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MENTAL HEALTH PARITY: WHERE DOL ENFORCEMENT IS FOCUSING IN 2026

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On September 8, 2026, the U.S. Department of Labor (DOL)'s Employee Benefits Security Administration (EBSA) announced that it is prioritizing enforcement of certain requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA).

Mental health and substance use disorder benefits have been subject to federal parity requirements for years, but the DOL's recent enforcement priorities signal renewed attention to how those requirements are applied in employer-sponsored health plans and, more importantly, how those plans operate in practice.

For employers, this is not a new mental health parity law. Instead, the guidance clarifies where federal regulators intend to focus their attention and gives employers an opportunity to review how their plans handle mental health and substance use disorder benefits.

UNDERSTANDING MENTAL HEALTH PARITY

MHPAEA was enacted to prevent health plans from treating mental health and substance use disorder benefits more restrictively than medical and surgical benefits. At its most basic level, parity means that plans cannot impose more restrictive financial requirements or treatment limitations on mental health and substance use disorder benefits than those applied to comparable medical and surgical benefits.

That sounds relatively straightforward. In practice, however, parity involves more than comparing copayments or deductibles.

Health plans use various rules and processes to determine whether care is covered, how much review is required, and which providers employees can access. Many of these are known as nonquantitative treatment limitations (NQTLs), including:

- Prior authorization and medical necessity determinations
- Utilization management processes
- Provider network and admission standards
- Provider reimbursement methodologies

MHPAEA does not necessarily prohibit limitations in these areas. Instead, it requires plans to evaluate how they are designed and applied to mental health and substance use disorder benefits compared with medical and surgical benefits.

A difference between the two is not automatically a parity violation, but it may warrant closer examination, particularly when it creates additional barriers to care.

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WHERE IS THE DOL FOCUSING ENFORCEMENT?

EBSA's September 2026 guidance identifies three enforcement priorities:

1 TREATMENT LIMITATIONS AND EXCLUSIONS

A health plan may cover a particular medical treatment while excluding a comparable treatment for a mental health or substance use disorder.

The existence of a difference does not necessarily mean the plan violates MHPAEA. The question is how the limitation was developed and whether comparable standards are used for medical and surgical benefits.

2 MEDICAL NECESSITY AND REVIEW PROCESSES

Health plans routinely use medical necessity criteria to determine whether treatment is appropriate and covered. Under MHPAEA, the standards and processes used for behavioral health must be evaluated against those used for medical and surgical care.

Differences in review frequency, documentation requirements, or other utilization management processes may warrant a closer look.

3 NETWORK ADEQUACY AND PROVIDER ACCESS

Then there is the issue employees may notice most directly: access to providers.

A health plan can offer mental health benefits on paper while an employee struggles to find an available in-network therapist, psychiatrist, or substance use disorder provider.

Suppose an employee is told that a mental health service is covered, but every in-network provider they contact has a long waitlist or is not accepting new patients. The employee may ultimately have to pay for an out-of-network provider or go without care.

This is why employers should look beyond whether a provider directory includes behavioral health providers. They also need to understand how their plan monitors provider availability, addresses network gaps, and handles out-of-network exceptions when appropriate care is not reasonably available in-network.

Provider participation matters, too. Different or more burdensome network admission requirements, credentialing processes, or reimbursement methodologies for behavioral health providers may warrant review under MHPAEA.

Employers may not have direct visibility into how these networks are built and maintained, but they should be comfortable asking their benefits partners about these practices.

THE IMPORTANT TAKEAWAY? Mental health parity is not just about what is written in plan documents. It also involves how benefits work when an employee actually needs them.

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WHAT ABOUT THE 2024 FINAL RULE?

Employers may also be hearing renewed discussion about the MHPAEA final rule issued by federal agencies in 2024.

The rule introduced significant changes to existing MHPAEA regulations, including additional requirements involving NQTLs, comparative analyses, and access to mental health and substance use disorder benefits.

However, the regulatory landscape changed in May 2025, when the Departments of Labor, Health and Human Services, and the Treasury announced that they would not enforce provisions of the 2024 final rule that were new compared with the 2013 regulations while litigation and reconsideration continue, and for an additional period following a final decision in the litigation.

That does not mean mental health parity requirements went away.

The agencies confirmed that MHPAEA's underlying statutory requirements remain in effect, including the comparative analysis requirements of the Consolidated Appropriations Act (CAA), 2021.

