

# **EXHIBIT A**

**Expert Report of Gregory Russo  
(October 4, 2023)**

**EXPERT REPORT OF GREGORY RUSSO**

***Blue Cross and Blue Shield of North Carolina v.  
North Carolina State Health Plan for Teachers and State Employees***

**North Carolina Office of Administrative Hearings**

**Case No. 23 INS 00738**

**October 4, 2023**

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## **I. Introduction**

My name is Gregory Russo. This report presents my expert opinions in the matter of *Blue Cross and Blue Shield of North Carolina v. North Carolina State Health Plan for Teachers and State Employees*.

I have been retained by Robinson Bradshaw on behalf of Petitioner Blue Cross and Blue Shield of North Carolina (“Blue Cross”) to provide independent analysis and expert testimony.

My opinions are based upon my education, training, and experience, as well as my analysis and review of data and documents available in this matter. The work I completed and my opinions are described in detail in this report. My opinions are stated with a reasonable degree of professional certainty. I reserve the right to supplement or amend this report based upon additional evidence put forth by the parties in this case, as well as any other information that may become available or any other analyses counsel may request. I further reserve the right to offer opinions within my area of expertise in response to additional opinions and/or subjects addressed by other experts.

## **II. Relevant Experience**

I am a Managing Director in the Health Analytics practice of Berkeley Research Group, LLC, an international consulting firm. I have previously worked in the healthcare practices of LECG, LLC and Navigant Consulting, Inc.

I have over 19 years of experience in the healthcare industry and have worked with numerous healthcare insurers, providers, and other entities on reimbursement issues. I routinely assist clients in conducting complex data analyses that relate to the regulatory environment in which healthcare companies operate. I have testified on issues relating to the complexity of the healthcare market and the manner in which healthcare services/supplies are reimbursed. I received my graduate degree from the Johns Hopkins Bloomberg School of Public Health with a focus in healthcare finance.

My curriculum vitae, which describes in detail my professional experience, publications, and educational credentials and includes a list of cases in which I have been deposed or have testified at trial in the past four years, is attached as Appendix A.

My fees are based on the number of hours worked and are not contingent on the outcome of the case. I am compensated at a rate of \$850 per hour.

## **III. Documents and Information Relied Upon**

Appendix B contains a list of the documents and information relied upon in the preparation of this report. Appendix C contains all of the images and figures in this report.

#### IV. Background of the Case

This case relates to the North Carolina Health Plan for Teachers and State Employees' ("the Plan's") Request for Proposal ("RFP") to award its Third-Party Administrator ("TPA") contract for three years, with two additional option years, beginning January 1, 2025.

##### *a. State Employee Health Plans and Third-Party Administrators*

Every state in the U.S. offers health insurance coverage to its state employees, although benefits vary across states in terms of coverage, eligibility rules, and premium contributions.<sup>1</sup> Some states, like North Carolina, have "self-funded" employee health plans. Under this model, the state contracts with a TPA for services including contracting with providers (resulting in a "provider network"), negotiating discounts for medical services, and processing health insurance claims. The state, not the TPA, is responsible for the payments—i.e., the state is "at risk." The TPA receives an administrative fee for the services it provides to the state.

In North Carolina, the Plan provides coverage to over 742,000 people, including approximately 490,000 active employees and their dependents and approximately 250,000 Medicare and non-Medicare retirees and disabled members and their dependents.<sup>2</sup> Blue Cross currently serves as the Plan's TPA. Actual claims payments for Plan members for calendar year 2021 were \$1.983 billion.<sup>3</sup>

##### *b. The RFP, Contract Award, and Protests*

The RFP was issued on August 30, 2022, and technical and cost proposals were due on November 7, 2022. Vendors submitted Best and Final Offers ("BAFOs") on November 22, 2022. The Plan engaged Segal, an actuarial and benefits consulting firm, to provide support for the RFP, including collecting data from the vendors and evaluating vendors' cost proposals.

Blue Cross (the incumbent), Aetna Life Insurance Company ("Aetna"), and UMR, Inc. (a subsidiary of United Healthcare) submitted bids in response to the RFP. On December 14, 2022, the contract was awarded to Aetna.

Blue Cross submitted a letter on January 12, 2023 to Sam Watts, Acting Executive Administrator of the Plan, requesting a protest meeting and reconsideration of the Plan's decision to award the contract to Aetna. UMR also submitted a letter requesting a protest meeting.<sup>4</sup> Both vendors were denied a protest

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<sup>1</sup> National Conference of State Legislatures. State Employee Health Benefits, Insurance Costs. May 01, 2020. Available at: <https://www.ncsl.org/health/state-employee-health-benefits-insurance-and-costs>.

<sup>2</sup> SHP 0072588.

<sup>3</sup> State of North Carolina, North Carolina State Health Plan for Teachers and State Employees. Financial Update, Board of Trustees Meeting. March 2, 2022. Available at: <https://www.shpnc.org/documents/board-trustees/march-2022-financial-report021622/download?attachment>.

<sup>4</sup> Letter from John K. Edwards to Sam Watts. January 13, 2023.

meeting.<sup>5,6</sup>

On February 16, 2023, Blue Cross filed a Petition for Contested-Case Hearing in the North Carolina Office of Administrative Hearings. In its Petition, Blue Cross requested that the Tribunal vacate the Plan's decision to award the contract to Aetna and award it to Blue Cross, or alternatively, vacate the Plan's decision and order the Plan to conduct a new RFP process.

## **V. Overview of Opinions**

My five opinions relate to aspects of the cost proposal for the 2022 RFP. My opinions focus on flaws in the evaluation criteria and approaches, incorrect assumptions made in the scoring process, and analyses that were either performed incorrectly or not performed at all.

Opinion 1 focuses on the pricing guarantees, for which the Plan and Segal erroneously assigned Blue Cross zero points. The evaluation of these guarantees was flawed because of the subjective and non-quantitative nature of the evaluation. Blue Cross's guarantees would result in lower costs to the Plan than those proposed by either of the other two vendors. This aspect of the guarantees contradicts the Plan's and Segal's conclusion that Blue Cross's guarantees provided the "least" value.

Opinion 2 addresses a discrepancy in the prices and discounts assumed by Aetna for providers with letters of intent. I have found that the discounts Aetna assumed for these providers in its bid are higher than the discounts that will be realized under the signed agreements. This difference will result in higher costs to the Plan than Aetna presented in its bid.

Opinion 3 relates to the Request for Clarifications process, in which Segal adjusted Blue Cross's proposed discounts downward. This adjustment resulted in Blue Cross and Aetna both scoring 6 points for this part of the proposal rather than Blue Cross scoring 6 points and Aetna scoring 3 points. I have found that this adjustment was made based on erroneous assumptions and without equivalent scrutiny of Aetna's discounts.

Opinion 4 concerns the lack of use of an external data source to validate the findings of the repricing exercise. Segal reviewed data that was favorable to Blue Cross, but neither Segal nor the Plan considered this data in its evaluation. The failure to consider this external data further undermines Segal's decision to adjust Blue Cross's discount percentage to a level below Aetna's.

Finally, Opinion 5 focuses on the differences between Blue Cross's and Aetna's networks—differences that received no weight in the scoring of the proposals. I have found that the Plan and Segal collected detailed data from the vendors but did not use it to compare the networks. I have used the data collected

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<sup>5</sup> Letter from Sam Watts to Matthew Sawchak. January 20, 2023.

<sup>6</sup> Letter from Sam Watts to John K. Edwards. January 20, 2023.

to show that Blue Cross's network offers more choices of providers. The data also shows that thousands of Plan members are likely to face disruption if Aetna becomes the TPA on January 1, 2025.

## VI. Cost Proposal Data Collection and Scoring

The 2022 RFP included both a technical proposal and cost proposal, each worth 50 percent of the total points available.<sup>7</sup> The cost proposal contained three components on which the vendors were evaluated: Network Pricing, Administrative Fees, and Network Pricing Guarantees. The vendors submitted cost proposals by completing Attachments A-1 through A-10 to the bids, as well as a large repricing file. Below, I describe the three components of the cost proposal and the related documents in Attachment A that the vendors submitted.<sup>8</sup>

1. *Network Pricing* – This part of the cost proposal estimated claims costs to be paid to providers by the Plan.
  - Each vendor received a claims file that included almost all of the Plan's actual claims for calendar year 2021.<sup>9</sup> The RFP directed vendors as follows: "Using the repricing file [provided to the vendors], Vendors are to provide the contracted allowed amount for each service in the file. Vendors are expected to reprice each claim line based on provider contracts in place, or near-future<sup>10</sup> contract improvements bound by letters of intent, at the time of the repricing."<sup>11</sup>
  - The fields contained in the claims file were listed in **Attachment A-3**<sup>12</sup> of the cost proposal. The vendors were asked to summarize the results of the repricing exercise described above by service category and network status in **Attachment A-4**<sup>13</sup> and by provider in **Attachment A-5**.<sup>14</sup> In **Attachment A-6**,<sup>15</sup> the vendors were asked to identify "known contract improvements" that would be realized by 2025.
  - The Network Pricing was worth 6 points. The RFP described the scoring methodology for Network Pricing as follows: "The highest ranked (or lowest network pricing) proposal will receive the full six (6) points allocated to this section. All other proposals will be ranked and will receive points based on the following criteria: within 0.5% of the first ranked proposal = 6 points; within 1.0% = 5 points; within 1.5% = 4 points, within 2.0% = 3 points, within 2.5% =

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<sup>7</sup> My opinions focus on the cost proposals, not the technical proposals.

<sup>8</sup> Specific healthcare terms and nomenclature relevant to the below proposal components are defined in the Opinions section of this report.

<sup>9</sup> SHP 0069462, SHP 0069463.

<sup>10</sup> The RFP does not define "near-future." Segal's corporate representative testified at deposition that 2023 would be considered "near future." Segal's 30(b)(6) Deposition, pg. 276, lines 11-23.

<sup>11</sup> SHP 0072588.

<sup>12</sup> SHP 0006964.

<sup>13</sup> SHP 0006961.

<sup>14</sup> SHP 0006963.

<sup>15</sup> SHP 0006962.

2 points, within 3.0% = 1 point, greater than 3.0% = 0 points.”<sup>16</sup>

- Aetna and Blue Cross each received 6 points and UMR received 5.
2. *Administrative Fees* – This part of the cost proposal stated fees that the TPA would charge for administering the Plan.
- Each vendor was required to indicate the monthly fee it would charge per Plan subscriber during the three-year contract period and the two option years.
  - **Attachment A-7**<sup>17</sup> stated the vendors’ proposed fees for each service.
  - The RFP described the scoring methodology for administrative fees as follows: “The highest ranked (or lowest administrative fees) proposal will receive the full two (2) points allocated to this section. All other proposals will be ranked and may receive one (1) or zero (0) points based on administrative fees in comparison to the lowest administrative fee proposal and the other proposals.”<sup>18</sup>
  - Blue Cross proposed the lowest administrative costs and thus earned 2 points. Aetna received 1 point and UMR received 0 points.
3. *Network Pricing Guarantees* – This part of the cost proposal stated pricing targets guaranteed by the vendors and the amount of administrative fees placed at risk if targets were not met.
- Vendors were required to propose specific network pricing targets for the three-year contract period and the two option years. For each target, vendors were required to identify the amount of administrative fees that would be refunded to the Plan if the target was not met.
  - Network pricing guarantees were stated in **Attachment A-8**.<sup>19</sup>
  - The RFP described the scoring methodology for network pricing guarantees as follows: “The proposal that offers the network pricing guarantees with the greatest value will be ranked the highest and will receive the full two (2) points allocated to this section. All other proposals will be ranked and may receive one (1) or zero (0) points based on the value of the proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.”<sup>20</sup>
  - The RFP did not define “value” as used in this scoring.
  - UMR received 2 points, Aetna 1 point, and Blue Cross 0 points.

There are also four attachments submitted as part of the cost proposal that did not relate to the Network

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<sup>16</sup> SHP 0072588.

<sup>17</sup> SHP 0006966.

<sup>18</sup> SHP 0072588.

<sup>19</sup> SHP 0006956.

<sup>20</sup> SHP 0072588.

#### Pricing, Administrative Fees, or Network Pricing Guarantees:

- **Attachment A-1**<sup>21</sup> contained information on the format of the member census data, which is a file containing information about each of the Plan’s members as of June 2022 (such as address, age, and gender). Attachment A-1 was provided *to* the vendors but did not collect information *from* the vendors.
- **Attachment A-2**<sup>22</sup> was used to collect information about each vendor’s provider network.
- **Attachment A-9**<sup>23</sup> allowed vendors to report additional adjustments to claims and administrative costs.
- **Attachment A-10**<sup>24</sup> was a certification of the costs contained in the proposal signed by either an actuary or the vendor’s CEO or CFO.

During the evaluation process, the vendors were sent “Clarification Requests” with questions about specific aspects of their proposals. They were also asked to resubmit Attachments A-7 (Administrative Fees) and A-8 (Network Pricing Guarantees) with their Best and Final Offers.

To evaluate and score the three components of the cost proposal, Segal used a templated Excel workbook to organize and analyze the data contained in the bids.<sup>25</sup> The template included sections (tabs) to evaluate each component and two additional tabs for summarizing the results of the scoring and the total costs to the Plan.

For the sum of Network Pricing and Administrative Fees, Blue Cross had the lowest overall cost, followed by Aetna, then UMR. Based on the Plan’s scoring methodology for the cost proposal, Aetna and Blue Cross each received 8 points out of a possible ten points. UMR received 7 points out of ten.

#### VII. Key Terms

In order to understand the central issues in my opinions, it is important to define certain concepts and terminology related to healthcare reimbursement. Additional key terms are defined throughout this report.

Healthcare providers such as hospitals and physicians establish prices for provided services. These are typically referred to as **billed charges**.

Separately, healthcare providers contract with payers to provide medical services to health plan members

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<sup>21</sup> SHP 0006960.

<sup>22</sup> SHP 0006965.

<sup>23</sup> SHP 0006955.

<sup>24</sup> SHP 0006959.

<sup>25</sup> SHP 0069464.

in exchange for a certain reimbursement amount or payment. The group of providers that have such a contract with a payer is called the payer's **network**. If a provider has signed a contract to participate in the vendor's network, it is considered **in-network**. Otherwise, the provider is considered **out-of-network**. Whether a provider is in-network or out-of-network is that provider's **network status**.

Billed charges are rarely paid in full. The rate a payer agrees to reimburse an in-network provider is referred to as the **contract rate, allowable, allowed amount, or allowed charge**. These amounts may be determined based upon fee schedules (i.e., a listing of services along with the contract rates) or payment formulas developed by the payer (often a percentage of billed charges). The **contracted amount** is the figure that a payer and an in-network provider have agreed to in a contract.

Contract rates are typically lower than the provider's billed charge. Thus, the contract rate is considered to be **discounted** from the billed charge. The discount is the difference between the billed charge and the contract rate. For example, if a healthcare provider charges \$100 for an office visit and the contract rate for that service is \$80, the discount is equal to 20 percent  $[(100-80)/100]$ .

Finally, the term **trend** refers to a measure of medical inflation: the percentage by which a health plan's total claims costs in a given year exceed a health plan's total claims costs in the preceding year.

## VIII. Opinions

**Opinion 1: The Plan’s assignment of zero points to Blue Cross’s pricing guarantees was subjective, reflecting little quantitative analysis and lacking a sufficient basis for the Plan’s assignment of points. Blue Cross’s pricing guarantees would provide lower costs to the Plan than Aetna’s discounts and guarantees.**

As discussed below, the Plan and Segal did not have a sufficient basis for awarding zero points to Blue Cross’s pricing guarantees.

The cost proposal required vendors to provide pricing guarantees to the Plan for the vendors’ discount percentages, rates in comparison to Medicare reimbursement rates, and trends for the years 2025 through 2029. For these metrics, the vendors were required to define targets for each of the three years of the TPA contract plus the two option years. Each target had to be accompanied by an agreement to refund a portion of the administrative fees (i.e., an amount placed “at risk”) to the Plan if the target was not met in any year.<sup>26</sup> Requiring TPAs to guarantee certain targets, coupled with the requirement to place a portion of the administrative fees at risk, provides incentives for TPAs to negotiate competitive contracts with providers in the network.

Based on the information I have reviewed, Segal<sup>27</sup> put little or no weight on the most valuable component of the pricing guarantees: the claims costs that would result from achievement of the targets guaranteed by each of the vendors. Instead, Segal’s scoring approach focused almost entirely on Segal’s view of the maximum amount of administrative fees placed at risk by each vendor, even though the comparative volume of any such refund is small compared to the Plan’s overall claims cost.

In the following paragraphs, I first describe the components of the pricing guarantees and the data submitted by the vendors. Next, I describe Segal’s evaluation of the data and the flaws in that evaluation. Finally, I address the impact of Segal’s flawed approach.

### **Components of the Pricing Guarantee and Data Submitted**

First, vendors were required to submit three types of pricing guarantees:

1. *Discount guarantees*, which were discount targets guaranteed each year from 2025 to 2029.
  - Vendors were required to provide separate discount targets for inpatient hospital services, outpatient hospital services, and professional services.
  - If the discount target in any given year for any of the service lines (inpatient, outpatient, or

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<sup>26</sup> The dollar value of the administrative fees was bid by the vendor in the separate administrative fees section of the cost proposal, so the pricing guarantee section incorporates the administrative fees bid by reference.

<sup>27</sup> Segal evaluated and scored the cost proposals for the Plan. Segal’s 30(b)(6) Deposition, pg. 224, lines 9-12.

professional) is missed (i.e., the discount achieved is lower than the discount target), the vendor must refund a specified portion of administrative fees to the Plan *for the service line in which the discount target is missed*.

- The refund amount is calculated based on the percentage of the claims cost shortfall the vendor has proposed to pay back for the service line at issue, as well as the percentage of the administrative fees that the vendor has put “at risk.”
2. *Percentage-of-Medicare guarantees*, which were the total allowed amount or claims cost expressed as a percentage of what Medicare would pay for the same services. Vendors were required to guarantee a certain relationship between contract rates and Medicare rates (a percentage of Medicare rates that the contract rates could not exceed) for each year from 2025 to 2029 for inpatient hospital, outpatient hospital, and professional services, separately. Vendors would be required to refund a certain portion of administrative fees if they missed any of these percentages.
  3. *Trend guarantee*, which was the percentage that the Plan’s claims cost per member per month (“PMPM”) was expected to increase on an annual basis from 2025 to 2029. If the actual trend percentage was greater than the guaranteed trend percentage, the vendor would be required to refund a certain portion of administrative fees, depending upon how much the actual trend deviated from the guaranteed trend.

The above guarantees involved seven separate targets and seven potential refunds to the Plan in each year of the contract: three targets and potential refunds for the discount guarantees, three targets and potential refunds for the percentage of Medicare guarantees, and one target and potential refund for the trend guarantee.

### **Segal’s Evaluation of the Guarantees and the Flaws in That Evaluation**

The scoring criteria for the pricing guarantee portion of the bids were set forth in the RFP: “Proposals will be evaluated and ranked based on their proposed network pricing guarantees. The value of the pricing guarantees will be based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk.”<sup>28</sup>

Based on this description, as well as my experience, I would expect that the pricing guarantees would have been evaluated quantitatively based on the combined bottom-line effect, under likely scenarios, of each vendor’s targets and amounts placed at risk. This analysis would determine which vendor’s pricing guarantees offered the most “value” to the Plan. Segal’s corporate representative testified consistently with this analysis: “[t]he goal [of the discount guarantees] is to produce the best cost for the State.”<sup>29</sup>

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<sup>28</sup> SHP 0072588.

<sup>29</sup> Segal’s 30(b)(6) Deposition, pg. 179, lines 20-25.

However, the scoring approach used by Segal to evaluate the pricing guarantees *did not* consider the combined bottom-line effect of the vendors' targets and amounts at risk. Instead, Segal's analysis involved little or no quantitative analysis. Prior to the submission of bids, Segal discussed internally that little quantitative analysis would likely be performed, indicating that the evaluation would instead be "subjective." This is shown in the following email chain on October 24, 2022, among Kenneth Vieira<sup>30</sup>, Stephen Kuhn<sup>31</sup>, and Stuart Wohl<sup>32</sup> of Segal:

Vieira: How are we doing the scoring on the guarantees – the guarantee or the amount at risk?

Kuhn: Both...there may have to be a subjective component to it. See below.

- 3) Network Pricing Guarantees – two (2) points
- a) Proposals will be evaluated and ranked based on their proposed network pricing guarantees. The value of the pricing guarantees will be based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk.
  - b) The proposal that offers the network pricing guarantees with the greatest value will be ranked the highest and will receive the full two (2) points allocated to this section.
  - c) All other proposals will be ranked and may receive one (1) or zero (0) points based on the value of their proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.

Vieira: I don't think this really answers how we will do it. Is there some math behind it? A low amount at risk for a high value might be better than a high amount at risk for a low value?

Wohl: I don't believe there is a formula. It will be very subjective and probably up for discussion.

Kuhn: Thanks Stu. Completely agree!<sup>33</sup>

On October 27 and 28, 2022, Kuhn communicated to the Plan that the evaluation would be subjective. In this exchange, Kuhn's responses, in red and all caps, follow Matthew Rish's<sup>34</sup> questions:

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<sup>30</sup> Kenneth C. Vieira, FSA, FCA, MAAA, Senior Vice President, is a member of the Segal team assisting the Plan.

<sup>31</sup> Stephen L. Kuhn, Vice President and Health Consultant, is a member of the Segal team assisting the Plan.

<sup>32</sup> Stuart Wohl, Senior Vice President, is a member of the Segal team assisting the Plan.

<sup>33</sup> SHP 0092745.

<sup>34</sup> Matthew T. Rish, Senior Director of Finance, Planning & Analytics at the Plan.

**Figure 1**

- 1) How is the value of the performance guarantees be determined? Is it solely based on the dollar amounts available? Will we take into account the probability of not meeting the discount guarantee? For example if Vendor A has a higher discount guarantee but lower amount at risk compared to Vendor B, how do we compare between the Vendors. **THIS SECTION'S SCORING IS BOTH SUBJECTIVE AND COMPARATIVE. THE SCORING WILL NEED TO CONSIDER EACH VENDOR'S GUARANTEE ON (1) HOW DOES IT RELATE TO THEIR OWN PRICING....ITS VALUE TO THE SHP AND (2) HOW IT COMPARES TO THE OTHER VENDOR PROPOSALS. YES, WE NEED TO CONSIDER BOTH THE GUARANTEED TARGETED LEVEL AND THE AMOUNT AT RISK IN DETERMINING THE OVERALL "VALUE" OF THE PROPOSED GUARANTEES.**
- 2) Can Segal Provide sample discount guarantees to show how ranking and scoring would be determined? **WE DON'T HAVE A SAMPLE ALREADY DRAFTED. AS INDICATED ABOVE, THIS ANALYSIS IS HEAVILY DEPENDENT ON WHAT WE RECEIVE FROM THE VENDORS. IT COULD BE AS SIMPLE AS A MULTIPLICATION OF THE GUARANTEE AND THE AMOUNT AT RISK, BUT IT WILL DEPEND ON WHAT THE VENDORS PROPOSE.**

**Source:** SHP 0070486.

When asked in deposition what he meant by “subjective,” Segal’s corporate representative testified, “[the evaluation] relies more on a review of the proposals versus the actual calculation. It's not quantitative.”<sup>35</sup> When asked whether Segal did “anything to combine the targets with the at-risk amounts,” Segal’s corporate representative responded, “[n]ot in a mathematical equation,” but “by looking at it . . . qualitatively.”<sup>36</sup> When Charles Sceiford<sup>37</sup>, the Plan’s actuary, was asked in his deposition whether he was surprised that Segal planned to conduct a subjective analysis, he stated, “seeing that it’s subjective did raise a potential issue [...] it was out of the ordinary.”<sup>38</sup>

I identified templates in Segal’s scoring workbooks that appear to have been created to compare guarantee percentages and the amounts at risk quantitatively, but these templates were not used. In Segal’s scoring workbook dated November 10, 2022, the “Pricing Guarantee” tab contains the template below (Figure 2).

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<sup>35</sup> Segal’s 30(b)(6) Deposition, pg. 162, lines 17-19.

<sup>36</sup> Segal’s 30(b)(6) Deposition, pg. 35, lines 1-11.

<sup>37</sup> Charles Sceiford, Actuary for the State Treasurer of North Carolina.

<sup>38</sup> Deposition of Charles Sceiford, pg. 79, lines 10-11, 18-19.

**Figure 2**  
**Segal's Pricing Guarantee Template**

Discount Guarantees	Inpatient	Outpatient	Professional	Total
<b>CY 2025</b>				
Aetna				0.0%
BCBSNC				0.0%
UMR				0.0%
<b>CY 2026</b>				
Aetna				0.0%
BCBSNC				0.0%
UMR				0.0%
<b>CY 2027</b>				
Aetna				0.0%
BCBSNC				0.0%
UMR				0.0%
<b>Amounts at Risk</b>				
	Year	Description		
<b>Aetna</b>	CY 2025			
	CY 2026			
	CY 2027			
<b>BCBSNC</b>	CY 2025			
	CY 2026			
	CY 2027			
<b>UMR</b>	CY 2025			
	CY 2026			
	CY 2027			

**Source:** SHP 0085016, "Pricing Guarantee" tab.

Regarding this workbook, Segal's corporate representative stated in deposition that "[the workbook] was a rough draft of the model as an example...We didn't use this model."<sup>39</sup>

In fact, Segal did not use any quantitative model. The final version of Segal's scoring workbook (dated November 29, 2022) is shown below in Figure 3. Although the workbook presents several figures, it uses a subjective narrative to evaluate the proposals.

<sup>39</sup> Segal's 30(b)(6) Deposition, pg. 166, lines 7-14.

**Figure 3**  
**Final Version of Segal’s Pricing Guarantee Scoring Worksheet**

**Discount Guarantees**

	Current Discount <sup>1</sup>	Vendor Projected Discount <sup>2</sup>	CY 2025 Guarantee <sup>3</sup>	Guarantee Compared to		Description of Guarantee Payout Methodology	CY 2025 Max at Risk		CY 2026 to CY 2029 Guarantees	Evaluation of Discount Guarantee
				Current Discount	Projected Discount		Dollar Amount	Discount for Max Payout		
<b>Aetna</b>	53.0%	54.0%	52.3%	-0.7%	-1.7%	20% of the discount shortfall to a max of 25% of admin fee (45% max across all guarantees)	\$22,305,000	50.3%	Same guarantee for each year with no changes in target discounts	Offers moderate comparative value. CY 2025 and beyond offer up to 25% of admin at risk at a discount target lower than current and projected. Offers protection from discount erosion.
<b>BCBSNC</b>	52.7%	57.8%	55.1%	2.4%	-2.7%	10% of the discount shortfall to a max of 5% of admin fee	\$2,653,000	54.7%	Same guarantee for each year with slight increases (<1%) in target discounts	Offers the least comparative value. The least value is due to a limited amount at risk at 5% of admin. Discount target is competitive and higher than current discounts and improves slightly through 2029, but remains lower than discounts projected by the vendor.
<b>UMR</b>	52.5%	54.1%	52.6%	0.1%	-1.5%	100% of the discount shortfall to a max of 100% of admin fee	\$95,101,000	50.9%	No guarantee after CY 2025	Offers the greatest comparative value. CY 2025 offers the highest value with a dollar-for-dollar guarantee up to 100% of the admin fee at risk, but no guarantee beyond year 1.

**Trend Guarantees**

	CY 2026 Guarantee	Description of Payout Methodology	CY 2026 Max at Risk		CY 2027 to CY 2029 Guarantees	Large Claimant Adjustments	Exclusions and Conditions	Evaluation of Discount Guarantee
			Dollar Amount	Trend for Max Payout				
<b>Aetna</b>	6.8%	3% of the admin fee for each full percentage point above the guarantee to a maximum of 25% of admin fee (45% max across all guarantees)	\$22,305,000	15.8%	Same guarantee with 0.3% increases in the trend each year	Claim amounts in excess of \$250,000 for any individual claimant are excluded	Pharmacy claims are excluded. Requires Aetna receives pharmacy data file feeds at a minimum bi-weekly basis to support the care management program. Aetna will adjust base year claims for factors impacting the relativity of the population such as changes in plan design, demographics, geography, included products, programs and services, third-party vendor solutions, or the impact of novel conditions.	Offers moderate comparative value. Offers the second lowest trend target and a reasonable amount at risk. Offers protection from increases in market/industry trend; however, the payouts are spread over excess trend up to 9% over the target.
<b>BCBSNC</b>	6.0%	10% of the excess trend dollars to a maximum of 5% of admin fee	\$2,653,000	10.0%	Same guarantee for each year with no changes in the 6% trend	All claims for individuals with claims in excess of \$250,000 are excluded	Pharmacy claims are excluded. Claims related to new services or benefits added at the discretion of the Plan during the term of this contract are excluded. Providers that sign up for the Clear Pricing Program are excluded.	Offers the least comparative value. While BCBSNC offers the lowest trend target, it is diminished by the lowest dollar amount at risk and the removal of all claims for individuals over \$250,000 (not just the amounts over \$250,000).
<b>UMR</b>	UHC book-of-business (BoB) trend minus 1%	Percent of admin returned based on trend ranges between UHC BoB minus 1% to UHC BoB plus 3% for the max. of 50% of admin fee	\$47,550,000	3% over UHC BoB Trend	UHC book-of-business (BoB) trend minus 1%	Claim amounts in excess of \$250,000 for any individual claimant are excluded	Pharmacy claims are excluded. Mental Health and Substance Use Disorder (MHSUD) claims are excluded.	Offers moderate comparative value. Illustrates a commitment to manage trend at least 1% lower than its BoB and places the most amount at risk. However, as it is prospectively based on UHC's BoB, it offers minimal protection from increases in market/industry trend. Also, does not include MHSUD claims.

Source: SHP 0069464.

In this table, Segal concluded that Blue Cross “Offers the least comparative value for both discount and trend guarantees, primarily due to the amount at risk. BCBSNC's low amount at risk is due to a combination of having significantly lower admin fees and only placing 5% at risk.” Based on this reasoning, Segal awarded Blue Cross zero points for its guarantees.

Segal concluded that Aetna “Offers both discount and trend guarantee of moderate comparative value.” Based on this reasoning, Segal awarded Aetna one point for its guarantees.

Segal concluded that UMR’s proposal “Offers the greatest comparative value discount guarantee with dollar-for-dollar up to 100% of admin fee and a moderate comparative value (including the most at risk) trend guarantee.” Based on this reasoning, Segal awarded UMR two points for its guarantees.

The scoring that resulted from these conclusions is shown in Figure 4 below.

Figure 4

**Network Pricing Guarantees Score**

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

Source: SHP 0069464.

In evaluating the bids and reaching these conclusions, Segal made several errors and flawed assumptions:

(1) Segal did not calculate the claims costs that would result from the achievement of the discount guarantee targets. When Segal scored the network pricing, it did not assess the bottom-line effect of each vendor's discount targets on the Plan's claims costs, even though claims costs have the largest impact on the Plan's outlays. In deposition, Segal's corporate representative testified: "The goal of [the discount guarantee] is to produce the best cost for the state...." Despite this goal, Segal ignored the fact that Blue Cross's discount targets would produce the best (lowest) cost to the state. Later in this opinion, I show the bottom-line effects that Segal ignored.

(2) Segal did not put weight on the relative aggressiveness of the proposed discount targets. The weighted average of Blue Cross's 2025 discount guarantee targets for inpatient, outpatient, and professional services is 55.1 percent—1.1 percentage points higher than the discount of 54 percent Blue Cross bid in the repricing exercise.<sup>40,41</sup> In addition, Blue Cross increased its discount guarantee target each year, reaching a guarantee target of 56.7 percent in 2029.<sup>42</sup>

In contrast, Aetna set its discount target at 52.25<sup>43</sup> percent for all years (2025-2029). This guarantee target is lower than the discount percentage Aetna calculated in the repricing exercise: 53 percent. This target resembles a "B" student guaranteeing that he would achieve at least a D+ average. Although Aetna placed

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<sup>40</sup> SHP 0069464.

<sup>41</sup> Figure 3 indicates that Blue Cross's current discount is 52.7 percent. That figure reflects an inappropriate downward adjustment made by the Plan and Segal to Blue Cross's repricing. That adjustment is further described in Opinion 3 of this report. The Plan's and Segal's adjustment to Blue Cross's discount results in a larger gap between Blue Cross's current discount and its discount targets.

<sup>42</sup> Segal calculated and scored the inpatient, outpatient, and professional discount guarantees using a weighted average of the discounts. For brevity, I refer to the discounts using the weighted averages, but I recognize that Blue Cross guaranteed three separate targets.

<sup>43</sup> This amount was rounded to 52.3 by Segal in its evaluation.

more at risk than Blue Cross, its conservative discount target means that it is unlikely that it would have to pay those at-risk amounts to the Plan.

Despite these facts, Segal determined that Aetna's discount had more value than Blue Cross's. That conclusion clashed with Segal's and the Plan's testimony on what creates value in the context of discount guarantees. As Segal's corporate representative stated in his deposition, a conservative guarantee "means [that a vendor] will, like, more than likely hit the guarantee, and the guarantee is worthless or has little value."<sup>44</sup> Sceiford (the Plan's actuary) agreed that a discount target that is higher than a vendor's current discount would be more valuable than a discount target that is lower than a vendor's current discount. Sceiford testified that this is the case "because they would have to work hard to try to meet that guarantee."<sup>45</sup>

Although Segal's analysis compared the vendors' current discounts with the vendors' discount targets, that comparison was not factored into the final scoring. Instead, the evaluation put more emphasis on the amount at risk than on the aggressiveness of the targets. The column "Evaluation of Discount Guarantee" notes that Blue Cross's discount target is "higher than current discounts" but states that Blue Cross's guarantee represents the "least value . . . due to a limited amount at risk."<sup>46</sup>

(3) Segal erred by minimizing the fact that Blue Cross's guarantee target improved over time, while Aetna's did not. Aetna's discount target is 52.3 percent<sup>47</sup> in 2025 and remains the same for the three-year contract plus two option years.<sup>48</sup> In contrast, Blue Cross's discount target is 55.1 percent in 2025 and increases incrementally to 56.74 percent in 2029.<sup>49</sup> Thus, Blue Cross not only guaranteed the best discount of all the vendors, but also guaranteed that it would improve on that discount each year over the life of the contract. The sum of these incremental improvements in guarantee targets means an estimated \$241 million in savings to the Plan and its members from 2026 to 2029.<sup>50</sup> Segal's comments on the value of the discount targets noted that Blue Cross guaranteed to improve its performance each year, but Segal appeared to put no weight on this fact.

(4) Segal erroneously assumed that Blue Cross's maximum amount at risk for all of the discount guarantees and all of the percentage-of-Medicare guarantees—as a group—was a total of 5 percent of the administrative fees. As described above, vendors were required to identify *separate* discount guarantee targets and percentage-of-Medicare targets for inpatient, outpatient, and professional services. Blue Cross followed these instructions. In doing so, Blue Cross placed a maximum of 5 percent of administrative fees at risk for each of its three discount guarantees, for each of its three percentage-of-

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<sup>44</sup> Segal's 30(b)(6) Deposition, pg. 178, lines 2-4.

<sup>45</sup> Deposition of Charles Sceiford, pg. 63, lines 20-21.

<sup>46</sup> SHP 0069464, "Pricing Guarantee" tab, cell K-L11.

<sup>47</sup> Aetna proposed a discount target of 52.25 percent. Segal rounded this target to 52.3 percent.

<sup>48</sup> SHP 0000010.

<sup>49</sup> SHP 0069503.

<sup>50</sup> The savings for 2025 to 2029 were calculated using the 2021 charges from the claims repricing file for each year.

Medicare guarantees, and for its trend guarantee. Each line of Blue Cross's guarantees stated a separate payout and a separate cap:

- Inpatient Facility Discount: "Payout = 10% of each dollar miss as measured by impact to paid inpatient claims; subject to maximum payout ('cap') of 5% of that year's total administrative fee attributable to in-state members, exclusive of fund administration fees and optional services fees."
- Outpatient Facility Discount: "Payout = 10% of each dollar miss as measured by impact to paid outpatient claims; subject to maximum payout ('cap') of 5% of that year's total administrative fee attributable to in-state members, exclusive of fund administration fees and optional services fees."
- Professional Fees Discount: "Payout = 10% of each dollar miss as measured by impact to paid outpatient claims; subject to maximum payout ('cap') of 5% of that year's total administrative fee attributable to in-state members, exclusive of fund administration fees and optional services fees."
- Inpatient Facility Costs (Percent of Medicare): "Payout = 10% of each dollar miss as measured by impact to paid inpatient claims; subject to maximum payout ('cap') of 5% of that year's total administrative fee attributable to in-state members, exclusive of fund administration fees and optional services fees."
- Outpatient Facility Costs (Percent of Medicare): "Payout = 10% of each dollar miss as measured by impact to paid outpatient claims; subject to maximum payout ('cap') of 5% of that year's total administrative fee attributable to in-state members, exclusive of fund administration fees and optional services fees."
- Professional Costs (Percent of Medicare): "Payout = 10% of each dollar miss as measured by impact to paid professional claims; subject to maximum payout ('cap') of 5% of that year's total administrative fee attributable to in-state members, exclusive of fund administration fees and optional services fees."
- Annual PMPM Incurred Medical Cost Trend (Trend Guarantee): "Payout = 10% of each dollar miss as measured by impact to paid total medical claims up to a 10% trend; subject to cap of 5% of that year's total administrative fee attributable to in-state members (exclusive of fund administration fees and optional services fees). If actual trends exceed 10%, Blue Cross NC will automatically pay out 5% of administrative fee attributable to in-state members even if cap has not been reached."<sup>51</sup>

As the above quotes from Blue Cross's Administrative Fee BAFO show, Blue Cross proposed three separate payouts related to discount targets and three separate payouts related to percentage of Medicare targets,

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<sup>51</sup> Blue Cross NC\_0000151.

each involving up to 5 percent at risk—a total of 30 percent at risk. In addition, Blue Cross also placed 5 percent of its administrative fees at risk under the trend guarantee, for a grand total of up to 35 percent of the administrative fees at risk.<sup>52</sup>

Both the Plan and Segal incorrectly concluded that Blue Cross placed only 5 percent total at risk for the discount guarantees and the percentage-of-Medicare guarantees, plus 5 percent at risk for the trend guarantee, for a total of 10 percent at risk.<sup>53,54</sup> Segal’s scoring entry on Blue Cross stated, “The least value is due to a limited amount at risk at 5% of admin.”<sup>55</sup> That conclusion missed the fact that Blue Cross’s guarantees, quoted above, stated seven separate “payouts,” each with its own separate 5 percent cap.

When the Plan and Segal evaluated Blue Cross’s guarantees, they showed doubt on how much Blue Cross was placing at risk. Sceiford wrote, “Coverage is limited to 5% of admin fee...what does it include?”<sup>56</sup> On November 16, 2022, Wohl says, “BCBS put only 5% at risk. Do we say something else?”<sup>57</sup> To resolve these doubts and to score Blue Cross’s guarantees accurately, the Plan and Segal could have sent Blue Cross a clarification request on this issue. After all, as discussed in Opinion 3, the Plan and Segal sent Blue Cross seven clarification requests on other issues. Segal and the Plan also could have considered the amount that Blue Cross historically placed at risk under its prior contracts with the Plan. This information could have shed light on the meaning of Blue Cross’s 2022 guarantee proposal.

In sum, the Plan and Segal incorrectly concluded Blue Cross put only 5 percent of its administrative fees per year at risk on its discount guarantees and 5 percent more at risk on its trend guarantees.

(5) Segal erred by downgrading Blue Cross for having a low amount at risk due to Blue Cross having “significantly lower admin fees.”<sup>58</sup> Lower administrative fees are beneficial to the Plan. Segal’s analysis implies the illogical conclusion that charging the Plan *higher* administrative fees would have made Blue Cross’s discount guarantee more valuable.<sup>59</sup>

(6) Segal erred by downplaying the fact that Blue Cross’s trend guarantee was more favorable than Aetna’s. Blue Cross guaranteed that the Plan’s claims costs would rise by no more than 6 percent per year. Aetna, in contrast, offered the less favorable trend target of 6.8 percent per year. This difference means that over 2026-2029, the Plan could incur an additional 0.8 percent per year in claims costs (about \$25 million per year) without triggering Aetna’s trend guarantee.

Segal's evaluation did not appear to put weight on these bottom-line concerns. Segal stated, “While [Blue

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<sup>52</sup> Blue Cross’s 30(b)(6) Deposition, pg. 106, lines 2-18.

<sup>53</sup> Segal’s 30(b)(6) Deposition, pgs. 210, 213-14, full pages.

<sup>54</sup> SHP 0093117.

<sup>55</sup> SHP 0069464, “Pricing Guarantee” tab, cell K11.

<sup>56</sup> SHP 0093117.

<sup>57</sup> SHP 0093060.

<sup>58</sup> SHP 0069464, “Pricing Guarantee” tab, cells D-H27.

<sup>59</sup> SHP 0069464, “Pricing Guarantee” tab.

Cross] offers the lowest trend target, it is diminished by the lowest dollar amount at risk.” As I explain in point 1 above, this singular focus on the amount at risk is irrational: Under most scenarios, the bottom-line costs to the Plan depend more on the trend rate achieved than on the payback amount at risk.

(7) Segal did not calculate claims costs for the two option years (2028 and 2029), even though the vendors included these years in the bids. Segal’s non-analysis of 2028 and 2029 advantaged Aetna by ignoring Blue Cross’s guarantees of discount improvements in those years. In most of my analysis below, I have focused on figures from 2025 to 2027, to address Segal’s evaluation as Segal framed it. But by doing so, I do not mean to ratify Segal’s decision to leave 2028 and 2029 out of its evaluation.

(8) The Plan and Segal put no weight on the reduced value posed by Aetna’s “composite” approach to its guarantees. Attachment A-8 to the RFP called for three separate discount guarantees and three separate percentage-of-Medicare guarantees, each with its own separate target and amount at risk. Although Aetna stated these separate targets and amounts at risk, Aetna’s use of a composite target attenuated the effects of the amounts at risk by stating that the guarantees would be reconciled annually “on an aggregate basis to [an] overall aggregate target.”<sup>60</sup>

The Plan and Segal ignored the fact that Aetna’s composite guarantee renders Aetna’s other guarantees relatively meaningless, because only a shortfall against the composite generates a payout.<sup>61</sup> By proposing a composite, Aetna allowed itself to offset a missed target on one service line by cross-subsidizing it with another service line. For example, Aetna could incur a discount shortfall for inpatient services (which would otherwise trigger a payout) but offset the shortfall with stronger than expected discounts in outpatient services and thus ultimately avoid making any payout. This potential cross-subsidization runs counter to the design of the RFP for network guarantees, which required each vendor to promise to repay the Plan for missing a target for one service type even if the vendor surpassed its target for another service type.

Sceiford, the Plan’s actuary, expressed concerns about Aetna’s “composite” approach in an email to Kuhn on November 14, 2022: “Discount and % of Medicare are based on a COMPOSITE of all components...(Composite line is a not a part of RFP)...”<sup>62</sup>

Despite the Plan’s actuary raising this concern, Segal does not seem to have changed the scoring of Aetna’s guarantees. In the end, the narrative in Segal’s scoring workbook made no mention of the composite nature of Aetna’s guarantees.<sup>63</sup> Thus, Aetna’s use of a composite guarantee is a value reduction on which the Plan and Segal apparently put no weight.

(9) Segal also erred in its background analysis of the effect of Aetna’s composite guarantees. In its

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<sup>60</sup> SHP 0000010, “Guarantees (In State)” tab, cells C-G24 and C-G41.

<sup>61</sup> SHP 0000010.

<sup>62</sup> SHP 0093117.

<sup>63</sup> SHP 0069464, “Pricing Guarantee” tab, columns N – U.

background analysis, Segal fused Blue Cross's and UMR's three separate discount guarantees into a composite discount target, using the respective weights of inpatient services, outpatient services, and professional services (on a 2021 billed-charge basis). Segal also ran this same calculation for Aetna. Segal's calculation for Aetna yielded a composite of 51.9 percent.<sup>64</sup> Despite this calculation, Segal's scoring workbook listed Aetna's discount target at 52.3 percent<sup>65</sup>—0.4 percent higher than Segal's calculated composite amount for Aetna.

The Plan and Segal sent five Requests for Clarification to Aetna. At no point in these requests was Aetna asked to clarify its composite guarantee or its guarantees for inpatient services, outpatient services, and professional services. This lack of probing contrasts sharply with the Plan's and Segal's approach, described in Opinion 3, to Blue Cross's repricing exercise: On the repricing exercise, the Plan and Segal downgraded Blue Cross's discount percentage to align with the Plan's and Segal's view of the RFP's instructions. On the discount guarantees, in contrast, the Plan and Segal chose instead to adjust the responses of the vendors who followed the RFP instructions (Blue Cross and UMR) to align them with the response of the vendor who did not (Aetna).

(10) The Plan and Segal erred by treating UMR's discount guarantees as offering the "greatest comparative value" even though UMR offered *no discount guarantee at all* for four of the five years covered by the RFP (2026 to 2029). At his deposition, Segal's corporate representative tried to justify this scoring by stating that after the first year, the trend guarantees "take over."<sup>66</sup> That rationalization, however, contradicts the Plan's decision to seek discount guarantees for all five years covered by the RFP. It also underscores the subjective way that the Plan and Segal scored the pricing guarantees.

(11) The Plan and Segal also erred by treating UMR's trend guarantees as offering "moderate comparative value" even though UMR did not guarantee any specific trend percentages. UMR stated its trend guarantee target as 1 percent lower than the "book-of-business trend" for UnitedHealthcare as a whole.<sup>67</sup> If UnitedHealthcare's book-of-business trend was adversely high, the Plan's claims costs would inflate accordingly, with no payout under UMR's trend guarantee.

This form of target violated the instructions on Attachment A-8, which called for a maximum "percent increase over prior year."<sup>68</sup> In addition, UMR's bid apparently provided no concrete information on UnitedHealthcare's historical or expected book-of-business trends.<sup>69</sup> Because of this lack of information, the Plan and Segal did not know whether UMR's trend target was better or worse than the 6 percent

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<sup>64</sup> SHP 0069503, "Aetna -->" tab, cell I25.

<sup>65</sup> SHP 0069464, "Pricing Guarantee" tab, cell D10.

<sup>66</sup> Segal's 30(b)(6) Deposition, pg. 219, line 3-7.

<sup>67</sup> The UnitedHealthcare book of business trend refers to the aggregate claims cost trend percentage across all of UnitedHealthcare's health insurance plans.

<sup>68</sup> SHP 0000010, "Guarantees (In-State)" tab, cell C43-46.

<sup>69</sup> UMR's bid states that, "Once the 2026 National Account Book of Business Covered Charge Trend % is known (about six months after the close of the guarantee period), UMR will compare that trend % to State of North Carolina's 2026 trend %." SHP 0069503, "UMR BAFO" tab.

target proposed by Blue Cross. Given this lack of information and given how much more guarantee targets affect the Plan's bottom line than at-risk amounts do, the Plan and Segal had no sound basis for scoring UMR's trend guarantee as more valuable than Blue Cross's.

(12) Finally, the Plan and Segal erred by excluding the percentage-of-Medicare guarantees from the scoring altogether. In his deposition, Segal's corporate representative admitted that the percentage of Medicare guarantees were not scored because, "[t]hey tend to get more complicated. And determining a basis point, we don't really have the ability to do that."<sup>70</sup> As far as the Segal representative was aware, moreover, the Plan raised no objection to the non-scoring of the percentage-of-Medicare guarantees.<sup>71</sup> That non-scoring contradicted the Plan's decision to seek percentage-of-Medicare guarantees. It also contradicted the Plan's focus on reference-based pricing (i.e., pricing pegged to Medicare rates)—a focus that the RFP stated in the first substantive section of the RFP.<sup>72</sup>

### **The Impact of Segal's Flawed Evaluation and Scoring**

The lack of quantitative analysis of the pricing guarantees, coupled with the above flaws in the Plan's and Segal's subjective evaluation of the guarantees, resulted in rankings and scores that lacked any sound basis.

The discount level achieved by a TPA affects the Plan's bottom line far more than the at-risk amount on pricing guarantees does.<sup>73</sup> As Segal's corporate representative admitted at his deposition, the goal of pricing guarantees is "to produce the best cost for the State," not to receive payouts of the at-risk amounts.<sup>74</sup>

Accordingly, to evaluate the "value" of a guarantee, one must assess the bottom-line impact to the Plan if the vendor achieved or missed its targets, including, in each scenario, the actual claims costs minus the guaranteed rebate amount.

If Segal had quantified these bottom-line impacts, it would have seen that Blue Cross's guarantees offered the Plan hundreds of millions of dollars of savings more than Aetna's guarantees offered. To illustrate this point, I have identified, in Figure 5 below, the price effect of the discount guarantees bid by each vendor: the claims cost that the Plan would incur if the vendor hit its guaranteed discount exactly. The blue cells mark years when Blue Cross guaranteed a lower claims cost than Aetna or UMR guaranteed.

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<sup>70</sup> Segal's 30(b)(6) Deposition, pg. 206, line 24 through pg. 207, line 2.

<sup>71</sup> Segal's 30(b)(6) Deposition, pg. 207, lines 16-25.

<sup>72</sup> SHP 0072588.

<sup>73</sup> Segal's 30(b)(6) Deposition, pg. 185, line 17 through pg. 186, line 4.

<sup>74</sup> Segal's 30(b)(6) Deposition, pg. 179, lines 23-24.

**Figure 5**  
**Summary of Vendor Guarantee Amounts and Claims Cost<sup>75</sup>**

		<b>2025</b>	<b>2026</b>	<b>2027</b>	<b>Total (2025-2027)</b>
<b>Aetna</b>	<b>Discount Guarantee</b>	52.3% <sup>76</sup>	52.3%	52.3%	
	<b>Claims Cost</b>	\$3,076,558,011	\$3,252,777,060	\$3,439,461,836	\$9,768,796,907
<b>Blue Cross</b>	<b>Discount Guarantee</b>	55.1%	55.5%	55.9%	
	<b>Claims Cost</b>	\$2,911,678,095	\$3,054,051,447	\$3,203,651,700	\$9,169,381,242
<b>UMR</b>	<b>Discount Guarantee</b>	52.6%	No Guarantee	No Guarantee	
	<b>Claims Cost</b>	\$3,059,737,643	N/A	N/A	N/A
<b>Amount that Aetna's Claims Cost is Higher than Blue Cross's</b>		<b>\$164,879,916</b>	<b>\$198,725,614</b>	<b>\$235,810,135</b>	<b>\$599,415,665</b>
<b>Amount that UMR's Claims Cost is Higher than Blue Cross's</b>		<b>\$148,059,548</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>

As the above figure shows, the bottom-line claims cost to the Plan would be \$599,415,665 less under Blue Cross's guarantees compared to Aetna's if each vendor were to hit its guarantee target. In addition, because Blue Cross's guarantee target improves over time while Aetna's stays the same, this total difference would be even greater if calculated over the entire 2025 to 2029 timeframe.

In short, Segal did not use claims costs to evaluate the pricing guarantees, even though these costs have the largest impact on the Plan's budget and, by extension, North Carolina taxpayers and the Plan's members.

The Plan and Segal also erred in their evaluation of possible *misses* (also called "shortfalls") of the vendors' guarantee targets.

As discussed above, the Plan and Segal misread Blue Cross's amounts at risk and did not ask any clarifying questions about these amounts. For Blue Cross's discount guarantees, these errors led Segal to calculate Blue Cross's maximum dollars at risk as \$2,653,011 (5 percent of Blue Cross's administrative fee) when the correct amount at risk on the discount guarantees was \$7,959,033 (15 percent of Blue Cross's administrative fee). Although Aetna's maximum amount at risk was higher than Blue Cross's, the

<sup>75</sup> The discount targets shown in this figure are the composite discount target proposed by Aetna and the weighted average discount target calculated for Blue Cross and UMR in Segal's formulas in SHP 0069503 on the "BCBS -->" and "UMR -->" tabs, respectively. (The differences shown in this figure would be even larger if the Plan and Segal had calculated Aetna's discount target in the same way that it calculated Blue Cross's and UMR's weighted average discount targets, as I describe above.) The claims cost in this figure is calculated by using the formulas built by Segal on the "Network Pricing" tab of SHP 0069464 by plugging in the discounts in the figure above into the Adjusted % column. On the same tab, the resulting claims costs are shown for Aetna, Blue Cross, and UMR on rows 25 to 27, which includes the non-Medicare and Medicare claims cost.

<sup>76</sup> Segal's weighted average discount percentage for Aetna (calculated in the same manner as the weighted average for Blue Cross and UMR) is 51.9 percent. SHP 0069503, "Aetna -->" tab.

difference—both in absolute dollars at risk and in the bottom-line impact of any guarantee payout—was not as large as Segal stated.

The total amount placed at risk and the shortfall that triggers a given payout are related variables. Typically, if the amount placed at risk is lower, a vendor will hit a given payout at a lower “miss” percentage. Conversely, if the amount placed at risk is higher, a vendor can miss its target by a much higher percentage and potentially never trigger the maximum payout.

Because of this interaction between miss percentages and at-risk amounts, when the Plan and Segal assessed the value of the vendors’ at-risk amounts, they should have evaluated the payouts associated with various miss percentages. If they had done so, they would have seen that Blue Cross’s discount guarantees offered greater value to the Plan than Aetna’s did.

Segal concluded that Blue Cross’s at-risk amount would be exhausted after only a 0.5 percentage-point<sup>77</sup> shortfall from Blue Cross’s discount targets.<sup>78</sup> As a result, Segal concluded that Blue Cross’s pricing guarantees delivered little value to the Plan. After correcting Segal’s error and accounting for the total of 15 percent (\$7,959,033) that Blue Cross placed at risk on its discount guarantees, I found (using Segal’s methodology) that the maximum amount Blue Cross would refund to the Plan would cover a discount-percentage miss of 1.4 percentage points.<sup>79</sup>

Aetna would not refund its maximum amount at risk unless it missed its discount target by a higher percentage: 1.9 percentage points.<sup>80</sup> As discussed above, Aetna’s discount target was conservative; therefore, it is unlikely that Aetna would miss by this large of a percentage. That large of a miss would mean an achieved discount percentage of only 50.4 percent—2.6 percentage points below the 53 percent discount that Aetna bid in its repricing exercise.

In addition, Aetna’s discount-guarantee target was a flat 52.3 percent for all five of the years covered by the RFP. Because achieved discount percentages (measured by contracted amounts and billed charges in the same year) tend to rise over time, the likelihood that Aetna would miss its 52.3 percent discount-guarantee target, let alone achieve a discount percentage as low as 50.4 percent, would decrease over the period in question.

For these reasons, when Segal focused on Aetna’s maximum payout under its discount guarantees—a payout associated with a 1.9-percentage-point miss—Segal focused on an amount at risk that Aetna is unlikely to ever pay.

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<sup>77</sup> Segal rounded this figure from 0.451775 percent to 0.5 percent.

<sup>78</sup> In these calculations, I have (for discussion purposes) used the same aggregation of the inpatient, outpatient, and professional discount targets that Segal used, as shown in SHP 0069464.

<sup>79</sup> See SHP 0069503.

<sup>80</sup> SHP 0069464, “Pricing Guarantee” tab, cell N10.

Most importantly, the Plan’s and Segal’s evaluation of the vendors’ “maximum miss” amounts and discounts overlooked the bigger picture of the bottom line to the Plan under “maximum miss” scenarios. Because Blue Cross proposed a more aggressive discount guarantee target, the net costs to the Plan (claim costs minus refund amount) if Blue Cross missed its target by 1.9 percentage points would be about \$138 million lower than the net costs to the Plan if Aetna missed its target by 1.9 percentage points. Figure 6 below shows this calculation. Cells highlighted in blue denote miss scenarios where Blue Cross has the better bottom-line claims costs after the payback amount has been refunded.

**Figure 6**  
**Bottom-Line Impact on Costs to the Plan**  
**Resulting From Maximum Miss in Discounts**

		<b>2025 Guarantee</b>	<b>Impact of 1.9% Miss</b>
<b>Aetna</b>	Discount	52.3%	50.3%
	Total Claims Cost	\$2,789,735,211	\$2,901,257,758
	Refund to the Plan	\$0	\$22,304,510
	Total Claims Costs Less Refund	\$2,789,735,211	\$2,878,953,249
<b>Blue Cross</b>	Discount	55.1%	53.2%
	Total Claims Cost	\$2,636,713,685	\$2,748,809,579
	Refund to the Plan	\$0	\$7,959,033
	Total Claims Costs Less Refund	\$2,636,713,685	\$2,740,850,546
<b>Bottom-Line Difference</b>		<b>\$153,021,526</b>	<b>\$138,102,703</b>

In its scoring workbook, Segal calculated the miss percentages that would trigger the maximum payouts under the guarantees. Segal’s narrative evaluation of the guarantees, however, makes no mention of the associated costs.<sup>81</sup>

Nor does Segal’s workbook calculate any other miss percentages and the associated paybacks and costs. In Figure 7 below, I have shown that Aetna could miss its discount guarantee by 1.0 percent and refund only a bit more than half of the maximum amount at risk. The figure shows that with a 1.0 percent shortfall and with other possible shortfall scenarios, Blue Cross’s discount guarantee produces a bottom line to the Plan that is better by more than \$140 million in any of these scenarios.

<sup>81</sup> SHP 0069464, “Pricing Guarantee” tab.

