



# Mental Health Parity Compliance and Oversight

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# Introduction

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In the State of Minnesota, the Department of Commerce (Commerce) and Department of Health (MDH) are tasked with reviewing health insurance plans to ensure they are compliant with mental health parity requirements. Nearly all health insurance plans in Minnesota are required to provide enrollees with mental health parity. This means that they need to cover care for mental health and substance use disorder (MH/SUD) at the same level (or higher) as medical and surgical care.<sup>1</sup> Mental health parity is required for many benefit components, including copays and other cost-sharing requirements, access to care, medical necessity reviews and determinations, and more.

Minnesota Statutes Section 62Q.47, subdivision (h), requires the Department of Commerce, in consultation with the Department of Health, to produce an annual report on the departments' efforts to regulate mental health parity.

This report encompasses compliance and oversight efforts by the Departments of Commerce and Health related to mental health parity for calendar year 2020. Because this is the first report, some sections may include some additional historical context prior to January 2020.

## Background: Mental Health Parity Laws

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

### Minnesota Law

Minnesota first enacted a mental health parity requirement in 1995. This law applies to state-regulated health plans, which generally are all non-grandfathered, fully-insured individual and group health plans. While Minnesota's original law has been modified over in the past 25 years, the parity requirement itself remains intact. Alcoholism services were included in 2008. In 2013, Minnesota added references to three (3) federal parity laws: The Mental Health Parity Act of 1996 (MHPA), the Paul Wellstone and Pete Domenici Mental Health

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<sup>1</sup> The requirements for MH/SUD coverage and MH/SUD parity are set in multiple laws with the combined effect of generally requiring MH/SUD coverage and parity for most health plans. Additional detail is provided in the *Background: Mental Health Parity Laws* section.

Parity and Addiction Equity Act of 2008 (MHPAEA), and the Affordable Care Act (ACA). In 2016, there was a change to the rule references.

More substantive changes were made in 2019. MDH and Commerce were given authority to collect information from health plans to evaluate compliance with parity laws. A provision was added that specifies that mental health therapy visits and medication maintenance visits are to be considered primary care visits for purposes of enrollee cost-sharing. A provision was also added that specified that non-quantitative treatment limitations (NQTLs) could not be applied more stringently to mental health than to medical and surgical benefits. NQTLs are non-numerical limits on the duration or scope of plan benefits, such as prior authorization, prescription drug formulary design, step therapy protocols, and network tier design. Finally, a requirement for annual reporting on compliance and oversight by the agencies was added in 2019 effective June 1, 2021.

## Federal Law

In 1996, the U.S. Congress passed the MHPA, which prohibited large group plans from imposing stricter annual and lifetime financial limits on mental health benefits than those applied to medical and surgical benefits.

The MHPAEA<sup>2</sup> built on MHPA and expanded mental health parity protections considerably. Again, it only applied to group health plans,<sup>3</sup> but it expanded the types of benefits for MH/SUD that were required to be no more limiting than medical and surgical benefits. These requirements only applied to plans that offer mental health and substance use disorder benefits.<sup>4</sup> Generally, MHPAEA expanded the MHPA by doing the following:

- Carried forward the parity requirement on annual and lifetime financial limits,
- Expanded requirements to substance use disorders (in addition to mental health),
- Added parity for other financial requirements (e.g., deductibles and co-payments),
- Added parity for treatment limitations (e.g., number of visits or days of coverage),
- Added parity for other benefit structures (e.g., in/out-of-network coverage and utilization management techniques), and
- Added 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 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. This effectively required mental health coverage and parity for nearly all health plans.

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<sup>2</sup> Federal rules implementing MHPAEA were published in 2013 and applied to plans beginning in 2014.

<sup>3</sup> Self-insured non-Federal government plans with 50 or fewer employers and self-insured plans for small private employers with 50 fewer employees are not included in MHPAEA requirements.

