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. The popular press continually chronicles the debate between not enough and too much information.

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
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

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.
“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.


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

7. VT. STAT. ANN. tit. 8, § 11 (2013); see VT. DEPT’D OF FIN. REG., TOGETHER . . . WORKING
%20-%20Narrative.pdf (discussing Banking, Securities, and Insurance divisions of the DFR); see also
Department’s mission and listing the Banking, Securities, Insurance, and Captives divisions of the
DFR).
licensed entities split among independent agencies and reporting structures. Some combine banking and insurance or insurance and securities under one agency. 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.

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. These laws recognize that certain information is so sensitive that its production would render harm to companies and not be in the public interest. 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


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.


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://www.2.leg.state.vt.us/CommitteeDocs/Public%20Records/Public%20Records%20Exemptions/November%201,2013/Department%20of%20Financial%20Regulation-Related%20Exemptions/11-1-2013-David%20Cassettty-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.” 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. 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. 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. 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. Vermont law acknowledges that RBC
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.” Further, RBC information is not “subject to subpoena.” In addition to shielding RBC ratios from competitors, regulators fear that laypeople will misinterpret the data attributed to a company and act irrationally. 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. RBC is a sophisticated regulatory tool, not a measure of whether consumers should cash in their life insurance policies.

[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.


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


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


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.

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.
Specific statutory exemptions from disclosure are probably an easy call, but many other informational “gray areas” exist that may or may not be protected.\textsuperscript{23} Trade secrets and other proprietary or sensitive information complicate the task of determining confidentiality.\textsuperscript{24} The disclosure of executive compensation is one gray area that receives much attention, particularly for health insurance companies.\textsuperscript{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.\textsuperscript{26} Ousized 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.\textsuperscript{27} The national debate raging over health care reform has prompted closer scrutiny of health insurers by both regulators and the public.\textsuperscript{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.\textsuperscript{29} Vermont had its own version of salary shock


\textsuperscript{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_pay_b_3137831.html (discussing Vermont’s new law making public the compensation of insurance companies’ CEOs).


\textsuperscript{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/june01/insurance-industry-faces-tough-scrutiny-from-federal-watchdogs.aspx (discussing effort to overhaul private insurance market).

when a former CEO of Blue Cross Blue Shield of Vermont (BCBSVT) received “a $7.2 million golden parachute” when he retired.  

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.  

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” and that this type of disclosure “will increase corporate board accountability to investors.” 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.” 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. 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. Furthermore, during the 2011–2012 legislative session Vermont passed a bill known as S.200 (now contained in Act 150) that requires


34. Id. at 60561.


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.\textsuperscript{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).\textsuperscript{38} The filing includes corporate officer and board of director compensation figures along with claims denial data, lobbying expenses, and marketing expenses.\textsuperscript{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.’”\textsuperscript{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.\textsuperscript{41}

Opponents of S.200 argued that the additional reporting requirement “went too far” by requiring disclosure of salaries, bonuses, and benefits.\textsuperscript{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.\textsuperscript{43} But the measure passed overwhelmingly in both chambers of the Vermont legislature and became effective July 1, 2012.\textsuperscript{44} Three health insurance companies (BCBSVT, MVP, and Cigna) met the statutory requirements and submitted the Addendum in 2013.\textsuperscript{45} BCBSVT and MVP documents are attached as Exhibits A and B.

\textsuperscript{37} Act 150, 2012 Vt. Acts & Resolves 530, 531 (codified as VT. STAT. ANN. tit. 18, § 9414(a) (2013)).
\textsuperscript{38} Id. at 530.
\textsuperscript{39} Id. at 530–531.
\textsuperscript{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/.
\textsuperscript{42} Dillon, supra note 40.
\textsuperscript{43} Id.
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. DFR then tracked the “hits” to its website to determine the amount of Internet traffic that went to the Addendum pages. Not surprising to some, the number of visits to the website totaled a mere 14 hits by September 2013. DFR experienced a minor increase in Internet traffic immediately after the required March 1 posting and then a dramatic drop off. 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. 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.” 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.

