DEPARTMENT OF COMMERCE AND INSURANCE
INSURANCE DIVISION

2026 MENTAL HEALTH PARITY REPORT

ISSUED PURSUANT TO TENN. CODE ANN. § 56-7-2360(e)

INTRODUCTION

The federal Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") (42 U.S.C. § 300gg-26) requires health insurance companies that cover both medical and surgical (M&S) benefits and mental health or substance use disorder (MH/SUD) benefits to provide the MH/SUD benefits in a manner that ensures the MH/SUD benefits are provided in parity with the M&S benefits covered by the plan.[1]

The Insurance Division of the Tennessee Department of Commerce and Insurance (the "Division") regulates companies selling insurance in Tennessee. In doing this, the Division also ensures health insurance companies operating in Tennessee comply with the MHPAEA, federal parity laws at 45 CFR § 146.136 and 45 CFR § 147.160, and state parity laws at Tenn. Code Ann. §§ 56-7-2601, 56-7-2602, and 56-7-2360. The laws collectively are referred to as "Mental Health Parity Laws" in this report.

Multiple sections within the Division play a role in ensuring the Division fulfills its obligation to oversee compliance with the Mental Health Parity Laws. The Policy Analysis Section reviews health insurance policies that are not federally regulated to ensure they adhere to Mental Health Parity Laws before the policies are approved.

Consumers and providers can file complaints with the Consumer Insurance Services Section if they believe an insurance company is violating Mental Health Parity Laws. The Consumer Insurance Services Section reviews the insurance policy and mediates between the insurance company and the complainant. The Section then determines whether the company acted in accordance with the policy and applicable laws. If the company is found to be in violation of the law, the case is referred to the Department of Commerce and Insurance's Office of Legal Counsel for review to determine if regulatory action is necessary and appropriate. If the company did not act in accordance with the policy or applicable laws, the process may result in the filing of an administrative action against the company and restitution for the consumer.

The Examinations Section performs full-scope examinations on insurance companies every five years and limited market-conduct reviews to assess a company's compliance with Mental Health Parity Laws if the company provides a health insurance plan that covers MH/SUD services.

This report, issued pursuant to Tenn. Code Ann. § 56-7-2360(e), provides a thorough explanation of the Division's activities to ensure companies' compliance with Mental Health Parity Laws. The report is subdivided into sections corresponding with the various subsections and subdivisions of Tenn. Code Ann. § 56-7-2360.

[1] 42 U.S.C. § 300gg-26(a).

MENTAL HEALTH PARITY REPORT

1. Tenn. Code Ann. § 56-7-2360(e): The department shall request from the United States department of labor and the United States department of health and human services copies of the NQTL analyses submitted to the departments the previous year in compliance with the federal Consolidated Appropriations Act of 2021 (Pub.L. 116-260) and incorporate these analyses into the report.

The Division requested a copy of the most recent non-quantitative treatment limitations ("NQTL") analyses from the United States Department of Health and Human Services and the United States Department of Labor, Employee Benefits Security Administration. In response, a representative from the Department of Labor, Employee Benefits Security Administration indicated that the most recent report is the 2024 MHPAEA Report to Congress dated January 2025. The report may be accessed via the Department of Labor's website.[2]

2. Tenn. Code Ann. § 56-7-2360(e)(1): List health plans sold in this state and over which of these plans the department has jurisdiction.

Individual (plans a consumer purchases on their own instead of from an employer)

- Alliant Health Plans
- BlueCross BlueShield of Tennessee, Inc.
- Celtic Insurance Company/Centene Venture Company Tennessee
- Cigna Health and Life Insurance Company
- Oscar Insurance Company
- UnitedHealthcare Insurance Company

Small Group (plans offered by employers with 50 or fewer full-time employees)

- Aetna Life Insurance Company
- BlueCross BlueShield of Tennessee, Inc.
- Cigna Health and Life Insurance Company
- UnitedHealthcare Insurance Company
- United Healthcare Insurance Company of the River Valley, Inc.

