Report to the Vermont State Legislature

Recommendations to Improve the Accessibility and Comprehensibility of Filings Required of Health Insurers

Pursuant to Act 150 of 2012: An Act Relating to Pharmacy Audits, Reimbursement for Ambulance Services, and the Reporting Requirement of Health Insurers

Submitted to: Senate Committee on Health and Welfare
and the House Committee on Health Care

Submitted by: Susan L. Donegan, Commissioner

Prepared by: David Martini, Esq.
Director of Health Insurance Policy

Report date: January 15, 2014

Vermont Department of Financial Regulation
89 Main St.
Montpelier, VT 05620-3101

VERMONT

Pursuant to Act No. 150 of 2012 Sec 2 (An act relating to pharmacy audits, reimbursement for ambulance services, and the reporting requirement of health insurers),

(a)The Department of Financial Regulation shall convene a working group on consumer-oriented insurance filings for the purpose of assessing and making recommendations to improve the accessibility and comprehensibility of filings required of health insurers by this act.

(b) The working group shall be composed of the following members:

(1) the commissioner of the Department of Financial Regulation (DFR) or designee, who shall serve as facilitator;

(2) the state health care ombudsman;

(3) a representative of a consumer advocacy group, appointed by the commissioner of DFR; and

(4) two individuals representing the interests of Vermont's insurance industry, appointed by the commissioner of DFR.

David Martini, DFR Commissioner Susan L. Donegan's designee; Trinka Kerr, the state health care ombudsman; Falko Schilling from Vermont Public Interest Research Group (VPIRG), Susan Gretowski from MVP Healthcare, and Jacqueline Hughes and Alison Partridge, both representing Blue Cross Blue Shield of Vermont, first met on August 14, 2013. The group reviewed the challenges associated with the current form and discussed the difficulties insurers had encountered in reporting data for 2012. The group concluded that due to data limitations, the reports for 2014 data will not include claims for pediatric dental or vision.

The group agreed to the following modification of the form:

The term "denied" replaced "overturned" on part II. A on page 4

Prior to the next meeting, the group was requested to review the revised form and provide any specific comments. The comments are provided in Attachment A.

A second meeting occurred on September 10, 2013. All of the prior attendees were present and the group was joined by Kaj Samsom, director of Company Licensing and Examinations at the Department of Financial Regulation. Mr. Samsom had provided insight into the drafting of the original Act 150 form, and discussed how the supplemental executive compensation exhibit is currently undergoing revision at the National Association of Insurance Commissioners (NAIC).

Following the September 10, 2013, meeting, the following language was submitted to address an issue of board compensation that had arisen in the 2012 filing:

A health insurer that is subject to reporting but whose corporate officer and board compensation is paid by an affiliate must report total compensation paid to its corporate officers and directors by the affiliate (unless the affiliate is also required to file this form and corporate officer and board compensation is reported in its entirety by the affiliate).

"Affiliate" of a [health insurer] means a company that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the [health insurer]. 8 V.S.A. § 3681 (1).

A draft of the proposed form was circulated to the group for final comments and approval. A redlined copy of the proposed form is attached as Attachment B. The proposed form is attached as Attachment C.

Attachment A

Falko Schilling, VPIRG:

Prior authorization denials

The reporting form as currently written created confusion as to what information concerning prior authorizations was being requested from the carriers. This resulted is a lack of uniformity in the reporting of information required under Part II.A of the form. We suggest that Part II.A be amended by making the following changes. In the section entitled "Medical Claims and Pharmacy Health Insurer (2)" "Total overturned:" should be revised to say "Total denied:", and "Overturned rate:" should be revised to say "Denial rate:". Under the section entitled "PMPM (3)" "Overturned" should be revised to say "Denied".

Online Advertising

In reviewing the current form it appears that online advertising does not fall under the definition of "Vermont Marketing and Advertising Expenses". We suggest that the definition of Vermont advertising and marketing expense be expanded to include "All online and social media advertising, excluding subjects dealing wholly with health and welfare."

