and reporting).

The report’s focus is federal private health insurance requirements; it does not compare state requirements or actual plan variations in coverage. This report also does not address mental health benefits in public programs such as Medicare and Medicaid.

¹ Estimates in this paragraph are from pp. 41, 58, and 51, respectively, of Substance Abuse and Mental Health Services Administration (SAMHSA), *Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health*, January 2023, at <https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report>. See the SAMHSA report for additional details, other estimates, and data sources and methodology. These data are not specific to individuals with private health insurance.

² See CRS In Focus IF10830, *U.S. Health Care Coverage and Spending*, for overviews of different sources of health coverage in the United States, including private health insurance, Medicare, and Medicaid.

³ Mental health and substance use are often collectively referenced as *behavioral health*, but this report generally does not use this term, given specific references in relevant private health insurance requirements to mental health and/or substance use conditions and/or benefits.

⁴ 42 U.S.C. §18022(b)(1)(E).

Legislative History

EHB and preventive services coverage requirements were enacted in 2010 via the Patient Protection and Affordable Care Act (ACA, as amended).⁵

The first federal mental health parity law, the Mental Health Parity Act of 1996 (MHPA), applied limited parity requirements to certain group health plans.⁶ The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) expanded on MHPA’s private health insurance parity requirements. Five laws have since amended MHPAEA and federal parity law with regard to private health insurance: the ACA in 2010; the Helping Families in Mental Health Crisis Reform Act of 2016 (Division B of the 21st Century Cures Act of 2016, or the Cures Act); the SUPPORT for Patients and Communities Act (SUPPORT Act), enacted in 2018; the Consolidated Appropriations Act, 2021 (CAA 2021), enacted in 2020; and the Consolidated Appropriations Act, 2023 (CAA 2023), enacted in 2022.

Over time, the legislative changes have increased the scope of parity law to include substance use disorder benefits in addition to mental health benefits; expanded the required areas of parity and addressed classification of benefits; expanded federal parity law’s applicability to most types of private health insurance plans; and specified that if an applicable plan covers eating disorder treatment, such coverage is subject to parity requirements. In addition, multiple changes have aimed to improve plans’ understanding of and compliance with parity requirements and increase federal enforcement of and reporting on parity requirements. Although MHPAEA has been amended multiple times, the body of federal parity law is still commonly called *MHPAEA*.⁷

In general, the Departments of Health and Human Services (HHS), Labor, and the Treasury (in this report, the Tri-Agencies) coordinate enforcement with respect to federal private health insurance requirements.

Benefit Coverage Requirements

MH/SUD benefits may include services, such as office visits or hospital stays, or items, such as prescription medications. MH/SUD benefits may be furnished by a range of providers (e.g., psychiatrists, psychologists, psychiatric nurses, licensed professional counselors) and via various settings and modalities (e.g., inpatient, outpatient, telehealth).

The two federal provisions most relevant to private health insurance coverage of MH/SUD benefits are the requirements that (1) certain plans cover a set of EHB and (2) most plans cover certain preventive services without cost sharing.⁸ These requirements are explained below (see

⁵ See **Table A-1** for full citations of and relevant details regarding all legislation in this section.

⁶ See “Plans Subject to Coverage and Parity Requirements” for more information about plan types and applicability of parity law.

⁷ Most of the private health insurance parity requirements from the above laws are codified as similar provisions in three separate federal statutes: the Public Health Service Act (PHSA) Section 2726, at 42 U.S.C. §300gg-26; the Employee Retirement Income Security Act (ERISA) Section 712, at 29 U.S.C. §1185a; and the Internal Revenue Code (IRC) Section 9812, at 26 U.S.C. §9812. This report generally uses the PHSA citations.

⁸ Other types of federal requirements—those not specific to mental health and substance use disorder (MH/SUD) benefit coverage or parity—also may be relevant. See, for example, “Requirements Related to Health Care Providers” in CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*, and network adequacy requirements in the “Qualified Health Plans” section of CRS Report R44065, *Overview of Health Insurance Exchanges*.

“Plans Subject to Coverage and Parity Requirements” regarding the requirements’ applicability to different types of private plans).

There is no federal requirement that all private health insurance plans cover a set of specific MH/SUD benefits (or M/S benefits), beyond what is described below.

