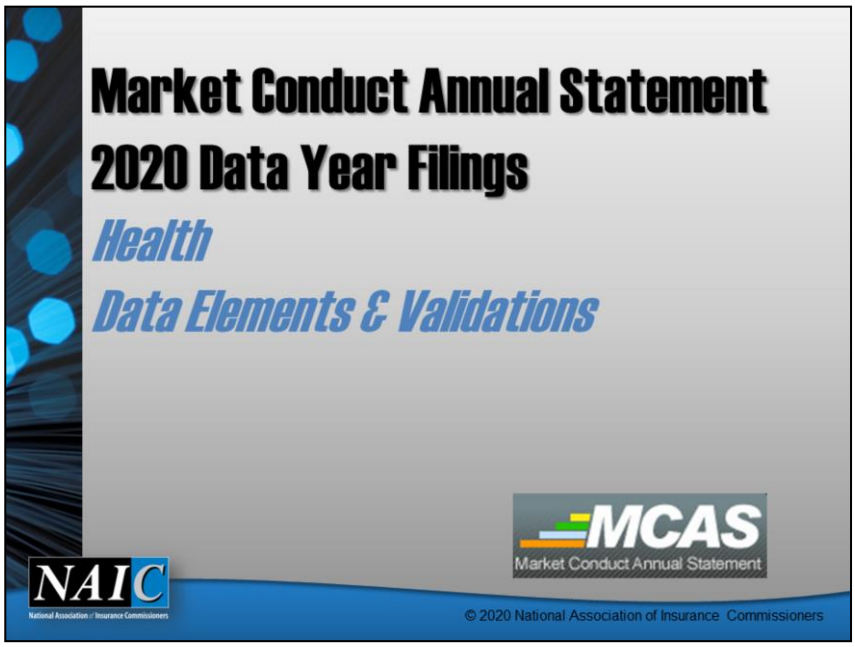
Market Conduct Annual Statement
2020 Data Year Filings
Health
Data Elements & Validations
MCAS
Market Conduct Annual Statement
NAIC
National Association of Insurance Commissioners
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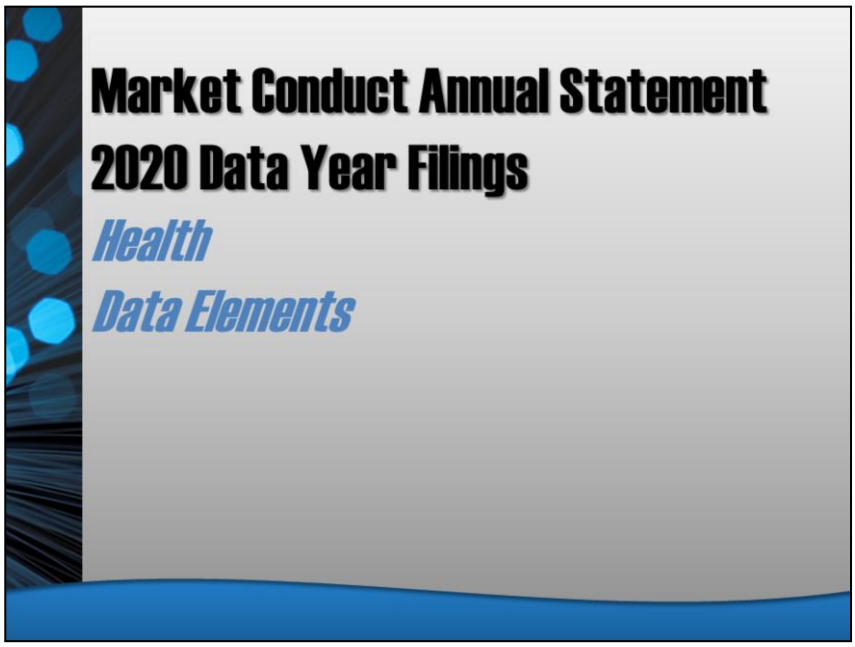
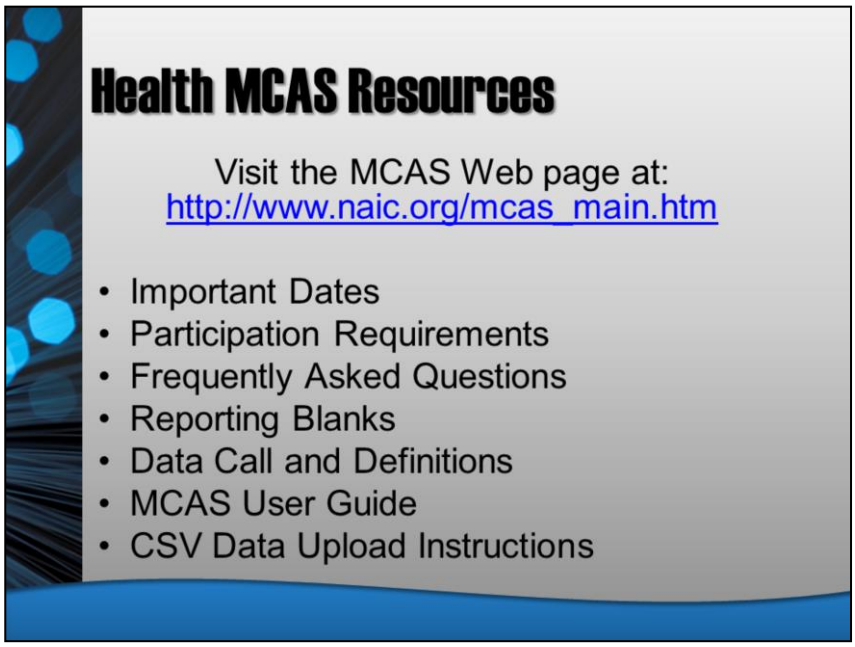


Hi…I'm Leana Massey .

In this section of the Market Conduct Annual Statement training we will be reviewing the data elements that must be provided for the Health MCAS.

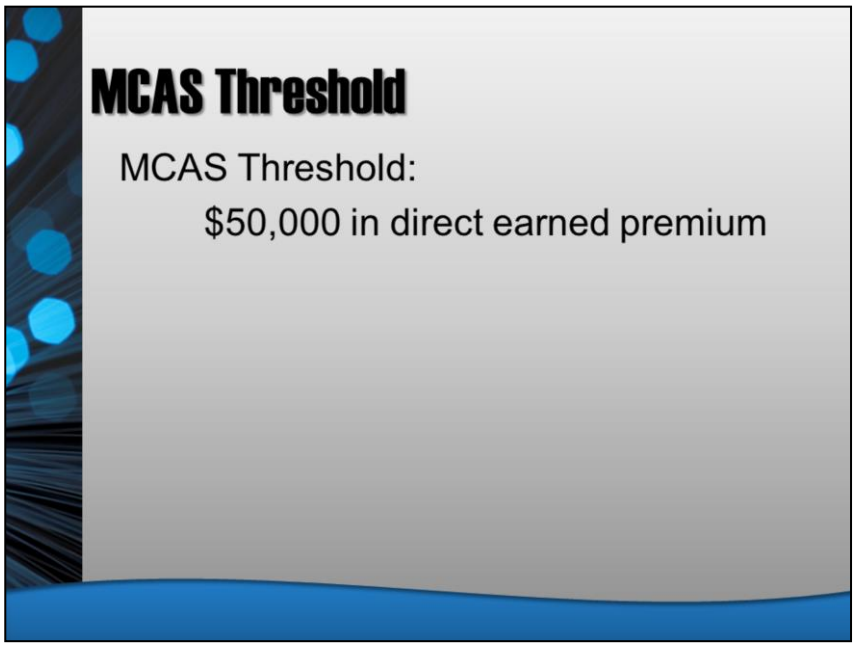


Many MCAS related resources are available to you on the MCAS web page. I encourage you to visit the page frequently to find the latest reporting information.

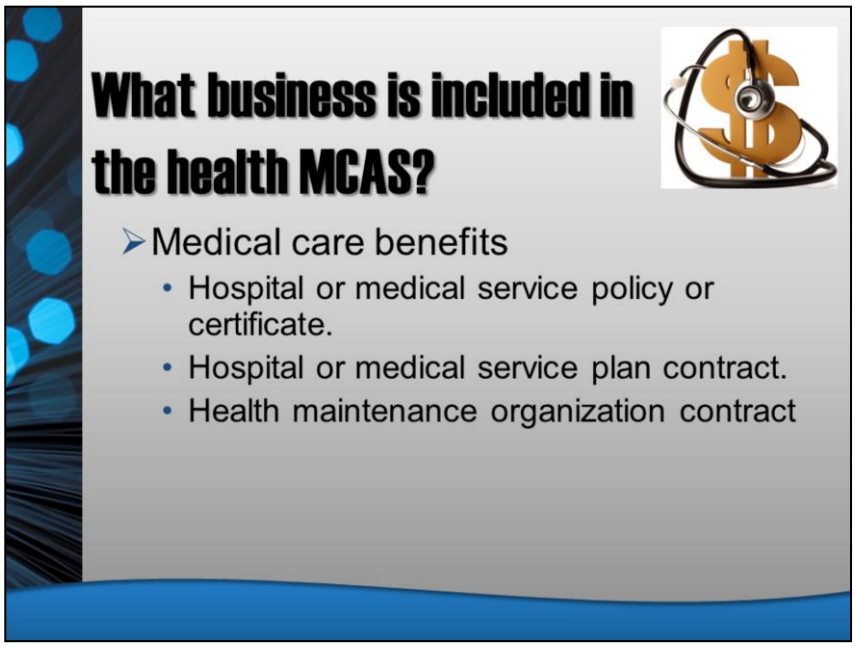
The available resources include:

- 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

The health MCAS data reporting period is January 1st through December 31st of the reporting year, and the health MCAS filing deadline is June 30th. This filing deadline extension was previously granted for data years through 2021. The Health MCAS due date for the 2022 data year will roll back to April 30th unless another extension is granted.

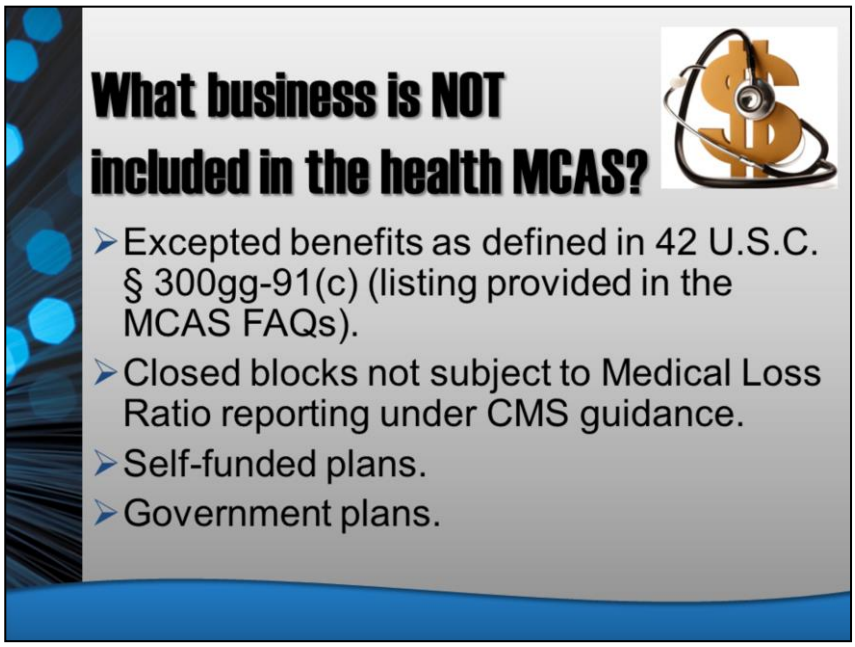


Companies reporting at least $50,000 of earned premium for MCAS applicable health insurance, in a MCAS participating jurisdiction, are required to submit health MCAS data to those participating jurisdictions where they meet the premium threshold. There are currently 49 participating MCAS jurisdictions.



Health insurance business reported in the MCAS includes:

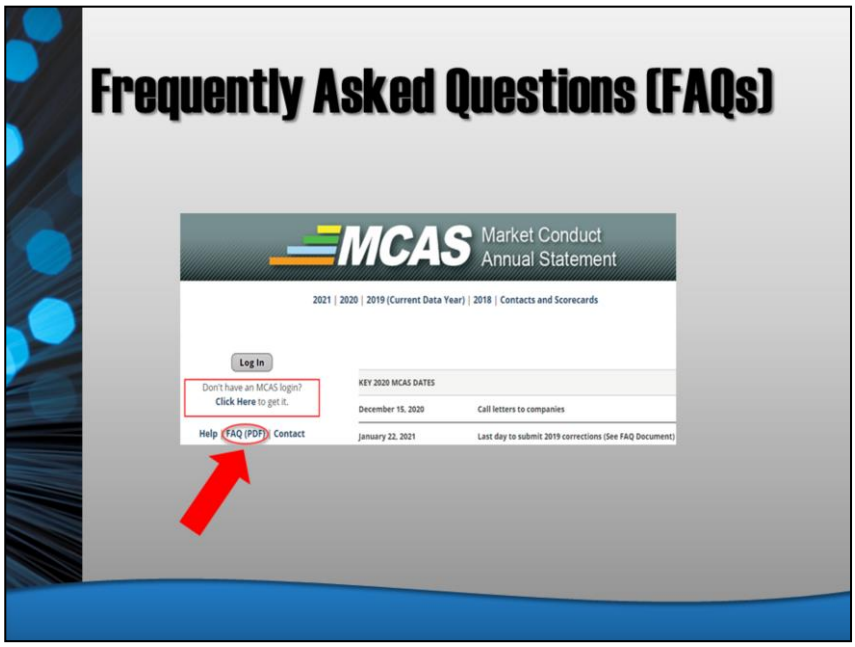
Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization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



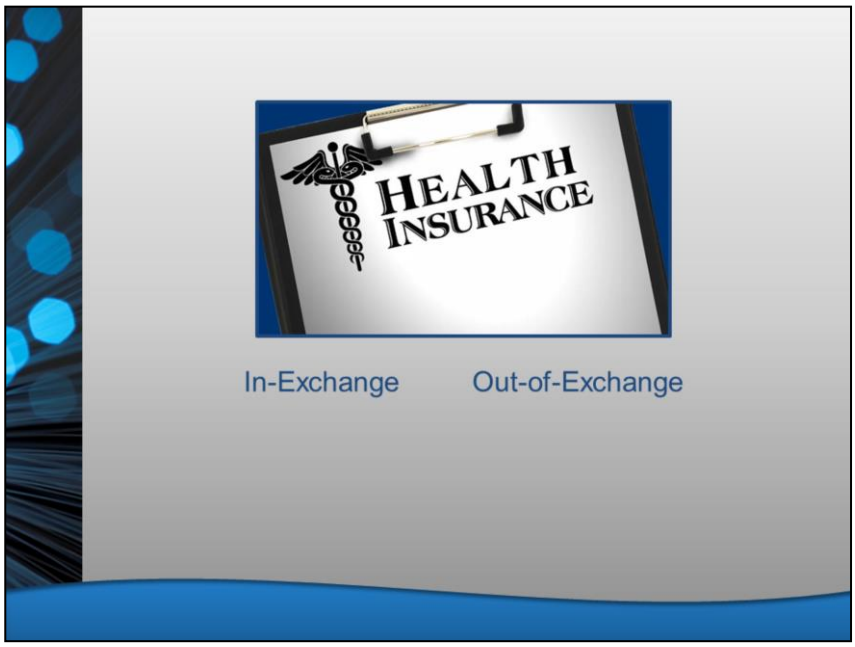
The reported data should NOT include:

- 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
- Or 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



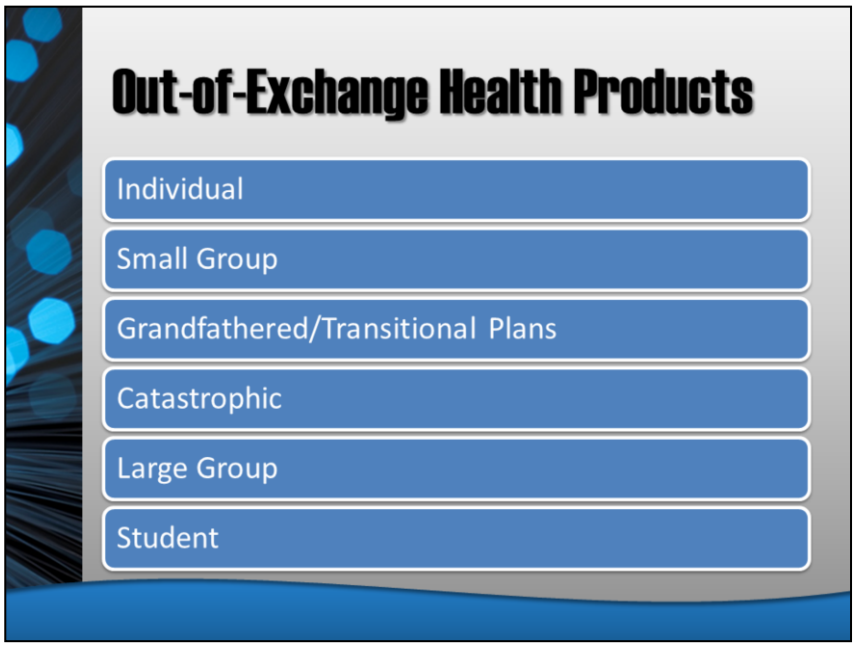
The MCAS Frequently Asked Questions or FAQs document can be found on the MCAS webpage. We will refer to questions found in the FAQ document throughout this tutorial.



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

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

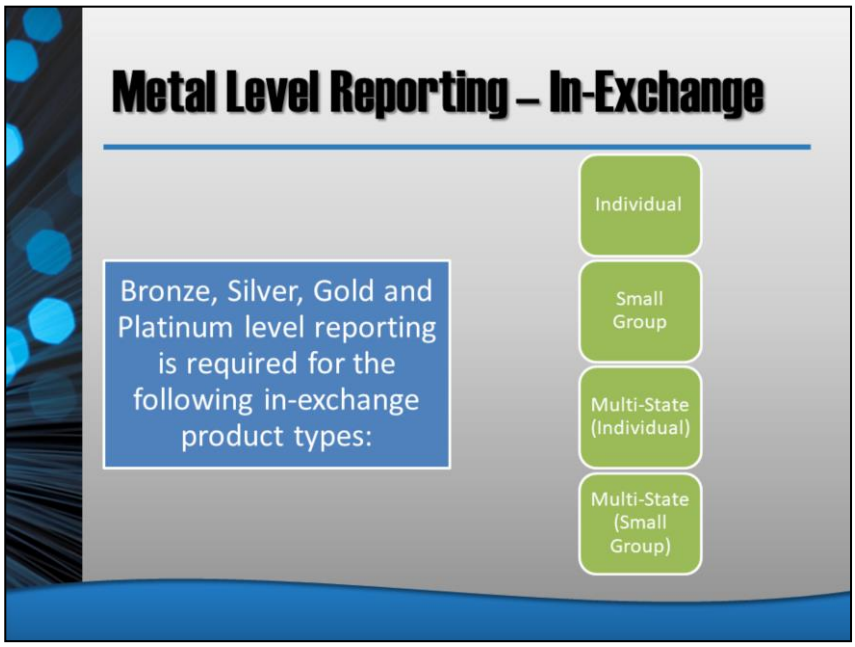
- Individual
- Small Group
- Catastrophic
- Multi-State – Individual
- And Multi-State – Small Group



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

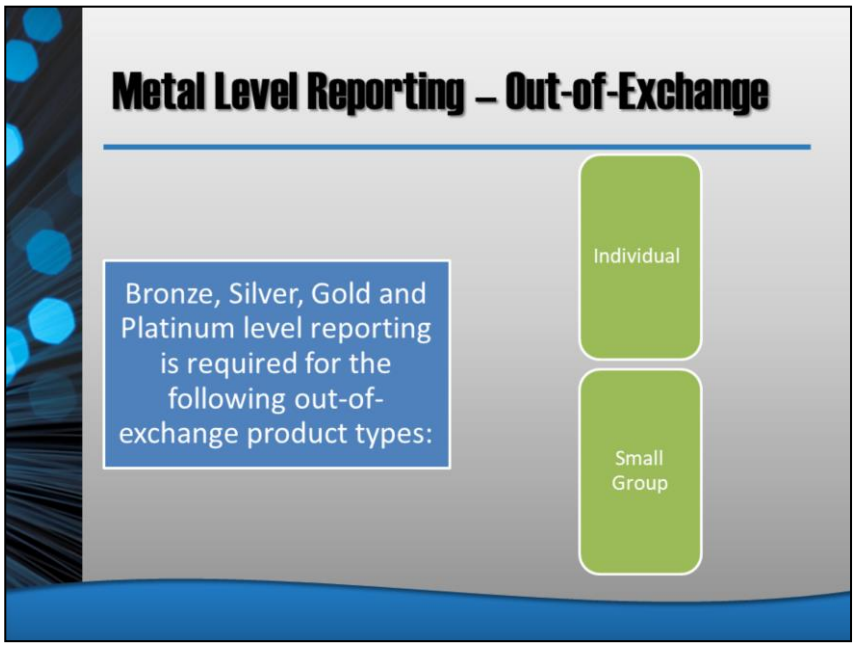
Definitions of the in-exchange and out-of-exchange products can be found in the data call and definitions document.



