STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2025 Individual Market Rate Filing	)))	GMCB-005-24rr SERFF No. MVPH-134081032

In re: MVP Health Plan, Inc. 2025 Small Group Market Rate Filing	)))	GMCB-006-24rr SERFF No. MVPH-134081005

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

On June 12, 2024, 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 eight questions (HCA Questions) pursuant to its statutorily defined right. 8 V.S.A. § 4062. On June 18, 2024, MVP objected to six, or 75%, of the HCA Questions (MVP Objections). The HCA responds to the MVP Objections as follows.

I. HCA Authority; Process Concerns

This year, MVP added a new paragraph to its prefatory material purporting to lay out the HCA's authority in rate review proceedings. MVP Objections ¶3. We disagree with MVP's characterization of the HCA's role as "limited." While MVP accurately cites the pertinent Vermont statutes, they fail to acknowledge that the HCA's role has been substantially fleshed out by GMCB Rule 2 and past practice. In fact, the HCA is a full party to these proceedings. GMCB Rule 2.105(b). Assertions that the HCA is not even authorized to suggest questions, or that the HCA is prohibited from developing the factual record on the various statutory rate review criteria, are without merit.

Second, MVP repeatedly suggests that the HCA is limited to suggesting only actuarial questions, when such an argument is not reasonable given Vermont law. For instance, MVP

objects to multiple HCA questions by stating they are "not an actuarial question and … therefore beyond the scope" of the type of questions the HCA can suggest. MVP Objections at 3, 5, and 7. Similarly, MVP repeatedly emphasizes the words "regarding the filing" as if to suggest that only actuarial questions can be related to the rate filing, or that MVP's Actuarial Memorandum defines the scope of the rate filing. Both these arguments directly conflict with the plain language of 8 V.S.A. § 4062, GMCB Rule 2.401, and past Board decisions. E.g., GMCB-004-23rr, Decision at 19 (stating "… MVP bears the burden of justifying its requested rates and, in connection with making that determination, the Board reviews whether the proposed rates are affordable; promote quality care; promote access to health care; protect insurer solvency; are not unjust, unfair, inequitable, misleading, or contrary to the laws of this State; and are not excessive, inadequate, or unfairly discriminatory."). As for what it means for a question to be "regarding the filing"—as the public advocate, we believe a broad interpretation is more in keeping with the spirit of the statute than the narrow interpretation clearly preferred by MVP.

Lastly, as we discussed at length last year in response to MVP's objections, the HCA continues to have concerns over the process for insurer objections to the HCA's suggested questions. See GMCB-004-23rr and 005-23rr, HCA Resp. to MVP Health Plan, Inc.'s Objects. to HCA Sugg. Qs. at 1-2. As we noted, allowing MVP to object to the HCA suggested questions, which the Board may or may not pose, is, absent Board rulemaking, a violation of Vermont law and the parties' due process rights. Id. Equally importantly, as we have previously asserted, allowing carriers to object to suggested questions, often with form objections lacking factual analysis, is inefficient and burdensome. Simply put, the current practice only benefits the regulated entity, burdens the public representative, and provides the Board with scant legal analysis to assist it in evaluating which suggested questions to pose. Furthermore, that the

process is not visible in the public record and does not result in any written decision to provide the parties guidance for future action or even apprise them of the underlying logic of Board action only further raises fundamental concerns of fairness and due process.

Notwithstanding these concerns and objections, we offer the following responses to the MVP Objections.

II. HCA Responses to MVP Objections

A. Question 1

Question 1 asks MVP for information about the Well-Being Reimbursement program MVP offers its members and for which MVP observed 600% cost growth from 2022 to 2023 and projects 20% annual trend from 2023 to 2025. Actuarial Mem. at 7. MVP objects that the question is overly broad, unduly burdensome, not relevant, not actuarial, and beyond the scope of the HCA's authority to suggest asking. MVP offers no factual support for the assertion that Question 1 is overly broad or unduly burdensome, and so those objections should be disregarded. The objection to the HCA's right to suggest questions that may be non-actuarial in nature is addressed in Part I. We detail why the question is relevant below.