Executive compensation

The form as written created confusion as to what corporate officials were covered by the disclosure requirements, and what compensation needed to be reported. We support the addition of the proposed language put forward in the comments on behalf of Blue Cross Blue Shield of Vermont.

Average member months

We believe the reporting of the number of average member months could be helpful in further explaining the information contained in the reporting form. We are interested in seeing the proposed language and hope that such information will be included in the final version of the 2013 reporting form.

Trinka Kerr, VT Legal Aid:

My only comment is that Part IV-Total Vermont Marketing & Advertising expenses should include expenses for online and social media marketing and advertising.

Susan Gretkowski, MVP:

…No changes need to be made in order for MVP to report by both its HMO company, MVP Health Plan, Inc., and its PPO/EPO company, MVP Health Insurance Company, Inc. going forward.

What happened last year was that MVP Health Insurance Company reported because it had over 2,000 lives; MVP Health Plan did not, because it had less than 2,000 lives. Certain payments flow through certain companies, which is why we did not report Board compensation (which is paid through MVP Health Plan, which did not report).

However, going forward, membership will increase in MVP Health Plan as that is the platform for our Exchange products. MVP Health Insurance Company will continue to be the vehicle for large group business. Here is the language from the current form, which requires a report for companies with 2000 or more lives OR that participate in the Exchange.

Jacqueline A. Hughes, KSE Partners, LLP:

We agree that section II.A, first row of the current form would have made more sense if it requested the total number of prior authorization requests, total number of denials and the resulting denial rate. We suggest that it be amended as follows:

1. Report on denial of prior authorizations
We agree that section II.A, first row of the current form would have made more sense if it requested the total number of prior authorization requests, total number of denials and the resulting denial rate. We suggest that it be amended as follows:

Part II.A—Member Based Prior Authorization Requests, Appeals and Pre-service

Requirement (1)	***Medical Claims & Pharmacy Health Insurer (2)***	***PMPM (3)***
Prior Authorizations, including prior authorizations to bypass medical or pharmacy utilization management programs	*Total requested:* *Total ~~overturned~~ denied:* *~~Overturned~~ Denial Rate:*	*Requested:* *~~Overturned~~ Denied:*

2. Pediatric vision and dental

As we explained at the workgroup meeting held on August 13, 2013, exchange products will be required to have pediatric vision and dental benefits starting January 1, 2014. We will not have the ability to report on those benefits until 2016, so we suggest that the final general instruction on page 1 be revised as follows:

Medical claims includes all categories of claims that are not pharmacy claims, but does not include pediatric dental or pediatric vision claims incurred in 2014 and reported in 2015.

3. Executive and Board Compensation

We understand that some legislators were disappointed that not all companies reported executive and board compensation when such compensation had been paid through an upstream holding or parent company that was not subject to the reporting requirement. We think that the form could be clarified to solve this problem by adding a final instruction to the Part III instructions such as: A health insurer that is subject to reporting but whose corporate officer and board compensation is paid by a parent or intermediate holding company must report total compensation paid to its corporate officers and directors by the parent or intermediate holding company (unless the parent or intermediate holding company is also required to file this form and corporate officer and board compensation is reported in its entirety by the parent or intermediate holding company).

4. Average member months

At the workgroup meeting there was discussion of adding new information on average member months. We question whether this type is helpful to consumers. We would like to reserve the opportunity to comment on whatever language is developed.

Attachment B

STATE OF VERMONT
Department of Financial Regulation
89 Main Street, Montpelier, VT 05620-3101
(802) 828-2470

Act 150 (2011 Adj. Sess.) Addendum to Health insurer Annual Statement
2013~~2~~ Annual Statement, due March 1, 2014~~3~~.

Submission of this form is required of all health insurers with a minimum of 2,000 Vermont lives covered at the end of the preceding year or who offer insurance through the Vermont health benefit exchange pursuant to 33 V.S.A. chapter 18, subchapter 1.

Name of Health Insurer: _____

State of Domicile: _____

Total number of states in which health insurer operates: _____

List names of states where licensed (other than Vermont):_____

_____

Total number of Vermont lives covered (defined as the total of the Individual Comprehensive Health Coverage, Small Group Comprehensive Health Coverage and Large Group Comprehensive Health Coverage columns in Part 1 of the filed Supplemental Healthcare Exhibit for the State of Vermont): _____

Contact Person: _____ Contact Phone Number: _____

General:
Reporting is on a calendar year basis.

