



Mental Health Parity Compliance in Flux: What Employers Need to Know Now

By: Dawnielle Wright

The regulatory landscape governing mental health and substance use disorder benefits has shifted significantly over the past year, leaving many employer plan sponsors uncertain about their current obligations. While the federal agencies responsible for enforcing the Mental Health Parity and Addiction Equity Act ("MHPAEA") have pulled back on certain new requirements, the underlying law remains fully in force and enforcement continues.

Background

Enacted in 2008, MHPAEA requires group health plans that offer mental health or substance use disorder benefits to do so on terms no more restrictive than the plan's medical and surgical benefits, including financial requirements such as deductibles and copayments, and treatment limitations such as visit caps and prior authorization requirements. MHPAEA does not require plans to offer mental health or substance use disorder benefits, but plans that do are subject to parity, and the requirements apply to fully-insured and self-funded plans alike. Since 2021, the Consolidated Appropriations Act ("CAA") has further required group health plans to conduct and maintain a written comparative analysis of how non-quantitative treatment limitations ("NQTLs"), such as prior authorization requirements and network composition standards, are applied to mental health or substance use disorder benefits versus medical and surgery benefits.

The 2024 Final Rule and Its Current Status

In September 2024, the Departments of Labor, Health and Human Services, and Treasury published a sweeping final rule expanding MHPAEA's requirements, introducing a "meaningful benefits" standard, new data evaluation obligations, a prohibition on discriminatory factors in NQTL design, and a requirement that ERISA plan fiduciaries certify their comparative analyses. Provisions were set to take effect on a staggered schedule beginning January 1, 2025, with the more complex requirements effective for plan years beginning on or after January 1, 2026.

The rule faced an immediate legal challenge when the ERISA Industry Committee filed suit on January 17, 2025. The Departments sought a stay of the litigation, which the court granted on May 12, 2025. On May 15, 2025, the Departments issued a formal non-enforcement statement declaring they will not enforce the 2024 Final Rule or pursue enforcement action for failures to comply occurring prior to a final decision in the litigation, plus an additional 18 months. The Departments also indicated that they may issue a proposed rulemaking to rescind or modify the rule entirely.

This relief covers only the provisions new to the 2024 Final Rule, including the fiduciary certification requirement and all provisions with 2025 and 2026 effective dates. The 2013 final regulations, the CAA's NQTL comparative analysis requirement, and all other foundational MHPAEA obligations remain fully enforceable.

The March 2026 Congressional Report



Inside this issue:

Mental Health Parity Compliance in Flux: What Employers Need to Know Now
PAGE 1

DOL Proposes Rule to Remove Restrictions on Alternative Investments in Retirement Plans
PAGE 2

FTC Settlements with ESI and CVS: What Employers Need to Know
PAGE 3

This Month's Compliance Corner: A Primer on Section 127 Educational Assistance Programs
PAGE 4

Stay in the Know
PAGE 4

This Month's Contributors
PAGE 5

On March 3, 2026, the Departments published their 2025 MHPAEA Report to Congress, the fourth annual report required under the CAA, covering enforcement activity from August 1, 2023 through July 31, 2025. The report provides the most current and detailed picture available of how the agencies are approaching MHPAEA enforcement and where plans continue to fall short.

The Departments acknowledged the “numerous challenges” MHPAEA compliance presents for employers and plan sponsors, recognized that those challenges can negatively impact individuals’ access to care, and expressed a commitment to ensuring protections are enforced “in a way that is not unduly burdensome for plans and issuers.” The Departments reiterated that they are reconsidering the 2024 Final Rule and undertaking a broader reexamination of their overall enforcement approach.

The report also documents the ongoing enforcement activity. During the reporting period, the Employee Benefits Security Administration’s (“EBSA”) enforcement work resulted in corrections affecting more than 18 million participants across more than 39,000 group health plans, including expanded access to opioid use disorder treatment for over 130,000 participants, reduced prior authorization barriers for more than 2 million participants, and expanded access to autism spectrum disorder treatments for over 800,000 participants. Since 2021, EBSA’s cumulative enforcement work has led to corrections across more than 77,000 group health plans and issuers, affecting over 23 million American workers and their families.