**Figure 7**  
**Bottom-Line Impact on Costs to the Plan**  
**Resulting From Incremental Misses in Discounts**

		<b>2025 Guarantee</b>	<b>Impact of 0.5% Miss</b>	<b>Impact of 1.0% Miss</b>	<b>Impact of 1.5% Miss</b>
<b>Aetna</b>	Discount	52.3%	51.8%	51.3%	50.8%
	Total Claims Cost	\$2,789,735,211	\$2,818,947,098	\$2,848,158,985	\$2,877,370,872
	Refund to the Plan	\$0	\$5,842,377	\$11,684,755	\$17,527,132
	Total Claims Costs Less Refund	\$2,789,735,211	\$2,813,104,720	\$2,836,474,230	\$2,859,843,740
<b>Blue Cross</b>	Discount	55.1%	54.6%	54.1%	53.6%
	Total Claims Cost	\$2,636,713,685	\$2,666,075,753	\$2,695,437,821	\$2,724,799,888
	Refund to the Plan	\$0	\$2,936,207	\$5,872,414	\$7,959,033
	Total Claims Costs Less Refund	\$2,636,713,685	\$2,663,139,546	\$2,689,565,407	\$2,716,840,855
<b>Bottom-Line Difference</b>		<b>\$153,021,526</b>	<b>\$149,965,174</b>	<b>\$146,908,823</b>	<b>\$143,002,885</b>

In summary, the data collected through the RFP allowed for a quantitative analysis of each component of the guarantees and the bottom-line effects of the guarantees. However, the Plan and Segal did not perform such a quantitative analysis. Instead, they waited until after they had received the bids and then conducted a subjective assessment that seems to have valued only the dollar amount Segal and the Plan believed to be at risk. In addition to being subjective, the Plan’s and Segal’s conclusions were flawed for at least the reasons stated above.

The Plan and Segal also ignored the most valuable feature of the pricing guarantees: the bottom-line costs to the Plan that would result from the discount targets proposed by each of the vendors. Instead of comparing these bottom-line costs, the Plan and Segal focused on the maximum amounts of administrative fees each vendor placed at risk. The Plan and Segal did so even though those maximum amounts are unlikely to be refunded to the Plan, and even though those amounts would affect the Plan’s bottom line far less than the discount targets themselves would.

**Opinion 2: For providers with letters of intent, the actual prices to which the providers agreed are higher than the prices Aetna used in the repricing exercise. That discrepancy will result in higher bottom-line costs to the Plan than Aetna presented in its bid.**

Aetna has letters of intent with [REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED] Plan members' claims attributable to these providers total [REDACTED] billed charges for the entire network of providers.

For these [REDACTED], Aetna's repricing bid apparently relied on letters of intent that promised reduced prices if Aetna wins the Plan's TPA contract. In document discovery, Aetna produced its letters of intent with these [REDACTED]. *The discounts in those letters of intent are not as deep as the discounts Aetna bid.* For [REDACTED] in particular, Aetna bid prices that are materially lower than the actual rates agreed to in the [REDACTED] letter of intent. As a result, the claims costs associated with these providers will be higher for the Plan than the prices in Aetna's proposal.

The claims and billed charges in the repricing file attributed to these providers are shown in Figures 8, 9 and 10.<sup>82</sup>

**Figure 8**  
**Aetna Claims and Billed Charges Attributable to [REDACTED]**

Provider Name	County	Claims	Charges
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

<sup>82</sup> SHP 0069462, SHP 0069463.

**Figure 9**  
**Aetna Claims and Billed Charges Attributable to REDACTED**

Provider Name	County	Claims	Charges
REDACTED			
REDACTED	REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED	REDACTED
REDACTED		REDACTED	REDACTED

**Figure 10**  
**Aetna Claims and Billed Charges Attributable to REDACTED**

Provider Name	County	Claims	Charges
REDACTED	REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED	REDACTED
REDACTED		REDACTED	REDACTED

I analyzed the claims found in the repricing file for REDACTED, as well as the contract rate terms contained in the letters of intent for the same providers, to identify differences between the rates Aetna bid for these providers and the actual rates that the Plan (through Aetna) would pay these providers if Aetna becomes the new TPA.

Among the documents I reviewed is a “Letter of Agreement” between REDACTED and Aetna with an REDACTED. It was REDACTED.<sup>83</sup> The agreement refers to Aetna’s networks called REDACTED and indicates that REDACTED will participate in these Aetna networks if Aetna becomes the TPA. It also states that Aetna will reduce the REDACTED rates by REDACTED if Aetna is awarded the Plan’s TPA contract. A second document produced by Aetna is a REDACTED between Aetna and REDACTED also with an effective date of January 1, 2023, and signed June 20, 2022. This agreement includes detailed rate schedules REDACTED, with rates REDACTED.<sup>84</sup>

Aetna signed REDACTED, effective July 15, 2022. This amendment states that the reimbursement for the Plan will be paid at REDACTED.<sup>85</sup> A

<sup>83</sup> AENTNA0001992.  
<sup>84</sup> AETNA0026101, pg. 107.  
<sup>85</sup> AETNA0014000.

REDACTED

<sup>86</sup>

Aetna also signed a REDACTED with REDACTED, effective July 15, 2022. This REDACTED specifies that REDACTED will be paid REDACTED of billed charges.<sup>87</sup>

The reimbursement rates in these agreements do not appear to align with the rates that Aetna assumed for these providers in the repricing exercise. To test this hypothesis, in the claims repricing file submitted by Aetna, I identified the REDACTED that apply specifically to REDACTED. Using the reimbursement terms found in the agreements, I priced REDACTED.

In Figure 11 below, REDACTED at issue, I compare the contracted amounts assumed by Aetna in the repricing exercise and the actual contracted amounts found in the letters of intent.<sup>88</sup>

**Figure 11**  
**Difference between Aetna’s Bid Amounts and Actual Contract Rates<sup>89</sup>**

Provider	Claims	Charges	Contracted Amount		Discount Percentage		
			Aetna’s Bid	Priced Using Actual Rates in Letters of Intent	Aetna’s Bid	Priced Using Actual Rates in Letters of Intent	Difference
REDACTED							

<sup>86</sup> AETNA0019463.

<sup>87</sup> AETNA0013892.

<sup>88</sup> SHP 0069462, SHP 0069463, SHP 0083572.

<sup>89</sup> Transplant services have been excluded from the analysis.



In summary, the actual rates in Aetna's agreements with REDACTED show that Aetna's repricing bid understated the network costs for services provided by these REDACTED. The amount of the understatement is almost \$30 million.

**Opinion 3: Through the clarifications process, the Plan and Segal erroneously decreased Blue Cross's discount. That erroneous adjustment resulted in Blue Cross and Aetna earning 6 points each for the repricing exercise, as opposed to Blue Cross earning 6 points and Aetna earning 3 points.**

This opinion focuses on the network pricing section of the cost proposal, which was scored based on the vendors' claims cost, i.e., the cost to Plan and members. In that section of the cost proposal, the Plan and Segal incorrectly calculated Blue Cross's claim cost. In particular, the Plan and Segal adjusted Blue Cross's discount percentage from 54.0 percent down to 52.7 percent, while leaving Aetna's discount percentage at 52.99 percent. Those decisions had a pivotal effect on the outcome of the repricing exercise in this RFP.

### **Overview**

Healthcare providers typically increase billed charges periodically. In my experience, these increases usually occur on an annual basis. Over time, these charge increases are referred to as a **charge trend**. For example, a provider's charge for an office visit may increase from \$100 in one year to \$115 the next year and \$130 the following year. The charge trend is equal to the percentage change in the dollar amounts from year to year—in this example, 15 percent from year one to year two and about 13 percent from year two to year three.

Contract rates typically increase from year to year as well. When payers and providers negotiate contracts, the parties typically agree on the amount that contract rates will increase and how often. Contract rate increases that occur over a specific period of time are referred to as an **allowed trend**. For example, the contract rate for the same office visit discussed in the above example may increase from \$80 in one year to \$90 the next year and \$100 the following year. In this example, the allowed trend would equal the percentage change in the dollar amounts from year to year—in this example, about 13 percent from year one to year two and about 11 percent from year two to year three.

Because of the likelihood that billed charges and contracted rates will go up over time, discount percentages shift over time as well. At any given time, the discount percentage depends on the then-prevailing allowed amounts and billed charges. In the above example, the discount percentage is 20 percent for year one. The discount percentage changes to about 22 percent  $[(115-90)/115]$  in year two. In year three, the discount percentage changes again to about 23 percent  $[(130-100)/130]$ . In the context of this RFP, the increase in the discount that occurs each year as a result of these changes was referred to as a **contract improvement**.

Payers calculate plan-wide discount percentages by applying the same calculation illustrated above across all providers.

Using the same example discussed above, Figure 12 illustrates how discount percentages change when billed charges and contract rates increase. This figure also shows how a discount percentage can improve even when the dollars being paid to providers are increasing.

**Figure 12**  
**Illustration of Discount-Percentage Calculation**

	<b>Billed Charge</b>	<b>Contract Rate</b>	<b>Discount<sup>90</sup></b>
<b>Year 1</b>	\$100	\$80	20%
<b>Year 2</b>	\$115	\$90	22%
<b>Year 3</b>	\$130	\$100	23%

In summary, billed charges and allowed amounts change over time. These changes often result in changes to discount percentages.

**Repricing Exercise Instructions and Scoring**

In the repricing exercise here, vendors were given a large data file with most of the Plan’s actual 2021 claims submitted by providers. The data included provider ID codes, provider location, member ID codes, plan type<sup>91</sup>, service type billing codes,<sup>92</sup> and the billed charges for each claim. The RFP instructions stated, “[u]sing the repricing file..., Vendors are to provide the contracted allowed amount for each service in the file. Vendors are expected to reprice each claim line based on provider contracts in place, or near-future contract improvements bound by letters of intent, at the time of the repricing.”<sup>93</sup> The vendors were required to summarize the results of this repricing exercise in Attachments to the cost proposal.

To convert the vendors’ discounts from the repricing exercise into allowed amounts (or claims cost), Segal followed a series of steps, which are found in Segal’s scoring workbook:<sup>94</sup>

- Segal identified the in-network discounts calculated by the vendors in the repricing exercise.<sup>95</sup>
- It adjusted the in-network discounts based on the Requests for Clarifications, a process described later in this opinion.
- Segal adjusted the discounts for “improvements,” which Segal calculated only if a vendor’s guaranteed discount was higher than the vendor’s discount in the repricing exercise. In that case, Segal calculated the “improvement” percentage of the billed charges represented by the vendor’s dollars at risk.

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<sup>90</sup> The discount percentages were rounded to the nearest percentage point.

<sup>91</sup> Base PPO Plan or Enhanced PPO Plan.

<sup>92</sup> Billing codes are standardized codes used to identify specific services. These include Diagnosis-Related Group (“DRG”) codes and Current Procedural Terminology (“CPT”) codes.

<sup>93</sup> The RFP did not specify a particular repricing date, but later clarification requests specify November 1, 2022 (the first day of the month that responses to the RFP were due from vendors) as the “repricing date.” See, e.g., SHP 0069464, “11-18 Clarifications” tab, in the row descriptions of the provided matrices.

<sup>94</sup> SHP 0069464.

<sup>95</sup> Segal combined letter of intent providers with in-network providers for the analysis.

- Segal then calculated an “Estimated Network Relative Value,” which is an index number that compares the adjusted in-network discount for each vendor with the actual discount realized by the Plan for 2021. Because of this definition, a lower estimated network relative value is better than a higher value.
- Segal then calculated an “Assumed Network Utilization:” the percentage of each vendor’s allowed amount that was in-network according to the repricing exercise.
- Segal then calculated an “Estimated Total Relative Value,” which is an index number that compares the total adjusted discount (including in-network and out-of-network claims) for each vendor with the actual total discount realized by the Plan for 2021. In this context, Segal valued each vendor’s out-of-network claims at a 50 percent discount. Here again, a lower estimated total relative value is better than a higher relative value.
- Segal then estimated baseline allowed amounts for the Plan 2025 to 2027 by adjusting the Plan’s actual 2021 allowed amounts<sup>96</sup> with annual trends and assumed changes in Plan enrollment.
- For each vendor, Segal then multiplied the Plan’s baseline allowed amount for 2025 to 2027 by the vendor’s Estimated Total Relative Value. That calculation resulted in each vendor’s estimated non-Medicare allowed amount by year.
- Segal then projected 2025 to 2027 allowed amounts for to the Plan’s Medicare-eligible population and added those figures (the same figures for all three vendors) to each vendor’s non-Medicare allowed amount.
- That addition yielded each vendor’s total projected allowed amount.

Although Segal’s final scoring tables showed the discount percentages that vendors calculated in the repricing exercise,<sup>97</sup> Segal ultimately did not rely on those discounts to score the repricing exercise. Instead, the network pricing evaluation relied on modified in-network discounts that Segal arrived at after a series of clarifications (especially to Blue Cross), adjustments based on effects of the pricing guarantees, and an assumed 50 percent out-of-network discount for all three vendors (as described above). This approach relied less on the results of each vendor’s repricing analysis and more on Segal’s assumptions and adjustments.

### **Requests for Clarification**

The Plan and Segal initiated a series of written “Requests for Clarification,” in which they sought additional information from the vendors regarding how the discounts were calculated in the repricing exercise. Through these clarification requests, Segal posed specific questions to each of the vendors. In some cases,

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<sup>96</sup> Segal used only the allowed amounts attributable to the Plan’s non-Medicare population.

<sup>97</sup> The aggregate discount percentage that resulted from the repricing exercise was found in each vendor’s Attachment A-4.

the questions were the same for multiple vendors. In other cases, the questions were different. Segal's corporate representative testified that Segal took the lead in making—and drafting—these clarification requests.<sup>98</sup> Segal, through the Plan, issued Requests for Clarification on November 10, 15, 18, 22, 23, and 28, 2022.<sup>99</sup> Four out of the six requests addressed to Blue Cross regarding the discounts required that responses be submitted within 24 hours.

In the November 10, 2022 clarification requests (Blue Cross Request for Clarification #2,<sup>100</sup> Aetna Request for Clarification #4<sup>101</sup>), Segal asked Blue Cross and Aetna the following: “In the claims repricing . . . please indicate whether your response is based only on provider contracts in place, or near-future contract improvements bound by letters of intent, at the time of the repricing; OR, your response reflects projected future discounts beyond those bound by letters of intent. If this is the case, provide the discount value of these future discounts.” Aetna responded that its repricing results were “based only on provider contracts in place, near-future contract improvements bound by letters of intent, and custom discounts specifically negotiated for the SHPNC which have been bound by letters of intent, at the time of the repricing.” Blue Cross responded that its repricing results were “based on provider contracts that are in place. There were not any adjustments made for letters of intent or future contract improvements.”

In the November 10 clarification requests, Segal also asked Blue Cross and Aetna whether the discount improvements in Attachment A-6 were included in the claims repricing responses.<sup>102</sup> Both vendors answered that discount improvements in Attachment A-6 were not included.

The next clarification request was issued on November 15, 2022, in which Segal asked Blue Cross a similar question to the first clarification request. Segal did not send a follow up-question to Aetna on this topic. The clarification request to Blue Cross stated, “a vendor's repricing may reflect contracted discount improvements to enforce provider contracts as well as near-future improvements bound by letters of intent. If these were reflected in your repricing as indicated in your response to Request for Clarification #2, provide the absolute value of the discount improvement associated and a detailed description of the improvement. If these were not included as they are not applicable to your provider contracting, indicate that.” Blue Cross answered that its “repricing [analysis] was done with historical discount data projected forward, capturing the signed 2023 contractual reimbursement rate changes. Projected discounts were then calculated using industry-approved methodologies, based on the submitted, known contracting changes and the UDS<sup>103</sup> prescribed billed charges trends.”<sup>104</sup> In other words, Blue Cross trended the 2021

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<sup>98</sup> Segal's 30(b)(6) Deposition, pg. 236, line 7 through pg. 237, line 5.

<sup>99</sup> The Plan and Segal issued clarification requests to UMR, which I have omitted from this report as they are not directly relevant to my opinions.

<sup>100</sup> SHP 0087957.

<sup>101</sup> SHP 0087964.

<sup>102</sup> As described previously, Attachment A-6 is called “Contract Improvements” and asked vendors to project the contract improvement percentage that they expected to achieve for each county by January 1, 2025.

<sup>103</sup> UDS stands for Uniform Discount Specifications or Uniform Discount Standard. UDS data contains claims submitted by health insurers and is used by actuarial firms and health insurers to identify billed charge trends and discount trends in markets, among other things. UDS is addressed in more detail in Opinion 4 of this report.

<sup>104</sup> SHP 0024720.

billed charges in the repricing file forward to the time of the repricing (November 1, 2022), identified the allowed amounts that would be paid according to contracts signed by then, then calculated the discount percentage based on those factors taken together (as illustrated in the example in Figure 12 above). Because the RFP instructed vendors to use contracts for “current” or “near future” services at the time of the repricing, Blue Cross included the allowed amounts under contracts it had already signed for 2022 and 2023. Applying those instructions, Blue Cross calculated a discount rate of 54 percent.

The next clarification request was issued on November 18, 2022 (Blue Cross Request for Clarification #4,<sup>105</sup> Aetna Request for Clarification #5<sup>106</sup>), in which Segal stated to Blue Cross that its repricing was “not consistent with the cost proposal instructions” and, “due to the lack of clarity in your responses,” asked Blue Cross to complete a table that was meant to identify the items included or not included in the discount calculation. Segal also asked Aetna to complete the table even though Segal stated that [Aetna’s] “proposal and subsequent clarifications appear to be consistent with the cost proposal instructions.”<sup>107</sup>

What follows this paragraph are images of the tables (in Figure 13 and Figure 14) included in the clarification requests issued on November 18, 2022. All of the numbers shown in these images were prepopulated for the vendors by Segal. The “Example” column appears to be designed to illustrate how each vendor was supposed to complete the table. In addition, Segal prepopulated the “In-Network Discount Accumulation” column with selected percentages. As shown below, Segal populated the line called “Expected 2025 Discounts” with 54 percent for Blue Cross and Aetna. Segal also populated the lines “Current Letters of Intent” and “Known Contract Improvements” with 53 percent for Aetna. Segal did not prepopulate these lines for Blue Cross.

**Figure 13**  
**Tables from Clarification Requests Sent to Vendors**  
**Blue Cross (left) and Aetna (right)**

	In -Network Discount Accumulation	Example		In -Network Discount Accumulation	Example
2021 Claims Data using 2021 Contracts	%	50.0%	2021 Claims Data using 2021 Contracts	%	50.0%
Indicate the increase in discounts attributed to each of the following:			Indicate the increase in discounts attributed to each of the following:		
Discounts as of Repricing Date (e.g., 11/1/22)	%	51.0%	Discounts as of Repricing Date (e.g., 11/1/22)	%	51.0%
Current Letters of Intent (should not include assumed increases in billed charges)	%	51.4%	Current Letters of Intent (should not include assumed increases in billed charges)	53.0%	51.4%
Known Contract Improvements (should not include assumed increases in billed charges)	%	52.5%	Known Contract Improvements (should not include assumed increases in billed charges)	53.0%	52.5%
Assumed Increases in Billed Charges	%	53.5%	Assumed Increases in Billed Charges	%	53.5%
Anticipated Contract Improvements	%	54.0%	Anticipated Contract Improvements	%	54.0%
Other (please clarify)	%	54.0%	Other (please clarify)	%	54.0%
Expected 2025 Discounts	54.0%	54.0%	Expected 2025 Discounts	54.0%	54.0%

Sources: SHP 0009869 (left), SHP 0069795 (right).

When the vendors returned these tables with numbers in response to the questions posed, the vendors reported numbers that were different from the Plan’s prepopulated numbers:

<sup>105</sup> SHP 0009869.

<sup>106</sup> SHP 0069744.

<sup>107</sup> SHP 0001952.

**Figure 14**  
**Tables from Clarification Answers from Vendors**  
**from Blue Cross (left) and Aetna (right)**

	In -Network Discount Accumulation	Example		In -Network Discount Accumulation	Example
2021 Claims Data using 2021 Contracts	51.2%	50.0%	2021 Claims Data using 2021 Contracts	51.97%	50.0%
Indicate the increase in discounts attributed to each of the following:			Indicate the increase in discounts attributed to each of the following:		
Discounts as of Repricing Date (e.g., 11/1/22)	54.0%	51.0%	Discounts as of Repricing Date (e.g., 11/1/22)	52.11%	51.0%
Current Letters of Intent (should not include assumed increases in billed charges)	54.0%	51.4%	Current Letters of Intent (should not include assumed increases in billed charges)	52.44%	51.4%
Known Contract Improvements (should not include assumed increases in billed charges)	54.0%	52.5%	Known Contract Improvements (should not include assumed increases in billed charges)	52.99%	52.5%
Assumed Increases in Billed Charges	57.8%	53.5%	Assumed Increases in Billed Charges	53.99%	53.5%
Anticipated Contract Improvements	57.8%	54.0%	Anticipated Contract Improvements	53.99%	54.0%
Other (please clarify)	57.8%	54.0%	Other (please clarify)	53.99%	54.0%
Expected 2025 Discounts	57.8%	54.0%	Expected 2025 Discounts	53.99%	54.0%

Sources: SHP 0024713 (left), SHP 0001952 (right).

As shown in Figure 14 above, Blue Cross reported a 54.0 percent discount as of the repricing date, which was derived from a total in-network allowed amount of \$2,686,255,626 and a total of \$5,841,369,152 in billed charges.<sup>108</sup> The 54.0 percent discount is reported on the “Discounts as of Repricing Date” line, not on the “Expected 2025 Discount” line, as Segal had prepopulated.

In addition to completing the table, Blue Cross stated, “[t]he repricing analysis submitted...is based on the 2023 signed contractual reimbursement rate changes and accounts for all known signed contracts. Blue Cross NC does not utilize letters of intent as they do not provide certainty. We rely solely on binding contracts.”<sup>109</sup> Since Blue Cross already had signed contracts (not letters of intent) in place for 2022 or 2023 with all of the providers in its proposed network, Blue Cross reported its same 54.0 percent discount on the lines called “Current Letters of Intent” And “Known Contract Improvements.” This figure showed that letters of intent and discount improvements were having no incremental effect on Blue Cross’s discount percentage.

Blue Cross’s discount percentages also reflected billed charges that corresponded to the dates of Blue Cross’s contracts. As I have described above, providers increase billed charges periodically. Because of these periodic increases in billed charges, an accurate statement of a discount percentage at a point in time must reflect the billed charges at that same point in time. For example, a white paper published by Milliman (a nationally recognized actuarial firm) states that an “effective discount should represent only the true negotiated savings *from billed charges* under the contract provisions.”<sup>110</sup>

In contrast, if a payer calculated its discount percentage by using the billed charges from an earlier year, that calculation would create a distorted result: a discount percentage based on a fraction whose numerator and denominator come from different time periods. Because that fraction would understate

<sup>108</sup> Blue Cross NC\_0001955.

<sup>109</sup> SHP 0024713.

<sup>110</sup> Milliman White Paper. Determining discounts. November 2012. Available at: <https://us.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/healthreform/pdfs/determining-discounts>.

the denominator, it would overstate the resulting price level (relative to true billed charges) and understate the resulting discount percentage. This concept is illustrated in Figure 15 below, using the numbers in the example in Figure 12 of my report:

**Figure 15**  
**Illustration of Understated “Discount” Percentages When Billed Charges Are Held Constant**

	<b>Billed Charge (Without Trend)</b>	<b>Contract Rate (Actual)</b>	<b>Distorted “Discount”</b>
<b>Year 1</b>	\$100	\$80	20%
<b>Year 2</b>	\$100	\$90	10%
<b>Year 3</b>	\$100	\$100	0%

To avoid stating distorted discount percentages, when Blue Cross answered the November 18 clarification request, it included billed charges that corresponded with Blue Cross’s contracts that were in place in late 2022 (which included some contracts for 2023). This calculation produced a 54.0 percent discount, as shown in the clarification table.

The final four rows of the table in the November 18 clarification request appeared to seek 2025 discount percentages. In those rows, Blue Cross projected an expected discount of 57.8 percent for 2025. This expected discount reflected the contract rates under Blue Cross’s contracts that were in place in late 2022, but it trended the billed charges forward to 2025, using data from UDS.<sup>111</sup> That calculation is illustrated in Figure 16 below, using the numbers from my previous example.

**Figure 16**  
**Illustration of Discount Percentage Calculation – Contract Rates Held Constant  
And Billed Charges Trended Forward**

	<b>Billed Charge (Trended)</b>	<b>Contract Rate (Actual)</b>	<b>Actual Projected Discount</b>
<b>Year 1</b>	\$100	\$80	20%
<b>Year 2</b>	\$115	\$80	30%
<b>Year 3</b>	\$130	\$80	38%

Aetna’s clarification table stated that Aetna’s “Discount as of Repricing Date” was 52.11 percent. Aetna then stated that when letters of intent were taken into account, its discount increased to 52.44 percent. Finally, Aetna stated that when known contract improvements were taken into account, its discount increased to 52.99 percent.<sup>112</sup> If, as the Plan and Segal apparently believed, the latter two figures excluded

<sup>111</sup> SHP 0024713.

<sup>112</sup> It is unclear why this percentage does not exactly match the repricing percentage of 53.04. Segal did not ask Aetna for additional clarification regarding the discrepancy. However, there is a comment in Segal’s analysis [SHP 0069494] stating that they rounded Aetna’s discount to 53.0 percent for the network pricing analysis.

any increase in billed charges, this would mean that Aetna had convinced providers to accept fewer dollars than they were receiving before. As stated above, absolute price decreases of that kind are rare in the healthcare industry.

In its response to the same clarification request, Aetna stated that “[t]he 1% discount improvements between the repricing result and expected 2025 discount (52.99 percent v. 53.99 percent) is *driven by assumed billed charge trend*.”<sup>113</sup>

After receiving the responses to the November 18 clarification requests, Segal issued no further requests for clarification to Aetna regarding its discounts. In contrast, Segal issued three more clarification requests to Blue Cross about its 54 percent discount. These clarifications are described below.

On November 22, 2022, the Plan and Segal sent Request for Clarification #5 to Blue Cross, in which Blue Cross was asked to confirm “that the 54.0% does not include any assumed increases in billed charges.” Blue Cross answered that the Plan asked for “provider contracts in place, or near-future contract improvements,” and that Blue Cross “completed the repricing using ‘current and near future’ provider contracts in the repricing analysis.” Blue Cross went on to state that “[t]he claims repricing analysis was conducted in November and the known ‘near future’ contracts include new contracts and rates into 2023.”<sup>114</sup> Blue Cross also stated that when a payer’s contracts include contract rate increases, the calculated discount rate must reflect both the increase in contract rates and the associated increase in billed charges. Blue Cross stated that “Without either of those, [the discount percentage] would not appropriately represent expectations for 2023”<sup>115</sup>—i.e., that it would be inaccurate.

On November 23, 2022, the Plan and Segal sent Request for Clarification #6 to Blue Cross, stating that Blue Cross’s “response [to Clarification #5] clearly indicates a portion of the discount improvement is simply the result of trending charges to 2023.” The clarification request continued: “What percent of the 2.8% improvement (from the 51.2% to 54.0%) is from the billed charge trends versus only contracted improvements?”<sup>116</sup> In response to this request, Blue Cross stated, “The only way for a discount to increase year over year while excluding the corresponding billed charge increase would be for the allowed charges to have a negative trend at the provider level year over year. This would imply that a carrier is able to negotiate lower fees with the providers statewide year over year, which is not consistent with our historical experience in North Carolina.”<sup>117</sup>

Blue Cross’s response aligns with my experience in the healthcare industry. If there were no increase in billed charges from one year to the next, the only way for a discount percentage to increase would be for the payer to pay providers fewer absolute dollars in later years. This outcome would be very unusual: providers typically do not accept lower allowed amounts over time. Historical trends (for both the Plan

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<sup>113</sup> SHP 0001952.

<sup>114</sup> SHP 0069756.

<sup>115</sup> *Id.*

<sup>116</sup> SHP 0087620.

<sup>117</sup> *Id.*

and the broader healthcare marketplace) demonstrate that allowed amounts generally trend upward, not downward, over time.<sup>118</sup>

The Plan and Segal sent Blue Cross a final clarification (Blue Cross Request for Clarification #7), stating,

“The RFP did not request Vendors provide estimated/projected discounts for 2023. Please note that the near-future contract improvements are only applicable in instances where discounts are increasing due to improved contract pricing (not assumed increases in billed charges). Based on Blue Cross NC’s responses to date, you have indicated a discount of 51.2% during 2021 and a projected 2023 discount of 54.0%. The Plan would deduce that your current discount at the time of the repricing is greater than the 51.2%, but lower than the 54.0%. Your responses have also indicated that the majority of the improvement is due to increases in billed charges. You have indicated estimate (*sic*) discount improvements of approximately 1.5% to 2.0% per year (51.2% in 2021, 54.0% in 2023, 57.8% in 2025). As such, is your current discount at the time of the repricing (e.g., November 1, 2022) approximately 52.7% (1.5% improvement for 10 months)?”<sup>119</sup>

Blue Cross responded, “The 2023 discount considering known/signed contract rates is expected to be 54.0%. The 2021 achieved discount experienced by the Plan is 51.2%. Therefore, the actual achieved discount as of November 2022 would be approximately 52.7%.”<sup>120</sup>

To arrive at 52.7 percent, Segal used an approximate midpoint between Blue Cross’s historical 2021 discount (51.2 percent) and Blue Cross’s discount that was based on contracts existing in late 2022 (54.0 percent).<sup>121</sup> In the clarification request, Segal justified the use of that midpoint by stating that vendors were not asked for “projected” increases and that “near future” increases should include only “contract improvements,” not increases in billed charges.

Segal’s reduction of Blue Cross’s discount percentage from 54 percent to 52.7 percent replaced Blue Cross’s actual discount percentage as of late 2022 with an artificially lowered discount percentage. That replacement reflected at least two analytical errors:

First, the replacement of 54.0 percent with 52.7 percent reflected the fallacy that Blue Cross’s stated discount of 54.0 percent was based on a “projection.” It was not. Instead, it was based on signed contracts that were in place in late 2022. The RFP explicitly allowed vendors to rely on contracts for “near future”

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<sup>118</sup> PwC Health Research Institute. Medical Cost Trend: Behind the numbers 2024. Available at: <https://www.pwc.com/us/en/industries/health-industries/library/assets/pwc-behind-the-numbers-2024.pdf>.

<sup>119</sup> SHP 0069760.

<sup>120</sup> SHP 0069760.

<sup>121</sup> Using the discounts Blue Cross included in its table for 2021, 2023, and 2025, Segal determined that Blue Cross’s discount increases approximately 1.5 to 2 percent per year. Segal determined the discount for November 1, 2022, by adding 1.5 to the 2021 discount of 51.2 to arrive at 52.7.

discounts. Segal's corporate representative agreed at his deposition that contracts signed for 2023 fit within this term in the RFP.<sup>122</sup>

Second, the replacement of 54.0 percent with 52.7 percent forced Blue Cross to exclude increases in billed charges. The language of Clarification Request #7 shows that Segal was trying to limit Blue Cross's discount percentage to "contract improvements" (increases in Blue Cross's discount percentage) that would not stem from increases in billed charges. "Contract improvements" of that type, in my experience, are exceedingly rare: they would reflect providers agreeing to accept fewer dollars for a service in year 2 than they accepted for the same service in year 1. That outcome does not align with historical trends or with the way that the healthcare market typically operates.

In contrast, Segal accepted Aetna's initial clarification response and left Aetna's discount percentage at 52.99 percent. It did so despite information that cast doubt on that figure:

- The discounts that Aetna assumed for providers with letters of intent were unrealistic. Aetna assumed discount rates for providers with letters of intent that are *higher* in the aggregate than the discounts for all other providers in Aetna's network. Neither the Plan nor Segal reviewed any of Aetna's signed letters of intent to validate these assumed discounts. As shown in Opinion 2, if the Plan and Segal had done that validation, they would have learned that Aetna's bid discounts from these providers were overstated by an average of 6 percentage points.
- Aetna's corporate representative testified that the discounts in the repricing exercise attributable to Aetna's providers with letters of intent are effective in 2025.<sup>123</sup> This testimony contradicts the proposition that Aetna's 52.99 percent discount uses only 2022 contract rates and 2021 billed charges—the calculation method that the Plan and Segal imposed on Blue Cross. Although this testimony postdates the RFP evaluation, it illustrates what the Plan and Segal could have learned if they had scrutinized Aetna's discount percentage as much as they scrutinized Blue Cross's.
- Aetna's stated 52.99 percent discount assumes that Aetna will pay providers fewer dollars in the future than Aetna pays now based on future contract improvements beyond those bound by letters of intent. That assumption does not align with trends in the healthcare market. In the table that Aetna submitted in response to the Plan's November 18 Request for Clarification, Aetna's stated discount increases from 52.11 percent as of the repricing date to 52.44 percent because of letters of intent. It increases further to 52.99 percent because of "additional contract improvements." When billed charges are held constant, as the Plan and Segal required of Blue Cross, discount percentages can increase *only if contract rates, in absolute dollars, are decreasing*. The proposition that Aetna's providers, on average, agreed to a 0.55 percent rate *decrease* from

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<sup>122</sup> Segal's 30(b)(6) Deposition, pg. 276, lines 11-23.

<sup>123</sup> Aetna's 30(b)(6) Deposition, pg. 249, line 23 through pg. 250, line 7.

2021 to 2022 is implausible, given that medical cost trends have ranged from 5 to over 7 percent for the past 10 years.<sup>124</sup>

Despite all these reasons for doubt, the Plan and Segal concluded that Aetna’s discount percentage of 52.99 fit the calculation method that the Plan and Segal imposed on Blue Cross. That conclusion, coupled with the Plan’s and Segal’s downward adjustment in Blue Cross’s discount percentage, changed the outcome of the repricing exercise.

**Impact of the Adjusted Discount on Scoring of the Network Pricing**

The downward adjustment of Blue Cross’s in-network discount percentage from 54.0 percent to 52.7 percent materially changed the vendors’ scores for the Network Pricing component of the cost proposal. Before the Plan’s and Segal’s downward adjustment of Blue Cross’s discount percentage, Blue Cross had the lowest claims cost; Aetna’s was 1.8 percent higher. After the adjustment, the Plan and Segal showed Blue Cross’s claims cost as 0.47 percent *higher* than Aetna’s.

Before the adjustment: In the November 15, 2022 version of Segal’s Cost Proposal Analysis (shown below in Figure 17),<sup>125</sup> Segal took billed charges, allowed amounts, and discount rates directly from each vendor’s repricing data. The analysis showed that Blue Cross had a higher discount rate than Aetna’s (54 percent versus 53 percent) and thus a lower allowed amount than Aetna’s (\$2,686,255,626 versus \$2,728,501,262).<sup>126,127</sup>

**Figure 17**  
**Before: Charges, Allowed Amounts and Discounts Taken from the Repricing Exercise**

Non-Medicare Network Discounts <sup>1</sup>	Charge Amount	Allowed Amount	Estimated Discounts			
			Base %	Adjustments	Improvements	Adjusted %
Baseline - CY 2021 <sup>2</sup>			51.8%	N/A	N/A	51.8%
Aetna	\$5,810,527,882	\$2,728,501,262	53.0%	0.0%	0.0%	53.0%
BCBSNC	\$5,841,369,152	\$2,686,255,626	54.0%	0.0%	0.0%	54.0%
UMR <sup>3,4</sup>	\$5,710,719,172	\$2,619,524,312	54.1%	-4.0%	0.3%	50.5%

**Source:** SHP 0085084, “Network Pricing” tab.

Segal also projected the allowed amounts in the above table forward to 2025, 2026, and 2027. That projection resulted in Blue Cross having the lowest total allowed amount for the projected three-year period and Aetna’s allowed amount being 1.85 percent higher.

The RFP’s scoring criteria for the repricing exercise were as follows:

<sup>124</sup> PwC Health Research Institute. Medical Cost Trend: Behind the numbers 2024. Available at: <https://www.pwc.com/us/en/industries/health-industries/library/assets/pwc-behind-the-numbers-2024.pdf>.

<sup>125</sup> SHP 0040105. Metadata indicates that this file was last modified on November 10, 2022.

<sup>126</sup> Blue Cross’s allowed amount was \$41,245,626 (2 percent) lower than Aetna’s.

<sup>127</sup> Through the clarification process, Segal adjusted UMR’s discount to 52.5 percent, which resulted in UMR having the highest allowed amount in later analyses.

- The highest ranked proposal (or lowest projected claims cost<sup>128</sup>) receives the full six (6) points allocated to this section.
- All other proposals receive points based on the following: within 0.5 percent of the lowest claims cost = 6 points; within 1.0 percent = 5 points; within 1.5 percent = 4 points; within 2.0% = 3 points; within 2.5 percent = 2 points; within 3.0 percent = 1; greater than 3.0 percent = 0 points.

Based on these scoring criteria, in the same November 15, 2022 version of Segal’s analysis, Blue Cross received 6 points and Aetna received 3 points. This outcome is shown in Figure 18 below.

**Figure 18**  
**Before: Scores for Network Pricing on November 15, 2022**

Total Projected Claims	CY 2025	CY 2026	CY 2027	Total (2025-2027)	% From Lowest Claims Cost	Network Pricing	
						Rank	Score
Aetna	\$3,031,470,897	\$3,205,206,389	\$3,389,268,586	\$9,625,945,873	1.85%	2	3
BCBSNC	\$2,976,283,077	\$3,146,978,629	\$3,327,830,721	\$9,451,092,427	0.00%	3	6
UMR	\$3,163,253,527	\$3,365,030,262	\$3,557,903,574	\$10,086,187,364	6.72%	1	0

Source: SHP 0085084, “Network Pricing” tab.

After the adjustment: A later version of Segal’s Cost Proposal Analysis (shown below in Figure 19),<sup>129</sup> dated November 29, 2022, reflects adjustments to the prior table based on vendors’ responses to the clarifications.<sup>130</sup> This November 29 version of the analysis shows that Segal had adjusted Blue Cross’s discount from 54.0 percent to 52.7 percent.<sup>131</sup>

**Figure 19**  
**After: Scores for Network Pricing on November 29, 2022**

Non-Medicare Network Discounts and Relative Values <sup>1</sup>	Estimated Network Discounts			
	Repricing %	Adjusted for Clarifications	Improvements	Adjusted %
Baseline - CY 2021 <sup>2</sup>				51.8%
Aetna	53.0%	53.0%	0.00%	53.0%
BCBSNC <sup>3,4</sup>	54.0%	52.7%	0.04%	52.7%
UMR <sup>3,5</sup>	54.1%	52.5%	0.09%	52.6%

Source: SHP 0069464, “Network Pricing” tab.

Segal’s adjustment of Blue Cross’s discount resulted in Aetna having the highest discount and the lowest projected claims cost for the three-year period of 2025 through 2027. This adjustment resulted in Aetna

<sup>128</sup> Claims cost is equal to the estimated allowed amount.

<sup>129</sup> SHP 0069464. Metadata indicates this file was last updated on January 9, 2023.

<sup>130</sup> The last Request for Clarification was sent to Blue Cross on November 28, 2022, with instructions to respond by 11am on November 29, 2022. This analysis was presented to the Plan on November 29, 2022.

<sup>131</sup> SHP 0069464.

scoring 6 points instead of 3 points. Because the scoring criteria stated that a vendor whose total claims cost was within 0.5 percent of the lowest claims cost would receive the full 6 points, Blue Cross also received 6 points. This outcome is shown in Figure 20 below.

**Figure 20**  
**Final Network Pricing Scores**

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

**Source:** SHP 0069464, “Network Pricing” tab.

In sum, the Plan’s and Segal’s decision to adjust Blue Cross’s discount percentage downward while leaving Aetna’s discount percentage unchanged caused the Plan and Segal to shift Blue Cross from being the lowest-cost bidder on the repricing by almost 2 percent to being the second-place bidder on the repricing by less than 0.5 percent. That shift resulted in Aetna receiving 6 points, rather than 3 points, on the Network Pricing component of the cost proposal.

As shown above, the Plan and Segal did not have a sufficient basis to adjust Blue Cross’s discount percentage downward while leaving Aetna’s discount percentage unchanged.

**Opinion 4: Segal’s review of external data further undermined Segal’s decision to adjust Blue Cross’s discount percentage to a level below Aetna’s.**

As I discuss in Opinion 3 above, the Plan and Segal did not have a sufficient basis to adjust Blue Cross’s discount percentage from 54 percent to 52.7 percent, a level below the 52.99 percent discount that the Plan and Segal ascribed to Aetna. This outcome is further undermined by the fact that external data, consulted by Segal, showed Blue Cross with a higher discount percentage than Aetna’s. Despite this finding, Segal did not adjust its evaluation of Blue Cross’s and Aetna’s proposals or even reexamine its evaluation in response to the data.

Uniform Discount Specification (“UDS”), also called the Uniform Discount Standard, is a collaborative effort among health insurance carriers and actuarial consulting firms to collect carrier data that can be used to calculate discounts for specific employers and/or markets. This consortium of carriers and consultants has also developed guidelines for the calculation and reporting of carrier discounts.<sup>132</sup> Although UDS data, like other benchmark data sources, may have shortcomings, it is still a useful indication of the insurers’ and TPAs’ relative price levels.

Segal has touted its use of UDS data to test vendor-calculated discounts. For example, in a 2018 proposal to renew its role as the Plan’s actuarial consultant, Segal stated that it “participates in the Uniform Data Specification task force...that [has] devised a common methodology of evaluating provider discounts that is accepted by most carriers.”<sup>133</sup> Segal went on to say that “[c]urrently Segal uses this database to validate results produced by the discount analyses”<sup>134</sup> conducted as part of RFPs.

In connection with the RFP at issue here, Segal consulted UDS data to check the discounts each vendor calculated in the repricing exercise.<sup>135</sup>

A document produced by the Plan on behalf of Segal<sup>136</sup> contains an analysis of UDS data. Page 85040 of this document, an excerpt of which is shown below in Figure 21, is titled “North Carolina: Discount Analysis – Overall Results – Adjusted Data.”<sup>137</sup> This summary identifies the percentage differences between the network pricing achieved by Blue Cross and the pricing achieved by other vendors, including Aetna. The summary calls Blue Cross the incumbent and treats Blue Cross’s pricing level as the benchmark. Based on my review, this UDS analysis shows that Aetna’s network pricing would be 1.1 percent higher (that is, more expensive) than Blue Cross’s pricing. Segal’s corporate representative agreed with this conclusion. He testified that “the UDS [data] said that Aetna is 1.1 percent more expensive than Blue Cross.”<sup>138</sup>

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<sup>132</sup> Milliman White Paper. Determining discounts. November 2012. Available at: <https://us.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/healthreform/pdfs/determining-discounts>.

<sup>133</sup> SHP 0002413.

<sup>134</sup> SHP 0002413.

<sup>135</sup> SHP 0085064.

<sup>136</sup> SHP 0085038.

<sup>137</sup> SHP 0085038.

<sup>138</sup> Segal’s 30(b)(6) Deposition, pg. 309, lines 7-10.

**Figure 21**  
**Excerpt of UDS North Carolina Discount Analysis**

**North Carolina**  
**Discount Analysis - Overall Results - Adjusted Data**

% Differences (cost impact) from Incumbent	BCBS	Aetna	Cigna	UHC
Overall including Wrap Networks with 50% weight (OON at 20%) - Discounts		1.1%	-1.5%	-1.5%

**Source:** SHP 0085038, pg. 85040.

Segal also produced a workbook that contains UDS data from multiple carriers, along with Segal’s analyses of the data.<sup>139</sup> The author of the workbook is Kenneth Schlapp, a Segal employee. The analyses in this workbook again state that, according to the UDS data, Blue Cross had a more favorable discount than Aetna’s.<sup>140</sup>

The conclusion that Blue Cross had a more favorable discount based on the UDS analysis reinforces the original result of the repricing exercise here: a Blue Cross discount percentage that exceeded Aetna’s discount percentage by one percentage point. More importantly, the UDS analysis conclusion further undermines the Plan’s and Segal’s decision to adjust Blue Cross’s discount to a level *below* Aetna’s discount.

I am aware of no evidence that Segal incorporated the UDS data into its analysis of the repricing bids. On the contrary, Segal executive Wohl testified directly that Segal ignored the UDS data.<sup>141</sup> He stated, “We found out that [the UDS analysis] was done and we stopped. We didn’t use it.”<sup>142</sup>

Nor, apparently did Segal present the UDS results to the Plan. On November 11, Segal’s Matthew Kersting<sup>143</sup> asked Kenneth Schlapp<sup>144</sup> (copying Kuhn) to run an analysis of the UDS data “as a reasonability check (not to be disclosed anywhere).” On November 14, Schlapp replied to Kersting and Kuhn that “without [a nondisclosure agreement] we cannot release this information to the client in any way. This means that if these results differ from the reprice, you can’t disclose that unless [a nondisclosure agreement] is signed.”<sup>145</sup> Segal’s corporate representative testified that the Plan never signed such a nondisclosure agreement.<sup>146</sup> Another email from Schlapp to Jessie White<sup>147</sup> states regarding the UDS

<sup>139</sup> SHP 0085064.

<sup>140</sup> SHP 0085064, “Vendor 1 Overall” and “Vendor 2 Overall” tabs.

<sup>141</sup> Deposition of Stuart Wohl, pg. 228, line 1.

<sup>142</sup> Deposition of Stuart Wohl, pg. 228, lines 21-22.

<sup>143</sup> Matthew A. Kersting, Vice President at Segal and member of the team that supported the Plan’s RFP.

<sup>144</sup> Kenneth Schlapp, VP & Health Consultant, is another member of the Segal team and is shown as the primary author of the UDS analysis found in SHP 0085064.

<sup>145</sup> SHP 0085064, tab “Request from Client Team.”

<sup>146</sup> Segal’s 30(b)(6) Deposition, pg. 290, lines 3-9.

<sup>147</sup> Jessie White, Health Benefits Analyst at Segal.

analysis, “We will not be sending this to either the Client or the client team, I just verbally discussed the results with Steve Kuhn.”<sup>148</sup>

Ultimately, the UDS results showed the same discount pattern as the repricing results calculated by the vendors: that Blue Cross’s discounts were higher than Aetna’s. Thus, Segal’s check of the UDS appeared to validate the results of the repricing exercise. When the Plan and Segal adjusted Blue Cross’s discount percentage to a level below Aetna’s, they contradicted the pattern shown in the UDS data.

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<sup>148</sup> SHP 0085097.

**Opinion 5: The Plan did not compare the vendors’ networks of providers, even though it had the data needed to do so. As a result, the Plan failed to consider the disruption that will occur if Aetna becomes the TPA on January 1, 2025.**

**Provider Networks Are Important to Plans and a Key Component of a TPA’s Role**

As described previously, self-funded state employee health plans typically contract with a TPA to administer health benefits, contract with healthcare providers, and pay claims, among other things. Provider contracting is a critical component of the administration of any health plan. By contracting with healthcare providers, TPAs and health insurers (on behalf of a “payer” or “health plan”) create networks of providers that health plan members can access for healthcare services. Providers that contract to participate in a health plan’s network, called “in-network” providers, agree to a certain level of payment or reimbursement and the health plan typically encourages members to use these providers. Health plans may create incentives to use in-network providers through the benefit structure, which includes the level of cost sharing<sup>149</sup> between the plan and the member. Benefits are often more generous, and members’ cost-sharing obligations are typically lower, when a member uses an in-network provider. Conversely, members generally pay more out of their own pockets when they use out-of-network providers.

The breadth and depth of a plan’s network determines whether members have access to a sufficient number of in-network providers that are conveniently located. Access to in-network providers is particularly important so that members can receive regular preventive care or specialist services such as cancer treatment close to home, work, or school.

In-network providers have signed a contract with a health insurer or TPA and agree to specific reimbursement rates over a specific time period. In my opinions on the pricing guarantees and network pricing, I have referred to contract rates, contracted amounts and allowed amounts in reference to these reimbursement rates. Out-of-network providers, in contrast, have not signed contracts with a health plan’s TPA or health insurer.

Health insurers and TPAs often have in-network contracts with fewer than all providers in a particular geographic location. As a result, health insurers and TPAs develop out-of-network policies and programs for reimbursing out-of-network providers according to agreements with plan sponsors (such as self-funded employers).

The text of the Plan’s RFP acknowledges the importance of the breadth of the TPA’s provider network. In section 1.1, entitled Network Access, the RFP states, “The Plan seeks to have a provider network in place that best meets the program’s long-term needs. *This includes a broad provider network with the least disruption and with competitive pricing.*”<sup>150</sup>

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<sup>149</sup> Cost sharing refers to the splitting of costs between the health plan and the member. The member’s cost sharing refers to coinsurance, copayments, and deductibles.

<sup>150</sup> SHP 0072588.

### **The Plan Could Have Compared the Vendors' Networks of Providers but Did Not Do So**

Provider networks can be compared. Indeed, in Segal's 2018 proposal to become the Plan's actuarial consultant, Segal identified metrics that it used to evaluate vendor provider networks for the State of Wisconsin's state employee health plan TPA contract.<sup>151</sup> This evaluation included a "Network Access" component. In that Wisconsin evaluation, according to Segal, vendors submitted data that identified the number of "members with and without provider access according to ... network access standards." "Vendors were assigned points based on the percentage that meet the access standard within each county and sub-category."<sup>152</sup> In its 2018 proposal to the Plan, Segal presented this Network Access metric as one to "consider in cost proposals."<sup>153</sup>

As Segal's 2018 presentation to the Plan stated, network access may be measured by identifying the percentage of members within a certain geographic area (such as a county) who have a specific level of access (such as having access to at least 1 in-network hospital within a certain number of miles). Health plans like Medicare Advantage plans, Medicaid managed care plans, and individual plans purchased on federal or state health insurance exchanges, may be required to demonstrate a certain level of access for members based on this formula (i.e., a minimum percentage of members within a set radius of various provider types). When these types of entities evaluate network adequacy, they typically develop minimum requirements that are graded on a pass/fail basis, establish scoring guidelines to assign points to levels of access, or both. Many states use this type of network access evaluation in connection with their public plans. For example, the State of New York uses such an approach.<sup>154</sup> Minnesota uses points to evaluate network adequacy and rank vendor bids in connection with its Medicaid Managed Care Organizations.<sup>155</sup> Tennessee's 2020 RFP for a TPA included both a minimum requirement that 95 percent of members meet certain access standards (such as having access to a certain number of providers within a certain radius)<sup>156</sup> and a scoring guideline that assigned points for "network analysis" and "disruption analysis."<sup>157</sup> New Jersey evaluates its Medicaid managed care plans using driving time or time on public transportation as a measure of access. It also evaluates access to specialized services such as perinatal and tertiary pediatric services.<sup>158</sup>

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<sup>151</sup> Segal's work for the State of Wisconsin was reported to North Carolina as an example of Segal's abilities in connection with Segal's bid for the actuarial contract from the Plan.

<sup>152</sup> SHP 0003962.

<sup>153</sup> SHP 0002295.

<sup>154</sup> Robert Wood Johnson Foundation. Analyzing Medicaid Managed Care Organizations: State Practices for Contracting With Managed Care Organizations and Oversight of Contractors. August 2020. Available at: <https://www.rwjf.org/en/insights/our-research/2020/08/analyzing-medicare-managed-care-organizations--state-practices-for-contracting-with-managed-care-organizations-and-oversight-of-contractors.html>.

<sup>155</sup> *Id.*

<sup>156</sup> State of Tennessee, Department of Finance and Administration. Request For Proposals for Third Party Administrator Services for The State's Public Sector Health Plans, pgs. 24, 41, 131. February 20, 2020. Available at: [https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/contracts/health\\_rfp\\_31786\\_00148.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/contracts/health_rfp_31786_00148.pdf).

<sup>157</sup> *Id.* at 18.

<sup>158</sup> HealthAffairs. Regulation of Health Plan Provider Networks. July 28, 2016. Available at: <https://www.healthaffairs.org/doi/10.1377/hpb20160728.898461/>.

In the 2022 RFP at issue here, the Plan required vendors to submit the data necessary to conduct these types of analyses. This data could have been used to assign points to network access or network adequacy in the same way that Segal assigned points in its evaluation for the State of Wisconsin.<sup>159</sup>

The Plan collected data from each of the vendors on the composition of their networks, including the types and locations of providers and the providers’ proximity to Plan members across the state. This information was submitted primarily through Attachment A-2.

On Attachment A-2, vendors were required to identify the number of members in each county with access to certain types of providers within a certain radius. These provider types and specialties are shown in Figure 22 below. The figure below shows a portion of Attachment A-2, which asked the vendors to identify the number of members in each county who reside within a certain radius for each of several provider types.

**Figure 22**  
**Excerpt of Attachment A-2**

Provider Type	Urban Parameters	North Carolina Urban Counties					
		Durham	Forsyth	Guilford	Mecklenburg	New Hanover	Wake
<b>Facilities</b>							
Hospitals	1 within 20-mile radius						
Ambulatory Surgical Centers	1 within 20-mile radius						
Urgent Care facilities	1 within 20-mile radius						
Imaging Centers	1 within 20-mile radius						
Inpatient Behavioral Health Facilities	1 within 20-mile radius						
<b>Professional Services</b>							
<b>Primary Care</b>							
General/Family Practitioner (includes Internal Medicine, Family Medicine, and General Medicine)	2 within 10-mile radius						
OB/GYN (female members, age 12 and older)	2 within 10-mile radius						
Pediatrician (members, birth through age 18)	2 within 10-mile radius						
<b>Specialists</b>							
Endocrinologist	2 within 20-mile radius						
Urologist	2 within 20-mile radius						
Cardiologist	2 within 20-mile radius						
Dermatologist	2 within 20-mile radius						
Allergist	2 within 20-mile radius						
Psychologist/Psychiatrist	2 within 20-mile radius						
General Surgeon	2 within 20-mile radius						
Hematologist/Oncologist	2 within 20-mile radius						
Chiropractor	2 within 20-mile radius						

Source: SHP 0006965

During the development of the RFP, the Plan and Segal considered comparing and even scoring the provider networks. In an email to the Plan, Segal’s Kuhn asked, “Did you want to make [network access] a minimum qualification? For example, ‘Bidder’s network must offer at least XX% overall network access ...?’”<sup>160</sup> The Plan’s Caroline Smart declined, responding, “I don’t believe we need a minimum on [network access]. If they have access problems, it should show up in the pricing in those areas.”<sup>161</sup>

<sup>159</sup> As explained above, Segal submitted materials and analyses from its work with Wisconsin as examples of its capabilities and experience in its proposal for the actuarial contract with the North Carolina State Health Plan. Accordingly, we can compare the number and nature of the analyses conducted by Segal in Wisconsin compared to North Carolina.

<sup>160</sup> SHP 0092423.

<sup>161</sup> SHP 0086294.

Although the Plan collected the raw numbers of members with the specified level of access to these provider types in each county, neither the Plan nor Segal did any scoring or analysis of this data. Segal's corporate representative testified that Segal did not "analyze in any way how many providers that are in network with Blue Cross would become out of network for the other bidders."<sup>162</sup>

Segal's corporate representative testified that Segal compared the vendors' network access "in a way" by comparing the vendors' percentages of in-network allowed amounts, using the data from the repricing exercise.<sup>163</sup> For several reasons, however, those percentages were not a meaningful comparison of the vendors' provider networks and the real level of access those networks provide to members:

- The comparison of in-network versus out-of-network providers across vendors was not conducted on a regional level and did not take into account where the Plan's members actually reside.<sup>164</sup> Because the analysis was done only on a plan-wide basis, a vendor with a surplus of providers in one region but with fewer providers in other regions could appear to have as broad a network as a network with a better geographic distribution of providers. In my experience, network access is typically determined by comparing the geographic distribution of providers to the geographic distribution of members. The Plan and Segal did no such analysis, as Segal's corporate representative acknowledged in his deposition.<sup>165</sup>
- Segal's comparison of in-network providers across vendors was also not conducted on a provider-type basis. Simple comparisons of total in-network providers do not address whether vendors have a sufficient number of specific types of providers such as pediatricians, obstetricians, and certain specialists to meet the needs of members.
- Comparing allowed amounts is not an accurate substitute for provider access, because it is subject to distortion by high-volume in-network providers and providers with especially high allowed amounts.
- In addition, comparisons in amounts paid by the Plan ignore the impact on network differences on *members'* out-of-pocket cost. By comparing only vendors' percentages of in-network allowed amounts, Segal and the Plan ignored the constituents who face the real impact of insufficient network access: the Plan's members.

### **The Plan's Flawed Collection of Network Data Hinders Meaningful Analysis Now**

Even if the Plan had been willing to compare the vendors' networks directly, the network-access data the Plan gathered was flawed. Attachment A-2 to the RFP did not define provider types and specialties or

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<sup>162</sup> Segal's 30(b)(6) Deposition, pg. 118, line 25 through pg. 119, line 4.

<sup>163</sup> Segal's 30(b)(6) Deposition, pg. 117, line 20 through pg. 118, line 2.

<sup>164</sup> Deposition of Stuart Wohl, pg. 160, lines 7-14.

<sup>165</sup> Segal's 30(b)(6) Deposition, pg. 120, lines 6-15.

provide any relevant guidance or instruction. As a result, Aetna and Blue Cross defined these fields differently.

For example, under Attachment A-2, a “hospital” could refer to short-term acute hospitals only, such as Duke University Medical Center in Durham. Alternatively, a “hospital” could include long-term care hospitals, such as Asheville Specialty Hospital in Asheville, and rehabilitation hospitals, such as Novant Health Rehabilitation Hospital in Winston-Salem. Thus, if a vendor counted only short-term acute hospitals in its totals while another vendor included other types of hospitals, any comparison of access figures in these categories would be invalid.

In addition, the instructions in Attachment A-2 state, “Do not count individuals more than once within the same county,” but it appears that Aetna did not follow these instructions. For example, in Orange County, Blue Cross reported having one hospital in-network (UNC Hospitals), whereas Aetna reported having four hospitals in-network. This discrepancy arose because Aetna counted UNC’s main campus location, the women’s hospital (at the same location), the children’s hospital (also at the same location), and the Hillsborough campus (a separate location in the same county) as four separate institutions, while Blue Cross considered all of these facilities and locations as one provider.<sup>166</sup>

Another example of an undefined term in Attachment A-2 is “general surgeon.” Any comparison on the vendors’ counts in this category would be invalid if one vendor included surgeons who specialize in broad areas, such as trauma or thoracic surgery, while another vendor did not include these types of surgeons. Without a clear definition, the vendors could overcount or undercount these providers. Indeed, Wohl acknowledged that if the vendors used inconsistent definitions, the results of analyses performed would not be comparable.<sup>167</sup>

This and similar methodological flaws in collecting provider network data make it difficult to compare the vendors’ respective provider networks. The Plan could have mitigated these difficulties, or even eliminated them altogether, had it identified standardized provider categories to use.

