BEFORE THE
MARYLAND STATE BOARD OF CONTRACT APPEALS

Appeal of MID ATLANTIC VISION SERVICE PLAN, INC.	)	
	)	Docket No. MSBCA 1368
Under DOP-2 Vision	)	

February 18, 1988

Responsibility - Equal Employment Opportunity/Affirmative Action - The requirement of the RFP to submit an Equal Employment Opportunity/Affirmative Action plan related to a matter of responsibility and not responsiveness.

Competitive Negotiation - In a competitive negotiation it is required that the solicitation document, the Request For Proposals (RFP), inform offerors of the broad scheme of scoring that the procuring agency intends to use to evaluate proposals and give reasonably definite information as to the relative importance of particular factors to be used in the evaluation of proposals in order to permit fair and equal competition.

APPEARANCES FOR APPELLANT: Jeffrey D. Herschman, Esq.
Kathleen A. Ellis, Esq.
Piper & Marbury
Baltimore, MD

APPEARANCES FOR RESPONDENT: Edward S. Harris
Joseph P. Gill
David R. Durfee, Jr.
Assistant Attorneys General

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Baltimore, MD

APPEARANCE FOR INTERESTED PARTY — Bernard J. Sevel, Esq.
Baltimore, MD

OPINION BY CHAIRMAN HARRISON

Appellant timely appeals the denial of its bid protest that its proposal for administering a vision care program was unfairly evaluated and that a competing offeror to whom the contract was awarded had submitted a nonresponsive proposal.

Findings of Fact

1. On August 29, 1987, the Department of Personnel (DOP) published a Request for Proposals (RFP) (Agency Report, Ex. 1) for the purpose of soliciting proposals to administer a vision care program for State employees, retirees and dependents for a two-year period. Proposals were due by October 9, 1987. Attached as part of the RFP were general specifications setting forth the requirements for the requested proposal. The requirements for the technical proposals are set forth on pp. 1-3 of the specifications (Agency Report, Ex. 2) and are summarized on pp. 2-3 of the Proposal

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Evaluation Criteria (PEC) contained in the Addendum to the RFP, Addendum No. 1, which was issued on September 15, 1987. (Agency Report, Ex. 3). The evaluation criteria are set forth in Exhibit A to this opinion. The vision care benefit requirements set forth required provision once within the two year period January 1, 1988-December 31, 1989 of:

A. One eye examination by a physician or an optometrist;

B. One additional medically necessary eye examination by any ophthalmologist when recommended by an optometrist;

C. One pair of lenses;

D. One pair of frames; and

E. Contact lenses when prescribed following cataract surgery or when elected in lieu of lenses and frames.

In addition, offerors were required to provide a schedule of vision care benefits and demonstrated ability to perform certain administrative services and controls.

The technical evaluation criteria set forth in the PEC advised offerors that 45% credit would be allocated to the technical proposals and that of this, separate ratings of 15% each would be given for (a) satisfaction of the basic vision care benefits criteria, (b) establishment of a schedule of vision care benefits, and (c) provision of administrative services and quality controls.

The RFP and Addendum also advised offerors that cost proposals could be submitted on one or both of the following bases: (a) Administrative Services Only (ASO), and/or (b) Reimbursement for Benefits, otherwise known as a "risk" proposal or plan. Under an ASO plan, the offeror has no liability for claims made by plan members. The offeror administers the ASO plan by remitting premiums paid by the State and plan members to the vision care provider and the State has ultimate liability for claims exceeding the amount of premium collected. Generally an ASO plan includes an administrative fee

payable by the State to the offeror, usually on an enrollee per month basis. Under a risk plan, the offeror is liable to plan providers for the actual costs of services rendered, even if those costs exceed the amount of premium collected; such that the offeror and not the State is "at risk" for payment for the vision care services whose cost exceeds premiums paid. The RFP, however, did not state that a risk proposal would receive more credit in the cost evaluation than an ASO proposal or otherwise quantify how a risk, ASO or combination proposal would be evaluated in comparison with one another.

To assist offerors in devising their cost proposals, the RFP provided State generated census information concerning State employees, retirees and dependents enrolled in the existing State-sponsored vision care plan pursuant to a contract with Appellant. The RFP also provided Quarterly Vision Care Utilization Reports generated from data provided by Appellant from the quarter ending 9/30/85 through the quarter ending 6/30/87 and monthly Vision Care Utilization Reports for the months of January, February and March, 1987. The reports showed, among other things, the historical total number of claims filed by State employees, retirees and dependents during quarterly, monthly and yearly periods, the total and average costs of the claims, who made the claims (i.e., employees, retirees or dependents) and to whom (panel[1] or non-panel members), as well as administrative costs. Thus, for example, the reports show that for the 1986 calendar year, when Appellant was the provider, 30,875 claims were made totalling $1,476,858.03, with associated administrative costs of $196,892.75.

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[1]Panel member refers to a participating member of Appellant's nonprofit vision care group of optometrists and ophthalmologists who provided services.

The specifications advised offerors that the award would be made "on the basis deemed to be most advantageous to the State."[2] Offerors were advised that the cost proposal would be weighted substantially greater than the technical proposal; specifically the financial evaluation was worth 55% of the total rating points compared with 45% for technical evaluation. Neither the RFP nor the Addendum prohibited co-payments or deductibles, whereby State employees and retirees would sustain an out-of-pocket expense for certain of the services rendered. The effect of a deductible or co-payment is to reduce the cost to the State. Thus, offerors were free to include (and some did include) member deductibles or co-payments as part of their proposals.

While not part of the technical evaluation criteria set forth in the PEC, the Addendum to the RFP required offerors who were proposing a vision care program utilizing panel providers to supply certain information. Specifically the Addendum provided in this regard:

> 21. PANEL DESCRIPTION
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> Vendors who offers [sic] a proposed Vision Care Program utilizing panel providers must supply the following information:
>
> 1. Accessibility of Care
>
> a. Number, by speciality, in Maryland
> b. Location, by county, in Maryland
> c. Number, by speciality, outside Maryland
> d. Number, by location, outside Maryland
>
> 2. Credentialing Process
>
> a. Use of Credential Providers
> b. Use or Non-credential Providers

[2] Offerors were advised that the State would subsidize 100% of the "Employee Only" (single employee, without spouse or dependents) level of coverage and all other coverage levels at the full "Employee Only" subsidy plus 85% of the difference up to the premium amount.

