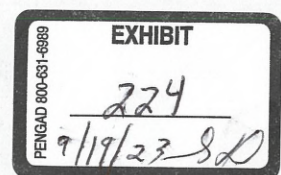


Documents produced natively

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BCNC2 1185





## ATTACHMENT A-8: NETWORK PRICING GUARANTEES - BAFO #1

Indicate the expected improvement on provider reimbursement arrangements by completing the exhibits on the "Guarantees (In State)" and "Guarantees (Out of State)" tabs.

The State Health Plan seeks the most favorable pricing from providers in the selected network and **seeks a contractor that is confident enough in its ability to secure discounts to assume the full risk for any shortfall in the contracted pricing guarantees.** From each bidder, the Plan is seeking (1) discount guarantees, (2) guarantees not to exceed a percentage of the fees charged by Medicare, and (3) guarantees to stay below an overall PMPM trend level. Bidders must provide the guarantee levels requested below and indicate whether they are willing to be at-risk for the full impact of any missed guarantees or a percentage of the full impact (with a minimum of 10% of the amount by which the guarantee was missed). Bidders will be scored on the guarantee levels and the amount placed at-risk. Guarantees can improve from one year to the next but should not become less favorable over time.

At the completion of each plan year, the Contractor shall provide an analysis of its performance against the guarantees. Guarantees will be calculated using claims from active employees and non-Medicare retirees; claims from Medicare retirees are excluded from the calculations.

### Network Pricing Guarantees Impact on Projected Costs

**Bidders should consider the following when providing their expected improvement in contracted discounts:**

- Discount improvements will only be reflected in projected costs to the extent the Vendor is willing to provide shortfall guarantees on a dollar-for-dollar basis. **Discount improvements without guarantees will not be reflected in the projected cost analysis and guarantees not on a dollar-for-dollar basis will only be reflected up to the dollar amount at-risk.**
- The State's expectation is that the following methodology will be used to calculate the average discount for the purposes of the dollar-for-dollar discount guarantee in each of the three contract years. Deviations from this methodology that diminish the value of the guarantee may result in no credit.

### Network Discount Guarantee Methodology – for ALL In-Network Claims

- Large claims over \$250,000 can be removed from the measurement. While bidders are requested to include all claims regardless of amount in their claims repricing and contracted future discounts, removing large claims over \$250,000 will be permitted in the discount guarantee calculation to offset the risk of unforeseen large claims.
- Covered Billed Charges = Total of all facility and professional provider submitted charges minus non-covered charges, ineligible amounts, COB (Coordination of Benefits) and Medicare savings
- Network Savings = Covered Billed Charges minus Cost of Benefits (prior to plan design)
- Achieved Discount % Savings = Network Savings divided by Covered Billed Charges



**ATTACHMENT A-8: NETWORK PRICING GUARANTEES (In State) - BAFO #1**

Proposer:	Aetna Life Insurance Company				
Network:	Broad CPIL Network				
The State Health Plan seeks the most favorable pricing from providers in the selected network and seeks a contractor that is confident enough in its ability to secure discounts to assume the full risk for any shortfall in the contracted pricing guarantees. From each bidder, the Plan is seeking (1) discount guarantees, (2) guarantees not to exceed a percentage of the fees charged by Medicare, and (3) guarantees to stay below an overall PMPM trend level. Bidders must provide the guarantee levels requested below and indicate whether they are willing to be at-risk for the full impact of any missed guarantees or a percentage of the full impact (with a minimum of 10% of the amount by which the guarantee was missed). Bidders will be scored on the guarantee levels and the amount placed at-risk. Guarantees can improve from one year to the next but should not become less favorable over time.					
At the completion of each plan year, the Contractor shall provide an analysis of its performance against the guarantees. Guarantees will be calculated using claims from active employees and non-Medicare retirees; claims from Medicare retirees are excluded from the calculations.					
	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 - 12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Discount Guarantees					
Inpatient Facility Discount (%) (e.g., 50% discount)	52.25%	52.25%	52.25%	52.25%	52.25%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) MINIMUM 10%	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Target Discount section below.				
Outpatient Facility Discount (%) (e.g., 50% discount)	53.95%	53.95%	53.95%	53.95%	53.95%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) MINIMUM 10%	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Target Discount section below.				
Professional Fees Discount (%) (e.g., 50% discount)	49.25%	49.25%	49.25%	49.25%	49.25%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) MINIMUM 10%	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Target Discount section below.				
Composite Target Discount (%) Combined In and Out of	52.25%	52.25%	52.25%	52.25%	52.25%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) MINIMUM 10%	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Aetna is providing a network discount guarantee covering the active employee and non-Medicare retiree population for Inpatient facility, Outpatient facility and Professional Services by placing up to 25%, (~\$22,475,000) of the administrative fees at risk on an annual basis. This guarantee will be reconciled at year end annually on an aggregate basis to the overall aggregate target reflecting the enrolled membership during the policy year. The aggregate target is calculated using the individual components weighted at a market-level utilization rate. The total amount of administrative fees at risk across all guarantees in this document is 45% (~\$40,460,000) annually.				
Percent of Medicare Guarantees					
Inpatient Facility Costs (%) (e.g., 135% of Medicare)	205%	205%	205%	205%	205%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) MINIMUM 10%	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Percent of Medicare Guarantee section below.				
Outpatient Facility Costs (%) (e.g., 135% of Medicare)	362%	362%	362%	362%	362%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) MINIMUM 10%	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	This is inclusive of all outpatient claims including Specialty Pharmacy. Refer to the explanation provided under the Composite Percent of Medicare Guarantee section below.				
Professional Costs (%) (e.g., 135% of Medicare)	154%	154%	154%	154%	154%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) MINIMUM 10%	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Percent of Medicare Guarantee section below.				
Composite Percent of Medicare Guarantees	216%	216%	216%	216%	216%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) MINIMUM 10%	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Aetna is providing a Percent of Medicare Guarantee covering the active employee and non-Medicare retiree population for Inpatient facility, Outpatient facility and Professional Services by placing up to 20%, (~\$18,000,000) of the administrative fees at risk on an annual basis. This guarantee will be reconciled at year end annually on an aggregate basis to the overall aggregate target reflecting the enrolled membership during the policy year. The aggregate target is calculated using the individual components weighted at a market-level utilization rate. The total amount of administrative fees at risk across all guarantees in this document is 45% (~\$40,460,000) annually.				
Trend Guarantee					
Annual PMPM Incurred Medical Cost Trend (%) (e.g., 6%)		6.81%	7.06%	7.31%	7.56%
Fees At-Risk		% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown)		20%	20%	20%	20%



Additional Info/Explanation of Calculation of Fees At-Risk		Aetna is providing an annual trend guarantee covering the entire active employee and non-Medicare retiree population on an annual basis by placing up to 25% (~\$22,475,000) of the administrative fees at risk on an annual basis starting in year 2. Each year an actual claim PMPM will be calculated and compared to the prior year's results. For each full percentage point of trend above the annual guaranteed trend figure Aetna will return 3% of the administrative fees to an annual maximum of 25% (~\$22,475,000). The total amount of administrative fees at risk across all guarantees in this document is 45% (~\$40,460,000) annually.	Aetna is providing an annual trend guarantee covering the entire active employee and non-Medicare retiree population on an annual basis by placing up to 25% (~\$22,475,000) of the administrative fees at risk on an annual basis starting in year 2. Each year an actual claim PMPM will be calculated and compared to the prior year's results. For each full percentage point of trend above the annual guaranteed trend figure Aetna will return 3% of the administrative fees to an annual maximum of 25% (~\$22,475,000). The total amount of administrative fees at risk across all guarantees in this document is 45% (~\$40,460,000) annually.	Aetna is providing an annual trend guarantee covering the entire active employee and non-Medicare retiree population on an annual basis by placing up to 25% (~\$22,475,000) of the administrative fees at risk on an annual basis starting in year 2. Each year an actual claim PMPM will be calculated and compared to the prior year's results. For each full percentage point of trend above the annual guaranteed trend figure Aetna will return 3% of the administrative fees to an annual maximum of 25% (~\$22,475,000). The total amount of administrative fees at risk across all guarantees in this document is 45% (~\$40,460,000) annually.	Aetna is providing an annual trend guarantee covering the entire active employee and non-Medicare retiree population on an annual basis by placing up to 25% (~\$22,475,000) of the administrative fees at risk on an annual basis starting in year 2. Each year an actual claim PMPM will be calculated and compared to the prior year's results. For each full percentage point of trend above the annual guaranteed trend figure Aetna will return 3% of the administrative fees to an annual maximum of 25% (~\$22,475,000). The total amount of administrative fees at risk across all guarantees in this document is 45% (~\$40,460,000) annually.
<b>Other Guarantees (Encouraged but not Required)</b>					
<b>Explain:</b>	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
<b>Fees At-Risk</b>	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Additional Info/Explanation of Calculation of Fees At-Risk		Not Applicable			



Describe your proposed formula for determining the actual performance against expected or quoted pricing guarantees?

**Discount Guarantee:**

The aggregate guaranteed percentage is calculated using the billed eligible charges by Inpatient Hospital, Outpatient Hospital and Physician/Other weighted by geographic utilization for active and non-Medicare primary employees.

The achieved discount percentage is calculated Negotiated Savings/Eligible Billed Charges, after removing large claimants over a \$250,000 threshold and Non-facility claims where the eligible billed charges are within three percent of the contractual allowed amount.

Negotiated Savings and Eligible Billed Charges follow the definition in the Industry Uniform Discount Data Specification; which also outlines various standard exclusions (e.g. claims where Aetna is a secondary payer on the claim, etc.)

These calculations are made using data from the Aetna Informatics® data warehouse and include three months of run-off experience.

\*\* The final fee adjustment in case of a discount shortage is calculated as below:

Minimum of % of discount shortage x 20% x The billed eligible charge as defined above and 25% of total annual fee

The total fee adjustment based on all guarantees will not exceed 45% of total annual fee.

**For the % of Medicare Guarantee:**

For Inpatient, Outpatient, Ambulatory Surgical Centers and Professional/Ancillary claims where Medicare allowable charge are available, Aetna shares claims data with a third-party vendor for repricing through its Medicare Grouper to return Medicare allowable rates where available. The aggregate percentage is calculated as the Aetna allowed spend where Medicare allowed is available/Medicare allowable returned. The percentage of Medicare will be determined using Aetna's contracted providers located in North Carolina, South Carolina, and Virginia inclusive of arrangements available to the State of North Carolina (e.g. custom rates, etc.).

The final fee adjustment in case of a % of Medicare overage is calculated as below:

Minimum of % of overage / 216% x 10% x State of NC Allowed Amount (where Medicare allowable rates are available) and 20% of total annual fee

The total fee adjustment based on all guarantees will not exceed 45% of total annual fee.

**For the Trend Guarantee:**

We calculate target allowed claims per-member, per-month (PMPM) by multiplying base year claims times the net allowed trend adjustment. Processed claim amounts in excess of \$250,000 for any individual claimant are excluded from the total allowed claims of both the base year and the guarantee period. Medical claims exclude pharmacy and specialty pharmacy claims, including those paid under the medical plan. Six months of runout data will be included in the calculation for the base and guarantee periods.

To ensure that we are comparing the base year and the projection year on the same basis, we adjust base year claims for factors impacting the relativity of the population such as changes in plan design, demographics, geography, included products, programs and services, third-party vendor solutions, or the impact of novel conditions.

We reserve the right to revise the guarantee if any of the following conditions are not met:

•The products, programs and services match those assumed in our proposed offer.

•Pharmacy Data: We receive pharmacy data file feeds at a minimum bi-weekly basis to support the care management program.

•Enrolled subscribers: The enrolled active employee and non-Medicare retiree population does not vary in size by more than 10 percent from the assumed enrollment of 333,445, or from the average enrollment in the base year.

•The Medical Trend Guarantee is considered met if:

•You terminate your Aetna medical plan in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal) prior to the end of the multi-year guarantee period, December 31, 2029.

•We do not receive all standard data submissions by December 7, 2024 (samples can be provided upon request).

The total fee adjustment based on all guarantees will not exceed 45% of total annual fee.

Describe the management information that you will provide SHP to support the year-end performance results.

The reconciliation of our guarantees will be included as part of the annual accounting package.

Provide samples of existing agreements, if any, that your network has used with other large plan sponsors to meet network discount targets or other network pricing guarantees.

Please refer to Attachment A-8.b Sample Existing Agreement for the sample documents.

Would you consider a gain-sharing arrangement off a negotiated PMPM claims cost? Perhaps, similar to the PMPM developed in the Self-Funded Claims Projection - Attachment A-9? If so,

We have not provided a guarantee at this time.



**ATTACHMENT A-8: NETWORK PRICING GUARANTEES (Out of State) - BAFO #1**

<b>Proposer:</b>	Aetna Life Insurance Company
<b>Network:</b>	Broad CPIX Network

The State Health Plan seeks the most favorable pricing from providers in the selected network and seeks a contractor that is confident enough in its ability to secure discounts to assume the full risk for any shortfall in the contracted pricing guarantees. From each bidder, the Plan is seeking (1) discount guarantees, (2) guarantees not to exceed a percentage of the fees charged by Medicare, and (3) guarantees to stay below an overall PMPM trend level. Bidders must provide the guarantee levels requested below and indicate whether they are willing to be at-risk for the full impact of any missed guarantees or a percentage of the full impact (with a minimum of 10% of the amount by which the guarantee was missed). Bidders will be scored on the guarantee levels and the amount placed at-risk. Guarantees can improve from one year to the next but should not become less favorable over time.

At the completion of each plan year, the Contractor shall provide an analysis of its performance against the guarantees. Guarantees will be calculated using claims from active employees and non-Medicare retirees; claims from Medicare retirees are excluded from the calculations.

