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STATE OF NORTH CAROLINA

COUNTY OF DURHAM

IN THE OFFICE OF ADMINISTRATIVE HEARINGS
23 INS 00738

Blue Cross and Blue Shield of North Carolina Petitioner, v. North Carolina State Health Plan for Teachers and State Employees Respondent. and Aetna Life Insurance Company Respondent-Intervenor.	**FINAL DECISION**

On February 13-16, 19, 22, 23, 26 and 28, 2024, Administrative Law Judge Melissa Owens Lassiter heard this contested case in the Office of Administrative Hearings in Raleigh, North Carolina, pursuant to N.C. Gen. Stat. § 150B-23 and a petition for a contested case hearing, filed by Petitioner Blue Cross and Blue Shield of North Carolina ("Petitioner" or "Blue Cross"), appealing the decision by the Respondent North Carolina State Health Plan for Teachers and State Employees ("Respondent" or "the Plan") to award Respondent-Intervenor Aetna Life Insurance Company ("Respondent-Intervenor" or "Aetna") the Plan's 2025-2027 contract for third-party administrative services ("TPA").

Upon consideration of the evidence presented in the contested case hearing including the sworn testimony of the witnesses, admitted exhibits, the arguments of the parties, and the applicable law, the Undersigned hereby finds by a preponderance of the evidence the following Findings of Fact, enters Conclusions of Law based thereon, and issues this Final Decision **AFFIRMING** the decision by the Plan's Board of Trustees to award the contract for TPA services for 2025-2027 to Respondent-Intervenor Aetna.

APPEARANCES

Petitioner Blue Cross and Blue Shield of North Carolina

Matthew W. Sawchak
Stephen F. Feldman
Robinson Bradshaw & Hinson PA
Raleigh, North Carolina

Nathan Chase
Benjamin C. DeCelle
Robinson Bradshaw & Hinson PA
Charlotte, North Carolina

Erik R. Zimmerman
Emily Schultz
Robinson Bradshaw & Hinson PA
Chapel Hill, North Carolina

Shannon Joseph
Morningstar Group
Raleigh, North Carolina 27601

Respondent North Carolina State Health Plan for Teachers and State Employees

Elizabeth Sims Hedrick
Marcus C. Hewitt
Fox Rothschild LLP
Raleigh, North Carolina

Robert H. Edmunds, Jr.
Fox Rothschild LLP
Greensboro, North Carolina

Respondent-Intervenor Aetna Life Insurance Company

Lee M. Whitman
Benjamin N. Thompson
Sophia V. Blair
WYRICK ROBBINS YATES & PONTON LLP
Raleigh, North Carolina

ISSUES

1. Did Respondent act erroneously, fail to use proper procedure, act arbitrarily or capriciously, or fail to act as required by law or rule in scoring of the pricing-guarantee component of the RFP for TPA services for 2025-2027?

2. Did Respondent act erroneously, fail to use proper procedure, act arbitrarily or capriciously, or fail to act as required by law or rule in its final scoring of the RFP for TPA services for 2025-2027?

3. If Respondent erred in awarding the RFP for TPA services to Respondent-Intervenor for 2025-2027, then did Respondent's errors substantially prejudice Petitioner's rights under N.C. Gen. Stat. § 150B-23(a)?

4. Should the decision by Respondent's Board of Trustees to award the contract for TPA services to Respondent-Intervenor for 2025-2027 be reversed and awarded to Blue Cross?

5. In the alternative, should the decision by Respondent's Board of Trustees to award the contract for TPA services to Respondent-Intervenor for 2025-2027 be reversed, and should Respondent be required to conduct a new RFP process for the TPA services contract for 2025-2027?

APPLICABLE STATUTES AND REGULATIONS

N.C. Gen. Stat. § 135-48.1(3), (14)
N.C. Gen. Stat. § 135-48.2(a)
N.C. Gen. Stat. § 135-48.20
N.C. Gen. Stat. § 135-48.21
N.C. Gen. Stat. § 135-48.22(4)
N.C. Gen. Stat. § 135-48.32
N.C. Gen. Stat. § 135-48.33
N.C. Gen. Stat. § 135-48.34
N.C. Gen. Stat. § 150B-1 and §150B-2
N.C. Gen. Stat. § 150B-22, et seq.
26 N.C.A.C. 03 .0101, et seq.

EXHIBITS ADMITTED INTO EVIDENCE[1]

Joint Exhibits

1, 3, 4, 5, 8, 11, 12, 14, 15, 17, 20, 21, 22, 28, 33, 35, 36, 37, 38, 39, 40, 42, 44, 46, 47, 48, 53, 54, 61, 63, 64, 66, 68, 69, 86, 87, 89, 90, 92, 93, 94, 200, 203, 209, 211 (AEO), 213, 214, 215, 216, 217, 218, 221, 222, 223, 224, 225, 232, 233, 235, 236, 237, 238 (AEO), 239 (AEO), 240, 241, 242 (AEO), 243 (AEO), 255, 256, 257 (AEO), 268 (AEO), 269 (AEO), 270 (AEO), 272, 294, 300, 301, 413, 418, 429

Petitioner's Exhibits

500, 502, 508, 518, 519, 520, 525, 527, 528, 546, 547, 548

Petitioner's Exhibits (Illustrative Purposes Only)

530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545

Respondent's Exhibits

601, 602, 605, 606, 607, 610, 611, 612, 614, 616, 617, 618, 619, 621, 624, 625, 626, 629, 630, 632, 633, 634, 635, 638 (AEO)

Respondent-Intervenor's Exhibits

700, 707

Respondent-Intervenor's Exhibits (Illustrative Purposes Only)

708 (AEO), 709

[1] "AEO" Exhibits are attorneys' eyes only pursuant to the Protective Order entered in this contested case.

WITNESSES

For Petitioner

1. Aimee Forehand, Associate Vice President, State Health Plan Segment, Blue Cross NC
2. Dorothy Jones, the Plan's former Executive Administrator
3. Matthew Rish, the Plan's Senior Director for Finance, Planning and Analytics
4. Stephen Kuhn, Vice President and Health Benefits Consultant, The Segal Company ("Segal")
5. Charles Sceiford, the Plan's Health, and Benefits Actuary
6. Gregory Russo, Managing Director at Berkeley Research Group (expert witness for Blue Cross NC)
7. Aetna's Rule 30(b)(6) Designee (Catherine Aguirre) (by deposition designation)
8. Daniel Baum, Managing Member, Navigator, LLC (by deposition designation)
9. Vanessa Davison, the Plan's former Contracting Agent (by deposition designation)
10. Dale Folwell, State Treasurer of North Carolina (by deposition designation)
11. Caroline Smart, the Plan's Senior Director of Plan Integration (by deposition designation)
12. Stuart Wohl, Senior Vice President and East Region Leader, Segal (by deposition designation)

For Respondent

1. Kenneth Vieira, Senior Vice President and East Region Public Sector Market Leader, Segal (expert witness for the Plan)
2. Caroline Smart, the Plan's Senior Director of Plan Integration
3. Dorothy Jones, the Plan's former Executive Administrator

For Respondent-Intervenor

1. Catherine Aguirre, Head of Public and Labor for Southeast Market, Aetna
2. Andrew Coccia, Senior Manager, Deloitte Consulting (expert witness for Aetna)
3. James Bostian, President of MidSouth and Capitol Markets, Aetna
4. Roy Watson, Jr., Vice President of Group and State Segment, Blue Cross NC (by deposition designation)

FINDINGS OF FACT

I. Procedural Background

1. On August 30, 2022, Respondent issued RFP # 270-20220830TPAS for a contract to provide TPA Services for the Plan ("2022 TPA RFP") for 2025-2027. (Jt. Ex. 5).

2. Three vendors submitted proposals in response to the RFP: Blue Cross, Aetna; and UMR, Inc. ("UMR"). UMR is not a party to this contested case. (Resp. Ex. 601; Stipulation ("Stip.") 36, 39) (*See* Joint Stipulation of Uncontested Facts, Attachment A, February 14, 2024 Prehearing Order)

3. On December 14, 2022, the Plan's Board of Trustees awarded the TPA Contract to Aetna and called each of the three vendors to inform them of the Plan's decision. (Jones, T. Vol. 2 p. 331, 339; Jt. Ex. 294, Resp. Ex. 614).

4. On December 15 and 16, 2022, the Plan held debrief meetings with each of the vendors to explain the basis for the award decision. (Jones, T. Vol. 2 p. 339; Forehand, T. Vol. 1 pp. 111, 132-33; Jt. Ex. 525).

5. On January 12, 2023, Blue Cross requested a protest meeting with the Plan. (Stip. No. 53; Forehand T. Vol. 1 pp. 149-50; Resp. Ex. 607).

6. The Plan timely denied Blue Cross' request for a protest meeting via letter dated January 20, 2023. (Stip. No. 54).

7. On February 16, 2023, Blue Cross filed the above-captioned petition for contested case against the Plan.

8. On March 13, 2023, Aetna was allowed to intervene as Respondent-Intervenor with all rights of a party. N.C. Gen. Stat. § 1A-1, Rule 24 of the North Carolina Rules of Civil Procedure.

A. The Parties and Relevant Non-Parties

9. Petitioner Blue Cross is a fully taxed, not-for-profit corporation that provides health insurance and third-party administrative services. (Forehand, T. Vol. 1 pp. 84-85). Blue Cross is the Plan's incumbent TPA and has held the TPA Contract for more than forty (40) years. (Forehand, T. Vol. 1 pp. 86-87).

10. Respondent Plan is a statutorily-created entity pursuant to N.C. Gen. Stat. Chapter 135, Article 3B and is a division of the North Carolina Department of State Treasurer ("DST"). The purpose of the Plan is to make a health benefit plan available for eligible teachers, state employees, retired employees, and certain of their eligible dependents. The Plan's governance includes an Executive Administrator and Board of

Trustees. N.C. Gen. Stat. §§ 135-48.20 to 135-48.23. Under that statutory authority, the Plan has broad authority to conduct a RFP process. (Jones, T. Vol 1 p. 228).

11. Respondent-Intervenor Aetna is a corporation that provides health insurance and third-party administrative services. (Aguirre, T. Vol. 9 p. 1985). In 2022, the Plan awarded Aetna the TPA contract that is the subject of this contested case. (Stip. No. 52. Aetna also submitted bids in response to the Plan's RFPs for the TPA Contract in 2017, 2019, and 2022. (Bostian, T. Vol. 8 pp. 2188-89, 2192-93, 2195; Stip. No. 52).

12. Non-party, The Segal Company Inc., as well as related entities (collectively "Segal"), is the Plan's actuarial services contractor. (Stip. No. 18). Segal is a national actuarial and health benefits consulting firm whom the Plan hired, through an RFP process, to assist the Plan in designing, drafting, and scoring the 2022 TPA RFP that is the subject of this contested case. (Jones, T. Vol 1, 214; Rish, T. Vol. 2 p. 453; Kuhn, T. Vol. 2, p. 503). Segal's team consisted of Stephen Kuhn, Ken Vieira, Stuart Wohl and Matt Kersting, all of whom have extensive experience with large public health plan RFPs. (Kuhn, T. Vol. 2 pp. 531-32). The Segal team was also supported by Albert Shaaya, who led Segal's data team, and Peter Wang, another actuary who focused on data files provided to vendors and data analysis, including the claims repricing. (Kuhn, T. Vol. 2 p. 532)

13. Non-party UMR, Inc. is a subsidiary of UnitedHealthcare. (Russo, T. Vol. 4, p. 996; Coccia, T. Vol. 8, p. 2164). UMR was one of three vendors who submitted proposals in response to the RFP. (Stip. Nos. ¶ 36-37).

B. Key Witnesses

14. Dorothy (Dee) Jones was the Executive Administrator of the Plan from June 2017 until December 16, 2022. (Jones, T. Vol. 1 p. 192; Stip. No.10). As Executive Administrator, Ms. Jones had overall responsibility for the Plan's contracting activities, including RFPs. She had extensive experience with state government procurements, both as the Plan's Executive Administrator, including the prior 2019 TPA RFP, and in prior positions as Chief Operating Officer ("COO") for North Carolina's Medicaid program, consultant to the North Carolina Secretary of Health and Human Services, COO for the Division of Health Benefits, and as COO for the North Carolina Department of Administration. (Jones, T. Vol. 1 pp. 192-93, 204-05).

15. Caroline Smart is the Senior Director of Plan Integration for the Plan and has served in that role or its equivalent since 2010. (Stip. No.11). Ms. Smart has been personally involved in four TPA contracts during her fourteen years at the Plan. (Smart, T. Vol. 8 p. 1964). Ms. Smart is responsible for managing the Plan's large service contracts, including the TPA Contract, and the integration between vendors. She is also responsible for the RFPs for those contracts. (Smart, T. Vol. 7 pp. 1826-27).

16. Stephen Kuhn is a Vice President and Health Benefits Consultant with Segal who has worked for Segal since 1999. (Stip. No.19). Mr. Kuhn led the TPA RFP project for Segal, led the Cost Proposal analysis, and served as the primary point of

contact between the Plan and Segal. (Kuhn, T. Vol. 2 pp. 496, 532). Most of Mr. Kuhn's experience in the past 10 years has been with large public health plans, and a significant amount of his work is on TPA RFPs. (Kuhn, T. Vol. 2 pp. 530-31).

17. Gregory Russo works as a consultant in healthcare analytics and healthcare finance for Berkley Research Group ("BRG"). (Russo, T. Vol. 3 p. 769). Mr. Russo was accepted by this Tribunal as an expert in healthcare finance. (Russo, T. Vol. 3 p. 876). However, Mr. Russo was not accepted by this Tribunal as an expert in the design or drafting of RFPs. (Id.). Mr. Russo has never worked or consulted for a state health plan on an RFP, nor does he have experience advising on the design of RFPs more generally. (e.g., Russo, T. Vol. 3 pp. 800-01, 802, 811, Vol. 5 p. 1273).

18. Kenneth Vieira is a Senior Vice President and East Region Public Sector Market Leader with Segal. (Stip. No. 20). Mr. Vieira has worked exclusively with public health plans over the past 20 years. (Vieira, T. Vol. 6 p. 1513-14). In the past 12 years at Segal, Mr. Vieira has worked on over 100 procurements for public health plans, in which he led the project or had the ultimate responsibility for the procurement project. Of those, approximately 70 were TPA procurements. (Vieira, T. Vol. 6 pp. 1523-25). Mr. Vieira is a certified actuary and has been a fellow of the American Society of Actuaries, its highest certification, since 1993. Actuaries are professionals who analyze risk and uncertainty, and use math, statistics, and finance theory to analyze and quantify risk. (Vieira, T. Vol. 6 pp. 1505-08). He was the lead actuary for Segal with the Plan. (Viera, T. Vol. p. 1503)

19. Mr. Vieira has worked with the Plan as a consultant for approximately 28 years, with Segal, and with a prior employer. (Vieira, T. Vol. 6 pp. 1504, 1521-22). Mr. Vieira served as a consultant for the Plan on the 2022 TPA RFP. His work for the Plan includes the full range of actuarial work such as financial projections, financial modeling, trend analysis, and reserve statements, as well as non-actuarial work managing RFPs or vendors. (Vieira, T. Vol. 6 p. 1503). Mr. Vieira was accepted by this Tribunal, and testified, as an expert the areas of public health benefit plan consulting, including third-party administrator contract procurements, RFP design and drafting, evaluation and scoring of proposals, and risk assessment and financial modeling. (Viera, T. Vol. 6 pp. 1536, 1539).

20. Andrew Coccia is a Senior Manager in the Human Capital and Workforce Transformation Practice at Deloitte Consulting LLP ("Deloitte") and has held that position for 16 years. (Coccia, T. Vol. 8 pp. 2051-52; see also Resp.-Intervenor Ex. 700). Mr. Coccia was accepted by this Tribunal as an expert in health plan RFP design and evaluation. (Coccia, T. Vol. 8 p. 2069). Mr. Coccia spends most of his time consulting for large public and private employers on their employee health benefit programs, including designing those programs, doing financial forecasting for those programs, and selecting vendors through RFP processes. (Coccia, T. Vol 8 p. 2052). Deloitte has approximately 100,000 employees in the Unites States, and of those employees, nobody has more experience than Mr. Coccia in the health benefits RFP space. (Coccia, T. Vol. 8 pp. 2067, 2069).

21. Before joining Deloitte, Mr. Coccia worked for four years at Mercer, which is the world's largest benefits consulting firm. At Mercer, Mr. Coccia almost exclusively advised employers on employee benefit program issues and learned how to design and conduct RFPs. (Coccia, T. Vol. 8 p. 2054; see also Resp.-Intervenor Ex. 700). Mr. Coccia has drafted or assisted in drafting more than 75 RFPs over his 26 years of experience. (Coccia, T. Vol. 8 pp. 2055-58). Mr. Coccia has worked directly with state and municipal health plans to design RFPs and evaluate RFP responses. (Coccia, T. Vol. 8 pp. 2057-58).

II. Function of the Plan's TPA

22. The Plan is a small organization consisting of 54 budgeted staff positions including contracting and compliance positions. (Jones, T. Vol. 2 pp. 340-41).

23. The Plan's leadership focuses on increased access to and quality of health care, as well as lowering the cost of that care. (Folwell Deposition ("Dep."), p. 95). Plan leadership is expected to exercise duties of loyalty and due care to the Plan's members. (Folwell Dep. p. 39).

24. The Plan currently has approximately 742,000 total members, including retirees and dependents. (Jt. Ex. 5, p. 9; Stip. No.2).

25. The TPA's services focus on the Plan's self-funded members rather than Plan members who use Medicare Advantage coverage, which is currently provided through Humana. The Plan currently has over 500,000 self-funded members. (Stip. Nos. 4−6).

26. The Plan is set up as a contract management customer service organization whereby the Plan contracts with a vendor, gives the scope of work to the vendor, and expects the vendor to perform that work. (Jones, T. Vol. 1 pp. 342-346)

27. The Plan conducts procurements regularly, including requests for proposals. (Stip. No. 3; Smart, T. Vol 7 p. 1827).

28. A third-party administrator is one of the Plan's vendors that provides administrative services for the Plan. Services provided by the Plan's TPA include providing a network of healthcare providers, negotiating discounts with those providers, and processing claims from providers who care for Plan members.

29. The TPA Contract is the Plan's largest expenditure or contract. The TPA manages about $3 billion in medical claims per year. (Jones, T. Vol. 1 pp. 193, 254-55).

30. While many of the Plan's contracts have generally been treated as subject to the North Carolina Department of Administration's contracting rules and procedures, certain large procurements concerning the administration of the Plan are specifically

exempt pursuant to N.C. Gen. Stat. § 135-48.34 but are subject to the requirements of N.C. Gen. Stat. § 135-48.33. (Jones, T. Vol. 1 pp. 262-63; N.C. Gen. Stat. § 135-48.34).

31. The exempt procurements valued at over $3 million still require approval by the Plan's Board of Trustees. (*Id.).* Exempt procurements are also subject to compliance review by the North Carolina Attorney General or their designee under N.C. Gen. Stat. § 135-48.33. (*Id.).*

32. The Plan does not have its own rules [in the North Carolina Administrative Code] that govern how the Plan has to conduct those statutorily-exempt procurements. (Jones, T. Vol. 1 p. 264).

A. Decision to Issue the 2022 TPA RFP

33. Blue Cross serves as the Plan's current TPA, having been awarded the TPA Contract through the Plan's 2019 RFP. (Stip. 7). The term of Blue Cross' current contract is January 1, 2022 through December 31, 2024, with two optional one-year renewal periods in 2025 and 2026. (Jt. Ex. 93, at § 4.1; Forehand, T. Vol. 1 pp. 87, 180-81). The Plan has not exercised those options. The Plan has until 30 days before the initial term of the current TPA contract ends on December 31, 2024 to exercise its extension option. Tr. 1831:9-20 (Smart).

34. On January 1, 2022, Blue Cross implemented and went live with a new computerized claims processing system called FACETS. (Resp. Ex. 616, p. 4, Resp. Ex. 626, p. 4). The FACETS implementation caused administrative problems for Blue Cross and the Plan that continued throughout 2022, including claims processing delays, member enrollment problems, and delayed claims payments. (Smart, T. Vol. 7 pp. 1832-34, Resp. Ex. 626, pp. 8-13).

35. The problems with FACETS negatively impacted the Plan's cash flow and required an enormous expenditure of time and money by Plan staff and the Plan's other vendors to resolve. (Jones, T. Vol. 1 pp. 253, 258-59, 262, Vol. 2 pp. 321-23, 326-30, 370-71; Resp. Exs. 626, 617). The majority of the issues with FACETS were resolved by the end of 2022, with the remaining issues being resolved in early 2023. (Forehand, T. Vol I p. 91).

36. At the March 2022 meeting of the State Health Plan's Board of Trustees ("Board"), multiple Board members asked whether Blue Cross could be fired in connection with problems caused by the FACETS implementation. (Jones, T. Vol. 1 pp. 194-95, Resp. Ex. 616, p. 4). The Plan's Executive Administrator, Ms. Jones, advised the Board that although terminating the Plan's contract with Blue Cross was possible in theory, it would be better to issue a new request for proposal for the TPA contract because the implementation process for any new vendor would take two years. (Jones, T Vol 2, p. 320).

37. After the March 2022 Board meeting, the Plan's leadership determined there was sufficient time to design, draft, and issue a RFP and to evaluate responsive

proposals. In April 2022, the Plan's leadership, with the Treasurer's approval, decided to issue a RFP for TPA Services later in the year. (Jones, T. Vol. 1 pp. 194-95, 248-52).

38. The Plan decided to proceed with a RFP because Blue Cross' FACETS implementation was causing delays in processing claims and paying providers, Blue Cross was not cooperative in meeting all the Plan's requirements, and Blue Cross was not cooperating with the Plan's data transparency efforts. (Jones, T. Vol. 1 pp. 194-95, 259-62, Vol. 2 pp. 370-73).

39. On April 5, 2022, Ms. Jones, on the Plan's behalf, notified Blue Cross, by phone, and in writing on April 20, 2022, that the Plan would issue a RFP for the TPA Contract in 2022. She informed Blue Cross that the Plan expected the RFP would be issued in the third quarter (Q3) of 2022 and awarded in December 2023/January 2024 timeframe and that the new contract would be live for Open Enrollment for the 2025 Plan Year. Ms. Jones advised Blue Cross that the "disappointing FACETS transition, lack of confidence in issue resolution and general the lack of cooperation and support relative to data transparency are the main reasons behind the decision" to put the TPA Contract up for bid. (Jones, T. Vol. 1 pp. 195-96, 259; Jt. Exs. 20, 21).

40. In May 2022, the Plan notified other potential vendors, including Aetna and UMR, that a RFP was forthcoming. (Aguirre, T. Vol. 8 pp. 2000-01; Bostian, T. Vol. 8 p. 2212; Jt. Ex. 239 (AEO)).

B. Drafting the 2022 TPA RFP

41. The Plan has the discretion and authority to change the format of a RFP from formats done in previous TPA RFPs. (Jones, T. Vol 1 p. 274).

42. From April through August 2022, numerous Plan staff, with the assistance of the Plan's actuarial services vendor, Segal, developed and drafted the 2022 TPA RFP. (Jones, T. Vol. 1 pp. 249-50, 282-83). Caroline Smart, the Senior Director of Plan Integration, was responsible for the initial draft of the Minimum Requirements and Technical Requirements. (Jones, T. Vol. 1 pp. 249-50, Smart, T. Vol. 7 pp. 1834-36).

43. The Plan used the 2019 TPA RFP as a template for the 2022 TPA RFP. (Smart, T. Vol. 7 pp. 1835-36; Jt. Ex. 217). Consistent with the 2019 TPA RFP, the Plan decided the 2022 TPA RFP would consist of three components: (1) Minimum Requirements, (2) Technical Proposal, and (3) Cost Proposal. (Jt. Ex. 5 at §§ 2.71, 2.7.2, Jt. Ex. 93; Jones T. Vol. 2 pp. 349-352). The Plan determined the evaluation criteria and scoring methodology in advance of the RFP being published. (Jones, T. Vol. 2 p. 352).

44. Vendors' responses to the RFP were divided into two phases: (1) a Minimum Requirements submission, and (2) a Technical Proposal and a Cost Proposal submission. (Stip. Nos. 32-33).