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3. Reimbursement Mechanism for Non-Panel Provider Utilization

a. If yes, provide fee schedule
b. If no, provide explanation

2. A pre-proposal conference was held on September 9, 1987. The conference was chaired by Assistant Secretary of Personnel, Catherine K. Austin. Various offerors attended the conference, including Appellant. At the conference, Assistant Secretary Austin reviewed each of the paragraphs of the RFP and the specifications. Dr. Mark Gordon, a member of Appellant's association and a representative of another potential offeror, and Appellant's President, Mr. Laney Hester, both of whom had attended the pre-proposal conference, testified that attendees at the conference were advised by Mrs. Austin that deductibles or co-payments were not acceptable as a "scam" on State employees or words to that effect. (Tr. 41, 59, 97-98). Mrs. Austin denied making such a statement, stating that in response to a question regarding deductibles she advised offerors in accordance with her typical response to such question that an offeror should prepare its proposal in a manner it felt would make it the most competitive offeror when the proposal was being evaluated. (Tr. 242). Mr. Mark Lynn, an account executive with Blue Cross/Blue Shield (BC/BS), responsible for the submission of the BC/BS proposal who attended the pre-proposal conference testified that he had no recollection of Mrs. Austin stating that deductibles or co-payments were prohibited. (Tr. 194-195).

Regarding the alleged oral prohibition against deductibles or co-payments asserted at the pre-proposal conference, the RFP does not contain any language which prohibits a proposal that includes a deductible or co-payment as part of the cost proposal or otherwise. The RFP provides in accordance with Maryland's procurement law that any substantive change or

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interpretation of the contract documents or specifications, if made, "will be made only by addendum duly issued." In response to various inquiries at the pre-proposal conference, DOP issued Addendum No. 1. The Addendum did not state that deductibles or co-payments were unacceptable and, in fact, did not mention deductibles or co-payments. The RFP further provides that "[t]he State will not be responsible for any other explanations, changes, or interpretations of the proposed documents made or given prior to the award of the contract."

3. The RFP advised offerors to submit, in separate sealed packages, a technical proposal and a cost proposal. Six offerors timely submitted proposals in response to the RFP: United Health Care, Inc. (United), Appellant, BC/BS, Professional Management Development Group (PMDG), Bankers Life & Casualty Co. (Bankers Life), and National Vision Administrators, Inc. (NVA).

4. These offerors submitted cost proposals that reflected the various options permitted by the RFP.

NVA submitted an ASO proposal including a $5 deductible for the eye examination and a $20 deductible for eyeglasses. Its total estimated cost under its proposal was $3,739,199.50 for two years. However, NVA did not submit a technical proposal.

PMDG submitted a reimbursement for benefits, or risk, proposal indicating premium levels for year 1 and year 2. Under a separate section entitled "Panel Co-Payment Responsibilities," PMDG's proposal stated that use of panel providers for vision care services would be "subject to the following out-of-pocket costs (co-payments)," which included a $5 service charge for examination, a $15 service charge for appliances, and a $5 dispensing fee for glasses.

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Bankers Life's proposal set forth two separate premium levels, one providing for retention of premiums by Bankers Life and the other for non-retention of premiums. However, the basis of the proposal (ASO, risk, or both) is unclear.

BC/BS submitted an ASO plan, termed a "marginless Retrospective with terminal deficit recoupment" plan. Under this arrangement rates are developed for the policy year which do not include margins and are not adjusted if actual experience differs from expected experience. However, the State is at risk ("retrospective" is the equivalent of self-insured) for the difference between actual and expected claims.

Appellant submitted both an ASO proposal and a risk proposal. However, Appellant's ASO proposal did not contain a submission of rates according to the premium schedule, as required by the RFP and Addendum. The premium schedule submitted with Appellant's ASO proposal included a $.15 per month per enrollee administrative charge and the cost of a plastic ID card and a total estimated cost of $4,257,758.70, but Appellant neglected to apportion the total estimated cost of the proposal through the premium schedule. Thus Appellant's ASO proposal was not evaluated.

United's proposal combined ASO and risk considerations. The proposal set forth capitation (per person) rates in the premium schedule based upon a guaranteed cost per claim of $54.42[3] derived from Appellant's claim experience under Appellant's existing contract with the State and a guaranteed total estimated cost of $2,996.809 derived by multiplying the $54.42 average claim

[3]The $54.42 amount was derived from the cost data included in the RFP for the period 7/1/85 - 6/30/87 which reflected a total cost of $2,996.809 paid by the State for claims and administration during this period and a total of 55,064 claims for the period. Dividing the total cost by the total claims yields the cost of $54.42 per claim.

cost by the 55,062 claims Appellant had reported during the period 7/1/85 - 6/30/87. The United proposal also included a provision for cost assumption which put the State at risk for the percentage of enrollees who filed a claim. Thus, United's cost proposal guaranteed the cost per claim at the per claim cost under Appellant's existing two year contract up to the number of claims reported by Appellant (55,062) with the State bearing the risk of any increase in the number of persons who actually utilize the program under the new contract. The formula for calculating any overages was the number of claims times $54.42 minus the amount paid to United in premiums. United bore the risk (of a refund to the State) in the event utilization was lower than anticipated. These calculations were to be performed annually.

5. Assistant Secretary Austin[4] and Harold Fairman, a principal of the Washington, D.C. consulting firm, Mercer-Meidinger-Hansen,[5] evaluated the vision care proposals on behalf of the procurement officer.[6]

Assistant Secretary Austin and Mr. Fairman separately reviewed and rated the vision care proposals on October 12 and 13. As noted, the technical evaluation criteria set forth in the PEC (see Exhibit A) advised offerors that 45% credit would be allocated to the technical proposals and that of this 45%, separate ratings of 15% each would be given for (a) satisfaction of the basic vision care benefits criteria, (b) establishment of a schedule of visions care benefits, and (c) provision of administrative services and controls. No points were set forth, however, for the various subfactors in

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[4]Before assuming her position as Assistant Secretary, Mrs. Austin was the Employee Benefits Administrator for the Civil Service Commission of the City of Baltimore.

[5]Mr. Fairman's firm, a subsidiary of Marsh & McLennan, is an employee benefits consultant firm. Mercer-Meidinger-Hansen was retained by DOP to provide technical assistance in the obtaining of various health programs for State employees, retirees and dependents.

[6]Mr. George Redtman, Director of Fiscal Management, DOP was the procurement officer.

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each 15% category; nor did the RFP or the PEC state that weights would to be given to provision of any one of the several requested items within each one of the 15 point categories. Assistant Secretary Austin and Mr. Fairman each developed separate point systems for allocating the 15% rating percentages for each of the various items set forth in these categories. Thus, for example, the PEC allocated 15% credit to the vision care benefits category; for the five vision care benefits listed (eye examination, lenses, etc.), 3.75% credit was allocated to provision of each item. They then evaluated the technical proposals in terms of whether the specified items were contained in the proposal with an offeror receiving full credit if it supplied all the requested information for each subcategory. Assistant Secretary Austin and Mr. Fairman completed and signed separate rating sheets for each proposal.

The results of their evaluations and the technical ratings given to each of the proposals are set forth below:

Proposal	Mr. Fairman's Rating	Assistant Secretary Austin's Rating
United	45	45
Mid-Atlantic	44.375	45
BC/BS	39.5	39.5
PMDG	27.62	Unacceptable
Bankers Life	27.2	Unacceptable
NVA	No Rating (no proposal received)	Unacceptable (no proposal submitted)

(Agency Report, Exs. 13-18).