Who must report –

Health insurers that file annual statements with the Department of Financial Regulation under 8 V.S.A. § 3561, 4516, 4588 or 5106 with a minimum of 2000 Vermont lives covered at the end of the preceding calendar year or who offer insurance through the Vermont health benefit exchange pursuant to 33 V.S.A. chapter 18, subchapter 1.

Health insurers are not required to report on "Administrative Services Only" business, but are required to include claims and appeals on insured lives that are handled by delegates.

Medical claims include all categories of claims that are not pharmacy claims. Medical claims do not include pediatric dental or pediatric vision claims incurred in 2014 and reported in 2015.

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Part I - Claim Submission & Denials

Instructions:

In Part I.A, health insurers must report total claims volume breaking out medical and pharmacy claims, denials, denial percentage and the rate of denials per member per month. Column (1) describes claim category; column (2) provide total volume of claims by category; column (3) provice total number of denied claims by category (4) provide total number of denied claims as a percentage of total claims; column (5) provide denied claims on a per member per month basis.

In Part I.B, health insurers must report total administrative claims and denial volume by type. Administrative denials are denials that involve provider contractual obligations or other contractual or administrative requirements (do not include claims that invclve member impact, see Part I.C below). Column (1) describes claim category; column (2) provide total volume of claims by category; column (3) provide total number of denied administrative claims by category (4) provide total number of denied administrative claims as a percentage of total claims; column (5) provide administrative claim denials on a per member per month basis.

Claims that involve Administrative Denials (including provider contract obligations or other contractual or administrative requirements) include:

- Denials with no member impact
- Duplicate, claim check
- Invalid place of service
- Invalid coding, including CPT HCPC
- Refill too soon
- Member not active – claims that are provider liability (member hold harmless)
- Other administrative denials

In Part I.C, health insurers must report total member impact claims volume and denial volume by type. Member impact claim denials are those claim denials that directly impact member cost sharing, member certificate compliance or coverage (do not include claims that involve provider contractual obligations or other contractual or

administrative requirements). Column (1) describes the claim category; column (2) provide total volume of claims by category; column (3) provide total number of denied member impact claims by category (4) provide total number of denied member impact claims as a percentage of total claims; column (5) provide member impact claim denials on a per member per month basis.

Claims that involve Member Impact include:

- Not covered/excluded
- Benefit limits met
- Paid at lower level of benefit
- Prior Approval was denied
- Claim submitted not FDA approved
- Step & quantity limits
- Out-of-network
- Investigational/experimental
- Waiting periods
- Not medically necessary
- Other Member Impact denials

Administrative claim denials reported in I.B and Member Impact claim denials reported in I.C must equal totals reported in Part I.A. Rates calculated on a per member basis must use the average number of members at the end of each month during the period for the applicable category of claims, i.e., medical claims or pharmacy claims, that is being reported.

Part I.A Total Claims and Denials

Claims Category (1)	**Total number (2)**	**Total denied (3)**	**Denial % (4)**	**PMPMPMPM Denial Rate (5)**
Medical claims				
Pharmacy Claims				
Grand Total				

Part I.B Administrative Denials Only

Claims Category (1)	**Total number (2)**	**Total denied (3)**	**Denial % (4)**	**PMPMPMPM Denial Rate (5)**
Medical claims				
Pharmacy Claims				
Grand Total				

Part I.C Member Impact Denials Only

Claims Category (1)	Total number (2)	Total denied (3)	Denial % (4)	PMPM~~PMPM~~ Denial Rate (5)
Medical claims				
Pharmacy Claims				
Grand Total				

Part II – Prior Approval & Appeals Reporting

In Part II.A, health insurers must report prior authorization and pre-service appeal activity. Row 1 is for prior authorization requests, Row 2 is 1st level appeals, Row 32 is 2nd level appeals and Row 34 is for external appeals. Column (1) describes the types of activity covered count on a per member per month basis. In Column (2) provide the total number of requests for prior authorization or appeals in the category, the total number denied (PA) or overturned (appeals) and the denial or overturned rate, respectively. In Column (3) provide requests for prior authorization or appeals on a PMPM basis and the requests denied or appeals overturned on a PMPM to members. Plans should report only "member based" appeals which includes requests or appeals filed by members or filed by a provider on behalf of a member but should not include requests or appeals that are not member based.

