REPORT ON SEMI-ANNUAL CLEAN CLAIMS DATA FILING FOR CALENDAR YEAR 2014

PUBLISHED May 2016

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ABOUT THIS REPORT

In November 2000, the Maryland Insurance Administration (MIA) issued Regulations required by §15-1003(d) of the Insurance Article Annotated Code of Maryland (Insurance Article) that govern how third-party payors process and pay claims made by health care providers. The resulting Regulation, Code of Maryland Regulations (COMAR) 31.10.11.14, established uniform standards for claims submission by health care providers to expedite and simplify claims processing, in an effort to reduce disputes between providers and third-party payors. The regulations apply to all third-party payors.[1] Insurers and non-profit health service plans are collectively referred to as "Insurers" in this report.

Twice each year, Payors must compile and report the required claim data from their own health claim processing operation, as well as claim data from all delegated agents who process health claims on their behalf.

Under the Regulations, the Insurance Commissioner is responsible for providing the public a summary of information submitted by Payors to the MIA. This report is the summary of claims data filings for Insurers and HMOs for the calendar year of 2014.

Semi-Annual Claims Data Filing

Using an online clean claims application developed by the MIA, Payors must file a report of their Maryland health care claims for the period of January 1 through June 30 by September 1 of the same calendar year. By March 1 of each year, Payors must file a report of their Maryland health care claims for the period of July 1 through December 31 of the previous calendar year.

Payors are required to provide information regarding claims received and processed for health care benefits under a policy, contract, plan, or certificate issued or delivered in Maryland. Payors must report health care claims data for medical, dental, behavioral health, vision, and prescription drug claims. Medicare, Federal Employee Health Benefit Plans, self-insured employer health care programs and other types of accident and health insurance plans (e.g., long-term care, disability) are not reported and are excluded from this report.

Payors who are not filing the required claims data reports or who submit inaccurate data are in violation of Maryland insurance laws and regulations and may be subject to penalties imposed by the Insurance Commissioner. Penalties may include more frequent or detailed reporting.

Certain Payors with minimal or no health business in the state are exempt from this filing at the discretion of the Commissioner. As in past filing periods, a number of Payors representing a negligible segment of the Maryland market received filing exemptions for 2014. Generally,

[1] Third-party payors include insurers, non-profit health service plans, HMOs and dental plan organizations, and are collectively referred to as "Payors" in this Report.

companies with health premiums that are less than $50,000 have received an exemption from filing their clean claims data.

Base Group

To facilitate effective and meaningful data analysis, the MIA established a Base Group of Payors. This Base Group includes 16 insurers and 10 HMOs, including 4 dental plan organizations. The 2013 Base Group consisted of 21 insurers and 12 HMOs, which included 3 dental plan organizations. A list of the Base Group Payors can be found in Exhibit 1 of this report.

In the 2014 reporting period, companies in the Base Group wrote approximately $11.1 billion in accident and health premium, accounting for approximately 94.44% of the total accident and health insurance market in Maryland, an increase from 93.17% in the 2013 reporting period.[2]

Along with accident and health premium written, the Covered Lives Report, which is required to be submitted to the MIA in accordance with §15-133 of the Insurance Article Annotated Code of Maryland, was used to determine the 2014 Base Group. Using both the accident and health premiums written, and the Covered Lives Report, provides a more accurate Base Group that best represents the current market.

Clean Claims

A key element of the semi-annual claims data filing and the subject of this report are Clean Claims. Clean Claims are those health care claims submitted by a health care provider that contain all essential information needed by a Payor for claims processing. COMAR 31.10.11 sets forth the essential data elements for Clean Claims. Payors may use this data set to determine what constitutes a Clean Claim, or they may choose to define Clean Claims using their own set of requirements that contains fewer elements than all of the essential data elements detailed in COMAR 31.10.11. Payors may require fewer data elements to determine Clean Claims, but may not require more data elements than those detailed in COMAR 31.10.11.

