

STATE OF NORTH CAROLINA
DURHAM COUNTY

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.

**AFFIDAVIT OF KENDALL BOURDON
IN SUPPORT OF RESPONDENT'S
MOTION FOR SUMMARY JUDGMENT**

I, Kendall Bourdon, being duly sworn, depose, and say:

1. I am over eighteen years of age and am competent to make this affidavit. I have personal knowledge of the matters addressed in this affidavit.

2. I am also an attorney licensed in North Carolina.

3. I was employed by the North Carolina Department of State Treasurer as the Director of Contracting and Compliance of the North Carolina State Health Plan for Teachers and State Employees (the "Plan") from December 2021 through May 2023. Prior to that I served as Assistant General Counsel from July 2018 through about December 2021.

4. I served as Director of Contracting and Compliance during the development and drafting of Request for Proposals # 270-20220830TPAS ("2022 TPA RFP"), which is the subject of this contested case. I remained in this role throughout the evaluation of the proposals and the

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decision by the Plan's Board of Trustees to award the third-party administrator ("TPA") contract in December 2022.

5. My responsibilities as Director of Contracting and Compliance included management of the Plan's procurements, including requests for proposals ("RFPs"), managing its current contracts, and oversight of the contracting team and compliance matters.

6. During my employment with the Plan, I was also involved in the previous TPA procurement in 2019, as well as numerous RFPs for other services.

7. In December 2021, independent of the 2022 RFP for the TPA contract, Dorothy (Dee) Jones, the Plan's Executive Administrator, directed me, in my capacity as the Plan's Director of Contracting and Compliance, to modernize the Plan's contracting processes, including eliminating narrative responses to the minimum requirements and technical requirements in the Plan's RFPs.

8. The design and drafting of the 2022 RFP was a large undertaking for the Plan, which required hundreds of hours of collaborative work from numerous Plan staff and consultants from Segal over a period of approximately five months between April and August 2022. The RFP document and its various attachments went through numerous drafts and revisions by groups of Plan employees and/or Segal personnel. Dee Jones had overall responsibility for the RFP, but the design and drafting of the RFP were a collective effort and generally based on consensus among the experienced Plan leadership and Segal consultants involved.

9. The RFP provided that proposals would be submitted by bidders and evaluated in two phases. First, minimum requirements proposals were due by September 26, 2022. Vendors that met the minimum requirements were notified by September 29, 2022, and allowed to submit

technical proposals and cost proposals by November 7, 2022. Any vendor who did not was disqualified from further consideration. (RFP Section 2.6.1).

10. The scoring methodology and weighting in section 3.4 of the RFP were decided by consensus by Dee Jones, Matt Rish, Caroline Smart and me, with input from Segal on certain aspects. We decided to give the cost proposal and the technical proposal equal, 50/50 weight in the overall scoring because we considered cost and the technical requirements to be of equal importance.

11. We also decided by consensus to rank the bidders' cost proposals, to separately rank the bidders' technical proposals, and to base the bidders' overall scores on the combination of those two ranks. That method of ranking and scoring the proposals would enable us to easily give the technical and cost proposals equal 50/50 weight and would clearly differentiate between the bidders even if the scoring of the technical and cost proposals were close, as we expected them to be.

12. Our consensus regarding the scoring of network pricing (via the Claims Repricing exercise) was to establish percentage ranges (which we referred to as a "bullseye") so that a bidder whose pricing was within 0.5% of the bidder with the lowest pricing would receive the same number of points. Because medical claims are the overwhelming majority of the Plan's costs, and because the bidders' network pricing had historically been very close, we believed a proposal that was not the best should still be competitive if there was only a relatively small difference between it and the proposal with the best pricing.

13. Potential Bidders had multiple opportunities for questions and feedback to the Plan regarding the 2022 RFP. In Spring 2022, before the RFP document was released, the Plan notified

all expected bidders, including Blue Cross and Blue Shield of North Carolina (“Blue Cross”), Aetna Life Insurance Company (“Aetna”), and UMR Inc. (“UMR”), that an RFP for the TPA contract would be issued. The Plan also initiated meetings with each bidder to discuss the upcoming RFP. Blue Cross’s pre-RFP meeting was held in June 2022 and was attended by Roy Watson (the vice president who oversees the relationship with the Plan for Blue Cross) and Aimee Forehand (the associate vice president of the State Health Plan segment for Blue Cross), and by Dee Jones and me for the Plan.

14. The Plan’s intent for the pre-RFP meetings was to educate the vendors on the changes to the RFP from prior iterations and to receive feedback that would help the Plan identify opportunities for improvement before the RFP was finalized. Dee Jones and I told all bidders about the modernized RFP format at the meetings, and that narrative responses to minimum requirements and technical requirements would not be allowed. No bidder objected or expressed any concerns, and some bidders said the new format was great and much easier than a narrative format.

15. Follow-up meetings were also available on request to address bidders’ questions, concerns or suggestions. Although a follow-up meeting was requested and held with at least one vendor, no bidder raised any concern about the modernized format of the RFP in any follow-up meeting.

16. The RFP was publicly posted and made available to bidders on August 30, 2022. Once the RFP was publicly posted, vendors were generally not permitted to communicate with the Plan about the RFP (except for clarifications requested by the Plan) until the contract award, which was referred to as the “silent period.” (RFP Attachment B, p. 88, Section 16).

17. However, the Plan held a remote meeting with potential bidders on September 1, 2022, after the RFP was posted. Such meetings are standard practice for the Plan. Both the Treasurer and I attended this meeting on behalf of the Plan. On this call I again explained the modernized, non-narrative format and invited comments and questions. No bidders objected or raised any concerns about the RFP during this call.

18. In addition, Sections 2.4 and 2.5 of the RFP allowed two periods for bidders to submit written questions regarding the RFP, after the RFP was posted and before proposals were due. (RFP, pp. 11-13). Under Section 2.3, bidders were urged and cautioned to raise any issues, exceptions, and/or requests to modify any of the RFP's terms, conditions, or components through this question-and-answer process. If the Plan determined that any changes to the RFP would be made as the result of questions, it would communicate the change through an addendum. (RFP, pp. 10-11).

19. The Plan selected an Evaluation Committee for the 2022 RFP consisting of seven voting members from the Plan's staff ("Evaluation Committee"). They were assisted by four non-voting members, including the Plan's Executive Administrator, actuary, and two in-house counsel. Three other members of the Plan's contracting and compliance organization and I also advised and assisted the Evaluation Committee. (Dep. Ex. 15).

20. Minimum requirements proposals were submitted by Blue Cross, Aetna, and UMR in response to the RFP. The Evaluation Committee met on September 27 and September 30, 2022, and determined that all three bidders met the minimum requirements, as documented in the Evaluation Summary prepared by the Plan. (SHP 0004568-0004573 (Eval. Summary)).

21. Technical Proposals and Cost proposals were submitted by all three bidders in the second phase on November 7, 2022, and were evaluated and scored as set forth in RFP section 3.4.

22. In its November 8, 2022, meeting the Evaluation Committee reviewed and scored the technical proposals. (SHP 04568/CTRL 00278 (Eval. Summary)). Aetna and UMR both confirmed all 310 technical requirements and were awarded 310 points. However, Blue Cross confirmed only 303 requirements, did not confirm seven, and therefore received 303 points.

23. Pursuant to Section RFP section 3.4(b), Aetna and UMR, who tied with 310 points each, received the highest rank of three. Blue Cross received the lowest rank of one.

Vendor	Final Technical Points	Final Technical Proposal Rank
Aetna	310	3
Blue Cross NC	303	1
UMR	310	3

24. Segal analyzed and scored the vendors' cost proposals. Blue Cross and Aetna each received 8 points out of 10, and UMR received seven points out of ten. Consistent with RFP Section 3.4(c), the bidders were ranked. Blue Cross and Aetna both received the highest rank of three, and UMR received the lowest rank of one. (Dep. Ex. 413).

25. Segal presented its analysis and scoring of the cost proposals to the Evaluation Committee at the committee's November 30, 2022 meeting. The Evaluation Committee agreed with and accepted the Plan's and Segal's evaluation and scoring. (SHP 0004568-0004573 (Eval. Summary)).

26. Giving the Technical Proposal and Cost Proposals equal weight, as stated in Section 3.4(a) of the RFP, Aetna received the highest combined technical and cost rank (6 points total), and Blue Cross and UMR tied at 4 points total. (SHP 0004568-0004573 (Eval. Summary)). In

order to weigh the cost proposal and the technical proposal equally, the Plan simply added each bidder's technical proposal ranking (1-3 points) to its technical proposal ranking (1-3 points), to arrive at a total score of 2-6 points for each bidder.

Vendor	Final Technical Proposal Rank	BAFO #1 Cost Proposal Rank	Final Technical Proposal and BAFO #1 Cost Proposal Rank
Aetna	3	3	6
Blue Cross NC	1	3	4
UMR	3	1	4

(Table above from SHP 04568 (Eval. Summary)).

27. Based on the evaluation and scores described above, the Evaluation Committee unanimously voted to present all three proposals to the Plan's Board of Trustees for consideration at the Board's December 14, 2022, meeting, with a recommendation to award the TPA contract to Aetna. The Evaluation Committee's recommendation was documented in a memo dated December 4, 2022. (Depo. Ex. 15).

28. At the direction of the Treasurer and because all three proposals were being submitted to the Board of Trustees, all three proposals were also submitted for review by the North Carolina Department of Justice. Review by the Attorney General or his designee is required pursuant to N.C. Gen. Stat. § 135-48.33(b) for certain contracts worth over \$1,000,000. All three proposals were subsequently approved by the Department of Justice.

29. All three proposals were presented to the Plan's Board of Trustees in executive session at the Board's December 14, 2022, meeting, which was attended by the Plan's Executive Administrator and leadership staff, as well as the Department of State Treasurer's leadership staff. As the Plan's Director of Contracting and Compliance, I presented a PowerPoint presentation

describing the contract modernization strategy and process, the development of the 2022 RFP, and the evaluation and scoring of the RFP. I also presented the Evaluation Committee's recommendation. (Dep. Ex. 14). The presentation and discussion were also documented in minutes from the executive session. (Dep. Ex. 294 (Exec. Session Minutes)).

30. After the presentation, the Trustees engaged in a robust discussion of the proposals with extensive questions from the Trustees to the Plan's leadership. Following this discussion, the Board unanimously voted to award the TPA contract to Aetna. (Dep. Ex. 294 (Exec. Session Minutes)). Pursuant to N.C. Gen. Stat. § 135-48.20, the Treasurer serves as chair of the Board of Trustees, but only votes in the event of a tie. Because the vote was unanimous, the Treasurer did not vote on the 2022 TPA contract award.

31. All bidders were notified of the outcome of the RFP, and debrief meetings were held with both unsuccessful bidders on December 15 and 16, 2022. Debrief meetings were part of an initiative the Plan had implemented in previous RFPs for all vendors to walk them through the RFP process, the evaluations, and the scoring, and to invite questions so unsuccessful bidders would better understand the outcome and the basis for the Plan's decision.

32. Blue Cross's debrief meeting was held December 16, 2022. It was attended by Roy Watson and Aimee Forehand for Blue Cross, and by Dee Jones and me on behalf of the Plan. The Plan staff presented a PowerPoint presentation explaining the evaluation and scoring, including all the scoring areas in which Blue Cross lost points. (Dep. Ex. 298). While Blue Cross expressed disappointment, its representatives voiced no disagreement or belief that the scoring was inaccurate or mistaken at the debrief meeting.

33. Blue Cross requested a protest meeting in writing on January 12, 2023, pursuant to RFP Attachment B, Section 15 (Protest Procedures) (RFP pp. 87-88). In its request, Blue Cross made many of the same arguments that were later made in its Petition for Contested Case Hearing. Among other things, Blue Cross disagreed with the design of the RFP and the evaluation of the proposals. Blue Cross asked that the contract award to Aetna be rescinded and the contract awarded to Blue Cross, or alternatively that a new procurement be conducted. (Blue Cross Request for Protest Meeting 1.12.2023).