Large Group Fully Insured (plans offered by employers with 51 or more full-time employees)

- Aetna Health Inc.
- Aetna Health Insurance Company
- BlueCross BlueShield of Tennessee, Inc.
- Cigna Health and Life Insurance Company
- Cigna Healthcare of Tennessee, Inc.
- Nippon Life Insurance Company of America
- United Healthcare Insurance Company
- United Healthcare of TN

[2] https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2024.pdf

- United Healthcare Insurance Company of the River Valley, Inc.

3. Tenn. Code Ann. § 56-7-2360(e)(2): Discuss the methodology the department is using to check for compliance with the MHPAEA, and any federal regulations or guidance relating to the compliance and oversight of the MHPAEA, including 45 CFR 146.136.

Policy Analysis Section

The Policy Analysis Section reviews policy rates, rules, and forms filed by insurance companies offering plans in Tennessee. Forms include policies, certificates, riders, declarations, amendments, endorsements, notices, disclosures, outlines of coverage, applications, and advertisement materials. Policies must be approved by this Section before they are offered in the Tennessee marketplace.

All forms are publicly available through the Division's website[3] by selecting the Consumer Resources tab, then selecting "Rate and Form Filings – SERFF" from the menu on the left side of that page. SERFF is an online filing system created by the National Association of Insurance Commissioners ("NAIC") for the use of states and insurance carriers.

During the form-review process, the Policy Analysis Section reviews companies' answers to the following questions to ensure compliance:

- Does the company have different cost-sharing requirements for M&S and MH/SUD benefits (e.g., copays, deductible, co-insurance)?
- Does the company have different visit limitations for M&S and MH/SUD benefits?
- Does the company impose non-quantitative treatment limitations ("NQTL") such as step therapy with drugs or procedures, different methods for determining usual and customary reimbursement, restrictions based on facility types or geographical location, or standards for providing out-of-network providers?

The federal Centers for Medicare and Medicaid Services ("CMS") also performs a nondiscrimination review of individual and small group filings for compliance and notifies the Policy Analysis Section if any noncompliance is identified. In 2025, no issues were identified by CMS.

Consumer Insurance Services Section

The Consumer Insurance Services Section ("CIS") reviews written complaints from consumers. When CIS receives a complaint, they review the consumer's policy to determine if the company was acting in accordance with the policy and state law. If CIS identifies any possible violations of Mental Health Parity Laws, CIS transfers the complaint to the Examination Section's Market Conduct team and the Division's Office of Legal Counsel.

If no violations occurred and the company refuses to overturn its initial decision, CIS sends the complainant a copy of the company's response for review. The complainant then has ten days to file a rebuttal if the complainant has new evidence that has not already been reviewed. CIS will send the

[3] https://www.tn.gov/commerce/insurance-division.html

rebuttal to the company and request a response within ten days of receipt. At the end of this mediation, if the company still refuses to overturn its initial decision, CIS will send a closing letter to the complainant.

CIS uses disposition codes to identify and track any violations of law or the complainant's policy and keeps detailed records of all complaints. CIS follows code requirements established by the NAIC to maintain records of each complaint.

Examinations Section

As part of regularly conducted full-scope financial examinations of all health insurance companies, the Examinations Section requests and reviews any analysis the insurance company has already performed to assess its compliance with Mental Health Parity Laws, including analyses done using the Self-Compliance Tool for the MHPAEA published by the federal Departments of Labor, Health and Human Services, and the Treasury.[4] The Self-Compliance Tool asks questions such as:

- Does the plan comply with requirements regarding financial requirements or quantitative treatment limits on MH/SUD benefits?
- Does it meet parity requirements regarding NQTLs?
- Does it comply with the MHPAEA disclosure requirements?

If no prior analysis has been done, the Examinations Section uses the List of Examination Questions and Data Collection Tool contained in the NAIC Market Regulation Handbook ("Handbook"), Chapter 24B, to assess the company's compliance. The Handbook's List of Examination Questions and Data Collection Tool are very similar to the federal Department of Labor's Self-Compliance Tool and are formatted in tables to allow regulators to cross reference coverage policies for MH/SUD benefits compared to M&S benefits. The NAIC most recently revised the Handbook's examination guidelines for mental health parity at its 2022 Summer Meeting. The NAIC added definitions and new standards which include lists of documents to be reviewed along with new review procedures and criteria.