The types of violations identified during the reporting period are instructive for plan sponsors. EBSA’s enforcement letters most frequently addressed provider network admission standards, exclusions of speech or occupational therapy, limits on autism services, exclusions of nutritional counseling, exclusions of ABA therapy, and exclusions of residential care or partial hospitalization. Prior authorization and concurrent review requirements were the most common categories resulting in initial determinations of noncompliance. The Centers for Medicare and Medicaid Services (“CMS”), which oversees non-federal governmental plans and fully-insured coverage, issued final determinations of noncompliance against several named plans and insurers, primarily for prior authorization and concurrent review practices that applied stricter standards to mental health or substance use disorder benefits than to comparable medical and surgery benefits.

The report also highlights an important compliance gap: many plan sponsors mistakenly believe that their service provider, whether a carrier, TPA, or behavioral health carve-out vendor, is responsible for MHPAEA compliance and has prepared the required comparative analysis. The Departments were direct in that the compliance obligation rests with the plan, not the service provider. Several enforcement actions were initiated against plans whose sponsors were unaware that their vendors had not prepared a comparative analysis, had refused to provide one, or had prepared one that was inadequate. Plans with carve-out arrangements where separate vendors administer mental health or substance use disorder benefits and medical and surgery benefits face particular complexity, as those vendors frequently do not coordinate with each other in ways sufficient to support a complete comparative analysis.

Practical Considerations for Plan Sponsors

For employers sponsoring fully-insured plans, primary MHPAEA compliance responsibility rests with the insurance carrier. However,

plan sponsors should request written confirmation from their carrier that the plan’s NQTL comparative analysis has been completed, reviewed, and is available for production upon request.

Self-funded plan sponsors carry a more direct compliance burden. These employers should confirm with their third-party administrator or other service providers that a current comparative analysis is in place and that it addresses how NQTLs, including prior authorization, step therapy, and network adequacy standards, are designed and applied with respect to mental health or substance use disorder benefits compared to medical and surgery benefits.

Conclusion

The current MHPAEA compliance environment is one of regulatory transition as the 2024 Final Rule is paused, federal enforcement has lessened, and further regulatory action, including the possibility of a new proposed rule, is anticipated. At the same time, the foundational requirements of MHPAEA, including the NQTL comparative analysis obligation, remain fully in effect. Employers would be well-served to use this period of quiet enforcement to assess their current compliance efforts and address any gaps before further regulatory action is implemented.



DOL Proposes Rule to Remove Restrictions on Alternative Investments in Retirement Plans

By Abby Blankenship

On March 30, 2026, the Department of Labor’s (DOL) Employee Benefits and Security Administration (EBSA) proposed a new rule that would make it easier for plan fiduciaries to include alternative assets, such as private equity and cryptocurrency, in retirement plan investment lineups.

Background

The proposal implements President Trump’s Executive Order 14430, “Democratizing Access to Alternative Assets for 401(k) Investors,” issued on August 7, 2025, which directed the DOL to broaden access to alternative investments in 401(k) plans. Historically, many plan fiduciaries have been hesitant to include these investments due to concerns around complexity, fees, and potential litigation exposure.

Overview of Proposed Rule

The proposed rule, titled “Fiduciary Duties in Selecting Designated Investment Alternatives,” introduces a process-based safe harbor under the Employee Retirement Income Security Act (ERISA). The safe harbor outlines specific steps that plan fiduciaries should follow

when selecting investment options for participant-directed defined contribution plans.

If the safe harbor requirements are satisfied, fiduciary decisions would be entitled to a presumption of prudence under ERISA and “significant deference,” which could help mitigate litigation risk.

