REPORT ON SEMI-ANNUAL CLAIMS DATA FILING FOR CALENDAR YEARS 2010 - 2012

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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] which include insurers and non-profit health service plans[2] , HMOs, and dental plan organizations.

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 calendar years 2010 - 2012.

Semi-Annual Claims Data Filing

Using a format developed by the MIA, Payors 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 report health care claims processing data for the period 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. Medicare, Federal Employee Health Benefit Plans, self-insured employer health care programs and other types of accident and health insurance (e.g., long-term care, disability) are not required to submit data and are excluded from this report. Payors must report health care claims data for medical, dental behavioral health, vision, and prescription drug claims.

Payors not filing the required claims data reports or 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 2012. Generally,

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

[2] Insurers and non-profit health service plans are collectively referred to as "insurers" 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 included 27 insurers and 7 HMOs and has remained relatively consistent since 2006. Because of changes in business and operations for several Payors (e.g., consolidation of companies or reduced marketing in Maryland), the Base Group for the 2012 report period is adjusted from the previous period and includes 28 insurers and 7 HMOs. The 2012 Base Group also includes 7 dental plan organizations. Previously, no dental organizations were represented. No vision plan organizations are included in the Base Group. A list of the Base Group Payors can be found in Exhibit 3 of this report.

In the 2012 reporting period, companies in the Base Group wrote approximately $6 billion in accident and health premium, accounting for about 74.7 percent of the total accident and health insurance market in Maryland. In the 2009 reporting period, the Base Group accounted for approximately 65 percent of the total accident and health premium written in Maryland.

As a result of this increase in the Base Group from 65 percent market share to 74.7 percent market share, direct comparison of the numbers of total claims received, total clean claims received and total benefits paid from year to year will not reflect actual trends in the market and should not be used for that purpose. The statistics presented in this report, however, remain valid because they reflect a ratio based on the companies actually reporting in that time period. Therefore, the ratios or percentages tracked in this report do provide some insight into trends within the Maryland 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.

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 claims data filing form designed by the MIA. Beginning with the 2007 claims data filing, Payors were given an option of submitting data electronically in lieu of submitting data in the traditional paper format. The electronic system is accessible through the same MIA webpage as the previous paper form: http://www.mdinsurance.state.md.us.

To promote uniformity and verification of data reporting between Payors and the MIA's new electronic filing system, the instructions for electronic claims data filing have replaced the instructions for completing the paper form on the MIA's website. A new paper form, an identical copy of the electronic application, is also available for Payors to submit claims if problems arise with the electronic system. Nearly all 2012 claims data filings were received electronically, and mandatory electronic filing is planned for the future.

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 and the benefit amounts paid, and processing time. Payors must also provide information on the most prevalent reasons for their denials of claims submitted.

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 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 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.

As reported by the Base Group in 2012, all five of the most prevalent reasons for claim denials fell under these 16 denial codes. Additionally, 99.3 percent of all claims denials reported in 2012 fell under these 16 denial codes. The list of codes can be found in Exhibit 2 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 the course of its analysis, the MIA was able to identify duplicate filings and certain other data anomalies. In these cases, the affected Payors were contacted for clarification or revised data.

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 State Government Article, §10-617 and Insurance Article §2-209(g), 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. In previous reports, no delegated agent claims data was included in the report. However, the data was included along with all other Base Group data in Exhibit 1.

Due to administrative changes in the process of collecting and reporting on behalf of delegated agents, this data is unavailable for the 2010 – 2012 reporting period. Data reported by delegated agents accounted for approximately 4% of the total benefits paid amount for 2009. The 2012 data constitutes approximately 1% of the total benefits paid. The delegated agent information reported for this period represents no significant value to the analysis.

SUMMARY OF 2010 – 2012 CLAIMS DATA FILINGS

Table 1 highlights information from the claims data filings of the Base Group for Calendar Year 2012 compared to the previous two years. The HMO and insurer data used to create the following tables is found in Exhibit 1 of this report.

