REPORT ON SEMI-ANNUAL CLEAN CLAIMS DATA FILING FOR CALENDAR YEAR 2013

PUBLISHED JULY 2015

200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
www.mdinsurance.state.md.us

LARRY HOGAN, JR.
Governor

BOYD K. RUTHERFORD
Lt. Governor

AL REDMER, JR.
Insurance Commissioner

ABOUT THIS REPORT

In November 2000, the Maryland Insurance Administration (MIA) issued Regulations required by §15-1003(d) of the Insurance Article Annotated Code of Maryland (Insurance Article) that govern how third-party payors process and pay claims made by health care providers. The resulting Regulation, Code of Maryland Regulations (COMAR) 31.10.11.14, established uniform standards for claims submission by health care providers to expedite and simplify claims processing, in an effort to reduce disputes between providers and third-party payors. The regulations apply to all third-party payors.[1] Insurers and non-profit health service plans are collectively referred to as "Insurers" in this Report.

Twice each year, Payors must compile and report the required claim data from their own health claim processing operation, as well as claim data from all delegated agents who process health claims on their behalf.

Under the Regulations, the Insurance Commissioner is responsible for providing the public a summary of information submitted by Payors to the MIA. This report is the summary of claims data filings for Insurers and HMOs for the calendar year of 2013.

Semi-Annual Claims Data Filing

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

Payors are required to provide information regarding claims received and processed for health care benefits under a policy, contract, plan, or certificate issued or delivered in Maryland. Payors must report health care claims data for medical, dental, behavioral health, vision, and prescription drug claims. Medicare, Federal Employee Health Benefit Plans, self-insured employer health care programs and other types of accident and health insurance plans (e.g., long-term care, disability) are not reported and are excluded from this report.

Payors that are not filing the required claims data reports or who submit inaccurate data are in violation of Maryland insurance laws and regulations and may be subject to penalties imposed by the Insurance Commissioner. Penalties may include more frequent or detailed reporting.

Certain Payors with minimal or no health business in the state are exempt from this filing at the discretion of the Commissioner. As in past filing periods, a number of Payors representing a negligible segment of the Maryland market received filing exemptions for 2013. Generally,

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

companies with health premiums that are less than $50,000 have received an exemption from filing their clean claims data.

Base Group

To facilitate effective and meaningful data analysis, the MIA established a Base Group of Payors. This Base Group includes 21 insurers and 12 HMOs, including 3 dental plan organizations. The 2012 Base Group consisted of 27 insurers and 7 HMOs, which included 7 dental plan organizations. A list of the Base Group Payors can be found in Exhibit 1 of this report.

In the 2013 reporting period, companies in the Base Group wrote approximately $21.3 billion in accident and health premium, accounting for approximately 93.17% of the total accident and health insurance market in Maryland, an increase from 74.7% in the 2012 reporting period.[2]

Along with accident and health premium written, the Covered Lives Report, which is required to be submitted to the MIA in accordance with §15-1003(d) of the Insurance Article Annotated Code of Maryland, was used to determine the 2013 Base Group. Using both the accident and health premiums written, and the Covered Lives Report, provides a more accurate Base Group that best represents the current market.

Clean Claims

A key element of the semi-annual claims data filing and the subject of this report are Clean Claims. Clean Claims are those health care claims submitted by a health care provider that contain all essential information needed by a Payor for claims processing. COMAR 31.10.11 sets forth the essential data elements for Clean Claims. Payors may use this data set to determine what constitutes a Clean Claim, or they may choose to define Clean Claims using their own set of requirements that contains fewer elements than all of the essential data elements detailed in COMAR 31.10.11. Payors may require fewer data elements to determine Clean Claims, but may not require more data elements than those detailed in COMAR 31.10.11.

