

UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

TIARA YACHTS, INC.,

Case No. 1:22-cv-603

Plaintiff,

Honorable \_\_\_\_\_

v.

BLUE CROSS BLUE SHIELD OF  
MICHIGAN,

Defendant.

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**COMPLAINT**

Plaintiff, Tiara Yachts, Inc., formerly S2 Yachts, Inc. ("Tiara Yachts"), by and through its counsel, Varnum LLP, hereby states for its Complaint against Defendant Blue Cross Blue Shield of Michigan ("BCBSM") as follows:

**NATURE OF ACTION**

1. Tiara Yachts hired BCBSM to administer its self-funded health benefits plan (the "Plan") that Tiara Yachts offers to its employees and their dependents. This arrangement is governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*, and the terms of the Plan.

2. Tiara Yachts recently discovered that BCBSM is aware of flaws in its claims processing system that caused it to overpay for claims with Tiara Yachts' money. Instead of fixing the system failures, BCBSM concealed them from Tiara Yachts for reasons that appear to advance BCBSM's own interests. BCBSM continues to conceal its misconduct, in part, by maintaining exclusive control of Tiara Yachts' complete claims data and other information, which is necessary to comprehensively identify all improper payments and other wrongdoing.

3. BCBSM's mismanagement of Plan Assets clearly constitutes a breach of BCBSM's fiduciary duty of care under ERISA. Tiara Yachts brings this suit to recover the misappropriated funds and obtain all other relief to which it is entitled.

**PARTIES, JURISDICTION AND VENUE**

4. Tiara Yachts is a Michigan corporation, with its principal location in Holland, Michigan.

5. BCBSM is a Michigan non-profit health care corporation organized under the Nonprofit Health Care Corporation Reform Act, MCL 550.1101, *et seq.*

6. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132 because Tiara Yachts' claims arise under ERISA.

7. Venue is proper in this Court pursuant to 28 U.S.C. § 1391(b) because BCBSM resides in the Western District of Michigan and a substantial part of the events or omissions giving rise to the claim occurred in the Western District of Michigan. Venue is also proper pursuant to 29 U.S.C. § 1132(e)(2).

**GENERAL ALLEGATIONS**

8. Tiara Yachts hereby incorporates by reference the allegations contained in the preceding paragraphs.

9. Tiara Yachts, formally S2 Yachts, Inc., is in the business of designing and manufacturing boats.

10. Tiara Yachts offers health care benefits through the Plan. Rather than buy health insurance to cover employee health care claims under the Plan, during the relevant time period Tiara Yachts opted to self-insure. As such, Tiara Yachts paid the actual employee health care costs covered by the Plan, up to a large threshold. Tiara Yachts bought "stop loss" insurance to cover claims that exceeded that threshold.

11. Years ago, BCBSM began providing administrative services to Tiara Yachts and Tiara Yachts' self-funded health benefits Plan.

12. A self-funded arrangement is one in which the company (Tiara Yachts in this case) self-insures the health care claims of its employees instead of buying an insurance policy. Generally speaking, for every dollar of claims incurred by an employee, the self-funded entity pays that dollar. In order to self-fund, the company contracts with an administrator to process and pay the claims in exchange for a disclosed fee.

**A. TIARA YACHTS HIRED BCBSM TO SERVE AS THE PLAN'S ADMINISTRATOR.**

15. Tiara Yachts hired BCBSM to provide administrative services for the Plan.

16. In exchange, BCBSM charged Tiara Yachts a monthly administrative fee.

17. BCBSM and Tiara Yachts first executed an Administrative Services Contract ("ASC") on January 1, 2006. They renewed the ASC annually, until Tiara Yachts terminated the relationship in or about December of 2018.

18. The ASC delegates to BCBSM certain Plan administration responsibilities that Tiara Yachts would otherwise retain, including but not limited to interpreting Plan terms, calculating benefits, and using Tiara Yachts' Plan assets to pay for health care services.

19. BCBSM's administrative fee included a host of services, including but not limited to claims processing, check writing, case management, anti-fraud services, and cost containment.

20. BCBSM was to perform its administrative services in accordance with the health care benefits selected by Tiara Yachts.

21. In essence, BCBSM would process and pay claims on behalf of Tiara Yachts using Tiara Yachts' Plan assets.

22. Tiara Yachts sent the required prepayments to a BCBSM-owned bank account, on a periodic basis, in order for BCBSM to pay claims on Tiara Yachts' behalf.

23. The prepayments sent to BCBSM's bank account were "Plan Assets" as defined by ERISA. *See* Findings of Fact & Conclusions of Law in *Hi-Lex Controls, Inc. v. BCBSM*, No. 11-cv-12557, 2013 WL 3773364 (E.D. Mich. July 17, 2013), and *aff'd sub nom. Hi-Lex Controls, Inc. v. BCBSM*, 751 F.3d 740 (6th Cir. 2014), (the "*Hi-Lex* FFCL") at ¶¶ 5, 6, & 180; *Hi-Lex*, 751 F.3d at 745-46.

24. BCBSM had complete authority and control over the bank account and the Plan assets sent to it by Tiara Yachts.

25. BCBSM (a) exercised discretionary authority and control with respect to management of the Plan; (b) exercised authority and control with respect to management and disposition of Plan Assets; or (c) had discretionary authority and responsibility in the administration of the Plan. *Hi-Lex* FFCL, at ¶¶ 180-82; *Hi-Lex*, 751 F.3d at 744-47.

26. BCBSM functioned as a fiduciary in its administration of the Plan. *See* 751 F.3d at 747 ("common law supports the conclusion that BCBSM was holding the funds wired by Hi-Lex 'in trust' for the purpose of paying plan beneficiaries' health claims and administrative costs. Accordingly, the district court did not err in finding that BCBSM held plan assets of the Hi-Lex Health Plan and, in doing so, functioned as an ERISA fiduciary").

**B. CLAIMS ASSOCIATED WITH OUT-OF-STATE PROVIDERS.**

27. BCBSM was also responsible for administering the plan with respect to claims submitted by out-of-state providers.

28. BCBSM is an independent licensee of the Blue Cross and Blue Shield Association ("Association").

29. The Association is a national federation comprised of 38 independently licensed, community-based and locally operated Blue Cross Blue Shield Companies. These companies are colloquially known as "The Blues."

30. BCBSM and other Blues participate in the BlueCard Program. The BlueCard Program is a national program that enables members of one Blue Plan to obtain health care service benefits while traveling or living in another Blue Plan's service area (the "Host Blue").

31. The BlueCard Program links participating health care providers with the independent Blue Plans operating throughout the world through a single electronic network for claims processing and reimbursement.

32. This program allows BCBSM to instantly transfer and receive claim and member-eligibility information between the Blues when processing out-of-state claims.

33. BCBSM remains responsible to the Group for fulfilling BCBSM's contractual obligations when members access covered health care services within the geographic area served by a Host Blue.

34. The Group's liability on claims submitted by participating providers is based on the negotiated price made available to BCBSM by the Host Blue.

35. BCBSM charged Tiara Yachts host fees for claims processed through the BlueCard Program, including but not limited to fees and compensation BCBSM pays to the Host Blues, the Association, and other vendors, an additional administrative service fee, and, if applicable, a network access fee.

**C. BCBSM'S PRACTICE OF PAYING IMPROPER CLAIMS COMES TO LIGHT.**

37. Dennis Wegner was a senior account manager at BCBSM. He worked at BCBSM for 18 years, serving many customers, and is now credited for bringing BCBSM's prolific mismanagement of customers' assets to light.

38. While serving as an account manager, Dennis Wegner was alerted by a BCBSM customer about a significant medical claim the customer received in excess of \$250,000.

39. Dennis Wegner investigated the customer's complaint and discovered that BCBSM was overpaying for routine medical testing.

40. In that particular customer's case, BCBSM had overpaid more than \$600,000 within a two-year period.

41. Dennis Wegner brought the issue to BCBSM's attention, and to Dennis Wegner's surprise BCBSM's management confirmed that BCBSM's payment of improper claims are known to happen in the BCBSM billing system, but BCBSM has done nothing to stop them.

42. Alarmed that BCBSM's payment of improper claims may not be isolated to one customer, Dennis Wegner researched claims and billings for two other BCBSM customers and found similar overpayments, totaling \$125,000 in one case, and \$75,000 in another case.

43. Again, Dennis Wegner brought his concerns about overpayments to BCBSM's attention, but was told to cease researching the issue, to "stand down," and to refrain from alerting any BCBSM customers of improper payments made by BCBSM.

44. The improper charges were known by many key employees and executives within BCBSM, including Rod Begosa, David Malik, Lori Shannon, Gary Gavin, Ken Dallafior, Carol Gawronski, Robert Hopper, Dianne Malmgren, Nadiya Delaney, Kimberly Jones-Schneider, Teresa Henry, Pamela A. Braund, Sandra Fester, Aaron Friedkin, Jason M. Hover, Michael McKay

Jr., Paul E. Ragos, Robert Rizzo, Diane VanEck, and Jeffrey Connolly. Yet no one at BCBSM took any action to stop the payment of improper claims.

45. After Dennis Wegner sounded the alarm, BCBSM's executives held a meeting to discuss the issue and afterwards sent a recap revealing troubling details. 9/14/2017 BCBSM Email Chain, **Exhibit A**.

46. BCBSM knew that the majority, if not all, of self-funded, non-auto customers on its NASCO platform, including Tiara Yachts, were impacted by this systems flaw. *Id.*

47. BCBSM maintained lists of customers that were affected by this problem. *See e.g., id.*, with 2017 List of Customers Impacted by Flip Logic, **Exhibit B**.

48. BCBSM attributed this problem to an intentional design in its programming called "flip logic." Ex. A, 9/14/2017 BCBSM Email Chain.

49. BCBSM implemented flip logic in 1997. Under the logic, when a claim is submitted associated with a non-participating provider, BCBSM's system "flips" the non-participating provider's status and processes the claim at charge. 9/19/2017 BCBSM Email Chain, **Exhibit C**.

