FINANCIAL SERVICES REGULATION: BALANCING CONFIDENTIALITY WITH A NEED TO KNOW

Susan L. Donegan*

The question of how much information people should have about the inner-workings of financial services companies is not new. The issues of disclosure and confidentiality of information have been part of the foundation of corporate and financial services law since the beginnings of government intervention. Over time, and now in the aftermath of the 2008 crisis in the financial markets, an increased appetite has emerged for corporate and government transparency.[1] The popular press continually chronicles the debate between not enough and too much information.[2]

At the state level, financial services regulators must balance the protection of necessary confidentiality contained in the regulatory process with the public's right or perceived need to have information about licensed entities. A recent change to Vermont insurance law that requires certain health insurers to disclose information in an annual supplemental regulatory filing illustrates this balancing act.

I. THE PURPOSE OF CONFIDENTIALITY AND DISCLOSURE

The democratic process arguably works best in an environment that allows people to see and understand the end-result of government practices. A capitalist society arguably works best through innovation and

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1. *See* Dodd-Frank Wall Street Reform and Consumer Protection (Dodd-Frank) Act, Pub. L. No. 111-203, 124 Stat. 1376, 1376 (2010) (codified as amended in scattered sections of 7, 12, 15, 18, 22, 31, and 42 U.S.C.) (increasing transparency of financial regulation system). Increased transparency and more effective disclosures between financial institutions and financial regulators, as well as between regulators and the public, are key motivations behind this law. Press Release, The White House, Remarks by the President at Signing of Dodd-Frank Wall Street Reform and Consumer Protection Act (July 21, 2010), *available at* http://www.whitehouse.gov/the-press-office/remarks-president-signing-dodd-frank-wall-street-reform-and-consumer-protection-act; Steven J. Markovitch, *The Dodd-Frank Act*, COUNCIL ON FOREIGN RELATIONS (Dec. 10, 2013), http://www.cfr.org/united-states/dodd-frank-act/p28735.

2. David M. Primo, *Against Disclosure*, N.Y. TIMES, Nov. 8, 2013, http://www.nytimes.com/2013/11/10/opinion/sunday/against-disclosure.html?_r=0.

competitive markets. The information that drives both of these goals relies on appropriate access to information by balancing various stakeholders' interests, particularly in the context of a regulated industry. The underlying theory is that "[a]n informed citizen is better equipped to participate in [the democratic] process" and to reap the benefits produced by private industry.[3]

Disclosure can mean many things depending on who is asking for information and who is supplying information. People often use the following words when they discuss disclosure: confidentiality, public or non-public, exempt, transparent, and privileged. Whatever the terminology, in the realm of financial services regulation the general purpose of disclosure—and its counterpart, confidentiality—is to protect sensitive, competitive information while granting public access to information that supports consumer protection and accountability.[4]

II. VERMONT FINANCIAL SERVICES REGULATORY FRAMEWORK

In its broadest sense, the financial services industry encompasses the banking, insurance, and securities sectors. In Vermont, the Department of Financial Regulation (DFR)[5] regulates this industry, guided by a myriad of statutes and regulations.[6] DFR is an unusual state government agency because Vermont is one of the few states that houses the entire financial services regulatory function under one roof.[7] Most states have their banking, securities, and insurance departments and relationships with

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3. DIV. OF PUB. RECORDS, SEC'Y OF THE COMMONWEALTH, A GUIDE TO THE MASSACHUSETTS PUBLIC RECORDS LAW (2013), *available at* www.sec.state.ma.us/pre/prepdf/guide.pdf.

4. *See generally* David Weil et al., *The Effectiveness of Regulatory Disclosure Policies*, 25 J. POL'Y ANALYSIS & MGMT. 155 (2006) (assessing the effectiveness of regulatory transparency). "If . . . information is useful to individual users or groups they may incorporate it into their ordinary decision-making processes in ways that alter their actions." *Id.* at 157.