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Since NVA did not submit a technical proposal, its offer was rejected and the technical proposals of PMDG and Bankers Life were rejected as being technically deficient. This left the proposals of BC/BS, Appellant and United in the running and the evaluators turned to the cost proposals of these offerors.[7]

The RFP provided that monthly rates (premiums) were required to be submitted for 16 categories of employees, retirees and dependents. In order to evaluate the cost proposals, both Mr. Fairman and Assistant Secretary Austin first took the unit price — i.e., the monthly premium rate per category of employee, retiree, dependent — multiplied this by 12 (months per year) and multiplied this figure by the total number of employees set forth in each category of the census totals[8] supplied as part of the specifications. This calculation yielded costs per category of employee. Adding the costs for all categories of employees yielded a total yearly cost for purposes of the evaluation. The cost proposals were all subjected to this analysis so that each would be rated according to the same standard criteria contained in the RFP.

Once this initial cost evaluation was accomplished, Assistant Secretary Austin and Mr. Fairman considered the details of each of the proposals.

7. BC/BS offered the State a "marginless Retrospective with terminal deficit recoupment." While the proposal states that the rates (i.e., premiums) will not be adjusted if actual experience differs from expected experience, the proposal is clear that the State is "at risk for the difference between actual and expected claims." Thus, BC/BS essentially proposed an ASO type

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[7]Since the scores in the technical evaluation of the proposals of United and Appellant were so close, they were both rated tied for first.

[8]The census totals were adjusted to reflect allocation of approximately 23,000 HMO enrollees who became eligible for vision care benefits under the new plan. Under the old plan only certain BC/BS enrollees were participants. This allocation is shown on the proposal evaluation criteria forms completed by Assistant Secretary Austin and Mr. Fairman. Appellant's cost proposal reflects the same allocation of new HMO enrollees.

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plan, where the State rather than the contractor is at risk. Utilizing the methodology described above, the yearly cost of the BC/BS proposal was estimated by the evaluators to be $2,308,569.

8. Appellant submitted two proposals, one on a risk basis and the other an ASO. The ASO plan, however, did not contain a submission of rates according to the premium schedule. As indicated above, while a $.15 service charge per category, the cost of a plastic ID card and the total estimated cost were shown, there were no premiums listed for the categories and Appellant's ASO plan was not considered.[9]

Appellant's risk proposal was evaluated. Under this proposal, the State would be charged the amount indicated in the premium rates and no more; Appellant was at risk if the amount of premium collected was not sufficient to cover the cost of claims made. On the other hand, if the cost of the claims made was less than the premiums collected by Appellant, Appellant would retain all premiums collected and the State would pay more for the plan than its actual costs. The evaluation committee's estimated yearly cost of Appellant's risk plan, based on the methodology described above, was $2,407,639, or approximately $100,000 more than BC/BS.

9. United's proposal, as noted above, combined aspects of an ASO plan and a risk plan. The cost per claim was guaranteed by United at $54.42 so that United bears the risk of an increase in per claim costs and also reaps the benefit of a decrease in per claim costs. Conversely, under the United proposal the State bears the risk of an increase in the percentage of enrollees who utilize the program (i.e. make claim) but would be entitled to the benefit of a decrease in the utilization (claim) rate. United's proposal

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[9]The PEC provides in the Mandatory Qualifications section that failure to submit rates according to the premium schedule "will result in automatic disqualification."

states that it was unwilling to bear the risk of fluctuations in the utilization rate because of its concerns regarding the new enrollment procedures. One of those concerns was that not all employees would decide to enroll in the vision plan and that many of those who did not enroll would be persons who did not use vision benefits, thereby creating "adverse selection," i.e. a situation where only persons expecting to make claims against a plan sign up for the plan, thus increasing the risk to the provider. Secondly, United was concerned that a percentage of employees who chose dependent coverage for the first year of the plan would receive the benefits for themselves and their family in calendar year 1988 and not re-enroll for calendar year 1989. United would therefore lose the opportunity of recouping in 1989 any losses it may have incurred in 1988 as a result of adverse selection.

As a result of these concerns, United proposed to "freeze the premium levels at the current rates with the understanding that United will be compensated for any costs caused by risks associated with the new enrollment procedures." Thus, while the State would be at risk for an upward fluctuation in the total number of claims beyond the experience of the past two years, the cost per claim would be capped at $54.42. The yearly cost of United's plan employing the above methodology was estimated to be $1,998,774. However, as discussed below, the evaluators estimated that the actual annual cost to the State of United's plan would be between 1.7 and 1.8 million dollars.

10. Assistant Secretary Austin and Mr. Fairman met together and discussed the various advantages and disadvantages of the proposals on October 14, 1987.[10] Ultimately, United's proposal to cap the claim rate at $54.42 per claim for the next two years was deemed to be the most

[10]Mr. Fairman's evaluation sheets were subsequently transmitted to Assistant Secretary Austin by letter of October 27, 1987.

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attractive. According to Assistant Secretary Austin's testimony, vision care benefits are highly predictable and it was unlikely that there would be a substantial fluctuation in claims made for the next two years. At the time of the evaluation, Mrs. Austin calculated that there were approximately 126,311 persons (employees, retirees, dependents) eligible to participate in the program administered by Appellant. Of these 126,311 total persons, approximately 60,637 were employees or retirees, and approximately 26,314 of these or 43% were single (no dependents) enrollees. She also calculated that 23,000 enrollees in existing HMO programs would be eligible for vision benefits under the instant RFP. Of these 23,000 enrollees, it was estimated that approximately 8,050 (35%) of these enrolled persons were single (no dependents) and 14,950 persons were family enrollees (65%), since experience showed that more families go into HMO's than BC/BS. Of the 14,950 family enrollees, family size was estimated at 2.5 per family for a total of 37,385 persons. The total number of new persons eligible for benefits was therefore estimated at 45,435 (37,385 + 8050 = 45,435). Thus total persons eligible for benefits under Mrs. Austin's calculations numbered approximately 171,746.

The 126,311 eligible persons at the time of issuance of the RFP generated 55,064 claims over the previous two year contract with Appellant (July 1,1985 -June 30, 1987), according to Appellant's statistics. Thus approximately 21% of the total covered persons filed claims annually.[11] However, Appellant's statistics reflected more claims than were actually filed because of duplicate claims in certain instances. Therefore, Mrs. Austin knew that the actual number of claims filed in the two year period was less than 55,064, so that using this figure gave a "cushion." Because the 45,435 new

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[11] 55,064 bi-annual claims divided by 2 equals 27,532 annual claims. 27,532 annual claims represents an annual claim by approximately 21% of the 126,311 eligible population.

persons in HMO's eligible for benefits under the RFP were considered to be a younger population group, on the basis that HMO employee enrollees and their dependent were a younger group of persons than BC/BS enrollees, and younger people have fewer eyesight problems than older people, Mrs. Austin estimated that 16% or approximately 7000 persons of this new group would file claims annually.

