# Identifying Potential Problems: If You See the Following in Written Plan Provisions or Plan Operations, Think Twice about Possible MHPAEA Compliance Problems

The Department of Labor's Employee Benefits Security Administration (EBSA) has identified addressing barriers to mental health and substance use disorder (MH/SUD) benefits as a national enforcement priority.[1] On September 8, 2026, EBSA issued Field Assistance Bulletin (FAB) 2026-03 announcing the agency's intent to prioritize and focus enforcement of the nonquantitative treatment limitation (NQTL) requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA), as amended by the Consolidated Appropriations Act, 2021 (CAA, 2021), on the following three categories of NQTLs: (1) separate treatment limitations, including exclusions; (2) medical necessity standards and review process; and (3) standards for determining network adequacy with a focus on network admission standards and provider reimbursement methodologies. FAB 2026-03 also states that, while EBSA will focus enforcement in these three areas, EBSA remains committed to protecting access to MH/SUD benefits for all plan participants and beneficiaries through its MHPAEA enforcement and therefore may need to investigate other categories of NQTLs as issues arise, particularly when responding to participant complaints.

Consistent with FAB 2026-03, this document sets forth EBSA's updated enforcement guidance under MHPAEA, providing clearer and more streamlined expectations to plans and issuers for NQTL compliance.

## *What should you look for when you're reviewing your plan for potential MHPAEA NQTL compliance problems?*

MHPAEA requirements, including NQTL compliance, can be complicated, especially since not all limitations on MH/SUD benefits are impermissible. It is generally a good starting point to look at written plan provisions as well as plan operations for compliance concerns.

Below are "red flags" often seen in EBSA investigations that have signaled potential MHPAEA compliance problems. If you see any of the below examples in your plan's written provisions or review of plan administration operations, you should reconsider whether your

[1] US Department of Labor's Employee Benefits Security Administration Updates National Enforcement Projects for Employee Benefit Plans (Jan. 15, 2026), available at https://www.dol.gov/newsroom/releases/ebsa/ebsa20260115.

plan complies with MHPAEA and its implementing regulations and take steps to assess the situation and rectify any compliance problems. These are not exhaustive lists of red flags.

## Examples of red flags in written plan provisions or applicable policies, such as exclusions, medical necessity policies and review processes, and network adequacy:

1. Exclusion of specific services for covered MH/SUD conditions:

    a. Exclusion of applied behavioral analysis (ABA) therapy, speech therapy, or occupational therapy for autism spectrum disorder and no similar exclusions of treatments for medical/surgical (M/S) conditions.
    b. 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."
    c. 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.
    d. 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.

2. Medical necessity standards and review process:

    a. 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.
    b. 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.
    c. 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."

d. Certain criteria required to obtain MH/SUD care that are not criteria required to obtain M/S care. These criteria are often found in medical necessity policies or plan documents. Examples include:

   i. Requirement that parents be involved in treatment of a child or adolescent, including being present or actively participating in treatment;
   ii. Requirement to exhaust or engage with "community resources";
   iii. Repeat diagnostic testing requirements for autism spectrum disorder;
   iv. Requirement for the patient to be fully motivated to participate in treatment;
   v. Imposing any step therapy or fail-first requirements to initiate or continue coverage; and
   vi. Treatment plan submission and revaluation requirements, especially where claims are denied if detailed content and formatting requirements are not met or the requirement is applied more frequently than for M/S care.

3. Standards for determining network adequacy, including network admission standards and provider reimbursement methodologies:

   a. 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. For example, requiring MH/SUD providers seeking to join the network to resubmit application paperwork multiple times and to wait for longer periods after approval before being listed in network provider directories, as compared to the application and approval practices for medical/surgical providers seeking to join the same network.
   b. 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.
   c. 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. These procedures can go by many names, such as "network gap" policies, "enhanced benefits" procedures, "single case agreements," "out-of-network exceptions," and "in-network for out-of-network" policies.
   d. Requirements for licensed MH/SUD providers to bill through another licensed provider, where no such requirement exists for M/S providers.
   e. 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.