1. Minimum Requirements

45. The "Minimum Requirements" were requirements a vendor must meet in order for a vendor's technical and cost responses to be evaluated by the Plan for possible award of the TPA Contract. (Jt. Ex. 5 at §§ 2.6.1(a), 5.1). Minimum Requirements were "non-negotiable and absolutely required." (Jones, T. Vol 1, p 218).

46. Section 5.1 of the 2022 TPA RFT specifically required, "Only vendors that meet 100% of the Minimum Requirements [of the RFP]" were eligible to submit proposals for the technical and cost sections of the RFP. (Jt. Ex. 5 at § 5.1; Stip. No.34).

2. Technical Proposal's Requirements and Specifications

47. The Technical Proposal section of the RFP consisted of 310 Technical Requirements. (Stip. No. 44). For each requirement, vendors were required to check one of two boxes: "Confirm" or "Does Not Confirm." (Stip. No. 44). Vendors were not allowed to submit any additional information with their responses to any Technical Requirement. (Stip. No. 45).

48. In contrast to the Minimum Requirements, the 310 Technical Requirements were not absolutely required, but rather, were items the Plan desired and would prefer any vendor who could meet all those requirements. (Jones, T. Vol. 1 pp. 218-19, 276; Smart, T. Vol. 8 p. 1967; *see also* Jt. Ex. 5 at § 5.2). The Technical Requirements were the "optional things" or the "nice-to-haves." (Smart Dep. 30:10-11).

49. In previous RFPs, the Plan required vendors provide a narrative description how they proposed to meet the Technical Requirements, including their ability to comply with each Technical Requirement and any limitations on their ability to do so. (Jt. Ex. 5, p. 118; Pet. Ex. 528; Jones, T. Vol. 1 pp. 224-26, 266-71).

a. Throughout the years in the RFP process, Ms. Jones realized that in every one of the large procurements, the evaluation process and the development process took up an inordinate amount of time of the Plan's staff. The "outcome and value was not what we [the Plan] would – any of us would hope." (Jones, T. Vol 1, pp. 266-271). Vendors would confirm or not confirm requirements, but then provide "ten pages of why it may or may not be done that way." (Jones, T. Vol 1, pp. 266-271). The narrative responses basically negated a confirmation, which made the Plan try to discern what the vendors meant by their descriptions. (Smart Dep., pp. 28-29).

b. Narrative responses were often lengthy, resulting in voluminous proposals that took weeks of time and effort for the Plan's evaluation committee to evaluate and score. (Jones, T. Vol. 1 pp. 266-71, 267-68, 295-96). Narrative responses were also difficult to evaluate because of what the Plan considered to be marketing, fluff, and "mumbo jumbo," and at times, led to some confusion over what the terms of the contract actually were. (Davison Dep., pp. 202-03; Forehand, T. Vol. 1 pp. 173-77; Jones, T. Vol. 1 p. 267). Further, decisions on how to award points to

narrative responses were subjective, and the Plan's evaluation committees often had difficulty agreeing how to score them. (Jones, T. Vol. 1 pp. 295-96; Rish, T. Vol 2 pp. 455-456) The Plan's evaluation of the narrative responses was very time consuming and the value out of that process was limited. (Rish, T. Vol 2 p. 455-456).

c. Through the RFP process, over the years, "we [the Plan] concluded that getting broad narrative responses was not valuable." (Jones, T. Vol. 1 p. 228). The value of the narrative responses was outweighed by the problems they caused. (*Id.*; Smart Dep., pp. 29, 223).

50. As a result, the Plan decided that eliminating narrative responses would improve the procurement process and resulting contracts by increasing objectivity, making it easier for vendors to respond to RFPs, making evaluations of proposals faster and more efficient; and creating clearer, less equivocal, and more enforceable contract terms. (Jones, T. Vol. 1 pp. 266-71; Davison Dep., pp. 199-200, 203).

51. Around late 2021 or early 2022, the Plan started using a yes-no format or confirm/not confirm format in the Technical Proposals, instead of allowing narrative responses, to improve the procurement process of all contracts. (Jones, T. Vol. 1 pp. 270-71). The Pharmacy Benefit Manager ("PBM") contract was the first contract the Plan used the yes-no format. (Jones, T. Vol. 1 pp. 269-270).

52. The 2022 TPA RFP was the first TPA RFP to use the modernized, non-narrative format for responses to the Technical Requirements. (Jones, T. Vol. 1 p. 271).

53. At hearing, Mr. Coccia agreed that the Plan's explanation for eliminating narrative responses was reasonable, and that there were benefits to doing so, including reducing the time needed to review responses, eliminating ambiguity and disagreement over what was proposed, and reducing ambiguity in the contract terms. (Coccia, T. Vol. 8 pp. 2074-76). Mr. Coccia had seen in his own work, and in the industry in general, a shift away from narrative responses and towards a more modern, streamlined approach. (Coccia, T. Vol. 8 pp. 2076-77).

3. Cost Proposal

54. The Plan decided what elements of the Cost Proposal it wanted scored and how many points would be assigned to each of those cost elements. (Rish, T. Vol. 2 pp. 428-429). The entire point of the Cost Proposal in the 2022 TPA RFP was to allow the Plan to evaluate the costs that the Plan would incur under each bidder's proposal. (Rish, T. Vol. 2 pp. 400-401).

55. The Plan engaged Segal to support and collaborate with the Plan to design the Cost Proposal and the requirements around the Cost Proposal for the 2022 TPA RFP, and to evaluate and score the vendors' Cost Proposals for the 2022 TPA RFP. (Jones, T. Vol. 1 pp. 213-15; Kuhn, T. Vol. II, p. 503; Jt. Ex. 11).

56. Segal is recognized as an expert in the public health plan industry and in conducting TPA procurements. (Jones, T. Vol. 2 pp. 341, 345-347, 355; Rish, T. Vol. 2 p. 416). The Plan relied on Segal's knowledge, their staff knowledge, breadth of work and experience to bring the Plan accurate results. (Jones, T. Vol. 2 pp. 341, 345-347).

57. Segal had assisted the Plan with the RFP issued for the 2019 TPA Contract ("2019 TPA RFP"). (Smart, T. Vol. 8 p. 1966). Segal's work on the 2022 TPA RFP was typical of the work Segal does to support the Plan on TPA RFPs. (Vieira, T. Vol. 6 p. 1531).

58. The Cost Proposal section of the RFP was scored on a ten-point scale and had three subparts: (a) a network pricing component worth six points, (b) an administrative fee component worth two points, and (c) a pricing guarantee component worth two points. (Stip. No. 49). The Plan thought that scoring these three subparts or subcomponents would capture the critical elements that the bidders would be putting forth. (Rish, T. Vol. 2 pp. 460-461).

a. Network Pricing Component

59. The network pricing part of the Cost Proposal, also referred to as the "repricing exercise," required vendors to calculate the Plan's claims costs under the vendor's network of health care providers. (Jt. Ex. 5 § 3.4(c)(1). Each vendor was given a file of the actual medical claims incurred by Plan members in 2021 and was instructed to "reprice" the claims. (Jt. Ex. 5, Attach. A § 1.2.1; Kuhn, T. Vol 2 pp. 543-544).

b. Administrative Fee Component

60. "Administrative fees" are the fees paid by the Plan to its contracted third-party administrator for the services provided by the third-party administrator. The administrative fee part of the Cost Proposal required each vendor to state the amounts the vendor would charge for its services as TPA. (Jt. Ex. 5, Attach. A § 1.3).

c. Pricing Guarantee Component

61. The pricing guarantee part of the Cost Proposal required vendors to provide three types of guarantees related to the Plan's costs: (1) discount guarantees, (2) a trend guarantee, and (3) percent-of-Medicare guarantees. For each guarantee, each vendor was required to indicate the level of performance it proposed to achieve, called a "target," and the amount of money the vendor would refund to the Plan if the target was not achieved, called an "amount at risk." (Pet. Ex. 508 at 1; Jt. Ex. 5, Attach. A § 1.4).

4. Scoring Methodology

62. In previous RFPs, the Plan used a more complicated system to weight the Technical Proposals and Cost Proposals. Specifically, in the 2019 TPA RFP, the Technical Proposals and Cost Proposals were each scored on a 10,000-point scale. (Jones, T. Vol. 1 pp. 285-86; Rish, T. Vol. 2 pp. 453-54). However, under that system,

there was a lot of subjectivity in how many points were assigned for those minimal or "maybe" answers. It was "not as objective as one would like it to be." (Jones, T. Vol. 1, p. 285). Mr. Rish thought the narrative responses either put limitations or qualifications on the bidders' responses. He also thought that scoring process became very time consuming and the value coming out of that was limited. (Rish, T. Vol. 2, pp. 455-456).

63. The Plan's staff concluded the more complex weighting systems used in past RFPs had provided little value. Therefore, the Plan chose a simpler system for the 2022 TPA RFP that would clearly show the difference between higher and lower-scoring vendors. (Rish, T. Vol. 2, pp. 455-456); Smart Dep. p. 223).

64. Before issuing the 2022 TPA RFP, the Plan decided to score and rank the vendors' Technical Proposals and the Cost Proposals separately, and then combine the rankings for a total score. (Jones, T. Vol. 1 p. 284, Vol. 2 pp. 349-50; Jt. Exs. 63, 87; Pet. Ex. 520). The Plan scored the Technical Proposal 50% and Cost Proposal 50% of the total score because the Cost Proposal and Technical Proposal were equally important to the Plan. (Jt. Ex. 5 at § 3.4(a); Jones, T. Vol. 1 pp. 284-85; Davison Dep., p. 208).

65. Section 3.4 of the 2022 TPA RFP described the evaluation criteria and scoring methodology that would be used in that procurement process. Section 3.4(a) "Overall Scoring Weights" stated:

> . . . The Technical Proposal and the Cost Proposal will be scored separately based on the overall point scale described below.
>
> *The total points scale will reflect the following weights*:
>
> | | |
> |---|---|
> | Technical Proposal | 50% |
> | Cost Proposal | 50% |
> | **Total:** | **100%** |

(Jt. Ex. 5, § 3.4(a), p. 24 of 119).

66. Section 3.4(b) of the 2022 TPA RFP stated that each of the 310 Technical Requirements in the Technical Proposal was worth one (1) point. Each confirmed requirement was awarded one (1) point, and requirements not confirmed were awarded zero (0) points. (Jt. Ex. 5 at § 3.4(b); Resp. Ex. 601, p. SHP 4571).

a. After the Technical Requirements were totaled for each vendor, the Plan then ranked the vendors' Technical Proposals "in descending order based on total points earned. The Vendor earning the least points out of the total 310 received a rank of one (1)." (Jt. Ex. 5 at 3.4(b)).

b. The other bids or proposals would fall in according to the total scored points, with the vendor earning the most points out of the total 310 received the highest rank. Should two vendors earn the same score in the technical points, they would be given equal rank. (Jt. Ex. 5 at § 3.4(b), p. 24)). That is, with three vendors,

each proposal would be awarded 1 to 3 rank-based points, with the highest-scoring proposal(s) receiving three rank-based points. (Jones, T. Vol. 2 pp. 349-50, Resp. Ex. 601, p. SHP 4571).

67. Section 3.4(c) described scoring of the Cost Proposals based on three components for a total of 10 points: network pricing (six (6) points), administrative fees (two (2) points) and network pricing guarantees (two (2) points). (Jt. Ex. 5 at § 3.4(c)).

a. Like the Technical Proposals, the Cost Proposals were "ranked in descending order based on the total Cost Proposal points earned. The Vendor earning the least cost proposal out of the total 10 will receive the rank of one (1)." (Jt. Ex. 5 at § 3.4(c)).

b. "The bids would fall in line according to total Cost Proposal points, with the vendor earning the most points out of the total 10 receiving the highest rank. Should two vendors earn the same score in the Cost Proposals, they would be given equal rank." (Jt. Ex. 5 at § 3.4(c)). In other words, with three vendors, each vendor would receive 1 to 3 rank-based points, with the highest-scoring proposal(s) receiving three rank-based points. (Jones, T. Vol. 2 pp. 349-50).

68. The Plan asked for Segal's input on the scoring of the RFP such as whether the Plan "should do ranks. How the points might work. Stuff like that. How much weight to give to different things." "The Plan and Segal "bounced ideas back and forth." (Wohl Dep., pp. 62-63, 67). But Segal was not involved in setting up the system of scoring, then ranking, and then rank-based scores in the end. (Wohl Dep., pp. 62-63)

69. The Plan utilized Segal to help with how the cost section of the RFP would be scored to make certain "that everything that was drafted in the narrative portions of the RFP were consistent with how it would actually be scored." (Rish, T. Vol. 2 pp. 428, 431). Mr. Rish asked Segal to initially draft some language on the scoring, then "give the Plan to opportunity to evaluate that, if that was necessary and finalize the document." (Rish, T. Vol. 2 pp. 427, 428, 431). Both Mr. Sceiford and Mr. Rish reviewed the scoring analysis document from Segal separately, reviewed such analysis jointly, then asked Segal questions who incorporated the edits suggested by Mr. Sceiford and Mr. Rish. (Rish, T. Vol 2 pp. 428, 431, 475-476).

70. With the Plan's oversight and input, Segal created the Cost Proposal spreadsheets reflected in Attachments A-2 through A-10 and attached to the 2022 TPA RFP using attachments from prior versions of the RFP. (Rish, T. Vol 2 pp. 413-414).

5. Network of Health Care Providers

71. The RFP also required each vendor to submit information on the network of health care providers that it would make available to Plan members. (Pet. Ex. 502). Vendors were required to identify every health care provider in their proposed networks. (Jt. Ex. 5, Attach. A §§ 1.1.2, 1.1.3). They were also required to complete tables identifying the number of Plan members located within certain health care access

parameters, i.e., 10 miles, 15, miles, 20 miles, 25 miles, and 35 miles of specified types of healthcare providers. (Jt. Ex. 5, Attach. A § 1.1.1). For example, for counties defined as "urban," vendors were required to identify the number of Plan members who live within 20 miles of at least one in-network hospital, within 10 miles of at least two in-network pediatricians. (Jt. Ex. 5, Attach. A § 1.1.1).

72. Past performance was not one of the evaluation criteria in the RFP. (Jt. Ex. 5 § 3.4; Jones T. Vol. 2, p. 374).

6. Timeline of RFP

73. The 2022 TPA RFP was developed, drafted, and released on a tighter time frame than the Plan's previous TPA RFPs. (Jones, T. Vol. I, p. 249; Rish, T. Vol. II, pp. 407-409; Smart, T. Vol. 7 pp. 1839-1840). Executive Administrator Jones, who had overall responsibility for the RFP, admitted that the Plan's schedule "created a timeline stress for a number of people." (Jones, T. Vol 1 p. 249) The Plan's Senior Director, Caroline Smart, acknowledged that the Plan usually knew much sooner that a RFP will be issued in a particular year. (Smart, T. Vol. 7 p. 1839). Matthew Rish, the Plan's Senior Director for Finance, Planning and Analytics, acknowledged at hearing that the timeline for the 2022 TPA RFP "was definitely a tighter timeframe" compared to prior RFPs. (Rish, T. Vol 2 p. 407).

74. Nonetheless, the Plan's staff still thought they had sufficient time to develop the RFP and evaluate proposals submitted in response. Ms. Smart opined at hearing that the Plan had sufficient time to draft the requirements, and that the timeline did not interfere with the Plan's ability to issue a RFP that met its expectations. (Smart, T. Vol. 7 pp. 1839-40). Ms. Jones thought the Plan's timetable to evaluate the Minimum and Technical Requirements could be met, in part, because of the streamlined binary responses to those requirements. (Jones, T. Vol. 1 pp. 196-99, 267, 296; Jt. Ex. 22). At the same time, Ms. Jones opined that there were no corners cut or necessary tasks left undone. (Jones, T. Vol. 1 pp. 251-52).

75. At hearing, Mr. Rish added that the lesser timeframe offered the Plan the "opportunity to find efficiencies within the process, with the new modernized approach. We were able to take out some of the non-valued-aspects of the previous RFP process." (Rish, T. Vol 2 pp. 407-409) Mr. Rish did not think the compressed timeline had any negative impact on the bidders' proposals or on the evaluation by the Evaluation Committee. (Rish, T. Vol. 2 p. 477)

76. Staff from Segal who worked on the 2022 TPA RFP knew the timeline of the RFP left no room for error. Segal's contract with the Plan provided that Segal understood "that there was no margin for error in the timeline for this RFP. Segal agrees to meet all turnaround times specified by the Plan." (Jt. Ex. 209)

77. When the Plan asked Segal to provide its draft cost analysis of the Cost Proposals one day earlier than planned, Stephen Kuhn told others he "had been concerned all along with the limited time they have given us to turn this around." (Jt. Ex.

203) However, Segal's Stuart Wohl thought Segal had enough time to analyze the Cost Proposal. "We knew what was coming, and we knew in advance, we were all able to adjust our schedules to make sure we had the dedicated time needed then to do the analysis." (Wohl Dep., pp. 62-63).

7. Comment and Question Period

78. In June 2022, approximately two months before the August 30, 2022 issuance of the 2022 TPA RFP, the Plan held meetings with potential vendors to address comments and questions and receive input from vendors. The Plan explained how the forthcoming 2022 TPA RFP would be different from the 2019 TPA RFP including that the RFP would reflect the modernized format that would not involve or allow narrative responses. (Jones, T. Vol. 1 pp. 199-200, 278-79; Forehand, T. Vol. 1 pp. 117-18, 177-79; Aguirre, T. Vol. 8 pp. 2007, 2009-10, 2012-14; Jt. Exs. 54, 240, 241).

79. During these pre-RFP meetings, none of the vendors objected to the modernized format of the 2022 TPA RFP. (Jones, T. Vol. 1 pp. 278-79; Rish, T. Vol. 2 p. 480).

80. Section 2.4 of the 2022 TPA RFP schedule also allowed for two question-and-answer periods before the submission of vendors' Technical and Cost Proposals; the second of which was for "all written questions." (Jt. Ex. 5 at §2.4). Section 2.3 of the 2022 TPA RFP instructed the vendors:

> If Vendors have questions, issues, or exceptions regarding any term, condition, or other component within this RFP, those must be submitted as questions in accordance with the instructions in Section 2.5 PROPOSAL QUESTIONS.

(Jt. Ex. 5 at § 2.3).

81. Ms. Smart and Ms. Jones expected vendors to raise questions, issues, and exceptions regarding any requirement, term, condition, or other component of the 2022 TPA RFP during the question-and-answer period and before the vendors submitted their proposals. (Smart, T. Vol. 8 p. 1965; Jones, T. Vol. 2 pp. 363-65; Davison Dep., pp. 200-02, 208, 213). That's why the Plan held multiple question periods and met with other people at other times so they could ask questions. (Smart, T. Vol. 8, p. 1965)

82. UMR, Aetna and Blue Cross collectively submitted 65 questions to the Plan about the 2022 TPA RFP. Aetna submitted 43 of the 65 questions, Blue Cross submitted 6 of the 65 questions, and UMR submitted 16 of the 65 questions.

83. The Plan timely responded to all questions in the form of addenda to the 2022 TPA RFP before the proposals were due. (Jt. Ex. 5 at § 2.3; Ex. 44).

84. None of the vendors objected to the modernized, non-narrative format of the Minimum and Technical Requirements, or requested changes to any of the Technical

Requirements during the question-and-answer periods. (Jt. Ex. 44; Rish, T. Vol. 2 pp. 480-481). Blue Cross never raised any issues or concerns with how the Cost Proposal would be scored in the 2022 TPA RFP. (Rish, T. Vol. 2 p. 483). Neither did Blue Cross express any concern about the Plan continuing to work with Segal. (Rish, T. Vol. 2 p. 480)

85. Aimee Forehand, Blue Cross' Associate Vice President, confirmed at hearing that Blue Cross submitted questions to the Plan about some of the Technical Requirements and their understanding of the requirements during both question-and-answer periods. Ms. Forehand acknowledged that Blue Cross did not ask questions about the format of the 2022 TPA RFP. (Forehand, T. Vol. 1, pp. 118-122). She acknowledged that Blue Cross did not tell the Plan it was confused about the format of the TPA RFP or confused about the scoring of the proposals (Forehand, T. Vol. 1, pp. 118-122).

86. Ms. Jones confirmed at hearing that Blue Cross never asked the Plan what was the mathematical justification for the scoring and ranking. (Jones, T. Vol. 2, p. 377; Jt. Ex. 44). In addition, Mr. Coccia's review of the procurement record verified that Blue Cross did not ask clarifying questions or submit any concerns to the Plan about the proposed scoring and ranking set forth in the 2022 TPA RFP. (Coccia, T. Vol. 8, p. 2082).

87. On August 30, 2022, the Plan issued the 2022 TPA RFP. (Jones, T. Vol. 1 pp. 194-96, 282-83; Jt. Ex. 5, p. 1).

88. The Plan established a committee to review the vendors' proposals (the "Evaluation Committee"). (Jt. Ex. 5 at § 3.3(b); Resp. Ex. 601, p. SHP 4568-69).

III. Evaluation of Vendors' Proposals

A. Evaluation of Minimum Requirements

89. On or about September 16, 2022, the Plan received Minimum Requirements proposals from Blue Cross, Aetna, and UMR. (Jt. Ex. 5 at § 2.4; Resp. Ex. 601, p. 4569-4571). From September 27-29, 2022, the Evaluation Committee reviewed and determined that all vendors met the Minimum Requirements. (Resp. Ex. 601, pp. SHP 4569-71).

B. Evaluation of Technical Proposal's Requirements

90. On November 7, 2022, all vendors submitted the Technical and Cost Proposals to the Plan. (Jt. Ex. 5 at § 2.4; Ex. 601, p. SHP 4571). On November 8, 2023, the Evaluation Committee met, and evaluated all vendors' Technical Proposals. (Jt. Ex. 5 at § 2.4.; Resp. Ex. 601, p. SHP 4570-4573).

91. Both Aetna and UMR confirmed all 310 Technical Requirements in their Technical Proposal and were awarded 310 points each. (Jones, T. Vol. 1 pp. 232-33;

Resp. Ex. 601, p. SHP 4571). Aetna and UMR tied for highest-scoring Technical Proposal at 310 points each, and as a result, each received three (3) rank-based points. (Jones, T. Vol. 1 pp. 232-33: Jt. Ex. 5 at § 3.4(b); Resp. Ex. 601, p. SHP 4571). Blue Cross confirmed only 303 Technical Requirements, and as a result, Blue Cross received only 303 points. (*Id.).* Consistent with the 2022 TPA RFP scoring requirements, Blue Cross received one (1) rank-based point because it had the lowest scoring Technical Proposal.

92. Blue Cross did not confirm the following seven (7) Technical Requirements:

> (1) Vendor will apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States. (5.2.3.2.b.iii).
>
> (2) Vendor will use the unique Member ID number provided by the EES vendor as the primary Member ID for claims processing, customer services and other operational purposes; therefore, the unique Member ID number provided by the EES vendor will be the sole Member ID on the ID Card. (5.2.6.2.b.xvi).
>
> (3-6) Vendor's member portal will accept and display Member-specific information from the other systems and Vendor's health team, including each of the following. Vendor shall confirm each below:
>
> - Electronic medical and health records (5.2.7.2.b.xxiv.1)
> - Disease Management Nurse notes. (5.2.7.2.b.xxiv.2)
> - Case Management notes. (5.2.7.2.b.xxiv.3)
> - Health Coach notes. (5.2.7.2.b.xxiv.4)
>
> (7) Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits. (5.2.8.2.b.v).

(Jt. Ex. 37; Resp. Ex. 602, pp. 7-8).

93. The seven (7) Technical Requirements that Blue Cross did not confirm, like all the other Technical Requirements, were important to the Plan. (Smart, T. Vol. 8 p. 1967; Jt. Ex. 37).

a. Applying the same utilization payment rules across providers was important to the Plan because it set a level playing field for all members, regardless of where in the United States the members receive services. The Plan's auditor had

identified Blue Cross' failure to apply the same payment rules nationwide as an issue affecting the Plan's costs. (Smart, T. Vol. 7 pp. 1849-50).

b. A unique Member ID number provided by the EES [Eligibility and Enrollment Services] vendor was an important requirement to the Plan because the Plan wanted a single ID across all vendors that would not change if the TPA changed and that could be used for operational purposes. (Smart, T. Vol. 7 p. 1846).

c. The member portal requirements were in previous RFPs and were important because the Plan desired to provide members a good customer experience and best-in-class portal, including a centralized place for members to view their health information. (Smart, T. Vol. 7 pp. 1856-57).

d. The assignment of benefits requirement was also in previous RFPs and is important to the Plan because the Plan prefers that claims are paid directly to the provider (instead of to the member, who then pays the provider). (Smart, T. Vol. 7 p. 1858). This requirement is intended to avoid situations where the Plan pays a member who is supposed to reimburse a healthcare provider, but the member then fails to pay the provider (as has happened previously). (Smart, T. Vol. 7 pp. 1858-59, Jt. Ex. 86, Slide SHP 0070513).

