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Opinion No. 11-25

Mental Health Parity and Addiction Equity Act of 2008

QUESTIONS

The United States Department of Health and Human Services, together with the United States Department of Labor and the United States Treasury Department, has promulgated interim final regulations to implement the Mental Health Parity and Addiction Equity Act of 2008 (the "Federal Parity Law"). The Federal Parity Law applies to certain health insurance policies that provide benefits for mental health treatment. It requires these policies generally to provide benefits for mental health treatment and substance use disorders on financial terms similar to benefits for medical and surgical treatment under the same plan. Three Tennessee statutes address the obligations of group health insurance policies with regard to benefits for coverage of substance use disorders: Tenn. Code Ann. §§ 56-7-2360, 56-7-2601, and 56-7-2602.

1. Which state department is responsible for the implementation and enforcement of Tenn. Code Ann. § 56-7-2602?

2. Does there exist a private cause of action under Tenn. Code Ann. § 56-7-2602?

3. Which state department is responsible for implementing and enforcing the Federal Parity Law and regulations promulgated by the United States Department of Labor at 29 C.F.R. §§ 2590, *et seq.*?

4. Does Tenn. Code Ann. § 56-7-2602 require insurers and health maintenance organizations to offer and make available benefits for the treatment of substance use disorders that are not less favorable than for medical and surgical benefits under the same plan?

5. United States Department of Labor regulations at 29 C.F.R. §§ 2590, *et seq.*, establish certain quantitative and qualitative standards within which certain insurance plans must administer benefits for the necessary care and treatment of alcohol and other drug dependency. Does Tenn. Code Ann. § 56-7-2602 impose the same requirements on insurers and health maintenance organizations?

6. United States Department of Labor regulations at 29 C.F.R. §§ 2590, *et seq.*, establish financial parameters within which certain insurance plans must administer benefits for the necessary care and treatment of alcohol and other drug dependency. Does Tenn. Code Ann. § 56-7-2602 impose the same requirements on insurers and health maintenance organizations?

7. What evidence is required under Tenn. Code Ann. § 56-7-2602 in order to show that an insurance company or managed care organization is administering benefits in a disparate manner?

8. When an allegation of disparity is made, must an insurance company or managed care organization, upon the request of a member or provider, provide documentation of the availability and/or administration of benefits including all treatment limitations, on the medical and surgical side of a plan?

OPINIONS

1. The Commissioner of the Tennessee Department of Commerce and Insurance (the "Commissioner") is responsible for enforcing Tenn. Code Ann. § 56-7-2602. But, with certain exceptions, the Federal Parity Law requires a group plan covering more than fifty employees that provides any substance abuse benefits to provide them in accordance with the parity requirements. Thus, an entity subject to the Federal Parity Law purchasing a group health plan may not purchase a lower level of coverage for substance abuse benefits; if it chooses to provide them at all, it must do so in accordance with the Federal Parity Law requirements. To this extent, therefore, the Federal Parity Law preempts Tenn. Code Ann. § 56-7-2602.

2. Tenn. Code Ann. § 56-7-2602 provides for administrative enforcement by the Commissioner and for criminal penalties for its violation. Tennessee courts have been reluctant to find that a statutory scheme providing for administrative and criminal enforcement also creates a private right of action. For this reason, it is our opinion that Tenn. Code Ann. § 56-7-2602 does not create a private right of action.

3. This Office is unaware of any statutory authority for a state agency to enforce the Internal Revenue Code or ERISA. No state agency, therefore, may enforce portions of the Federal Parity Law that amend those statutory schemes. The Commissioner, through her general regulatory authority, may enforce the Federal Parity Law and regulations to the extent they apply to group health insurance policies offered and sold in Tennessee.

4. Yes, by its terms, Tenn. Code Ann. § 56-7-2602 requires insurers selling group health insurance plans to offer coverage for the treatment of alcohol and substance abuse on the same terms as medical and surgical benefits; but the entity purchasing the insurance is free to reject this coverage.