Coverage of the Essential Health Benefits

Certain plans must cover a core package of 10 categories of health care benefits, known as the *essential health benefits*.⁹ One category of EHB is “mental health and substance use disorder services, including behavioral health treatment.”¹⁰ Other EHB categories also may include benefits relevant to MH/SUD.¹¹ For example, current EHB prescription drug coverage regulations effectively require applicable plans (those subject to EHB requirements) to cover at least one form of naloxone, a drug that can treat opioid overdoses.¹²

States, rather than the federal government, generally specify the benefit coverage requirements within the EHB categories. Current regulation allows each state to select an EHB *benchmark plan*, within certain parameters. The benchmark plan serves as a reference for applicable plans in that state, which must provide EHB coverage that is “substantially equal” to such coverage in the benchmark plan, as specified in regulations.¹³ Because states select their own EHB benchmark plans, EHB coverage may vary considerably from state to state.¹⁴

Federal law permits consumer cost sharing (e.g., deductibles, coinsurance, and co-payments, up to an annual out-of-pocket limit) for most categories of EHB. Coverage and cost sharing for EHB furnished by out-of-network providers may vary, subject to applicable federal and state requirements.¹⁵ Certain federal limits on cost sharing, such as a prohibition on lifetime and annual coverage limits, apply to the EHB.¹⁶

⁹ 42 U.S.C. §300gg-6; 42 U.S.C. §18022; 45 C.F.R. §156.115.

¹⁰ 42 U.S.C. §18022(b)(1)(E).

¹¹ The 10 essential health benefit (EHB) categories are (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

¹² Department of Health and Human Services (HHS), “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019,” 83 *Federal Register* 16930, April 17, 2018. See footnote 64, referencing 45 C.F.R. §156.122(a)(1) and other sections of regulation.

¹³ 45 C.F.R. §156.115(a)(1).

¹⁴ For more information on the process for defining the EHB, and for links to state benchmark plans, see Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), “Information on Essential Health Benefits (EHB) Benchmark Plans,” at <https://www.cms.gov/cciiio/resources/data-resources/ehb>.

¹⁵ In general, beginning with each plan year, an enrollee pays 100% of costs for covered health care benefits until the costs meet a certain threshold amount called a *deductible*. Exceptions apply. After that, the enrollee pays coinsurance (a percentage amount) or co-payments (a flat amount) for covered benefits, and the plan pays the rest. If an enrollee’s spending meets an annual out-of-pocket limit, the plan generally will pay 100% of covered costs for the remainder of the plan year. See CRS Report RL32237, *Health Insurance: A Primer*, for further explanations of cost sharing, including when benefits are furnished by out-of-network providers.

¹⁶ Plans are prohibited from setting lifetime or annual dollar limits on their coverage of the EHB, generally whether provided in network or out of network. This prohibition applies to individual and fully insured small-group plans, which are subject to EHB requirements. It also applies to large-group and self-insured plans; because these plans are not required to cover EHB, regulations address how the plans may define their benefits for purposes of this

Coverage of Certain Preventive Services Without Cost Sharing

There is also a federal requirement that most plans cover specified preventive services and items without cost sharing.¹⁷ These services and items include, at a minimum, four categories of preventive benefits recommended by specified entities, such as the United States Preventive Services Task Force (USPSTF). The recommendations include various MH/SUD screenings for specified populations, such as men and/or women of certain ages, pregnant and postpartum persons, adolescents, and children.¹⁸

The recommended benefits are meant to be *preventive* in nature—that is, provided to specified populations without regard to the presence of a diagnosis or particular symptoms. Preventive benefits include, for example, depression screenings for the general adult population as recommended by the USPSTF. If an individual has symptoms and needs a certain screening (e.g., a depression screening) for purposes of *diagnosis*, that screening may not necessarily be covered without cost sharing per this federal requirement. The same is true if a screening identifies a condition that needs further treatment. However, the plan may cover diagnostic screenings and treatments (with or without cost sharing), including due to other applicable federal requirements (e.g., EHB) or state requirements.

Mental Health Parity Requirements

Federal parity law does not require private health insurance plans to cover MH/SUD benefits, when such coverage is not otherwise required by federal or state law. However, when an applicable plan covers both MH/SUD benefits and M/S benefits,¹⁹ federal parity law generally prohibits the imposition of more restrictive limits on MH/SUD benefits than on M/S benefits, as specified below and summarized in **Table 1**. Parity law also includes information disclosure and other requirements discussed later in this section.

Although this body of law is commonly referred to as *mental health parity*, and although initial parity law did apply only to mental health benefits, current parity law applies to both mental health and substance use disorder benefits (to the extent they are covered).

Parity Law Definitions of MH/SUD Benefits

The question of whether a covered benefit is considered an MH/SUD benefit can have implications for the applicability of parity requirements. Within mental health parity statute, the definition of *mental health benefits* is “benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law” (emphasis added).²⁰ Similarly, the definition of *substance use disorder benefits* references benefits with respect to services for substance use disorders. The terms *mental health*

requirement. See CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*, for additional information on this and other federal requirements relevant to consumer cost sharing.

