John R. Kasich, Governor

Mary Taylor, Lt. Governor/Director

The Annual Health Claims External Review Report For the Year 2012

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 12th annual report, summarizing the data the Ohio Department of Insurance has collected regarding external reviews conducted from January 1, 2012 through December 31, 2012.

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 2012, 190 cases, involving over $4.1 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 twenty-five percent of these cases, saving Ohio health insurance consumers approximately $1,132,000 or about 28% of the cost of all health care benefits and services reviewed.

About 82% of the IRO reviews completed in 2012 were for health care services related to the medical specialties of psychiatry, oncology, and cardiovascular disease.

IRO reversals for drug therapies and surgery totaled over $788,000. Reversals for hospitalization totaled about $183,000. Together, these health care service categories accounted for approximately 86% 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 2012, 84 cases were submitted to ODI for contractual review. Four of the 84 cases submitted to ODI for contractual review resulted in reversal of previously denied benefits, recovering over $128,000 in additional benefits for Ohio consumers.

Total Benefits to Consumers since Enactment

Since the 1999 enactment of Ohio's external review law, 4,673 cases have been reviewed by ODI and/or IROs, recovering over $15.1 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, 2012 to December 31, 2012, shows that IRO reviews involved benefit determinations amounting to approximately $4.1 million. IRO decisions reversing adverse benefit determinations saved covered persons over $1,132,000. The total benefits recovered for the top 5 cases where Health Plan determinations were reversed exceeded $330,000.

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	**$240,000**
Organ Transplant	**$230,000**
Drug Therapy	**$100,000**
Durable Medical Equipment	**$64,000**
Inpatient Rehabilitation	**$49,000**

Number of IRO Reviews Conducted / Outcomes

For the reporting period of January 1, 2012 to December 31, 2012, 190 external review requests were assigned to IROs for review.

Standard reviews, permitting a 30-day maximum review period, were requested in 176 of the cases. The IROs reversed adverse benefit determinations in 41 standard reviews (23%) and affirmed the Health Plan's determination in the remaining 135 standard reviews (77%).

Fourteen IRO cases were expedited, requiring a 72-hour maximum review period. In 7 of those cases (50%), 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 27 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 2012, the total cost to Ohio Health Plans for IRO reviews was approximately $147,000. The average cost per standard review was about $777; while the average cost per expedited review was approximately $1,139. Expedited review costs accounted for $15,940 (11%) of total review costs.

Summary of Services and Procedures

In 2012, IRO external reviews spanned a wide variety of health service categories. The highest proportion of reviews was for testing (22%) followed by reviews for hospitalization (18%). Reversal of adverse benefit determinations in these two service categories accounted for approximately $200,000 or nearly 19%, of the over $1,132,000 in benefit determinations reversed by IRO decisions. Together, review of drug therapies, surgery, and durable medical equipment comprised another 42% of the reviews conducted and a corresponding 78% of the benefit determination amounts reversed. These 5 service categories represent approximately 82% of the 190 cases reviewed and about 96% of the total adverse benefit determination amounts that were reversed in 2012. ***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)	**36**	**$1,964,940**	**$142,310**
Oncology Specialties	**25**	**$634,530**	**$552,750**
Cardiovascular & Vascular Medicine	**21**	**$134,625**	**$50,390**
Orthopedics	**10**	**$293,392**	**$57,414**
Neurology	**10**	**$93,791**	**$6,896**

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, 2012 to December 31, 2012, 84 contractual external reviews were completed by ODI. As a result, Ohio consumers received $128,000 of previously denied health benefits.

Health Plan contractual adverse benefit determinations were upheld in 80 cases (95%) and reversed in 4 cases (5%).

