REPORT ON SEMI-ANNUAL CLEAN CLAIMS DATA FILING FOR CALENDAR YEAR 2015

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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 2015.

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 2015. 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 15 insurers and 11 HMOs, including 4 dental plan organizations. The 2014 Base Group consisted of 16 insurers and 10 HMOs, which included 4 dental plan organizations. A list of the Base Group Payors can be found in Exhibit 1 on page 12 of this report.

In the 2015 reporting period, companies in the Base Group wrote approximately $11 billion in accident and health premium, accounting for approximately 93.72% of the total accident and health insurance market in Maryland, a decrease from 94.44% in the 2014 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 2015 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.

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.

[2] A direct comparison of the numbers of total claims received, total clean claims received, and total benefits paid year over one year will not reflect actual trends as a result of the 0.72% decrease in the Base Group market share from 2014 to 2015.

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 18 denial codes established by the MIA. The list of codes can be found in Exhibit 2 on page 15 of this report.

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.

SUMMARY OF 2015 CLAIMS DATA FILINGS

Table 1 highlights information from the claims data filings of the Base Group for Calendar Year 2015 compared to the previous three years. The HMO and Insurer data used to create the following tables is found in Exhibit 3 on page 17 of this report.

Table 1 – Summary of Base Group

Data Class	2015	2014	2013	2012
Total claims received	60.4 million	51.4 million	58.2 million	45.6 million
Total clean claims received	52.7 million	46.2 million	54.0 million	42.8 million
Total benefits paid	$11.9 billion	$9.8 billion	$10.53 billion	$8.4 billion
Clean claims as a percentage of total claims received	87.3%	89.9%	92.8%	93.8%
Denied claims as a percentage of total claims received	15.6%	15.4%	15.9%	15.6%
Denied clean claims as a percentage of total clean claims received	5.1%	3.3%	4.1%	0.4%
Percentage of all claims processed within 30 days	99.2%	98.9%	99.0%	96.5%

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 2015 report period was adjusted to reflect the approximately 0.72% decrease 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 14.8 million. Clean Claims received by the Base Group has increased from 42.8 million in 2012 to 52.7 million in 2015. The total benefit amount paid by the Base Group increased by approximately $3.5 billion from 2012 to 2015.

The percentage of clean claims received by companies slightly decreased from 89.9% in 2014 to 87.3% in 2015.The Base Group denied 5.1% of the total clean claims received while 15.6% of the total claims received were denied. In 2014, 3.3% of clean claims were denied while 15.4% of total claims received were denied.

The number of total claims processed within 30 days has increased from 51 million in 2014 to 62 million in 2015. In 2014, 98.9% of all claims were processed within 30 days, while in 2015, 99.2% of all claims were processed within 30 days.

The average amount paid per processed claim increased 1.19% from approximately $189.51 in 2014 to $191.77 in 2015.

In 2015, 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 (36.76%)
- Duplicate expense or claim received was previously considered or paid (19.82%)
- Miscellaneous other reasons for denial not listed or explained by other codes (11.19%)
- Additional miscellaneous information not described by other denial reasons but is needed from patient or provider to process claim (9.07%)
- UCR allowable fee amount exceeded; coding problem including bundling or incidental procedure (5.02%)

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%)

All denial code reasons are listed in Exhibit 2 on page 15 of this report. The most significant change was the percentage of claims denied for “Miscellaneous other reasons for denial not listed or explained by other codes”, which decreased from 7.3% in 2013 to 3.87% in 2014 and increased to 11.19% in 2015.

The “Maximum plan reimbursement exceeded; plan service frequency limit reached”, moved out of the top five reasons of claim denials and the “Miscellaneous other reasons for denial not listed or explained by other codes” moved into the top five reasons of claim denials. All the other top 5 reasons of claim denials in 2014 remained in the top 5 in 2015.

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.

2015 HMO RESULTS

Table 2 displays information from the claims data filings of the HMOs in the Base Group for 2015 compared to the previous 3 years.

