Market Conduct Annual Statement
2023 Data Year Filings
Health
Data Elements & Validations

NAIC
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MCAS
Market Conduct Annual Statement

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In this handout, we will be reviewing the data elements that must be provided for the Health MCAS.

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Health MCAS Resources

Visit the MCAS Web page at:
https://content.naic.org/mcas-2023.htm

- Important Dates
- Participation Requirements
- Frequently Asked Questions
- Reporting Blanks
- Copy of the Call Letter
- Data Call and Definitions
- MCAS User Guide
- CSV Data Upload Instructions

Many MCAS related resources are available to you on the MCAS web page. I encourage you to visit the page frequently to find the latest reporting information.

The available resources include:

- A Listing of Important Dates
- Participation Requirements
- Frequently Asked Questions
- Reporting Blanks
- Data Call and Definitions
- Copy of the Call Letter
- MCAS User Guide
- And CSV Data Upload Instructions

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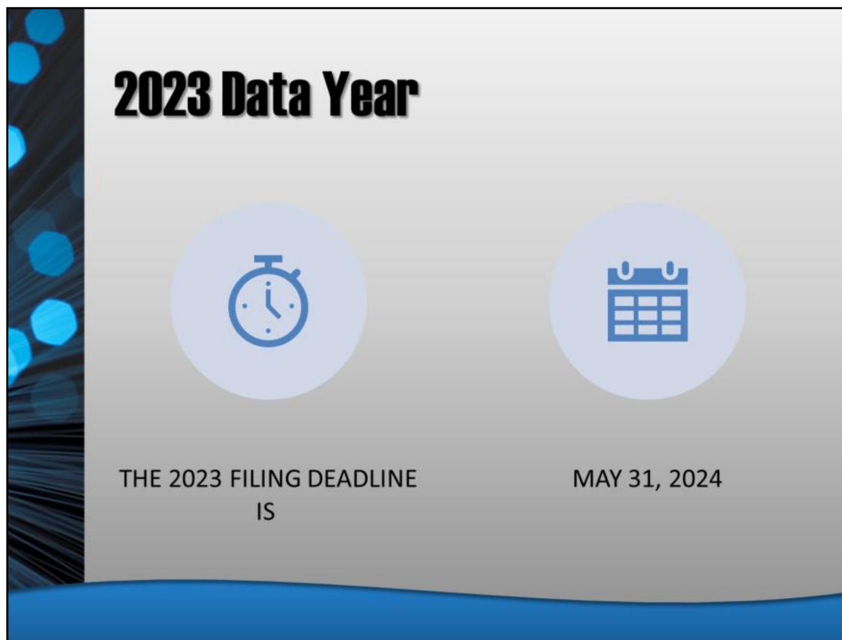

The health MCAS data reporting period is January 1st through December 31st of the reporting year, and the health MCAS filing deadline is May 31st.

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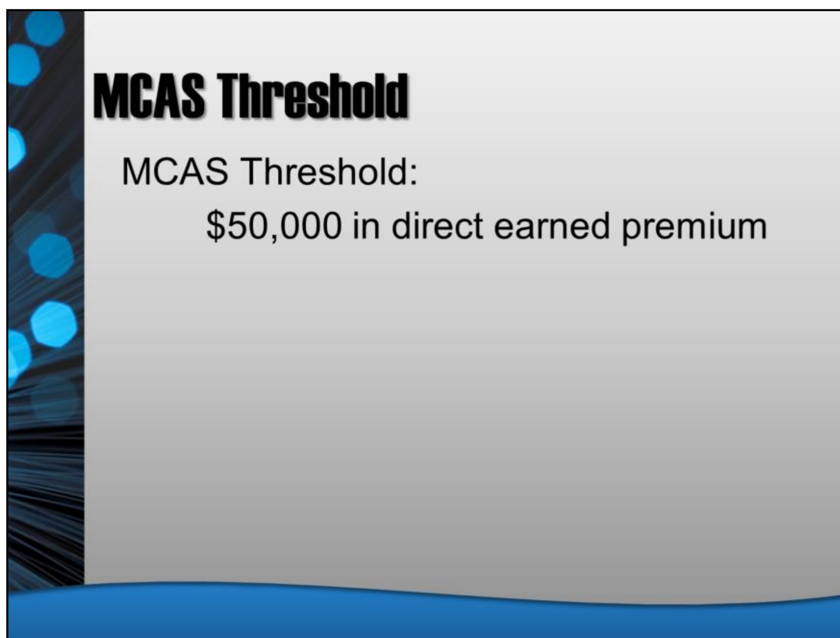

Companies reporting at least $50,000 of earned premium for MCAS applicable health insurance, in a MCAS participating jurisdiction, are required to submit health MCAS data to those participating jurisdictions where they meet the premium threshold. There are currently 49 participating MCAS jurisdictions.

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What business is included in the health MCAS?

- Medical care benefits
  - Hospital or medical service policy or certificate.
  - Hospital or medical service plan contract.
  - Health maintenance organization contract

Health insurance business reported in the MCAS includes:

"Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. "

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What business is NOT included in the health MCAS?

- Excepted benefits as defined in 42 U.S.C. § 300gg-91(c) (listing provided in the MCAS FAQs).
- Closed blocks not subject to Medical Loss Ratio reporting under CMS guidance.
- Self-funded plans.
- Government plans.

The reported data should NOT include:

- Excepted benefits as defined in 42 U.S.C. § 300gg-91(c).
- Closed blocks not subject to Medical Loss Ratio (MLR) reporting under Centers for Medicare & Medicaid Services (CMS) guidance.
- Self-funded plans.
- Government plans such as Medicare, Medicare Advantage, Medicaid, Federal Employee Plans and TriCare.

A listing of the excepted benefits can be found in the MCAS Frequently Asked Questions

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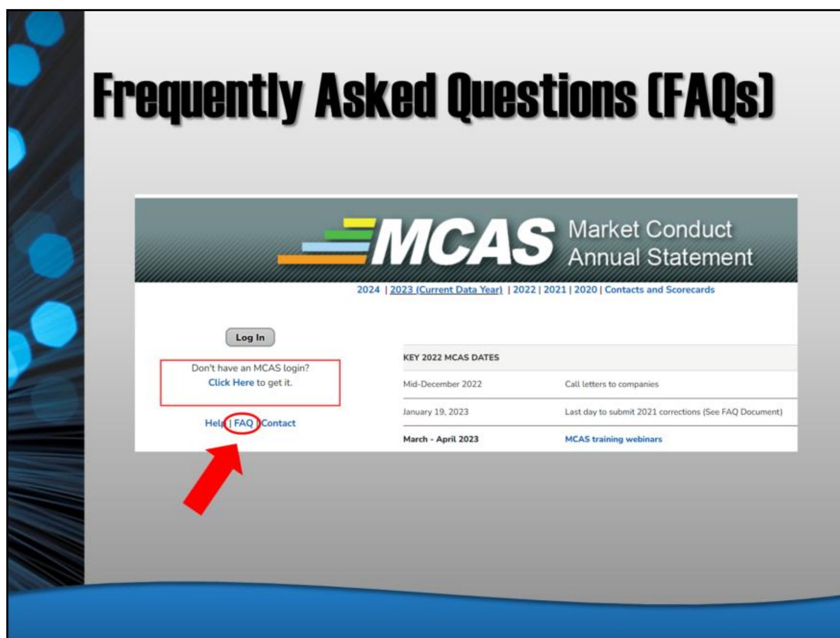

The MCAS Frequently Asked Questions or FAQs document can be found on the MCAS webpage. We will refer to questions found in the FAQ document throughout this tutorial.

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Data is to be reported separately for plans offered through an Affordable Care Act Exchange program and those offered outside the Exchange program.

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The data reported for In-Exchange health products is broken out according to types of products. There is reporting for:

- Individual
- Small Group
- Catastrophic
- Multi-State – Individual
- And Multi-State – Small Group

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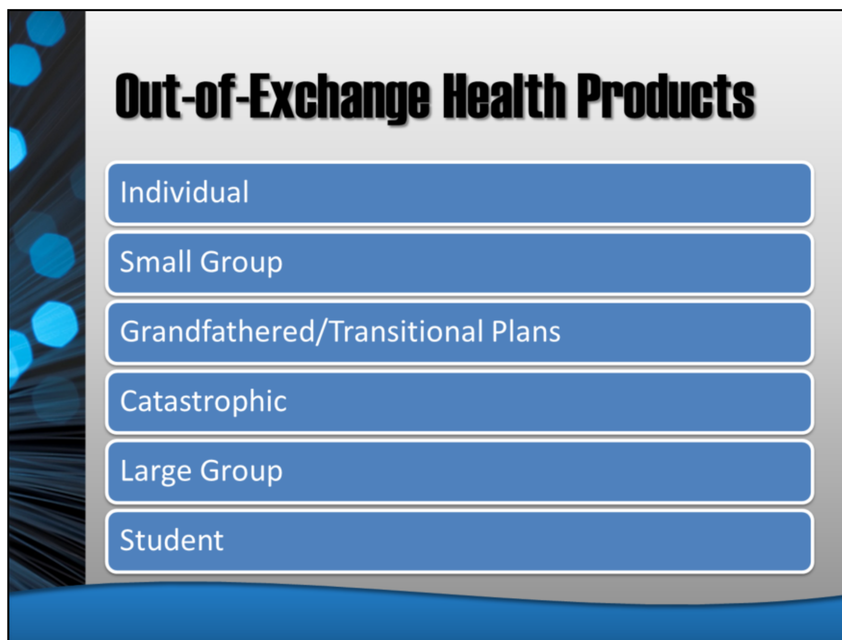

The data reported for Out-of-Exchange health products is broken out for:

- Individual
- Small Group
- Grandfathered/Transitional Plans
- Catastrophic
- Large Group
- And Student plans

Definitions of the in-exchange and out-of-exchange products can be found in the data call and definitions document.

