John R. Kasich, Governor

Mary Taylor, Lt. Governor/Director

The Annual Health Claims External Review Report For the Year 2015

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 15th annual report, summarizing the data the Ohio Department of Insurance has collected regarding external reviews conducted from January 1, 2015 through December 31, 2015.

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 2015, 362 cases, involving almost $4.4 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 forty-four percent of these cases, saving Ohio health insurance consumers approximately $2,074,000 or about 47% of the cost of all health care benefits and services reviewed.

Over half (54%) of the IRO reviews completed in 2015 were for health care services related to 5 medical specialties (gastroenterology, oncology, surgery, cardiovascular disease, and emergency medicine).

IRO reversals for hospitalization and drug therapy totaled approximately $1,386,000. Reversals for hospitalization totaled almost $744,000, while reversals for drug therapy totaled over $642,000. Together, these health care service categories accounted for approximately 67% 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 2015, 122 cases were submitted to ODI for contractual review. Seven of the 122 cases submitted to ODI for contractual review resulted in reversal of previously denied benefits, recovering over $46,000 in additional benefits for Ohio consumers.

Total Benefits to Consumers since Enactment

Since the 1999 enactment of Ohio's external review law, 5,847 cases have been reviewed by ODI and/or IROs, recovering over $18.6 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, 2015 to December 31, 2015, shows that IRO reviews involved benefit determinations amounting to almost $4.4 million. IRO decisions reversing adverse benefit determinations saved covered persons approximately $2,074,000. The total benefits recovered for the top 5 cases where Health Plan determinations were reversed was approximately $957,904.

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)
Hospitalization	**$414,453**
Surgery	**$157,554**
Drug	**$146,000**
Drug	**$120,000**
Hospitalization	**$119,897**

Number of IRO Reviews Conducted / Outcomes

For the reporting period of January 1, 2015 to December 31, 2015, 362 external review requests were assigned to IROs for review.

Standard reviews, permitting a 30-day maximum review period, were requested in 308 of the cases. The IROs reversed adverse benefit determinations in 130 standard reviews (42%) and affirmed the Health Plan's determination in the remaining 178 standard reviews (58%).

Fifty-four IRO cases were expedited, requiring a 72-hour maximum review period. In 29 of those cases (54%), 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 24 days. Ninety-two 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 2015, the total cost to Ohio Health Plans for IRO reviews was approximately $292,188. The average cost per standard review was about $763; while the average cost per expedited review was approximately $1,061. Expedited review costs accounted for $57,300 (20%) of total review costs.

Summary of Services and Procedures

In 2015, IRO external reviews spanned a wide variety of health service categories. The highest proportion of reviews were for testing (26%) and drug therapy (22%) followed by reviews for hospitalization (13%) and durable medical equipment (12%). These four service categories accounted for approximately 73% of the reviews conducted and $1,575,254 or about 76%, of the approximately $2,074,000 in benefit determinations reversed by IRO decisions. Together, review of surgery and emergency transport comprised another 21% of the reviews conducted and a corresponding 23% of the benefit determination amounts reversed. These 6 service categories represent approximately 94% of the 362 cases reviewed and over 99% of the total adverse benefit determination amounts that were reversed in 2015. ***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)
Gastroenterology	**57**	**$555,554**	**$357,471**
Oncology	**41**	**$470,540**	**$61,549**
Cardiovascular Disease	**38**	**$517,024**	**$131,917**
Surgery	**38**	**$396,595**	**$247,352**
Emergency Medicine	**23**	**$449,609**	**$141,304**

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, 2015 to December 31, 2015, 122 contractual external reviews were completed by ODI. As a result, Ohio consumers received $46,483 of previously denied health benefits.

Health Plan contractual adverse benefit determinations were upheld in 115 cases (94%) and reversed in 7 cases (6%).