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.

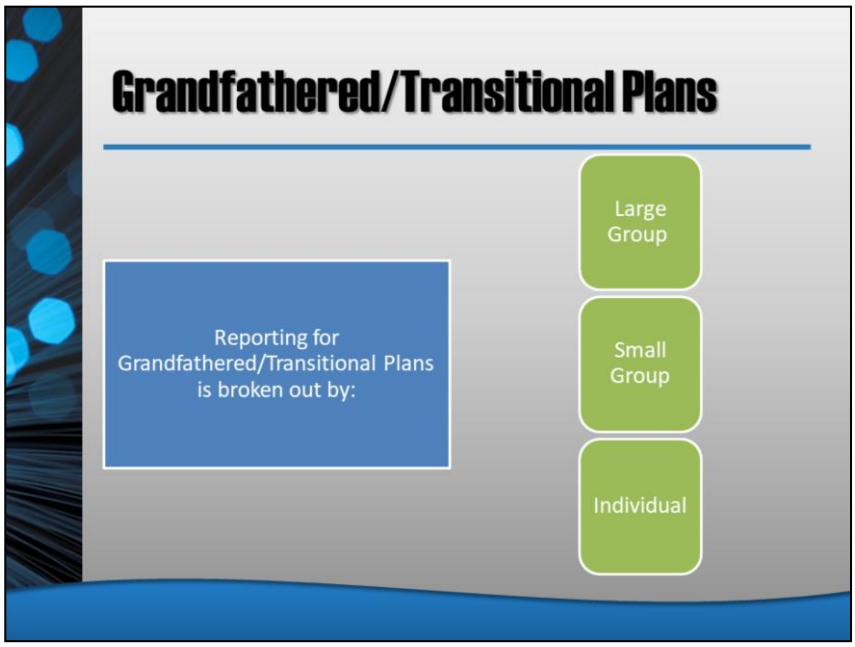
In-Exchange metal level data is to be reported for:

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



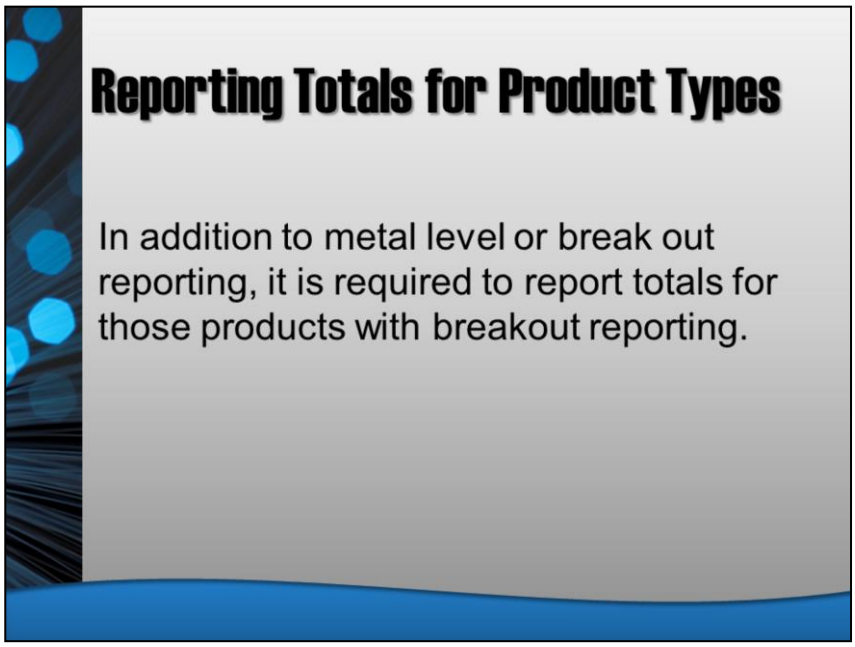
Out-of-Exchange metal level data is to be reported for:

- Individual
- And Small Group product types

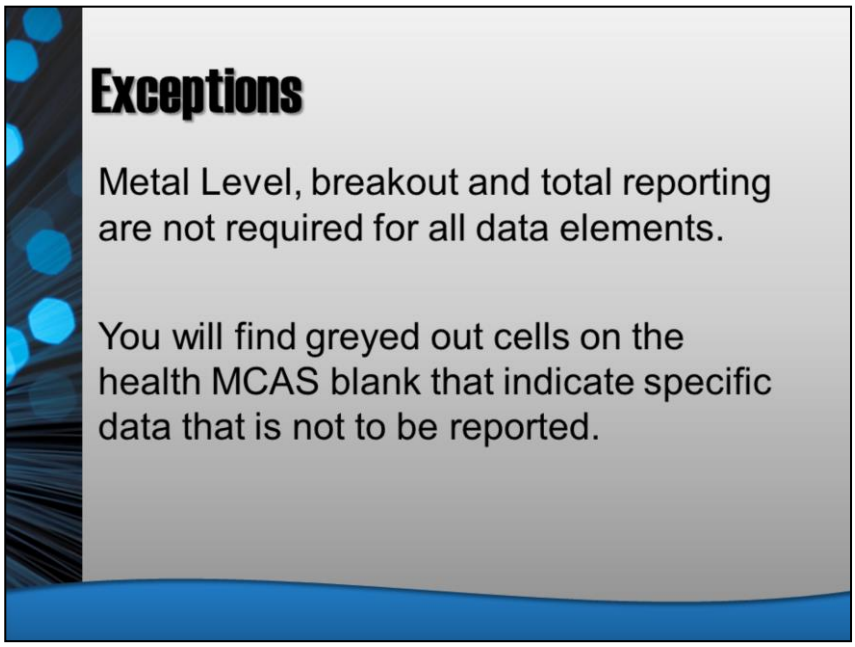


Out-of-Exchange Grandfathered and Transitional plans are to be reported with breakouts for:

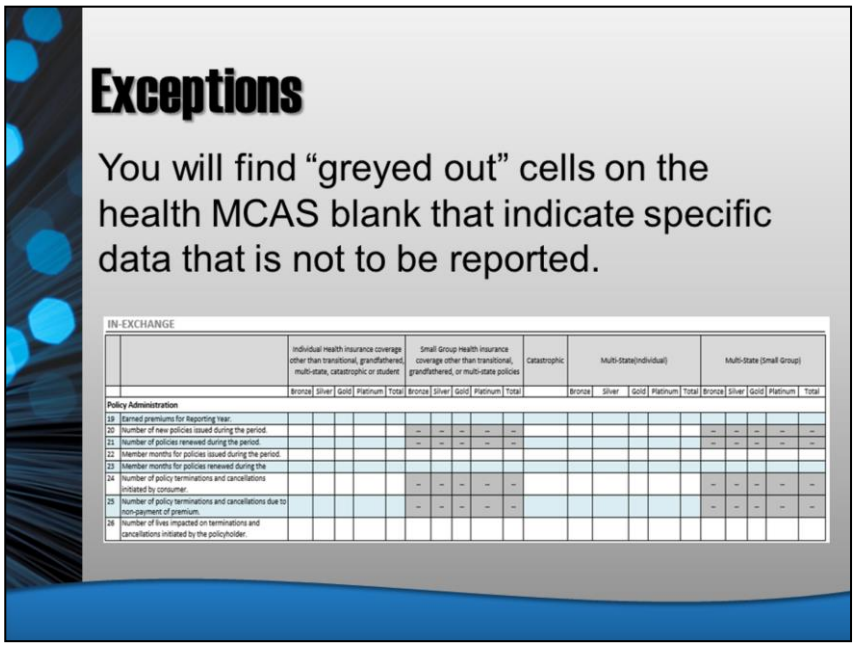
- Large Group
- Small Group
- And Individual products



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.



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.

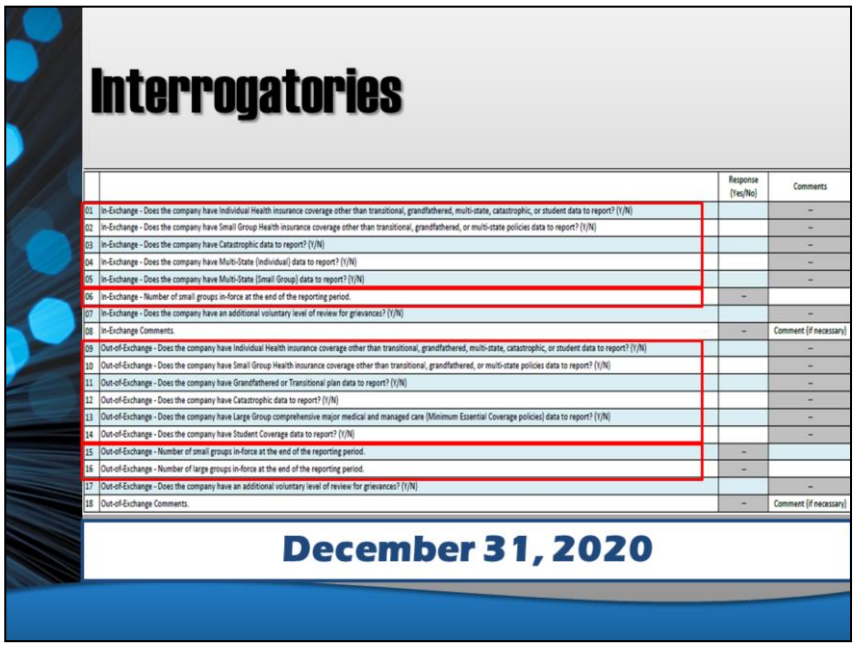


As shown on the slide, data elements that are not to be reported for specific product types and/or breakouts are denoted by the “greyed out” cells on the health MCAS reporting blank.

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.

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

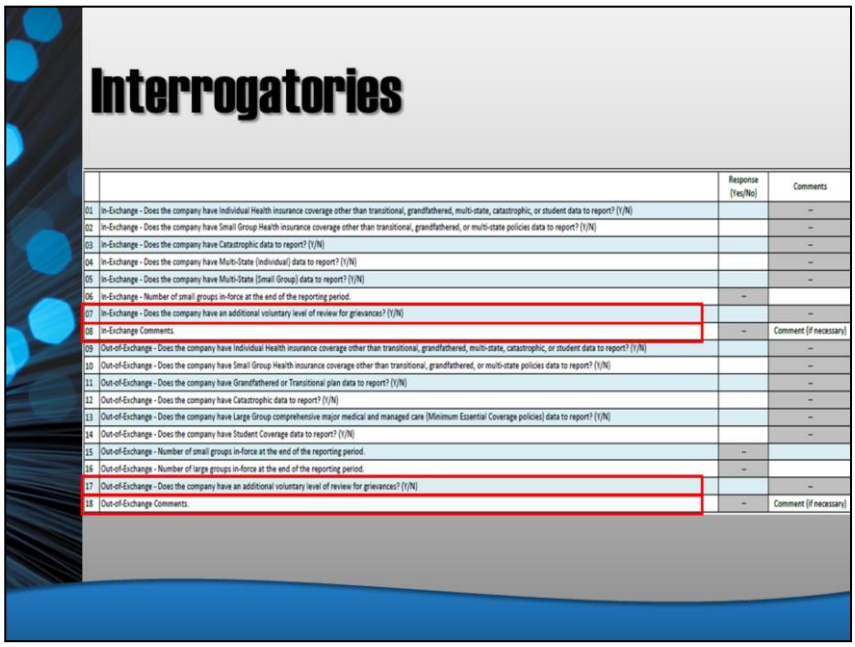
- Interrogatories
- Policy Administration
- Prior Authorizations (Excluding Pharmacy)
- Prior Authorizations (Pharmacy Only)
- Claims Administration (Excluding Pharmacy)
- Claims Administration (Pharmacy Only)
- Consumer Requested Internal Reviews (Including Pharmacy)
- Consumer Requested External Reviews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



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.

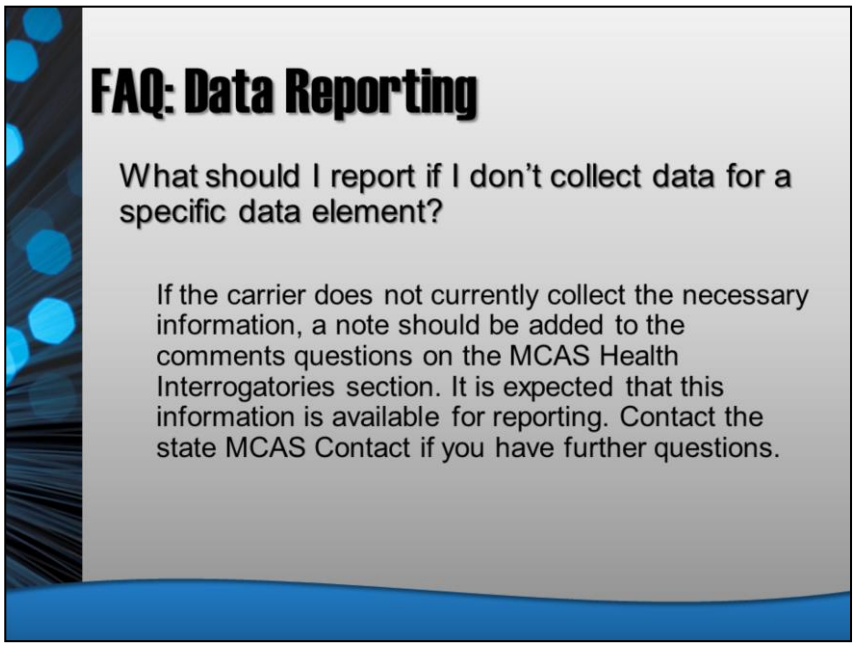
There are questions that ask the company to indicate if they have data to report for each of the in-exchange and out-of-exchange products. Only a yes/no response is required for each of these questions.

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.



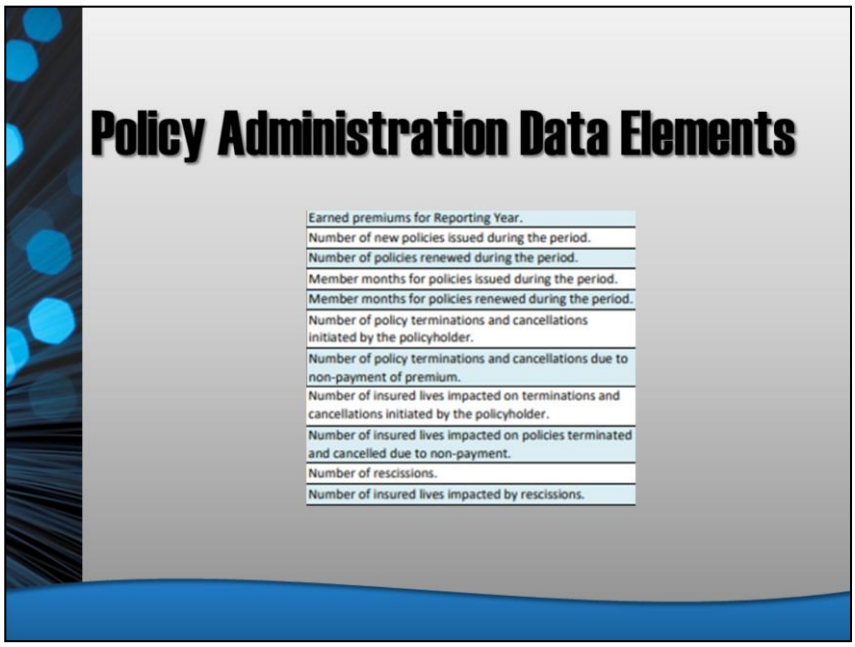
For both in and out-of-exchange, the interrogatories ask if the company has an additional voluntary level of review for grievances. This would be a level of review beyond the normal internal appeals process.

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.



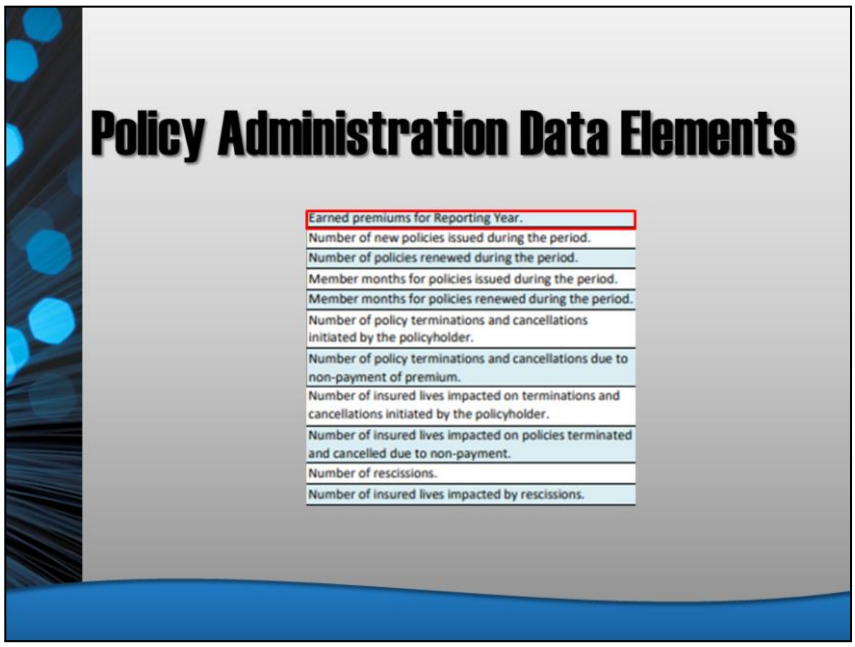
The first FAQ that we'll review deals with data the company is unable to report…If your company is unable to report data for a specific data element within the health MCAS, a note should be added to the Interrogatories section of the filing to explain the reason for the company's inability to report.

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



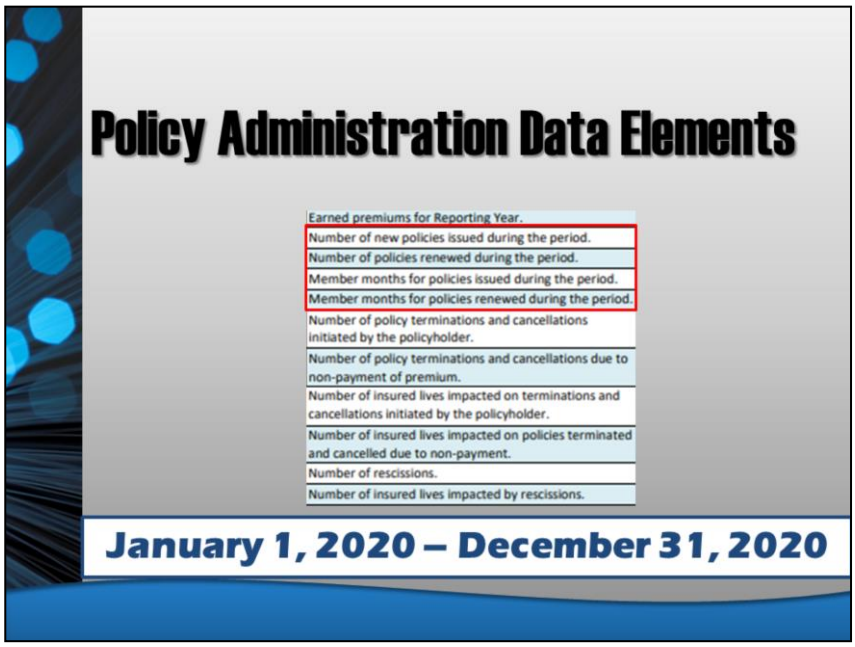
The policy administration data elements reflect data for:

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



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

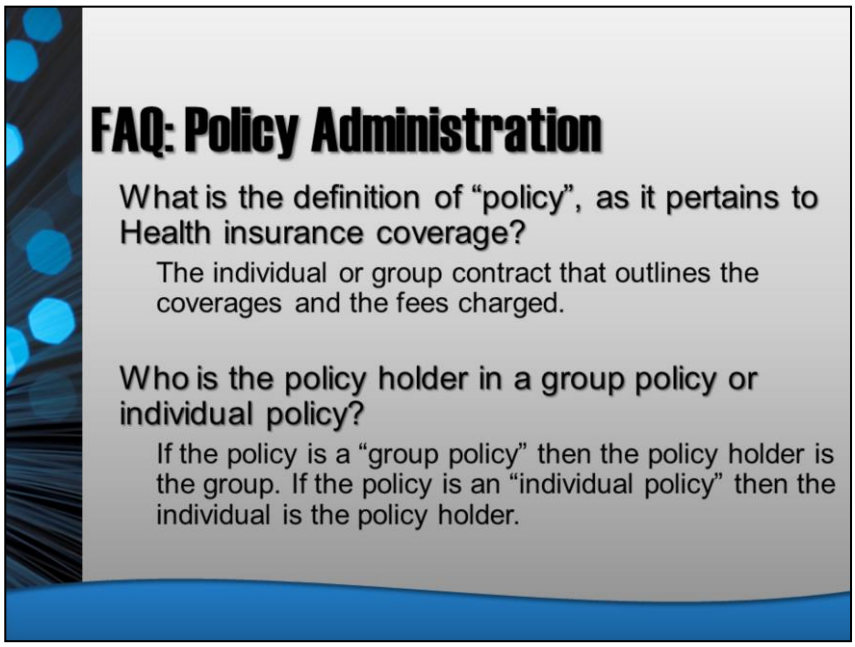
If some of your company's business is not applicable for MCAS reporting, then you will not be able to directly tie the MCAS premiums to the earned premiums reported by state in the Financial Annual Statement Supplemental Health Care Exhibit



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.

