REPORT ON SEMI-ANNUAL

CLAIMS DATA FILING

FOR CALENDAR YEAR 2004

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MARYLAND INSURANCE ADMINISTRATION

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STATE OF MARYLAND INSURANCE ADMINISTRATION REPORT ON SEMI-ANNUAL CLAIMS DATA FILING FOR CALENDAR YEAR 2004

Background

The Maryland Insurance Administration (MIA) is an independent state agency that regulates, among other things, health insurers and health maintenance organizations (HMOs) offering policies in Maryland.

The MIA is responsible for investigating and resolving consumer complaints and answering consumer questions about insurance companies and HMOs operating in the State. The MIA also conducts reviews and investigations of insurers and HMOs to determine whether they are complying with insurance laws and regulations and if they are operating in the best interest of consumers.

The MIA is committed to a systematic collection and analysis of data to identify disruptions, compliance deficiencies and related problems in the insurance marketplace as early and efficiently as possible and to eliminate or limit any harm to consumers. Market analysis is an emerging process that helps the MIA better prioritize and coordinate its regulatory effort and establish an integrated system of proportional responses to market problems.

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 insurance companies and non-profit health service plans (collectively referred to as *insurers* in this report) and HMOs. These Payors are identifiable by their national company code numbers established by the National Association of Insurance Commissioners (NAIC).

Delegated agents contract to process health claims for third-party payors

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 third annual summary of claims data filings. Where pertinent, the report contains data from previous years for comparison.

Semi-Annual Claims Data Filing

Payors file their Maryland claims data semi-annually

Using a format developed by the MIA, Payors file a written 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, and self-insured employer health care programs. Payors must report data for medical, dental, vision, prescription drug, behavioral health, substance abuse and Medicare-supplement insurance claims. Claims data for Long-Term Care benefit plans, cancer benefit plans and certain other indemnity benefit plans is not reportable.

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. In general, Payors having less than $50,000 direct annual health insurance premium in the State may be exempted.

Approximately 400 insurers and HMOs were authorized to offer medical, dental, vision, prescription drug, behavioral health, substance abuse and Medicare-supplement insurance in Maryland in 2004. The MIA exempts the majority of these Payors from filing because of minimal or no reportable health business in the State. Over 120 licensed Payors reported health claims data for 2004, approximately the same number as in 2003.

Insurers and HMOs filing in 2004 are largely the same as 2003

The change in reporting Payors is, in part, attributable to a number of insurers and HMOs restructuring their business, which included consolidation of operations, reduced market activity and withdrawal of products. Incomplete claims data filing by several Payors also affected reporting.

Base Group

To expedite and simplify analysis of data in previous years, the MIA established a *Base Group* of Payors as the representative sample of Maryland Payors. For meaningful comparison, that practice is continued and 41 insurers and 9 HMOs comprise the 2004 Base Group. The 2003 Base Group consisted of 40 insurers and 11 HMOs.

Criteria for selecting Payors included direct health coverage premium written in the State (i.e., market share), as well as representation of a variety of domestic and foreign entities serving various lines of business. The market share of the 2004

Base Group is approximately 84% compared to 85% in 2003 and 84% in 2002.

Changes in the composition of the Base Group resulted from:

- Health and dental insurers acquired by or merged with other entities;
- Health and dental insurers withdrawing from business operations in Maryland;
- Health and dental insurers renamed and/or operated under different NAIC company code numbers;
- HMOs consolidated under another entity; and
- Payor filing and/or reporting difficulties.

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 and Uniform Claim Forms are defined by Title 31, Subtitle 10, Chapter 11 of the Code of Maryland Regulations

Clean Claims by definition must also include essential information needed by a Payor for processing. COMAR 31.10.11 sets forth the e*ssential 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.

Claims submitted by insureds, subscribers, or members (collectively referred to as "Members"), or submitted by health

care providers on forms other than the two standard forms identified above are not considered to be Clean Claims for claims data filing.

Prompt Payment

Another key element of the reporting is *prompt payment.* Maryland insurance law requires the prompt payment of all health claims submitted to Payors. Payment is required within 30 calendar days from the date a Payor receives a claim with the essential information (i.e., a Clean Claim) needed for processing. Interest becomes due and must be paid on claims paid after 30 days.

The prompt payment law is Title 15, Subtitle 10, Section 1005 of the Insurance Article

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.