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	86	$45,522
Denial to Issue Coverage	30	$666
Eligibility for Coverage	5	N/A
Emergency Services/Prudent Layperson Standard	1	$295

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 2015 was 43 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, 5,847 external reviews have been conducted, recovering over $18.6 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, 2015 - December 31, 2015

SERVICES & PROCEDURES	# CASES/ PERCENTAGE		TOTAL IRO REVIEW COST/ PERCENTAGE		TOTAL BENEFIT $'S REVIEWED/ PERCENTAGE		BENEFIT $'s REVERSED	BENEFIT $'s UPHELD
Testing	94	26.0%	$81,001	27.7%	$332,225	7.6%	$65,148	$267,077
Drug	81	22.4%	$64,845	22.2%	$1,082,115	24.7%	$642,310	$439,805
Hospitalization	46	12.7%	$32,973	11.3%	$1,224,011	27.9%	$743,702	$480,309
Durable Medical Equipment	43	11.9%	$36,691	12.6%	$566,386	12.9%	$124,094	$442,292
Surgery	39	10.8%	$36,231	12.4%	$314,530	7.2%	$214,662	$99,868
Emergency Transport	38	10.5%	$24,744	8.5%	$775,306	17.7%	$272,035	$503,270
Therapy	12	3.3%	$10,254	3.5%	$50,429	1.2%	$3,029	$47,400
Other	3	0.8%	$1,200	0.4%	$1,417	0.0%	$417	$1,000
Skilled Nursing/Hospice/Home Health	3	0.8%	$2,350	0.8%	$34,500	0.8%	$8,500	$26,000
Emergency Room	2	0.6%	$1,325	0.5%	$650	0.0%	$100	$550
Dental	1	0.3%	$575	0.2%	$2,500	0.1%	$0	$2,500
Grand Totals:	**362**		**$292,189**		**$4,384,069**		**$2,073,997**	**$2,310,071**

April 08, 2016

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

ATTACHMENT 3

IRO REVIEWS BY MEDICAL SPECIALTY
JANUARY 1, 2015 - DECEMBER 31, 2015

MEDICAL SPECIALTY	# OF REVIEWS	TOTAL IRO REVIEW COSTS	TOTAL BENEFIT $'s REVIEWED	BENEFIT $'s REVERSED	BENEFIT $'s UPHELD
Gastroenterology	57	$49,313	$555,554	$357,471	$198,083
Cardiovascular Disease	38	$28,699	$517,024	$131,917	$385,107
Emergency Medicine	23	$15,438	$449,609	$141,304	$308,306
Hematology/Oncology	19	$14,755	$262,197	$22,268	$239,929
Psychiatry	18	$11,887	$218,554	$30,295	$188,259
Internal Medicine	16	$13,546	$118,229	$12,665	$105,564
Neurology	14	$12,319	$307,321	$132,235	$175,086
Surgery, General	14	$10,068	$101,772	$49,201	$52,571
Orthopedics	13	$12,944	$168,720	$134,049	$34,671
Medical Oncology	11	$13,210	$151,087	$9,143	$141,944
Otolaryngology	11	$6,672	$38,120	$25,020	$13,100
Endocrinology	8	$7,039	$27,744	$17,894	$9,850
Neurologic Surgery	8	$9,560	$227,051	$176,985	$50,066
Pediatric Endocrinology	8	$7,670	$64,881	$21,381	$43,500
Physical Medicine/Rehabilitation	8	$5,790	$67,561	$8,500	$59,061
Family Medicine	7	$5,875	$448,183	$447,633	$550
Ob/Gyn	7	$4,749	$13,596	$551	$13,045
Radiation Oncology	7	$7,625	$23,506	$19,138	$4,368
Pain Management	6	$4,250	$2,720	$1,520	$1,200
Plastic Surgery	6	$3,124	$18,325	$11,568	$6,757

