



The primary focus of mental health parity is to ensure that insurance plans do not make access to mental health and substance use disorder (collectively known as behavioral health) treatment more cost-prohibitive or restrictive than access to medical or surgical care. Restrictive access to behavioral health treatment in insurance plans led to enactment of federal and state-level mental health parity legislation, as shown in the table below.¹

There is strong evidence that mental health benefits legislation, which includes parity requirements, increases access to mental health services and reduces patient costs.² Evidence on cost impacts to insurers is mixed. Most research has found that parity requirements do not significantly increase annual costs per health plan member overall³, although several studies have found modest increases.⁴

Federal and state mental health parity laws, 1990-2025

This table includes the most influential laws enacted in Ohio and the U.S. related to mental health insurance benefits and mental health parity between 1990 and 2025.

	1990-1999	2000-2009	2010-2019	2020-2026
 Federal laws	1996: Mental Health Parity Act – Narrow initial federal parity law that prohibited large group health plans from establishing annual or lifetime dollar limits on mental health benefits that are more restrictive than any such limits for medical/ surgical benefits	2008: Mental Health Parity and Addiction Equity Act (MHPAEA) – <ul style="list-style-type: none"> Extended the 1996 law to substance use disorder (SUD) benefits Required fully-insured and self-insured large group plans (50+ employees) to provide benefits for behavioral health conditions that are comparable with medical/ surgical benefits⁵ 	2010: Patient Protection and Affordable Care Act – <ul style="list-style-type: none"> Extended parity requirements to individual and small group plans Required parity for the Medicaid expansion population (i.e., Group VIII) Required individual and small group plans to cover “Essential Health Benefits” which include mental health and substance use services* 2014: Final MHPAEA rules issued	Consolidated Appropriations Act of 2021 – Requires insurance plans to perform analyses showing how they are using non-quantitative treatment limitations (NQTLs) for behavioral health and medical/surgical care and make this information available upon request of the federal government 2024: Updated MHPAEA regulations – The U.S. Departments of Labor, Treasury, and Health and Human Services released updated mental health parity regulations (were legally challenged) 2025: The Trump administration announced they would not enforce the 2024 parity regulations
 State laws		2006: Senate Bill 116 of the 126th General Assembly - Required individual, group and public employee health insurance plans to cover treatment for “biologically-based” mental illnesses (listed on page 2) at parity with physical health benefits (does not apply to self-insured plans)	2017: House Bill 463 of the 131st General Assembly – Required insurance coverage for screening, diagnosis and treatment of autism spectrum disorders (does not apply to private employer-sponsored self-insured plans)	2021: Senate Bill 284 of the 133rd General Assembly – <ul style="list-style-type: none"> Aligned state and federal law, requiring health insurers and Medicaid managed care organizations (MCOs) to comply with MHPAEA Requires the Superintendent of Insurance and the Ohio Medicaid Director to implement and enforce MHPAEA

* To define the Essential Health Benefits, each state selected a benchmark plan to determine the services and quantity of services that must be covered.

Note: Dates in this table are when laws became effective; descriptions do not describe all of the laws' provisions

Sources: “Mental Health Parity at a Crossroads.” KFF. Aug. 2022. See also “Pursuit of Parity: Where Ohio Stands on Insurance Coverage of Mental Illness and Substance Use Disorders.” Center for Community Solutions. May 2019.

► What do federal mental health parity laws require?

The federal Mental Health Parity and Addiction Equity Act (MHPAEA), enacted in 2008, built on the 1996 Mental Health Parity Act. For health plans that offer behavioral health services, MHPAEA requires those benefits to be comparable to medical/surgical benefits. However, the law does not require plans to provide behavioral health benefits. MHPAEA addressed some of the limitations in Ohio's 2006 law, described below.

MHPAEA requires parity in:⁶

- **Financial requirements** (e.g., copayments, out-of-pocket maximums, lifetime dollar limits)
- **Quantitative treatment limitations (QTLs)**: Care benefits with numerical limitations (e.g., number of visits covered annually, number of days of hospitalization covered)
- **Non-quantitative treatment limitations (NQTLs)**: Insurance plan features without a numerical value that can limit care (e.g., prior authorizations; medical necessity determinations; step therapy/fail-first policies; provider network participation standards; restrictions based on geographic location, facility type, provider specialty or other criteria that may limit service benefits)

MHPAEA parity requirements apply to six types of benefits: Inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs.

► To which plans do federal parity requirements apply?

MHPAEA identified an initial set of plan types to which parity requirements applied. The Patient Protection and Affordable Care Act (ACA) expanded this list. Current mental health parity requirements apply to the following types of public and private health plans that include coverage for behavioral health services:

- **Fully insured (individual, small group and large group plans)**, which are purchased from a commercial insurer by individuals, or by an employer or association for their employees or members.⁷
- **Self-insured plans (except plans covering 50 or fewer employees)**, which refer to when an employer assumes financial responsibility for employees' health benefits by paying for claims directly.
- **Medicaid managed care**

Self-insured plans that cover fewer than 50 employees are exempt from parity requirements.⁸ MHPAEA does not apply to Medicare or Medicaid fee-for-service, except for the Medicaid expansion/Group VIII population. Finally, the increased cost exemption allows large group plans to be exempt if they incur a 1% cost increase or more in a year due to complying with MHPAEA and meet certain requirements.⁹ This exemption lasts one plan year but can be claimed for another year if a plan continues to meet requirements.¹⁰

For more explanation of fully insured and self-insured health plans in Ohio's health insurance market, see HPIO's [Insurance coverage and affordability of mental health care for Ohio children and youth](#) policy brief.