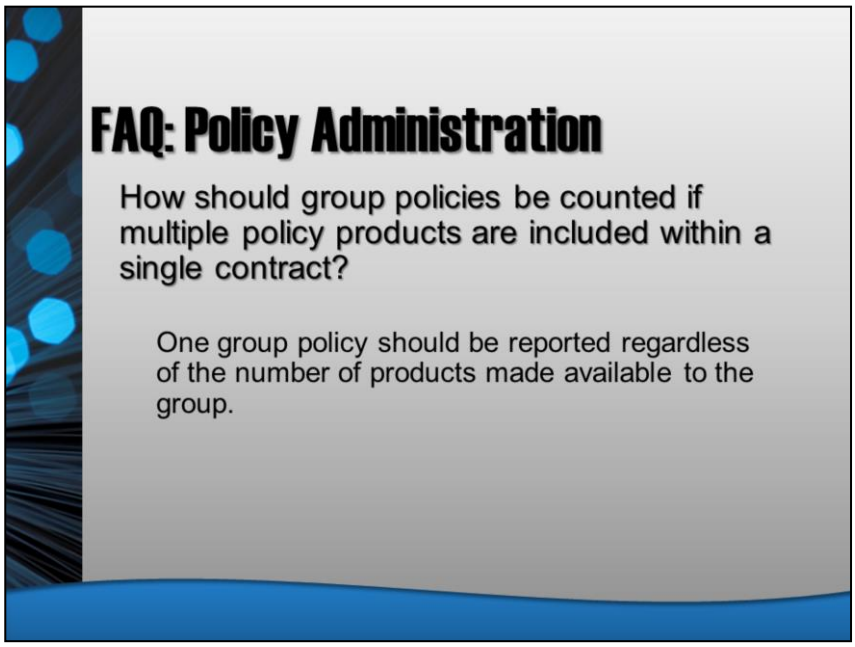
The Data Call and Definitions specify that in determining if a policy was issued or renewed, if the policyholder number remains unchanged, the policy or contract should be considered as renewed.



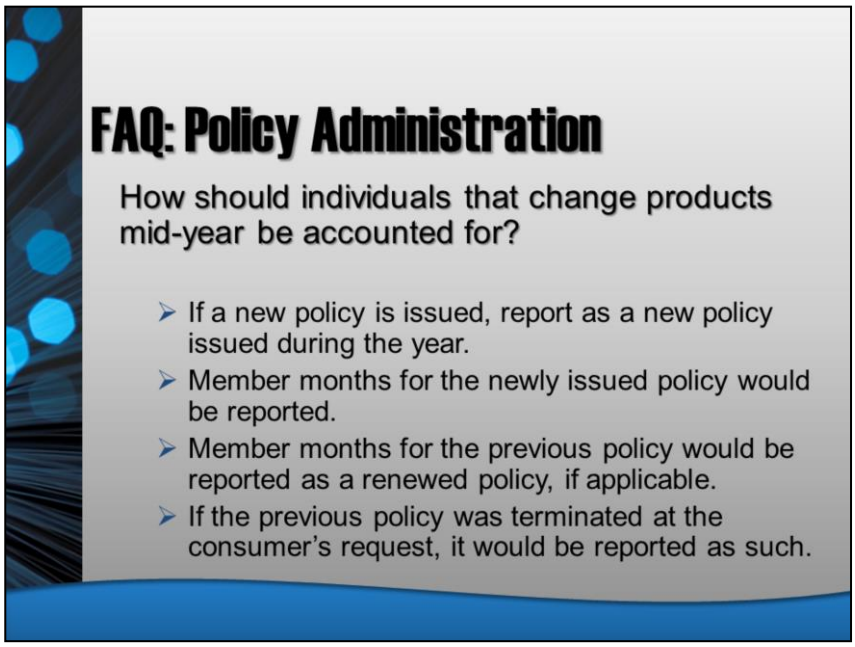
For the health MCAS, a policy should be considered as the individual or group contract that outlines the coverages and fees charged.

The policy holder for a group policy is the group

And, the policy holder for an individual is the individual.

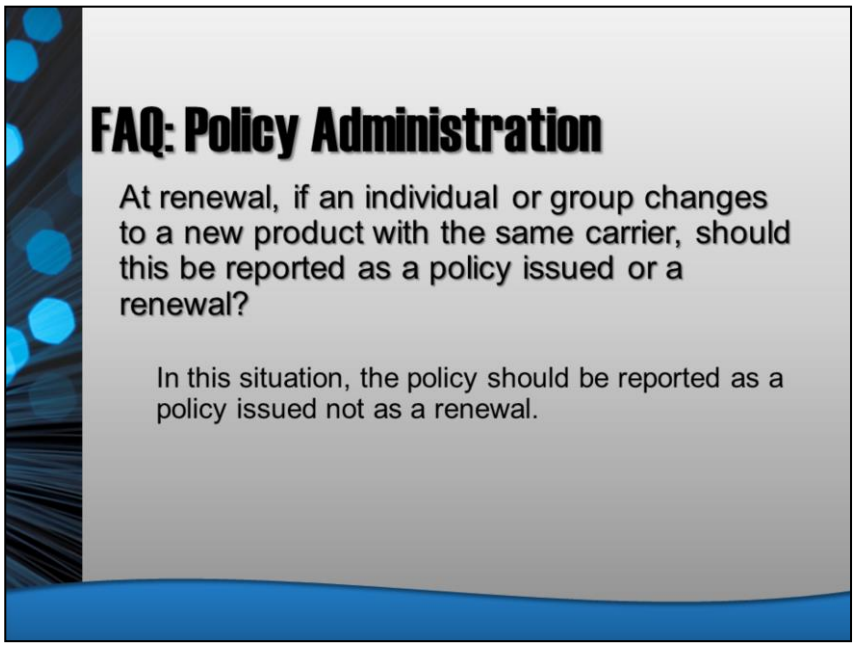


When reporting the number of group policies, one group policy should be reported regardless of the number of products made available to the group within a single contract.

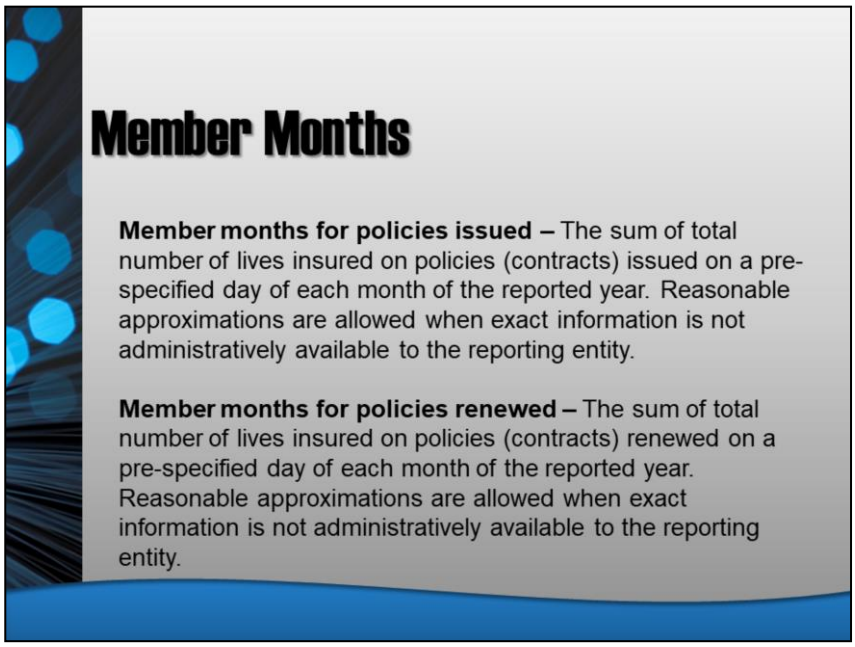


When individuals change products during the data year, the following should be considered:

- 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.



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.

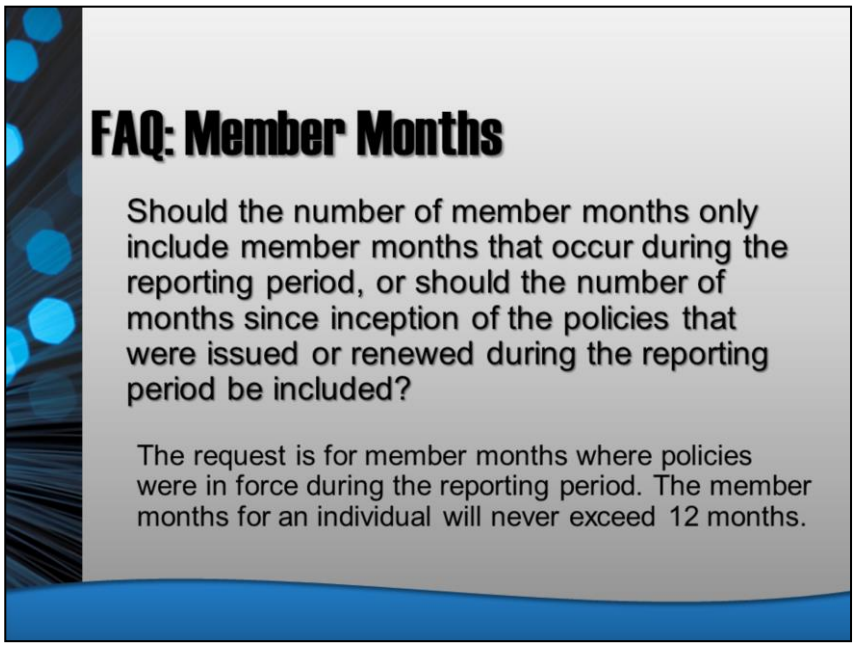


The concept of “Member Months” can be a bit confusing. In the simplest of terms, a policy that is issued to a member on January 1st and remains in-force through December 31st of the same year would equal 12 member months. The member’s policy was in-force for 12 months of the year.

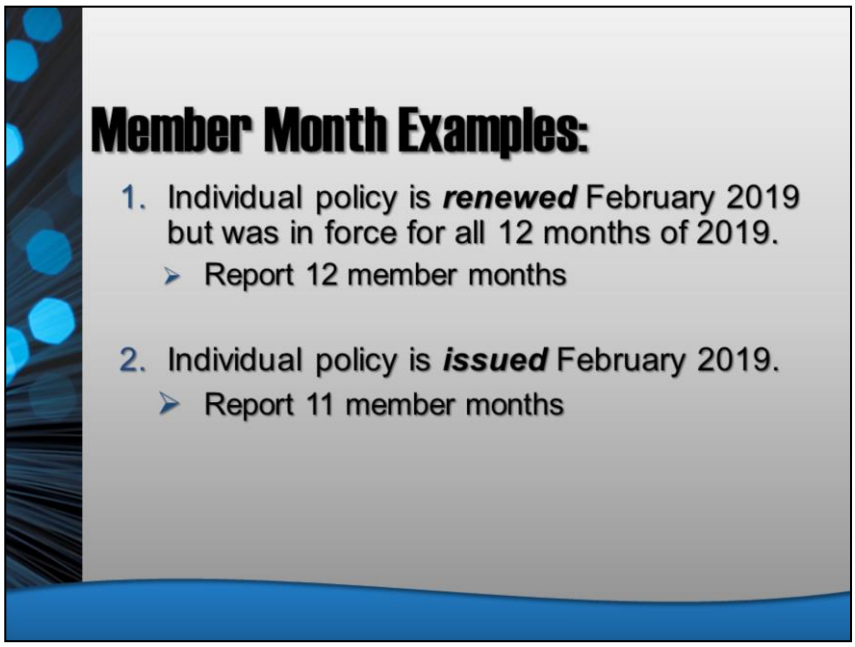
Keep in mind that only those member months that occur during the data year should be included. So, a policy for an individual renewed on October 15th of the current data reporting year, and in force for the entire 12 months of that same data reporting year, would be counted as 12 member months. Member 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.



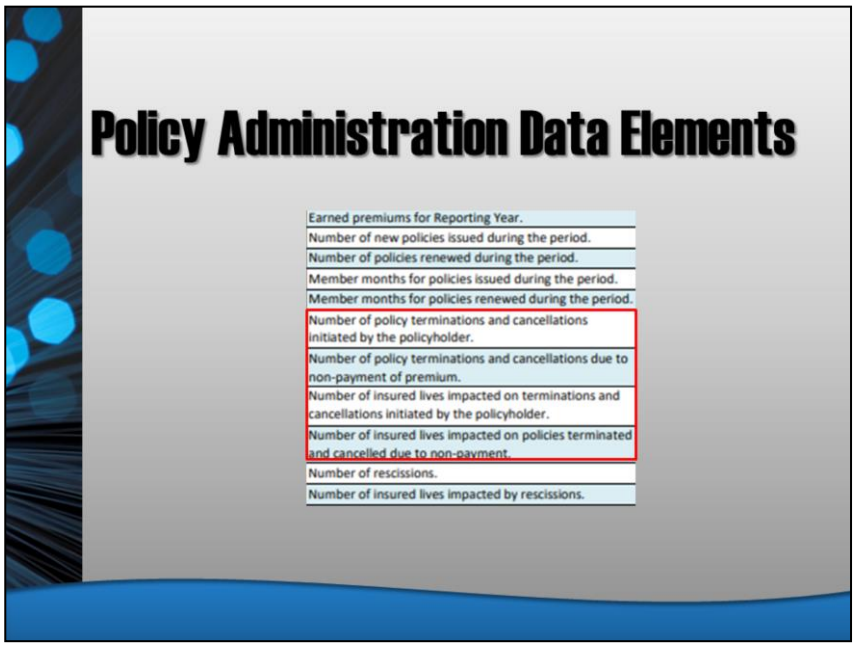
Remember…member months should only include member months where policies were in force during the reporting period. This means that the member months for an individual will never exceed 12 months.



Let's review a member months reporting example…

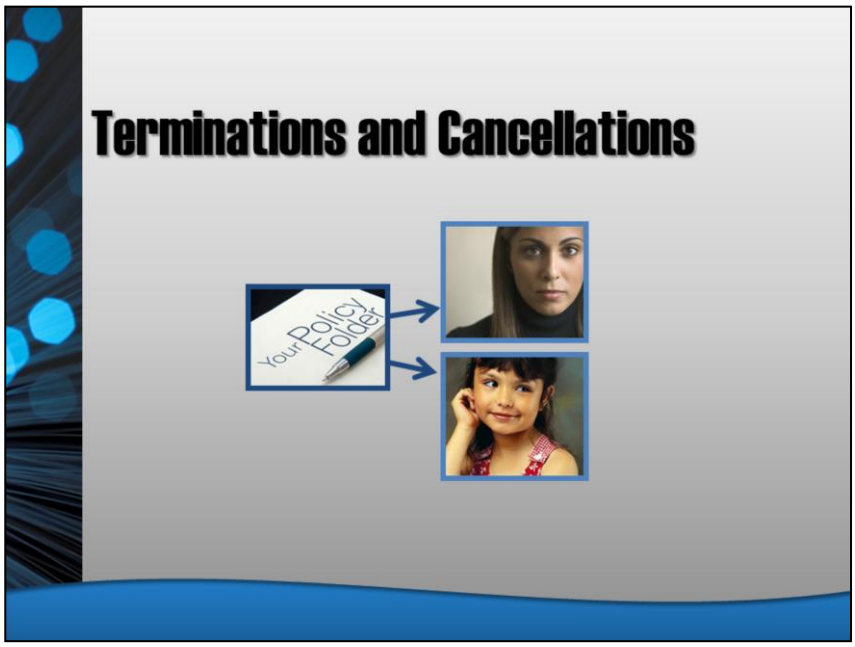
If a policy is ***renewed*** in February, during the reporting period, and the policy was in force for all 12 months during the reporting period, you will report 12 member months.

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

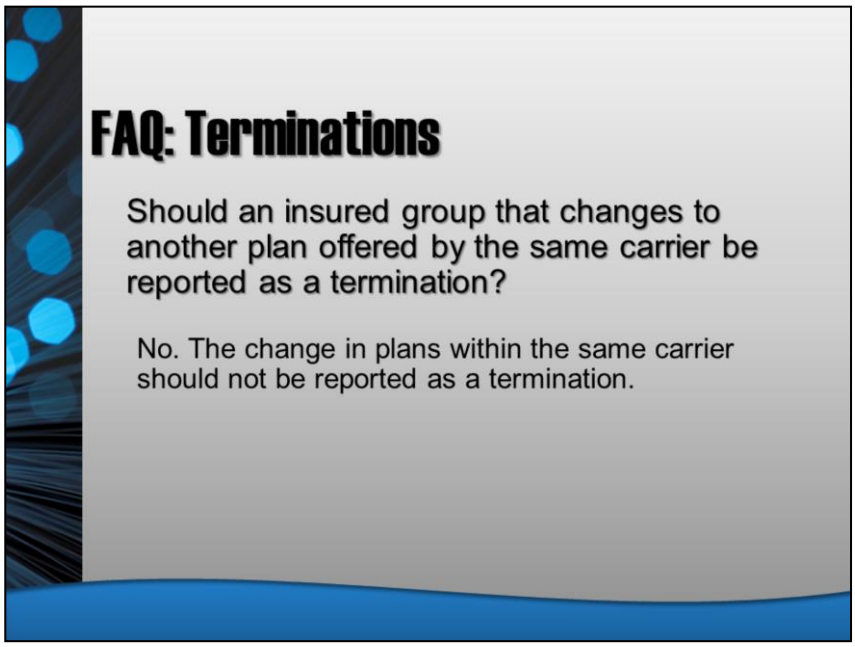


The next section of questions deal with the number of policy terminations and cancellations and the number of lives impacted by terminations and cancellations.

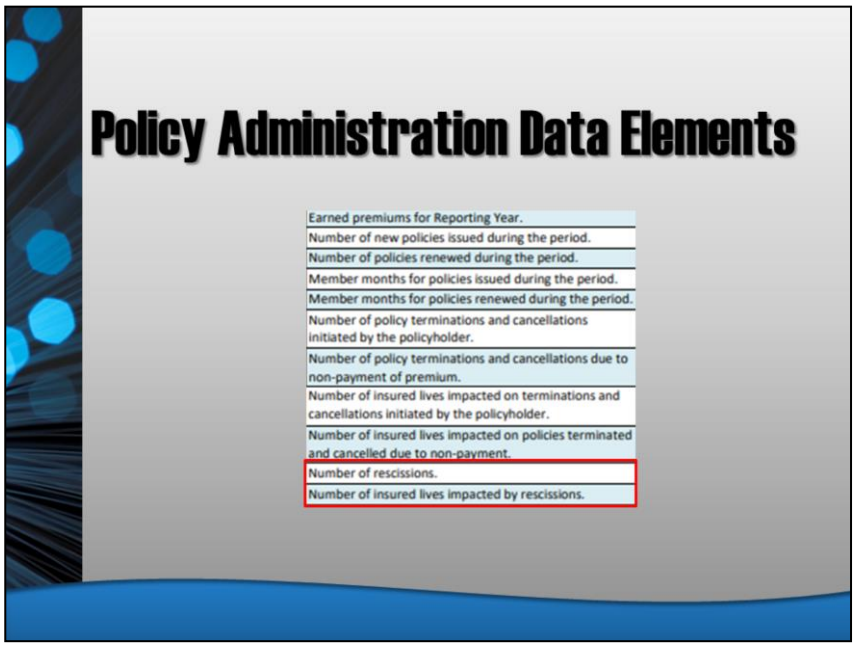
Terminations and Cancellations are to be reported separately if the termination was at the insured's request vs. if the termination was due to non-payment of premium



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.