Examinations Section staff are pursuing additional education and training in assessing MHPAEA compliance. This has included attending seminars and NAIC Working Group meetings along with participation in the Behavioral Health Parity Auditor (BHPA) training courses developed by the Insurance Regulatory Examiners Society (IRES). Examinations Section staff will pursue the full BHPA designation once it is available from IRES.

Federal Developments in 2025

The federal Centers for Medicare and Medicaid Services (CMS) is responsible for enforcing applicable provisions of title XXVII of the Public Health Service Act (PHS Act), including those added by the Affordable Care Act (ACA), the No Surprises Act (NSA) and the Transparency provisions of the Consolidated Appropriations Act, 2021 (CAA, 2021), and the Mental Health Parity and Addiction Equity Act (MHPAEA) with respect to health insurance issuers in certain circumstances. CMS is also

[4] The tool can be found on the Department of Labor's website here: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.

responsible for enforcing the provisions of title XXVII of the PHS Act that are applicable to non-Federal governmental plans (such as plans for state and local government employees) in all states, the District of Columbia, and the territories. Additionally, CMS is responsible for enforcement of provisions of the NSA and Transparency provisions applicable to providers, facilities, and providers of air ambulance services in a state, if CMS determines that the state is not substantially enforcing one or more of the applicable NSA requirements. Tennessee has been determined to be such a state that lacks authority to enforce certain provisions of the NSA.

In 2024, CMS completed two (2) examinations of Tennessee plans. The examination period for both was January 1, 2022, through December 31, 2022. The examination of both companies yielded two findings for each company. More details on the specific findings and CMS's compliance and enforcement efforts can be found on CMS's website.[5]

No Tennessee companies or plans were examined by CMS in 2025. There were no other federal developments of note in 2025.

4. Tenn. Code Ann. § 56-7-2360(e)(3): Discuss the methodology the department uses to check for compliance with this section and §§ 56-7-2601 and 56-7-2602.

The discussion in the previous section of this report encompasses the Division's enforcement of state laws regarding parity in coverage for MH/SUD benefits as required by Tenn. Code Ann. §§ 56-7-2601, 56-7-2602, and 56-7-2360, the latter of which also requires compliance with the MHPAEA and 45 CFR § 146.136 and 45 CFR § 147.160.

5. Tenn. Code Ann. § 56-7-2360(e)(4): Identify market conduct examinations and full scope examinations conducted or completed during the preceding twelve-month period and summarize the results of the examinations. Individually identifiable information must be excluded from the reports consistent with federal privacy protections, including, but not limited to, 42 U.S.C. § 290dd-2 and regulations found at 42 CFR § 2.1 through 42 CFR § 2.67. This discussion must include:

(A) The number of full scope examinations and market conduct examinations initiated and completed;

(B) The benefit classifications examined by each market conduct examination and full scope examination;

(C) The subject matter of each market conduct examination, including quantitative and non-quantitative treatment limitations;

(D) A summary of the basis for the final decision rendered in each market conduct examination; and

[5] All of CMS's federal market conduct examination final reports can be found here: https://www.cms.gov/marketplace/private-health-insurance/consumer-protections-enforcement.

(E) A detailed explanation regarding parity in coverage and rates of reimbursement for mental health services and alcoholism and drug dependency services in compliance with this title;

(A) Examinations initiated and completed

The Examinations Section completed 12 full scope financial examinations in 2025. One of the insurance companies examined was subject to the Mental Health Parity Laws. At the end of 2025, the Section was conducting 11 open full-scope financial examinations. None of those companies are subject to mental health parity review. Each examination includes a limited market conduct review. The Examinations Section may perform targeted market conduct examinations to address specific issues when a regulatory concern is noted.

