

# **EXHIBIT A**

**GREGORY RUSSO  
EXPERT REPORT  
DATED 10/4/2023**

**EXPERT REPORT OF GREGORY RUSSO**

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

**North Carolina Office of Administrative Hearings**

**Case No. 23 INS 00738**

**October 4, 2023**

## Table of Contents

<b>I. Introduction .....</b>	<b>3</b>
<b>II. Relevant Experience .....</b>	<b>3</b>
<b>III. Documents and Information Relied Upon.....</b>	<b>3</b>
<b>IV. Background of the Case .....</b>	<b>4</b>
<b>V. Overview of Opinions .....</b>	<b>5</b>
<b>VI. Cost Proposal Data Collection and Scoring.....</b>	<b>6</b>
<b>VII. Key Terms .....</b>	<b>8</b>
<b>VIII. Opinions.....</b>	<b>10</b>
Opinion 1: The Plan’s assignment of zero points to Blue Cross’s pricing guarantees was subjective, reflecting little quantitative analysis and lacking a sufficient basis for the Plan’s assignment of points. Blue Cross’s pricing guarantees would provide lower costs to the Plan than Aetna’s discounts and guarantees. ....	10
Opinion 2: For providers with letters of intent, the actual prices to which the providers agreed are higher than the prices Aetna used in the repricing exercise. That discrepancy will result in higher bottom-line costs to the Plan than Aetna presented in its bid. ....	27
Opinion 3: Through the clarifications process, the Plan and Segal erroneously decreased Blue Cross’s discount. That erroneous adjustment resulted in Blue Cross and Aetna earning 6 points each for the repricing exercise, as opposed to Blue Cross earning 6 points and Aetna earning 3 points. ....	32
Opinion 4: Segal’s review of external data further undermined Segal’s decision to adjust Blue Cross’s discount percentage to a level below Aetna’s. ....	45
Opinion 5: The Plan did not compare the vendors’ networks of providers, even though it had the data needed to do so. As a result, the Plan failed to consider the disruption that will occur if Aetna becomes the TPA on January 1, 2025. ....	48

## **I. Introduction**

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

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

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

## **II. Relevant Experience**

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

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

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

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

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

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

#### IV. Background of the Case

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

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

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

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

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

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

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

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

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

<sup>2</sup> SHP 0072588.

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

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

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

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

## **V. Overview of Opinions**

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

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

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

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

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

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

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

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

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

## VI. Cost Proposal Data Collection and Scoring

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

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

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

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

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

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

<sup>11</sup> SHP 0072588.

<sup>12</sup> SHP 0006964.

<sup>13</sup> SHP 0006961.

<sup>14</sup> SHP 0006963.

<sup>15</sup> SHP 0006962.

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

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

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

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<sup>16</sup> SHP 0072588.

<sup>17</sup> SHP 0006966.

<sup>18</sup> SHP 0072588.

<sup>19</sup> SHP 0006956.

<sup>20</sup> SHP 0072588.

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

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

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

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

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

#### VII. Key Terms

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

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

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

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<sup>21</sup> SHP 0006960.

<sup>22</sup> SHP 0006965.

<sup>23</sup> SHP 0006955.

<sup>24</sup> SHP 0006959.

<sup>25</sup> SHP 0069464.

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

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

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

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

## VIII. Opinions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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<sup>28</sup> SHP 0072588.

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

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

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

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

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

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

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

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

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

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

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

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

<sup>33</sup> SHP 0092745.

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

**Figure 1**

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

**Source:** SHP 0070486.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Discount Guarantees**

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

**Trend Guarantees**

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

Source: SHP 0069464.

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

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

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

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

Figure 4

**Network Pricing Guarantees Score**

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

Source: SHP 0069464.

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

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

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

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

<sup>40</sup> SHP 0069464.

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

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

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

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

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

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

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

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

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

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

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

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

<sup>48</sup> SHP 0000010.

<sup>49</sup> SHP 0069503.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>54</sup> SHP 0093117.

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

<sup>56</sup> SHP 0093117.

<sup>57</sup> SHP 0093060.

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

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

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

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

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

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

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

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

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

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

<sup>61</sup> SHP 0000010.

<sup>62</sup> SHP 0093117.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>72</sup> SHP 0072588.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>83</sup> AENTNA0001992.

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

<sup>85</sup> AETNA0014000.

REDACTED

.<sup>86</sup>

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

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

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

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

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

<sup>86</sup> AETNA0019463.

<sup>87</sup> AETNA0013892.

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

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



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

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

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

### **Overview**

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

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

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

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

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

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

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

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

**Repricing Exercise Instructions and Scoring**

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

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

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

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

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

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

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

<sup>94</sup> SHP 0069464.

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

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

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

### **Requests for Clarification**

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

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

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

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

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

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

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

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

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

<sup>100</sup> SHP 0087957.

<sup>101</sup> SHP 0087964.

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

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

<sup>104</sup> SHP 0024720.

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

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

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

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

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

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

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

<sup>105</sup> SHP 0009869.

<sup>106</sup> SHP 0069744.

<sup>107</sup> SHP 0001952.

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

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

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

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

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

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

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

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

<sup>109</sup> SHP 0024713.

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

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

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

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

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

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

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

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

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

<sup>111</sup> SHP 0024713.

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

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

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

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

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

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

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

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<sup>113</sup> SHP 0001952.

<sup>114</sup> SHP 0069756.

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

<sup>116</sup> SHP 0087620.

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

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

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

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

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

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

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

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

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

<sup>119</sup> SHP 0069760.

<sup>120</sup> SHP 0069760.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Source: SHP 0085084, “Network Pricing” tab.

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

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

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

Source: SHP 0069464, “Network Pricing” tab.

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

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

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

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

<sup>131</sup> SHP 0069464.

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>133</sup> SHP 0002413.

<sup>134</sup> SHP 0002413.

<sup>135</sup> SHP 0085064.

<sup>136</sup> SHP 0085038.

<sup>137</sup> SHP 0085038.

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

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

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

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

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

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

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

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

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

<sup>139</sup> SHP 0085064.

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

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

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

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

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

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

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

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

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

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

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<sup>148</sup> SHP 0085097.

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

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

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

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

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

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

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

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

<sup>150</sup> SHP 0072588.

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

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

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

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

<sup>152</sup> SHP 0003962.

<sup>153</sup> SHP 0002295.

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

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

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

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

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

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

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

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

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

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

Source: SHP 0006965

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

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

<sup>160</sup> SHP 0092423.

<sup>161</sup> SHP 0086294.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

County	County Type	Blue Cross		Aetna		Difference	
		Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount
MOORE	Rural	913	\$53,751	REDACTED	\$REDACTED	REDACTED	\$REDACTED
ORANGE	Suburban	2,128	\$167,898	REDACTED	\$REDACTED	REDACTED	\$REDACTED
MECKLENBURG	Urban	2,924	\$387,854	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CUMBERLAND	Suburban	297	\$12,697	REDACTED	\$REDACTED	REDACTED	\$REDACTED
GUILFORD	Urban	1,987	\$160,402	REDACTED	\$REDACTED	REDACTED	\$REDACTED
WAKE	Urban	17,068	\$1,103,721	REDACTED	\$REDACTED	REDACTED	\$REDACTED
PITT	Suburban	1,128	\$55,785	REDACTED	\$REDACTED	REDACTED	\$REDACTED
NEW HANOVER	Urban	794	\$49,204	REDACTED	\$REDACTED	REDACTED	\$REDACTED
BUNCOMBE	Suburban	3,185	\$173,588	REDACTED	\$REDACTED	REDACTED	\$REDACTED
FORSYTH	Urban	584	\$62,537	REDACTED	\$REDACTED	REDACTED	\$REDACTED
All Other		24,122	\$1,679,747	REDACTED	\$REDACTED	REDACTED	\$REDACTED
<b>Total</b>		<b>55,130</b>	<b>\$3,907,185</b>	REDACTED	\$REDACTED	REDACTED	\$REDACTED

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

If the Plan had performed a disruption analysis, it would have identified [REDACTED] who see providers that are in-network with Blue Cross but are out-of-network with Aetna (based on the Plan’s 2021 claims). My analysis shows that [REDACTED] members received services from providers that are in-network with Blue Cross but are out-of-network with Aetna. [REDACTED] live in rural counties.

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

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

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

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

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

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

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network		
			Claims	Members	Charges
WAKE	Urban	72,570	REDACTED	REDACTED	\$REDACTED
MECKLENBURG	Urban	28,723	REDACTED	REDACTED	\$REDACTED
GUILFORD	Urban	23,826	REDACTED	REDACTED	\$REDACTED
DURHAM	Urban	18,335	REDACTED	REDACTED	\$REDACTED
ORANGE	Suburban	17,888	REDACTED	REDACTED	\$REDACTED
PITT	Suburban	16,004	REDACTED	REDACTED	\$REDACTED
FORSYTH	Urban	14,684	REDACTED	REDACTED	\$REDACTED
ALAMANCE	Suburban	11,669	REDACTED	REDACTED	\$REDACTED
NEW HANOVER	Urban	11,291	REDACTED	REDACTED	\$REDACTED
CUMBERLAND	Suburban	10,971	REDACTED	REDACTED	\$REDACTED
All Other		70,544	REDACTED	REDACTED	\$REDACTED
<b>Total</b>		<b>296,505</b>	REDACTED	REDACTED	\$REDACTED

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

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

**Figure 27  
Disruption in Rural Counties**

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network		
			Claims	Members	Charges
JOHNSTON	Rural	12,748	REDACTED	REDACTED	\$REDACTED
WAYNE	Rural	7,832	REDACTED	REDACTED	\$REDACTED
ROBESON	Rural	7,440	REDACTED	REDACTED	\$REDACTED
BURKE	Rural	7,255	REDACTED	REDACTED	\$REDACTED
RANDOLPH	Rural	6,249	REDACTED	REDACTED	\$REDACTED
ONSLow	Rural	5,993	REDACTED	REDACTED	\$REDACTED
NASH	Rural	5,838	REDACTED	REDACTED	\$REDACTED
SURRY	Rural	5,574	REDACTED	REDACTED	\$REDACTED
HARNETT	Rural	5,555	REDACTED	REDACTED	\$REDACTED
CLEVELAND	Rural	5,260	REDACTED	REDACTED	\$REDACTED
All Other		152,588	REDACTED	REDACTED	\$REDACTED
<b>Total</b>		<b>222,332</b>	REDACTED	REDACTED	\$REDACTED

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

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

October 4, 2023

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

## **GREG RUSSO**

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### **SUMMARY**

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

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

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

### **PROFESSIONAL EXPERIENCE**

#### **LITIGATION SUPPORT**

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

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

#### *INTERNAL INVESTIGATIONS*

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

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

#### *STRATEGIC SUPPORT*

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

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

#### *PROGRAM DESIGN & EVALUATION*

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

#### **EDUCATION**

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

#### **PUBLICATIONS**

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

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

## **PRESENTATIONS**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## TESTIMONY

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

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

**PRESENT POSITION**

Berkeley Research Group, 2010 – present

**PREVIOUS POSITIONS**

LECG, 2009 – 2010

Navigant Consulting, Inc., 2004 – 2009

Jersey Shore University Medical Center, 2001 - 2003

**PROFESSIONAL AFFILIATIONS**

*American Health Lawyers Association*

*Healthcare Financial Management Association*

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

## **Case Documents and Data**

AETNA0001992

AETNA0013892

AETNA0014000

AETNA0019463

AETNA0026101

Aetna's 30(b)(6) Deposition

Blue Cross NC\_0000151

Blue Cross NC\_0001955

Blue Cross NC\_0001953

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

Deposition of Charles Sceiford

Deposition of Stuart Wohl

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

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

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

NCSHP\_Medical\_RFP\_Census\_File

Segal's 30(b)(6) Deposition

SHP 0000010

SHP 0001779

SHP 0001952

SHP 0002295

SHP 0002413

SHP 0003962

SHP 0006955

SHP 0006956

SHP 0006959

SHP 0006960

SHP 0006961

SHP 0006962

SHP 0006963

SHP 0006964

SHP 0006965

SHP 0006966

SHP 0009869

SHP 0024713

SHP 0024720

SHP 0040105

SHP 0069462

SHP 0069463

SHP 0069464

SHP 0069494

SHP 0069503

SHP 0069736

SHP 0069744

SHP 0069756

SHP 0069760

SHP 0069795

SHP 0070486

SHP 0072588

SHP 0083572

SHP 0085016

SHP 0085038

SHP 0085064

SHP 0085084

SHP 0085919

SHP 0086294

SHP 0087620

SHP 0087957

SHP 0087964

SHP 0092423

SHP 0092745

SHP 0093060

SHP 0093117

SHP 069464

## **Publicly Available Materials**

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

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

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

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

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

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

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

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

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

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

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

### **Additional Data**

NPI\_Registry\_Taxonomy.txt

Provider\_Addresses\_w\_Coordinates.txt

Subscriber\_Addresses\_w\_Coordinates.txt

Zip\_to\_County.txt

**Appendix C**  
**Exhibits**

### Figure 1

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

**Source:** SHP 0070486

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

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

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

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

**Discount Guarantees**

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

**Trend Guarantees**

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

Source: SHP 0069464

**Figure 4**

**Network Pricing Guarantees Score**

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

**Source:** SHP 0069464

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

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

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

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

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

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

Figure 8

Aetna Claims and Billed Charges Attributable to [REDACTED]

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

Figure 9

Aetna Claims and Billed Charges Attributable to [REDACTED]

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

Figure 10

Aetna Claims and Billed Charges Attributable to [REDACTED]

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



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

**Figure 12**

**Illustration of Discount-Percentage Calculation**

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

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

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

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

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

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

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

**Figure 15**

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

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

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

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

**Figure 17**

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

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

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

**Figure 18**

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

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

Source: SHP 0085084.xlsx, Network Pricing tab

**Figure 19**

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

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

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

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

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

Source: SHP 0069464, Network Pricing tab

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

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

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

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

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

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

Source: SHP 0006965

**Figure 23**

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

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

**Figure 24  
Provider Availability to Members**

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

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

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

County	County Type	Blue Cross		Aetna		Difference	
		Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount
MOORE	Rural	913	\$53,751	REDACTED	\$REDACTED	REDACTED	\$REDACTED
ORANGE	Suburban	2,128	\$167,898	REDACTED	\$REDACTED	REDACTED	\$REDACTED
MECKLENBURG	Urban	2,924	\$387,854	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CUMBERLAND	Suburban	297	\$12,697	REDACTED	\$REDACTED	REDACTED	\$REDACTED
GUILFORD	Urban	1,987	\$160,402	REDACTED	\$REDACTED	REDACTED	\$REDACTED
WAKE	Urban	17,068	\$1,103,721	REDACTED	\$REDACTED	REDACTED	\$REDACTED
PITT	Suburban	1,128	\$55,785	REDACTED	\$REDACTED	REDACTED	\$REDACTED
NEW HANOVER	Urban	794	\$49,204	REDACTED	\$REDACTED	REDACTED	\$REDACTED
BUNCOMBE	Suburban	3,185	\$173,588	REDACTED	\$REDACTED	REDACTED	\$REDACTED
FORSYTH	Urban	584	\$62,537	REDACTED	\$REDACTED	REDACTED	\$REDACTED
All Other		24,122	\$1,679,747	REDACTED	\$REDACTED	REDACTED	\$REDACTED
<b>Total</b>		<b>55,130</b>	<b>\$3,907,185</b>	REDACTED	\$REDACTED	REDACTED	\$REDACTED

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

County	County Type	Blue Cross		Aetna		Difference	
		Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount
MOORE	Rural	913	\$53,751	REDACTED	\$REDACTED	REDACTED	\$REDACTED
ORANGE	Suburban	2,128	\$167,898	REDACTED	\$REDACTED	REDACTED	\$REDACTED
MECKLENBURG	Urban	2,924	\$387,854	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CUMBERLAND	Suburban	297	\$12,697	REDACTED	\$REDACTED	REDACTED	\$REDACTED
GUILFORD	Urban	1,987	\$160,402	REDACTED	\$REDACTED	REDACTED	\$REDACTED
WAKE	Urban	17,068	\$1,103,721	REDACTED	\$REDACTED	REDACTED	\$REDACTED
PITT	Suburban	1,128	\$55,785	REDACTED	\$REDACTED	REDACTED	\$REDACTED
NEW HANOVER	Urban	794	\$49,204	REDACTED	\$REDACTED	REDACTED	\$REDACTED
BUNCOMBE	Suburban	3,185	\$173,588	REDACTED	\$REDACTED	REDACTED	\$REDACTED
FORSYTH	Urban	584	\$62,537	REDACTED	\$REDACTED	REDACTED	\$REDACTED
WATAUGA	Rural	343	\$12,041	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CATAWBA	Suburban	315	\$13,750	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CRAVEN	Rural	38	\$2,601	REDACTED	\$REDACTED	REDACTED	\$REDACTED
DURHAM	Urban	9,426	\$650,780	REDACTED	\$REDACTED	REDACTED	\$REDACTED
WAYNE	Rural	9	\$464	REDACTED	\$REDACTED	REDACTED	\$REDACTED
HENDERSON	Suburban	154	\$18,204	REDACTED	\$REDACTED	REDACTED	\$REDACTED
PASQUOTANK	Rural	255	\$16,759	REDACTED	\$REDACTED	REDACTED	\$REDACTED
BURKE	Rural	715	\$34,376	REDACTED	\$REDACTED	REDACTED	\$REDACTED
NASH	Rural	120	\$5,311	REDACTED	\$REDACTED	REDACTED	\$REDACTED
SURRY	Rural	24	\$1,175	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CHEROKEE	Rural	473	\$7,751	REDACTED	\$REDACTED	REDACTED	\$REDACTED
SAMPSON	Rural	20	\$1,869	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CALDWELL	Rural	15	\$2,992	REDACTED	\$REDACTED	REDACTED	\$REDACTED
ONSLow	Rural	77	\$5,689	REDACTED	\$REDACTED	REDACTED	\$REDACTED
HALIFAX	Rural	1	\$35	REDACTED	\$REDACTED	REDACTED	\$REDACTED
HARNETT	Rural	110	\$6,408	REDACTED	\$REDACTED	REDACTED	\$REDACTED
ROWAN	Suburban	47	\$2,362	REDACTED	\$REDACTED	REDACTED	\$REDACTED
WILSON	Rural	29	\$5,290	REDACTED	\$REDACTED	REDACTED	\$REDACTED
RUTHERFORD	Rural	22	\$825	REDACTED	\$REDACTED	REDACTED	\$REDACTED
HAYWOOD	Rural	31	\$640	REDACTED	\$REDACTED	REDACTED	\$REDACTED
LENOIR	Rural	10	\$3,951	REDACTED	\$REDACTED	REDACTED	\$REDACTED
BRUNSWICK	Rural	195	\$19,353	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CARTERET	Rural	54	\$4,994	REDACTED	\$REDACTED	REDACTED	\$REDACTED
RANDOLPH	Rural	128	\$4,166	REDACTED	\$REDACTED	REDACTED	\$REDACTED
WILKES	Rural	5	\$139	REDACTED	\$REDACTED	REDACTED	\$REDACTED
SWAIN	Rural	108	\$35,714	REDACTED	\$REDACTED	REDACTED	\$REDACTED

County	County Type	Blue Cross		Aetna		Difference	
		Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount
MCDOWELL	Rural	79	\$13,075	REDACTED	\$REDACTED	REDACTED	\$REDACTED
GASTON	Suburban	612	\$23,403	REDACTED	\$REDACTED	REDACTED	\$REDACTED
DARE	Rural	46	\$1,689	REDACTED	\$REDACTED	REDACTED	\$REDACTED
ASHE	Rural	1	\$49	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CABARRUS	Suburban	214	\$5,972	REDACTED	\$REDACTED	REDACTED	\$REDACTED
GRANVILLE	Rural	5	\$267	REDACTED	\$REDACTED	REDACTED	\$REDACTED
LEE	Rural	49	\$1,671	REDACTED	\$REDACTED	REDACTED	\$REDACTED
COLUMBUS	Rural	40	\$12,775	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CHATHAM	Rural	177	\$14,606	REDACTED	\$REDACTED	REDACTED	\$REDACTED
UNION	Suburban	145	\$5,793	REDACTED	\$REDACTED	REDACTED	\$REDACTED
SCOTLAND	Rural	-	\$0	REDACTED	\$REDACTED	REDACTED	\$REDACTED
ROBESON	Rural	71	\$6,480	REDACTED	\$REDACTED	REDACTED	\$REDACTED
WASHINGTON	Rural	2	\$426	REDACTED	\$REDACTED	REDACTED	\$REDACTED
DAVIDSON	Suburban	120	\$1,942	REDACTED	\$REDACTED	REDACTED	\$REDACTED
BEAUFORT	Rural	-	\$0	REDACTED	\$REDACTED	REDACTED	\$REDACTED
EDGECOMBE	Rural	-	\$0	REDACTED	\$REDACTED	REDACTED	\$REDACTED
LINCOLN	Suburban	-	\$0	REDACTED	\$REDACTED	REDACTED	\$REDACTED
AVERY	Rural	7	\$190	REDACTED	\$REDACTED	REDACTED	\$REDACTED
STANLY	Rural	3	\$2,624	REDACTED	\$REDACTED	REDACTED	\$REDACTED
ROCKINGHAM	Rural	10	\$406	REDACTED	\$REDACTED	REDACTED	\$REDACTED
ALLEGHANY	Rural	-	\$0	REDACTED	\$REDACTED	REDACTED	\$REDACTED
DUPLIN	Rural	-	\$0	REDACTED	\$REDACTED	REDACTED	\$REDACTED
IREDELL	Suburban	602	\$40,302	REDACTED	\$REDACTED	REDACTED	\$REDACTED
DAVIE	Rural	10	\$212	REDACTED	\$REDACTED	REDACTED	\$REDACTED
ALEXANDER	Rural	6	\$165	REDACTED	\$REDACTED	REDACTED	\$REDACTED
HERTFORD	Rural	-	\$0	REDACTED	\$REDACTED	REDACTED	\$REDACTED
PERQUIMANS	Rural	-	\$0	REDACTED	\$REDACTED	REDACTED	\$REDACTED
STOKES	Rural	9	\$2,468	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CLEVELAND	Rural	12	\$6,016	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CLAY	Rural	-	\$0	REDACTED	\$REDACTED	REDACTED	\$REDACTED
ANSON	Rural	-	\$0	REDACTED	\$REDACTED	REDACTED	\$REDACTED
TRANSYLVANIA	Rural	19	\$1,948	REDACTED	\$REDACTED	REDACTED	\$REDACTED
FRANKLIN	Rural	14	\$5,712	REDACTED	\$REDACTED	REDACTED	\$REDACTED
YANCEY	Rural	1	\$112	REDACTED	\$REDACTED	REDACTED	\$REDACTED
CHOWAN	Rural	-	\$0	REDACTED	\$REDACTED	REDACTED	\$REDACTED
BERTIE	Rural	-	\$0	-	\$0	-	\$0
YADKIN	Rural	-	\$0	-	\$0	-	\$0
MADISON	Rural	38	\$4,375	REDACTED	\$REDACTED	REDACTED	\$REDACTED
MONTGOMERY	Rural	-	\$0	-	\$0	-	\$0

County	County Type	Blue Cross		Aetna		Difference	
		Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount	Out-of-Network Claims	Estimated Member Paid Amount
GATES	Rural	-	\$0	-	\$0	-	\$0
GRAHAM	Rural	-	\$0	-	\$0	-	\$0
CAMDEN	Rural	-	\$0	-	\$0	-	\$0
MITCHELL	Rural	4	\$1,152	REDACTED	\$REDACTED	REDACTED	\$REDACTED
TYRRELL	Rural	-	\$0	-	\$0	-	\$0
CASWELL	Rural	-	\$0	-	\$0	-	\$0
CURRITUCK	Rural	-	\$0	-	\$0	-	\$0
JONES	Rural	-	\$0	-	\$0	-	\$0
WARREN	Rural	-	\$0	-	\$0	-	\$0
HYDE	Rural	-	\$0	-	\$0	-	\$0
MACON	Rural	13	\$1,279	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
PERSON	Rural	37	\$1,617	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
ALAMANCE	Suburban	916	\$72,294	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
NORTHAMPTON	Rural	1	\$1,125	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
RICHMOND	Rural	123	\$9,298	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
GREENE	Rural	2	\$3,853	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
BLADEN	Rural	26	\$1,140	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
POLK	Rural	25	\$5,036	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
VANCE	Rural	3	\$5,847	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
PAMLICO	Rural	5	\$3,177	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
PENDER	Rural	14	\$19,222	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
MARTIN	Rural	73	\$26,090	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
JACKSON	Rural	197	\$78,302	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
JOHNSTON	Rural	1,861	\$136,296	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
HOKE	Rural	5,806	\$303,702	REDACTED	\$REDACTED	REDACTED	-\$REDACTED
<b>Total</b>		<b>55,130</b>	<b>\$3,907,185</b>	<b>REDACTED</b>	<b>\$REDACTED</b>	<b>REDACTED</b>	<b>-\$REDACTED</b>

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

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network		
			Claims	Members	Charges
WAKE	Urban	72,570	REDACTED	REDACTED	\$REDACTED
MECKLENBURG	Urban	28,723	REDACTED	REDACTED	\$REDACTED
GUILFORD	Urban	23,826	REDACTED	REDACTED	\$REDACTED
DURHAM	Urban	18,335	REDACTED	REDACTED	\$REDACTED
ORANGE	Suburban	17,888	REDACTED	REDACTED	\$REDACTED
PITT	Suburban	16,004	REDACTED	REDACTED	\$REDACTED
FORSYTH	Urban	14,684	REDACTED	REDACTED	\$REDACTED
ALAMANCE	Suburban	11,669	REDACTED	REDACTED	\$REDACTED
NEW HANOVER	Urban	11,291	REDACTED	REDACTED	\$REDACTED
CUMBERLAND	Suburban	10,971	REDACTED	REDACTED	\$REDACTED
All Other		70,544	REDACTED	REDACTED	\$REDACTED
<b>Total</b>		<b>296,505</b>	REDACTED	REDACTED	\$REDACTED

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

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network		
			Claims	Members	Charges
JOHNSTON	Rural	12,748	REDACTED	REDACTED	\$REDACTED
WAYNE	Rural	7,832	REDACTED	REDACTED	\$REDACTED
ROBESON	Rural	7,440	REDACTED	REDACTED	\$REDACTED
BURKE	Rural	7,255	REDACTED	REDACTED	\$REDACTED
RANDOLPH	Rural	6,249	REDACTED	REDACTED	\$REDACTED
ONslow	Rural	5,993	REDACTED	REDACTED	\$REDACTED
NASH	Rural	5,838	REDACTED	REDACTED	\$REDACTED
SURRY	Rural	5,574	REDACTED	REDACTED	\$REDACTED
HARNETT	Rural	5,555	REDACTED	REDACTED	\$REDACTED
CLEVELAND	Rural	5,260	REDACTED	REDACTED	\$REDACTED
All Other		152,588	REDACTED	REDACTED	\$REDACTED
<b>Total</b>		<b>222,332</b>	REDACTED	REDACTED	\$REDACTED

Figure 27a

Disruption in All Counties

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network			Aetna In-Network/Blue Cross Out-of-Network		
			Claims	Members	Charges	Claims	Members	Charges
WAKE	Urban	72,570	REDACTED	REDACTED	\$REDACTED	12,672	3,622	\$3,981,544
MECKLENBURG	Urban	28,723	REDACTED	REDACTED	\$REDACTED	2,247	522	\$1,488,220
GUILFORD	Urban	23,826	REDACTED	REDACTED	\$REDACTED	1,749	703	\$608,071
DURHAM	Urban	18,335	REDACTED	REDACTED	\$REDACTED	8,006	4,361	\$2,485,832
ORANGE	Suburban	17,888	REDACTED	REDACTED	\$REDACTED	418	96	\$128,058
PITT	Suburban	16,004	REDACTED	REDACTED	\$REDACTED	819	241	\$209,670
FORSYTH	Urban	14,684	REDACTED	REDACTED	\$REDACTED	411	320	\$236,542
JOHNSTON	Rural	12,748	REDACTED	REDACTED	\$REDACTED	1,861	1,063	\$621,259
ALAMANCE	Suburban	11,669	REDACTED	REDACTED	\$REDACTED	854	562	\$319,964
NEW HANOVER	Urban	11,291	REDACTED	REDACTED	\$REDACTED	386	91	\$106,301
CUMBERLAND	Suburban	10,971	REDACTED	REDACTED	\$REDACTED	261	113	\$50,723
BUNCOMBE	Suburban	10,204	REDACTED	REDACTED	\$REDACTED	2,895	1,403	\$725,211
CABARRUS	Suburban	9,825	REDACTED	REDACTED	\$REDACTED	201	198	\$16,565
UNION	Suburban	9,283	REDACTED	REDACTED	\$REDACTED	142	17	\$25,865
WAYNE	Rural	7,832	REDACTED	REDACTED	\$REDACTED	7	2	\$1,837
GASTON	Suburban	7,703	REDACTED	REDACTED	\$REDACTED	591	125	\$104,651
ROBESON	Rural	7,440	REDACTED	REDACTED	\$REDACTED	60	22	\$28,840
BURKE	Rural	7,255	REDACTED	REDACTED	\$REDACTED	702	278	\$149,901
CATAWBA	Suburban	7,118	REDACTED	REDACTED	\$REDACTED	226	46	\$40,097
IREDELL	Suburban	6,899	REDACTED	REDACTED	\$REDACTED	581	223	\$170,330
RANDOLPH	Rural	6,249	REDACTED	REDACTED	\$REDACTED	128	17	\$17,657
ONslow	Rural	5,993	REDACTED	REDACTED	\$REDACTED	74	23	\$22,446
NASH	Rural	5,838	REDACTED	REDACTED	\$REDACTED	106	19	\$19,662
DAVIDSON	Suburban	5,829	REDACTED	REDACTED	\$REDACTED	16	2	\$3,750
SURRY	Rural	5,574	REDACTED	REDACTED	\$REDACTED	24	3	\$4,700
HARNETT	Rural	5,555	REDACTED	REDACTED	\$REDACTED	54	20	\$14,298
ROWAN	Suburban	5,431	REDACTED	REDACTED	\$REDACTED	47	12	\$10,969
CLEVELAND	Rural	5,260	REDACTED	REDACTED	\$REDACTED	12	8	\$25,090
BRUNSWICK	Rural	5,248	REDACTED	REDACTED	\$REDACTED	188	133	\$89,051
WATAUGA	Rural	5,117	REDACTED	REDACTED	\$REDACTED	44	16	\$14,262
CALDWELL	Rural	4,711	REDACTED	REDACTED	\$REDACTED	11	5	\$13,130
HENDERSON	Suburban	4,529	REDACTED	REDACTED	\$REDACTED	112	23	\$64,938
LENOIR	Rural	4,456	REDACTED	REDACTED	\$REDACTED	2	2	\$16,556
CHATHAM	Rural	4,292	REDACTED	REDACTED	\$REDACTED	154	114	\$56,496
WILSON	Rural	4,206	REDACTED	REDACTED	\$REDACTED	29	10	\$24,811
RUTHERFORD	Rural	4,174	REDACTED	REDACTED	\$REDACTED	22	1	\$3,300
FRANKLIN	Rural	4,133	REDACTED	REDACTED	\$REDACTED	14	13	\$25,564

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network			Aetna In-Network/Blue Cross Out-of-Network		
			Claims	Members	Charges	Claims	Members	Charges
CRAVEN	Rural	4,126	REDACTED	REDACTED	\$REDACTED	28	14	\$8,432
MOORE	Rural	4,068	REDACTED	REDACTED	\$REDACTED	821	253	\$202,037
LEE	Rural	3,801	REDACTED	REDACTED	\$REDACTED	13	6	\$2,255
STANLY	Rural	3,791	REDACTED	REDACTED	\$REDACTED	3	2	\$10,521
COLUMBUS	Rural	3,754	REDACTED	REDACTED	\$REDACTED	38	35	\$56,083
LINCOLN	Suburban	3,723	REDACTED	REDACTED	\$REDACTED	-	-	\$0
SAMPSON	Rural	3,636	REDACTED	REDACTED	\$REDACTED	19	19	\$8,606
GRANVILLE	Rural	3,588	REDACTED	REDACTED	\$REDACTED	3	2	\$328
CARTERET	Rural	3,547	REDACTED	REDACTED	\$REDACTED	54	32	\$22,060
WILKES	Rural	3,540	REDACTED	REDACTED	\$REDACTED	1	1	\$130
BEAUFORT	Rural	3,264	REDACTED	REDACTED	\$REDACTED	-	-	\$0
HAYWOOD	Rural	3,239	REDACTED	REDACTED	\$REDACTED	18	7	\$2,310
ROCKINGHAM	Rural	3,234	REDACTED	REDACTED	\$REDACTED	-	-	\$0
PENDER	Rural	3,113	REDACTED	REDACTED	\$REDACTED	13	13	\$69,206
JACKSON	Rural	3,080	REDACTED	REDACTED	\$REDACTED	197	183	\$358,591
MCDOWELL	Rural	2,871	REDACTED	REDACTED	\$REDACTED	79	69	\$59,453
PASQUOTANK	Rural	2,715	REDACTED	REDACTED	\$REDACTED	193	173	\$66,651
DUPLIN	Rural	2,511	REDACTED	REDACTED	\$REDACTED	-	-	\$0
RICHMOND	Rural	2,486	REDACTED	REDACTED	\$REDACTED	123	102	\$42,468
HALIFAX	Rural	2,468	REDACTED	REDACTED	\$REDACTED	-	-	\$0
VANCE	Rural	2,408	REDACTED	REDACTED	\$REDACTED	3	2	\$29,236
PERSON	Rural	2,211	REDACTED	REDACTED	\$REDACTED	37	12	\$7,141
BLADEN	Rural	2,207	-	-	\$0	26	17	\$5,297
ASHE	Rural	2,112	REDACTED	REDACTED	\$REDACTED	1	1	\$246
STOKES	Rural	2,051	REDACTED	REDACTED	\$REDACTED	8	5	\$1,564
EDGEcombe	Rural	2,037	REDACTED	REDACTED	\$REDACTED	-	-	\$0
DARE	Rural	2,016	REDACTED	REDACTED	\$REDACTED	16	11	\$3,489
ALEXANDER	Rural	1,967	REDACTED	REDACTED	\$REDACTED	6	6	\$804
DAVIE	Rural	1,907	REDACTED	REDACTED	\$REDACTED	10	3	\$1,035
YADKIN	Rural	1,865	-	-	\$0	-	-	\$0
MARTIN	Rural	1,848	REDACTED	REDACTED	\$REDACTED	73	67	\$119,866
MONTGOMERY	Rural	1,662	-	-	\$0	-	-	\$0
SCOTLAND	Rural	1,568	REDACTED	REDACTED	\$REDACTED	-	-	\$0
ANSON	Rural	1,563	REDACTED	REDACTED	\$REDACTED	-	-	\$0
HOKE	Rural	1,554	REDACTED	REDACTED	\$REDACTED	5,806	4,752	\$1,378,210
MACON	Rural	1,374	REDACTED	REDACTED	\$REDACTED	10	9	\$5,750
AVERY	Rural	1,341	REDACTED	REDACTED	\$REDACTED	7	3	\$950
YANCEY	Rural	1,276	REDACTED	REDACTED	\$REDACTED	-	-	\$0
CHEROKEE	Rural	1,268	REDACTED	REDACTED	\$REDACTED	238	37	\$21,893

Provider County	County Type	Total Members	Blue Cross In-Network/Aetna Out-of-Network			Aetna In-Network/Blue Cross Out-of-Network		
			Claims	Members	Charges	Claims	Members	Charges
MITCHELL	Rural	1,193	-	-	\$0	-	-	\$0
GREENE	Rural	1,190	REDACTED	REDACTED	\$REDACTED	2	1	\$19,263
TRANSYLVANIA	Rural	1,180	REDACTED	REDACTED	\$REDACTED	16	8	\$7,500
BERTIE	Rural	1,179	-	-	\$0	-	-	\$0
MADISON	Rural	1,141	-	-	\$0	-	-	\$0
CHOWAN	Rural	1,031	REDACTED	REDACTED	\$REDACTED	-	-	\$0
HERTFORD	Rural	982	REDACTED	REDACTED	\$REDACTED	-	-	\$0
CURRITUCK	Rural	923	-	-	\$0	-	-	\$0
PERQUIMANS	Rural	895	REDACTED	REDACTED	\$REDACTED	-	-	\$0
POLK	Rural	829	REDACTED	REDACTED	\$REDACTED	25	22	\$23,986
WASHINGTON	Rural	811	REDACTED	REDACTED	\$REDACTED	-	-	\$0
NORTHAMPTON	Rural	774	REDACTED	REDACTED	\$REDACTED	1	1	\$4,500
WARREN	Rural	758	-	-	\$0	-	-	\$0
CASWELL	Rural	739	-	-	\$0	-	-	\$0
ALLEGHANY	Rural	737	REDACTED	REDACTED	\$REDACTED	-	-	\$0
JONES	Rural	656	-	-	\$0	-	-	\$0
SWAIN	Rural	615	REDACTED	REDACTED	\$REDACTED	108	78	\$162,537
CAMDEN	Rural	601	-	-	\$0	-	-	\$0
PAMLICO	Rural	597	REDACTED	REDACTED	\$REDACTED	5	2	\$15,885
GATES	Rural	538	-	-	\$0	-	-	\$0
CLAY	Rural	502	REDACTED	REDACTED	\$REDACTED	-	-	\$0
GRAHAM	Rural	498	-	-	\$0	-	-	\$0
HYDE	Rural	408	-	-	\$0	-	-	\$0
TYRRELL	Rural	407	-	-	\$0	-	-	\$0
<b>Total</b>		<b>518,837</b>	<b>REDACTED</b>	<b>REDACTED</b>	<b>\$REDACTED</b>	<b>44,127</b>	<b>20,377</b>	<b>\$14,644,443</b>

# **EXHIBIT B**

**MARY KAREN WILLS, CPA  
EXPERT REPORT  
DATED 10/4/2023**

STATE OF NORTH CAROLINA  
DURHAM COUNTY

IN THE OFFICE OF  
ADMINISTRATIVE HEARINGS  
23 INS 738

BLUE CROSS AND BLUE SHIELD OF  
NORTH CAROLINA,  
Petitioner,

v.

NORTH CAROLINA STATE HEALTH  
PLAN FOR TEACHERS AND STATE  
EMPLOYEES,  
Respondent,

and

AETNA LIFE INSURANCE COMPANY,  
Respondent-Intervenor.

EXPERT REPORT

Mary Karen Wills, CPA

BERKELEY RESEARCH GROUP  
1800 M Street, N. W.  
Suite 200  
Washington, DC 20036

October 4, 2023

CONFIDENTIAL

**TABLE OF CONTENTS**

I. INTRODUCTION AND SCOPE OF ASSIGNMENT ..... 1

II. QUALIFICATIONS ..... 1

III. FACTS AND DATA CONSIDERED ..... 2

IV. SUMMARY OF OPINIONS ..... 2

V. BACKGROUND ..... 2

VI. DETAILED OPINIONS ..... 3

    OPINION A ..... 3

    OPINION B ..... 6

    OPINION C ..... 11

VII. POSSIBLE REVISIONS TO THIS REPORT..... 15

VIII. COMPENSATION ..... 15

**ATTACHMENTS**

- Attachment A: Mary Karen Wills, Curriculum Vitae
- Attachment B: Expert Testimony of Mary Karen Wills, Previous Four Years
- Attachment C: Facts or Data Considered in Connection with this Report

## **I. INTRODUCTION AND SCOPE OF ASSIGNMENT**

1. My name is Mary Karen Wills. This report presents my expert opinions in the matter of *Blue Cross and Blue Shield of North Carolina v. North Carolina State Health Plan for Teachers and State Employees*.
2. I have been retained by Robinson Bradshaw on behalf of its client, Petitioner Blue Cross and Blue Shield of North Carolina (“Blue Cross NC”), to provide independent analysis and expert testimony related to the North Carolina State Health Plan for Teachers and State Employees’ (“SHP’s” or “the Plan’s”) request for proposal (“RFP”) and procurement process for the Plan’s 2025-2027 contract for third-party administrative services.
3. The expert opinions presented in this report are based on my education and experience, as well as my analysis and review of relevant documents. I have been asked to form my own conclusions based upon the record, my training and education, and my extensive professional experience working on procurements, bid protests, and federal, state, and local government contract practices and processes. My opinions are stated with a reasonable degree of professional certainty. I reserve the right to modify the opinions contained in this report should additional documents, deposition testimony, or information become available. I further reserve the right to offer additional opinions within my areas of expertise in response to opinions or subjects offered by other experts in this matter.

## **II. QUALIFICATIONS**

4. I am a Managing Director at the Berkeley Research Group LLC (“BRG”) in Washington, D.C., where I lead BRG’s Government Contract Advisory Services Group. I am a CPA with over 35 years of experience providing audit, consulting, advisory, and litigation services primarily for, but not limited to, companies that perform federal, state, and local government contracts. My experience involves assisting companies to address business processes and compliance matters arising from procurements with federal, state, and local governments. I have extensive experience working on procurement-related and bid-protest matters, where I serve as an expert and routinely examine RFPs, cost and technical evaluations of proposals, and award determinations. I have experience across a wide variety of industries, including health care, health insurance, manufacturing, professional services, technology, security, and utilities, among others.
5. My experience with litigation services and expert testimony includes government contract accounting, procurement, contract administration, pricing, compliance matters, cost accounting, alleged fraud, internal controls, and claims asserted under the False Claims Act and the Contract Disputes Act. I have worked extensively on bid protest matters, where I have been accepted as an expert pursuant to protective orders with the General Accounting Office and Court of Federal Claims, as well as other federal and state courts.

6. Prior to my role at BRG, I led the Government Contract Practice for Arthur Andersen LLP in Washington, D.C., where I performed financial-statement audits and provided government-contract consulting services to publicly traded and privately held companies. I have also led similar practices at other firms, where I was responsible for each firm’s government-contracting-services practice, which included engagements involving bid protests, procurement, disputes, and myriad other assignments. My curriculum vitae is attached as **Attachment A**. A list of my expert testimony in the previous four years is attached as **Attachment B**.

### **III. FACTS AND DATA CONSIDERED**

7. My opinions are based on my analysis of the documents listed in **Attachment C**.

### **IV. SUMMARY OF OPINIONS**

8. It is my opinion that:
  - a. The Plan’s final scoring methodology for the RFP—a methodology in which the Plan assigned the vendors one set of points on each of two components, then ranked the vendors based on that first set of points, then assigned a different set of points based on those ranks, and then ranked the vendors again based on that second set of points—failed to follow best practices for procurements.
  - b. The Plan’s scoring methodology for the cost component of the RFP—a methodology that was not explained in the RFP, and that was subjective and unreasoned—did not follow best practices for procurements.
  - c. The Plan’s approach to the technical component of the RFP—an approach in which the Plan barred all narrative responses, yet did nothing to validate any part of the vendors’ technical proposals—did not follow best practices for procurements.

### **V. BACKGROUND**

9. The Plan is a self-insured, government-sponsored health plan that provides health-care coverage to nearly 750,000 teachers, state employees, retirees, and their dependents.<sup>1</sup>
10. Blue Cross NC is a fully taxed, not-for-profit North Carolina corporation in the business of providing health-insurance services.<sup>2</sup> Blue Cross NC has served as the Plan’s Third-Party Administrator (“TPA”) for many years, most recently being awarded the contract

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<sup>1</sup> <https://www.shpnc.org/who-we-are>.

<sup>2</sup> <https://www.bluecrossnc.com/about-us>.

from January 1, 2022 to December 31, 2024 as a result of the Plan’s 2019 RFP for TPA services (the “2019 TPA RFP”).<sup>3</sup>

11. In April 2022, the Plan informed Blue Cross NC that the Plan would issue a new TPA RFP (the “2022 TPA RFP”) for services to begin on January 1, 2025.<sup>4</sup> After meeting with potential vendors, the Plan issued the 2022 TPA RFP on August 30, 2022.<sup>5</sup> Aetna Life Insurance Company (“Aetna”), Blue Cross NC, and UMR, Inc. (“UMR”) were the three companies (collectively, “Vendors”) that submitted proposals in response to the 2022 TPA RFP.
12. The Segal Company, Inc. (“Segal”) is a multinational benefits, compensation, and human-resources consulting firm headquartered in New York City.<sup>6</sup> Segal assisted the Plan in preparing and evaluating the 2022 TPA RFP.<sup>7</sup>
13. On December 14, 2022, the Plan awarded the contract to Aetna.

## VI. DETAILED OPINIONS

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

14. The 2022 TPA RFP required vendors to submit separate technical and cost proposals.<sup>8</sup>
15. The RFP stated that the technical and cost proposals would be weighted equally:<sup>9</sup>

Technical Proposal:	50%
Cost Proposal:	<u>50%</u>
Total:	100%

16. The RFP’s technical component required binary “confirm” or “does not confirm” responses to 310 technical statements. Vendors received one point for each “confirm” response and zero points for each “does not confirm” response. The maximum score on the technical component was therefore 310 points.<sup>10</sup>

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<sup>3</sup> Petition for a Contested Case Hearing dated February 16, 2023, Attachment A ¶ 1.

<sup>4</sup> SHP 0075507.

<sup>5</sup> SHP Request for Proposal #270-20220830TPAS dated August 30, 2022 (“2022 TPA RFP”).

<sup>6</sup> <https://www.segalco.com/about-us>.

<sup>7</sup> SHP 0000001.

<sup>8</sup> The RFP also required vendors to submit responses to a set of minimum requirements.

<sup>9</sup> 2022 TPA RFP at 24.

<sup>10</sup> 2022 TPA RFP at 24 & Attachment L.

17. The maximum score on the cost component, in contrast, was 10 points. The cost component was divided into three categories, and those categories were assigned points as follows:<sup>11</sup>
- Network Pricing (6 points),
  - Administrative Fees (2 points), and
  - Network-Pricing Guarantees (2 points).
18. The Plan used a final scoring methodology that ranked the Vendors based on one set of points, then assigned a different set of points to the Vendors based on those ranks, then ranked the Vendors again based on the second set of points:
- Based on their point scores on the technical component's 310-point scale and the cost component's 10-point scale, the Vendors were ranked on each component.
  - Based on their ranks, the Vendors were then assigned a different set of points for each component.
  - Based on the totals that they received in that second set of points, the Vendors were then ranked again.
19. This scoring methodology played out as follows:
- On the technical component, Aetna and UMR each received 310 points and were ranked first; Blue Cross NC received 303 points and was ranked third. On the cost component, Blue Cross NC and Aetna each received 8 points and were ranked first; UMR received 7 points and was ranked third.<sup>12</sup>
  - In the second set of point scoring, based on their ranks for the technical component, Aetna and UMR were each assigned 3 points, and Blue Cross NC was assigned 1 point. Based on their ranks on the cost component, Blue Cross NC and Aetna were each assigned 3 points, and UMR was assigned 1 point.<sup>13</sup>
  - In this second set of points, Aetna received 6 total points, and Blue Cross NC and UMR each received 4 total points. Aetna was thus ranked first overall, and Blue Cross NC and UMR were ranked

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<sup>11</sup> 2022 TPA RFP at 24-25.

<sup>12</sup> SHP 0025420 at 0025422-0025423.

<sup>13</sup> *Id.*

second overall.<sup>14</sup>

20. Based on my experience, the Plan's final scoring methodology conflicts with best practices for procurements.
21. In my 35-year career, I have reviewed hundreds of RFPs. I have read dozens of books and articles on procurement practices. I have attended numerous conferences about the procurement industry and have had countless conversations with others in the industry. I do not recall ever seeing, or even hearing any mention of, an RFP that used the type of points-to-ranks-to-points-to-ranks scoring methodology that the Plan used here. Furthermore, in an internal email, Segal personnel stated that the Plan was "going the wrong way" with this scoring methodology.<sup>15</sup>
22. In my experience, the best practice for a final scoring methodology is instead to assign ranks only once, at the end of the scoring process, after combining each vendor's points (properly weighted) for all components of the RFP.
23. A good example of a scoring methodology that follows this best practice comes from a well-regarded expert publication on RFP best practices, guidelines, and explanations entitled The Request for Proposal Handbook ("RFP Handbook"). The RFP Handbook illustrates this practice by citing an RFP example from Tarrant County, Texas's Purchasing Department that discusses the ranking of proposals. The RFP example states that "the Points awarded to the Technical and Cost Proposals will be added together to determine the total score and the ranking of each Proposal."<sup>16</sup>
24. Based on my experience, this established practice of assigning ranks only once is a best practice because it avoids skewing vendors' final scores.
25. The approach that the Plan used here skewed the Vendors' final scores. On the cost component, Blue Cross NC and Aetna received the same best-and-final-offer cost-proposal total score of 8 points.<sup>17</sup> On the technical component, Aetna received 310 points, and Blue Cross NC received 303 points.<sup>18</sup> Blue Cross NC thus received 100% of Aetna's cost score and 97.74% of Aetna's technical score. But under the Plan's final scoring methodology, Aetna received a final combined score of 6 points, and Blue Cross NC received a final combined score of only 4 points. Blue Cross NC's final combined score was thus only two-thirds, or 66.67%, of Aetna's final combined score. The Plan's approach thus skewed Blue Cross NC's final combined score by a substantial margin.
26. An approach that followed best practices would not have skewed Blue Cross NC's final

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<sup>14</sup> *Id.*

<sup>15</sup> SHP 0092427 at 0092428.