In Part II.B, health insurers must report post-service appeal activity. Row 1 is 1st level, Row 2 is 2nd level and Row 3 is for external appeals. Column (1) describes the types of activity covered count on a per member per month basis. In Column (2) provice the total number of appeals in the category, the total number overturned and the overturned rate. In Column (3) provide appeals on a PMPM basis and the appeals overturned on a PMPM to members.

The prior authorization and appeal activity reported should include each level of appeal concluded during the calendar year even though this could result in overstatement due to members accessing more than one appeal level for the same claim. First level appeals that are taken to second level or to external review are not netted out. Second level appeals that are taken to external review are not netted out. Rates calculated per member per month must use the average number of members at the end of each month during the period for the applicable category of claims, i.e., medical claims or pharmacy claims, that is being reported.

Part II.A—Member Based Prior Authorization Requests, Appeals and Pre-service

Requirement (1)	Medical Claims & Pharmacy Health Insurer (2)	PMPM (3)

Prior Authorizations, including prior authorizations to bypass medical or pharmacy utilization management programs	Total Requested: Total ~~Overturned~~ Denied: ~~Overturned~~ Denial Rate:	Requested: ~~Overturned~~ Denied :
First level prior authorization and pre-service appeals	Total Appeals: Total Overturned: Overturned Rate:	Appeals: Overturned:
Second level prior authorization and pre-service appeals	Total Appeals: Total Overturned: Overturned Rate:	Appeals: Overturned:
External review of prior authorization and pre-service appeals	Total Appeals: Total Overturned: Overturned Rate:	Appeals: Overturned:

Part II. B Post-Service Appeals Reporting

Requirement (1)	**Medical Claims & Pharmacy Health Insurer (2)**	**PMPM (3)**
First level appeals of post-service adverse determinations.	Total Appeals: Total Overturned: Overturned Rate:	Appeals: Overturned:
Second level appeals of post-service adverse determinations.	Total Appeals: Total Overturned: Overturned Rate:	Appeals: Overturned:
External review of post-service appeal determinations	Total Appeals: Total Overturned: Overturned Rate:	Appeals: Overturned:

Part III – Corporate Officer and Board Compensation

Each health insurer shall report corporate officer and board compensation in Part III, regardless of the amount of total compensation. In Column (1) provide the title of the company officer. Column (2): Salary means fixed compensation paid regularly for services and includes compensation withheld and payable only upon achievement of pre-established performance metrics. Column (3): Bonus means money or its equivalent given on a discretionary basis in addition to an employee's salary as a premium based on performance or other measure. Column (4): Other Compensation means any and all other remuneration paid to or on behalf of an officer of the company including but not limited to commissions, stock grants, and gains from the exercise of stock options, but does not include the value of health insurance or other employee benefits that are generally made available to all full-time company employees. Compensation and

stipends paid to board members for services as a director should be reported in Column (2) of Part III.B.

Insurers must report amounts paid to corporate officers on a gross basis and not on an allocated basis.

A health insurer that is subject to reporting but whose corporate officer and board compensation is paid by an affiliate must report total compensation paid to its corporate officers and directors by the affiliate (unless the affiliate is also required to file this form and corporate officer and board compensation is reported in its entirety by the affiliate).

"Affiliate" of a [health insurer] means a company that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the [health insurer]. 8 V.S.A. § 3681 (1).

