

**REPORT ON SEMI-ANNUAL
CLAIMS DATA FILING
FOR CALENDAR YEAR 2003**

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**525 St. Paul Place
Baltimore, Maryland 21202
www.mdinsurance.state.md.us**

**Robert L. Ehrlich, Jr.
Governor**

**Michael S. Steele
Lieutenant Governor**

**R. Steven Orr
Insurance Commissioner**

**James V. McMahan, III
Deputy Insurance Commissioner**

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**STATE OF MARYLAND INSURANCE
ADMINISTRATION REPORT ON SEMI-
ANNUAL CLAIMS DATA FILING FOR
CALENDAR YEAR 2003**

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 audits and reviews 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.

In November 2000, the MIA released new regulations governing all aspects of how health insurers and HMOs process and pay health care provider claims. The regulations were designed to expedite and simplify the claims process while reducing disputes between providers and insurers, uniform standards for the submission of claims by providers were established and insurers, non-profit health service plans

and HMOs were required to provide data to the MIA semi-annually, concerning their claims paying activity.

About This Report

The Insurance Commissioner is responsible for providing the public a summary of information contained in the health claims data filings. The report, required by statute, looks at how well the claims regulations have worked and if they are producing the intended results. This report is the Commissioner's second summary of claims data filings and, where pertinent, 2002 data is presented for comparison to 2003 data.

In the report, insurance companies and non-profit health service plans are collectively referred to as insurers. Insurers and HMOs are considered to be third-party payors (referred to hereafter as "Payors") and must compile and report the required claim data to the MIA every six months. Included must be data from their own health claim processing operation, as well claim data from all *delegated agents* who process health claims on their behalf.

Delegated agents are contracted by third-party payors to process health claims

Claims Data Filing Requirement

According to insurance regulations, Payors must complete and submit a semi-annual report of their Maryland health care claims. September 1 of each year, data for the period of January 1 through June 30 of the same calendar year is due. March 1 of each year, data for the period July 1 through December 31 of the previous calendar year is due.

Payors must submit data on their Maryland claims semi-annually

Payors must file information on claims received and processed for health care benefits under a policy, contract, plan, or certificate issued or delivered in Maryland. Claims for Medicare, Federal Employee Health Benefit Plans, and self-insured employer health care programs are excluded from reporting.

Many insurers are exempt because they have little or no health business in the State

If Payors do not file the required claims data reports, they may be in violation of Maryland insurance laws and regulations. These Payors are subject to penalties imposed by the Insurance Commissioner. Certain Payors with minimal or no health business in the State may be exempted from the filings at the discretion of the Commissioner.

To date, the Commissioner has elected not to impose penalties on Payors that did not report claims data or submit reports on time, as required. This decision was based primarily on the computer programming difficulties many Payors experienced in their efforts to comply with the reporting requirement. The MIA plans to enforce compliance with the semi-annual claims data filing report requirement beginning with 2005 filings. Penalties may be imposed for noncompliance.

Base Group

In 2003 there were approximately 400 companies licensed to write medical, dental, vision, prescription drug, behavioral health, substance abuse and Medicare-supplement insurance in Maryland. Claims data was reported by approximately 200 licensed companies. The majority of non-reporting companies are exempt from filing.

Thus, as in the 2002 report, a *Base Group* of Payors was formed by the MIA to represent the entire market for this analysis. The companies forming the group changed slightly from 2002, but it remains largely in tact for meaningful comparison. Certain changes may be attributed to companies restructuring their business, while other changes may be the result of market activity or incomplete claims data filing.

The 2003 Base Group consists of 40 insurers and 11 HMOs representing 85% of the State's health market

The Base Group for this report includes 40 leading health insurers and 11 HMOs doing business in Maryland in 2003. In 2002, the group was comprised of 45 insurers and 12 HMOs. Using 2002 claims received as a base, the net change resulting from the reduction in companies is estimated to be

less than 0.6%. Using direct health coverage premium written in the State as a basis, the market share of the 2003 Base Group is approximately 85% compared to 84% for 2002.

