STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2024 Individual Market Rate Filing	)))	GMCB-004-23rr SERFF No. MVPH-133660955

In re: MVP Health Plan, Inc. 2024 Small Group Market Rate Filing	)))	GMCB-005-23rr SERFF No. MVPH-133660956

HCA RESPONSE TO MVP HEALTH PLAN, INC.'S OBJECTIONS TO HCA SUGGESTED QUESTIONS

On June 8, 2023, the Office of the Health Care Advocate (HCA) proposed questions for the Green Mountain Care Board (GMCB or Board) to ask MVP Health Plan, Inc. (MVP) in the above captioned matters. The HCA proposed 13 questions (HCA Questions) pursuant to its statutorily defined right. 8 V.S.A. § 4062. On June 15, 2023, MVP objected to five of the HCA Questions (MVP Objections). The HCA responds to the MVP Objections as follows.

I. Process Concerns

As an initial matter, the HCA has concerns about the undefined process whereby the HCA is compelled to respond to MVP's objections to its suggested questions.

The current practice of allowing carrier objections to HCA questions does not conform with GMCB Rule 2.000 or the Board's governing statute. Rule 2.000 and 8 V.S.A. § 3046 permit the HCA to suggest questions and for the Board, at its discretion, to pose some, none, or all of the suggested questions to MVP. The only limits on the HCA's right to suggest questions are that the questions be submitted within 30 days of the filing and that the questions be in writing. 18 V.S.A. § 3046. In the absence of a defined and authorized process, carrier objections to HCA questions should not be allowed. See, In re Peel Gallery of Fine Arts, 149 Vt. 348, 351 (1988) ("An administrative agency must abide by its regulations as written until it rescinds or amends

them."); Martin v. State Agency of Transp. Dep't of Motor Vehicles, 2003 VT 14 ¶ 8 ("Indeed, the State has cited no case law, and we have found none, suggesting that an administrative agency can promulgate regulations inconsistent with an unambiguous statute…."). Nowhere in Rule 2.000 or § 3046 is MVP's right to object to HCA suggested questions specified. The process for objecting, responding, and ruling on objections is not defined, and the GMCB's practice was not subject to public comment, review by the Legislative Committee on Agency Rules (LCAR), or Board vote. Therefore, the Board should not consider the MVP Objections.

Additionally, the current practice is inefficient and places a substantial burden on the HCA. By allowing MVP to object to HCA suggested questions—often with form objections lacking any factual analysis—the HCA is placed in the untenable position of either 1) expending substantial resources responding to objections without clear standards for how the objections will be decided, or 2) ignoring the objections and thereby allowing MVP to have an undue influence on the Board's decision which questions to pose. This singular non-administrative departure from GMCB Rule 2.000 benefits the regulated entity while burdening the public's representative. Although we question the underlying validity of the process, we urge the Board, should it decide to continue the process, to require the parties to work collaboratively through teleconferences or email to resolve disagreements about the HCA questions. If differences cannot be resolved, a status conference before Board counsel could dispense with any remaining concerns over the course of an hour, instead of days of briefing.

Notwithstanding our concerns about the process, we offer the following responses to the MVP Objections.

II. HCA Responses to MVP Objections

A. Question 4

Question 4 asks MVP to detail how it determined that its pharmacy benefit manager (PBM) is complying with Act 131 (2022) and to describe the impact Act 131 has on the proposed rates. MVP objects that the question is not relevant, is vague and ambiguous, seeks confidential or proprietary business information, and seeks information protected by attorney client privilege. All objections but for relevancy are inapplicable or asserted without sufficient factual analysis and should thus be disregarded. We detail why the question is relevant below.

MVP is required to prove that its rates are "affordable" and "promote access". Contrary to MVP's assertion that Act 131 is "primarily concerned with the rights of small pharmacies" and "is not concerned with health insurance rate review", the *first stated purpose* of Act 131 is to "increase access to needed medications by making prescription drugs more *affordable* and *accessible* to Vermonters." Act 131 (2022), Sec. 1 (emphasis added). Thus, Act 131 speaks directly to two of the rate review criteria that MVP is required to prove.

