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# A Nuanced Reading Of DOL's Mental Health Parity Guidance

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On Sept. 8, the U.S. Department of Labor's Employee Benefits Security Administration released two pieces of guidance on the Mental Health Parity and Addiction Equity Act that, when read together, send a more nuanced message than either does on its own.

The first, Field Assistance Bulletin No. 2026-03, sets out guiding principles for EBSA's enforcement of the MHPAEA's nonquantitative treatment limitation, or NQTL, requirements.[1] The second, a companion tool, sets forth red flags that EBSA has commonly encountered in plan documents and plan operations, along with best practices for monitoring compliance and overseeing service providers.[2]

On an initial read, the bulletin might be viewed as a signal that agency enforcement pressure on group health plans with respect to mental health parity is easing. In our view, however, the takeaway from the bulletin is more complex.

While the bulletin identifies three areas in which EBSA will focus its enforcement efforts, it preserves EBSA's ability to act in other areas, particularly in response to participant complaints. The red flags guidance, while providing actionable insight for plan sponsors, is also notable because it reflects certain concepts from the 2024 final rule discussed below, including reliance on data and outcomes to demonstrate that NQTLs are in compliance.

**How Did We Get Here?**

The MHPAEA generally requires group health plans that provide mental health and substance use disorder, or MH/SUD, benefits to ensure that the financial requirements and NQTLs applied to those benefits are no more restrictive than those applied to medical/surgical benefits.

The Consolidated Appropriations Act codified the requirement that plans prepare comparative analyses of the design and application of those NQTLs to MH/SUD benefits compared to medical/surgical benefits, and make them available to regulators upon request.

In September 2024, the U.S. Department of Labor, U.S. Department of Health and Human

Services, and U.S. Department of the Treasury issued a final rule that would have significantly expanded the NQTL comparative analysis requirements. The 2024 final rule would have, among other things, required plans to collect and evaluate outcomes data showing the impact of NQTLs on access to MH/SUD benefits.

In January 2025, in ERISA Industry Committee v. Department of Health and Human Services, the ERISA Industry Committee challenged the 2024 final rule in the U.S. District Court for the District of Columbia, claiming that the 2024 final rule exceeded the departments' statutory authority, and violated both the due process clause and the Administrative Procedure Act.[3]

In May 2025, the three departments announced that they would not enforce provisions of the 2024 final rule that were new relative to the 2013 final rule or pursue enforcement based on a failure to comply until 18 months after a final decision is issued in that litigation.[4] Importantly, the MHPAEA's statutory obligations, including the NQTL comparative analysis requirements added by the Consolidated Appropriations Act, continue to apply.

**What the Field Assistance Bulletin Does**

The bulletin does two principal things. First, it confirms the nonenforcement posture of the departments with respect to the new provisions of the 2024 final rule. Second, because MHPAEA's statutory obligations and the 2013 final rule remain in effect, the bulletin explains how EBSA will approach enforcement of the NQTL requirements going forward.

EBSA will narrow its primary focus to the following three NQTL categories that it views as presenting the highest potential for significant harm to participants and beneficiaries.[5]

***Separate Treatment Limitations, Including Exclusions***

EBSA will focus on blanket plan exclusions of treatments for covered MH/SUD conditions where similar treatments are covered for medical/surgical conditions. For example, EBSA would be concerned with a blanket exclusion of applied behavior analysis therapy for

autism spectrum disorder, but no comparable blanket exclusion for a treatment or therapy for a medical/surgical condition.[6]

***Medical Necessity Standards and Review Processes***

EBSA will focus on prior authorization, concurrent review and retrospective review. This might include a plan imposing prior authorization on all or nearly all MH/SUD benefits but not medical/surgical benefits.[7]

***Network Adequacy Standards***

EBSA will focus on network admission standards and provider reimbursement methodologies. As an example, this includes more burdensome credentialing or divergent reimbursement methodologies for MH/SUD providers compared to medical/surgical providers.[8]

A critical point is that the bulletin does not draw a hard boundary around these three categories.

According to the bulletin, EBSA "remains committed to protecting MH/SUD benefits for all plan participants and beneficiaries" and "therefore may need to investigate other categories of NQTLs as issues arise, particularly when responding to participant complaints."[9] In other words, the three priorities discussed above tell plans where EBSA intends to start, not where it is required to stop.