Semi-Annual Claims Data Filing Reports

There are specific instructions for claims data filing on a 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

Title 31, Subtitle 10, Chapter 11 of the Code of Maryland Regulations establishes the Claims Data Filing requirement

In general, Payors must 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 collected 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.

Regardless of the approach Payors use to file, the MIA is concerned about the completeness and validity of the data reported. In the course of analysis, the MIA identified certain anomalies, deficiencies and discrepancies in various claims data filings for 2004 and contacted the reporting Payors for clarification or revised data. Also contacted by the MIA were certain other Payors not filing the required reports.

Payors corrected most of the questionable data or filed missing reports, however the MIA determined that several Payors experienced a variety of problems and were unable to report accurate information for all or part of 2004. MIA analysts reviewed each situation and determined whether partial data was acceptable and the Payor could remain in the Base Group.

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 2004 CLAIMS DATA FILING

Background

More than 120 licensed Payors submitted information for 2004, which is approximately the same number filing for the previous period. There is, however, a variance in the composition of the group, in part, attributable to a significant number of insurers and HMOs restructuring their business, which included consolidation of operations. Reduced market activity, withdrawal of products, and incomplete claims data filing by several Payors also affected the number reporting.

From this group, the 2004 Base Group of 9 HMOs and 41 insurers was established for analysis and comparison with previous years. Following is a summary of the Base Group results.

Base Group Results

Briefly, in 2004 Payors in the Base Group:

- Received more claims than in 2003, but less than 2002;
- Processed substantially fewer claims than in 2003 and 2002;
- Paid significantly less benefit dollars than in 2003 but approximately the same as in 2002;
- Paid less interest on delayed claims than in 2003 but approximately the same as in 2002
- Received more Clean Claims continuing the trend from 2002;
- Denied fewer Clean Claims continuing the trend from 2002; and
- Ended with slightly lower claim inventories (i.e., claims received but not processed) than in previous years.

The following table highlights information from 2004 claims data filings of the Base Group compared to 2003 and 2002.

Table 1 – Summary of Base Group

Clean Claims Data Summary	2004	2003	2002
Base Group Market Share of Total Direct Health Premium Written	84%	85%	84%
Total Claims Reported as Received	34.0 million	33.0 million	37.3 million
Total Claims Reported as Processed (includes paid and denied)	21.8 million	34.1 million	26.2 million
Total Clean Claims Reported as Received	28.9 million	27.6 million	26.8 million
Total Claim Benefits Paid	$2.8 billion	$3.7 billion	$2.8 billion
Total Interest Paid on All Delayed Claims	$1.3 million	$1.4 million	$1.2 million
% of Total Claims Received Were Clean Claims	84.8%	83.5%	71.7%
% of Total Claims Received Were Denied	14.7%	16.5%	15.7%
% of Clean Claims Received Were Denied	1.6%	1.7%	2.4%
% of All Claims Processed Within 30 Days	98.2%	93.8%	97.3%
Total Claims Received and Unprocessed (inventory)	.4 million	.5 million	.6 million

Benefits paid declined 22.7% in 2004 despite a 3.1% increase in the number of claims received

The Base Group received more than 34 million claims and paid approximately 2.8 billion dollars in health benefits in 2004 compared to 33 million claims received and 3.7 billion dollars of health benefits paid in 2003. Thus, despite a modest 3.1% increase in received claims in 2004, there was a significant 22.7% reduction in benefits paid from the previous year. The 2004 results are comparable to 2002 and consistent with last year's observation that many claims received in 2002 were most likely duplicates of previously processed claims or were processed on an untimely basis in 2003.

36% fewer claims were processed in 2004

Another interesting relationship is the 36.0% decrease in total claims processed in 2004 compared to 2003. The Base Group processed only 21.8 million claims in 2004 despite receiving more than 34 million claims suggesting an anomaly in the filed data.

The 21.8 million processed claims in 2004 is comparable to the 26.2 million processed in 2002.

Analysis of the claims received and claims processed data reveals that since 2002, one large Payor consistently reports substantially more claims as received than as processed because of its characterization of certain risk-based, expense-incurred business. In previous years, this practice did not dramatically affect results as it apparently has in 2004. However, the proportion of processed claims to received claims in 2004 approximates data filed in 2003. This relationship suggests that while the volume of total claim receipts increased, the volume of claims processed by other Payors declined.