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Metal Level Reporting – In-Exchange

Bronze, Silver, Gold and Platinum level reporting is required for the following in-exchange product types:

Individual

Small Group

Multi-State (Individual)

Multi-State (Small Group)

In addition to the product type breakouts, data is to be reported according to the product metal level for some of the in-exchange and out-of-exchange products.

In-Exchange metal level data is to be reported for:

- Individual
- Small Group
- Multi-State – Individual
- And Multi-State – Small Group product types

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Metal Level Reporting – Out-of-Exchange

Bronze, Silver, Gold and Platinum level reporting is required for the following out-of-exchange product types:

Individual

Small Group

Out-of-Exchange metal level data is to be reported for:

- Individual
- And Small Group product types

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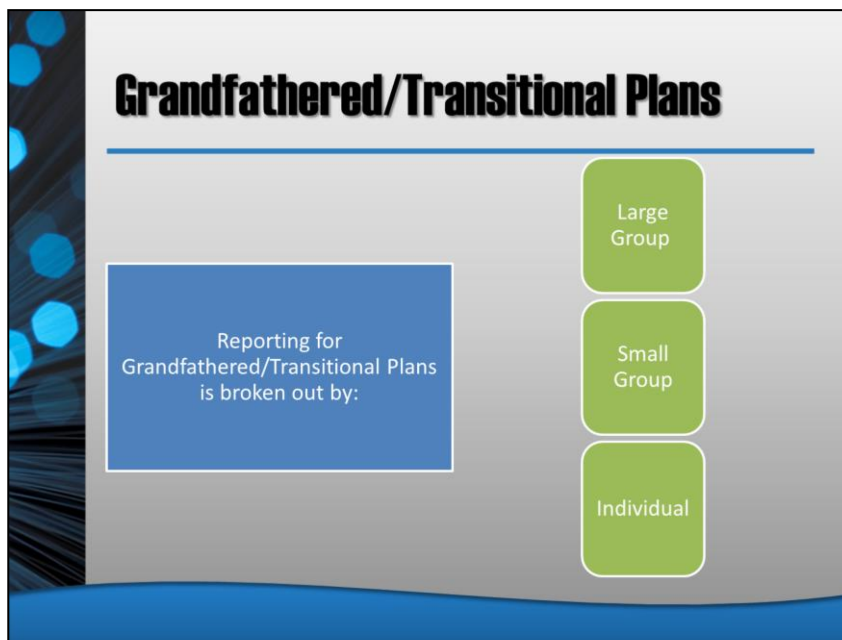

Out-of-Exchange Grandfathered and Transitional plans are to be reported with breakouts for:

- Large Group
- Small Group
- And Individual products

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In addition to metal level or break out reporting, it is required to report totals for those products with breakout reporting.

For those products that have reporting breakouts, total values must also be reported. The total values must equal the sum of the values reported with breakout reporting.

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Metal Level, breakout and total reporting are not required for all data elements.

You will find greyed out cells on the health MCAS blank that indicate specific data that is not to be reported.

However, there are exceptions to the breakout reporting. It was determined that some data elements would not be reported for specified product types. There are also some data elements for which only total amounts are required.

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Exceptions

IN-EXCHANGE

		Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic or student					Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies					Catastrophic	Multi-State(Individual)					Multi-State (Small Group)				
		Bronze	Silver	Gold	Platinum	Total	Bronze	Silver	Gold	Platinum	Total		Bronze	Silver	Gold	Platinum	Total	Bronze	Silver	Gold	Platinum	Total
Policy Administration																						
19	Earned premiums for Reporting Year.																					
20	Number of new policies issued during the period.						--	--	--	--	--							--	--	--	--	--
21	Number of policies renewed during the period.						--	--	--	--	--							--	--	--	--	--
22	Member months for policies issued during the period.																					
23	Member months for policies renewed during the period.																					
24	Number of policy terminations and cancellations initiated by the policyholder.						--	--	--	--	--							--	--	--	--	--
25	Number of policy terminations and cancellations due to non-payment of premium.						--	--	--	--	--							--	--	--	--	--

You will find “greyed out” cells on the health MCAS blank that indicate specific data that is not to be reported.

As shown on the slide, data elements that are not to be reported for specific product types and/or breakouts are denoted by the “greyed out” cells on the health MCAS reporting blank.

When entering data into the MCAS submission application you will see the data elements that are not to be reported, however they are not fillable. You will be unable to enter data for these elements.

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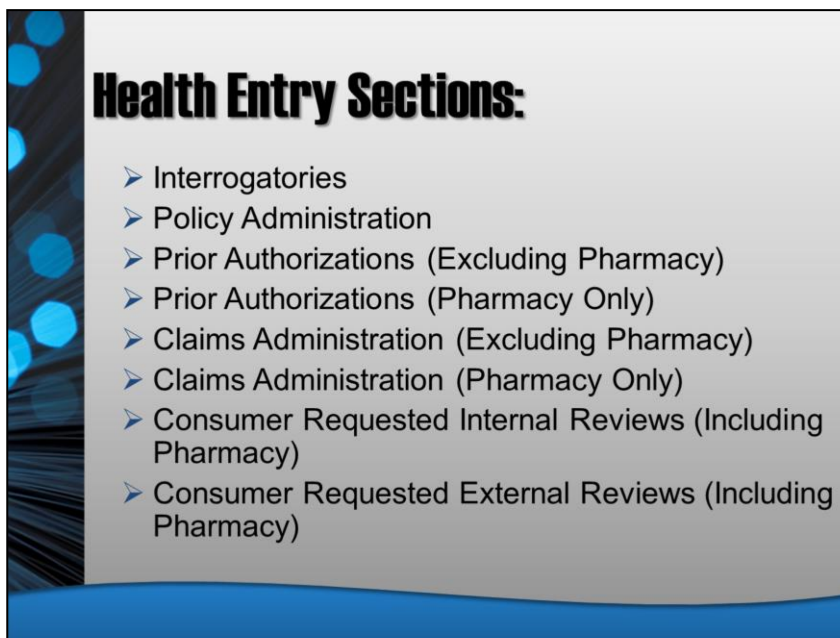

Both In-Exchange and Out-of-Exchange data elements are divided into eight sections:

- Interrogatories
- Policy Administration
- Prior Authorizations (Excluding Pharmacy)
- Prior Authorizations (Pharmacy Only)
- Claims Administration (Excluding Pharmacy)
- Claims Administration (Pharmacy Only)
- Consumer Requested Internal Reviews (Including Pharmacy)
- Consumer Requested External Reviews (Including Pharmacy)

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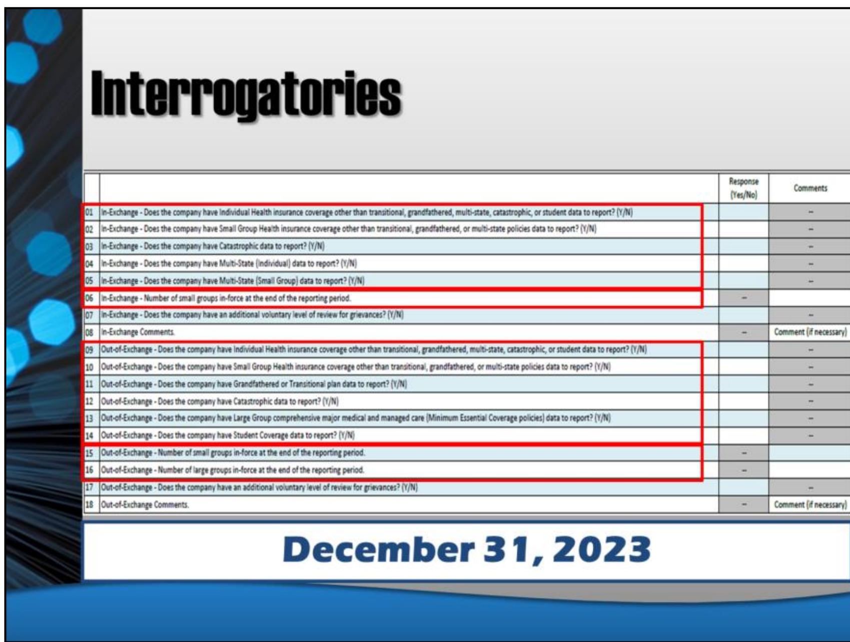

Interrogatories

		Response (Yes/No)	Comments
01	In-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)		–
02	In-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)		–
03	In-Exchange - Does the company have Catastrophic data to report? (Y/N)		–
04	In-Exchange - Does the company have Multi-State (Individual) data to report? (Y/N)		–
05	In-Exchange - Does the company have Multi-State (Small Group) data to report? (Y/N)		–
06	In-Exchange - Number of small groups in-force at the end of the reporting period.	–	
07	In-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)		–
08	In-Exchange Comments.	–	Comment (if necessary)
09	Out-of-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)		–
10	Out-of-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)		–
11	Out-of-Exchange - Does the company have Grandfathered or Transitional plan data to report? (Y/N)		–
12	Out-of-Exchange - Does the company have Catastrophic data to report? (Y/N)		–
13	Out-of-Exchange - Does the company have Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report? (Y/N)		–
14	Out-of-Exchange - Does the company have Student Coverage data to report? (Y/N)		–
15	Out-of-Exchange - Number of small groups in-force at the end of the reporting period.	–	
16	Out-of-Exchange - Number of large groups in-force at the end of the reporting period.	–	
17	Out-of-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)		–
18	Out-of-Exchange Comments.	–	Comment (if necessary)

December 31, 2023

The first section of questions that you will see in the data entry screen is the interrogatories. The interrogatories provide one location for all comments and questions that require a text response.