What are Clean Claims?

A key element of the reporting 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: either a HCFA 1500 form used by doctors, or a UB 92 form used by hospitals or their electronic equivalent. Clean Claims must also include essential information needed by a Payor for processing.

Essential data elements for Clean Claims are set forth by the Code of Maryland Regulations (COMAR). Payors may use this data set to determine Clean Claims, or they may use 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.

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

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

The claims data filing regulations require that Payors report the number of health claims processed, 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 may be found on the MIA's website.

**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 identify 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.

If the Insurance Commissioner determines that a Payor, or an entity to which a Payor has delegated claims processing, does not comply with Maryland insurance laws, the Commissioner may require that the Payor submit claims data filings more frequently than twice a year.

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.

The MIA is, of course, concerned about the completeness and validity if the data reported. In the course of analysis, the MIA identified certain deficiencies and discrepancies in various claims data filings for 2003 and contacted the reporting Payors for clarification and, in some cases, revised data. Additionally, several Payors failed to report. The MIA contacted these organizations to obtain the required information

Also, it should be noted that certain data results (e.g., per cent of total claims denied) shown in the 2002 report may vary slightly from the comparative results presented in this report. These differences are attributable to slight variations in the *rounding* approaches used for certain data in the 2002 calculations.

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.

In general, claims data filings of Payors are not available to the public. However, Payor claim 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 2003 CLAIMS DATA FILINGS

Overview – Base Group Results

Briefly, claims data reported by Payors for 2003 compared to 2002 indicates:

- Significantly fewer claims were received;
- Significantly more claims were processed;
- Significantly more benefit dollars were paid;
- More Clean Claims were received;
- Fewer Clean Claims were denied; and
- Interest paid on delayed claims increased.

The following table highlights 2003 data compared to 2002 data for the Base Group.

Table 1

Clean Claims Data Summary	2003	2002
Base Group Market Share of Total Direct Health Premium Written	85%	84%
Total Claims Reported as Received	33.0 million	37.3 million
Total Claims Reported as Processed (includes paid and denied)	34.1 million	26.2 million
Total Clean Claims Reported as Received	27.6 million	26.8 million
Total Claim Benefits Paid	\$3.7 billion	\$2.8 billion
% of Total Claims Received Were Clean Claims	83.6%	71.9%
% of Total Claims Received Were Denied	16.5%	15.7%
% of Clean Claims Received Were Denied	1.7%	2.4%
% of All Claims Processed Within 30 Days	93.8%	97.3%
Total Interest Paid on All Delayed Claims	\$1.4 million	\$1.2 million

Many claims received in 2002 may have been duplicates or not have been paid until 2003

In 2003, the Base Group received more than 33 million claims and paid approximately 3.7 billion dollars in health benefits compared to 37 million claims received and 2.8 billion dollars of health benefits paid in 2002. The 11.5% reduction in total claims received relative to the 28.4% increase in benefit payments is significant, especially considering that 34.1 million claims were processed in 2003 compared to only 26.2 million in 2002. These numbers suggest that many claims received in 2002 were duplicates of previously processed claims or were processed on an untimely basis in 2003.

The total number of Clean Claims received by Payors rose slightly from 26.8 million to 27.6 million, however Clean Claims represent 83.6% of total claims received in 2003 compared to 71.9% of total claims received in 2002. Only 1.7% of the Clean Claims received were denied in 2003, which represents a 28.0% decrease from the denial of 2.4% of the Clean Claims received in 2002. The increase in Clean Claims receipts in 2003 may also have contributed to fewer claims being received overall by Payors by eliminating the redundancy of providers resubmitting certain denied or delayed claims.

The number of claims processed by delegated agents dropped substantially from 4.4 million to 460,000. Similarly, interest paid by delegated agents decreased from 228 million dollars to only 36 million dollars in 2003. This change may be partially attributable to Payors restructuring or eliminating their claims administration arrangements with delegated agents and partially attributable to the way Payors are reporting claims data.