34. The Plan denied Blue Cross's request for protest meeting by letter dated January 20, 2023, which was executed by the Plan's current Executive Administrator, who succeeded Dee Jones on December 16, 2022. (SHP 0025822-0025832 (Denial of Req for Protest Meeting)).

35. The denial letter explained that the Plan had reviewed Blue Cross's request for protest meeting and responded in detail to the arguments raised by Blue Cross. Consistent with the protest procedures in the RFP, the denial letter explained the Executive Administrator's determination that Blue Cross's protest had no merit and that a protest meeting would serve no purpose. (SHP 0025822-0025832 (Denial of Req for Protest Meeting)).

36. The documents referred to in this Affidavit and attached to the Appendix filed contemporaneously herewith are correct and true copies identified in the below table:

Deposition Exhibit No.	Bates Nos.	Description
14	SHP 0024050-0024063	Presentation to 12.14.2022 Meeting of State Health Plan Board of Trustees Meeting
15	SHP 0025420-0025425	Evaluation Committee Recommendation Memo 12.14.2022

Deposition Exhibit No.	Bates Nos.	Description
294	SHP 0075511-0075512	Minutes – State Health Plan Board of Trustees Meeting, Executive Session, 12.14.2022
298	SHP 0094284-0094298	PowerPoint Presentation from Blue Cross Debrief Meeting, 12.16.2022
413	SHP 0085912-0085925	Segal Cost Proposal Analysis, Reflects Clarifications and BAFO #1, 11.29.2022
NA	SHP 0004568-0004573	Summary of the Evaluation Process Memo, 12.7.2022
NA	NA	Blue Cross's Request for Protest Meeting on RFP # 270-20220830TPAS, 1.12.2023
NA	SHP 0025822-0025832	Denial of Blue Cross Request for Protest Meeting, 1.20.2023

37. Based on my personal knowledge and involvement in the 2022 TPA procurement, and everything I have seen and heard since, I believe the procurement was conducted properly and fairly by the Plan and its contractor Segal, and that they acted fairly, carefully, diligently and in good faith at all times. I am not aware of any violation of any legal requirements by the Plan or Segal, and I believe that they acted appropriately and within their authority and discretion throughout the procurement.

Further, the affiant sayeth not.

[SIGNATURE ON FOLLOWING PAGE]

STATE OF NORTH CAROLINA)
)
COUNTY OF WAKE)

Kendall M Bourdon
Kendall Bourdon

Sworn to and subscribed before me this, the 14th day of December 2023.

NOTARY STAMP
STEPHEN M. SCHMOEGER
NOTARY PUBLIC
WAKE COUNTY, N.C.
My Commission Expires 10/18/2026

My Commission Expires: 10/18/2026

Stephen M. Schmoeger
Stephen M. Schmoeger
Notary Public

CERTIFICATE OF SERVICE

The undersigned does hereby certify that a true and correct copy of the foregoing document was served upon counsel for all parties at the addresses indicated below in accordance with the North Carolina Rules of Civil Procedure and the Rules of the Office of Administrative Hearings by electronic mail as follows:

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This, the 15th day of December 2023.

/s/ Marcus C. Hewitt

Marcus C. Hewitt

STATE OF NORTH CAROLINA
DURHAM COUNTY

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Respondent-Intervenor.)

AFFIDAVIT OF DOROTHY C. JONES

I, Dorothy C. Jones, being duly sworn, depose and say:

1. I am over eighteen years of age and am competent to make this affidavit. I have personal knowledge of the matters addressed in this affidavit.

2. I was employed by the North Carolina Department of State Treasurer and appointed as Executive Administrator of the North Carolina State Health Plan for Teachers and State Employees ("Plan") from June 2017 until December 16, 2022.

3. As Executive Director, one of my responsibilities was for the Plan's contracting activities with outside vendors. Preparing, issuing and evaluating requests for proposals ("RFPs") to select vendors to which contracts will be awarded is a significant component of the Plan's contracting activity. The Plan routinely conducted several RFPs per year, for a wide range of services and vendors, and routinely had several RFPs in ongoing in various stages at any given time.

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4. One major type of vendor with which the Plan contracts is the Plan's third-party administrator ("TPA"), which provides administrative services to support the Plan's operations. I served as Executive Administrator for the Plan during the development and drafting of Request for Proposals # 270-20220830TPAS ("2022 TPA RFP"), which is the subject of this contested case, as well as the previous TPA RFP in 2019.

5. Neither the North Carolina Department of State Treasurer nor the Plan has adopted regulations for its contracting activities. Some contracting activities of the department are subject to Department of Administration procedures, but the 2022 TPA RFP (and previous TPA RFPs) were exempt from those procedures pursuant to N.C. Gen. Stat. § 135-48.34. Therefore, no statutes or administrative rules establish procedures for the 2022 TPA RFP. The Plan has an internal contract procurement policy and procedure, but it does not specify what information the plan should request from vendors in any given RFP.

6. Prior to the 2022 TPA RFP, the plan issued RFPs for its TPA contract on numerous occasions, most recently in 2017 and 2019. Prior to the 2022 TPA RFP, Blue Cross and Blue Shield of North Carolina ("Blue Cross") had been awarded the Plan's TPA contract in a number of consecutive RFPs, and had served as the Plan's TPA almost continuously for over 40 years.

7. Beginning in approximately December 2021, I directed the Plan's Director of Contracting and Compliance to modernize its contracting processes, including RFPs, in order to address certain problems resulting from the way in which RFPs were historically drafted and evaluated. One main goal of the modernization effort was to eliminate narrative responses to minimum requirements and technical requirements in RFPs.

8. Minimum requirements and technical requirements are part of the "scope of work" of a given RFP, i.e, the specific work or tasks the vendor will be contracted to perform for the

Plan. Tasks that are absolutely required and non-negotiable are designated minimum requirements, and those that are beneficial to and strongly preferred by the Plan, but not necessarily essential or critical, are designated as technical requirements.

9. The Plan's RFPs contain the contract terms between the Plan and the vendor whose response (proposal) is selected. After competing proposals are evaluated, the selected vendor's response to the RFP (including its responses to the "minimum requirements" and "technical requirements," and its cost proposal) are attached to the RFP and become part of the contract. As a result, a vendor's responses to the RFP requirements are binding contractual obligations if its proposal is accepted and is signed by the vendor upon submission as confirmation of this fact.

10. Minimum requirements and technical requirements in previous RFPs (including the 2019 RFP for the TPA contract) described the Plan's requirements and included open-ended questions asking vendors to provide certain information, describe how the vendor would meet the Plan's requirements, and/or describe any limitations on its ability to meet the Plan's requirements. The resulting proposals were consistently very long, narrative discussions with subjective or vague language, and included voluminous attachments and materials that the Plan's evaluation committee had to review and assess.

11. In addition, competing vendors frequently responded to the same requirements differently, and included different forms of supporting information, which required subjective judgments as to whether and to what extent each vendor met each requirement.

12. As a result, evaluating and scoring RFPs was extremely time consuming for the evaluation committees. The Plan has limited staff, and the time commitment to evaluate multiple RFPs per year significantly reduced the staff's ability to meet their other responsibilities, and made some staff reluctant to participate on evaluation committees. Further, the necessity of parsing

narrative responses also made reaching consensus difficult, resulted in disagreements and tension between committee members, introduced bias and subjectivity, and made it difficult to ensure that competing proposals were evaluated fairly and consistently.

13. Further, the Plan experienced multiple issues and disputes in the past when vendors (including Blue Cross) resisted performance of contract requirements, by relying on equivocal, subjective, and/or vague language in their RFP narrative responses.

14. Therefore, my goals in the modernization effort for RFPs included:

- a. Improving objectivity in evaluating and scoring RFP responses, to ensure fairness and consistency;
- b. Avoiding equivocation and subjectivity in RFP responses that could undermine vendors' contractual obligations;
- c. Simplifying and shortening the RFP evaluation process, reducing the time commitment by Plan staff serving on the evaluation committee;
- d. Reducing difficulty in parsing subjective narrative responses and stress on the evaluation committee to reach consensus; and
- e. Reducing reluctance of Plan staff to serve on evaluation committees.

15. By approximately March 2022, Plan leadership had reached consensus to implement a two-choice format for minimum requirements and technical requirements, in which each of the Plan's requirements was stated, and vendors could choose "confirm" (agree to meet) that requirement or "does not confirm" (does not agree to meet) that requirement. Vendors would not be asked *or allowed* to respond with narrative language that could undermine or complicate their responses.

16. Plan leadership decided it was acceptable to forego vendors' written explanations of how the vendor would meet requirements. The Plan's contracts typically include an implementation period before the contract term begins in which the Plan's staff and vendors collaborate to develop processes, integrate their systems, and ensure that all contract requirements are met. These process details are finalized in an administrative decision memo between the Plan and a vendor.

17. Further, because the RFP responses are binding contract terms, the vendor assumes responsibility to meet each requirement. In the event a vendor ultimately cannot or does not meet a given requirement, the Plan can exercise contractual remedies, including performance guarantees, termination of a contract, and/or suing the vendor for breach of contract and damages or specific performance. The objective format for the RFP requirements therefore shifts more of the risk of non-performance to the vendor compared with the earlier, narrative format.

18. Also, narrative responses describing how requirements would be met are not always effective in preventing nonperformance. The Plan has had instances with past RFPs where a vendor that provided narrative responses was still unable to perform contract requirements.

19. The Plan's leadership considered the concerns of some Plan staff about doing away with narrative responses. The quote on page 3 of Blue Cross's Motion to Compel (from page SHP 0025036 of the Plan's discovery document production) was a June 8, 2022 comment by Vanessa Davison on an early draft of technical requirements. Ms. Davison was not the Plan's Director of Procurements and Contracts as the Motion states. Ms. Davison was one of the Plan's Contracting Agents, which are not part of the Plan's leadership team. Regardless, I was aware of and considered concern at the time. However, the Plan's leadership decided that the benefits of

not accepting narrative responses resolved or outweighed the types of concerns Ms. Davison raised for the reasons discussed above.

20. The Plan first used the modernized, non-narrative format for RFP responses in an RFP issued in May 2022 for its pharmacy benefits management audit contract. The 2022 TPA RFP that is the subject of this contested case was the second RFP in which the Plan used the modernized format.

21. From the beginning of the drafting process for the 2022 TPA RFP in approximately April 2022 until it was completed and publicly posted for vendors on August 30, 2022, all drafts followed the modernized, non-narrative format.

22. The 2022 TPA RFP clearly stated that that narrative responses to the minimum requirements and technical requirements would not be accepted (See RFP Attachment K (Minimum Requirements), Attachment L (Technical Proposal)).

23. The 2022 TPA RFP also called for cost proposals in which Vendors were required to identify their network of healthcare providers under contract or binding letters of intent, and to quantify their network pricing. The Plan did not require vendors to submit copies of such contracts or letters of intent to validate or verify their networks or pricing, in part because the cost proposal (which determines the cost of healthcare services incurred by the Plan for its members) is also a binding contract term, for which the Plan has contractual remedies if the approved vendor cannot meet. Not requiring such supporting documentation for the cost proposals was not new. Prior TPA RFPs (including the most recent TPA RFP in 2019) required no such documentation.

24. The Plan also did not require vendors to submit provider contracts and/or letters of intent because the Plan had insufficient staff and time to review or verify contracts or letters of

intent for many thousands of healthcare providers per vendor, and each vendor's network pricing was accompanied by a certified actuarial opinion. Further, the Plan would likely discover any misrepresentation of a vendor's provider network during the implementation period, which would greatly harm the vendor's reputation, especially if the misrepresentation were intentional, and the Plan could have remedies for fraudulent misrepresentation or other claims. Accordingly, consistent with past TPA RFPs, the Plan considered it reasonable to rely on the networks and network pricing in the vendors' cost proposals.