There are questions that ask the company to indicate if they have data to report for each of the in-exchange and out-of-exchange products. Only a yes/no response is required for each of these questions.

Companies are asked to provide the number of groups in-force at the end of the reporting period. These counts are to reflect the number of group contracts in place as of December 31st.

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Interrogatories

		Response (Yes/No)	Comments
01	In-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)		–
02	In-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)		–
03	In-Exchange - Does the company have Catastrophic data to report? (Y/N)		–
04	In-Exchange - Does the company have Multi-State (Individual) data to report? (Y/N)		–
05	In-Exchange - Does the company have Multi-State (Small Group) data to report? (Y/N)		–
06	In-Exchange - Number of small groups in-force at the end of the reporting period.	–	
07	In-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)		–
08	In-Exchange Comments.	–	Comment (if necessary)
09	Out-of-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)		–
10	Out-of-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)		–
11	Out-of-Exchange - Does the company have Grandfathered or Transitional plan data to report? (Y/N)		–
12	Out-of-Exchange - Does the company have Catastrophic data to report? (Y/N)		–
13	Out-of-Exchange - Does the company have Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report? (Y/N)		–
14	Out-of-Exchange - Does the company have Student Coverage data to report? (Y/N)		–
15	Out-of-Exchange - Number of small groups in-force at the end of the reporting period.	–	
16	Out-of-Exchange - Number of large groups in-force at the end of the reporting period.	–	
17	Out-of-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)		–
18	Out-of-Exchange Comments.	–	Comment (if necessary)

For both in and out-of-exchange, the interrogatories ask if the company has an additional voluntary level of review for grievances. This would be a level of review beyond the normal internal appeals process.

Lastly, the interrogatories ask for any comments that the submitter would like to add. Any areas of your data that may cause questions, or that generated a warning message when validating your data, should be explained fully in these comment areas. At the end of this tutorial, we will discuss the MCAS validations in more detail along with the importance of using the comments sections.

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What should I report if I don’t collect data for a specific data element?

If the carrier does not currently collect the necessary information, a note should be added to the comments questions on the MCAS Health Interrogatories section. It is expected that this information is available for reporting. Contact the state MCAS Contact if you have further questions.

The first FAQ that we’ll review deals with data the company is unable to report…If your company is unable to report data for a specific data element within the health MCAS, a note should be added to the Interrogatories section of the filing to explain the reason for the company’s inability to report.

It is expected that any company unable to report some of the requested data will work to enable the reporting in future years.

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Policy Administration Data Elements

Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
Member months for policies issued during the period.
Member months for policies renewed during the period.
Number of policy terminations and cancellations initiated by the policyholder.
Number of policy terminations and cancellations due to non-payment of premium.
Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.

The policy administration data elements reflect data for:

- Premium
- Policy counts
- Member months
- Terminations
- And rescissions

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Policy Administration Data Elements

Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
Member months for policies issued during the period.
Member months for policies renewed during the period.
Number of policy terminations and cancellations initiated by the policyholder.
Number of policy terminations and cancellations due to non-payment of premium.
Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.

The reported earned premium should correspond to only that business that is applicable to MCAS reporting.

If some of your company's business is not applicable for MCAS reporting, then you will not be able to directly tie the MCAS premiums to the earned premiums reported by state in the Financial Annual Statement Supplemental Health Care Exhibit.

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Policy Administration Data Elements

Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
Member months for policies issued during the period.
Member months for policies renewed during the period.
Number of policy terminations and cancellations initiated by the policyholder.
Number of policy terminations and cancellations due to non-payment of premium.
Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.

January 1, 2023 – December 31, 2023

The data elements related to new policies issued, policies renewed, and member months for those policies issued and renewed, are limited to those policies that are issued and renewed during the reporting period.

So, only policies issued or renewed from January 1st through December 31st will be included.

The Data Call and Definitions specify that in determining if a policy was issued or renewed, if the policyholder number remains unchanged, the policy or contract should be considered as renewed.

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What is the definition of “policy”, as it pertains to Health insurance coverage?

The individual or group contract that outlines the coverages and the fees charged.

Who is the policy holder in a group policy or individual policy?

If the policy is a “group policy” then the policy holder is the group. If the policy is an “individual policy” then the individual is the policy holder.

For the health MCAS, a policy should be considered as the individual or group contract that outlines the coverages and fees charged.

The policy holder for a group policy is the group, and the policy holder for an individual is the individual.

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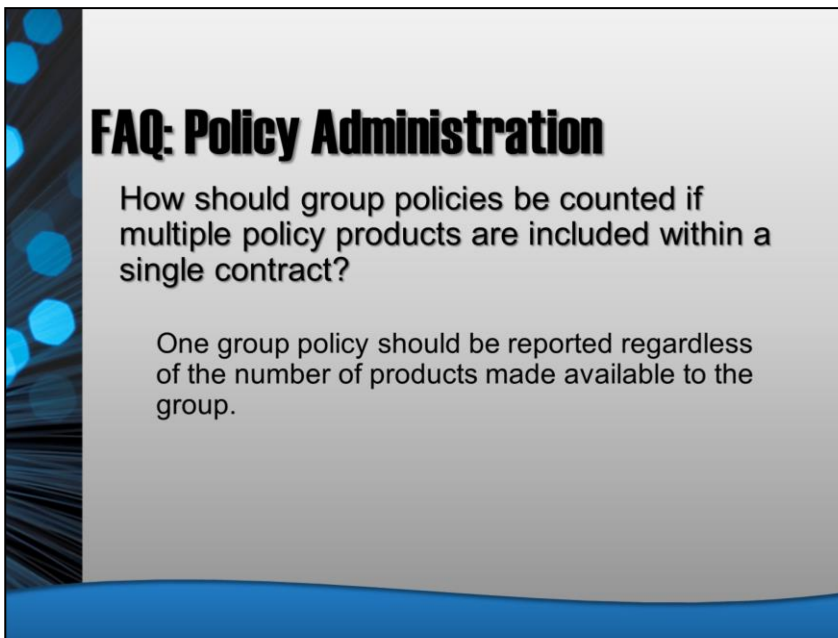

When reporting the number of group policies, one group policy should be reported regardless of the number of products made available to the group within a single contract.

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How should individuals that change products mid-year be accounted for?

- If a new policy is issued, report as a new policy issued during the year.
- Member months for the newly issued policy would be reported.
- Member months for the previous policy would be reported as a renewed policy, if applicable.
- If the previous policy was terminated at the consumer's request, it would be reported as such.

When individuals change products during the data year, the following should be considered:

- If a new policy is issued, report as a new policy issued during the year.
- Member months for the newly issued policy would be reported.
- Member months for the previous policy would be reported as a renewed policy, if applicable.
- If the previous policy was terminated at the consumer's request, it would be reported as such.

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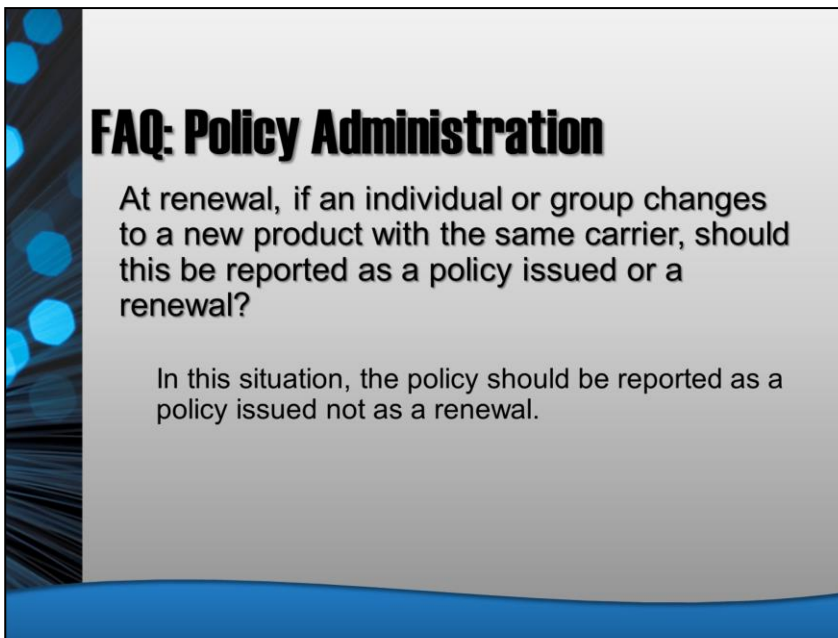

At renewal, if an individual or group changes to a new product with the same carrier, the policy should be reported as a policy issued not as a renewal.

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The concept of "Member Months" can be a bit confusing. In the simplest of terms, a policy that is issued to a member on January 1st and remains in-force through December 31st of the same year would equal 12 member months. The member's policy was in-force for 12 months of the year.

Keep in mind that only those member months that occur during the data year should be included. So, a policy for an individual renewed on October 15th of the current data reporting year, and in force for the entire 12 months of that same data reporting year, would be counted as 12 member months. Member months that the policy was in force outside of the data year being reported would not be included

The language used in the member months definitions was taken from the Financial Annual Statement Supplemental Health Care Exhibit Instructions. The definition of Member Months for Policies Issued reads…"The sum of total number of lives insured on policies (contracts) issued on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity."

Policies are not always issued or terminated on the first day of a given month. So, the purpose of using a pre-specified day is to allow for consistent consideration of months where policies were in force.

