STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2025 Small Group and Individual Group Vermont Health Connect Rate Filing SERFF Nos. MVPH-134081005 MVPH-134081032	))))))	DOCKET NOS. GMCB-005-24rr GMCB-006-24rr

MVP'S OBJECTIONS TO THE HEALTH CARE ADVOCATE'S JUNE 12, 2024 INTERROGATORIES

1. MVP Health Plan, Inc., ("MVP") by and through Primmer Piper Eggleston & Cramer PC, hereby objects to the Health Care Advocate's ("HCA") Interrogatories submitted to the Green Mountain Care Board ("Board" or "GMCB") on June 12, 2024, and requests that the Board exercise its discretion and decline to propound the HCA's Interrogatory Nos. 1, 2, 4, 5, 7 and 8 for the following reasons:

2. On May 13, 2024, MVP filed its 2025 Rate Filings. The HCA has thirty days to submit "suggested questions regarding the [rate filing]" to the Board. *8 V.S.A. § 4062(c)(3)(A); State of Vermont Green Mountain Care Board Rule 2.000: Health Insurance Rate Review ("Rules"), Rule 2.202(c): Public Access to Information.*

3. The HCA's authority in these proceedings is limited and the HCA may: 1) submit questions to the Board to provide to its actuary (8 V.S.A. § 4062(c)(3)(A)); 2) submit comments to the Board targeted at the substance of the rate request (8 V.S.A. § 4062(c)(3)(B)); 3) testify at the rate review hearing and object to admission of evidence (8 V.S.A. § 4062(e)(1)(B); GMCB Board rule 2.307); 4) appeal the Board's decision (8 V.S.A. § 4062(g)); and, 5) advise the Board on Board policies, procedures and rules (18 V.S.A. § 9374(f)). The Board should not accept Interrogatory questions on subjects that stray beyond this authority, in particular, the substance of the rate request.

4. On June 12, 2024, the HCA requested that the Board propound 8 Interrogatories to MVP.

5. The Board has the discretion to limit suggested Interrogatories. *Rule 2.202(c).*

6. In past rate filings, the Board has exercised its discretion and eliminated and narrowed the HCA's suggested Interrogatories before propounding the HCA's Interrogatories to MVP. *See Ruling Regarding HCA's Suggested Questions to MVP, In re: MVP Health Plan, Inc. 2015 Vermont Health Connect Rate Filing, GMCB-17-14rr (July 8, 2014)* ("*2015 Order")* *(eliminating three Interrogatories)*; *In re: MVP Health Plan, Inc. 2019 Vermont Health Connect Rate Filing, GMCB-008-18rr (eliminating HCA Non-Actuarial Interrogatory No. 1); In re: MVP Health Plan, Inc. 2020 Vermont Health Connect Rate Filing, GMCB-005-19rr) (modifying HCA's Actuarial Interrogatory No. 1)*; *In re: MVP Health Plan, Inc. 2023 Vermont Health Connect Rate Filing, GMCB-004-23rr (eliminating two non-actuarial Interrogatories).*

7. The Board is free to consider whether an Interrogatory is beyond the scope of relevancy to the rate filing dockets, unduly burdensome, or overly broad taking into account the needs of the case and the importance of the particular issue at stake in the rate filings. *See V.R.C.P. 26*. Requests for Information that are unreasonably cumulative, duplicative, or obtainable from some other source that is more convenient, less burdensome, and less expensive should be denied. *See id*. Interrogatories are vehicles for seeking factual information about the rate filings, not for posing hypotheticals, particularly if they are not relevant to the rate filings. *See V.R.C.P. 33(b)*; 8 V.S.A. § 4062(c)(3)(A); *Rule 2.202(c); Rule 2.304.* Although the Board is not bound by the Vermont Rules of Civil Procedure, they do provide a helpful guide for determining the scope of a reasonable Interrogatory in this instance.

8. The Board should exercise its discretion and decline to propound HCA's suggested Interrogatories (Nos. 1, 2, 4, 5, 7 and 8 identified below) to MVP, as set forth below. MVP does not object to the remaining interrogatories: 3 and 6.

