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Employee Benefit Plan Review

Ask the Experts

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Equal Benefits Ordinances

Q Our company is opening an office in a city where we previously did not have one. Our insurance and employee benefits broker has sent us information indicating that the city has an equal benefits ordinance, and the broker is asking us to confirm whether we need or want to comply with the ordinance. Do we need to comply?

A We assume that, when you refer to an equal benefits ordinance, you are referring to a law that requires certain businesses who offer employee benefits to an employee's spouse (such as health insurance) to also extend those benefits to an employee's domestic partner. In other words, the law prevents discrimination against domestic partners as compared with spouses. To our knowledge, San Francisco was the first U.S. jurisdiction to enact an equal benefits ordinance, when it amended its law in 1996 (effective in 1997). A number of jurisdictions have followed San Francisco's lead in the more-than-two-decades since, although the call for enacting these laws has died down somewhat since the U.S. Supreme Court upheld same sex marriage (thus, in the minds of some, doing away with the need to protect domestic partners).

Equal benefits ordinances typically only apply to employers who are doing business with the city (for example, by selling products or services to the city, or by renting store space or other property owned by the city). While you should check with your attorneys, if you are not doing business with the city (directly or as a subcontractor), then you will likely not be subject to that city's equal benefits ordinance.

An interesting question is whether or not these equal benefits ordinances are valid exercises of municipal power, at least as they apply to benefits governed by ERISA (such as health insurance and retirement plans). There was some litigation about this question in the late-1990s and early-2000s, to mixed results. The argument supporting these laws is that, when a city is acting as a market participant (i.e., it is choosing to do business only with those businesses that do not discriminate against domestic partners), it should be free to do so. This argument requires the corresponding conclusion that the city is not also at the same time acting as a market regulator; if it is, then the city's attempt to regulate ERISA plans would generally be pre-empted by ERISA and unenforceable. We are not familiar with recent attempts to invalidate these laws.

Non-Quantitative Treatment Limitations and the Mental Health Parity Rules

Q My company is a private company with approximately 150 employees. It sponsors a self-insured health insurance plan. We are auditing our plan costs to see how we can revise coverage to achieve cost savings for the upcoming plan year. In the past, our plan has

covered treatment for eating disorders, but we notice that mental health benefits for inpatient treatment for eating disorders has been very costly. Can we amend the plan for the next plan year to continue to generally provide treatment for eating disorders, but specifically exclude coverage for mental health benefits for inpatient treatment for eating disorders?

A If your company is subject to the Mental Health Parity and Addiction Equity Act ("MHPAEA") and your plan generally provides treatment for eating disorders but specifically excludes coverage for mental health benefits for inpatient treatment for eating disorders, your plan would likely violate the MHPAEA. The MHPAEA is a federal law that generally prevents certain group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

The MHPAEA applies to self-insured private employers that have more than 50 employees.

The MHPAEA applies to self-insured private employers that have more than 50 employees. However, there are exemptions for group health plans and health insurance issuers based on increased costs. Under the increased cost exemption, group health plans and health insurance issuers may claim an exemption from the MHPAEA if the plan or issuer makes a change to comply with the MHPAEA and incurs an increased cost of at least two percent in the first year that the MHPAEA applies to the plan or coverage or at least one percent in any subsequent year. If the increased cost occurs, an exemption generally applies for the plan or policy year following the year the cost increase was incurred. If the exemption applies, it will apply for one year, unless a subsequent increase in cost occurs of at least one percent in that plan or policy year.

If your company's plan is subject to the MHPAEA, it is important to note that coverage of eating disorder-related mental health benefits under the MHPAEA was explicitly clarified by the 21st Century Cures Act in 2017. Section 13007 of the 21st Century Cures Act states that if a group health plan provides coverage for eating disorder benefits, the benefits must be consistent with MHPAEA parity requirements. The Department of Labor also issued a specific FAQ addressing this point in 2017.[1]

Under the MHPAEA, plans must provide parity between medical/surgical benefits and eating disorder benefits as to annual or lifetime limits, financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations. Non-quantitative treatment limitations are limitations, often non-numeric, on the scope or duration of benefits for treatment. Plan or coverage restrictions based on the type of facility (e.g., inpatient vs. outpatient) are non-quantitative treatment limitations under the final MHPAEA regulations. Under the final MHPAEA regulations, a plan may impose a non-quantitative treatment limitation if, under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors used by the plan or issuer in applying its exclusion with respect to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those used in applying the non-quantitative treatment limitation to medical/surgical benefits in the same classification.

In evaluating whether the exclusion of an intermediate level of care, including inpatient treatment, complies with the MHPAEA, it must be determined if the intermediate level of care is assigned to one of six benefit classifications in the same way for both medical/surgical and mental health/substance use disorder benefits. If so, then the basis for the exclusion (in this case, inpatient treatment) in the classification must be reviewed to determine if the processes, strategies, evidentiary standards, and other factors used to apply the exclusion of mental health/substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and other factors used in applying the non-quantitative treatment limitation to medical/surgical benefits in the same classification.

If your company's plan can articulate comparable and no more stringently applied processes, strategies, evidentiary standards, or other factors to exclude non-hospital residential treatment for mental health/substance use disorder benefits in certain circumstances, your plan may be able to demonstrate that the exclusion is consistent with the regulations under the MHPAEA. However, if your company's plan covers inpatient treatment for medical/surgical conditions under any conditions (including if your plan requires pre-authorization and other requirements to be met for coverage) while unequivocally excluding all inpatient treatment for eating disorders, then the restriction on inpatient treatment for eating disorders is not comparable to the plan's coverage restrictions for inpatient treatment for medical/surgical conditions. If that is the case, the exclusion of inpatient treatment for eating disorders will not comply with the MHPAEA.

A plan may rely on one or more factors to develop and apply a non-quantitative treatment limitation,

provided that the factors are comparable and no more stringently applied to mental health/substance use disorder benefits as compared to medical/surgical benefits. These factors can be a mix of statistical, clinical, or other factors, such as high incidence of fraud with respect to services in a particular classification. The plan should document any factors relied upon in developing and applying this non-quantitative treatment limitation.[2]

Notes

1. *See FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 38, Q1* (June 16, 2017).
2. *See FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39, Q8* (September 5, 2019).

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