**The Red Flags Guidance**

Building on prior enforcement guidance provided over the years, the companion red flags guidance that was released the same day as the bulletin provides plan sponsors with actionable examples of common MHPAEA compliance issues.

***Written Plan Provisions***

The guidance's red flags for written plan provisions are organized around the bulletin's

three enforcement priorities. Examples include blanket exclusions of certain therapies for MH/SUD diagnoses, but no similar blanket exclusions for treatments for medical/surgical diagnoses; exclusions of intermediate levels of MH/SUD care, where intermediate medical/surgical care is covered; and prior authorization imposed on all or nearly all MH/SUD benefits but not medical/surgical benefits.[10]

Importantly, notwithstanding the narrowing of focus suggested by the bulletin, the red flags guidance also identifies red flags that go beyond the bulletin's three priority enforcement areas, including blanket exclusions based on chronic symptoms or the unlikelihood of improvement, requirements that an employee assistance program be exhausted before MH/SUD services are covered, and the failure to cover MH/SUD telehealth when medical/surgical telehealth is covered.[11]

***Plan Operations***

The most significant feature of the red flags guidance is its treatment of plan operations. First, the red flags guidance is replete with actionable, real-life examples of plan operations issues that should be helpful for plan sponsors. Second, the red flags guidance suggests that the following are red flags, all of which are based on data and outcomes inputs, which echo the new provisions of the 2024 final rule:

- Out-of-network provider utilization that is much higher for MH/SUD services as compared to medical/surgical services in the same benefit classification, with such disparities "suggest[ing] potential discrepancies in the efforts, processes, and procedures to assemble MH/SUD networks as compared to M/S networks";

- Disparate reimbursement rate methodologies for MH/SUD providers compared to medical/surgical providers and lack of meaningful negotiations with MH/SUD providers when deciding whether they leave or join a network;

- Disparate access standards for service providers monitoring whether sufficient MH/SUD providers are in-network compared to medical/surgical providers, and disparate corrective measures to address identified gaps in the network; and

- Longer prior authorization timelines for MH/SUD services.[12]

***Echoes of the 2024 Final Rule***

The bulletin expressly lists the 2024 final rule's relevant data evaluation requirements among the provisions EBSA will not enforce.[13] Yet the red flags guidance, issued the same day, seems focused on that kind of evaluation. The red flags guidance does not mention the 2024 final rule, but the operational red flags reflect the theme that plans must demonstrate, through data and actual outcomes, that NQTLs do not restrict access to MH/SUD benefits more than they restrict access to medical/surgical benefits.

Given that recent rulemaking by the departments has focused on data and transparency, including recently revised transparency in coverage rules for group health plans, perhaps it is not surprising that data analysis remains a key focus for EBSA.

Reimbursement methodologies illustrate the point. A plan may use the same process to set out-of-network reimbursement rates for MH/SUD and medical/surgical providers. But if the resulting MH/SUD rates are not sufficient to retain providers, the NQTL may be comparable on paper and more restrictive in operation. That is the kind of disparity on which the 2024 final rule's outcomes-data provisions were focused, and also one that plan sponsors were concerned would be challenging to address.

So what's the practical takeaway here for plans? Plan sponsors should be aware that notwithstanding the current hold on the data and outcome provisions of the 2024 final rule, EBSA may expect to see operational data during investigations and, as the red flags guidance explains, any responses to EBSA should include "data-driven and factual support, not generalities."[14]

**Practical Considerations for Plan Sponsors and Fiduciaries**

***Do not mistake prioritization for a safe harbor.***

The bulletin's three priority categories should help plans allocate compliance resources but are not the outer limit of EBSA's authority. EBSA has reserved the right to investigate other NQTLs, especially in response to participant complaints, and the red flags guidance

lists issues outside the three categories.

Plans should maintain complete comparative analyses for all NQTLs and be prepared to produce them promptly upon request. Because complaints are the trigger EBSA itself names, consider training staff to track and handle complaints as the red flags guidance recommends.

***Use the red flags as a self-audit checklist.***

The red flags are drawn from EBSA's enforcement experience and represent the issues most likely to raise scrutiny. Plans should consider reviewing the red flags guidance against the plan document, summary plan description and vendor benefit booklets, starting with the three priority categories.

Because the red flags guidance emphasizes that plan terms may differ from actual practice, the review should not end with the documents; consider including interviews with vendors about how claims are actually processed. Plans may want to consider starting with plan-design exclusions because they may be the easiest issues to find and fix.