Employers should therefore distinguish between existing legal requirements and provisions of the 2024 final rule that are subject to the current federal enforcement policy. Given these complexities, it remains important to work with benefits advisors, carriers, third-party administrators (TPAs), and legal counsel, as appropriate.

EMPLOYER ACTION PLAN

The September 2026 guidance does not mean employers need to conduct clinical reviews or rebuild their provider networks themselves. Instead, it provides a reason to better understand who is responsible for these functions and what information is available to the plan sponsor.

A conversation with a carrier, TPA, broker, or benefits advisor is a good starting point.

QUESTIONS EMPLOYERS SHOULD ASK

- ☑ What NQTLs apply to our mental health and substance use disorder benefits, and how are they evaluated for parity?
- ☑ Are medical necessity standards and review processes comparable to those used for medical and surgical care?
- ☑ How are behavioral health provider networks monitored, and how are providers admitted and reimbursed?
- ☑ What happens when an employee cannot find an available in-network provider?
- ☑ What comparative analysis documentation is available, and who maintains and updates it?

Employers should also consider how their plans function in practice. Employee complaints, out-of-network utilization, claims and appeals, and provider access issues can reveal potential barriers that may not be obvious from plan documents alone.

Not every difference between behavioral health and medical benefits represents a compliance problem. The goal is to understand those differences, how they were established, and whether they are consistent with applicable parity requirements.

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BEYOND COVERAGE: THE BIGGER PARITY QUESTION

Mental health parity is about more than whether a health plan covers behavioral health. It is also about the rules and processes surrounding that coverage and whether employees face impermissible restrictions or barriers compared with medical and surgical care.

For employers, the DOL's renewed enforcement focus presents an opportunity to ask a more meaningful question than simply, “Does our plan cover mental health?”

> How does our plan administer mental health and substance use disorder benefits, and are those processes consistent with mental health parity requirements?

Starting that conversation with benefits partners can help employers better understand their responsibilities, identify areas warranting further review, and support access to the behavioral health benefits employees rely on.



A NEW LOOK AT THE DCAP 55% TEST

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For employers sponsoring a Dependent Care Assistance Program (DCAP), nondiscrimination testing (NDT) is essential to maintaining the benefit's tax-favored status. One requirement that has long raised questions for employers and administrators is the 55% Average Benefits Test, particularly when a plan has a large eligible population but low participation.

On August 11, 2026, the U.S. Department of the Treasury and the Internal Revenue Service (IRS) issued proposed regulations addressing DCAP NDT requirements under Internal Revenue Code (IRC) § 129. Among other provisions, the proposed regulations clarify how to calculate the 55% Average Benefits Test. For employers that have struggled with this test in the past, the clarification may be a welcome development.

WHY THE 55% TEST HAS BEEN CHALLENGING

The 55% Average Benefits Test compares the average dependent care benefits received by highly compensated employees (HCEs) with those received by non-highly compensated employees (NHCEs). Generally, the average benefits provided to NHCEs must be at least 55% of the average benefits provided to HCEs for the plan to satisfy the test.

Historically, a key question has been whether to include DCAP-eligible employees who receive no benefits in the calculation. Including these employees effectively adds $0 to the average, potentially lowering the result for groups with low participation.

This can create challenges when participating HCEs and NHCEs receive similar benefits but have different overall participation rates. A large number of eligible NHCEs receiving no benefits could lower the NHCE average enough to cause the plan to fail the test.

The proposed regulations take a different approach to how these employees factor into the calculation.

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HOW THE CALCULATION IS CHANGING

Under the methodology described in proposed Treas. Reg. § 1.129-2(d), the average benefit is calculated by dividing the total dependent care assistance provided to a group by the number of employees in that group who actually received benefits during the plan year.

Employees who receive no dependent care assistance are excluded from the denominator, even if they are eligible to participate. This distinction between eligibility and actual participation can significantly affect testing results.

THE 55% TEST IN PRACTICE

Consider an employer with 15 eligible HCEs and 15 eligible NHCEs. During the plan year:

- 11 HCEs receive $7,500 each, totaling $82,500
- 4 NHCEs receive $7,500 each, totaling $30,000
- The remaining eligible employees receive no dependent care assistance

Under the previous calculation approach, including all eligible employees produces an NHCE average of $2,000 compared with an HCE average of $5,500. The NHCE average is only 36.36% of the HCE average, so the test fails.