Table 1 – Summary of Base Group

Data Class	2012	2011	2010
Total claims received	45.6 million	40.2 million	40.1 million
Total clean claims received	42.8 million	37.1 million	33.8 million
Total benefits paid	$8.4 billion	$8 billion	$8.8 billion
Clean claims as a percentage of total claims received	93.8%	92.3%	84.2%
Denied claims as a percentage of total claims received	15.6%	14.6%	15.5%
Denied clean claims as a percentage of total clean claims received	0.4%	0.5%	0.6%
Percentage of all claims processed within 30 days	96.5%	97.2%	97.4%

As previously described, 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 2012 report period is adjusted from the previous periods to reflect a 9.7 percent increase in market share.

As a result of this increase in the Base Group market share over the past three years, from 65 percent to 74.7 percent, a direct comparison of the numbers of total claims received, total clean claims received, and total benefits paid from year to year will not reflect actual trends in the market and should not be used for that purpose. However, the percentages presented in this

report may be compared from year to year to provide some insight into trends within the Maryland market.[3] A list of Base Group Payors can be found in Exhibit 3 of this report.

Recognizing that the adjustment to the Base Group resulted in a 9.7 percent increase in the percentage of the Maryland healthcare market represented, the data filed continues to show a number of pertinent relationships between the current and previous years. Over the three year period, the market share increased by 9.7 percent, the number of claims received increased 13.7 percent and the total benefit amount paid decreased by 5 percent. Much of the decrease in payments occurred between 2010 and 2011 when the total benefits paid decreased from $8.8 billion to $8 billion. However, total benefits paid increased 4.9 percent to $8.4 billion in 2012.

The percentage of clean claims received by companies has steadily increased every year since 2010. The percentage of Clean Claims received by the Base Group has increased 9.6% from 84.2 percent in 2010 to 93.8 percent in 2012.

The percentage of clean claims paid by the Base Group has increased since 2012. In 2012, 99.6 percent of the clean claims received were paid while only 84.4 percent of all claims received were paid. In 2011, 85.4 percent of all claims received were paid; 84.5 percent of all claims received were paid in 2010.

In year 2012, the Base Group denied 0.4 percent of clean claims received were denied while 15.6 percent of all claims received were denied. In 2011, 14.6 percent of all claims received were denied; 15.5 percent was denied in 2010.

Finally, the average amount paid per processed claim decreased from approximately $218 in 2010 to $183 in 2012, a decrease of 16 percent. Since 2010, the percentage of all claims processed within 30 days has increased by 12.1 percent to 44.1 million in 2012.

These numbers indicate that in Maryland a higher percentage of clean claims is being received by the Base Group, a higher percentage of clean claims received is being paid, and a higher amount of all claims are being paid and processed within 30 days. But, the average amount paid per processed claim has decreased.

In 2012, Payors reported the most prevalent reasons for claim denials were:

- Duplicate claim submission (49.4 percent, a 14.2 percent increase from 2010)
- Noncovered expense or service; not reimbursable due to deductible or copay/coinsurance (23.3 percent, more than doubled from 11.2 in 2010)
- UCR/allowable fee amount exceeded; coding problem including bundling or incidental procedure (7.2 percent, a 40 percent decrease from 12 percent in 2010)

[3] Since each percentage is a comparison of the data submitted to the actual Base Group in existence during that particular year, each percentage has already taken into account the appropriate decrease in market share among the Base Group companies.

- Miscellaneous/other reasons for denial (6.5 percent, a 43 percent decrease from 11.4 percent in 2010)

Concerning the most prevalent reasons for denied claims, the Base Group did not report a reason for denial that is not otherwise listed as a denial code in Exhibit 2.

Regarding the most common reasons for claim denials, the most significant change is the percentage of claims denied for "Noncovered expense or service; not reimbursable due to deductible or copay/coinsurance" [4]. "Noncovered" denials increased by 107.5 percent between 2010 and 2012. 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.

Of note, although the amount of all claims processed within 30 days has increased, the percentage of all claims processed within 30 days decreased from a high of 97.4 percent in 2010 to 96.5 percent in 2012.

HMO RESULTS

Table 2 displays information from the claims data filings of the HMOs in the Base Group for 2012 compared to the previous two years.