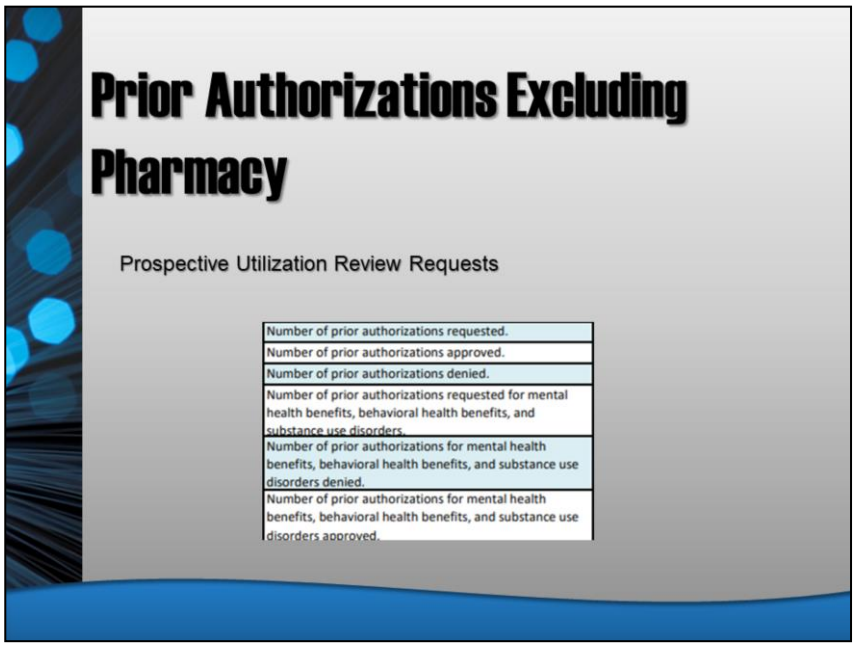


An FAQ was added to clarify that if an insured group changes to another plan offered by the same carrier, this change should NOT be reported as a termination.

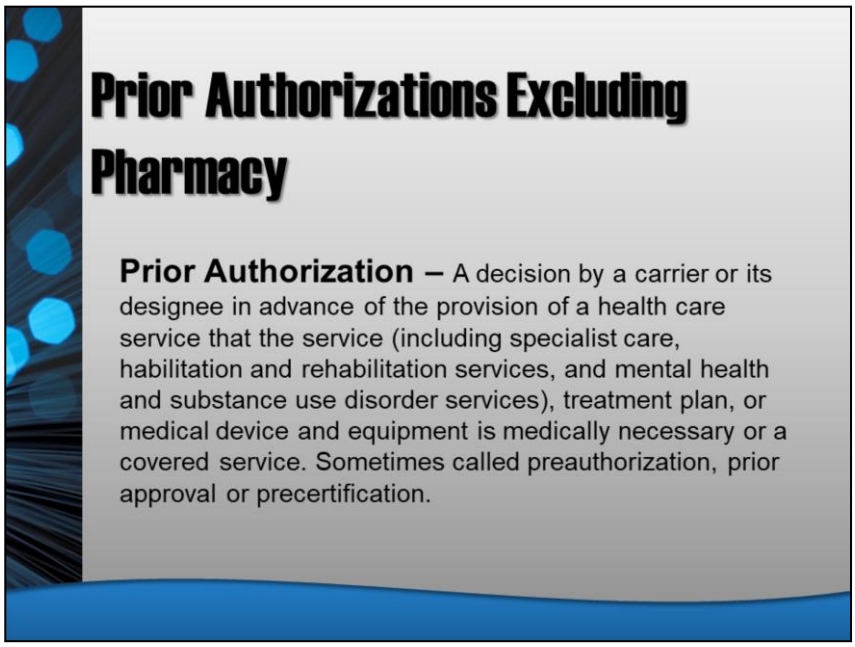


The final policy administration data elements deal with the reporting of rescissions.

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.



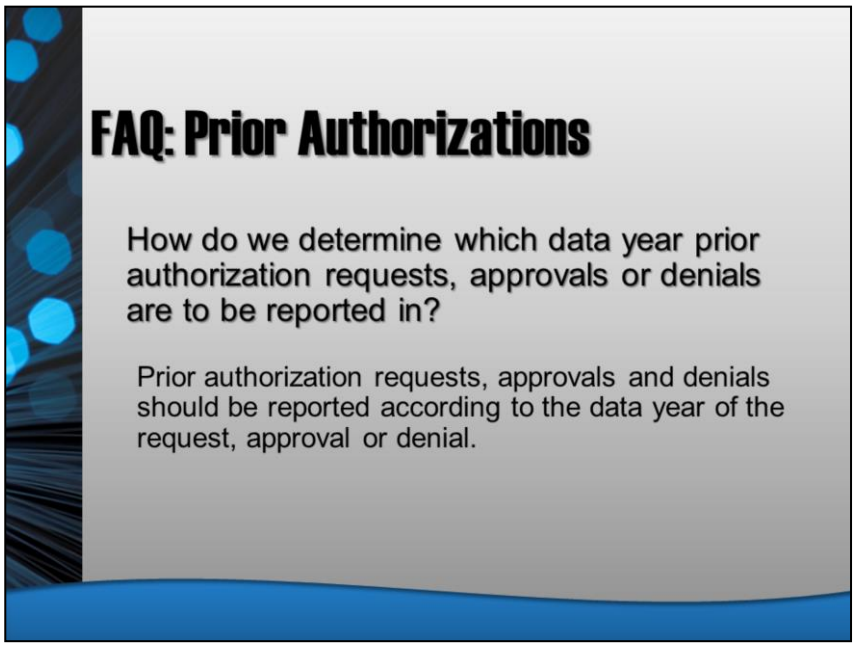
Now we'll move to the Prior Authorizations Excluding Pharmacy section of reporting.



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."

You are to report the number of Prior Authorizations:

- Requested
- Approved
- And Denied.

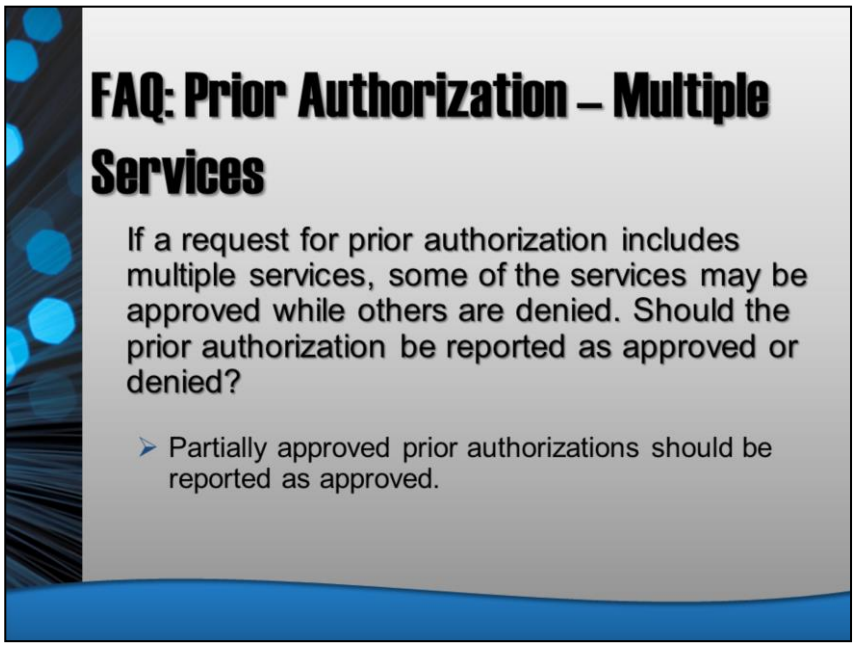


Prior Authorization requests, approvals and denials should be reported according to the data year of the request, approval or denial.

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

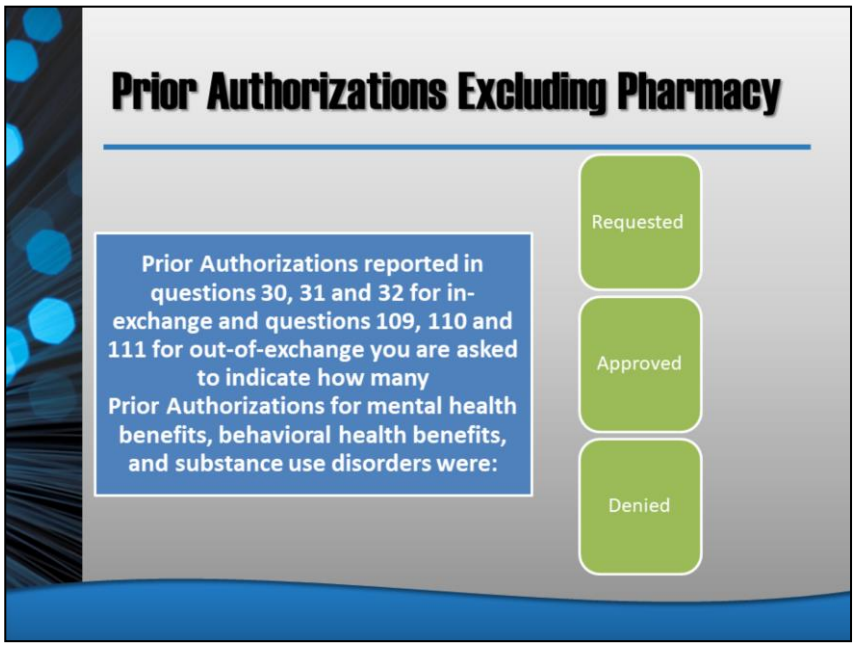
If a prior authorization was approved during the reporting period, report it as an approval.

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



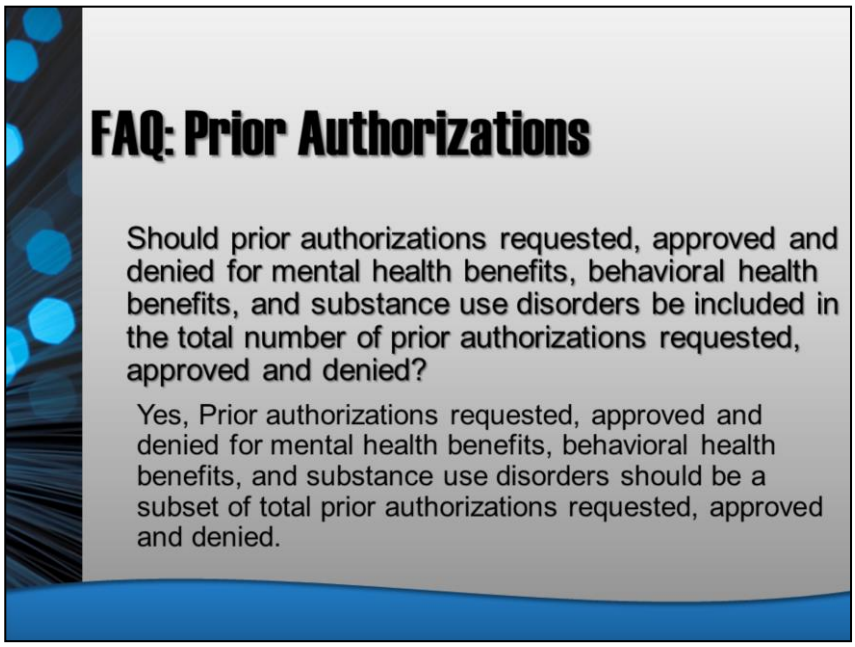
The FAQs include a question regarding prior authorizations that include multiple services and how to report the prior authorization if some services are approved and others are denied.

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



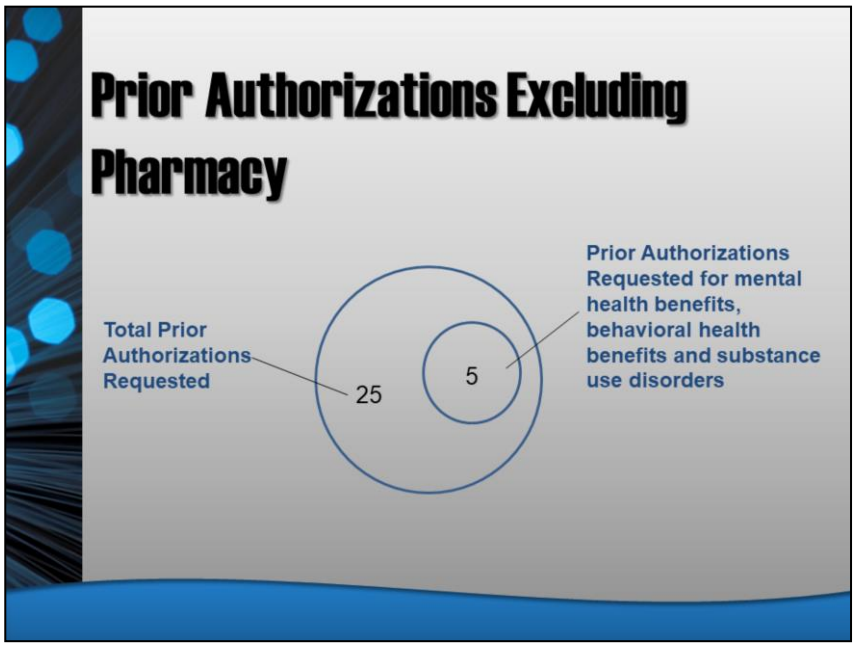
Of the Prior Authorizations reported in questions 30, 31 and 32 for in-exchange, and questions 109, 110 and 111 for out-of-exchange, you are asked to indicate how many Prior Authorizations for mental health benefits, behavioral health benefits, and substance use disorders were:

- Requested
- Approved, and
- Denied

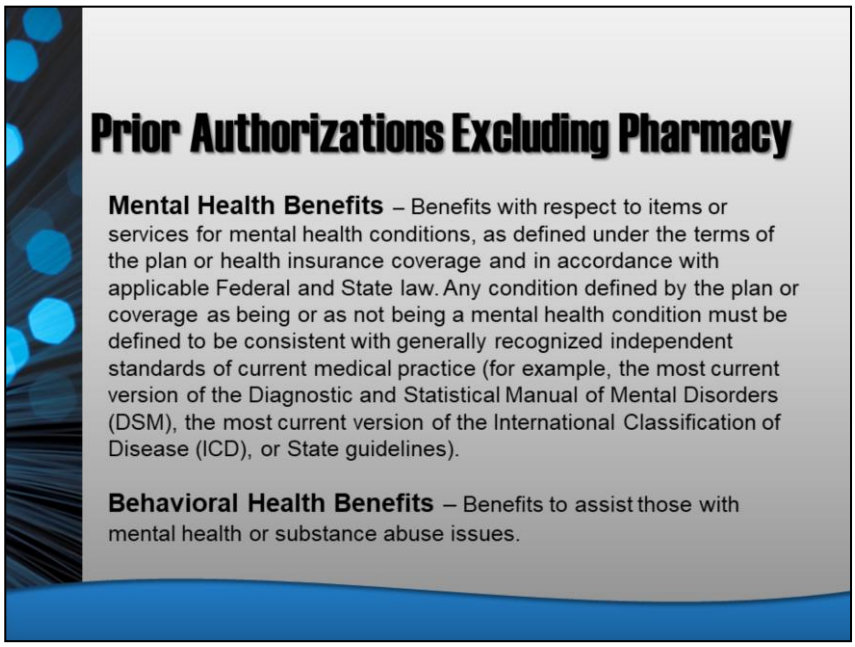


The next FAQ we're going to discuss was added to clarify reporting in the prior authorization data elements related to mental health benefits, behavioral health benefits, and substance use disorders.

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.

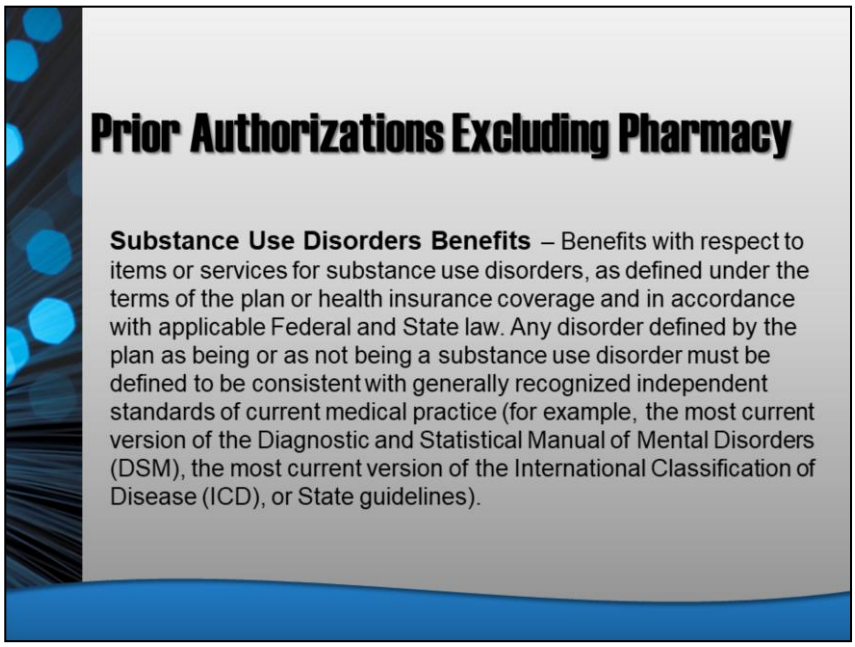


This means if there were 25 prior authorization requests during the year and 5 were for mental health benefits, behavioral health benefits and substance use disorders., you would report 25 total prior authorization requests and 5 prior authorization requests for mental health benefits, behavioral health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

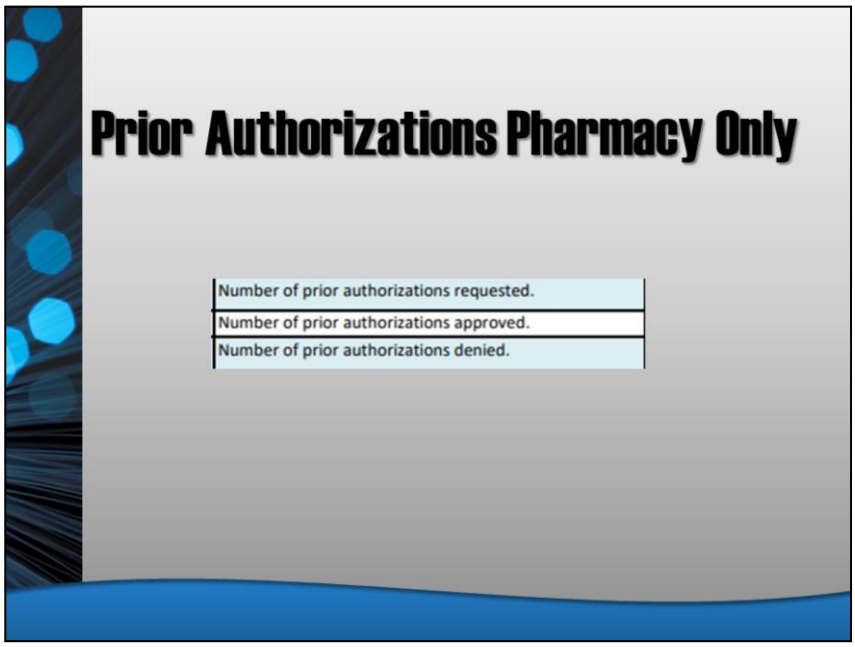


According to the Data Call and Definitions, Mental Health Benefits are those benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the 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),

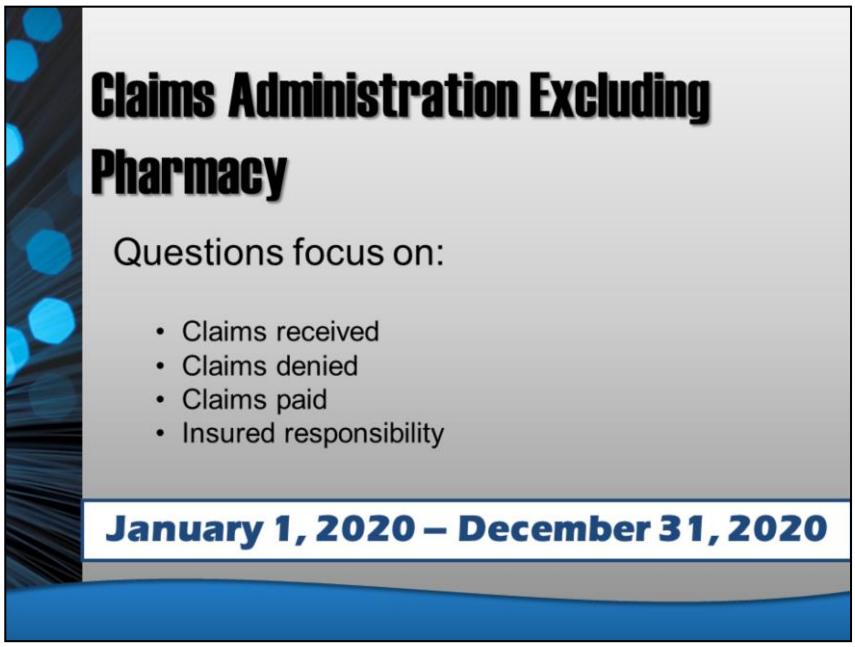
And Behavioral Health Benefits assist those with mental health or substance abuse issues.