Contractual Reasons for Review

Based on the number of reviews, the top five categories for contractual reviews performed by ODI during this reporting period were:

REVIEW CATEGORY	TOTAL NUMBER OF REVIEWS	TOTAL BENEFIT $'s PAID (Reversed)
Service Not Covered-Non-medical Judgment	36	$123,033
Eligibility for Coverage	20	N/A
Denial to Issue Coverage	24	N/A
Emergency Services/Prudent Layperson Standard	2	$270
Denial of External Review Request	1	$4,796

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 2012 was 38 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, 4,673 external reviews have been conducted, recovering over $15.1 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, Legislative Liaison; (614) 644-2475

Media Inquiries:

- Chris Brock, Director of Communications (614) 728-1539

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, 2012 - December 31, 2012

SERVICES & PROCEDURES	# CASES/ PERCENTAGE		IRO COST/ PERCENTAGE		BENEFIT $'s REVIEWED/ PERCENTAGE		BENEFIT $'s REVERSED	BENEFIT $'s AFFIRMED
Testing	40	21.9%	$33,878	23.4%	$139,290	3.4%	$17,419	$121,870
Hospitalization	33	18.0%	$24,235	16.8%	$2,127,980	51.3%	$182,866	$1,945,114
Drug	30	16.4%	$29,234	20.2%	$866,359	20.9%	$491,046	$375,312
Surgery	24	13.1%	$17,228	11.9%	$481,177	11.6%	$297,280	$183,897
Durable Medical Equipment	23	12.6%	$18,261	12.6%	$380,431	9.2%	$89,700	$290,731
Therapy	12	6.6%	$7,304	5.1%	$34,675	0.8%	$19,850	$14,825
Emergency Room	10	5.5%	$6,695	4.6%	$18,445	0.4%	$11,272	$7,172
Other	8	4.4%	$5,645	3.9%	$79,688	1.9%	$6,875	$72,813
Skilled Nursing/Hospice/Home Health	2	1.1%	$1,358	0.9%	$17,257	0.4%	$7,920	$9,337
Dental	1	0.5%	$675	0.5%	$3,000	0.1%	$0	$3,000
Grand Totals:	183		$144,511		$4,148,301		$1,124,229	$3,024,072

*Data indicating type of service was not provided by 7 of the 190 cases reviewed in 2012.

ATTACHMENT 3

IRO REVIEWS BY MEDICAL SPECIALTY
JANUARY 1, 2012 - DECEMBER 31, 2012

MEDICAL SPECIALTY	# OF REVIEWS	IRO COSTS	BENEFIT $'s REVIEWED	BENEFIT $'s REVERSED	BENEFIT $'s AFFIRMED
Psychiatry	22	$15,767	$239,554	$78,449	$161,106
Cardiovascular Disease	15	$10,160	$83,046	$23,190	$59,856
Addiction Psychiatry	13	$9,225	$1,712,171	$50,646	$1,661,525
Hematology/Oncology	12	$11,140	$102,080	$64,000	$38,080
Orthopedics	10	$8,654	$293,392	$57,414	$235,978
Emergency Medicine	9	$5,435	$16,650	$10,688	$5,962
Chiropractic	8	$4,329	$7,540	$50	$7,490
Internal Medicine	8	$5,823	$51,447	$32,091	$19,356
Neurology	8	$4,231	$76,791	$6,896	$69,895
Ob/Gyn Oncology	8	$11,622	$46,900	$14,000	$32,900
Medical Oncology	5	$3,670	$485,550	$474,750	$10,800
Pediatric Endocrinology	5	$3,589	$125,485	$42,000	$83,485
Physical Medicine/Rehabili	5	$3,900	$47,515	$17,800	$29,715
Gastroenterology	4	$3,075	$15,041	$2,000	$13,041
Ob/Gyn	4	$1,765	$56,629	$0	$56,629
Oral & Maxillofacial Surger	4	$2,845	$44,880	$980	$43,900
Pain Management	4	$3,225	$75,384	$8,384	$67,000
Dermatology	3	$2,522	$18,626	$450	$18,176
Opthamology	3	$4,124	$180,618	$6,740	$173,878
Plastic Surgery	3	$2,500	$22,489	$0	$22,489

