Mental Health and Substance Use Disorder Parity Compliance and Oversight Report

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Contents

Introduction

The Minnesota Department of Commerce (Commerce) and Minnesota Department of Health (MDH) (collectively, the Departments) are tasked with reviewing health insurance plans' compliance with mental health parity requirements to cover care for mental health and substance use disorder (MH/SUD) at the same level (or higher) as medical and surgical (M/S) care. Parity is required for many benefit components, including copays and other cost-sharing requirements, access to care, medical necessity reviews and determinations, and more.

Minn Stat. § 62Q.47(k), requires Commerce, in consultation with MDH, to produce an annual report on the departments' efforts to regulate mental health parity. This report encompasses compliance and oversight efforts by Commerce and MDH related to mental health parity for calendar year 2024.

Background: Mental Health Parity Laws

State and federal laws requiring mental health parity have grown considerably over the past 25 years. Today, between state and federal law, the level and types of coverage offered for MH/SUD must be equal to the level and types of coverage offered for M/S services for nearly all health plans. This means copayments, visit limitations, prior authorizations, pharmacy benefits, and more cannot be more restrictive for mental health and substance use services than for M/S benefits.

Minnesota Law

Minnesota first enacted a mental health parity requirement in 1995 with Minn Stat. § 62Q.47. This law applies to state-regulated health plans, which generally are all non-grandfathered, fully funded, individual, and small group health plans. While Minnesota's original law has been modified over the past 25 years, the parity requirement itself remains intact. Substance use disorder services were added in 2008. In 2013, the Minnesota Legislature added references to three federal parity laws: the Mental Health Parity Act of 1996 (MHPA), the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and the Affordable Care Act (ACA).

The legislature passed several laws during the 2024 session to help strengthen Commerce and MDH's enforcement and monitoring of parity compliance. These laws are highlighted below. The Departments are currently implementing or collecting data on these additional protections and will document any findings in future reports.

- Utilization Review Changes
    - Minn. Stat. § 62M.19 Requires utilization review organizations to submit annual reports to the Department of Health on their use of prior authorization, including the number of requests received, the decisions, number reversed upon repeal, the top type of care denied, etc. This will help better track parity in utilization reviews. Minn. Stat. § 62M.07 Prohibits plans from requiring prior authorization for certain services, including emergency confinement or an emergency service, outpatient mental health treatment or outpatient substance use disorder treatment. (Not effective until January 1, 2026)

    - Minn. Stat. § 62M.02 Expands the definition of adverse determination to include the authorization of a health care service that is less intensive than the service requested.

- Network Changes
    - Minn. Stat. § 62Q.19 Amends language to state that a health plan company must offer a provider contract to all designated essential community providers located within the area served by the company and must include them in every network.

- Benefit Coverage
    - Minn. Stat. § 62Q.585 Clarifies that health insurance plans cannot exclude or restrict coverage of medically necessary gender-affirming care, with some exceptions for an employer's religious objections.

Federal Law

In 1996, Congress passed the Mental Health Parity Act (MHPA), which prohibited large group plans from imposing stricter annual and lifetime financial limits on mental health benefits than those applied to M/S benefits. The Mental Health Parity and Addiction Equity Act (MHPAEA) built on MHPA and expanded mental health parity protections considerably. Although it only applied to group health plans, it expanded the types of benefits for MH/SUD ensuring that they be no more limiting than M/S benefits. Generally, MHPAEA expanded the MHPA by doing the following:

- Carrying forward the parity requirement on annual and lifetime financial limits
- Expanding requirements to substance use disorders (in addition to mental health)
- Adding parity for other financial requirements (e.g., deductibles and co-payments)
- Adding parity for treatment limitations (e.g., number of visits or days of coverage)
- Adding parity for other benefit structures (e.g., in/out-of-network coverage and utilization management techniques)
- Adding a requirement for plans to disclose their medical necessity criteria and, upon request, the rationale for claim denials.

The applicability of these requirements was expanded in 2010 to individual health plans through the Affordable Care Act (ACA). The ACA also applied mental health parity requirements to small group plans by requiring nearly all plans to cover MH/SUD through Essential Health Benefit categories. These requirements, however, only apply to plans that offer mental health and substance use disorder benefits.