III.A Corporate Officer Compensation

Title of Company Officers(1)	**Salary (2)**	**Bonus (3)**	**Other Compensation (4)**
Chief Executive Officer			
Treasurer			
Secretary			
Vice President			
Vice President			
Vice President			
Vice President			
Vice President			
Vice President			
Vice President			

III.B Board Compensation

Board Members	**Salary**	**Bonus**	**Other Compensation**
Board Chair			
Board Member			
Board Member			

Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			

Part IV – Total Vermont Marketing & Advertising expenses (includes sponsorships)

Each health insurer shall report total Vermont marketing and advertising expenses in Part IV. Marketing and advertising expenses shall include:

- newspaper, magazine and trade journal advertising for the purpose of solicitation and conservation of business;
- sign and directory advertising;
- public or charitable event sponsorships;
- television, radio broadcasting and motion picture advertising, excluding subjects dealing wholly with health and welfare;
- all canvassing or other literature, such as pamphlets, circulars, leaflets, policy illustration forms and other sales aids, printed material, etc., prepared for distribution to the public by agents or through the mail for purposes of solicitation and conservation of business;
- all advertising novelties and promotional items intended for distribution to the public;
- printing, paper stock, etc., in connection with advertising;
- prospect and mailing lists when used for advertising purposes; and
- fees and expenses of advertising agencies related to advertising.

Marketing and advertising expenses do not include:

- pamphlets on health, welfare and educational subjects;
- advertising required by law, regulation or ruling except to the extent that it substantially exceeds the space required for compliance;
- salaries and expenses of advertising department;
- help wanted advertisements; and
- advertising in connection with investments.

Part VI Total Vermont Marketing and Advertising Expenses: $ _____

Part V – Lobbying expenses

Each health insurer shall report total federal and Vermont-specific lobbying expenses in Part V.

Federal lobbying expenses shall mean total expenditures that are not deductible under the IRC (26 U.S.C.) § 162 (e)(1)(A) and that are spent to influence legislation within the meaning of 26 U.S.C. § (e)(4). Vermont-specific lobbying expenses means expenditures required to be reported under Title 2 V.S.A. chapter 11.

Federal lobbying expenditures: $ _____

Vermont lobbying expenditures: $ _____

Part VI – Political Contributions

In Part VI, each health insurer shall report cash or cash equivalent (in-kind) political contributions made to Vermont state election campaigns or political parties. In Column (1) provide name of recipient. In column (2) indicate whether the contributions was made for a candidate was running for Vermont state office (s) or a political party (p). In column (3) provide the total amount for the year.

Part VI- Political Contributions

Recipient (1)	(2) Vermont candidate (c) or party (p)	(3) Amount of cash or cash equivalent (in-kind)

Part VII – Dues to trade groups that engage in lobbying or make political contributions

In Part VII, each health insurer shall report dues paid to any trade groups that engage in lobbying or that make political contributions to federal or Vermont-state public office candidates. Provide the name of the trade group in column (1) and the dues paid in column (2) that are for lobbying or political contributions. A trade group is defined as

an association of organizations in the same industry that is formed to represent and further the interests of the member organizations primarily through lobbying or public relations activities. Only the portion of dues paid with respect to activities that are lobbying or political contributions are required to be reported. Dues paid for other services or activities of the trade group such as charitable events, advertising, education, licensing or support services are not required to be reported.

Trade organization	Dues

Part VIII – Legal expenses related to claims or services denials

Each health insurer shall report legal expenses related to claims or service denials for Vermont members during the preceding year in Part VIII. Legal expenses means court costs, penalties and all fees or retainers for legal services or expenses in connection with matters before an administrative body or court involving claims or service denials. Legal fees and expenses do not include salaries and expenses of company personnel, or legal expenses associated with investigation, litigation and settlement of policy claims.

Total Legal Expenses $ _____

Part IX – Vermont Charitable Contribution

Each health insurer shall report all contributions made to Vermont charitable organizations that are deductible under federal law. Note: public or charitable event sponsorships are reported in Part IV and are not to be included in this Part IX.

Total Charitable Contributions $ _____

Attachment C

STATE OF VERMONT
Department of Financial Regulation
89 Main Street, Montpelier, VT 05620-3101
(802) 828-2470

Act 150 (2011 Adj. Sess.) Addendum to Health insurer Annual Statement
2013 Annual Statement, due March 1, 2014.

