

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.)

**BLUE CROSS NC'S RESPONSE
IN OPPOSITION TO MOTIONS
FOR SUMMARY JUDGMENT**

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INTRODUCTION

This case involves the health care of more than half a million North Carolinians.

The North Carolina State Health Plan for Teachers and State Employees provides health coverage to our state's teachers, state employees, retirees, and family members. In 2022, the Plan requested proposals to serve as the Plan's third-party administrator, or TPA. The Plan's TPA creates a network of health-care providers, negotiates prices with those providers, and processes the providers' claims. The TPA does all of this work for the benefit of the Plan's members.

Three vendors submitted proposals for the TPA contract. Blue Cross and Blue Shield of North Carolina offered the lowest cost and the broadest provider network. Despite those facts, the Plan awarded the contract to Aetna Life Insurance Company.

In discovery, Blue Cross NC has uncovered evidence that the Plan made multiple errors in its evaluation and scoring of the RFP. This evidence deserves to be fully aired at next month's hearing, where this Tribunal can hear live testimony and judge the credibility of the parties' witnesses.

The Plan and Aetna ask this Tribunal to block a full airing of the evidence by granting summary judgment. In making that request, the Plan and Aetna make different sets of arguments. Both sets fail.

The Plan argues that its contract award is effectively unreviewable. It also argues that Blue Cross NC has no evidence of any legal violations in the RFP

process. The Plan is wrong on both counts. North Carolina law makes clear that a contract award like this one is reviewable. And substantial evidence shows that the Plan committed multiple legal violations that changed the outcome of this RFP.

Aetna, for its part, argues that Blue Cross NC has waived certain claims: those that challenge the RFP's terms. But that argument clashes with the RFP and with North Carolina law. In any event, the claims at the center of this case do not challenge the RFP's terms. Those claims challenge actions that *violate* the RFP's terms. Aetna's waiver argument does not apply to those claims.

In sum, the Plan and Aetna offer no sound basis for cutting short this important case. Blue Cross NC asks that the Tribunal decide the important issues raised here after a full hearing on the merits.

BACKGROUND

A. Factual background

1. The Plan and its TPA

The Plan has over half a million members. RFP § 1.2, at 9.¹ Those members live in every corner of the state. *See id.* § 5.1.3(b), at 37. The Plan pays billions of

¹ This brief uses "RFP" to refer to the request for proposal at issue in this case, filed as Ex. 1 to Blue Cross NC's petition for a contested-case hearing.

This brief uses "Plan Mot.," "Plan Br.," "Aetna Mot.," and "Aetna Br." to refer to the Plan's and Aetna's summary-judgment motions and briefs.

When this brief cites documents filed with the parties' summary-judgment papers, the brief notes where those documents are located in the parties' filings. For documents in the Plan's appendix, the brief notes the relevant volume and page

dollars in claims every year for members' health services. Jones Dep. 70:17-71:10 (P3 395). Plan members share in these costs. See Sceiford Dep. 132:24-25 (P3 663); Smart Dep. 47:12-14 (P3 684).

A key player in the Plan's work is the Plan's TPA. The TPA recruits a network of health-care providers and negotiates prices with them. See Plan Br. 3; Smart Dep. 47:6-17 (P3 684). The Plan pays those negotiated prices for services to Plan members. See Jones Second Aff. ¶ 21 n.2 (P4 888); Rish Aff. ¶¶ 8-9 (P4 916). The TPA also handles the complex task of analyzing claims from providers who care for Plan members. See Plan Br. 3.

Blue Cross NC currently serves as the Plan's TPA. Jones First Aff. ¶ 6 (P4 876).

2. The Plan's accelerated timeline for the RFP

In March 2022, one of the Plan's board members asked if the Plan could fire Blue Cross NC. Jones Dep. 38:21-23 (P3 387). The Plan then decided to issue an RFP for the TPA contract. *Id.* at 38:15-39:5 (P3 387).

The Plan decided to release the RFP in August 2022 and award a new contract in December 2022. See RFP at 1; Dep. Ex. 22 at 5 (BCNC1 945). The Plan's executives have called this timeline "very accelerated," "really accelerated,"

of that appendix. For example, "(P1 2-3)" refers to volume 1 and pages 2-3 of the Plan's appendix. For documents in Blue Cross NC's appendix, this brief notes the relevant volume and page of that appendix. For example, "(BCNC1 941-42)" refers to volume 1 and pages 941-42 of Blue Cross NC's appendix.

and “compressed.” Dep. Ex. 22 at 5 (BCNC1 945); Jones Dep. 269:15-17 (P3 444); Smart Dep. 31:14 (P3 680); Rish Dep. 164:22 (P3 582).

The Plan engaged a private consulting firm, the Segal Company, to help with the RFP. Jones Second Aff. ¶¶ 15, 17 (P4 886-87). When Segal submitted a draft proposal for its work, the Plan edited the proposal to insert a warning that there was “no margin for error in the timeline for this RFP.” Dep. Ex. 209 at SHP 86108 (BCNC2 1175); *see* Wohl Dep. 137:8-20 (BCNC2 1444).

Documents produced in discovery provide context for the Plan’s accelerated timeline. While the RFP was being prepared, Jim Bostian (an Aetna executive) spoke with Caroline Smart (a Plan executive) about the Plan’s schedule. *See* Dep. Ex. 239 at Navigator 2189 (BCNC2 1193). **REDACTED**

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3. The evaluation and scoring of the RFP

The RFP process had two phases.

In the first phase, the Plan required vendors to confirm that they would meet a set of minimum requirements. RFP §§ 2.6.1-2.6.2, at 13-14. Three vendors did so: Blue Cross NC, Aetna, and UMR. Bourdon Aff. ¶ 20 (P4 867).

In the second phase, the Plan required each vendor to submit two proposals: a cost proposal and a technical proposal. RFP § 2.6.1, at 13.

Blue Cross NC's claims focus on the evaluation and scoring of the vendors' proposals in this second phase.

a. The cost proposal

The cost proposal had three parts: (1) network pricing, (2) administrative fees, and (3) pricing guarantees. RFP § 3.4(c), at 24-25.

The cost proposal was scored on a ten-point scale. *Id.* at 24. The RFP assigned six points to network pricing, two points to administrative fees, and two points to pricing guarantees. *Id.* at 24-25.

Segal scored the vendors' cost proposals. *E.g.*, Plan Br. 9, 14.

Segal found that Blue Cross NC's proposal offered the lowest total costs to the Plan by almost \$45 million over the initial term of the contract. *See* Dep. Ex. 15 at SHP 25423-24 (P1 29-30); Jones Dep. 222:10-22 (P3 433). Even so, Segal gave Blue Cross NC and Aetna equal scores on the cost proposal. Dep. Ex. 413 at SHP 85915 (P2 293). Segal reached that result as described below.

For network pricing, the Plan gave vendors a data file that showed claims paid by the Plan for members' health-care services in 2021. Rish Aff. ¶ 8 (P4 916); RFP, Attach. A, § 1.2.1, at 83. The Plan told the vendors to "reprice" those claims based on the vendors' contracts and letters of intent with providers. RFP, Attach. A, § 1.2.1, at 83. The purpose of this repricing exercise was to show what the Plan's claim costs would be with each vendor's provider network. Rish Aff. ¶ 8 (P4 916).

Segal eventually concluded that the Plan's claim costs would be the lowest with Aetna's network, that those costs would be 0.47% higher with Blue Cross NC's network, and that those costs would be 0.93% higher with UMR's network. *See* Dep. Ex. 413 at SHP 85916 (P2 294). Based on the scoring rubric in the RFP, Segal gave Aetna and Blue Cross NC six points each on network pricing, and gave UMR five points. *See id.*; RFP § 3.4(c)(1)(b)-(c), at 25.

On administrative fees, each vendor proposed the amount that it would charge the Plan for the vendor's services. Plan Br. 16; RFP, Attach. A, § 1.3, at 84. Blue Cross NC proposed the lowest fee: \$223 million. Dep. Ex. 413 at SHP 85917 (P2 295). Aetna proposed \$294 million; UMR proposed \$357 million. *Id.* For this part of the cost proposal, Segal gave Blue Cross NC two points, Aetna one point, and UMR zero points. *Id.*

In the pricing-guarantee proposal, each vendor guaranteed that it would hit certain pricing targets. Each vendor also put certain amounts of its administrative fee "at risk" by promising to refund those amounts to the Plan if the vendor missed its targets. *See* Kuhn Aff. ¶ 27 (P4 904-05); Rish Aff. ¶ 12 (P4 917); RFP, Attach. A, § 1.4, at 84.

Segal did not create its scoring method for the pricing guarantees until it reviewed the vendors' proposals. Kuhn Aff. ¶ 28 (P4 905). Segal admitted that the scoring method it ultimately applied was "very subjective." Dep. Ex. 429 at SHP 92745 (BCNC2 1221); *accord* Segal 30(b)(6) Dep. 161:9-25 (P3 497).

Blue Cross NC guaranteed better pricing targets than Aetna or UMR offered. *See* Dep. Ex. 413 at SHP 85918 (P2 296). Because Blue Cross NC proposed smaller amounts at risk, however, Segal gave Blue Cross NC no points for its pricing guarantees. *See id.* at SHP 85919 (P2 297). Segal gave UMR two points and Aetna one point. *Id.*

In sum, Segal scored the cost proposals as follows:

Vendor	Network Pricing	Administrative Fee	Pricing Guarantees	Total Cost Points
Aetna	6	1	1	8
Blue Cross NC	6	2	0	8
UMR	5	0	2	7

See Dep. Ex. 413 at SHP 85915 (P2 293).

b. The technical proposal

On the technical proposal, the Plan created a set of 310 requirements. Plan Br. 8. The Plan had the vendors use checkmarks to show whether the vendors confirmed each requirement. *Id.* at 8-9; RFP, Attach. L, at 118; Dep. Ex. 37 at Blue Cross NC 670-716 (P1 32-78). The Plan barred the vendors from providing any other information. *See* Plan Br. 7-9; RFP, Attach. L, at 118.

The image below, taken from Blue Cross NC's technical proposal, illustrates this checkmark-based approach:

xiv. Vendor has the system capability to support capitated payments.	
Confirm <input checked="" type="checkbox"/>	Does Not Confirm <input type="checkbox"/>
xv. Vendor has the capability to manage two-sided risk and upon request will implement a custom risk arrangement for the Plan.	
Confirm <input checked="" type="checkbox"/>	Does Not Confirm <input type="checkbox"/>
xvi. If the Plan deploys a custom network or reimbursement models, Vendor's provider portal will allow Providers to submit claims, access policies, receive announcements, and perform other functions necessary for proper participation in the Plan's custom network.	
Confirm <input checked="" type="checkbox"/>	Does Not Confirm <input type="checkbox"/>

Dep. Ex. 37 at Blue Cross NC 679 (P1 41).

The technical proposals were scored on a 310-point scale. RFP § 3.4(b), at 24. Each vendor received one point for each technical requirement that the vendor confirmed. *See id.*

The Plan's evaluation committee scored the technical proposals. Bourdon Aff. ¶¶ 21-22 (P4 868). The committee did so by counting the vendors' checkmarks. Bourdon Dep. 145:4-147:9, 155:6-156:18 (P3 350-51, 353); Jones Dep. 159:19-161:1 (P3 417); Smart Dep. 116:23-117:18 (P3 701). This process took only ninety minutes. Jones Dep. 161:13-18 (P3 417).

The RFP allowed the Plan to have discussions with vendors about their technical proposals. RFP § 3.3(a), at 22. The Plan did not do so. *See Jones Dep. 187:12-17 (P3 424); Smart Dep. 105:2-16 (P3 698); Jones Second Aff. ¶ 42 (P4 893).*

Aetna and UMR confirmed all 310 technical requirements, and Blue Cross NC confirmed 303. Bourdon Aff. ¶ 22 (P4 868). Thus, the Plan gave 310 points to Aetna and UMR and 303 points to Blue Cross NC. *Id.* ¶ 23 (P4 868).

c. The final scoring

After Segal scored the cost proposals and the Plan scored the technical proposals, the Plan used a final-scoring scheme to decide the winner of the RFP.

Under that scheme, the Plan turned the vendors' points on the cost and technical proposals into ranks. Plan Br. 13, 17. The Plan then turned those ranks into different sets of points for each proposal. Plan Br. 18. The Plan then added those new points together to calculate the vendors' final scores. *Id.*

As the Plan admits, the RFP did not explicitly describe this approach. *See id.* at 49 & n.15. Nor has the Plan pointed to any earlier RFP in which it used this scheme.

The Plan's scoring scheme gave Aetna a final score of 6 and gave Blue Cross NC and UMR final scores of 4. *See id.* at 17-18; Dep. Ex. 15 at SHP 25423 (P1 29).

Based on these final scores, with the approval of the Plan's board of trustees, the Plan awarded the TPA contract to Aetna. Plan Br. 18-19.

B. Procedural background

Blue Cross NC submitted a timely request for a protest meeting to the Plan. *See* RFP, Attach. B, § 15, at 87-88; Blue Cross NC's Request for Protest Meeting (Jan. 12, 2023) (Protest Ltr.) (P1 220-35). The Plan denied Blue Cross NC's request. *See* Response to Blue Cross NC's Request for Protest Meeting at SHP 25822-32 (Jan. 20, 2023) (P1 143-53) (Protest Resp.). Blue Cross NC then filed a timely petition for a contested-case hearing in this Tribunal. *See* N.C. Gen. Stat. § 150B-23(f); Blue Cross NC's Pet. for Contested-Case Hrg. 25 (Feb. 16, 2023) (Pet.).

After Aetna intervened, the parties engaged in discovery.

During discovery, Aetna refused to produce certain documents, including its letters of intent with certain health-care providers. *See* Blue Cross NC's Mot. to Compel Discovery from Aetna 5 (June 9, 2023). This Tribunal granted Blue Cross NC's motion to compel the production of those documents. Order Granting Mot. to Compel 1 (June 29, 2023).

Blue Cross NC's expert witness, Gregory Russo, was then able to compare the pricing in Aetna's letters of intent with the pricing in the proposal that Aetna submitted to the Plan. Mr. Russo found that the pricing in these letters of intent is higher than the pricing stated in Aetna's proposal. The discrepancy is almost \$30 million per year. *See* Expert Rep. of Gregory Russo 27-31 (Oct. 4, 2023) (Russo Rep.) (BCNC2 1253-57).