8.0% fewer claims were denied in 2004

The number of total denied claims declined 8.0% from 5.5 million in 2003 to 5.0% in 2004. The total of claims denied in 2002 was 5.9 million.

84.8% of total claims were Clean Claims

The total number of Clean Claims received by Payors rose slightly from 27.6 million to 28.9 million in 2004. Further, the trend of Clean Claims representing a higher percentage of all claims received continued in 2004. Data shows that 84.8% of total claims received in 2004 were Clean Claims compared to 83.6% in 2003 and 71.9% of total claims received in 2002. Payors denied only 1.6% of the Clean Claims received in 2004 compared to 1.7% in 2003 and 2.4% in 2002.

Significantly fewer claims were processed by Delegated Agents

The number of claims processed by delegated agents dropped 47.5% from 460,000 in 2003 to 240,297 in 2004. In 2002, delegated agents paid 4.4 million claims on behalf of contracting Payors. Benefits paid by delegated agents decreased 33.3% from 36 million dollars in 2003 to 24 million dollars. In 2002, 228 million dollars was paid.

For the second consecutive year, interest paid by delegated agents on delayed claims was less than $20,000. Seemingly, Payors continue to restructure or eliminate claims administration arrangements with delegated agents. Also, some Payors may be consolidating data previously filed by their delegated agents into their data filings.

Payors reported processing 98.2% of claims within 30 days

In 2002, 97.3% of all claims were processed within 30 days but decreased to 93.8% in 2003. In 2004, the number of claims processed in 30 days or less improved substantially to 98.2%. While the number of claims processed beyond the 30-day prompt payment requirement increased substantially in 2003 from 2002, the number of delayed claims declined 81.2% from 2.1 million in 2003 to .4 million in 2004. Some of this decrease may be attributable to the previously described data filing practices of one Payor. Nonetheless, the decrease is significant and comparable to the .7 million delayed claims reported for 2002.

Total interest paid on delayed claims decreased 7.6% from 1.4 million dollars in 2003 to 1.3 million dollars in 2004.

End-of year claim inventory continued to decline from 2002 and 2003 levels

According to the data filed, the end-of-year claim inventory decreased noticeably from 470,459 claims in 2003 to 395,447 in 2004. Payors showed a slight improvement in the second half of the year by reducing the inventory from 444,130 to 395,447. The year-end inventory for 2004 represents 1.2% of all claims received.

However, because of computer, software and other technical problems, a number of Payors and their delegated agents again indicated an inability to provide accurate information about their work-in-process. In particular, beginning and mid-year claim inventory data is either not available, or is estimated.

Claim inventory information continues as a required data element of the semi-annual claims data filing and the MIA emphasizes its importance in monitoring Payors' work-in-process respect to their building or reducing levels of unprocessed claims. Fluctuating inventories frequently correlate to consumer and/or provider complaints to the MIA about a Payor failing to meet the State's prompt pay requirements.

In addition to reporting the number of denied claims, Payors must identify the five most prevalent reasons for claim denials based on frequency. Although many Payors use common or similar terminology to describe certain reasons for claim denials,

there are far too many different reasons reported making it difficult to draw meaningful conclusions. Therefore, to simply, compare and promote uniformity of terminology and definition, the Payors' denial codes were matched to the set of 16 basic denial codes developed by the MIA. In previous years, there were 32 basic denial codes.

For some Payors, there is not a one-to-one relationship between the number of claims reported as denied and the number of denials reported by reason code. This occurs because a claim frequently is comprised of multiple services rendered by one or more providers and, therefore, may be paid or denied on a service or *line item* basis. For example, processing of a single claim for three services may result in denial of each line item for a different reason. While a Payor could count this as a single denied claim, another Payor may report three different denial reason codes on its semi-annual claims data filing. Thus, information reported by Payors on the most prevalent reasons for claim denials should be viewed as a market indicator only.

In 2004, the 16 most basic denial codes accounted for approximately 4.5 million or 90% of the total 5.0 million denied claims. Payors reported 5.5 million denied claims in 2003 and 5.9 million claims in 2002 were due to the 32 most basic denial reasons.

More than half of denied claims were duplicates of previously considered claims

Duplicate claims remain the most prevalent reason for claim denials by Payors. Approximately 56.0% or 2.8 million of 5.0 million denied claims were duplicates of previously submitted or processed claims in 2004. This result is comparable to 2003 when over 3 million of 5.5 million claims (54.4%) were denied, in part or in total, as a duplicate or previously processed claim. The next 5 most prevalent denial codes reported by Payors accounted for 1.4 million claim denials in 2004.

