

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2018)
Vermont Health Connect Rate Filing)
) GMCB-07-17-rr
)

HCA’s Response to MVP’s Objection to HCA’s Suggested Questions

The Office of the Health Care Advocate (HCA) respectfully submits the following response to MVP’s Objection to HCA’s June 12 Suggested Questions:

1. The HCA represents the interests of the people of Vermont in health insurance rate review cases before the Green Mountain Care Board (the Board or GMCB). The HCA acts on behalf of health insurance consumers, who will pay the insurance premiums affected by this rate increase request. The HCA’s questions serve the public interest and are part of an essential exchange of information that allows us to thoroughly evaluate the factors that have led to the proposed rate increase and best represent the interests of Vermonters.
2. None of the questions are beyond the scope of the inquiry. The Board’s inquiry is broad in scope: When “deciding whether to approve, modify, or disapprove each rate request, the Board shall determine whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to law, and is not excessive, inadequate, or unfairly discriminatory.” GMCB Rule 2.000 § 2.301(b); GMCB Rule 2.000 § 2.401; *see also* 8 V.S.A. § 4062(a)(3). In addition, the Board must take into consideration “the

requirements of the underlying statutes, changes in health care delivery, changes in payment methods and amounts, protecting insurer solvency, and other issues at the discretion of the Board.” 18 V.S.A. § 9375(b)(6); *see also* GMCB Rule 2.000 § 2.401.

3. MVP Health Plan, Inc. (MVP) objects to certain questions on the basis that some of the information the HCA requests is available from public sources. However, in the past insurers have objected to the HCA’s referring to figures from public sources on the basis that the information can be misconstrued. *See, e.g.*, GMCB Docket No. 04-17rr, BCBSVT Reply Memo, p. 2 (May 17, 2017). The HCA is therefore asking for information directly from the insurers to avoid misunderstandings. If MVP believes that a publically available document fully speaks for itself, MVP is welcome to identify that document in its response. In one question the HCA itself identifies the public document and simply asks MVP to confirm that it may be relied upon. In response to the HCA’s question #34, “Are your actual income to actual expenses for the past five years accurately reflected in your annual reports?”, MVP may simply answer, “yes” if there are no qualifications to the information in the annual reports. If the answer is no, the HCA believes it is important to understand why.
4. MVP states that, in the rate-setting process, “differences between the actuaries are fleshed out the old-fashioned way, through cross-examination.” This is simply untrue. The hearings give the parties a chance to present their arguments to the Board and allow the Board to ask questions. The hearing takes place after the actuarial memoranda are submitted. It is not meant to be an opportunity for evidence gathering. Further, if information gathering was left to the hearing, it would require a much longer hearing,

perhaps extending into several days. In addition, due to the quantitative nature of rate review cases, written answers are often much clearer than verbal answers.

5. To the extent that MVP is objecting that the answers are proprietary, that is a basis for asking that the answers be kept confidential, not a basis to keep the answers from the Board or the HCA.
6. MVP complains that the HCA waited until the 30th day to pose its questions. The statute gives the HCA 30 days to submit questions in order to afford a full review of the materials and we met the required deadline. 8 V.S.A. § 4062(c)(3)(A).
7. Several of the questions MVP objects to as unduly burdensome are “yes” or “no” questions that should not require significant research. Although written answers allow for maximum transparency, the HCA is willing to arrange an actuary to actuary phone call to discuss several of the questions. Specifically, questions # 1, 2, 7, 8, 13, 27, 29, 31, and 36 could be answered by phone. For questions 22 and 34, we ask MVP to simply answer yes or no and any further clarification can be given by phone.
8. The HCA was not copied on the first objection letter to MVP and the second objection letter was submitted the day after the HCA submitted our questions. To the extent that L&E has asked the same question of MVP, MVP is welcome to refer to those answers.
9. MVP compares the HCA’s questions to federal rules of civil procedure which limit interrogatories to 25. It should be noted that federal courts have the discretion to allow for more questions and regularly do so. Further, the HCA does not have access to other forms of discovery in the rate review process such as opportunities to depose witnesses and request document production other than through our questions. Under the federal rules, a party can depose up to ten individuals for up to seven hours each, or longer at the

court's discretion. F.R.C.P. 30 The federal rules also allow for unlimited requests for the production of documents. F.R.C.P. 34.