94. At hearing, Aimee Forehand explained that Blue Cross did not confirm one of the Technical Requirements because it was a business decision. Blue Cross did not confirm the other six Technical Requirements because Blue Cross didn't believe any vendor could meet those requirements. "We [Blue Cross] don't think it's possible. Or it just didn't make sense." (Forehand, T. Vol. 1 pp. 131, 160, 162-63).

95. In spite of this, Blue Cross did not raise any concerns or request the Plan to change or remove any of the Technical Requirements during the question-and-answer periods. (Forehand 118-22, Jt. Ex. 44 (Addendum 2)). Neither did Blue Cross ask the Plan, during the question-and-answer periods, about the Technical Requirements that Blue Cross didn't confirm. (Forehand, T. Vol. 1, pp. 118-122).

96. At the time of hearing, Aetna had successfully implemented the seven (7) Technical Requirements that Blue Cross did not confirm. (Aguirre, T. Vol. 8 p. 2023).

C. Evaluation of Cost Proposals

97. Segal analyzed and evaluated the vendors' Cost Proposals to arrive at proposed scoring and presented a draft of its preliminary analysis to the Evaluation Committee. (Rish, T. Vol. 2 pp. 413-15; Kuhn, T. Vol. 3 pp. 661-62; Jt. Ex. 413). In Mr. Coccia's experience, it is typical for a governmental entity publishing a healthcare RFP to retain a third-party consultant with expertise and experience evaluating the cost aspect of the RFP. (Coccia, T. Vol. 8 p. 2065).

98. On November 16, 2022, Matt Rish and Charles Sceiford, the Plan's Health and Benefits Actuary, reviewed Segal's proposed preliminary analysis and scoring of the

network pricing guarantees component of the Cost Proposal. They made minor suggested edits but generally agreed with Segal's analysis. (Kuhn, T. Vol. 2 pp. 590-92; Rish, T. Vol. 2 pp. 414-17; Sceiford, T. Vol. 3 pp. 760-61; Resp. Ex. 619). Segal incorporated Mr. Rish's and Mr. Sceiford's input and presented its preliminary analysis of the Cost Proposals to the Evaluation Committee at a November 17, 2022 meeting. The Evaluation Committee considered Segal's analysis, and asked questions to understand the analysis and make sure the tenets of the RFP were met. (Rish, T. Vol. 2 pp. 418-420; Kuhn, T. Vol. 2 pp. 590-92; Smart, T. Vol. 8 p. 1972; Resp. Ex. 619; Jt. Ex. 17 (Preliminary Cost Proposal analysis).

99. Segal's draft of the preliminary Cost Proposal analysis and scoring was incomplete because it did not reflect the full or complete clarification answers from the vendors. Segal had requested written clarifications from the vendors to ensure the vendors' claims repricing submissions were prepared consistently so Segal could make an apples-to-apples comparison of the vendors. At that time, Segal was only partway through its review of a series of written clarifications from the vendors. (Kuhn, T. Vol. 2 pp. 569-72; Jt. Ex. 17).

100. The draft or preliminary Cost Proposal analysis showed Blue Cross as the highest scoring vendor on the Cost Proposal. (Kuhn, T. Vol. 2 pp. 572-74; Resp. Exs. 619, 601, pp. SHP 4571-72). Segal recommended the Plan seek further clarifications on the network pricing component of the vendors' Cost Proposals and request Best and Final Offers ("BAFOs") from all the vendors on the administrative fees and pricing guarantees components. (Jt. Ex. 17, pp. 4-5; Kuhn, T. Vol. 2 pp. 570-71, 574-75). After considering the vendors' clarifications and BAFOS, Blue Cross and Aetna tied for first place in the Cost Proposal. When the Plan combined the ranks of the Technical Proposal and Cost Proposal, Aetna had the highest overall score. (Jones, T. Vol. 2 pp. 300-06; Resp. Ex. 601, pp. 4571-62).

101. The Evaluation Committee voted to seek additional clarifications recommended by Segal to evaluate the network pricing, and to request BAFOs for the administrative fees and pricing guarantees. (Resp. Ex. 601, pp. SHP 4571-72, Sections J, K).

102. On November 22, 2022, the vendors submitted their BAFOs for network pricing guarantees to the Plan. (Kuhn, T. Vol. 2 pp. 575-78; Resp. Exs. 621, 624). After receiving the additional clarifications and BAFOs, Segal provided its final Cost Proposal analysis to Matt Rish and Charles Sceiford for review. (Kuhn, pp. 661-63; Rish, T. Vol. 2 pp. 474-75).

103. At a November 30, 2022 meeting, Segal presented its final cost proposal analysis to the Evaluation Committee. After discussion and questions, the Evaluation Committee unanimously voted to accept and adopt Segal's analysis and proposed scoring. (Kuhn, T. Vol. 2 pp. 574-75, Vol. 3 pp. 661-63; Jt. Ex. 413; Resp. Ex. 601, pp. SHP 4572-73, Section L).

104. On the final Cost Proposal analysis and scoring adopted by the Evaluation Committee, Aetna and Blue Cross tied on the Cost Proposal with eight points each, while UMR received seven points. (Jones, T. Vol. 1 pp. 302-05; Jt. Ex. 413; Resp. Ex. 601, p. SHP 4572-73).

105. As illustrated below, Aetna and Blue Cross tied for six points each in the network pricing. (Jt. Ex. 413, pp. 4−5). Blue Cross received two points for administrative fees, and Aetna received one point. (Jt. Ex. 413, pp. 4, 6). Aetna received one point for pricing guarantees, while Blue Cross received zero points. (Jt. Ex. 413, pp. 4, 8).

Total Projected Claims	CY 2025	CY 2026	CY 2027	Total (2025-2027)	% From Lowest Claims Cost	Network Pricing	
						Rank	Score
Aetna	$3,035,662,403	$3,209,628,778	$3,393,934,782	$9,639,225,963	0.00%	3	6
BCBSNC	$3,049,930,581	$3,224,682,897	$3,409,818,837	$9,684,432,315	0.47%	2	6
UMR	$3,060,066,924	$3,241,165,545	$3,427,210,176	$9,728,442,644	0.93%	1	5

(Jt. Ex. 413, p. 5).

Total Administrative Cost	CY 2025	CY 2026	CY 2027	Total (2025-2027)	Administrative Fees	
					Rank	Score
Aetna	$97,471,644	$98,194,549	$97,931,923	**$293,598,116**	2	1
BCBSNC	$52,694,491	$74,047,011	$96,549,928	**$223,291,430**	3	2
UMR	$112,194,585	$122,070,115	$122,954,779	**$357,219,479**	1	0

(Jt. Ex. 413, p. 6).

	Rank	Score	Summary Comments
Aetna	2	1	Offers both discount and trend guarantees of moderate comparative value.
BCBSNC	1	0	Offers the least comparative value for both discount and trend guarantees, primarily due to the amount at risk. BCBSNC's low amount at risk is due to a combination of having significantly lower admin fees and only placing 5% at risk.
UMR	3	2	Offers the greatest comparative value discount guarantee with dollar-for-dollar up to 100% of admin fee and a moderate comparative value (including the most at risk) trend guarantee.

(Jt. Ex. 413, p. 8).

106. As shown below, the vendors were ranked in descending order on their Cost Proposals, with Aetna and Blue Cross each receiving three rank-based points, and UMR as the lowest-scoring Cost Proposal receiving one rank-based point. (Jt. Ex. 413, p. 4; Resp. Ex. 601, p. SHP 4573).

Vendor	Network Pricing	Administrative Fees	Network Pricing Guarantees	Cost Proposal Total Score	Cost Proposal Rank
Allocated Points	6	2	2	10	
Aetna	6	1	1	8	3
BCBSNC	6	2	0	8	3
UMR	5	0	2	7	1

(Jt. Ex. 413, p. 4).

D. Network Pricing Guarantee Scoring

107. The Plan is self-insured, meaning that the Plan, not the TPA, bears the financial risk of changes in the cost of care provided to the Plan's members. The Plan bears all the risk, except for the small amounts in the guarantee. (Vieira, T. Vol. 6 pp. 1550-51). Because the Plan is self-funded by taxpayer dollars, the Plan has the responsibility to keep costs as low as they possibly can. (Rish, T. Vol. 2 pp. 465-466).

108. Network pricing guarantees are used in RFPs to align the TPA's interests with the Plan's by incentivizing the TPA to control or hold down costs for the Plan. (Vieira, T. Vol. 6 pp. 1543-44, 1552; Kuhn, T. Vol. 2 pp. 579-80; Coccia, T. Vol. 8 pp. 2091-92, 2093-96). The purpose of network pricing is to determine the projected claim cost that would result with each of the three bidders. (Kuhn, T. Vol. 2 pp. 551-552)

109. Network pricing guarantees are set by the vendor and are a combination of a financial target (*e.g.*, a discount percentage or trend percentage) and an amount at risk. The "amount at risk" is a percentage of the TPA's fee that the vendor agrees to refund to the Plan if the target is not met. (Kuhn, T. Vol. 2 pp. 579-81; Vieira, T. Vol. 6 pp. 1543-45, 1552). The term "guarantee" is a misnomer because a network pricing guarantee does not ensure or guarantee that the target will actually be achieved. (Kuhn, T. Vol. 2 pp. 579-81, Vol. 3 p. 640; Vieira, T. Vol. 6 p. 1545; Russo, T. Vol. 5 p. 1231). The amount at risk is a penalty the vendor must pay if the target is not achieved. Thus, the amount at risk should be large enough to incentivize the vendor to meet the target, and a small amount at risk provides little incentive to meet the target. (Kuhn, T. Vol. 3 pp. 580-81).

110. The vendors were asked to propose three types of network pricing guarantees under the 2022 TPA RFP: (1) discount guarantees, (2) trend guarantees, and (3) percentage of Medicare guarantees. (Jt. Ex. 5, pp. 84, Attachment A at § 1.4; Pet. Ex. 508).

111. "Discount guarantees" set a target percentage discount off healthcare providers' billed charges. (Jt. Ex. 5, pp. 84, Attachment A).

112. "Trend" refers to year-over-year increases in the cost of healthcare claims paid by the plan; accordingly, trend guarantees set a target trend percentage, which is a percentage yearly increase in the total claims cost paid by the Plan. (Kuhn, T. Vol. 2 pp. 593-94, 580, Vol. 3, p. 640).

113. "Percentage of Medicare guarantees" set a target percentage above the federally set Medicare fee schedule. (Kuhn, T. Vol. 3 pp. 656-57).

114. Under the 2022 TPA RFP, network pricing guarantees were worth two (2) out of ten (10) total points for the Cost Proposals. Points were awarded by comparing the vendors' network pricing guarantees based on their value to the Plan. The Plan was looking for the proposal that allowed for the greatest value to the Plan. (Rish, T. Vol. 2 pp. 467-471)

115. The value of the guarantees was to be determined based on the combination of the competitiveness of the guaranteed targets and the amounts put at risk by the vendors. (Jt. Ex. 5 at § 3.4(c)(3)). The weight placed on the target and the amount at risk proposed varied depending upon the relationship between the two, but the Plan and Segal did not script how that was going to work. (Rish, T. Vol. 2 pp. 433, 467, 472). For example, a very large discount might be given considerable weight if there was a sufficient amount at risk to incentivize the provider to attempt to achieve the discount; but the discount would not be given much weight if the amount at risk was too small to incentivize the vendor. (Rish, T. Vol. 2 pp. 472-473).

116. Segal analyzed the vendors' guarantee targets and amounts at risk for the discount guarantees and trend guarantees and determined the comparative value of each. (Jt. Ex. 413, pp. 7−8). Segal determined that Blue Cross' discount and trend guarantees had the least comparative value, Aetna's discount and trend guarantees had moderate comparative value, and UMR's discount and trend guarantees had the greatest comparative value. (Jt. Ex. 413, pp. 7-8). Accordingly, Segal proposed awarding Blue Cross zero (0) points, Aetna one (1) point, and UMR two (2) points. (*Id.).*

117. Consistent with the language in the 2022 TPA RFP, Segal's analysis thoroughly assessed the value of the vendors' network pricing guarantees based on the combination of the guaranteed targets and the amounts put at risk by considering and accounting for numerous variables in the vendors' proposed guarantees. Segal witnesses testified in detail regarding their calculations and consideration of the vendors' targets and amounts put at risk, as well as their consideration of multiple factors and differences between the guarantees that affected their comparative values. Segal documented its calculations in their written analysis presented to the Plan's Evaluation Committee. (Kuhn, T. Vol. 2 pp. 579, 594-06, Vol. 3 pp. 640-55; Vieira, T. Vol. 6 pp. 1565-66, 1571, 1574-76; Jt. Ex. 413, pp. 7-8).

118. Segal's analysis considered and recognized that, while Blue Cross' guarantee targets were competitive, they were outweighed by the small amounts Blue Cross put at risk, which were, by far, the least of all three vendors by far. (Jt. Ex. 413, pp. 7−8; Kuhn, T. Vol. 2 pp. 603-06, Vol. 3 pp. 651-54; Coccia, T. Vol. 8 pp. 2089-94, 2097).

IV. Recommendation to and Decision by Plan's Board of Trustees

119. At the Evaluation Committee meeting on November 30, 2022, the Evaluation Committee adopted Segal's analysis and scoring, and then updated the Plan's master scoring tool. The Evaluation Committee determined that Aetna received the highest overall score of six (6) points, compared with four (4) points each for Blue Cross and UMR. (Jones, T. pp 305-07; Resp. Ex. 601, Section L).

120. The Evaluation Committee unanimously voted to present all three proposals for consideration by the Board of Trustees at its December 2022 meeting, with a recommendation to award the TPA Contract to Aetna. (*Id.*).

121. All three proposals were presented for consideration by the Board of Trustees because, pursuant to N.C. Gen. Stat. § 135-48.33(a), it was solely the Board of Trustee's role to award the contract. The Board of Trustees is an independent decision maker. The Board had departed from the Evaluation Committee's recommendation in the past. (Jones, T. Vol. 2 pp. 306-07, Vol. 3 pp. 338-39).

122. Before the December 2022 meeting of the Board of Trustees, the Plan also submitted all three proposals to the Attorney General's office for review. Such review was timely completed. (Smart, T. Vol. 7 p. 1914; Resp. Ex. 601, p. SHP 4573, Section M).

123. The Plan's staff kept the Board of Trustees informed of the progress of the RFP at the Board's regular 2022 board meetings. Two days before the December 2022 meeting, Kendall Bourdon, the Plan's Director of Contracting and Compliance, electronically mailed ("e-mailed") copies of the RFP, the Minimum Requirements and Technical Proposals, the evaluation scoring tool tabulating the vendors' responses to the Minimum and Technical Requirements, and a summary comparison of the vendors' Cost Proposals to the Trustees. (Jones, T. Vol. 2 p. 317, Vol. 8 pp. 1941-49, Exs. 606, 610, 611, 612). Ms. Bourdon sent these materials in advance to inform the Trustees about the process followed in the procurement and to allow the Trustees time to study before the meeting. (Jones, T. Vol. 8 pp. 1941-42).

124. Dee Jones and Plan leadership attended the Board of Trustees meeting held on December 14, 2022. (Resp. Ex. 602; Jt. Ex. 294).

125. Kendall Bourdon gave a presentation to the Board of Trustees in executive session explaining the procurement process, differences from past RFPs, the scoring of the Cost and Technical Proposals, and the recommendation from the Evaluation Committee. (Jones, T. Vol. 2 pp. 332-33; Smart, T. Vol. 7 p. 1911; Resp. Ex. 602). This presentation included the vendors' claims cost for the network pricing, base administrative fees, discount, and trend guarantees, and amounts at risk for 2025−2027, the separate scoring and ranking for the Cost and Technical Proposals, and the final scores. (Resp. Ex. 602, pp. 7, 9−12).

126. The Board of Trustees discussed and asked questions on various issues, including the importance of the Technical Requirements that Blue Cross did not confirm,

network access and disruption, the scoring of the pricing guarantees, and Blue Cross' lower administrative fees. (Smart, T. Vol. 8 p. 1973) Regarding network access and disruption, Plan staff described that all the vendors had broad networks that covered the state adequately, explained that only 1% or less disruption was expected, and described efforts to educate members about available providers. (Jones, T. Vol. 2 pp. 332-38; Jt. Ex. 294). Staff also explained that a new vendor would have a two-year implementation period during which they would be expected to recruit new providers to their network. (Smart, T. Vol. 7 p. 1917).

127. The Plan staff and the Board discussed that Blue Cross' proposed administrative fees were significantly lower than Aetna's and UMR's fees. Blue Cross' proposal did not include many items that were included in Aetna's and UMR's fees and thus, would cost the Plan more if those services were needed. Historically, the Plan has had to pay more than Blue Cross' base fees for such services because Blue Cross' services and fees for such services had become more "à la carte" than an all-comprehensive administrative fee. "There was value in an all-comprehensive admin fee." (Jones, T. Vol 2 p. 336). Nevertheless, Bue Cross received the most points of any vendor for the administrative fees because the RFP scored the administrative fees based on the vendor's base fees. (Jones, T. Vol. 2 pp. 335-336; Jt. Ex. 294).

128. The Board of Trustees unanimously voted to award the TPA Contract to Aetna. (Jones, T. Vol. 2 p. 338; Jt. Ex. 294).

129. While Treasurer Dale Folwell attended the December 2022 Board of Trustees meeting, he did not vote because the decision to award the TPA contract to Aetna was unanimous. By statute, Treasurer Folwell only votes if needed to break a tie. N.C. Gen. Stat. § 135-48.20(c). (Jt. Ex. 294 at SHP 0075512). In his designated deposition testimony, Treasurer Folwell, an *ex officio* member of the Plan's Board of Trustees, testified that the Board's decision to award the contract to Aetna was based on the recommendation made by the Evaluation Committee under the 2022 TPA RFP. (Folwell Dep., pp. 10, 110).

130. None of the Board of Trustees testified at the hearing, and no evidence was presented at the contested case hearing regarding how the Board of Trustees would have voted under alternative circumstances, including if Blue Cross had been the highest-scoring vendor, or if the Evaluation Committee had recommended awarding the contract to Blue Cross.

V. Analysis

A. The Plan's Procurement Policy

131. Blue Cross contended that the Plan violated the Plan's mandatory "Contract Procurement Policy and Procedure" ("Procurement Policy") (Jt. Ex. 4, Section II, A) when it failed to evaluate and finalize a scoring method of the network pricing guarantees before the 2022 TPA RFP was posted.

132. The purpose of the Procurement Policy was to "establish a standard procedure for the procurement of goods and services" for the Plan. (Jt. Ex. 4, p. 1).

133. Part II, Section A of the Procurement Policy provided:

> Development of Evaluation Criteria and Determination of Scoring Methodology is critical to ensure a fair and impartial evaluation process for all proposals.
>
> RPFs **should not** be posted until the evaluation criteria and scoring methodology are finalized. A scoring tool **may** be developed after posting the RFP but must be finalized before bids are opened. All scoring tools must take into consideration RFP Addenda that resulted in changes to the RFP.

(Jt. Ex. 4, p. 7; emphasis added)

134. On October 24, 2022, after the 2022 TPA RFP was issued, but before the Cost Proposals were submitted by the vendors, Mr. Kuhn e-mailed draft templates for the Cost Proposal analysis to the Plan for review. While Kuhn noted that the network pricing guarantees "scoring model" could change based on the proposals received, he also noted that these templates were "based on the models on the Cost Proposal scoring in the RFP document." (Jt. Ex. 64, p. SHP 0070489).

135. On October 27, 2022, the Plan asked Segal by email how it would determine the value of the network guarantees and for sample discount. In Segal's assessment, it was not possible to develop a formula or mathematical model that would fairly and adequately compare the value of the guarantees because of the numerous variables that would have to be accounted for. (Jt. Ex. 64; Kuhn, T. Vol. 2 p. 522-23, 584-85; Vieira, T. Vol. 6 pp. 1578-79, 1571-72)

136. The Plan did not want to limit the types of guarantees the vendors could propose because giving vendors flexibility to propose what they wanted to propose was likely to result in a guarantee that would have more value than what the Plan might have prescribed. (Rish, T. Vol. 2 pp. 467-68).

137. Segal responded that the scoring of those guarantees would need to consider (1) how each vendor's guarantee relates to their own pricing and its value to the Plan, and (2) how it compares to the other vendor proposals. "We need to consider both the guaranteed targeted level and the amount of risk in determining the overall value of the proposed guarantees." (Jones, T. Vol. 2 pp. 354-55; Kuhn, T. Vol. 2 pp. 523-28; Jt. Ex. 64) Segal responded that the scoring would require comparing vendors' guarantee targets and amounts at risk, and that the comparison would be comparative and subjective. Segal did not have a sample pricing guarantee or a sample guarantee scoring already drafted, because the evaluation would depend on what the vendors submitted. (Jones, T. Vol. 2 pp. 354-55; Kuhn, T. Vol. 2 pp. 523-26; Jt. Ex. 64.)

138. Segal informed the Plan that they would create a template or table to calculate the pricing guarantees but would have to wait until they received the vendors' RFP responses to actually finalize the calculation. (Jones, T. Vol. 2 pp. 355-356; (Jt. Ex. 64).

139. With that understanding, the Plan did not require Segal to devise a sample or formula in advance of receiving the Cost Proposals to compare the pricing guarantees. (Kuhn, T. Vol. 2 pp. 523-26; Jones, T. Vol. 2 pp. 354-55; Rish, T. Vol. 2 pp. 434-38; Sceiford, T. Vol. 3 p. 753; Jt. Ex. 64).

140. The evidence at hearing showed that the Plan complied with the Procurement Policy by finalizing the evaluation criteria and scoring methodology for the network pricing guarantees and incorporating such criteria and scoring methodology into Section 3.4 of the 2022 TPA RFP before the TPA RFP was issued. (Jones, T. Vol. 2 pp. 351-53, 358, 382; Rish, T. Vol. 2 pp. 454-457; Jt. Ex. 5 at § 3.4(c)(3)).

a. The e-mail chain from August 18-22, 2022, between Mr. Rish, Ms. Smart, Ms. Jones, Kendall Bourdon, the Plan's Evaluation Committee, documented the Plan's establishment and selection of the evaluation criteria and the scoring methodology as follows:

> [G]ive 1 point for admin and guarantees and 3 points for network that will enable us to rank the bidders in a 4, 3, 2, 1 (assuming 4 bidders). Then doing the same with the technical scores, then combine rankings for a total score with the top scorers going to the board.

(Jt. Ex. 87, p. SHP 0092243; Pet. Ex. 520) The e-mail chain also documented the Plan's discussion with Segal about their selection of the evaluation criteria and specifics of the scoring methodology and that "other states use/have used the ranking method." (Jt. Ex. 87, pp. 0092244-00902245).

b. The Plan's August 2022 e-mails also documented the Plan's determination that disruption would be captured in the network pricing "as the projected claims will be a function of network size and discounts." (Jt. Ex. 87, p. SHP 0092243; Pet. Ex. 520).

c. The specific allocation of points and ranking for network pricing, administrative fees, and guarantees was defined in the Evaluation Committee's e-mails of August 25-26, 2022. (Pet. Ex. 520).

d. The Evaluation Committee decided to do the same ranking methodology on the technical side so they could "bring those two [Cost Proposal and technical proposal] together and achieve the 50/50 weighting that we had established in the RFP." (Jones, T. Vol. 2 pp. 454-455)

e. Thereafter, the Committee incorporated the Plan's evaluation criteria and scoring methodology, described in the August 2022 e-mails, into Section 3.4 of the 2022 TPA RFP. (Rish, T. Vol. 2 pp. 454-457; Jt. Ex. 5). The evaluation criteria and scoring methodology did not change after the Plan received the vendors' proposals. (Davison Dep., pp. 213-14). Accordingly, there was no deviation from the Plan's Procurement Policy. (Jones, T. Vol. 2 pp. 351-53, 358, 382).

f. The scoring tool Segal later developed for the pricing guarantees, after reviewing the vendors' pricing guarantees, was based on the models of the Cost Proposal scoring in the RFP document.

