Market Conduct Annual Statement

Industry User Guide

2018 Data Year Filings

National Association of Insurance Commissioners

MCAS Industry User Guide

2018

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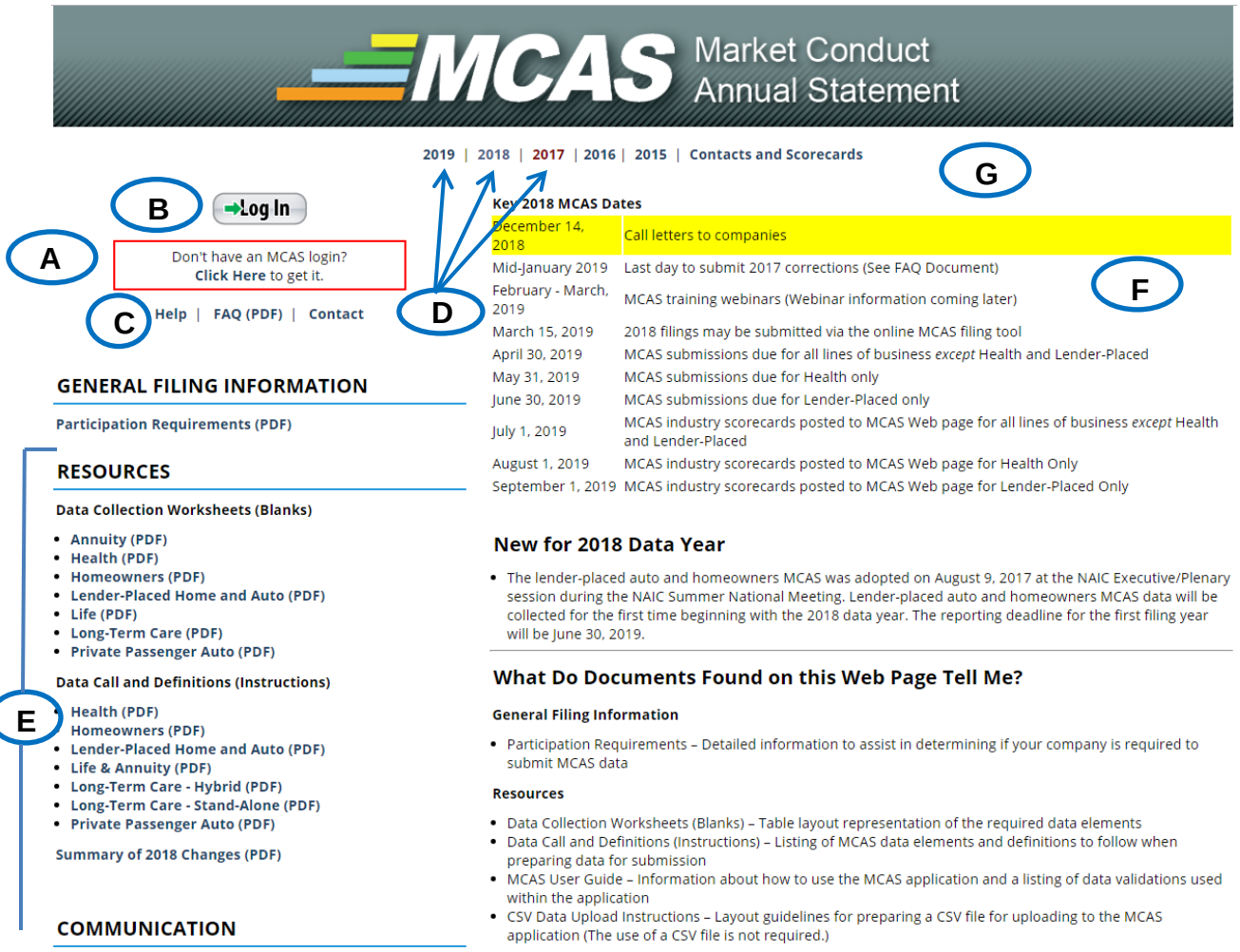
MCAS Web Page

Getting Started

The NAIC MCAS Web page (www.naic.org/mcas_main.htm) is the primary source of information related to MCAS. A company might find it helpful to bookmark this page and check it frequently during the MCAS filing period.



A

Request for MCAS Login or Password Reset

Every individual wanting entry into the MCAS system must first request an MCAS login through the NAIC. This is done by completing and submitting the Request for MCAS Login form available through the Click here link in the red box. Anyone who received an MCAS login in a previous year does **not** need to request another one. For password reset, enter your MCAS ID on the form, and a request will be generated and sent to the NAIC Help Desk. Typically, the NAIC Help Desk creates a new MCAS login and

completes the password resets within four business hours of request receipt, but please allow two business days for completion of this task.

Log In

A click on this button launches the sign-in screen for the online application. The confidentiality of MCAS data is taken very seriously. Therefore, an individual must have both an NAIC MCAS login **and** must be authorized to access a company's data by the company's MCAS Administrator. Further information about obtaining company authorization is available in the User Assignment section of this guide.

Help | FAQ | Contact

A click on the **Help** link will open an online NAIC Help Desk form designed specifically for those seeking MCAS technical assistance. Help requests received on this form are prioritized higher than phone calls or general e-mail correspondence. The **FAQ** link will open a document of common MCAS questions and answers for those who prefer do-it-yourself assistance. The **Contact** link opens an email pre-addressed to the MCAS area of the NAIC where MCAS business questions should be directed.

MCAS Navigation Bar

Because the information in the 

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 areas varies from one filing year to the next, a navigation bar was introduced to allow ease of movement between year-specific web pages. In addition, this navigation bar includes access to a map of participating jurisdictions for contact and instructional information that is unique by state.

Link Categories

There are additional links grouped into the categories of General Filing Information, Resources, and Communication. Among the Resources category is a tool called Data Collection Worksheets (Blanks). These worksheets are printable PDF files patterned after the MCAS application entry screens. They are designed to assist a company with manual data collection in preparation for data entry into the MCAS online system.

Key Dates

The key dates associated with the selected MCAS filing year are located in this area. The highlighting of key dates changes as the current filing year progresses.

Body

This area contains information relevant to the filing year for the web page displayed. Items regarding changes and clarifications from the previous year, announcements, and MCAS status updates may be found in this section.

MCAS Application

Overview

The Market Conduct Annual Statement (MCAS) application is the method by which industry files its market data with the states. The current web-based MCAS application was introduced for the 2010 data filing year. This portion of the User Guide contains instructions on how to access the MCAS application and details about each of the application's components:

- Log In
- Terms of Use
- Home
- Filing Matrix
- Lines of Business
    * Annuity
    * Life
    * Homeowners
    * Private Passenger Auto
    * Long-Term Care
    * Health
    * Lender-Placed Insurance
- Data Upload
- Waivers and Extensions
- Attestation
- Company Ratios
- User Assignments

Helpful Hints

Before beginning the MCAS filing process, here are some things to note to improve your experience with this application.

System Requirements

The NAIC recommends using Chrome or Firefox, when working with MCAS, however, Internet Explorer (IE) version 9, 10 or 11 can be used. A higher resolution (i.e., 1024 x 768 or more) is recommended for the best viewing experience. Higher resolutions reduce the amount of screen scrolling needed to view an entire page.

Browser Back Button

Once inside the MCAS application the NAIC discourages use of your browser's [Back] button. The recommended method for movement within the application is through use of the blue navigation bar, located at the top of the screen, and the action buttons displayed on the left side of each screen. Because different browsers behave differently with this application, using your browser's [Back] button might cause an error screen to display or force an immediate exit from the MCAS application. In either situation, there is a risk of losing any unsaved data.

Help Desk Form

The NAIC Help Desk form (described in a previous section) is available on the navigation bar within the MCAS application. When initiated from the application the user and company fields are pre-populated on the form. Any screen name, state, keying sequence or other detail information included in the Questions/Comments/Situation Description section assists the Help Desk staff identify and resolve a reported issue more quickly. The result is a more comprehensive response in less time.

Log In

The 

button on the MCAS webpage launches a sign-in screen where an individual enters his/her NAIC user ID and password. New NAIC users will be asked to set up security questions and change their password at initial log in. Once security questions are in place, future password resets can be handled by the individual without the need for involvement of the NAIC Help Desk.

Terms of Use

The first time an individual logs into the MCAS application, the Terms of Use screen is displayed. It is necessary to click the “I accept” box in order to proceed into the application. This acknowledgement of acceptance is valid for 365 days during which time the Terms of Use screen will not appear again. At the end of the 365-day period the individual will be prompted to accept the terms of use once more.

Filing Matrix

The purpose of this screen is to display the current filing status for the selected company and year. This page has four sections:

1. **Selection Pane:** This is where the user selects company and filing year, and access Legacy MCAS for prior year filings.

   The list of companies that appears in the drop-down field is customized to display only the signed-on individual’s authorizations. If an expected company is missing from the list, or an unexpected company is included in the list, please contact the MCAS Administrator for the company in question. The company’s MCAS Administrator manages who has access to its MCAS data.

2. **Filing Matrix:** This displays all states and available lines of business. The default view is by state, and the user can click on a specific state to view the available MCAS filings.
3. **Actions Pane:** This section has links to submit attestation, waivers and extensions, upload data files and view company ratios for submitted filings.
4. **Filters Pane:** This is where the user can narrow Filing Matrix results by state, line of business, Filing Status, Required to File flag, Waivers and Extensions status.

The Filing Matrix section displays the current filing status by state and line of business. The lines of business available to a user are based on the company's financial filing statement type as shown below:

Company Type	Filing Statement Type	Available Lines of Business (LOB)
Life	L	• Life* • Annuity* • Long-Term Care* • Health*
Property	P	• Private Passenger Auto* • Homeowners* • Long-Term Care* • Health* • Lender-Placed Insurance*
Health	X	• Life* • Long-Term Care* • Health*

Indicates an MCAS filing is required for this line of business for that state. Please see* ***Premium note below for more information.*

***Premium**: The "required" or "not required" status is based on a company's licensure in a state **and** its state premium as reported in its financial annual statement. It is important to note that premium reported in the financial annual statement may include coverages that are **excluded** from MCAS premium. Therefore, depending on a company's product lines, MCAS premium might or might not match financial annual statement premium. Regardless of the status displayed, it is the responsibility of each company to calculate its own MCAS premium to determine if filing in a state **is** or **is not** required. Please refer to the *MCAS Participation Requirements and General Information* document for further information.

A MCAS filing can be in one of the statuses below:

- **Not Started** – Filing is available, but no data has been entered or uploaded.
- **In Progress** – A filing has been started either by manual data entry or through a csv data file that has been uploaded.
  ***If the data validation checks have been performed, the Error and Warnings columns would also be populated accordingly.*
- **Processing** – Filing has been submitted and is being processed.
- **Filed** – Filing has been successfully submitted and processed.

User Administration

The User Administration page allows the MCAS Administrator to add/remove or update users. There can be multiple users but only one MCAS Administrator and one MCAS Contact. The MCAS Administrator can also be the MCAS Contact.

Common Functionality

Before starting a filing, it is important to verify that the data to be entered is associated with the state displayed. There is no automated method to move or copy data from one state to another if entered for an incorrect state.

Messages on the screen include coverage identifiers and question numbers to assist in identifying which sections and fields contain an error/warning. Fields with warnings will be highlighted in yellow, whereas fields with errors will be highlighted in red. Please note that a field may have both warnings and errors, and therefore will be highlighted with the most severe state – red.

For additional information about messages, their severities, and their meanings, refer to the MCAS Message section at the end of this User Guide.

The following buttons are available on the Lines of Business screens, although *not all buttons are always available.* They function as described below.

Button	Action	Description
Save	Saves data without validating it.	Displays informational message for saving the filing.
Save & Validate	Saves (see above) then performs calculation checks and tests data business rules.	Displays informational, warning and/or error messages that might require correction before data submission.
Submit	Submits the company data to the NAIC for use by the states even if there are warning messages displayed.	Displays informational message when submission is successful (see ***Submit** note below).
Close	Exits the current Filing and takes you to the Filing Matrix	No Message displayed.
View Submitted Data	Displays prompt message to Open or Save a pdf file of submitted data for the year specified on the button selected.	If OPEN is selected, a new browser window is opened, and the data is displayed in it. If SAVE is selected, a prompt for save location is displayed. The pdf may be printed from either option.
Print Displayed Data	Prints the current displayed section.	No Message displayed.

***Submit**: When a record is submitted for a state and line of business, that record goes into a "processing" status temporarily. During this time, the record is unavailable for update by the company while the data is transferred to the appropriate state. Typically, the transfer process completes in less than two hours. However, if the record is still "processing" 24 hours or more after submission, please complete and submit a Help Desk form.

Life

The Life screen contains two sections: Interrogatory and Data. There are two coverage columns in the Data section: Individual Life Cash Value and Individual Life Non-Cash Value. The data in each column is unrelated to the other, although the combined premium for the two columns is used to meet the $50,000 threshold for filing. Responses to questions in the Interrogatory section determine which columns require completion in the Data section.

Annuity

As with Life, the Annuity screen contains two sections: Interrogatory and Data. There are two coverage columns in the Data section: Individual Fixed Annuities and Individual Variable Annuities. The data in each column is unrelated to the other, although the combined premium for the two columns is used to meet the $50,000 threshold for filing. Responses to questions in the Interrogatory section determine which columns require completion in the Data section.

Private Passenger Auto (PPA)

The Private Passenger Auto screen contains three sections: Interrogatory, Claims, and Underwriting. There are nine coverage columns in the Claims section: Collision, Comprehensive, Bodily Injury, Property Damage, UMBI & UIMBI, UMPD & UIMPD, Medical Payments, Combined Single Limits, and Personal Injury Protection. Responses to questions in the Interrogatory section determine which columns require completion in the Claims section. All data in the Underwriting section is mandatory.

If your company has no claims information to report, but does have underwriting data to report, you will then enter all zeros in the claims sections for those coverages for which you answered “Y” to the interrogatory question, “Were there policies in force during the reporting period that provided “xxx” coverage. Conversely, you will leave all data elements null (i.e., unanswered) in the claims section for those coverages for which you answered “N” to the interrogatory question, “Were there policies in force during the reporting period that provided “xxx” coverage.

Homeowners (HO)

The Homeowners screen contains three sections: Interrogatory, Claims, and Underwriting. There are five coverage columns in the Claims section: Dwelling, Personal Property, Liability, Medical Payments, and Loss of Use. Responses to questions in the Interrogatory section determine which columns require completion in the Claims section. All data in the Underwriting section is mandatory.

If your company has no claims information to report, but does have underwriting data to report, you will then enter all zeros in the claims sections for those coverages for which you answered “Y” to the interrogatory question, “Were there policies in force during the reporting period that provided “xxx” coverage. Conversely, you will leave all data elements null (i.e., unanswered) in the claims

section for those coverages for which you answered “N” to the interrogatory question, “Were there policies in force during the reporting period that provided “xxx” coverage.

Long-Term Care (LTC)

The Long-Term Care screen contains five sections: Interrogatory, General Information, Claimant Activity, Benefit Payment Activity, and Lawsuits. There are three coverage columns in the sections following the Interrogatory section: Stand Alone LTC, Life LTC Hybrid and Annuity LTC Hybrid. Responses to questions in the Interrogatory section determine which columns require completion.

Health

The Health screen contains three sections: Interrogatory, In-Exchange and Out-of-Exchange. There are five tables in the In-Exchange section: Individual Health, Small Group Health, Catastrophic, Multi-State Individual and Multi-State Small Group. Each table, except for Catastrophic, has five columns broken down into metal levels (Bronze, Silver, Gold, Platinum and Total). Catastrophic is reported in total only. There are six tables in the Out-of-Exchange section: Individual Health, Small Group Health, Grandfathered/Transitional Plans, Catastrophic, Large Group and Student Coverage. The Individual and Small Group tables each have five columns broken down into metal levels (Bronze, Silver, Gold, Platinum and Total). The Grandfathered/Transitional Plans are broken down into four columns: Large Group, Small Group, Individual, and Total. Catastrophic, Large Group, and Student Coverage are reported in total only. Responses to questions in the Interrogatory section determine which tables require completion.

Lender-Placed Insurance (LPI)

The Lender-Placed Insurance (LPI) screen contains three sections: Interrogatory, Claims Activity and Underwriting Activity. Data elements in the claims and underwriting activity sections are collected for eight coverage types namely;

- Single-Interest Auto (SIA)
- Dual-Interest Auto (DIA)
- Single-Interest Home Hazard (SIHH)
- Dual-Interest Home Hazard (DIHH)
- Single-Interest Home Flood (SIHF)
- Dual-Interest Home Flood (DIHF)
- Single-Interest Home Wind-Only (SIHWO)
- Dual-Interest Home Wind-Only (DIHWO)

Accordingly, responses to questions in the Interrogatory section determine which columns require completion.

Re-filing

Current Data Year

Regardless of the line of business, re-filing for the current data year is handled much the same as the initial filing. The appropriate screen is accessed through the Filing Matrix where the most recently saved data is displayed. Changes are made by replacing the old values with new ones where needed. Once changed, the data may be saved, validated and submitted again when ready. When the refiling is processed, the refiled data replaces the previously submitted data.

Previous Data Year

Re-filing for the previous data year requires approval by the impacted state(s). Upon receipt of approval from the state(s), NAIC staff will "unlock" the record for the year, cocode, state, and line of business specified. Once in the unlocked status, the company may process the re-filing by clicking on the 'Access Legacy MCAS' link on the company selection pane. Re-filings for years prior to 2016 cannot be accepted.

Data Upload

The data upload process is an optional alternative to the manual data entry process. The Data Upload screen accepts data exclusively in a .csv file format to populate the line of business screens. Use the [Browse] button on the Data Upload screen to locate and select the file. An uploaded data file may contain records for multiple lines of business, only some columns within a line of business or only a few fields for a column. Data submitted through the file upload process overlays whatever data currently exists on the respective Line of Business screen. The details about .csv file structure and record layouts are located in the MCAS 2018 Data File Instructions Guide.

Waivers & Extensions

In some instances, a company might need to request an extension of the filing due date or a complete waiver in a state. The MCAS application includes the capability for a company to generate an electronic request to one or more states for consideration. After the affected state receives notification of the request, they approve or deny the request online. Once the state action is determined and the request is updated, the decision is immediately available for viewing by the requesting company through the MCAS application.

For example, if a company requests a waiver from Kansas for life and annuity, two records are created, and two lines are displayed. The request status options are:

Status	**Description**
Pending	Company submitted a request to the state and is awaiting a response.
Approved	State granted the request.
Denied	State rejected the request.

Access to an existing request is available through the Waiver/Extension status column section of every line of business by state in the Filing Matrix.

Waiver & Extension Requests

Companies can submit new Waiver or Extension requests by clicking on the appropriate button on the Actions pane. Requests are made by line of business and can be submitted for multiple states. Only required-to-file states are available for waiver requests. Once a request is submitted, it is added to the Waivers & Extensions List where it becomes visible to all participating states. The new requests are also visible on the filing matrix, where they can be accessed to view for any updates.

When a request is in pending status, a company may modify or delete it. However, once a state updates a request with a decision, the company's access to that request is limited to view only. If a change is necessary after the state's action is recorded, the company must contact the state to discuss resolution. It is the company's responsibility to check the Waivers & Extensions List or the Filing Matrix periodically to see if the state has taken any action.

Attestation

The Attestation screen is a single click agreement that includes fields to record the names and titles of the company representatives serving as attesters. By clicking on the attestation, the company's representatives are attesting to the accuracy of the MCAS data for the original filings as well as any re-filings necessary for the selected data year. The Attestation screen must be completed before any filings can be submitted.

The Company Comments field is located on this screen, as well. This field is available for the company to proactively communicate circumstances or conditions that might affect the company's MCAS numbers as a whole for the filing data year. Comments relating to a specific product line are better noted in the Comment Box associated with the respective line of business.

Company Ratios

The Company Ratios screen provides a post-filing report by state of the statistics associated with the company's submission. This information is available for review on the day following a successful submission. As filings are completed in additional states, additional data is displayed on this screen. Once a company completes all its filings, it is beneficial to print a final copy of this report. When the states' Scorecards become available in July, the company can use this report to compare their ratios to the Scorecard ratios of those states in which they do business.

User Assignment

Administration of access to the MCAS application is controlled by way of the User Assignment screen. Through this screen, the company's MCAS Administrator has the authority to add and remove users to the MCAS application on behalf of the company. In addition, the Administrator may designate a specific MCAS contact to serve as the point person for MCAS filing issues and regulator questions. All users, including the

Administrator and Contact, must obtain an MCAS userid from the NAIC help desk prior to being added to the User Assignment screen.

Administrator

The Administrator has the authority to add and remove MCAS system access for other users on behalf of the company and the authority to assign the Contact. NAIC staff can assign the Administrator role to the Market Conduct Contact, or Financial Statement Contact, as identified on the latest financial annual statement filing. This role may be assigned or reassigned to another company user.

Contact

The Contact person is the company's designated "go to" person for any questions from state insurance regulators and/or the NAIC related to the company's MCAS filing. Only one individual may have this role at a time, although it may be reassigned any time the company wishes to make a change.

Users

The User Assignment screen displays the names and roles of other individuals associated with the same company code. A role assignment is indicated with a filled radio button in the Administrator and/or Contact column next to an individual's name. A user can update their demographic information by clicking on the 'My Profile' link under their name on the upper right section of the MCAS Application.

MCAS Messages

Message Basics

Messages are displayed in red or yellow on the screen and they have different levels of severity, as shown below. If a validation fails, the message displays the validation rule ID in () following the message. For prior year filings, many messages include column (Col) and/or line (Ln) values to assist in identifying which cells contain an error. To correct the error, the data involved in the validation must be changed.

For example, if Col 1 Ln 10 = 1 and Col 1 Ln 11 = 2 and Col 1 Ln 12 = 5 and the message **ERROR: Col 1 Ln 10 + Ln 11 => Ln 12** appears, it is indicating that 1 + 2 => 5 is **not** accurate. To make the equation correct, the value of Col 1 Ln 10 or Col 1 Ln 11 needs to increase, or Col 1 Ln 12 needs to decrease.

Severity	**Type** *(LOB tables below)*	**Meaning**
Error	E	Corrective action required before submission can occur.
Warning	W	No corrective action required in order to proceed; however, there is some anomaly that warrants a second look before submission. If a filing is submitted with Warnings, comments should be added to the interrogatories section to address why the data is correct despite the warning.

For current year filings, data validation messages utilize coverage identifiers, sections and question numbers to reference fields with errors. Using the example above, the validation error would read as follows:

ERROR: “Insurance Coverage Type”: Q10 + Q11 => Q12

The following is a comprehensive set of MCAS messages listed by line of business and the last 5 characters of the rule ID. For example, message **(LZABN020001)** is associated with Life coverage and the rule ID is 20001. The Col value is replaced with the coverage type and the Ln value is replaced with the data element in these descriptions.