25. The Plan staff and the State Treasurer held a phone call with all interested vendors September 1, 2022 in which the new format of the RFP was discussed, including the prohibition on narrative responses to the technical and minimum requirements, and vendors were invited to ask questions. In addition, before the RFP was made public, the Plan invited prospective vendors to meet with our Director of Contracting and Compliance and me about the upcoming TPA RFP. We held several meetings with individual vendors between June and August 2022, including Blue Cross, in which we explained the non-narrative format and the Plan's reasons for the change.


26. The 2022 TPA RFP also allowed for two rounds of written questions from interested vendors before the submission of responses, and specifically urged vendors to raise any questions, issues or exceptions to the RFP and/or any desired modification of the terms and conditions of this solicitation during the question period. (RFP Section 2.3). The RFP stated that "If the State determines that any changes will be made as a result of the questions asked, then such decisions will be communicated in the form of an Addendum." (RFP Section 2.3)

27. No vendor objected to the non-narrative format of the RFP during either the Sept. 1 phone call or the individual meetings with vendors in June-August 2022, and no vendor raised

any questions, exceptions, or desired modification to the RFP format (including the non-narrative format and the information requested in the cost proposals) during the written question and answer periods. Accordingly, no changes were considered or made to require different or additional information or documents from vendors in response to the 2022 TPA RFP.

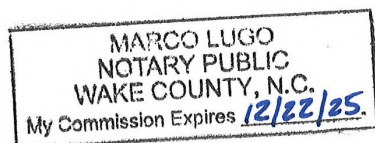

Dorothy C. Jones

Sworn to and subscribed before me this the 16th day of June, 2023.


Notary Public

My Commission Expires: 12/22/2025

[NOTARIAL STAMP OR SEAL]



STATE OF NORTH CAROLINA
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**SECOND AFFIDAVIT OF DOROTHY C.
JONES IN SUPPORT OF
RESPONDENT'S MOTION FOR
SUMMARY JUDGMENT**

I, Dorothy C. Jones, being duly sworn, depose, and say:

1. I am over eighteen years of age and am competent to make this affidavit. I have personal knowledge of the matters addressed in this affidavit.
2. I was employed by the North Carolina Department of State Treasurer and appointed as Executive Administrator of the North Carolina State Health Plan for Teachers and State Employees (the "Plan") from June 2017 until December 16, 2022.
3. As Executive Administrator, I was responsible for the Plan's contracting activities with outside vendors. One significant component of the Plan's contracting activity is preparing, issuing, and evaluating requests for proposals ("RFPs") to select which vendors will be awarded contracts by the Plan. The Plan routinely conducted several RFPs per year, for a wide range of services and vendors, and routinely had several RFPs ongoing in various stages at any given time.

4. In competitive contract procurements, including RFP processes, multiple companies can submit proposals (also called “bids”) to the procuring entity, which decides which, if any, of the proposals are responsive to the requirements and will be accepted. Entities submitting proposals are commonly referred to as “vendors” or “bidders.”

5. The Plan’s third-party administrator (“TPA”) is one major type of vendor with which the Plan contracts. The Plan’s TPA provides administrative services to support the Plan’s core medical claims operations. I served as Executive Administrator for the Plan during the development and drafting of Request for Proposals # 270-20220830TPAS (the “RFP”), which is the subject of this contested case, as well as the previous TPA RFP in 2019 and for part of the evaluation period of the Plan’s 2016 TPA RFP. I remained in this role throughout the evaluation of the proposals submitted and the decision by the Plan’s Board of Trustees to award the TPA contract in December 2022.

6. I have been involved in three third-party administrator (“TPA”) procurements for the North Carolina State Health Plan (the “Plan” or “SHP”).

7. N.C. Gen. Stat. § 135-48.23(c2) authorizes the Plan’s Executive Administrator to contract with third parties as needed to carry out her responsibilities. Certain contracts worth more than \$1,000,000 must be submitted for review by the N.C. Attorney General or his designee, and all contracts over \$3,000,000 (such as the TPA Contract) must be approved by the Plan’s Board of Trustees. N.C. Gen. Stat. § 135-48.33.

8. The Plan’s authority for procuring goods and services is very flexible. There are no administrative rules governing the Plan’s procurement or RFP processes. While some of the Plan’s contracts are subject to the procurement procedures of the North Carolina Department of

Administration (“DOA”), certain contracts, including the TPA contract, are exempt from DOA procedures and oversight pursuant to N.C. Gen. Stat. § 135-48.34.

9. The Plan has an internal contract procurement policy and procedure (SHP-POL-2001-SHP), but the Policy is not an administrative rule and is not mandatory. Instead, the Policy is a guideline created by the Plan to help promote continuity, consistency, and fair and impartial procurements. The policy is generally followed, but the Plan may deviate from the policy when circumstances warrant. (Dep. Ex. 4).

10. Blue Cross and Blue Shield of North Carolina (“Blue Cross”) is the incumbent TPA. The current TPA contract with Blue Cross, awarded in a 2019 procurement (“2019 TPA Contract”), has a three-year term, from January 1, 2022, until December 31, 2024, with two optional one-year extension periods.

11. In approximately April 2022, the Plan leadership and the Treasurer decided not to exercise the optional renewals in the 2019 TPA Contract and to put the TPA contract out for bid again in 2022, as a result of problems the Plan was having at the time with Blue Cross’s performance under the 2019 TPA Contract. Doing so meant the 2019 TPA Contract would expire on December 31, 2024, and that the new TPA contract would have to be ready by January 1, 2025.

12. The plan works on a calendar year basis, and the implementation of a TPA contract typically takes about two years after the contract is awarded. Consequently, to have a new TPA contract ready by January 1, 2025, the Plan needed to issue an RFP, evaluate the responses, and award the TPA contract by the end of 2022. Doing so would allow the necessary two years to implement the new TPA contract.

13. It is not unusual for the Plan to conduct procurements far in advance of the date services will begin under a new contract because of the large number of procurements that must be managed, limited staff to conduct procurements, and long implementation periods. TPA contracts in particular require long implementation periods.

14. The decision to put the TPA contract out for bids without exercising the optional renewals did not mean that Blue Cross could not or would not be awarded the new TPA contract. In fact, the last two TPA contract procurements (RFPs issued in 2016 and 2019) were conducted during the first year of the then-current TPA contract (both of which also had a three-year term and optional renewal periods that were not exercised), and Blue Cross was the approved bidder in both. Regardless of whether the new contract was awarded to another vendor or to Blue Cross, the Plan intended for the RFP to result in a contract with different and more favorable terms than the current 2019 TPA Contract.

15. The RFP was designed and drafted by the Plan staff, with input from its actuarial services contractor, the Segal Company (“Segal”), between approximately April and August 2022.

16. All of the Plan leadership that participated in the design and drafting of the RFP, including me, Caroline Smart, Kendall Bourdon, and Matt Rish, had worked on numerous earlier RFPs for the Plan, including at least one prior TPA RFP. Also, before I became the Plan’s Executive Administrator, I served as Chief Operating Officer at the NC Department of Administration from February 2013 to October 2014. In that role I oversaw procurements and the State’s Chief Procurement Officer reported to me.

17. Segal is a consulting company that was engaged to provide assistance and support for the RFP under its actuarial services contract. Segal is considered an industry expert in public health plan procurements, including state health plan TPA contracts. Segal was engaged primarily

to help design the cost proposal component of the RFP, manage and provide data to the bidders for their use in the claims repricing component of the cost proposal, and to evaluate and score the bidders' cost proposals. Segal had also done similar work the Plan's TPA procurements in 2016 and 2019.

18. The design and drafting of the RFP was a large undertaking for the Plan, which required hundreds of hours of collaborative work from numerous Plan staff and consultants from Segal over a period of approximately five months between April and August 2022. The RFP document and its various attachments went through numerous drafts and revisions by groups of Plan employees and/or Segal personnel. I had overall responsibility for the RFP, but the design and drafting of the RFP were a collective effort and generally based on consensus among the experienced Plan leadership and Segal consultants involved.

19. The RFP provided that proposals would be submitted by bidders and evaluated in two phases. First, minimum requirements proposals were due by September 26, 2022. Vendors that met the minimum requirements were notified by September 29, 2022, and allowed to submit technical proposals and cost proposals by November 7, 2022. Any vendor who did not would be disqualified from further consideration. (RFP Section 2.6.1).

20. The second phase included a technical proposal and cost proposal. The technical proposal consisted of 310 "requirements" or specifications desired by the Plan. Each of the technical requirements followed the modernized, non-narrative format in which bidders could only confirm or not confirm each requirement, and narrative responses were not permitted. (*See* Dep. Ex. 37, RFP, Attachment L).¹

¹ The Plan's decision to adopt the modernized, non-narrative format was described in detail in my previous affidavit dated June 23, 2023.

21. The cost proposal component required bidders to submit a series of attachments with pricing data,² provider network data, the vendors' proposed administrative fees and network pricing guarantees, and other information. (*See* RFP, pp. 81-85, Attachment A).

22. The evaluation criteria and scoring of the technical and cost proposals are described in detail in RFP Section 3.4, which stated the following:

- The Technical Proposal and Cost proposal would each receive 50% of the weight in the final score. (RFP Section 3.4(a)).
- The Technical Proposal (which included 310 technical requirements to be confirmed or not confirmed) would be scored on a 310-point scale divided into 11 technical areas. The RFP stated that the bidders would be ranked, with the highest-ranked technical proposal(s) receiving most points (*i.e.*, the highest-ranked cost proposal out of three bidders would receive 3 points, and the lowest-ranked would receive one point). (RFP Section 3.4(b)).
- Cost proposals would be scored using a 10-point scale, based on three components. (RFP Section 3.4(c)):
 - Network pricing – up to 6 points
 - Administrative fees – up to 2 points
 - Network pricing guarantees – Up to 2 points
- Cost proposals would be ranked, with the highest-ranked cost proposal(s) receiving the most points. (RFP Section 3.4(c)).

23. The scoring methodology and weighting in section 3.4 of the RFP were decided by consensus by Kendall Bourdon, Matt Rish, Caroline Smart and me, with input from Segal on certain aspects. We decided to give the cost proposal and the technical proposal equal, 50/50 weight in the overall scoring because we expected that the cost differential between the bidders would not be very significant compared to the Plan's overall expenditures, and we were also confident that the likely bidders (who were all large carriers with broad provider networks in North

² Pricing data was submitted in the form of a "claims repricing" in which vendors were directed to reprice the Plan's historical claims data from 2021 based on reimbursement rates agreed-upon between the vendor and healthcare providers. (RFP p. 83, Attachment A, Section 1.2.1).

Carolina) were all capable of performing the TPA's responsibilities. In the prior 2019 TPA procurement the technical proposal was weighted 60%, but in this RFP we thought Blue Cross may choose not to confirm some technical requirements based on our experience with Blue Cross. Therefore, to avoid disadvantaging Blue Cross, we reduced the weight of the technical proposal from 60% to 50%.

24. We also decided by consensus to rank the bidders' cost proposals, to separately rank the bidders' technical proposals, and to base the bidders' overall scores on the combination of those two ranks. That method of ranking and scoring the proposals would enable us to easily give the technical and cost proposals equal 50/50 weight and would clearly differentiate between the bidders even if the scoring of the technical and cost proposals were close, as we expected them to be.

25. Our consensus regarding the scoring of network pricing (via the Claims Repricing exercise) was to establish percentage ranges (which we referred to as a "bullseye") so that a bidder whose pricing was within 0.5% of the bidder with the lowest pricing would receive the same number of points. Because medical claims are the overwhelming majority of the Plan's costs, and because the bidders' network pricing had historically been very close, we believed a proposal that was not the best should still be competitive if there was only a relatively small difference between it and the proposal with the best pricing.