<sup>16</sup> The Request for Proposal Handbook, The Best RFP Practices, Checklists, Guidelines, Examples and Regulations from More Than 100 State and Local Governments and Their Agencies; Fifth Edition; Michael Asner; September 2014, at 201-202.

<sup>17</sup> SHP 0025420 at 0025423.

<sup>18</sup> *Id.* at 0025422.

combined score in this way. Under a best-practices approach, the Plan would have scaled the Vendors' cost and technical scores to each other—for example, by converting the cost scores to the same 310-point scale as the technical scores. The Plan then would have combined each Vendor's cost and technical scores. Only after combining those scores would the Plan have ranked the Vendors. In fact, the Plan used this approach to score the combined technical and cost proposals during the 2019 TPA RFP.<sup>19</sup> Additionally, a draft version of the 2022 TPA RFP assigned a maximum 310 points to the cost proposal.<sup>20</sup>

27. Under this best-practices approach to the final scoring, all else equal, Aetna would have received a final combined score of 558, and Blue Cross NC would have received a final combined score of 551.<sup>21</sup> Blue Cross NC thus would have received 98.7% of Aetna's final combined score.
28. By the same token, under this best-practices approach to the final scoring, only a small upward change to Blue Cross NC's cost score, or a small downward change to Aetna's cost score, would have changed the final result. For example, if Blue Cross NC had received 9 points on the cost component instead of 8 points, its final combined score under this best-practices approach would have been 582 points. Or if Aetna had received 7 points on the cost component instead of 8 points, its total score under this best-practices approach would have been 527 points.
29. In sum, the Plan did not follow best practices in its final scoring methodology. The Plan's methodology skewed Blue Cross NC's final score. Absent that skew, a small change in the Vendors' cost scores would have changed the outcome of the RFP.

**B. The Plan's scoring methodology for the cost component of the RFP—a methodology that was not explained in the RFP, and that was subjective and unreasoned—did not follow best practices for procurements.**

30. The Plan also failed to follow best practices in its methodology for scoring the cost component of the RFP. That is the case because (a) the Plan's distribution of points among the three parts of the cost component was unreasoned, and (b) the Plan's methodology for awarding points for administrative fees and for network-pricing guarantees was not explained in the RFP and was subjective and unreasoned.
  - i. **The Plan's distribution of points among the three categories of the cost proposal was unreasoned.**

31. As discussed above, the maximum score on the cost component of the RFP was 10 points.

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<sup>19</sup> SHP Request for Proposal #270-20191001TPAS at 21.

<sup>20</sup> SHP 0075767 at 0075787.

<sup>21</sup> These scores are calculated by multiplying Aetna and Blue Cross NC's cost proposal scores by 31 (so that cost and technical scores both have a maximum total of 310 points), and then adding each Vendor's cost-proposal score to its technical-proposal score.

The Plan divided those 10 points among the three categories in a 6-2-2 distribution: 6 points for network pricing, 2 points for administrative fees, and 2 points for network-pricing guarantees.

32. Table 1 below depicts the Plan’s and Segal’s final scoring of cost proposals:

**Table 1<sup>22</sup>**

<b>Cost Proposal Scoring Summary</b>				
<b>Vendor</b>	<b>Network Pricing</b>	<b>Administrative Fees</b>	<b>Network Pricing Guarantees</b>	<b>Cost Proposal Total Score</b>
<b>Allocated Points</b>	<b>6</b>	<b>2</b>	<b>2</b>	<b>10</b>
<b>Aetna</b>	6	1	1	<b>8</b>
<b>BCBSNC</b>	6	2	0	<b>8</b>
<b>UMR</b>	5	0	2	<b>7</b>

33. Based on my experience and my review of the evidence in this case, the Plan failed to follow best practices when it used this 6-2-2 distribution of points. That is so because the Plan appears to have lacked a reasoned basis for this 6-2-2 distribution.
34. Based on my experience, the best practice is to distribute points among different parts of an RFP in a way that corresponds to the relative significance of those parts, as opposed to distributing points using an unreasoned scale.
35. In my 35 years of experience reviewing RFPs, studying literature on procurement practices, attending conferences, and working with other practitioners in the industry, I do not recall ever seeing, or even hearing mention of, an RFP that distributed scoring points among different parts of an RFP without a reasoned basis. To the contrary, the RFPs that I have reviewed have distributed points based on the relative significance of the corresponding parts of the RFP. That is also the practice that I have observed, studied, and approved throughout my career.
36. The Plan’s own procurement policy endorses the practice of distributing points based on relative significance when that policy calls for each component of an RFP to be assigned an “appropriate number of point[s] relative to the importance of the component.”<sup>23</sup>
37. Based on my review of the evidence in this case, the Plan failed to follow best practices on the distribution of points. My staff and I have reviewed the deposition testimony of the Plan’s witnesses. None of those witnesses offered a sound justification for the 6-2-2 distribution of points among the three parts of the cost proposal. The Plan’s 6-2-2 distribution thus appears to have been chosen without a reasoned basis.

<sup>22</sup> SHP 0069475 at 0069478.

<sup>23</sup> SHP 0092221 at 0092228.

38. The lack of a basis for this 6-2-2 distribution is particularly evident in the Plan's assignment of 2 points both for administrative fees and for network-pricing guarantees. Administrative fees are fixed costs for the Plan.<sup>24</sup> Network-pricing guarantees, in contrast, are contingent rebates that the Plan can recover only if a Vendor does not meet its pricing commitments.<sup>25</sup> Fixed costs are, in my experience, more significant than contingent costs and contingent rebates. As a result, the Plan's assignment of equal points to fixed costs and contingent costs highlights the absence of reasoning for its distribution of points within the RFP's cost component.
39. In fact, in its 2019 TPA RFP, the Plan's cost-proposal criteria did not even include network-pricing guarantees as a component that would be included or evaluated in scoring. Further, in Segal's proposal to provide third-party evaluation services to the Plan for its TPA procurement, Segal included an RFP design for a previous client's insurance program. It is of note that the RFP design also did not assign **any** points to network-pricing guarantees in the financial evaluation.<sup>26</sup> These other RFPs illustrate the lower relative significance of network-pricing guarantees.
40. The Plan's failure to follow best practices on the distribution of points mattered to the outcome of the scoring for the RFP's cost component.
41. Blue Cross NC received 2 points for administrative fees and 0 points for network-pricing guarantees. And Blue Cross NC and Aetna tied for overall points on the cost component. If the Plan had instead distributed more points to administrative fees than to network-pricing guarantees, Blue Cross NC would have had the highest overall score on the cost proposal.
42. In sum, the Plan did not follow best practices when it distributed the points for the three parts of the RFP's cost component in an unreasoned way. If the Plan had instead distributed those points in a reasoned way, Blue Cross NC would have won the cost proposal.
- ii. The Plan's methodology for awarding points for administrative fees and for network-pricing guarantees was not explained in the RFP, resulting in a subjective and unreasoned point scoring method.**
43. Based on my experience and my review of the evidence in this case, the Plan also failed to follow best practices in its methodology for awarding points for administrative fees and for network-pricing guarantees.
44. For administrative fees, the Plan used a methodology in which it awarded 2 points to the Vendor with the highest-ranked proposal and awarded either 1 point or 0 points to the

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<sup>24</sup> 2022 TPA RFP, Attachment A: Pricing.

<sup>25</sup> *Id.*

<sup>26</sup> SHP 0003962 at 0004054-0004091.

Vendors with the second- and third-ranked proposals.<sup>27</sup>

45. The Plan followed the same approach for network-pricing guarantees.<sup>28</sup>
46. The RFP did not state how the Plan would decide between awarding 1 point or 0 points to the second- and third-ranked proposals. The RFP stated only that the second- and third-ranked proposals “may receive one (1) or zero (0) points based on their administrative fees in comparison to the lowest administrative fee proposal and the other proposals,” and “may receive one (1) or zero (0) points based on the value of their proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.”<sup>29</sup>
47. Based on my experience and my analysis of the information I considered in this case, the Plan failed to follow best practices in its methodology for awarding points for administrative fees and for network-pricing guarantees. That is because the Plan’s methodology was not specifically described in the RFP and was subjective and unreasoned.
48. Based on my 35 years of experience reviewing RFPs, studying literature on procurement practices, attending conferences, and working with other practitioners in the industry, my understanding is that the best practice for awarding points for parts of an RFP is to use a process that is (a) described in the RFP, (b) objective, and (c) rational.
49. Numerous resources confirm that the best practice is for the RFP to describe the process that will be used to award points. For example, The Harvard Kennedy School’s Government Performance Lab has published the Guidebook: Crafting a Result-Driven Request for Proposals (RFP) (“Guidebook”). This notable publication on RFPs describes five characteristics of good evaluation criteria. The third characteristic is that evaluation criteria should “[p]rovide sufficient information to let proposers know what a successful response looks like.”<sup>30</sup> The Guidebook elaborates on this characteristic by explaining that an “evaluation committee should have a clear idea of what a high scoring proposal would look like in each criterion before evaluations begin.”<sup>31</sup>
50. Here, because of the lack of a stated methodology for awarding points on administrative fees and network-pricing guarantees, the Plan did not have a clear idea before the evaluations began of how administrative fees and network-pricing guarantees were to be evaluated. This problem contributed to a subjective and unreasoned point-scoring method.
51. As another example, the RFP Handbook states that an RFP should “provide potential responders with an understanding of how proposals will be reviewed, both individually

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<sup>27</sup> 2022 TPA RFP at 25.

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

<sup>30</sup> Harvard Kennedy School, Government Performance Lab, Guidebook: Crafting a Result-Driven Request for Proposals (RFP) at 55.

<sup>31</sup> *Id.*

and in comparison, with other proposals.”<sup>32</sup>

52. The RFP Handbook also discusses a state procurement standard that requires RFPs to “provide a description of the factors that will be considered by the procurement officer when evaluating the proposals received, including the relative importance of price and other evaluation factors.”<sup>33</sup>
53. The North Carolina Department of Administration’s procurement standards similarly state that the “scoring methodology must be spelled out in the solicitation document.”<sup>34</sup>
54. Numerous resources also confirm that the best practice is for the RFP to award points in an objective way. For example, the Harvard Kennedy School’s Guidebook highlights the need for an unbiased and objective perspective. In the Guidebook’s five characteristics of good evaluation criteria, the fifth characteristic states that proper evaluation criteria “[a]re fair to all proposers [and] free of bias.”<sup>35</sup>
55. Likewise, the North Carolina Department of Administration’s procurement standards state that evaluations of bids “shall be based on measurable and objective criteria.”<sup>36</sup>
56. Similarly, the Plan’s own procurement policy states that the development of a scoring methodology “is critical to ensure a fair and impartial evaluation process for all proposals.”<sup>37</sup>
57. Based on my review of the evidence in this case, the Plan failed to follow best practices in its methodology for awarding points for administrative fees and for network-pricing guarantees, because the Plan did not use a process that was described in the RFP or that was objective and rational. The Plan instead used a process that was not described in the RFP and that was subjective and unreasoned.
58. As noted above, the RFP did not describe how the Plan would decide between awarding 1 point or 0 points to the second- and third-ranked proposals on administrative fees and on network-pricing guarantees. The RFP stated only that the second-and-third ranked proposals “may receive one (1) or zero (0) points based on their administrative fees in comparison to the lowest administrative fee proposal and the other proposals,” and “may receive one (1) or zero (0) points based on the value of their proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.”<sup>38</sup> Based on my experience, those statements were too vague to provide the type of description of the Plan’s scoring methodology that best practices demand.

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<sup>32</sup> RFP Handbook at 424.

<sup>33</sup> *Id.* at 193.

<sup>34</sup> North Carolina Procurement Manual; NC DOA Department of Administration Purchase & Contract 2022 (“2022 North Carolina Procurement Manual”) at 60.

<sup>35</sup> Guidebook at 55.

<sup>36</sup> 2022 North Carolina Procurement Manual at 60.

<sup>37</sup> SHP 0092221 at 0092227.

<sup>38</sup> 2022 TPA RFP at 25.

59. The decision between awarding 1 point or 0 points to the second- and third-ranked proposals was also subjective and unreasoned. My staff and I have reviewed the deposition testimony of the Plan's and Segal's witnesses, and no Plan or Segal representative has offered an objective or sound justification for how these decisions were made. To the contrary, the Plan and Segal stated in contemporaneous emails that the scoring of the network-pricing guarantees would be *subjective*.<sup>39</sup>
60. The Plan's failure to follow best practices for the scoring process for administrative fees and for network-pricing guarantees mattered to the outcome on the RFP's cost component and mattered to the Plan's determination of the most competitive cost proposal.
61. On administrative fees, Blue Cross NC received 2 points, and Aetna received 1 point.<sup>40</sup> If Aetna had instead received 0 points, Blue Cross NC would have had the highest overall score on the cost proposal.
62. On network-pricing guarantees, Aetna received 1 point, and Blue Cross NC received 0 points.<sup>41</sup> If Aetna had instead received 0 points, or if Blue Cross NC had instead received 1 point, Blue Cross NC would have had the highest overall score on the cost proposal.
63. In sum, the Plan did not follow best practices when it used a process for awarding points for administrative fees and network-pricing guarantees that was not described in the RFP and that was subjective and unreasoned. If the Plan had instead used a described, objective, and rational process, Blue Cross NC might have won the cost proposal.

**C. The Plan's approach to the technical component of the RFP—an approach in which the Plan barred all narrative responses, yet did nothing to validate any part of the vendors' technical proposals—did not follow best practices for procurements.**

64. The Plan also failed to follow best practices in its approach to evaluating the RFP's technical component. That is the case because the Plan barred the Vendors from submitting any narrative responses in their technical proposals, and did nothing to validate any part of the Vendors' technical proposals.<sup>42</sup>
65. The Plan's approach to the technical component relied solely on a set of binary "confirm" or "does not confirm" responses to 310 technical requirements. The Plan did not allow for narrative responses, descriptions, or any exchange of information on any of these

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<sup>39</sup> SHP 0070486; SHP 0085692 at 0085693.

<sup>40</sup> SHP 0069475 at 0069478.

<sup>41</sup> *Id.*

<sup>42</sup> Transcript of Deposition of Caroline Smart dated September 13, 2023 ("Smart Dep."), at 61-62.

requirements. Nor did the Plan take any steps to validate any of the Vendors' responses. The Plan thus effectively turned the RFP's technical component into an exercise in which each Vendor self-certified whether it would meet each technical requirement, and in which the Plan did nothing to evaluate each Vendor's actual ability to meet each requirement.

66. Based on my experience, this approach failed to follow best practices. In my 35 years of experience reviewing RFPs, studying literature on procurement practices, attending conferences, and working with other practitioners in the industry, I do not recall ever seeing, or even hearing mention of, an approach to technical proposals like the approach that the Plan used here: an approach that barred narrative responses and completely lacked validation of Vendors' technical proposals. My view, informed by my experience, is that the best practice for the technical component of an RFP is, at a minimum, to accept at least some narrative responses and to do at least some validation of Vendors' technical-proposal responses.
67. Based on my experience, at a minimum, technical proposals should include narrative responses from vendors that enable a robust, objective evaluation of each vendor's actual ability to meet the technical requirements. Responses should also include explicit descriptions of limitations affecting the ability to fully deliver on various technical requirements. Without offering an opportunity to describe limitations, a purchasing organization is left to assume that a vendor responding "confirm" will adhere to a technical requirement 100% of the time. Without explanations, vendors are forced to consider and respond to the wording of a technical statement *quite literally* without revealing potential circumstances that could cast doubt on a "confirm" response in some cases. In these ways, the failure to allow selected narrative responses does not follow best practices for procurements and ultimately places too much pressure on the wording of technical requirements.
68. The Tarrant County, Texas RFP referenced in the RFP Handbook illustrates the best practice for a technical evaluation. In that example, technical proposals were "scored according to how well [each vendor] responded to each of the requirements in the Technical Proposal Section."<sup>43</sup> The technical proposals were not scored, as here, simply by counting each vendor's "confirm" responses.
69. The best-practice approach of accepting at least some narrative responses and doing at least some validation of vendors' technical proposals aligns with what I, based on my experience, understand the underlying purpose of a technical evaluation to be: to determine whether vendors can actually meet the RFP's technical requirements and to assess potential technical risks such as disruption, increased costs, the need for increased oversight, and unsuccessful contract performance.
70. The Harvard Kennedy School's Guidebook also illustrates how an RFP should request detailed information from vendors so that the purchasing organization has all the

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<sup>43</sup> RFP Handbook at 201-202.

information necessary to properly evaluate the vendors. In the Guidebook's five characteristics of good evaluation criteria, the fourth characteristic is that evaluation criteria should "[c]learly align to proposal responses and submittals requested."<sup>44</sup> The Guidebook elaborates that each piece of information requested should tell the evaluator what she "need[s] to know to assess a proposer on the evaluation criterion to which [that piece of information] corresponds."<sup>45</sup>

71. Based on my 35 years of experience reviewing RFPs, studying literature on procurement practices, attending conferences, and working with other practitioners in the industry, my view is that the underlying purpose of a technical evaluation is served by an approach that allows at least some narrative responses and involves at least some validation of vendors' technical proposals. That is because narrative responses and validation allow the government purchaser to gain more insight into whether and how a vendor will be able to meet the RFP's technical requirements, and to avoid the problems that result when a vendor cannot meet those requirements. Put differently, this best-practices approach gives the purchaser more clarity on more intricate technical requirements and facilitates a more effective and nuanced assessment of the strengths, weaknesses, and value-added aspects of each technical proposal.
72. In contrast, my experience-based assessment is that the approach that the Plan took here did not serve the underlying purpose of a technical evaluation. Reducing technical proposals to binary "confirm" or "does not confirm" responses exposes purchasing organizations to the risk that vendors will confirm technical statements that they do not understand or do not actually have the ability to perform. In other words, by barring any narrative responses, the Plan refused to accept information that would have allowed it to gain insight into whether and how the Vendors would be able to satisfy the RFP's technical requirements.
73. The Plan also refused to seek out that information in the evaluation phase. That is so because the Plan declined to validate any of the Vendors' technical responses, and instead "evaluated" the Vendors' responses simply by counting the number of technical requirements that each Vendor confirmed.<sup>46</sup> As a result, it took the Plan only 90 minutes to evaluate technical proposals, despite the fact that it previously took the Plan over one month to do so.<sup>47</sup> This "evaluation" lacked any meaningful assessment, validation, comments, critiques, or conclusions with regard to the Vendors' technical proposals. The record is devoid of any in-depth discussion supporting the technical evaluation, consideration of strengths and weaknesses of each Vendor, or conclusions on Vendor technical capabilities. The Plan's own employees expressed concerns about this simplistic evaluation approach.<sup>48</sup>

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<sup>44</sup> Guidebook at 55.

<sup>45</sup> *Id.*

<sup>46</sup> Smart Dep. at 111-113.

<sup>47</sup> Transcript of Deposition of Dorothy Jones dated August 30, 2023, at 160-161; Smart Dep. at 118.

<sup>48</sup> SHP 0025036.

74. The Plan's approach creates the possibility that the winning Vendor, Aetna, will not be able to meet the technical requirements that it confirmed. As a result, the Plan's approach may force the Plan and its members to suffer problems such as schedule disruptions, increased costs, the need for increased Plan oversight, and unsuccessful performance of the TPA contract.
75. The Plan's failure to follow best practices in its approach to the RFP's technical component mattered to the outcome on that component. For example, if the Plan had allowed at least some narrative responses and done at least some validation of the Vendors' proposals, the Plan might have determined that Aetna was unable to meet some of the technical requirements that it confirmed. Thus, under a best-practices approach, Aetna might have received a lower score on the RFP's technical component.
76. Based on my experience, I would have expected that *at the very least* the Plan would have (i) requested clarification from the incumbent, Blue Cross NC, as to why it could not confirm certain technical requirements,<sup>49</sup> and (ii) requested clarification from Aetna and UMR as to how they would be able to achieve and implement the seven technical requirements Blue Cross NC did not confirm. Had the Plan taken those minimal steps, the scoring on the technical component could have changed.
77. Finally, it is worth noting that in my 35 years of experience reviewing RFPs, I have never seen an RFP where, as here, each technical requirement is weighted equally. Typically, I would expect to see each technical requirement weighted based on the relative importance of that requirement, which was not done here.<sup>50</sup>

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<sup>49</sup> The Plan did not ask Blue Cross NC for any such clarification. Transcript of Deposition of Matthew Rish dated September 11, 2023, at 156-157.

<sup>50</sup> Smart Dep. at 133-135.

**VII. POSSIBLE REVISIONS TO THIS REPORT**

78. The opinions I have expressed in this report are based upon the currently available information. I expressly reserve the right to supplement this report upon the receipt of additional information, if necessary, and as set forth in this report.

**VIII. COMPENSATION**

79. The compensation to BRG for work on this engagement is not contingent on the outcome of this matter. The compensation to BRG for my work on this engagement is on an hourly rate basis, at the rate of \$850 per hour, based on actual hours expended. The compensation to BRG for the BRG associates who assisted me with this assignment is on an hourly rate basis, at rates ranging from \$385-\$675, based on actual hours expended.

*Mary Karen Wills*

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Mary Karen Wills, CPA  
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Dated October 4, 2023

## Curriculum Vitae

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### EDUCATION AND PROFESSIONAL CERTIFICATIONS

B.S. Commerce, Concentration in Accounting, University of Virginia

Certified Public Accountant (CPA) licensed in Washington, D.C., Virginia, and Maryland

Certified Fraud Examiner (CFE)

### PRESENT EMPLOYMENT

#### **Managing Director, Leader of the Government Contracts Practice at the Berkeley Research Group, LLC.**

Ms. Wills leads the Government Contracts practice area for the Berkeley Research Group (“BRG”). BRG is an expert services consulting firm that provides strategic consulting and litigation consulting across many industries and competencies. Ms. Wills is responsible for overseeing the Government Contracting practice area’s activities including serving as an expert on client matters and executing projects successfully.

Ms. Wills is an expert in the field of government contract accounting, administration, and compliance. She has over 30 years of experience providing regulatory consulting, auditing and accounting, litigation consulting, and financial advisory services to Companies that range from middle market to the Fortune 100. Ms. Wills has in-depth experience with the Federal Acquisition Regulation (“FAR”), the Cost Accounting Standards (“CAS”), and other Federal government procurement regulations.

Ms. Wills’ expertise includes working with companies in virtually every industry, including professional services, aerospace, defense, higher education, health insurance, manufacturing, information technology, telecommunications, professional services, utilities, construction and engineering, high tech, energy, biotech, pharma and not-for-profit industries, most of whom receive Federal contracts. She specializes in advising commercial companies how to adapt practices to conform to the complex government contracting regulated environment.

Ms. Wills has experience with all forms of government contract acquisition matters, from competitive procurements to commercial item exemptions, as well as GSA Schedule and

other Government-Wide Acquisition Vehicles. She has expertise assisting companies obtain GSA Schedules, undergo audits of GSA Schedules, and defending in asserted price reduction matters. She assists throughout the entire life cycle of government contracts, as well as providing expert advice on a myriad of complex government contract accounting and contract administration related matters. She has experience working with companies contracting with virtually every Federal agency, including DoD, NIH, CDC, BARDA/ASPR, USAID among others.

Ms. Wills has extensive experience working with companies that have been terminated, suspended or debarred from Federal government contracting activities. Her work entails assisting companies in designing compliance programs and corporate integrity agreements to mitigate identified government contracting issues and defending contractor performance and protocols.

Ms. Wills has worked with companies on due diligence assignments, as well as complex transaction structuring and post-acquisition integration. She is an expert at assisting organizations as they restructure for competitive purposes, including the strategic, organizational, cost accounting, and other regulatory impacts associated with mergers and acquisitions.

Ms. Wills has directed special investigations, fraud investigations, alleged False Claims investigations, Qui Tam/whistleblower allegation investigations, and other litigation consulting assignments. She has assisted companies prepare and deliver voluntary disclosures, whereby results and findings were presented in connection with settlement negotiations. She has testified as an expert witness on varied matters, including False Claims, lost profits, damages, government contract claims, and other disputes. Ms. Wills has been admitted under protective orders before the Government Accountability Office and the Court of Federal Claims for bid protest and other matters and as a testifying expert.

Ms. Wills performed financial statement audits of publicly-traded and private companies as a partner with Arthur Andersen. She has extensive experience preparing and analyzing financial statements and disclosures, and in applying and adhering to Generally Accepted Accounting Principles, with special expertise relating to government contracting industry accounting and audit matters.

## **SELECTED AREAS OF EXPERIENCE**

### **Regulatory Compliance and Governance**

- Performed assessments of compliance with Federal and state and local procurement regulations, including CAS, FAR, and Agency Supplements including USAIDAR, DFARs, and other Agency Specific Regulations
- Business Systems Assessment and Remediation pursuant to DFARs Business Systems Requirements, including Accounting, Purchasing, EVMS, Property, Estimating
- Internal control reviews, outsourced and co-sourced internal audits, enterprise risk projects and business system assessments, including accounting system adequacy, cost estimating systems, labor charging, billing, contractor purchasing systems, material

management systems

- Instituted comprehensive compliance programs and policies
- Instituted and served on organizational compliance steering committees
- Developed ethics policies, conflict of interest policies, programs and code of conduct policies
- Training in governance matters

### **Government Contract Accounting and Contract/Grant Administration**

- Consultation on FAR, CAS, OMB Circulars, including OMB A-21, A-110 and A-122
- Cost Accounting Standard compliance assessments and Disclosure Statement preparation
- Cost Impact proposal development and quantification
- Indirect rate development and restructuring
- Incurred Cost Submissions
- DCAA, SIGAR, OIG and other Government Audit Support
- Accounting System Design and Implementation
- Contract and Grant Management System and Processes
- Contract Closeout
- Terminations, REAs and Change Orders
- Small business, SBIR, STTR, Other Cooperative Agreement consultation
- False Claims and Truth in Negotiations Act Compliance, Violations and Investigations

### **Federal Supply Schedule (GSA and VA Schedule) Contracts and Commercial Acquisitions**

- Performed analysis for preparation of commercial sales practices “CSP” disclosures
- Performed historical commercial pricing and discounting analysis for clients in connection with submissions, compliance assessments, investigations, audits, disclosures, and false claims matters.
- Evaluated client GSA Schedule submissions, including CSP for accuracy, completeness and currency.
- Assisted in development and implementing compliance programs around GSA Schedules to address PRC, CSP, IFF, and other requirements of the GSA Schedule program.
- Evaluated contractor compliance with Price Reduction clause monitoring and reporting and IFF payment and sales reporting requirements.
- Pre-award, Post-award and renewal OIG audit report
- Compliance with sales reporting and IFF reporting
- Investigations and voluntary disclosures involving GSA schedule and commercial pricing matters
- Assisted clients and client counsel with analysis of FSS contract compliance and

associated impact calculations as part of False Claims Act investigations and settlements.

- Served as expert on false claims investigations, litigation, and damages reports submitted in connection with these matters, and with voluntary disclosures.

### **Merger and Acquisition Assistance/Strategic Business Consulting**

- Performed due diligence assessments and assisted in sale of companies
- Assisted in integration activities, including consolidation of entities, accounting systems and rate structures, as well as earn-out calculations
- Assisted in negotiating novation agreements
- Developed consolidation and carve-out strategies and methodologies
- Created home office, shared services and service center structures and rate models
- Facilitated development of strategic plans, comprehensive budgets and forward pricing rate models
- Restructuring proposal preparation

### **Special Investigations, Voluntary Disclosures and Legal Support**

- Worked with legal counsel on comprehensive internal investigations and legal proceedings, many of which resulted in voluntary disclosures to U.S. Government and included potential False Claim and/or Qui Tam/whistleblower Allegations
- Worked with compliance monitors to implement remediation measures and compliance programs
- Testifying expert on government contract related disputes and damages, including disputes at the Court of Federal Claims, District Court and State Courts, and arbitration proceedings
- Assisted companies facing debarment and suspension to remediate issues and demonstrate present responsibility
- Assisted counsel with complex termination and dispute matters involving constructive change consideration and complex damages determinations. She leads multi-disciplinary teams including technical experts in resolving these matters.

### **PREVIOUS POSITIONS**

Director, Leader of the Business Consulting and Government Contracts Group for Argy, Wiltse & Robinson, P.C., now part of BDO.

Director, Leader of the Business Consulting and Government Contract Practice for Beers & Cutler PLLC, now Baker Tilly

Partner, Arthur Andersen Washington, D.C., Director of Government Contracts Group

## **PROFESSIONAL ASSOCIATIONS AND OUTSIDE AFFILIATIONS**

Certified Public Accountant, Virginia, Maryland, and District of Columbia  
Association of Certified Fraud Examiners (ACFE)  
American Institute of Certified Public Accountants  
Virginia Society of CPAs  
National Defense Industrial Association  
Professional Services Council  
Institute of Management Accountants  
National Contract Management Association  
American Bar Association - Associate Member of Section of Public Contract Law  
Greater Washington Society of Certified Public Accountants  
The Society of Construction Law North America

## **NOT-FOR-PROFIT AFFILIATIONS**

Member of the Board of Directors - Girl Scouts of the Nation's Capital, Nominating Committee  
Board of Directors – Counterpart International, Chair and Finance and Audit Committee Member  
Board of Directors – IntraHealth International – Chair, Finance and Audit Committee Chair  
Member of the Board of Directors - The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Audit Committee Chair  
Advisory Board Member – QED Group, LLC  
Audit and Finance Committee and Golf Committee, Rehoboth Beach Country Club

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**Expert Testimony of Mary Karen Wills**  
**Previous Four Years**

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<b>Case Name</b>	<b>Venue</b>	<b>Testimony</b>
<i>Dairyland Power Cooperative v. United States</i>	United States Court of Federal Claims No. 18-1922C	Deposition Testimony Trial Testimony 2021
<i>In re David Pruitt</i>	U.S. Securities and Exchange Commission File No. 3-17950	Administrative Proceeding Trial Testimony 2019
<i>Therapure Biopharma Inc. v. DynPort Vaccine Co.</i>	United States District Court for the District of Maryland No. 1:19-cv-02092	Deposition Testimony 2021
<i>United States ex rel. Hunt v. Cochise Consultancy, Inc.</i>	United States District Court for the Northern District of Alabama No. 5:13-cv-02168	Deposition Testimony 2022

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**Legal**

- 1 Blue Cross NC Request for Protest Meeting dated January 12, 2023
- 2 NC State Health Plan Response to Blue Cross NC Protest Letter dated January 23, 2023
- 3 Petition for a Contested Case Hearing dated February 16, 2023
- 4 NC State Health Plan Response to Blue Cross NC's First Set of Interrogatories dated April 25, 2023
- 5 NC State Health Plan Amended Response to Blue Cross NC's First Set of Interrogatories dated May 10, 2023
- 6 Blue Cross NC Motion to Compel Discovery from Aetna dated June 9, 2023
- 7 Affidavit of Dorothy Jones dated June 16, 2023
- 8 Aetna Response to Blue Cross NC Motion to Compel Discovery dated June 19, 2023
- 9 NC State Health Plan Response to Blue Cross NC Motion to Compel Discovery from Aetna dated June 19, 2023
- 10 Amended Scheduling Order dated July 12, 2023

**Depositions and Exhibits**

- 11 Deposition of Vanessa Davison dated August 25, 2023, and Exhibits
- 12 Deposition of Dorothy Jones dated August 30, 2023, and Exhibits
- 13 Deposition of Aimee Forehand dated September 7, 2023, and Exhibits
- 14 Deposition of Thomas Matthew Rish dated September 11, 2023, and Exhibits
- 15 Deposition of Charles Sceiford dated September 12, 2023, and Exhibits
- 16 Deposition of Caroline Smart dated September 13, 2023, and Exhibits
- 17 Deposition of Stuart Wohl dated September 15, 2023, and Exhibits
- 18 Deposition of Stephen Kuhn dated September 19, 2023, and Exhibits

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**Blue Cross and Blue Shield of North Carolina v. North Carolina State Health Plan  
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**Blue Cross and Blue Shield of North Carolina v. North Carolina State Health Plan  
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**Blue Cross and Blue Shield of North Carolina v. North Carolina State Health Plan  
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560 SHP 0073344.pdf	606 SHP 0075200.pdf
561 SHP 0073345.pdf	607 SHP 0075213.pdf
562 SHP 0073349.pdf	608 SHP 0075221.pdf
563 SHP 0074865.pdf	609 SHP 0075223.pdf
564 SHP 0074866.pdf	610 SHP 0075406.pdf
565 SHP 0074870.xlsx	611 SHP 0075507.pdf
566 SHP 0074871.xlsx	612 SHP 0075508.pdf
567 SHP 0074872.pdf	613 SHP 0075511.pdf
568 SHP 0074875.pdf	614 SHP 0075517.pdf
569 SHP 0074876.pdf	615 SHP 0075544.pdf
570 SHP 0074880.xlsx	616 SHP 0075759.pdf
571 SHP 0074881.xlsx	617 SHP 0075764.pdf
572 SHP 0074882.pdf	618 SHP 0076005.pdf

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**Bates Labeled Documents Continued**

619 SHP 0076445.pdf	665 SHP 0085000.pdf
620 SHP 0076455.pdf	666 SHP 0085001.pdf
621 SHP 0076514.pdf	667 SHP 0085002.pdf
622 SHP 0076639.pdf	668 SHP 0085003.pdf
623 SHP 0076646.pdf	669 SHP 0085004.pdf
624 SHP 0076655.pdf	670 SHP 0085005.pdf
625 SHP 0076690.pdf	671 SHP 0085006.pdf
626 SHP 0076745.pdf	672 SHP 0085007.pdf
627 SHP 0077570.pdf	673 SHP 0085008.pdf
628 SHP 0077639.pdf	674 SHP 0085009.pdf
629 SHP 0077988.pdf	675 SHP 0085010.pdf
630 SHP 0079184.pdf	676 SHP 0085011.pdf
631 SHP 0079816.pdf	677 SHP 0085012.pdf
632 SHP 0080119.pdf	678 SHP 0085013.pdf
633 SHP 0080147.pdf	679 SHP 0085014.pdf
634 SHP 0080278.pdf	680 SHP 0085015.pdf
635 SHP 0080507.pdf	681 SHP 0085016.xlsx
636 SHP 0081033.pdf	682 SHP 0085017.pdf
637 SHP 0081172.pdf	683 SHP 0085023.pdf
638 SHP 0081204.pdf	684 SHP 0085037.xlsx
639 SHP 0081205.pdf	685 SHP 0085038.pdf
640 SHP 0081442.pdf	686 SHP 0085050.pdf
641 SHP 0082022.pdf	687 SHP 0085064.xlsm
642 SHP 0082031.pdf	688 SHP 0085065.pdf
643 SHP 0082056.pdf	689 SHP 0085066.pdf
644 SHP 0082100.pdf	690 SHP 0085067.pdf
645 SHP 0082411.pdf	691 SHP 0085068.pdf
646 SHP 0082449.pdf	692 SHP 0085069.pdf
647 SHP 0083558.pdf	693 SHP 0085070.pdf
648 SHP 0083562.pdf	694 SHP 0085071.pdf
649 SHP 0083572.txt	695 SHP 0085072.pdf
650 SHP 0083575.pdf	696 SHP 0085073.pdf
651 SHP 0083583.pdf	697 SHP 0085074.pdf
652 SHP 0083628.pdf	698 SHP 0085075.pdf
653 SHP 0083642.pdf	699 SHP 0085076.pdf
654 SHP 0084699.pdf	700 SHP 0085077.pdf
655 SHP 0084731.pdf	701 SHP 0085078.pdf
656 SHP 0084736.pdf	702 SHP 0085079.pdf
657 SHP 0084846.pdf	703 SHP 0085080.pdf
658 SHP 0084909.pdf	704 SHP 0085081.pdf
659 SHP 0084985.pdf	705 SHP 0085082.pdf
660 SHP 0084992.pdf	706 SHP 0085083.pdf
661 SHP 0084996.xlsm	707 SHP 0085084.xlsx
662 SHP 0084997.pdf	708 SHP 0085085.pdf
663 SHP 0084998.pdf	709 SHP 0085097.pdf
664 SHP 0084999.pdf	710 SHP 0085099.pdf

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

**Attachment C**

*Facts or Data Considered in Connection with this Report*

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**Bates Labeled Documents Continued**

711 SHP 0085106.pdf	755 SHP 0086105.pdf
712 SHP 0085113.pdf	756 SHP 0086265.pdf
713 SHP 0085119.pdf	757 SHP 0086268.pdf
714 SHP 0085133.pdf	758 SHP 0086294.pdf
715 SHP 0085140.xlsx	759 SHP 0086453.pdf
716 SHP 0085141.xlsx	760 SHP 0086478.pdf
717 SHP 0085142.pdf	761 SHP 0086483.pdf
718 SHP 0085144.xlsx	762 SHP 0086490.pdf
719 SHP 0085145.pdf	763 SHP 0086562.pdf
720 SHP 0085146.pdf	764 SHP 0086582.pdf
721 SHP 0085148.xlsx	765 SHP 0086648.pdf
722 SHP 0085149.pdf	766 SHP 0086655.pdf
723 SHP 0085161.pdf	767 SHP 0087071.pdf
724 SHP 0085167.pdf	768 SHP 0087602.pdf
725 SHP 0085177.pdf	769 SHP 0087604.pdf
726 SHP 0085189.pdf	770 SHP 0087606.pdf
727 SHP 0085191.pdf	771 SHP 0087668.pdf
728 SHP 0085193.xlsx	772 SHP 0087892.pdf
729 SHP 0085195.pdf	773 SHP 0087900.xlsx
730 SHP 0085202.pdf	774 SHP 0092221.pdf
731 SHP 0085206.xlsx	775 SHP 0092306.pdf
732 SHP 0085207.pdf	776 SHP 0092328.pdf
733 SHP 0085211.xlsx	777 SHP 0092360.pdf
734 SHP 0085212.pdf	778 SHP 0092423.pdf
735 SHP 0085216.pdf	779 SHP 0092426.pdf
736 SHP 0085305.pdf	780 SHP 0092427.pdf
737 SHP 0085332.pdf	781 SHP 0092477.pdf
738 SHP 0085421.pdf	782 SHP 0092745.pdf
739 SHP 0085423.pdf	783 SHP 0092974.pdf
740 SHP 0085437.pdf	784 SHP 0093002.pdf
741 SHP 0085664.pdf	785 SHP 0093005.pdf
742 SHP 0085692.pdf	786 SHP 0093030.pdf
743 SHP 0085762.pdf	787 SHP 0093060.pdf
744 SHP 0085763.pdf	788 SHP 0093117.pdf
745 SHP 0085848.pdf	789 SHP 0093137.pdf
746 SHP 0085885.pdf	790 SHP 0093141.pdf
747 SHP 0085888.pdf	791 SHP 0093173.pdf
748 SHP 0085889.pdf	792 SHP 0093841.pdf
749 SHP 0085911.pdf	793 AETNA0035405.pdf
750 SHP 0085912.pdf	794 AETNA0037847.pdf
751 SHP 0085943.pdf	795 AETNA0037466.pdf
752 SHP 0085977.pdf	796 SHP 0025036.pdf
753 SHP 0085988.pdf	797 SHP 0025420.pdf
754 SHP 0086093.pdf	798 SHP 0075767.pdf

**No. Document**

**External Research and Publicly Available Documents**

- 799 SHP TPA RFP Transparency Website Documents, at <https://www.shpnc.org/tpa-rfp-transparency>
- 800 North Carolina State Health Plan Request for Proposal #270-20210521PBMS
- 801 North Carolina Administrative Code, Title 20, Chapter 01
- 802 North Carolina Administrative Code, Title 20, Chapter 12
- 803 North Carolina General Statutes, Chapter 135, Article 3B
- 804 North Carolina General Statutes, Chapter 143, Article 3
- 805 North Carolina General Statutes, Chapter 143, Article 8
- 806 Department of Defense Source Selection Procedures dated August 20, 2022, and Appendices
- 807 <https://www.linkedin.com/pulse/precision-accuracy-utility-numerical-evaluations-part-pennington/>
- 808 Federal Acquisition Regulation 15.404-1 Proposal analysis techniques
- 809 National Association of State Procurement Officials Procurement Toolbox, Issue 1
- 810 Contract Pricing Reference Guides Volume 1 dated February 21, 2012, Defense Acquisition University
- 811 North Carolina Procurement Manual, Department of Administration, Purchase & Contract, 2022
- 812 North Carolina Executive Order dated October 18, 2017
- 813 Federal Acquisition Regulation 15.101 Lowest price technically acceptable source selection process
- 814 <https://www.missouristate.edu/Procurement/policy.htm>
- 815 <https://info.buy.nsw.gov.au/buyer-guidance/source/select-suppliers/probity-and-fairness#:~:text=You%20must%20be%20seen%20to,stifle%20innovation%20by%20reducing%20risk>
- 816 Department of Defense Encyclopedia of Ethical Failure updated October 2014
- 817 International Handbook of Public Procurement edited by Khi V. Thai
- 818 OECD Principles for Integrity in Public Procurement
- 819 OECD Recommendation of the Counsel on Public Procurement
- 820 The World Bank Procurement Regulations for IPF Borrowers, Fifth Edition
- 821 Social Development Foundation Procurement Manual dated July 2015
- 822 World Bank Institute Procurement Innovation Challenge
- 823 North Carolina Department of Health and Human Services Policy and Procedures Procurement Manual
- 824 American Bar Association 2000 Model Procurement Code for State and Local Governments
- 825 National Association of State Procurement Officials 2022 Survey of State Procurement Practices Report
- 826 Army Source Selection Supplement dated November 28, 2017
- 827 American Bar Association Guide to State Procurement, Third Edition
- 828 Increased Transparency in Bases of Selection and Award Decisions by Jonathan Mak
- 829 The Request for Proposal Handbook by Michael Asner, Third Edition
- 830 Department of Commerce Acquisition Manual 1315.3 revised July 2014
- 831 Gallagher Interesting Examples of Evaluation Criteria and Scoring ([ajg.com](http://ajg.com))
- 832 [https://www.naspo.org/rosp/category.php?rosp\\_category=Best%20Value%20Procurement&desc=&display\\_fields=Best%20Value%20Procurement,State,Definition%20of%20Best%20Value%20Procurement,Citation%20Language,Citation,Public%20Link,Best%20Value%20Procurement,Description%20for%20Best%20Value%20Procurement,Comments](https://www.naspo.org/rosp/category.php?rosp_category=Best%20Value%20Procurement&desc=&display_fields=Best%20Value%20Procurement,State,Definition%20of%20Best%20Value%20Procurement,Citation%20Language,Citation,Public%20Link,Best%20Value%20Procurement,Description%20for%20Best%20Value%20Procurement,Comments)
- 833 University of North Dakota RFP Evaluator's Guide
- 834 NIGP Public Procurement Practice Request for Proposals
- 835 Pennsylvania Evaluating Request for Proposal (RFP) Responses Presentation
- 836 Congressional Research Service TRICARE's Next Generation Contracts: T-5 dated August 6, 2021
- 837 Proposal Evaluation Tips & Tricks: How to Select the Best Vendor for the Job by Rebecca Graffy
- 838 What is Procurement Excellence? by Kailey Burger Ayogu, Elena Hoffnagle, Jeffrey Liebman, and Kate Mertz; Harvard Kennedy School Government Performance Lab

**No. Document**

**External Research and Publicly Available Documents Continued**

- 839 Evaluation Scorecards by Tomás Aponte, Lars Benson, and Rebecca Graffy; Harvard Kennedy School Government Performance Lab
- 840 Guidebook: Crafting a Results-Driven Request for Proposals (RFP), Harvard Kennedy School Government Performance Lab
- 841 <https://www.shpnc.org/who-we-are>
- 842 <https://www.bluecrossnc.com/about-us>
- 843 <https://www.segalco.com/about-us>
- 844 Federal Acquisition Regulation Part 15 - Contracting by Negotiation
- 845 Everybody Wins: Crafting a Solicitation that Fosters Transparency, Best Value, and Collaborative Partnership; The NIGP Business Counsel, 2014
- 846 Best Practices/Lessons Learned for Competitive Acquisitions; Office of the Principal Director, Defense Pricing and Contracting, February 6, 2022
- 847 The Request for Proposal Handbook by Michael Asner, Fifth Edition

# **EXHIBIT C**

## **MARY KAREN WILLS, CPA DEPOSITION EXCERPTS**

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STATE OF NORTH CAROLINA  
COUNTY OF DURHAM  
-----  
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.  
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\*\* CONFIDENTIAL \*\*  
VIDEO DEPOSITION OF  
MARY KAREN WILLS, CPA  
NOVEMBER 17, 2023  
9:21 a.m.

Robinson Bradshaw & Hinson PA  
1450 Raleigh Road, Suite 100  
Chapel Hill, North Carolina

Reported by: Audra M. Smith, RPR, FCRR  
Video by: John Roberts

Page 14

1 first time that you reviewed it?  
2 A Pretty early. We were engaged in June  
3 of 2023. Pretty shortly thereafter.  
4 Q Okay. And did -- in preparation for  
5 your deposition testimony today, did you talk to  
6 anyone at Blue Cross Blue Shield of North Carolina?  
7 A No.  
8 Q And did you discuss the fact that you  
9 were being deposed today with any of your colleagues  
10 at BRG or Berkeley Research Group?  
11 A I had two colleagues that have assisted  
12 me on this matter, that I have discussed preparing  
13 for this matter with. I believe they're on the  
14 call, at least one, Zachary and Rob that assisted  
15 me.  
16 Q And their full names again?  
17 A Zachary Skrehot, S-K-R-E-H-O-T.  
18 Q And?  
19 A Rob McDonald.  
20 Q Okay. What is the -- how would you  
21 describe the general nature of BRG's work?  
22 A The general nature is, I would describe  
23 as, expert consulting where very seasoned experts  
24 assist clients with complex matters, whether they  
25 result in litigation or whether they're complex to

Page 15

1 their business, and apply -- our experts apply their  
2 core skills, industry skills, competencies to help  
3 the clients kind of reach conclusions or resolve  
4 issues that tend to be pretty important to the  
5 organization.  
6 Q Okay. Would you say that a significant  
7 portion of the work that BRG does is providing  
8 expert testimony in a deposition or at trial?  
9 A Yes.  
10 Q Okay. And what percentage of work  
11 would you say that the -- is done at BRG that  
12 involves either deposition -- expert testimony at a  
13 deposition or at trial?  
14 A Would say probably 60 percent of the  
15 firm's work culminates around expert testimony,  
16 supportive litigation and the other 40 percent being  
17 advisory-type work.  
18 Q Are there other fields that BRG assists  
19 clients with other than the procurement arena?  
20 A Health care is a large area of focus  
21 for our firm.  
22 Q Okay. How many health care cases have  
23 you worked on?  
24 A I've worked on several. Over my career  
25 -- when you say "cases," are you speaking only to

Page 16

1 litigation matters or other matters as well?  
2 Q Just generally. Any review or to serve  
3 as a consultant, how many do you recall?  
4 A At least probably between 10 and 15.  
5 Q Okay. And of that 10 or 15, it's my  
6 understanding that you have not worked on the state  
7 health care procurement before?  
8 A Correct.  
9 Q Okay. Now, you mentioned the RFP. And  
10 when I say "the RFP," can we agree -- so I won't  
11 have to say this every time -- the 2020 TPA RFP  
12 issued by the State Health Plan. Can we agree on  
13 that?  
14 A The 2022.  
15 Q Excuse me. The 2022, yes, ma'am.  
16 A Yes.  
17 Q Can we agree on that? So when I say  
18 RFP, unless I say something else, you'll understand  
19 what I'm talking about?  
20 A Yes.  
21 Q Okay. Now, you mentioned the RFP. Do  
22 you recall what other documents that you personally  
23 reviewed during the course of your engagement in  
24 this case?  
25 A In this case?

Page 17

1 Q Yes, ma'am.  
2 A Yes, sir. I've reviewed a substantial  
3 volume of documents. I've tried to list a  
4 comprehensive list attached to my report. Many of  
5 those I have personally reviewed, including email  
6 correspondence, Segal analysis, work papers  
7 supporting their work that they performed on behalf  
8 of the State Health Plan. I've reviewed the  
9 detailed proposals that were submitted by each of  
10 the offerers in this matter. I've reviewed the  
11 legal proceedings. I reviewed multiple sources that  
12 I use in connection with my work on bid protests  
13 regarding best practices for procurements. I've  
14 reviewed a lot.  
15 Q Okay. And when you said the -- I can't  
16 remember exactly what you said about the pleadings  
17 in this case or the papers in this case, are you  
18 talking about the pleadings that each side has filed  
19 in this case, like the complaint, the answer, and  
20 discovery responses?  
21 A Yes.  
22 Q Okay. And did anyone else assist you  
23 in review of documents that create the universe of  
24 documents that you considered in formulating your  
25 expert report?

