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January 12, 2023

Hand-Delivered

Mr. Sam Watts
Acting Executive Administrator
North Carolina State Health Plan for Teachers and State Employees
3200 Atlantic Avenue
Raleigh, North Carolina 27604

Re: Blue Cross Blue Shield of North Carolina's Request for Protest Meeting on Request for Proposal #270-20220830TPAS

Dear Mr. Watts:

Blue Cross Blue Shield of North Carolina (Blue Cross NC) requests a protest meeting on, and reconsideration of, the North Carolina State Health Plan for Teachers and State Employees' (the Plan's) decision to award the 2025-2027 contract for third-party administrative services to Aetna.

Blue Cross NC makes this request under section 15 of Attachment B of RFP #270-20220830TPAS. The Plan's contract for third-party administrative services was awarded no earlier than December 14, 2022. This request for a protest meeting is submitted within 30 calendar days of December 14 and is therefore timely.

This request is based on the limited information now available to Blue Cross NC. To seek transparency on the Plan's decision-making process, Blue Cross NC has submitted two requests under North Carolina's Public Records Act, N.C. Gen. Stat. § 132-6, for documents related to the 2022 RFP. Those requests were submitted on December 15 and December 20, 2022. To date, Blue Cross NC has not received any records or any timeline for their production. Blue Cross NC therefore reserves all rights, remedies, and arguments related to the Plan's award.

An executive summary and the substance of the protest follow below.

EXECUTIVE SUMMARY

- The Plan's 2022 RFP relied on arbitrary criteria and a distorted scoring system.

- The scoring system assigned no points to the strength, depth, and breadth of each bidder's provider network. Those networks play a pivotal role in North Carolinians' access to high-quality health care.

- The RFP also did not analyze the disruption that a change in network would cause to Plan members, such as the need to change providers, the need to adjust to different approaches to reviewing claims, and the need to request new prior authorizations for certain treatments. This lack of analysis contradicted the RFP's stated objective of selecting a vendor with a broad network with the least disruption.

- The Plan's scoring of cost proposals used vague standards—standards that appear to have been dispositive.

- The RFP scored technical proposals based only on answers to 310 yes-or-no questions. Even though the subjects of the 310 questions varied significantly in impact to Plan members, all 310 answers received the exact same weight.

- The Plan refused to allow *any* narrative explanation of any vendor's technical capabilities. Thus, the Plan lacks information on Aetna's detailed capabilities on those requirements.

- The scoring system in the 2022 RFP differs dramatically from the Plan's 2019 RFP. For example, the 2019 RFP scored cost proposals on a 10,000-point scale; the 2022 RFP scored cost proposals on a 10-point scale.

- The change in the scoring system in the 2022 RFP had a pivotal impact. Had Blue Cross NC been awarded just one more point for its cost proposal, it would have won the bid.

- Blue Cross NC confirmed 303 of the RFP's 310 technical requirements. At a post-award meeting, the Plan told Blue Cross NC that it lost the bid because of the seven non-confirmed requirements. If the Plan had allowed Blue Cross NC to explain why it did not confirm those requirements, the Plan would have seen that those explanations enhanced the strength and credibility of Blue Cross NC's proposal. The Plan instead penalized Blue Cross NC for the careful nature of its responses. The RFP's ban on explanations also limited the Plan's ability to evaluate other vendors' confirmed responses.

BACKGROUND

1. The 2022 RFP

The Plan provides health care coverage to hundreds of thousands of teachers, state employees, retirees, and their dependents.

Blue Cross NC is a fully taxed, not-for-profit North Carolina insurance company with a mission to support health care in North Carolina. It has major operation centers in Durham and Winston-Salem, and it employs nearly 5,000 North Carolinians.

On August 30, 2022, the Plan issued the 2022 RFP, seeking a vendor to manage its health plan by assembling a network of providers, negotiating discounts with those providers, processing claims, and administering other services. A copy of the 2022 RFP is attached to this letter as Exhibit 1. The RFP set a deadline of September 26, 2022, for vendors to submit responses to certain minimum requirements.