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Should the number of member months only include member months that occur during the reporting period, or should the number of months since inception of the policies that were issued or renewed during the reporting period be included?

The request is for member months where policies were in force during the reporting period. The member months for an individual will never exceed 12 months.

Remember…member months should only include member months where policies were in force during the reporting period. This means that the member months for an individual will never exceed 12 months.

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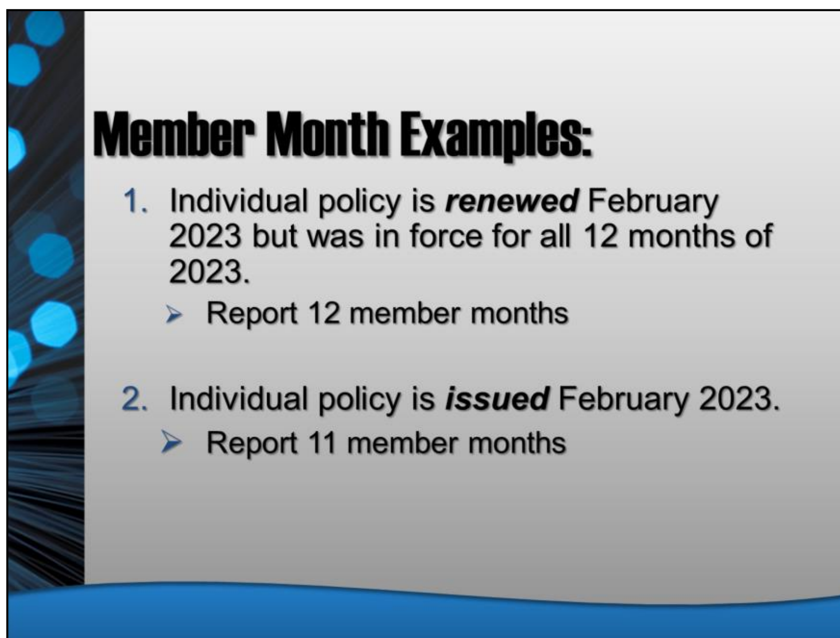

Let's review a member months reporting example…

If a policy is ***renewed*** in February, during the reporting period, and the policy was in force for all 12 months during the reporting period, you will report 12 member months.

If a policy is ***issued*** in February, during the reporting period, you will report 11 member months.

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Policy Administration Data Elements

Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
Member months for policies issued during the period.
Member months for policies renewed during the period.
Number of policy terminations and cancellations initiated by the policyholder.
Number of policy terminations and cancellations due to non-payment of premium.
Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.

The next section of questions deal with the number of policy terminations and cancellations and the number of lives impacted by terminations and cancellations.

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Terminations and Cancellations

Insured's Request

Non-Payment of Premium

Terminations and Cancellations are to be reported separately if the termination was at the insured's request vs. if the termination was due to non-payment of premium

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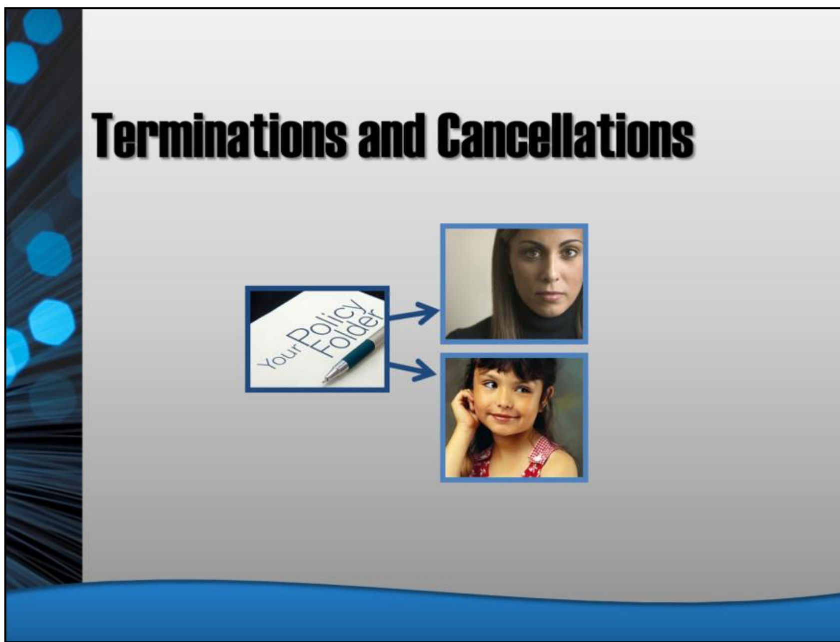

The number of lives impacted by Terminations and Cancellations will not always be equal to the number of policies or contracts terminated. A single policy or contract may cover more than one person.

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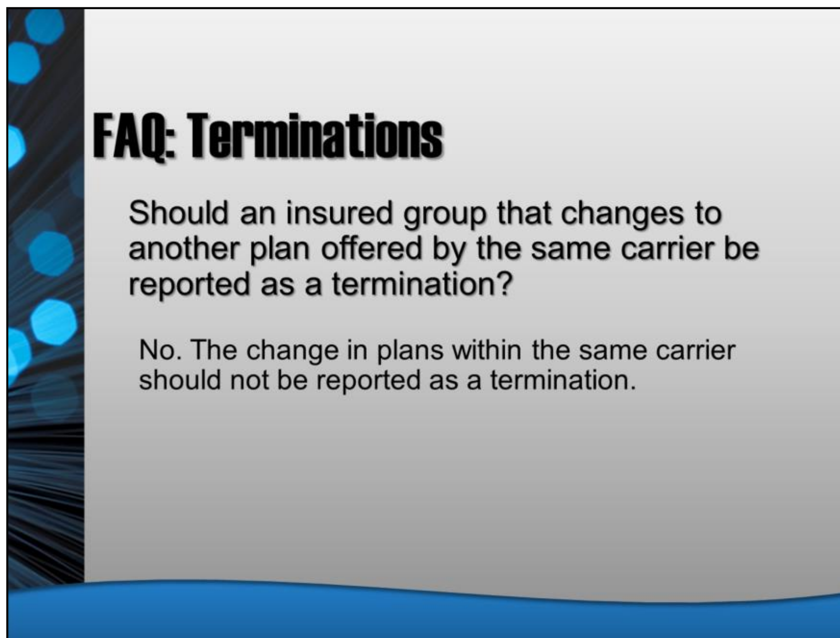

An FAQ was added to clarify that if an insured group changes to another plan offered by the same carrier, this change should NOT be reported as a termination.

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Policy Administration Data Elements

Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.
Number of rescissions.
Number of insured lives impacted by rescissions.

A rescission is a cancellation or discontinuance of coverage that has retroactive effect due to fraudulent or material misrepresentation. (Does not include cancellations for non-payment.)

The final policy administration data elements deal with the reporting of rescissions.

To rescind a policy means to retroactively cancel the entire policy. This is sometimes done if a mistake is found on the application for insurance. According to HealthCare.gov, rescissions are illegal under the Affordable Care Act, except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverages.

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Prior Authorizations Excluding Pharmacy

Prospective Utilization Review Requests

Number of prior authorizations requested.
Number of prior authorizations approved.
Number of prior authorizations denied.
Number of prior authorizations requested for mental health benefits, behavioral health benefits, and substance use disorders.
Number of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders denied.
Number of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders approved.

Now we'll move to the Prior Authorizations Excluding Pharmacy section of reporting.

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Prior Authorization – A decision by a carrier or its designee in advance of the provision of a health care service that the service (including specialist care, habilitation and rehabilitation services, and mental health and substance use disorder services), treatment plan, or medical device and equipment is medically necessary or a covered service. Sometimes called preauthorization, prior approval or precertification.

A Prior Authorization is …" A decision by a carrier or its designee in advance of the provision of a health care service that the service (including specialist care, habilitation and rehabilitation services, and mental health and substance use disorder services), treatment plan, or medical device and equipment is medically necessary or a covered service. Sometimes called preauthorization, prior approval or precertification."

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You are to report the number of Prior Authorizations:

- Requested
- Approved
- And Denied.

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How do we determine which data year prior authorization requests, approvals or denials are to be reported in?

Prior authorization requests, approvals and denials should be reported according to the data year of the request, approval or denial.

Prior Authorization requests, approvals and denials should be reported according to the data year of the request, approval or denial.

So, if a prior authorization was requested during the reporting period, report it as a request.

If a prior authorization was approved during the reporting period, report it as an approval.

If a prior authorization was denied during the reporting period, report it as a denial.

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If a request for prior authorization includes multiple services, some of the services may be approved while others are denied. Should the prior authorization be reported as approved or denied?

- Partially approved prior authorizations should be reported as approved.

The FAQs include a question regarding prior authorizations that include multiple services and how to report the prior authorization if some services are approved and others are denied.

You are to report all partially approved prior authorizations as approved.