Mr. Russo was also able to use data produced in discovery to compare the vendors' networks of health-care providers. Although the RFP required vendors to submit data about their networks, the Plan did not analyze the data. *See* RFP, Attach. A, § 1.1, at 81-83; Wohl Dep. 82:13-19, 129:20-130:17 (BCNC2 1435, 1438-39); Rish Dep. 108:3-12, 123:19-23 (P3 568, 572); Smart Dep. 67:6-16, 68:21-24 (P3 689); Coccia Dep. 266:8-9 (BCNC2 1415). When Mr. Russo analyzed the data, he found that Blue Cross NC's network has more providers than Aetna's and UMR's networks do, both statewide and in rural areas. *See* Russo Rep. 52-59 (BCNC2 1278-85).

LEGAL STANDARDS

The Plan's and Aetna's summary-judgment motions implicate two sets of legal standards: (A) the standards for summary judgment under Rule 56, and (B) the standards for review of agency action under section 150B-23(a).

A. Summary-judgment standards

"Summary judgment is a drastic measure and should be used with caution." *Mozingo v. Pitt Cnty. Mem'l Hosp., Inc.*, 331 N.C. 182, 187, 415 S.E.2d 341, 344 (1992). It is granted only when "there is no genuine issue as to any material fact" and a "party is entitled to a judgment as a matter of law." N.C. Gen. Stat. § 1A-1, Rule 56(c). A factual issue is genuine when it is supported by substantial evidence; a factual issue is material when it affects the outcome of the case. *See DeWitt v. Eveready Battery Co.*, 355 N.C. 672, 681, 565 S.E.2d 140, 146 (2002).

As the moving parties, the Plan and Aetna "must clearly demonstrate the lack of any triable issue of fact and entitlement to judgment as a matter of law." *Marcus Bros. Textiles v. Price Waterhouse, LLP*, 350 N.C. 214, 220, 513 S.E.2d 320, 324 (1999). The evidence is construed in the light most favorable to Blue Cross NC, and all factual inferences are drawn in Blue Cross NC's favor. *DeWitt*, 355 N.C. at 682, 565 S.E.2d at 146. The "slightest doubt as to the facts entitles [Blue Cross NC] to a trial." *Atl. Coast Props., Inc. v. Saunders*, 243 N.C. App. 211, 214, 777 S.E.2d 292, 295 (2015) (quoting *Snipes v. Jackson*, 69 N.C. App. 64, 72, 316 S.E.2d 657, 661 (1984)).

Even though Blue Cross NC has not moved for summary judgment here, the Tribunal may enter summary judgment in Blue Cross NC's favor on any issues for which the material facts are undisputed and Blue Cross NC is entitled to judgment as a matter of law. *See* N.C. Gen. Stat. § 1A-1, Rule 56(c); *Sullivan v. Pender Cnty.*, 196 N.C. App. 726, 731, 676 S.E.2d 69, 72 (2009).

B. Standards for review of agency action

Under section 150B-23(a) of the North Carolina General Statutes, this Tribunal may overturn an agency's action if the agency has substantially prejudiced the petitioner's rights and has done any of the following:

1. Exceeded the agency's authority or jurisdiction.
2. Acted erroneously.
3. Failed to use proper procedure.
4. Acted arbitrarily or capriciously.
5. Failed to act as required by law or rule.

N.C. Gen. Stat. § 150B-23(a).

In its brief, the Plan does not dispute that its actions have substantially prejudiced Blue Cross NC. *See* Plan Br. 22-25, 50. Nor does the Plan dispute that a vendor is substantially prejudiced when, if not for the agency's acts or omissions in an RFP process, the vendor had a substantial chance of receiving the contract award. *Keefe Commissary Network, LLC v. N.C. Dep't of Pub. Safety*, Nos. 21 CPS 4633, 21 CPS 4788, 2023 WL 3335618, Conclusions ¶ 10 (N.C. Ofc. Admin. Hrgs. Mar. 13, 2023). As Blue Cross NC discusses below, that is true here.

Instead of arguing a lack of prejudice, the Plan argues that its actions are effectively unreviewable. *See* Plan Br. 24-25, 50. According to the Plan, the RFP here was not governed by any separate statute or regulation, so the only standard in section 150B-23(a) that applies here is the arbitrary-and-capricious standard. *Id.* at 24. The Plan then frames the arbitrary-and-capricious standard as being so agency-friendly that it can be violated only in extreme cases. *See id.* at 23-25.

Those arguments misstate the law under section 150B-23(a).

This Tribunal's decisions make clear that RFP results are not exempt from review under section 150B-23(a). This Tribunal overturns the result of an RFP when the RFP process violates the section 150B-23(a) standards.²

The decisions of this Tribunal and of the North Carolina appellate courts also show that there are multiple ways for agency action to violate section 150B-23(a)

² Examples include: *Keefe*, 2023 WL 3335618; *eDealer Servs. LLC v. N.C. Dep't of Transp.*, No. 20 DOA 04356, 2021 WL 6752477 (N.C. Ofc. Admin. Hrgs. Dec. 29, 2021); *CE Offs. LLC v. N.C. Dep't of Admin.*, No. 21 DOA 1993, 2021 WL 6752495 (N.C. Ofc. Admin. Hrgs. Dec. 7, 2021); *Carolina Cmty. Support Servs., Inc. v. All. Behav. Healthcare*, No. 14 DHR 1500, 2015 WL 3813964 (N.C. Ofc. Admin. Hrgs. Apr. 29, 2015); *Fidelity Cmty. Support Grp., Inc. v. All. Behav. Healthcare*, No. 14 DHR 1594, 2015 WL 2380647 (N.C. Ofc. Admin. Hrgs. Apr. 2, 2015); *Sunrise Clinical Assocs. v. All. Behav. Healthcare*, No. 14 DHR 1503, 2015 WL 2380645 (N.C. Ofc. Admin. Hrgs. Apr. 2, 2015); *Heartfelt Alts., Inc. v. Alliance Behav. Healthcare*, No. 13 DHR 19958, 2014 WL 7653620 (N.C. Ofc. Admin. Hrgs. Dec. 9, 2014); *Myers' Investigative & Sec. Servs., Inc. v. N.C. Dep't of Admin.*, No. 09 DOA 3931, 2010 WL 690251 (N.C. Ofc. Admin. Hrgs. Jan. 1, 2010); *Corp. Express Off. Prods., Inc. v. N.C. Div. of Purchase & Cont.*, No. 06 DOA 112, 2006 WL 2190500 (N.C. Ofc. Admin. Hrgs. May 17, 2006).

even if that action does not violate a separate statute or regulation. Examples include:

- Violating an agency's own RFP.³
- Violating agency procedures.⁴
- Making an objective mistake.⁵
- Not considering all relevant factors.⁶

³ See *Keefe*, 2023 WL 3335618, Conclusions ¶ 58 (holding that an agency failed to use proper procedure, failed to act as required by law or rule, and acted arbitrarily and capriciously because the agency violated its own RFP); *eDealer*, 2021 WL 6752477, Conclusions of Law ¶¶ 8-34 (similar); *CE Offices*, 2021 WL 6752495, Conclusions of Law ¶¶ 9, 11-14 (similar); *Fidelity*, 2015 WL 2380647, Findings of Fact ¶¶ 50-61 & Conclusions of Law ¶ 31 (similar).

⁴ See *Tully v. City of Wilmington*, 370 N.C. 527, 535-36, 810 S.E.2d 208, 215 (2018) (holding that an agency's violation of its own procedures is arbitrary and capricious); *Joyce v. Winston-Salem State Univ.*, 91 N.C. App. 153, 156-57, 370 S.E.2d 866, 868-69 (1988) (same).

⁵ See *eDealer*, 2021 WL 6752477, Conclusions of Law ¶ 76 (holding that an agency acted arbitrarily and capriciously in a procurement by giving two vendors the same grade on part of their proposals, even though one vendor's proposal was "objectively superior" on that part); *Fidelity*, 2015 WL 2380647, Findings of Fact ¶¶ 47, 61 (holding that a Medicaid contractor acted erroneously and acted arbitrarily and capriciously in a procurement because the contractor made a mathematical error in scoring a vendor's proposal).

⁶ See *Sheffield v. NCDMF*, No. 16 EHR 2397, 2016 WL 7032839, Conclusions of Law ¶ 30 (N.C. Ofc. Admin. Hrgs. Oct. 5, 2016) ("A decision is arbitrary when it is not predicated upon a fair consideration of all necessary facts and factors" or when it "ignores the relevant factors critical to the decision."); *Wake Stone Corp. v. N.C. Dep't of Env't Quality*, No. 22 EHR 952, 2023 WL 5508130, Conclusions of Law ¶ 8 (N.C. Ofc. Admin. Hrgs. Aug. 11, 2023) (similar); *eDealer*, 2021 WL 6752477, Conclusions of Law ¶¶ 40-41, 44 (holding that an agency acted arbitrarily and

- Not making a fair, careful, and impartial decision.⁷
- Making a decision that is not supported by substantial evidence or that lacks a substantial relationship to the facts in the record.⁸
- Making a decision that rests on subjectivity, speculation, or opinion.⁹
- Acting unreasonably.¹⁰

capriciously in a procurement because the agency ignored key parts of vendors' proposals).

⁷ See *Joyce*, 91 N.C. App. at 156, 370 S.E.2d at 868 (“[A]n agency decision is arbitrary and capricious if it clearly evinces a lack of fair and careful consideration or want of impartial, reasoned decisionmaking.”); *Fidelity*, 2015 WL 2380647, Conclusions of Law ¶ 34 (holding that a Medicaid contractor’s evaluation process for an RFP was arbitrary and capricious because the process “clearly lacked fair and careful consideration” and was done in “a haphazard and illogical manner”).

⁸ See *Godfrey v. Zoning Bd. of Adjustment of Union Cnty.*, 317 N.C. 51, 60, 344 S.E.2d 272, 278 (1986) (holding that an agency decision is arbitrary when it “is not supported by substantial evidence,” or when “there is no substantial relationship between the facts disclosed by the record and conclusions reached by the [agency]”); *Wake Stone*, 2023 WL 5508130, Conclusions of Law ¶ 8 (following this principle from *Godfrey*).

⁹ See *Weaverville Partners, LLC v. Town of Weaverville Zoning Bd. of Adjustment*, 188 N.C. App. 55, 63, 654 S.E.2d 784, 790 (2008) (“Speculative assertions and mere opinion evidence do not constitute competent evidence.”); *Wake Stone*, 2023 WL 5508130, Conclusions of Law ¶ 9 (following this principle from *Weaverville Partners*); *Fidelity*, 2015 WL 2380647, Findings of Fact ¶¶ 33-35, 41-45, 64, Conclusions of Law ¶¶ 4, 32-34 (holding that an evaluation of proposals in a procurement was erroneous and arbitrary and capricious because that evaluation was subjective).

¹⁰ See *Wake Stone*, 2023 WL 5508130, Conclusions of Law ¶ 9 (holding that agency action is arbitrary when the agency applies an “unreasonable standard”). Here, the Plan itself equates unreasonable action with arbitrary-and-capricious

- Treating vendors inconsistently.¹¹
- Failing to require an applicant to provide support for its assertions and assumptions, or overlooking errors and omissions in an application.¹²
- Giving a consultant too much control over an RFP.¹³

These points show that the arbitrary-and-capricious standard is not the only standard in section 150B-23(a) that applies to this case. They also show that the Plan’s discussion of the arbitrary-and-capricious standard is incomplete.

action. *See* Plan Mot. 2; Plan Br. 25, 27; Plan’s Resp. to Blue Cross NC’s Mot. to Compel Discovery from Aetna 9 (June 19, 2023) (Plan Resp. to Mot. to Compel).

¹¹ *See eDealer*, 2021 WL 6752477, Conclusions of Law ¶¶ 39, 47 (holding that an agency acted arbitrarily and capriciously because it treated vendors’ proposals inconsistently by giving one vendor a worse grade on parts of its proposal that were identical to or better than the same parts of another vendor’s proposal).

¹² *See WR Imaging LLC v. N.C. Dep’t of Health & Hum. Servs.*, No. 22 DHR 415, 2022 WL 5242619, Findings of Fact ¶ 327 (N.C. Ofc. Admin. Hrgs. Aug. 8, 2022) (holding that “[a]n Agency decision is erroneous where the Agency fails to require the applicant to provide support for its assertions and assumptions, or where the Agency overlooks errors and omissions in an application”), *aff’d*, No. COA22-1008, 2023 WL 5691023 (N.C. Ct. App. Sept. 5, 2023); *see also id.*, Conclusions of Law ¶ 40 (observing that if an agency adopts a criterion for applicants to meet, the agency must “do its duty” to enforce that criterion, “ask the hard questions,” and “receive properly supported and provable assurances,” as opposed to “metaphorically shrug[ging] its shoulders”).

¹³ *See Corporate Express*, 2006 WL 2190500, Conclusions of Law ¶ 6 (“By giving [a consultant] too much control over the drafting and development of the RFP, [the agency] acted erroneously”); *City of Fayetteville v. N.C. Env’t Mgmt. Comm’n*, Nos. 15 EHR 3241, 16 EHR 5130, 2017 WL 8896072, Conclusions of Law ¶¶ 48-55 (N.C. Ofc. Admin. Hrgs. Feb. 7, 2017) (holding that an agency acted arbitrarily and capriciously because it did not do an independent analysis and instead accepted the work of the parties’ consultants).

The Plan also argues that this Tribunal owes deference to the Plan. Plan Br. 22-23. But that deference has limits.

This Tribunal does not owe deference to the Plan when the Tribunal asks whether the Plan failed to use proper procedure, failed to act as required by law or rule, or acted erroneously. That point flows from decisions that apply the analogous standards in section 150B-51(b). In those decisions, courts have held that the question whether an agency decision was made upon unlawful procedure or affected by other error of law is reviewed de novo. *E.g., Semelka v. Univ. of N.C.*, 275 N.C. App. 662, 671-72, 854 S.E.2d 34, 40-41 (2020).

The Plan notes that section 150B-34(a) instructs the Tribunal to give “due regard to the demonstrated knowledge and [expertise] of the agency with respect to facts and inferences within the specialized knowledge of the agency.” Plan Br. 23. But that statute has limits as well.

First, “due regard” does not mean “blanket deference” or “lack of inquiry.” *Umstead Coal. v. N.C. Dep’t of Env’t Quality Div. of Water Res.*, No. 20 EHR 3014, 2021 WL 5400975, Conclusions of Law ¶ 13 (N.C. Ofc. Admin. Hrgs. Sept. 27, 2021).