Clean Claims must be submitted on one of two industry standard billing forms or their electronic equivalents. In Maryland, CMS Form 1500 (used by doctors) and CMS Form 1450/UB04 (formerly known as UB 92 and used by hospitals) are considered Uniform Claim Forms. The acronym "CMS" refers to the Federal Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

[2] A direct comparison of the numbers of total claims received, total clean claims received, and total benefits paid year over year will not reflect actual trends as a result of the 1.27% increase in the Base Group market share from 2013 to 2014. The percentages presented in this report may be compared year over year to provide some insight into trends within the Maryland market, despite the market share increase over the past four years.

By regulation, these CMS forms are the sole instruments for health care providers to file health claims with third-party payors for professional, hospital and related services in Maryland.

Although patients may file health care claims with Payors for reimbursement for professional, hospital and related services, they are not considered to be Clean Claims according to COMAR 31.10.11 and are not required to contain all the essential data elements. These patient-submitted claims are included in the information filed by third-party payors, but are not part of the data incorporated into Clean Claims for the purpose of this report.

Semi Annual Claims Data Filing Reports

There are specific instructions for completing the clean claims data filing form designed by the MIA. The application has Payor verification capabilities as well as automatic data validation to allow for more sensitive and reliable data collection. The application is accessible through the MIA webpage: **http://insurance.maryland.gov/**

In general, Payors are required to submit information on the total number of health claims received and denied, the number of Clean Claims received and denied, the inventory of unprocessed claims, the number of claims adjudicated, the benefit amounts paid, and the processing time. Payors must also provide information on the most prevalent reasons they deny claims.

Completion of the claims data filing requires Payors to affirm whether they use the essential data elements specified by COMAR 31.10.11 to determine Clean Claims, or whether the COMAR 31.10.11 data set is not used. As previously stated, Payors may require fewer data elements to determine Clean Claims, but may not require more data elements than mandated by the regulations.

Prompt Payment

Another key element of the semi-annual claims data filing is prompt payment. According to the Insurance Article, §15-1005(c), Insurers and HMOs must take certain action on a claim within 30 days. If payment is due on the claim and payment is not made within 30 calendar days from the date a Payor receives the claim, an interest penalty must be paid to the person entitled to the reimbursement pursuant to Insurance Article, §15-1005(f).

As part of their filing, Payors must report the number of health claims processed within certain timeframes, the total dollar amount of health benefits paid within those timeframes, and the total interest amount paid on claims processed in excess of 30 calendar days.

Denied Claims

Part of the claims data filing process requires that Payors report the number of claims denied according to the five most prevalent reasons for claim denials. To simplify this process and to

promote uniform reporting for comparison, Payors must report data based on a set of 16 denial codes established by the MIA. The list of codes can be found in Exhibit 2 of this report.

As reported by the Base Group in 2014, all five of the most prevalent reasons for claim denials fell under these 16 denial codes.

Verification of Data Reported

Data is self-reported by Payors and by delegated agents on behalf of the Payors they serve. However, reporting is ultimately the responsibility of the Payor. Some Payors collect reports from their delegated agents for submission along with their internally-generated reports while other delegated agents submit reports directly to the MIA on behalf of their contracting Insurers or HMOs. As such, the MIA assumes claims data has been verified for accuracy by Payors and delegated agents prior to submission. In previous reporting periods, the MIA was able to identify duplicate filings and certain other data anomalies. In these cases, the affected Payors were contacted for clarification and the required revisions were made accordingly.

Confidentiality of Information

Claims data filings are used, in part, by the Insurance Commissioner to monitor the general business practices of Payors and their delegated agents. The information provided to the MIA in these filings is considered confidential commercial information and is protected under the State Government Article §10-617 and the Insurance Article §2-209(g) of the Annotated Code of Maryland except when aggregated with data from all other respondents in a manner that does not permit the identification of individual respondent information.

Thus, semi-annual claims data filings of specific Payors are not available to the public. Pursuant to Insurance Article §2-205, however, Payor claims data filings may be used by the Commissioner as a basis for analysis or investigation of a Payor's business practices. Further, based on the analysis or assessment of a Payor's semi-annual claims data filing, the Commissioner may issue an Order or take any other action authorized or reasonably implied by the Insurance Article, including the imposition of an administrative penalty and/or requiring payment of interest due.

Delegated Agents

Payors must compile and report the required claim data from their own health claim processing operation, as well as claim data from all delegated agents who process health claims on their behalf.