5. VT. DEP'T OF FIN. REG., http://www.dfr.vermont.gov/ (last visited Apr. 24, 2014).

6. *See* VT. STAT. ANN. tit. 8, §§ 1–4126 (2013) (laying out the implementing statutes that guide Vermont's DFR); VT. STAT. ANN. tit. 9, §§ 41–5101 (2013); *see, e.g.*, VT. STAT. ANN. tit. 8, § 11 (2013) (creating DFR's jurisdiction); VT. STAT. ANN. tit. 8, § 15 (2013) (granting the Commissioner authority to promulgate rules and orders); VT. STAT. ANN. tit. 9, § 4302 (2013) (requiring insurance stockholders and officers to file statements with the DFR); 21-66 VT. CODE R. § 1 (2013) (providing example of DFR regulation of health plans); *see also* VT. STAT. ANN. tit. 1, § 317 (2013) (containing a list of DFR public records and exemptions). All Vermont laws can be accessed online at VT. STATE LEGISLATURE, http://www.leg.state.vt.us/statutesmain.cfm (last visited Apr. 24, 2014).

7. VT. STAT. ANN. tit. 8, § 11 (2013); *see* VT. DEP'T OF FIN. REG., TOGETHER . . . WORKING FOR VERMONT (2013), *available at* http://www.leg.state.vt.us/jfo/appropriations/fy_2014/Fin.%20Reg.%20-%20Narrative.pdf (discussing Banking, Securities, and Insurance divisions of the DFR); *see also* VT. DEP'T OF FIN. REG., http://www.dfr.vermont.gov (last visited Apr. 24, 2014) (describing the Department's mission and listing the Banking, Securities, Insurance, and Captives divisions of the DFR).

licensed entities split among independent agencies and reporting structures.[8] Some combine banking and insurance or insurance and securities under one agency.[9] One advantage of having all three sectors in an independent department is that it allows for appropriate functional regulation to occur, which encourages government efficiency, consistency, and cooperation.[10]

The DFR's implementing statutes contain an array of provisions that protect from disclosure—even subpoena power—certain records and information considered not public and/or confidential.[11] These laws recognize that certain information is so sensitive that its production would render harm to companies and not be in the public interest.[12] For example, information related to an insurance company's market conduct (i.e., compliance and enforcement activity), including annual statements of performance and investigations, "shall be confidential and privileged, shall

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8. *See, e.g.*, MASS. GEN. LAWS ch. 24A, § 1 (2010) (establishing the Office of Consumer Affairs and Business Regulation within the Office of Housing and Economic Development); MASS. GEN. LAWS ch. 110A, § 406 (2002) (placing the administration of the Uniform Securities Act under the Secretary of the Commonwealth).

9. *See, e.g.*, N.Y. DEP'T OF FIN. SERVS., http://www.dfs.ny.gov (last visited Apr. 24, 2014) (combining banking and insurance); *see also* MONT. OFFICE OF COMMISSIONER OF SEC. AND INS., http://www.csi.mt.gov (last visited Apr. 24, 2014) (regulating insurance and securities).

10. *See* TOGETHER . . . WORKING FOR VERMONT, *supra* note 7 (discussing centralized operations and efficiency). The term functional regulation refers to a regulatory approach not entirely dependent on industry classifications but one that integrates product and market functionality among and between sectors. *See also* John Shad, Functional Regulation: The Concept and its Applications, Remarks to the Exchequer Club at the Capital Hilton Hotel 1–2, 4 (May 21, 1986) (discussing regulation duplication among agencies and proposed changes to the regulation structure). For example, a variable annuity is regulated under insurance and securities laws. *Variable Annuities: What You Should Know*, SEC, https://www.sec.gov/investor/pubs/varannty.htm (last modified Apr. 18, 2011). At the DFR, variable annuities are viewed simultaneously from both subject matter and legal points of view; in other states, a variable annuity could easily be regulated by a separate securities division and a separate insurance division that might result in duplicative or varying decisions. *See* Jason A. Richardson, *Is a Variable Annuity a "Security"? Making Sense of Inconsistent State and Federal Securities Statutes*, 14 PUB. INVESTORS ARB. BAR ASS'N J. 38, 38, 43–45, 47 (2007).

11. *See* VT. STAT. ANN. tit. 8, § 22(c) (2009) (allowing Commissioner to designate information confidential and "not . . . subject to subpoena"); *see also* VT. STAT. ANN. tit. 8, § 3561(b)(2) (2009) (providing that certain insurance statements are "not . . . subject to subpoena"). According to the recent January 2013 *Interim Report* by the Vermont Legislature's Public Records Study Committee, there are "30 statutory provisions that exempt certain Department of Financial Regulation-related records from inspection and copying under the Public Records Act." LEGISLATIVE COUNCIL, PUBLIC RECORDS STUDY COMMITTEE 2013 INTERIM REPORT, Vt. Leg. 285118, at app. 47 (2013), *available at* http://www.leg.state.vt.us/reports/2013ExternalReports/285233.pdf.

