The Parity Protection
Medicaid Compliance with the Parity Act in the Context of Public Law 119-21

Background

The Mental Health Parity and Addiction Equity Act (Parity Act) was enacted in 2008 to remove discriminatory barriers to mental health and substance use disorder treatment. Whereas previously health insurance plans had often offered less favorable coverage of these conditions, the Parity Act required health plans that offer mental health and substance use disorder benefits to cover them in a way that is comparable to how they cover medical benefits and surgical procedures. The law not only applies to most commercial health insurance plans, but it also applies to the following Medicaid financing systems:[1]

- Medicaid managed care organizations (MCOs), which include prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs) when they provide care for MCO enrollees;
- Medicaid benchmark and benchmark-equivalent plans, also known as Alternative Benefit Plans (ABPs); and
- the Children's Health Insurance Program (CHIP).

Public Law 119-21 (the reconciliation package Congress passed and the President signed into law on July 4, 2025) will result in a projected reduction of nearly $1 trillion of federal funding of the Medicaid program.[2] This cost shift is now requiring states to make difficult decisions about how to keep their low-income residents healthy, which may include lowering provider reimbursement rates, cutting optional benefits or populations from the program, or imposing more barriers to care to keep costs down.[3] There are also specific provisions in Public Law 119-21 that interact with Parity Act requirements, which states must now review to ensure compliance with both laws.

Importantly though, states cannot take actions that are separate or more harmful for mental health and substance use disorder coverage. This issue brief reviews the requirements of the Parity Act as applied to Medicaid coverage, with a focus on what it means for state policymakers, plans, and advocates in the wake of Public Law 119-21.

Medicaid, Parity, and Public Law 119-21

The overall objective of the Parity Act is to ensure that Medicaid enrollees who need mental health and/or substance use disorder benefits can access them similarly to how they access medical and surgical benefits.[4] In a nutshell, the Parity Act requires the comparison of these benefits to make sure they are covered equally.[5]

For context, the federal regulations implementing the Parity Act in Medicaid give states the authority to decide what is considered a "mental health benefit," a "substance use disorder benefit," or a "medical/surgical benefit." However, states must define these conditions in accordance with applicable federal and state law, and in a way that is "consistent with generally recognized independent standards of current medical practice," such as the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the International Classification of Diseases (ICD), or state guidelines.[6] The same benefit could be provided for both mental health and medical conditions, and it is categorized based on the condition that is being treated.

Generally, the Parity Act imposes several requirements on Medicaid MCOs, ABPs, and CHIP, described below. The requirements do not apply directly to Medicaid fee-for-service or non-ABP state plan services. However, if the state delivers some benefits through an MCO while carving out others to be delivered through fee-for-service, then the state must ensure the entire benefit package – including those delivered through fee-for service – complies with the Parity Act requirements.[7] Moreover, the Centers for Medicare & Medicaid Services "encourage states to provide state plan benefits in a way that comports with the mental health parity requirements."[8]

1. No Separate or More Restrictive Aggregate Lifetime and Annual Dollar Limits

Medicaid MCOs and CHIP cannot impose an overall limit on the amount the plan will spend – in a year, or over the course of an enrollee's lifetime – on a person's mental health or substance use disorder benefits that is separate or less than what they will spend on that person's medical or surgical benefits.[9]

Notably, the Affordable Care Act generally prohibits these lifetime and annual spending limits on essential health benefits (EHBs), which include mental health and substance use disorder services. Accordingly, Medicaid ABPs cannot impose lifetime or annual spending limits on mental health or substance use disorder services that are covered as EHBs.[10]

Pub. Law 119-21 Implication

Even with federal funding cuts, Medicaid MCOs, ABPs, and CHIP cannot impose separate or more restrictive caps on how much they will spend on mental health and substance use disorder care compared to medical/surgical care.

2. Scope of Services

The Parity Act by itself does not require or mandate coverage of mental health and substance use disorder benefits. However, when mental health or substance use disorder benefits are covered in any one classification of benefits – inpatient, outpatient, emergency services, or prescription drugs – then they must be covered in any other classifications in which medical and surgical benefits are covered. All states provide some coverage for mental health and substance use disorder benefits, including the mandatory benefit for all FDA-approved medications for opioid use disorder and counseling services and behavioral therapy provided with such medications.[11] Accordingly, all Medicaid plans must ensure that coverage of opioid use disorder treatment is available in the other benefit classifications as well, to the extent the state covers medical and surgical benefits in those other categories.

Pub. Law 119-21 Implication

Even with federal funding cuts, states cannot eliminate coverage in a benefit classification for a mental health condition or substance use disorder, assuming the state covers medical/surgical benefits in that classification. For example, a state could not eliminate coverage of inpatient opioid use disorder treatment, because the state is already required to cover opioid use disorder prescription medications and is required to cover other inpatient services.