The Base Group of Payors and their delegated agents reported the following 5 most frequently cited reasons for denial of health care claims:

- The claim received duplicated a previously received or processed claim;

- The expense exceeded the usual and customary fee, was miscoded by the provider, or represented an unbundled service or incidental procedure not covered by plan;

- A pre-treatment authorization or referral for services was not obtained or unauthorized services performed were not covered by plan;

- The patient was not covered or eligible for benefits at the time services occurred; and

- Expenses were for services not covered by the plan (other than Medicare related items); or the expense was not payable due to plan deductible or co-payment provisions.

Other common reasons reported for claim denials were:

- Coordination of benefits (COB) information or the primary payor's explanation of benefits (EOB) was needed;

- The provider claim was submitted after the Payor's timely filing deadline and not eligible for reimbursement;

- Reimbursement was not due because the health care provider was not contracted with or covered by the plan, or because of the provider's global or capitation fee arrangement with the plan; and

- Additional information from the claimant or provider was needed to continue processing the claim.

HMO RESULTS

Background

9 HMOs submitted data for 2004

Claim data reports were filed by 9 HMOs operating in Maryland during all, or a portion of calendar year 2004 compared to 11 in 2003. Claims data reported includes all health claims processed by an HMO including certain point-of-service (POS) claims offered to its Members through the HMO.

Several HMOs experienced organizational changes in 2004 such as terminating operations, merging all or parts of plans into other plans and restructuring administrative arrangements with parent companies or delegated agents. As noted previously in this report, these changes may account for certain variances in the data reported in 2004. Other variances may be attributable to market conditions including the claim submission patterns of providers and benefit plan utilization by Members. Based on the analysis of previously submitted data and the manner in which the Base Group is constructed, the MIA believes that these variances do not materially alter the information compiled and the following analysis.

HMO Results

Briefly, in 2004 HMOs:

- Received more claims than in 2003 and 2002;
- Processed more claims than in 2003 and 2002;
- Paid more benefit dollars than in 2003 and 2002;
- Paid more interest on delayed claims than in 2003 and 2002 despite paying more claims within 30 days;
- Received substantially more Clean Claims than in 2003 and 2002;

- Denied more Clean Claims than in 2003 and 2002 although the percentage of Clean Claim denials decreased; and
- Ended with lower claim inventory despite receiving more claims than in previous years.

The following Table 2 highlights the key results of the HMO claims data filings.

Table 2

HMO Claims Data Summary	2004	2003	2002
Total Claims Reported as Received	**9.8 million**	**8.6 million**	**9.5 million**
Total Clean Claims Reported as Received	**7.2 million**	**5.8 million**	**5.7 million**
Total Claim Benefits Paid	**$1.5 billion**	**$1.2 billion**	**$1.2 billion**
% of Total Claims Received Were Clean	**73.7%**	**66.9%**	**60.0%**
% of Total Claims Received Were Denied	**14.4%**	**15.9%**	**15.1%**
% of Clean Claims Received Were Denied	**2.8%**	**3.2%**	**3.5%**
% HMO Claims Processed Within 30 Days	**98.2%**	**92.4%**	**97.3%**
Total Interest Paid on Delayed Claims	**$654,281**	**$440,500**	**$596,500**

HMOs received 13.3% more claims in 2004 than in 2003

In 2004, HMOs reported receiving 9.8 million claims compared to 8.6 million claims in 2003 and 9.5 million claims received in 2002. This 13.3% increase suggests that ongoing market consolidation has not reduced HMO claims activity in the State and that 2003 may indicate an anomaly in market conduct and/or reporting

The number of Clean Claims received in 2004 increased 24.7% to 7.2 million from 5.8 million in 2003 and exceeds the 5.7 million received in 2002 by 26.0%. This significant increase means 73.7% of claims received by HMOs were Clean Claims in 2004 compared to 66.9% in 2003 and 60.0% in 2002.

9.7 million claims were processed resulting in 1.5 billion dollars in paid benefits

Total claims processed increased 7.54% from 9.0 million in 2003 to 9.7 million in 2004. Similarly, the total benefit amount paid rose 27.05% from 1.2 billion dollars in 2003 to 1.5 billion in 2004. The

total number of claims processed by HMOs in 2002 was 9.5 million and the total amount of benefits payments in 2002 slightly exceeded 1.2 billion dollars.