Page 18

1 A Yes. My teammates, Zach and Rob.  
2 Q Okay. How about the depositions in  
3 this case?  
4 A Yes.  
5 Q How many depositions have you  
6 personally reviewed?  
7 A I believe approximately eight of the  
8 depositions.  
9 Q Okay. Do you recall which depositions  
10 that you reviewed?  
11 A Yes. Forehand.  
12 Q Is that Aimee Forehand?  
13 A Aimee Forehand.  
14 I think The Segal -- is it Mr. Kuhl,  
15 K-U-H-L [sic] I believe? Charles Sceiford with the  
16 State Health Plan. Let me think who else, the  
17 other.  
18 Is it "Borhand"? "Borland"? I might  
19 be saying her name wrong.  
20 Q Ms. Bourdon?  
21 A Sorry, that's it. I think I identified  
22 them in my expert report. I'm drawing a blank. Let  
23 me think here. Mr. Rish, with the State Health  
24 Plan. Dee Jones with the State Health Plan.  
25 Vanessa Davison; is that her last name? That's all

Page 19

1 I remember off the top of my head.  
2 Q Okay. Now, do you recall when you were  
3 initially engaged to work with Blue Cross Blue  
4 Shield of North Carolina in this case, that you  
5 provided a list of documents that you wanted to  
6 review or were documents provided to you by either  
7 Blue Cross and Blue Shield of North Carolina or  
8 counsel?  
9 A Documents were provided by counsel.  
10 Q Okay. So you didn't have a laundry  
11 list of things you wanted to look at; is that  
12 correct?  
13 A In my head I did, but everything was  
14 provided, so I didn't have to provide a formal list.  
15 Q Okay. Now, I assume that you're not  
16 appearing here out of the goodness of your heart.  
17 So are you being compensated for your work in this  
18 case?  
19 A Yes, sir.  
20 Q Okay. And did you enter into an  
21 engagement letter with anyone for your services as  
22 an expert in this case?  
23 A Yes.  
24 Q And who is that with?  
25 A With Robinson Bradshaw.

Page 20

1 Q Okay. You don't have a separate  
2 agreement directly with Blue Cross Blue Shield, I  
3 take it?  
4 A That's correct.  
5 Q Okay. Now can you tell me  
6 approximately how many hours, prior to today, you  
7 have spent in connection with your review of the  
8 information that was provided to you and the  
9 preparation of the documents that we'll be reviewing  
10 this morning?  
11 A I would say between 175 and 200 hours.  
12 Q And that's --  
13 A Me personally.  
14 Q Okay. So in addition to the 175 to 200  
15 hours that you have personally devoted to this case,  
16 how about work by others, others employed with BRG,  
17 what would you say the total amount of time that has  
18 been expended by others at BRG in connection with  
19 this engagement?  
20 A I can only speak to the hours spent by  
21 my team.  
22 Q Okay.  
23 A So Zach and Rob, which is approximately  
24 700 hours --  
25 Q Okay.

Page 21

1 A -- combined.  
2 Q And of your team, do you know the  
3 amount of money that you have invoiced Robinson  
4 Bradshaw for your work in this case to date?  
5 A I think it's approximately 400,000.  
6 Q Okay. And of the 400,000, that's only  
7 for your work and the work of those on your team as  
8 you described it; is that correct?  
9 A Correct.  
10 Q Okay. And you're a director at BRG, is  
11 that correct?  
12 A Managing director.  
13 Q Okay. And your role is managing  
14 director, are you -- do you have access to the  
15 invoicing the company does for various clients?  
16 A For my clients I do have access.  
17 Q Okay. Is Blue Cross Blue Shield your  
18 client?  
19 A Yes, I have a separate matter number.  
20 And Robinson Bradshaw is my client, so I am able to  
21 pull up the invoice and other administrative records  
22 for that relationship through our accounting system.  
23 Q Okay. So what I'm trying to get, an  
24 estimate of what you believe that Blue Cross or  
25 Robinson Bradshaw has been billed for the services

Page 30

1 before the general accounting -- or the GAO?  
2 A Yes, at a hearing.  
3 Q Okay. At a hearing. Okay. And when  
4 was that?  
5 A That would be probably five to six  
6 years ago.  
7 Q Can you remember the name of that case?  
8 A I'd have to look. I can see the judge.  
9 I can see the trier. But I can't remember  
10 specifically. Let me think about which case it  
11 might have been. Marcia Madsen was on the other  
12 side, and it may have been one of the health  
13 care-related matters that I worked on.  
14 Q That was going to be my next question.  
15 Do you remember which area of government contracting  
16 was involved? Was it defense? Was it IT? Was it  
17 health care; do you recall?  
18 A Most likely, to the best of my  
19 knowledge, it was health care-related -- health  
20 insurance, not dissimilar to the types of issues we  
21 have here.  
22 Q Okay. And do you recall the agency  
23 that was involved?  
24 A Yeah. I've worked on bid protests for  
25 similar matters with TRICARE Defense Health Agency,

Page 31

1 CMS. Let me think who else were the others.  
2 Several with TRICARE. Mostly CMS or TRICARE.  
3 Q All right. So the one that you said  
4 you testified five or six years ago, do you recall  
5 if that was CMS?  
6 A I believe it was a CMS-related matter.  
7 Q Okay. And do you remember what federal  
8 agency was the procuring activity there?  
9 A CMS would be the federal -- part of  
10 DHHS.  
11 Q Okay. All right. So you don't recall  
12 if it was issued by CMS or Department of Health and  
13 Human Services?  
14 A I believe it was issued by CMS, but it  
15 was too long ago.  
16 Q All right. And before that, do you  
17 recall testifying at the GAO before as an expert  
18 witness?  
19 A And again, when you say testify, I  
20 would say it was a little less formal than typical  
21 testimony because there wasn't an expert report. It  
22 was more specific questions or analyses in support  
23 of conclusions that were provided.  
24 Q But it was your testimony that you  
25 actually had some type of hearing?

Page 32

1 A Correct.  
2 Q Okay. And that type of hearing you  
3 provided testimony?  
4 A Correct.  
5 Q Okay. Were you tendered as an expert  
6 witness in that case, do you remember?  
7 A Not in the same fashion as the formal  
8 testimony in the Court of Federal Claims.  
9 Q I'm talking about just GAO right now.  
10 A Yes. As a bid protest expert.  
11 Q Okay. And the hearing -- attorney  
12 advisor accepted you as an expert in that area?  
13 A Yes.  
14 Q Okay. Let me ask you, have you ever  
15 been accepted as an expert witness in state court  
16 outside of North Carolina?  
17 A I don't believe so.  
18 Q Okay. And have you ever been accepted  
19 as an expert witness in the North Carolina state  
20 court?  
21 A No.  
22 Q Okay. And from your answer, I take it  
23 you've never been accepted as an expert witness in a  
24 proceeding pending before the North Carolina Office  
25 of Administrative Hearings; is that correct?

Page 33

1 A That's correct.  
2 Q Okay. Ms. Wills, are you familiar with  
3 the standard under North Carolina General Statute  
4 150B-23(a), against which an agency conduct is  
5 scrutinized under the North Carolina Administrative  
6 Procedure Act?  
7 A I don't know the specifics related to  
8 that rule.  
9 Q Okay. Have you ever reviewed that  
10 statute to your knowledge?  
11 A I've reviewed some statutes in  
12 connection with this matter, but I don't -- I don't  
13 know that specific standard.  
14 Q Okay.  
15 A Or statute, excuse me.  
16 Q Well, the question is, are you aware of  
17 the standard, that agencies' decisions are measured  
18 under North Carolina General Statute 150B-23(a)?  
19 A Since I don't know specifically, you  
20 know, what that statute says, I can't say that I'm  
21 fully aware of the answer to that question.  
22 Q Okay. Ms. Wills, have you ever given  
23 expert testimony in dispute concerning a procurement  
24 for a government health care plan?  
25 A Yes.

Page 34

1 Q Okay. Tell me about that.  
2 A I've worked on several bid protests  
3 related to TRICARE health plans for managed care  
4 support contractors.  
5 Q And were all of those bid protests,  
6 were those agency bid protests?  
7 A Correct.  
8 Q Okay. How many of them were protests  
9 that were pending before the general -- the  
10 government accountability office?  
11 A All of them. I mean, at least -- you  
12 know, I can at least remember four TRICARE  
13 procurements.  
14 Q In reading your resume, it indicates  
15 you had extensive experience in federal  
16 procurements, correct?  
17 A Correct.  
18 Q Okay. So tell me, a contractor who has  
19 a dispute that would lead to a protest, where are  
20 the areas that that contractor could file his -- a  
21 particular protest, where are the three areas that  
22 they can file?  
23 A I'm not sure I know what you mean by  
24 "area."  
25 Q Okay. Well, the forums -- you

Page 35

1 understand that there are several different ways  
2 that a contractor can protest an agency decision.  
3 A Yes.  
4 Q What is your understanding the ways  
5 that they can protest?  
6 A Well, it's my understanding they can  
7 protest with the agency itself.  
8 Q Okay.  
9 A Then the GAO. And the Court of Federal  
10 Claims would be another option. But again, I'm not  
11 -- I don't -- I'm not an attorney. I don't know all  
12 of the legal requirements on the timing, and  
13 especially related to the Court of Federal Claims as  
14 a venue.  
15 Q Okay. How many times have you  
16 testified as an expert in the United States Court of  
17 Federal Claims?  
18 A At least two that I just described.  
19 Q Okay. One, the Dairyland case and the  
20 other one I believe you said was in 2014; is that  
21 correct?  
22 A Yes.  
23 Q Okay. Other than that, do you recall  
24 any other testimony -- any other times that you  
25 testified as a witness in the Court of Federal

Page 36

1 Claims?  
2 A Not off the top of my head.  
3 Q Okay. Ms. Wills, have you ever given  
4 expert testimony in a dispute involving a  
5 procurement for a third-party administrative  
6 services in connection with a state health plan?  
7 A Can you repeat that?  
8 Q Yes. Have you ever given expert  
9 testimony in a dispute concerning a procurement for  
10 third-party administrative services in connection  
11 with a state government health plan?  
12 A Other than this matter, no.  
13 Q Okay. Have you ever, in your career,  
14 participated in the drafting of a request for  
15 proposal?  
16 A Yes.  
17 Q Okay. Tell me about that.  
18 A I've -- both in my career and I serve  
19 on several boards, and I've assisted clients,  
20 developed requests for proposal for various types of  
21 services, including third-party audit services,  
22 subcontract requests for proposals. A wide variety  
23 of types of services or types of RFPs.  
24 Q And are all of those services that you  
25 just testified regarding, are those private services

Page 37

1 as opposed to government-related services?  
2 A Some subcontract RFPs would include  
3 government services. Some companies providing  
4 services pursuant to federal contracts.  
5 Q All right. So let me make sure I  
6 understand. Are you talking about working on RFPs  
7 that a prime contractor who has a government -- has  
8 a contract with a government agency, an RFP that  
9 they would use with a subcontractor to fulfill part  
10 of the services they're required to do?  
11 A Correct.  
12 Q Okay. Have you ever participated --  
13 excuse me. Strike that.  
14 Have you ever served in either a  
15 government-related procurement or a private  
16 procurement as a member of an evaluation panel?  
17 A I have.  
18 Q Okay. How many times?  
19 A Probably three or four.  
20 Q Okay. Tell me about that. What do you  
21 recall?  
22 A Primarily, in my capacity as a board  
23 member. If -- it's, many times, selection of an  
24 audit firm, for example, when an organization may be  
25 looking to change their external auditors.

Page 50

1 Schultz.  
2 Q Okay. I don't want to know anything  
3 you and Ms. Schultz talked about. So Ms. Schultz  
4 reached out to you and spoke to you about this case?  
5 A Correct.  
6 Q Now, the Exhibit 403 is your initial  
7 expert report. Did you prepare any drafts of your  
8 report?  
9 A I did prepare drafts.  
10 Q Okay. Did you keep those drafts?  
11 A I did retain drafts.  
12 Q Do you have those drafts with you?  
13 A No.  
14 Q Do you have those drafts available?  
15 A On our -- probably on our shared drive  
16 network. As I revise drafts I tend to archive those  
17 in an old folder.  
18 Q Okay. But you did maintain those  
19 drafts?  
20 A Yes.  
21 Q How about other working papers that you  
22 used as far as referring to source materials or any  
23 other information that you used in preparing your  
24 work to serve as an expert witness in this case?  
25 A Yes. I don't have a lot of detailed

Page 51

1 work papers but I did retain any work papers that I  
2 may have created in connection with reaching my  
3 conclusions for my expert report.  
4 MR. THOMPSON: All right. Counsel, we  
5 would formally request copies of drafts and  
6 working papers. As a certified public  
7 accountant, I believe Ms. Wills is required  
8 to retain those and that is producible under  
9 the CPA standards. Would you agree with  
10 that?  
11 MR. ZIMMERMAN: Objection. I mean,  
12 don't believe those are producible. We'll  
13 have to look at the rule. But drafts are  
14 protected by Rule 26, so we'll have to deal  
15 with that later.  
16 BY MR. THOMPSON:  
17 Q Okay. Do you understand, your working  
18 papers, if you serve as an expert in a -- in any  
19 type of case and you rely upon your training and  
20 experience as a certified public accountant, that  
21 you're required to maintain and produce your working  
22 papers?  
23 MR. ZIMMERMAN: Objection.  
24 A Yeah. I typically perform and label  
25 all my work papers as privileged during the course

Page 52

1 of the engagement, prepared for counsel, and draft,  
2 and it's my understanding those are protected by  
3 attorney-client privilege, but I'm not a lawyer to  
4 provide the answer. But I do retain copies of my  
5 work.  
6 BY MR. THOMPSON:  
7 Q What's the purpose of retaining copies  
8 of your drafts and your working papers?  
9 A I have a practice of not destroying  
10 those items.  
11 Q And is the practice consistent with the  
12 requirements that are standard that certified public  
13 accountants are required to maintain especially in  
14 litigation cases?  
15 MR. ZIMMERMAN: Objection.  
16 A Yes.  
17 BY MR. THOMPSON:  
18 Q Ms. Schultz -- excuse me -- Ms. Wills,  
19 sorry, Ms. Wills.  
20 MR. THOMPSON: I'll ask you a question  
21 later.  
22 BY MR. THOMPSON:  
23 Q Ms. Wills, have you developed any  
24 opinions in addition to those that are in your  
25 initial expert report and the rebuttal report, which

Page 53

1 you're prepared to give in this trial?  
2 A No other opinions than what's provided  
3 in my report.  
4 Q Okay. Now, let's turn to your opinions  
5 -- I want to go to the beginning on page 3, the  
6 Detailed Opinion. Do you have that?  
7 A Yes.  
8 Q Ms. Wills, would you please read into  
9 the record the bolded print under Section A, which  
10 constitutes, as I understand it, your opinion -- one  
11 of your opinions?  
12 A Yes.  
13 "The Plan's final scoring methodology  
14 for the RFP, a methodology in which the Plan  
15 assigned the vendors one set of points on each of  
16 two components, then ranked the vendors based on  
17 that first set of points. Then assigned a different  
18 set of points based on those rankings. And then  
19 ranked the vendors again based on that second set of  
20 points. Failed to follow best practices for  
21 procurements."  
22 Q Okay. Ms. Wills, are you aware of any  
23 authority that states it was improper for the North  
24 Carolina State Health Plan to use points to rank to  
25 points to rank, "final scoring methodology" as you

Page 54

1 called it?  
2 A No.  
3 Q Okay. In paragraph 21 of your Opinion  
4 A, you state that you do not recall ever seeing a  
5 "points to rank to points to rank" methodology  
6 employed by the Plan; is that correct?  
7 A Correct.  
8 Q So is it your opinion the practice is  
9 improper just because you have not personally  
10 recalled seeing one before?  
11 A No.  
12 Q Okay. In paragraph 23 of your opinion,  
13 you refer to a publication which is a Request For  
14 Proposal Handbook by Michael Asner; is that correct?  
15 A Correct.  
16 Q Now, I am the proud owner --  
17 A All right.  
18 Q -- of one of these.  
19 MR. THOMPSON: Emily would not send me  
20 a copy but she sent counsel for the State  
21 Health Plan. I want to go on record that,  
22 you know --  
23 MS. SCHULTZ: I owe you one.  
24 MR. THOMPSON: She owes me one.  
25 A It's actually available free online

Page 55

1 now, too.  
2 BY MR. THOMPSON:  
3 Q It's available free online, but you  
4 can't -- I mean, you can't look at it, apparently,  
5 based upon what we've seen.  
6 So I now have --  
7 A The Bible.  
8 Q The Bible. Okay.  
9 Now, this Request For Proposal  
10 Handbook, let's go ahead and mark this, and I'm not  
11 -- not the entire book. I'm just going to talk  
12 about a few.  
13 Where are we at, 20, I mean, 40?  
14 MR. HEWITT: 404.  
15 (Exhibit Number 404 marked for  
16 identification.)  
17 BY MR. THOMPSON:  
18 Q The book that you're referring to in  
19 paragraph 23 of your opinion is this Request For  
20 Proposal Handbook prepared by -- or written by  
21 Michael Asner; is that correct?  
22 A That's correct.  
23 Q And this is a -- would you agree this  
24 is a 2014 dated publication?  
25 A Yes.

Page 56

1 Q Are you aware of any recent editions to  
2 this particular handbook?  
3 A No.  
4 Q Who is Michael Asner?  
5 A Michael Asner is a recognized expert in  
6 state and local procurement.  
7 Q And where does Mr. Asner live?  
8 A I don't recall.  
9 Q Do you recall that he lived in  
10 Vancouver, British Columbia, Canada?  
11 A No.  
12 Q Let me ask you to take a look at the  
13 first page of Exhibit Number 4.  
14 Do you see that up at the top left-hand  
15 corner, "This publication is a product of."  
16 Do you see that?  
17 A Yes.  
18 Q And please read the address for Michael  
19 Asner Consulting.  
20 A "Suite 2003, 1028 Barclay Street,  
21 Vancouver, British Columbia, Canada, V6E 0B1."  
22 Q Does this refresh your recollection  
23 that Mr. Asner is a resident of Canada?  
24 A This was -- I don't know whether his  
25 whole life he's been from Canada. He does identify

Page 57

1 Canadian examples in the book as well as United  
2 States examples.  
3 Q So does --  
4 A But currently his address, at this  
5 time, was Vancouver.  
6 Q So at the time he drafted this document  
7 that you relied upon in your report you would agree  
8 he was a resident of Canada.  
9 A Yes.  
10 Q Okay. Now, let me ask you --  
11 A Can I clarify?  
12 Q Sure.  
13 A I don't know if he was a resident, but  
14 his consulting company is identified as being  
15 located in Canada.  
16 Q Fair enough. Under the paragraph under  
17 the heading Disclaimer, would you read that into the  
18 record?  
19 A "Great care has been taken to ensure  
20 that the information presented is accurate; however,  
21 this information is still subject to errors and  
22 subject to change. The examples have been obtained  
23 from many jurisdictions throughout North America and  
24 may not be applicable in every jurisdiction."  
25 Q Okay. Now, to your knowledge Ms.

Page 58

1 Wills, is Mr. Asner considered an authority on  
2 federal public procurements?  
3 A I don't know whether he's considered an  
4 expert on federal procurements.  
5 Q Okay. Is he considered an expert on  
6 state procurements?  
7 A Yes.  
8 Q Okay. And what do you base that on?  
9 A I base that on numerous articles,  
10 presentations, discussions identified on industry  
11 associations for state procurement officials.  
12 Q Now, are you basing that answer based  
13 upon the information that's contained in this RFP  
14 manual?  
15 A No.  
16 Q Okay. So you're saying that there are  
17 other things that you base your opinion, that he's  
18 an expert on state procurements?  
19 A Correct.  
20 Q Okay. How about local procurements?  
21 A In my opinion, local procurements are  
22 very parallel to state procurements, and therefore  
23 his expertise extends to local procurements.  
24 Q Okay. So you -- if I'm understanding  
25 your answer correctly, you -- it's your

Page 59

1 understanding that local procurements most often  
2 mirror state procurements; is that correct?  
3 A State and local government procurements  
4 are often the local governments are -- how do we  
5 say, parallel, consistent with the state government  
6 practices, especially related to procurement.  
7 Q How about for the state of North  
8 Carolina; would the answer still be the same?  
9 A I don't know enough about the local  
10 counties to be able to make that conclusion,  
11 local --  
12 Q Okay. So you're making -- what are you  
13 basing your statement on, that you believe that the  
14 local government procurements mirror those of state  
15 procurements?  
16 A Many -- some of the matters that I've  
17 worked on that are with local governments where the  
18 RFP practices are very consistent with state  
19 practices. Examples that I've seen of local RFPs  
20 are often reflective of state practices.  
21 Q But we've already established you don't  
22 have any experience working with local governments  
23 in North Carolina, correct?  
24 A Correct.  
25 Q And this particular engagement that you

Page 60

1 are serving as an expert for Blue Cross Blue Shield  
2 in this proceeding is the first time that you've  
3 been involved with state procurements in the state  
4 of North Carolina?  
5 A With the State Health Plan of North  
6 Carolina or state procurements of North Carolina,  
7 yes.  
8 Q Okay. Now, in -- let's look at  
9 paragraph 23 of your opinion, you make reference to,  
10 again, to Mr. Asner's handbook. And specifically  
11 you're referring to a RFP example from Tarrant  
12 County, Texas; is that correct?  
13 A That's correct.  
14 Q Ms. Wills, what authority can you point  
15 to that the rules, procedures, and guidelines that  
16 govern the purchasing department for Tarrant County,  
17 Texas have any bearing on procurements by the state  
18 of North Carolina, and particularly the State Health  
19 Plan?  
20 MR. ZIMMERMAN: Objection to form.  
21 A I'm not pointing to a requirement. I'm  
22 pointing to practices that are best practices,  
23 regardless of the state or the local government that  
24 they relate to.  
25 BY MR. THOMPSON:

Page 61

1 Q Well, my question specifically, Ms.  
2 Wills, is that you're saying that Mr. Asner's  
3 comment that the RFP example in Tarrant County, that  
4 is included in his book, is a good example of the  
5 ranking of proposals. And my question is, what  
6 authority can you point to that the rules,  
7 procedures, and guidelines that govern the  
8 purchasing department for Tarrant County, Texas,  
9 have any bearing at all on procurements by the North  
10 Carolina State Health Plan?  
11 MR. ZIMMERMAN: Objection to form.  
12 A I'm not -- I guess I'm not certain --  
13 could you just repeat that question?  
14 BY MR. THOMPSON:  
15 Q Okay. My point is, that you're using  
16 the reference that Mr. Asner provided as to the  
17 Tarrant County, Texas as being a good example for  
18 the ranking a proposal. And my question is, what  
19 authority can you point to me that any of the rules,  
20 procedures, and guidelines that Mr. Asner said were  
21 good examples from the purchasing department for  
22 Tarrant County, Texas, have any bearing at all on  
23 procurements issued by the North Carolina State  
24 Health Plan?  
25 MR. ZIMMERMAN: Objection to form.

Page 62

1 A In my opinion, state regulations don't  
2 mandate the way that these practices need to be  
3 performed. That's why best practices and processes  
4 have arisen that are fairly consistent across  
5 whatever state or local government is involved with  
6 the procurement, because they're not specifically  
7 addressed with any specific regulations or laws as  
8 to how these methodologies need to work.  
9 BY MR. THOMPSON:  
10 Q Well, let's look at the State Health  
11 Plan procurement regarding the RFP in question here.  
12 What would you say controls the review and the  
13 response to that RFP by prospective offerers?  
14 A The RFP itself.  
15 Q Okay.  
16 A And if there are policies and  
17 guidelines as in the State Health Plan has policies  
18 related to procurements, those would not be as much  
19 applicable to offerers, but to the State Health Plan  
20 in terms of how it's performing its procurement  
21 duties relative to this RFP.  
22 Q Would you agree with me that the State  
23 Health Plan in this particular case had wide  
24 latitude in the methodology and requirements that it  
25 included in the RFP in question?

Page 63

1 A Yes.  
2 Q Okay. And that would be consistent  
3 with your -- throughout the federal and state arena  
4 that governments have wide latitude in deciding what  
5 requirements and what methodology they will use in  
6 the evaluation of proposals in response to RFPs,  
7 correct?  
8 A Correct.  
9 Q Paragraph 24 of your opinion, you state  
10 that, "Based on my experience, this established  
11 practice of assigning ranks only once is a best  
12 practice because it avoids skewing vendors' final  
13 scores."  
14 Did I state that correct?  
15 A Yes.  
16 Q First of all, I noticed in your initial  
17 report you used the phrase "best practice," but in  
18 your rebuttal report you had a footnote that changed  
19 that to "standard practice."  
20 Why did you do that?  
21 A When I prepared my initial report, I  
22 neglected to define best practices, and during the  
23 rebuttal, I tried to use it as an opportunity to  
24 make that understanding of what best practices  
25 stands for a little more apparent, so that's why the

Page 64

1 clarification was included in the rebuttal report.  
2 Q Okay. So when you're saying that --  
3 just so I'm clear, you're using the terms  
4 interchangeably, best practices and standard  
5 practices; is that correct?  
6 A Standard practices for public  
7 procurements is how I would define the way best  
8 practices is used in my initial report.  
9 Q When you talk about best practices or a  
10 standard practice, are you saying that state  
11 governments are precluded from using any other  
12 practice other than what would be a standard  
13 practice?  
14 A No.  
15 Q Again, the state governments have wide  
16 latitudes to decide what the requirements that they  
17 need, how they want to tailor an RFP, and how they  
18 want to conduct the evaluation process, correct?  
19 A Correct.  
20 Q Now in paragraph 26 of your opinion,  
21 Exhibit 403, you state that, "Under a best practices  
22 approach the Plan would have scaled the vendors'  
23 cost and technical scores to each other."  
24 Is that correct?  
25 A Correct.

Page 65

1 Q Okay. "For example, by converting the  
2 cost scores to the same 300 points as the technical  
3 scores."  
4 Is that correct?  
5 A Yes.  
6 Q Okay. Ms. Wills, what is the basis for  
7 your opinion that scaling the vendors' cost and  
8 technical scores to each other is a best practice or  
9 a standard practice?  
10 A It's based on my review of a multitude  
11 of RFPs and how Plan -- how RFPs specify weighting  
12 criteria between cost and technical proposals and  
13 how that weighting is accomplished to make sure that  
14 it's appropriately followed.  
15 Q Okay. Now, we talked about a little  
16 bit that states have wide latitude to determine what  
17 requirements and what methodology it will include in  
18 RFPs.  
19 Let me ask you: The RFPs you reviewed  
20 over the course of your career, would you agree that  
21 the technical and cost proposals employed a variety  
22 of scoring methodologies?  
23 A Yes.  
24 Q Okay. What are some of the other  
25 scoring methodologies that you have seen in addition

Page 70

1 So you're saying, it's your contention,  
2 as I understand it, that the State Health Plan  
3 failed to follow the requirements, the evaluation  
4 criteria set forth in 3.4 of the RFP; is that  
5 correct?  
6 A Yes.  
7 Q Now, regarding the Plan's distribution  
8 of points for network pricing, administrative fees  
9 and network pricing guarantees, you state in  
10 paragraph 34 of your opinion that, "The best  
11 practice is to distribute points based on relative  
12 significance of the components."  
13 Is that correct?  
14 A Yes.  
15 Q Do you agree with the proposition, Ms.  
16 Wills, that the State Health Plan was in the best  
17 position to determine the relative significance of  
18 different components of its own RFP?  
19 A Yes.  
20 Q Okay. Paragraph 37 of your Opinion B,  
21 you state that, "the Plan did not have a reasoned  
22 basis for the 6-2-2 distribution of points for the  
23 cost proposal components;" is that correct?  
24 A Yes.  
25 Q What deposition testimony did you

Page 71

1 and/or your staff review in connection with  
2 developing this opinion?  
3 A I believe Dee Jones' testimony, and Mr.  
4 Rish's testimony.  
5 Q Okay. Why do you believe that the --  
6 well, strike that.  
7 Based upon Ms. Jones' and Mr. Rish's  
8 testimony, did you understand they provided  
9 justifications for the methodology that they used  
10 for the 6-2-2 distribution of points?  
11 A In my opinion they did not supply a  
12 distinct methodology supporting the 6-2-2.  
13 Q And why do you believe that?  
14 A Because reviewing their deposition  
15 testimony, that's my recollection; that neither had  
16 a sufficient rationale supporting the distribution  
17 of the points or specific requirements for how Segal  
18 was to perform its analysis supporting the award of  
19 those points.  
20 Q Okay. With respect to the Plan's  
21 methodology for awarding points for administrative  
22 fees and pricing guarantees, you state in paragraph  
23 48 of your opinion that, "The best practice for  
24 awarding points is a process that, A, described in  
25 the RFP; B, objective; and C, rational."

Page 72

1 Is that correct?  
2 A That's correct.  
3 Q Is it your opinion that the Plan's  
4 scoring methodology for the administrative fees and  
5 pricing guarantees was not objective?  
6 A It's my opinion that it was not  
7 objective and it was not defined before the  
8 evaluation took place.  
9 Q Okay. So what evidence do you have to  
10 support that that it was not objective and was not  
11 defined?  
12 A Communications with Segal where Segal  
13 identified that until they received responses back,  
14 they were unsure how they would be evaluating the  
15 network guarantees, for example. That was  
16 correspondence with the Plan.  
17 Q Is it your opinion, Ms. Wills, that an  
18 RFP must be 100 percent objective in order to be  
19 sound?  
20 A I don't articulate that. 100 percent  
21 is the bar that is required.  
22 Q Okay. Is it your opinion that the  
23 Plan's scoring methodology for the administrative  
24 fees and pricing guarantees was not rational?  
25 A Yes.

Page 73

1 Q Okay. Why?  
2 A With respect to, for example, the  
3 network pricing guarantees, again, there was no  
4 specified methodology that defined -- if you look at  
5 Section B, how to determine a greatest value, what  
6 the greatest value -- how it would be measured, how  
7 it would be assessed in reaching a conclusion  
8 relative to the number of points that would be  
9 identified.  
10 Q In paragraph 59 of your Opinion B, you  
11 state that you and your staff "reviewed the  
12 deposition testimony of the Plan and The Segal Group  
13 witnesses and they did not offer a sound or reasoned  
14 justification for the decision between awarding one  
15 or zero points to second or third ranked proposals."  
16 Is that correct?  
17 A Yes.  
18 Q Okay. What testimony did you review?  
19 A Again, Mr. -- I may not be saying it  
20 right, but Kuhl with Segal, Mr. Rish, Dee Jones, I  
21 believe as well.  
22 Q Why do you not believe that the Plan  
23 and Segal's justifications were not sound and  
24 objective?  
25 A Again, they did not identify a specific

<p style="text-align: right;">Page 86</p> <p>1 the first two sentences under concept 3 on page 55 2 -- excuse me, on Exhibit 405? 3 (Exhibit Number 405 marked for 4 identification.) 5 A "Provide sufficient information to let 6 proposers know what a successful response looks 7 like." 8 Is that the right section, concept 3? 9 Q Yes, ma'am. 10 A "Generally you and your evaluation 11 committee should have a clear idea of what a high 12 scoring proposal would look like in each criterion 13 before evaluations begin. Depending on the RFP, it 14 could be helpful to share this information with 15 proposers." 16 Q Let me stop you right there. 17 A Okay. 18 Q So, in fact, the guidebook that you're 19 referring to says that depending on the RFP, it 20 could be helpful -- is that correct -- to share this 21 information with proposers? 22 A Yes. 23 Q Okay. Would you agree that the Harvard 24 guidebook doesn't say sharing this information is 25 required or even a best or standard practice?</p>	<p style="text-align: right;">Page 88</p> <p>1 Q The drafters of the guidebook that 2 you're referring to place specific emphasis on the 3 fact that the evaluation criteria should not be 4 biased in favor of the incumbent vendor, right? 5 A Yes. 6 Q Okay. And you know that Blue Cross 7 Blue Shield of North Carolina was -- is the 8 incumbent vendor for the TPA contract? 9 A Yes. 10 Q And has been for some 30-plus years? 11 A Yes. 12 Q Okay. Ms. Wills, it's not your opinion 13 in your report that scoring methodology for the 14 administrative fees and prices guarantee were 15 biased, are you? 16 A I have not asserted that opinion. 17 Q Okay. Now, in paragraphs 51 and 52 of 18 your opinion you cite to the -- again, to the RFP 19 Handbook by Mr. Asner that we discussed earlier. 20 Specifically in paragraph 51, you quote 21 language from page 424 of Mr. Asner's RFP Handbook. 22 Do you have that? 23 A Is that one of the pages? 24 Q Yes, ma'am. It should be. 25 A Oh, thanks.</p>
<p style="text-align: right;">Page 87</p> <p>1 A Sure. This is talking about high 2 scoring proposals, yeah. 3 Q Okay. In paragraph 54 of your opinion, 4 you also cite to page 55, which is these 5 characteristics of good evaluation criteria. Would 6 you read paragraph 54 of your opinion into the 7 record? 8 A Sure. "Numerous resources also confirm 9 that the best practice is for the RFP to award 10 points in an objective way. For example, the 11 Harvard Kennedy School's Guidebook highlights the 12 need for an unbiased and objective perspective in 13 the guidebook's five characteristics of good 14 evaluation criteria. The fifth characteristic 15 states that proper evaluation criteria are fair to 16 all proposers and free of bias." 17 Q Okay. Now, looking at page 55, the 18 fifth characteristic of evaluation criteria, under 19 the category says, all fair to -- "Are fair to all 20 proposers, free of bias, consistent, and not overly 21 restrictive. You should ensure that all evaluation 22 criteria are fair, and do not give a preference to 23 incumbent vendors." 24 Did I cite that correctly? 25 A Yes.</p>	<p style="text-align: right;">Page 89</p> <p>1 Q I hope it is. 2 A I'm sorry, did you say 424? There it 3 is. Yes, I have it. 4 Q Are you familiar with that particular 5 section of Mr. Asner's handbook that you quoted in 6 your report or you referred to -- 7 A Yes -- 8 Q -- in your report? 9 A If I could just take a minute to review 10 it and just refresh. 11 Yes. 12 Q Okay. And on that -- on paragraph 51, 13 you are referring to the -- one of the points Mr. 14 Asner makes under the heading, Evaluation Criteria, 15 right? 16 A Yes. 17 Q And you see there's a footnote to the 18 side of the heading Evaluation Criteria, correct? 19 A Yes. 20 Q And that footnote is a reference to a 21 publication, Integrated Justice Information Systems 22 Institute. 23 Are you familiar with that institute? 24 A I don't specifically know that toolkit 25 that it refers to, or "the institute."</p>

Page 90	Page 92
<p>1 Q So you're not aware of that institute? 2 A No. 3 Q Okay. To your knowledge, does that 4 institute have any bearing on procurements issued by 5 the North Carolina State Health Plan? 6 A I haven't looked at it. I don't know 7 that it would. 8 Q Okay. In paragraph 52 of your Opinion 9 B, you quote language on page 193 of Mr. Asner's 10 handbook. And if we turn to page 193 in Chapter 6 11 of the RFP Handbook, the language you quote -- you 12 quoted is from the State Procurement Code for 13 Alaska; is that correct? 14 A I'm sorry, are you at paragraph 51? 15 Q Fifty-two, I'm sorry. 16 A Yes. 17 Q Okay. And if we turn to -- again, page 18 193 of the Asner RFP manual, again, that's referring 19 to the procurement code for Alaska, right? 20 A It's using Alaska as an example of a 21 best practice for public procurement. 22 Q Okay. But again, it's a reference to 23 the Alaska Procurement Code, correct? 24 A Correct. 25 Q Now did you check the current state</p>	<p>1 Q Okay. Let me ask you to look at 2 paragraphs 53 and 55 of your Opinion B. 3 A Yes. 4 Q Ms. Wills, I'm showing you what's been 5 marked for identification as Exhibit Number 406. 6 (Exhibit Number 406 marked for 7 identification.) 8 BY MR. THOMPSON: 9 Q Which I will represent to you is the 10 State of North Carolina Procurement Manual that you 11 referenced in paragraphs 53 and 55 of your Opinion 12 B. 13 A Yes. 14 Q Did you read -- review this procurement 15 manual prior to the preparation of your initial 16 opinion, expert opinion report? 17 A Yes. 18 Q Okay. And paragraphs 53 and 55, you 19 cite to the North Carolina Procurement Manual for -- 20 from the North Carolina Department of Administration 21 in support of your Opinion Number 2; is that 22 correct? 23 A Yes. 24 Q Is it -- do you have an understanding, 25 Ms. Wills, that -- as to whether this North Carolina</p>
Page 91	Page 93
<p>1 procurement code for Alaska to determine if this is 2 a part of the current policy for that state policy? 3 A I did not. 4 Q Okay. Separate and apart from your 5 last answer, did you have any knowledge or have any 6 belief that the language you relied upon for the 7 Alaska state procurement code has any bearing on 8 procurements by the North Carolina State Health 9 Plan? 10 A Again, these are best practices that 11 apply regardless of which state is involved, in my 12 opinion. 13 Q So this is your opinion, not Mr. 14 Asner's opinion? 15 A I believe Mr. Asner is asserting that 16 this is a good example of how to evidence specific 17 evaluation, how evaluations will be performed in a 18 way that can be communicated to an offerer and 19 understood by all involved and reduce, you know, the 20 potential bias or lack of objectivity. 21 Q So it's your testimony that the 22 language that you relied upon in a 2014 Asner RFP 23 manual establishes a best practice that North 24 Carolina should have followed? 25 A Yes.</p>	<p>1 Department of Administration Procurement Manual is 2 any way applicable to the RFP in the process used by 3 the State Health Plan? 4 A I know that there are separate policies 5 that have been identified for the treasurer's 6 department that reference the procurement manual. 7 This procurement manual includes substantially more 8 detail regarding how procurements in -- much of 9 procurements in North Carolina should be made and 10 provides good best practices that aren't necessarily 11 articulated in the State Health Plan's own policy. 12 Q My question, Ms. Wills, is it your 13 understanding that the North Carolina Department of 14 Administration Procurement Manual that you cited to 15 in paragraphs 53 and 55 of your opinion, are in any 16 way applicable to the RFP in question here? 17 A In my opinion, there are practices 18 identified in this procurement manual that should 19 have the -- the State Health Plan should have 20 deployed. Those are the same principles included in 21 its own policies relative to these areas of my 22 opinion. 23 Q So if I understand your testimony 24 correctly, the State Health Plan should have 25 followed the provisions of the Department of</p>

<p style="text-align: right;">Page 94</p> <p>1 Administration Procurement Manual? 2 A I cannot speak to having seen any 3 instructions relative to the State Health Plan and 4 its use of this procurement manual. I know it has 5 its own policies. I point to this as indicative of 6 the practices that should be followed regardless 7 whether you have to adhere to this manual or not. 8 Q Okay. Let me ask you to look at, 9 again, Exhibit Number 5, and particularly Section 10 3.1 of the RFP, page 21. Specifically, I'm 11 directing your attention to Section 3.1 of Exhibit 12 Number 5, Method of Award. Would you read the first 13 sentence into the record? 14 A Yeah. "Pursuant to NCGS 135-48.34, 15 this solicitation is not subject to the requirements 16 of Article 3 of Chapter 143 of the North Carolina 17 General Statutes." 18 Q Okay. And let me ask you to look at -- 19 hold on one second. 20 Ask you to look at, again, Exhibit 21 Number 5, which is the RFP, and specifically page 22 87, beginning with page 87 of 119. Do you see that 23 section? 24 A Yes. 25 Q Under Protest Procedures. Let me ask</p>	<p style="text-align: right;">Page 96</p> <p>1 which you relied upon in your opinion, would you now 2 agree that that's not applicable to this 2022 TPA 3 RFP? 4 MR. ZIMMERMAN: Object to form. 5 A Yeah. I haven't seen anything 6 articulated that says how exemption from Article 3 7 of Chapter 143 means you don't need to comply with 8 any of the terms of the procurement manual. 9 BY MR. THOMPSON: 10 Q Well, or it says "any rules promulgated 11 thereunder," Article 3, Chapter 143 of the North 12 Carolina General Statutes "or any rules promulgated 13 thereunder." You would agree the procurement manual 14 are rules promulgated in that statute, would you 15 not? 16 MR. ZIMMERMAN: Object to form. 17 A I don't know how to construe what -- 18 how rule is identified here. Whether a rule is a 19 specific law, is it a regulation, is it the 20 procurement manual? 21 BY MR. THOMPSON: 22 Q Well, your reliance upon the 23 procurement manual, you would agree that you have 24 relied on two occasions on paragraphs 53 and 55 upon 25 the language of the North Carolina Department of</p>
<p style="text-align: right;">Page 95</p> <p>1 you to turn to the next page, page 88. And the last 2 paragraph of Section 15 beginning with the word -- 3 the words "Inclusion of this protest procedure," 4 would you read that into the record? 5 A "Inclusion of this protest procedure is 6 not intended to, and does not waive, the Plan's 7 exemption from Article 3 of Chapter 143 of the North 8 Carolina General Statutes or any rules promulgated 9 thereunder." 10 Q So even though the North Carolina 11 Department of Administration Procurement Manual, 12 which covers procurements given by Chapter 143, 13 Article 3 is not applicable to the RFP in question 14 here, you did rely upon that manual in your report; 15 is that correct? 16 MR. ZIMMERMAN: Object to form. 17 A Yeah. I relied upon the standard 18 industry practices that are identified in that 19 procurement manual. 20 BY MR. THOMPSON: 21 Q Ma'am, that was not my question. 22 A Okay. 23 Q My question was: Despite the fact that 24 the procurement manual that we just identified as an 25 exhibit, the North Carolina Procurement Manual,</p>	<p style="text-align: right;">Page 97</p> <p>1 Administration Procurement Manual, correct? 2 A Yes. 3 Q Okay. You discussed over the course of 4 the last few minutes that the statutory authority 5 for the North Carolina Procurement Manual as 6 contained on page 2 of Exhibit 406, is exempted from 7 the procurement in question here, right? 8 MR. ZIMMERMAN: Object to form. 9 A Yeah. Again, I'm not a legal expert as 10 to what that means that they're completely exempted, 11 you know, given that, again, it's a public 12 procurement, and they have taxpayers that will be 13 affected by the transaction. I don't think you can 14 ignore procurement procedures that are applicable to 15 the state of North Carolina and point to a 16 regulation that's unclear as to what that means. 17 Does that mean it's the Wild Wild West, they can do 18 whatever they want with the procurement? 19 BY MR. THOMPSON: 20 Q I don't want to beat this to death, but 21 let me ask you to look at the procurement manual 22 again on page 2 [sic]. 23 A So it says, "P&amp;C oversees procurement 24 for all state departments, institutions, agencies, 25 universities, community colleges."</p>

Page 98

1 Q It says, "The procurement of non-IT  
2 goods and services in the state is governed by  
3 Chapter 143, Article 3 of the North Carolina General  
4 Statutes."  
5 Correct? That's the statutory  
6 authority for this manual, would you agree?  
7 MR. ZIMMERMAN: Object to form.  
8 A I'm sorry. Where were you reading?  
9 BY MR. THOMPSON:  
10 Q Page 2 under Statutory Authority.  
11 A I'm sorry, I'm on the wrong page. Yes.  
12 Q You would agree with that?  
13 MR. ZIMMERMAN: Object to form.  
14 A Procurement of non-IT goods and  
15 services is governed by Chapter 143, Article 3, yes.  
16 BY MR. THOMPSON:  
17 Q You would also agree that the RFP for  
18 the 2022 TPA contract was specifically exempted from  
19 the provisions of Chapter 143, Article 3?  
20 MR. ZIMMERMAN: Object to form.  
21 BY MR. THOMPSON:  
22 Q Correct?  
23 A Again, I don't know the linkage between  
24 saying a procurement manual with best practices is  
25 not applicable by pointing to this statute and

Page 99

1 saying, you know, there's no procurement procedures  
2 applicable. That's not --  
3 Q Well, my point is, you relied upon the  
4 North Carolina Procurement Manual for support for  
5 your opinions, correct?  
6 A Correct.  
7 Q Okay. We'll leave it up to the Court  
8 to decide whether it's applicable or not.  
9 All right. Let's take about a  
10 five-minute break, please.  
11 THE VIDEOGRAPHER: The time is 11:31  
12 a.m. We're now off the record.  
13 (A recess was taken from 11:31 a.m.)  
14 11:47 a.m.)  
15 THE VIDEOGRAPHER: The time is 11:47  
16 a.m. We're on the record.  
17 BY MR. THOMPSON:  
18 Q Ms. Wills, I'd like to turn now to  
19 Opinion C on page 11 of your initial expert report.  
20 In Opinion C you say, "The Plan's approach to the  
21 technical component of the RFP, an approach in which  
22 the Plan barred all narrative responses, yet did  
23 nothing to validate any part of the vendor's  
24 technical proposals, did not follow best practices  
25 for procurements."

Page 100

1 Did I state that correctly?  
2 A Yes.  
3 Q And are you aware, Ms. Wills, of any  
4 authority that states it is improper to use binary  
5 questions in response to technical requirements of a  
6 proposal?  
7 A No.  
8 Q Okay. During the course of your work  
9 for Robinson Bradshaw, and by extension Blue Cross  
10 Blue Shield of North Carolina, did you have an  
11 opportunity to review the current contract that Blue  
12 Cross was performing under the 2019 TPA?  
13 A No.  
14 Q Are you aware under the 2019 TPA RFP  
15 that the State Health Plan allowed for narrative  
16 responses in addition to the confirm/not confirm  
17 responses to the technical requirements?  
18 A Yes.  
19 Q Okay. Are you further aware there were  
20 questions raised by the State Health Plan concerning  
21 Blue Cross Blue Shield's performance under the  
22 current contract because of some of the narrative  
23 responses Blue Cross had provided in response to the  
24 2019 RFP?  
25 A I'm not aware of issues related to

Page 101

1 their performance that were correlated to responses  
2 to the 2019 RFP.  
3 Q Okay. And then from the testimony of  
4 the State Health Plan officials, based on the  
5 depositions that you reviewed, are you aware that  
6 because of the issues that had arisen under the 2019  
7 TPA RFP and the current contract and Blue Cross'  
8 narrative responses to that RFP, that was one of the  
9 reasons the State Health Plan decided to proceed  
10 with binary responses for the 310 Technical  
11 Requirements?  
12 MR. ZIMMERMAN: Object to form.  
13 A It's my understanding that the Plan was  
14 trying to avoid offerers somehow using narrative  
15 responses to back away from their binary response,  
16 whether it was specific to Blue Cross Blue Shield or  
17 just a practice across all offerers. I do  
18 understand that was part of their rationale.  
19 BY MR. THOMPSON:  
20 Q But you're not aware of specific issues  
21 that the State Health Plan had with Blue Cross Blue  
22 Shield under its current contract regarding some of  
23 the narrative responses that it provided in  
24 connection with the 2019 RFP?  
25 A I don't have specific knowledge there.

Page 102

1 Q Okay. Ms. Wills, you had not offered  
2 any opinions that I have seen -- please confirm --  
3 as to whether Aetna or UMR misrepresented their  
4 ability to meet the technical requirements they  
5 confirmed?  
6 A No, I'm not offering any opinions --  
7 Q Okay.  
8 A -- in that regard.  
9 Q And you do not have any specific  
10 knowledge of what Aetna's technical capabilities  
11 will be as of January 1, 2025, do you?  
12 A I do not.  
13 Q Do you agree that there are certain  
14 benefits to binary questions for technical  
15 proposals?  
16 A Yes.  
17 Q Let me ask you to look at page --  
18 excuse me -- paragraph 77 of your opinion. Let me  
19 ask you, if you would, please, if you'd read that  
20 paragraph 77 into the record.  
21 A "Finally, it is worth noting that in my  
22 35 years of experience reviewing RFPs, I've never  
23 seen an RFP whereas here, each technical requirement  
24 is weighted equally. Typically, I would expect to  
25 see each technical requirement weighted based on the

Page 103

1 relative importance of that requirement, which was  
2 not done here."  
3 Q Okay. And in your experience of 35  
4 years reviewing RFPs, again, approximately how many  
5 state RFPs have you reviewed over that period of  
6 time?  
7 A Again, if you're only limiting to  
8 state, maybe 25, 20. If you, you know, broaden it,  
9 again, to federal, which is a larger part of my  
10 experience, it's a lot more than that.  
11 Q Let me ask you to look at page 427 of  
12 Exhibit 404, which is the RFP Handbook prepared by  
13 Mr. Asner, and specifically I'm looking at page 427.  
14 A Yes.  
15 Q Okay. Let me ask you to look at the  
16 second full paragraph on page 427, beginning the  
17 fifth line down, and I'd like for you to read the  
18 sentence: "To establish the relative importance."  
19 Would you read the next two sentences  
20 into the record, please?  
21 A "To establish the relative importance  
22 of evaluation criteria, the RFP may simply state  
23 that the evaluation criteria are listed in order of  
24 relative importance or the RFP may state that the  
25 evaluation criteria listed are all of equal weight."

Page 104

1 Q Okay. So you would agree at least Mr.  
2 Asner is seeing examples of state procurements where  
3 the technical requirements are all listed as of  
4 equal weight?  
5 MR. ZIMMERMAN: Objection to form.  
6 A Yeah, I think this is referring to the  
7 weighting between technical or price or the specific  
8 evaluation -- the elements that are important to the  
9 evaluation overall, not the technical evaluation.  
10 That's my interpretation of this paragraph.  
11 BY MR. THOMPSON:  
12 Q Okay. You're not -- you don't believe  
13 that Mr. Asner is discussing technical approaches in  
14 the weighting, the various importance that  
15 governmental units may place on technical criteria?  
16 A Yeah. My opinion is that the 310  
17 Technical Requirements here, being weighted equally,  
18 didn't provide a basis for selecting the best  
19 technical offer, because of the equal weighting, and  
20 that that's not a best practice in any venue.  
21 Q Well, but you would agree, at least Mr.  
22 Asner says that -- it references RFP -- that states  
23 the evaluation criteria are listed of all being of  
24 equal weight?  
25 A Yes, he identifies that in that

Page 105

1 sentence.  
2 Q Okay. Ms. Wills, at any point during  
3 the preparation of your initial report did you  
4 assess the North Carolina State Health Plan's  
5 explanation for its methodology in developing the  
6 2022 TPA RFP?  
7 A Can you -- I'm sorry, can you say that  
8 again?  
9 Q Yes. At any point during the  
10 preparation of your report, did you assess the State  
11 Health Plan's explanation for its methodology in  
12 developing the RFP requirements as contained in the  
13 2022 TPA RFP?  
14 A I developed an understanding that the  
15 Plan was attempting to modernize their approach to  
16 the development of the RFP from Dee Jones and other  
17 depositions that I reviewed that spoke to that.  
18 Q But you don't consider that approach,  
19 the modernization approach to be consistent with  
20 best practices or standard practices?  
21 A No, that's not my opinion. A  
22 modernization approach could be consistent with best  
23 practices. There's several ways. Other states, and  
24 at the federal level, procurements have modernized  
25 their approach in these proposals, too.