	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 - 12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 - 12/31/28	01/01/29 - 12/31/29
<b>Discount Guarantees</b>					
<b>Inpatient Facility Discount (%)</b> (e.g., 50% discount)	54.55%	54.55%	54.55%	54.55%	54.55%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) <b>MINIMUM 10%</b>	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Target Discount section below.				
<b>Outpatient Facility Discount (%)</b> (e.g., 50% discount)	53.75%	53.75%	53.75%	53.75%	53.75%
Fees At-Risk (select from dropdown list)	Full shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) <b>MINIMUM 10%</b>	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Target Discount section below.				
<b>Professional Fees Discount (%)</b> (e.g., 50% discount)	53.75%	53.75%	53.75%	53.75%	53.75%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) <b>MINIMUM 10%</b>	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Target Discount section below.				
<b>Composite Target Discount (%) Combined In and Out of</b>	52.25%	52.25%	52.25%	52.25%	52.25%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) <b>MINIMUM 10%</b>	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Aetna is guaranteeing out of state employees network discounts as a component of the active employee and non-Medicare retiree population which will be reconciled on an aggregate basis. The percentages guaranteed and the amount at risk is detailed within the "Guarantees (In State)" document in the Discount Guarantee section under Composite Target Discount %.				
<b>Percent of Medicare Guarantees</b>					
<b>Inpatient Facility Costs (%)</b> (e.g., 135% of Medicare)	205%	205%	205%	205%	205%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) <b>MINIMUM 10%</b>	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Percent of Medicare Guarantee section below.				
<b>Outpatient Facility Costs (%)</b> (e.g., 135% of Medicare)	362%	362%	362%	362%	362%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) <b>MINIMUM 10%</b>	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Percent of Medicare Guarantee section below.				
<b>Professional Costs (%)</b> (e.g., 135% of Medicare)	154%	154%	154%	154%	154%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) <b>MINIMUM 10%</b>	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Percent of Medicare Guarantee section below.				
<b>Composite Percent of Medicare Guarantees</b>	216%	216%	216%	216%	216%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) <b>MINIMUM 10%</b>	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Aetna is guaranteeing out of state employees percent of Medicare results as a component of the entire active employee and non-Medicare retiree population which will be reconciled on an aggregate basis. The percentages guaranteed and the amount at risk is detailed within the "Guarantees (In State)" document in Percent of Medicare Guarantees section under Composite % of Medicare Combined.				
<b>Trend Guarantee</b>					
<b>Annual PMPM Incurred Medical Cost Trend (%)</b> (e.g., 6%)		6.81%	7.06%	7.31%	7.56%
Fees At-Risk		% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown)		20% total	20% total	20% total	20% total



Additional Info/Explanation of Calculation of Fees At-Risk		Starting year 2, Aetna is guaranteeing year over year trend experienced by out of state employees as a component of the active employee and non-Medicare retiree population which will be reconciled on an aggregate basis. The percentages guaranteed and the amount at risk is detailed within the "Guarantees (In State)" document in the Trend Guarantee section under Annual PMPM Incurred Medical Cost Trend %	Starting year 2, Aetna is guaranteeing year over year trend experienced by out of state employees as a component of the active employee and non-Medicare retiree population which will be reconciled on an aggregate basis. The percentages guaranteed and the amount at risk is detailed within the "Guarantees (In State)" document in the Trend Guarantee section under Annual PMPM Incurred Medical Cost	Starting year 2, Aetna is guaranteeing year over year trend experienced by out of state employees as a component of the active employee and non-Medicare retiree population which will be reconciled on an aggregate basis. The percentages guaranteed and the amount at risk is detailed within the "Guarantees (In State)" document in the Trend Guarantee section under Annual PMPM Incurred Medical Cost	Starting year 2, Aetna is guaranteeing year over year trend experienced by out of state employees as a component of the active employee and non-Medicare retiree population which will be reconciled on an aggregate basis. The percentages guaranteed and the amount at risk is detailed within the "Guarantees (In State)" document in the Trend Guarantee section under Annual PMPM Incurred Medical Cost Trend %
Trend guarantee begins in Year 2. Guarantee is percent increase over prior year.					
Other Guarantees (Encouraged but not Required)					
Explain:	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Fees At-Risk	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Additional Info/Explanation of Calculation of Fees At-Risk			Not Applicable		



Describe your proposed formula for determining the actual performance against expected or quoted pricing guarantees?

**Discount Guarantee:**

The aggregate guaranteed percentage is calculated using the billed eligible charges by Inpatient Hospital, Outpatient Hospital and Physician/Other weighted by geographic utilization for active and non-Medicare primary employees.

The achieved discount percentage is calculated Negotiated Savings/Eligible Billed Charges, after removing large claimants over a \$250,000 threshold and Non-facility claims where the eligible billed charges are within three percent of the contractual allowed amount.

Negotiated Savings and Eligible Billed Charges follow the definition in the Industry Uniform Discount Data Specification; which also outlines various standard exclusions (e.g. claims where Aetna is a secondary payer on the claim, etc.)

These calculations are made using data from the Aetna Informatics® data warehouse and include three months of run-off experience.

**\*\* The final fee adjustment in case of a discount shortage is calculated as below:**

Minimum of % of discount shortage x 20% x The billed eligible charge as defined above and 25% of total annual fee

The total fee adjustment based on all guarantees will not exceed 45% of total annual fee.

**For the % of Medicare Guarantee:**

For Inpatient, Outpatient, Ambulatory Surgical Centers and Professional/Ancillary claims where Medicare allowable charge are available, Aetna shares claims data with a third-party vendor for repricing through its Medicare Group to return Medicare allowable rates where available. The aggregate percentage is calculated as the Aetna allowed spend where Medicare allowed is available/Medicare allowable returned. The percentage of Medicare will be determined using Aetna's contracted providers located in North Carolina, South Carolina, and Virginia inclusive of arrangements available to the State of North Carolina (e.g. custom rates, etc.).

The final fee adjustment in case of a % of Medicare coverage is calculated as below:

Minimum of % of coverage / 216% x 10% x State of NC Allowed Amount (where Medicare allowable rates are available) and 20% of total annual fee

The total fee adjustment based on all guarantees will not exceed 45% of total annual fee.

**For the Trend Guarantee:**

We calculate target allowed claims per-member, per-month (PMPM) by multiplying base year claims times the net allowed trend adjustment. Processed claim amounts in excess of \$250,000 for any individual claimant are excluded from the total allowed claims of both the base year and the guarantee period. Medical claims exclude pharmacy and specialty pharmacy claims, including those paid under the medical plan. Six months of runout data will be included in the calculation for the base and guarantee periods.

To ensure that we are comparing the base year and the projection year on the same basis, we adjust base year claims for factors impacting the relativity of the population such as changes in plan design, demographics, geography, included products, programs and services, third-party vendor solutions, or the impact of novel conditions.

We reserve the right to revise the guarantee if any of the following conditions are not met:

- The products, programs and services match those assumed in our proposed offer.
- Pharmacy Data: We receive pharmacy data file feeds at a minimum bi-weekly basis to support the care management program.
- Enrolled subscribers: The enrolled active employee and non-Medicare retiree population does not vary in size by more than 10 percent from the assumed enrollment of 333,445, or from the average enrollment in the base year.
- The Medical Trend Guarantee is considered met if:
  - You terminate your Aetna medical plan in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal) prior to the end of the multi-year guarantee period, December 31, 2029.
  - We do not receive all standard data submissions by December 7, 2024 (samples can be provided upon request).

The total fee adjustment based on all guarantees will not exceed 45% of total annual fee.

Describe the management information that you will provide SHP to support the year-end performance results.

The reconciliation of our guarantees will be included as part of the annual accounting package.

Provide samples of existing agreements, if any, that your network has used with other large plan sponsors to meet network discount targets or other network pricing guarantees.

Please refer to Attachment A-8.b Sample Existing Agreement for the sample documents.

Would you consider a gain-sharing arrangement off a negotiated PMPM claims cost? Perhaps, similar to the PMPM developed in the Self-Funded Claims Projection - Attachment A-9? If

We have not provided a guarantee at this time.



Message

**From:** Kuhn, Stephen [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=46024D291B6540739B86102699395C17-KUHN, STEPH]  
**Sent:** 10/24/2022 10:05:23 PM  
**To:** Wohl, Stuart [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=6f70feb61f154acfbcd15b2103f78154-Wohl, Stuar]  
**Subject:** RE: SHPHC - Medical TPA - Cost Proposal Templates

Thanks Stu. Completely agree!

Stephen L. Kuhn  
**Segal**  
T 617.424.7341 | M 617.875.7018

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**From:** Wohl, Stuart <SWohl@Segalco.com>  
**Sent:** Monday, October 24, 2022 6:03 PM  
**To:** Vieira, Kenneth C. <kvieira@segalco.com>; Kuhn, Stephen <SKuhn@segalco.com>; Kersting, Matthew <MKersting@segalco.com>  
**Cc:** Wang, Peter <pwang@segalco.com>; Shaaya, Albert <ashaaya@segalco.com>  
**Subject:** RE: SHPHC - Medical TPA - Cost Proposal Templates

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

I think you can send to Sharon and Matt whenever it is ready – as a draft, of course.

---

**From:** Vieira, Kenneth C. <kvieira@segalco.com>  
**Sent:** Monday, October 24, 2022 5:48 PM  
**To:** Kuhn, Stephen <SKuhn@segalco.com>; Wohl, Stuart <SWohl@Segalco.com>; Kersting, Matthew <MKersting@segalco.com>  
**Cc:** Wang, Peter <pwang@segalco.com>; Shaaya, Albert <ashaaya@segalco.com>  
**Subject:** RE: SHPHC - Medical TPA - Cost Proposal Templates

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

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---

**From:** Kuhn, Stephen <SKuhn@segalco.com>  
**Sent:** Monday, October 24, 2022 5:45 PM  
**To:** Vieira, Kenneth C. <kvieira@segalco.com>; Wohl, Stuart <SWohl@Segalco.com>; Kersting, Matthew <MKersting@segalco.com>  
**Cc:** Wang, Peter <pwang@segalco.com>; Shaaya, Albert <ashaaya@segalco.com>  
**Subject:** RE: SHPHC - Medical TPA - Cost Proposal Templates

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





3) Network Pricing Guarantees – two (2) points

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

Stephen L. Kuhn  
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---

**From:** Vieira, Kenneth C. <[kvieira@segalco.com](mailto:kvieira@segalco.com)>  
**Sent:** Monday, October 24, 2022 5:41 PM  
**To:** Wohl, Stuart <[SWohl@Segalco.com](mailto:SWohl@Segalco.com)>; Kuhn, Stephen <[SKuhn@segalco.com](mailto:SKuhn@segalco.com)>; Kersting, Matthew <[MKersting@segalco.com](mailto:MKersting@segalco.com)>  
**Cc:** Wang, Peter <[pwang@segalco.com](mailto:pwang@segalco.com)>; Shaaya, Albert <[ashaaya@segalco.com](mailto:ashaaya@segalco.com)>  
**Subject:** RE: SHPHC - Medical TPA - Cost Proposal Templates

That's fine. Basically this got way overexaggerated last time – Gina & Patrick had everything in there – just extra info that most would want to know. Like they got regional stuff, but didn't want it. I guess the big things was there wasn't a final page that just did the cost like they wanted – which you have in this one. The 6,2,2 is also interesting – will have to see how that works out.

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

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**From:** Wohl, Stuart <[SWohl@Segalco.com](mailto:SWohl@Segalco.com)>  
**Sent:** Monday, October 24, 2022 5:10 PM  
**To:** Vieira, Kenneth C. <[kvieira@segalco.com](mailto:kvieira@segalco.com)>; Kuhn, Stephen <[SKuhn@segalco.com](mailto:SKuhn@segalco.com)>; Kersting, Matthew <[MKersting@segalco.com](mailto:MKersting@segalco.com)>  
**Cc:** Wang, Peter <[pwang@segalco.com](mailto:pwang@segalco.com)>; Shaaya, Albert <[ashaaya@segalco.com](mailto:ashaaya@segalco.com)>  
**Subject:** RE: SHPHC - Medical TPA - Cost Proposal Templates

Yes. This will also head off the issues we ran into in other bids of providing too much or not enough info.

---

**From:** Vieira, Kenneth C. <[kvieira@segalco.com](mailto:kvieira@segalco.com)>  
**Sent:** Monday, October 24, 2022 5:08 PM  
**To:** Kuhn, Stephen <[SKuhn@segalco.com](mailto:SKuhn@segalco.com)>; Kersting, Matthew <[MKersting@segalco.com](mailto:MKersting@segalco.com)>; Wohl, Stuart <[SWohl@Segalco.com](mailto:SWohl@Segalco.com)>  
**Cc:** Wang, Peter <[pwang@segalco.com](mailto:pwang@segalco.com)>; Shaaya, Albert <[ashaaya@segalco.com](mailto:ashaaya@segalco.com)>  
**Subject:** RE: SHPHC - Medical TPA - Cost Proposal Templates



Not really – are we sending this because they wanted a sample of what the output would look like?

**Kenneth C. Vieira, FSA, FCA, MAAA**  
**Senior Vice President**  
**East Region Public Sector Market Leader**  
**Segal**

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**From:** Kuhn, Stephen <[SKuhn@segalco.com](mailto:SKuhn@segalco.com)>  
**Sent:** Monday, October 24, 2022 5:06 PM  
**To:** Vieira, Kenneth C. <[kvieira@segalco.com](mailto:kvieira@segalco.com)>; Kersting, Matthew <[MKersting@segalco.com](mailto:MKersting@segalco.com)>; Wohl, Stuart <[SWohl@Segalco.com](mailto:SWohl@Segalco.com)>  
**Cc:** Wang, Peter <[pwang@segalco.com](mailto:pwang@segalco.com)>; Shaaya, Albert <[ashaaya@segalco.com](mailto:ashaaya@segalco.com)>  
**Subject:** RE: SHPHC - Medical TPA - Cost Proposal Templates

So I put dummy numbers in the exhibit and added the first tab that includes the section of the RFP document.

I will make it clear in the email that these are examples. I will also remove the "(2)" in the tab names.

Ken, Any additional comments?

Thanks

Stephen L. Kuhn  
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---

**From:** Vieira, Kenneth C. <[kvieira@segalco.com](mailto:kvieira@segalco.com)>  
**Sent:** Monday, October 24, 2022 3:25 PM  
**To:** Kersting, Matthew <[MKersting@segalco.com](mailto:MKersting@segalco.com)>; Wohl, Stuart <[SWohl@Segalco.com](mailto:SWohl@Segalco.com)>; Kuhn, Stephen <[SKuhn@segalco.com](mailto:SKuhn@segalco.com)>  
**Cc:** Wang, Peter <[pwang@segalco.com](mailto:pwang@segalco.com)>; Shaaya, Albert <[ashaaya@segalco.com](mailto:ashaaya@segalco.com)>  
**Subject:** RE: SHPHC - Medical TPA - Cost Proposal Templates

Total claims are included – 2<sup>nd</sup> pass last time – they wanted them in there. Mainly because admin is off the total and wanted a grand total amount.

**Kenneth C. Vieira, FSA, FCA, MAAA**  
**Senior Vice President**  
**East Region Public Sector Market Leader**  
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**From:** Kersting, Matthew <[MKersting@segalco.com](mailto:MKersting@segalco.com)>  
**Sent:** Monday, October 24, 2022 2:59 PM



**To:** Wohl, Stuart <SWohl@Segalco.com>; Kuhn, Stephen <SKuhn@segalco.com>  
**Cc:** Vieira, Kenneth C. <kvieira@segalco.com>; Wang, Peter <pwang@segalco.com>; Shaaya, Albert <ashaaya@segalco.com>  
**Subject:** RE: SHPHC - Medical TPA - Cost Proposal Templates

**Network Pricing:**

- Why are we including Medicare claims in the analysis, when they all get the same amount?
- For the first set up, Bidder 2 shows the highest overall allowed claims ... but calculates the largest discount, so prices out as the best. Are we comfortable with this outcome?