### **Blue Cross’s Network Offers More Providers**

Compensating for the shortcomings in the Plan’s data collection to the extent possible,<sup>168</sup> I performed multiple comparisons of Blue Cross’s and Aetna’s networks based on the data the Plan collected in the RFP. I found that Aetna’s network has fewer providers than Blue Cross’s network both statewide and on a regional basis.

Because the Plan neglected to give the vendors guidance or instructions on the definitions of provider

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<sup>166</sup> SHP 0001779, Blue Cross NC\_0001953.

<sup>167</sup> Deposition of Stuart Wohl, pg. 181, line 22 through pg. 182, line 7.

<sup>168</sup> The methodology I used to normalize the data is described in the following paragraphs.

types and specialties, I first used the National Provider Identifier (“NPI”)<sup>169</sup> taxonomy to normalize provider type definitions. The NPI taxonomy codes classify healthcare providers into provider type groups and specialties based on the services delivered and their credentials.<sup>170</sup> Classifying healthcare providers using the NPI taxonomy allowed me to make important distinctions between certain types of providers, as well as physician specialties. For example, short-term acute hospitals have a different taxonomy code (282N0000X) from rehabilitation hospitals (283X0000X). The NPI taxonomy allowed me to classify the individual providers identified by Blue Cross and Aetna through a uniform coding scheme.

Using the normalized provider type definitions, and focusing on the core provider types, the first analysis I performed compares the number of providers for each core provider type between Blue Cross and Aetna, using the provider listings from Attachment A-2.<sup>171</sup> <sup>172</sup>These comparisons, shown in Figure 23, show that Blue Cross has over 2,000 more distinct providers<sup>173</sup> within these core provider types across North Carolina than Aetna has. In particular, Blue Cross has more providers in the Suburban and Rural regions. In the figure, provider types for which Blue Cross has more providers than Aetna has are highlighted in blue.

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<sup>169</sup> The NPI is a unique 10-digit identification number assigned to healthcare providers that is used administrative and financial transactions. The Health Insurance Accountability and Portability Act (“HIPAA”) requires the use of a standard, unique health identifier for each healthcare provider. Centers for Medicare and Medicaid Services, “NPI: What You Need to Know,” MLN909434 March 2022.

<sup>170</sup> The NPI taxonomy codes are maintained by the National Uniform Claims Committee (“NUCC”). Examples of taxonomy codes are 207N00000X, corresponding to “Allopathic and Osteopathic Physicians, Dermatology” and 282N00000X, corresponding to “Hospital – Acute Care.”

<sup>171</sup> SHP\_0001779, Blue Cross NC\_0001953.

<sup>172</sup> Zip\_to\_County.txt, NPI\_Registry\_Taxonomy.txt.

<sup>173</sup> A distinct provider in this analysis is identified as a unique combination of NPI and county. I defined a provider in this way because the instructions in Attachment A-2 state, “...an individual may be counted as a provider in each separate county in which he/she has at least one practice location.”

**Figure 23**  
**In-Network Distinct Provider Counts for Core Provider Types by Region**

	Urban			Suburban			Rural		
	Blue Cross	Aetna	Difference	Blue Cross	Aetna	Difference	Blue Cross	Aetna	Difference
Facilities <sup>174</sup>	146	139	7	104	103	1	211	145	66
Primary Care Providers <sup>175</sup>	7,091	8,014	(923)	8,501	7,104	1,397	8,764	8,290	474
Specialists <sup>176</sup>	5,801	6,273	(472)	6,684	4,650	2,034	5,268	4,661	607
<b>Total</b>	<b>13,038</b>	<b>14,426</b>	<b>(1,388)</b>	<b>15,289</b>	<b>11,857</b>	<b>3,432</b>	<b>14,243</b>	<b>13,096</b>	<b>1,147</b>

I also performed an additional analysis with the same data and found that Blue Cross has more choices of providers than Aetna has. As shown in Figure 24, Blue Cross has more providers within the specified distance of members (using the distance parameters by core provider type and county identified in Attachment A-2 to the RFP) than Aetna has for 12 out of the 17 core provider types.<sup>177, 178, 179</sup> In the table, provider types for which Blue Cross has more providers than Aetna has are highlighted in blue. Blue Cross’s greater choice of providers is especially evident in suburban and rural counties.

<sup>174</sup> Hospitals, ASCs, Imaging Centers, Inpatient Behavior Health Facilities, and Urgent Care Centers.

<sup>175</sup> General/Family Practitioners (including Internal Medicine), OB/GYNs, and Pediatricians.

<sup>176</sup> Allergists, Cardiologists, Chiropractors, Dermatologists, Endocrinologists, General Surgeons, Hematologists/Oncologists, Psychologists/Psychiatrists, and Urologists.

<sup>177</sup> SHP 0001779, Blue Cross NC\_0001953.

<sup>178</sup> Zip\_to\_County.txt, NPI\_Registry\_Taxonomy.txt, \_ Subscriber\_Addresses\_w\_Coordinates.txt, Provider\_Addresses\_w\_Coordinates.txt.

<sup>179</sup> NCSHP\_Medical\_RFP\_Census\_File.

**Figure 24**  
**Provider Availability to Members**  
**Average Number of Providers within the Radius of Member Specified in Attachment A-2**

Provider Type	Urban		Suburban		Rural		Overall Average	
	Blue Cross	Aetna	Blue Cross	Aetna	Blue Cross	Aetna	Blue Cross	Aetna
<b>Facilities</b>								
Hospitals	10	7	11	8	12	8	11	8
Ambulatory Surgical Centers	15	13	9	9	7	7	10	10
Urgent Care	10	9	7	7	7	5	8	7
Imaging Centers	11	7	12	9	12	8	12	8
Inpatient Behavioral Health Facilities	4	4	2	3	2	2	3	3
<b>Primary Care</b>								
General/Family Practitioner (Including Internal Medicine)	692	810	781	629	320	303	552	546
OB/GYN	151	191	133	143	41	53	99	120
Pediatrician	162	186	104	116	44	49	97	110
<b>Specialists</b>								
Endocrinologists	50	52	47	38	27	23	39	36
Urologists	71	59	95	51	65	41	74	49
Cardiologists	206	192	236	151	169	131	197	156
Dermatologists	94	96	101	62	66	44	84	65
Allergists	31	30	39	23	23	15	29	22
Psychologists/Psychiatrists	543	567	439	392	294	238	410	382
General Surgeons	203	292	225	231	147	164	184	222
Hematologists/Oncologists	128	184	147	149	87	101	115	140
Chiropractors	136	158	90	109	64	70	94	108
<b>Overall Average</b>	<b>2,509</b>	<b>2,850</b>	<b>2,468</b>	<b>2,123</b>	<b>1,375</b>	<b>1,255</b>	<b>2,006</b>	<b>1,984</b>

**A Change from Blue Cross to Aetna Poses Disruption for Plan Members**

Disruption refers to the impact that switching networks has on members. Specifically, a disruption analysis focuses on the members whose providers go from in-network to out-of-network because of a change in TPA.

One way to assess disruption directly is to compare two networks and to identify providers that do not overlap. Consider a member who uses a provider that is currently in-network, but after a change in TPA, becomes out-of-network. That member experiences “disruption” because she either has to find a new, in-network provider or use pay extra to see a provider that is now out-of-network.

Because of these problems, disruption can affect members' access to healthcare providers, undermine the continuity of members receive, and create unnecessary health risks. These issues have been studied extensively among Medicaid recipients, because they frequently experience disruptions in coverage and changes in health plans and providers. Those disruptions can undermine the quality of care.<sup>180</sup> In addition, disruption can increase members' out-of-pocket expenses and expose members to "surprise bills."<sup>181, 182</sup>

To show the cost implications of the network differences between Blue Cross and Aetna,<sup>183</sup> I compared the out-of-pocket costs that members would pay Blue Cross's out-of-network providers with the out-of-pocket costs that that members would pay Aetna's out-of-network providers. I conducted this analysis based on utilization data from the repricing exercise.<sup>184</sup> As shown in Figure 25, based on the Plan's claims from 2021, members who use Aetna's out-of-network providers would pay an estimated \$7 million more in out-of-pocket costs than members who use Blue Cross's out-of-network providers would pay. The figure shows the 10 counties where Blue Cross has the lowest estimated amounts paid out of pocket by members compared to Aetna. These differences are highlighted in blue. A full list containing all counties in North Carolina can be found in Appendix C, Figure 25a.

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<sup>180</sup> Office of the Assistant Secretary for Planning and Evaluation. Medicaid Churning and Continuity of Care. April 11, 2021. Available at: <https://aspe.hhs.gov/reports/medicaid-churning-continuity-care>.

<sup>181</sup> A surprise bill is an unexpected bill from an out-of-network provider. Surprise bills occur most often in emergency situations where the member cannot choose which provider to see.

<sup>182</sup> CMS, The No Surprises Act's Continuity of Care, Provider Directory, and Public Disclosure Requirements. Available at: <https://www.cms.gov/files/document/a274577-1b-training-2nsa-disclosure-continuity-care-directoriesfinal-508.pdf>.

<sup>183</sup> National Association of Insurance Commissioners, Network Adequacy, June 1, 2023. Available at: <https://content.naic.org/cipr-topics/network-adequacy#:~:text=Issue%3A%20Network%20adequacy%20refers%20to,the%20terms%20of%20the%20contract>.

<sup>184</sup> The repricing exercise used the Plan's actual 2021 claims data, which was provided to all of the vendors.

**Figure 25**  
**Difference in 2021 Out-of-Network Claims between Blue Cross and Aetna**  
**Impact on Estimated Member Paid Amount by County<sup>185</sup>**

County	County Type	Blue Cross		Aetna		Difference	
		Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount
MOORE	Rural	913	\$53,751	3,421	\$948,723	2,508	\$894,972
ORANGE	Suburban	2,128	\$167,898	16,383	\$927,429	14,255	\$759,530
MECKLENBURG	Urban	2,924	\$387,854	11,525	\$1,053,456	8,601	\$665,602
CUMBERLAND	Suburban	297	\$12,697	5,919	\$484,262	5,622	\$471,565
GUILFORD	Urban	1,987	\$160,402	7,160	\$586,254	5,173	\$425,852
WAKE	Urban	17,068	\$1,103,721	30,818	\$1,490,603	13,750	\$386,882
PITT	Suburban	1,128	\$55,785	7,993	\$420,979	6,865	\$365,194
NEW HANOVER	Urban	794	\$49,204	7,490	\$378,870	6,696	\$329,666
BUNCOMBE	Suburban	3,185	\$173,588	7,376	\$460,664	4,191	\$287,076
FORSYTH	Urban	584	\$62,537	5,637	\$281,529	5,053	\$218,992
All Other		24,122	\$1,679,747	66,655	\$4,156,031	42,533	\$2,476,283
<b>Total</b>		<b>55,130</b>	<b>\$3,907,185</b>	<b>170,377</b>	<b>\$11,188,800</b>	<b>115,247</b>	<b>\$7,281,615</b>

Based on the documents and testimony I reviewed, the Plan did not evaluate potential disruption to members as part of the scoring of this RFP. In addition, the Plan did not identify provider types or geographic areas that might pose the most disruption. For example, when asked, “did you analyze in any way how many providers that are in network with Blue Cross would become out of network for the other bidders?” Segal’s corporate representative confirmed that Segal did not do so.<sup>186</sup> Segal’s representative further confirmed that Segal performed no analysis on any geography smaller than the total network.<sup>187</sup>

If the Plan had performed a disruption analysis, it would have identified tens of thousands of members who see providers that are in-network with Blue Cross but are out-of-network with Aetna (based on the Plan’s 2021 claims). My analysis shows that over 37,000 Plan members received services from providers that are in-network with Blue Cross but are out-of-network with Aetna. Nearly half of these members (47 percent) live in rural counties.

If Aetna becomes the new TPA, these members will either need to change to a new provider for these services or face higher cost sharing under the terms of the Plan. The 2021 charges attributable to claims

<sup>185</sup> Members with the High Deductible Health Plan (“HDHP”) plan type are excluded from this summary. To estimate member paid amounts, I start by assuming a 50% discount for out-of-network claims for both Blue Cross and Aetna (as Segal assumed when it scored the repricing exercise). Next, I calculate member responsibility as 40% of the allowed amount for members with the 80/20 plan and 50% for members with the 70/30 plan.

<sup>186</sup> Segal’s 30(b)(6) Deposition, pg. 118, line 25 through pg. 119, line 7.

<sup>187</sup> Segal’s 30(b)(6) Deposition, pg. 120, lines 6-15.

from these providers were nearly \$50 million. I calculate these figures in Figures 26 and 27 below.<sup>188</sup> In the figures, I have shown the counties with the highest number of Plan members. A full list containing all counties in North Carolina can be found in Appendix C, Figure 27a. In these figures, cells highlighted in blue signify that the number of claims, members, or charges that are in network for Blue Cross but out of network for Aetna is larger than the inverse.

**Figure 26**  
**Disruption in Urban and Suburban Counties<sup>189</sup>**

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network		
			Claims	Members	Charges
WAKE	Urban	72,570	26,421	2,958	\$5,934,602
MECKLENBURG	Urban	28,723	10,848	1,834	\$4,522,638
GUILFORD	Urban	23,826	6,922	1,924	\$2,650,103
DURHAM	Urban	18,335	13,522	1,564	\$3,354,777
ORANGE	Suburban	17,888	14,673	1,934	\$3,746,717
PITT	Suburban	16,004	7,684	1,476	\$1,891,893
FORSYTH	Urban	14,684	5,464	1,698	\$1,276,039
ALAMANCE	Suburban	11,669	1,359	197	\$327,593
NEW HANOVER	Urban	11,291	7,082	1,366	\$1,641,685
CUMBERLAND	Suburban	10,971	5,883	1,273	\$2,220,232
All Other		70,544	15,032	3,601	\$4,994,055
<b>Total</b>		<b>296,505</b>	<b>114,890</b>	<b>19,825</b>	<b>\$32,560,333</b>

<sup>188</sup> SHP 0001779, Blue Cross NC\_0001953, SHP 0083572, SHP 0069736.

<sup>189</sup> I also analyzed the change for members receiving services from providers that are out-of-network with Blue Cross but in-network with Aetna. The results of this analysis appear in Appendix C in Figure 27a.

**Figure 27**  
**Disruption in Rural Counties**

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network		
			Claims	Members	Charges
JOHNSTON	Rural	12,748	951	86	\$180,498
WAYNE	Rural	7,832	5,394	2,164	\$753,662
ROBESON	Rural	7,440	308	96	\$95,095
BURKE	Rural	7,255	2,119	1,221	\$783,441
RANDOLPH	Rural	6,249	605	342	\$206,737
ONSLow	Rural	5,993	1,406	270	\$391,530
NASH	Rural	5,838	2,057	1,156	\$586,571
SURRY	Rural	5,574	1,306	449	\$542,640
HARNETT	Rural	5,555	880	211	\$336,624
CLEVELAND	Rural	5,260	137	31	\$32,503
All Other		152,588	29,320	11,566	\$12,267,332
<b>Total</b>		<b>222,332</b>	<b>44,483</b>	<b>17,592</b>	<b>\$16,176,633</b>

In summary, the Plan collected detailed data from the vendors about the providers in their networks, including type, specialty, and location, but it did not use the data to score the networks or conduct a disruption analysis. Thus, the Plan neglected to identify important differences between Aetna’s and Blue Cross’s network, including the fact that Blue Cross provides a broader choice of providers across North Carolina, especially in rural areas. As a result, tens of thousands of members who currently use providers that are not in Aetna’s network face having to change providers and/or by having to pay more out of pocket.

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This report is based on information known to me as of this date. I reserve the right to correct, update, supplement, or otherwise modify this report if additional information becomes available. I also reserve the right to present additional opinions, or opinions on additional issues, if asked.

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October 4, 2023

**Appendix A**  
**Greg Russo CV**

## **GREG RUSSO**

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### **SUMMARY**

Greg Russo is a Managing Director with Berkeley Research Group's Health Analytics practice in Washington, DC. Mr. Russo specializes in providing strategic advice to healthcare organizations through his use of complex data analyses and financial modeling. His clients typically seek his expert understanding of the regulatory environment in which healthcare organizations operate. Mr. Russo primarily focuses on harnessing the wealth of information available in large, multipart data sets to bring results and insights to clients with complex, unstructured issues. He utilizes this data in providing clients with strategic advice as it relates to damage calculations, government investigations, internal investigations, business planning and provider reimbursement.

In his 19 years of experience, Mr. Russo's services have related to both litigation and non-litigation issues. His clients most often include health insurers and provider organizations; however, his clients have spanned the healthcare continuum to include state agencies, federal agencies, and life sciences companies. Prior to becoming a consultant, Mr. Russo worked for three years at the Jersey Shore University Medical Center, a Meridian Health hospital. Mr. Russo completed his undergraduate degree at The College of William and Mary and received his master's degree in Health Finance and Management from The Johns Hopkins Bloomberg School of Public Health.

Mr. Russo is a member of both the American Health Lawyers Association (AHLA) and the Healthcare Financial Management Association (HFMA).

### **PROFESSIONAL EXPERIENCE**

#### **LITIGATION SUPPORT**

- Assisted in the calculation of reasonable value of healthcare services in personal injury cases. Analyzed data to determine the reasonable value of future services included in life care plan as well as past services. In certain cases, worked to identify the rates that would be paid by the Medicare program/Medicaid program or other applicable program.
- Assisted a large health insurer in litigation with another large health insurer over the rates that the insurer reimbursed hospitals. Analyzed changes in reimbursement to hospitals before and after most favored nation clauses incorporated into hospital contracts. Working with antitrust experts to connect the competitive/anti-competitive nature of the contracts with effects on the healthcare industry including reimbursement rates and premiums.
- Assisted a large health insurer defend against a class action lawsuit relating to out-of-network reimbursement for outpatient services.

- Assisted several health insurers with respect to challenges/issues involving out-of-network reimbursement. Services analyzed have included inpatient services, ASC, and professional services.
- Assisted health insurers with investigations/litigations related to the Medicare Advantage program including issues involving diagnosis coding, Risk Adjustment Payment System filtering logic, Encounter Data Processing System submissions, and chart reviews.
- Assisted one of the largest post-acute care providers in the United States with a qui tam suit regarding allegations of unnecessary care being provided. Analyzed company data to assist in rebutting the allegations. Utilized Medicare's skilled nursing facility data to benchmark care being provided.
- Assisted a large rehabilitation hospital chain with allegations made by the Department of Justice. Utilized Medicare data to analyze the care provided at specific rehabilitation hospitals. Developed a peer group of facilities to provide benchmark statistics. Continuing to assist Counsel in this ongoing work.
- Assisted several skilled nursing facility clients regarding allegations of unnecessary therapy services being delivered to patients. Utilized publicly available data to analyze patient metrics and benchmark the level of care provided. Supported external counsel in conversations and presentations to the Department of Justice and the Office of the Inspector General.
- Assisted a large long term acute care hospital chain involving a government investigation of patient lengths of stay and the extent to which the facility was providing medically unnecessary care. Utilized publicly available data to analyze the government's proposed sample of patients and benchmark this sample against a broader group of patients. Analyzed lengths of stay for facilities at-issue and against benchmark facilities.
- Assisted a large provider organization better understand the drivers behind their earnings growth. This organization was involved in litigation regarding its earnings compared with budgeted projections. Tasks included analyzing claims and financial data to assess drivers of earnings.
- Assisted a large, acute care hospital chain with analysis of interventional cardiology services performed over a multi-year period at all facilities. Utilized public and proprietary data to identify trends in the care provided.
- Assisted a large provider organization analyze cardiology services provided. Analyzed trends of procedures performed, diagnoses present and utilization of different places of service.
- Assisted a large provider of inpatient psychiatric services with an investigation of the care provided to Medicare and Medicaid patients. Analyzed proprietary and publicly available data to understand the provider's practice and benchmark this to the industry.

#### *INTERNAL INVESTIGATIONS*

- Managed project team tasked with developing the financial impact of a programmatic error that led to incorrect data being reported to CMS for Medicare Advantage beneficiaries. Developed model utilizing CMS prepared software to determine the premium associated with each individual member by month. Determined that the error led to a \$150M+ overpayment of health premiums by CMS to the Fortune 500 health insurer. Prepared expert reports summarizing our methodology and conclusions for CMS as well as a report for the provider community impacted by this error.

- Managed project investigating commission payments made in conjunction with Medicare Advantage sales. Developed analyses to investigate extent of fraudulent behavior and support lawyers in their investigation.
- Assisted a hospital organization in its investigation of a coding/billing errors made regarding its post-acute care team. Worked with certified coders to identify accurate coding and calculated overpayments to government payment programs.
- Managed an audit of the pharmacy at a large academic medical center that was experiencing issues tracking narcotics after having been dispensed from the pharmacy. Led the team in identifying, collecting and analyzing data housed in automatic medication dispensing machines. Conducted interviews with executives and management to identify gaps in the dispensing system.

#### *STRATEGIC SUPPORT*

- Evaluated a health insurer's entry into the Medicare Advantage market. Reviewed the health insurer's financial model to estimate bid rates, risk scores, and claims costs to render an opinion as to the reasonableness of the assumptions and projections.
- Redesigned the professional fee schedule for several large insurers. Utilized market data, governmental fee schedules and proprietary data to recommend new fees to appropriately reimburse for services. Reviewed the reimbursement for all physician and ancillary services including routine office visit codes to complex surgeries. Analyzed the use of medical equipment to accurately reflect the difference reimbursement in a facility versus non-facility setting. Developed a methodology that can be easily updated in time by the insurer to account for increasing costs.
- Analyzed quality incentive programs to determine the effect on medical spend of a commercial insurer. Determined how the quality incentive programs should be incorporated to shifting reimbursement methodologies.
- Assisted in the redesign of payment methodologies used for ancillary services including durable medical equipment, specialty pharmaceuticals, ambulance services, laboratory services and radiology services.
- Assisted a large health insurer redesign reimbursement to ambulatory surgery centers to more accurately reflect actual costs to provide services. Tasks included studying supply costs, conducting provider interviews and analyzing the current fee schedule.
- Studied the Medicare program to reimburse providers for hip and knee replacements using a bundled payment. This program is known as the Comprehensive Care for Joint Replacement and began in April 2016.
- Assisted the California Department of Corrections Receivership in its assessment of the healthcare contracting unit. Developed recommendations to drive quality and control costs while recognizing adequate access to services must exist. Conducted data analysis to better understand rate setting and utilization.
- Assisted a large health insurer that considered converting from a non-profit to a different type of corporate entity. Delivered market expertise and strategic insights to team of executives as to the effects such a change could have on the sale of insurance and the provider networks, both regarding to contracts and reimbursement.

- Assisted multiple commercial payers with the design and implementation of reimbursement strategies for both in-network and out-of-network providers. Past projects include those for physical therapy services, outpatient hospital services, laboratory services, physician services, ambulance services and specialty services.
- Assisted a health insurer with reimbursement for inpatient psychiatric services. Tasks included drafting policy paper on history of Medicare reimbursement for these services and options for the insurer. Analyzed claims data to assess impact of reimbursement changes.
- Aided in the development of reimbursement strategies for spinal implant manufacturer. Worked with approximately 50 hospitals throughout the United States to coordinate a release of data to supplement a cost analysis of the spinal implant. Prepared reports, which were to be presented to CMS in support of additional reimbursement for providers when using the device.

#### *PROGRAM DESIGN & EVALUATION*

- Supported the MA-PD and PDP offices at CMS to validate marketing materials from all Part D plans. This project included accessing the secure CMS Gateway Portal housing marketing materials and the reviews performed by CMS Regional Offices and contractors. Our team produced a final report to the CMS Central Office staff, which helped identify areas of deficiency in evaluating marketing materials. Our team also coordinated training for CMS Regional Office staff regarding more thorough evaluation of these materials.
- Supported New York State in the design and application of a 1915 (c) waiver to the Centers for Medicare and Medicaid Services. This project produced multiple HCBS waivers resulting in a cross-disability program. This program entitled, Bridges to Health, is designed integrate child welfare, juvenile justice and disability services systems in response to the needs of children and adolescents.
- Evaluated National Rural/Frontier Women’s Health Coordinating Centers for the U.S. Office on Women’s Health within the Department of Health and Human Services. Conducted site visits at multiple locations to gauge participation, efficiency of operations and ability to continue operations without government funding.

#### **EDUCATION**

- M.H.S. Health Finance & Management, Johns Hopkins Bloomberg School of Public Health, 2005
- B.A. The College of William and Mary, 2003

#### **PUBLICATIONS**

- D. Hettich, G. Russo. “Are You on Target? An Analysis of Medicare’s Target Prices under the New CJR Program and Where Your MSA Stands Now?” Reimbursement Advisor, Vol. 31, No. 6, February 2016.
- K. Pawlitz, G. Russo. “Proactively Responding to Government Investigations Using Data Analytics: An Examination of Data Considerations in the Post-Acute Context.” American Bar Association’s The Health Lawyer, Vol. 29, No. 5, June 2017.

- B. Akanbi, G. Russo. "Hospital Contract Labor: Where Has It Been and Who Is Using It?" Whitepaper, BRG, 2017.
- H. Miller, G. Russo, J. Younts. "Measuring the Value of Medical Services in Personal Injury Suits." Whitepaper, BRG, 2017.
- A. Asgeirsson, G. Russo. "Long-Term Acute Care Hospitals: Bracing for Change." Whitepaper, BRG, 2018.
- J. Gibson, G. Russo. "False Claims Act – Investigative Tools of the Trade." American Bar Association's Health eSource, April 2018.
- A. Asgeirsson, E. DuGoff, G. Russo. "Short Supply: The Availability of Healthcare Resources During the COVID-19 Pandemic." Whitepaper, BRG, 2020.
- J. Younts, G. Russo. "The Nitty-Gritty of Price Transparency." American Bar Association's The Health Lawyer, Vol. 33, No. 6, August 2021.

## **PRESENTATIONS**

*Proactively Responding to Government Investigations Using Data Analytics*, American Health Lawyers Association's Long Term Care & The Law, February 2016.

*How Does Medicare Reduce Payments? Let Us Count the Ways*, King & Spalding's 25<sup>th</sup> Annual Health Law & Policy Forum, March 2016.

*Structural and Transactional Implications of Medicare Payment Reform*, American Health Lawyers Association's Institute on Medicare and Medicaid Payment Issues, April 2016.

*Proactively Responding to Government Investigations Using Data Analytics*, Reed Smith Health Care Conference, May 2016.

*Value-Based Reimbursement – It's Here*, Texas Health Law Conference, October 2016.

*Effective Use of Your Own Data – Mining Your Own Data for Compliance*, Nashville Healthcare Fraud Conference, December 2016.

*Data Analytics: How Data Will Shape Payer, Provider, and Policy in 2017 and Beyond*, BRG Healthcare Leadership Conference, December 2016.

*Take Data by the Horns: Turn Analytics to Your Advantage*, American Bar Association's Emerging Issues Conference, March 2017.

*The Past, Present, and Future of Medicare Value Based Purchasing Programs*, AHLA Institute on Medicare and Medicaid Payment Issues, March 2017.

*Post-Acute Roundtable*, BRG Executive Roundtable Series, September 2017.

*Contracting for Ancillary Services*, BRG Executive Roundtable Series, November 2017.

*Mine Your Own Data: The Role of Data in Dealing with Healthcare Fraud Issues*, Nashville Healthcare Fraud Conference, December 2017.

*Data Analytics: The Road to Improving Healthcare*, BRG Healthcare Leadership Conference, December 2017.

*A Guide to Interacting with the DOJ and the Settlement Process in Enforcement Matters*, American Bar Association's Emerging Issues Conference, February 2018.

*Anatomy of a Healthcare Fraud Investigation*, Healthcare Law & Compliance Institute, March 2018.

*Bending the Cost Curve, but in which Direction—How are Bundled Payments and Value Based Purchasing Programs Working with Respect to Reducing Physicians' and Acute Care Hospitals' Costs*, American Health Lawyers Association's Institute on Medicare and Medicaid Payment Issues, March 2018.

*Best Practices in Managing Internal Investigations and Compliance*, McGuire Woods' 5<sup>th</sup> Annual Healthcare Litigation and Compliance Conference, May 2018.

*How Healthcare Providers Can Make the Best Use of Their Data*, Nashville Healthcare Fraud Conference, December 2018.

*Provider-Based Rules: Recent Developments in Site Neutrality and Co-Location*, Boston Bar Association Healthcare Law Conference, May 2019.

*Fraud & Abuse Initiatives by Health Insurers*, Nashville Healthcare Fraud Conference, December 2019.

*Navigating the Future of American Healthcare: What Litigators Should Know about Value-Based Reimbursement*, 11<sup>th</sup> Annual Advanced Forum on Managed Care Disputes and Litigation. July 2020.

*Data Analytics*, Nashville Regional Health Care Compliance Conference. November 2022.

## TESTIMONY

1. *Dee Ann Schirlls v. Robert Crust and WCA Waste Corporation*. (State of Missouri Circuit Court of Cass County, Case No. 18CA-CC00082).
2. *Crescent City Surgical Centre v. Cigna Health and Life Insurance Company, Cigna Healthcare Management Inc., Cigna Health Insurance Company* (United States District Court for the Eastern District of Louisiana, 2:18-CV-11385).
3. *Private Arbitration between Wisconsin health care providers*.
4. *Savannah Massey, by and through Joy Massey, v. SSM Health Care St. Louis D/B/A SSM Health DePaul Hospital – St. Louis* (State of Missouri Circuit Court of St. Louis County, Case No. 18SL-CC03032).
5. *Hot Springs National Hospital Holdings, LLC D/B/A National Park Medical Center & National Park Cardiology Services, LLC D/B/A Hot Springs Cardiology Associates v. Jeffrey George Tauth, M.D.* (American Health Lawyers Association Arbitration, Case No. 5819).
6. *Eliot McArdel v. King County Public Hospital District No. 1, d/b/a Valley Medical Center* (State of Washington Superior Court of King County, 18-2-14500-7 KNT).
7. *Christopher Moore, et al. v. Daniel Wagner, et al.* (State of Ohio Court of Montgomery County, 2019-CV-02758).
8. *Blue Cross and Blue Shield of Florida Inc et al v. DaVita Inc.* (United States District Court for the Middle District of Florida Jacksonville Division, 3:19-cv-00574).
9. *James Russo and Cheryl Russo v. Dr. Jeffrey Blatnik and Barnes Jewish Hospital* (State of Missouri Circuit Court of the City of Saint Louis, 1922-CC11151).
10. *Fresenius Medical Care Orange County, LLC; DaVita inc., Fresenius Medical Care Holdings, Inc., d/b/a Fresenius Medical Care North America; U.S. Renal Care, Inc. v. Rob Bonta, in his Official Capacity as Attorney General of California; Ricardo Lara, in his Official Capacity as California Insurance Commissioner; Shelly Rouillard, in her Official Capacity as Director of the California Department of Managed Health Care; and Tomas Aragon, in his Official Capacity as Director of the California Department of Public Health* (United States District Court for the Central District of California Southern Division, 8:19-cv-02130). *Jane Doe; Stephen Albright; American Kidney Fund, Inc.; Dialysis Patient Citizens, Inc. v. Rob Bonta, in his Official Capacity as Attorney General of California; Ricardo Lara, in his Official Capacity as California Insurance Commissioner; Shelly Rouillard, in her Official Capacity as Director of the California Department of Managed Health Care; and Tomas Aragon, in his Official Capacity as Director of the California Department of Public Health* (United States District Court for the Central District of California Southern Division, 8:19-cv-02105).
11. *Abeba Tesariam, et al. v. Vibhakar Mody, M.D., et al.* (State of Maryland Circuit Court of Montgomery County, Case No. 472767-V).
12. *In re: Out of Network Substance Use Disorder Claims Against UnitedHealthcare* (United States District Court for the Central District of California, 8:19-cv-02075).
13. *Katherine Villagomez, et al. v. PeaceHealth, The Vancouver Clinic, Inc. and William Herzig, M.D.* (State of Washington Superior Court of Clark County, 18-2-01491-7).
14. *UnitedHealthcare Insurance Company v. Sahara Palm Plaza, LLC, and Alexander Javaheri* (United States District Court for the Central District of California, 8:20-cv-02221).
15. *United States of America, ex rel. Henry B. Heller v. Guardian Pharmacy, LLC and Guardian Pharmacy of Atlanta, LLC.* (United States District Court for the Northeast District of Georgia, 1:18-cv-03728-SDG).

16. *Kayla Magness, et al. v. The Charlotte-Mecklenburg Hospital Authority, Carolinas Physicians Network, Inc., et al.* (State of North Carolina Circuit Court of Lincoln County, Case No. 19CV-00934).
17. *North Broward Hospital District d/b/a Broward Health v. Oscar Insurance Company of Florida* (State of Florida Circuit Court of Broward County, Case No. CACE-20-010648).
18. *United States of America v. William Harwin* (United States District Court for the Middle District of Florida, 2:20-cr-00115).
19. *Wykeya Williams, et al. v. First Student, Inc.* (United States District Court for the District of New Jersey, 2:20-cv-001176).
20. *Kaitlynn Livingston, natural mother and next friend of Z.L., a minor, v. St. Louis Children's Hospital, The Washington University, and Tasnim Najaf, M.D.* (State of Missouri Circuit Court of St. Louis City, Case No. 2022-CC00325).
21. *United States of America, et al. v. Exactech, Inc.* (United States District Court for the Northern District of Alabama, 2:18-cv-01010).
22. *Maurice Gibbons v. Joel Soltren and Marietta Fence Company, Inc.* (State of Georgia Circuit Court of Cobb County, 19A4187).
23. *Erika Warren, et al. v. State of Washington d/b/a University of Washington Medical Center – Northwest and Childbirth Center at UW Medical Center – Northwest* (State of Washington Superior Court for King County, 21-2-06153-9).
24. *Annette Robinson, et al. v. David Berry, M.D., Neonatology and Pediatric Acute Care Specialists, PC, and Catawba Valley Medical Center* (State of North Carolina Superior Court of Catawba County, 18-CVS-3237).
25. *Taylor Cayce v. Mercy Hospitals East Communities, d/b/a Mercy Hospital St. Louis, Mercy Clinic East Communities, d/b/a Mercy Clinic OB/GYN, Jason Phillips, M.D., and April Parker, M.D.* (State of Missouri Circuit Court of St. Louis County, Case No. 18SL-CC03681).
26. *Crescent City Surgical Centre v. UnitedHealthcare of Louisiana, Inc.* (State of Louisiana District Court for the Parish of Jefferson, 2:19-cv-12586).
27. *United States of America and the State of Tennessee ex rel. Jeffrey Liebman and David Stern, M.D. vs. Methodist Le Bonheur Healthcare, Methodist Healthcare-Memphis Hospitals, Chris McLean, and Gary Shorb* (United States District Court for the Middle District of Tennessee, 3:17-cv-00902).
28. *Jade Nesselhauf v. Cardinal Glennon Children's Foundation d/b/a SSM Health Cardinal Glennon Children's Hospital and St. Louis University d/b/a SLUCARE Physicians Group* (State of Missouri Circuit Court of St. Louis County, Case No. 1822-CC10878).
29. *Jheri Shields v. Mark Barber, Mark E Barber d/b/a Mark Barber Trucking; LAD Truck Lines, Inc. and Protective Insurance Company* (State of Georgia Court of Hall County, Case No. 2021SV418D).
30. *Shannon Bristow, et al. v. The Nemours Foundation d/b/a Nemours/A.I. duPont Hospital for Children and/or d/b/a Nemours-A.I. duPont Hospital for Children; and Specialtycare, Inc., et al.* (State of Delaware Superior Court, Case No. N21C-03-240 JRJ).
31. *Derek Williams v. James Robinson and Georgia Sand & Stone, Inc.* (State of Georgia Court of Walton County, Case No. 2020001022).

**PRESENT POSITION**

Berkeley Research Group, 2010 – present

**PREVIOUS POSITIONS**

LECG, 2009 – 2010

Navigant Consulting, Inc., 2004 – 2009

Jersey Shore University Medical Center, 2001 - 2003

**PROFESSIONAL AFFILIATIONS**

*American Health Lawyers Association*

*Healthcare Financial Management Association*

**Appendix B**  
**Documents and Information Relied on**

## **Case Documents and Data**

AETNA0001992

AETNA0013892

AETNA0014000

AETNA0019463

AETNA0026101

Aetna's 30(b)(6) Deposition

Blue Cross NC\_0000151

Blue Cross NC\_0001955

Blue Cross NC\_0001953

Blue Cross's 30(b)(6) Deposition

Deposition of Charles Sceiford

Deposition of Stuart Wohl

Letter from John K. Edwards to Sam Watts. January 13, 2023

Letter from Sam Watts to John K. Edwards. January 20, 2023

Letter from Sam Watts to Matthew Sawchak. January 20, 2023

NCSHP\_Medical\_RFP\_Census\_File

Segal's 30(b)(6) Deposition

SHP 0000010

SHP 0001779

SHP 0001952

SHP 0002295

SHP 0002413

SHP 0003962

SHP 0006955

SHP 0006956

SHP 0006959

SHP 0006960

SHP 0006961

SHP 0006962

SHP 0006963

SHP 0006964

SHP 0006965

SHP 0006966

SHP 0009869

SHP 0024713

SHP 0024720

SHP 0040105

SHP 0069462

SHP 0069463

SHP 0069464

SHP 0069494

SHP 0069503

SHP 0069736

SHP 0069744

SHP 0069756

SHP 0069760

SHP 0069795

SHP 0070486

SHP 0072588

SHP 0083572

SHP 0085016

SHP 0085038

SHP 0085064

SHP 0085084

SHP 0085919

SHP 0086294

SHP 0087620

SHP 0087957

SHP 0087964

SHP 0092423

SHP 0092745

SHP 0093060

SHP 0093117

SHP 069464

## **Publicly Available Materials**

Centers for Medicare and Medicaid Services, "NPI: What You Need to Know," MLN909434 March 2022.

CMS. The No Surprises Act's Continuity of Care, Provider Directory, and Public Disclosure Requirements. Available at: <https://www.cms.gov/files/document/a274577-1b-training-2nsa-disclosure-continuity-care-directoriesfinal-508.pdf>.

HealthAffairs. Regulation of Health Plan Provider Networks. July 28, 2016. Available at: <https://www.healthaffairs.org/doi/10.1377/hpb20160728.898461/>.

Milliman White Paper. Determining discounts. November 2012. Available at: <https://us.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/healthreform/pdfs/determining-discounts>.

National Association of Insurance Commissioners, Network Adequacy, June 1, 2023. Available at: <https://content.naic.org/cipr-topics/network-adequacy#:~:text=Issue%3A%20Network%20adequacy%20refers%20to,the%20terms%20of%20the%20contract>.

National Conference of State Legislatures. State Employee Health Benefits, Insurance Costs. May 01, 2020. Available at: <https://www.ncsl.org/health/state-employee-health-benefits-insurance-and-costs>.

Office of the Assistant Secretary for Planning and Evaluation. Medicaid Churning and Continuity of Care. April 11, 2021. Available at: <https://aspe.hhs.gov/reports/medicaid-churning-continuity-care>.

PwC Health Research Institute. Medical Cost Trend: Behind the numbers 2024. Available at: <https://www.pwc.com/us/en/industries/health-industries/library/assets/pwc-behind-the-numbers-2024.pdf>.

Robert Wood Johnson Foundation. Analyzing Medicaid Managed Care Organizations: State Practices for Contracting With Managed Care Organizations and Oversight of Contractors. August 2020. Available at: <https://www.rwjf.org/en/insights/our-research/2020/08/analyzing-medicaid-managed-care-organizations--state-practices-for-contracting-with-managed-care-organizations-and-oversight-of-contractors.html>.

State of North Carolina, North Carolina State Health Plan for Teachers and State Employees. Financial Update, Board of Trustees Meeting. March 2, 2022. Available at: <https://www.shpnc.org/documents/board-trustees/march-2022-financial-report021622/download?attachment>.

State of Tennessee, Department of Finance and Administration. Request For Proposals for Third Party Administrator Services for The State's Public Sector Health Plans, pgs. 24, 41. February 20, 2020, pg. 131. Available at: [https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/contracts/health\\_rfp\\_31786\\_00148.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/contracts/health_rfp_31786_00148.pdf).

### **Additional Data**

NPI\_Registry\_Taxonomy.txt

Provider\_Addresses\_w\_Coordinates.txt

Subscriber\_Addresses\_w\_Coordinates.txt

Zip\_to\_County.txt

**Appendix C**  
**Exhibits**

**Figure 1**

- 1) How is the value of the performance guarantees be determined? Is it solely based on the dollar amounts available? Will we take into account the probability of not meeting the discount guarantee? For example if Vendor A has a higher discount guarantee but lower amount at risk compared to Vendor B, how do we compare between the Vendors. **THIS SECTION'S SCORING IS BOTH SUBJECTIVE AND COMPARATIVE. THE SCORING WILL NEED TO CONSIDER EACH VENDOR'S GUARANTEE ON (1) HOW DOES IT RELATE TO THEIR OWN PRICING....ITS VALUE TO THE SHP AND (2) HOW IT COMPARES TO THE OTHER VENDOR PROPOSALS. YES, WE NEED TO CONSIDER BOTH THE GUARANTEED TARGETED LEVEL AND THE AMOUNT AT RISK IN DETERMINING THE OVERALL "VALUE" OF THE PROPOSED GUARANTEES.**
  
- 2) Can Segal Provide sample discount guarantees to show how ranking and scoring would be determined? **WE DON'T HAVE A SAMPLE ALREADY DRAFTED. AS INDICATED ABOVE, THIS ANALYSIS IS HEAVILY DEPENDENT ON WHAT WE RECEIVE FROM THE VENDORS. IT COULD BE AS SIMPLE AS A MULTIPLICATION OF THE GUARANTEE AND THE AMOUNT AT RISK, BUT IT WILL DEPEND ON WHAT THE VENDORS PROPOSE.**

**Source:** SHP 0070486

**Figure 2  
Segal's Pricing Guarantee Template**

Discount Guarantees				
	Inpatient	Outpatient	Professional	Total
<b>CY 2025</b>				
Aetna				0.0%
BCBSNC				0.0%
UMR				0.0%
<b>CY 2026</b>				
Aetna				0.0%
BCBSNC				0.0%
UMR				0.0%
<b>CY 2027</b>				
Aetna				0.0%
BCBSNC				0.0%
UMR				0.0%
<b>Amounts at Risk</b>				
	Year	Description		
<b>Aetna</b>	CY 2025			
	CY 2026			
	CY 2027			
<b>BCBSNC</b>	CY 2025			
	CY 2026			
	CY 2027			
<b>UMR</b>	CY 2025			
	CY 2026			
	CY 2027			

**Source:** SHP 0085016. Pricing Guarantee tab.

**Figure 3**  
**Final Version of Segal's Pricing Guarantee Scoring Worksheet**

**Discount Guarantees**

	Current Discount <sup>1</sup>	Vendor Projected Discount <sup>2</sup>	CY 2025 Guarantee <sup>3</sup>	Guarantee Compared to		Description of Guarantee Payout Methodology	CY 2025 Max at Risk		CY 2026 to CY 2029 Guarantees	Evaluation of Discount Guarantee
				Current Discount	Projected Discount		Dollar Amount	Discount for Max Payout		
<b>Aetna</b>	53.0%	54.0%	52.3%	-0.7%	-1.7%	20% of the discount shortfall to a max of 25% of admin fee (45% max across all guarantees)	\$22,305,000	50.3%	Same guarantee for each year with no changes in target discounts	Offers moderate comparative value. CY 2025 and beyond offer up to 25% of admin at risk at a discount target lower than current and projected. Offers protection from discount erosion.
<b>BCBSNC</b>	52.7%	57.8%	55.1%	2.4%	-2.7%	10% of the discount shortfall to a max of 5% of admin fee	\$2,653,000	54.7%	Same guarantee for each year with slight increases (<1%) in target discounts	Offers the least comparative value. The least value is due to a limited amount at risk at 5% of admin. Discount target is competitive and higher than current discounts and improves slightly through 2029, but remains lower than discounts projected by the vendor.
<b>UMR</b>	52.5%	54.1%	52.6%	0.1%	-1.5%	100% of the discount shortfall to a max of 100% of admin fee	\$95,101,000	50.9%	No guarantee after CY 2025	Offers the greatest comparative value. CY 2025 offers the highest value with a dollar-for-dollar guarantee up to 100% of the admin fee at risk, but no guarantee beyond year 1.

**Trend Guarantees**

	CY 2026 Guarantee	Description of Payout Methodology	CY 2026 Max at Risk		CY 2027 to CY 2029 Guarantees	Large Claimant Adjustments	Exclusions and Conditions	Evaluation of Discount Guarantee
			Dollar Amount	Trend for Max Payout				
<b>Aetna</b>	6.8%	3% of the admin fee for each full percentage point above the guarantee to a maximum of 25% of admin fee (45% max across all guarantees)	\$22,305,000	15.8%	Same guarantee with 0.3% increases in the trend each year	Claim amounts in excess of \$250,000 for any individual claimant are excluded	Pharmacy claims are excluded. Requires Aetna receives pharmacy data file feeds at a minimum bi-weekly basis to support the care management program. Aetna will adjust base year claims for factors impacting the relativity of the population such as changes in plan design, demographics, geography, included products, programs and services, third-party vendor solutions, or the impact of novel conditions.	Offers moderate comparative value. Offers the second lowest trend target and a reasonable amount at risk. Offers protection from increases in market/industry trend; however, the payouts are spread over excess trend up to 9% over the target.
<b>BCBSNC</b>	6.0%	10% of the excess trend dollars to a maximum of 5% of admin fee	\$2,653,000	10.0%	Same guarantee for each year with no changes in the 6% trend	All claims for individuals with claims in excess of \$250,000 are excluded	Pharmacy claims are excluded. Claims related to new services or benefits added at the discretion of the Plan during the term of this contract are excluded. Providers that sign up for the Clear Pricing Program are excluded.	Offers the least comparative value. While BCBSNC offers the lowest trend target, it is diminished by the lowest dollar amount at risk and the removal of all claims for individuals over \$250,000 (not just the amounts over \$250,000).
<b>UMR</b>	UHC book-of-business (BoB) trend minus 1%	Percent of admin returned based on trend ranges between UHC BoB minus 1% to UHC BoB plus 3% for the max. of 50% of admin fee	\$47,550,000	3% over UHC BoB Trend	UHC book-of-business (BoB) trend minus 1%	Claim amounts in excess of \$250,000 for any individual claimant are excluded	Pharmacy claims are excluded. Mental Health and Substance Use Disorder (MHSUD) claims are excluded.	Offers moderate comparative value. Illustrates a commitment to manage trend at least 1% lower than its BoB and places the most amount at risk. However, as it is prospectively based on UHC's BoB, it offers minimal protection from increases in market/industry trend. Also, does not include MHSUD claims.

Source: SHP 0069464

**Figure 4**

**Network Pricing Guarantees Score**

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

**Source:** SHP 0069464

**Figure 5**

**Summary of Vendor Guarantee Amounts and Claims Cost**

		<b>2025</b>	<b>2026</b>	<b>2027</b>	<b>Total (2025-2027)</b>
<b>Aetna</b>	<b>Discount Guarantee</b>	52.3%	52.3%	52.3%	
	<b>Claims Cost</b>	\$3,076,558,011	\$3,252,777,060	\$3,439,461,836	\$9,768,796,907
<b>Blue Cross</b>	<b>Discount Guarantee</b>	55.1%	55.5%	55.9%	
	<b>Claims Cost</b>	\$2,911,678,095	\$3,054,051,447	\$3,203,651,700	\$9,169,381,242
<b>UMR</b>	<b>Discount Guarantee</b>	52.6%	No Guarantee	No Guarantee	
	<b>Claims Cost</b>	\$3,059,737,643	N/A	N/A	N/A
<b>Amount that Aetna's Claims Cost is Higher than Blue Cross's</b>		<b>\$164,879,916</b>	<b>\$198,725,614</b>	<b>\$235,810,135</b>	<b>\$599,415,665</b>
<b>Amount that UMR's Claims Cost is Higher than Blue Cross's</b>		<b>\$148,059,548</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>

**Figure 6**  
**Bottom-Line Impact on Costs to the Plan**  
**Resulting From Maximum Miss in Discounts**

		<b>2025 Guarantee</b>	<b>Impact of 1.9% Miss</b>
<b>Aetna</b>	Discount	52.3%	50.3%
	Total Claims Cost	\$2,789,735,211	\$2,901,257,758
	Refund to the Plan	\$0	\$22,304,510
	Total Claims Costs Less Refund	\$2,789,735,211	\$2,878,953,249
<b>Blue Cross</b>	Discount	55.1%	53.2%
	Total Claims Cost	\$2,636,713,685	\$2,748,809,579
	Refund to the Plan	\$0	\$7,959,033
	Total Claims Costs Less Refund	\$2,636,713,685	\$2,740,850,546
<b>Bottom-Line Difference</b>		<b>\$153,021,526</b>	<b>\$138,102,703</b>

**Figure 7**  
**Bottom-Line Impact on Costs to the Plan**  
**Resulting From Incremental Misses in Discounts**

		<b>2025 Guarantee</b>	<b>Impact of 0.5% Miss</b>	<b>Impact of 1.0% Miss</b>	<b>Impact of 1.5% Miss</b>
<b>Aetna</b>	Discount	52.3%	51.8%	51.3%	50.8%
	Total Claims Cost	\$2,789,735,211	\$2,818,947,098	\$2,848,158,985	\$2,877,370,872
	Refund to the Plan	\$0	\$5,842,377	\$11,684,755	\$17,527,132
	Total Claims Costs Less Refund	\$2,789,735,211	\$2,813,104,720	\$2,836,474,230	\$2,859,843,740
<b>Blue Cross</b>	Discount	55.1%	54.6%	54.1%	53.6%
	Total Claims Cost	\$2,636,713,685	\$2,666,075,753	\$2,695,437,821	\$2,724,799,888
	Refund to the Plan	\$0	\$2,936,207	\$5,872,414	\$7,959,033
	Total Claims Costs Less Refund	\$2,636,713,685	\$2,663,139,546	\$2,689,565,407	\$2,716,840,855
<b>Bottom-Line Difference</b>		<b>\$153,021,526</b>	<b>\$149,965,174</b>	<b>\$146,908,823</b>	<b>\$143,002,885</b>

Figure 8

Aetna Claims and Billed Charges Attributable to REDACTED

Provider Name	County	Claims	Charges
REDACTED			

Figure 9

Aetna Claims and Billed Charges Attributable to REDACTED

Provider Name	County	Claims	Charges
REDACTED			

Figure 10

Aetna Claims and Billed Charges Attributable to REDACTED

Provider Name	County	Claims	Charges
REDACTED			



Provider	Claims	Charges	Contracted Amount		Discount Percentage		
			Aetna's Bid	Priced Using Actual Rates in Letters of Intent	Aetna's Bid	Priced Using Actual Rates in Letters of Intent	Difference
REDACTED							

**Figure 12**

**Illustration of Discount-Percentage Calculation**

	<b>Billed Charge</b>	<b>Contract Rate</b>	<b>Discount</b>
<b>Year 1</b>	\$100	\$80	20%
<b>Year 2</b>	\$115	\$90	22%
<b>Year 3</b>	\$130	\$100	23%

**Figure 13**  
**Tables from Clarification Requests Sent to Vendors**  
**Blue Cross (left) and Aetna (right)**

	In -Network Discount Accumulation	Example		In -Network Discount Accumulation	Example
2021 Claims Data using 2021 Contracts	%	50.0%	2021 Claims Data using 2021 Contracts	%	50.0%
Indicate the increase in discounts attributed to each of the following:			Indicate the increase in discounts attributed to each of the following:		
Discounts as of Repricing Date (e.g., 11/1/22)	%	51.0%	Discounts as of Repricing Date (e.g., 11/1/22)	%	51.0%
Current Letters of Intent (should <u>not</u> include assumed increases in billed charges)	%	51.4%	Current Letters of Intent (should <u>not</u> include assumed increases in billed charges)	53.0%	51.4%
Known Contract Improvements (should <u>not</u> include assumed increases in billed charges)	%	52.5%	Known Contract Improvements (should <u>not</u> include assumed increases in billed charges)	53.0%	52.5%
Assumed Increases in Billed Charges	%	53.5%	Assumed Increases in Billed Charges	%	53.5%
Anticipated Contract Improvements	%	54.0%	Anticipated Contract Improvements	%	54.0%
Other (please clarify)	%	54.0%	Other (please clarify)	%	54.0%
Expected 2025 Discounts	54.0%	54.0%	Expected 2025 Discounts	54.0%	54.0%

Sources: SHP 0009869 (left), SHP 0069795 (right)

**Figure 14**  
**Tables from Clarification Answers from Vendors**  
**from Blue Cross (left) and Aetna (right)**

	In -Network Discount Accumulation	Example		In -Network Discount Accumulation	Example
2021 Claims Data using 2021 Contracts	51.2%	50.0%	2021 Claims Data using 2021 Contracts	51.97%	50.0%
Indicate the increase in discounts attributed to each of the following:			Indicate the increase in discounts attributed to each of the following:		
Discounts as of Repricing Date (e.g., 11/1/22)	54.0%	51.0%	Discounts as of Repricing Date (e.g., 11/1/22)	52.11%	51.0%
Current Letters of Intent (should not include assumed increases in billed charges)	54.0%	51.4%	Current Letters of Intent (should not include assumed increases in billed charges)	52.44%	51.4%
Known Contract Improvements (should not include assumed increases in billed charges)	54.0%	52.5%	Known Contract Improvements (should not include assumed increases in billed charges)	52.99%	52.5%
Assumed Increases in Billed Charges	57.8%	53.5%	Assumed Increases in Billed Charges	53.99%	53.5%
Anticipated Contract Improvements	57.8%	54.0%	Anticipated Contract Improvements	53.99%	54.0%
Other (please clarify)	57.8%	54.0%	Other (please clarify)	53.99%	54.0%
Expected 2025 Discounts	57.8%	54.0%	Expected 2025 Discounts	53.99%	54.0%

Sources: SHP 0024713 (left), SHP 0001952 (right)

**Figure 15**

**Illustration of Understated “Discount” Percentages When Billed Charges Are Held Constant**

	<b>Billed Charge (Without Trend)</b>	<b>Contract Rate (Actual)</b>	<b>Distorted “Discount”</b>
<b>Year 1</b>	\$100	\$80	20%
<b>Year 2</b>	\$100	\$90	10%
<b>Year 3</b>	\$100	\$100	0%

**Figure 16**  
**Illustration of Discount Percentage Calculation – Contract Rates Held Constant**  
**And Billed Charges Trended Forward**

	<b>Billed Charge (Trended)</b>	<b>Contract Rate (Actual)</b>	<b>Actual Projected Discount</b>
<b>Year 1</b>	\$100	\$80	20%
<b>Year 2</b>	\$115	\$80	30%
<b>Year 3</b>	\$130	\$80	38%

**Figure 17**

**Before: Charges, Allowed Amounts and Discounts Taken from the Repricing Exercise**

Non-Medicare Network Discounts <sup>1</sup>	Charge Amount	Allowed Amount	Estimated Discounts			
			Base %	Adjustments	Improvements	Adjusted %
Baseline - CY 2021 <sup>2</sup>			51.8%	N/A	N/A	51.8%
Aetna	\$5,810,527,882	\$2,728,501,262	53.0%	0.0%	0.0%	53.0%
BCBSNC	\$5,841,369,152	\$2,686,255,626	54.0%	0.0%	0.0%	54.0%
UMR <sup>3,4</sup>	\$5,710,719,172	\$2,619,524,312	54.1%	-4.0%	0.3%	50.5%

**Source:** SHP 0085084.xlsx, Network Pricing tab

**Figure 18**

**Before: Scores for Network Pricing on November 15, 2022**

Total Projected Claims	CY 2025	CY 2026	CY 2027	Total (2025-2027)	% From Lowest Claims Cost	Network Pricing	
						Rank	Score
Aetna	\$3,031,470,897	\$3,205,206,389	\$3,389,268,586	\$9,625,945,873	1.85%	2	3
BCBSNC	\$2,976,283,077	\$3,146,978,629	\$3,327,830,721	\$9,451,092,427	0.00%	3	6
UMR	\$3,163,253,527	\$3,365,030,262	\$3,557,903,574	\$10,086,187,364	6.72%	1	0

Source: SHP 0085084.xlsx, Network Pricing tab

**Figure 19**

**After: Scores for Network Pricing on November 29, 2022**

Non-Medicare Network Discounts and Relative Values <sup>1</sup>	Estimated Network Discounts			
	Repricing %	Adjusted for Clarifications	Improvements	Adjusted %
Baseline - CY 2021 <sup>2</sup>				51.8%
Aetna	53.0%	53.0%	0.00%	53.0%
BCBSNC <sup>3,4</sup>	54.0%	52.7%	0.04%	52.7%
UMR <sup>3,5</sup>	54.1%	52.5%	0.09%	52.6%

**Source:** SHP 0069464, Network Pricing tab

**Figure 20**  
**Final Network Pricing Scores**

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

**Source:** SHP 0069464, Network Pricing tab

**Figure 21**  
**Excerpt of UDS North Carolina Discount Analysis**

**North Carolina**  
**Discount Analysis - Overall Results - Adjusted Data**

% Differences (cost impact) from Incumbent	BCBS	Aetna	Cigna	UHC
Overall including Wrap Networks with 50% weight (OON at 20%) - Discounts		1.1%	-1.5%	-1.5%