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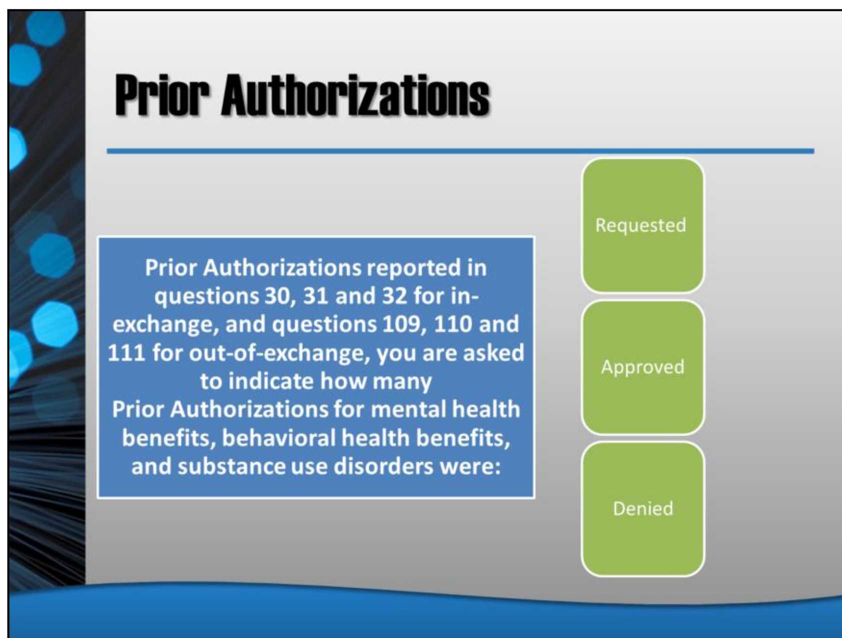

Of the Prior Authorizations reported in questions 30, 31 and 32 for in-exchange, and questions 109, 110 and 111 for out-of-exchange, you are asked to indicate how many Prior Authorizations for mental health benefits, behavioral health benefits, and substance use disorders were:

- Requested
- Approved
- Denied

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Should prior authorizations requested, approved and denied for mental health benefits, behavioral health benefits, and substance use disorders be included in the total number of prior authorizations requested, approved and denied?

Yes, Prior authorizations requested, approved and denied for mental health benefits, behavioral health benefits, and substance use disorders should be a subset of total prior authorizations requested, approved and denied.

The next FAQ we're going to discuss was added to clarify reporting in the prior authorization data elements related to mental health benefits, behavioral health benefits, and substance use disorders.

Prior authorizations requested, approved and denied for mental health benefits, behavioral health benefits, and substance use disorders should be a subset of total prior authorizations requested, approved and denied.

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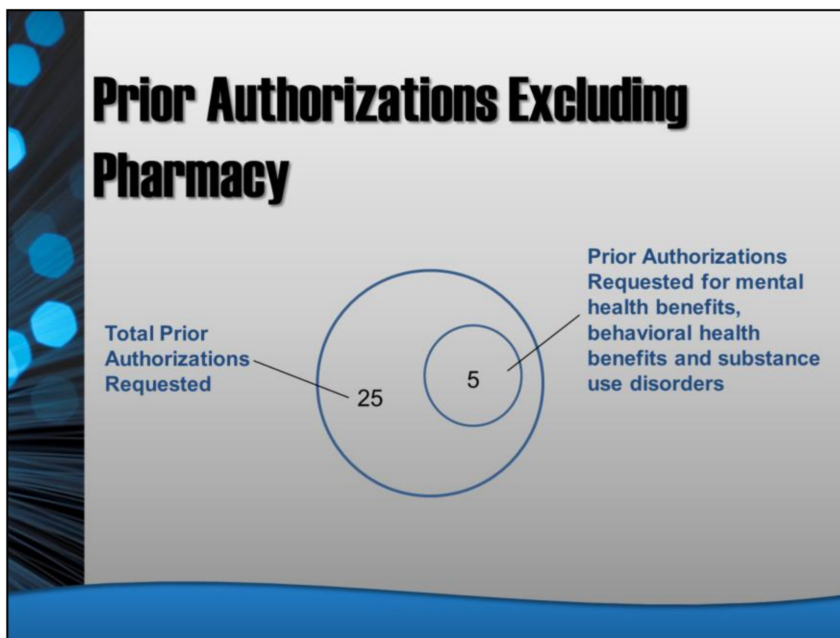

This means if there were 25 prior authorization requests during the year and 5 were for mental health benefits, behavioral health benefits and substance use disorders., you would report 25 total prior authorization requests and 5 prior authorization requests for mental health benefits, behavioral health benefits and substance use disorders. The 5 requests would be included within the 25 total requests.

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Mental Health Benefits – Benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines).

Behavioral Health Benefits – Benefits to assist those with mental health or substance abuse issues.

According to the Data Call and Definitions, Mental Health Benefits are those benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines),

And Behavioral Health Benefits assist those with mental health or substance abuse issues.

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Substance Use Disorders Benefits – Benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines).

Substance Use Disorders Benefits are defined as Benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines).

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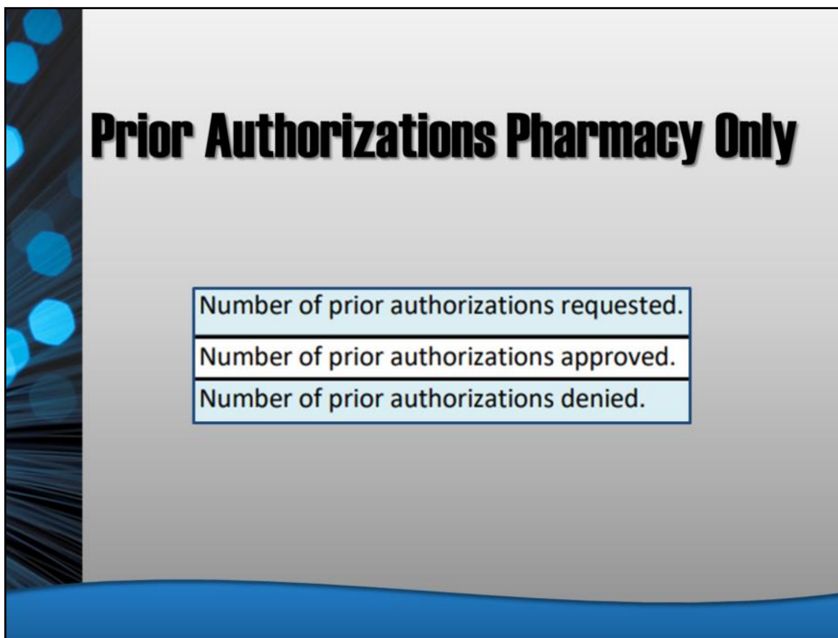

The next reporting sections is Prior Authorizations for Pharmacy. You are asked to report pharmacy prior authorizations that were requested, approved and denied during the data year.

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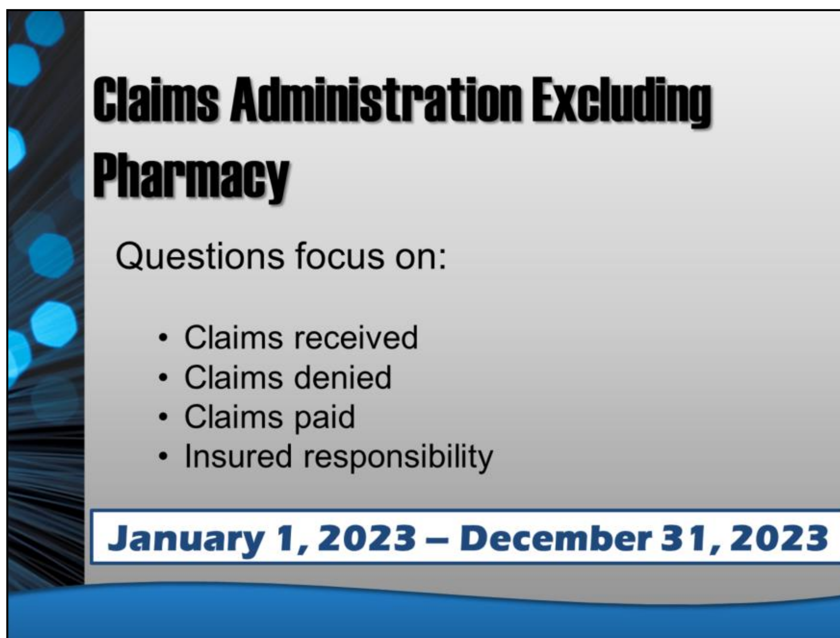

Now we'll review the Claims Administration (Excluding Pharmacy) section. Data elements within this section focus on claims received, claims denied, claims paid and insured responsibility.

Remember that all data should reflect claims received, submitted, denied and paid, during the reporting year.

Also, each individual line of service within a claim should be counted as a separate claim.

There are several frequently asked questions related to claims reporting. We will review each of the relevant FAQs.

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When reporting claims received and or claims denied, which date should we use as the anchor date for reporting?

In an effort to create uniformity with the anchor date used for claims received and denied, it is recommended that the received/determination date be used as the anchor date.

When reporting claims received it is recommended that you use the date the claim was “received” as the anchor date. Likewise, when reporting claims denied, it is recommended that you use the claim determination date as the anchor.

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How do we determine which data year claims received, paid or denied are to be reported in?

Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.

Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.

If a claim is received during the data year, it should be reported as received.

If a claim is paid during the data year, it should be reported as paid.

If a claim is denied during the data year, it should be reported as denied.

It is understood that a claim may have been opened in the prior data year and paid or denied during the current data year. In this case, the claim would only be reported as paid or denied during the current data year.

