John R. Kasich, Governor

Mary Taylor, Lt. Governor/Director

The Annual Health Claims External Review Report For the Year 2013

Since 1999, Ohio law provides consumers with the opportunity to request an independent, external review for denial, reduction, or termination by their health plan of certain health care services. In 2011, the Ohio Legislature updated the law on external review, incorporating required federal changes and enhancing features of the previous state external review process. The new requirements, codified in Ohio Revised Code (ORC) §3922, became effective for all external review requests submitted on or after January 1, 2012. A summary of the changes and enhancements is provided as ***Attachment 1, Substitute H.B. 218 External Review Revision Highlights.***

ORC §3922 requires "health plan issuers" (Health Plans), to provide the opportunity for either an external clinical peer review by an accredited Independent Review Organization (IRO) or a contractual review by the Ohio Department of Insurance (ODI) whenever the Health Plan makes an "adverse benefit determination:"

- To deny, reduce, or terminate a health care service or payment;
- Not to issue individual health insurance coverage; or
- To rescind health plan coverage.

The law also directs the Department of Insurance to compile and annually publish information regarding independent external review outcomes. This is the 13th annual report, summarizing the data the Ohio Department of Insurance has collected regarding external reviews conducted from January 1, 2013 through December 31, 2013.

Executive Summary of Independent External Review Outcomes

Medical Peer Reviews by Independent Review Organizations (IRO)

A health plan member or their authorized representative ("covered person"), or a health care provider on behalf of the covered person, may request IRO review of an adverse benefit determination made through a Health Plan's internal appeal process, if the determination involved a medical judgment or was based on any medical information.

During 2013, 208 cases, involving over $3.3 million in health care benefits and services, were submitted for IRO review to determine the appropriateness of a Health Plan's adverse benefit determination. The Health Plan's determination was reversed by the IRO in thirty-six percent of these cases, saving Ohio health insurance consumers approximately $851,000 or about 26% of the cost of all health care benefits and services reviewed.

Over half (53%) of the IRO reviews completed in 2013 were for health care services related to 5 medical specialties (psychiatry, surgery, oncology, orthopedics, and internal medicine).

IRO reversals for drug therapies and surgery totaled over $512,000. Reversals for hospitalization totaled about $145,078. Together, these health care service categories accounted for approximately 77% of the benefit amounts that were reversed in IRO decisions.

Contractual Reviews by the Ohio Department of Insurance (ODI)

When a Health Plan's internal appeal process results in an adverse benefit determination that is based on a contractual issue (not involving medical judgment or medical information), an external request may be submitted by the Health Plan for contractual review by ODI.

During 2013, 135 cases were submitted to ODI for contractual review. One of the 135 cases submitted to ODI for contractual review resulted in reversal of previously denied benefits, recovering almost $7,000 in additional benefits for Ohio consumers.

Total Benefits to Consumers since Enactment

Since the 1999 enactment of Ohio's external review law, 5,016 cases have been reviewed by ODI and/or IROs, recovering over $15.9 million in previously denied health care benefits and services for Ohio consumers.

Overview of Ohio External Review Law

ORC §3922 provides that the law applies to "health benefit plans" provided by "health plan issuers," which is defined as including the following entities:

- Traditional Health Insurers;
- Preferred Provider Organizations;
- Health Insuring Corporations (HMOs);
- Fraternal Benefit Societies;
- Self-funded Multiple Employer Welfare Arrangements (MEWAs);
- Nonfederal Government Health Plans; and
- Third Party Administrators (TPAs) administering health benefit plans.

The law requires Health Plans to create an internal appeals process providing covered persons with the opportunity to challenge the denial of health care services or eligibility for coverage. In addition, health care services or coverage denied through a Health Plan's internal appeals process that meet statutorily specified criteria, qualify for external review. Upon request by a covered person, or a health care provider on behalf of a covered person, an external review is required to be completed at no additional cost to the covered person.

A standard external review is required to be completed within thirty (30) days. An expedited review is required to be completed within no more than seventy-two (72) hours for conditions that the covered person's physician certifies could:

- seriously jeopardize the life or health of the covered person;
- jeopardize the covered person's ability to regain maximum function; or
- be significantly less effective if not initiated promptly (for experimental or investigational treatment).

The law provides that clinical peer review by an IRO that has been accredited by ODI must be conducted for any external review request of an adverse benefit determination that is based on medical judgment or involves consideration of medical information. Adverse benefit determinations that do not involve medical judgment or consideration of medical information require contractual review by ODI. Contractual reviews could include adverse benefit determinations based on whether a health care service is a covered service under a Health Plan contract, application of cost sharing or network limitations, or coverage eligibility determinations.

Subject to the other terms, limitations, and conditions of the health plan contract, upon receipt of a notice by an IRO or by ODI to reverse the adverse benefit determination, a Health Plan is required to provide coverage for the health care service(s) in question.

ORC 3922.17(C) directs ODI to compile information about external review outcomes and to publish and provide a report of that information annually to:

- The Governor;
- The speaker and minority leader of the Ohio House of Representatives
- The president and minority leader of the Ohio Senate; and
- The chairs and ranking minority members of the House and Senate committees with jurisdiction over health and insurance issues.

Discussion of Review Outcomes

External Reviews by Independent Review Organizations (IRO)

An analysis of the data over the 12-month period from January 1, 2013 to December 31, 2013, shows that IRO reviews involved benefit determinations amounting to approximately $3.3 million. IRO decisions reversing adverse benefit determinations saved covered persons almost $851,000. The total benefits recovered for the top 5 cases where Health Plan determinations were reversed was approximately $373,000.