Source: SHP 0085038, pg. 85040

**Figure 22**  
**Excerpt of Attachment A-2**

Provider Type	Urban Parameters	North Carolina Urban Counties					
		Durham	Forsyth	Guilford	Mecklenburg	New Hanover	Wake
<b>Facilities</b>							
Hospitals	1 within 20-mile radius						
Ambulatory Surgical Centers	1 within 20-mile radius						
Urgent Care facilities	1 within 20-mile radius						
Imaging Centers	1 within 20-mile radius						
Inpatient Behavioral Health Facilities	1 within 20-mile radius						
<b>Professional Services</b>							
<b>Primary Care</b>							
General/Family Practitioner (includes Internal Medicine, Family Medicine, and General Medicine)	2 within 10-mile radius						
OB/GYN (female members, age 12 and older)	2 within 10-mile radius						
Pediatrician (members, birth through age 18)	2 within 10-mile radius						
<b>Specialists</b>							
Endocrinologist	2 within 20-mile radius						
Urologist	2 within 20-mile radius						
Cardiologist	2 within 20-mile radius						
Dermatologist	2 within 20-mile radius						
Allergist	2 within 20-mile radius						
Psychologist/Psychiatrist	2 within 20-mile radius						
General Surgeon	2 within 20-mile radius						
Hematologist/Oncologist	2 within 20-mile radius						
Chiropractor	2 within 20-mile radius						

Source: SHP 0006965

**Figure 23**

**In-Network Distinct Provider Counts for Core Provider Types by Region**

	Urban			Suburban			Rural		
	Blue Cross	Aetna	Difference	Blue Cross	Aetna	Difference	Blue Cross	Aetna	Difference
Facilities	146	139	7	104	103	1	211	145	66
Primary Care Providers	7,091	8,014	(923)	8,501	7,104	1,397	8,764	8,290	474
Specialists	5,801	6,273	(472)	6,684	4,650	2,034	5,268	4,661	607
<b>Total</b>	<b>13,038</b>	<b>14,426</b>	<b>(1,388)</b>	<b>15,289</b>	<b>11,857</b>	<b>3,432</b>	<b>14,243</b>	<b>13,096</b>	<b>1,147</b>

**Figure 24  
Provider Availability to Members**

**Average Number of Providers within the Radius of Member Specified in Attachment A-2**

Provider Type	Urban		Suburban		Rural		Overall Average	
	Blue Cross	Aetna	Blue Cross	Aetna	Blue Cross	Aetna	Blue Cross	Aetna
<b>Facilities</b>								
Hospitals	10	7	11	8	12	8	11	8
Ambulatory Surgical Centers	15	13	9	9	7	7	10	10
Urgent Care	10	9	7	7	7	5	8	7
Imaging Centers	11	7	12	9	12	8	12	8
Inpatient Behavioral Health Facilities	4	4	2	3	2	2	3	3
<b>Primary Care</b>								
General/Family Practitioner (Including Internal Medicine)	692	810	781	629	320	303	552	546
OB/GYN	151	191	133	143	41	53	99	120
Pediatrician	162	186	104	116	44	49	97	110
<b>Specialists</b>								
Endocrinologists	50	52	47	38	27	23	39	36
Urologists	71	59	95	51	65	41	74	49
Cardiologists	206	192	236	151	169	131	197	156
Dermatologists	94	96	101	62	66	44	84	65
Allergists	31	30	39	23	23	15	29	22
Psychologists/Psychiatrists	543	567	439	392	294	238	410	382
General Surgeons	203	292	225	231	147	164	184	222
Hematologists/Oncologists	128	184	147	149	87	101	115	140
Chiropractors	136	158	90	109	64	70	94	108
<b>Overall Average</b>	<b>2,509</b>	<b>2,850</b>	<b>2,468</b>	<b>2,123</b>	<b>1,375</b>	<b>1,255</b>	<b>2,006</b>	<b>1,984</b>

**Figure 25**  
**Difference in 2021 Out-of-Network Claims between Blue Cross and Aetna**  
**Impact on Estimated Member Paid Amount by County**

County	County Type	Blue Cross		Aetna		Difference	
		Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount
MOORE	Rural	913	\$53,751	3,421	\$948,723	2,508	\$894,972
ORANGE	Suburban	2,128	\$167,898	16,383	\$927,429	14,255	\$759,530
MECKLENBURG	Urban	2,924	\$387,854	11,525	\$1,053,456	8,601	\$665,602
CUMBERLAND	Suburban	297	\$12,697	5,919	\$484,262	5,622	\$471,565
GUILFORD	Urban	1,987	\$160,402	7,160	\$586,254	5,173	\$425,852
WAKE	Urban	17,068	\$1,103,721	30,818	\$1,490,603	13,750	\$386,882
PITT	Suburban	1,128	\$55,785	7,993	\$420,979	6,865	\$365,194
NEW HANOVER	Urban	794	\$49,204	7,490	\$378,870	6,696	\$329,666
BUNCOMBE	Suburban	3,185	\$173,588	7,376	\$460,664	4,191	\$287,076
FORSYTH	Urban	584	\$62,537	5,637	\$281,529	5,053	\$218,992
All Other		24,122	\$1,679,747	66,655	\$4,156,031	42,533	\$2,476,283
<b>Total</b>		<b>55,130</b>	<b>\$3,907,185</b>	<b>170,377</b>	<b>\$11,188,800</b>	<b>115,247</b>	<b>\$7,281,615</b>

**Figure 25a**  
**Difference in 2021 Out-of-Network Claims between Blue Cross and Aetna**  
**Impact on Estimated Member Paid Amount by County**

County	County Type	Blue Cross		Aetna		Difference	
		Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount
MOORE	Rural	913	\$53,751	3,421	\$948,723	2,508	\$894,972
ORANGE	Suburban	2,128	\$167,898	16,383	\$927,429	14,255	\$759,530
MECKLENBURG	Urban	2,924	\$387,854	11,525	\$1,053,456	8,601	\$665,602
CUMBERLAND	Suburban	297	\$12,697	5,919	\$484,262	5,622	\$471,565
GUILFORD	Urban	1,987	\$160,402	7,160	\$586,254	5,173	\$425,852
WAKE	Urban	17,068	\$1,103,721	30,818	\$1,490,603	13,750	\$386,882
PITT	Suburban	1,128	\$55,785	7,993	\$420,979	6,865	\$365,194
NEW HANOVER	Urban	794	\$49,204	7,490	\$378,870	6,696	\$329,666
BUNCOMBE	Suburban	3,185	\$173,588	7,376	\$460,664	4,191	\$287,076
FORSYTH	Urban	584	\$62,537	5,637	\$281,529	5,053	\$218,992
WATAUGA	Rural	343	\$12,041	4,467	\$226,777	4,124	\$214,736
CATAWBA	Suburban	315	\$13,750	2,338	\$221,069	2,023	\$207,319
CRAVEN	Rural	38	\$2,601	1,974	\$205,318	1,936	\$202,717
DURHAM	Urban	9,426	\$650,780	14,942	\$823,895	5,516	\$173,115
WAYNE	Rural	9	\$464	5,396	\$168,627	5,387	\$168,164
HENDERSON	Suburban	154	\$18,204	1,074	\$179,347	920	\$161,143
PASQUOTANK	Rural	255	\$16,759	1,159	\$164,249	904	\$147,490
BURKE	Rural	715	\$34,376	2,132	\$167,906	1,417	\$133,529
NASH	Rural	120	\$5,311	2,071	\$127,671	1,951	\$122,360
SURRY	Rural	24	\$1,175	1,306	\$117,411	1,282	\$116,236
CHEROKEE	Rural	473	\$7,751	469	\$100,386	(4)	\$92,635
SAMPSON	Rural	20	\$1,869	2,100	\$89,981	2,080	\$88,111
CALDWELL	Rural	15	\$2,992	1,173	\$85,806	1,158	\$82,814
ONslow	Rural	77	\$5,689	1,409	\$86,868	1,332	\$81,179
HALIFAX	Rural	1	\$35	530	\$73,345	529	\$73,310
HARNETT	Rural	110	\$6,408	936	\$74,997	826	\$68,589
ROWAN	Suburban	47	\$2,362	979	\$68,849	932	\$66,487
WILSON	Rural	29	\$5,290	1,828	\$63,386	1,799	\$58,096
RUTHERFORD	Rural	22	\$825	274	\$50,750	252	\$49,925
HAYWOOD	Rural	31	\$640	1,247	\$49,026	1,216	\$48,386
LENOIR	Rural	10	\$3,951	1,002	\$51,693	992	\$47,742
BRUNSWICK	Rural	195	\$19,353	615	\$65,660	420	\$46,307
CARTERET	Rural	54	\$4,994	911	\$48,824	857	\$43,830
RANDOLPH	Rural	128	\$4,166	605	\$45,470	477	\$41,304
WILKES	Rural	5	\$139	1,028	\$37,840	1,023	\$37,701
SWAIN	Rural	108	\$35,714	726	\$69,980	618	\$34,266

County	County Type	Blue Cross		Aetna		Difference	
		Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount
MCDOWELL	Rural	79	\$13,075	878	\$46,219	799	\$33,144
GASTON	Suburban	612	\$23,403	1,333	\$55,836	721	\$32,433
DARE	Rural	46	\$1,689	847	\$28,135	801	\$26,446
ASHE	Rural	1	\$49	100	\$24,983	99	\$24,934
CABARRUS	Suburban	214	\$5,972	782	\$28,912	568	\$22,940
GRANVILLE	Rural	5	\$267	13	\$20,188	8	\$19,920
LEE	Rural	49	\$1,671	424	\$21,401	375	\$19,730
COLUMBUS	Rural	40	\$12,775	573	\$31,007	533	\$18,232
CHATHAM	Rural	177	\$14,606	827	\$32,570	650	\$17,964
UNION	Suburban	145	\$5,793	676	\$22,599	531	\$16,806
SCOTLAND	Rural	-	\$0	252	\$16,293	252	\$16,293
ROBESON	Rural	71	\$6,480	319	\$21,282	248	\$14,802
WASHINGTON	Rural	2	\$426	374	\$13,814	372	\$13,387
DAVIDSON	Suburban	120	\$1,942	220	\$14,698	100	\$12,756
BEAUFORT	Rural	-	\$0	307	\$12,540	307	\$12,540
EDGECOMBE	Rural	-	\$0	272	\$11,096	272	\$11,096
LINCOLN	Suburban	-	\$0	119	\$8,116	119	\$8,116
AVERY	Rural	7	\$190	193	\$8,196	186	\$8,006
STANLY	Rural	3	\$2,624	243	\$9,803	240	\$7,179
ROCKINGHAM	Rural	10	\$406	187	\$7,442	177	\$7,036
ALLEGHANY	Rural	-	\$0	190	\$6,863	190	\$6,863
DUPLIN	Rural	-	\$0	173	\$5,789	173	\$5,789
IREDELL	Suburban	602	\$40,302	718	\$45,229	116	\$4,927
DAVIE	Rural	10	\$212	67	\$5,092	57	\$4,880
ALEXANDER	Rural	6	\$165	32	\$4,378	26	\$4,212
HERTFORD	Rural	-	\$0	31	\$4,156	31	\$4,156
PERQUIMANS	Rural	-	\$0	34	\$2,742	34	\$2,742
STOKES	Rural	9	\$2,468	74	\$5,041	65	\$2,573
CLEVELAND	Rural	12	\$6,016	137	\$6,942	125	\$926
CLAY	Rural	-	\$0	41	\$889	41	\$889
ANSON	Rural	-	\$0	38	\$786	38	\$786
TRANSYLVANIA	Rural	19	\$1,948	70	\$2,300	51	\$352
FRANKLIN	Rural	14	\$5,712	116	\$5,978	102	\$265
YANCEY	Rural	1	\$112	6	\$367	5	\$255
CHOWAN	Rural	-	\$0	1	\$20	1	\$20
BERTIE	Rural	-	\$0	-	\$0	-	\$0
YADKIN	Rural	-	\$0	-	\$0	-	\$0
MADISON	Rural	38	\$4,375	38	\$4,375	-	\$0
MONTGOMERY	Rural	-	\$0	-	\$0	-	\$0

County	County Type	Blue Cross		Aetna		Difference	
		Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount
GATES	Rural	-	\$0	-	\$0	-	\$0
GRAHAM	Rural	-	\$0	-	\$0	-	\$0
CAMDEN	Rural	-	\$0	-	\$0	-	\$0
MITCHELL	Rural	4	\$1,152	4	\$1,152	-	\$0
TYRRELL	Rural	-	\$0	-	\$0	-	\$0
CASWELL	Rural	-	\$0	-	\$0	-	\$0
CURRITUCK	Rural	-	\$0	-	\$0	-	\$0
JONES	Rural	-	\$0	-	\$0	-	\$0
WARREN	Rural	-	\$0	-	\$0	-	\$0
HYDE	Rural	-	\$0	-	\$0	-	\$0
MACON	Rural	13	\$1,279	29	\$1,209	16	-\$70
PERSON	Rural	37	\$1,617	67	\$1,305	30	-\$312
ALAMANCE	Suburban	916	\$72,294	1,421	\$71,883	505	-\$411
NORTHAMPTON	Rural	1	\$1,125	9	\$484	8	-\$641
RICHMOND	Rural	123	\$9,298	254	\$8,605	131	-\$693
GREENE	Rural	2	\$3,853	6	\$2,863	4	-\$989
BLADEN	Rural	26	\$1,140	-	\$0	(26)	-\$1,140
POLK	Rural	25	\$5,036	84	\$3,579	59	-\$1,457
VANCE	Rural	3	\$5,847	40	\$2,763	37	-\$3,085
PAMLICO	Rural	5	\$3,177	2	\$18	(3)	-\$3,160
PENDER	Rural	14	\$19,222	194	\$10,916	180	-\$8,305
MARTIN	Rural	73	\$26,090	6	\$1,674	(67)	-\$24,416
JACKSON	Rural	197	\$78,302	38	\$1,338	(159)	-\$76,964
JOHNSTON	Rural	1,861	\$136,296	951	\$38,801	(910)	-\$97,495
HOKE	Rural	5,806	\$303,702	154	\$8,240	(5,652)	-\$295,462
<b>Total</b>		<b>55,130</b>	<b>\$3,907,185</b>	<b>170,377</b>	<b>\$11,188,800</b>	<b>115,247</b>	<b>\$7,281,615</b>

**Figure 26**  
**Disruption in Urban and Suburban Counties**

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network		
			Claims	Members	Charges
WAKE	Urban	72,570	26,421	2,958	\$5,934,602
MECKLENBURG	Urban	28,723	10,848	1,834	\$4,522,638
GUILFORD	Urban	23,826	6,922	1,924	\$2,650,103
DURHAM	Urban	18,335	13,522	1,564	\$3,354,777
ORANGE	Suburban	17,888	14,673	1,934	\$3,746,717
PITT	Suburban	16,004	7,684	1,476	\$1,891,893
FORSYTH	Urban	14,684	5,464	1,698	\$1,276,039
ALAMANCE	Suburban	11,669	1,359	197	\$327,593
NEW HANOVER	Urban	11,291	7,082	1,366	\$1,641,685
CUMBERLAND	Suburban	10,971	5,883	1,273	\$2,220,232
All Other		70,544	15,032	3,601	\$4,994,055
<b>Total</b>		<b>296,505</b>	<b>114,890</b>	<b>19,825</b>	<b>\$32,560,333</b>

**Figure 27**  
**Disruption in Rural Counties**

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network		
			Claims	Members	Charges
JOHNSTON	Rural	12,748	951	86	\$180,498
WAYNE	Rural	7,832	5,394	2,164	\$753,662
ROBESON	Rural	7,440	308	96	\$95,095
BURKE	Rural	7,255	2,119	1,221	\$783,441
RANDOLPH	Rural	6,249	605	342	\$206,737
ONslow	Rural	5,993	1,406	270	\$391,530
NASH	Rural	5,838	2,057	1,156	\$586,571
SURRY	Rural	5,574	1,306	449	\$542,640
HARNETT	Rural	5,555	880	211	\$336,624
CLEVELAND	Rural	5,260	137	31	\$32,503
All Other		152,588	29,320	11,566	\$12,267,332
<b>Total</b>		<b>222,332</b>	<b>44,483</b>	<b>17,592</b>	<b>\$16,176,633</b>

**Figure 27a**  
**Disruption in All Counties**

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network			Aetna In-Network/Blue Cross Out-of-Network		
			Claims	Members	Charges	Claims	Members	Charges
WAKE	Urban	72,570	26,421	2,958	\$5,934,602	12,672	3,622	\$3,981,544
MECKLENBURG	Urban	28,723	10,848	1,834	\$4,522,638	2,247	522	\$1,488,220
GUILFORD	Urban	23,826	6,922	1,924	\$2,650,103	1,749	703	\$608,071
DURHAM	Urban	18,335	13,522	1,564	\$3,354,777	8,006	4,361	\$2,485,832
ORANGE	Suburban	17,888	14,673	1,934	\$3,746,717	418	96	\$128,058
PITT	Suburban	16,004	7,684	1,476	\$1,891,893	819	241	\$209,670
FORSYTH	Urban	14,684	5,464	1,698	\$1,276,039	411	320	\$236,542
JOHNSTON	Rural	12,748	951	86	\$180,498	1,861	1,063	\$621,259
ALAMANCE	Suburban	11,669	1,359	197	\$327,593	854	562	\$319,964
NEW HANOVER	Urban	11,291	7,082	1,366	\$1,641,685	386	91	\$106,301
CUMBERLAND	Suburban	10,971	5,883	1,273	\$2,220,232	261	113	\$50,723
BUNCOMBE	Suburban	10,204	7,086	1,674	\$2,074,660	2,895	1,403	\$725,211
CABARRUS	Suburban	9,825	769	85	\$123,855	201	198	\$16,565
UNION	Suburban	9,283	673	60	\$106,106	142	17	\$25,865
WAYNE	Rural	7,832	5,394	2,164	\$753,662	7	2	\$1,837
GASTON	Suburban	7,703	1,312	172	\$261,660	591	125	\$104,651
ROBESON	Rural	7,440	308	96	\$95,095	60	22	\$28,840
BURKE	Rural	7,255	2,119	1,221	\$783,441	702	278	\$149,901
CATAWBA	Suburban	7,118	2,249	1,045	\$1,013,125	226	46	\$40,097
IREDELL	Suburban	6,899	697	153	\$197,951	581	223	\$170,330
RANDOLPH	Rural	6,249	605	342	\$206,737	128	17	\$17,657
ONslow	Rural	5,993	1,406	270	\$391,530	74	23	\$22,446
NASH	Rural	5,838	2,057	1,156	\$586,571	106	19	\$19,662
DAVIDSON	Suburban	5,829	116	13	\$65,305	16	2	\$3,750
SURRY	Rural	5,574	1,306	449	\$542,640	24	3	\$4,700
HARNETT	Rural	5,555	880	211	\$336,624	54	20	\$14,298
ROWAN	Suburban	5,431	979	192	\$320,614	47	12	\$10,969
CLEVELAND	Rural	5,260	137	31	\$32,503	12	8	\$25,090
BRUNSWICK	Rural	5,248	608	283	\$301,653	188	133	\$89,051
WATAUGA	Rural	5,117	4,168	1,739	\$1,011,641	44	16	\$14,262
CALDWELL	Rural	4,711	1,169	816	\$391,967	11	5	\$13,130
HENDERSON	Suburban	4,529	1,032	166	\$791,506	112	23	\$64,938
LENOIR	Rural	4,456	994	537	\$235,255	2	2	\$16,556
CHATHAM	Rural	4,292	804	81	\$145,632	154	114	\$56,496
WILSON	Rural	4,206	1,828	1,020	\$289,857	29	10	\$24,811
RUTHERFORD	Rural	4,174	274	146	\$237,086	22	1	\$3,300
FRANKLIN	Rural	4,133	116	6	\$25,775	14	13	\$25,564

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network			Aetna In-Network/Blue Cross Out-of-Network		
			Claims	Members	Charges	Claims	Members	Charges
CRAVEN	Rural	4,126	1,964	397	\$929,872	28	14	\$8,432
MOORE	Rural	4,068	3,329	1,189	\$4,326,791	821	253	\$202,037
LEE	Rural	3,801	388	70	\$91,184	13	6	\$2,255
STANLY	Rural	3,791	243	33	\$43,929	3	2	\$10,521
COLUMBUS	Rural	3,754	571	57	\$144,220	38	35	\$56,083
LINCOLN	Suburban	3,723	119	41	\$39,274	-	-	\$0
SAMPSON	Rural	3,636	2,099	1,214	\$407,650	19	19	\$8,606
GRANVILLE	Rural	3,588	11	3	\$100,010	3	2	\$328
CARTERET	Rural	3,547	911	268	\$222,090	54	32	\$22,060
WILKES	Rural	3,540	1,024	595	\$174,974	1	1	\$130
BEAUFORT	Rural	3,264	307	105	\$59,402	-	-	\$0
HAYWOOD	Rural	3,239	1,234	373	\$223,641	18	7	\$2,310
ROCKINGHAM	Rural	3,234	177	128	\$32,725	-	-	\$0
PENDER	Rural	3,113	193	20	\$39,980	13	13	\$69,206
JACKSON	Rural	3,080	38	7	\$6,310	197	183	\$358,591
MCDOWELL	Rural	2,871	878	67	\$217,759	79	69	\$59,453
PASQUOTANK	Rural	2,715	1,097	463	\$734,536	193	173	\$66,651
DUPLIN	Rural	2,511	173	37	\$25,465	-	-	\$0
RICHMOND	Rural	2,486	254	86	\$38,640	123	102	\$42,468
HALIFAX	Rural	2,468	529	226	\$327,216	-	-	\$0
VANCE	Rural	2,408	40	24	\$12,808	3	2	\$29,236
PERSON	Rural	2,211	67	4	\$5,475	37	12	\$7,141
BLADEN	Rural	2,207	-	-	\$0	26	17	\$5,297
ASHE	Rural	2,112	100	39	\$118,710	1	1	\$246
STOKES	Rural	2,051	73	6	\$13,810	8	5	\$1,564
EDGEcombe	Rural	2,037	272	32	\$51,526	-	-	\$0
DARE	Rural	2,016	817	247	\$125,669	16	11	\$3,489
ALEXANDER	Rural	1,967	32	29	\$20,570	6	6	\$804
DAVIE	Rural	1,907	67	20	\$24,950	10	3	\$1,035
YADKIN	Rural	1,865	-	-	\$0	-	-	\$0
MARTIN	Rural	1,848	6	2	\$6,695	73	67	\$119,866
MONTGOMERY	Rural	1,662	-	-	\$0	-	-	\$0
SCOTLAND	Rural	1,568	252	215	\$73,579	-	-	\$0
ANSON	Rural	1,563	38	32	\$3,705	-	-	\$0
HOKE	Rural	1,554	154	136	\$37,277	5,806	4,752	\$1,378,210
MACON	Rural	1,374	26	3	\$4,360	10	9	\$5,750
AVERY	Rural	1,341	193	45	\$38,320	7	3	\$950
YANCEY	Rural	1,276	5	2	\$1,275	-	-	\$0
CHEROKEE	Rural	1,268	234	191	\$466,296	238	37	\$21,893

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network			Aetna In-Network/Blue Cross Out-of-Network		
			Claims	Members	Charges	Claims	Members	Charges
MITCHELL	Rural	1,193	-	-	\$0	-	-	\$0
GREENE	Rural	1,190	6	3	\$14,316	2	1	\$19,263
TRANSYLVANIA	Rural	1,180	67	13	\$9,355	16	8	\$7,500
BERTIE	Rural	1,179	-	-	\$0	-	-	\$0
MADISON	Rural	1,141	-	-	\$0	-	-	\$0
CHOWAN	Rural	1,031	1	1	\$100	-	-	\$0
HERTFORD	Rural	982	31	23	\$19,030	-	-	\$0
CURRITUCK	Rural	923	-	-	\$0	-	-	\$0
PERQUIMANS	Rural	895	34	4	\$13,590	-	-	\$0
POLK	Rural	829	84	61	\$16,559	25	22	\$23,986
WASHINGTON	Rural	811	372	41	\$62,577	-	-	\$0
NORTHAMPTON	Rural	774	9	1	\$2,421	1	1	\$4,500
WARREN	Rural	758	-	-	\$0	-	-	\$0
CASWELL	Rural	739	-	-	\$0	-	-	\$0
ALLEGHANY	Rural	737	190	167	\$31,830	-	-	\$0
JONES	Rural	656	-	-	\$0	-	-	\$0
SWAIN	Rural	615	726	223	\$303,112	108	78	\$162,537
CAMDEN	Rural	601	-	-	\$0	-	-	\$0
PAMLICO	Rural	597	2	2	\$70	5	2	\$15,885
GATES	Rural	538	-	-	\$0	-	-	\$0
CLAY	Rural	502	41	34	\$4,090	-	-	\$0
GRAHAM	Rural	498	-	-	\$0	-	-	\$0
HYDE	Rural	408	-	-	\$0	-	-	\$0
TYRRELL	Rural	407	-	-	\$0	-	-	\$0
<b>Total</b>		<b>518,837</b>	<b>159,373</b>	<b>37,417</b>	<b>\$48,736,966</b>	<b>44,127</b>	<b>20,377</b>	<b>\$14,644,443</b>

# **EXHIBIT B**

**Rebuttal Expert Report of  
Gregory Russo  
(November 10, 2023)**

**REBUTTAL EXPERT REPORT OF GREGORY RUSSO**

*Blue Cross and Blue Shield of North Carolina v.  
North Carolina State Health Plan for Teachers and State Employees*

**North Carolina Office of Administrative Hearings**

**Case No. 23 INS 00738**

**November 10, 2023**

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## **I. Introduction**

This report provides my responses to expert reports submitted by the Plan's expert, Kenneth Vieira, and Aetna's expert, Andrew Coccia. In their reports, both Mr. Vieira and Mr. Coccia offer no affirmative opinions, only responses to my report dated October 4, 2023 (my "Initial Report"). The portions of Mr. Vieira's and Mr. Coccia's reports that are responsive to my Initial Report generally follow the order of my opinions relating to the following:

- 1) Pricing guarantee evaluation;
- 2) Discrepancies between the discounts Aetna presented in the repricing exercise versus the letters of agreement for three health systems;
- 3) Segal's adjustment of Blue Cross's discount in the network pricing evaluation;
- 4) Segal's use of UDS data; and
- 5) Vendor network comparisons.

I have included my updated CV as Appendix A. Additional documents relied on can be found in Appendix B. All figures in this report are included in Appendix C.

## **II. Responses to the Reports of Mr. Vieira and Mr. Coccia**

Contained herein are my responses to Mr. Vieira's and Mr. Coccia's reports.<sup>1</sup>

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<sup>1</sup> This report incorporates the terms defined in my Initial Report.

## Opinion 1: Pricing Guarantees

As explained in this section, Mr. Coccia and Mr. Vieira premise their rebuttals to Opinion 1 of my Initial Report on errors of logic and methodology.

The RFP states that “[t]he value of the pricing guarantees will be based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk.”<sup>2</sup> The “competitiveness” of the guaranteed targets refers to a comparison of how the percentage targets bid by the vendors will affect the Plan’s bottom line. Blue Cross had the most competitive discount *and* trend targets, but Mr. Vieira and Mr. Coccia downplay the importance of the targets and focus almost exclusively on the amount of administrative fees placed at risk.

Under section 3.4(c)(3)(a) of the RFP, the amount placed at risk is to be evaluated *in concert with* the target percentages.<sup>3</sup> This is something Segal, Mr. Vieira, and Mr. Coccia all failed to do. In their reports, both Mr. Coccia and Mr. Vieira disregard the RFP language regarding the combination of factors to be considered. This contradicts internal Segal emails indicating that the combination of the competitiveness of the guaranteed targets and the amount at risk would be used to assess the value of the pricing guarantees,<sup>4</sup> as well as the testimony of Segal’s corporate representative, who acknowledged that this approach would be used.<sup>5</sup> Segal has also admitted that the bottom-line impact to the Plan’s costs is ultimately what matters in evaluating the value of the bidders’ pricing guarantees<sup>6</sup>—an analysis that neither Segal (during the RFP) nor Mr. Vieira or Mr. Coccia (in responding to my Initial Report) has done.

Despite the RFP’s statement that the value of a bidder’s pricing guarantee will depend in part on the competitiveness of the guaranteed discount targets, Mr. Coccia argues that it is inappropriate to take into account the financial effect of the discount targets offered as part of each bidder’s guarantee because doing so would result in “double counting” the strength of the bidder’s discounts.<sup>7</sup> He states that “discounts were scored separately from guarantees via the Claims Cost section of the financial analysis...as such, inclusion of the financial effect of the discount guarantees on the Plan in the ranking of discount guarantees would have double-counted this area in the scoring process.”<sup>8</sup> That argument is illogical and contrary to the terms of the RFP. Mr. Coccia’s view would leave nothing to score on the guarantees except

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<sup>2</sup> SHP 0072588.

<sup>3</sup> SHP 0072588.

<sup>4</sup> Vieira: “How are we doing the scoring on the guarantees – the guarantee or the amount at risk?” Kuhn: “Both”. SHP 0092745.

<sup>5</sup> “A. [S]ome guarantees are, in my opinion, worthless, and some have little value, and some have more value. Q. What does the value depend on? A. The target of the guarantee and how much is at risk.” Segal’s 30(b)(6) Deposition, pg. 162, lines 8-13.

<sup>6</sup> “Q. Because the goal of all this is to produce the best bottom line for the Plan, right? A. Yes.” Segal’s 30(b)(6) Deposition, pg. 179, lines 20-25.

<sup>7</sup> Expert Report of Andrew Coccia, p. 25

<sup>8</sup> Expert Report of Andrew Coccia, p. 25.

the amount placed at risk. This is inconsistent with the RFP's instruction that the evaluation would consider the competitiveness of the guaranteed targets *and* the amount placed at risk.

**a. Discount Guarantees**

**Based on the effects on the Plan's bottom line under likely scenarios, Blue Cross's discount guarantees offered greater value than Aetna's and UMR's guarantees offered.**

Although Mr. Coccia opines that the amount placed at risk outweighs all other factors in determining the value of the pricing guarantees, a portion of his report nonetheless focuses on one aspect of the discount targets offered by each vendor. Specifically, Mr. Coccia assesses the difference between each vendor's expected (projected) discount and guaranteed discounts and lays out those differences in Table 1 of his report.<sup>9</sup> Mr. Coccia asserts that this comparison is important because it is relevant to each vendor's incentive to hit its guaranteed targets. He poses the question, "Is the vendor incentivized to deliver on its promise, or has the vendor built in so much conservatism that the incentive is diminished?"<sup>10</sup> He goes on to say the measure of this incentive is the difference between "what the vendor expects to achieve [and] what the vendor promises. Under this construct, small differences are good—and large differences are not."<sup>11</sup> Whether a vendor anticipates or expects to achieve more or less does not affect its incentive to deliver on a separate, guaranteed discount.

By itself, a vendor's *projected* discount has no impact on the Plan, so the difference between that projected discount and the vendor's guaranteed discount is not an accurate measure of value. By focusing on that measure, Mr. Coccia chooses a measure that favors Aetna over Blue Cross and ignores several other measures where the results favor Blue Cross.

Mr. Coccia's evaluation of the guarantees is flawed because it does not measure whether a vendor would be a prudent buyer of healthcare services<sup>12</sup> over the period covered by the contract. Ensuring this prudence is the measure of the "value" offered by a vendor's discount guarantee.

Further, Mr. Coccia's comparison contradicts the testimony of Segal's corporate representative, who testified that the relevant comparison is the difference between a vendor's *current discount* (as calculated in the repricing exercise) and its *guaranteed discount*: "[the vendors] were valued off of the current discounts. So the [guarantee] target is really an opportunity for them to -- you know, to be valued for more than that."<sup>13</sup> As shown in Figure 1, Aetna's current discount in its repricing proposal is 53 percent, while its 2025 guaranteed discount is 52.5 percent. Blue Cross's current discount (before downward

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<sup>9</sup> Expert Report of Andrew Coccia, pg. 22-23.

<sup>10</sup> Expert Report of Andrew Coccia, pg. 22.

<sup>11</sup> Expert Report of Andrew Coccia, pg. 22.

<sup>12</sup> A prudent buyer of healthcare services seeks to pay the lowest reasonable value for services in a willing buyer-willing seller transaction.

<sup>13</sup> Segal's 30(b)(6) Deposition, pg. 179, lines 11-14.

adjustment by the Plan) is 54 percent, compared to its 2025 guaranteed discount of 55.1 percent. UMR’s current discount is 52.5 percent, compared to a 2025 guaranteed discount of 52.6 percent. As Figure 1 shows, Blue Cross’s guaranteed target promised 1.1 percentage points more discount than Blue Cross’s current discount as calculated in the repricing exercise—and 2.4 percentage points more discount than its current discount as adjusted by Segal and the Plan. That target gives Blue Cross an incentive to be a prudent buyer of healthcare services. Aetna’s target offered far less of an incentive because the value it guaranteed *is below Aetna’s current discount*.

**Figure 1**  
**Comparison of Current Discounts and 2025 Discount Guarantees**

	<b>Aetna</b>	<b>Blue Cross</b>	<b>UMR</b>
Current Discount	53.0	54.0/52.7*	52.5
2025 Discount Guarantee	52.5	55.1	52.6
<b>Incremental Discounting (in percentage points) Needed to Achieve Guaranteed Discount</b>	<b>-0.5</b>	<b>+1.1/+2.4</b>	<b>+0.1</b>

\*54.0 percent is the discount Blue Cross calculated in the repricing exercise (prior to Segal’s adjustment). 52.7 percent is Blue Cross’s discount after Segal adjusted it during the clarifications process.

To illustrate these points another way, Figure 2 below displays the guaranteed discounts for each vendor relative to the vendor’s current and projected discounts. All three vendors’ guaranteed targets are below their projected discounts. Because the vendors are not accountable for their *projected* discounts, the difference between the guaranteed target and the projected discount is not a useful measure; in other words, no vendor’s guarantee provides an incentive to hit their projections. The important measures are: 1) the *level* of the guaranteed discount targets (the green circles), 2) the *difference* between a vendor’s own guaranteed discount target and its current discount (the vertical distance from the dark blue circle to each of the green circles), 3) and the change in the guaranteed target over the years. As Figure 2 illustrates:

- Blue Cross not only has the highest guaranteed target, but it is also the *only* vendor that has a target that is more than 1 percentage point higher than the vendor’s current discount. Blue Cross is also the *only* vendor that guarantees a better discount target each year.
- UMR’s 2025 discount guarantee is only 0.1 percent higher than UMR’s current discount. UMR, moreover, offered no discount guarantee at all for 2026-2029.
- Aetna’s guaranteed targets for 2025 to 2029 are *below* Aetna’s reported current discount.

**Figure 2**  
**Guaranteed Discounts Compared to Current and Projected Discounts**

**C** = Current Discount    **P** = Projected Discount    **G** = Guaranteed Discount



As illustrated by Figures 1 and 2, Aetna’s guaranteed discounts has three prominent failings: (1) it has a low absolute value relative to Blue Cross, (2) it is low relative to Aetna’s current discount, (3) and it stays flat over the contract period (whereas Blue Cross’s target improves over the years). With such a low relative target, Aetna has no incentive to be a more prudent buyer of healthcare services by negotiating more

competitive discounts with providers. These factors produce a discount guarantee of lower relative value.<sup>14</sup>

In contrast, Blue Cross is incentivized to achieve more aggressive discounts for the Plan, because its target discount is 1.1 percentage points *greater* than its current discount. This analysis is consistent with the testimony of the Plan’s actuary Charles Sceiford, who was asked about his understanding of the competitiveness of the guaranteed targets as stated in the RFP. He testified, “in my opinion... the competitiveness would be how aggressive that the guarantees themselves would be in the sense of if you have a guarantee trigger point that would never be met, then it's not really a guarantee.”<sup>15</sup> Aetna’s “guarantee trigger point”—the target that, if missed, would trigger partial refunds of administrative fees—is unlikely to be met, because it is below Aetna’s current discount. As Mr. Sceiford explained, such a guarantee is “not really a guarantee.” That is not the case for Blue Cross, which guaranteed a discount target that offered the greatest improvement between the current discount and the guaranteed target discount.

**Ultimately, as stated in my Initial Report, the best measure of the competitiveness of a discount guarantee is the combined bottom-line effect of the discount percentage and the amount at risk under likely scenarios.** Segal’s corporate representative agreed with this fundamental premise, testifying that “The goal of [the discount guarantee] is to produce the best cost for the state...”<sup>16</sup> He went on to testify that if “Blue Cross achieves a 54 percent discount, which is less than their guarantee, but higher than Aetna’s...if they achieve 53 percent, then yes, you know, the result—again, a greater discount, regardless of who achieves it, is better for the Plan, in general.”<sup>17</sup> The testimony of the Plan’s Matthew Rish was consistent with this point. Mr. Rish testified that the combination of discount targets and the amount at risk is “important because the first one is competitiveness of their bid. The second one is how firm they feel about it.”<sup>18</sup> Mr. Vieira likewise emphasizes the effects on the Plan’s bottom line in his comments regarding Mary Karen Wills’ expert report when he says, “the primary goal for large self-insured plans, like the Plan, is to obtain good pricing.”<sup>19</sup>

Finally, in another passage of his testimony, Segal’s corporate representative admitted that a deeper discount target is better for the Plan:

*Q: So of these two targets alone, leaving the other variables aside, Blue Cross's target of 55.1 percent or Aetna's at 52.3 percent, which one, if performed, would lead to a better bottom line for the Plan?*

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<sup>14</sup> Similarly, UMR is not strongly incentivized to be a prudent buyer of healthcare services, because UMR has only a 0.1-percentage-point difference between its current discount and its guaranteed target.

<sup>15</sup> Deposition of Charles Sceiford, pg. 58, line 25 through pg. 59, line 17.

<sup>16</sup> Segal’s 30(b)(6) Deposition, pg. 179, lines 20-25 through pg. 180, line 1.

<sup>17</sup> Segal’s 30(b)(6) Deposition, pg. 223, lines 12-18.

<sup>18</sup> Deposition of Matthew Rish, pg. 208, lines 1-3.

<sup>19</sup> Expert Report of Kenneth C. Vieira, pg. 14.

*A. Are you asking if the Plan got a 55 percent discount or a 52 percent discount, which would be better for the Plan?*

*Q. Yes.*

*A. A 55 percent discount.<sup>20</sup>*

Here, Blue Cross guarantees the deepest discount target compared to UMR and Aetna. A larger discount produces lower claims costs for the Plan and for the members. The objective should be for a vendor to strike the best *absolute* bargain with providers (i.e., the deepest discount). After all, the absolute discount achieved by a vendor is the main factor that drives the claims costs for the Plan and out-of-pocket costs for the members. Segal's corporate representative agreed with this point when he testified, "[F]or every percentage point in the discount that the Plan misses, you're talking about dollar amounts that are significantly higher than... the amounts placed at risk."<sup>21</sup>

Contradicting the RFP's instructions to evaluate the *combination* of the targets and the amounts placed at risk, both Mr. Coccia and Mr. Vieira incorrectly take a one-dimensional view of the pricing guarantees, focusing solely on the amount placed at risk. In Table 2 of his report, Mr. Coccia sets out the total dollars at risk and the percentage of administrative fees at risk for each vendor's discount guarantee. Mr. Coccia asserts that the differences in the amounts placed at risk by each vendor support his (and Segal's) focus on this element in valuing the vendors' pricing guarantees. But Mr. Coccia's analysis improperly excludes other relevant information about the value of the discount guarantees.

In addition to contradicting the RFP's stated criteria as well as testimony from Segal and the Plan, this one-dimensional approach of evaluating only the amount at risk to determine the value of a discount guarantee is unreasonable from the Plan's perspective because it does not measure the guarantees' total financial impact on the Plan. Plan sponsors must pay the costs of the claims that result from the discounts achieved by their TPA. As Segal's corporate representative admitted in the passage quoted above, under most scenarios, the bottom-line effect of the discount level achieved by a vendor overcomes the effect of any partial fee refund paid by a vendor.<sup>22</sup>

Here, neither Blue Cross nor Aetna proposed dollar-for-dollar guarantees. For guarantees of that kind, it is especially important to evaluate the value offered by each of these vendors' guarantees by considering the claims costs that would result from the guaranteed discount percentages and the amounts placed at risk by these vendors. It is true that Aetna's maximum amount at risk (\$22 million) is higher than Blue Cross's amount at risk (\$7.9 million). However, when the discounts and the amounts placed at risk are

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<sup>20</sup> Segal's 30(b)(6) Deposition, pg. 195.

<sup>21</sup> Segal's 30(b)(6) Deposition, pg. 186.

<sup>22</sup> Segal's 30(b)(6) Deposition, pg. 186.

considered together, as required by the RFP, the Plan would pay lower claims costs under Blue Cross's proposal than it would pay under Aetna's under likely scenarios. This is the value measurement required by the RFP. As my Initial Report shows in detail, Blue Cross's guarantees offer superior value by that measure.<sup>23</sup>

Mr. Vieira misconstrues the RFP's value criteria, as well as my opinion on the value of the vendors' guarantees, by using a "straw man" example. He suggests that I would consider a vendor guaranteeing an 80 percent discount but putting zero dollars at risk to be the best value for the Plan. This example is not persuasive, because it is far outside the range of the proposals here. As I emphasized in my Initial Report, the key to assessing the value of price guarantees is to analyze the bottom-line effects on the plan *under likely scenarios*.

On pages 21 and 22 of his report, Mr. Vieira presents the amounts that would be refunded to the Plan under a range of discount scenarios. But in addition to ignoring the effect of these scenarios on the Plan's bottom line, Mr. Vieira's illustration fails to consider the likelihood of each of the vendors hitting the discount percentages stated in the table. When the likelihood of achieving each discount level is assessed (in light of each vendor's current discount), it becomes evident that the larger payouts offered by Aetna (and by UMR in 2025 alone) are unlikely to ever be made. I have reproduced Mr. Vieira's table in Figure 3 below but have added columns that show the likelihood of a payout or refund occurring under each of these scenarios based on a comparison of the stated discounts and the vendors' current and target discounts.<sup>24</sup>

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<sup>23</sup> Expert Report of Gregory Russo, pg. 23-26.

<sup>24</sup> I added rows for the vendors current and target discounts where Mr. Vieira left them out of his table. The amount at risk for Blue Cross has been updated to reflect that Blue Cross will refund up to 15% of the administrative fee if the discount targets are missed. Additionally, Mr. Vieira's claims costs and payouts were not calculated consistently. The claims cost and payouts have been recalculated based on a consistent charge amount for 2025. This charge amount is calculated by using the baseline 2021 discount and claims cost from SHP 0069464.xlsx to determine the 2021 charge amount and then inflating it by the trend factor for 2025. The corrected values are shown in Figure 3.

**Figure 3  
Likelihood of Payout**

Current and Guaranteed Discounts	Discount	Claims Cost	Payout			Likelihood of Payout <sup>1, 2, 3</sup>			Reasonably Possible Payout		
			Aetna	Blue Cross	UMR	Aetna	Blue Cross	UMR	Aetna	Blue Cross	UMR
	50.3%	\$3,202,274,299	\$22,305,000	\$7,959,000	\$95,100,546	Unlikely	Unlikely	Unlikely	\$0	\$0	\$0
	50.8%	\$3,170,058,260	\$19,329,624	\$7,959,000	\$95,100,546	Unlikely	Unlikely	Unlikely	\$0	\$0	\$0
	51.3%	\$3,137,842,221	\$12,886,416	\$7,959,000	\$83,761,702	Unlikely	Unlikely	Unlikely	\$0	\$0	\$0
	51.8%	\$3,107,071,541	\$6,732,280	\$7,959,000	\$52,991,023	Unlikely	Unlikely	Unlikely	\$0	\$0	\$0
Aetna Guarantee	52.3%	\$3,073,410,142	\$0	\$7,959,000	\$19,329,624	N/A	Unlikely	Unlikely	\$0	\$0	\$0
UMR Current	52.5%	\$3,060,523,726	\$0	\$7,959,000	\$6,443,208	N/A	Unlikely	Unlikely	\$0	\$0	\$0
UMR Guarantee	52.6%	\$3,054,080,519	\$0	\$7,959,000	\$0	N/A	Unlikely	N/A	\$0	\$0	\$0
	52.8%	\$3,041,194,103	\$0	\$7,959,000	\$0	N/A	Unlikely	N/A	\$0	\$0	\$0
Aetna Current	53.0%	\$3,028,307,687	\$0	\$7,959,000	\$0	N/A	Unlikely	N/A	\$0	\$0	\$0
	53.3%	\$3,008,978,064	\$0	\$7,959,000	\$0	N/A	Unlikely	N/A	\$0	\$0	\$0
	53.8%	\$2,976,762,024	\$0	\$7,959,000	\$0	N/A	Unlikely	N/A	\$0	\$0	\$0
Blue Cross Current	54.0%	\$2,963,875,609	\$0	\$7,087,529	\$0	N/A	Unlikely	N/A	\$0	\$0	\$0
	54.3%	\$2,944,545,985	\$0	\$5,154,566	\$0	N/A	Possible	N/A	\$0	\$5,154,566	\$0
	54.8%	\$2,912,329,946	\$0	\$1,932,962	\$0	N/A	Possible	N/A	\$0	\$1,932,962	\$0
Blue Cross Guarantee	55.1%	\$2,893,000,322	\$0	\$0	\$0	N/A	N/A	N/A	\$0	\$0	\$0
	55.3%	\$2,880,113,907	\$0	\$0	\$0	N/A	N/A	N/A	\$0	\$0	\$0

[1] Yellow cells indicate rows where the discount is at or below the vendor's current discount.

[2] Green cells indicate rows where the discount is above the vendor's current discount and below the vendor's guaranteed discount.

[3] White cells indicate rows where the discount is at or above the vendor's guaranteed discount.

As shown in the table, Aetna’s discount target (52.5 percent) is lower than its current discount. For that reason, it is unlikely that Aetna would miss the targets under the scenarios that Mr. Vieira presents, resulting in Aetna’s guarantee offering little or no value regardless of the amount at risk.

The same is true for UMR, because its discount target (in the one year for which UMR offered any discount guarantee) is only 0.1 percentage points above its current discount; thus, the likelihood that UMR will miss the target under the scenarios Mr. Vieira presents is also low. Even though UMR placed a dollar-for-dollar amount at risk in 2025, the low likelihood of a payout associated with that amount, as well as the “one year only” duration of the guarantee, diminishes the value of UMR’s guarantee.

In contrast, Blue Cross is the *only* vendor of the three that has any scenarios in Mr. Vieira’s table where a payout is reasonably possible (at achieved discount levels of 54.3 and 54.8 percent); the payout amounts for these scenarios are \$5.1 million and \$1.9 million, respectively.

In summary, the RFP is clear: the value of pricing guarantees is defined as a combination of the discount targets and the amount at risk. Mr. Vieira and Mr. Coccia disregard this directive and give undue weight to the amount placed at risk with almost no consideration of the competitiveness of the discount targets or the bottom-line effects of those targets.

#### **b. Trend Guarantees**

**Blue Cross’s guarantee offered the most competitive medical cost trend targets, and nothing in Mr. Vieira’s or Mr. Coccia’s reports meaningfully challenges that conclusion.**

Blue Cross’s trend targets were superior to Aetna’s and UMR’s. Blue Cross guaranteed a trend no higher than 6 percent—a maximum rate of medical inflation that is materially lower than Aetna’s guaranteed maximum rate of 6.8 percent. Blue Cross’s trend target also compared favorably to UMR’s, since UMR guaranteed a “book of business” trend that UMR’s corporate parent would have the ability to manipulate and the exclusive ability to measure easily.

Mr. Vieira and Mr. Coccia offer arguments that try to divert attention from these comparisons, but those arguments suffer from several fallacies.

First, both Mr. Vieira and Mr. Coccia analyze only the trend guarantee for 2026 and ignore the fact that the vendors were asked to provide guarantees for 2026 to 2029. When all of these years are considered, Blue Cross’s targets become even more favorable than Aetna’s. Aetna guaranteed an *increasing* trend target over the four-year period beginning in 2026 (6.81, 7.06, 7.31 and 7.56 percent). Trend targets that increase over time are worse for the Plan. Figure 4 below shows the bottom-line effects of the differences between Blue Cross’s and Aetna’s trend guarantees.

**Figure 4  
Trends and Claims Costs**

Year	Blue Cross		Aetna		Amount by which Aetna's Claims Cost is Greater than Blue Cross's
	Trend Guarantee	Claims Cost	Trend Guarantee	Claims Cost	
2025 <sup>1</sup>		\$2,846,864,260		\$2,846,864,260	\$0
2026	6.0%	\$3,017,676,116	6.8%	\$3,040,735,716	\$23,059,601
2027	6.0%	\$3,198,736,683	7.1%	\$3,255,411,658	\$56,674,975
2028	6.0%	\$3,390,660,883	7.3%	\$3,493,382,250	\$102,721,366
2029	6.0%	\$3,594,100,536	7.6%	\$3,757,481,948	\$163,381,411
				<b>Total</b>	<b>\$345,837,353</b>

[1] The 2025 claims cost is based on the non-Medicare baseline projected incurred in SHP 0006964. The same claims cost is used for Blue Cross and Aetna to isolate the impact of the trend.

Second, Mr. Vieira and Mr. Coccia ignore the combined effect of the vendors' discount targets and trend targets. As described above, Aetna guaranteed the *same* discount target for all five years (52.5 percent). At the same time, Aetna guaranteed a *worsening* trend target over the 2026-2029 period. Blue Cross guaranteed the opposite combination—an increasing discount target and a constant trend target—a combined offer that is better for the Plan.

Third, neither Mr. Vieira nor Mr. Coccia engages meaningfully with the fact that UMR provides no fixed trend target and instead ties its guarantee to the trend level for the entire United Healthcare (“UHC”) book of business. Mr. Vieira assumes in his report that UMR's discount guarantee for 2026 would be 4.96 (a figure based on a 10-year average<sup>25</sup> in a survey published by Segal<sup>26</sup>), but he states no basis for making this assumption. Mr. Vieira's unsupported assumption entirely disregards the possibility that UHC could have a trend across its book of business that exceeds the industry average. It also disregards the possibility that the Plan and UMR could have disputes over what the UHC book-of-business trend really was.

Fourth, Mr. Vieira's analyses of the value of the vendors' trend guarantees overlooks points that show greater value of Blue Cross's trend guarantees. The table on page 25 of Mr. Vieira's report shows that because of its more favorable trend, Blue Cross would be required to refund a portion of its administrative fees beginning *earlier* (i.e., at lower trend percentages) than Aetna would. Blue Cross would also owe the Plan *larger* refunds than Aetna would owe under Mr. Vieira's 6.5 percent, 7.0 percent, and 7.5 percent scenarios.<sup>27</sup>

<sup>25</sup> Vieira subtracts 1 percent from the Segal Survey average of 5.96 to obtain 4.96 percent.

<sup>26</sup> Expert Report of Kenneth C. Vieira, pg. 25.

<sup>27</sup> Expert Report of Kenneth C. Vieira, pg. 25.

In a table on page 24 of his report, Mr. Vieira shows the average trend percentages from 2013 to 2022 based on Segal's Health Plan Cost Trend Survey. According to this survey, the average trend percentage (yearly increase in claims costs) for this period was 5.96 percent. Blue Cross's trend guarantee percentage of 6 percent is consistent with this average. Blue Cross's guarantee assures the Plan that its costs would not rise at levels above what has historically been experienced. Aetna's guarantee, by contrast, would allow the Plan's costs to rise at higher rates than the Plan has historically experienced before any payout occurs under the guarantee. Aetna's guarantee, moreover, would grow weaker with each passing year. The Segal survey cited by Mr. Vieira projects the 2024 trend increase to be 6.8 percent, which is what Aetna guarantees in 2026. But based on its own industry and Plan experience, Blue Cross guarantees something more favorable to the Plan: an increase of only 6 percent for 2026, 2027, 2028, and 2029.<sup>28</sup> Mr. Vieira ignores the greater competitiveness of Blue Cross's guarantee, as well as the favorable level of Blue Cross's trend target, as measured by Segal's own trend data.

Mr. Vieira also compares the Segal survey averages to the Plan's actual trend experience for 2017 to 2021. This comparison further shows why Aetna's trend guarantee has low value. Mr. Vieira's table shows that there is only one year within the timeframe of 2017 to 2021 in which Aetna would have paid the maximum amount it put at risk for its trend guarantee. That year was 2021, when trend percentages were extraordinarily high due to deferred medical costs associated with the COVID-19 pandemic.<sup>29</sup>

Fifth, Mr. Coccia entirely ignores the trend percentages and focuses only on the amounts at risk. In Table 3 of his report, Mr. Coccia shows only the amounts placed at risk by each vendor for its trend guarantee. Mr. Coccia has simply ignored the differences in the trend percentages in each vendor's guarantee. He offers no basis for this approach, which contradicts the RFP's specifications.

In sum, both Mr. Coccia and Mr. Vieira cherry-pick aspects of the trend guarantees that are less favorable for Blue Cross and ignore elements more favorable to Blue Cross. When all the relevant information on the trend guarantees is considered, Blue Cross has the more competitive guarantee.

Although Mr. Vieira and Mr. Coccia purport to rebut my opinion that the Plan and Segal erred in assigning zero points to Blue Cross's pricing guarantees because Blue Cross's pricing guarantees would provide lower costs to the Plan than Aetna's, nothing in their reports affects the analyses or conclusions offered in Opinion 1 of my Initial Report.

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<sup>28</sup> Segal. 2024 Health Plan Cost Trends & Strategies. October 5, 2023. Available at:

<https://www.segalco.com/media/3491/2024-health-plan-cost-trends-strategies-webinar.pdf>

<sup>29</sup> Segal. Webinar on Projected 2024 Health Plan Cost Trends. October 5, 2023. Time stamp 8:17 – 8:59. Available at: <https://www.segalco.com/consulting-insights/2024-health-plan-cost-trend-survey-webinar>

## Opinion 2: Discrepancy between repricing and LOI rates

In my Initial Report, I identified notable discrepancies between the discounts Aetna assumed in its repricing exercise and the discounts reflected in the actual letters of intent for two of the three REDACTED REDACTED for which Aetna produced its underlying agreements: REDACTED

REDACTED In response to my findings, neither Mr. Coccia nor Mr. Vieira have raised any questions about my calculations or offered any non-speculative explanation for the differences.

Mr. Vieira simply says that “I will assume that Mr. Russo...performed the relevant calculations correctly when determining that Aetna understated their claims by nearly \$30 million per year.”<sup>30</sup>

Mr. Coccia does not dispute my calculations either. Instead, he spends several paragraphs speculating about possible reasons for the discrepancies. Among the possible reasons that Mr. Coccia hypothesizes are stop-loss provisions, exclusion criteria related to inpatient admissions, and multiple procedure discounting related to outpatient visits.<sup>31</sup> But Mr. Coccia does not opine that any of these factors are the *actual* reason for the discrepancies; he merely offers them as hypothetical possibilities. As Aetna’s expert, he could have requested additional data, documents, contracts, or any other information to determine the actual reason why the differences exist, but he apparently did not do so.

Mr. Coccia goes on to assert that “the health plan itself (in this case, Aetna) is in the best position to make those analytical assumptions in a repricing analysis, given their understanding of their contracts, provider practices, and book-of-business experience...I have seen no indication that Mr. Russo even attempted to obtain an understanding of Aetna’s actual experience.”<sup>32</sup> The basis for Opinion 2 in my Initial Report is that I repriced the relevant claims, according to the methodology prescribed in the RFP’s cost proposal, using the discounts indicated in the Letters of Intent produced by Aetna. Although Mr. Coccia contends that my analysis was incorrect, he does not counter my analysis with his own assessment of “Aetna’s actual experience” or explain the origin of the discrepancy between Aetna’s repricing results and Aetna’s contracted pricing for those providers. Since Mr. Coccia (Aetna’s own expert) could have obtained an understanding of Aetna’s actual experience and could have stated the results in his report, it is notable that he did not do so.

In summary, my conclusion that Aetna meaningfully overstated its discounts for two REDACTED REDACTED stands un rebutted, even by Aetna’s own expert. Mr. Coccia’s list of possible

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<sup>30</sup> Expert Report of Kenneth C. Vieira, pg. 30.

<sup>31</sup> Stoploss refers to reimbursement for extraordinarily costly cases. Exclusion criteria relate to care authorization policies and procedures used by health plans. Multiple procedure discounting refers to reductions in reimbursement that are applied when certain procedures are performed at the same time.

<sup>32</sup> Expert Report of Andrew Coccia, pg. 30.

reasons for the discrepancies only adds to the reasons why Segal and the Plan should have probed Aetna's reported discounts as vigorously as it probed Blue Cross's.

Furthermore, the impact of this discrepancy could be larger than Mr. Vieira concludes. Mr. Vieira downplays the magnitude of the discrepancies I identified by saying that they yield a "less than .5% difference."<sup>33</sup> But Mr. Vieira ignores the possibility that the discrepancies I identified may be the tip of the iceberg: my Initial Report compared Aetna's repricing results with the contracts *for only three* [REDACTED]. Also, I performed calculations only for inpatient and outpatient hospital services for [REDACTED]; I did not analyze other services, such as professional, lab, or behavioral-health services. In my Initial Report, moreover, I have pointed out other anomalies in the scoring of the repricing exercise that, if corrected, would likely place Blue Cross more than 0.5 percentage points ahead of Aetna in terms of claims cost.<sup>34</sup>

In Mr. Vieira's report, he presents a table on page 30 (recreated below) purporting to demonstrate that the anomalies I found in analyzing Aetna's letters of intent and repricing data would only have "a less than .5% difference." What Mr. Vieira fails to recognize is that my analysis was confined to just three [REDACTED] because those were the only providers for which I had Aetna's contracts. Mr. Vieira did nothing to prove that the remainder of Aetna's pricing data is accurate; instead, his "less than .5% difference" opinion *assumes* that the remainder of Aetna's repricing exactly matches the reimbursement rates outlined in Aetna's contracts. Mr. Vieira could, instead, have assumed that the same error rate I found for three [REDACTED] would also be found in the remainder of Aetna's pricing data. If Mr. Vieira had adopted that assumption, his table would look like Figure 5 below. It would show Blue Cross receiving 6 points for its repricing proposal and Aetna receiving 0 points:

**Figure 5**  
**Variation on Table from Page 30 of Vieira's Report**

	<b>Total Claims (2025-2027)</b>	<b>% From Lowest Claims Cost</b>	<b>Network Score</b>	<b>Total Claims (2025-2027) - Adjusted</b>	<b>% From Lowest Claims Cost</b>	<b>Network Score</b>
<b>Aetna</b>	\$9,639,225,963	0.00%	6	\$10,276,470,452	6.11%	0
<b>Blue Cross</b>	\$9,684,432,315	0.47%	6	\$9,684,432,315	0.00%	6

[1] Aetna's adjusted claims cost is estimated by assuming the same error rate that was calculated in my Initial Report (using rates contained in the letters of intent) for all inpatient and outpatient claims.