Messages by Line of Business

Annuity

Coverage Identifiers	Description of Coverage Identifiers
IFA	Individual Fixed Annuity
IVA	Individual Variable Annuity

Rule ID	Type	Description
10001	W	Total considerations for IFA and IVA should be => $50,000.
10002	E	If there is no data to report for IFA and IVA, then an Annuity filing is not needed.
10102	E	If there is no Individual Fixed Annuities (IFA) data to report, the outlier question response for IFA must be "N".
10103	E	If there are Individual Fixed Annuities (IFA) irregularities to report, the IFA explanation field must not be blank.
10104	E	If there are no IFA irregularities to report, the IFA explanation field must be blank.
10105	E	If you reported having Individual Fixed Annuities (IFA) product data to report, then all corresponding IFA data must be reported.
10106	E	If you reported not having any Individual Fixed Annuities (IFA) product data to report, then all corresponding IFA data must be blank.
10120	E	If there is IFA data to report, some IFA data elements must contain non-zero data.
10121	E	If there is no IFA data to report, all IFA data elements must be null.
10129	E	All IFA data elements must be => 0 except dollar amount of annuity considerations during the period.
10161	E	IFA Number of Internal + external replacement contracts issued must be => Number of replacement contracts issued.
10162	E	IFA number of new deferred contracts issued for all annuitant ages must be => number of all deferred contracts issued.
10163	E	IFA number of contracts surrendered during the period must be => the number of contracts surrendered between 0 and 10 years from policy issue during the period.
10164	E	IFA number of contracts replaced for all insured ages must be => number of contracts replaced.
10165	W	IFA number of contracts applied for during period should be => number of immediate contracts issued + number of deferred contracts issued during period.
10166	W	IFA number of contracts in force at end of period should be => number of immediate contracts issued + number of deferred contracts issued during period.
10202	E	If there is no IVA data to report, the outlier question response for IVA must be "N".
10203	E	If there are Individual Variable Annuities (IVA) irregularities to report, then the IVA explanation field must be completed.

Rule ID	Type	Description
10204	E	If there are no Individual Variable Annuities (IVA) irregularities to report, then no IVA explanation field is allowed.
10205	E	If you reported having Individual Variable Annuities (IVA) product data to report, then all corresponding IVA data must be reported.
10206	E	If you reported not having any Individual Fixed Annuities (IVA) product data to report, then all corresponding IVA data must be blank.
10220	E	If there is IVA data to report, some IVA data elements must contain non-zero data.
10221	E	If there is no IVA data to report, no IVA data elements may be entered.
10229	E	All IVA data elements must be => 0 except dollar amount of annuity considerations during the period.
10261	E	IVA Number of Internal + external replacement contracts issued must be => Number of replacement contracts issued.
10262	E	IVA number of new deferred contracts issued for all annuitant ages must be => number of all deferred contracts issued.
10263	E	IVA number of contracts surrendered during the period must be => the number of contracts surrendered between 0 and 10 years from policy issue during the period.
10264	E	IVA number of contracts replaced for all insured ages must be => number of contracts replaced.
10265	W	IVA number of contracts applied for during period should be => number of immediate contracts issued + number of deferred contracts issued during period.

Life

Coverage Identifiers	Description of Coverage Identifiers
ICVP	Individual Life Cash Value
INCVP	Individual Life Non-Cash Value

Rule ID	Type	Description
20001	W	Total direct written premium amount for ICVP and INCVP should be => $50,000.
20002	E	If there is no data to report for ICVP and INCVP, then a Life filing is not needed.
20102	E	If there is no ICVP data to report, the ICVP outlier question response must be "N".
20103	E	If there are ICVP irregularities to report, the ICVP explanation field must be completed.
20104	E	If there are no ICVP irregularities to report, the ICVP explanation field must be blank.
20105	E	If you reported having Individual Life Cash Value (ICVP) product data to report, then all corresponding ICVP data must be reported.
20106	E	If you reported not having Individual Life Cash Value (ICVP) product data to report, then all corresponding ICVP data must be blank.
20129	E	All ICVP data elements must be => 0 except dollar amount of direct written premium and face amount of insurance issued during the period.
20161	E	ICVP internal + external replacement policies must be => replacement policies issued.
20162	E	ICVP number of policies replaced for all insured ages must be => number of replacement policies issued.
20163	E	ICVP number of policies surrendered must be => the number of policies surrendered for all insured ages.
20164	E	ICVP number of new policies issued for all insured ages must be => number of new policies issued.
20165	W	ICVP number of policies in force at end of period should be => number of new policies issued during period.
20166	E	ICVP number of new policies issues > 0, then ICVP face amount issued must be > 0
20167	W	If ICVP number of new policies issued + ICVP number of policies in force at end of period > 0 then ICVP dollar amount of written premium should be > 0
20168	W	ICVP face amount of policies in force at end of period should be => ICVP face amount of new policies issued.
20169	W	If ICVP dollar amount of premium > 0, then ICVP number of policies in force at end of period + ICVP number of new policies issued during period should be > 0.
20170	E	If ICVP face amount of insurance in force at end of period > 0, then ICVP number of policies in force at end of period must be > 0.
20171	E	If ICVP number of policies in force at end of period > 0, then ICVP face amount of insurance in force at end of period > 0.

Rule ID	Type	Description
20172	W	ICVP death claims closed within 60 days + death claims closed beyond 60 days should be > death claims denied, resisted, or compromised.
20173	W	ICVP number of policies applied for during period should be => number of new policies issued during period.
20202	E	If there is no INCVP data to report, the INCVP outlier question response must be "N".
20203	E	If there are INCVP irregularities to report, the INCVP explanation field must be completed.
20204	E	If there are no INCVP irregularities to report, the INCVP explanation field must be blank.
20205	E	If you reported having Individual Life Non-Cash Value (INCVP) product data to report, then all corresponding INCVP data must be reported.
20206	E	If you reported not having Individual Life Non-Cash Value (INCVP) product data to report, then all corresponding INCVP data must be blank.
20229	E	All INCVP data elements must be => 0 except dollar amount of direct written premium and face amount of insurance issued during the period.
20261	E	INCVP Internal + external replacements must be => replacements issued.
20265	W	INCVP number of policies in force at end of period should be => number of new policies issued during period.
20266	E	INCVP number of new policies issues > 0, then INCVP face amount issued must be > 0
20267	W	If INCVP number of new policies issued + INCVP number of policies in force at end of period > 0 then INCVP dollar amount of written premium should be > 0.
20268	W	INCVP face amount of policies in force at end of period should be => INCVP face amount of new policies issued during period.
20269	W	If INCVP dollar amount of premium > 0, then INCVP number of policies in force at end of period + INCVP number of new policies issued during period should be > 0.
20270	E	If INCVP face amount of insurance in force at end of period > 0, then INCVP number of policies in force at end of period must be > 0.
20271	E	If INCVP number of policies in force at end of period > 0, then INCVP face amount of insurance in force at end of period > 0.
20272	W	INCVP death claims closed within 60 days + INCVP death claims closed beyond 60 days should be > INCVP death claims denied, resisted, or compromised.
20273	W	INCVP number of policies applied for during period should be => number of new policies issued during period.

Private Passenger Auto

Coverage Identifiers	Description of Coverage Identifiers
COL	Collision
COMP	Comprehensive
BI	Bodily Injury
PD	Property Damage
UMBI & UIMBI	Uninsured Motorists and Underinsured Motorists
UMPD & UIMPD	Uninsured Motorists and Underinsured Motorists
MP	Medical Payments
CSL	Combined Single Limits
PIP	Personal Injury Protection

Rule ID	Type	Description
30002	E	Since all PPA data-to-report indicators = N, do not submit PPA for this state.
30101	E	If significant event or business strategy change = Y, an explanation is required.
30102	E	If significant event or business strategy change = N, then no explanation is allowed.
30103	E	If any of this business was sold, closed, or moved to another company, an explanation is required.
30104	E	If none of this business was sold, closed, or moved to another company, then no explanation is allowed.
30105	E	An answer is required regarding treatment of supplemental or additional payments on previously reported claims.
30106	E	If the Company writes in the non-standard market = Y, a percent is required.
30107	E	If the Company writes in the non-standard market = N, then no percent is allowed.
30966	E	If company writes business in the non-standard market = Y, then explanation must not be blank.
30967	E	If company writes business in the non-standard market = N, then explanation must be blank.
30121	E	If there is no Collision (Coll) data to report, all corresponding Collision claims and suits data must be blank.
30140	E	All Underwriting data elements are required.
30141	E	Number of autos with policies in force at the end of the period must be => number of policies in force at end of period.
30142	E	If number of autos with policies in force at the end of the period > 0, then number of policies in force at end of period must be > 0.
30143	E	If number of policies in force at end of period > 0, then number of autos with policies in force at the end of the period must be > 0.
30144	W	Number of policies in force at end of period should be => number of new policies written during the period.

Rule ID	Type	Description
30145	W	If number of new policies written during the period > 0, then direct premium written during the period should be > 0.
30146	W	Direct written premium during the period should be => 50000.
30149	E	All Underwriting data elements must be => 0 except dollar amount of direct written premium during the period.
30150	E	Underwriting data elements must be provided for the Private Passenger Auto coverages you indicated your company wrote or had in-force.
30151	E	You indicated not having any PPA coverage data to report, and therefore, all corresponding underwriting activity data must be blank.
30160	E	Collision (Coll) claims closed with payment during the period = sum of Coll claims closed with payment by day range categories.
30161	E	Collision (Coll) claims closed without payment during the period = sum of Coll claims without payment by day range categories.
30162	W	Collision (Coll) suits open at the beginning of the period + Coll suits opened during the period - Coll suits closed during the period = Coll suits open at the end of the period.
30163	E	Collision (Coll) claims open at the beginning + Coll claims opened during - Coll claims closed with payment - Coll claims closed without payment must equal Coll claims open at the end of the period.
30164	W	Collision (Coll) claims closed with payment during the period should be => Coll claims closed without payment during the period.
30165	W	Collision claims median days reported on line 26 should correspond to the date range of median claim reported on questions 27-32. For additional information, please refer to the median day validation section of this User Guide.
30166	E	If there is Collision (Coll) data to report, all corresponding Collision claims and suits data must not be blank.
30221	E	If there is no Comprehensive (Comp) data to report, all corresponding Comprehensive claims and suits data must be blank!
30260	E	Comprehensive (Comp) claims closed with payment during the period = sum of Comp claims closed with payment by day range categories.
30261	E	Comprehensive (Comp) claims closed without payment during the period = sum of Comp claims without payment by day range categories.
30262	W	Comprehensive (Comp) suits open at the beginning of the period + Comp suits opened during the period - Comp suits closed during the period = Comp suits open at the end of the period.
30263	E	Comprehensive (Comp) claims open at the beginning + Comp claims opened during - Comp claims closed with payment - Comp claims closed without payment = Comp claims open at the end of the period.
30264	W	Comprehensive (Comp) claims closed with payment during the period should be => Comp claims closed without payment during the period.
30265	W	Comprehensive claims median days reported on question 26 should correspond to the date range of median claim reported on questions 27-32. For additional information, please refer to the median day validations section.
30266	E	If there is Comprehensive (Comp) data to report, all corresponding Comprehensive claims and suits data must not be blank!
30321	E	If there is no Bodily Injury (BI) data to report, all corresponding Bodily Injury claims and suits data must be blank!

Rule ID	Type	Description
30360	E	Bodily Injury (BI) claims closed with payment during the period = sum of BI claims closed with payment by day range categories.
30361	E	Bodily Injury (BI) claims closed without payment during the period = sum of BI claims without payment by day range categories.
30362	W	Bodily Injury (BI) suits open at the beginning of the period + BI suits opened during the period - BI suits closed during the period = BI suits open at the end of the period.
30363	E	Bodily Injury (BI) claims open at the beginning + BI claims opened during - BI claims closed with payment - BI claims closed without payment = BI claims open at the end of the period.
30364	W	Bodily Injury (BI) claims closed with payment during the period should be => BI claims closed without payment during the period.
30365	W	Bodily Injury claims median days reported on question 26 should correspond to the date range of median claim reported on questions 27-32. For additional information, please refer to the median day validations section.
30366	E	If there is Bodily Injury (BI) data to report, all corresponding Bodily Injury claims and suits data must not be blank!
30421	E	If there is no Property Damage (PD) data to report, all corresponding Property Damage claims and suits data must be blank!
30460	E	Property Damage (PD) claims closed with payment during the period = sum of PD claims closed with payment by day range categories.
30461	E	Property Damage (PD) claims closed without payment during the period = sum of PD claims without payment by day range categories.
30462	W	Property Damage (PD) suits open at the beginning of the period + PD suits opened during the period - PD suits closed during the period = PD suits open at the end of the period.
30463	E	Property Damage (PD) claims open at the beginning + PD claims opened during - PD claims closed with payment - PD claims closed without payment = PD claims open at the end of the period.
30464	W	Property Damage (PD) claims closed with payment during the period should be => PD claims closed without payment during the period.
30465	W	Property Damage claims median days reported on question 26 should correspond to the date range of median claim reported on question 27-32. For additional information, please refer to the median day validations section.
30466	E	If there is Property Damage (PD) data to report, all corresponding Property Damage claims and suits data must not be blank!
30521	E	If there is no UMBI data to report, all corresponding UMBI & UIMBI claims and suits data must be blank!
30560	E	UMBI claims closed with payment during the period = sum of UMBI claims closed with payment by day range categories.
30561	E	UMBI claims closed without payment during the period = sum of UMBI claims without payment by day range categories.
30562	W	UMBI suits open at the beginning of the period + UMBI suits opened during the period - UMBI suits closed during the period = UMBI suits open at the end of the period.
30563	E	UMBI claims open at the beginning + UMBI claims opened during - UMBI claims closed with payment - UMBI claims closed without payment must = UMBI claims open at the end of the period.

Rule ID	Type	Description
30564	W	UMBI claims closed with payment during the period should be => UMBI claims closed without payment during the period.
30565	W	UMBI claims median days reported on question 26 should correspond to the date range of median claim reported one questions 27-32. For additional information, please refer to the median day validations section.
30566	E	If there is UMBI data to report, all corresponding UMBI & UIMBI claims and suits data must not be blank!
30621	E	If there is no UMPD data to report, all corresponding UMPD & UIMPD claims and suits data must be blank!
30660	E	UMPD claims closed with payment during the period = sum of UMPD claims closed with payment by day range categories.
30661	E	UMPD claims closed without payment during the period = sum of UMPD claims without payment by day range categories.
30662	W	UMPD suits open at the beginning of the period + UMPD suits opened during the period - UMPD suits closed during the period = UMPD suits open at the end of the period.
30663	E	UMPD claims open at the beginning + UMPD claims opened during - UMPD claims closed with payment - UMPD claims closed without payment = UMPD claims open at the end of the period.
30664	W	UMPD claims closed with payment during the period should be => UMPD claims closed without payment during the period.
30665	W	UMPD claims median days reported on question 26 should correspond to the date range of median claim reported on questions 27-32. For additional information, please refer to the median day validations section.
30666	E	If there is UMPD data to report, all corresponding UMPD & UIMPD claims and suits data must not be blank!
30721	E	If there is no PPA Medical Payments (MP) data to report, all corresponding Medical Payments claims and suits data must be blank!
30760	E	PPA Medical Payments (MP) claims closed with payment during the period = sum of PPA MP claims closed with payment by day range categories.
30761	E	PPA Medical Payments (MP) claims closed without payment during the period = sum of PPA MP claims without payment by day range categories.
30762	W	PPA Medical Payments (MP) suits open at the beginning of the period + PPA MP suits opened during the period - PPA MP suits closed during the period = PPA MP suits open at the end of the period.
30763	E	PPA Medical Payments (MP) claims open at the beginning + PPA MP claims opened during - PPA MP claims closed with payment - PPA MP claims closed without payment = PPA MP claims open at the end of the period.
30764	W	PPA Medical Payments (MP) claims closed with payment during the period should be => PPA MP claims closed without payment during the period.
30765	W	PPA Medical Payments claims median days reported on question 26 should correspond to the date range of median claim reported on questions 27-32. For additional information, please refer to the median day validations section.
30766	E	If there is PPA Medical Payments (MP) data to report, all corresponding Medical Payments claims and suits data must not be blank!

Rule ID	Type	Description
30821	E	If there is no Combined Single Limits (CSL) data to report, all corresponding Combined Single Limits claims and suits data must be blank!
30860	E	Combined Single Limits (CSL) claims closed with payment during the period = sum of CSL claims closed with payment by day range categories.
30861	E	Combined Single Limits (CSL) claims closed without payment during the period = sum of CSL claims without payment by day range categories.
30862	W	Combined Single Limits (CSL) suits open at the beginning of the period + CSL suits opened during the period - CSL suits closed during the period = CSL suits open at the end of the period.
30863	E	Combined Single Limits (CSL) claims open at the beginning + CSL claims opened during - CSL claims closed with payment - CSL claims closed without payment = CSL claims open at the end of the period.
30864	W	Combined Single Limits (CSL) claims closed with payment during the period should be => CSL claims closed without payment during the period.
30865	W	Combined Single Limits (CSL) claims median days reported on question 26 should correspond to the date range of median claim reported on questions 27-32. For additional information, please refer to the median day validations section.
30866	E	If there is Combined Single Limits (CSL) data to report, all corresponding Combined Single Limits claims and suits data must not be blank!
30921	E	If there is no Personal Injury Protection (PIP) data to report, all corresponding Personal Injury Protection claims and suits data must be blank!
30960	E	Personal Injury Protection (PIP) claims closed with payment during the period = sum of PIP claims closed with payment by day range categories.
30961	E	Personal Injury Protection (PIP) claims closed without payment during the period = sum of PIP claims without payment by day range categories.
30962	W	Personal Injury Protection (PIP) suits open at the beginning of the period + PIP suits opened during the period - PIP suits closed during the period = PIP suits open at the end of the period.
30963	E	Personal Injury Protection (PIP) claims open at the beginning + PIP claims opened during - PIP claims closed with payment - PIP claims closed without payment must = PIP claims open at the end of the period.
30964	W	Personal Injury Protection (PIP) claims closed with payment during the period should be => PIP claims closed without payment during the period.
30965	W	Personal Injury Protection claims median days reported on question 26 should correspond to the date range of median claim reported on questions 27-32. For additional information, please refer to the median day validations section.
30968	E	If there is Personal Injury Protection (PIP) data to report, all corresponding Personal Injury Protection claims and suits data must not be blank!

Homeowners

Coverage Identifiers	Description of Coverage Identifiers
DWEL	Dwelling
PP	Personal Property
LIAB	Liability
MP	Medical Payments
LoU	Loss of Use

Rule ID	Type	Description
40002	E	Since all HO data-to-report indicators = N, do not submit HO for this state.
40101	E	If company writes business in the non-standard market = Y, then a percent of business is required.
40102	E	If company writes business in the non-standard market = N, then no percent is allowed.
40103	E	If significant event or business strategy change = Y, an explanation is required.
40104	E	If significant event or business strategy change = N, then no explanation is allowed.
40105	E	An answer is required regarding treatment of supplemental or additional payments on previously reported claims.
40106	E	If any of this business was sold, closed, or moved to another company, an explanation is required.
40107	E	If none of this business was sold, closed, or moved to another company, then no explanation is allowed.
40566	E	If company writes business in the non-standard market = Y, then explanation must not be blank.
40567	E	If company writes business in the non-standard market = N, then explanation must be blank.
40121	E	If there is no Dwelling (Dwell) data to report, all corresponding Dwelling claims and suits data must be blank.
40140	E	All Underwriting data elements are required.
40141	W	Number of dwellings with policies in force at the end of the period should be => number of dwelling policies in force at end of period.
40142	E	If number of dwellings with policies in force at the end of the period > 0, then number of policies in force at end of period must be > 0.
40143	E	If number of policies in force at end of period > 0, then number of dwellings with policies in force at the end of the period must be > 0.
40144	W	Number of policies in force at end of period should be => number of new policies written during the period.
40145	W	If number of new policies written during the period > 0, then direct premium written during the period should be > 0.
40146	W	Direct written premium during the period should be => $50,000.
40149	E	All Underwriting data elements must be => 0 except dollar amount of direct written premium during the period.
40150	E	Underwriting data elements must be provided for the homeowner's coverages you indicated your company wrote or had in-force.

Rule ID	Type	Description
40160	E	Dwelling (Dwell) claims closed with payment during the period must be = sum of Dwelling claims closed with payment by day range categories.
40161	E	Dwelling (Dwell) claims closed without payment during the period must be = sum of Dwelling claims without payment by day range categories.
40162	W	Dwelling (Dwell) suits open at the beginning of the period + Dwell suits opened during the period - Dwell suits closed during the period should be = Dwell suits open at the end of the period.
40163	E	Dwelling (Dwell) claims open at the beginning + Dwell claims opened during - Dwell claims closed with payment - Dwell claims closed without payment must be = Dwell claims open at the end of the period.
40164	W	Dwelling (Dwell) claims closed with payment during the period should be => Dwell claims closed without payment during the period.
40165	W	Dwelling claims median days reported on question 22 should correspond to the date range of median claims reported on questions 23-28. For additional information, please refer to the median day validations section.
40166	E	If there is Dwelling (Dwell) data to report, all corresponding Dwelling claims and suits data must not be blank.
40221	E	If there is no Personal Property (PP) data to report, all corresponding Personal Property claims and suits data must be blank!
40260	E	Personal Property (PP) claims closed with payment during the period must be = sum of PP claims closed with payment by day range categories.
40261	E	Personal Property (PP) claims closed without payment during the period must be = sum of PP claims without payment by day range categories.
40262	W	Personal Property (PP) suits open at the beginning of the period + PP suits opened during the period - PP suits closed during the period should be = PP suits open at the end of the period.
40263	E	Personal Property (PP) claims open at the beginning + PP claims opened during - PP claims closed with payment - PP claims closed without payment must be = PP claims open at the end of the period.
40264	W	Personal Property (PP) claims closed with payment during the period should be => PP claims closed without payment during the period.
40265	W	Personal Property claims median days reported on question 22 should correspond to the date range of median claims reported on questions 23-28. For additional information, please refer to the median day validations section.
40266	E	If there is Personal Property (PP) data to report, all corresponding Personal Property claims and suits data must not be blank!
40321	E	If there is no Liability data to report, all corresponding Liability claims and suits data must be blank!
40360	E	Liab claims closed with payment during the period = sum of Liab claims closed with payment by day range categories.
40361	E	Liab claims closed without payment during the period must be = sum of Liab claims without payment by day range categories.
40362	W	Liab suits open at the beginning of the period + Liab suits opened during the period - Liab suits closed during the period should be = Liab suits open at the end of the period.