Six Safe Harbor Factors

To rely on the safe harbor, fiduciaries must engage in objective, thorough, and analytical evaluation of the following factors:

1. **Performance:** The fiduciary would need to assess and evaluate the investment’s expected returns after accounting for all fees and expenses.
2. **Fees:** The fiduciary would need to consider “similar alternatives and determine that the fees and expenses of the designated investment alternative are appropriate.” It is worth noting that the rule does not require the fiduciary to automatically select the lowest-cost option.
3. **Liquidity:** The fiduciary would need to consider and assess whether such alternative investment “will have sufficient liquidity to meet the anticipated needs of the plan at both the plan and individual levels.”
4. **Valuation:** The fiduciary would need to ensure that the investment can be timely and accurately valued.
5. **Benchmarking:** The fiduciary would need to compare the investment against an appropriate and meaningful benchmark.
6. **Complexity:** The fiduciary would need to consider the “complexity of the designated investment alternative and determine that it has the skills, knowledge, experience, and capacity to comprehend it sufficiently enough to discharge its obligations under ERISA and the governing plan documents or whether it must seek assistance from a qualified investment advice fiduciary, investment manager, or other individual.”

The proposed rule also includes illustrative examples to help fiduciaries apply each of these factors in practice.

Key Takeaways

If finalized, the proposed rule could increase the availability of alternative assets in 401(k) and other participant-directed account plans. It also reinforces that a prudent process remains essential to fiduciary decision-making under ERISA.

The proposed rule is subject to a 60-day public comment period, with comments due by June 1, 2026. In the meantime, plan sponsors and fiduciaries may want to review their current investment selection processes and governance practices to ensure they align with the proposed framework – particularly if they are contemplating implementing alternative investment options.



FTC Settlements with ESI and CVS: What Employers Need to Know

By Kate Belyayeva

In September 2024, the Federal Trade Commission (“FTC”) brought an administrative action against the three largest pharmacy benefit managers (“PBMs”) in the U.S. (i.e., Express Scripts, Inc. (“ESI”), CVS/Caremark (“CVS”), and OptumRx) and their affiliates group purchasing organizations, alleging that they engaged in anticompetitive and unfair rebating practices that inflated insulin prices. The case is notable given the market concentration of these PBMs—the three PBMs administer approximately 80% of prescriptions in the U.S.—amplifying the potential system-wide impact of their pricing practices. This article summarizes the final settlement between ESI as well as the proposed settlement with CVS and potential impact on employers.

Background

According to the FTC, PBMs leveraged their control over formularies to demand higher rebates from drug manufacturers in exchange for favorable placement, which contributed to increasing drug list prices and higher out-of-pocket costs for patients. The FTC specifically alleged that these practices “artificially inflated the list price of insulin drugs,” impaired access to lower-cost alternatives, and shifted costs to patients. In early 2026, the FTC reached a landmark settlement with ESI and subsequently announced that CVS had entered into a proposed settlement, with final terms still pending.

Key Provisions: ESI

On February 4, 2026, the FTC finalized a settlement with ESI requiring “fundamental changes” to its PBM business practices. The settlement is expected to reduce patient out-of-pocket drug costs by up to \$7 billion over 10 years and increase transparency in PBM operations.

Key provisions with respect to the Express Scripts’ settlement with the FTC include:

1. **Formulary and Pricing Restrictions.** ESI may not steer patients to higher-cost drugs over lower-cost alternatives where both are available. Member cost-sharing must be based on the net cost of a drug rather than its list price.
2. **Rebate and Compensation Reforms.** Compensation from pharmaceutical manufacturers may not be tied to prices on the drug list. Members must receive the benefit of negotiated rebates at the point of sale without additional fees.
3. **Prohibition on Spread Pricing.** ESI is prohibited from charging plan sponsors more than it reimburses pharmacies for a given drug.
4. **Pharmacy Reimbursement Changes.** Retail pharmacies must be reimbursed based on their acquisition cost plus a dispensing fee.
5. **Enhanced Transparency and Reporting.** Plan sponsors must receive detailed reporting, including claim-level data and disclosure of all compensation, including payments to brokers or consultants.
6. **Structural and Operational Changes.** ESI must relocate certain

rebate-related operations to the U. S. The PBM must also implement a “standard offering” for plan sponsors incorporating these reforms by January 1, 2028.

7. Compliance Oversight. A compliance monitor will oversee adherence to the settlement for three years, and the order will remain in effect for up to 10 years.