Table 2 – Summary of HMOs in the Base Group

Data Class	2015	2014	2013	2012
Total claims received	29.7 million	21.0 million	25.0 million	7.0 million
Total clean claims received	23.1 million	16.9 million	21.9 million	7.0 million
Total benefits paid	$5.0 billion	$3.7 billion	$4.14 billion	$1.4 billion
Clean claims as a percentage of total claims received	77.8%	80.4%	87.6%	99.6%
Denied claims as a percentage of total claims received	21.1%	21.8%	22.0%	30.8%
Denied clean claims as a percentage of total clean claims received	11.2%	8.5%	9.7%	0.7%
Percentage of all claims processed within 30 days	99.3%	99.3%	99.2%	99.2%

As previously discussed, the Base Group for the 2015 report period reflects an approximately 0.72% decrease in the market share from the previous reporting period. HMOs accounted for 49.18% of the total claims in the Base Group in 2015 and 42.43% of the total benefit amount paid.

The percentage of clean claims received by the HMO Base Group decreased from 80.4% in 2014 to 77.8% in 2015. The number of total claims received by HMOs in the Base Group increased by 41% while total benefits paid increased by 35% from 2014 to 2015.

In the HMO Base Group, the data indicates that Clean Claims were significantly less likely to be denied as compared to regular claims. In 2015, only 21.06% of all claims received were denied versus 8.79% of Clean Claims as compared to total claims received were denied.

The average amount paid per processed claim decreased from approximately $172.12 in 2014 to $160.70 in 2015, a decrease of 6.63%. The percentage of all claims processed within 30 days remained steady at 99.3% in both 2014 and 2015.

2015 INSURER RESULTS

Table 3 highlights information from the health claims data filings of the Insurers in the Base Group for 2015 and compared to the previous 3 years.

Table 3 – Summary of Insurers in the Base Group

Data Class	2015	2014	2013	2012
Total claims received	30.7 million	30.4 million	33.2 million	38.6 million
Total clean claims received	29.6 million	29.3 million	32.1 million	35.8 million
Total benefits paid	$6.9 billion	$6.1 billion	$6.39	$7.0 billion
Clean claims as a percentage of total claims received	96.4%	96.4%	96.7%	92.7%
Denied claims as a percentage of total claims received	10.5%	11.0%	11.3%	12.9%
Denied clean claims as a percentage of total clean claims received	0.3%	0.4%	0.3%	0.3%
Percentage of all claims processed within 30 days	99.4%	98.7%	98.8%	96.0%

As previously stated, the Base Group for the 2015 report period reflects an approximately 0.72% decrease in the market share from the previous reporting period.

The number of total claims received by insurers in the Base Group increased by 0.98% while total benefits paid increased by 13.11% from 2014 to 2015. The number of Clean Claims received slightly increased 1.02% from 29.3 million in 2014 to 29.6 million in 2015.

Insurers accounted for 50.82% of total claims received by the Base Group in 2015 and 57.57% of total benefits paid. The average amount paid per processed claim increased from approximately $201.69 in 2014 to $223.62 in 2015, an increase of 10.87%.

Clean Claims were significantly less likely to be denied. In the 2015 Insurer Base Group, only 10.39% of all claims received were denied while 0.31% of all Clean Claims received were denied.

The percentage of claims processed within 30 days or less increased slightly from 98.7% in 2014 to 99.05% in 2015.

CONCLUSIONS

Overall in 2015, the Base Group represented 93.72% of the total market share in the accident and health market in Maryland as compared to 94.44% in 2014. Thus, direct comparisons of the numbers of claims received and benefits paid 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 2015, the Base Group received 60.4 million claims and paid $11.9 billion in benefits. The HMOs in the Base Group accounted for approximately 49.18% of the total claims received and 42.43% of the total benefits paid. The Insurers in the Base Group accounted for 50.82% of the total claims received and 57.57% of the total benefit paid.

In 2015, approximately 15.64% of the total claims received by the entire Base Group were denied. This number has remained relatively consistent, showing only a slight increase of about 1.42% over year 2014. In 2015, 4.48% of total clean claims were denied, an increase from 3.3% from year 2014.

The Clean Claims as a percentage of total claims received by the entire Base Group decreased slightly from 89.9% in 2014 to 87.3% in 2015. The Insurers in the Base Group remained the same from 2014 to 2015 at 96.4%.The HMOs in the Base Group showed a 2.6% decrease in 2015, from 80.4% in 2014 to 77.8% in 2015.

The total benefits paid by the entire Base Group increased by approximately 21.42% from 2014 to 2015. When combined with the total number of claims received, this produces an increase in the average benefit paid per claim from $189.51 in 2014 to 191.77 in 2015.