5. and 6. As discussed in the answer to Question 1, to the extent that it conflicts with the Federal Parity Law, Tenn. Code Ann. § 56-7-2602(b)(1) has been preempted. But the requirement that a group health insurance plan offer benefits for the "necessary care and treatment of alcohol and other drug dependency" has not been preempted. Thus, all group health plans offered or sold in Tennessee must meet this requirement. It is not clear, however, whether this mandated offer must meet all the requirements that a plan covering more than fifty employees must meet under the Federal Parity Law once it provides any such benefits. The answer to Questions 5 and 6 ultimately depends on the standards that the Commissioner determines are "benefits for the necessary care and treatment of alcohol and other drug

dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors" within the meaning of Tenn. Code Ann. § 56-7-2602(b)(1). These standards may, but do not necessarily, include some or all of the standards established by the Federal Parity Law and implementing regulations.

7. Evidence required for the Commissioner's enforcement of Tenn. Code Ann. § 56-7-2602 would depend on the statute under which she is acting. The Commissioner's written order to a company in the course of an examination must be supported by some material evidence. The Commissioner's decision to impose penalties after a contested case hearing under Tenn. Code Ann. § 56-2-305 must be supported by evidence that is both substantial and material in light of the entire record of the hearing. Other enforcement proceedings by the Commissioner may be subject to different levels of review. Evidence is sufficient to support a finding of guilt in a criminal action if any rational trier of fact could have found the essential elements of the crime beyond a reasonable doubt.

8. By its terms, 42 U.S.C. § 300gg-26(a)(4)[1], part of the Public Health Service Act added by the Federal Parity Law, requires a health insurance issuer of a group health plan to provide criteria for medical necessity determinations only with respect to mental health or substance use disorder benefits. It does not require the issuer to provide criteria with respect to medical and surgical limitations. This Office is unaware of any other statute that might impose this requirement.

It is possible that this question refers to the requirement, under the Federal Parity Law, that a policy limiting payment for mental health or substance use disorder benefits must apply the same limits to medical and surgical benefits. In this case, the question is whether, where a group insurance plan limits reimbursement to a provider for mental health or substance use disorder benefits, the insurance company or managed care organization must disclose to the provider or the member the extent to which it is applying corresponding limits to medical and surgical benefits. This Office is unaware of any statute requiring the insurer to disclose such information to a provider. Presumably, an individual covered by the group policy would have access to its terms through the employer or other organization paying for the plan. No statute, however, explicitly requires an insurance company to divulge this information to an individual covered by the plan. Any party that suspects an insurer is violating the Federal Parity Law may wish to contact the Commissioner of Commerce and Insurance, who is charged with enforcing it.

[1] 42 U.S.C. § 300gg-26 is one of the provisions held unconstitutional as not severable in *Florida ex rel. Bondi v. U.S. Dept. of Health and Human Services*, ___ F.Supp.2d ___, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011). The District Court held that the individual mandate provision (42 U.S.C. § 18091) of the Patient Protection and Affordable Care Act (PPACA) is unconstitutional under the Commerce Clause of the United States Constitution. The Court did not enjoin enforcement of the Act pending appeal. On March 3, 2011, the Court stayed its declaratory judgment pending appeal. The Court stated that the stay would be lifted unless the defendants filed their appeal within seven calendar days. The defendants in the action filed a notice of appeal March 8, 2011.

ANALYSIS

This opinion addresses a number of questions about the relationship between existing state law and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Federal Parity Law"), Pub. L. No. 110-343 §§ 512-513, 122 Stat. 3765, 3881 (codified in scattered sections, United States Code Titles 26, 29, and 42). This opinion will address the obligations of insurance companies and other issuers of health insurance in Tennessee. It does not address the obligations of Tennessee agencies with regard to federal entitlement programs such as Medicare and TennCare.

A. The Federal Parity Law

The Federal Parity Law amends three federal statutory schemes: The Employee Retirement Income Security Act of 1974 ("ERISA"), the Public Health Service Act, and the Internal Revenue Code. Generally, the Internal Revenue Code is enforced by the United States Department of Revenue, and ERISA provisions governing certain types of employee benefit plans are enforced by the United States Department of Labor. *See*, *e.g.*, 29 U.S.C. § 1144 (providing that ERISA supersedes all state laws that relate to employee benefit plans); 29 U.S.C. §§ 1201, *et seq.* (outlining jurisdiction and enforcement of ERISA). This opinion, therefore, will not discuss Federal Parity Law amendments to ERISA and the Internal Revenue Code. But the Public Health Service Act provides that states "may" enforce it. This discussion, therefore, will address the amendments to that law.