## Other examples of red flags in written plan provisions or applicable policies:

1. Requirement that a participant must complete a full course of MH/SUD treatment or excluding coverage of subsequent treatment if a prior course of treatment was not completed in full, where there is no similar requirement for M/S treatment.
2. Exclusion of MH/SUD treatments based on unlikelihood of improvement or unlikelihood of substantial improvement in participant's functioning or condition, without a similar exclusion for M/S treatments.
3. Exclusion of MH/SUD treatments for MH/SUD symptoms that are deemed chronic or long-term in nature, without a similar exclusion for M/S treatments for chronic or long-term M/S symptoms.
4. Not covering telehealth MH/SUD treatment, where telehealth is covered for M/S treatment.
5. Employee Assistance Program (EAP) services act as a gatekeeper to MH/SUD treatment under the plan. This includes plans that require participants to exhaust all EAP services before MH/SUD services under the plan will be covered, or plans that require an assessment from an EAP provider or a referral from an EAP provider before the plan covers any MH/SUD services, without requiring a gatekeeping program to obtain M/S services.
6. Coverage documents indicate that some MH/SUD services are excluded from coverage or are subject to additional restrictions, but coverage documents do not state which MH/SUD services are excluded or subject to the additional restrictions. No similar language is found in the coverage documents relating to M/S services.
7. Copay dollar amounts or coinsurance percentages are higher for in-network MH/SUD office visits than for in-network M/S office visits, like primary care visits.
8. Copay dollar amounts or coinsurance percentages are higher for MH/SUD inpatient care than for M/S inpatient care.
9. Visit limits or episodic limits apply to MH/SUD services and not to M/S services.
10. Annual dollar limits or lifetime dollar limits apply to MH/SUD services and not to M/S services (But see section 2711 of the Public Health Service Act, which prohibits imposing lifetime and annual limits on the dollar value of essential health benefits).

## Examples of red flags found in plan operations:

1. Written provisions in coverage documents do not match what happens in practice, and what happens in practice is more burdensome or harmful to participant access to MH/SUD care than to M/S care. For example, written provisions in a plan document might note parental involvement or use of a care manager are best

practices, but are not clearly requirements to obtain MH/SUD care. However, in practice, parental involvement or use of the plan's care manager are requirements that result in claim denial if not met. Another example is EAP used as a gatekeeper to MH/SUD benefits in practice, but written documents describe EAP only as an added benefit. Participant complaints about unfair claim denials can draw attention to these kinds of concerns that are not necessarily apparent from coverage documents.

2. Longer timelines to obtain prior authorization or concurrent care review of MH/SUD claims, as compared to timelines for M/S claims. This includes differences in goals or standards for reviewing such claims or actual differences in how much time a plan takes to review such claims.
3. Many MH/SUD and M/S benefits require prior authorization, but the prior authorization process for M/S benefits is generally conducted through automated submissions and approvals. The prior authorization process for MH/SUD benefits is manual and involves a more burdensome exchange of documents and information.
4. Special provider designation is available to M/S providers who meet specific requirements, allowing them to submit claims without the need for prior authorization, even though prior authorization would otherwise be required for such services. However, this preferred status is not available to MH/SUD providers who meet the same specific requirements.
5. Differences in how long services are authorized or how long requested services are permitted to be authorized, such that shorter timelines are approved for MH/SUD services than are approved for M/S services. These differences in authorization periods can appear as differences in baseline approved lengths of stay or continued stay approvals.
6. More burdensome practices for MH/SUD providers to join a network, as compared to practices for M/S providers to join a network. This includes use of disparate reimbursement rate methodologies, in practice, and use of (or prohibition of) meaningful negotiation between network representatives and a MH/SUD provider seeking to join a network or deciding whether to stay in a network.
7. Differences in activities to monitor a network to ensure adequate numbers of MH/SUD providers as compared to activities to monitor a network to ensure adequate numbers of M/S providers. This includes differences in access standards used, in practice, to evaluate whether a network has enough of each provider type in each applicable geographic area to provide timely services to a covered population. This also includes differences in measures taken to address identified gaps in the provider network. For example, plans or service providers may have targeted recruitment efforts for M/S providers in geographies where there are network gaps, but no efforts to recruit MH/SUD providers in geographies where there are similar or worse network gaps.