3. No Separate or More Restrictive Financial Requirements and Quantitative Treatment Limitations

Medicaid MCOs, ABPs, and CHIP cannot have separate or more restrictive financial requirements or quantitative treatment limitations that apply only to mental health or substance use disorder benefits.[12] Financial requirements are what the Medicaid enrollee has to pay, including deductibles, co-pays, co-insurance, and out-of-pocket expenses. Quantitative treatment limitations include limits on the frequency of treatment, number of visits, days of coverage, or other similar numerical limits on the scope or duration of treatment. Both of these limits are compared across classifications of benefits: inpatient, outpatient, emergency services, and prescription drugs. The plan may impose these types of requirements and limitations on mental health and substance use disorder benefits in a classification if the same rule applies to at least two-thirds of medical/surgical benefits in that classification.

Beginning on October 1, 2028, section 71120 of Pub. Law 119-21 imposes new cost sharing requirements on individuals whose income is between 100% and 138% of the federal poverty level (in 2026, this would be an annual income between $15,960 and $22,024.80 for a single adult)[13] who are eligible for Medicaid because of the Affordable Care Act's expansion to low-income adults without dependents (the "expansion population"). States will have to determine how much these individuals need to pay for their benefits, which must be greater than $0 but no more than $35 per item or service

(excluding prescription drugs, for which states may still charge a nominal amount). However, certain services are fully exempt from this cost sharing requirement, including mental health and substance use disorder services, and may not be imposed under the state plan.[14]

Pub. Law 119-21 Implications

- Even with the new requirement to impose cost sharing on many medical/surgical Medicaid benefits for the expansion population, states are prohibited from adding cost sharing for mental health and substance use disorder benefits under the state plan for Medicaid expansion enrollees whose incomes fall between 100-138% of the federal poverty level. States may need to reevaluate existing cost sharing amounts for this population to comply with Pub. Law 119-21.
- Even with federal funding cuts, Medicaid MCOs, ABPs, and CHIP cannot impose separate or more restrictive financial requirements or quantitative treatment limitations on mental health or substance use disorder care compared to medical/surgical care within the same classification.

4. Comparable and No More Restrictive Non-Quantitative Treatment Limitations

The same prohibition against separate or more restrictive treatment limitations also applies to things that are not numerical in nature, also known as non-quantitative treatment limitations (NQTLs).[15] These include, but are not limited to:[16]

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Network tier design for plans with multiple network tiers (such as preferred providers and participating providers);
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment;
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan; and
- Standards for providing access to out-of-network providers.

Instead of a mathematical test for this requirement, compliance hinges on how the treatment limitation was developed and is being used by the plan (or by the state, if managed care is not used for ABPs or for CHIP). More specifically, the rule looks at whether the factors that led to the design and application of that NQTL are comparable and no more restrictive for mental health or substance use disorder benefits than for medical/surgical benefits in the same benefit classification (inpatient, outpatient, emergency services, prescription drugs).

Pub. Law 119-21 Implication

To the extent that budget concerns or other considerations from Public Law 119-21 may be a factor leading states to consider restricting access to care, states cannot solely or disproportionately target mental health or substance use disorder benefits for such restrictions. This applies both for treatment limitations "as written" into plan policies, as well as "in operation" for how the plan implements the policies.

RED FLAGS

Example: A state is concerned about the budget implications of Public Law 119-21 and decides to add prior authorization requirements onto all mental health and substance use disorder services in its ABP, but does not have comparable requirements for the majority of medical/surgical benefits. This would likely be a Parity Act violation because the factor leading to the design of this NQTL is separately, and more restrictively, being applied to mental health and substance use disorder benefits as compared to medical/surgical benefits.

Example: A Medicaid MCO decides to add a requirement that any enrollee who needs residential substance use disorder care will need to "fail first" at outpatient substance use disorder treatment before it will approve residential care. If there is no similar refusal to pay for the higher cost level of care before the lower cost level of care has been shown to be ineffective for residential (such as skilled nursing facility) treatment for medical/surgical care, and the decision to impose this requirement was based on budgetary factors, this would likely be a Parity Act violation.

Example: A Medicaid MCO contracts with a separate entity to administer its behavioral health services, and that entity adds new concurrent review (ongoing approval) requirements to outpatient children and family treatment and support services for mental health care because its cost per enrollee has been capped. If the Medicaid MCO has not added similar concurrent review for a majority of its outpatient medical/surgical care, this would likely be a Parity Act violation.

Example: A state set its reimbursement rates for CHIP providers by using the Medicare Physician Fee Schedule as a benchmark, and decided to increase the reimbursement rates for non-physician medical providers – such as nurse practitioners and physician assistants – at the beginning of the year, while it did not do so for similarly licensed non-physician mental health providers – such as clinical social workers and licensed mental health counselors. Because the state used separate and more restrictive strategies and processes in setting these reimbursement rates for mental health providers than for medical providers, this would likely be a Parity Act violation.