26. Potential Bidders had multiple opportunities for questions and feedback to the Plan regarding the 2022 RFP. In Spring 2022, before the RFP document was released, the Plan notified all expected bidders (including Blue Cross, Aetna Life Insurance Company ("Aetna"), and UMR,

Inc. (“UMR”), and Cigna³), that an RFP for the TPA contract would be issued. The Plan also initiated meetings with each bidder to discuss the upcoming RFP. Blue Cross’s pre-RFP meeting was held in June 2022 and was attended by Roy Watson and Aimee Forehand for Blue Cross. All bidders were told at these meetings about the modernized RFP format and that narrative responses would not be allowed. Bidders were invited to ask questions and give their input on the RFP process. No bidder objected or expressed any concerns, and some bidders said the new format was great and much easier than a narrative format.

27. Sections 2.4 and 2.5 of the RFP allowed two periods for bidders to submit written questions regarding the RFP, after the RFP was posted and before proposals were due (one period before minimum requirements proposals were due and another before technical proposals and cost proposals were due). Under Section 2.3, bidders were urged and cautioned to raise any issues, exceptions, and/or requests to modify any of the RFP’s terms, conditions or components through this question and answer process. If the plan determined that any changes to the RFP would be made as the result of questions, it would communicate the change through an addendum.

28. A number of Questions were submitted by bidders during the question and answer period, all of which were timely responded to by the Plan in addenda, pursuant to Section 2.5 of the RFP. None of the bidders raised any concerns or objections to the non-narrative format during the question periods. (*See* Dep. Ex. 43, 44).

29. The Plan selected an Evaluation Committee for the 2022 RFP consisting of seven voting members from the Plan’s staff (“Evaluation Committee”). They were assisted by four non-voting members, including the Plan’s actuary, two in-house counsel and me (the Executive

³ Cigna did not submit a proposal in response to the RFP.

Administrator). An additional four members of the Plan's contracting and compliance organization also advised and assisted the Evaluation Committee. (Dep. Ex. 15).

30. Minimum requirements proposals were submitted by Blue Cross, Aetna and UMR in response to the RFP. The Evaluation Committee met on September 27 and September 30, 2022, and determined that all three bidders met the minimum requirements, as documented in the Evaluation Summary prepared by the Plan. (SHP 0004568-0004573 ("Evaluation Summary")).

31. Technical Proposals and Cost Proposals were submitted by all three bidders in the second phase, on November 7, 2022, and were evaluated and scored as set forth in RFP section 3.4.

32. The Evaluation Committee met and reviewed and scored the Technical Proposals at its November 8, 2022 meeting. (Evaluation Summary). Aetna and UMR both confirmed all 310 technical requirements, and each received 310 points. However, Blue Cross confirmed only 303 requirements and therefore received 303 points.

33. Pursuant to RFP Section 3.4(b), the bidders were ranked in descending order. Aetna and UMR, who tied with 310 points each, both received the highest rank of three. Blue Cross received the lowest rank of one.

Vendor	Final Technical Points	Final Technical Proposal Rank
Aetna	310	3
Blue Cross NC	303	1
UMR	310	3

34. Meanwhile, Segal analyzed and scored the vendors' cost proposals. Blue Cross and Aetna each received 8 points out of 10, and UMR received seven points out of ten. Consistent with RFP Section 3.4(c), the bidders were ranked. Blue Cross and Aetna both received the highest rank of three, and UMR received the lowest rank of one. (Dep. Ex. 413).

35. Segal presented its analysis and scoring of the cost proposals to the Evaluation Committee at the committee's November 30, 2022 meeting. After reviewing Segal's analysis and asking any questions the committee members had, the Evaluation Committee agreed with and accepted Segal's evaluation and scoring. (Dep. Ex. 413; Evaluation Summary).

36. Giving the Technical Proposal and Cost Proposal equal weight as stated in Section 3.4(a) of the RFP, Aetna received the highest combined technical and cost rank (6 points total), and Blue Cross and UMR tied at 4 points total. (Evaluation Summary). In order to weigh the cost proposal and the technical proposal equally, the Plan simply added each bidder's technical proposal ranking (1-3 points) to its cost proposal ranking (1-3 points), to arrive at a total score of 2-6 points for each bidder.

Vendor	Final Technical Proposal Rank	BAFO #1 Cost Proposal Rank	Final Technical Proposal and BAFO #1 Cost Proposal Rank
Aetna	3	3	6
Blue Cross NC	1	3	4
UMR	3	1	4

37. Based on the evaluation and scores described above, the Evaluation Committee unanimously voted to recommend awarding the TPA contract to Aetna but to present all three proposals to the Plan's Board of Trustees for consideration at the Board's December 14, 2022, meeting. The Evaluation Committee's recommendation was documented in a memo dated December 14, 2022. (Dep. Ex. 15). The Evaluation Process was also documented in detail in an internal Plan Memorandum. (Evaluation Summary).

38. Because the Evaluation Committee presented all three proposals to the Board of Trustees, the Treasurer directed that all three proposals be submitted for review by the North

Carolina Department of Justice, as required pursuant to N.C. Gen. Stat. § 135-48.33(b) for certain contracts worth more than \$1,000,000. All three proposals were subsequently approved by the Department of Justice.

39. All three proposals were presented to the Plan's Board of Trustees in executive session at the Board's December 14, 2022, meeting, which I attended along with the Plan's leadership staff and the Department of State Treasurer's leadership staff. Kendall Bourdon, the Plan's Director of Contracting and Compliance, gave a presentation describing the contract modernization strategy and process (including the non-narrative format of the technical proposals), the development of the 2022 RFP, and the evaluation and scoring of the RFP. Ms. Bourdon also presented the Evaluation Committee's recommendation. (Dep. Ex. 14). The presentation and discussion were also documented in minutes from the executive session. (Dep. Ex. 294 (Exec. Session Minutes)).

40. After Ms. Bourdon's presentation, the Trustees engaged in a robust discussion of the proposals with extensive questions from the Trustees to the Plan's leadership. Following this discussion, the Board unanimously voted to award the TPA contract to Aetna. (Dep. Ex. 294 (Exec. Session Minutes)).

41. Pursuant to Sections 2.8(l), 3.3(a), and 4.13 of the RFP, the Plan may request clarifications and/or oral presentations from bidders in the RFP process but is not obligated to do so.

42. The Plan did not request any oral presentations in connection with the RFP. The Plan is familiar with the vendors that bid in response to the RFP and expected each of them could meet the minimum requirements. Also, in the past, oral presentations tend to be mostly marketing information, which the Plan leadership believes had little value.

43. The Plan also did not request any clarifications regarding the bidders' technical proposals. The bidders' responses to the technical requirements (either "confirmed" or "not confirmed" as to each) were unequivocal, and thus the Plan saw no need to request clarifications or invite oral presentations from any bidder.

44. The documents referred to in this Affidavit and attached to the Appendix filed contemporaneously herewith, identified in the below table, are correct and true copies:

Deposition Exhibit No.	Bates Nos.	Description
4	SHP 0092221-0092231	Contract Procurement Policy and Procedure, SHP-POL-2001-SHP, 9.12.2022
14	SHP 0024050-0024063	Presentation to 12.14.2022 Meeting of State Health Plan Board of Trustees Meeting
15	SHP 0025420-0025425	Evaluation Committee Recommendation Memo 12.14.2022
37	Blue Cross NC_0000670 - 0000716	Blue Cross Technical Proposal (RFP Attachment L)
43	NA	RFP Addendum 1, Responses to Questions, 9.16.2022
44	Blue Cross NC_0000633 - 0000644	RFP Addendum 2, Responses to Questions, 10.14.2022
294	SHP 0075511-0075512	Minutes – State Health Plan Board of Trustees Meeting, Executive Session, 12.14.2022
413	SHP 0085912-00085925	Segal Cost Proposal Analysis, Reflects Clarifications and BAFO #1, 11.29.2022
NA	SHP 0004568-0004573	Summary of the Evaluation Process Memo, 12.7.2022 ("Evaluation Summary")

45. Based on my personal knowledge and involvement in the 2022 TPA procurement, and everything I have seen and heard since, I believe the procurement was conducted properly and fairly by the Plan and its contractor Segal, and that they acted fairly, carefully, diligently and in

good faith at all times. I am not aware of any violation of any legal requirements by the Plan or Segal, and I believe that they acted appropriately and within their authority and discretion throughout the procurement.

Further, the affiant sayeth not.

[SIGNATURE ON FOLLOWING PAGE]


STATE OF NORTH CAROLINA)
)
COUNTY OF WAKE)



Dorothy C. Jones

Sworn to and subscribed before me this, the 14th day of December 2023.





Notary Public Annette K Buss

My Commission Expires: 8/29/2028

CERTIFICATE OF SERVICE

The undersigned does hereby certify that a true and correct copy of the foregoing document was served upon counsel for all parties at the addresses indicated below in accordance with the North Carolina Rules of Civil Procedure and the Rules of the Office of Administrative Hearings by electronic mail as follows:

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This, the 15th day of December 2023.

/s/ Marcus C. Hewitt

Marcus C. Hewitt

STATE OF NORTH CAROLINA

DURHAM COUNTY

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.)

**AFFIDAVIT OF STEPHEN KUHN IN
SUPPORT OF RESPONDENT'S MOTION
FOR SUMMARY JUDGMENT**

I, Stephen Kuhn, being duly sworn, depose, and say:

1. I am over eighteen years of age and am competent to make this affidavit. I have personal knowledge of the matters addressed in this affidavit.

2. I am a vice president and health benefits consultant with The Segal Company (Eastern States), Inc. ("Segal"). I have been employed by Segal since 1999 and my responsibilities include consulting to group health plans, including large public employers. This work includes, but is not limited to, projecting healthcare costs and conducting procurements for medical plan administration.

3. Segal has served as a contractor for the North Carolina State Health Plan for Teachers and State Employees (the "Plan") plan for approximately 14 years, and has assisted the

Plan in numerous requests for proposal (“RFPs”), including several previous RFPs for the Plan’s third-party administrator (“TPA”) contract.

4. Segal was engaged to provide assistance and support for the Plan’s 2022 TPA RFP (the “RFP”) under its contract with the Plan for actuarial services. Segal was engaged primarily to help design and to evaluate the cost proposal, manage and provide data to the bidders for the claims repricing component of the cost proposal, and also to evaluate and score the bidders’ cost proposals. Segal is an industry expert in public health plan procurements.

5. I led Segal’s work on the cost proposal for the 2022 TPA RFP. In my employment with Segal, I serve as a consultant to numerous state health plans doing similar work, and have worked on dozens of RFPs in my career.

Segal’s Evaluation and Scoring of Cost Proposals

6. Section 3.4(c) of the RFP provided that cost proposals would be evaluated and scored using a 10-point scale, based on three components:

- Network pricing – up to 6 points
- Administrative fees – up to 2 points
- Network pricing guarantees – up to 2 points

7. Cost proposals were received from the bidders on November 7, 2022. At Segal’s recommendation, the Plan issued a series of clarifications to the bidders between November 10-November 28, 2022, to clarify the basis for their claims repricing exercise, which was the basis for scoring network pricing, and make sure that the vendors were being compared fairly. (Dep. Ex. 30-35). These clarifications are discussed in more detail below. Partway through these clarifications, on November 17, 2022, Segal presented a preliminary cost proposal analysis to the plan (Dep. Ex. 17) which recommended further clarifications to the vendors to confirm their claims repricings as there was concern the results were not comparable.

