

STATE OF NORTH CAROLINA
DURHAM COUNTY

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
23 INS 00738

BLUE CROSS AND BLUE SHIELD OF)
 NORTH CAROLINA,)
)
 Petitioner,)
 v.)
)
 NORTH CAROLINA STATE HEALTH)
 PLAN FOR TEACHERS AND STATE)
 EMPLOYEES,)
)
 Respondent.)
)
 and)
)
 AETNA LIFE INSURANCE COMPANY,)
)
 Respondent-Intervenor.)
 _____)

RESPONDENT’S MEMORANDUM IN SUPPORT OF
MOTION FOR SUMMARY JUDGMENT
AS TO ALL CLAIMS OF PETITIONER

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INTRODUCTION

In this contested case, Petitioner Blue Cross and Blue Shield of North Carolina (“Blue Cross”) challenges the decision by Respondent North Carolina State Health Plan for Teachers and State Employees (“Plan”) to award a contract as part of a competitive procurement and to deny Blue Cross’s bid protest. Blue Cross was one of three bidders who responded to the Plan’s Request for Proposals (RFP) # 270-20220830TPAS (the “RFP”)¹ for third-party administrator (TPA) services for 2025-2027. Based on its evaluation of the proposals, and with the approval of its Board of Trustees, the Plan awarded the contract to Respondent-Intervenor Aetna Life Insurance Company (“Aetna”). As explained below, there is no genuine issue of material fact and that the Plan should be granted judgment as a matter of law.

Blue Cross argues that the Plan should have designed the RFP differently, weighted the scoring differently, and scored the bidders’ proposals differently. Not surprisingly, Blue Cross would have the Plan first design the RFP and then weight and score the proposals in a way that would have resulted in the award of the contract to Blue Cross rather than Aetna. Its position suffers from an overriding flaw—it fails to identify any error that would support reversal under General Statutes Section 150B-23. Instead, Blue Cross merely disagrees with decisions that are well within the discretion and authority of the Plan and asks this tribunal to substitute its judgment for that of the Plan. This tribunal, however, cannot do so under North Carolina law. Without evidence that the Plan exceeded its authority or jurisdiction, committed legal error, failed to follow proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule, the Plan is entitled to summary judgment in its favor as a matter of law.

¹ The RFP was previously filed with this tribunal on March 20, 2023, as part of the documents constituting the agency action at issue in this contested case. Rather than re-file the lengthy document as part of this Motion, all citations to the “RFP” herein refer the tribunal to Exhibit 1 to the March 20, 2023, Notice of Filing.

STATEMENT OF UNDISPUTED FACTS

I. The State Health Plan

The Plan is a division of the North Carolina Department of State Treasurer (“Department”), an agency of the State led by the State Treasurer of North Carolina (“Treasurer”). The Plan’s statutory purpose is to provide a health benefits plan for eligible state employees, retired employees, and their dependents. N.C. Gen. Stat. § 135-48.2. The Plan is managed, operated, and administered by the Treasurer, Department, and an Executive Administrator and is governed by a Board of Trustees (“Board”), a statutory creation entrusted with fiduciary responsibilities and certain approval and consulting authority. *See* N.C. Gen. Stat. §§ 135-48.20, 135-48.22, 135-48.23.

Currently, the Plan has approximately 742,000 members, including retirees and dependents. Most of the Plan’s members reside in North Carolina, but the Plan has members throughout the United States. (APPX V4.0930 ¶ 4).²

The Plan currently has approximately thirty staff, all of whom are employed by the Department. The Plan is a “lean” organization and relies on outside contractors (also referred to as “vendors”)³ for many aspects of the Plan’s operations and activities, as authorized by General Statutes Section 135-48.23. (APPX V4.0930 ¶ 5). Accordingly, contracting with outside vendors is one of the Executive Administrator’s key responsibilities. The Plan routinely conducts several

² All evidence submitted by the Plan in connection to its motion for summary judgment were filed in an appendix with four volumes and are cited to by the appendix page number for ease of reference. All documentary exhibits are included in Volume 1 (which begins at page APPX V1.0001 and contains all non-confidential exhibits) or Volume 2 (which begins at page APPX V2.0236 and contains all exhibits designated CONFIDENTIAL or HIGHLY CONFIDENTIAL—ATTORNEYS’ EYES ONLY). All deposition transcripts or excerpts thereof are included in Volume 3 (which begins at page APPX V3.0306). Finally, all affidavits are contained in Volume 4 (which begins at page APPX V4.0705).

³ “Contractor” and “vendor” are used interchangeably herein.

RFPs each year for a wide range of services and vendors, and it routinely has several RFPs ongoing in various stages at any given time (APPX V4.0975 ¶ 3).

II. The TPA Contract is a Key Contract to the Plan's Operations

Among the Plan's contractors is a third-party administrator that provides administrative services to support the Plan's operations. The TPA contract is one of the major contracts entered into periodically by the Plan. (APPX V4.0876 ¶ 4; APPX V4.0930 ¶ 7). Services provided by the TPA include providing a network of healthcare providers, processing and paying bills (called "claims") from providers for care provided to members, coverage determinations, appeals of denied benefits, claims review, and providing call center services for members and providers. (*See generally* RFP Section 5.1).

Before the RFP at issue in this case, the Plan had conducted procurements for TPA services via competitive RFPs on numerous occasions over several decades, most recently in 2016 and 2019. Prior to the RFP issued in 2022, Blue Cross was awarded the Plan's TPA contract in a number of consecutive RFPs and had served as the Plan's TPA almost continuously for more than 40 years. (APPX V4.0876 ¶ 6)

III. The Plan Has Wide Latitude in Procurements

The Plan's Executive Administrator is authorized to contract with third parties as needed to carry out his or her responsibilities. N.C. Gen. Stat. § 135-48.23(c). Certain contracts worth over \$1 million must be submitted for review by the North Carolina Attorney General or his designee, and all contracts over \$3 million (like the TPA contract) must be approved by the Plan's Board of Trustees. N.C. Gen. Stat. § 135-48.33.

The Plan's procurement authority is necessarily flexible. Neither the Department nor the Plan has adopted regulations for its contracting activities. (APPX V4.0876 ¶ 5). Although some of the Plan's contracting activities are subject to Department of Administration contracting

procedures pursuant to North Carolina General Statutes Chapter 143, Article 3, other contracts—including the TPA contract—are exempt from those procedures pursuant to General Statutes Section 135-48.34.⁴ (APPX V4.0876 ¶ 5). Therefore, no statutes or administrative rules establish procedures for the RFP. (*Id.*).

Although the Plan has an internal contract procurement policy and procedure (SHP-POL-2001-SHP), the policy is not a rule and is not mandatory. Instead, the policy is a guideline to promote continuity in procurements. The policy is generally followed, but the Plan has discretion to deviate from the policy when circumstances warrant. (APPX V1.0001-.0011; APPX V4.0884 ¶ 9; APPX V3.0414-.0415; APPX V3.0371-.0372).

IV. The RFP Was Issued According to Schedule

The existing TPA contract with Blue Cross (the “2019 TPA contract”) resulted from a 2019 RFP. It has a 3-year term (January 1, 2022, through December 31, 2024) with two optional one-year extension periods. Around April 2022, having run into a number of problems with Blue Cross’s performance, the Plan leadership and the Treasurer decided not to exercise the optional renewals in the 2019 TPA contract. (APPX V4.0885 ¶ 11). To have a new TPA contract ready by the expiration of the 2019 TPA contract on December 31, 2024, as it had done in the past, the Plan elected to put the TPA contract out for bids⁵ again in the first contract year (2022) to obtain more favorable contract terms for the Plan. (APPX V4.0885-.0886 ¶¶ 11-12, 14; APPX V3.03441).

The Plan works on a calendar year basis, and the implementation of a TPA contract typically takes about two years after the contract is awarded. Thus, if the Plan did not exercise the optional renewals in the 2019 TPA contract, an RFP needed to be issued and a new contract

⁴ See RFP § 3.1, pp. 21-22.

⁵ In competitive contract procurements, including RFP processes, multiple entities can submit proposals (also called “bids”) to the procuring entity, which decides which, if any, of the proposals to accept. Entities submitting proposals are referred to as “vendors” or “bidders.”

awarded by the end of 2022 to allow two years for implementation of the new contract before the end of the 2019 TPA contract in December 2024. (APPX V3.0387). It is not unusual for the Plan to conduct procurements far in advance, because of the large number of procurements that must be managed, limited staff to conduct procurements, and long implementation periods. (APPX V4.0886 ¶ 13).

The decision to put the TPA contract out for bids without exercising the optional renewals did not mean that Blue Cross could not or would not be awarded the next TPA contract. In fact, illustrating the Board's and the Treasurer's usual long-term planning, the last two TPA contract procurements (which both resulted in a contract award to Blue Cross) were conducted during the first year of Blue Cross's prior TPA contract, which had a three-year term and optional renewal periods that were not exercised. (APPX V4.0886 ¶ 14; APPX V3.0441).

V. The Plan Designed the RFP as Part of a Broader Contracting Modernization Effort

In late 2021, independent of the RFP, Dee Jones, the Plan's Executive Administrator, directed Kendall Bourdon, the Plan's Director of Contracting and Compliance, to modernize the Plan's contracting processes, including eliminating narrative responses to the minimum requirements and technical requirements in the Plan's RFPs⁶ and instead requiring binary "confirmed" or "does not confirm" responses. (APPX V4.0876 ¶ 7).

Bidders' responses to minimum requirements and technical requirements in RFPs become part of the resulting contract between the Plan and the vendor. (APPX V4.0876-.0877 ¶¶ 8-9). Minimum requirements and technical requirements in previous RFPs described the obligations the Plan required or desired and asked open-ended questions, allowing the vendor to describe how the

⁶ RFPs generally include both minimum requirements and technical requirements. Minimum requirements are those requirements that are essential to the Plan. Generally, technical requirements are not absolutely essential, but are desired by and important to the Plan. (APPX V4.0931 ¶ 10).

vendor would meet the Plan's requirements and any limitations on its ability to do so. The resulting proposals were consistently long narrative discussions with subjective, contradictory, or vague language, and they included voluminous, time-consuming, and unhelpful attachments that the Plan's evaluation committee had to review and assess. (APPX V4.0877 ¶ 10).

In addition, competing vendors frequently responded to the same requirements differently, and included different forms of supporting information, requiring subjective judgments as to whether and to what extent each vendor met each requirement. As a result, evaluating and scoring RFPs was extremely time consuming for the Plan's small staff, significantly reducing their ability to meet other responsibilities. Some staff became reluctant to participate on evaluation committees. The necessity of parsing narrative responses also made reaching consensus difficult, introduced the potential for bias and subjectivity, and made it difficult to ensure that competing proposals were evaluated fairly and consistently. (APPX V4.0877-.0878 ¶¶ 11-12).