Currently, three of the 60 insurance companies domiciled in Tennessee must comply with the Mental Health Parity Laws. The other Tennessee-domiciled companies do not offer health insurance and are not subject to Mental Health Parity Laws.

(B) Benefit classifications examined

A review for compliance with Mental Health Parity Laws will be performed for any applicable company. Both quantitative and non-quantitative treatment limitations will be reviewed.

The examination will include a review of the details of the health plans that are being written to determine compliance within each classification of benefits. Under the MHPAEA regulations, the six classifications of benefits are inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency room visits, and prescriptions.

(C) Subject matter of each examination, including quantitative and non-quantitative treatment limitations

Standard market-conduct reviews specifically examine the following subjects for each company:

- Operations and management
- Complaint/grievance handling
- Marketing and sales
- Producer licensing
- Policyholder service
- Underwriting and rating
- Claims handling

Examiners review the company's antifraud initiatives to prevent, detect, and mitigate fraud; complaint data and the company's complaint-handling manuals; the licensure of the company's producers; marketing materials; the company's response time to policyholder requests; fair methods of underwriting practices; and the company's claims-handling practices. Additionally, examiners may review other company actions or practices.

In addition to the standard market-conduct procedures, the Examination Section will evaluate each company's compliance using the federal Self-Compliance Tool, if applicable. If the company has not

performed its own analysis, the Section will request completion of the questionnaire from the NAIC Handbook and review the company's responses.

(D) Summary of the basis for final decision rendered in each exam

During 2025, the company examined failed to demonstrate comparability and relative stringency in the application of the return-on-investment factor for prior authorization; failed to provide sufficient information and supporting documentation regarding the factors considered in the design and application of the NQTL, as written and in operation, for prior authorization; and failed to demonstrate comparability regarding the processes, strategies, evidentiary standards, and other factors used to apply the NQTL, as written for step therapy.

(E) Explanation regarding parity in coverage and rates of reimbursement for MH/SUD services

The federal government has identified reimbursement rates as a possible NQTL impermissible under the federal Mental Health Parity Laws. Tennessee law requires enforcement of MH/SUD services parity laws akin to federal Mental Health Parity Laws on plans regulated by the Department of Commerce and Insurance. When the same procedure codes are used, parity in reimbursement should be easily observable. It is the Department's understanding that the procedure codes used for mental health services and the procedure codes used for substance abuse services may be different. The Department does not currently maintain clinical staff necessary to make a determination of equivalence between different procedure codes in order to assess whether they are covered and reimbursed at parity.

In addition, Tennessee, via the Division's Examination Section, continues to participate in a multi-state market conduct examination of a group of health insurance companies with active policies in Tennessee. Pennsylvania is the lead state for this examination. The multi-state market conduct examination follows a market conduct examination performed by the Insurance Department of the Commonwealth of Pennsylvania that found that the company failed on numerous occasions to provide comparative analyses of NQTLs applied to covered benefits, therefore not complying with Mental Health Parity Laws. Similar issues found in Illinois and Rhode Island contributed to the commencement of the multi-state examination.

The NAIC's Market Actions Working Group has asked other states to suspend any individual market regulation action related to these issues while a thorough, national examination is being performed. The final report will include findings from all the participating states and, if it results in a settlement, a portion of the penalty funds will be divided among the participating states based on the percentage of premium written in each state. Once the final report is complete, the Division's Examination Section will review the report for accuracy and completeness and/or certification of the examination on a timely basis.

6. Tenn. Code Ann. § 56-7-2360(e)(5): Detail educational or corrective actions the department of commerce and insurance has taken to ensure health benefit plan compliance with this section, the MHPAEA, 42 U.S.C. § 18031(j), and §§ 56-7-2601 and 56-7-2602.

There were no legal enforcement actions during 2025 to enforce compliance with Mental Health Parity Laws.

The Consumer Insurance Services Section and the Division's Education and Outreach Specialist have encouraged consumers and providers to file complaints if they suspect violations of Mental Health Parity Laws by a health insurance company in Tennessee.