8. In addition, on November 18, 2022, the Evaluation Committee voted to request “best and final offers” (“BAFOs”) from all bidders in accordance with the RFP schedule and as allowed by RFP Section 3.3(a). The request for BAFOs invited all bidders to improve their proposed administrative fees and network pricing guarantees. (SHP 4568 (“Evaluation Summary”) at 4571); SHP 004447-SHP 004450 (“Request for BAFO #1”). It is common for the Plan and other public health plans to request at least one BAFO from bidders in the course of an RFP process.

9. After additional clarifications and the bidders’ BAFOs were received and evaluated, Segal completed its final analysis of the cost proposals on November 29, 2022. (Dep. Ex. 413).

10. Blue Cross and Aetna both received six points out of six for network pricing. Aetna’s network pricing (total claims cost of \$9.639B) was slightly lower than Blue Cross’s (\$9.684B), but Blue Cross’s pricing was within 0.5%, and therefore both received six points as stated in RFP Section 3.4(c)(1). (Dep. Ex. 413, p. 5).

11. In the administrative fees component, worth two points, Blue Cross’s administrative fees for the three-year contract term were lowest, and Aetna’s were next lowest, followed by UMR with the highest fees. Blue Cross therefore received two points, Aetna one point, and UMR zero points, consistent with RFP Section 3.4(c)(2). (Depo. Ex. 413, p. 6).

12. For the pricing guarantees component, worth two points, Segal analyzed the relative value of the bidders proposed network pricing guarantees based on each bidder’s proposed guarantee targets and the amounts each placed at risk if its targets were not met, consistent with RFP Section 3.4(c)(3) Segal conducted a detailed comparative analysis as shown in its cost proposal analysis (Dep. Ex. 413, pp. 7-8). Accordingly, Segal determined that UMR’s

guarantees provided the most value (awarded two points); Aetna’s pricing guarantees were second (awarded one point), and Blue Cross’s guarantees provided the least value (awarded zero points). (Dep. Ex. 413, pp. 7-8).

13. Combining the scores for all three components of the cost proposal, Blue Cross and Aetna tied at 8 points out of 10, while UMR received seven points. Pursuant to RFP Section 3.4(c), UMR was ranked lowest, and received one point out of three, while Aetna and Blue Cross, who tied with eight points each, both received three points out of three. (See Dep. Ex. 413, p. 4)

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

14. Segal presented its final cost proposal analysis to the Evaluation Committee on November 30 (Dep. Ex. 413). The Evaluation Committee agreed with and accepted Segal’s evaluation and scoring. (SHP 04568 (Evaluation Summary)).

Evaluation and Scoring of Network Pricing (Claims Repricing Exercise)

15. As stated in the RFP, bidders’ network pricing (worth 6 out of 10 points on the cost proposal) was evaluated using a claims repricing exercise, where bidders were given a data file of all medical claims incurred by the Plan in 2021 and directed to “reprice” those claims by providing “the contracted allowed amount for each service in the file ... based on [that bidder’s] provider contracts in place, or near-future contract improvements bound by letters of intent, at the time of the repricing.” (RFP p. 24-25, Section 3.4(c), p. 83, Section 1.2.1]

16. The instructions to reprice the claims file based on provider contracts in place or “near-future contract improvements bound by letters of intent” was intended to capture

improvements in agreed-upon pricing between bidders and healthcare providers conditioned on the bidder being awarded the TPA contact.

17. For that reason, bidders were not directed or expected to “trend” (assume an increase) in billed charges. Instead, billed charges were fixed at the actual amount billed in 2021 as shown in the claims repricing file that was provided to the bidders. The claims repricing exercise was intended to allow the Plan and Segal to determine the relative value of the claims based on each bidder’s current contracted rates and letters of intent or contract improvements, not including any artificial or “manufactured” improvements based on increasing charges.

18. The purpose of the claims repricing was to compare the bidders' network discounts (sometimes called “pricing”) on a fair, “apples-to-apples” basis. However, after the submission of cost proposals on November 7, 2022, Segal was concerned that the bidders’ repricing methodologies were not “apples to apples” and would not allow for a fair comparison.

19. The Plan and Segal had questions about the bidders’ repricing as there appeared to be potential inconsistencies in their approaches. Blue Cross’s claims repricing indicated a discount that was higher than expected in comparison to the discounts achieved in 2021, and UMR’s response to Attachment A-6 (regarding its projected discounts through 2025), indicated that those same discount improvements were included in its claims repricing. Thus, for different reasons, Blue Cross’s and UMR’s cost proposals suggested to Segal that Blue Cross and UMR may have assumed billed charge increases, inconsistent with the RFP’s directions.

20. Because Segal was concerned that the vendors’ repricing methodologies could not be compared apples to apples, Segal and the Plan sent a series of clarifications (as allowed by the RFP) to the bidders.

21. The clarifications asked the bidders to (a) quantify their current network discount percentage, and (b) itemize the additional discounts that factored into its claims repricing (i) based on letters of intent, and (ii) based on other contractual improvements. Bidders were also separately asked to identify any discount improvements that resulted from assumed increases in billed charges (which were not to be included in the claims repricing), in order to confirm if any bidders had improperly assumed charge increases that would artificially inflate its discounts. (See Depo. Exs 32 (Blue Cross Clarification #4) and 256 (Aetna Clarification #5).

22. Aetna's response to the clarifications did not indicate that Aetna's claims repricing assumed any increases in billed charges. (see SHP 087964 – SHP 087965 (Aetna Clarification #4), Dep. Ex. 256 (Aetna Clarification #5)). In contrast, Blue Cross's clarification #3 (and several subsequent clarifications) confirmed that Blue Cross had assumed billed charges would increase, and this assumption increased its discount percentage by over one percent. (See Dep. Ex. 30-35).

23. In response, Segal informed Blue Cross that its assumed charge increases were contrary to the RFP instructions. (Dep. Ex. 32 (Blue Cross Clarification #4)). In several subsequent clarifications, Segal asked Blue Cross to identify its discount based on the RFP instructions without including increases based on assumed charge increases. (Dep. Ex. 33-34). Ultimately, after failing to obtain a clear response from Blue Cross in several clarifications, Blue Cross confirmed that its current discount was 52.7%. (Dep. Ex. 35 (Blue Cross Clarification #7)). Segal, having already confirmed that Blue Cross's near future contract improvements were impermissibly based on increased charges, adjusted Blue Cross's discount downward to the 52.7% discount confirmed by Blue Cross which was the discount that could be fairly measured to the other two bidders.

24. After adjusting Blue Cross's discount percentage to 52.7% as confirmed by Blue Cross (and after adjusting UMR's discount % to reflect the correct percentage confirmed by it), the Plan calculated projected claims cost for each bidder based on its adjusted network discount percentages. (See Dep. Ex. 413, p. 5).

25. To summarize, Segal adjusted Blue Cross's and UMR's claims repricing results after both confirmed in response to clarifications that they had assumed future increases in billed charges, which Segal determined was contrary to the RFP's instructions and which improperly inflated their network discounts. (see Dep. Ex. 413, p. 5; Dep. Ex. 30-35).

26. Aetna's claims repricing did not raise any questions or appear inconsistent with the RFP's directions; however, Segal requested clarifications #4 and #5 from Aetna to ensure its consistency with the RFP's directions. Once Aetna confirmed that its claims repricing did not assume increases in billed charges, Segal had no concerns and saw no need to question Aetna's claims repricing. If Segal had questions or concerns about Aetna's claims repricing, Segal would have recommended further clarifications be requested from Aetna.

Evaluation and Scoring of Pricing Guarantees

27. The RFP provided that pricing guarantees (worth 2 out of 10 points on the cost proposal) would be compared to determine their relative value to the Plan, and that value would be evaluated based on the competitiveness of the guaranteed targets and the amount placed at risk (RFP, p. 25, Section 3.4(c)(3)). Pricing guarantees provide a health plan protection against higher claim costs and also indicate a bidder's confidence with its submitted proposal and its level of commitment to a client in controlling plan costs. The guarantee target is the specific value the bidder is offering to achieve for the plan, for example a claims discount of at least 50% or a claims trend increase of no greater than 5%. The amount at risk is how much of its own

money the bidder is willing to repay to the plan if it does not meet its guarantee targets, and for medical TPA contracts it is typically a percentage of the bidder's administrative fee.

28. The Plan initially asked Segal to provide a model for scoring the pricing guarantees in October 2022, but Segal determined and informed the Plan that Segal could not provide a model or determine how to compare guarantees in advance, because the structure of bidders' pricing guarantees were likely to vary considerably. Because the bidders' guarantees were to be compared and ranked, the scoring would necessarily be comparative and subjective, and the specific manner of analyzing the guarantees should be determined after the proposals were received (*see* SHP 0085692-SHP 085694, at SHP 085694). The Plan agreed with this approach.

29. If Segal had developed a template or model to score pricing guarantees before proposals were received, it would have been very likely that one or more of the proposed guarantees would not have fit the model, which would then require Segal to change the model or the guarantees could not have been compared, which is more problematic.

30. After the cost proposals were received, Segal conducted an extensive analysis that quantified the guarantee targets and the amounts placed at risk by each vendor, with respect to both discount guarantees and trend guarantees, ranked the discount guarantees and trend guarantees in order of relative value, and included a narrative explanation of the reasons for its ranking. (Dep. Ex. 413, pp. 7-8).

31. Segal quantified and compared the bidders' discount targets and amounts at risk for 2025, the first year of the contract. For a new TPA contract, the discount guarantee is particularly important in the first contract year because it may provide a level of protection from downside risk (or increased claims cost) and, as mentioned above, it may indicate the level of

confidence a bidder has with its claims repricing and in initially maintaining competitive discounts. After the first contract year, trend guarantees become more important than discount guarantees because they protect the Plan against increases in claims cost year over year. Discount guarantees provide less protection from cost increases after the first contract year because, if charges billed by providers increase, then total claims cost can also increase without causing the discount percentage to decrease.

32. Segal determined that Blue Cross's discount guarantees and trend guarantees had the least comparative value of all three bidders, mostly because Blue Cross put much less money at risk than either of the other bidders. For example, Segal determined that Blue Cross put only 5% of its 2025 administrative fee (which amounts to \$2,653,000) at risk for its discount guarantees, and the same amount at risk for its trend guarantee. Aetna and UMR each put far more money at risk, both as a percentage of their fee and in terms of dollars. Although Blue Cross's guarantee targets were somewhat more aggressive than Aetna's or UMR's, they were outweighed by the very low amount Blue Cross put at risk.

33. Segal's determination that Blue Cross put only 5% of its fee at risk for its discount guarantee was based on the language of its proposed guarantee, which stated that all three categories of its discount guarantees were "subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to in-state member, exclusive of fund administration fees and optional services fees." (Dep. Ex. 225).

34. I was asked at deposition if Blue Cross meant to put 5% of its fee at risk for each of the three categories of its discount guarantees (15% total). I did not read Blue Cross's proposal to offer three separate 5% caps. In my experience, a vendor offering 15% at risk for its discount guarantee would clearly state that 15% was being put at risk. In any event, I would not

have scored Blue Cross's pricing guarantees any differently if it had put 15% at risk for discount guarantees, because that would still be only approximately \$7,959,000, and its payout schedule was also the lowest at 10% of any shortfall. Aetna put about 2.8 times that amount at risk for its discount guarantees (\$22,305,000) and its payout schedule was double Blue Cross's at 20% of any shortfall. Further, Blue Cross only put 5% at risk (\$2,653,000) for its trend guarantee, which was just as important as the discount guarantees in the scoring (for comparison, Aetna put \$22,305,000 at risk). Accordingly, Blue Cross would have been ranked last (0 points) for its pricing guarantees even if it had put 15% at risk for its discount guarantee.