Further, the Plan faced multiple issues and disputes after prior contracts were awarded when contractors (including Blue Cross) resisted performing contract requirements by relying on equivocal, subjective, or vague language in their RFP narrative responses. (APPX V4.0878 ¶ 13).

Consequently, the goals of the modernization effort for RFPs included:

- Improving objectivity in evaluating and scoring RFP responses, to ensure fairness and consistency;
- Disallowing equivocation and subjectivity in RFP responses that vendors could use to weaken their contractual obligations;
- Simplifying and shortening the RFP evaluation process, reducing the time commitment by Plan staff serving on the evaluation committee;
- Reducing difficulty in parsing subjective narrative responses and stress on the evaluation committee seeking to reach consensus; and
- Reducing reluctance of Plan staff to serve on evaluation committees.

The Plan's leadership implemented a new RFP format in which the Plan's requirements were stated, and vendors could choose only "confirm" (vendor agrees to meet) that requirement or "does not confirm" (vendor does not agree to meet) that requirement. Vendors would not be asked *or allowed* to respond with narrative language that could undermine or complicate their responses. (APPX V4.0878 ¶ 15).

The Plan leadership decided that it was acceptable to forego vendors' written explanations of how the vendor would meet requirements. The Plan's contracts typically include an implementation period before the contract term begins during which the Plan's staff and vendors work collaboratively to ensure that all contract requirements are met. Further, because the RFP responses are binding contract terms, the vendor assumes responsibility to meet each requirement that it confirms, and the Plan can exercise contractual remedies if the vendor ultimately cannot meet the obligations it assumed. Experience has shown that narrative descriptions of how requirements will be met are not always effective in preventing nonperformance. (APPX V4.0879 ¶¶ 16-18).

VI. The Plan Designed a Reasoned Scoring Methodology for the RFP

The RFP was designed and drafted by the Plan staff, with input from its actuarial services contractor, the Segal Company ("Segal"), between approximately April and August 2022. (APPX V4.0886 ¶ 15). The RFP was comprised of three primary components: minimum requirements (requirements every bidder must agree to meet to be considered for the contract), technical requirements (things the Plan wanted bidders to agree to do but to which a bidder could say "not confirm" without automatic disqualification), and a cost proposal (a section that looked at the financial implications of the bid in three components: network pricing ("Claims Repricing"), administrative fees ("Fees"), and network pricing guarantees ("Guarantees")). Each of these components is described in more detail below.

The Plan leadership that participated in the design and drafting of the RFP, including Dee Jones, Caroline Smart, Kendall Bourdon, and Matt Rish, had all been involved with numerous earlier RFPs for the Plan, including at least one prior TPA RFP. (APPX V4.0884 ¶ 6; APPX V4.0915 ¶ 4; APPX V4.0864 ¶ 6; APPX V4.0931 ¶¶ 8-9). Dee Jones, in particular, had significant experience with RFPs. She had previously served as Chief Operating Officer at the North Carolina Department of Administration where the State’s Chief Procurement Officer reported to her. (APPX V4.0886 ¶ 16; APPX V3.0381),

Because the TPA contract is one of the Plan’s largest contracts, the design and drafting of the RFP was a big undertaking for the Plan. It required hundreds of hours of collaborative work from numerous Plan staff and consultants from Segal over a period of approximately five months between April and August 2022. The RFP document and its various attachments went through numerous drafts and revisions by groups of Plan employees and Segal personnel. Dee Jones had overall responsibility for the RFP, but the design and drafting were a collective effort and generally based on consensus among the experienced Plan leadership team and Segal consultants involved. (APPX V4.0887 ¶ 18; APPX V4.0864 ¶ 8).

The RFP provided that proposals would be submitted by bidders and evaluated in two phases. First, minimum requirements proposals were due by September 26, 2022. Vendors that met the minimum requirements were notified by September 29, 2022, and allowed to submit technical proposals and cost proposals by November 7, 2022. Any vendor who did not meet all the Minimum Requirements would be disqualified from further consideration. (APPX V4.0887 ¶ 19; RFP § 2.6.1).

The second phase included a technical proposal and cost proposal. The technical proposal consisted of 310 “requirements” or services the Plan wanted each vendor to provide. Each of the

technical requirements followed the modernized format in which bidders could only confirm or not confirm each requirement. Narrative responses were not permitted. (*See* APPX V1.0032-.0078; RFP, Attachment L, p. 118; APPX V4.0887 ¶ 20).

The cost proposal component required bidders to submit a series of attachments with pricing data (based on reimbursement rates agreed-upon between the vendor and healthcare providers for care provided to Plan members), provider network data, the vendors' proposed administrative fees and network pricing guarantees, and other information. (*See* RFP Attachment A, pp. 81-85). It was comprised of three components that were to be scored separately (described below) and combined into a total cost proposal score. (*Id.*).

Segal is the Plan's actuarial services vendor. As part of those services, it provided assistance and support for the RFP. Segal is an industry expert in public health plan procurements. Its primary responsibilities with respect to the RFP were to design the cost proposal component, manage and provide data to the bidders for their use in part of the cost proposal, and evaluate and score the bidders' cost proposals. (APPX V4.0886-.0887 ¶ 17; APPX V4.0918 ¶ 15; APPX V3.0548).

Segal has served as a contractor for the plan for approximately fourteen years, and has assisted the Plan in numerous RFPs, including several TPA RFPs. (APPX V4.0918 ¶ 14). Segal's lead actuary for the State Health Plan had also assisted the Plan with TPA RFPs while employed with another consulting firm before joining Segal. (APPX V3.0743). Steve Kuhn led Segal's work on the cost proposal for the RFP. He has been employed at Segal for over 20 years, serves as a consultant to numerous state health plans, and has worked on dozens of RFPs in his career. (APPX V4.00899 ¶ 5; APPX V3.0467-.0468).

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

- The technical proposal and cost proposal would each receive 50% of the weight in the final score.
- The technical proposal would be scored on a 310-point scale divided into 11 technical areas. The RFP stated that the bidders would then be ranked, with the highest-ranked technical proposal(s) receiving the most points (i.e., the highest-ranked cost proposal out of three bidders would receive three points, and the lowest-ranked would receive one point).
- Cost proposals would be scored using a 10-point scale, based on three components:⁷
 - Claims Repricing – up to 6 points
 - Fees – up to 2 points
 - Guarantees – up to 2 points
- Cost proposals would then be ranked, with the highest-ranked cost proposal(s) receiving the most points.

(APPX V4.0888 ¶ 22; RFP § 3.4, pp. 23-25).

VII. The Plan Allowed Bidders’ Opportunities for Feedback on RFP

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

⁷ For consistency and brevity, the following defined terms will be used throughout to refer to the three components of the cost proposal pursuant to Section 3.4(c) of the RFP: “Claims Repricing” will refer to the evaluation and scoring of network pricing under Section 3.4(c)(1), which was scored on the basis of a claims repricing exercise; “Fees” will refer to the evaluation and scoring of Administrative fees pursuant to Section 3.4(c)(2), and “Guarantees” will refer to the evaluation and scoring of pricing guarantees pursuant to Section 3.4(c)(3).

expected bidders, including Blue Cross, that an RFP for the TPA contract would be issued. The Plan also initiated meetings with each bidder to discuss the upcoming RFP. Blue Cross's pre-RFP meeting was held in June 2022 and was attended by Roy Watson (Blue Cross's vice president responsible for the relationship with the Plan) and Aimee Forehand (associate vice president for Blue Cross's State Health Plan segment). (APPX V4.0889-.0890 ¶ 26; APPX V4.0865-.0866 ¶ 13).

The Plan's intent for the pre-RFP meetings was to educate the vendors on the changes to the RFP from prior iterations and to receive feedback that would help the Plan identify opportunities for improvement before finalizing the RFP. (APPX V4.0866 ¶ 14; APPX V3.0344). All bidders were told about the modernized RFP format at the meetings and were explicitly advised that narrative responses would not be allowed. (APPX V4.0881 ¶ 25; APPX V4.0866 ¶ 14; APPX V3.0388, .0392). Bidders were invited to ask questions and give their input on the RFP process. No bidder objected or expressed any concerns, and some bidders said the new format was great and much easier than a narrative format. (APPX V4.0889-0890 ¶ 26; APPX V4.0866 ¶ 14; APPX V3.0388).

Follow-up meetings were also available on request to address bidders' questions, concerns, or suggestions. Although a follow-up meeting was requested and held with at least one vendor, no bidder raised any concern about or objection to the modernized format of the RFP in any follow-up meeting. (APPX V4.0866 ¶ 15).

The RFP was publicly posted and made available to bidders on August 30, 2022. Following the posting, a "silent period" ensued, during which vendors generally were not permitted to communicate with the Plan about the RFP (except for clarifications requested by the

Plan or other communications initiated by the Plan) until the contract award. (APPX V4.0866 ¶ 16; RFP, Attachment B, p. 88, § 16).

On September 1, 2022, the Plan held a remote meeting with all potential bidders after the RFP was posted, which is standard practice for the Plan. The call was attended by the Treasurer and Kendall Bourdon on behalf of the Plan. (APPX V4.0867 ¶ 17; APPX V3.0347). On this call Ms. Bourdon again explained the modernized, non-narrative format and invited comments and questions. No bidders objected or raised any concerns about the RFP during this call. (APPX V4.0867 ¶ 17).

In addition, Sections 2.4 and 2.5 of the RFP allowed two periods for bidders to submit written questions regarding the RFP, after it was posted and before proposals were due. Under Section 2.3, bidders were urged and cautioned to raise any issues, exceptions, or requests to modify any of the RFP's terms, conditions, or components through this question and answer process. If the Plan determined that any changes to the RFP would be made as the result of the bidder's questions, it would communicate the changes through an addendum. (RFP pp. 10-13; APPX V4.0890 ¶ 27; APPX V4.0867 ¶ 18).

Various questions were submitted by bidders during the question and answer period, all of which were timely responded to by the Plan in addenda, pursuant to Section 2.5 of the RFP. (APPX V4.0890 ¶ 28; APPX V1.0079-.0090; APPX V2.0263-.0274). However, none of the bidders raised any concerns or objections to the non-narrative format during the question periods. (APPX A4.0881-.0882 ¶ 27; RFP § 2.3, pp. 10-11).