50. Thus, by using the flip logic, BCBSM allowed "providers [to] bill and get fully reimbursed for highly inflated cost of services." Ex. A, 9/14/2017 BCBSM Email Chain. Essentially, BCBSM would pay whatever was charged for a service, regardless of whether the claim was proper under the plan terms or other applicable reimbursement guidelines and policies. *Id.*

51. To be clear, this problem was not isolated to claims associated with laboratory services. The improper payments were not only associated with laboratories, but also with, for

example, hospitals, x-rays, and office visits. In reality, anyone could take advantage of BCBSM's flawed system logic.

52. BCBSM knew that this "ha[d] been an issue within the company for a number of years." Ex. C, 9/19/2017 BCBSM Email Chain. But, "[i]n the absence of controls in the system logic that would flag suspicious claim activity, claims continue to be processed as '*pay sub at charge*,' often many times over and above the customary amount for such services." *Id.*

53. Compounding the issue, BCBSM identified at least 201 customers which had "elected to pay at the Host-allowed rate for non-par claims." Ex. C, 9/19/2017 BCBSM Email Chain, *with* Ex. B, 2017 List of Customers Impacted by Flip Logic.

54. Thus, according to Tiara Yachts' Plan, Tiara Yachts should have been paying for out-of-state, non-par claims at a lower rate set by the applicable Host Blue plan. BCBSM knew this, stating "'Flipping' logic is in direct contradiction with the group-elected benefit." Ex. C, 9/19/2017 BCBSM Email Chain.

55. In 2016 alone, "BCBSM processed 30,000 non-par claims at charge when Host pricing was available. The sum of those [flip] charges was \$30.5M and resulted in a payment amount of \$26.7M." Had BCBSM applied the Host plan pricing as it was required to do, "the total allowed amount for these claims would have been \$7.1M; a potential savings of \$23.0M in benefit costs." *Id.* (emphasis added).

56. It gets worse. BCBSM expressly recognized that it had a "fiduciary responsibility to [its] ASC customers" and that its "lack of control over the issue [would be] viewed as a failure to fulfill this responsibility." *Id.*

57. However, instead of accepting responsibility as fiduciary for a flawed logic that it created over four decades ago and failed to correct, BCBSM worked to conceal the issue.

58. BCBSM acknowledged that its "customers may not be fully aware of the implications of the 'flipping' system logic," and took active steps to conceal the problem from its customers, including Tiara Yachts. Ex. A, 9/14/2017 BCBSM Email Chain.

59. BCBSM was worried that a "Provider pursuing [a] member for [a] large balance may cause a spike in member inquires and groups' dissatisfaction." *Id.* Thus, BCBSM would temporarily assume liability for any inconspicuous overcharges that resulted from the flip logic, in order to keep its mismanagement of its customers' plans hidden. *Id.*

60. Some BCBSM employees suggested that BCBSM "make a global change to discontinue the logic and pay at Host allowed." *Id.* Essentially, the suggestion was to process claims in compliance with customers' selected benefit plans—what BCBSM should have been doing all along. Additionally, the BCBSM employees suggested making impacted customers "aware, educated, and their concurrence be documented." *Id.* These suggestions were ignored.

64. BCBSM continued to conceal its misconduct, and on November 14, 2018, BCBSM terminated Dennis Wegner's employment after he refused to cease investigating and pressing the issue.

65. On February 5, 2019, Dennis Wegner filed a lawsuit against BCBSM, alleging violations of the Michigan Whistleblowers' Protection Act and Michigan Bullard-Plawecki Employee Right-to-Know-Act. *See Dennis Wegner v. BCBSM*, No 19-001808-CD (Wayne Cnty. Cir. Ct.), attached as **Exhibit D**.

**D. BCBSM CAPITALIZES ON ITS MISCONDUCT AND MISMANAGEMENT OF ITS CUSTOMERS' PLAN ASSETS.**

70. Around the time BCBSM's practice of reimbursing claims at charge was being called into question, BCBSM formulated a plan to capitalize on its misconduct.

71. Effective January 1, 2018, BCBSM implemented a package of Payment Integrity Services for all of its self-funded customers using a shared savings arrangement (collectively called the shared savings program ("SSP")). SSP Internal Memo, **Exhibit E**.

72. The SSP includes four primary services: a pre-pay forensic bill review, advanced payment analytics, subrogation, and credit balance recovery. *Id.*

73. "Pre-pay Forensic Bill Review provides a review of high cost inpatient claims to detect and resolve billing errors *after* adjudication, but prior to payment." These services are performed by a third-party vendor called Equian. *Id.*

74. Equian reviews "all claims meeting [a] \$25,000 threshold that are inpatient and are paid as outliers to current diagnostic edit process, OR are paid under a percent charge reimbursement methodology. This includes both in and out-of-state claims, and Par and Non-par providers." *Id.*

75. Subrogation generally "involves the detection and recovery of 3rd-party liability claims where a 3rd party is accountable for the expense." *Id.*

76. Credit Balance Recovery entails the detection and recovery of credit balances on hospital patient accounting systems due to ASC customers, such as Tiara Yachts. *Id.*

77. Last, Advanced Payment Analytics works to identify "claim overpayments not previously detected and recover the overpayment from providers after payment is rendered." These services are performed by a third-party vendor called Cotiviti. *Id.*

78. Prior to implementing Advanced Payment Analytics, BCBSM purportedly performed several post-pay claim review services, included as part of its administrative services fee. These included data mining for provider billing errors, coordination of benefits, and

overpayment identification. Cotiviti differs from these services in that it offers a "2nd pass" review for improper payments. *Id.*

79. BCBSM's engagement with Cotiviti was not new. BCBSM had previously engaged Cotiviti to provide improper payment detection services for BCBSM's own fully insured book of business, and had realized savings of \$12–15 million per year. BCBSM, however, did not engage Cotiviti for its self-insured groups until 2018. *Id.*

80. The SSP came with a catch. For any improper payments detected and recovered in connection with these programs, *but only as they applied to BCBSM's self-funded customers*, BCBSM would retain 30 percent of the avoided or recovered payment. BCBSM marketed its compensation as "administrative compensation." *Id.*

81. BCBSM also made it mandatory for its self-insured customers to participate and automatically opted all self-funded customers into the program. *Id.*

82. Cotiviti's review in particular would apply retroactively to improper payments extending back to January 1, 2016. *Id.*

83. In effect, for any improper payments Cotiviti detected and recovered—including the improper payments BCBSM knew existed as a result of its flip logic and beyond—BCBSM would take a 30 percent cut.

84. Essentially, BCBSM devised a scheme that would allow it to profit on its own mismanagement of plan assets. The more improper payments BCBSM let slide through its system, the more money it would make on the back end. Unfortunately, this came at the expense of BCBSM's self-insured customers, including Tiara Yachts.

85. As an ERISA fiduciary, BCBSM must avoid any conflicts of interest concerning the manner in which it performs its fiduciary duty. The SSP creates an impermissible conflict of interest.

**E. BCBSM FURTHER CONCEALS ITS MISCONDUCT BY GATEKEEPING INFORMATION NECESSARY TO IDENTIFY IMPROPER CHARGES.**

86. BCBSM has designed a system in which it knowingly and improperly pays claims, later corrects the claim charge to what it should have been in the first place, at its discretion, and then collects a recovery fee for "catching" the error.

87. BCBSM impedes its self-funded customers, including Tiara Yachts', ability to evaluate whether BCBSM is properly paying claims by significantly limiting access to each customers' claims data and other documents that set forth the guidelines and rules for claims processing and pricing.

88. Claims data is incredibly in-depth electronic information gathered from medical bills or claims submitted to BCBSM. For example, claims data identifies who rendered a service, the rendering provider(s) specialties and credentials, what service(s) was performed, what amount was billed for the service, what amount BCBSM allowed to be paid out of what was charged, who BCBSM paid, when and where the service was provided, the patient's identity and age, and diagnoses.

89. Claims data also shows the line-item detail associated with each claim. For example, when a provider submits a claim for orthopedic surgery, the claim will have each associated cost and service broken down by service line showing the total the provider charged, the amount BCBSM allowed, and what was ultimately paid.

90. Claims data is essential to identifying improper claims and payments.

91. Throughout the parties' relationship, BCBSM maintained exclusive control and access to Tiara Yachts claims data. Tiara Yachts never had and still does not have access to its own *complete* claims data. BCBSM's exclusive control and access to its customers' claims data is yet another tool BCBSM utilizes to conceal its misconduct.

92. Tiara Yachts' claims data should reflect all information necessary to ascertain whether a claim was properly processed and/or paid. To the extent it does not, BCBSM's failure to collect and/or maintain such data would itself be a breach of fiduciary duty.

93. Such data deficiencies may include, for example: missing provider information, missing payee information, rolled-up financials, financials that do not reconcile, claims showing as rejected but still paid, fields compromised by BCBSM's flip logic, or even claims that are altogether missing.

94. **Missing Provider Information.** An NPI is a unique government ID number issued to medical professionals and businesses and is required to be used in health care transactions by the Health Insurance Portability and Accountability Act ("HIPAA"). Claims without provider information, such as an NPI, are incapable of being analyzed for the identification of improper payments. BCBSM requires an NPI on every claim prior to reimbursement. *See, e.g.*, BCBSM Provider Manual<sup>1</sup> ("If NPI is missing or illegible, claim will be rejected."). It is the responsibility of BCBSM, as the Plan fiduciary, to provide industry standard oversight, such as confirming that the health care service provider is a covered entity as described within the plan document.

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<sup>1</sup><https://www.bcbsm.com/content/dam/public/Providers/Documents/help/medicare-plus-blue-ppo-manual.pdf>.

95. **Missing Payee Information.** Claims missing payee information fail to disclose where or to whom plan funds were spent. As the fiduciary, BCBSM was responsible for tracking to whom and where plan assets are distributed.

96. **Rolled-Up Financial Details.** Claims should reflect a line-by-line detail of each claim's associated costs and reimbursements. For example, each item within a claim should have itemized details regarding the amounts billed and paid. A consolidation, or "roll-up", of a claim's line-by-line detail makes it impossible to verify whether a claim was properly made and/or paid.