**Pricing Guarantee:**

- A11 should be CY 2026, not 2025
- I'm also not totally clear with what we're scoring here

**Total Cost**

- Are we doing anything with this? Or is it just another check?

---

**From:** Wohl, Stuart <SWohl@Segalco.com>  
**Sent:** Monday, October 24, 2022 1:18 PM  
**To:** Kuhn, Stephen <SKuhn@segalco.com>  
**Cc:** Vieira, Kenneth C. <kvieira@segalco.com>; Kersting, Matthew <MKersting@segalco.com>; Wang, Peter <pwang@segalco.com>; Shaaya, Albert <ashaaya@segalco.com>  
**Subject:** FW: SHPHC - Medical TPA - Cost Proposal Templates

Thanks Steve. I'm assuming we are getting rid of the old stuff. Somewhere, we will need to include any caveats that the bidders included. I wonder if that should be the first tab?

---

**From:** Kuhn, Stephen <SKuhn@segalco.com>  
**Sent:** Monday, October 24, 2022 12:56 PM  
**To:** Wohl, Stuart <SWohl@Segalco.com>; Kersting, Matthew <MKersting@segalco.com>; Vieira, Kenneth C. <kvieira@segalco.com>; Wang, Peter <pwang@segalco.com>; Shaaya, Albert <ashaaya@segalco.com>  
**Subject:** RE: SHPHC - Medical TPA - Cost Proposal Templates

Thanks Stu.

See comments below.

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---

**From:** Wohl, Stuart <SWohl@Segalco.com>  
**Sent:** Monday, October 24, 2022 12:40 PM  
**To:** Kuhn, Stephen <SKuhn@segalco.com>; Kersting, Matthew <MKersting@segalco.com>; Vieira, Kenneth C. <kvieira@segalco.com>; Wang, Peter <pwang@segalco.com>; Shaaya, Albert <ashaaya@segalco.com>  
**Subject:** RE: SHPHC - Medical TPA - Cost Proposal Templates

**A few comments/questions:**

1. The charge amount would be different if (a) different networks and/or (b) something didn't get repriced? For example, in the illustrations, Bidder 3 has the lowest allowed amount but also a higher billed charge amount. Yes, charge amounts vary based on the reasons you mention. The charge versus allowed is used to calculate the discount that gets factored into the relative value that gets



applied to the same base claims. I'm not sure I follow your second comment. Let me know if these were just statements or if you are identifying something I may have overlooked. The 2<sup>nd</sup> part was just an example.

2. Will the trends be the same for everyone? Typically, yes.
3. Higher rank (3) is better than lower rank (1). My initial instinct was that best was ranked 1. I don't think it really matters, just commenting. This isn't my choice, it's how it is written in the RFP document.
4. How many decimal points do we look at? In the example, bidder 3 is 0.5% worse, therefore, 6 points. But that could have been the rounding (it isn't in this case). But would 0.49999% off get 6 points but 0.511111% only get 5 points? Both round to 0.5%. I was proposing the 2 percentage decimals illustrated in the exhibit, but can certainly ask. Definitely worth asking.
5. Were there any optional administrative fees? I remember they really tried to limit those. Yes and Yes, they are in a separate table in Attachment A-7 (this tab is in the document I sent). I see Attachment A-7. Lots of potential additional items. I'm assuming ultimately, they will pick which ones to include.
- 6.

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**From:** Kuhn, Stephen <[SKuhn@segalco.com](mailto:SKuhn@segalco.com)>  
**Sent:** Monday, October 24, 2022 10:18 AM  
**To:** Kersting, Matthew <[MKersting@segalco.com](mailto:MKersting@segalco.com)>; Vieira, Kenneth C. <[kvieira@segalco.com](mailto:kvieira@segalco.com)>; Wang, Peter <[pwang@segalco.com](mailto:pwang@segalco.com)>; Shaaya, Albert <[ashaaya@segalco.com](mailto:ashaaya@segalco.com)>  
**Cc:** Wohl, Stuart <[SWohl@Segalco.com](mailto:SWohl@Segalco.com)>  
**Subject:** FW: SHPHC - Medical TPA - Cost Proposal Templates

Just checking in on the below email to see if people will be able to look at this today.

For ease of reference, I've attached the final RFP document and the cost proposal scoring details start on page 24 of 119. Based on what I heard about prior analysis, I've also tried to keep this as simple as possible with only providing information that is being scored. (Other than the total cost, which I'm fine with leaving out if others agree.)

Thanks,  
Steve

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---

**From:** Kuhn, Stephen  
**Sent:** Thursday, October 20, 2022 9:29 PM  
**To:** Kersting, Matthew <[MKersting@segalco.com](mailto:MKersting@segalco.com)>; Vieira, Kenneth C. <[kvieira@segalco.com](mailto:kvieira@segalco.com)>; Wang, Peter <[pwang@segalco.com](mailto:pwang@segalco.com)>; Shaaya, Albert <[ashaaya@segalco.com](mailto:ashaaya@segalco.com)>  
**Cc:** Wohl, Stuart <[SWohl@Segalco.com](mailto:SWohl@Segalco.com)>  
**Subject:** SHPHC - Medical TPA - Cost Proposal Templates

All,



For your review, here are some template exhibits (light blue tabs). Some still have some values from the last RFP, I'm likely going to delete them before we send. **I'd like to send this out on Monday as we indicated the end of this week.**

The discount guarantee slide setup is likely going to be dependent on what we receive from the bidders and I will note that to the State when I send it. Also note the ranking is a little weird based on the RFP, the higher number is better.

**Peter/Albert**, Are you able to populated the baseline data? We are looking for the eligible and allowed and then the total paid as well as enrollment. It's okay if you can do that by Monday. Also, would you please confirm whether you will be available November 8-16 to assist on the analysis of proposals? It's a crazy turnaround, so it would be great if you are able to block off time to help us (especially on the front end of that time).

Please note that I'm off tomorrow, but will be back online on Monday (and also some point on Sunday).

Thanks,  
Steve

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**EXPERT REPORT OF GREGORY RUSSO**

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

**North Carolina Office of Administrative Hearings**

**Case No. 23 INS 00738**

**October 4, 2023**



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## **I. Introduction**

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

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

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

## **II. Relevant Experience**

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

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

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

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

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

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

#### IV. Background of the Case

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

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

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

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

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

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

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

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

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

<sup>2</sup> SHP 0072588.

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

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



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

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

## **V. Overview of Opinions**

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

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

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

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

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

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

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

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

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

## VI. Cost Proposal Data Collection and Scoring

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

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

---

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

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

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

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

<sup>11</sup> SHP 0072588.

<sup>12</sup> SHP 0006964.

<sup>13</sup> SHP 0006961.

<sup>14</sup> SHP 0006963.

<sup>15</sup> SHP 0006962.



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

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

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

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<sup>16</sup> SHP 0072588.

<sup>17</sup> SHP 0006966.

<sup>18</sup> SHP 0072588.

<sup>19</sup> SHP 0006956.

<sup>20</sup> SHP 0072588.

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

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

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

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

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

## VII. Key Terms

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

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

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

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<sup>21</sup> SHP 0006960.

<sup>22</sup> SHP 0006965.

<sup>23</sup> SHP 0006955.

<sup>24</sup> SHP 0006959.

<sup>25</sup> SHP 0069464.



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

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

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

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

## VIII. Opinions

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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<sup>28</sup> SHP 0072588.

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

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

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

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

3) Network Pricing Guarantees – two (2) points

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

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

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

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

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

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

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

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

<sup>33</sup> SHP 0092745.

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

**Figure 1**

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

**Source:** SHP 0070486.

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

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

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

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

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

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



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

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

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

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

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

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

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

**Discount Guarantees**

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

**Trend Guarantees**

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

**Source:** SHP 0069464.

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

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

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

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

**Figure 4**

**Network Pricing Guarantees Score**

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

**Source:** SHP 0069464.

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

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

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

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

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<sup>40</sup> SHP 0069464.

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

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

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



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

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

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

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

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

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

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

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

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

<sup>48</sup> SHP 0000010.

<sup>49</sup> SHP 0069503.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>54</sup> SHP 0093117.

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

<sup>56</sup> SHP 0093117.

<sup>57</sup> SHP 0093060.

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

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



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

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

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

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

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

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

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

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

<sup>61</sup> SHP 0000010.

<sup>62</sup> SHP 0093117.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>72</sup> SHP 0072588.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

Aetna has letters of intent with REDACTED

REDACTED  
REDACTED  
REDACTED  
REDACTED  
REDACTED

REDACTED Plan members' claims attributable to these providers total REDACTED billed charges for the entire network of providers.

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

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

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

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

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

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

Provider Name	County	Claims	Charges
REDACTED			

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

Provider Name	County	Claims	Charges
REDACTED			

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

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

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

<sup>83</sup> AENTNA0001992.

<sup>84</sup> AETNA0026101, pg. 107.

<sup>85</sup> AETNA0014000.

REDACTED

<sup>86</sup>

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

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

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

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

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

<sup>86</sup> AETNA0019463.

<sup>87</sup> AETNA0013892.

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

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

[illegible]

As the above figure shows, the actual contracted amount priced using Aetna's letters of intent is REDACTED, which is nearly \$30 million higher than the contracted amount Aetna used for these providers in the repricing exercise. In addition, the average discount across these providers is REDACTED —a discount that is REDACTED than the discount percentage Aetna assumed for these providers in the repricing exercise. The differences are especially pronounced for REDACTED REDACTED, including REDACTED, where the difference between the discount Aetna proposed and the contracted discount REDACTED



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

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

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

### **Overview**

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

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

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

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

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

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

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

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

### **Repricing Exercise Instructions and Scoring**

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

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

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

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

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

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

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

<sup>94</sup> SHP 0069464.

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

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

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

### **Requests for Clarification**

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

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

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



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

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

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

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

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

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

<sup>100</sup> SHP 0087957.

<sup>101</sup> SHP 0087964.

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

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

<sup>104</sup> SHP 0024720.

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

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

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

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

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

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

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

<sup>105</sup> SHP 0009869.

<sup>106</sup> SHP 0069744.

<sup>107</sup> SHP 0001952.

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

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

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

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

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

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

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

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

<sup>109</sup> SHP 0024713.

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

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

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

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

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

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

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

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

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

<sup>111</sup> SHP 0024713.

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

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

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

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

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

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

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

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<sup>113</sup> SHP 0001952.

<sup>114</sup> SHP 0069756.

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

<sup>116</sup> SHP 0087620.

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



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

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

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

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

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

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

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

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

<sup>119</sup> SHP 0069760.

<sup>120</sup> SHP 0069760.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>131</sup> SHP 0069464.

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

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

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

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

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

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



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

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

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

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

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

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

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

<sup>133</sup> SHP 0002413.

<sup>134</sup> SHP 0002413.

<sup>135</sup> SHP 0085064.

<sup>136</sup> SHP 0085038.

<sup>137</sup> SHP 0085038.

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

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

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

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

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

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

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

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

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

<sup>139</sup> SHP 0085064.

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

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

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

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

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

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

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

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

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

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

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<sup>148</sup> SHP 0085097.

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

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

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

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

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

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

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

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

<sup>150</sup> SHP 0072588.

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

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

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

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

<sup>152</sup> SHP 0003962.

<sup>153</sup> SHP 0002295.

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

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

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

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

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



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

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

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

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

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

**Source:** SHP 0006965

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

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

<sup>160</sup> SHP 0092423.

<sup>161</sup> SHP 0086294.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



October 4, 2023

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

## **GREG RUSSO**

Managing Director, BRG Health Analytics

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### **SUMMARY**

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

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

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

### **PROFESSIONAL EXPERIENCE**

#### **LITIGATION SUPPORT**

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



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

#### *INTERNAL INVESTIGATIONS*

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

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

#### *STRATEGIC SUPPORT*

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

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

#### *PROGRAM DESIGN & EVALUATION*

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

#### **EDUCATION**

M.H.S. Health Finance & Management, Johns Hopkins Bloomberg School of Public Health, 2005

B.A. The College of William and Mary, 2003

#### **PUBLICATIONS**

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

B. Akanbi, G. Russo. "Hospital Contract Labor: Where Has It Been and Who Is Using It?" Whitepaper, BRG, 2017.

H. Miller, G. Russo, J. Younts. "Measuring the Value of Medical Services in Personal Injury Suits." Whitepaper, BRG, 2017.

A. Asgeirsson, G. Russo. "Long-Term Acute Care Hospitals: Bracing for Change." Whitepaper, BRG, 2018.

J. Gibson, G. Russo. "False Claims Act – Investigative Tools of the Trade." American Bar Association's Health eSource, April 2018.

A. Asgeirsson, E. DuGoff, G. Russo. "Short Supply: The Availability of Healthcare Resources During the COVID-19 Pandemic." Whitepaper, BRG, 2020.

J. Younts, G. Russo. "The Nitty-Gritty of Price Transparency." American Bar Association's The Health Lawyer, Vol. 33, No. 6, August 2021.