ATTACHMENT 3

IRO REVIEWS BY MEDICAL SPECIALTY
JANUARY 1, 2015 - DECEMBER 31, 2015

MEDICAL SPECIALTY	# OF REVIEWS	TOTAL IRO REVIEW COSTS	TOTAL BENEFIT $'s REVIEWED	BENEFIT $'s REVERSED	BENEFIT $'s UPHELD
Dermatology	5	$6,330	$21,801	$1,001	$20,800
Pulmonary Medicine	5	$3,895	$147,600	$146,500	$1,100
Ob/Gyn Oncology	4	$2,041	$33,750	$11,000	$22,750
Opthamology	4	$3,115	$17,559	$17,559	$0
Oral & Maxillofacial Surgery	4	$2,720	$28,349	$5,000	$23,349
Pediatric Gastroenterology	4	$3,500	$7,600	$5,000	$2,600
Addiction Psychiatry	3	$2,400	$54,623	$14,494	$40,129
Pediatrics, General	3	$1,695	$6,272	$0	$6,272
Vascular Surgery	3	$2,100	$4,598	$4,598	$0
Anesthesiology	2	$1,475	$5,500	$5,500	$0
Chiropractic	2	$1,445	$287	$232	$55
Pediatric Critical Care	2	$1,145	$31,041	$0	$31,041
Pediatric Physical Medicine	2	$1,450	$7,876	$0	$7,876
Rheumatology	2	$1,575	$2,200	$1,000	$1,200
Sleep Studies	2	$1,531	$3,089	$0	$3,089
Surgery, Gastric	2	$1,445	$1,500	$0	$1,500
Urology	2	$1,375	$12,668	$11,124	$1,544
Colon & Rectal Surgery	1	$900	$15,000	$0	$15,000
Critical Care Medicine	1	$354	$34,796	$0	$34,796
Dentistry	1	$800	$500	$0	$500

ATTACHMENT 3

IRO REVIEWS BY MEDICAL SPECIALTY
JANUARY 1, 2015 - DECEMBER 31, 2015

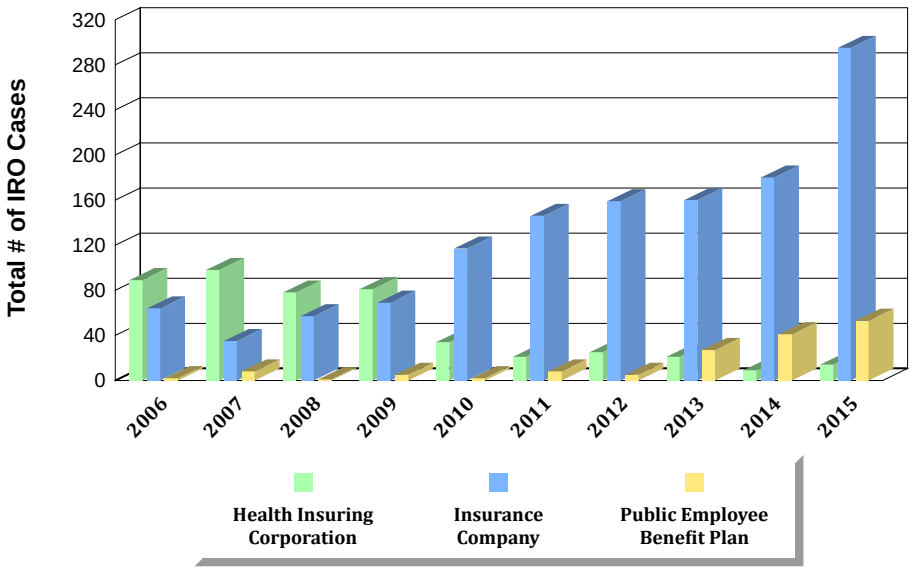
MEDICAL SPECIALTY	# OF REVIEWS	TOTAL IRO REVIEW COSTS	TOTAL BENEFIT $'s REVIEWED	BENEFIT $'s REVERSED	BENEFIT $'s UPHELD
Durable Medical Equipment	1	$800	$76,000	$11,000	$65,000
General Medicine	1	$800	$34,850	$34,850	$0
Hepatology	1	$625	$500	$500	$0
Molecular Genetics	1	$531	$455	$0	$455
Pediatric Cardiology	1	$900	$3,000	$3,000	$0
Pediatric Pulmonology	1	$900	$5,000	$5,000	$0
Psychology	1	$715	$33,340	$33,340	$0
Pulmonary Critical Care	1	$575	$12,461	$12,461	$0
Speech Pathology	1	$519	$100	$100	$0
Grand Totals:	362	$292,189	$4,384,069	$2,073,997	$2,310,071