Section 512(b) of the Federal Parity Law amends section 2705 of the Public Health Service Act, now codified at 42 U.S.C. § 300gg-26. This section of the Public Health Service Act was originally added by the Mental Health Parity Act of 1996, Pub. L. No. 104-204, Title VII, § 703, 110 Stat. 2944. The law generally applies to group health plans or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits. 42 U.S.C. § 300gg-26(a)(1). The statute generally excludes group health plans and health insurance issuers offering group or individual health insurance coverage for any plan year of a small employer. 42 U.S.C. § 300gg-26(c)(1). The term "small employer," as amended by the Patient Protection and Affordable Care Act, includes employers with one hundred employees or fewer. 42 U.S.C. § 300gg-91(e)(4).[2] But the United States Department of Health and Human Services has taken the position that, for employers and health insurance issuers subject to ERISA and the Internal Revenue Code, group health plans with more than fifty employees are subject to the Federal Parity Law. For nonfederal governmental plans, the Federal Parity Law applies to group health plans with more than one hundred employees. *See* "Affordable Care Act Implementation FAQs Fifth Set of FAQs issued December 22, 2010," Q8, http://www.hhs.gov/ociio/ regulations/ implementation_faq.html.

The terms "health insurance coverage" and "health insurance issuer" are broadly defined in 42 U.S.C. § 300gg-91(b)(1) and (2) of the Public Health Service Act as follows:

[2] 42 U.S.C. § 300gg-91 is another federal statute held unconstitutional as not severable by *Florida ex rel. Bondi v. U.S. Dept. of Health and Human Services*, __ F.Supp.2d __, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011). *See* note 1.

> (b) Definitions relating to health insurance
> (1) Health insurance coverage
>
> The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract *offered by a health insurance issuer.*
>
> (2) Health insurance issuer
>
> The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) *which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974) [29 U.S.C.A. § 1144(b)(2)]. Such term does not include a group health plan.*

(emphasis added). The Federal Parity Law requires group health plans or related insurance that provide both medical and mental health or substance use disorder types of benefits to make them available subject to financial requirements and treatment limitations that are equally restrictive. 42 U.S.C. § 300gg-26(a)(3). Nothing in this statute is to be construed as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance abuse disorder benefits. 42 U.S.C. § 300gg26(b)(1). The United States Departments of the Treasury, Labor, and Health and Human Services have issued interim final rules under the Federal Parity Law. 75 F.R. 5410 (February 2, 2010).

B. Tennessee Parity Statutes

The request cites Tenn. Code Ann. § 56-7-2602. This statute provides:

> (a) Purpose. The purpose of this section is to encourage consumers to avail themselves of basic levels of benefits under group health insurance policies and contracts for the care and treatment of alcohol and other drug dependency, *and to preserve the rights of the consumer to select the coverage according to the consumer's medical-economic needs.*
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> (b) Availability of Coverage for Alcohol and Other Drug Dependency.
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> (1) Insurers, nonprofit hospitals and medical service plan corporations and health maintenance organizations transacting health insurance in this state shall offer and make available under group policies, contracts and plans providing hospital and medical coverage on an expense-incurred, service or pre-paid basis, benefits for the necessary care and treatment of alcohol and other drug dependency that are not less favorable than for physical illness generally, subject to the same durational

> limits, dollar limits, deductibles and coinsurance factors, *and that offer of benefits shall be subject to the right of the group policy or contract holder to reject the coverage or to select any alternative level of benefits if the right is offered by or negotiated with the insurer, service plan corporation or health maintenance organization.*
>
> (2) Any benefits so provided shall be determined as if necessary care and treatment in an alcohol or other drug dependency treatment center were care and treatment in a hospital. For purposes of this section, "alcohol or other drug dependency treatment center" means a facility that provides a program for the treatment of alcohol or other drug dependency pursuant to a written treatment plan approved and monitored by a physician, and which facility is also:
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> (A) Affiliated with a hospital under a contractual agreement with an established system for patient referral;
>
> (B) Licensed, certified or approved as an alcohol or other drug dependency treatment center by the department of mental health; or
>
> (C) Accredited as such a facility by the joint commission on accreditation of hospitals.
>
> (c) Applicability. This section shall apply to group policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after October 1, 1982; but shall not apply to blanket, short term travel, accident only, limited or specified disease, individual conversion policies or contracts, or to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as medicare, 42 U.S.C. § 1395 et seq., or any other similar coverage under state or federal governmental plans.