[2] The error rate was used to calculate an adjusted in-network discount percent for Aetna. First, the percentage difference in the contracted amount between Aetna's bid and the actual rates in the letters of intent was calculated. The total in-network contracted amounts for inpatient and outpatient claims that Aetna reported in the repricing

<sup>33</sup> Expert Report of Kenneth C. Vieira, pg. 30.

<sup>34</sup> Expert Report of Gregory Russo, pg. 40-41.

exercise were increased by this percentage. The professional and ancillary contracted amounts were not adjusted because they were not included in my analysis of the letters of intent. Next, an adjusted discount percentage, using the increased contracted amount, was calculated. The adjusted discount was inserted into Segal's network pricing scoring sheet (SHP 0069464.xlsx) to determine the total claims cost for 2025 to 2027 at the adjusted discount percentage.

In sum, my Opinion 2 demonstrates that Aetna repriced at least some of its claims incorrectly. Mr. Vieira does not dispute that this is the case but dismisses the issue as not having an impact on the scoring. At the same time, he assumes without empirical analysis that all other aspects of Aetna's repricing—including the alleged exclusion of trends in billed charges from the repricing exercise—are correct. But these factors, and especially Mr. Coccia's insistence that "variations in assumptions and methodologies can have a significant impact on repricing outcomes"<sup>35</sup> and that "pricing of a claim is not as simple as a rate match from a service to a provider,"<sup>36</sup> undermine the integrity of Aetna's bid and Segal's evaluation of it.

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<sup>35</sup> Expert Report of Andrew Coccia, pg. 28.

<sup>36</sup> Expert Report of Andrew Coccia, pg. 31.

### Opinion 3: Discount Adjustment

Both Mr. Coccia and Mr. Vieira state that the impetus for adjusting Blue Cross's discount as reflected in the repricing exercise was to create an "apples to apples" comparison of discounts across the vendors. Specifically, Mr. Coccia states that "it is necessary to reflect discounts included in the scoring analysis on the same basis for all vendors."<sup>37</sup> Mr. Vieira states that "Segal took all reasonable steps to ensure that the vendors' pricing was consistently and fairly compared."<sup>38</sup>

I agree that an apples-to-apples comparison of the vendors' repricing results was a legitimate objective. However, my Initial Report points out a reason to doubt that Segal and the Plan achieved that objective. In particular, Segal and the Plan scrutinized and adjusted Blue Cross's discounts without subjecting Aetna's discounts to similar scrutiny and adjustment, despite indications that similar scrutiny was warranted. Instead, Segal adjusted Blue Cross's current discount (its discount percentage in the repricing exercise) significantly downward without a sufficient basis to do so, but left Aetna's current discount the same (except for minor rounding).

Mr. Coccia states on page 32 of his report that "Segal's approach...was acceptable because it served to represent all Vendors' discounts on the same basis and time period." Earlier in his report, however, Mr. Coccia lists numerous "potential variations in assumptions and applied methodology, both in repricing and in claims systems, that are common in this industry."<sup>39</sup> I see no evidence that any of these variations were addressed in Segal's clarification requests or its adjustments to the repricing results. That omission casts doubt on the discount percentages that Segal and the Plan used to score this RFP.<sup>40</sup>

Segal had ample information to investigate questions or concerns that it may have had regarding the repricing and the discounts calculated, including the repricing file detail. A review of the repricing files by healthcare experts accustomed to viewing claims files may have revealed differences in the vendors' repricing methodologies and/or raised questions that could have been asked of all vendors. The absence of this analysis is especially notable for Aetna's repricing proposal. Aetna told Segal that it excluded any billed-charge trend from Aetna's discount calculations. Segal took that statement at face value, even as it probed Blue Cross on that same issue through multiple clarification requests. It is notable that Mr. Coccia, Aetna's own expert, does not state—let alone include an analysis to verify—that Aetna's repricing results excluded any trending of billed charges.

My review of the repricing files, moreover, revealed potential anomalies in Aetna's repricing file that the Plan and Segal could have investigated by clarifications or otherwise. Figure 6, for example, identifies

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<sup>37</sup> Expert Report of Andrew Coccia, pg. 32.

<sup>38</sup> Expert Report of Kenneth C. Vieira, pg. 34.

<sup>39</sup> Expert Report of Andrew Coccia, pg. 28.

<sup>40</sup> This doubt is especially pronounced because Mr. Coccia invokes these "variations" to explain the demonstrated discrepancy between Aetna's agreements with three providers and the discounts Aetna bid for those providers. See *generally* my Opinion 2.

claims for DRG 787 (Cesarean section without sterilization with complication or comorbidity). The repricing instructions required the vendors to indicate the “Type of Network Contract” that would apply for each claim. Among the choices were “Fee Schedule” and “Discount off eligible charges.”<sup>41</sup> Aetna’s repricing file indicates that all claims are priced according to the contract type “Fee Schedule.” Given that a Fee Schedule contract type was indicated rather than a discount off eligible charges, I would not expect to see the same discount percentage across claims for the same service. Instead, I would expect to see a consistent allowed amount.

As indicated, Figure 6 includes claims related to Cesarean section or “C-section.” These are actual claims included in the repricing file provided to the vendors. Given the description of that file, I understand that these claims relate to members of the Plan who delivered a child via C-section in 2021. All of these C-sections occurred at REDACTED Aetna’s Letter of Intent with REDACTED indicates that REDACTED

However, none of the claims below were repriced at this rate. Instead, the claims were repriced at the same discount of REDACTED. This finding suggests that the contract type is actually “discount off eligible charges” even though Aetna indicated that these claims were repriced using a fee schedule. The consistent discount and the fee schedule contract type is just one example of the type of discrepancy available to the Plan and Segal during the RFP that should have raised concerns and prompted further investigation into Aetna’s repricing.

**Figure 6**  
**Examples from Aetna’s Repricing File**

Provider Name	Claim Number	DRG	Start Date	End Date	Length of Stay	Charges	Allowed Amount	Discount	Contract Type
REDACTED					1				
					1				
					1				
					1				
					1				

Also, as Opinion 2 of my Initial Report and this rebuttal report states, my review of Aetna’s repricing file in concert with its contracts has raised questions about the accuracy of Aetna’s repricing results. As I have stated previously in this report, the discrepancies between Aetna’s repricing file and its contracts are indicative of larger issues with the accuracy of Aetna’s bid. To address the issues raised by Mr. Coccia, Segal could have performed this same level of scrutiny of each vendors’ repricing exercise, but it did not.

<sup>41</sup> SHP 0006964.

Mr. Coccia raises further questions about the comparability of the vendors’ discount percentages when he states that repricing “typically carr[ies] a +/- 2 discount point margin of error when displaying results”<sup>42</sup> and that this margin of error “can create a broad range of outcomes.”<sup>43</sup> Not only does this reasoning cast additional doubt on the repricing methodologies, calculations, and results, it also raises questions about why the scoring ranges used by Segal and the Plan used narrower differences (0.5-percentage-point differences in claims cost) to analyze bids and assign points.

In sum, there is reason to doubt that Segal and the Plan achieved an apples-to-apples comparison here. Instead, the adjustments Segal imposed on Blue Cross’s discount percentage undermined an objective comparison of the vendors’ repricing proposals.

In Mr. Vieira’s report, he provides a table purporting to show that the outcome for the RFP would have been the same under an alternative scoring methodology that he proposes. That table, however, does not reflect the impact of the issues discussed above. To illustrate the scoring impact of *just one* correction, in Figure 7 below, I leave Mr. Vieira’s table and underlying assumptions unchanged, but adjust the claims cost for Blue Cross to reflect the 54 percent discount reported by Blue Cross, versus the 52.7 percent discount that Segal used. Under Mr. Vieira’s proposed scoring methodology, that one correction alone changes Aetna’s cost score to 301.93 out of a hypothetical 310 cost points and makes Blue Cross the winner of the RFP. Note that the table below does not take into account any other corrections, such as changes to address the issues that I have identified with Aetna’s repricing (see Opinion 2 of my Initial Report as well as the section above discussing that Opinion). Further corrections would further increase Aetna’s claims cost and increase Blue Cross’s relative score.

**Figure 7**  
**Variation on Table from Page 10 of Mr. Vieira’s Report**

	Technical Score	Total Projected Costs	Cost Ratio	Cost Score	Total Score	Overall Rank
	<i>Out of 310</i>	<i>2025 – 2027</i>	<i>(Lowest Cost)/Cost</i>	<i>Cost Ratio x 310</i>		
<b>Aetna</b>	310	\$9,932,824,079	97.40%	301.93	611.93	2
<b>Blue Cross</b>	303	\$9,674,191,837	100.00%	310.00	613.00	1
<b>UMR</b>	310	\$10,085,662,123	95.92%	297.35	607.35	3

[1] The only adjustment made to Mr. Vieira’s table was to change Blue Cross’s discount from 52.7% to 54%. This resulted in a decrease in the total projected costs for Blue Cross, which then decreased the relative cost score for Aetna and UMR. When the total score is calculated using the updated values, Blue Cross has the highest total score and ranks first.

<sup>42</sup> Expert Report of Andrew Coccia, pg. 42.

<sup>43</sup> Expert Report of Andrew Coccia, pg. 42.

#### Opinion 4: UDS Data

Both Mr. Coccia and Mr. Vieira misinterpret my opinion on the use of the UDS data in the context of the TPA evaluation. At no point in my report did I state that the UDS data should have been used to *score* the bids. Instead, I stated that “the UDS results showed the same discount pattern as the repricing results calculated by the vendors: that Blue Cross’s discounts were higher than Aetna’s. Thus, Segal’s check of the UDS appeared to validate the results....” Despite this validation of the unadjusted repricing results, Segal and the Plan moved forward with their downward adjustment of Blue Cross’s discount—an adjustment that flipped the discounting rank shown by the UDS results.

Internal emails between Segal employees referred to Segal’s consultation of the UDS data as a “smell test.” Using a similar metaphor in his report, Mr. Coccia refers to such a consultation as a “gut check” and implies that using the UDS data in this way is appropriate.<sup>44</sup> In addition, Mr. Vieira concedes that the UDS showed that Blue Cross’s discount would result in Blue Cross being 1.1 percent less expensive in terms of claims cost than Aetna.<sup>45</sup> Despite this agreement on the role of UDS data, Segal chose to ignore the results of the gut check that Segal itself performed.

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<sup>44</sup> Expert Report of Andrew Coccia, pg. 42.

<sup>45</sup> Expert Report of Kenneth C. Vieira, pg. 35.

## Opinion 5: Network Disruption

In my Initial Report, I stated that Segal and the Plan did not include a network analysis as part of the scoring, and I opined that the networks should have been scored. The RFP calls for a broad network “with the least disruption,” yet there was no opportunity for vendors to earn points for having those network characteristics. The analyses I presented in my report demonstrated that Blue Cross’s network is the network that best meets these RFP criteria. Neither Mr. Coccia nor Mr. Vieira disputes that conclusion.

Mr. Coccia offers his own analysis of the networks and concludes that Aetna’s network is “acceptable.” But acceptability is not the criterion stated in the RFP. Instead, the RFP calls for a broad network with the least disruption.

As I stated in my Initial Report, Segal and the Plan did not use the data contained in Attachment A-2, which would have allowed the types of analyses that Mr. Coccia presents. Using this data, I found that Blue Cross’s network is larger than Aetna’s and provides more choices of providers, especially in rural areas.<sup>46</sup> Segal and the Plan could have used the data in Attachment A-2 to conduct a proper network analysis and could have included that analysis in the scoring of the cost proposal. They did not do so.

To try to rationalize the omission of an actual network comparison, Mr. Coccia and Mr. Vieira offer a flawed measure of network adequacy. Mr. Coccia’s Table 6 presents an “in-network assumption” for each of the vendors, which is the same in-network assumption used by Segal in its Network Pricing scoring.<sup>47</sup> This figure refers to the percentage of claims that were identified as being submitted by in-network providers in the repricing exercise. The assumption is that 99.0 percent of claims are in-network with Aetna, 99.4 percent are in-network with Blue Cross, and 98.5 percent are in-network with UMR.<sup>48</sup> Mr. Vieira presents the same percentages in his report.<sup>49</sup> Both Mr. Coccia and Mr. Vieira imply that Segal and the Plan were justified in using these percentages as the only measure of disruption.

That approach is flawed. In considering only the percentage of in-network claims in the aggregate, Mr. Coccia and Mr. Vieira ignore geographic variation in the distribution of in-network providers and claims. As I demonstrated in my Initial Report, in many counties in North Carolina, especially rural counties, Aetna has gaps in its network (resulting in more out-of-network claims and higher member out-of-pocket costs)<sup>50</sup> that are not apparent from the aggregate percentage of in-network claims across the state. Members in these counties may experience considerable disruption, yet Mr. Coccia and Mr. Vieira ignore the impact on the members who would lose convenient provider access if Aetna becomes the TPA.

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<sup>46</sup> Expert Report of Gregory Russo, pg. 55.

<sup>47</sup> Expert Report of Andrew Coccia, pg. 45.

<sup>48</sup> Expert Report of Andrew Coccia, Table 6, pg. 45.

<sup>49</sup> Expert Report of Kenneth C. Vieira, pg. 37.

<sup>50</sup> Expert Report of Gregory Russo, pg. 59.

Mr. Vieira claims that Blue Cross would be given an unfair advantage in this analysis when he states, “Putting more weight on the network provides a significant advantage to the incumbent, since the data is based on their current network.”<sup>51</sup> However, if Aetna had more providers than Blue Cross, i.e., a broader network in a particular geographic area, a comparison of the networks would not favor Blue Cross; it would favor Aetna. In any event, Mr. Vieira’s argument overlooks the real experiences of members who will lose their in-network providers or be forced to pay out-of-network cost-sharing amounts if Aetna is awarded the contract.

A handwritten signature in black ink, appearing to be 'J. Vieira', written over a horizontal line.

November 10, 2023

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<sup>51</sup> Expert Report of Kenneth C. Vieira, pg. 37.

**Appendix A**  
**Greg Russo CV**

## **GREG RUSSO**

Managing Director, BRG Health Analytics

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### **SUMMARY**

Greg Russo is a Managing Director with Berkeley Research Group's Health Analytics practice in Washington, DC. Mr. Russo specializes in providing strategic advice to healthcare organizations through his use of complex data analyses and financial modeling. His clients typically seek his expert understanding of the regulatory environment in which healthcare organizations operate. Mr. Russo primarily focuses on harnessing the wealth of information available in large, multipart data sets to bring results and insights to clients with complex, unstructured issues. He utilizes this data in providing clients with strategic advice as it relates to damage calculations, government investigations, internal investigations, business planning and provider reimbursement.

In his 19 years of experience, Mr. Russo's services have related to both litigation and non-litigation issues. His clients most often include health insurers and provider organizations; however, his clients have spanned the healthcare continuum to include state agencies, federal agencies, and life sciences companies. Prior to becoming a consultant, Mr. Russo worked for three years at the Jersey Shore University Medical Center, a Meridian Health hospital. Mr. Russo completed his undergraduate degree at The College of William and Mary and received his master's degree in Health Finance and Management from The Johns Hopkins Bloomberg School of Public Health.

Mr. Russo is a member of both the American Health Lawyers Association (AHLA) and the Healthcare Financial Management Association (HFMA).

### **PROFESSIONAL EXPERIENCE**

#### **LITIGATION SUPPORT**

- Assisted in the calculation of reasonable value of healthcare services in personal injury cases. Analyzed data to determine the reasonable value of future services included in life care plan as well as past services. In certain cases, worked to identify the rates that would be paid by the Medicare program/Medicaid program or other applicable program.
- Assisted a large health insurer in litigation with another large health insurer over the rates that the insurer reimbursed hospitals. Analyzed changes in reimbursement to hospitals before and after most favored nation clauses incorporated into hospital contracts. Working with antitrust experts to connect the competitive/anti-competitive nature of the contracts with effects on the healthcare industry including reimbursement rates and premiums.
- Assisted a large health insurer defend against a class action lawsuit relating to out-of-network reimbursement for outpatient services.

- Assisted several health insurers with respect to challenges/issues involving out-of-network reimbursement. Services analyzed have included inpatient services, ASC, and professional services.
- Assisted health insurers with investigations/litigations related to the Medicare Advantage program including issues involving diagnosis coding, Risk Adjustment Payment System filtering logic, Encounter Data Processing System submissions, and chart reviews.
- Assisted one of the largest post-acute care providers in the United States with a qui tam suit regarding allegations of unnecessary care being provided. Analyzed company data to assist in rebutting the allegations. Utilized Medicare's skilled nursing facility data to benchmark care being provided.
- Assisted a large rehabilitation hospital chain with allegations made by the Department of Justice. Utilized Medicare data to analyze the care provided at specific rehabilitation hospitals. Developed a peer group of facilities to provide benchmark statistics. Continuing to assist Counsel in this ongoing work.
- Assisted several skilled nursing facility clients regarding allegations of unnecessary therapy services being delivered to patients. Utilized publicly available data to analyze patient metrics and benchmark the level of care provided. Supported external counsel in conversations and presentations to the Department of Justice and the Office of the Inspector General.
- Assisted a large long term acute care hospital chain involving a government investigation of patient lengths of stay and the extent to which the facility was providing medically unnecessary care. Utilized publicly available data to analyze the government's proposed sample of patients and benchmark this sample against a broader group of patients. Analyzed lengths of stay for facilities at-issue and against benchmark facilities.
- Assisted a large provider organization better understand the drivers behind their earnings growth. This organization was involved in litigation regarding its earnings compared with budgeted projections. Tasks included analyzing claims and financial data to assess drivers of earnings.
- Assisted a large, acute care hospital chain with analysis of interventional cardiology services performed over a multi-year period at all facilities. Utilized public and proprietary data to identify trends in the care provided.
- Assisted a large provider organization analyze cardiology services provided. Analyzed trends of procedures performed, diagnoses present and utilization of different places of service.
- Assisted a large provider of inpatient psychiatric services with an investigation of the care provided to Medicare and Medicaid patients. Analyzed proprietary and publicly available data to understand the provider's practice and benchmark this to the industry.

#### *INTERNAL INVESTIGATIONS*

- Managed project team tasked with developing the financial impact of a programmatic error that led to incorrect data being reported to CMS for Medicare Advantage beneficiaries. Developed model utilizing CMS prepared software to determine the premium associated with each individual member by month. Determined that the error led to a \$150M+ overpayment of health premiums by CMS to the Fortune 500 health insurer. Prepared expert reports summarizing our methodology and conclusions for CMS as well as a report for the provider community impacted by this error.

- Managed project investigating commission payments made in conjunction with Medicare Advantage sales. Developed analyses to investigate extent of fraudulent behavior and support lawyers in their investigation.
- Assisted a hospital organization in its investigation of a coding/billing errors made regarding its post-acute care team. Worked with certified coders to identify accurate coding and calculated overpayments to government payment programs.
- Managed an audit of the pharmacy at a large academic medical center that was experiencing issues tracking narcotics after having been dispensed from the pharmacy. Led the team in identifying, collecting and analyzing data housed in automatic medication dispensing machines. Conducted interviews with executives and management to identify gaps in the dispensing system.

#### *STRATEGIC SUPPORT*

- Evaluated a health insurer's entry into the Medicare Advantage market. Reviewed the health insurer's financial model to estimate bid rates, risk scores, and claims costs to render an opinion as to the reasonableness of the assumptions and projections.
- Redesigned the professional fee schedule for several large insurers. Utilized market data, governmental fee schedules and proprietary data to recommend new fees to appropriately reimburse for services. Reviewed the reimbursement for all physician and ancillary services including routine office visit codes to complex surgeries. Analyzed the use of medical equipment to accurately reflect the difference reimbursement in a facility versus non-facility setting. Developed a methodology that can be easily updated in time by the insurer to account for increasing costs.
- Analyzed quality incentive programs to determine the effect on medical spend of a commercial insurer. Determined how the quality incentive programs should be incorporated to shifting reimbursement methodologies.
- Assisted in the redesign of payment methodologies used for ancillary services including durable medical equipment, specialty pharmaceuticals, ambulance services, laboratory services and radiology services.
- Assisted a large health insurer redesign reimbursement to ambulatory surgery centers to more accurately reflect actual costs to provide services. Tasks included studying supply costs, conducting provider interviews and analyzing the current fee schedule.
- Studied the Medicare program to reimburse providers for hip and knee replacements using a bundled payment. This program is known as the Comprehensive Care for Joint Replacement and began in April 2016.
- Assisted the California Department of Corrections Receivership in its assessment of the healthcare contracting unit. Developed recommendations to drive quality and control costs while recognizing adequate access to services must exist. Conducted data analysis to better understand rate setting and utilization.
- Assisted a large health insurer that considered converting from a non-profit to a different type of corporate entity. Delivered market expertise and strategic insights to team of executives as to the effects such a change could have on the sale of insurance and the provider networks, both regarding to contracts and reimbursement.

- Assisted multiple commercial payers with the design and implementation of reimbursement strategies for both in-network and out-of-network providers. Past projects include those for physical therapy services, outpatient hospital services, laboratory services, physician services, ambulance services and specialty services.
- Assisted a health insurer with reimbursement for inpatient psychiatric services. Tasks included drafting policy paper on history of Medicare reimbursement for these services and options for the insurer. Analyzed claims data to assess impact of reimbursement changes.
- Aided in the development of reimbursement strategies for spinal implant manufacturer. Worked with approximately 50 hospitals throughout the United States to coordinate a release of data to supplement a cost analysis of the spinal implant. Prepared reports, which were to be presented to CMS in support of additional reimbursement for providers when using the device.

#### *PROGRAM DESIGN & EVALUATION*

- Supported the MA-PD and PDP offices at CMS to validate marketing materials from all Part D plans. This project included accessing the secure CMS Gateway Portal housing marketing materials and the reviews performed by CMS Regional Offices and contractors. Our team produced a final report to the CMS Central Office staff, which helped identify areas of deficiency in evaluating marketing materials. Our team also coordinated training for CMS Regional Office staff regarding more thorough evaluation of these materials.
- Supported New York State in the design and application of a 1915 (c) waiver to the Centers for Medicare and Medicaid Services. This project produced multiple HCBS waivers resulting in a cross-disability program. This program entitled, Bridges to Health, is designed integrate child welfare, juvenile justice and disability services systems in response to the needs of children and adolescents.
- Evaluated National Rural/Frontier Women’s Health Coordinating Centers for the U.S. Office on Women’s Health within the Department of Health and Human Services. Conducted site visits at multiple locations to gauge participation, efficiency of operations and ability to continue operations without government funding.

#### **EDUCATION**

- M.H.S. Health Finance & Management, Johns Hopkins Bloomberg School of Public Health, 2005
- B.A. The College of William and Mary, 2003

#### **PUBLICATIONS**

- D. Hettich, G. Russo. “Are You on Target? An Analysis of Medicare’s Target Prices under the New CJR Program and Where Your MSA Stands Now?” Reimbursement Advisor, Vol. 31, No. 6, February 2016.
- K. Pawlitz, G. Russo. “Proactively Responding to Government Investigations Using Data Analytics: An Examination of Data Considerations in the Post-Acute Context.” American Bar Association’s The Health Lawyer, Vol. 29, No. 5, June 2017.

- B. Akanbi, G. Russo. "Hospital Contract Labor: Where Has It Been and Who Is Using It?" Whitepaper, BRG, 2017.
- H. Miller, G. Russo, J. Younts. "Measuring the Value of Medical Services in Personal Injury Suits." Whitepaper, BRG, 2017.
- A. Asgeirsson, G. Russo. "Long-Term Acute Care Hospitals: Bracing for Change." Whitepaper, BRG, 2018.
- J. Gibson, G. Russo. "False Claims Act – Investigative Tools of the Trade." American Bar Association's Health eSource, April 2018.
- A. Asgeirsson, E. DuGoff, G. Russo. "Short Supply: The Availability of Healthcare Resources During the COVID-19 Pandemic." Whitepaper, BRG, 2020.
- J. Younts, G. Russo. "The Nitty-Gritty of Price Transparency." American Bar Association's The Health Lawyer, Vol. 33, No. 6, August 2021.

## **PRESENTATIONS**

*Proactively Responding to Government Investigations Using Data Analytics*, American Health Lawyers Association's Long Term Care & The Law, February 2016.

*How Does Medicare Reduce Payments? Let Us Count the Ways*, King & Spalding's 25<sup>th</sup> Annual Health Law & Policy Forum, March 2016.

*Structural and Transactional Implications of Medicare Payment Reform*, American Health Lawyers Association's Institute on Medicare and Medicaid Payment Issues, April 2016.

*Proactively Responding to Government Investigations Using Data Analytics*, Reed Smith Health Care Conference, May 2016.

*Value-Based Reimbursement – It's Here*, Texas Health Law Conference, October 2016.

*Effective Use of Your Own Data – Mining Your Own Data for Compliance*, Nashville Healthcare Fraud Conference, December 2016.

*Data Analytics: How Data Will Shape Payer, Provider, and Policy in 2017 and Beyond*, BRG Healthcare Leadership Conference, December 2016.

*Take Data by the Horns: Turn Analytics to Your Advantage*, American Bar Association's Emerging Issues Conference, March 2017.

*The Past, Present, and Future of Medicare Value Based Purchasing Programs*, AHLA Institute on Medicare and Medicaid Payment Issues, March 2017.

*Post-Acute Roundtable*, BRG Executive Roundtable Series, September 2017.

*Contracting for Ancillary Services*, BRG Executive Roundtable Series, November 2017.

*Mine Your Own Data: The Role of Data in Dealing with Healthcare Fraud Issues*, Nashville Healthcare Fraud Conference, December 2017.

*Data Analytics: The Road to Improving Healthcare*, BRG Healthcare Leadership Conference, December 2017.

*A Guide to Interacting with the DOJ and the Settlement Process in Enforcement Matters*, American Bar Association's Emerging Issues Conference, February 2018.

*Anatomy of a Healthcare Fraud Investigation*, Healthcare Law & Compliance Institute, March 2018.

*Bending the Cost Curve, but in which Direction—How are Bundled Payments and Value Based Purchasing Programs Working with Respect to Reducing Physicians' and Acute Care Hospitals' Costs*, American Health Lawyers Association's Institute on Medicare and Medicaid Payment Issues, March 2018.

*Best Practices in Managing Internal Investigations and Compliance*, McGuire Woods' 5<sup>th</sup> Annual Healthcare Litigation and Compliance Conference, May 2018.

*How Healthcare Providers Can Make the Best Use of Their Data*, Nashville Healthcare Fraud Conference, December 2018.

*Provider-Based Rules: Recent Developments in Site Neutrality and Co-Location*, Boston Bar Association Healthcare Law Conference, May 2019.

*Fraud & Abuse Initiatives by Health Insurers*, Nashville Healthcare Fraud Conference, December 2019.

*Navigating the Future of American Healthcare: What Litigators Should Know about Value-Based Reimbursement*, 11<sup>th</sup> Annual Advanced Forum on Managed Care Disputes and Litigation. July 2020.

*Data Analytics*, Nashville Regional Health Care Compliance Conference. November 2022.

## TESTIMONY

1. *Dee Ann Schirlls v. Robert Crust and WCA Waste Corporation*. (State of Missouri Circuit Court of Cass County, Case No. 18CA-CC00082).
2. *Crescent City Surgical Centre v. Cigna Health and Life Insurance Company, Cigna Healthcare Management Inc., Cigna Health Insurance Company* (United States District Court for the Eastern District of Louisiana, 2:18-CV-11385).
3. *Private Arbitration between Wisconsin health care providers*.
4. *Savannah Massey, by and through Joy Massey, v. SSM Health Care St. Louis D/B/A SSM Health DePaul Hospital – St. Louis* (State of Missouri Circuit Court of St. Louis County, Case No. 18SL-CC03032).
5. *Hot Springs National Hospital Holdings, LLC D/B/A National Park Medical Center & National Park Cardiology Services, LLC D/B/A Hot Springs Cardiology Associates v. Jeffrey George Tauth, M.D.* (American Health Lawyers Association Arbitration, Case No. 5819).
6. *Eliot McArdel v. King County Public Hospital District No. 1, d/b/a Valley Medical Center* (State of Washington Superior Court of King County, 18-2-14500-7 KNT).
7. *Christopher Moore, et al. v. Daniel Wagner, et al.* (State of Ohio Court of Montgomery County, 2019-CV-02758).
8. *Blue Cross and Blue Shield of Florida Inc et al v. DaVita Inc.* (United States District Court for the Middle District of Florida Jacksonville Division, 3:19-cv-00574).
9. *James Russo and Cheryl Russo v. Dr. Jeffrey Blatnik and Barnes Jewish Hospital* (State of Missouri Circuit Court of the City of Saint Louis, 1922-CC11151).
10. *Fresenius Medical Care Orange County, LLC; DaVita inc., Fresenius Medical Care Holdings, Inc., d/b/a Fresenius Medical Care North America; U.S. Renal Care, Inc. v. Rob Bonta, in his Official Capacity as Attorney General of California; Ricardo Lara, in his Official Capacity as California Insurance Commissioner; Shelly Rouillard, in her Official Capacity as Director of the California Department of Managed Health Care; and Tomas Aragon, in his Official Capacity as Director of the California Department of Public Health* (United States District Court for the Central District of California Southern Division, 8:19-cv-02130). *Jane Doe; Stephen Albright; American Kidney Fund, Inc.; Dialysis Patient Citizens, Inc. v. Rob Bonta, in his Official Capacity as Attorney General of California; Ricardo Lara, in his Official Capacity as California Insurance Commissioner; Shelly Rouillard, in her Official Capacity as Director of the California Department of Managed Health Care; and Tomas Aragon, in his Official Capacity as Director of the California Department of Public Health* (United States District Court for the Central District of California Southern Division, 8:19-cv-02105).
11. *Abeba Tesariam, et al. v. Vibhakar Mody, M.D., et al.* (State of Maryland Circuit Court of Montgomery County, Case No. 472767-V).
12. *In re: Out of Network Substance Use Disorder Claims Against UnitedHealthcare* (United States District Court for the Central District of California, 8:19-cv-02075).
13. *Katherine Villagomez, et al. v. PeaceHealth, The Vancouver Clinic, Inc. and William Herzig, M.D.* (State of Washington Superior Court of Clark County, 18-2-01491-7).
14. *UnitedHealthcare Insurance Company v. Sahara Palm Plaza, LLC, and Alexander Javaheri* (United States District Court for the Central District of California, 8:20-cv-02221).
15. *United States of America, ex rel. Henry B. Heller v. Guardian Pharmacy, LLC and Guardian Pharmacy of Atlanta, LLC.* (United States District Court for the Northeast District of Georgia, 1:18-cv-03728-SDG).

16. *Kayla Magness, et al. v. The Charlotte-Mecklenburg Hospital Authority, Carolinas Physicians Network, Inc., et al.* (State of North Carolina Circuit Court of Lincoln County, Case No. 19CV-00934).
17. *North Broward Hospital District d/b/a Broward Health v. Oscar Insurance Company of Florida* (State of Florida Circuit Court of Broward County, Case No. CACE-20-010648).
18. *United States of America v. William Harwin* (United States District Court for the Middle District of Florida, 2:20-cr-00115).
19. *Wykeya Williams, et al. v. First Student, Inc.* (United States District Court for the District of New Jersey, 2:20-cv-001176).
20. *Kaitlynn Livingston, natural mother and next friend of Z.L., a minor, v. St. Louis Children's Hospital, The Washington University, and Tasnim Najaf, M.D.* (State of Missouri Circuit Court of St. Louis City, Case No. 2022-CC00325).
21. *United States of America, et al. v. Exactech, Inc.* (United States District Court for the Northern District of Alabama, 2:18-cv-01010).
22. *Maurice Gibbons v. Joel Soltren and Marietta Fence Company, Inc.* (State of Georgia Circuit Court of Cobb County, 19A4187).
23. *Erika Warren, et al. v. State of Washington d/b/a University of Washington Medical Center – Northwest and Childbirth Center at UW Medical Center – Northwest* (State of Washington Superior Court for King County, 21-2-06153-9).
24. *Annette Robinson, et al. v. David Berry, M.D., Neonatology and Pediatric Acute Care Specialists, PC, and Catawba Valley Medical Center* (State of North Carolina Superior Court of Catawba County, 18-CVS-3237).
25. *Taylor Cayce v. Mercy Hospitals East Communities, d/b/a Mercy Hospital St. Louis, Mercy Clinic East Communities, d/b/a Mercy Clinic OB/GYN, Jason Phillips, M.D., and April Parker, M.D.* (State of Missouri Circuit Court of St. Louis County, Case No. 18SL-CC03681).
26. *Crescent City Surgical Centre v. UnitedHealthcare of Louisiana, Inc.* (State of Louisiana District Court for the Parish of Jefferson, 2:19-cv-12586).
27. *United States of America and the State of Tennessee ex rel. Jeffrey Liebman and David Stern, M.D. vs. Methodist Le Bonheur Healthcare, Methodist Healthcare-Memphis Hospitals, Chris McLean, and Gary Shorb* (United States District Court for the Middle District of Tennessee, 3:17-cv-00902).
28. *Jade Nesselhauf v. Cardinal Glennon Children's Foundation d/b/a SSM Health Cardinal Glennon Children's Hospital and St. Louis University d/b/a SLUCARE Physicians Group* (State of Missouri Circuit Court of St. Louis County, Case No. 1822-CC10878).
29. *Jheri Shields v. Mark Barber, Mark E Barber d/b/a Mark Barber Trucking; LAD Truck Lines, Inc. and Protective Insurance Company* (State of Georgia Court of Hall County, Case No. 2021SV418D).
30. *Shannon Bristow, et al. v. The Nemours Foundation d/b/a Nemours/A.I. duPont Hospital for Children and/or d/b/a Nemours-A.I. duPont Hospital for Children; and SpecialtyCare, Inc., et al.* (State of Delaware Superior Court, Case No. N21C-03-240 JRJ).
31. *Derek Williams v. James Robinson and Georgia Sand & Stone, Inc.* (State of Georgia Court of Walton County, Case No. 2020001022).

32. *Ronald Asher and Christi Asher v. SSM Health Care St. Louis d/b/a SSM Health St. Clare Hospital - Fenton and SSM Health Neurosciences and the Ernst Radiology Clinic, Inc.* (State of Missouri Circuit Court of St. Louis County, Case No. 21SL-CC01613).
33. *Renee Walters, et al. v. Emory Healthcare, Inc. d/b/a Emory Decatur Hospital; Dekalb Medical Center, Inc. d/b/a Dekalb Medical Center; Dekalb Women's Specialists II, LLC; Dekalb Women's Specialists, PC; Albert Scott, Jr, MD; Chakeeta Williams, CNM; Regina Google, RN; and Premier Healthcare Professionals, Inc.* (State of Georgia Court of Dekalb County, Case No. 20A82774).

**PRESENT POSITION**

Berkeley Research Group, 2010 – present

**PREVIOUS POSITIONS**

LECG, 2009 – 2010

Navigant Consulting, Inc., 2004 – 2009

Jersey Shore University Medical Center, 2001 - 2003

**PROFESSIONAL AFFILIATIONS**

*American Health Lawyers Association*

*Healthcare Financial Management Association*

**Appendix B**  
**Additional Documents and Information Relied on**

## **Case Documents and Data**

Deposition of Matthew Rish

Expert Report of Andrew Coccia

Expert Report of Gregory Russo

Expert Report of Kenneth C. Vieira

## **Publicly Available Materials**

Segal. 2024 Health Plan Cost Trends & Strategies. October 5, 2023. Available at:

<https://www.segalco.com/media/3491/2024-health-plan-cost-trends-strategies-webinar.pdf>.

Segal. Webinar on Projected 2024 Health Plan Cost Trends. October 5, 2023. Time stamp 8:17 – 8:59.

Available at: <https://www.segalco.com/consulting-insights/2024-health-plan-cost-trend-survey-webinar>.

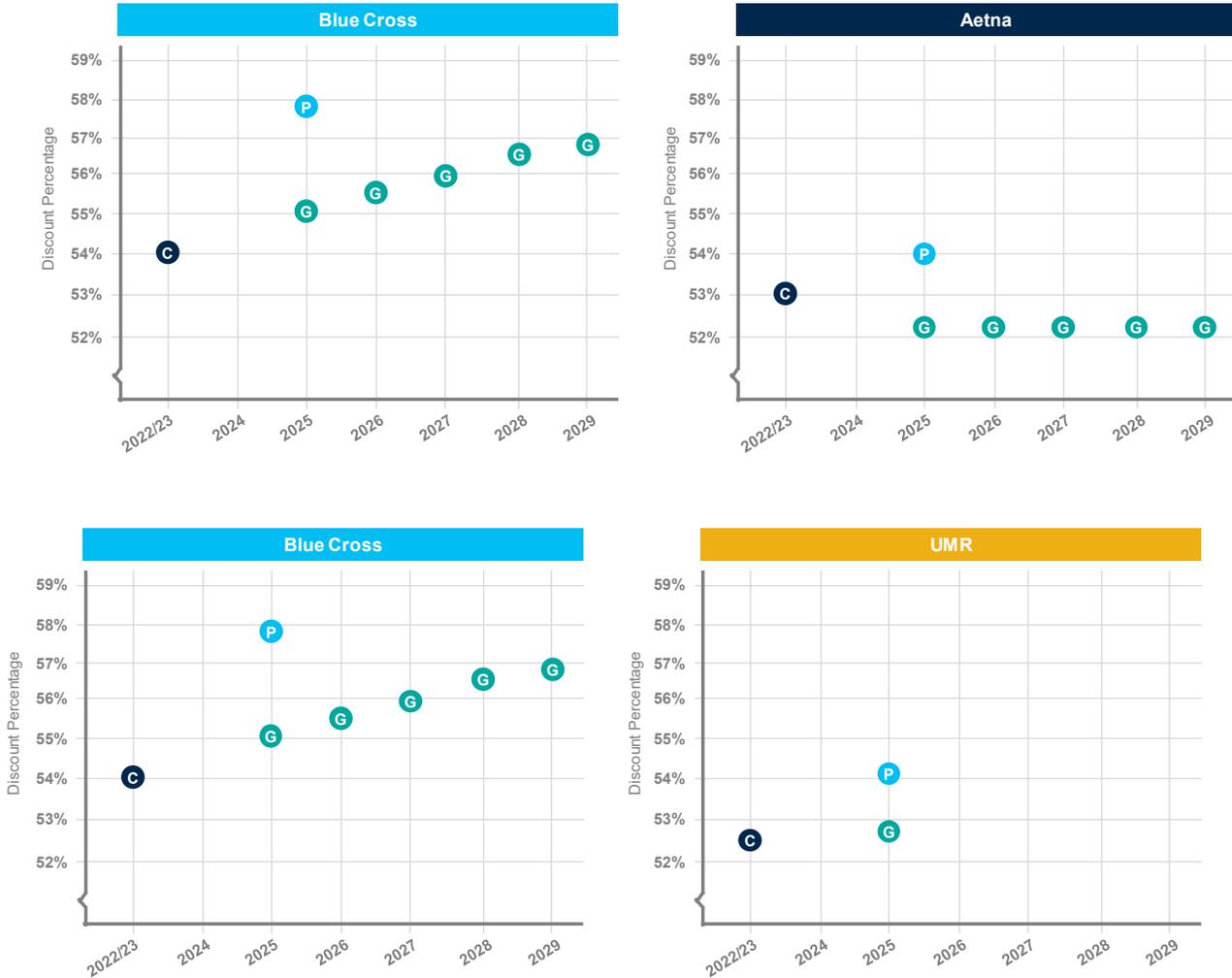
**Appendix C**  
**Exhibits**

**Figure 1**  
**Comparison of Current Discounts and 2025 Discount Guarantees**

	<b>Aetna</b>	<b>Blue Cross</b>	<b>UMR</b>
Current Discount	53.0	54.0/52.7*	52.5
2025 Discount Guarantee	52.5	55.1	52.6
<b>Incremental Discounting (in percentage points) Needed to Achieve Guaranteed Discount</b>	<b>-0.5</b>	<b>+1.1/+2.4</b>	<b>+0.1</b>

**Figure 2**  
**Guaranteed Discounts Compared to Current and Projected Discounts**

**C** = Current Discount    **P** = Projected Discount    **G** = Guaranteed Discount



**Figure 3  
Likelihood of Payout**

Current and Guaranteed Discounts	Discount	Claims Cost	Payout			Likelihood of Payout <sup>1, 2, 3</sup>			Reasonably Possible Payout		
			Aetna	Blue Cross	UMR	Aetna	Blue Cross	UMR	Aetna	Blue Cross	UMR
	50.3%	\$3,202,274,299	\$22,305,000	\$7,959,000	\$95,100,546	Unlikely	Unlikely	Unlikely	\$0	\$0	\$0
	50.8%	\$3,170,058,260	\$19,329,624	\$7,959,000	\$95,100,546	Unlikely	Unlikely	Unlikely	\$0	\$0	\$0
	51.3%	\$3,137,842,221	\$12,886,416	\$7,959,000	\$83,761,702	Unlikely	Unlikely	Unlikely	\$0	\$0	\$0
	51.8%	\$3,107,071,541	\$6,732,280	\$7,959,000	\$52,991,023	Unlikely	Unlikely	Unlikely	\$0	\$0	\$0
Aetna Guarantee	52.3%	\$3,073,410,142	\$0	\$7,959,000	\$19,329,624	N/A	Unlikely	Unlikely	\$0	\$0	\$0
UMR Current	52.5%	\$3,060,523,726	\$0	\$7,959,000	\$6,443,208	N/A	Unlikely	Unlikely	\$0	\$0	\$0
UMR Guarantee	52.6%	\$3,054,080,519	\$0	\$7,959,000	\$0	N/A	Unlikely	N/A	\$0	\$0	\$0
	52.8%	\$3,041,194,103	\$0	\$7,959,000	\$0	N/A	Unlikely	N/A	\$0	\$0	\$0
Aetna Current	53.0%	\$3,028,307,687	\$0	\$7,959,000	\$0	N/A	Unlikely	N/A	\$0	\$0	\$0
	53.3%	\$3,008,978,064	\$0	\$7,959,000	\$0	N/A	Unlikely	N/A	\$0	\$0	\$0
	53.8%	\$2,976,762,024	\$0	\$7,959,000	\$0	N/A	Unlikely	N/A	\$0	\$0	\$0
Blue Cross Current	54.0%	\$2,963,875,609	\$0	\$7,087,529	\$0	N/A	Unlikely	N/A	\$0	\$0	\$0
	54.3%	\$2,944,545,985	\$0	\$5,154,566	\$0	N/A	Possible	N/A	\$0	\$5,154,566	\$0
	54.8%	\$2,912,329,946	\$0	\$1,932,962	\$0	N/A	Possible	N/A	\$0	\$1,932,962	\$0
Blue Cross Guarantee	55.1%	\$2,893,000,322	\$0	\$0	\$0	N/A	N/A	N/A	\$0	\$0	\$0
	55.3%	\$2,880,113,907	\$0	\$0	\$0	N/A	N/A	N/A	\$0	\$0	\$0

[1] Yellow cells indicate rows where the discount is at or below the vendor's current discount.

[2] Green cells indicate rows where the discount is above the vendor's current discount and below the vendor's guaranteed discount.

[3] White cells indicate rows where the discount is at or above the vendor's guaranteed discount.

**Figure 4  
Trends and Claims Costs**

Year	Blue Cross		Aetna		Amount by which Aetna's Claims Cost is Greater than Blue Cross's
	Trend Guarantee	Claims Cost	Trend Guarantee	Claims Cost	
2025 <sup>1</sup>		\$2,846,864,260		\$2,846,864,260	\$0
2026	6.0%	\$3,017,676,116	6.8%	\$3,040,735,716	\$23,059,601
2027	6.0%	\$3,198,736,683	7.1%	\$3,255,411,658	\$56,674,975
2028	6.0%	\$3,390,660,883	7.3%	\$3,493,382,250	\$102,721,366
2029	6.0%	\$3,594,100,536	7.6%	\$3,757,481,948	\$163,381,411
				<b>Total</b>	<b>\$345,837,353</b>

**Figure 5**  
**Variation on Table from Page 30 of Vieira’s Report**

	<b>Total Claims (2025-2027)</b>	<b>% From Lowest Claims Cost</b>	<b>Network Score</b>	<b>Total Claims (2025-2027) - Adjusted</b>	<b>% From Lowest Claims Cost</b>	<b>Network Score</b>
<b>Aetna</b>	\$9,639,225,963	0.00%	6	\$10,276,470,452	6.11%	0
<b>Blue Cross</b>	\$9,684,432,315	0.47%	6	\$9,684,432,315	0.00%	6

**Figure 6**  
**Examples from Aetna's Repricing File**

Provider Name	Claim Number	DRG	Start Date	End Date	Length of Stay	Charges	Allowed Amount	Discount	Contract Type
REDACTED					1				
					1				
					1				
					1				
					1				

**Figure 7**  
**Variation on Table from Page 10 of Mr. Vieira's Report**

	<b>Technical Score</b>	<b>Total Projected Costs</b>	<b>Cost Ratio</b>	<b>Cost Score</b>	<b>Total Score</b>	<b>Overall Rank</b>
	<i>Out of 310</i>	<i>2025 – 2027</i>	<i>(Lowest Cost)/Cost</i>	<i>Cost Ratio x 310</i>		
<b>Aetna</b>	310	\$9,932,824,079	97.40%	301.93	611.93	2
<b>Blue Cross</b>	303	\$9,674,191,837	100.00%	310.00	613.00	1
<b>UMR</b>	310	\$10,085,662,123	95.92%	297.35	607.35	3

# **EXHIBIT C**

**Amended Expert Report of  
Kenneth C. Vieira  
(October 31, 2023)**

**AMENDED EXPERT REPORT OF KENNETH C. VIEIRA, FSA, FCA, MAAA**

***Blue Cross and Blue Shield of North Carolina vs.  
North Carolina State Health Plan for Teachers and State Employees***

**North Carolina Office of Administrative Hearings**

**Case No. 23 INS 00738**

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    B. Expert Report Opinions from Gregory Russo from the Berkeley Research Group           19

## **1. Introduction**

My name is Kenneth Vieira. This report presents my expert opinions in the matter of *Blue Cross and Blue Shield of North Carolina v. North Carolina State Health Plan for Teachers and State Employees*.

I have been retained by Fox Rothschild LLP on behalf of Respondent North Carolina State Health Plan for Teachers and State Employees (the “Plan”) to provide analysis and expert testimony.

The opinions expressed in this report are stated with a reasonable degree of professional certainty based upon my education, training, and experience. I reserve the right to supplement or amend this report based upon additional evidence put forth by the parties in this case, as well as any other information that may become available or any other analyses counsel may request. I further reserve the right to offer opinions within my area of expertise in response to additional opinions and/or subjects addressed by other experts.

## **2. Qualifications**

I am a Senior Vice President with The Segal Group, Inc. (“Segal”) and the East Region Public Sector Market Leader. Among other duties, I currently serve as the Lead Actuary for the Plan. I have been working with the Plan for over 25 years, 11 years with Segal and 14 years with a prior employer, Aon plc. Over my years, I have been through numerous procurements with the Plan.

I work exclusively with state health plans. During my career, I have worked with over 20 state programs in various capacities, either as their Lead Actuary, Account Manager or Subject Matter Expert. All of these plans procure their medical benefits and I/Segal have been involved in procurement at various levels – reviewing cost, technical, communicating with bidders as appropriate, data, etc. Segal performs procurements for a number of benefit types, but I have primarily been involved in the Medical TPA and Pharmacy PBM procurements, since those represent the bulk of a plan’s spend. Each state has their own procurement rules, processes, and expertise, and as a consulting firm, Segal works with each state’s team and procurement offices to meet their internal needs and requirements.

My curriculum vitae, which describes in detail my professional experience and educational credentials, is attached as Appendix A.

My fees are based on the number of hours worked and are not contingent on the outcome of the case. Segal is compensated at a rate of \$490 per hour for my work. Additional team members who were utilized on the report have Segal billing rates that range from \$356 to \$490 for the Plan.

## **3. Documents and Information Relied Upon**

I have reviewed the two Expert Reports prepared on behalf of Blue Cross and Blue Shield of North Carolina (“Blue Cross” or “BCBSNC”) by the Berkley Research Group, both dated October 4, 2023. Specifically, the following two reports:

The first report is from Mary Karen Wills, CPA. She has three summary opinions, listed below, under **Section IV. Summary of Opinions:**

- a. *The Plan’s final scoring methodology for the RFP—a methodology in which the Plan assigned the vendors one set of points on each of two components, then ranked the vendors based on that first set of points, then assigned a different set of points based on those ranks, and then*

*ranked the vendors again based on that second set of points—failed to follow best practices for procurements.*

- b. The Plan’s scoring methodology for the cost component of the RFP—a methodology that was not explained in the RFP, and that was subjective and unreasoned—did not follow best practices for procurements.*
- c. The Plan’s approach to the technical component of the RFP—an approach in which the Plan barred all narrative responses, yet did nothing to validate any part of the vendors’ technical proposals—did not follow best practices for procurements.*

The second report is from Gregory Russo. He has five summary opinions, listed below, under **Section V. Overview of Opinions:**

*Opinion 1 focuses on the pricing guarantees, for which the Plan and Segal erroneously assigned Blue Cross zero points. The evaluation of these guarantees was flawed because of the subjective and nonquantitative nature of the evaluation. Blue Cross’s guarantees would result in lower costs to the Plan than those proposed by either of the other two vendors. This aspect of the guarantees contradicts the Plan’s and Segal’s conclusion that Blue Cross’s guarantees provided the “least” value.*

*Opinion 2 addresses a discrepancy in the prices and discounts assumed by Aetna for providers with letters of intent. I have found that the discounts Aetna assumed for these providers in its bid are higher than the discounts that will be realized under the signed agreements. This difference will result in higher costs to the Plan than Aetna presented in its bid.*

*Opinion 3 relates to the Request for Clarifications process, in which Segal adjusted Blue Cross’s proposed discounts downward. This adjustment resulted in Blue Cross and Aetna both scoring 6 points for this part of the proposal rather than Blue Cross scoring 6 points and Aetna scoring 3 points. I have found that this adjustment was made based on erroneous assumptions and without equivalent scrutiny of Aetna’s discounts.*

*Opinion 4 concerns the lack of use of an external data source to validate the findings of the repricing exercise. Segal reviewed data that was favorable to Blue Cross, but neither Segal nor the Plan considered this data in its evaluation. The failure to consider this external data further undermines Segal’s decision to adjust Blue Cross’s discount percentage to a level below Aetna’s.*

*Finally, Opinion 5 focuses on the differences between Blue Cross’s and Aetna’s networks—differences that received no weight in the scoring of the proposals. I have found that the Plan and Segal collected detailed data from the vendors but did not use it to compare the networks. I have used the data to show that Blue Cross’s network offers more choices of providers. The data also shows that thousands of Plan members are likely to face disruption if Aetna becomes the TPA on January 1, 2025.*

Other documents I reviewed and relied on in the course of preparing this report are noted in the body and/or in footnotes throughout.

#### 4. Summary Opinion

It is my opinion that the procurement released by the Plan was fair, impartial, fully documented, thoughtfully crafted and reasonable. While BCBSNC may disagree with the result, manipulating scoring methodologies to best meet the needs of one particular vendor is neither in the best interest of the Plan, nor does it represent a best practice. Given the compressed timeframe for my expert opinion, I will focus the report on the key components detailed in their reports and utilized in an attempt to support their summary opinions. It does not appear that either expert from the Berkley Research Group has ever worked on a procurement for a Medical TPA or for any state health plan and neither expert appears to understand the challenges in delivering complicated healthcare benefits to the membership of state health plans.

The opinions offered either have no merit or have no impact on the selection of the winning vendor. Even totally changing the scoring method would have resulted in the same outcome, with Aetna being in first place. The only difference would have been the spread in the scores, not the final order. Clearly, BCBSNC was the last place vendor on the technical proposal – there is no dispute or opinion against that – ranked 3<sup>rd</sup> out of 3. Based on the criteria clearly indicated in the RFP, whether Aetna was 1<sup>st</sup> or 2<sup>nd</sup> on financial would also have no impact on the results, because BCBSNC was 3<sup>rd</sup> in technical and not disputed. The opinions trying to put some question on the results or methodology in the cost proposal are not valid. This report will go through the various opinions and demonstrate that BCBSNC has not identified any mistakes, errors or ways in which the Plan acted unreasonably. Rather, BCBSNC has attempted to selectively change multiple key parts of the RFP design and evaluation and retroactively substitute its own choices for the Plan's, in order to reach an outcome where BCBSNC outsourced the other bidders.

#### 5. Detailed Opinions

##### A. Expert Report Opinions from Mary Karen Wills, CPA from the Berkeley Research Group

***Opinion A: “The Plan’s final scoring methodology for the RFP—a methodology in which the Plan assigned the vendors one set of points on each of two components, then ranked the vendors based on that first set of points, then assigned a different set of points based on those ranks, and then ranked the vendors again based on that second set of points—failed to follow best practices for procurements.”<sup>1</sup>***

Ms. Wills indicates that ranking technical and cost is not common and stating “In my 35-year career, I have reviewed hundreds of RFPs. I have read dozens of books and articles on procurement practices. I have attended numerous conferences about the procurement industry and have had countless conversations with others in the industry. I do not recall ever seeing, or even hearing any mention of, an RFP that used the type of points-to-ranks-to-points-to-ranks scoring methodology that the Plan used here.”<sup>2</sup> However, several other states currently rank bidders’ technical and cost proposals separately. For example, the State of Maryland ranks technical and cost separately and then puts them together for the award recommendation, very similar to what the Plan did in this procurement.

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<sup>1</sup> Wills Report, p. 3, heading VI.A.

<sup>2</sup> Wills Report, p. 5, ¶21.

In SOLICITATION NO. F10B3400022<sup>3</sup>, Health Plan Administration and Services (PPO, EPO, IHM) from the Maryland Department of Budget and Management, Employee Benefits Division, they clearly define that they will rank technical and cost separately. In RFP SECTION 5 – EVALUATION COMMITTEE, EVALUATION CRITERIA, AND SELECTION PROCEDURE they go into great detail on ranking technical and cost proposals. Specifically, they include in 5.5.3:

#### “5.5.3 Award Determination

Upon completion of the Technical Proposal and Financial Proposal evaluations and rankings, each Offeror will receive an overall ranking. The Procurement Officer will recommend award of the Contract(s) to the responsible Offeror(s) that submitted the Proposal(s) determined to be the most advantageous to the State. In making this most advantageous Proposal determination, technical factors will receive equal weight with financial factors.”

Additionally, in their award letter they state:

“Among the four qualified proposals for the PPO, the proposal submitted by CareFirst of Maryland, Inc. (CareFirst) was determined to be the most advantageous for the State. CareFirst’s proposal was ranked number one technically and number two financially, with an evaluated price less than 0.1% higher than the evaluated price of the lowest-priced proposal. It was determined that the merits of CareFirst’s technical proposal outweighed this price differential, and CareFirst’s proposal was determined to be the highest ranked overall.”

I am familiar with other state health plans, that have scored and ranked only the technical component with the intent of getting the best performing vendor, and to negotiate costs only with that one vendor. These plans also indicate if negotiations fall through, they will go to the second place technical vendor and so on. An example of this type is in the Commonwealth of Virginia. The most recent RFP by the Department of Human Resource Management for Administrative Services and Fully Insured Health Benefits Plans<sup>4</sup>, discussed their scoring method in **Section 5.1 of the RFP**:

#### “5.1 METHOD OF AWARD

5.1.1 The Department shall select two or more Offerors per product deemed to be fully qualified and best suited among those Offerors submitting proposals, unless the Department has made a determination in writing that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration. The selection of Offerors will be based on the evaluation factors included in this RFP. Negotiations shall be conducted with the

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<sup>3</sup> See:

<https://dbm.maryland.gov/contracts/Documents/ContractLibrary/EmplBen/HealthPlanAdminSvcs/F10B3400022-RFP.pdf>;

<https://dbm.maryland.gov/contracts/Documents/ContractLibrary/EmplBen/HealthPlanAdminSvcs/F10B3400022-4-S-dbm.pdf>

<sup>4</sup> See:

[https://mvendor.cgieva.com/Vendor/public/VBODetails.jsp?PageTitle=SO%20Details&DOC\\_CD=RFP&Details\\_Page=VBOSODetails.jsp&DEPT\\_CD=A129&INTRNL\\_NO=140650&ID\\_NO=OHB%2019-01&ID\\_VERS\\_NO=1](https://mvendor.cgieva.com/Vendor/public/VBODetails.jsp?PageTitle=SO%20Details&DOC_CD=RFP&Details_Page=VBOSODetails.jsp&DEPT_CD=A129&INTRNL_NO=140650&ID_NO=OHB%2019-01&ID_VERS_NO=1)

selected Offeror(s). Price shall be considered when selecting finalists for negotiation, but shall not be the sole determining factor.

