REPORT ON SEMI-ANNUAL
CLAIMS DATA FILING
FOR CALENDAR YEARS 2005-2007

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INSURANCE ADMINISTRATION

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ABOUT THIS REPORT

In November 2000, the 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. 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, thereby reducing disputes between providers and third-party payors. The regulations apply to all third-party payors (Payors) including insurers and non-profit health service plans (collectively referred to as *insurers* in this report), 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 claim as 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 2005, 2006 and 2007.

Semi-Annual Claims Data Filing

Using a format developed by the MIA, Payors file a report of their Maryland health care claims processing by September 1 of each year for the period of January 1 through June 30 of the same calendar year. By March 1 of each year, health care claims processing data for the period July 1 through December 31 of the previous calendar year is due.

Payors must provide information on claims received and processed for health care benefits under a policy, contract, plan, or certificate issued or delivered in Maryland. Excluded from reporting is data for 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). Payors must report data for medical, dental, vision, and prescription drug claims.

Payors not filing the required claims data reports or filing inaccurate data may violate Maryland insurance laws and regulations and are 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 may be exempted from the filings at the discretion of the Commissioner.

Base Group

To expedite data analysis, the MIA established a *Base Group* of Payors. The Base Group for the 2005-2007 claims data filings includes 33 insurers and 8 HMOs and is virtually unchanged from 2004. No dental plan organizations are included in the Base Group. A list of the Base Group Payors is found in Exhibit 3 of this report.

In 2007, the Base Group wrote over $5 billion in accident and health premium, accounting for about 82 percent of the total accident and health insurance market.

What are Clean Claims?

A key element of the semi-annual claims data filing is *Clean Claims*. Clean Claims are those health care claims submitted by a health care provider on one of two widely used industry standard billing forms including their electronic equivalents. In Maryland, *CMS Form 1500* used by doctors and *CMS Form UB 92* used by hospitals are considered *Uniform Claim Forms*. By regulation, these forms are the sole instruments for filing health claims with third-party payors for professional, hospital and related services. CMS means the Federal Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

Clean Claims by definition must also include essential information needed by a Payor for processing. COMAR 31.10.11 sets forth the *essential data elements for Clean Claims*. Payors may use this data set to determine Clean Claims, or they may determine Clean Claims from their own data set that contains fewer than all of the essential data elements of COMAR 31.10.11. Payors may not require more data elements than those of COMAR 31.10.11.

Prompt Payment

Another key element of the reporting is *prompt payment*. Maryland insurance law encourages the prompt payment of all health claims submitted to Payors.

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.

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

Denied Claims

Part of the claims data filings requires that Payors report the number of claims denied payment according to the five most prevalent reasons for claim denials. To simplify and promote uniform reporting for comparison, Payors must report data based on a set of 16 denial codes established by the MIA. In 2004, these 16 denial codes accounted for about 90 percent of all claims denied. The list of codes is found in Exhibit 2 of this report.

Semi-Annual Claims Data Filing Reports

There are specific instructions for completing the claims data filing form designed by the MIA for this purpose. These instructions and the form remain unchanged since inception and are found on the MIA's website: www.mdinsurance.state.md.us

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. Instructions for electronic claims data filing are also found on the MIA's website.

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 processed and benefit amounts paid, and processing time. Payors must also provide information on the most prevalent reasons for claim denials.

Payors must also list the essential data elements they use to determine and report Clean Claim information if the COMAR 31.10.11 data set is not used. Payors may require fewer data elements to determine Clean Claims, but may not require more data elements than presented in the regulations.

Verification of Data Reported

Data is self-reported by Payors and by delegated agents on behalf of the Payors they serve. Reporting is the responsibility of the Payor. Some Payors collect reports from their delegated agents for submission along with their internally-generated reports. Other delegated agents submitted reports directly to the MIA on behalf of their contracting insurers or HMOs.

In the course of analysis, the MIA identified what appeared to be 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. Information in these filings is considered confidential commercial information in accordance with State Government Article, §10-617, Annotated Code of Maryland.

Thus, semi-annual claims data filings of Payors are not available to the public. However, Payor claims data filings that may be used by the Commissioner as a basis for imposing interest or penalties shall be available for public inspection only as pertinent to the interest or penalties imposed.

SUMMARY OF 2005 - 2007 CLAIMS DATA FILINGS

Table 1 highlights information from the claims data filings of the Base Group for 2005 to 2007 compared to 2004. Actual data used to create the following tables is found in Exhibit 1 of this report.