Based on the amount of benefits paid, the top 5 cases reversed through the IRO external review process during this reporting period were:

HEALTH CARE SERVICE	EST. BENEFIT $'s PAID (Reversed)
Drug Therapy	**$100,000**
Drug Therapy	**$93,000**
Hospitalization	**$76,000**
Surgery	**$56,000**
Drug Therapy	**$48,000**

Number of IRO Reviews Conducted / Outcomes

For the reporting period of January 1, 2013 to December 31, 2013, 208 external review requests were assigned to IROs for review.

Standard reviews, permitting a 30-day maximum review period, were requested in 185 of the cases. The IROs reversed adverse benefit determinations in 64 standard reviews (35%) and affirmed the Health Plan's determination in the remaining 121 standard reviews (65%).

Twenty-three IRO cases were expedited, requiring a 72-hour maximum review period. In 10 of those cases (43%), the IROs reversed the Health Plan's original determination.

Average Time Required to Conduct IRO Reviews

The average time to process a standard IRO review was 21 days. Eighty-nine percent of all IRO reviews were completed without complication and within appropriate timeframes.

Cost of IRO External Reviews

The cost of an external review by an IRO is based on several factors, including, whether the review type is standard or expedited, the Health Plan basis for the adverse benefit determination, and the medical condition involved. For example, a review to determine medical necessity only requires one reviewer, while review of experimental or investigational services may require a panel of reviewers. IRO review cost is paid by the Health Plan. In 2013, the total cost to Ohio Health Plans for IRO reviews was approximately $164,649. The average cost per standard review was about $765; while the average cost per expedited review was approximately $1,008. Expedited review costs accounted for $23,180 (14%) of total review costs.

Summary of Services and Procedures

In 2013, IRO external reviews spanned a wide variety of health service categories. The highest proportion of reviews were for drug therapy and testing (both at 17.8%) followed by reviews for hospitalization (17.3%). These three service categories accounted for approximately 53% of the reviews conducted and $575,000 or nearly 68%, of the approximately $851,000 in benefit determinations reversed by IRO decisions. Together, review of surgery and durable medical equipment comprised another 26% of the reviews conducted and a corresponding 22% of the benefit determination amounts reversed. These 5 service categories represent approximately 78% of the 208 cases reviewed and about 90% of the total adverse benefit determination amounts that were reversed in 2013. ***See Attachment 2, IRO Reviews By Services and Procedures.***

Medical Specialty Types

During the process to initiate an IRO review, a Health Plan identifies the medical specialty category required for the review. Case review activity by category of medical specialty is listed in ***Attachment 3, IRO Reviews by Medical Specialty***.

Based on the number of reviews, the five medical specialties most often required for IRO review during this reporting period were:

MEDICAL SPECIALTY	NUMBER OF REVIEWS	TOTAL BENEFIT $'s REVIEWED	TOTAL BENEFIT $'s PAID (Reversed)
Psychiatry / Psychology (includes Addiction)	**34**	**$690,940**	**$80,082**
Surgery	**22**	**$379,883**	**$157,310**
Oncology Specialties	**21**	**$274,872**	**$80,429**
Orthopedics	**18**	**$237,211**	**$96,933**
Internal Medicine	**16**	**$921,838**	**$9,066**

External Contractual Reviews by ODI

The law requires ODI to review contractual adverse benefit determinations that do not involve medical judgment or consideration of medical information. Examples include determination that a health care service is not a covered benefit under the contract, eligibility for coverage (including determinations not to issue or to rescind coverage), and application of contractual cost sharing or network limitations. If ODI finds that a contractual external review request involves medical judgment or consideration of medical information, ODI immediately directs the Health Plan to submit the request for review by an IRO.

ODI has established an internal contractual review team comprised of specialists from the Office of Legal Services, the Office of Product Regulation, and the Consumers Services Division. There is no charge to Health Plans for contractual external reviews.

Number of Contractual Reviews Conducted / Outcomes

From January 1, 2013 to December 31, 2013, 135 contractual external reviews were completed by ODI. As a result, Ohio consumers received $6,921 of previously denied health benefits.

Health Plan contractual adverse benefit determinations were upheld in 134 cases (99%) and reversed in 1 case (1%).

Contractual Reasons for Review

The breakdown by category for contractual reviews performed by ODI during this reporting period is as follows:

REVIEW CATEGORY	TOTAL NUMBER OF REVIEWS	TOTAL BENEFIT $'s PAID (Reversed)
Service Not Covered-Non-medical Judgment	113	$6,921
Denial to Issue Coverage	15	N/A
Eligibility for Coverage	5	N/A
Emergency Services/Prudent Layperson Standard	1	$0
Denial of External Review Request	1	$0

Average Time Required to Conduct Contractual Reviews

The time required to conduct a comprehensive contractual review is dependent on the complexity of the case and the need for legal review of a consumer's contract. The average time for ODI completion of a contractual review in 2013 was 55 days.

Conclusion

Since enactment of Ohio law in 1999, providing consumers with the opportunity for independent external appeal of adverse health insurance determinations, ODI has maintained a significant investment of staff resources and technology to ensure thorough and timely resolution of external review appeals. As a result, 5,016 external reviews have been conducted, recovering over $15.9 million in previously denied health care benefits for Ohio consumers.