Page 106

1 Q Okay. Now, would you agree, Ms. Wills,  
2 that governmental agencies have a wide discretion in  
3 the design and drafting of RFP requirements?  
4 A Yes.  
5 Q Okay. Would you also agree that  
6 governmental entities have the discretion in the  
7 evaluation process of those that would be used to  
8 evaluate the proposals, so long as the evaluation  
9 process is consistent with the terms of the RFP and  
10 applicable law?  
11 A Yes.  
12 Q Okay. Would you also agree that the  
13 governmental entities have wide discretion as to the  
14 proposal -- as to the proposal score methodology  
15 that is used, so long as that methodology is  
16 consistent with RFP requirements and is conducted in  
17 a fair and consistent manner?  
18 MR. ZIMMERMAN: Object to form.  
19 A Yes.  
20 BY MR. THOMPSON:  
21 Q Ms. Wills, what is your understanding  
22 with respect to who awarded the contract in response  
23 to the 2022 TPA RFP to Aetna?  
24 A I'm sorry. Could you say that again?  
25 Q Yes. What is your understanding as to

Page 107

1 who awarded the contract to Aetna in response to the  
2 2022 TPA RFP?  
3 A The State Health Plan.  
4 Q Okay. What body or person within the  
5 State Health Plan made that decision?  
6 A It's my understanding the board made  
7 that decision.  
8 Q Okay. Do you have an understanding  
9 that the board of trustees had to recommend -- had  
10 to recommend a contract to Aetna because it was the  
11 highest ranked?  
12 MR. ZIMMERMAN: Object to form.  
13 A Again, in my opinion, the board had a  
14 requirement to select the most advantageous proposal  
15 and make the award based on whichever offerer had  
16 the most advantageous proposal.  
17 BY MR. THOMPSON:  
18 Q Okay. And what evidence do you have  
19 that the board, in making a recommendation to the  
20 Plan's executive administrator that a contract be  
21 awarded to Aetna, did not follow the terms of the  
22 RFP?  
23 MR. ZIMMERMAN: Object to form.  
24 A First, the RFP never defined how the  
25 most advantageous proposal -- what that definition

Page 108

1 meant in terms of the winning offerer. Second,  
2 there's no written documentation that supports how  
3 the board of trustees came to their conclusion that  
4 Aetna was the most advantageous proposal and that --  
5 and in my opinion, there's no requirement that the  
6 board had to blindly adopt the  
7 point-score-point-score-rank results as their  
8 conclusion.  
9 BY MR. THOMPSON:  
10 Q You would agree that the board of  
11 trustees had wide discretion in evaluating the  
12 various proposals that were submitted in response to  
13 the RFP in question?  
14 MR. ZIMMERMAN: Object to form.  
15 A Absolutely.  
16 BY MR. THOMPSON:  
17 Q Ms. Wills, let me show you what we  
18 previously marked as Deposition Exhibit 400.  
19 (Previously marked Exhibit Number 400  
20 was identified.)  
21 BY MR. THOMPSON:  
22 Q I'm going to ask if you have ever seen  
23 that document before.  
24 A I don't remember the handwriting on the  
25 documents. I've seen one on the transparency

Page 109

1 website, but I don't believe I've seen one that has  
2 handwritten comments. I don't recall seeing that.  
3 Q All right. I will represent to you  
4 that this was a PowerPoint presentation used by  
5 Kendall Bourdon to present to the Plan board of  
6 trustees at its December 14, 2022 meeting, during  
7 which they voted to award the TPA contract to Aetna,  
8 and I believe -- further I represent to you -- that  
9 the handwritten notations on there are Ms.  
10 Bourdon's.  
11 Would you agree -- from looking at the  
12 contents of this Exhibit Number 400, would you agree  
13 that the board of trustees knew at the time it  
14 recommended the award to Aetna, that Blue Cross Blue  
15 Shield of North Carolina had confirmed seven fewer  
16 technical requirements than UMR and Aetna?  
17 A If you're referring to the chart on  
18 page 7 that identifies Blue Cross Blue Shield with  
19 303 versus Aetna and UMR at 310, yes.  
20 Q Well, you are familiar with the fact  
21 that Blue Cross Blue Shield chose not to confirm 7  
22 of the technical requirements, are you not?  
23 A Yes, sir.  
24 MR. ZIMMERMAN: Object to form.  
25 BY MR. THOMPSON:

Page 114

1 A No.  
2 Q Has a tribunal ever excluded any of  
3 your testimony or written opinions?  
4 A Yes.  
5 Q Okay. Has a tribunal ever refused to  
6 give any weight to the testimony that you proposed  
7 to provide or any written opinions that you  
8 presented to the court as being improper?  
9 A I don't know how to interpret your  
10 question, but I do know that some of the scope of  
11 what my reports or work has covered in the past has  
12 been questioned as to whether the scope was into  
13 legal territory versus my expertise, and while I  
14 don't profess to be an attorney and I don't provide  
15 legal opinions, the opinions of the judges I  
16 respect, and I believe some of those have excluded  
17 some of my work, based on their conclusions.  
18 Q Okay. And you listed, I believe, four  
19 matters in your report that you had worked on in the  
20 last few years; is that correct?  
21 A Yes.  
22 Q Okay. Other than those matters that  
23 you listed in your report, do you recall other cases  
24 where a part of your testimony was excluded or the  
25 opinions that you proposed to provide to the Court

Page 115

1 were excluded by the court?  
2 A One of those was what I was just  
3 describing. I don't recall if it's listed. It's  
4 probably further back than four years. The Bona  
5 Fide matter is one.  
6 Q Okay. How many cases do you recall  
7 that portions of your expert opinions have been  
8 excluded by the Court?  
9 A Three to four.  
10 Q Okay. Let's look at this. Ms. Wills,  
11 I'm going to show you what we're marking as Exhibit  
12 Number 407.  
13 (Exhibit Number 407 marked for  
14 identification.)  
15 BY MR. THOMPSON:  
16 Q Which is an order on challenges to  
17 expert reports in a proceeding pending before the  
18 securities and exchange commission.  
19 Do you see that document?  
20 A Yes.  
21 Q Have you ever seen it before?  
22 A I have not.  
23 Q You have not. Do you know whether the  
24 administrative law judge in that case entered this  
25 order?

Page 116

1 A It's my understanding that he did -- he  
2 or she did.  
3 Q Okay. And what was the nature of this  
4 proceeding?  
5 A This was an SEC proceeding against an  
6 individual for violating SEC books and records,  
7 regulations relative to financial reporting for a  
8 government contractor.  
9 Q In what context?  
10 A Overstated revenue recognition related  
11 to certain claims that had been presented to the  
12 government that should not have been recognized as  
13 revenue. The CFO was -- as well as the  
14 organization, had been charged with violating the  
15 SEC regs relative to maintaining accurate books and  
16 records and not misleading the auditors.  
17 Q Okay. And was that an inquiry as to  
18 the allowability of cost or the recognition of  
19 revenue on a part 33 of the Federal Acquisition  
20 Regulation?  
21 A No, it was a generally accepted  
22 accounting principles matter.  
23 Q Okay. What was the nature of the  
24 government contract?  
25 A It was a contract that L3 had for

Page 117

1 maintaining Air Force -- aircraft -- different types  
2 of aircraft. A very complex contract as to how they  
3 were reimbursed for the operations and maintenance  
4 work and provisions that they made to -- I forget  
5 which specific aircraft were involved.  
6 Q And L3 is a defense contractor?  
7 A Correct.  
8 Q And this was a defense-related  
9 procurement?  
10 A Correct.  
11 Q Okay. Let me ask you to look at page 5  
12 of this Exhibit 407. And looking at the second  
13 paragraphs -- second paragraph on page number 5,  
14 would you read that paragraph into the record?  
15 A "Paragraphs 87 through 147 present a  
16 mixture of permissible and impermissible statements.  
17 At the outset in portions of Will's report  
18 containing otherwise permissible statements, I will  
19 view her use of the words false, fictitious or  
20 improper when describing the invoices at issue in  
21 this case in the context of her otherwise  
22 permissible expert opinions, but I will ultimately  
23 decide whether the invoices can be described using  
24 these or other objectives. I will give no weight in  
25 these paragraphs to Will's description of the

Page 118	Page 120
<p>1 alleged facts in this case, except insofar as they 2 provide context for her opinions." 3 Q I'll ask you to turn to page 6. In the 4 last paragraph on that page, if you would, read that 5 into the record, please. 6 A The "Turning to Wills' discussion of 7 the internal controls, she does not address the 8 ambiguity I noted regarding the meaning of a 9 particular internal control. She also does not 10 offer an opinion based on her experience as to what 11 someone in her industry would understand certain 12 internal controls to mean. Indeed, she does not 13 explain the meaning of any internal control. 14 Instead, she provides her bare opinion without 15 explanation or analysis that Pruitt violated several 16 internal controls." 17 Q Okay. Thank you. Let me ask you to 18 turn to page 7 of that document and ask you to read 19 into the record the first full paragraph on that 20 page. 21 A "Wills also supplied a report rebutting 22 Pruitt's experts, Mitchell S. Friedman and John 23 Riley. In Will's rebuttal report, I will give no 24 weight to her discussion of what was proper under 25 the L3 contract at the heart of this matter or her</p>	<p>1 A No. 2 Q Did not limit your testimony consistent 3 with this order? 4 A I don't know what the judge regarded in 5 terms of my testimony. When I was testifying there 6 was no objections. There were no objections that 7 were made to the testimony that I provided, so -- 8 Q Was your testimony limited in that 9 proceeding that you provided at the trial to be 10 consistent with the order that we just reviewed? 11 A Not during the trial. 12 Q Okay. All right. What was the result 13 of that case? 14 A He was found guilty of charges. 15 Q Okay. 16 A The invoices were fraudulent. 17 Q Ms. Wills, let me now show you what 18 we're marking as Exhibit 408. 19 (Exhibit Number 408 marked for 20 identification.) 21 BY MR. THOMPSON: 22 Q Ask you if you recognize that document. 23 A I recognize it. 24 Q Do you recall the Bona Fide 25 Conglomerate v. SourceAmerica case?</p>
Page 119	Page 121
<p>1 discussion of the results of her 'detailed 2 analysis', the contract's provisions. As with 3 Wills' initial report, I will give no weight to her 4 opinion about whether Pruitt violated any statute or 5 regulation or her opinion about his state of mind." 6 Q Let me ask you to look at page -- on 7 page 13 through 16, the administrative -- would you 8 agree the administrative law judge also found that 9 you failed to disclose all the materials that you 10 had considered or relied upon? 11 A Yes. 12 Q Okay. And in paragraph -- in the last 13 paragraph on page 16, the judge ordered you to 14 disclose all materials you considered and stated 15 that appropriate sanctions would be discussed at the 16 prehearing conference. 17 Do you agree with that? 18 A Yes. 19 Q Okay. Were sanctions ultimately 20 ordered in this case? 21 A No. 22 Q Did you testify at court? 23 A Yes. 24 Q Okay. Did the judge limit your 25 testimony at court?</p>	<p>1 A I do. 2 Q And is Exhibit 408 an order that was in 3 response to a motion to exclude your testimony? 4 A That's my understanding. 5 Q Okay. What was the nature of this 6 case, the Bona Fide Conglomerate case? 7 A This was a case dealing with the 8 AbilityOne program and SourceAmerica participates in 9 that program, and whether it had provided fair 10 opportunity for Bona Fide to compete and be selected 11 for procurement determinations. 12 Q Is that a manufacturing contract, the 13 AbilityOne program? 14 A It could have been manufacturing. It 15 could have been services provided by disadvantaged 16 workers. I don't recall exactly what Bona Fide was 17 providing. 18 Q Do you recall the opinions you proposed 19 to offer in that case? 20 A I don't recall specific opinions. 21 Q But you do recall the Court excluded 22 some of the proposed expert opinions that you were 23 prepared to give; is that correct? 24 A I do have that understanding after the 25 fact of the matter.</p>

Page 134

1 the North Carolina Procurement Manual?  
2 A It's unclear to me -- again, I'm not a  
3 lawyer, I'm not trying to interpret what those  
4 statutes mean as to what they're exempt from or  
5 what's applicable to them. My opinion, and my  
6 understanding at the time, was that includes good  
7 procurement processes that elaborate more  
8 extensively than their own policy, and that that  
9 would be a policy they would look to in terms of  
10 putting together an RFP -- this RFP.  
11 Q I think I understand. But still, did  
12 you have an understanding, one way or another, about  
13 whether the State Health Plan was required to follow  
14 the North Carolina Procurement Manual?  
15 A At the time, no.  
16 Q Ms. Wills, Mr. Thompson touched on this  
17 with you as well, but in your rebuttal report, which  
18 was -- we'll go ahead and mark that one.  
19 I do need a sticker for this one. I'm  
20 marking the rebuttal report as Exhibit 410.  
21 (Exhibit Number 410 marked for  
22 identification.)  
23 BY MR. HEWITT:  
24 Q Ms. Wills, do you recognize this as  
25 your expert witness rebuttal report?

Page 135

1 A I do.  
2 Q Okay. And so if you would, turn to  
3 page 2, please. And footnote 1, you discuss your  
4 use of the terms "best practices" in your initial  
5 report and "standard practices" in your rebuttal  
6 report, right?  
7 A Correct.  
8 Q Okay. So can you explain again why you  
9 changed your terms -- or your term from "best  
10 practices" to "standard practices" for your rebuttal  
11 report?  
12 A It wasn't necessarily a change. It was  
13 an attempt to better explain the use of the word  
14 "best practices" and why those practices are  
15 expected to be in place for public procurements. It  
16 was the label that I used in the initial report, and  
17 at the time, I probably should have defined it  
18 better in its usage, because "best practices" can  
19 have a number of interpretations.  
20 Q Okay. And I guess the beginning of  
21 this footnote says, "Mr. Vieira interprets the  
22 phrase 'best practices' to suggest that 'any other  
23 approach is inferior.'"  
24 So I guess why did that have anything  
25 to do with why you changed the use of "standard

Page 136

1 practices" in your rebuttal report?  
2 A That didn't really influence why I  
3 included a further definition.  
4 Can you repeat the question? Maybe I  
5 didn't understand the way you asked.  
6 Q Well, sure. The first -- do me a favor  
7 and read the first two sentences of your footnote  
8 number 1 into the record.  
9 A Sure.  
10 "My Initial Report 14-29. My initial  
11 report referred to 'best practices for  
12 procurements.' Mr. Vieira interprets the phrase  
13 'best practices' to suggest that 'any other approach  
14 is inferior.' Vieira Report at 10. To be clear, as  
15 I used it in my Initial Report. The phrase 'best  
16 practices' is synonymous for 'standard practices'  
17 for public procurements. This rebuttal report uses  
18 these phrases interchangeably."  
19 Q Why did you mention Mr. Vieira's  
20 criticism in your footnote here?  
21 A That's a good question. I don't  
22 recall.  
23 Q Did you write that?  
24 A I did, but now I'm trying to figure out  
25 what's in the footnote.

Page 137

1 Q Does your use of "standard practices"  
2 in the rebuttal report versus "best practices" in  
3 your initial report, does that change the meaning of  
4 the term that you used in the first report?  
5 A Absolutely not.  
6 Q Right. Because you say here that this  
7 rebuttal report uses these phrases interchangeably?  
8 A Correct.  
9 Q So your -- and for the rest of this  
10 deposition, I may use the terms interchangeably.  
11 But when you say "best practices" and when you say  
12 "standard practices," you're talking about the same  
13 thing, aren't you?  
14 A I am. "Standard practices" expected  
15 for public procurements, and "best practices" can be  
16 used interchangeably in my report.  
17 Q When you say "expected for public  
18 procurements," that word doesn't show up in your  
19 footnote, who expects those practices to be  
20 followed?  
21 A The taxpayers, theoretically, that --  
22 whose money may be utilized for public procurements.  
23 Any -- you know, the transparency associated with  
24 public procurements and the ability to challenge or  
25 question those procurements leads to a higher

Page 138

1 level or a higher expectation on the part of those  
2 who have entrusted that government to make sure that  
3 they're operating in a fair, you know, consistent,  
4 uniform fashion.  
5 And so when I say "expected," you know,  
6 as opposed to commercial procurement practices that  
7 may be utilized to buy a commodity, in situations  
8 like this that are more sophisticated, there is a  
9 higher -- what I'll call a higher bar that is --  
10 that goes along with having to make these types of  
11 procurement decisions.  
12 Q I realize this is a pretty broad  
13 question, but what's your basis for knowing what the  
14 taxpayers expect?  
15 A The taxpayers should expect what's  
16 identified here that they're going to receive the  
17 most, you know, benefits that the Plan has deemed to  
18 be, you know, the most -- the result of a most  
19 advantageous offer, or technically, the best  
20 technical approach at the best price they could  
21 receive, especially here where 700,000 or so  
22 participants in the Plan are going to be the ones  
23 who have to potentially make a shift to a new  
24 provider.  
25 Q Your answer started with the word "the

Page 139

1 taxpayers should expect."  
2 Do you have any understanding what the  
3 taxpayers do expect?  
4 A I think the taxpayers expect that  
5 procurement decisions using moneys that they have  
6 paid are going to be disbursed with the lack of  
7 waste or abuse or corruption and that there are  
8 policies that have been put in place to prevent that  
9 from happening and making sure that the decisions  
10 that are made by these agencies, public procurements  
11 in particular, you know, are supportable, objective,  
12 free from bias, and follow the intended purpose of  
13 the procurement.  
14 Q What's your basis for saying that  
15 that's what -- sorry.  
16 What is your basis for saying that  
17 that's what taxpayers expect?  
18 A Well, I'm a taxpayer. That's what I  
19 expect when my county or my state is making some  
20 large decisions that may affect me personally; that  
21 the funds I'm paying are going to be used in a  
22 fashion that prevents all those things that I cited  
23 from happening.  
24 Q Any other basis?  
25 A I am confident that some of the sources

Page 140

1 that I cited, whether it's OECG, some of the  
2 industry associations articulate that as why there  
3 are standards expected related to procurement of --  
4 public procurement, excuse me.  
5 Q If there is any support in any of those  
6 sources that you're talking about, that's not  
7 anything that's stated in any of your reports, is  
8 it?  
9 A Relative to the taxpayer, I believe  
10 it's not, it's not linked in my report.  
11 Q We probably already talked about it,  
12 but in case it was not completely covered, you would  
13 agree that the best practices and/or the standard  
14 practices that you talk about in your reports, those  
15 are not requirements, are they?  
16 A They're not requirements to the RFP.  
17 Q Are they any kind of requirements that  
18 would be binding on the North Carolina State Health  
19 Plan?  
20 A Actually, the DST policy I believe has  
21 language in there that demonstrates that it is  
22 required and that employees who don't follow the  
23 policy are subject to disciplinary action.  
24 Q Is that policy something that is cited  
25 in your report?

Page 141

1 A It is.  
2 Q Do you know where?  
3 A It's -- let me find the number. It's  
4 included in the items referenced, the DST policy.  
5 As to whether it's in the initial or rebuttal, let  
6 me see here.  
7 (Sotto Voce.)  
8 A Of course, I don't know what page  
9 number it has.  
10 Let me see if I...  
11 Thirty-seven -- it's in paragraph 56.  
12 The Plan's own procurement policy. It's footnote  
13 37.  
14 Q Okay. And so there's a footnote there  
15 that refers to --  
16 A It's DST procurement policies.  
17 Q So the footnote reads SHP 0092221 at  
18 page 92227; is that right?  
19 A Correct.  
20 Q Okay. Thank you.  
21 Other than that policy, is there any  
22 requirement that the North Carolina State Health  
23 Plan follow any of the best practices that you state  
24 in either of your reports?  
25 MR. ZIMMERMAN: Object to form.

Page 142

1 A Not that I'm aware of.  
2 BY MR. HEWITT:  
3 Q In general, who decides what is a best  
4 practice or a standard practice and what isn't?  
5 A The State Health Plan should decide for  
6 itself what is a best practice relative to  
7 procurements of this nature. Typically, each  
8 organization, whether it's a state government, local  
9 government, federal government, determines those  
10 controls and processes that it will put in place,  
11 specific to the items that it is procuring, to  
12 ensure that it adheres to its regulations and ensure  
13 it has the appropriate controls to prevent, you  
14 know, the potential that nonobjective, inconsistent  
15 or unfair procurement decisions are made. So it  
16 would be that entity themselves.  
17 Q I understand. My question was actually  
18 a little bit different. And throughout your report  
19 and in your rebuttal report, you state a number of  
20 things that you say are either best practices or  
21 standard practices, right?  
22 A Yes.  
23 Q And so in your opinion, you talk about  
24 best practices. And so my question, as a general  
25 proposition, is who is it that decides what is a

Page 143

1 best practice and what isn't?  
2 A Okay. Relative to public procurement,  
3 there's a number of what I would say organizations  
4 that are identified as, what I'll call "standard  
5 setters" relative to the practices that are  
6 expected. When I say, the standard practices for  
7 public procurement. They include organizations like  
8 OECG, the National Institute of Government  
9 Procurement, for example, the federal government,  
10 the Federal Acquisition Regulations, and the DOD  
11 acquisition procedures, the United Nations, the  
12 World Bank. You know, a lot of organizations that  
13 are well esteemed that perform a lot of procurement  
14 that, again, are using federal or public dollars to  
15 make those procurements, are looked at as  
16 identifying practices that are recommended for  
17 public procurement.  
18 And in this case, North Carolina itself  
19 developed its own procurement manuals and policies,  
20 some of which stem directly from some of those  
21 recommendations. There's also organizations that  
22 provide training, provide a lot of materials that  
23 are available to state government procurement  
24 officials to draw upon to form those practices and  
25 policies.

Page 144

1 Q Okay. So you've identified a number of  
2 different standards organizations, trade  
3 organizations, State of North Carolina, different, I  
4 guess, federal and state entities; is that fair?  
5 A Yes.  
6 Q Okay. So do they all each have their  
7 own best practices or is there a single set of best  
8 practices that apply to all of them?  
9 A There's no single set that applies to  
10 them all, but there's a lot of commonalities that  
11 are included in all.  
12 Q So would you agree the best practices  
13 can differ depending on an individual organizations'  
14 goals and the purposes of its procurements?  
15 A Yes.  
16 Q And that would include "differing,"  
17 based on what kind of product or services is being  
18 sought?  
19 A Correct.  
20 Q Are best practices mandatory?  
21 A If an organization deems them to be  
22 mandatory, then they could be mandatory. It really,  
23 again, depends on the organization.  
24 Q Okay. Are the best practices that you  
25 have stated in your reports mandatory?

Page 145

1 A They're not mandatory.  
2 Q Is the North Carolina State Health Plan  
3 required to follow any of the best practices that  
4 you identified in your reports?  
5 A I would say to the extent that they're  
6 incorporated in the DST policy that I referenced,  
7 that I would deem those to be mandatory for the  
8 State Health Plan to follow.  
9 Q Are any of them incorporated into that  
10 policy?  
11 A I believe there are some incorporated  
12 in that policy. I would have to take a look at the  
13 specific policy again.  
14 Q Did you identify any of them in your  
15 report that were incorporated into the State Health  
16 Plan policy?  
17 A I do believe there are some identified  
18 in the report. I'm trying to think of the best way  
19 to figure out what those are.  
20 I believe one has to do with the -- let  
21 me just see if it's in here.  
22 The -- there is one at paragraph 36 of  
23 my initial report that identifies the Plan's own  
24 procurement policy, endorses the practice of  
25 distributing points based on relative significance

Page 146

1 when the policy calls for each component of an RFP  
2 to be assigned an appropriate number of points  
3 relative to the importance of the component.  
4 Q You said that's a concept, right?  
5 A That's included in the Plan's policy.  
6 Q Okay. What else? It's not necessarily  
7 a memory test, by the way. So if you don't happen  
8 to remember them off the top of your head, would you  
9 have cited to the Plan's own policy if you believed  
10 that the Plan's policy made those practices  
11 mandatory?  
12 A Yes.  
13 Q Thank you.  
14 Does the State Health Plan have the  
15 authority to decide not to follow a best practice?  
16 A Yes.  
17 Q And you relied a lot in your reports on  
18 the RFP Handbook by, I believe, Michael Asner; is  
19 that right?  
20 A Yes.  
21 Q And also you've cited several times to  
22 the guidebook, which is the Harvard Kennedy School  
23 document?  
24 A Yes.  
25 Q Those have been marked as Exhibits 404

Page 147

1 and 405.  
2 Have you relied on those authorities  
3 for purposes of supporting expert witness opinions  
4 before this case?  
5 A Yes.  
6 Q How many times?  
7 A Not all my matters deal with issues  
8 like this, but to the extent that the cases have  
9 dealt with procurement-related matters, I have used  
10 those as sources.  
11 Q To your knowledge, has anybody else  
12 relied on those sources as authority for expert  
13 witness opinions?  
14 A I don't know specifically.  
15 Q Are you aware of any procurement  
16 decisions that have ever been reversed for not  
17 following best practices or standard practices?  
18 A Through bid protest, yes, multiple.  
19 Q When you say "through bid protest," are  
20 you talking about where the procuring entity itself  
21 decides in response to a protest to reverse its  
22 initial determination?  
23 A It could be the procuring entity, it  
24 could be the attorney that is overseeing the bid  
25 protest proceedings, the results of the bid protest.

Page 148

1 Oftentimes, if it is unclear, for example, the basis  
2 for the evaluation criteria or the ultimate decision  
3 is not supported by the documentation of the  
4 specific procurement, you know, some of the exact  
5 same things that I've cited here are bases for  
6 decisions that have overturned awards in other  
7 procurements that I've been involved with in my  
8 experience.  
9 Q Okay. I guess more specifically, are  
10 you aware of any procurements that have been  
11 overturned specifically because the -- either the  
12 procuring entity or whoever was deciding that  
13 protest determined that there was a failure to  
14 follow best practices?  
15 A If literally the decision was based on  
16 and articulated as the failure to follow a best  
17 practice, no.  
18 Q Okay. Same question but with standard  
19 practices.  
20 A Standard practices for procurement? I  
21 don't know whether that language is used in a  
22 decision. But the failure to follow a standard  
23 practice has been the basis, in my experience, for  
24 many bid protests to be overturned.  
25 Q When you say "many," well, again, I'm

Page 149

1 trying to be very specific here, because your  
2 opinions are specifically phrased in terms of "best  
3 practices --"  
4 A Yes.  
5 Q -- or "standard practices."  
6 Are you aware specifically of any  
7 procurements that have been overturned because they  
8 failed to follow -- specifically because they failed  
9 to follow standard practices?  
10 A Yes. For example, best-value  
11 determinations, to the extent that those are not  
12 documented and those are not -- they don't follow  
13 what has explicitly been stated in the RFP as the  
14 basis for making that best-value determination, that  
15 award has been overturned as a result. That is a  
16 standard practice that is an example where the use  
17 of that standard practice, how you should document a  
18 best-value determination and the lack of that  
19 documentation was a reason that that procurement was  
20 overturned.  
21 Q Can you give me an example, like a  
22 specific example of a procurement where that has  
23 happened?  
24 A It's a pretty common one. Let me look  
25 at my CV and look at the list -- no, it's not on

Page 154

1 Q So that's -- it tracks or is parallel  
2 with the language in Section 3.4(b), right?  
3 A Yes.  
4 Q So bidders knew when they bid that they  
5 would be ranked on the technical proposal and the  
6 cost proposal separately, right?  
7 A Yes.  
8 Q Now, to the extent that Mr. Thompson  
9 didn't cover it, are you aware of whether Blue Cross  
10 objected or tried to get the Plan to change that  
11 part of the scoring methodology before it bid?  
12 A If you're asking did they submit a  
13 question asserting there was an issue relative to  
14 that area, I'm not aware that they submitted a  
15 question in that regard.  
16 Q Or any kind of an objection or any kind  
17 of concern in the question-and-answer period?  
18 A It's my understanding they did not.  
19 Q Would you have expected them to?  
20 A If they fully understood how the  
21 evaluation was going to occur and they could  
22 foresee, you know, a potential issue with the way  
23 that it occurred, I don't think that they foresaw  
24 that the methodology would transpire as it did, and  
25 thus didn't contemplate that that's how this would

Page 155

1 be interpreted, so they didn't raise a question.  
2 That's my understanding.  
3 Q Well, I mean, nobody foresaw exactly  
4 how it turned out, was going to turn out because  
5 nobody knew what the scores were going to be or the  
6 proposals were going to look like, right?  
7 A And no one understood in full what  
8 methodology was going to be applied, for example,  
9 whether it would be a 1 point or a 0 point or how  
10 many points people would get.  
11 Ranking doesn't necessarily equate to a  
12 specific number of points or a methodology for the  
13 points.  
14 Q What other purpose would the State have  
15 for giving the lowest ranked bidder the rank of 1  
16 and the highest ranked bidder -- or excuse me, and  
17 the highest ranked bidder the highest numerical rank  
18 as what is described here?  
19 A No other purpose.  
20 Q So that's what the Plan did, right,  
21 when it scored the proposals, the Plan ranked Blue  
22 Cross last in the technical proposal, and so it got  
23 a 1 on that part, right?  
24 A Yes.  
25 Q And UMR and Aetna both were -- both

Page 156

1 confirmed all 310 technical requirements, and so  
2 they both tied on that part at 3, right?  
3 A Yes.  
4 Q So the Plan scored that consistently  
5 with what was stated in the RFP, right?  
6 MR. ZIMMERMAN: Object to form.  
7 A Yeah. They scored -- they afforded  
8 those ranked in the way that this paragraph  
9 describes that they would.  
10 BY MR. HEWITT:  
11 Q And so is it your opinion that there  
12 were any math errors in the scoring of the technical  
13 proposal?  
14 A No.  
15 Q And I guess, similarly, on the cost  
16 proposal, isn't it true that the Plan assigned those  
17 ranks, exactly the way it said it was going to do in  
18 the RFP?  
19 A Yes.  
20 Q Okay. And -- or is it your contention  
21 that there were any math errors in the scoring or  
22 the ranking in the cost proposals?  
23 A It's not my contention that there were  
24 errors. It's my contention it was unclear, for  
25 example, whether they would provide a 1 point or a 0

Page 157

1 point because it's not articulated within the  
2 description that's provided here.  
3 Q In your opinion report, paragraph 20 --  
4 actually, more specifically in 22. This is on page  
5 5 of Exhibit 403. Are you there, ma'am?  
6 A Yes, I think I am.  
7 Q Okay. So it says, in part -- well, it  
8 says, quote: "In my experience, the best practice  
9 for a final scoring methodology is instead to assign  
10 ranks only once, at the end of the scoring process,  
11 after combining each vendor's points (properly  
12 weighted) for all components of the RFP."  
13 Do you see that?  
14 A Yes.  
15 Q Okay. Is that a best practice that is  
16 followed by all procuring authorities?  
17 A I would say that's specified within the  
18 RFP and most RFPs do specify, you know, that --  
19 how -- the technical proposal and the cost proposal  
20 would be weighted and scored.  
21 Q My question was actually, is the best  
22 practice that you state here, which is to only  
23 assign ranks once after combining each vendor's  
24 points for all components, is that a practice  
25 that's -- best practice that's followed by all

Page 170

1 the technical proposal, the use of ranks, it would  
2 consistently skew the results in favor of the high  
3 scoring bidder, right?  
4 A I think mathematically it would tend to  
5 do that.  
6 Q Okay. So it's not -- it's not always  
7 going to skew it in favor of Blue Cross or Aetna or  
8 UMR?  
9 A Right, the methodology.  
10 Q It's going to skew in favor of the high  
11 scoring bidder?  
12 A I think that's right.  
13 Q And in your opinion, you disagree that  
14 that's how the Plan should have done it?  
15 A Yes.  
16 Q Are you aware of any example of where a  
17 procurement was reversed because the chosen  
18 methodology in the RFP skewed the bidder's scores?  
19 A I can't think of a specific procurement  
20 right here.  
21 Q In paragraph 26 of your report, you  
22 talk -- you suggest a different type of approach of  
23 using scaled scores or scaling both scores to a 310  
24 point scale.  
25 Do you see that?

Page 171

1 A Yes, yes.  
2 Q You use -- in the second -- I think  
3 it's the second sentence reads: "Under a  
4 best-practices approach, the Plan would have scaled  
5 the vendors' cost and technical scores to each  
6 other -- for example, by converting the cost scores  
7 to the same 310 point scale as the technical  
8 scores."  
9 Do you see that?  
10 A Yes.  
11 Q That's an example, right?  
12 A Yes.  
13 Q Okay. And there are other ways the  
14 Plan could have done it, too, right?  
15 A Correct.  
16 Q And in the same paragraph, you talk  
17 about the 2019 RFP.  
18 A Yes.  
19 Q Okay. But have you looked at -- have  
20 you read that RFP?  
21 A Yes.  
22 Q Okay. The scoring methodology  
23 described in the 2019 RFP was different, wasn't it?  
24 A Correct.  
25 Q It actually said it was going to scale

Page 172

1 the technical and the cost to each other, right?  
2 A It identified specific point scores for  
3 the various pieces of the technical and the cost  
4 proposals. It didn't use rankings in the way that  
5 this RFP for 2022 used rankings.  
6 Q But the two were drafted differently?  
7 A Correct.  
8 Q You recognize in paragraph 27, even if  
9 the best practices, as you've described it, approach  
10 was used in paragraph 26, that in the final score  
11 Blue Cross would have still scored less than Aetna,  
12 right?  
13 A Right. That's if none of the other  
14 arbitrary scores were reversed or revised, that's  
15 right.  
16 Q All other things equal --  
17 A Correct.  
18 Q -- if it just used an approach where  
19 both parts of the -- excuse me -- both the technical  
20 and the cost proposals were scaled to each other  
21 using a 310 point scale, all else equal, Blue Cross  
22 would still score lower than Aetna?  
23 A Correct.  
24 Q So in order to reach an outcome where  
25 Blue Cross outsourced Aetna, it would require

Page 173

1 changing both the scoring weights and the cost  
2 scores, wouldn't it?  
3 A Potentially it would require a change  
4 in the allocation of point scores. For example,  
5 with respect to the network pricing guarantees,  
6 whether 0, 1, 2 points should have been awarded to  
7 Blue Cross, that would have potentially resulted in  
8 Blue Cross having been selected; or if Aetna had  
9 received 0 points instead of 1 point on the network  
10 pricing guarantee, there's a lot of places where  
11 the -- there's ambiguity as to how to award 1 or 0  
12 points to the non-highest-ranked offerer that could  
13 have resulted in a change in the ultimate scoring  
14 points.  
15 Q But if all you changed was the scores  
16 being scaled to each other using the scale you  
17 proposed here, the outcome would not change, right?  
18 A Correct.  
19 Q In your rebuttal report, which is  
20 Exhibit 410, you give the example of -- or excuse  
21 me -- you respond to the Maryland RFP. Page 3 of  
22 your rebuttal report, paragraph 12. Do you see  
23 that?  
24 A Yes.  
25 Q Okay. You talk about the Maryland RFP.

Page 230

1 are subjective because they take multiple elements  
2 into account that may not be specifically  
3 articulated within a provision.  
4 Q So I guess if something's not  
5 adequately explained in an RFP, in your opinion,  
6 that would lead to it being potentially subjective?  
7 A Yes. Or if it could be interpreted in  
8 a variety of ways.  
9 Q Do you think "objective" could also be  
10 interpreted in a variety of ways?  
11 A I do.  
12 Q Is there any technical definition that  
13 you're aware of for "objective" or "subjective"?  
14 A I'm sure there is. I don't know what  
15 it is, sitting right here at this point in the day.  
16 Q And I believe Mr. Thompson asked you  
17 before about whether or not, in your opinion -- I'm  
18 probably going to get this wrong, so I'll probably  
19 just try to ask my own question.  
20 In your opinion, are objectivity and  
21 subjectivity mutually exclusive?  
22 A Mutually exclusive in what -- that it  
23 either has to be objective or subjective, you mean?  
24 Q Yes.  
25 A No.

Page 231

1 Q Okay. So in some cases, for example,  
2 evaluation criteria could be partly objective and  
3 partly subjective?  
4 A Correct.  
5 Q If an RFP evaluation process or a  
6 scoring methodology is partly or entirely  
7 subjective, does that necessarily mean that it's  
8 invalid?  
9 A Not necessarily.  
10 Q Okay. And is a procuring authority  
11 required to use only 100 percent objective criteria  
12 and evaluation processes?  
13 A No.  
14 Q Okay. I mean, you would agree with me  
15 it's -- frequently evaluation processes and scoring  
16 methodologies have some component of subjectivity?  
17 A Correct.  
18 Q In paragraph 49, you refer to the  
19 Harvard Kennedy School guidebook. Let's look at  
20 that one again briefly, please. That is  
21 Exhibit 405, if I can find it.  
22 If you would, just turn to page 55,  
23 please. All right. In paragraph 49 of your expert  
24 report, you cite to that -- give me just a moment,  
25 please.

Page 232

1 And you said the third  
2 characteristic -- and you're referring to page 55  
3 here. You say the third characteristic is that  
4 evaluation criteria should provide sufficient  
5 information to let proposers know what a successful  
6 response looks like, correct?  
7 A Yes.  
8 Q And below that, you also quote the  
9 guidebook as saying: "An evaluation committee  
10 should have a clear idea of what a high-scoring  
11 proposal would look like in each criterion before  
12 the evaluations begin."  
13 Right?  
14 A Yes.  
15 Q Okay. The guidebook here that we're  
16 looking at doesn't give any standard for what level  
17 of explanation is sufficient, does it?  
18 A It does not.  
19 Q Okay. And, in fact, as Mr. Thompson, I  
20 think pointed out, it says, in part, "depending on  
21 the RFP it can be helpful to share this information  
22 with proposers."  
23 Right?  
24 A Yes.  
25 Q Okay. And so would you also agree with

Page 233

1 me, this section of the guidebook does not say that  
2 the process has to be objective?  
3 A This section does not.  
4 Q Have you -- do you know whether the RFP  
5 guidebook from the Harvard Kennedy School says  
6 anywhere that an evaluation process or a scoring  
7 methodology has to be objective?  
8 A I can't recall. I'd have to look  
9 through it.  
10 Q And so I guess a clarification question  
11 on your opinions here in this part of your report,  
12 is the problem, in your opinion, the way the RFP --  
13 the way the scoring methodology was explained in the  
14 RFP, or is the problem, in your opinion, the way  
15 that the RFP was actually scored by Segal? And I'm  
16 talking about the cost proposal.  
17 A Yes. In my opinion, especially with  
18 respect to the network pricing guarantees, I think  
19 it's both of those aspects. Had the RFP been clear,  
20 it could have reduced the ambiguity, in my opinion,  
21 that could be applied to evaluate that criteria, and  
22 it could have led to a more objective evaluation.  
23 Q Okay. And in paragraph 50, you say:  
24 "The Plan did not have a clear idea before the  
25 evaluations began of how administrative fees and

Page 262

1 to use a binary technical proposal format with no  
2 narrative?  
3 A I think with respect to best-value  
4 determinations, there's not enough information --  
5 given that this is a most advantageous, which in the  
6 Plan's own policy speaks to being best value or  
7 having some -- at least consideration of what is the  
8 most advantageous proposal, that there have to be  
9 criteria that enable you to make that determination  
10 based on the results of the technical evaluation.  
11 Every source that I identify speaks to  
12 having criteria that are important to determining  
13 who would be the best technical proposal as well as  
14 cost proposal. And in this case, those criteria  
15 weren't specified, and the 310 responses don't  
16 really support a conclusion regarding which criteria  
17 drove, you know, a technical determination that  
18 could be used to determine a most advantageous  
19 offerer.  
20 Q Other than yourself, are you aware of  
21 any other authority for the proposition that binary  
22 criteria -- confirm versus not confirm -- are  
23 improper or insufficient for a technical proposal?  
24 A Stated that simply, no.  
25 Q Would you agree that the State Health

Page 263

1 Plan had the authority to use a binary format with  
2 no narrative?  
3 A Yes.  
4 Q Was there any requirement that you're  
5 aware of that required that the State Health Plan  
6 allowed narrative responses?  
7 A No.  
8 Q And was the State Health Plan required  
9 to do any validation of vendors' capabilities to  
10 meet the technical requirements?  
11 A In my opinion, yes, they had a duty to  
12 assess the ability of offerers to be able to meet  
13 those 310 criteria as of January 1, 2025, especially  
14 in specific areas that they had experienced  
15 performance issues with the incumbent, BCBS, service  
16 provider.  
17 Q Because my question was in the context  
18 of a requirement for validation, is there a statute,  
19 rule, or policy that you can point to that required  
20 the State Health Plan to do any kind of validation?  
21 MR. ZIMMERMAN: Object to form.  
22 A I don't believe I can point to, for  
23 example, their policy does not include that  
24 requirement, the DST policy that we looked at  
25 earlier.

Page 264

1 BY MR. HEWITT:  
2 Q I'm sorry. It does or it does not?  
3 A It does not.  
4 Q Okay. And you can't point to any other  
5 requirement that validation be performed?  
6 MR. ZIMMERMAN: Object to form.  
7 A Again, it's a best practice.  
8 BY MR. HEWITT:  
9 Q In paragraph 67 of your report, there  
10 are a couple statements that I want to ask you  
11 about. One of them -- have you got that where you  
12 can see it, ma'am?  
13 A I do.  
14 Q Okay. So starting on about the fifth  
15 line of paragraph 67, there's a sentence that reads:  
16 "Without offering an opportunity to describe  
17 limitations, a purchasing organization is left to  
18 assume that a vendor responding 'confirm' will  
19 adhere to a technical requirement 100 percent of the  
20 time."  
21 So I want to ask -- well, actually then  
22 I'll go ahead and read the next one, too. The next  
23 sentence says: "Without explanations, vendors are  
24 forced to consider and respond to the wording of a  
25 technical requirement statement quite literally

Page 265

1 without revealing potential circumstances that could  
2 cast doubt on a 'confirm' response in some cases."  
3 Did I read that about -- correctly?  
4 A Yes.  
5 Q All right. So can you give me an  
6 example of a situation where a vendor might need to  
7 describe the limitations on its ability to perform a  
8 requirement?  
9 A Sure. One of the examples would be --  
10 one of the responses that Blue Cross Blue Shield  
11 when it was unable to confirm, for example, that it  
12 would be able to adopt the EES funder as the primary  
13 identification for all of the members of the Plan,  
14 without being able to explain what the impact of  
15 that would be -- and especially since they're the  
16 incumbent, to the extent that they have an inability  
17 to perform some of these, I think it's incumbent on  
18 the Plan to have a duty to understand why, if the  
19 incumbent can't do it, how is it that others that  
20 have never been in here can suddenly do some of  
21 those things?  
22 So whether it's through clarifications  
23 or whether it's through some kind of a narrative  
24 explanation, to me, it begs the need to, from a  
25 rational standpoint, ensure that all offerers made a

BC and BS of NC v. NC State Health Plan for Teachers, et al.