(emphasis added). This statute was adopted in 1982 and has not been substantively amended since that time. 1982 Tenn. Pub. Acts, ch. 831. By its terms, this statute merely requires insurers to offer coverage for the treatment of alcohol and substance abuse on the same terms as medical and surgical benefits; but the entity purchasing the insurance is free to reject this coverage.

Tenn. Code Ann. § 56-7-2602 must be read in conjunction with Tenn. Code Ann. §§ 56-7-2601 and 56-7-2360. Like Tenn. Code Ann. § 56-7-2602, subsections (b), (c), and (d) of Tenn. Code Ann. § 56-7-2601 require insurers to offer mental health benefits within policies that offer major medical coverage. But the purchaser may reject the coverage or purchase less extensive coverage for mental health benefits. Subsections (e) and (f) require health insurance plans that provide benefits for mental health, substance abuse, and mental illness to reimburse for these benefits when provided at a facility that meets certain criteria. Neither subsection (e) nor (f) requires a health insurance plan to provide any particular level of benefits.

Subsection (g) of Tenn. Code Ann. § 56-7-2601 and Tenn. Code Ann. § 56-7-2360 both mandate certain levels of coverage for mental health benefits. Because subsection (g) does not

apply to benefits for services furnished on or after September 30, 2001, however, this opinion will address only requirements under Tenn. Code Ann. § 56-7-2360. Under subsection (a) of this statute, any group health plan issued by any entity regulated by insurance law under Title 56 must provide coverage for mental health services subject to the same aggregate lifetime and annual limits and out-of-pocket sharing requirements as the plan's coverage for mental and surgical benefits. But (a)(2) of this statute provides:

> The mandate to provide coverage for mental health services at the same rates and terms as coverage provided for all medical and surgical conditions under this subsection (a) *shall not be applicable to services for the abuse of or dependency on alcohol or drugs.*

(emphasis added). Subsection (a)(4) provides that it does not apply to group health plans issued to small employers, defined as those with two to twenty-five employees. Thus, under current state statutes, group health plans are subject to certain parity requirements with respect to mental health benefits, but not with respect to benefits for abuse of or dependency on alcohol or drugs. These state law parity requirements continue to apply to group plans covering from twenty-six to fifty employees. But they have been preempted by the Federal Parity Law with respect to most group health plans covering more than fifty employees.

1. State Department Charged with Enforcement of Tenn. Code Ann. § 56-7-2602

The first question inquires as to which state department is charged with enforcing Tenn. Code Ann. § 56-7-2602. Under Tenn. Code Ann. § 56-1-204, the Commissioner of the Tennessee Department of Commerce and Insurance (the "Commissioner") or the Commissioner's deputies are authorized to inquire into any violation of Title 56. Further, any company entering into a contract of insurance as an insurer or transacting insurance business in this state must obtain a certificate of authority from the Commissioner. Tenn. Code Ann. § 56-2-105. The Commissioner has regulatory authority over insurance companies operating in this state and over the business of insurance in this state. *See*, *e.g.*, Tenn. Code Ann. § 56-1-411(examination of insurance companies); Tenn. Code Ann. §§ 56-2-302, -304, -305 (enforcement actions); and Tenn. Code Ann. §§ 56-9-101, *et seq.* (rehabilitation and liquidation). Health maintenance organizations are regulated under Tenn. Code Ann. §§ 56-32-101, *et seq*. Other types of health insurance issuers are subject to regulation by the Commissioner under applicable specialized statutory schemes in Title 56. The Commissioner of the Tennessee Department of Commerce and Insurance, therefore, is charged with enforcing Tenn. Code Ann. § 56-7-2602.

This discussion, however, would not be complete without considering whether the Federal Parity Law has preempted Tenn. Code Ann. § 56-7-2602 in whole or in part. The Public Health Service Act, which portions of the Federal Parity Law amended, preempts some state laws. 42 U.S.C. § 300gg-23(a)(1)[3] provides:

> (a) Continued applicability of State law with respect to health insurance issuers

[3] 42 U.S.C. § 300gg-23 is another federal statute held unconstitutional as not severable by *Florida ex rel. Bondi v. U.S. Dept. of Health and Human Services*, __ F.Supp.2d __, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011). *See* note 1.