Submission of this form is required of all health insurers with a minimum of 2,000 Vermont lives covered at the end of the preceding year or who offer insurance through the Vermont health benefit exchange pursuant to 33 V.S.A. chapter 18, subchapter 1.

Name of Health Insurer: _____

State of Domicile: _____

Total number of states in which health insurer operates: _____

List names of states where licensed (other than Vermont):_____

_____

Total number of Vermont lives covered (defined as the total of the Individual Comprehensive Health Coverage, Small Group Comprehensive Health Coverage and Large Group Comprehensive Health Coverage columns in Part 1 of the filed Supplemental Healthcare Exhibit for the State of Vermont): _____

Contact Person: _____ Contact Phone Number: _____

General:
Reporting is on a calendar year basis.

Who must report –Health insurers that file annual statements with the Department of Financial Regulation under 8 V.S.A. § 3561, 4516, 4588 or 5106 with a minimum of 2000 Vermont lives covered at the end of the preceding calendar year or who offer insurance through the Vermont health benefit exchange pursuant to 33 V.S.A. chapter 18, subchapter 1.

Health insurers are not required to report on "Administrative Services Only" business, but are required to include claims and appeals on insured lives that are handled by delegates. Medical claims include all categories of claims that are not pharmacy claims. Medical claims do not include pediatric dental or pediatric vision claims incurred in 2014 and reported in 2015.

Attachment C

Part I - Claim Submission & Denials

Instructions:

In Part I.A, health insurers must report total claims volume breaking out medical and pharmacy claims, denials, denial percentage and the rate of denials per member per month. Column (1) describes claim category; column (2) provide total volume of claims by category; column (3) provide total number of denied claims by category (4) provide total number of denied claims as a percentage of total claims; column (5) provide denied claims on a per member per month basis.

In Part I.B, health insurers must report total administrative claims and denial volume by type. Administrative denials are denials that involve provider contractual obligations or other contractual or administrative requirements (do not include claims that involve member impact, see Part I.C below). Column (1) describes claim category; column (2) provide total volume of claims by category; column (3) provide total number of denied administrative claims by category (4) provide total number of denied administrative claims as a percentage of total claims; column (5) provide administrative claim denials on a per member per month basis.

Claims that involve Administrative Denials (including provider contract obligations or other contractual or administrative requirements) include:

- Denials with no member impact
- Duplicate, claim check
- Invalid place of service
- Invalid coding, including CPT HCPC
- Refill too soon
- Member not active – claims that are provider liability (member hold harmless)
- Other administrative denials

In Part I.C, health insurers must report total member impact claims volume and denial volume by type. Member impact claim denials are those claim denials that directly impact member cost sharing, member certificate compliance or coverage (do not include claims that involve provider contractual obligations or other contractual or administrative requirements). Column (1) describes the claim category; column (2) provide total volume of claims by category; column (3) provide total number of denied member impact claims by category (4) provide total number of denied member impact claims as a percentage of total claims; column (5) provide member impact claim denials on a per member per month basis.

Claims that involve Member Impact include:

- Not covered/excluded
- Benefit limits met
- Paid at lower level of benefit
- Prior Approval was denied
- Claim submitted not FDA approved
- Step & quantity limits
- Out-of-network
- Investigational/experimental
- Waiting periods

- Not medically necessary
- Other Member Impact denials

Administrative claim denials reported in I.B and Member Impact claim denials reported in I.C must equal totals reported in Part I.A. Rates calculated on a per member basis must use the average number of members at the end of each month during the period for the applicable category of claims, i.e., medical claims or pharmacy claims, that is being reported.