The ODI website offers secure, easy access to both the IRO and the contractual external review processes. A secure web-accessible application is the portal used by Health Plans and IROs to facilitate the IRO review process and to provide outcome reporting to ODI. This technology is also utilized by ODI to closely monitor IRO review activity.

ODI's ongoing efforts to publicize the opportunity and the process for external review include providing information in consumer guides and on the department website (www.insurance.ohio.gov). Consumers can also contact ODI for information or assistance with the external review process by completing an online consumer complaint form on the department website.

ODI and the Ohio State Medical Association (OSMA) collaborated to develop and distribute an external review "toolkit" of informative materials targeted specifically to Ohio consumers and health care providers. An online version of this toolkit is available on the department's website at http://www.insurance.ohio.gov/Consumer/Pages/HealthCoverageAppealToolkit.aspx.

ODI is committed to ensuring that the protections and benefits provided under Ohio external appeal laws are increasingly made known and remain highly accessible to all eligible Ohio consumers.

For more information, please contact the following individuals:

Consumer Inquiries:

- Jana Jarrett, Assistant Director, Consumer Services, (614) 644-3378

Legislative Inquiries:

- Allison Conklin, Assistant Director, Government Relations, (614) 644-2475

Media Inquiries:

- David Hopcraft, Director of Communications, (614) 728-1014

Attachments

- **Attachment 1 - Substitute HB218 Revision Highlights**
- **Attachment 2 – IRO Reviews By Type Of Services**
- **Attachment 3 – IRO Reviews By Medical Specialty**
- **Attachment 4 – 10 Year Comparison of IRO Cases By Report Year**
- **Attachment 5 – Five Year Health Carrier Summary**
- **Attachment 6 – Total Number of IRO Cases By Report Year**
- **Attachment 7 – Health Carrier Summary**

Substitute H.B. 218 External Review Revision Highlights

Code Reference	Enhancement
3922.03 C	Health plan issuers are required to provide effective written notice to covered persons of their right to external review.
3922.04	The internal appeal process must be exhausted prior to initiating an external review except in the following instances: • The health plan issuer agrees to waive the exhaustion requirement • The covered person did not receive a written decision of their internal appeal within the required time frame • The health plan issuer fails to meet all requirements of the internal appeal process unless the failure: o Was de minimis o Does not cause or is not likely to cause prejudice or harm to the covered person o Was for good cause and beyond the control of the health plan issuer o Is not reflective of a pattern or practice of non-compliance • An expedited external review is sought simultaneously with an expedited internal review
3922.02 C	There is no minimum dollar amount required in order to be eligible to request an internal appeal or external review.
3922.02 B	Ohio law continues to allow covered persons 180 days to file a request for external review after completion of the internal appeal process and receipt of the notice of adverse benefit determination.
3922.05 D, G and 3922.06	Health plan issuers are required to notify the covered person of the opportunity to submit, within 10 days after receipt of the notice, additional information to the IRO or superintendent for consideration when conducting an external review. The IRO will forward the information within 1 business day of receipt to the health plan issuer. Upon receipt, the health plan issuer may reconsider their adverse benefit determination and provide coverage for the health care service.
3922.05 H 3922.10 M	Ohio law continues to require the IRO to provide notice of its decision to uphold or reverse an adverse benefit determination within 30 days of receipt, by the health plan issuer, of the request for a standard external review.
3922.09	Notice of a decision to uphold or reverse the adverse benefit determination for an **expedited** external review must be provided as expeditiously as possible, but no later than 72 hours after receipt, by the health plan issuer, of the request for external review.

Code Reference	Enhancement
3922.03 3922.19	Health plan issuers must provide a description of internal appeal and external review procedures in or attached to the policy, certificate or evidence of coverage provided to the covered person.
3922.10	Eligibility for an external review that involves an experimental or investigational treatment must be certified by the covered person's physician.
3922.18	Ohio will continue to require the health plan issuer to bear the cost of the external review.
3922.12	The IRO decision is binding on both the covered person and the health plan issuer. (except for other remedies under law)
3922.11	The covered person must contact the health plan issuer to initiate a request for external review by the superintendent.

ATTACHMENT 2

IRO Reviews By Type of Services Reported

January 1, 2013 - December 31, 2013

SERVICES & PROCEDURES	# CASES/ PERCENTAGE		TOTAL IRO REVIEW COST/ PERCENTAGE		TOTAL BENEFIT $'S REVIEWED/ PERCENTAGE		BENEFIT $'s REVERSED	BENEFIT $'s UPHELD
Drug	37	17.8%	$30,939	18.8%	$513,188	15.4%	$403,880	$109,308
Testing	37	17.8%	$25,974	15.8%	$144,278	4.3%	$25,731	$118,547
Hospitalization	36	17.3%	$28,065	17.0%	$1,550,837	46.5%	$145,078	$1,405,759
Surgery	30	14.4%	$30,964	18.8%	$376,182	11.3%	$108,766	$267,416
Durable Medical Equipment	23	11.1%	$18,344	11.1%	$251,793	7.5%	$79,466	$172,327
Therapy	14	6.7%	$9,974	6.1%	$137,178	4.1%	$13,501	$123,678
Emergency Transport	13	6.3%	$8,197	5.0%	$258,622	7.8%	$57,782	$200,840
Emergency Room	8	3.8%	$5,488	3.3%	$9,846	0.3%	$2,853	$6,993
Skilled Nursing/Hospice/Home Health	6	2.9%	$4,179	2.5%	$88,236	2.6%	$13,771	$74,465
Other	3	1.4%	$1,850	1.1%	$285	0.0%	$85	$200
Dental	1	0.5%	$675	0.4%	$5,549	0.2%	$0	$5,549
Grand Totals:	**208**		**$164,649**		**$3,335,993**		**$850,912**	**$2,485,081**