(1) In general

> Subject to paragraph (2) and except as provided in subsection (b) of this section, this part and part C of this subchapter insofar as it relates to this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage *except to the extent that such standard or requirement prevents the application of a requirement of this part.*

(emphasis added). Comments to regulations under the Federal Parity Act indicate that this statute was added by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). 75 F.R. 5418 (February 2, 2010). These comments cite the HIPAA conference report for the proposition that this provision is intended to be the "narrowest" preemption of state laws. *Id.* With regard to preemption, the comments state:

> A State law, for example, that mandates that an issuer offer a minimum dollar amount of mental health or substance use disorder benefits does not prevent the application of MHPAEA [the Federal Parity Act]. Nevertheless, an issuer subject to MHPAEA may be required to provide mental health or substance use disorder benefits beyond the State law minimum in order to comply with MHPAEA.

Id.

Because the Federal Parity Law generally excludes plans that cover fifty or fewer employees, Tenn. Code Ann. § 56-7-2602 continues to apply to plans of this size. The statute requires a group health insurance issuer to offer alcohol and substance abuse benefits in a group health insurance plan "that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors[.]" Tenn. Code Ann. § 56-7-2602(b)(1). This requirement does not prevent enforcement of the Federal Parity Law requirements. Further, the Federal Parity Law expressly states that it does not require a group plan to provide mental health *or* substance abuse benefits. Thus, the proviso in the state statute that the entity purchasing the plan may reject coverage for substance abuse benefits entirely would not conflict with the Federal Parity Law. But the Federal Parity Law requires a group plan covering more than fifty employees that provides any substance use disorder benefits to provide them in accordance with the parity requirements. Thus, an entity purchasing a group health plan subject to the Federal Parity Law may not purchase a lower level of coverage for substance abuse benefits; if it chooses to provide them at all, it must do so in accordance with the Federal Parity Law requirements. To this extent, therefore, the Federal Parity Law preempts Tenn. Code Ann. § 56-7-2602.

2. Private Cause of Action

The second question inquires as to whether Tenn. Code Ann. § 56-7-2602 provides for a private right of enforcement. Determining whether a statute creates a private right of action is a matter of statutory construction. *Brown* v. *Tennessee Title Loans, Inc.* 328 S.W.3d 850, 855

(Tenn. 2010). The analysis begins with an examination of the statutory language. In this case, Tenn. Code Ann. § 56-7-2602 does not contain a provision authorizing a private right of action. The next inquiry is whether the legislature otherwise indicated an intention to imply such a right of action in the statute. *Id.* Appropriate factors to consider include (1) whether the party bringing the cause of action is an intended beneficiary of the statute; (2) whether there is any indication of legislative intent, express or implied, to create or deny the private right of action, and (3) whether implying such a remedy is consistent with the underlying purposes of the legislation. *Id.* The burden ultimately falls on the plaintiff to establish that a private right of action exists under the statute. *Id.* at 328 S.W.3d 856.

Here, the legislative history of the act does not reflect any legislative intent to create a private right of action. The statute itself is part of Title 56, Chapter 7, which the Commissioner of Commerce and Insurance is responsible for enforcing. The Commissioner's enforcement authority includes licensing, regulation, and examination of companies engaged in the business of insurance. A violation of Tenn. Code Ann. § 56-7-2602 is also a Class C misdemeanor. Tenn. Code Ann. § 56-1-801. None of these statutory schemes explicitly creates a private right of action in beneficiaries of a health insurance plan. Tennessee courts have been reluctant to find that a statutory scheme providing for administrative and criminal enforcement also creates a private right of action. *See Brown,* 328 S.W.3d at 863 (Tenn. 2010) (holding that Tennessee Title Pledge Act did not provide right of action by borrowers); *Petty v. Daimler/Chrysler Corp.,* 91 S.W.3d 765, 768 (Tenn. Ct. App. 2002), *p.t.a. denied* (2002) (holding that motor vehicle safety glass statute did not create private right of action by car owners); *Reed v. Alamo Rent-A-Car, Inc.,* 4 S.W.3d 677, 689-90 (Tenn. Ct. App. 1999), *p.t.a. denied* (1999) (concluding that provision of workers' compensation law requiring Commissioner of Labor to establish system for case management did not create private right of action by employees against employers); *Premium Finance Corp. of America v. Crump Ins. Services of Memphis, Inc.,* 978 S.W.2d 91, 94 (Tenn. 1998) (holding that Premium Finance Company Act did not create private right of action by premium finance companies against insurance companies). Accordingly, it is our opinion that Tenn. Code Ann. § 56-7-2602 does not create a private right of action.