Clean Claims must be submitted on one of two industry standard billing forms or their electronic equivalents. In Maryland, CMS Form 1500 (used by doctors) and CMS Form 1450/UB04 (formerly known as UB 92 and used by hospitals) are considered Uniform Claim Forms. The acronym "CMS" refers to the Federal Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

[2] A direct comparison of the numbers of total claims received, total clean claims received, and total benefits paid year over year will not reflect actual trends as a result of the 18.47% increase in the Base Group market share from 2012 to 2013. The percentages presented in this report may be compared year over year to provide some insight into trends within the Maryland market, despite the market share increase over the past four years.

By regulation, these CMS forms are the sole instruments for health care providers to file health claims with third-party payors for professional, hospital and related services in Maryland.

Although patients may file health care claims with Payors for reimbursement for professional, hospital and related services, they are not considered to be Clean Claims according to COMAR 31.10.11 and are not required to contain all the essential data elements. These patient-submitted claims are included in the information filed by third-party payors, but are not part of the data incorporated into Clean Claims for the purpose of this report.

Semi Annual Claims Data Filing Reports

There are specific instructions for completing the claims data filing form designed by the MIA. After the 2012 reporting period, the MIA developed its own in-house "Semi-Annual Claims Data Application". The application was developed in response to the loss of the third party that previously administered the MIA's electronic filing system. The new application has Payor verification capabilities as well as automatic data validation to allow for more sensitive and reliable data collection.

The application is accessible through the same MIA webpage as the previous electronic filing system: http://www.mdinsurance.state.md.us.

The instructions for electronic claims data filing have replaced the instructions for completing the paper form on the MIA's website. A new paper form, an identical copy of the data collection application, is also available for Payors to submit claims if problems arise with the new application. The 2013 reporting period was the first period in which claims filings were received through the new data collection application.

In general, Payors are required to submit information on the total number of health claims received and denied, the number of Clean Claims received and denied, the inventory of unprocessed claims, the number of claims adjudicated, the benefit amounts paid, and the processing time. Payors must also provide information on the most prevalent reasons they deny claims.

Completion of the claims data filing requires Payors to affirm whether they use the essential data elements specified by COMAR 31.10.11 to determine Clean Claims, or whether the COMAR 31.10.11 data set is not used. As previously stated, Payors may require fewer data elements to determine Clean Claims, but may not require more data elements than mandated by the regulations.

Prompt Payment

Another key element of the semi-annual claims data filing is prompt payment. According to the Insurance Article, §15-1005(c), Insurers and HMOs must take certain action on a claim within 30 days. If payment is due on the claim and payment is not made within 30 calendar days from the

date a Payor receives the claim, an interest penalty must be paid to the person entitled to the reimbursement pursuant to Insurance Article, §15-1005(f).

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

Denied Claims

Part of the claims data filing process requires that Payors report the number of claims denied according to the five most prevalent reasons for claim denials. To simplify this process and to promote uniform reporting for comparison, Payors must report data based on a set of 17 denial codes established by the MIA. The list of codes can be found in Exhibit 2 of this report.

As reported by the Base Group in 2013, all five of the most prevalent reasons for claim denials fell under these 17 denial codes. Additionally, 100% of all claim denials reported in 2013 fell under these 17 denial codes.

Verification of Data Reported

Data is self-reported by Payors and by delegated agents on behalf of the Payors they serve. However, reporting is ultimately the responsibility of the Payor. Some Payors collect reports from their delegated agents for submission along with their internally-generated reports while other delegated agents submit reports directly to the MIA on behalf of their contracting Insurers or HMOs. As such, the MIA assumes claims data has been verified for accuracy by Payors and delegated agents prior to submission. In previous reporting periods, the MIA was able to identify duplicate filings and certain other data anomalies. In these cases, the affected Payors were contacted for clarification or revised data.

Payors using the new data collection application are validated with either a FEIN or NAIC number upon log-in to the system. Payor submitted claims numbers and dollar values are validated under their respective sections in the report.

Confidentiality of Information

Claims data filings are used, in part, by the Insurance Commissioner to monitor the general business practices of Payors and their delegated agents. The information provided to the MIA in these filings is considered confidential commercial information and is protected under the State Government Article §10-617 and the Insurance Article §2-209(g) of the Annotated Code of Maryland except when aggregated with data from all other respondents in a manner that does not permit the identification of individual respondent information.