Specifically, the General Assembly sought to promote prescription drug affordability and access through Act 131 by:

- Eliminating specialty pharmacy networks by requiring that PBMs allow retail pharmacies to fill "all prescription drugs" regardless of whether the drug is considered by the PBM to be a specialty drug (Act 131, Sec. 4(b); 8 V.S.A. § 4089j(b));
- Prohibiting mandatory mail order and other PBM patient steering mechanisms, including mail order solicitation and mail order incentivizing (Act 131, Sec. 4(d); 8 V.S.A. § 4089j(d));

- Limiting the amount a PBM can require a covered person to pay for a drug to no more than cost sharing, the maximum allowable cost (MAC), or cash price, whichever is less (Act 131, Sec. 2; 18 V.S.A. § 9472(f));
- Requiring PBMs to identify where a drug can be purchased at MAC, and if it cannot, to adjust the MAC and compensate pharmacies accordingly (Act 131, Sec. 2; 18 V.S.A. § 9473(f));
- Establishing minimum reimbursement rates to 340B entities and prohibiting PBM interference with an eligible patient's choice to receive drugs from a 340B entity (Act 131, Sec. 2; 18 V.S.A. § 9473(h));
- Prohibiting PBMs from reimbursing PBM affiliate pharmacies at a higher rate than non PBM pharmacies (Act 131, Sec. 2; 18 V.S.A. § 9473(i)).

Additionally, Act 131 establishes that PBMs have a fiduciary duty to their health insurer clients, including a requirement that PBMs be fair and truthful and act in the health insurer's best interests. Act 131, Sec. 2; 18 V.S.A. § 9472(a).

The first part of HCA Suggested Question 4 asks MVP to describe whether and how it evaluated its PBMs compliance with Act 131. MVP's response will provide evidence as to whether MVP's rates promote affordability and access.

The second part of HCA Suggested Question 4 asks MVP to detail the impact of compliance with Act 131 on the proposed rates. That MVP's use of a PBM impacts premium rates is self-evidently relevant to these dockets.

B. Question 7

Question 7 asks MVP to provide support for its claim that a 1.5% contribution to reserves (CTR) is required to maintain a "statutory reserve requirement". MVP objects that the question is

overly broad, cumulative, unduly burdensome, and vague and ambiguous. Each of these objections is made without support, making it impossible for us to formulate a reasoned reply.

MVP alleges that the question is vague, ambiguous, and overly broad on the basis that it is "open ended." The HCA is unable to respond to this allegation as MVP provides no factual basis for why this is allegedly the case. We note, however, that the suggested question asks for the evidentiary basis for MVP's assertion that it must charge Vermonters a 1.5% CTR to meet an undefined "statutory reserve requirement." The question simply asks MVP to provide some facts that justify its own claim.

MVP also contends that the question is cumulative. Asking MVP to provide evidentiary support for its unsupported contention in the filing cannot, by definition, be cumulative.

Next, MVP alleges that answering the question would unduly burden it. On the issue of burden, MVP provides no analysis of how answering the question is burdensome. The HCA is thus unable to respond on the issue of burden.

Lastly, MVP contends that, "as a procedural matter," the HCA cannot even suggest the question as it requests "*additional* information" (emphasis in original). A regulated entity cannot create procedures, let alone procedures that conflict with the plain language of GMCB rule and the governing statute. Also, if MVP's logic were sound, then the majority of Lewis and Ellis' questions are invalid.

C. Question 9

Question 9 asks MVP to recalculate its PMPM COVID-19 vaccine assumptions had it selected the lower end of the ingredient and administration cost ranges cited in its filing. MVP objects that the question is overly broad, unduly burdensome, and not relevant.

Regarding burden, MVP provides no evidence as to why responding to the suggested question would burden it. The HCA is thus unable to respond to MVP's burden objection.

MVP also contends the question is overly broad because it asks a "hypothetical". MVP bases its unit cost assumptions on a Kaiser Family Foundation (KFF) web post related to the estimated cost of COVID-19 vaccines following commercialization, i.e., once the federal government ceases picking up the cost. MVP, in its actuarial memorandum, fails to mention that the KFF web post it uses to justify its COVID-19 vaccine cost assumptions was not intended for use by private payers to build premium rates or that the web post lists a range of COVID-19 vaccine ingredient cost estimates ($110-$130) and administration cost estimates ($25-$40) rather than point estimates. MVP simply selects, without justification, the high end of both ranges. Because MVP cannot state that the high end of the range is the only possible estimate to select, and therefore assert that there is somehow no range of possible values given by KFF, this question is not overly broad. We note, too, L&E posed a related question in Objection 5, Question 2, asking MVP to explain its choice of the $130 ingredient cost, a question to which MVP presumably does not object.

Lastly, MVP contends the question is not relevant. The HCA is baffled by the contention that the very range that MVP relies on in its filings is not relevant to the filings.