April 08, 2016

Office of Product Regulation & Actuarial Services - Life & Health Division

ATTACHMENT 3

IRO REVIEWS BY MEDICAL SPECIALTY
JANUARY 1, 2013 - DECEMBER 31, 2013

MEDICAL SPECIALTY	# OF REVIEWS	TOTAL IRO REVIEW COSTS	TOTAL BENEFIT $'s REVIEWED*	BENEFIT $'s REVERSED*	BENEFIT $'s UPHELD*
Psychiatry	29	$23,388	$524,210	$80,082	$444,128
Orthopedics	17	$12,161	$187,211	$96,933	$90,278
Internal Medicine	16	$11,398	$921,838	$9,066	$912,771
Physical Medicine/Rehabilitation	12	$7,905	$96,189	$27,000	$69,189
Neurology	11	$9,000	$87,767	$31,748	$56,019
Emergency Medicine	10	$7,075	$66,783	$24,985	$41,798
Gastroenterology	10	$7,767	$47,849	$5,500	$42,349
Medical Oncology	9	$6,955	$131,080	$62,000	$69,080
Cardiovascular Disease	8	$5,850	$63,509	$40,101	$23,408
Ob/Gyn	6	$3,259	$27,914	$768	$27,146
Pediatric Endocrinology	6	$4,897	$135,366	$118,345	$17,021
Hematology/Oncology	5	$3,551	$103,580	$5,800	$97,780
Neurologic Surgery	5	$4,090	$89,370	$78,370	$11,000
Pediatrics, General	5	$3,104	$42,404	$6,369	$36,035
Surgery, General	5	$2,340	$60,207	$1,263	$58,944
Addiction Psychiatry	4	$2,171	$166,730	$0	$166,730
Oral & Maxillofacial Surgery	4	$8,937	$63,892	$40,213	$23,679
Pain Management	4	$4,178	$30,580	$8,500	$22,080
Plastic Surgery	4	$4,365	$141,450	$30,000	$111,450
Pulmonary Medicine	4	$5,570	$6,552	$2,000	$4,552

ATTACHMENT 3

IRO REVIEWS BY MEDICAL SPECIALTY
JANUARY 1, 2013 - DECEMBER 31, 2013

MEDICAL SPECIALTY	# OF REVIEWS	TOTAL IRO REVIEW COSTS	TOTAL BENEFIT $'s REVIEWED*	BENEFIT $'s REVERSED*	BENEFIT $'s UPHELD*
Critical Care Medicine	3	$1,746	$43,836	$8,824	$35,011
Radiation Oncology	3	$2,750	$3,500	$2,000	$1,500
Chiropractic	2	$1,525	$1,232	$0	$1,232
Medical Genetics	2	$1,190	$425	$109	$316
Ob/Gyn Oncology	2	$1,475	$12,000	$0	$12,000
Otolaryngology	2	$1,619	$7,800	$1,000	$6,800
Pediatric Hemotology	2	$2,945	$64,000	$48,000	$16,000
Pediatric Oncology	2	$1,225	$24,712	$10,629	$14,083
Rheumatology	2	$1,300	$100,413	$100,413	$0
Allergy/Immunology	1	$575	$395	$395	$0
Colon & Rectal Surgery	1	$675	$21,434	$7,134	$14,300
Diagnostic Radiology	1	$561	$1,000	$1,000	$0
Opthamology	1	$625	$1,460	$1,460	$0
Pediatric Neurology	1	$525	$100	$0	$100
Pediatric Orthopedics	1	$825	$50,000	$0	$50,000
Psychology	1	$483	$0	$0	$0
Pulmonary Critical Care	1	$650	$3,000	$0	$3,000
Speech Pathology	1	$575	$2,100	$0	$2,100
Surgery, Gastric	1	$900	$330	$330	$0
Thoracic Surgery	1	$2,195	$3,200	$0	$3,200

ATTACHMENT 3

IRO REVIEWS BY MEDICAL SPECIALTY
JANUARY 1, 2013 - DECEMBER 31, 2013

MEDICAL SPECIALTY	# OF REVIEWS	TOTAL IRO REVIEW COSTS	TOTAL BENEFIT $'s REVIEWED*	BENEFIT $'s REVERSED*	BENEFIT $'s UPHELD*
Urology	1	$951	$0	$0	$0
Vascular Interventional Radiology	1	$900	$573	$573	$0
Vascular Surgery	1	$475	$0	$0	$0
Grand Totals:	**208**	**$164,649**	**$3,335,993**	**$850,912**	**$2,485,081**