97. **Claim Financials Do Not Add Up.** The maximum reimbursement for health care service is determined by the contracted rate applicable to each service billed. The maximum reimbursement is paid by the Plan after member liability (deductible, co-insurance, and co-pays) has been applied. Thus, the combination of plan paid amount and member liability should represent maximum reimbursement to a network health care provider. When this combination does not reconcile with BCBSM's allowable amount (also called the approved amount), the claim financials do not add up and this raises fiduciary concerns.

98. **Rejected Claims that Report as Paid.** Claims that are rejected should be denied with no payable amount. If rejected claims showing a paid amount were in actually paid, these claims are a fiduciary violation and would be considered improper payments.

99. **Systematic Pricing Failure of Out-of-Network Claims – Flip Logic.** Due to BCBSM's flip logic, many claims may be labeled as in-network in the data and allowed at 100 percent, when in fact they were out-of-network and should have been reduced according to Tiara Yacht's elected Plan benefits.

100. **Missing Claims Data.** Tiara Yacht's claims data should reconcile with the financial transactions BCBSM reported to Tiara Yacht's. A gap between the paid amounts in the

claims data and financial reports, means that either claims data is missing or Tiara Yachts was overcharged.

101. BCBSM processes all claims for all non-auto NASCO customers, such as Tiara Yachts, on the same claims processing system. Thus, errors or deficiencies identified in claims associated with one customer can reasonably be expected to exist for other customers using the same system.

102. BCBSM's NASCO claims processing system has been found to consistently result in improper payments of claims. These processing errors result in wasted Plan assets in breach of BCBSM's fiduciary duty.

103. Common errors associated with BCBSM's NASCO claims processing system include, for example: unbundling, upcoding, medically unlikely claims, non-adherence to payment guidelines, and BCBSM's flip logic.

104. **Unbundling.** Unbundling is when a health care service provider uses the billing codes for two or more separate procedures when the procedures were actually performed together and only one code should be paid. Within the health care industry, procedure-to-procedure ("PTP") edits are used to identify various types of unbundling. These edits work by defining pairs of Healthcare Common Procedure Coding System ("HCPCS") and Current Procedural Terminology ("CPT") codes that should not be reported together on a claim for a variety of reasons, such as a provider performing several laboratory tests for a patient that are commonly grouped as a panel and fall under a single billing code. The provider may try to increase their reimbursement by submitting claim codes for each individual test in the panel. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported. As the Plan

administrator tasked with responsibility of processing claims, BCBSM should allow and pay unbundled claims.

105. **Medically Unlikely Edits (MUE).** An MUE for a code is the maximum units of service that a provider would report under most circumstances for a single patient on a single date of service. In other words, MUEs represent an upper limit that unquestionably requires further documentation to support. These edits are designed to limit fraud and/or coding errors. As the Plan administrator tasked with responsibility of processing claims, BCBSM should not allow and pay claims that exceed the maximum number of units allowed.

106. **Upcoding.** Upcoding occurs when health care providers submit inaccurate billing codes to insurance companies in order to receive inflated reimbursements. As the Plan administrator, BCBSM should not allow and pay upcoded claims.

107. **Non-Adherence to Payment Guidelines.** Payment guidelines are established to determine the appropriate reimbursement amounts when processing a claim. In general, Payment Guidelines dictate the reimbursement methodology used to determine the maximum allowable for any given service and provider type. As the Plan administrator, BCBSM must adhere to payment guidelines when processing and paying claims.

108. The aforementioned improper payments are non-exclusive examples of improper payments BCBSM regularly makes when processing claims for NASCO customers, and therefore also made when processing claims for Tiara Yachts. This Complaint is intended to cover all further improper payments and misuses of plan assets discovered hereafter once Tiara Yachts has the opportunity to analyze its own complete claims data.

**F. BCBSM'S PRACTICE OF KNOWINGLY PAYING IMPROPER CLAIMS IS INCONSISTENT WITH INDUSTRY STANDARDS, INCONSISTENT WITH HOW BCBSM HOLDS ITSELF OUT TO THE PUBLIC, AND INCONSISTENT WITH REPRESENTATIONS IT MAKES TO CUSTOMERS.**

95. BCBSM's practice of paying Providers' improper claims is contrary to standards and norms in the health insurance industry, contrary to how BCBSM markets itself to the public, and is contrary to representations it makes to customers.

96. BCBSM represents that its "claims processing practices consistently deliver industry-leading outcomes with respect to claim payments, and average above 99% accuracy." Payment Integrity Presentation, **Exhibit F**.

97. BCBSM says that it "takes actions to ensure health claims are submitted, and paid accurately, proactively and correctly, by the responsible party, for eligible members, according to medical, benefit and reimbursement policies and contractual term. Not in error or duplicate and free of wasteful or abusive practices." *Id.*

98. Indeed, BCBSM charges its customers for its investigation, detection, and recovery of improper claims.

99. BCBSM's practice of knowingly paying improper claims is entirely inconsistent with such representations, and with industry standards.

100. Likewise, BCBSM's payment of claims that lack basic information, such as the provider's identity and qualifications that is essential to avoiding improper payments, is inconsistent with industry standards and BCBSM's own policies.

101. Tiara Yachts never imagined, nor had reason to imagine based on BCBSM's own representations, that BCBSM knowingly paid Providers' improper claims or that BCBSM knew of flaws in its system affecting Tiara Yachts and failed to disclose and correct the issue.

102. The limited reporting information BCBSM provided to Tiara Yachts contained no information about BCBSM's practice of paying Providers' improper claims or its flawed systems.

103. Based on BCBSM's own representations – that BCBSM is as an industry expert in fraud prevention – and the fact that information BCBSM provided Tiara Yachts contained no information about its practice of paying Providers' improper claims, Tiara Yachts trusted and believed that BCBSM was acting in Tiara Yachts' best interest. As explained above, Tiara Yachts was wrong.

104. BCBSM, as a fiduciary to Tiara Yachts, had a duty to disclose all material facts related to its claims processing, including all Plan assets that had been mis-mismanaged. BCBSM failed to do so.

**COUNT I**  
**Breach of Fiduciary Duty – ERISA**

105. Plaintiff hereby incorporates by reference the allegations contained in the preceding paragraphs.

106. At all times relevant, BCBSM was a fiduciary pursuant to 29 U.S.C. § 1002(21)(A) with respect to Tiara Yachts' Plan because (a) it exercised discretionary authority and control over management of the Plan; (b) it exercised authority and control over management and disposition of the Plan's assets; or (c) it had discretionary authority and responsibility in the administration of the Plan.

107. As a fiduciary, BCBSM was required, among other things, to discharge its duties solely in the interest of the employees and beneficiaries of the Plan, preserve Plan assets, fully disclose its actions, avoid making false or misleading statements, avoid conflicts of interest, and abide by any statutory obligations or restrictions imposed on it. BCBSM also held a duty to act in accordance with the documents and instruments governing the Plan.

108. BCBSM breached its fiduciary duties in numerous ways, including, but not limited to:

(a) Knowingly using Tiara Yachts' Plan assets to pay claims impacted by BCBSM's systems flip logic, fully aware such flip logic had been flawed for decades and was causing Tiara Yachts' Plan to overpay for benefits;

(b) Failing to implement or correct controls in its systems logic that would flag suspicious claim activity, when BCBSM knew that its systems logic was flawed and causing claims to be processed at charges in contradiction with Tiara Yachts' elected Plan benefits;

(c) Concealing from, and otherwise failing to disclose to Tiara Yachts, the full implications of and flaws associated with its systems logic and the overpayments BCBSM made as a result;

(d) Misleading and deceiving Tiara Yachts by implementing a Shared Savings Program when it knew Tiara Yachts' Plan assets were being used to overpay for benefits, allowing BCBSM to capitalize on its own misconduct and mismanagement, which was a clear conflict of interest;

(e) Using its considerable discretionary authority to advance interests other than those of Tiara Yachts' Plan or its members;

(f) Failing to implement and exercise sufficient quality control and oversight of BCBSM's claims processing systems and discretionary review of claims pre- and post-payment;

(g) Consistently paying claims suffering from a range of coding and billing issues, including but not limited to unbundling, upcoding, medically unlikely services, and

reimbursing claims in non-adherence to its own and/or industry standard reimbursement guidelines;

(h) Failing to implement industry standard claims processing edits to prevent Tiara Yachts' Plan assets from being used to pay improper charges;

(i) Concealing from, and otherwise failing to disclose to Tiara Yachts the payment of improper claims;

(j) Concealing from, and otherwise failing to disclose to Tiara Yachts all documents and information that govern BCBSM's methodology for determining covered charges under Tiara Yachts' Plan and amounts to be paid to providers, affording BCBSM complete discretionary control and preventing Tiara Yachts from verifying whether reimbursements made by BCBSM using its Plan assets were calculated and made in accordance with the Plan's terms, operative pricing rates, rules, policies, and contracts;

(k) Paying claims lacking standard information necessary to properly adjudicate claims in accordance with industry standards and BCBSM's own policies and procedures, or otherwise failing to maintain claims data necessary to identify and recover incorrectly paid amounts and identify the full scope of BCBSM's misconduct and mismanagement;

(l) Failing to exercise the care, skill, prudence, and diligence under the circumstances that a prudent fiduciary acting in a like capacity and familiar with such matters would use in paying for health care claims, and otherwise administering Tiara Yachts' ERISA-governed Plan.

109. BCBSM's breach of its fiduciary duty has proximately caused substantial damages to Tiara Yachts.

**COUNT II**  
**Engaging in Prohibited Transactions**

110. Plaintiff hereby incorporates by reference the allegations contained in the preceding paragraphs.

111. At all times relevant, and with respect to the actions described above, BCBSM was an ERISA fiduciary. Therefore, under 29 U.S.C. § 1106, BCBSM was prohibited from dealing with the assets of Tiara Yachts' Plan in its own interest or for its own account.

112. As described above, BCBSM instituted a mandatory Shared Savings Program whereby it was paid 30 percent of certain recoveries.

113. Whether Tiara Yachts agreed to pay 30 percent is immaterial, because the amount of the "recoveries" were in the unilateral control of BCBSM.

114. The more improper claims that BCBSM failed to detect on the front end, the higher the recoveries on the back end, and the more it got paid.

115. By instituting a system that allowed it to unilaterally control the amount of its own compensation, BCBSM dealt with Tiara Yachts' Plan assets in its own interest and for its own account in violation of Section 1106.