Due to administrative changes in the process of collecting and reporting on behalf of delegated agents, this data was unavailable for the 2010 – 2011 reporting period. In 2009, data reported by delegated agents accounted for approximately 4% of the total benefits paid amount. The 2012 data was approximately 1% of the total benefits paid and the 2013 and 2014 data was less than

1% of the total benefits paid. The delegated agent information reported for this period represents no significant value to the analysis.

SUMMARY OF 2014 CLAIMS DATA FILINGS

Table 1 highlights information from the claims data filings of the Base Group for Calendar Year 2014 compared to the previous three years. The HMO and Insurer data used to create the following tables is found in Exhibit 3 of this report.

Table 1 – Summary of Base Group

Data Class	2014	2013	2012	2011
Total claims received	51.4 million	58.2 million	45.6 million	40.2 million
Total clean claims received	46.2 million	54.0 million	42.8 million	37.1 million
Total benefits paid	$9.8 billion	$10.53 billion	$8.4 billion	$8 billion
Clean claims as a percentage of total claims received	89.9%	92.8%	93.8%	92.3%
Denied claims as a percentage of total claims received	15.4%	15.9%	15.6%	14.6%
Denied clean claims as a percentage of total clean claims received	3.3%	4.1%	0.4%	0.5%
Percentage of all claims processed within 30 days	98.9%	99.0%	96.5%	97.2%

Due to changes in business and operations for several Payors (e.g. consolidation of companies or reduced marketing in Maryland), the Base Group for the 2014 report period was adjusted to reflect the approximately 1.27% increase in the market share from the previous reporting period. The data filed continued to show a number of pertinent relationships between the current and previous years.

Over the four year period, the total number of claims received increased by approximately 11.2 million. However, from 2013 to 2014, claims received decreased by 6.8 million. Clean Claims received by the Base Group has increased from 37.1 million in 2011 to 54.0 million in 2013, but did decrease by approximately 7.8 million from 2013 to 2014.

The total benefit amount paid by the Base Group increased by approximately $1.8 billion from 2011, but did decrease slightly from 2013 to 2014.

The percentage of clean claims received by companies slightly decreased from 92.8% in 2013 to 89.9% in 2014. The Base Group denied 3.3% of the total clean claims received while 15.4% of the total claims received were denied. In 2013, 4.1% of clean claims were denied while 15.9% of total claims received were denied.

The number of all claims processed within 30 days has decreased from 58 million in 2013 to 51 million in 2014. In 2013, 99% of all claims were processed within 30 days, while in 2014, 98.9% of all claims were processed within 30 days.

The average amount paid per processed claim increased 5.44% from approximately $179.73 in 2013 to $189.51 in 2014.

These numbers indicate that in 2014 in Maryland, a lower percentage of clean claims were received by the Base Group. As such, a lower amount for the total claims received was paid and processed within 30 days. Also, the average amount paid per claim processed increased, while a higher percentage of clean claims received were paid.

In 2014, Payors reported the following as the most prevalent reasons for claim denials:

- Non-covered expense or service; not reimbursable due to deductible or copay/coinsurance (38.97%)
- Duplicate expense or claim received was previously considered or paid (23.78%)
- Additional miscellaneous information not described by other denial reasons but is needed from patient or provider to process claim (11.97%)
- Maximum plan reimbursement exceeded; plan service frequency limit reached (5.52%)
- UCR allowable fee amount exceeded; coding problem including bundling or incidental procedure (3.90%)

In 2013, Payors reported the following as the most prevalent reasons for claim denials:

- Duplicate expense or claim received was previously considered or paid (32.6%)
- Non-covered expense or service; not reimbursable due to deductible or copay/coinsurance (29.2%)
- Additional miscellaneous information not described by other denial reasons but is needed from patient or provider to process claim (7.6%)
- Miscellaneous other reasons for denial not listed or explained by other codes (7.3%)
- UCR allowable fee amount exceeded; coding problem including bundling or incidental procedure (7.2%)

All are listed amongst the denial codes in Exhibit 2. The most significant change was the percentage of claims denied for "Non-Covered expense or service; service not reimbursable due to deductible or copay/coinsurance", which increased from 29.2% in 2013 to 38.97% in 2014. The second most common reason for claim denials, "Duplicate expense or claim received was previously considered or paid" decreased by 8.82% from 2013 to 2014.

