Health
January 1, 2025 through December 31, 2025
May 31, 2026

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

1-01

2A-30/103	*Number of prior authorizations requested
2A-31/104	*Number of prior authorizations approved
2A-32/105	*Number of prior authorizations denied
2A-33/106	

4-76/149	*Number of claims received
4-77/150	*Number of claim denials for in-network claims
4-78/151	*Number of claim denials for out-of-network claims
4-79/152	*Number of paid claims for in-network services
4-80/153	*Number of paid claims for out-of-network services
4-81/154	*Claims paid
4-82/155	*Insured/beneficiary co-payment responsibility
4-83/156	*Insured coinsurance responsibility
4-84/157	*Insured deductible responsibility

** - These data elements are not reported at the metal level. Instead they are reported in aggregate for the following products: IEIH, IESG, IEMI, IEMS, OEIH and OESG.*

5-85/158

The allocation of premium and claims between

Health insurance coverage offered in the small group market.

Individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents, that meets the following conditions: (1) Does not make health insurance coverage available other than in connection with enrollment as a student (or as a dependent of a student) in the institution of higher education. (2) Does not condition eligibility for the health insurance coverage on any health status-related factor relating to a student (or a dependent of a student). (3) Meets any additional requirement that may be imposed under State law.

Plans that are issued pursuant to the policy promulgated by the Centers for Medicare & Medicaid Services (CMS) in a letter dated November 14, 2013 to the State Insurance Commissioners. If permitted by applicable State authorities, health insurance issuers may choose to continue certain coverage that would otherwise be cancelled or modified to comply with the ACA, and affected individuals and small businesses may choose to re-enroll in such coverage. CMS has further stated that, under the transitional policy, non-grandfathered health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014 and October 1, 2016 will not be considered to be out of compliance with certain market reforms if certain specific conditions are met including the approval of state authorities.

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.)

Total premium earned from all policies written by the insurer during the specified period.

Number of policies for health insurance coverage issued during the specified period.

Number of policies for health insurance coverage renewed during the specified period. If the policyholder number remains the same, count the policy as renewed.

Number of policies cancelled as a result of a rescission.

Total number of lives which were no longer covered as a result of rescissions. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

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.

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

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).

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).

Total number of claims received by a carrier asking for a payment or reimbursement by or on behalf of an out-of-network health care provider (such as a hospital or doctor) that is not contracted to be part of a carrier's network (such as an HMO or PPO) and subsequently paid by the carrier. Note: For the purposes of this data call a claim means any individual line of service. Include claims that were pended for additional information and subsequently paid.

A grouping of number of days that it has taken to pay out-of-network claims. (0