Second, the statute calls for due regard to “the agency.” It does not call for deference to a private consultant, such as Segal. In *Umstead Coalition*, for example, this Tribunal held that section 150B-34(a) did not call for deference to a private party or private engineers. *See id.*

Third, the statute calls for due regard when the agency “demonstrate[s]” that it has specialized knowledge and expertise on relevant facts and inferences. On

issues for which the Plan has not made that demonstration, no deference is due. For example, in *City of Fayetteville*, this Tribunal held that no deference was owed where an agency put “blind reliance” on the work of the parties’ consultants and “demonstrated no particular knowledge or expertise.” 2017 WL 8896072, Findings of Fact ¶ 224, Conclusions of Law ¶ 11.

In sum, the legal standards that govern this case call for a more rigorous review of the Plan’s actions than the Plan admits.

SUMMARY OF ARGUMENT

This brief first discusses the Plan’s motion for summary judgment. It then discusses Aetna’s motion for partial summary judgment.

The Plan’s motion fails because there is substantial evidence that the Plan and Segal violated section 150B-23(a) when they evaluated and scored the vendors’ proposals.

First, Segal committed multiple independent errors in its scoring of the RFP’s cost proposal:

- Segal’s scoring of the pricing guarantees was erroneous in multiple ways. If Segal had avoided any one of those errors, Blue Cross NC would have received at least one point for its pricing guarantees, instead of the zero points that Segal gave it. With that additional point, Blue Cross NC would have won the cost proposal. *See infra* pp. 21-34.

- Segal's scoring of network pricing was also erroneous. Segal did not account for a discrepancy in Aetna's pricing: The prices that Aetna has negotiated with providers are tens of millions of dollars higher than the prices stated in Aetna's proposal. If Segal had accounted for this discrepancy, Aetna would have lost at least one point, and Blue Cross NC would have won the cost proposal. *See infra* pp. 34-39.

Second, when the Plan combined the vendors' cost scores with their technical scores, the Plan used a scoring scheme that was arbitrary and that violated the RFP. If the Plan had used a lawful scoring method, and if Segal had not erred in its scoring of the cost proposal, Blue Cross NC would have won the RFP. *See infra* pp. 39-48.

Third, the Plan prioritized work avoidance and speed over fairness. As a result, the Plan made three further errors:

- The Plan turned over control of the cost-proposal scoring to its private consultant, Segal. North Carolina law required the Plan to maintain control over that scoring. *See infra* pp. 49-52.
- The Plan's evaluation of the vendors' technical proposals was superficial. That superficial evaluation breached the RFP and was arbitrary and capricious. *See infra* pp. 52-55.
- The Plan likewise conducted only a superficial evaluation of the vendors' provider networks. The RFP and North Carolina law required a more robust evaluation. *See infra* pp. 55-60.

Aetna's motion for partial summary judgment also fails.

Aetna argues that Blue Cross NC has waived any of its claims that challenge the RFP's terms. But the claims at the center of this case do not challenge the RFP's terms. They instead challenge the evaluation and scoring of the vendors' proposals. Aetna's waiver argument does not apply to these claims. *See infra* pp. 61-63.

In any event, Aetna's waiver argument fails as a matter of law:

- Aetna tries to find support for its waiver argument in North Carolina laches doctrine and certain provisions of the RFP. But Aetna cannot meet key elements of laches, and its arguments clash with the RFP's text. *See infra* pp. 63-71.
- Aetna also tries to find support in federal waiver doctrine. That doctrine, however, does not apply in this Tribunal. Even if that doctrine did apply, Blue Cross NC's claims would not be waived, because it would have been pointless for Blue Cross NC to raise its claims earlier than it did. *See infra* pp. 71-78.

ARGUMENT

I. The Plan and its consultant, Segal, committed multiple violations of section 150B-23(a).

Substantial evidence shows that the Plan and Segal violated section 150B-23(a) in multiple ways. This evidence bars summary judgment for the Plan.

A. Segal made multiple errors in its scoring of the cost proposal.

The scoring of the cost proposal involved multiple violations of section 150B-23(a).

Segal scored the cost proposal. Plan Br. 9, 14. The Plan does not dispute that it is accountable for Segal's scoring. To the contrary, the Plan tries to defend Segal's actions. *See, e.g., id.* at 31, 34-35, 39. Thus, if Segal violated section 150B-23(a), so did the Plan.

Those violations happened here. Segal committed multiple independent errors in its scoring of the pricing guarantees and of network pricing. If Segal had avoided any one of those errors, Blue Cross NC would have won the cost proposal.

1. Segal erred in multiple ways when it scored the pricing-guarantee proposals.

Segal's scoring of the vendors' pricing guarantees was erroneous in several ways. Because of these errors, Segal gave Blue Cross NC zero points for its pricing guarantees. Under lawful scoring, Segal would have given Blue Cross NC at least one point. With that change alone, Blue Cross NC would have received nine points on the cost proposal, beating Aetna's score of eight.

a. Segal erred by not scoring the pricing guarantees based on their value.

Segal's first error was its failure to score the vendors' pricing guarantees by the standard set in the RFP: the guarantees' value. *See* RFP § 3.4(c)(3)(b)-(c), at 25.

A pricing guarantee has two parts.

First, a vendor guarantees that an aspect of the Plan's claim costs will meet a certain target. For example, one type of pricing guarantee that the vendors offered here was a discount guarantee. *Id.*, Attach. A, § 1.4, at 84. In a discount guarantee, the vendor guarantees that its discount percentage will not fall below a certain target. *See* Kuhn Aff. ¶ 27 (P4 904-05); Rish Aff. ¶ 12 (P4 917). A higher discount percentage means lower claim costs for the Plan. *See* Russo Rep. 9 (BCNC2 1235); Rish Dep. 210:6-24 (P3 594).¹⁴

Second, the vendor sets an amount of money that the vendor will refund to the Plan if the vendor does not meet its target. This amount of money is called the amount at risk. *See* Russo Rep. 10 (BCNC2 1236); Rish Dep. 211:2-11 (P3 594).

Both parts of a pricing guarantee affect the Plan's bottom line. *See* Russo Rep. 11 (BCNC2 1237); Rish Dep. 206:14-208:3 (P3 593). For example, imagine that a vendor guarantees that the Plan's claim costs will not exceed \$3 billion and puts \$10 million at risk. If the Plan's actual claim costs are \$3.1 billion, the Plan's bottom-line costs are \$3.09 billion: \$3.1 billion in claim costs minus the \$10 million that the vendor refunds to the Plan.

¹⁴ A vendor's discount percentage reflects the discounts that the vendor has negotiated with health-care providers. It is calculated by comparing two numbers: the billed charge and the allowed amount. *See* Russo Rep. 32 (BCNC2 1258). The billed charge is the "rack rate" that the provider sets for a health-care service. *See id.* at 8 (BCNC2 1234). The allowed amount is the amount that a payor agrees to pay the provider for that service. *Id.* at 9 (BCNC2 1235). For example, the billed charge for an office visit might be \$100, and the allowed amount for that visit might be \$80. In this example, the vendor's discount percentage is 20%. *See id.*

Here, the RFP called for Segal to evaluate the impact of the pricing guarantees on the Plan's bottom line.

The RFP did so when it stated that the vendors' pricing guarantees would be scored based on their value. RFP § 3.4(c)(3)(b)-(c), at 25. The value of a pricing guarantee depends on the guarantee's impact on the Plan's bottom line. As the Plan admits, the purpose of a pricing guarantee is to achieve lower costs for the Plan. Plan Br. 35. Segal's corporate designee, Stephen Kuhn, confirmed that the goal of a pricing guarantee "is to produce the best bottom line for the Plan." Segal 30(b)(6) Dep. 179:20-23 (P3 502); *accord* Russo Rep. 11, 22 (BCNC2 1237, 1248); Rebuttal Expert Rep. of Gregory Russo 8 (Nov. 10, 2023) (Russo Rebuttal Rep.) (BCNC2 1344). Thus, to comply with the RFP's requirement to score the vendors' pricing guarantees based on their value, Segal needed to assess the effect of those guarantees on the Plan's bottom line.

Segal did not do so. Segal 30(b)(6) Dep. 220:4-12 (P3 512).

If Segal had evaluated the guarantees' bottom-line impact under likely scenarios, it would have found that Blue Cross NC's pricing guarantees were more valuable than Aetna's by hundreds of millions of dollars.

For example, Blue Cross NC guaranteed a discount percentage of at least 55.1% for all three years of the contract. Aetna, in contrast, guaranteed a discount percentage of only 52.3%. Dep. Ex. 413 at SHP 85918 (P2 296).

In a scenario where Blue Cross NC and Aetna each hit these targets, the Plan's bottom-line costs over three years would be \$600 million lower under Blue

Cross NC's proposal than they would be under Aetna's proposal. Russo Rep. 22-23 (BCNC2 1248-49).

Similarly, in a scenario where Blue Cross NC and Aetna each missed their targets by amounts that would trigger their maximum refunds to the Plan, the Plan's bottom-line costs for a single year would be \$138 million lower under Blue Cross NC's proposal than under Aetna's proposal. *Id.* at 24-25 (BCNC2 1250-51).

As these examples show, when Segal failed to measure the bottom-line impact of the vendors' pricing guarantees, it failed to score those guarantees based on their value. That failure violated the RFP. *See* RFP § 3.4(c)(3)(b)-(c), at 25. By not accounting for the superior value of Blue Cross NC's guarantees, Segal also made an objective mistake, did not consider all relevant factors, did not make a careful decision, made a decision that lacks a substantial relationship to the facts in the record, and acted unreasonably. The Plan and Segal therefore violated section 150B-23(a). *See supra* pp. 14-15.

b. Segal erred by focusing almost entirely on the amounts that the vendors put at risk.

Segal's analysis of the pricing guarantees was also flawed for a second reason. Instead of balancing both parts of the guarantees—the targets and the amounts at risk—Segal concentrated almost exclusively on the amounts at risk.

The RFP required Segal to weigh both parts of the pricing guarantees. The RFP promised that the guarantees would be scored “based on the *combination* of the

competitiveness of the guaranteed targets and the amount placed at risk.” RFP § 3.4(c)(3)(a), at 25 (emphasis added).

Substantial evidence shows that Segal did not meet this requirement.

Segal gave Blue Cross NC’s pricing guarantees zero points. Dep. Ex. 413 at SHP 85919 (P2 297). Segal’s contemporaneous scoring summary says that this score was “primarily due to the amount at risk.” *Id.*

Segal’s 30(b)(6) witness confirmed this point. He testified that the amount at risk was the most significant factor in Segal’s scoring of Blue Cross NC’s discount guarantees. *See* Segal 30(b)(6) Dep. 190:1-9, 215:4-13 (P3 505, 511). He also testified that Segal’s scoring of Blue Cross NC’s trend guarantee, another type of pricing guarantee that the vendors submitted, rested “strictly [on] the amount at risk.” *Id.* at 221:4-7 (P3 512).

As this evidence shows, Segal’s scoring of the pricing guarantees focused almost entirely on the amounts at risk. Segal therefore violated the RFP’s promise that the scoring of the pricing guarantees would be based not just on the amounts at risk, but on the competitiveness of the guarantee targets as well.

Even if the RFP had not made that promise, Segal still would have erred by focusing so heavily on the amounts at risk. That approach caused Segal to disregard the pricing guarantees’ effects on the Plan’s bottom line, as discussed above. It also caused Segal to overlook multiple other ways in which Blue Cross NC’s guarantees offered more value to the Plan than Aetna’s did.

First, Blue Cross NC offered a more aggressive discount-percentage target. Blue Cross NC's target for 2025 was *higher* than the discount percentage in its network-pricing proposal. Dep. Ex. 413 at SHP 85918 (P2 296). As the Plan admits, that aggressive target gave Blue Cross NC a strong incentive to negotiate lower prices with providers. *See* Sceiford Dep. 63:12-21 (P3 646). Segal has likewise admitted that higher guarantee targets are better for the Plan, because the goal of guarantees is not for the vendor to pay the at-risk amounts, but “to produce the best cost for the State.” Segal 30(b)(6) Dep. 179:23-24 (P3 502).

Aetna, by contrast, offered a target that was *lower* than the discount percentage in its network-pricing proposal. Dep. Ex. 413 at SHP 85918 (P2 296). This type of conservative guarantee offers less value because the vendor is likely to achieve the target even without the guarantee, so the amount at risk is unlikely ever to be refunded. *See* Sceiford Dep. 63:12-21 (P3 646); Segal 30(b)(6) Dep. 177:17-178:8 (P3 501-02); Russo Rep. 16-17, 24 (BCNC2 1242-43, 1250). Despite those indicators of low value, Segal still decided that Aetna's discount guarantees had more value than Blue Cross NC's because Aetna put more at risk.

Second, Blue Cross NC promised that its discount target would improve each year. *See* Dep. Ex. 225 at 3, 6 (P2 280, 283). These discount improvements would generate \$241 million in savings for the Plan from 2026 to 2029. Russo Rep. 17 (BCNC2 1243). Aetna's discount target, in contrast, remained constant over the life of the contract. *See* Dep. Ex. 224 at 3, 6 (BCNC2 1187, 1190). Segal's focus on amounts at risk led it to ignore this advantage of Blue Cross NC's proposal.

Third, Blue Cross NC offered a better trend target than Aetna did. “Trend” refers to medical inflation: the percentage by which the Plan’s claim costs grow from one year to the next. Russo Rep. 9 (BCNC2 1235).

Blue Cross NC’s trend guarantee promised that the Plan’s claim costs would grow by no more than 6% each year. Dep. Ex. 413 at SHP 85918 (P2 296). Aetna offered a less favorable trend target of 6.8% per year in 2026. *Id.* That 0.8% difference would mean an additional \$25 million in claim costs for the Plan under Aetna’s proposal. *See* Russo Rep. 19 (BCNC2 1245). Exacerbating that difference, Aetna’s trend target went up over the life of the contract, exposing the Plan to even more medical inflation. *See* Dep. Ex. 413 at SHP 85918 (P2 296). Despite these points, Segal concluded that Blue Cross NC’s trend guarantee had less value than Aetna’s did, based on the amounts at risk. *Id.*

In sum, because Segal focused almost exclusively on the amounts at risk, Segal breached the RFP’s requirement to score the guarantees based on the combination of the guarantee targets and the amounts at risk. RFP § 3.4(c)(3)(a), at 25. Further, by not giving Blue Cross NC credit for the superior value that its guarantee targets offered, Segal made an objective mistake, did not consider all relevant factors, did not make a careful decision, made a decision that lacks a substantial relationship to the facts in the record, and acted unreasonably. The Plan and Segal therefore violated section 150B-23(a). *See supra* pp. 14-15.

c. Segal erred by misreading Blue Cross NC's proposal.

Segal aggravated the effect of focusing on amounts at risk when it made another error: It misread Blue Cross NC's amount at risk.