ATTACHMENT 4

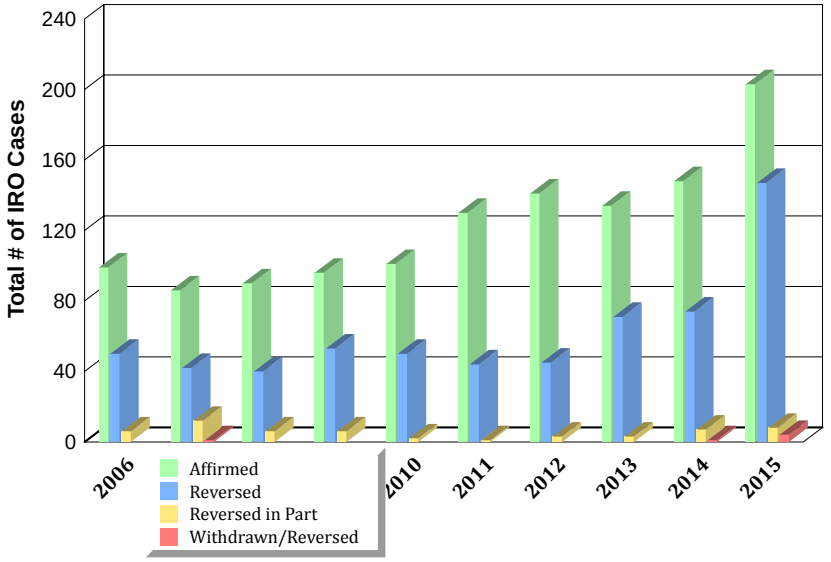
10 YEAR COMPARISON OF IRO CASES BY REPORT YEAR