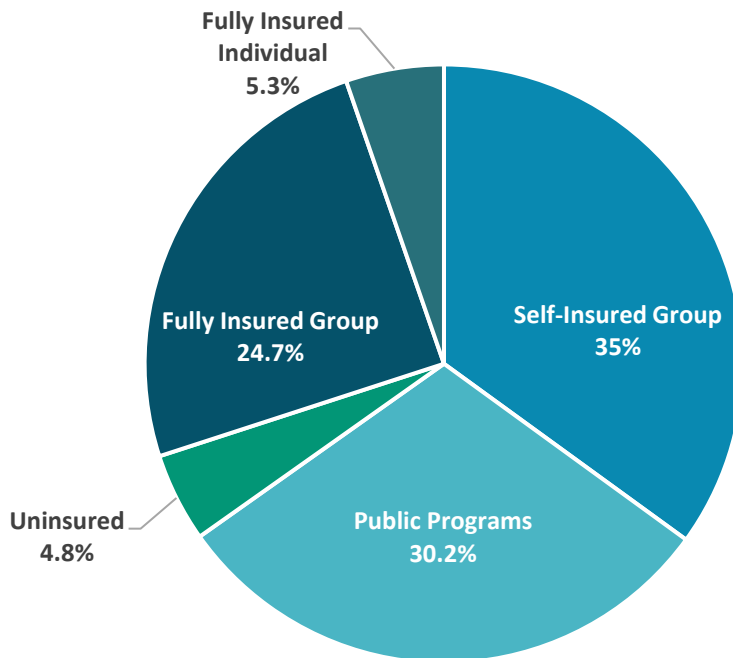
<sup>4</sup> Additional information on MHPAEA and exceptions to MHPAEA can be found here: [https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea\\_factsheet](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet)

Most recently, the December 2020 No Surprises Act, which was part of the Consolidated Appropriations Act, added requirements for plans to demonstrate their compliance with MHPAEA. Specifically, plans must document that their MH/SUD NQTLs are no more restrictive than their medical/surgical NQTLs by completing a comprehensive comparative analysis and making it available to state and federal regulating authorities. Federal officials are also directed to issue program guidance to help promote compliance.

## Background: Regulatory Authority of the Departments of Commerce and Health

The Departments of Commerce and Health have regulatory authority over Minnesota’s fully insured health plans, comprising approximately 30 percent (30%) of the covered population (See **Exhibit 1** below). Minn. Stat. § 62Q.021 provides the Commissioners of the Departments of Commerce and Health the authority to enforce statutes relating to health insurance. The Department of Commerce regulates health insurance companies and the Department of Health regulates Health Maintenance Organizations (HMOs).

**Exhibit 1: Health plan coverage of Minnesotans in 2019<sup>5</sup>**



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<sup>5</sup> Minnesota, State Health Compare. State Health Access Data Assistance Center (SHADAC)  
<http://statehealthcompare.shadac.org/table/11/health-insurance-coverage-type-by-total#25/5,4,10,86,9/27/21,22>

## Description of the Enforcement and Consumer Protection Grant work from 2016-2019

Over the past five years, Commerce and MDH have focused on improving health insurer mental health parity compliance. In October 2016, the Department of Commerce was awarded approximately \$1.2 million in funds under the Health Insurance Enforcement and Consumer Protections Grant. Half of the funds were allotted for Commerce to focus work on mental health parity. The Departments also participated in the Substance Abuse and Mental Health Services Administration (SAMHSA) Parity Academy in 2017 along with colleagues from the Department of Human Services, helping to refine work in the area of compliance and oversight. The Parity Academy usefully paired with the grant activities which ended on October 30, 2019.

During the course of the grant, the Department was able to use funds for staffing of positions dedicated solely to grant work. The funding helped the Departments engage in stakeholder outreach, participate in seminars, provide training, and also allowed for the creation of a continuing education course with the National Association of Insurance Commissioners (NAIC). This course provides a professional development opportunity for state insurance regulators across the country to learn about parity requirements and review regulatory filings with a parity lens.

The Departments continue to join other states at national NAIC meetings and have been an important part of continuing to push conversations about mental health parity among other state regulators. In partnership with other states, the NAIC has formed a formal subcommittee to work specifically with mental health parity issues.

## COVID-19 Impact

The COVID-19 pandemic changed the mental health landscape in Minnesota, increasing the need for mental health services and affecting the way in which mental health and substance use disorder treatment is delivered. State and federal requirements for mental health parity remained the same; however, the importance of implementation has only increased.

During the emergency response, the State took several steps to help expand mental health access via telehealth. Executive Order 20-28 allowed out-of-state mental health care providers to provide telehealth services in Minnesota. Two (2) laws were also passed by the Legislature to ensure patients could receive telehealth care in their own homes, expand which providers could provide telehealth services, ensure telephone visits were covered, and prevent health plans from discriminating coverage based on the platform by which telehealth was delivered. These laws, however, are temporary.<sup>6</sup>

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<sup>6</sup> See [Minnesota laws of 2020, Chapter 70, Article 3](#), as amended by [Laws of 2020, 7<sup>th</sup> Special Session, Chapter 1, Article 4](#), which expires June 30, 2021, and [Minnesota laws of 2020, Chapter 74, Article 1, Section 15](#), which expires 60 days after the Minnesota Peacetime Emergency ends.