Believing that there was a cushion in the 55,064 claim figure, i.e. that it was high, Mrs. Austin, anticipated that no more than 31,000 to 33,000 claims would be generated annually by the total anticipated eligible population of approximately 171,736 people covered by the RFP. Multiplying this number of claims (31,000 - 33,000) by the capped cost per claim under the United proposal of 54.42 yielded the annual cost of between 1.7 and 1.8 million that the evaluators estimated the services would actually cost the State. (Tr. 171-192). Thus, in her opinion, the proposals of Appellant and BC/BS would result in higher costs to the State than United's proposal, because Appellant's fixed price proposal of $2,407,639 annually and the ASO proposal of BC/BS with a floor of $2,308,575 annually reflected costs $400,000 - $500,000 more than she estimated would be actually expended for claims made. (Tr. 155-192). Based on their joint evaluation of the cost proposals, Assistant Secretary Austin and Mr. Fairman rated United number one, BC/BS number two, and Appellant number three. (Tr. 253-257). To reflect this ranking, their proposals were assigned percentages of 55, 39.6 and 18.3, respectively. At the end of this process, United's proposal which had received the highest rated score for the cost component and tied for the highest rated score for the technical component was ranked as the top proposal.

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11. On October 21, 1987, Assistant Secretary Austin appeared before the Board of Public Works (BPW). Assistant Secretary Austin advised the BPW that three proposals had been fully evaluated and that of these, the United proposal was recommended for approval. The BPW approved DOP's recommendation for award to United. Subsequent to the BPW approval, United and DOP prepared a contract incorporating the terms of the RFP and United's proposal.

12. By letter of October 27, 1987, Appellant protested the award of the vision care contract to United generally on grounds that the evaluation of proposals was not fairly conducted. The grounds of the protest as more particularly set forth in Appellant's subsequent letter of November 19, 1987, were as follows:

> "In response to your request that we further specify the basis for this conclusion, (that the United proposal was not in compliance with the technical requirements of the RFP and received a higher score than it should have), we would point you to several provisions of the RFP.
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> The RFP requires that the covered benefits include one eye examination every 24 months and one pair of medically required lenses and frames every 24 months. In explaining this requirement at the pre-bid conference, the State advised prospective bidders that any plan providing for a "deductible" or a "co-payment" by the beneficiary would be rejected. The United proposal, however, does provide for a deductible of $10 for an eye examination and $10 for lenses or frames when the beneficiary utilizes a panel provider designated as a "B" provider. While the information provided to us does not give the number of "B" providers, it is obvious that a substantial number of beneficiaries will, by United's own admission, patronize so called "B" providers. United's proposal recites that United contends (a contention which cannot yet be tested for validity because we have not been provided with any identification as to the locale of the "A" as opposed to "B" panel providers) that 90% of the beneficiaries will have convenient access to "B" providers and 80% will have convenient access to "A" providers. Presumably, at the very least 10% of the total beneficiaries will patronize "B" panel providers and thus be charged these deductibles.
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> Second, the RFP anticipated that all beneficiaries will have easy access to covered services and would receive prompt services from panel providers. Thus, insofar as the technical proposal is concerned, the greater the number of available and

existing outlets for services, the higher the technical rating for an individual proposal ought to have been. Insofar as we can ascertain, no consideration was given to accessibility in the technical evaluation of either the United or the Mid-Atlantic proposals. As you will see from a review of those proposals, Mid-Atlantic has several times the number of available locations within the State of Maryland as does United.

Finally, the true total cost of the United proposal was not properly evaluated. The RFP does not make any provision for any deductible for covered services rendered through a panel provider. Indeed, as previously noted, at the pre-bid conference all bidders were told that such a deductible would be unacceptable and would lead to a rejection of the bid containing such a deductible. The propriety and reason for this were obvious. If one bidder is permitted to transfer a portion of the basic cost to the beneficiary thus producing a lower cost bid to the State without the State recognizing and evaluating the bid for what it does, then the entire bidding process becomes skewed and the State is no longer evaluating similar proposals.

Such is precisely what occurred in this instance. Although the evaluation sheets suggest that United will not be charging beneficiaries for eye examinations rendered by a panel provider and for basic lenses and frames provided by a panel provider, that is not the case. If that beneficiary visits a "B" panel provider he or she will be charged $10 for the examination and $10 for any lenses or frames. That is not the case with the Mid-Atlantic proposal.

Without knowing the number and location of the "A" panel provider as opposed to "B" panel providers it is difficult to quantify the hidden cost of the United proposal. It is apparent that that hidden cost will be significant. If one were to assume that those beneficiaries which United admits will have convenient access only to "B" panel providers (10%) will patronize those providers and that the "A" panel providers and "B" panel providers will be equally successful in competing for the patronage of beneficiaries having equal access to both (80%), then fully 50% (10% plus one-half of 80%) will patronize the "B" panel providers and be compelled to pay a $20 deductible at a cost of many hundreds of thousands of dollars.

The point is simply that had the State wished to entertain a program providing for a deductible, then it should have so stated in its RFP and should not have indicated to prospective bidders that such a deductible would be unacceptable. Had the acceptability of such a deductible been established and the amount of any deductible established, Mid-Atlantic could and would have adjusted its bid accordingly. To misinform prospective bidders and then to accept a single proposal having a deductible without making any analysis of the cost of that deductible to the beneficiaries is arbitrary and capricious.

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13. In its November 19, 1987 letter, Appellant also sets forth as an additional grounds for its protest that the alleged failure of United to include Equal Opportunity and Affirmative Action forms and plan (EEO/AA plan) made the proposal nonresponsive.

14. In a separate letter dated October 27, 1987, Appellant also requested certain documents from DOP. The State responded to Appellant's document request by letters of November 3 and November 16, 1987. Appellant and DOP met on December 7, 1987 to discuss the protest.

15. On December 8, United was told to submit its Affirmative Action plan. The plan was received by DOP on December 16, 1987. Assistant Secretary Austin testified that the plan was reviewed and approved by both herself and the Secretary of DOP prior to execution of the contract with United. The contract with United was executed on December 21 and contains a copy of the EEO/AA plan submitted by United.

16. The procurement officer issued a decision on December 24 denying the protest. Appellant filed its appeal with this Board on December 31, 1987. On January 6, 1988, the BPW ratified the execution of the United contract with knowledge of Appellant's pending bid protest appeal.

17. On January 13, 1988, Appellant filed an Amended Notice of Appeal challenging the evaluation of the BC/BS proposal and also asserting a further ground of alleged improper evaluation of the United proposal based on the alleged failure of the evaluators to consider the true cost of United's proposal which required that it be paid for costs associated with "adverse selection." (See Finding of Fact No. 9).

18. Pursuant to agreement of the parties, the Agency Report was filed with this Board and distributed to the parties on January 18, 1988 and the matter heard on January 21 and 22, 1988.

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Decision

As an affirmative defense, DOP asserts that Appellant lacks standing to brings its appeal because of an alleged failure of Appellant to timely challenge the BC/BS proposal until it filed its Amended Notice of Appeal with this Board on January 13, 1988. Absent a challenge to the second ranked BC/BS proposal, DOP asserts that Appellant cannot prevail, because even if the protest against United were sustained on this appeal, BC/BS would stand in line for award of the contract and not Appellant. We disagree.