In 2002, 97.3% of all claims were processed within 30 days but decreased to 93.8% in 2003. The number of claims processed beyond the 30 day prompt payment requirement increased substantially to from 700,000 to 2.1 million and the amount of interest paid on delayed claims increased slightly from 1.2 million dollars in 2002 to 1.4 million dollars in 2003. These results suggest further evidence of a significant number of claims received in 2002 were delayed processing until 2003

even though the overall change in inventory from 2002 to 2003 was a reported reduction of only 90,000 claims.

Claims inventory information reported may not be a reliable market indicator

Although Payors have had two full years to develop a means to report claim inventory information, they continue to have reporting deficiencies. Because of computer, software and other technical problems, a number of Payors and their delegated agents again stated 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. Consequently, the information submitted on the claims data filings is not considered to be an accurate representation of the Base Group's actual work-in-process. The MIA believes that this problem will not improve in 2004 and claim processing inventory data will continue to be understated.

Claim inventory data may, however, be useful in monitoring the work-in-process of individual Payors with respect to their building or reducing of unprocessed claims. Fluctuating inventories may correlate to consumer and/or provider complaints to the MIA about a Payor failing to meet the prompt pay requirements.

Payors reported the five most prevalent reasons for claim denials based on the number of denials occurring and the applicable denial code. To promote uniformity of terminology and definition, the Payors' denial codes were matched to the set of 32 basic denial codes developed by the MIA in 2002.

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

The results for 2003 are not remarkably different than for 2002. The Base Group of Payors and their delegated agents reported the most frequently cited reasons for denial as:

- The claim received is a duplicate of a previous claim;
- Charges submitted are not covered by the plan in force;
- Pre-treatment authorization for services was not obtained;

- The provider claim was submitted after the Payor's timely filing deadline; and
- The services received were not authorized or approved by the health plan.

Other common reasons reported for claim denials were:

- The claimant coverage terminated, lapsed is not in force, or the claimant is otherwise not eligible for benefits;
- The benefit plan limit on covered services or the benefit maximum amount payable was exceeded;
- Charges received may be covered by another benefit plan;
- Services are covered by a capitation or global fee arrangement not subject to benefit reimbursement; and
- Additional information from the claimant or provider is needed to continue processing the claim.

Payors are asked to report denied claims on the basis of the one or primary reason for denial. However, many Payors receive claims for multiple services by providers and, therefore, may assign multiple denial codes to denied or partially paid claims. Thus, 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.

However, it is interesting to note that in 2003 over 3 million claims were denied, in part or in total, as a duplicate or previously processed claim. In contrast, the combined total for the next two most frequently reported reasons for denial – non-covered charges and absence of provider authorization for treatment – is approximately 730,000 claims. Payors reported that 5.5 million of 33 million claims received were denied in 2003. In 2002, 5.9 million of 37.3 million claims received were denied.

Duplicate claims were significant in both 2003 and 2002

HMO Results

Claim data reports were filed by 11 HMOs operating in Maryland during all, or a portion of calendar year 2003.

Claims data reported includes all health claims processed by an HMO including certain point-of-service (POS) claims that may be offered to its Members through the HMO.

The number of covered Members increased 1.3% in 2003

The number of covered HMO Members in 2003 increased 1.3% from 2002. As in 2002, several HMOs experienced enrollment changes and/or organizational changes such as terminating operations, merging all or parts of plans into other plans, or restructuring administrative arrangements with delegated agents in 2003. These changes may account for certain variances in the data reported for the two periods by some HMOs. Other variances may be attributable to changes in provider claim submission patterns as well as changes in benefit plan utilization by Members.

One HMO only reported partial data for the first half of 2003. Based on 2002 data submitted and the partial data from 2003, it is estimated that the omission of this Payor's data from the overall results represents less than 0.6% of claims received and is determined to not materially affect the aggregated results of the Base Group.