## **PRESENTATIONS**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## TESTIMONY

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



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

**PRESENT POSITION**

Berkeley Research Group, 2010 – present

**PREVIOUS POSITIONS**

LECG, 2009 – 2010

Navigant Consulting, Inc., 2004 – 2009

Jersey Shore University Medical Center, 2001 - 2003

**PROFESSIONAL AFFILIATIONS**

*American Health Lawyers Association*

*Healthcare Financial Management Association*

## **Appendix B**

### **Documents and Information Relied on**

## **Case Documents and Data**

AETNA0001992

AETNA0013892

AETNA0014000

AETNA0019463

AETNA0026101

Aetna's 30(b)(6) Deposition

Blue Cross NC\_0000151

Blue Cross NC\_0001955

Blue Cross NC\_0001953

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

Deposition of Charles Sceiford

Deposition of Stuart Wohl

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

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

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

NCSHP\_Medical\_RFP\_Census\_File

Segal's 30(b)(6) Deposition

SHP 0000010

SHP 0001779

SHP 0001952

SHP 0002295

SHP 0002413

SHP 0003962

SHP 0006955

SHP 0006956

SHP 0006959

SHP 0006960

SHP 0006961

SHP 0006962

SHP 0006963

SHP 0006964

SHP 0006965

SHP 0006966

SHP 0009869

SHP 0024713

SHP 0024720

SHP 0040105

SHP 0069462

SHP 0069463

SHP 0069464

SHP 0069494

SHP 0069503

SHP 0069736

SHP 0069744

SHP 0069756

SHP 0069760

SHP 0069795

SHP 0070486

SHP 0072588

SHP 0083572

SHP 0085016

SHP 0085038

SHP 0085064

SHP 0085084

SHP 0085919

SHP 0086294

SHP 0087620

SHP 0087957

SHP 0087964

SHP 0092423

SHP 0092745

SHP 0093060

SHP 0093117

SHP 069464



## **Publicly Available Materials**

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

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

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

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

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

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

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

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

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

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

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

### **Additional Data**

NPI\_Registry\_Taxonomy.txt

Provider\_Addresses\_w\_Coordinates.txt

Subscriber\_Addresses\_w\_Coordinates.txt

Zip\_to\_County.txt

## **Appendix C**

### **Exhibits**

**Figure 1**

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

**Source:** SHP 0070486

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

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

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

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

**Discount Guarantees**

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

**Trend Guarantees**

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

Source: SHP 0069464

**Figure 4**

**Network Pricing Guarantees Score**

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

**Source:** SHP 0069464



**Figure 5**  
**Summary of Vendor Guarantee Amounts and Claims Cost**

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

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

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

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

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

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

Provider Name	County	Claims	Charges
REDACTED			

Figure 9

Aetna Claims and Billed Charges Attributable to REDACTED

Provider Name	County	Claims	Charges
REDACTED			

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

Provider Name	County	Claims	Charges
REDACTED			





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

**Figure 12**

**Illustration of Discount-Percentage Calculation**

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

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

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

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

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

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

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

**Figure 15**

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

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

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

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

**Figure 17**

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

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

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



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

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

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

**Figure 19**

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

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

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

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

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

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

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

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

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

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

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

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

**Source:** SHP 0006965

**Figure 23**

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

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

**Figure 24**  
**Provider Availability to Members**

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

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

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

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



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

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

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

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

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

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

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

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

Figure 27a

## Disruption in All Counties

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

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

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



**REBUTTAL EXPERT REPORT OF GREGORY RUSSO**

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

**North Carolina Office of Administrative Hearings**

**Case No. 23 INS 00738**

**November 10, 2023**

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## **I. Introduction**

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

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

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

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

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

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

## Opinion 1: Pricing Guarantees

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

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

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

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

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<sup>2</sup> SHP 0072588.

<sup>3</sup> SHP 0072588.

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

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

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

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

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

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

**a. Discount Guarantees**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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



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

*Q. Yes.*

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

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

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

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

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

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

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

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

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

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

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

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

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

**Figure 3**  
**Likelihood of Payout**

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

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

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

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

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

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

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

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

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

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

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

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

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

**Figure 4**  
**Trends and Claims Costs**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Opinion 2: Discrepancy between repricing and LOI rates

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

[REDACTED] for which Aetna produced its underlying agreements: REDACTED

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

### Opinion 3: Discount Adjustment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>41</sup> SHP 0006964.

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

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

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

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

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

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

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

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

#### Opinion 4: UDS Data

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

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

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

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

## Opinion 5: Network Disruption

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

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

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

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

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

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

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

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

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

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

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



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November 10, 2023

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

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



## **GREG RUSSO**

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### **SUMMARY**

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

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

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

### **PROFESSIONAL EXPERIENCE**

#### **LITIGATION SUPPORT**

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

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

#### *INTERNAL INVESTIGATIONS*

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

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

#### *STRATEGIC SUPPORT*

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

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

#### **PROGRAM DESIGN & EVALUATION**

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

#### **EDUCATION**

M.H.S. Health Finance & Management, Johns Hopkins Bloomberg School of Public Health, 2005

B.A. The College of William and Mary, 2003

#### **PUBLICATIONS**

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

B. Akanbi, G. Russo. "Hospital Contract Labor: Where Has It Been and Who Is Using It?" Whitepaper, BRG, 2017.

H. Miller, G. Russo, J. Younts. "Measuring the Value of Medical Services in Personal Injury Suits." Whitepaper, BRG, 2017.

A. Asgeirsson, G. Russo. "Long-Term Acute Care Hospitals: Bracing for Change." Whitepaper, BRG, 2018.

J. Gibson, G. Russo. "False Claims Act – Investigative Tools of the Trade." American Bar Association's Health eSource, April 2018.

A. Asgeirsson, E. DuGoff, G. Russo. "Short Supply: The Availability of Healthcare Resources During the COVID-19 Pandemic." Whitepaper, BRG, 2020.

J. Younts, G. Russo. "The Nitty-Gritty of Price Transparency." American Bar Association's The Health Lawyer, Vol. 33, No. 6, August 2021.

## **PRESENTATIONS**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## TESTIMONY

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

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



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

**PRESENT POSITION**

Berkeley Research Group, 2010 – present

**PREVIOUS POSITIONS**

LECG, 2009 – 2010

Navigant Consulting, Inc., 2004 – 2009

Jersey Shore University Medical Center, 2001 - 2003

**PROFESSIONAL AFFILIATIONS**

*American Health Lawyers Association*

*Healthcare Financial Management Association*

## **Appendix B**

### **Additional Documents and Information Relied on**

## **Case Documents and Data**

Deposition of Matthew Rish

Expert Report of Andrew Coccia

Expert Report of Gregory Russo

Expert Report of Kenneth C. Vieira

## **Publicly Available Materials**

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

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

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

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

## **Appendix C**

### **Exhibits**

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

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

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



**Figure 3**  
**Likelihood of Payout**

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

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

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

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

**Figure 4**  
**Trends and Claims Costs**

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



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

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

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

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

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

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

## Blue Cross of NC vs. NC State Health Plan

Page 1

HIGHLY CONFIDENTIAL -ATTORNEYS' EYES ONLY

STATE OF NORTH CAROLINA

IN THE OFFICE OF  
ADMINISTRATIVE HEARINGS

COUNTY OF DURHAM

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.  
-----

\*\* HIGHLY CONFIDENTIAL \*\*

ATTORNEYS' EYES ONLY\*\*

VIDEO 30(b)(6) DEPOSITION OF AETNA LIFE INSURANCE  
COMPANY

CATHERINE RODRIGUEZ AGUIRRE

SEPTEMBER 21, 2023

9:07 a.m.

Raleigh, North Carolina

Reported by: Audra M. Smith, FCRR

Video by: John Roberts

1 Q What's that mean?

2 A [REDACTED]

3 [REDACTED]

4 [REDACTED]

5 Q [REDACTED]

6 [REDACTED]

7 A [REDACTED]

8 Q [REDACTED]

9 [REDACTED]

10 A Yes. We entered into custom deals with  
11 three providers.

12 Q [REDACTED]

13 A [REDACTED]

14 Q [REDACTED]

15 [REDACTED]

16 A [REDACTED]

17 Q [REDACTED]

18 [REDACTED]

19 [REDACTED]

20 [REDACTED]

21 A [REDACTED]

22 Q [REDACTED]

23 [REDACTED]

24 A [REDACTED]

25 [REDACTED]

1 [REDACTED]

2 [REDACTED]

3 Q Putting the RFP aside.

4 A Yeah.

5 Q You're familiar with the term "disruption"  
6 in your job?

7 A Yes, I am.

8 Q What's it mean?

9 A Disruption is typically when you evaluate  
10 how many members will have to pick a new provider.

11 Q [REDACTED]

12 [REDACTED]

13 [REDACTED]

14 A [REDACTED]

15 [REDACTED]

16 [REDACTED]

17 [REDACTED]

18 [REDACTED]

19 Q [REDACTED]

20 [REDACTED]

21 [REDACTED]

22 [REDACTED]

23 [REDACTED]

24 [REDACTED]

25 A [REDACTED]

1 [REDACTED]

2 Q [REDACTED]

3 [REDACTED]

4 [REDACTED]

5 A [REDACTED]

6 Q [REDACTED]

7 [REDACTED]

8 [REDACTED]

9 [REDACTED]

10 A [REDACTED]

11 Q [REDACTED]

12 A [REDACTED]

13 Q [REDACTED]

14 A [REDACTED]

15 Q [REDACTED]

16 [REDACTED]

17 [REDACTED]

18 A [REDACTED]

19 Q [REDACTED]

20 [REDACTED]

21 A [REDACTED]

22 [REDACTED]

23 [REDACTED]

24 [REDACTED]

25 [REDACTED]

1 on by the State Health Plan, by Aetna, by all the  
2 other vendors, that participate in this process.

3 Q And what's that solution look like in  
4 terms of what number appears on the card?

5 A The UPID number. I cannot confirm how  
6 many other numbers but UPID number was a requirement  
7 we had to invest and build it.

8 Q So the State Health Plan's unique  
9 identifier for any particular member is going to  
10 show up on the face of the card?

11 A Yes.

12 Q And that's in compliance with the  
13 technical requirement --

14 A Correct.

15 Q -- that was in the RFP?

16 Are any other numbers going to show up on  
17 the card? Let me start with the W number.

18 A I don't know, because I did not attend all  
19 the implementation meetings. What I do know was  
20 that we resolved, for the technical requirement,  
21 allowing the UPID to be included, so there could be  
22 multiple numbers, I just don't know.

23 Q I think what you said a moment ago, the  
24 State Health Plan has signed off -- excuse me,  
25 assigned off on the approach that Aetna has proposed



1 for that requirement?

2 A Correct.

3 Q Do you know who that would be at the Plan  
4 who ultimately signs off on that?

5 A There's four individuals, if I'm not  
6 mistaken, that report up to Caroline and are in  
7 charge of operations. I don't know for certain. I  
8 don't want to assume, so I just don't know.

9 Q That's fine.

10 You mentioned a moment ago that you just  
11 can't say whether any additional members --

12 A Correct.

13 Q -- other than the Plan's unique number  
14 will show up on the face of the card. Who at Aetna  
15 would know that sitting here today, who would know  
16 that?

17 A Angela Ramsammy, Mike Green. Those are  
18 two who would know.

19 Q They've been involved in that whole  
20 process?

21 A They're responsible for implementation.

22 Q Okay. You can put that one aside. Total  
23 gear shift here, change of topics.

24 A Okay.

25 Q It's the case -- it's true that Aetna

1       relied on letters of intent with providers in  
2       putting together its proposal in response to the  
3       2022 RFP, right?

4               MR. WHITMAN:  Objection to the form.

5               A       Aetna had contracts with three providers.  
6       We were able to secure unit cost improvements.  So  
7       we had underlying contracts, supplemented by either  
8       a letter of -- hold on, because I got to get the  
9       name right -- letter of agreement, or an amendment  
10      to the contract.

11      BY MR. CHASE:

12              Q       So I'll just ask a different question  
13      given your answer there to make sure I understand,  
14      did -- do you know what a letter of intent is?

15              A       Yes, I do.

16              Q       Okay.  What is it?

17              A       It's a letter agreeing to -- whatever  
18      we're agreeing to.  In this case, improved pricing.

19              Q       What's the difference in a letter of  
20      intent and a contract?

21              MR. WHITMAN:  Objection to the extent it  
22      calls for a legal conclusion.

23              But you can answer to the best of your  
24      knowledge.

25              A       To the best of my knowledge, a contract

1 has been executed, a letter of intent is intended,  
2 and they're in the process of preparing the  
3 documents. So the letter of intent, once the  
4 documents are completed, refer to the new contract.  
5 BY MR. CHASE:

6 Q We've talked a couple times today about --  
7 I'm going to use the word "agreements" and I'm not  
8 trying to trip you up. So if you disagree with that  
9 word, tell me.

10 But we've talked about agreements between

11 [REDACTED]

12 [REDACTED]

13 Do you remember that?

14 A Yes.

15 Q Okay. Take those three, put them to the  
16 side. Did Aetna's proposal in response to the 2022  
17 RFP, rely on letters of intent as that term is used  
18 in the RFP, with any other provider, or is it just  
19 those three?

20 A Just those three.

21 Q Okay. Are each of those three -- I think  
22 you already answered, but it's been a long day, are  
23 each of those three already in Aetna's network?

24 A They've always been part of Aetna's  
25 network.

1 Q So these are the custom deals we talked  
2 about where they're promising better pricing if  
3 Aetna were to win the State Health Plan's business?

4 A Correct.

5 Q Okay. Do you know how many providers in  
6 Aetna's RFP submission were covered by those three  
7 agreements that we've been talking about, at the  
8 provider level?

9 A A lot. I don't know the number.

10 Q If I told you it was around 2700, would  
11 that sound about right?

12 A It would be a guess on my part.


13 Q Okay. Fair enough.

14 Handing you a document that's been marked  
15 Exhibit 250. It's been designated as Attorneys  
16 Eyes' Only.

17 (Exhibit Number 250 marked for  
18 identification as of this date.)

19 BY MR. CHASE:

20 Q Just for the record, this is an agreement

21   
22 document is about 500 and something pages long. So  
23 what I've given you is just the primary portion of  
24 the agreement, the initial part of the agreement and  
25 one exhibit, and the exhibit is past that red page

1 that you're seeing there. Does that make sense?

2 A Yes.

3 BY MR. CHASE:

4 Q Okay. So to avoid printing out 500 pages  
5 times six, that's the way we did it.

6 Ready?

7 A I'm ready.

8 Q Okay. Is this the agreement with

9 [REDACTED]

10 [REDACTED]

11 [REDACTED]

12 A I have -- I don't like assuming, right?  
13 But it is dated January of 2023. I cannot confirm  
14 that this is the agreement that is in effect for  
15 January of '25. So I want to point that out. I do  
16 know we have a custom deal. But I can't confirm  
17 this is the number of 2025.

18 Q Okay. Do you know whether this agreement  
19 and the rates that are reflected in the attachment  
20 that I've provided you there, were the rates that  
21 were used in the repricing exercise that Aetna  
22 conducted in response to the RFP?

23 A Without speaking to the subject matter  
24 expert, I cannot confirm that.

25 Q Just don't know?

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savings number, is what you're saying that that is some type of industry estimate of savings when coordinating between a third-party administrator and PBM, or is that a Aetna-specific number?

A Every carrier has their own number that they come up with. It's an industry standard when you have your PBM and your TPA under the same umbrella. There's the value of time, integration, resources. There's the value of having the claims information.

So a United and an Optum, a Cigna and Express Scripts. You know, the carriers combine to tout that there is value to integration. So he

1 Q And I'm not -- I appreciate all that. I'm

2 [REDACTED]  
3 [REDACTED]  
4 text, is he talking about a number that's specific  
5 to Aetna?

6 A Specific to Aetna and CVS for the value of  
7 integration.

8 Q Okay. That's a number that Aetna and CVS  
9 Caremark have calculated in terms of the savings  
10 that they can offer to a joint client; is that fair?

11 A Right. And there are different variables  
12 depending on what's being offered. That's why  
13 there's a broad range.