141. Even if the Plan did not develop a scoring analytical tool before the RFP was issued, the Plan did not err, fail to use proper procedure, act inconsistent with law or rule, and did not act arbitrarily or capriciously because the Procurement Policy was not a binding or mandatory "rule" under N.C. Gen. Stat. § 150B-2(8a)c.

a. N.C. Gen. Stat. § 150B-2(7a) defines "policy" as:

> Any nonbinding interpretative statements within the delegated authority of an agency that merely define, interpret, or explain the meaning of a statute or rule. The term includes any document issued by an agency that is intended and used purely to assist a person to comply with the law, such as a guidance document.

b. N.C. Gen. Stat. § 150B-2(8a)c. defines a "rule" as any agency regulation, standard or statement of general applicability that implements or interprets an enactment of the General Assembly or describes the procedure or practice requirements of an agency. A "rule" explicitly does not include a "policy" as defined in N.C. Gen. Stat. § 150B-2(7a).

c. The clear language of the Plan's Procurement Policy and the testimony at hearing proved that the Plan's Procurement Policy is a "policy," pursuant to N.C. Gen. Stat. § 150B-2(8a)c., and not a "rule" under N.C. Gen. Stat. § 150B-2(8a)c. The Plan's Procurement Policy explicitly provided that its purpose was to establish a "standard procedure for the procurement of goods and services for the Plan." (Jt. Ex. 4, pg. 1). The Policy provided that "RFPs should not be posted until the evaluation criteria and scoring methodology are finalized." (Jt. Ex. 4, p. 7) The Policy did not require that the evaluation criteria and scoring methodology be finalized before the RFP was posted, as it did not use the mandatory words "shall" or "must" in that sentence.

d. There was no evidence presented at hearing proving that Procurement Policy has been promulgated as a "rule" by DST or the Plan, under Chapter 150B of the N.C. General Statutes or was part of a statute, which bound or required the Plan to comply with the Procurement Policy during the 2022 TPA RFP process.

142. The Policy further authorized Ms. Jones, as the Plan's Executive Administrator "**shall** have the authority to interpret and apply this policy." (Jt. Ex. 4, pg. 10 (emphasis added)). Under that authority, Ms. Jones interpreted the Procurement Policy as a guideline, and a framework that the Plan and its staff should generally try to follow but is not a requirement to follow everything detailed in the Procurement Policy. The Plan has "the statutory authority to work around the Procurement Policy as needed." She credibly opined that the Plan can stay within the guidelines of the Procurement Policy but does deviate from the Procurement Policy when circumstances warrant. (Jones, T. Vol. 1 pp. 210-11, 264-65).

143. The Procurement Policy also stated that "[n]on-compliance with this policy is a serious matter that **may** result in disciplinary action, up to and including termination." (Jt. Ex. 4, pg. 10 (emphasis added)). Ms. Jones credibly testified that this language could be implicated in extreme cases such as a biased RFP or a failure to obtain statutorily required approvals. (Jones, T. Vol. 1 pp. 264-66). Ms. Jones' interpretation was consistent with the use of "may" in the Plan's Procurement Policy, which further demonstrated its discretionary nature. (Jt. Ex. 5, p. 19).

B. 5% vs 15% at Risk for Discount Guarantees

144. Blue Cross contended that one factor that contributed to Blue Cross receiving a lower score than it should have for network pricing guarantees was the determination that Blue Cross put only 5% of its administrative fee at risk for its discount guarantee (Russo, T. Vol. 4 p. 986), far less than UMR and Aetna. (Jt. Ex. 413). Blue Cross argued that Segal misread Blue Cross' proposal by concluding that the total amount at risk on Blue Cross' three discount guarantees was only 5%, not 15%. (Jt. Ex. 413; Kuhn, T. Vol. 3 p. 628).

145. The discount guarantees included three subcomponents: (1) inpatient facility discount, (2) outpatient facility discount, and (3) professional fees discount. (Pet. Ex. 508; Jt. Ex. 225). At hearing, Aimee Forehand of Blue Cross testified that Blue Cross had put 5% at risk for each subcomponent, totaling 15% at risk for the discount guarantees, and that Segal misread Blue Cross' proposal. (Forehand, T. Vol. 1 pp. 102, 142-43; Jt. Ex. 225).

146. Blue Cross used identical language regarding a 5% maximum payout in all three subcomponents of its discount guarantee. In contrast, Blue Cross did not use the same defined "cap" language with respect to the amount at risk for its trend guarantee. (Jt. Exs. 225, 413). Segal and the Plan interpreted Blue Cross' identical language in each subcomponent as applying the same 5% maximum payout, which Blue Cross defined as a "cap," across all three subcomponents. (Jt. Ex. 413; Kuhn T. Vol 3, pp. 623-628). In Segal's experience, vendors proposing an aggregate or cumulative amount at risk explicitly make that clear. (Kuhn, T. Vol. 3 pp. 625-29, 636, 675-77; Vieira, T. Vol. 6 pp. 1580-81; Jt. Ex. 225).

147. Everyone on the Segal team (Steve Kuhn, Matt Kersting, and Kenneth Vieira) and the Plan's staff, who read and reviewed the proposed guarantees in Blue

Cross' proposal, consistently understood the wording of Blue Cross' proposal, that Blue Cross was putting 5% at risk, in total for its discount guarantee. None of the Segal witnesses considered Blue Cross' proposal ambiguous or unclear with respect to the amount put at risk. (Kuhn, T. Vol. 3 pp. 676, 688-89; Vieira, T. Vol. 6 pp. 1580-81).

148. Mr. Viera credibly testified that the wording of Blue Cross' discount guarantee "reads fairly clearly that there's a 'cap of 5 percent.' And I think our interpretation is reasonable. . . [Y]ou had five different people read Blue Cross' wording and everyone took it as 5 percent." In addition, "every other vendor clearly said the total risk that they were putting" up. (Vieira, T. Vol. 6 pp. 1580-81; Jt. Exs. 223, 413).

149. Segal and the Plan reasonably interpreted Blue Cross' proposal as putting only 5% at risk for its discount guarantees.

150. Even if Segal had questioned the amount that Blue Cross intended to put at risk, the onus was on Blue Cross to submit a clear proposal, not on the Plan to seek clarification. (Kuhn, T. Vol. 3 p. 677). Under the 2022 TPA RFP, vendors were cautioned that "the evaluators are not required to request presentations or other clarifications and often do not. Therefore, all proposals should be complete and reflect the most favorable terms available from Vendor." (Jt. Ex. 5 at § 3.3(a)).

151. In the template for responding to the network pricing component, which was Attachment A-8 to the 2022 TPA RFP, there were several spaces where Blue Cross could have explained that they were proposing a cumulative or aggregate discount, but Blue Cross did not do so. (Kuhn, T. Vol. 3 pp. 630-35, 676, 701-03; Vieira, T. Vol. 6 pp. 1581; Pet. Ex. 508; Jt. Ex. 225.) In addition, there were no limits on the amount of text Blue Cross could enter into various cells of Attachment A-8 to clarify if it was placing 15% amount at risk in its discount guarantees by adding all three subcomponents together. (Kuhn, T. Vol 3, pp. 630-632).

152. Nonetheless, even if Segal had read Blue Cross' discount guarantee language as putting 15% total amount at risk, the result of the analysis would remain the same. Blue Cross' proposal would still be less valuable than Aetna because Aetna would have 25% amount at risk versus Blue Cross would have 15% amount at risk. (Kuhn, T. Vol. 3 pp. 632-635) In addition, Segal would still have given 2 points for UMR, 1 point for Aetna, and 0 points for Blue Cross in the final Network Pricing Guarantees Score. (Jt. Ex. 413, p. SHP 085919; Kihn, T. Vol. 3, pp. 632-634).

C. Subjectivity and "Bottom-Line" Comparison

153. At the contested case hearing, Mr. Russo criticized Segal's analysis of the network pricing guarantees for being subjective and qualitative, and opined that the value of the guarantees should have been quantified by assessing the bottom-line cost to the Plan under likely scenarios. (Russo, T. Vol. 3 pp. 893-95, 910-11). To illustrate his opinion, Mr. Russo offered various discount scenarios, which he contended would have resulted in Blue Cross' guarantees having the most favorable impact on the Plan's bottom-line costs. (Russo, T. Vol. 4 pp. 950-54, 979-80; Pet. Exs. 532, 533, 535). Based on his

analysis, Mr. Russo concluded only that Blue Cross' guarantees were "at least as valuable" as those offered by Aetna. (Russo, T. Vol. 4 pp. 990, 1004, 1016, 1156).

154. While objectivity is desirable, the Plan and Segal both recognized that 100% objectivity cannot always be achieved (Vieira, T. Vol. 6 p. 1572, Kuhn, T. Vol. 3 pp. 588-89, Jones, T. Vol. 1 p. 205-06), and subjectivity does not necessarily render an evaluation unfair. (Jones, T. Vol. 1 p. 205-06, Vol. 2 pp. 356-57; Kuhn, T. Vol. 3 pp. 589-90). Mr. Russo himself conceded that "value" is generally a subjective determination, though he contended that it was not subjective in this specific circumstance. (Russo, T. Vol. 5 pp. 1282-83).

155. Despite criticizing subjectivity in Segal's analysis, Mr. Russo acknowledged his analysis was based on his own subjective assumption that Blue Cross would actually achieve better discount and trend percentages than Aetna in every scenario merely because Blue Cross set more aggressive targets and made these assumptions despite not having done any analysis to determine whether Blue Cross or Aetna were actually more likely to achieve its targets. (Russo, T. Vol. 5 pp. 1127, 1132, 1171, 1237-39, 1250-52, 1257, 1286, 1328, 1334; Vieira, T. Vol. 7 pp. 1643-44; Pet. Exs. 532, 533, 535 541, 544).

156. More importantly, Mr. Russo's assumptions were flawed. (Vieira, T. Vol. 7 pp. 1636-18, 1650; Coccia, T. Vol. 8 pp. 2099-100). Mr. Coccia, Mr. Vieira, and Mr. Kuhn consistently agreed that TPAs cannot control the actual discount or trend percentages they achieve, and that merely setting a guaranteed target does not ensure that the target will be met. (Russo, T. Vol. 5 pp. 1238-39; Vieira, T. Vol. 6 pp. 1561-62, Vol. 7 pp. 1636-39; Coccia, T. Vol. 8 pp. 2089-90; Kuhn, T. Vol. 2 pp. 579-82). This is because TPAs must negotiate the percentage of the billed amount that it will actually pay to the healthcare providers, also referred to as an "allowed amount." Similarly, TPAs can adopt policies or medical management initiatives to hold down cost trends, but they do not control the ultimate discount or trend achieved. (Kuhn, T. Vol. 2 pp. 581-82; Vieira, T. Vol. 6 pp. 1545-46, Vol. 7 pp. 1636-39). While a TPA can influence discounts and trends by trying to negotiate favorable pricing for the Plan and with medical management policies and programs, it cannot control or predict with certainty the discount percentage or trend percentage that will be achieved. (*Id.*).

157. Mr. Russo's subjective analysis also did not comport with his own opinion that an objective analysis must assess the likelihood of the various scenarios it assumes. (Russo, T. Vol. 3 pp. 894-95).

158. Mr. Russo repeatedly characterized his analysis as a "probabilistic model" and relied, in part, on Mr. Sceiford's testimony. (Russo, T. Vol. 3 pp. 931-932, 1150-1151). Mr. Russo claimed that Mr. Sceiford testified "that the pricing guarantees should have been approached using a probabilistic model," and that a "probabilistic analysis that one could create." (Russo, T. Vol. 4 pp. 931, 932, 1150-1151).

159. However, Mr. Russo misunderstood Mr. Sceiford's testimony. Contrary to Mr. Russo's understanding of Mr. Sceiford's testimony, the official transcript showed that

Mr. Sceiford testified that a probabilistic model could "potentially" be done and "may be possible," but that there were many variables that would have to be taken into account and that would render any such model complex and in need of verification that it would work accurately. (Sceiford, T. Vol. 3 pp. 750-51).

160. Mr. Viera opined that a probabilistic model would be impossible to do as it was unlikely to work as intended to value guarantees because there are no probabilities available and there would be too many variables. He therefore believed that a subjective analysis is more effective. (Vieira, T. Vol. 6 pp. 1578-79, Vol. 7 pp. 1769-70).

161. Mr. Vieira also thought Ms. Sceiford was "pushed" to say that you could do a probabilistic model theoretically, after being asked a line of hypothetical questions. (Viera, T. Vol. 6 pp. 1578-1579). The official record was clear that Mr. Sceiford never testified that a model should have been done in this instance; to the contrary, he expressed comfort with the analysis Segal performed. (Sceiford, T. Vol. 3 p. 765).

162. Regardless, Mr. Russo did not assess the likelihood of his various scenarios. (Russo, T. Vol. 5 p. 1334) He acknowledged that he had done no analysis to determine whether Blue Cross or Aetna was more likely to hit their targets despite having assumed various scenarios. (Russo, T. Vol. 5 p. 1334)

163. Nor did Mr. Russo offer any explanation how one could objectively determine the likelihood of potential outcomes other than to offer the opinion that discounts increase over time. (Russo, T. Vol. 4 pp. 944-45). In contrast, other evidence in the record illustrated that discounts do not always increase over time; evidence such as the decline of the Plan's discounts in 2 of the last 5 years, and the lack of provider charges or prices increasing to drive up discounts the way they had in the past. (Vieira, T. Vol. 6 pp. 1554-55, Vol. 7 pp. 1755-56; Aguirre, T. Vol. 8 pp. 2025-26, 2028, 203-34; Bostian, T. Vol. 8 pp. 2231-33).

164. In Mr. Vieira's opinion, the chance that a given vendor would hit or miss its guarantee targets is uncertain, and there are no actuarial tools available to try to assign probabilities to potential outcomes. Accordingly, attempting to design a probabilistic model would itself require numerous subjective assumptions without sufficient basis. (Vieira, T. Vol. 6 pp. 1553-56).

165. Blue Cross estimated that its discount would improve about 1.5% every year (Jt. Ex. 33, p. 1). Mr. Russo opined that the increase to Blue Cross' discount targets year-over-year was reasonable and achievable. (Russo, T. Vol. 5 pp. 1304-05). However, Blue Cross' discount guarantee targets for 2022 under its current contract and the actual discounts Blue Cross achieved for 2022 rebutted the notion that Blue Cross could reasonably expect to achieve a 1.5% increase in its actual discount year over year. (Coccia, T. Vol. 8 pp. 2100-03, 2104-10 (AEO); Jt. Ex. 35; Resp. Ex. 638 (AEO); Resp.-Intervenor's Ex. 708 (AEO)).

166. Mr. Kuhn and Mr. Vieira credibly opined that a formula or mathematical model could not have been developed that would have fairly and adequately compared

the value of the guarantees, or reduced such value to a bottom-line number, because of the numerous variables that would have to be accounted for. Instead, the only way to account for such variables adequately is the narrative, subjective, and qualitative analysis used by Segal, which is standard practice when comparing pricing guarantees for a public health plan TPA RFP. (Kuhn, T. Vol. 2 p. 522-23, 584-88; Vieira, T. Vol. 6 pp. 1554-56, 1565-66, 1578-79, 1571-72, Vol. 7 pp. 1652-53; *see also* Wohl Dep., pp. 234-35; Jt. Ex. 413, p. 7).

167. Mr. Russo based his proposed calculation of "bottom line" values of the vendors' guarantees on his experience as to the meaning of the term "value" in other contexts within the healthcare industry, not on any industry practice. Admittedly, Mr. Russo had never previously compared the value of pricing guarantees for purposes of a RFP or in any other context. (Russo, T. Vol. 3 pp. 846-47, 893, Vol. 4 pp. 1155-1157, 1161; Pet. Exs. 532,533, 535). He also conceded that his analysis was not the only way to effectively analyze pricing guarantees. (Russo, T. Vol. 4 p. 1156, Vol. 5 pp. 1286-87).

168. Mr. Russo's methodologies, models and comparisons were outside the standard practice used to compare pricing guarantees in a public health plan TPA RFP and were not an accurate or reliable measure of the value of the pricing guarantees proposed by the vendors in this procurement. (Vieira, T. Vol. 7 pp. 1642-44, 1650-54; Coccia, T. Vol. 8 pp. 2099-100).

D. Blue Cross' Other Criticisms of Network Pricing Guarantee Scoring

1. Aetna's Discount Targets

169. Mr. Russo criticized Aetna's discount targets because they remained constant over the contract term and were lower than Aetna's current discount, whereas Blue Cross' targets increased over time. (Russo, T. Vol. 4 p. 941).

170. The results of Aetna's repricing exercise reflected a discount of 53%, which Russo treated as Aetna's current discount. (Jt. Ex. 413, p. 7; Russo, T. Vol. 4 pp. 939-40). Aetna proposed a slightly lower discount target of 52.25% for all contract years. (Jt. Ex. 224).

171. Aetna used conservative discount targets for several reasons. (Jt. Ex. 224). First, Ms. Aguirre and Mr. Bostian explained that Aetna proposed more conservative discount guarantees due to certain market conditions that signaled flat and/or modest increases in vendor discounts over the next few years. (Aguirre, T. Vol. 8 pp. 2025-26, 2028, 2033-34; Bostian, T. Vol. 8 pp. 2231-33).

172. Second, the lingering impact of the COVID-19 pandemic heightened costs for healthcare providers in the form of increased employment costs to recruit and retain nurses and increases in supply chain costs, particularly in rural markets. (Aguirre, T. Vol. 8 p. 2027; Bostian, T. Vol. 8 p. 2235). Aetna therefore anticipated that healthcare providers will be less likely to agree to higher discounts when negotiating contracts with TPAs due to their increased costs. (Bostian, T. Vol. 8 pp. 2235-37).

173. Third, Aetna considered the impact of a federal transparency law that became effective in January 2021. Due to the federal transparency law, a lot of providers were either increasing their billed charges more conservatively, keeping their charges flat, or adjusting their charges slightly less than what they had historically adjusted; a few had actually dropped billed charges. (Aguirre, T. Vol. 8 pp. 2027-28; Bostian, T. Vol. 8 p. 2234). Aetna had observed this phenomenon not only in providers in local markets but with several major healthcare systems in North Carolina including Duke, Cape Fear Valley Health System, and WakeMed. (Aguirre, T. Vol. 8 p. 2033; Bostian, T. Vol. 8 p. 2233). Based on these circumstances, Aetna considered it likely that future discounts may not increase at their historical rate. (Bostian, T. Vol. 8 pp. 2233-34).

174. Fourth, Aetna also considered the impact of the Clear Pricing Project ("CPP") implemented by the Plan. (Aguirre, T. Vol. 8 p. 2028; Bostian, T. Vol. 8 pp. 2237-39). Under the CPP, 27,000 healthcare providers have agreed to a fixed fee higher than what Aetna pays those providers under its existing contracts, resulting in erosion of vendor-negotiated discounts with providers. (Aguirre, T. Vol. 8 p. 2014; Bostian, T. Vol. 8 pp. 2237-39).

175. Mr. Vieira and Mr. Kuhn explained that a discount target that is slightly lower than the current discount still aligns the vendor's incentives with the Plan's because it protects against discount erosion, which is a decline in the discount over time. (Vieira, T. Vol. 6 p. 1560, Kuhn, T. Vol. 2 pp. 595-96, 605-06).

176. Contrary to Mr. Russo's criticisms, Aetna had a well-reasoned basis for setting its discount targets conservatively.

2. UMR's Discount Guarantees Not Confirmed for Every Contract Year

177. Blue Cross claimed that UMR failed to follow the 2022 TPA RFP by not proposing discount guarantees in all contract years on Attachment A-8, Network Guarantees spreadsheet, of the RFP which required the bidders submit guarantees in all contract years. In Mr. Russo's opinion, UMR's failure to list any discount guarantees for years 2026 through 2029, in Attachment A-8, hampered his ability, and in fact, anyone's ability, to analyze the value of its guarantees. He opined that without a stated guaranteed target after 2025, the Plan would have no recourse against UMR if UMR became the Plan's TPA. (Russo, T. Vol. 4 pp. 991-994; Pet. Ex. 508; Vieira, T. Vol. 7 pp. 1774-76, 1812).

178. However, Mr. Russo's argument was baseless and unsupported.

a. The general instructions on Attachment A, Section 1.4 of the RFP stated that the bidders "must provide" network discount guarantees, a percentage of Medicare guarantees, trend guarantees, the target and amount at risk. (Jt. Ex. 5, p. 84 of the RFP). At the top of Attachment A-8, it instructed, "[B]idders must provide the guarantee levels requested below and indicate whether they are willing to be at-risk for the full impact of any missed guarantees or a percentage of the full

impact (with a minimum of 10% of the amount by which the guarantee was missed)." (Jt. Ex. 222).

b. On its Attachment A-8, UMR proposed 100% guarantees ("100% of the proposed fee at risk") for the first year of the TPA RFP contract for 2025. For the years 2026 - 2029, UMR marked "NA" in each field of subcategory of discount guarantees. In the fields titled "Additional Information/Explanation of Calculation of Fees At-Risk," under each discount guarantee subcategory of Attachment A-8, UMR provided an additional explanation including, "… The Discount Guarantee only applies in 2025." (Jt. Ex. 222)

c. The plain language of the instructions of Attachment A-8 and UMR's completion of its Attachment A-8 showed that UMR complied with the instructions for completing Attachment A-8. UMR offered a 100% guarantee in the first year of each subcategory of the discount guarantee and indicated they were not offering any dollar guarantees the years thereafter by writing "N/A" in those respective fields. (Viera, T. Vol. 7 pp. 1813-1818). Therefore, Segal's determination that UMR's responses in Attachment A-8 were consistent with the instructions in Attachment A-8 was reasonable. "UMR offered a guarantee for the category of guarantee. They just didn't offer it every year." (Vieira, T. Vol. 7 pp. 1813-1817)

3. UMR's Discount Guarantees

179. Mr. Russo also opined that UMR's discount guarantees had less value because UMR did not propose a discount guarantee after the first contract year (2025). (Russo, T. Vol. 4 pp. 991-92; Pet. Ex. 519, p. 2). Segal recognized that UMR offered a discount guarantee in 2025 only. (Vieira, T. Vol. 6 pp. 1576-77; Kuhn, T. Vol. 2 pp. 600-602; Jt. Ex. 413, p. 7). However, the fact that UMR offered no guarantees after calendar year 2025 didn't matter in Segal's analysis. Segal believed the first year was the most important because "after the first year, the trend guarantee becomes more important." (Kuhn, T. Vol. 2 pp. 600-03). That is, "after the first year, the trend guarantee starts taking over." In addition, discounts over time can grow artificially just by an increase in billed charges, i.e., by inflation." (Kuhn, T. Vol. 2 pp. 600-03). So, not offering a discount guarantee after the first year didn't hurt UMR because Segal was focusing on 2025, the first year. (Kuhn, T. Vol. 2 pp. 600-03).

4. Aetna and UMR Composite Discount Guarantees

180. Mr. Russo criticized Aetna and UMR for providing composite discount guarantees and composite percentage of Medicare guarantees on their respective Attachment A-8s, instead of individual guarantees. Mr. Russo defined a "composite guarantee" as a single discount target that combined the discounts for each type of facility on a weighted or aggregate basis, rather relying on a separate target or guarantee for inpatient facilities, outpatient facilities, and professional services. Russo opined that a composite guarantee allows a vendor, i.e., Aetna, to shift a "miss" of one target or guarantee but avoid a payout under for that miss, by making up that miss by using one of the other provider types in the composite guarantee. (Russo, T. Vol. 4 p. 967-969).

181. Mr. Russo's criticism seemed to stem from his interpretation of Attachment A-8 to the RFP. However, the Attachment A-8 did not specifically reference composite guarantees. (Russo, T. Vol. 5 pp. 1203-04). At the same time, Mr. Russo acknowledged that the RFP did not prohibit bidders from proposing a composite guarantee, either. (*Id.*; Kuhn, T. Vol. 3 pp. 636-37; Vieira, T. Vol. 7 pp. 1773-74; Jt. Ex. 5, p. 84, Attachment A, Section 1.4; Pet. Ex. 508). The RFP's guarantees spreadsheet (Attachment A-8) could be modified to include additional fields for composite targets, or vendors could propose composite targets in several other existing fields for narrative comments and explanation, or in attachments to the form.