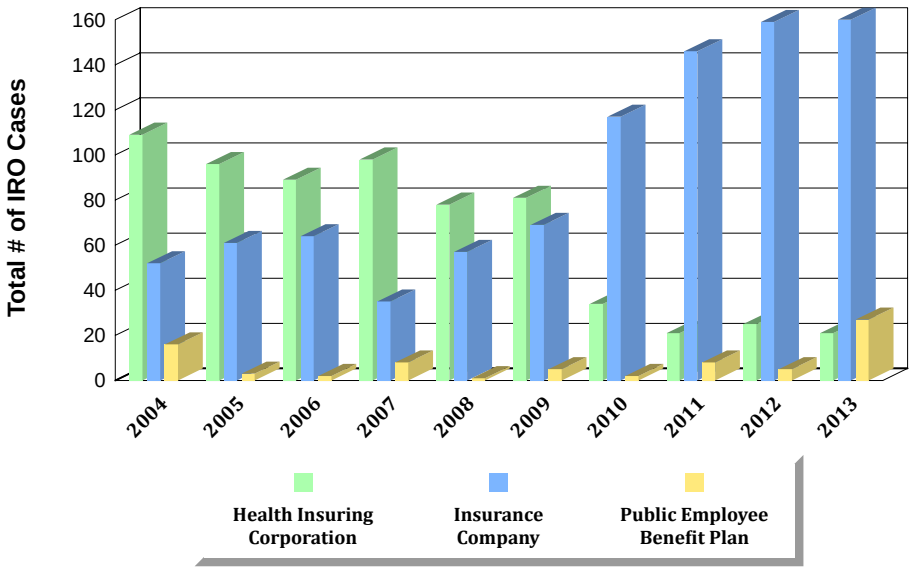
***Information not available from carrier for 15 cases during the reporting period.*

ATTACHMENT 4

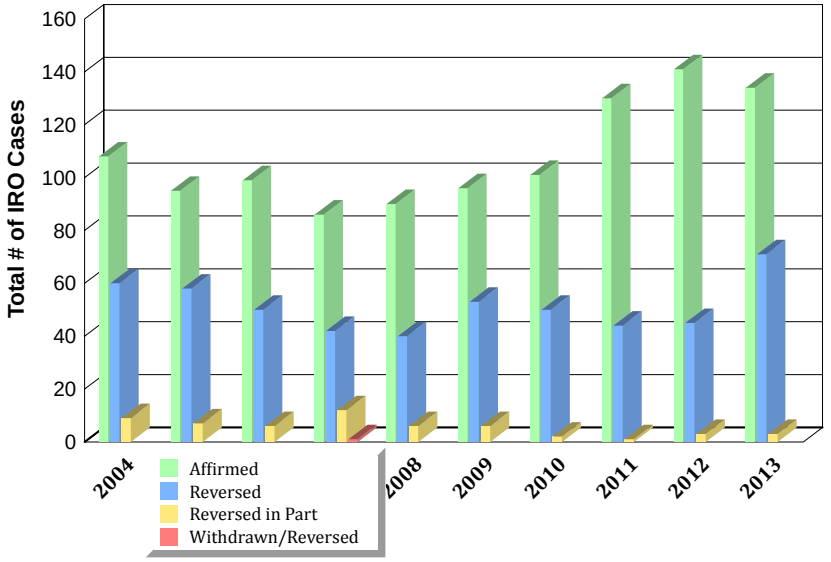
10 YEAR COMPARISON OF IRO CASES BY REPORT YEAR