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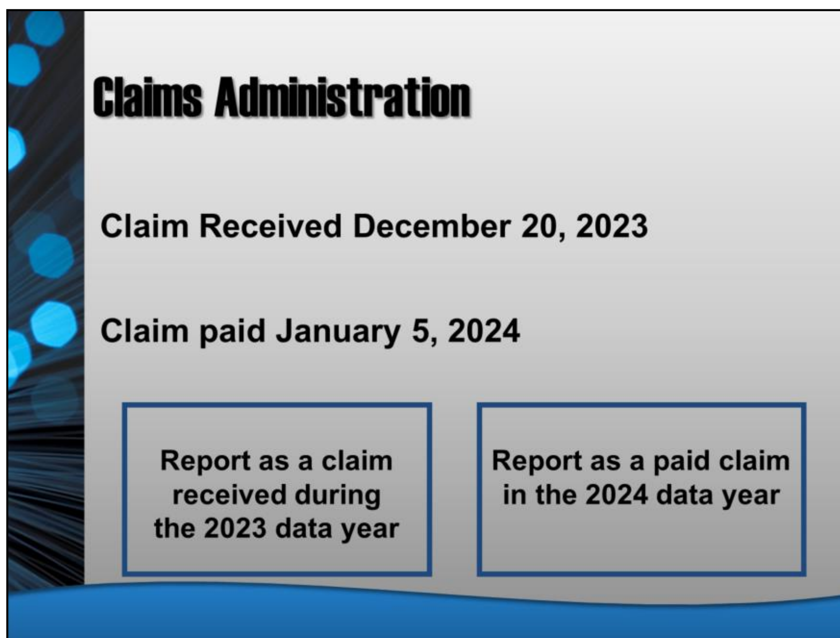

For example, if the claim is received December 20th of the current reporting year, and paid January 5th of the next reporting year, the claim would be reported as received in the current reporting year and paid in the next reporting year.

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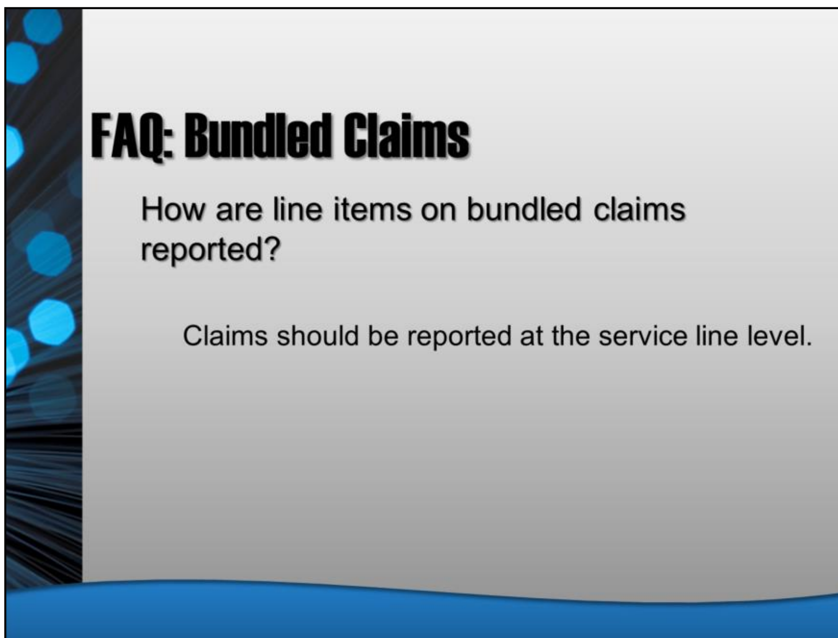

The next FAQ clarifies that bundled claims should be reported at the service line level.

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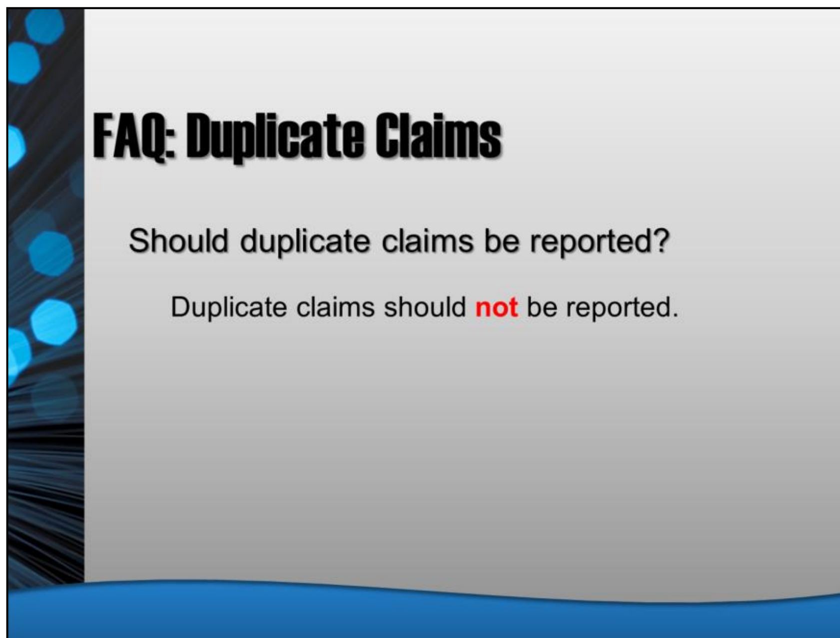

Duplicate claims have resulted in several questions. This FAQ clarifies that duplicate claims should NOT be reported within the health MCAS.

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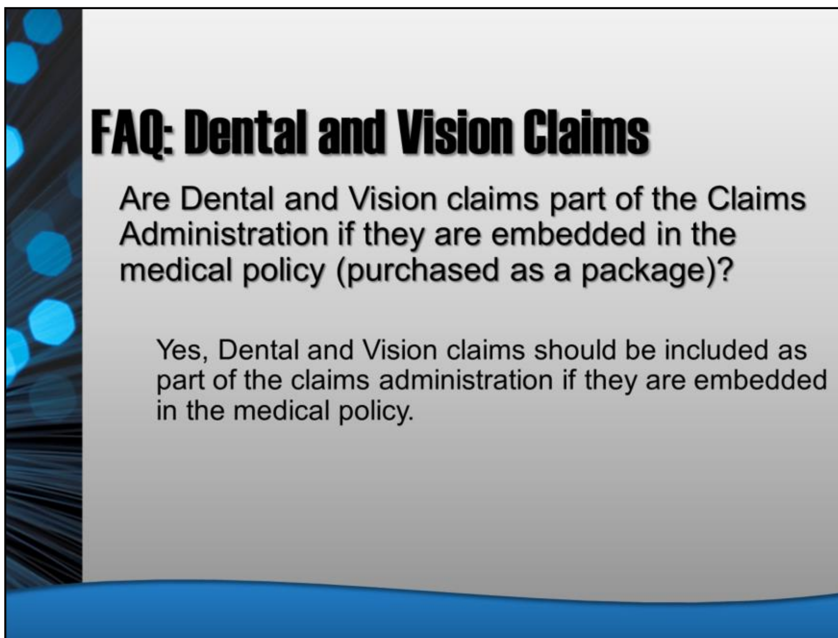

If Dental and Vision coverages are included within the medical policy, you should report the dental and vision claims. Dental and vision policies that are issued separate from the medical policy are not included within the health MCAS reporting.

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How are claim payment adjustments reported?

A claim payment adjustment would only be considered as a separate claim if it receives a different/new claim number. If the original claim number is used (reopened), it would be considered as part of the original claim and would be aged from receipt of the original claim.

A claim payment adjustment would only be considered as a separate claim if it receives a different/new claim number. If the original claim number is used (or reopened), it would be considered as part of the original claim and would be aged from receipt of the original claim.

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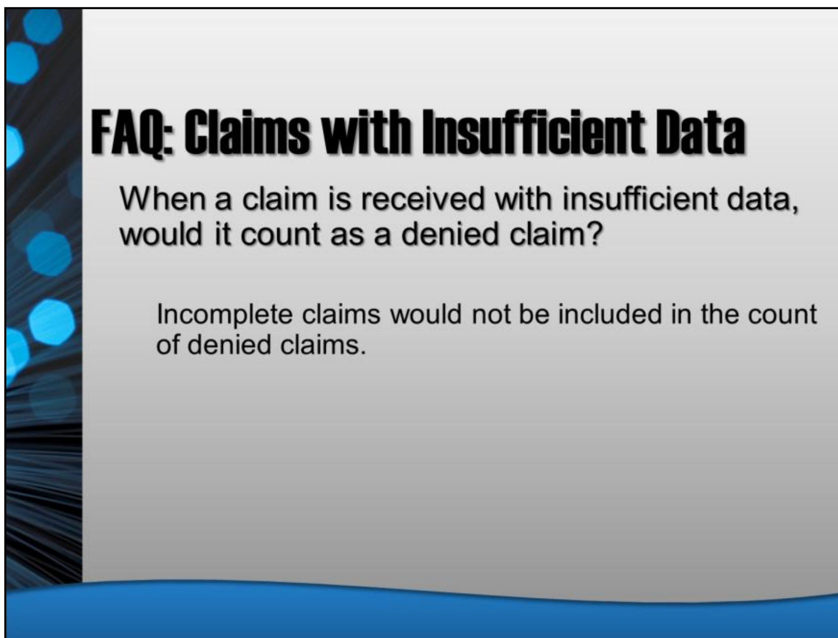

Incomplete claims are not to be included in the claim reporting.

