STATE OF VERMONT
Department of Financial Regulation
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INSTRUCTIONS

Addendum to Health Insurer Annual Statement

Implementing 18 V.S.A. § 9414a and Act 152 (2015, Adj. Sess., § 8) due annually March 1, for the preceding calendar year basis information.

General Instructions:

Completion and submission of this form is required of all health insurers that:

1. have 2,000 or more Vermont lives covered at the end of the preceding calendar year or who offered insurance through the Vermont health benefit exchange pursuant to 33 V.S.A. chapter 18, subchapter 1, in the preceding calendar year; and
2. file annual (financial) statements with the Department of Financial Regulation under 8 V.S.A. § 3561, 4516, 4588 or 5106.

The health insurer must report using calendar year basis information.

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.

The definitions for the terms adverse benefit determination, claim, concurrent review, grievance, independent external review, post-service review, pre-service review and utilization review as used in these instructions are contained in 18 V.S.A. § 9414a (a). Except as otherwise noted, medical claims include all categories of claims that are not pharmacy claims. Where mental health-substance abuse services claims are required to be separated from total medical claims, claims involving mental health-substance abuse diagnoses are to be reported in aggregate. Medical claims do not include pediatric dental or pediatric vision claims incurred in [calendar year] and reported March 1 of the next year.

Each health insurer required to report shall post the completed annual report on its website. The websites for the Department and the Health Care Advocate's Office shall provide links to each health insurer's website posting.

Tab 1: Health insurer information, 18 V.S.A. § 9414a (b)(1), (2) and (3)

In the health insurer information section, insert the name of the health insurer, its state of domicile, the number of states in which it operates, together with a list of states where it is licensed (other than Vermont), together with the total number of Vermont lives covered. For purposes of this report, the total number of Vermont lives covered is 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.

Insert the name of the health insurer's contact person and phone number in the contact information section.

Tab 2 –Claim submission & denials, 18 V.S.A. § 9414a (b)(4), (8) and (13)

In Table 2.1, health insurers must report total claims submitted to the health insurer, total number of claims denied, denial percentage and the rate of denials per member per month, using breakouts for medical claims (not including mental health-substance abuse claims), mental health-substance abuse claims and pharmacy claims. For each category of claims described in Table 2.1 Column (1), provide the total number of claims in column (2); the total number of claims denied in column (3); the total number of denied claims as a percentage of total claims in column (4); and the total number of denied claims on a per member per month basis in column (5).

In Table 2.2, health insurers must report total administrative claims and denial volume by claim service category. For each category of claims described in Table 2.2 Column (1), provide the total number of administrative claims by category in column (2); the total number of administrative claims denied in column (3); the total number of denied administrative claims as a percentage of total claims in column (4); and the total number of denied administrative claims on a per member per month basis in column (5).

> Administrative denials are denials that involve provider contractual obligations or other contractual or administrative requirements (do not include claims that involve member impact, see Table 2.3 below). Claims that involve administrative denials (including provider contract obligations or other contractual or administrative requirements) include:
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> - 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 Table 2.3, health insurers must report total member impact claims and denial volume by claim service category. For each category of claims described in Table 2.3 Column (1), provide the total number of member impact claims in column (2); the total number of member impact claims denied in column (3); the total number of denied member impact claims as a percentage of total claims in column (4); and the total number of denied member impact claims on a per member per month basis in column (5).

> 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). 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 claims and denials reported in Table 2.2 and member impact claims and denials reported in Table 2.3 together must equal total claims and denials reported in Table 2.1.

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 claims, i.e., medical, mental health-substance abuse or pharmacy claims, that are being reported.

Tab 3 – Member based requests and appeals involving utilization review, 18 V.S.A. § 9414a (b)(5) (Member Based Prior Authorization Requests, Prior Authorization and Pre-service Appeals, and Post Service Requests Based on Utilization Review)

In Tab 3, health insurers must report utilization review activity on pre-service/prior authorization, concurrent and post-service bases, broken out by category and by review level. For purposes of this Tab 3, concurrent means utilization review conducted during a member's stay in a hospital or other facility or to extend a previously approved course of treatment, for requests made within the timeframes set forth in the U.S. Department of Labor's claims procedure rule, 29 C.F.R. § 2560.503-1 (f)(2)(ii). Requests received outside of DOL timeframes should be reported as Pre-service.

Table 3.1 covers the number and percentage of pre-service/prior authorization requests, denials and appeals based on utilization review received in the preceding calendar year.