**PRAYER FOR RELIEF**

Plaintiff respectfully requests that this Court enter judgment in its favor and against BCBSM as follows:

A. Order BCBSM to provide a full and complete accounting of all payments and uses of Tiara Yachts' Plan assets;

B. Order BCBSM to provide a full and complete accounting of all monies taken or charged by BCBSM to Tiara Yachts;

C. Declare that BCBSM breached its fiduciary duty owed to Tiara Yachts and otherwise violated federal law by (1) mismanaging Tiara Yachts' Plan assets; (2) not exercising the care, skill, prudence, and diligence under the circumstances that a prudent fiduciary acting in a like capacity and familiar with the such matters would use in paying for health care claims, or otherwise administering Tiara Yachts' Plan; (3) not making decisions, regarding Plan assets, with an eye single to the interests of Tiara Yachts' Plan participants and beneficiaries; (4) concealing and failing to implement or correct controls in its claims processing system known to cause Tiara Yachts to overpay for elected benefits; (5) using its considerable discretionary authority to advance interests other than those of Tiara Yachts' Plan or its members; (6) failing to disclose its mistakes, overpayments, improper payments or other mismanagement of Plan assets; (7) capitalizing on its own mismanagement and misconduct, at the expense of Tiara Yachts' Plan; (8) failing to implement and exercise sufficient quality control and oversight of claims progressing, review, and payment; (9) consistently reimbursing improper claims causing Tiara Yachts' plan to overpay for benefits; (10) failing to implement standard claims processing edits to avoid overcharges to Tiara Yachts' Plan; (11) concealing from Tiara Yachts all documents and information necessary to verify whether reimbursements made by BCBSM with Tiara Yachts' Plan assets were calculated and made in accordance with the Plan's terms, operative pricing rates, rules, policies, and controls; and (12) paying claims lacking information necessary to properly adjudicate and reimburse claims in accordance with industry standards and BCBSM's own policies and procedures, or otherwise failing to maintain claims data necessary to identify and recover overpaid amounts and/or identify the full scope of BCBSM's misconduct or mismanagement;

D. Awarding restitution to Tiara Yachts for all improper misuses of Tiara Yachts' Plan assets;

E. Awarding restitution to Tiara Yachts for all administrative compensation collected by BCBSM under its Shared Savings Program;

F. Awarding monetary damages, costs, interest, disgorgement of BCBSM's profits, and attorneys' fees (including statutory attorneys' fees under ERISA) to the fullest extent of the law; and

G. Awarding all other relief to which Tiara Yachts may be entitled.

Respectfully submitted,

VARNUM LLP  
Attorneys for Plaintiff

Dated: July 1, 2022

By: /s/ Aaron M. Phelps  
Perrin Rynders (P38221)  
Aaron M. Phelps (P64790)  
Kyle P. Konwinski (P76257)  
Chloe N. Cunningham (P83904)  
Bridgewater Place, P.O. Box 352  
Grand Rapids, MI 49501-0352  
(616) 336-6000  
[prynders@varnumlaw.com](mailto:prynders@varnumlaw.com)  
[amphelps@varnumlaw.com](mailto:amphelps@varnumlaw.com)  
[kpkonwinski@varnumlaw.com](mailto:kpkonwinski@varnumlaw.com)  
[cncunningham@varnumlaw.com](mailto:cncunningham@varnumlaw.com)

19294942.4

UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

TIARA YACHTS, INC.,

Plaintiff,

v.

BLUE CROSS BLUE SHIELD OF  
MICHIGAN,

Defendant.

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**INDEX OF EXHIBITS TO COMPLAINT**

<b><u>Exhibit</u></b>	<b><u>Description</u></b>
A	9/14/17 BCBSM Email Chain
B	2017 List of Customers Impacted by Flip Logic
C	9/19/17 BCBSM Email Chain
D	Wegner Complaint
E	SPP Internal Memo
F	Payment Integrity Presentation

# EXHIBIT A

Message

---

From: Gawronski, Carol [CGawronski@bcbsm.com]  
Sent: 9/14/2017 11:41:58 AM  
To: Hopper, Robert [RHopper@bcbsm.com]  
CC: Malmgren, Dianne [DMalmgren@bcbsm.com]; Delaney, Nadiya [NDelaney@bcbsm.com]  
Subject: FW: 9-7-17 Meeting Notes - Action Item follow up

## Redacted - Attorney Work Product

**From:** Malmgren, Dianne  
**Sent:** Wednesday, September 13, 2017 4:30 PM  
**To:** Hopper, Robert <RHopper@bcbsm.com>  
**Cc:** Shannon, Lori <LShannon2@bcbsm.com>; Wegner, Dennis <DWegner@BCBSM.com>; Malik, David R. <DMalik@bcbsm.com>; Jones-Schneider, Kimberly <KJonesl@bcbsm.com>; Begosa, Rod <RBegosa@BCBSM.com>; Gawronski, Carol <CGawronski@bcbsm.com>; Delaney, Nadiya <NDelaney@bcbsm.com>; Henry, Teresa <TMHenry@bcbsm.com>  
**Subject:** RE: 9-7-17 Meeting Notes - Action Item follow up

Team — Attached is the list of non-auto NASCO classic groups that are affected. CFI expects to be able to provide more detail per group by next week.

Dianne Malmgren, Manager  
Benefit Admin - Sales Support  
Phone: 313-448-5299  
Cell: 248-921-3101  
Fax: 866-582-4027

**From:** Hopper, Robert  
**Sent:** Tuesday, September 12, 2017 12:49 PM  
**To:** Begosa, Rod <RBegosa@BCBSM.com>; Malmgren, Dianne <DMalmgren@bcbsm.com>; Gawronski, Carol <CGawronski@bcbsm.com>  
**Cc:** Shannon, Lori <LShannon2@bcbsm.com>; Wegner, Dennis <DWegner@BCBSM.com>; Malik, David R. <DMalik@bcbsm.com>; Jones-Schneider, Kimberly <KJonesl@bcbsm.com>  
**Subject:** RE: UTC Labs

Rod

As far as the "attention it deserves commentary," I need to be clear that this is not an instance where people are not paying attention to the issue. I empathize with David's sentiment in that we need to be able to determine the root cause and work to rectify which is why the cross functional stakeholders are being pulled together. In fact, a lot of people met late last week to try to get to the bottom of what this is and how we might be able to solve it. Have you been able to ascertain from the customer that they understand the ramifications of the switch in processing and its impacts to increasing member liability? Please review the below so that you can be aware of what is happening behind the scenes.

Meeting recap is below:

Attended: Jones-Schneider, Kimberly; Gawronski, Carol; Malmgren, Dianne; Montagano Roegner, Michele; Nagy, Karol; Hopper, Robert; Ozdarski, Paul; Beauregard, Maureen Ellen; Collins, Marianne; Harrison, Larry; Boillat, Erik L; Henry, Teresa; Welch, Paul; Byrd, Bruce; Delaney, Nadiya

Notes:

Who is impacted?

BlueCard transactions initiated by non-par provider for all customer groups on NASCO Classic with exception of Auto. MOS processing is not impacted at large, unless group made a request for exception processing by means of MOS mod/rider. MOS default logic is to pay Host allowed.

How parties are impacted?

Majority of non-Auto groups on NASCO Classic are following logic created some time back to flip the par status on the claim and process at charge when a referring provider information is submitted. This is done without checking whether providers are participating, as we do not currently have the capability to do so for out state providers. Although this logic was implemented with intention to hold member harmless in situations of no choice or limited provider availability, overtime dynamic shifted and BCBSM is observing abusive provider practices.

By allowing reimbursement at charge, providers bill and get fully reimbursed for highly inflated cost of services. In most scenarios, member is not aware or consented to referral being made out of network (for example labs).

It has been suggested that group customers may not be fully aware of the implications of the "flipping" system logic, as its intent has changed over time.

As reimbursement at charge in most case by far exceeds allowed amount, it became lucrative for providers to de-par.

What has been suggested?

1. It is workgroup's suggestion to make a global change to discontinue the logic and pay at Host allowed, but allow group customers to opt out on the individual basis, ensuring they fully understand possible consequences, including BCBSM limitation in preventing abusive provider behavior.

To clarify: is there any exceptions to the suggestion above? I think, I heard somebody saying that flip logic will continue in situations of emergency or facility stay (no choice). Please address!!!

2. Impacted group customers should be made aware, educated and their concurrence be documented.

3. Provider outreach to curtail the behavior.

Business Readiness/What we need answers for?

For customer communication:

- prepare a list of impacted customers by name — D. Malmgren and T. Henry
- prepare a scrip for account management team to follow in their conversation with groups - TBD
- 1 year data comparison for each impacted group of non-par pay sub BlueCard claims paid vs host allowed. This will inform the group's decision maker of the magnitude of the issue and support our suggestion for the change — P. Ozdarski and K. Nagy
- ensure that the appropriate executive team is briefed and aligned to the above recommendation (this issue will be included on the Global Issues workgroup agenda)— R. Hopper

For provider communication:

- need to engage provider relations to understand how we educate the provider community and if there is a way to enforce the desired behaviors thru shifting financial responsibility — N. Delaney

What risks do we need to address?

- We have fiduciary responsibility to our ASC customers. Our lack of control over the issue was viewed as failure to fulfill this responsibility and a settlement was requested (= **example**).
- It is unclear what our group customers currently understand in term of rules for processing BlueCard non-par claims. Demonstrating effects of the "flip" logic may cause groups to question their original consent to it.

- The source of the consent also came into question. We need to be able to demonstrate that consent was provided by the group's decision maker at that time, and not by any other party (example).
- As the change takes effect, we need to ensure that member is held harmless. Provider pursuing member for large balance may cause a spike in member inquiries and groups' dissatisfaction.