MVP objects that the three subparts of Question 1 seek information that is not relevant to the rate filings. The first subpart asks about "categories" for which members can receive reimbursement. The second subpart asks about the "method" that members use to submit for reimbursement. The third subpart asks MVP for any information it has demonstrating the cost effectiveness of the program. As to the first two subparts, MVP refers to both "categories" and the "method" when discussing the program in the rate filing. Actuarial Mem. at 7 ("MVP's expectation is that the utilization of this program will continue to grow, given . . . the broad range of categories from which members can submit for reimbursement, and the method which MVP

has chosen to allow members to submit for reimbursement."). After experiencing 600% growth, MVP is now projecting 20% annual trend for a program about which we have very little information. A "Well-Being Reimbursement" sounds like it ought to be worthwhile and beneficial to members. But maybe MVP has opted to allow reimbursement in such a broad range of "categories" as to undermine the utility of the program. Or, maybe the "method" MVP allows members to submit for reimbursement is so open as to make the program ripe for fraud or abuse. The first two subparts of Question 1 ask for additional factual information about the program so as to enable an evaluation of it. The final subpart asks whether MVP has any information that the program is beneficial and, if so, to provide that information. Notably, the final subpart does not ask MVP to create additional evidence, it simply asks MVP if it has any information, and if so, to provide it. Therefore, MVP's objection that Question 1 is not relevant to the filing is false and should be rejected.

B. Question 2

MVP objects to Question 2 about claims edits and payment policies impacted by H.766 as substantively identical to a question posed by L&E and therefore duplicative. However, Question 2 is not substantively identical to any question posed by L&E to date. In Objection 1, Question 16, L&E requested "quantitative and qualitative support for the derivation of the applied impact due to H.766." MVP replied confidentially providing a specific dollar amount attributable to the claims edits and payment policies provisions of H.766. L&E submitted follow up questions about H.766 impacts in Objection 2, Question 9. None of the subparts of that question ask what is asked for in HCA Question 2: identify claims edits and payment policies that will be removed or restricted due to H.766 and provide dollar amounts for each that add up

to the dollar amount listed in MVP's response to Objection 1, Question 16. As such, HCA Question 2 is not duplicative.

We note, however, that MVP has since responded to L&E's follow up questions about H.766 impacts, saying essentially, considering passage of H.890, which if allowed to become law would delay implementation of most of the claims edits provisions of H.766 for one year, MVP prefers not to answer any additional questions about H.766 at this time. The HCA agrees that MVP's request is reasonable. However, given that the deadline by which the governor must take action on H.890 falls outside the window the HCA has to respond to these objections, we propose that the question be submitted to MVP, with the acknowledgement that, if H.890 becomes law, MVP need not answer it.

C. Questions 4 and 5

Questions 4 and 5 ask MVP about its pharmacy benefit management (PBM) contract and about MVP's due diligence regarding PBM contracting. MVP objects to both questions as seeking confidential and proprietary business information, as not actuarial, as beyond what the HCA can suggest, and for going beyond the scope of the rate filings.

That a question might touch upon confidential or proprietary business information is not a valid objection in rate review proceedings. All parties to rate review proceedings are subject to the Board's standing order regarding the treatment of confidential information. Already in the proceedings this year, the HCA has received confidential information from MVP, including, in response to Objection 1, Question 8, information from MVP's PBM labeled confidential and proprietary. Indeed, MVP is not objecting to HCA Question 6 asking about "known contract changes for 2024 and 2025" reflected in the Rx trend factors, which if answered in the same manner as MVP responded to a similar question last year, will include confidential information.

Since confidentiality concerns are not reason enough to object to answering Questions 4 and 5, and the HCA's right to suggest questions that may be non-actuarial in nature is addressed in Part I, we are left with whether the questions are relevant and within the scope of the rate filings. We assert they are.

From Exhibit 3 in the rate filing, we can calculate that Rx spending before rebates accounts for 18% and 20% of experience period claims in the individual and small group markets, respectively.[1] Like nearly all health insurers, MVP relies on a PBM to manage many aspects of the pharmacy benefit, including "negotiating lower drug prices with manufacturers, network management, drug utilization review, and claims processing." Letter from Jordan Estey, Sr. Dir., Gov't Affairs, MVP Health Care, to Vt. House Comm. on Health Care (Feb. 14, 2024), https://legislature.vermont.gov/Documents/2024/WorkGroups/House%20Health%20Care/Bills/H.233/Witness%20Testimony/H.233~Jordan%20Estey~MVP%20Health%20Care%20Testimony~2-15-2024.pdf. In other words, MVP's contract with its PBM controls tens of millions of dollars in Vermont health care spending. Clearly, the contract is highly consequential and related to the rate filing.

Questions 4 and 5 are reasonable questions geared toward probing how MVP approaches the relationship with its PBM and the extent to which MVP engages in due diligence with respect to that relationship. We know from previous filings that MVP's prior PBM contract was set to expire December 31, 2023. From the current filing, we know that MVP renewed the contract with CVS Caremark. The contract renewal period would have presented MVP with an opportunity to negotiate for better terms, particularly in a market for a service like pharmacy benefit management, in which there is ample competition. Question 4 seeks to find out how

[1] The percentages were calculated from Exhibit 3 as follows: Line 6 / (Line 10 + Line 7) * 100.