8. Differences in requirements, processes, or level of scrutiny needed to qualify for exceptions or accommodations (such as a network gap exception or single case agreement) when participants cannot find an available network provider resulting in less access to these exceptions or accommodations for participants seeking MH/SUD services.
9. Disparate out-of-network reimbursement rate methodologies for MH/SUD claims as compared to M/S claims, resulting in participants being balance billed at higher rates for MH/SUD services as compared to M/S services.
10. Out-of-network utilization is much higher for MH/SUD services than for M/S services in the same benefit classification. Utilization should be measured consistently – e.g., using relative shares of claim volume, claim activity, or participants – across MH/SUD and M/S benefits. Out-of-network utilization can be compared using relative percentages of claim activity, percentages of claim volume, and/or percentages of participants who obtain care from out-of-network providers. Disparities in such measurements between MH/SUD and M/S services or high out-of-network utilization generally can suggest potential discrepancies in the efforts, processes, and procedures to assemble MH/SUD networks as compared to M/S networks.
11. Disproportionate number of participant complaints related to the ability to access care from in-network MH/SUD providers, as compared to such complaints related to inability to access care from in-network M/S providers.

## *Best Practices for Keeping MHPAEA Compliance in Mind When Selecting Health Plan Service Providers*

Health plan fiduciaries must prudently select and monitor plan service providers and are responsible for ensuring that the benefits those providers administer comply with MHPAEA. Health plan service providers can include many different types of entities, such as third-party administrators (TPAs), managed behavioral health organizations, claims administrators, consultants, and network administrators.

EBSA recommends that health plan fiduciaries consider MHPAEA compliance when selecting service providers. Plan fiduciaries should ask existing and prospective service providers the following types of MHPAEA-focused questions:

### Questions about MHPAEA Compliance:

1. What MH/SUD benefits are offered, and what limitations apply to these services?
2. How often do you review your processes and procedures for developing your network, and benefits for MHPAEA compliance?
3. What do you do to review for MHPAEA compliance?

4. Will you share with me any MHPAEA-specific compliance reports or compliance analyses applicable to this plan or coverage?
5. Do you assist with evaluating MHPAEA compliance, including preparing a comparative analysis for each NQTL that is specific to my plan?

    a. What if my coverage is self-funded? What if I customize my MH/SUD benefit options?
    b. What if my coverage is fully-insured?
    c. 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.
    d. 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?
    e. Upon request, will I have access to underlying data relating to MHPAEA compliance?
    f. What assistance will be provided if my plan is the subject of a state or federal mental health parity investigation?
    g. Are your assistance and such reports included in my contract without an additional fee?

6. Do you cover telehealth MH/SUD services?
7. Are there differences between how MH/SUD claims are administered and how M/S claims are administered?
8. 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?
9. 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?
10. How do you ensure a robust MH/SUD network?
11. 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?
12. 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?
13. 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?
14. 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?

## *Best Practices for Monitoring Operational Compliance for Specific NQTLs*

There are certain NQTLs that are present in most, if not all, plans. While common, these NQTLs can be impermissible if the processes, strategies, evidentiary standards, and other factors used to apply them to MH/SUD benefits are not comparable to, or are applied more stringently than the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to M/S benefits. When monitoring the common NQTLs listed below, be sure to look beyond what is written in the plan documents to how the NQTLs are applied in practice. See below for tips for reviewing these common NQTLs to ensure that NQTLs applicable to MH/SUD services satisfy parity requirements as compared to M/S services:

### Medical Necessity Standards and Review Process:

1. Check the list of benefits subject to the NQTL(s) for both MH/SUD and M/S benefits; flag significant disparities in scope of applicability.
2. Understand why and how benefits are added or removed from the list. If standards are used to make such decisions, compare standards applied to MH/SUD benefits vs. M/S benefits.
3. Review prior authorization and concurrent review (PA/CR) claims submission process, considering the burden on participants and providers, such as the kinds of documents required as part of the review; the required frequency of review; length of time for each approval; and use of automated vs. manual review, including use of peer reviews or subject matter experts in the claim review process.
4. Track and respond to participant complaints, and train staff on handling complaints, including available resources to address complaints.
5. Compare penalties for failure to get PA/CR for MH/SUD and M/S benefits.
6. Periodically review datapoints related to how PA/CR and retrospective review are applied in practice and trends over time. Consider tracking claim volume and denial rates separately by benefit type and provider type, as well as monitoring turnaround time for review.
7. Review plan documents and disclosures to participants for inaccurate information.
8. Create and follow a written policy for monitoring the above or incorporate it into existing monitoring policies.
9. If red flags or disparities are detected through such monitoring, take action in response and document it.