N

**From:** Begosa, Rod  
**Sent:** Tuesday, September 12, 2017 12:36 PM  
**To:** Malmgren, Dianne <[DMalmgren@bcbsm.com](mailto:DMalmgren@bcbsm.com)>; Gawronski, Carol <[CGawronski@bcbsm.com](mailto:CGawronski@bcbsm.com)>; Hopper, Robert <[RHopper@bcbsm.com](mailto:RHopper@bcbsm.com)>  
**Cc:** Shannon, Lori <[LShannon2@bcbsm.com](mailto:LShannon2@bcbsm.com)>; Wegner, Dennis <[DWegner@BCBSM.com](mailto:DWegner@BCBSM.com)>; Malik, David R. <[DMalik@bcbsm.com](mailto:DMalik@bcbsm.com)>; Jones-Schneider, Kimberly <[KJonesl@bcbsm.com](mailto:KJonesl@bcbsm.com)>  
**Subject:** FW: UTC Labs  
**Importance:** High

Team:

It appears we have evidence that the Pay charge for non-par provider referral claims (labs) is not isolated to [redacted] We need to verify and discuss whether this is a global issue.

Carol, in the interim, can we place claims on stop for looth [redacted] ?

Thanks.

Rod

**From:** Malik, David R.  
**Sent:** Tuesday, September 12, 2017 11:50 AM  
**To:** Begosa, Rod <[RBeosa@bcbsm.com](mailto:RBeosa@bcbsm.com)>  
**Subject:** FW: UTC Labs  
**Importance:** High

Rod,  
This clearly needs to get elevated to receive the attention it deserves!...

*David R. Malik*  
Regional Manager - Key Accounts I Health Plan Business  
Blue Cross Blue Shield & Blue Care Network of Michigan  
600 E. Lafayette Blvd., Detroit, MI 48226-2998 I Mail Code 517H  
Desk: (313) 448-2335 Mobile: (313) 550-9170

**From:** Wegner, Dennis  
**Sent:** Tuesday, September 12, 2017 11:24 AM  
**To:** Malik, David R. <[DMalik@bcbsm.com](mailto:DMalik@bcbsm.com)>  
**Subject:** UTC Labs

David,

I found something interesting with claim for the same provider—UTC labs. We are paying 100 percent of charge for all labs, just like is \$126,000 for one member for 2017. When I applied the report filters to I found a The total paid

111111111.had a similar issue, but with a different provider. The total paid for their outpatient labs is around \$62k.

I wanted to bring this to your attention and the potential impact for other customers.

**Dennis J. Wegner**

**Account Manager, Key & Large Group Business**

**Blue Cross Blue Shield of Michigan**

600 E. Lafayette Blvd, Detroit MI 48226 | Mail Code 517D | 313.448.8095 Direct | 586.839.8621 Cell | 866.264.4050 Fax

[dwegner@bcbsrn.com](mailto:dwegner@bcbsrn.com)

# **EXHIBIT B**

	A	B	C	D	E	F
1	Group	Group Number	Account Manager			
2			Jensen, Kollin R.			
3			Squires, Mark			
4			Riden, Nathan			
5			Kelly, Stephanie			
6			Kelly, Stephanie			
7						
8			Marvin, Dawn			
9			Barry, Dree			
10			Johnson, Jennifer R.			
11			Figurski, Ryan			
12			Nosakowski, Jennifer			
13			Nosakowski, Jennifer			
14			Nosakowski, Jennifer			
15			Parenteau, Karen A.			
16			Nunnally, Jennifer			
17			Parenteau, Karen A.			
18			Kish, Kimberly			
19			Kish, Kimberly			
20			Kish, Kimberly			
21			Felton, Deborah M.			
22			Huntoon, Jason			
23			Huntoon, Jason			

	A	B	C	D	E	F
24			Nosakowski, Jennifer			
25			Kabongo, Jacques			
26			Parenteau, Karen A.			
27			Moore, Tani			
28			Navarra, Jonathan			
29			Hahka, John			
30			Squires, Mark			
31			Landin, Jennifer			
32			Linville, Sarah L.			
33			Gray, Daga			
34						
35			Kisiel, Gina			
36			Felton, Deborah M.			
37			Kolen, Denise			
38			Parenteau, Karen A.			
39			Whitley, Ryan D.			
40			Bickley, Kim			
41			Khoury, Michael			
42	Comau LLC	71587	Wegner, Dennis			
43			Notter, Josondra B.			
44			Kolen, Denise			
45			Karim, Derrick			
46			Donovan, Randy			
47			Doebel, Sherri K.			
48			Moore, Yvonne			

	A	B	C	D	E	F
49			Bengel, Ashley S.			
50			Morrone, Lynsi A.			
51			Huntoon, Jason			
52			Bengel, Ashley S.			
53			Squires, Mark			
54			Squires, Mark			
55			Donovan, Randy			
56			Khoury, Michael			
57			Nosakowski, Jennifer			
58			Karim, Derrick			
59			Moore, Tani			
60			Smith, Daniel J.			
61			Delaney, Brandon			
62			Huntoon, Jason			
63			Notter, Josondra B.			
64			Johnson, Jennifer R.			
65			Kelly, Stephanie			
66			Kelly, Stephanie			
67			Crandall, Steve			
68			Bengel, Ashley S.			
69			Harvey, Lynne			
70			Beachnau, Kevin			
71			Jurmu, Brad			

	A	B	C	D	E	F
72			Briggs, Whitney W.			
73			Donovan, Randy			
74			Squires, Mark			
75			Schnelker, Deborah L.			
76			Felton, Deborah M.			
77			Riden, Nathan			
78			Nosakowski, Jennifer			
79			Karim, Derrick			
80			Khoury, Michael			
81			Kelly, Stephanie			
82			Khoury, Michael			
83			Squires, Mark			
84			Linville, Sarah L.			
85			Linville, Sarah L.			
86			Town, Timothy S.			
87			Bouman, Joan			
88			Notter, Josondra B.			
89			Linville, Sarah L.			
90			Khoury, Michael			
91			Jensen, Kollin R.			
92			Gray, Daga			
93			Hagood, Rebecca			
94			Kabongo, Jacques			

	A	B	C	D	E	F
95			Lanfear, Vincine R.			
96			Briggs, Whitney W.			
97			Linville, Sarah L.			
98			Huntoon, Jason			
99			Middleton, Julie Smith			
100			Kiszka, Mark			
101			Landin, Jennifer			
102			Jensen, Kollin R.			
103			Coon, Philip			
104			Karim, Derrick			
105			Kik, Julie			
106			Huntoon, Jason			
107			Kiesel, Gina			
108			Kiesel, Gina			
109			Nosakowski, Jennifer			
110			Nunnally, Jennifer			
111			Moore, Yvonne			
112			Felton, Deborah M.			
113			Huntoon, Jason			
114			Hahka, John			
115			Kiesel, Gina			
116			Parenteau, Karen A.			
117			Kabongo, Jacques			
118			Delaney, Brandon			
119			Roberts, Andrea			
120			Nunnally, Jennifer			

	A	B	C	D	E	F
121			Nunnally, Jennifer			
122			Wegner, Dennis			
123			Stine, Dawn E.			
124			Figurski, Ryan			
125			Dye, Frank			
126			Hughes, Veronique			
127			Martin, Rachele A.			
128			Zdyrski, Gregory			
129			Kelly, Stephanie			
130			Khoury, Michael			
131			Moore, Tani			
132			Wegner, Dennis			
133			Saputo- Abarca, Rachel			
134			Erhart, Brandon			
135			Kabongo, Jacques			
136			Whitley, Ryan D.			
137			Kolen, Denise			
138			Coon, Philip			
139			Hagood, Rebecca			
140			Huntoon, Jason			
141			Karim, Derrick			
142			Jensen, Kollin R.			
143			Kolen, Denise			

	A	B	C	D	E	F
144			Briggs, Whitney W.			
145			Johnson, Jennifer R.			
146			Hahka, John			
147			Marvin, Dawn			
148			Harvey, Lynne			
149			Notter, Josondra B.			
150			Notter, Josondra B.			
151			Nunnally, Jennifer			
152			Barry, Dree			
153			Hahka, John			
154			Khoury, Michael			
155			Khoury, Michael			
156			Kolen, Denise			
157						
158			Bouman, Joan			
159			Briggs, Whitney W.			
160			Wegner, Dennis			
161			Bouman, Joan			
162			Marvin, Dawn			
163			Dye, Frank			
164			Moore, Yvonne			
165			Tyler, Shelby L.			
166						
167			Nakfoor, Jacqueline E.			
168			Jensen, Kollin R.			

	A	B	C	D	E	F
169			Hagood, Rebecca			
170			Martin, Rachele A.			
171			Beachnau, Kevin			
172			Linville, Sarah L.			
173			Martin, Rachele A.			
174			Zakarias, Wendy R.			
175			Navarra, Jonathan			
176			Nosakowski, Jennifer			
177			Coon, Philip			
178			Johnson, Jennifer R.			
179			White, Gretchen			
180			Middleton, Julie Smith			
181			Lanfear, Vincine R.			
182			Johnson, Jennifer R.			
183			Linville, Sarah L.			
184			Gray, Daga			
185			Wegner, Dennis			
186			Doebel, Sherri K.			
187						
188			Kish, Kimberly			
189			Mutch, Paula			
190			Landin, Jennifer			
191			Newble, Crystal			
192			Doebel, Sherri K.			
193			Beachnau, Kevin			

	A	B	C	D	E	F
194			Kelly, Stephanie			
195			Crandall, Steve			
196			Donovan, Randy			
197			Squires, Mark			
198			Navarra, Jonathan			
199			Kolen, Denise			
200			Fox, Amy			
201			Kolen, Denise			
202			Doebel, Sherri K.			

