U.S. Department of Labor
Employee Benefits Security Administration
Room N5511
200 Constitution Avenue, NW
Washington, DC 20210

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2010

Form M-1 Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)

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II. Determining Compliance with the Mental Health Parity Act (MHPA) and Mental Health Parity and Addiction Equity Act (MHPAEA) Provisions in Part 7 of ERISA

If you answer "No" to any of the questions below, the group health plan is in violation of the MHPA or MHPAEA (the mental health parity) provisions in Part 7 of ERISA.

	YES	NO	N/A
If the plan provides either mental health or substance use disorder benefits and medical and surgical benefits, the plan may be subject to the mental health parity provisions in Part 7 of ERISA. (Note, if under an arrangement(s) to provide medical care by an employer or employee organization, any participant or beneficiary can simultaneously receive coverage for medical/surgical benefits and mental health benefits, the mental health requirements apply separately with respect to each combination of medical/surgical benefits and mental health benefits and all such combinations are considered to be a single group health plan. *See 29 CFR 2590.712(e).*) If this is the case, answer Questions 36-44. If the plan does not provide mental health or substance use disorder benefits, check "N/A" here and skip to Part III of this checklist. Also, the plan may be exempt from the mental health parity provisions under the small employer (50 employees or fewer) exception or the increased cost exception. (To be eligible for the increased cost exception, the plan must have filed a notice with EBSA and notified participants and beneficiaries.) If the plan is exempt, check "N/A" here and skip to Part III of this checklist. ..... ***NOTE: Any reference in this checklist to mental health benefits includes both mental health and substance use disorder benefits.**			☐
Question 36 – Does the plan comply with the mental health parity provisions for lifetime dollar limits on mental health benefits? ..... ◆ A plan may not impose a lifetime dollar limit on mental health/substance use disorder benefits that is lower than the lifetime dollar limit imposed on medical/surgical benefits. *See 29 CFR 2590.712(b).* (Only limits on what the plan is willing to pay are taken into account.)	☐	☐	
Question 37 – Does the plan comply with the mental health parity provisions for annual dollar limits on mental health benefits? ..... ◆ A plan may not impose an annual dollar limit on mental health/substance use disorder benefits that is lower than the annual dollar limit imposed on medical/surgical benefits. *See 29 CFR 2590.712(b).* (Only limits on what the plan is willing to pay are taken into account.) **Tip:** There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits, discussed later in this checklist at question 41. A plan may impose annual dollar out-of-pocket limits on participants and beneficiaries if done in accordance with the rule regarding cumulative limits.	☐	☐	

	YES	NO	N/A
Question 38 – Does the plan comply with the mental health parity provisions for parity in financial requirements and quantitative treatment limitations?.....	☐	☐	

- A plan may not impose a financial requirement or quantitative treatment limitation applicable to mental health/substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. *See 29 CFR 2590.712(c)(2).*
  - Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. *See 29 CFR 2590.712(c)(1)(ii).*
  - Types of quantitative treatment limits include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. *See 29 CFR 2590.712(c)(1)(ii).*
    - The six classifications of benefits are:
      1) inpatient, in-network;
      2) inpatient, out-of-network;
      3) outpatient, in-network;
      4) outpatient, out-of-network;
      5) emergency care; and
      6) prescription drugs

    See 29 CFR 2590.712(c)(2)(ii).

- Under the plan, any financial requirement or quantitative treatment limitation that applies to mental health benefits within a particular classification **cannot be more restrictive** than the predominant requirement or limitation that applies to substantially all medical/surgical benefits within the same classification. *See 29 CFR 2590.712(c)(2).*

  (Note, see below discussion of enforcement safe harbor for determining parity with respect to outpatient benefits provided under two sub-classifications.)

  - To determine parity each type of financial requirement or treatment limitation within a coverage unit (Coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions, for example, self-only, family, employee plus spouse. *See 29 CFR 2590.712(c)(1)(iv).)* must be analyzed separately within each classification. *See 29 CFR 2590.712(c)(2)(i).* If a plan applies different levels of a financial requirement or treatment limitation to different coverage units in a classification of medical/surgical benefits (for example, a $250 deductible for self-only and a $500 deductible for family coverage), the predominant level is determined separately for each coverage unit. *See 29 CFR 2590.712(c)(3)(ii).*
  - Generally, a financial requirement or treatment limitation is considered to apply to substantially all medical/surgical benefits if it applies to two-thirds or more of the medical/surgical benefits. *See 29 CFR 2590.712(c)(3)(i)(A).* This two-thirds calculation is based on the dollar amount of plan payments expected to be paid for the year. *See 29 CFR 2590.712(c)(3)(i)(C).* (Any reasonable method can be used for this calculation. *See 29 CFR 2590.712(c)(3)(i)(E).)*