January 1, 2006 - December 31, 2015

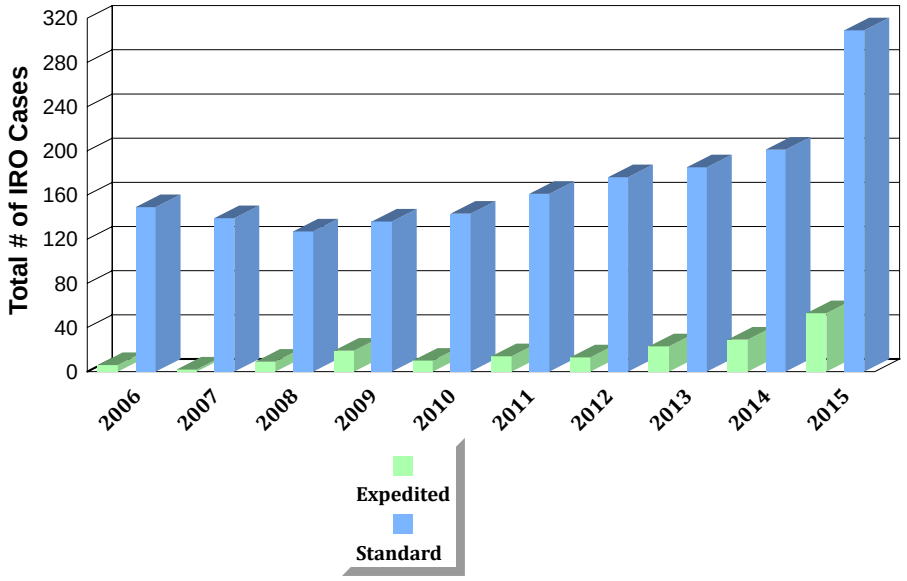
TYPE OF HEALTH CARRIER



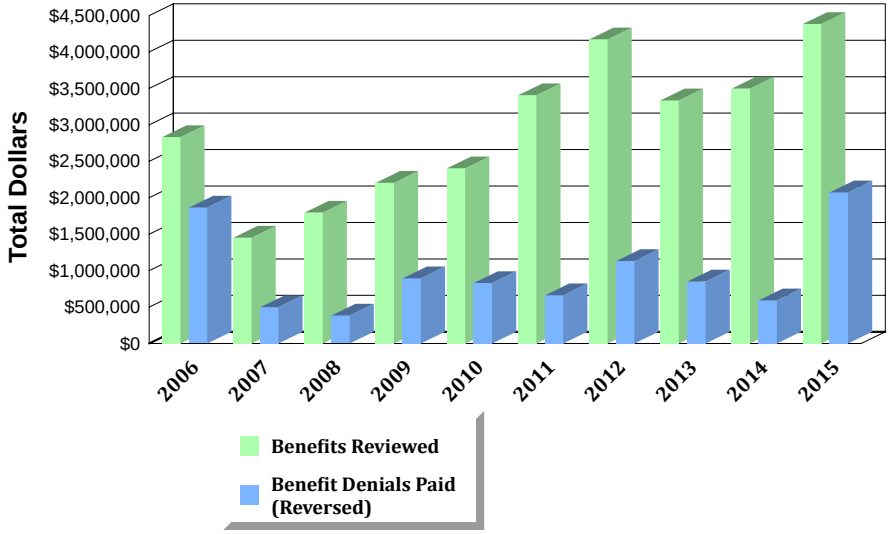
IRO OUTCOME DECISIONS



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, 2011 - DECEMBER 31, 2015

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	$13,792,367,025	2,205	44%	1,105	50%	1,100	50%	$18,742,779	23%	$12,860,490	69%	$5,882,289	31%	$200,000	$100,000
MEDICAL MUTUAL OF OHIO	$11,848,275,945	1,135	22%	605	53%	530	47%	$33,616,523	42%	$27,731,043	82%	$5,885,480	18%	$850,000	$242,750
UNITEDHEALTHCARE INSURANCE COMPANY	$4,464,450,241	632	12%	320	51%	312	49%	$13,187,907	17%	$10,907,349	83%	$2,280,558	17%	$1,571,739	$94,689
HEALTHSPAN INTEGRATED CARE	$1,365,067,451	95	2%	35	37%	60	63%	$1,129,525	1%	$930,765	82%	$198,760	18%	$50,000	$15,000
AETNA LIFE INSURANCE COMPANY	$1,174,897,218	45	1%	25	56%	20	44%	$124,425	0%	$103,500	83%	$20,925	17%	$20,000	$2,185
SUMMA INSURANCE COMPANY INC	$1,054,484,202	50	1%	50	100%	0	0%	$340,255	0%	$340,255	100%	$0	0%	$20,617	$0
AULTCARE INSURANCE COMPANY	$1,030,409,424	170	3%	135	79%	35	21%	$2,230,079	3%	$1,382,813	62%	$847,266	38%	$50,000	$157,554
HUMANA HEALTH PLAN OF OHIO INC	$966,387,089	125	2%	60	48%	65	52%	$1,709,826	2%	$1,133,062	66%	$576,764	34%	$130,000	$66,781
AETNA HEALTH INC (PA)	$965,928,661	10	0%	5	50%	5	50%	$2,500	0%	$0	0%	$2,500	100%	$0	$500
GOLDEN RULE INSURANCE COMPANY	$445,481,121	105	2%	80	76%	25	24%	$2,044,042	3%	$1,490,395	73%	$553,647	27%	$173,878	$76,945