### Processes for Achieving and Determining Network Adequacy

1. Inquire and assess how your network administrator evaluates the adequacy of the network to meet the plan's coverage needs and ensure timely access to care. Identify any applicable standards, how they are assessed, and whether they are met. Ask about what is done when any standard is not met.
2. If your plan allows out-of-network (OON) exceptions for participants who cannot find a network provider, review those policies and the data relating to their implementation, checking for disparities between MH/SUD and M/S benefits.
3. If special efforts are made to address network gaps for M/S services, understand whether and why such efforts are made to address network gaps for MH/SUD services.
4. Monitor OON utilization of M/S services as compared to MH/SUD services. Track trends over time. Consider comparing percentages of overall claim volume, claim value, and participant volume by benefit type and provider type.
5. Track and respond to participant complaints, and train staff on handling complaints, including available resources to address complaints.
6. Review processes for providers to join the network and related summary data. Consider comparing M/S vs. MH/SUD percentages of applications approved versus denied, applications withdrawn, and average time to approve or deny the application.
7. Assess patient wait times, any applicable standards, how they are assessed, and whether they are met, and note any differences between M/S and MH/SUD services.
8. Create and follow a written policy for monitoring the above data or incorporate it into existing monitoring policies.
9. If monitoring indicates access problems, disparities, or other red flags, take action in response and document it.

### OON Reimbursement Methodologies

1. Compare M/S vs. MH/SUD provider rates relative to a benchmark in accordance with the MHPAEA Self-Compliance Tool Appendix.
2. Check written plan documents and internal policies for disparities in rate-setting processes, such as rate reductions for mid-level providers that are greater for MH/SUD than for M/S.

## *Examples of How Plans have Addressed Concerns during NQTL Investigations*

Below are examples from Department of Labor NQTL investigations where the Department was able to work with the plan and quickly resolve any issues / end the NQTL investigation:

1. A network adequacy parity concern was voluntarily resolved through a demonstration of proactive measures and ongoing monitoring practices, which included increasing telehealth, expanding gap policies, expanding monitoring using more robust data, and increasing recruitment efforts, for MH/SUD providers.
2. Blanket preauthorization on MH/SUD services and not M/S services was addressed voluntarily by decreasing the number of MH/SUD services subject to preauthorization based on application of a comparable and no more stringently applied standard, and distributing notices and disclosures to participants informing them of the change.
3. A preauthorization auto-approval system that was previously only offered for M/S services, and not MH/SUD services, was revised to include MH/SUD services.
4. An ABA therapy exclusion to treat autism spectrum disorder where there was no similar treatment exclusion for M/S services was corrected by removing the exclusion both prospectively and retroactively, and an opportunity to resubmit claims was offered to participants potentially affected by the exclusion.
5. An exclusion of medications to treat opioid use disorder was corrected voluntarily by removing the exclusion both prospectively and retroactively, and an opportunity to resubmit claims was offered to participants potentially affected by the exclusion.
6. A drug testing limit that applied only to MH/SUD services was removed at the service provider level, which included sending notices to participants notifying them of the removal of the limitation and the service provider adopted new internal procedures for handling drug testing claims. Because the issue was corrected at the service provider level, the DOL did not need to open additional cases on the individual plan clients.
7. An age limit on ABA therapy to treat autism spectrum disorder where there was no similar age limit for M/S services was removed voluntarily, and notices were sent to participants, practices/plan documents were revised, and affected claims were reprocessed.

## *Tips for Plans Being Reviewed by DOL for NQTL Compliance*

If your plan has been identified for an NQTL compliance review by the DOL, please review the aforementioned guidance and see additional tips below:

Be prepared, follow tips for complying in advance.

1. Have your documentation ready – coverage documents, comparative analyses, supporting documents, and documents showing monitoring activities.
2. Establish an internal response process for communicating with DOL and key stakeholders; ensure timely and organized responses.

3. Re-review your comparative analyses to refresh your memory. Double check to ensure they are complete and accurate.
4. Respond to requests/follow up questions from DOL with detailed, complete answers that include data-driven and factual support, not generalities.
5. Expect questions about apparent disparities.
6. Expect questions about how an NQTL is applied in practice.
7. If concerns or violations are noted, ensure you understand the issues and propose appropriate corrective action. When fixing problems, consider how to address the problem going forward and whether/how participants were harmed in the past, and if so, how to address those past harms.
8. Share proof of voluntary corrective action with DOL.