The Consolidated Appropriations Act, 2021 (CAA) amended MHPAEA to require certain plans to perform and document an analysis demonstrating parity compliance in their use of non-quantitative treatment limits (NQTL). NQTLs limited the scope or duration of benefits or treatment and include things like prior authorization and medical necessity. As of February 10, 2021, group health plans and issuers that cover MH/SUD and M/S benefits must provide this comparative analysis to plan participants and state and federal government agencies, upon request.

Most recently, the U.S. Departments of Health and Human Services, Labor and Treasury put forth final rules amending MHPAEA. Released in September 2024, finalizing these rules helps ensure that MH/SUD benefits are provided on par with M/S benefits. Key provisions of the revised regulations include:

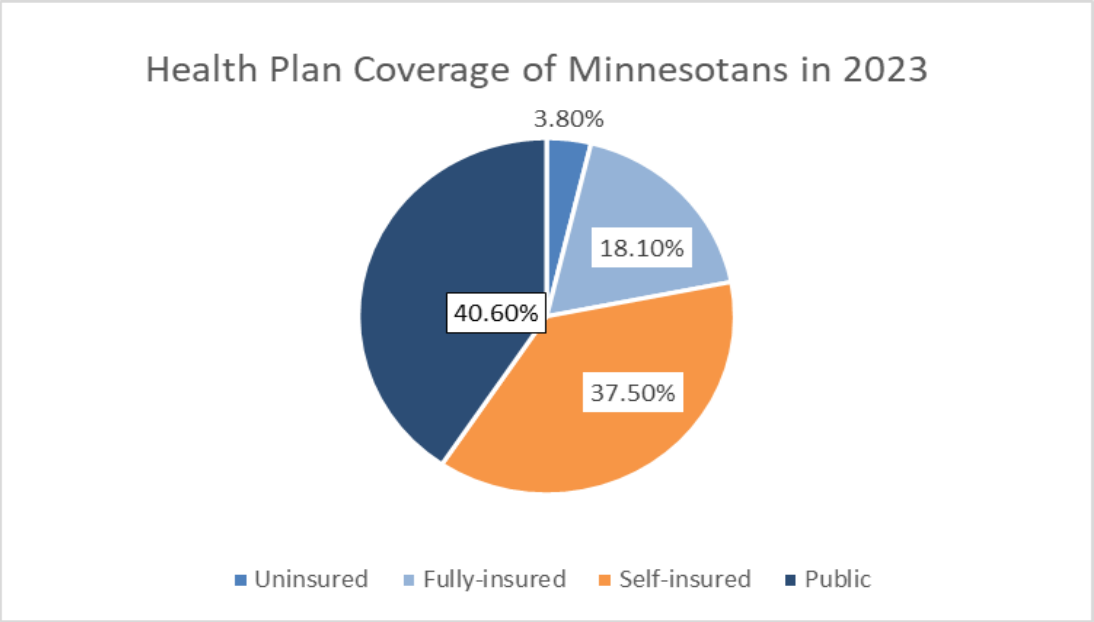
- **Focus on Nonquantitative Treatment Limitations (NQTLs)**: The rules prohibit health plans and insurance issuers from using NQTLs that place greater restrictions on MH/SUD benefits compared to M/S benefits. Examples of NQTLs include prior authorization requirements and medical management techniques.
- **Comparative Analyses**: Plans and issuers must conduct comparative analyses to measure the impact of NQTLs on access to MH/SUD benefits and take reasonable action to address any material differences.
- **Meaningful Benefits**: The rules require that plans provide meaningful benefits for MH/SUD treatments, defined as standard treatments indicated by generally recognized independent standards of current medical practice.
- **Data Collection and Evaluation**: Plans and issuers must collect and evaluate data to assess the impact of NQTLs and address any disparities in access to MH/SUD benefits as compared to M/S benefits.
- **Effective Dates**: Most provisions took effect on January 1, 2025, with some provisions scheduled to take effect on January 1, 2026.

These rules are part of ongoing efforts to address disparities in coverage and ensure that individuals seeking treatment for MH/SUD conditions do not face greater burdens than those seeking medical or surgical treatment. Currently, a suit has been filed against the federal government to stop the final parity rule and a stay has been granted. In a May 12, 2025, court filing, the federal government informed the court that it does not plan to enforce the final parity rule and may rescind it.