¹⁷ 42 U.S.C. §300gg-13; 45 C.F.R. §147.130.

¹⁸ For the preventive benefits that must be covered (1) for all adults, (2) additionally for women, and (3) for children and adolescents, from across the four categories of recommendations, see HealthCare.gov, “Preventive Health Services,” at <https://www.healthcare.gov/preventive-care-benefits/>. For more information on the coverage requirement and recommendation categories, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

¹⁹ Regarding applicable plans, see “Plans Subject to Coverage and Parity Requirements.”

²⁰ See 42 U.S.C. §300gg-26(e) for these definitions of mental health benefits and substance use disorder benefits.

conditions and *substance use disorders* are not further defined in mental health parity statutory language.

In parity regulations, the definitions of *mental health benefits* and *substance use disorder benefits* include additional clarifications. For example, the regulatory definition of mental health benefits states that “any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines).”²¹

In general, parity law does not further specify that any particular type of benefits be considered MH/SUD benefits. However, a provision of the Cures Act specified that parity requirements apply to eating disorder benefits, if these benefits are covered.²² (See also the discussion below of “Coverage of MH/SUD Benefits in the Six Classifications.”)

Parity Requirements Related to Coverage Limits and Benefit Classifications

Parity Requirements and Parity Tests

Statutory and regulatory parity requirements focus primarily on whether and how plans may impose certain types of coverage limits on their MH/SUD benefits, within six classifications of benefits. Parity law provides different tests to determine compliance with the various requirements.

Parity requirements apply to the following types of coverage limits:²³

- **Aggregate Lifetime Limits and Annual Limits:** Dollar limits on plans’ coverage of benefits
- **Financial Requirements:** Consumer cost-sharing requirements for covered benefits (e.g., co-payments)
- **Quantitative Treatment Limitations (QTLs):** Numeric benefit coverage limits (e.g., number of days or visits covered)
- **Non-quantitative Treatment Limitations (NQTLs):** Non-numeric benefit coverage limits (e.g., utilization review requirements)

The above are all types of coverage limits that a plan may impose on any benefit it covers (not just MH/SUD), subject to federal and state law. For example, a plan may specify that inpatient hospital stays for certain conditions are covered only when the plan has provided preauthorization to the enrollee or provider; this example would be a type of NQTL.

Parity requirements related to these coverage limits apply in each of six classifications of benefits that parity regulations have established: (1) in-network inpatient, (2) out-of-network inpatient, (3)

²¹ 45 C.F.R. §146.136(a). The ICD is the Internal Classification of Diseases. Also see the Department of Labor (DOL), HHS, and Department of the Treasury, “Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA),” updated October 2020, at <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf> (hereinafter referred to as Tri-Agency Self-Compliance Tool 2020).

²² 42 U.S.C. §300gg-26, Statutory Note, “Clarification of Existing Parity Rules.”

²³ 42 U.S.C. §300gg-26(a)(1, 2, 3) and 45 C.F.R. §146.136(a-c).

in-network outpatient, (4) out-of-network outpatient, (5) emergency care, and (6) prescription drugs.²⁴

In short, parity statute and regulations prohibit plans from imposing more restrictive limits on MH/SUD benefits than on M/S benefits, in terms of *each* type of coverage limit listed above, within *each* of these benefit classes. For example, a plan must ensure its NQTL requirements are no more restrictive for MH/SUD benefits than for M/S benefits for in-network inpatient services and, separately, for emergency care.²⁵

The tests for determining parity compliance are specified in statute and regulation. For example, there is one test for quantitative parity requirements (including financial requirements and QTLs), a different test for NQTL parity requirements, and another test for aggregate lifetime and annual limits. **Table 1** summarizes all of the parity requirements and their parity tests.

Table 1. Parity Requirements Related to Coverage Limits (Private Health Insurance)