PARAMOUNT CARE, INC	$332,247,568	3	0%	0	0%	3	100%	$88,200	0%	$88,200	100%	$0	0%	$29,400	$0
HEALTH PLAN OF UPPER OH VALLEY INC	$297,285,256	10	0%	5	50%	5	50%	$455,000	1%	$135,000	30%	$320,000	70%	$27,000	$64,000
CARESOURCE	$288,973,696	12	0%	6	50%	6	50%	$4,245	0%	$3,000	71%	$1,245	29%	$1,000	$215
COVENTRY HEALTH AND LIFE INSURANCE COMPANY	$215,891,272	140	3%	75	54%	65	46%	$1,139,519	1%	$512,737	45%	$626,781	55%	$40,000	$41,808
CONNECTICUT GENERAL LIFE INSURANCE COMPANY	$189,727,974	45	1%	25	56%	20	44%	$348,259	0%	$155,374	45%	$192,885	55%	$14,459	$36,000
HUMANA INSURANCE COMPANY	$176,024,734	25	0%	15	60%	10	40%	$183,567	0%	$95,000	52%	$88,567	48%	$15,000	$16,213
TIME INSURANCE COMPANY	$151,244,631	16	0%	8	50%	8	50%	$472,000	1%	$30,000	6%	$442,000	94%	$5,000	$86,000
COORDINATED HEALTH MUTUAL INC	$117,971,317	14	0%	4	29%	10	71%	$253,705	0%	$11,375	4%	$242,329	96%	$3,773	$120,000
FEDERATED MUTUAL INSURANCE COMPANY	$93,512,656	20	0%	10	50%	10	50%	$214,260	0%	$179,781	84%	$34,480	16%	$34,077	$6,896
HEALTHSPAN INC	$63,046,099	2	0%	2	100%	0	0%	$910	0%	$910	100%	$0	0%	$455	$0
TRUSTMARK LIFE INSURANCE COMPANY	$54,644,597	5	0%	5	100%	0	0%	$3,036	0%	$3,036	100%	$0	0%	$607	$0
NIPPON LIFE INSURANCE COMPANY OF AMERICA	$50,484,876	5	0%	5	100%	0	0%	$12,500	0%	$12,500	100%	$0	0%	$2,500	$0
MEDICAL BENEFITS MUTUAL LIFE INSURANCE COMPANY	$24,585,692	5	0%	5	100%	0	0%	$195,511	0%	$114,360	58%	$81,152	42%	$22,872	$16,230