The RFP required each vendor to propose three separate discount guarantees. *See* Russo Rep. 10-11 (BCNC2 1236-37). For each one, Blue Cross NC's proposal stated that its amount at risk on that guarantee was "subject to a maximum payout ('cap') of 5% of that year's total administrative fee." Dep. Ex. 225 at 3, 6 (P2 280, 283). This language put a separate 5% of Blue Cross NC's fee at risk on each discount guarantee. Thus, for the three discount guarantees combined, Blue Cross NC put a total of 15% of its fee at risk. *See id.*; Forehand Dep. 99:13-20, 108:25-109:3 (BCNC1 1153, 1156-57).

Segal erroneously concluded, however, that the total amount at risk for Blue Cross NC's three discount guarantees was 5%, not 15%. *See* Segal 30(b)(6) Dep. 209:13-210:13 (P3 509-10); Dep. Ex. 413 at SHP 85918 (P2 296). Because Segal made this objective mistake, the Plan and Segal violated section 150B-23(a). *See supra* p. 14.

This error prejudiced Blue Cross NC. Segal misread the part of Blue Cross NC's proposal that mattered most to Segal: the amount at risk. The Plan's actuary, Charles Sceiford, has conceded that the value of Blue Cross NC's pricing guarantees depended on how Segal interpreted Blue Cross NC's amount at risk. Sceiford Dep. 99:5-19 (P3 655). The Plan's expert, Kenneth Vieira, has also stated that Blue Cross NC's and Aetna's proposals were "close" in value, but that Aetna's proposal

“nudged ahead” because of the amounts at risk. Vieira Dep. 460:17-25 (P3 846).¹⁵

Thus, if Segal had understood Blue Cross NC’s proposal correctly, there is a substantial chance that Segal’s scoring would have changed. *See Keefe*, 2023 WL 3335618, Conclusions ¶ 10 (stating the “substantial chance” standard).

d. Segal erred by scoring the pricing guarantees subjectively.

Segal made another error when it scored the pricing guarantees subjectively.

In an earlier case, this Tribunal held that a Medicaid contractor’s scoring of proposals in an RFP was erroneous and arbitrary and capricious because the scoring was subjective. *Fidelity*, 2015 WL 2380647, Findings of Fact ¶¶ 33-35, 41-45, 64, Conclusions of Law ¶¶ 4, 32-34.

Here, the Plan’s executives agreed that subjectivity is problematic:

- Ms. Jones, who had overall responsibility for the RFP, testified that the Plan’s procurement policies require “an objective process.” Jones Dep. 112:13-14 (P3 405); *see id.* at 152:3-9 (P3 415). She also testified that it is important for an RFP to be “extremely objective.” *Id.* at 33:19-20, 65:7 (P3 385, 393).
- Ms. Bourdon, the Plan’s director of contracting and compliance, testified that one of the Plan’s overarching goals was to “remove

¹⁵ Mr. Vieira was part of the Segal team that scored the cost proposal. *See* Vieira Dep. 146:1-147:9 (P3 768).

subjectivity in the interest of trying to achieve objectivity.” Bourdon Dep. 216:5-7 (P3 368); *see* Bourdon Aff. ¶ 3 (P4 863).

- Dale Folwell, the State Treasurer, likewise found it important that the Plan’s RFP be objective. *See* Folwell Dep. 52:25-53:3, 54:11-14, 55:5-18 (BCNC1 1126-29).

Despite these points, Segal’s scoring of the pricing guarantees was subjective. Segal admitted this point both during and after the RFP process.

During the RFP process, Segal stated in an email that its scoring of the pricing guarantees would be “very subjective.” Dep. Ex. 429 at SHP 92745 (BCNC2 1221).

In later deposition testimony, Segal’s corporate designee admitted that Segal’s scoring was subjective. Segal 30(b)(6) Dep. 161:9-25 (P3 497). He also admitted that Segal’s analysis did not use “a mathematical equation” or even an “actual calculation.” *Id.* at 35:3, 162:18 (P3 466, 498).

Aetna’s expert, Andrew Coccia, described the guarantee scoring this way: Segal “put it all into the bag and shook it up.” Coccia Dep. 185:25-186:1 (BCNC2 1411-12).

The Plan responds that Segal’s scoring needed to be subjective. Plan Br. 34. That response fails for three reasons.

First, the response lacks evidentiary support. The Plan relies on conclusory assertions by Segal that the pricing-guarantee scoring needed to be subjective. *See*

id. at 34-35. The Plan does not point to any evidence that actually supports those assertions.

Second, Mr. Russo has shown that the scoring of the pricing guarantees did not need to be subjective. Mr. Russo's method for evaluating the pricing guarantees, a method that analyzes the guarantees' impact on the Plan's bottom line, is an objective one. *See* Russo Rep. 22-27 (BCNC2 1248-53).

Third, the Plan's own actuary expressed doubt that Segal's approach needed to be subjective. When Mr. Sceiford learned of Segal's approach, he stated that "there should be a discussion regarding the discount performance guarantee evaluation being 'subjective,' " because that subjectivity "could expose the contract [to] greater challenges from vendors." Dep. Ex. 64 at SHP 70486 (P1 91). Mr. Sceiford later confirmed that Segal's subjective method for scoring "was out of the ordinary." Sceiford Dep. 78:25-79:19 (P3 650).

For these reasons, there is a genuine factual dispute on whether Segal needed to score the pricing guarantees subjectively.

As noted above, this Tribunal held in *Fidelity* that subjective scoring was arbitrary and capricious. *See Fidelity*, 2015 WL 2380647, Findings of Fact ¶¶ 33-35, 41-45, 64, Conclusions of Law ¶¶ 4, 32-34. And the Plan does not contest that if Segal's scoring of the pricing guarantees was *unnecessarily* subjective, Segal's scoring was arbitrary and capricious. *See* Plan Br. 34-35. As a result, the factual dispute over whether Segal's scoring needed to be subjective bars summary judgment for the Plan on the lawfulness of Segal's scoring.

e. Segal erred by creating its scoring methodology after it reviewed the vendors' proposals.

Segal's scoring of the guarantees was procedurally erroneous as well. That is because Segal waited to choose its scoring method for the pricing guarantees until *after* it had received and reviewed the vendors' proposals. *See* Kuhn Aff. ¶ 28 (P4 905).

That delay violated section 150B-23(a) for at least two reasons.

First, the Plan's procurement policy states that "RFPs should not be posted until the evaluation criteria and scoring methodology are finalized." Dep. Ex. 4 at SHP 92227 (P1 7). By not following that procedure, the Plan and Segal violated section 150B-23(a). *See supra* p. 14.

The Plan responds that its procurement policy is just optional. *See* Plan Br. 4. But the policy does not say that. It says the opposite: "The purpose of this [policy] is to establish a standard procedure," and "[n]on-compliance with this policy is a serious matter that may result in disciplinary action, up to and including termination." Dep. Ex. 4 at SHP 92221, 92230 (P1 1, 10).

In any event, the Plan does not address the decisions that have held that agency action violates section 150B-23(a) when the agency violates its own procedures. *See supra* p. 14 n.4. Those decisions contradict the Plan's assertion that it can violate its own procedures with impunity.

Second, to comply with section 150B-23(a), a scoring method must be fair and impartial. *See supra* p. 15 & n.7. A scoring method is not fair and impartial if it is

chosen after the proposals are reviewed. At that point, the evaluator can—consciously or unconsciously—adjust the method to produce a desired outcome.

The Plan argues that Segal could not choose a scoring method for the pricing guarantees until after Segal reviewed the proposals, because “the Plan and Segal did not know how the bidders would structure their proposals.” Plan Br. 34. That argument has multiple flaws:

- Segal’s delay in choosing a scoring method came as a surprise to Matthew Rish, a Plan executive and a member of the RFP’s evaluation committee. Rish Dep. 218:15-219:2 (P3 596). Mr. Rish could not recall another instance in which the scoring method for any part of an RFP was established after proposals were submitted. *Id.* at 220:22-221:9 (P3 596).
- It was up to the Plan to decide how vendors could structure their proposals. The Plan could have chosen a scoring method in advance and required vendors to structure their proposals to fit that method.
- Segal eventually chose a scoring method that focused on the vendors’ amounts at risk. The Plan does not offer a reason why Segal could not have chosen that approach—or a less flawed approach—in advance.

At a minimum, these points create a genuine factual dispute about whether Segal needed to wait to choose its scoring method until after it reviewed the proposals. That factual dispute bars summary judgment for the Plan on the guarantee scoring.

* * *

For the reasons discussed above, Segal committed multiple independent errors when it scored the vendors' pricing guarantees. If Segal had avoided any one of these errors, Blue Cross NC's score on the pricing guarantees would have increased from zero to at least one. Blue Cross NC's score on the cost proposal thus would have increased to at least nine, compared to Aetna's eight. As a result, Blue Cross NC would have won the cost proposal overall.

2. Segal erred by not accounting for a discrepancy in Aetna's network-pricing proposal.

Segal's errors in scoring the cost proposal were not limited to the pricing guarantees. Segal also made an error in its scoring of network pricing: It did not account for a discrepancy in Aetna's proposal. Discovery has shown that Aetna's prices from providers are higher than the prices that Aetna stated in its proposal. If Segal had accounted for this discrepancy, Aetna's network-pricing score would have decreased by at least one point, and Blue Cross NC would have won the cost proposal.

Aetna's network-pricing proposal relied on the prices in letters of intent that Aetna has negotiated with three REDACTED. Aetna 30(b)(6) Dep. 207:10-20 (BCNC2 1387). Those providers are REDACTED

REDACTED

REDACTED See Dep.

Exs. 259 (BCNC2 1212-16), 260 (BCNC2 1217-18), & 261 (BCNC2 1219-20); Aetna 30(b)(6) Dep. 263:17-268:5 (BCNC2 1395-1400).

In discovery, this Tribunal granted Blue Cross NC's motion to compel Aetna to produce its letters of intent with these three providers. *See* Order Granting Mot. to Compel 1. Mr. Russo has compared Aetna's actual pricing under these letters of intent with the pricing in Aetna's proposal. Russo Rep. 27-29 (BCNC2 1253-55).

The result is striking. Mr. Russo found that for these three providers alone, Aetna's actual pricing is higher than the pricing in Aetna's proposal by almost \$30 million per year. *See id.* at 30-31 (BCNC2 1256-57).

If Segal had accounted for this discrepancy in Aetna's pricing, the outcome of the cost proposal would have changed.

When Segal scored the network pricing, it believed that Aetna's total claim costs were lower than Blue Cross NC's by 0.47%. *See* Dep. Ex. 413 at SHP 85916 (P2 294). The RFP stated that vendors whose total claim costs were within 0.5% of each other would receive the same score on network pricing. RFP § 3.4(c)(1)(c), at 25. As a result, Segal gave Aetna and Blue Cross NC the same score (six points) on their network pricing. Dep. Ex. 413 at SHP 85916 (P2 294).

In contrast, when Aetna's actual pricing under its letters of intent is taken into account, Aetna's total claim costs are more than 0.5% *higher* than Blue Cross NC's. *See* Russo Dep. 133:25-135:18 (BCNC1 1161-63); Vieira Dep. 342:5-343:7 (P3 817). Under the RFP's scoring system, accounting for this difference of more than 0.5% would have caused Aetna's network-pricing score to drop from six points to

five points. *See* RFP § 3.4(c)(1)(c), at 25. The result would have been a six-to-five win for Blue Cross NC on the network-pricing proposal, and thus an eight-to-seven win for Blue Cross NC on the cost proposal overall.

The discrepancy identified by Mr. Russo may be the tip of the iceberg. Aetna produced its letters of intent with three providers, but not its other provider contracts. As a result, Mr. Russo did not analyze Aetna's other contracts. But if the same error rate that Mr. Russo found in Aetna's pricing for three providers also exists in Aetna's pricing for all its providers, the total magnitude of the discrepancy is almost \$640 million over three years. Russo Rebuttal Rep. 16 (BCNC2 1352). In that scenario, Aetna's network-pricing score would have dropped all the way to zero, and Blue Cross NC would have won the cost proposal by an even wider margin. *See id.*

In sum, Aetna's network-pricing proposal contained a discrepancy. If Segal had accounted for this discrepancy, Blue Cross NC would have won the cost proposal.

The Plan does not dispute the accuracy of Mr. Russo's pricing calculations. The Plan instead responds in other ways. Those responses do not succeed.

First, the Plan points to testimony from Aetna's corporate designee that Aetna "validated" its own network-pricing proposal. Plan Br. 28. But the evidence discussed above shows that Aetna's validation efforts fell short. Thus, at best for the Plan, the testimony from Aetna's corporate designee creates a factual dispute about the accuracy of Aetna's proposal.

Second, the Plan argues that “different assumptions and methodologies” can affect the results of a repricing analysis. *Id.* But the Plan does not cite any evidence that any difference in assumptions or methodologies actually caused the discrepancy here. *See id.* This argument therefore lacks evidentiary support.

Third, the Plan notes that Mr. Russo checked Aetna’s pricing alone. *Id.* But Mr. Russo had good reason to take that approach. In Aetna’s network-pricing proposal, Aetna relied on letters of intent to increase its stated discounts. *See* Dep. Ex. 256 at Aetna 170 (P2 286); Aetna 30(b)(6) Dep. 205:25-208:4 (BCNC2 1385-88); Russo Rep. 41 (BCNC2 1267). Blue Cross NC, in contrast, relied only on actual contracts with providers. *See* Forehand Dep. 22:18-23, 92:20-23 (BCNC1 1133, 1150). In any event, the Plan does not point to any evidence of an error in Blue Cross NC’s proposal. Thus, any speculation by the Plan that Blue Cross NC’s proposal might contain an error is just that: speculation. That speculation is no defense to the evidence of a discrepancy in Aetna’s proposal.

Fourth, the Plan argues that it would be impractical for the Plan or Segal to check all of the pricing in vendors’ proposals. Plan Br. 28-29. That argument attacks a straw man. No one is saying that the Plan or Segal needed to do a universal check. Because Aetna relied on letters of intent to increase its stated discounts, however, the Plan or Segal needed to do a targeted check of Aetna’s pricing under those letters of intent.

Finally, the Plan states that if Aetna’s cost proposal is inaccurate, the Plan can take corrective action later. *Id.* at 29. That argument misses the point: The

inaccuracy in Aetna's cost proposal caused Aetna to win, and Blue Cross NC to lose, the role as the Plan's TPA. Blue Cross NC is seeking relief from that outcome now.