Coverage Limits Subject to Parity Law ^a	Definition of Coverage Limit in Parity Law	Test for Determining Parity Compliance
Aggregate Lifetime Limits	Dollar limitations on the “total amount” the plan will pay for specified benefits for a “coverage unit” (e.g., an enrollee or family).	If a plan <i>does not</i> include aggregate lifetime or annual limits on <i>substantially all</i> medical/surgical (M/S) benefits, it may not impose <i>any</i> such limits on mental health/substance use disorder (MH/SUD) benefits. ^b
Annual Limits	Dollar limitations on the total amount the plan will pay for specified benefits “in a 12-month period” for a coverage unit.	
Financial Requirements	Cost-sharing requirements for coverage units such as co-payments and coinsurance, and “cumulative financial requirements” such as deductibles and out-of-pocket maximums.	A plan may not impose a financial requirement or QTL on MH/SUD benefits that is “more restrictive than the <i>predominant</i> financial requirement or treatment limitation of that type applied to <i>substantially all</i> [M/S] benefits” in the same classification. ^c
Quantitative Treatment Limitations (QTLs)	Numeric benefit coverage restrictions or plan attributes, such as limits on the number of days or visits covered.	
Non-Quantitative Treatment Limitations (NQTLs)	Non-numeric benefit coverage restrictions or plan attributes. Examples of NQTLs include “medical management standards (e.g., limits based on medical necessity or if a treatment is experimental);” drug formularies; step therapy requirements; and “standards for provider admission to participate in a network, including reimbursement rates.”	A plan may not impose an NQTL on MH/SUD benefits unless “any processes, strategies, evidentiary standards, or other factors” used in applying the NQTL to MH/SUD benefits are “ <i>comparable to, and are applied no more stringently than,</i> ” the processes, etc., used in applying the limitation with respect to M/S benefits in the same classification. ^d

Source: CRS analysis of statutory and regulatory provisions at 42 U.S.C. §300gg-26 and 45 C.F.R. §146.136. Quoted language in the table is from these provisions. For example, see the definitions of aggregate lifetime limits and annual limits at 42 U.S.C. §300gg-26(e), and see examples of NQTLs at 45 C.F.R. §146.136(c)(4).

Notes: Certain emphases added (e.g., predominant and substantially all).

- a. As specified, these coverage limits for MH/SUD benefits must be no more restrictive than such coverage limits for M/S benefits, within each of six benefit classifications in which MH/SUD benefits are covered: (1) in-network inpatient, (2) out-of-network inpatient, (3) in-network outpatient, (4) out-of-network outpatient, (5) emergency care, and (6) pharmacy.

²⁴ 45 C.F.R. §146.136(c)(2)(ii). Also see 42 U.S.C. §300gg-26(a)(4) regarding coverage of benefits furnished by out-of-network providers.

²⁵ See Tri-Agency Self-Compliance Tool 2020, Section B regarding the benefit classifications, including determining which class a benefit (such as certain “intermediate” services) belongs in and allowable subclassifications (e.g., outpatient office visits versus all other outpatient services).

- b. Statutory and regulatory parity language also provide for situations in which a plan *does* include an aggregate lifetime or annual limit on substantially all M/S benefits or on different categories of benefits. However, given other federal provisions that prohibit most plans from imposing lifetime or annual limits on coverage (as specified by such provisions), parity regulations and guidance acknowledge that such situations are rare. See 45 C.F.R. §146.136(b) and Tri-Agency Self-Compliance Tool 2020, Section C.
- c. Regulations apply numerical standards to the terms *predominant* and *substantially all*, and establish a two-step mathematical test by which applicable plans can determine allowable restrictions on MH/SUD benefits in each classification. To explain the two-step test via an example, an applicable plan may impose a deductible on its in-network inpatient MH/SUD benefits only if it also imposes a deductible on at least two-thirds (i.e., *substantially all*) of its in-network inpatient M/S benefits. If that is the case, the deductible for such MH/SUD benefits may not be higher than the deductible applied to more than half (i.e., the *predominant*) of the in-network inpatient M/S benefits. For further details, see 45 C.F.R. §146.136(c)(3)(i)(A), 45 C.F.R. §146.136(c)(3)(i)(B)(I), and the Tri-Agency Self-Compliance Tool 2020, Sections D and E.
- d. For example, what are the standards by which a plan applied a medical necessity determination to MH/SUD benefits in a class, as compared with M/S benefits in that class? Or, what are the factors a plan used to set its provider reimbursement rates and otherwise establish its provider network for MH/SUD providers as compared with M/S providers? MH/SUD provider reimbursement rates need not be the *same* as M/S provider reimbursement rates, nor does parity law require any particular MH/SUD reimbursement rates, but parity guidance provides various “warning signs” to plans about provider reimbursement rates and related topics (see Tri-Agency Self-Compliance Tool 2020 Appendix II). For more information about NQTL parity requirements, see 45 C.F.R. §146.136(c)(4) and the Tri-Agency Self-Compliance Tool 2020, Section F.