In 2003 more claims were processed by HMOs than received whereas more claims were received than processed in 2004, as would be expected. In 2004 98.9% of total claims received were processed which is comparable to 98.2% in 2002.

This trend supports the previously introduced conclusion of an anomaly in 2003 data, which is attributable, in part, to HMOs as well as insurers. However, as discussed later in this report, there is a greater disparity in data reported by insurers suggesting greater market conduct and/or reporting issues for that group of Payors.

Interestingly, despite noticeable changes in the total number of claims received since 2002, the total number of claims denied is virtually the same. In 2004, the number of denials increased 2.1% to 1.41 million from 1.37 million in 2003. In 2002, 1.43 million of the total claims received were denied.

Clean Claim denials represent 2.1% of total claims received

Only 2.8% of Clean Claims received were denied in 2004 compared to 3.2% in 2003 and 3.5% in 2002. Despite significant 2004 increases in total claims received by HMOs, the ratio of Clean Claim denials to total claims received remained steady at 2.1% compared to 2.2% in 2003 and 2.1% in 2002.

The percentage of all claims denied decreased noticeably from 15.9% in 2003 to 14.4% in 2004. In 2002, the percentage was 15.1%.

Delegated agents again processed fewer claims than in the previous year

HMOs again reported a significant decline in the number of claims processed and benefits paid on their behalf by delegated agents. In 2004, delegated agents paid $19,867,424 in benefits. However, they processed only 191,496 of 9,764,706 (1.96%) total claims received, whereas 3.3% (285,500) of all HMO claims received totaling 27.3 million dollars in benefits were processed in 2003. In 2002, delegated agents processed 690,500, or 7.30% of

total claims received. The amount paid by delegated agents in 2002 was 32.7 million dollars, or 2.63% of the total amount paid.

The number of total claims processed in excess of 30 days to total claims processed decreased dramatically in 2004 to 1.8% from 7.6% in 2003. However, in 2004, HMOs paid $654,281 on 191,496 delayed claims compared to $440,500 of interest on 684,434 delayed claims in 2003 and $596,500 on 255,110 delayed claims in 2002. Thus, while fewer claims were delayed in 2004, delays were apparently longer, which resulted in higher interest payments. Claims paid over 30 days represent violations of Maryland's prompt payment law, §15-1005 of the Insurance Article.

More interest was paid yet fewer claims were delayed in 2004

Some HMOs and/or delegated agents again reported paying claims in excess of 30 calendar days without paying the interest required by Maryland's prompt payment law. However, the number of these filings diminished in 2004 presumably because, in part, fewer entities reported and, in part, because reporting entities were more diligent. The MIA believes the deficiency in the amount of paid interest reported is minimal and has no material effect on the analysis and results presented herein. The MIA continues to monitor these organizations.

The total ending claim inventory data submitted by HMOs reveals a reduction from previous years despite the substantial increase in claims received and processed in 2004. This result, though interesting, appears to be consistent with other reported data. As stated earlier in this report, computer, software and other technical problems by insurers and their delegated agents again affected the accuracy of inventory information reported.

HMOs reported the most frequently cited reasons for claim denial as:

The most common reason for claim denial is receipt of a previously processed claim

- The claim received duplicated a previously considered claim;
- Pre-treatment authorization for services was not obtained; or services received by claimants were not authorized or approved by the health plan.

- Charges submitted were not covered by the plan in force;
- The provider submitted the claim after the HMO's timely filing deadline; and
- The claimant was not eligible for benefits.

INSURER RESULTS

Background

The following information comes from claim data filed by the 41 leading insurers, non-profit health service plans, dental plans, and vision plans comprising the 2004 Base Group.

As with HMOs, several insurers experienced organizational changes including terminating or merging all or parts of their Maryland business. Restructuring arrangements with affiliated companies or delegated agents may also account for certain variances in the information reported in 2004 by insurers, as may changes in provider claim submission patterns and benefit plan utilization by Members.