Thus, semi-annual claims data filings of specific Payors are not available to the public. Pursuant to Insurance Article §2-205, however, Payor claims data filings may be used by the

Commissioner as a basis for analysis or investigation of a Payor's business practices. Further, based on the analysis or assessment of a Payor's semi-annual claims data filing, the Commissioner may issue an Order or take any other action authorized or reasonably implied by the Insurance Article, including the imposition of an administrative penalty and/or requiring payment of interest due.

Delegated Agents

Payors must compile and report the required claim data from their own health claim processing operation, as well as claim data from all delegated agents who process health claims on their behalf.

Due to administrative changes in the process of collecting and reporting on behalf of delegated agents, this data was unavailable for the 2010 – 2011 reporting period. In 2009, data reported by delegated agents accounted for approximately 4% of the total benefits paid amount. The 2012 data was approximately 1% of the total benefits paid and the 2013 data was less than 1% of the total benefits paid. The delegated agent information reported for this period represents no significant value to the analysis.

SUMMARY OF 2013 CLAIMS DATA FILINGS

Table 1 highlights information from the claims data filings of the Base Group for Calendar Year 2013 compared to the previous three years. The HMO and Insurer data used to create the following tables is found in Exhibit 3 of this report.

Table 1 – Summary of Base Group

Data Class	2013	2012	2011	2010
Total claims received	58.2 million	45.6 million	40.2 million	40.1 million
Total clean claims received	54.0 million	42.8 million	37.1 million	33.8 million
Total benefits paid	$10.53 billion	$8.4 billion	$8 billion	$8.7 billion
Clean claims as a percentage of total claims received	92.8%	93.8%	92.3%	84.2%
Denied claims as a percentage of total claims received	15.9%	15.6%	14.6%	15.5%
Denied clean claims as a percentage of total clean claims received	4.1%	0.4%	0.5%	0.6%
Percentage of all claims processed within 30 days	99.0%	96.5%	97.2%	97.4%

Due to changes in business and operations for several Payors (e.g. consolidation of companies or reduced marketing in Maryland), the Base Group for the 2013 report period was adjusted to reflect the approximately 18.47% increase in the market share from the previous reporting

period. The data filed continued to show a number of pertinent relationships between the current and previous years.

Over the four year period, the total number of claims received increased by approximately 18.1 million. Clean Claims received by the Base Group has increased from 33.8 million in 2010 to 54 million in 2013.

The total benefit amount paid by the Base Group increased by approximately $1.83 billion from 2010. Much of the increase in payments occurred between 2012 and 2013 when the total benefits paid increased from $8.4 billion to $10.53 billion.

The percentage of clean claims received by companies slightly decreased from 93.8% in 2012 to 92.8% in 2013. The Base Group denied 4.1% of clean claims received while 15.9% of all claims received were denied. In 2012, 0.4% of clean claims were denied while 15.6% of all claims received were denied.

Since 2010, the number of all claims processed within 30 days has increased from 44.1 million in 2012 to 58 million in 2013. In 2012, 96.5% of all claims were processed within 30 days, while in 2013, 99% of all claims were processed within 30 days.

The average amount paid per processed claim decreased 1.8% from approximately $183 in 2012 to $179.73 in 2013.

These numbers indicated that year over year in Maryland, a higher percentage of clean claims are being received by the Base Group and a higher amount of all claims are being paid and processed within 30 days. Also, the average amount paid per processed claim has decreased, while a lower percentage of clean claims received are being paid.