14 Q And you note that the Plan wasn't allowing  
15 any narrative responses in the RFP responses, right?

16 A Yes.

17 Q [REDACTED]  
18 [REDACTED]  
19 [REDACTED]  
20 [REDACTED]

21 A [REDACTED]

22 Q [REDACTED]  
23 [REDACTED]  
24 [REDACTED]  
25 [REDACTED]

1 A [REDACTED]

2 [REDACTED]

3 [REDACTED]

4 Q [REDACTED]

5 [REDACTED]

6 [REDACTED]

7 [REDACTED]

8 A [REDACTED]

9 Q [REDACTED]

10 [REDACTED]

11 A [REDACTED]

12 Q [REDACTED]

13 [REDACTED]

14 A [REDACTED]

15 Q [REDACTED]

16 [REDACTED]

17 [REDACTED]

18 A [REDACTED]

19 Q We talked this morning about the concept  
20 of a firewall. What steps did Aetna take to ensure  
21 that its consultants, for example, Mr. Baum,  
22 complied with that firewall requirement that is in  
23 the 2022 RFP?

24 A Neither Daniel Baum or Courtney have  
25 access to any business information. They're



1 responsible for relationships, legislative affairs  
2 and the other items I described earlier.

3 Q Well, Mr. Baum knows that Aetna and CVS  
4 Caremark estimate that the savings, when

5 [REDACTED]

6 [REDACTED]

7 A But not specific to SHP. That was a  
8 presentation that he attended. And it was an  
9 average based on our sales pitch.

10 Q Aetna's sales pitch?

11 A Aetna's sales pitch.

12 Q Okay. Well, you said that neither  
13 Mr. Baum nor Ms. Herring have any access to any  
14 business information. What does the term "business  
15 information" mean?

16 A Contracts, fees, pharmacy deals. They  
17 don't get into that. They just don't have access to  
18 it. I don't have access to anything the PBM  
19 presents, and they don't have access to our deals  
20 either.

21 Q Do you know who Brian Hermreck is?

22 A He is the -- I don't know what his exact  
23 title is, but I would characterize him as the Angela  
24 Ramsammy for the PBM.

25 Q An implementation-type person?

1 A [REDACTED]

2 [REDACTED]

3 [REDACTED]

4 Q Okay. That's enough.

5 Were you aware, Ms. Aguirre, that the  
6 State Health Plan had put Blue Cross Blue Shield's  
7 top management team on notice as of April 5, 2022,  
8 that an RFP would be issued on the TPA?

9 A I was not aware of that date.

10 Q Okay. You can put that aside.

11 With regard to these custom deals that you  
12 testified about, you identified very early in the  
13 day there were three custom deals that Aetna was  
14 aware of and utilized with the custom pricing with  
15 regard to the cost proposal and financial repricing  
16 exercises in this RFP; is that correct?

17 A Correct.

18 Q And do you recall that during your  
19 30(b)(6) examination, Mr. Chase showed you some  
20 documents from each of the three vendors you  
21 identified?

22 A Yes, I recall.

23 Q [REDACTED]

24 A [REDACTED]

25 Q [REDACTED]

1 A Correct.

2 Q [REDACTED]

3 [REDACTED]

4 A Correct.

5 Q Is that true?

6 A Correct.

7 Q And he asked you to look at some of those  
8 documents and asked you some questions regarding the  
9 discounts that would be reflected by them. Did you  
10 express some confusion during that process as to  
11 whether those were the actual documents utilized by  
12 your company in the repricing exercises?

13 A I did.

14 Q Okay. Let me show you -- what's the next  
15 exhibit?

16 MR. CHASE: 259.

17 MR. WHITMAN: What I'm going to mark as  
18 Exhibit 259, Ms. Aguirre.

19 Take a moment to look at that.

20 (Exhibit Number 259 marked for  
21 identification as of this date.)

22 BY MR. WHITMAN:

23 Q It's an Attorneys Eyes' Only, highly  
24 confidential document.

25 Do you see in the bottom right-hand

1 corner, Ms. Aguirre, that this was produced in  
2 discovery in this case by your company?

3 A Yes.

4 Q Okay. And what is the title of this  
5 document?

6 A A letter of agreement.

7 Q Okay. And who is it with?

8 A [REDACTED]

9 Q And what is the effective date at the top?

10 A June 17, 2022.

11 Q Okay. Was this part of that thick

12 [REDACTED]  
13 showed you and asked you questions about during your  
14 deposition?

15 A I did not see it.

16 Q Okay. And if we turn to the back of this  
17 Deposition Exhibit 259, is it signed?

18 A Yes, it is signed.

19 Q Is this the document you were referring to  
20 in your testimony when you indicated that Aetna had

21 [REDACTED]  
22 to the custom deal?

23 A Yes.

24 Q All right. You can put that aside.

25 Show you what's been -- what I'm going to

1 mark Exhibit 260, Ms. Aguirre.

2 (Exhibit Number 260 marked for  
3 identification as of this date.)

4 BY MR. WHITMAN:

5 Q Let me know when you've had a chance to  
6 look at that.

7 A Yes.

8 Q Can you identify -- if you look at the  
9 bottom right-hand corner, this is marked highly  
10 confidential, Attorneys Eyes' Only. Does it appear  
11 to have been produced by your company in discovery  
12 in this action?

13 A Yes.

14 Q [REDACTED]  
15 [REDACTED]

16 A Yes.

17 Q It's titled Amendment Number 6?

18 A Correct.

19 Q What's the effective date of this  
20 document?

21 A July 15, 2022.

22 Q Okay. And the document -- do you recall  
23 [REDACTED]

24 you was not signed?

25 A It was not signed.

1 Q And did you express some confusion as to  
2 whether that was the document that was utilized by

3 [REDACTED]

4 [REDACTED]

5 A Yes, as I had seen the signed document.

6 Q Is Exhibit 260, Amendment Number 6 with

7 [REDACTED]

8 A Yes, it is.

9 Q Okay. Is this the document you were

10 [REDACTED]

11 A This is the document.

12 Q Show you what I'm going to mark as  
13 Exhibit 261.

14 (Exhibit Number 261 marked for  
15 identification as of this date.)

16 BY MR. WHITMAN:

17 Q The third custom deal you identified

18 [REDACTED]

19 [REDACTED]

20 [REDACTED]

21 A Correct. Correct.

22 Q And do you see -- this is a highly  
23 confidential, Attorneys Eyes' Only document. Do you  
24 see in the bottom right-hand corner it was produced  
25 by your company in discovery in this action?

1 A Yes.

2 Q What is the title of this document?

3 A [REDACTED]

4 [REDACTED]

5 Q What is the effective date of this  
6 document?

7 A 7/15/2022.

8 Q Do you recall when Mr. Chase was

9 [REDACTED]

10 [REDACTED]

11 that the document he provided to you was not signed?

12 Do you recall that?

13 A Yes.

14 Q Okay. And if we look at Exhibit -- what  
15 are we on? 261?

16 Ms. Aguirre, is that document signed on

17 [REDACTED]

18 A Yes.

19 Q The effective date is what?


20 A July 15, 2022.

21 Q Is that prior to the time that your  
22 company put its bid in?

23 A Yes.

24 Q On August 7, 2022?

25 A Correct.

1 Q Is this the document you were referring to  
2 when you said that your company had a signed custom  
3   
4 repricing exercise?

5 A Yes.

6 Q The last document I want to ask you about,  
7 Ms. Aguirre, you can put that aside, is Exhibit 256.  
8 Do you have that over there? It's one of the last  
9 documents Mr. Chase asked you about. Aetna's  
10 Response to Request for Clarification Number 5.

11 A Yes.

12 Q Do you recall that?

13 A Yes, I do.

14 Q Okay. And then there was some discussion  
15 during the questions that he asked you about a COLA,  
16 cost of living adjustment, and a charge -- was it a  
17 chargemaster adjustment? Do you recall that?

18 A Correct.

19 Q Okay. I want to clarify for the record,  
20 if you look at the in-network discount accumulation  
21 column on the far left, Ms. Aguirre?

22 A Yes.

23 Q Can you clarify for the record whether  
24 Aetna made any assumptions with regard to  
25 chargemaster, COLA, or otherwise with regard to the



1 four numbers reflected in the first four columns  
2 there?

3 A Not in regard to the four numbers as we  
4 followed the instructions. The fifth number, 53.99,  
5 asked us to assume increases in billed charges.

6 MR. WHITMAN: Thank you very much. That's  
7 all the questions I have.

8 EXAMINATION

9 BY MS. HEDRICK:

10 Q Ms. Aguirre, I have just a couple followup  
11 questions.

12 I think you testified earlier today that  
13 it was -- Aetna had determined it was possible that  
14 Aetna could comply with all the technical  
15 requirements.

16 A Correct.

17 Q Even if it hadn't identified or  
18 implemented a solution at the time that the contract  
19 was awarded; is that right?

20 A Correct.

21 Q All right. And I think you also testified  
22 that Aetna had authority for money or IT resources  
23 that would be needed to solve -- or to comply with  
24 any of those?

25 A Correct.

1 STATE OF NORTH CAROLINA IN THE OFFICE OF  
2 COUNTY OF DURHAM ADMINISTRATIVE HEARINGS  
23 INS 738

3 BLUE CROSS AND BLUE SHIELD  
4 OF NORTH CAROLINA,

5 Petitioner,

6 v.

7 NORTH CAROLINA STATE HEALTH  
8 PLAN FOR TEACHERS AND STATE  
9 EMPLOYEES,

10 Respondent,

11 and

12 AETNA LIFE INSURANCE COMPANY,

13 Respondent-Intervenor.

14 \*\* CONFIDENTIAL \*\*

15 \*\*PORTIONS CONTAIN ATTORNEYS' EYES ONLY\*\*

16 VIDEO DEPOSITION OF  
17 ANDREW DAVID COCCIA  
18 DECEMBER 1, 2023

19 9:03 a.m.

20 Raleigh, North Carolina

21  
22  
23  
24 Reported by: Audra M. Smith, FCRR

25 Video by: John Roberts

1        imagine if a Plan sponsor chose to put 100 percent  
2        of value on something that would not be considered  
3        by most to be important -- you know, an important  
4        value to hold -- that would be problematic, I think  
5        was the word you used.

6                Q        When you say "if they placed  
7        100 percent of value on something that would not be  
8        considered by most to be important," what did you  
9        mean by "most" in that answer?

10              A        I think there's general consensus, in  
11        my opinion, of key aspects that a health plan would  
12        deliver that most plan sponsors would agree are  
13        important.

14                      So in this example, if the Plan sponsor  
15        would have put undue weight on something that's not  
16        among those key aspects, it could be problematic.

17              Q        Turn back to paragraph 18 of your  
18        report, towards the end of that paragraph.

19              A        Excuse me.

20              Q        You say that: "If bids are compared  
21        using a clear, consistent and objective process and  
22        the scoring reflects the value placed on the  
23        components by the Plan sponsor, then the outcome is  
24        reasonable."

25                      Do you see that?

1           A       Yes, sir.

2           Q       What does the word "objective" mean as  
3 it's used here in your report?

4           A       What I'm getting at in this sentence is  
5 fairness. So in the perspective of fairness,  
6 objectivity is important. And by "objectivity," I  
7 mean taking a disinterested view of the bids,  
8 looking at them to ensure without any kind of, you  
9 know, emotion, if you will, or outside influence  
10 that what you're looking at is, you know, apples to  
11 apples. It's, you know, based on fact. And in so  
12 doing, you're trying to review all the bids through  
13 a lens of fairness.

14          Q       So "objectivity," as you've used it  
15 here, is synonymous with fairness. Is that what  
16 you're saying?

17          A       I'm saying it is part of what you need  
18 to do to ensure that you have a fair result.

19          Q       You used the term "disinterested view"  
20 in your response. What do you mean by that?

21          A       I mean that you shouldn't view bids  
22 with any prejudice.

23          Q       That would be a problem, right?

24          A       I believe so.

25          Q       That would not be consistent with an

1 objective process, right?

2 A True.

3 Q It would not be consistent with a fair  
4 process, right?

5 A Agreed.

6 Q Okay. How can a Plan sponsor go about  
7 ensuring that the process that they use is  
8 objective, as you define that term?

9 A I think that in order to ensure that a  
10 process is objective, you need to apply consistent  
11 standards to your review and analysis, such that  
12 when you are getting to the point of saying, I  
13 believe I have gotten to a point where everything is  
14 on an apples-to-apples-to-apples basis, then you can  
15 say that you can now be objective in your analysis  
16 of what you're looking at.

17 Q So the only thing a Plan sponsor needs  
18 to do to ensure that the process they use is  
19 objective is to make sure they're conducting an  
20 apples-to-apples comparison?

21 A I wouldn't say it's the only thing.

22 Q What else?

23 A Yeah. So, in my experience, an  
24 objective process -- and I'm going to come back to  
25 this concept of fairness -- is where everyone's

1 take your cost rank, we are going to add it to your  
2 technical rank, and that will be your final score.

3 That would have been easy to do, right?

4 MR. THOMPSON: Object to form.

5 A Yeah, that would have been easy to do.

6 BY MR. CHASE:

7 Q What other RFPs are you aware of where  
8 the bidders were ranked from best to worst, and then  
9 the ranks themselves were added together to  
10 determine the final score?

11 A Yeah. In nearly every government RFP  
12 I've ever worked on, the technical and the cost  
13 sections are scored separately --

14 Q Sure.

15 A -- by different teams.

16 And when you score bidders, then the  
17 natural implication is that you then rank them, top  
18 to bottom, who's best -- you know, who scored the  
19 best, who scored next, who scored next, and so on.

20 Then it's natural, common to then bring  
21 together the results of the technical and the cost  
22 somehow and come up with an overall result.

23 And so I would submit to you that,  
24 while everyone does it a little differently, that it  
25 is common practice for, you know, when scoring

1 technical and cost separately, to then bring them  
2 together.

3 Q Sure. You have to bring them  
4 together -- right? -- to determine a final score,  
5 the different elements of an RFP, right?

6 A Agreed.

7 Q Okay. I didn't think that one was  
8 controversial.

9 So the question is how that is done,  
10 right? That's what I'm driving at. And my question  
11 specifically is: The way that the Plan did it here  
12 to rank bidders on cost, rank bidders on technical  
13 responses, and then add those ranks together to  
14 determine a final score -- which we agree is what  
15 they did -- what other RFPs have you worked on where  
16 that specific methodology was used?

17 A Well, like I said, I've worked on a lot  
18 of RFPs. When you've seen one, you've seen one.

19 I've never seen an RFP that takes 310  
20 questions and reviews them and assigns a rank and  
21 then has a 10-point scale for cost and assigns that  
22 a rank and puts them together. That one's new.

23 Q And I'm not asking about that.

24 A Right? So what I'm saying is I -- you  
25 know, this is the first time I've seen this exact

1 approach, in my experience.

2 Q And I want to make sure we're talking  
3 about the same level of generality. I'm not talking  
4 about the fact that the technical proposals were  
5 scored on a 310-point scale as opposed to a  
6 210-point scale, right? You understand that?