Coverage of MH/SUD Benefits in the Six Classifications

Besides their relevance to the specified coverage limits, the six classifications of benefits also are related to a coverage requirement for plans that are subject to parity law. Although parity law does not include a benefit coverage mandate in general, it does provide that if an applicable plan covers MH/SUD benefits in *any* of the six classifications, the plan must cover MH/SUD benefits in *all* of the classes in which it also covers M/S benefits.²⁶

This does not necessarily require plans to cover particular MH/SUD benefits within a class, but it means a plan cannot exclude coverage of a whole class of MH/SUD benefits if the plan covers M/S benefits in that class. For example, if a plan provides any coverage of out-of-network outpatient M/S services, it also must cover some out-of-network outpatient MH/SUD services. By contrast, if a plan does *not* cover any M/S benefits in a class (which may be the case for inpatient or outpatient out-of-network benefits), the plan does not have to cover any MH/SUD benefits in that class.²⁷

Parity Requirements Related to Disclosure and Documentation

Information Disclosure to Enrollees and Others

Applicable plans are required to disclose certain information related to medical necessity determinations and/or denials of payment, with respect to MH/SUD benefits, upon request by specified parties. Per parity statutory and regulatory provisions,²⁸

²⁶ 45 C.F.R. §146.136(c)(2)(ii)(A). Also see 42 U.S.C. §300gg-26(a)(5), specific to coverage of MH/SUD benefits provided out-of-network, if medical/surgical benefits are covered out-of-network.

²⁷ See the Tri-Agency Self-Compliance Tool 2020, Section B, for further discussion and examples of this requirement, including as related to coverage of medication-assisted treatment for opioid use disorder.

²⁸ See 42 U.S.C. §300gg-26(a)(4) for requirements listed in both bullets, including quoted language. Also see 45 C.F.R. §146.136(d). As discussed in such parity regulations and in the Tri-Agency Self-Compliance Tool 2020, Section G, there are also relevant federal requirements not specific to parity (e.g., 29 U.S.C. §1133 and 29 C.F.R. §2560.503-1, regarding claims procedures).

- **“The criteria for medical necessity determinations”** made with respect to MH/SUD benefits must be disclosed to “any current or potential participant, beneficiary, or contracting provider upon request.”
- **“The reason for any denial ... of reimbursement or payment for services”** with respect to MH/SUD benefits, including applicable medical necessity criteria as applied to that enrollee, must be disclosed to any participant or beneficiary who receives such a denial.

Annual NQTL Comparative Analyses

As discussed above, federal requirements prohibit applicable plans from imposing more restrictive NQTLs (and other specified types of limits) on MH/SUD benefits than on M/S benefits.

Per the CAA 2021, plans also are required to annually “perform and document comparative analyses of the design and application of NQTLs” and to make such analyses available to the Tri-agency Secretaries or applicable state authorities, upon request (see “Federal Oversight of Parity Requirements” section below).²⁹ These analyses must include statutorily specified information, such as a description of all MH/SUD and M/S benefits to which each NQTL applies in each benefit classification, and demonstrations of compliance with NQTL parity standards.

Parity Requirements Related to Oversight and Reporting

Parity law includes oversight and reporting requirements for federal agencies. There are also newly authorized grants to states for parity enforcement.

Federal Oversight of Parity Requirements³⁰

The Tri-Agency Secretaries must annually request and review at least 20 of the NQTL analyses described above from plans that “involve potential [parity] violations” or complaints of noncompliance, or in “any other instances in which the Secretary determines appropriate.”³¹ Required follow-up actions are specified if more information is needed or parity violations are found.

In addition, per the Cures Act, if the Tri-Agency Secretaries determine a plan has violated parity requirements five times, the Secretaries must audit plan documents in the following plan year.³²

Required Federal Reports, Rulemaking, Guidance, and Other Activities

The Tri-Agencies are required to submit annual and biannual reports to Congress on issues related to parity compliance, including the NQTL analyses discussed above.³³ Parity law also includes requirements for agency guidance (including a “compliance program guidance document” and “additional guidance” as specified), and other activities (e.g., a public meeting of stakeholders “to

²⁹ 42 U.S.C. §300gg-26(a)(8)(A).

³⁰ For additional information about federal enforcement of private health insurance requirements in general, see CRS Report R46637, *Federal Private Health Insurance Market Reforms: Legal Framework and Enforcement*.

³¹ 42 U.S.C. §300gg-26(a)(8)(B).

³² 42 U.S.C. §300gg-26, Statutory Note, “Improving Compliance.”