Rule ID	Type	Description
40363	E	Liab claims open at the beginning + Liab claims opened during - Liab claims closed with payment - Liab claims closed without payment must be = Liab claims open at the end of the period.
40364	W	Liab claims closed with payment during the period should be => Liab claims closed without payment during the period.
40365	W	Liab claims median days reported on question 22 should correspond to the date range of median claims reported on questions 23-28. For additional information, please refer to the median day validations section.
40366	E	If there is Liability (Liab) data to report, all corresponding Liability claims and suits data must not be blank!
40421	E	If there is no HO Medical Payments (MP) data to report, all corresponding Medical Payments claims and suits data must be blank!
40460	E	HO Medical Payments (MP) claims closed with payment during the period must be = sum of HO MP claims closed with payment by day range categories.
40461	E	HO Medical Payments (MP) claims closed without payment during the period must be = sum of HO MP claims without payment by day range categories.
40462	W	HO Medical Payments (MP) suits open at the beginning of the period + HO MP suits opened during the period - HO MP suits closed during the period should be = HO MP suits open at the end of the period.
40463	E	HO Medical Payments (MP) claims open at the beginning + HO MP claims opened during - HO MP claims closed with payment - HO MP claims closed without payment must be = HO MP claims open at the end of the period.
40464	W	HO Medical Payments (MP) claims closed with payment during the period should be => HO MP claims closed without payment during the period.
40465	W	HO Medical Payments claims median days reported on question 22 should correspond to the date range of median claims reported on questions 23-28. For additional information, please refer to the median day validations section.
40466	E	If there is HO Medical Payments (MP) data to report, all corresponding Medical Payments claims and suits data must not be blank!
40521	E	If there is no Loss of Use (LoU) data to report, all corresponding Loss of Use claims and suits data must not be blank!
40560	E	HO Loss of Use (LoU) claims closed with payment during the period must be = sum of HO Loss of Use claims closed with payment by day range categories.
40561	E	HO Loss of Use (LOU) claims closed without payment during the period must be = sum of HO LOU claims without payment by day range categories.
40562	W	HO Loss of Use (LOU) suits open at the beginning of the period + HO LOU suits opened during the period - HO LOU suits closed during the period should be = HO LOU suits open at the end of the period.
40563	E	HO Loss of Use (LOU) claims open at the beginning + HO LOU claims opened during - HO LOU claims closed with payment - HO LOU claims closed without payment = HO LOU claims open at the end of the period.

Rule ID	Type	Description
40564	W	HO Loss of Use (LOU) claims closed with payment during the period should be => HO LOU claims closed without payment during the period.
40565	W	HO Loss of Use claims median days reported on question 22 should correspond to the date range of median claims reported on questions 23-28. For additional information, please refer to the median day validations section.
40568	E	If there is HO Medical Payments (MP) data to report, all corresponding Loss of Use claims and suits data must not be blank!

Long-Term Care

Coverage Identifiers	Description of Coverage Identifiers
SLTC	Stand-Alone LTC
LHLTC	Life LTC Hybrid
AHLTC	Annuity LTC Hybrid

Rule ID	Type	Description
50002	E	Since all LTC data-to-report indicators = N, do not submit LTC for this state.
50102	E	If there is no Stand-Alone LTC (SLTC) data to report, the response whether the company had any significant event or business strategy change question for SLTC must also be 'No'.
50103	E	If the company had a significant event or business strategy change that would affect the Stand-Alone LTC (SLTC) data for this reporting period, then comments are required on the explanation field.
50104	E	If the company did not have any significant event or business strategy change that would affect the Stand-Alone LTC (SLTC) data for this reporting period, then the explanation field must be blank.
50105	E	The explanation field must not be blank if you had any Stand-Alone LTC business that was sold, closed, or moved to another company.
50106	E	The explanation field must be blank if you did not have any Stand-Alone LTC business that was sold, closed, or moved to another company.
50121	E	If there is no Stand-Alone LTC (SLTC) data to report, all corresponding SLTC data elements must be blank!
50122	E	If there is Stand-Alone LTC (SLTC) data to report, all corresponding Stand-Alone LTC data must not be blank!
50140	W	Stand-Alone LTC (SLTC) policies in force at beginning of the period + SLTC policies issued during the period - SLTC cancellations, lapses & rescissions during the period should be within 20% of SLTC policies in force at end of period.
50150	E	Number of Stand-Alone LTC pending claimant request determinations at beginning of period + number of new claimants during the period - all claimant requests denied, not paid, or closed without payment during the period must be => number of pending claimant requests determinations at end of period.
50151	W	The number of Stand-Alone LTC claimant requests denied, not paid, or closed without payment during the period should be less than half of the total determinations.
50160	E	Number of Stand-Alone LTC (SLTC) benefit payment requests pending at beginning of period + number of SLTC benefit payment requests received during the period must be => number of SLTC benefit payment requests denied or not paid during the period.

Rule ID	Type	Description
50161	E	Number of Stand-Alone LTC (SLTC) benefit payment requests pending at beginning of period + number of SLTC benefit payment requests received during the period - number of SLTC denied or not paid benefit payment requests during the period must be => number of SLTC pending benefit payment requests at end of period.
50162	E	Number of Stand-Alone LTC (SLTC) benefit payment requests denied or not paid within 30, 60, 90 and beyond 90 days must be = number of SLTC benefit payment requests denied or not paid during the period.
50170	E	Number of Stand-Alone LTC (SLTC) lawsuits open + number of SLTC lawsuits opened during the period - number of SLTC lawsuits closed during the period must be = number of SLTC lawsuits open at end of period.
50171	W	Number of Stand-Alone LTC (SLTC) lawsuits closed during the period should be => number of SLTC lawsuits closed during the period with consideration for the consumer.
50202	E	If there is no Life LTC Hybrid (LHLTC) data to report, the significant event or business strategy change question for LHLTC must be 'N'.
50203	E	If the company had a significant event or business strategy change that would affect the Life LTC Hybrid (LHLTC) data for this reporting period, then comments are required on the explanation field.
50204	E	If the company did not have any significant event or business strategy change that would affect the Life LTC Hybrid (LHLTC) data for this reporting period, then the explanation field must be blank.
50205	E	The explanation field must not be blank if you had any Life Hybrid LTC business that was sold, closed, or moved to another company.
50206	E	The explanation field must be blank if you did not have any Life Hybrid LTC business that was sold, closed, or moved to another company.
50221	E	If there is no Life LTC Hybrid (LHLTC) data to report, all LHLTC data elements must be blank.
50222	E	If there is Life LTC Hybrid (LHLTC) data to report, all corresponding Life Hybrid LTC data must not be blank!
50240	W	Life LTC Hybrid (LHLTC) policies in force at beginning of the period + LHLTC policies issued during the period - LHLTC cancellations, lapses & rescissions during the period should be within 20% of LHLTC policies in force at end of period.
50241	E	Life LTC Hybrid (LHLTC) internal + external replacements must be = sum of LHLTC replacements by age group.
50250	E	Number of Life LTC Hybrid pending claimant request determinations at beginning of period + number of new claimants during the period - all claimant requests denied, not paid, or closed without payment during the period must be => number of pending claimant requests determinations at end of period.
50251	W	The number of Life LTC Hybrid claimant requests denied, not paid, or closed without payment during the period should be less than half of the total determinations.
50260	E	Number of Life LTC Hybrid (LHLTC) benefit payment requests pending at beginning of period + number of LHLTC benefit payment requests received during the period must be => number of LHLTC benefit payment requests denied or not paid during the period.

Rule ID	Type	Description
50261	E	Number of Life LTC Hybrid (LHLTC) benefit payment requests pending at beginning of period + number of LHLTC benefit payment requests received during the period - number of LHLTC denied or not paid benefit payment requests during the period must be => number of LHLTC pending benefit payment requests at end of period.
50262	E	Number of Life LTC Hybrid (LHLTC) benefit payment requests denied or not paid within 30, 60, 90 and beyond 90 days must be = number of LHLTC benefit payment requests denied or not paid during the period.
50270	E	Number of Life LTC Hybrid (LHLTC) lawsuits open + number of LHLTC lawsuits opened during the period - number of LHLTC lawsuits closed during the period must be = number of LHLTC lawsuits open at end of period.
50271	W	Number of Life LTC Hybrid (LHLTC) lawsuits closed during the period should be => number of LHLTC lawsuits closed during the period with consideration for the consumer.
50302	E	If there is no Annuity LTC Hybrid (AHLTC) data to report, the significant event or business strategy change question for AHLTC must be N.
50303	E	If the company had a significant event or business strategy change that would affect the Annuity LTC Hybrid (AHLTC) data for this reporting period, then comments are required on the explanation field.
50304	E	If the company did not have any significant event or business strategy change that would affect the Annuity LTC Hybrid (AHLTC) data for this reporting period, then the explanation field must be blank.
50305	E	The explanation field must not be blank if you had any Annuity LTC Hybrid business that was sold, closed, or moved to another company.
50306	E	The explanation field must be blank if you did not have any Annuity Hybrid LTC business that was sold, closed, or moved to another company.
50321	E	If there is no Annuity LTC Hybrid (AHLTC) data to report, all AHLTC data elements must be blank.
50322	E	If there is no Annuity LTC Hybrid (AHLTC) data to report, all corresponding Annuity LTC Hybrid data must not be blank!
50340	W	Annuity LTC Hybrid (AHLTC) policies in force at beginning of the period + AHLTC policies issued during the period - AHLTC cancellations, lapses & rescissions during the period should be within 20% of AHLTC policies in force at end of period.
50341	E	Annuity LTC Hybrid (AHLTC) internal + external replacements must be = sum of AHLTC replacements by age group.
50350	E	Number of Annuity LTC Hybrid pending claimant request determinations at beginning of period + number of new claimants during the period - all claimant requests denied, not paid, or closed without payment during the period must be => number of pending claimant requests determinations at end of period.
50351	W	The number of Annuity LTC Hybrid claimant requests denied, not paid, or closed without payment during the period should be less than half of the total determinations.

Rule ID	Type	Description
50360	E	Number of Annuity LTC Hybrid (AHLTC) benefit payment requests pending at beginning of period + number of AHLTC benefit payment requests received during the period must be => number of AHLTC benefit payment requests denied or not paid during the period.
50361	E	Number of Annuity LTC Hybrid (AHLTC) benefit payment requests pending at beginning of period + number of AHLTC benefit payment requests received during the period - number of AHLTC denied or not paid benefit payment requests during the period must be => number of AHLTC pending benefit payment requests at end of period.

Health

Coverage Identifiers	Description of Coverage Identifiers
IEX	In-Exchange
IEIH	In-Exchange: Individual Health
IESG	In-Exchange: Small Group Health
IECA	In-Exchange: Catastrophic
IEMI	In-Exchange: Multi-State – Individual
IEMS	In-Exchange: Multi-State – Small Group
OEX	Out-of-Exchange
OEIH	Out-of-Exchange: Individual Health
OESG	Out-of-Exchange: Small Group Health
OEGT	Out-of-Exchange: Grandfathered/Transitional Plans
OECA	Out-of-Exchange: Catastrophic
OELG	Out-of-Exchange: Large Group
OESP	Out-of-Exchange: Student Plans

Rule ID	Type	Description
60001	E	Responses to all MCAS Interrogatory questions must not be blank!
60002	E	If you indicated that your company does not have any health insurance data to report, then no MCAS Health Filing is required.
60003	E	If the company has Small Group or Multi-State Small Group data to report, then the number of small groups (Question 6) in-force at the end of the reporting period must not be blank!
60004	E	If the company does not have Small Group or Multi-State Small Group data to report, then the number of small groups (Item 6) in-force at the end of the reporting period must be blank!
60007	E	OESG: If the company has any Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report, then the number of small groups must not be blank.
60008	E	OESG: If the company does not have any Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report, then the number of small groups must be blank.
60009	E	OELG: If the company has any Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then the number of large groups must not be blank.
60010	E	OELG: If the company does not have any Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then the number of large groups must be blank.
61101	E	IEIH-Bronze: If the company has In-Exchange Individual Health insurance (IEIH) Bronze plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all IEIH-Bronze data elements must be reported.

Rule ID	Type	Description
61102	E	IEIH-Bronze: If the company does not have In-Exchange Individual Health insurance (IEIH) Bronze plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all IEIH-Bronze data elements.
61104	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
61105	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61106	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61107	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61108	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61110	W	IEIH-Bronze: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Bronze health plans, the total policies issued, and policies renewed for IEIH-Bronze should be greater than zero.
61111	W	IEIH-Bronze: If the company reported new policies issued greater than zero for In-Exchange Individual Health Bronze health plans, the member months for policies issued for IEIH-Bronze should be greater than zero.
61112	W	IEIH-Bronze: If the company reported policies renewed greater than zero for In-Exchange Individual Health Bronze health plans, the member months for policies renewed for IEIH-Bronze should be greater than zero.
61113	W	IEIH-Bronze: If the company reported terminations and cancellations initiated by the policyholder greater than zero for In-Exchange Individual Health Bronze health plans, the number of lives impacted on terminations and cancellations initiated by the policyholder for IEIH-Bronze should be greater than zero.
61114	W	IEIH-Bronze: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Individual Health Bronze health plans, the number of lives impacted on terminations and cancellations due to non-payment of premium for IEIH-Bronze should be greater than zero.
61117	W	IEIH-Bronze: For In-Exchange Individual Health Bronze health plans, the number of claims paid for IEIH-Bronze should be greater than the number of claims denied.

Rule ID	Type	Description
61119	W	IEIH-Bronze: For In-Exchange Individual Health Bronze health plans, the number of claims submitted by network providers for IEIH-Bronze should be greater than the number of claims submitted by out-of-network providers.
61121	W	IEIH-Bronze: For In-Exchange Individual Health Bronze health plans, the total amount of claims paid for IEIH-Bronze should be less than the reported Earned Premiums.
61122	W	IEIH-Bronze: For In-Exchange Individual Health Bronze health plans, the number of adverse determinations upheld for IEIH-Bronze should be greater than the number of adverse determinations overturned for grievances involving adverse determinations (excluding voluntary levels of reviews).
61129	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
61130	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
61201	E	IEIH-Silver: If the company has In-Exchange Individual Health insurance (IEIH) Silver plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all IEIH-Silver data elements must be reported.
61202	E	IEIH-Silver: If the company does not have In-Exchange Individual Health insurance (IEIH) Silver plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all IEIH-Silver data elements.
61204	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
61205	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61206	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61207	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

Rule ID	Type	Description
61208	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61210	W	IEIH-Silver: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Silver health plans, the total policies issued, and policies renewed for IEIH-Silver should be greater than zero.
61211	W	IEIH-Silver: If the company reported new policies issued greater than zero for In-Exchange Individual Health Silver health plans, the member months for policies issued for IEIH-Silver should be greater than zero.
61212	W	IEIH-Silver: If the company reported policies renewed greater than zero for In-Exchange Individual Health Silver health plans, then the member months for policies renewed for IEIH-Silver should be greater than zero.
61213	W	IEIH-Silver: For In-Exchange Individual Health Silver health plans, the number of lives impacted on terminations and cancellations initiated by the policyholder for IEIH-Silver should be greater than zero for terminations and cancellations initiated by consumer greater than zero.
61214	W	IEIH-Silver: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Individual Health Silver health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEIH-Silver should be greater than zero.
61217	W	IEIH-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Silver health plans, then the number of claims paid for IEIH-Silver should be greater than the number of claims denied.
61219	W	IEIH-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Silver health plans, then the number of claims submitted by network providers for IEIH-Silver should be greater than the number of claims submitted by out-of-network providers.
61221	W	IEIH-Silver: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Silver health plans, then the total amount of claims paid for IEIH-Silver should be less than the reported Earned Premiums.
61222	W	IEIH-Silver: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Individual Health Silver health plans, then the number of adverse determinations upheld for IEIH-Silver should be greater than the number of adverse determinations overturned.
61229	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.

Rule ID	Type	Description
61230	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
61301	E	IEIH-Gold: If the company has In-Exchange Individual Health insurance (IEIH) Gold plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all IEIH-Gold data elements must be reported.
61302	E	IEIH-Gold: If the company does not have In-Exchange Individual Health insurance (IEIH) Gold plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all IEIH-Gold data elements.
61304	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
61305	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61306	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61307	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61308	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61310	W	IEIH-Gold: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Gold health plans, then the total policies issued, and policies renewed for IEIH-Gold should be greater than zero.
61311	W	IEIH-Gold: If the company reported new policies issued greater than zero for In-Exchange Individual Health Gold health plans, then the member months for policies issued for IEIH-Gold should be greater than zero.
61312	W	IEIH-Gold: If the company reported policies renewed greater than zero for In-Exchange Individual Health Gold health plans, then the member months for policies renewed for IEIH-Gold should be greater than zero.
61313	W	IEIH-Gold: If the company reported terminations and cancellations initiated by consumer greater than zero for In-Exchange Individual Health Gold health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEIH-Gold should be greater than zero.

Rule ID	Type	Description
61314	W	IEIH-Gold: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Individual Health Gold health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEIH-Gold should be greater than zero.
61317	W	IEIH-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Gold health plans, then the number of claims paid for IEIH-Gold should be greater than the number of claims denied.
61319	W	IEIH-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Gold health plans, then the number of claims submitted by network providers for IEIH-Gold should be greater than the number of claims submitted by out-of-network providers.
61321	W	IEIH-Gold: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Gold health plans, then the total amount of claims paid for IEIH-Gold should be less than the reported Earned Premiums.
61322	W	IEIH-Gold: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Individual Health Gold health plans, then the number of adverse determinations upheld for IEIH-Gold should be greater than the number of adverse determinations overturned.
61329	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
61330	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
61401	E	IEIH-Platinum: If the company has In-Exchange Individual Health insurance (IEIH) Platinum plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all IEIH-Platinum data elements must be reported.
61402	E	IEIH-Platinum: If the company does not have In-Exchange Individual Health insurance (IEIH) Platinum plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all IEIH-Platinum data elements.
61404	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of claims (excluding pharmacy claims) received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.

Rule ID	Type	Description
61405	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61406	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61407	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61408	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61410	W	IEIH-Platinum: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Platinum health plans, then the total policies issued, and policies renewed for IEIH-Platinum should be greater than zero.
61411	W	IEIH-Platinum: If the company reported new policies issued greater than zero for In-Exchange Individual Health Platinum health plans, then the member months for policies issued for IEIH-Platinum should be greater than zero.
61412	W	IEIH-Platinum: If the company reported policies renewed greater than zero for In-Exchange Individual Health Platinum health plans, then the member months for policies renewed for IEIH-Platinum should be greater than zero.
61413	W	IEIH-Platinum: If the company reported terminations and cancellations initiated by consumer greater than zero for In-Exchange Individual Health Platinum health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEIH-Platinum should be greater than zero.
61414	W	IEIH-Platinum: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Individual Health Platinum health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEIH-Platinum should be greater than zero.
61417	W	IEIH-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Platinum health plans, then the number of claims paid for IEIH-Platinum should be greater than the number of claims denied.
61419	W	IEIH-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Platinum health plans, then the number of claims submitted by network providers for IEIH-Platinum should be greater than the number of claims submitted by out-of-network providers.

Rule ID	Type	Description
61421	W	IEIH-Platinum: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Platinum health plans, then the total amount of claims paid for IEIH-Platinum should be less than the reported Earned Premiums.
61422	W	IEIH-Platinum: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Individual Health Platinum health plans, then the number of adverse determinations upheld for IEIH-Platinum should be greater than the number of adverse determinations overturned.
61429	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
61430	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
61501	E	IEIH-Total: If the company has In-Exchange Individual Health insurance (IEIH) plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all IEIH-Total data elements must be reported.
61502	E	IEIH-Total: If the company does not have In-Exchange Individual Health insurance (IEIH) plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all IEIH-Total data elements.
61504	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
61505	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61506	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61507	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

Rule ID	Type	Description
61508	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61510	W	IEIH-Total: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Total health plans, then the total policies issued, and policies renewed for IEIH-Total should be greater than zero.
61511	W	IEIH-Total: If the company reported new policies issued greater than zero for In-Exchange Individual Health Total health plans, then the member months for policies issued for IEIH-Total should be greater than zero.
61512	W	IEIH-Total: If the company reported policies renewed greater than zero for In-Exchange Individual Health Total health plans, then the member months for policies renewed for IEIH-Total should be greater than zero.
61513	W	IEIH-Total: If the company reported terminations and cancellations initiated by consumer greater than zero for In-Exchange Individual Health Total health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEIH-Total should be greater than zero.
61514	W	IEIH-Total: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Individual Health Total health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEIH-Total should be greater than zero.
61515	W	IEIH-Total: If the company reported rescissions greater than zero for In-Exchange Individual Health Total health plans, then the number of lives impacted by rescissions for IEIH-Total should be greater than zero.
61516	W	IEIH-Total: If the company reported prior authorizations requested greater than zero for In-Exchange Individual Health Total health plans, then the number of prior authorizations approved for IEIH-Total should be greater than the number of prior authorizations denied.
61517	W	IEIH-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Total health plans, then the number of claims paid for IEIH-Total should be greater than the number of claims denied.
61518	W	IEIH-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Individual Health Total health plans, then the number of claims paid for IEIH-Total should be greater than the number of claims denied.
61519	W	IEIH-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Total health plans, then the number of claims submitted by network providers for IEIH-Total should be greater than the number of claims submitted by out-of-network providers.
61520	W	IEIH-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Individual Health Total health plans, then the number of claims paid for in-network services for IEIH-Total should be greater than the number of claims paid for out-of-network services.

Rule ID	Type	Description
61521	W	IEIH-Total: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Total health plans, then the total amount of claims paid for IEIH-Total should be less than the reported Earned Premiums.
61522	W	IEIH-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Individual Health Total health plans, then the number of adverse determinations upheld for IEIH-Total should be greater than the number of adverse determinations overturned.
61523	W	IEIH-Total: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for In-Exchange Individual Health Total health plans, then the number of final adverse determinations upheld for IEIH-Total should be greater than the number of final adverse determinations overturned.
61524	W	IEIH-Total: For In-Exchange Individual Health plans, the number of prior authorizations (excluding pharmacy-only) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) requested.
61525	W	IEIH-Total: For In-Exchange Individual Health plans, the number of prior authorizations (excluding pharmacy-only) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) denied.
61526	W	IEIH-Total: For In-Exchange Individual Health plans, the number of prior authorizations (excluding pharmacy-only) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) approved.
61529	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
61530	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
61601	E	IEIH: The sum of earned premiums reported for bronze, silver, gold and platinum coverages must equal the total earned premiums for in-exchange individual health insurance coverage for reporting year.

Rule ID	Type	Description
61602	E	IEIH: The sum of number of new policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of new policies issued for in-exchange individual health insurance coverage during the period.
61603	E	IEIH: The sum of number of policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policies renewed for in-exchange individual health insurance coverage during the period.
61604	E	IEIH: The sum of member months for policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of member months for policies issued for in-exchange individual health insurance coverage during the period.
61605	E	IEIH: The sum of member months for policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of member months for policies renewed for in-exchange individual health insurance coverage during the period.
61606	E	IEIH: The sum of number of policy terminations and cancellations initiated by consumer reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations initiated by consumer reported for in-exchange individual health insurance coverage during the period.
61607	E	IEIH: The sum of number of policy terminations and cancellations due to non-payment of premium reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations due to non-payment of premium for in-exchange individual health insurance coverage during the period.
61608	E	IEIH: The sum of number of lives impacted on terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on terminations and cancellations initiated by the policyholder for in-exchange individual health insurance coverage during the period.
61609	E	IEIH: The sum of number of lives impacted on policies terminated and cancelled due to non-payment reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on policies terminated and cancelled due to non-payment reported for in-exchange individual health insurance coverage during the period.
61611	E	IEIH: The sum of number of lives impacted by rescissions reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted by rescissions reported for in-exchange individual health insurance coverage during the period.
61615	E	IEIH: The sum of number of claims received (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total number of claims received reported for in-exchange individual health insurance coverage during the period.
61616	E	IEIH: The sum of number of claims submitted (excluding pharmacy claims) by network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by network providers reported for in-exchange individual health insurance coverage during the period.