Background: Regulatory Authority of the Departments of Commerce and Health

Commerce and MDH have regulatory authority over Minnesota's fully insured health plans, comprising 18.10% of the covered population. (See below.) Commerce regulates health insurance companies, and MDH regulates Health Maintenance Organizations (HMOs).

Exhibit 1: Health plan coverage of Minnesotans in 2023[1]



Process for Compliance Reviews

Commerce and MDH use several tools and processes to review for mental health parity compliance. Some review takes place before health policies are offered to enrollees, and some review takes place after enrollees sign up and begin using their health policy. These are referred to as the pre-market and post-market phases.

Pre-market reviews from Commerce and MDH have included use of tools from the Centers for Medicare & Medicaid Services (CMS) that flag possible issues with plan and formulary design. Specifically, Commerce and MDH use tools that assess plan benefits and ensure that certain financial requirements (such as copayments and out-of-pocket limitations) are no more restrictive on the MH/SUD side than they are on the medical/surgical side. Commerce and MDH also analyze health plan formularies using CMS tools that specifically look for unexpectedly large numbers of prescription drugs subject to utilization review requirements, including mental health drugs.

Commerce and MDH continue to evaluate best practices for mental health parity compliance reviews. In 2024, Commerce and MDH requested that all health plans provide evidence of their compliance with NQTLs using a form developed by Commerce and MDH. All health plan filings in 2024 for the 2025 plan year complied with the state agencies' requests to use the tool and submit their results for review.

[1] Chartbook Section 2: Trends and Variation in Health Insurance Coverage. Minnesota Department of Health. Accessed at: https://www.health.state.mn.us/data/economics/chartbook/docs/section2.pdf

Exhibit 2 outlines Minnesota's regulatory requirements associated with MH/SUD parity and how the state's existing processes address these requirements.