Insurer Results

Briefly, in 2004 insurers:

- Received approximately the same amount of claims as in 2003, though somewhat less than in 2002;
- Processed approximately 52% fewer claims than in 2003 and 28% fewer than in 2002;
- Paid approximately 49% less benefit dollars than in 2003 and 16% less than in 2002;
- Paid a higher percentage of claims within 30 days in compliance with Maryland law than in previous years;
- Paid considerably less interest on delayed claims than in 2003 and slightly less than in 2002;

- Received virtually the same number of Clean Claims as in 2003 and 2002;
- Denied fewer Clean Claims than in 2003 and significantly less than in 2002; and
- Ended with a smaller claim inventory than in previous years, despite receiving approximately the same number of claims.

The following Table 3 illustrates the results of the claims data filings of the 41 insurers of the Base Group.

Table 3

Insurer Claims Data Summary	2004	2003	2002
Total Claims Reported as Received	**24.3 million**	**24.4 million**	**27.8 million**
Total Clean Claims Reported as Received	**21.7 million**	**21.8 million**	**21.1 million**
Total Claim Benefits Paid	**$1.4 billion**	**$2.5 billion**	**$1.6 billion**
% of Total Claims Received Were Clean	**89.3%**	**89.3%**	**75.7%**
% of Total Claims Received Were Denied	**14.9%**	**16.7%**	**16.0%**
% of Clean Claims Received Were Denied	**1.2%**	**1.3%**	**2.2%**
% Insurer Claims Processed Within 30 Days	**98.2%**	**94.4%**	**97.3%**
Total Interest Paid on Delayed Claims	**$610,891**	**$928,000**	**$626,000**

Substantially fewer claims were processed in 2004

Insurers reported less than a 1% decrease from 24,414,313 total claims received in 2003 to 24,281,558 in 2004. In 2002, 27,811,753 total health claims were received. However, there was a substantial (52%) decrease in the total number of claims processed in 2004 from 25,109,459 in 2003 to only 12,172,516, which more closely resembles 2002 data. These results show that 50.1% of all claims received in 2004 and 60.5% in 2002 were processed, whereas insurers processed 3% more claims than those received in 2003. This trend supports the conclusion of an anomaly in 2003 data, which is attributable, in part, to insurers as well as HMOs. However there is a greater disparity in data

reported by insurers suggesting greater market conduct and/or reporting issues for that group of Payors.

Clean Claim denials were 1.04% of total claims received in 2003

Clean claims represented 89.3% of total claims received in 2004, as in 2003, compared to only 75.7% in 2002. Clean Claim denials as a percentage of total claims received again declined from the previous years to 1.04% compared to 1.17% in 2003 and 1.64% in 2002.

In 2004, 3,609,681 claims were denied, of which 252,347 or 7.0% were Clean Claims. Despite a reduction in total claims denied, the 2004 relationship of Clean Claims denied to the total number of denials remains the same (7.0%), as for 2003. Also, in 2003 284,502 of 4,086,756 denials were Clean Claims compared to 2002 when 455,268 of 4,445,168 claims denied (10.2%) were Clean Claims.

Total benefit dollars paid by insurers decreased by 45.9%

In keeping with the dramatic decrease in the number of claims processed, insurers paid $1,146,956,369 or 45.9% less in health benefits in 2004 than in 2003. Insurers reported benefit payments totaling $1,352,554,084 in 2004 compared to $2,499,510,453 in 2003 and $1,607,984,083 in 2002. The difference of $891,526,370 represented a 55.4% increase in 2003 over 2002.

Delegated agents processed 3,751,065 or 13.49% of all claims on behalf of insurers in 2002, but only 172,293 claims in 2003. This number decreased again in 2004 to only 48,801 processed claims further demonstrating a significant trend toward insurers restructuring or eliminating their claims administration arrangements with delegated agents and, perhaps in part, reporting claims data differently.

Insurers paid $610,891 in interest in 2004

Insurers paid $610,891 interest on 225,172 claims processed in excess of 30 calendar days in 2004. Maryland law requires that claims be processed within 30 calendar days from the date the essential data needed is received. Insurers reported payment of $928,164 on 1,417,086 delayed claims in 2003 compared to interest of $625,988 on 448,702 delayed claims in 2002. Delayed claims (processed in excess of 30 calendar days) decreased to 1.8% of total claims processed compared to 5.6% in 2003 and 2.7% in 2002.

Delegated agents paid only $1,086 in interest in 2004, whereas $2,619 was paid in 2003 and $53,946 was paid in 2002.