Confidential Mary Karen Wills, CPA (#6305927)

ACKNOWLEDGEMENT OF DEPONENT

I, CONFIDENTIAL Mary Karen Wills, CPA, do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

Mary Karen Wills

CONFIDENTIAL Mary Karen Wills, CPA

12/13/23

Date

NOTARY:

SUBSCRIBED AND SWORN TO BEFORE ME THIS

13<sup>th</sup> DAY OF December 2023



NOTARY PUBLIC

Andrea Simms McCray

ANDREA SIMMS MCCRAY  
NOTARY PUBLIC DISTRICT OF COLUMBIA  
My Commission Expires January 1, 2027

ERRATA

Mary Karen Wills Deposition dated November 17, 2023

page #	line #	Change From	Change To
5	23	Coccari	Coccia
17	10	offerers	offerors
25	12	Horne	Horn
72	20	I don't articulate that.	I don't articulate that (strike the period in middle of line)
77	13	offerer	offeror
78	8	offerer	offeror
91	18	offerer	offeror
101	14	offerer	offeror
158	13	in proper	improper
169	13	offerers	offerors
169	15	offerer	offeror
178	1	Oh	Both
182	10	offerers	offerors
186	24	"6-2..."	"6-2-2"
215	23	offerers	offerors
215	25	herein	therein
219	18	offerers	offerors
220	1	offerers	offerors
220	13	offerers	offerors
220	16	offerers	offerors
240	1	offerers	offerors
240	23	valuations	evaluations
249	2	was that	were that
251	3	7048	70486
261	2	offerers	offerors
262	19	offerer	offeror
265	25	offerers	offerors
270	18	offerers	offerors
272	5	offerer	offeror
273	7	is	delete "is"
273	21	offerer	offeror
280	4	offerers	offerors
281	9	offerers	offerors
282	15	offerer	offeror
289	4	offerers	offerors
290	3	offerers	offerors
290	18	have as	have had as

**EXHIBIT D**

**GREGORY RUSSO  
DEPOSITION EXCERPTS**

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STATE OF NORTH CAROLINA  
COUNTY OF DURHAM  
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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.  
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\*\* CONFIDENTIAL \*\*  
\*\*PORTIONS CONTAIN ATTORNEYS' EYES ONLY\*\*  
VIDEO DEPOSITION OF  
GREGORY RUSSO  
NOVEMBER 28, 2023  
9:21 a.m.  
Raleigh, North Carolina

Reported by: Audra M. Smith, FCRR  
Video by: John Roberts

Page 38	Page 40
<p>1 A They had litigation aspects. They were 2 litigation cases, how much I was or am supporting 3 Blue Cross Blue Shield member association companies. 4 Q All right. So what types of cases are we 5 talking about? Fraud and abuse? 6 A Yes. 7 Q Dialysis? 8 A Fraud and abuse. 9 Q Fraud and abuse? 10 A Not dialysis. 11 Q Okay. All right. Fraud and abuse cases? 12 A Yes. 13 Q Did any of the cases that you're referring 14 to where you've had some strategic role for or on 15 behalf of a Blue Cross Association member involve 16 any aspect of Blue Cross responding to a state 17 government request for proposal for a health plan? 18 A I have assisted Blue Cross Blue Shield 19 member association companies with aspects of the 20 Medicare Advantage program -- 21 Q Okay. 22 A -- and with the Medicare Advantage program 23 that is a program for which the companies need to 24 make a bid to the federal government to offer that 25 insurance.</p>	<p>1 Q Okay. Well, I'm just trying to draw the 2 distinction. To your knowledge, have you performed 3 any work for a member of a Blue Cross association 4 that involved any aspect of a state government's 5 request for a proposal for a state health plan? 6 A So at some point in my career, I recollect 7 working on Medicaid issues, and those would be run 8 by a state. I don't remember if I did them for Blue 9 Cross -- did work like that for a Blue Cross Blue 10 Shield member association or not, though. 11 Q Well, we'll look at your CV and maybe -- 12 I'll give it to you. I'm not trying to have you 13 memorize it. Maybe that can give us some more -- 14 put some more meat on the bones here. 15 At the time you were retained, Mr. Russo, 16 did you have any familiarity with or understand who 17 The Segal Group was? 18 A I had heard of their name, but I didn't 19 have any familiarity other than that. 20 Q You don't have any experience working with 21 or against them on any engagements that you've been 22 retained for? 23 A That's correct. 24 Q How much of your time would you estimate 25 is devoted to serving in a litigation context as an</p>
Page 39	Page 41
<p>1 Q Yeah, I'm aware of that. So let me ask 2 you, have you assisted them in putting Blue Cross 3 and putting together actual bid responses for -- to 4 the federal government in response to RFPs under the 5 Medicare Advantage program? 6 A No. I haven't. Remember we're talking 7 about litigation work. 8 Q Yes. 9 A And so, no, it hasn't been -- 10 Q Okay. 11 A We haven't been putting together bids in 12 the course of that litigation work. 13 Q Okay. This is after a decision was made 14 by the federal government one way or the other? 15 A Yes. Decisions have been made that the 16 company may have been operating a plan in accordance 17 with its contract with the federal government -- 18 Q Okay. All right. 19 A -- and there were questions as to its 20 operation. 21 Q All right. Understood. 22 Now, that's a federal procurement process 23 for Medicare Advantage, correct? 24 A I don't know how you would typify it. 25 It's a federal program.</p>	<p>1 expert witness for the purposes of drafting reports, 2 giving depositions or testimony? 3 A Of my billable time -- 4 Q Right. 5 A -- about 80, 85 percent. 6 Q Okay. And in the 20 to -- 15 to 7 20 percent of the billable time that you have at BRG 8 where you're not serving in the role as an expert 9 witness in any of those three categories, 10 development of expert reports, depositions or 11 testimony at trial, what role do you perform or task 12 do you perform at BRG for the other 15 to 20 percent 13 of your time? 14 MS. JOSEPH: Objection to form. 15 A And I just want to make sure it's clear, I 16 think you will appreciate this distinction. This is 17 of my billable time, right? 18 BY MR. WHITMAN: 19 Q Yes. 20 A So we're not talking about any of my 21 nonbillable administrative -- roles. 22 Q Right. Of course, I do appreciate that. 23 At the end of the day, especially in December, we're 24 all talking about billable time. 25 A I know we are.</p>

<p style="text-align: right;">Page 42</p> <p>1 Q So, I'm interested -- you understood my 2 question correctly. Of the billable -- the time you 3 bill out to clients -- 4 A That's right. 5 Q -- 80 to 85 percent of your practice is 6 this litigation support as an expert witness, 7 correct? 8 A Yes, that's correct. 9 Q Okay. So I'm just simply asking, in the 10 15 to 20 percent of your billable time that does not 11 involve those types of services, what do you do? 12 A So I assist clients with investigations 13 and issues that they have regarding investigations, 14 as well as, in some instances, working on 15 strategic-related questions that the clients may 16 have. 17 Q Okay. I just want to -- I understand the 18 terms that you're using when you say "strategic 19 questions," because I see that on your résumé as 20 well. 21 You're talking about something internal 22 that a client brings to you and says, We want you to 23 evaluate and analyze this and help us decide whether 24 we do X, Y, Z with it. Is that fair? 25 A That's correct, yes.</p>	<p style="text-align: right;">Page 44</p> <p>1 Carolina State Superior Court? 2 A I don't believe that I have had an 3 opportunity to do so. 4 Q Okay. And how about in any North Carolina 5 federal court? 6 A I also do not believe that I've had an 7 opportunity to do so. 8 Q Okay. To your knowledge, Mr. Russo, have 9 you ever previously given expert testimony in a 10 dispute concerning a procurement for a third-party 11 services contract from a state government health 12 plan? 13 A No, I don't believe that I have. 14 Q Okay. How about any type of government 15 health plan, governmental health plan? 16 A I would want to look back over my CV. 17 Q Okay. 18 A There are often Medicare and Medicare 19 Advantage and sometimes Medicaid issues that are 20 included within the matters in which I'm testifying. 21 Q Okay. Well, and we'll look at your CV in 22 just a moment. 23 Have you ever previously given expert 24 testimony in the form of a report, a deposition, or 25 testimony in court in any case that involves the</p>
<p style="text-align: right;">Page 43</p> <p>1 Q Okay. It doesn't involve a government 2 investigation, correct? 3 A That's correct. It does not involve a 4 government investigation -- 5 Q Right. 6 A -- or an active litigation. 7 Q Okay. Okay. That's -- 8 A It's typically just -- 9 Q Okay. That's -- that's what I understood, 10 but I want to be sure we're talking about the same 11 thing when you say "strategic." 12 All right. Now, Mr. Russo, are you aware 13 of which court in North Carolina this case is 14 currently pending before? 15 A My understanding, it's Court of 16 Administrative Hearings. 17 Q Yeah, Office of Administrative Hearings. 18 Okay. 19 And to your knowledge, have you ever been 20 previously accepted as an expert witness by the 21 North Carolina OAH? 22 A I do not believe that I have. I don't 23 believe I've had an opportunity to. 24 Q Okay. To your knowledge, have you ever 25 been accepted as an expert witness in the North</p>	<p style="text-align: right;">Page 45</p> <p>1 propriety of a scoring or ranking of a cost proposal 2 submitted in response to a state governmental RFP? 3 A No, I have not. 4 Q Okay. Have you ever advised a state 5 government health plan what should or should not be 6 included in an RFP for its own health plan? 7 A No, I have not. 8 Q Have you ever drafted a request for 9 proposal for a state government? 10 A No, I have not. 11 Q Have you ever been a member of an 12 evaluation committee whose job it is to review, 13 evaluate, and score proposals from insurance 14 companies in response to a state government RFP? 15 A No, I have not. 16 Q Have you ever been hired or retained by a 17 state government health plan to do anything? 18 MS. JOSEPH: I'm going to object to form. 19 A I don't recollect being hired before by a 20 state health plan. 21 BY MR. WHITMAN: 22 Q Okay. And my previous questions were 23 about an RFP for a state government health plan. 24 Have you ever drafted any type of request for 25 proposal for a governmental entity?</p>

Page 46	Page 48
<p>1 A There were elements of my work for the New 2 York Division of Budget, for which I wrote a waiver 3 to the federal government, and as part of that 4 waiver, there were -- there was a need to find 5 providers that would be able to serve children in 6 foster care, and elements of the application that I 7 made to the federal government were then used in the 8 request for proposal that the Division of Budget 9 released. 10 Q Okay. So and I understand the waiver 11 document is separate from an RFP, though, correct? 12 A That's correct. 13 Q So some of the work you did at the New 14 York Division of Budget, you prepared a waiver that 15 was submitted to the federal government; is that 16 correct? 17 A Yes, that's correct. 18 Q And some aspects of your waiver 19 application or waiver request were ultimately 20 incorporated into the federal agency's RFP? 21 A It was a state agency -- 22 Q A state agency? Sorry. 23 A -- not a federal agency. 24 Q Okay. Which state was that, New York? 25 A It was New York, yes.</p>	<p>1 that apply to state procurements for governmental 2 health plans? 3 A No, I'm not familiar with the rules and 4 the law concerning state procurements. 5 MR. WHITMAN: All right. Let's go ahead 6 and mark your CV. And I'm going to use the 7 amended or updated CV that was attached to your 8 rebuttal report, just to be sure we're using 9 the latest one. 10 (Exhibit Number 415 marked for 11 identification.) 12 BY MR. WHITMAN: 13 Q I'm going to show you what's been marked 14 as Exhibit 415 and ask if you recognize that as your 15 updated CV. 16 A Yes, I do. 17 Q Okay. Did you personally prepare this 18 document? 19 A Yes. 20 Q And review it for accuracy and 21 completeness? 22 A Yes, I have. 23 Q Okay. Now, to my review, the only thing 24 that was changed or updated in this CV as compared 25 to the CV provided with your initial opinion is that</p>
Page 47	Page 49
<p>1 Q Okay. 2 A It was a 1915(c) waiver. 3 Q Okay. 4 A Which is a waiver from the federal 5 government that ultimately operated by the state. 6 Q And what year was that? 7 A That's testing my knowledge. I don't 8 remember what year that was. Let's call it around 9 2010. 10 Q So you started at Berkeley in 2010. So it 11 had to be before that, right? 12 A Yeah, I think it was just before that. 13 Q Other than 1915(c) waiver that you just 14 described at the New York Division of Budget, can 15 you recall any other time that you've actually 16 drafted any portion of a request for proposal for a 17 state government entity? 18 A No, I don't believe so. 19 Q All right. Have you ever been retained or 20 been employed to make the decision regarding which 21 vendor to award a contract to in response to a 22 submission made via a state government RFP? 23 A No, I have not. 24 Q Do you have any particular familiarity or 25 experience with the rules, processes, and procedures</p>	<p>1 you added two more cases as Number 32 and Number 33 2 to the Testimony section. 3 Is that your recollection and is that 4 accurate? 5 A I do believe that -- 6 Q Yeah, okay. 7 A -- was the only change between those two 8 CVs. 9 Q Okay. Those are the only ones I could 10 find. All right. 11 Otherwise, no changes were made to the CV 12 that was attached to your original expert report in 13 this case, right? 14 A I don't believe so. 15 Q Okay. So let's look at your CV now. I 16 have some questions about it. I'm going to look in 17 the initial summary paragraph, Mr. Russo, where it 18 says you're managing director with BRG, in the 19 health analytics practice, and you specialize in 20 providing strategic advice to healthcare 21 organizations through the use of complex data 22 analysis and financial modeling. 23 Correct? 24 A Yes, that's what it says. 25 Q All right. So, first, nothing involved in</p>

Page 78	Page 80
<p>1 it's a selection of the projects I've done and a 2 description of my overall experience. I don't 3 believe that those words that you mentioned are 4 included here. 5 Q Okay. Would you agree, Mr. Russo, that 6 based on the experience that you do have, that an 7 agency, a state agency, has wide latitude and 8 discretion to determine the evaluation and criteria 9 that will be contained in its own request for 10 proposals? 11 A I don't know what you mean by "wide 12 latitude." 13 Q Do you understand what "discretion" means? 14 A I do. But I don't understand what "wide 15 latitude" means in your context. 16 Q Okay. Well, would you agree an agency has 17 discretion to determine the evaluation criteria that 18 it will include in its own request for proposal? 19 A My understanding is that they -- the 20 agency has the ability to design the request for 21 proposal and outline the criteria. 22 Q Okay. 23 A I don't know that they have wide latitude. 24 I'm not sure what that means. 25 Q Do you agree and understand that an agency</p>	<p>1 case in this specific instance. 2 BY MR. WHITMAN: 3 Q So you just don't know whether Blue Cross 4 has the burden of proof in this case or not? 5 A I don't have an opinion on that. 6 Q Okay. Do you know or are you familiar 7 with the standard that the administrative law judge 8 must apply in this case to determine that question? 9 A No, I'm not familiar with that. 10 Q All right. Mr. Russo, what specifically 11 did you do to prepare for your deposition you've 12 been giving here today? 13 A I reviewed the data and documents upon 14 which I've relied. 15 Q Okay. 16 A I reviewed the reports that I've submitted 17 in this case. And I had meetings. 18 Q Okay. The meetings that you've 19 referenced, were those with counsel for Blue Cross 20 Blue Shield North Carolina? 21 A Yes, they were. 22 Q How many meetings did you have with 23 counsel for Blue Cross to prepare for your 24 deposition here today? 25 A I haven't counted how many. It was a</p>
Page 79	Page 81
<p>1 likewise has discretion to determine the methodology 2 that will be used to evaluate vendor proposals in 3 response to that RFP? 4 A They have the discretion to do so and to 5 describe that in the RFP so it's clear to the 6 vendors. 7 Q Okay. Now, are you aware that the issue 8 in this case, Mr. Russo, is whether the North 9 Carolina State Health Plan erred in awarding the 10 contract for third-party administrative services to 11 Aetna? 12 MS. JOSEPH: Objection to form. 13 BY MR. WHITMAN: 14 Q Is that your understanding? 15 A Yes, I have that understanding. 16 Q Okay. And do you understand that Blue 17 Cross Blue Shield of North Carolina has the burden 18 of proving that the North Carolina State Health Plan 19 erred in awarding the contract for TPA services to 20 Aetna? 21 A I -- 22 MS. JOSEPH: Objection to form. 23 A I am not an attorney, and I have a general 24 understanding that the plaintiff usually holds the 25 burden of proof, but I am not certain if that is the</p>	<p>1 handful or so. 2 Q Okay. And are you including conference 3 calls on that, when we say -- or video calls when 4 you say meeting? 5 A Yes, I do, sorry. 6 Q That's okay. No, I think we all do that. 7 A Yeah. 8 Q I just wanted to be clear. 9 A Yes. 10 Q Okay. 11 A I only had one in-person meeting. 12 Q And that was yesterday? 13 A Yes. Yes, that's correct. Everything 14 else was virtual. 15 Q How long did that meeting last? 16 A Sorry. I'm just -- 17 Q That's all right. 18 A Everything else was virtual. 19 Q Understood. 20 One in-person meeting, which was 21 yesterday? 22 A Yes, that's correct. 23 Q Who was present for that meeting? 24 A Shannon was present in the room, and Emily 25 was dialed in.</p>

Page 82

1 Q Any other attorneys that you can recall?  
2 A There were no other attorneys in the room.  
3 Q All right. How long did you meet in  
4 person?  
5 A About six or so hours substantively.  
6 Q Okay.  
7 A There was a lunch break in there.  
8 Q Sure. Okay.  
9 What documents did you review specifically  
10 to prepare for your deposition here today?  
11 A As I had mentioned, I reviewed my reports  
12 and the data and documents upon which I've relied.  
13 Q Okay. Anything other than those two  
14 categories of documents that you reviewed to prepare  
15 for your deposition today?  
16 A No.  
17 Q Did you review the deposition of Ms. Wills  
18 that was taken on November 17th?  
19 A No, I did not.  
20 Q Are there any particular documents that  
21 you reviewed that are not identified in either of  
22 your two reports as materials that you relied upon  
23 for the opinions that appear there?  
24 A No, I don't believe so.  
25 Q Okay. Now, did you speak to anyone at

Page 83

1 Blue Cross Blue Shield North Carolina to prepare for  
2 your deposition?  
3 A No, I did not.  
4 Q Did you --  
5 A Can I ask how we are doing on time?  
6 Q Sure.  
7 MS. JOSEPH: I was going to ask, are you  
8 coming to a chapter change so that we can take  
9 a break?  
10 MR. WHITMAN: We can break whenever, if he  
11 wants to take a break. Y'all just let me know.  
12 Would you like to take a break?  
13 MS. JOSEPH: Let's take a break.  
14 MR. WHITMAN: Okay.  
15 THE WITNESS: Let's go.  
16 THE VIDEOGRAPHER: The time is 10:54.  
17 We're off the record.  
18 (A recess was taken from 10:54 a.m. to  
19 11:06 a.m.)  
20 THE VIDEOGRAPHER: The time is 11:06.  
21 We're on the record.  
22 BY MR. WHITMAN:  
23 Q Mr. Russo, were you able to check with  
24 your accounting department over the break to  
25 determine how much you've billed Robinson Bradshaw

Page 84

1 for your services in this case?  
2 A I checked with my colleague who's on the  
3 line who had checked with our accounting department.  
4 Q Okay. And what was the answer?  
5 A We've billed roughly 1.2 million.  
6 Q And do you know what period of time -- is  
7 that up until today or some other period in time?  
8 A I don't know the answer to that.  
9 Q All right. Fair enough.  
10 (Discussion off the stenographic record.)  
11 BY MR. WHITMAN:  
12 Q Just to clarify, Mr. Russo, does that  
13 1.2 million just for your team, under your  
14 engagement letter, or does that include the times  
15 for Ms. Wills and her team?  
16 MS. JOSEPH: Objection to form.  
17 BY MR. WHITMAN:  
18 Q I'm just trying to determine whether  
19 that's the services that you and your team had  
20 provided only?  
21 A I do not believe that that includes the  
22 time for MK's team.  
23 Q Okay. Thanks.  
24 All right. Now, right before the break, I  
25 was asking had you spoken to anybody at Blue Cross

Page 85

1 Blue Shield in connection with preparing for your  
2 deposition, but let me broaden that.  
3 Did you speak to any principals at Blue  
4 Cross Blue Shield North Carolina for any aspect of  
5 the development of the opinions you are prepared to  
6 offer in this case?  
7 A I don't know what you mean by  
8 "principals."  
9 Q Did you interview anybody at Blue Cross?  
10 Did you speak to them on the phone, did you send  
11 them questions by email, that kind of thing?  
12 A There was one conversation that I had, but  
13 I'm not relying upon that conversation for the  
14 opinions that I'm offering.  
15 Q Okay. Who was that with?  
16 A I don't remember.  
17 Q All right. Okay. And have you had a  
18 substantive discussion with MK Wills since she was  
19 deposed on November 17th about this case?  
20 A No, I have not spoken to her at all since  
21 that point.  
22 Q Okay. Now, you did not attend any of the  
23 depositions in this case personally; is that right?  
24 A That is correct.  
25 Q Either by phone or in person; is that

Page 90

1 report?  
2 A Yes.  
3 Q Okay. And did you make any substantive  
4 changes to this report, Deposition Exhibit 417,  
5 based on comments you received back from legal  
6 counsel?  
7 MS. JOSEPH: Objection.  
8 Instruct not to answer.  
9 BY MR. WHITMAN:  
10 Q Are you going to take your counsel's  
11 advice?  
12 A Yes, I am.  
13 Q Okay. All right.  
14 Now, what were you asked to do in  
15 preparing the rebuttal report that you issued? And  
16 that's separate from Exhibit 417, correct?  
17 A Yes.  
18 Q Okay.  
19 A That is separate from, yeah, Exhibit 417.  
20 Q What were you asked to do in preparing  
21 that rebuttal report?  
22 MS. JOSEPH: Objection to form.  
23 A I was asked to review the reports of  
24 Mr. Vieira and Mr. Coccia. And let me make sure  
25 that I'm pronouncing that correctly. Okay.

Page 91

1 MR. COCCIA: Nailed it.  
2 THE WITNESS: I don't want to sit here and  
3 mispronounce your name all day.  
4 BY MR. WHITMAN:  
5 Q Well, you were asked to look at those then  
6 develop or indicate whether you had a rebuttal to  
7 the opinions offered by Mr. Vieira and Mr. Coccia,  
8 correct?  
9 A That's correct. I was asked to review  
10 them and to offer the opinions that I have with  
11 respect to their rebuttal of my opinions.  
12 Q And what role did your team play in  
13 helping you develop that rebuttal report?  
14 A They assisted in reviewing the reports and  
15 documents and data. They assisted in drafting some  
16 sections of the report.  
17 Q Did you draft some sections of the  
18 rebuttal report as well?  
19 A Yes, I did.  
20 Q Was it likewise the case that there was an  
21 organic version of your rebuttal report as opposed  
22 to standalone drafts?  
23 A I believe it was an organic version.  
24 Q Okay. And did you likewise submit a  
25 proposed or a version of your rebuttal report to

Page 92

1 counsel for Blue Cross before it was finalized and  
2 submitted?  
3 A Yes.  
4 Q And did you make any substantive changes  
5 to the rebuttal report based upon comments from  
6 counsel for Blue Cross?  
7 MS. JOSEPH: Objection.  
8 Instruct you not to answer.  
9 BY MR. WHITMAN:  
10 Q Are you going to follow her advice?  
11 A Yes, I am.  
12 Q Okay. Now, prior to reading the rebuttal  
13 report -- or prior to preparing the rebuttal report,  
14 were you familiar with Ken Vieira of The Segal  
15 Group? I know you've heard of The Segal Group, but  
16 did you know who Mr. Vieira was?  
17 A Could you re-ask your question?  
18 (Overlapping speakers.)  
19 Q Yeah. Yeah. I mean, when you got the  
20 reports that were issued by Mr. Coccia and  
21 Mr. Vieira, had you ever heard of Mr. Vieira before?  
22 A Yes. I had. His name was present in some  
23 of the documents I had reviewed.  
24 Q Okay. Did you do any research on  
25 Mr. Vieira?

Page 93

1 A I think I Googled his name and looked at a  
2 picture of him, and that was the extent of it.  
3 Q That was it? All right.  
4 Now, were you aware, Mr. Russo, The Segal  
5 Group had also been retained by the North Carolina  
6 State Health Plan to evaluate, score, and rank cost  
7 proposals in the 2019 RFP for the state for the  
8 third-party administrative services contract for the  
9 State Health Plan? Were you aware of that?  
10 THE WITNESS: Audra, would you mind doing  
11 that question back to me?  
12 THE STENOGRAPHER: Sure.  
13 THE WITNESS: Please.  
14 (Record read back.)  
15 A Yes, I was aware of that.  
16 BY MR. WHITMAN:  
17 Q Okay. And were you aware that Blue Cross  
18 Blue Shield North Carolina took no issue with the  
19 methodology, process, or procedures that The Segal  
20 Group had used to evaluate, score, and rank the cost  
21 proposals in the 2019 RFP?  
22 A I don't have any information on that.  
23 Q Did you or anybody on your team do any  
24 analysis to compare the process used by The Segal  
25 Group to evaluate and score the cost proposals

<p style="text-align: right;">Page 94</p> <p>1 during the 2019 RFP with the process used by The 2 Segal Group to evaluate and score cost proposals 3 during the 2022 RFP? 4 A That work was not done at my direction. I 5 don't have any knowledge of it. 6 Q Okay. Well, you could have done that 7 analysis and comparison, but you did not do so; is 8 that right? 9 A I didn't have access to the 2019 bids. 10 Q Well, you could have asked for it is my 11 point. 12 A I don't know if I -- if it would have been 13 given if I had asked for it. 14 Q Okay. You don't know if it would have 15 been given because you didn't ask for it, right? 16 A That's correct. I did not ask for it. 17 Q Okay. So you were aware or made aware 18 that The Segal Group had been retained by the State 19 Health Plan to perform the same role that it had for 20 the State Health Plan in 2022; but you did not 21 request any information relating to the processes, 22 procedures, or results of The Segal Group's work 23 from the 2019 RFP so that you could evaluate or 24 compare that to what they did in 2022. 25 Is that correct?</p>	<p style="text-align: right;">Page 96</p> <p>1 your expert report and your rebuttal report in this 2 case? 3 MS. JOSEPH: Objection. 4 BY MR. WHITMAN: 5 Q And have you been asked to offer any other 6 type of opinions other than what we have in the form 7 of those two documents? 8 MS. JOSEPH: Objection to form. 9 A I'm sorry. I think I need to hear the 10 question one more time. 11 BY MR. WHITMAN: 12 Q Sure. I'm just trying to determine, 13 Mr. Russo, have you been asked by or on behalf of 14 Blue Cross Blue Shield North Carolina to analyze, 15 evaluate, or offer any opinions other than those 16 that appear in your expert report, which is 17 Exhibit 417, or your rebuttal report? 18 A I have not been asked to offer additional 19 opinions that are not contained within my report. 20 Q Okay. 21 A I have additional criticisms that are -- 22 some referenced in my reports and others -- some not 23 referenced in the reports, but those are criticisms 24 and not additional opinions. 25 Q So is it my understanding, based on your</p>
<p style="text-align: right;">Page 95</p> <p>1 MS. JOSEPH: Objection. 2 A That's correct. I did not request the 3 data. 4 BY MR. WHITMAN: 5 Q All right. All right. Now, prior to 6 reading the report that Andy Coccia of Deloitte 7 prepared in this case, did you have any familiarity 8 with Mr. Coccia? 9 A No, I did not. 10 Q Did you do any research on him -- 11 A Yes, I Googled his name and looked at a 12 picture of him. 13 Q -- on the internet? Anything beyond that? 14 MS. JOSEPH: I'll object. Just my job, 15 so -- 16 A No. 17 BY MR. WHITMAN: 18 Q Okay. Did you have any criticisms of 19 Mr. Coccia's education, training, background, or 20 experience for the purposes of his offering opinions 21 in this case? 22 A I do not recollect what those were. 23 Q Okay. All right. And have you been asked 24 by Blue Cross or otherwise to consider any 25 additional information, other than what appears in</p>	<p style="text-align: right;">Page 97</p> <p>1 response, that you did not -- your rebuttal 2 report -- does it not contain all of the criticisms 3 that you had of the work performed by Mr. Vieira 4 and/or Mr. Coccia in their reports? 5 MS. JOSEPH: Objection to form. 6 A It contains my criticisms, but it doesn't 7 contain all of my criticisms. There are some 8 additional criticisms that I do have. 9 BY MR. WHITMAN: 10 Q Okay. Well, why didn't your rebuttal 11 report include all of your criticisms? 12 A It contained what I thought were the most 13 relevant criticisms at the time of drafting. 14 Q Is that still your opinion, or do you now 15 believe some of the additional criticisms that you 16 have that are not in your report are more relevant? 17 A I don't -- I haven't ranked their 18 relevancy, but I think in the course of our 19 conversation today, there may be additional 20 criticisms that come up based on the questions that 21 I'm asked. 22 Q Okay. Well, the only opinions that I know 23 about are the ones that you've included in both of 24 your reports. So if you intend to offer any 25 opinions or criticisms beyond what's in the four</p>

<p style="text-align: right;">Page 102</p> <p>1 Q All right. Now, you stated that Opinion 2 2 and all the Opinions 1 through 5 are your opinions, 3 correct? 4 A Yes, that's correct. 5 Q What portion of the expert report under 6 Opinion 2 in Exhibit 417 do you recall specifically 7 being the lead drafter on, if any? 8 A I don't recollect whether -- what sections 9 of the Opinion 2 I was the lead drafter on. 10 Q So you can't look at the pages under 11 Opinion 2, which range from pages 27 to 31, and 12 indicate to me where, if at all, you were the lead 13 drafter of any of those paragraphs or charts? 14 A No. I don't have a recollection of 15 whether I was the lead drafter of those paragraphs 16 or not. 17 Q Do you know or can you identify who on 18 your team did what with respect to the development 19 of Opinion 2, as it appears here? 20 A No. It was a collective effort, and there 21 were a number of individuals involved, as I 22 described earlier. I don't recollect whether all of 23 the team was involved in developing Opinion 2 or 24 whether it was just some portion of the team. 25 Q Okay. And I think that I understand the</p>	<p style="text-align: right;">Page 104</p> <p>1 A Yes, I have been involved in that. 2 Q In what capacity? 3 A As an external consultant. 4 Q For which companies? 5 A I have done so for Blue Cross Blue Shield 6 Association companies. 7 Q Have you ever done so for Blue Cross Blue 8 Shield North Carolina? 9 A I do not recollect having participated in 10 a negotiation process with a provider for Blue Cross 11 Blue Shield of North Carolina. 12 Q Have you ever negotiated for discounts and 13 how and when those discounts will be applied across 14 a provider's network? 15 A Across a provider's network? As in -- 16 Q Yeah. Have you -- well, have you ever -- 17 on behalf of an insurance company or a client, have 18 you been engaged to actually negotiate for a 19 discount, what discount, if any, will apply to 20 claims? 21 MS. JOSEPH: Objection to form. 22 A Yes. I have been involved in the 23 negotiation of the reimbursement rates for claims. 24 BY MR. WHITMAN: 25 Q Okay. On behalf of insurance companies?</p>
<p style="text-align: right;">Page 103</p> <p>1 answer to this based on our prior question and 2 answer, Mr. Russo, but it is true that this case is 3 the first time you've been retained by a client to 4 perform a claims repricing exercise for the purposes 5 of cost proposals that were submitted in response to 6 a state government RFP for a health plan; is that 7 right? 8 A It is correct that this is the first time 9 I have performed a repricing exercise or evaluated a 10 repricing exercise for the purposes of responding to 11 an RFP, but it's not the first time that I have 12 worked on repricing exercises, as I've indicated -- 13 Q Right. 14 A -- in our conversation today. 15 Q But it's also true that you've never 16 actually performed a repricing exercise for or on 17 behalf of a client that was then used for a 18 submission in response to an RFP; is that right? 19 A Yes, that's correct. I have not -- 20 Q Okay. 21 A -- done so with respect to submittal of an 22 RFP, but I have worked on many repricing exercises. 23 Q Do you have any experience with actually 24 negotiating contracts with providers on behalf of 25 insurance companies?</p>	<p style="text-align: right;">Page 105</p> <p>1 A Yes. I've done that on behalf of 2 insurance companies. I've also worked on that for 3 provider organizations. 4 Q Does that include work negotiating for 5 discounts? Have you done any work for entities 6 within the Blue Cross Blue Shield Association? 7 A I'm sorry, I don't think I understand your 8 question. 9 Q Yeah. So the type of work that we're 10 talking about, negotiating for discounts -- 11 right? -- that will apply to certain services for an 12 insurance company's clients? 13 A Yes. Well, what we're talking about is -- 14 Q Right. 15 A -- rates. 16 Q Yes. 17 A Yes. 18 Q Have you done that for Blue Cross Blue 19 Shield Association members? 20 A Yes. As I indicated before, I have done 21 that work on behalf of insurance companies, 22 including Blue Cross Blue Shield Association 23 companies, as well as having done work like that for 24 provider organizations. 25 Q Have you ever done work like that for</p>

Page 106

1 Aetna?  
2 A I don't believe that I have. I don't  
3 recollect having done so.  
4 Q Do you have any experience with actually  
5 paying claims for a health plan?  
6 A I think that that's a bit of a nebulous  
7 question. I have never physically written the check  
8 for an insurance company to pay a provider, but I  
9 have been involved in the adjudication process and  
10 the assessment of the adjudication process.  
11 Q What methodology, Mr. Russo, did you or  
12 your team use to assess the accuracy of Aetna's  
13 repricing exercise for the three providers  
14 referenced in their letters of agreement?  
15 A The process that is described in my report  
16 was to take the claims for the three providers for  
17 whom I was provided the letters of intent and to  
18 identify the inpatient and outpatient services, and  
19 then to identify the payment determined in the  
20 letters of intent and apply those payment terms.  
21 There was one additional group of  
22 inpatient services that was excluded from that  
23 calculation, and that is described in footnote 89 of  
24 my report on page 29, and those services are  
25 transplant services.

Page 107

1 Q Why were those excluded?  
2 A I believe that the letter of intent has  
3 identified that transplant services were paid  
4 according to a different and separate methodology.  
5 There were not many inpatient transplant services,  
6 as you can imagine, and so I felt that it was most  
7 accurate to exclude them.  
8 Q Did you or your team perform any analysis  
9 of the repricing exercise contained within Blue  
10 Cross Blue Shield North Carolina's cost proposal?  
11 A No, we did not. I didn't have the  
12 contracts to be able to do so.  
13 Q But that was your client; you could have  
14 asked them for copies of those contracts, correct?  
15 A Yes, I could have.  
16 Q Yeah. But you chose not to, right?  
17 A I didn't feel it was necessary to do so.  
18 Q And did you or your team perform any  
19 analysis of the repricing exercise that was  
20 contained within the cost proposal from United to  
21 the North Carolina State Health Plan?  
22 A No. I did not. I did not have the  
23 detailed repricing data that UMR submitted to the  
24 state. So I would have been unable to begin the  
25 exercise.

Page 108

1 Q Well, once again, that's information you  
2 could have requested from counsel for Blue Cross if  
3 you had wanted or needed to make that comparison,  
4 correct?  
5 A I could have asked for it. I don't know  
6 if I would have gotten it or not.  
7 Q We don't know because you didn't ask,  
8 right?  
9 A Yes, I did not ask.  
10 Q So the analysis that you performed on  
11 repricing was limited to the three providers and the  
12 letters of agreement between Aetna --  
13 (Stenographer requested clarification.)  
14 Q Yeah.  
15 So the repricing analysis that you did for  
16 Opinion 2 was limited to the subset analysis of the  
17 claims and discounts under the letters of agreement  
18 with the **REDACTED** that Aetna had,  
19 right?  
20 A It was with the **REDACTED** that  
21 Aetna had.  
22 Q And it wasn't any broader than that,  
23 correct, it didn't go beyond what discounts Aetna  
24 had in place via existing contracts with other  
25 providers?

Page 109

1 A Yes, that's correct. It was -- Opinion 2  
2 relates to the **REDACTED** that are defined  
3 on page 27 of my initial report.  
4 Q All right. So since you didn't analyze,  
5 review, or evaluate the cost proposals or repricing  
6 exercises from Blue Cross or United, you don't know,  
7 as you sit here today, whether there are or were any  
8 discrepancies in those cost proposals that could  
9 have resulted in higher bottom-line cost to the Plan  
10 than Blue Cross presented in its bid, correct?  
11 A I have not evaluated that.  
12 Q So for the purposes of what appears in  
13 Opinion 2, is it accurate to say that you assumed  
14 that what Blue Cross Blue Shield submitted in its  
15 cost proposal was accurate?  
16 MS. JOSEPH: Objection.  
17 A No. That's not what Opinion 2 is.  
18 Opinion 2 is an evaluation of the letters of intent  
19 that Aetna had with the three providers.  
20 BY MR. WHITMAN:  
21 Q Okay. But we'll get to it in Opinion 3.  
22 But you didn't do any analysis,  
23 evaluation, or assessment of whether any aspect of  
24 the cost proposal that was submitted by Blue Cross  
25 in this case, including the repricing exercise, was

Page 118	Page 120
<p>1 A -- to inpatient hospital for a behavioral 2 health issue. 3 Q Did your analysis include professional 4 fees? 5 A No, it did not include professional fees. 6 I included the fees with respect to the inpatient 7 and outpatient hospital services. 8 Q Did your analysis include laboratory 9 services? 10 A No, it did not include lab services. 11 Q Okay. So we don't know what impact, if 12 any, in your inclusion of professional services 13 and/or lab services would have made to the opinion 14 you offered in Opinion 2 because you didn't include 15 them, correct? 16 A That is correct, that I didn't include 17 them. And as I sit here now, I don't recollect what 18 the charges were that exist on professional and lab 19 claims that were excluded from the inpatient and 20 outpatient analysis. However, in my experience, 21 typically professional and lab claims are far 22 smaller amounts than what is included on inpatient 23 and outpatient hospital bills. 24 Q Well, whether typical or not, those were 25 not included, what I'm trying to establish -- I</p>	<p>1 understanding you had, that was with your own team, 2 right? 3 A Yes, that's correct. 4 Q All right. Let me ask you to look at 5 Exhibit 5, which is the RFP in this case for the 6 third-party administrative services. It's a big, 7 thick document, but I need to give you the whole 8 thing, but I'm just going to ask you to direct your 9 attention to page -- let's see -- 83 of 119. Under 10 the section 1.2.1, Claims Repricing File. 11 Let me know when you've found that. 12 (Previously marked Exhibit Number 5 was 13 identified.) 14 MS. JOSEPH: I'm sorry, I missed the page. 15 MR. WHITMAN: It's 83 of 119, State Health 16 Plan 72670. And we're looking at 17 section 1.2.1, Claims Repricing File. 18 A I'm there. 19 BY MR. WHITMAN: 20 Q Are you there? 21 A Yes. 22 Q Okay. Now, the third paragraph on page 83 23 here states -- and this is in the RFP, correct? 24 A Yes. 25 Q That the vendors received, right?</p>
Page 119	Page 121
<p>1 think you've agreed -- in the analysis you performed 2 and opined under Opinion 2 did not include an actual 3 assessment or evaluation of what impact, including 4 professional or lab services, would have made on 5 your analysis? 6 A I did not include them, and I recollect 7 there being a discussion at some point about the 8 charges that exist on the claims for these three 9 providers and what portion of those charges were 10 represented on the inpatient/outpatient side. 11 And I recollect there being a consistency 12 with my understanding of the marketplace, in my 13 experience in the marketplace, which is the majority 14 of the expense, when you're looking at services that 15 are the full breadth of services, the majority of 16 the expense sits with inpatient and outpatient 17 hospital services. 18 Q What discussion are you referring to when 19 you say that? 20 A I'm referencing the discussion that I had 21 with my team as I was directing them to do the 22 analysis, and we were looking at the letters of 23 intent, and I was identifying the payment terms. 24 Q So the discussion you're referring to 25 whereby you say it was consistent with the</p>	<p>1 A Yes. 2 Q Okay. Quote: "Using the repricing file 3 referenced above, vendors are to provide the 4 contracted allowed amount for each service in the 5 file. Vendors are expected to reprice each claim 6 line based on provider contracts in place, or 7 near-future contract improvements bound by letters 8 of intent, at the time of repricing." 9 Correct? 10 A Yes, that is what it says. 11 Q Okay. Now, did you rely on that 12 instruction in performing your analysis of Aetna's 13 repricing exercise? 14 A Yes, I did, with respect to the three 15 providers that -- for which I analyzed the inpatient 16 and outpatient services. Right. 17 Q That's the subset analysis you performed 18 as we discussed, correct? You only analyzed the 19 claims under those three letters of agreement? 20 A Yes. I analyzed the inpatient and 21 outpatient claims -- 22 Q Right. 23 A -- under those three letters of intent. 24 Q Did you rely on any other instructions in 25 this RFP to determine the methodology you would be</p>

Page 122

1 used to reprice a subset of Aetna's claims with  
2 **REDACTED**  
3 A No, I don't believe that I did.  
4 Q Okay. Now, this instruction that we just  
5 looked at under 1.2.1 Claims Repricing File in the  
6 RFP does not state that vendors are permitted to use  
7 any assumed increases in billed charges in its  
8 repricing exercise, does it?  
9 A It neither includes nor excludes language  
10 about billed charges, right.  
11 Q It doesn't make any reference at all to  
12 using assumed increases in billed charges, does it?  
13 A It does not explicitly identify billed  
14 charges. But it does say that they are -- vendors  
15 are expected to reprice each claim based on provider  
16 contracts in place or near-future contract  
17 improvements bound by letters of intent at the time  
18 of repricing. Given that the repricing file  
19 contained, in 2021, claims and the request here is  
20 for the repricing based on contracts that were in  
21 place in 2022 or near-future contract improvements,  
22 there would have to be a trend to the billed  
23 charges.  
24 Q So is that an assumption you made in your  
25 review of this instruction in 1.2.1 of the RFP that

Page 123

1 that's what the State Health Plan wanted?  
2 A It's based on my industry experience in  
3 conducting repricing exercises where one is  
4 calculating the discount. It is what needs to be  
5 done.  
6 Q Well, that's what needs to be done, in  
7 your opinion, if you're trying to determine the  
8 overall total value of the claims -- right? -- of  
9 the discount?  
10 A If you're trying to calculate a discount,  
11 you need to consider what is included within the  
12 discount calculation, and that calculation is based  
13 both on the allowed amounts, which is sort of the  
14 top of the equation, so essentially what the health  
15 insurance company would pay, as well as the  
16 denominator, the bottom of the equation, which would  
17 be the charges.  
18 Q But that's not necessarily how you would  
19 go about it if you wanted to make an  
20 apples-to-apples comparison in the claims repricing  
21 exercise, is it?  
22 MS. JOSEPH: Objection to form.  
23 A Yes. It is what you would do.  
24 BY MR. WHITMAN:  
25 Q All right. So is it your opinion or

Page 124

1 understanding that all providers that were  
2 responding to this RFP and performing a repricing  
3 exercise size would have used the same assumed  
4 increases in billed charges for the purposes of the  
5 exercise?  
6 A My understanding of this paragraph, which  
7 is consistent with the manner in which I've  
8 conducted repricing exercises is that one would need  
9 to adjust the charges to reflect that the exercise  
10 is being done in 2022 and one would need to apply  
11 the current contracts that are in place, as well as  
12 those that are in the near future, which is what the  
13 instructions say.  
14 Q Yes. But that would not monitor or  
15 determine what rate of assumed increases and billed  
16 charges a particular vendor was using, would it?  
17 A I'm sorry. Could you say that again?  
18 Q Yeah. That that would not identify to the  
19 State Health Plan or The Segal Group what assumed  
20 increase in billed charges a particular vendor was  
21 using for the purposes of that repricing exercise,  
22 would it?  
23 A Conducting that exercise would -- and what  
24 has been requested here in the RFP would not  
25 identify what trend was being applied. It's

Page 125

1 something that could have been instructed by Segal  
2 and the Plan to the vendors.  
3 Q You know, but it wasn't asked for, was it?  
4 It wasn't referenced at all, as you said. There's  
5 no reference in this instruction to assumed  
6 increases in billed charges, right?  
7 MS. JOSEPH: Objection to form.  
8 A That's correct. Segal and the Plan did  
9 not indicate to the vendors the manner in which  
10 they -- the vendors could trend the billed charges.  
11 They could have provided that clarification and  
12 instruction to ensure that all vendors did so in a  
13 similar fashion.  
14 BY MR. WHITMAN:  
15 Q Okay. Instead they used the clarification  
16 process to do that, right?  
17 A To do what?  
18 Q To be sure that they were getting an  
19 apples-to-apples comparison for the comparison and  
20 evaluation of the claims repricing exercises  
21 submitted by the vendors.  
22 A They attempted to use the clarification  
23 process to do so. I'm not sure that was done  
24 effectively and that the answers are -- fully  
25 elucidate what was done by the vendors.

Page 126	Page 128
<p>1 Q That's your opinion that you're offering 2 in this case, right? 3 A Yes, that is an opinion that I'm offering. 4 Q Now, would you agree, based on all this 5 experience you've described for me doing repricing 6 in other cases -- you would agree, Mr. Russo, that 7 there are multiple repricing methodologies that can 8 be used -- right? -- and while different, they're 9 still deemed to be reasonable, acceptable in the 10 industry? 11 A No, I don't think that there are multiple 12 methodologies to doing the repricing when you have 13 instructions of this sort. 14 Q Okay. Well, what I'm trying to establish, 15 Mr. Russo, there's not simply one universal 16 repricing methodology that is used or deemed to be 17 correct and uniformly used by all insurance 18 companies in responding to RFPs, is there? 19 A I think that the general methodology is 20 similar, but I do think there are nuances to it that 21 may differ. 22 Q Okay. Well, in your initial report, which 23 is Exhibit 417, you cited to a white paper published 24 by Milliman at two different places in this 25 report -- correct? -- footnotes 110 and 132?</p>	<p>1 report was published in 2012; is that correct? 2 A Yes, I believe it was published November 3 of 2012. 4 Q Do you know if there's any more recent 5 versions of that white paper available? 6 A I don't know the answer to that. 7 Q Do you believe or agree this white paper 8 from Milliman is an authoritative source? 9 A I believe that it is an authoritative 10 source. 11 MR. WHITMAN: Okay. Let me -- let's mark 12 that white paper as Exhibit 418, Mr. Russo. 13 (Exhibit Number 418 marked for 14 identification as of this date.) 15 THE WITNESS: Can I put away the RFP for a 16 moment? 17 MR. WHITMAN: Yes, certainly. 18 THE WITNESS: Okay. 19 BY MR. WHITMAN: 20 Q Just ask you, can you identify Exhibit 418 21 as the Milliman White Paper that's cited to as an 22 authoritative source twice in your expert report? 23 A Yes, it appears to be that white paper. 24 Q Now, according to this white paper, there 25 is no single acceptable repricing methodologies, is</p>
<p>Page 127</p> <p>1 A I don't recollect how many times I cited 2 to that. 3 Q Okay. Well, could you just pull up 4 Exhibit 417? Let me know when you have that. 5 A I have it. What page are you on? 6 Q Okay. Would you check footnote 110, 7 please. 8 A Yes, 110 cites the Milliman White Paper. 9 Q And footnote 132. 10 A Also cites the Milliman White Paper. I 11 don't recollect if there was another cite to it in 12 the other footnotes. 13 Q Okay. What or who is Milliman? You 14 described it earlier in your testimony. 15 A Milliman is the actuarial firm. 16 Q Okay. Are you familiar with this author, 17 Liz Myers, who authored this white paper who you 18 cited in your report? 19 A I have heard her name before, but I 20 wouldn't say that I'm familiar with her. I've never 21 met her nor spoken to her. 22 Q But you're familiar with her company, 23 Milliman? 24 A Yes, I am. 25 Q And the white paper you cited in your</p>	<p>Page 129</p> <p>1 there? 2 A This identifies that there are multiple 3 repricing methodologies that one could conduct. 4 Q Right. So if you turn to page 2 of the 5 Milliman White Paper, Figure 3 identifies five 6 different repricing methodologies which can and are 7 used in the industry, correct? 8 A Yes, that's correct. But you've -- going 9 to have to remember that my answer before with 10 respect to a repricing methodology is that in the 11 context of the data that was being requested, the 12 instructions that were being required in the RFP, 13 there was a methodology. 14 Q And that's your opinion that you're 15 offering in this case, right? 16 A Yes, that is correct. 17 Q Okay. Now, looking at the five different 18 repricing methodologies identified by Milliman, are 19 you able to identify which, if any of those, were 20 used for the purposes of your Opinion 2 analysis? 21 A The work that I did was at the provider 22 and detailed service level. 23 Q Okay. That's A of the A, B, C, D, and E? 24 A Yes, that's correct. 25 Q And then Milliman identifies at least four</p>

Page 138

1 And there was a disconnect because the  
2 three providers that I analyzed had a letter of  
3 intent indication of the repricing exercise, but  
4 were listed as being in network. And that was  
5 something that does not fit with what the industry  
6 standard is. And so I had questions as to how a  
7 provider could be in network and have a letter of  
8 intent. And because of that, I asked the questions  
9 that I did.  
10 Blue Cross does not have any providers in  
11 its repricing exercise that were listed as letters  
12 of intent, and so I didn't have the same questions  
13 of Blue Cross that I had of Aetna.  
14 BY MR. WHITMAN:  
15 Q Well, I understand your testimony with  
16 regard to letters of intent, but my question is  
17 broader than that.  
18 You didn't evaluate any aspect of the cost  
19 proposal or repricing exercise that Blue Cross  
20 performed to determine, to your satisfaction,  
21 whether there were errors, mistakes, overstatements.  
22 None of that was assessed, was it?  
23 A I did not go through and do the detailed  
24 analysis of checking the contracts against what --  
25 Q Right.

Page 139

1 A -- Blue Cross had done.  
2 But I do have an understanding of what  
3 Blue Cross did in its repricing exercise.  
4 Q Well, but you made the assumption, did you  
5 not, Mr. Russo, for the purposes of these charts  
6 like Figure 5, that everything Blue Cross submitted  
7 was exactly right?  
8 A For the purposes of Figure 5, Figure 5  
9 relates to my Opinion 2, and my Opinion 2 relates to  
10 the discrepancies that exist in Aetna's repricing  
11 exercise. And so there is no adjustment to Blue  
12 Cross because the opinion doesn't relate to what  
13 Blue Cross did in its repricing exercise, the  
14 Opinion relates to what Aetna did.  
15 Q But you take what you do in these Opinions  
16 and you project that to say, Well, Blue Cross should  
17 have received 6 points and Aetna should have  
18 received 3 or 0 later in your Opinions, correct?  
19 A I don't recollect where you're saying  
20 later I said either 3 or 0.  
21 Q What I'm trying to establish, Mr. Russo,  
22 is that you specifically analyzed a subset of claims  
23 for Aetna with regard to the three letters of  
24 agreement, correct?  
25 A I analyzed the inpatient and outpatient --

Page 140

1 Q Okay.  
2 A -- claims for three letters of intent  
3 which Aetna has with **REDACTED**.  
4 Q Right. You didn't evaluate, assess, do  
5 calculations, or look for any errors in any other  
6 aspect of the cost proposal that Aetna submitted,  
7 did you?  
8 A I did not request additional contracts to  
9 go through the process of checking the additional  
10 information that Aetna had submitted. But there are  
11 questions that I still have with respect to the  
12 remainder of Aetna's information.  
13 Q Well, you may have questions, but you  
14 didn't request the data you would need to answer the  
15 questions that you had, right?  
16 A Yes, that's correct. I'm not sure that  
17 there would have been documents that -- or data that  
18 would have provided me with those answers.  
19 Q So for example, in Figure 5 here on  
20 page 16 of your rebuttal report, you take an error  
21 rate that you calculated based on your analysis of  
22 the three letters of agreement from Aetna, and then  
23 you basically project it. And you don't know  
24 whether that error rate or any different error rate,  
25 0 or otherwise, would extend to Aetna's other

Page 141

1 providers, do you?  
2 A I have as much basis to assume that that  
3 error rate would apply as Mr. Vieira assumes that no  
4 error rate would apply.  
5 Q Okay. Well, my question didn't have  
6 anything to do with Mr. Vieira. My question is:  
7 You're assuming -- you don't have any information at  
8 all that would confirm or deny whether the error  
9 rate reflected in Figure 5 in your rebuttal report  
10 would or would not apply or extend to Aetna's other  
11 providers, right?  
12 A That's right. It could apply or it could  
13 not apply. And so there could be the same error  
14 rate that exists for the remainder of Aetna's  
15 providers.  
16 Q And there could not, right? You don't  
17 know because you didn't check?  
18 A I did not have the data to check.  
19 Q So looking at Figure 5, the notion that  
20 the error rate you calculated for a portion of  
21 Aetna's claims would extend to Aetna's entire  
22 repricing exercise, that's an assumption, correct?  
23 A Yes. Both Mr. Vieira and I made  
24 assumptions. Mr. Vieira made an assumption that  
25 there would be no errors in the remainder of Aetna's

Page 142

1 repricing exercise, and what I have illustrated here  
2 is that there would be an adjustment to the claims  
3 cost if one did assume that that error rate applied.  
4 Q And there was no analysis done by you or  
5 anyone on your team to determine whether, to what  
6 extent, Blue Cross' repricing exercise was or was  
7 not accurate?  
8 A Both I and my team did not review Blue  
9 Cross' contracts to ensure the accuracy, but I do  
10 have an understanding of the manner in which Blue  
11 Cross went through their repricing exercise.  
12 Q And you also did not analyze whether UMR's  
13 repricing exercise was accurate, correct?  
14 A I did not do so because I did not have  
15 UMR's repricing exercise.  
16 Q You didn't ask for it, correct?  
17 A I did not ask for it. It was not within  
18 my scope of work.  
19 Q And you did not ask for copies of Blue  
20 Cross' contracts that were utilized for the purposes  
21 of its repricing analysis, right?  
22 A That is correct. I did not request  
23 contracts for Blue Cross because I did not have the  
24 same questions about Blue Cross' repricing exercise  
25 that I had of Aetna's repricing exercise.

Page 143

1 Q Let's turn now to Opinion 3 in your  
2 primary expert report.  
3 MS. JOSEPH: As you're reaching for that,  
4 may I ask what the custom is in all the  
5 depositions you've been doing for breaking for  
6 lunch? Do y'all have a time that you do that?  
7 MR. WHITMAN: We don't have a set time,  
8 but we usually break. We shoot for 30 minutes,  
9 and if it takes longer, it takes longer, we  
10 just come back.  
11 MS. JOSEPH: Oh. I just meant what time  
12 are we going to have lunch?  
13 MR. WHITMAN: Now is fine. Now's a good  
14 time because we are about to get to Opinion 3.  
15 THE VIDEOGRAPHER: The time is 12:18 p.m.  
16 We're off the record.  
17 (A recess was taken from 12:18 p.m. to  
18 1:02 p.m.)  
19 THE VIDEOGRAPHER: The time is 1:02.  
20 We're on the record.  
21 BY MR. WHITMAN:  
22 Q Mr. Russo, I'd like to move now, my  
23 questions, to Opinion 3 in your initial report,  
24 which is Exhibit 417. And your Opinion 3 starts at  
25 page 32. Are you there?