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).



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.

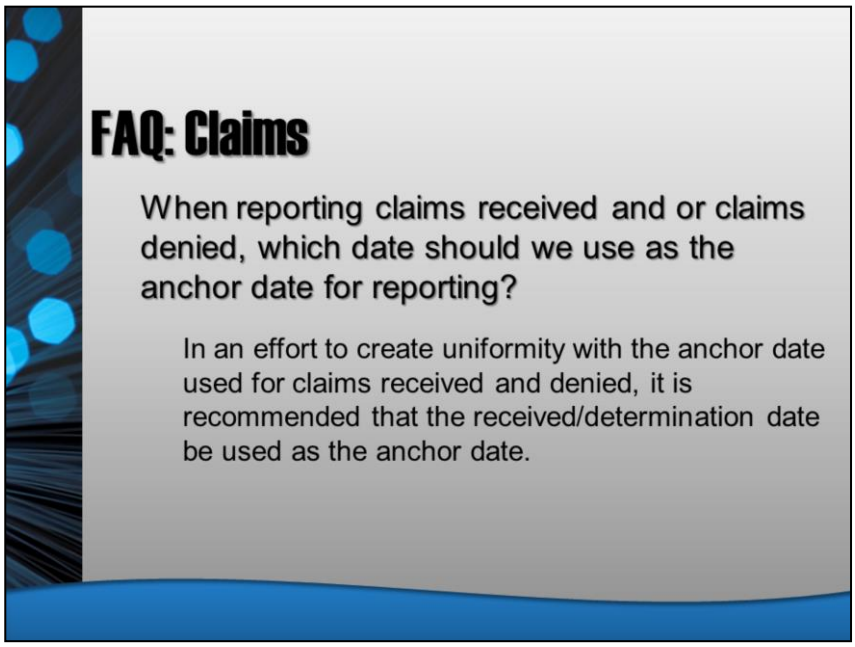


Now we'll review the Claims Administration (Excluding Pharmacy) section. Data elements within this section focus on claims received, claims denied, claims paid and insured responsibility.

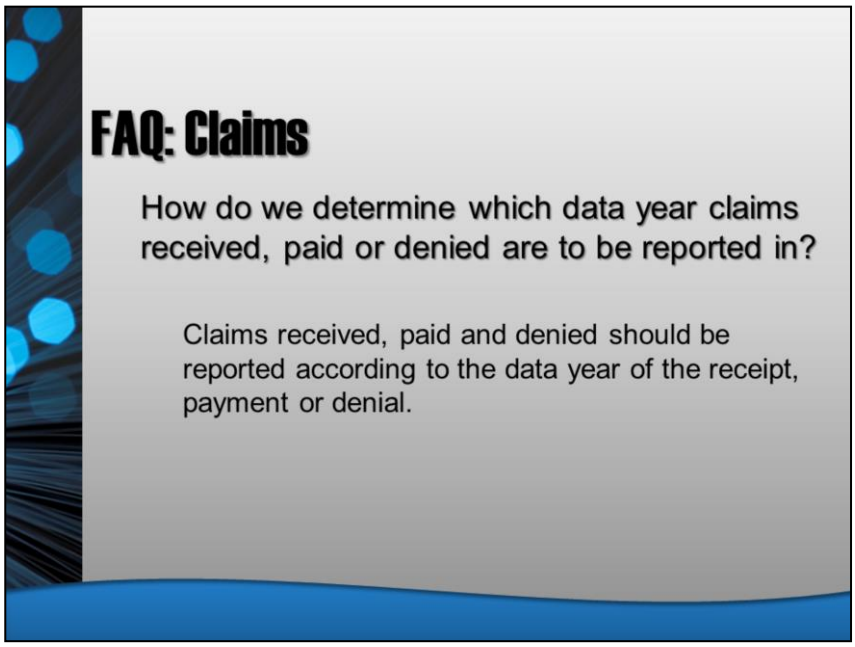
Remember that all data should reflect claims received, submitted, denied and paid, during the reporting year.

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.



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.



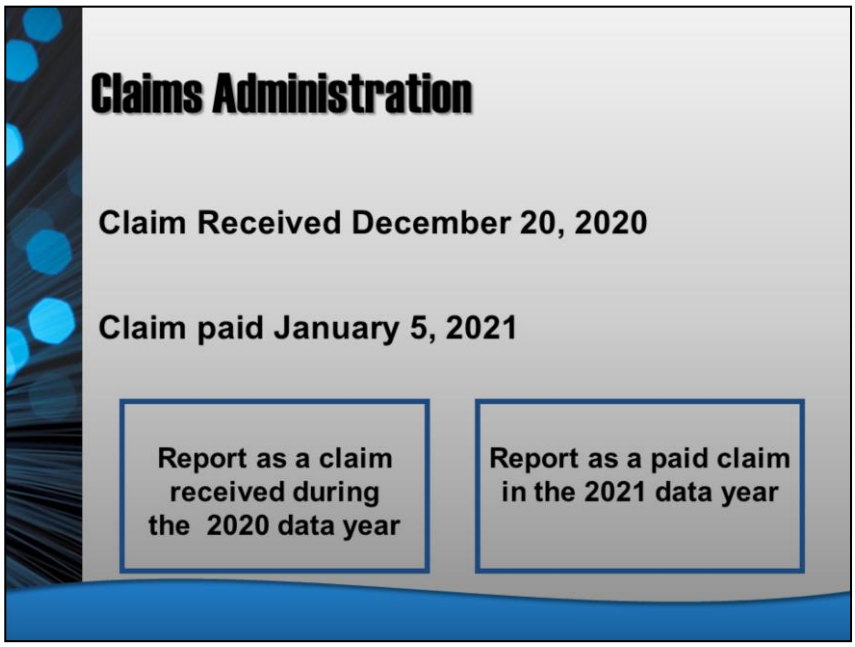
Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.

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

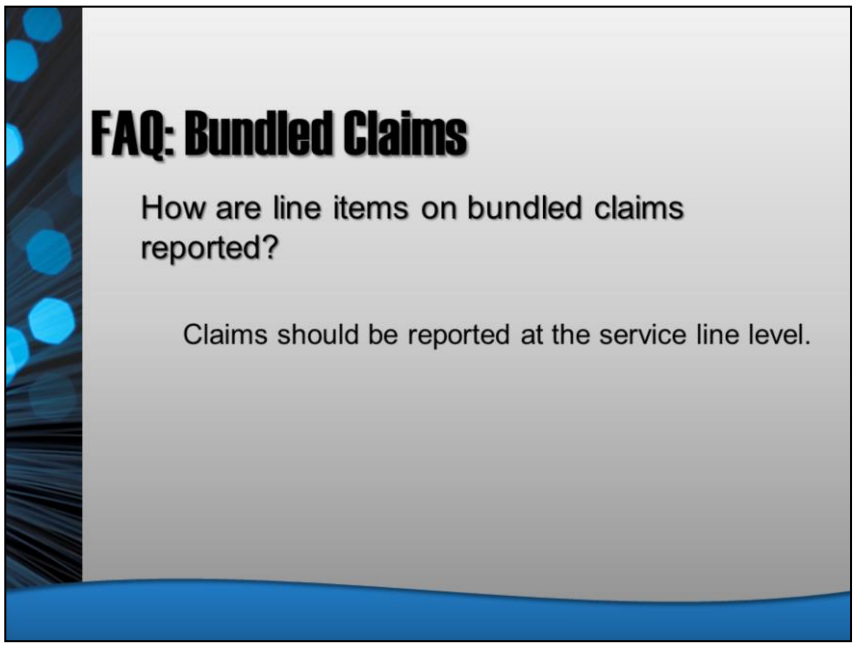
If a claim is paid during the data year, it should be reported as paid.

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

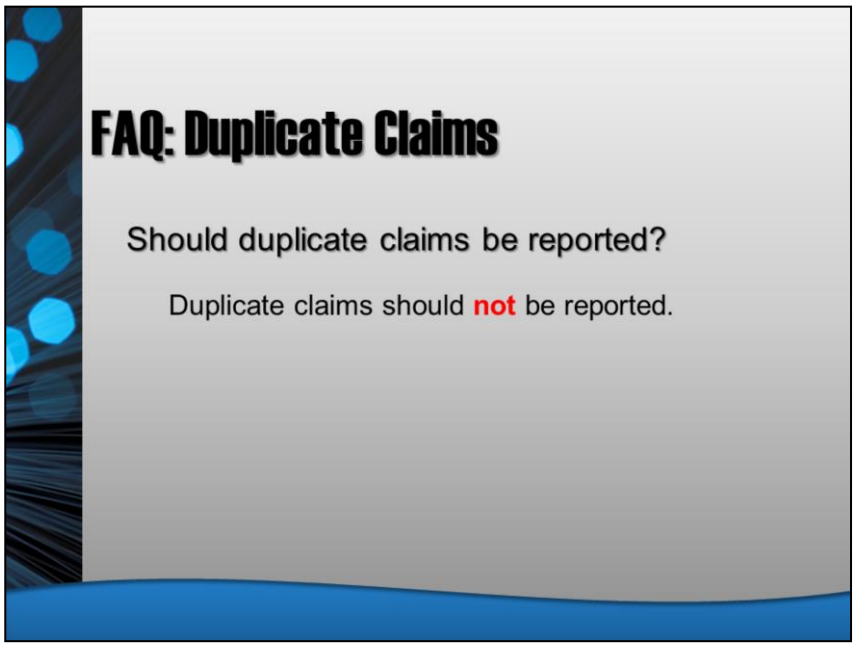
It is understood that a claim may have been opened in the prior data year and paid or denied during the current data year. In this case, the claim would only be reported as paid or denied during the current data year.



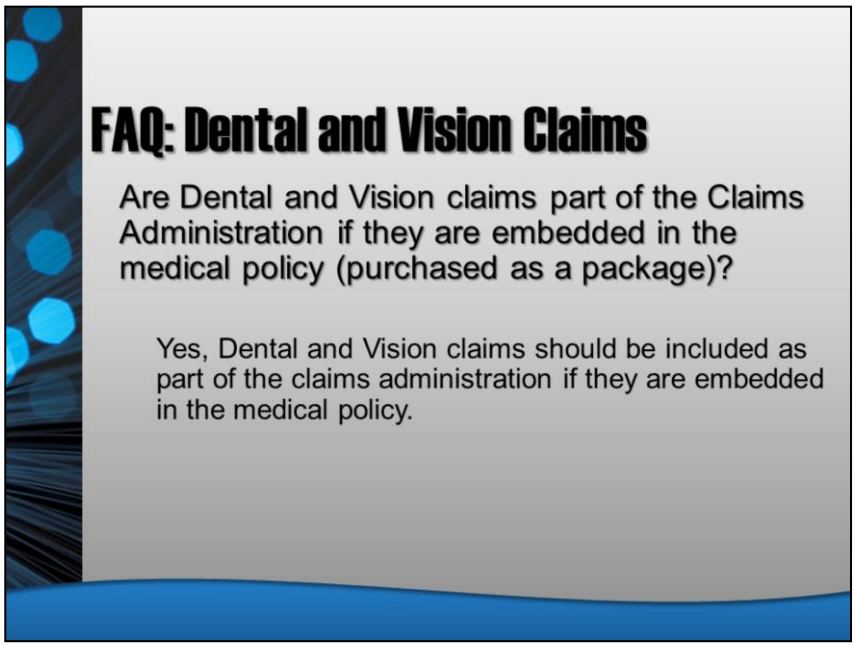
For example, if the claim is received December 20, 2020, and the claim is paid on January 5, 2021, the claim would be reported as received in the 2020 data year and paid in the 2021 data year.



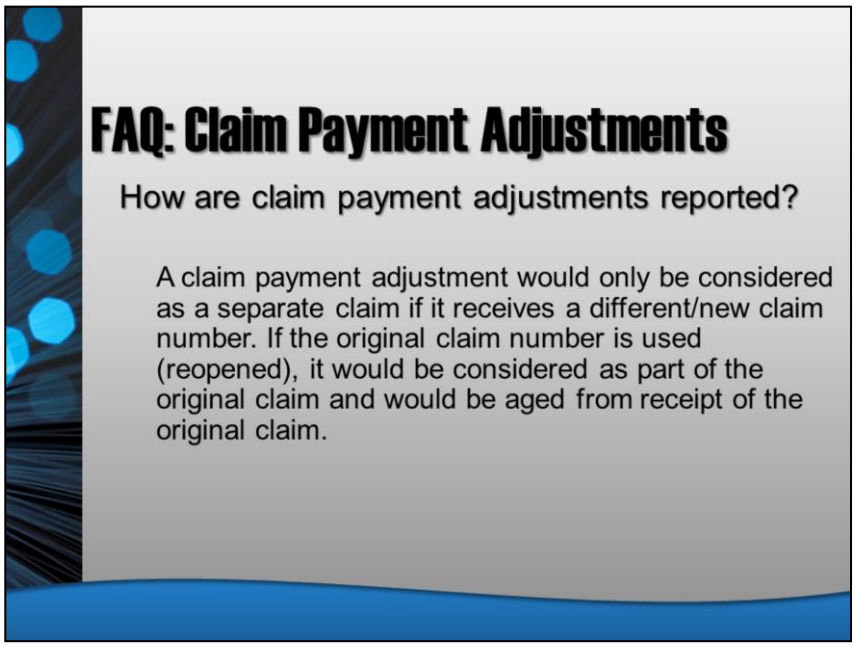
The next FAQ clarifies that bundled claims should be reported at the service line level.



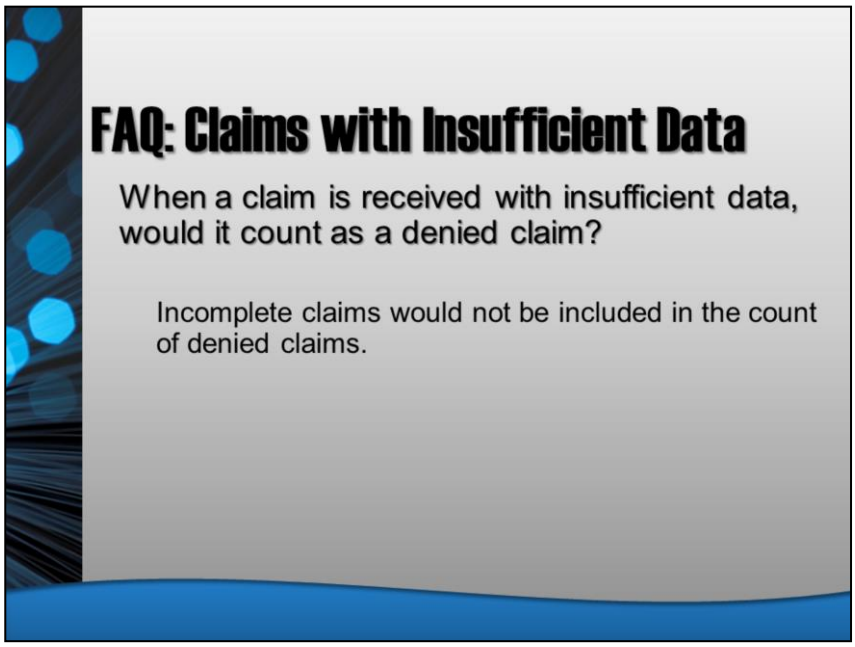
Duplicate claims have resulted in several questions. This FAQ clarifies that duplicate claims should NOT be reported within the health MCAS.



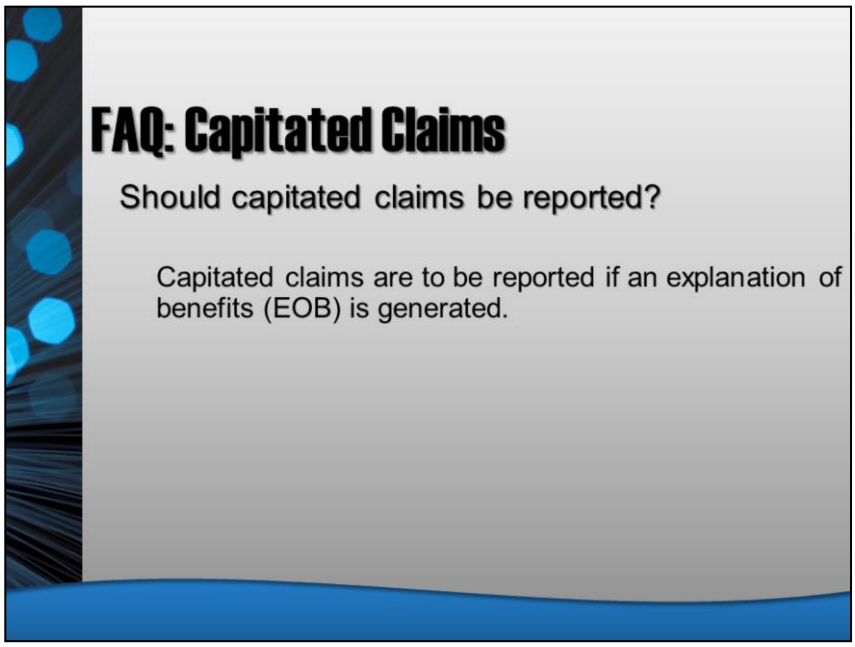
If Dental and Vision coverages are included within the medical policy, you should report the dental and vision claims. Dental and vision policies that are issued separate from the medical policy are not included within the health MCAS reporting.



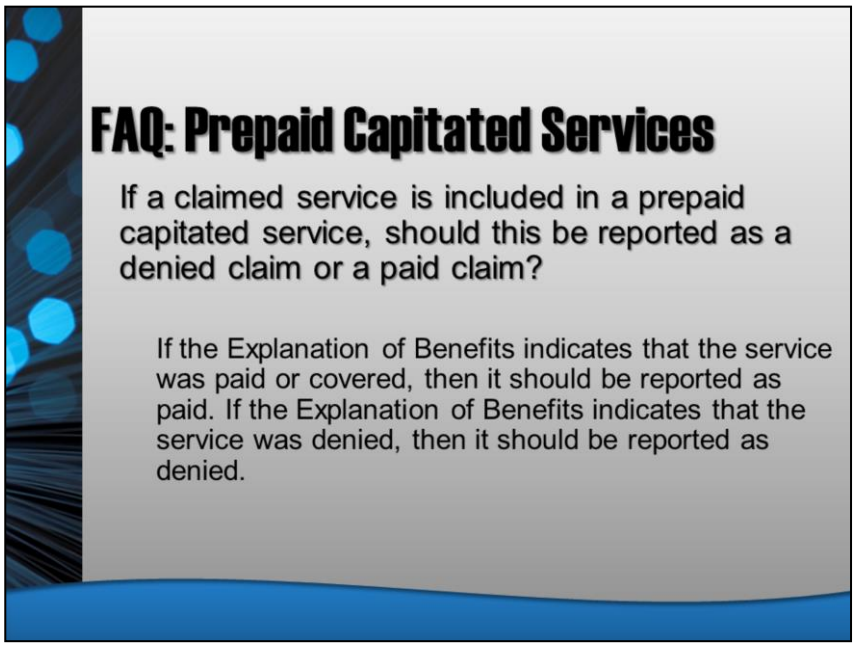
A claim payment adjustment would only be considered as a separate claim if it receives a different/new claim number. If the original claim number is used (or reopened), it would be considered as part of the original claim and would be aged from receipt of the original claim.



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

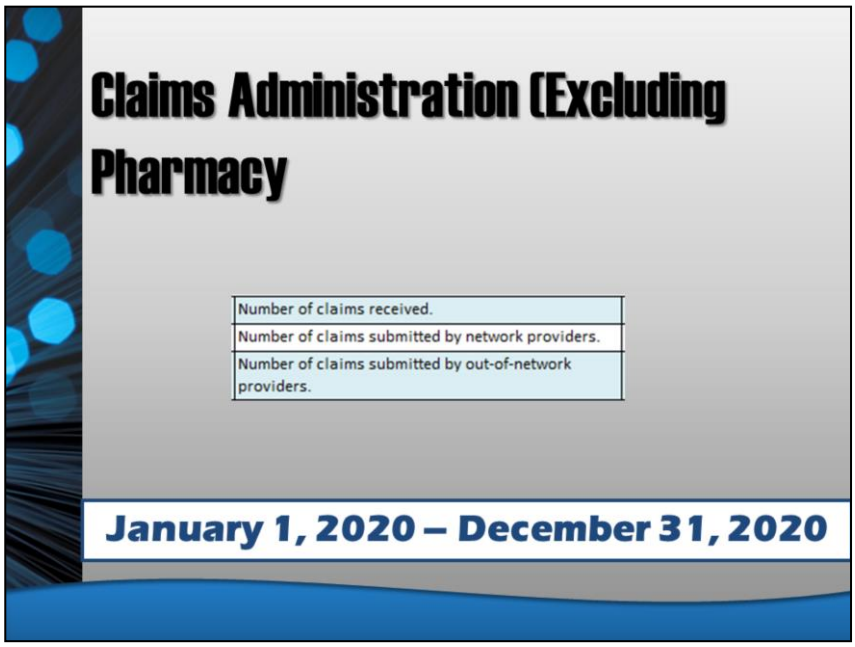


If the company generates an explanation of benefits for a capitated claim, then it should be included in the health MCAS reporting.