For 2013, Payors reported the following as the most prevalent reasons for claim denials:

- Duplicate expense or claim received was previously considered or paid (32.6%)
- Non-covered expense or service; not reimbursable due to deductible or copay/coinsurance (29.2%)
- Additional miscellaneous information not described by other denial reasons but is needed from patient or provider to process claim (7.6%)
- Miscellaneous other reasons for denial not listed or explained by other codes (7.3%)
- UCR allowable fee amount exceeded; coding problem including bundling or incidental procedure (7.2%)

All are listed amongst the denial codes in Exhibit 2. The most significant change was the percentage of claims denied for “Duplicate expense or claim received was previously considered or paid”, which decreased from 49.4% in 2012 to 32.6% in 2013. The second most common reason for claim denials, “Non-covered expense or service; not reimbursable due to deductible or copay/coinsurance”, increased 5.9% from 2012 to 2013

Significant changes in the number of claims denied or the reasons for denial often reflect changes in the administrative practices of Payors. Such changes may lead to delayed claims processing and corresponding interest payments, the number and amount of claim payments, and consumer complaints.

2013 HMO RESULTS

Table 2 displays information from the claims data filings of the HMOs in the Base Group for 2013 compared to the previous 3 years.

Table 2 – Summary of HMOs in the Base Group

Data Class	2013	2012	2011	2010
Total claims received	25.0 million	7.0 million	7.1 million	7.7 million
Total clean claims received	21.9 million	7.0 million	7.0 million	7.4 million
Total benefits paid	$4.14 billion	$1.4 billion	$1.3 billion	$1.7 billion
Clean claims as a percentage of total claims received	87.6%	99.6%	98.7%	95.7%
Denied claims as a percentage of total claims received	22.0%	30.8%	23.8%	21.2%
Denied clean claims as a percentage of total clean claims received	9.7%	0.7%	0.9%	1.0%
Percentage of all claims processed within 30 days	99.2%	99.2%	97.6%	97.9%

As previously discussed, the Base Group for the 2013 report period reflects an approximately 18.47% increase in the market share from the previous reporting period. HMOs accounted for 43% of the total claims in the Base Group in 2013 and 39.31% of the total benefit amount paid. The percentage of clean claims received by the HMO Base Group decreased from 99.6% in 2012 to 87.6% in 2013. The number of claims received by HMOs in the Base Group increased 257.14% while total benefits paid increased by 195.71% from 2012 to 2013.

In the HMO Base Group, the data indicates that Clean Claims were significantly less likely to be denied; in 2013, 22% of all claims received were denied versus 9.7% of total Clean Claims that were denied.

The average amount paid per processed claim decreased from approximately $198 in 2012 to $163.02 in 2013, a decrease of 17.66%. The percentage of all claims processed within 30 days has remained at 99.2% since 2012.

2013 INSURER RESULTS

Table 3 highlights information from the claims data filings of the Insurers in the Base Group for 2013 compared to the previous 3 years.

Table 3 – Summary of Insurers in the Base Group

Data Class	2013	2012	2011	2010
Total claims received	33.2 million	38.6 million	33.1 million	32.4 million
Total clean claims received	32.1 million	35.8 million	30.1 million	26.4 million
Total benefits paid	$6.39 billion	$7.0 billion	$6.7 billion	$7.1 billion
Clean claims as a percentage of total claims received	96.7%	92.7%	90.9%	81.4%
Denied claims as a percentage of total claims received	11.3%	12.9%	12.6%	14.1%
Denied clean claims as a percentage of total clean claims received	0.3%	0.3%	0.4%	0.6%
Percentage of all claims processed within 30 days	98.8%	96.0%	97.1%	97.3%

As previously stated, the Base Group for the 2013 report period reflects an approximately 18.47% increase in the market share from the previous reporting period.

The number of total claims received by insurers in the Base Group decreased by 13.99% while total benefits paid decreased slightly by 8.71% from 2012 to 2013. The number of Clean Claims received has decreased 10.34% from 35.8 million in 2012 to 32.1 million in 2013.

Insurers accounted for 57% of total claims received by the Base Group in 2013 and 60.69% of total benefits paid. The average amount paid per processed claim increased from approximately $181 in 2012 to $192.51 in 2013, an increase of 6.36%.

Clean Claims were significantly less likely to be denied. In the 2013 Insurer Base Group, 11.3% of all claims received were denied while only 0.3% of all Clean Claims received were denied.

The percentage of claims processed within 30 days or less increased slightly from 96% in 2012 to 98.8% in 2013.