Here, in sum, the Plan is "metaphorically shrug[ging] its shoulders" at a demonstrated error in Aetna's network-pricing proposal. *WR Imaging*, 2022 WL 5242619, Conclusions of Law ¶ 40. That is just what this Tribunal has held that an agency may not do.

The Plan's indifference to the discrepancy in Aetna's pricing also clashes with the Plan's and Segal's overall approach to the network-pricing proposals. The Plan put significant weight on those proposals in the RFP, assigning them 60% of the available points for the cost proposal. *See* RFP § 3.4(c), at 24-25. Segal also applied a fine-tooth comb to Blue Cross NC's network-pricing proposal through a series of clarification requests. *See* Plan Br. 14-15, 30. Despite the importance that the Plan put on network pricing and the scrutiny that Segal applied to Blue Cross NC's proposal, the Plan and Segal have not applied the same scrutiny to Aetna's proposal.

By not accounting for the discrepancy in Aetna's proposal, the Plan and Segal violated section 150B-23(a) in multiple ways. They made an objective mistake. They did not consider all relevant factors. They did not make a fair or careful decision. They acted unreasonably. They treated Blue Cross NC and Aetna inconsistently. And they overlooked errors in Aetna's proposal.

If the Plan and Segal had accounted for the discrepancy in Aetna's pricing, Aetna would have lost at least one point on the network-pricing proposal. *See supra*

pp. 35-36. As a result, Blue Cross NC would have won both the network-pricing proposal and the cost proposal overall.

* * *

In sum, Segal made multiple independent errors in its scoring of the vendors' pricing guarantees and of their network pricing. If Segal had scored the vendors' pricing guarantees properly, Blue Cross NC would have gained at least one cost point and would have won the cost proposal nine to eight. If Segal had scored the vendors' network pricing properly, Aetna would have lost at least one cost point, and Blue Cross NC would have won the cost proposal eight to seven. Either way, Blue Cross NC would have won the cost proposal.

Moreover, as shown below, if Blue Cross NC had won the cost proposal, and if the Plan had used a lawful final-scoring method, Blue Cross NC would have won the RFP.

B. The Plan's calculation of final scores was arbitrary and violated the RFP.

The errors in this case were not confined to the scoring of the cost proposals. The Plan also erred when it combined the cost-proposal scores and the technical-proposal scores into final scores.

To calculate those final scores, the Plan used a new scheme that skewed the scoring in Aetna's favor. Ms. Jones has admitted that this scheme had no mathematical justification. As a result, the final scoring was arbitrary and capricious. It also violated the plain language of the RFP.

1. The Plan’s final-scoring scheme was arbitrary.

The parties do not dispute how the Plan calculated final scores.

First, the Plan calculated an initial set of technical points and an initial set of cost points for each vendor:

Vendor	Initial Technical Points
Aetna	310
Blue Cross NC	303
UMR	310

Vendor	Initial Cost Points
Aetna	8
Blue Cross NC	8
UMR	7

See supra pp. 5-8; Plan Br. 13, 17.

The Plan then separately ranked the vendors’ technical proposals and cost proposals.

Next, the Plan turned these ranks into a different set of technical “points” and a different set of cost “points”:

Vendor	Technical Rank	Final Technical “Points”
Aetna	1	3
Blue Cross NC	3	1
UMR	1	3

Vendor	Cost Rank	Final Cost “Points”
Aetna	1	3
Blue Cross NC	1	3
UMR	3	1

See supra p. 9; Plan Br. 13, 17.

The Plan then added each vendor’s final technical “points” to that vendor’s final cost “points.” The Plan calls the result of this addition the vendor’s “final score” (a term that does not appear in the RFP):

Vendor	Final Technical “Points”	Final Cost “Points”	Final “Score”
Aetna	3	3	6
Blue Cross NC	1	3	4
UMR	3	1	4

See Plan Br. 17-18.

This points-to-ranks-to-points scoring scheme was new. The Plan has not pointed to any earlier RFP in which it used this scheme. Nor have the Plan’s and Aetna’s experts ever seen an RFP that used this final-scoring scheme. *See* Coccia Dep. 102:11-103:23 (BCNC2 1407-08); Vieira Dep. 357:3-18 (P3 820).

When Segal personnel learned about this scoring scheme, they stated that the Plan was “going the wrong way.” Dep. Ex. 216 at SHP 92428 (BCNC2 1180).

That is no wonder. This scheme is arbitrary.

As the charts above show, the Plan’s scoring scheme transformed a close competition between Blue Cross NC and Aetna into a lopsided outcome. On the cost proposal, Blue Cross NC and Aetna received the same initial points. On the technical proposal, Blue Cross NC’s and Aetna’s initial points differed by only about 2% (7 out of 310). Yet in the final technical “points,” that 2% difference ballooned to 67%.

The Plan admits that inflating the difference between the vendors’ scores in this way was intentional. Three Plan affidavits state that the Plan used this scoring scheme because it “would clearly differentiate between the bidders even if the scoring of the technical and cost proposals were close, as we expected them to be.” Bourdon Aff. ¶ 11 (P4 865); Jones Second Aff. ¶ 24 (P4 889); Rish Aff. ¶ 6 (P4 915). In other words, the Plan believed that the proposals would be close, so it used a scoring system that would make the final scores *not close*.

There is no logical reason, however, to turn a close contest into a rout. The Plan does not offer one. Instead, Ms. Jones has admitted that the Plan was not interested in a mathematically coherent scoring system. In her words: “I would go so far as to say there’s no math justification because the math—it was not intended to be that.” Jones Dep. 138:14-21 (P3 412).

This Tribunal has held that a similarly arbitrary scoring system for an RFP violated section 150B-23(a). In *Medical Review of North Carolina v. North Carolina Department of Administration*, the agency initially scored vendors’ references on a 5-point scale. See No. 13 DOA 12702, 2013 WL 12413478, Findings of Fact ¶ 36

(N.C. Ofc. Admin. Hrgs. Aug. 30, 2013). The agency then converted those scores to a 50-point scale. *Id.* When it did so, the agency gave the full 50 points to each vendor whose original score was at least 3 out of 5. *Id.* But the agency gave only 20 points to a vendor whose original score was 2.5 out of 5. *Id.* ¶¶ 42, 45.

This Tribunal held that this scoring system was arbitrary and capricious. *Id.*, Conclusions of Law ¶ 11. The Tribunal reached that conclusion because the scoring system took small differences in the original scores and turned them into large differences in the final scores. In *Medical Review*, the agency's scheme turned a difference of 0.5 points in the original scores (3 versus 2.5) into a difference of 30 points in the final scores (50 versus 20). *See id.*, Findings of Fact ¶¶ 36, 42, 45. As this Tribunal observed, that scoring was "akin to someone scoring a 51 on a test and receiving a grade of 100 while another scored a grade of 49 and [was] required to keep that 49 grade." *See id.*, Conclusions of Law ¶ 10.

The Plan's scoring system here involved the same error that the Tribunal reversed in *Medical Review*: The final scoring took small differences in the vendors' original scores and arbitrarily turned them into large differences in the final scores.

The Plan's points-to-ranks-to-points scheme was arbitrary in other ways as well.

For example, under the Plan's approach, it did not matter whether Blue Cross NC confirmed 303, 309, or even zero technical requirements. Either way, Blue Cross NC would have received the same number of final technical points: one. *See Jones Dep.* 128:22-129:8, 133:17-134:2 (P3 409-11).

Further, no matter what Blue Cross NC proposed on cost, the Plan’s scoring scheme made it impossible for Blue Cross NC to win the RFP. To illustrate this point, suppose that:

- Blue Cross NC proposed an administrative fee of \$0, and thus offered to serve as the TPA for free;
- Blue Cross NC’s network pricing was billions of dollars lower than Aetna’s; and
- Blue Cross NC confirmed 99% of the technical requirements.

Even then, under the Plan’s approach, Blue Cross NC still would have scored lower than Aetna:

Vendor	Final Cost “Points”	Final Technical “Points”	Final “Score”
Aetna	2	3	5
Blue Cross NC	3	1	4

For these reasons, the Plan’s final-scoring scheme was arbitrary. By using an arbitrary scoring scheme, the Plan violated section 150B-23(a).

2. The Plan’s final-scoring scheme violated the RFP’s text.

The Plan’s points-to-ranks-to-points approach violated section 150B-23(a) for a second reason as well: It violated the text of the RFP.

The RFP stated that the Plan would use a “total points scale” that equally weighted the technical and cost proposals. RFP § 3.4(a), at 24. The RFP also used

the phrase “total points” to refer to the initial 310-point scale for the technical proposals and the initial 10-point scale for the cost proposals. *Id.* §§ 3.4(b)-(c), at 24-25. Thus, under the RFP, the “total points” that were to be given equal weight were the initial technical points and the initial cost points.

Even though the RFP required it, the Plan did not give those initial points equal weight. The Plan instead gave equal weight to the *final* technical points and the *final* cost points that the Plan made out of the *ranks* of the vendors’ technical and cost proposals. *See* Plan Br. 49.

The Plan does not identify any statement in the RFP that the Plan would achieve equal weighting by adding together the vendors’ final, rank-based “points.” The Plan instead argues that the RFP made this approach “implicit.” *Id.* at 49 n.15.

That argument is wrong. The RFP did not make implicit that the Plan would give equal weight to the vendors’ rank-based “points.” The RFP instead made *explicit* that the Plan would give equal weight to the vendors’ initial technical points and initial cost points. As a result, the Plan is mistaken when it argues that the vendors’ scores were determined “exactly as described in the RFP.” Plan Br. 46.

But even if the RFP *had* made the Plan’s scoring system implicit, the Plan still would have violated section 150B-23(a). Both the Plan’s contracting policy and administrative-law principles require a fair process. *See* Dep. Ex. 4 at SHP 92221, 92227 (P1 1, 7); *supra* p. 15. Awarding a multi-billion-dollar contract based on a scoring system that is only *implicit* would not be fair. As Ms. Jones testified, the “key” to a fair scoring process is “objectivity,” which means that the RFP’s terms are

“black-and-white” and not open to a lot of interpretation. Jones Dep. 19:23-20:11, 35:13-17 (P3 382, 386). Aetna’s expert likewise testified that objectivity “is part of what you need to do to ensure that you have a fair result.” Coccia Dep. 75:17-18 (BCNC2 1404).

Nor would using a scoring system that is only implicit be reasonable, as the Plan concedes its approach had to be. *See* Plan Mot. 2; Plan Br. 25, 27; Plan Resp. to Mot. to Compel 9 (June 19, 2023).

The Plan’s other defenses of its final-scoring scheme fail as well. The Plan defends the rationality of equal weighting, *see* Plan Br. 49, but that argument misses Blue Cross NC’s point: The Plan’s final-scoring approach *eliminated* the equal weighting that the RFP required.

The Plan also argues that its scoring scheme “was reasoned and within the Plan’s discretion.” *Id.* at 50. As shown above, however, the Plan’s scheme was not reasoned. It was arbitrary. *See supra* pp. 40-44. The Plan’s scheme also violated the RFP. This scheme therefore violated section 150B-23(a). The Plan did not have discretion to use a scoring scheme that violated section 150B-23(a).

3. The Plan’s final-scoring scheme prejudiced Blue Cross NC.

The Plan does not deny that Blue Cross NC suffered prejudice from the final-scoring scheme. Nor could it. Under a lawful scoring of the cost proposal, the Plan’s scoring approach would have made the difference between Blue Cross NC winning and losing the RFP.

If Segal had lawfully scored the cost proposal, Blue Cross NC would have won the cost proposal either nine to eight or eight to seven. *See supra* p. 39.

The RFP said that the Plan would equally weight the initial technical points and the initial cost points. *See supra* pp. 44-45. Under an equal weighting of those points, the Plan would have needed to scale the 10 points on the cost proposal to match the 310 points on the technical proposal (or vice versa). Either way, 1 initial cost point would have equaled 31 initial technical points.

Under this equal weighting, if Blue Cross NC had won the cost proposal 9-8, the final scores would have turned out like this:

Vendor	Initial Technical Points	Initial Cost Points	Total Points
Blue Cross NC	303	279 (9 x 31)	582
Aetna	310	248 (8 x 31)	558
UMR	310	217 (7 x 31)	527

If Blue Cross NC had won the cost proposal 8-7, under equal weighting, the final scores would have turned out like this:

Vendor	Initial Technical Points	Initial Cost Points	Total Points
Blue Cross NC	303	248 (8 x 31)	551
Aetna	310	217 (7 x 31)	527
UMR	310	217 (7 x 31)	527

Ms. Jones testified that the Plan awarded the contract to Aetna because Aetna was the “math winner.” Jones Dep. 30:24-25 (P3 385). As these charts show, if the Plan had lawfully scored the cost proposal and used the final-scoring method described in the RFP, the math winner would instead have been Blue Cross NC.

* * *

In sum, the Plan’s final-scoring scheme was arbitrary and violated the RFP. That scheme therefore violated section 150B-23(a). For these reasons, Blue Cross NC asks that this Tribunal deny the Plan’s request for summary judgment on the lawfulness of its scoring scheme.

Indeed, the Tribunal need not stop there. The material facts on the unlawfulness of the Plan’s final-scoring scheme are undisputed, and this issue can be resolved as a matter of law. As a result, summary judgment for Blue Cross NC is warranted on the unlawfulness of the final-scoring scheme. *See* N.C. Gen. Stat. § 1A-1, Rule 56(c).

C. By prioritizing work avoidance and speed, the Plan committed three other independent errors.

In addition to the errors described above, the Plan violated section 150B-23(a) in three other ways. Each of these three violations is a further reason to vacate the contract award to Aetna.

These violations share a common theme: The Plan prioritized work avoidance and speed over fairness. The Plan admits that its timeline for the RFP was “accelerated” and “compressed.” *Supra* pp. 3-4; Dep. Ex. 22 at 5 (BCNC1 945);

Jones Dep. 269:15-16 (P3 444); Smart Dep. 31:14 (P3 680); Rish Dep. 164:22 (P3 582). To score the RFP on that compressed timeline, the Plan cut corners at multiple turns.

1. The Plan handed over control of the cost-proposal scoring to a private consultant.

The first way that the Plan prioritized work avoidance was to outsource the entire scoring of the cost proposal to its private consultant, Segal.

An agency may engage a consultant to help with an RFP. But when an agency does so, it must “maintain firm control over the RFP process.” *Corporate Express*, 2006 WL 2190500, Conclusions of Law ¶ 5. If the agency instead gives its consultant control over key decisions, the agency violates section 150B-23(a). *Id.* ¶¶ 4-6; *accord, e.g., City of Fayetteville*, 2017 WL 8896072, Conclusions of Law ¶¶ 48-55. That is especially true when “new and untested procurement methods are used” or when “very small changes” could “determine the outcome of the award.” *Corporate Express*, 2006 WL 2190500, Conclusions of Law ¶¶ 4-5.