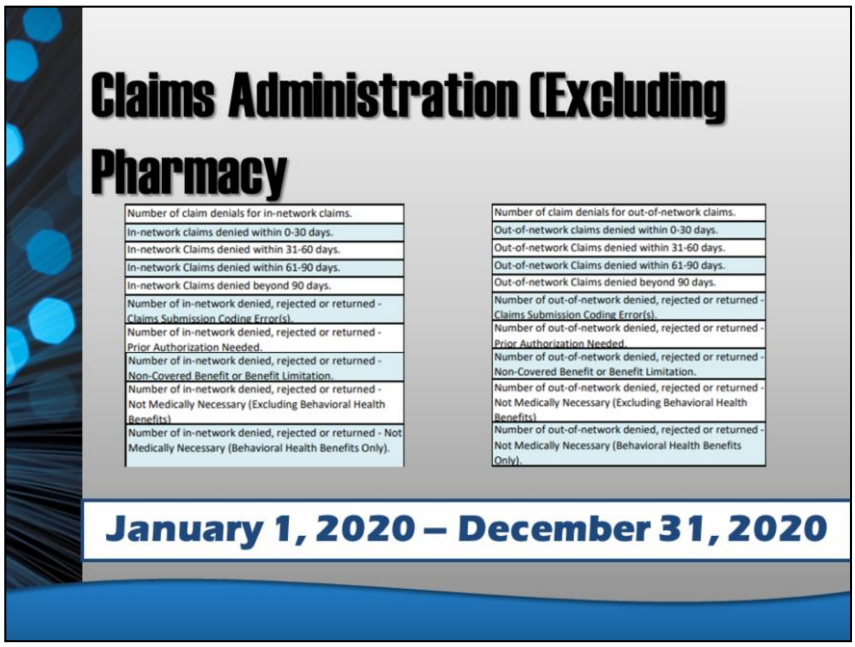
You should report claims that are included in a prepaid capitated service according to the determination shown on the explanation of benefits.

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.



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.



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

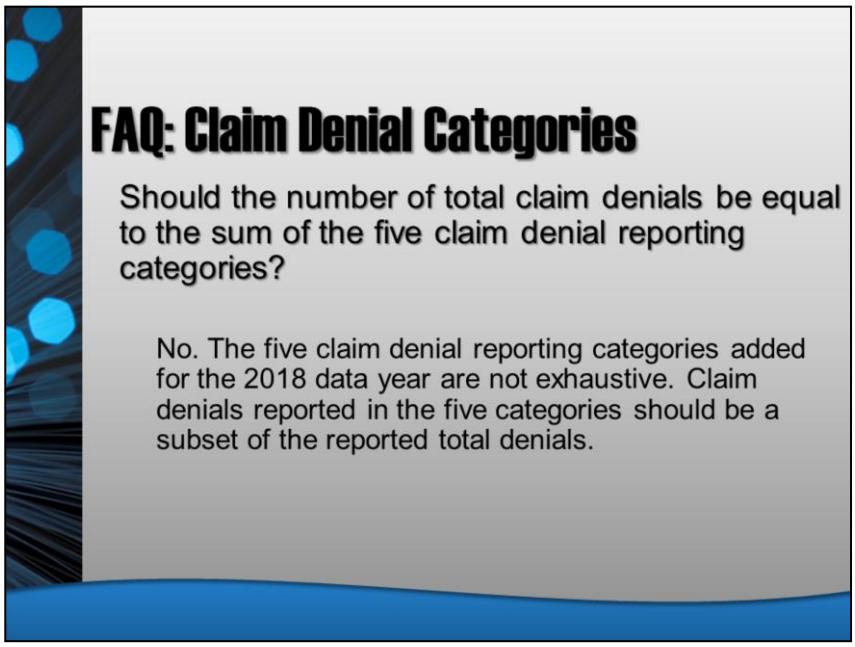
In addition to reporting the total number of denials, you are to report the denials according to the length of time it took the carrier to make the denial determination.

The breakouts are:

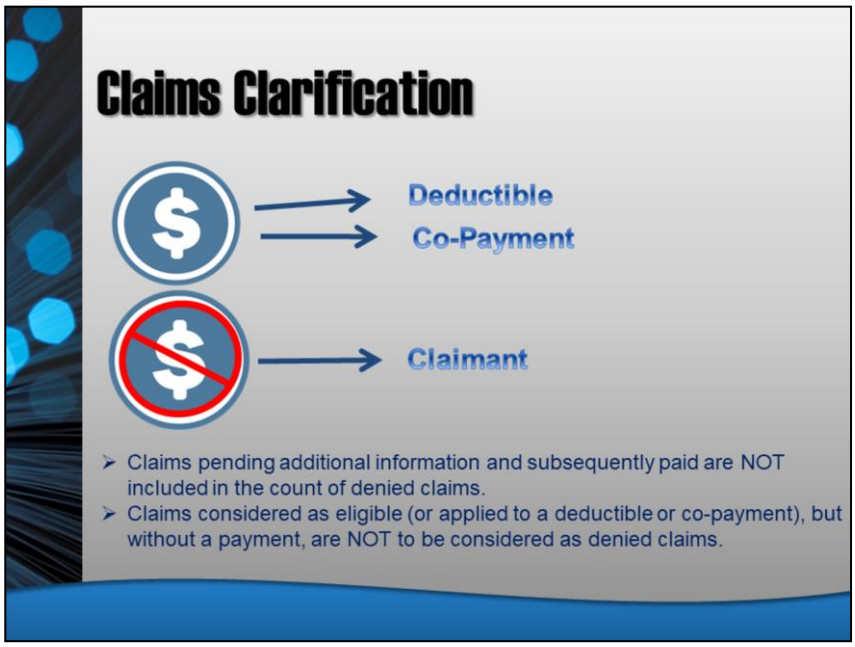
- 0-30 days
- 31-60 days
- 61-90 days
- And beyond 90 days

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)



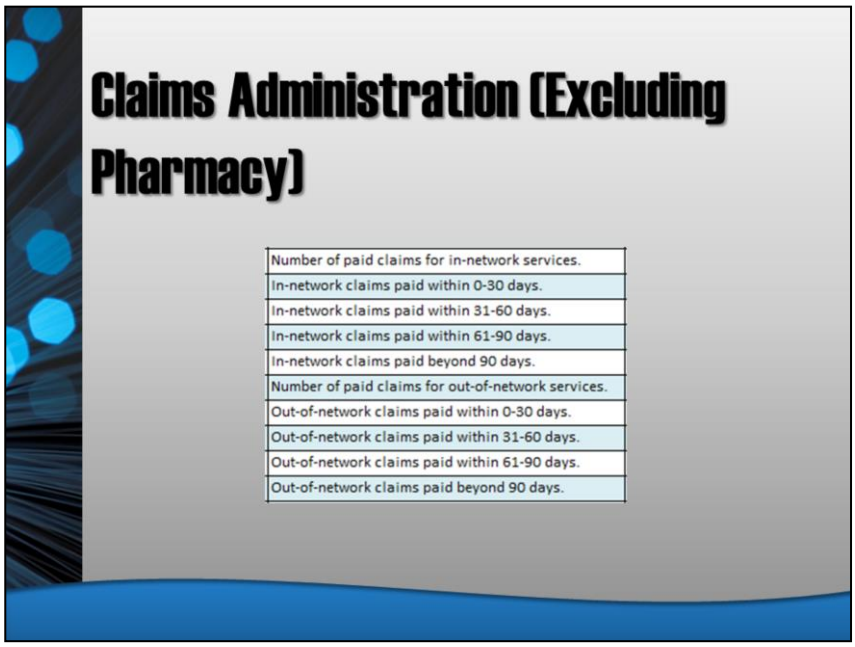
The five claim denial reporting categories added for the 2018 data year are not exhaustive. Claim denials reported in the five categories should be a subset of the reported total denials.



Keep in mind…

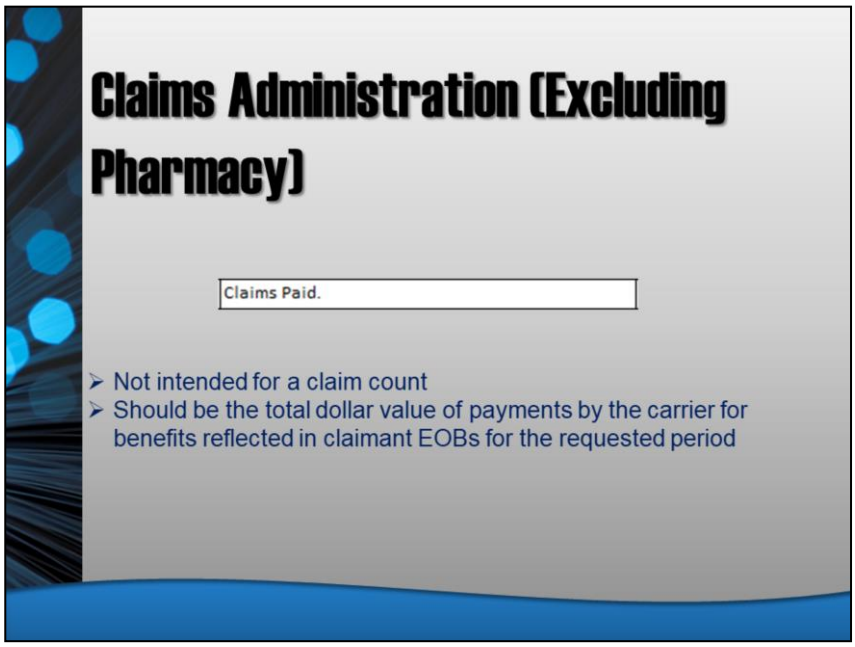
- Claims that are pended for additional information and subsequently paid are not to be included in the count of denied claims.
- Also, a claim that is considered as eligible (or applied to a deductible or co-payment), but is without a payment, is not to be considered as a denied claim.

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.

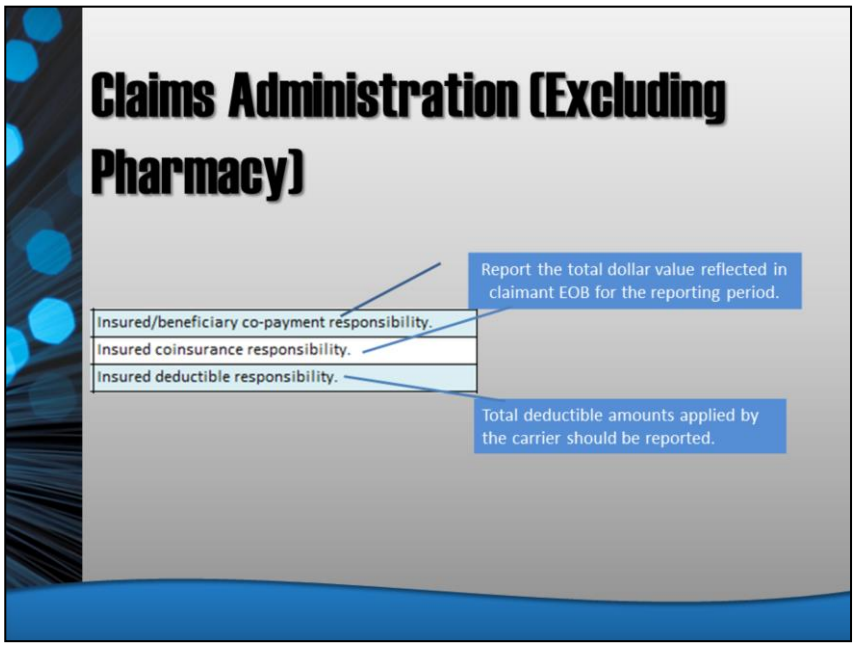


The next grouping of data elements record the number of in-network and out-of-network claims that were paid.

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.



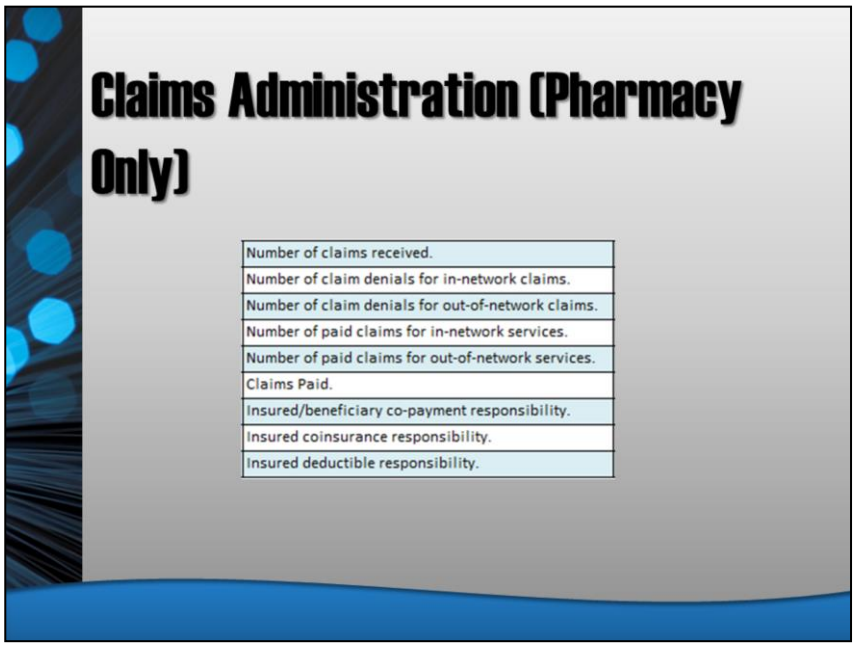
Special attention should be given to the Claims Paid data element. This field is not intended for a count of claims, but instead, the total dollar value of payments by the carrier for benefits reflected in claimant Explanations of Benefits (EOBs) for the requested period should be reported.



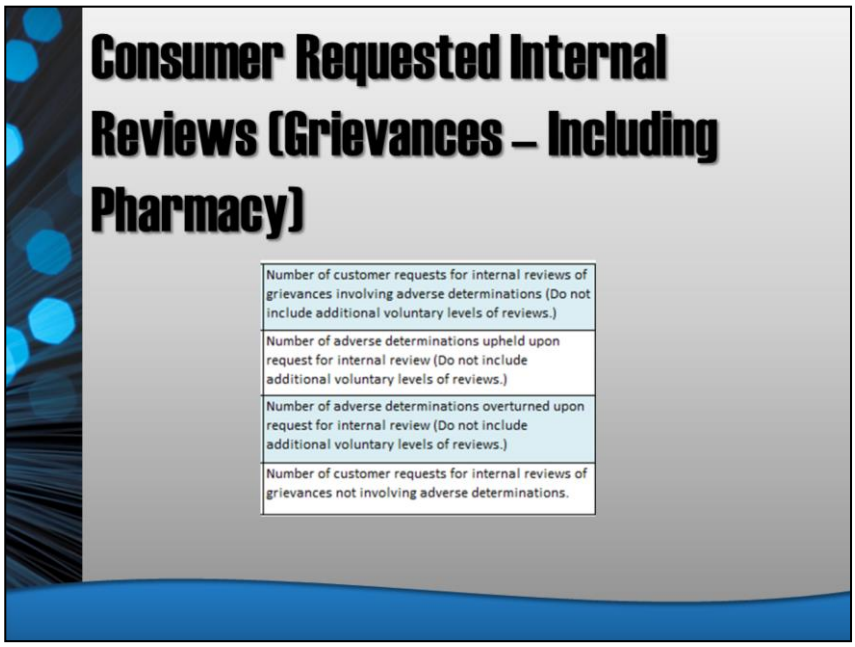
The final claims data elements (excluding pharmacy) deal with copayment, coinsurance and deductible responsibility.

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.

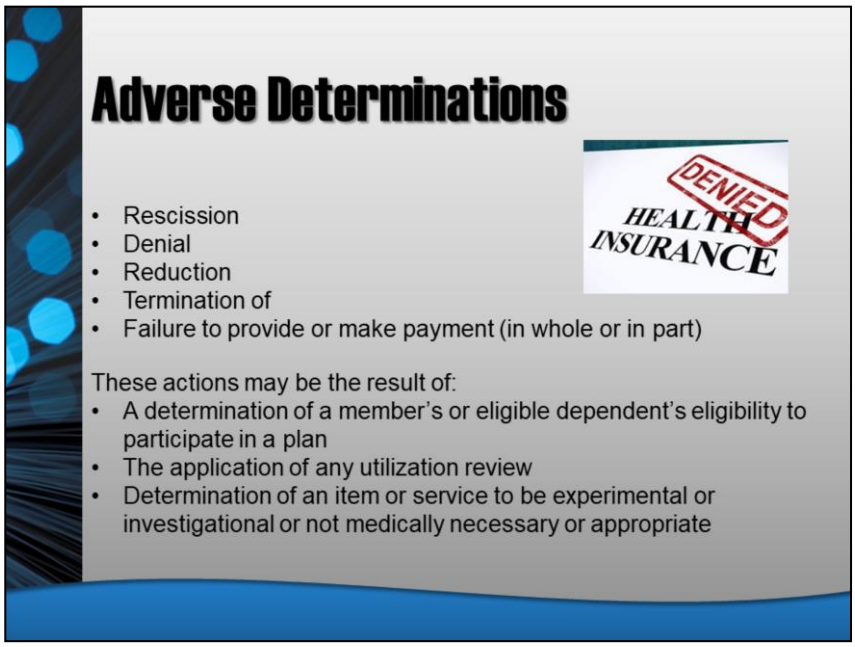


The Claims Administration (Pharmacy Only) section of the health MCAS contains a subset of the data elements reported for the Claims Administration (Excluding Pharmacy) section. So, we are not going to review these elements again.



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

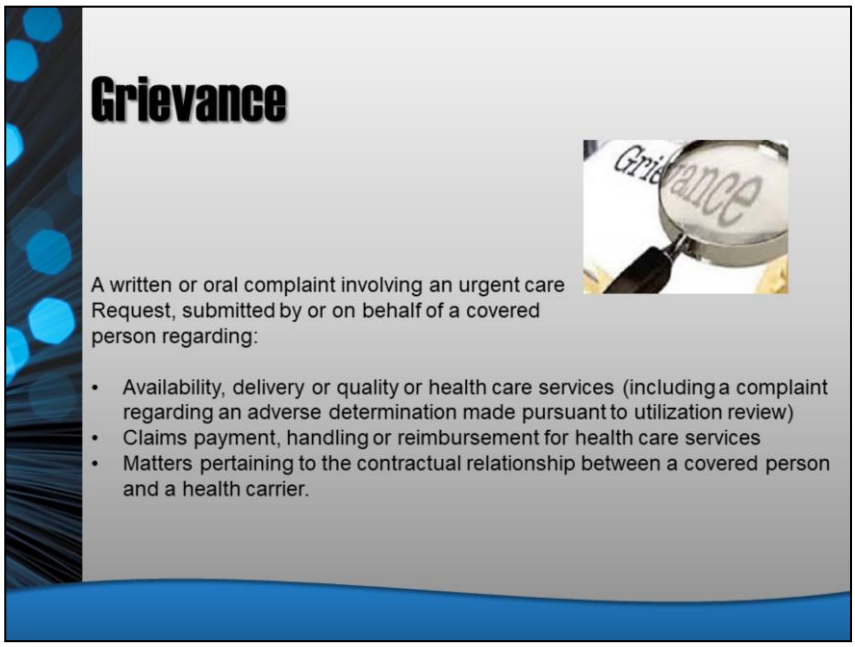
These data elements include terminology that may need to be clarified.