- For each category of claims described in Column (1) provide the total number of prior authorization requests in Column (2) and percent of total requests that were denied in Column (3).
- For each category of prior authorization request provide the total number that were appealed to the first level in Column (4), the percent of the total number appealed to first level in Column (5), the number of appeals overturned at first level in Column (6) and the percent of appeals that were overturned at first level in column (7).
- For each category of prior authorization request provide the total number appealed to the second level in Column (8), the percent of the total number appealed to second level in Column (9), the number of appeals overturned at second level in Column (10) and the percent of appeals that were overturned at second level in column (11).
- For each category of prior authorization request provide the total number appealed to external appeal in Column (12), the percent of the total number appealed to external review in Column (13), the number of appeals overturned at external review level in

Column (14) and the percent of total number of appeals that were overturned at external review level in column (15).

Table 3.2 covers the number and percentage of concurrent care requests and denials based on utilization review that were received in the preceding calendar year.

- For each category of claims described in Column (1) provide the total number of concurrent care requests in Column (2) and percent of total requests that were denied in Column (3).
- For each category of concurrent prior authorization request provide the total number that were appealed to the first level in Column (4), the percent of the total number that were appealed to first level in Column (5), the number of appeals overturned at first level in Column (6) and the percent of appeals overturned at first level in column (7).
- For each category of concurrent prior authorization request provide the total number appealed to the second level in Column (8), the percent of the total number appealed to second level in Column (9), the number of appeals overturned at second level in Column (10) and the percent of appeals overturned at second level in column (11).
- For each category of concurrent prior authorization request provide the total number appealed to external appeal in Column (12), the percent of the total number appealed to external review in Column (13), the number of appeals overturned at external review level in Column (14) and the percent of total number of appeals overturned at external review level in column (15).

Table 3.3 covers the number and percentage of post-service review requests and denials based on utilization review that were received in the preceding calendar year

- For each category of claims described in Column (1) provide the total number of post-service review requests based on utilization review in Column (2) and percent of total requests that were denied in Column (3).
- For each category of post-service review request provide the total number that were appealed to the first level in Column (4), the percent of the total number that were appealed to first level in Column (5), the number of appeals overturned at first level in Column (6) and the percent of appeals overturned at first level in column (7).
- For each category of post-service review request provide the total number appealed to the second level in Column (8), the percent of the total number appealed to second level in Column (9), the number of appeals overturned at second level in Column (10) and the percent of appeals overturned at second level in column (11).
- For each category of post-service review request provide the total number appealed to external appeal in Column (12), the percent of the total number appealed to external review in Column (13), the number of appeals overturned at external review level in Column (14) and the percent of total number of appeals overturned at external review level in column (15).

The prior authorization and appeal activity reported in Tab 3 should include each level of review and appeal concluded during the calendar year even though this could result in an 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.

Note: Plans should report only "member based" appeals which includes requests or appeals filed by members or filed by a provider on behalf of a member and should not include requests or appeals that are not member based.

Tab 4 – Adverse benefit determinations without utilization review activity, 18 V.S.A. § 9414a (b)(6)

In Tab 4, health insurers must report post-service appeals that did not involve utilization review activity.

Column (1) describes the level of appeal covered in each row. Provide the total number of appeals in the category in Column (2), the total number overturned in Column (3), and the overturned rate in Column (4). The per-member per-month number of appeals are reported in Column (5) and the percentage overturned on a per-member per-month basis are reported in Column (6).

The appeal activity reported in Tab 4 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.

Tab 5 – Claims processed in timely manner, 18 V.S.A. § 9414a (b)(9)

Health insurers shall survey their members annually to determine whether members view the plan as processing claims in a timely manner. Plans must use the question from the most recent version of the CMS Health Plan Consumer Assessment of Health Care Providers & Systems® ("CAPHS®") survey adopted on or before the first day of the calendar year being reported that measures members' views on timely processing of claims For calendar year 2016, the survey results for Question 40 of version 5.0H shall be used by a health insurer for the reporting required in this Tab.

The total number of survey results received for Question 40 should be inserted in column (1) and used as the denominator to calculate the rate for each category of response. The number of responses indicating the health insurer never processes claims in a timely manner should be inserted in column (2) and the resulting rate (column (2) numerator ÷ column (1) denominator) should be calculated and inserted in column (3). The number of responses indicating the health insurer sometimes processes claims in a timely manner should be inserted in column (4) and the resulting rate (column (4) numerator ÷ column (1) denominator) should be calculated and

inserted in column (5). The number of responses indicating the health insurer usually processes claims in a timely manner should be inserted in column (6) and the resulting rate (column (6) numerator ÷ column (1) denominator) should be calculated and inserted in column (7). The number of responses indicating the health insurer always processes claims in a timely manner should be inserted in column (8) and the resulting rate (column (8) numerator ÷ column (1) denominator) should be calculated and inserted in column (9).