Table 1 – Summary of Base Group

	2007	2006	2005	2004
Total claims received	40.5 million	38.9 million	34.6 million	33.4 million
Total clean claims received	30.5 million	28.5 million	26.8 million	28.9 million
Total benefits paid	$5.8 billion	$3.5 billion	$2.7 billion	$2.8 billion
Clean claims as a percentage of total claims received	75.4%	73.3%	77.2%	86.5%
Denied claims as a percentage of total claims received	15.7%	16.1%	14.9%	14.4%
Denied clean claims as a percentage of total clean claims received	5.3%	1.5%	1.4%	1.6%
Percentage of all claims processed within 30 days	98.6%	98.4%	98.0%	98.2%

The Base Group received more than 40 million claims and paid approximately $5.8 billion in health benefits in 2007 compared to 33.4 million claims received and $2.8 billion of health benefits paid in 2004.

Over the four year period, the number of claims received increased about 21 percent while the amount paid increased about 111 percent. Much of the increase in payments occurred in 2007 when the total benefit amount exceeded the prior year by 65.7 percent. The average amount paid per processed claim increased from $130.63 in 2004 to $143.92 in 2007.

The percentage of clean claims received decreased from 86.5 percent in 2004 to 75.4 percent in 2007. Clean claims are less likely to be denied. In 2007, 15.7 percent of all claims received were denied compared to 14.4 percent in 2004. More significantly, the percent of clean claims denied increased from 1.6 percent in 2004 to 5.3 percent in 2007.

The percentage of claims processed in 30 days or less continues to exceed 98 percent.

In 2007, Payors reported the most prevalent reasons for claim denials were:

- Duplicate claim submission (31.7 percent)
- A pre-treatment authorization or referral for services was not obtained or unauthorized services performed were not covered by plan (19.8 percent)
- The patient was not covered or eligible for benefits at the time services occurred (9 percent)
- The patient had met the maximum benefit at the time services occurred (9 percent)

Only 1.1 percent of all claims denials were made because the insurer or HMO needed additional information not otherwise identified by one of the remaining 15 denial codes.

Although the number of claims denied as duplicate submissions has not changed appreciably since 2004, duplicate claim submissions accounted for more than 56 percent of claim denials then compared to 31.7 percent in 2007. The most significant change in 2007 from the previous three years is the nearly four-fold increase in the number of claims denied because a pre-treatment authorization or referral for services was not obtained or unauthorized services performed.

Part of this increase may be attributable to the large increase in the number of claims processed. Denials for lack of pre-treatment authorization or referrals may occur because a provider failed to follow a Payor's administrative rules or because of a processing error (e.g., claim not properly matched to pre-treatment authorization).

The MIA will continue to monitor the most prevalent reasons for claim denials to assess if further review is warranted.

HMO RESULTS

Table 2 highlights information from the claims data filings of the HMOs in the Base Group for 2005 to 2007 compared to 2004. (Actual data is found in Exhibit 1 of the report.)

Table 2 – Summary of HMOs in the Base Group

	2007	2006	2005	2004
Total claims received	15.4 million	15.4 million	12.1 million	9.8 million
Total clean claims received	7.5 million	6.9 million	6.1 million	7.2 million
Total benefits paid	$1.9 billion	$2.0 billion	$1.4 billion	$1.5 billion
Clean claims as a percentage of total claims received	49%	45%	50.6%	73.7%
Denied claims as a percentage of total claims received	21.3%	20.3%	18.6%	14.4%
Denied clean claims as a percentage of total clean claims received	3.5%	3.3%	3.0%	2.8%
Percentage of all claims processed within 30 days	99.1%	98.8%	98.0%	98.2%

HMOs received more than 15.4 million claims and paid approximately $1.9 billion in health benefits in 2007 compared to 9.8 million claims received and $1.5 billion of health benefits paid in 2004. HMOs accounted for 38.1 percent of the claims in the Base Group in 2007 and 33 percent of the total benefit amount paid.

Over the four year period, the number of claims received increased about 59.7 percent while the amount paid increased about 30.9 percent. The average amount paid per processed claim decreased from $152.90 in 2004 to $125.30 in 2007.

The percentage of clean claims received decreased from 73.7 percent in 2004 to 49 percent in 2007. Clean claims are less likely to be denied. In 2007, 21.3 percent of all claims received were denied while only 3.5 percent of all clean claims received were denied.

There has been a modest improvement in the percentage of claims processed in 30 days or less. In 2007, virtually all claims were processed in 30 days or less.

INSURER RESULTS

Table 3 highlights information from the claims data filings of the insurers in the Base Group for 2005 to 2007 compared to 2004. (Actual data is found in Exhibit 1 of the report.)