# EXHIBIT C

## Message

**From:** Hopper, Robert [RHopper@bcbsm.com]  
**Sent:** 9/19/2017 9:56:30 **PM**  
**To:** Braund, Pamela A. [PBraund@bcbsm.com]; Hopper, Robert [RHopper@bcbsm.com]; Fester, Sandra [SFester@BCBSM.com]; Friedkin, Aaron [AFriedkin@bcbsm.com]; Gavin, Gary [GGavin@bcbsm.com]; Hover, Jason M. [JHover@bcbsm.com]; McKay Jr., Michael [MMcKay@bcbsm.com]; Ragos, Paul E. [PRagos@bcbsm.com]; Rizzo, Robert [RRizzo@bcbsm.com]; Shannon, Lori [LShannon2@bcbsm.com]; VanEck, Diane [DVanEck@BCBSM.com]; Connolly, Jeffrey [JConnolly@bcbsm.com]  
**Subject:** Non Par Pay Sub Blue Card Claims  
**Importance:** High

All —

Tomorrow morning, we have a meeting at 7 AM, of which the below is one of the topics for your awareness and our collective discussion and alignment on the way forward. The issue of "Non Par Pay Sub Blue Card Claims" has been an issue within the company for a number of years, but its impact and the manner in which we have coded our systems plus a lack of controls surrounding abusive billing practices has recently come to light within a couple of our ASC customers as you will note below. A digest of the issue follows, below. I am also attaching a list of 201 ASC customers we suspect are impacted by the system logic conflict currently in play. We currently do not understand the full extent of potential financial impact. However, a proposal is on the table for our review and discussion in stemming go-forward impact (below). I need to call out that Carol Gawronski and her team as well as our partners in, CFI, Claims Ops and IT are rallying around this to help us drive to the right outcome.

#### Background

In 1997 processing logic was implemented for non-par claims that would *flip* the par status on the claim and process at charge when referring provider information is submitted on the claim. It was assumed that the referring provider is most likely par and thus will be referrin

ntly have the capability for providers outside of Michigan.

#### Issue(s)

1. Recent review of benefit design documents confirmed that the majority of non-Auto groups on NASCO Classic platform (201 in total) have elected to pay at the Host-allowed rate for non-par claims, with the exception of a "no-choice" situation (services performed by hospital-based providers where the member has no ability to select a provider). "Flipping" logic is in direct contradiction with the group-elected benefit.
2. In the past few years, the dynamic shifted and BCBSM is observing abusive provider billing practices. In the absence of controls in the system logic that would flag suspicious claim activity, claims continue to be processed as "pay sub at charge," often many times over and above the customary amount for such services. The account is the latest group to raise a concern on lab fees (urinalysis) in excess of \$300K for one of their members in one year.

In 2016, BCBSM processed 30,000 non-par claims at charge when Host pricing was available. The sum of those charges was \$30.5M and resulted in a payment amount of \$26.7M. With the application of the Host plan pricing, the total allowed amount for these claims would have been \$7.1M; a potential savings of \$23.0M in benefit costs.

#### Who Is Impacted?

- BlueCard transactions initiated by non-par providers for 201 customer groups on NASCO Classic with exception of Auto.
- MOS processing is not impacted at large, unless a group made a request for exception processing by means of MOS mod/rider. MOS default logic is to pay "Host allowed."

By allowing reimbursement "at charges," providers bill and get fully reimbursed for highly inflated costs of services. In most scenarios, the member is not aware or consented to a referral being made out of network (for example labs). It has been suggested that group customers may not be fully aware of the implications of the "flipping" system logic. As reimbursement "at charges" in most case by far exceeds the Host plan allowed amount, it became lucrative for providers to de-par to circumvent host plan cost controls.

What Has Been Suggested?

1. **Short Term Solution:** Make a global change to discontinue the logic and pay at Host allowed, except for global selection - no choice services. Also allow group customers to opt out on the individual basis, ensuring they fully understand possible consequences, including BCBSM limitation in preventing abusive provider behavior.
2. **Long Term Solution:** implement SBP 18642 BlueCard Non-par Payment that would introduce a robust select criteria for if/when they wish to pay at charge in benefits (currently undergoing feasibility review and estimation). A key business requirement is that the necessary controls are put in place to curtail potential provider fraud and abuse in addition to leveraging host plan allowed amounts.

In counsel with the OGC,<sup>1</sup>

**Redacted - Attorney-Client Privilege**

**Redacted - Attorney-Client Privilege**

4. Provider outreach to curtail the behavior,
5. Member outreach for education.

Business Readiness/What We Need Answers For

- Ensure that the appropriate executive team is briefed and aligned to the above recommendation (this issue will be included on the Global Issues workgroup agenda) - R. Hopper
- Prepare a script for the account management team to follow in their conversation with groups - **TBD**
- 1-year data comparison for each impacted group of non-par pay sub BlueCard claims paid vs host allowed. This will inform the group's decision maker of the magnitude of the issue and support our suggestion for the change - P. Ozdarski and K. Nagy (Claims Ops)
- Need to engage provider relations to understand how we educate the provider community and if there is a way to enforce the desired behaviors thru shifting financial responsibility - N. Delaney

What Risks Do We Need To Address?

- We have fiduciary responsibility to our ASC customers. Our lack of control over the issue was viewed as failure to fulfill this responsibility and a settlement was requested (**example**).
- It is unclear what our **group** customers currently understand in term of rules for processing BlueCard non-par claims. Demonstrating effects of the "flip" logic may cause groups to question their original consent to it.
- As the change takes effect, we need to ensure that member is fully aware of the possible balanced-billing as member liability could likely increase. Providers pursuing members for large balances may cause a spike in member inquires and groups' dissatisfaction.

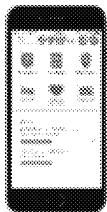
*R.crb-*

Rob Hopper

Director, Group Customer Activation

Group Customer Advocate and Performance

Health Plan Business  
Blue Cross Blue Shield of Michigan  
Office: 313.448.2339  
Mobile: 586.863.6002  
[Download our mobile app](#)



# EXHIBIT D

STATE OF MICHIGAN  
IN THE WAYNE COUNTY CIRCUIT COURT

DENNIS WEGNER,

Plaintiff

Case No. 2019 - - CD  
Hon.

-vs-

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

---

AMANDA J. SHELTON (P67770)  
MARY K. DEON (P63019)  
Shelton & Deon Law Group  
612 East 4<sup>th</sup> Street  
Royal Oak, MI 48067  
(248) 494-7444  
Attorneys for Plaintiff

---

There is no other pending or resolved civil action arising out of the transaction or occurrence alleged in the complaint.

**VERIFIED COMPLAINT**

Plaintiff DENNIS WEGNER, by his attorneys, Shelton & Deon Law Group, asserts the following complaint against Defendant BLUE CROSS BLUE SHIELD OF MICHIGAN:

**Jurisdiction and Parties**

1. This is an action for violation of the Michigan Whistleblowers' Protection Act, MCL 15.361 et seq.

19-001808-CD FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 2/7/2019 11:00 AM Debra Bynum

19-001808-CD FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 2/7/2019 11:00 AM Debra Bynum

2. Plaintiff Dennis Wegner is a resident of Macomb County.
3. Defendant Blue Cross Blue Shield of Michigan is a Michigan corporation doing business in Wayne County, Michigan.
4. The events giving rise to this cause of action occurred in Wayne County, Michigan.
5. The amount in controversy exceeds \$25,000, exclusive of interest, costs, and attorney fees.

**Background Facts**

6. Plaintiff was an account manager with Defendant corporation for the past 18 years. Plaintiff managed insurance accounts for a number of companies.
7. During his employment a customer alerted Defendant regarding a significant medical claim in excess of \$250,000.
8. Plaintiff researched the complaint and discovered that a medical provider was taking advantage of Defendant's claims processing system and overcharging significantly for routine medical testing.
9. By way of example, the medical provider was billing between \$5,000 - \$15,000 for routine urinalysis that actually costs \$10.00 or less.
10. Defendant paid the total amounts billed by the medical provider and charged the customer the amounts billed.
11. Shocked to learn that this customer was being overbilled, Plaintiff conducted additional research and discovered a pattern with other medical providers and over a two-year period Defendant paid over \$600,000 for over-charged procedures.
12. Upon bringing Plaintiff to Defendant's attention and with the customer's knowledge of the overbilling, Defendant ultimately did reimburse that customer for the total amount of overbilling, an amount in excess of \$600,000.00 for that one customer.
13. Plaintiff was concerned that other customers had been likewise overbilled and forced to pay excess medical fees as a result of Defendant's failure to appropriately oversee the claims.
14. Plaintiff began researching claims and billings for two of his other customers and found similar issues totaling \$125,000 and \$75,000.

15. When Plaintiff brought this to Defendant's attention he was specifically told to cease researching into the issues, to "stand down" and that he was not to alert the other two customers of the fraudulent charges.

16. Plaintiff believes that the fraudulent overcharging was widespread and would have cost the Defendant significant funds to correct and reimburse all of Defendant's customers who had unwittingly been forced to pay grossly inflated and fraudulent charges.

17. Defendant was aware of Plaintiff's knowledge and concerns regarding the legality of Defendant's actions and specifically threatened Plaintiff that he was to stand down and not inform other customers of the fraudulent charges they were unwittingly required to pay.

18. Plaintiff began researching various state agencies, including the Michigan Department of Insurance and Financial Services, about the problem of fraudulent insurance billing.

19. Plaintiff expressed to Defendant's supervisor his opposition to what he believed were unlawful insurance practices of Defendant corporation.

20. After Plaintiff raised questions or complained, his treatment and his relations with the management of Defendant corporation changed for the worse.

21. On November 14, 2018, Defendant terminated Plaintiff's employment.

**Count I:**  
**Violation of Michigan Whistleblowers' Protection Act**

22. Plaintiff incorporates by reference paragraphs 1 through 21.

23. At all material times, Plaintiff was an employee, and Defendant was his employer, covered by and within the meaning of the Whistleblowers' Protection Act, MCL 15.361 et seq.

24. Defendant violated the Whistleblowers' Protection Act when it discriminated against Plaintiff as described regarding the terms, benefits, conditions, and privileges of his employment because he was on the verge of reporting a violation or suspected violation of a law, regulation, or rule of the State of Michigan and opposed practices made illegal by the laws, regulations, or rules of the State of Michigan.

25. The actions of Defendant were intentional.

26. As a direct and proximate result of Defendant's unlawful actions against Plaintiff as described, Plaintiff has sustained injuries and damages, including, but not limited to, loss of earnings; loss of career opportunities; mental and emotional distress; loss

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of reputation and esteem in the community; and loss of the ordinary pleasures of everyday life, including the opportunity to pursue gainful occupation of choice.