Proposed Settlement With CVS

In March 2026, CVS reached a proposed settlement with the FTC related to the same insulin pricing allegations. As of now, the settlement has been approved at the staff level but remains subject to final agency approval, with additional details to be released once officially finalized. Because final terms are not yet public, employers should expect that any CVS-related changes will likely align closely with the ESI framework, including similar reforms to pricing transparency and compensation structures, but may include variations depending on negotiation outcomes.

Employer Impact

The ESI settlement (and any upcoming settlements with CVS and OptumRx) signals that PBM contracting and pricing structures may continue to change over time. Although the FTC settlements apply directly to PBMs, they are likely to have significant downstream implications for employers sponsoring group health plans.

First, the ESI settlement requires detailed reporting to plan sponsors, including claim-level data and full disclosure of compensation arrangements. This may provide employers with greater visibility into prescription drug costs and PBM revenue streams than previously available.

As ESI begins implementing these changes, plan sponsors should also expect proposals and contract structures to evolve. In particular, the settlement’s requirements with respect to pricing reflect a broader shift toward pricing models based on the net cost of drugs rather than list price and rebates. Although pricing based on net cost (rather than rebates) may improve member affordability, these changes could impact the timing and allocation of rebate dollars, which may impact employer budgeting and cost projections. This suggests that plan sponsors should engage pharmacy consultants or other advisors to evaluate the potential financial and operational implications of these changes on their health plans.

The requirement that ESI offer a standardized, compliant model by 2028 further suggests that PBM contract structures may evolve in response to regulatory expectations. Given the fact that similar regulatory actions apply to CVS and OptumRx, employers in the U.S. may encounter new pricing models or market standards with respect to contractual terms, even if a PBM other than ESI is providing the services. Accordingly, plan sponsors should consider reviewing PBM contract terms and renewal timing in light of the settlement’s anticipated 2027–2028 implementation window.

Conclusion

The FTC’s settlements with ESI and the proposed agreement with CVS represent a significant development in the regulation of PBM practices. Importantly, while the FTC’s case focused on insulin, the settlement applies broadly to pharmaceutical products, signaling a wider restructuring of PBM pricing practices. As additional details

emerge, employers should continue monitoring how these regulatory changes may affect their health plan arrangements and pharmacy benefit strategies.



Compliance Corner: A Primer on Section 127 Educational Assistance Programs

By: Abby Blankenship

As employers continue to look for different ways to attract and retain employees, offering educational assistance programs as part of their benefits package has become increasingly popular. This month’s Compliance Corner provides an overview of educational assistance programs under section 127 of the Internal Revenue Code (the “Code”), including key requirements and important considerations for employers considering implementing such programs.

Overview of Program

Section 127 of the Code allows employers to provide up to \$5,250 annually in tax-free educational assistance benefits to employees. These payments may be used for both undergraduate- and graduate-level courses. Additionally, the payments do not have to be for work-related courses.

Eligible Educational Assistance Benefits

Generally, tax-free educational assistance benefits under a section 127 educational assistance program include payments for:

- Tuition, fees and similar expenses
- Books, supplies and equipment

Additionally, these programs may be used to pay principal and interest payments on qualified education loans, provided that the loans were incurred by the employee for the employee’s own education (and not for a spouse or dependent). Payments may be made either directly to the employee or to a third party, such as a lender.

However, certain expenses are specifically excluded from tax-free treatment under these programs. These include:

- Meals, lodging or transportation
- Tools or supplies (other than textbooks) that the employee may keep after completing the course
- Courses involving sports, games or hobbies, unless they: (i) have a reasonable relationship to the employer’s business, or (ii) are required as part of a degree program.

Program Requirements

To qualify for favorable tax treatment, section 127 educational assistance programs must meet several specific requirements:

1. Written Plan Document: The program must be established and maintained pursuant to a written plan document. The document should outline eligibility, benefits, and administrative procedures.
2. Nondiscrimination Considerations: The program cannot discriminate in favor of highly compensated employees. Additionally, no more than 5% of total benefits paid during the year can be provided to shareholders or owners (or their spouses or dependents) who own more than 5% of the business.
3. Notification Requirements: Employers must provide reasonable notice of the program to eligible employees.
4. No Cash Option: Employers cannot choose between receiving cash or other benefits that must be included in gross income instead of educational assistance.