Here, the Plan used new and untested procurement methods. For example, the Plan awarded points for pricing guarantees—an approach it had not taken in the previous TPA RFP. *See* Dep. Ex. 217 at 21 (BCNC1 974). And, as shown above, small changes in the scoring of the cost proposal determined the RFP’s outcome. *See supra* pp. 39, 47.

Despite these points, the Plan did not keep firm control over the scoring of the cost proposal. The Plan instead farmed out that scoring to Segal.

The Plan admits that “Segal was primarily responsible for the evaluation and scoring of the cost proposals.” Plan Br. 14. In fact, the Plan’s brief devotes multiple pages to describing how Segal controlled the cost scoring. *See id.* at 14-15, 34-39.

The testimony of the Plan’s witnesses confirms that Segal was in control.

Mr. Rish admitted the following points:

- “[T]he Plan contracted with Segal to do” the cost-proposal work, and “Segal went and did that work.” Rish Dep. 28:24-29:1 (P3 548).
- After Segal had the cost-proposal data, the Plan gave Segal “no direction.” *Id.* at 29:1.
- The Plan chose to “defer to [Segal’s] expertise.” *Id.* at 29:3-4.
- The “evaluation and scoring process” was “Segal’s to handle” and “to own.” *Id.* at 161:18-22 (P3 581).

Mr. Sceiford made similar admissions:

- Segal was “responsible for the cost analysis.” Sceiford Dep. 39:21-22 (P3 640).
- Segal reviewed the cost proposals, calculated the costs, and “award[ed] points.” *Id.* at 40:19 (P3 640).
- Sceiford did not know what Segal did in its analysis, did not have visibility into Segal’s work, and did not know what method Segal used to analyze the pricing guarantees. *Id.* at 41:25-42:5, 74:9-12 (P3 641, 649).

- The guarantee scoring was done by Segal alone. *Id.* at 74:13-75:12 (P3 649).

The Segal executive who oversaw Segal's work on the RFP, Stuart Wohl, agreed that "Segal essentially ran the show on the cost proposal." Wohl Dep. 58:22-23 (BCNC2 1431); *see id.* at 58:22-59:12 (BCNC2 1431-32). Segal's 30(b)(6) witness concurred: "We scored the [cost] proposals." Segal 30(b)(6) Dep. 96:17-18 (P3 481).

The Plan offers no valid response to these points.

The Plan states that Segal's analysis was "accepted and adopted by the Plan's Evaluation Committee." Plan Br. 39. Perhaps, but the evaluation committee did not review Segal's work in any substantive way. According to Caroline Smart, the RFP's "business owner," the evaluation committee "would not have done" a substantive review of Segal's analysis. Smart Dep. 11:4, 39:3 (P3 675, 682). That was because "the evaluation team for the most part are not subject matter experts on the cost proposal." *Id.* at 39:4-5 (P3 682).

Mr. Rish has also asserted in an affidavit that he and Mr. Sceiford "thoroughly reviewed Segal's cost proposal analysis." Rish Aff. ¶ 23 (P4 920). To try to support that assertion, Mr. Rish asserts that he and Mr. Sceiford "understood and were comfortable with the methodology Segal followed." *Id.* But that conclusory statement is contradicted by Mr. Rish's and Mr. Sceiford's own testimony that they deferred to Segal and did not know what methods Segal was using. *See*

supra pp. 50-51. Self-serving descriptions of the interaction between the Plan and Segal cannot support summary judgment for the Plan.

As this Tribunal has held, section 150B-23(a) forbids handing control of a public agency's contracting decisions to a consultant. That approach is especially problematic in a contracting decision of this magnitude, where the results will affect the welfare of hundreds of thousands of public servants and their family members. The Plan therefore erred when it abdicated its duty to control the scoring of the cost proposal.

2. The Plan's evaluation of the vendors' technical capabilities was superficial.

The Plan did no better on the technical proposal. Although the Plan did not turn over the technical evaluation to Segal, the Plan still found a way to avoid work: It reduced the technical proposal to a checklist.

The RFP contained 310 technical requirements. Plan Br. 8. The Plan instructed the vendors, in their technical proposals, to use checkmarks to show whether the vendors confirmed each requirement. *See id.* at 8-9; RFP, Attach. L, at 118; Dep. Ex. 37 at Blue Cross NC 670-716 (P1 32-78); *supra* pp. 7-8. The Plan barred the vendors from supplementing these checkmarks with any factual information about the vendors' technical capabilities. *See* Plan Br. 7-9; RFP, Attach. L, at 118.

Neither the Plan's expert nor Aetna's expert has ever seen a TPA RFP that shut out all details on vendors' technical abilities like this. *See* Vieira Dep. 118:22-

119:19 (P3 761); Coccia Dep. 300:25-301:16 (BCNC2 1426-27). This approach also differed from the Plan’s approach in earlier TPA RFPs, where the Plan allowed vendors to offer factual information on their capabilities. *See* Jones First Aff. ¶ 20 (P4 880) (explaining that the 2022 TPA RFP was the first TPA RFP where the Plan had used a “non-narrative format for RFP responses”).

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REDACTED Dep. Ex. 257 at Navigator 5212 (BCNC2 1211); *see also* Aetna 30(b)(6) Dep. 254:17-255:18 (BCNC2 1391-92).

The RFP allowed the Plan to seek facts on the vendors’ capabilities by requesting oral presentations or holding discussions with the vendors. RFP § 3.3(a), at 22. During the evaluation process, however, the Plan chose not to use this option. Instead, the Plan’s evaluation committee simply added up each vendor’s checkmarks. Bourdon Dep. 145:4-147:9, 155:6-156:18 (P3 350-51, 353); Jones Dep. 159:19-161:1 (P3 417); Smart Dep. 116:23-117:18 (P3 701).

This “evaluation” took ninety minutes. Jones Dep. 161:13-18 (P3 417). Instead of discussing the vendors’ technical abilities, the committee members discussed how easy the process of counting checkmarks was. *See* Smart Dep. 116:15-22 (P3 701).

As the committee discovered when it counted the checkmarks, Aetna and UMR confirmed all of the technical requirements, and Blue Cross NC confirmed all but seven. Plan Br. 13. Ms. Smart was surprised; she “would have expected . . .

there to be more not-confirms.” Smart Dep. 113:22-23 (P3 700). That was because “in previous RFPs . . . the bidders [didn’t] always confirm every option.” *Id.* at 114:8-11 (P3 701). Despite that surprise, the Plan chose not to follow up with the vendors about their responses. *See* Jones Dep. 187:12-17 (P3 424); Smart Dep. 105:2-16 (P3 698).

The Plan does not contest these points. Instead, the Plan cites the drawbacks of allowing “long narrative discussions” in vendors’ technical proposals. Plan Br. 46; *see also id.* at 5-7. But the question here is not a policy debate about the pros and cons of allowing narrative discussions. Instead, the question is a narrow one: As a matter of law, was the Plan allowed to evaluate the technical part of this multi-billion-dollar RFP by counting checkmarks alone?

No, for at least three reasons.

First, the RFP demanded that the Plan conduct a “comprehensive” evaluation. RFP § 3.3(a), at 23. Counting checkmarks is far from comprehensive.

Second, an agency decision is arbitrary and capricious if it lacks “careful consideration” or “reasoned decisionmaking.” *Joyce*, 91 N.C. App. at 156, 370 S.E.2d at 868. The evaluation here was superficial, not careful or reasoned.

Third, both section 150B-23(a) and the Plan’s contracting policy require that an RFP be conducted fairly. *See Fidelity*, 2015 WL 2380647, Conclusions of Law ¶¶ 32-34; Dep. Ex. 4 at SHP 92221, 92227 (P1 1, 7). The process here was not fair. The Plan admits that Blue Cross NC, the low-cost bidder, “lost the entire thing” by not confirming 7 out of 310 technical requirements. Jones Dep. 108:21 (P3 404); *see*

id. at 109:2-4 (P3 404). Yet the Plan had no discussions with Blue Cross NC (or any vendor) about its technical capabilities.

For these reasons, the Plan's superficial evaluation of the technical proposal violated section 150B-23(a).

3. The Plan's evaluation of network access and disruption was superficial as well.

The Plan also avoided work in a third way: It did only a superficial evaluation of the vendors' networks of providers. A thorough comparison of those networks was critical to the welfare of the Plan's members. By doing only a surface-level assessment, the Plan violated the RFP and ignored factors that were key to its decision.

As the Plan admits, its members depend on the network offered by the Plan's TPA. *See* Smart Dep. 48:2-9, 64:19-65:15 (P3 684, 688); Wohl Dep. 168:7-11 (BCNC2 1452). A broader network gives members more access to in-network providers, producing lower out-of-pocket costs. *See* Russo Rep. 48 (BCNC2 1274). As Ms. Jones noted, network access is a particular concern in North Carolina's rural areas. *See* Jones Dep. 242:25-243:12 (P3 438).

An important part of analyzing provider networks is analyzing disruption. Disruption refers to the impact on the Plan's members if the Plan chooses a new TPA. *See* Rish Dep. 107:12-16 (P3 568); Smart Dep. 46:21-47:5 (P3 684); Aetna 30(b)(6) Dep. 161:9-10 (BCNC2 1382); Russo Rep. 55 (BCNC2 1281). If a new TPA's provider network is narrower than the existing TPA's network, some providers will

move from in-network to out-of-network. As a result, some Plan members will need to switch providers or pay more to continue seeing their current providers. *See* Rish Dep. 107:17-108:2 (P3 568); Smart Dep. 47:8-17 (P3 684); Aetna 30(b)(6) Dep. 161:9-10 (BCNC2 1382); Russo Rep. 55 (BCNC2 1281).

The RFP required the Plan to evaluate the breadth of the vendors' networks and disruption. The RFP did so when it stated that the Plan sought "a broad provider network with the least disruption." RFP, Attach. A, § 1.1, at 81. By stating that the Plan sought the network with "the least" disruption, the RFP required the Plan to *compare* the disruption posed by each vendor's network.

The RFP also required the vendors to submit the data needed for the Plan to compare the vendors' networks. Russo Rep. 50 (BCNC2 1276). The RFP asked each vendor to submit an accessibility, or GeoAccess, report. RFP, Attach. A, § 1.1.1, at 81. With this data, the Plan could analyze whether its "members would have access to providers of all different types and specialties regardless of their location throughout the state." Rish Dep. 119:10-13 (P3 571). In other words, the Plan could identify any "holes" in each vendor's network. Smart Dep. 64:4 (P3 688).

To cover this issue, the Plan added a specific requirement to Segal's proposal for its work on the RFP. The added language required Segal to "provide a Disruption Analysis, based on the Geo Access reporting requirement in the RFP." Dep. Ex. 209 at SHP 86107 (BCNC2 1174); Wohl Dep. 135:4-13 (BCNC2 1442); *see also* Dep. Ex. 11 at SHP 2 (BCNC2 1166).

When it came time to evaluate the proposals, however, neither the Plan nor Segal did the network comparison that the Plan had mandated. Segal did not analyze how many providers are in-network for Blue Cross NC and out-of-network for the other vendors. Segal 30(b)(6) Dep. 118:25-119:7 (P3 487). Nor did the Plan or Segal analyze the vendors' networks in particular regions of the state. *See* Wohl Dep. 82:13-17, 129:20-130:17 (BCNC2 1435, 1438-39); Rish Dep. 108:3-12, 123:19-23 (P3 568, 572); Smart Dep. 67:6-16, 68:21-24 (P3 689); Coccia Dep. 266:8-9 (BCNC2 1415). Despite the language the Plan inserted in Segal's proposal, the Plan told Segal not to do that detailed analysis. Wohl Dep. 82:13-23 (BCNC2 1435).

To try to rationalize the Plan's decision to skip a detailed network analysis, the Plan's employees, in their depositions, offered a variety of conflicting reasons:

- Mr. Rish pointed to the RFP's accelerated timeline. Rish Dep. 110:18-111:1 (P3 569).
- Ms. Smart said that network access is "not something that we have been concerned about." Smart Dep. 85:19-86:3 (P3 693-94).
- Kendall Bourdon, the Plan's head of contracting, said that measuring disruption would be "inappropriate" because it would "necessarily benefit" the incumbent TPA. Bourdon Dep. 178:20-179:23 (P3 359).

These explanations conflict with each other. They also clash with the Plan's admissions about the importance of evaluating network access and disruption. But no matter what the Plan's rationale was, the Plan still violated the RFP's requirement that the Plan compare the vendors' networks.

That violation has serious practical consequences for the Plan's members.

If the Plan had really compared the vendors' networks, it would have found that Blue Cross NC's network is broader than Aetna's. *See* Russo Rep. 52-55 (BCNC2 1278-81). Blue Cross NC has at least 2,000 more providers statewide than Aetna has. *Id.* at 52-53 (BCNC2 1278-79). Blue Cross NC's network also beats Aetna's network in rural areas—the areas where, Ms. Jones admitted, network-access concerns are most acute. *See* Jones Dep. 242:25-243:12 (P3 438). In those areas, Blue Cross NC has about 1,100 more providers than Aetna has. Russo Rep. 54 (BCNC2 1280).

The Plan also would have found that switching from Blue Cross NC to Aetna would hurt many Plan members. *See id.* at 55-59 (BCNC2 1281-85). In 2021, more than 37,000 Plan members received services from providers that are in-network with Blue Cross NC but are out-of-network with Aetna. *Id.* Nearly half of those 37,000 members live in rural counties. *Id.* Thus, if Aetna becomes the TPA, many members will face a difficult choice between leaving their current providers or paying more out of their own pockets for their health care. *Id.* at 57, 59 (BCNC2 1283, 1285).

The Plan's responses to these points fail.

First, the Plan notes that the RFP required the vendors to check a box to confirm that their networks “will support Plan Members residing in all 100 counties in North Carolina and throughout the United States.” Plan Br. 26 (quoting RFP § 5.1.3, at 37). The Plan also says that the vendors here “were all established

national companies with broad provider networks.” *Id.* But these points say nothing about which vendor’s network would cause “the least disruption”—the issue that the RFP required the Plan to assess. RFP, Attach. A, § 1.1, at 81.

Second, the Plan denies that the RFP actually required a comparison of the vendors’ networks. Plan Br. 26. The RFP said, however, that the Plan sought “a broad provider network with *the least* disruption.” RFP, Attach. A, § 1.1, at 81 (emphasis added). The Plan does not explain how it could judge which network has “the least” disruption without doing a comparison.