182. In responding to state health plan RFPs, it is very typical and almost standard practice that vendors will attach another document to further explain their discount guarantees. (Vieira, T. Vol. 6 pp. 1592-93, Vol. 7 pp. 1778-81; Jt. Ex. 222; Pet. Ex. 508). It is common for vendors to propose composite discount guarantee targets. (Viera, T. Vol. 6, p. 1593) Segal did not consider either separate or composite targets to be superior to the other because either can be more beneficial to the Plan depending on the circumstances. (Kuhn, T. Vol. 3 pp. 637-39; Vieira, T. Vol. 6 pp. 1591-93, Vol. 7 p. 1821). Accordingly, Segal's analysis calculated a weighted average of Blue Cross' separate discount guarantee targets so they could be compared against the composite targets proposed by the other bidders, Aetna and UMR. (Vieira, T. Vol. 6 pp. 1594-99; Jt. Ex. 222). Segal's comparison of the discount guarantee targets was consistent with its normal practice and did not contain errors. (Vieira, T. Vol. 6 p. 1601).

5. Impact of Trend Guarantees Becoming Less Favorable Over Time

183. Petitioner argued that Segal disregarded the instruction in Attachment A-8 that "[g]uarantees can improve from one year to the next but **should** not become less favorable over time," (Jt. Ex. 224, p. 3; emphasis added.) by awarding Blue Cross the worst score for this guarantee even though Aetna and UMR both proposed guarantees the became less favorable over time. (Pet. Ex. 508; Jt. Ex. 224, p. 3) Specifically, Mr. Russo opined that Aetna's trend guarantees did not comply with the instructions from Attachment A-8 because Aetna's trend guarantees became less favorable in 2026−2029. UMR did not offer any discount or percentage of Medicare guarantees after 2025. (Pet. Ex. 519) In contrast, Blue Cross offered trend targets that stayed constant for the entire TPA RFP contract, and discount targets and percentage of Medicare targets got better every year. (Jt. Ex. 225)

184. At hearing, Mr. Russo questioned whether Segal correctly analyzed the trend guarantees of the vendors in determining which vendor provided more "value" for the Plan since Segal did not perform a quantitative and objective model to identify the value of the guarantees." (Russo, T. Vol 4 pp. 1197-1199) He opined that trend guarantees or targets increasing over time is indicative that guarantees would allow costs to grow at higher and higher rates. (Russo, T. Vol. 4 p. 975; Jt. Exs. 224, 413).

185. Mr. Russo's opinion was misplaced. The instructions in Attachment A-8 of the 2022 TPA RFP explicitly stated: "Guarantees can improve from one year to the next

but *should* not become less favorable over time." (Pet. Ex. 508; emphasis added). Section 2.8 "Definitions, Acronyms, and Abbreviations" of the TPA RFP defined: "SHOULD: Denotes that which is recommended or preferred, but not mandatory." (Jt. Ex. 5 at § 2.8(jjj)). Section 2.8 also defined: "SHALL OR MUST: Denotes that which is a mandatory requirement." (Jt. Ex. 5 at § 2.8(iii)). Applying the RFP's definition of "should" in context with the remainder of the plain language of Attachment A-8 instructions, vendors were permitted to propose trend guarantees that become less favorable over time, though it was not preferred.

186. In contrast to Mr. Russo's experience, Segal's team members had extensive experience with large public health plan RFPs upon which they relied in evaluating this RFP procurement. (Kuhn, T. Vol. 2 pp. 531-32).

187. When Segal analyzed the trend guarantees of the Aetna and Blue Cross proposals, Segal considered that Aetna's targets became less favorable by increasing over time, and that Blue Cross' trend guarantee remained constant. However, Segal looked at all the targets in the totality and concluded that Blue Cross' trend guarantees were the least valuable, in part, because (1) Blue Cross' trend target excluded all claims for individuals who had claims that exceeded $250,000 from their proposed trend guarantees, thus making Blue Cross' trend target very close to Aetna's target (Viera, T. Vol 6, pp. 1588, 1589) and (2) Blue Cross' amount at risk was far less than either other bidder. (Jt. Ex. 413, p. 7; Vieira, T. Vol. 7 pp. 1588-1590, 1788-90).

188. Segal concluded that Aetna's trend guarantee was clearly better than Blue Cross' trend guarantee because Aetna put $22 million at risk versus Blue Cross putting $2.6 million at risk. (Jt. Ex. 413, p. 7; Viera, T. Vol. 6 pp. 1588 – 1590) Segal's analysis in looking at the targets in the totality was reasonable and supported by the language in the first paragraph of Attachment A-8 that said, "Bidders will be scored on the guarantee levels and the amount placed at-risk." (Pet. Ex. 508)

189. Mr. Russo's analysis of the comparative value of the vendors' trend guarantees was also flawed because he failed to consider the impact that the exclusions had on the vendors' stated trend targets. (Vieira, T. Vol. 6 pp. 1584-89, Pet. Ex. 535; Coccia, T. Vol. 8 p. 2117). Blue Cross' trend target of 6.0% was less favorable or approximately equivalent to Aetna's trend target of 6.8%, because Blue Cross' trend calculation excluded *all* claims for certain high-cost Plan members whose total claims exceeded $250,000 in a year. Blue Cross' trend target was unlike Aetna's and UMR's, which included the first $250,000 and excluded only claim amounts above $250,000 for those members. This distinction was not recognized by Mr. Russo's calculations but was considered in Segal's analysis. (Kuhn, T. Vol. 3 pp. 646-47; Vieira, T. Vol. 6 pp. 1584-89, Vol. 7 pp. 1788-90; Jt. Ex. 413, p. 7).

190. While Mr. Russo argued that the exclusions listed by each vendor were unclear and that the Plan should have sought clarification (Russo, T. Vol. 4 pp. 1167-68), the language in the vendors' proposals was consistent with Segal's interpretation described above. (*See* Resp. Exs. 621 and 624).

191. Additionally, while Mr. Russo's analysis relied on the option years under the TPA Contract, Segal's comparison was based only on the base years of 2025–2027. (Jt. Ex. 5 at § 4.1; Pet. Ex. 535). Segal rationally did not base its assessment of the value of the guarantees on the option years under the TPA Contract because those contract years are optional and are not a guaranteed renewal. Segal never considers the optional years in a Cost Proposal analysis for that reason. (Vieira, T. Vol. 6 pp. 1589-90).

6. Trend Guarantees Based on Book of Business

192. Mr. Russo argued that Attachment A-8 of the 2022 TPA RFP required vendors state their trend targets or guarantees in concrete or fixed percentages, and that Segal erred by disregarding that requirement and allowing UMR to set its trend target on the "book-of-business" trend from UMR's parent company, UnitedHealth Group, instead of a fixed percentage. Mr. Russo opined that UMR should not have been able to set its trend target based on UMR's "book-of-business" instead of as a stated percentage. He defined a "book of business" as a benchmark collectively based on the cost trends of its other clients. (Russo, T. Vol. 4 pp. 996-1003).

193. Under the "Trend Guarantee" line item in the Plan's template Attachment A-8, as shown below, it states "*e.g.*, 6%:"

<table>
<tr><td></td><td colspan="3">Initial Contract Term</td><td>1st Renewal Period</td><td>2nd Renewal Period</td></tr>
<tr><td></td><td>01/01/25 - 12/31/25</td><td>01/01/26 - 12/31/26</td><td>01/01/27 - 12/31/27</td><td>01/01/28 - 12/31/28</td><td>01/01/29 - 12/31/29</td></tr>
<tr><td>Trend Guarantee</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Annual PMPM Incurred Medical Cost Trend (%) (e.g., 6%)</td><td rowspan="4">Trend guarantee begins in Year 2. Guarantee is percent increase over prior year.</td><td>%</td><td>%</td><td>%</td><td>%</td></tr>
<tr><td>Fees At-Risk</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Percentage of Overage (if selected from dropdown)</td><td>%</td><td>%</td><td>%</td><td>%</td></tr>
<tr><td>Additional Info/Explanation of Calculation of Fees At-Risk</td><td colspan="4"></td></tr>
</table>

(Pet. Ex. 508, in pertinent part)

194. The abbreviation "*e.g.*" is the abbreviation for the Latin phrase *exempli gratia*, meaning "for example." Given the plain language of the Attachment A-8 of the 2022 TPA RFP, the 2022 TPA RFP did not limit bidders (or vendors) to stating their trend discounts as a percentage and did not prohibit bidders from proposing a trend target that was based on a book of business. Bidders were free to base their trend targets on any sort of benchmark such as their book of business. (Vieira, T. Vol. 7 pp. 1611-12, 1625-26).

195. In UMR's Attachment A-8, line item "Additional Info/Explanation of Calculation of Fees At- Rick," UMR indicated that its trend target will be less than 1% of the "book of business" trend of its parent company, UnitedHealthcare for the year the Trend Guarantee applied. (Jt. Ex. 413, p. 7; Pet. Ex. 519, p. 3)

a. It is not uncommon or unusual for vendors or bidders "to propose a floating trend target where the RFP does not say, one way or the other, whether or not they have to provide a fixed percentage or a floating percentage." (Vieira, T. Vol. 7 pp. 1611-12, 1625-26). Other states have done trend guarantees based on a benchmark. The trend guarantee could be a book of business, or an actuarial trend survey such as a Segal trend survey or a Milliman trend number. (Vieira, T. Vol. 7 pp. 1615-26; Resp. Exs. 632, 633).

b. Mr. Viera disagreed with Mr. Russo's criticism of UMR's book of business trend guarantee and Russo's criticism of the conclusion that UMR's trend guarantee had the most comparative value. Viera explained that book-of-business targets are floating targets and acknowledged that Segal recognized offer little protection from increases in a market/industry trend (Jt. Ex. 413 p. 7). Yet, UMR's book-of-business minus 1% target is favorable if the market performs better than expected.

196. Segal recognized the potential for variability by comparing UMR's trend guarantee to historical cost trend data. In doing so, Segal used its annual trend survey of historical cost trend data that showed variations of trend year over year over multiple years. Segal compiled this data based on the books of business of approximately twenty of the "big players" in the healthcare marketplace, such as Aetna, United, Blue Cross, Anthem, and others and displayed the averages of those trends by type of plan. (Vieira, T. Vol. 7 pp. 1615-17; Resp. Exs. 632, 633). "The numbers are very consistent between all the different firms." (Vieira, T. Vol. 7 pp. 1616-1617) The Plan provided Segal's trend survey and the Plan's experience trend from 2018 to 2022 to the bidders before they submitted their proposals. (Vieira, T. Vol. 7 pp. 1615-1616).

197. Due to UMR's size, its trend aligned with the average market trends. The historical cost trend data showed that UMR's trend targets were likely more favorable than other vendors' targets. (Vieira, T. Vol. 7 pp. 1615-26; Resp. Exs. 632, 633).

7. Percentage of Medicare Guarantees Not Scored

198. Mr. Russo also opined that Segal should have scored the vendors' percentage of Medicare guarantees under the terms of the 2022 TPA RFP. (Russo, T. Vol. 4 pp. 1011-12).

199. While the 2022 TPA RFP required vendors to propose three types of network pricing guarantees (discount, trend, and percentage of Medicare), it did not state that all three types would be scored. (Jt. Ex. 5 at §3.4(c)(3)).

200. Segal's decision not to score the vendors' percentage of Medicare guarantees was intentional and well-reasoned.

a. First, while the Plan eventually hoped to move to reference-based pricing, i.e., paying claims as a percentage of Medicare, the Plan has not implemented reference-based pricing yet. (Kuhn, T. Vol. 3 p. 660; Vieira, T. Vol. 7 pp. 1628-29). Because the Plan does not presently pay claims as a percentage of Medicare, the Plan's data provides no basis against which to compare and assess the value of the vendors' percentage of Medicare guarantees. (Kuhn, T. Vol. 2 pp. 518-20, Vol. 3 p. 657, 661; Vieira, T. Vol. 7 pp. 1626-27). Nevertheless, the Plan asked the vendors to propose percentage of Medicare guarantees because they may become relevant in future contract years given the Plan's objective to eventually move to reference-based pricing. (Kuhn, T. Vol. 3 p. 660; Vieira, T. Vol. 7 pp. 1628-29).

b. Second, even if "you looked at the [Medicare] guarantees, they're very comparable to the discount guarantees in which the Blue Cross guarantee was the worst. If we scored them, Blue Cross would have come in last with the Medicare guarantees as well." (Kuhn, T. Vol 2, p. 520)

201. Even though Mr. Russo thought Segal should have scored the vendors' percentage of Medicare guarantees under the terms of the 2022 TPA RFP, he nonetheless agreed that vendors could not be fairly scored on their Medicare guarantees. (Russo, T. Vol. 4 p. 1178). Furthermore, although Segal did not score the percentage of Medicare guarantees, Segal's analysis noted that the value of the percentage of Medicare guarantees was consistent with the relative values of the discount and trend guarantees. (Jt. Ex. 413, p. 8, Vieira, T. Vol. 7 pp. 1630-31).

202. Both Mr. Vieira and Mr. Coccia testified credibly that Segal's pricing guarantees analysis was appropriate and consistent with standard practice when comparing pricing guarantees in a public health plan RFP for TPA services. (Vieira, T. Vol. 6 pp. 1564-66, 1569-70; Coccia, T. Vol. 8 pp. 2083-84, 2087, 2117-18). Their testimony was also uncontroverted.

203. Aetna's expert witness, Mr. Coccia, agreed that in his significant experience evaluating pricing guarantees in a RFP setting, there were too many factors inherent to pricing guarantees to create a usable financial model. Mr. Coccia concurred that Segal's analysis is consistent with how pricing guarantees are compared in the industry, how pricing guarantees are compared at Deloitte and at Mercer in his experience, and how he compares pricing guarantees in his own work. Coccia would have reached the same conclusions as Segal. (Coccia, T. Vol. 8 pp. 2098-99, 2100, 2117-18).

204. Even if Segal and the Plan had scored the percentage of Medicare guarantees, both Mr. Vieira and Mr. Kuhn testified credibly it would not have changed the outcome as Blue Cross' percentage of Medicare guarantees clearly had the worst value or the least value among all three bidders, as well as the lowest amount placed at risk. Mr. Vieira performed an analysis and prepared an expert report of the percentage of

Medicare guarantees in response to Mr. Russo's opinion that Segal should have scored the percentage of Medicare guarantees. Vieira's analysis was consistent with Segal's analysis during the RFP process that Blue Cross had the lowest percentage of Medicare target or guarantee. (Resp. Ex. 634; Vieira, T. Vol. 7 pp. 1632-1634)

205. In summary, the Tribunal finds that Segal's analysis and proposed scoring of the network pricing guarantees were rational, reasonable, and consistent with the RFP and with standard practice in the industry, and that the Plan's acceptance and adoption of Segal's analysis and scoring was likewise rational and reasonable.

206. In reaching this determination, the Tribunal assigns greater weight to the testimony and opinions of Mr. Coccia and Mr. Vieira than Mr. Russo. While Mr. Coccia and Mr. Vieira have not previously testified as expert witnesses, they both have extensive experience evaluating and scoring pricing guarantees for public health RFP plans. (Coccia, T. Vol. 8 pp. 2061, 2063-64, 2065; Vieira, T. Vol. 6 pp. 1523-25, 1565-66). Mr. Russo, on the other hand, had never previously compared the value of pricing guarantees for purposes of a RFP or in any other context. (Russo, T. p. 1157). In the end, Mr. Russo's criticisms were merely disagreement with the reasoned discretionary decisions by Segal and did not prove that Segal made mistakes or errors or that Segal and the Plan's analysis were arbitrary and capricious.

E. Network Access and Disruption

207. The Minimum Requirements in the 2022 TPA RFP required vendors confirm they would "provide a network that will support Plan Members residing in all 100 counties in North Carolina and throughout the United States." Vendors were also required to provide Network Access Reports (Attachment A-2) with extensive data regarding their healthcare provider networks. (Jt. Ex. 5, p. 37 at § 5.1.3(b); pp. 81-83, §§ 1.1.1-1.1.3).

208. "Network access" is the number of providers in a certain location in relationship to where your network membership lives, i.e., the number of doctors within a certain mile radius of where a member lives. (Kuhn, T. Vol. 2 p. 560). Whereas "disruption" looks at the actual doctors, hospitals, and facilities that Plan member are actually using who are in-network for Plan members but will become out-of-network with a change in TPA. Disruption measures the impact that a change in TPA will have on Plan's members continuity of care. (Russo, T. Vol. 4 pp. 1020, 1021; Kuhn, T. Vol. 2 p. 560) Disruption could also result in inconvenience or higher costs for the members. (Vieira, T. Vol. 7 pp. 1664-65; Kuhn, T. Vol. 2 p. 560).

209. Mr. Russo argued that based on the language of the 2022 TPA RFP and his experience in working in the marketplace, the Plan should have considered network access or disruption as part of the RFP's evaluation process. (Russo, T. Vol. 4 pp. 1067-76). However, during cross-examination, Mr. Russo conceded that the evaluation criteria in Section 3.4 of the TPA RFP did not require or even mention network access and disruption to be scored. (Russo, T. Vol. 4 pp. 1067-76; (Jones, T. Vol. 2 pp. 347-48; see Jt. Ex. 5 at § 3.4).). Mr. Russo also did not know of any statutory, regulatory, or other state or federal requirement that the Plan compare or score disruption or network access.

(Russo, T. Vol. 4 pp. 1070-1071). Neither the evaluation criteria nor the scoring methodology in Section 3.4 of the 2022 TPA RFP (Evaluation Criteria) mention either network access or disruption.

210. The undisputed evidence established that the Plan decided in advance of issuing the 2022 TPA RFP that it would not score network access or disruption because the Plan knew that any significant issues with network access and disruption would be apparent from the network pricing component of the Cost Proposals. (Jones, T. Vol. 2 pp. 347-48; Smart, T. Vol. 7 pp. 1864-67; Rish, T. Vol. 2 pp. 461, 464; Jt. Exs. 63, 87). The Plan knew that the potential vendors all provided broad networks with state-wide coverage (Jones, T. Vol. 2 pp. 383-84; Smart, T. Vol. 7 p. 1863). The Plan also knew that if Blue Cross was not awarded the contract, the new vendor would be able to further expand its network during the two-year implementation period. (Smart, T. Vol. 7 pp. 1917, 1920).

211. While the Plan seeks to minimize disruption, some disruption is inevitable. Either some of the healthcare services and claims covered by the Plan will invariably be provided by out-of-network providers for multiple reasons or certain providers simply do not like to contract with insurance carriers. (Kuhn, T. Vol. 2 pp. 553-55; Vieira, T. Vol. 7 pp. 1665-66). The actual repricing data from Blue Cross' contract with the Plan from 2021 showed 1% of claims submitted to the Plan were out-of-network. (Kuhn, T. Vol. 2 pp. 553-55; Vieira, T. Vol. 7 pp. 1665-66).

212. Nevertheless, the Plan still measured and compared disruption in the evaluation of the network pricing component of the 2022 TPA RFP. (Wohl Dep., pp. 151-53). The vendors were asked to "reprice" the Plan's actual claims data from 2021 using more than 15 million records reflecting claims submitted to approximately 100,000 different healthcare providers. (Kuhn, T. Vol. 2 pp. 544-46; Jt. Ex. 5, p. 83 at § 1.2.1). As part of that repricing exercise, the vendors identified whether each provider in the Plan's claims file from 2021 was in or out-of-network under that vendor's contracted provider network, and for every claim, identified whether the claim would be in or out-of-network, and the amount it would pay the provider for that service. (Kuhn, T. Vol. 2 pp. 543-45, 556, Jt. Ex. 5, p. 83 at § 1.2.1).

213. The "baseline" (status quo) disruption data against which the vendors were compared was the Plan's actual in-network percentage in 2021. In that year, 99% of the claims dollars that Blue Cross paid as the incumbent vendor were in-network. (Kuhn, T. Vol. 2 pp. 554-55; Jt. Ex. 413, p. 5).

214. The results of the repricing exercise demonstrated that Aetna would pay 99% of those claims dollars to in-network providers, Blue Cross would pay 99.4% of the claims dollars to in-network providers, and UMR would pay 98.5% of claims dollars to in-network providers. (*Id.*). Therefore, the network pricing component of the RFP showed that the potential disruption with Aetna as the TPA was consistent with the status quo 2021 claims experience under Blue Cross' contract. (Jt. Ex. 413, p. 5; Kuhn, T. Vol. 2 p. 557; Coccia, T. Vol. 8 p. 2124).

215. The Plan determined disruption to be negligible for all three vendors. (Kuhn, T. Vol. 3 pp. 553-54, 557-59; Vieira, T. Vol. 7 pp. 1664-67; Jt. Ex. 413).

216. Once Mr. Kuhn calculated the assumed network utilization as a measure of disruption and noted all three of the bidders had in-network percentages around 99 percent, he determined that it was not necessary to look at Network Access Reports because the disruption was so low. (Kuhn, T. Vol 3 pp. 555-559, 559-562). Mr. Kuhn opined that 99% of claims dollars to in-network providers, or 1% disruption, was "immaterial." (Kuhn, T. Vol. 2 pp. 553-54, 557-59).

217. Nonetheless, Mr. Vieira still reviewed and compared the vendors' Network Access Reports (Attachment A-2) as a cross-check to assess their consistency with the negligible disruption percentages. He calculated the percentage of Plan members in every county that met the geographic access standards set forth in the RFP for each provider type and compared those percentages for all three vendors. Mr. Vieira concluded that all three vendors' networks were very close and provided excellent coverage. (Vieira, T. Vol. 7 pp. 1682-93).

218. Mr. Vieira and Mr. Coccia both thought that 1% disruption was excellent and a negligible amount of disruption in their experience. (Vieira, T. Vol. 7 pp. 1664-67; Coccia, T. Vol. 8 pp. 2061, 2123-24; *see also* Wohl Dep., p. 153). Their testimony was not contradicted by Blue Cross' expert, Mr. Russo, who offered no opinion as to what amount of disruption is typical when a public health plan changes TPAs.

219. Second, Mr. Russo contended that based on the language from Attachment A-8 to the 2022 TPA RFP, Segal and the Plan did not evaluate provider networks and access properly, and Blue Cross had a broader network of providers than Aetna. Russo relied on the following Attachment A-8 language:

> The Plan seeks to have a provider network in place that best meets the program's long-term needs. This includes a broad provider network with the least disruption and with competitive pricing.

(Russo, T. Vol. 4 pp. 1016, 1040-42, 1060, 1078; Jt. Ex. 5 p. 81, Attachment A, Section 1.1)

220. The evidence at hearing showed that Segal used the 2019 RFP as a basis to draft Attachment A of the 2022 TPA RFP. The phrase "broad provider network with the least disruption" was taken directly from the 2019 RFP and included in the 2022 TPA RFP unchanged. (Kuhn, T. Vol. 3 pp. 619-20) Mr. Kuhn credibly testified that Segal typically included that language in a RFP to ensure that bidders knew the Plan was looking for the Plan's broad network of providers.

221. Mr. Kuhn also testified credibly that the phrase "broad provider network with the least disruption" meant the individual bidder's broadest network and did not mean the Plan would favor the vendor whose network had the most contracted providers. (Kuhn, T. Vol. 3 pp. 619-20) TPA vendors offer multiple networks, and "broad network" is a term-

of-art in the healthcare industry meaning each vendor's largest ("broad") network, not the vendors' "narrow" or "preferred" network, which is a select network with fewer healthcare providers with which a TPA has preferred pricing. (Kuhn, T. Vol. 3 pp. 619-20)

222. Mr. Kuhn's testimony was corroborated by the second addendum to the 2022 TPA RFP where one of the vendors asked: "Can you confirm providers requested in the 'Provider Listing' tab should be our North Carolina broad network?" The Plan replied: "Vendor's broad network should be used." (Jt. Ex. 44).

223. Therefore, the preponderance of the evidence supports that Attachment A: Pricing, Section 1.1 Network Access was not a representation that the TPA Contract would be awarded to the vendor with the network with the most providers, least disruption, and most competitive pricing. Indeed, such a reading would conflict with the evaluation criteria in Section 3.4 of the 2022 TPA RFP.