Claims Repricing Not Validated With Provider Contracts or Commercial Market Data

35. Segal did not obtain copies of the bidders' network contracts, agreements, or letters of intent to validate or check them against the results of the bidders' claims repricing. In public health plan TPA procurements, validation of this kind is neither required nor typical. It is common practice to accept bidders' claims repricing without auditing or validating the bidders' results by reviewing their network contracts or agreements. Because claims repricing in this context typically involves thousands or tens of thousands of provider contracts, it is not practical or feasible for the Plan or Segal to review network contracts to attempt to validate network pricing. Also, network contracts are typically confidential, so it is doubtful that Segal or the Plan could obtain them.

36. Even if the vendors' network agreements were available, they would not allow Segal or the Plan to reliably validate or replicate the results of the network repricings. There are multiple accepted methods for repricing claims in this context, with different assumptions and methodologies that can quantitatively affect the result. Different vendors use different methods,

and the quantitative results of a claims repricing will vary depending on the method and assumptions used. Therefore, there is no single correct result.

37. The Uniform Data Specification (“UDS”) is a source of data regarding network pricing that is available to consultants, but Segal does not generally base its evaluation of network pricing on UDS data, especially if it is conducting a separate repricing exercise as is the case for large state health plan procurements such as the Plan’s. UDS data does not necessarily reflect network pricing accurately for purposes of a procurement because, among other reasons, the data is dated, does not consider future events such as letters of intent for conditional pricing improvements, and it is based on zip codes instead of a plan’s actual utilization.

38. If UDS data is used at all in a public procurement, it is generally used only as a check against the results of another analysis such as a claims repricing.

39. The Plan did not ask Segal to consult UDS data or any other market data in evaluating network pricing or for any other purpose, and the RFP did not state that UDS data or any other market data would be used in the network pricing analysis.

40. However, a member of the Segal team obtained a UDS analysis for use as a reasonableness check against the results of the claims repricing, the high-level results of which were shared with me, and which indicated all the bidders had discounts close to each other. During my deposition, we reviewed the data reflected in the UDS report that showed that Blue Cross’s discount percentage was 1.1% higher than Aetna’s and UHC/UMR’s was 1.5% higher than Blue Cross’s. However, I give this result little weight because I do not consider UDS data sufficiently accurate in this instance for the reasons described above. Further, it is worth repeating that the UDS data was more than a year older than the requested repricing data and, in addition, the UDS results did not reflect any pricing improvements that would result from the

acquisition of an account the size of the State Health Plan, such as letters of intent (which Segal knew were part of Aetna's repricing). Consequently, any additional attention to the results of the UDS analysis would be inappropriate.

No Separate Score for Network Access or Disruption

41. The Plan determined what elements of the cost proposal would be scored, as listed in Section 3.4(c) of the RFP (RFP pp. 24-25). Those elements were network pricing (claims repricing), administrative fees, and network pricing guarantees. The Plan told Segal it had considered whether to score network access and disruption, but decided that it would not score either. The Plan and Segal discussed that disruption would show up in network pricing.

42. Accordingly, and consistent with section 3.4 of the RFP, Segal did not compare the bidders' networks against each other or score network access or disruption,. However, as part of Segal's evaluation of the bidders' claims repricing exercise, Segal calculated the percentage of all claims that would be in-network for each of the bidders, which is a measure of disruption. (*see* Dep. Ex. 413, p. 5 (column "assumed network utilization")). The data in the bidders' claims repricing files allowed Segal to calculate the percentage of claims for each vendor that would be in-network or out-of-network.

43. Segal's calculation showed that 99% of the claims used in the claims repricing would be in-network for Aetna, and that Aetna's in-network percentage was only 0.4% lower than Blue Cross (the incumbent provider), which is nearly the same and indicates a relatively insignificant amount of disruption for a health plan of the SHP's size.

44. The documents referred to in this Affidavit and attached to the Appendix filed contemporaneously herewith are correct and true copies identified in the below table:

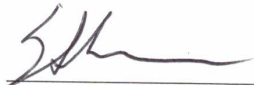
Deposition Exhibit No.	Bates Nos.	Description
30	SHP 0074489 – SHP 074490	Blue Cross Clarification #2, 11.10.2022
31	SHP 0074493	Blue Cross Clarification #3, 11.15.2022
32	SHP 074494 – SHP 074496	Blue Cross Clarification #4, 11.18.2022
33	SHP 074501 – SHP 074503	Blue Cross Clarification #5, 11.22.2022
34	SHP 074504 – SHP 074505	Blue Cross Clarification #6, 11.23.2022
35	SHP 074506 – SHP 074507	Blue Cross Clarification #7, 11.28.2022
17	SHP 025014 – SHP 025027	Segal Preliminary Cost Proposal Analysis, 11.17.2022
225	SHP 069727	Blue Cross Attachment A-8: Network Pricing Guarantees – BAFO #1
256	AETNA 0000170 – AETNA 000173	Aetna Clarification #5, 11.18.2022
413	SHP 085912 – SHP 085925	Segal Cost Proposal Analysis, Reflects Clarifications and BAFO #1, 11.29.2022
NA	SHP 087964 – SHP 087965	Aetna Clarification #4, 11.10.2022
NA	SHP 004568 – SHP 004573	Summary of the Evaluation Process Memo, 12.7.2022 (“Evaluation Summary”)
NA	SHP 004447 – SHP 004450	Request for BAFO #1, 11.18.2022 (“Request for BAFO #1”)
NA	SHP 085692 – SHP 085694	Email exchange between S. Kuhn and M. Rish, 10.24.2022-10.28.2022

45. Based on my personal knowledge and involvement in the 2022 TPA procurement, and everything I have seen and heard since, I believe the procurement was conducted properly and fairly by the Plan and its consultant, Segal, and that they acted fairly, carefully, diligently

and in good faith at all times. I am not aware of any violation of any legal requirements by the Plan or Segal, and I believe that each acted appropriately and within their authority and discretion throughout the procurement.

Further, the affiant sayeth not.

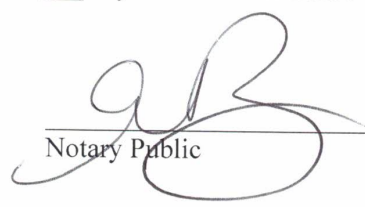
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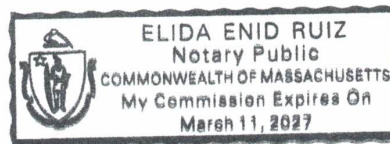

Stephen Kuhn

Sworn to and subscribed before me this, the 14th day of December 2023.

[NOTARY STAMP OR SEAL]

My Commission Expires: 03/11/2027


Notary Public



CERTIFICATE OF SERVICE

The undersigned does hereby certify that a true and correct copy of the foregoing document was served upon counsel for all parties at the addresses indicated below in accordance with the North Carolina Rules of Civil Procedure and the Rules of the Office of Administrative Hearings by electronic mail as follows:

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Counsel for Proposed Respondent-Intervenor Aetna Life Insurance Company

This, the 15th day of December 2023.

/s/ Marcus C. Hewitt

Marcus C. Hewitt

STATE OF NORTH CAROLINA
DURHAM COUNTY

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.

**AFFIDAVIT OF MATTHEW RISH IN
SUPPORT OF RESPONDENT'S MOTION
FOR SUMMARY JUDGMENT**

I, Matthew Rish, being duly sworn, depose, and say:

1. I am over eighteen years of age and am competent to make this affidavit. I have personal knowledge of the matters addressed in this affidavit.
2. I am employed by the North Carolina Department of State Treasurer as the Senior Director for Finance, Planning, and Analytics of the North Carolina State Health Plan for Teachers and State Employees (the "Plan"). My responsibilities include financial and operational reporting for the Plan, managing analytics for the Plan, and overseeing the Plan's actuarial contract with the Segal Company ("Segal"). I have been in this position since 2018.
3. I served in this role during the development and drafting of Request for Proposals # 270-20220830TPAS (the "RFP"), which is the subject of this contested case, as well as the

previous TPA RFP in 2019. I was involved in the design and development of the RFP and served as a voting member of the Evaluation Committee.

4. The Plan leadership team that participated in the design and drafting of the RFP, including Dee Jones, Caroline Smart, Kendall Bourdon, and me—were all involved with numerous earlier RFPs for the Plan, including at least one prior TPA RFP.

Design of the RFP Scoring Methodology

5. The scoring methodology and weighting in section 3.4 of the RFP were decided by consensus by Dee Jones, Kendall Bourdon, Caroline Smart, and me, with input from the Plan's actuarial services contract vendor, Segal, on certain aspects. We decided to give the cost proposal and the technical proposal equal, 50/50 weight in the overall scoring because we considered cost and the technical requirements equally important. Further, in the prior 2019 TPA procurement the technical proposal was weighted 60 percent, but in this RFP we thought Blue Cross might choose not to confirm some of the technical requirements based on their proposals submitted for prior TPA RFPs. Therefore, we also reduced the weight of the technical proposal from 60% to 50% in part to avoid disadvantaging Blue Cross.

6. We also decided by consensus to rank the bidders' cost proposals, to separately rank the bidders' technical proposals, and to base the bidders' overall scores on the combination of those two ranks. That method of ranking and scoring the proposals would enable us to easily give the technical and cost proposals equal 50/50 weight and would more clearly differentiate between the bidders even if the scoring of the technical and cost proposals were close, as we expected them to be.

7. We designed the cost proposal to score three separate components: network pricing; administrative fees; and pricing guarantees. The total available points for all three components was ten points.

8. We decided that network pricing would be worth six of the ten points because it determines the cost of claims incurred by the Plan, which is by far the Plan's biggest expense. Network pricing is evaluated via a "claims repricing" exercise, where each vendor is provided with a dataset of all the actual claims submitted in 2021 for care provided to Plan members. The vendor "reprices" all the claims in the dataset as if the claims were incurred using that vendor's agreed-upon reimbursement rates with its network of healthcare providers (or its out-of-network rules for any providers not in its network), according to the instructions in the RFP.

9. Our consensus regarding the scoring of network pricing (via the claims repricing exercise) was to establish percentage ranges (which we referred to as a "bullseye") so that a bidder whose pricing was within 0.5% of the bidder with the lowest pricing would receive the same number of points. Because medical claims are the overwhelming majority of the Plan's costs, and because the bidders' network pricing had historically been very close, we believed a proposal that was not the best should still be competitive if there was only a relatively small difference between it and the proposal with the best pricing. Also, because network pricing is a future estimate, there is typically some "margin of error" between the results of the claims repricing and actual results when the contract takes effect several years later. The Plan used percentage ranges partly to avoid penalizing a vendor whose results were within this margin of error.

10. We decided that administrative fees, which are the fees that the bidder charges the Plan for providing the third-party administrative services, would be worth two of the ten available points.

11. We decided that the pricing guarantees would be worth the remaining two available points.

12. To score the pricing guarantees, we decided to compare the value of each bidder's proposed guarantees against each other, and that the guarantees would be valued based on a combination of the competitiveness of the guarantee targets and the amount placed at risk. Guarantee targets are the discounts from billed charged amounts (expressed as a discount percentage) that the bidder agrees to achieve through their contracts with providers. The amounts at risk are the amount of money a vendor agrees to repay as a penalty if it does not meet its guaranteed targets.

13. We decided to put equal scoring weight on administrative fees and pricing guarantees because pricing guarantees can be worth less, the same, or potentially more than administrative fees. Strong network guarantees (a Vendor putting a lot of money at risk) would give the Plan greater certainty and confidence that the Vendor would meet its proposed network pricing. Similarly, a Vendor that did not put as much money at risk would give the Plan less certainty and confidence that it would meet the proposed pricing. Historically, vendors have structured their proposed guarantees in various ways. The Plan had no way of knowing in advance the value of Vendors' proposed network guarantees or how Vendors' guarantees would be structured. Therefore, the plan exercised its discretion to weight the network guarantees and administrative fees equally.