12. VT. PUBLIC RECORDS LEGISLATIVE STUDY COMMITTEE, COMMENTS BY DAVID CASSETTY, GENERAL COUNSEL, VT. DEP'T OF FINANCIAL REGULATION 1 (Nov. 1, 2013), *available at* http://www2.leg.state.vt.us/CommitteeDocs/Public%20Records/Public%20Records%20Exemptions/November%201,%202013/Department%20of%20Financial%20Regulation-Related%20Exemptions/11-1-2013~David%20Cassetty~Comments%20of%20the%20Department%20of%20Financial%20Regulation.pdf.

not be made public, shall not be subject to subpoena, and shall not be subject to discovery or introduction into evidence in any private civil action."[13] Laws that shield such documents from public disclosure assist regulators in rooting out illegal conduct and concluding enforcement actions. Without such protections, regulators would not be able to rely on "tips" to combat fraud, engage in candid exchanges with licensees, and encourage consumers to come forward with complaints without fear of reprise. But what about financial information? To what extent should financial services companies be required to disclose this type of information?

III. COMPANY FINANCIAL DISCLOSURE GENERALLY

Disclosure of financial information in the financial services regulatory world can be achieved in several ways. Companies may be legally obligated to release certain information to the public to operate as a company.[14] For example, securities disclosure laws apply to "public" companies that have their stock listed on a stock exchange—and even some private companies that wish to raise capital.[15] These laws also require state-licensed financial services entities to submit extensive and ongoing financial information to banking and insurance regulators to monitor safety and soundness, and solvency and capital adequacy respectively.[16] Apart from the financial results that companies are directly required to make public, what is the utility or danger of requiring that other financial information be released?

Risk-Based Capital (RBC) is an example of financial information that must be submitted to regulators by domestic insurance companies, yet it remains outside public access.[17] Vermont law acknowledges that RBC

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13. VT. STAT. ANN. tit. 8, § 3561(b)(2) (2009).

14. *Researching Public Companies Through EDGAR: A Guide for Investors*, SEC, http://www.sec.gov/investor/pubs/edgarguide.htm#P33_2288 (last modified July 18, 2007).

15. *See id.* ("The SEC requires public companies to disclose meaningful financial and other information to the public, which provides a public source for all investors to use to judge for themselves if a company's securities are a good investment."); *see also Small Business and the SEC: How can my small business raise capital?*, SEC, http://www.sec.gov/info/smallbus/qasbsec.htm#capital (last modified Oct. 10, 2013) (discussing obligations of public companies and private companies considering securities offerings).

16. *See, e.g.*, VT. STAT. ANN. tit. 8, § 3561(a) (2009) (requiring insurance companies to submit financial statements to the DFR Commissioner).

17. *Risk-Based Capital*, NAT'L ASS'N OF INS. COMM'RS (Dec. 9, 2013), http://www.naic.org/cipr_topics/topic_risk_based_capital.htm; NAT'L ASS'N OF INS. COMM'RS, RISK-BASED CAPITAL GENERAL OVERVIEW 2 (2009), *available at* http://www.naic.org/documents/committees_e_capad_RBCoverview.pdf. The National Association of Insurance Commissioners (NAIC) defines Risk-Based Capital (RBC) as:

reports and plans "constitute information that might be damaging to the insurer if made available to its competitors, and therefore shall be kept confidential and privileged by the Commissioner."[18] Further, RBC information is not "subject to subpoena."[19] In addition to shielding RBC ratios from competitors, regulators fear that laypeople will misinterpret the data attributed to a company and act irrationally.[20] For example, an RBC ratio of 500 for one company might indicate a need for regulatory intervention but may not call financial stability into question for others.[21] RBC is a sophisticated regulatory tool, not a measure of whether consumers should cash in their life insurance policies.[22]

> [A] method of measuring the minimum amount of capital appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile. RBC limits the amount of risk a company can take. It requires a company with a higher amount of risk to hold a higher amount of capital. Capital provides a cushion to a company against insolvency. RBC is intended to be a minimum regulatory capital standard and not necessarily the full amount of capital that an insurer would want to hold to meet its safety and competitive objectives. In addition, RBC is not designed to be used as a stand-alone tool in determining financial solvency of an insurance company; rather it is one of the tools that give regulators legal authority to take control of an insurance company.