VIII. The Plan Conducted a Fair and Reasoned Review of Proposals

The Plan selected an Evaluation Committee for the RFP consisting of seven voting members from the Plan's staff ("Evaluation Committee"). They were assisted by four non-voting members, including the Plan's Executive Administrator, actuary, and two in-house counsel. An

additional four members of the Plan’s contracting and compliance organization also advised and assisted the Evaluation Committee. (APPX V4.0867 ¶ 19; APPX V4.0886 ¶ 29; APPX V1.0026).

Minimum requirements proposals were submitted by Blue Cross, Aetna, and UMR in response to the RFP. The Evaluation Committee met on September 27 and September 30, 2022, and determined that all three bidders met the minimum requirements, as documented in the Evaluation Summary prepared by the Plan. (APPX V4.0867 ¶ 20; APPX A4.0891 ¶ 30; APPX V1.0138).

Technical proposals and cost proposals were submitted by all three bidders in the second phase, on November 7, 2022, and were evaluated and scored as set forth in RFP section 3.4. (APPX A4.0868 ¶ 21; APPX V4.0891 ¶ 31).

A. The Technical Proposals Were Scored According to the RFP Based and on the Specialized Knowledge and Expertise of the Plan

The Evaluation Committee reviewed and scored the technical proposals on November 8, 2022, consistent with the RFP. (APPX V4.0891 ¶¶ 31-32; APPX V1.0137-.0142). Aetna and UMR both confirmed all 310 technical requirements and were awarded 310 points. However, Blue Cross confirmed only 303 requirements, did not confirm seven, and therefore received 303 points.

Pursuant to RFP section 3.4(b), Blue Cross was ranked lowest, and received one point out of three, while Aetna and UMR, who tied with 310 points each, both received three points out of three. (APPX V4.0868 ¶¶ 22-23; APPX V4.0891 ¶ 33).

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

B. The Cost Proposals Were Scored According to the RFP Based on the Specialized Knowledge and Expertise of the Plan and Its Consultants

Segal was primarily responsible for the evaluation and scoring of the cost proposals. (APPX V2.0270-.0303; APPX V3.0581-.0582). Segal evaluated the cost proposals in a preliminary analysis and later in a final cost proposal analysis, which took into account clarifications and a request for best and final offers (“BAFOs”), as described further below.⁸

1. Claims Repricing Scores

Network pricing, which was worth 60% of the cost proposal score (or six points), was scored on the basis of the Claims Repricing exercise by the bidders. (RFP § 3.4(c)(1), pp. 24-25; RFP Attachment A § 1.2.1, p. 83). In that process, each bidder was provided with a dataset of actual claims and asked to “reprice” the claims as if they had been incurred using the bidder’s agreed-upon reimbursement rates with its network of healthcare providers (or its out-of-network rules). (APPX A4.0916 ¶ 8). This process is meant to give the Plan a fair idea of the cost it will pay for the medical care received by its members. For that evaluation to be meaningful, the Plan needs to compare the bidders’ network discounts (sometimes called “pricing”) on an “apples-to-apples” basis. (APPX V3.0518-.0520). However, after the submission of the cost proposals, Segal noticed significant variance among the bidders’ pricing. This variance made Segal concerned that the bidders’ repricing methodologies were not apples-to-apples and would not allow for a fair comparison (APPX V4.0902 ¶¶ 19-20; APPX V3.0517).

At Segal’s recommendation, the Plan issued a series of clarifications to the bidders between November 10 and November 28, 2022, to clarify the basis for bidders’ Claims Repricing exercise

⁸ The Evaluation Committee voted to request “best and final offers” (“BAFOs”) from all bidders in accordance with the RFP schedule and as allowed by RFP Section 3.3(a). The request for BAFOs invited all bidders to improve their proposed Fees and Guarantees. (APPX V4.0900 ¶ 8; APPX V3.0599-.0600; APPX V1.0133-.0136). It is common for the Plan to request at least one BAFO from bidders during an RFP process. (APPX V4.0919 ¶ 20; APPX V3.0415, .0429).

and ensure that they, and their network discounts, were being compared fairly. (APPX V4.0902-.0903 ¶¶ 19-21; APPX V3.0516, .0520; *see, e.g.*, APPX V2.0250-.0262; APPX V2.0286-.0289; APPX V2.0304-.0305). On November 17, 2022, partway through these clarifications, Segal presented a preliminary cost proposal analysis to the Plan (APPX V2.0236-.0249) that recommended further clarifications to the vendors to confirm the Claims Repricing.

Ultimately, Segal made adjustments to Blue Cross’s and UMR’s Claims Repricing results. The instructions in the RFP told each bidder to reprice the claims using the bidder’s “contracts in place, or near-future contract improvements bound by the letters of intent, at the time of the repricing.” (RFP pp. 24-25). The intent was to capture pricing based on current contracts in place at the time of the exercise or improvements conditioned on the bidder being awarded the TPA contract. (APPX V4.0901-.0902 ¶ 16). The Plan did not expect or intend for bidders to assume increases in those charges that had not been reduced to a contract yet, since that assumption could artificially inflate a bidder’s discounts compared to other bidders. (*See* APPX V4.0902-.0903 ¶¶ 17-18, 22).

In the clarifications, both Blue Cross and UMR confirmed what Segal suspected—that they had assumed future increases in billed charges, contrary to the RFP’s instructions and improperly inflated their network discounts. (*See* APPX V2.0296; APPX V2.0250-.0262). To compare them to Aetna—who assumed no increases as instructed—Segal adjusted Blue Cross’s and UMR’s results to the actual discount levels revealed in the clarifications. (APPX V4.0902-.0904 ¶¶ 20-26; APPX V3.0525-.0526; APPX V2.0286-.0289; APPX V2.0304-.0305).

After these adjustments, both Blue Cross and Aetna received six out of six points for network pricing. Aetna’s network pricing (total claims cost of \$9.639 billion) was slightly better

than Blue Cross's (\$9.684 billion), but Blue Cross's pricing was within 0.5%, and therefore both received six points as stated in RFP Section 3.4(c)(1). (APPX V2.0294).

2. Fees Scoring

The Fees component, worth two points, evaluated the amount of fees each bidder proposed charging the Plan for its services. Blue Cross's administrative fees for the three-year contract term were lowest, and Aetna's were next lowest, followed by UMR with the highest fees. Blue Cross therefore received two points, Aetna one point, and UMR zero points, consistent with RFP Section 3.4(c)(2). (APPX V4.0900 ¶ 11; APPX V2.0295).

3. Guarantees Scoring

The Guarantees component, worth two points, compares the value of pricing guarantees proposed by the bidders. Each bidder proposed certain targets which were secured by an amount the bidder put "at risk" if it failed to meet its guarantee target. (APPX V4.0917 ¶ 12).⁹ Segal analyzed the relative value of the Guarantees based on each bidder's proposed guarantee targets and the amounts each placed at risk, consistent with RFP Section 3.4(c)(3). Segal conducted a detailed comparative analysis as shown in its cost proposal analysis. (APPX V2.0296-.0297). Accordingly, Segal determined that UMR's Guarantees provided the most value (awarded two points); Aetna's Guarantees were second (awarded one point), and Blue Cross's Guarantees provided the least value (awarded zero points). (APPX V4.0900-.0901 ¶ 12; APPX V2.0296-.0297).

⁹ A guarantee target is a specific value the bidder is offering to achieve for the plan (e.g., a percentage discount from billed charges of at least 50% or a claims trend increase of no greater than 5%). (APPX V4.0904-0905 ¶ 27). The amount at risk is the amount of the bidder's own money the bidder is willing to repay to the plan if it does not meet its guaranteed targets. For TPA contracts the amount at risk is typically a percentage of the bidder's administrative fee. (*Id.*).

4. Total Cost Proposal Scores

After clarifications and the bidders’ BAFOs were received and evaluated, Segal completed its final analysis of the cost proposals on November 29, 2022, as described above. (APPX V4.09009; APPX V2.0290-.0303). Combining the scores for all three components of the cost proposal, Blue Cross and Aetna tied at 8 points out of 10, while UMR received seven points. Pursuant to RFP Section 3.4(c), UMR was ranked lowest, receiving one point out of three, while Aetna and Blue Cross, who tied with 8 points each, both received three points out of three. (APPX V4.0901 ¶ 13; APPX V2.0293).

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

C. The Plan Reasonably Combined the Technical and Cost Proposal Scores to Obtain a Final Score for Each Bidder

Segal presented its final cost proposal analysis to the Evaluation Committee on November 30, 2023. (APPX V4.0901 ¶ 14; APPX V2.0290-.0303). After discussion to ensure it understood Segal’s evaluation, the Evaluation Committee agreed with and accepted Segal’s evaluation and scoring. (APPX V4.0868 ¶¶ 24-25; APPX V4.0892 ¶ 35; APPX V1.0140-.0142).

After giving the technical proposals and cost proposals equal weight as stated in Section 3.4(a) of the RFP, Aetna received the highest final score of 6, and Blue Cross and UMR tied at 4. (APPX V4.0868-.0869 ¶ 26; APPX V4.0892 ¶ 36; APPX V1.0142).

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

IX. Board of Trustees Reviewed the Scoring and Approved the Plan’s Recommendation

Based on the evaluation and scores described above, the Evaluation Committee unanimously voted to present all three proposals to the Plan’s Board of Trustees for their consideration at the Board’s December 14, 2022, meeting, with a recommendation to award the TPA contract to the bidder that received the most points—Aetna. The Evaluation Committee’s documented its recommendation in a memo dated December 14, 2022. (APPX V4.0869 ¶ 27; APPX V4.0892 ¶ 37; APPX V1.0012-.0025). The Evaluation Process was also documented in detail in an internal Plan memorandum. (APPX V4.0892 ¶ 37; APPX V1.0137-.0142).

At the direction of the Treasurer, and because the Evaluation Committee voted to present all three proposals to the Board of Trustees, all three proposals were also submitted to the Department of Justice for review to comply with General Statutes Section 135-48.33(b), which requires approval of certain contracts worth more than \$1 million. All three proposals were subsequently approved by the Department of Justice. (APPX V4.0892-.0893 ¶ 38; APPX V3.0360).

All three proposals were presented to the Plan’s Board of Trustees in executive session at the Board’s December 14, 2022, meeting, which was attended by the Plan’s Executive Administrator and other staff, including leadership. Kendall Bourdon described the contract modernization strategy and process, the development of the RFP, and the evaluation and scoring of the RFP in a PowerPoint presentation. (APPX V1.0012-.0025). Ms. Bourdon also presented the Evaluation Committee’s recommendation. The presentation and discussion were also

documented in minutes from the executive session. (APPX V4.0869-.0870 ¶ 29; APPX V4.0893 ¶ 39; APPX V1.0116-.0117).