14. Segal is a consulting company that the Plan has engaged under an actuarial services contract. Segal is considered an industry expert in public health plan procurements. Segal has served as a contractor for the Plan since 2010 and has assisted the Plan in numerous RFPs, including the 2019 TPA RFP, since I joined the Plan in 2018.

15. With respect to the 2022 TPA RFP, Segal was primarily engaged to evaluate and score the cost proposals using the evaluation methodology in the RFP, manage and provide data to the bidders for their use in the claims repricing component of the cost proposal, and to evaluate and score the bidders' cost proposals.

16. Steve Kuhn led Segal's work on the cost proposal for the RFP.

17. The Plan initially asked Segal to provide a model for determining the value of the pricing guarantees for purposes of scoring that component before the RFP was issued. Segal determined and informed the Plan that it could not provide a model or determine in advance how to compare guarantees because the bidders' pricing guarantees were likely to vary considerably in the way in which they were structured. Because the bidders' guarantees were to be compared and ranked accordingly, the scoring would necessarily be comparative and partly subjective. The specific manner of analyzing the guarantees could therefore better be determined after the proposals were received, once Segal understood what exactly it was comparing. After receiving this explanation, the Plan understood Segal's reasoning and agreed with this approach.

Evaluation and Scoring of the Cost Proposals

18. After cost proposals were received and evaluation of the cost proposals began, Segal identified potential inconsistencies in the vendors claims repricing exercises and determined that clarifications from the vendors were needed.

19. At Segal's recommendation, the Plan issued a series of clarifications to the bidders between November 10 and November 28, 2022, to clarify the basis for their claims repricing exercise, and to make sure that the vendors were being compared fairly. Partway through these clarifications, on November 17, 2022, Segal presented a preliminary cost proposal analysis to the plan (Dep. Ex. 17) which recommended further clarifications to the vendors to confirm the claims repricing. Typically, when evaluating a vendor's claims repricing, the Plan does not attempt to validate the pricing by recreating the exercise; instead, we seek clarification from the bidders if anything in the exercise looks questionable.

20. In addition to the clarifications regarding claims repricing, on November 18, 2022, the Evaluation Committee voted to request "best and final offers" ("BAFOs") from all bidders in accordance with the RFP schedule and as allowed by RFP Section 3.3(a). The request for BAFOs invited all bidders to improve their proposed administrative fees and network pricing guarantees. (SHP 04568, Evaluation Summary). It is common for the Plan to request at least one BAFO from bidders in the course of an RFP process.

21. After receiving and reviewing the clarifications and the BAFOs, Segal finalized its evaluation, which was provided to the Plan on November 29, 2022. (*See* Depo. Ex. 413). With respect to the claims repricing, Segal adjusted Blue Cross and UMR's projected discounts based on the information obtained in the clarifications so that all three proposals could be compared on an apples-to-apples basis.

22. With respect to the pricing guarantees, Segal performed an extensive analysis quantifying the guarantee targets and the amounts placed at risk by each vendor, with respect to both discount guarantees and trend guarantees. It then ranked the discount guarantees and trend

guarantees in order of relative value and included a narrative explanation of the reasons for its ranking. (Dep. Ex. 413, p. 7).

23. The Plan's Actuary, Charles Sceiford, and I thoroughly reviewed Segal's cost proposal analysis (Dep. Ex. 413) and had a remote meeting with Segal to discuss the analysis, including the analysis of the claims repricing and the analysis of pricing guarantees. In this meeting, Mr. Sceiford and I asked questions of Segal to make sure that we understood and were comfortable with the methodology Segal followed. Based on our review and the discussion with Segal, we agreed with Segal's analysis and scoring.

24. Subsequently, Segal presented its final cost proposal analysis to the Plan's evaluation committee at its November 30, 2022 meeting. (Dep. Ex. 413). After hearing and discussing Segal's reasoning, the Evaluation Committee agreed with and adopted Segal's evaluation and scoring of the cost proposals. (SHP 04568, Evaluation Summary).

25. I agree with all aspects of Segal's scoring of cost proposals, including pricing guarantees. The RFP format gave bidders considerable freedom to structure their guarantees as they wished.

26. The Composite guarantee structure proposed by Aetna is not prohibited by the RFP, and is not unusual. Aetna and UMR both proposed composite guarantees in prior TPA RFPs.

27. The documents referred to in this Affidavit and attached to the Appendix filed contemporaneously herewith are correct and true copies identified in the below table:

Deposition Exhibit No.	Bates Nos.	Description

5	SHP 072588 - SHP 072796	State Health Plan Request for Proposals # 270-20220830TPAS
17	SHP 025014 – SHP 025027	Segal Preliminary Cost Proposal Analysis, 11.17.2022
413	SHP 085912 – SHP 085925	Segal Cost Proposal Analysis, Reflects Clarifications and BAFO #1, 11.29.2022
NA	SHP 004568 – SHP 004573	Summary of the Evaluation Process Memo, 12.7.2022

28. Based on my personal knowledge and involvement in the 2022 TPA procurement, and everything I have seen and heard since, I believe the procurement was conducted properly and fairly by the Plan and its contractor Segal, and that they acted fairly, carefully, diligently and in good faith at all times. I am not aware of any violation of any legal requirements by the Plan or Segal, and I believe that they acted appropriately and within their authority and discretion throughout the procurement.

Further, the affiant sayeth not.

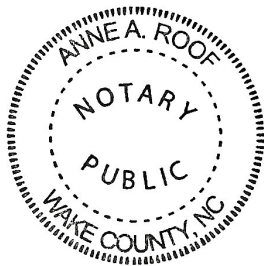
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Matthew Rish
Matthew Rish

Sworn to and subscribed before me this, the 14th day of December 2023.

My Commission Expires: 04-25-2026

Anne A. Roof
Notary Public



CERTIFICATE OF SERVICE

The undersigned does hereby certify that a true and correct copy of the foregoing document was served upon counsel for all parties at the addresses indicated below in accordance with the North Carolina Rules of Civil Procedure and the Rules of the Office of Administrative Hearings by electronic mail as follows:

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Counsel for Proposed Respondent-Intervenor Aetna Life Insurance Company

This, the 15th day of December 2023.

/s/ Marcus C. Hewitt

Marcus C. Hewitt

STATE OF NORTH CAROLINA
DURHAM COUNTY

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.)

**AFFIDAVIT OF CHARLES SCEIFORD
IN SUPPORT OF RESPONDENT'S
MOTION FOR SUMMARY JUDGMENT**

I, Charles Sceiford, being duly sworn, depose, and say:

1. I am over eighteen years of age and am competent to make this affidavit. I have personal knowledge of the matters addressed in this affidavit.

2. I am employed by the North Carolina Department of State Treasurer as the Health and Benefits Actuary for the North Carolina State Health Plan for Teachers and State Employees (the "Plan"). My responsibilities include providing financial and claims projections, reviewing The Segal Company's ("Segal") work, and interpreting it for members within our organization, making it more understandable for a nontechnical audience.

3. I have been in this position since 2018, and I report to Matt Rish. I was in this role throughout the development and drafting of Request for Proposals # 270-20220830TPAS (the "RFP"), which is the subject of this contested case, and remained in this role throughout the evaluation of the proposals and the decision by the Plan's Board of Trustees to award the third-

party administrator (“TPA”) contract in December 2022. I also served as an advisory, non-voting member of the Evaluation Committee for the RFP.

4. I was tasked with reviewing the cost proposals submitted by each bidder in response to the RFP to make sure there were no significant omissions that required a clarification. I also worked with Segal to evaluate the cost proposals, reviewed Segal’s work, and relayed questions or problems to the Plan. I made sure Segal’s work was reasonable and followed the vendors’ responses. I reviewed Segal’s analysis that is contained in Deposition Ex. 413, and I agreed with Segal’s scoring, as did the Evaluation Committee.

5. The Plan initially asked that Segal provide a model for determining the value of the pricing guarantees for purposes of scoring that component before the RFP was issued. Segal informed the Plan that it could not provide a model or determine in advance how to compare guarantees because each bidder’s pricing guarantees were likely to vary considerably in the way in which they were structured. Because the bidders’ guarantees were to be compared and ranked accordingly, the scoring would necessarily be comparative and thus somewhat subjective. The specific manner of analyzing the guarantees could therefore be better determined after the proposals were received, once Segal understood what exactly it was comparing. After receiving this explanation, the Plan (including me) understood Segal’s reasoning and agreed with this approach (see Dep. Ex. 64).

6. I also communicated with Segal throughout the evaluation of the cost proposals to communicate questions and issues as they arose. I had multiple meetings and calls with Steve Kuhn and others at Segal to discuss and resolve these issues (see e.g., Dep. Ex. 68). In these discussions and my review of Segal’s preliminary and final cost proposal analyses (Dep. Ex. 17,

413), any concerns or questions I had were addressed and I fully agreed with Segal's analysis and the scoring of the vendors' cost proposals.

7. The documents referred to in this Affidavit and attached to the Appendix filed contemporaneously herewith, identified in the below table, are correct and true copies:

Deposition Exhibit No.	Bates Nos.	Description
17	SHP 0025014-0025027	Segal Preliminary Cost Proposal Analysis, 11.17.2022
64	SHP 0070486-0070489	Email exchange with M. Rish, Segal Representatives, and Charles Sceiford, 10.24.2022-10.28.2022
68	SHP 0093117-0093119	Email exchange with Charles Sceiford and Segal Representatives, 11.14.2022-11.15.2022
413	SHP 0085912-00085925	Segal Cost Proposal Analysis, Reflects Clarifications and BAFO #1, 11.29.2022

8. Based on my personal knowledge and involvement in the 2022 TPA procurement, and everything I have seen and heard since, I believe the procurement was conducted properly and fairly by the Plan and its contractor Segal, and that they acted fairly, carefully, diligently and in good faith at all times. I am not aware of any violation of any legal requirements by the Plan or Segal, and I believe that they acted appropriately and within their authority and discretion throughout the procurement.

Further, the affiant sayeth not.

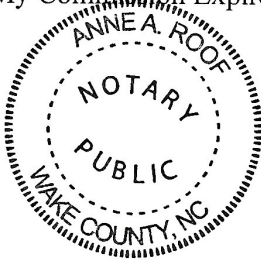
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Charles Sceiford
Charles Sceiford

Sworn to and subscribed before me this, the 14th day of December 2023.

Anne A. Roof
Notary Public

My Commission Expires: 04-25-2026



CERTIFICATE OF SERVICE

The undersigned does hereby certify that a true and correct copy of the foregoing document was served upon counsel for all parties at the addresses indicated below in accordance with the North Carolina Rules of Civil Procedure and the Rules of the Office of Administrative Hearings by electronic mail as follows:

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Counsel for Proposed Respondent-Intervenor Aetna Life Insurance Company

This, the 15th day of December 2023.

/s/ Marcus C. Hewitt

Marcus C. Hewitt

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Respondent.)

and)

AETNA LIFE INSURANCE COMPANY,)

Respondent-Intervenor.)

**AFFIDAVIT OF CAROLINE SMART IN
SUPPORT OF RESPONDENT'S MOTION
FOR SUMMARY JUDGMENT**

I, Caroline Smart, being duly sworn, depose, and say:

1. I am over eighteen years of age and am competent to make this affidavit. I have personal knowledge of the matters addressed in this affidavit.

2. I am employed by the North Carolina Department of State Treasurer as the Senior Director of Plan Integration of the North Carolina State Health Plan for Teachers and State Employees (the "Plan"). I served in this role during the development and drafting of Request for Proposals # 270-20220830TPAS (the "RFP"), which is the subject of this contested case, as well as the evaluation of proposals and the resulting contract award. My responsibilities include the overall operations of the Plan including program management of the Plan's service contracts and the data and systems integration between Plan vendors.