MVP'S RESPONSES TO THE HCA'S SUGGESTED INTERROGATORIES

1. Please provide more information about the Well-Being Reimbursement program. [Question 1] What are the categories for which members can receive reimbursement? [Question 2] What method has MVP chosen to allow members to submit for reimbursement? [Question 3] Provide any evidence MVP possesses showing that the program is improving member health and lowering claims costs overall.

Response: The Interrogatory includes three separate questions which we have marked for reference above. MVP objects to this Interrogatory as overly broad, unduly burdensome, and seeking information that is not relevant to this rate filing.

Questions 1 and 2 seek information not relevant to the 2025 rate filings. 8 V.S.A. § 4062(c)(3)(A). The categories of [treatment] for which members can receive reimbursement under the Well-Being Reimbursement program are not related to the 2025 rate filings. The same is true for the method by which MVP allows members to submit for reimbursement. That information is not used by MVP in the development of the rate filings.

Question 3 does not seek information about MVP's rate filings, it is not an actuarial question, and is therefore beyond the scope and exceeds HCA's statutory authority. As a procedural matter, pursuant to 8 V.S.A. § 4062(a)(3)(A), the HCA is permitted to submit to the Board, "suggested questions *regarding the filing* for the Board to provide to its contracting actuary, if any." ***See also Rule 2.202(c)*****. MVP's rate filing does not contain an accounting of the Well-Being Reimbursement program's direct impact on claim costs overall. Thus, the HCA is asking a question beyond the scope of MVP's rate filing. MVP can determine what evidence it wishes to present on non-actuarial criteria through its original rate filing, pre-filed testimony, exhibits, and at hearing to meet its burden of proof.**

The HCA is not statutorily or by rule vested with the authority to ask MVP to create *additional* evidence in an interrogatory. MVP's witness will be available for HCA cross-examination.

In sum, pursuant to the Rules and Statute, the HCA is not authorized to suggest this Interrogatory seeking information neither discussed in, nor pertinent to, the rate filings. This Interrogatory does not seek information about MVP's rate filings, is not an actuarial question, and is therefore beyond the scope and exceeds HCA's statutory authority.

2. Please provide additional information about MVP's current claims edits and payment policies that will be removed or restricted upon enactment of H.766. For each edit or policy (or category thereof), provide the corresponding dollar amount, ensuring that the total equals the billed charges amount mentioned in MVP's response to Objection 1, Question 16.

<u>Response</u>: MVP objections to this Interrogatory as duplicative. MVP is responding to a substantively identical questions posed by L&E. Please see MVP's June 19, 2024 response to L&E's Objection letter No. 2 at response to Question 7.

4. Confirm that MVP has renewed its contract with CVS/Caremark for pharmacy benefit management (PBM) services and state when the new contract term ends. Did MVP negotiate with CVS/Caremark over the terms of the new contract? If so, please describe any contract enhancements that MVP received as a result of the negotiations and demonstrate the impact of those enhancements on the filed rates.

<u>Response</u>: MVP objects to this Interrogatory because it seeks confidential or proprietary business information regarding MVP's contractual relationship with its PBM and goes beyond the scope of these rate filings.

While questions related to PBMs may implicate Title 18 concerns generally, the question the HCA is posing goes beyond its statutory charge in Title 8. Pursuant to 8 V.S.A. § 4062(c)(3)(A), the HCA is permitted to submit to the Board, "suggested questions *<u>regarding</u>*

the filing **for the Board to provide to its contracting actuary, if any."** ***See also Rule 2.202(c).*** **Pursuant to the Rules and Statute, the HCA is not authorized to suggest this Interrogatory seeking information neither discussed in, nor pertinent to, the rate filings. This Interrogatory does not seek information about MVP's rate filings, is not an actuarial question, and is therefore beyond the scope and exceeds HCA's statutory authority. The HCA is not authorized to seek information about the functioning of PBMs or their contractual relationships with providers.**

Furthermore, The Board's own demand for information is limited in scope by its ***Rules*** **to information about the rate filings.** ***Rule 2.304*****. The HCA cannot ask the Board to propound an Interrogatory that exceeds the Board's own authority under its** ***Rules*****.**

5. Prior to renewing the contract with CVS/Caremark, did MVP:

   a. audit CVS/Caremark's performance under the prior contract? If so, describe all aspects of the audit.

   b. perform any market comparison checks to evaluate whether MVP is receiving the best possible terms for PBM services? If so, thoroughly describe the process, including timelines, evaluation criteria, and benchmarks.

   c. solicit or receive bids or outreach from any PBM other than CVS/Caremark?