ATTACHMENT 3
IRO REVIEWS BY MEDICAL SPECIALTY
JANUARY 1, 2012 - DECEMBER 31, 2012

MEDICAL SPECIALTY	# OF REVIEWS	IRO COSTS	BENEFIT $'s REVIEWED	BENEFIT $'s REVERSED	BENEFIT $'s AFFIRMED
Pulmonary Medicine	3	$2,240	$36,529	$0	$36,529
Surgery, General	3	$2,270	$39,579	$11,579	$28,000
Cardiothoracic Surgery	2	$3,025	$44,612	$21,740	$22,872
Endocrinology	2	$1,325	$87,144	$42,096	$45,048
Family Medicine	2	$1,500	$7,205	$0	$7,205
Neurologic Surgery	2	$1,396	$17,000	$0	$17,000
Pediatric Cardiology	2	$1,465	$6,060	$5,460	$600
Pediatric Rheumatology	2	$1,645	$12,042	$12,042	$0
Pediatrics, General	2	$1,400	$100,000	$100,000	$0
Rheumatology	2	$1,225	$3,521	$3,000	$521
Speech Pathology	2	$1,150	$2,535	$0	$2,535
Vascular Surgery	2	$1,375	$907	$0	$907
Addiction Psychology	1	$775	$13,215	$13,215	$0
Allergy/Immunology	1	$1,025	$15	$0	$15
Critical Care Medicine	1	$700	$8,450	$0	$8,450
Dentistry	1	$775	$1,335	$1,335	$0
Durable Medical Equipmen	1	$800	$2,000	$0	$2,000
Hematology	1	$575	$10,000	$10,000	$0
Infectious Disease	1	$575	$22,780	$0	$22,780
Otolaryngology	1	$650	$28,297	$0	$28,297

ATTACHMENT 3

IRO REVIEWS BY MEDICAL SPECIALTY
JANUARY 1, 2012 - DECEMBER 31, 2012

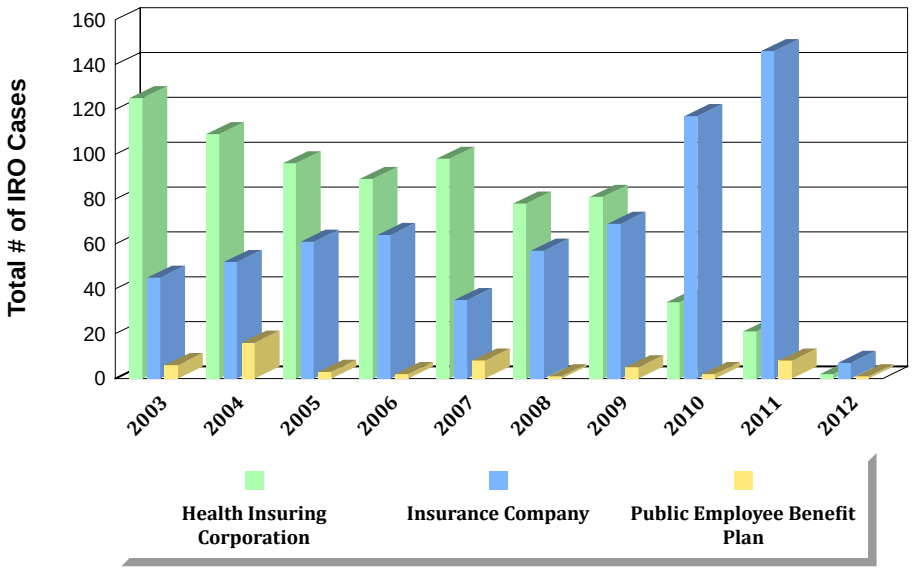
MEDICAL SPECIALTY	# OF REVIEWS	IRO COSTS	BENEFIT $'s REVIEWED	BENEFIT $'s REVERSED	BENEFIT $'s AFFIRMED
Pediatric Physical Medicin	1	$2,195	$8,064	$0	$8,064
Surgery, Gastric	1	$775	$21,000	$21,000	$0
Urology	1	$750	$244	$244	$0
Grand Totals:	190	$147,211	$4,174,323	$1,132,238	$3,042,085