3. I have been in this position since September 1, 2017, with essentially the same job responsibilities since October 3, 2010, although my title has changed with each new

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administration. For example, I was the Chief Operating Officer under the Janet Cowell administration performing essentially the same job responsibilities as my current role under the Dale Folwell administration.

4. Currently, the Plan has approximately 742,000 members, including active employees, retirees and dependents. Most of the Plan's members reside in North Carolina. However, the SHP has members throughout the United States.

5. The Plan has approximately 30 staff, all of whom are employed by the Department of State Treasurer. The Plan is a "lean" organization and relies on outside contractors (also referred to as "vendors") for many aspects of the Plan's operations and activities, as authorized by N.C. Gen. Stat. § 135-48.23. In my role, I work with the Plan's vendors continuously to ensure the accurate and timely enrollment of members, invoicing and collection of premiums, administration of benefits and payment of claims.

6. The Plan routinely conducts several competitive bidding processes via requests for proposal ("RFPs") each year for a wide range of services and vendors, and routinely has several RFPs ongoing in various stages at any given time. I am involved in these procurements including drafting the Plan's minimum requirements and technical requirements, as well as responding to bidder questions and evaluating bidder responses.

7. Among the Plan's contractors is a third-party administrator ("TPA") that provides administrative services to support the Plan's operations. The TPA contract is one of the major contracts entered into periodically by the Plan.

8. The Plan's contract for TPA services is put out for competitive bids every 3-5 years via RFP. During my employment with the Plan, I have been involved in four TPA contract procurements.

9. I was heavily involved in the design and development of the RFP in 2022, including drafting the minimum requirements and technical requirements. I participated in the design of the scoring weights and methodology described in the RFP along with other members of the Plan's leadership. I also served as a voting member of the Evaluation Committee for the RFP.

10. RFPs generally include both minimum requirements and technical requirements. Minimum requirements are those requirements that are essential. Generally, technical requirements are not absolutely essential, but are desired by and important to the Plan. In the RFP, the Plan did not consider each of the technical requirements to be absolutely essential, but all of them were important to the Plan.

11. In past RFPs, the Plan has required bidders for the TPA contract to provide geographic access reports of their provider networks but has not scored those reports. Instead, geographic access reports are requested in case the Plan needed them during implementation of the contract to understand gaps in the provider network that may need correction.

12. During development of the RFP, the Plan leadership considered the elements to be scored as part of the cost proposal (which required network access reports) and decided that it was unnecessary to score network access or disruption, because a bidder's network pricing would be higher if its provider network was inadequate. Therefore, access and disruption issues would be apparent from the bidder's network pricing (*see* Dep. Ex. 87).

13. Blue Cross and Blue Shield of North Carolina (“Blue Cross”), Aetna Life Insurance Company (“Aetna”) and UMR, Inc. (“UMR”) submitted proposals in response to the RFP. All three have also bid in the past several TPA RFPs. The other Plan leadership and I are familiar with these companies, and all are established national insurance carriers with broad provider networks.

14. Aetna and UMR both confirmed all 310 technical requirements. Blue Cross did not confirm seven technical requirements.

15. Blue Cross did not confirm Technical Requirement 5.2.3.2.b.iii, which was worth one point. (Dep. Ex. 37, p. 8). It reads: “Vendor will apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States.” This was a new requirement that was not present in prior TPA RFPs.

16. The Plan included this requirement in the RFP because many members live or seek care out of state, and the use of the same rules nationwide promotes transparency and certainty of administering benefits out of state.

17. Historically, claims from out-of-state, in-network providers that are part of Blue Cross’s “Blue Card” network (which Blue Cross refers as inter-plan processing or “IPP” claims) have frequently failed to follow Blue Cross’s utilization management and payment rules. For example, IPP claims have not been subjected to Blue Cross’s reimbursement limits or inpatient authorization requirements, which increases the Plan’s costs and undermines the Plan’s efforts to manage care. The Plan has been aware of this issue anecdotally and asked Blue Cross to correct it in the past without success. In the past few years, the Plan’s auditor has also identified the TPA’s failure to apply the same utilization management and payment rules to out-of-state providers (IPP

claims) as a problem that should be corrected, as shown on its Audit report for 2021 (Dep. Ex. 94, pp. 10-11, ¶¶ 9, 13).

18. Although one vendor asked a clarification question about this requirement during the RFP's question and answer period (see Dep. Ex. 44 p. 5, Question 17), none requested that this requirement be removed or changed. (See Dep. Exs. 43, 44)

19. Blue Cross did not confirm Technical Requirement 5.2.6.2.b.xvi, which was worth one point. (Dep. Ex. 37, p. 21). It reads "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."

20. The purpose of this requirement is to simplify the Plan's operations and enable the Plan's systems and all its various contractors' systems to share data through the use of the same member ID number for every member. To avoid reliance on any given contractor (including TPA contractors), the Plan desires that all contractors use unique member ID numbers assigned by the Plan's enrollment and eligibility services (EES) vendor.

21. A differently-worded version of this requirement was in the last TPA RFP in 2019, which was confirmed by Blue Cross. However, the earlier version confirmed by Blue Cross did not specifically require that the unique member ID must be the sole ID number on the ID card. Under the current contract, Blue Cross proposed using two member ID numbers on member cards: its own Blue Cross member ID and EES vendor's member ID, but Blue Cross's systems would only use only its own member ID, which defeats the purpose of the requirement because any data exchange with Blue Cross must rely on Blue Cross's member ID number. For this reason, the

requirement was re-worded in the 2022 TPA, and Blue Cross declined to confirm it. (Dep. Ex. 37, p. 21).

22. None of the vendors asked questions about this requirement or asked that it be removed or changed during the question and answer periods. (See Dep. Ex. 43, 44.)

23. Blue Cross did not confirm Technical Requirements 5.2.7.2.b.xxiv.1-4, which were four of seven subparts of that requirement, and were collectively worth four points. They read: “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:

- 1) Electronic medical and health records.
- 2) Disease Management Nurse notes.
- 3) Case Management notes.
- 4) Health Coach notes.”

24. The purpose of the member portal requirements is to promote transparency and improve plan members’ experience. These requirements have been in the last three TPA RFPs and were originally drafted by the Plan’s population health management group as part of a best-in-class health plan offering.

25. In the past, Blue Cross has confirmed some of these requirements and not confirmed others. The Plan did not include these requirements, or any other of the Technical Requirements, based on which bidders would or would not confirm, but rather based on what was important to the Plan.

26. If any of the notes or other information covered by this requirement were not intended by healthcare providers for members to see, the TPA and the Plan could work out how to handle any such information during implementation.

27. None of the vendors asked questions about these requirements or requested that any of them be changed or removed during the question and answer periods. (See Dep. Ex. 43, 44.) Nor did any vendor communicate any concern with the Plan that any of the records or information required to be available through the member portal should not be seen by patients or Plan members.

28. Blue Cross did not confirm Technical Requirement 5.2.8.2.b.v, which was worth one point. It reads: “Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits.”

29. Assignments of benefits (“AOBs”) are agreements between a Plan member and a healthcare provider authorizing the Plan (through its TPA) to pay healthcare providers directly for medical care provided to its members, instead of paying the member who must then pay the provider. The purpose of this requirement is to reduce the administrative burden on members, improve service, and also to avoid situations where the Plan pays the member but the member fails to pay the healthcare provider for the care they received.

30. For example, the Plan has had one instance in which Blue Cross paid a member thousands of dollars for reimbursement for medical care, which the member used to pay off the member’s house, leaving the medical provider unpaid. The Plan was not able to recover the funds from the member and the provider went unpaid. Another example (which occurred to a different health plan) illustrates this need for this requirement: a plan paid \$33,000 to a man struggling with addiction, who used the cash to go on a binge and died as a result.

31. This requirement has been in several previous TPA RFPs verbatim. Blue Cross has never yet agreed to pay claims based on AOBs. Nevertheless, the Plan considers this requirement important.

32. None of the vendors asked questions about this requirement or asked that it be removed or changed during the question and answer periods. (See Dep. Ex. 43, 44.)

33. As noted above, the Plan leadership decided that it was unnecessary to score network access or disruption in the RFP, because access and disruption issues would be apparent from the bidder's network pricing.

34. Accordingly, as part of its evaluation of the bidders' network pricing, Segal used data in the bidders' claims repricing files to calculate "assumed network utilization," the percentage of all claims that would be in-network for each of the bidders, which is a measure of relative disruption on which the providers can be compared. (Dep. Ex. 413, p. 5 ("assumed network utilization" column)).

35. Segal's calculation showed that 99% of the claims would be in-network for Aetna, and that Aetna's in-network percentage was only 0.4% lower than Blue Cross (the incumbent provider), which is excellent and almost perfect for a health plan of the SHP's size.

36. The scoring of the proposals was completed on November 30, 2022, and Aetna's proposal received the highest overall score of 6. The Evaluation Committee unanimously voted to recommend to the Plan's Board of Trustees that the TPA Contract be awarded to Aetna. The Trustees unanimously voted to award the contract to Aetna at the Board's December 14, 2022 meeting. The TPA contract with Aetna was executed by the Executive Administrator and the Treasurer on December 14, 2022.

37. Pursuant to the contract, implementation began immediately. As of today's date, the Plan staff has been working diligently for almost a year to prepare and develop the necessary systems, processes, and capabilities for Aetna to successfully administer the Plan's operations as TPA. There are six Plan staff members fully dedicated to the implementation and nine others contributing as needed. The implementation also involves approximately eight staff throughout the Department of State Treasurer to do things such as establish new banking arrangements, secure data transfers and data repositories. Finally, the implementation requires integration with other Plan vendors at a cost of approximately \$2,000,000.00. That effort is ongoing and will continue until the end of the current TPA contract terms on December 31, 2024. The Plan's staff time and expense described above do not include any of the manpower, time and expense invested by Aetna in the implementation.

38. The documents referred to in this Affidavit and attached to the Appendix filed contemporaneously herewith are correct and true copies identified in the below table:

Deposition Exhibit No.	Bates Nos.	Description
37	Blue Cross NC_0000670 - 0000716	Blue Cross Technical Proposal (RFP Attachment L)
43	None.	RFP Addendum 1, Responses to Questions, 9.16.2022
44	Blue Cross NC_0000633 - 0000644	RFP Addendum 2, Responses to Questions, 10.14.2022
87	SHP 0092243-0092245	Email between D. Jones and C. Smart 08.22.2022 re: Segal TPA Cost Scoring
94	SHP 0093927-0093943	Healthcare Horizons 2021 Annual Audit Summary Report, NC State Health Plan – Blue Cross Blue Shield of North Carolina, 6.9.2022

39. Based on my personal knowledge and involvement in the 2022 TPA procurement, and everything I have seen and heard since, I believe the procurement was conducted properly and fairly by the Plan and its contractor Segal, and that they acted fairly, carefully, diligently and in good faith at all times. I am not aware of any violation of any legal requirements by the Plan or Segal, and I believe that they acted appropriately and within their authority and discretion throughout the procurement.

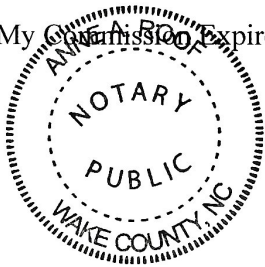
Further, the affiant sayeth not.

[SIGNATURE ON FOLLOWING PAGE]

Caroline Smart
Caroline Smart

Sworn to and subscribed before me this, the 13th day of December 2023.

My Commission Expires: 04-25-2026



Anne A. Roof
Notary Public

CERTIFICATE OF SERVICE

The undersigned does hereby certify that a true and correct copy of the foregoing document was served upon counsel for all parties at the addresses indicated below in accordance with the North Carolina Rules of Civil Procedure and the Rules of the Office of Administrative Hearings by electronic mail as follows:

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This, the 15th day of December 2023.

/s/ Marcus C. Hewitt

Marcus C. Hewitt