***Prepare for an inquiry before it arrives.***

The red flags guidance's tips for plans under review are a useful readiness checklist. Plans should consider having coverage documents, comparative analyses and monitoring records organized and accessible, establishing an internal response process, and periodically updating comparative analyses for completeness and accuracy. Plans should also consider designating a response coordinator; the 10-day production window for comparative analyses leaves little time to locate materials.

***Understand what data exists.***

Regardless of the outcome of the litigation over the 2024 final rule, plans should assume that an EBSA investigation may request operational data. Plans may wish to consider what metrics their service providers can produce, such as prior authorization approval

and denial rates and turnaround times, so they are not caught off guard by a request.

***Press vendors on substance.***

The red flags guidance recommends that plan fiduciaries consider MHPAEA compliance when selecting and monitoring service providers and offers questions about whether providers will assist with plan-specific comparative analyses and supply periodic reports and underlying MH/SUD claims data.

Plans assessing their vendors' analyses should consider asking whether an analysis addresses NQTLs in operation and what data supports its conclusions. Plans may also consider building these questions into RFPs and renewals, including data access, investigation support and whether assistance comes at no additional fee.

***Document everything and act on what you find.***

A strong compliance record is the best defense in an investigation. Plans should think about incorporating MHPAEA compliance monitoring into existing governance processes and maintaining records of monitoring activities, findings, vendor oversight and corrective actions.

Where a self-audit reveals a potential problem, prompt voluntary correction is generally the better course. The red flags guidance describes investigations that ended after plans voluntarily corrected issues, including extending a prior authorization auto-approval system to MH/SUD services and expanding telehealth and recruitment of MH/SUD providers to address network gaps.[15] These examples suggest EBSA will work with plans that demonstrate good faith compliance.

***Keep watching the regulatory landscape.***

The current enforcement relief in the bulletin is temporary and conditional. It is tied to a final decision in the ERIC litigation plus 18 months, and the departments have indicated that they intend to issue new proposed rulemaking in the interim.[16] The timing of any proposal remains uncertain, with early 2027 likely to be the soonest a new proposed rule

would be released, so plans should monitor developments closely.

**Conclusion**

The bulletin provides welcome clarity about where EBSA intends to focus its MHPAEA enforcement resources and confirms that new requirements in the 2024 final rule remain on hold. But the companion red flags guidance makes clear that EBSA will continue to look closely at how NQTLs operate in practice, using data and outcomes that track concepts in the 2024 final rule.

Plan sponsors and fiduciaries should therefore consider using the red flags guidance to self-audit, understand what operational data their service providers can produce if EBSA asks, and build a record demonstrating compliance under any version of the rules.

[1] U.S. Dep't of Labor, Emp. Benefits Sec. Admin., Field Assistance Bulletin No. 2026-03, Guiding Principles for EBSA's Enforcement of the Mental Health Parity and Addiction Equity Act's Nonquantitative Treatment Limitation Requirements (Sept. 8, 2026), https://beta.dol.gov/system/files/media/policy-regulations/guidance-search/ebsa-field-assistance-bulletin-no-2026-03.pdf.

[2] U.S. Dep't of Labor, Emp. Benefits Sec. Admin., Identifying Potential Problems: If You See the Following in Written Plan Provisions or Plan Operations, Think Twice about Possible MHPAEA Compliance Problems (Sept. 8, 2026), https://beta.dol.gov/policy-regulations/pay-benefits/health-plans/mental-health-and-substance-use-disorder-parity/identifying-potential-problems-possible-mhpaea-compliance-problems.

[3] Complaint, ERISA Indus. Comm. v. Dep't of Health & Hum. Servs., No. 1:25-cv-00136 (D.D.C. Jan. 17, 2025).

[4] FAB 2026-03, supra note 1 (describing the Departments' nonenforcement policy).

[5] Id.

[6] Id.

[7] Id.

[8] Id.

[9] Id.

[10] Identifying Potential Problems, supra note 2.

[11] Id.

[12] Id.

[13] FAB 2026-03, supra note 1.

[14] Identifying Potential Problems, supra note 2.

[15] Id.

[16] Joint Status Report, ERISA Indus. Comm. v. Dep't of Health & Hum. Servs., No. 1:25-cv-00136 (D.D.C. Mar. 30, 2026).

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