Three vendors met those minimum requirements and were allowed to move on to the next phase of the RFP: Blue Cross NC, Aetna, and United Healthcare. Each of these vendors then submitted a proposal on November 7, 2022, responding to questions on costs and technical requirements. Blue Cross NC's response to these technical requirements is attached as Exhibit 2.

The 2022 RFP process evaluated each vendor's proposal on two main criteria: (1) a cost proposal and (2) responses to 310 technical questions. The RFP stated that each vendor's final score would be divided equally between these two elements. *See* 2022 RFP § 3.4(a).

Cost proposals were scored on a 10-point scale, with three different cost categories evaluated: network pricing (with six available points), administrative fees (with two available points), and a network-pricing guarantee (with two available points):

- The network-pricing element involved the "repricing" of a set of claims data that the Plan provided to each vendor. Each vendor was asked to state what the total cost of the identified claims would be based on the vendor's negotiated prices. According to the RFP, the proposal that reflected the lowest network pricing would receive a full six points for this category, as would any proposal within 0.5% of the lowest-priced vendor. Other vendors would receive fewer points depending on how close their proposal was to the lowest-priced vendor.

- The administrative-fees element evaluated the administrative fees that each vendor proposed to charge the Plan for its third-party administrative services. The lowest-cost proposal would receive the full two points available for this category. The remaining proposals would receive zero or one point.

- The network-pricing-guarantee element evaluated, in theory, the refunds that each vendor was willing to offer the Plan if the vendor failed to deliver on its stated ability to negotiate prices with providers. The 2022 RFP stated that the Plan would decide the "value" of each vendor's network-pricing guarantee "based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk." The proposal that offered network-pricing guarantees "with the greatest value" would receive the full two points available for this category. All other proposals would 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." 2022 RFP § 3.4(c)(3)(c).

During a post-award meeting on December 16, 2022, Plan officials told Blue Cross NC that its cost proposal tied for first place with Aetna, and that its administrative-fee proposal offered lower costs than Aetna's proposal. Blue Cross NC received the full six points available for network pricing. The officials also said that Blue Cross NC received the full two points for administrative fees. Blue Cross NC received a total cost score of eight points, so it apparently received zero points for its network-pricing guarantee. Plan officials also told Blue Cross NC that Aetna also received a cost score of eight and that United received a cost score of seven.

On the technical requirements, the 2022 RFP process allocated one point to each of 310 technical questions or sub-questions. *See* 2022 RFP § 3.4(b). If a vendor

confirmed a technical requirement, that vendor received one point; if not, that vendor received zero points. For scoring purposes, the RFP weighted each of the 310 technical requirements the same. In the December 16 meeting, the Plan told Blue Cross NC that it received a technical-proposal score of 303 out of 310 possible points, and that Aetna and United each received 310 points.

2. Differences between the 2022 RFP and 2019 RFP

The 2022 RFP departed in many ways from the RFP that the Plan used in 2019.

a. Scoring of Cost Proposals

As noted above, the 2022 RFP evaluated each vendor's cost proposal on a 10-point scale.

The 2019 RFP, in contrast, scored each vendor's cost proposal on a 10,000-point scale. *See* 2019 RFP § 3.4(c)(i).

By compressing the cost-scoring scale by a factor of 1,000, the 2022 RFP's scoring process eliminated almost all distinctions between cost proposals. The RFP's scoring results confirm this point. The scoring yielded almost no difference in cost scores among vendors. Two of the three vendors received a cost score of 8 out of 10, while the third received a cost score of 7.

The 2022 RFP also used a different form of cost scoring from the 2019 RFP. The 2019 RFP said that the Plan would award the maximum number of points to the vendor with the "lowest total cost[,] with others receiving points proportionately." 2019 RFP § 3.4(c). In contrast, the 2022 RFP stated that the maximum number of points would be awarded to the vendor "offering the most competitive cost proposal, with others receiving points proportionately." 2022 RFP § 3.4(c). The 2022 RFP did not explain how the committee evaluating each vendor's proposal would decide which proposal was "most competitive."

b. Weight Given to Cost and Technical Scores

The 2022 RFP also changed the relative weight given to each vendor's scores for the cost and technical elements.