Table 2 – Summary of HMOs in the Base Group

Data Class	2012	2011	2010
Total claims received	7.0 million	7.1 million	7.7 million
Total clean claims received	7.0 million	7.0 million	7.4 million
Total benefits paid	$1.4 billion	$1.3 billion	$1.7 billion
Clean claims as a percentage of total claims received	99.6%	98.7%	95.7%
Denied claims as a percentage of total claims received	30.8%	23.8%	21.2%
Denied clean claims as a percentage of total clean claims received	0.7%	0.9%	1.0%
Percentage of all claims processed within 30 days	99.2%	97.6%	97.9%

As previously described, due to changes in business and operations for several Payors (e.g., consolidation of companies or reduced marketing in Maryland), the HMO Base Group for the

[4] "Noncovered expense or service; not reimbursable due to deductible or copay/coinsurance" is represented by "Expense or services not covered by plan (other than Medicare related items)", number 10 on the Claim Submission Denial Reason Codes in Exhibit 2.

2012 report period is adjusted from the previous period to reflect 9.7 percent increase in the market share[5].

The percentage of clean claims received by the HMO Base Group has been steadily increasing from 95.7 percent in 2010 to 99.6 percent in 2012.

HMOs accounted for 15.3 percent of the total claims in the Base Group in 2012 and 16.7 percent of the total benefit amount paid. The average amount paid per processed claim decreased from approximately $220 in 2010 to $198 in 2012, a decrease of 10 percent.

There has been a continued improvement in the percentage of claims processed by HMOs in 30 days or less. In 2012, 99.2 percent of all claims were processed within 30 days. HMOs have typically outperformed insurers in this area by approximately one to three percent; in 2012 the HMO percentage was 3.2 percent higher than insurers.

Over the three year period, the number of claims received by HMOs in the Base Group decreased 9.7 percent while total benefits paid decreased by 18.2 percent.

In the HMO Base Group, the data indicates that Clean Claims are significantly less likely to be denied; in 2012, 30.8 percent of all claims received were denied compared to 0.7 percent of Clean Claims.

INSURER RESULTS

Table 3 highlights information from the claims data filings of the insurers in the Base Group for 2012 compared to the previous two years.

Table 3 – Summary of Insurers in the Base Group

Data Class	2012	2011	2010
Total claims received	38.6 million	33.1 million	32.4 million
Total clean claims received	35.8 million	30.1 million	26.4 million
Total benefits paid	$7.0 billion	$6.7 billion	$7.1 billion
Clean claims as a percentage of total claims received	92.7%	90.9%	81.4%
Denied claims as a percentage of total claims received	12.9%	12.6%	14.1%
Denied clean claims as a percentage of total clean claims received	0.3%	0.4%	0.6%
Percentage of all claims processed within 30 days	96.0%	97.1%	97.3%

[5] As a result of this increase in the Base Group from 65 percent market share to 74.7 percent market share, direct comparison of the numbers of total claims received, total clean claims received and total benefits paid from year to year will not reflect actual trends in the market and should not be used for that purpose.

As previously described, 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 2012 report period is adjusted from the previous periods to reflect a 9.7 percent increase in market share[6].

The percentage of Clean Claims received has increased substantially from 81.4 percent in 2010 to 92.7 percent in 2012, but remains lower than the 2012 HMO percentage of 99.6.

Insurers accounted for 84.7 percent of total claims received by the Base Group in 2012 and 83.3 percent of total benefits paid. The average amount paid per processed claim decreased from approximately $218 in 2010 to $181 in 2012, a decrease of 17.2 percent, a shift nearly double a similar shift seen in the HMO data.

The percentage of claims processed within 30 days or less decreased slightly from 97.3 percent in 2010 to 96 percent in 2012.

Over the three year period, the number of claims received by insurers in the Base Group increased by 19.3 percent while total benefits paid decreased slightly by 1.8 percent.

As previously stated, Clean Claims are significantly less likely to be denied. In 2012, 12.9 percent of all claims received were denied while only 0.3 percent of all Clean Claims received were denied.

CONCLUSIONS

Overall, in 2012 the Base Group represented 74.7 percent of the total written premium in the accident and health market in Maryland as compared to 65 percent in 2009. Thus, direct comparisons of the numbers of claims received and benefits paid in 2012 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 2012, the Base Group received 45.6 million claims and paid $8.4 billion in benefits. The HMOs accounted for approximately 15.3 percent of the received claims and 16.7 percent of the total benefits paid; the insurers accounted for 84.7 percent of the received claims and 83.3 percent of the total benefit paid.