Exhibit 2: Minnesota State Requirements

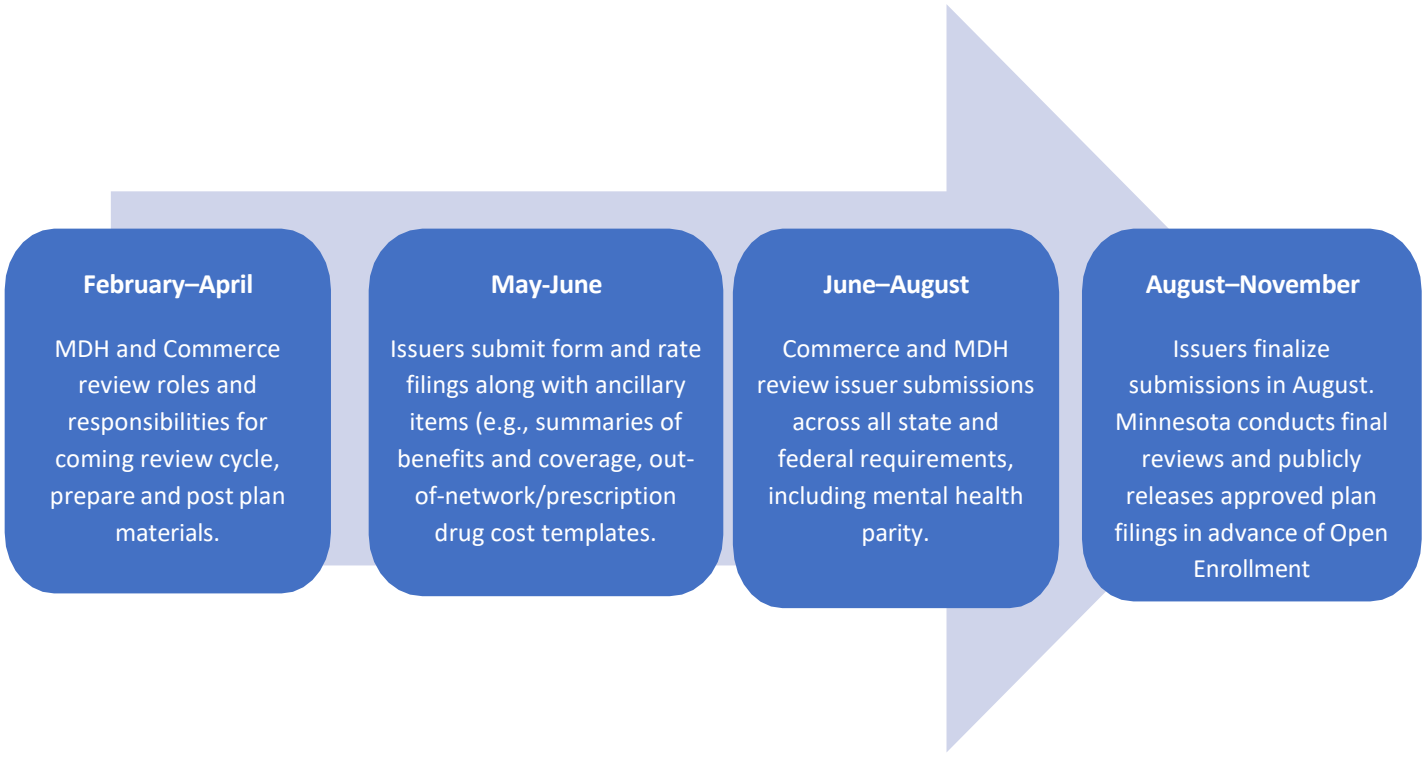
Statute	Requirement	Minnesota Review
§ 62Q.47(b) and (c)	Requires cost sharing and benefit limits for outpatient and inpatient MH/SUD benefits be no more restrictive than analogous inpatient and outpatient medical benefits.	As part of pre-market reviews, Commerce and MDH review cost sharing and benefit limits within issuer filings to identify potential parity issues that warrant further analysis.
§ 62Q.47(d)	Prohibits health plans from imposing NQTLs more restrictive for MH/SUD benefits than the medical benefits within the same classification.	As part of premarket reviews, Minnesota requires health plans complete a NQTL process review form. The agencies collect information on provider directories, networks, and utilization management. Commerce and MDH also utilize this document to require issuers attest to having performed comparative analyses in accordance with Consolidated Appropriations Act.
§ 62Q.47(e)	Requires all health plans to meet parity requirements of MHPAEA in enforcement of: • Quantitative treatment limitations (QTLs) • Annual and lifetime dollar limits • Cost sharing • Financial requirements • Out-of-pocket limits • Deductibles • Use of substantially all/predominant test for six classifications of benefits • NQTLs (E.g., pre-authorization, medical necessity)	Commerce and MDH require issuers to attest to meeting cost sharing and QTL parity requirements. Issuers may voluntarily provide results of the Centers for Medicare & Medicaid Services (CMS) mental health parity tool. In addition, pre-market reviews of benefit NQTLs assess for compliance with federal requirements. MDH's post-market quality assurance exams assess health maintenance organization (HMO) utilization management to ensure their application of medical necessity meets parity requirements.
§ 62Q.47(f)	Provides Commerce and MDH commissioners with authority to collect information and data necessary to confirm health plan compliance with Minn Stat., § 62Q.47 and § 62Q.53.	As part of pre-market reviews, Commerce and MDH collect a wide range of documents and data outlining health plan coverage including benefit coverage, cost sharing, QTLs, NQTLs, provider networks, and drug coverage.

		In addition, MDH's post-market quality assurance exams review issuer data on complaints, prior authorization, and other utilization management processes to assess for any parity concerns.
§ 62Q.47(g)	Requires health plans to treat mental health therapy visits and medication maintenance visits as primary care visits for the purpose of applying any enrollee cost sharing requirements.	Non-compliance is identified by pre-market reviews of issuers' filings.
§62Q.47(h)	Requires health plans to reimburse benefits delivered through the psychiatric Collaborative Care Model (CoCM)	In 2024, Commerce and MDH updated the provider contract attestation form to include attesting to compliance of reimbursing providers in accordance with §62Q.47(h).
§ 62Q.53	Establishes a definition of "medically necessary care." Prohibits health plans from enforcing more stringent definitions of medical necessity in their utilization management of MH/SUD benefits.	Issuers are required to attest that they comply with Minn. Stat. § 62Q.53 and specifically with providing plan coverage for all medically necessary mental health prescriptions prescribed for enrollees. Issuers also attest that their utilization review guidelines pertaining to the definition of medical necessity are no more restrictive than the definition. Pre-market filing reviews also assess medical necessity language for MH/SUD benefits to ensure medical necessity language is either consistent with § 62Q.53's definition or no more stringent. MDH's post-market quality assurance exams' assessment of HMOs' utilization management ensures medical necessity definition is incorporated in utilization review policy and is no more stringent than defined under this statute.