The Policy Analysis Section reviews policies from health insurance companies to ensure compliance. If the policy is not in compliance, the Policy Analysis Section returns the policy to the company detailing the requirements that must be corrected before it can be approved. The Policy Analysis Section had no objections in 2024 and 2025. The Department believes this is an indication that companies are more successfully following Mental Health Parity Laws at the time of filing.

7. Tenn. Code Ann. § 56-7-2360(e)(6): Detail the department's educational approaches relating to informing the public about mental health or alcoholism or drug dependence parity protections under state and federal law.

In 2025, the Division took numerous measures to better educate Tennessee consumers about Mental Health Parity Laws.

- The Division's Communications team worked with the Tennessee Department of Mental Health and Substance Abuse Services to create a press release for Mental Health Awareness Month in May. The press release mentioned mental health insurance coverage and the Mental Health Parity Laws.

- The Education and Outreach Specialist and the Consumer Insurance Services Director participated as a vendor in the National Alliance of Mental Illness's Tennessee Convention in September and spoke with several leaders and consumers about Mental Health Parity Laws.

- The Education and Outreach Specialist and the Consumer Insurance Services Director participated as a vendor in the Mental Health Matters Fair held by the Tennessee Commission on Children and Youth in May.

- The Education and Outreach Specialist distributed the NAIC Using Your Health Plan booklet at several outreach events, which includes information about coverage for substance use disorders.

- In addition, the Division maintains information on MHPAEA on its website at https://www.tn.gov/commerce/insurance/consumer-edu/health.html.

8. Tenn. Code Ann. § 56-7-2360(e)(7): Describe how the department examines any provider or consumer complaints related to denials or restrictions for possible violations of this section, the MHPAEA, 42 U.S.C. § 18031(j), and §§ 56-7-2601 and 56-7-2602, including complaints regarding, but not limited to:

(A) Denials of claims for residential treatment or other inpatient treatment on the grounds that such a level of care is not medically necessary;

(B) Claims for residential treatment or other inpatient treatment that were approved but for a fewer number of days than requested;

(C) Denials of requests, authorizations, pre-authorizations, prior authorizations, concurrent reviews, or claims for residential treatment or other inpatient treatment because the beneficiary had not first attempted outpatient treatment, medication, or a combination of outpatient treatment and medication;

(D) Denials of claims for medications such as buprenorphine or naltrexone on the grounds that they are not medically necessary;

(E) Step therapy requirements imposed before buprenorphine or naltrexone are approved;

(F) Prior authorization requirements imposed on claims for buprenorphine or naltrexone, including those imposed because of safety risks associated with buprenorphine; and

(G) Denial of in-network authorization or denials of out-of-network services or claims where there is not an in-network provider within seventy-five (75) miles of the insured patient's home.

The Consumer Insurance Services (CIS) Section reviews complaints from consumers and providers, then investigates to see if the company was acting in accordance with the insurance policy and Mental Health Parity Laws.

In 2025, CIS reviewed 14 complaints related to Mental Health Parity Laws. Eleven complaints were from patients and four were from providers. Not all 2025 complaints have been closed as of publication of this report.

- Two complaints were from members of a self-funded health insurance plan not regulated by the Department.
- One complaint was about downcoding of a provider billing.
- One complaint was from a policyholder that had not received their policy card yet.
- Three complaints were for claim-processing delays.
- Three complaints were for claim-payment reimbursements.
- One complaint was about a copay dispute.
- One complaint was an in-network rate dispute.
- One complaint was a provider-contract dispute.
- One complaint was a billing dispute.

(A) Denials of claims for residential treatment or other inpatient treatment on the grounds that such a level of care is not medically necessary;

There were no complaints received for denial of residential or other inpatient treatment.

(B) Claims for residential treatment or other inpatient treatment that were approved but for a fewer number of days than requested;

There were no complaints received about the number of approved inpatient days.

(C) Denials of requests, authorizations, pre-authorizations, prior authorizations, concurrent reviews, or claims for residential treatment or other inpatient treatment because the beneficiary had not first attempted outpatient treatment, medication, or a combination of outpatient treatment and medication;

There were no complaints received regarding denials of requests, authorizations, pre-authorizations, prior authorizations, concurrent reviews, or claims for residential treatment or other inpatient treatment because the beneficiary had not first attempted outpatient treatment, medication, or a combination of outpatient treatment and medication.