³³ As required biannually (beginning in 2012) by MHPAEA: 29 U.S.C. §1185a(f). As required annually (beginning December 2021) by the CAA 2021: 42 U.S.C. §300gg-26(a)(8)(B)(iv). The Cures Act, as amended by the SUPPORT Act, also required annual reporting for five years on federal investigations into parity compliance. See **Table A-1**.

produce an action plan for improved federal and state coordination” related to enforcement of MHPAEA and state parity laws).³⁴ MHPAEA required Tri-Agency rulemaking on parity requirements.³⁵ Examples of reports, guidance, and other deliverables created to fulfill these requirements include the following:³⁶

- A January 2022 Tri-Agency report to Congress meets several agency reporting requirements for the year, including the Departments’ first required review of plans’ NQTL comparative analyses and discussions of other compliance issues.³⁷
- A Self-Compliance Tool (i.e., the compliance program guidance document), last updated in October 2020, is meant to help applicable plans, state regulators, and other stakeholders understand and comply with parity requirements.³⁸
- Several Tri-Agency FAQs, issued between June 2017 and September 2019, are examples of the required additional guidance.³⁹ They addressed information disclosure requirements, NQTL parity requirements, and required agency activities (e.g., the stakeholder meeting and action plan).
- A November 2013 final rule implemented MHPAEA and ACA parity requirements.⁴⁰

In addition, certain parity provisions have required Government Accountability Office (GAO) reports to Congress. GAO has published multiple reports on mental health parity and mental health access in private health insurance, for example in 2011,⁴¹ 2019,⁴² 2021,⁴³ and 2022.⁴⁴

³⁴ See 42 U.S.C. §300gg-26(a)(6) regarding the “compliance program guidance document”; 42 U.S.C. §300gg-26(a)(7) regarding “additional guidance”; and Cures Act, Division B, Title XIII, §13002 regarding the action plan.

³⁵ MHPAEA, Division C, Title V, Subtitle B, §512(d).

³⁶ See additional resources, including prior-year reports to Congress, at DOL and HHS parity webpages: <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>; and https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.

³⁷ DOL, HHS, and the Treasury, *Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage*, 2022 MHPAEA Report to Congress, January 2022, at <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf>.

³⁸ Tri-Agency Compliance Tool 2020, as cited at footnote 21.

³⁹ Tri-Agency FAQs 38, 39, and related documents (June 2017-September 2019), at CMS, CCIIO, “Fact Sheets and Frequently Asked Questions (FAQs),” at https://www.cms.gov/ccio/resources/fact-sheets-and-faqs#Mental_Health_Parity. Also see Tri-Agency FAQ 45 (April 2021) on the NQTL comparative analyses.

⁴⁰ Treasury, Internal Revenue Service; DOL, Employee Benefits Security Administration; and HHS, CMS, “Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program,” 78 *Federal Register* 68239, November 13, 2013.

⁴¹ Government Accountability Office (GAO), *Mental Health and Substance Use: Employers’ Insurance Coverage Maintained or Enhanced Since Parity Act, But Effect of Coverage on Enrollees Varied*, GAO-12-63, November 30, 2011, at <https://www.gao.gov/products/gao-12-63>.

⁴² GAO, *Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies*, GAO-20-150, December 13, 2019, at <https://www.gao.gov/products/gao-20-150>.

⁴³ GAO, *Behavioral Health: Patient Access, Provider Claims Payment, and the Effects of the COVID-19 Pandemic*, GAO-21-437R, March 31, 2021, at <https://www.gao.gov/products/gao-21-437r>.

⁴⁴ GAO, *Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts*, GAO-22-104597, March 30, 2022, at <https://www.gao.gov/products/gao-22-104597>.

Grants to States for Parity Enforcement

The CAA 2023 established new HHS grants for states “to enforce and ensure compliance with” mental health parity requirements.⁴⁵ The act authorized to be appropriated \$10 million for each of the first five fiscal years beginning after the date of enactment, to remain available until expended, for purposes of awarding these grants. To be eligible for the grants, states must agree to request and review (an unspecified number of) the NQTL comparative analyses required of plans, as described above. The HHS Secretary is otherwise required to specify the timing, manner, and information requirements for state applications for the grants.

Plans Subject to Coverage and Parity Requirements

Broadly, private health insurance includes *group plans* of several types and *nongroup plans*. Federal private health insurance requirements may apply to some or all such plans.⁴⁶

Group plans largely refer to health benefits provided to employees (and their dependents) by employers that sponsor such benefits. Employers and other group health plan sponsors may purchase coverage from a state-licensed insurer and offer it to their group (i.e., they may *fully insure*). Sponsors may instead finance coverage themselves (i.e., they may *self-insure*). Fully insured plans may be purchased in the large- or small-group markets. For purposes of private health insurance regulation, a *small group* is typically defined as a group of up to 50 individuals (e.g., employees) and a *large group* is typically defined as one with 51 or more individuals.