After Ms. Bourdon's presentation, the Trustees engaged in a robust discussion of the proposals with extensive questions from the Trustees to the Plan's leadership. Following this discussion, the Board unanimously voted to award the TPA contract to Aetna. (APPX A4.0870 ¶ 30; APPX V4.0893 ¶ 39; APPX V1.0116-.0117). Pursuant to General Statutes Section 135-48.20, the Treasurer serves as chair of the Board of Trustees, but only votes in the event of a tie. Because the vote was unanimous, the Treasurer did not vote on the contract award. (APPX V4.0870 ¶ 30).

X. Despite a Debrief Meeting to Understand the Plan's Reasoning, Blue Cross Submitted a Bid Protest

All bidders were notified of the outcome of the RFP, and debrief meetings were subsequently held with both unsuccessful bidders on December 15 and 16, 2022. Debrief meetings were part of an initiative the Plan had previously implemented for all vendors to walk them through the RFP process, the evaluations and the scoring, and to invite questions so unsuccessful bidders would better understand the outcome and the basis for the Plan's decision. (APPX V4.0870 ¶ 31, APPX V3.0372).

Blue Cross's debrief meeting was held on December 16, 2022, and was attended by Roy Watson and Aimee Forehand for Blue Cross; and by Kendall Bourdon, Dee Jones and Ben Garner on behalf of the Plan. Ms. Bourdon presented a slide deck at the meeting explaining the evaluation and scoring, including all the scoring areas in which Blue Cross lost points. (APPX V4.0870 ¶ 32; APPX V1.0118-0132). While Blue Cross expressed disappointment, its representatives voiced no disagreement or belief that the scoring was inaccurate or mistaken at the debrief meeting. (APPX V4.0870 ¶ 32).

Blue Cross requested a protest meeting in writing on January 12, 2023, pursuant to RFP Attachment B, Section 15 (Protest Procedures). (RFP pp. 87-88). In its request, Blue Cross made many of the same arguments that were later made in its Petition for Contested Case Hearing—it disagreed with the design of the RFP and the evaluation of the proposals, and it asked that the contract award to Aetna be rescinded and the contract awarded to Blue Cross (or alternatively that a new procurement be conducted). (APPX V4.0871 ¶ 33; APPX V1.0220-0235 (Blue Cross Req. for Protest Meeting)).

The Plan denied Blue Cross’s request for protest meeting by letter dated January 20, 2023, which was executed by the Plan’s current Executive Administrator, Sam Watts, who succeeded Dee Jones on December 19, 2022. (APPX V4.0871 34; APPX V1.0143-.0153 (Denial of Req for Protest Meeting)). The denial letter explained that the Plan had reviewed Blue Cross’s request for a protest meeting and responded in detail to the arguments raised by Blue Cross as to the basis for the basis and authority for the Plan’s decision. Consistent with the protest procedures in the RFP, the denial letter explained the Executive Administrator’s determination that Blue Cross’s protest had no merit and that a protest meeting would serve no purpose. (APPX V4.0871¶ 35; APPX V1.0143-.0153).

XI. The Plan is Diligently Focused on Implementing the Aetna TPA Contract

The TPA contract with Aetna was executed by the Executive Administrator and the Treasurer on December 14, 2022. Pursuant to the contract, implementation began immediately. As of today’s date, the Plan staff has been working diligently with Aetna for almost a year to prepare and develop the necessary systems, processes, and capabilities for Aetna to successfully administer the Plan’s operations as its TPA. That effort is ongoing and will continue until the end of the current TPA contract on December 31, 2024. (APPX V4.0937 ¶ 37).

The TPA contract implementation has required and will continue to require approximately eight members of the Plan’s staff to devote almost all their working time to the implementation. The Plan has also incurred significant expense to integrate Aetna with other Plan vendors, which is expected to total approximately \$2 million through the completion of the implementation. The Plan’s staff time and expense do not include any of the manpower, time, and expense invested by Aetna in the implementation. (APPX V4.0937 ¶ 38).

LEGAL STANDARD

Summary judgment must be granted “forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that any party is entitled to a judgment as a matter of law.” N.C. R. Civ. P. 56(c). “A fact is material if it would constitute or would irrevocably establish any material element of a claim or defense.” *Bernick v. Jurden*, 306 N.C. 435, 440, 293 S.E.2d 405, 409 (1982) (cleaned up). A purported issue as to a material fact is only deemed “genuine” if it “may be maintained by substantial evidence.” *Id.* “Substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion and means more than a scintilla or a permissible inference.” *DeWitt v. Eveready Battery Co.*, 355 N.C. 672, 681, 565 S.E.2d 140, 146 (2002) (internal citations and quotations omitted). “Summary judgment is not a disfavored procedural shortcut; rather it is an important procedure designed to secure the just, speedy, and inexpensive determination of every action.” *Optima Family Care et al. v. N.C. Dep’t of Health & Human Servs.*, 19 DHR 01959, 02032, and 02194 at ¶ 53 (N.C. O.A.H. Sept. 9, 2020) (granting summary judgment to government in procurement challenge) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 327 (1986); *Est. of Williams v. Pasquotank Cty. Parks & Rec. Dep’t*, 366 N.C. 195, 198, 732 S.E.2d 137, 140 (2012)) (unpublished) (cleaned up) (copy included in Appendix Volume 1 at APPX V1.0154-.0219).

A respondent may meet its summary judgment burden in one of three ways. A respondent can prove that an essential element of the petitioner’s claim is nonexistent. A respondent can also show that the petitioner cannot produce evidence to support an essential element of his claim. Finally, a respondent can show that the petitioner cannot overcome an affirmative defense which bars the claim. *See Rich v. Shaw*, 98 N.C. App. 489, 490, 391 S.E.2d 220, 221-22 (1990). “Once the moving [respondent] meets its burden, then the non-moving [petitioner] must produce a forecast of evidence demonstrating that the [non-moving petitioner] will be able to make out at least a prima facie case at trial.” *Purvis v. Moses H. Cone Mem. Hosp. Serv. Corp.*, 175 N.C. App. 474, 477, 624 S.E.2d 380, 383 (2006). “In deciding the motion, all inferences of fact must be drawn against the movant and in favor of the party opposing the motion.” *Id.* at 476, 624 S.E.2d at 383 (cleaned up). “The party moving for summary judgment has the burden of establishing the lack of any triable issue.” *Id.* at 477, 624 S.E.2d at 383.

Where a petitioner challenges an agency action under General Statutes Section 150B-23(a), as Blue Cross has done here, it “must establish facts which establish that the agency in question ‘deprived the petitioner of property . . . or has otherwise substantially prejudiced the petitioner’s rights and (1) exceeded its authority or jurisdiction; (2) acted erroneously; (3) failed to use proper procedure; (4) acted arbitrarily or capriciously; or (5) failed to act as required by law or rule’” to defeat an agency’s motion for summary judgment. *Pamlico-Tar River Found. v. N.C. Dep’t of Env’t & Nat. Res.*, 2015 WL 3813960, 13 HER 17938 (N.C. O.A.H. March 20, 2015) (quoting N.C. Gen. Stat. § 150B-23(a)).

At summary judgment, the ALJ must apply the presumption that “the agency acted in good faith,” with the burden on the petitioner “to prove otherwise.” *Optima Family Care* at ¶ 61 (APPX V1.0173); *Richardson v. DPI Licensure Section*, 199 N.C. App. 219, 223-24, 681 S.E.2d 479, 483

(2009). If Blue Cross cannot produce a genuine issue of material fact to overcome this presumption, summary judgment is proper. *Optima Family Care* at ¶ 61 (APPX V1.0173). When considering whether to grant summary judgment, “a reviewing court does not have authority to override decisions within agency discretion when that discretion is exercised in good faith and in accordance with law.” *Id.* at ¶ 59 (quoting *Lewis v. N.C. Dep’t of Human Res.*, 92 N.C. App. 737 (1989)) (APPX V1.0172). It is further required at summary judgment to give “due regard to the demonstrated knowledge and experience of the agency with respect to facts and inferences within the specialized knowledge of the agency.” *Id.* at ¶ 56 (quoting N.C. Gen. Stat. § 150B-34(a)) (APPX V1.0171). These presumptions owed to the Plan “place[] a heavy burden on the party challenging the validity of public officials’ actions to overcome [them] by competent and substantial evidence” at summary judgment. *Id.* at ¶ 61 (APPX V1.0173); *see also Strickland v. Hedrick*, 194 N.C. App. 1, 10, 669 S.E.2d 61, 68 (2008).

When a petitioner claims that the agency’s decision was arbitrary and capricious, this burden becomes even harder to overcome. *See Town of Leland v. N.C. Dep’t of Env. Quality*, 2017 WL 7052568, 17 HER 03759, COL 4 (N.C. O.A.H. Dec. 21, 2017). Indeed, “with regard to its claims that the agency acted arbitrarily or capriciously, the [p]etitioner cannot meet its burden of showing a genuine issue as to any material fact by showing a disagreement with the agency position. It must present facts that [the agency’s] decision was ‘whimsical’ or made in ‘bad faith.’” *Id.* (citing *ACT-UP Triangle v. Comm’n for Health Servs.*, 345 N.C. 699, 707, 483 S.E.2d 388, 393 (1997)). Mere disagreement with the Plan’s conclusions does not entitle a Petitioner to relief. *See Little v. Bd. of Examiners*, 64 N.C. App. 67, 69-70, 306 S.E.2d 534, 536-37 (1983) (holding that contradictory evidence or a difference of opinion with an agency does not lead to a conclusion

that the agency’s decision was arbitrary and capricious if the agency decision is supported by substantial evidence).

ARGUMENT

Most North Carolina state procurements are subject to significant statutory and regulatory procedures and requirements. *See* N.C. Gen. Stat. Ch. 143, Art. 3; 01 N.C.A.C. Ch. 5. But the General Assembly specifically exempted the Plan from these general requirements. N.C. Gen. Stat. § 135-48.34. Instead, the Plan has just a few discrete requirements with which it must comply. N.C. Gen. Stat. § 135-48.33.¹⁰ Otherwise, it has discretion to act within its statutory purpose: making available a state health plan for the benefit of eligible employees, retired employees, and certain dependents. *See* N.C. Gen. Stat. § 135-48.2; *Byrd v. Wilkins*, 69 N.C. App. 516, 519, 317 S.E.2d 108, 109 (1984) (“When discretionary authority is vested in [an administrative agency], the Court has no power to substitute its discretion for that of the [agency]; and, in the absence of fraud, manifest abuse of discretion or conduct in excess of lawful authority, the court has no power to intervene.”).