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).
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.
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
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

<table>
<thead>
<tr>
<th>Claims Category</th>
<th>Total number (2)</th>
<th>Total denied (3)</th>
<th>Denial % (4)</th>
<th>PMPM Denial Rate (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical claims</td>
<td>1,340,555</td>
<td>99,053</td>
<td>7.4%</td>
<td>0.06568</td>
</tr>
<tr>
<td>Pharmacy Claims</td>
<td>1,232,174</td>
<td>95,443</td>
<td>7.7%</td>
<td>0.06625</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2,572,729</td>
<td>194,496</td>
<td>7.6%</td>
<td>0.12896</td>
</tr>
</tbody>
</table>

### Part I.B Administrative Denials Only

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

### Part I.C Member Impact Denials Only

<table>
<thead>
<tr>
<th>Claims Category</th>
<th>Total number (2)</th>
<th>Total denied (3)</th>
<th>Denial % (4)</th>
<th>PMPM Denial Rate (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical claims</td>
<td>1,340,555</td>
<td>10,080</td>
<td>0.7%</td>
<td>0.00568</td>
</tr>
<tr>
<td>Pharmacy Claims</td>
<td>1,232,174</td>
<td>10,131</td>
<td>0.8%</td>
<td>0.00703</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2,572,729</td>
<td>20,211</td>
<td>0.8%</td>
<td>0.01340</td>
</tr>
</tbody>
</table>

### 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 and 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 and 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

<table>
<thead>
<tr>
<th>Requirement (1)</th>
<th>Medical Claims &amp; Pharmacy Health Insurer (2)</th>
<th>PMPM (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorizations, including prior authorizations to bypass medical or pharmacy utilization management programs</td>
<td>Total requested: 53,124 Total overturned: 155 Overturned Rate: 0%</td>
<td>Requested: 0.03522 Overturned: 0.00001</td>
</tr>
<tr>
<td>First level prior authorization and pre-service appeals</td>
<td>Total Appeals: 43 Total Overturned: 17 Overturned Rate: 39%</td>
<td>Appeals: 0.00003 Overturned: 0.00001</td>
</tr>
<tr>
<td>Second level prior authorization and pre-service appeals</td>
<td>Total Appeals: 6 Total Overturned: 3 Overturned Rate: 50%</td>
<td>Appeals: 0.0000 Overturned: 0.0000</td>
</tr>
<tr>
<td>External review of prior authorization and pre-service appeals</td>
<td>Total Appeals: 0 Total Overturned: 0 Overturned Rate: -</td>
<td>Appeals: 0.0000 Overturned: 0.0000</td>
</tr>
</tbody>
</table>

Part II. B Post-Service Appeals Reporting

<table>
<thead>
<tr>
<th>Requirement (1)</th>
<th>Medical Claims &amp; Pharmacy Health Insurer (2)</th>
<th>PMPM (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First level appeals of post-service adverse determinations</td>
<td>Total Appeals: 271 Total Overturned: 126 Overturned Rate: 46%</td>
<td>Appeals: 0.00018 Overturned: 0.00008</td>
</tr>
<tr>
<td>Second level appeals of post-service adverse determinations</td>
<td>Total Appeals: 21 Total Overturned: 8 Overturned Rate: 38%</td>
<td>Appeals: 0.00001 Overturned: 0.00000</td>
</tr>
<tr>
<td>External review of post-service appeal determinations</td>
<td>Total Appeals: 2 Total Overturned: 1 Overturned Rate: 50%</td>
<td>Appeals: 0.0000 Overturned: 0.00000</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Title of Company Officers</th>
<th>Salary (2)</th>
<th>Bonus (3)</th>
<th>Other Compensation (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive Officer</td>
<td>579,913</td>
<td>12,271</td>
<td></td>
</tr>
<tr>
<td>Treasurer</td>
<td>342,516</td>
<td>225,326</td>
<td></td>
</tr>
<tr>
<td>Secretary</td>
<td>290,657</td>
<td>7,782</td>
<td></td>
</tr>
<tr>
<td>Vice President, Operations</td>
<td>242,244</td>
<td>213,024</td>
<td></td>
</tr>
<tr>
<td>President of Subsidiary</td>
<td>310,620</td>
<td>64,782</td>
<td></td>
</tr>
<tr>
<td>VP and Chief Medical Officer</td>
<td>301,047</td>
<td>4,338</td>
<td></td>
</tr>
<tr>
<td>VP, External Affairs and Sales</td>
<td>261,402</td>
<td>10,795</td>
<td></td>
</tr>
<tr>
<td>Vice President, Planning</td>
<td>254,671</td>
<td>5,767</td>
<td></td>
</tr>
<tr>
<td>Chief Actuary</td>
<td>236,562</td>
<td>8,303</td>
<td></td>
</tr>
<tr>
<td>Vice President and CIO</td>
<td>234,208</td>
<td>433</td>
<td></td>
</tr>
</tbody>
</table>