In 2012, approximately 15.6 percent of the total claims received by the Base Group were denied. This number has remained relatively consistent, showing only a slight increase of about one-tenth of a percent over the period of 2010 through 2012. Denied Clean Claims as a percentage of total claims received accounted for only 0.4 percent of the total number of claims denied, a number that has shown great improvement since its 2007 high of 5.3 percent.

[6] As a result of this increase in the Base Group from 65 percent market share to 74.7 percent market share, direct comparison of the numbers of total claims received, total clean claims received and total benefits paid from year to year will not reflect actual trends in the market and should not be used for that purpose.

The percentage of Clean Claims received by the Base Group increased notably from 84.2 percent of the total claims received in 2010 to 93.8 percent of the total claims received in 2012. It seems that insurers accounted for this increase in Clean Claims received as a percentage of total claims received. Insurers showed a significant increase of about 11.3 percent in the proportion of Clean Claims received in 2012. HMOs have had consistently poor numbers relative to insurers in past reporting periods. However, 2012 HMOs registered a 3.9 percent increase in the proportion of Clean Claims received, representing the best year in the sample period of 2010 to 2012.

The total benefits paid by the Base Group decreased by about 5 percent between 2010 and 2012, but remains higher than previous reporting periods. This number is more significant when combined with the total number of claims received producing an average benefit paid per processed claim. This calculation illustrates a decrease from $218 per processed claim in 2010 to $181 in 2012 for insurers while the HMO average benefit paid per processed claim decreased from $220 in 2010 to $198 in 2012 for the same period.

Based on the semi-annual claims data filings of the Base Group of Payors, it appears that some Payors may have experienced a significant decrease in the average cost per claim. This is demonstrated by the decrease in the average benefit paid per processed claim by 10 percent for HMOs and 17.2 percent for insurers. The overall health insurance market trends regarding the total number of health claims received, processed, paid or denied have remained relatively consistent.

Regarding the reasons for claim denials, duplicate claim submissions increased slightly from past years, but remains the most common reason for claim denial at 49.4 percent in 2012. The second most prevalent reason cited by the Base Group for claims denials was based on “Noncovered expense or service; not reimbursable due to deductible or copay/coinsurance.” This reason accounted for 23.3 percent of all denials in 2012 compared to only 11.2 percent in 2010. The overall percentage of total claims denied has not changed significantly during the comparative period, and it appears that changes to the reasons for denial have not noticeably affected the processing and payment of claims.

EXHIBIT 1

SUMMARY OF BASE GROUP CLAIMS DATA FILINGS FOR CALENDAR YEARS 2010 – 2012

HMO Claims Reported	Total 2012	Total 2011	Total 2010
Total Claims received	6,979,342	7,103,874	7,733,176
Total Claims Denied	2,149,534	1,689,535	1,638,545
Total Claims Processed	7,019,230	7,148,949	7,768,300
Clean Claims Received	6,954,128	7,008,273	7,401,290
Clean Claims Denied	51,386	60,044	70,385
Total Benefit Amount paid	$1,394,661,716	$1,326,538,101	$1,705,931,505
Total Claims Processed <30 days	6,961,649	6,976,703	7,603,694
Total Claims Processed >30 days	57,581	172,246	164,606
Interest Paid on Delayed Claims	$1,338,925	$1,233,551	$1,959,688
Total Ending Claim Inventory	79,261	179,727	173,236
Insurer Claims Reported	**Total 2012**	**Total 2011**	**Total 2010**
Total Claims received	38,615,440	33,119,117	32,376,561
Total Claims Denied	4,971,504	4,180,594	4,560,890
Total Claims Processed	38,650,624	33,167,608	32,609,888
Clean Claims Received	35,798,896	30,107,947	26,353,102
Clean Claims Denied	116,396	120,093	146,490
Total Benefit Amount paid	$6,985,222,270	$6,660,601,752	$7,114,489,665
Total Claims Processed <30 days	37,120,103	32,220,821	31,717,125
Total Claims Processed >30 days	1,530,521	946,787	892,763
Interest Paid on Delayed Claims	$2,597,530	$1,595,109	$3,160,860
Total Ending Claim Inventory	1,151,352	803,327	623,745
All Claims Reported	**Total 2012**	**Total 2011**	**Total 2010**
Total Claims received	45,594,782	40,222,991	40,109,737
Total Claims Denied	7,121,038	5,870,129	6,199,435
Total Claims Processed	45,669,854	40,316,557	40,378,188
Clean Claims Received	42,753,024	37,116,220	33,754,392
Clean Claims Denied	167,782	180,137	216,875
Total Benefit Amount paid	$8,379,883,985	$7,987,139,853	$8,820,421,170
Total Claims Processed <30 days	44,081,752	39,197,524	39,320,819
Total Claims Processed >30 days	1,588,102	1,119,033	1,057,369
Interest Paid on Delayed Claims	$3,936,455	$2,828,660	$5,120,548
Total Ending Claim Inventory	1,230,613	983,054	796,981