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Ohio Department of Insurance
Office of Product Regulation & Actuarial Services
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ATTACHMENT 5
FIVE YEAR HEALTH CARRIER SUMMARY
JANUARY 1, 2011 - DECEMBER 31, 2015

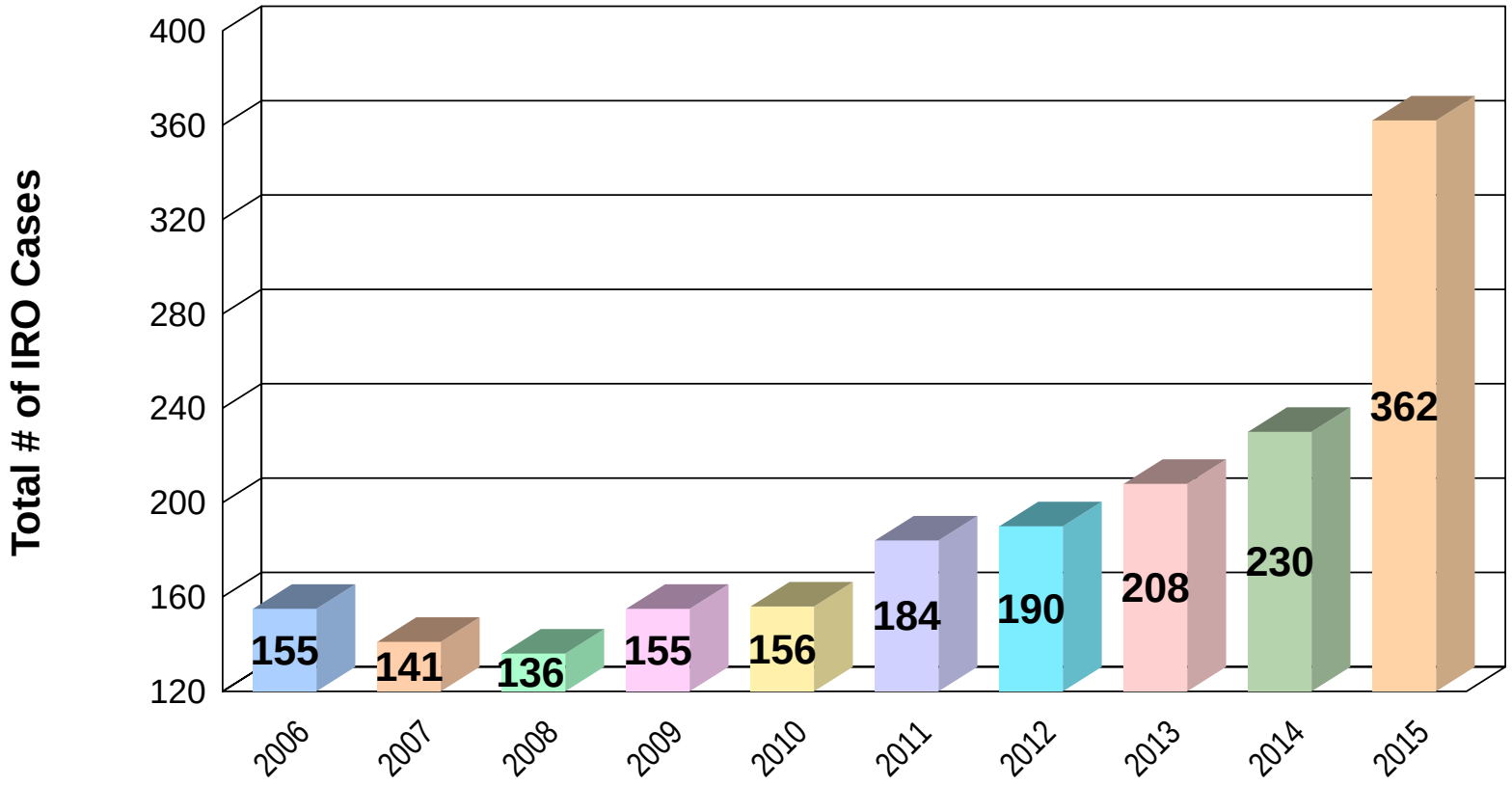
HEALTH CARRIER	ESTIMATED 5 YEAR PREMIUM	CASE VOLUME						BENEFIT DOLLARS REVIEWED							
	As Reported on ODI Annual Health Report	# Reviews % of Total		# Affirmed		# Reversed		$ Reviewed % of Total		$ Affirmed		$ Reversed		Maximum $ Affirmed	Maximum $ Reversed
		#	%	#	%	#	%	$	%	$	%	$	%		
PRINCIPAL LIFE INSURANCE COMPANY	$18,983,374	20	0%	0	0%	20	100%	$585,372	1%	$167,112	29%	$418,260	71%	$36,347	$63,760
AETNA HEALTH INSURANCE COMPANY	$13,499,469	5	0%	0	0%	5	100%	$14,630	0%	$0	0%	$14,630	100%	$0	$2,926
STANDARD SECURITY LIFE INSURANCE CO OF NEW YORK	$8,817,304	10	0%	5	50%	5	50%	$33,754	0%	$2,750	8%	$31,004	92%	$550	$6,201
SUMMACARE INC	$2,126,954	4	0%	2	50%	2	50%	$13,000	0%	$12,200	94%	$800	6%	$6,100	$400
TRUSTMARK INSURANCE COMPANY	$475,118	5	0%	5	100%	0	0%	$16,825	0%	$16,825	100%	$0	0%	$3,365	$0
AETNA HEALTH AND LIFE INSURANCE COMPANY*	$0	15	0%	8	53%	7	47%	$129,299	0%	$25,346	20%	$103,953	80%	$15,930	$40,933
PUBLIC EMPLOYEE BENEFIT PLANS*		134	3%	79	59%	55	41%	$2,538,953	3%	$1,284,962	51%	$1,253,991	49%	$550,000	$414,453
Grand Totals:	**$39,207,290,964**	**5,067**		**2,684**	**53%**	**2,383**	**47%**	**$79,830,407**		**$59,730,141**	**75%**	**$20,100,265**	**25%**		

*Premium data unavailable.

