STATE OF VERMONT
Department of Financial Regulation
89 Main Street, Montpelier, VT 05620-3101
(802) 828-3301

Act 150 (2011 Adj. Sess.) Addendum to Health insurer Annual Statement
2015 Annual Statement, due March 1, 2016.

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: Blue Cross and Blue Shield of Vermont

State of Domicile: Vermont

Total number of states in which health insurer operates: 1

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): 152,352

Contact Person: Chris Gannon Contact Phone Number: (802) 371-3292

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 includes all categories of claims that are not pharmacy claims. Medical claims do not include pediatric dental or pediatric vision claims incurred in 2015 and reported in 2016.

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	1,668,189	105,059	6.3%	0.05710
Pharmacy Claims	1,332,069	139,841	10.5%	0.07601
Grand Total	3,000,258	244,900	8.2%	0.13312

Part I.B Administrative Denials Only

Claims Category (1)	Total number (2)	Total denied (3)	Denial % (4)	PMPM Denial Rate (5)
Medical claims	1,668,189	100,863	6.0%	0.05482
Pharmacy Claims	1,332,069	115,447	8.7%	0.06275
Grand Total	3,000,258	216,310	7.2%	0.11758

Part I.C Member Impact Denials Only

Claims Category (1)	Total number (2)	Total denied (3)	Denial % (4)	PMPM Denial Rate (5)
Medical claims	1,668,189	4,196	0.3%	0.00228
Pharmacy Claims	1,332,069	24,394	1.8%	0.01326
Grand Total	3,000,258	28,590	1.0%	0.01554

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 and the denial and overturned rate, respectively. In Column (3) provide requests for prior approval 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: 36,565 Total Denied: 2,038 Denial Rate: 6.0%	Requested: 0.01987 Denied: 0.00111
First level prior authorization and pre-service appeals	Total Appeals: 108 Total Overturned: 56 Overturned Rate: 52%	Appeals: 0.00006 Overturned: 0.00003
Second level prior authorization and pre-service appeals	Total Appeals: 6 Total Overturned: 5 Overturned Rate: 83%	Appeals: 0.00000 Overturned: 0.00000
External review of prior authorization and pre-service appeals	Total Appeals: 3 Total Overturned: 2 Overturned Rate: 67%	Appeals: 0.00000 Overturned: 0.00000

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: 313 Total Overturned: 168 Overturned Rate: 54%	Appeals: 0.00017 Overturned: 0.00009
Second level appeals of post-service adverse determinations.	Total Appeals: 18 Total Overturned: 12 Overturned Rate: 67%	Appeals: 0.00001 Overturned: 0.00001
External review of post-service appeal determinations	Total Appeals: 4 Total Overturned: 1 Overturned Rate: 25%	Appeals: 0.00000 Overturned: 0.00000

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	604,094		22,271
Vice President	355,878		19,644
Vice President & Treasurer	339,369		11,282
Vice President & Secretary	310,610		19,758
Vice President	311,869		10,856
Vice President	136,174		159,247
Vice President	279,591		15,242
Vice President	113,077		35

III.B Board Compensation

Board Members	Salary	Bonus	Other Compensation
Board Chair	37,600		
Board Member	26,800		
Board Member	26,800		
Board Member	26,400		
Board Member	20,800		
Board Member	20,800		
Board Member	20,000		
Board Member	20,000		
Board Member	18,800		
Board Member	18,000		
Board Member	17,200		
Board Member	16,400		
Board Member	6,800		
Board Member	5,500		

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 IV Total Vermont Marketing and Advertising Expenses: $ 794,202

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: $ 0

Vermont lobbying expenditures: $ 20,884

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)
NONE		

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
Blue Cross Blue Shield Association	$ 58,775

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 $ 0

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 $ 19,221