Pre-Market Reviews

On an annual basis, Commerce and MDH collect a range of forms and data from issuers before a given benefit year to ensure that all individual and small group health insurance offerings meet state and federal regulatory requirements, including mental health parity requirements. As detailed in the Annual Instructions Guide distributed to health insurers before filing for approval to sell products, Minnesota collects forms and health plan data that outline the benefits, limitations, provider networks, rates, and other health plan attributes for all small group and individual health plans issuers intend to offer for an upcoming benefit year. Staff from both Commerce and MDH review these submissions; notify issuers of any identified data integrity or compliance deficiencies; and, upon resolution of any identified deficiencies, finalize all plan submissions prior to Open Enrollment. Exhibit 3 outlines the high-level timeline for this process.

Exhibit 3: Individual and Small Group Regulatory Review Timeline



Commerce and MDH Pre-Market Review Processes

The following sections outline Commerce and MDH's pre-market review processes, with special focus on MH/SUD parity.

Review Preparation and Issuer Data Submission

Commerce and MDH staff meet near the end of each year to update the Annual Instructions Guide for issuers' submissions as well as to confirm each agency's roles and responsibilities for the coming review cycle. A preliminary Annual Instructions Guide, with instructions and deadlines for submitting form, rate, and binder filings for all individual and small group health plans to be offered in the coming benefit year, is typically distributed to issuers in January. A final guide is typically distributed in April.

MDH is responsible for conducting benefit reviews of the HMO-submitted templates, as well as reviewing all provider networks to ensure compliance with network adequacy and essential community provider requirements. Commerce is responsible for conducting benefit reviews for all non-HMO plans as well as rate and submitted template review (e.g., confirming issuers provide working hyperlinks to provider directories and confirming the submission of accurate Transparency in Coverage information). In general, issuers submit the following through the System for Electronic Rates & Forms Filing (SERFF):

- **Form Filings:** These documents provide evidence of coverage or individual policy information, describe the schedule of benefits for each product the health insurer intends to offer, and include other supporting documents.
- **Rate Filings:** These documents outline a health insurer's proposed rate schedule for their plans. They provide the actuarial justification for proposed rates. Commerce's review of rates is not relevant to the State's enforcement of MH/SUD parity compliance.
- **Binder Submission:** Health insurers' binder submissions are a series of completed templates that include benefit coverage, cost sharing, rates, network, drug coverage, service area, and other relevant data for individual and small group health insurance plans. Summary of Benefits and Coverage (SBC), which describes plans' coverage through a standardized template required under the Affordable Care Act (ACA) are included in the binder submissions as well. This data is also used to populate health plan information on Minnesota's health insurance exchange, MNsure.

Review Execution

Commerce and MDH staff review filings to ensure compliance with federal and state MH/SUD parity compliance. The sections that follow outline these components.

Form Filing Reviews

Both Commerce and MDH perform benefit-level reviews of form filings to identify any clear parity violations (such as differential in copayments between MH/SUD and medical/surgical services on an outpatient level), as well as any QTLs or NQTLs that may be more stringent for MH/SUD services than for their analogous medical benefits. NQTLs may include any treatment limit that is non-quantitative in nature, including prior authorization requirements, medical necessity requirements, exclusions, and other utilization management policies.

Commerce and MDH review all exclusions and flag any that are MH/SUD-related. In addition, Minnesota requires that issuers' definition of medical necessity applied to MH/SUD benefits be no more restrictive than the definition established under Minn. Stat. § 62Q.53. Commerce and MDH review any medical necessity language provided within the issuers' forms to ensure the issuer defines medical necessity using the language provided by Minnesota statute or, if using different language, that the issuer's definition is no more stringent than the State's definition.