224. Third, Mr. Russo criticized Segal's disruption analysis because it looked at disruption on a statewide level which he claimed could mask geographic disparities. (Russo, T. Vol. 4 p. 1057). Mr. Russo analyzed disruption on a more regional level and showed that Blue Cross' network included more providers than Aetna's in certain regions and fewer in others. (Russo, T. Vol. 4 pp. 1040-42). For instance, in rural areas, Blue Cross had on average more in-network core providers in proximity to Plan members than Aetna had, both overall and in 10 of the 17 individual core-provider categories. (Russo, T. Vol. 4 p. 1118). On a statewide basis, Blue Cross also had on average more in-network core providers in proximity to Plan members than Aetna has. (Russo, T. Vol. 4 p. 1119).

225. However, the 2022 TPA RFP required the winning bidder's network to support members residing in <u>each</u> of the State's counties, not based on specific geographic areas or categories. (Jt. Ex. 5, p. 37 at § 5.1.3(b); Vieira, T. Vol. 7 p. 1711). In addition, regardless of the results of Mr. Russo's analysis, his analysis did not show that any particular geography lacked adequate access to services.

226. Mr. Russo conducted an extensive series of analysis in evaluating network access and disruption and concluded that Blue Cross proposed a broader, and thus, superior, network than Aetna proposed. (Pet. Exs. 537- 545). In conducting this analysis, Mr. Russo initially standardized the network-provider listings in Attachment A-2 of the 2022 TPA RFP by using National Provider Identifiers ("NPIs") so he could compare the vendors' networks on an apples-to-apples basis. (Russo, T. Vol. 4 pp 1040-1041, 1044, 1045, Pet. Exs. 537-545)

a. In his first analysis, Russo compared the number of in-network providers Blue Cross and Aetna had in each North Carolina county for each 17 core-provider types in the RFP, grouped the 17 core provider types into three categories as defined in the RFP and then grouped all 100 North Carolina counties into the three categories defined in the RFP of urban, suburban, and rural. (Russo, T. Vol, 4 pp. 1041, 1052; Pet. Ex. 543). Based on his analysis, Russo opined that Blue Cross' network had 3,432 more core providers than Aetna's network had in suburban

counties and Blue Cross NC's network had 1,147 more core providers than Aetna's network had in rural counties. (Russo, T. Vol 4 p. 1053).

b. In his second analysis, Mr. Russo identified the number of in-network core providers located within a certain number of miles of each Plan member's home address, and then calculated the average number of in-network core providers for Blue Cross and Aetna respectively, on a county-by-county basis, within each specified radius of Plan members. (Russo, T. Vol 4 p. 1044). Mr. Russo categorized these results by (1) each of the 17 core-provider types and by (2) urban, suburban, and rural counties. (Russo, T. Vol. p. 1044). Based on his analysis, Mr. Russo opined that in rural areas, Blue Cross had on average more in-network core providers in proximity to Plan members than Aetna has, both overall and in 10 of the 17 individual core-provider categories. (Russo, T. Vol. 4 p. 1118). On a statewide basis, Blue Cross also has on average more in-network core providers in proximity to Plan members than Aetna had. (Russo, T. Vol. 4 p. 1119).

c. Lastly, Mr. Russo evaluated network disruption by examining how many claims from the Plan's 2021 claims file, as used in the repricing exercise, would be in-network with Blue Cross NC but out-of-network with Aetna. (Russo, T. Vol. 4 p. 1048). He also identified how many members had claims that fit this description and calculated the total charges for those claims. (Russo, T. Vol. 4 p. 1048). Mr. Russo then did the opposite analysis, evaluating claims from the repricing exercise that would be in-network with Aetna but out-of-network with Blue Cross NC. (Russo, T. Vol. 4 p. 1050).

d. In Russo's opinion, his disruption analysis showed that, statewide, approximately 160,000 claims would be in-network with Blue Cross NC but out-of-network with Aetna, and only 44,000 claims would be in-network with Aetna but out-of-network with Blue Cross NC. (Russo, T. Vol. 2 pp. 1054-1055). Thus, there were over three times as many claims that are in-network with Blue Cross NC but out-of-network with Aetna as there are claims that are in-network with Aetna but out-of-network with Blue Cross NC. (Russo, T. Vol. 4 pp.1054-1055). Mr. Russo concluded that Blue Cross proposed a broader network than Aetna proposed and that Blue Cross' network would pose less disruption and/or the "least disruption" for the Plan's members than Aetna's network would pose. (Russo, T. Vol. 4 pp. 1016-1017, 1056-1057; Pet. Exs. 543, 544)

227. However, Mr. Russo's comparison was irrelevant to the network access and disruption issue posed by the RFP because his comparison was not based on the metrics the Plan was measuring in the RFP. The RFP's network access standards asked for the number of members within a certain radius of at least one or two providers. In contrast, Mr. Russo used the distance from a member to a specific provider type to determine the number of providers within a radius of a Plan member. (Russo, T. Vol. 4, 1111-1112)

228. Mr. Russo acknowledged, at hearing, that he understood the difference between the metrics he analyzed and the metrics of the RFP. "One's a recognition of

member choice, and one's a recognition of just simply access." (Russo, T. Vol. 4 pp. 1111-1112) He conceded that while his analysis measured network choice, in addition to network access, network choice is a different measure from network access. (Russo, T. Vol. 4 p. 1117). Most notably, while the Plan could have adopted a standard around the metric he used, it did not. "It wasn't in the RFP." (Russo, T. Vol. 4 p. 1112). Ultimately, Mr. Russo admitted he did not perform any quantitative comparison of the vendors' or bidders' networks against each other to quantify the relative number of Plan members who met the standards within any given county. (Russo, T. Vol. 4 p. 1117).

229. Despite these opinions, Mr. Russo agreed that Blue Cross' and Aetna's networks were very similar and conceded that he was not saying that Aetna's network was inadequate. (Russo, T. Vol. 4 p. 1056, Vol. 5 pp. 1359-60). He also admitted that there are no clear objective standards for measuring network access. (Russo, T. Vol. 4 p. 1132). As a result, it is unclear how, or even if, Mr. Russo's analysis would have affected the outcome of the 2022 TPA RFP award.

230. Finally, comparing Mr. Russo's disruption analysis with Segal's Network Pricing Scoring analysis showed that Mr. Russo's opinion, that Blue Cross posed less disruption than Aetna, was consistent with the conclusions drawn by Segal in their analysis. Mr. Russo deduced in his analysis that Blue Cross had only a 1.1% higher number or network of providers, at the statewide overall level for all 17 provider types, than Aetna. (i.e., Blue Cross had 2006 providers compared to Aetna's 1984 providers). Segal's Network Pricing Scoring Analysis determined that Blue Cross' disruption was 0.4% less than Aetna's. (Russo, T. Vol. 4 p. 1017; Jt. Ex. 413, p. 5)

231. Mr. Kuhn disagreed with Mr. Russo's opinion and analysis that Blue Cross' network was superior to Aetna's. He pointed out that while Mr. Russo gave a count of providers, in his analysis in Petitioner's Exhibit No. 538, Mr. Russo did not specify how many of the providers were even utilized by any of the Plan's members. As a result, "you could have . . . way more providers that aren't even utilized, that don't provide anything here." (Vieira, T. Vol. 7 pp. 1669-73). Therefore, even if one considered that Blue Cross had 0.4% greater in-network utilization than Aetna, as noted in the network pricing component of the RFP, Russo's comparison does not prove anything. (Vieira, T. Vol. 7 pp. 1669-71; Jt. Ex. 413, p. 5).

232. Mr. Coccia credibly testified that, in his experience, it is more important to have the right providers, i.e., those that the plan's members actually use, than have the largest overall number of providers. (Coccia, T. Vol. 8 pp. 2063, 2122).

233. Additionally, though network access and disruption were not scored as an independent component of the 2022 TPA RFP, the Board of Trustees did discuss the network adequacy, especially for rural areas, and the network adequacy evaluation performed as part of the RFP's Minimum requirement with Plan staff before voting to award the TPA Contract to Aetna. (Smart, T. Vol. 7 pp. 1917-20; Jt. Ex. 294).

234. Since the Plan awarded the RFP to Aetna, Aetna has expanded its network during the first year of the implementation period by adding 3,500 providers, including

1,800 mental health providers. (Bostian, T. Vol. 8 p. 2225). This brings Aetna up to 99.4% in-network, which is approximately the same as Blue Cross. (Bostian, T. Vol. 8 p. 2229).

F. Calculation of Final Scores

235. Blue Cross argued that the Plan's final score calculation, of combining the rank-based points for a total score, was contrary to the language and methodology stated in the 2022 TPA RFP. (T. Vol. 9 p. 2362).

236. On August 22, 2022, the Plan's Executive Administrative Group consisting of Ms. Jones, Ms. Smart, Mr. Rish, and Ms. Bourdon, decided how to score the technical and Cost Proposal separately, rank them, and combine those ranks for a final score.

> Like we discussed last week, if we give 1 point for admin and guarantees and 3 points for network then that will enable us to rank the bidders in a 4,3,2,1 (assuming 4 bidders). Then doing the same with the technical scores, then combining rankings for a total score with top scorers going to the board. If necessary, we take all bidders to the board.

(Jt. Ex. 87)

237. The next day, August 23, 2022, Mr. Rish notified the Segal team of the Plan's decision about the final scoring calculation.

> We have discussed internally and would like to score the Network, Administrative Law Judge and Guarantees sections. We're thinking 1 point each for Admin and Guarantees and 3 points for Network. Then the bidders can be ranked 4,3,2,1, (assuming 4 bidders). We would then do the same on the technical scores and combine the rankings for a total score.

(Jt. Ex. 63).

238. As noted above, on August 30, 2022, Respondent issued the 2022 TPA RFP. Consistent with the Plan's decision and direction to Segal on scoring, Section 3.4 Evaluation Criteria of the 2022 TPA RFP included the Plan's scoring language as follows:

> **a) Overall Scoring Weights:**
>
> Every Vendor's proposal will be evaluated and scored on several factors. The Technical Proposal includes the written proposal and oral presentation, if applicable. The Technical Proposal and the Cost Proposal will be scored separately based on the overall point scale described below:
>
> *The total points scale will reflect the following weights:*
>
> | | |
> |---|---|
> | Technical Proposal | 50% |
> | Cost Proposal | 50% |

Total: 100%

b) Technical Requirements & Specifications:

. . .

The Vendors will be ranked in descending order based on the total points earned. The Vendor earning the least points out of the total 310 will receive the rank of one (1). The bids will fall in line according to total scored points, with the Vendor earning the most points out of the total 310 receiving the highest rank. Should two (2) Vendors earn the same score in the technical points, they will be given equal rank.

c) Cost Proposal:

. . .

The Vendors will be ranked in descending order based on the total Cost Proposal points earned. The Vendor earning the least Cost Proposal points out of the total 10 will receive the rank of one (1). The bids will fall in line according to total Cost Proposal points, with the Vendor earning the most points out of the total 10 receiving the highest rank. Should two Vendors earn the same score in the Cost Proposals, they will be given equal rank.

(Jt. Ex. 5 at § 3.4, pp. 22-25 of 119; emphasis in original).

239. In applying the scoring calculation from Section 3.4, the Plan awarded 1 to 3 rank-based points for each vendor's Technical Proposal, awarded 1 to 3 rank-based points for each vendor's Cost Proposal, and then, combined the rank-based points for a total score. (Jones, T. Vol. 1 pp. 232-35; Resp. Ex. 601; Jt. Ex. 14, Jt. Ex. 15).

240. Blue Cross and UMR tied at 4 points each, and Aetna received the highest total score of 6 points. (Jones, T. Vol. 1 pp. 305-06; Resp. Ex. 601; Jt. Ex. 14).

	Maximum Points	Vendor		
		Aetna	BCBSNC	UMR
TOTAL TECHNICAL POINTS	310	310	303	310
BAFO #1 COST POINTS	10	8	8	7
FINAL RANKING TECHNICAL		3	1	3
FINAL RANKING COST		3	3	1
FINAL RANKING TECHNICAL AND COST		6	4	4

(Resp. Ex. 602, p. 12).

241. The Plan did not add the 310 total points for the Technical Proposal and the ten (10) total points for the Cost Proposal together to calculate the final score because. "We [the Plan] weren't weighting points on a point basis. We were rating ranks." (Jones, T. Vol 1 pp. 238-239, 241, 242). "It was the rank-based points that were added together to get a final score." (Jones, T. Vol 1 pp. 238-239, 241-242).

242. The Plan separately scored the vendors' Technical Proposals and Cost Proposals on their respective 310 and 10-point scales, and separately ranked them in descending order. The Plan's calculation of final scores was consistent with the terms of the 2022 TPA RFP. (Jones, T. Vol. 1 pp. 285-88, Vol. 2 pp. 349-50; Kuhn, T. Vol. 2 pp. 537-38; Jt. Exs. 63, 87).

243. There would be no reason for the Plan to include the language in Sections 3.4(b) and 3.4(c) of the 2022 TPA RFP, regarding separate ranking of the Technical and Cost Proposals and assignment of ranks in descending order, unless the Plan intended to use rank-based points to calculate a total score as the Plan's witnesses testified. (Jones, T. Vol. 1 pp. 285-88, Vol. 2 pp. 349-50; Vieira, T. Vol. 7 pp. 1743-46; Coccia, T. Vol. 8 pp. 2125, 2146).

244. Both Mr. Vieira and Mr. Coccia opined that the language of Section 3.4 was clear that the Technical Proposal and Cost Proposal would be ranked. Mr. Vieira credibly testified that it seemed fairly logical if you are ranking them, and then you're weighting them together, that you're ranking them. Otherwise, "What would be the reason to rank?" (Vieira, T. Vol. 7 pp. 1743-46; Jones, T. Vol. 1 pp. 285-88, Vol. 2 pp. 349-50; Coccia, T. Vol. 8 pp. 2125, 2146, Resp.- Interv. Ex. 709). In other words, there was no other purpose for the language in Sections 3.4(b) and 3.4(c) of the 2022 TPA RFP than to combine the rank-based points for a final score.

245. Blue Cross' reading, that the "total points' scale" refers to 310 points for technical and 10 points for cost, was not reasonable as it completely ignored the plain language in Sections 3.4(b) and (c) and made that language superfluous and unnecessary.

246. Both Mr. Vieira and Mr. Voccia credibly testified that the scoring systems used in RFPs vary greatly and that the Plan's use of rank was not improper or cause for concern. (Vieira, T. Vol. 7 p. 1662; Coccia, T. Vol. 8 pp. 2058-59, 2077-79).

247. Dee Jones, the Plan's Executive Administrator, acknowledged that Blue Cross confirmed over 97% of the Technical Requirements but received only one point for the Technical Proposal because Aetna and UMR both confirmed 100%. She credibly testified that the outcome was fair because the margin of difference was not what was important, comparing the Plan's use of ranks in the scoring to competitive swimming and academic class ranks, in which winners or valedictorians are often decided by very small margins. (Jones, T. Vol. 1 pp. 245-46).

248. The Plan's decision to award points based on ranks was a simple, rational, reasonable, and fair way to weight the technical and Cost Proposals equally, and to clearly

differentiate between higher and lower-scoring vendors. (Jones, T. Vol. 1 pp. 285-86; Rish, T. Vol. 2 pp. 453-54).

G. Impact of Pricing Guarantee Scoring and Final Scoring Calculation on Total Scores

249. Mr. Kuhn, Mr. Vieira, and Mr. Coccia credibly testified that, even if Blue Cross were given credit for putting 15% at risk on its discount guarantee, 15% of Blue Cross' administrative fee was still much less than any other vendors put at risk, and it would not have changed the assessment that Blue Cross offered the least comparative value on the network pricing guarantees. (Kuhn, T. Vol. 3 pp. 632-33, 678-69, 702-03; Vieira, T. Vol. 6 pp. 1582-83; Coccia, T. Vol. 8 p. 2095).

250. Even if the Plan should have awarded Blue Cross one point for its pricing guarantees, Aetna would still have had the highest overall score. (Resp. Ex. 601; Coccia, T. Vol. 8 pp. 2125-26; Resp-Intervenor Ex. 709; Jones T. Vol 1 p. 245). If Blue Cross received one extra point for its network pricing guarantees, Aetna would have five (5) total points, and Blue Cross and UMR would each have had four (4) total points, similar to the incomplete "preliminary" scoring from the Evaluation Committee's November 17, 2022 meeting. (Resp-Intervenor Ex. 709; Resp. Ex. 601, pp. SHP 4571-72).

251. Similarly, even if the total scores were calculated as Blue Cross argued they should have been, Aetna would still have had the highest overall score because Blue Cross scored lowest on the Technical Proposal. (Coccia, T. Vol. 8 pp. 2125-26; Resp-Intervenor Ex. 709). If the Plan had used a multiplication factor on the cost points before adding the cost and technical points together and ranking the vendors, Aetna would have had 279 points, Blue Cross would have had 275.5 points, and UMR would have had 263.5 points. (Resp-Intervenor Ex. 709).

VI. No Evidence of Bias

252. This procurement, including the design and drafting of the 2022 TPA RFP and the evaluation and scoring of proposals, was conducted in good faith, and was not affected by any bias for or against any vendor.

253. Blue Cross' struggle with the FACETS implementation caused the Plan extensive problems and was part of the reason the Plan decided to put the TPA Contract out for bid in 2022 and to not exercise either of the optional renewal periods under the 2020 TPA Contract. (Jones, T. Vol. 1 pp. 194-96, 259-60; Smart, T. Vol. 7 pp. 1833-34).

254. However, past performance was not among the evaluation criteria for the 2022 TPA RFP (Jt. Ex. 5 at § 3.4). Blue Cross had the same opportunity to win as the other vendors. (Jones, T. Vol. 1 pp. 274-77, Vol. 2 pp. 368-69, 374-75; Smart, T. Vol. 7 pp. 1834, 1926-27; Aguirre, T. Vol. 8 pp. 2031-32).

255. The Plan also made efforts to avoid disadvantaging Blue Cross. The Plan moved some requirements, which were important to the Plan, but which Blue Cross had not confirmed in past RFPs, from the Minimum Requirements to the Technical Requirements so that Blue Cross would not be disqualified for failing to meet one or more Minimum Requirements. (Jones, T. Vol. 1 pp. 276-77).

256. Through designated deposition testimony, Blue Cross introduced a Highly Confidential/Attorney's Eyes-Only Aetna PowerPoint presentation regarding Aetna's internal strategy and plan of action for responding to the RFP for the TPA Contract. One slide referenced a purported conversation between Dee Jones and Daniel Baum, a registered lobbyist for Aetna's parent company, CVS Health. (Jt. Ex. 242 (AEO); Baum Dep., pp. 43-44, 203, 205, 217; *see also* Aetna 30(b)(6) Dep. (Aguirre), pp. 45-46, 126-27).

257. Blue Cross did not question any of the witnesses at the contested case hearing about the slide within Joint Exhibit 242, including Cathy Aguirre, who sent the e-mail to which the PowerPoint presentation was attached; Jim Bostian, who received the e-mail; or even Dee Jones as one of the purported participants in the alleged conversation referenced on the slide. Additionally, even though Cathy Aguirre identified the drafter of the PowerPoint presentation in Joint Exhibit 242 in her designated deposition testimony, Blue Cross did not subpoena or call that individual to testify at the contested case hearing. (Aetna 30(b)(6) Dep. (Aguirre), pp. 129, 148-49; *see also* Baum Dep., p. 173).

258. The preponderance of the evidence in the record established that the purported conversation between Dee Jones and Daniel Baum referenced in the slide within the PowerPoint Presentation in Joint Exhibit 242 never took place. (*See* Baum Dep., pp. 205-06, 207-08, 220; Jones, T. Vol. 8 pp. 1950-52). Dee Jones offered unrebutted testimony at the contested case hearing, which established that the purported conversation never occurred (Jones, T. Vol. 8 pp. 1950-52). Daniel Baum called the recitation of the purported conversation in the slide within the PowerPoint Presentation in Joint Exhibit 242 "patently false," "puffery," and "inaccurate." (Baum Dep., pp. 217-18, 218-20).

259. Every Segal and Plan witness that was asked plausibly testified that they were not aware of any evidence of bias or bad faith. (Jones, T. Vol. 2 pp. 358-60, 378-79; Smart, T. Vol. 7 pp. 1926-28; Rish, T. Vol. 2 pp. 467-77; Sceiford, T. Vol. 3 pp. 758-59; Kuhn, T. Vol. 3 pp. 665-66, 680-81; Vieira, T. Vol. 7 pp. 1715-16; Folwell Dep., pp. 53, 127; Davison Dep., p. 214; Wohl Dep., pp. 136, 242).

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has personal and subject matter jurisdiction over this contested case, and the parties received proper notice of the hearing in this matter. All parties have been correctly designated and there is no question as to misjoinder or nonjoinder of parties.

2. Blue Cross is an aggrieved person and is entitled to commence a contested case under Chapter 150B of the North Carolina General Statutes. N.C. Gen. Stat. § 150B-2(6).

3. To the extent that the Findings of Fact are or contain Conclusions of Law, or that the Conclusions of Law are or contain Findings of Fact, they should be so considered without regard to the given labels. *City of Charlotte v. Heath*, 226 N.C. 750, 405 S.E.2d 600 (1946); *Peters v. Pennington*, 210 N.C. App. 1, 707 S.E.2d 724 (2011).

4. The Tribunal is not required to find all the facts shown by the evidence, but only enough material facts to support the decision. *Green v. Green*, 54 N.C. App. 571, 575, 284 S.E.2d 171, 174 (1981); *In re Custody of Sta*ncil, 10 N.C. App. 545, 549, 179 S.E.2d 844, 847 (1971).

I. Standard of Review

5. As the Petitioner, Blue Cross had the burden of proving by a preponderance of the evidence that Respondent acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by rule or law; and otherwise substantially prejudiced Petitioner's rights in violation of N.C. Gen. Stat. § 150B-23(a). N.C. Gen. Stat. § 150B-25.1(a).

6. North Carolina law presumes that an agency has performed its duties properly. *See, e.g.*, *Adams v. N.C. State Bd. of Registration for Pro. Eng'rs & Land Surveyors*, 129 N.C. App. 292, 501 S.E.2d 660 (1998); *In re Land & Mineral Co.*, 49 N.C. App. 529, , 272 S.E.2d 6 (1980), *disc. rev. denied*, 302 N.C. 397, 272 S.E.2d 6 (1981) (holding that "[t]he official acts of a public agency . . . are presumed to be made in good faith and in accordance with the law").

7. Due regard is given to the demonstrated knowledge and expertise of the agency with respect to facts and inferences within the specialized knowledge of the agency. N.C. Gen. Stat. § 150B-34(a). The Undersigned emphasizes that this statutory directive is to the "facts and inferences" that are particularized to the "specialized knowledge" of the agency. In rendering the decision herein, due regard has been given to the demonstrated knowledge and expertise of the agency with respect to facts and inferences within the specialized knowledge of the agency.

8. "In an administrative proceeding, it is the prerogative and duty of [the ALJ], once all the evidence has been presented and considered, to determine the weight and sufficiency of the evidence and the credibility of the witnesses, to draw inferences from the facts, and to appraise conflicting and circumstantial evidence. The credibility of witnesses and the probative value of particular testimony are for the [ALJ] to determine, and [the ALJ] may accept or reject in whole or part the testimony of any witness." *Harris v. N.C. Dep't of Pub. Safety,* 252 N.C. App. 94, 798 S.E.2d 127 (2017) (citing *N.C. Dep't of Pub. Safety v. Ledford*, 247 N.C. App. 266,_, 786 S.E.2d 50, 64 (2015) (quoting *City of*

Rockingham v. N.C. Dep't of Env't. & Natural Res., 224 N.C. App. 228, 239, 736 S.E.2d 764, 771 (2012), review allowed, _ N.C. _, 792 S.E.2d 152 (2016).

9. The question before this Tribunal was whether the Plan substantially prejudiced Blue Cross and failed to act as required by law or rule, acted erroneously, arbitrarily, or capriciously, or failed to use proper procedure.

10. The "arbitrary and capricious" standard is a difficult one to meet. *Blalock v. N.C. Dep't of Health & Human Servs.*, 143 N.C. App. 470, 475 (2001). Administrative agency decisions may be reversed as arbitrary and capricious only if they are "patently in bad faith," or "whimsical" in the sense that "they indicate a lack of fair and careful consideration" or "fail to indicate *any* course of reasoning in the exercise of judgment." *ACT-UP Triangle v. Comm'n for Health Servs. of State of N.C.*, 345 N.C. 699, 707, 483 S.E.2d 388 (1997) (internal citation and quotations omitted).