ATTACHMENT 4

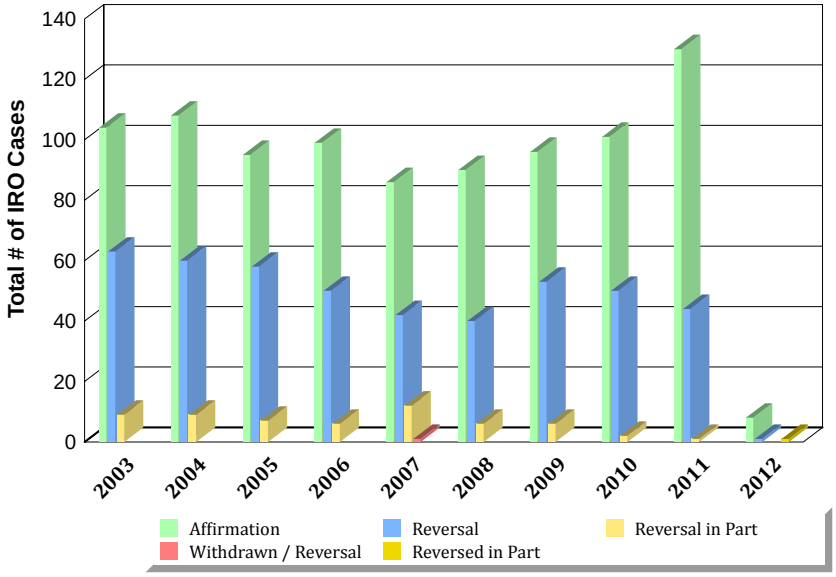
10 YEAR COMPARISON OF IRO CASES BY REPORT YEAR