The number of claims received dropped in 2003, but more Clean Claims were received

Despite the slight increase in membership, HMOs reported receiving only 8.6 million claims in 2003, a 9.4% decrease from 9.5 million claims received in 2002. Conversely, the number of Clean Claims received in 2003 increased slightly from 5.7 million in 2002 to 5.8 million. As a result, the corresponding percentage of total claims received being Clean Claims increased from 60.0% in 2002 to 66.9% in 2003.

HMOs paid about 1.2 billion dollars in benefits in 2003, essentially unchanged from 2002

In 2003, a total of 9.0 million claims were processed and the total benefits payments approached 1.2 billion dollars. The total number of claims processed in 2002 was 9.3 million. The total amount of benefits payments in 2002 slightly exceeded 1.2 billion dollars.

Clean Claim denials represent 2.2% of total claims received

Only 3.5% of Clean Claims received were denied in 2002. The percentage decreased slightly to 3.2% in 2003. Clean Claim denials are only 2.2% of total claims received in 2003 compared to 2.1% for 2002. The percentage of all claims denied increased slightly from 15.1% in 2002 to 15.9% in 2003.

According to filed reports, delegated agents processed only 2.4% (285,500) of all HMO claims received totaling 27.3 million dollars in benefits in 2003. These numbers are significantly lower than 2002 when delegated agents processed 690,500, or 7.30% of total claims received by HMOs. The amount paid by delegated agents in 2002 was 32.7 million dollars, or 2.63% of the total amount paid.

The number and percentage of delayed claims increased in 2003

In addition to these benefit payments, HMOs paid a total of \$440,500 of interest on delayed claims in 2003 compared to \$596,500 in 2002. The percentage of claims processed in excess of 30 days increased in 2003 to 7.6% from 2.7% in 2002. Claims paid over 30 days represent violations of Maryland's prompt payment law.

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

Table 2

Clean Claims Data Summary	2003	2002
<i>HMO Plans (11)</i>		
Total Claims Reported as Received	8.6 million	9.5 million
Total Clean Claims Reported as Received	5.8 million	5.7 million
Total Claim Benefits Paid	\$1.2 billion	\$1.2 billion
% of Total Claims Received Were Clean	66.9%	60.0%
% of Total Claims Received Were Denied	15.9%	15.1%
% of Clean Claims Received Were Denied	3.2%	3.5%
% HMO Claims Processed Within 30 Days	92.4%	97.3%
Total Interest Paid on Delayed Claims	\$440,500	\$596,500

Several 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. The MIA has investigated several of these filings where the incidence of nonpayment was determined to be significant. The MIA is monitoring these organizations and initiated a market conduct examination of one Payor's claim practices.

In general, the inventory data submitted by HMOs for 2003 shows little variation from 2002, suggesting that work-in-process remains consistent and no large claim processing backlogs are evident. This conclusion appears to be consistent with other HMO data reported. HMOs and their delegated agents reported the most frequently cited reasons for claim denial as:

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

- The claim received is a duplicate of a previous claim;
- Pre-treatment authorization for services was not obtained;
- Charges submitted are not covered by the plan in force;
- The provider claim was submitted after the HMO's timely filing deadline; and
- The services received by claimants were not authorized or approved by the health plan.

Other common reasons reported for claim denials were:

- The claimant coverage terminated, lapsed is not in force, or the claimant is otherwise not eligible for benefits;
- Charges received may be covered by another benefit plan;
- Services are covered by a capitation or global fee arrangement not subject to benefit reimbursement; and
- Additional information from the claimant or provider is needed to continue processing the claim.

Insurer Results

The following information is compiled from claim data filed for 40 leading insurers, non-profit health service plans, dental plans, and vision plans operating in Maryland during all, or a portion of calendar year 2003.

Comparative information concerning covered Members is not readily available for insurers. Several insurers are known to have experienced organizational changes including terminating or merging all or parts of their Maryland business, as well as restructuring arrangements with their affiliated companies or delegated agents. These changes may account for certain variances in the semi-annual data reported by insurers as may changes in provider claim submission patterns and benefit plan utilization by Members. However, comparison of premium and related financial data suggests that the overall change in membership from 2202 to 2003 is not of the magnitude to have a significant effect on claims data filings.