The CAPHS® surveys were developed, implemented and are administered by the Centers for Medicare & Medicaid Services (CMS) to measure patient experience with a focus on matters that patients themselves say are important to them and for which patients are the best and/or only source of information. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/index.html

Tab 6 - Claims processed accurately (financially & administratively), 18 V.S.A. § 9414a (b)(10)

Health insurers shall survey their members annually to determine whether members view the plan as processing claims accurately (financially and administratively). Plans must use the question from the most recent version of the CMS Health Plan Consumer Assessment of Health Care Providers & Systems® ("CAPHS®") survey adopted on or before the first day of the calendar year being reported that measures members' views on claims accuracy. For calendar year 2016, the survey results for question 41 of version 5.0H shall be used by a health insurer for the reporting required in this Tab.

The total number of survey results for Question 41 received should be inserted in column (1) and used as the denominator to calculate the rate for each category of response. The number of responses indicating the health insurer never processes claims accurately should be inserted in column (2) and the resulting rate (column (2) numerator ÷ column (1) denominator) should be calculated and inserted in column (3). The number of responses indicating the health insurer sometimes processes claims accurately should be inserted in column (4) and the resulting rate (column (4) numerator ÷ column (1) denominator) should be calculated and inserted in column (5). The number of responses indicating the health insurer usually processes claims accurately should be inserted in column (6) and the resulting rate (column (6) numerator ÷ column (1) denominator) should be calculated and inserted in column (7). The number of responses indicating the health insurer always processes claims accurately should be inserted in column (8) and the resulting rate (column (8) numerator ÷ column (1) denominator) should be calculated and inserted in column (9).

The CAPHS® surveys were developed, implemented and are administered by the Centers for Medicare & Medicaid Services (CMS) to measure patient experience with a focus on matters that patients themselves say are important to them and for which patients are the best and/or only source of information. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/index.html

Tab 7 - Utilization review decision timelines, 18 V.S.A. § 9414a (b)(11)

In this Tab, health insurers report on the number and percentage of utilization review decisions according to the relevant timelines: 1) Concurrent reviews requested within the applicable DOL timeframes are decided: a) within 24 hours of (timely) receipt for emergency care; b) as soon as possible for requests to extend care taking into account the medical exigencies; and, c) before the expiration of a previously approved course of treatment that is being terminated or reduced; 2) urgent preservice reviews are decided within 48 hours of receipt; 3) non-urgent preservice reviews are decided within two business days of receipt; and 4) post-service reviews are decided within 30 days of receipt.

Weekends and legal holidays do not count as business days. Non-urgent requests received after normal business hours are deemed to have been received on the next business day. Requests for review while in facility or to extend a previously approved course of treatment that are received after the applicable DOL timelines have expired shall be treated as pre-service requests taking into account the medical exigencies. For review requests that are filed without sufficient information, the tolling of timeframes for the health insurer to request and receive necessary information are to be handled as provided by applicable law. Reporting in this Tab shall separate medical services (without mental health or substance abuse services), mental health or substance abuse services, and pharmacy claims.

Table 7.1 Medical Services Decisions (not including mental health and substance abuse services decisions reported in table 7.2)

For each category of review listed in column (1) provide the number of utilization review decisions made in column (2), broken down by whether they were timely or not, and then the total count. Provide the percentage of the total in each subcategory in column (3).

Table 7.2 Mental Health and Substance Abuse Services Decisions

For each category of review listed in column (1) provide the number of utilization review decisions made in column (2), broken down by whether they were timely or not, and then the total count. Provide the percentage of the total in each subcategory in column (3).

Table 7.3 Pharmacy Decisions
For each category of review listed in column (1) provide the number of utilization review decisions made in column (2), broken down by whether they were timely or not, and then the total count. Provide the percentage of the total in each subcategory in column (3).

Tab 8 - Quality of Care Grievances, 18 V.S.A. § 9414a (b)(12)

In Tab 8, health insurers report the number of grievances received that are unrelated to an adverse benefit determination but related to availability, delivery or quality of health care services or related to the contractual relationship between a member and the health insurer. Grievance are to be reported broken down by health care provider performance issues; plan administration; and access to health care, including mental health-substance abuse providers and services.