The 2019 RFP provided that the cost score would account for 40% of each vendor's final overall score, with the technical proposal accounting for the remaining 60%. *See* 2019 RFP § 3.4(a). The 2022 RFP changed this approach and weighted vendors' cost and technical proposals equally. *See* 2022 RFP § 3.4(a).

Combined with the change to the method for scoring cost proposals described above, the 2022 RFP *increased* the importance of cost scores, while *decreasing* the ability to measure differences in each vendor's cost proposal.

c. Permitted Responses to Technical Questions

As noted above, the 2022 RFP restricted each vendor's ability to respond to the Plan's 310 technical questions. Vendors were allowed to give only a binary yes-or-no response to each question. The Plan did not allow vendors to add any explanation or other information.

The 2019 RFP, in contrast, allowed vendors to offer narrative responses to similar technical questions. (The 2019 RFP is attached as Exhibit 3.) Blue Cross NC provided narrative responses for nearly all of the technical questions in the 2019 RFP. These narrative responses allowed Blue Cross NC to describe the basis for its responses and to state whether there would be any impact to the Plan or its members as a result. As discussed below, the inability to do so here prevented Blue Cross NC from providing helpful context and explanation for its responses. If Blue Cross NC could not confirm any element of a proposed requirement—even an immaterial element—it was forced to answer "no" without further explanation.

d. Scoring of Technical Proposals

The 2022 RFP also changed the scoring method for each vendor's responses to technical questions.

The 2019 RFP stated that each vendor's responses to the Plan's technical questions would be scored on a 10,000-point scale, just as the cost proposals were. *See* 2019 RFP § 3.4(b). The 2022 RFP, in contrast, used a 310-point scale, with one

point being awarded for the response to each of the 310 yes-or-no technical questions in the RFP. *See* 2022 RFP § 3.4(b). This change dramatically increased the importance of a vendor's response to each yes-or-no question.

e. Eliminated Preference for a North Carolina Vendor

The 2019 RFP stated a preference for vendors "with resources in North Carolina." 2019 RFP § 5.2.2.1. The 2022 RFP eliminated this preference.

BASIS FOR PROTEST

As shown below, the award of this contract to Aetna was an arbitrary and capricious decision. That award is not in the best interests of the Plan or its members.

1. Failure to Score Each Vendor's Network

For members, network strength is critical to whether the Plan meets the members' health needs. Plan members stretch across North Carolina, from Murphy to Manteo. Those members, regardless of their geographic location, deserve high-quality health care that is actually available to them. That availability requires a deep provider network.

The RFP's stated scoring process failed to consider these critical issues. Instead, the Plan treated Blue Cross NC's and Aetna's networks as equivalent as long as both vendors met certain minimum thresholds. Those networks, however, are not equivalent at all. Based on a preliminary review of publicly available data, Blue Cross NC has 38% more provider locations in North Carolina than does Aetna. In the vast majority of North Carolina's 100 counties, Blue Cross NC also has more provider locations than Aetna has.

The scoring system further failed to consider whether choosing a given vendor, with its network, would cause disruption to the Plan's members. Disruption can come in many forms, including forcing members to change providers because their Blue Cross NC provider is not in Aetna's network. The 2022 RFP itself noted the importance of minimizing disruption: it stated that the Plan was seeking a vendor that provided "a broad provider network with the least

disruption." 2022 RFP, att. A, § 1.1. The RFP undermined this goal by assigning no points to it.

2. Scoring of Cost Proposals

The RFP's scoring system for cost proposals was arbitrary.