Blue Cross does not argue—and indeed there is no evidence—that the Plan violated any statutory requirements such that there could be any violation of Section 150B-23(a)(1), (2), (3), or (5). Nor are there any rules or binding policies that govern this procurement. (APPX V4.0885 ¶ 9; APPX V3.0414-.0415; APPX V3.0371-.0372). Instead, Blue Cross essentially argues that the award to Aetna (and the decisions that preceded it) were arbitrary and capricious.

¹⁰ These requirements are (1) approval by the Plan’s Board of Trustees if the contract exceeds \$3 million; (2) review of the contract by the Attorney General if the contract exceeds \$1 million; (3) contract language providing for audit rights by the Plan and the State Auditor; and (4) avoidance of cost plus percentage of cost contracts. N.C. Gen. Stat. § 135-48.33. Neither the Department nor the Plan has adopted rules that govern this process. (APPX A4.0876 ¶ 5).

Arbitrary and capricious are largely synonymous terms. *In re Housing Auth. v. City of Salisbury*, 235 N.C. 463, 468, 70 S.E.2d 500, 503 (1952). “An administrative ruling is deemed arbitrary and capricious when it is whimsical, willful, and an unreasonable action without consideration or in disregard of facts or law, without determining principle.” *Donnelly v. Univ. of N.C.*, 236 N.C. App. 32, 37, 763 S.E.2d 154, 158 (2014) (cleaned up). When an agency is engaged in a discretionary act, the terms denote an abuse of discretion. *In re Housing Auth.*, 235 N.C. at 468, 70 S.E.2d at 503. But as explained above and argued further below, the Plan made reasoned and considered decisions at each step of the RFP—from the design to the evaluation and award. While Blue Cross (or even the ALJ) might have reasonably made different decisions had it been charged with making the decision, that is not a basis to change the Plan’s decision. If a reasonable mind could accept the evidence as adequate to support the Plan’s conclusions, its decision must stand. *See, e.g., N.C. Dep’t of Env. & Nat. Res. v. Carroll*, 358 N.C. 649, 660, 599 S.E.2d 888, 895 (2004).

In its petition, Blue Cross contends that the Plan’s contract award decision was flawed in various way that it argues warrant reversal. As discussed below, there is no genuine issue of material fact as to any of these arguments.

I. Plan’s Evaluation of Network Access was Reasonable

In its Petition, Blue Cross alleges that the Plan judged network access “on only a pass-fail basis” (Pet. ¶ 46) and that its decision was erroneous, arbitrary, and capricious because the Plan did not score the bidders’ networks or measure disruption to the Plan’s members. (Pet. ¶¶ 45-52). However, there was no requirement that the Plan specifically score network access or disruption. (*See, e.g., APPX V4.0876* ¶ 5). Nevertheless, as described below, the evaluation of the bidders’ proposals took network access and disruption into account in a reasoned manner.

First, the RFP required each vendor to “provide a network that will support Plan Members residing in all 100 counties in North Carolina and throughout the United States.” (RFP p. 37). Because this was a minimum requirement, any vendor who could not confirm its ability to provide such a network would have been disqualified from further consideration. (RFP p. 37). All three bidders confirmed. (APPX V4.0891 ¶ 30; APPX V4.0867 ¶ 20).

Although the RFP’s cost proposal required each vendor to submit a network access report for its proposed provider network and stated that the Plan seeks “a broad provider network with the least disruption and with competitive pricing” (RFP pp. 81-82), nowhere did the RFP suggest that network access or disruption would be scored or that bidders’ networks would be directly compared. Section 3.4 of the RFP, which described the evaluation criteria and scoring, does not mention either network access or disruption. (*See* RFP pp. 23-25). That was not unusual. In past RFPs, the Plan has similarly asked for network access reports without scoring them. The Plan asks for the reports in case they are needed during the implementation period to understand any gaps in the provider networks that may exist. (APPX V4.0931 ¶ 11; APPX V3.0688-.0689).

Second, in this RFP, the Plan decided network access could be indirectly evaluated as part of the cost proposal rather than as a standalone criterion. It reasoned that any network disruption would be apparent in a bidder’s network pricing. (APPX V3.0689-.0690, .0725-.0726; APPX V1.0096-.0098). If a bidder’s provider network was inadequate, its network pricing would be significantly higher. (*Id.*). The Plan also expected the same bidders who participated in past RFPs to bid in response to this RFP. (APPX V3.0690). The Plan knew those bidders were all established national companies with broad provider networks. (*Id.*).

Segal’s evaluation of the bidders’ network pricing also calculated the percentage of all claims that would be in-network for each of the bidders—a measure of disruption. (APPX

V2.0294 (“assumed network utilization” column); APPX V3.0486-.0487, .0538). Segal calculated that 99% of Aetna’s claims would be in-network, only 0.4% lower than Blue Cross, the existing TPA. (APPX V2.0294). While not separately scored, this metric shows that there were no anticipated disruption issues with any bidder. (APPX V4.0909 ¶¶ 41-42). As Segal’s actuary put it, the in-network percentages for each bidder were “incredibly high” and “off the charts high in the network access study” with no meaningful difference between Aetna and Blue Cross. (APPX V3.0764-.0765; .0792).

The Plan’s approach adhered to the RFP. The RFP did not suggest that bidders would be compared or scored on their provider networks or disruption, and there is no legal requirement that the Plan do so. The Plan’s choice not to separately score network access or disruption was within its authority and was reasonable under the circumstances. As such, Blue Cross can show no Agency error under N.C. Gen. Stat. § 150B-23 with respect to network access or disruption.

II. The Plan’s Cost Proposal Scoring was Reasoned and Rational

As discussed above, the Plan scored the bidders’ cost proposals on three metrics: Claims Repricing, Fees, and Guarantees.¹¹ Blue Cross raises issue with each.

A. The Claims Repricing Scoring was Reasoned and Rational

1. No validation of the Claims Repricing Was Required

In its petition, Blue Cross contends that the Claims Repricing scoring was flawed because the Plan did not test the accuracy of the bidders’ self-reported pricing or discounts in the Claims Repricing exercise in the way Blue Cross desires. (Pet. ¶¶ 55-56). They also assert “[o]n information and belief” that Aetna’s network pricing in North Carolina is higher than Blue Cross’ and it was therefore a “significant error” to award Aetna and Blue Cross the same number of points

¹¹ Defined in Statement of Undisputed Facts, Section VI above.

on the Claims Repricing exercise. (Pet. ¶¶ 57-58). The problem is that Blue Cross merely speculates its pricing is superior, and such speculation is irrelevant because the Plan scored the claims repricing on the basis of the Claims Repricing exercise, consistently with the RFP, and there was no requirement that the claims repricing be scored differently.

As Aetna's corporate designee testified, Aetna based its repricing on the actual contracts it has with various providers adjusted prospectively for the effective date of the contract based on current information, using a model designed for this very purpose. (*See, e.g.*, APPX V3.0307-0310). It was validated by multiple constituencies within Aetna. (APPX V3.0309). Although one of Blue Cross' designated experts testified that he believed Aetna had overstated its discounts, he admitted that there are several accepted ways of repricing claims but did not know which method Aetna used.¹² (APPX V3.0621-.0628). There are multiple accepted methods for repricing claims in this context, with different assumptions and methodologies that can quantitatively affect the result. Consequently, the quantitative results of a claims repricing will vary depending on the method and assumptions used, and there is no single correct result. (APPX V4.0907-.0908 ¶ 36). Nor did Blue Cross's expert do the same exercise for Blue Cross using the same method he applied to Aetna's repricing, thus preventing an inference that Aetna's pricing was inferior to Blue Cross's under his "validation" method. (APPX V3.0616-.0620).

Nor is there any requirement that the Plan spend the extraordinary time and effort required to test the accuracy of the bidders' self-reported pricing or discounts using Blue Cross's expert's self-serving method. (*See, e.g.*, APPX V4.0876, .0880-.0881 ¶¶ 5, 24). It is not common practice to audit or validate vendors' claims repricing in health plan procurements. For large public health

¹² Regardless, Mr. Russo lacks the qualifications and expertise to draw that conclusion. As he testified, his analysis for this case was the first time he had ever performed a repricing exercise or evaluated a repricing exercise in the context of an RFP. (APPX V3.0629-.0630).

plan procurements like this one, a validation of the type suggested by Blue Cross is not practical, because it would require the Plan to attempt to reprice claims based on thousands or tens of thousands of proprietary contracts between the bidder and providers—contracts that are typically not available to the health plan or its consultants. (APPX V3.0907 ¶ 35; APPX V3.0495-.0496). Even if such an effort could be undertaken, it would not reliably validate the bidders’ own repricing, because of the variability in methods and assumptions used in claims repricing, noted above. (APPX V4.0907-.0908 ¶ 36).

For these reasons, the Plan has not validated Claims Repricing in past TPA RFPs; instead, it seeks clarification from the bidders if anything in the repricing exercise looks questionable. (APPX V4.0919 ¶ 19; APPX V4.0880-.0881 ¶ 23-24). Further, the winning bidder’s cost proposal would become a binding contract term for which the Plan has contractual remedies if the approved vendor breaches the agreement. (*See* APPX V4.0880 ¶ 23). Accordingly, in the exercise of its discretion, the Plan found no reason to depart from its prior practices regarding validation.

2. Segal’s adjustment of Blue Cross’s pricing was warranted and reasonable

In discovery, Blue Cross has also raised issues about the Plan’s adjustment of Blue Cross’s repricing discount. In the instructions to the repricing exercise, the RFP stated that the bidder should reprice historical claims by providing “the contracted allowed amount for each service . . . based on [the bidder’s] provider contracts in place, or near-future contract improvements bound by letters of intent.” (RFP § 3.4(c), pp. 24-25; RFP Attachment A § 1.2.1, p. 83). This language was intended to capture current network pricing and binding, agreed-upon pricing improvements in the event the bidder obtained the Plan’s TPA contract. (APPX V4.0901-.0902 ¶ 16; APPX V3.0490).