The protest initially filed by Appellant challenges the appropriateness of the evaluations on grounds that all offerors were not accorded equal treatment. Appellant asserts that the evaluators improperly evaluated and considered in their ranking of proposals co-payments structured in the cost proposals of certain offerors without conducting discussions with all offerors, including Appellant, to thus afford Appellant (and others) the opportunity to offer a cost proposal including co-payments. If Appellant's assertion that the RFP did not permit co-payments is correct, and if Appellant was not afforded the opportunity to amend its cost proposal, if it so chose, to include co-payments and thus be considered on an equal basis with offerors whose cost proposals containing co-payments were considered, then it is not possible to state that Appellant might not have submitted a more favorable proposal than BC/BS had the evaluation been lawfully conducted. Stated another way, since Appellant is alleging (in its initial protest) that it was unfairly treated in the evaluation process, the possibility exists that it would have been in line for award if, assuming arguendo the truth of its allegations, it had been treated fairly. See Baltimore Motor Coach Company, MSBCA 1216, 1 MSBCA ¶94 (1985). Therefore, Appellant's appeal will be considered on its merits.

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Appellant filed a protest alleging that DOP's evaluation committee, Assistant Secretary Austin and Mr. Fairman, unlawfully used criteria to evaluate the proposals that were not included in the RFP specifications. Specifically, Appellant asserted that because the RFP did not include provisions for co-payments (deductibles) and because discussions were not conducted with all offerors inviting them to amend their proposals to include co-payments, favorable consideration by the evaluators of United's submission of a proposal with co-payments for certain services was unlawful since all offerors were thus not competing on the same basis.[12] Appellant also asserts that co-payments were orally stated to be unacceptable at the pre-proposal conference and thus consideration thereof by the evaluators was precluded. DOP disagrees contending that deductibles were not precluded by the RFP or otherwise.

The RFP advised offerors that the award would be made "on the basis deemed to be most advantageous to the State." Neither the RFP nor the Addendum prohibited member co-payments or deductibles. Absent a prohibition express or implied, on co-payments or deductibles, offerors were free to include them as part of their proposals.

In fact, three of six offerors submitted proposals containing some form of co-payments. NVA submitted a proposal including a $5 deductible for the eye examination and a $20 deductible for eyeglasses. PMDG submitted a

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[12]Appellant's protest in effect challenges the awarding of full credit to United's technical proposal wherein the deductibles were proposed. Appellant also suggested in its protest that inclusion of a deductible paid by the employees/retirees/dependents made a proposal more costly due to the hidden cost reflected in the deductible. However, the cost that is in issue in this procurement is the cost to the State, not the cost to employees/retirees/-dependents of the cost of the vision care program. The effect of a co-payment is to reduce the cost of the vision care plan to the State by shifting part of the cost to the members, thereby making an offer more advantageous fiscally to the State.

proposal containing a separate section entitled "Panel Co-Payment Responsibilities," indicating, among other things, a $5 service charge for examination, a $15 service charge for appliances, and a $5 dispensing fee for glasses. United's proposal included a $10 deductible for members who selected a certain class of providers, deemed the "B" panel, whereas there was no deductible for the "A" panel providers.

Appellant also asserts that at the pre-proposal conference offerors were told that co-payments or deductibles were prohibited, and thus consideration thereof by the evaluators without discussions inviting all offerors to propose a vision plan structure that included co-payments was unlawful. The record is inconclusive on whether such a statement was made. However, assuming such a statement was made, the RFP cannot be amended by oral statements. COMAR 21.05.03.02D provides that pre-proposal conferences held in connection with a negotiated procurement are governed by the provisions of COMAR 21.05.02.07, relating to pre-bid conferences, which states, in pertinent part:

> . . . Nothing stated at the pre-bid conference shall change the invitation for bids unless a change is made by the procurement officer by written amendment.

The prohibition against oral amendment of the RFP is reiterated in the solicitation documents. The RFP, ¶10, states that any substantive change or interpretation of the contract documents or specifications, if made, "will be made only by Addendum duly issued." The RFP, ¶10, further provides: "The State will not be responsible for any other explanations, changes or interpretations of the proposed documents made or given prior to the award of the contract." Written amendments are required to change an RFP so that the inevitable disputes as to what was said or what was heard at a pre-proposal conference or elsewhere will not interfere with the formation of a contract.

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As noted, the RFP does not prohibit use of deductibles or co-payments as part of a vision care plan, nor was any such prohibition set forth in the Addendum issued immediately following the pre-proposal conference — an Addendum issued for the very purpose of clarifying questions raised at the conference. Half of the offerors proposed some form of co-payment provision and we find that offerors were not misled by the terms of the RFP concerning what types of offers were permitted. Appellant cannot now object to DOP's acceptance of proposals with co-payment features when the RFP did not preclude the consideration of such proposals. Nor do we find the fact that some offerors included co-payment features in their proposals thereby required DOP to engage in discussions with offerors who did not include such features in order to attempt to obtain the proposal "most advantageous to the State,"[13] and Appellant's appeal on the co-payment issue is denied.

Appellant next contends that it should have received a higher technical score than United on the issue of access of members to providers. As noted in Finding of Fact No. 1, the RFP (Addendum) required the successful offeror to provide access (Accessibility of Care) to covered services for all members. Specifically the addendum provided in this regard:

> 21. PANEL DESCRIPTION
>
> Vendors who offers [sic] a proposed Vision Care Program utilizing panel providers must supply the following information:
>
> 1. Accessibility of Care
>
> a. Number, by speciality, in Maryland

[13]Subsection (d) of section 11-111, Division II, State Finance and Procurement Article, effective July 1, 1987 dealing with competitive sealed proposals provides in this regard:

> Discussions.—(1) After proposals are received and before award, the procurement agency may conduct discussions, as provided under this subsection and in accordance with regulations adopted under this subtitle, for the purpose of assuring full understanding of the State's requirements, as described in the request for proposals, and of the offerors' proposals, and to obtain the best price for the State.

b. Location, by county, in Maryland
c. Number, by speciality, outside Maryland
d. Number, by location, outside Maryland

Appellant argues that its proposal offered better access to health care providers than the United proposal since it (1) offered to provide more than twice as many provider locations particularly in more populated areas like Baltimore City and (2) offered to provide 161 optometrists versus 57 optometrists. It thus contends that its proposal should have been ranked higher than United's. DOP disagrees, asserting that quality of access, as such, was not an evaluation criteria and that the ranking of the two proposals as functionally equal was reasonable. The short answer to Appellant's contention is that access was not an evaluation criteria.