The "Miscellaneous other reasons for denial not listed or explained by other codes", moved out of the top five reasons of claim denials and was replaced by "Maximum plan reimbursement exceeded; plan service frequency limit reached" as the fourth most popular reason for claim denial.

Significant changes in the number of claims denied or the reasons for denial often reflect changes in the administrative practices of Payors. Such changes may lead to delayed claims

processing and corresponding interest payments, the number and amount of claim payments, and consumer complaints.

2014 HMO RESULTS

Table 2 displays information from the claims data filings of the HMOs in the Base Group for 2014 compared to the previous 3 years.

Table 2 – Summary of HMOs in the Base Group

Data Class	2014	2013	2012	2011
Total claims received	21.0 million	25.0 million	7.0 million	7.1 million
Total clean claims received	16.9 million	21.9 million	7.0 million	7.0 million
Total benefits paid	$3.7 billion	$4.14 billion	$1.4 billion	$1.3 billion
Clean claims as a percentage of total claims received	80.4%	87.6%	99.6%	98.7%
Denied claims as a percentage of total claims received	21.8%	22.0%	30.8%	23.8%
Denied clean claims as a percentage of total clean claims received	8.5%	9.7%	0.7%	0.9%
Percentage of all claims processed within 30 days	99.3%	99.2%	99.2%	97.6%

As previously discussed, the Base Group for the 2014 report period reflects an approximately 1.27% increase in the market share from the previous reporting period. HMOs accounted for 40.92% of the total claims in the Base Group in 2014 and 37.42% of the total benefit amount paid.

The percentage of clean claims received by the HMO Base Group decreased from 87.6% in 2013 to 80.4% in 2014. The number of total claims received by HMOs in the Base Group decreased by 16% while total benefits paid decreased by 10.63% from 2013 to 2014.

In the HMO Base Group, the data indicates that Clean Claims were significantly less likely to be denied as compared to regular claims. In 2014, 21.8% of all claims received were denied versus only 8.5% of total Clean Claims were denied.

The average amount paid per processed claim increased from approximately $163.02 in 2013 to $172.12 in 2014, an increase of 5.28%. The percentage of all claims processed within 30 days increased slightly from 99.2% in 2013 to 99.3% in 2014.

2014 INSURER RESULTS

Table 3 highlights information from the claims data filings of the Insurers in the Base Group for 2014 compared to the previous 3 years.

Table 3 – Summary of Insurers in the Base Group

Data Class	2014	2013	2012	2011
Total claims received	30.4 million	33.2 million	38.6 million	33.1 million
Total clean claims received	29.3 million	32.1 million	35.8 million	30.1 million
Total benefits paid	$6.1 billion	$6.39 billion	$7.0 billion	$6.7 billion
Clean claims as a percentage of total claims received	96.4%	96.7%	92.7%	90.9%
Denied claims as a percentage of total claims received	11.0%	11.3%	12.9%	12.6%
Denied clean claims as a percentage of total clean claims received	0.4%	0.3%	0.3%	0.4%
Percentage of all claims processed within 30 days	98.7%	98.8%	96.0%	97.1%

As previously stated, the Base Group for the 2014 report period reflects an approximately 1.14% increase in the market share from the previous reporting period.

The number of total claims received by insurers in the Base Group decreased by 8.43% while total benefits paid decreased slightly by 4.5% from 2013 to 2014. The number of Clean Claims received has decreased 8.72% from 32.1 million in 2013 to 29.3 million in 2014.

Insurers accounted for 59.08% of total claims received by the Base Group in 2014 and 62.58% of total benefits paid. The average amount paid per processed claim increased from approximately $192.51 in 2013 to $201.69 in 2014, an increase of 4.77%.

Clean Claims were significantly less likely to be denied. In the 2014 Insurer Base Group, 11% of all claims received were denied while only 0.4% of all Clean Claims received were denied.

The percentage of claims processed within 30 days or less decreased slightly from 98.8% in 2013 to 98.7% in 2014.