Insurers reported receiving 24,414,313 health claims in 2003, a 12.2% decrease compared to 27,811,753 health claims in 2002. More significantly, the total of 25,109,459 claims processed in 2003 increased by 49.1% over the 2002 total of 16,838,723.

Insurers reported Clean Claims represented 75.7% of 21,051,613 total claims received in 2002. In 2003, 21,812,420, Clean Claims represented 89.3% of 24,414,313 total claims received, an increase of 13.6% from the prior year.

Clean Claim denials decreased to only 1.17% of total claims received in 2003

In 2003, a total of 4,086,756 claims were denied, of which 284,502, or 7.0% were Clean Claims. In 2002, a total of 4,445,168 claims were denied, of which 455,268, or 10.2% were Clean Claims. Clean Claim denials represented only 1.17% of total claims received by insurers in 2003 compared to 1.64% of total claims received by insurers in 2002.

**Insurers paid
55.4% more dollars
in benefits in 2003**

Insurers paid \$1,607,984,083 in health benefits in 2002. Payors reported payment of \$2,499,510,453 in 2003 benefit payments. The difference of \$891,526,370 represents 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. Processing by delegated agents declined substantially to only 172,293 claims in 2003. This significant difference may be partially attributable to insurers restructuring or eliminating their claims administration arrangements with delegated agents and partially attributable to the way insurers are reporting claims data.

**Insurers paid
\$928,164 in
interest in 2003**

Insurers paid \$928,164 interest 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) increased to 5.6% of 2003 claims from 2.7% in 2002.

The following Table 3 illustrates the results of the claims data filings of the 40 insurers of the Base Group.

Table 3

Clean Claims Data Summary	2003	2002
<i>Insurers (40)</i>		
Total Claims Reported as Received	24.4 million	27.8 million
Total Clean Claims Reported as Received	21.8 million	21.1 million
Total Claim Benefits Paid	\$2.5 billion	\$1.6 billion
% of Total Claims Received Were Clean	89.3%	75.7%
% of Total Claims Received Were Denied	16.7%	16.0%
% of Clean Claims Received Were Denied	1.3%	2.16%
% Insurer Claims Processed Within 30 Days	94.4%	97.3%
Total Interest Paid on Delayed Claims	\$928,000	\$626,000

Claims paid in excess of 30 days represent violations of Maryland's prompt payment law. 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 has investigated several insurer data filings where the incidence of nonpayment was determined to be significant. In one situation, a market conduct examination of the insurer's administrative practices was initiated. The MIA continues to monitor insurers to ensure they comply with Maryland prompt payment law. Noncompliance may result in the assessment of penalties to the insurers.

Although Payors have had a full year to develop a means to report claim inventory information, they continue to have reporting deficiencies. Because of computer and other technical problems, a number of insurers and their delegated agents stated 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. Consequently, the information reported is not considered to be representative of the Base Group, but, is useful in monitoring the work-in-process of individual reporting Payors with respect to their building or reducing of unprocessed claims. Fluctuating inventories may correlate to a Payor meeting or failing to meet the prompt payment requirements.

Claims inventory information reported may not be a reliable market indicator

In general, the inventory data submitted by insurers for 2003 declined somewhat from 2002, suggesting that work-in-process remains consistent and no large claim processing backlogs are evident. However, significant changes in the number of claims processed, benefits paid, claims received, interest and delayed claims suggest that the end-of-year inventory for 2002 was understated and many such claims were processed in 2003.

Insurers and their delegated agents reported the most frequently cited reasons for claim denial. The results for 2003 are not remarkably different than for 2002. The Base Group

of insurers and their delegated agents indicated the most frequently cited reasons for claim denial were:

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

- The claim received is a duplicate of a previous claim;
- Charges submitted are not covered by the plan in force;
- Pre-treatment authorization for services was not obtained;
- The claimant coverage terminated, lapsed is not in force, or the claimant is otherwise not eligible for benefits; and
- Charges received may be covered by another benefit plan.