A proposal offering to provide State-wide vision care services to State employees had to reflect that employees had access to vision care providers. This was a basic requirement for a State-wide plan and on some level, access was assumed in all proposals. Assistant Secretary Austin and Mr. Fairman determined that United met the basic requirements of providing a State-wide plan by providing access to panel providers for 80 percent of the members and to non-panel providers for 90 percent of the members in all counties, including multiple locations in many counties. Assistant Secretary Austin testified in this regard that all that was required of a proposal to satisfy the access requirement was to set forth the information required respecting number, speciality and location of providers as set forth above and that neither quality of access nor whether the providers were panel or non-panel were evaluation criteria. (Jan. 21, Tr. 106, 121-137, 247-249).

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While quality of access perhaps should have been made an evaluation criteria as such, it was not. Therefore, we must view the evaluation of the technical proposals on the basis of the criteria set forth in the PEC only and the responses actually provided to the information sought therein.

Respecting evaluation of proposals by evaluators, this Board has noted that:

> "The determination of the needs of the . . . [State] and the method of accommodating such needs is primarily the responsibility of the procuring agency which therefore is responsible for the overall determination of the relative desirability of proposals." Health Management Systems, Comp. Gen. Dec. B-200775, 81-1 CPD ¶255 (1981). Accordingly, procuring officials enjoy a reasonable degree of discretion in evaluating proposals and such discretion may not be disturbed unless shown to be arbitrary or in violation of procurement statutes and regulations. Beilers Crop Services, MSBCA 1066 (September 16, 1982) at p. 6; Health Management Systems, supra; Comp. Gen. Dec. B-179703, 53 Comp. Gen. 800 (1974); compare Biddison v. Whitman, 183 Md. 620, 624-25 (1944); Hanna v. Board of Education, 200 Md. 49, 51, 87 A.2d 846, 847 (1952); B. Paul Blaine Associates, Inc., supra, at p. 14. [B. Paul Blaine Associates, Inc., MSBCA 1123, 1 MSBCA ¶58 (1983)].

Transit Casualty Company, MSBCA 1260, 2 MSBCA ¶119 at p. 55 (1985).

The Board has also observed that:

> . . . in competitive negotiations it is necessary to evaluate technical factors along with price to determine which proposal is most advantageous to the State and that the review of these technical factors requires the exercise of judgment which necessarily is subjective. B. Paul Blaine Associates, Inc., supra, at p. 13. . . . [T]here is also no experiential benchmark from which to review the bona fides of an evaluator's judgment.

Transit Casualty Company, supra, 2 MSBCA ¶119 at p. 55. See also Baltimore Motor Coach Co., supra; Systems Associates, Inc., MSBCA 1257, 2 MSBCA ¶116 (1985).

Applying these legal criteria to the evaluation at hand, we find that the decision of Assistant Secretary Austin and Mr. Fairman to give full credit to the technical proposals of both United and Appellant clearly was a decision within the ambit of their discretion. Based on the record before us, it has

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not been demonstrated that their exercise of this discretion in giving equal ranking to the technical proposals was arbitrary, notwithstanding Appellant's belief that it should have received more credit for its technical proposal.

However, before proceeding to the next issue a comment concerning the evaluation of the technical proposals herein is warranted. Subsection (b) of section 11-111 of the General Procurement Law[14] provides in relevant part that "proposals shall be solicited by a request for proposals which shall at a minimum include: (1) a statement of the scope of the contract; and (2) a list of the factors and relative importance of each factor, including price, that will be used in evaluating proposals." The RFP, through the Addendum, in this case only marginally, if at all, meets the requirement to list the factors and the relative importance of each factor in the technical evaluation criteria. The relative importance of the sub-criteria within each 15 point grouping are not set forth and the evaluators determined that full credit of 15 points would be achieved if offerors merely supplied the pertinent information. In the absence of any timely allegation that offerors were mislead by the failure of the RFP to set forth how subfactors would be evaluated or that offerors were not competing on an equal basis, such matter is not before us. Appellant has only challenged the failure of the evaluators to evaluate properly the question of access, a matter which was not an evaluation criteria. However, this challenge highlights the mere bare bones compliance with State procurement law in this case which in future procurements may further invite the ultimate delay attendant to dispute resolution. See AGS Genasys Corporation, MSBCA 1325, 2 MSBCA ¶158 (1987) and cases cited therein at p. 25. The check-off approach to the technical evaluation herein does not permit the procuring agency to most effectively evaluate the best

[14]Division II, State Finance and Procurement Article.

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combination of technical merit and price to determine the proposal that is most advantageous to the State, wherein a higher priced proposal might truly be judged the most advantageous. While the RFP provides that the cost proposal would be weighted substantially greater than the technical proposal, the approach used in this case places the focus almost entirely on lowest cost to the State.

Appellant next asserts that its cost proposal was in fact the most advantageous to the State and should have received the highest ranking. This assertion is based on Appellant's belief as articulated in its Amended Notice of Appeal that the evaluators failed to consider the cost in the BC/BS and United proposals associated with "adverse selection." It argues that since the State must pay BC/BS and United under their proposals all costs that exceed the guaranteed cost per claim times a specified number of claims that its proposal which proposes to charge the fixed rates set forth in the premium schedule and no more is the least costly and its proposal to assume the risk of adverse selection should have received more credit. DOP on the other hand contends that the cost of adverse selection was considered and that the evaluators made a conscious business judgment that adverse selection would not drive the United cost above the fixed cost proposed by Appellant. We agree with DOP.

It is clear from the testimony of Assistant Secretary Austin that the evaluators made certain assumptions concerning the extent of adverse selection and actual costs of the vision program to the State. It was determined that the actual cost to the State would not exceed and indeed would be less than the fixed amount proposed by Appellant and the amount anticipated to be paid to BC/BS and United under their proposals. In other words, the evaluators made assumptions under which the estimated yearly cost

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of Appellant's plan ($2,407,639) though a fixed cost was more expensive than the estimated annual cost (between 1.7 and 1.8 million) derived by applying such assumptions to the United plan and the estimated annual cost of $2,308,575 under the BC/BS plan. See Finding of Fact No. 10. Appellant has failed to demonstrate that these assumptions were unreasonable or that they were improperly applied to the proposals. Nor were the evaluators precluded from making such assumptions by the RFP or otherwise. As noted above, this Board does not second guess an evaluation of a proposal but merely concerns itself with whether a reasonable basis exists for the conclusions and results reached or determined. Baltimore Motor Coach Co., supra; Transit Casualty Company, supra; AGS Genasys Corporation, supra. A reasonable basis having been articulated for the conclusions and results of the evaluation, we deny Appellant's appeal on grounds of improper evaluation of the true cost of the respective proposals respecting the potential for adverse selection and the failure of the evaluators to accord Appellant credit for assuming the risk of adverse selection.