7 A I understand that.

8 Q And that the cost proposal was scored  
9 on a 10-point scale instead of a 10,000-point scale,  
10 right?

11 A Yes, sir.

12 Q The question is: In terms of the  
13 Plan's methodology of determining a rank, ranking  
14 the bidders on technical, ranking the bidders on  
15 cost, and adding those ranks together to determine  
16 the final score, what other RFPs have you worked on  
17 where you've seen that specific methodology used?

18 A That specific methodology appears to be  
19 a reasonable methodology, but I can't call to mind  
20 the exact approach taken on other clients.

21 Q So sitting here today, the answer to my  
22 question is none?

23 A Yes, sir.

24 Q Okay. Tell me your understanding of  
25 Ms. Wills' opinion with respect to the method the



1 Plan used to determine final overall scores.

2 A My opinion, in what respect? Do I like  
3 it?

4 Q Your -- no. Your understanding of her  
5 opinion.

6 A Oh. My understanding of her opinion --

7 Q Yes.

8 A My understanding is that she didn't  
9 like it.

10 Q Can you be any more specific than that?  
11 Well, let me withdraw that question.

12 Your report responds to Ms. Wills'  
13 report, right?

14 A Yes.

15 Q Okay. So I take that to mean you had  
16 an understanding of the opinion she was offering as  
17 a part of formulating your opinions in response to  
18 her opinions, right?

19 A Yes.

20 Q Okay. So what I'm asking is for you to  
21 tell me your understanding of what opinion or  
22 opinions Ms. Wills has offered with respect to the  
23 method that the Plan used to determine final scores  
24 for each bidder?

25 A Ms. Wills' opinion -- my understanding

1 paragraph 53.

2 Q Okay. And that's what Segal did, to  
3 your understanding?

4 A To my understanding, Segal took a  
5 number of factors into consideration when scoring  
6 all of the performance guarantees. And they noted  
7 those considerations in their performance guarantee  
8 analysis, which appears in their -- in the  
9 presentations.

10 I think one of the major issues that  
11 they took into consideration was the total dollars  
12 at risk and the percentage of fees at risk, because,  
13 once again, it gets back to, the partnership that  
14 the State Health Plan could expect to have with its  
15 chosen -- excuse me -- health plan vendor to attempt  
16 to blunt any kind of trend growth should that trend  
17 growth exceed what the guarantee is.

18 Q I just want to get a clear answer to my  
19 question.

20 A Oh, I'm sorry if I'm not being clear.

21 Q Well, I may be the one who's not  
22 tracking. But it's a simple question. I think what  
23 you're saying in paragraph 53 is that Segal looked  
24 at the trend guarantee percentages. Given that they  
25 were all reasonable, Segal said, Okay, we can now

1 score these three trend guarantees by looking at the  
2 amount at risk.

3 Is that your understanding or not?

4 A It is not.

5 Q Okay.

6 A I'm going to go back to, I think, it  
7 was a major factor in Segal's scoring, but based on  
8 my review of Segal's analysis, they note more than  
9 just the amount at risk in their analysis of the  
10 various financial performance guarantees.

11 So I'm not in their heads -- right? --  
12 back when they did this scoring. I'm viewing this  
13 as an independent third party. But I can conclude  
14 that it would appear that the amounts at risk were a  
15 significant factor in the scoring.

16 Q You said that your review of Segal's  
17 work papers indicated that they noted -- your  
18 word -- more than the amount at risk for each  
19 vendor, right?

20 A They did, yeah.

21 Q What did they do with that information  
22 that they noted? How did it -- what part did it  
23 play in their valuation of the trend guarantees?

24 A Mm-hmm. Presumably, they took it all  
25 into consideration, right? They put it all into the

1 bag and shook it up. And that's what we do as  
2 consultants, right? We can't focus on one thing to  
3 the exclusion of everything else. We have to take  
4 in all the facts and then make a -- you know, make a  
5 recommendation.

6 Q That would be inappropriate in valuing  
7 any pricing guarantee; focusing on one thing to the  
8 exclusion of everything else, right?

9 A Did you say "inappropriate"?

10 Q Inappropriate.

11 A I think, you know, having so narrow of  
12 a focus as to exclude facts is not an appropriate  
13 approach.

14 Q So it would be inappropriate to focus  
15 on one factor to the exclusion of all others in  
16 evaluating and valuing a pricing guarantee, right?

17 MR. THOMPSON: Objection, form.

18 A A pricing guarantee, as was requested  
19 in this process, network pricing guarantees,  
20 examined multiple kinds of pricing guarantees. And  
21 as we talked about before, it got back apples and  
22 oranges and bananas, so it would have been  
23 impossible to focus on only one factor. And based  
24 on my review of Segal's analysis, their commentary  
25 in their workbooks, their commentary in their

1 presentations, it would appear that they took into  
2 account many factors in their scoring and ultimately  
3 ranking of the performance guarantees.

4 BY MR. CHASE:

5 Q It wouldn't be impossible to focus on  
6 any one factor in scoring a pricing guarantee. For  
7 example, you could look only at the amount at risk  
8 that was put at risk by any vendor. You could do  
9 that, right? It's not impossible?

10 A Yeah. I -- in that hypothetical  
11 situation, you -- I will submit to you, you could do  
12 that.

13 Q That would not be an appropriate way to  
14 value any pricing guarantee, would it?

15 A You know, in my years of consulting and  
16 experience, a consultant looks at all of the facts,  
17 considers those. Some components of a pricing  
18 guarantee may be more important than others. Some  
19 may cancel each other out.

20 You know, one bidder's really good in  
21 one way, bad in another and so on and so forth, it's  
22 a -- when you get an apple, an orange and a banana,  
23 you have to, you know, look at them and try to --  
24 right? -- boil it down to the very best value for  
25 your client.

1           Q       It doesn't tell us anything about the  
2       availability of the providers in any one particular  
3       county or geographic region, right?

4           A       This is a -- correct. This is a  
5       roll-up of all the data.

6           Q       Did the Plan or Segal, to your  
7       knowledge, analyze vendor networks at any level  
8       other than the statewide level?

9           A       I'm just trying to think about that. I  
10      do not believe that the Plan analyzed a network  
11      match or network disruption at any level other than  
12      a statewide level.

13                   There are other kinds of network  
14      analysis, and Geo Access analysis is another kind of  
15      network analysis that shows what percentage of  
16      members have access to a reasonable choice of  
17      providers within a reasonable distance of their  
18      homes, or their home ZIP codes, if you will.

19                   And it's my understanding that that Geo  
20      Access analysis was collected at the urban,  
21      suburban, and rural levels, to -- you know, to look  
22      at that.

23           Q       You said it was collected at the urban,  
24      suburban, and rural level. Was it analyzed to your  
25      knowledge by the Plan or Segal?

1           A       I don't know.

2           Q       Would it surprise you if you learned  
3       that despite being collected, it was not analyzed by  
4       the Plan or Segal?

5           A       I'm going to revise my answer, because  
6       now that I think about it, I do know. I'm sorry.  
7       It's been a long day.

8                   I do recall that Segal did not analyze  
9       the Geo Access analysis.

10          Q       So your answer before when I asked you  
11       was any analysis done at anything other than a  
12       statewide level, you talked about the Geo Access --

13          A       So I would revise that answer, then,  
14       and say, no, I do not believe that any analysis was  
15       done at other than the statewide level. And I  
16       apologize. I'm just a little tired.

17          Q       Do you know why that was the case, why  
18       no analysis was done at anything other than the  
19       statewide level by the Plan or Segal?

20          A       Well, I think I do.

21                   So I read, during my analysis of the  
22       process, emails that were interchanged between Segal  
23       and the State Health Plan around the topic of  
24       network access. And my interpretation of those  
25       emails was that the State Health Plan felt that not

1       only would network access not be something that they  
2       valued scoring independently, but that it would be  
3       incorporated into the financial analysis and be  
4       scored via this disruption analysis shown in Table 6  
5       in my report.

6               Q       And that was your understanding from  
7       reading the emails that you referred to between  
8       Segal and the Plan?

9               A       Yeah. It's my understanding that those  
10       emails predated the RFP release. They were talking  
11       about, you know, the design of the RFP, the design  
12       of the scoring and what would be -- how the RFP  
13       would thus be built.

14                    So based on that, and I would say based  
15       on the scoring methodology here and the technical  
16       and in the cost proposals, there is no place in  
17       there where Geo Access is scored. So I would  
18       conclude that if it's not scored, and if, in my  
19       position, my client said to me, the disruption  
20       analysis and its impact on costs is a sufficient  
21       measure, I would respect that and analyze the  
22       results accordingly.

23       Q.   Do you know why the Plan and Segal collected the Geo  
24       Access data if they weren't going to use it?

25               A       Well, I don't know why, but based on my



1 experience, I could surmise why one might do that.  
2 And one might do that because after the RFP process  
3 is conducted, you might want to use that data. You  
4 might wish to conduct that analysis on a regular  
5 basis and see areas that need to be addressed; hot  
6 spots, if you will, of poor access.

7 There could be a variety of reasons why  
8 you might collect that data. And I'll tell you,  
9 after doing this for 25 years, I can tell you with  
10 utmost honesty that when -- not everything that you  
11 collect in an RFP ultimately gets scored or  
12 analyzed. Sometimes you collect data to have it.  
13 Maybe you collect it to have it, to use in the  
14 future.

15 Q Do most of the -- sorry. Are you done?

16 A I don't know how to wrap that one up,  
17 so I'll stop there.

18 Q Do most of the RFPs that you've worked  
19 on include some type of disruption analysis in one  
20 form or another?

21 A Yes, sir.

22 Q Okay. Do they all?

23 A I would say nearly --

24 Q Fair.

25 A -- all RFPs that I've performed have

1       some disruption analysis.

2               Q       How many of those RFPs use the method  
3       that the Plan used here to look only at the portion  
4       of in-network claims and use that as a measure for  
5       disruption? Of the RFPs you've worked on, how many  
6       have used that methodology?

7               A       I'm just going to need a little  
8       clarification.

9               Q       Sure.

10              A       So when you say "only looked at the  
11       portion of in-network claims," as opposed to --  
12       could you, you know, maybe prompt me with what  
13       you're thinking?

14              Q       Any other method by which disruptions  
15       analyzed in any of the RFPs you've worked on.

16              A       So sometimes, and this is going to vary  
17       from consultant to consultant, I can really only  
18       speak to what I've done --

19                      (Teleconference operator interruption.)

20              A       All right. When I've done disruption  
21       analyses, sometimes I like to look at the percentage  
22       of claims that are currently in network and stay in  
23       network, current in network and go out of network,  
24       currently out of network but come back into the  
25       network, and out of network that stay out of

1 network.

2 And so it gives you a little bit more  
3 detail, because what you can see here -- take Aetna  
4 at 99 percent, that doesn't mean that 99 out of 100  
5 people don't have to change their provider. It  
6 could mean -- or don't, you know, let me rephrase  
7 that.

8 Ninety-nine out of a hundred people's  
9 provider falls out of network. What it means is --  
10 what it could mean -- is that maybe one person's  
11 provider out of a hundred is not in Aetna's network,  
12 but -- I'm not going to do the math right. I'm  
13 getting a little tired.

14 Some people who are using a provider  
15 today under Blue Cross might be going out of  
16 network. And they find out that that provider is  
17 contracted by Aetna. So they're positively impacted  
18 by the change.

19 Some people are using a provider under  
20 Blue Cross that we find that provider's not  
21 contracted under Aetna. They are negatively  
22 impacted by the change.

23 The 99 percent is the absolute value of  
24 those positive and negatively impacted people. When  
25 I perform a disruption analysis, I generally try, if

1 I have the data available, to show it at that level  
2 of specificity.

3 Q So a couple things. You told me, I  
4 think, earlier based on the emails that you  
5 reviewed, that the Plan was going to use the  
6 repricing -- results of the repricing analysis as a  
7 measure of disruption; that any differences in the  
8 network would be surfaced through that repricing  
9 analysis.

10 Do I have that right?

11 A My recollection is that in the email  
12 interchange between Segal and the State Health Plan,  
13 the State Health Plan said something to the  
14 effect -- and I'll paraphrase -- that network  
15 accessibility, which would include repricing and  
16 other areas does not require its own scoring section  
17 of the RFP, because the influence of the disruption  
18 analysis would be incorporated into the financial  
19 analysis.

20 Q Exactly.

21 A That's my recollection.

22 Q Perfect. And my question is: Of the  
23 75 or so RFPs that you've worked on, how many have  
24 used that method that you just described to measure  
25 disruption?

1                   And I'm not interested in the way  
2     you -- it could be done or, you know, the various  
3     ways it could be done. I'm just interested in the  
4     75 or so RFPs that you've worked on, how many have  
5     used that method that the Plan used here?

6                   A       Sure. Nearly every RFP that I've  
7     performed for a large, self-insured employer, for  
8     whom I've conducted a disruption analysis,  
9     incorporates that disruption analysis into the  
10    financial projections, because that's how you do it.

11                  Q       So nearly -- I'm sorry. Were you  
12    finished? I didn't want to cut you off.

13                  A       I think I'm finished.

14                  Q       Nearly every RFP -- it's your testimony  
15    here today that nearly every RFP that you've worked  
16    on uses the method that the Plan used here to  
17    measure disruption, and no other method.

18                  A       No, that's not what I said.

19                  Q       Okay.

20                  A       Yeah, yeah.

21                  Q       Help me here. Where am I off track?

22                  A       Sure, sure, sure.

23                           What I'm saying is that it's standard  
24    operating procedure to incorporate the results of  
25    the disruption analysis into your financial

1 projections.

2 Q I'm not sure what you mean by that. I  
3 don't want to cut you off, but before you get  
4 down --

5 A No, no, no. That's cool.

6 Q I don't know what you mean.

7 A So throughout this RFP process, Segal  
8 took great pains to figure out who's got what  
9 discount, but that discount only applies to  
10 in-network providers.

11 So in order to only apply that discount  
12 to the in-network providers under a health plan, a  
13 proposing health plan, you've got to incorporate the  
14 in-network assumption into your financial  
15 projections.

16 So the two are married, right? You'd  
17 need to do the disruption, and you incorporate the  
18 results into your financial projections, as Segal  
19 did. And I do that on all or nearly all of the big  
20 self-insured RFPs that I manage.

21 Now, I think what you're looking for is  
22 do we look at other measures of network  
23 accessibility, and the answer is oftentimes we do.

24 Q How often?

25 A Very often.

1 Q More than 90 percent of the time?

2 A Probably.

3 Q More than 95 percent of the time?

4 A Probably.

5 Q Almost 100 percent the time?

6 A Sure.

7 Q Okay. Of the 75 or so RFPs that you've  
8 worked on, how many analyze disruption at the  
9 statewide level only, as opposed to some other  
10 geographic area, a county, for example? How many?

