



HIGHLIGHTS

- The DOL's new MHPAEA guidance provides employers with a roadmap of where to focus their compliance efforts.
- The DOL identified three categories of NQTLs that the DOL intends to prioritize for enforcement.
- The DOL provided a list of warning signs of common problems, as well as best practices, examples and tips for MHPAEA compliance.
- The DOL also provided a list of questions that health plan fiduciaries should ask their existing and prospective service providers about MHPAEA compliance.

Mental Health Parity: DOL Provides Employers With a Compliance Roadmap

On Sept. 8, 2026, the U.S. Department of Labor (DOL) issued [Field Assistance Bulletin No. 2026-03](#) (Bulletin) to clarify its approach to enforcing the parity requirements for nonquantitative treatment limitations (NQTLs) under the Mental Health Parity and Addiction Equity Act (MHPAEA). The Bulletin specifically identifies three categories of NQTLs that the DOL intends to prioritize and focus its enforcement efforts on.

The DOL also launched an accompanying [webpage](#) that provides a variety of resources for employers on MHPAEA compliance, including a description of warning signs that have often signaled potential compliance problems, best practices for monitoring operational compliance for specific NQTLs, examples of how health plans have addressed concerns during NQTL investigations, tips for health plans being reviewed by the DOL for NQTL compliance, and a list of questions that health plan fiduciaries should ask service providers regarding MHPAEA compliance.

Employers should work with their service providers to review their health plan's written terms and operations for warning signs of MHPAEA noncompliance, taking into account the DOL's enforcement guidance.

Background

MHPAEA generally prohibits health plans and health insurance issuers from imposing barriers on access to mental health or substance use disorder (MH/SUD) benefits that do not apply to medical and surgical (M/S) benefits. MHPAEA's parity requirements apply to financial requirements and to quantitative treatment limitations and NQTLs, which generally limit the scope or duration of benefits. MHPAEA requires health plans and issuers to perform and document comparative analyses of the design and application of NQTLs used for MH/SUD benefits compared to M/S benefits.

The DOL's [national enforcement priorities for 2026](#) include addressing barriers to MH/SUD benefits. The DOL has received reports that prior enforcement of MHPAEA's NQTL comparative analysis requirements created "substantial confusion and unnecessary burdens" on health plans. The Bulletin is intended to provide a framework for complying with MHPAEA's NQTL requirements.

DOL Investigations: Three Key Focus Areas

The Bulletin provides that the DOL will prioritize and focus on NQTL comparative analysis enforcement in the following three areas where there is the highest potential harm to participants and beneficiaries:

1. **Separate treatment limitations for MH/SUD conditions**, including blanket exclusions;
2. **Medical necessity standards and review process**, including prior authorization, concurrent review and retrospective review; and
3. **Standards for determining network adequacy**, with a focus on network admission standards and provider reimbursement methodologies.

While the DOL will focus enforcement in these three areas, the Bulletin provides that the DOL may need to investigate other categories of NQTLs as issues arise, particularly when responding to participant complaints.

Warning Signs of Noncompliance

The DOL's new webpage identifies numerous "red flags" often seen in DOL investigations that have signaled MHPAEA compliance problems, including those described in the table below.