3. State Enforcement of the Federal Parity Law and Regulations

The next question inquires as to which department of state government is responsible for enforcing the Federal Parity Law and the regulations promulgated under it. This Office is unaware of any statutory authority for a state agency to enforce the Internal Revenue Code or ERISA. No state agency, therefore, may enforce portions of the Federal Parity Law that amend those statutory schemes.

But the Public Health Service Act, also amended by the Federal Parity Law, provides:

> (a) State enforcement
> (1) State authority
>
> Subject to section 300gg-23 of this title, each State ***may*** require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual or group market meet the requirements of this part with

> respect to such issuers.
>
> (2) Failure to implement provisions
>
> In the case of a determination by the Secretary that a State has failed to substantially enforce a provision (or provisions) in this part with respect to health insurance issuers in the State, the Secretary shall enforce such provision (or provisions) under subsection (b) of this section insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans or individual health insurance coverage in such State.

42 U.S.C. § 300gg-22[4], formerly Section 2722 of the Public Health Service Act (emphasis added). Thus, any state "may" enforce the part of the Federal Parity Law now codified at 42 U.S.C. § 300gg-26. Of course, the authority of the Tennessee Department of Commerce and Insurance to enforce these provisions ultimately depends on Tennessee state law. With respect to this issue, the interim final regulations provide:

> In the Departments' [Department of Labor and Department of Health and Human Services] view, these regulations have federalism implications, because they have direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. However, in the Departments' view, the federalism implications of these regulations are substantially mitigated because, with respect to health insurance issuers, *the Departments expect that the majority of States have enacted or will enact laws or take other appropriate action resulting in their meeting or exceeding the federal MHPAEA standards.*

75 F.R. 5430 (February 2, 2010) (emphasis added).

The question then becomes whether Tennessee law authorizes the Commissioner to enforce the standards imposed under 42 U.S.C. § 300gg-26 and the federal regulations that implement it. As discussed in the response to Question 1, the Commissioner has broad regulatory authority over companies carrying on the business of insurance in this state. This authority is not explicitly limited to enforcing state law. For example, under Tenn. Code Ann. § 56-1-409(b), the Commissioner may investigate an insurer "[f]or the purpose of ascertaining financial condition or *legality of conduct* . . . ." (emphasis added). The Commissioner may examine a foreign insurance company applying for admission to operate in Tennessee "[w]hen the commissioner or the commissioner's deputy deems it prudent for the protection of policyholders in this state[.]" Tenn. Code Ann. § 56-1-410(a). As part of her regulatory authority, the Commissioner may order an insurance company to take corrective action "[i]f the examination report reveals that the company is operating in violation of *any* law, regulation, or prior order of the commissioner[.]" Tenn. Code Ann. § 56-1-411(d)(2)(A) (emphasis added). Under Tenn. Code Ann. § 56-2-305(a), the Commissioner may penalize an insurer, person, or

[4] 42 U.S.C. § 300gg-22 is another federal statute held unconstitutional as not severable by *Florida ex rel. Bondi v. U.S. Dept. of Health and Human Services*, ___ F.Supp.2d ___, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011). *See* note 1.

entity required to be licensed if, after a contested case hearing, the Commissioner finds that the entity has violated "*any* statute, rule or order . . . ." (emphasis added).

Under Tenn. Code Ann. § 56-2-407(1), the Commissioner may revoke the authority of a foreign insurance company "[i]f it violates or neglects to comply with *any* law obligatory upon it." (emphasis added). Logically, the Commissioner should be able to exercise the same authority with regard to an insurance company licensed in Tennessee. It is the opinion of this Office that these regulatory statutes generally authorize the Commissioner to enforce compliance with applicable provisions of federal law, even where those statutes preempt state laws with very different requirements. For this reason, the Commissioner is authorized to enforce the Federal Parity Law and regulations as applied with respect to group health insurance policies offered or sold in the State of Tennessee.