Under the proposed methodology, employees receiving no benefits are excluded. Both groups have an average benefit of $7,500, meaning the NHCE average is 100% of the HCE average, and the plan passes the test.

This example illustrates how excluding eligible nonparticipants can change the testing outcome without changing the benefits actually provided.

	Previous Approach	Proposed Methodology
HCE Benefits	$82,500	$82,500
HCE Count	15	11
HCE Average	$5,500	$7,500
NHCE Benefits	$30,000	$30,000
NHCE Count	15	4
NHCE Average	$2,000	$7,500
NHCE Average as % of HCE Average	36.36%	100%
Test Result	FAIL	PASS

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WHAT HASN'T CHANGED?

Although the proposed methodology changes how employees receiving no benefits are counted, it does not eliminate the other nondiscrimination requirements that apply to DCAPs.

Eligibility still matters. There is an important distinction between an eligible employee who chooses not to participate and an employee improperly excluded from eligibility. Employers must continue using reasonable, objective eligibility criteria that do not discriminate in favor of HCEs. They cannot simply change eligibility provisions to improve their testing results.

Satisfying the 55% Average Benefits Test does not, by itself, establish compliance with all DCAP nondiscrimination requirements under Section 129. Employers must still consider:

- ☑ Eligibility requirements
- ☑ Contributions and benefits testing
- ☑ Owner concentration requirements
- ☑ Actual plan operations

Employers should also ensure their written plan documents align with how they administer the DCAP. Accurate employee and benefit data remain essential to the testing process.

In other words, the proposed regulations clarify one aspect of DCAP testing; they do not provide a way to bypass the plan's other compliance obligations.

WHAT DOES THIS MEAN FOR EMPLOYERS?

Although the regulations are not yet final, the Treasury Department and the IRS have stated that taxpayers may rely on the proposed methodology for plan years beginning before the final regulations are published. The proposed regulations are currently scheduled to apply to plan years beginning on or after the date the final regulations are published in the Federal Register.

IT'S A REASON TO REVISIT THE NUMBERS

Employers conducting DCAP testing can evaluate whether the proposed calculation would affect their results. Those with previous 55% Average Benefits Test failures resulting from eligible NHCEs receiving no benefits may also want to review their results, particularly if participating HCEs and NHCEs received comparable benefits. A previous failure may not recur if the calculation only includes employees who actually received benefits.

However, employers should not recalculate a prior failed test without considering the applicable plan year, original testing data, eligibility provisions, and whether reliance on the proposed regulations is appropriate. Employers should discuss these considerations with their legal or tax advisors.

SOURCES:

IRC § 129(d)(8): 55% Average Benefits Test for dependent care assistance programs
IRC § 129(d)(2)-(4): DCAP nondiscrimination rules for contributions and benefits, eligibility, and more-than-5% owner concentration
IRC § 129(d)(9): Excluded employees for eligibility and average benefits testing
Employer Contributions to Trump Accounts and Nondiscrimination Rules for Dependent Care Assistance Programs: 26 CFR Part 1, 91 Fed. Reg. 51611 (Aug. 11, 2026) (proposed regulations)

CAN WORKPLACE CONVERSATIONS ABOUT MEDICAL INFORMATION VIOLATE HIPAA?

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An employee shares details about a medical condition with a coworker. Before long, that information makes its way around the workplace. Does repeating someone's medical information constitute a HIPAA violation?

The practical answer is usually no, provided the information came from the employee's own voluntary disclosure rather than a group health plan, health care provider, business associate, or plan records.

HIPAA does not regulate every conversation involving health information. The HIPAA Privacy Rule applies to covered health plans, health care clearinghouses, and certain health care providers that conduct standard electronic transactions. Business associates are also subject to applicable HIPAA requirements. The Department of Health and Human Services (HHS) clarifies that the Privacy Rule does not regulate employers acting in their role as employers.

For employers sponsoring group health plans, the distinction between the employer and the plan is important. While a group health plan may be a HIPAA-covered entity, sponsoring the plan does not automatically make the employer one. Under HIPAA, the group health plan is treated as legally separate from the employer or plan sponsor.

This legal distinction does not, however, mean workplace gossip about medical conditions is harmless. Supervisors and managers should avoid participating in or amplifying medical gossip, refrain from soliciting unnecessary medical details, and maintain strict need-to-know boundaries.