Consumers purchase *nongroup plans* directly from an insurer. In general, nongroup plans are fully insured. The nongroup market (also called the *individual market*) and the small-group market include plans sold on and off the health insurance exchanges—the individual exchanges and Small Business Health Options Program exchanges, respectively.⁴⁷

Federal private health insurance requirements generally apply to some or all of the following types of plans: (1) fully insured group plans offered by large employers (i.e., large-group plans), (2) fully insured group plans offered by small employers (i.e., small-group plans), (3) self-insured group plans, and (4) nongroup plans. Federal requirements on self-insured group plans generally do not depend on group size; however, due to certain details regarding parity requirements, this report specifies the following variations: (3a) self-insured group plans offered by large employers and (3b) self-insured group plans offered by small employers.

Table 2 summarizes the applicability of EHB, preventive services, and mental health parity requirements to such plans. Additional discussion of parity applicability follows the table.

⁴⁵ 42 U.S.C. §300gg-94(c)(3).

⁴⁶ For simplicity, this report refers to requirements on private health insurance *plans*, but such requirements are generally on the health insurance *issuers* that sell plans or the sponsors (such as employers) that offer plans.

⁴⁷ The exchanges are government-administered marketplaces in which consumers and small businesses can purchase private health insurance offered by participating insurers. Plans sold in the individual and Small Business Health Options Program exchanges must meet the requirements applicable to the nongroup and small-group markets, respectively. Additional requirements apply only to exchange plans. For more information, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

Table 2. Applicability of Mental Health Parity and Selected Benefit Coverage Requirements to Specified Types of Private Health Insurance Plans

Type of Plan	Essential Health Benefits (EHB)	Preventive Services Without Cost Sharing	Mental Health Parity ^a
Fully Insured Group Plan (Large Employer)	NA	√	√ ^b
Fully Insured Group Plan (Small Employer) ^c	√	√	√ ^d
Self-Insured Group Plan (Large Employer)	NA	√	√ ^b
Self-Insured Group Plan (Small Employer)	NA	√	NA
Nongroup Plan ^c	√	√	√

Sources: CRS analysis of statutory and regulatory provisions. **EHB:** 42 U.S.C. §300gg-6; 42 U.S.C. §18022; 45 C.F.R. §156.115. **Preventive Services:** 42 U.S.C. §300gg-13; 45 C.F.R. §147.130. **Parity:** 42 U.S.C. §300gg-26, 45 C.F.R. §146.136.

Notes: NA = not applicable. See “Plans Subject to Coverage and Parity Requirements” regarding the plan types listed above.

- Specified plans are subject to parity requirements *if* they cover mental health/substance use disorder benefits and medical/surgical benefits.
- These plans can request time-limited parity exemptions if implementation would increase their costs, as specified in law. See footnote 49 for details.
- Nongroup and small-group plans (i.e., fully insured group plans offered by small employers) include those sold on and off the exchanges.
- These plans are subject to parity primarily because of the incorporation of parity into EHB requirements.

As shown above, most types of private health insurance plans are subject to federal parity laws *if they cover* MH/SUD benefits and unless otherwise exempted. Small, self-insured group plans are exempt from parity requirements.⁴⁸ Certain plans also may qualify for an *increased cost exemption* under parity law (i.e., plans for which implementing parity would result in increased costs above specified thresholds).⁴⁹

Although the parity exemption for small employers initially applied to both self-insured and fully insured plans, plans subject to EHB requirements also are subject to parity requirements, per EHB and parity regulations.⁵⁰

In contrast to the relationship between EHB and parity requirements, the preventive services coverage requirements do not trigger parity requirements. In other words, if the only MH/SUD benefits a plan covers are the MH/SUD preventive services, in compliance with that federal requirement, this does not constitute coverage of MH/SUD benefits that would generally trigger the requirement to comply with federal parity law.⁵¹ By contrast, if state law requires a plan to cover MH/SUD benefits, the plan would then also be subject to federal parity law, unless otherwise exempt.

⁴⁸ 42 U.S.C. §300gg-26(c)(1) and 45 C.F.R. §146.136(f).

⁴⁹ 42 U.S.C. §300gg-26(c)(2) and 45 C.F.R. §146.136(g). Plans that incur increased “actual total costs” (due to parity requirements, as specified) above 1% in a plan year may claim an exemption from parity law for the following plan year. However, nongroup and small-group plans that must cover the EHB and thus are subject to parity requirements (as discussed in this section) do not appear to be eligible for this exemption, per 45 C.F.R. §146.136(e)(4).

⁵⁰ 45 C.F.R. §146.136(e)(4), 45 C.F.R. §156.115(a)(3).