January 1, 2002 - December 31, 2011

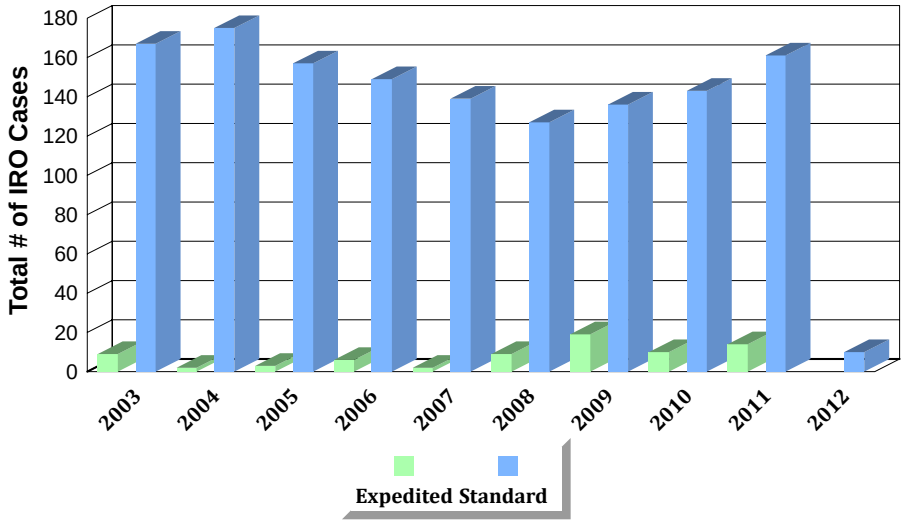
TYPE OF HEALTH CARRIER



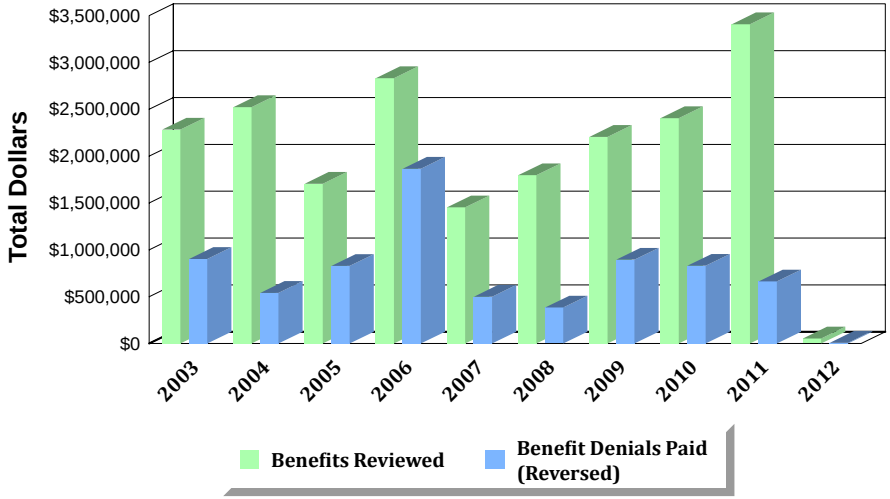
IRO OUTCOME DECISIONS



IRO REVIEW TYPE



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



December 12, 2014

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

ATTACHMENT 5
FIVE YEAR HEALTH CARRIER SUMMARY
JANUARY 1, 2008 - DECEMBER 31, 2012

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	$14,522,850,188	250	30%	54	22%	196	78%	$4,302,345	31%	$3,055,526	71%	$1,246,819	29%	$200,000	$165,000
MEDICAL MUTUAL OF OHIO	$9,452,412,574	210	26%	25	12%	185	88%	$3,042,321	22%	$2,199,902	72%	$842,419	28%	$250,000	$242,750
UNITEDHEALTHCARE INSURANCE COMPANY	$4,637,915,148	84	10%	25	30%	59	70%	$2,607,589	18%	$2,117,242	81%	$490,346	19%	$1,571,739	$103,000
KAISER FOUNDATION HEALTH PLAN OF OHIO	$1,864,044,906	23	3%	3	13%	20	87%	$180,896	1%	$140,167	77%	$40,729	23%	$42,000	$15,000
UNITED HEALTHCARE INSURANCE COMPANY OF OHIO	$1,319,353,617	1	0%	0	0%	1	100%	$2,600	0%	$2,600	100%	$0	0%	$2,600	$0
AULTCARE INSURANCE COMPANY	$999,850,122	44	5%	11	25%	33	75%	$500,810	4%	$390,016	78%	$110,794	22%	$50,000	$51,484
HUMANA HEALTH PLAN OF OHIO INC	$967,788,919	34	4%	2	6%	32	94%	$311,151	2%	$260,877	84%	$50,274	16%	$130,000	$16,371
SUMMA INSURANCE COMPANY INC	$815,287,590	2	0%	2	100%	0	0%	$2,535	0%	$2,535	100%	$0	0%	$2,500	$0
Paramount Care, Inc.	$740,412,744	2	0%	0	0%	2	100%	$67,400	0%	$67,400	100%	$0	0%	$38,000	$0