	YES	NO	N/A
❖ Generally, the predominant level will apply to more than one-half of the medical/surgical benefits in that classification subject to the requirement or limitation. *See 29 CFR 2590.712(c)(3)(i)(B)(1).* If there is no single level that applies to one-half of medical/surgical benefits in the classification, the plan can combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the requirement or limitation in the classification. The least restrictive level within the combination is considered the predominant level. *See 29 CFR 2590.712(c)(3)(i)(B)(2).* **Safe Harbor:** ◆ Until the issuance of final regulations, for purposes of determining parity for outpatient benefits (in-network and out-of network), the Departments have established an enforcement safe harbor under which no enforcement action will be taken against a plan or issuer that divides its benefits furnished on an outpatient basis into two sub-classifications, specifically 1) office visits and 2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules under MHPAEA. ❖ After the sub-classifications are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any sub-classification (i.e., office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the interim final rules. ❖ Other than as permitted under this enforcement policy, and except as permitted under the interim final rules for multi-tier prescription drug formularies, sub-classifications are not permitted when applying the financial requirement and treatment limitation rules under MHPAEA. Accordingly, and as stated in the preamble to the interim final rules, separate sub-classifications for generalists and specialists are not permitted. **Tips:** Ensure that the plan does not impose cost-sharing requirements or quantitative treatment limitations that are applicable **only** to mental health/substance use disorder benefits. For a simpler method of compliance when a type of financial requirement or treatment limitation applies to at least two-thirds of medical surgical benefits in the classification, but no single level is predominant, a plan can treat the least restrictive level of financial requirement or treatment limitation applied to medical/surgical benefits as predominant.			

	YES	NO	N/A
Question 39 – Does the plan comply with the mental heath parity provisions for parity in classifications of benefits? ..... ◆ If a plan provides mental health or substance use disorder benefits in any classification of benefits (The classifications are listed in question 32.), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. *See 29 CFR 2590.712(c)(2)(ii)(A).* ◆ In determining the classification in which a particular benefit belongs, a plan must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits. *See 29 CFR 2590.712(c)(2)(ii)(A).* **Tip:** This rule applies to out-of-network providers. If the plan does not contract with a network of providers, all benefits are out-of-network. If a plan that has no network imposes a financial requirement or treatment limitation on in-patient or outpatient benefits, the plan is imposing the requirement or limitation within classifications (inpatient, out-of-network or outpatient, out-of-network), and the rules for parity will be applied separately for the different classifications. *See 29 CFR 2590.712(c)(2)(ii)(B).*	☐	☐	
Question 40 – Does the plan comply with the mental health parity provisions for multi-tiered prescription drug benefits? ..... ◆ There is a special rule for multi-tiered prescription drug benefits. A plan complies with the mental health parity provisions if the plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors (determined in accordance with the mental health provisions relating to nonquantitative treatment limitations discussed in this checklist at question 42) and without regard to whether a drug is generally prescribed for medical/surgical or mental health benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. *See 29 CFR 2590.712(c)(3)(iii).*	☐	☐	
Question 41 – Does the plan comply with the mental health parity provisions on cumulative financial requirements or cumulative quantitative treatment limitations? ..... ◆ A plan may not apply any cumulative financial requirement or cumulative quantitative treatment limitation (for example a $250 deductible) for mental health benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. *See 29 CFR 2590.712(c)(3)(v).*	☐	☐	

	YES	NO	N/A
Question 42 – Does the plan comply with the mental health parity provisions for parity within nonquantitative treatment limitations?	☐	☐	

- Nonquantitative treatment limitations include:
  - medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
  - formulary design for prescription drugs;
  - standards for provider admission to participate in a network, including reimbursement rates;
  - plan methods for determining usual, customary, and reasonable charges;
  - refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and
  - exclusions based on failure to complete a course of treatment.

This is an **illustrative, nonexhaustive** list. *See 29 CFR 2590.712(c)(4)(ii).*

- A plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification (such as inpatient, out-of-network) unless under the terms of the plan, as written or in operation, any processes, strategies, evidentiary standards, or other factors used in applying the limitation to mental health benefits in the classification are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the limitation with respect to medical/surgical benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference. *See 29 CFR 2590.712(c)(4)(i).*
  - An example of a permissible nonquantitative treatment limitation would be a plan requirement that participants obtain prior approval that a course of treatment is medically necessary for out-patient, in-network medical/surgical and mental health benefits. The plan denies payment for any medical/surgical or mental health treatments that did not have prior approval. *See 2590.712(c)(4)(iii).*
  - An example of an impermissible nonquantitative treatment limitation would be a plan requirement that participants obtain prior approval that a course of treatment is medically necessary for out-patient, in-network medical/surgical and mental health benefits. The plan denies payment for mental health treatments that did not receive prior approval. However, for medical/surgical benefits that did not have prior approval, the plan pays for the treatments at a 25 percent reduction in benefits the plan would otherwise pay. *See 2590.712(c)(4)(iii).*

Tip: Do not focus on results. Look at the processes used in applying nonquantitative limitations to mental health and medical/surgical benefits to determine that there are not arbitrary, discriminatory differences and that any differences in processes are based on recognized, clinically appropriate standards.

	YES	NO	N/A
Question 43 – Does the plan comply with the mental health parity provisions requiring the availability of plan information regarding criteria for medical necessity determinations? ..... ◆ The plan administrator (or the health insurance issuer) must make available the criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) to any current or potential participant, beneficiary, or contracting provider upon request. *See 29 CFR 2590.712(d)(1).*	☐	☐	
Question 44 – Does the plan comply with the mental health parity provisions requiring the availability of plan information regarding the reason for a denial of reimbursement or payment ? ..... ◆ The plan administrator (or health insurance issuer) must make available the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits to any participant or beneficiary in a form and manner consistent with the rules in 2560.503-1(The Claims Procedure Rule). *See 29 CFR 2590.712(d)(2).*	☐	☐	