CONCLUSIONS

Overall in 2014, the Base Group represented 94.44% of the total market share in the accident and health market in Maryland as compared to 93.17% in 2013. Thus, direct comparisons of the numbers of claims received and benefits paid in 2013 are illustrative only. Comparisons of the percentages of Clean Claims, paid claims, denied claims and timely processing of claims, however, remain relevant for the reasons stated above.

In 2014, the Base Group received 51.4 million claims and paid $9.8 billion in benefits. The HMOs in the Base Group accounted for approximately 40.92% of the total claims received and

37.42% of the total benefits paid. The Insurers in the Base Group accounted for 59.08% of the total claims received and 62.58% of the total benefit paid.

In 2014, approximately 15.42% of the total claims received by the entire Base Group were denied. This number has remained relatively consistent, showing only a slight decrease of about 3.02% over year 2013. In 2014, 3.3% of total clean claims were denied, a decrease from 4.1% from year 2013.

The Clean Claims as a percentage of total claims received by the entire Base Group decreased slightly from 92.8% in 2013 to 89.9% in 2014. The Insurers in the Base Group showed a slight decrease of 0.3% in 2014, from 96.7% in 2013 to 96.4% in 2014. The HMOs in the Base Group showed a 7.2% decrease in 2014, from 87.6% in 2013 to 80.4% in 2014.

The total benefits paid by the Base Group decreased by approximately 6.93% from 2013 to 2014. When combined with the total number of claims received, this produces an increase in the average benefit paid per claim from $192.51 in 2013 to $201.69 in 2014 for Insurers. For the HMOs in the Base Group, there was an increase from $163.02 average benefit paid per claim in 2013 to $172.12 in 2014. The average amount per claim of the entire Base Group was $189.51 for 2014, up from $179.73 in 2013. Based on the semi-annual claims data filings of the entire Base Group, some Payors have experienced a slight increase in the average cost per claim. This is demonstrated by the increase in the average benefit paid per claim processed by 5.44% for the entire Base Group.

The most prevalent reason for claim denials, “Non-covered expense or service; not reimbursable due to deductible or copay/coinsurance”, increased from 2013 and is now at 38.97%. The second most prevalent reason cited by the Base Group for claims denials was based on “Duplicate expense or claim received was previously considered or paid”. This reason accounted for 23.78% of all denials in 2014 compared to 32.6% in 2013. The total number of reasons for claim denials has decreased from 18 in 2012 to 17 in 2013 and then 16 in 2014. The overall percentage of total claims denied did not change significantly during the comparative period, and it appears that changes to the reasons for denial did not noticeably affect the processing and payment of claims.

EXHIBIT 1

BASE GROUP PAYORS FOR CALENDAR YEAR 2014

PAYORS 2014 BASE GROUP

The following is a list, in alphabetical order, of the 10 HMOs and the 16 Insurers that make up the Base Group for the 2014 Claims Data Filing:

HMOs

CareFirst BlueChoice, Inc.

United Healthcare of the Mid-Atlantic, Inc.

AMERIGROUP Maryland, Inc.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Aetna Health Inc. (a Pennsylvania corporation)

Optimum Choice, Inc.

Coventry Health Care of Delaware, Inc.

Medstar Family Choice, Inc.

Jai Medical System, Inc.

Priority Partners MCO, Inc.

Insurers, Non-Profit Health Service Plans

Carefirst of Maryland, Inc.

Group Hospitalization and Medical Services, Inc.

Coventry Health and Life Insurance Company

MAMSI Life and Health Insurance Company

Kaiser Permanente Insurance Company

Aetna Life Insurance Company

CIGNA Health and Life Insurance Company

Golden Rule Insurance Company

Time Insurance Company

UnitedHealthcare Insurance Company

USAA Life Insurance Company

Humana Insurance Company

United Concordia Dental Plans, Inc.

Cigna Dental Health of Maryland, Inc.

DentaQuest Mid-Atlantic, Inc.