GOLDEN RULE INSURANCE COMPANY	$359,472,792	11	1%	4	36%	7	64%	$503,235	4%	$262,099	52%	$241,136	48%	$173,878	$215,000
HEALTH PLAN OF UPPER OH VALLEY INC	$336,857,991	4	0%	0	0%	4	100%	$194,633	1%	$130,633	67%	$64,000	33%	$99,999	$64,000
CONNECTICUT GENERAL LIFE INSURANCE COMPANY	$330,618,793	2	0%	1	50%	1	50%	$5,247	0%	$0	0%	$5,247	100%	$0	$5,247
HUMANA INSURANCE COMPANY	$314,513,443	15	2%	0	0%	15	100%	$51,427	0%	$45,527	89%	$5,900	11%	$30,000	$1,500
TIME INSURANCE COMPANY	$155,474,060	7	1%	0	0%	7	100%	$118,221	1%	$11,292	10%	$106,929	90%	$9,042	$86,000
UNITED HEALTHCARE OF OHIO INC	$148,948,760	8	1%	0	0%	8	100%	$208,210	1%	$144,441	69%	$63,769	31%	$123,298	$33,364
PRINCIPAL LIFE INSURANCE COMPANY	$131,136,263	11	1%	0	0%	11	100%	$176,364	1%	$59,375	34%	$116,989	66%	$36,347	$63,760
COVENTRY HEALTH AND LIFE INSURANCE COMPANY	$122,805,119	35	4%	10	29%	25	71%	$340,483	2%	$237,063	70%	$103,420	30%	$150,000	$40,000
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	$121,807,622	9	1%	0	0%	9	100%	$290,713	2%	$268,856	92%	$21,857	8%	$93,421	$17,084
JOHN ALDEN LIFE INSURANCE COMPANY	$88,978,114	5	1%	0	0%	5	100%	$8,132	0%	$5,397	66%	$2,735	34%	$2,885	$2,735
FEDERATED MUTUAL INSURANCE COMPANY	$87,731,836	2	0%	0	0%	2	100%	$40,973	0%	$34,077	83%	$6,896	17%	$34,077	$6,896
SUMMACARE INC	$87,233,444	7	1%	0	0%	7	100%	$27,425	0%	$25,000	91%	$2,425	9%	$10,000	$2,025
MEGA LIFE AND HEALTH INSURANCE COMPANY, THE	$36,984,787	2	0%	0	0%	2	100%	$63,314	0%	$57,000	90%	$6,314	10%	$57,000	$6,314
TRUSTMARK LIFE INSURANCE COMPANY	$35,325,993	1	0%	1	100%	0	0%	$607	0%	$607	100%	$0	0%	$607	$0