11 A That's a little harder. Not every  
12 client is primarily, you know, geographically  
13 centralized in a state, right? A lot of them are  
14 spread across the country or spread across a region.  
15 So the answer is it depends, and I know that's a  
16 very consultancy kind of answer.

17 But it -- sometimes you look at it on a  
18 national basis or for the entire population.  
19 Sometimes you break it down based on where they have  
20 manufacturing sites or offices, for example.  
21 Sometimes you look at it on a state-by-state basis.  
22 It really depends on the client and the needs of the  
23 client, and that drives the level of specificity at  
24 which you look.

25 Sometimes you make that decision based

1 on the rolled-up data. So you might say, at a  
2 99 percent match, it's not necessary to look at it  
3 at finer level of detail; but if I saw it a  
4 90 percent match, I might say, Hm, what's going on  
5 here? Is there a major provider that's not in my  
6 network? Is there a hot spot region? And then you  
7 drill down.

8 So I can't say with any degree of  
9 certainty, you know, if there's a standard of, you  
10 know, how frequently we look at it on state basis, a  
11 regional basis, a national basis; or if you look at  
12 one way and then later roll it or look at it in a  
13 finer way. And I wish I could, I just...

14 I can't.

15 Q You -- a couple quick questions about  
16 Table 6. You don't -- well, let me back up. The  
17 difference between Aetna's in-network assumption and  
18 Blue Cross' is .4 percent?

19 A Yes.

20 Q These are dollars. We talked about  
21 that before, right?

22 A Yes, sir.

23 Q You don't know how many claims that  
24 represents, do you?

25 A I do not know.



1 make up the 80 in that 80/20. And by that I mean  
2 the cost proposal and the pricing guarantee  
3 proposal. Right?

4 A That's correct.

5 Q The cost proposal was 6 points, the  
6 pricing guarantee was 2 points out of -- you add  
7 those together and you get 80 percent of the  
8 available points, right?

9 A Yes, sir.

10 Q You haven't expressed any opinion on  
11 the -- excuse me, the 6:2 ratio between network  
12 pricing and pricing guarantees being appropriate or  
13 inappropriate, right?

14 A Correct.

15 Q Okay. An allocation of 7 points for  
16 network pricing and 1 point for pricing guarantees  
17 would still meet this 80/20 guideline that you've  
18 discussed in your report, right?

19 A Yes, sir.

20 Q Five points for network pricing and  
21 three points for pricing guarantees would meet that  
22 80/20 guideline that you talked about?

23 A Yes, sir.

24 Q Okay. In paragraph 36, we moved on to  
25 Opinion 6 in your report which talks about the use

1 of what you termed "binary responses" to technical  
2 requirements.

3 Do you see that?

4 A Yes.

5 Q And what we're talking about here is  
6 the fact that bidders in this RFP were limited on  
7 technical responses to choosing between a response  
8 of "confirm" and a response of "not confirmed,"  
9 right?

10 A Yes, sir.

11 Q In paragraph 36, at the beginning, you  
12 say nearly every RFP in which you participated  
13 recently includes a section of binary (confirmed/not  
14 confirmed) response requirements covering the  
15 sponsor's minimum requirements and/or technical  
16 requirements, right?

17 A Yes, sir.

18 Q In this RFP, bidders were limited to  
19 that binary confirm/do not confirm choice for every  
20 single minimum requirement, right?

21 A Yes, they were.

22 Q And every single technical response --  
23 technical requirement response, right?

24 A Yes, they were.

25 Q Of the 75 or so RFPs that you've worked

1 on, how many of them have followed that methodology,  
2 and specifically I mean allowing only confirm or not  
3 confirm for every single minimum requirement and  
4 every single technical requirement.

5 A This is the first time in my experience  
6 I have seen an RFP use only a binary response option  
7 for their technical requirements. It's not unheard  
8 of for minimum requirements, of course. You either  
9 meet the minimums or you don't.

10 But I got to say I like it, and I  
11 understand why they did it that way. And that might  
12 be a new best practice, in my opinion.

13 Q And in the 75 RFPs, you're saying this  
14 is the first time you've seen that methodology used  
15 for responses to all the technical requirements?

16 A Yes, sir.

17 Q Okay. You said with respect to minimum  
18 requirements that you often see binary yes/no  
19 responses -- well, I'll withdraw that. We'll come  
20 back to that. I know that's the last thing you want  
21 to hear at this point in the day, is that we are  
22 going to come back to something.

23 A I am here at your service.

24 Q Turn to paragraph 37 of your report.  
25 We're still talking about this same Opinion C.

1                   You say: "Based on my analysis, it  
2                   appears that the 310 questions in the technical  
3                   proposal were detailed and specific, indicating to  
4                   me that the Plan was thoughtful and intentional  
5                   about the information sought, consistent with  
6                   leading practices."

7                   Do you see that?

8                   A        Yes, sir.

9                   Q        What analysis did you perform, as  
10                  referenced here, to conclude that the 310 technical  
11                  requirements were detailed and specific? What was  
12                  involved in that analysis? Was it just reading?

13                  A        I read the RFP.

14                  Q        Was there anything else that was part  
15                  of that analysis that you reference here?

16                  A        The analysis I'm referring to is kind  
17                  of my analysis that we did on the project, not  
18                  specific to -- to this specific question. But in  
19                  answer -- and direct answer to your question, no, I  
20                  read the questions, and thought about them and said,  
21                  If I were a bidder, would this make sense to me?  
22                  And if it didn't, would I ask a question?

23                  Q        What was the basis for your conclusion  
24                  that the technical questions were detailed -- or  
25                  excuse me -- were thoughtful and intentional?

IN THE OFFICE OF  
ADMINISTRATIVE HEARINGS  
23 INS 738  
STATE OF NORTH CAROLINA  
DURHAM COUNTY

BLUE CROSS AND BLUE SHIELD  
OF NORTH CAROLINA,

Petitioner,

-vs-

NORTH CAROLINA STATE HEALTH PLAN FOR  
TEACHERS AND STATE EMPLOYEES,  
Respondent,

-and-

AETNA LIFE INSURANCE COMPANY

Respondent-Intervenor.

-----/  
DEPOSITION OF: STUART IRA WOHL  
DATE: Friday, September 15, 2023  
TIME: 9:00 a.m. - 4:15 p.m.

PLACE: FOX ROTHSCHILD LLP  
2 S. Biscayne Boulevard  
Suite 2750  
Miami, Florida 33131

STENOGRAPHICALLY  
REPORTED BY: VANESSA OBAS, RPR

1 Q. Did Segal play any role in the decision to  
2 issue this RFP?

3 A. No.

4 Q. No role at all?

5 A. No.

6 Q. Did Segal play any role in the overall design  
7 of the RFP? And by that I mean the major components of  
8 what the RFP would ask for.

9 MR. HEWITT: Object to form.

10 THE WITNESS: We -- we probably saw some of the  
11 technical sections and know what they were  
12 requesting about, but we did not get very much  
13 involved in the technical sign-offs. I don't know  
14 everything they asked for there.

15 On the cost side, we had a lot of involvement  
16 on what was asked for.

17 BY MR. SAWCHAK:

18 Q. The RFP -- I'm sorry to interrupt.

19 A. I just want to make sure I was talking loud  
20 enough.

21 Q. I have the same problem.

22 The RFP, as I understand it, involved certain  
23 minimum requirements that all bidders had to sign off  
24 on, so to speak.

25 Are you aware of that?

1           A.    I think I heard that.  I don't know if I ever  
2   saw that.

3           Q.    Was Segal involved in framing those minimum  
4   requirements in any way?

5           A.    I don't believe so.

6           Q.    And then there were certain technical  
7   requirements that postdated the minimum requirements.  
8   Was Segal involved in choosing those?

9           A.    No.

10          Q.    The cost proposal involved multiple components;  
11   is that correct?

12          A.    Yes.

13          Q.    Did Segal play any role in deciding what those  
14   components would be?

15          A.    Yes.

16          Q.    What was the role?

17          A.    We drafted the initial cost proposal  
18   specifications, sent it to the client, and probably had  
19   back-and-forth with them about what's included and  
20   what's not included.

21          Q.    Several of the witnesses for the plan have  
22   testified that Segal essentially ran the show on the  
23   cost proposal.

24               MR. HEWITT:  Object to form.

25

1 BY MR. SAWCHAK:

2 Q. I'm paraphrasing.

3 A. (Witness nodding.)

4 Q. Do you have any reason to disagree with that  
5 description?

6 MR. HEWITT: Object to form.

7 MR. THOMPSON: Object to form.

8 BY MR. SAWCHAK:

9 Q. Please answer.

10 A. No.

11 Q. You have no reason to disagree with it?

12 A. No.

13 Q. To your knowledge, did the plan ever consider  
14 dividing up the TPA role in 2022; that is to say,  
15 dividing it up among multiple competing TPAs or dividing  
16 it by region or another factor of division?

17 A. Can you restate the beginning of that question?

18 Q. Did the plan ever consider dividing up the TPA  
19 role in 2022?

20 A. I do not know.

21 Q. Have you heard of any consideration of that?

22 A. I've seen it with other clients. I don't know  
23 if they considered it or not.

24 Q. Is that something that Segal made a  
25 recommendation on one way or the other here in 2022?



1 A. I don't believe so.

2 Q. Has the plan ever considered such a division on  
3 any TPA RFP, as far as you're aware?

4 A. I don't know.

5 Q. Has Segal made any recommendations to the plan  
6 on such a division?

7 A. I don't know.

8 Q. Who would know?

9 MR. HEWITT: Objection. Form.

10 THE WITNESS: I have no clue who would know.

11 BY MR. SAWCHAK:

12 Q. Is that fairly common in other states, to  
13 divide up the TPA role?

14 A. Some states have multiple TPAs involved; some  
15 states have one. I'm not sure what the count is of  
16 each.

17 Q. What factors counsel dividing up the TPA role?

18 MR. HEWITT: Object to form.

19 THE WITNESS: I have no idea.

20 BY MR. SAWCHAK:

21 Q. Who within Segal would have an idea?

22 MR. HEWITT: Object to form.

23 THE WITNESS: There's probably a host of  
24 people, the people I mentioned already. Maybe Ed  
25 Kaplan. Maybe Richard Ward. Anybody who deals with

1 BY MR. SAWCHAK:

2 Q. Please answer.

3 A. We are helping the plan by talking about what  
4 we did.

5 Q. Talking internally to the plan or being  
6 deposed?

7 A. Being deposed. We have had -- I don't think  
8 we've had any discussions with the plan.

9 Q. Is Segal getting paid for participating in  
10 depositions in this case?

11 A. Yes.

12 Q. Likewise, are you getting paid for preparation  
13 for the depositions?

14 A. Yes.

15 Q. And at the rates shown on Exhibit 11?

16 A. No.

17 Q. How -- strike that.

18 What's the basis of payment, the monetary basis  
19 of payment?

20 A. We have a different rate structure in place  
21 with the 2023 agreement.

22 Q. So you're being --

23 A. Extension.

24 Q. Strike that. I'm -- excuse me for speaking  
25 over you.

1           You're saying that the -- you're being paid  
2     hourly rates for preparation and deposition, but at the  
3     prevailing 2023 rates.

4           A.     Yes.

5           Q.     And your hourly rate under that structure is  
6     roughly what?

7           A.     \$490 an hour.

8           Q.     On Pages 1 and 2, there's a section entitled  
9     "Obligations of Segal," and it goes on to say, "Segal  
10    shall," and then there's a list of items.

11                  Do you see that?

12           A.     Yes.

13           Q.     .4 under the list says, "Provide a disruption  
14    analysis based on the GeoAccess reporting requirement in  
15    the RFP."

16                  Did Segal do that?

17           A.     No.

18           Q.     Why not?

19           A.     The State decided they did not want it.

20           Q.     How did you become aware of that decision of  
21    the State not to do it?

22           A.     I believe Steve Kuhn asked them that question,  
23    and they responded.

24           Q.     "Steve Kuhn asked them that question, and they  
25    responded" was your statement?

1 A. Yes.

2 Q. When in the timeline of the RFP work did that  
3 question and answer occur?

4 A. I don't remember exactly when.

5 Q. Later than this letter of agreement, though.

6 A. Yes.

7 Q. What's your understanding of why the State  
8 decided not to do a disruption analysis?

9 A. I believe what I saw said the pricing analysis  
10 will show what portion of the claims are out of network,  
11 and --

12 THE COURT REPORTER: I'm sorry.

13 THE WITNESS: I'm sorry. The pricing analysis  
14 will show what portions of the claims are out of  
15 network, and that will identify whether there's an  
16 issue or not.

17 Sorry.

18 THE COURT REPORTER: That's okay.

19 BY MR. SAWCHAK:

20 Q. Is there any other reason why Segal did not do  
21 a disruption analysis?

22 A. No.

23 Q. How long does a disruption analysis take to do,  
24 roughly?

25 A. I have no clue.

1 GeoAccess reporting review. Let me know if I missed  
2 anything from the previous LOA.

3 LOA there is letter of agreement?

4 A. Yes.

5 Q. And that's the type of document that we looked  
6 at before as Exhibit 11, the one that you signed on  
7 page 4; is that right?

8 A. I don't know it was page 4, but, yes. It was a  
9 type of document from earlier.

10 Q. When Mr. Rish says, in the passage I read,  
11 second line, "the same scope as before," is that, from  
12 context, the same scope as on the 2019 TPA RFP?

13 A. I would say yes.

14 Q. How did the scope of what Segal ultimately did  
15 on the 2022 RFP compare to the scope of what Segal did  
16 in 2019?

17 A. I have no clue.

18 Q. Can you think of any differences --

19 A. I --

20 Q. -- in the scope of your work?

21 A. I was involved very little in -- 2019?

22 Q. Yes.

23 Less so than you were involved in 2022?

24 A. Yes.

25 Q. Why the difference?

1           A.     I wanted to make sure this one was done right.  
2     I wanted to make sure I kept the team going.  I want --  
3     just wanted to make sure our client was happy.

4 Q. Was the client unhappy with the result of the  
5 2019 RFP?

6           A.    They were not happy -- they were not -- unhappy  
7    with the results.

8 Q. What were they unhappy about?

9           A.    We gave them a little too much information at  
10    one time.

11 Q. Any other aspects that the client was unhappy  
12 about?

13           A.    I believe we may have sent out a data file that  
14   needed further explanation, initially.

15 Q. Anything else that the client was unhappy  
16 about --

17 A. Not that I --

18 Q. -- in the 2019 process?

19           A.     Not that I know of.

20 Q. This passage mentions, in .4, GeoAccess  
21 reporting review.

22 What does that mean?

23           A.     A GeoAccess report is many times asked for as  
24     part of a bid for this sort of work. A GeoAccess report  
25     asks basic questions like, based on each -- where each

1 person lives in the plan, do they have access to a  
2 certain number of providers, different types of  
3 providers, when they are a certain distance?