(D) Denials of claims for medications such as buprenorphine or naltrexone on the grounds that they are not medically necessary;

None of the consumer complaints received by Consumer Insurance Services in 2025 pertained to the medical necessity of buprenorphine or naltrexone.

(E) Step therapy requirements imposed before buprenorphine or naltrexone are approved

None of the consumer complaints received by Consumer Insurance Services in 2025 pertained to step therapy.

(F) Prior authorization requirements imposed on claims for buprenorphine or naltrexone, including those imposed because of safety risks associated with buprenorphine

None of the consumer complaints received by Consumer Insurance Services in 2025 pertained to prior authorizations of buprenorphine or naltrexone.

(G) Denial of in-network authorization or denials of out-of-network services or claims where there is not an in-network provider within seventy-five (75) miles of the insured patient's home

One complaint was about out-of-state/out-of-network care. However, it was closed due to lack of jurisdiction and because proximity to a provider was not a factor.

The Department had no observable increase in calls concerning the lack of in-network mental health specialists in 2025 compared to call volume from 2024, and no complaints were filed for this issue.

While consumer complaints are confidential, the number of complaints against a company in each state is available by visiting the Department’s website, accessing the Insurance Division’s webpage, and selecting “Complaint Data” under the Consumer Resources section. This data, collected by the NAIC, includes generic reasons the complaints were submitted.

The Department continues to work diligently to ensure compliance with Mental Health Parity Laws among applicable companies in Tennessee and to pursue more education and outreach opportunities for Tennessee consumers.

9. Tenn. Code Ann. § 56-7-2360(f): The report issued pursuant to subsection (e) must be written in non-technical, readily understandable language and be made available to the public by posting the report on the department's website and by other means as the department finds appropriate. The name and identity of the health insurance carrier must be given confidential treatment, may not be made public by the commissioner or another person, and are not subject to public inspection pursuant to § 10-7-503

The Department has attempted to publish this report in non-technical, readily understandable language. This report is accessible on the Division's website. No health insurance carriers are named in this report.

THE DIVISION OF TENNCARE

There are three health maintenance organizations that contract with the Division of TennCare ("TennCare") as the managed care organizations ("MCO") that provide M&S and MH/SUD benefits to TennCare enrollees. This contract is referred to as the TennCare Contractor Risk Agreement ("CRA"). The MCOs are required to provide all covered benefits in accordance with the plan designed by TennCare and as set forth in the CRA.

As required by Tenn. Code Ann. § 71-5-154, TennCare receives and reviews on an annual basis a Behavioral Health Coverage Annual Report prepared by each MCO. This report contains information for enrollees in the TennCare program regarding coverage of mental health and alcohol and drug dependence benefits. The report contains updated information about the MCOs' processes for determining prior authorizations and denials, medical necessity criteria, and NQTLs across both MH/SUD and M&S benefits. The MCOs also conduct an analysis of how these factors affect prior authorization outcomes and submit findings and conclusions demonstrated by these analyses.

After review of the 2024 reports, TennCare staff did not identify any deficiencies or parity imbalances, therefore no additional actions were taken. TennCare staff will continue to receive and review the annual reports.

The TennCare Oversight Division of the Department of Commerce and Insurance coordinates with TennCare to ensure that the TennCare MCOs operate in compliance with applicable state and federal Mental Health Parity Laws. Complaints by TennCare enrollees alleging MH/SUD services have been denied, delayed, reduced, suspended, or terminated are referred to the appropriate MCO and TennCare's Member Services Section to initiate a medical appeal in accordance with established TennCare procedures. In addition, the TennCare Oversight Division coordinates the review of the MCOs' provider agreements and provider manuals with TennCare to ensure the MCOs' medical necessity criteria guidelines and non-quantitative treatment limitations comply with applicable state and federal Mental Health Parity Laws.