January 1, 2004 - December 31, 2013

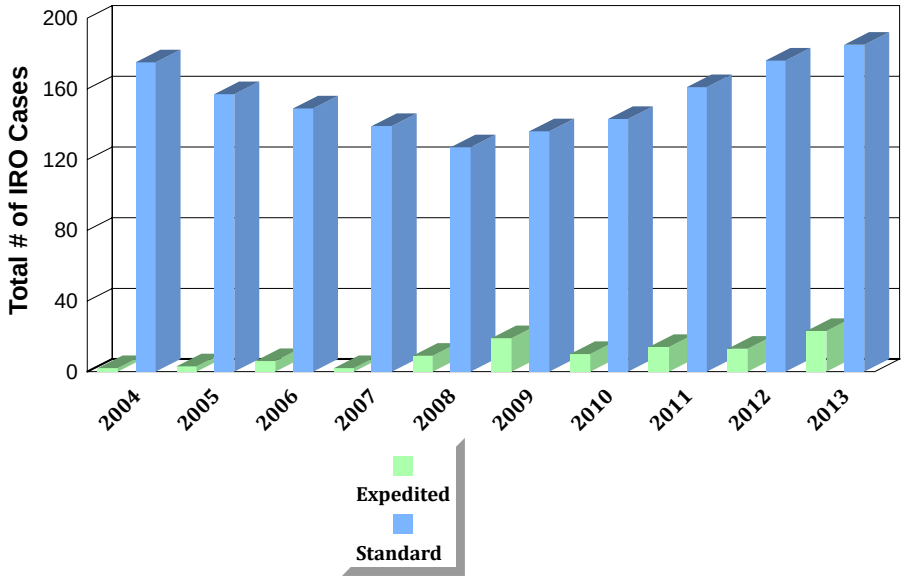
TYPE OF HEALTH CARRIER



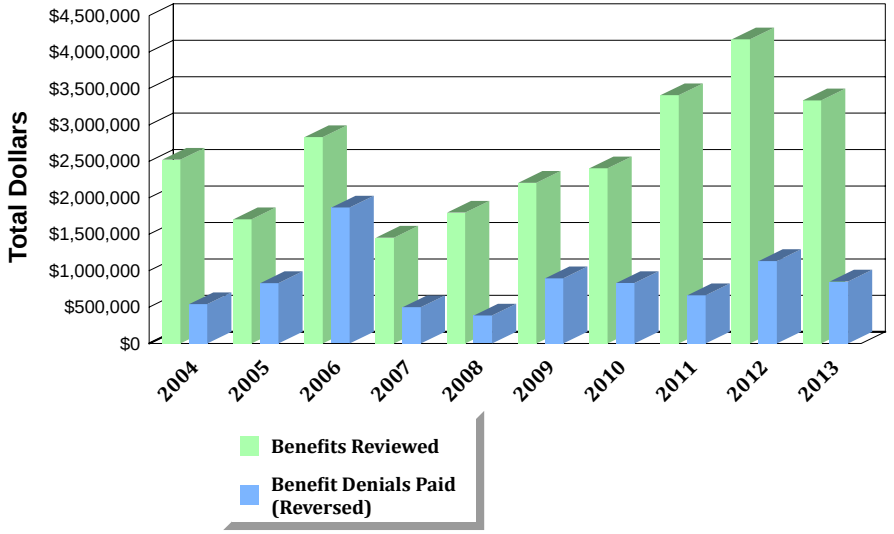
IRO OUTCOME DECISIONS



IRO REVIEW TYPE



TOTAL IRO BENEFITS REVIEWED vs. BENEFIT DENIALS PAID (REVERSED)



April 08, 2016

Ohio Department of Insurance
Office of Product Regulation & Actuarial Services / Life & Health Division

ATTACHMENT 5
FIVE YEAR HEALTH CARRIER SUMMARY
JANUARY 1, 2009 - DECEMBER 31, 2013

HEALTH CARRIER	ESTIMATED 5 YEAR PREMIUM	CASE VOLUME						BENEFIT DOLLARS REVIEWED							
	As Reported on ODI Annual Health Report	# Reviews	% of Total	# Affirmed		# Reversed		$ Reviewed	% of Total	$ Affirmed		$ Reversed		Maximum $ Affirmed	Maximum $ Reversed
		#	%	#	%	#	%	$	%	$	%	$	%		
COMMUNITY INSURANCE COMPANY	$14,273,877,170	1,485	36%	470	32%	1,010	68%	$22,527,299	31%	$15,657,110	70%	$6,870,189	30%	$200,000	$165,000
MEDICAL MUTUAL OF OHIO	$9,866,576,935	1,045	25%	250	24%	795	76%	$20,389,126	28%	$15,561,556	76%	$4,827,570	24%	$850,000	$242,750
UNITEDHEALTHCARE INSURANCE COMPANY	$5,109,815,986	550	13%	240	44%	310	56%	$15,420,292	21%	$12,305,826	80%	$3,114,466	20%	$1,571,739	$103,000
KAISER FOUNDATION HEALTH PLAN OF OHIO	$1,712,522,371	120	3%	30	25%	90	75%	$1,106,482	2%	$927,837	84%	$178,645	16%	$50,000	$15,000
AULTCARE INSURANCE COMPANY	$974,757,663	200	5%	100	50%	100	50%	$1,934,839	3%	$1,425,218	74%	$509,621	26%	$50,000	$51,484
SUMMA INSURANCE COMPANY INC	$903,896,522	15	0%	15	100%	0	0%	$23,175	0%	$23,175	100%	$0	0%	$2,500	$0
HUMANA HEALTH PLAN OF OHIO INC	$878,264,601	140	3%	25	18%	115	82%	$1,385,809	2%	$1,228,987	89%	$156,823	11%	$130,000	$16,371
PARAMOUNT CARE, INC.	$625,267,830	10	0%	0	0%	10	100%	$337,000	0%	$337,000	100%	$0	0%	$38,000	$0
GOLDEN RULE INSURANCE COMPANY	$403,900,844	65	2%	35	54%	30	46%	$2,656,510	4%	$1,450,833	55%	$1,205,678	45%	$173,878	$215,000
HEALTH PLAN OF UPPER OH VALLEY INC	$321,853,698	20	0%	0	0%	20	100%	$973,165	1%	$653,165	67%	$320,000	33%	$99,999	$64,000
CONNECTICUT GENERAL LIFE INSURANCE COMPANY	$300,772,082	15	0%	10	67%	5	33%	$0	0%	$0	0%	$0	0%	$0	$0
HUMANA INSURANCE COMPANY	$214,907,642	55	1%	0	0%	55	100%	$296,517	0%	$187,990	63%	$108,527	37%	$30,000	$16,213
TIME INSURANCE COMPANY	$162,189,777	30	1%	0	0%	30	100%	$639,145	1%	$7,000	1%	$632,145	99%	$1,400	$86,000
COVENTRY HEALTH AND LIFE INSURANCE COMPANY	$138,984,828	155	4%	70	45%	85	55%	$1,675,058	2%	$1,276,095	76%	$398,963	24%	$150,000	$40,000
PRINCIPAL LIFE INSURANCE COMPANY	$99,404,064	55	1%	0	0%	55	100%	$881,820	1%	$296,875	34%	$584,945	66%	$36,347	$63,760
FEDERATED MUTUAL INSURANCE COMPANY	$88,840,393	10	0%	0	0%	10	100%	$204,865	0%	$170,385	83%	$34,480	17%	$34,077	$6,896
JOHN ALDEN LIFE INSURANCE COMPANY	$83,966,637	15	0%	0	0%	15	100%	$22,985	0%	$9,310	41%	$13,675	59%	$1,200	$2,735
UNITEDHEALTHCARE OF OHIO INC	$74,775,026	20	0%	0	0%	20	100%	$649,390	1%	$635,440	98%	$13,950	2%	$123,298	$2,790
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	$74,283,512	18	0%	0	0%	18	100%	$581,426	1%	$537,712	92%	$43,714	8%	$93,421	$17,084
SUMMACARE INC	$52,565,702	20	0%	4	20%	16	80%	$58,000	0%	$56,400	97%	$1,600	3%	$6,100	$400
TRUSTMARK LIFE INSURANCE COMPANY	$49,042,311	5	0%	5	100%	0	0%	$3,036	0%	$3,036	100%	$0	0%	$607	$0
NIPPON LIFE INSURANCE COMPANY OF AMERICA	$41,227,896	5	0%	0	0%	5	100%	$29,820	0%	$29,820	100%	$0	0%	$5,964	$0
MEGA LIFE AND HEALTH INSURANCE COMPANY, THE	$28,278,544	5	0%	0	0%	5	100%	$31,570	0%	$0	0%	$31,570	100%	$0	$6,314