Risk-Based Capital, NAT'L ASS'N OF INS. COMM'RS (Dec. 9, 2013), http://www.naic.org/cipr_topics/topic_risk_based_capital.htm. "The [NAIC] is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories." Sen. Ben Nelson, *About the NAIC*, NAT'L ASS'N OF INS. COMM'RS, http://www.naic.org/index_about.htm (last visited Apr. 24, 2014).

18. VT. STAT. ANN. tit. 8 § 8308(a) (2013).

19. *Id.*

20. Annette L. Nazareth & Margaret E. Tahyar, *Transparency and Confidentiality in the Post Financial Crisis World—Where to Strike the Balance?*, 1 HARV. BUS. L. REV. 145, 155 (2011).

21. *See id*. (noting the confusion that can result when the public interprets certain data).

22. *Risk-Based Capital*, NAT'L ASS'N OF INS. COMM'RS (Dec. 9, 2013), http://www.naic.org/cipr_topics/topic_risk_based_capital.htm.

> The RBC regime was created to provide a capital adequacy standard that is related to risk, raises a safety net for insurers, is uniform among the states, and provides regulatory authority for timely action. It has two main components: 1) the risk-based capital formula . . . and 2) a risk-based capital model law that grants automatic authority to the state insurance regulator to take specific actions based on the level of impairment.
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> The Risk Based Capital Formula was developed as an additional tool to assist regulators in the financial analysis of insurance companies. The purpose of the formula is to establish a minimum capital requirement based on the types of risks to which a company is exposed. Separate RBC models have been developed for each of the primary insurance types: Life, Property/Casualty, Health and Fraternal.

Id.

Specific statutory exemptions from disclosure are probably an easy call, but many other informational "gray areas" exist that may or may not be protected.[23] Trade secrets and other proprietary or sensitive information complicate the task of determining confidentiality.[24] The disclosure of executive compensation is one gray area that receives much attention, particularly for health insurance companies.[25]

IV. VERMONT'S ADDENDUM TO HEALTH INSURER ANNUAL STATEMENT

The financial crisis brought many issues of corporate behavior to the surface. Executive compensation captured the public's attention like no other.[26] Outsized salaries and pay packages highlighted the abuses on Wall Street by some of the country's biggest companies, including those that took government bailout funds.[27] The national debate raging over health care reform has prompted closer scrutiny of health insurers by both regulators and the public.[28] In 2011, a nerve was struck in Massachusetts when it was revealed that a nonprofit health insurance company handsomely paid a departing chief executive while it asked regulators for double-digit rate increases.[29] Vermont had its own version of salary shock

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23. Peter J. Henning, *The Gray Line of 'Confidential' Information*, N.Y. TIMES, Aug. 5, 2013, http://dealbook.nytimes.com/2013/08/05/the-sometimes-gray-line-of-confidential-information/.

24. Anne Margaret Thompson, SEC Confidential Treatment Orders: Balancing Competing Regulatory Objectives 1–2, 5–6 (Aug. 2011) (unpublished dissertation, Texas A&M University) (on file with Office of Graduate Studies, Texas A&M University), *available at* http://repository.tamu.edu/bitstream/handle/1969.1/ETD-TAMU-2011-08-9742/THOMPSON-DISSERTATION.pdf?sequence=2.

25. *See* Wendell Potter, *The Higher Health Insurers' Claim Denial Rate, the Higher the CEO Pay*, HUFFINGTON POST (Apr. 23, 2013, 7:51 AM), http://www.huffingtonpost.com/wendell-potter/the-higher-health-insurer_b_3137831.html (discussing Vermont's new law making public the compensation of insurance companies' CEOs).

26. *See, e.g.*, *In a Weak Economy, Why Is CEO Pay on the Rise?*, PBS NEWSHOUR (Oct. 4, 2011), http://www.pbs.org/newshour/bb/business/july-dec11/ceopay_10-04.html (discussing quadrupling of median executive compensation).

27. *See, e.g.*, Jonathan Weisman & Joann S. Lublin, *Obama Lays Out Limits on Executive Pay*, WALL ST. J., Feb. 5, 2009, http://online.wsj.com/news/articles/SB123375514020647787 (detailing regulations imposed on executive compensation).