Delta Dental of Pennsylvania

EXHIBIT 2

CLAIMS SUBMISSION DENIAL CODES

CLAIMS SUBMISSION DENIAL REASON CODES

The following claim submission denial codes were established by the MIA for Payors to use when reporting the five most prevalent reasons for denying claims:

1. ADDITIONAL miscellaneous information not described by other denial reasons but is needed from patient or provider to process claim

2. AUTHORIZATION (pre-treatment authorization) not obtained; provider referral not obtained; unauthorized services received are not covered

3. BILL error or discrepancy; required billing information incomplete or missing

4. COB (excepting Medicare) other coverage information needed; primary payor EOB needed

5. DUPLICATE expense or claim received was previously considered or paid

6. EOB (Explanation of Benefits)

7. INELIGIBLE claimant not covered or coverage not effective at time of service

8. MAXIMUM plan reimbursement exceeded; plan service frequency limit reached

9. MEDICARE all Medicare issues including coordination of benefits (EOMB needed), deductible not covered or service or expense not approved by Medicare

10. MISCELLANEOUS other reasons for denial not listed or explained by other codes

11. NOT APPLICABLE; zero or no other denials reportable

12. NON-COVERED expense or service; service not reimbursable due to deductible or copay/coinsurance

13. PROVIDER out-of-network, not contracted or covered; service covered by global or capitated fee or other network coverage issue

14. TERMINATED coverage; coverage lapsed, or cancelled; dependent no longer covered; premium payments not current

15. UCR allowable fee amount exceeded; coding problem including bundling or incidental procedure

16. UNTIMELY filing of claim by patient or provider; exceeds plan claim filing limitation

EXHIBIT 3

SUMMARY OF THE BASE GROUP'S CLAIMS DATA FILINGS FOR CALENDAR YEAR 2014

SUMMARY OF THE BASE GROUP'S CLAIMS DATA FILINGS

FOR CALENDAR YEAR 2014

HMO Base Group Totals	Period 1	Period 2	Totals
Total Claims Received	8,477,504	12,555,121	21,032,625
Total Claims Denied	1,668,455	2,922,085	4,590,540
Total Claims Processed	8,317,624	12,963,044	21,280,668
Clean Claims Received	6,445,191	10,472,655	16,917,846
Clean Claims Denied	72,869	1,360,397	1,433,266
Total Benefit Amount Paid	$1,730,530,991.83	$1,932,256,163.58	$3,662,787,155.41
Total Claims Processed < 30 Days	8,221,770	12,899,584	21,121,354
Total Claims Processed > 30 Days	95,854	63,460	159,314
Interest Paid on Delayed Claims	$435,574.22	$373,866.20	$809,440.42
Total Ending Claim Inventory	137,530	415,718	553,248
Insurer Base Group Totals	**Period 1**	**Period 2**	**Totals**
Total Claims Received	15,145,901	15,215,693	30,361,594
Total Claims Denied	1,771,139	1,565,782	3,336,921
Total Claims Processed	15,153,945	15,221,284	30,375,229
Clean Claims Received	14,612,863	14,662,876	29,275,739
Clean Claims Denied	54,664	58,919	113,583
Total Benefit Amount Paid	$3,040,579,562.88	$3,085,913,586.71	$6,126,493,149.60
Total Claims Processed < 30 Days	14,917,763	15,073,770	29,991,533
Total Claims Processed > 30 Days	236,182	147,514	383,696
Interest Paid on Delayed Claims	$347,590.16	$316,243.92	$663,834.08
Total Ending Claim Inventory	168,007	145,543	313,550
Base Group Totals	**Period 1**	**Period 2**	**Totals**
Total Claims Received	23,623,405	27,770,814	51,394,219
Total Claims Denied	3,439,594	4,487,867	7,927,461
Total Claims Processed	23,471,569	28,184,328	51,655,897
Clean Claims Received	21,058,054	25,135,531	46,193,585
Clean Claims Denied	127,533	1,419,316	1,546,849
Total Benefit Amount Paid	$4,771,110,554.71	$5,018,169,750.30	$9,789,280,305.01
Total Claims Processed < 30 Days	23,139,533	27,973,354	51,112,887
Total Claims Processed > 30 Days	332,036	210,974	543,010
Interest Paid on Delayed Claims	$783,164.38	$690,110.12	$1,473,274.50
Total Ending Claim Inventory	305,537	561,261	866,798