Key Takeaways for Employers

While section 127 educational assistance programs can be a valuable addition to an employer's benefits offerings, careful design and administration are essential for compliance.

1. Eligibility and Plan Design: Employers should ensure that the written plan document clearly defines eligibility criteria, covered expenses, and reimbursement procedures.
2. Tax Reporting: Proper administration is critical to ensure that qualifying benefits are excluded from employees' taxable wages. Furthermore, amounts exceeding the \$5,250 annual limit must be included in taxable income and reported accordingly.
3. Sample Plan Document: It is worth noting that the Internal Revenue Service provides a sample plan document on its website that employers may use as a starting point. However, employers should work closely with legal and tax advisors to tailor the plan to their specific needs and ensure compliance with all applicable requirements.



STAY IN THE KNOW...

- Under the Consolidated Appropriations Act of 2021, all employer-sponsored group health plans, fully-insured and self-funded alike, regardless of size or grandfathered status, are required to submit detailed prescription drug and health care spending data to CMS annually by June 1. CMS has released updated reporting instructions for the 2025 reference year, confirming no major changes from the prior year's requirements. Employers sponsoring fully-insured plans should confirm with their carrier that a written agreement is in place and that the carrier will be submitting the report on their behalf, while self-funded plan sponsors are directly responsible for the filing and should coordinate with their TPA or PBM now to ensure timely and complete submission ahead of the June 1 deadline.
- On March 9, 2026, the U.S. District Court for the Southern District of New York issued a decision in *Stern v. JPMorgan Chase & Co.*, an ERISA class action challenging the management of prescription drug benefits under a self-funded plan. The court dismissed the plaintiffs' fiduciary breach claims, finding they were based on plan design (a settlor function), but allowed the prohibited transaction claims to proceed.
- Last month, the Department of the Treasury published long-awaited regulations to implement Trump Accounts, created under the One Big Beautiful Bill Act. The proposed regulations clarify the accounts as a distinct category of traditional IRA specifically for eligible minors, allowing tax deferred income on earnings with permissible contributions until December 31 of the year in which the beneficiary turns 17. Trump Accounts can be implemented effective July 4, 2026.

This Month's Contributors

**Kate Belyayeva**

Associate | kbelyayeva@maynardnexsen.com | 205.488.3597

Kate joined the firm in 2022 after graduating magna cum laude from Cumberland School of Law. Her practice is largely focused on the design, implementation, and maintenance of 401(k), profit sharing, defined benefit/pension (including cash balance), employee stock ownership and welfare plans, as well as executive and deferred compensation programs.

**Abby Blankenship**

Associate | ablankenship@maynardnexsen.com | 205.488.3607

Abby is an Associate in Maynard Nexsen's Employee Benefits & Executive Compensation practice group. Abby is experienced in advising public and private companies on various aspects of corporate and tax law, including mergers & acquisitions, private equity & venture capital, antitrust & trade regulation, and healthcare, franchise, and name, image & likeness (NIL) matters.

**Matt Stiles**

Shareholder | mstiles@maynardnexsen.com | 205.254.1071

Matt has over twenty years of experience representing employers in all facets of the employment relationship, including employee benefits and executive compensation, trade secrets and restrictive covenants, SCA and federal contract employer compliance, PEO, and staffing industry law. Matt regularly advises employers and benefits consultants in strategic benefit plan design, implementation, and compliance. He has extensive experience counseling employers involved in federal and state agency investigations.

**Dawnielle Wright**

Law Clerk | dwright@maynardnexsen.com | 803.253.8272

Dawnielle is a 3rd year law clerk in Maynard Nexsen's Employee Benefits & Executive Compensation practice group. As a 3rd year student at Wake Forest School of Law and full-time extern, Dawnielle works closely with and learns from the attorneys in the group on a range of employee benefits and executive compensation matters.