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Ohio Department of Insurance
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ATTACHMENT 5
FIVE YEAR HEALTH CARRIER SUMMARY
JANUARY 1, 2008 - DECEMBER 31, 2012

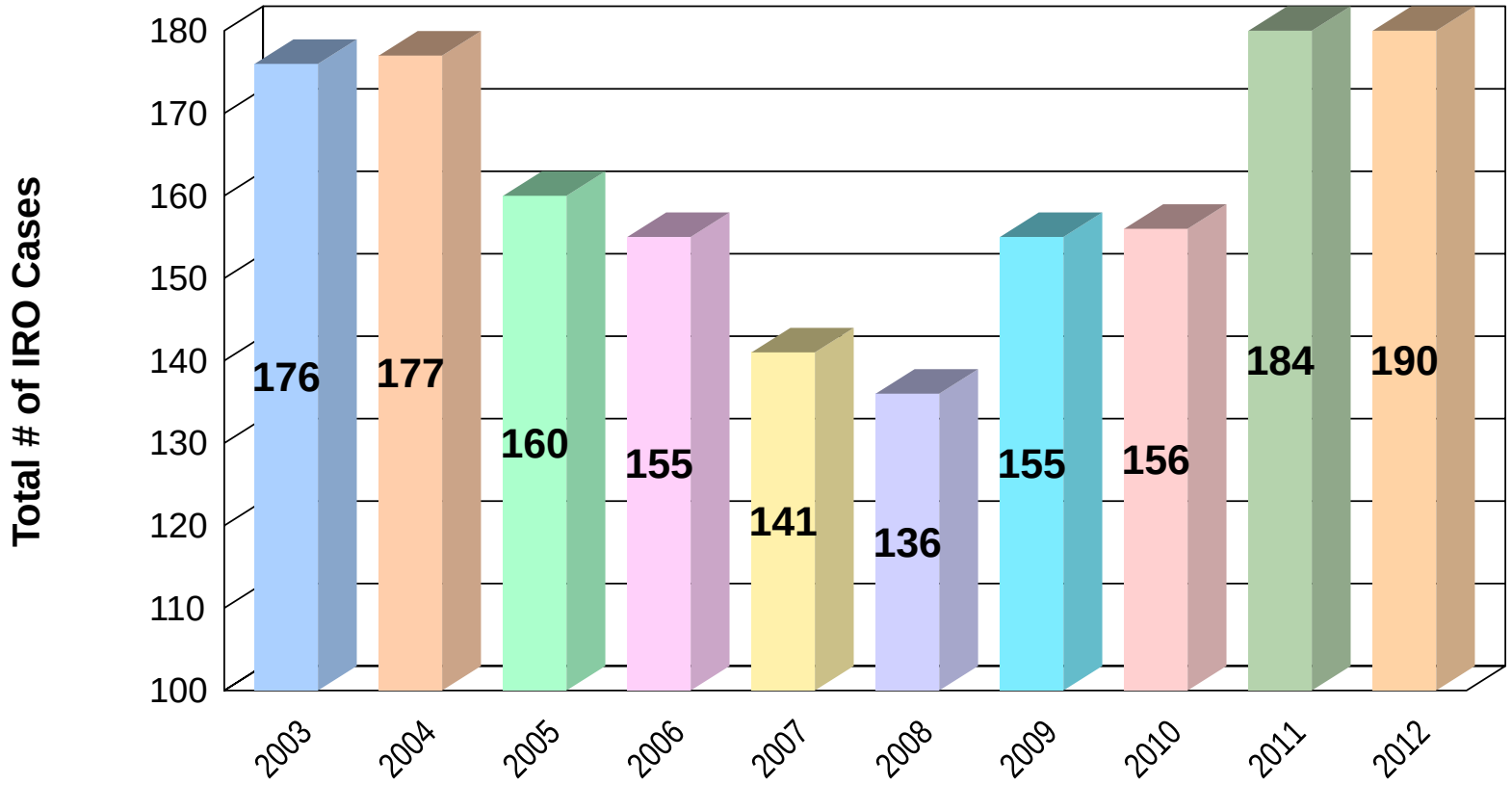
HEALTH CARRIER	ESTIMATED 5 YEAR PREMIUM	CASE VOLUME						BENEFIT DOLLARS REVIEWED							
	As Reported on ODI Annual Health Report	# Reviews % of Total		# Affirmed		# Reversed		$ Reviewed % of Total		$ Affirmed		$ Reversed		Maximum $ Affirmed	Maximum $ Reversed
		#	%	#	%	#	%	$	%	$	%	$	%		
NIPPON LIFE INSURANCE COMPANY OF AMERICA	$31,047,293	1	0%	0	0%	1	100%	$5,964	0%	$5,964	100%	$0	0%	$5,964	$0
MEDICAL BENEFITS MUTUAL LIFE INSURANCE COMPANY	$19,068,812	1	0%	1	100%	0	0%	$39,102	0%	$22,872	58%	$16,230	42%	$22,872	$16,230
GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	$11,445,293	3	0%	0	0%	3	100%	$4,743	0%	$0	0%	$4,743	100%	$0	$2,548
HEALTHAMERICA PENNSYLVANIA INC	$6,065,357	3	0%	0	0%	3	100%	$331,170	2%	$229,570	69%	$101,600	31%	$229,570	$98,100
TRUSTMARK INSURANCE COMPANY	$783,591	1	0%	0	0%	1	100%	$3,349	0%	$0	0%	$3,349	100%	$0	$3,349
INDEPENDENCE AMERICAN INSURANCE COMPANY	$541,794	1	0%	0	0%	1	100%	$50,334	0%	$50,334	100%	$0	0%	$50,334	$0
NATIONWIDE MUTUAL INSURANCE COMPANY	$313,463	1	0%	0	0%	1	100%	$13,921	0%	$13,921	100%	$0	0%	$13,921	$0
FIRST HEALTH LIFE & HEALTH INSURANCE COMPANY	$195,482	1	0%	0	0%	1	100%	$20,000	0%	$0	0%	$20,000	100%	$0	$20,000
AETNA HEALTH AND LIFE INSURANCE COMPANY		18	2%	0	0%	18	100%	$325,951	2%	$158,415	49%	$167,536	51%	$50,000	$80,000
PUBLIC EMPLOYEE BENEFIT PLAN		22	3%	2	9%	20	91%	$256,765	2%	$169,189	66%	$87,576	34%	$70,000	$53,800
Grand Totals:	**$37,747,265,910**	**821**		**141**	**17%**	**680**	**83%**	**$14,097,930**		**$10,167,899**	**72%**	**$3,930,031**	**28%**		

*Premium data unavailable.