Response: MVP objects to this Interrogatory because it seeks confidential or proprietary business information regarding MVP's contractual relationship with its PBM, is not relevant, and is beyond the scope of the rate filings.

MVP's contractual relationship with its PBM is not discussed in the rate filings nor relevant to whether the rates as proposed meet the statutory criteria. Pursuant to ***Rule 2.202(c)*****, "the Advocate may submit to the Board . . . suggested questions regarding the request for the Board to provide to its consulting actuary."** ***8 V.S.A. § 4062(c)(3)(A)*****. Pursuant to the Rules and Statute, the HCA is not authorized to suggest this Interrogatory**

seeking information neither discussed in, nor pertinent to, the rate filings. The Board's own demand for information is limited in scope by its *Rules* to information about the rate filings. *Rule 2.304*. The HCA cannot ask the Board to propound an Interrogatory that exceeds the Board's own authority under its *Rules*.

7. The Rx trend projection data provided by MVP's PBM and produced in response to Objection 1, Question 8, presents the Rx trend data in terms of gross costs. We note that MVP's PBM announced a new product last year, CVS Caremark TrueCost. An executive summary of the new product describes the current system of drug pricing as "no longer sustainable" and "ready for industry-shifting change." The new product provides a "multi-year net cost guarantee that incorporates all of the discounts" and "a deeper level of transparency while ensuring the same or better value." Does MVP agree with its PBM that the current system is no longer sustainable? Has MVP evaluated whether a system of pharmacy benefit management based on true net costs plus dispensing and administrative fees would benefit its members? If so, please share the findings of the evaluation.

Response: MVP objects to this Interrogatory because the information it seeks is confidential and proprietary, not relevant, is beyond the scope of this year's rate filing, and calls for speculation.

The information sought in this Interrogatory is not related to MVP's 2025 rate filings, is not an actuarial question, and is therefore beyond the scope and exceeds HCA's statutory authority. The information sought has absolutely no impact on the amount or basis of MVP's 2025 rate increase requests before the Board.

Furthermore, MVP objects to this Interrogatory because it calls for speculation and opinions. This Interrogatory asks MVP to opine or comment on a statement made by CVS/Caremark in promotional material identified as an "executive summary" of a new CVS/Caremark product, in which MVP had no involvement. MVP further objects to HCA's perfunctory characterization of the CVS promotional materials, which is stripped from its context and fails to acknowledge that it is certain *tools* historically used within the drug cost management structure that are no longer sustainable to employ given the evolving pharmacy

landscape, not the entire current system. The purpose of Interrogatories is to seek factual information, not to pose hypotheticals, or require parties to create new documents. *Rule 2.203; V.R.C.P. 33(b*

8. Does MVP acknowledge that some of its members are purchasing prescriptions "off benefit" through services such as GoodRx or Mark Cuban Cost Plus Drug Company, because, in many cases, those members are able to obtain lower prices "off benefit" than they receive through their benefit plan? Does MVP or its PBM have hard data on the amount of such "off benefit" spending by its Vermont QHP membership? If so, please provide the data. What does MVP see as the plusses and minuses of "off benefit" drug spending?

Response: MVP objects to this Interrogatory because it calls for speculation and goes beyond the scope of the rate filings. The purpose of Interrogatories is to seek factual information, not to pose hypotheticals, or require parties to create new documents. *Rule 2.203; V.R.C.P. 33(b)*. Furthermore, the information sought in this Interrogatory is not related to MVP's 2025 rate filings, is not an actuarial question and is therefore beyond the scope and exceeds HCA's statutory authority. The information sought has absolutely no impact on the amount or basis of MVP's 2025 rate increase requests before the Board.

Dated: June 18, 2024

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