10. MVP submitted less information in its rate filing than Blue Cross and Blue Shield of Vermont (BCBSVT). In many cases, the HCA is looking to fill in the missing information. MVP's argument that the questions should be kept to the "four corners" of the rate filing is self-serving and nonsensical in that it would bar questions on any subject or detail MVP chooses to omit from its initial filing.
11. MVP proposes to respond by July 5, 2017 to a very limited set of questions. This is not a reasonable timeframe as it gives the HCA less than a week to prepare our actuarial memorandum in this case, which is due July 11, 2017. We ask the Board to require MVP to respond by June 27, 2017.
12. The HCA responds specifically to each objection as follows:
 - a) Question 1 (a-d): MVP states that this question is outside of the scope of review in part because it asks for 2013 information when the Exchange did not exist until 2014. We will clarify the question to refer to plan years 2014-2016. The original question included the year 2013 as 2013 was the year the 2014 rate filings were submitted to the Board. Further, the HCA is interested in whether MVP believes the records of these past rate filings need to be clarified in any way and wants to ensure there is a meeting of the minds on the analysis. As stated above, the HCA would be willing to discuss this by phone.
 - b) Question 2: The HCA agrees that the information may be in some documents available to the HCA, but the HCA would like to know if any

pertinent information is missing from those documents. As stated above, the HCA would be willing to discuss this by phone.

- c) Question 7: This question is related to administrative costs and quality of care, which are issues within the scope of the Board's review. These questions should not be burdensome to answer. BCBSVT included an estimate of this cost in its rate filing.
- d) Question 8: The validity of data is within the scope of the Board's review and the question should not be difficult to answer. It is a yes/no question.
- e) Questions 10 and 11: Methodology for developing the rates is within the scope of the Board's review. MVP's objection to questions 10 and 11 refer to ex parte communications between the insurer and the Board's actuaries. The HCA has not been informed of these communications or any agreements arising from them. We ask that these understandings be documented in writing, and that the agreed-upon methodology be described so the HCA's actuary has the benefit of that information.
- f) Question 12: We believe it is important for MVP to verify in writing if its clinical team does not play any role in assessing the utilization trends for the development of the rate filing. MVP should be able to explain its utilization trend projections.
- g) Question 13: The HCA is asking for verification: a simple yes or no. As stated above, the HCA would be willing to discuss any additional response by phone.
- h) Question 14: The question asks for a yes or no answer.

- i) Question 15 (3): This question relates to the reliability of the data and methodology that MVP is using for one of its main drivers of cost increases. MVP can reasonably be expected to know and to demonstrate whether this source (its PBM) has been reliable in the past. It is not possible for the HCA's actuary to validate the PBM using available information.
- j) Question 21(a): This question refers to a significant cost driver for the rates and is therefore within the scope of review.
- k) Question 21(c): This is a significant question for cost control. If MVP has not utilized enough alternative provider payment arrangements to impact 1% of cost, MVP can state that in its answer.
- l) Question 22: This question requires simple yes or no answers, including whether or not MVP could perform the specified study (for example, if requested by the Board). The question does not require MVP to perform the study if it has not been performed. Cost drivers are within the scope of review.
- m) Question 23: Numerous studies support the concept that quality primary care lowers costs.¹ The response to this question need not be burdensome. The first sentence asks for a yes or no answer. If the answer is no, MVP can provide a general description of how they would approach the question.

¹ See, e.g. Mark W. Friedberg, Peter S. Hussey, and Eric C. Schneider, *Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care*, Health Affairs vol. 29, no. 5 (May 2010).