Even when HIPAA or Americans with Disabilities Act (ADA) confidentiality requirements do not apply, other legal and workplace concerns may arise, including state privacy laws, harassment or bullying rules, potential retaliation claims, workplace conduct policies, and employee relations issues.

A conversation may fall outside HIPAA, but how managers respond to medical information can still create workplace risks.

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Managers also need to recognize when information about an employee's medical condition may suggest a need for leave, workplace accommodations, schedule changes, or other support. In those situations, managers should refer the matter to the appropriate HR, benefits, leave administration, or ADA/FMLA personnel. They should not disregard information suggesting a potential need for leave or accommodations simply because the employee has not yet made a formal request.

For example, obligations under the Family and Medical Leave Act (FMLA) may arise before an employee submits the required paperwork. According to the DOL, employees do not need to specifically mention "FMLA" when first requesting qualifying leave. They must, however, provide enough information for the employer to reasonably determine whether the law may apply. This can include information about hospitalization, pregnancy-related incapacity, inability to perform job functions, or continuing treatment by a health care provider.

Not every workplace conversation about medical information raises a HIPAA concern, but employers should still approach these situations carefully. Understanding where HIPAA applies, maintaining appropriate confidentiality, and recognizing potential leave or accommodation needs can help reduce legal and employee relations risks.

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UPCOMING DEADLINES

DEC 15 — PROVIDE SUMMARY ANNUAL REPORT (SAR) TO PARTICIPANTS

Calendar-year plans required to file Form 5500 must distribute the SAR to plan participants by December 15, 2026, if they obtained an extension to file Form 5500.

DEC 31 — SUBMIT ANNUAL GAG CLAUSE ATTESTATION

Group health plans and insurers must submit their annual Gag Clause Prohibition Compliance Attestation. Fully insured plans may rely on their insurer; self-insured plans may arrange submission through a TPA.

JAN 2027 — CONDUCT NONDISCRIMINATION TESTING

Employers offering Section 125, 129, or 105(h) plans must complete annual nondiscrimination testing during the plan year. Midyear testing is recommended to identify issues early, while first-quarter testing is recommended for DCAPs.

FEB 01 — REPORT HEALTH PLAN COSTS ON FORM W-2

Employers must furnish 2026 Forms W-2 to employees and file them with the SSA. Health coverage cost reporting generally applies to employers that filed 250 or more W-2s for 2025.

MAR 01 — MAIL ACA FORMS 1094-C AND 1095-C

Applicable large employers (ALEs) filing fewer than 10 aggregate information returns may file paper ACA forms with the IRS. Employers meeting the electronic filing threshold must file electronically.

MAR 01 — MAIL ACA FORMS 1094-B AND 1095-B

Non-ALEs with self-insured health plans must report coverage information to the IRS. Paper filing is generally permitted only when filing fewer than 10 aggregate information returns.

MAR 01 — REPORT HIPAA BREACHES TO OFFICE OF CIVIL RIGHTS (OCR)

Covered entities must report breaches affecting fewer than 500 individuals within 60 days of the end of the plan year. Breaches affecting 500 or more individuals require notification without unreasonable delay, within 60 days of discovery.

MAR 01 — SUBMIT MEDICARE PART D DISCLOSURE TO CMS

Calendar-year group health plans offering prescription drug coverage to Medicare-eligible individuals must disclose to CMS whether their coverage is creditable or non-creditable, within 60 days after the plan year begins.

MAR 02 — FURNISH ACA FORM 1095-C TO EMPLOYEES

ALEs must furnish Forms 1095-C for 2026 coverage by March 2, unless they satisfy the alternative furnishing requirements through a timely website notice and provide forms upon request.

MAR 02 — FURNISH ACA FORM 1095-B TO INDIVIDUALS

Coverage providers must furnish Forms 1095-B by March 2, unless they satisfy the alternative furnishing requirements through a timely website notice and provide forms upon request.

MAR 31 — ELECTRONICALLY FILE ACA FORMS 1094-C AND 1095-C

ALEs must electronically file 2026 coverage information with the IRS if they are required to file 10 or more information returns during the year. An automatic 30-day filing extension is available through timely submission of Form 8809.

MAR 31 — ELECTRONICALLY FILE ACA FORMS 1094-B AND 1095-B

Non-ALEs with self-insured health plans must electronically file 2026 coverage information if they are required to file 10 or more information returns during the year. An automatic 30-day extension is available through timely submission of Form 8809.



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