MVP approached those negotiations and whether they succeeded in obtaining any enhancements to the contract. Question 5 seeks to ascertain whether MVP engaged in ordinary due diligence prior to renewing the contract with CVS Caremark. As noted, tens of millions of dollars are at stake. Additionally, while CVS Caremark owes a fiduciary duty to MVP, the dialogue surrounding PBMs generally is rife with alleged misconduct. Question 5 asks MVP, considering the sheer importance of this relationship, did you audit CVS Caremark's performance under the contract, perform any market comparison checks, or solicit or receive any competing bids? And, if so, to please describe. These questions are reasonable and relevant. They will enable an evaluation of MVP's efforts to control costs to promote affordability and access and touch upon quality of care, too.

D. Questions 7 and 8

Questions 7 and 8 ask MVP about two current trends in pharmacy benefit management—cost-plus drug pricing and off-benefit drug spending. MVP again objects that the questions seek confidential and proprietary business information, are not actuarial, are beyond the scope of the HCA's authority to suggest asking, are not relevant, and are beyond the scope of the rate filings. Additionally, MVP objects that the questions call for speculation. We previously addressed the confidentiality objection under Questions 4 and 5. The HCA's right to suggest questions that may be non-actuarial in nature is addressed in Part I. We will not repeat those arguments here. Instead, we will address the questions' relevance and whether they call for speculation.

As stated in response to the previous two objections, Rx spending accounted for between 18% and 20% of experience period claims, equivalent to tens of millions of dollars. Rx spending keeps trending upward, year after year, indicating, as even CVS Caremark appears to acknowledge, that the current system of drug pricing is no longer sustainable. Counsel for MVP

can object that our characterization of the CVS Caremark literature somehow misses the mark. But the materials speak for themselves, as does the state of the market, considering that each of the big three PBMs announced versions of cost-plus pricing models within the past year.

But the relevance of Question 7 is this: for yet another year, in setting Rx trends, MVP relies on cost trend data provided by its PBM expressed in terms of gross costs. It is generally understood, however, that gross Rx costs are inflated and do not account for the multitude of rebates, discounts, PBM fees, and other price concessions that reduce gross spending to net spending. Which is what the cost-plus phenomenon is about and what the CVS Caremark promotional material is offering to its plan sponsor customers. And so, the question to MVP is simple and relevant: your PBM, who oversees tens of millions of dollars in annual spending for you, is actively promoting a product that offers "a deeper level of transparency" and "the same or better value"—has MVP evaluated that product to determine whether it would benefit its members? If so, what were the findings?

The relevance of Question 8, which asks about off-benefit drug spending, is perhaps even more concrete. If some amount of Rx spending is occurring off-benefit, that necessarily impacts MVP's rate filings. MVP's rates are lower than they would need to be if all its members used their prescription drug benefit, instead of resorting to cash pay services like GoodRx and Mark Cuban Cost Plus Drug Company. At the same time, when members buy prescriptions off-benefit, MVP loses insight into those members' health conditions and the opportunity to help those members remain adherent to treatment and improve their health, further impacting claims experience. Question 8 does not present a hypothetical or require speculation. Rather, the question asks MVP to provide any factual information it has about how much drug spending is occurring off-benefit—perhaps this is information CVS Caremark has access to by processing

and analyzing claims data. The question then asks MVP to elaborate on what it sees as the possible positive or negatives of such spending. That members are buying prescriptions off benefit addresses the rate review criteria of affordability, access, and quality, and so the question is relevant.

As stated herein, the HCA Questions are reasonable, related to the rate filing, not overly broad or unduly burdensome to answer, do not present hypotheticals or call for speculation. For these reasons, the Board should pose the HCA Questions to MVP through the Board's actuary, as suggested.

Dated in Rutland, Vermont, this 21st day of June 2024.

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CERTIFICATE OF SERVICE

I, Charles Becker, hereby certify that I have served the above HCA Reply to MVP Health Plan Inc.'s Objections to HCA Suggested Questions on Michael Barber, Laura Beliveau, and Tara Bredice of the Green Mountain Care Board and Gary Karnedy, Ryan Long, and Hannah Lebel, Primmer Piper Eggleston & Cramer PC, representatives of MVP Health Care in the above-captioned matters, by electronic mail, delivery receipt requested, this 21st day of June 2024.

/s/ Charles Becker
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