Part I.A Total Claims and Denials

Claims Category (1)	Total number (2)	Total denied (3)	Denial % (4)	PMPM Denial Rate (5)
Medical claims				
Pharmacy Claims				
Grand Total				

Part I.B Administrative Denials Only

Claims Category (1)	Total number (2)	Total denied (3)	Denial % (4)	PMPM Denial Rate (5)
Medical claims				
Pharmacy Claims				
Grand Total				

Part I.C Member Impact Denials Only

Claims Category (1)	Total number (2)	Total denied (3)	Denial % (4)	PMPM Denial Rate (5)
Medical claims				
Pharmacy Claims				
Grand Total				

Part II – Prior Approval & Appeals Reporting

In Part II.A, health insurers must report prior authorization and pre-service appeal activity. Row 1 is for prior authorization requests, Row 2 is 1st level appeals, Row 3 is 2nd level appeals and Row 4 is for external appeals. Column (1) describes the types of activity covered count on a per member per month basis. In Column (2) provide the total number of requests for prior authorization or appeals in the category, the total number denied (PA) or overturned (appeals) and the denial or overturned rate, respectively. In Column (3) provide requests for prior authorization or appeals on a PMPM basis and the requests denied or appeals overturned on a PMPM to members. Plans should report only "member based" appeals which includes requests or appeals filed by members or filed by a provider on behalf of a member but should not include requests or appeals that are not member based.

In Part II.B, health insurers must report post-service appeal activity. Row 1 is 1st level, Row 2 is 2nd level and Row 3 is for external appeals. Column (1) describes the types of activity covered count on a per member per month basis. In Column (2) provide the total number of appeals in the category, the total number overturned and the overturned rate. In Column (3) provide appeals on a PMPM basis and the appeals overturned on a PMPM to members.

The prior authorization and appeal activity reported should include each level of appeal concluded during the calendar year even though this could result in overstatement due to members accessing more than one appeal level for the same claim. First level appeals that are taken to second level or to external review are not netted out. Second level appeals that are taken to external review are not netted out. Rates calculated per member per month must use the average number of members at the end of each month during the period for the applicable category of claims, i.e., medical claims or pharmacy claims, that is being reported.

Part II.A—Member Based Prior Authorization Requests, Appeals and Pre-service

Requirement (1)	**Medical Claims & Pharmacy Health Insurer (2)**	**PMPM (3)**
Prior Authorizations, including prior authorizations to bypass medical or pharmacy utilization management programs	Total Requested: Total Denied: Denial Rate:	Requested: Denied :
First level prior authorization and pre-service appeals	Total Appeals: Total Overturned : Overturned Rate:	Appeals: Overturned:
Second level prior authorization and pre-service appeals	Total Appeals: Total Overturned: Overturned Rate:	Appeals: Overturned:
External review of prior authorization and pre-service appeals	Total Appeals: Total Overturned: Overturned Rate:	Appeals: Overturned:

Part II. B Post-Service Appeals Reporting

Requirement (1)	**Medical Claims & Pharmacy Health Insurer (2)**	**PMPM (3)**
First level appeals of post-service adverse determinations.	Total Appeals: Total Overturned: Overturned Rate:	Appeals: Overturned:
Second level appeals of post-service adverse determinations.	Total Appeals: Total Overturned: Overturned Rate:	Appeals: Overturned:
External review of post-service appeal determinations	Total Appeals: Total Overturned: Overturned Rate:	Appeals: Overturned:

Part III – Corporate Officer and Board Compensation

Each health insurer shall report corporate officer and board compensation in Part III, regardless of the amount of total compensation. In Column (1) provide the title of the company officer. Column (2): Salary means fixed compensation paid regularly for services and includes compensation withheld and payable only upon achievement of pre-established performance metrics. Column (3): Bonus means money or its equivalent given on a discretionary basis in addition to an employee's salary as a premium based on performance or other measure. Column (4): Other Compensation means any and all other remuneration paid to or on behalf of an officer of the company including but not limited to commissions, stock grants, and gains from the exercise of stock options, but does not include the value of health insurance or other employee benefits that are generally made available to all full-time company employees. Compensation and stipends paid to board members for services as a director should be reported in Column (2) of Part III.B.

Insurers must report amounts paid to corporate officers on a gross basis and not on an allocated basis.

A health insurer that is subject to reporting but whose corporate officer and board compensation is paid by an affiliate must report total compensation paid to its corporate officers and directors by the affiliate (unless the affiliate is also required to file this form and corporate officer and board compensation is reported in its entirety by the affiliate).

"Affiliate" of a [health insurer] means a company that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the [health insurer]. 8 V.S.A. § 3681 (1).