Rule ID	Type	Description
61617	E	IEIH: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by out-of-network providers reported for in-exchange individual health insurance coverage during the period.
61618	E	IEIH: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for in-network claims reported for in-exchange individual health insurance coverage during the period.
61619	E	IEIH: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number in-network claims denied within 0-30 days reported for in-exchange individual health insurance coverage during the period.
61620	E	IEIH: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 31-60 days reported for in-exchange individual health insurance coverage during the period.
61621	E	IEIH: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 61-90 days reported for in-exchange individual health insurance coverage during the period.
61622	E	IEIH: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied beyond 90 days reported for in-exchange individual health insurance coverage during the period.
61623	E	IEIH: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for out-of-network claims reported for in-exchange individual health insurance coverage during the period.
61624	E	IEIH: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 0-30 days reported for in-exchange individual health insurance coverage during the period.
61625	E	IEIH: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 31-60 days reported for in-exchange individual health insurance coverage during the period.
61626	E	IEIH: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 61-90 days reported for in-exchange individual health insurance coverage during the period.

Rule ID	Type	Description
61627	E	IEIH: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied beyond 90 days reported for in-exchange individual health insurance coverage during the period.
61628	E	IEIH: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for in-network services reported for in-exchange individual health insurance coverage during the period.
61629	E	IEIH: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 0-30 days reported for in-exchange individual health insurance coverage during the period.
61630	E	IEIH: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 31-60 days reported for in-exchange individual health insurance coverage during the period.
61631	E	IEIH: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 61-90 days reported for in-exchange individual health insurance coverage during the period.
61632	E	IEIH: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid beyond 90 days reported for in-exchange individual health insurance coverage during the period.
61633	E	IEIH: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for out-of-network services reported for in-exchange individual health insurance coverage during the period.
61634	E	IEIH: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 0-30 days reported for in-exchange individual health insurance coverage during the period.
61635	E	IEIH: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 31-60 days reported for in-exchange individual health insurance coverage during the period.
61636	E	IEIH: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 61-90 days reported for in-exchange individual health insurance coverage during the period.

Rule ID	Type	Description
61637	E	IEIH: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid beyond 90 days reported for in-exchange individual health insurance coverage during the period.
61638	E	IEIH: The sum of claims paid reported for bronze, silver, gold and platinum coverages must equal the total claims paid (excluding pharmacy claims) reported for in-exchange individual health insurance coverage during the period.
61639	E	IEIH: The sum of insured/beneficiary co-payment responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured/beneficiary co-payment responsibility amount reported for in-exchange individual health insurance coverage during the period.
61640	E	IEIH: The sum of insured coinsurance responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured coinsurance responsibility reported for in-exchange individual health insurance coverage during the period.
61641	E	IEIH: The sum of insured deductible responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured deductible responsibility reported for in-exchange individual health insurance coverage during the period.
61642	E	IEIH: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange individual health insurance coverage during the period.
61643	E	IEIH: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for in-exchange individual health insurance coverage during the period.
61644	E	IEIH: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange individual health insurance coverage during the period.
61645	E	IEIH: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange individual health insurance coverage during the period.
61646	E	IEIH: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange individual health insurance coverage during the period.

Rule ID	Type	Description
61647	E	IEIH: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange individual health insurance coverage during the period.
61648	E	IEIH: The sum of out-of-network claims denied, rejected or returned for lacking Prior Authorization reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for needing Prior Authorization for in-exchange individual health insurance coverage during the period.
61649	E	IEIH: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange individual health insurance coverage during the period.
61650	E	IEIH: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange individual health insurance coverage during the period.
61651	E	IEIH: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange individual health insurance coverage during the period.
61652	E	IEIH: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for in-exchange individual health insurance coverage during the period.
61653	E	IEIH: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for in-exchange individual health insurance coverage during the period.
61654	E	IEIH: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for in-exchange individual health insurance coverage during the period.
61655	E	IEIH: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for in-exchange individual health insurance coverage during the period.

Rule ID	Type	Description
62101	E	IESG-Bronze: If the company has In-Exchange Small Group Health insurance (IESG) Bronze plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all IESG-Bronze data elements must be reported.
62102	E	IESG-Bronze: If the company does not have In-Exchange Small Group Health insurance (IESG) Bronze plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all IESG-Bronze data elements.
62104	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of claims (excluding pharmacy claims) received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
62105	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62106	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62107	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62108	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62117	W	IESG-Bronze: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Bronze health plans, then the number of claims paid for IESG-Bronze should be greater than the number of claims denied.
62119	W	IESG-Bronze: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Bronze health plans, then the number of claims submitted by network providers for IESG-Bronze should be greater than the number of claims submitted by out-of-network providers.
62121	W	IESG-Bronze: If the company reported Earned Premiums greater than zero for In-Exchange Small Group Health Bronze health plans, then the total amount of claims paid for IESG-Bronze should be less than the reported Earned Premiums.
62122	W	IESG-Bronze: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Small Group Health Bronze health plans, then the number of adverse determinations upheld for IESG-Bronze should be greater than the number of adverse determinations overturned.

Rule ID	Type	Description
62129	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
62130	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
62201	E	IESG-Silver: If the company has In-Exchange Small Group Health insurance (IESG) Silver plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all IESG-Silver data elements must be reported.
62202	E	IESG-Silver: If the company does not have In-Exchange Small Group Health insurance (IESG) Silver coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all IESG-Silver data elements.
62204	E	IESG-Silver: For In-Exchange Silver Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
62205	E	IESG-Silver: For In-Exchange Silver Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62206	E	IESG-Silver: For In-Exchange Silver Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62207	E	IESG-Silver: For In-Exchange Silver Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62208	E	IESG-Silver: For In-Exchange Silver Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62217	W	IESG-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Silver health plans, then the number of claims paid for IESG-Silver should be greater than the number of claims denied.

Rule ID	Type	Description
62219	W	IESG-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Silver health plans, then the number of claims submitted by network providers for IESG-Silver should be greater than the number of claims submitted by out-of-network providers.
62221	W	IESG-Silver: If the company reported Earned Premiums greater than zero for In-Exchange Small Group Health Silver health plans, then the total amount of claims paid for IESG-Silver should be less than the reported Earned Premiums.
62222	W	IESG-Silver: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Small Group Health Silver health plans, then the number of adverse determinations upheld for IESG-Silver should be greater than the number of adverse determinations overturned.
62229	E	IESG-Silver: For In-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
62230	E	IESG-Silver: For In-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
62301	E	IESG-Gold: If the company has In-Exchange Small Group Health insurance (IESG) Gold plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all IESG-Gold data elements must be reported.
62302	E	IESG-Gold: If the company does not have In-Exchange Small Group Health insurance (IESG) Gold plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all IESG-Gold data elements.
62304	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
62305	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62306	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

Rule ID	Type	Description
62307	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62308	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62317	W	IESG-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Gold health plans, then the number of claims paid for IESG-Gold should be greater than the number of claims denied.
62319	W	IESG-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Gold health plans, then the number of claims submitted by network providers for IESG-Gold should be greater than the number of claims submitted by out-of-network providers.
62321	W	IESG-Gold: If the company reported Earned Premiums greater than zero for In-Exchange Small Group Health Gold health plans, then the total amount of claims paid for IESG-Gold should be less than the reported Earned Premiums.
62322	W	IESG-Gold: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Small Group Health Gold health plans, then the number of adverse determinations upheld for IESG-Gold should be greater than the number of adverse determinations overturned.
62329	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
62330	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
62401	E	IESG-Platinum: If the company has In-Exchange Small Group Health insurance (IESG) Platinum plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all IESG-Platinum data elements must be reported.
62402	E	IESG-Platinum: If the company does not have In-Exchange Small Group Health insurance (IESG) Platinum plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all IESG-Platinum data elements.

Rule ID	Type	Description
62404	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
62405	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62406	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62407	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62408	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62417	W	IESG-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Platinum health plans, then the number of claims paid for IESG-Platinum should be greater than the number of claims denied.
62419	W	IESG-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Platinum health plans, then the number of claims submitted by network providers for IESG-Platinum should be greater than the number of claims submitted by out-of-network providers.
62421	W	IESG-Platinum: If the company reported Earned Premiums greater than zero for In-Exchange Small Group Health Platinum health plans, then the total amount of claims paid for IESG-Platinum should be less than the reported Earned Premiums.
62422	W	IESG-Platinum: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Small Group Health Platinum health plans, then the number of adverse determinations upheld for IESG-Platinum should be greater than the number of adverse determinations overturned.
62429	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.

Rule ID	Type	Description
62430	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
62501	E	IESG-Total: If the company has In-Exchange Small Group Health insurance (IESG) plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all IESG-Total data elements must be reported.
62502	E	IESG-Total: If the company does not have In-Exchange Small Group Health insurance (IESG) plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all IESG-Total data elements.
62504	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
62505	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62506	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62507	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62508	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62515	W	IESG-Total: If the company reported rescissions greater than zero for In-Exchange Small Group Health Total health plans, then the number of lives impacted by rescissions for IESG-Total should be greater than zero.
62516	W	IESG-Total: If the company reported non-pharmacy prior authorizations requested greater than zero for In-Exchange Small Group Health Total health plans, then the number of prior authorizations approved for IESG-Total should be greater than the number of prior authorizations denied.
62517	W	IESG-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Total health plans, then the number of claims paid for IESG-Total should be greater than the number of claims denied.
62518	W	IESG-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Small Group Health Total health plans, then the number of claims paid for IESG-Total should be greater than the number of claims denied.

Rule ID	Type	Description
62519	W	IESG-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Total health plans, then the number of claims submitted by network providers for IESG-Total should be greater than the number of claims submitted by out-of-network providers.
62520	W	IESG-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Small Group Health Total health plans, then the number of claims paid for in-network services for IESG-Total should be greater than the number of claims paid for out-of-network services.
62521	W	IESG-Total: If the company reported Earned Premiums greater than zero for In-Exchange Small Group Health Total health plans, then the total amount of claims paid for IESG-Total should be less than the reported Earned Premiums.
62522	W	IESG-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Small Group Health Total health plans, then the number of adverse determinations upheld for IESG-Total should be greater than the number of adverse determinations overturned.
62523	W	IESG-Total: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for In-Exchange Small Group Health Total health plans, then the number of final adverse determinations upheld for IESG-Total should be greater than the number of final adverse determinations overturned.
62524	W	IESG-Total: For In-Exchange Small Group Health plans, the number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders should be less than or equal to the total number of prior authorizations (excluding pharmacy) requested.
62525	W	IESG-Total: For In-Exchange Small Group Health plans, the number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
62526	W	IESG-Total: For In-Exchange Small Group Health plans, the number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
62529	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.

Rule ID	Type	Description
62530	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
62601	E	IESG: The sum of earned premiums reported for bronze, silver, gold and platinum coverages must equal the total earned premiums for in-exchange Small Group Health insurance coverage for reporting year.
62604	E	IESG: The sum of member months for policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of member months for policies issued for in-exchange Small Group Health insurance coverage during the period.
62605	E	IESG: The sum of policy terminations and cancellations for policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies renewed for in-exchange Small Group Health insurance coverage during the period.
62608	E	IESG: The sum of number of lives impacted on terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on terminations and cancellations initiated by the policyholder for in-exchange Small Group Health insurance coverage during the period.
62609	E	IESG: The sum of number of lives impacted on policies terminated and cancelled due to non-payment reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on policies terminated and cancelled due to non-payment reported for in-exchange Small Group Health insurance coverage during the period.
62611	E	IESG: The sum of number of lives impacted by rescissions reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted by rescissions reported for in-exchange Small Group Health insurance coverage during the period.
62615	E	IESG: The sum of number of claims received (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total number of claims received reported for in-exchange Small Group Health insurance coverage during the period.
62616	E	IESG: The sum of number of claims submitted (excluding pharmacy claims) by network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by network providers reported for in-exchange Small Group Health insurance coverage during the period.
62617	E	IESG: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted for by out-of-network providers reported for in-exchange Small Group Health insurance coverage during the period.

Rule ID	Type	Description
62618	E	IESG: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for in-network claims reported for in-exchange Small Group Health insurance coverage during the period.
62619	E	IESG: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number in-network claims denied within 0-30 days reported for in-exchange Small Group Health insurance coverage during the period.
62620	E	IESG: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 31-60 days reported for in-exchange Small Group Health insurance coverage during the period.
62621	E	IESG: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 61-90 days reported for in-exchange Small Group Health insurance coverage during the period.
62622	E	IESG: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied beyond 90 days reported for in-exchange Small Group Health insurance coverage during the period.
62623	E	IESG: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for out-of-network claims reported for in-exchange Small Group Health insurance coverage during the period.
62624	E	IESG: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 0-30 days reported for in-exchange Small Group Health insurance coverage during the period.
62625	E	IESG: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 31-60 days reported for in-exchange Small Group Health insurance coverage during the period.
62626	E	IESG: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 61-90 days reported for in-exchange Small Group Health insurance coverage during the period.
62627	E	IESG: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied beyond 90 days reported for in-exchange Small Group Health insurance coverage during the period.

Rule ID	Type	Description
62628	E	IESG: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for in-network services reported for in-exchange Small Group Health insurance coverage during the period.
62629	E	IESG: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 0-30 days reported for in-exchange Small Group Health insurance coverage during the period.
62630	E	IESG: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 31-60 days reported for in-exchange Small Group Health insurance coverage during the period.
62631	E	IESG: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 61-90 days reported for in-exchange Small Group Health insurance coverage during the period.
62632	E	IESG: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid beyond 90 days reported for in-exchange Small Group Health insurance coverage during the period.
62633	E	IESG: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for out-of-network services reported for in-exchange Small Group Health insurance coverage during the period.
62634	E	IESG: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 0-30 days reported for in-exchange Small Group Health insurance coverage during the period.
62635	E	IESG: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 31-60 days reported for in-exchange Small Group Health insurance coverage during the period.
62636	E	IESG: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 61-90 days reported for in-exchange Small Group Health insurance coverage during the period.
62637	E	IESG: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid beyond 90 days reported for in-exchange Small Group Health insurance coverage during the period.

Rule ID	Type	Description
62638	E	IESG: The sum of claims paid (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total claims paid reported for in-exchange Small Group Health insurance coverage during the period.
62639	E	IESG: The sum of insured/beneficiary co-payment responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured/beneficiary co-payment responsibility amount reported for in-exchange Small Group Health insurance coverage during the period.
62640	E	IESG: The sum of insured coinsurance responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured coinsurance responsibility reported for in-exchange Small Group Health insurance coverage during the period.
62641	E	IESG: The sum of insured deductible responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured deductible responsibility reported for in-exchange Small Group Health insurance coverage during the period.
62642	E	IESG: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange small group health insurance coverage during the period.
62643	E	IESG: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for in-exchange small group health insurance coverage during the period.
62644	E	IESG: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange small group health insurance coverage during the period.
62645	E	IESG: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange small group health insurance coverage during the period.
62646	E	IESG: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange small group health insurance coverage during the period.
62647	E	IESG: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange small group health insurance coverage during the period.

Rule ID	Type	Description
62648	E	IESG: The sum of out-of-network claims denied, rejected or returned for lacking Prior Authorization reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for needing Prior Authorization for in-exchange small group health insurance coverage during the period.
62649	E	IESG: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange individual health insurance coverage during the period.
62650	E	IESG: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange small group health insurance coverage during the period.
62651	E	IESG: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange small group health insurance coverage during the period.
62652	E	IESG: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for in-exchange small group health insurance coverage during the period.
62653	E	IESG: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for in-exchange small group health insurance coverage during the period.
62654	E	IESG: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for in-exchange small group health insurance coverage during the period.
62655	E	IESG: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for in-exchange small group health insurance coverage during the period.
63101	E	IEMI-Bronze: If the company has In-Exchange Multi-State (Individual) Health insurance (IEMI) Bronze plan coverage data to report, then all IEMI-Bronze data elements must be reported.

Rule ID	Type	Description
63102	E	IEMI-Bronze: If the company does not have In-Exchange Multi-State (Individual) Health insurance (IEMI) Bronze plan coverage data to report, then no data is allowed for all IEMI-Bronze data elements.
63104	E	IEMI-Bronze: For In-Exchange Bronze Multi-State (Individual) Health Plans, the number of claims (excluding pharmacy claims) received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
63105	E	IEMI-Bronze: For In-Exchange Bronze Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63106	E	IEMI-Bronze: For In-Exchange Bronze Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63107	E	IEMI-Bronze: For In-Exchange Bronze Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63108	E	IEMI-Bronze: For In-Exchange Bronze Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63110	W	IEMI-Bronze: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the total policies issued, and policies renewed for IEMI-Bronze should be greater than zero.
63111	W	IEMI-Bronze: If the company reported new policies issued greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the member months for policies issued for IEMI-Bronze should be greater than zero.
63112	W	IEMI-Bronze: If the company reported policies renewed greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the member months for policies renewed for IEMI-Bronze should be greater than zero.
63113	W	IEMI-Bronze: If the company reported terminations and cancellations initiated by consumer greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEMI-Bronze should be greater than zero.
63114	W	IEMI-Bronze: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEMI-Bronze should be greater than zero.
63117	W	IEMI-Bronze: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the number of claims paid for IEMI-Bronze should be greater than the number of claims denied.

Rule ID	Type	Description
63119	W	IEMI-Bronze: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the number of claims submitted by network providers for IEMI-Bronze should be greater than the number of claims submitted by out-of-network providers.
63121	W	IEMI-Bronze: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the total amount of claims paid for IEMI-Bronze should be less than the reported Earned Premiums.
63122	W	IEMI-Bronze: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the number of adverse determinations upheld for IEMI-Bronze should be greater than the number of adverse determinations overturned.
63129	E	IEMI-Bronze: For In-Exchange Multi-State Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
63130	E	IEMI-Bronze: For In-Exchange Multi-State Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
63201	E	IEMI-Silver: If the company has In-Exchange Multi-State (Individual) Health insurance (IEMI) Silver plan coverage data to report, then all IEMI-Silver data elements must be reported.
63202	E	IEMI-Silver: If the company does not have In-Exchange Multi-State (Individual) Health insurance (IEMI) Silver plan coverage data to report, then no data is allowed for all IEMI-Silver data elements.
63204	E	IEMI-Silver: For In-Exchange Silver Multi-State (Individual) Health Plans, the number of claims (excluding pharmacy claims) received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
63205	E	IEMI-Silver: For In-Exchange Silver Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63206	E	IEMI-Silver: For In-Exchange Silver Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

Rule ID	Type	Description
63207	E	IEMI-Silver: For In-Exchange Silver Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63208	E	IEMI-Silver: For In-Exchange Silver Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63210	W	IEMI-Silver: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the total policies issued, and policies renewed for IEMI-Silver should be greater than zero.
63211	W	IEMI-Silver: If the company reported new policies issued greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the member months for policies issued for IEMI-Silver should be greater than zero.
63212	W	IEMI-Silver: If the company reported policies renewed greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the member months for policies renewed for IEMI-Silver should be greater than zero.
63213	W	IEMI-Silver: If the company reported terminations and cancellations initiated by consumer greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEMI-Silver should be greater than zero.
63214	W	IEMI-Silver: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEMI-Silver should be greater than zero.
63217	W	IEMI-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the number of claims paid for IEMI-Silver should be greater than the number of claims denied.
63219	W	IEMI-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the number of claims submitted by network providers for IEMI-Silver should be greater than the number of claims submitted by out-of-network providers.
63221	W	IEMI-Silver: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the total amount of claims paid for IEMI-Silver should be less than the reported Earned Premiums.
63222	W	IEMI-Silver: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the number of adverse determinations upheld for IEMI-Silver should be greater than the number of adverse determinations overturned.

Rule ID	Type	Description
63229	E	IEMI-Silver: For In-Exchange Multi-State Silver Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
63230	E	IEMI-Silver: For In-Exchange Multi-State Silver Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
63301	E	IEMI-Gold: If the company has In-Exchange Multi-State (Individual) Health insurance (IEMI) Gold plan coverage data to report, then all IEMI-Gold data elements must be reported.
63302	E	IEMI-Gold: If the company does not have In-Exchange Multi-State (Individual) Health insurance (IEMI) Gold plan coverage data to report, then no data is allowed for all IEMI-Gold data elements.
63304	E	IEMI-Gold: For In-Exchange Gold Multi-State (Individual) Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
63305	E	IEMI-Gold: For In-Exchange Gold Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63306	E	IEMI-Gold: For In-Exchange Gold Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63307	E	IEMI-Gold: For In-Exchange Gold Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63308	E	IEMI-Gold: For In-Exchange Gold Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63310	W	IEMI-Gold: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the total policies issued, and policies renewed for IEMI-Gold should be greater than zero.
63311	W	IEMI-Gold: If the company reported new policies issued greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the member months for policies issued for IEMI-Gold should be greater than zero.

Rule ID	Type	Description
63312	W	IEMI-Gold: If the company reported policies renewed greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the member months for policies renewed for IEMI-Gold should be greater than zero.
63313	W	IEMI-Gold: If the company reported terminations and cancellations initiated by consumer greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEMI-Gold should be greater than zero.
63314	W	IEMI-Gold: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEMI-Gold should be greater than zero.
63317	W	IEMI-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the number of claims paid for IEMI-Gold should be greater than the number of claims denied.
63319	W	IEMI-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the number of claims submitted by network providers for IEMI-Gold should be greater than the number of claims submitted by out-of-network providers.
63321	W	IEMI-Gold: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the total amount of claims paid for IEMI-Gold should be less than the reported Earned Premiums.
63322	W	IEMI-Gold: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the number of adverse determinations upheld for IEMI-Gold should be greater than the number of adverse determinations overturned.
63329	E	IEMI-Gold: For In-Exchange Multi-State Gold Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
63330	E	IEMI-Gold: For In-Exchange Multi-State Gold Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
63401	E	IEMI-Platinum: If the company has In-Exchange Multi-State (Individual) Health insurance (IEMI) Platinum plan coverage data to report, then all IEMI-Platinum data elements must be reported.

Rule ID	Type	Description
63402	E	IEMI-Platinum: If the company does not have In-Exchange Multi-State (Individual) Health insurance (IEMI) Platinum plan coverage data to report, then no data is allowed for all IEMI-Platinum data elements.
63404	E	IEMI-Platinum: For In-Exchange Platinum Multi-State (Individual) Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
63405	E	IEMI-Platinum: For In-Exchange Platinum Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63406	E	IEMI-Platinum: For In-Exchange Platinum Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63407	E	IEMI-Platinum: For In-Exchange Platinum Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63408	E	IEMI-Platinum: For In-Exchange Platinum Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63410	W	IEMI-Platinum: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the total policies issued, and policies renewed for IEMI-Platinum should be greater than zero.
63411	W	IEMI-Platinum: If the company reported new policies issued greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the member months for policies issued for IEMI-Platinum should be greater than zero.
63412	W	IEMI-Platinum: If the company reported policies renewed greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the member months for policies renewed for IEMI-Platinum should be greater than zero.
63413	W	IEMI-Platinum: If the company reported terminations and cancellations initiated by consumer greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEMI-Platinum should be greater than zero.
63414	W	IEMI-Platinum: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEMI-Platinum should be greater than zero.
63417	W	IEMI-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the number of claims paid for IEMI-Platinum should be greater than the number of claims denied.