Warning Sign	Examples
Separate treatment exclusions for MH/SUD conditions	• Exclusion of applied behavioral analysis (ABA) therapy, speech therapy or occupational therapy for autism spectrum disorder and no similar exclusions of treatments for M/S conditions. • Exclusion of medications for addiction treatment, such as methadone, naltrexone or buprenorphine, or other evidence-based treatments for opioid or other substance use disorders, especially where similar services or the same medications are covered to treat M/S conditions. Such exclusions may be described in plan documents using terms such as "medication-assisted treatment." • Exclusion of nutritional counseling or medical nutrition therapy for eating disorders, especially where the same or similar services are covered for M/S conditions like diabetes, obesity or stroke recovery. • Exclusion of residential treatment programs, intensive outpatient programs or partial hospitalization programs for MH/SUD conditions, especially where intermediate levels of care like skilled nursing, home health or rehabilitation programs are covered for M/S conditions.
Medical necessity standards and review process	• Prior authorization or concurrent care review is required for all or almost all MH/SUD benefits but is not required for any (or only required for a few) M/S benefits in the same benefit classification. • Age limits on certain MH/SUD services, like ABA therapy, or on all services to treat autism spectrum disorder, with no or few such limitations for M/S benefits in the same benefit classification. • Extra review requirements to obtain MH/SUD services, when they apply to some MH/SUD services and not to any M/S services, or they apply to all MH/SUD services and less than all M/S services in a benefit classification. Such review requirements can go by many names, including "care manager" requirements and "utilization management" or "utilization review" requirements, or "prepayment review." • Certain criteria required to obtain MH/SUD care that are not criteria required to obtain M/S care, such as a requirement to exhaust or engage with community resources, repeat diagnostic testing requirements for autism spectrum disorder or imposing step therapy or fail-first requirements to initiate or continue coverage. These criteria are often found in medical necessity policies or plan documents.
Standards for determining network adequacy, including network admission standards and provider reimbursement methodologies	• More burdensome processes or stricter criteria for MH/SUD providers to participate in a network as compared to processes or criteria for M/S providers. • Wait time standards or maximum response timelines for MH/SUD claims and appeals are longer than the standards or response timelines for M/S claims and appeals. • Procedures exist to help participants and beneficiaries who cannot find an available network provider for M/S services, but no procedures exist for MH/SUD services, or such procedures are more burdensome for participants and beneficiaries seeking MH/SUD services. • Requirements for licensed MH/SUD providers to bill through another licensed provider, where no such requirement exists for M/S providers. • Methodologies for calculating network or out-of-network provider reimbursement amounts are different for MH/SUD providers than for M/S providers. Examples include policies that apply a set

percentage discount to reimbursement rates for masters-level MH/SUD providers while masters-level M/S providers receive no discount or a smaller one.

List of Questions for Service Providers

Health plan fiduciaries should keep MHPAEA compliance in mind when selecting and monitoring service providers. The DOL's webpage includes the following list of questions that plan fiduciaries should ask existing and prospective service providers:

- What MH/SUD benefits are offered, and what limitations apply to these services?
- How often do you review your processes and procedures for developing your network and benefits for MHPAEA compliance?
- What do you do to review for MHPAEA compliance?
- Will you share with me any MHPAEA-specific compliance reports or compliance analyses applicable to this plan or coverage?
- Do you assist with evaluating MHPAEA compliance, including preparing a comparative analysis for each NQTL that is specific to my plan?
 - What if my coverage is self-funded? What if I customize my MH/SUD benefit options?
 - What if my coverage is fully insured?
 - What compliance assistance will you provide if my plan uses a different administrator or different network for MH/SUD benefits than for M/S benefits? These are often called carve-out arrangements, where MH/SUD benefits are purchased or managed separately from M/S benefits.
 - Will you provide me with periodic reports so I can monitor trends in MH/SUD claims, including out-of-network utilization for my plan? If so, will such reports be customized to my plan?
 - Upon request, will I have access to the underlying data relating to MHPAEA compliance?
 - What assistance will be provided if my plan is the subject of a state or federal mental health parity investigation?
 - Are your assistance and such reports included in my contract without an additional fee?
- Do you cover telehealth MH/SUD services?
- Are there differences between how MH/SUD claims are administered and how M/S claims are administered?
- Are there any timing differences or additional administrative burdens applied to MH/SUD claims that differ from those applicable to M/S claims prior to approval?
- What providers are available in-network for both MH/SUD and M/S? What specialties and subspecialties are available in-network for both MH/SUD and M/S?
- How do you ensure a robust MH/SUD network?
- What steps are taken to recruit and keep providers in the network? How do those steps differ, if at all, between MH/SUD providers and M/S providers?
- What assistance is available to plan participants who are unable to find an available and appropriate in-network MH/SUD provider? How does that assistance vary as compared with M/S providers?
- Do you use access goals and metrics to evaluate the adequacy of the network? If so, what are the goals and metrics? Are the access goals and metrics different for MH/SUD care as compared to M/S care? Have you found that there is parity in network adequacy between MH/SUD and M/S networks?
- Do you have a process for receiving and documenting participant complaints? What is that process? How does that process differ, if at all, between complaints related to MH/SUD benefits vs. M/S benefits? What are your most common reasons for complaints?