The Departments hope to analyze mental health patient outcomes in future reports as the full impact of the COVID-19 pandemic is assessed.

## Process for Compliance Reviews

Commerce and MDH use many tools and processes to review for mental health parity. Some review takes place before health policies are offered to enrollees and some review takes place after enrollees are signed-up and utilizing their health policy. These are referred to as the pre-market and post-market phases.

Both Departments continuously evaluate how to best review for mental health parity compliance. In the spring of 2021, Commerce and MDH partnered with an outside entity to conduct a gaps analysis of the agencies' current review processes. Both Commerce and MDH are assessing the recommendations made and are determining what changes can be made going forward given current resources.

**Table 1** outlines Minnesota's regulatory requirements associated with MH/SUD parity and how the State's existing processes address these requirements.

**Table 1: 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.	
§ 62Q.47(e)	Requires all health plans meet parity requirements of MHPAEA in the enforcement of: <ul style="list-style-type: none"> <li>• Annual and lifetime dollar limits</li> <li>• Cost sharing</li> <li>• Financial requirements</li> <li>• Out-of-pocket limits</li> </ul>	Minnesota requires issuers to attest to meeting cost sharing and QTL parity requirements. Issuers may voluntarily provide results of the Centers for Medicare and Medicaid Services (CMS) mental health parity tool. <sup>7</sup> In addition, pre-market reviews of

<sup>7</sup> Centers for Medicare and Medicaid Services. (2020). *MHPAEA Tool*. Available from the state of Minnesota upon request.



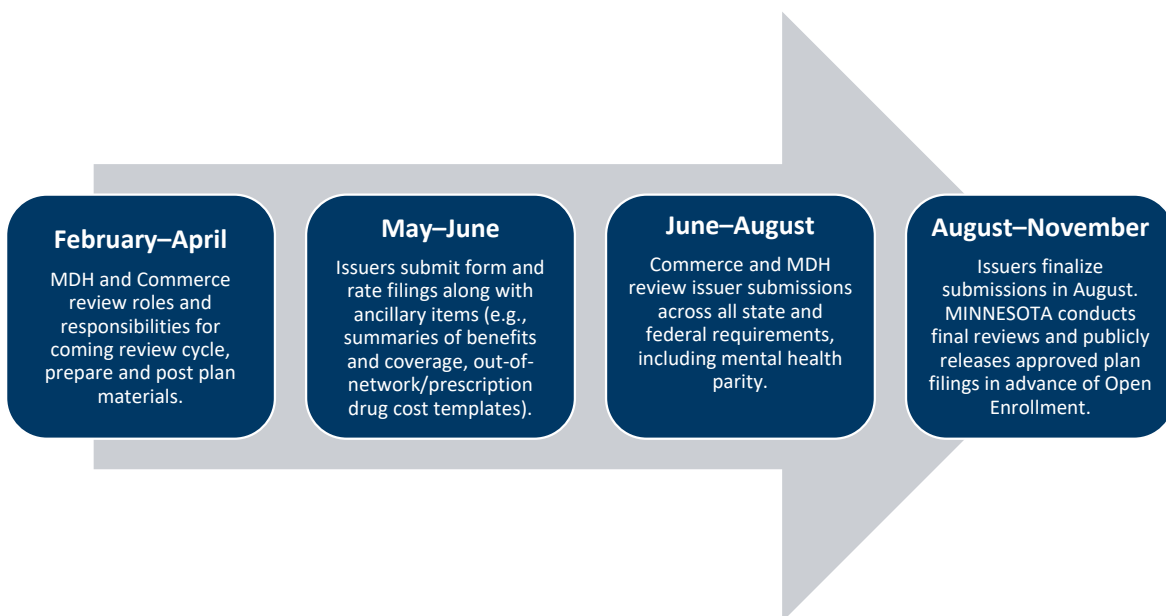
Statute	Requirement	Minnesota Review
	<ul style="list-style-type: none"> <li>• Deductibles</li> <li>• Quantitative treatment limitations (QTLs)</li> <li>• E.g., limits on days</li> <li>• NQTLs</li> <li>• E.g., pre-authorization</li> <li>• Use of substantially all/predominant test for six classifications of benefits</li> <li>• Medical necessity</li> </ul>	<p>benefit NQTLs assess for compliance with federal requirements.</p> <p>MDH’s post-market quality assurance exams assess health maintenance organization (HMO) utilization management to ensure their application of medical necessity meets parity requirements.</p>
§ 62Q.47(f)	Provides Commerce and MDH commissioners with authority to collect information and data necessary to confirm health plan compliance with Minnesota Statutes, § 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.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