Rule ID	Type	Description
63419	W	IEMI-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the number of claims submitted by network providers for IEMI-Platinum should be greater than the number of claims submitted by out-of-network providers.
63421	W	IEMI-Platinum: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the total amount of claims paid for IEMI-Platinum should be less than the reported Earned Premiums.
63422	W	IEMI-Platinum: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the number of adverse determinations upheld for IEMI-Platinum should be greater than the number of adverse determinations overturned.
63429	E	IEMI-Platinum: For In-Exchange Multi-State Platinum Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
63430	E	IEMI-Platinum: For In-Exchange Multi-State Platinum Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
63501	E	IEMI-Total: If the company has In-Exchange Multi-State (Individual) Health insurance (IEMI) plan coverage data to report, then all IEMI-Total data elements must be reported.
63502	E	IEMI-Total: If the company does not have In-Exchange Multi-State (Individual) Health insurance (IEMI) plan coverage data to report, then no data is allowed for all IEMI-Total data elements.
63504	E	IEMI-Total: For In-Exchange Multi-State (Individual) Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
63505	E	IEMI-Total: For In-Exchange Multi-State (Individual) Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63506	E	IEMI-Total: For In-Exchange Multi-State (Individual) Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

Rule ID	Type	Description
63507	E	IEMI-Total: For In-Exchange Multi-State (Individual) Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63508	E	IEMI-Total: For In-Exchange Multi-State (Individual) Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63510	W	IEMI-Total: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the total policies issued, and policies renewed for IEMI-Total should be greater than zero.
63511	W	IEMI-Total: If the company reported new policies issued greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the member months for policies issued for IEMI-Total should be greater than zero.
63512	W	IEMI-Total: If the company reported policies renewed greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the member months for policies renewed for IEMI-Total should be greater than zero.
63513	W	IEMI-Total: If the company reported terminations and cancellations initiated by consumer greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEMI-Total should be greater than zero.
63514	W	IEMI-Total: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEMI-Total should be greater than zero.
63515	W	IEMI-Total: If the company reported rescissions greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of lives impacted by rescissions for IEMI-Total should be greater than zero.
63516	W	IEMI-Total: If the company reported prior authorizations requested greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of prior authorizations approved for IEMI-Total should be greater than the number of prior authorizations denied.
63517	W	IEMI-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of claims paid for IEMI-Total should be greater than the number of claims denied.
63518	W	IEMI-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of claims paid for IEMI-Total should be greater than the number of claims denied.
63519	W	IEMI-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of claims submitted by network providers for IEMI-Total should be greater than the number of claims submitted by out-of-network providers.

Rule ID	Type	Description
63520	W	IEMI-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of claims paid for in-network services for IEMI-Total should be greater than the number of claims paid for out-of-network services.
63521	W	IEMI-Total: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the total amount of claims paid for IEMI-Total should be less than the reported Earned Premiums.
63522	W	IEMI-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of adverse determinations upheld for IEMI-Total should be greater than the number of adverse determinations overturned.
63523	W	IEMI-Total: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of final adverse determinations upheld for IEMI-Total should be greater than the number of final adverse determinations overturned.
63524	W	IEMI-Total: For In-Exchange Multi-State Health plans, the number of prior authorizations (excluding pharmacy-only) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) requested.
63525	W	IEMI-Total: For In-Exchange Multi-State Health plans, the number of prior authorizations (excluding pharmacy-only) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) denied.
63526	W	IEMI-Total: For In-Exchange Multi-State Health plans, the number of prior authorizations (excluding pharmacy-only) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) approved.
63529	E	IEMI-Total: For In-Exchange Multi-State Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
63530	E	IEMI-Total: For In-Exchange Multi-State Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.

Rule ID	Type	Description
63601	E	IEMI: The sum of earned premiums reported for bronze, silver, gold and platinum coverages must equal the total earned premiums for in-exchange Multi-State (Individual) Health insurance coverage for reporting year.
63602	E	IEMI: The sum of number of new policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of new policies issued for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63603	E	IEMI: The sum of number of policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policies renewed for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63604	E	IEMI: The sum of member months for policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of member months for policies issued for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63605	E	IEMI: The sum of member months for policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of member months for policies renewed for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63606	E	IEMI: The sum of number of policy terminations and cancellations initiated by consumer reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations initiated by consumer reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63607	E	IEMI: The sum of number of policy terminations and cancellations due to non-payment of premium reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations due to non-payment of premium for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63608	E	IEMI: The sum of number of lives impacted on terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on terminations and cancellations initiated by the policyholder for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63609	E	IEMI: The sum of number of lives impacted on policies terminated and cancelled due to non-payment reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on policies terminated and cancelled due to non-payment reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63611	E	IEMI: The sum of number of lives impacted by rescissions reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted by rescissions reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63615	E	IEMI: The sum of number of claims received (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total number of claims received reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.

Rule ID	Type	Description
63616	E	IEMI: The sum of number of claims submitted (excluding pharmacy claims) by network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by network providers reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63617	E	IEMI: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted for by out-of-network providers reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63618	E	IEMI: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for in-network claims reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63619	E	IEMI: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number in-network claims denied within 0-30 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63620	E	IEMI: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 31-60 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63621	E	IEMI: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 61-90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63622	E	IEMI: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied beyond 90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63623	E	IEMI: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for out-of-network claims reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63624	E	IEMI: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 0-30 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63625	E	IEMI: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 31-60 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.

Rule ID	Type	Description
63626	E	IEMI: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 61-90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63627	E	IEMI: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied beyond 90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63628	E	IEMI: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for in-network services reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63629	E	IEMI: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 0-30 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63630	E	IEMI: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 31-60 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63631	E	IEMI: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 61-90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63632	E	IEMI: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid beyond 90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63633	E	IEMI: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for out-of-network services reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63634	E	IEMI: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 0-30 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63635	E	IEMI: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 31-60 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.

Rule ID	Type	Description
63636	E	IEMI: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 61-90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63637	E	IEMI: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid beyond 90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63638	E	IEMI: The sum of claims paid (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total claims paid reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63639	E	IEMI: The sum of insured/beneficiary co-payment responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured/beneficiary co-payment responsibility amount reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63640	E	IEMI: The sum of insured coinsurance responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured coinsurance responsibility reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63641	E	IEMI: The sum of insured deductible responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured deductible responsibility reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63642	E	IEMI: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange multi-state health insurance coverage during the period.
63643	E	IEMI: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for in-exchange multi-state health insurance coverage during the period.
63644	E	IEIH: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange multi-state health insurance coverage during the period.
63645	E	IEMI: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange multi-state health insurance coverage during the period.

Rule ID	Type	Description
63646	E	IEMI: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange multi-state health insurance coverage during the period.
63647	E	IEMI: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange multi-state health insurance coverage during the period.
63648	E	IEMI: The sum of out-of-network claims denied, rejected or returned for lacking Prior Authorization reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for needing Prior Authorization for in-exchange multi-state health insurance coverage during the period.
63649	E	IEMI: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange multi-state health insurance coverage during the period.
63650	E	IEMI: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange multi-state health insurance coverage during the period.
63651	E	IEMI: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange multi-state health insurance coverage during the period.
63652	E	IEMI: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for in-exchange multi-state health insurance coverage during the period.
63653	E	IEMI: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for in-exchange multi-state health insurance coverage during the period.
63654	E	IEMI: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for in-exchange multi-state health insurance coverage during the period.

Rule ID	Type	Description
63655	E	IEMI: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for in-exchange multi-state health insurance coverage during the period.
64101	E	IEMS-Bronze: If the company has In-Exchange Multi-State (Small Group) Health insurance (IEMS) Bronze plan coverage data to report, then all IEMS-Bronze data elements must be reported.
64102	E	IEMS-Bronze: If the company does not have In-Exchange Multi-State (Small Group) Health insurance (IEMS) Bronze plan coverage data to report, then no data is allowed for all IEMS-Bronze data elements.
64104	E	IEMS-Bronze: For In-Exchange Bronze Multi-State (Small Group) Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
64105	E	IEMS-Bronze: For In-Exchange Bronze Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64106	E	IEMS-Bronze: For In-Exchange Bronze Multi-State (Small Group) Health Plans, the number of claim denials for out-of-network claims (excluding pharmacy claims) must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64107	E	IEMS-Bronze: For In-Exchange Bronze Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64108	E	IEMS-Bronze: For In-Exchange Bronze Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64117	W	IEMS-Bronze: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Bronze health plans, then the number of claims paid for IEMS-Bronze should be greater than the number of claims denied.
64119	W	IEMS-Bronze: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Bronze health plans, then the number of claims submitted by network providers for IEMS-Bronze should be greater than the number of claims submitted by out-of-network providers.
64121	W	IEMS-Bronze: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Small Group) Bronze health plans, then the total amount of claims paid for IEMS-Bronze should be less than the reported Earned Premiums.
64122	W	IEMS-Bronze: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Small Group) Bronze health plans, then the number of adverse determinations upheld for IEMS-Bronze should be greater than the number of adverse determinations overturned.

Rule ID	Type	Description
64129	E	IEMS-Bronze: For In-Exchange Bronze Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
64130	E	IEMS-Bronze: For In-Exchange Bronze Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
64201	E	IEMS-Silver: If the company has In-Exchange Multi-State (Small Group) Health insurance (IEMS) Silver plan coverage data to report, then all IEMS-Silver data elements must be reported.
64202	E	IEMS-Silver: If the company does not have In-Exchange Multi-State (Small Group) Health insurance (IEMS) Silver plan coverage data to report, then no data elements are allowed for all IEMS-Silver data elements.
64204	E	IEMS-Silver: For In-Exchange Silver Multi-State (Small Group) Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
64205	E	IEMS-Silver: For In-Exchange Silver Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64206	E	IEMS-Silver: For In-Exchange Silver Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64207	E	IEMS-Silver: For In-Exchange Silver Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64208	E	IEMS-Silver: For In-Exchange Silver Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64217	W	IEMS-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Silver health plans, then the number of claims paid for IEMS-Silver should be greater than the number of claims denied.
64219	W	IEMS-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Silver health plans, then the number of claims submitted by network providers for IEMS-Silver should be greater than the number of claims submitted by out-of-network providers.

Rule ID	Type	Description
64221	W	IEMS-Silver: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Small Group) Silver health plans, then the total amount of claims paid for IEMS-Silver should be less than the reported Earned Premiums.
64222	W	IEMS-Silver: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Small Group) Silver health plans, then the number of adverse determinations upheld for IEMS-Silver should be greater than the number of adverse determinations overturned.
64229	E	IEMS-Silver: For In-Exchange Bronze Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
64230	E	IEMS-Silver: For In-Exchange Bronze Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
64301	E	IEMS-Gold: If the company has In-Exchange Multi-State (Small Group) Health insurance (IEMS) Gold plan coverage data to report, then all IEMS-Gold data elements must be reported.
64302	E	IEMS-Gold: If the company does not have In-Exchange Multi-State (Small Group) Health insurance (IEMS) Gold plan coverage data to report, then no data is allowed for all IEMS-Gold data elements.
64304	E	IEMS-Gold: For In-Exchange Gold Multi-State (Small Group) Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
64305	E	IEMS-Gold: For In-Exchange Gold Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64306	E	IEMS-Gold: For In-Exchange Gold Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64307	E	IEMS-Gold: For In-Exchange Gold Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64308	E	IEMS-Gold: For In-Exchange Gold Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

Rule ID	Type	Description
64317	W	IEMS-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Gold health plans, then the number of claims paid for IEMS-Gold should be greater than the number of claims denied.
64319	W	IEMS-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Gold health plans, then the number of claims submitted by network providers for IEMS-Gold should be greater than the number of claims submitted by out-of-network providers.
64321	W	IEMS-Gold: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Small Group) Gold health plans, then the total amount of claims paid for IEMS-Gold should be less than the reported Earned Premiums.
64322	W	IEMS-Gold: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Small Group) Gold health plans, then the number of adverse determinations upheld for IEMS-Gold should be greater than the number of adverse determinations overturned.
64329	E	IEMS-Gold: For In-Exchange Gold Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
64330	E	IEMS-Gold: For In-Exchange Gold Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
64401	E	IEMS-Platinum: If the company has In-Exchange Multi-State (Small Group) Health insurance (IEMS) Platinum plan coverage data to report, then all IEMS-Platinum data elements must be reported.
64402	E	IEMS-Platinum: If the company does not have In-Exchange Multi-State (Small Group) Health insurance (IEMS) Platinum plan coverage data to report, then no data is allowed for all IEMS-Platinum data elements.
64404	E	IEMS-Platinum: For In-Exchange Platinum Multi-State (Small Group) Health Plans, the number of claims (excluding pharmacy claims) received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
64405	E	IEMS-Platinum: For In-Exchange Platinum Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

Rule ID	Type	Description
64406	E	IEMS-Platinum: For In-Exchange Platinum Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64407	E	IEMS-Platinum: For In-Exchange Platinum Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64408	E	IEMS-Platinum: For In-Exchange Platinum Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64417	W	IEMS-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Platinum health plans, then the number of claims paid for IEMS-Platinum should be greater than the number of claims denied.
64419	W	IEMS-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Platinum health plans, then the number of claims submitted by network providers for IEMS-Platinum should be greater than the number of claims submitted by out-of-network providers.
64421	W	IEMS-Platinum: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Small Group) Platinum health plans, then the total amount of claims paid for IEMS-Platinum should be less than the reported Earned Premiums.
64422	W	IEMS-Platinum: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Small Group) Platinum health plans, then the number of adverse determinations upheld for IEMS-Platinum should be greater than the number of adverse determinations overturned.
64429	E	IEMS-Platinum: For In-Exchange Platinum Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
64430	E	IEMS-Platinum: For In-Exchange Platinum Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
64501	E	IEMS-Total: If the company has In-Exchange Multi-State (Small Group) Health insurance (IEMS) plan coverage data to report, then all IEMS-Total data elements must be reported.

Rule ID	Type	Description
64502	E	IEMS-Total: If the company does not have In-Exchange Multi-State (Small Group) Health insurance (IEMS) plan coverage data to report, then no data is allowed for all IEMS-Total data elements.
64504	E	IEMS-Total: For In-Exchange Multi-State (Small Group) Health Plans, the total number of claims (excluding pharmacy claims) received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
64505	E	IEMS-Total: For In-Exchange Multi-State (Small Group) Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64506	E	IEMS-Total: For In-Exchange Multi-State (Small Group) Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64507	E	IEMS-Total: For In-Exchange Multi-State (Small Group) Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64508	E	IEMS-Total: For In-Exchange Multi-State (Small Group) Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64515	W	IEMS-Total: If the company reported rescissions greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of lives impacted by rescissions for IEMS-Total should be greater than zero.
64516	W	IEMS-Total: If the company reported prior authorizations requested greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of prior authorizations approved for IEMS-Total should be greater than the number of prior authorizations denied.
64517	W	IEMS-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of claims paid for IEMS-Total should be greater than the number of claims denied.
64518	W	IEMS-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of claims paid for IEMS-Total should be greater than the number of claims denied.
64519	W	IEMS-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of claims submitted by network providers for IEMS-Total should be greater than the number of claims submitted by out-of-network providers.
64520	W	IEMS-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of claims paid for in-network services for IEMS-Total should be greater than the number of claims paid for out-of-network services.

Rule ID	Type	Description
64521	W	IEMS-Total: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the total amount of claims paid for IEMS-Total should be less than the reported Earned Premiums.
64522	W	IEMS-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of adverse determinations upheld for IEMS-Total should be greater than the number of adverse determinations overturned.
64523	W	IEMS-Total: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of final adverse determinations upheld for IEMS-Total should be greater than the number of final adverse determinations overturned.
64524	W	IEMS-Total: For In-Exchange Multi-State Small Group Health plans, the number of prior authorizations (excluding pharmacy-only) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) requested.
64525	W	IEMS-Total: For In-Exchange Multi-State Small Group Health plans, the number of prior authorizations (excluding pharmacy-only) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) denied.
64526	W	IEMS-Total: For In-Exchange Multi-State Small Group Health plans, the number of prior authorizations (excluding pharmacy-only) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) approved.
64529	E	IEMS-Total: For In-Exchange Multi-State Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
64530	E	IEMS-Total: For In-Exchange Multi-State Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
64601	E	IEMS: The sum of earned premiums reported for bronze, silver, gold and platinum coverages must equal the total earned premiums for in-exchange Multi-State (Small Group) Health insurance coverage for reporting year.

Rule ID	Type	Description
64604	E	IEMS: The sum of member months for policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of member months for policies issued for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64605	E	IEMS: The sum of member months for policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of member months for policies renewed for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64608	E	IEMS: The sum of number of lives impacted on terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on terminations and cancellations initiated by the policyholder for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64609	E	IEMS: The sum of number of lives impacted on policies terminated and cancelled due to non-payment reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on policies terminated and cancelled due to non-payment reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64611	E	IEMS: The sum of number of lives impacted by rescissions reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted by rescissions reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64615	E	IEMS: The sum of number of claims received (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total number of claims received reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64616	E	IEMS: The sum of number of claims submitted by network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by network providers reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64617	E	IEMS: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted for by out-of-network providers reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64618	E	IEMS: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for in-network claims reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64619	E	IEMS: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number in-network claims denied within 0-30 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.

Rule ID	Type	Description
64620	E	IEMS: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 31-60 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64621	E	IEMS: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 61-90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64622	E	IEMS: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied beyond 90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64623	E	IEMS: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for out-of-network claims reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64624	E	IEMS: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 0-30 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64625	E	IEMS: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 31-60 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64626	E	IEMS: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 61-90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64627	E	IEMS: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied beyond 90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64628	E	IEMS: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for in-network services reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64629	E	IEMS: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 0-30 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.

Rule ID	Type	Description
64630	E	IEMS: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 31-60 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64631	E	IEMS: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 61-90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64632	E	IEMS: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid beyond 90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64633	E	IEMS: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for out-of-network services reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64634	E	IEMS: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 0-30 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64635	E	IEMS: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 31-60 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64636	E	IEMS: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 61-90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64637	E	IEMS: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid beyond 90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64638	E	IEMS: The sum of claims paid (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total claims paid reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64639	E	IEMS: The sum of insured/beneficiary co-payment responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured/beneficiary co-payment responsibility amount reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.

Rule ID	Type	Description
64640	E	IEMS: The sum of insured coinsurance responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured coinsurance responsibility reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64641	E	IEMS: The sum of insured deductible responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured deductible responsibility reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64642	E	IEMS: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange multi-state small group health insurance coverage during the period.
64643	E	IEMS: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for in-exchange multi-state small group health insurance coverage during the period.
64644	E	IEMS: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange multi-state small group health insurance coverage during the period.
64645	E	IEMS: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange multi-state small group health insurance coverage during the period.
64646	E	IEMS: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange multi-state small group health insurance coverage during the period.
64647	E	IEMS: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange multi-state small group health insurance coverage during the period.
64648	E	IEMS: The sum of out-of-network claims denied, rejected or returned for lacking Prior Authorization reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for needing Prior Authorization for in-exchange multi-state small group health insurance coverage during the period.

Rule ID	Type	Description
64649	E	IEMS: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange multi-state small group health insurance coverage during the period.
64650	E	IEMS: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange multi-state small group health insurance coverage during the period.
64651	E	IEMS: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange multi-state small group health insurance coverage during the period.
64652	E	IEMS: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for in-exchange multi-state small group health insurance coverage during the period.
64653	E	IEMS: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for in-exchange multi-state small group health insurance coverage during the period.
64654	E	IEMS: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for in-exchange multi-state small group health insurance coverage during the period.
64655	E	IEMS: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for in-exchange multi-state small group health insurance coverage during the period.
65001	E	IECA: If the company has In-Exchange Catastrophic Health insurance (IECA) plan coverage data to report, then all IECA data elements must be reported.
65002	E	IECA: If the company does not have In-Exchange Catastrophic Health insurance (IECA) plan coverage data to report, then no data is allowed for all IECA data elements.

Rule ID	Type	Description
65004	E	IECA: For In-Exchange Catastrophic Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
65005	E	IECA: For In-Exchange Catastrophic Health Plans, the total number of claim denials for in-network claims (excluding pharmacy claims) must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, and 61-90 days and beyond 90 days.
65006	E	IECA: For In-Exchange Catastrophic Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65007	E	IECA: For In-Exchange Catastrophic Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65008	E	IECA: For In-Exchange Catastrophic Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65010	W	IECA: If the company reported Earned Premiums greater than zero for In-Exchange Catastrophic health plans, then the total policies issued, and policies renewed for IECA should be greater than zero.
65011	W	IECA: If the company reported new policies issued greater than zero for In-Exchange Catastrophic health plans, then the member months for policies issued for IECA should be greater than zero.
65012	W	IECA: If the company reported policies renewed greater than zero for In-Exchange Catastrophic health plans, then the member months for policies renewed for IECA should be greater than zero.
65013	W	IECA: If the company reported terminations and cancellations initiated by consumer greater than zero for In-Exchange Catastrophic health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IECA should be greater than zero.
65014	W	IECA: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Catastrophic health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IECA should be greater than zero.
65015	W	IECA: If the company reported rescissions greater than zero for In-Exchange Catastrophic health plans, then the number of lives impacted by rescissions for IECA should be greater than zero.
65016	W	IECA: If the company reported prior authorizations requested greater than zero for In-Exchange Catastrophic health plans, then the number of prior authorizations approved for IECA should be greater than the number of prior authorizations denied.
65017	W	IECA: If the company reported non-pharmacy claims received greater than zero for In-Exchange Catastrophic health plans, then the number of claims paid for IECA should be greater than the number of claims denied.

Rule ID	Type	Description
65018	W	IECA: If the company reported pharmacy-only claims received greater than zero for In-Exchange Catastrophic health plans, then the number of claims paid for IECA should be greater than the number of claims denied.
65019	W	IECA: If the company reported non-pharmacy claims received greater than zero for In-Exchange Catastrophic health plans, then the number of claims submitted by network providers for IECA should be greater than the number of claims submitted by out-of-network providers.
65020	W	IECA: If the company reported pharmacy-only claims received greater than zero for In-Exchange Catastrophic health plans, then the number of claims paid for in-network services for IECA should be greater than the number of claims paid for out-of-network services.
65021	W	IECA: If the company reported Earned Premiums greater than zero for In-Exchange Catastrophic health plans, then the total amount of claims paid for IECA should be less than the reported Earned Premiums.
65022	W	IECA: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Catastrophic health plans, then the number of adverse determinations upheld for IECA should be greater than the number of adverse determinations overturned.
65023	W	IECA: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for In-Exchange Catastrophic health plans, then the number of final adverse determinations upheld for IECA should be greater than the number of final adverse determinations overturned.
65024	W	IECA: For In-Exchange Catastrophic Health plans, the total number of prior authorizations (excluding pharmacy-only) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) requested.
65025	W	IECA: For In-Exchange Catastrophic Health plans, the total number of prior authorizations (excluding pharmacy-only) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) denied.
65026	W	IECA: For In-Exchange Catastrophic Health plans, the total number of prior authorizations (excluding pharmacy-only) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) approved.
65029	E	IECA: For In-Exchange Catastrophic Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.