ATTACHMENT 6

TOTAL NUMBER OF IRO CASES
BY REPORT YEAR

January 1, 2006 - December 31, 2015



ATTACHMENT 7
HEALTH CARRIER SUMMARY
JANUARY 1, 2015 - DECEMBER 31, 2015

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	$2,541,575,948	146	40%	74	51%	72	49%	$767,641	18%	$462,883	60%	$304,758	40%	$86,959	$32,000
MEDICAL MUTUAL OF OHIO	$1,978,706,042	66	18%	44	67%	22	33%	$1,404,084	32%	$1,110,259	79%	$293,825	21%	$126,000	$96,957
AETNA LIFE INSURANCE COMPANY	$373,439,092	5	1%	3	60%	2	40%	$3,185	0%	$0	0%	$3,185	.00%	$0	$2,185
AULTCARE INSURANCE COMPANY	$230,696,372	5	1%	4	80%	1	20%	$233,243	5%	$75,689	32%	$157,554	68%	$36,000	$157,554
SUMMA INSURANCE COMPANY INC	$215,785,554	5	1%	5	100%	0	0%	$48,216	1%	$48,216	100%	$0	0%	$20,617	$0
HUMANA HEALTH PLAN OF OHIO INC	$213,378,260	6	2%	3	50%	3	50%	$11,396	0%	$7,612	67%	$3,784	33%	$5,112	$3,552
HEALTHSPAN INTEGRATED CARE	$196,990,403	2	1%	0	0%	2	100%	$5,544	0%	$0	0%	$5,544	.00%	$0	$5,000
AETNA HEALTH INC (PA)	$172,367,305	1	0%	1	100%	0	0%	$0	0%	$0	0%	$0	0%	$0	$0
CARESOURCE	$141,712,032	4	1%	2	50%	2	50%	$1,415	0%	$1,000	71%	$415	29%	$1,000	$215
COORDINATED HEALTH MUTUAL INC	$102,325,155	5	1%	1	20%	4	80%	$122,839	3%	$1,914	2%	$120,925	98%	$1,089	$120,000
GOLDEN RULE INSURANCE COMPANY	$80,625,132	2	1%	1	50%	1	50%	$16,934	0%	$16,934	100%	$0	0%	$16,934	$0
HEALTH PLAN OF UPPER OH VALLEY INC	$53,376,969	1	0%	1	100%	0	0%	$27,000	1%	$27,000	100%	$0	0%	$27,000	$0
HEALTHSPAN INC	$42,947,883	1	0%	1	100%	0	0%	$455	0%	$455	100%	$0	0%	$455	$0
HUMANA INSURANCE COMPANY	$39,619,191	3	1%	3	100%	0	0%	$19,000	0%	$19,000	100%	$0	0%	$15,000	$0
FEDERATED MUTUAL INSURANCE COMPANY	$20,269,447	2	1%	2	100%	0	0%	$1,879	0%	$1,879	100%	$0	0%	$1,047	$0
CONNECTICUT GENERAL LIFE INSURANCE CO	$2,582,071	3	1%	1	33%	2	67%	$50,776	1%	$14,459	28%	$36,317	72%	$14,459	$36,000
AETNA HEALTH INSURANCE COMPANY	$2,310,396	1	0%	0	0%	1	100%	$2,926	0%	$0	0%	$2,926	.00%	$0	$2,926
STANDARD SECURITY LIFE INSURANCE CO OF NEW	$609,618	2	1%	1	50%	1	50%	$6,751	0%	$550	8%	$6,201	92%	$550	$6,201
UNITEDHEALTHCARE INSURANCE COMPANY*		42	12%	19	45%	23	55%	$347,398	8%	$164,651	47%	$182,747	53%	$62,913	$94,689

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ATTACHMENT 7
HEALTH CARRIER SUMMARY
JANUARY 1, 2015 - DECEMBER 31, 2015

HEALTH CARRIER	PREMIUM: As Reported on ODI Annual Health Report	CASE VOLUME: # Reviews		# Affirmed		# Reversed		BENEFIT DOLLARS REVIEWED: $ Reviewed		$ Affirmed		$ Reversed		Maximum $ Affirmed	Maximum $ Reversed
		#	% of Total	#	%	#	%	$	% of Total	$	%	$	%		
AETNA HEALTH AND LIFE INSURANCE COMPANY*		5	1%	4	80%	1	20%	$4,900	0%	$900	18%	$4,000	82%	$500	$4,000
TIME INSURANCE COMPANY*		2	1%	2	100%	0	0%	$12,500	0%	$7,500	60%	$5,000	40%	$5,000	$5,000
PUBLIC EMPLOYEE BENEFIT PLAN		53	15%	31	58%	22	42%	$1,295,988	30%	$349,170	27%	$946,818	73%	$126,000	$414,453
Grand Totals:		**362**		**203**	**56%**	**159**	**44%**	**$4,384,069**		**$2,310,071**	**53%**	**$2,073,997**	**47%**		

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

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