Other common reasons reported for claim denials were:

- The provider claim was submitted after the insurer's timely filing deadline;
- The services received were not authorized or approved by the health plan;
- The benefit plan limit on covered services or the benefit maximum amount payable was exceeded; and
- Additional information from the claimant or provider is needed to continue processing the claim.

PAYORS – 2003 BASE GROUP

Following (in alphabetical order) is a list of the 11 HMOs and 40 insurers forming the Base Group. Their claims data filings were used in compiling this summary report.

HMOs

Aetna Health, Inc.
CareFirst BlueChoice, Inc.
CIGNA HealthCare Mid-Atlantic, Inc.
Coventry Health Care of Delaware, Inc.
Delmarva Health Plan, Inc.
FreeState Health Plan, Inc.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
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
Allianz Life Insurance Company of North America
American Republic Insurance Company
Ameritas Life Insurance Company
CareFirst of Maryland, Inc.
CIGNA Dental Health of Maryland, Inc.
Connecticut General Life Insurance Company
Continental General Life Insurance Co.
Delta Dental of Pennsylvania
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
Metropolitan Life Insurance Company
Monumental Life Insurance Company
Mutual of Omaha Insurance Co.
New York Life Insurance Company
Principal Life Insurance Company
Prudential Insurance Company of America
Reliance Standard Life Insurance Company
State Farm Mutual Automobile Insurance Company
The Dental Network, Inc.
The Dental Practice Association of Maryland, Inc.
The Guardian Life Insurance Company of America
Trustmark Insurance Company
Unicare Life & Health Insurance Co.
Unimerica Insurance Co., Inc.
Union Labor Life Insurance Company
United HealthCare Insurance Company
United of Omaha Life insurance Company
USAA Life Insurance Company