5.1.2 After negotiations have been conducted with each selected Offeror, the Department shall select the Offeror, which, in its opinion, has made the best proposal. The Department shall award the contract to that Offeror. The Department may cancel this RFP, or reject proposals at any time prior to an award. The Department is not required to furnish a statement of the reason why a particular Offeror was not deemed to have made the best proposal (Section 2.2-4359, Code of Virginia).”

The technical scoring procedure is detailed in **Section 6.8 Criteria**:

“Proposals for each Component will be evaluated as listed below:

Component Number One--Statewide PPO and HDHP Medical/Surgical, Behavioral Health (to include EAP), Vision, and Hearing administrative services for the state employee, TLC, and LODA plans:

The total score available for Component Number One is 100 points.

Medical/Surgical, Behavioral Health, and Vision/Hearing are each scored separately, and combined they are worth 80 points. Med/Surg is weighted at 80% of total score for these elements (this is calculated by multiplying the number of earned points by .8). Behavioral Health is weighted at 15% of total score (this is calculated by multiplying the number of earned points by .15), and Vision/Hearing is scored together and weighted at 5% of total score (this is calculated by multiplying the number of earned points by .05).

Offerors must complete and submit a separate Exhibit Two for each Component offered, recognizing that there may be a different mix of small business participation for each Component. Small business participation is scored as a single total for the Offeror, and is worth 20 points.”

The highest ranked technical is then negotiated on the financials. In their notice of intent to award letter they state:

“The Department of Human Resource Management, pursuant to the Request for Proposals (RFP): OHB19-01 Administrative Services and Fully Insured Health Benefits Plans published August 3, 2018, has decided to award a contract for Component One (Statewide Preferred Provider Organization (PPO) and High Deductible Health Plan (HDHP) Medical/Surgical, Behavioral Health (to include Employee Assistance Plan (EAP), Vision, and Hearing administrative services for the state employee, TLC, and LODA plans) to Anthem Blue Cross and Blue Shield to provide the procured services to the Department.

Anthem Blue Cross and Blue Shield provided an excellent proposal, which addressed all required areas in the RFP for Component 1.

The award is based on the careful evaluation of all proposals and negotiations with the finalists. The criteria weights were established prior to the evaluation of the proposals and were not changed thereafter.”

Maryland and Virginia are just two examples of states who use points to determine rankings for technical proposals. Maryland separately ranks their cost proposals and awards a contract based on the combination of the two components. This is no different than how the Plan awarded this contract. Virginia is slightly different, where the complete ranking is based on the highest ranked technical vendor only with award contingent on a successful financial negotiation. Also note, the examples cited are for Medical TPA services which are similar to the procurement issued by the Plan.

Although ranking bidders' technical and cost proposals separately may not be the most common method of procurement, there are states who have used this method and continue to do so. The procurement of a state health plan is challenging and requires unique expertise and experience to perform. It is clearly not the same as the procurements mentioned in the experience of Ms. Wills or the example provided from her referenced "The Request for Proposal Handbook". Furthermore, I do not agree with Ms. Wills' summarization that this is a "points-to-rank-to-points-to-rank" scoring methodology. It seems fairly straightforward and logical that the Plan ranked the technical component and ranked the cost component of the RFP, then came up with an overall ranking for recommendation of award to the Board. In this case, Aetna was ranked the highest on the Technical as well as the Cost, and therefore was recommended by the evaluation committee with the highest overall ranking. This is in contrast with Maryland above where the highest Technical was not the highest ranked Cost, but they were awarded the contract and "determined to be the highest ranked overall".

The Plan clearly defined in the RFP how the technical and cost proposals were going to be scored and rated under **RFP Section 3.4 - Evaluation Criteria**.

RFP Section 3.4(a) first defined the relative weight given to each component.

**a) Overall Scoring Weights:**  
Each Vendor's proposal will be evaluated and scored on several factors. The Technical Proposal includes the written proposal and oral presentation, if applicable. The Technical Proposal and the Cost Proposal will be scored separately based on the overall point scale described below.

*The total points scale will reflect the following weights:*

Technical Proposal	50%
Cost Proposal	50%
<b>Total:</b>	<b>100%</b>

In this procurement, the Plan weighted the technical and cost proposals evenly. The weighting of scores in a given RFP varies based on the state and the importance of each piece. In my experience, the weight assigned to cost proposals varies from 20% to 80% of the total score, with 50% being a common weight for medical TPA procurements. As mentioned earlier, some states negotiate costs after selecting the highest-ranking technical vendor only. The weight given to the cost proposals is highly dependent on what is being procured.

RFP Section 3.4(a) then detailed how each technical proposal was to be evaluated.

**b) Technical Requirements & Specifications:**

Scoring points for the Technical Proposal will be allocated as follows:

<b>TECHNICAL AREAS</b>	<b>MAXIMUM POINTS</b>
Section 5.2.1 Account Management	20
Section 5.2.2 Finance and Banking	19
Section 5.2.3 Network Management	28
Section 5.2.4 Product and Plan Design Management	4
Section 5.2.5 Medical Management	18
Section 5.2.6 Enrollment, EDI, and Data Management	40
Section 5.2.7 Customer Experience	52
Section 5.2.8 Claims Processing and Appeals Management	16
Section 5.2.9 Claims Audit, Recovery, and Investigation	25
Section 5.2.10 Initial Implementation and Ongoing Testing	3
Section 5.2.11 Reporting	48
<b>Total</b>	<b>310</b>

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

This explanation is very clear, showing the relative importance of each section of the technical proposal and the points assigned. It is also very clear that the total points will determine the ranking of the technical proposals. Note that the **Attachment L** to the RFP **Technical Requirements Response** was also made available to bidders when the RFP was posted publicly on August 30, 2022. Attachment L further detailed all the questions in each section, which corresponded to the maximum points listed above.

**RFP Section 3.4(c)** detailed how the cost proposal would be evaluated.

**c) Cost Proposal:**

Cost Proposals will be scored based upon the Vendor's response to ATTACHMENT A. The maximum number of total points will be awarded to Vendor offering the most competitive cost proposal with others receiving points proportionately.

Vendor responses to the cost specifications in ATTACHMENT A will be evaluated in three (3) categories representing 10 total points.

1) Network Pricing – six (6) points

- a) Projected claim costs will be calculated for each Vendor based on their response to the cost specifications.
- b) The highest ranked (or lowest network pricing) proposal will receive the full six (6) points allocated to this section.
- c) All other proposals will be ranked and will receive points based on the following criteria: within 0.5% of the first ranked proposal = 6 points; within 1.0% = 5 points; within 1.5% = 4 points, within 2.0% = 3 points, within 2.5% = 2 points, within 3.0% = 1 point, greater than 3.0% = 0 points.

2) Administrative Fees – two (2) points

- a) Projected administrative fees will be calculated for each Vendor based on their response to the cost specifications.
- b) The highest ranked (or lowest administrative fees) proposal will receive the full two (2) points allocated to this section.
- c) All other proposals will be ranked and may receive one (1) or zero (0) points based on their administrative fees in comparison to the lowest administrative fee proposal and the other proposals.

3) Network Pricing Guarantees – two (2) points

- a) Proposals will be evaluated and ranked based on their proposed network pricing guarantees. The value of the pricing guarantees will be based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk.
- b) The proposal that offers the network pricing guarantees with the greatest value will be ranked the highest and will receive the full two (2) points allocated to this section.
- c) All other proposals will be ranked and may receive one (1) or zero (0) points based on the value of their proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.

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

The evaluation of the cost proposal has 3 components, as opposed to the 11 components in the technical proposal. Again, the RFP very clearly described how the proposals will be evaluated and scored. It also discussed how the Plan will rank the cost proposal as well, which was similar to how the technical proposal would be ranked.

Throughout her report, Ms. Wills repeatedly discusses “best practices”, referencing a book called *The Request for Proposal Handbook*<sup>5</sup> multiple times. While many of the concepts described in the book

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<sup>5</sup> Michael Asner, *The Request for Proposal Handbook* (5<sup>th</sup> ed.2014)

may be utilized by state procurement offices, in my experience, this book is not considered a definitive resource for “best practices” for state health plan procurements. Despite Ms. Wills’ and the author’s opinion, neither myself nor my colleagues are familiar with this book, and I have never heard a single state health plan procurement team talk about this book in my 30+ years of experience.

In my experience, there are no definitive best practices for public procurement that support Ms. Wills’ opinions criticizing the 2022 TPA procurement – procuring agencies employ various approaches based on, among other things, regulatory requirements of their state/municipality and the nature of the goods or services being procured. This is particularly true in the realm of state health plan procurements, which are unique in terms of their goals and complexity. Additionally, Ms. Wills fails to identify any general best practice that would prohibit the Plan from conducting the RFP in the manner it did.

The “good example” Ms. Wills cites in her report<sup>6</sup> is from an RFP for an Integrated Criminal Justice Information System conducted in 2002, over 20 years ago for Tarrant County, Texas. She states, “*The RFP example states that ‘the Points awarded to the Technical and Cost Proposals will be added together to determine the total score and the ranking of each Proposal’*”. This is a common approach, and has been in place for at least 20 years. This simply adds the technical and cost together to get an overall score, but it is not the only way to rank proposals. In the example cited, the county defined how they intended to score the proposals – all points and then rank in total. Similarly, in the 2022 TPA procurement, the Plan clearly explained how they were intending to score and rank the proposals – that the technical and cost proposals would be scored and ranked separately. As the book stated, this 20-year-old RFP was an example (that I note assigned 75% of the total score to technical and only 25% to cost) and there are many ways to evaluate a procurement<sup>7</sup>. The key best practice is to say how you are scoring proposals, which the Plan did – in great detail – throughout the -RFP process.

Doing a cursory review of the book given the short timeline, I do believe there are some valid guidelines in the book that are common sense that most states follow and which are typically reflected in each state’s procurement laws.

Ms. Wills disagrees with the Plan’s use of a ranking approach, which she says skews the scores in the 2022 TPA procurement. She declares: “*The approach that the Plan used here skewed the Vendors’ final scores.*”<sup>8</sup> However, as explained in Sections 3.4(b) and (c) of the RFP (reproduced above), scoring and points were utilized to provide a ranking **only**. Scoring 303 out of 310 points does not necessarily mean that BCBSNC’s technical value is 97.7% of UMR’s and Aetna’s. Instead, it resulted in BCBSNC’s technical proposal landing in last place and, thus, receiving one point, as clearly described in the RFP. Apparently, BCBSNC could not perform at least 7 key technical requirements that Aetna and UMR could. If a ranking system was not going to be utilized, the weights might have been different to put more spread on the numbers. With whatever technical scoring methodology was utilized, the results would have been

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<sup>6</sup> Wills Report, p. 5, ¶23.

<sup>7</sup> See Asner, supra, Chapter 11 (e.g. p. 424-425 “Evaluation criteria are as different as people. Some are very specific and easy to assess. Others are vague and highly subjective; and, some would argue arbitrary...As the RFP is developed, the evaluation criteria are identified...the specific evaluation criteria are based on the specific requirements of the RFP.”; p. 433 “There is no underlying scientific or economic theory that establishes the weights for each evaluation factor. Simply stated, these weights reflect the importance of the factors in that particular agency and in that specific procurement. The weights reflect the best business judgment of the agency as to how to how attain ‘best value’”)

<sup>8</sup> Wills Report, p. 5, ¶25.

identical, with BCBSNC still being in 3<sup>rd</sup> place of the three vendors due to the capabilities requested in the RFP. The Plan selected a prescribed method utilized by other states and documented it clearly in the RFP. I have not seen any evidence or opinions that BCBSNC should not have been third place in the technical proposal.

The same logic would apply to the cost proposal scoring. The scoring was used to develop a ranking of proposals, as explained in RFP Section 3.4(c), with each component having inherent value. This is similar to the technical component having multiple sections (11) with questions in each. Ms. Wills says “Under a best-practices approach, the Plan would have scaled the Vendors’ cost and technical scores to each other”<sup>9</sup>. I disagree that scaling vendors’ technical and cost proposals scores to each other was a “best practices approach” because that statement suggests that any other approach is inferior. Scaling vendor’s scores on the technical and cost proposals to each other, and ranking vendors separately on the technical and cost proposals, are two of many possible approaches that the Plan could have taken, it was up to their discretion. The specific approach was for the Plan to decide, and the Plan clearly explained how the proposals would be scored and weighted – both had ranked scores 3, 2, or 1 and both were weighted equally. The final score added them together, representing exactly the same 50/50 weighting the Plan indicated in the RFP.

Ms. Wills suggests using a different scoring method, which she called the “best practice” ratio method. What Ms. Wills is recommending is irrelevant, because the Plan clearly defined how they would score the proposals, and you cannot change scoring method after the fact. What Ms. Wills fails to mention is that “if” the Plan wanted to use the so called “best practice” ratio method and documented that approach prior to the RFP release, it would not ratio the scores used to develop a ranking, but rather would be based on a ratio of total projected costs. This was how the Plan did the scoring in the prior two Medical TPA RFPs<sup>10</sup>. While using this scoring method would have given BCBSNC the most cost section points due to their lower administrative costs, the overall results would have moved BCBSNC to third place vs. tied for second place in this procurement due to their being last in the technical and losing more points in that section. This methodology also would have produced the same winning vendor, Aetna.

The chart below shows the calculation. For comparison purposes and to be consistent with Ms. Wills’ examples, I ratioed the Cost score to be 310 points. The point allocation could have been any number, as long as they are identical to the technical – making the weight 50/50.

	Technical Score	Total Projected Cost	Cost Ratio	Cost Score	Total Score	Overall Rank
	Out of 310	2025-2027	(Lowest Cost) /Cost	Cost Ratio x 310		
<b>Aetna</b>	310	\$9,932,824,079	99.7%	309.22	619.22	1
<b>BCBSNC</b>	303	\$9,907,723,745	100.0%	310.00	613.00	3
<b>UMR</b>	310	\$10,085,662,123	98.2%	304.53	614.53	2

<sup>9</sup> Wills Report, p. 6, ¶ 26.

<sup>10</sup> See 2019 RFP (deposition exhibit 217, available at: <https://www.shpnc.org/2019-tpa-rfp/download?attachment>); see 2017 RFP (available at: <http://www.bidnet.com/bneattachments/?444625894.pdf>)

I've never seen points or ranking from a cost proposal proportioned like she mentions, it would have been on total using cost projections only, consistent with the above. However, even Ms. Wills' proportional approach had Aetna winning over BCBSNC<sup>11</sup>.

Note that the example above is intended to demonstrate how scoring similar to the last RFP was done. This is not how the 2022 TPA RFP was to be scored – rather it is intended to show that nothing would have changed with regards to the rankings. Furthermore, the Plan thoughtfully developed a new method in this procurement to best meet their long-term goals and objectives.

### In Summary

There was nothing wrong with how the Plan designed the procurement, and the ranking of technical and cost separately is acceptable and reasonable. It is not an uncommon practice, as the two other large states cited above employ similar processes for their procurements, and specifically for their Medical TPA procurements. For all of these procurements, the spread in the scores is not relevant, the order on the rankings is relevant. The paramount best practice in all procurements is for every bidder to have a fair and equal opportunity to be awarded the contract, and this was accomplished. The Plan was very clear in their approach, there was no misunderstanding on how it would be done by vendors, met the objectives of the Plan, and was thoughtful and fair.

***Opinion B: “The Plan’s scoring methodology for the cost component of the RFP—a methodology that was not explained in the RFP, and that was subjective and unreasoned—did not follow best practices for procurements.”<sup>12</sup>***

Once again Ms. Wills repeatedly cites so-called “best practices” in RFPs, but none appear to be in reference to a Medical TPA procurement related to a large state health plan (nor any health plan), suggesting that she does not have that specific expertise. As the Plan described in multiple briefings with the bidders prior to the proposals being submitted, the strategy used in developing this RFP was to modernize it and remove as much subjectivity as possible. Obviously, there are very complicated cost components that require an objective analysis and, at appropriate times, requires some subjective analysis. However, saying this RFP was not explained, unreasoned and fully subjective has no merit, nor is there any argument that supports these allegations. The Plan spent a great deal of time and months of work creating the strategy and re-designing this RFP process. I believe this approach will be used in their procurements going forward and potentially followed by other states.

Applying Ms. Wills' preferred approach would not have resulted in a change to the awarded vendor. The entire scoring model was set forth in the RFP and clearly explained. When the RFP was issued, the Plan provided an opportunity for the bidders to ask questions.

The following is an excerpt from Section 2.3 of the RFP and includes the opening of Section 2.5:

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

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<sup>11</sup> Wills Report, p. 6, ¶ 27

<sup>12</sup> Wills Report, p. 6, heading IV.B.

## 2.5 PROPOSAL QUESTIONS

*Upon review of the RFP documents, Vendors may have questions to clarify or interpret the RFP in order to submit the best proposals possible. To accommodate the Proposal Questions process, Vendors shall submit any such questions by the above due dates. Questions received after these dates will not receive a response.”*

Questions and Answers to the RFP were released on October 14, 2022.<sup>13</sup> The plan received only 1 question on scoring (question #43 shown below) with no question about the ranking approach.

43.	Phase II - General Question	Can you clarify the scoring metrics for each of the required attachments A-L?	Attachment A: “Pricing” and Attachment L: “Technical Requirements Response” will be scored in accordance with RFP Section 3.4 “Evaluation Criteria.” There are no points allocated to Attachments B through K. However, Attachment B: “Instructions to Vendors” and Attachment F: “Supplemental Vendor Information” are required to be submitted in accordance with RFP Section 2.7.2 “Technical and Cost Proposal Contents.” Attachments C, D, E, G, H, I, J, and K were submitted in response to RFP Sections 2.7.1 “Minimum Requirements Proposal Contents” and 5.1 “Minimum Requirements.”
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There were two additional questions asking about the process for clarifications and how the claims repricing should be done, included here to demonstrate how the Plan and Segal were willing to and provided clarity to the bidders.

The response to Question 56 indicates the Plan would use clarifications, which was done.

56.	Attachment A - Pricing 1.2.1 Claims Repricing File	What is the Plan’s evaluation process specific to the review of the repricing (Attachments A) with the qualified vendors? Will there be any question/answer, clarifications or other types of exchanges during the review process in order for the State to fully understand the network value put forth by the vendor? If so, how will those exchanges be handled?	Attachment A: “Pricing” will be evaluated and scored in accordance with RFP Section 3.4.c) “Evaluation Criteria – Cost Proposal.” The Plan will communicate with Vendors as needed through the written request for clarification process.
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The response to Question 61 re-iterated how to do the re-pricing exercise at the time of repricing, not mentioning anything about using a claims trend.

<sup>13</sup> SHP 004848-4859

61.	Attachments A-3 and A-6	<p>Please confirm the claim time period to be used for the repricing analysis is incurred January 2021 through December 2021, paid through June 2022.</p> <p>Please confirm the instructions on attachment A-6 indicate that we should use results on attachment A-3 to illustrate contract improvements for 2025.</p>	<p>The claims data provided for repricing represents incurred January 1, 2021, through December 31, 2021, paid through June 30, 2022. In its response to Attachments A-3, A-4, and A-5, Vendor is expected to reprice each claim line based on provider contracts in place, or near- future contract improvements bound by letters of intent, <u>at the time of the repricing</u>. Vendor's response to Attachment A-6 should reflect anticipated improvements in its reimbursement arrangements from after the claims repricing analysis (i.e., not reflected in the claims repricing) to January 1, 2025.</p>
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Ms. Wills affirmatively states that “*The Plan’s 6-2-2 distribution thus appears to have been chosen without a reasoned basis*”.<sup>14</sup> This is inaccurate. Matt Rish and Dee Jones testified about the Plan’s reasoning for this distribution in their depositions.<sup>15</sup> Ms. Wills repeatedly criticizes the 6-2-2 distribution assigned prior to the RFP release date, but neglects to mention that not a single bidder asked any questions about or objected to the distribution. While Ms. Wills indicates she does not agree with it or like it for her client, she has no justification or support for saying it was without reason. State health plans, and in this case, the Plan, spend a lengthy amount of time preparing RFPs and thinking through all the components, as shown in the excerpts from the depositions cited above and described in more detail below. Regardless of whether Ms. Wills agrees with the Plan’s reasoning, the weighting of the cost proposal components was reasonable, clearly explained in the RFP, and consistent with how the cost proposals were actually scored and ranked.

There are three important financial elements to RFPs in this space – network pricing, administrative fees and pricing guarantees. Network pricing is by far the most important, with paid claims representing nearly 97% of total expenditures, and represents the starting point in the contract period. Administrative costs are fees paid to the vendors for performing the services required in this contract. In this case, the fees are approximately 3% of total projected costs. The last element is the guarantees, which directly relate to the 97% of costs resulting from network pricing as well as the year-over-year

<sup>14</sup> Wills Report, p. 7, ¶ 37.

<sup>15</sup> M. Rish Deposition, pp. 178-190; D. Jones Deposition, pp. 165-167.

change in total cost (or “trend”) of the plan. If a vendor can guarantee better pricing over time and put dollars at risk behind that, it could impact the 97% number and have great importance.

Medical plan procurements have a lot of nuances, but a major component is whether the plan is fully-insured or self-insured. For some products, like the Plan’s Medicare Advantage Employer Group Waiver Plan (EGWP) with Humana, where coordination with federal subsidies makes it beneficial to be fully insured, Humana is at risk for any financial deviations. For large health plans, like a state health plan, it is typical to be self-insured, meaning that the plan holds the risk, avoiding additional risk surcharges and profit margin from the vendor, in exchange for lowering administrative costs. With that in mind, the primary goal for large self-insured plans, like the Plan, is to obtain good pricing, a vendor’s commitment to manage future costs and to have the vendor be at risk for that pricing and trend as much as possible, without having the larger administrative load that comes with fully insured products – typically 10-15% of costs for fully insured vs. 3% noted above for self-insured plans. Note that a pharmacy benefit contract with a Pharmacy Benefit manager (PBM) is often self-insured and typically has guarantees that are paid dollar-for-dollar, meaning they pay a minimum of the contract guarantees and not a percentage of their administrative fees. For pharmacy plans, this can have very a big impact on the financial analysis. While the medical market is slowly moving this way, currently it is not the same pharmacy and PBM market. I believe the Plan was hoping to get a greater value in the previous medical TPA procurement in 2019, but got a small incremental guarantee, which would have a negligible impact on the plan costs due to the low amounts at risk<sup>16</sup>.

As a result of the limited guarantees resulting from the prior medical TPA procurement – which resulted in BCBSNC being awarded the contract – It would be reasonable for the Plan to assign a greater weight to the administrative costs and pricing guarantees in order to encourage vendors to offer a more aggressive guarantee, while not increasing the administrative costs to cover it. Additionally, it would be reasonable to weight administrative costs and pricing guarantees equally to avoid vendors significantly increasing their fees to offset an aggressive guarantee. By weighting equally, it would deter this approach. This approach seems very reasonable to me and a good goal for the procurement.

Additionally, over time we have seen network pricing converge for the vendors. It is reasonable to assume that, if a new vendor is awarded the contract with a large state health plan, the vendor will have increased purchasing power within the state and would have improved negotiation clout in their upcoming contract renewals, further converging the numbers toward the mean. In addition, there was a strategy described in the technical section to have a vendor that could help them negotiate a narrow network, similar to the Plan’s current Clear Pricing Project (CPP), which would generally put less weight on the current pricing contracts. This further supports the reasonableness of not apportioning 97% of the points to network pricing and giving more proportional weight to both the administrative fees and pricing guarantees.

Ms. Wills goes on to say, “*The Plan’s methodology for awarding points for administrative fees and for network-pricing guarantees was not explained in the RFP, resulting in a subjective and unreasoned point scoring method*”.<sup>17</sup> I disagree. The methodology was clearly defined in Section 3.4(c) of the RFP and the scoring was based on the competitiveness of the bids. BCBSNC had administrative fees that were very

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<sup>16</sup> See BAFO #3 2019 RFP.

<sup>17</sup> Wills Report, p.8, ¶ heading B.ii

low and received the full points for the administrative fees. By contrast, UMR's administrative fees were the highest, with fees 60% higher than BCBSNC; UMR received 0 points. Aetna's fees were 30% higher than BCBSNC's and received the midpoint, which was reasonable and based on objective information. They were scored 2, 1 and 0 appropriately as it said in the RFP.

As I mentioned earlier, guarantees are significant when there is a reasonable target and a significant financial component at risk. In scoring pricing guarantees, it is not possible to avoid some subjectivity<sup>18</sup>, but the guarantees in the TPA RFP were scored fairly, based on objective information. Ms. Wills criticizes the scoring of the pricing guarantees as subjective.<sup>19</sup> While objectivity is a worthwhile goal, subjectivity cannot always be avoided, as noted above. In this procurement, a fair quantitative methodology to rank the pricing guarantees could not be determined until cost proposals were received, because of the uncertainty about how vendors' guarantees would be structured and the probability that any model that was designed in advance might have to be changed to fairly compare the bidders.<sup>20</sup>

Once the cost proposals were submitted and reviewed, it was clear that BCBSNC had the lowest amount at risk, even though some of their targets may have been more competitive. So, although BCBSNC's proposal offered a more favorable discount guarantee target, with so little at risk in actual dollars the guarantee targets become less impactful or meaningful. UMR, on the other hand, proposed dollar-for-dollar amounts at risk up to their entire administrative fee. On the discount guarantee, BCBSNC had the lowest amount at risk by far with only \$2.6 million compared to UMR with \$95 million and Aetna with \$22 million. Similarly on the trend guarantee, BCBSNC had approximately \$2.6 million at risk, with UMR at \$47 million and Aetna at \$22 million. The trend guarantee targets were more comparable than the discount targets. Clearly, UMR had the most valuable guarantee and BCBSNC the least valuable, primarily due to BCBSNC's small amount at risk, with Aetna in the middle. Points were awarded this way, 2, 1 and 0 appropriately as it said in the RFP. Later in this report I will go into more details while discussing Mr. Russo's expert report.

Ms. Wills cites an example RFP provided by Segal to the State that did not include points assigned to network pricing guarantees and incorrectly concludes that this indicates a lack of importance.<sup>21</sup> Network pricing guarantees have been assigned points to varying degrees in a number of Segal medical TPA RFPs. Specifically in Ms. Wills response, she cites our example in our RFP Proposal Response in 2018. She references our sample work in the State of Wisconsin in 2016 from that proposal. Ms. Wills, however, fails to acknowledge that Segal clearly assigned three (3) points on page "SHP 0004079" to "Fees at Risk for Discount Guarantees".

In my opinion, it was perfectly reasonable to use the 6-2-2 weighting on the cost proposals to determine the overall score that best meets the RFP objectives. It sends the correct message to the vendors on what is important for long-term success of the Plan. It was also scored fairly and as objectively as possible.

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<sup>18</sup> S. Kuhn Deposition, pp. 190-193

<sup>19</sup> Wills Report, pp. 9-11, ¶¶ 47-63.

<sup>20</sup> Kuhn Depo, pp. 160-165, 170-173, 190-193; SHP 70486-70490.

<sup>21</sup> Wills Report, p. 8, ¶ 39

Ms. Wills states that “best practice for awarding points for parts of an RFP is to use a process that is (a) described in the RFP, (b) objective, and (c) rational”.<sup>22</sup> I agree with that statement as a general principle, and all of these were included in the Plan’s processes – the cost proposal scoring was clearly defined in the RFP and through the Q&A process, and it was highly rational and as objective as possible. Once again, just because Ms. Wills does not like the Plan’s newer approach does not mean there was anything wrong with or unreasonable about the process. Note that practice identified by Ms. Wills has been done for years and has not resulted in the healthcare system controlling costs in our country.

Ms. Wills also states: “As another example, the RFP Handbook states that an RFP should ‘provide potential responders with an understanding of how proposals will be reviewed, both individually and in comparison, with other proposals.’”<sup>23</sup> In my opinion, when compared with the Medical TPA RFPs for other large states, the Plan’s description of the cost proposal scoring weights and methodology were very clear in the Plan’s RFP, on which virtually no questions from the vendors were received. It is also much more detailed than the majority of state Medical TPA procurements, where it’s not uncommon to provide only the technical and cost weightings.

***Opinion C: The Plan’s approach to the technical component of the RFP—an approach in which the Plan barred all narrative responses, yet did nothing to validate any part of the vendors’ technical proposals—did not follow best practices for procurements.***

The modernized, non-narrative format for the technical proposals was deliberately and thoughtfully designed by the Plan to address the Plan's needs and the clear disadvantages of the narrative format used in previous RFPs. Regardless of whether Ms. Wills has seen this type of approach, it was a valid, reasonable format for the technical proposal. The Plan followed this approach for a number of reasons, including:

- Making the evaluation process much more objective.
- Shortening the process and reducing the Plan staff's time and energy necessary for evaluations.
- Reducing the burden on vendors responding to the RFP.
- Eliminating vague and equivocal responses that can be used by vendors to avoid performing contract obligations they supposedly agreed to.<sup>24</sup>

I have observed that state agencies are increasingly trying to improve efficiency by limiting the number of questions in RFPs that can be answered using large, lengthy responses that often don’t answer the question asked. Technical proposals are moving in the direction of a required services for vendors. I am currently aware that Segal will be issuing an RFP for another State Health Plan using exactly this format – yes/no with no clarifications.

Ms. Wills appears to think the Plan should have used a narrative format as a means to validate bidders’ technical proposals.<sup>25</sup> However, in my experience, narrative responses to technical requirements are long and convoluted, both requiring a great deal of time and effort to review and score and creating an inherently subjective evaluation and scoring process. Further, this form of proposal often does little to

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<sup>22</sup> Wills Report, p. 9, ¶ 48

<sup>23</sup> Wills Report pp. 9-10 ¶ 51

<sup>24</sup> D. Jones Affidavit (Deposition Exhibit 13); D. Jones Deposition, pp. 21-23, 68, 162, 245-253.

<sup>25</sup> Wills Report, p. 12, ¶¶ 66-75.

ensure that a vendor will actually perform a given obligation, and very often include qualifications, limitations and equivocal language that undermine the bidder's commitment to meet the relevant requirement. As a result, in my opinion, it was very reasonable for the Plan to determine that any benefits of a narrative format were outweighed by the disadvantages.

Ms. Wills declares *"The Plan also failed to follow best practices in its approach to evaluating the RFP's technical component. That is the case because the Plan barred the Vendors from submitting any narrative responses in their technical proposals, and did nothing to validate any part of the Vendors' technical proposals"*.<sup>26</sup> The Plan barred the vendors from submitting narrative responses in order to limit the bidders' ability to obfuscate their responses. For example, the Plan's prior TPA RFP, permitted long, narrative responses and I believe BCBSNC was still unable to process claims in a timely manner using its new claims processing system, and ultimately paid large fines to the Plan as a result. It is also not typical or necessary to validate all the elements in a Medical TPA procurement, which becomes part of their contract.

Again Ms. Wills cites no experience with state health plans, and instead cites a 20-year-old, non-health plan example from the RFP handbook: *"The Tarrant County, Texas RFP referenced in the RFP Handbook illustrates the best practice for a technical evaluation. In that example, technical proposals were "scored according to how well [each vendor] responded to each of the requirements in the Technical Proposal Section." The technical proposals were not scored, as here, simply by counting each vendor's 'confirm' responses."*<sup>27</sup> As discussed above, many current RFPs use a number of yes/no answers and are electronic, designed to simplify and control vendor responses. The goal is to avoid responses that don't directly answer the question. From my cursory review of the technical proposal, the Plan's TPA RFP's questions are binary questions that do not require narrative answers. For example, an excerpt from the RFP Technical Response question is below:

*"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.*
- 5) Vendor analytical system alerts, such as gaps in care.*
- 6) Progress towards incentives earned, if applicable."*

Each subsection is a binary question that would not require, nor need, a lengthy response. An explanation from a bidder saying why cannot or will not meet the requirement does not change the fact that the requirement is not met and would have gotten a "0" for that score vs. a "1" for those who can. I believe this format was reasonable, and it is standard to expect binary answers to direct yes/no questions.

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<sup>26</sup> Wills Report p. 11, ¶ 64

<sup>27</sup> Wills Report, p. 12, ¶ 68.

If any vendor believed that a given technical requirement was unreasonable, impossible, or that there were “potential circumstances that could cast doubt on a ‘confirm’ response in some cases,”<sup>28</sup> they had the opportunity in advance to ask questions or ask the Plan to remove that technical requirement. I do not believe there were any questions asked by vendors during the Q&A period related to technical responses and asking whether they could provide a narrative answer. I also do not believe there were any question specific to items a specific vendor knew they would lose points for. If vendors had an issue, they should have asked a question like: “What if the answer is not clear, for example...how should we respond?”. The RFP was issued on August 30, 2022, and deadline for vendor questions was October 10, 2022. Vendors had more than a month to review all the RFP documents and raise any questions or concerns regarding the inability to provide narrative responses in the technical section. The lack of vendor questions indicates that the vendors were not concerned about the yes/no nature of the technical questions. Without those questions it seems clear, to anyone who reads the RFP, what they should expect in scoring and the “ATTACHMENT L Technical Requirements Response” was available for them at the RFP release as well. They could easily have questioned it, since it was obvious how it would be scored. They had the points in the Scoring Description, 310, and it matched the number of questions/answers, 310 – obviously 1 point per question.

Ms. Wills again says: *“Based on my 35 years of experience reviewing RFPs, studying literature on procurement practices, attending conferences, and working with other practitioners in the industry, my view is that the underlying purpose of a technical evaluation is served by an approach that allows at least some narrative responses and involves at least some validation of vendors’ technical proposals.”*<sup>29</sup> I am not aware of Ms. Wills having worked for a single state health plan in conducting a Medical TPA procurement or has any expertise in Medical TPA procurements in general. This may be an approach she is not familiar with, but it was fair and reasonable.

Ms. Wills concludes her opinions by stating: *“Finally, it is worth noting that in my 35 years of experience reviewing RFPs, I have never seen an RFP where, as here, each technical requirement is weighted equally. Typically, I would expect to see each technical requirement weighted based on the relative importance of that requirement, which was not done here”*.<sup>30</sup> Note that there are 11 sections in the technical component, all with different weighting based on the number of questions. One could assume the importance of each requirement or section is incorporated in the weight and number of questions. On a high-level review of the point distribution, it seems reasonable.

In Opinion B, Ms. Wills criticizes the RFP setup for having subjective review built into the cost proposal around the guarantees. As we discussed, this was as objective as possible, but it did include some element of subjectivity given the ability for varied responses related to targets and amounts at risk. Conversely, in Opinion C, Ms. Wills criticizes the RFP for not having subjectivity in the technical proposal. We recognize that this is a newer approach, but it was 100% in line with the Plan’s goals and objectives clearly documented from the start. In the Plan’s Media Briefing Presentation, they were very clear one of the goals was to remove subjectivity as much as possible and streamline the responses.<sup>31</sup> I am not

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<sup>28</sup> Wills report, p. 12, ¶ 67

<sup>29</sup> Wills report, p. 13, ¶ 71.

<sup>30</sup> Wills report, p. 14 ¶ 77

<sup>31</sup> See <https://www.shpnc.org/tparfptransparencymediabriefing/download?attachment>, p. 17

sure which approach Ms. Wills is recommending. It seems to change based on whatever would have produced the best scoring for BCBSNC in each component.

**B. Expert Report Opinions from Gregory Russo from the Berkeley Research Group**

***“Opinion 1 focuses on the pricing guarantees, for which the Plan and Segal erroneously assigned Blue Cross zero points. The evaluation of these guarantees was flawed because of the subjective and nonquantitative nature of the evaluation. Blue Cross’s guarantees would result in lower costs to the Plan than those proposed by either of the other two vendors. This aspect of the guarantees contradicts the Plan’s and Segal’s conclusion that Blue Cross’s guarantees provided the “least” value.”<sup>32</sup>***

Mr. Russo appears to have misunderstood how the guarantees work and what is important. He says “Based on the information I have reviewed, Segal put little or no weight on the most valuable component of the pricing guarantees: the claims costs that would result from achievement of the targets guaranteed by each of the vendors. Instead, Segal’s scoring approach focused almost entirely on Segal’s view of the maximum amount of administrative fees placed at risk by each vendor, even though the comparative volume of any such refund is small compared to the Plan’s overall claims cost.”<sup>33</sup> If the guarantee was paid 100%, “dollar for dollar” on the miss vs. a percentage of their admin (on average 3% of costs), then I would agree with Mr. Russo completely. I discussed earlier that Pharmacy PBM contracts, in fact, have this type of “dollar for dollar” guarantee and thus forms the basis for their entire cost analysis. But that is not the case here.

I think Mr. Russo’s analysis simply shows that, all else equal, achieving a higher discount would result in lower costs.<sup>34</sup> If BCBSNC would have guaranteed an 80% discount, (even though it is unobtainable) it would have unjustifiably made Mr. Russo’s numbers look even better for BCBSNC. In fact, in Mr. Russo’s example, it would not matter at all if the vendor had **no money at risk** and his analysis would still show that it’s the best overall value.

**It is obvious and common sense that more money at risk is important to align incentives between the Plan and the vendor.** A guarantee with minimal financial components at risk is practically worthless, even with a higher guaranteed target. Putting 5% of administrative costs at risk that represent 3% of total costs for the Plan, means the plan only has downside protection representing 0.15% of the total costs. For real commitment by the vendor, there would have to be a larger share of their fees at risk, making achievement of the target more likely by aligning their incentives. This seems like a fairly basic concept – a guarantee with no risk is not much of a guarantee at all.

There are a couple of White Papers published by actuarial companies that discuss medical claims repricing and discount analyses – specifically, one by Milliman,<sup>35</sup> and another by Wakely<sup>36</sup> In these White Papers, they discuss many of the concepts we mention throughout our report. Regarding guarantees, the Milliman report states, “A competitive discount without a strong guarantee offers little

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<sup>32</sup> Russo report, p. 5

<sup>33</sup> Russo report, p. 10

<sup>34</sup> Russo report, pp. 23-26, Fig. 5, 6, 7

<sup>35</sup> *Determining Discounts*. <https://www.milliman.com/en/insight/healthreform/determining-discounts/>

<sup>36</sup> *WakeDat: Frequently Asked Questions*

<https://www.wakely.com/sites/default/files/files/content/wakedatfaq.pdf>

consolation to the employer if the promised discount is not realized”. They go on to say, “A guarantee that reimburses an employer on a dollar-for-dollar basis or on a percentage of the missed discount helps mitigate the downside risk for the group.”

Below is a quick summary of the three bids’ percentage amount at risk for the discount, percentage of Medicare and trend guarantees. Note the trend guarantee does not apply in the first year of the contract, and for UMR it is the only guarantee in 2026 and 2027, with 50% of fees at risk. In stark contrast, for the trend guarantee, BCBSNC is only offering an additional 5% at risk in both years with Aetna is in the middle at 25%.

<b>2025 Guarantees</b>				
<b>% of Admin</b>	Discount	Medicare	Trend	Annual Max
<b>Aetna</b>	25%	20%	N/A	45%
<b>BCBSNC</b>	5%	5%	N/A	10%
<b>UMR</b>	100%	25%	N/A	100%

<b>2026 and 2027 Guarantees</b>				
<b>% of Admin</b>	Discount	Medicare	Trend	Annual Max
<b>Aetna</b>	25%	20%	25%	45%
<b>BCBSNC</b>	5%	5%	5%	15%
<b>UMR</b>	None	None	50%	50%

Mr. Russo asserts that “*Segal erroneously assumed that Blue Cross’s maximum amount at risk for all of the discount guarantees and all of the percentage-of-Medicare guarantees—as a group—was a total of 5 percent of the administrative fees.*”. In each of the guarantees (discount guarantees and percentage-of-Medicare guarantees), BCBSNC included a statement for each major service category (Inpatient, Outpatient and Professional) that specifically stated “subject to maximum payout (‘cap’) of 5% of that year’s total administrative fee” with the exact same language for each. There was no definition of the ‘cap’, and Segal interpreted the ‘cap’ in each category (discount guarantees and percentage-of-Medicare guarantees) as one total amount on each. Additionally, BCBSNC included under the trend guarantee a slightly different language from the other six. It reads, “subject to cap of 5% of that year’s total administrative fee”.<sup>37</sup> This slightly different language provided additional indication that the 5% was across the three service categories and not individual guarantees for each. While I see how it could be interpreted in the way Mr. Russo describes above, Segal’s interpretation was reasonable given no additional information.

Mr. Russo goes on to state “*As the above quotes from Blue Cross’s Administrative Fee BAFO show, Blue Cross proposed three separate payouts related to discount targets and three separate payouts related to percentage of Medicare targets, each involving up to 5 percent at risk—a total of 30 percent at risk. In addition, Blue Cross also placed 5 percent of its administrative fees at risk under the trend guarantee, for a grand total of up to 35 percent of the administrative fees at risk.*”<sup>38</sup> Nowhere in BCBSNC’s response

<sup>37</sup> Russo report, p. 17

<sup>38</sup> Russo report, p. 19

did they express having 35% of administrative fees at risk. Blue Cross’s discount guarantee in the current contract, which includes BAFO#3 that BCBSNC submitted in the prior RFP, states: *“The maximum payout for all guarantees including operational guarantees, operational flat dollar guarantees, discount guarantees, Medicare guarantees and trend guarantees in any given contract year is 25% of administrative fees for that contract year.”* There was nothing in the proposal to clarify or make their bid clearly read 35% and it was reasonable to assume the 15% amount (combined for discount, percentage of Medicare, and Trend) was consistent with the current 25%, that included operational guarantees in the total. Note that both of the other vendors clearly expressed what their annual amount at risk was in their financial proposal, where BCBSNC did not.<sup>39</sup> We believe the 15% (combined for discount, percentage of Medicare, and Trend) was a reasonable interpretation.

Note that even if BCBSNC’s intent was to have 15% vs. 5% per category, their total percentage at risk would still be the lowest of the three bidders. In 2024, BCBSNC would have been 30% vs. UMR at 100% and Aetna at 45%, as specified in their cost proposals. Adding in the trend guarantee in 2025 & 2026 would have given BCBSNC 35% vs. UMR at 50% and Aetna at 45%. The same exact order that Segal scored the guarantees – UMR Ranked 1<sup>st</sup>, Aetna Ranked 2<sup>nd</sup> and BCBSNC Ranked 3<sup>rd</sup>. That would be a better guarantee for BCBSNC and would have been more competitive; however, they still would have been 3<sup>rd</sup> place.

As Mr. Russo mentions, there were three (3) different pricing guarantee categories: the discount guarantee, percentage of Medicare guarantee pricing and the trend guarantee. Each guarantee is important in its own right, and I’ll go through the analysis for all three individually. Pricing guarantee scoring was based on reviewing all the proposals individually and in comparison to each other.

1. Discount Guarantee

BCBSNC had the highest discount target, but also had the lowest amount at risk at 5% of administrative fees and the lowest payout schedule with 10% of the shortfall. UMR offered a competitive guarantee target, but also placed the greatest amount at risk with 100% of their fees and a “dollar for dollar” payout schedule for any shortfall. Aetna falls between BCBSNC and UMR with 25% of fees and a payout schedule with 20% of the shortfall.

Using all the above-mentioned guarantees, we have calculated the expected payout based on the Plan achieving a discount level in 2025 (note that the yellow line represents the current discount of 51.8%).

	Baseline	Aetna	BCBSNC	UMR
<b>Current Discount</b>	51.8%	53.0%	52.7%	52.5%
<b>Discount Guarantee</b>		52.3%	55.1%**	52.6%
<b>Amount at Risk</b>		\$22,305,000	\$2,653,000	\$95,101,000
<b>Shortfall Payment</b>		20% of miss up to 25% of admin	10% of miss up to 5% of admin	100% of miss up to 100% of admin*
<b>Achieved</b>	2025 Actual	Payout		
<b>Discount</b>	Claims	Aetna	BCBSNC	UMR

<sup>39</sup> See BAFO #3 2019 RFP.

50.3%	\$3,195,666,902	\$22,305,000	\$2,653,000	\$95,101,000
50.8%	\$3,166,135,115	\$17,719,072	\$2,653,000	\$95,101,000
51.3%	\$3,136,603,328	\$11,812,715	\$2,653,000	\$76,782,646
51.8%	\$3,107,071,541	\$5,906,357	\$2,653,000	\$47,250,859
52.3%	\$3,077,539,754	\$0	\$2,653,000	\$17,719,072
52.8%	\$3,048,007,967	\$0	\$2,653,000	\$0
53.3%	\$3,018,476,180	\$0	\$2,653,000	\$0
53.8%	\$2,988,944,393	\$0	\$2,653,000	\$0
54.3%	\$2,959,412,606	\$0	\$2,653,000	\$0
54.8%	\$2,929,880,819	\$0	\$1,771,907	\$0
55.3%	\$2,900,349,032	\$0	\$0	\$0

\* Note that UMR’s discount guarantee is only for 2025. In 2026 & 2027, UMR offers the trend guarantee only.

\*\* Note that BCBSNC’s total was a weighted average of repricing data, Aetna & UMR proposed an overall target.

A review of this component in isolation would put UMR as the most competitive offer, with their discount target in line with their current discounts and offering a “dollar-for-dollar” difference on the miss (or shortfall) up to their full administrative fee. Aetna offers a competitive amount at risk and payout schedule, but has discount targets slightly below their current discount levels. Note that BCBSNC also only pays 10% of the miss, with Aetna paying 20% and UMR paying 100%. Both UMR & Aetna have stronger downside guarantees with a significant amount at risk.

It is slightly subjective since UMR’s whole guarantee goes to the Trend Guarantee after 2025, but their amount at risk in 2025 is still significantly more than the other vendors would put at risk for all three years. It’s important to note that we focus more on trend guarantees after the first contract year as a vendor’s ability to manage year-over-year claims increases becomes more important to the total program cost.

## 2. Percentage of Medicare

Over the years the Plan has had challenges getting claims repriced as a percent of Medicare. It is also our understanding that, without the annual percentage of Medicare calculations, the Plan has not been able to evaluate PGs related to these percentage of Medicare guarantees going back to the 2019 contract.

With the above in mind, Segal did not have the exact percentage of Medicare current reimbursement levels and could not get an accurate analysis to look at its overall value. Without the baseline data, it is difficult to determine if the guarantees would be valuable. It is important to note that the guarantee is a crucial component for the Plan to get into a contract, with the long-term plan to move reimbursement in this direction with reference-based pricing and away from fee-for-service discounts.

Therefore, Segal did not incorporate these guarantees into the scoring, despite the results being fairly consistent with the discount guarantee review. Aetna’s percentage of Medicare guarantee does appear to be more competitive than UMR’s over the three-year contract, and BCBSNC’s guarantee remains the least competitive.

Below is a summary of the proposed guarantees for each vendor by type of service:

<b>Year 1: 2025 Guarantee</b>	<b>Aetna</b>	<b>BCBSNC</b>	<b>UMR</b>
<b>In-State *</b>			
<b>Inpatient Hospital</b>	205%	179%	182%
<b>Outpatient Hospital</b>	362%	308%	322%
<b>Professional</b>	154%	182%	156%
<b>Overall Total ** (In &amp; Out-of-State)</b>	216%	232%	222%
<b>Payout Schedule</b>	10% of shortfall	10% of shortfall	Payout ranges in increments of 5% of admin
<b>% Of Admin at Risk</b>	20%	5%	25%
<b>\$ at Risk in 2025</b>	\$17.8 million	\$2.7 million	\$23.8 million

\* In-State claims represent the majority of the Plan's claim costs.

\*\*Note that BCBSNC's total was a weighted average of repricing data, Aetna & UMR proposed an overall target<sup>40</sup>.

Aetna and UMR had the most competitive guarantees in Year 1. Aetna had the lowest target (meaning the best target), and UMR had the most at risk with a slightly higher target. BCBSNC was behind in both target (due to professional) and amount (% and \$) at risk.

For Years 2 & 3 of the contract, BCBSNC's percentage of Medicare numbers improved by about 1% each year, with Aetna having the same target. UMR chose to put all their guarantees into the trend guarantee and only offered a percentage of Medicare guarantee for year 1 of the contract. Note that UMR's trend guarantee was significant, and the base year should include all the data from their discounts and percentage of Medicare experience as a baseline.

Overall, for this category in isolation, Aetna would have the highest ranking due to the 3-year guarantee and BCBSNC would be a distant third, having the lowest ranking based on their target and 3-year total at risk being significantly less than UMR's Year 1 at risk amount. UMR would be in the middle.

I further note that had the Plan applied the methodology chosen by Mr. Russo to compare in the discount analysis, BCBSNC would have the highest overall costs of the three vendors, with Aetna having the lowest. As previously noted, in evaluating the cost proposals, Segal could not calculate to the absolute number because Segal did not have the current percentage of Medicare reimbursement levels, but the relative value of the calculations above are valid.

While Segal did not reflect the percentage of Medicare guarantees in the scoring, incorporating them would not have changed the pricing guarantee scoring and the results of the cost proposal analysis would be the same with UMR getting 2 points, Aetna 1 point, and BCBSNC 0 points.

### 3. Trend Guarantee

The last component is a guarantee as to how much the overall claims would increase in the additional contract years. This guarantee focuses on the overall management of the costs by the vendor and how they believe they can impact trends. In theory, if the discounts improve, one would expect the trend to

<sup>40</sup> See Segal Pricing Guarantee Analysis, SHP 69503

be lower, reflecting that impact. So, we would expect a vendor with higher improvements in their discount guarantees to have a lower trend guarantee target to be consistent.

For example, an increase in the discount of 1%, from 52% to 53% would have costs decrease by over 2%, with what the Plan paying dropping from 48% to 47% of the charge amount (98% or 47% divided by 48%). The remaining contributing factors to trend would be medical inflation and utilization changes.

As noted in my comments regarding the discount guarantees, in analyzing this RFP response Segal focused more on trend guarantees after the first contract year as a vendor’s ability to manage year-over-year claims increases becomes more important and incorporates the actual discount/percent-of-Medicare achieved.

The vendors bid the following trend guarantees:

	<b>Aetna</b>	<b>BCBSNC</b>	<b>UMR</b>
<b>2026</b>	6.81%	6%	1% less than UMR book-of-business
<b>2027</b>	7.06%	6%	
<b>% Of Admin at Risk</b>	25%	5%	50%
<b>\$ at Risk in 2026</b>	\$22.3 million	\$2.7 million	\$47.6 million

UMR’s trend guarantee was the most competitive in both the target and amount at risk. While I would have liked to have UMR propose a fixed maximum target number, that does not mean using their book-of-business (BOB) is a bad deal for the Plan.

Looking at Segal’s 2024 Health Plan Cost Trend Survey<sup>41</sup>, the average actual cost increase over the last 10-years for open access PPO plans has been 5.96%. If we review the trend data provided in Addendum 2 to RFP, Question 47, the Plan has had a 6.17% trend over the last 5-years.<sup>42</sup> This was very comparable to the Segal trend survey that showed 6.22% over that same period.

<b>Year</b>	<b>Segal Trend Survey*</b>	<b>State Health Plan**</b>
<b>2013</b>	5.7%	
<b>2014</b>	6.5%	
<b>2015</b>	6.8%	
<b>2016</b>	7.1%	
<b>2017</b>	6.7%	3.5%
<b>2018</b>	6.3%	5.0%
<b>2019</b>	6.8%	3.8%
<b>2020</b>	-2.1%	2.9%
<b>2021</b>	14.0%	16.2%
<b>2022</b>	2.5%	
<b>2013-2022</b>	5.96%	
<b>2017-2021</b>	6.22%	6.17%

<sup>41</sup> See: <https://www.segalco.com/consulting-insights/2024-health-plan-cost-trend-survey>

<sup>42</sup> SHP 004848-4859

\* Reported in 2024 Segal Health Plan Cost Trend Survey

\*\* Reported in Q&As released in Addendum 2 to RFP, Question 47

Although it is not a hard percentage, UMR BOB numbers are expected to be similar to the market and are very competitive. With the large amount at risk, it is fair for them to incorporate market changes from a broader perspective. The UMR guarantee becomes more competitive if industry trends are lower than expected, while providing less protection if trends are higher than projected. In any event, UMR’s amount at risk far exceeds the other vendors.

Using all the above-mentioned guarantees and assumptions, we have calculated the expected payout based on the Plan trend realized in 2026, the shortfall payment method and the amount at risk. We have also assumed a \$3B starting point for 2025 in the analysis. Note that the yellow line is approximately what the plan has achieved historically, 6%.

		<b>Aetna</b>	<b>BCBSNC</b>	<b>UMR</b>
<b>Trend Guarantee</b>		6.81%	6.00%	4.96%*
<b>Projected 2025</b>	\$3,000,000,000			
<b>Amount At Risk</b>		\$22,305,000	\$2,653,000	\$47,550,000
<b>Shortfall Payment</b>		3% for every % different up to 45% of admin	10% of miss up to 5% of admin	10% for every % different up to 50% of admin
	2026 Actual	Payout		
<b>Trend</b>	Claims	Aetna	BCBSNC	UMR
<b>4.0%</b>	\$3,120,000,000	\$0	\$0	\$0
<b>4.5%</b>	\$3,135,000,000	\$0	\$0	\$0
<b>5.0%</b>	\$3,150,000,000	\$0	\$0	\$9,510,000
<b>5.5%</b>	\$3,165,000,000	\$0	\$0	\$9,510,000
<b>6.0%</b>	\$3,180,000,000	\$0	\$0	\$19,020,000
<b>6.5%</b>	\$3,195,000,000	\$0	\$1,500,000	\$19,020,000
<b>7.0%</b>	\$3,210,000,000	\$508,554	\$2,653,000	\$28,530,000
<b>7.5%</b>	\$3,225,000,000	\$1,846,854	\$2,653,000	\$28,530,000
<b>8.0%</b>	\$3,240,000,000	\$3,185,154	\$2,653,000	\$38,040,000
<b>8.5%</b>	\$3,255,000,000	\$4,523,454	\$2,653,000	\$38,040,000
<b>9.0%</b>	\$3,270,000,000	\$5,861,754	\$2,653,000	\$47,550,000
<b>9.5%</b>	\$3,285,000,000	\$7,200,054	\$2,653,000	\$47,550,000
<b>10.0%</b>	\$3,300,000,000	\$8,538,354	\$2,653,000	\$47,550,000
<b>10.5%</b>	\$3,315,000,000	\$9,876,654	\$2,653,000	\$47,550,000
<b>11.0%</b>	\$3,330,000,000	\$11,214,954	\$2,653,000	\$47,550,000
<b>11.5%</b>	\$3,345,000,000	\$12,553,254	\$2,653,000	\$47,550,000
<b>12.0%</b>	\$3,360,000,000	\$13,891,554	\$2,653,000	\$47,550,000
<b>12.5%</b>	\$3,375,000,000	\$15,229,854	\$2,653,000	\$47,550,000
<b>13.0%</b>	\$3,390,000,000	\$16,568,154	\$2,653,000	\$47,550,000
<b>13.5%</b>	\$3,405,000,000	\$17,906,454	\$2,653,000	\$47,550,000
<b>14.0%</b>	\$3,420,000,000	\$19,244,754	\$2,653,000	\$47,550,000
<b>14.5%</b>	\$3,435,000,000	\$20,583,054	\$2,653,000	\$47,550,000

<b>15.0%</b>	\$3,450,000,000	\$21,921,354	\$2,653,000	\$47,550,000
<b>15.5%</b>	\$3,465,000,000	\$22,305,000	\$2,653,000	\$47,550,000
<b>16.0%</b>	\$3,480,000,000	\$22,305,000	\$2,653,000	\$47,550,000

\*UMR Trend Guarantee is their BOB less 1%. The 4.96% is calculated based on the 10-year survey average

Consistent with our prior analysis, BCBSNC’s guarantee at 6% is competitive, but their amount at risk, whether percentage or \$, is a small fraction of what the other vendors are offering. Clearly, UMR has the best deal for the Plan, with an aggressive trend and amount at risk. Aetna’s target trend is slightly higher than BCBSNC, but their amount at risk is more than 8 times what BCBSNC is offering.

Reviewing this component in isolation, UMR has the best guarantee and would be ranked the highest. As we’ve said before and noted in the guarantee review presented to the Plan, BCBSNC’s guarantee target is competitive, but their amount at risk, both as percentage of admin and \$ at risk make their offer the worst of the three bidders, putting their rank last. Aetna, with a slightly higher trend but much more at risk would be ranked in the middle.

#### Overall Ranking

Combining the discount and trend guarantees together required some level of subjectivity, but they were highly objective, as indicated above. UMR’s offering was unique offering 100% of administrative fees at risk in year 1 for discount guarantees, and also because their years 2 and 3 were solely based on their trend guarantee, putting 50% of their fees at risk. Segal would have preferred to also have had their guarantees in years 2 and 3 for the discounts and percentage of Medicare, but Segal could understand their commitment and overall they clearly offered the best guarantees on this contract and were given the 2 points. Aetna offers up to 45% of their administrative fees at risk, slightly lower than UMR. Segal believed Aetna was a distant 2<sup>nd</sup> to UMR because their targets overall were slightly higher, depending on the category. In last place was BCBSNC, primarily due to the lowest amount at risk (5%-10% of admin) and the lowest payout schedule (10%) on the miss. Both BCBSNC’s discount and trend target guarantees were competitive, but offered the lowest administrative fees at risk which provides little financial backing and illustrates a lower level of commitment to managing the Plan’s costs. (I further note that while the percentage-of-Medicare guarantee was not incorporated into the scoring, BCBSNC had the worst of all bidders in both the target guarantee and the amount at risk.)

Given its experience, Segal expected vendors to bid guarantees that were not a simple calculation. The comparison was reasonable and completed as documented in the RFP. As I have stated above, the results of UMR with the highest rank, BCBSNC with the lowest and Aetna in the middle, is consistent with our analysis and the bids offered.

Mr. Russo claims that “1) Segal did not calculate the claims costs that would result from the achievement of the discount guarantee targets. When Segal scored the network pricing, it did not assess the bottom-line effect of each vendor’s discount targets on the Plan’s claims costs”.<sup>43</sup> However, it was clearly in the cost proposal that any guarantee above the current discount levels that was guaranteed on a “dollar for dollar” basis would be taken into account in the network pricing scoring, which it was.