**Count II:**

**Michigan Bullard-Plawecki Employee Right-to-Know-Act**

26. Plaintiff incorporates by reference paragraphs 1 through 25.
27. Pursuant to the Bullard Plawecki Employee Right-to-Know-Act MCL 423.501 Plaintiff is entitled to a copy of any information contained in his personnel record.
28. Plaintiff requested his employee file pursuant to the Bullard Plawecki Employee Right-to-Know-Act MCL 423.501 on November 29, 2018.
28. At no time since Plaintiff's request on November 29, 2018, Defendant did not provide Plaintiff an opportunity to review his personnel record.
29. At no time since Plaintiff's request on November 29, 2018, Defendant did not mail Plaintiff his personnel record.
30. Defendant willfully and knowingly violated the Bullard Plawecki Employee Right-to-Know-Act MCL 423.501.

WHEREFORE, Plaintiff requests that this court enter judgment against Defendant as follows:

- a. statutory damages in whatever amount he is found to be entitled;
- b. compensatory damages in whatever amount he is found to be entitled;
- c. exemplary damages in whatever amount he is found to be entitled
- d. judgment for lost wages, past and future, in whatever amount he is found to be entitled
- e. an award for the value of lost fringe and pension benefits, past and future
- f. an award of interest, costs, and reasonable attorney fees
- g. whatever other equitable relief appears appropriate at the time of final judgment

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**DEMAND FOR JURY TRIAL**

Plaintiff hereby demands trial by jury in the above-captioned cause.

Respectfully submitted,

Dated: February 5, 2019

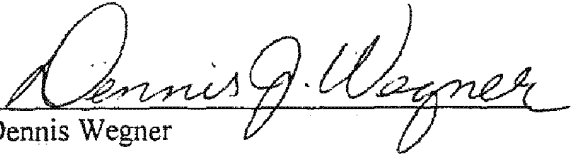


Shelton & Deon Law Group  
MARY K. DEON (P63019)  
AMANDA J. SHELTON (P67770)  
612 East 4<sup>th</sup> Street  
Royal Oak, MI 48067  
(248) 494-7444


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**VERIFICATION**

I, DENNIS WEGNER, state under oath that the factual statements contained in the Verified Complaint are true and correct to the best of my knowledge, information and belief.

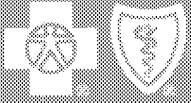
  
Dennis Wegner

Subscribed and sworn to before me this 4 day of February, 2019.

  
\_\_\_\_\_  
NOTARY PUBLIC  
Acting in the County of Oakland

MARY K. DEON  
NOTARY PUBLIC - STATE OF MICHIGAN  
COUNTY OF OAKLAND  
My Commission Expires Feb. 12, 2019  
Acting in the County of Oakland

# EXHIBIT E



## ASC Shared Savings | Internal Sales FAQs

### **SHARED SAVINGS OVERVIEW**

#### **What is shared savings?**

Blue Cross is launching a package of Payment Integrity services using a shared savings arrangement. Shared savings enables Blue Cross to introduce various programs to avoid cost or recover savings for its customers, while retaining or "sharing" in a portion of the savings. On behalf of our customers, we've strategically partnered with several vendors that will enable us to capture additional savings on claims. With their technology, we can reduce re-work, maximize cost-cutting measures, and make sure our customers are getting the best value from doing business. This program does not affect administration fees.

#### **What is happening and why is Blue Cross moving in this direction?**

To better address cost management needs, Blue Cross is offering new services to generate incremental value for our customers. The initial set of services included within this shared savings approach will focus on avoiding or recovering overpayments due to a variety of provider billing errors. This 'shared savings' model will better align incentives to encourage more innovation in cost saving programs we design on behalf of our customers. The recoveries that Blue Cross retains helps to make investment in technologies to further advance our capabilities for customers. This move aligns Blue Cross to what is already happening in the market with other national carriers as well as other Blue Cross plans, but does so with a very thoughtful approach — choosing only those services that make most sense for both the customer and Blue Cross. By establishing certain services in a shared savings model (mainly focused on programs with high value propositions). We're able to invest in new ways to increase the value of our customers' health care dollar.

#### **How is the approach Blue Cross is taking compared to what is happening in the market?**

Strategically, Blue Cross has chosen very specific services in which to apply the shared savings model. This is focused on five principles: 1) Incremental margin. The need for Blue Cross to drive sustainable margin improvements. 2) Aligning incentives. The enhanced savings model enables Blue Cross to align financial incentives with ASC groups.

3) Incremental and transparent. The program offers opportunities for our groups to capture additional savings over what they currently receive from our programs. With enhanced reporting, they will see these dollars laid out in their savings invoice. (provided by the technology of new vendor- CDR Associates). 4) Competitive pricing. Pricing is structured and priced to align with our competitors and the industry at large. 5) Scalable. This is an outward focused approach.



## ASC Shared Savings | Internal Sales FAQs

The vendors chosen to aid Blue Cross in executing the additional programs are experts in the field and help us lay the groundwork for future enhancements. If decided, more programs can easily be appended to the enhanced offerings. Other carriers, including United Health Care, Aetna and Cigna have launched a variety of shared savings initiatives for their ASC customers, which add up to significant fees. But our approach has been to ensure services are chosen carefully, and incentives are aligned to deliver value and positive ROI to our customers.

### **Why is Blue Cross doing this now?**

Blue Cross has historically performed several cost management services within the base administrative fee our customers pay. Our ASC customers have told us they're looking for new ideas to help curb claim cost. In order to bring incremental value to our customers without the need to raise fixed administrative fees, Blue Cross has decided to align to what is already occurring out in the market. This enables the investment in further advancing these efforts to create a win-win for our customers.

### **Who does this impact?**

All ASC customers will be included in these new programs (both PPO and HMO). In the unlikely event that a group customer does not want to participate, there will be a robust opt out process that will need to be followed with the appropriate VP/executive approvals. This process will be followed to ensure the customer understands the incremental value they are declining.

### **When will this start for ASC customers?**

This new model will start upon renewal with January 1, 2018 effective dates and upon renewal thereafter.

## **PAYMENT INTEGRITY PACKAGE**

### **What programs is Blue Cross including in the shared savings model?**

Initially, Blue Cross is offering a **Payment Integrity** package within the shared savings pricing model.

The Payment Integrity package includes Pre-pay Forensic Bill Review, Advanced Payment Analytics, Subrogation and Credit Balance Recovery services. Other programs are currently being evaluated, including things like pharmacy rebates and out-of-network discounts.

#### **1. Pre-pay Forensic Bill Review. What does it entail?**

Pre-pay Forensic Bill Review provides a review of high cost inpatient claims to detect and resolve billing errors *after* adjudication, but prior to payment. These services will be performed by a 3<sup>rd</sup> party vendor called **Equian**.



## ASC Shared Savings | Internal Sales FAQs

### **What is different about Pre-pay Forensic Bill Review vs. what is already being offered to ASC customers today?**

Today, Blue Cross reviews claims prior to payment as part of the base administration fee for self-funded groups, but not itemized provider bills. The high dollar edit reviews we currently perform post payment focus on pricing accuracy rather than billing accuracy.

In addition, our current post-pay audits primarily focus on clinical appropriateness and they exclude out-of-state facilities and some in-state facilities. Moving forward with *Pre-pay Forensic Bill Review*, a thorough and comprehensive review of the hospital's itemized bill is done by a 3<sup>rd</sup> party vendor, Equian. Sophisticated technology and data analytics in addition to expert clinical review by nurses, physicians, accountants and certified coders to identify errors and compliance issues *before the claim is paid*. This program will review all claims meeting the \$25,000 threshold that are inpatient and are paid as outliers to current diagnostic edit process, **OR** are paid under a percent charge reimbursement methodology. This includes both in and out-of-state claims, and Par and Non-par providers.

### **Does Pre-pay Forensic Bill Review include behavioral health?**

Yes, for inpatient facilities only.

### **Since Pre-pay Forensic Bill Review is all about avoidance vs. recovery, how does my customer get the procedure detail?**

We are currently working on an inquiry process to handle these requests from your customers.

## **2. Advanced Payment Analytics. What does it entail?**

Advanced Payment Analytics offers advanced data mining capabilities to identify claim overpayments not previously detected and recover the overpayment from providers after payment is rendered. These services will be performed by a 3<sup>rd</sup> party vendor called Cotiviti.

### **What is different about Advanced Payment Analytics vs. what is already being offered to ASC customers today?**

Today, Blue Cross performs several post-pay claim review services under the base ASC admin fee. This includes data mining for provider billing errors, COB, and overpayment identification. It also includes provider audits for catastrophic outliers, facility outpatient issues, readmission, etc. Fraud, waste and abuse is also part of our base fee, including investigations, detection and recovery. Cotiviti is currently engaged in Blue Cross's fully insured book of business, delivering millions worth of incremental savings. We will now engage Cotiviti as a 2nd pass or "safety net" for our ASC customers who participate in the Payment Integrity package. With Cotiviti, we enhance our post-pay efforts with a robust library of proprietary data mining algorithms and analytics to detect overpayment on paid claims.



## ASC Shared Savings | Internal Sales FAQs

In addition, we will leverage dedicated doctors, nurses, claims coders, auditors and other experts at Cotiviti to validate potential overpayments for customers and continuously monitor hundreds of medical and payment policy content resources to develop new algorithms to help recover more.

Blue Cross will continue to make every attempt to recover savings using our internal base services, but Cotiviti will lag our internal operations by 90 — 120 days to ensure Blue Cross still has time to run its robust processes prior to initiating its 2<sup>nd</sup> pass run.

### **What is the dollar threshold for Advanced Payment Analytics?**

There is no dollar threshold. Cotiviti will review all charges, regardless of dollar amount.

### **If a customer stays opted in, effective 1/1/18, will Cotiviti review claims prior to this date?**

Yes. Reviews will go back 18 — 24 months, retroactive to 1/1/18.

### **Are pharmacy claims included in Advanced Payment Analytics?**

Not now, but this feature is under future consideration.

### **3. Subrogation. What does it entail?**

Subrogation involves the detection and recovery of 3<sup>rd</sup>-party liability claims where a 3<sup>rd</sup> party is accountable for the expense. Blue Cross currently performs these services in-house today, but is making investments to enhance the program moving forward.

### **What is different about Subrogation vs. what is already being offered to ASC customers today?**

Blue Cross will continue to manage its high-performance Subrogation process internally without the use of a vendor. We are continuously enhancing our processes to deliver maximum savings to our customers. Shifting toward a shared savings approach with this service will ensure Blue Cross is able to invest to further advance its capability on behalf of our customers.