EXHIBIT 1

SUMMARY OF BASE GROUP CLAIMS DATA FILINGS

2003

SUMMARY OF BASE GROUP CLAIMS DATA FILINGS

2003 HMO Claims Reported	1/1/03 - 6/30/03	7/1/03 - 12/31/03	Total 2003	Total 2002	% Change
Total Claims Received	4,300,069	4,318,047	8,618,116	9,512,623	-9.40%
Total Claims Denied	698,148	669,126	1,367,274	1,432,699	-4.57%
Total Claims Processed	4,715,135	4,263,145	8,978,280	9,338,200	-3.85%
Clean Claims Received	2,911,811	2,857,435	5,769,246	5,708,917	1.06%
Clean Claims Denied	87,504	98,512	186,016	198,133	-6.12%
Total Benefit Amount Paid	\$566,915,028	\$595,097,330	\$1,162,012,358	\$1,243,887,666	-6.58%
Total Claims Processed <30 Days	4,121,802	4,172,044	8,293,846	9,082,090	-8.68%
Total Claims Processed >30 Days	593,333	91,101	684,434	255,110	168.29%
Interest Paid on Delayed Claims	\$291,883	\$148,596	\$440,479	\$596,499	-26.16%
Processed by Delegated Agents	174,768	110,680	285,448	690,541	-58.66%
Benefit Amount Paid by Delegated Agents	\$17,507,225	\$9,807,707	\$27,314,932	\$32,735,662	-16.56%
Interest Paid by Delegated Agents	\$11,411	\$2,356	\$13,767	\$4,298	220.31%
Total Ending Claim Inventory	217,269	236,886	236,886	230,256	2.88%
2003 Insurer Claims Reported	1/1/03 - 6/30/03	7/1/03 - 12/31/03	Total 2003	Total 2002	% Change
Total Claims Received	12,576,215	11,838,098	24,414,313	27,811,753	-12.22%
Total Claims Denied	2,099,761	1,986,995	4,086,756	4,445,168	-8.06%
Total Claims Processed	13,319,718	11,789,741	25,109,459	16,838,723	49.12%
Clean Claims Received	11,266,365	10,546,055	21,812,420	21,051,613	3.61%
Clean Claims Denied	164,275	120,227	284,502	455,268	-37.51%
Total Benefit Amount Paid	\$1,258,823,465	\$1,240,686,988	\$2,499,510,453	\$1,607,984,083	55.44%
Total Claims Processed <30 Days	12,264,920	11,427,453	23,692,373	16,390,021	44.55%
Total Claims Processed >30 Days	1,054,798	362,288	1,417,086	448,702	215.82%
Interest Paid on Delayed Claims	\$497,228	\$430,936	\$928,164	\$625,988	48.27%
Processed by Delegated Agents	113,551	58,742	172,293	3,751,065	-95.41%
Benefit Amount Paid by Delegated Agents	\$4,986,820	\$3,762,923	\$8,749,743	\$195,209,145	-95.52%
Interest Paid by Delegated Agents	\$1,830	\$789	\$2,619	\$53,946	-95.15%
Total Ending Claim Inventory	250,873	233,573	233,573	331,436	-29.53%
2003 All Claims Reported	1/1/03 - 6/30/03	7/1/03 - 12/31/03	Total 2003	Total 2002	% Change
Total Claims Received	16,876,284	16,156,145	33,032,429	37,324,376	-11.50%
Total Claims Denied	2,797,909	2,656,121	5,454,030	5,877,867	-7.21%
Total Claims Processed	18,034,853	16,052,886	34,087,739	26,176,923	30.22%
Clean Claims Received	14,178,176	13,403,490	27,581,666	26,760,530	3.07%
Clean Claims Denied	251,779	218,739	470,518	653,401	-27.99%
Total Benefit Amount Paid	\$1,825,738,493	\$1,835,784,318	\$3,661,522,811	\$2,851,871,749	28.39%
Total Claims Processed <30 Days	16,386,722	15,599,497	31,986,219	25,472,111	25.57%
Total Claims Processed >30 Days	1,648,131	453,389	2,101,520	703,812	198.59%
Interest Paid on Delayed Claims	\$789,111	\$579,532	\$1,368,643	\$1,222,487	11.96%
Processed by Delegated Agents	288,319	169,422	457,741	4,441,606	-89.69%
Benefit Amount Paid by Delegated Agents	\$22,494,045	\$13,570,630	\$36,064,675	\$227,944,807	-84.18%
Interest Paid by Delegated Agents	\$13,241	\$3,145	\$16,386	\$58,244	-71.87%
Total Ending Claim Inventory	468,142	470,459	470,459	561,692	-16.24%

Note: Results are limited to data reported by the Base Group of 11 HMOs and 40 Insurers that represent 85% of the total health market in Maryland

EXHIBIT 2

CLAIM SUBMISSION DENIAL REASON CODES

2003

CLAIM SUBMISSION DENIAL CODES

1. Additional information from member needed
2. Accident details or explanation required
3. Additional information from provider needed
4. Provider billing error
5. Services not reimbursable, covered by capitation or global fee
6. Coordination of benefits/prime payor or Medicare EOB needed
7. Provider not contracted
8. Provider services not covered
9. Expense applied to deductible or copayment
10. Dental services not covered (under health plan)
11. Dependent expenses not covered
12. Expense previously considered; duplicate submission
13. Service exceeds plan frequency of services limitation
14. Dependent full time student status required
15. Patient not covered or ineligible/coverage not effective
16. Work related expenses not covered
17. Expense exceeds benefit plan maximum
18. Benefit not approved/covered by Medicare, not covered by plan
19. Medicare deductible not covered
20. Expense not covered by plan
21. Pre-treatment authorization or referral not obtained
22. Pre-existing condition not covered
23. Pre-operative X-rays required for claim consideration
24. Routine exams (services) not covered
25. Prescription drug not covered
26. Coverage terminated, cancelled or lapsed
27. Expense exceeds usual & customary fee; unbundled fee/incidental procedure not covered
28. Unauthorized services not covered
29. Untimely filing of claim by provider
30. Vision services not covered (under health plan)
31. Six month waiting period exclusion not satisfied
32. Miscellaneous other conditions or reasons for denial