11. A decision is arbitrary when it is not predicated upon a fair consideration of all necessary facts and factors. Courts have defined arbitrary and capricious as "willful and unreasonable action without consideration or in disregard of facts or without determining principle*." Black's Law Dictionary* 96 (5th ed. 1979)

12. In determining whether the Plan's actions were considered or reasoned, this Tribunal may only judge the Plan's decision upon the grounds "which the record discloses that its action was based." *Sec. & Exch. Comm'n v. Chenery Corp.*, 318 U.S. 80, 87 (1943). "[C]ourts may not accept . . . *post hoc* rationalizations for agency action." *Amanini v. N.C. Dep't of Hum. Res.*, 114 N.C. App. 668, 443 S.E.2d 114 (1994) (quoting *Cone Mills Corp. v. N.L.R.B.*, 413 F.2d 445, 452 (4th Cir. 1969).

II. Exemption from Procurement Procedures of Chapter 143, Article 3

13. The 2022 TPA RFP procurement is exempt from certain procurement procedures. Article 3 of Chapter 143 of the North Carolina General Statutes generally governs procurements by North Carolina agencies, which are overseen by the North Carolina Department of Administration, Division of Purchase and Contract. N.C. Gen. Stat. § 143-48, *et seq.* Under N.C. Gen. Stat. § 143-53(a)(1), the Secretary of Administration is empowered to adopt rules governing "the routine and procedures to be followed in canvassing bids and awarding contracts[.]"

14. However, pursuant to N.C. Gen. Stat. § 135-48.34, the requirements of Article 3 of Chapter 143 of the North Carolina General Statutes do not apply to Plan contracts for "the design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans." The TPA RFP contract between the Plan and its TPA vendor falls under the exemption in Section 135-48.34.

15. The 2022 TPA Contract was subject to certain statutory review and approval requirements. Under N.C. Gen. Stat. § 135-48.33, Plan procurements exceeding $1

million must be reviewed by the Attorney General or his designee, and contracts exceeding $3 million must be approved by the Plan's Board of Trustees. In accordance with N.C. Gen. Stat. § 135-48.33, the Department of Justice reviewed the contract award to Aetna and then the Board of Trustees approved such contract award.

III. The Plan's Discretion to Conduct Procurements and Delegate to Segal

16. Blue Cross argued that it was error for the Plan to rely on Segal to analyze and score the vendors' Cost Proposals, relying on two non-binding contested cases– *Corporate Express Office Products, Inc. v. North Carolina Division of Purchase & Contract*, 0D DOA 0112, 2006 WL 2190500 (N.C.O.A.H. May 17, 2006), and *City of Fayetteville v. North Carolina Environmental Management Commission*, 15 EHR 03241, 2017 WL 8896072 (N.C.O.A.H. Feb. 7, 2017), as the basis for its argument.

17. In *Corporate Express*, the Division of Purchase and Contract ("Division") hired a consultant, Accenture, to develop a pilot reverse auction program for certain procurements. *Id.* at FOF ¶ 11. The Division identified a contract for state office supplies as a candidate for the pilot reverse auction program and put the contract out for bid in 2005. *(Id.* at FOF ¶¶ 2, 12). Accenture drafted the RFP for the office supplies contract, which included terms that prejudiced offerors without retail stores. (*Id*. at FOF ¶¶ 19).

a. Two of Accenture's clients bid on the contract, and Accenture did not disclose to the Division that it was aware that at least one of its clients responded to the RFP. (*Id.* at FOF ¶¶ 46-47, 50). When the Division of Purchase and Contract scored the proposals, it used the scoring guide prepared by Accenture and did not deviate from the guide, treating it instead as criteria that must be followed. *Id*. at FOF ¶ 53. Accenture's clients scored first and second, and the contract was ultimately awarded to one of Accenture's clients. (*Id.* at FOF ¶¶ 57, 68).

b. The matter was appealed to the Office of Administrative Hearings. The OAH Tribunal reversed the award to Accenture's client, holding that the Division did not maintain control over the process, ensure fairness and avoid the appearance of impropriety, and the record did not support that the contract award was most advantageous to the State. (*Id.* at COL ¶¶ 5-17).

18. There are no similar facts in this contested case. Segal had no part in drafting the Minimum or Technical Requirements for the RFP, but only assisted in drafting scoring language in the RFP at the direction of the Plan. There is no evidence that any part of the scoring language or Segal's scoring of the Cost Proposal was intended to favor any bidder. Nor was there any evidence that Segal had any undisclosed financial relationship with any of the vendors. Moreover, the Administrative Law Judge in *Corporate Express* concluded that the RFP violated N.C. Gen. Stat. §§ 143-52 and 143-129(b) – statutes that do not apply to this procurement. (*Id.* at COL ¶ 20).

19. Similarly, *the City of Fayetteville* case, which did not involve a procurement at all, is also readily distinguishable from this case. The *City of Fayetteville* case

concerned the appeal of the issuance of an inter-basin transfer certificate allowing Cary and Apex to increase the volume of daily transfers of river water from the Cape Fear River. *City of Fayetteville*, 15 EHR 03241, 2017 WL 8896072, at FOF ¶ 25. Petitioners challenged the award of the certificate by on the grounds that the EMC and the DEQ failed to adequately assess the environmental impact of the proposed increase. The applicants in that case hired a consultant to prepare the environmental assessment documents required by statute to accompany their application. (Id. at FOF ¶¶ 36-42). Rather than independently assessing the work of the applicants' consultant, the state agencies, the N.C. Environmental Management Commission ("EMC") and the N.C. Department of Environmental Quality ("DEQ") accepted the consultant's work at face value. (*See,* e.g., Id. at FOF ¶¶ 73, 87-88, 106, 301-309). The Administrative Law Judge found error with the agency's reliance on the consultant of a party with vested interests – the applicant. (*See Id.* at FOF ¶ 309, COL ¶¶ 48-58). The *City of Fayetteville* case has no relevance to the question at issue in this case: whether the Plan could rely on *its own* consultant to provide specialized expertise and assist the Plan in scoring Cost Proposals based on the methodology the Plan had drafted and adopted.

20. In this case, the Plan's reliance on their own consultant, Segal, did not constitute error. By exempting certain Plan contracts, including the TPA RFP Contract, from oversight by the N.C. Department of Administration, our General Assembly gave the Plan broad discretion to conduct its own procurements, which falls squarely within the demonstrated knowledge and experience of the Plan. Moreover, the Plan's Executive Administrator had the discretion and authority to contract with third parties in the performance of her duties and responsibilities under N.C. Gen. Stat. § 135-48.23(c2), and the Executive Administrator's decision to delegate her authority to Segal was sound and reasonably based. Because the Plan is a contract/vendor management organization that is budgeted for only 54 staff positions, the Plan has limited resources. Segal is an industry expert with a full staff of actuaries and data analysts who has historically consulted for the Plan on past procurements for the TPA Contract. (Jones, T. Vol. 2 p. 342). Segal's analyses and recommendations, which Blue Cross challenged in this case, were properly within the scope of Segal's engagement with and its role as the Plan's actuarial services contractor. (Jt. Ex. 11).

21. The preponderance of the evidence demonstrated that the Plan designed and controlled the Cost Proposal for the 2022 TPA RFP and established a scope of work for Segal to perform for such Cost Proposal. (Jones, T. Vol. 1 pp. 342-346; Rish, T. Vol. 2 pp. 401- 408) The Plan did not accept Segal's analysis of the Cost Proposals without question. Mr. Sceiford and Mr. Rish from the Plan reviewed Segal's analysis and gave Segal feedback, which Segal then incorporated into its analysis. The analysis was subsequently presented to the Evaluation Committee who reviewed and adopted Segal's analysis. Therefore, the Plan acted within its discretion and authority by contracting with Segal to support the Plan's 2022 TPA RFP.

IV. Network Pricing Guarantees Scoring

22. Blue Cross contended that the Plan and Segal made errors of both process and substance when it evaluated and scored the network pricing guarantees and therefore, in so doing, violated the Plan's written Procurement Policy, the terms of the 2022 TPA RFP, and otherwise acted arbitrarily and capriciously.

A. The Plan's Procurement Policy

23. Blue Cross argued that Segal and thus, the Plan violated the Plan's Procurement Policy and acted arbitrarily and capriciously by failing to evaluate and finalize a scoring method for the network pricing guarantees until after it saw the vendors' bid proposals.

24. A preponderance of the evidence proved that the evaluation and scoring of the network pricing guarantees were consistent with the Plan's Procurement Policy. The Plan's Evaluation Committee created and adopted the evaluation criteria and scoring methodology through a chain of e-mails from August 18-22, 2022. During these e-mail exchanges, the Evaluation Committee decided on the overall scoring of the RFP, and the ranking and scoring of each evaluation criteria. The Plan advised Segal of their decision shortly thereafter. (Jt. Ex. 87; Pet. Ex. 520) Through another e-mail exchange from August 25-26, 2022, the Evaluation Committee allocated the specific points and ranking for network pricing, administrative fees, and guarantees. (Pet. Ex. 520) The Plan then incorporated their evaluation criteria and scoring methodology for the network pricing guarantees into Section 3.4 of the 2022 TPA RFP as follows:

> Proposals will be evaluated and ranked based on their proposed network pricing guarantees. The value of the pricing guarantees will be based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk.

(Jt. Ex. 5 at § 3.4(c)(3)).

25. Segal did not have a sample template or calculations to provide the Plan before the RFP was issued on August 30, 2022 because the analysis depended heavily on what the vendors proposed. (Jt. Ex. 64, p. SHP 70488; Kuhn, T. Vol. 2 pp. 525-26, Vol. 3 pp. 663-64; Rish, T. Vol. 2 pp. 434-38). However, the absence of a template or pre-determined scoring formula did not suggest that the evaluation criteria or the scoring methodology were unknown or developed after the fact. Rather, as Mr. Kuhn and Mr. Vieira both testified, a meaningful comparison of pricing guarantees could not be conducted in advance because of the numerous variables involved. Moreover, the Plan did not want to set artificial limits on the vendors' proposals that might prevent the vendors from proposing something that would have been more valuable to the Plan that what it prescribed. (Rish, T. Vol. 2 pp. 467-48).

26. While Segal did not develop an analytical scoring tool of the pricing guarantees until October 2022, after Segal reviewed the vendors' respective pricing

guarantees, the evidence at hearing established that the scoring model Segal developed was based on the models of the Cost Proposal scoring already provided in the RFP document and the network pricing guarantees were evaluated and scored consistently with those stated criteria and methodology. (Jones, T. Vol. 2 pp. 351-53, 358; Kuhn, T. Vol. 2 p. 579, Vol. 3 pp. 665, 681; Vieira, T. Vol. 6 pp. 1570-71, Vol. 7 p. 1821; Jt. Ex. 64, p. SHP 70488).

27. Blue Cross disputed Mr. Kuhn's and Mr. Vieira's testimony that a mathematical formula or model could not have been developed in advance to score the network pricing guarantees. However, it is immaterial whether someone could theoretically develop such a model because this Tribunal is charged with reviewing the decision the Plan *actually made*, not one that it might have or could have made.

28. Even if the network pricing guarantee scoring had deviated from the Plan's Procurement Policy, Petitioner failed to prove that any such deviation was erroneous, arbitrary, or capricious, violated any law or rule, or constituted improper procedure.

29. The Plan's Procurement Policy is not part of the North Carolina Administrative Code and is not a "rule." *See* N.C. Gen. Stat. § 150B-2(8a) (c). A "policy" is defined as "[a]ny nonbinding interpretive statement within the delegated authority of an agency that merely defines, interprets, or explains the meaning of a statute or rule," which includes "any document issued by an agency that is intended and used purely to assist a person to comply with the law, such as a guidance document." N.C. Gen. Stat. § 150B-2(7a).

30. The Plan's Procurement Policy meets the definition of "policy." The Policy states:

> The purpose of this Contract Procurement Policy and Procedure is to establish a standard procedure for the procurement of goods and services for the North Carolina State Health Plan for Teachers and State Employees ("Plan"). This Policy is intended to ensure that the Plan is compliant with the North Carolina General Statutes; the rules promulgated by the North Carolina Department of Administration, Division of Purchase and Contract (DOA P&C); the North Carolina Department of Information Technology, Statewide IT Procurement Office (DIT); Department of State Treasurer (DST) Procurement and Contracting policies (FOD-POL-9010-ALL) and (FOD-POL-9020-ALL); and the policies and rules adopted by the Plan.

(Jt. Ex. 4, pg. 1).

31. Part II, Section A. of the Plan's Procurement Policy states in part, "RFPs **should** not be posted until the evaluation criteria and scoring methodology are finalized. **A scoring tool may** be developed after posting the RFP but must be finalized before bids are opened." (Jt. Ex. 4, p. 7; emphasis added).

32. The plain ordinary meaning of “should” is to “express obligation or duty,” or “express probability or expectation,” or have an obligation to” or “ought.” https://www.thefreedictionary.com/should (2024: Online Ed).

33. While “[[]t is well established that the word shall is generally imperative or mandatory. . .” *Inspection Station No. 31327 v. N.C. DMV*, 244 N.C. App. 416, 781 S.E.2d 79 (2015), the use of the word "may" in a statute generally connotes permissive or discretionary action and does not mandate or compel a particular act. *China Grove 152, LLC v. Town of China Grove*, 242 N.C. App. 1, 2, 773 S.E.2d 566 (2015).

34. Because Part II, Section A. of the Procurement Policy uses the words “should” and “may, instead of the words “shall” or “must,” the Procurement Policy expected, but did not require the Plan to finalize the evaluation criteria and scoring methodology before the 2022 TPA RFP was posted. (Jones, T. Vol. 1, p. 264). Given the definition of “policy,” the plain language of the Plan’s Procurement Policy and the witnesses’ testimony thereon, the Plan’s Procurement Policy is a “policy” intended to guide Plan staff in complying with statutes and with procurement rules, none of which actually apply to the 2022 TPA RFP procurement.

35. Even absent the above Conclusions of Law, the language of the Plan’s Procurement Policy explicitly outlined the Executive Administrator’s discretion and authority to determine when and whether the policy applies, and/or whether a deviation is permissible or warrants disciplinary action. “The Executive Administrator of the SHP shall have the authority to interpret and apply this policy. This policy may be amended at any time. Non-compliance with this policy is a serious matter that may result in disciplinary action, up to and including termination.” (Jt. Ex. 4, pg. 10).

36. Consistent with this language and the authority designated to Ms. Jones, Ms. Jones interpreted the Procurement Policy, during the 2022 TPA RFP procurement, as a guideline that the Plan usually followed and that the Plan can and does depart from the Procurement Policy when circumstances warrant. (Jones, T. Vol. 1 pp. 210-11, 264-65).

37. Blue Cross argued that any deviation from a written policy constitutes a “violation” of that policy that is inherently arbitrary and capricious. (Zimmerman, T. Vol. 6 pp. 1448, 1455; Sawchak, T. Vol. 9 p. 2338). However, this argument ignores that “policies” are “nonbinding interpretive statement[s]” by definition under N.C. Gen. Stat. § 150B-2(7a) and incorrectly relied on two North Carolina Opinions that turned on very specific facts, showing arbitrary and capricious agency actions, which are not analogous here.

38. In *Tully v. City of Wilmington*, 370 N.C. 527, 810 S.E.2d 208 (2018), a police officer brought civil constitutional claims under Article I, Sections 1 and 19 of the North Carolina Constitution related to denial of a promotion by his employer, the City of Wilmington. The police officer alleged that the City of Wilmington had arbitrarily and capriciously denied him the ability to appeal a promotion by using an answer key to score a written examination that was part of the promotion process, and which was based on

superseded law. The police officer had accurately answered questions on the written examination based on prevailing law. *Id.* at 528−29, 810 S.E.2d at 210−11. The police officer contended that these acts violated a city policy, which required written examinations to have "demonstrated content and criterion validity [,]" and also provided that "[c]andidates may appeal any portion of the selection process." *Id.* at 529−31, 810 S.E.2d at 211−12.

39. The trial court dismissed the police officer's claims on a motion for judgment on the pleadings, and the North Carolina Court of Appeals reversed. *Id.* at 531, 810 S.E.2d at 212. The North Carolina Supreme Court reviewed the case *de novo*, ruling that the police officer had stated a claim only under Article I, Section 1 of the North Carolina Constitution, *Id.* at 532−39, 810 S.E.2d at 213−17, but not expressing an "opinion on the ultimate viability of Tully's claim." *Id.* at 537, 810 S.E.2d at 216.

40. There are several key factors that distinguish *Tully* from the contested case at bar. First, in *Tully*, the Plaintiff brought claims under the North Carolina Constitution, not under N.C. Gen. Stat. § 150B-23(a). Second, *Tully* was decided at the pleadings stage when the police officer's allegations of the City of Wilmington's arbitrary and capricious conduct had to be taken as true. This contested case is being resolved on the merits based on a preponderance of the evidence. Third, the *Tully* Supreme Court found that the Plaintiff:

> . . . adequately stated a claim under the portion of Article I, Section 1 safeguarding the fruits of his labor because . . . he alleges that the City arbitrarily and capriciously denied him the ability to appeal an aspect of the promotional process despite the Policy Manual's plain statement that '[c]andidates may appeal any portion of the selection process.' Tully's allegations state that by summarily denying his grievance petition *without any reason or rationale* other than that the examination answers 'were not a grievable item' despite their being a 'portion of the selection process,' the City ignored its own established *rule*.

Tully v. City of Wilmington, 370 N.C. at 536, 810 S.E.2d at 215; emphasis added. Here, the Plan did not depart from its Procurement Policy, and expressed a reasoned basis for its actions. Even if the Plan had deviated from the Procurement Policy, the Plan did not err because the Procurement Policy is not a nonbinding, interpretative policy under N.C. Gen. Stat. § 150B-2(7a) and is discretionary by definition.

41. Blue Cross also relied on *Joyce v. Winston-Salem State University*, 91 N.C. App. 153, 370 S.E.2d 866 (1988), an employment case, in which Winston-Salem State University ("WSSU") denied an employee a promotion in violation of a State personnel policy, i.e., 25 NCAC 01D .0301, that required WSSU to fill vacancies with qualified, eligible employees where possible by hiring a non-WSSU employee who did not meet the stated qualifications before even posting the position. *Id.* Our Court of Appeals reversed the State Personnel Commission's decision upholding the WSSU's denial of promotion, holding that the Commission failed to fairly and carefully consider whether WSSU followed the rule in reviewing WSSU's underlying decision. *Id.*

42. As with *Tully*, the *Joyce* Opinion is distinguishable from this contested case. First, *Joyce* was an employment case. Second, *Joyce* involved a university's failure to apply a rule, i.e., 25 NCAC 01D .0301. In this case, the Plan's Procurement Policy is not a promulgated "rule" under N.C. Gen. Stat. § 150B-2 (8a) but is a "nonbinding interpretive statement" or "policy" under N.C. Gen. Stat. § 150B-2(7a).

43. Further, neither *Tully* nor *Joyce* support the general proposition that a policy strips discretionary powers from an agency or that an agency may never deviate from a written policy under any circumstances. Neither case is analogous to the facts here, which show the Plan made a good-faith, reasoned decision based on the recommendation of its expert consultant, Segal.

44. Even if the Plan's actions could be construed as inconsistent with the terms of the Plan's Procurement Policy, the Plan did not fail to act as required by law or rule, act erroneous, or fail to use proper procedure because the Procurement Policy is not a rule and is a non-binding internal policy over which Ms. Jones, as the Executive Administrator, "shall have the authority to interpret and apply this policy." While the Procurement Policy suggests that non-compliance with the Policy is a serious matter that **may** result in disciplinary action, the Policy fails to define what is a "serious matter," who decides what constitutes "non-compliance" with the Policy and provides no mechanism by which any disciplinary action can or will be imposed. Furthermore, the Procurement Policy specifically notes that "Only the EA [Executive Administrator], together with the State Treasurer, may legally bind the Plan" (Jt. Ex. 4, p. 4).

45. The preponderance of the evidence proved that the Plan's actions during the 2022 TPA RFP were not arbitrary or capricious but were reasoned and ensured a rational evaluation of the network pricing guarantees.

B. Subjective and Qualitative Evaluation of the Pricing Guarantees

46. Blue Cross' expert witness, Mr. Russo, criticized Segal's analysis of the network pricing guarantees and characterized such analysis as subjective or qualitative rather than objective or quantitative. (Russo, T. Vol. 3 p. 909). Mr. Russo opined that measuring a "bottom line" impact to the Plan in dollars would constitute an objective, quantitative analysis measuring value. Under Russo's alternative "bottom line" analysis, Blue Cross offered pricing guarantees that were at least as valuable to the Plan as Aetna's. (Russo, T. Vol. 4 pp. 932-42, 1004, 1016, 1156).

47. The "bottom-line" approach advocated by Mr. Russo is neither persuasive nor trustworthy. Mr. Russo's method was not based on any industry practice, any example from an actual RFP, or, in some instances, the actual parameters of the 2022 TPA RFP. (Kuhn, T. Vol. 2 pp. 541, 544) Rather, it was premised on his own interpretation that the term "value" in the 2022 TPA RFP referred to the "bottom-line" impact to the Plan's costs.

48. Moreover, Mr. Russo's analysis relied on his own subjective and unsubstantiated assumptions that Blue Cross would achieve much better discounts and trends than Aetna merely by setting more optimistic targets and based on Blue Cross' historical experience of achieving 1.5% increases to its discounts year-over-year. With respect to the latter, Blue Cross contends that Mr. Coccia's rebuttal that Blue Cross could not reasonably expect to achieve a 1.5% discount year-over-year constituted improper post hoc rationalization of the Plan's contract award decision. *Amanini v. North Carolina Dep't of Human Resources, Special Care Ctr.,* 114 N.C. App. 668, 443 S.E.2d 114 (1994)("[C]ourts may not accept . . . post hoc rationalizations for agency action." (citation omitted).

49. This argument is without merit. Neither the Plan nor Aetna have attempted to change or substitute a new rationale for the contract award to Aetna, but instead merely responded to Blue Cross's evidence and litigation positions to show why Blue Cross's attempt to offer an alternative analysis is not persuasive.

50. The evidence at hearing proved that Segal's analysis was consistent with the 2022 TPA RFP, was rational, reasoned, fair, and consistent with standard industry practice. (Vieira, T. Vol. 6 pp. 1565-66, 1570-71, Vol. 7 p. 1821; Coccia, T. Vol. 8 pp. 2083-84, 2087, 2098-99, 2100, 2117-18). In turn, the Plan's adoption of Segal's analysis was in good faith, properly within the Plan's discretion, and in accordance with law. Accordingly, the Petitioner failed to demonstrate by a preponderance of the evidence that the evaluation and scoring of the pricing guarantees was arbitrary or capricious, erroneous, improper, or inconsistent with law or rule.

C. Amounts at Risk

51. The evidence at hearing established that Segal's analysis considered both the targets and the amounts at risk and was consistent with the RFP. (Jt. Ex. 413, pp. 7−8; Kuhn, T. Vol. 2 pp. 579, 595-97, Vol. 3 pp. 640-41, 651-54; Vieira, T. Vol. 6 pp. 1543-44, 1570-71, 1574-76).

52. Relying on this Tribunal's Decision in *eDealer Services LLC v. North Carolina Department of Transportation*, 20 DOA 04356, 2021 WL 6752477, COL ¶¶ 40-41, 44 (N.C.O.A.H. Dec. 29, 2021), Blue Cross also argued that the Plan's decision was arbitrary and capricious because the Plan failed to give Blue Cross credit for supposedly putting 15% of its administrative fee at risk and thus, failed to consider key components of Blue Cross' proposal. In *eDealer*, the evaluation committee ignored three of the five evaluation criteria in making a recommendation of award. (*Id.).*

53. In contrast, here, all members of the Segal team and of the Plan's staff consistently and reasonably read Blue Cross's proposed guarantees to apply the same 5% "maximum payout ('cap')" to all three categories of its discount guarantee—an interpretation Blue Cross's own expert agreed was reasonable. (Russo, T. Vol. 5 p. 1224.) Nowhere did Blue Cross's proposal clearly state that the 5% cap on each category was separate or cumulative, and—reasonably—neither Segal's nor the Plan's experienced staff believed or questioned whether Blue Cross intended to put 15% of its administrative

fee at risk. (Jt. Ex. 225; Kuhn, T. Vol. 3 pp. 636, 676; Vieira, T. Vol. 6 pp. 1580-81, Vol. 7 pp. 1799-1800.)