CONCLUSIONS

Overall, in 2013 the Base Group represented 93.17% of the total market share in the accident and health market in Maryland as compared to 74.72% in 2012. Thus, direct comparisons of the numbers of claims received and benefits paid in 2013 are illustrative only. Comparisons of the percentages of Clean Claims, paid claims, denied claims and timely processing of claims, however, remain relevant for the reasons stated above.

In 2013, the Base Group received 58.2 million claims and paid $10.5 billion in benefits. The HMOs in the Base Group accounted for approximately 43% of the received claims and 39.31% of the total benefits paid. The Insurers in the Base Group accounted for 57% of the received claims and 60.69% of the total benefit paid.

In 2013, approximately 15.91% of the total claims received by the entire Base Group were denied. This number has remained relatively consistent, showing only a slight increase of about 0.3% over year 2012. In 2013, 4.1% of total clean claims were denied, an increase from 0.4% from year 2012.

The Clean Claims as a percentage of total claims received by the entire Base Group decreased slightly from 93.8% in 2012 to 92.8% in 2013. The Insurers in the Base Group showed a slight increase of 4% in 2013, from 92.7% in 2012 to 96.7% in 2013. The HMOs in the Base Group showed a 12% decrease in 2013, from 99.6% in 2012 to 87.6% in 2013.

The total benefits paid by the Base Group increased by approximately 25.36% between 2012 and 2013. At $10.53 billion, this is the highest Total Benefits Paid by the Base Group has been over the last 4 years. When combined with the total number of claims received, this produces an increase in the average benefit paid per processed claim from $181 per processed claim in 2012 to $192.51 in 2013 for Insurers, and a decrease from $198 in 2012 to $163.02 in 2013 for HMOs. The average amount per claim on the entire Base Group was $179.73 for 2013, down from $183 in 2012. Based on the semi-annual claims data filings of the Base Group, some Payors have experienced a slight decrease in the average cost per claim. This is demonstrated by the decrease in the average benefit paid per processed claim by 17.66% for HMOs.

The most prevalent reason for claim denials, “Duplicate expense or claim received was previously considered or paid”, decreased slightly from 2012, but remains the most common reason for claim denial at 32.6% in 2013. The second most prevalent reason cited by the Base Group for claims denials was based on “Non-covered expense or service; not reimbursable due to deductible or copay/coinsurance”. This reason accounted for 29.2% of all denials in 2013 compared to 23.3% in 2012. The total number of reasons for claim denials decreased from 18 in 2012 to 17 in 2013. The overall percentage of total claims denied did not change significantly during the comparative period, and it appears that changes to the reasons for denial did not noticeably affected the processing and payment of claims.

EXHIBIT 1

BASE GROUP PAYORS FOR CALENDAR YEAR 2013

PAYORS 2013 BASE GROUP

The following is a list, in alphabetical order, of the 12 HMOs and the 21 Insurers that make up the Base Group for the 2013 Claims Data Filing:

HMOs

AMERIGROUP Maryland, Inc.

Coventry Health Care of Delaware, Inc.

JAI Medical Systems MCO, Inc.

Maryland Care, Inc. (Maryland Physicians Care)

MedStar Family Choice, Inc.

Priority Partners MCO, Inc.

United HealthCare of the Mid - Atlantic, Inc.

CareFirst BlueChoice, Inc.

Aetna Health Inc.

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

MD-Individual Practice Association, Inc.

Optimum Choice, Inc.

Insurers, Non-Profit Health Service Plans

Aetna Life Insurance Company

Bankers Life and Casualty Co.

Carefirst of Maryland, Inc.

CIGNA Dental Health of Maryland, Inc.

CIGNA Health and Life Insurance Company

Colonial Penn Life Insurance Company

Connecticut General Life Insurance Company

Coventry Health & Life Insurance Company

DentaQuest Mid-Atlantic, Inc.

Golden Rule Insurance Company

Group Hospitalization and Medical Services, Inc.

