LEGAL UPDATES

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MHPAEA September 2026 Update: Enforcement Updates and Compliance "Red Flags" for Employers and Plans

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Earlier this month, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) issued new guidance, narrowing its enforcement focus under the Mental Health Parity and Addiction Equity Act (MHPAEA).

Background

As discussed in our previous article, MHPAEA implementation has been disjointed. Most recently, the Departments of Labor, Health and Human Services, and Treasury jointly issued a Final Rule (the 2024 Rule) to clarify MHPAEA compliance, particularly non-quantitative treatment limitations (NQTLs). In 2025, the ERISA Industry Committee (ERIC) filed a federal lawsuit challenging the 2024 Rule, and the departments requested time to reexamine MHPAEA enforcement, stating that they would not enforce the 2024 Rule while they reconsidered.

In the meantime, plans must continue to comply with the departments' 2013 Final Regulations (the 2013 Rule). Specifically, plans must ensure parity in financial requirements, qualitative treatment limitations (QTL), and NQTLs for mental health and substance use disorder (MH/SUD) benefits compared to medical/surgical (M/S) benefits, across all benefit classifications. Plans must also regularly perform and document comparative analyses of the design and application of NQTLs, as required by the Consolidated Appropriations Act (CAA).

2026 EBSA Guidance

On September 8, EBSA issued Field Assistance Bulletin No. 2026-03 and published an accompanying compliance tool. The new guidance focuses on the following points:

Enforcement focused on three NQTL categories. EBSA will direct its comparative analysis enforcement resources to the following three NQTLs:

1) Separate treatment limitations and blanket exclusions that apply only to MH/SUD benefits;

2) Medical necessity standards and the review process for prior authorization, concurrent review, and retrospective review; and

3) Network adequacy standards, with particular attention to network admission standards and provider reimbursement methodologies.

Blanket MH/SUD-only exclusions are a top target. Plans generally may not apply exclusions that apply only to MH/SUD conditions where comparable M/S treatments are covered. EBSA will focus on blanket exclusions but may pursue narrower exclusions as well, particularly in response to participant complaints.

Proprietary medical necessity criteria are permitted but must be produced on request. Plans may use proprietary clinical guidelines for medical necessity determinations, provided the processes and standards applied to MH/SUD benefits are comparable to, and no more stringent than, those applied to M/S benefits. Plans, issuers, and their service providers must make those guidelines available to EBSA during investigations and to participants and beneficiaries on request.

Network adequacy gaps that push participants out-of-network are a priority. Where MH/SUD provider networks are inadequate, participants often face a choice between higher out-of-pocket costs out-of-network or forgoing treatment altogether. EBSA will scrutinize whether plans have taken adequate steps to help participants access in-network MH/SUD care before they are exposed to out-of-network costs.

Red Flags—What employers should not do. The new compliance tool identifies the following treatment limitations and exclusions as "red flags":

Exclusions and coverage limits:

- Excluding applied behavioral analysis (ABA)/speech/occupational therapy for autism, addiction medications (methadone, naltrexone, buprenorphine),

nutritional counseling for eating disorders, or MH/SUD residential and intensive outpatient programs, while covering comparable M/S care.

- Requiring full completion of a prior MH/SUD treatment course, excluding "chronic" or "unlikely to improve" MH/SUD conditions, denying MH/SUD telehealth, or applying higher copays, visit limits, or dollar limits to MH/SUD versus M/S benefits.

Medical necessity and utilization review:

- Requiring prior authorization or added review steps for most MH/SUD benefits but few or no M/S benefits in the same classification or imposing MH/SUD-only age limits.
- Applying MH/SUD-specific criteria absent from M/S review, such as mandatory parental involvement, community-resource exhaustion, repeat autism testing, "fully motivated" patient standards, or step therapy.
- Using an employee assistance program (EAP) as a gatekeeper to MH/SUD care or letting actual practice (manual/slower MH/SUD review, shorter authorized stays) diverge from more favorable written terms.

Network adequacy and reimbursement:

- Imposing tougher network-admission processes, longer wait-time standards, or missing network-gap exceptions for MH/SUD providers, or requiring them (unlike M/S providers) to bill through another provider.
- Using reimbursement methodologies that discount MH/SUD provider rates more than comparable M/S providers.
- Under-investing in MH/SUD network recruitment and gap remediation related to M/S or ignoring high MH/SUD out-of-network utilization and access complaints as parity warning signs.

Fiduciary and vendor oversight:

- Selecting or retaining service providers without assessing their MHPAEA compliance capabilities.
- Monitoring only written plan terms rather than actual practice or failing to adopt a written monitoring policy and act on red flags once identified.

Next Steps for Employers and Plan Sponsors

Looking ahead, employers and health plans should consider the following steps:

1. **Review NQTL comparative analyses for the three priority areas.** Confirm that current comparative analyses specifically address blanket MH/SUD exclusions, medical necessity review processes, and network adequacy.
2. **Confirm plan documents do not include MH/SUD-only exclusions.** Identify and correct any exclusion, limitation, or precertification requirement that applies only to behavioral health or substance use disorder benefits without a comparable requirement on the M/S side.
3. **Confirm with your vendors that medical necessity criteria can be produced promptly upon audit.** Work with claims administrators and utilization review vendors to ensure proprietary clinical guidelines used for MH/SUD medical necessity determinations can be retrieved and produced quickly if EBSA opens an investigation or a participant makes a request.
4. **Assess network adequacy for MH/SUD providers.** Evaluate whether MH/SUD provider networks and reimbursement methodologies are comparable to M/S networks, and document any steps taken to help participants access in-network care.
5. **Develop a process to evaluate service providers for compliance with MHPAEA.**

What This Means for You

Employers and plan sponsors should treat EBSA's narrowed enforcement focus as a roadmap for where audits and participant complaints are most likely to land, not as a signal to relax broader MHPAEA compliance efforts. In-house counsel and benefits leaders should prioritize a review of NQTL comparative analyses against the three enforcement priorities identified above, confirm that plan documents and summary plan descriptions contain no MH/SUD-only exclusions or precertification requirements, and verify with claims administrators and utilization review vendors that proprietary medical necessity criteria can be produced on short notice. Given EBSA's stated focus on network adequacy, plan sponsors should also document any steps taken to help participants access in-network MH/SUD care, since gaps here are now a stated enforcement priority. Taking these steps now can reduce exposure in the event of an EBSA investigation or participant complaint.

Contact Us

For further assistance with MHPAEA compliance or to discuss how these developments may impact your plan, please contact Craig Kovarik, Molly Hobbs, or another member of the Employee Benefits team.

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