28. *See, e.g.*, Julie Appleby, *Insurance Industry Faces Tough Scrutiny from Federal Watchdogs*, KAISER HEALTH NEWS (June 1, 2010), http://www.kaiserhealthnews.org/stories/2010/june/01/insurance-industry-faces-tough-scrutiny-from-federal-watchdogs.aspx (discussing effort to overhaul private insurance market).

29. Robert Weisman, *Insurer Battles Identity Crisis*, BOSTON GLOBE, Mar. 20, 2011, http://www.boston.com/business/healthcare/articles/2011/03/20/blue_cross_battles_an_identity_crisis_amid_outcry_over_pay/.

when a former CEO of Blue Cross Blue Shield of Vermont (BCBSVT) received "a $7.2 million golden parachute" when he retired.[30]

Recently, the U.S. Securities & Exchange Commission (SEC) proposed a new rule requiring public companies to disclose the ratio of its CEO's compensation to the median compensation of its employees.[31] Supporters of the rule suggest that such information would "'help investors understand how issuers are distributing compensation dollars throughout the firm in ways that may help improve employee morale and productivity'"[32] and that this type of disclosure "will increase corporate board accountability to investors."[33] Commenters with opposing views dispute the potential benefits and "assert[] that this type of disclosure would not be material to investors or useful to an investment or voting decision."[34] The questions of what type and how much information is truly helpful to the public are difficult to evaluate. When does the quest for transparency simply sound good on the evening news or on the floor of a legislature, but ultimately fail to achieve the goal of assisting consumers, policyholders, or investors? The public might have a right to know, but it is hard to conjure up much public outcry for more disclosure of financial details.

While publicly traded companies must disclose compensation in various filings to the SEC, private or nonprofit health insurance companies are not subject to the same disclosure requirements.[35] In Vermont, however, each insurance carrier must submit an annual financial condition statement to the state regulator to receive a state license to engage in the insurance business.[36] Furthermore, during the 2011–2012 legislative session Vermont passed a bill known as S.200 (now contained in Act 150) that requires

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30. Andy Bromage, *Why Blue Cross May Owe Its Former CEO Another $575,000, Plus Interest*, SEVEN DAYS (July 18, 2012), http://www.7dvt.com/2012why-blue-cross-may-owe-its-former-ceo-another-575-000-plus-interest.

31. Pay Ratio Disclosure, Dodd-Frank Act Release No. 33-9452, 78 Fed. Reg. 60560, 60562 (proposed Sept. 18, 2013) (to be codified at 17 C.F.R. pts. 229; 249), *available at* http://www.gpo.gov/fdsys/pkg/FR-2013-10-01/pdf/2013-23073.pdf.

32. *Id.* at 60562 n.24 (quoting Letter from Stu Dalheim, Dir., Shareholder Advocacy, to Elizabeth M. Murphy, Sec'y, SEC (May 27, 2011), *available at* http://www.sec.gov/comments/df-title-ix/executive-compensation/executivecompensation-75.pdf).

33. *Id.* (quoting Letter from Meredith Miller, Corporate Governance Officer, UAW Retiree Med. Benefits Trust, to Elizabeth M. Murphy, Sec'y, SEC (Apr. 14, 2011), *available at* http://www.sec.gov/comments/df-title-ix/executive-compensation/executivecompensation-65.pdf).

34. *Id.* at 60561.

35. *See* 17 C.F.R. § 200.2(a) (2013) (stating relevant SEC laws apply to "[p]ublic disclosure of pertinent facts concerning public offerings . . . ."); 17 C.F.R. § 229.402(a) (2013) (requiring SEC disclosure of executive compensation of public companies and not private companies); *Public Companies*, SEC, https://www.investor.gov/introduction-markets/how-markets-work/public-companies#.Ux0MOYUwAuv (last visited Apr. 15, 2014).