Rule ID	Type	Description
65030	E	IECA: For In-Exchange Catastrophic Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65101	E	OEIH-Bronze: If the company has Out-of-Exchange Individual Health insurance (OEIH) Bronze plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all OEIH-Bronze data elements must be reported.
65102	E	OEIH-Bronze: If the company does not have Out-of-Exchange Individual Health insurance (OEIH) Bronze plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all OEIH-Bronze data elements.
65104	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
65105	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65106	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65107	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65108	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65110	W	OEIH-Bronze: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the total policies issued, and policies renewed for OEIH-Bronze should be greater than zero.
65111	W	OEIH-Bronze: If the company reported new policies issued greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the member months for policies issued for OEIH-Bronze should be greater than zero.
65112	W	OEIH-Bronze: If the company reported policies renewed greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the member months for policies renewed for OEIH-Bronze should be greater than zero.

Rule ID	Type	Description
65113	W	OEIH-Bronze: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEIH-Bronze should be greater than zero.
65114	W	OEIH-Bronze: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEIH-Bronze should be greater than zero.
65117	W	OEIH-Bronze: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the number of claims paid for OEIH-Bronze should be greater than the number of claims denied.
65119	W	OEIH-Bronze: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the number of claims submitted by network providers for OEIH-Bronze should be greater than the number of claims submitted by out-of-network providers.
65121	W	OEIH-Bronze: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the total amount of claims paid for OEIH-Bronze should be less than the reported Earned Premiums.
65122	W	OEIH-Bronze: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the number of adverse determinations upheld for OEIH-Bronze should be greater than the number of adverse determinations overturned.
65129	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65130	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65201	E	OEIH-Silver: If the company has Out-of-Exchange Individual Health insurance (OEIH) Silver plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all OEIH-Silver data elements must be reported.

Rule ID	Type	Description
65202	E	OEIH-Silver: If the company does not have Out-of-Exchange Individual Health insurance (OEIH) Silver plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all OEIH-Silver data elements.
65204	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
65205	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65206	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65207	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65208	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65210	W	OEIH-Silver: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Silver health plans, then the total policies issued, and policies renewed for OEIH-Silver should be greater than zero.
65211	W	OEIH-Silver: If the company reported new policies issued greater than zero for Out-of-Exchange Individual Health Silver health plans, then the member months for policies issued for OEIH-Silver should be greater than zero.
65212	W	OEIH-Silver: If the company reported policies renewed greater than zero for Out-of-Exchange Individual Health Silver health plans, then the member months for policies renewed for OEIH-Silver should be greater than zero.
65213	W	OEIH-Silver: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Individual Health Silver health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEIH-Silver should be greater than zero.
65214	W	OEIH-Silver: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Individual Health Silver health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEIH-Silver should be greater than zero.
65217	W	OEIH-Silver: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Silver health plans, then the number of claims paid for OEIH-Silver should be greater than the number of claims denied.

Rule ID	Type	Description
65219	W	OEIH-Silver: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Silver health plans, then the number of claims submitted by network providers for OEIH-Silver should be greater than the number of claims submitted by out-of-network providers.
65221	W	OEIH-Silver: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Silver health plans, then the total amount of claims paid for OEIH-Silver should be less than the reported Earned Premiums.
65222	W	OEIH-Silver: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Individual Health Silver health plans, then the number of adverse determinations upheld for OEIH-Silver should be greater than the number of adverse determinations overturned.
65229	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65230	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65301	E	OEIH-Gold: If the company has Out-of-Exchange Individual Health insurance (OEIH) Gold plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all OEIH-Gold data elements must be reported.
65302	E	OEIH-Gold: If the company does not have Out-of-Exchange Individual Health insurance (OEIH) Gold plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all OEIH-Gold data elements.
65304	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
65305	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65306	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

Rule ID	Type	Description
65307	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65308	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65310	W	OEIH-Gold: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Gold health plans, then the total policies issued, and policies renewed for OEIH-Gold should be greater than zero.
65311	W	OEIH-Gold: If the company reported new policies issued greater than zero for Out-of-Exchange Individual Health Gold health plans, then the member months for policies issued for OEIH-Gold should be greater than zero.
65312	W	OEIH-Gold: If the company reported policies renewed greater than zero for Out-of-Exchange Individual Health Gold health plans, then the member months for policies renewed for OEIH-Gold should be greater than zero.
65313	W	OEIH-Gold: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Individual Health Gold health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEIH-Gold should be greater than zero.
65314	W	OEIH-Gold: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Individual Health Gold health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEIH-Gold should be greater than zero.
65317	W	OEIH-Gold: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Gold health plans, then the number of claims paid for OEIH-Gold should be greater than the number of claims denied.
65319	W	OEIH-Gold: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Gold health plans, then the number of claims submitted by network providers for OEIH-Gold should be greater than the number of claims submitted by out-of-network providers.
65321	W	OEIH-Gold: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Gold health plans, then the total amount of claims paid for OEIH-Gold should be less than the reported Earned Premiums.
65322	W	OEIH-Gold: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Individual Health Gold health plans, then the number of adverse determinations upheld for OEIH-Gold should be greater than the number of adverse determinations overturned.

Rule ID	Type	Description
65329	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65330	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65401	E	OEIH-Platinum: If the company has Out-of-Exchange Individual Health insurance (OEIH) Platinum plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all OEIH-Platinum data elements must be reported.
65402	E	OEIH-Platinum: If the company does not have Out-of-Exchange Individual Health insurance (OEIH) Platinum plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all OEIH-Platinum data elements.
65404	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
65405	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65406	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65407	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65408	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65410	W	OEIH-Platinum: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the total policies issued, and policies renewed for OEIH-Platinum should be greater than zero.
65411	W	OEIH-Platinum: If the company reported new policies issued greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the health plans, then the member months for policies issued for OEIH-Platinum should be greater than zero.

Rule ID	Type	Description
65412	W	OEIH-Platinum: If the company reported policies renewed greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the member months for policies renewed for OEIH-Platinum should be greater than zero.
65413	W	OEIH-Platinum: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEIH-Platinum should be greater than zero.
65414	W	OEIH-Platinum: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEIH-Platinum should be greater than zero.
65417	W	OEIH-Platinum: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the number of claims paid for OEIH-Platinum should be greater than the number of claims denied.
65419	W	OEIH-Platinum: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the number of claims submitted by network providers for OEIH-Platinum should be greater than the number of claims submitted by out-of-network providers.
65421	W	OEIH-Platinum: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the total amount of claims paid for OEIH-Platinum should be less than the reported Earned Premiums.
65422	W	OEIH-Platinum: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the number of adverse determinations upheld for OEIH-Platinum should be greater than the number of adverse determinations overturned.
65429	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65430	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.

Rule ID	Type	Description
65501	E	OEIH-Total: If the company has Out-of-Exchange Individual Health insurance (OEIH) plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all OEIH-Total data elements must be reported.
65502	E	OEIH-Total: If the company does not have Out-of-Exchange Individual Health insurance (OEIH) plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all OEIH-Total data elements.
65504	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
65505	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65506	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65507	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65508	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65510	W	OEIH-Total: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Total health plans, then the total policies issued, and policies renewed for OEIH-Total should be greater than zero.
65511	W	OEIH-Total: If the company reported new policies issued greater than zero for Out-of-Exchange Individual Health Total health plans, then the health plans, then the member months for policies issued for OEIH-Total should be greater than zero.
65512	W	OEIH-Total: If the company reported policies renewed greater than zero for Out-of-Exchange Individual Health Total health plans, then the member months for policies renewed for OEIH-Total should be greater than zero.
65513	W	OEIH-Total: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEIH-Total should be greater than zero.
65514	W	OEIH-Total: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEIH-Total should be greater than zero.

Rule ID	Type	Description
65515	W	OEIH-Total: If the company reported rescissions greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of lives impacted by rescissions for OEIH-Total should be greater than zero.
65516	W	OEIH-Total: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of prior authorizations approved for OEIH-Total should be greater than the number of prior authorizations denied.
65517	W	OEIH-Total: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of claims paid for OEIH-Total should be greater than the number of claims denied.
65518	W	OEIH-Total: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of claims paid for OEIH-Total should be greater than the number of claims denied.
65519	W	OEIH-Total: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of claims submitted by network providers for OEIH-Total should be greater than the number of claims submitted by out-of-network providers.
65520	W	OEIH-Total: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Individual Health Total health plans, then the health plans, then the number of claims paid for in-network services for OEIH-Total should be greater than the number of claims paid for out-of-network services.
65521	W	OEIH-Total: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Total health plans, then the total amount of claims paid for OEIH-Total should be less than the reported Earned Premiums.
65522	W	OEIH-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of adverse determinations upheld for OEIH-Total should be greater than the number of adverse determinations overturned.
65523	W	OEIH-Total: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of final adverse determinations upheld for OEIH-Total should be greater than the number of final adverse determinations overturned.
65524	W	OEIH-Total: For Out-of-Exchange Individual Health plans, the number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) requested.

Rule ID	Type	Description
65525	W	OEIH-Total: For Out-of-Exchange Individual Health plans, the number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
65526	W	OEIH-Total: For Out-of-Exchange Individual Health plans, the number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
65529	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65530	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65601	E	OEIH: The sum of earned premiums reported for bronze, silver, gold and platinum coverages must equal the total earned premiums for out-of-exchange Individual Health insurance coverage for reporting year.
65602	E	OEIH: The sum of number of new policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of new policies issued for out-of-exchange Individual Health insurance coverage during the period.
65603	E	OEIH: The sum of number of policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policies renewed for out-of-exchange Individual Health insurance coverage during the period.
65604	E	OEIH: The sum of policy terminations and cancellations for policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies issued for out-of-exchange Individual Health insurance coverage during the period.
65605	E	OEIH: The sum of policy terminations and cancellations for policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies renewed for out-of-exchange Individual Health insurance coverage during the period.
65606	E	OEIH: The sum of number of policy terminations and cancellations initiated by consumer reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations initiated by consumer reported for out-of-exchange Individual Health insurance coverage during the period.

Rule ID	Type	Description
65607	E	OEIH: The sum of number of policy terminations and cancellations due to non-payment of premium reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations due to non-payment of premium for out-of-exchange Individual Health insurance coverage during the period.
65608	E	OEIH: The sum of number of lives impacted on terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on terminations and cancellations initiated by the policyholder for out-of-exchange Individual Health insurance coverage during the period.
65609	E	OEIH: The sum of number of lives impacted on policies terminated and cancelled due to non-payment reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on policies terminated and cancelled due to non-payment reported for out-of-exchange Individual Health insurance coverage during the period.
65611	E	OEIH: The sum of number of lives impacted by rescissions reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted by rescissions reported for out-of-exchange Individual Health insurance coverage during the period.
65615	E	OEIH: The sum of number of claims received (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total number of claims received reported for out-of-exchange Individual Health insurance coverage during the period.
65616	E	OEIH: The sum of number of claims submitted (excluding pharmacy claims) by network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by network providers reported for out-of-exchange Individual Health insurance coverage during the period.
65617	E	OEIH: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted for by out-of-network providers reported for out-of-exchange Individual Health insurance coverage during the period.
65618	E	OEIH: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for in-network claims reported for out-of-exchange Individual Health insurance coverage during the period.
65619	E	OEIH: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number in-network claims denied within 0-30 days reported for out-of-exchange Individual Health insurance coverage during the period.
65620	E	OEIH: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 31-60 days reported for out-of-exchange Individual Health insurance coverage during the period.

Rule ID	Type	Description
65621	E	OEIH: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 61-90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65622	E	OEIH: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied beyond 90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65623	E	OEIH: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for out-of-network claims reported for out-of-exchange Individual Health insurance coverage during the period.
65624	E	OEIH: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 0-30 days reported for out-of-exchange Individual Health insurance coverage during the period.
65625	E	OEIH: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 31-60 days reported for out-of-exchange Individual Health insurance coverage during the period.
65626	E	OEIH: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 61-90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65627	E	OEIH: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied beyond 90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65628	E	OEIH: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for in-network services reported for out-of-exchange Individual Health insurance coverage during the period.
65629	E	OEIH: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 0-30 days reported for out-of-exchange Individual Health insurance coverage during the period.
65630	E	OEIH: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 31-60 days reported for out-of-exchange Individual Health insurance coverage during the period.

Rule ID	Type	Description
65631	E	OEIH: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 61-90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65632	E	OEIH: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid beyond 90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65633	E	OEIH: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for out-of-network services reported for out-of-exchange Individual Health insurance coverage during the period.
65634	E	OEIH: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 0-30 days reported for out-of-exchange Individual Health insurance coverage during the period.
65635	E	OEIH: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 31-60 days reported for out-of-exchange Individual Health insurance coverage during the period.
65636	E	OEIH: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 61-90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65637	E	OEIH: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid beyond 90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65638	E	OEIH: The sum of claims paid (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total claims paid reported for out-of-exchange Individual Health insurance coverage during the period.
65639	E	OEIH: The sum of insured/beneficiary co-payment responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured/beneficiary co-payment responsibility amount reported for out-of-exchange Individual Health insurance coverage during the period.
65640	E	OEIH: The sum of insured coinsurance responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured coinsurance responsibility reported for out-of-exchange Individual Health insurance coverage during the period.

Rule ID	Type	Description
65641	E	OEIH: The sum of insured deductible responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured deductible responsibility reported for out-of-exchange Individual Health insurance coverage during the period.
65642	E	OEIH: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for out-of-exchange individual health insurance coverage during the period.
65643	E	OEIH: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for out-of-exchange individual health insurance coverage during the period.
65644	E	OEIH: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for out-of-exchange individual health insurance coverage during the period.
65645	E	OEIH: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for out-of-exchange individual health insurance coverage during the period.
65646	E	OEIH: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for out-of-exchange individual health insurance coverage during the period.
65647	E	OEIH: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for out-of-exchange individual health insurance coverage during the period.
65648	E	OEIH: The sum of out-of-network claims denied, rejected or returned for lacking Prior Authorization reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for needing Prior Authorizations for out-of-exchange individual health insurance coverage during the period.
65649	E	OEIH: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for out-of-exchange individual health insurance coverage during the period.

Rule ID	Type	Description
65650	E	OEIH: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for out-of-exchange individual health insurance coverage during the period.
65651	E	OEIH: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for out-of-exchange individual health insurance coverage during the period.
65652	E	OEIH: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for out-of-exchange individual health insurance coverage during the period.
65653	E	OEIH: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for out-of-exchange individual health insurance coverage during the period.
65654	E	OEIH: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for out-of-exchange individual health insurance coverage during the period.
65655	E	OEIH: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for out-of-exchange individual health insurance coverage during the period.
66101	E	OESG-Bronze: If the company has Out-of-Exchange Small Group Health insurance (OESG) Bronze plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all OESG-Bronze data elements must be reported.
66102	E	OESG-Bronze: If the company does not have Out-of-Exchange Small Group Health insurance (OESG) Bronze plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all OESG-Bronze data elements.
66104	E	OESG-Bronze: For Out-of-Exchange Bronze Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.

Rule ID	Type	Description
66105	E	OESG-Bronze: For Out-of-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66106	E	OESG-Bronze: For Out-of-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66107	E	OESG-Bronze: For Out-of-Exchange Bronze Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66108	E	OESG-Bronze: For Out-of-Exchange Bronze Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66117	W	OESG-Bronze: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Bronze health plans, then the number of claims paid for OESG-Bronze should be greater than the number of claims denied.
66119	W	OESG-Bronze: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Bronze health plans, then the number of claims submitted by network providers for OESG-Bronze should be greater than the number of claims submitted by out-of-network providers.
66121	W	OESG-Bronze: If the company reported Earned Premiums greater than zero for Out-of-Exchange Small Group Health Bronze health plans, then the total amount of claims paid for OESG-Bronze should be less than the reported Earned Premiums.
66122	W	OESG-Bronze: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Small Group Health Bronze health plans, then the number of adverse determinations upheld for OESG-Bronze should be greater than the number of adverse determinations overturned.
66129	E	OESG-Bronze: For Out-of-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
66130	E	OESG-Bronze: For Out-of-Exchange Small Group Bronze Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.

Rule ID	Type	Description
66201	E	OESG-Silver: If the company has Out-of-Exchange Small Group Health insurance (OESG) Silver plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all OESG-Silver data elements must be reported.
66202	E	OESG-Silver: If the company does not have Out-of-Exchange Small Group Health insurance (OESG) Silver plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all OESG-Silver data elements.
66204	E	OESG-Silver: For Out-of-Exchange Silver Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
66205	E	OESG-Silver: For Out-of-Exchange Silver Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66206	E	OESG-Silver: For Out-of-Exchange Silver Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66207	E	OESG-Silver: For Out-of-Exchange Silver Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66208	E	OESG-Silver: For Out-of-Exchange Silver Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66217	W	OESG-Silver: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Silver health plans, then the number of claims paid for OESG-Silver should be greater than the number of claims denied.
66219	W	OESG-Silver: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Silver health plans, then the number of claims submitted by network providers for OESG-Silver should be greater than the number of claims submitted by out-of-network providers.
66221	W	OESG-Silver: If the company reported Earned Premiums greater than zero for Out-of-Exchange Small Group Health Silver health plans, then the total amount of claims paid for OESG-Silver should be less than the reported Earned Premiums.
66222	W	OESG-Silver: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Small Group Health Silver health plans, then the number of adverse determinations upheld for OESG-Silver should be greater than the number of adverse determinations overturned.

Rule ID	Type	Description
66229	E	OESG-Silver: For Out-of-Exchange Small Group Silver Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
66230	E	OESG-Silver: For Out-of-Exchange Small Group Silver Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
66301	E	OESG-Gold: If the company has Out-of-Exchange Small Group Health insurance (OESG) Gold plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all OESG-Gold data elements must be reported.
66302	E	OESG-Gold: If the company does not have Out-of-Exchange Small Group Health insurance (OESG) Gold plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all OESG-Gold data elements.
66304	E	OESG-Gold: For Out-of-Exchange Gold Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
66305	E	OESG-Gold: For Out-of-Exchange Gold Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66306	E	OESG-Gold: For Out-of-Exchange Gold Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66307	E	OESG-Gold: For Out-of-Exchange Gold Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66308	E	OESG-Gold: For Out-of-Exchange Gold Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66317	W	OESG-Gold: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Gold health plans, then the number of claims paid for OESG-Gold should be greater than the number of claims denied.

Rule ID	Type	Description
66319	W	OESG-Gold: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Gold health plans, then the number of claims submitted by network providers for OESG-Gold should be greater than the number of claims submitted by out-of-network providers.
66321	W	OESG-Gold: If the company reported Earned Premiums greater than zero for Out-of-Exchange Small Group Health Gold health plans, then the total amount of claims paid for OESG-Gold should be less than the reported Earned Premiums.
66322	W	OESG-Gold: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Small Group Health Gold health plans, then the number of adverse determinations upheld for OESG-Gold should be greater than the number of adverse determinations overturned.
66329	E	OESG-Gold: For Out-of-Exchange Small Group Gold Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
66330	E	OESG-Gold: For Out-of-Exchange Small Group Gold Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
66401	E	OESG-Platinum: If the company has Out-of-Exchange Small Group Health insurance (OESG) Platinum plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all OESG-Platinum data elements must be reported.
66402	E	OESG-Platinum: If the company does not have Out-of-Exchange Small Group Health insurance (OESG) Platinum plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all OESG-Platinum data elements.
66404	E	OESG-Platinum: For Out-of-Exchange Platinum Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
66405	E	OESG-Platinum: For Out-of-Exchange Platinum Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66406	E	OESG-Platinum: For Out-of-Exchange Platinum Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

Rule ID	Type	Description
66407	E	OESG-Platinum: For Out-of-Exchange Platinum Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66408	E	OESG-Platinum: For Out-of-Exchange Platinum Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66417	W	OESG-Platinum: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Platinum health plans, then the number of claims paid for OESG-Platinum should be greater than the number of claims denied.
66419	W	OESG-Platinum: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Platinum health plans, then the number of claims submitted by network providers for OESG-Platinum should be greater than the number of claims submitted by out-of-network providers.
66421	W	OESG-Platinum: If the company reported Earned Premiums greater than zero for Out-of-Exchange Small Group Health Platinum health plans, then the total amount of claims paid for OESG-Platinum should be less than the reported Earned Premiums.
66422	W	OESG-Platinum: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Small Group Health Platinum health plans, then the number of adverse determinations upheld for OESG-Platinum should be greater than the number of adverse determinations overturned.
66429	E	OESG-Platinum: For Out-of-Exchange Small Group Platinum Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater than or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
66430	E	OESG-Platinum: For Out-of-Exchange Small Group Platinum Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
66501	E	OESG-Total: If the company has Out-of-Exchange Small Group Health insurance (OESG) plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all OESG-Total data elements must be reported.
66502	E	OESG-Total: If the company does not have Out-of-Exchange Small Group Health insurance (OESG) plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all OESG-Total data elements.

Rule ID	Type	Description
66504	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
66505	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66506	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66507	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of paid claims for (excluding pharmacy claims) in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66508	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66515	W	OESG-Total: If the company reported rescissions greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of lives impacted by rescissions for OESG-Total should be greater than zero.
66516	W	OESG-Total: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of prior authorizations approved for OESG-Total should be greater than the number of prior authorizations denied.
66517	W	OESG-Total: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of claims paid for OESG-Total should be greater than the number of claims denied.
66518	W	OESG-Total: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of claims paid for OESG-Total should be greater than the number of claims denied.
66519	W	OESG-Total: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of claims submitted by network providers for OESG-Total should be greater than the number of claims submitted by out-of-network providers.
66520	W	OESG-Total: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of claims paid for in-network services for OESG-Total should be greater than the number of claims paid for out-of-network services.
66521	W	OESG-Total: If the company reported Earned Premiums greater than zero for Out-of-Exchange Small Group Health Total health plans, then the total amount of claims paid for OESG-Total should be less than the reported Earned Premiums.

Rule ID	Type	Description
66522	W	OESG-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of adverse determinations upheld for OESG-Total should be greater than the number of adverse determinations overturned.
66523	W	OESG-Total: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of final adverse determinations upheld for OESG-Total should be greater than the number of final adverse determinations overturned .
66524	W	OESG-Total: For Out-of-Exchange Small Group Health plans, the number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders should be less than or equal to the total number of prior authorizations (excluding pharmacy) requested.
66525	W	OESG-Total: For Out-of-Exchange Small Group Health plans, the number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
66526	W	OESG-Total: For Out-of-Exchange Small Group Health plans, the number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
66529	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
66530	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
66601	E	OESG: The sum of earned premiums reported for bronze, silver, gold and platinum coverages must equal the total earned premiums for out-of-exchange Small Group Health insurance coverage for reporting year.
66604	E	OESG: The sum of policy terminations and cancellations for policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies issued for out-of-exchange Small Group Health insurance coverage during the period.