Page 144

1 A Yes, I am.  
2 Q In Opinion 3, you opine that the State  
3 Health Plan and Segal Group improperly decreased  
4 Blue Cross Blue Shield North Carolina's repricing  
5 discount through the clarification process, which  
6 resulted in Aetna and Blue Cross each receiving  
7 6 points for the repricing exercise, where you opine  
8 Aetna should have only received 3.  
9 Is that a fair summary of this opinion?  
10 A Yes.  
11 Q Okay. Now, let's look at -- well, before  
12 we do that, you further contend in this opinion that  
13 the State Health Plan should have sought further  
14 clarifications from Aetna after the November 18,  
15 2022, request for clarifications that were sent to  
16 all vendors, as it did from Blue Cross.  
17 Is that also part of this opinion?  
18 A Yes, it is.  
19 Q Okay. So now let's turn to Figure 14 on  
20 page 37 of your initial report. Mr. Russo, in this  
21 opinion you basically reproduced the tables that  
22 Blue Cross and Aetna were asked to complete in the  
23 November 18, 2022, Request for Clarification; is  
24 that right?  
25 A Yes, these are copies --

Page 145

1 Q Yeah.  
2 A -- of those two tables for the  
3 clarifications.  
4 Q Okay. And UMR was asked to complete that  
5 same table as well by the State Health Plan,  
6 correct?  
7 A Yes, they were.  
8 Q Okay. Now, in these tables, the repricing  
9 discount should be represented in the Known Contract  
10 Improvements line; is that right?  
11 A I'm sorry, could you say that again?  
12 Q Sure. In these tables, the repricing  
13 discount that the State Health Plan was after should  
14 be represented in the Known Contract Improvements  
15 line. Do you agree?  
16 A Yes. I believe -- believe that is what  
17 the State Health Plan and Segal were looking for.  
18 They were looking for the claims to be repriced as  
19 of 2022, reflecting known contract improvements and  
20 letters of intent that were going to be in place in  
21 the near future.  
22 Q Okay. Thank you.  
23 And that's that instruction 1.2.1 that you  
24 and I looked at in the RFP -- correct? -- of the  
25 repricing?

Page 146

1 A The instructions are in the RFP, and, yes,  
2 that's what I'm referencing. I don't remember what  
3 the section number is of the RFP.  
4 Q Okay. Okay. You recall you and I looked  
5 at the RFP and we looked at section 1.2.1 regarding  
6 repricing, which stated exactly what you just said,  
7 right?  
8 A I recollect we looked at the RFP and we  
9 looked at the instructions for repricing. I don't  
10 remember what this --  
11 Q Okay.  
12 A And I've just looked it up and it is  
13 1.2.1.  
14 Q Okay.  
15 A Yep, I agree.  
16 Q Now, and the known Contracts Improvement  
17 line that we're talking about here, Mr. Russo, is  
18 not -- is supposed to exclude, under the  
19 interpretation of the State Health Plan and Segal  
20 Group -- is supposed to exclude assumed increases in  
21 billed charges, right?  
22 A According to what was written on the  
23 clarification matrix, it says should not include  
24 assumed increases in billed charges.  
25 Q Okay. All right. And then the lines that

Page 147

1 follow after Known Contract Improvements -- stuff  
2 like Assumed Increases in Billed Charges and  
3 Expected 2025 Discounts -- those were captured in  
4 other areas of the vendor proposal, such as in  
5 Attachment A-6, correct?  
6 MS. JOSEPH: Objection to form.  
7 A Yes. A-6 would have had the discounts  
8 that were expected in 2025.  
9 BY MR. WHITMAN:  
10 Q Okay. Now -- sorry, I didn't want to cut  
11 you off.  
12 A That's okay.  
13 Not in the same manner, though. A-6 does  
14 not have the discounts in the same manner as what is  
15 here. I believe that was required -- A-6 required  
16 the discounts to be projected by county, I believe,  
17 and by line of business, if I'm recollecting.  
18 Q I agree with you. And that's why I said  
19 it's captured by other aspects of the RFP and what  
20 they subsequently asked the vendors to provide in  
21 these tables during the clarification process.  
22 A Yes. There was other information that was  
23 provided in the RFP that related to some of the  
24 information here.  
25 MR. WHITMAN: Okay. Let's look at some of

Page 148

1 the clarifications. I'll show you what was  
2 already previously marked as Exhibit 32,  
3 Mr. Russo. And this is, I'll represent to you,  
4 Blue Cross' Response to Clarification Number 4.  
5 (Previously marked Exhibit Number 32 was  
6 identified.)  
7 BY MR. WHITMAN:  
8 Q See that document?  
9 A Yes, I do.  
10 Q Okay. Now, is it consistent with your  
11 understanding, Mr. Russo, that all three vendors got  
12 this exact same clarification request from the State  
13 Health Plan and Segal Group dated November 18, 2022?  
14 A I have not checked word for word the  
15 clarifications that were sent. I understand that  
16 each of the vendors were sent the same matrix, but I  
17 don't recollect whether all of the verbiage for the  
18 other questions was the exact same or not.  
19 Q Okay. But if I represent to you it was  
20 the same, do you have any reason, as we sit here  
21 today, to question that?  
22 A I do not.  
23 Q Okay. So let's look at Request for  
24 Clarification -- now, the clarification numbers were  
25 different, I'll represent that to you, Mr. Russo,

Page 149

1 just depending on other clarifications that the  
2 State Health Plan had sent to the vendors. But my  
3 point is, on November 18, 2022, all three vendors  
4 received the exact Request for Clarification that  
5 appears in substance in Exhibit 32.  
6 Do you have any reason to question that?  
7 A I do not have a reason to question that,  
8 if you're representing that that's --  
9 Q All right. I am representing that -- for  
10 the purposes of my question, I believe it to be  
11 true.  
12 Now, under question 1 in Clarification  
13 Number 4 to Blue Cross, the State Health Plan  
14 states: "In your response to Request for  
15 Clarification Number 3, you stated: 'The repricing  
16 analysis was done with historical discount data  
17 projected forward, capturing the signed 2023  
18 contractual reimbursement rate changes. Projected  
19 discounts were then calculated using  
20 industry-approved methodologies, based on the  
21 submitted, known contracting changes and the Uniform  
22 Data Standards' prescribed billed charges trends.  
23 No adjustments were made for letters of intent."  
24 Do you see that?  
25 A I do, and that makes me question what you

<p style="text-align: right;">Page 150</p> <p>1 represented a moment ago, because you said that they 2 were all the same, that each of the -- 3 Q Right. I should have been more specific. 4 I mean, the request for information to populate the 5 chart. 6 A To populate the matrix. 7 Q That's right. The matrix was the same, 8 provided to all three. 9 A Okay. 10 Q That's a fair question you asked me back, 11 and that's what I meant: the matrix. 12 A Okay. 13 Q Okay. And then Segal Group or the State 14 Health Plan makes the statement: "This is not 15 consistent with the cost proposal instructions." 16 Do you see that? 17 A I do see that, yes. 18 Q Okay. And was it your understanding from 19 your review of these documents, these clarification 20 responses, Mr. Russo, that Blue Cross had already 21 acknowledged that it did use billed charge trends in 22 its repricing in Clarification Number 3? 23 A Yes. As is indicated here, Blue Cross 24 identified in Clarification Number 3, which I don't 25 have in front of me, but is referenced here, that</p>	<p style="text-align: right;">Page 152</p> <p>1 conducted the repricing analysis in the way that 2 it's described in Clarification Number 3 and is 3 consistent with the instructions in the RFP. 4 Q Okay. Let's go back even further and look 5 at Clarification Number 2, Blue Cross, which is 6 previously marked in this case as Exhibit 30. 7 (Previously marked Exhibit Number 30 was 8 identified.) 9 BY MR. WHITMAN: 10 Q I'll give that to you, Mr. Russo. 11 Do you recognize that as Blue Cross' 12 response to Request for Clarification Number 2? 13 A Yes. 14 Q And in Request for Clarification Number 2, 15 does it indicate that the State Health Plan is 16 asking Blue Cross to clarify whether its repricing 17 reflected future discounts beyond those bound by 18 letters of intent? 19 A The first question in Clarification 20 Number 2 says: "...please indicate whether your 21 response is based only on provider contracts in 22 place or near-future contract improvements bound by 23 letters of intent at the time of repricing." 24 Q Right. 25 A "Or, your response reflects projected</p>
<p style="text-align: right;">Page 151</p> <p>1 the repricing analyses were done with historical 2 discount data projected forward, capturing the 3 signed 2023 contractual reimbursement rate changes. 4 Projected discounts were then calculated using 5 industry-approved methodologies, based on the 6 submitted, known contracting changes and the UDS 7 prescribed billed charges trends. 8 Q Okay. Let me show you what's been 9 previously marked in this case as Exhibit 31 and 10 represent to you it's Blue Cross' response to 11 Request for Clarification Number 3. 12 (Previously marked Exhibit Number 31 was 13 identified.) 14 BY MR. WHITMAN: 15 Q Just so the record is clear, do you see 16 what you just read into the record, is, in fact, the 17 response that Blue Cross provided in response to 18 Request for Clarification Number 3? 19 A Yes, I do see that. 20 Q And would you agree, based on your 21 experience in reviewing that response, Mr. Russo, 22 that Blue Cross is admitting or stating that it used 23 assumed increases and billed charges for its 24 repricing exercise? 25 A Yes. Blue Cross is recognizing that it</p>	<p style="text-align: right;">Page 153</p> <p>1 future discounts beyond those bound by letters of 2 intent. If this is the case, provide the discount 3 value for these -- of these future discounts." 4 Q Okay. So if we look at the response to 5 Request for Clarification Number 3 from Blue Cross, 6 which was Exhibit 31 -- you just looked at it -- it 7 confirmed that Blue Cross' repricing exercise did 8 reflect future discounts beyond those bound by 9 letters of intent, correct? 10 A No. Projected future discounts are not 11 bound by letters of intent. It says no adjustments 12 were made for letters of intent. 13 Q Right. But Blue Cross confirmed in 14 response that projected discounts were calculated 15 using industry-approved methodologies, based on 16 submitted, known contracting changes and the UDS 17 billed charge trends, correct? 18 A That is what it says. 19 Q Right. But what -- the response to 20 Clarification Number 3 does not provide the discount 21 value of those future discounts, does it? 22 A No, it does not provide the discount 23 value. 24 Q Okay. Can you see, in Request for 25 Clarification Number 2, Segal Group and the State</p>

<p style="text-align: right;">Page 154</p> <p>1 Health Plan were asking if this is the case, provide 2 the discount value of these future discounts? 3 Do you see that question, in Question 4 Number 1 of Clarification Number 2 in Exhibit 30? 5 A Yes. If there are projected future 6 discounts, which are not those that are near-future 7 contract improvements. 8 Q Right. And it asks if that's the case, 9 provide the discount value of those future 10 discounts, right? 11 A Yes. If there are future discounts which 12 are not those that are near-future contract 13 improvements. 14 Q Right. And in its answer to Question 1 in 15 Request for Clarification Number 2, Blue Cross Blue 16 Shield of North Carolina does not provide any 17 discount value for future discounts that were 18 utilized for the purposes of its repricing exercise, 19 does it? 20 A Blue Cross wasn't relying on the future 21 discounts. They were relying on the near-future 22 contract improvements that were in place, and so 23 this clarification requests that if the response 24 reflects projected future discounts -- which Blue 25 Cross does not -- then provide the discount value.</p>	<p style="text-align: right;">Page 156</p> <p>1 Q Sure. Yep. 2 A Okay. 3 Q So my question is: Would you'd agree that 4 Blue Cross' response to Clarification Number 4, as 5 indicated here in Exhibit 32, does not indicate to 6 The Segal Group or State Health Plan how much of the 7 2.8 percent difference between the 2021 claims data 8 using 2021 contracts and known contracts and 9 improvements is attributable to assumed increases in 10 billed charges. 11 A The response here does not differentiate 12 between those two. Differentiating between those 13 two is an exercise that is not pertinent for the 14 reasons of calculating a discount, because when one 15 calculates a discount, you need to be both concerned 16 with what is happening with the denominator of the 17 equation, the bottom of the equation, which is the 18 charges, and the top of the equation, which is the 19 payments. 20 Q Well, my question is, Mr. Russo, if the 21 State Health Plan or Segal Group wanted to know how 22 much of the 2.8 percent difference between the two 23 rates provided by Blue Cross in its response were, 24 you would have to ask for additional clarification 25 from Blue Cross -- wouldn't it?</p>
<p style="text-align: right;">Page 155</p> <p>1 Q Well, I'm trying to get my arms around 2 this. Let's go back to Exhibit 32, which is Blue 3 Cross' Clarification Number 4, Mr. Russo. You 4 should have that, it's Exhibit 32. 5 A Yes. 6 Q And since the billed charge trends were 7 not supposed to be included in the Known Contracts 8 Improvement line in this clarification, as we've 9 discussed, would you agree that Blue Cross' response 10 to Clarification Number 4 does not indicate how much 11 of the 2.8 percent difference between the 2021 12 Claims Data Using 2021 Contracts and Known Contract 13 Improvements lines is attributable to assumed 14 increases in billed charges? 15 A I'm going to need that question one more 16 time, please. 17 Q Okay. No problem. 18 Since the billed charge trends were not 19 supposed to be included in the Known Contracts 20 Improvement line in this clarification -- remember 21 we discussed that earlier? 22 A Yes, I do recollect -- 23 Q Okay. All right. 24 A -- discussing that. So if you'll give 25 me just one moment to review something.</p>	<p style="text-align: right;">Page 157</p> <p>1 A Yes, it would, and I do believe that it 2 did. 3 Q All right. And that's what the State 4 Health Plan did, it issued a Request for 5 Clarification Number 5 after this, didn't it? 6 A Yes, it did. 7 MR. WHITMAN: Let's look at that Request 8 for Clarification, which was previously marked 9 in this case as Exhibit 33. 10 (Previously marked Exhibit Number 33 was 11 identified.) 12 BY MR. WHITMAN: 13 Q Do you recognize Exhibit 33 as the Blue 14 Cross North Carolina response to Clarification 15 Number 5? 16 A Yes, I do. 17 Q In this clarification, the State Health 18 Plan is asking Blue Cross Blue Shield of North 19 Carolina to confirm that the 54 percent known 20 contracts improvement does not include any assumed 21 increases in billed charges, correct? 22 A Yes, that is correct, they are requesting 23 that. 24 Q And instead Blue Cross Blue Shield of 25 North Carolina confirmed that the 54 percent did</p>

Page 158

1 include assumed increases in billed charges,  
2 correct?  
3 MS. JOSEPH: Objection to form.  
4 A Yes, as indicated in the second paragraph,  
5 "As Blue Cross North Carolina confirmed in  
6 Clarification Number 3, 2023 repriced discounts were  
7 calculated using industry-approved methodology,  
8 based on the 2023 contracting changes, and including  
9 industry-standard UDS prescribed billed charge  
10 trends."  
11 BY MR. WHITMAN:  
12 Q But --  
13 A Sorry, let me just finish that paragraph.  
14 Q Yeah, absolutely.  
15 A "These charge trends would be consistent  
16 with accepted industry standards in completing a  
17 repricing exercise."  
18 Q Okay. Thank you.  
19 But in providing this response, Blue Cross  
20 Blue Shield North Carolina does not give a precise  
21 percentage of the 54 percent that is attributable to  
22 the assumed increases in billed charges, does it?  
23 A No, it does not. It is noteworthy that  
24 this was sent on November 22, asking for a response  
25 on November 23.

Page 159

1 The repricing exercise is a complex  
2 exercise, and so to have issued instructions in an  
3 RFP that were, as we have discussed, laid out in  
4 section 1.2.1 of the RFP, and do not include any  
5 discussion of the charge trend, then Blue Cross  
6 would have been left with very little time to  
7 have -- to have done the calculation that was being  
8 asked.  
9 And, furthermore, they did the calculation  
10 initially that followed the instructions of the RFP.  
11 Q Well, from the Blue Cross -- from the  
12 State Health Plan Segal Group perspective, they had  
13 been asking for that information since Clarification  
14 Number 2, had they not?  
15 A They provided the matrix that we are  
16 discussing in Clarification Number 2, which is  
17 the -- the first time I believe that there was a  
18 discussion of charges.  
19 MR. WHITMAN: Okay. Let's look -- let me  
20 show you what was previously marked as Exhibit  
21 Number 34 in this case. I will represent to  
22 you that Blue Cross' response to Clarification  
23 Number 6.  
24 (Previously marked Exhibit Number 34 was  
25 identified.)

Page 160

1 BY MR. WHITMAN:  
2 Q Here, the State Health Plan asks Blue  
3 Cross directly, right?  
4 "What percent of the 2.8 percent  
5 improvement (from 51.2 percent to 54 percent) is  
6 from billed charge trends versus only contract  
7 improvements?"  
8 Right?  
9 A Yes, they do request that.  
10 Q But Blue Cross North Carolina does not  
11 respond to Clarification Number 6 with a number  
12 between 0 and 2.8 percent, does it?  
13 A It does. The second page.  
14 Q Where? Show me where you're looking.  
15 A To summarize the 2.8 percent difference is  
16 composed of...  
17 Q Uh-huh.  
18 A And then it's contractual improvements of  
19 2 percent, billed charge trends between 2021 and  
20 2023, which yield a positive .3.8 percent  
21 adjustment.  
22 And so, yes, they aren't responding with a  
23 number between 0 and 2.8, but they're accounting for  
24 that 2.8 percent difference.  
25 Q Well, but, again, Blue Cross had failed to

Page 161

1 provide the number that The Segal Group and State  
2 Health Plan was specifically looking for, which was  
3 the percentage of the difference, the 2.8 percent  
4 difference that was attributable to the use of  
5 assumed billed charge increases, correct?  
6 MS. JOSEPH: Objection, form.  
7 A No. I believe that Blue Cross provided  
8 that on the second page.  
9 BY MR. WHITMAN:  
10 Q Well, Segal Group and/or the State Health  
11 Plan felt the need to seek even further  
12 clarification after Clarification Number 6, correct?  
13 A Yes, they did.  
14 MR. WHITMAN: Okay. Let me show you  
15 what's been previously marked in this case as  
16 Exhibit 35. I represent to you that it's Blue  
17 Cross' response to Request for Clarification  
18 Number 7.  
19 (Previously marked Exhibit Number 35 was  
20 identified.)  
21 BY MR. WHITMAN:  
22 Q In this clarification, Blue Cross Blue  
23 Shield of North Carolina confirms that its actual  
24 achieved discount -- or agrees that its actual  
25 achieved discount as of November 2022 was

Page 162

1 52.7 percent, correct?  
2 A Yes, that is what it says.  
3 Q Right. Not the 54 percent, as Blue Cross  
4 had indicated in Clarification Number 4, correct?  
5 A It indicates that, as of the time of  
6 repricing -- November 1, 2022 -- that their discount  
7 is 52.7. The discount that takes into account the  
8 near-future contracts is reflected in the 2023  
9 discount that is identified on Clarification  
10 Number 7 and is 54 percent.  
11 Q So in its response to Clarification  
12 Number 7 here, which is Exhibit Number 35, Blue  
13 Cross Blue Shield North Carolina agrees that  
14 52.7 percent was an agreed upon value after making  
15 adjustments to its billed charges, assumptions,  
16 correct?  
17 A No. Blue Cross identifies that 52.7 is  
18 the discount as of November 2022, and 54 percent is  
19 the discount using the contracts that go into place  
20 in January of 2023. This is not an adjustment for  
21 billed charges.  
22 Q That's not how you read this?  
23 A It doesn't say that.  
24 Q Well, do you recall that in Mr. Coccia's  
25 report, he documented that the 52.7 percent value

Page 163

1 still reflects some value of the billed charge  
2 increases, given that the midpoint was used?  
3 A I don't believe that I have Mr. Coccia's  
4 report. And so...  
5 Q I haven't marked it. I'm just asking, do  
6 you recall that that was one of the points that he  
7 made?  
8 A I don't recollect. I did not memorize his  
9 report.  
10 Q Well, okay, if there were no billed charge  
11 trends applied to the Blue Cross Blue Shield North  
12 Carolina repricing exercise, isn't it possible,  
13 then, that the discount rate would be even lower  
14 than the 52.7 percent that Blue Cross agreed to?  
15 A Sorry, I'm going to need that question one  
16 more time.  
17 Q Yeah. If there were no billed charge  
18 trends at all applied to Blue Cross' repricing  
19 analysis, then it's possible that the discount rate  
20 would have been even lower than 52.7 percent because  
21 the midpoint was used in calculating that by Segal  
22 Group and the State Health Plan.  
23 A No, because it would have been a discount  
24 rate. To be able to calculate the discount rate,  
25 you need to be concerned both with the numerator and

Page 164

1 the denominator. So you can't take 2023 paid  
2 amounts and 2021 billed charges. That's not a  
3 discount rate. That's two different time periods  
4 that you're comparing.  
5 Q And did you understand that Segal Group  
6 was attempting to have an apples-to-apples  
7 comparison at a certain point in time for the  
8 purpose of the repricing analysis.  
9 A I understood that --  
10 Q Okay.  
11 A -- from the reports that Mr. Vieira and  
12 Mr. Coccia authored.  
13 Q And you acknowledge in your rebuttal  
14 report that it's a valid goal, it's a reasonable  
15 goal to attempt to have an apples-to-apples  
16 comparison of that data, correct?  
17 A Yes, it is.  
18 Q Okay.  
19 A In doing a repricing analysis, one wants  
20 to have apples-to-apples comparison.  
21 Q Now, you don't dispute, do you, Mr. Russo,  
22 that Blue Cross Blue Shield North Carolina did use  
23 trended data when it initially reported its discount  
24 of 54 percent to the State Health Plan, do you?  
25 A Blue Cross, in reporting the discount,

Page 165

1 followed the instructions that were in the RFP to  
2 price each claim based on the provider contracts in  
3 place or near-future contract improvements. That  
4 exercise required Blue Cross to utilize the  
5 information in its contracts and to trend the billed  
6 charges.  
7 Q So that wasn't really my question. My  
8 question is: You don't dispute that Blue Cross  
9 North Carolina did use trended data when it  
10 initially reported its 54 percent discount to the  
11 State Health Plan?  
12 MS. JOSEPH: Objection to form.  
13 BY MR. WHITMAN:  
14 Q Based on what you just said, you  
15 acknowledge that.  
16 A Based on what I said --  
17 Q Right.  
18 A -- Blue Cross followed the instructions  
19 that were in the RFP to reprice the claim using the  
20 provider contracts in place or near-future contract  
21 improvements, and it did so by relying on that  
22 information to identify the paid amounts that would  
23 be applicable, and the trend -- trended the billed  
24 charges to reflect the same time period for which  
25 the paid amounts would reflect.

<p style="text-align: right;">Page 166</p> <p>1 Q Let's go to your -- the expert report, 2 your initial report, Exhibit 417, and ask you to 3 turn to page 40 within Opinion 3. 4 A Yes. I'm there. 5 Q Okay. Now, on page 40 of your initial 6 report, in the second paragraph from the bottom, you 7 state: "Segal's reduction of Blue Cross' discount 8 percentage from 54 percent to 52.7 percent replaced 9 Blue Cross' actual discount percentage as of late 10 2022 with an artificially lowered discount 11 percentage." 12 Did I read that correctly? 13 A Yes, you did. 14 Q Okay. And in the second paragraph, if we 15 look at your rebuttal report, which is Exhibit 420, 16 on page 18 -- 17 Bless you. 18 THE WITNESS: Bless you. 19 BY MR. WHITMAN: 20 Q Let me know when you get to page 18 of 21 your rebuttal report, which is Exhibit 420. 22 A Yes, I'm there. 23 Q All right. In the second paragraph, there 24 on page 18, you state that: "Segal adjusted Blue 25 Cross' current discount" -- right? -- "its discount</p>	<p style="text-align: right;">Page 168</p> <p>1 not contesting that number, are you? 2 MS. JOSEPH: Objection to form. 3 A The 52.7 isn't a correction for billed 4 charges. It's a correction for the time period. 5 And so, yes, I don't agree with your question and 6 your premise. 7 BY MR. WHITMAN: 8 Q And that's why you're saying in your 9 rebuttal report that, in your opinion, there is not 10 a sufficient basis for The Segal Group to adjust 11 Blue Cross Blue Shield North Carolina's initially 12 claimed discount of 54 percent down to 52.7, even 13 though Blue Cross Blue Shield North Carolina 14 admitted in Clarification Number 7 that was the 15 right number? 16 MS. JOSEPH: Objection, form. 17 A I disagree with your premise that it is 18 the right number. 19 BY MR. WHITMAN: 20 Q Okay. 21 A What Blue Cross identified was that, as of 22 November 2022, the discount was 52.7. However, what 23 Blue Cross recognizes in Clarification Number 7 is 24 that there are instructions in the RFP, and those 25 instructions ask the vendor to reprice the claims</p>
<p style="text-align: right;">Page 167</p> <p>1 percentage in the repricing exercise significantly 2 downward without a sufficient basis to do so." 3 Was that the opinion you expressed in your 4 rebuttal report? 5 A Yes, it is. 6 Q So given that we've already discussed in 7 Clarification Number 7 that Blue Cross agreed with 8 the State Health Plan that the actual achieved 9 discount as of November of 2022 would be 10 approximately 52.7 percent, you don't believe that's 11 a sufficient basis for The Segal Group to have used 12 52.7? 13 A No, I don't. The instructions in the RFP 14 identify the vendors are expected to reprice each 15 claim line based on provider contracts in place or 16 near-future contract improvements. The exercise was 17 being done in November of 2022. Near-future 18 contract improvements are reflective of the 19 contracts that would be in place as of 2023. That's 20 what Aetna indicated they did. 21 Q Mr. Russo, though, you're not contesting 22 that the 52.7 percent that Blue Cross Blue Shield 23 North Carolina ultimately agreed to in Clarification 24 Number 7 is -- was its discount if the assumed 25 increases in billed charges were excluded; you're</p>	<p style="text-align: right;">Page 169</p> <p>1 using near-future contract improvements, which in 2 the testimony that has been provided in this case 3 has identified that 2023 are applicable contracts 4 for the purposes of that exercise. 5 Q Anything else as to why you disagree? 6 A Not at this time. 7 MR. WHITMAN: Okay. Let's now look at the 8 clarifications, the request for clarifications 9 to Aetna, and show you what was previously 10 marked as Exhibit 256 in this case, which is 11 Aetna's response to Request for Clarification 12 Number 5. 13 (Previously marked Exhibit Number 256 was 14 identified.) 15 BY MR. WHITMAN: 16 Q Do you see this is also dated November 18, 17 2022? 18 A Yes, I do. 19 Q And it provides the same chart to be 20 populated that was provided to Blue Cross? 21 A Yes, it includes the same chart. 22 Q Okay. Now, contrary to Clarification 23 Number 4 to Blue Cross, in which the State Health 24 Plan stated in writing that Blue Cross' prior 25 response to clarifications were not consistent with</p>

Page 170

1 the cost proposal instructions.  
2 In this clarification to Aetna, the State  
3 Health Plan stated: "Aetna's proposal and  
4 subsequent clarifications appear to be consistent  
5 with the cost proposal instructions."  
6 Do you see that?  
7 A Yes, I do. I do see that.  
8 Q Number 1?  
9 A I do see that.  
10 Q Okay.  
11 A I don't necessarily agree with it, but I  
12 see it.  
13 Q Now, on page 39 of your expert report,  
14 Exhibit 417, you reference Aetna's response to  
15 Question Number 2 in this Clarification Number 5 in  
16 which Aetna states that: "The 1 percent discount  
17 improvements between the repricing result and  
18 expected 2025 discount (52.99 percent versus  
19 53.99 percent) is driven by assumed billed charge  
20 trend," and that emphasis was in your report,  
21 correct?  
22 A Yes, that is correct.  
23 Q Okay. Here in clarification, in response  
24 to Clarification Number 5, which is Exhibit 256,  
25 Aetna is not stating that its repricing percentage

Page 171

1 of 52.99 percent in the Known Contract Improvement  
2 line includes assumed increases in billed charges,  
3 is it?  
4 A According to the way that Aetna responded  
5 to this Request for Clarification, they're  
6 indicating that the known contract improvements,  
7 when those are incorporated, that their discount is  
8 52.99.  
9 As I've indicated in my report, though,  
10 there are questions as to whether or not charges  
11 would be trended by Aetna to arrive at that  
12 discount, even though they're indicating that they  
13 were not.  
14 Q I understand what's in your report. My  
15 question is, I'm looking at the response to Aetna's  
16 response to Clarification Number 5, and I'm asking,  
17 do you see that Aetna is not stating to the State  
18 Health Plan or Segal that its repricing percentage  
19 of 52.99 percent in the Known Contracts Improvement  
20 line includes assumed increases in billed charges?  
21 That's not what this says, is it?  
22 A It does not say that it assumes increases  
23 in billed charges --  
24 Q Yeah.  
25 A -- even though it might.

Page 172

1 Q All Aetna is stating here is that the  
2 difference between the repricing discount of  
3 52.99 percent in the Known Contract Improvements  
4 line and the 53.99 percent discount in the Assumed  
5 Increases In Billed Charges line -- that difference  
6 is based on an assumed billed charge trend.  
7 Do you see where it says that?  
8 A Yes, I do see where it says that.  
9 Q Okay. Aetna does not state anywhere in  
10 response to Clarification Number 5 that it billed  
11 assumed increases and billed charges or a billed  
12 charge trend into a repricing discount of  
13 52.99 percent, does it?  
14 A Aetna does not indicate as such.  
15 Q Okay.  
16 A There are reasons to question whether or  
17 not there is an increase in billed charges.  
18 MR. WHITMAN: I'll show you what we're  
19 going to mark as Exhibit Number 421.  
20 (Exhibit Number 421 marked for  
21 identification.)  
22 BY MR. WHITMAN:  
23 Q Mr. Russo, I indicate to you this is  
24 Aetna's response to Clarification Number 4.  
25 And in Question 1 of this clarification to

Page 173

1 Aetna is: State Health Plan is asking Aetna the  
2 exact same question that it posed to Blue Cross in  
3 Clarification Number 2, which is Exhibit 30, which  
4 you and I looked at earlier, correct?  
5 A Exhibit 2 -- or sorry, Exhibit --  
6 Q 30.  
7 A -- 30 is Request for Clarification  
8 Number 2 to Blue Cross.  
9 Q Right.  
10 A And you're asking now if the text is the  
11 exact same?  
12 Q Question Number 1.  
13 A It appears to be the same in my brief  
14 review of it.  
15 Q Okay. Do you see anywhere in this  
16 clarification where Aetna indicates that it included  
17 assumed increases in billed charges in its repricing  
18 discount?  
19 A No. Aetna is not indicating that, even  
20 though the repricing exercise does.  
21 Q Now, through the November 18, 2022,  
22 clarifications referenced in your report and that  
23 you and I have looked at, Clarification Number 4 for  
24 Blue Cross, and Clarification Number 5 for Aetna,  
25 Blue Cross was the only vendor that stated in

<p style="text-align: right;">Page 174</p> <p>1 writing or otherwise that it did include assumed 2 increases in billed charges for its repricing 3 discount, agreed? 4 A I don't recollect what the responses were 5 from UMR. 6 Q Okay. Well, how about as between Aetna 7 and Blue Cross? Blue Cross is the only vendor that 8 stated in writing or otherwise that it included 9 assumed increases in billed charges in its repricing 10 discount, agreed? 11 A I agree that in response to the multiple 12 clarifications that Blue Cross received that it 13 identified the process and methodology that it 14 undertook to calculate the prices in the repricing 15 file. 16 Q Right. 17 A And that methodology included following 18 the instructions that were in the RFP. 19 Q Well, you keep referring to those 20 instructions in the RFP, Mr. Russo, but we've now 21 looked at Clarifications 2, 3, 4, 5, 6, and 7 to 22 your client Blue Cross and Blue Shield of North 23 Carolina which indicated -- I think you agreed 24 earlier in your deposition -- a clear indication 25 that the State Health Plan and Segal Group did not</p>	<p style="text-align: right;">Page 176</p> <p>1 that process in the request for clarifications. 2 Aetna, in its responses, did not indicate that it 3 trended charges. But as I have described in my 4 reports, there are anomalies within Aetna's 5 repricing file that make one question the 6 methodology that Aetna undertook to calculate the 7 prices. 8 Q Yeah. That made you question it as a 9 hired consultant, but not enough to make Segal Group 10 or the State Health Plan have concern, correct? 11 MS. JOSEPH: Objection. 12 A As I have indicated, a reasonable 13 individual working in the healthcare marketplace 14 would have had questions as to the repricing file 15 that Aetna had submitted. 16 BY MR. WHITMAN: 17 Q And we looked at the Request for 18 Clarifications 4 and 5 to Aetna that the State 19 Health Plan made, seeking to understand whether 20 Aetna had included assumed increases in billed 21 charges, right? 22 MS. JOSEPH: Objection. 23 A Yes, we did, but we did not see any 24 additional questions about the anomalies that exist 25 within the repricing exercise and the repricing data</p>
<p style="text-align: right;">Page 175</p> <p>1 want any assumed increases in billed charges used 2 for purposes of repricing. 3 Do you agree? 4 MS. JOSEPH: Objection to form. 5 A I don't remember agreeing to that. 6 BY MR. WHITMAN: 7 Q Okay. 8 A The RFP was published and had the 9 instructions in it. The clarifications came after 10 the fact, with the little time for the vendors to 11 respond. And that's where Segal and the Plan begin 12 to discuss billed charges. 13 There's no discussion of billed charges in 14 the instructions for the RFP, and if one were to 15 follow the instructions for the RFP, as Blue Cross 16 did, and follow industry standard, you need to 17 adjust the charges that are included in the data, 18 because the charges that are in the data are 2021 19 charges, but yet the instructions are asking for 20 2022 and 2023 payments. 21 Q If that's true, Mr. Russo, do you have an 22 explanation as to why your client Blue Cross is the 23 only one of the vendors that interpreted the 24 instruction in the RFP that way? 25 A Blue Cross is the entity that described</p>	<p style="text-align: right;">Page 177</p> <p>1 that Aetna had provided. 2 BY MR. WHITMAN: 3 Q Well, let's -- since you've criticized the 4 State Health Plan and Segal Group for sending 5 further clarifications to Blue Cross but not the 6 Aetna, let's compare even further the responses that 7 the two companies made to the clarifications. 8 Do you have Aetna's response to 9 Clarification Number 5, which is 256? 10 A Yes, I have that. 11 Q Do you have Blue Cross' response to 12 Clarification Number 4, which is Exhibit 32? 13 A Yes, I do. 14 Q Do you see in there Aetna's Clarification 15 Number 5 response that there is an increase of 16 1.02 percent from the 2021 claims data using 2021 17 contracts to known contract improvements? 18 A I'm sorry, I don't see that. 19 Q Okay. Do you see Aetna's discount 20 52.9 percent to 52.99 percent Charleston County? 21 A Yeah, that's 51.97 to 52.99. 22 Q Yes, sir. 23 Do you calculate that to be an increase of 24 1.02 percent? 25 A Yes.</p>

Page 182

1 A Yes, I do.  
2 Q And then it says: "Reconciliation between  
3 the incumbent's historical and reprice discounts  
4 allows for an understanding of the carrier's  
5 estimated change in contracts between the time  
6 periods."  
7 Right?  
8 A Yes.  
9 Q Then it says: "While it is reasonable to  
10 expect a small discount change (in either  
11 direction), significant differences require  
12 additional validation."  
13 Did I read that correct?  
14 A Yes, you did.  
15 Q Okay. And here Segal Group and the State  
16 Health Plan did exactly what this recommends and  
17 sought additional validation as to how Blue Cross  
18 was arriving at 54 percent, didn't it?  
19 A Yes. It sought additional clarification  
20 and then also went and analyzed the UDS data.  
21 Q While we're in this exhibit, Mr. Russo, do  
22 you recall, on page 2, me asking you earlier about  
23 the fact that the Milliman White Paper had  
24 identified at least five ways that you could use  
25 repricing analyses, all of which are deemed

Page 183

1 acceptable in the industry.  
2 Do you recall that?  
3 A I do see those five, yes.  
4 Q Okay. And I asked you which one of the  
5 five -- A, B, C, D or E -- you used for purposes of  
6 the subset repricing analysis you did of Aetna for  
7 Opinion 2. Do you recall that?  
8 A Yes, I do.  
9 Q And you indicated it would have been  
10 section A?  
11 A Yes, I believe that's correct.  
12 Q -- repricing.  
13 Are you able to discern or determine which  
14 of the repricing methods -- A, B, C, D, or E -- were  
15 utilized by the State Health Plan or Segal Group in  
16 this case?  
17 A I didn't understand that the State Health  
18 Plan and The Segal Group had repriced claims data.  
19 Q Well, they were assessing the repricing  
20 exercises of the vendors, correct?  
21 A Yes, but they weren't doing the repricing.  
22 Q Understood.  
23 Do you have an understanding as to -- as  
24 between B, C, D, and E which method of the repricing  
25 exercise The Segal Group understood the vendors to

Page 184

1 have been using?  
2 A I understood it to be at the provider and  
3 detailed service levels since that fits with the  
4 instructions that were in the RFP, which is that the  
5 vendors are expected to reprice each claim line  
6 based on provider contracts in place or near-future  
7 contract improvements.  
8 Q Well, which of these methods did Blue  
9 Cross use, do you know?  
10 A I don't have an understanding of which  
11 method they used. I believe they used the provider  
12 and detailed service.  
13 Q So if they actually used the provider and  
14 major service category there in section B, that  
15 would be news to you?  
16 A It wouldn't necessarily be news to me.  
17 Q Okay. You just don't know which method  
18 they used, do you?  
19 A No. I don't have enough information. I  
20 think there should have been additional information  
21 sought in the clarifications from all of the  
22 vendors.  
23 Q Well, you could have had any information  
24 you wanted from Blue Cross because that's your  
25 client, right? You could have asked which method

Page 185

1 they used.  
2 A I -- I could have, had I asked that  
3 question. It wasn't a pertinent question for me to  
4 ask, though.  
5 Q Now, going back to your initial report,  
6 Mr. Russo, which is Exhibit 417, under Opinion 3 you  
7 also make the claim on pages 41 and 42 that the  
8 State Health Plan should have been suspicious that  
9 Aetna's repricing discount of 52.99 percent excluded  
10 assumed increases in billed charges, right? These  
11 are these anomalies you referenced earlier.  
12 A Yes. And, I'm sorry, could you just  
13 indicate where you're reading from?  
14 Q Yeah, I'm just looking at the information  
15 on pages 41 and 42 of your expert report, where you  
16 claim that the State Health Plan should have been  
17 suspicious that Aetna's repricing discount of  
18 52.99 percent excluded assumed increases in billed  
19 charges.  
20 A Yes, that's correct. I thought you were  
21 reading a quote from it.  
22 Q No.  
23 A That's what I was looking for.  
24 Q I was summarizing.  
25 A Sorry.

Page 186

1 Q I was just giving -- I mean, we only have  
2 a certain amount of time. I'm trying to summarize  
3 what's on 41 and 42. That's essentially what I  
4 understood you to be saying.  
5 A Yes, I agree with that.  
6 Q Okay. But did you read the deposition  
7 that was taken of Aetna's corporate representative  
8 Cathy Aguirre, where she was asked specifically at  
9 that deposition whether Aetna's 52.99 percent in the  
10 Known Contracts Improvement line included assumed  
11 increases in billed charges? Did you read her  
12 testimony?  
13 A Yes, I do -- yes, I did.  
14 Q What do you recall she said?  
15 A I recall that she said that Aetna did not  
16 trend charges --  
17 Q Okay.  
18 A -- in its repricing exercise.  
19 Q Do you have any evidence to suggest or  
20 prove that that was incorrect?  
21 A I don't have evidence to prove that it was  
22 incorrect, but I have questions about the repricing  
23 data, as is indicated in my report, in my rebuttal  
24 report, and I would have sought additional  
25 information from Aetna to ensure that the

Page 187

1 information that Ms. Aguirre provided was accurate.  
2 Q So you're stating what you would have done  
3 if you were sitting in the position of Segal Group  
4 and actually assessing and evaluating and ranking  
5 cost proposals from vendors in response to a state  
6 health plan RFP, right?  
7 A I would have asked questions, which is  
8 something that I do in any repricing exercise that  
9 I'm doing to ensure that I am understanding the  
10 manner in which the repricing exercise is being  
11 done.  
12 Q But you've never actually sat in the seat  
13 of Segal Group and its folks where you were actually  
14 paid, retained, or employed to evaluate, score, and  
15 rank cost proposals from vendors in response to a  
16 state RFP for a health plan, right?  
17 A I've not sat in that chair, but I have sat  
18 in the chair of assessing repricing exercises for a  
19 number of different entities. And in doing that  
20 work, which is similar to the work that is here, I  
21 have asked questions of the entities to ensure that  
22 I understand the manner in which the repricing  
23 exercises have occurred.  
24 Q Now, let's look on page 41 of your expert  
25 report, Exhibit 417. I think we're in the

Page 188

1 neighborhood there, Mr. Russo. The first bullet,  
2 kind of halfway down page 41 -- do you see that,  
3 where I am?  
4 A Yes.  
5 Q You made the statement that Aetna's  
6 discounts for providers with the letters of intent  
7 were unrealistic and higher in aggregate than the  
8 discounts for all other providers in Aetna's  
9 network, correct?  
10 A Yes, that's correct.  
11 Q And in bullet 3, you state that  
12 52.99 percent discount would mean Aetna would be  
13 paying providers fewer dollars in the future than it  
14 is now, which does not align with the trends in the  
15 healthcare market, right?  
16 A Yes, that is correct.  
17 Q Okay. Now, in your experience, is it  
18 unheard of for a carrier to negotiate discounts that  
19 will result in an absolute reduction in dollars to a  
20 provider, or is it simply less common?  
21 A It is extremely rare in my experience.  
22 Q Okay. So it's rare?  
23 A Extremely rare.  
24 Q But not unheard of?  
25 A I believe that I have seen that situation

Page 189

1 with professional contracts, but I've never seen  
2 that situation with a **REDACTED**.  
3 Q Now, Aetna's letters of agreement  
4 contained customer-specific discounts for the State  
5 Health Plan, didn't they?  
6 A Yes, it did.  
7 Q All right. So --  
8 A However --  
9 Q Go ahead.  
10 A Those discounts would go into place in  
11 2023, when the State Health Plan would not get the  
12 benefit of the bargain, because the State Health  
13 Plan wouldn't yet be paying the bill. Those  
14 discounts are then eliminated by 2025, when the  
15 State Health Plan would then be paying the bill.  
16 So the letters of intent and the  
17 additional discount in them is used for a function  
18 of the repricing exercise, not for a function of  
19 benefiting the State Health Plan.  
20 Q Well, did you consider, Mr. Russo, whether  
21 Aetna was able to negotiate higher discounts for a  
22 specific client like the State Health Plan versus a  
23 discount that would apply to all customers serviced  
24 by Aetna?  
25 A I haven't seen all of their contracts.

Page 194

1 A No, I did not ask that question.  
2 Q And at no time during any of those RFPs,  
3 both of which resulted in contract awards to Blue  
4 Cross, did they take any issue with method or  
5 methodology, process or procedures used by the State  
6 Health Plan or Segal Group to evaluate the cost  
7 proposals in those RFPs, to your knowledge, did  
8 they?  
9 A I don't know who "they" is in your  
10 question --  
11 Q Okay.  
12 A -- so could you clarify that for me?  
13 Q Sure. "They" is Blue Cross.  
14 Do you have any knowledge or information  
15 that would suggest that Blue Cross took any issue  
16 with the fact that the State Health Plan had not  
17 asked for copies of vendor contracts in the 2017 or  
18 2019 RFPs in which it was awarded the contract?  
19 A No, I don't have the -- no, I don't have  
20 information as to whether they did.  
21 Q And here on page 41 of your report, you're  
22 criticizing or you're making the point that the Plan  
23 or Segal didn't review any of Aetna's signed letters  
24 of intent to validate assumed discounts, and you  
25 made the statement, I sure hope they had asked for

Page 195

1 them in the past.  
2 Do you have any knowledge or are you  
3 aware, Mr. Russo, that, in fact, Blue Cross and Blue  
4 Shield of North Carolina has actively fought against  
5 providing transparency of contracts to the State  
6 Health Plan?  
7 MS. JOSEPH: Objection to form.  
8 BY MR. WHITMAN:  
9 Q Did anybody tell you that?  
10 A I don't have any information about that.  
11 But I do have to clarify a point of your question --  
12 Q Okay.  
13 A -- which indicated that I had identified  
14 that I hoped in prior evaluations that there had  
15 been a request for contracts, and that -- I believe  
16 what I said, when I testified to that, was that I  
17 hope they requested the contracts if they saw  
18 anomalies of the sort that were seen in these  
19 repricing files.  
20 Q Fair enough. Okay.  
21 But to go back to my question that was on  
22 the table, you are not aware -- no one made you  
23 aware through any documents discovery, discussions  
24 or otherwise, that Blue Cross Blue Shield has  
25 actively -- throughout its entire tenure as the TPA

Page 196

1 services contract provider to this State Health  
2 Plan, actively fought against transparency about  
3 providing its provider contract to the State Health  
4 Plan.  
5 Did you know that?  
6 A I don't have any information on whether  
7 they have done so or not.  
8 Q Okay.  
9 A Fought, not fought, that's not information  
10 I have on.  
11 Q Okay. Do you have any information on the  
12 fact that Blue Cross and Blue Shield of North  
13 Carolina has even lobbied the North Carolina  
14 legislature to present transparency in the provision  
15 of its provider contracts to the State Health Plan?  
16 MS. JOSEPH: Objection.  
17 A No, that's not information that I have --  
18 BY MR. WHITMAN:  
19 Q So you --  
20 A -- received.  
21 Blue Cross must follow the payor  
22 transparency laws for which they have to report  
23 contracted rates, and so that information is  
24 publicly available.  
25 Q And I'll still on page 41 of your initial

Page 197

1 report, Mr. Russo, where you're critical of the  
2 State Health Plan for adjusting Blue Cross'  
3 repricing discount from 54 percent to 52.7 percent  
4 because it "forced Blue Cross to exclude increases  
5 in billed charges."  
6 Did I read that correctly?  
7 A Yes, you did.  
8 Q Okay. And we've been over this, but are  
9 you aware of anywhere in this RFP, which is  
10 Exhibit 5, where the State Health Plan instructs  
11 vendors to include increases in billed charges in  
12 its repricing discount?  
13 A The RFP does not explicitly state that  
14 trends in billed charges should be included or  
15 excluded. The requirements in the RFP are such that  
16 one would reasonably trend the billed charges since  
17 what is being asked for is a repricing of each claim  
18 line, based on provider contracts that are in place  
19 or near-future contract improvements.  
20 Q But you recognize and agree that if the  
21 State Health Plan had allowed vendors to project out  
22 healthcare trends, including billed charges, some  
23 vendors might have used higher trends than others,  
24 right?  
25 MS. JOSEPH: Objection to form.