Third, the Plan argues that it and Segal evaluated network access and disruption “indirectly,” by analyzing the vendors’ network pricing. Plan Br. 26-27. But network pricing is an aggregate, statewide metric. Russo Rebuttal Rep. 22 (BCNC2 1358). It does not show whether networks have gaps in particular geographic areas, such as rural ones. *See id.* For this reason, the Plan’s “indirect” analysis of network access and disruption was superficial at best. Aetna’s expert, Mr. Coccia, confirmed this point when he testified that nearly every RFP that he has worked on used some additional measure of network access and disruption, rather than relying on network pricing alone. Coccia Dep. 268:18-274:6 (BCNC2 1417-23).

In sum, a comparison of the vendors’ networks was critical to the Plan’s choice of a TPA. The RFP expressly required that comparison. But the Plan did not conduct a meaningful network comparison. The Plan therefore violated the RFP

and ignored factors that were critical to its decision, in violation of section 150B-23(a). *See supra* p. 14.

* * *

Substantial evidence shows that the Plan and Segal committed multiple violations of section 150B-23(a). Segal's scoring of the cost proposal violated the RFP and was arbitrary and capricious. The same is true of the Plan's final-scoring scheme. The Plan unlawfully handed over control of the cost-proposal scoring to Segal. And the Plan conducted only a superficial evaluation of the vendors' technical capabilities and networks.

These and other points bar summary judgment for the Plan.

II. Aetna's waiver argument lacks merit.

Unlike the Plan, Aetna has not moved for summary judgment on all of Blue Cross NC's claims. Aetna asks for summary judgment only to the extent that Blue Cross NC's claims "challenge the terms of the 2022 TPA RFP." Aetna Mot. 2.

Aetna asks for partial summary judgment on claims of that type by arguing that Blue Cross NC has waived them. *Id.* at 1-2; Aetna Br. 2, 8-9.

This Tribunal has seen Aetna's waiver argument before. Aetna made the same argument in its response to Blue Cross NC's motion to compel in June. Aetna's Resp. in Opp. to Blue Cross NC's Mot. to Compel Discovery 5-10 (June 19, 2023). Rather than accept Aetna's argument, this Tribunal granted Blue Cross NC's motion. Order Granting Mot. to Compel 1-2.

Aetna's waiver argument has not improved since. This Tribunal should reject that argument for two reasons.

First, Aetna's waiver argument does not apply to the claims at the center of this case.

Second, Aetna's waiver argument fails as a matter of law in any event.

A. Aetna's waiver argument does not apply to the claims at the center of this case.

Aetna's waiver argument is limited to claims that "challenge the terms of the 2022 TPA RFP." Aetna Br. 9. Aetna does not argue that Blue Cross NC has waived any other claims, such as claims that challenge the Plan's and Segal's evaluation and scoring of the vendors' proposals. *See id.* As shown above, however, those claims are the essence of this case.

Take, for example, Blue Cross NC's challenges to Segal's scoring of the vendors' cost proposals, discussed above in section I.A. These claims argue that Segal *violated* the RFP. *See supra* pp. 21-29. As these claims illustrate, Blue Cross NC is seeking to enforce the RFP's terms, not to challenge them.

Aetna mostly agrees. In its brief, Aetna lists the claims that Aetna views as challenges to the RFP's terms. Aetna Br. 8-9. That list omits most of the claims discussed in section I.A.

Aetna's list does include the Plan's "fail[ure] to validate Aetna's repricing submission." *Id.* at 9. That may be a reference to Segal's failure to account for the discrepancy in Aetna's network-pricing proposal. *See supra* pp. 34-39. But the RFP

did not say anything about how Segal and the Plan would handle discrepancies like that one. Thus, Blue Cross NC's challenge regarding the discrepancy is not a challenge to the RFP's terms.

Consider next Blue Cross NC's challenge to the Plan's final-scoring scheme, discussed above in section I.B. This claim points out that the Plan used a scoring system that departed from the language of the RFP. *See supra* pp. 39, 44-46. Like Blue Cross NC's claim about the cost scoring, its claim about the final scoring seeks to enforce the RFP's terms, not to challenge them.

Aetna does not dispute this point. Aetna does not argue that the RFP stated that the Plan would add together rank-based "points" to create the vendors' final scores. *See Aetna Br. 9, 11-12.* Nor does Aetna argue that Blue Cross NC has waived its challenge to this unstated part of the Plan's scoring scheme. *See id.*

Finally, consider the claims discussed above in section I.C. In those claims, Blue Cross NC argues that the Plan erred by giving Segal control over the scoring of the cost proposal and by conducting a superficial evaluation of the vendors' technical capabilities and networks. Like Blue Cross NC's other claims, these claims challenge errors that happened in the evaluation phase, after the RFP was already in effect.

Again, Aetna largely agrees. Aetna does not argue that any of these claims challenge the RFP's terms. *See id.* at 8-9.

To be sure, as Aetna points out, the RFP barred narrative statements in the technical proposals and did not include network access or disruption in its scoring

criteria. *Id.* at 11-13. But as discussed above, even though the RFP barred narrative responses, it still allowed the Plan to seek factual information about the vendors' capabilities. *See supra* pp. 8, 53. Similarly, even though the RFP did not include network access or disruption in its scoring criteria, it still required the Plan to *analyze* those issues. *See supra* pp. 55-60. Thus, on these issues as well, Blue Cross NC is seeking to enforce the RFP's terms, not to challenge them.

In sum, Aetna asks for summary judgment on claims that challenge the RFP's terms. The claims at the center of this case do not fit that description.

B. In any event, Aetna's waiver argument fails on the merits.

Even if any of Blue Cross NC's claims did challenge the RFP's terms, Aetna's waiver argument would still lack merit. Aetna tries to base its waiver theory on North Carolina laches doctrine and federal waiver doctrine. Both arguments fail.

1. Laches does not bar any of Blue Cross NC's claims.

Aetna argues that laches bars any claims that challenge the terms of the RFP. Aetna Br. 9-18. That argument does not succeed.

Aetna admits that laches is an affirmative defense. *Id.* at 10. As a result, Aetna has the burden to prove that laches applies here. *Id.*; *accord, e.g., Stratton v. Royal Bank of Can.*, 211 N.C. App. 78, 89, 712 S.E.2d 221, 231 (2011).

Aetna cannot meet that burden. Aetna lacks any evidence to support three elements of laches: (1) that Blue Cross NC had earlier knowledge of its claims, (2) that Blue Cross NC unreasonably delayed in bringing those claims, and (3) that

Aetna was prejudiced as a result. *See, e.g., Johnson v. N.C. Dep't of Cultural Res.*, 223 N.C. App. 47, 55, 735 S.E.2d 595, 600 (2012) (describing the elements of laches). This lack of evidence defeats Aetna's motion for partial summary judgment.

a. Aetna has not shown that Blue Cross NC had earlier knowledge of its claims.

One element of laches is that the claimant had earlier knowledge of its claims. *See, e.g., Johnson*, 223 N.C. App. at 55, 735 S.E.2d at 600. Aetna has not met this element.

Aetna argues that Blue Cross NC had earlier knowledge of its claims that purportedly challenge the terms of the RFP. Aetna Br. 9-13. Aetna does not argue that Blue Cross NC had earlier knowledge of any other claims. *See id.*

As shown above, the claims at the center of this case do not challenge the RFP's terms. Blue Cross NC's claims instead challenge the evaluation and scoring of the vendors' proposals. *See supra* pp. 61-63. Aetna does not argue that Blue Cross NC had earlier knowledge of those claims.

b. Aetna has not shown that Blue Cross NC unreasonably delayed in bringing its claims.

A second element of laches is that the claimant unreasonably delayed in bringing its claims. *E.g., Johnson*, 223 N.C. App. at 55, 735 S.E.2d at 600. Aetna has not met this element either.

Aetna cannot show any delay by Blue Cross NC, much less an unreasonable one. Blue Cross NC met the two express deadlines that applied to its claims.

Blue Cross NC first met the RFP's deadline for filing a protest.

- The RFP contained a section on “protest procedures.” RFP, Attach. B, § 15, at 87 (capitalization changed). That section stated that “[t]o protest a contract award,” a vendor “shall submit a written request for a protest meeting” to the Plan’s executive administrator “within 30 calendar days from the date of the Contract award.” *Id.* at 87-88.
- Blue Cross NC met this deadline. The Plan awarded the contract to Aetna on December 14, 2022. Smart Aff. ¶ 36 (P4 936). Blue Cross NC submitted its written request for a protest meeting 29 days later, on January 12, 2023. Protest Ltr. 1 (P1 220).

Blue Cross NC then met the North Carolina APA’s deadline for filing its contested-case petition in this Tribunal.

- Section 150B-23(f) of the North Carolina General Statutes requires a petitioner to file its contested-case petition within 60 days after the agency gives notice of its decision. N.C. Gen. Stat. § 150B-23(f).
- Blue Cross NC met this deadline as well. The Plan gave notice of its decision to deny Blue Cross NC’s request for a protest meeting on January 20, 2023. Protest Resp. at SHP 25822 (P1 143). Blue Cross NC filed its petition 27 days later, on February 16, 2023. Pet. 25.

Because Blue Cross NC met these express deadlines, laches has no role to play in this case. When the claimant meets an express statutory deadline, “equity will not bar relief on the ground of laches except upon special facts demanding

exceptional relief.” *Howell v. Alexander*, 3 N.C. App. 371, 380, 165 S.E.2d 256, 263 (1969). Here, Blue Cross NC met the express deadlines set by the RFP and by statute. Thus, for laches to apply, Aetna would need to show special facts demanding exceptional relief. But Aetna does not mention this standard, much less try to satisfy it.

Aetna instead tries to show unreasonable delay by arguing that two other sections of the RFP, sections 2.3 and 2.5, required Blue Cross NC to bring its claims earlier than it did. Aetna Br. 13-14. Sections 2.3 and 2.5 established time periods in which vendors could, before submitting their proposals, ask the Plan questions about the requirements that the RFP imposed on vendors. RFP §§ 2.3, 2.5, at 10-13. Aetna argues that these sections required Blue Cross NC, on pain of waiver, to challenge the RFP’s terms during the question-and-answer periods. Aetna Br. 13-14.

That argument fails for four reasons.

First, Aetna’s argument would create a conflict within the RFP. Section 15 of attachment B allowed protests only *after* the contract was awarded. *See* RFP, Attach. B, § 15, at 87. But Aetna reads sections 2.3 and 2.5 to make some protests due in the question-and-answer periods, *before* the contract was awarded. Thus, under Aetna’s reading, the RFP set conflicting deadlines for protests.

As Aetna admits, the RFP’s provisions should be read in harmony, not in conflict. Aetna Br. 15. The way to achieve harmony here is to recognize that section 15 of attachment B, and that section alone, set the deadline for protests.

Second, and relatedly, sections 2.3 and 2.5 did not address the types of claims at issue here.

Section 2.5 stated that if vendors had “questions to clarify or interpret the RFP in order to submit the best proposals possible,” vendors needed to submit those questions during the question-and-answer periods. RFP § 2.5, at 12. Blue Cross NC’s challenges to the way that the Plan and Segal evaluated and scored the vendors’ proposals are not “questions to clarify or interpret the RFP.” Thus, exchanges with the Plan on these issues would not have affected Blue Cross NC’s effort to submit the best proposal possible. As a result, section 2.5 did not require Blue Cross NC to raise its claims during the question-and-answer periods.

Nor did section 2.3 require Blue Cross NC to raise its claims during those periods. Section 2.3 instead allowed questions on a different topic: the RFP’s requirements for vendors.

Section 2.3 called for vendors to submit “questions, issues, or exceptions regarding any term, condition, or other component within this RFP” during the question-and-answer periods. RFP § 2.3, at 11.

Section 2.3 made clear that these “terms,” “conditions,” and “other components” meant the requirements that the RFP imposed on vendors, not its methods for evaluation and scoring. Section 2.3 made this point when it stated that vendors must read the “the State’s terms and conditions” and “any other components made a part of this RFP” and “*comply with* all requirements and specifications herein.” *Id.* at 10-11 (emphasis added). That language equated

terms, conditions, and other components with the requirements that the vendors needed to comply with.

As a result, when section 2.3 referred to questions, issues, or exceptions on the RFP's terms, conditions, or other components, it was referring to questions, issues, or exceptions on the requirements that the RFP imposed on vendors. It was not referring to questions, issues, or exceptions on the Plan's methods for evaluating or scoring proposals. Thus, section 2.3 did not require Blue Cross NC to raise its evaluation-related or scoring-related claims during the question-and-answer periods.

Third, Aetna is wrong when it argues that the questions that other vendors submitted and the answers that the Plan gave during the question-and-answer periods put Blue Cross NC on notice that it needed to raise its claims during those periods. Aetna Br. 16-17.

The questions and answers that Aetna highlights support Blue Cross NC's understanding of sections 2.3 and 2.5, not Aetna's. Those questions and answers were about the requirements that the RFP imposed on vendors. They were not challenges to how the Plan would evaluate and score proposals.

For example, Aetna describes questions on whether the Plan would amend the RFP's minimum requirements. *Id.* at 16. Aetna also discusses an answer from the Plan that questions on the technical requirements should be submitted in the question-and-answer period for those requirements. *Id.* at 16-17.

The minimum requirements and technical requirements were requirements that the RFP imposed on vendors. *See* RFP §§ 5.1-5.2, at 33-74.

As a result, the questions and answers that Aetna cites confirm that sections 2.3 and 2.5 addressed the requirements that the RFP imposed on vendors, not the evaluation and scoring of proposals.

Finally, even if the RFP were ambiguous, Aetna has not shown that Blue Cross NC's understanding of the RFP was unreasonable. Aetna thus has not met its burden to show an unreasonable delay by Blue Cross NC.

In sum, Blue Cross NC brought its claims within the deadlines set by the RFP and by the APA. Sections 2.3 and 2.5 of the RFP did not set an earlier deadline for Blue Cross NC's claims. Aetna thus has not shown that Blue Cross NC unreasonably delayed in bringing its claims.

c. Aetna has not shown that its alleged prejudice was caused by Blue Cross NC's purported delay.

A third element of laches is that the claimant's delay caused prejudice to the defendant. *See, e.g., Johnson*, 223 N.C. App. at 55, 735 S.E.2d at 600; *Phoenix Ltd. P'ship of Raleigh v. Simpson*, 201 N.C. App. 493, 506, 688 S.E.2d 717, 726 (2009). Here, Aetna has not shown a causal link between Blue Cross NC's purported delay and Aetna's alleged prejudice.