Rule ID	Type	Description
66605	E	OESG: The sum of policy terminations and cancellations for policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies renewed for out-of-exchange Small Group Health insurance coverage during the period.
66608	E	OESG: The sum of number of lives impacted on terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on terminations and cancellations initiated by the policyholder for out-of-exchange Small Group Health insurance coverage during the period.
66609	E	OESG: The sum of number of lives impacted on policies terminated and cancelled due to non-payment reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on policies terminated and cancelled due to non-payment reported for out-of-exchange Small Group Health insurance coverage during the period.
66611	E	OESG: The sum of number of lives impacted by rescissions reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted by rescissions reported for out-of-exchange Small Group Health insurance coverage during the period.
66615	E	OESG: The sum of number of claims received (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total number of claims received reported for out-of-exchange Small Group Health insurance coverage during the period.
66616	E	OESG: The sum of number of claims submitted (excluding pharmacy claims) by network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by network providers reported for out-of-exchange Small Group Health insurance coverage during the period.
66617	E	OESG: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted for by out-of-network providers reported for out-of-exchange Small Group Health insurance coverage during the period.
66618	E	OESG: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for in-network claims reported for out-of-exchange Small Group Health insurance coverage during the period.
66619	E	OESG: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number in-network claims denied within 0-30 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66620	E	OESG: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 31-60 days reported for out-of-exchange Small Group Health insurance coverage during the period.

Rule ID	Type	Description
66621	E	OESG: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 61-90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66622	E	OESG: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied beyond 90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66623	E	OESG: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for out-of-network claims reported for out-of-exchange Small Group Health insurance coverage during the period.
66624	E	OESG: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 0-30 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66625	E	OESG: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 31-60 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66626	E	OESG: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 61-90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66627	E	OESG: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied beyond 90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66628	E	OESG: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for in-network services reported for out-of-exchange Small Group Health insurance coverage during the period.
66629	E	OESG: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 0-30 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66630	E	OESG: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 31-60 days reported for out-of-exchange Small Group Health insurance coverage during the period.

Rule ID	Type	Description
66631	E	OESG: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 61-90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66632	E	OESG: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid beyond 90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66633	E	OESG: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for out-of-network services reported for out-of-exchange Small Group Health insurance coverage during the period.
66634	E	OESG: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 0-30 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66635	E	OESG: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 31-60 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66636	E	OESG: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 61-90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66637	E	OESG: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid beyond 90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66638	E	OESG: The sum of claims paid (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total claims paid reported for out-of-exchange Small Group Health insurance coverage during the period.
66639	E	OESG: The sum of insured/beneficiary co-payment responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured/beneficiary co-payment responsibility amount reported for out-of-exchange Small Group Health insurance coverage during the period.
66640	E	OESG: The sum of insured coinsurance responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured coinsurance responsibility reported for out-of-exchange Small Group Health insurance coverage during the period.

Rule ID	Type	Description
66641	E	OESG: The sum of insured deductible responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured deductible responsibility reported for out-of-exchange Small Group Health insurance coverage during the period.
66642	E	OESG: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for out-of-exchange small group health insurance coverage during the period.
66643	E	OESG: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for out-of-exchange small group health insurance coverage during the period.
66644	E	OESG: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for out-of-exchange small group health insurance coverage during the period.
66645	E	OESG: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for out-of-exchange small group health insurance coverage during the period.
66646	E	OESG: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for out-of-exchange small group health insurance coverage during the period.
66647	E	OESG: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for out-of-exchange small group health insurance coverage during the period.
66648	E	OESG: The sum of out-of-network claims denied, rejected or returned for lacking Prior Authorization reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for needing Prior Authorizations for out-of-exchange individual small group insurance coverage during the period.
66649	E	OESG: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for out-of-exchange small group health insurance coverage during the period.

Rule ID	Type	Description
66650	E	OESG: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for out-of-exchange small group health insurance coverage during the period.
66651	E	OESG: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for out-of-exchange small group health insurance coverage during the period.
66652	E	OESG: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for out-of-exchange small group health insurance coverage during the period.
66653	E	OESG: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for out-of-exchange small group health insurance coverage during the period.
66654	E	OESG: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for out-of-exchange small group health insurance coverage during the period.
66655	E	OESG: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for out-of-exchange small group health insurance coverage during the period.
67101	E	OEGT-Large Group: If the company has Out-of-Exchange Grandfathered/Transitional Health insurance (OESG) Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then all OEGT-Large Group data elements must be reported.
67102	E	OEGT-Large Group: If the company does not have Out-of-Exchange Grandfathered/Transitional Health insurance (OESG) Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then no data is allowed for all OEGT-Large Group data elements.

Rule ID	Type	Description
67104	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
67105	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67106	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67107	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67108	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67110	W	OEGT-Large Group: If the company reported Earned Premiums greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the total policies issued, and policies renewed for OEGT-Large Group should be greater than zero.
67111	W	OEGT-Large Group: If the company reported new policies issued greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the member months for policies issued for OEGT-Large Group should be greater than zero.
67112	W	OEGT-Large Group: If the company reported policies renewed greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the member months for policies renewed for OEGT-Large Group should be greater than zero.
67113	W	OEGT-Large Group: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEGT-Large Group should be greater than zero.
67114	W	OEGT-Large Group: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEGT-Large Group should be greater than zero.

Rule ID	Type	Description
67115	W	OEGT-Large Group: If the company reported rescissions greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of lives impacted by rescissions for OEGT-Large Group should be greater than zero.
67116	W	OEGT-Large Group: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of prior authorizations approved for OEGT-Large Group should be greater than the number of prior authorizations denied.
67117	W	OEGT-Large Group: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of claims paid for OEGT-Large Group should be greater than the number of claims denied.
67118	W	OEGT-Large Group: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of claims paid for OEGT-Large Group should be greater than the number of claims denied.
67119	W	OEGT-Large Group: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of claims submitted by network providers for OEGT-Large Group should be greater than the number of claims submitted by out-of-network providers.
67120	W	OEGT-Large Group: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of claims paid for in-network services for OEGT-Large Group should be greater than the number of claims paid for out-of-network services.
67121	W	OEGT-Large Group: If the company reported Earned Premiums greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the total amount of claims paid for OEGT-Large Group should be less than the reported Earned Premiums.
67122	W	OEGT-Large Group: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of adverse determinations upheld for OEGT-Large Group should be greater than the number of adverse determinations overturned.
67123	W	OEGT-Large Group: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of final adverse determinations upheld for OEGT-Large Group should be greater than the number of final adverse determinations overturned.

Rule ID	Type	Description
67124	W	OELG: For Out-of-Exchange Large Group Health plans, the total number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) requested.
67125	W	OELG: For Out-of-Exchange Large Group Health plans, the total number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
67126	W	OELG: For Out-of-Exchange Large Group Health plans, the total number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
67129	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
67130	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
67201	E	OEGT-Small Group: If the company has Out-of-Exchange Grandfathered/Transitional Health insurance (OEGT) Small Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then all OEGT-Small Group data elements must be reported.
67202	E	OEGT-Small Group: If the company does not have Out-of-Exchange Grandfathered/Transitional Health insurance (OEGT) Small Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then no data is allowed for all OEGT-Small Group data elements.
67204	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health Plans, the number of claims received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
67205	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health Plans, the number of claim denials for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

Rule ID	Type	Description
67206	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health Plans, the number of claim denials for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67207	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health Plans, the number of paid claims for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67208	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health Plans, the number of paid claims for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67215	W	OEGT-Small Group: If the company reported rescissions greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of lives impacted by rescissions for OEGT-Small Group should be greater than zero.
67216	W	OEGT-Small Group: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of prior authorizations approved for OEGT-Small Group should be greater than the number of prior authorizations denied.
67217	W	OEGT-Small Group: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of claims paid for OEGT-Small Group should be greater than the number of claims denied.
67218	W	OEGT-Small Group: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of claims paid for OEGT-Small Group should be greater than the number of claims denied.
67219	W	OEGT-Small Group: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of claims submitted by network providers for OEGT-Small Group should be greater than the number of claims submitted by out-of-network providers.
67220	W	OEGT-Small Group: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of claims paid for in-network services for OEGT-Small Group should be greater than the number of claims paid for out-of-network services.
67221	W	OEGT-Small Group: If the company reported Earned Premiums greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the total amount of claims paid for OEGT-Small Group should be less than the reported Earned Premiums.

Rule ID	Type	Description
67222	W	OEGT-Small Group: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of adverse determinations upheld for OEGT-Small Group should be greater than the number of adverse determinations overturned.
67223	W	OEGT-Small Group: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of final adverse determinations upheld for OEGT-Small Group should be greater than the number of final adverse determinations overturned.
67224	E	OEGT: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for large group, small group and individual plans must equal the total number of out-of-network claims denied within 0-30 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67225	E	OEGT: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for large group, small group and individual plans must equal the total number of out-of-network claims denied within 31-60 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67226	E	OEGT: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for large group, small group and individual plans must equal the total number of out-of-network claims denied within 61-90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67229	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
67230	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
67301	E	OEGT-Individual: If the company has Out-of-Exchange Grandfathered/Transitional Health insurance (OEGT) Individual comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then all OEGT-Individual data elements must be reported.

Rule ID	Type	Description
67302	E	OEGT-Individual: If the company does not have Out-of-Exchange Grandfathered/Transitional Health insurance (OEGT) Individual comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then no data is allowed for all OEGT-Individual data elements.
67304	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
67305	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67306	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67307	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67308	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67310	W	OEGT-Individual: If the company reported Earned Premiums greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the total policies issued, and policies renewed for OEGT-Individual should be greater than zero.
67311	W	OEGT-Individual: If the company reported new policies issued greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the member months for policies issued for OEGT-Individual should be greater than zero.
67312	W	OEGT-Individual: If the company reported policies renewed greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the member months for policies renewed for OEGT-Individual should be greater than zero.
67313	W	OEGT-Individual: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEGT-Individual should be greater than zero.

Rule ID	Type	Description
67314	W	OEGT-Individual: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEGT-Individual should be greater than zero.
67315	W	OEGT-Individual: If the company reported rescissions greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of lives impacted by rescissions for OEGT-Individual should be greater than zero.
67316	W	OEGT-Individual: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of prior authorizations approved for OEGT-Individual should be greater than the number of prior authorizations denied.
67317	W	OEGT-Individual: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of claims paid for OEGT-Individual should be greater than the number of claims denied.
67318	W	OEGT-Individual: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of claims paid for OEGT-Individual should be greater than the number of claims denied.
67319	W	OEGT-Individual: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of claims submitted by network providers for OEGT-Individual should be greater than the number of claims submitted by out-of-network providers.
67320	W	OEGT-Individual: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of claims paid for in-network services for OEGT-Individual should be greater than the number of claims paid for out-of-network services.
67321	W	OEGT-Individual: If the company reported Earned Premiums greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the total amount of claims paid for OEGT-Individual should be less than the reported Earned Premiums.
67322	W	OEGT-Individual: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of adverse determinations upheld for OEGT-Individual should be greater than the number of adverse determinations overturned.
67323	W	OEGT-Individual: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of final adverse determinations upheld for OEGT-Individual should be greater than the number of final adverse determinations overturned.

Rule ID	Type	Description
67324	W	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health plans, the number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) requested.
67325	W	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health plans, the number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
67326	W	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health plans, the number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
67329	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
67330	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
67401	E	OEGT-Total: If the company has Out-of-Exchange Grandfathered/Transitional Health insurance (OESG) Individual comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then all OEGT-Total data elements must be reported.
67402	E	OEGT-Total: If the company does not have Out-of-Exchange Grandfathered/Transitional Health insurance (OEGT) Individual comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then no data is allowed for all OEGT-Total data elements.
67404	E	OEGT-Total: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.

Rule ID	Type	Description
67405	E	OEGT-Total: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67406	E	OEGT-Total: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67407	E	OEGT-Total: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67408	E	OEGT-Total: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67415	W	OEGT-Total: If the company reported rescissions greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of lives impacted by rescissions for OEGT-Total should be greater than zero.
67416	W	OEGT-Total: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of prior authorizations approved for OEGT-Total should be greater than the number of prior authorizations denied.
67417	W	OEGT-Total: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of claims paid for OEGT-Total should be greater than the number of claims denied.
67418	W	OEGT-Total: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of claims paid for OEGT-Total should be greater than the number of claims denied.
67419	W	OEGT-Total: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of claims submitted by network providers for OEGT-Total should be greater than the number of claims submitted by out-of-network providers.
67420	W	OEGT-Total: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of claims paid for in-network services for OEGT-Total should be greater than the number of claims paid for out-of-network services.
67421	W	OEGT-Total: If the company reported Earned Premiums greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the total amount of claims paid for OEGT-Total should be less than the reported Earned Premiums.

Rule ID	Type	Description
67422	W	OEGT-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of adverse determinations upheld for OEGT-Total should be greater than the number of adverse determinations overturned.
67423	W	OEGT-Total: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of final adverse determinations upheld for OEGT-Total should be greater than the number of final adverse determinations overturned.
67424	W	OEGT-Total: For Out-of-Exchange Grandfathered/Transitional Health plans, the total number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) requested.
67425	W	OEGT-Total: For Out-of-Exchange Grandfathered/Transitional Health plans, the total number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
67426	W	OEGT-Total: For Out-of-Exchange Grandfathered/Transitional Health plans, the total number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
67429	E	OEGT-Total: For Out-of-Exchange Grandfathered/Transitional Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
67430	E	OEGT-Total: For Out-of-Exchange Grandfathered/Transitional Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater than or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
67601	E	OEGT: The sum of earned premiums reported for large group, small group and individual plans must equal the total earned premiums for out-of-exchange Grandfathered/Transitional Health insurance plans for reporting year.
67604	E	OEGT: The sum of policy terminations and cancellations for policies issued during the period reported for large group, small group and individual plans must equal the total number of policy terminations and cancellations for policies issued for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.

Rule ID	Type	Description
67605	E	OEGT: The sum of policy terminations and cancellations for policies renewed during the period reported for large group, small group and individual plans must equal the total number of policy terminations and cancellations for policies renewed for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67608	E	OEGT: The sum of number of lives impacted on terminations and cancellations initiated by the policyholder reported for large group, small group and individual plans must equal the total number of lives impacted on terminations and cancellations initiated by the policyholder for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67609	E	OEGT: The sum of number of lives impacted on policies terminated and cancelled due to non-payment reported for large group, small group and individual plans must equal the total number of lives impacted on policies terminated and cancelled due to non-payment reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67610	E	OEGT: The sum of number of rescissions reported for large group, small group and individual plans must equal the total number of rescissions reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67611	E	OEGT: The sum of number of lives impacted by rescissions reported for large group, small group and individual plans must equal the total number of lives impacted by rescissions reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67612	E	OEGT: The sum of number of prior authorizations requested reported for large group, small group and individual plans must equal the total number of prior authorizations requested reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67613	E	OEGT: The sum of number of prior authorizations approved reported for large group, small group and individual plans must equal the total number of prior authorizations approved reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67614	E	OEGT: The sum of number of prior authorizations denied reported for large group, small group and individual plans must equal the total number of prior authorizations denied reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67615	E	OEGT: The sum of number of claims received (excluding pharmacy claims) reported for large group, small group and individual plans must equal the total number of claims received reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67616	E	OEGT: The sum of number of claims submitted (excluding pharmacy claims) by network providers reported for large group, small group and individual plans must equal the total number of claims submitted by network providers reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.

Rule ID	Type	Description
67617	E	OEGT: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for large group, small group and individual plans must equal the total number of claims submitted for by out-of-network providers reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67618	E	OEGT: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for large group, small group and individual plans must equal the total number of claim denials for in-network claims reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67619	E	OEGT: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for large group, small group and individual plans must equal the total number in-network claims denied within 0-30 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67620	E	OEGT: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for large group, small group and individual plans must equal the total number of in-network claims denied within 31-60 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67621	E	OEGT: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for large group, small group and individual plans must equal the total number of in-network claims denied within 61-90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67622	E	OEGT: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for large group, small group and individual plans must equal the total number of in-network claims denied beyond 90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67623	E	OEGT: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for large group, small group and individual plans must equal the total number of claim denials for out-of-network claims reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67624	E	OEGT: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for large group, small group and individual plans must equal the total number of out-of-network claims denied within 0-30 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67625	E	OEGT: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for large group, small group and individual plans must equal the total number of out-of-network claims denied within 31-60 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67626	E	OEGT: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for large group, small group and individual plans must equal the total number of out-of-network claims denied within 61-90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.

Rule ID	Type	Description
67627	E	OEGT: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for large group, small group and individual plans must equal the total number of out-of-network claims denied beyond 90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67628	E	OEGT: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for large group, small group and individual plans must equal the total number of paid claims for in-network services reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67629	E	OEGT: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for large group, small group and individual plans must equal the total number of in-network claims paid within 0-30 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67630	E	OEGT: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for large group, small group and individual plans must equal the total number of in-network claims paid within 31-60 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67631	E	OEGT: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for large group, small group and individual plans must equal the total number of in-network claims paid within 61-90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67632	E	OEGT: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for large group, small group and individual plans must equal the total number of in-network claims paid beyond 90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67633	E	OEGT: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for large group, small group and individual plans must equal the total number of paid claims for out-of-network services reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67634	E	OEGT: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for large group, small group and individual plans must equal the total number of out-of-network claims paid within 0-30 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67635	E	OEGT: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for large group, small group and individual plans must equal the total number of out-of-network claims paid within 31-60 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67636	E	OEGT: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for large group, small group and individual plans must equal the total number of out-of-network claims paid within 61-90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.

Rule ID	Type	Description
67637	E	OEGT: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for large group, small group and individual plans must equal the total number of out-of-network claims paid beyond 90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67638	E	OEGT: The sum of claims paid (excluding pharmacy claims) reported for large group, small group and individual plans must equal the total claims paid reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67639	E	OEGT: The sum of insured/beneficiary co-payment responsibility reported for large group, small group and individual plans must equal the total insured/beneficiary co-payment responsibility amount reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67640	E	OEGT: The sum of insured coinsurance responsibility reported for large group, small group and individual plans must equal the total insured coinsurance responsibility reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67641	E	OEGT: The sum of insured deductible responsibility reported for large group, small group and individual plans must equal the total insured deductible responsibility reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67642	E	OEGT: The sum of number of claims received reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67643	E	OEGT: The sum of number of claim denials for in-network claims reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67644	E	OEGT: The sum of number of claim denials for out-of-network claims reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67645	E	OEGT: The sum of number of paid claims for in-network services reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67646	E	OEGT: The sum of number of paid claims for out-of-network services reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67647	E	OEGT: The sum of claims paid reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67648	E	OEGT: The sum of Insured/beneficiary co-payment responsibility reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.

Rule ID	Type	Description
67649	E	OEGT: The sum of Insured coinsurance responsibility reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67650	E	OEGT: The sum of Insured deductible responsibility reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67651	E	OEGT: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for large group, small group and individual coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for out-of-exchange Grandfathered/Transitional health insurance coverage during the period.
67652	E	OEGT: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for large group, small group and individual coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for out-of-exchange Grandfathered/Transitional health insurance coverage during the period.
67653	E	OEGT: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for out-of-exchange small group health insurance coverage during the period.
67654	E	OEGT: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for out-of-exchange small group health insurance coverage during the period.
67655	E	OEGT: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for out-of-exchange small group health insurance coverage during the period.
67656	E	OEGT: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for out-of-exchange small group health insurance coverage during the period.
67657	E	OEGT: The sum of out-of-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for needing Prior Authorizations for out-of-exchange individual small group insurance coverage during the period.

Rule ID	Type	Description
67658	E	OEGT: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for out-of-exchange small group health insurance coverage during the period.
67659	E	OEGT: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for out-of-exchange small group health insurance coverage during the period.
67660	E	OEGT: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for out-of-exchange small group health insurance coverage during the period.
67661	E	OEGT: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for out-of-exchange small group health insurance coverage during the period.
67662	E	OEGT: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for out-of-exchange small group health insurance coverage during the period.
67663	E	OEGT: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for out-of-exchange small group health insurance coverage during the period.
67664	E	OEGT: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for out-of-exchange small group health insurance coverage during the period.
67665	E	OEGT: The number of customer requested appeals on final adverse determinations to external review organizations reported for large group, small group and individual coverages must equal the total number of customer requested appeals on final adverse determinations to external review organizations for out-of-exchange Grandfathered/Transitional health insurance coverage during the period.

Rule ID	Type	Description
67666	E	OEGT: The number of final adverse determinations upheld upon request for external reviews reported for large group, small group and individual coverages must equal the total number of final adverse determinations upheld for out-of-exchange Grandfathered/Transitional health insurance coverage during the period.
67667	E	OEGT: The number of final adverse determinations overturned upon request for external reviews reported for large group, small group and individual coverages must equal the total number of final adverse determinations overturned for out-of-exchange Grandfathered/Transitional health insurance coverage during the period.
68001	E	OECA: If the company has Out-of-Exchange Catastrophic Health insurance (OECA) plan coverage data to report, then all corresponding OECA Policy Administration, Prior Authorizations, Claims and Consumer Requested Review data elements must be reported.
68002	E	OECA: If the company does not have Out-of-Exchange Catastrophic Health insurance (OECA) plan coverage data to report, then no data is allowed for all OECA data elements.
68004	E	OECA: For Out-of-Exchange Catastrophic Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
68005	E	OECA: For Out-of-Exchange Catastrophic Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68006	E	OECA: For Out-of-Exchange Catastrophic Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68007	E	OECA: For Out-of-Exchange Catastrophic Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68008	E	OECA: For Out-of-Exchange Catastrophic Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68010	W	OECA: If the company reported Earned Premiums greater than zero for Out-of-Exchange Catastrophic health plans, then the total policies issued, and policies renewed for OECA should be greater than zero.
68011	W	OECA: If the company reported new policies issued greater than zero for Out-of-Exchange Catastrophic health plans, then the member months for policies issued for OECA should be greater than zero.
68012	W	OECA: If the company reported policies renewed greater than zero for Out-of-Exchange Catastrophic health plans, then the member months for policies renewed for OECA should be greater than zero.

Rule ID	Type	Description
68013	W	OECA: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Catastrophic health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OECA should be greater than zero.
68014	W	OECA: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Catastrophic health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OECA should be greater than zero.
68015	W	OECA: If the company reported rescissions greater than zero for Out-of-Exchange Catastrophic health plans, then the number of lives impacted by rescissions for OECA should be greater than zero.
68016	W	OECA: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Catastrophic health plans, then the number of prior authorizations approved for OECA should be greater than the number of prior authorizations denied.
68017	W	OECA: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Catastrophic health plans, then the number of claims paid for OECA should be greater than the number of claims denied.
68018	W	OECA: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Catastrophic health plans, then the number of claims paid for OECA should be greater than the number of claims denied.
68019	W	OECA: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Catastrophic health plans, then the number of claims submitted by network providers for OECA should be greater than the number of claims submitted by out-of-network providers.
68020	W	OECA: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Catastrophic health plans, then the number of claims paid for in-network services for OECA should be greater than the number of claims paid for out-of-network services.
68021	W	OECA: If the company reported Earned Premiums greater than zero for Out-of-Exchange Catastrophic health plans, then the total amount of claims paid for OECA should be less than the reported Earned Premiums.
68022	W	OECA: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Catastrophic health plans, then the number of adverse determinations upheld for OECA should be greater than the number of adverse determinations overturned.
68023	W	OECA: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for Out-of-Exchange Catastrophic health plans, then the number of final adverse determinations upheld for OECA should be greater than the number of final adverse determinations overturned.