Statute	Requirement	Minnesota Review
		<p>language is either consistent with § 62Q.53's definition or no more stringent.</p> <p>MDH's post-market quality assurance exams' assessment of HMOs' utilization management ensures medical necessity definition is no more stringent than defined under this statute.</p>

## Pre-Market Reviews

On an annual basis, Commerce and MDH collect a range of forms and data from issuers prior to 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 Departments 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 2** outlines the high-level timeline for this process.

### *Exhibit 2: Minnesota Pre-Market Filing Review Timeline*



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

## Review Preparation and Issuer Data Submission

In February and March of each year, MDH and Commerce staff meet 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. MDH is responsible for conducting benefit reviews of the HMO-submitted templates, as well as reviewing 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 April, Commerce and MDH release annual filing guidance to health insurers that provides instructions and deadlines for submitting document and data filings for all health plans to be offered in the coming benefit year. 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 such as the Summary of Benefits and Coverage (SBC), which describes plans' coverage through a standardized template required under the Patient Protection and Affordable Care Act.
- **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 Excel templates that provide benefit coverage, cost sharing, rates, network, drug coverage, service area, and other relevant data for individual and small group health insurance plans. This data is also used to populate health plan information on Minnesota's health insurance exchange, MNsure.

## Review Execution

Commerce and MDH staff reviews of filings are designed 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 with the intent 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 read through all exclusions and flag any that are MH/SUD-related.

In addition, Minnesota requires that issuers' definition of medical necessity applied to mental health and SUD benefits be no more restrictive than the definition established under Minnesota Statutes § 62Q.53.<sup>8</sup> 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 the "substantially all and predominant"<sup>9</sup> MH/SUD parity requirements. The issuers may complete the CMS MHPAEA tool, though Minnesota does not recommend a specific tool.

The CMS tool allows issuers to upload their completed Plan & Benefits Template, which contains information on their plans' 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 categories for the purposes 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 CFR 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. While issuers have the option to complete this tool and are required to attest to parity compliance, the only reviews tool outputs that are submitted.

Finally, MDH conducts network adequacy reviews of network data included in the binder submissions for all plans (both HMOs and non-HMOs). Geographic access standards, according to Minn. Stat. § 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

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<sup>8</sup> § 62Q.53 defines medically necessary care as "health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

- (1) help restore or maintain the enrollee's health; or
- (2) prevent deterioration of the enrollee's condition."

<sup>9</sup> "H.R. 6983 — 110th Congress: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008." www.GovTrack.us. 2008. May 11, 2021 <https://www.govtrack.us/congress/bills/110/hr6983>

same standard applies to general hospital providers, primary care providers, and pediatric primary care providers, while the geographic access standard for all other provider types is 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 they are applied equally to MH/SUD and medical and surgical providers.

## **Objection Resolution Process**

Across filing and binder submission reviews, MDH and Commerce 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 have the opportunity to either revise the benefit coverage, cost sharing, and limitations or submit a justification that addresses the compliance concern. These issues are resolved between Minnesota 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 1st during which 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 the post-market exams 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.

Minnesota conducts post-market checks for MH/SUD parity compliance. Pre-market reviews can catch “as written” violations, such as failure to comply with the substantially all/predominant test for QTLs, financial requirements, and utilization management criteria. Post-market reviews, however, are necessary to evaluate whether benefits are actually provided in parity, for example, in the application of utilization management criteria.

MDH also conducts post-market enforcement activities for HMO plans. MDH holds quality assurance exams for all Minnesota licensed HMOs every three years. MH/SUD parity enforcement is inherent across all components of these exams. See **Table 2** for the four components of these exams and how MH/SUD parity review is incorporated.

**Table 2: Current MH/SUD Parity Review in Quality Exams**

Component	Incorporation of MH/SUD Parity
<b>Quality</b>	<ul style="list-style-type: none"> <li>• Ensure that mental health quality is incorporated into their quality oversight programs.</li> </ul>
<b>Complaint System</b>	<ul style="list-style-type: none"> <li>• Identify trends in consumer complaints received by the HMO regarding access to mental health services.</li> <li>• Ensure the HMO has adequate policies and procedures for addressing complaints.</li> </ul>
<b>Access and Availability</b>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<b>Utilization Management</b>	<ul style="list-style-type: none"> <li>• 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).</li> <li>• Pull a sample of enrollee files and review the adjudication of utilization management processes to identify any evidence of unequal enforcement of utilization management.</li> </ul>

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 and may involve penalty fees.