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 (including workers compensation) or explanation required
2. Additional information from member or provided needed
3. Provider billing error or discrepancy; billing information missing
4. Coordination of benefits information or primary Payor EOB needed
5. Provider not contracted or covered by plan; not covered due to provider global or capitation fee arrangement
6. Expense previously considered or paid; duplicate submission
7. Service exceeds plan frequency of services limitation
8. Patient not covered or ineligible for benefits; coverage not effective
9. Expense or services not approved or covered by Medicare; Medicare deductible not covered by plan
10. Expense or services not covered by plan (other than Medicare related items)
11. Pre-treatment authorization or referral not obtained; unauthorized services not covered by plan
12. Pre-existing condition not covered by plan
13. Coverage terminated, cancelled or lapsed
14. Expense exceeds usual and customary fee; miscoded service, unbundled fee or incidental procedure not covered by plan
15. Untimely filed claim by provider not accepted for reimbursement
16. Miscellaneous other conditions or reasons for denial

EXHIBIT 3

BASE GROUP PAYORS FOR CLANDAR YEARS

2010 – 2012

PAYORS – 2010 - 2012 BASE GROUP

The following is a list, in alphabetical order, of the 7 HMOs and the 28 insurers that make up the Base Group for the 2010 – 2012 Claims Data Filing. The Base Group for the 2012 report period is adjusted from the previous period and includes 28 insurers and 7 HMOs. The 2012 Base Group also includes seven dental plan organizations. Previously, no dental organizations were represented. No vision plan organizations are included in the Base Group.

HMOs

Aetna Health, Inc.

CareFirst BlueChoice, Inc.

CIGNA HealthCare Mid-Atlantic, Inc.

Coventry Health Care of Delaware, Inc.

Coventry Life and Health Insurance Company

MD – Individual Practice Association, Inc.

Optimum Choice, Inc.

Insurers, Non-Profit Health Service Plans

Aetna Life Insurance Company

Bankers Life and Casualty

CareFirst Blue Cross Blue Shield (Claims data for this company was reported under "insurer" by Payor, Argus Heath, despite additional claims reported under the same NAIC number under "HMO")

CareFirst of Maryland, Inc.

CIGNA Dental Health of Maryland, Inc.

Connecticut General Life Insurance Company

Delta Dental Insurance Company

Delta Dental of Pennsylvania

Dental Benefit Providers, Inc.

DentaQuest Mid-Atlantic

Fidelity Security Life Insurance Company

Golden Rule Insurance Company

Group Dental Service of Maryland, Inc.

Group Hospitalization & Medical Services, Inc.

Guardian Life Insurance Company of America

Kaiser Permanente Insurance Company

MAMSI Life & Health Insurance Co.

Principal Life Insurance Company

Spectera, Inc.

Standard Life and Accident Insurance Company

The MEGA Life and Health Insurance Company

Time Insurance Company

United Concordia Dental Plans, Inc.

United Concordia Life & Health Ins Co

United World Life Insurance Company

UnitedHealthcare Insurance Company

UnitedHealthcare of the Mid Atlantic

USAA Life Insurance Company