Rule ID	Type	Description
68024	W	OECA: For Out-of-Exchange Catastrophic Health plans, the total number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) requested.
68025	W	OECA: For Out-of-Exchange Catastrophic Health plans, the total number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
68026	W	OECA: For Out-of-Exchange Catastrophic Health plans, the total number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
68029	W	OECA: For Out-of-Exchange Catastrophic Health plans, the number of final adverse determinations upheld for consumer requested external reviews (including pharmacy) should be greater than the number of final adverse determinations overturned.
68101	E	OELG: If the company has Out-of-Exchange Large Group Comprehensive Health insurance (OELG) plan coverage other than transitional, grandfathered, multi-state, Large Group Comprehensive, or student data to report, then all OELG data elements must be reported.
68102	E	OELG: If the company does not have Out-of-Exchange Large Group Comprehensive Health insurance (OELG) plan coverage other than transitional, grandfathered, multi-state, Large Group Comprehensive, or student data to report, then no data is allowed for all OELG data elements.
68104	E	OELG: For Out-of-Exchange Large Group Comprehensive Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
68105	E	OELG: For Out-of-Exchange Large Group Comprehensive Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68106	E	OELG: For Out-of-Exchange Large Group Comprehensive Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68107	E	OELG: For Out-of-Exchange Large Group Comprehensive Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68108	E	OELG: For Out-of-Exchange Large Group Comprehensive Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

Rule ID	Type	Description
68110	W	OELG: If the company reported Earned Premiums greater than zero for Out-of-Exchange Large Group health plans, then the total policies issued, and policies renewed for OELG should be greater than zero.
68111	W	OELG: If the company reported new policies issued greater than zero for Out-of-Exchange Large Group health plans, then the member months for policies issued for OELG should be greater than zero.
68112	W	OELG: If the company reported policies renewed greater than zero for Out-of-Exchange Large Group health plans, then the member months for policies renewed for OELG should be greater than zero.
68113	W	OELG: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Large Group health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OELG should be greater than zero.
68114	W	OELG: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Large Group health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OELG should be greater than zero.
68115	W	OELG: If the company reported rescissions greater than zero for Out-of-Exchange Large Group health plans, then the number of lives impacted by rescissions for OELG should be greater than zero.
68116	W	OELG: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Large Group health plans, then the number of prior authorizations approved for OELG should be greater than the number of prior authorizations denied.
68117	W	OELG: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Large Group health plans, then the number of claims paid for OELG should be greater than the number of claims denied.
68118	W	OELG: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Large Group health plans, then the number of claims paid for OELG should be greater than the number of claims denied.
68119	W	OELG: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Large Group health plans, then the number of claims submitted by network providers for OELG should be greater than the number of claims submitted by out-of-network providers.
68120	W	OELG: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Large Group health plans, then the number of claims paid for in-network services for OELG should be greater than the number of claims paid for out-of-network services.
68121	W	OELG: If the company reported Earned Premiums greater than zero for Out-of-Exchange Large Group health plans, then the total amount of claims paid for OELG should be less than the reported Earned Premiums.

Rule ID	Type	Description
68122	W	OELG: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Large Group health plans, then the number of adverse determinations upheld for OELG should be greater than the number of adverse determinations overturned.
68123	W	OELG: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for Out-of-Exchange Large Group health plans, then the number of final adverse determinations upheld for OELG should be greater than the number of final adverse determinations overturned.
68124	W	OELG: For Out-of-Exchange Large Group Health plans, the total number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) requested.
68125	W	OELG: For Out-of-Exchange Large Group Health plans, the total number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
68126	W	OELG: For Out-of-Exchange Large Group Health plans, the total number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
68131	W	OELG: For Out-of-Exchange Large Group health plans, the number of final adverse determinations upheld for consumer requested external reviews (including pharmacy) should be greater than the number of final adverse determinations overturned.
68201	E	OESP: If the company has Out-of-Exchange Student Health insurance (OESP) plan coverage data to report, then all OESP data elements must be reported.
68202	E	OESP: If the company does not have Out-of-Exchange Student Health insurance (OESP) plan coverage to report, then no data is allowed for all OESP data elements.
68204	E	OESP: For Out-of-Exchange Student Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
68205	E	OESP: For Out-of-Exchange Student Health Plans, the total number of claim denials for in-network claims (excluding pharmacy claims) must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68206	E	OESP: For Out-of-Exchange Student Health Plans, the total number of claim denials for out-of-network claims (excluding pharmacy claims) must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

Rule ID	Type	Description
68207	E	OESP: For Out-of-Exchange Student Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68208	E	OESP: For Out-of-Exchange Student Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68210	W	OESP: If the company reported Earned Premiums greater than zero for Out-of-Exchange Student Coverage health plans, then the total policies issued, and policies renewed for OESP should be greater than zero.
68211	W	OESP: If the company reported new policies issued greater than zero for Out-of-Exchange Student Coverage health plans, then the member months for policies issued for OESP should be greater than zero.
68212	W	OESP: If the company reported policies renewed greater than zero for Out-of-Exchange Student Coverage health plans, then the member months for policies renewed for OESP should be greater than zero.
68213	W	OESP: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Student Coverage health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OESP should be greater than zero.
68214	W	OESP: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Student Coverage health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OESP should be greater than zero.
68215	W	OESP: If the company reported rescissions greater than zero for Out-of-Exchange Student Coverage health plans, then the number of lives impacted by rescissions for OESP should be greater than zero.
68216	W	OESP: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Student Coverage health plans, then the number of prior authorizations approved for OESP should be greater than the number of prior authorizations denied.
68217	W	OESP: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Student Coverage health plans, then the number of claims paid for OESP should be greater than the number of claims denied.
68218	W	OESP: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Student Coverage health plans, then the number of claims paid for OESP should be greater than the number of claims denied.
68219	W	OESP: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Student Coverage health plans, then the number of claims submitted by network providers for OESP should be greater than the number of claims submitted by out-of-network providers.
68220	W	OESP: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Student Coverage health plans, then the number of claims paid for in-network services for OESP should be greater than the number of claims paid for out-of-network services.

Rule ID	Type	Description
68221	W	OESP: If the company reported Earned Premiums greater than zero for Out-of-Exchange Student Coverage health plans, then the total amount of claims paid for OESP should be less than the reported Earned Premiums.
68222	W	OESP: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Student Coverage health plans, then the number of adverse determinations upheld for OESP should be greater than the number of adverse determinations overturned.
68223	W	OESP: If the company reported numbers of customer requested appeals on final adverse determinations to an external review organization (ERO) greater than zero for Out-of-Exchange Student Coverage health plans, then the number of final adverse determinations upheld for OESP should be greater than the number of final adverse determinations overturned.
68224	W	OESP: For Out-of-Exchange Student Health plans, the total number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) requested.
68225	W	OESP: For Out-of-Exchange Student Health plans, the total number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
68226	W	OESP: For Out-of-Exchange Student Health plans, the total number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.

Lender-Placed Insurance (LPI)

Coverage Identifiers	Description of Coverage Identifiers
SIA	Single-Interest Auto
DIA	Dual-Interest Auto
SIHH	Single-Interest Home Hazard
DIHH	Dual-Interest Home Hazard
SIHF	Single-Interest Home Flood
DIHF	Dual-Interest Home Flood
SIHWO	Single-Interest Home Wind-Only
DIHWO	Dual-Interest Home Wind-Only

Rule ID	Type	Description
70001	E	Responses must be provided to all Interrogatories in the 'Yes/No Response' column.
70002	E	You are not required to submit a MCAS Filing for this state since you answered 'No' to Interrogatory questions regarding having in-force lender-placed insurance coverage.
70003	E	You indicated having significant event/business strategy changes potentially affecting data for the reporting period; however, you did not provide additional comments.
70004	E	You reported that all or part of the block of business has been sold, closed or moved to another company during the year; however, you did not provide additional comments.
70101	E	You indicated that you have in-force Single-Interest Auto (SIA) Insurance Coverage; however, you did not provide a response for the percentage of Single-Interest Auto (SIA) Insurance Coverage policies/certificates issued during the period.
70102	E	You indicated that you have in-force Single-Interest Auto (SIA) Insurance Coverage in Question 1; however, you did not provide responses to all corresponding Single-Interest Auto (SIA) Coverage data in the Claims section.
70103	E	For Single-Interest Auto (SIA) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70104	E	For Single-Interest Auto (SIA) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70105	E	For Single-Interest Auto (SIA) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.

Rule ID	Type	Description
70106	E	For Single-Interest Auto (SIA) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70107	W	For Single-Interest Auto (SIA) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70108	W	For Single-Interest Auto (SIA) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70109	E	You indicated that you did not have in-force Single-Interest Auto (SIA) Insurance Coverage; therefore, responses to all corresponding Single-Interest Auto (SIA) Insurance Coverage data in the Claims Activity section must be blank.
70111	E	For Single-Interest Auto (SIA) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70112	E	For Single-Interest Auto (SIA) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70113	E	For Single-Interest Auto (SIA) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70114	E	For Single-Interest Auto (SIA) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70115	E	For Single-Interest Auto (SIA) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70116	W	For Single-Interest Auto (SIA) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70117	W	For Single-Interest Auto (SIA) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70118	W	For Single-Interest Auto (SIA) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.

Rule ID	Type	Description
70119	E	You indicated that you have in-force Single-Interest Auto (SIA) Insurance Coverage; however, you did not provide responses to all corresponding Single-Interest Auto (SIA) Insurance Coverage data in the Underwriting Activity section.
70120	E	You indicated that you did not have in-force Single-Interest Auto (SIA) Insurance Coverage; therefore, responses to all corresponding Single-Interest Auto (SIA) Insurance Coverage data in the Underwriting Activity section must be blank.
70201	E	You indicated that you have in-force Dual-Interest Auto (DIA) Insurance Coverage; however, you did not provide a response for the percentage of Dual-Interest Auto (DIA) Insurance Coverage policies/certificates issued during the period.
70202	E	You indicated that you have in-force Dual-Interest Auto (DIA) Insurance Coverage in Question 3; however, you did not provide responses to all corresponding Dual-Interest Auto (DIA) Insurance Coverage data in the Claims section.
70203	E	For Dual-Interest Auto (DIA) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70204	E	For Dual-Interest Auto (DIA) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70205	E	For Dual-Interest Auto (DIA) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70206	E	For Dual-Interest Auto (DIA) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70207	W	For Dual-Interest Auto (DIA) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70208	W	For Dual-Interest Auto (DIA) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70209	E	You indicated that you did not have in-force Dual-Interest Auto (DIA) Insurance Coverage; therefore, responses to all corresponding Dual-Interest Auto (DIA) Insurance Coverage data in the Claims Activity section must be blank.
70211	E	For Dual-Interest Auto (DIA) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.

Rule ID	Type	Description
70212	E	For Dual-Interest Auto (DIA) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70213	E	For Dual-Interest Auto (DIA) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70214	E	For Dual-Interest Auto (DIA) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70215	E	For Dual-Interest Auto (DIA) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70216	W	For Dual-Interest Auto (DIA) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70217	W	For Dual-Interest Auto (DIA) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70218	W	For Dual-Interest Auto (DIA) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70219	E	You indicated that you have in-force Dual-Interest Auto (DIA) Insurance Coverage; however, you did not provide responses to all corresponding Dual-Interest Auto (DIA) Insurance Coverage data in the Underwriting Activity section.
70220	E	You indicated that you did not have in-force Dual-Interest Auto (DIA) Insurance Coverage; therefore, responses to all corresponding Dual-Interest Auto (DIA) Insurance Coverage data in the Underwriting Activity section must be blank.
70301	E	You indicated that you have in-force Single-Interest Home Hazard (SIHH) Insurance Coverage; however, you did not provide a response for the percentage of Single-Interest Home Hazard (SIHH) Insurance Coverage policies/certificates issued during the period.
70302	E	You indicated that you have in-force Single-Interest Home Hazard (SIHH) Insurance Coverage in Question 5; however, you did not provide responses to all corresponding Single-Interest Home Hazard (SIHH) Insurance Coverage data in the Claims section.
70303	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.

Rule ID	Type	Description
70304	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70305	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70306	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70307	W	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70308	W	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70309	E	You indicated that you did not have in-force Single-Interest Home Hazard (SIHH) Insurance Coverage; therefore, responses to all corresponding Single-Interest Home Hazard (SIHH) Insurance Coverage data in the Claims Activity section must be blank.
70311	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70312	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70313	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70314	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70315	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.

Rule ID	Type	Description
70316	W	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70317	W	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70318	W	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70319	E	You indicated that you have in-force Single-Interest Home Hazard (SIHH) Insurance Coverage; however, you did not provide responses to all corresponding Single-Interest Home Hazard (SIHH) Insurance Coverage data in the Underwriting Activity section.
70320	E	You indicated that you did not have in-force Single-Interest Home Hazard (SIHH) Insurance Coverage; therefore, responses to all corresponding Single-Interest Home Hazard (SIHH) Insurance Coverage data in the Underwriting Activity section must be blank.
70401	E	You indicated that you have in-force Dual-Interest Home Hazard (DIHH) Insurance Coverage; however, you did not provide a response for the percentage of Dual-Interest Home Hazard (DIHH) Insurance Coverage policies/certificates issued during the period.
70402	E	You indicated that you have in-force Dual-Interest Home Hazard (DIHH) Insurance Coverage in Question 7; however, you did not provide responses to all corresponding Dual-Interest Home Hazard (DIHH) Insurance Coverage data in the Claims section.
70403	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70404	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70405	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70406	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70407	W	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.

Rule ID	Type	Description
70408	W	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70409	E	You indicated that you did not have in-force Dual-Interest Home Hazard (DIHH) Insurance Coverage; therefore, responses to all corresponding Dual-Interest Home Hazard (DIHH) Insurance Coverage data in the Claims Activity section must be blank.
70411	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70412	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70413	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70414	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70415	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70416	W	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70417	W	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70418	W	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70419	E	You indicated that you have in-force Dual-Interest Home Hazard (DIHH) Insurance Coverage; however, you did not provide responses to all corresponding Dual-Interest Home Hazard (DIHH) Insurance Coverage data in the Underwriting Activity section.

Rule ID	Type	Description
70420	E	You indicated that you did not have in-force Dual-Interest Home Hazard (DIHH) Insurance Coverage; therefore, responses to all corresponding Dual-Interest Home Hazard (DIHH) Insurance Coverage data in the Underwriting Activity section must be blank.
70501	E	You indicated that you have in-force Single-Interest Home Flood (SIHF) Insurance Coverage; however, you did not provide a response for the percentage of Single-Interest Home Flood (SIHF) Insurance Coverage policies/certificates issued during the period.
70502	E	You indicated that you have in-force Single-Interest Home Flood (SIHF) Insurance Coverage in Question 9; however, you did not provide responses to all corresponding Single-Interest Home Flood (SIHF) Insurance Coverage data in the Claims section.
70503	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70504	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70505	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70506	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70507	W	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70508	W	For Single-Interest Home Flood (SIHF) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70509	E	You indicated that you did not have in-force Single-Interest Home Flood (SIHF) Insurance Coverage in Question 9; therefore, responses to all corresponding Single-Interest Home Flood (SIHF) Insurance Coverage data in the Claims Activity section must be blank.
70511	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.

Rule ID	Type	Description
70512	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70513	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70514	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70515	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70516	W	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70517	W	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70518	W	For Single-Interest Home Flood (SIHF) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70519	E	You indicated that you have in-force Single-Interest Home Flood (SIHF) Insurance Coverage in Question 9; however, you did not provide responses to all corresponding Single-Interest Home Flood (SIHF) Insurance Coverage data in the Underwriting Activity section.
70520	E	You indicated that you did not have in-force Single-Interest Home Flood (SIHF) Insurance Coverage in Question 9; therefore, responses to all corresponding Single-Interest Home Flood (SIHF) Insurance Coverage data in the Underwriting Activity section must be blank.
70601	E	You indicated that you have in-force Dual-Interest Home Flood (DIHF) Insurance Coverage; however, you did not provide a response for the percentage of Dual-Interest Home Flood (DIHF) Insurance Coverage policies/certificates issued during the period.
70602	E	You indicated that you have in-force Dual-Interest Home Flood (DIHF) Insurance Coverage in Question 11; however, you did not provide responses to all corresponding Dual-Interest Home Flood (DIHF) Insurance Coverage data in the Claims section.

Rule ID	Type	Description
70603	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70604	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70605	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70606	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70607	W	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70608	W	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70609	E	You indicated that you did not have in-force Dual-Interest Home Flood (DIHF) Insurance Coverage in Question 9; therefore, responses to all corresponding Dual-Interest Home Flood (DIHF) Insurance Coverage data in the Claims Activity section must be blank.
70611	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70612	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70613	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70614	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.

Rule ID	Type	Description
70615	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70616	W	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70617	W	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70618	W	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70619	E	You indicated that you have in-force Dual-Interest Home Flood (DIHF) Insurance Coverage in Question 9; however, you did not provide responses to all corresponding Dual-Interest Home Flood (DIHF) Insurance Coverage data in the Underwriting Activity section.
70620	E	You indicated that you did not have in-force Dual-Interest Home Flood (DIHF) Insurance Coverage in Question 9; therefore, responses to all corresponding Dual-Interest Home Flood (DIHF) Insurance Coverage data in the Underwriting Activity section must be blank.
70701	E	You indicated that you have in-force Single-Interest Home Wind-Only (SIHWO) Insurance Coverage; however, you did not provide a response for the percentage of Single-Interest Home Wind-Only (SIHWO) Insurance Coverage policies/certificates issued during the period.
70702	E	You indicated that you have in-force Single-Interest Home Wind-Only (SIHWO) Insurance Coverage in Question 11; however, you did not provide responses to all corresponding Single-Interest Home Wind-Only (SIHWO) Insurance Coverage data in the Claims section.
70703	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70704	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70705	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.

Rule ID	Type	Description
70706	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70707	W	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70708	W	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70709	E	You indicated that you did not have in-force Single-Interest Home Wind-Only (SIHWO) Insurance Coverage; therefore, responses to all corresponding Single-Interest Home Wind-Only (SIHWO) Insurance Coverage data in the Claims Activity section must be blank.
70711	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70712	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70713	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70714	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70715	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70716	W	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70717	W	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.

Rule ID	Type	Description
70718	W	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70719	E	You indicated that you have in-force Single-Interest Home Wind-Only (SIHWO) Insurance Coverage; however, you did not provide responses to all corresponding Single-Interest Home Wind-Only (SIHWO) Insurance Coverage data in the Underwriting Activity section.
70720	E	You indicated that you did not have in-force Single-Interest Home Wind-Only (SIHWO) Insurance Coverage; therefore, responses to all corresponding Single-Interest Home Wind-Only (SIHWO) Insurance Coverage data in the Underwriting Activity section must be blank.
70801	E	You indicated that you have in-force Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage; however, you did not provide a response for the percentage of Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage policies/certificates issued during the period.
70802	E	You indicated that you have in-force Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage in Question 11; however, you did not provide responses to all corresponding Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage data in the Claims section.
70803	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70804	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70805	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70806	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70807	W	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70808	W	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.

Rule ID	Type	Description
70809	E	You indicated that you did not have in-force Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage; therefore, responses to all corresponding Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage data in the Claims Activity section must be blank.
70811	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70812	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70813	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70814	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70815	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70816	W	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70817	W	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70818	W	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70819	E	You indicated that you have in-force Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage; however, you did not provide responses to all corresponding Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage data in the Underwriting Activity section.

Rule ID	Type	Description
70820	E	You indicated that you did not have in-force Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage; therefore, responses to all corresponding Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage data in the Underwriting Activity section must be blank.

Median Day Validation

A median is defined as the middle value in a series of ordered values. A median is found by counting the entities in the series and selecting the entity that has an equal number of entities above it and below it. MCAS is requesting the days to payment of the median (or the middle) claim which was closed with payment. To verify that the value reported in this field passes the "reasonableness" test, a validation is performed using the following steps.

Example using an **odd** number of claims closed with payment:

<table>
<tr><th>Calculation Steps</th><th colspan="2">Example</th></tr>
<tr><td>1. Divide the value reported as "claims closed with payment" by 2 to determine median value. When the total claims are an odd number, the median value is rounded up.</td><td colspan="2">Claims closed with payment = 101
101/2 = 50.5
Median = 51 (rounded up)</td></tr>
<tr><td rowspan="6">2. Count the number of claims reported in each timeframe bucket (0-30 days, 31-60 days, etc.) until the median claim value is reached.</td><td></td><td>Running Total</td></tr>
<tr><td>0-30 days = 30</td><td>30</td></tr>
<tr><td>31-60 days = 14</td><td>(30 + 14) = 44</td></tr>
<tr><td>61-90 days = 12</td><td>(44 + 12) = 56</td></tr>
<tr><td>91-180 days = 21</td><td>(56 + 21) = 77</td></tr>
<tr><td>181-365 days = 24</td><td>(76 + 24) = 101</td></tr>
<tr><td>3. Compare value entered in MCAS to timeframe bucket calculated.</td><td colspan="2">MCAS value entered = 66
Median range calculated = 61-90</td></tr>
<tr><td>4. Test that the 51st value is within the 61 - 90 range AND the MCAS entered value of 66 is also within the 61 - 90 range.</td><td colspan="2">Validation passes.</td></tr>
</table>

Example using an **even** number of claims closed with payment:

<table>
<tr><th>Calculation Steps</th><th colspan="2">Example</th></tr>
<tr><td>1. Divide the value reported as “claims closed with payment” by 2 to determine median value. When the total claims are an even number, the median value includes the calculated number and the calculated number +1 in order to maintain an equal number of entities above and below the median.</td><td colspan="2">Claims closed with payment = 100
100/2 = 50
Median = 50 and 51</td></tr>
<tr><td rowspan="6">2. Count the number of claims reported in each timeframe bucket (0-30 days, 31-60 days, etc.) until the median claim values are reached. Both median values must be tested for the timeframe bucket. *</td><td></td><td>Running Total</td></tr>
<tr><td>0-30 days = 30</td><td>30</td></tr>
<tr><td>31-60 days = 14</td><td>(30 + 14) = 44</td></tr>
<tr><td>61-90 days = 12</td><td>(44 + 12) = 56</td></tr>
<tr><td>91-180 days = 20</td><td>(56 + 20) = 76</td></tr>
<tr><td>181-365 days = 24</td><td>(76 + 24) = 100</td></tr>
<tr><td>3. Compare value entered in MCAS to timeframe bucket calculated.</td><td colspan="2">MCAS value entered = 62
Median range calculated = 61-90</td></tr>
<tr><td>4. Test that both the 50th and 51st values are within the 61 - 90 range AND the MCAS entered value of 62 is also within the 61 - 90 range.</td><td colspan="2">Validation passes.</td></tr>
</table>

*If the 50th claim was in the 31-60 timeframe bucket and the 51st claim was in the 61-90 timeframe bucket, then an acceptable MCAS “median days to final payment” value would be a number that falls between 31-90 days.