While not directly related to MH/SUD parity reviews, Commerce and MDH staff also ensure that MH/SUD benefits are covered in a manner that is consistent with the state's essential health benefit benchmark plan.

Binder Reviews

As part of binder submissions, Minnesota requires health insurers to submit an actuary's attestation to their compliance with "substantially all and predominant" MH/SUD parity requirements. The issuers may complete the CMS MHPAEA tool, though Minnesota does not require them to do so.

The CMS tool allows issuers to upload their completed Plan & Benefits Template, which contains information on benefit coverage, cost sharing, and limitations and classifies benefits into inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drug for the purpose of comparing MH/SUD benefits to analogous medical benefits. The tool detects possible compliance issues with quantitative parity requirements under the MHPAEA regulations at 45 C.F.R. 146.136(c)(2), which generally provide that a plan may not impose a financial requirement or QTL applicable to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or QTL of that type applied to substantially all medical/surgical benefits in the same classification.

Network Adequacy Reviews

MDH conducts reviews of network data included for fully funded individual and small group plans (both HMOs and non-HMOs). Geographic access standards, according to Minnesota Statutes, section § 62K.10, require that the maximum travel distance or time to a mental health provider be the lesser of 30 miles or 30 minutes.

This same standard applies to general hospital, primary care, and pediatric primary care providers. The geographic access standard for all other specialty provider types, including substance use disorder (SUD), is the lesser of 60 miles or 60 minutes. Health plans marketing networks unable to meet geographic access standards may apply for waivers, which are granted when no providers are present in the given area, the health plan and provider cannot come to contract terms, the provider cannot meet credentialing standards, and/or the network is an Accountable Care Organization (ACO) or narrow network. Waivers are not used as an enforcement mechanism and are applied equally to MH/SUD and M/S providers.

Minnesota Statutes, section 62K.10 was amended in 2023 to require provider networks to include psychiatric residential treatment facilities (PRTF) and to allow MDH to measure the sufficiency of a network by any reasonable standard. MDH required health plans to attest that they had at least one PRTF in their networks effective July 1, 2023. For the 2025 plan year, MDH is evaluating provider networks based on several mental health categories, instead of reviewing mental health services as an aggregate. The categories are based on

mental health providers who prescribe medicine and those who don't write prescriptions. Future considerations for network evaluations include additional mental health category changes, telehealth, and appointment wait times.

Object Resolution Process

Across filing and binder submission reviews, Commerce and MDH document any compliance concerns in the Master Medical Forms Checklist. The checklist requires reviewers to confirm compliance with all federal and state requirements to include mental health and SUD benefits. Upon completion of the checklist, Commerce and MDH staff compose a letter outlining any compliance concerns identified. Health insurers can either revise the benefit coverage, cost sharing, and limitations or submit a justification that addresses the compliance concern. These issues are resolved between Commerce and MDH and the health insurer on a case-by-case basis.

Review Finalization and Open Enrollment

Pre-market reviews and associated health insurer updates are typically completed by Commerce and MDH staff by mid-August. Following the completion of reviews, plan data is submitted to MNsure. MNsure reviews internal attestations from Commerce and MDH that document their review and approval for compliance across federal and state requirements, including mental health parity. MNsure staff also carry out some high-level reviews of plan submissions for compliance. If MNsure flags any potential issues, they work with MDH and Commerce to review and address them with issuers. Upon completion of all reviews from Commerce, MDH, and MNsure and the final submission of health plan data, Open Enrollment begins on November 1, when consumers can enroll in health care coverage for the coming benefit year.

Post-Market

MHPAEA requires issuers to demonstrate compliance with NQTLs "as written and in operation," and market conduct examinations are essential to ensuring compliance in operation. Minnesota does this through market conduct exams conducted by Commerce and quality assurance exams conducted by MDH. Complaints play a key role in how the agencies identify, and respond to, issues affecting Minnesotans.

MDH conducts post-market enforcement activities for HMO plans. MDH conducts quality assurance exams for all Minnesota licensed HMOs and county-based purchasers every three years. MH/SUD parity enforcement is incorporated across all components of these exams. See Exhibit 4 for the four components of these exams and how MH/SUD parity review is incorporated.