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 1.19% 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”, decreased from 2014 and is now at 36.76%. 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 19.82% of all denials in 2015 compared to 23.78% 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 2015

2015 Payor Base Group

The following is a list of the 11 HMOs/MCOs and the 15 Insurers that make up the Base Group for the 2015 Claims Data Filing:

HMOs/MCOs

Aetna Health, Inc.

AMERIGROUP Maryland, Inc.

CareFirst BlueChoice, Inc.

Evergreen Health Cooperative

Jai Medical Systems, Inc.

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

Maryland Physicians Care

MedStar Family Choice, Inc.

Optimum Choice, Inc.

Priority Partners, Inc.

UnitedHealthcare of the Mid-Atlantic, Inc.

Insurers, Non-Profit Health Service Plans

Aetna Life Insurance Company

CareFirst of Maryland, Inc.

CIGNA Dental Health of Maryland Inc.

CIGNA Health and Life Insurance Company

Coventry Health and Life Insurance Company

Delta Dental Insurance Company

Delta Dental of Pennsylvania

Golden Rule Insurance Company

Group Dental Service of Maryland, Inc.

Group Hospitalization and Medical Services, Inc.

Humana Insurance Company

MAMSI Life and Health Insurance Company

United Concordia Life and Health Insurance Company

UnitedHealthcare Insurance Company

USAA Life Insurance Company

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. ACCIDENT details needed from insured or provider; includes Workers Comp investigation details

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

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

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

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

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

7. EOB (Explanation of Benefits)

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

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

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

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

12. NOT APPLICABLE; zero or no other denials reportable

13. NONCOVERED expense or service; service not reimbursable due to deductible or copay/coinsurance

14. PREEXISTING condition not covered; waiting period exclusion or limitation applies

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

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

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

18. 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 2015

SUMMARY OF THE BASE GROUP'S CLAIMS DATA FILINGS

FOR CALENDAR YEAR 2015

HMO Base Group Totals	Period 1	Period 2	Totals
Total Claims Received	14,944,113	14,769,049	29,713,162
Total Claims Denied	3,148,258	3,108,919	6,257,177
Total Claims Processed	16,431,399	15,043,288	31,474,687
Clean Claims Received	11,653,699	11,486,629	23,140,328
Clean Claims Denied	1,318,977	1,292,169	2,611,146
Total Benefit Amount Paid	$2,489,986,694.11	$2,567,974,764.23	$5,057,961,458.33
Total Claims Processed < 30 Days	16,326,773	14,935,268	31,262,041
Total Claims Processed > 30 Days	104,626	108,020	212,646
Interest Paid on Delayed Claims	$493,314.14	$573,651.08	$1,066,965.22
Total Ending Claim Inventory	1,759,897	325,374	2,085,271
Insurer Base Group Totals	**Period 1**	**Period 2**	**Totals**
Total Claims Received	15,215,163	15,489,117	30,704,280
Total Claims Denied	1,557,847	1,632,949	3,190,796
Total Claims Processed	15,210,319	15,484,454	30,694,773
Clean Claims Received	14,652,372	14,926,722	29,579,094
Clean Claims Denied	50,620	43,568	94,188
Total Benefit Amount Paid	$3,117,913,511.83	$3,746,070,995.15	$6,863,984,506.98
Total Claims Processed < 30 Days	15,012,653	15,390,103	30,402,756
Total Claims Processed > 30 Days	197,666	94,351	292,017
Interest Paid on Delayed Claims	$311,014.24	$312,544.94	$623,559.18
Total Ending Claim Inventory	146,004	143,432	289,436
Base Group Totals	**Period 1**	**Period 2**	**Totals**
Total Claims Received	30,159,276	30,258,166	60,417,442
Total Claims Denied	4,706,105	4,741,868	9,447,973
Total Claims Processed	31,641,718	30,527,742	62,169,460
Clean Claims Received	26,306,071	26,413,351	52,719,422
Clean Claims Denied	1,369,597	1,335,737	2,705,334
Total Benefit Amount Paid	$5,607,900,205.94	$6,314,045,759.37	$11,921,945,965.31
Total Claims Processed < 30 Days	31,339,426	30,325,371	61,664,797
Total Claims Processed > 30 Days	302,292	202,371	504,663
Interest Paid on Delayed Claims	$804,328.38	$886,196.02	$1,690,524.40
Total Ending Claim Inventory	1,905,901	468,806	2,374,707