Table 3 – Summary of Insurers in the Base Group

	2007	2006	2005	2004
Total claims received	25.0 million	23.4 million	22.5 million	23.6 million
Total clean claims received	22.9 million	21.6 million	20.6 million	21.7 million
Total benefits paid	$3.9 billion	$1.5 billion	$1.4 billion	$1.3 billion
Clean claims as a percentage of total claims received	91.6%	92.0%	91.6%	91.8%
Denied claims as a percentage of total claims received	12.2%	13.3%	13%	14.4%
Denied clean claims as a percentage of total clean claims received	5.9%	0.9%	0.9%	1.2%
Percentage of all claims processed within 30 days	98.3%	97.9%	98.0%	98.1%

Insurers received more than 25 million claims and paid approximately $3.9 billion in health benefits in 2007 compared to 23.6 million claims received and $1.3 billion of health benefits paid in 2004. Insurers accounted for 61.9 percent of total claims received by the Base Group in 2007 and about 67 percent of the total benefit paid.

Over the four year period, the number of claims received increased about 5.9 percent while the amount paid increased over 200 percent. The average amount paid per processed claim increased from $112.02 in 2004 to $155.34 in 2007.

The percentage of clean claims received remained relatively constant over this four year period at about 92 percent. Clean claims are less likely to be denied. In 2007, 12.2 percent of all claims received were denied while 5.9 percent of all clean claims received were denied.

The percentage of claims processed in 30 days or less also remained relatively constant during the four year period. In 2007, 98.3 percent of all claims were processed in 30 days or less compared to 98.1 percent in 2004.

CONCLUSIONS

The Base Group received 40.5 million claims in 2007 and paid $5.8 billion in benefits. The HMOs accounted for 38.1 percent of the received claims and 33 percent of the total benefits paid; the insurers accounted for 61.9 percent of the received claims and 67 percent of the total benefit paid.

The percentage of clean claims received by the Base Group has declined from 86.5 percent of the total claims received in 2004 to 75.4 percent in 2007. Insurers received a higher percentage of clean claims in 2007 (91.6 percent) than HMOs (49.0 percent).

Clean claims are less likely to be denied. In 2007, 15.7 percent of the total claims received by the Base Group were denied, however only 5.3 percent of clean claims were denied.

The number of claims received by the Base Group increased 21 percent between 2004 and 2007. The number of claims received by HMOs increased 59.7 percent and for insurers 5.9 percent.

The total benefits paid increased 111 percent between 2004 and 2007. During this period, the total benefit amount paid increased 200 percent for insurers compared to 30.9 percent for HMOs. Additionally, the average benefit paid per processed claim increased from $112.02 in 2004 to $155.34 in 2007 for insurers while the HMO average benefit paid per processed claim decreased from $152.90 to $125.30 for the same period.

Although duplicate claim submissions decreased from more than 56 percent of all claim denials in 2004 to 31.7 percent in 2007, they remain the most prevalent reason for claim denial. The second most prevalent reason cited by the Base Group for claims denials was a pre-treatment authorization or referral for services was not obtained or unauthorized services performed were not covered by the health benefits plan. This accounted for 19.8 percent of all denials in 2007. The MIA will continue to monitor the most prevalent reasons for claim denials to assess if further review is warranted.