### III.B Board Compensation

<table>
<thead>
<tr>
<th>Board Members</th>
<th>Salary</th>
<th>Bonus</th>
<th>Other Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Chair</td>
<td>28,950</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Member</td>
<td>25,600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Member</td>
<td>21,450</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Member</td>
<td>20,850</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Member</td>
<td>20,300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Member</td>
<td>18,300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Member</td>
<td>16,823</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Member</td>
<td>16,450</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Member</td>
<td>16,450</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**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. § (6)(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 were made for a candidate who was running for Vermont state office (s) or a political party (p). In column (3) provide the total amount for the year.

<table>
<thead>
<tr>
<th>Recipient (1)</th>
<th>(2) Vermont candidate (s) or party (p)</th>
<th>(3) Amount of cash or cash equivalent (in-kind)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Trade organization</th>
<th>Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield Association</td>
<td>$5,919</td>
</tr>
</tbody>
</table>

Part VIII – Legal expenses related to claims or service 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


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 5105 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 HCPCS
- 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**

<table>
<thead>
<tr>
<th>Claims Category</th>
<th>Total number (2)</th>
<th>Total denied (3)</th>
<th>Denial % (4)</th>
<th>PMPM Denial Rate (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical claims</td>
<td>248,812</td>
<td>14,591</td>
<td>5.9%</td>
<td>0.05</td>
</tr>
<tr>
<td>Pharmacy Claims</td>
<td>330,690</td>
<td>75,250</td>
<td>22.78%</td>
<td>0.24</td>
</tr>
<tr>
<td>Grand Total</td>
<td>579,502</td>
<td>99,841</td>
<td>15.5%</td>
<td>0.25</td>
</tr>
</tbody>
</table>

**Part I.B Administrative Denials Only**

<table>
<thead>
<tr>
<th>Claims Category</th>
<th>Total number (2)</th>
<th>Total denied (3)</th>
<th>Denial % (4)</th>
<th>PMPM Denial Rate (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical claims</td>
<td>248,812</td>
<td>10,857</td>
<td>4.4%</td>
<td>0.04</td>
</tr>
<tr>
<td>Pharmacy Claims</td>
<td>315,720</td>
<td>58,290</td>
<td>18.56%</td>
<td>0.19</td>
</tr>
<tr>
<td>Grand Total</td>
<td>562,532</td>
<td>69,147</td>
<td>12.33%</td>
<td>0.23</td>
</tr>
</tbody>
</table>

**Part I.C Member Impact Denials Only**

<table>
<thead>
<tr>
<th>Claims Category</th>
<th>Total number (2)</th>
<th>Total denied (3)</th>
<th>Denial % (4)</th>
<th>PMPM Denial Rate (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical claims</td>
<td>248,812</td>
<td>3,734</td>
<td>1.5%</td>
<td>0.01</td>
</tr>
<tr>
<td>Pharmacy Claims</td>
<td>272,410</td>
<td>16,970</td>
<td>6.23%</td>
<td>0.06</td>
</tr>
<tr>
<td>Grand Total</td>
<td>521,222</td>
<td>20,704</td>
<td>3.97%</td>
<td>0.07</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Requirement (1)</th>
<th>Medical Claims &amp; Pharmacy Health Insurer (2)</th>
<th>PMFM (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorizations, Including prior authorizations to bypass medical or pharmacy utilization management programs</td>
<td>Total requested: 6,805</td>
<td>Requested: .02222</td>
</tr>
<tr>
<td></td>
<td>Total overturned: see below</td>
<td>Overturned: see below</td>
</tr>
<tr>
<td></td>
<td>Overturned Rate: see below</td>
<td></td>
</tr>
<tr>
<td>First level prior authorization and pre-service appeals</td>
<td>Total Appeals: 46</td>
<td>Appeals: .0016</td>
</tr>
<tr>
<td></td>
<td>Total Overturned: 26</td>
<td>Overturned: .00090</td>
</tr>
<tr>
<td></td>
<td>Overturned Rate: 56.52%</td>
<td></td>
</tr>
<tr>
<td>Second level prior authorization and pre-service appeals</td>
<td>Total Appeals: 7</td>
<td>Appeals: .00024</td>
</tr>
<tr>
<td></td>
<td>Total Overturned: 0</td>
<td>Overturned: 0</td>
</tr>
<tr>
<td></td>
<td>Overturned Rate: 0%</td>
<td></td>
</tr>
<tr>
<td>External review of prior authorization and pre-service appeals</td>
<td>Total Appeals: 3</td>
<td>Appeals: .00010</td>
</tr>
<tr>
<td></td>
<td>Total Overturned: 0</td>
<td>Overturned: 0</td>
</tr>
<tr>
<td></td>
<td>Overturned Rate: 0%</td>
<td></td>
</tr>
</tbody>
</table>