36. VT. STAT. ANN. tit. 8, § 3561(a) (2009).

certain health insurance companies to assemble categories of financial and operational information in a separate addendum to the annual statement filing.[37] Health insurers with a minimum of 2,000 Vermont lives covered at the end of the preceding year or that offer major medical health insurance on the state's new health exchange, Vermont Health Connect, are further subject to the Health Insurer Annual Statement Addendum (Addendum).[38] The filing includes corporate officer and board of director compensation figures along with claims denial data, lobbying expenses, and marketing expenses.[39]

Proponents of the law felt that this information would give a "'blueprint of what the company's history is with claims and their finances.'"[40] They also felt that the new document would provide Vermonters with "'one easy place'" to find and use this information, presumably as guidance for selecting insurance.[41]

Opponents of S.200 argued that the additional reporting requirement "went too far" by requiring disclosure of salaries, bonuses, and benefits.[42] Insurance companies complained that these new reporting requirements were burdensome and duplicative because they already provide much of the information to the DFR in various other filings.[43] But the measure passed overwhelmingly in both chambers of the Vermont legislature and became effective July 1, 2012.[44] Three health insurance companies (BCBSVT, MVP, and Cigna) met the statutory requirements and submitted the Addendum in 2013.[45] BCBSVT and MVP documents are attached as Exhibits A and B.

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37. Act 150, 2012 Vt. Acts & Resolves 530, 531 (codified as VT. STAT. ANN. tit. 18, § 9414(a) (2013)).

38. *Id.* at 530.

39. *Id.* at 530–531.

40. John Dillon, *Under House Bill, Insurers to Disclose Claims Denials*, VT. PUB. RADIO (Apr. 25, 2012), http://www.vpr.net/news_detail/94268/under-house-bill-insurers-to-disclose-claims-denia/.

41. *Id.* The Vermont Public Interest Research Group (VPIRG) indicates on its website that it "led the charge in fighting for more transparency and disclosure from health insurance companies operating in Vermont" and counts S.200 as one of its legislative victories to prevent health insurers from padding the bottom line. *2012 Legislative Accomplishments*, VPIRG (May 8, 2012), http://www.vpirg.org/news/2012-legislative-accomplishments/.

42. Dillon, *supra* note 40.

43. *Id.*

44. *Id.*; Act 150, 2012 Vt. Acts & Resolves 536 (codified at VT. STAT. ANN. tit. 18, § 9414(a) (2013)). S.200 gained preliminary approval by a vote of 135 to 1 from the House on April 24, 2012, with the lone dissenting vote cast by Representative Tom Burditt of West Rutland. H. JOURNAL, 2d Sess., at 1229–30 (Vt. 2012), *available at* http://www.leg.state.vt.us/docs/2012/journal/HJ120424.pdf#page=73.

45. Wendell Potter, *OPINION: Vermont Law Illuminates Claims Statistics*, PUB. INTEGRITY PROJECT (Apr. 22, 2013), http://www.publicintegrity.org/2013/04/22/12526/opinion-vermont-law-illuminates-claims-statistics.

In addition to requiring health insurers submit the Addendum, the law mandated that DFR post the filings on its website to give the public access to the information.[46] DFR then tracked the "hits" to its website to determine the amount of Internet traffic that went to the Addendum pages.[47] Not surprising to some, the number of visits to the website totaled a mere 14 hits by September 2013.[48] DFR experienced a minor increase in Internet traffic immediately after the required March 1 posting and then a dramatic drop off.[49] Based on various follow-up calls from the media to DFR and subsequent articles published, one can assume that journalists—and not the public—generated the flurry of activity.[50] If true, this raises the question: did consumers really want or need the information in S.200 as certain legislators and advocates assumed? Apart from perhaps reading about the reports in a news article, consumers did not rush to download the information directly. One can surmise that there is truly little interest in what the CEO of Blue Cross Blue Shield receives as compensation. Thus, when consumers elect to purchase a health insurance plan, they will undoubtedly find the price point comparison between insurance companies much more relevant than executive pay, lobby expenses, or charitable contributions. Has the Addendum achieved the honor of being too much information? Where is the balance of needing to know versus confidentiality? The Vermont Supreme Court has observed that "courts often require a balancing of the public interest in disclosure against the harm to the individual."[51] Perhaps in the information age, balancing the public interest in disclosure against its usefulness to the individual might be an effective way to consider the need for transparency.

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46. VT. STAT. ANN. tit. 18, § 9414(d)(1) (2013).

47. GOOGLE ANALYTICS, UNIQUE VISITS TO PAGE: MAR. 1, 2013–FEB. 27, 2014, at 1 (Feb. 27, 2014) (on file with author) (displaying custom graph of total visits to particular DFR webpage that has links to Addendum pages: http://www.dfr.vermont.gov/insurance/health-insurance/health-insurers-annual-reports).