EXHIBIT 1

SUMMARY OF BASE GROUP CLAIMS DATA FILINGS FOR CALENDAR YEARS 2005 - 2007

HMO Claims Reported	Total 2007	Total 2006	Total 2005	Total 2004
Total Claims Received	15,413,706	15,446,306	12,128,710	9,764,706
Total Claims Denied	3,282,419	3,129,519	2,251,197	1,407,057
Total Claims Processed	15,419,980	13,518,820	10,620,501	9,655,347
Clean Claims Received	7,546,681	6,949,417	6,142,303	7,195,030
Clean Claims Denied	260,891	227,896	186,875	203,974
Total Benefit Amount Paid	$1,932,048,502	$2,024,874,945	$1,380,291,468	$1,476,326,237
Total Claims Processed <30 Days	15,278,011	13,362,814	10,412,347	9,486,063
Total Claims Processed >30 Days	141,969	156,006	208,154	169,293
Interest Paid on Delayed Claims	$268,038	$450,262	$404,168	$654,281
Processed by Delegated Agents	6,300,914	4,611,164	3,388,060	191,496
Benefit Amount Paid by Delegated Agents	$339,076,858	$354,818,377	$216,276,952	$19,867,424
Interest Paid by Delegated Agents	$1,663	$7,178	$8,466	$18,647
Total Ending Claim Inventory	146,308	198,801	149,815	189,306
Insurer Claims Reported	**Total 2007**	**Total 2006**	**Total 2005**	**Total 2004 ***
Total Claims Received	25,031,410	23,440,252	22,520,762	23,633,094
Total Claims Denied	3,052,764	3,128,061	2,919,133	3,401,864
Total Claims Processed	25,141,605	11,630,953	11,168,095	11,553,103
Clean Claims Received	22,928,790	21,557,304	20,624,230	21,685,488
Clean Claims Denied	1,360,089	199,850	182,436	252,347
Total Benefit Amount Paid	$3,905,549,411	$1,498,337,389	$1,352,634,729	$1,294,189,636
Total Claims Processed <30 Days	24,718,246	11,384,702	10,949,167	11,331,764
Total Claims Processed >30 Days	422,359	246,251	218,928	221,339
Interest Paid on Delayed Claims	$604,275	$519,075	$522,042	$610,519
Processed by Delegated Agents	890,689	200,834	46,642	48,801
Benefit Amount Paid by Delegated Agents	$117,769,769	$19,480,692	$4,366,100	$4,196,049
Interest Paid by Delegated Agents	$9,641	$8,312	$1,328	$1,086
Total Ending Claim Inventory	324,046	294,187	167,120	201,883
All Claims Reported	**Total 2007**	**Total 2006**	**Total 2005**	**Total 2004**
Total Claims Received	40,445,116	38,886,558	34,649,472	33,397,800
Total Claims Denied	6,335,183	6,257,580	5,170,330	4,808,921
Total Claims Processed	40,561,585	25,149,773	21,788,596	21,208,450
Clean Claims Received	30,475,471	28,506,721	26,766,533	28,880,518
Clean Claims Denied	1,620,980	427,746	369,311	456,321
Total Benefit Amount Paid	$5,837,597,913	$3,523,212,334	$2,732,926,197	$2,770,515,873
Total Claims Processed <30 Days	39,996,257	24,747,516	21,361,514	20,817,827
Total Claims Processed >30 Days	564,328	402,257	427,082	390,632
Interest Paid on Delayed Claims	872,313	969,337	926,210	1,264,800
Processed by Delegated Agents	7,191,603	4,811,998	3,434,702	240,297
Benefit Amount Paid by Delegated Agents	456,846,627	374,299,069	220,643,052	24,063,473
Interest Paid by Delegated Agents	11,304	15,490	9,794	19,733
Total Ending Claim Inventory	470,354	492,988	316,935	391,189

- Note that 2004 Insurer data presented here reflects adjustment for removal of dental claim filings included in Report on Semi-Annual Claims Data for Calendar Year 2004.

EXHIBIT 2

CLAIM SUBMISSION DENIAL CODES

CLAIM 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

SUMMARY OF BASE GROUP CLAIMS DATA FILINGS FOR CLALENDAR YEARS 2005 - 2007

PAYORS – 2005 - 2007 BASE GROUP

Following (in alphabetical order) is a list of the 8 HMOs and 33 Insurers forming the Base Group during the period 2005 - 2007.

HMOs

Aetna Health, Inc.
CareFirst BlueChoice, Inc.
CIGNA HealthCare Mid-Atlantic, Inc.
Coventry Health Care of Delaware, Inc.
Kaiser Foundation Health Plan Mid Atlantic
MD – Individual Practice Association, Inc.
Optimum Choice, Inc.
United Healthcare of the Mid-Atlantic, Inc.

Insurers, Non-Profit Health Service Plans

Aetna Life Insurance Company
American Republic Insurance Company
Ameritas Life Insurance Company
CareFirst of Maryland, Inc.
Combined Insurance Company of America
Connecticut General Life Insurance Company
Golden Rule Insurance Company
Graphic Arts Benefit Corporation
Great-West Life & Annuity Co.
Group Hospitalization and Medical Services, Inc.
Jefferson Pilot Financial Insurance Co.
Life Investors Insurance Company of America
MAMSI Life & Health Insurance Co.
Monumental Life Insurance Company
Nationwide Life Insurance Company
New York Life Insurance Company
Physicians Mutual Insurance Company
Principal Life Insurance Company
State Farm Mutual Automobile Insurance Company
The Guardian Life Insurance Company of America

The Mega Life & Health Insurance Company
The Prudential Insurance Company of America
Time Insurance Company
Sun Life and Health Insurance Company
Unicare Life & Health Insurance Co.
Unimerica Insurance Co., Inc.
Union Labor Life Insurance Company
Union Security Insurance Company
United American Insurance Company
United Concordia Life and Health Insurance Co.
United HealthCare Insurance Company
United of Omaha Life insurance Company
USAA Life Insurance Company