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<sup>43</sup> Russo report, p. 16

**ATTACHMENT A: PRICING, Section 1.4 Network Pricing Guarantees of ATTACHMENT A: PRICING** to the TPA RFP states: *“Discount improvements guarantees will only be reflected in projected costs to the extent Vendor is willing to provide shortfall guarantees on a dollar-for-dollar basis. Discount improvements without guarantees will not be reflected in the projected cost analysis and guarantees not on a dollar-for-dollar basis will only be reflected up to the dollar amount at-risk”*.<sup>44</sup> As part of that scoring, both BCBSNC and UMR received an increased discount of 0.04% and 0.09%, respectively.<sup>45</sup> Aetna did not receive any additional discount. Note that if either vendor offered greater amounts at risk and offered “dollar-for-dollar” guarantees above the projected levels, further discount improvements would have been included in the analysis. So, in summary, Segal did exactly what was documented in the RFP.

Mr. Russo claims that: *“(5) Segal erred by downgrading Blue Cross for having a low amount at risk due to Blue Cross having ‘significantly lower admin fees.’ Lower administrative fees are beneficial to the Plan. Segal’s analysis implies the illogical conclusion that charging the Plan higher administrative fees would have made Blue Cross’s discount guarantee more valuable”*.<sup>46</sup> This is not what Segal did – Segal’s opinion regarding the guaranteed amounts was informed by BCBSNC’s placing only 5% of their administrative fees at risk. Nowhere did Segal imply that higher fees are better for the Plan. It is worth noting that BCBSNC’s lower administrative fees resulted in BCBSNC getting scored the highest on administrative costs component and receiving the maximum of 2 points.

While BCBSNC’s administrative fees were lower than the other vendors, they were only a minor contributing factor to the total dollar amount at risk. The 5% at risk for BCBSNC compared to 25% at risk for Aetna guarantees, 100% at risk for the UMR discount guarantee and 50% for the UMR trend guarantee was the main reason for BCBSNC’s lowest score. Had that percentage been higher than Aetna or UMR, BCBSNC might have been ranked higher.

Mr. Russo affirmatively states that: *“(7) Segal did not calculate claims costs for the two option years (2028 and 2029), even though the vendors included these years in the bids. Segal’s non-analysis of 2028 and 2029 advantaged Aetna by ignoring Blue Cross’s guarantees of discount improvements in those years”*. However, in my experience, the option years in a contract are typically not evaluated in for scoring. It is standard practice to limit the analysis to the contract period being bid since a plan would be under no commitment to enter into the option years. For example, the Plan could have extended the option years for BCBSNC under the current contract and opted not to.

Mr. Russo further tries to diminish Aetna’s offering by pointing to the composite structure of its guarantee, saying *“Despite the Plan’s actuary raising this concern, Segal does not seem to have changed the scoring of Aetna’s guarantees. In the end, the narrative in Segal’s scoring workbook made no mention of the composite nature of Aetna’s guarantees. Thus, Aetna’s use of a composite guarantee is a value reduction on which the Plan and Segal apparently put no weight”*.<sup>47</sup> Segal’s analysis presented to the plan<sup>48</sup> did in fact indicate that both Aetna and UMR discount guarantees were aggregate guarantees, and that doing so is a common industry practice. Three individual guarantees may be better than a

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<sup>44</sup> TPA RFP p. 84

<sup>45</sup> SHP 069464, Tab “Network Pricing”

<sup>46</sup> Russo report, p. 18

<sup>47</sup> Russo report, p. 20

<sup>48</sup> SHP 0085912-85925, p. 8, note #3

composite discount under certain circumstances, but that is not necessarily correct when bidders include a “maximum at risk” for each individual item. A large miss in one guarantee would be limited and the composite guarantee with 3 times that at risk might pay out more. Let’s compare three guarantees to one composite guarantee, similar to what Mr. Russo is looking at.

Here’s a simplified example assuming a vendor had individual guarantees per item of \$10M vs. the same vendor having an overall composite guarantee of \$30M. Assume the composite is just a weighted average of the individual guarantees. Also assume a 100% payment of the amount they miss, up to the maximum amount at risk.

	Annual Claims	Maximum At Risk	Performance		Payout
			%	\$	
Inpatient	\$1,000,000,000	\$10,000,000	-1.0%	-\$10,000,000	\$10,000,000
Outpatient	\$2,000,000,000	\$10,000,000	1.0%	\$20,000,000	\$0
Professional	\$2,000,000,000	\$10,000,000	-2.0%	-\$40,000,000	\$10,000,000
Total	\$5,000,000,000	\$30,000,000	-0.6%	-\$30,000,000	<b>\$20,000,000</b>
Composite	\$5,000,000,000	\$30,000,000	-0.6%	-\$30,000,000	<b>\$30,000,000</b>

In the above example, missing significantly on professional had a greater composite payout because it was not limited by the \$10M maximum at risk for each individual guarantee and the full \$30M is available for payment under the composite guarantee. It also didn’t matter that they overperformed in the Outpatient discount since the Professional discount missed by much more. In general, there are scenarios that give advantage/disadvantage to composite/individual guarantees. In this example, if there were not a dollar maximum at risk for each individual guarantee, the analysis would always be better for the individual vs. composite guarantees, but that is not the case here.

In its response to the 2022 TPA RFP, Aetna offered 25% on the composite discount and 20% on the composite Medicare. Overall, these values are far greater than BCBSNC’s in both amount at risk and percentage of admin at risk for each guarantee. Aetna further offered to pay back 20% of the discount guarantee difference, whereas BCBSNC offered to pay only 10% of the difference.

Mr. Russo commented: *“(9) Segal also erred in its background analysis of the effect of Aetna’s composite guarantees. In its background analysis, Segal fused Blue Cross’s and UMR’s three separate discount guarantees into a composite discount target, using the respective weights of inpatient services, outpatient services, and professional services (on a 2021 billed-charge basis). Segal also ran this same calculation for Aetna. Segal’s calculation for Aetna yielded a composite of 51.9 percent. Despite this calculation, Segal’s scoring workbook listed Aetna’s discount target at 52.3 percent—0.4 percent higher than Segal’s calculated composite amount for Aetna.”*<sup>49</sup> Mr. Russo goes on to question why no clarifications were sought with Aetna on the difference. There was no error in this analysis or any reason to seek clarification. BCBSNC’s individual service category guarantees were combined for comparison purposes using expected weights of those services, which is a standard industry practice. Both Aetna

<sup>49</sup> Russo report pp. 20-21

and UMR provided aggregate guarantees and the weighted average calculated by Segal did not apply as the actual aggregate guarantee proposed by Aetna and UMR was appropriately used.

Mr. Russo further claims: *“On the repricing exercise, the Plan and Segal downgraded Blue Cross’s discount percentage to align with the Plan’s and Segal’s view of the RFP’s instructions. On the discount guarantees, in contrast, the Plan and Segal chose instead to adjust the responses of the vendors who followed the RFP instructions (Blue Cross and UMR) to align them with the response of the vendor who did not (Aetna).”*<sup>50</sup> This is a complete misrepresentation of the analysis performed by Segal and the Plan. During the repricing exercise, BCBSNC’s discounts were adjusted in order to be consistent with the other vendors, as BCBSNC’s original proposal included projected discounts, an approach that **was not** consistent with what was requested in the RFP. No vendors, including BCBSNC, were “downgraded” as claimed. Regarding the discount guarantees, both Aetna and UMR provided aggregate discount guarantees and those were valued as proposed.

Mr. Russo later adds *“12) Finally, the Plan and Segal erred by excluding the percentage-of-Medicare guarantees from the scoring altogether. In his deposition, Segal’s corporate representative admitted that the percentage of Medicare guarantees were not scored because, “[t]hey tend to get more complicated. And determining a basis point, we don’t really have the ability to do that.” As far as the Segal representative was aware, moreover, the Plan raised no objection to the non-scoring of the percentage-of-Medicare guarantees. That non-scoring contradicted the Plan’s decision to seek percentage-of-Medicare guarantees. It also contradicted the Plan’s focus on reference-based pricing (i.e., pricing pegged to Medicare rates)—a focus that the RFP stated in the first substantive section of the RFP.”*<sup>51</sup> While Segal did not score the percentage of Medicare guarantees, doing so would not have had an impact on the overall ranking, as BCBSNC offered the worst percent of Medicare guarantee. Nothing would have changed in the evaluation. As stated above, the decision not to score the % of Medicare guarantees was not an error. It was intentional and reasonable for the reasons described above.

Mr. Russo’s concept on how a discount guarantee should be evaluated does not make sense to me. He claims that: *“[To] evaluate the “value” of a guarantee, one must assess the bottom-line impact to the Plan if the vendor achieved or missed its targets, including, in each scenario, the actual claims costs minus the guaranteed rebate amount”.*<sup>52</sup> Following this logic, a vendor that offers an incredibly high and likely unattainable target (e.g. 80% discount) with a minimal amount at risk (e.g. \$500 total), would be preferable to a vendor offering a lower target (e.g. 55%) with a significantly larger amount at risk (e.g. \$50M). I would completely agree with Mr. Russo if the vendors paid the difference “dollar for dollar”, but only paying a small percentage of the difference undermines the value of the guarantee. There needs to be incentive in place to hit a target.

Mr. Russo further states that: *“If Segal had quantified these bottom-line impacts, it would have seen that Blue Cross’s guarantees offered the Plan hundreds of millions of dollars of savings more than Aetna’s guarantees offered”.*<sup>53</sup> Mr. Russo’s analysis on this is saying higher discounts will give you lower costs, which is seems incredibly basic and obvious.<sup>54</sup> The flaw in his analysis is that someone saying we are

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<sup>50</sup> id.

<sup>51</sup> Russo Report p. 22

<sup>52</sup> id.

<sup>53</sup> id.

<sup>54</sup> Russo report, pp. 23-26, Fig 5, 6, 7

going to get way more discounts doesn't mean it is going to happen. Following Mr. Russo's logic, a 55.1% discount target (BCBSNC's target guarantee) would have saved the plan \$599 million, regardless of the small amount at risk (\$2.7 million). If BCBSNC was so confident in that approach they should have put more money at risk and pay 100% of the difference – then the Plan definitely would have saved \$599 million, whether they hit the discount or not.

Mr. Russo's provides an analysis comparing the impact of incremental misses in discounts between Aetna and BCBSNC.<sup>55</sup> His example is oversimple and flawed as it makes the inaccurate assumption that Aetna and BCBSNC would experience the exact same misses in any given year. There are infinite scenarios that can play out with achieved discounts and pricing guarantees. There is no way to accurately evaluate them all in a 100% objective manner. In reality, the only fair way to evaluate the proposed pricing guarantees was to use the combined objective and subjective approach with the explanation narrative included in the RFP.<sup>56</sup>

***“Opinion 2 addresses a discrepancy in the prices and discounts assumed by Aetna for providers with letters of intent. I have found that the discounts Aetna assumed for these providers in its bid are higher than the discounts that will be realized under the signed agreements. This difference will result in higher costs to the Plan than Aetna presented in its bid.”<sup>57</sup>***

Segal does not receive provider contracts and/or letters of intent during a procurement, as the carriers view them as confidential/proprietary information. In my 30+ years working with state health plans, I have never seen a vendor provide those details to my client or consultant. It is challenging enough to get the vendors to provide provider repricing data and disclosing their discount by provider by service. Additionally, given the sheer number of provider contracts and letters of intent the carriers have, it is not practical to undertake a review of these materials.

For this analysis, I will assume that Mr. Russo had all the relevant data he needed and performed the relevant calculations correctly when determining that Aetna understated their claims by nearly \$30 million per year.<sup>58</sup> However, given the size of the Plan, as illustrated below, that deviation still amounts to a less than .5% difference.

	Total Claims (2025-2027)	% From Lowest Claims Cost	Network Score	Total Claims (2025-2027) – Adjusted \$90M	% From Lowest Claims Cost	Network Score
<b>Aetna</b>	\$9,639,225,963	0.00%	6	\$9,729,225,963	0.46%	6
<b>BCBSNC</b>	\$9,684,432,315	0.47%	6	\$9,684,432,315	0.00%	6

Since both vendors are still within 0.5% of each other they would have received the same exact score, as stated in Section 3.4(a) of the RFP, and there would be no change in the result.

<sup>55</sup> Russo report p. 25, Figure 7

<sup>56</sup> RFP p. 25, Section 3.4.

<sup>57</sup> Russo report, p. 5

<sup>58</sup> Russo report p. 30

Note - I am not agreeing with his calculation since we do not have all the information, did not have it during the procurement, nor would we ever get that during a procurement. We rely on vendors to reprice their claims based on their contracts and do not/could not audit their contracts. All I'm commenting on is that even if what he did was correct and Aetna reported it incorrectly, **both Aetna's and BCBSNC's network pricing score would remain unchanged at 6.**

***“Opinion 3 relates to the Request for Clarifications process, in which Segal adjusted Blue Cross’s proposed discounts downward. This adjustment resulted in Blue Cross and Aetna both scoring 6 points for this part of the proposal rather than Blue Cross scoring 6 points and Aetna scoring 3 points. I have found that this adjustment was made based on erroneous assumptions and without equivalent scrutiny of Aetna’s discounts.”<sup>59</sup>***

The re-pricing instructions were very clear in **ATTACHMENT A: PRICING, 1.2.1 Claims Repricing File** of the RFP which stated:

*“A claims repricing file, containing participant claims experience for calendar year 2021, will be made available through a secure file transfer protocol to Vendors meeting the minimum requirements.*

*The layout of the fields that will be included in the repricing file are detailed in Attachment A-3. This attachment also contains supporting field descriptions that may be beneficial to Vendor.*

*Using the repricing file referenced above, Vendors are to provide the contracted allowed amount for each service in the file. Vendors are expected to reprice each claim line based on provider contracts in place, or near-future contract improvements bound by letters of intent, at the time of the repricing.”<sup>60</sup>*

These instructions clearly state that the pricing should be based on **contracts in place at the time of repricing with known contract improvements**. There was **one** RFP question (61) that was included in the Q&A amendment and included below on how to re-price claims:

61.	Attachments A-3 and A-6	<p>Please confirm the claim time period to be used for the repricing analysis is incurred January 2021 through December 2021, paid through June 2022.</p> <p>Please confirm the instructions on attachment A-6 indicate that we should use results on attachment A-3 to illustrate contract improvements for 2025.</p>	<p>The claims data provided for repricing represents incurred January 1, 2021, through December 31, 2021, paid through June 30, 2022. In its response to Attachments A-3, A-4, and A-5, Vendor is expected to reprice each claim line based on provider contracts in place, or near-future contract improvements bound by letters of intent, <u>at the time of the repricing</u>. Vendor’s response to Attachment A-6 should reflect anticipated improvements in its reimbursement arrangements from after the claims repricing analysis (i.e., not reflected in the claims repricing) to January 1, 2025.</p>
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<sup>59</sup> Russo report, p. 5

<sup>60</sup> RFP p. 83

Again, the answer to this question was very clear and consistent with all prior communications. When we got the re-priced claims, due to significant variation, we decided a clarification was necessary to be sent to all bidders. Ultimately, BCBSNC required six (6) cost proposal related clarifications in total, UMR required three (3) and Aetna required two (2).

All vendors were asked similar clarifications with the goal of minimizing variations in vendor repricing approaches. Our goal throughout the RFP was to value contracts in place at the time of repricing, or near-future contract improvements bound by letters of intent. The instructions in the RFP, the Q&As and the clarifications were consistent, and instructions were clear. Segal and the Plan did not want vendors projecting out healthcare trends (including billed charges) and artificially inflating their discounts. The reason for this is that one vendor could calculate higher discounts if they used a higher trend, causing unfair variation between vendors simply due to that assumption.

For example, using Mr. Russo’s \$80 contract rate example, assuming a higher trend in billed charges in any given year would increase/distort the discount:

<u>Contract Rate</u>	<u>Billed Charge</u>	<u>Trend</u>	<u>Discount</u>
\$80	\$100	0%	20%
\$80	\$105	5%	24%
\$80	\$110	10%	27%

In this example, if one vendor assumed 10% trend and the other 5%, the actual contract rate would be the same, but the one assuming a higher trend would be rewarded with a better discount assumption. This was not a fair way to do an analysis and is even more problematic if a vendor does it across their entire bid.

Our review of the vendors' claims repricing strongly suggested that the vendors had not repriced the claims consistently. Therefore, Segal sent out clarifications and required each vendor to fill in identical tables in order to demonstrate how the vendor’s actuarial team projected the discounts in the cost proposal. Per the instructions, our goal was to have the vendors populate the analysis with known contract improvement and letters of intent. We did not want any trends included in the calculation.

As Milliman mentions in the White Paper: Determining discounts, “Understanding the differences in carriers’ repricing methodologies is important when comparing medical repricing results in order to identify any assumptions used and limitations with the analysis.” Aetna and UMR required fewer clarifications than BCBSNC because they each clearly answered the questions and had reasonable numbers in each bucket. They also did not respond with additional opinions contrary to what was being requested. Aetna’s response is provided below. Note Aetna’s table shows small contract improvements from 2021 contracts through the “Known Contract Improvements” line.

	<b>In-Network Discount Accumulation</b>	<b>Example</b>
<b>2021 Claims Data using 2021 Contracts</b>	<b>51.97%</b>	50.0%
<b>Indicate the increase in discounts attributed to each of the following:</b>		

<b>Discounts as of Repricing Date (e.g., 11/1/22)</b>	<b>52.11%</b>	51.0%
<b>Current Letters of Intent (should not include assumed increases in billed charges)</b>	<b>52.44%</b>	51.4%
<b>Known Contract Improvements (should not include assumed increases in billed charges)</b>	<b>52.99%</b>	52.5%
<b>Assumed Increases in Billed Charges</b>	<b>53.99%</b>	53.5%
<b>Anticipated Contract Improvements</b>	<b>53.99%</b>	54.0%
<b>Other (please clarify)</b>	<b>53.99%</b>	54.0%
<b>Expected 2025 Discounts</b>	<b>53.99%</b>	54.0%

We also asked UMR for the same clarification. UMR’s response was below:

	<b>In-Network Discount Accumulation</b>	<b>Example</b>
<b>2021 Claims Data using 2021 Contracts</b>	<b>50.1%</b>	50.0%
<b>Indicate the increase in discounts attributed to each of the following:</b>		
<b>Discounts as of Repricing Date (e.g., 11/1/22)</b>	<b>51.1%</b>	51.0%
<b>Current Letters of Intent (should <u>not</u> include assumed increases in billed charges)</b>	<b>51.1%</b>	51.4%
<b>Known Contract Improvements (should <u>not</u> include assumed increases in billed charges)</b>	<b>52.5%</b>	52.5%
<b>Assumed Increases in Billed Charges</b>	<b>53.7%</b>	53.5%
<b>Anticipated Contract Improvements</b>	<b>54.1%</b>	54.0%
<b>Other (please clarify)</b>	<b>54.1%</b>	54.0%
<b>Expected 2025 Discounts</b>	<b>54.1%</b>	54.0%

Like Aetna, UMR completed the table in the manner requested and indicated improvements from line-to-line over the same period. Where Aetna increased 1.02% in discounts (51.97% to 52.99%), UMR increased 2.4% (50.1% to 52.5%) through the “Known Contract Improvements” line. The results appeared reasonable between the two. Note that assuming increases in billed charges increased UMR’s discount 1.2% from its assumed trend and Aetna’s discount increased 1.0%, again very similar and reasonable.

BCBSNC was asked the same clarification, to fill out the same chart and provided it below:

	<b>In -Network Discount Accumulation</b>	<b>Example</b>
<b>2021 Claims Data using 2021 Contracts</b>	<b>51.2%</b>	50.0%
<b>Indicate the increase in discounts attributed to each of the following:</b>		

<b>Discounts as of Repricing Date (e.g., 11/1/22)</b>	<b>54.0%</b>	51.0%
<b>Current Letters of Intent</b> (should <u>not</u> include assumed increases in billed charges)	<b>54.0%</b>	51.4%
<b>Known Contract Improvements</b> (should <u>not</u> include assumed increases in billed charges)	<b>54.0%</b>	52.5%
<b>Assumed Increases in Billed Charges</b>	<b>57.8%</b>	53.5%
<b>Anticipated Contract Improvements</b>	<b>57.8%</b>	54.0%
<b>Other (please clarify)</b>	<b>57.8%</b>	54.0%
<b>Expected 2025 Discounts</b>	<b>57.8%</b>	54.0%

Segal noted that BCBSNC’s responses were very different than the Aetna and UMR responses and clearly included a methodology difference. In 2025 they were showing a 3.8% improvement, whereas the other vendors were 1.2% and 1%.

As Milliman also mentions in the White Paper: Determining discounts, “Reconciliation between the incumbent’s historical and repriced discounts allows for an understanding of the carrier’s estimated change in contracts between the time periods. While it is reasonable to expect a small discount change (in either direction), significant differences require additional validation.”

BCBSNC’s responses suggested that they were not accurately responding to the requested exercise. In Clarification #5 BCBSNC said: “As Blue Cross NC confirmed in Clarification #3, 2023 repriced discounts were calculated using industry approved methodology based on the 2023 contracting changes and including industry standard UDS prescribed billed charge trends.” This confirmed that BCBSNC used charge trends in its claims repricing, where the other vendors confirmed they had not. As noted in the chart the vendor “should **not** include assumed increase in billed charges” in connection with letters of intent or known contract improvements.

In the final Clarification #7, BCBSNC confirmed that at the time of repricing (November 2022) their discount would be 52.7%. This made sense to Segal, since BCBSNC’s response to Clarification #6 showed its 2025 expected discount to be 57.8%, increasing about 1.9% per year solely due to billed charges over the 2023’s 54% discount. It now seemed consistent with the incremental steps made by the other vendors.

Segal took numerous steps to ensure every vendor had ample opportunity to explain how it had repriced the claims in the repricing file and clarify that vendors could not use different trend assumptions to manipulate their discounts. Through these clarifications, Segal took all reasonable steps to ensure that the vendors’ pricing was consistently and fairly compared.

***“Opinion 4 concerns the lack of use of an external data source to validate the findings of the repricing exercise. Segal reviewed data that was favorable to Blue Cross, but neither Segal nor the Plan***

***considered this data in its evaluation. The failure to consider this external data further undermines Segal's decision to adjust Blue Cross's discount percentage to a level below Aetna's.***<sup>61</sup>

Uniform Discount and Data Specifications (UDS) is a collaborative effort between carriers and benefit consulting companies to compile commercial book-of-business discount data at a 3-digit ZIP code level by major service category (Inpatient facility, Outpatient facility and Professional). Many of our smaller clients who are self-insured use UDS for procurements when data is not available or credible for multiple reasons. However, we do not use UDS for large state clients, as it has limitations and is not as accurate as repricing. The major disadvantages are listed in Milliman's White Paper and include, "(1) Assumes the mix of providers for the group is comparable to book-of-business; and (2) assumes the mix of services within the category (IP, OP, PROF) is consistent with book-of-business." Our large state health plan clients can be significantly different than book-of-business. Another actuarial White Paper from Wakely states, "We have not performed any specific testing of the UDS data to determine actual versus relative performance. The carriers typically reference a +/- 2 discount point corridor around calculated discounts to reflect differences in the employer's actual mix of providers and services." This can cause relative discounts between plans to vary by as much as 4 percentage points on discounts, which could leverage to over an 8% differential in program costs. For example, a 50% book-of-business discount could range from an employer-specific discount of 48% to 52%, but the cost differential would equate to  $.52/.48 = 8.3\%$ . This variation alone makes it not practical for a state procurement, nor does it validate findings in a repricing exercise.

For some clients, as part of a reasonableness check, Segal will run a report to compare repricing results. For our large state health plan clients, we have large complete data sets that include all the components necessary for repricing and represent the mix of providers and services inherent in the population. It is more common to use a UDS report to see if regional pricing could potentially provide better financial coverage vs. one statewide vendor in preparation for an upcoming RFP. For a public procurement, we would only use a UDS report as an additional data point to cross-check what we received. I have never relied on a UDS report, nor used the report in any capacity when scoring a state health plan procurement. The data in these reports are very dated and do not reflect letters of intent or known contract improvements. In our experience, we have seen significant variations when comparing to repricing results at both statewide and regional levels.

In the case of North Carolina, there was no mention of incorporating this in the evaluation. While Segal did run this reasonableness test internally, only high-level results were shared – verbally - with the Segal team responsible for the RFP.<sup>62</sup>

Mr. Russo states the opinion that the UDS data contradicts Segal's network pricing analysis. I had not seen the UDS report prior to writing this opinion. However, I disagree with Mr. Russo's opinion. The UDS discount analysis showed that UMR and Cigna (who did not bid on the RFP) were 1.5% less expensive than BCBSNC (the incumbent) and BCBSNC was 1.1% less expensive than Aetna. Note that the UDS data was based on claims from July-2020 thru June-2021, which is over a year old from the requested repricing conducted in November 2022. Also, the UDS data is not Plan specific as there is nothing in the numbers to represent the Plan's utilization, vendors' new provider contracts negotiated over the year,

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<sup>61</sup> Russo report, p. 5

<sup>62</sup> See S.Kuhn deposition – pp. 290-294

or vendors' letters of intent with providers. Segal understood one of the Plan's goals was to have the vendors actively try to improve their networks, the year plus old data in UDS becomes even less representative of what the Plan would experience. Also, as Mr. Russo mentions earlier, 10% of the claims from Aetna came from providers with letters of Intent, meaning they would not be reflected in any data reported to UDS.

We have seen variances as much as 10% for some large bids. So had we actually used the UDS to validate, it would not have changed anything and proved that the clarifications were needed to make sure everyone was fairly compared and the results after clarification were reasonable and within UDS variances. As mentioned earlier, UDS uses a trend assumption in their numbers which are likely being handled differently by each vendor.

The initial bids showed BCBSNC with a 6.7% advantage over UMR. Based on our previous work with the Plan, BCBSNC had not experienced a spread like this in the past. Actual experience shows BCBSNC within 1% for many years, which strongly suggested that the vendors had not repriced the Plan's claims consistently, and that clarifications were needed. In the dated UDS report cited by Mr. Russo, it shows the discounts close as well. With clarifications, BCBSNC had a 0.5% advantage over UMR and a 0.5% disadvantage to Aetna. All the bidders are within 1%, which is consistent with prior analyses and are well within the expected variances of +/-2 points as listed above and quoted by Wakely.

Even if we had used UDS to attempt to validate the repricing, we would have followed the same process and sought clarifications like we did as the 6.7% differential was not reasonable nor consistent with the UDS report. Although the absolute final numbers are slightly different the spread between all the vendors looks consistent with the UDS report.

A full review of the UDS system and its capabilities is beyond this report. In the context of large state health plans, it should be used only as a cross-check, if at all. It does not appear from Mr. Russo's report that he has ever worked with UDS data, run a UDS report or knows the details of what is involved. In my opinion, the data in the UDS report, which were not used by Segal, were still consistent with the results of Segal's network pricing analysis, and within the typical variance of UDS data. The UDS data also support Segal's conclusion that discount percentages after the clarifications are much more reasonable than those initially provided or in the UDS.

***"Opinion 5: The Plan did not compare the vendors' networks of providers, even though it had the data needed to do so. As a result, the Plan failed to consider the disruption that will occur if Aetna becomes the TPA on January 1, 2025"***<sup>63</sup>

Mr. Russo's final opinion focuses on the differences between Blue Cross's and Aetna's networks and claims the differences received no weight in the scoring of the proposals. He states that *"I have found that the Plan and Segal collected detailed data from the vendors but did not use it to compare the networks. I have used the data to show that Blue Cross's network offers more choices of providers. The data also shows that thousands of Plan members are likely to face disruption if Aetna becomes the TPA on January 1, 2025."*<sup>64</sup>

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<sup>63</sup> Russo report, p. 48

<sup>64</sup> Russo report, pp. 5-6

This is not the case as the impact of disruption is incorporated in the financial analysis. A vendor with a lower in-network percentage would have higher overall pricing (lower discount) and be penalized in their network cost score. For example, if two vendors have the same in-network percentage but one has 10% out-of-network and the other 20%, the one with 10% would have a better discount and a better score. Assume both vendors have a 50% in-network discount and a 20% out-of-network discount:

	<b>Vendor A</b>	<b>Vendor B</b>
<b>1. % In-Network</b>	<b>80%</b>	90%
<b>2. % Out-of-Network</b>	20%	10%
<b>3. In-Network Discount</b>	50%	50%
<b>4. Out-of-Network Discount</b>	20%	20%
<b>5. Total Discount = (1x3)+(2x4)</b>	44%	47%

In this example, Vendor B would be rewarded with a better overall discount than Vendor A, solely due to Vendor B’s network disruption score being 10% better.

Additionally, all of the vendors have very broad networks, covering all the North Carolina counties as required by the RFP. The Cost Proposal Analysis, Network Pricing Scoring<sup>65</sup> shows:

	<b>Non-Medicare percentage of Projected Claims In-Network</b>
<b>Baseline</b>	99.0%
<b>Aetna</b>	99.0%
<b>BCBSNC</b>	99.4%
<b>UMR</b>	98.5%

This means that Aetna has the same percentage of provider claims paid in-network as the current BCBSNC re-pricing data. It also shows BCBSNC improving their network to cover 0.4% more than their current network. All three network disruption scores are excellent, and for a non-incumbent, would imply that disruption was not an issue for these networks. Putting more weight on the network provides a significant advantage to the incumbent, since the data is based on their current network. The fact that Aetna only has 1% of claims with providers not in their network is outstanding and would really be considered almost no disruption during a large procurement like this. It is also worth noting that BCBSNC’s would still have 0.6% of claims with providers not in their network as well, with UMR at 1.5%. So even if some type of scoring methodology was put in place (and documented in the RFP), as suggested by Mr. Russo, they are within normal margins, and would likely have been scored the same for that component.

We understand the numbers that Mr. Russo discusses,<sup>66</sup> but they are distorted due to the Plan size. With 742,000 members, even 1% would be 7,420 members who would need to change the provider for the service utilized. That member could have had 10 services in-network and only one service (like a lab) out of network. This is typically why the data shows higher disruption on the number of claims than on claims dollars. Additionally, during implementation, the awarded vendor will receive additional

<sup>65</sup> SHP 069464, Tab “Network Pricing”

<sup>66</sup> Russo report, pp. 52-59, Fig 23-27

claims and network data and look to close any provider gaps, further reducing disruption by adding contracts with frequently utilized providers who are currently not under contract and whose claims would be processed out of network.

As Milliman mentions in the White Paper: *Determining discounts*, “Provider disruption identifies the providers’ statuses with an alternative network based on the providers currently utilized by the employer group.<sup>67</sup> It is frequently requested as an independent comparison or may be included as part of a repricing. Provider tax ID, name, and ZIP code are needed in the historical data to complete a disruption. The benefit of a disruption in a repricing is twofold: (a) it reflects network size; and (b) it incorporates total discount into the repricing, where total discount represents both in-network and out-of-network services.” They go on to say, “Disruption measures the impact and can be calculated based on eligible billed dollars, count of claims, count of providers, or count of members. A provider disruption is typically based on the providers currently utilized with the incumbent’s network without any adjustments for provider steerage. It is reasonable to expect some improvement in the alternative network penetration rate if the group makes a switch depending on the benefit design and the alternative carrier’s network offering.” These comments are consistent with our explanations of work Segal performed on this RFP regarding disruption.

Some states have put more emphasis on the network disruption piece. These states have a number of local provider groups who are not contracted across multiple networks and are regional. He mentions Wisconsin, but that procurement was based on combining multiple regions and consolidating 13 health plans, so disruption numbers were obviously much higher and anticipated; therefore, measuring overall disruption was more relevant. Wisconsin is not comparable to North Carolina, where the Plan uses one vendor with a broad network to cover the state while providing minimal disruption. In this procurement, all three vendors’ networks overlap significantly. Although I recognize that disruption is an inconvenience or potentially a hardship in individual circumstances, this amount of disruption is insignificant in the context of a large state health plan procurement.

In addition, the argument that a member’s cost would go up significantly is not correct and heavily overstated.<sup>68</sup> His analysis is based on charges, there would be discounts on out-of-network claims as well, typically slightly less than the in-network discounts. After that members would have their higher cost sharing applied to the lower eligible charge. However, what typically happens, if the new vendor is unable to recruit a specific provider during the implementation process, is that the members change their providers for those services and pick a network provider. This is not uncommon in the industry and is standard practice.

\* \* \* \* \*

This report is based on information known to me as of this date. I reserve the right to correct, update, supplement, or otherwise modify this report if additional information becomes available. I also reserve the right to present additional opinions, or opinions on additional issues, if asked.

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Kenneth Vieira  
October 31, 2023

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<sup>67</sup> See <https://www.milliman.com/en/insight/healthreform/determining-discounts/>

<sup>68</sup> Russo report, pp. 56-59, Fig 25-27

**Kenneth C. Vieira, FSA, FCA, MAAA**  
**Senior Vice President, East Region Public Sector Market Leader, Atlanta**

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**Expertise**

Ken is a Senior Vice President and Consulting Actuary in Segal's Atlanta office with nearly 35 years of experience as an account manager, actuary and consultant. He serves as East Region Public Sector Market Leader and is a member of the East Management Team.

Ken works exclusively in the public sector, focusing on large state engagements. He brings a full complement of actuarial and consulting expertise to his clients. He has extensive experience in strategic consulting, procurements, benefit plan design and evaluation, financial forecasting, trend analysis, risk profiling, new product design, plan rating, premium rate development, data analytics, retiree medical, statistical modeling and other medical management programs.

Ken's current public sector clients include:

- North Carolina State Health Plan
- Alabama Public Education Employees Health Insurance Plan
- Alabama State Employees Health Insurance Board
- Arkansas Bureau of Legislative Research
- Missouri Consolidated Healthcare Plan
- State of Iowa
- State of Illinois – Department of Central Management Services
- State of Nebraska
- State of Wisconsin – Department of Employee Trust Fund
- State of Kansas
- Teachers' Retirement System of Texas

In addition, Ken has managed or provided actuarial support to the following additional state clients while at a prior employer:

- State of Tennessee
- Commonwealth of Kentucky

- Georgia State Health Benefit Plan

In addition to his specialty in the governmental sector, Ken has worked with large employers, healthcare providers and health plans. His varied projects have included packaging and pricing medical services, developing claims data reporting, utilizing risk management software, developing HMO rates and renewal support, and developing prospective payment systems.

### **Professional background**

Prior to joining Segal, Ken was the head of the Government Programs Health Practice at a large consulting firm in Atlanta. He has worked extensively with states and other large governmental employers on state health plans, Medicaid programs and a broad range of actuarial issues. With many of these states, Ken served as both the account manager/account executive and actuary and provided a wide array of strategic consulting.

### **Education/professional designations**

Ken received a BS in Software Engineering from Syracuse University. He is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, a Fellow of the Conference of Consulting Actuaries, and a retired Enrolled Actuary. He is also a licensed Life and Health Insurance Consultant in Georgia, Tennessee, North Carolina and many other states.

# **EXHIBIT D**

**Expert Report of Andrew Coccia  
(October 31, 2023)**

STATE OF NORTH CAROLINA  
DURHAM COUNTY

IN THE OFFICE OF  
ADMINISTRATIVE HEARINGS  
23 INS 738

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. )

**EXPERT REPORT OF ANDREW COCCIA**

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**October 31, 2023**

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**I. BACKGROUND OF THE WITNESS**

1. I, Andrew Coccia, am a Senior Manager in the Human Capital practice of Deloitte Consulting LLP (“Deloitte Consulting”). I have over 25 years of experience in the Total Rewards<sup>1</sup> industry related to benefits consulting and plan sponsor roles and have led over 100 benefits strategy projects. I have over 18 years of experience at Deloitte Consulting related to health and welfare benefits consulting for large plan sponsors. In my role, I develop strategies to enable employers to manage employee benefits spend in ways that are cutting-edge, sustainable, aligned with business and human resource objectives, while reducing impact on employees. I have extensive background in financial planning, strategy development, benchmarking, data analyses and developing and conducting Requests for Proposals (“RFPs”). In my roles at and prior to Deloitte Consulting, I have had extensive experience both creating and scoring nearly all aspects of employee benefits RFPs for government and commercial plan sponsors of all sizes, (including those of comparable size to the North Carolina State Health Plan for Teachers and State Employees) including roles advising on application of scoring methodologies and the detailed analysis of all aspects of the technical and financial proposals. Additionally, over the course of my career I have managed upwards of 75 RFP and procurement initiatives for large employers, including RFPs specifically related to the selection of health care administrators and insurers.

2. Prior to joining Deloitte Consulting, I was a senior consultant and local sales leader at Willis Towers Watson, leading the health and welfare services for several large commercial and governmental clients. Before Willis Towers Watson, I was a project leader at General Electric (“GE”), setting GE Capital’s health care benefits strategy and implementing health care pay-for-

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<sup>1</sup> “Total Rewards” refers to the combination of benefits, compensation, and rewards employees receive from their organizations.

performance programs. I began my career at Mercer, a leading benefits consulting firm, where I ran health and benefits RFPs and benchmarking studies and also developed a global health consulting capability. During this time, I consulted with global employers and insurers to advise on US market entry and provided in-depth analyses of competition and growth opportunities. My collective education and experience have provided me insights in forming my opinions in this matter.

3. Attached as **Appendix 1** is my curriculum vitae. I have not authored any publications in the past 10 years, and I have no prior testimony experience.

## **II. SCOPE OF ENGAGEMENT**

4. Wyrick Robbins Yates & Ponton LLP (“Counsel”) engaged Deloitte Financial Advisory Services LLP (“Deloitte FAS”), an affiliate of Deloitte Consulting, in connection with Counsel’s representation of Aetna Life Insurance Company and its affiliates and subsidiaries (“Aetna” or the “Company”) in *Blue Cross and Blue Shield of North Carolina, Petitioner, v. North Carolina State Health Plan for Teachers and State Employees, Respondent*, 23 INS 738.

5. Pursuant to this engagement, Counsel asked me to opine on and respond to certain opinions set forth in the expert report of Gregory Russo (“Mr. Russo”) dated October 4, 2023 (the “Russo Report”), and the expert report of Mary Karen Wills (“Ms. Wills”) dated October 4, 2023 (the “Wills Report”).

## **III. INFORMATION CONSIDERED**

6. In forming my opinions set forth in this report, I have relied upon information (referred to hereinafter as the “Information Considered”) provided to me by Counsel, certain

published regulatory literature and guidelines, and my own knowledge and experience. **Appendix 2** to my report lists the Information Considered in the preparation of this report.

7. I understand that this matter is ongoing and additional information may be provided to me. My report reflects my opinions based on the Information Considered and work or analysis performed as of the date of this report. I reserve the right to revise and supplement this report and my opinions based on any additional information obtained or any additional work or analysis that I may perform or review subsequent to the date of this report.

#### **IV. COMPENSATION**

8. In performing my work, I have been assisted by Deloitte<sup>2</sup> personnel working at my direction. Deloitte is compensated for the services of its personnel on an hourly basis and is being reimbursed for out-of-pocket expenses. My rate for this engagement is \$637 per hour. Rates for other Deloitte personnel working on this engagement range from \$304 to \$777 per hour. Deloitte's compensation is neither contingent upon the opinions or conclusions I reach nor the outcome of this matter.

#### **V. BACKGROUND OF THE MATTER**

9. The North Carolina State Health Plan for Teachers and State Employees (the "Plan") is a self-insured, government-sponsored health plan that provides health care coverage to more than 742,000 teachers, state employees, retirees, and their eligible dependents.<sup>3</sup>

10. In April 2022, the Plan informed Blue Cross and Blue Shield of North Carolina ("Blue Cross NC"), which had served as the Plan's Third- Party Administrator ("TPA") for

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<sup>2</sup> As used in this report, "Deloitte" refers to Deloitte Consulting LLP and Deloitte Financial Advisory Services LLP.

<sup>3</sup> 2022 TPA RFP, Section 1.2.

decades,<sup>4</sup> that the Plan would issue a new RFP for TPA services, for services to begin on January 1, 2025 (the “2022 TPA RFP”). The Plan issued the 2022 TPA RFP on August 30, 2022.<sup>5</sup>

11. In response to the 2022 TPA RFP, three vendors submitted proposals on November 7, 2022: Aetna, Blue Cross NC, and UMR, Inc. (“UMR”) (collectively, the “Vendors”).<sup>6</sup> The 2022 TPA RFP required all interested vendors to submit separate technical and cost proposals (the “Technical Proposal” and “Cost Proposal,” respectively) to be weighted equally. While the Technical Proposal required a binary confirmation on a series of technical requirements, the Cost Proposal was split into three categories: Network Pricing, Administrative Fees, and Network-Pricing Guarantees.<sup>7</sup> During the RFP process, the Vendors had two opportunities to ask questions of the Plan regarding the 2022 TPA RFP.<sup>8</sup>

12. Upon receipt of proposals from the three Vendors, the Plan scored and ranked the Vendors using a detailed scoring system that would weigh the Technical and Cost Proposals equally, with the support of the Segal Company, Inc. (“Segal”).<sup>9</sup> Segal is a multinational benefits, compensation, and human-resources consulting firm headquartered in New York City that assisted the Plan in preparing and evaluating the Cost Proposals submitted in response to the 2022 TPA RFP.<sup>10</sup>

13. After completing its scoring and ranking procedures, the Plan determined that Aetna placed first overall, above Blue Cross NC and UMR, and on December 14, 2022, the Plan awarded the contract to Aetna.<sup>11</sup>

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<sup>4</sup> Petition for Contested Case Hearing, para. 1.

<sup>5</sup> Petition for Contested Case Hearing, p. 3.

<sup>6</sup> Petition for Contested Case Hearing, p. 3.

<sup>7</sup> Petition for Contested Case Hearing, p. 4.

<sup>8</sup> 2022 TPA RFP, Section 2.4.

<sup>9</sup> Petition for Contested Case Hearing, p. 3.

<sup>10</sup> <https://www.segalco.com/about-us/locations>

<sup>11</sup> Petition for Contested Case Hearing, p. 9.

14. Blue Cross NC and UMR then made written requests for protest meetings to the Plan pursuant to the procedures in 2022 TPA RFP, which the Plan denied in written decisions.<sup>12</sup>

15. Blue Cross NC has since filed a petition for a contested case hearing in the North Carolina Office of Administrative Hearings.<sup>13</sup> Blue Cross NC claims that the Plan made the award to Aetna based on improper procedures, including “arbitrary and capricious criteria and scoring.”<sup>14</sup>

## **VI. SUMMARY OF OPINIONS**

16. Based on my analysis of the Information Considered, as well as my own knowledge and experience, it is my opinion that:

- a. Contrary to the opinion expressed in the Wills Report, the final scoring methodology utilized in the 2022 TPA RFP is consistent with standard industry practice.
- b. Contrary to the opinion expressed in the Wills Report, the scoring methodology utilized in the Cost Proposal of the 2022 TPA RFP is an acceptable industry practice. This scoring methodology was specifically articulated in the 2022 TPA RFP and was available to all vendors.
- c. Contrary to the assertions set forth in the Wills Report, the Plan’s use of binary response options without corresponding narrative for the Technical Proposal of the 2022 TPA RFP is a common and acceptable industry practice.
- d. Contrary to the opinion expressed in the Russo Report, the Plan’s scoring of pricing guarantees is an acceptable industry practice.

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<sup>12</sup> Petition for Contested Case Hearing, p. 9.

<sup>13</sup> Petition for Contested Case Hearing, p. 10.

<sup>14</sup> Petition for Contested Case Hearing, p. 10.

- e. Mr. Russo's calculation of the impact of alleged discrepancies in Aetna's bid pricing does not appear to consider key factors and thus is incomplete.
- f. Contrary to Mr. Russo's assertion, Segal's analysis of repricing, and the subsequent adjustments to Blue Cross NC's calculated value, followed an acceptable industry practice of presenting values on the same basis for comparison of the Vendors.
- g. Segal appropriately excluded its analysis of external data as a point of comparison from impacting the results of Segal's scoring under the rules of the 2022 TPA RFP.
- h. Contrary to the opinion expressed in the Russo Report, the Plan and Segal did consider network disruption and reviewed other measures of network accessibility in the analysis of the Vendors' bids.

## **VII. OVERVIEW OF TPA PROCUREMENT CONSIDERATIONS**

17. While there are many organizations that provide health plan TPA services, in my experience not all administrators provide the same services in the same manner. The potential differences across TPA vendors and their services can be described as analogous to purchasing a car: a sports car, a pickup truck, and a sport utility vehicle will each get you from point A to point B, but there are significant differences in the brand, miles per gallon, comfort, and features. In a similar way, there are inherent and significant differences in how health plan administrators operate, such as how they: contract with health care providers, perform condition management services, provide customer and account services, and deliver reporting. Some such differences are quantifiable and can be objectively measured (e.g., price). Other differences may require a degree of subjective interpretation for purposes of comparison. An RFP process attempts to fairly distill these differences in ways that allow for comparison and judgement of value. Different plan sponsors, who set forth RFPs for TPA services, may define "value" differently, and accordingly

may, at their discretion, apply different weights to those aspects of the services they consider important.

18. In a formal procurement process, in my experience, a typical key point of importance to vendors is that their bids are understood by the plan sponsor and are fairly compared using the same criteria across each vendor. And typically, a key point of importance to the plan sponsor is that the plan sponsor selects the vendor that will provide the sponsor with the greatest value and provide the strongest strategic fit for the sponsor's membership and organizational goals. Accordingly, it is typically important to health plan sponsors that their particular values be reflected directly in the scoring methodology. Thus, if bids are compared using a clear, consistent, and objective process, and the scoring reflects the value placed on the components by the plan sponsor (in this case, the Plan), then the outcome is reasonable.

## **VIII. ANALYSES SUPPORTING OPINIONS**

### **A. Contrary to the opinion expressed in the Wills Report, the final scoring methodology utilized in the 2022 TPA RFP is consistent with standard industry practice.**

19. The Wills Report criticizes the final scoring methodology utilized in the Plan's evaluation of the 2022 TPA RFP, describing the method as "points-to-ranks-to-points-to-ranks" and suggesting this was an uncommon practice which purportedly "skewed the Vendors' final scores."<sup>15</sup> I disagree with these assertions. Rather, based on my professional experience, the "points to rank" approach utilized by the Plan for each component is consistent with common industry practice.

20. As an initial point, in my decades of experience participating in and evaluating RFPs, it is a common practice for state governments and other public sector entities to separate the

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<sup>15</sup> Wills Report, para. 21 and 25.

scoring of technical proposals from the scoring of cost proposals. One reason sponsors choose to separate these two proposal components and review them distinctly is because different skillsets may be needed to evaluate these different components (e.g., individuals with finance or government pricing backgrounds may be better suited to analyze cost proposals, while individuals with Human Resources or other technical/business backgrounds may be better suited to analyze technical proposals). Often, the RFP sponsors utilize different teams to review these distinct components of the proposals, and evaluate and score them independently. Further, in my experience, RFP sponsors often rank the responding vendors high to low based on their resulting score in each component. This scoring and ranking is precisely what transpired in this matter:

- a. The 2022 TPA RFP included minimum technical requirements (“Minimum Requirements”). Only Vendors that first confirmed their ability to confirm all Minimum Requirements were allowed to submit Cost and Technical Proposals.<sup>16</sup>  
*This approach is typical in my experience.*
- b. The Vendors’ Technical Proposals were scored based on points, and then ranked high to low.<sup>17</sup> *This approach is typical in my experience.*
- c. The Vendors’ Cost Proposals were scored based on points and then ranked high to low.<sup>18</sup> *This approach is typical in my experience.*
- d. The ranked Vendors were then assessed based on their overall ranks in both categories.<sup>19</sup> *This approach is typical in my experience.*

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<sup>16</sup> 2022 TPA RFP, Section 2.6.2.

<sup>17</sup> 2022 TPA RFP, Section 3.4.

<sup>18</sup> 2022 TPA RFP, Section 3.4.

<sup>19</sup> 2022 TPA RFP, Section 3.4.

21. The process described above, which the Plan employed in evaluating the 2022 TPA RFP responses (and which Wills describes as “*points-to-ranks-to-points-to-ranks*”), is reasonable. As an advisor for different plan sponsors (e.g., governments, commercial employers) it is common in my experience for plan sponsors to score and rank RFP components such as technical and cost and then consolidate the results into a final score to select a vendor.

22. **Scoring and ranking creates quantifiable distinctions amongst vendors.** Ms. Wills claims that the Plan’s scoring methodology “skewed” the Vendors’ responses.<sup>20</sup> This is a mischaracterization. In my experience, scoring and ranking is a useful way to differentiate between scores for the RFP components that may be close, assisting in the evaluation of the vendors. This process is akin to an Olympic footrace like the 100-yard dash. The runners are scored (reflected by their times to run the race) and then ranked (Gold, Silver, Bronze). This is done even when the scores are very close (hundredths of a second in some cases). Differentiating between who received a Gold vs. Silver medal is not “skewing” the results. Similarly, in my experience, an RFP scoring and ranking methodology allows a sponsor to evaluate one vendor’s proposal “head-to-head” against the other vendors – even when the vendors are very close in merit. In my opinion, this facilitates efficient and effective evaluation of value and fit, and ultimately decision making. For example, assigning a points scoring system to the various discounts included in vendors’ proposals allows the sponsor to quickly quantify how the vendors’ responses line up on a holistic level. By using a scoring and ranking methodology, as illustrated in this example, the Plan was able to empirically rank the responses – even in instances where vendors are close in score.<sup>21</sup>

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<sup>20</sup> Wills Report, para. 25.

<sup>21</sup> Notably, it is a common and leading practice in my experience in governmental RFPs to differentiate vendors by points, and in some cases, to award business to the highest scoring vendor when scores are very close, even if the scores were differentiated by a single point out of many possible points available.

23. When utilizing a scoring and ranking methodology to evaluate technical and cost proposals separately, it is also common in my experience that the points allotted to each section are on a different scale. This was the case for the 2022 TPA RFP, where there were 310 possible points for the Technical Proposal and 10 points for the Cost Proposal, but the two proposals had equal weight.<sup>22</sup> There are two common ways to normalize these differences in scoring scales to allow for an appropriate combination:

- a. **Option 1:** Scale the available points to the same basis. For example, the results for the technical and cost proposals could be scaled to be worth 50 points each.
- b. **Option 2:** Define a pre-determined set of values that align to scoring, and apply the mapping based on the sponsor's pre-set weights. For example, the top score gets a value of "3", next a "2" and so on. Then, the scored values are combined based on the sponsor's perceived value, or weighting, of each section.

24. In the case of the 2022 TPA RFP, the Plan elected to normalize the Cost and Technical Proposals' scores using an approach consistent with "Option 2" above, in which the Plan assigned a scoring methodology to both the Technical and Cost Proposals, and then assigned equal weight to the scores from each.<sup>23</sup> As a practical matter, both options above would yield Aetna in first place followed by Blue Cross NC, based on the points allocations proscribed in the RFP. My analysis of the Information Considered would not have led me to recommend using Option 1 over Option 2 above, and thus, I find the approached used reasonable.

25. **Scoring and ranking facilitates consideration of key requirements.** A scoring and subsequent ranking methodology allows the reviewers to rank vendors lower, based on their

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<sup>22</sup> 2022 TPA RFP, Section 3.4.

<sup>23</sup> 2022 TPA RFP, Section 3.4.

answers, due to non-compliance with or inability to confirm key questions of importance to the sponsor. In my view, this facilitates an expedited decision-making process, as sponsors and scorers can quickly identify and rank lower instances where key components will not be met by the vendor.

26. In the case of this 2022 TPA RFP, for example, the 2022 TPA RFP sought confirmation of 310 technical requirements in the Technical Proposal.<sup>24</sup> Aetna and UMR confirmed all 310 technical requirements.<sup>25</sup> Blue Cross NC only confirmed 303 because it either claimed it could not confirm, or made the business decision not to confirm seven of the requirements; it is my understanding that Blue Cross NC could have invested capital to achieve technical compliance with those seven requirements but chose not to do so.<sup>26</sup> Accordingly, the Plan ranked Blue Cross NC the lowest in the Technical Proposal because of Blue Cross NC's business decision not to confirm several technical requirements which the Plan had deemed as important, and which were confirmed by Aetna and UMR.<sup>27</sup> Blue Cross NC's failure to confirm these seven requirements created a quantifiable differentiation between Aetna, UMR, and Blue Cross NC, and aligns with Blue Cross NC's last place ranking for its Technical Proposal under this scoring approach.

27. As a final observation, I note that even under Ms. Wills' claimed "*best-practices approach to the final scoring*", **Blue Cross NC would still have been ranked below Aetna**. The Wills Report states in part: "... all else equal, Aetna would have received a final combined score of 558, and Blue Cross NC would have received a final combined score of 551."<sup>28</sup>

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<sup>24</sup> Petition for Contested Case Hearing, para. 30.

<sup>25</sup> Petition for Contested Case Hearing, para. 37.

<sup>26</sup> Petition for Contested Case Hearing, para. 35. *See also* Deposition of Aimee Forehand, p. 230.

<sup>27</sup> Deposition of Aimee Forehand, p. 230.

<sup>28</sup> Wills Report, para. 27.

28. Based on my professional experience, and my analysis of the Information Considered, the “points to rank” approach utilized by the Plan is consistent with standard industry practices. Furthermore, based on the rules of the RFP, had I scored and ranked the Vendors, my outcome would have been identical to that of the Plan.

**B. Contrary to the opinion expressed in the Wills Report, the scoring methodology utilized in the Cost Proposal of the 2022 TPA RFP is an acceptable industry practice. This scoring methodology was specifically articulated in the 2022 TPA RFP and available to all Vendors.**

29. The Wills Report criticizes the scoring methodology for the Cost Proposal of the 2022 TPA RFP. Wills states in part: *“The Plan’s scoring methodology for the cost component of the RFP—a methodology that was not explained in the RFP, and that was subjective and unreasoned—did not follow best practices for procurements.”*<sup>29</sup> I disagree with this assertion, and it is my opinion that there are several important factors in the scoring methodology which, in my experience, demonstrate that the Cost Proposal scoring methodology was acceptable. These factors include: 1) the cost scoring and weighting methodology was described with specificity in the RFP document, and was available to all of the Vendors;<sup>30</sup> 2) during the RFP process, the Vendors had two opportunities to ask clarifying questions of the Plan regarding the RFP, and Blue Cross NC could have (but did not) raise questions or concerns with the Cost Proposal scoring methodology;<sup>31</sup> and 3) although it is the Plan’s prerogative to assign weight to scores, the cost score weighting assigned by the Plan (which was also detailed in the RFP) is consistent with typical cost proportions of medical benefit programs.

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<sup>29</sup> Wills Report, Opinion B.

<sup>30</sup> 2022 TPA RFP, Section 3.4, pp. 24-25.

<sup>31</sup> 2022 TPA RFP, Section 2.4.

30. **The scoring and weighting methodology was described in the RFP.** As outlined in the 2022 TPA RFP, the Plan’s scoring methodology for the Cost Proposal gave “major” weights to each of the following three cost sections: Network Pricing (6 points); Administrative Fees (2 points); and Network Pricing – Guarantees (2 points).<sup>32</sup> The methodology and scoring for each of these three cost sections was described under each major section, including how ranking would be determined and points allocated.<sup>33</sup> Based on my analysis of the Information Considered, I understand that all three of the Vendors had access to the RFP, including the sections describing the scoring and weighting methodology for the Cost Proposal.<sup>34</sup> Making available to vendors a written description of the scoring methodology is, in my view, an important factor in assessing the adequacy of the scoring process. There are a variety of acceptable methodologies an RFP sponsor may leverage to score responses; accordingly, providing details of the specific method to be used in a given RFP gives vendors insight into how their responses will be measured, and allows the vendors to make informed decisions about how to respond such that they may increase their chances of achieving a high score. As such, the Plan’s detailed disclosure of the scoring process for the Cost Proposal supports that the Plan employed a transparent scoring methodology, which supports an acceptable scoring process.

31. **The Vendors had an opportunity to ask questions about the cost scoring and weighting methodology.** Another important factor in assessing the adequacy of a scoring methodology is whether the vendors have an opportunity to seek clarification on points they may find confusing or ambiguous. Similar to the disclosure of the scoring methodology itself, an opportunity to ask questions offers vendors the opportunity for additional insight that can assist

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<sup>32</sup> 2022 TPA RFP, Section 3.4c.

<sup>33</sup> 2022 TPA RFP, Section 3.4c.

<sup>34</sup> Petition for Contested Case Hearing, para. 9.

vendors in preparing their responses. That is precisely what the Plan offered in this instance.<sup>35</sup> Namely, the Vendors were provided an opportunity to ask questions of the Plan regarding the RFP, including questions about the minimum requirements, technical requirements, cost and pricing requirements, and the scoring methodology.<sup>36</sup> Notably, Blue Cross NC did not avail themselves of this option, and asked no questions of the Plan regarding the scoring methodology.<sup>37</sup> Rather, the first time Blue Cross NC raised questions or concerns about the scoring methodology was after Blue Cross NC was advised they were not awarded the contract pursuant to the 2022 TPA RFP.<sup>38</sup> The absence of questions on the scoring process despite the opportunity to raise questions or concerns, and the fact that Blue Cross NC did not raise any objections to the methodology until after it lost, suggests to me that Blue Cross NC understood how its responses to the Cost Proposal would be scored under the methodology set forth in the 2022 TPA RFP at the time it submitted its Cost and Technical Proposals.

32. **The Cost Proposal score weighting assigned by the Plan is consistent with typical cost breakouts of self-insured medical plans.** In my 25 years of experience underwriting and developing cost projections for medical plans, claim costs (also referred to as variable costs) generally account for 80%-95% of a typical medical plan cost, whereas administrative fees (also referred to as fixed costs) typically account for 5%-20%. Ranges are due to the performance of the plan (e.g., how close the variable costs were to what was estimated) and buy-up and other programs (which may change the fixed cost). Published information from U.S. Centers for Medicare & Medicaid Services supports my assertion, describing what's known as the "80/20 Rule": *"The 80/20 Rule generally requires insurance companies to spend at least 80% of the*

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<sup>35</sup> 2022 TPA RFP, Section 2.5.