48. *Id.*

49. *Id.*

50. *See, e.g.*, Andrew Stein, *New Disclosures Show MVP Denied 15.5 Percent of Patient Claims in 2012; Blue Cross Denied 7.6 Percent*, VTDIGGER (Mar. 20, 2013), http://vtdigger.org/2013/03/20/new-disclosures-show-mvp-denied-15-5-percent-of-patient-claims-in-2012-blue-cross-denied-7-6-percent/ (providing example of an article published about the new disclosure information after contacting the DFR).

51. Trombley v. Bellows Falls Union High Sch. Dist. No. 27, 160 Vt. 101, 109, 624 A.2d 857, 863 (1993).

EXHIBIT A

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
2012 Annual Statement, due March 1, 2013.

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): 132,963

Contact Person: Steven Peake Contact Phone Number: (802) 371-3287

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.

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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) 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	1,340,555	99,053	7.4%	0.06568
Pharmacy Claims	1,232,174	95,443	7.7%	0.06625
Grand Total	2,572,729	194,496	7.6%	0.12896

Part I.B Administrative Denials Only

Claims Category (1)	Total number (2)	Total denied (3)	Denial % (4)	PMPM Denial Rate (5)
Medical claims	1,340,555	88,973	6.6%	0.05899
Pharmacy Claims	1,232,174	85,312	6.9%	0.05922
Grand Total	2,572,729	174,285	6.8%	0.11556

Part I.C Member Impact Denials Only

Claims Category (1)	Total number (2)	Total denied (3)	Denial % (4)	PMPM Denial Rate (5)
Medical claims	1,340,555	10,080	0.7%	0.00668
Pharmacy Claims	1,232,174	10,131	0.8%	0.00703
Grand Total	2,572,729	20,211	0.8%	0.01340

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 1st level appeals, Row 2 is 2nd level appeals 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. Plans should report only "member based" appeals which includes appeals filed by members or filed by a provider on behalf of a member but should not include 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:53,124 Total overturned: 155 Overturned Rate: 0%	Requested: 0.03522 Overturned: 0.00001
First level prior authorization and pre-service appeals	Total Appeals: 43 Total Overturned: 17 Overturned Rate: 39%	Appeals: 0.00003 Overturned: 0.00001
Second level prior authorization and pre-service appeals	Total Appeals: 6 Total Overturned: 3 Overturned Rate: 50%	Appeals: 0.0000 Overturned: 0.0000
External review of prior authorization and pre-service appeals	Total Appeals: 0 Total Overturned: 0 Overturned Rate: -	Appeals: 0.0000 Overturned: 0.0000

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: 271 Total Overturned: 126 Overturned Rate: 46%	Appeals: 0.00018 Overturned: 0.00008
Second level appeals of post-service adverse determinations.	Total Appeals: 21 Total Overturned: 8 Overturned Rate: 38%	Appeals: 0.00001 Overturned: 0.00000
External review of post-service appeal determinations	Total Appeals: 2 Total Overturned: 1 Overturned Rate: 50%	Appeals: 0.0000 Overturned: 0.0000

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.

III.A Corporate Officer Compensation

Title of Company Officers(1)	Salary (2)	Bonus (3)	Other Compensation (4)
Chief Executive Officer	574,913		12,271
Treasurer	342,516		225,329
Secretary	290,832		7,782
Vice President, Operations	242,244		213,024
President of Subsidiary	310,620		64,782
VP and Chief Medical Officer	301,047		4,338
VP, External Affairs and Sales	261,402		10,795
Vice President, Planning	254,671		5,767
Chief Actuary	236,562		8,303
Vice President and CIO	234,208		433

III.B Board Compensation

Board Members	Salary	Bonus	Other Compensation
Board Chair	28,950		
Board Member	25,600		
Board Member	21,450		
Board Member	21,450		
Board Member	20,850		
Board Member	20,300		
Board Member	20,050		
Board Member	18,300		
Board Member	16,823		
Board Member	16,450		
Board Member	16,450		

Board Member	14,050		
Board Member	11,450		
Board Member	7,400		
Board Member	5,000		
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: $ 743,968

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: $ 258,347

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	55,919

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 $ 164,869

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 $ 46,245

EXHIBIT 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
2012 Annual Statement, due March 1, 2013.