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

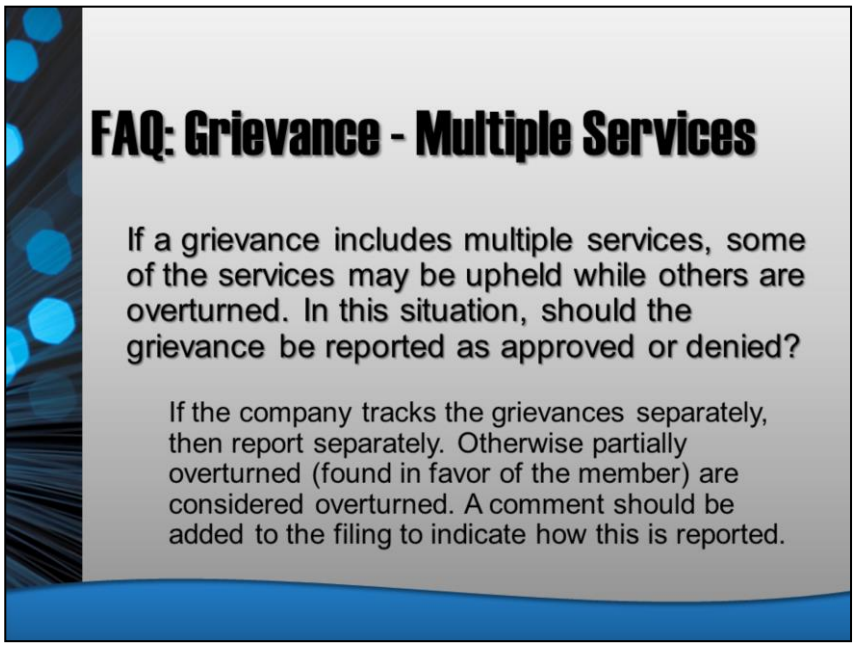
The Adverse Determinations can be the result of:

- 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



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

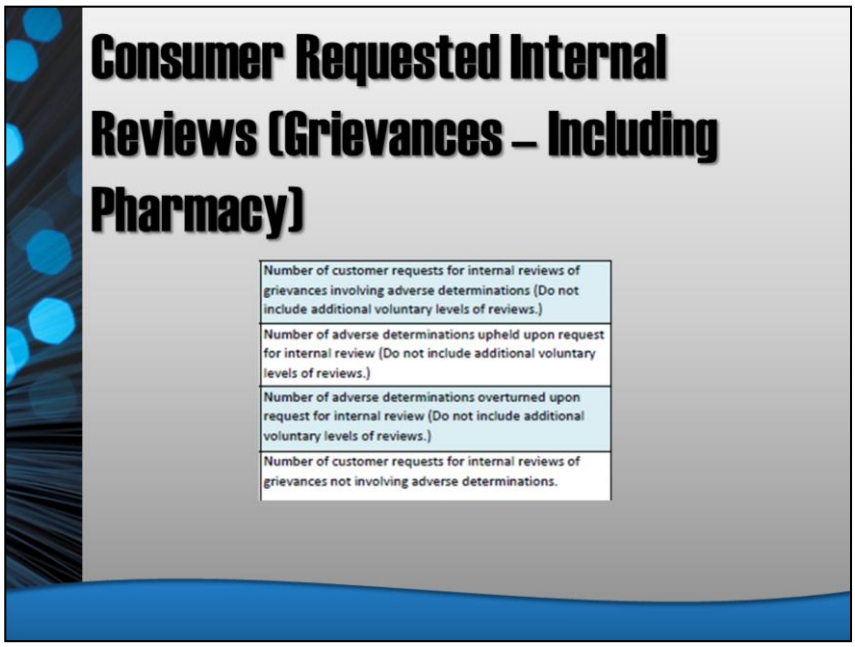
- Availability, delivery or quality or health care services (including a complaint regarding an adverse determination made pursuant to utilization review)
- Claims payment, handling or reimbursement for health care services
- Or, Matters pertaining to the contractual relationship between a covered person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



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

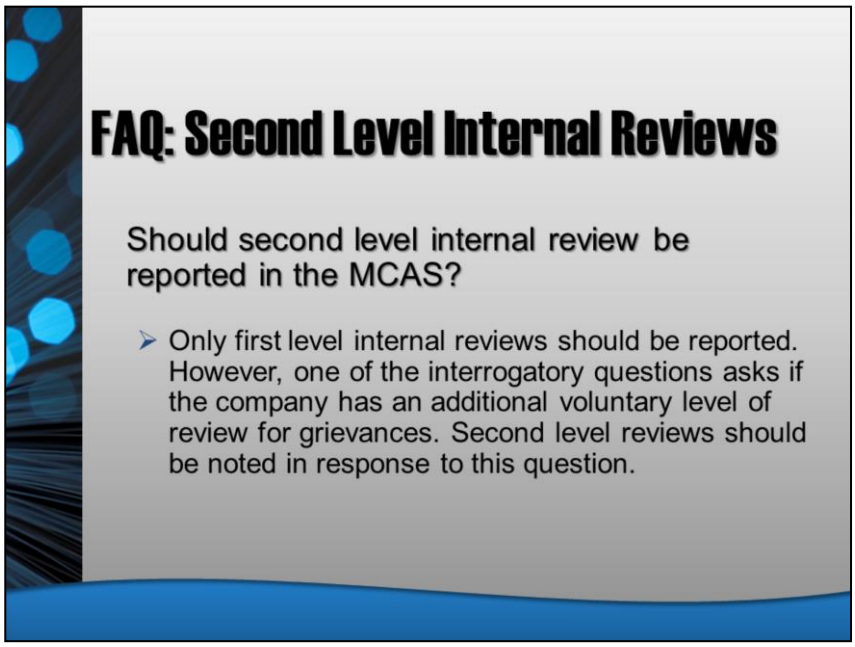
If the company tracks the grievances separately, then they should be reported separately. Otherwise partially overturned (found in favor of the member) are considered overturned.

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



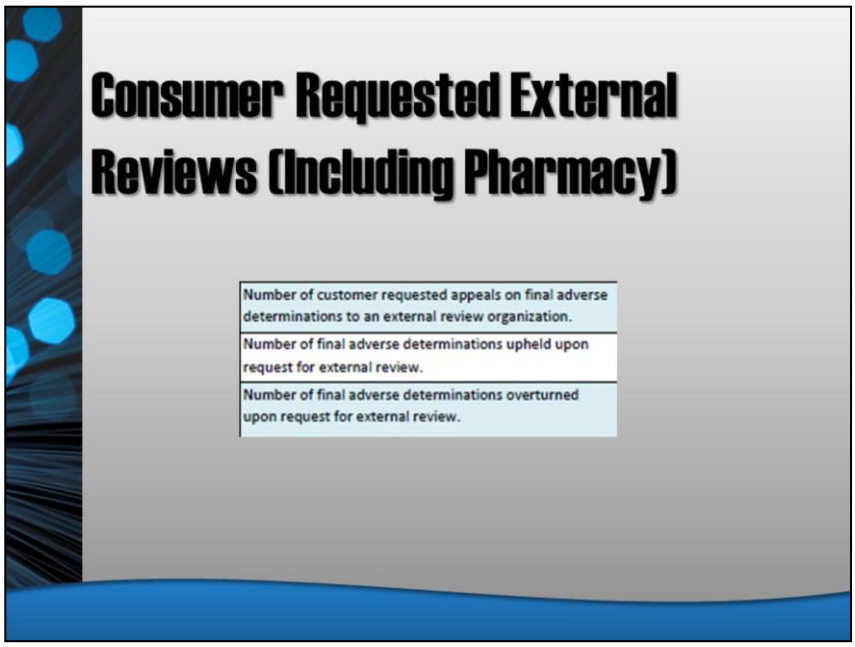
You are to report the number of requests for internal review of grievances involving adverse determinations, how many of those were upheld, and how many of them were overturned.

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

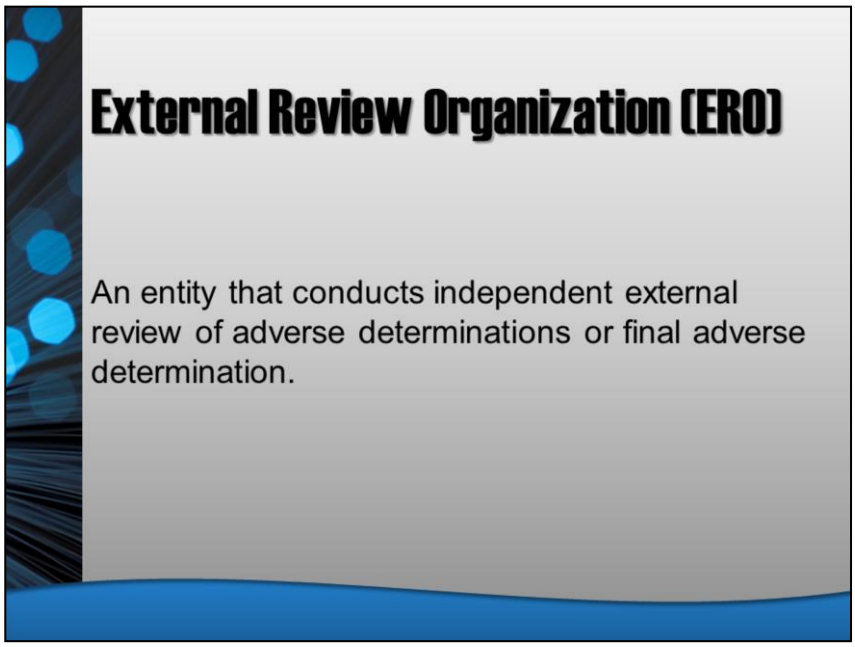


Only first level internal reviews should be reported. However, one of the interrogatory questions asks if the company has an additional voluntary level of review for grievances.

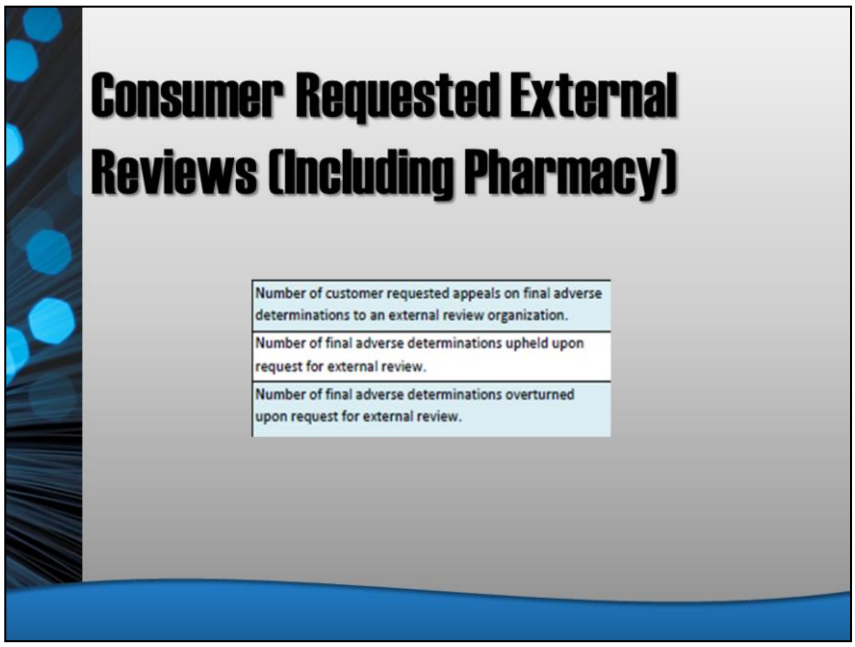
Second level reviews should be noted in response to this question.



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

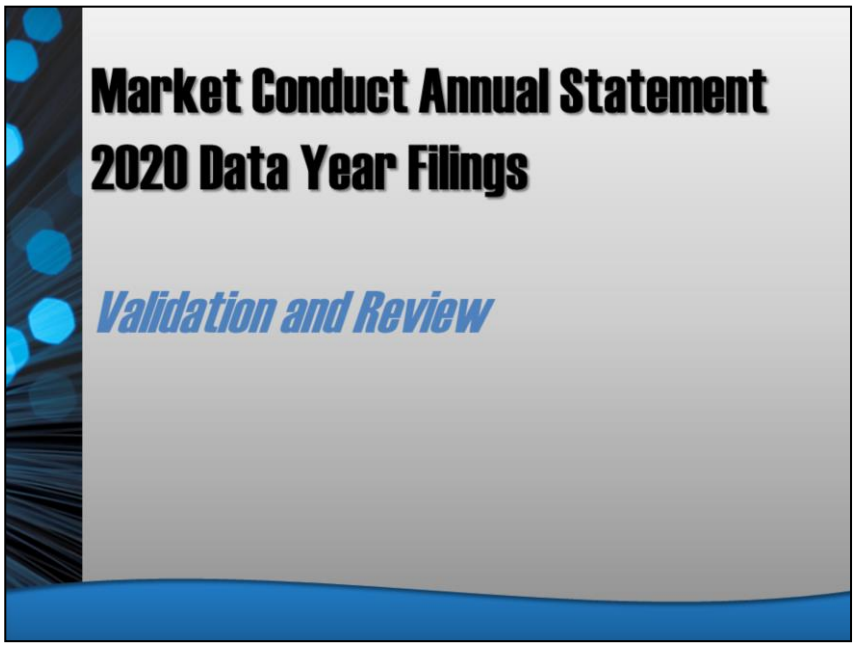


An External Review Organization or ERO is an entity that conducts independent external review of adverse determinations or final adverse determination.

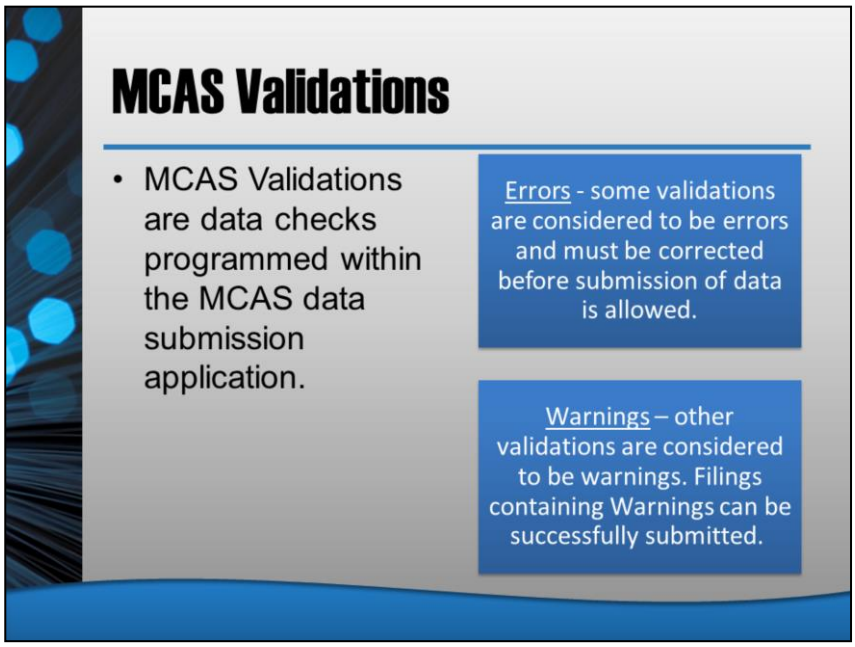


You are asked to report the number of requested appeals on final adverse determinations to an external review organizations. Of those requests, you will report the number of adverse determinations upheld and overturned.

This concludes the data elements review portion of the tutorial. Now we'll discuss the MCAS data validations.

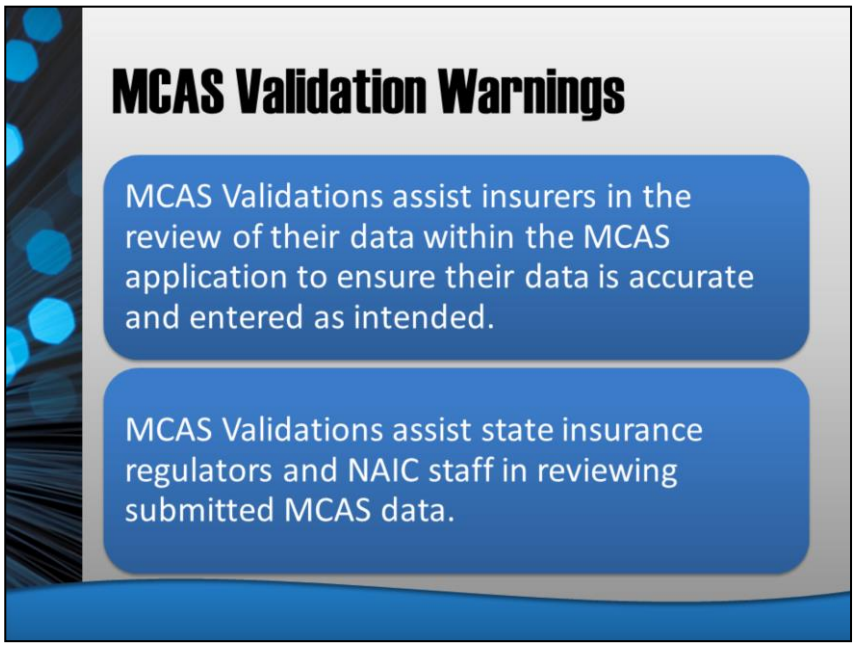


MCAS Validation and Review



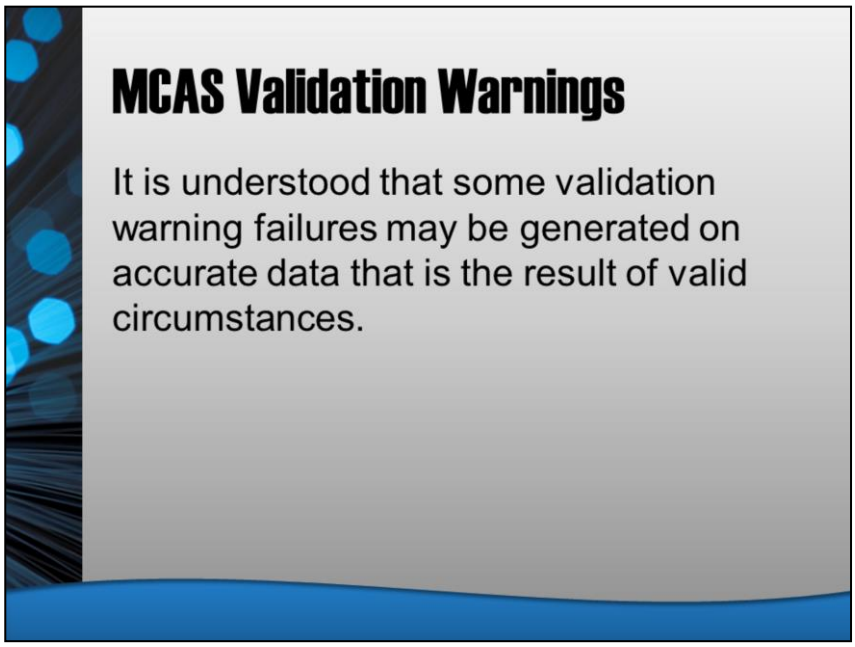
MCAS Validations are data checks programmed within the MCAS data submission application.

- Some validations are considered to be Errors and must be corrected before submission of data is allowed.
- Other validations are considered to be Warnings. Filings containing Warnings can be successfully submitted.

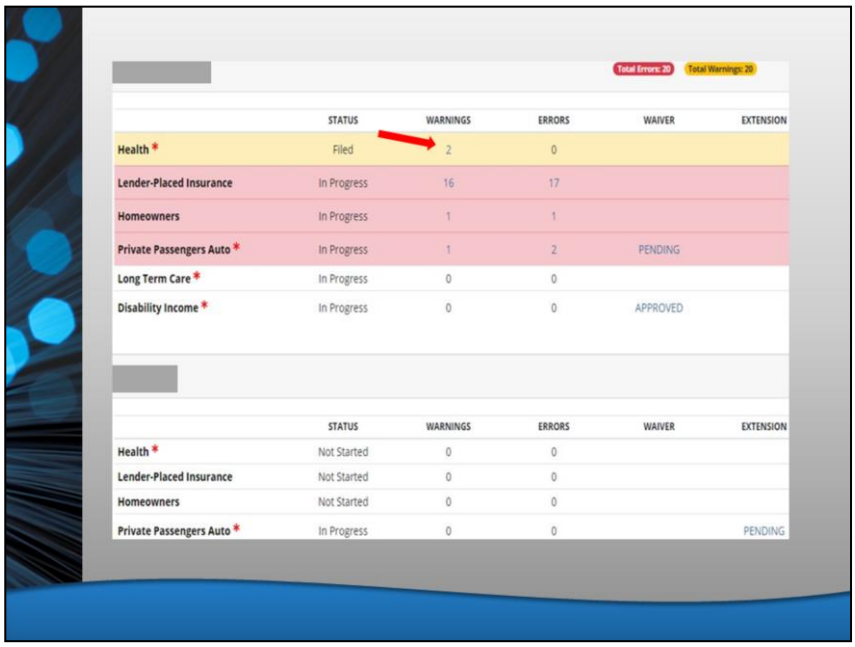


MCAS Validations have multiple purposes.