54. Mr. Russo opined that the Plan and Segal should have sought clarification from Blue Cross as to the amount at risk. (Russo, T. Vol. 5 p. 1224). Setting aside the fact that the Plan and Segal did not identify any ambiguity in Blue Cross' proposed amounts at risk, Section 3.3(a) of the 2022 TPA RFP advised vendors that the evaluators were not required to seek clarifications from vendors. Accordingly, the burden was on each vendor to make its proposal clear; the burden was not on the Plan or Segal as its contractor to identify and clarify ambiguities in the proposals. *See, e.g., CMI Mgmt. v. United States*, 115 Fed. Cl. 276, 288-89 (2014) (holding that bidder has a duty to adequately describe its proposal and the procuring entity has no obligation to clarify ambiguities).

55. Therefore, Segal and the Plan reasonably interpreted Blue Cross' proposal as putting only 5% at risk for its discount guarantees. Blue Cross failed to prove by a preponderance of evidence that Segal's treatment and consideration of Blue Cross' amount at risk was arbitrary and capricious.

D. Russo's Other Criticisms of Pricing Guarantees Evaluation and Scoring

56. Blue Cross' expert, Mr. Russo, also disagreed with the scoring of pricing guarantees based on several other criticisms, including that:

a. The vendors' percentage-of-Medicare guarantees were not scored.
b. UMR did not propose discount guarantees after the first contract year (2025).
c. UMR's trend guarantee target was not a fixed percentage, but instead was based on UnitedHealth Group's "book of business" cost trend percentage.
d. Aetna's discount guarantee target was lower than its current discount percentage.
e. Aetna's trend guarantee targets became less favorable over the term of the contract, and
f. UMR and Aetna proposed composite discount guarantee targets, unlike Blue Cross, which proposed separate discount targets for inpatient facilities, outpatient facilities, and professional fees.

57. However, in making these arguments, Blue Cross identified no statute or rule that Segal, or the Plan, violated. Segal reasonably determined that Aetna's and UMR's pricing guarantees complied with the TPA RFP's instructions, and Segal's analysis and proposed scoring of the pricing guarantees was consistent with the TPA RFP.

58. Likewise, none of Mr. Russo's criticisms identify any math errors, mistakes, or similar faults on the part of Segal or the Plan that were erroneous. Instead, each of Mr. Russo's criticisms merely amounted to Blue Cross' disagreement with Segal's good faith, reasoned judgment in the analysis and scoring of the pricing guarantees, which analysis and scoring were accepted by the Plan in the exercise of its discretion.

59. Mere disagreement with the Plan's discretionary decisions is not enough to carry Petitioner's burden in this contested case. *See Little v. N.C. State Bd. of Exam'rs*, 64 N.C. App. 67, 306 S.E.2d 534 (1983) (holding that contradictory evidence or a difference of opinion with an agency does not lead to a conclusion that the agency's decision was arbitrary and capricious if the agency decision is supported by substantial evidence). The Petitioner failed to prove that the Plan's judgment in the analysis and scoring of the guarantees was arbitrary or capricious, erroneous, failed to follow improper procedure, or was inconsistent with any law or rule.

E. Calculation of Final Scores

60. Blue Cross argued either that the RFP clearly required the Plan to convert the Cost and Technical proposals to an equal basis and add those two scores together instead of using rank-based points as the Plan did, or that the RFP was ambiguous and should be construed against the Plan as the drafter of the document. (*See, e.g.*, T. Vol. 9, p. 2362.) However, the evidence at hearing showed that the Plan's use of rank-based points for the Technical Proposal and rank-based points for the Cost Proposal to reach an overall score was consistent with the language of 2022 TPA RFP.

61. Blue Cross incorrectly claimed that the "total points scale" language in Section 3.4(a) of the TPA RFP was undefined and ambiguous. Blue Cross also incorrectly argued that the phrase "total points scale" must refer to the initial cost and technical points, not the rank-based points, because Sections 3.4(b) and (c) of the RFP required the proposals to be ranked based on the "total points" earned in the technical scoring and the "total cost proposal points" earned in the cost scoring. (Jt. Ex. 5).

62. Blue Cross' reading failed to recognize that the technical and cost points in the RFP were used to rank the proposals in descending order. (Jt. Ex. 5 at §§ 3.4(b)−(c)). Uncontroverted evidence at hearing established that the sole purpose for that language in the RFP was to allow the rank-based points to be combined for an overall score. Such evidence also proved that the Plan intended the rank-based points be combined for an overall score. (Jt. Exs. 63, 87; Jones, T. Vol. 1 pp. 285-88, Vol. 2 pp. 349-50; Vieira, T. Vol. 7 pp. 1743-46). Blue Cross' failure to understand the final scoring methodology at the time of the procurement did not render the final scoring methodology inconsistent with the RFP. If Blue Cross was unclear about the scoring or ranking process, it could have sought clarification from the Plan prior to submitting its proposal. The undisputable evidence showed that Blue Cross never asked the Plan for any such clarification.

63. In this case, the Plan's addition of the rank-based points for the Technical and Cost Proposals for a total score was reasonable and consistent with the language of the RFP. Blue Cross interpreted the "total points scale" language in the RFP to require the Plan to multiply the 10 Cost Proposal points by 31 to weight the Technical Proposal points and Cost Proposal points equally while ignoring the rank-based points. However, such an interpretation is unreasonable because it would render the separate scoring and descending-order ranking language in Sections 3.4(b) and (c) superfluous. *See NVT*

Techs., 370 F.3d 1153 (Fed. Cir. 2004); *see also Gay v. Saber Healthcare Grp., L.L.C.*, 271 N.C. App. 1, 842 S.E.2d 635 (2020), *aff'd*, 376 N.C. 726, 854 S.E. 2d 578 (2021).

64. Because the RFP language can only be reasonably construed as the Plan intended in order to give effect to all its provisions, it is not ambiguous or in conflict and need not be construed against the Plan. *Gay*, 271 N.C. App. at 7, 854 S.E.2d at 640 (internal citations omitted) ("[P]rovisions should not be construed as conflicting unless no other reasonable interpretation is possible." "Where no other reasonable, nonconflicting interpretation is possible, 'the court is to construe the ambiguity against the drafter—the party responsible for choosing the questionable language.'")

65. No statute, rule, or mandatory procedure dictates how the final score must be calculated. Accordingly, the use of separate ranks and rank-based points was within the Plan's discretion. As such, the Plan's use of rank-based points in the overall score was neither erroneous nor arbitrary or capricious.

66. Blue Cross argued that a similar scoring system was found to be arbitrary and capricious in *Medical Review of North Carolina, Inc. v. North Carolina Department of Administration*, 2013 WL 12413478, 13 DOA 12702, FOF ¶¶ 5-7 (N.C.O.A.H. Aug. 30, 2013). However, the *Medical Review* case is distinguishable. That contested case not only involved a different type of RFP contract, and evaluation criteria than in this case, but different parties, a different State agency, and a different Administrative Law Judge. The issue in *Medical Review* reviewed a state agency's action of specifically changing the scoring of a RFP, and then treating the bidders differently when it came to scoring the references, with some less favorable references receiving the full 50 points. (*Id.* at COL ¶ 10).

67. Here, the scoring was not changed. The 2022 TPA RFP detailed the process of first scoring each component and then converting that score to a descending rank. The Plan's leadership made a deliberate and discretionary decision, in advance, to separately score and rank the Technical and Cost Proposals and to combine those separate ranks for a total score, as a simple way to weight the Technical and Cost Proposals equally, and which would clearly distinguish between higher and lower-scoring vendors. (*See* Jt. Exs. 63, 87). The rank-based points were calculated and combined correctly, and the evidence did not show a lack of fair and careful consideration. The use of ranks was also fair and in good faith: it favored no particular bidder, but rather whichever bidder scored highest on both the Technical and Cost Proposals. *See ACT-UP Triangle*, 345 N.C. 699, 707, 483 S.E. 2d 388 (1997). Blue Cross' mere disagreement with the Plan's use of ranks in the total score does not render it arbitrary or capricious. *See Little*, 64 N.C. App. at 69-70, 306 S.E.2d at 537.

68. Petitioner failed to prove the Plan's final scoring was erroneous, arbitrary, or capricious, failed to follow proper procedure, or inconsistent with any law or rule.

F. Blue Cross as the "Low-Cost Vendor" with the Best Network

69. Blue Cross incorrectly argued that it should have been awarded the TPA Contract because it was the "lowest-cost" vendor, i.e., the vendor with the lowest administrative fee which would create the least disruption with the largest network. (Russo, T. Vol. 4 pp. 1040-42, 1056, 1060, 1078; Pet.'s Exs. 538, 544). Blue Cross based its argument on Attachment A: Pricing, Section 1.1 Network, which stated: "The Plan seeks to have a provider network in place that best meets the program's long-term needs. This includes a broad provider network with the least disruption and with competitive pricing."

70. However, neither Section 1.1 of Attachment A nor any other section of the 2022 TPA RFP, nor any statute, rule, or procedure required the Plan to award the TPA RFP Contract to the vendor with the "lowest administrative fee" and the greatest total number of providers and least disruption.

71. During the second question-and-answer period, the Plan answered vendors' questions by issuing an Addendum 2 to the 2022 TPA RFP. (Jt. Ex. 44) In Addendum 2, the Plan advised vendors that the "broad provider network" language in Attachment A: Pricing, Section 1.1 Network Access was not a Minimum Requirement in Section 4.0 of the 2022 TPA RFP, not a Technical Requirement in Section 5.0, or a scored evaluation criteria in Section 3.4. Mr. Kuhn explained at hearing that even if it were, "broad provider network" did not mean the vendor whose network includes the most providers. (Kuhn, T. Vol. 3 pp. 619-20; Jt. Ex. 44, p. 10; emphasis added). The objective for including the "broad provider network" language in the 2022 TPA RFP was for the vendors "to provide the largest network they have available" along with competitive pricing. (Kuhn, T. Vol. 3 p. 620). The Plan did not mean the best bidder would be the bidder with the broadest network among all the bidders. (Kuhn, T. Vol. 3 p. 620).

72. To the extent Blue Cross contended that the TPA RFP required the RFP be awarded to the provider with the broadest network, least disruption, and most competitive pricing, such contention ignores not only two out of the three scored cost components—network pricing and pricing guarantees—but also ignores the Technical Requirements.

73. While the evaluation criteria and scoring methodology in Section 3.4 considered administrative fees, they also relied on other factors such as network pricing (claims cost), pricing guarantees and, most importantly, vendors' willingness to partner with the Plan by agreeing to the Plan's Technical Requirements. (Jt. Ex. 5 at § 3.4).

74. While Blue Cross scored highest on the administrative fees (worth two points), Aetna had the lowest claims cost of all the vendors (worth six points) and beat Blue Cross on the pricing guarantees (worth 2 points). (Jt. Ex. 5 at § 3.4(c); Jt. Ex. 413, p. 4).

75. As a self-funded health plan, the annual administrative fee is a small component of the Plan's annual costs related to the TPA Contract as compared to the claims cost (in the billions of dollars). (Jt. Ex. 413, pp. 5−6).

76. While Blue Cross was awarded the most points for its administrative fee under the instructions in the TPA RFP, the actual cost to the Plan was often higher because of additional services not included in Blue Cross' base fee. (Jones, T. Vol. 2 p. 335). Blue Cross excluded several services from its base fee that Aetna and UMR did not. As a result, Blue Cross' excluded services would likely result in extra administrative fees if Blue Cross were the TPA. (Jones, T. Vol. 2 p. 335; Jt. Ex. 28).

77. Additionally, while Blue Cross confirmed only 303 Technical Requirements, Aetna confirmed all 310, and thus demonstrated a greater willingness or ability to meet the Plan's operational objectives. (Jt. Ex. 37).

78. The Plan's decision not to separately score network access and disruption was consistent with Attachment A: Pricing, Section 1.1, and did not suggest that the provider network was unimportant to the Plan and its members. First, the Plan required vendors to confirm that they would "provide a network that will support Plan Members residing in all 100 counties in North Carolina and throughout the United States" as a minimum requirement (Jt. Ex. 5 at § 5.13(b)). Second, the Plan knew that network disruption would show up in the network pricing component of the Cost Proposals (Jones, T. Vol. 2 pp. 347-48; Smart, T. Vol. 7 pp. 1864-67; Jt. Ex. 87), and that if a new vendor was awarded the TPA Contract, it would be able to expand its network during the two-year implementation period (Smart, T. Vol. 7 pp. 1917 1920). Third, the Plan reviewed, but did not score, the Network Access Reports that the vendors were required to provide under Attachment A: Pricing, Section 1.1.1 of the RFP. (Jt. Ex. 5, p. 81; Vieira, T. Vol. 7 pp. 1682-93).

79. Moreover, testimony by Mr. Vieira, Mr. Kuhn, and Mr. Coccia rebutted Mr. Russo's opinions and calculations, and demonstrated that there were no significant issues regarding access or disruption. (Vieira, T. Vol. 7 pp. 1664-67; Kuhn, T. Vol. 2 pp. 553-54, 557-59; Coccia, T. Vol. 8 pp. 2061, 2123-24).

80. The preponderance of the evidence established that the Plan followed the evaluation criteria and scoring methodology in the 2022 TPA RFP. Mr. Russo's opinions regarding Blue Cross' total number of providers and calculations regarding disruption failed to show the Plan erred, acted improperly, failed to act by law or rule, or acted arbitrarily or capriciously under N.C. Gen. Stat. § 150B-23(a) and § 150B-25.1.

G. Timeline of RFP Process

81. Throughout this contested case, Blue Cross has pointed out testimony that the 2022 TPA procurement was conducted on an accelerated timetable compared with earlier RFPs and suggested that timeline led to errors in the pricing guarantee scoring and the calculation of overall scores. (*See, e.g.*, T. Vol. 9 p. 2335).

82. Although the 2022 TPA RFP may not have taken as much time as past TPA procurements, the evidence showed that the decision to conduct the RFP on that schedule was carefully considered before the Plan embarked on the 2022 TPA RFP

process. (Jones, T. Vol. 1 pp. 194-95, 241-52; Smart, T. Vol. 7 pp. 1839-40). The evidence also established that the Plan conducted a thorough and fair RFP, consistent with the 2022 TPA RFP and within the Plan's discretion and authority.

83. The evidence at hearing showed that the Plan was able to conduct such a complex procurement on a shorter schedule through the hard work of the Plan's staff, and Segal's expertise and valuable contributions. In addition, the Plan's non-narrative Technical Proposal format greatly reduced the time needed to evaluate the proposals. The use of Segal and the innovative Technical Proposal format were properly within the Plan's discretion and authority.

84. However, Blue Cross' evidence failed to show that the pricing guarantee scoring or calculation of the overall scores were impacted by the timetable for the 2022 TPA RFP. More importantly, Blue Cross did not prove by a preponderance of the evidence that the Plan erred under N.C. Gen. Stat. § 150B-23(a) with respect to the guarantee scoring, the overall scoring, or any other component of this RFP procurement.

H. Harmless Error

85. Blue Cross argued that but for the Plan's supposed errors, Blue Cross would have been awarded the TPA Contract because Blue Cross would have had the highest scoring proposal. However, to receive the highest overall score, Blue Cross would have had to prove by a preponderance of the evidence that the guarantees scoring *and* the calculation of overall scores were improper or erroneous.

86. For the reasons stated above, Blue Cross failed to meet its burden. Even if Blue Cross had proved that the Plan erred with respect to guarantee scoring *or* the calculation of the overall scores, the error would be harmless because it would not change the fact that Aetna scored the highest overall. *See Britthaven, Inc. v. N.C. Dep't of Hum. Res., Div. of Facility Servs.*, 118 N.C. App. 379, 386−89, 455 S.E.2d 455 (1995) (affirming lower court's conclusion that the Agency's error was harmless because "the same result would have been reached if the Agency had analyzed the applications in the manner prescribed" by the Petitioner Appellant).

87. Blue Cross also argued that the testimony by Mr. Kuhn, Mr. Vieira, and Mr. Coccia, that Blue Cross' pricing guarantees would have had the least comparative value if Blue Cross had put 15% of its fee at risk, constituted improper *post hoc* rationalization of the Plan's contract award decision. *See Amanini*, 114 N.C. App. at 681, 443 S.E.2d at 122 (citations omitted). However, none of these witnesses sought to *change* the basis for the Plan's decision. To the contrary, Mr. Kuhn, Mr. Vieira, and Mr. Coccia all stood by Segal's initial reasoning, but also observed that accepting Mr. Russo's premise as true would not have changed the scores. Their testimony proved that any error in interpreting Blue Cross' discount guarantees as 5% instead of 15% was harmless, and not an attempt to offer a different basis for the decision they made. *Britthaven, Inc.*, 118 N.C. App. 379, 386−89, 455 S.E.2d at 461-462.

I. Substantial Prejudice

88. Separate and apart from its burden to demonstrate agency error, Petitioner Blue Cross had the burden to show by a preponderance of the evidence that the alleged errors by the Plan substantially prejudiced Blue Cross. N.C. Gen. Stat. §§ 150B-23(a), 150B-25.1.

89. To demonstrate substantial prejudice, Blue Cross must show that, but for the respondent's alleged errors, Petitioner "would have been awarded" the contract. At a minimum, the Petitioner must show a "substantial likelihood" that it would have received the contract but for the alleged errors. *See Surgical Care Affiliates, LLC v. N.C. Dep't of Health and Human Services,* 235 N.C. App. 620, 762 S.E.2d 468 (2014), *denied review, 368 N.C. 242, 768 S.E.2d 564 (2015).* (holding that when the petitioner alleges that the Agency did not properly apply its own rules, the petitioner must also prove, and the ALJ must separately decide the issue of, substantial prejudice, i.e., that the Agency's failure to follow its rules actually caused sufficient harm to the petitioner and the Agency's mere failure to follow its own rules is not enough.)

90. Even if Blue Cross had proved agency error, Blue Cross did not meet its burden to prove substantial prejudice. Blue Cross' substantial prejudice argument suffered from the flawed premise that the highest-scoring vendor would have necessarily been awarded the TPA Contract. Pursuant to N.C. Gen. Stat. § 135-48.33, the contract award required the approval of the Plan's Board of Trustees. The Trustees are obligated to act as fiduciaries for the Plan pursuant to N.C. Gen. Stat. § 135-48.4 but were not obligated to follow the Plan's recommendation. In fact, the Board had rejected a prior evaluation committee's recommendation in the past. (Jones, T. Vol. 2 p. 306; Smart, T. Vol. 7 pp. 1911-14)

91. Here, the plain language of Section 3.3(b) of the 2022 TPA RFP explicitly informed all vendors that the Evaluation Committee would present its *recommendation* to the Board, but the Board, not the Evaluation Committee, would make the *final* award decision, which is consistent with its statutory mandate under N.C. Gen. Stat. § 135-48.33. (Jt. Ex. 5, p. 23).

92. Accordingly, Blue Cross did not demonstrate by a preponderance of the evidence that, but for the supposed errors by the Plan, Blue Cross would have or would likely have been awarded the TPA Contract. Consequently, Blue Cross failed to demonstrate that any of the alleged errors by the Plan substantially prejudiced its rights and thus, did not met its burden under N.C. Gen. Stat. § 150B-23(a). Neither did Blue Cross challenge the terms of the RFP or identify any way in which the Plan exceeded its authority or jurisdiction, used improper procedure, acted erroneously, arbitrarily, or capriciously, or violated any statute or rule.

93. To the contrary, the preponderance of the evidence showed that the Plan conducted the procurement carefully and thoughtfully, fairly and in good faith, and that its decisions were properly within its discretion. It also showed that the vendors' proposals were evaluated and scored carefully, accurately, and fairly by the Plan and Segal as the

Plan's contractor, and that to the extent the Plan relied on Segal's analyses and recommendations, that reliance was in good faith and properly within the Plan's discretion.

94. Separately, Blue Cross failed to demonstrate that any alleged errors by the Plan or Segal substantially prejudiced its rights.

FINAL DECISION

WHEREFORE, based on the Findings of Fact and Conclusions of Law set forth herein, the Undersigned finds that Petitioner has not met its burden of demonstrating, by a preponderance of the evidence, that the Respondent acted erroneously; failed to use proper procedure; acted arbitrarily or capriciously, or failed to act as required by rule or law; and that Petitioner was substantially prejudiced thereby.

ACCORDINGLY, the decision of the Plan's Board of Trustees to award the contract for TPA services to Aetna should be and hereby is **AFFIRMED**.

NOTICE OF APPEAL

This is a Final Decision issued under the authority of N.C. Gen. Stat. § 150B-34. Under the provisions of North Carolina General Statute § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file a Petition for Judicial Review in the Superior Court of the county where the person aggrieved by the administrative decision resides, or in the case of a person residing outside the State, the county where the contested case which resulted in the final decision was filed. The appealing party must file the petition within 30 days after being served with a written copy of the Administrative Law Judge's Final Decision.

In conformity with the Office of Administrative Hearings' rule, 26 N.C. Admin. Code 03 .0102, and the Rules of Civil Procedure, N.C. General Statute 1A-1, Article 2, this Final Decision was served on the parties as indicated by the Certificate of Service attached to this Final Decision. N.C. Gen. Stat. § 150B-46 describes the contents of the Petition and requires service of the Petition on all parties. Under N.C. Gen. Stat. § 150B-47, the Office of Administrative Hearings is required to file the official record in the contested case with the Clerk of Superior Court within 30 days of receipt of the Petition for Judicial Review. Consequently, a copy of the Petition for Judicial Review must be sent to the Office of Administrative Hearings at the time the appeal is initiated to ensure the timely filing of the record.

SO ORDERED, this the 8th day of July, 2024.

Melissa Owens Lassiter
Administrative Law Judge

CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, the Office of Administrative Hearings sent the foregoing document to the persons named below at the addresses shown below, by electronic service as defined in 26 N.C. Admin. Code 03 .0501(4), or by placing a copy thereof, enclosed in a wrapper addressed to the person to be served, into the custody of the North Carolina Mail Service Center which will subsequently place the foregoing document into an official depository of the United States Postal Service.

Stephen D. Feldman
Robinson, Bradshaw & Hinson, P.A.
SFeldman@robinsonbradshaw.com
Attorney For Petitioner

Shannon R. Joseph
Morningstar Law Group
sjoseph@morningstarlawgroup.com
Attorney For Petitioner

Matthew W. Sawchak
Robinson, Bradshaw & Hinson, P.A.
MSawchak@robinsonbradshaw.com
Attorney For Petitioner

Nathan C. Chase Jr.
Robinson, Bradshaw & Hinson, P.A.
NChase@robinsonbradshaw.com
Attorney For Petitioner

Douglas M Jarrell
Robinson, Bradshaw & Hinson, P.A.
DJarrell@robinsonbradshaw.com
Attorney For Petitioner

Benjamin C DeCelle
Robinson, Bradshaw & Hinson, P.A.
BDecelle@robinsonbradshaw.com
Attorney For Petitioner

Emily J Schultz
Robinson, Bradshaw & Hinson, P.A.
ESchultz@robinsonbradshaw.com
Attorney For Petitioner

Erik R Zimmerman
Robinson, Bradshaw & Hinson, P.A.
EZimmerman@robinsonbradshaw.com
Attorney For Petitioner

Joel Heimbach
NC State Health Plan, NC DST
Joel.Heimbach@nctreasurer.com
Respondent

Aaron Douglas Vodicka Esq.
NC State Health Plan - TSERS
aaron.vodicka@nctreasurer.com
Attorney For Respondent

Marc C Hewitt
Fox Rothschild
mhewitt@foxrothschild.com
Attorney For Respondent

Robert H Edmunds
Fox Rothschild LLP
bedmunds@foxrothschild.com
Attorney For Respondent

Elizabeth Sims Hedrick
Fox Rothschild LLP
ehedrick@foxrothschild.com
Attorney For Respondent

Benjamin N. Thompson
Wyrick Robbins Yates & Ponton LLP
bthompson@wyrick.com
Attorney for Respondent-Intervenor

Lee M Whitman
Wyrick Robbins Yates & Ponton, LLP
lwhitman@wyrick.com
Attorney for Respondent-Intervenor

Sophia V. Blair
Wyrick Robbins Yates & Ponton LLP
sblair@wyrick.com
Attorney for Respondent-Intervenor

This the 8th day of July, 2024.

Julie B. Eddins

Julie B. Eddins
Paralegal
N. C. Office of Administrative Hearings
1711 New Hope Church Road
Raleigh, NC 27609-6285
Phone: 984-236-1850