### Part II. B Post-Service Appeals Reporting

<table>
<thead>
<tr>
<th>Requirement (1)</th>
<th>Medical Claims &amp; Pharmacy Health Insurer (2)</th>
<th>PMFM (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First level appeals of post-service adverse determinations.</td>
<td>Total Appeals: 22</td>
<td>Appeals: .00076</td>
</tr>
<tr>
<td></td>
<td>Total Overturned: 6</td>
<td>Overturned: .00021</td>
</tr>
<tr>
<td></td>
<td>Overturned Rate: 27.27%</td>
<td></td>
</tr>
<tr>
<td>Second level appeals of post-service adverse determinations.</td>
<td>Total Appeals: 1</td>
<td>Appeals: .00003</td>
</tr>
<tr>
<td></td>
<td>Total Overturned: 0</td>
<td>Overturned: 0</td>
</tr>
<tr>
<td></td>
<td>Overturned Rate: 0%</td>
<td></td>
</tr>
<tr>
<td>External review of post-service appeal determinations</td>
<td>Total Appeals: 0</td>
<td>Appeals: 0</td>
</tr>
<tr>
<td></td>
<td>Total Overturned: 0</td>
<td>Overturned: 0</td>
</tr>
<tr>
<td></td>
<td>Overturned Rate: 0%</td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Title of Company Officers(1)</th>
<th>Salary (2)</th>
<th>Bonus (3)</th>
<th>Other Compensation (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive Officer</td>
<td>704000</td>
<td>241324</td>
<td>305176</td>
</tr>
<tr>
<td>Treasurer</td>
<td>379000</td>
<td>80613</td>
<td>70317</td>
</tr>
<tr>
<td>Secretary</td>
<td>450598</td>
<td>59667</td>
<td>194646</td>
</tr>
<tr>
<td>Vice President</td>
<td>444519</td>
<td>80000</td>
<td>39880</td>
</tr>
<tr>
<td>Vice President</td>
<td>300300</td>
<td>66276</td>
<td>29611</td>
</tr>
<tr>
<td>Vice President</td>
<td>251474</td>
<td>97840</td>
<td>316997</td>
</tr>
<tr>
<td>Vice President</td>
<td>92015</td>
<td>48836</td>
<td>424641</td>
</tr>
<tr>
<td>Vice President</td>
<td>306353</td>
<td>70382</td>
<td>187430</td>
</tr>
<tr>
<td>Vice President</td>
<td>161250</td>
<td>93999</td>
<td>234667</td>
</tr>
<tr>
<td>Vice President</td>
<td>120230</td>
<td>45889</td>
<td>309221</td>
</tr>
</tbody>
</table>

### III.B Board Compensation

<table>
<thead>
<tr>
<th>Board Members</th>
<th>Salary</th>
<th>Bonus</th>
<th>Other Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Member</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Board Member</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>Board Member</td>
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<td>Board Member</td>
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<td>0</td>
</tr>
<tr>
<td>Board Member</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
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 contribution was made for a candidate was running for Vermont state office (c) or a political party (p). In column (3) provide the total amount for the year.

<table>
<thead>
<tr>
<th>Recipient (1)</th>
<th>(2) Vermont candidate (c) or party (p)</th>
<th>(3) Amount of cash or cash equivalent (in-kind)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Trade organization</th>
<th>Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>America's Health Insurance Plan (AHIP)</td>
<td>$120,495.58</td>
</tr>
<tr>
<td>Vermont Business Roundtable</td>
<td>$246.75</td>
</tr>
<tr>
<td>Vermont Business for Social Responsibility</td>
<td>$325.00</td>
</tr>
<tr>
<td>Lake Champlain Regional Chamber of Commerce</td>
<td>$130.00</td>
</tr>
</tbody>
</table>

### 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