Because the Plan was trying to compare each bidder’s repricing on an equal basis, bidders were not directed or expected to assume or project future increases in *billed charges* (called “trending” billed charges). When the repricing results varied between bidders more than expected, Segal was concerned that variances in the bidders’ repricing methodologies would prohibit an apples-to-apples comparison. (APPX V4.0902 ¶ 18; APPX V3.0517, .0520). To attempt to confirm and correct this problem, Segal and the Plan sent the bidders a series of clarifications (as allowed by Sections 2.8(l) and 4.13(d) of the RFP) (RFP §§ 2.8(l) and 4.13(d)). (*Id.*). These clarifications asked for various pieces of information that would allow Segal to determine whether any bidders had assumed billed charge increases that artificially inflated its discounts:

Due to the lack of clarity in your responses, we require that the chart below be filled out in its entirety. Based on your prior responses, we prepopulated, to the best of our understanding, your levels in the appropriate row. If our interpretation is incorrect, please move those numbers to the appropriate position in the chart. All rows are to be populated with the discount increases attributed to the listed item. If the listed item is not considered in your submission, the discount should be the same as the line above. It is not acceptable to provide the same discount for all line items and indicate that the discount increase for all these items are combined together.

	In -Network Discount Accumulation	Example
2021 Claims Data using 2021 Contracts	51.2%	50.0%
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%
Current Letters of Intent (should <u>not</u> include assumed increases in billed charges)	54.0%	51.4%
Known Contract Improvements (should <u>not</u> include assumed increases in billed charges)	54.0%	52.5%
Assumed Increases in Billed Charges	57.8%	53.5%
Anticipated Contract Improvements	57.8%	54.0%
Other (please clarify)	57.8%	54.0%
Expected 2025 Discounts	57.8%	54.0%

(APPX V2.0253 (yellow highlighting reflects Blue Cross response)).

Aetna's response confirmed that its claims repricing had assumed no increases in billed charges, but Blue Cross's responses confirmed that it had. (APPX V4.0903 ¶ 22; APPX V2.0252-.0255). To create an apples-to-apples comparison, Segal informed Blue Cross that it was not to assume increases in billed charges, and requested additional information to quantify Blue Cross's discount without the assumed charge increases. (See APPX V2.0253-.0262). Blue Cross ultimately confirmed its current discount (without trending billed charges) was 52.7 percent. (APPX V2.0261-.0262). Segal intentionally and reasonably used this discount in its evaluation. (See APPX V4.0903-.0904 ¶¶ 23-26; APPX V2.0294, n.4). Taking that adjustment into account, Blue Cross's pricing was slightly higher than Aetna's, but received the same score (6 points) because Aetna's and Blue Cross's total claims cost were less than 0.5% apart, consistent with the stated scoring methodology). (APPX V4.0900 ¶ 10; APPX V2.0294).

There is nothing impermissible or unreasonable about this approach or Segal's analysis. The RFP allowed the Plan to seek clarifications when needed and provided that any clarifications become part of the bidder's response. (RFP §§2.8(l), 4.13(d), pp. 17, 31). Segal used the 52.7% discount that Blue Cross confirmed in its clarification, which excluded the improper assumption of increased billed charges, to ensure that all three bidders were compared fairly and apples-to-apples. That choice adhered to the language of the RFP and was necessary for a fair comparison of the proposals in Segal's experienced judgment. Thus, there was no error in the adjustment, nor did that adjustment result in an arbitrary or capricious scoring. The Claims Repricing scoring was therefore reasoned and rational.

B. The Plan's Scoring of Fees and Guarantees was Reasoned and Rational

As discussed above, the Plan put equal weight on Fees and Guarantees, assigning two points in the cost proposal scoring to each. Blue Cross challenges the scoring for several reasons. It contends that it was error to weight them equally, that the RFP did not sufficiently explain the

scoring, and that the Guarantee scoring was subjective. None of these complaints satisfies the standard in N.C. Gen. Stat. § 150B-23.

1. It was well within the Plan's discretion to weight certain components equally

Blue Cross contends that the equal weight between Fees and Guarantees was irrational, arbitrary, and capricious because administrative fees are actual costs to the Plan, and pricing guarantees are relevant only if the TPA does not meet its promised pricing. (*See* Pet. ¶¶ 60-64). To be sure, an argument could be made that one component or the other should be weighted more heavily. But absent some legal requirement that sets the weight that must be applied, any number of approaches could be considered reasonable. There were no such legal requirements here. (*See* APPX V4.0876 ¶ 5). The question is only whether weighting the components equally is *arbitrary or capricious*.

In the Plan's view when deciding how to score them, pricing guarantees and administrative fees could be equal or very close to equal value on a dollar basis. (APPX V3.0588-.0589). Pricing guarantees and administrative fees, which are in tens of millions of dollars annually, are also both significantly less than the claims costs covered by the Claims Repricing exercise, which in total are billions of dollars. (*Id.*). Moreover, strong network guarantees (where the bidder puts a lot of money at risk if it fails to meet the guaranteed target) give the Plan greater certainty and confidence that the bidder will meet its targets. (APPX V4.0917 ¶ 13). On the other hand, a bidder who puts little money at risk creates uncertainty and less confidence that its guarantee targets will be met. (*Id.*). Without knowing how the various bidders would structure their guarantees or how much they would put at risk, the Plan could not evaluate whether they would be significantly more or less valuable than the administrative fees. Accordingly, the Plan chose to place equal weight on them (and place more weight on the Claims Repricing). (APPX V4.0917 ¶ 13; APPX V3.0588-

.0589). This decision was both reasoned and rational. The scoring was therefore within the Plan's discretion and cannot be disturbed. *See Byrd*, 69 N.C. App. at 519, 317 S.E.2d at 109.

2. The RFP adequately explained the cost proposal scoring

Blue Cross also criticizes the Plan's explanation of the way it would score Fees and Guarantees, suggesting it was not specific on how points would be allocated among the various bidders. The RFP stated that on both components, the highest ranked proposal would earn two points and "all other proposals will be ranked and may receive one (1) or zero (0) points based on" a comparison to the other proposals. (RFP p. 25). Following this clearly stated methodology, the Plan awarded the second-ranked proposal one point and the third-ranked proposal zero points for each component. (*See APPX V2.0295-.0297*).

Blue Cross's criticism seems to arise from the difference between the scoring methodology for these components and that for Claims Repricing. (*See Pet.* ¶¶ 17-21). The RFP set forth more detailed requirements allowing multiple proposals to gain the same number of points in the repricing exercise. Specifically, it stated that the highest ranked proposal would receive six points, as would any proposal within 0.5% of the highest ranked proposal. It then set forth specific point values that would be awarded to other bidders based on how far away the other bidders were from the first-placed bidder (in 0.5% increments). (RFP pp. 24-25). Because the cost of claims is the Plan's largest expense by far, and bidders' network pricing had historically been very close, the Plan leadership believed a proposal that was not the best should still be competitive if the relative difference between it and the best proposal was small. Also, because network pricing is a future estimate, there is typically some "margin of error" between the results of the claims repricing and actual results when the contract takes effect several years later. The Plan used percentage ranges partly to avoid penalizing a vendor whose results were within this margin of error. (APPX V4.0916 ¶ 9).

Blue Cross ignores the fact that there is no requirement that each part of the scoring be done the same way. (*See* APPX V4.0876 ¶ 5). In fact, it would be irrational to require scoring of different elements to follow the same methodology when there might be good reasons to treat them differently. Nor is there any requirement that the scoring methodology be specifically stated in the RFP, or that any particular level of detail be provided (although it was specific here, and it was followed). As such, there is no evidence sufficient to show any error or that the Plan’s approach was arbitrary and capricious.

3. The pricing guarantees were reasonably evaluated.

Blue Cross also suggests that the evaluation criteria for the Guarantees were not specifically explained in the RFP and were too subjective. The RFP stated that the Plan would value the Guarantees “based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk.” (RFP p. 25). Again, there is no legal requirement or rule that requires the RFP to include any level of detail about the evaluation criteria (*see* APPX V4.0876 ¶ 5), and the RFP here put the bidders on notice of the criteria that would be important (competitiveness and amount at risk) (RFP p. 25). And those are the criteria the Plan evaluated.

But the specifics of how to compare the Guarantees could not be determined in advance because the Plan and Segal did not know how the bidders would structure their proposals. The Plan initially asked Segal to provide a model for scoring the guarantees before the RFP went out. But Segal determined, based on its experience, that creating a scoring model for guarantees before the proposed guarantees are submitted is problematic because it is entirely possible that the model would have to be changed if the proposed guarantees failed to fit that model. (APPX V4.0918 ¶ 17; APPX V4.0925 ¶ 5; APPX V3.0498). Rather than “handcuff” the Plan to a model that might be useless or require changes later, Segal reasonably determined (and the Plan accepted) that the scoring would necessarily be comparative and subjective, and that the specific analysis to

determine value could not be determined until it knew what it would be valuing. (APPX V4.0905 ¶¶ 28-29, APPX V4.0918 ¶ 17; APPX V4.0925 ¶ 5; APPX V3.0498, .0500).

Again, there is no rule that the Plan make that decision before bids are received. (See APPX V4.0876 ¶ 5). Under the circumstances, Segal and the Plan intentionally and reasonably waited to decide the specifics of how to compare bids until it knew what it was comparing.

Further, Segal’s analysis and scoring of the Guarantees was a thorough, reasoned comparison based on Segal’s experience, and was consistent with the RFP, which said the value of the guarantees would be based on a combination of the (a) competitiveness of the guaranteed targets and (b) the amounts placed at risk.¹³ (See RFP § 3.4(c)(3), p. 25).

a. Comparison of Bidder’s Discount Guarantees

The Plan seeks to lower its costs by obtaining greater discounts from healthcare providers’ billed charges. Accordingly, discount guarantees are an agreement by a TPA to repay money to the Plan if the actual discounts achieved by the TPA in a future year are *less* than a target discount percentage (a “shortfall”). Segal compared the bidders’ discount guarantees in a table (APPX V2.0296) (blue, red and green rectangles added for emphasis):

Discount Guarantees

	Current Discount ¹	Vendor Projected Discount ²	CY 2025 Guarantee ³	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.

As shown above, Segal quantified each bidder’s guaranteed targets (in terms of a percentage discount from billed charges) and compared them against that bidder’s current

¹³ Guarantee targets and amounts at risk defined in Footnote 9 above.

discounts and projected discounts (shown in blue rectangle). (APPX V2.0296). Segal then described each bidder’s payout methodology, which quantified the amounts put at risk by each bidder, in terms of percentage of the discount shortfall and maximum payout as a percentage of the bidder’s administrative fee. Segal followed this by calculating the maximum total dollars at risk (shown in red rectangle). (*Id.*) Segal’s analysis also noted various ways in which the bidders structured their guarantees differently, which differences affect the value of the guarantees (shown in green rectangle). (*Id.*)

Finally, as shown below, Segal summarized its conclusions regarding the relative value of the discount guarantees, noting the relative strengths and weaknesses of each. Segal noted that Blue Cross’s discount target was competitive but was outweighed by its limited amount at risk (shown in blue rectangle). (*Id.*)

Evaluation of Discount Guarantee
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.
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.
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.

b. Comparison of Bidders’ Trend Guarantees

The Plan also seeks to lower costs by minimizing the year-to-year increase (“trend”) in total claims costs. Trend guarantees are an agreement by a TPA to repay money to the Plan if the actual annual increase in claims cost over the prior year is higher than the target percentage

(an “overage”). (APPX V2.0296) As with the discount guarantees, Segal compared the bidders’ trend guarantees in a table (*id.*) (blue, red and green rectangles added for emphasis):

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 relative 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.