<p style="text-align: right;">Page 198</p> <p>1 A I don't know what the vendors would have 2 used. But what Segal and the Plan could have done 3 is they could have identified within the RFP 4 instructions how the vendors should have trended 5 billed charges. 6 BY MR. WHITMAN: 7 Q They could have done a lot of things. 8 Blue Cross and Blue Shield of North Carolina also 9 could have sought clarification during the two 10 different question-and-answer periods if the RFP 11 allowed that -- correct? -- if they had any 12 questions? 13 A Yes, but my understanding was those 14 question-and-answer periods predated the request for 15 clarifications. 16 Q Well, they most certainly did, but if 17 there was any question about whether they were to 18 include assumed increases in billed charges, those 19 questions could have been asked in advance? 20 A There wasn't a question as to whether or 21 not those should have been included, because a 22 reasonable individual working on repricing exercises 23 would have trended the billed charges, based on the 24 instructions. It's not until the clarifications 25 start coming in late November of 2022 that there's</p>	<p style="text-align: right;">Page 200</p> <p>1 costs and, therefore, wanted to understand the 2 discounts. 3 Q Well, when we saw the report from 4 Mr. Vieira of The Segal Group and he mentioned the 5 efforts to obtain an apples-to-apples comparison, 6 you acknowledged on page 18 of your rebuttal report 7 that an apples-to-apples comparison of vendors' 8 repricing results was, in fact, a legitimate 9 objective, correct? 10 A Yes, that's correct. When evaluating 11 repricing exercises, one needs to get to an 12 apples-to-apples comparison. The concern that 13 exists here is that with respect to Blue Cross, 14 Segal was making adjustments to get to what they 15 thought was an apple. But with respect to Aetna, we 16 don't really know whether Aetna was an apple or a 17 pear or an orange. 18 Q Well, you don't know if it was an apple, a 19 pear, or an orange, but The Segal Group and the 20 State Health Plan apparently had no problem seeing 21 it as an apple, correct? 22 MS. JOSEPH: Objection. 23 A The Segal Group and the State Health Plan 24 had no problem in interpreting that as an apple and 25 ignoring the data that was in front of them.</p>
<p style="text-align: right;">Page 199</p> <p>1 then an indication that the billed charges should 2 not be trended. 3 Q So it's your opinion, Mr. Russo, that the 4 actuarial professionals within UnitedHealthcare and 5 Aetna were wrong to read the instructions 6 differently than you and Blue Cross apparently read 7 them? 8 MS. JOSEPH: Objection. 9 A I am not certain how the actuarial 10 professionals within Aetna read the instructions. 11 As I have indicated, I have questions about Aetna's 12 repricing exercise. 13 BY MR. WHITMAN: 14 Q Did you ultimately or ever consider 15 whether the State Health Plan might have a different 16 objective for the repricing exercise than simply 17 predicting future discounts? 18 A I -- no, I did not. I was following what 19 the description in the RFP is, which is that the 20 Plan seeks to contract with an organization that has 21 proven success in managing provider cost and will 22 submit data timely in the required format. 23 And as it goes on to describe the 24 repricing exercise, I understood that the Plan was 25 the most -- was most interested in managing provider</p>	<p style="text-align: right;">Page 201</p> <p>1 BY MR. WHITMAN: 2 Q And if they had interpreted the 3 information from Blue Cross in previous RFPs in the 4 same format, same process, same method that was 5 utilized here, would -- none of which Blue Cross 6 ever questioned when they won, you're just not aware 7 of that? 8 MS. JOSEPH: Objection. 9 A Sorry. I need that one more time. 10 BY MR. WHITMAN: 11 Q Yeah. If The Segal Group and the State 12 Health Plan used the same process, methodology, and 13 undertakings to evaluate, compare, score, and rank 14 the repricing exercises and the cost proposals from 15 vendors in the 2017-2019 RFPs, the same way they did 16 in 2022 without complaint by Blue Cross, you're not 17 aware of that? 18 MS. JOSEPH: Objection. 19 A No, I'm not aware of that. What I'm aware 20 of is what transpired in this RFP and the responses, 21 and I have questions as to what transpired in the 22 repricing exercises, as I've outlined in my report. 23 BY MR. WHITMAN: 24 Q All right. Now, let's go to page 20 of 25 your rebuttal report.</p>

Page 210

1 ahead and take a break.  
2 THE VIDEOGRAPHER: The time is 2:18 p.m.  
3 We're off the record.  
4 (A recess was taken from 2:18 p.m. to  
5 2:29 p.m.)  
6 THE VIDEOGRAPHER: The time is 1:02.  
7 We're on the record.  
8 EXAMINATION  
9 BY MR. HEWITT:  
10 Q Good afternoon, Mr. Russo. We met very  
11 quickly. I'm Marc Hewitt, counsel for the North  
12 Carolina State Health Plan. I want to direct your  
13 attention to your Opinion 1 from your rebuttal  
14 report and your -- excuse me -- your initial expert  
15 report and your rebuttal report. So let's start  
16 with 4 -- I believe -- 17 which was your initial  
17 report.  
18 And that opinion, generally speaking,  
19 relates to your opinion about the State Health  
20 Plan's scoring of Blue Cross' pricing guarantees,  
21 correct?  
22 A Yes, that is correct.  
23 Q Okay. Do you have Exhibit 5, the RFP  
24 where you can reach it? I think you may be touching  
25 it right now.

Page 211

1 A Yes.  
2 Q If you would turn to page, I believe it's  
3 24 and 25, which is where Section 3.4 is.  
4 A Yes. I have turned to page 24 and 25.  
5 Q Thank you. So you've seen that section of  
6 the RFP before, I know, but would you agree that the  
7 RFP said that the vendors' pricing guarantees would  
8 be compared based on their value to the State Health  
9 Plan, and that the value would be based on a  
10 combination of competitiveness of the guaranteed  
11 targets and the amount placed at risk.  
12 A Yes, it does say that.  
13 Q Okay. I'm going to get back into that,  
14 but I want to back up for a minute and talk about  
15 your experience, specifically with respect to  
16 pricing guarantees.  
17 Do you have any prior -- I know we talked  
18 about your experience in general, but do you have  
19 any prior experience drafting or evaluating or  
20 analyzing pricing guarantees?  
21 A I have experience with respect to the  
22 medical cost that would be incurred by a health plan  
23 and by a Plan sponsor. And so to the extent that  
24 guarantees are related to that, then, yes, I do have  
25 the experience. But I have not drafted a pricing

Page 212

1 guarantee.  
2 Q Okay. Or have you evaluated or analyzed  
3 pricing guarantees before this engagement?  
4 A I have not evaluated pricing guarantees  
5 for the purposes of an RFP response. I have  
6 evaluated, though, the cost -- the medical cost that  
7 would -- that would be incurred by a plan and by a  
8 plan sponsor.  
9 Q And who were you working for when you did  
10 that type of evaluation of the medical cost?  
11 A So that has been involved in a number of  
12 engagements where I have been working on  
13 reimbursement-related issues for insurance  
14 companies.  
15 Q Have you had a lot of engagements in the  
16 past where you were analyzing those in the context  
17 of a pricing guarantee?  
18 A Analyzing medical costs?  
19 Q In terms of pricing guarantees, yes.  
20 A Not in the context of pricing guarantees.  
21 In the context of the medical costs that would be  
22 incurred by a health plan and how a health plan  
23 would value its operations.  
24 Q Okay. My question was specific to your  
25 experience with analyzing or evaluating pricing

Page 213

1 guarantees.  
2 A Yes.  
3 Q So of the engagements that you've had  
4 before, how many prior engagements have you had  
5 where you've had to analyze or evaluate the value of  
6 pricing guarantees?  
7 A Right. And as I've indicated in my  
8 responses, I have not evaluated pricing guarantees  
9 in the context of an RFP. But what I have done is I  
10 have evaluated the costs that will be incurred by  
11 plans and plan sponsors.  
12 Q But in those instances, it was not in the  
13 context of pricing guarantees, was it?  
14 A It was in the context of the medical costs  
15 and the overall value that an insurer would ascribe  
16 to a given book of business.  
17 Q And you have never worked for a health  
18 plan in -- or have any experience, either working  
19 for or on behalf of a health plan, in assessing the  
20 value of pricing guarantees, have you?  
21 A I don't -- I don't believe that I have,  
22 but I do recollect there was -- yes. You know, I  
23 did, because I worked on a project for a health  
24 insurance company that had certain guarantees with  
25 providers in terms of the reimbursement that was

<p style="text-align: right;">Page 218</p> <p>1 A Yes. Those were pricing guarantees in 2 that context. 3 Q On your report, page 11, Exhibit 417, on 4 page 11, let me find the quote, please. 5 A I'm sorry. 6 Q Give me just a moment. 7 There's a heading about two-thirds of the 8 way down the page way is Segal's Evaluation of the 9 Guarantees and the Flaws in that Evaluation. 10 Do you see that? 11 A Yes, I do see that. 12 Q Second paragraph under the heading you 13 say: "Based on this description as well as my 14 experience, I would expect that the pricing 15 guarantees would have been evaluated, quantitatively 16 based on the combined bottom line effect under 17 likely scenarios of each vendor's targets and 18 amounts placed at risk." 19 Do you see that? 20 A Yes, I do. 21 Q What specific experience of yours are you 22 talking about when you say "my experience"? 23 A The experience that I have in, first, 24 going to graduate school at the Johns Hopkins 25 Bloomberg School of Public Health and understanding</p>	<p style="text-align: right;">Page 220</p> <p>1 value of the pricing guarantee would be based on the 2 combination of the competitiveness of the guaranteed 3 targets and the amount placed at risk. 4 Q Anything else? 5 A No. I don't believe that there are other 6 requirements with respect to the network pricing 7 guarantee. 8 Q You -- your report includes several 9 tables -- I believe it is Figures 5, 6, and 7 in 10 your initial report stating how you compared the 11 vendors' pricing guarantees; is that fair? 12 A Those are illustrative examples as I have 13 described in those pages of my report. 14 Q To illustrate what? How the Plan could 15 have, should have, or had to evaluate the pricing 16 guarantees? 17 A They are illustrative examples of ways 18 that the pricing guarantees could have been compared 19 and considered. 20 Q Okay. But those aren't the only way a 21 plan could decide to value or compare pricing 22 guarantees, are they? 23 A No, they aren't the only way. The RFP 24 provides the construct under which one should value 25 the pricing guarantees, as the RFP identifies that</p>
<p style="text-align: right;">Page 219</p> <p>1 the manner in which the healthcare marketplace works 2 and how medical cost and medical expense is a key 3 driver to that -- the operations of that 4 marketplace. 5 And further, the almost 20 years of 6 experience that I have working with payors and 7 providers in the marketplace where there is an 8 understanding of the medical expenses and the 9 evaluation of those medical expenses as the key 10 driver in affecting the manner in which the 11 marketplace operates. 12 Q Anything more specific than that? 13 MS. JOSEPH: Objection. 14 A So I have done work for several health 15 insurance companies with respect to the evaluation 16 of medical expenses and medical costs that are 17 referenced therein. 18 BY MR. HEWITT: 19 Q Anything else? 20 A Not that comes to mind at this moment. 21 Q Are there any requirements on how the 22 North Carolina State Health Plan had to evaluate or 23 compare the bidders' pricing guarantees? 24 A I understand that it had to follow the 25 requirements in the RFP, which indicate that the</p>	<p style="text-align: right;">Page 221</p> <p>1 they should be valued based on the combination of 2 the competitiveness of the guaranteed targets and 3 the amount placed at risk. 4 Q The method that you use in your 5 illustrative exhibits in your report, have you done 6 this type of analysis to compare or evaluate pricing 7 guarantees against each other before in another 8 engagement? 9 A I don't recollect having done an analysis 10 of this sort in another engagement. 11 Q Have other experts used that type of 12 analysis to compare the value of pricing guarantees? 13 A The work that is done in the figures that 14 you have identified, as well as what is included in 15 my rebuttal report, reflect the instructions that 16 the RFP has provided. And I have not seen another 17 engagement with specific instructions like this in 18 an RFP. 19 Q So you're not aware of any? 20 MS. JOSEPH: Objection. 21 A I am not aware that the instructions have 22 been outlined like this in another situation. 23 BY MR. HEWITT: 24 Q Are you aware of any similar analyses that 25 have been done to compare pricing guarantees in any</p>

<p style="text-align: right;">Page 222</p> <p>1 other context regardless of whether the RFP 2 instructions were similar or not? 3 A I'm sorry. Could you give that to me 4 again? 5 Q Are you aware of any similar analyses that 6 have been done to compare pricing guarantees in any 7 other context regardless of whether the RFP 8 instructions were similar or not? 9 A No, not that I recollect. 10 Q Have you ever done any type of analysis to 11 compare the value of pricing guarantees in the 12 context of an RFP? 13 A As I've indicated, in the context of an 14 RFP, I have not evaluated the pricing guarantees, 15 but evaluating the value that is provided to a plan 16 based on the combination of the competitiveness and 17 the amount placed at risk is something that I have 18 done because I have concern -- I have, in the course 19 of my career, done a number of engagements with 20 respect to the ultimate medical cost that are -- 21 that a plan and a plan sponsor would incur. 22 Q But never for a state health plan and 23 never in the context of an RFP, correct? 24 A Not in the context of an RFP. 25 Q How about for a state health plan?</p>	<p style="text-align: right;">Page 224</p> <p>1 It was a federally qualified health center. 2 Q If you would turn to pages 14 and 15 of 3 your report, Exhibit 417. Let me know when you're 4 there. 5 A Fourteen and 15 you said? 6 Q Yes, sir. 7 A I'm there. 8 Q All right. And here, especially on page 9 15, you've got a Figure 3, which that's an excerpt 10 from an analysis that Segal did, correct? 11 A It is an excerpt of Segal's Pricing 12 Guarantee Scoring worksheet. 13 Q Okay. So to your understanding, is this 14 the analysis that Segal used to assess and score the 15 bidder's pricing guarantees for this RFP? 16 A It is their evaluation of it. 17 Q Okay. I would just note for the record 18 that the source that you state is Bates page number 19 SHP 69464. I'll represent to you that that's an 20 Excel document. I want to show you what's 21 previously been marked as Deposition Exhibit Number 22 413. 23 (Previously marked Exhibit Number 413 was 24 identified.). 25</p>
<p style="text-align: right;">Page 223</p> <p>1 A I believe that I have done work for 2 Medicaid-managed care at some point in my career. 3 Q Did that work involve pricing guarantees? 4 A No. It involved the analysis of medical 5 expenses. 6 Q Right. So my question was whether or not 7 you have evaluated pricing guarantees in the context 8 of a state health plan or an RFP. So does your 9 Medicaid-managed care work include pricing 10 guarantees? 11 MS. JOSEPH: Objection to form. 12 A So as I think through now, it was not 13 Medicaid-managed care. It was an engagement that 14 involved a federally qualified health center, and 15 there were guarantees with respect to the pricing 16 that it would receive, and there was an evaluation 17 that I did of that work. 18 BY MR. HEWITT: 19 Q Pricing guarantee -- pricing that it would 20 receive from whom? 21 A From another entity that was similar to a 22 plan sponsor. 23 Q Okay. But this was not a state health 24 plan RFP, correct? 25 A No, it was not a state health plan RFP.</p>	<p style="text-align: right;">Page 225</p> <p>1 BY MR. HEWITT: 2 Q And if you would -- 3 Have you seen this document before, 4 Mr. Russo? 5 A Yes, I have. 6 Q Okay. So I'll represent to you that this 7 was Segal's presentation to the State Health Plan 8 Evaluation Committee with its final analysis of the 9 entire cost proposal submitted by all three bidders. 10 And if you'll turn to page number 7 on 11 that document, which is Bates page SHP 85918. Take 12 a look at the table there. The heading Network 13 Pricing Guarantee Scoring. Can you identify whether 14 you believe this is what's excerpted in Figure 3 in 15 your report, please? 16 A I do believe that it is the same based on 17 my prior review of these documents, but I don't 18 recollect having checked every word between the two. 19 Q Okay. Because it's a little larger and 20 easier to read, I want to ask you questions based on 21 this, but if you have any concern at any point that 22 this does not reflect what you've seen before, 23 please say so, okay? 24 A Yes. 25 Q So to your understanding, this page in</p>

Page 226

1 Deposition Exhibit 413 is the Segal analysis that it  
2 used to score the pricing guarantees, right?  
3 A It is the evaluation, the summary of the  
4 evaluation Segal did.  
5 Q Okay. And one of the criticisms you had  
6 of Segal's scoring evaluation was that it was  
7 narrative and not quantitative, I believe is how you  
8 put it; is that fair?  
9 A Yes, that's correct.  
10 Q And I think you also referred to it as  
11 subjective.  
12 So is there any requirement you're aware  
13 of that Segal's evaluation of the pricing guarantees  
14 had to be 100 percent objective?  
15 A No, I didn't see a requirement that it be  
16 objective. I saw a requirement that the value of  
17 the pricing guarantees had to be based on the  
18 combination of the competitiveness of the guaranteed  
19 targets and the amount placed at risk.  
20 Q Okay. Are you aware of any requirement  
21 that Segal couldn't use a narrative type of  
22 evaluation instead of a quantitative-type  
23 evaluation?  
24 A I am not aware of that requirement. I was  
25 surprised to see that, and I don't believe that I

Page 227

1 was the only one surprised to see that. When the  
2 Plan's actuary was asked in his deposition about the  
3 analysis of the pricing guarantees, Charles Sceiford  
4 said -- and I quote: "Seeing that it's subjective  
5 did raise a potential issue. It was out of the  
6 ordinary."  
7 Q Okay. And that quote is in your report,  
8 isn't it?  
9 A Yes, it is.  
10 Q Okay. Now, in Mr. Steve Kuhn's  
11 deposition, the 30(b)(6) Deposition of The Segal  
12 Group, have you reviewed Mr. Kuhn's testimony as to  
13 their reasoning for why the evaluation that Segal  
14 did was somewhat subjective in a narrative format?  
15 A I believe that I reviewed it. I don't  
16 recollect it as I sit here, though.  
17 Q Okay. Do you recall him saying that Segal  
18 couldn't develop a mathematical model in advance  
19 because what they -- how they would have to review  
20 it would be heavily dependent on what the proposals  
21 were that they received?  
22 A I do recollect that.  
23 Q Do you also remember him stating that the  
24 proposal -- if they developed a model ahead of time  
25 and the proposals came in and one or more of them

Page 228

1 didn't fit the model, that Segal would then  
2 potentially be in a position of having to change the  
3 model?  
4 A Yes. Segal was also in the position of  
5 being able to request the information since they  
6 helped in the RFP process.  
7 Q And as it says here on page -- I believe  
8 it's 13 of your report -- there's a quote in here.  
9 It's actually the red and black excerpts from an  
10 email chain back and forth between Steve Kuhn and  
11 Matt Rish where Segal in red is explaining its  
12 rationale for not developing a model in advance.  
13 Do you see that?  
14 A Yes, that's correct. And as Stuart Wohl  
15 had identified in his email exchange on October 24,  
16 it will be very subjective and probably up for  
17 discussion.  
18 Q Okay. And that was communicated to the  
19 plan ahead of time in this email chain, correct?  
20 A I don't recollect whether the plan was  
21 copied on that email from Mr. Wohl or not.  
22 Q Okay. Well, at least with respect to the  
23 quote that's from -- that's in Figure 1 of your  
24 report, this was communicated in the plan in early  
25 November before any of the cost proposals were

Page 229

1 received, correct?  
2 A Yes. Figure 1 in my report is an email  
3 that went back to the Plan's Matt Rish.  
4 Q Okay. And there was reasoning -- Segal's  
5 reasoning in that plan that was communicated --  
6 excuse me. Segal's reasoning in that email was  
7 communicated to the Plan as to why it would have to  
8 assess the value of the pricing guarantees after it  
9 received those guarantees from the bidders, correct?  
10 A So Segal does indicate that they don't  
11 have the sample drafted because it's heavily  
12 dependent on what is received from the vendors. I  
13 think that calls into question why Segal didn't  
14 ensure that it was getting the necessary information  
15 from the vendors that it could then assess to  
16 determine the value to -- of the pricing guarantees  
17 to the Plan.  
18 Q My question was, was this communicated to  
19 the Plan before the pricing guarantees were received  
20 from the bidders?  
21 A This was communicated to the Plan at the  
22 end of October. And so I believe that was before  
23 the bids were submitted.  
24 Q And so let me ask you now some questions  
25 about your opinions about the flaws in Segal

Page 242

1 Plan's actuary, agreed that a discount target that's  
2 higher than the vendor's current discount will be  
3 more valuable than a discount target that is lower  
4 than a vendor's current discount."  
5 Q Yeah, I see that.  
6 A Then it continues on.  
7 Q Did Sceiford testify that Aetna's pricing  
8 guarantee had no value or was he talking -- was this  
9 a general statement?  
10 A I don't recollect whether this was a  
11 hypothetical or not. I believe it might have been  
12 the hypothetical -- a hypothetical because the quote  
13 that I have, which is on the next line, is that  
14 Sceiford testified that this is the case, quote,  
15 "because they would have to work hard to try to meet  
16 that guarantee."  
17 Q I'm sorry. You said you thought that was  
18 or was not a hypothetical he was testifying about?  
19 A I believe that it was a hypothetical, but  
20 I don't recollect exactly, so I would need to see  
21 his testimony.  
22 Q I wasn't going to ask you about that part.  
23 The next sentence I was talking about was  
24 in the following paragraph. It's in the paragraph  
25 that begins with the word "Although Segal's

Page 243

1 analysis."  
2 Do you see that paragraph?  
3 A Yes.  
4 Q Second sentence reads: "Instead the  
5 evaluation put more emphasis on the amount at risk  
6 than on the aggressiveness of the targets."  
7 Do you see that?  
8 A Yes, I do.  
9 Q Okay. So I think that's a relative  
10 emphasis. You're saying more emphasis was put on  
11 amount at risk and less emphasis on aggressiveness  
12 of the targets.  
13 Is that fair?  
14 A My reading of the scoring, which Segal has  
15 summarized, is that that scoring is reflective of  
16 the amount that is placed at risk, not based on the  
17 guaranteed targets. And I think this is evidenced  
18 both on page 8 of Exhibit 413, as well as on page 7  
19 of Exhibit 413 where the discount guarantees that  
20 are identified on page 7 include only the Calendar  
21 Year 2025 guarantee. There's nothing identified  
22 about the remaining years that have been provided.  
23 And we know that Aetna's guarantee of  
24 52.3 percent does not change for the remainder of  
25 the contract, while as -- whereas Blue Cross'

Page 244

1 increases each year, and UMR's is nonexistent after  
2 the first year.  
3 Q Okay. The point, though, the question I  
4 actually had was, you used the language "more  
5 emphasis," rather than "no emphasis."  
6 My question to you is: Is it your  
7 testimony that the amounts put at risk got  
8 100 percent of the weight in this assessment or just  
9 got more? I guess the question, is it all or  
10 nothing or is it the amounts at risk outweigh the  
11 guaranteed targets?  
12 A It appears that the assessment was done  
13 based on the amounts that are placed at risk, and  
14 that there was no consideration to the  
15 competitiveness of the guaranteed targets. And that  
16 opinion fits with the statement that I have there;  
17 that more emphasis is placed on the amount at risk.  
18 Q Well, in some places you say no emphasis  
19 or no weight and in some places you say less weight,  
20 more or less, or all or none. I guess my question  
21 is: Which is it? Is it your testimony that the  
22 State Health Plan and Segal took no notice, no  
23 consideration whatsoever of the guaranteed targets  
24 or is it they just took less -- they give those less  
25 weight?

Page 245

1 A Well, they do recognize them, because as  
2 you see on page 7 they have included those numbers  
3 within the summary. But I don't believe based on  
4 the review that they are giving them any weight.  
5 Now, it is challenging to assess whether  
6 they are or are not giving them any weight because  
7 ultimately their review is not quantitative. And if  
8 their review is quantitative, then we would be able  
9 to clearly understand how they have weighted those  
10 two portions of the guarantee.  
11 Q So the way Segal actually did the  
12 analysis, you can't definitively say one way or  
13 another whether or not Segal put any weight on the  
14 competitiveness of the guaranteed targets. Is that  
15 fair?  
16 A It's unclear. It's indicative that it was  
17 based on the amount placed at risk based on the  
18 scores that are provided. But again, because the  
19 analysis was not quantitative, one cannot get in the  
20 minds of what Segal was doing.  
21 Q And I think we already covered, but there  
22 was not a requirement that it be quantitative as  
23 opposed to narrative like this?  
24 A I don't see a requirement that it be  
25 quantitative, but it was surprising to the Plan that

Page 266

1 MS. JOSEPH: Please hold just a second.  
2 Okay.  
3 BY MR. HEWITT:  
4 Q Excuse me, Blue Cross did actually get six  
5 points, I misspoke, for the network pricing  
6 component of the cost analysis, right?  
7 A Yes, it did, for the network pricing.  
8 Q Okay. And so --  
9 A I'm sorry. Do we need to pause?  
10 (Pause off the stenographic record for  
11 in-room video monitor interference.)  
12 BY MR. HEWITT:  
13 Q And I'm looking at page 5 of Deposition  
14 Exhibit 413, which is Segal's cost analysis  
15 evaluation presentation.  
16 A Yes.  
17 Q You agree that Blue Cross actually got the  
18 highest possible score for its network pricing,  
19 right?  
20 A Yes. It received six points out of six  
21 potential points.  
22 Q Okay. And that was -- so it got credit  
23 for its -- I'm sorry, I'm looking at the wrong page,  
24 I apologize. I meant to refer you to the  
25 Administrative Fees' page which is a separate one,

Page 267

1 and that is page 6. Blue Cross got the best score  
2 out of all three bidders, and this is Bates page SHP  
3 85917.  
4 Would you agree with that?  
5 A For the Administrative Fees Scoring, Blue  
6 Cross received 2 points out of the potential 2  
7 points.  
8 Q Okay. And neither the other two bidders  
9 got the high score on that component, correct?  
10 A That's correct. Aetna received 1 point  
11 and UMR received 0 points.  
12 Q Okay. So to the extent the Plan was  
13 scoring or evaluating vendors on the basis of their  
14 administrative fees, you would agree that Blue Cross  
15 got credit for having the lowest administrative fees  
16 elsewhere in the cost proposal, wouldn't you?  
17 A Well, they got credit here, but they  
18 shouldn't have gotten a demerit because they had a  
19 lower administrative fee when discussing the network  
20 pricing guarantees, and that's what Segal seems to  
21 suggest.  
22 Q Well, would you -- strike that.  
23 Are you aware of any requirement that was  
24 violated by Segal's factoring in the effect of lower  
25 administrative fees when it was comparing the

Page 268

1 pricing guarantees? I'll clarify my question.  
2 You mentioned it being illogical. My  
3 question is, did it violate any requirements?  
4 A The intent of the Plan, as described in  
5 the RFP, is the Plan intends to be a leader in North  
6 Carolina known for providing cost effective, quality  
7 healthcare program for its membership.  
8 And so I would think that that's  
9 indicative that the Plan seeks to identify a vendor  
10 who has low administrative fees. And Segal and the  
11 Plan recognize that in the scoring of the  
12 administrative fees, which is evidenced on SHP  
13 0085917, and as I've indicated, having a low  
14 administrative fee, it should not, then, comport  
15 with getting a demerit on the network pricing  
16 guarantee scoring.  
17 Q Okay. I understand that your opinion is  
18 that it should not. My question, though, was: Are  
19 you aware of any requirements that the Plan violated  
20 when it factored in the lower amount of Blue Cross'  
21 administrative fees when it was assessing the value  
22 of Blue Cross' pricing guarantees?  
23 A Well, it would be running contrary to the  
24 intent in the Plan for a cost effective quality  
25 healthcare program.

Page 269

1 Q My question was whether it violated any  
2 requirements. Let me try to be a little more  
3 specific. Did it violate any statute or rule or  
4 policy that you can cite to me?  
5 MS. JOSEPH: Objection.  
6 A I'm not an attorney, so I don't have a  
7 statute that I can cite to for that. What I have is  
8 the RFP, and what the Plan describes as its intent  
9 therein and the requirements therein.  
10 BY MR. HEWITT:  
11 Q Anything more specific than that?  
12 A No, nothing more specific than the RFP and  
13 what the RFP says about its intent to find a cost  
14 effective -- or to run a cost effective program.  
15 MS. JOSEPH: Mark, when you get to a  
16 stopping place, can we take a break?  
17 MR. HEWITT: Sure, now is as good as any.  
18 THE WITNESS: Ten minutes?  
19 MS. JOSEPH: Ten minutes.  
20 THE VIDEOGRAPHER: The time is 3:55.  
21 We're off the record.  
22 (A recess was taken from 3:55 p.m. to  
23 4:08 p.m.)  
24 THE VIDEOGRAPHER: The time is 4:08.  
25 We're on the record.

Page 290

1 discount target at 52.3 percent - 0.4 percent higher  
2 than Segal's calculated composite amount for Aetna."  
3 Is that what you mean?  
4 A Yes, that's correct.  
5 Q Okay. So your testimony is that number is  
6 not tying?  
7 A That's correct. Those numbers do not tie.  
8 The weighted average calculation, which is,  
9 according to Mr. Vieira's standard industry  
10 practice, arrives at a different number than Aetna's  
11 discount target. And standard industry practice in  
12 the healthcare marketplace is, when numbers don't  
13 tie, one seeks to resolve those discrepancies.  
14 Q And you think the calculation that he was  
15 doing was -- that resulted in 51.9 percent, was the  
16 weighted average calculation. Is that what your  
17 testimony is?  
18 A That's right, that's what it shows in  
19 their work papers.  
20 Q Based on Mr. Vieira's report, is it your  
21 understanding that the number that Segal chose to  
22 use, 52.3 percent, was on purpose?  
23 A I don't know what you mean by "on  
24 purpose"?  
25 Q Let me turn your attention to .10 in your

Page 291

1 report, that -- well, let me back up. Before I move  
2 off that point.  
3 The quote that I read to you before --  
4 well, actually I'm just going to read it directly  
5 from Mr. Vieira's report. It says -- I'm sorry, I  
6 already read it into the record.  
7 You pointed out this supposed discrepancy  
8 in your initial report, and in response Mr. Vieira's  
9 report said, in part: "There was no error in this  
10 analysis or any reason to seek clarification,"  
11 unquote, and then he goes on with an explanation  
12 from there.  
13 Do you recall that?  
14 A I do see that in his report, yes.  
15 Q Okay. And so is it your testimony that --  
16 well, strike that.  
17 In -- let me now turn your attention to  
18 point 10 in your report starting on page 21. Your  
19 opinion here is that the Plan and Segal erred by  
20 treating UMR's discount guarantees as offering the  
21 greatest comparative value even though UMR offered  
22 no discount guarantee at all past 2025.  
23 Is that fair?  
24 A Yes, that's correct.  
25 Q Okay. And you include a quote that's only

Page 292

1 two words long from Steve Kuhn's deposition  
2 testimony about after the first year, the trend  
3 guarantees "take over." Do you see that?  
4 A I do see that, yes.  
5 Q So Mr. -- I went back and reviewed it,  
6 Mr. Kuhn's deposition testimony, about the rationale  
7 there. It actually goes on from pages 217 to 220,  
8 so about four or five pages -- sorry, four pages of  
9 his deposition transcript in which he explained  
10 Segal's reasoning.  
11 Did you review all that?  
12 A I don't know what you mean by "all that."  
13 Q We can take a look at it. We already  
14 marked his deposition testimony as an exhibit. It's  
15 Exhibit 424. Let me have you turn to page 217,  
16 please. It starts on page 217, line 9. Just let me  
17 know when you're there, please.  
18 A Yes, I'm there.  
19 Q Okay. And if you would, just read from  
20 there through the top of page 220, and just let me  
21 know when you're done.  
22 A Read into the record?  
23 Q No, no, no. You can, but it's already --  
24 if you would just take a second to review it for  
25 yourself from 217, line 9, through the top of 220.

Page 293

1 And just let me know when you're done.  
2 A Okay.  
3 Q So he spent several pages explaining why,  
4 in Segal's estimation, the discount guarantees are  
5 most important in the first year and significantly  
6 less important after the first year of a new  
7 contract; is that fair?  
8 A Yes. He describes that.  
9 Q Do you disagree with Segal's reasoning  
10 about that point?  
11 A Yes. I do disagree that there should be  
12 only weight given to the trend guarantee. The RFP  
13 requested guarantees for the discount in all five  
14 years if the -- and the RFP could have asked for a  
15 discount guarantee only in the first year and then  
16 trend guarantees in the remaining years of the  
17 amounts --  
18 Q Sorry. Do other experts always compare  
19 discount guarantees in all years of a contract?  
20 MS. JOSEPH: Objection.  
21 A I don't know if other experts would  
22 compare in all years of the contract. The  
23 requirements of the RFP were such that the vendors  
24 had to respond to the discount guarantees and  
25 provide them for all years of the contract,

<p style="text-align: right;">Page 294</p> <p>1 including the two option years, and that the Plan 2 sought to run a cost effective program. And so it's 3 reasonable in my mind, and I think the 4 reasonableness standard exists, that one would 5 evaluate the information that was required. 6 BY MR. HEWITT: 7 Q Okay. And that's the basis for your 8 disagreement with how Segal did it here? 9 A Yes, that is. 10 Q Let me turn your attention to point 11 in 11 your report: "The Plan and Segal also erred by 12 treating UMR's trend guarantees as offering moderate 13 comparative value even though UMR did not guarantee 14 any specific trend percentages," unquote. And you 15 also talk about that UMR's guaranteed was based on 16 1 percent lower than its book-of-business trend. 17 A Yes. 18 Q All right. You understand that Segal had 19 some data that it referred to as to what UMR's 20 book-of-business trend was, correct? 21 A I don't know that they did have data on 22 UHC's book-of-business trend. 23 (Stenographer requested clarification.) 24 Q Do you recall what Mr. Kuhn testified on 25 that point in his deposition?</p>	<p style="text-align: right;">Page 296</p> <p>1 initial report; is that right? 2 A I believe it is in my initial report. 3 Q What you were just talking about in that 4 last answer when you referred to Mr. Vieira's 5 report, Mr. Vieira did not rely on any 6 PricewaterhouseCoopers data, did he? 7 A No. What I was referencing was the table 8 on page 24 of Mr. Vieira's report where he relied on 9 the Segal trend survey and data from the state 10 health plan. I don't have the 11 PricewaterhouseCoopers' data memorized. But when 12 I've reviewed that data and compared it with the 13 Segal trend survey, I found that both of those data 14 sources were similar in their findings for medical 15 costs over the time period analyzed. 16 Q And what all -- well, is the 17 PricewaterhouseCoopers data reflective of UMR's 18 book-of-business trend? Do you have any way of 19 knowing that? 20 A It is a broader industry survey than just 21 a single health insurer. 22 Q Is it limited to health insurers, or is it 23 bigger than that? 24 A I don't recollect. It is, though, titled 25 "Medical cost trend" behind the numbers 2024. And</p>
<p style="text-align: right;">Page 295</p> <p>1 A No, I don't recollect him testifying about 2 the data that was available to them. 3 Q Did you have -- did you have or consult 4 any data on what UHC or United's book-of-business 5 trend is? 6 A No. I didn't specifically analyze UHC's 7 book-of-business trend, but I had referenced in my 8 report and earlier testimony an analysis that 9 PricewaterhouseCoopers did of the trend in medical 10 expenses. And Mr. Vieira has included that trend in 11 medical expenses within the table that's on page 24 12 of his report. And -- 13 Q I'm sorry, which page of his report? 14 A Twenty-four. 15 And what we see, in looking at the medical 16 expenses over time, is that they are between, 17 generally, about 5 and a half and 6 and a half or 7 18 percent, except for in 2021 where the growth rate 19 for the Segal trend survey is 14 percent. And the 20 State Health Plan business was a growth of 21 16 percent, which varies significantly from what the 22 trend guarantees are that were offered by both Aetna 23 and Blue Cross. 24 Q You mentioned Pricewaterhouse medical cost 25 trend data. That was cited, I guess, in your</p>	<p style="text-align: right;">Page 297</p> <p>1 so I would think it's medical costs. 2 Q Well, could it be, I guess -- when you say 3 medical costs, could it be the amount of money that 4 like hospital systems and health systems incur in 5 actually providing care versus amounts that are like 6 allowed amounts that are actually paid to settle 7 healthcare claims? 8 A Well, it could be, but that's not my 9 recollection of it at all. My recollection of it 10 was that it was the study of medical expenses and 11 the growth of medical expenses in a similar way that 12 the Segal trend survey was done. 13 Q Is there any -- is there any industry 14 practice or standard that would have prevented or 15 that precluded, I guess, UMR from proposing a trend 16 guarantee that was based on its book-of-business 17 trend as opposed to an absolute percentage? 18 A I think the industry standard of 19 reasonableness would have -- should have precluded 20 the ranking of that as a value to the Plan. There 21 is ambiguity in identifying a book-of-business 22 trend, and that ambiguity would then need to be 23 sorted out over the course of the contract. And 24 that ambiguity could create a dispute between the 25 Plan and the vendor.</p>

Page 298

1 Q What is the industry standard of  
2 reasonableness?  
3 MS. JOSEPH: Objection.  
4 A The industry standard of reasonableness is  
5 to clearly identify in the contracts that you have  
6 the terms of reimbursement and money that would  
7 exchange hands. As I've negotiated contracts with  
8 payors and providers, it's better to have as much  
9 stipulated so that there is no ambiguity that will  
10 arise in the operation of the contract.  
11 BY MR. HEWITT:  
12 Q Is that an industry standard that is  
13 specific to network pricing guarantees?  
14 A It is an industry standard as it relates  
15 to contracts in the healthcare marketplace.  
16 Q Is it specific or limited to relations  
17 between plans and -- health plans and TPAs?  
18 A I've seen it with respect to contracts  
19 between plans and TPAs -- or, sorry, between Plan  
20 sponsors and TPAs.  
21 Q But it's not limited to that context,  
22 right?  
23 A No, it's broader than that context. Two  
24 entities that are operating and exchanging money in  
25 the healthcare context would like as much outlined

Page 299

1 and detailed in their contract so there's not  
2 ambiguity.  
3 Q Okay. Is it specific or limited to the  
4 context of RFPs?  
5 A No. I don't know that it's specific or  
6 limited to that.  
7 Q Okay. And so do other experts base their  
8 opinions -- to your knowledge, do other experts base  
9 their opinions about the propriety of the scoring of  
10 network pricing guarantees on the industry standard  
11 of reasonableness?  
12 MS. JOSEPH: Objection.  
13 A I don't have an opinion on that.  
14 BY MR. HEWITT:  
15 Q So in the same point, in point 11 of your  
16 report -- and I'm actually looking at the very top  
17 of page 22. You say -- the last sentence reads:  
18 Given this lack of information and given how much  
19 more guaranteed targets affect the Plan's bottom  
20 line than at-risk amounts do, the Plan and Segal had  
21 no sound basis for scoring UMR's trend guarantees as  
22 more valuable than Blue Cross'", unquote.  
23 Do you see that sentence?  
24 A I do, yes.  
25 Q So it is fair to say that you disagree

Page 300

1 with how Segal compared the trend guarantees?  
2 A Yes, I do.  
3 Q Are you aware of any requirement that  
4 Segal was under in this particular RFP context to  
5 assess or evaluate the trend guarantees differently  
6 than it did?  
7 A The RFP identifies the operation of a cost  
8 effective Plan. And so Segal had the requirement to  
9 evaluate the bids and reflect, in its evaluation,  
10 the intent that the Plan sought to be cost  
11 effective. And I think that it's important to  
12 discuss the past few years of data that is shown on  
13 page 24 of Mr. Vieira's report.  
14 The state health plan business in 2021 had  
15 an increase of 16 percent. The industry, according  
16 to Segal's trend survey, was at 14 percent. If we  
17 assume that UHC's book of business was similar to  
18 that 14 percent, then UHC's guarantee, their trend  
19 guarantee in that year would have been 13 percent.  
20 Q And that is data that you didn't even have  
21 when you did your initial report disagreeing with  
22 the way Segal had scored the trend guarantees,  
23 correct?  
24 A The data that Mr. Vieira has outlined on  
25 page 24 is similar to the data that exists in the

Page 301

1 PWC health research institute medical cost trend  
2 that I have referenced on page 42 of my report. And  
3 so I had very similar data. I did not reference the  
4 Segal trend survey, though.  
5 Q You don't reference the  
6 PricewaterhouseCoopers data in this part about the  
7 pricing guarantees, do you? That's in connection  
8 with a completely different opinion.  
9 A That's right. It's not referenced here.  
10 It's referenced elsewhere.  
11 Q Okay. So you didn't do any sort of a  
12 comparison against data in connection with the  
13 pricing guarantees scoring for trend guarantees, did  
14 you?  
15 A I -- I had the information that exists in  
16 the PWC data in my evaluation and my drafting of  
17 that section.  
18 The information that's contained in PWC's  
19 data, as well as what's in Segal's trend survey,  
20 fits with what we in the healthcare marketplace know  
21 happened in the past few years with respect to  
22 medical expenses. The medical costs in the  
23 marketplace went down in 2020 further than expected  
24 and then came back significantly in 2021.  
25 Q Okay. The last point in your initial

Page 306	Page 308
<p>1 Is it your -- considering that no basis 2 point was provided for bidders, is it still your -- 3 in light -- sorry. 4 Considering that no basis point was 5 provided for bidders, it is still your testimony 6 that the Plan and Segal should have evaluated and 7 scored the bidders against each other on their 8 percentage of Medicare guarantees; is that right? 9 MS. JOSEPH: Objection to form. 10 A Segal and the Plan failed to provide ample 11 information to the vendors such that the vendors 12 could have been fairly compared on the percentage of 13 Medicare guarantees. 14 BY MR. HEWITT: 15 Q Okay. So we've, at a high level, talked 16 about all 12 of the areas that you say were flaws in 17 Segal's assessment or comparison and evaluation of 18 the network pricing guarantees; is that correct? 19 A I believe that we have. 20 Q Okay. And based on having talked through 21 those, would you agree with me that all those 22 decisions by Segal in evaluating the pricing 23 guarantees the way it did, those were all 24 intentional decisions? 25 A I'm not going to opine on Segal's intent.</p>	<p>1 any statements on here, on this page, that are 2 factually incorrect? 3 And what I'm getting at, are there any 4 errors in the nature of just factually incorrect 5 statements other than understanding you believe that 6 they were factually incorrect as far as the amount 7 of money that Blue Cross put at risk in its discount 8 guarantees? 9 MS. JOSEPH: Objection. 10 A I have not verified every single aspect of 11 what exists on page 7, but from what I have 12 reviewed, I have not identified things that are 13 factually incorrect except for the amount at risk 14 for Blue Cross. 15 BY MR. HEWITT: 16 Q Okay. That's what I thought. I just 17 wanted to make sure I understood correctly. 18 Other than -- with the same exception, 19 other than the amount that Blue Cross put at risk in 20 its discount guarantee, are there any calculations 21 in this analysis that you contend are wrong? 22 A Sorry. I need to clarify one other thing 23 that is incorrect. 24 Q What's that? 25 A And that is the current discount for Blue</p>
Page 307	Page 309
<p>1 Q Okay. Is it your opinion that any of 2 those were accidents or I guess mistakes as opposed 3 to being intentional? 4 A I'm not going to opine on Segal's intent. 5 Q But you disagree with how Segal scored the 6 guarantees -- 7 A Yes, I do. 8 Q -- for all the 12 categories of reasons 9 that we've talked through? 10 A Yes, I do. 11 Q And you disagree with the Plan's decision 12 to score Blue Cross or award Blue Cross zero points 13 on the pricing guarantees; is that fair? 14 A Yes, I disagree with that. 15 Q And among the reasons for that is that you 16 disagree -- I think this was maybe point number 4, 17 but that you disagree with how Segal interpreted the 18 amount that Blue Cross put at risk in its pricing 19 guarantees, right? 20 A Yes. That is point number 4, and that is 21 one of the items -- one of the areas of criticism 22 that I've offered. 23 Q Okay. Looking back at the Network Pricing 24 Guarantee Scoring analysis, we're still looking at 25 Exhibit 413. My question is going to be: Are there</p>	<p>1 Cross is listed at 52.7, and that should be at 54. 2 Q And is that just based on the opinions 3 that you talked through with Mr. Whitman earlier in 4 the day? 5 A Yes, that is. 6 Q Okay. Other than those two, any other 7 factually incorrect statements? 8 A The first point that I provided regarding 9 Blue Cross' amount at risk relates to two of the 10 cells that are on this page, and I wanted to make 11 sure that you noted that. So, yes, it is one 12 criticism, but there are two cells. 13 Q And those are the cells that read -- that 14 start with the words 10 percent of the discount 15 shortfall? That's one of them? 16 A Yes, that's one of them. 17 Q And the next one is the figure \$2,653,000? 18 A Yes, that is correct. 19 Q Okay. Any others? 20 A No, I don't believe so as I sit here right 21 now. 22 Q Okay. So same question: Are there any 23 calculations on this analysis that you contend are 24 wrong? 25 A Yes. The comparison of Blue Cross'</p>

Page 310

1 current discount to the Calendar Year 2025  
2 guarantee.  
3 Q That's currently 2.4 percent?  
4 A Yes, that's correct.  
5 Q Any others?  
6 A The Aetna Calendar Year 2025 guarantee is  
7 listed at 52.3, but as we talked about before,  
8 there's a question as to whether that should be  
9 51.9. That would then affect the calculations that  
10 flow from that.  
11 Q Okay. Any others?  
12 A No other calculations. I do want to make  
13 sure, though, that where I have identified that  
14 there was something factually incorrect in one of  
15 the cells, that it would then affect the evaluation  
16 of the discount guarantee cell. That is all the way  
17 over on the right-hand side in blue.  
18 Q And we've talked through each of the  
19 points that you just made with respect to Blue  
20 Cross' current discount and Blue Cross' amount at  
21 risk, as well as your opinion about Aetna's  
22 guaranteed target earlier in your testimony today,  
23 correct?  
24 A That's correct, yes, we've discussed them.  
25 Q And you understand, though, that Segal's

Page 311

1 testimony and the documents indicate that those were  
2 all intentional decisions as opposed to, for  
3 example, a math error or a calculation error?  
4 A I'm not sure what you mean by  
5 "intentional."  
6 Q Well, with respect to Blue Cross' current  
7 discount of being 52.7 versus 54 percent, that's the  
8 result of adjustments to Blue Cross' current  
9 discount based on clarifications in the repricing  
10 exercise, right?  
11 A Yes, that is. It was done in error.  
12 Q Well, it was done intentionally by Segal,  
13 and you just disagree with their determination to  
14 that effect; is that fair?  
15 A In my opinion it was wrong.  
16 Q Okay. But you understand that they  
17 understood what they were doing?  
18 A I don't have an understanding of what  
19 Segal understands.  
20 Q With respect to the 5 percent amount at  
21 risk versus 15 percent amount at risk, you  
22 understand that was based on Segal's reading of the  
23 language of Blue Cross' discount guarantees that  
24 they submitted as part of their RFP response, right?  
25 A That was what they indicated.

Page 312

1 Q Okay. So that was on purpose. That was  
2 based on their reading of the language in Blue  
3 Cross' submission?  
4 A I don't know if that was the basis for it.  
5 I think they have indicated that was how they  
6 interpreted it.  
7 Q And with respect to Aetna's guaranteed  
8 target of being 52.3 versus 51.9, you recall we  
9 talked about that Mr. Vieira's report said that that  
10 was not an error, that was based on -- that was  
11 based on Aetna's BAFO in its pricing guarantee. It  
12 would have been attachment A-8. It's BAFO  
13 attachment A-8 that outlined its pricing guarantee?  
14 A He doesn't say that's what the basis was.  
15 He just says there was no error in this analysis,  
16 and I disagree. I think there was an error. And  
17 the calculation that Mr. -- that Segal performed  
18 arrived at 51.9, and A-8 showed 52.3. That's a  
19 .4 percent difference.  
20 Q And in his report, at least there was the  
21 statement -- I think you just referenced it -- that  
22 was not an error?  
23 A He indicates there was no error in this  
24 analysis. You had indicated that he based that  
25 opinion on the BAFOs, and I don't see that he based

Page 313

1 it on the BAFOs as a reason that there was no error.  
2 Q Are you aware of any statute, rule,  
3 regulation, or policy that Segal violated in  
4 assessing the pricing guarantees the way that it  
5 did?  
6 A I am not an attorney, so I'm not going to  
7 opine on North Carolina law and whether or not that  
8 was violated. What I have in terms of my evaluation  
9 is the RFP and the requirements of the RFP. And  
10 it's my opinion that Segal did not follow what were  
11 the requirements in the RFP.  
12 Q And that's just based on your reading of  
13 the RFP language itself, right?  
14 A That's right. I read the RFP and used  
15 that language as a guide.  
16 Q And given your experience, you're also not  
17 relying on any industry practice that there may be  
18 with respect to comparing pricing guarantees for  
19 purposes of RFPs for TPA services for health plans?  
20 MS. JOSEPH: Objection to form.  
21 A With respect to that narrow of a focus,  
22 no. But I am applying a reasonableness standard  
23 with respect to the valuation of the guarantees as I  
24 have described in our conversation.  
25

Page 314

1 BY MR. HEWITT:  
2 Q Was that the industry standard of  
3 reasonableness that we talked about before?  
4 A Yes, that is correct.  
5 Q And in the next part of your report  
6 starting on page 22, you get into some calculations  
7 to evaluate the value of the pricing guarantees.  
8 And so on page 22, under the heading The Impact of  
9 Segal's Flawed Evaluation in Scoring, the third  
10 paragraph that starts with the word "Accordingly."  
11 Do you see that?  
12 A Yes.  
13 Q You say: "Accordingly, to evaluate the  
14 'value' of a guarantee, one must assess the  
15 bottom-line impact to the Plan if the vendor achieve  
16 or missed its targets, including, in each scenario,  
17 the actual claims cost minus the guaranteed rebate  
18 amount."  
19 Do you see that?  
20 A Yes, I do.  
21 Q You say "one must assess," and then you go  
22 on to describe this type of analysis.  
23 Is it your opinion that there is only one  
24 correct way to determine the value of pricing  
25 guarantees?

Page 315

1 A No. There may be different quantitative  
2 analyses that one could do to evaluate. But in that  
3 evaluation process, it is my opinion that you must  
4 assess the bottom line impact to the Plan if the  
5 vendor achieved or missed its targets as I show in  
6 my report as well as in Figure 4 of my rebuttal  
7 report.  
8 Q Do state plans always do that type of  
9 bottom line analysis when they are assessing --  
10 excuse me, when they are comparing the value of  
11 pricing guarantees in TPA RFPs?  
12 A If they have a goal of running a  
13 cost-effective plan, then I would think that they  
14 would be doing so.  
15 Q No. My question was factually, is that  
16 what state health plans do?  
17 A In the prior work that I have done related  
18 to RFPs, I have seen an evaluation of the costs to  
19 the Plan.  
20 Q None of those were in the context of a  
21 state health plan TPA RFP, were they?  
22 A One was in the context of a federal  
23 healthcare TPA, federal healthcare program TPA. And  
24 one is in with respect to a city health plan TPA.  
25 Q And were you involved in a comparison of

Page 316

1 the value of TPA pricing guarantees in those  
2 situations?  
3 A Those elements were included within those  
4 matters.  
5 Q You didn't do them, though, correct?  
6 A I did not draft the guarantees.  
7 Q Did you assess or compare the guarantees  
8 or the value of the guarantees?  
9 A I did not compare the guarantees.  
10 Q Did you --  
11 A But I did in -- with respect to the  
12 federal program, I recollect reviewing the  
13 guarantee.  
14 Q Who were you working for in that  
15 particular procurement?  
16 A I was working for a health insurance  
17 company.  
18 Q Was it a bidder?  
19 A It was, yes.  
20 Q Was there a protest or litigation over  
21 that procurement?  
22 A There was not.  
23 Q All right. Other than those two instances  
24 that you just mentioned, do you have any knowledge  
25 of whether or not state health plans do the type of

Page 317

1 analysis that you say must be done when they compare  
2 the value of pricing guarantees?  
3 A No, not as I sit here.  
4 Q And the compare- -- the quantitative  
5 analysis that's in your report in Figures 5, 6, and  
6 7, did you do that quantitative analysis, or did  
7 your team do that?  
8 A It was done at my direction. The team  
9 that I had performed the analyses that I had  
10 requested.  
11 Q Okay. Were you basing that analysis on  
12 some other analysis that you've seen done before in  
13 the context of a TPA procurement?  
14 A No, I was not. I was basing it on the  
15 evaluation of the medical expenses to the Plan and  
16 the Plan sponsor.  
17 Q All right. And explain to me what you did  
18 in Figure 5, please.  
19 A Figure 5 is a representation of the  
20 discount guarantees that the three vendors have  
21 provided in each year and the claims cost that would  
22 be incurred if those discount guarantees were met.  
23 And then at the bottom of Figure 5 is the difference  
24 between the claims cost for Aetna and Blue Cross and  
25 then UMR and Blue Cross.