Commerce's Enforcement Division is primarily responsible for post-market reviews regarding mental health parity compliance. The Enforcement Division includes the Consumer Services Center (CSC), civil investigators, and the Market Conduct Examination Team.

Commerce's Market Conduct unit has the authority to examine insurance companies at any time regarding enforcement of the law. Market conduct examinations are intensive reviews and are governed by a specific section of state law. The content of market conduct examinations are confidential until the examination is completed or resolved.

The Market Conduct unit utilizes national databases and other data sources to compare findings in Minnesota. The unit also conducts interviews with third parties that can provide relevant information to the investigation. For mental health parity, market conduct examiners have interviewed mental health providers to obtain information relevant to an exam, and to confirm compliance with applicable law.

## **Complaints and Appeals**

As part of ensuring that 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 tracked for patterns and put into the following categories:

- Access
- Communication and behavior
- Health plan administration (vast majority of complaints fall into this category)
- Facilities and environment
- Coordination of care
- Technical competence and appropriateness
- MH/SUD parity

MDH asks general clarifying questions and may request call transcripts or copies of all correspondence sent to a health plan enrollee. Each complaint received is reviewed and investigated. 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 includes Consumer Services Center (CSC) representatives that field inquiries as well as complaints. As mentioned previously, representatives of the CSC refer complaints to investigators for follow-up as appropriate within the scope of the Department's regulatory authority. The work done by CSC representatives and investigators aligns much more closely with the work done by staff at MDH resolving complaints. Commerce CSC and civil enforcement staff both review and investigate complaints. Complaint patterns can inform subsequent market conduct examinations.

MDH and Commerce review appeals related to MH/SUD services, including QTLs and NQTLs. Minnesota law allows consumers in fully-insured plans to appeal to state agencies, who 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.

## **Coordination Between Commerce, MDH, and MNSure**

Commerce, MDH, and MNSure collaborate to ensure that the state reviews health plans for MH/SUD compliance both before and after plans are available to consumers. As described above, MDH does benefit-level filing reviews for HMOs in pre-market reviews as well as network adequacy reviews across all plans. MDH also conducts network adequacy reviews on behalf of Commerce. HMOs are subject to stringent quality assurance

exams, and all other plans are subject to market conduct exams by Commerce. Commerce does benefit-level form filing reviews for all other plans and reviews binder submissions for MH/SUD parity by requiring an attestation from insurance companies and reviewing formulary templates. MNsure works with Commerce and MDH to confirm that plans available on the exchange do not have any apparent parity violations.

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. The results of a Commerce market conduct exam are not public until the exam is complete. Quality assurance exam results are available on the MDH website<sup>10</sup>, and issues are shared with Commerce if pertinent to Commerce lines of business.

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## Enforcement Actions

For the 2020 calendar year, Commerce did not have any public enforcement actions against any regulated industry related to mental health parity compliance.

The Department of Health found no mental health parity violations as a result of quality exams in calendar year 2020 and took no enforcement actions.

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## Corrective Actions

For the 2020 calendar year, Commerce did not have any specific corrective actions against any regulated industry related to mental health parity compliance.

The Department of Health found no mental health parity violations as a result of quality exams in calendar year 2020 and took no corrective actions.

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## Information Provided to the Public

The Minnesota Department of Health provides resources to the public relating to mental health parity using several formats. The MDH website displays information on separate pages which can be found here:

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

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<sup>10</sup> <https://www.health.state.mn.us/facilities/insurance/managedcare/reports/index.html>



- [Opioids Prescribing Practices Parity Legislation - Minnesota Department of Health](https://www.health.state.mn.us/communities/opioids/prevention/parity.html)  
<https://www.health.state.mn.us/communities/opioids/prevention/parity.html>

In addition, MDH has a handheld FAQ card which is traditionally given out at public events, but due to COVID-19, all in-person events were cancelled for 2020. MDH has promoted its online information relating to parity using its social media platforms in the past and will continue to do so in the future.

Lastly, 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://www.health.state.mn.us/communities/opioids/prevention/parity.html)  
<https://www.health.state.mn.us/communities/opioids/prevention/parity.html>