April 10, 2016

Ohio Department of Insurance
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ATTACHMENT 5
FIVE YEAR HEALTH CARRIER SUMMARY
JANUARY 1, 2009 - DECEMBER 31, 2013

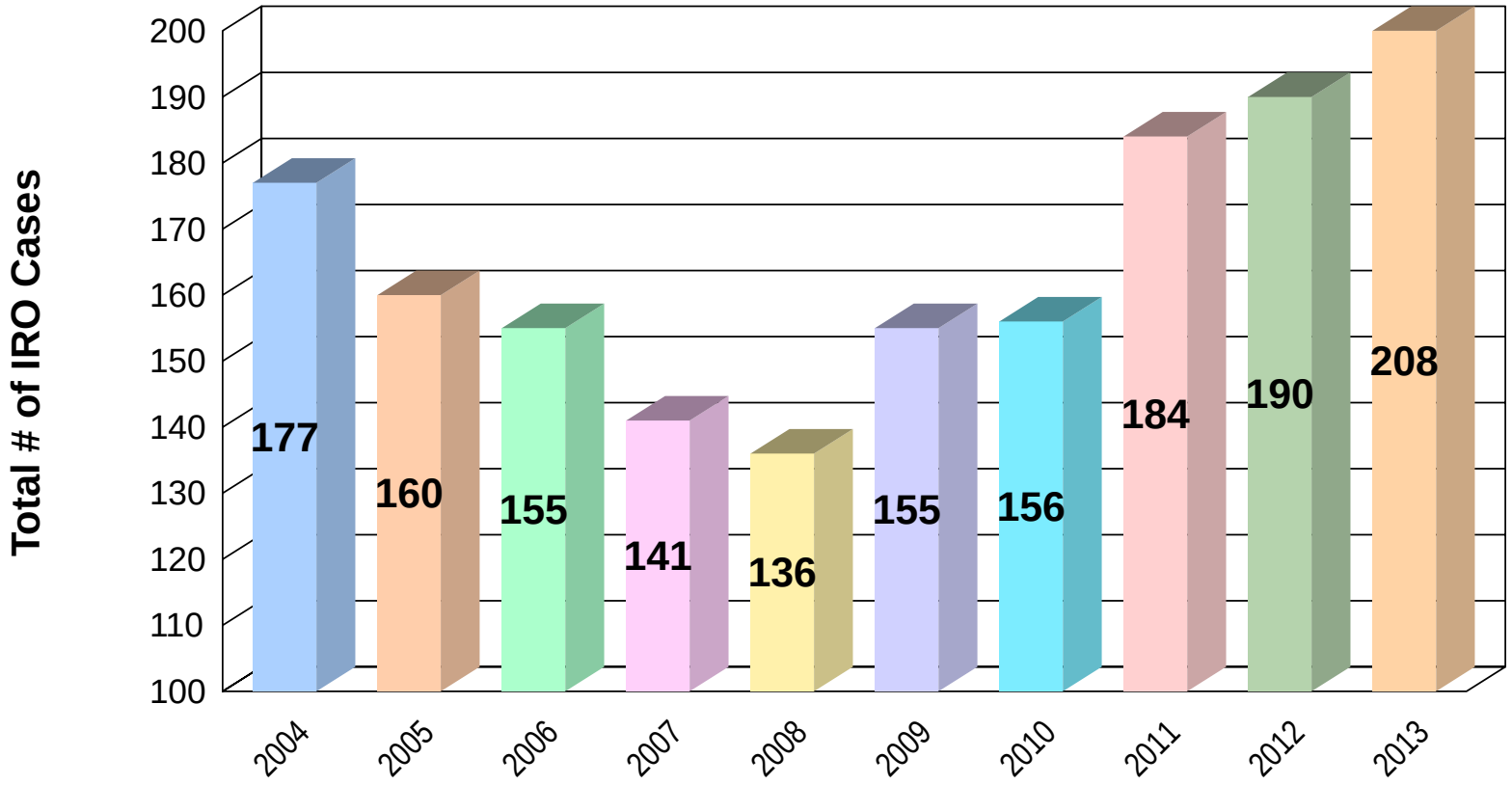
HEALTH CARRIER	ESTIMATED 5 YEAR PREMIUM	CASE VOLUME						BENEFIT DOLLARS REVIEWED							
	As Reported on ODI Annual Health Report	# Reviews	% of Total	# Affirmed		# Reversed		$ Reviewed	% of Total	$ Affirmed		$ Reversed		Maximum $ Affirmed	Maximum $ Reversed
		#	%	#	%	#	%	$	%	$	%	$	%		
MEDICAL BENEFITS MUTUAL LIFE INSURANCE COMPANY	$27,437,819	5	0%	5	100%	0	0%	$195,511	0%	$114,360	58%	$81,152	42%	$22,872	$16,230
GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	$7,395,882	10	0%	0	0%	10	100%	$18,740	0%	$0	0%	$18,740	100%	$0	$2,548
HEALTHAMERICA PENNSYLVANIA INC	$1,320,727	4	0%	0	0%	4	100%	$392,400	1%	$0	0%	$392,400	100%	$0	$98,100
TRUSTMARK INSURANCE COMPANY	$662,182	5	0%	5	100%	0	0%	$16,825	0%	$16,825	100%	$0	0%	$3,365	$0
INDEPENDENCE AMERICAN INSURANCE COMPANY	$605,173	5	0%	0	0%	5	100%	$251,670	0%	$251,670	100%	$0	0%	$50,334	$0
FIRST HEALTH LIFE & HEALTH INSURANCE COMPANY	$54,483	3	0%	0	0%	3	100%	$60,000	0%	$0	0%	$60,000	100%	$0	$20,000
AETNA HEALTH AND LIFE INSURANCE COMPANY*		20	0%	3	15%	17	85%	$351,580	0%	$124,091	35%	$227,489	65%	$50,000	$80,000
PUBLIC EMPLOYEE BENEFIT PLANS*		48	1%	19	40%	29	60%	$533,106	1%	$326,868	61%	$206,239	39%	$70,000	$56,000
Grand Totals:	**$36,517,448,300**	**4,158**		**1,286**	**31%**	**2,867**	**69%**	**$73,647,161**		**$53,614,583**	**73%**	**$20,032,578**	**27%**		