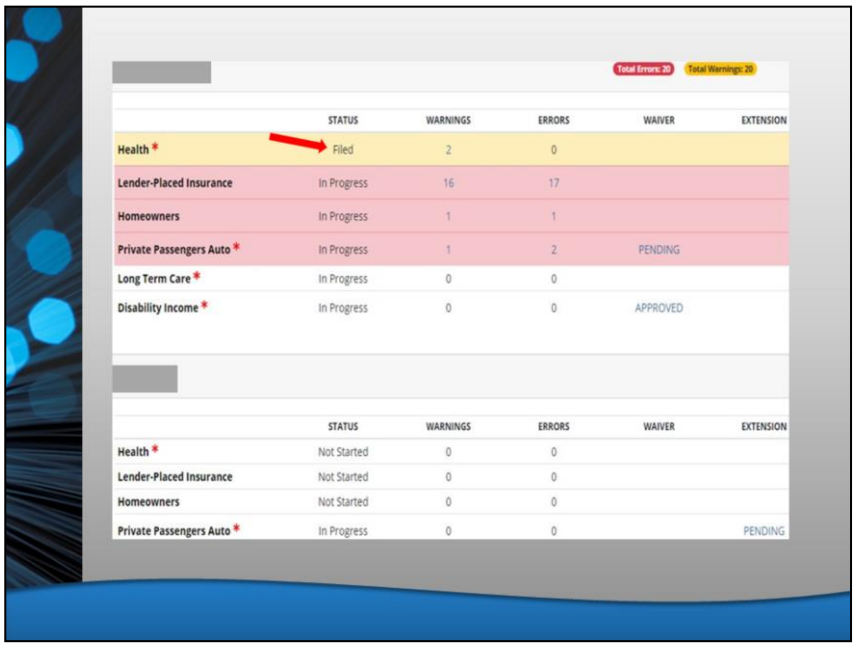
- They assist insurers in the review of their data within the MCAS application to ensure their data is accurate and entered as intended. For example: the validations can point out data issues that are a result of data entry errors or coding errors,
- And they assist state insurance regulators and NAIC staff in reviewing submitted MCAS data.



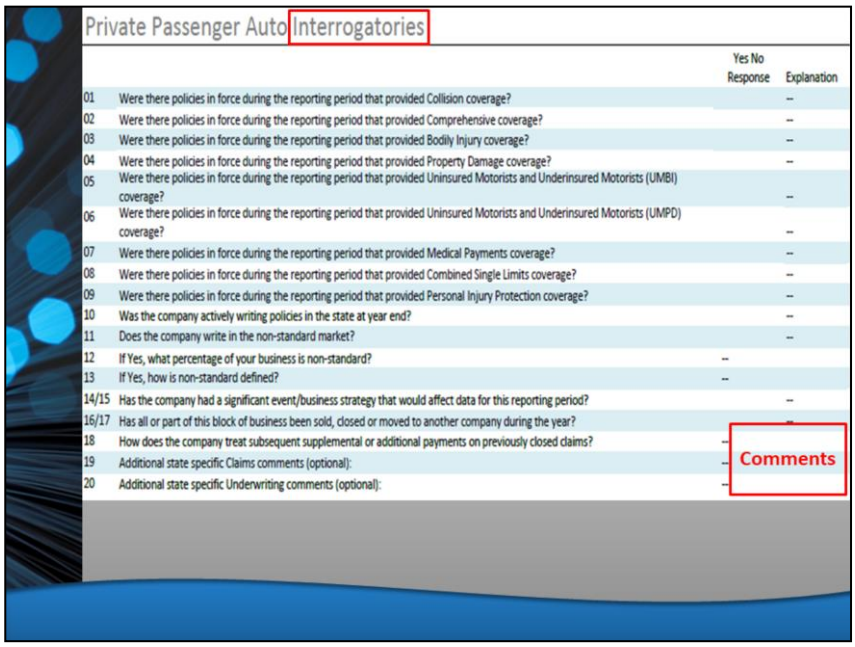
It is understood that some validation warning failures may be generated on accurate data that is the result of valid circumstances; for example, companies with small amounts of business to report, or runoff business to report may trigger validation warning failures that are not concerning.



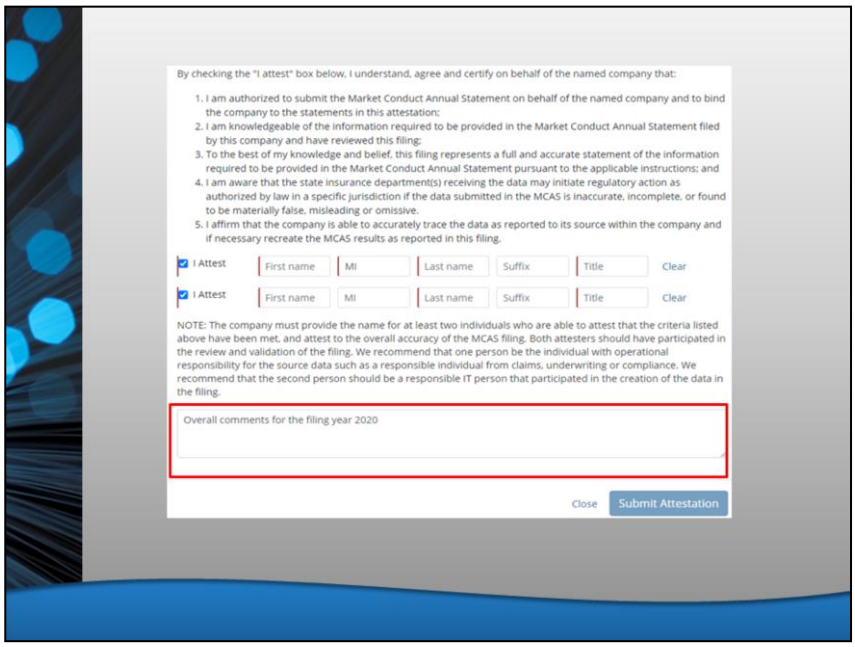
The MCAS system filing matrix provides the MCAS user with information regarding their filings. The filing matrix displays the number of warnings found in submitted or started filings. Before a company submits each filing containing warnings, they are prompted to add comments regarding any outstanding warnings in the submission.



Once a company has filed the MCAS data, the filing matrix will display a status of “filed” for each state and line of business submitted. At this point in the process, NAIC staff will begin a review of the data, checking for data inconsistencies and anomalies.

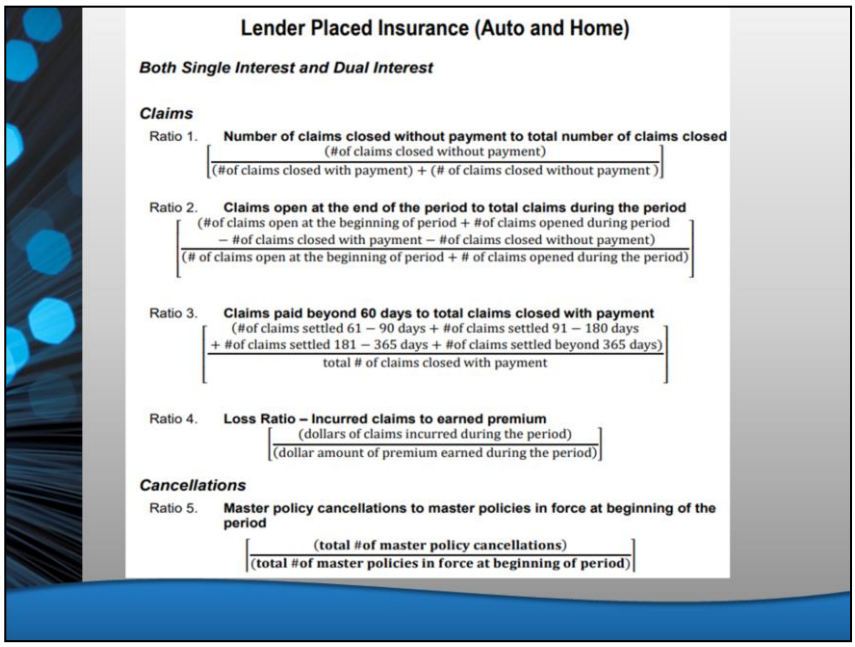


As NAIC analysts review company filings, they view comments found in the interrogatories,



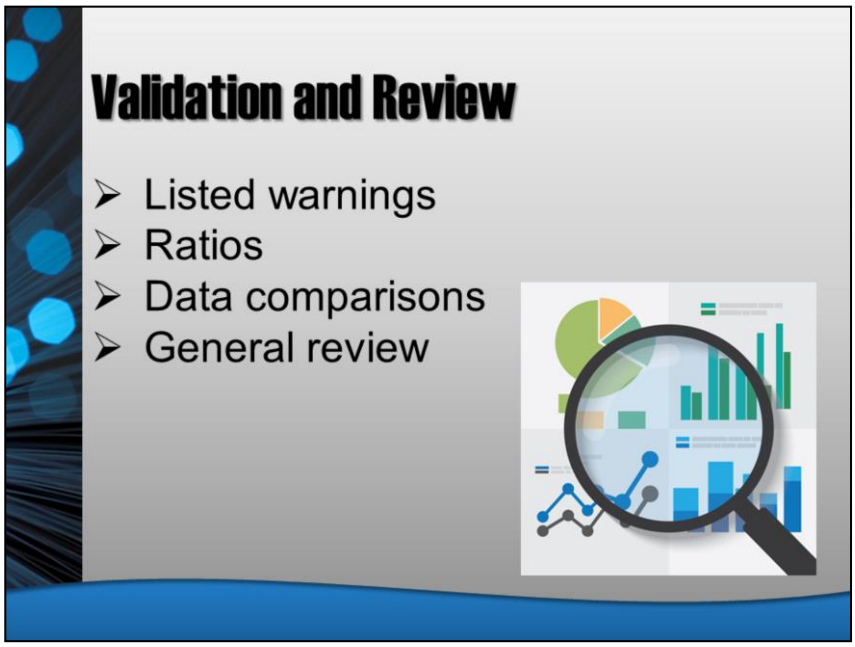
and in the attestation to determine if the warnings have been sufficiently addressed.

If a filing contains “warning messages,” and there are no comments entered by the company, it is more likely that the company will be contacted for an explanation by NAIC staff.



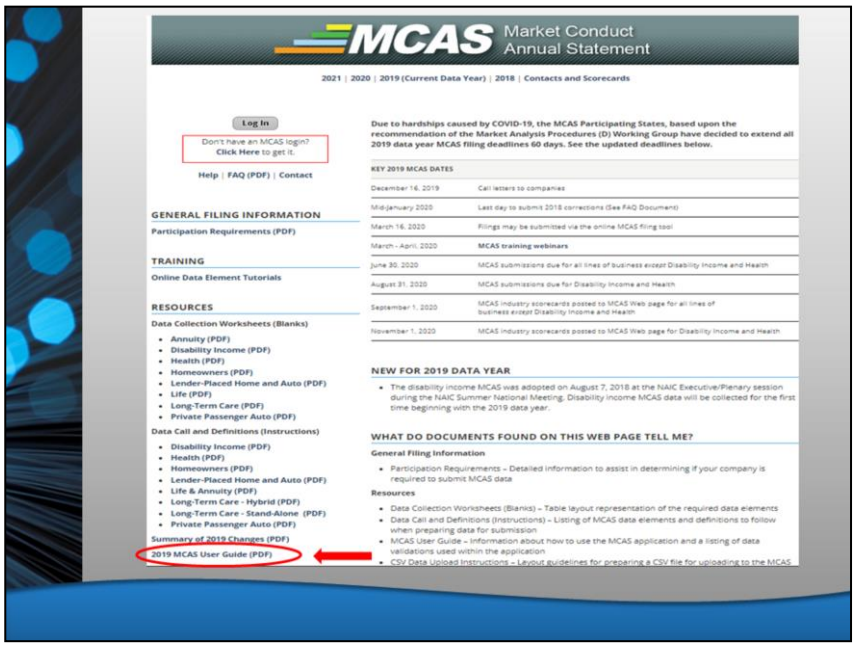
The company's standard ratio results are also reviewed. A listing of the scorecard ratios can be found on the MCAS web page.

During review of a company's ratio results, values that are significantly different than the expected value are identified, along with any significant changes in a company's ratio values year to year. Companies will be notified of these anomalies to allow verification of the submitted data.



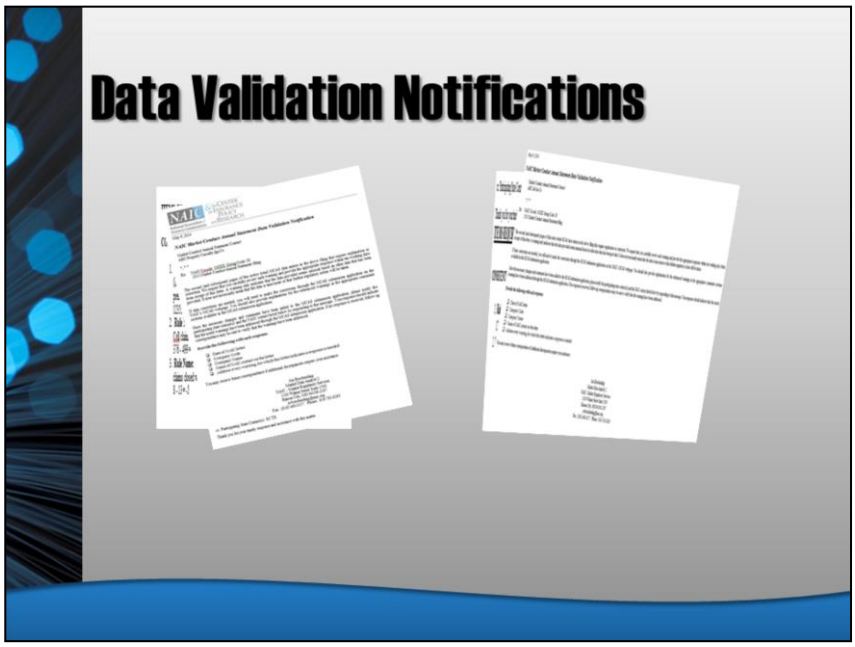
In addition to warnings and ratios, data relationships within the submission are reviewed. An example would be a comparison of policies in-force to the number of claims. Another example would be the comparison of polices in-force to written premiums. If an unusual data relationship is identified, the company will be asked to explain.

A final review is a general review of the data for potential data inaccuracies. An example of this might be the submission of a data element that contains a value much larger than expected; perhaps too many zeros were added, or two data elements were transposed. Again, if these anomalies are identified, the company will be asked to review the data.

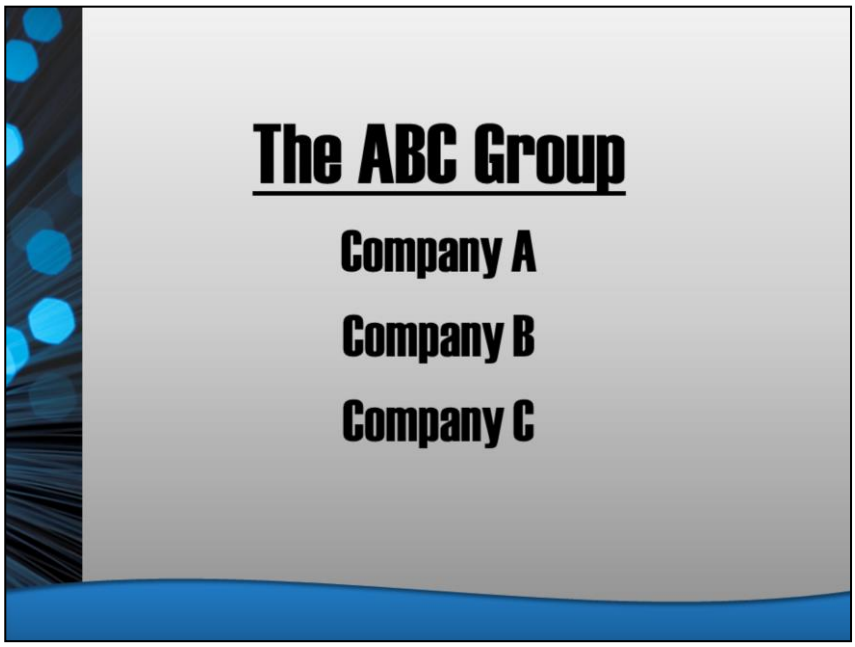


The MCAS User Guide, (found on the MCAS webpage) lists the data validation messages that may be encountered while validating data. This includes both “Error” and “Warning” messages. Use the listing to prepare data and to determine comments that will be needed to explain “Warning” messages received during the data validation process.

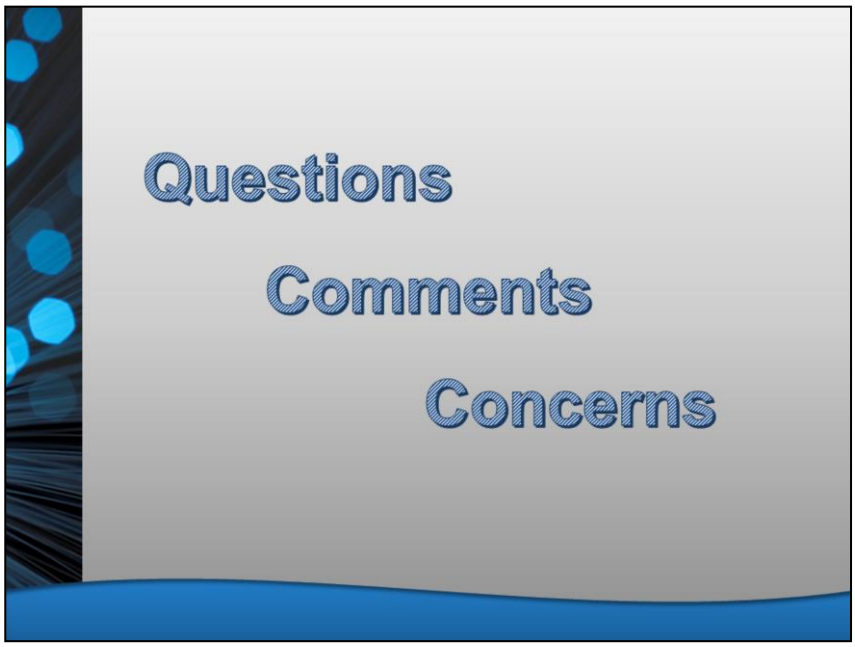
It is important to note, state regulators have full access to all data and will also review data for accuracy. State regulators will concentrate on submission for their states only, while the NAIC will review the data and look for potential trends in data filed within **multiple** states.



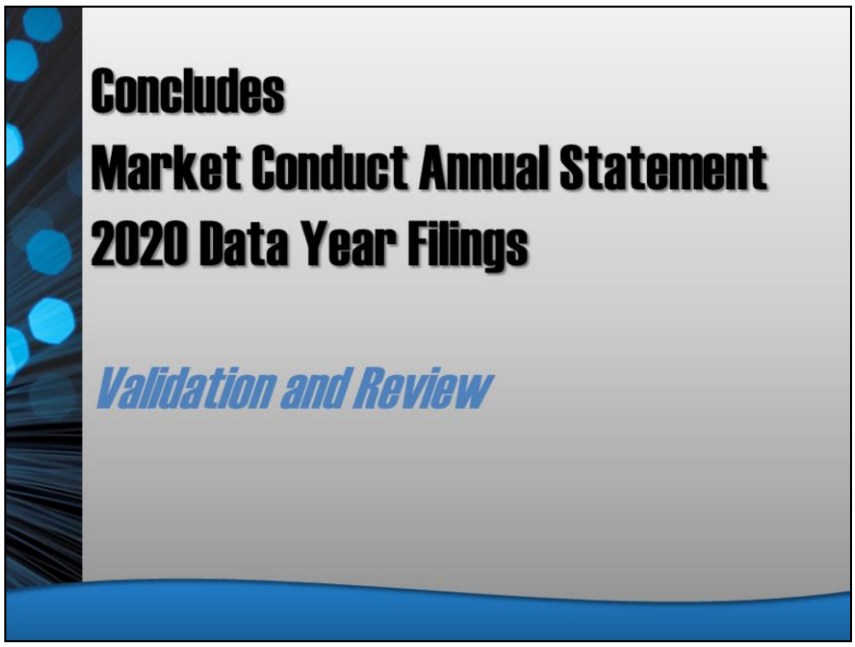
If there is reported data that appears to be mis-reported or inaccurate based on a review of data for states where data was submitted, NAIC will send an email letter to the Market Conduct Annual Statement Contact. When contact is made with individual companies, state regulators are notified of this correspondence. If they have additional questions or concerns, they may also contact the company. However, keeping state regulators in the line of communication, should lessen the number of inquiries received for any particular data concern.



If company A is part of ABC group, and the same observations are made for other companies within the group, then separate correspondence will be sent to each company. It is important to respond to requests in a timely manner to avoid follow up from the NAIC or state regulators. In the company response to the NAIC, please include comments on what action the company will take.



If you receive correspondence from an NAIC analyst, we encourage you to reach out to the analyst with any questions, comments or concerns you may have regarding the correspondence, the validations, or other MCAS filing related issues.



Thank you for your time. This concludes the filing validation and review discussion. Additional questions may be sent to mcas@naic.org.