



Date: 1/31/19

*Interim Meeting  
Dallas, Texas*

**MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP  
January 23 – 24, 2019**

**Recap of Clarifications and Decisions**

The Market Conduct Annual Statement Blanks (D) Working Group met on Jan. 23 and 24, 2019. During this meeting, the Working Group:

1. Agreed to move the 2018 data year filing due date to June 30, 2019. All subsequent data years remain due on April 30 of the following year.
2. Agreed to review whether to post the Health MCAS scorecards for the 2018 data year.
3. Agreed to have NAIC staff provide clarification of validation warnings and errors.
4. Agreed to review the validations.
5. Agreed to arrange future open conference calls to routinely consider industry questions regarding the MCAS filing.
6. Clarified that a Group policy will be reported as one policy regardless of the number of products available to the Group and agreed to clarify the definition of group in the Frequently Asked Questions (FAQ) and the Data Call & Definitions.
7. Agreed to consider using the Financial Annual Statement (FAS) Schedule T Definition of “Situs”.
8. Agreed to revise the FAQ to remove the health line of business from the guideline that premium deviations more or less than 20% of the FAS Supplemental Health Care Exhibit (SCHE) should be explained. NAIC will include the possible reasons for deviations in regulator training programs.
9. Agreed to add a data element to collect the “number of member months for policies terminated during the period” (effective for the 2020 data year.)
10. Agreed to review adding a requirement to report the total number of small group “policies issued”, “policies renewed”, “terminations and cancellations initiated by consumer”, and “terminations and cancellations due to non-payment of premium,”
11. Clarified that if an insured group changes plans to another plan offered by the same carrier it should not be reported as a termination.
12. Clarified that a consumer at renewal who changes to a new product with the same carrier will be reporting as a policy issued, not as a renewal. This will be clarified in the FAQ and the Data Call & Definitions.
13. Agreed to change the language in the Policy Administration Termination and Cancellation data elements to consistently refer to the insured as “policyholder” and change “lives impacted” to “insured lives impacted”. An FAQ will be developed explaining the requirements.
14. Agreed to revise the Section 2 definition of “Prior Authorization” to read “carrier or its designee” instead of just “carrier”.
15. Agreed that partially approved prior authorizations will be reported as “approved.” For future data years, the Working Group will consider adding a data element to report partially approved prior authorizations.
16. Clarified that prior authorization requests, approvals and denials should be reported according to the data year of the request, approval or denial.

17. Clarified that claims received, paid and denied should be reported according to the data year if the receipt, payment or denial.
18. Clarified that claims are to be reported at the service line level.
19. Clarified that capitated claims are reported if an Explanation of Benefits (EOB) is generated.
20. Clarified that the denial categories are not exhaustive. Not all denials will fit into the available categories. Those denials would not be reported in the denial categories but would still be reported in the total denials.
21. Agreed that duplicate claim service lines are not required to be reported. The FAQ will be revised.
22. Clarified that behavioral health denials are a subset of the total claims denials and are to be reported in the totals as well as in the behavioral health sections of claims denials. Agreed to provide clarification in the FAQ regarding the reporting of behavioral health denials.