The RFP does not explain, for example, why the administrative-fee and network-pricing-guarantee categories each received two points, even though administrative fees reflect *actual* costs to the Plan and its members, while pricing guarantees are rebates that will be paid only if a vendor does not meet its pricing commitments. Had the administrative fee received more weight than the network-pricing guarantee, Blue Cross NC would have received the highest overall score, because it was apparently the only vendor that received all available points for administrative fees.

The RFP also used vague and undefined standards for scoring network-pricing guarantees. The RFP states that the "proposal that offers the network pricing guarantee with the greatest value will be ranked the highest" and will receive two points. 2022 RFP § 3.4(c)(3)(b). It does not say, however, how the Plan would decide which guarantee provides "the greatest value," or what that term even means.

The RFP is equally vague on how many points would be awarded to the vendors that were not ranked highest on network-pricing guarantees. The RFP says that the vendor that does not provide the "greatest value" through its network-pricing guarantee "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." 2022 RFP § 3.4(c)(3)(c). It does not explain how the Plan would decide whether to award zero points or one point.

Based on this vague scoring, the Plan apparently awarded Blue Cross NC zero points for its network-pricing guarantee. That unexplained decision was pivotal. Had the Plan awarded Blue Cross NC even one point here, Blue Cross NC would have received the highest overall score.

Indeed, if Blue Cross NC had received only one point on the network-pricing guarantee, Blue Cross NC would have won by a margin *three times higher* than Aetna's winning margin. Under those circumstances, Blue Cross NC would have

won nine of the ten available points on its cost proposal. That is equivalent to 279 of the 310 available technical points. Blue Cross NC's total score thus would have been 582 (279 plus 303). Aetna's total score would have been 558 (248—80 percent of the available cost proposal points—plus 310).

In the post-award meeting with Blue Cross NC, the Plan's representatives said that Blue Cross NC did not rank the highest on the guarantee because of the amount of its administrative fee that Blue Cross NC agreed to put at risk if the guarantee failed.

In view of the context here, however, the Plan had no reason to put dispositive weight on these guarantees. Under the 2019 contract with the Plan, Blue Cross NC consistently met its contracted discounts.

3. Scoring of Technical Proposals

The Plan's method for scoring technical proposals was equally arbitrary. The Plan evaluated each vendor's technical proposal based only on yes-or-no responses to 310 technical requirements. The Plan awarded one point for each requirement that was confirmed and zero points for each requirement that was not.

This scoring presumes that each of the 310 technical requirements deserves equal weight. The Plan has offered no justification for this equal weighting.

Some of the 310 technical requirements are central to the proper functioning of the Plan's third-party administrator. For example, vendors were asked to confirm that they have experience with, and will support the implementation of, care models designed to reduce costs for Plan members. *See* Requirements 5.2.3.2(b)(xii) and (xiii). Vendors were also asked to confirm their ability to provide services to members who have an urgent medical need while outside the United States. *See* Requirement 5.2.3.2(b)(ii).

Other requirements are less central—for example, the vendor's ability to display the name of a member's employer in the vendor's online portal (Requirement 5.2.7.2(b)(xiv)) and confirmation that the vendor would provide and moderate online chat groups (Requirement 5.2.7.2(b)(xxi)).

Despite the difference in these and other technical requirements, the Plan gave every one of them the same scoring weight. That equal weight was arbitrary.

In addition, because the Plan demanded that vendors give yes-or-no answers to the 310 technical requirements, the Plan did not consider whether any vendor—including the winning vendor, Aetna—had conditions or limits on its ability to meet the requirements. Instead, the yes-or-no scoring motivated each vendor to superficially "confirm" its ability to meet each requirement *regardless* of its current capabilities or any limits on the vendor's ability to satisfy the requirement in the future.

The binary form of the questions also penalized Blue Cross NC for its attention to detail. Because Blue Cross NC knew the history and context of the Plan's stated requirements, it truthfully noted the seven requirements that it could not confirm without additional discussion. It received zero points for those responses. The Plan's refusal to consider any explanation for these responses led to a decision that was uninformed and arbitrary.