Example: Inpatient hospitals start to notice an increase in denials for substance use disorder treatment they bill to Medicaid. The state has not changed its policies or medical necessity criteria, but reviewers are using their discretion to deny more claims, whereas that level of discretion is not used for medical/surgical inpatient claims nor resulting in the same level of denials. This would likely be an "in operation" Parity Act violation.

5. Availability of Information and Transparency Requirements

Medicaid MCOs, ABPs, and CHIP must make their medical necessity criteria – that is, the list of symptoms, circumstances, or rules in which an enrollee can receive a specific benefit – to any enrollee, potential enrollee, or contracting provider upon request.[17] In addition, if a provider requests a benefit for a Medicaid enrollee and the plan denies the service – or authorizes the service in an amount, duration, or scope that is less than requested – then the plan must notify the provider as well as the enrollee of the reason for that denial.[18]

Providers and patients should request this information if they do not receive it automatically. The medical necessity criteria and reasons for denial can be helpful when an individual needs to appeal. This information can also be helpful in reviewing for and identifying potential Parity Act violations related to NQTLs.

States are also required to provide documentation of compliance with the Parity Act requirements to the general public. States had to post this information on their Medicaid website by October 2, 2017, to reflect their compliance with the regulations, and they are required to update this documentation before making any change in benefits.[19]

Pub. Law 119-21 Implication

Before a state or MCO does make any changes to its coverage of mental health, substance use disorder, or medical/surgical benefits, it must update its documentation of compliance with the Parity Act and publish this documentation on its state Medicaid website.

Other Key Protections in Medicaid

The Parity Act only requires comparisons of mental health and substance use disorder care to medical/surgical care. However, there are other Medicaid protections that may go further than this comparison to ensure enrollees can get the treatment they need.[20] Some examples include:

- Medicaid services must be "sufficient in **amount, duration and scope** to reasonably achieve their purpose," and states may not "arbitrarily deny or reduce the amount, duration or scope of such services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition"[21] such as a mental health condition or substance use disorder.
- Medicaid services must be **available and accessible** to enrollees in a timely manner, and states must ensure that each MCO "maintains and monitors a network of appropriate providers" that "is sufficient to provide adequate access to all services covered…for all enrollees, including those with limited English proficiency or physical or mental disabilities."[22]
    - With respect to **reimbursement rates**, the Medicaid "agency's payments must be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population."[23]
    - MCOs must adequately and timely cover **out-of-network** necessary services if the plan's provider network is unable to provide them, at no greater cost to the enrollee than if the services were provided in-network.[24]
- Medicaid enrollees have a right to **due process** – a notice and a fair hearing – when benefits are denied, reduced, or cut off or for eligibility determinations.[25] In Public Law 119-21, Congress included the same requirement for Medicaid expansion enrollees who are unable to demonstrate compliance with or exemption from the new "community engagement" requirements.[26] Among other populations, people with substance use disorders and disabling mental disorders are exempt,[27] and thus have a right to a fair hearing if the state fails to identify them as such. Moreover, before the state can dis-enroll an individual for non-compliance, the state must first determine if there is any other basis for Medicaid eligibility or for another insurance affordability program.[28]

Conclusion

The Parity Act serves as an important backstop – especially in light of Public Law 119-21 – to ensure that Medicaid enrollees with mental health conditions and substance use disorders can continue to access the care they need. However, states and stakeholders will need to monitor the implementation of this new law to ensure that MCOs, ABPs, and CHIP continue to comply with Parity, and resolve any outstanding disproportionate barriers to care that may need to be addressed.