Appellant's final ground of protest relates to the failure of United to submit an Equal Employment Opportunity/Affirmative Action Plan (EEO/AA plan) with its proposal.[15] United's proposal states that "United is making a

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[15]The procurement officer's decision notes that:

> You argue that paragraph 7.A. of the general specifications and paragraph 17 of the proposal information in the RFP required all bidders to provide data with regard to equal employment opportunity and affirmative action. Paragraph 17 states that "Failure of any bidder to complete the equal opportunity and affirmative action forms and submit the required information will result in the bid being declared nonresponsive." However, as you know, there were no equal opportunity or affirmative action forms provided by the Department with the RFP. Consequently, the Department was asking bidders to perform an act - to complete forms and to submit required information by completing those forms - which could not be performed by bidders. Hence, a bidder's failure to do what was asked in paragraph 17 did not render the proposal unacceptable.

good faith effort to establish an equal opportunity and affirmative action plan." Appellant argues that the failure of United to submit an EEO/AA plan with its proposal makes its proposal nonresponsive. DOP argues that the EEO/AA plan involves a matter of responsibility in the context of this RFP which may be satisfied by submission of a plan prior to award. We agree with DOP that the requirement to submit the EEO/AA plan under the instant procurement involved a matter of responsibility.[16] See Systems Associates, Inc., supra, 2 MSBCA ¶116 at pp. 11-12; Beilers Crop Service, MSBCA 1066, 1 MSBCA ¶25 at p. 5 (1982). We believe that United's statement concerning its good faith effort to establish an EEO/AA plan demonstrated that its proposal was at least potentially acceptable pending receipt and evaluation of the plan prior to award.[17] DOP requested that United submit a plan for evaluation. The plan was submitted reviewed and approved by Assistant Secretary Austin and the Secretary of DOP prior to the execution of the contract which included a copy of the approved plan. See Finding of Fact No. 15. Under such circumstances, we deny Appellant's appeal on this final ground as well.

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[16]The requirement to submit an EEO/AA plan stems from the requirements of the RFP. It is not otherwise required by the General Procurement Law or its implementing regulations.

[17]There is a suggestion in the Agency Report that the mere submission of the EEO/AA plan without any review by DOP suffices to legitimize award. This is not the case. A valid responsibility determination requires actual review prior to award. See COMAR 21.06.01.01.

Concurring Opinion by Mr. Ketchen

In a competitive negotiation it is fundamental that the solicitation document, the request for proposals (RFP), inform offerors of the broad scheme of scoring that the procuring agency intends to use to evaluate proposals and give reasonably definite information as to the relative importance of particular factors to be used in the evaluation of proposals in order to permit fair and equal competition. B. Paul Blaine Associates, MSBCA 1123, 1 MSBCA ¶58 (1983). As mandated by Md. Ann. Code, State Finance and Procurement Article §11-111, an RFP should apprise potential offerors of the relative importance of price and technical evaluation factors in order to avoid the possibility that offerors will submit proposals which unwittingly emphasize factors of little importance or de-emphasize factors of critical importance to the selection decision. Each offeror should be able to understand the agency's intent either to achieve a minimum standard at the lowest cost or whether cost is secondary to quality, i.e., offerors are entitled to know the relative importance of technical excellence and price. See: 55 Comp. Gen. 60, 80 (1975); 52 Comp. Gen. 161 (1972); Signatron, Inc., 54 Comp. Gen. 530 (1974).

Here the RFP indicated that price was relatively more important than the technical aspects of proposals. Price was thus weighted at 55% and technical evaluation at 45%. However, nowhere does the RFP indicate that proposals offering to meet the criteria (including "benefits" criteria) listed in the RFP would receive full credit while those proposals not offering to meet a listed criteria would receive no credit. Technical proposals thus were evaluated based on a pass/fail system or check-off system as to the technical evaluation criteria and their subcriteria. In other words, all technical proposals indicating that they would meet all the criteria listed in the RFP

would receive the full credit of 45 points without distinction being made among proposals as to quality of services offered to meet the criteria. Price thus became the primary selection factor for those proposals meeting the required criteria on a minimum acceptable level. It is on this basis that I disagree that the RFP complied with Md. Ann. Code, §11-111(b) merely by listing the technical evaluation criteria with point scores and the statement that price would be relatively more important than technical requirements in the evaluation of proposals. Offerors reasonably could not have understood the relative importance between technical considerations and price because the RFP did not put them on notice that DOP intended to use the pass/fail system employed for the technical evaluation and that DOP did not intend to evaluate the quality of services among the proposals offering to meet each RFP listed criteria.

The RFP provides in pertinent part, as follows:

> 3. PROPOSAL EVALUATION
>
> Technical Proposals will be evaluated first by an Evaluation Committee designated for the task. The Technical Proposals will be evaluated in accordance with criteria set forth in this RFP and ranked within the following categories upon completion of the initial technical evaluation:
>
> (a) Category 1- Acceptable proposals: Proposals that meet or exceed all requirements specified in the RFP.
>
> (b) Category 2 - Potentially acceptable proposals: Proposals that materially meet RFP requirements but contain some terms and conditions that do not meet the State's requirements.
>
> (c) Category 3 - Unacceptable proposals:
>
> * * *
>
> The proposals will then receive a final technical evaluation. All proposals found to be acceptable, will be placed in Category 1. If the Committee finds a proposal still falls in Category 2, it will be placed in Category 3 and rejected. After the final evaluation has been made and all Technical Proposals have been ranked, the Committee will open the Cost Proposals of offerors that have Technical Proposals considered

> acceptable (Category 1). The Cost Proposal will then be evaluated according to established requirements. At this point, all offerors in Category 1 may be requested to meet with the Issuing Office to discuss aspects of their cost proposal in the same manner as indicated for Technical Proposals (above).
>
> A final evaluation will rank each of the acceptable proposals, considering both Technical and Cost Proposals with cost weighted substantially greater than technical. When the Committee has recommended its selection, the Issuing Office will negotiate a contract. (Underscoring added).

(Agency Report, Ex. 2, pp. 6-7). Offerors further were told that, "[a]ward will be made on the basis deemed to be most advantageous to the State" (Agency Report Ex. 2, p. 4) and that the technical evaluation of proposals would be conducted on a 45 point (45%) basis with each of the three major technical evaluation criteria to be evaluated on a 15 point (15%) basis. (Agency Report Ex. 3, "Proposed Evaluation Criteria," unnumbered page 3).

The RFP statement that proposals would be evaluated on a technical basis of a maximum total of 45 points in my view would have led reasonably prudent offerors to presume that offerors technical proposals would be judged under a weighing process on a scale ranging from 0 to 45 points. However, under the system employed it made little difference whether 45 points (or less or more) were assigned to the technical evaluation criteria since all acceptable proposals were leveled at the same technical score of 45 points if they offered to meet each of the RFP listed criteria.