<p style="text-align: right;">Page 318</p> <p>1 Q Again, that was assuming that each of 2 their targets -- their guaranteed targets were hit 3 exactly? 4 A Yes, that is correct. 5 Q Okay. And then what was the analysis in 6 figure 6? 7 A Figure 6 is a calculation of the claims 8 cost if the two vendors, Aetna and Blue Cross, were 9 to have missed the discount guarantee in 2025 by 10 1.9 percent. And then there's a comparison at the 11 bottom that is the total claims cost less the refund 12 for Aetna compared to Blue Cross. 13 Q Why 1.9 percent? 14 A 1.9 percent was the maximum payout -- or 15 sorry, the percentage miss at which the maximum 16 payout would occur for Aetna. 17 Q Why did you use Aetna's maximum payout 18 percentage instead of some other percentage? 19 A I used it to illustrate what the claims 20 cost would be. I could have used Blue Cross' as 21 well, but I didn't feel that it was necessary to do 22 so. I thought that the "miss" percentage for Aetna 23 was acceptable so that we had the full extent of 24 Aetna's refund. If I had used Blue Cross' miss 25 percentage, then it wouldn't have been the full</p>	<p style="text-align: right;">Page 320</p> <p>1 A They are based on the 2025, 2026, and 2027 2 guarantees that have been provided, but then there 3 are scenarios that are percentages off of those 4 guarantees as I discussed. 5 Q Right. So while each of the targets would 6 vary by vendor depending on what their target was 7 and their guarantee, the assumptions that you make 8 are fixed -- either a 0 percent variance from that 9 guaranteed target or some other percentage variance? 10 A That's correct. 11 Q And the variances are constant across all 12 three bidders, but the starting point, I guess, the 13 guaranteed target is -- varies by what that vendor 14 proposed, right? 15 A Yes. 16 Q Is that type of comparison typical when 17 state health plans compare the value of pricing 18 guarantees when they're doing TPA RFPs? 19 A I don't have information on whether state 20 health plans would value it -- would conduct the 21 analysis in exactly that same manner. But what I do 22 have as the guide is what is stated in the RFP. And 23 recognizing that the RFP is looking for a 24 cost-effective program and measuring medical 25 expenses fits with the discounts -- the discounting</p>
<p style="text-align: right;">Page 319</p> <p>1 extent of Aetna's refund. 2 Q And what is the analysis in Figure 7? 3 A Figure 7 is an illustration of what the 4 impact would be at three different miss scenarios 5 compared to the 2025 guarantee. So it's a 6 .5 percent miss, then a 1 percent miss, and then a 1 7 and a half point miss. It shows what the claims 8 cost and refund would be as well as what -- and the 9 total claims cost less the refund is. And 10 ultimately the bottom line compares Aetna and Blue 11 Cross. 12 Q All right. And so is this method and 13 these particular comparisons that are -- first of 14 all, is it fair to say that the assumptions about 15 the actual discounts achieved in all three of these 16 calculations are based on the discount guaranteed 17 targets that each of them proposed? 18 A I'm sorry, could you ask that question one 19 more time? Or read it back to me? 20 Q I'll try. In all three of those 21 comparisons, are the comparisons between Aetna, Blue 22 Cross, and UMR all based on the discount targets 23 that each of them propose when you are assuming the 24 amount -- sorry, when you are assuming the discount 25 that each bidder actually were to achieve?</p>	<p style="text-align: right;">Page 321</p> <p>1 scenarios that I have included in Figures 5, 6, and 2 7. 3 Q Have these types of comparisons been, you 4 know, endorsed or adopted by any trade associations? 5 MS. JOSEPH: Objection to form. 6 A I am not aware that trade associations 7 have provided an opinion on evaluating discount 8 guarantees. 9 BY MR. HEWITT: 10 Q Have these types of comparisons like 11 you've shown in your report in Figures 5, 6, and 7, 12 have these types of comparisons been accepted or 13 endorsed by other experts? 14 A The calculation of medical expenses and 15 looking at discounts off charges is something that I 16 have done and that experts from many other 17 consulting firms and research institutions have done 18 as those individuals have worked on cases with me 19 and/or against me. 20 Q I'm talking about in the context of -- 21 specifically within the context of the comparison of 22 a value of pricing guarantees. 23 A The value of the pricing guarantees, which 24 is ranked as the combination of the competitiveness 25 of the guaranteed targets and the amount placed at</p>

Page 322

1 risk, reflects the concept of medical expense. And  
2 so it is applicable to discuss what I have already  
3 done. So with respect to calculating medical  
4 expense and the expense to the Plan sponsor.  
5 Q I'm not talking about the general concept  
6 of a medical expense. I'm talking about whether --  
7 what I want to know is whether or not you know if  
8 any other experts have used these types of  
9 comparisons to compare the value of pricing  
10 guarantees in the context of state health plan TPA  
11 RFPs?  
12 A As I have indicated, the language that is  
13 in the RFP is reflective of the combination of the  
14 competitiveness of the guaranteed targets and the  
15 amount placed at risk. And while the work that I am  
16 referencing is not with respect to state health plan  
17 RFPs, there is still the concept of the calculation  
18 of medical expense as that is the value that the  
19 Plan sponsor would evaluate.  
20 Q Okay. But I haven't heard you identify  
21 any other experts who have used this type of  
22 comparison when they are assessing the value of  
23 pricing guarantees in the context of a state health  
24 plan TPA RFP. Have you got any of those experts, or  
25 can you identify any of those experts?

Page 323

1 MS. JOSEPH: Objection to form.  
2 A Not that I recollect as I sit here.  
3 BY MR. HEWITT:  
4 Q And backing up to a more broad concept.  
5 And this is not specific necessarily to pricing  
6 guarantees. But how are discount percentages --  
7 excuse me. Let me start that question over.  
8 This is specific to the concept of pricing  
9 guarantees. How are discount percentages for  
10 purposes of the discount targets calculated? And we  
11 can refer to Exhibit 225 if we need to. And that  
12 was Blue Cross' proposal submission.  
13 Let me just get that for you.  
14 A I'm sorry, I don't understand the  
15 question.  
16 Q I'll try again.  
17 This has previously been marked as  
18 Deposition Exhibit Number 225.  
19 (Previously marked Exhibit Number 225 was  
20 identified.)  
21 BY MR. HEWITT:  
22 Q So my question in general is for purposes  
23 of a pricing guarantee, how is the discount  
24 percentage calculated? And I guess what I'm talking  
25 about is to determine whether or not the bidder

Page 324

1 actually achieves its target discount or not.  
2 And, first of all, do you know without me  
3 referring you to anything?  
4 MS. JOSEPH: Objection to form.  
5 A I believe there's a section of the RFP  
6 that references the calculation.  
7 BY MR. HEWITT:  
8 Q Okay. Where is that?  
9 A There is the third-party administration  
10 performance guarantees. But, no, sorry those --  
11 that's not the section.  
12 Q Well, it may -- let me ask a question  
13 based on this exhibit.  
14 I've already handed you what's previously  
15 been marked as Deposition Exhibit 225, and I'll  
16 represent to you this is Blue Cross' attachment 8,  
17 which was its proposed guarantees in this RFP.  
18 Do you recognize this document?  
19 A I do, yes.  
20 Q Okay. So on the -- the pages aren't  
21 numbered, but it is, I guess, the third or fourth  
22 page. It's right after the table with the trend  
23 guarantees. It looks like this.  
24 A Yes. The big yellow --  
25 Q Big yellow square at the bottom?

Page 325

1 A Box, yes.  
2 Q The heading above the big yellow box is  
3 "Describe your proposed formula for determining the  
4 actual performance against expected or quoted  
5 pricing guarantees."  
6 Do you see that?  
7 A Yes, I do.  
8 Q Under the heading Discount Guarantee,  
9 there's language saying discount percent will be  
10 calculated as follows for each measurement year, and  
11 then it goes through 1 through 4.  
12 Do you see that?  
13 A Yes, I do.  
14 Q So that's where Blue Cross says in its RFP  
15 response how its discount percentage would be  
16 calculated; is that fair?  
17 A Yes. That is where they identify that.  
18 Q Okay. And I'm looking at Number 4 there.  
19 It's discount percentage equals total savings  
20 divided by the difference between billed charges and  
21 noneligible -- excuse me, divided by billed charges  
22 less noneligible charges; is that right?  
23 A Yes.  
24 Q And then going back up to bullet point 1,  
25 total savings is equal to billed charges less

Page 362

1 that exceeds the industry average. It also  
2 disregards the possibility that the Plan and UMR  
3 could have disputes over what the UHC  
4 book-of-business trend really was."  
5 Do you see that statement?  
6 A Yes, I do.  
7 Q Okay. What's your basis for thinking that  
8 disputes between the Plan and UMR are likely, are  
9 common, or that that type of dispute is common?  
10 A I don't believe that I said it was likely  
11 or common. I said that it -- and I'll quote my  
12 report for you: "It also disregards the possibility  
13 that the Plan and UMR could have disputes over what  
14 the UHC book-of-business trend really was."  
15 Q Okay. So you're not contending that  
16 that's actually likely, you're just saying that his  
17 opinion disregards that possibility, whatever that  
18 likelihood might be?  
19 A The report, and I'll quote it again for  
20 you, says, quote: "It also disregards the  
21 possibility that the Plan and UMR could have  
22 disputes over what the UHC book-of-business trend  
23 really was."  
24 Q I've asked the same question a couple of  
25 times. Are you actually contending that that is

Page 363

1 likely?  
2 MS. JOSEPH: Objection.  
3 A As I have indicated, the report identifies  
4 that it, quote: "Disregards the possibility that  
5 the Plan and UMR could have disputes over what the  
6 UHC book-of-business trend really was. I'm not  
7 opining on the likelihood or the unlikelihood that  
8 that's going to occur. It's a possibility."  
9 BY MR. HEWITT:  
10 Q Thank you.  
11 I want to ask about your Opinion 4 now,  
12 which is going back to your original report,  
13 Exhibit 417, I think, that is -- starts on page 45.  
14 What experience do you have working with  
15 UDS data?  
16 A I have not previously worked with UDS data  
17 personally.  
18 Q Has anybody on your team?  
19 A No. We are not licensees of the UDS data.  
20 That is, in my understanding, reserved for actuarial  
21 firms.  
22 Q And none of you guys are actuaries. I  
23 think we covered that earlier; is that right?  
24 A Yes, we did cover that.  
25 Q Are any of your team actuaries?

Page 364

1 A No.  
2 Q And your report on page 45 has a  
3 description in here of what UDS data is. I'm  
4 looking at the second paragraph under the heading  
5 for Opinion 4. Do you see that paragraph?  
6 A Yes, I do.  
7 Q And there's a description here about what  
8 UDS data is and where it comes from and what it's  
9 used for, and it cites to footnote 132, which is the  
10 Milliman white paper. Do you see that?  
11 A Yes, I do.  
12 Q Do you have any other basis for what's in  
13 that paragraph?  
14 MS. JOSEPH: Objection to form.  
15 A No. The Milliman white paper describes  
16 it. I've heard of the UDS data in the course of my  
17 work as well.  
18 BY MR. HEWITT:  
19 Q Okay. But you've not worked with it  
20 before?  
21 A That's correct, I have not worked with it.  
22 Q So Steve Kuhn, on behalf of Segal,  
23 testified why he generally does not use UDS data to  
24 compare or assess discounts for claims repricing,  
25 didn't he?

Page 365

1 A I don't recollect what his testimony was  
2 on that.  
3 Q I'm sorry. Say that again.  
4 The realtime says your answer was, "I  
5 don't recollect what his testimony was on that."  
6 Is that what you said?  
7 A Yes.  
8 Q Okay. Let me have you look in  
9 Exhibit 424, which was his deposition transcript.  
10 So pages 2 -- starting on page 286, please.  
11 Starting on page 286, line 12 where he says, "I  
12 typically don't use UDS for state bids, especially  
13 ones the size of the State Health Plan; and in this  
14 situation the data, as I mentioned earlier today,  
15 the data is really dated. It's roughly -- you know,  
16 it's over 12 months old in a market where bidders  
17 are making efforts to improve their discounts, it  
18 becomes even more dated; in a situation where we're  
19 asking for letters of intent, it becomes even more  
20 dated. So it's also based off of ZIP codes of the  
21 participants and not their actual utilization.  
22 "When you talk about a health plan the  
23 size of the state, it's better to actually use  
24 utilization. Like their utilization, not  
25 assumptions of utilization."

Page 366

1 Have you seen that testimony before?  
2 A Yes, I have.  
3 Q All right. And so Mr. Kuhn explained the  
4 reasoning for why Segal didn't use or doesn't  
5 generally use UDS to score or assess discounts; is  
6 that fair?  
7 A He has described what his opinion is with  
8 respect to the UDS data.  
9 Q Okay. Do you disagree with that opinion?  
10 A I disagree with this opinion for a few  
11 reasons. First, Segal, in its proposal to the State  
12 Health Plan, identified that it had access to the  
13 UDS data and that it had relied upon the UDS data in  
14 evaluating repricing exercises. And so that is an  
15 indication that Segal has done the work and they  
16 were informing the State Health Plan that it was a  
17 reason -- a benefit to the State Health Plan to go  
18 with Segal as the actuarial firm.  
19 Furthermore, I disagree with this opinion  
20 because while I understand that benchmarking data  
21 may be dated, benchmarking data is something that is  
22 routinely used in the industry when repricing  
23 exercises are being evaluated. It's something that  
24 I do on a regular basis to seek additional data to  
25 validate the repricing exercise. It's not just

Page 367

1 something that I do. It's something that other  
2 individuals in the marketplace, other consultants,  
3 other experts are doing as well.  
4 Q What is your experience evaluating claims  
5 repricing -- correct me if I'm wrong, but we covered  
6 earlier in the day that you have never done a claims  
7 repricing or evaluated a claims repricing that was  
8 part of the submission for an RFP?  
9 A For the purposes of submitting an RFP,  
10 that is correct. However, I have done claims  
11 repricing exercises on many occasions as I  
12 described.  
13 Q Yeah. And a lot of those were in  
14 connection with litigation matters like disputes  
15 between healthcare plans and -- let me back up a  
16 step.  
17 A lot of those were in the context of  
18 disputes between, for example, providers and  
19 healthcare plans, right?  
20 MS. JOSEPH: Objection.  
21 A Some of that experience does involve  
22 disputes between providers and healthcare plans.  
23 Some of the work is also strategic work that I have  
24 done for health insurance companies as they're  
25 evaluating the reimbursement rates that they pay in

Page 368

1 a geographic marketplace.  
2 BY MR. HEWITT:  
3 Q And as far as how healthcare plans assess  
4 claims repricings in the context of an RFP for a  
5 large state health plan like the state of North  
6 Carolina, you haven't done that yourself; is that  
7 fair?  
8 A I haven't specifically done that, but I  
9 have done repricing exercises for large healthcare  
10 plans.  
11 Q Isn't it true that in Mr. Vieira's report,  
12 he stated that UDS data can have a plus or minus  
13 2 percent discount quarter because of differences in  
14 the actual mix of providers and services? Do you  
15 remember that?  
16 A Mr. Vieira does indicate that in his  
17 report.  
18 Q Isn't it true in Mr. Vieira's report he  
19 stated that UDS data can have a plus or minus  
20 2 percent discount quarter because of differences in  
21 the actual mix of providers and services?  
22 Do you remember that?  
23 A Mr. Vieira does indicate that in his  
24 report.  
25 Q Okay. Do you have a reason to disagree

Page 369

1 with that?  
2 A I have not studied whether the UDS data  
3 has a plus or minus 2 percent range. I know that  
4 that is quoted in the Milliman study. And  
5 Mr. Vieira, I think, relies upon the Milliman study,  
6 if I recollect correctly.  
7 The data -- the UDS data, though, can  
8 still be informative as to the exercise.  
9 Q Okay. But if you'll recall -- would you  
10 agree with me that the UDS comparison that was  
11 discussed verbally with Steve Kuhn in this  
12 evaluation showed a 1.1 percentage point difference  
13 between Aetna's and Blue Cross' discounts?  
14 A Yes, I do agree with that.  
15 Q And that's well below the 2 percentage  
16 point variance in UDS data?  
17 A Yes, it is below the 2 percent variation  
18 that was identified by Mr. Vieira. I'm surprised  
19 that Segal would have identified in its proposal to  
20 the State Health Plan that it had access to the UDS  
21 data for the purposes of evaluating repricing  
22 exercises if the data had these issues that  
23 Mr. Vieira has identified.  
24 Q Well, whether or not you might be  
25 surprised by that, would you agree with me that the

<p style="text-align: right;">Page 370</p> <p>1 RFP didn't say that the network pricing scoring 2 would be based on UDS data? 3 A The network pricing scoring does not 4 indicate that it would be based on UDS data. What 5 is reasonable in the marketplace and what I see in 6 the marketplace when repricing exercises are done is 7 that one seeks additional data, external data to 8 validate what one is doing. 9 Q Are you -- in your opinion is there any 10 requirement that Segal had to rely on UDS data for 11 the claims repricing exercise in this RFP? 12 A I don't see a requirement in the RFP that 13 the UDS data be used, but I think that it would be 14 reasonable to look to external data to validate the 15 repricing exercise, especially in light of the 16 adjustment of Blue Cross' discount percentage. 17 Q Let me ask you some questions about your 18 Opinion Number 5, please, as to the Plan's -- starts 19 on page 48 of your report about the Plan's not 20 comparing the vendors' network of providers. 21 Starting on page 49 there, middle 22 paragraph, the paragraph begins with the words "As 23 Segal's 2018 presentation to the Plan stated." 24 Do you see that paragraph? 25 A Yes, I do.</p>	<p style="text-align: right;">Page 372</p> <p>1 A I am familiar -- I have familiarity with 2 the Medicare Advantage requirements, and I have 3 assessed those for health plans before. Medicaid 4 managed care plans are regulated -- or not 5 regulated. They have network adequacy rules that 6 are state specific, and so there's not a single set 7 of network adequacy rules with which I can be 8 familiar. 9 I have some familiarity with some of the 10 states, but I don't have familiarity with all 51, I 11 think it is, different Medicaid agencies because 12 each state has a Medicaid agency, and then DC has a 13 Medicaid agency. 14 Q At the federal level, though, Medicaid 15 managed plans -- excuse me. At the federal level, 16 states are required to establish network adequacy 17 standards for Medicaid managed care plans, though, 18 aren't they? 19 A I don't know if that's a requirement at 20 the federal level or not. 21 Q All right. Well, with respect -- let's 22 just -- since you're familiar with the Medicare 23 Advantage requirements, you know that's a matter 24 that's regulated under federal regulations, right? 25 A I believe it's regulated under federal</p>
<p style="text-align: right;">Page 371</p> <p>1 Q About three lines down into that 2 paragraph, there's a statement or a sentence that 3 reads: "Health plans like Medicare Advantage plans, 4 Medicaid managed care plans, and Individual plans 5 purchased on federal or state health insurance 6 exchanges, may be required to demonstrate a certain 7 level of access for members based on this formula," 8 and it then continues with a parenthetical. 9 Do you see that sentence? 10 A Yes, I do. 11 Q So why did you cite to Medicare Advantage 12 and Medicaid plans, Medicaid managed care plans? 13 A Network adequacy is something in the 14 healthcare marketplace that we have been more 15 recently measuring, and state and federal 16 governmental entities have incorporated the 17 requirements into some of their programs. And so 18 I've identified some of the examples that 19 incorporate those requirements, Medicare Advantage 20 plans, Medicaid managed plans, as well as Individual 21 plans that are purchased on the exchange. 22 Q All right. Are you familiar with the 23 network adequacy requirements for Medicare Advantage 24 and Medicaid managed plans under the Code of Federal 25 Regulations?</p>	<p style="text-align: right;">Page 373</p> <p>1 regulations. 2 Q And those don't apply to the North 3 Carolina State Health Plan, do they? 4 A No, they don't. 5 Q Okay. And similarly with Medicaid managed 6 care plans, whatever network adequacy requirements 7 there may be, those don't relate or apply to the 8 North Carolina State Health Plan, do they? 9 A No, they do not. 10 Q Is there any regulation that does apply to 11 the North Carolina State Health Plan that requires 12 any particular level of network adequacy? 13 A Not of which I am aware; however, there is 14 the language in the RFP which indicates that the RFP 15 seeks to establish a broad network with the least 16 disruption and with competitive pricing. 17 Q But you would agree that Section 3.4 of 18 the RFP that discusses how the RFP cost proposals 19 will be scored doesn't say anything about being 20 scored on the basis of any comparison of networks or 21 disruption, does it? 22 A No, it does not indicate that there will 23 be an evaluation of the -- or there will be scoring 24 based on the network; however, the RFP does indicate 25 that the Plan seeks to have a broad provider network</p>

Page 374

1 with the least disruption and with competitive  
2 pricing.  
3 Q Is that the most specific language there  
4 is in the RFP to your knowledge that would support  
5 the idea that network adequacy or disruption should  
6 have been compared?  
7 A Yes.  
8 Q Your report --  
9 A I'm sorry. We've been going for about an  
10 hour. And I'm getting a little hungry. So...  
11 MS. JOSEPH: Let's pause and talk about  
12 scheduling.  
13 MR. HEWITT: Go off the record.  
14 MS. JOSEPH: Not quite yet. We've been on  
15 the record with breaks about ten hours. Where  
16 are we headed now? Because we started around  
17 9:00. It's about 7:00 now. So not excluding  
18 breaks, we're coming up on ten hours of all  
19 being together. So what's the thinking on --  
20 MR. HEWITT: I'm trying to get to the end  
21 here. I'm trying to move quickly and get to  
22 the end of his opinion. And Opinion 5 is the  
23 last one that I'm going to cover.  
24 THE WITNESS: I think I'm trying to assess  
25 whether I should have a snack or have dinner.

Page 375

1 MR. HEWITT: My preference would be a  
2 snack.  
3 MS. JOSEPH: We can go off the record.  
4 His preference is to know how long this is --  
5 sorry, go ahead.  
6 THE VIDEOGRAPHER: The time is 7:01.  
7 We're now off the record.  
8 (A recess taken from 7:01 p.m. to  
9 7:17 p.m.)  
10 THE VIDEOGRAPHER: The time is 7:17 p.m.  
11 We're on the record.  
12 MR. HEWITT: Thank you.  
13 BY MR. HEWITT:  
14 Q Mr. Russo, in page -- in your report, page  
15 50, I believe, at the very bottom of the page  
16 there's a reference to Caroline Smart, who is one of  
17 the State Health Plan's leadership, stating "I don't  
18 believe we need a minimum on [network access]. If  
19 they have access problems, it should show up in the  
20 pricing in those areas."  
21 Do you see that?  
22 A Yes, I do.  
23 Q So that -- to your understanding were you  
24 citing that as the Plan's justification or reasoning  
25 for not scoring disruption or network access?

Page 376

1 A Yes, that as well as Segal's indication or  
2 questioning the process to evaluate the networks.  
3 Q When you say Segal's "questioning the  
4 process to evaluate the networks," what do you mean?  
5 A I mean the other reference that's in that  
6 paragraph. Segal's Kuhn asked did you want to make,  
7 quote, network access a minimum qualification, for  
8 example, bidders must offer at least X percent over  
9 all network access, and then the Plan's Caroline  
10 Smart responds to that.  
11 Q And what I just read into the record from  
12 her quote was her response to that question?  
13 A That was the response to the question that  
14 I read.  
15 Q Let me give you what we previously marked  
16 as Deposition Exhibit Number 87. If you would take  
17 a second and see if you recognize that document.  
18 (Previously marked Exhibit Number 87 was  
19 identified.)  
20 A Okay.  
21 BY MR. HEWITT:  
22 Q Do you recognize that document?  
23 A I don't recollect as I sit here.  
24 Q Okay. Do you see that it's an email  
25 exchange from August of 2022 in which -- and I'm

Page 377

1 looking at the second page here Bates Number SHP  
2 92244 where Matt Rish is asking about things that  
3 the Plan may -- may or may not decide to score. And  
4 it's at the bottom of that page in the second black  
5 bullet where it says: "They can score components,"  
6 and then it lists five components below that.  
7 A Yes, it does.  
8 Q And then he responds further up the page,  
9 August 22, to a group of people saying: "Thoughts?"  
10 And the response on the front page of  
11 Exhibit 87 from Caroline Smart on the same day,  
12 August 22 was: "I'm all about simplicity. I still  
13 think there are just three primary areas.  
14 Disruption and geo access will show up in pricing."  
15 Do you see that?  
16 A Yes.  
17 Q Have you seen this email before?  
18 A I don't recollect having seen it before.  
19 Q So whether based on this email or based on  
20 your other information you have available to you,  
21 it's your understanding, isn't it, that the Plan's  
22 decision not to score geographic access and  
23 disruption was intentional?  
24 A It appears that they made that decision.  
25 Q Intentionally?

Page 378

1 A I -- I'm not going to opine on someone's  
2 intent. They made the decision.  
3 Q Okay. And the reasoning that was stated,  
4 at least in her email that I just showed you, is  
5 that disruption and geographic access would show up  
6 in pricing; is that fair?  
7 A That was what she indicated in her email.  
8 Q In your report, page 51, you talk about  
9 what Segal did. And I'm looking at page 51, second  
10 paragraph starts with the words "Segal's corporate  
11 representative testified."  
12 A Yes.  
13 Q Okay. And his testimony was about how  
14 Segal compared the percentages of in-network claims  
15 using data in the repricing exercise.  
16 Is that fair?  
17 A Yes, that was the indication.  
18 Q Okay. And then you say right after that,  
19 "For several reasons, however, those percentages  
20 were not a meaningful comparison of the vendors'  
21 provider networks and the real level of access those  
22 networks provide to members."  
23 A Yes, that's correct.  
24 Q So you don't cite to any authority for the  
25 proposition that those percentages aren't a

Page 379

1 meaningful comparison of vendors' provider networks.  
2 So is that just your opinion?  
3 A No, it's not just my opinion. It's the  
4 manner in which the healthcare marketplace works in  
5 evaluating networks. It needs to be done with  
6 respect to the geographies that are smaller than an  
7 overall state. So the evaluation that's being done  
8 here is being done at such a high level that it's  
9 masking what may exist as network issues in some  
10 areas of the state.  
11 Q Okay. So you think the comparison of  
12 in-network/out-of-network claims percentages was an  
13 inadequate measure of network access or disruption?  
14 A It was an inadequate measure when  
15 performed at the overall level and when not taking  
16 into account smaller geographic areas.  
17 Q Okay. Well, you don't cite to any  
18 particular authority other than just making that  
19 statement. And so what are you relying on when you  
20 say that?  
21 A I'm relying on the manner in which  
22 networks are assessed, and that is something that is  
23 done in the marketplace. There are a number of  
24 companies that assess markets. I've interacted with  
25 some of those companies. Clients of mine have hired

Page 380

1 some of those companies. I have assessed markets as  
2 well for clients and determined network adequacy and  
3 whether the -- whether the standards were met.  
4 And then furthermore, as I had indicated,  
5 the network adequacy standards that exist in the  
6 market for Medicare Advantage plans and Medicaid  
7 managed care plans are not done at the overall  
8 level. They're done with respect to smaller  
9 geographic regions and typically a mileage distance  
10 between a member or a beneficiary and a provider.  
11 Q Do any of those standards you're talking  
12 about apply to the North Carolina State Health Plan?  
13 A I don't know if they apply to the State  
14 Health Plan specifically, but I do know that the  
15 State Health Plan has indicated in the RFP that they  
16 intend to have a broad provider network with the  
17 least disruption and with competitive pricing, as  
18 well as indicating that the Plan intends to provide  
19 a cost-effective quality healthcare program for its  
20 membership. And to provide a quality cost-effective  
21 healthcare program, a vendor needs to have a network  
22 that can adequately serve its membership.  
23 Q Is there anything more specific in the  
24 language of the RFP than what you just pointed out  
25 that supports the idea that the Plan had to compare

Page 381

1 network access or disruption on a smaller geographic  
2 level?  
3 A No, I don't believe that there is, other  
4 language in the RFP that identifies the evaluation  
5 should have been at a smaller geographic level than  
6 the entire state.  
7 Q And have you ever done a comparison of  
8 provider networks like you did in this report? And  
9 I'm talking about Figures 23 through 27 other than  
10 in this engagement.  
11 A Yes, I have.  
12 Q For what purpose?  
13 A I evaluated networks for insurance  
14 companies as it related to their determination of  
15 contracting. And I have also evaluated networks in  
16 the context of litigation matters that have related  
17 to antitrust violations.  
18 Q But not in connection with comparing one  
19 bidder's network against another bidder in the  
20 context of an RFP, correct?  
21 A That is correct. Not in the context of  
22 the RFP -- not in the context of a RFP. In the  
23 context of just assessing the adequacy of a network.  
24 Q Okay. And some of those situations were  
25 those some that you have done this type of analysis,

<p style="text-align: right;">Page 382</p> <p>1 was that in situations where there were network 2 adequacy standards that plans were required to meet? 3 A In some cases, yes, there were. And in 4 other cases there was just the decision that was 5 being made as to the availability of providers to 6 serve the members of a Plan. 7 Q So what level of disruption is typical 8 when a State Health Plan changes TPAs? 9 A I don't have an opinion on that. 10 Q And let me show you Exhibit 413 again. 11 That was the Segal presentation that we've looked at 12 several times already in connection with other 13 opinions. Looks like this. 14 A Yes. 15 Q Let's turn to the pricing page, which is 16 page 5, Bates page 85916. Just let me know when 17 you're there. 18 A Yes, I'm there. 19 Q Okay. You're aware, aren't you, that -- 20 well, let me direct your attention in the top table 21 there, Non-Medicare Network Discounts and Relative 22 Values, second column from the right. The heading 23 the Assumed Network Utilization. 24 That's the comparison that Segal's 25 representative pointed to when talking about what</p>	<p style="text-align: right;">Page 384</p> <p>1 "And we sent it to bidders, and bidders 2 line by line said yes or no whether they were in 3 network -- or, actually, yes, no, or letter of 4 intent whether they were in network. 5 "So when you wrap -- you roll that up for 6 each of the bidders, you can determine whether -- 7 what percentage of claims would be in network under 8 the bidder and which percentage would be out of 9 network." 10 Do you see that language? 11 A Yes, but I'm still reading it. So if you 12 could give me a moment, please. 13 Okay. 14 Q All right. So that was his explanation of 15 how Segal used data from the claims repricing to 16 come up with this assumed network utilization 17 figure, correct? 18 A Yes, that's correct. 19 Q Okay. And that is a measure of 20 disruption, isn't it? 21 A It is a measure of disruption. It is an 22 inappropriate measure of disruption, but it is a 23 measure of disruption. 24 Q And according to their calculations' 25 baseline based on the experience period was that</p>
<p style="text-align: right;">Page 383</p> <p>1 the Plan did to compare disruption, correct? 2 A Yes. 3 Q Do you recall that in his deposition he 4 testified that providers had to respond to a claims 5 repricing file for the network pricing part of the 6 cost proposal and they had to indicate line by line 7 whether a certain claim was in network or out of 8 network and that using that data, that it could be 9 determined what percentage of claims was in network 10 or out of network for each bidder? 11 A I'm going to ask that you read your 12 question back because I think you've misstated 13 something. 14 Q Well, let me just have you look at his 15 deposition transcript so I don't mess up the 16 transcript. And this is Deposition Exhibit 17 Number 424 starting on page 119. Should be toward 18 the front. 19 Starting on Bates page 119, line 13, he 20 testified: 21 "I believe the experience period was 22 2021" -- and I'm skipping down a line or two -- 23 "Calendar Year 2021. And that would have all 24 providers used by the state membership during that 25 period.</p>	<p style="text-align: right;">Page 385</p> <p>1 99 percent of the claims during the 2021 calendar 2 year were in network, right? 3 A Yes, that is correct. 4 Q And under Blue Cross' claims repricing, 5 Blue Cross claims would have been 99.4 percent in 6 network, right? 7 A Yes, that is correct. 8 Q And compared with Aetna's claims repricing 9 which showed that 99.0 percent of claims would be in 10 network, right? 11 A Yes, that's correct. 12 Q So based on that, Aetna's in-network 13 claims were only 0.4 percent different compared with 14 Blue Cross'; is that right? 15 A Yes, that's correct. 16 Q And Aetna's were about the same as the 17 baseline experience period, right? 18 A That's correct, yes, based on this overall 19 statewide analysis. 20 Q Yes. And the difference between Aetna and 21 Blue Cross of 0.4 percent, that works out to be four 22 claims out of every thousand claims; is that 23 correct? 24 A Yes, I think. 25 Q 0.4 percent, four-tenths of 1 percent</p>

<p style="text-align: right;">Page 386</p> <p>1 would be four claims out of a thousand? 2 A I'm not doing math on the record. If you 3 represent you've done it correctly, then I'll agree 4 with you. 5 Q Have you seen Mr. Vieira's report on this 6 subject? And we can look, if you'd like. It's on 7 pages 36 and 37 of his report. 8 So on page -- right below the middle table 9 on page 37 of Mr. Vieira's report, Deposition 10 Exhibit 4- -- 11 A -- -19. 12 Q Thank you. 13 A You're welcome. 14 Q This paragraph begins with the words "This 15 means that Aetna." 16 Do you see that paragraph? 17 A Yes, I do see. 18 Q All right. So in the middle of that 19 paragraph, starting with the third sentence, he 20 says: "All three network disruption scores are 21 excellent, and for a non-incumbent, would imply the 22 disruption was not an issue for these networks." 23 Do you see that sentence? 24 A I do, yes. 25 Q And he also says: "Putting more weight on</p>	<p style="text-align: right;">Page 388</p> <p>1 disruption. 2 Q Let me have you look at the Milliman White 3 Paper that we've looked at a couple of times. If 4 you could put your hands on it. 5 Do you have a copy of it? 6 A Yes, I do. 7 Q That's Deposition Exhibit 418. Can you 8 turn to page 4, please? And there's a heading. Are 9 you already there? Okay. 10 There's a heading in the right-hand 11 column, "Should provider disruption be included in a 12 repricing analysis." 13 Do you see that? 14 A Yes, I do. 15 Q So you would agree that the Milliman paper 16 says the disruption can be done as an independent 17 analysis or it can be done as part of a repricing, 18 right? 19 A Yes. The Milliman paper also identifies 20 that provider tax ID, name, and ZIP code are needed 21 in the historical data to complete a disruption. 22 And what is implied there is that the analysis is 23 going to be done at a level that is not a statewide 24 level, otherwise there would be no reason for 25 requesting a ZIP code if one intends to just do the</p>
<p style="text-align: right;">Page 387</p> <p>1 the network provides a significant advantage for the 2 incumbent since data is based on their current 3 network," right? 4 A Yes, I do see that sentence. 5 Q I'm going to also read the next sentence 6 in, and then I'll ask a few questions. 7 The next sentence says: "The fact that 8 Aetna only has 1 percent of claims with providers 9 not in their network is outstanding and would really 10 be considered almost no disruption during a large 11 procurement like this." 12 And so with all three of those sentences, 13 do you disagree with his opinions that he stated? 14 A I don't necessarily disagree with the 15 opinions that he's stating there. The opinion that 16 I have offered in Opinion 5 is that the Plan did not 17 compare the vendors' network even though it had the 18 data to do so. And the valuation that was done 19 using the projected claims cost is done at the 20 statewide level, which is an inappropriate level to 21 conduct the exercise. 22 Q Would you agree, in general, that some 23 disruption is to be expected any time a State Health 24 Plan changes TPAs? 25 A I would expect that there would be some</p>	<p style="text-align: right;">Page 389</p> <p>1 analysis at the statewide level. 2 Q You said there's no other possible reason 3 that a provider ID, name, and ZIP code could be 4 needed unless it's to do a smaller geographic 5 disruption analysis; is that right? Did I 6 understand you correctly? 7 A Yes, that's correct. And that fits with 8 what the industry standard is in evaluating network 9 adequacy. 10 Q Do you see that there are benefits to 11 doing disruption as part of a repricing that are 12 mentioned right there below that same sentence, that 13 "Disruption is part of a repricing, reflects network 14 size, and incorporates total discount into the 15 repricing"? 16 A Yes, I do see that. That is identified 17 after the sentence that identifies that a ZIP code 18 is needed in the historical data to complete a 19 disruption. 20 Q Okay. And is there anything in your 21 experience or the Milliman -- well, strike that. 22 Do you see also, in the next paragraph 23 down, the paragraph starts with the words "Employers 24 are concerned"? 25 Do you see that paragraph?</p>

Page 390

1 A Yes, I do.  
2 Q Last sentence of that paragraph reads:  
3 "It is reasonable to expect some improvement in the  
4 alternative network penetration rate if the group  
5 makes a switch depending on the benefit design and  
6 the alternative carrier's network offering."  
7 Do you see that?  
8 A Yes, I do.  
9 Q Do you understand that to mean that when a  
10 Plan changes TPAs, that there would be an incentive  
11 or a tendency for the network penetration rate to  
12 increase for that particular TPA?  
13 A I think the network penetration could  
14 increase. I think that it depends on the scenario  
15 and the differences between the incumbent's network  
16 and the now new TPA's network.  
17 Q Network penetration rate, that's -- what?  
18 -- the number of providers in the marketplace that  
19 are part of the TPA's network?  
20 A Yes.  
21 Q Would you agree that if the Plan in this  
22 context, if the North Carolina State Health Plan  
23 awarded the contract to Aetna, there would be an  
24 incentive for providers that may not currently be  
25 part of Aetna's network to join Aetna's network?

Page 391

1 A There may be an incentive.  
2 Q I guess there may be an incentive if those  
3 providers treat patients or want to treat patients  
4 who are North Carolina State Health Plan members; is  
5 that fair?  
6 A Yes, it's fair.  
7 Q So whatever difference there may be in the  
8 percentage of in-network claims between Aetna and  
9 Blue Cross at the time that the cost proposals were  
10 analyzed, there would be a tendency for that  
11 difference to decrease after Aetna is awarded the  
12 contract; isn't that right?  
13 A I don't know that there's a tendency to.  
14 I think that this white paper says it's reasonable  
15 to expect some improvements, but I think there are a  
16 lot of variables that come into play as to whether  
17 there would be improvements in this scenario.  
18 Q On pages 52 and 53 of -- just make sure I  
19 didn't skip over it. I know I asked the question in  
20 the context of whether there were any regulations  
21 that required North Carolina State Health Plan to  
22 compare or score network access or disruption.  
23 Other than any such regulations, are you  
24 aware of any other requirement, whether statute,  
25 rule, regulation, or otherwise, that would have

Page 392

1 required the State Health Plan to compare or score  
2 on the basis of disruption or network adequacy? I'm  
3 sorry, network access.  
4 A The RFP's language to operate a  
5 cost-effective, quality healthcare program, in my  
6 opinion, requires the evaluation of the networks and  
7 an evaluation of the networks at a more granular  
8 level than the evaluation was done, which was at the  
9 state level.  
10 The reason being is that the evaluation  
11 that's done across the state can mask potential  
12 issues in the networks that may exist in suburban  
13 and rural areas of the state.  
14 Q And what language from the RFP is that?  
15 A "The Plan intends to be a leader in North  
16 Carolina known for providing cost-effective, quality  
17 healthcare programs for its membership."  
18 Q Anything else?  
19 A No.  
20 Yes, actually. It goes on to stay: "The  
21 Plan's focus will continue to be on the key  
22 principles of transparent pricing, high quality care  
23 and service, and effective vendor partnerships."  
24 Q Anything else?  
25 A No, not at this time.

Page 393

1 Q On pages 52 and 53, you discuss how you  
2 took the data that was in the claims repricing  
3 exercise and came up with an analysis of -- or a  
4 comparison, I guess, of the number of providers in  
5 Blue Cross' network versus Aetna's; is that fair?  
6 A Yes, that is a fair characterization of  
7 the description on 52 and 53.  
8 Q On page 53, one of the things that you say  
9 is that you use the NPI taxonomy to normalize  
10 provider-type definitions.  
11 Did Attachment A-2 from each of the  
12 bidders include each provider's NPI?  
13 A Yes, I believe it does include the NPI.  
14 Q Okay. And so how did you go through --  
15 how did you code each individual provider based on  
16 that taxonomy? Did you just automate it, match up  
17 NPI numbers with the -- whatever category they were  
18 assigned to under the NPI taxonomy?  
19 A No. So the N- -- first, "NPI" stands for  
20 National Provider Identifier, and it is a 10-digit  
21 ID number that healthcare providers in the United  
22 States have to apply to the federal government and  
23 get. It is a common number that is used across  
24 federal healthcare programs, state healthcare  
25 programs, as well as commercial insurers in

<p style="text-align: right;">Page 394</p> <p>1 contracting with providers, as well as reimbursing 2 for providers. 3 The federal government maintains the NPI 4 data, and that data is publicly available. For each 5 individual provider's NPI, there is information that 6 the federal government publishes about that 7 provider. They publish their name, their address. 8 They also publish the taxonomy code that that 9 provider has identified that -- and the taxonomy 10 code identifies the type of provider that it is. 11 Q And -- 12 A I'm sorry, I'm not quite done. You asked 13 the process. 14 And so in conducting the analysis using 15 the data that was in A-2, I was able to contact the 16 NPIs in A-2 to the NPIs that exist in the National 17 Provider Identifier Directory to identify the 18 taxonomies, and specifically the primary taxonomies, 19 that are attributed to each of the providers. 20 Q Okay. I think that's what I asked. But I 21 appreciate the thorough answer. 22 The analysis that you did, it says on page 23 53 that you focused on core provider types. What 24 are core provider types? Is that your decision on 25 what was a core provider type, or is that something</p>	<p style="text-align: right;">Page 396</p> <p>1 analysis where you're comparing the number of 2 providers in each of the respective networks, the 3 overall average numbers that you came up with were, 4 for Blue Cross, 2006 providers, of these core 5 providers, correct? 6 A That's correct. 2006 is the average 7 number of providers within the radius of the members 8 as specified in Attachment A-2. 9 Q And that is compared with a total overall 10 average for Aetna of 1,984, right? 11 A Yes, that is correct. 12 Q Okay. I will represent to you that I 13 compared those two numbers, and that is a difference 14 of 1.1 percent in your analysis. I know you don't 15 like to do calculations on the fly, but does that 16 look about right to you? 17 A It looks about right. 18 Q And Figure 25, can you explain what the 19 purpose of this calculation was? 20 A The purpose of this calculation is to 21 identify the impact on the members by county, and 22 specifically that impact is the claims that would be 23 out of network if the winning vendor were Blue Cross 24 or the winning vendor were Aetna. And so I used the 25 repricing data to identify each of the</p>
<p style="text-align: right;">Page 395</p> <p>1 that the NPI taxonomy includes? 2 A It is not something that I decided, nor 3 was it something that the NPI directory provides. I 4 used the information in Attachment A-2 as to the 5 identification of the core provider types. You'll 6 see the figure 22 of my report on page 50 has an 7 excerpt of Attachment A-2. And those provider types 8 that are listed there were defined by the Plan and 9 Segal. So those are the provider types that I have 10 used in the analysis. 11 Now, I did need to go about defining those 12 provider types in the NPI directory because there is 13 not a common definition of some of those provider 14 types. For instance, "general surgeon" is not a 15 provider type in the NPI directory. And it's not a 16 provider type that individuals in the healthcare 17 marketplace also reference. There are many types of 18 surgeons, and general surgeon is not one of them. 19 And so I went through and identified the 20 provider types, the provider taxonomy codes in the 21 NPI directory that matched to those core provider 22 types. This information has been provided in the 23 supporting materials that I have produced and that 24 support this opinion. 25 Q On the bottom of Figure 24 in your</p>	<p style="text-align: right;">Page 397</p> <p>1 out-of-network claims in each county and then 2 summarized the number of claims as well as the 3 estimated member paid amount. 4 Now, what I provide here in Figure 25 is 5 the top 10 counties -- sorry, the 10 counties where 6 Blue Cross has the lowest estimated amounts paid out 7 of pocket by members compared to Aetna. However, 8 within the supporting materials that I have provided 9 to my report, the full list of counties is included, 10 and that's in -- on page appendix C28. 11 Q But in your table here, the total line at 12 the bottom, that includes all 100 counties, doesn't 13 it? 14 A That's correct. It includes all 100 15 counties, but the data is reported by county on 16 page C28 through C30. 17 Q And your conclusion here was that there 18 was a difference <b>REDACTED</b> out-of-network 19 claims based on Aetna's network than there would be 20 based on Blue Cross' network, right? 21 A Yes, that is correct, and that the members 22 would have an estimated paid amount that would 23 <b>REDACTED</b>, and that does not 24 take into account the additional cost that would be 25 borne by the Plan for the out-of-network claims.</p>

Page 410

1 STATE OF NORTH CAROLINA )  
 2 COUNTY OF FORSYTH )  
 3 REPORTER'S CERTIFICATE  
 4 I, Audra Smith, Registered Professional Reporter  
 5 in and for the above county and state, do hereby certify that  
 6 the deposition of the person hereinbefore named was taken  
 7 before me at the time and place hereinbefore set forth; that  
 8 the witness was by me first duly sworn to testify to the  
 9 truth, the whole truth and nothing but the truth; that  
 10 thereupon the foregoing questions were asked and the foregoing  
 11 answers made by the witness which were duly recorded by me by  
 12 means of stenotype; which is reduced to written form under my  
 13 direction and supervision, and that this is, to the best of my  
 14 knowledge and belief, a true and correct transcript.  
 15 I further certify that I am neither of counsel to  
 16 either party nor interested in the events of this case.  
 17 IN WITNESS WHEREOF, I have hereto set my hand this  
 18 3rd day of December 2023.  
 19 Audr   
 20 \_\_\_\_\_  
 21 Audra Smith, RPR, FCRR  
 22 Notary Number: 201329000033  
 23 Commission Expires: June 26, 2025  
 24  
 25

Page 411

1 Gregory Russo  
 2  
 3 December 4, 2023  
 4 RE: Blue Cross And Blue Shield Of North Carolina v. North  
 Carolina State Health Plan For Teachers And State Employees  
 5 11/28/2023, CONF/AEO Gregory Russo (#6305930)  
 6 The above-referenced transcript is available for  
 7 review.  
 8 Within the applicable timeframe, the witness should  
 9 read the testimony to verify its accuracy. If there are  
 10 any changes, the witness should note those with the  
 11 reason, on the attached Errata Sheet.  
 12 The witness should sign the Acknowledgment of  
 13 Deponent and Errata and return to the deposing attorney.  
 14 Copies should be sent to all counsel, and to Veritext at  
 15 LITSUP-GA@VERITEXT.COM  
 16  
 17 Return completed errata within 30 days from  
 18 receipt of testimony.  
 19 If the witness fails to do so within the time  
 20 allotted, the transcript may be used as if signed.  
 21  
 22 Yours,  
 23 Veritext Legal Solutions  
 24  
 25

Page 412

1 Blue Cross And Blue Shield Of North Carolina v. North Carolina  
 State Health Plan For Teachers And State Employees  
 2 CONF/AEO Gregory Russo (#6305930)  
 3 E R R A T A S H E E T  
 4 PAGE \_\_\_ LINE \_\_\_ CHANGE \_\_\_\_\_  
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 6 REASON \_\_\_\_\_  
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 23 \_\_\_\_\_  
 24 CONF/AEO Gregory Russo Date  
 25

Page 413

1 Blue Cross And Blue Shield Of North Carolina v. North Carolina  
 State Health Plan For Teachers And State Employees  
 2 CONF/AEO Gregory Russo (#6305930)  
 3 ACKNOWLEDGEMENT OF DEPONENT  
 4 I, CONF/AEO Gregory Russo, do hereby declare that I  
 5 have read the foregoing transcript, I have made any  
 6 corrections, additions, or changes I deemed necessary as  
 7 noted above to be appended hereto, and that the same is  
 8 a true, correct and complete transcript of the testimony  
 9 given by me.  
 10 \_\_\_\_\_  
 11 \_\_\_\_\_  
 12 CONF/AEO Gregory Russo Date  
 13 \*If notary is required  
 14 SUBSCRIBED AND SWORN TO BEFORE ME THIS  
 15 \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_.  
 16  
 17  
 18 \_\_\_\_\_  
 19 NOTARY PUBLIC  
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