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[1] 42 U.S.C. §§ 1396u-2(b)(8) (applicability of the Parity Act to Medicaid MCOs) 1396u-7(b)(6) (applicability of the Parity Act to Medicaid ABPs), 1937cc(c)(7) (applicability of the Parity Act to CHIP).
[2] Congressional Budget Office, "Supplemental Cost Estimate: Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 Title VII, Finance, Subtitle B, Health, Chapter 1, Medicaid" (Oct. 28, 2025), https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf.
[3] *See, e.g.*, Celli Hortsman & Akelisa Coleman, "States are Planning Their Responses to H.R. 1 Cuts in Medicaid Funding – Will Enrollees Lose Benefits," Commonwealth Fund (Oct. 14, 2025), https://www.commonwealthfund.org/blog/2025/states-responses-hr-1-cuts-medicaid-funding; Sarah Ladd, "Legislators seek to examine Kentucky Medicaid for Ways to Contain Costs," Kentucky Lantern (Mar. 11, 2025), https://kentuckylantern.com/2025/03/11/legislators-seek-to-examine-kentucky-medicaid-for-ways-to-contain-costs/.
[4] *See* Centers for Medicare & Medicaid Services, "Instructional Guide for Mental Health and Substance Use Disorder Parity State Summary Template" 4 (Sept. 2024), https://www.medicaid.gov/medicaid/downloads/parity-state-summary-temp-instr-guide.pdf.
[5] For a deeper dive on the federal Parity Act, *see* "Health Insurance for Addiction & Mental Health Care: A Guide to the Federal Parity Law," Legal Action Center (updated May 2019), https://www.lac.org/assets/files/LAC-Parity-Guide.pdf. For best practices on state enforcement of the Parity Act in Medicaid, *see* Legal Action Center & The Kennedy Forum, "Standard Medicaid and MHPAEA Gold Standards" (Feb. 2026), https://www.thekennedyforum.org/app/uploads/2026/02/Gold-Standard-Medicaid-dn-MHPAEA-Recommendations_V3.pdf.
[6] 42 C.F.R. §§ 438.900, 440.395(a), 457.496(a).
[7] 42 C.F.R. § 438.920(a), (b)(2).
[8] 81 Fed. Reg. 18390, 18410 (Mar. 30, 2016).
[9] 42 C.F.R. §§ 438.905, 457.496(c).
[10] 81 Fed. Reg. at 18394.
[11] 42 U.S.C. § 1396d(a)(29).
[12] 42 C.F.R. §§ 438.910, 440.395(b), 457.496(d).
[13] U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, "2026 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)," https://aspe.hhs.gov/sites/default/files/documents/b1bfa16b20ae9b89d525bc35de7c1643/detailed-guidelines-2026.pdf.
[14] In addition to mental health and substance use disorder services, the law also exempts primary care services and services received at federally qualified health centers (FQHCs), certified community behavioral health clinics (CCBHCs), and rural health clinics (RHCs). Other services for which cost sharing was already prohibited, and continues to be prohibited, include: services furnished to pregnant individuals if such services relate to the pregnancy or any medical condition which may complicate the pregnancy, including tobacco cessation-related services (or at the option of the state, any services furnished to pregnant individuals; services furnished to an individual who is inpatient in a hospital, skilled nursing facility, intermediate care facility for mental health, or other medical institutions; emergency services; family planning services and supplies; services furnished to an individual in hospice; approved vaccines recommended by the Advisory Committee on Immunization Practices; and COVID-19 testing-related services for which payment may be made under the state plan. 42 U.S.C. § 1396o(k)(2)(B)(i).
[15] 42 C.F.R. §§ 438.910(d)(1), 440.395(b)(4)(i), 457.496(d)(4)(i) and (5).
[16] 42 C.F.R. §§ 438.910(d)(2), 440.395(b)(4)(ii), 457.496(d)(4)(ii).
[17] 42 C.F.R. §§ 438.915, 440.395(d), 457.496(e).
[18] 42 C.F.R. §§ 438.210(c), 440.395(c)(2), 457.496(e).
[19] 42 C.F.R. § 438.920(b)(1); 81 Fed. Reg. at 18415-16.

[20] "Highlights: What Makes Medicaid, Medicaid? Enrollee Protections and Due Process," National Health Law Program (Jan. 2025), https://healthlaw.org/wp-content/uploads/2025/01/HIGHLIGHTS-What-Makes-Medicaid-Series-Due-Process-2025.pdf.
[21] 42 C.F.R. § 440.230(b), (c).
[22] 42 C.F.R. § 438.206(a), (b).
[23] 42 C.F.R. § 447.204(a).
[24] 42 C.F.R. § 438.206(b)(4), (5).
[25] 42 C.F.R. § 431.200 et seq.
[26] 42 U.S.C. § 1396a(xx)(6)(A)(iii)(II).
[27] 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V)(bb), (cc). For more information about community engagement requirements and people with substance use disorders, see "Protecting People with Substance Use Disorders and Formerly Incarcerated Individuals from Losing Medicaid Coverage: Recommendations on Implementing the H.R. 1 Work Reporting Requirements," Legal Action Center (Aug. 2025), https://www.lac.org/assets/files/Protecting-People-with-SUDs-and-Formerly-Incarcerated-Individuals-from-Losing-Medicaid-Coverage.pdf. For more information about the community engagement requirements and people with mental health conditions, see "Work Reporting Requirements and Mental Health: Recommendations to Protect Individuals with Mental Health Conditions from Losing Medicaid," National Alliance on Mental Illness (Nov. 2025), https://www.nami.org/wp-content/uploads/2025/11/2025-Work-Reporting-Requirements-and-Mental-Health.pdf.
[28] 42 U.S.C. § 1396a(xx)(6)(A)(iii)(I).