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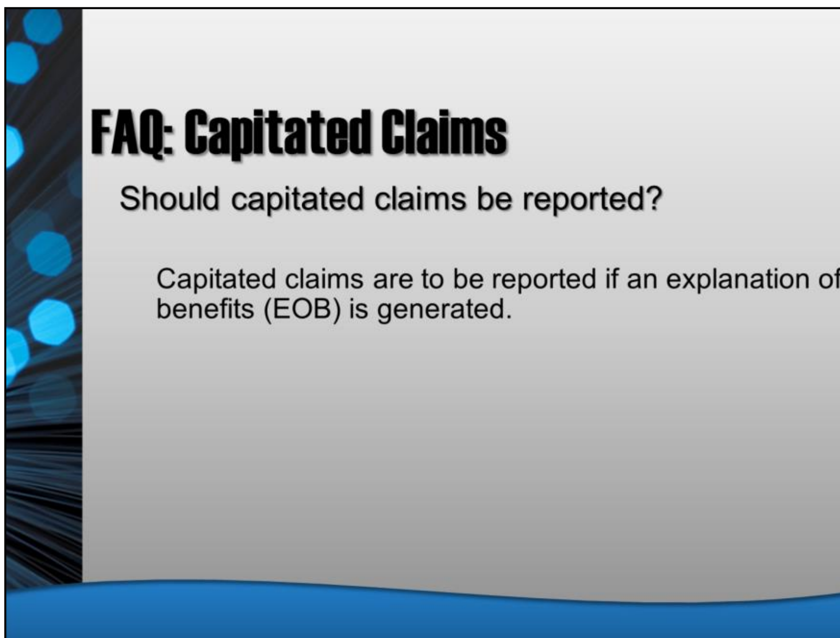

If the company generates an explanation of benefits for a capitated claim, then it should be included in the health MCAS reporting.

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If a claimed service is included in a prepaid capitated service, should this be reported as a denied claim or a paid claim?

If the Explanation of Benefits indicates that the service was paid or covered, then it should be reported as paid. If the Explanation of Benefits indicates that the service was denied, then it should be reported as denied.

You should report claims that are included in a prepaid capitated service according to the determination shown on the explanation of benefits.

If the Explanation of Benefits indicates that the service was paid or covered, then it should be reported as paid. If the Explanation of Benefits indicates that the service was denied, then it should be reported as denied.

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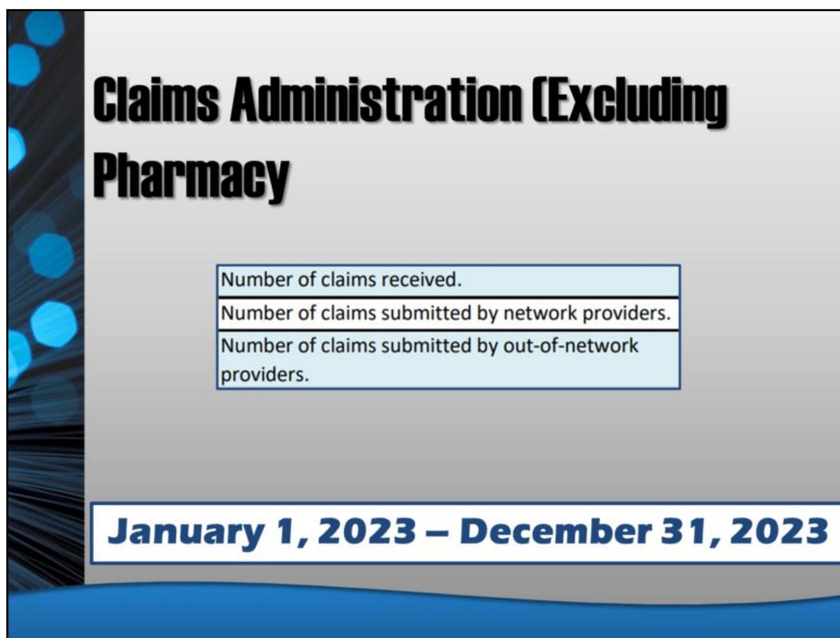

Within the Claims Administration (Excluding Pharmacy) section, you are first asked to report the number of claims received, the number of claims received from network providers and the number of claims received from out-of-network providers.

The sum of submitted network and out-of-network claims should equal the total claims received.

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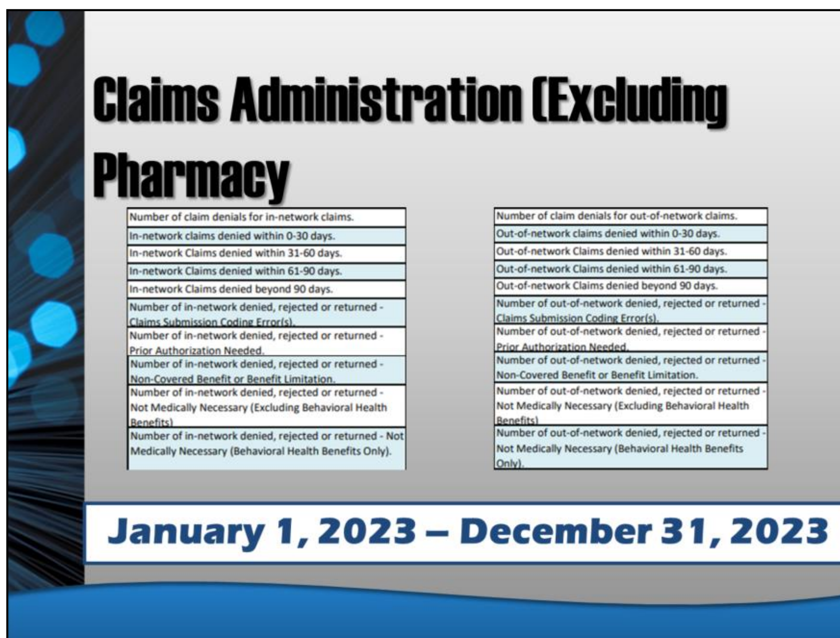

The next grouping of data elements records the number of in-network and out-of-network claims that were denied.

In addition to reporting the total number of denials, you are to report the denials according to the length of time it took the carrier to make the denial determination.

The breakouts are:

- 0-30 days
- 31-60 days
- 61-90 days
- And beyond 90 days

You are also asked to report in-network and out-of-network claims that are denied, rejected or returned according to the reasons for the denial, rejection or return.

The reporting categories are:

- Claim submission coding errors
- Prior authorization needed
- Non-covered benefit or benefit limitation
- Not medically necessary (Excluding Behavioral Health Benefits)
- And Not medically necessary (Behavioral Health Benefits Only)

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Should the number of total claim denials be equal to the sum of the five claim denial reporting categories?

No. The five claim denial reporting categories added for the 2018 data year are not exhaustive. Claim denials reported in the five categories should be a subset of the reported total denials.

The five claim denial reporting categories added for the 2018 data year are not exhaustive. Claim denials reported in the five categories should be a subset of the reported total denials.

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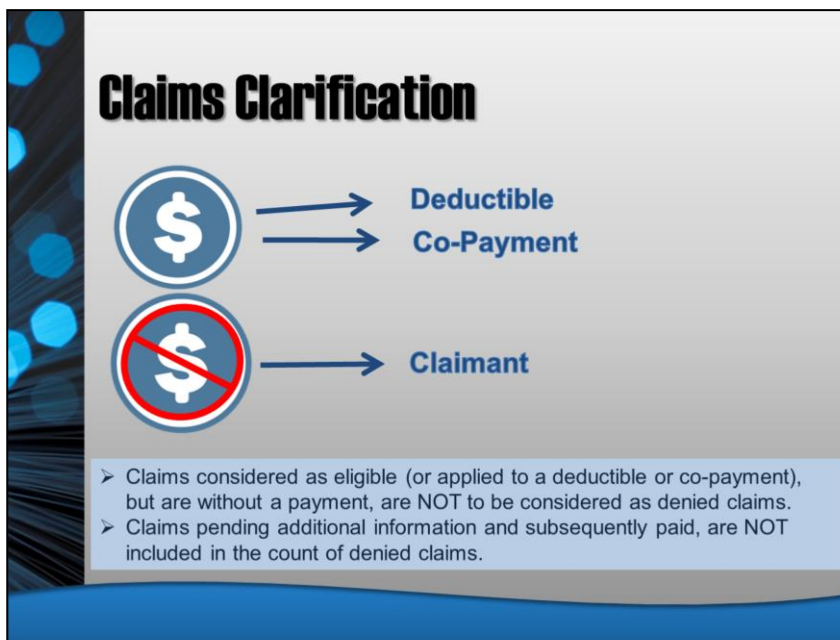

Keep in mind…

- Claims that are pended for additional information and subsequently paid are not to be included in the count of denied claims.
- Also, a claim that is considered as eligible (or applied to a deductible or co-payment), but is without a payment, is not to be considered as a denied claim.

This means, if the claimed amount goes toward a Deductible or a Co-Payment, and no funds go to the claimant, the claim should not be considered a denied claim.

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Claims Administration (Excluding Pharmacy)

Number of paid claims for in-network services.
In-network claims paid within 0-30 days.
In-network claims paid within 31-60 days.
In-network claims paid within 61-90 days.
In-network claims paid beyond 90 days.
Number of paid claims for out-of-network services.
Out-of-network claims paid within 0-30 days.
Out-of-network claims paid within 31-60 days.
Out-of-network claims paid within 61-90 days.
Out-of-network claims paid beyond 90 days.

The next grouping of data elements record the number of in-network and out-of-network claims that were paid.

As with the denied claims, the claims paid are broken out according to the length of time it took the carrier to pay the claim.

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Claims Administration (Excluding Pharmacy)

Out-of-network claims paid within 61-90 days.
Out-of-network claims paid beyond 90 days.
Claims Paid.
Insured/beneficiary co-payment responsibility.
Insured coinsurance responsibility.

- Not intended for a claim count
- Should be the total dollar value of payments by the carrier for benefits reflected in claimant EOBs for the requested period

Special attention should be given to the Claims Paid data element. This field is not intended for a count of claims, but instead, the total dollar value of payments by the carrier for benefits reflected in claimant Explanations of Benefits (EOBs) for the requested period should be reported.