*Premium data unavailable.

ATTACHMENT 6

TOTAL NUMBER OF IRO CASES
BY REPORT YEAR

January 1, 2004 - December 31, 2013



ATTACHMENT 7
HEALTH CARRIER SUMMARY
JANUARY 1, 2013 - DECEMBER 31, 2013

HEALTH CARRIER	PREMIUM	CASE VOLUME						BENEFIT DOLLARS REVIEWED							
	As Reported on ODI Annual Health Report	# Reviews % of Total		# Affirmed		# Reversed		$ Reviewed % of Total		$ Affirmed		$ Reversed		Maximum $ Affirmed	Maximum $ Reversed
		#	%	#	%	#	%	$	%	$	%	$	%		
COMMUNITY INSURANCE COMPANY	$2,752,403,123	66	32%	40	61%	26	39%	$656,614	20%	$360,339	55%	$296,275	45%	$100,000	$100,000
MEDICAL MUTUAL OF OHIO	$2,196,036,756	43	21%	25	58%	18	42%	$1,556,699	47%	$1,390,565	89%	$166,134	11%	$850,000	$42,500
UNITEDHEALTHCARE INSURANCE COMPANY	$1,176,551,428	30	14%	23	77%	7	23%	$480,461	14%	$346,752	72%	$133,709	28%	$70,370	$93,000
KAISER FOUNDATION HEALTH PLAN OF OHIO	$273,318,741	3	1%	3	100%	0	0%	$50,400	2%	$50,400	100%	$0	0%	$50,000	$0
SUMMA INSURANCE COMPANY INC	$221,580,522	1	0%	1	100%	0	0%	$2,100	0%	$2,100	100%	$0	0%	$2,100	$0
AULTCARE INSURANCE COMPANY	$200,153,256	10	5%	9	90%	1	10%	$92,670	3%	$80,821	87%	$11,849	13%	$40,000	$8,849
HUMANA HEALTH PLAN OF OHIO INC	$186,012,738	5	2%	3	60%	2	40%	$9,919	0%	$6,100	62%	$3,819	38%	$6,000	$3,245
GOLDEN RULE INSURANCE COMPANY	$98,786,790	3	1%	3	100%	0	0%	$31,567	1%	$31,567	100%	$0	0%	$16,021	$0
COVENTRY HEALTH AND LIFE INSURANCE CO	$39,587,792	7	3%	4	57%	3	43%	$49,766	1%	$24,969	50%	$24,797	50%	$18,130	$24,000
CONNECTICUT GENERAL LIFE INSURANCE CO	$39,141,379	2	1%	1	50%	1	50%	$0	0%	$0	0%	$0	0%	$0	$0
TIME INSURANCE COMPANY	$38,243,808	1	0%	0	0%	1	100%	$19,500	1%	$0	0%	$19,500	100%	$0	$19,500
HUMANA INSURANCE COMPANY	$31,743,512	1	0%	0	0%	1	100%	$16,213	0%	$0	0%	$16,213	100%	$0	$16,213
TRUSTMARK INSURANCE COMPANY	$107,614	1	0%	1	100%	0	0%	$3,365	0%	$3,365	100%	$0	0%	$3,365	$0
SUMMACARE INC*		1	0%	1	100%	0	0%	$6,100	0%	$6,100	100%	$0	0%	$6,100	$0
AETNA HEALTH AND LIFE INSURANCE CO*		7	3%	3	43%	4	57%	$77,199	2%	$17,246	22%	$59,953	78%	$15,930	$40,933
PUBLIC EMPLOYEE BENEFIT PLAN		27	13%	17	63%	10	37%	$283,420	8%	$164,758	58%	$118,663	42%	$42,500	$56,000
Grand Totals:		**208**		**134**	**64%**	**74**	**36%**	**$3,335,993**		**$2,485,081**	**74%**	**$850,912**	**26%**		

*****No available premium data for carrier.

April 09, 2016

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