Attachment C

III.A Corporate Officer Compensation

Title of Company Officers(1)	Salary (2)	Bonus (3)	Other Compensation (4)
Chief Executive Officer			
Treasurer			
Secretary			
Vice President			
Vice President			
Vice President			
Vice President			
Vice President			
Vice President			
Vice President			

III.B Board Compensation

Board Members	Salary	Bonus	Other Compensation
Board Chair			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			

Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			
Board Member			

Part IV – Total Vermont Marketing & Advertising expenses (includes sponsorships)

Each health insurer shall report total Vermont marketing and advertising expenses in Part IV. Marketing and advertising expenses shall include:

- newspaper, magazine and trade journal advertising for the purpose of solicitation and conservation of business;
- sign and directory advertising;
- public or charitable event sponsorships;
- television, radio broadcasting and motion picture advertising, excluding subjects dealing wholly with health and welfare;
- all canvassing or other literature, such as pamphlets, circulars, leaflets, policy illustration forms and other sales aids, printed material, etc., prepared for distribution to the public by agents or through the mail for purposes of solicitation and conservation of business;
- all advertising novelties and promotional items intended for distribution to the public;
- printing, paper stock, etc., in connection with advertising;
- prospect and mailing lists when used for advertising purposes; and
- fees and expenses of advertising agencies related to advertising.

Marketing and advertising expenses do not include:

- pamphlets on health, welfare and educational subjects;
- advertising required by law, regulation or ruling except to the extent that it substantially exceeds the space required for compliance;
- salaries and expenses of advertising department;
- help wanted advertisements; and
- advertising in connection with investments.

Part VI Total Vermont Marketing and Advertising Expenses: $ _____

Attachment C

Part V – Lobbying expenses

Each health insurer shall report total federal and Vermont-specific lobbying expenses in Part V.

Federal lobbying expenses shall mean total expenditures that are not deductible under the IRC (26 U.S.C.) § 162 (e)(1)(A) and that are spent to influence legislation within the meaning of 26 U.S.C. § (e)(4). Vermont-specific lobbying expenses means expenditures required to be reported under Title 2 V.S.A. chapter 11.

Federal lobbying expenditures: $ _____

Vermont lobbying expenditures: $ _____

Part VI – Political Contributions

In Part VI, each health insurer shall report cash or cash equivalent (in-kind) political contributions made to Vermont state election campaigns or political parties. In Column (1) provide name of recipient. In column (2) indicate whether the contributions was made for a candidate was running for Vermont state office (s) or a political party (p). In column (3) provide the total amount for the year.

Part VI- Political Contributions

Recipient (1)	**(2) Vermont candidate (c) or party (p)**	**(3) Amount of cash or cash equivalent (in-kind)**

Part VII – Dues to trade groups that engage in lobbying or make political contributions

In Part VII, each health insurer shall report dues paid to any trade groups that engage in lobbying or that make political contributions to federal or Vermont-state public office candidates. Provide the name of the trade group in column (1) and the dues paid in column (2) that are for lobbying or political contributions. A trade group is defined as an association of organizations in the same industry that is formed to represent and further the interests of the member organizations primarily through lobbying or public relations activities. Only the portion of dues paid with respect to activities that are lobbying or political contributions are required to be reported. Dues paid for other services or activities of the trade group such as charitable events, advertising, education, licensing or support services are not required to be reported.

Trade organization	Dues

Part VIII – Legal expenses related to claims or services denials

Each health insurer shall report legal expenses related to claims or service denials for Vermont members during the preceding year in Part VIII. Legal expenses means court costs, penalties and all fees or retainers for legal services or expenses in connection with matters before an administrative body or court involving claims or service denials. Legal fees and expenses do not include salaries and expenses of company personnel, or legal expenses associated with investigation, litigation and settlement of policy claims.

Total Legal Expenses $ _____

Part IX – Vermont Charitable Contribution

Each health insurer shall report all contributions made to Vermont charitable organizations that are deductible under federal law. Note: public or charitable event sponsorships are reported in Part IV and are not to be included in this Part IX.

Total Charitable Contributions $ _____