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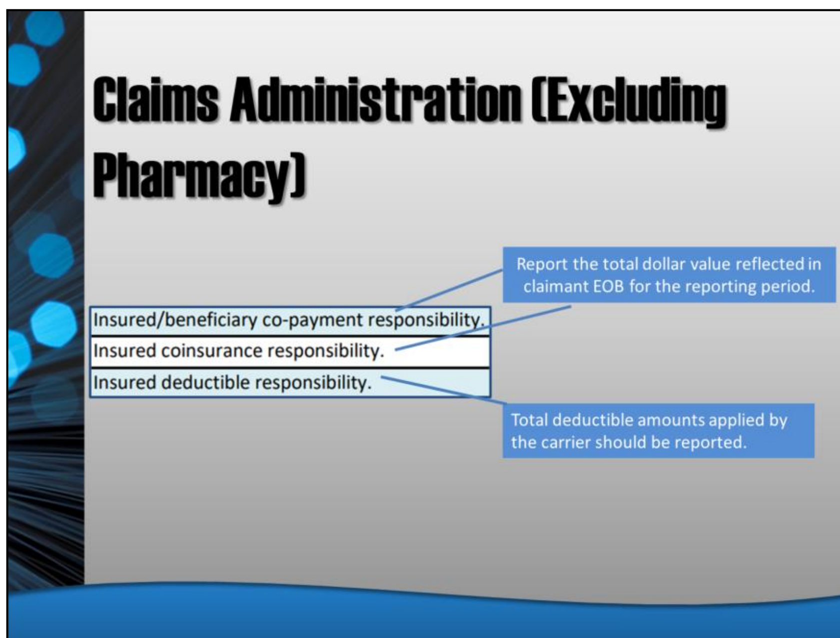

The final claims data elements (excluding pharmacy) deal with copayment, coinsurance and deductible responsibility.

The total dollar value of all co-payments and co-insurance reflected in claimant Explanation of Benefits for the reporting period should be reported.

Likewise, the total deductible amounts applied by the carrier should be reported.

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Claims Administration (Pharmacy Only)

Number of claims received.
Number of claim denials for in-network claims.
Number of claim denials for out-of-network claims.
Number of paid claims for in-network services.
Number of paid claims for out-of-network services.
Claims Paid.
Insured/beneficiary co-payment responsibility.
Insured coinsurance responsibility.
Insured deductible responsibility.

The Claims Administration (Pharmacy Only) section of the health MCAS contains a subset of the data elements reported for the Claims Administration (Excluding Pharmacy) section. So, we are not going to review these elements again.

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Consumer Requested Internal Reviews (Grievances – Including Pharmacy)

Number of customer requests for internal reviews of grievances involving adverse determinations (Do not include additional voluntary levels of reviews.)
Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels of reviews.)
Number of adverse determinations overturned upon request for internal review (Do not include additional voluntary levels of reviews.)
Number of customer requests for internal reviews of grievances not involving adverse determinations.

The next four data elements deal with internal review of grievances, both those involving adverse determinations and those that do not involve adverse determinations.

These data elements include terminology that may need to be clarified.

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Adverse Determinations

- Rescission
- Denial
- Reduction
- Termination of
- Failure to provide or make payment (in whole or in part)

These actions may be the result of:

- A determination of a member's or eligible dependent's eligibility to participate in a plan
- The application of any utilization review
- Determination of an item or service to be experimental or investigational or not medically necessary or appropriate

Adverse Determinations can be a rescission, denial, reduction , termination of, or failure to provide or make payment (in whole or in part).

The Adverse Determinations can be the result of:

- A determination of a member's or eligible dependent's eligibility to participate in a plan
- The application of any utilization review
- Or Determination of an item or service to be experimental or investigational or not medically necessary or appropriate

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Grievance

A written or oral complaint involving an urgent care Request, submitted by or on behalf of a covered person regarding:

- Availability, delivery or quality or health care services (including a complaint regarding an adverse determination made pursuant to utilization review)
- Claims payment, handling or reimbursement for health care services
- Matters pertaining to the contractual relationship between a covered person and a health carrier.

A grievance is a written or oral complaint involving an urgent care request, submitted by or on behalf of a covered person regarding:

- Availability, delivery or quality or health care services (including a complaint regarding an adverse determination made pursuant to utilization review)
- Claims payment, handling or reimbursement for health care services
- Or, Matters pertaining to the contractual relationship between a covered person and a health carrier.

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If a grievance includes multiple services, some of the services may be upheld while others are overturned. In this situation, should the grievance be reported as approved or denied?

If the company tracks the grievances separately, then report separately. Otherwise partially overturned (found in favor of the member) are considered overturned. A comment should be added to the filing to indicate how this is reported.

If a grievance includes multiple services, some of the services may be upheld while others are overturned.

If the company tracks the grievances separately, then they should be reported separately. Otherwise partially overturned (found in favor of the member) are considered overturned.

A comment should be added to the filing to indicate how this is reported.

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Consumer Requested Internal Reviews (Grievances – Including Pharmacy)

Number of customer requests for internal reviews of grievances involving adverse determinations (Do not include additional voluntary levels of reviews.)
Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels of reviews.)
Number of adverse determinations overturned upon request for internal review (Do not include additional voluntary levels of reviews.)
Number of customer requests for internal reviews of grievances not involving adverse determinations.

You are to report the number of requests for internal review of grievances involving adverse determinations, how many of those were upheld, and how many of them were overturned.

You are also asked to report the number of requests for internal reviews of grievances NOT involving adverse determinations.

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Should second level internal review be reported in the MCAS?

- Only first level internal reviews should be reported. However, one of the interrogatory questions asks if the company has an additional voluntary level of review for grievances. Second level reviews should be noted in response to this question.

Only first level internal reviews should be reported. However, one of the interrogatory questions asks if the company has an additional voluntary level of review for grievances.

Second level reviews should be noted in response to this question.

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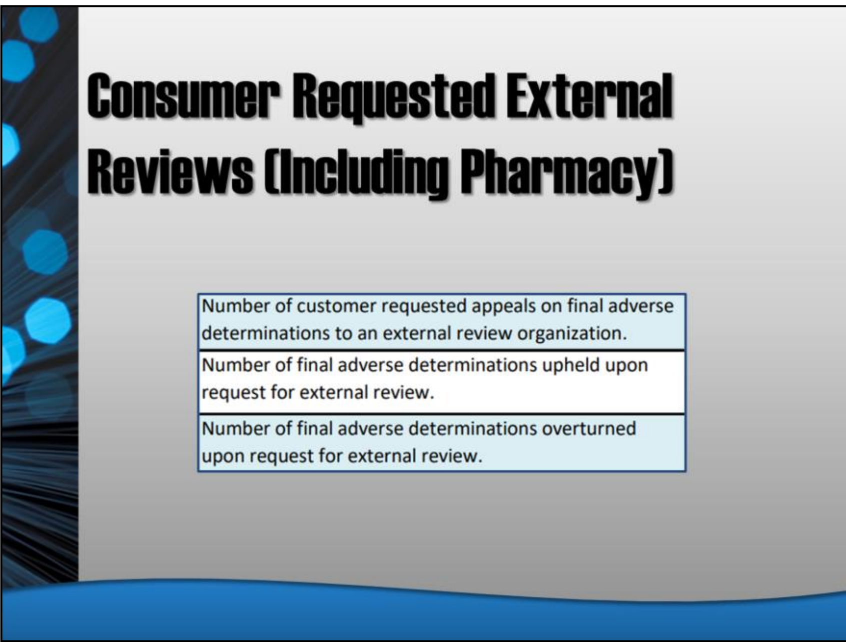

Finally, you are asked to report on consumer requested external reviews.

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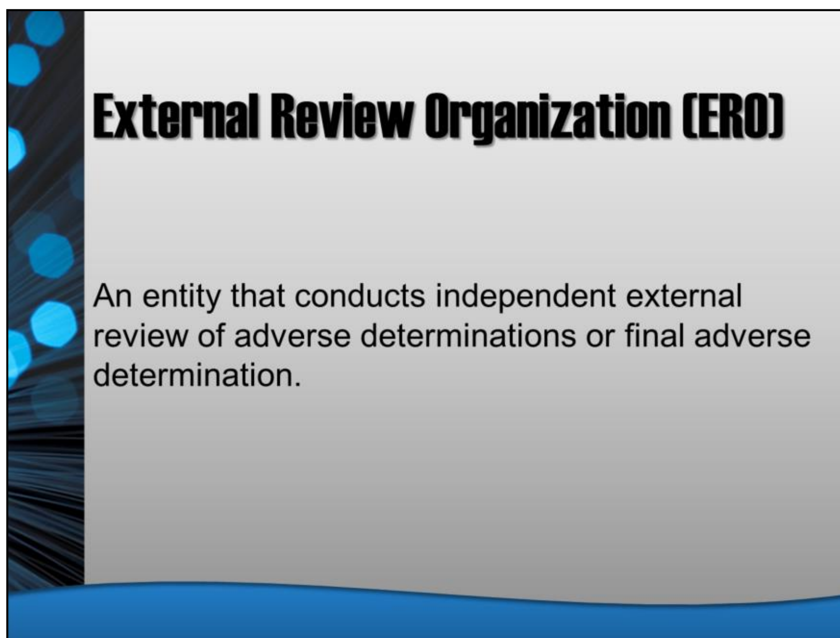

An External Review Organization or ERO is an entity that conducts independent external review of adverse determinations or final adverse determination.

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Consumer Requested External Reviews (Including Pharmacy)

Number of customer requested appeals on final adverse determinations to an external review organization.
Number of final adverse determinations upheld upon request for external review.
Number of final adverse determinations overturned upon request for external review.

You are asked to report the number of requested appeals on final adverse determinations to an external review organizations. Of those requests, you will report the number of adverse determinations upheld and overturned.

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Health

Data Elements

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