D. Question 12

Question 12 asks MVP to account for the return on a $40-million investment in a related company that dropped from MVP's annual statement in 2022. MVP objects that the question seeks publicly available information, is not relevant, is cumulative, overly broad, and unduly burdensome. The substance of MVP's objection alleges only that the requested information is publicly available and that the requested information is not relevant. We respond accordingly.

The information is not publicly available. From 2021 to 2022, the $40 million investment in Hudson Health, Inc., simply drops from MVP's 2022 Annual Statement. There is no way for the HCA to account for this apparent loss of $40 million that impacts MVP's reserve level.

Indeed, the HCA contracted with a health finance expert who is a tenured professor at one of the top universities in the world. That expert traced financial flows between the 19 companies in MVPs corporate structure. The expert could not discern where the $40-million investment in Hudson Health, Inc., a company that provides health insurance in New York, was reflected in MVP's 2022 Annual Statement, in part because the company Hudson Health, Inc. is no longer listed in MVP's 19 company corporate structure.

We also note that the assertion of one party that it does not need to answer interrogatories that seek information derivable from public sources ignores the fact that there may be an advantage derived from the party stating the fact on the record including, but not limited to, witness impeachment and/or narrowing the scope of issues at hearing. MVP should not be able to dictate HCA hearing strategy through objections that lack factual support.

Regarding relevancy, we are confused how a $40 million "investment" in another company that was a potential complete loss and that led to a $40 million drop in reserves is not relevant to the present dockets. Such an "investment" impacts both the solvency of MVP and the need to charge ratepayers a CTR.

E. Question 13

Question 13 asks MVP to recalculate its pricing actuarial values, rates, and rate increases for on-exchange Silver plans using a methodology comparable to the methodology Blue Cross Blue Shield of Vermont used in implementing the Board's silver alignment guidance. MVP objects that the question is not relevant, is overly broad, and overly burdensome. The substance of MVP's objection seems to be that the question presents a hypothetical and therefore is inappropriate for an interrogatory, and that the HCA could hire its own actuary to make the calculation.

The Board instituted the silver alignment guidance in order to align the price of on-exchange Silver plans across carriers to the actuarial value of those plans of both CSR and non-CSR plans. The Board allowed each carrier to use their own silver experience to calculate the silver load, but the intention was for the carriers to adopt a common methodology, hence the Board's guidance. Unfortunately, the carriers did not adopt a consistent methodology. Question 13 asks MVP to calculate on-exchange Silver pricing using Blue Cross's methodology. An answer to this question will allow an apples-to-apples comparison across carriers to enable an assessment of which methodology achieves the policy goal behind Silver alignment, reducing consumer cost barriers to health insurance. The question is thus highly relevant to these dockets.

MVP also contends the suggested question is overly broad. The question, however, asks for specific information and MVP provides no analysis of why it is broad. Instead, MVP's counsel asserts, again with no evidence, that the HCA's actuary could somehow calculate the answer to this question which is not true. Regardless, it is not for MVP to say who the HCA should contract with, what its experts should do, nor is it proper for MVP to judge whether there is value in having it respond to the HCA's question on the record.

Lastly, MVP objects to the question on the grounds that it is burdensome. It provides no information about how responding to this suggested question overly burdens it. As has been the case regarding all of MVP's objections on burden grounds, the HCA is unable to reply because of MVP's decision to not provide any evidence supporting the alleged burden.

For the above-stated reasons, the HCA respectfully requests that the GMCB pose all of the HCA Questions. The HCA also respectfully asks the GMCB to issue a ruling on these various matters so that the parties have a general idea of the standard the GMCB uses to resolve these objections, assuming the GMCB finds allowing such carrier objections consistent with rule and

statute. We ask that this order also delineate the allowed grounds for objections and the minimal standard for factual analysis of valid objections.

Dated in Montpelier this 20th day of June 2023.

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CERTIFICATE OF SERVICE

I, Eric Schultheis, hereby certify that I have served the above HCA RESPONSE TO MVP HEALTH PLAN, INC.'S OBJECTIONS TO HCA SUGGESTED QUESTIONS on Michael Barber, Laura Beliveau, Jennifer DaPolito, and Geoffrey Battista of the Green Mountain Care Board; and Gary Karnedy, Ryan Long, and Maggie Kushner, Primmer Piper Eggleston & Cramer PC, representatives of MVP Health Care in the above-captioned matters, by electronic mail, delivery receipt requested, this 20th day of June, 2023.

/s/ Eric Schultheis
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