As shown above, Segal first quantified each bidder’s guaranteed targets in terms of a percentage increase over the prior year’s expense (shown in blue rectangle). (*Id.*) Segal then described each bidder’s payout methodology, which quantified the amounts put at risk by each bidder in terms of percentage of the overage above the trend target and the maximum payout as a percentage of the bidder’s administrative fee, and calculated the maximum total dollars at risk in 2026 and the trend (percentage increase over the prior year) at which the bidder would reach its maximum payout (shown in red rectangle). (*Id.*) Segal described each bidder’s trend guarantees from 2027-2029 and described adjustments for large claims and exclusions and conditions placed by the bidders on their trend guarantees, all of which could affect the value of the guarantees (shown in green rectangle). (*Id.*)

Finally, as shown below, Segal summarized its conclusions regarding the relative value of the trend guarantees, noting the relative strengths and weaknesses of each. Segal noted that, while Blue Cross offered the lowest trend target, its value was diminished by the lowest dollar amount

at risk and the exclusion of claims by certain high-cost Plan members (shown in blue rectangle).
(*Id.*).

	Discount Guarantee
a	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.
y	
r	
	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).
	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.

Based on the analysis of the bidders' discount guarantees and trend guarantees, Segal determined that UMR's Guarantees collectively offered the highest value, Aetna's were second, and Blue Cross's Guarantees offered the least comparative value. Segal assigned UMR, Aetna and Blue Cross two points, one point, and zero points, respectively. (APPX V2.0297).

Network Pricing Guarantees Score

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

As described above, Segal’s analysis of the bidders’ Guarantees was reasoned, thoughtful, and considered the bidders’ guaranteed targets and the amounts put at risk, consistent with the RFP. (*See* RFP §3.4(c)(3), p. 25). This analysis was also accepted and adopted by the Plan’s Evaluation Committee. While Blue Cross may not agree with the manner or the outcome of Segal’s analysis, there is no evidence sufficient to show any error or that the Segal’s or the Plan’s approach was arbitrary and capricious.

III. The Technical Requirements Were Reasonably Designed and Scored

As discussed above, the Plan adopted 310 technical “requirements” that represented contract terms the Plan concluded were beneficial to and strongly preferred by the Plan. (APPX V4.0931 ¶ 10; APPX V4.0876-.0877 ¶ 8). Each term was important to one or more constituencies within the Plan, and different requirements were considered critical by different constituencies. (APPX V3.0423). Accordingly, the Plan chose to value each the same. (*Id.*). As the contracting agency, it rests soundly within the Plan’s discretion to determine what its business needs are and how to value those needs.

Blue Cross chose not to confirm seven of the 310 technical requirements, with full knowledge that those choices would hurt its score (*see* RFP p. 24):

- Applying the same utilization management and payment rules for providers in North Carolina and throughout the United States (APPX V1.0039)
- Using a unique member ID number provided by the EES vendor as primary member ID for claims processing, customer services, and other operational purposes and having that be the sole member ID on the member ID cards. (APPX V1.0052)
- Accepting and displaying electronic medical and health records from other systems and BCBS’ health team in the member portal (APPX V1.0058)
- Accepting and displaying disease management nurse notes from other systems and BCBS’ health team in the member portal (*id.*)
- Accepting and displaying case management notes from other systems and BCBS’ health team in the member portal (*id.*)
- Accepting and displaying health coach notes from other systems and BCBS’ health team in the member portal (*id.*)
- Paying all claims, including non-network claims, based on assignment of benefits when requested (APPX V1.0061).

Its failure did not disqualify Blue Cross,¹⁴ but the Plan appropriately rewarded the two bidders who confirmed every requirement with higher points, consistent with the RFP. Following the methodology described in the RFP (*see* RFP p. 24), the Plan ranked Blue Cross—“[t]he Vendor earning the least points out of the total 310”—the lowest rank of one, with the “Vendor[s] earning the most points out of the total 310 receiving the highest rank” of three.

A. Plan Reasonably Included Requirements that Blue Cross Failed to Confirm

Blue Cross spends pages of its Petition explaining why it did not confirm seven requirements, suggesting for some that it was impossible for any bidder to meet these requirements, implying that its competitors lied about their ability or willingness to comply and second-guessing the Plan’s reasoning for including these requirements. (*See* Pet. ¶¶ 85-107).

¹⁴ In fact, the Plan chose to put certain requirements in the Technical Requirements rather than in the Minimum Requirements specifically to ensure fairness to Blue Cross, and to avoid disqualifying any bidder who might not confirm them. (APPX V3.0384, 0427).

Frankly, it does not matter whether “Blue Cross had good reasons for not confirming seven out of the 310 technical requirements in the RFP.” (Pet. ¶ 106). Nor does it matter whether bidders could already meet every requirement when their proposals were submitted in 2022. The RFP clearly provided for a two-year implementation period before the TPA begins providing services under the contract in January 2025. (RFP p. 26). The Plan’s expectation was not necessarily that bidders could meet all the technical requirements in 2022, but rather that they would contractually commit to the requirements and develop any necessary capabilities during the implementation period. (APPX V3.0393-.0394, APPX V3.0697).

The Plan did not include any of the Technical Requirements in the RFP based on which bidders would or would not confirm, but rather based on what was important to the Plan. (APPX V4.0934 ¶ 25). The Plan was seeking a vendor who would commit to meet as many of the technical requirements as possible, and it reasonably rewarded those who agreed to meet all of them. And no evidence suggests that Aetna or UMR lied about their ability to meet the Plan’s requirements. To the contrary, Aetna confirmed that it determined it could comply with all technical requirements by the time the contract was implemented. (APPX V3.0312-.0313).

Nor can Blue Cross’s value judgments supplant the reasoned judgments of the Plan. Each of the seven requirements that Blue Cross chose not to confirm was considered important by the Plan and was intentionally included by the Plan in the exercise of its discretion, consistent with its purpose of providing a high-quality health benefit plan to its members.

1. Same Utilization Management and Payment Rules Nationwide

One of the requirements Blue Cross did not confirm requires the vendors to “apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States.” (APPX V1.0039; APPX V4.0932 ¶ 15). The Plan had not included this requirement in prior TPA RFPs, but many members live or seek care out of state. (APPX

V4.0932 ¶ 16). The use of the same rules nationwide streamlines the administration of benefits out of state. (*Id.*).

Historically, Blue Cross has frequently not followed its own utilization management and payment rules for claims from out-of-state, in-network providers that are part of Blue Cross's "Blue Card" network (which Blue Cross refers as inter-plan processing or "IPP" claims). For example, Blue Cross has not subjected IPP claims to its reimbursement limits or inpatient authorization requirements, which increases the Plan's costs and undermines the Plan's efforts to manage care. The Plan has asked Blue Cross to correct this issue in the past without success. The Plan's auditor has also identified the TPA's failure to apply the same utilization management and payment rules to out-of-state providers (IPP claims) as a problem that should be corrected (APPX V4.0932-.0933 ¶ 17; APPX V1.0109-.0110, ¶¶ 9, 13).

Although one vendor asked a clarification question about this requirement during the RFP's question and answer period (*see* APPX V2.0267, Question 17), none requested that this requirement be removed or changed. (APPX V4.0933 ¶ 18; *see* APPX V1.0079-.0090; APPX V2.0263-.0274).

2. Unique Member ID Number

Blue Cross also chose not to confirm the requirement that the vendor "use the unique Member ID number provided by the EES vendor as the primary Member ID for claims processing, customer services and other operational purposes; therefore, the unique Member ID number provided by the EES vendor will be the sole Member ID on the ID Card." (APPX V1.0052; APPX V4.0933 ¶ 19). The purpose of this requirement is to simplify the Plan's operations and enable the Plan's systems and all its various contractors' systems to share data through the use of the same member ID number for every member. To avoid reliance on any given contractor (including TPA

contractors), the Plan desires that all contractors use unique member ID numbers assigned by the Plan's enrollment and eligibility services (EES) vendor. (APPX V4.0933 ¶ 20).

A differently worded version of this requirement was in the last TPA RFP in 2019, which was confirmed by Blue Cross. (APPX V4.0933 ¶ 21). However, the earlier version did not specifically require that the unique member ID be the sole ID number on the ID card. Under the current contract, Blue Cross proposed using two member ID numbers on member cards: its own Blue Cross member ID and EES vendor's member ID. But Blue Cross's systems would only use only its own member ID, which defeats the purpose of the requirement because any data exchange with Blue Cross must rely on Blue Cross's member ID number. For this reason, the requirement was re-worded in the RFP. (APPX V4.0933-.0934 ¶ 21).

None of the vendors asked questions about this requirement or asked that it be removed or changed during the question and answer periods. (APPX V4.0934 ¶ 22, see APPX V1.0079-.0090, APPX V2.0263-.0274)).

3. Member Portal Information

Blue Cross also chose not to confirm technical requirements 5.2.7.2.b.xxiv.1-4 which required:

Vendor's member portal will accept and display Member-specific information from the other systems and Vendor's health team, including each of the following. Vendor shall confirm each below:

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

(APPX V1.0058; APPX V4.0934 ¶ 23).

The purpose of the member portal requirements is to promote transparency and improve Plan members' experience. (APPX V4.0934 ¶ 24). These requirements have been in the last three

TPA RFPs and were originally drafted by the Plan’s population health management group as part of a best-in-class health plan offering. (APPX V4.0934 ¶ 24). In the past, Blue Cross has confirmed some of these requirements and not confirmed others. (APPX V4.0934 ¶ 25).

If any of the notes or other information covered by this requirement were not intended by healthcare providers for members to see, the TPA and the Plan could work out how to handle any such information during implementation. (APPX V4.0935 ¶ 26).

None of the vendors asked questions about these requirements or requested that any of them be changed or removed during the question and answer periods. (See APPX V1.0079-.0090; APPX V2.0263-.0274; APPX V4.0935 ¶ 27). Nor did any vendor communicate any concern with the Plan that any of the records or information required to be available through the member portal should not be seen by patients or Plan members. (*Id.*).