Claims paid in excess of 30 days represent violations of Maryland's prompt payment law. In the past, several insurers and their delegated agents reported claims paid beyond 30 days without paying the interest required by Maryland's prompt payment law. The MIA found fewer reporting deficiencies in 2004, in part, because fewer entities reported and, in part, because reporting entities were more diligent. In some cases, the MIA was able to obtain the needed information in most cases by contacting the reporting Payor. The MIA believes this deficiency in paid interest is minimal and has no material effect on the analysis and results reported herein. The MIA continues to monitor these organizations.

The total ending claim inventory data submitted by insurers reveals a reduction from previous years despite the substantial difference between the total numbers of claims received and processed in 2004. This result, though interesting, appears to be consistent with other reported data. As stated earlier in this report, computer software and other technical problems by insurers and their delegated agents again affected the accuracy of inventory information reported.

The most common reason for claim denial is receipt of a previously processed claim

As in previous years, insurers were asked to identify the 5 most frequent reasons for claim denials. The most frequent reasons for claim denial are:

- The claim received duplicated a previously considered claim;
- Charges submitted for services exceeded the usual and customary amount, were miscoded, or otherwise not covered by plan as a result of the provider's billing;
- Charges received may be covered by another benefit plan.

- Pre-treatment authorization for services was not obtained; or services received by claimants were not authorized or approved by the health plan;

- Charges submitted were not covered by the plan in force; and

- The claimant was not eligible for benefits.

EXHIBIT 1

SUMMARY OF BASE GROUP CLAIMS DATA FILINGS 2004

SUMMARY OF BASE GROUP CLAIMS DATA FILINGS

2004 HMO Claims Reported	1/1/04 - 6/30/04	7/1/04 - 12/31/04	Total 2004	Total 2003	Total 2002
Total Claims Received	5,195,300	4,569,406	9,764,706	8,618,116	9,512,623
Total Claims Denied	732,225	674,832	1,407,057	1,367,274	1,432,699
Total Claims Processed	5,028,436	4,626,911	9,655,347	8,978,280	9,338,200
Clean Claims Received	3,848,737	3,346,293	7,195,030	5,769,246	5,708,917
Clean Claims Denied	107,472	96,502	203,974	186,016	198,133
Total Benefit Amount Paid	$746,952,639	$729,373,598	$1,476,326,237	$1,162,012,358	$1,243,887,666
Total Claims Processed <30 Days	4,961,104	4,524,959	9,486,063	8,293,846	9,082,090
Total Claims Processed >30 Days	67,331	101,962	169,293	684,434	255,110
Interest Paid on Delayed Claims	$319,144	$335,137	$654,281	$440,479	$596,499
Processed by Delegated Agents	102,248	89,248	191,496	285,448	690,541
Benefit Amount Paid by Delegated Agents	$8,446,028	$11,421,396	$19,867,424	$27,314,932	$32,735,662
Interest Paid by Delegated Agents	$14,675	$3,972	$18,647	$13,767	$4,298
Total Ending Claim Inventory	267,140	189,306	189,306	236,886	230,256

2004 Insurer Claims Reported	1/1/04 - 6/30/04	7/1/04 - 12/31/04	Total 2004	Total 2003	Total 2002
Total Claims Received	12,147,678	12,133,880	24,281,558	24,414,313	27,811,753
Total Claims Denied	1,810,803	1,798,878	3,609,681	4,086,756	4,445,168
Total Claims Processed	6,094,944	6,077,572	12,172,516	25,109,459	16,838,723
Clean Claims Received	10,932,027	10,753,461	21,685,488	21,812,420	21,051,613
Clean Claims Denied	128,788	123,559	252,347	284,502	455,268
Total Benefit Amount Paid	$665,618,189	$686,935,895	$1,352,554,084	$2,499,510,453	$1,607,984,083
Total Claims Processed <30 Days	5,966,344	5,980,960	11,947,304	23,692,373	16,390,021
Total Claims Processed >30 Days	128,641	96,531	225,172	1,417,086	448,702
Interest Paid on Delayed Claims	$306,218	$304,673	$610,891	$928,164	$625,988
Processed by Delegated Agents	25,199	23,602	48,801	172,293	3,751,065
Benefit Amount Paid by Delegated Agents	$2,564,142	$1,631,907	$4,196,049	$8,749,743	$195,209,145
Interest Paid by Delegated Agents	$469	$617	$1,086	$2,619	$53,946
Total Ending Claim Inventory	176,990	206,141	206,141	233,573	331,436