ATTACHMENT 6

TOTAL NUMBER OF IRO CASES BY REPORT YEAR

January 1, 2003 - December 31, 2012



ATTACHMENT 7
HEALTH CARRIER SUMMARY
JANUARY 1, 2012 - DECEMBER 31, 2012

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	$2,782,791,423	68	36%	54	79%	14	21%	$830,108	20%	$620,153	75%	$209,955	25%	$200,000	$100,000
MEDICAL MUTUAL OF OHIO	$2,108,851,569	36	19%	24	67%	12	33%	$779,111	19%	$195,260	25%	$583,851	75%	$28,000	$242,750
UNITEDHEALTHCARE INSURANCE COMPANY	$1,192,941,419	33	17%	25	76%	8	24%	$1,972,246	47%	$1,824,749	93%	$147,496	7%	$1,571,739	$48,800
KAISER FOUNDATION HEALTH PLAN OF OHIO	$296,914,914	5	3%	3	60%	2	40%	$43,386	1%	$35,016	81%	$8,370	19%	$17,387	$7,920
SUMMA INSURANCE COMPANY INC	$206,921,580	2	1%	2	100%	0	0%	$2,535	0%	$2,535	100%	$0	0%	$2,500	$0
AULTCARE INSURANCE COMPANY	$194,467,259	7	4%	6	86%	1	14%	$32,392	1%	$32,342	100%	$50	0%	$21,105	$50
McKINLEY LIFE INSURANCE COMPANY	$194,467,259	5	3%	5	100%	0	0%	$28,150	1%	$28,150	100%	$0	0%	$20,000	$0
HUMANA HEALTH PLAN OF OHIO INC	$176,887,524	3	2%	2	67%	1	33%	$39,805	1%	$23,434	59%	$16,371	41%	$18,000	$16,371
GOLDEN RULE INSURANCE COMPANY	$88,089,713	7	4%	4	57%	3	43%	$206,055	5%	$179,919	87%	$26,136	13%	$173,878	$17,000
CONNECTICUT GENERAL LIFE INSURANCE COMPANY	$75,239,802	1	1%	1	100%	0	0%	$0	0%	$0	0%	$0	0%	$0	$0
HEALTH PLAN OF UPPER OH VALLEY INC	$68,407,881	1	1%	0	0%	1	100%	$64,000	2%	$0	0%	$64,000	100%	$0	$64,000
COVENTRY HEALTH AND LIFE INSURANCE COMPANY	$35,703,254	14	7%	10	71%	4	29%	$118,520	3%	$74,436	63%	$44,084	37%	$40,000	$40,000
FEDERATED MUTUAL INSURANCE COMPANY	$18,240,836	1	1%	0	0%	1	100%	$6,896	0%	$0	0%	$6,896	100%	$0	$6,896
TRUSTMARK LIFE INSURANCE COMPANY	$15,972,503	1	1%	1	100%	0	0%	$607	0%	$607	100%	$0	0%	$607	$0
MEDICAL BENEFITS MUTUAL LIFE INSURANCE COMPANY	$6,192,768	1	1%	1	100%	0	0%	$39,102	1%	$22,872	58%	$16,230	42%	$22,872	$16,230
PUBLIC EMPLOYEE BENEFIT PLAN		5	3%	2	40%	3	60%	$11,410	0%	$2,610	23%	$8,800	77%	$2,000	$3,000
Grand Totals:	**$7,462,089,704**	**190**		**140**	**74%**	**50**	**26%**	**$4,174,323**		**$3,042,085**	**73%**	**$1,132,238**	**27%**		

***Premium amount estimated based on available data.**

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