In Table 8, for each type of grievance described in column (1) provide the total number received during the calendar year in column (2), the total per 1000 members in column (3), the number of grievances remaining unresolved from the prior calendar year in column (4), the total number resolved after first review in column (5), the number of first reviews resolved in the member's favor in column (6), the percentage of reviews resolved in the member's favor after first review in column (7), the total number resolved after second review in column (8), the number of second reviews resolved in the member's favor in column (9), the percentage of reviews resolved in the member's favor after second review in column (10).

Tabs 9A and 9B - Provider Satisfaction Surveys and Survey Action Plan, 18 V.S.A. § 9414a (b)(14) and (15)

Health insurers shall survey health care providers on their level of satisfaction with the health insurer using a set of questions approved by Department of Financial Regulation and report the results in Tab 9.A. In addition, health insurers shall provide a narrative describing actions they have taken or will take in response to provider satisfaction surveys in Tab 9.B. (Nothing in this report requirement shall prevent a health insurer from surveying providers in more depth or in additional areas not covered by the Department of Financial Regulation questions.)
Special Instruction for reporting provider satisfaction survey results for calendar year 2016 in Tab 9.A: Recognizing that Act 152, 2015 (Adj. Sess.) was enacted after some health insurers had already sent surveys to providers for calendar year 2016, health insurers shall provide in Tab 9.A the same type of information in the same format for calendar year 2016 that they provided to the Department for calendar year 2015 in connection with Rule 9-03 reporting.

Instruction for reporting provider satisfaction survey results for calendar year 2017 and subsequent calendar years in Tab 9.A. Starting with calendar year 2017 reporting, health insurers shall report in Table 9.A their survey results using the survey questions that will be finalized by the Department of Financial Regulation in early 2017.

Tab 10 – Corporate Officer and Board Compensation, 18 V.S.A. § 9414a (b)(16)

Each health insurer shall report corporate officer compensation in Table 10.1 and board compensation in Table 10.2, regardless of the amount of total compensation or whether the officer or board member held such position office for all 12 months of the calendar year.

In Column (1) of Table 10.1 provide the title of the company officer. In column (2) provide the officer's Salary. Compensation and stipends paid to board members for services as a director should be reported in Column (2) of Table 10.2. For both Table 10.1 and 10.2 provide any Bonus paid in column (3) and the amount of Other Compensation paid in column (4) for each officer or director, respectively.

For purposes of Table 10.1, "Salary" means fixed compensation paid regularly for services and includes compensation withheld and payable only upon achievement of pre-established performance metrics. For purposes of Table 10.2, "Direct Compensation" includes Salary,

stipend or per meeting payments made to board members. For purposes of Tables 10.1 and 10.2, "Bonus" means money or its equivalent given on a discretionary basis in addition to salary or stipend as a premium based on performance or other measure. For purposes of Tables 10.1 and 10.2, "Other Compensation" means any and all other remuneration paid to or on behalf of an officer or director 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.

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

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

"Affiliate" of a health insurer means a company that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the health insurer as determined under the definitions found in 8 V.S.A. § 3681.

Tab 11– Total Vermont Marketing & Advertising expenses (includes sponsorships), 18 V.S.A. § 9414a (b)(17)

Each health insurer shall report total Vermont marketing and advertising expenses in Tab 11. 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.

Tab 12 – Lobbying expenses, 18 V.S.A. § 9414a (b)(18)

Each health insurer shall report total federal and Vermont-specific lobbying expenses in Tab 12. 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.

Tab 13 – Political Contributions, 18 V.S.A. § 9414a (b)(19)

In Tab 13, 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 the name of recipient. In column (2) indicate whether the contribution was made to a candidate running for Vermont state office (s) or to a political party (p). In column (3) provide the total amount of contribution for the year.

Tab 14 – Dues to trade groups that engage in lobbying or make political contributions, 18 V.S.A. § 9414a (b)(20)

In Tab 14, 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.

Tab 15 – Legal expenses related to claims or services denials, 18 V.S.A. § 9414a (b)(21)

Each health insurer shall report legal expenses related to claims or service denials for Vermont members during the preceding year in Tab 15. 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.

Tab 16 – Vermont Charitable Contribution, 18 V.S.A. § 9414a (b)(21)

Each health insurer shall report the total of all contributions made to Vermont charitable organizations that are deductible under federal law. Note: public or charitable event sponsorships are reported in Tab 11 and are not to be included in this Tab 16.