This system gave a great advantage to offerors who might choose to provide a lesser quality of benefits and services, although their proposals indicated they would at a minimum meet all the RFP technical criteria listed and thus were acceptable for evaluation purposes. For example, United's proposal arguably offers a package of vision care benefits of lesser quality than Appellant's because its B panel system of providers contains specified deductibles or co-payments for beneficiaries selecting B panel doctors (which

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I agree was permissible under the RFP) and because its offer arguably may provide less access (which I agree was not listed expressly as an evaluation factor) to subscribers (employees). However, United's proposal was not evaluated on this basis. For that matter none of the offerors' proposals were rated or evaluated at all on how well they met the specified technical evaluation criteria but were given full credit if they were adjudged to have minimally met the criteria.[18]

One can only speculate as to whether this permitted United to structure its proposal to offer its benefits and services at lower costs and whether Appellant and other offerors would have structured their offers in a different manner had they known there would be no discrimination among offerors' technical proposals meeting the minimum criteria set forth in the RFP and thus that price essentially became the sole selection factor. In my view, the RFP thus failed to inform potential offerors in any meaningful way pursuant to Md. Ann. Code §11-111(b) of "the relative importance of each factor, including price, that will be used in evaluating proposals," since it did not notify potential offerors that all technically acceptable proposals meeting all the technical criteria listed would be evaluated equally at 45 points, leaving price as the sole basis for selecting the most advantageous offer.

I believe that the evaluation process was conducted in good faith and, further, that there is nothing inherently improper with the evaluation system employed in this competitive negotiation procurement. However, as discussed above, my view is that Md. Ann. Code §11-111(b) intends that in a competitive sealed proposal procurement the RFP must reasonably inform offerors as to the evaluation system to be used so as to permit full and fair

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[18]Blue Cross/Blue Shield lost full points on certain specified subcriteria because it did not offer to meet it, although its proposal was not rejected for not offering to meet that particular subcriteria. See Finding of Fact No. 5.

competition on an equal basis. An agency in its discretion may select the evaluation methodology it will employ. However, it must inform potential offerors when it intends to make an award based solely on the evaluation of price among the technically acceptable proposals, i.e. relative technical superiority is not to be a factor in award selection so long as minimum requirements are met. See: Datawest Corporation, Comp. Gen. Dec. B-185060, February 17, 1976, 76-1 CPD ¶106. See also: RKFM Products Corporation, Comp. Gen. Dec. B-186424, September 15, 1976, 76-2 CPD ¶247.

Although Appellant contends that it should have received higher scores on the technical evaluation of proposals based on the "deductibles" and "access" comparisons, which I agree were not evaluation criteria, Appellant here does not directly contest the procurement award based on the fact that the RFP did not inform potential offerors of the pass/fail technical evaluation system employed. Thus, the principle laid down concerning what is required for an RFP to comply with §11-111(b) that I feel obliged to discuss is not an issue before this Board. See generally: Transit Casualty Co., MSBCA 1260, 2 MSBCA ¶119 (1985); Tekmatix, N.A. Corp., MSBCA 1333, July 8, 1987, 2 MSBCA ¶153 (1987); Chesapeake Bus and Equipment Co., MSBCA 1347, November 2, 1987, 2 MSBCA ¶163 (1987). Accordingly, I concur in the denial of the appeal.

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Concurring Opinion by Mr. Levy

I will concur in the opinion that the appeal should be denied but with the following comment. Mr. Harrison has expressed in his opinion that the decision of Assistant Secretary Austin and Mr. Fairman to give full credit to the technical proposals of both United and Appellant clearly was a decision within the ambit of their discretion; that it was not demonstrated that exercise of their discretion was arbitrary. He notes that the RFP, through its addenda, marginally meets the requirement to list the factors and relative importance of each factor, including price, that will be used in the evaluating proposals as provided for in §11-111, State Finance and Procurement Article, Md. Ann. Code. He notes that the relative importance of the subcriteria within each 15 point grouping were not set forth. However, the evaluators determined to give the full 15 point credit if an offeror merely supplied the minimal pertinent information. In effect a check-off or pass/fail approach was utilized for the evaluation of the technical proposals and as he notes this has the effect of placing the focus almost entirely on lowest cost to the State. What Mr. Harrison has implied is that §11-111 allows this type of check-off or pass/fail approach to technical proposal evaluation without the need of advising the offerors that it will be used. This is where I must disagree with him.

I believe, as Mr. Ketchen has enunciated in his concurring opinion, that §11-111 allows for the use of a check-off or pass/fail approach to evaluate technical proposal; however, that approach has to be brought to the attention of the offerors in the RFP. There is nothing inherently wrong with the use of this type of technical proposal evaluation but the offerors must reasonably be informed of the evaluation system that will be used. I disagree with Mr. Ketchen, however, in this particular case since offerors could reasonably infer

from the RFP that a check-off system of technical proposal evaluation would be used. The language of the PROPOSAL EVALUATION section clearly shows a scheme to place the technical proposals into three categories; acceptable, potentially acceptable and unacceptable. It then talks of a "final technical evaluation" which would place all proposals into either the acceptable or unacceptable category. It then provides for a final evaluation to rank the acceptable proposals considering both the technical and cost proposals with cost weighted substantially greater than technical. I believe the evaluation committee conducted its evaluation in line with this outline.

I would, therefore, deny the appeal for the above reasons.

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A. Technical Evaluation (45%)

Criteria	Maximum Rating Percent	Rating
1. Provision of Vision Care Benefits	15%	

A. One eye examination by a Physician or an Optometrist which may include:

1. complete case history;
2. eye pathology (including tonometry);
3. vision survey and analysis;
4. complete refraction
5. coodination measurements and test;
6. prescription for lenses;
7. post-examination visit.

B. One pair of lenses which are:

1. prescribed during the examination; and
2. non-tinted, photochromic or tinted no darker than No. 2 tint.

C. One pair or frames.

D. Contact lenses when:

1. prescribed following cataract surgery;
2. prescribed when visual acuity is correctable to 20/70 or better only by the use or contract lenses; or
3. the Member elects contact lenses prescribed in lieu of lenses and frames. (The allowance toward the cost of such contact lenses shall not exceed the amount payable toward the cost of single vision lenses and frames).

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2. Schedule of Vision Care Benefits 15% _____

Procedure

Eye Examination

Prescription Lenses (per pair)

Single Vision
Bifocal (single)
Bifocal (double)
Trifocal

Aphakic (cataract)

Glass
Plastic
Aspheric

Frames (per frame)

Contact Lenses (per pair)

Medically indicated after cataract surgery or when visual acuity is correctable to 20/70 or better only by use of contact lenses or for Cosmetic purposes in lieu of lenses and frames

Exclusions:

Sunglasses or any lenses in red darker than No. 2 tint;
Replacement or repair of broken or lost frames and/or lenses;
Vision Care services and materials required as a condition of employment, or rendered by a facility under agreement with the Employer;
Vision Care services and materials provided by any other Plan;
Vision Care services of any kind other than defined and limited herein;
Vision Care services provided prior to the effective date of the member's coverage.

3. Provision of Administrative Services and Controls 15% _____

Demonstration of the ability to perform the following administrative services and controls

A. Maintain liaison between licensed insurer and/or administrator and State employees, retirees and State administrative personnel, as applicable.

B. Expedite and verify claims. Pay justified claims promptly.

C. Maintain liaison between State and the State's employees and retirees.

D. Provide audit controls and audit trails.

E. Provide the necessary authorization forms to employees, retirees and dependents. ¶173

F. Safeguard against duplicate payments.