Aetna alleges that it has been prejudiced because it has incurred costs in preparing to perform the TPA contract. Aetna Br. 18. Aetna is arguing, in other words, that it was prejudiced by winning the contract.

To show that this alleged prejudice was caused by Blue Cross NC's purported delay, Aetna would need to show that if Blue Cross NC had raised its claims earlier, the Plan would have changed course in a way that favored Blue Cross NC.

Aetna does not even try to make this showing. It could not make this showing if it tried.

The evidence shows that the Plan was not willing to change course in response to vendors' questions. When vendors asked if the Plan would change several of the RFP's requirements, the Plan said no every time. *See* Dep. Ex. 43 at 7 (P1 85) (questions and answers 11, 12, 14, and 16).

Likewise, the Plan's witnesses have stressed that their decisions about the parts of the RFP at issue here—the RFP's evaluation and scoring methodologies—were deliberate ones. Bourdon Aff. ¶¶ 8, 10-12 (P4 864-65); Jones Second Aff. ¶¶ 18, 23-25 (P4 887-89); Rish Aff. ¶¶ 5-13 (P4 915-17); Smart Aff. ¶¶ 12, 33 (P4 931, 936). These statements confirm that the Plan would not have changed course in response to questions from Blue Cross NC.

The Plan's decision to bar narrative statements in the vendors' technical proposals illustrates this point. The Plan's leadership decided to bar narrative statements as part of an intentional effort to save work for the Plan's staff. *See* Jones First Aff. ¶¶ 7-20 (P4 876-80). Before the Plan published the RFP here, the Plan's leadership considered and rejected concerns raised by a Plan employee on this issue. *Id.* ¶ 19 (P4 879-80). Ms. Jones has described the Plan's decision to bar

narrative statements as “intentional and resolute.” Jones Dep. 187:19 (P3 424); *see id.* at 187:18-23 (P3 424).

Because the Plan was unwilling to change course on its approach to evaluating and scoring the RFP, it would have been futile for Blue Cross NC to raise its claims during the question-and-answer period. As a result, Aetna cannot show that Blue Cross NC’s purported delay in bringing its claims caused Aetna’s alleged prejudice.

* * *

In sum, Aetna has not satisfied three elements of laches. Aetna has not shown that Blue Cross NC had earlier knowledge of its claims, that Blue Cross NC unreasonably delayed in bringing those claims, or that Aetna was prejudiced as a result. For these reasons, laches does not apply here.

2. Federal waiver doctrine does not bar any of Blue Cross NC’s claims.

Aetna’s brief also relies on a doctrine that federal courts have adopted for federal bid-protest cases. Aetna Br. 18-23. That doctrine is not, and should not become, the law in this state.

Under the federal doctrine that Aetna cites, if a vendor misses an opportunity to protest an RFP’s terms before the vendor submits its proposal, the vendor cannot later challenge the RFP’s terms in the U.S. Court of Federal Claims. *See Blue & Gold Fleet, L.P. v. United States*, 492 F.3d 1308, 1315 (Fed. Cir. 2007); *Bannum, Inc. v. United States*, 779 F.3d 1376, 1380-81 (Fed. Cir. 2015).

Aetna’s discussion of this federal waiver doctrine does not support its motion for partial summary judgment. Federal waiver doctrine does not govern this case. And in any event, federal waiver doctrine would not bar the claims at issue here.

a. Federal waiver doctrine does not apply in this Tribunal.

Aetna concedes that federal waiver doctrine “is not controlling on this Tribunal.” Aetna Br. 19. But Aetna asks this Tribunal to follow federal waiver doctrine anyway. *See id.* That request fails for four reasons.

First, if this Tribunal adopted federal waiver doctrine, it would be making new law and departing from earlier decisions.

No North Carolina tribunal has adopted federal waiver doctrine. Aetna does not point to any decision of this Tribunal or of a North Carolina court that has even mentioned the doctrine, much less embraced it.

In fact, this Tribunal’s decisions clash with federal waiver doctrine. In at least two bid-protest decisions, this Tribunal has ruled on the merits of challenges to the terms of RFPs without mentioning any potential waiver problem.

In one of those decisions, the petitioner challenged an RFP term that made price the least important factor. *See Corvel Enter. Comp v. N.C. Dep’t of Admin. Div. of Purchase & Cont.*, No. 19 DOA 5891, 2021 WL 1087852, Findings of Fact ¶ 18, Conclusions of Law ¶¶ 10-16 (N.C. Ofc. Admin. Hrgs. Jan. 14, 2021). In the other decision, the petitioner challenged an RFP term that called for the use of a

reverse auction. *Corporate Express*, 2006 WL 2190500, Findings of Fact ¶ 32, Conclusions of Law ¶ 18.

Neither decision suggested that the petitioners had raised these challenges to the RFP's terms before they submitted their proposals. Under Aetna's view of federal waiver doctrine, these challenges would have been waived.

But this Tribunal did not hold that the challenges were waived. It instead decided the challenges on their merits. *See Corvel*, 2021 WL 1087852, Conclusions of Law ¶¶ 10-16; *Corporate Express*, 2006 WL 2190500, Conclusions of Law ¶ 18.

Second, federal waiver doctrine is based on a federal statute and a federal regulation. North Carolina has no similar statute or regulation that could provide a basis for adopting the doctrine.

Federal waiver doctrine is based on "a specific statutory authorization." *Insero Corp. v. United States*, 961 F.3d 1343, 1349 n.1 (Fed. Cir. 2020). A federal statute requires federal courts to give due regard to "the need for expeditious resolution" of federal bid-protest cases. 28 U.S.C. § 1491(b)(3). The Federal Circuit relied on this federal statute when it created the federal waiver doctrine, holding that the doctrine "furthers this statutory mandate." *Blue & Gold*, 492 F.3d at 1313.

The federal waiver doctrine is also based on a federal regulation. *See id.* at 1314. A regulation issued by the U.S. Government Accountability Office provides that "[p]rotests based upon alleged improprieties in a solicitation which are apparent prior to bid opening or the time set for receipt of initial proposals shall be filed prior to bid opening or the time set for receipt of initial proposals." 4 C.F.R.

§ 21.2(a)(1). The Federal Circuit relied on this regulation, too, when it adopted the federal waiver doctrine. *Blue & Gold*, 492 F.3d at 1314.

North Carolina has no similar statute or regulation. Aetna does not point to any North Carolina statute or regulation that could provide a basis for applying federal waiver doctrine. Nor is Blue Cross NC aware of any such statute or regulation.

This absence is key. This Tribunal's powers come solely from North Carolina statutes and regulations. *See Clark v. N.C. Dep't of Health & Hum. Servs.*, No. 18 DHR 2882, 2018 WL 4279616, § VII (N.C. Ofc. Admin. Hrgs. July 30, 2018). Because no authorizing statute or regulation applies here, it would be unsound for this Tribunal to apply federal waiver doctrine.

In this way, this case differs from earlier cases, invoked by Aetna, where this Tribunal has looked to federal law for guidance on issues of North Carolina law. *See Aetna Br. 19* (citing *Long Term Care Mgmt. Servs. LLC v. N.C. Dep't of Admin.*, No. 21 DOA 4990, 2023 WL 2424088 (N.C. Ofc. Admin. Hrgs. Jan. 13, 2023); *EDS Info. Servs., LLC v. Off. of Info. Tech. Servs. & N.C. Dep't of Health & Hum. Servs.*, No. 04 DHR 1066, 2005 WL 1413576 (N.C. Ofc. Admin. Hrgs. Jan. 11, 2005)).

In those cases, this Tribunal was construing the explicit requirements of North Carolina statutes. It was in that context that the Tribunal considered federal decisions that addressed analogous requirements. *See Long Term Care*, 2023 WL 2424088, Conclusions of Law ¶¶ 26, 31-32; *EDS*, 2005 WL 1413576, Conclusions of Law ¶¶ 2, 4, 8.

Here, in contrast, this Tribunal has no North Carolina statute or regulation to construe. Federal decisions construing federal statutes and regulations therefore offer no relevant guidance.

The North Carolina Court of Appeals addressed a similar situation in *Myers v. Myers*. There, a trial court followed federal decisions that were based on provisions in the Federal Rules of Civil Procedure. *See* 269 N.C. App. 237, 255-56, 837 S.E.2d 443, 456 (2020). But the North Carolina Rules of Civil Procedure did not contain those provisions. *See id.* As a result, the Court of Appeals held that the trial court erred by following the federal decisions. *See id.*

It would be equally erroneous here to follow federal decisions that depend on federal statutes and regulations with no counterparts in North Carolina law.

Third, Aetna's policy arguments in favor of federal waiver doctrine fail.

Aetna argues that federal waiver doctrine is good policy because it promotes efficiency and encourages vendors to bring protests early in the RFP process. Aetna Br. 21-22. The question for this Tribunal, however, is not whether federal waiver doctrine is good policy. The question is whether North Carolina law provides any basis for applying federal waiver doctrine in this case. As just discussed, it does not. Thus, Aetna's policy arguments are irrelevant.

Aetna's policy arguments also fail for another reason. The policy arguments for federal waiver doctrine depend on features of the federal procurement system that are absent in North Carolina.

In the federal procurement system, before a vendor even submits its proposal, it can file a formal protest that challenges the terms of an RFP. *See Bannum*, 779 F.3d at 1380. Filing a formal protest triggers an automatic stay that bars the agency from awarding the contract. *See id.* at 1380-81. Federal law also sets deadlines that ensure the prompt resolution of a formal protest. *See id.*

The federal waiver doctrine cited by Aetna depends on the existence of these pre-award protest mechanisms. The Federal Circuit has adopted its waiver doctrine precisely because these mechanisms offer an efficient way to resolve protests before a contract is awarded. *See id.*

That reasoning does not work in North Carolina.

Unlike the federal procurement system, the North Carolina system does not allow vendors to file formal protests before they submit their proposals.

North Carolina regulations establish procedures for filing certain protests with the agency that issued an RFP. But those regulations call for the protests to be filed *after the relevant contracts are awarded*. *See* 1 N.C. Admin. Code 5B.1519(a)(1), (b)(1); 9 N.C. Admin. Code 6B.1102(c)(1), (d)(1), (e)(1). The RFP here, likewise, allowed only a post-award protest. *See supra* pp. 65-66.

Nor can a vendor file a bid-protest case in this Tribunal until after a contract is awarded. To file a contested case, a vendor must show that (1) the agency has made a final decision, (2) the vendor has exhausted its administrative remedies within the agency, and (3) the vendor has suffered substantial prejudice. *See* N.C. Gen. Stat. § 150B-23(a), (f); *Phase Acad. of Jacksonville, Inc. v. Pub. Schs. of N.C.*,

State Bd. of Educ., No. 00 EDC 2119, 2001 WL 34055936, Conclusions of Law ¶ 3 (N.C. Ofc. Admin. Hrgs. Nov. 7, 2001); *Clark*, 2018 WL 4279616, § V. A vendor cannot satisfy these requirements before a contract is awarded.

For similar reasons, a vendor cannot file a bid-protest case in a North Carolina Superior Court before a contract is awarded. To file such a case, a vendor must show that (1) the vendor has been aggrieved, (2) there was a contested case, (3) there is a final agency decision, and (4) the vendor has exhausted its administrative remedies. *See* N.C. Gen. Stat. § 150B-43; *Huang v. N.C. State Univ.*, 107 N.C. App. 710, 713, 421 S.E.2d 812, 814 (1992). A vendor cannot satisfy these requirements before a contract is awarded either.

Nor does the North Carolina procurement system contain the other key parts of the federal system that underlie the waiver doctrine Aetna cites: an automatic stay of a contract award and a guarantee of a prompt resolution of a vendor's protest. As a result, even if a vendor could file a formal protest before submitting its proposal, that protest would not bring about a resolution before the contract was awarded. Instead, the protest would still be decided *after* the contract was awarded, eliminating any purported benefits of filing the protest earlier.

Thus, the federal courts' reasons for adopting their waiver doctrine do not apply in the North Carolina system.

In fact, applying federal waiver doctrine in North Carolina would put vendors in a bind. Under federal doctrine, for a vendor to avoid waiver, the vendor must file a formal protest before submitting its proposal. *Bannum*, 779 F.3d at 1380-81. As

shown above, a vendor *cannot* file a formal protest before submitting its proposal in North Carolina. Thus, if federal waiver doctrine applied in North Carolina, vendors would have no way to avoid waiving their claims. It would not be sound policy for North Carolina to adopt a waiver rule that vendors could never meet.

For these reasons, Aetna's request that this Tribunal follow federal waiver doctrine fails.

b. Even if federal waiver doctrine applied, it would not bar Blue Cross NC's claims.

Even if this Tribunal applied federal waiver doctrine in this case, Blue Cross NC's claims still would not be waived. That is so for two reasons.

First, federal waiver doctrine applies to challenges to an RFP's terms, not challenges to the evaluation of proposals. *See, e.g., Raytheon Co. v. United States*, 809 F.3d 590, 597-98 (Fed. Cir. 2015). Blue Cross NC's claims are evaluation-related claims. Federal waiver doctrine does not address claims of that type.

Second, even if any of Blue Cross NC's claims could be considered challenges to the RFP's terms, they still would not be waived. Federal waiver doctrine does not bar a post-award challenge when an earlier challenge would have been futile. *See Boeing Co. v. United States*, 968 F.3d 1371, 1377 (Fed. Cir. 2020); *G4S Secure Integration LLC v. United States*, 161 Fed. Cl. 387, 409 (2022). Here, the evidence shows that the Plan would not have changed course on its evaluation and scoring scheme if Blue Cross NC had raised its claims earlier. Thus, it would have been futile for Blue Cross NC to bring an earlier challenge. *See supra* pp. 70-71.

* * *

In sum, Aetna's waiver argument fails. The argument does not apply to the claims at the center of this case. And neither laches doctrine nor federal waiver doctrine supports Aetna's waiver argument in any event.

The reasons why Aetna's waiver argument fails are legal ones, not factual ones. Blue Cross NC therefore asks that this Tribunal grant summary judgment against Aetna's waiver defense. *See* N.C. Gen. Stat. § 1A-1, Rule 56(c).

At a minimum, Blue Cross NC asks that this Tribunal deny Aetna's motion for partial summary judgment.

CONCLUSION

Blue Cross NC respectfully requests that this Tribunal deny both the Plan's motion for summary judgment and Aetna's motion for partial summary judgment.

This 11th day of January, 2024.

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CERTIFICATE OF SERVICE

I certify that today, I caused this response to be filed through this Tribunal's electronic-filing system. Under Rule 03.0501(4), the system will electronically serve the response on the following counsel:

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This 11th day of January, 2024.

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