Exhibit 4: Current MH/SUD Parity Review in HMO Quality Assurance Exams

Component	Incorporation of MH/SUD Parity
Quality	• Ensure that mental health quality is incorporated into their quality oversight programs, including an ongoing quality evaluation of mental health services, along with other medical services, and the health plan's efforts to monitor and improve behavioral health care.
Complaint System	• Identify trends in consumer complaints received by the HMO regarding access to mental health services. • Ensure the HMO has adequate policies and procedures for addressing complaints.
Access and Availability	• Review HMO provider networks to ensure that maximum travel distance or time for an enrollee to the nearest primary care, mental health, or general hospital service is less than 30 miles or 30 minutes. • Review policies to ensure that HMO standards are established to provide timely access to health services, including mental health services.
Utilization Management	• Identify any policies that may indicate an MH/SUD parity issue (e.g., prior authorization policies and procedures that are more stringent for mental health services). • Ensure that utilization determinations concerning mental health care are reviewed by peer providers with mental health expertise. • Pull a sample of enrollee files and review the adjudication of utilization management processes to identify any evidence of unequal enforcement of utilization management.

Any findings from the review require the HMO to produce a corrective action plan. As part of the corrective action plan, the HMO may provide quarterly status updates to MDH on progress made toward rectifying any identified issues. MDH issues administrative monetary penalties for findings of violations of Minnesota statutes and rules.

Commerce's Enforcement Division is primarily responsible for post-market reviews regarding mental health parity compliance.

The Commissioner of Commerce has the authority to issue an examination order to examine the market conduct of any insurance company operating in Minnesota. Market conduct examinations are intensive reviews and are governed by Minn. Stat. § 60A.031. These examinations are completed by the Market Conduct Examination Team within the Enforcement Division. The content and underlying data obtained during a market conduct examination is confidential. If there is a settlement involving the findings in the market conduct examination, the settlement agreement, known as a Consent Order, is public information.

Additionally, the Market Conduct Examination Team (MCE) works with other Commerce and MDH staff to develop existing health plan reporting requirements into useful data sources for market analysis and

surveillance. MCE also works with MDH staff to develop useful provider reimbursement benchmarks from the All-Payer Claims Database as akin to CMS provider reimbursement benchmarks.

Mental Health Parity and Substance Abuse Accountability Office

In 2023, Minn. Stat. § 62Q.465 was enacted, directing Commerce to develop the Mental Health Parity and Substance Abuse Accountability Office. The office was created in 2024 and a director was hired. The office will be involved in compliance reviews, stakeholder engagement, reviewing consumer and provider complaints, developing parity compliance strategies for Individual, Small, and Large Group Markets with the Departments, and serve as a resource for ensuring health plan compliance with mental health and substance abuse parity requirements. The Office is being built with a "No Wrong Door" approach allowing the Office to educate and assist all Minnesotans, helping reduce barriers by taking the burden off consumers in determining which agency regulates their health plan. This approach also allows the Office to track parity related trends for all Minnesotans. The Office's director has spent her first year fostering stakeholder engagement, engaging in education and outreach, and tracking and analyzing data.

Complaints and Appeals

As part of ensuring health plans maintain compliance, Minnesota also tracks complaints from consumers and providers. MDH and Commerce track all complaints and inquiries received. At MDH, these complaints are also tracked for patterns.

MDH reviews and investigates complaints. MDH asks general clarifying questions and may request call transcripts or copies of all correspondence sent to a health plan enrollee. MDH contacts the appropriate health plan to resolve the enrollee's concerns and ensure applicable state and federal regulations are being followed. Due to the wide range of types of complaints received, investigations also vary depending on the grievance.

Commerce's Enforcement Division fields inquiries, reviews complaints, and investigates complaints. The Enforcement Division includes the Consumer Services Center (CSC), Insurance Enforcement Team (InsET) and the MCE, as discussed above. The work performed by the CSC and InsET aligns closely with the work done by staff at MDH resolving complaints. Due to the wide range and types of complaints received, investigations vary depending on the issue.

Complaints related to behavioral health continue to increase annually. In 2023, Commerce received 64 complaints. In 2024, 106 complaints related to behavioral health were received. As a result of the 'No Wrong Door' approach, these numbers include complaints that were both investigated by Commerce, as well as those that are forwarded to the appropriate regulating agency.