4. Obligation under Tenn. Code Ann. § 56-7-2602

The fourth question inquires as to whether Tenn. Code Ann. § 56-7-2602 requires insurers and health maintenance organizations to offer and make available benefits for the treatment of substance use disorders that are not less favorable than for medical and surgical benefits under the same plan. Tenn. Code Ann. § 56-7-2602(b)(1) provides:

> (b) Availability of coverage for alcohol and other drug dependency.
>
> (1) Insurers, nonprofit hospitals and medical service plan corporations and health maintenance organizations transacting health insurance in this state shall offer and make available under group policies, contracts and plans providing hospital and medical coverage on an expense-incurred, service or pre-paid basis, *benefits for the necessary care and treatment of alcohol and other drug dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors,* and that offer of benefits shall be subject to the right of the group policy or contract holder to reject the coverage or to select any alternative level of benefits if the right is offered by or negotiated with the insurer, service plan corporation or health maintenance organization.

(emphasis added). By its terms, therefore, the statute requires insurers and health maintenance organizations to offer and make available benefits for the treatment of substance use disorders that are not less favorable than for medical and surgical benefits under the same plan.

5. & 6. Level of Benefits that Must be Offered Under State Law

Questions 5 and 6 address the relationship between Tenn. Code Ann. § 56-7-2602 and federal regulations implementing the Federal Parity Law. The request specifically refers to United States Department of Labor regulations at 29 C.F.R. §§ 2590, *et seq.*, establishing standards and financial parameters within which insurance plans must administer benefits for the necessary care and treatment of alcohol and other drug dependency. The request asks whether

Tenn. Code Ann. § 56-7-2602 imposes the same requirements on insurers and health maintenance organizations.

This Office assumes the question refers to 29 C.F.R. § 2590.712, as recently amended by the regulations under the Federal Parity Law. As discussed above, these Department of Labor regulations implement Federal Parity Law amendments to ERISA. No Tennessee department is authorized to enforce ERISA. But states are permitted to enforce portions of the Public Health Service Act, including the parity requirements at 42 U.S.C. § 300gg-26. The Department of Health and Human Services also promulgated regulations to implement Federal Parity Law amendments to this act. This regulation appears at 45 C.F.R. § 146.136.

Under Tenn. Code Ann. § 56-7-2602(b)(1), insurers and other regulated entities offering group insurance plans must offer "benefits for the necessary care and treatment of alcohol and other drug dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors . . . ." The plan purchaser may reject the coverage or purchase a lower level of coverage. By contrast, the Federal Parity Law does not require group health insurance plans that cover more than fifty employees to offer or provide any coverage for substance use disorders; but, if the plan includes coverage for substance use disorders, that coverage must comply with the standards and parameters in the Federal Parity Law and regulations promulgated under that law.

As discussed in the answer to Question 2, to the extent that it conflicts with the Federal Parity Law, Tenn. Code Ann. § 56-7-2602(b)(1) has been preempted. But the requirement that a group health insurance plan offer benefits for the "necessary care and treatment of alcohol and other drug dependency" has not been preempted. Thus, all group health plans offered or sold in Tennessee must meet this requirement. It is not clear, however, whether this mandated offer must meet all the requirements that a plan covering more than fifty employees must meet under the Federal Parity Law once it provides any such benefits. The Commissioner of the Tennessee Department of Commerce and Insurance has not promulgated regulations interpreting this statutory requirement. The answer to Questions 5 and 6 ultimately depends on the standards that the Commissioner determines are "benefits for the necessary care and treatment of alcohol and other drug dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors" within the meaning of Tenn. Code Ann. § 56-7-2602(b)(1). These standards may, but do not necessarily, include some or all of the standards established by the Federal Parity Law and implementing regulations.

7. Evidence to Establish Violation of Tenn. Code Ann. § 56-7-2602

The next question inquires as to what evidence is necessary to establish a violation of Tenn. Code Ann. § 56-7-2602. The statutory scheme provides two methods by which it may be enforced. First, the Commissioner may enforce it through her general regulatory authority over Tennessee health insurance issuers. Second, violators are subject to criminal prosecution for a Class C misdemeanor.