⁵¹ See “Mental Health Parity Requirements.”

Certain Other Types of Plans

Certain other types of private health plans, such as *grandfathered plans* and *short-term, limited-duration insurance*, do not have to comply with most or all federal health insurance requirements. These and other coverage types are discussed in a separate CRS report.⁵²

That report also discusses *self-insured, nonfederal governmental plans*, which previously could opt out of parity and other specified federal requirements. Per the CAA 2023, these plans can no longer opt out of mental health parity requirements.⁵³

⁵² See CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

⁵³ 42 U.S.C. §300gg-21(a)(2)(F).

Appendix. Legislative History Summary Table

Table A-I. Legislative History of Mental Health Parity and Selected Benefit Coverage Requirements Applicable to Private Health Insurance Plans

Public Law	Summary of Relevant Provisions
Mental Health Parity Act of 1996 (MHPA) P.L. 104-204, Title VII (§§701-703)	Required parity in terms of annual and lifetime limits for MH benefits. Applied parity law to large-employer plans (fully or self-insured) that covered MH and M/S benefits. Provided exemptions for small-employer plans (fully or self-insured) and for plans facing increased costs due to parity implementation. As enacted, set to expire September 30, 2001. (Extended by other laws between 1997 and 2008.)
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) P.L. 110-343, Division C, Title V, Subtitle B (§§511-512)	Expanded scope of parity law to include SUD in addition to MH benefits. Added new parity requirements regarding financial requirements and treatment limitations, benefits furnished by out-of-network providers, and information disclosure. Amended the small-employer and increased-cost exemption provisions. Required biannual DOL reports to Congress on parity compliance, Tri-Agency rulemaking and guidance on parity requirements, and a GAO report on MH/SUD benefit coverage and exclusions. Removed parity law sunset dates.
Patient Protection and Affordable Care Act (ACA , as amended, 2010) P.L. 111-148 (§§1001, 1201, 1302, 1311, 1563)	Required nongroup and small-group plans (i.e., fully insured plans offered by small employers) to cover the EHB, and most plans to cover preventive services without cost sharing. Directly and/or effectively expanded the applicability of parity law to nongroup and small-group plans, as specified.
Helping Families in Mental Health Crisis Reform Act of 2016 (21 st Century Cures Act of 2016, Division B) P.L. 114-255, Division B, Title XIII (§§13001-13004, 13007)	Required Tri-Agency reports to Congress on federal parity investigations, annually for five years as specified. Required Tri-Agency “compliance program guidance document” and “additional guidance,” other agency activities, and a GAO report to Congress on parity compliance and enforcement. Specified that if the Tri-Agency Secretaries determine a plan has violated parity requirements five times, the Secretaries must audit plan documents in the following plan year. Specified that parity requirements apply to eating disorder benefits, if covered.
SUPPORT for Patients and Communities Act (SUPPORT Act , 2018) P.L. 115-271 (§7182)	Amended Cures Act requirements regarding the content of Tri-Agency reports to Congress on federal parity investigations.
Consolidated Appropriations Act, 2021 (CAA 2021 , enacted 2020) P.L. 116-260, Division BB, Title II (§203)	Required plans to perform and document comparative analyses of their NQTLs for MH/SUD and M/S benefits, as specified. Required Tri-Agencies to annually request and review at least 20 NQTL comparative analyses, follow up as specified on noncompliance, and annually report to Congress on these analyses. Amended Cures Act requirements regarding the “compliance program guidance document” and “additional guidance.”
Consolidated Appropriations Act, 2023 (CAA 2023 , enacted 2022) P.L. 117-328, Division FF, Title I (§§1321, 1331)	Provided that self-insured, nonfederal governmental plans may no longer opt out of mental health parity requirements. Established HHS grants to states “to enforce and ensure compliance with” mental health parity requirements, including the NQTL comparative analyses. Authorized to be appropriated \$10 million per year for five fiscal years following enactment for such grants.

Source: CRS analysis of relevant private health insurance provisions in the laws cited. Some of these laws also include parity provisions relevant to public programs (e.g., Medicaid), which are not included in this report.

Notes: MH = mental health; M/S = medical / surgical; SUD = substance use disorder; GAO = Government Accountability Office; Tri-Agency = Department of Health and Human Services (HHS), Department of Labor (DOL), and Department of the Treasury; EHB = essential health benefits; NQTLs = non-quantitative treatment limitations. See “Legislative History” in this report regarding codification of these provisions. See “Plans Subject to Coverage and Parity Requirements” for discussion of plan types. See “Required Federal Reports, Rulemaking, Guidance, and Other Activities” for links to agency reports, guidance, and other resources.

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