- n) Question 24: The incentives given to providers to manage costs are relevant to this process given that providers are a significant driver of costs. It should not be burdensome to provide a general description of the incentives MVP utilizes.
- o) Question 25: BCBSVT's filing states this is a factor in rate increases. This is a significant issue that is believed to impact rates.
- p) Question 26: The question is directly relevant to MVP's unit cost assumptions which directly impact rates. Unit cost is increasing for providers significantly faster than inflation. The insurers should be able to explain what factors are considered in setting provider rates. The other carrier has mentioned this as a factor driving unit costs.
- q) Question 27: The HCA can clarify that the question was meant to refer to standard provider contracting templates, which outline provider reimbursement. Relevant information would include fee schedules, provider incentives, and risk contracts.
- r) Question 28: This pertains to an issue that has a significant impact on rates. The HCA should be allowed to inquire about it.
- s) Question 29: L&E asked the first part of this question only. If cost-sharing reduction (CSR) subsidies are not funded, it is unclear what the process and timeframe will be for approval of modified rates. It is possible the timeframe will be quite short and the opportunity for input will be limited. We therefore think it is appropriate to ask for more detail. The HCA believes the rest of the inquiry regarding the CSR issue is important for

clarifying MVP's position on an approach that has received significant attention from national consumer protection groups.

- t) Question 31: These questions are related to analyzing MVP's administrative costs and contributions to reserves.
- u) Question 32: The HCA will withdraw this question, as L&E asked a significantly similar question. We note, however, that MVP could simply refer to its response to L&E.
- v) Question 33(a), (c): This is information that BCBSVT provides in its filing. It is directly relevant to reviewing MVP's CTR request. If MVP does not have a target RBC, it can answer no to question 33 (c).
- w) Question 34: This question requires a simple yes or no to verify the information. If clarification is needed, that information would be helpful for the review. As stated above, the HCA would be willing to discuss any clarifications by phone.
- x) Question 35: The HCA will withdraw this question, as L&E asked a substantially similar question. We note, however, that MVP could simply refer to its response to L&E.
- y) Question 36: If this information is included in the filing, we ask MVP to provide the relevant page number.
- z) Question 37: The insurers have stated that they set executive compensation at levels comparable to other similar organizations. If this is true, it should not be difficult for the insurers to provide the information they look to in order to set salaries. This is directly applicable to

administrative costs and an issue that the public is significantly interested in.

aa) Questions 38 and 39: These questions relate directly to administrative costs. The HCA recognizes that Act 152 documents are publically available and contain some answers to these questions, but they do not contain all of the relevant information. For example, we have been told that the lists of executive pay “include the full year compensation of all individuals who served in a Vice President role at any time during the year.” GMCB 04-17rr, BCBSVT Reply Memo, p. 2. If there is turnover mid-year, the disclosures appear to show more vice president positions than actually existed. *See Id.* We are asking MVP to explain the data in a way that allows a fair comparison of executive pay compensation from year to year. There is significant public interest in this topic and the information should be transparent. Further, question 39 relates not only to how much money is spent on compensation, but what incentives employees are given to impact the costs and quality of Exchange products.

WHEREFORE, the HCA respectfully requests that the Board:

- A. Submit the HCA’s questions to MVP, with the exception of questions 32 and 35;
- B. Permit MVP to respond in writing “yes” or “no” to questions 22 and 34, with additional clarification to be given on an actuary-to-actuary phone call to take place no later than June 26, 2017;

- C. If the Board determines that MVP is not required to respond to all HCA questions in writing, permit MVP to respond to questions 1, 2, 7, 8, 13, 27, 29, 31, and 36 via an actuary-to-actuary phone call to take place no later than June 26, 2017; and
- D. Require written responses, where applicable, by June 27, 2017.

Dated at Montpelier, Vermont this 19th Day of June, 2017.

/s/ Kaili Kuiper
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CERTIFICATE OF SERVICE

I, Kaili Kuiper, hereby certify that I have served the above Memorandum on Judith Henkin, General Counsel to the Green Mountain Care Board; Noel Hudson, Health Policy Director of the Green Mountain Care Board; and Gary Karnedy, MVP Health Plan representative, by electronic mail, return receipt requested, this 19th Day of June, 2017.

/s/ Kaili Kuiper
Kaili Kuiper
Staff Attorney
Office of the Health Care Advocate