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: **MVP Health Insurance Company**

State of Domicile: **New York**

Total number of states in which health insurer operates: **2**

List names of states where licensed (other than Vermont): **New York**

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): **28,329 at December 31, 2012**

Contact Person: **Ulkem Crisafulli** Contact Phone Number: **518-388-2519**

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.

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	248,812	14,591	5.9%	0.05
Pharmacy Claims	330,690	75,250	22.76%	0.24
Grand Total	579,502	89,841	15.5%	0.29

Part I.B Administrative Denials Only

Claims Category (1)	Total number (2)	Total denied (3)	Denial % (4)	PMPM Denial Rate (5)
Medical claims	248,812	10,857	4.4%	0.04
Pharmacy Claims	313,720	58,280	18.58%	0.19
Grand Total	562,532	69,137	12.29%	0.23

Part I.C Member Impact Denials Only

Claims Category (1)	Total number (2)	Total denied (3)	Denial % (4)	PMPM Denial Rate (5)
Medical claims	248,812	3,734	1.5%	0.01
Pharmacy Claims	272,410	16,970	6.23%	0.06
Grand Total	521,222	20,704	3.97%	0.07

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 1st level appeals, Row 2 is 2nd level appeals 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. Plans should report only "member based" appeals which includes appeals filed by members or filed by a provider on behalf of a member but should not include 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: **6,805** Total overturned: **see below** Overturned Rate: **see below**	Requested: **.02222** Overturned: **see below**
First level prior authorization and pre-service appeals	Total Appeals: **46** Total Overturned: **26** Overturned Rate: **56.52%**	Appeals: **.0016** Overturned: **.00090**
Second level prior authorization and pre-service appeals	Total Appeals: **7** Total Overturned: **0** Overturned Rate: **0%**	Appeals: **.00024** Overturned: **0**
External review of prior authorization and pre-service appeals	Total Appeals: **3** Total Overturned: **0** Overturned Rate: **0%**	Appeals: **.00010** Overturned: **0**

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: **22** Total Overturned: **6** Overturned Rate: **27.27%**	Appeals: **.00076** Overturned: **.00021**
Second level appeals of post-service adverse determinations.	Total Appeals: **1** Total Overturned: **0** Overturned Rate: **0%**	Appeals: **.00003** Overturned: **0**
External review of post-service appeal determinations	Total Appeals: **0** Total Overturned: **0** Overturned Rate: **0%**	Appeals: **0** Overturned: **0**

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.

III.A Corporate Officer Compensation

Title of Company Officers(1)	Salary (2)	Bonus (3)	Other Compensation (4)
Chief Executive Officer	704000	241324	305176
Treasurer	379000	80613	70317
Secretary	450508	99667	104646
Vice President	444519	80000	39880
Vice President	300300	66276	29611
Vice President	251474	97840	316997
Vice President	93015	48836	424641
Vice President	306353	70382	187430
Vice President	163250	93993	234667
Vice President	120230	40889	309221

III.B Board Compensation

Board Members	Salary	Bonus	Other Compensation
Board Member	0	0	0
Board Member	0	0	0
Board Member	0	0	0
Board Member	0	0	0
Board Member	0	0	0
Board Member	0	0	0
Board Member	0	0	0
Board Member	0	0	0
Board Member	0	0	0
Board Member	0	0	0
Board Member	0	0	0
Board Member	0	0	0
Board Member	0	0	0

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: **$516,358 (excludes Catamount)**

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.

Please note that MVP Health Insurance Company is a subsidiary of MVP Health Care, Inc. Lobbying expenditures are paid through another MVP Health Care, Inc. subsidiary, MVP Health Plan Inc., and allocated to various MVP entities through a cost allocation process. At this time, we are not reporting on behalf of MVP Health Plan due to total Vermont lives covered being less than 2,000. The numbers reported are the entity wide totals. This also applies to Part VII of this form.

Federal lobbying expenditures: **$ 160,000**

Vermont lobbying expenditures: **$ 55,366.09**

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)

No MVP company makes direct political contributions. MVP participates in the Vermont political process, however, through an affiliated political action committee (PAC). PAC campaign finance reports are a matter of public record and are on file with the Vermont Secretary of State.

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
America's Health Insurance Plans (AHIP)	$ 120,495.58
Vermont Business Roundtable	$ 246.75
Vermont Businesses for Social Responsibility	$ 125.00
Lake Champlain Regional Chamber of Commerce	$ 130.50

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 **$ 0**