► What does Ohio law require?

The State of Ohio's mental health parity requirements primarily came from two laws enacted in 2006 and 2021. Notably, laws passed by Ohio related to health insurance do not apply to private self-insured plans, which are regulated by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA).

Ohio's 2006 law required fully-insured individual, small group and large group plans and public (e.g., state or local government) self-insured health plans to provide coverage for "biologically based mental illnesses." These include only schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent Diagnostic and Statistical Manual of Mental

Disorders (DSM).¹¹ A requirement for coverage of screening, diagnosis and treatment of autism spectrum disorders was added in 2017. Another state law had required coverage for alcoholism treatment for all plans “delivered, issued for delivery, or renewed in Ohio on or after January 1, 1979.”¹²

However, these laws had limitations. They only apply to a subset of conditions and do not address certain methods used by insurers that can restrict care (e.g., prior authorization). Plans do not need to comply with coverage for biologically-based mental illnesses if they prove these requirements led their claims or premium costs to increase 1% or more.¹³

Ohio's 2021 law required health insurers and Medicaid managed care organizations (MCOs) to comply with MHPAEA, aligning state and federal parity laws. The law also requires Ohio's Superintendent of Insurance to implement and enforce all MHPAEA provisions, including adopting rules as necessary to enforce and continually monitor compliance, and evaluate all parity-related complaints. The law makes similar requirements for the Ohio Medicaid Director to monitor compliance by the MCOs.

Separate Ohio legislation required the Ohio Department of Insurance (ODI) and the Ohio Department of Behavioral Health to jointly develop an annual **Mental Health Parity report** on the departments' consumer and payer outreach activities and efforts to identify trends and barriers to access and coverage in Ohio.

► **Mental health parity implementation**

Current mental health parity requirements, especially for NQTLs, are complex and difficult to enforce, and non-compliance findings are common.¹⁴ Regulatory oversight and enforcement are critical but difficult and resource intensive.¹⁵

Financial requirements and QTLs have been easier to enforce. Researchers have found that QTLs almost entirely disappeared under MHPAEA.¹⁶

NQTLs are often cited as the most difficult requirements with which to comply according to insurers and policy experts.¹⁷ The Consolidated Appropriations Act of 2021 required plans to begin performing analyses on their design and application of NQTLs for behavioral health compared to medical and surgical care.¹⁸ Until the 2024 regulations, there was no formal guidance from the federal government on how these analyses should be conducted. However, those regulations were legally challenged, and in May 2025, the Trump Administration announced it would not enforce the new regulations.¹⁹

► **Actions taken by other states**

States are taking a variety of actions to improve parity and access to behavioral health services. **Illinois** is considered to have the most comprehensive mental health parity laws. A 2025 study found that states with more comprehensive parity implementation (i.e., exceeding federal requirements) and enforcement had greater mental health workforce availability and a smaller percentage of the population living in a mental health professional shortage area.²⁰

Examples of common actions taken by other states:

- **Strengthening enforcement and taking corrective action when plans are found to be noncompliant.** For example, Pennsylvania requires corrective action plans for MHPAEA violations with mandatory timelines, benchmarks, data reporting and audits. Pennsylvania law also allows its Insurance Commissioner to impose penalties of up to \$10,000 per willful violation, with a \$1,000,000 maximum annual penalty.²¹
- **Defining which conditions health plans must classify as behavioral health conditions.** Some states, including West Virginia and Washington, have laws requiring insurers to include all conditions in the current version of the DSM when applying parity standards.²²
- **Instituting network adequacy requirements.** For example, Maryland requires access to urgent behavioral healthcare within 72 hours and within 10 days for non-urgent care.²³

Due to the complexity of enforcing parity, states are increasingly turning to separate policy approaches that bolster behavioral health benefits outside of parity. Some states have taken a **variety of actions** to reform prior authorizations. For example, at least 10 states, including West Virginia, have adopted “gold card” exemptions for providers with high rates of approved prior authorization requests. These exemptions can apply for certain services or prescription drugs.²⁴

Another example is that at least seven states, including California and Georgia, have defined evidence-informed generally accepted standards of care that health plans must use when determining medical necessity for behavioral health treatment. These states have implemented guidelines as outlined in the **Ramstad Model**.

There are a variety of actions that Ohio policymakers can take to improve mental health parity compliance and access to behavioral health care. In addition to examples in this document, policy recommendations are included in HPIO’s **Insurance coverage and affordability of mental health care for Ohio children and youth** policy brief.

Additional resources

- **Parity Track** monitors parity implementation work happening across the U.S.
- **Enforcing Mental Health Parity: State Options to Improve Access to Care**, a 2024 issue brief by The Commonwealth Fund
- **State parity gold standards**, a series of briefs on important parity concepts for states to consider, developed by the Kennedy Forum and Legal Action Center

Notes

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