Because all the Plan relied on here was a small number of technical requirements with no allowance for an explanation, the Plan could not adequately complete its due diligence review of Blue Cross NC's proposal. The binary response format also precluded the Plan from properly assessing the remaining vendors on the same technical requirements that they had marked "confirmed."

In sum, the Plan could not make a reliable and informed decision about the technical capabilities of any vendor by treating each of 310 technical requirements as equally important, then refusing to accept any explanation on a vendor's detailed capabilities. The Plan nonetheless made its decision on that basis. At the post-award meeting with Blue Cross NC, Plan representatives admitted that because Blue Cross NC and Aetna had the same cost scores, the Plan awarded the bid to Aetna based on the difference in the vendors' technical scores. Seven superficial yes-or-no answers, out of 310 technical questions, decided the entire RFP.

Choosing the vendor of a multi-billion-dollar contract that affects hundreds of thousands of North Carolinians based on seven yes-or-no responses—and refusing to accept any explanation about those responses—is illogical and arbitrary.

4. Failure to Allow Explanations on Technical Questions

The Plan's decision to award Blue Cross NC zero points for each "not confirmed" response assumes that those responses reflect a deficiency. But the opposite is true.

Had the RFP allowed Blue Cross NC to submit narrative explanations with its answers, those explanations would have shown the legitimate reasons why Blue Cross NC did not confirm seven technical requirements.

If Blue Cross NC had been allowed to do so, it would have offered the following information on the seven technical requirements at issue:

a. Requirement 5.2.3.2(b)(iii): "Vendor will apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States."

Blue Cross NC did not confirm this sweeping condition for good reason. On rare occasions, key out-of-state providers (for example, the Mayo Clinic) might provide care to members without first getting prior authorization for that care. Under the terms of contracts between Blue entities and these out-of-state providers, the provider is not charged a penalty for providing this care. Because of these contracts, Blue Cross NC could not accurately state that the exact same utilization-management and payment rules would apply to every single provider across the country.

Requiring mechanical sameness across all providers would not be in the best interest of the Plan or its members. Rigid enforcement of a prior-authorization requirement could prevent Plan members from receiving necessary medical care. And it would not produce any cost savings or other benefits for the Plan, for several reasons:

- First, the waiver of these penalties is rare. In over 99% of cases, these out-of-state providers get prior authorization.

- Second, in virtually all cases, the provider *would have* received prior authorization had it sought it. Thus, mechanically enforcing a requirement of prior authorization would deny treatment to Plan members over a mere "touch foul."

- Third, this lack of absolute sameness across the country is a necessary result of having out-of-state providers in the Blue network—a network that provides significant benefits to Plan members.

- Fourth, Blue Cross NC believes that the out-of-state providers at issue demand similar penalty waivers from all third-party administrators, including Aetna and United. It is therefore unlikely that these vendors can comply with the absolute-sameness requirement stated in the RFP.

b. Requirement 5.2.7.2(b)(xxiv): "Vendor's member portal will accept and display Member-specific information from the other systems and Vendor's health team, including . . . Electronic medical and health records, Disease Management Nurse notes, Case Management notes, [and] Health Coach notes . . . ."

These requirements—four of the seven technical questions not confirmed by Blue Cross NC—are not technically feasible or not in the best interest of the Plan's members.

Blue Cross NC's member portal does not allow it to display electronic medical records (EMRs) from a provider. Providers have different and widely varying EMR systems, so displaying EMRs on a member's portal would require a universal platform that is compatible with each provider's system. Blue Cross NC is not aware of any third-party administrator that can offer this feature. It believes that the other vendors who confirmed this requirement did not appreciate its full implications.

In addition, the three categories of notes discussed in this technical requirement are notes made for the third-party administrator's own internal use, not notes meant for members' review. At times, the notes contain candid comments on whether a patient is following a provider's recommended course of treatment.