4. Payment of Claims Based on Assignment of Benefits

Blue Cross also chose not to confirm the requirement that it “pay all claims, including non-network claims, based on assignment of benefits” when requested. (APPX V1.0061; APPX V4.0935 ¶ 28). Assignments of benefits (“AOBs”) are agreements between a Plan member and a healthcare provider authorizing the Plan (through its TPA) to pay healthcare providers directly for medical care provided to its members, instead of paying the member who must then pay the provider. (APPX V4.0935 ¶ 29). The purpose of this requirement is to reduce the administrative burden on members, improve service, and also to avoid situations where the Plan pays the member, but the member fails to pay the healthcare provider for the care they received. (*Id.*).

For example, the Plan has had an instance in which Blue Cross paid a member thousands of dollars for reimbursement for medical care that the member used to pay off the member’s house, leaving the medical provider unpaid. The Plan was unable to recover the funds from the member and the provider went unpaid. (APPX V4.0935 ¶ 30). Another example (which occurred to a

different health plan) illustrates this need for this requirement: a plan paid \$33,000 to a man struggling with addiction, who used the cash to go on a binge and died as a result. (*Id.*).

This requirement has been in several previous TPA RFPs stated verbatim. (APPX V4.0936 ¶ 31). Blue Cross has never yet agreed to pay claims based on AOBs. (*Id.*). Nevertheless, the Plan considers this requirement important. (*Id.*). None of the vendors asked questions about this requirement or asked that it be removed or changed during the question and answer periods. (*Id.* at ¶32; *see* APPX V1.0079-0090; APPX V2.0263-0274).

Consequently, all seven of the technical requirements not confirmed by Blue Cross were included by the Plan intentionally, reasonably, and in the proper exercise of the Plan's discretion. Blue Cross's self-serving disagreement with the Plan's reasoned selection of requirements is irrelevant and no basis for reversal since it impermissibly asks the tribunal to substitute its judgment for the Plan's. *See Byrd*, 69 N.C. App. at 519, 317 S.E.2d at 109.

B. Plan Reasonably Chose Not to Allow Non-Narrative Responses

Blue Cross also criticizes the Plan's modernized RFP format, including the binary (Confirmed vs. Not Confirmed) format of the technical requirements. It contends that if the Plan had allowed explanations for each bidder's responses, "the Plan would have been able to assess each vendor's capabilities on these points based on complete information." (Pet. ¶ 106). But there is no legal requirement that the Plan allow narrative responses or follow any specific format. (*See, e.g.*, APPX V4.0884-.0885 ¶¶ 8-9, APPX V4.0876 ¶ 5). And while Aetna's expert, Andrew Coccia, had never been involved in an RFP that did not allow narrative explanations, he "like[d] it" and believed that this approach "may be a new best practice." (APPX V3.0376).

The choice to disallow narrative explanations was an intentional and reasoned choice by the Plan based on experience and as part of its effort to modernize its RFP processes in general. (APPX V4.0878-.0879 ¶¶ 7, 15-17). The contract awarded in an RFP like this one incorporates

the winning bidder's response. (APPX V4.0877 ¶ 9; RFP § 4.13(d), pp. 31-32). In prior RFPs, the Plan discovered that the narrative responses that become part of the contract's terms often incorporate subjective, contradictory, or vague language that becomes problematic during performance of the contract. (APPX V4.0877-.0878 ¶¶ 10, 13). Moreover, the long narrative discussions often include voluminous materials that greatly lengthen and complicate the Plan's evaluation and require subjective judgments as to whether and to what extent each vendor met each requirement. (*Id.* at ¶¶ 10-12). The Plan has a very lean staff, and these lengthy, subjective evaluations had become extremely time-consuming, which prevented the committee members from other pressing responsibilities. (*Id.* at ¶12). By moving to non-narrative format, the Plan hoped to avoid problems associated with the vague language in narrative responses and to shift the risk of non-performance to the contracted vendor. (*Id.* at ¶ 17). The Plan considered competing viewpoints and ultimately concluded that the non-narrative approach best served the needs of the Plan. (*Id.* at ¶ 19).

While Blue Cross may disagree with the format of the technical proposal, that format was neither arbitrary nor capricious, nor did it constitute any other error under General Statutes Section 150B-23(a).

IV. The Final Scoring was Reasonably Based on the Cost and Technical Rankings

After attacking each component of the scoring, Blue Cross also complains that the way the components were combined into a final score was arbitrary and capricious. (*See* Pet. ¶ 108). The bidders' scores and rankings were determined exactly as described in the RFP, as follows:

A. Technical Requirements:

- Each bidder received one point for each technical requirement it confirmed, up to 310 points. (RFP § 3.4(b), p. 24; APPX V1.0018).
- The bidders were "ranked in descending order based on the total points earned" (RFP p. 24), with the bidder earning the fewest points (Blue Cross) ranked one and

the bidders earning the most points ranked highest (Aetna and UMR). (*Id.*; APPX V1.0018).

RFP Section	Title	Maximum Points	Vendor		
			Aetna	BCBSNC	UMR
5.2.1	Account Management	20	20	20	20
5.2.2	Finance and Banking	19	19	19	19
5.2.3	Network Management	28	28	27	28
5.2.4	Product and Plan Design Management	41	41	41	41
5.2.5	Medical Management Programs	18	18	18	18
5.2.6	Enrollment, EDI, and Data Management	40	40	39	40
5.2.7	Customer Experience	52	52	48	52
5.2.8	Claims Processing and Appeals Management	16	16	15	16
5.2.9	Claims Audit, Recovery, and Investigation	25	25	25	25
5.2.10	Initial Implementation and Ongoing Testing	3	3	3	3
5.2.11	Reporting	48	48	48	48
TOTAL TECHNICAL POINTS		310	310	303	310

(APPX V1.0018)

B. Cost Proposals:

- Each bidder could receive up to ten points across three components. (RFP §3.4(c), p. 24).
- On the networking pricing, points were assigned as follows, consistent with RFP Section 3.4(c)(1):
 - The bidder with the lowest network pricing (Aetna) and any bidder within 0.5% of the lowest bidder’s pricing (Blue Cross) received six points. (RFP p. 25; APPX V1.0020).
 - Any bidder whose pricing was within 1.0% of the lowest bidder’s pricing (UMR) received 5 points. (RFP p. 25; APPX V1.0020).

BAFO #1							
Network Pricing (Claims \$M)							
Vendor	2025	2026	2027	Total	Ranking	% Diff	Score
Aetna	3,035.7	3,209.6	3,393.9	9,639.2	3	0.00%	6
BCBS	3,049.9	3,224.7	3,409.8	9,684.4	2	+0.47%	6
UMR	3,060.1	3,241.2	3,427.2	9,728.4	1	+0.93%	5

(APPX V1.0020).

- On administrative fees, points were assigned as follows, consistent with RFP Section 3.4(c)(2):
 - The bidder with the lowest administrative fees (Blue Cross) received the full two points allocated to this section. (RFP p. 25; APPX V1.0020).
 - The bidder with the next lowest administrative fees (Aetna) received one point. (RFP p. 25; APPX V1.0020).
 - The bidder with the lowest administrative fees (UMR) received zero points. (RFP p. 25; APPX V1.0020).

BAFO #1						
Vendor	Base Admin Fee (PSPM)			Total Cost (\$M)	Rank	Score
	2025	2026	2027			
Aetna	22.75	22.75	22.75	293.6	2	1
BCBS	13.53	14.21	14.92	223.3	3	2
UMR	24.25	24.50	24.75	357.2	1	0

(APPX V1.0020).

- On pricing guarantees, points were assigned as follows, consistent with RFP Section 3.4(c)(3):
 - The bidder offering the pricing guarantees with the greatest value (UMR) received the full two points allocated to this section. (RFP p. 25; APPX V1.0021).
 - The bidder offering the pricing guarantees with the next best value (Aetna) received one point. (RFP p. 25; APPX V1.002).
 - The bidder offering the pricing guarantees with the lowest value (Blue Cross) received zero points. (RFP p. 25; APPX V1.002).

Pricing Guarantees		
Vendor	Rank	Score
Aetna	2	1
BCBS	1	0
UMR	3	2

(APPX V1.002)

- Vendors were “ranked in descending order based on the total cost proposal points earned” (RFP p. 25) with the bidders with the most points ranked 3 (Aetna and Blue Cross, 8 points each) and the bidder with the fewest points (UMR) ranked one.

1. Final Scoring

- The technical proposal and cost proposal each made up 50% of the bidder’s final score, pursuant to RFP Section 3.4(a):

The total points scale will reflect the following weights:

Technical Proposal	50%
Cost Proposal	50%
Total:	100%

(RFP p. 24).

- Accordingly, the Plan added each bidder’s rank on the technical proposal to its rank on the cost proposal to get to a final score as follows:

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

(APPX V1.0023).

As shown above, the Plan’s final scoring is entirely consistent with the language of the RFP. There was no legal requirement that the Plan score bidders otherwise, or state with more specificity its intent to add the two ranks for a final score.¹⁵ (See APPX V4.0876 ¶ 5). It was not irrational for the Plan to give the technical and cost proposals equal weight. To the contrary, the Plan intentionally modified the 60/40 weighting of Technical to Cost used in the 2019 TPA RFP because it considered the Technical Proposal and Cost Proposal to be equally important. In addition, the Plan equalized the weighting because it anticipated that Blue Cross might not score as high on the technical proposal based on its performance of the 2019 contract and wanted to ensure it was not unfairly disadvantaging Blue Cross. (APPX V4.0888 ¶ 23; APPX V4.0915 ¶ 5,

¹⁵ Regardless, its stated intent to “rank” the proposals in “descending” order made implicit, if not explicit, that the bidders’ ranks would be added for a final score.

APPX V3.0401). Because the scoring methodology was reasoned and within the Plan’s discretion, it cannot be disturbed. *See Byrd*, 69 N.C. App. at 519, 317 S.E.2d at 109.

CONCLUSION

Throughout the RFP, the Plan made reasoned decisions based on reasonable design and scoring choices within its discretion. The Plan and its contractor Segal then thoughtfully and fairly evaluated and scored the bidders’ proposals consistently with the RFP. Because Blue Cross cannot forecast evidence of an essential element of its claim—error under N.C. Gen. Stat. § 150B-23(a)—the Plan respectfully requests that the administrative law judge grant summary judgment for Respondent and Respondent-Intervenor.

This the 15th day of December, 2023.

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CERTIFICATE OF SERVICE

The undersigned does hereby certify that a true and correct copy of the foregoing document was uploaded electronically with the Office of Administrative Hearings, causing electronic service, as defined in 26 N.C.A.C. 03 .0501(4), to be made upon the following:

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