2004 All Claims Reported	1/1/04 - 6/30/04	7/1/04 - 12/31/04	Total 2004	Total 2003	Total 2002
Total Claims Received	17,342,978	16,703,286	34,046,264	33,032,429	37,324,376
Total Claims Denied	2,543,028	2,473,710	5,016,738	5,454,030	5,877,867
Total Claims Processed	11,123,380	10,704,483	21,827,863	34,087,739	26,176,923
Clean Claims Received	14,780,764	14,099,754	28,880,518	27,581,666	26,760,530
Clean Claims Denied	236,260	220,061	456,321	470,518	653,401
Total Benefit Amount Paid	$1,412,570,828	$1,416,309,493	$2,828,880,322	$3,661,522,811	$2,851,871,749
Total Claims Processed <30 Days	10,927,448	10,505,919	21,433,367	31,986,219	25,472,111
Total Claims Processed >30 Days	195,972	198,493	394,465	2,101,520	703,812
Interest Paid on Delayed Claims	$625,362	$639,810	$1,265,172	$1,368,643	$1,222,487
Processed by Delegated Agents	127,447	112,850	240,297	457,741	4,441,606
Benefit Amount Paid by Delegated Agents	$11,010,170	$13,053,303	$24,063,473	$36,064,675	$227,944,807
Interest Paid by Delegated Agents	$15,144	$4,589	$19,733	$16,386	$58,244
Total Ending Claim Inventory	444,130	395,447	395,447	470,459	561,692

EXHIBIT 2

CLAIM SUBMISSION DENIAL REASON CODES
2004

CLAIM SUBMISSION DENIAL REASON CODES

To promote uniformity of terminology and definition, claim denial information reported by Payors in 2004 was classified according to the following list developed by the MIA:

1. Accident details or explanation needed (including possible workers compensation claims)
2. Additional information from claimant or provider needed
3. Provider billing error or discrepancy; billing information missing
4. Coordination of benefits (COB) information or primary payor explanation of benefits (EOB) needed
5. Provider not contracted or covered by plan; or not covered due to provider global or capitation fee arrangement
6. Expense previously considered or paid; duplicate submission
7. Service exceeds benefit plan maximum or frequency of services limitation
8. Patient not covered or ineligible for benefits; coverage not effective at time of service
9. Expense or services not approved or covered by Medicare; Medicare deductible not covered by plan; Medicare EOB needed
10. Expense or services not covered by plan (other than Medicare related items); expense not payable due to plan deductible or co-payment
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. Claim filed untimely by provider not accepted for reimbursement
16. Miscellaneous other conditions or reasons for denial

EXHIBIT 3

PAYORS – 2004 BASE GROUP

PAYORS – 2004 BASE GROUP

Following (in alphabetical order) is a list of the 9 HMOs and 41 insurers forming the 2004 Base Group.

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.
PHN-HMO, 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.
CIGNA Dental Health of Maryland, Inc.
Combined Insurance Company of America
Connecticut General Life Insurance Company
Continental General Insurance Co.
Delta Dental of Pennsylvania
Dental Benefit Providers of Maryland
DentaQuest Mid-Atlantic, Inc.
Fortis Benefits Insurance Company
Fortis Insurance Company
GE Group Life Assurance Company
Golden Rule Insurance Company
Graphic Arts Benefit Corporation
Great-West Life & Annuity Co.
Group Dental Service of Maryland, Inc.
Group Hospitalization and Medical Services, Inc.
Jefferson Pilot Financial Insurance Co.
Life Investors Insurance Company of America

MAMSI Life & Health Insurance Co.
Mega Life & Health Insurance Company
Monumental Life Insurance Company
Mutual of Omaha Insurance Co.
Nationwide Life Insurance Company
New York Life Insurance Company
Physicians Mutual Insurance Company
Principal Life Insurance Company
Prudential Insurance Company of America
State Farm Mutual Automobile Insurance Company
The Guardian Life Insurance Company of America
Unicare Life & Health Insurance Co.
Unimerica Insurance Co., Inc.
Union Labor Life Insurance Company
United American Insurance Company
United Concordia Dental Plans, Inc.
United Concordia Life and Health Insurance Company
United HealthCare Insurance Company
United of Omaha Life insurance Company
USAA Life Insurance Company