4 Q. Did Segal do that in 2019?

5 A. I don't know.

6 Q. Did Segal do it in 2022?

7 A. It may have been asked for as part of the -- of  
8 the bid submissions, but I don't think we analyzed it.

9 Q. So you believe that you received GeoAccess  
10 reports but did not analyze them in 2022?

11 A. That's what I think. I'd have to look at all  
12 of the exhibits, A1 through 8 or whatever.

13 Q. But you have no recollection of analysis of  
14 GeoAccess reports.

15 A. Correct.

16 Q. In 2022.

17 A. I'm sorry. Yes, correct.

18 Q. Let me show you another exhibit. This is 209.

19 (Petitioner's Exhibit Number 209,  
20 Correspondence, Bates Number SHP 0086102 - 86111,  
21 was marked for Identification.)

22 THE WITNESS: Thank you.

23 BY MR. SAWCHAK:

24 Q. This is an e-mail exchange between the state  
25 health plan people and Segal people; is that right?

1 A. Yes.

2 Q. And this is before the letter of agreement with  
3 the plan that we saw as Exhibit 11; is that right?  
4 Before the signed version of Exhibit 11?

5 A. Yes.

6 Q. Because that was in June of 2022, Exhibit 11  
7 was?

8 A. I believe so.

9 Q. Is the context of this e-mail exchange  
10 preparation for a 2022 RFP?

11 A. Yes.

12 Q. Mr. Rish's e-mail on 86103, I'd like to look  
13 at, please.

14 And there's an attachment to the exhibit or --  
15 I should correct my description of the exhibit. This is  
16 an e-mail exchange that attached a marked-up document;  
17 is that right?

18 A. Yes.

19 Q. And is the marked-up document a draft of your  
20 letter of agreement with the state health plan?

21 A. No.

22 Q. What is it?

23 A. It's a draft of proposal from Segal to help the  
24 state health plan before -- help the -- help the state  
25 health plan on their TPA RFP.



1 A. Sure.

2 Q. But it didn't -- do you have any understanding  
3 of why it didn't start the RFP work earlier?

4 A. No.

5 Q. Did you have the sense in your work on the RFP  
6 that the decision to issue the RFP was stimulated by  
7 something in particular?

8 MR. HEWITT: Object to form.

9 THE WITNESS: No.

10 BY MR. SAWCHAK:

11 Q. Let's look, please, at the attachment. There  
12 are a couple marginal comments that say "MR1," "MR2."  
13 Looks like you see the first one there that says "MR1."

14 Are those Matt Rish's comments, would you say?

15 A. It just says "MR." I'll have to make that  
16 assumption, yes.

17 Q. On page 86106 on the top -- toward the top,  
18 there's quite a bit of language about meetings with  
19 vendors and the like and most of that, if not all of it,  
20 is deleted in the comments; is that right?

21 A. Yes.

22 Q. What's your understanding of why that was  
23 deleted?

24 A. My gut is we included that in the last RFP as  
25 something we could do for them. I don't know if we did

1       it or not. And they may not have wanted it done this  
2       time -- or they may not have wanted us involved this  
3       time.

4           Q.    On the top of page 86107, the commenter on what  
5       is changed from B to C makes an insertion saying:  
6       "Segal will provide a disruption analysis based on the  
7       GeoAccess reporting requirement in the RFP"; is that  
8       right?

9           A.    Yes.

10          Q.    So at this point in the process, Segal is being  
11       asked to do a disruption analysis?

12               MR. HEWITT: Object to form.

13               THE WITNESS: Yes.

14       BY MR. SAWCHAK:

15          Q.    How much later than this did the plan decide  
16       not to do a disruption analysis?

17               MR. HEWITT: Object to form.

18               THE WITNESS: Some other exhibit, I believe,  
19       that's -- that I saw said not to do it. I don't  
20       know when it was.

21       BY MR. SAWCHAK:

22          Q.    You mentioned before, in relation to the  
23       timeline, that the plan was shooting for a January 1,  
24       2025, date for the service of the new TPA; correct?

25          A.    I agree that that was the date that the

1 contract starts.

2 Q. And during the whole work by Segal on this RFP,  
3 were there ever any communications with the plan that  
4 made you think that the plan would prefer to change  
5 TPAs, if possible?

6 A. No.

7 MR. THOMPSON: Objection. Form.

8 BY MR. SAWCHAK:

9 Q. Did you consider it likely that there would be  
10 a change?

11 MR. HEWITT: Object to form.

12 MR. THOMPSON: Object to form.

13 THE WITNESS: I didn't give it any thought,  
14 whether there would be a change or not.

15 BY MR. SAWCHAK:

16 Q. This draft or this proposal, I might say,  
17 that's the attachment to Exhibit 209, states a cost  
18 figure totaling \$257,000 and some. The Exhibit 11 that  
19 we reviewed states a final estimate of \$216,000.

20 Why did the estimate go down?

21 A. I would think it's because of the section we  
22 got rid of about setting up prebid meetings, that whole  
23 section on 86106.

24 Q. So the -- the scope of the work was narrowed?

25 A. Yes.

1 Q. Was cost saving an objective of the plan --  
2 that is, saving cost on Segal's work an objective of the  
3 plan?

4 A. I don't --

5 MR. HEWITT: Object to form.

6 THE WITNESS: I don't believe so.

7 BY MR. SAWCHAK:

8 Q. And look with me, please, at 86108 in the  
9 middle. There's an insert here I'd like to read to you.  
10 It says: "Segal understands that there is no  
11 margin for error in the timeline for this RFP. Segal  
12 agrees to meet all turnaround time specified by the plan  
13 for all deliverables specified for this project. It is  
14 incumbent upon Segal to adhere to the project  
15 specifications and time frames as any inaccuracies or  
16 errors will be detrimental to the overall success of the  
17 project."

18 That's language that the plan inserted here; is  
19 that right?

20 A. Yes.

21 Q. You said before that this was a proposal. Why  
22 would the plan be making insertions of this nature to  
23 your proposal?

24 A. They just wanted it to be clear to us. They  
25 wanted to make a statement that we understood.

1 Q. What was your reaction to this edit?

2 A. As I said earlier, there were two -- there was  
3 a data file that went wrong on a prior one, and we gave  
4 too much information on one. They just wanted to make  
5 sure we followed the rules and gave them what they  
6 needed.

7 Q. What about the first sentence saying: "Segal  
8 understands that there is no margin for error in the  
9 timeline for this RFP"?

10 What was your reaction to that insertion?

11 A. We knew. The State deadlines don't change. So  
12 if we agree to a deadline, we meet it.

13 Q. And no margin for error is a pretty emphatic  
14 statement, wouldn't you say?

15 MR. HEWITT: Object to the form.

16 THE WITNESS: I don't know.

17 BY MR. SAWCHAK:

18 Q. You don't consider it emphatic?

19 A. They just wanted to make sure we were aware we  
20 had deadlines to meet.

21 Q. But this is more forceful than that, wouldn't  
22 you say?

23 A. No.

24 Q. This is -- let me ask a different question.

25 Have you ever seen another client modify one of

1 your proposals to say that there's no margin for error  
2 in the timeline?

3 A. We have -- I've never seen this language put in  
4 before, that I remember.

5 Q. Have you seen the substance of this message  
6 inserted into one of your proposals?

7 A. Inserting the proposal, no. But I've seen it  
8 in the agreements where if you don't hit deadlines,  
9 there are penalties or other things that can happen.

10 MR. SAWCHAK: So I think we're at the end of  
11 the media time. It's 12:45.

12 Do you want to take -- take a bit of a lunch  
13 break, or what do you want to do?

14 MS. KOSKI: Let's go off.

15 MS. SCHULTZ: Off.

16 MS. KOSKI: Yeah.

17 MR. SAWCHAK: Let's go off the record. Sorry.

18 THE VIDEOGRAPHER: Stand by. Going off the  
19 record. The time is 12:45.

20 (Thereupon, a lunch recess was taken in the  
21 deposition, after which the deposition continued as  
22 follows:)

23 THE VIDEOGRAPHER: All right. Good afternoon.  
24 We're now back on the video record. The time is  
25 1:22 p.m. This is Media Card Number 3.

1                   You may proceed.

2       BY MR. SAWCHAK:

3           Q.     Mr. Wohl, let me ask a couple follow-ups from  
4       this morning. About that April 6th meeting we  
5       discussed, did you hear the discussion of that meeting  
6       during Mr. Rish's deposition?

7           A.     I don't remember.

8           Q.     Okay.

9           A.     I'd say no.

10          Q.     So your recollection of that meeting, as stated  
11       this morning, is that your completely independent  
12       recollection, or did something refresh your  
13       recollection?

14          A.     Completely independent.

15          Q.     All right. And question about the cost  
16       proposal scoring and your familiarity with it.

17                 If you had to re-create the cost proposal  
18       scoring yourself, could you?

19          A.     No.

20          Q.     How would you describe your level of  
21       familiarity with it?

22          A.     I know the concepts, but I don't know any --  
23       most of the details of how they do it.

24          Q.     The calculations, not familiar?

25          A.     No.

1 A. Not that I'm aware of.

2 Q. Instead, the bidders were asked to identify the  
3 raw number of members who met the criteria?

4 A. That's what I read that paragraph above to say.  
5 I don't know. There could be more language in here I'm  
6 not aware of.

7 Q. But the -- the number of members who did not  
8 enjoy this level of network access was not measured in  
9 the RFP; is that right?

10 MR. HEWITT: Object to form.

11 THE WITNESS: It measures both. If -- if  
12 there's 500,000 people and 498,000 have access,  
13 2,000 do not, so --

14 BY MR. SAWCHAK:

15 Q. But --

16 A. Both numbers are there.

17 Q. The bidders were not asked to define a  
18 percentage of members needing it or -- or even to -- to  
19 do the quantification of those without the access; is  
20 that right?

21 A. I haven't looked at a GeoAccess report in a  
22 number of years, but my memory of them is it would  
23 actually show that on there.

24 They would say for suburban -- I'll just pick  
25 on suburban hospitals. One hospital within 25 miles.



1 The report will say something to the effect of -- my  
2 memory, there are 3,222 people who are suburban, and  
3 99.2 percent of them have access.

4 I think it does give that level of detail, but  
5 I have not looked at one in a long time.

6 Q. Did Segal -- strike that.

7 Did Segal do anything to compare the GeoAccess  
8 reports of the bidders?

9 A. I do not believe so.

10 Q. Let me ask you some questions about the  
11 provider type column in the table on 72669. One of the  
12 provider types -- it's actually the very top one -- is  
13 hospitals.

14 The RFP did not define that term, did it?

15 A. I don't know.

16 Q. I don't see a definition here. I'll represent  
17 to you, we have not found any.

18 Does that sound wrong --

19 A. I don't know.

20 Q. -- that such a definition would be lacking?

21 A. I don't know.

22 Q. You have considerable experience in the health  
23 care industry.

24 Would that be fair to say?

25 A. Yes.

1 Q. Hospital could mean a short-term, acute-care  
2 hospital, a long-term hospital, a rehab hospital, a  
3 satellite hospital; isn't that right?

4 A. I guess. I -- like I said, I have experience  
5 with health care, but I haven't dealt with this in a  
6 really long time.

7 Q. Did Segal or the plan do anything to check  
8 whether the bidders were using a consistent definition  
9 of the term "hospital"?

10 A. I don't believe Segal looked at it, so I don't  
11 think we would have known if there was a consistent  
12 usage of the phrase "hospital."

13 Q. Is that true for all of the provider types in  
14 the first column here, that Segal did not do anything to  
15 make sure that these figures were comparable from one  
16 bidder to another?

17 A. As far as I know, because, like I said, I don't  
18 know everything that's in the proposal that they ask  
19 for.

20 Q. But you're not aware of any -- any analysis  
21 that Segal -- any -- let me start again.

22 You're not aware of any efforts on Segal's part  
23 to make sure that the provider -- that the bidders used  
24 consistent provider definitions, one bidder to the  
25 other?

1 out-of-network pricing, and then it hurts the  
2 participants. We wanted to make sure that everything  
3 was on even basis for a very small portion of the  
4 claims. But even that's a stretch of what I know.

5 (A discussion was held off the record.)

6 BY MR. SAWCHAK:

7 Q. Is it fair to say that a bidder that has the  
8 highest number of in-network claims among all the  
9 bidders has the least disruption or poses the least  
10 disruption?

11 MR. THOMPSON: Object to form.

12 THE WITNESS: That's fair.

13 BY MR. SAWCHAK:

14 Q. Is the breadth of network access offered by the  
15 TPA something that's important to the welfare of the  
16 state health plan?

17 MR. HEWITT: Objection to form.

18 THE WITNESS: Based on what you've read before,  
19 they want a broad network. To the health of the  
20 state health plan, I don't know.

21 BY MR. SAWCHAK:

22 Q. Or is it important to the -- the soundness of  
23 the state health plan?

24 MR. HEWITT: Objection to form.

25 THE WITNESS: I don't know.

1 BY MR. SAWCHAK:

2 Q. Is it important to the welfare of the members  
3 of the state health plan?

4 MR. HEWITT: Objection to form.

5 THE WITNESS: Repeat the question, please.

6 BY MR. SAWCHAK:

7 Q. Is -- is the breadth of network access  
8 something important to the welfare of the members of the  
9 state health plan?

10 MR. HEWITT: Objection to form.

11 THE WITNESS: Yes.

12 BY MR. SAWCHAK:

13 Q. For purposes of this RFP, were -- let me start  
14 again.

15 For purposes of the repricing exercise, were  
16 the bidders allowed to include providers under a letter  
17 of intent as in-network providers?

18 A. That is my understanding.

19 Q. Were they treated differently from providers  
20 under firm contracts in any respect?

21 A. Not that I know.

22 Q. Who made that decision, Segal or the plan?

23 A. I do not know.

24 Q. Do you recall any communications with the plan  
25 on how to approach that issue?

1           A.    I don't recall any.

2           Q.    Looking at the RFP, please, at page 72670 --  
3           staying with the page we're on, I think, Section 1.1.3,  
4           it reads "Vendors are required to submit a listing of  
5           the entire proposed provider network in Attachment A-2.  
6           The file should contain information for each proposed  
7           network, including the format disclosed" -- sorry --  
8           "using the format disclosed in identifying whether each  
9           provider is currently under contract or has entered a  
10          legally binding letter of intent with the vendor."

11                Did I read that correctly?

12          A.    Yes.

13          Q.    Did Segal draft this language?

14          A.    I do not know.

15          Q.    The term "legally binding letter of intent," is  
16          that a term with a meaning that you understand?

17          A.    No.

18          Q.    Are you familiar with letters of intent in  
19          health care contracting, generally?

20          A.    No.

21          Q.    So, for example, imagine a letter of intent --  
22          strike that.

23                Can you define the term "letter of intent"  
24          generally --

25                MR. HEWITT:  Objection.