<sup>36</sup> 2022 TPA RFP, Section 2.5.

<sup>37</sup> Deposition of Aimee Forehand, p. 88; Blue Cross NC\_0000348; SHP0009429.

<sup>38</sup> Petition for Contested Case Hearing, para. 3.

money they take in from premiums on health care costs and quality improvement activities. The other 20% can go to administrative, overhead, and marketing costs.”<sup>39</sup> While the “80/20 Rule” is only a *requirement* for fully-insured organizations, in my experience, these proportions of claims and administration costs apply generally to self-insured organizations as well. While each organization is unique and purchases different levels of administrative services, in my experience medical plans generally incur a *majority* of their costs associated with variable costs (i.e., claims) with the balance being fixed costs (i.e., administration).

33. Although it was the Plan’s prerogative to assign weighting to the scoring sections of the Cost Proposal, I observed that the weighting for the Cost Proposal described in the 2022 TPA RFP is consistent with this same “80/20 Rule”. Namely, the cost components directly relating to the variable cost in the RFP analysis (Network Pricing = 6 points, and Network Pricing Guarantees = 2 points) represent 8 out of 10 possible points for the Cost Proposal, or 80%.<sup>40</sup> The fact that the Plan weighted the value of the scores of the variable and fixed pricing components in a proportion consistent with how medical plans generally incur costs further demonstrates to me that the Cost Proposal methodology employed by the Plan was acceptable in my opinion.

34. In summary, I disagree with the opinions expressed in the Wills Report regarding the scoring methodology for the Cost Proposal of the 2022 TPA RFP. In my opinion, for the reasons described above, the Cost Proposal scoring methodology was consistent with common industry practice.

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<sup>39</sup> <https://www.healthcare.gov/health-care-law-protections/rate-review/>

<sup>40</sup> 2022 TPA RFP, Section 3.4c.

**C. Contrary to the assertions set forth in the Wills Report, the Plan’s use of binary response options without corresponding narrative for the Technical Proposal of the 2022 TPA RFP is a common and acceptable industry practice.**

35. The Wills Report criticizes the Plan’s scoring methodology for the Technical Proposal, claiming: “*The Plan’s approach to the technical component of the RFP—an approach in which the Plan barred all narrative responses, yet did nothing to validate any part of the vendors’ technical proposals—did not follow best practices for procurements*”.<sup>41</sup> Once again, I disagree with the conclusion in the Wills Report. In my experience, the use of a binary “confirmed/not confirmed” model for the detailed requirements of the Technical Proposal is an increasingly common practice which I have utilized in my work with RFPs. It is my opinion that binary or closed-ended responses to detailed, specific RFP requirements facilitate an efficient and effective RFP review and scoring process.

36. Nearly every RFP in which I have participated in recent years includes a section of binary (confirmed/not confirmed) response requirements covering the sponsor’s minimum requirements and/or technical requirements. Typically, these binary response questions are detailed and specific. In my experience, it is a leading practice to ask detailed and specific RFP questions, particularly in the context of questions which will have binary responses. The greater the detail in the question, the more clarity the vendor has on the sponsor’s specific requirements, decreasing the risk of confusion or misunderstanding. Furthermore, and as described in detail previously in paragraph 31, it is a leading practice to provide vendors an opportunity to ask questions during the RFP process, so that vendors have a chance to clarify questions they perceive to be unclear. As I described previously, the 2022 TPA RFP process allowed an opportunity for the Vendors to clarify in narrative any of the RFP’s specific requirements before confirming or not

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<sup>41</sup> Wills Report, Opinion C.

confirming. Furthermore, the Vendors (including Blue Cross NC) could ask questions with respect to any aspect of the RFP (e.g., minimum requirements or other sections) as noted in the RFP instructions.<sup>42</sup> In my opinion, this process to have specific opportunities to ask detailed questions is important when using binary answers to score vendors, which was followed in the 2022 TPA RFP and aligns with leading practices.

37. In this 2022 TPA RFP, the Plan asked 310 questions in the Technical Proposal.<sup>43</sup> Based on my analysis, it appears that the 310 questions in the Technical Proposal were detailed and specific, indicating to me that the Plan was thoughtful and intentional about the information sought, consistent with leading practices. This indicates to me that each of these 310 detailed questions were important to the Plan, and as such it was reasonable to assign each an equal weight.

38. It is also my opinion that the inclusion of binary questions in an RFP facilitates an efficient and effective RFP response review process. First, binary questions facilitate a more efficient, more objective, and less labor-intensive approach to scoring. Scoring narrative responses frequently requires the selection committee to read hundreds of pages of responses, distill and summarize the key highlights of the responses, and evaluate the vendors' answers. This labor-intensive process can be vulnerable to pitfalls such as subjectivity and bias, misunderstanding, disagreement amongst the scorers, and human error. By contrast, binary responses require no subjective analysis or interpretation by the scorers – simply put, the responses are not subject to interpretation. In turn, this leads to a more uniform and streamlined scoring process than the labor-intensive scoring analyses that often accompany open-ended questions.

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<sup>42</sup> 2022 TPA RFP, Section 2.5.

<sup>43</sup> 2022 TPA RFP, Section 3.4b.

39. In addition to being more efficient, binary questions can offer greater clarity to the RFP sponsor on the vendors' responses. By their nature, binary questions are designed to restrict a vendor from offering a response that does not fully address the question, or a response that may seem positive but comes with caveats, or language that is otherwise confusing or ambiguous to the RFP sponsor. Said differently – binary questions allow the RFP sponsor to clearly understand, in simple terms, “will you, or will you not, do what I am asking?” In turn, this offers RFP sponsors an ability to objectively and efficiently quantify whether their key requirements will be fulfilled by a given vendor and is thus an acceptable practice in my opinion. I also rely on binary questions in almost all RFPs I help craft.

40. Finally, Ms. Wills criticizes the Plan for not “validating” the Vendors' responses to the Technical Proposal.<sup>44</sup> This lacks merit. There is no need to validate a “confirmed/ not confirmed” response as there is no ambiguity in the answer – the Vendors stated they would either meet the requirement, or they would not. To suggest that the Plan should have validated the Vendors' binary responses would suggest that the Vendors were either mistaken in quoting their capabilities, or deliberately misrepresented their offer. Ms. Wills has offered no basis to suggest that either of these scenarios are plausible, and Ms. Wills cannot know what capabilities any vendor would have on January 1, 2025. The winning vendor is obligated to fulfill the requirements that were confirmed in its RFP responses, and the RFP sponsor has a right to rescind the contract should the selected vendor fail to meet the confirmed requirements.<sup>45</sup> As such, Ms. Wills' claim that the Plan should have “validated” the Vendors' responses is without merit.

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<sup>44</sup> Wills Report, para. 64.

<sup>45</sup> 2022 TPA RFP, Section 2.3.

41. In summary, based on my analysis of the Information Considered, I find the scoring of the Technical Proposal of the 2022 TPA RFP to be acceptable and consistent with leading practices for RFPs. As such, I disagree with the criticisms of the Technical Proposal scoring process expressed in the Wills Report.

**D. Contrary to the opinion expressed in the Russo Report, the Plan’s scoring of pricing guarantees is an acceptable industry practice.**

42. The first opinion in the Russo Report criticizes the scoring of the pricing guarantees in the Cost Proposal. The Russo Report states in part, “*The Plan’s assignment of zero points to Blue Cross’s pricing guarantees was subjective, reflecting little quantitative analysis and lacking a sufficient basis for the Plan’s assignment of points.*”<sup>46</sup> I disagree with Mr. Russo. In my professional opinion and based on my experience, the approach to scoring the pricing guarantees in the Cost Proposal followed an acceptable methodology for the following key reasons:

- a. Segal’s scoring of the discount guarantees focused on the maximum dollars at risk to each Vendor and the proportion of each Vendor’s administrative fees represented by these dollars;
- b. Segal’s methodology for ranking discount guarantees used variables that focused on aligning Vendor performance failures to penalties (thus aligning interests between the Plan and Vendor), consistent with my experience;
- c. Segal appropriately assessed trend guarantees by focusing on the key aspects of these guarantees which would most closely align the interests of the Vendors to those of the Plan; and

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<sup>46</sup> Russo Report, Opinion 1.

- d. Discount guarantees and percent of Medicare guarantees essentially measure the same thing, in my opinion – the average unit cost reimbursed to providers compared to a benchmark (e.g., eligible charges or Medicare). While Segal’s report did not summarize the Vendors’ percent of Medicare guarantees,<sup>47</sup> the key factors – the maximum dollars at risk to each Vendor and the proportion of each Vendor’s administrative fees represented by these dollars, result in the conclusion that Blue Cross NC’s 15% of administrative at risk (~\$8M) was below that of Aetna (20% and ~\$18M).<sup>48</sup>

43. To assess Segal’s scoring approach, it is important to first understand the context of performance guarantees. The 2022 TPA RFP stated the following with respect to scoring of performance guarantees: *“Proposals will be evaluated and ranked based on their proposed network pricing guarantees. The value of the pricing guarantees will be based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk.”*<sup>49</sup> To assess the “competitiveness of the guaranteed targets,” it is appropriate in my experience to examine each vendor’s projected discount and guarantee from the perspective of: “Is the vendor incentivized to deliver on its promise, or has the vendor built in so much conservatism that the incentive is diminished?” This “conservatism” is measured by subtracting what the vendor expects to achieve from what the vendor promises. Under this construct, small differences are good—and large differences are not. The table below illustrates the Vendors’ results in the 2022 TPA RFP:

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<sup>47</sup> Segal’s 30b6 Deposition, p. 206.

<sup>48</sup> SHP0000010; Blue Cross NC\_0000151

<sup>49</sup> 2022 TPA RFP, Section 3.4c.

**Table 1: Guarantee Differences<sup>50</sup>**

	Aetna	Blue Cross NC	UMR
What the Vendor expects:	54.00%	57.80%	54.10%
2025 Guarantee:	52.30%	55.10%	52.60%
Difference in Guaranteed vs. Projected:	-1.7 points	-2.7 points	-1.5 points
Difference	Middle	Largest	Smallest

44. As the table above illustrates, consideration of both projected discounts and guarantees provides additional insight in the competitiveness of the guarantees provided. As shown in this table, Aetna is within 1.7% of their projected 2025 values, while Blue Cross NC has the largest difference at 2.7%. Thus, and as I will describe below, it is my opinion that Segal’s approach of using the dollars and percentage of fees at risk to score the discount guarantees submitted by the Vendors was acceptable and appropriate, and consistent with how I would have scored the Vendors’ responses since the 2022 TPA RFP pricing guarantee responses were scored based on “...the combination of the competitiveness of the guaranteed targets and the amount placed at risk.”<sup>51</sup>

45. In addition to the “competitiveness of the guaranteed targets” which I describe above, the second component of the RFP’s stated scoring criteria was “the amount placed at risk.”

46. **Segal’s consideration of the amount placed at risk focused on the maximum dollars at risk and the proportion of the vendor’s administrative fees represented by these dollars.** The goal of discount guarantees (and other performance guarantees) is to put the selected vendor at *meaningful risk* for delivering on their promises. As an initial point, it is important to

<sup>50</sup> SHP0069464.

<sup>51</sup> 2022 TPA RFP, Section 3.4c.

bear in mind that the promise itself (e.g., the discount or the trend) is scored separately in the financial projection scoring in the 2022 TPA RFP, as it was scored in the Network Pricing portion of the scoring.<sup>52</sup> If the Plan is satisfied with the scoring of the discount itself, then what is important in the scoring of the guarantee is the *effectiveness of the incentive for the Vendor to deliver*. Segal’s methodology for considering the amount placed at risk used factors consistent with my experience. Based on my analysis of the Information Considered, it is evident to me that Segal considered the amount at risk based on the **total dollars** put at risk by the Vendors, and as a **percentage of administrative fees**. The table below summarizes my understanding of the Vendors’ dollars at risk and the percent of administrative fees represented, as well as how Segal ranked each Vendor’s discount guarantee:

**Table 2: Discount Guarantees by Vendor<sup>53</sup>**

	Aetna	Blue Cross NC	UMR
Total dollars at risk	\$22.3M	\$8.0M <sup>(1)</sup>	\$95.1M
Proportion of administrative fees at risk	25%	15%	100%
Segal Ranking	Middle	Worst	Best

<sup>(1)</sup> Segal interpreted the Blue Cross NC guarantees as 5% of administrative costs and \$2.65M. However, even if Segal had utilized \$8.0M and 15%, the rankings would not have changed.

47. A strong guaranteed discount rate with relatively few dollars at risk, in my experience, may not give vendors as much incentive to fulfill their commitments. Thus, it is reasonable that Segal’s scoring of the discount guarantees focused on the “conservatism” between what the vendor expected to deliver and their guarantee, the maximum dollars at risk and the proportion of the vendor’s administrative fees represented by these dollars.

<sup>52</sup> 2022 TPA RFP, Section 3.4c.

<sup>53</sup> SHP0069489.

48. These measures (difference between expected and guaranteed discounts, dollars at risk and proportion of administrative fees at risk) are key factors to consider when evaluating discount guarantees, **particularly in situations where calculated discounts are scored separately from discount guarantees.** In the case of the 2022 TPA RFP, discounts were scored separately from guarantees via the Claims Cost section of the financial analysis (worth 6 out of 10 points).<sup>54</sup> As such, inclusion of the financial effect of the discount guarantees on the plan in the ranking of the discount guarantees would have **double-counted** this area in the scoring process, since strength of discounts was already measured in the financial projections analysis. Considering this fact pattern, if I were given the facts and circumstances that were present in this matter, I would have scored and ranked the vendors based on the difference between expected and guaranteed discount, the total dollars at risk and the percentage of fees at risk to the vendor, consistent with what Segal did in this instance. As such, my rankings of the Vendors' discount guarantees would have been consistent with those of Segal.

49. **Segal appropriately assessed trend guarantees by focusing on the key aspects of these guarantees which would most closely align the interests of the Vendors to those of the Plan.** In my experience, trend guarantees have a different purpose than discount guarantees. A trend guarantee offers to put a limit on actual per capita cost growth, and imposes a penalty if costs exceed this limit.<sup>55</sup> Similar to discount guarantees, if a vendor submits a guarantee that is higher than likely cost trends, or if the vendor puts relatively small dollar amounts at risk, the value of the guarantees to the RFP sponsor is reduced.

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<sup>54</sup> 2022 TPA RFP, Section 3.4c.

<sup>55</sup> <https://www.milliman.com/en/insight/considering-trend-guarantees-in-your-next-tpa-selection-analysis>

50. In the measurement of trend, many factors are considered in my professional experience. The unit prices of services (as informed by the discounts achieved) are a major factor.

However, other factors can be significant, including, but not limited to, the following:

- a. The vendor's ability to steer care to higher quality or lower cost providers;
- b. The vendor's ability to steer care to alternative places of service (e.g., office to telemedicine or inpatient to outpatient);
- c. The vendor's ability to steer care to alternate care pathways (e.g., diet/exercise/therapy vs. surgery);
- d. The vendor's ability to improve or maintain member health through its care and condition management programs (e.g., teaching a member with diabetes or asthma how to better manage their condition to avoid emergency situations or a worsening of the condition);
- e. The strictness of the vendor's approval process for discretionary or overused services (e.g., chiropractic care or high-cost imaging);
- f. The vendor's predictive capabilities (enabling better management of high-cost claims, such as high-risk pregnancy);
- g. The vendor's access to and use of social determinants of health to incorporate these data into health management practices and member communications; and
- h. The quality of the vendor's fraud, waste and abuse programs at identifying and recovering inappropriate claim payments.

51. The industry term for the collective costs produced by a vendor is the “Total Cost of Care.”<sup>56</sup> A vendor’s guarantee that the cost trend will not exceed a certain threshold is a function of the vendor’s anticipated ability to influence the Total Cost of Care through its discounts, networks, and strength of the above programs and activities.

52. In my analysis of the trend guarantee information related to this matter, I noted the following data points: 1) Blue Cross NC and Aetna put similar cost trend guarantees in their proposals (6.0% and 6.8%, respectively).<sup>57</sup> Based on my knowledge of the health plan industry, these trend rates are consistent with typical recent and future trend estimates, and thus are acceptable. 2) UMR’s guarantee indicated that it would achieve UnitedHealthcare’s (“UHC’s”) Book of Business (“BoB”) trend minus 1%, which is competitive with the other Vendors’ guarantees.<sup>58</sup> Based on these facts, in my opinion each of the trend guarantees set forth by the Vendors is reasonable.

53. Since all of the Vendors’ trend guarantees appear reasonable, in my opinion it was appropriate for Segal to then score the vendor based on the **total dollars at risk and the percentage of fees at risk**, as illustrated below:

**Table 3: Trend Guarantees by Vendor<sup>59</sup>**

	Aetna	Blue Cross NC	UMR
Total admin. dollars at risk	\$22.3M	\$2.65M	\$47.5M
Proportion of administrative fees at risk	25%	5%	50%
Ranking	Middle	Worst	Best

<sup>56</sup> [https://www.bcbs.com/smarter-better-healthcare/mini-white-paper/understanding-the-full-picture-of-total-cost-of-care#:~:text=Total%20Cost%20of%20Care%20\(TCOC,your%20employees%20and%20their%20dependents.](https://www.bcbs.com/smarter-better-healthcare/mini-white-paper/understanding-the-full-picture-of-total-cost-of-care#:~:text=Total%20Cost%20of%20Care%20(TCOC,your%20employees%20and%20their%20dependents.)

<sup>57</sup> SHP0069489.

<sup>58</sup> SHP0069489.

<sup>59</sup> SHP0069464.

54. In conclusion, to evaluate the Vendors' guarantees in a consistent manner, Segal focused on the most important and comparable elements – the dollars at risk and how these dollars compared to each vendor's proposed administrative fees. Furthermore, to avoid double counting, Segal reasonably set aside elements which were captured and scored in other RFP scoring areas. For example, the Network Pricing section considered already the impact on projected costs of the Vendors' discounts. Similarly, the Administrative Fees section scored the impact of Vendors' administrative fees. As such, it is my opinion that the approach taken by Segal was acceptable and avoided double-counting. Furthermore, based on my analysis of the Information Considered, my rankings would have been consistent with those of Segal had I scored the performance guarantees.

**E. Mr. Russo's calculation of the impact of alleged discrepancies in Aetna's bid pricing does not appear to consider key factors and thus is incomplete**

55. The Russo Report contends that for the **REDACTED** for which Aetna had letters of intent ("LOIs"), "*The discounts in those letters of intent are not as deep as the discounts Aetna bid...As a result the claims costs associated with these providers will be higher for the Plan than the prices in Aetna's proposal.*"<sup>60</sup> Based on my professional experience and my analysis of the Information Considered, it is my opinion that the analyses and conclusions in the Russo Report do not appear to adequately account for the many potential variations in assumptions and applied methodology, both in repricing and in claims systems, that are common in this industry. In my experience, even slight variations in assumptions and methodologies can have a significant impact on repricing outcomes. These potential variations in practices include, at a minimum: 1) variety of practice and assumptions permitted by the 2022 TPA RFP; and 2) contractual terms beyond the

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<sup>60</sup> Russo Report, p. 27.

rate schedule. As such, since there are key considerations which the Russo Report does not appear to include, it is my opinion that the Russo Report's calculations are incomplete.

56. **Variety of practice / assumptions permitted by the 2022 TPA RFP.** In my opinion, the repricing of the claims, and the instructions to do so articulated in the 2022 TPA RFP, allowed for potential variation in certain pricing details and assumptions. For example, the 2022 TPA RFP did not specify whether repricing should be applied to billed charges or only eligible charges. Eligible charges are generally lower – they exclude services that are not covered by the plan or amounts that may be paid by other insurers (through Coordination of Benefits).<sup>62</sup> I observed that both “available billed charges” and “eligible charges” data fields were provided to the Vendors, and the use of one of those fields over another would have yielded very different results.

57. **Other contractual terms beyond the rate schedules can have a significant impact on the discount calculation.** An LOI may include a schedule of reimbursements (rates/fee schedules) for various procedures, and it may also contain language around discounts and other factors that may alter the reimbursements. Furthermore, a full contract with a hospital or other provider will include many terms that affect the amount allowed. I have listed many examples of these terms below in paragraph 58. However, the Russo Report appears to narrowly focus on the unadjusted fee schedules from Aetna's LOIs to create a final priced amount.<sup>63</sup>

58. **A repricing analysis is not the same as a health plan paying a claim.** It is important to recall that a repricing analysis is just that – an analysis. In my experience, a repricing analysis is akin to an illustrative exercise, in that less information is available about the claim, and

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<sup>62</sup> <https://www.healthcare.gov/glossary/allowed-amount/>

<sup>63</sup> Russo Report, Figures 8, 9, 10, and 11.

some assumptions must be made about the factors that can modify the allowed amount. In my opinion, the health plan itself (in this case, Aetna) is in the best position to make those analytical assumptions in a repricing analysis, given their understanding of their contracts, provider practices, and book-of-business experience. Conversely, in my opinion, I have seen no indication that Mr. Russo even attempted to obtain an understanding of Aetna's actual experience.

59. My understanding of repricing claims is that the fee schedule is a starting point but may not always match the final amount reimbursed to the provider based on all adjustments made – sometimes, there are other contractual provisions that impact price. Examples that are commonly found in contracts where this creates discrepancies in the final payments are:

- a. Stop loss provisions, which create limits at which different payments can apply before and after the bill charges stop loss threshold is reached.
- b. Inpatient payment windows, which assume that outpatient services associated with an inpatient admission are paid under the inpatient admission only. **REDACTED**  
**REDACTED** many conditions may correspond to this term, such as admission from an emergency room or admission as a result of observation services. Based on the contract, these would be grouped together and paid on the appropriate admission rate.
- c. Exclusion criteria, which assume that the plan may be able to determine and not include payment for services that are not deemed medically necessary or experimental.

- d. For outpatient services, often times payers have logic when multiple procedures are performed during a single encounter. As an example, in an Ambulatory Surgery setting, the primary surgical procedure will be identified as the highest applicable category and will be reimbursed at 100% of the contracted rate; subsequent procedures will be reimbursed at a lower %.

60. In summary, based on the Information Considered, I would not have expected the Russo Report to be able to match exactly the rates of Aetna's repricing exercise without detailed consideration of at least these key areas of variation. Pricing of a claim is not as simple as a rate match from a service to a provider, and each vendor has rules and polices that are in force to manage and administer claims processing in a way that is consistent with their overall contract language, and publicly available provider policies. It would be difficult for any organization to be able to reprice with accuracy the values for an organization based on this knowledge, and yet the Russo Report appears to consider very limited information. As such, it is my opinion that the repricing conclusions in the Russo Report are incomplete.

**F. Contrary to Mr. Russo's assertion, Segal's analysis of repricing, and the subsequent adjustments to Blue Cross NC's calculated value, followed an acceptable industry practice of presenting values on the same basis for comparison of the Vendors.**

61. The third opinion in the Russo Report suggests that the Plan and Segal erroneously lowered Blue Cross NC's discount in the repricing exercise. The Russo Report states in part: *"Through the clarifications process, the Plan and Segal erroneously decreased Blue Cross's discount. That erroneous adjustment resulted in Blue Cross and Aetna earning 6 points each for the repricing exercise, as opposed to Blue Cross earning 6 points and Aetna earning 3 points."*<sup>65</sup> Based on my analysis of the Information Considered, as well as my professional experience, I

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<sup>65</sup> Russo Report, Opinion 3.

disagree with the Russo Report's conclusion that the Plan and Segal erroneously reduced Blue Cross NC's discount. Rather, it is my opinion that Segal's analysis of the repricing exercise for the Cost Proposal was acceptable and *actually favorable* to Blue Cross NC.

62. In order to evaluate vendors' financial proposals in a consistent manner, in my experience it is necessary to reflect discounts included in the scoring analysis on the *same basis* for all vendors. In the case of the 2022 TPA RFP, the RFP clarifications were clear that billed charges should not be trended.<sup>66</sup> However, Segal identified (and Blue Cross NC confirmed) that Blue Cross NC had trended billed charges, the effect of which appeared to improve Blue Cross NC's discount in relation to the other Vendors who did not employ trending.<sup>67</sup> In order to conduct an "apples to apples" analysis of these discounts, in my experience Segal would have had two approaches they could employ: 1) ask all Vendors to restate to incorporate trend into the billed charges; or 2) ask Blue Cross NC to confirm its un-trended discounts. From my experience, either approach would put the Vendors' discounts on an equivalent basis. In this instance, Segal employed the second approach and requested Blue Cross NC to provide un-trended discount information.<sup>68</sup>

63. In my opinion, Segal's approach of using the un-trended Blue Cross NC discount was acceptable because it served to represent all Vendors' discounts on the same basis and time period. The analysis was designed to evaluate all discounts on the same basis through a process that allowed for consistent adjustments, as well as input from the Vendors to confirm the adjustments were being represented appropriately. Indeed, Segal submitted a series of clarification requests to the Vendors in the course of Segal's analysis, to which the Vendors provided Segal

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<sup>66</sup> Segal 30b6 Deposition, p. 249.

<sup>67</sup> Segal 30b6 Deposition, p. 249.

<sup>68</sup> Segal 30b6 Deposition, pp. 236-237.

written responses which Segal then used to finalize its calculations.<sup>69</sup> In my experience, Segal's approach was acceptable, as it addressed key points that can complicate the discount evaluation process:

- a. Discounts affect the vast majority of program costs and represent a key consideration in the RFP evaluation process. Unfortunately, in my experience, discounts are notoriously difficult to evaluate on an "apples-to-apples" basis, given the many factors that affect how discounts are measured and reported (e.g., trended versus un-trended discounts).
- b. Provider contracts may stipulate a set of reimbursement dollar amounts by service. Alternatively, in my experience some contracts may offer a flat discount off of billed charges. Furthermore, some contracts – especially hospital contracts – may employ a mixed model of dollar reimbursement, discounts, and other language that modifies these payments in cases of emergency treatment, attainment of certain quality standards, large claims and other factors. The diversity of practice in provider contracts further complicates the ability for RFP responses related to discounts to be compared on a "side-by-side" uniform basis.
- c. Several other factors can significantly influence the measurement and reporting of discounts, such as: 1) Timeframe of measurement (e.g., historical vs. projected); 2) Adjustments based on future contracts; and 3) Use of capitation, incentives, withholds, and other risk sharing arrangements.

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<sup>69</sup> Segal 30b6 Deposition, pp. 236-237.

64. Segal employed a claims analysis to compare the historical 2021 claims, trended to 2023-2025 and applying a factor to these claim projections, based on each Vendor's calculated discount value as of November 2022.<sup>70</sup> By giving specific instruction to the Vendors on what data and information to include in their discount responses, Segal designed an approach that would illustrate each Vendor's discounts as of a specific point in time – November 2022 – with an allowance for adjustments for any signed LOIs and known contract improvements.<sup>71</sup> This analysis did not employ the use of trend assumptions for the calculation of discounts.

65. Importantly, Segal's analysis did not attempt to predict *future* discounts, but rather developed a calculation which in my view would allow for consistent and uniform comparison of each of the three Vendors' responses. The Russo Report criticizes Segal's approach, focusing on examples of how discounts can increase over time due to the change in eligible and allowed charges.<sup>72</sup> However, in my professional opinion, Mr. Russo misses the point of Segal's exercise. Segal's analysis was not attempting to predict discounts over time. Rather, Segal was attempting to isolate the discount at the time of repricing (November 2022), modified only by the LOIs and known contract improvements as illustrated in Table 4 below and the various clarification emails submitted during the 2022 TPA RFP scoring process.

66. The table below summarizes Segal's calculations of discount in Segal's Network Pricing Analysis:

**Table 4: Discounts used in Segal's Network Pricing Analysis<sup>73</sup>**

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<sup>70</sup> SHP0069464.

<sup>71</sup> SHP0069464.

<sup>72</sup> Russo Report, pp. 32-44.

<sup>73</sup> SHP0069464.

Vendor	2021 reported discount (A)	Discount as of 11/22 (B)	Adjusted for letters of intent (C)	Known contract improvements (D)	Final discount used in the Segal analysis (E)	Ranking
Aetna	51.97%	52.11%	52.44%	52.99%	53.0%	Best
Blue Cross NC	51.2%	52.7%	No LOIs	N/A	52.7%	Middle
UMR	50.1%	51.1%	No LOIs	52.5%	52.5%	Worst

(A)	Each Vendor repriced the Plan’s claims, based on what they would have paid the providers at the time of the claim and for the services rendered. Based on this, a discount was calculated for the calendar year 2021
(B)	Vendors were asked to identify how any contractual changes would apply to the same Plan claims based on 2022 contracted rates in force. Given that the billed charges remain the same, that Vendors were allowed to use new rates in force, and that rate reductions typically only come through volume-based negotiations, I would anticipate only small adjustments.
(C)	Some providers signed LOIs indicating they would accept lower reimbursements from Aetna if Aetna won the RFP, because Aetna would be the health plan that would be steering new covered members to them.
(D)	Some providers sign long-term contracts that have lower reimbursement levels for some portion of services, especially if they believe the health plan will bring them more business.
(E)	This is the final “adjusted” number employed in Segal’s financial modeling.

67. The final discounts in Table 4 above were derived from the Vendors’ clarification responses dated November 18, 2022 and November 28, 2022, respectively, and align to those used in the Segal analysis.<sup>74</sup>

68. It is important to highlight that, contrary to Mr. Russo’s assertion, Segal’s process *did not “decrease” Blue Cross NC’s discount.*<sup>75</sup> Rather, as I described above, Segal used un-

<sup>74</sup> SHP0069464.

<sup>75</sup> Russo Report, Opinion 3.

trended discounts applicable at the time of the repricing of each claim and adjusted for known contract improvements and letters of intent as applicable, to arrive at a final calculation. All Vendors' discounts were ultimately represented as of November 2022, and Blue Cross NC agreed with Segal's calculation of 52.7% as of that date.<sup>76</sup> While the Vendors may have preferred that Segal use some future estimated discount, especially if it appears more favorable, by using discounts as of November 2022 Segal employed a consistent and equitable analytic process. Using Blue Cross NC's confirmed 52.7% discount was necessary to compare the pricing across the Vendors without unfairly inflating Blue Cross NC's discounts, due to the fact that Blue Cross NC *included trended data* when reporting its discounts and the other Vendors did not.

69. The Russo Report also criticizes the additional clarification requests Segal made of Blue Cross NC only.<sup>77</sup> In my opinion, and based on my analysis of the Information Considered, it was prudent of Segal to continue to seek clarification regarding the Blue Cross NC number of 54%. Blue Cross NC's experience and contracted rates as of the date of the claims used for repricing was 51.2%.<sup>78</sup> As Mr. Russo points out, contract rates rarely decrease, but often times, in the normal course of business, have annual increases.<sup>79</sup> The result of such increases that Mr. Russo points out would be an increase to the amount paid to a provider while holding billed charges the same, per the communication with the Plan during the correspondence that followed.<sup>80</sup> This would decrease the overall discount if that were the case, as Mr. Russo himself observes.<sup>81</sup> Blue Cross NC's calculation that their negotiated rates as of November 2022, based on the RFP correspondence, went from 51.2% in the base year of 2021 repricing to 54% as of rates in force on

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<sup>76</sup> SHP0069464.

<sup>77</sup> Russo Report, p. 80.

<sup>78</sup> SHP0069760.

<sup>79</sup> Russo Report, p. 32.

<sup>80</sup> SHP0069464.

<sup>81</sup> Russo Report, p. 32.

November 2022, without an increase in billed charges would imply *significant* rate cuts for providers, and as Mr. Russo highlights, this is not how rates for providers are typically negotiated.<sup>82</sup> As such, it was not reasonable in my opinion for Blue Cross NC to have a discount that improved by 2.8% without having an assumption regarding trended billed charges (which was inconsistent with both the direction to vendors in the RFP, and the basis utilized by Aetna and UMR). Accordingly, it was acceptable in my opinion for Segal to reach back out to Blue Cross NC for multiple clarifications until it was satisfied with an answer. For example, in the clarification sent by Segal on November 15, 2022, Blue Cross NC documented that their rate was based on “known contracting changes and the UDS prescribed billed charges trends”.<sup>83</sup> While this might be an accurate way to project forward looking discounts, this methodology made Blue Cross NC’s calculated value incomparable to Aetna and UMR. I would have continued to ask questions of Blue Cross NC just as Segal had done.

70. On the other hand, based on my analysis of the documentation Segal collected, as well as Segal’s clarifications, I would have found the documentation and correspondence provided by Aetna as of November 18, 2022 adequate for a number of reasons:

- a. Aetna’s discount on actual contracted rates in 2021 was 51.97% based on what Aetna would have paid on the date of service on each claim.<sup>84</sup> Correspondence and the additional exhibits were clear to base that discount on in-force contracts at the time.<sup>85</sup> This acts as the baseline for the subsequent adjustments per the RFP instructions.<sup>86</sup>

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<sup>82</sup> Russo Report, p. 39.

<sup>83</sup> SHP0069464.

<sup>84</sup> SHP0001952.

<sup>85</sup> SHP0001952.

<sup>86</sup> SHP0001952.

- b. Next, when comparing contracted rates during 2021, which provided a discount of 51.97%, to the repricing using contracted rates as of November 2022, Aetna showed only a 0.14% increase in discount.<sup>87</sup> This implies a very modest improvement on rates to providers, likely the result of a handful of favorable contract negotiations. This brings Aetna's new value to 52.11%.<sup>88</sup>
- c. From that calculated value of 52.11%, based on the information provided to Segal, there were signed LOIs, which clearly state that Aetna would have rate *decreases* approved if the Plan's contract was awarded, and other known contractual improvements (e.g., for pre-existing, multi-year contracts).<sup>89</sup> These would result in 52.44% and 52.99%.<sup>90</sup> Given that the increase in discount was modest (reflecting reasonable improvement in rates based on the acquisition of new enrolled members), in my opinion no further inquiries were needed to confirm that Aetna's number met Segal's objective to compare to the other Vendors.

71. Based on the Information Considered and correspondence provided to Segal, I would have been comfortable that the number used was reflective of the calculated discount and aligned to the methodology outlined in the correspondence between Segal and Aetna.

72. Although the Russo Report criticizes Segal's use of 52.7% as the comparable value for Blue Cross NC,<sup>91</sup> in my opinion this was actually a *favorable* view of the comparable discount, based on my understanding and the Information Considered provided to Segal. In clarification #6 on November 23, 2022, Blue Cross NC answered the question about how much of the discount is

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<sup>87</sup> SHP0001952.

<sup>88</sup> SHP0001952.

<sup>89</sup> See, for example, AETNA0001992.

<sup>90</sup> SHP0001952.

<sup>91</sup> Russo Report, p. 40.

rate improvement versus increases in billed charges with the following: “*The only way for a discount to increase year over year while excluding the corresponding billed charge increase would be for the allowed charges to have a negative trend at the provider level year over year. This would imply that a carrier is able to negotiate lower fees with the providers statewide year over year, which is not consistent with our historical experience in North Carolina.*”<sup>92</sup> Blue Cross NC did not have historical experience that improved the contract performance or rate position. Given that scenario, and no assumed billed charges increase from 2021 (as were expectations set forth based on Segal’s correspondence), Blue Cross NC’s rate of 51.2% *could only go down if they had negotiated rates lower than what they had during contract year 2021*. Based on Blue Cross NC’s experience, Blue Cross NC itself admits this was not the case,<sup>93</sup> and I would have then expected a number that was at or *below* 51.2%. Segal, through the clarifications, determined that some portion of the 2.8% difference was related to billed charge trends.<sup>94</sup> Therefore, Segal utilized the average change in discount and calculated a point in time value of 52.7% which Blue Cross NC confirmed.<sup>95</sup> In my opinion, 52.7% was a favorable outcome for Blue Cross NC based on how Segal performed the calculation. The comparable calculation as of November 2022 was supposed to be without the use of *any* billed charges increases. Blue Cross NC very clearly stated it had improvement in its discount, which was based on billed charge trends to some extent.<sup>96</sup> Given that billed charges were to be held constant, and Blue Cross NC acknowledged that it would be very difficult to get rate improvements for services, it would have been reasonable for Segal to have calculated a number much closer to 51.2%.

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<sup>92</sup> SHP0087620.

<sup>93</sup> SHP0087620.

<sup>94</sup> Segal 30b6 Deposition, p. 236.

<sup>95</sup> SHP0069464.

<sup>96</sup> SHP0087620.

73. Based on my experience and my analysis of the Information Considered, I would have reached the same conclusions for Aetna's discount, which showed modest improvement over time based on the fact that they would be acquiring the substantial membership of the Plan. I would have also had similar questions and correspondence with Blue Cross NC as Segal did, given the substantial increase in discount from 2021 repricing to November 2022, and based on Blue Cross NC's responses, may have arrived at a final calculation that was below the 52.7% that Segal ultimately finalized for Blue Cross NC.<sup>97</sup>

74. Importantly, in the final scoring of Network Pricing, Segal considered more than the discounts discussed here. Segal also applied the percentage of claims that would be subject to those discounts by applying a factor of "Assumed Network Utilization."<sup>98</sup> This is common practice when considering the impact discounts may have on projected claims. The assumed in-network utilization was based on the results of the repricing exercise, in which the Vendors identified whether the providers in the repricing file were in their respective networks.<sup>99</sup> Ultimately, it was this blend of discounts and in-network usage that led to the scoring of Aetna as best, Blue Cross NC as second best and within 0.5% (thus receiving the same score), and UMR as the bottom scorer and more than 0.5% but within 1.0% from the first-place scorer.<sup>100</sup>

75. As a final point, the Russo Report attempts to cast doubt on Aetna's responses, suggesting that the only way Aetna could have achieved the discounts set forth would be to convince providers to accept lower reimbursements.<sup>101</sup> Contrary to the argument that Mr. Russo makes in his report, my experience has shown that better (i.e., lower) rates payable to providers

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<sup>97</sup> SHP0069489.

<sup>98</sup> SHP0069464.

<sup>99</sup> SHP0069464.

<sup>100</sup> SHP0069489.

<sup>101</sup> Russo Report, p. 39.

can be achieved by specific health plans under the circumstance that a health plan is bringing more enrolled members to a provider. For this tactic to be effective, the number of enrolled members needs to be significant enough to impact the volume from the health plan to the provider, which is the case for the members covered under the Plan, and it would only work for non-incumbent carriers (i.e., Aetna and UMR). It would not work for Blue Cross NC because as the incumbent, it would not be offering more enrolled members to providers. In this case, Aetna was the health plan that would gain enrolled members, and based on my understanding of the letters of intent, Aetna was using the acquisition of enrolled members to negotiate lower rates to providers, and thus an increase of overall discount (regardless of the trending of billed charges). Blue Cross NC already had these covered enrolled members, and was not bringing new enrolled members to providers, and would thus not have leverage to negotiate lower rates.

76. In summary, it is my opinion that Segal's analysis of repricing, and the subsequent adjustments to Blue Cross NC's calculated value, was acceptable and appropriate. Based on the vendors' input and confirmations, Segal calculated an estimated discount as of November 2022, without the impact of trend and only allowing adjustments for known contractual improvements and signed letters of intent consistent with the correspondence and communication throughout the RFP process.

**G. Segal appropriately excluded its analysis of external data as a point of comparison from impacting the results of Segal's scoring under the rules of the 2022 TPA RFP**

77. The fourth opinion in the Russo Report suggests that Segal's examination of data collected outside of the RFP process supports the claim that Blue Cross NC's discounts were superior to those of Aetna. Russo states, in part: "*Segal's review of external data further undermined Segal's decision to adjust Blue Cross's discount percentage to a level below*

*Aetna's.*"<sup>102</sup> I disagree with this characterization. Based on my experience, Segal's consideration of other data sources to serve as a benchmark or "gut-check" for the results of Segal's own repricing analysis is a typical and acceptable industry practice.

78. Segal reviewed its Uniform Discount Specification ("UDS") data as a check against the Vendors' reported discounts. Segal appropriately opted not to rely on this data in their final analysis. Repricing and UDS are two distinct, but acceptable, methodologies for evaluating vendor performance in a procurement setting. However, only one should be used. Utilizing both in the same exercise can lead to conflicting results for the following reasons:

- a. Repricing is performed by each vendor on the plan sponsor's specific claims experience. Vendors attempt to best match their expected pricing to each claim line and output a good faith estimate of what their overall discount would have been.
- b. UDS is an industry accepted methodology for health insurers to submit book-of-business discounts. This repository of data is collected by consulting and brokerage firms for evaluating health plan discounts on a consistent basis. There is limited opportunity to calibrate UDS results to a specific plan sponsor – the only calibration that exists is in service area and the composite blend of Inpatient, Outpatient, and Professional discounts based on a client's distribution of claims.
- c. Both repricing and UDS results typically carry a +/- 2 discount point margin of error when displaying results. Utilizing both datasets with this margin of error can create a broad range of outcomes (i.e., if repricing states a 50% discount and UDS states

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<sup>102</sup> Russo Report, Opinion 4.

52%, the range of discounts could be 48% to 54%). To limit the variability of results, only one methodology should be chosen.

- d. UDS data was likely not collected or adjusted on the same basis as the discounts in the bids. For example, the UDS data represented a different timeframe (in this case, July 2020 to June 2021), whereas Segal’s analysis was putting all vendor discounts on a November 2022 basis with adjustments for known contract improvements and letters of intent. UDS data would not be reflective of client-specific letters of intent.<sup>103</sup>

79. Since the decision was made by the Plan at the outset of the RFP to utilize repricing as the comparison methodology, Segal appropriately did not utilize UDS results except as a secondary point of reference (“gut-check”) to determine if each vendor’s repriced discounts were within reasonable range (i.e., that Vendors were not overstating their discount).<sup>104</sup>

80. Notably, while Mr. Russo points out that UDS data showed Blue Cross NC as having a discount advantage over Aetna, he seems to conveniently ignore that the very same UDS data showed UMR as having a *discount advantage over Blue Cross NC*.

**Table 5: UDS Data**<sup>105</sup>

Vendor	RFP discount	Ratio (best = 1.000)	UDS discount (In-network only)	UDS Ratio (best = 1.000)
Aetna	53.0%	1.000 <b>Best</b>	50.2%	0.973 <b>Worst</b>
Blue Cross NC	52.7%	0.994 <b>Middle</b>	50.8%	0.985 <b>Middle</b>
UMR	52.5%	0.991 <b>Worst</b>	51.6%	1.000 <b>Best</b>

<sup>103</sup> SHP0085038, p.1.

<sup>104</sup> Segal 30b6 Deposition, p. 286.

<sup>105</sup> SHP0085038.

81. In summary, given that (1) repricing was the selected methodology defined at the beginning of the RFP, (2) RFPs should use only one methodology for use in scoring RFPs, and (3) the incorporating the results of UDS data with repricing data would have created inconsistent RFP results, I agree with Segal's decision not to incorporate UDS data in their final analysis.

**H. Contrary to the opinion expressed in the Russo Report, the Plan and Segal did consider network disruption and reviewed other measures of network accessibility in the analysis of the Vendors' bids**

82. Russo's fifth and final opinion suggests that the Plan erred in failing to compare the vendor's networks. Russo states: *"The Plan did not compare the vendors' networks of providers, even though it had the data needed to do so. As a result, the Plan failed to consider the disruption that will occur if Aetna becomes the TPA on January 1, 2025"*.<sup>106</sup> Based on my analysis of the Information Considered, in my professional opinion, the Plan and Segal did consider network disruption in the analysis of the Vendors' bids.

83. Network disruption refers to a situation in which the health care providers previously used by a member are no longer in-network. Members who find themselves in a situation where their doctor, hospital or other provider is not in the new network are considered "disrupted." In my industry experience, some level of disruption is inevitable. Even with incumbent vendors, in my experience there is an ebb and flow of providers joining and leaving the network, resulting in some member disruption each year. In my experience, plan sponsors recognize disruption is a concern and an issue to manage and attempt to ameliorate during the implementation process.

84. Health plans and health providers are incentivized to minimize disruption, and in my experience, minimization of disruption is a key initiative vendors undertake during the

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<sup>106</sup> Russo Report, Opinion 5.

implementation period for a TPA contract. As such, in my opinion, it would be acceptable to presume that Aetna would take measures to minimize network disruption in the time leading up to January 1, 2025 by seeking to contract with key providers used by the Plan’s members, which were not already in Aetna’s network. In turn, these providers are incentivized to join Aetna’s network, as failure to do so potentially puts them at risk of losing patients and revenue.

85. As a point of fact, the Plan and Segal did consider network disruption in their analyses of the Vendors’ bids. (Notably, the arithmetic inverse of “network disruption” is the “network match” or “in-network assumption. Thus a 99% network match yields a 1% network disruption.) Specifically, Segal employed an In-Network Assumption in the scoring and ranking of the Network Pricing analysis. In the repricing analysis, Vendors were required to identify if providers were in-network. Segal calculated the weighted average of those deemed by the Vendors to be in-network. Only in-network claims (based on the In-Network Assumption) were assumed to be paid at the calculated discount, and all other claims were considered at a different, out-of-network discount of 50%. This impacted the final overall Network Pricing and final discounts for each Vendor scored by the Plan and Segal. In the repricing analyses, the Vendors identified whether certain providers were in their networks and the results are as follows:<sup>107</sup>

**Table 6: In-Network Assumption**

Vendor	In-Network Assumption
Aetna	99.0%
Blue Cross NC	99.4%
UMR	98.5%

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<sup>107</sup> SHP0069464.

86. These results suggest a strong match to the key providers used by the Plan's members.

87. I also conducted analyses to assess Aetna's network accessibility, in response to Mr. Russo's criticisms. Network accessibility is measured two ways: 1) Network size: the number of unique providers in the geographic regions where members reside; 2) Network access (aka GeoAccess): this measures the percentage of members with access to a choice of in-network providers within a reasonable distance from their home zip code. While these measures of network accessibility were not scored, they were collected as part of the 2022 TPA RFP process. Based on my analysis, it is my opinion that Aetna offers a network of providers with a strong match to those used by The Plan's members, and in close proximity to these members' homes.

88. **Network size.** When analyzing network size, there are often significant differences in how health plans report provider counts, making comparisons challenging. For example, some providers have multiple specialties. Some have multiple offices, at times in different counties. And health plans may consider stand-alone hospitals separately or collectively when a hospital system is reported, and this may be based on how the hospital is contracted, different Tax Identification Numbers ("TIN"s) for each hospital, different facility types, or other naming conventions. I analyzed the network listings of both Blue Cross NC and Aetna as provided in their RFP submissions. Due to differences in how providers were reported, comparisons between the two for common provider types failed to yield comparable results.

89. **Network access ("GeoAccess").** As part of their proposal submissions, the Vendors performed GeoAccess analyses to determine the percentage of the Plan's enrollees with access to a choice of providers within a reasonable distance of their homes.<sup>108</sup> For purposes of this

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<sup>108</sup> 2022 TPA RFP, Attachment A.

analysis, Vendors were instructed to use the following parameters to identify the reasonable distance:

**Table 7: GeoAccess Parameters<sup>109</sup>**

	Hospitals	PCP, OB/GYN, Pediatrician	Other specialists
Urban zip codes	1 in 20	2 in 10	2 in 20
Suburban zip codes	1 in 25	2 in 15	2 in 25
Rural zip codes	1 in 35	2 in 20	2 in 35

90. Based on the Blue Cross NC and Aetna submissions, both vendors offer strong accessibility based on GeoAccess submissions. Below I illustrate a summary of the access for Urban, Suburban and Rural areas:<sup>110</sup>

**Table 8: Urban, Suburban, and Rural Access<sup>111</sup>**

<u>Urban</u>	Aetna				Blue Cross NC			
	Wake	Mecklenburg	Guilford	Total NC	Wake	Mecklenburg	Guilford	Total NC
Enrollees:	72,570	28,723	23,826	169,429	72,570	28,723	23,826	169,429
Primary Care (PCP)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	99.8%
Pediatrician*	99.3%	100.0%	100.0%	100.0%	99.5%	100.0%	96.4%	99.0%
OB/GYN*	97.6%	100.0%	98.6%	98.8%	99.1%	100.0%	95.2%	98.6%
<b>Total</b>								
<u>Suburban</u>	Aetna				Blue Cross NC			

<sup>109</sup> 2022 TPA RFP, Attachment A.

<sup>110</sup> According to the RFP specifications, access submissions for Pediatricians and OB/GYNs were to be run on a subset of members (i.e., children under age 19, and women aged 12 and over). It appears that Blue Cross NC ran the analysis based on all members, and Aetna followed the instructions. I adjusted the denominator for Pediatrician and OB/GYN access to represent both Vendors on a comparable basis. This analysis resulted in better than 100% access in some cases, likely due to the age calculations and date of birth assumptions, so where Aetna is shown at 100%, it is possible their results were slightly lower. However, the access results are expected to remain very strong. Blue Cross NC results were not adjusted, but represent access for all members, not the subset specified in the RFP.

<sup>111</sup> Data analysis relied on Blue Cross NC\_0001953 and SHP 0001779

**Public version with redactions as of 1/16/24**

	Orange				Pitt						
	Enrollees:	17,888	16,004	11,669	Total NC	127,076	17,888	16,004	11,669	Total NC	127,076
Primary Care (PCP)	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	99.9%
Pediatrician*	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	99.6%	100.0%	100.0%	99.2%
OB/GYN*	100.0%	99.4%	99.4%	99.8%	100.0%	98.8%	100.0%	97.4%	99.8%	100.0%	98.8%

**Total**

**Rural**

	Aetna				Blue Cross NC					
	Enrollees:	Johnston	Wayne	Robeson	Total NC	12,748	7,832	7,440	Total NC	222,332
Primary Care (PCP)	100.0%	100.0%	100.0%	99.7%	100.0%	99.8%	100.0%	100.0%	100.0%	99.8%
Pediatrician*	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	100.0%	100.0%	97.9%
OB/GYN*	100.0%	100.0%	100.0%	99.2%	100.0%	97.6%	100.0%	99.5%	100.0%	97.6%

**Total**

91. Accordingly, it is my opinion that Aetna offered an acceptable network for the members of the Plan; as such it is my view that Mr. Russo’s assertions are without merit.

**IX. CONCLUSION**

92. For the reasons described in this report, and based on my experience and analysis of the documents provided to me, it is my opinion that:

- a. Contrary to the opinion expressed in the Wills Report, the final scoring methodology utilized in the 2022 TPA RFP is consistent with standard industry practice.
- b. Contrary to the opinion expressed in the Wills Report, the scoring methodology utilized in the Cost Proposal of the 2022 TPA RFP is an acceptable industry

practice. This scoring methodology was specifically articulated in the 2022 TPA RFP and was available to all vendors.

- c. Contrary to the assertions set forth in the Wills Report, the Plan's use of binary response options without corresponding narrative for the Technical Proposal of the 2022 TPA RFP is a common and acceptable industry practice.
- d. Contrary to the opinion expressed in the Russo Report, the Plan's scoring of pricing guarantees is an acceptable industry practice.
- e. Mr. Russo's calculation of the impact of alleged discrepancies in Aetna's bid pricing does not appear to consider key factors and thus is incomplete.
- f. Contrary to Mr. Russo's assertion, Segal's analysis of repricing, and the subsequent adjustments to Blue Cross NC's calculated value, followed an acceptable industry practice of presenting values on the same basis for comparison of the Vendors.
- g. Segal appropriately excluded its analysis of external data as a point of comparison from impacting the results of Segal's scoring under the rules of the 2022 TPA RFP.
- h. Contrary to the opinion expressed in the Russo Report, the Plan and Segal did assess and incorporate the impact of network disruption in the analysis of the Vendors' bids.

93. I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.



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Andrew Coccia  
October 31, 2023



## Appendix 1: Curriculum Vitae of Andrew Coccia

### Andrew Coccia

Mobile: 518.545.7376

[acoccia@deloitte.com](mailto:acoccia@deloitte.com)

<https://www.linkedin.com/in/andrew-coccia-5a9920/>

#### Summary of Experience:

- 25+ years of Total Rewards industry experience (benefits consulting and plan sponsor roles)
- Led 100+ benefits strategy projects
- Global health program leader for GE Capital (100,000 employees)

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**DELOITTE CONSULTING LLP**

**Present**

**February 2016 to**

**September 2003 to**

**March 2014**

*Senior Manager, Human Capital/Workforce Transformation (Rewards & Well-being Practice)*

- Led great teams, both internal and at my clients, that developed and executed multi-year strategic plans in partnership with the C-suite, incorporating total rewards and well-being concepts
- Performed health and welfare RFPs/RFIs and advised on vendor contracts for major employers such as the US Postal Service, the Health Action Council, Belk Stores, the Department of Defense, and Disney.
- Redesigned total rewards programs incorporating the concepts such as optimizing the employee experience and rebalancing based on preference data to create differentiated, preferred employee value propositions
- Performed health equity studies leveraging Social Determinants of Health (SDoH) data
- Led diversity, equity and inclusion (DE&I) project to drive improvement in the employee experience
- Financial forecasting and planning for total rewards budgets in excess of \$1 Billion
- Public speaker on employer health care leading trends, compliance and the employee experience
- Conducted post-merger benefits integration activities from close of sale to “Day-1” readiness
- Lead consultant to Deloitte’s internal benefits group; 85,000+ employees, high-touch Partnership
- Specific skills: financial planning (underwriting, cost reduction), global benefits, strategy development, sourcing, benchmarking, compliance, claim audits, well-being and population health improvement, M&A support, HR operations, data analyses, and mentoring junior teammates

**WILLIS TOWERS WATSON**

**March 2014 to February 2016**

*Senior Consultant and Local Sales Leader, Health and Group Benefits*

- Lead consultant for key clients; responsible for all aspects of service delivery, including strategy, team leadership and client satisfaction
- Instituted account planning program and promoted practice growth through team-based initiatives and individual goals; linked sales goals to practice growth objectives
- New business development: annuity relationships, product sales (including private exchange for actives and retirees, pharmacy and stop loss coalitions) and led proposal efforts on key prospects

**GENERAL ELECTRIC COMPANY**

**July 2001 to September 2003**

*Project Leader, Group Health Programs (GE Corporate – Oct. 2002 – Sept. 2003)*

*Health Care Team Leader (GE Capital – July 2001 – Oct. 2002)*

- Set GE Capital's program strategy. Managed all health and welfare programs including budget setting, vendor management, communications, and compliance
- Implemented pay-for-performance programs through the Bridges-to-Excellence initiative and implemented Online Expert Medical Opinions
- Instituted population-based national wellness programs including Mothers' Rooms; national Flu Shots, and Mobile Mammography
- Participated in transition team for GE Capital restructuring; responsible for layoff communications and calculations
- Participated in union negotiations; researched and crafted proposals, successful negotiation of most aggressive health care package in GE history

**MERCER HUMAN RESOURCES CONSULTING**

**August 1997 to July 2001**

*Consultant, Health Care and Group Benefits*

**Domestic health care and group benefits consulting:** Lead project consultant for key Boston clients including Corning, Incorporated and Tyco International

- Led RFP and renewals and conducted financial analysis, claim projections, rate and contribution development, network access, discount and disruption analysis and vendor negotiations (all lines of coverage, all funding arrangements)
- Developed post-merger integration strategy for Corning's M&A activity (nine acquisitions)
- Trained team members on new tools and processes; responsible for mentoring analysts

**Global health care consulting:** Consulted to multinational employers and insurers. Responsible for new business, project management and transfer of tools/intellectual capital to overseas markets

- Advised BUPA International on U.S. market entry. Performed in-depth analysis of competition and sized the U.S. expatriate market to estimate growth opportunity
- Performed global pricing research for CIGNA International to predict expatriate cost relativities in key countries (Brazil, Mexico, Germany, UK)
- Performed on-site market evaluation in Brazil by conducting executive interviews with multinational firms and presented recommendations to Johnson & Johnson leadership
- Advised Mercer's global health care leadership team on internal market opportunities and competition worldwide

## **EDUCATION**

Union College, Schenectady, NY

- MBA - Health Systems Administration, 1997
- BA - Political Science / Philosophy, 1996

**Appendix 2: Information Considered**

2022 TPA RFP
AETNA0001992
AETNA0013892
AETNA0014000
AETNA0019463
AETNA0026101
Blue Cross NC_0000348
Blue Cross NC_0000151
Blue Cross NC_0001953
Expert Report of Gregory Russo dated October 4, 2023
Expert Report of Mary Karen Wills dated October 4, 2023
Forehand Deposition
<a href="https://www.bcbs.com/smarter-better-healthcare/mini-white-paper/understanding-the-full-picture-of-total-cost-of-care#:~:text=Total%20Cost%20of%20Care%20(TCOC,your%20employees%20and%20their%20dependents.">https://www.bcbs.com/smarter-better-healthcare/mini-white-paper/understanding-the-full-picture-of-total-cost-of-care#:~:text=Total%20Cost%20of%20Care%20(TCOC,your%20employees%20and%20their%20dependents.</a>
<a href="https://www.healthcare.gov/glossary/allowed-amount/">https://www.healthcare.gov/glossary/allowed-amount/</a>
<a href="https://www.healthcare.gov/health-care-law-protections/rate-review/">https://www.healthcare.gov/health-care-law-protections/rate-review/</a>
<a href="https://www.milliman.com/en/insight/considering-trend-guarantees-in-your-next-tpa-selection-analysis">https://www.milliman.com/en/insight/considering-trend-guarantees-in-your-next-tpa-selection-analysis</a>
<a href="https://www.segalco.com/about-us/locations">https://www.segalco.com/about-us/locations</a>
Petition for Contested Case Hearing
Segal 30b6 Deposition
SHP0000010
SHP0001952
SHP0009429
SHP0069464
SHP0069489
SHP0069760
SHP0085038
SHP0085912
SHP0001779
SHP0085064
SHP0069503
Repricing_Analysis_LOI.xlsx
State of NC Census 093022.xlsx