The Plan has not once raised the question of access to these internal notes during Blue Cross NC's long history as the Plan's third-party administrator. Even so, because of the scoring method that the Plan used to evaluate proposals here, this issue was given near-dispositive weight.

c. Requirement 5.2.8.2(b)(v): "Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits."

Blue Cross NC does not allow assignment of benefits to providers for out-of-network claims. This policy exists for the benefit of the Plan and its members. If an out-of-network provider can count on receiving payment directly from Blue Cross NC, that provider will have little incentive to join the Blue Cross NC network. The lack of such an incentive would undermine Blue Cross NC's ability to negotiate discounts for Plan members. Thus, treating assignment of benefits for out-of-network providers as a preferred feature of a vendor is a serious mistake.

By itself, moreover, assignment of benefits would have little benefit to Plan members. If this requirement is meant to streamline billing for out-of-network services and therefore reduce the burden on Plan members, it will not be enough to meet that objective. Any streamlining of billing would occur only when the out-of-network payment made by Blue Cross NC under an assignment of benefits is accepted as payment in full.

If, in contrast, the requirement of assignment of benefits is motivated by a concern that a large benefits payout to a member might not get paid to a provider, Blue Cross NC has already implemented safeguards to prevent this from occurring.

d. Requirement 5.2.6.2(b)(xvi): "Vendor will use the unique Member ID number provided by the [Plan's eligibility and enrollment] vendor as the primary Member ID for claims processing, customer services and other operational purposes; therefore, the unique Member ID number provided by the [eligibility and enrollment] vendor will be the sole Member ID on the ID Card."

Blue Cross NC had good reasons for not confirming this requirement as well. This requirement is technically infeasible and would cause needless headaches for Plan members.

As the Plan knows, each of its vendors—including its eligibility vendor and its pharmacy-benefits vendor—has its own form of member ID. Each vendor's form of ID is designed to be compatible with that vendor's systems. Blue Cross NC, for example, has a sixteen-character form of ID that includes a particular prefix. When

a Plan member visits a provider, that provider is familiar with and expects to see a sixteen-character form of ID and is prepared to use that form of ID in its billing systems.

Because of providers' expectations, enforcing a "single ID number" requirement would be counterproductive for the Plan's members. It would cause confusion and disruption with providers.

As the above discussion shows, Blue Cross NC had good reason for not confirming these seven out of 310 technical requirements in its proposal. If the Plan had allowed Blue Cross NC to explain these points, it would have done so. Then, the Plan—in the proper exercise of its diligence—would have been able to assess confirmed responses from other vendors on the same point.

In any event, if the Plan had scored the technical proposal less mechanistically, the outcome of this RFP would have been different.

CONCLUSION AND REQUEST FOR RELIEF

The Plan has described the criteria and scoring of the 2022 RFP as a modernization effort, but there was nothing modern about this RFP process.

Instead, the Plan took a complex decision—selecting the third-party administrator for a health plan that covers hundreds of thousands of North Carolinians—and tried to turn it into a checklist. That approach ignored critical issues that will affect the welfare of the State and the welfare of the Plan's members.

The Plan's third-party administration is not a back-office function. Instead, the third-party administrator has responsibilities that play a central role in defining member benefits. The administrator must also deliver a provider network with the strength, depth, and reach to offer high-quality, accessible health care to Plan members.

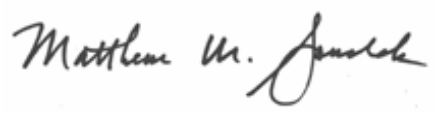
The Plan gave short shrift to these factors when it chose its next third-party administrator. That choice was arbitrary and capricious.

In light of the problems noted above, Blue Cross NC respectfully requests that the Plan (a) declare Blue Cross NC the winning vendor and award Blue Cross NC the contract, or (b) in the alternative, vacate its award to Aetna and conduct a new and more sound RFP process.

We look forward to meeting with the Plan to discuss these issues further.

Sincerely,

ROBINSON, BRADSHAW & HINSON, P.A.



Matthew W. Sawchak

MWS/wp
Attachments: Exhibits 1-3