MDH and Commerce also facilitate external appeals of MH/SUD services, including determinations that are partially or wholly adverse involving the application of QTLs and NQTLs. Minnesota law allows consumers covered by fully insured individual and small group plans to appeal to Commerce and MDH, which jointly

contract with external reviewers for both clinical and non-clinical cases. Under federal law, participants in self-funded plans only have rights to an external reviewer for cases in which medical judgment is required.

Enforcement Actions

Commerce completed two market conduct examinations related to mental health parity in 2023 and an additional one in 2024. The following enforcement actions were the result of these examinations.

Commerce entered into a consent order with Medica alleging Medica violated mental health parity laws by reimbursing certain medical/surgical providers at a higher rate than mental health providers, failing to maintain accurate provider directories to identify in-network providers for mental health treatment, providing inadequate explanation of benefits statements that could cause confusion about mental health coverage, and conducting utilization reviews disproportionately for mental health claims. Commerce imposed a $300,000 fine and continues to monitor Medica's implementation of required corrective action in 2024.

Commerce entered into a consent order with HealthPartners alleging HealthPartners violated mental health parity laws by reimbursing certain medical/surgical providers at a higher rate than mental health providers, failing to maintain accurate provider directories to identify in-network providers for mental health treatment, providing inadequate explanation of benefits statements that could cause confusion about mental health coverage, and conducting utilization reviews disproportionately for mental health claims. Commerce imposed a $150,000 fine and continued to monitor HealthPartners' implementation of required corrective actions in 2024.

In May 2024, Commerce entered into a consent order with UnitedHealthcare Insurance Company and PreferredOne Insurance Company (collectively, UHC) alleging UHC violated mental health parity laws by failing to demonstrate comparability in reimbursement rates between mental health providers and those offering other types of care, failing to maintain accurate provider directories, providing inadequate explanation of benefits, engaging in improper utilization review practices, and applying formulary design restrictions more stringently for certain mental health and substance abuse prescription drugs. Commerce's consent order with UHC imposed a $450,000 fine with $150,000 stayed upon condition that UHC complete specific corrective actions. Commerce continues to monitor UHC's implementation of these actions.

Coordination Between Commerce, MDH and MNsure

Commerce, MDH, and MNsure collaborate to ensure the state reviews health plans for MH/SUD compliance both before and after plans are available to consumers. As described above, MDH preforms review for HMOs in pre-market reviews as well as network adequacy reviews across all individual and small group plans, including those regulated by Commerce. HMOs are subject to quality assurance exams by MDH, and commercial plans are subject to market conduct exams by Commerce. Commerce does benefit-level form filing reviews for insurance companies and reviews binder submissions from insurance companies and HMOs for MH/SUD parity by requiring an attestation and reviewing formulary templates.

The Departments also work together to communicate about potential issues/enforcement. Any issues raised in form reviews are communicated across Departments. Commerce and MDH share and discuss the types of complaints received on an ad hoc basis. If Commerce or MDH notices a pattern among complaints received, the agencies will coordinate to see if they have encountered similar issues and to determine if a joint enforcement communication or action is required. MDH publishes quality assurance reports on the MDH website and shares issues with Commerce if pertinent to Commerce lines of business.

Information Provided to the Public

The Director of the Mental Health Parity and Substance Abuse Accountability Office engages in multiple outreach and education opportunities with the public and with providers. The Office regularly staffs a booth at behavioral health conferences and events throughout the state, engaging with providers and consumers, informing them of the existence of the office, providing education on parity and consumer rights, and engaging in discussions regarding parity related concerns. The office regularly engages with behavioral health advocacy groups and associations and provider groups and provides ongoing support.

MDH has a public-facing mental health parity informational page, which can be found here:

- Mental Health and Substance Use Disorder Parity: Know Your Benefits (https://www.health.state.mn.us/facilities/insurance/managedcare/faq/parity.html)

Commerce has information on its website relating to parity and insurance coverage. That information can be found here:

- Mental Health & Substance Use Disorder Treatment (https://mn.gov/commerce/insurance/health/mental-health/)

Lastly, the Departments have promoted their online information relating to parity using its social media platforms in the past and will continue to do so.