Guardian Life Insurance Company of America

Kaiser Permanente Insurance Company

MAMSI Life and Health Insurance Company

MEGA Life and Health Insurance Company

Omaha Life Insurance Company

Time Insurance Company

United Concordia Dental Plans, Inc.

United Healthcare Insurance Company

United World Life Insurance Company

USAA Life Insurance Company

EXHIBIT 2

CLAIMS SUBMISSION DENIAL CODES

CLAIMS SUBMISSION DENIAL REASON CODES

The following claim submission denial codes were established by the MIA for Payors to use when reporting the five most prevalent reasons for denying claims:

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

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

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

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

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

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

7. EOB (Explanation of Benefits)

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

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

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

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

12. NOT APPLICABLE; zero or no other denials reportable

13. NON-COVERED expense or service; service not reimbursable due to deductible or copay/coinsurance

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

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

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

17. UNTIMELY filing of claim by patient or provider; exceeds plan claim filing limitation

EXHIBIT 3

SUMMARY OF THE BASE GROUP'S CLAIMS DATA FILINGS FOR CALENDAR YEAR 2013

SUMMARY OF THE BASE GROUP'S CLAIMS DATA FILINGS FOR CALENDAR YEAR 2013

HMO Claims Reported	Total 2013	Total 2012	Total 2011	Total 2010
Total Claims Received	25,027,415	6,979,342	7,103,874	7,733,176
Total Claims Denied	5,514,200	2,149,534	1,689,535	1,638,545
Total Claims Processed	25,400,065	7,019,230	7,148,949	7,768,300
Clean Claims Received	21,916,587	6,954,128	7,008,273	7,401,290
Clean Claims Denied	2,132,014	51,386	60,044	70,385
Total Benefit Amount Paid	$4,140,843,071	$1,394,661,716	$1,326,538,101	$1,705,931,505
Total Claims Processed <30 days	25,185,235	6,961,649	6,976,703	7,603,694
Total Claims Processed >30 days	214,830	57,581	172,246	164,606
Interest Paid on Delayed Claims	$1,208,904	$1,338,925	$1,233,551	$1,959,688
Total Ending Claim Inventory	590,253	79,261	179,727	173,236
Insurer Claims Reported	**Total 2013**	**Total 2012**	**Total 2011**	**Total 2010**
Total Claims Received	33,180,695	38,615,440	33,119,117	32,376,561
Total Claims Denied	3,749,213	4,971,504	4,180,594	4,560,890
Total Claims Processed	33,202,218	38,650,624	33,167,608	32,609,888
Clean Claims Received	32,096,693	35,798,896	30,107,947	26,353,102
Clean Claims Denied	102,737	116,396	120,093	146,490
Total Benefit Amount Paid	$6,391,835,170	$6,985,222,270	$6,660,601,752	$7,114,489,665
Total Claims Processed <30 days	32,809,441	37,120,103	32,220,821	31,717,125
Total Claims Processed >30 days	392,777	1,530,521	946,787	892,763
Interest Paid on Delayed Claims	$1,104,814	$2,597,530	$1,595,109	$3,160,860
Total Ending Claim Inventory	405,260	1,151,352	803,327	623,745
All Claims Reported	**Total 2013**	**Total 2012**	**Total 2011**	**Total 2010**
Total Claims Received	58,208,110	45,594,782	40,222,991	40,109,737
Total Claims Denied	9,263,413	7,121,038	5,870,129	6,199,435
Total Claims Processed	58,602,283	45,669,854	40,316,557	40,378,188
Clean Claims Received	54,013,280	42,753,024	37,116,220	33,754,392
Clean Claims Denied	2,234,751	167,782	180,137	216,875
Total Benefit Amount Paid	$10,532,678,242	$8,379,883,985	$7,987,139,853	$8,820,421,170
Total Claims Processed <30 days	57,994,676	44,081,752	39,197,524	39,320,819
Total Claims Processed >30 days	607,607	1,588,102	1,119,033	1,057,369
Interest Paid on Delayed Claims	$2,313,719	$3,936,455	$2,828,660	$5,120,548
Total Ending Claim Inventory	995,513	1,230,613	983,054	796,981