Evidence necessary for the Commissioner to enforce the statute against a health insurance issuer would depend on the particular statute under which the Commissioner is acting. For

example, under Tenn. Code Ann. § 56-1-409, the Commissioner is generally authorized to examine an insurance company licensed in Tennessee. Under Tenn. Code Ann. § 56-1-411(d)(3), if the examination reveals that the company is operating in violation of any law, the Commissioner may, by written order, require the company to take any action she considers necessary or appropriate. Orders under this statute are subject to review under Tenn. Code Ann. §§ 27-9-101, *et seq.,* providing for a writ of certiorari. The Court's scope of review under this statute would be limited to determining whether the Commissioner exceeded her jurisdiction, followed an unlawful procedure, acted illegally, arbitrarily, or fraudulently, or acted without material evidence to support her decision. *See*, *e.g.*, *Harding Academy v. The Metropolitan Government of Nashville and Davidson County,* 222 S.W.3d 359, 363 (Tenn. 2007).

Under Tenn. Code Ann. § 56-2-305(a), the Commissioner may penalize an insurer, person, or entity required to be licensed if, after a contested case hearing, the Commissioner finds that the entity has violated "any statute, rule or order[.]" This provision authorizes the Commissioner to enforce Tenn. Code Ann. § 56-7-2602. The Commissioner's final order after a contested case hearing is subject to judicial review under Tenn. Code Ann. § 4-5-322. The reviewing court may reverse the decision if, among other grounds, he or she finds that it is unsupported by evidence that is both substantial and material in light of the entire record. Tenn. Code Ann. § 4-5-322(h)(5)(A). In determining the substantiality of evidence, the Court must take into account whatever in the administrative record fairly detracts from its weight, but the Court may not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact. Tenn. Code Ann. § 4-5-322(h)(5)(B). Other enforcement proceedings by the Commissioner may be subject to different levels of review.

Violation of Tenn. Code Ann. § 56-7-2602 is a Class C misdemeanor. Evidence is sufficient to support a finding of guilt in a criminal action if any rational trier of fact could have found the essential elements of the crime beyond a reasonable doubt. *State v. Swift,* 308 S.W.3d 827, 830 (Tenn. 2010).

8. Providing Information under the Federal Parity Law

The last question inquires as to whether an insurance company or managed care organization must provide documentation, upon the request of a member or provider, of the availability and/or administration of benefits, including all treatment limitations, on the medical/surgical side of a plan when an allegation of disparity is made. The Federal Parity Law adds the following subsection (a)(4) to 42 U.S.C. § 300gg-26(a):

> (4) Availability of Plan Information
>
> The criteria for medical necessity determinations made under the plan *with respect to mental health or substance use disorder benefits* (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services *with*

> *respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall*, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(emphasis added). By its terms, this provision requires a health insurance issuer of a group insurance plan to provide criteria for medical necessity determinations only with respect to mental health or substance use disorder benefits. It does not require the issuer to provide criteria with respect to medical and surgical limitations. This Office is unaware of any other statute that might impose this requirement.

It is possible that this question refers to the requirement, under the Federal Parity Law, that a policy limiting payment for mental health or substance use disorder benefits must apply the same limits to medical and surgical benefits. In this case, the question is whether, where a group insurance plan limits reimbursement for mental health or substance use disorder benefits to a provider, the insurance company or managed care organization must disclose to the provider or the member the extent to which it is applying corresponding limits to medical and surgical benefits. This Office is unaware of any statute requiring the insurer to disclose such information to a provider. The provider's contract with the insurer might provide such access.

We assume the term "member" refers to the individual for whom mental health or substance use disorder benefits were provided. Presumably, an individual covered by the group policy would have access to its terms through the employer or other organization paying for the plan. *See also* Tenn. Code Ann. § 56-26-202(b)(2) (individual certificate setting forth benefits and exceptions under a group accident and health insurance policy must be delivered to the persons insured under the policy). No statute, however, explicitly requires an insurance company to divulge this information to an individual not covered by the plan. Any party that suspects an insurer is violating the Federal Parity Law may wish to contact the Commissioner of Commerce and Insurance, who is charged with enforcing it.

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