### **4. Credit Balance Recovery. What does it entail?**

Credit Balance Recovery is the detection and recovery of credit balances on hospital patient accounting systems due to Blue Cross (i.e. ASC customers). These services will be performed by a 3<sup>rd</sup> party vendor called CDR. Today, approximately \$8 million per year is recovered for both fully insured business and ASC.

### **What is different about Provider Credit Balance Recovery vs. what is already being offered to ASC customers today?**

Blue Cross currently performs several post-pay claims review services for ASC customers in Michigan.



## ASC Shared Savings | Internal Sales FAQs

Moving forward, we are expanding our partnership with **CDR Associates** to get them into more facilities, to detect, analyze and resolve credit balances on hospital patient accounting systems. Proprietary analytic software will identify credit balances currently hidden within hospital systems. A dedicated team will work with hospital management to facilitate approval and resolution of credit balances.

### **What's in it for ASC customers with the Payment Integrity package? What's the value?**

In total, Blue Cross estimates that the services delivered under the Payment Integrity package drive incremental savings of \$3.50 per contract per month. The Prepay and Advanced Payment Analytics services are net-new and incremental to what ASC customers experience from Blue Cross today. The other services within the Payment Integrity package are enhanced offerings. This presents a significant opportunity for our customers to receive additional value through the implementation of these programs. Under the shared savings arrangement, our customers only incur costs to operate the programs when savings are realized. Therefore, they are risk free, incremental and deliver a guaranteed ROI for our customers.

### **Will Blue Cross be using outside vendors to perform these additional services?**

**Yes.** Blue Cross will be employing the services of outside vendors to deliver incremental value to customers.

We will be bringing these vendors into our current operating model. These vendors include, but are not limited to Equian, Cotiviti, and CDR Associates.

These vendors are leaders in their respective areas of specialty. By employing 3<sup>rd</sup> party vendors to deliver on the bulk of these value-added programs, we help ensure that the latest technologies, processes and techniques are regularly introduced on behalf of our customers.

### **If this is so good, will Blue Cross be implementing these programs for its own fully insured book of business?**

**Yes.** Blue Cross believes strongly in the value of these programs and is contracting with these same vendors to realize savings through recoveries in its own fully insured population. For example, Blue Cross engages with Equian today for Pre-pay Forensic Bill Review (effective 1/1/17) and is projected to realize \$15 — 20 million in savings.

Blue Cross also contracts with Cotiviti today for Advanced Payment Analytics on its fully insured population and realizes savings of \$12 — 15 million per year.



## ASC Shared Savings | Internal Sales FAQs

**Will there be a fixed administrative fee to operate any of these programs?**

**No.** Rather than charging our customers a fixed administration fee for these programs, Blue Cross will wait until the customers realize savings and then retain a portion of savings to help cover our costs for the programs.

**Will this change result in a reduction of administrative fees for ASC customers?**

**No.** The Payment Integrity package represents incremental value to ASC customers for the services offered. There will be no adjustments to the administration fee as a direct result of a group moving to the package.

**From a member perspective, what happens if a member has already paid a provider (e.g. member with a high-deductible plan with HSA), and it is determined through these additional reviews that the provider made an error?**

Similar to any situation where a provider has overbilled and so forth, the provider would then be responsible for crediting the patient's account or issue a refund check to the member.

### **ADMINISTRATION**

Under normal business process, if an account manager has an at jeopardy group that requires review of admin fees, this would follow the normal review process, but not because of this program.

**Since some of the services offered within the Payment Integrity package are already included in the base admin fee today (e.g. Subrogation), but wouldn't there be an adjustment to the admin fee?**

Blue Cross is making these changes to align with what is already happening in the self-funded market. Even considering the changes being made, Blue Cross remains very competitive from a total cost standpoint with our customers. By shifting very focused services to a different pricing model, this helps to ensure Blue Cross can innovate and amplify the savings we deliver to our customers.

**Why isn't Blue Cross reducing our admin expense since subrogation will no longer be covered under the ASC agreement?**

Blue Cross is focused on introducing new and enhanced programs that will directly bring quantifiable cost savings to our ASC customers.

Significant (multi million) capital investment is required for Blue Cross to launch and operate these cost-saving programs and fully integrate them into our business model. As a result, we will not be reducing admin expense.



## ASC Shared Savings | Internal Sales FAQs

### **What happens if a customer chooses not to participate in the Payment Integrity package?**

If a customer chooses to 'opt out' of the Payment Integrity package, they will not realize the incremental savings of the services provided. Blue Cross will offer Subrogation exclusively within the Payment Integrity package and no longer part of base admin services.

### **Are customers required to participate in all 4 of the services that are part of the Payment Integrity package?**

**Yes.** The Payment Integrity package is offered as a 'package,' meaning that it is an all-in deal. The underlying services included in the package cannot be offered in a piecemealed fashion.

### **My customer currently carves out Subrogation to a 3<sup>rd</sup> party vendor. How will this be handled?**

Customers who currently carve out Subrogation services to a 3<sup>rd</sup> party vendor will have an opportunity to participate in the Payment Integrity package. As a matter of fact, this represents an opportunity to bring Subrogation business back to Blue Cross. The customer will be permitted to opt into the package and given a one year grace period to bring their Subrogation business to Blue Cross. If this does not occur within a year, the group will be removed from the package.

### **Is it mandatory for customers to participate?**

**Yes.** To ensure our group customers don't miss out on the value, Blue Cross will automatically opt ASC group customers into the Payment Integrity package.

In the unlikely event that a customer does not want to obtain this additional value and wishes to 'opt out' of the program, a robust exception process will need to be followed, including approvals by appropriate segment VPs. This process is in place to ensure customers fully understand the decision they're making by declining these value-added services.

### **What kind of documentation is needed in terms of contracts, etc.?**

The new Payment Integrity shared savings programs will be disclosed on a new version of the Schedule A that customers will need to sign prior to their renewal date. A new contract outlines that Blue Cross will no longer be performing Subrogation, for instance, under the base administration services. A signed amended contract and new schedule A will be required for these new programs to operate for the customer. This contract language will be the same for both PPO and HMO business.

### **How are customers with multi-year contracts to be handled?**

ASC customers will have the option of joining the Payment Integrity package now or at the specified contract renewal time.



## ASC Shared Savings | Internal Sales FAQs

### **INVOICING AND REPORTING**

#### **How will ASC customers be charged for the new Payment Integrity services being offered by Blue Cross?**

It is important to note; Blue Cross will only retain its portion of the savings once the customer has realized the incremental benefit expense savings. A fee of 30% of each recovery will be retained for self-funded customers. This fee supports vendor costs and internal administrative costs associated with these services.

#### **What's in the fee that Blue Cross is collecting?**

The 30% Blue Cross retains from these recoveries supports all vendor costs and internal administrative costs associated with these services. Our customers do NOT pay a fee on top of this. Blue Cross contracts with and pays vendors directly for their services for these programs as part of the savings it retains.

#### **How will customers see these charges?**

Blue Cross will include line items on the monthly customer invoice. In addition, detailed reporting will be accessible via e-bookshelf to provide claim level detail to support the charges each month.

#### **How will my customers know they're getting value out of this program?**

Each month, Blue Cross will generate detailed reporting to outline costs that were avoided or recovered through the services offered within the Payment Integrity package.

### **COMMUNICATING THIS TO CUSTOMERS**

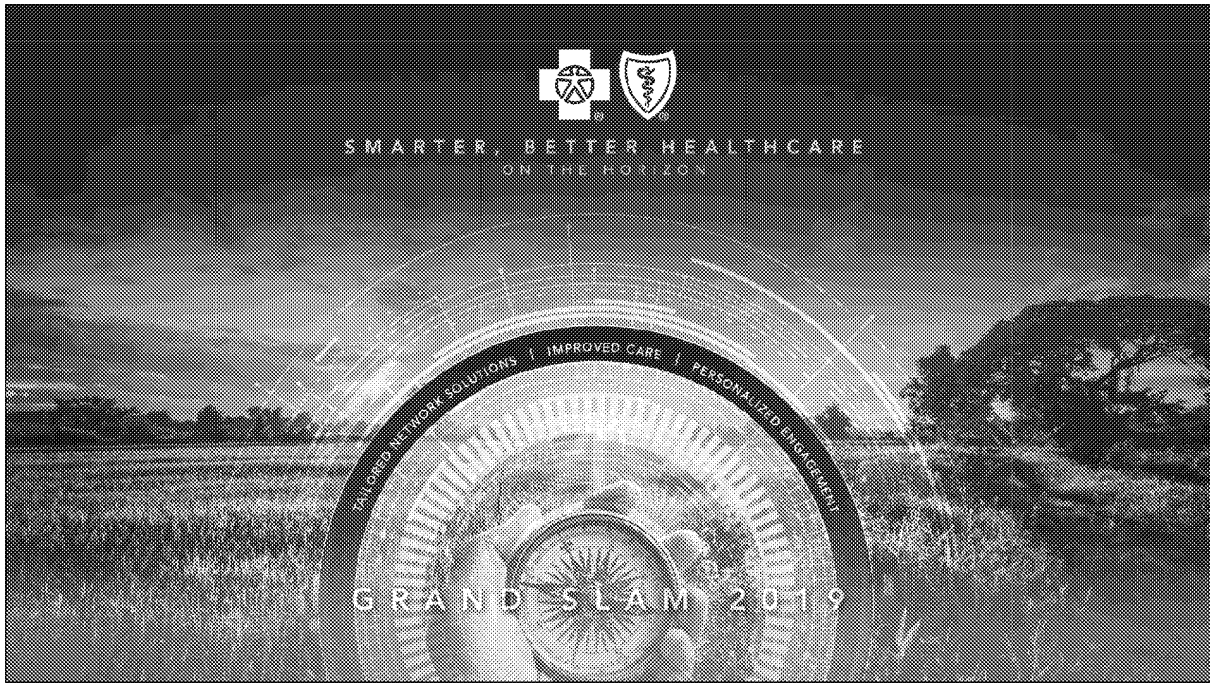
#### **How will this be communicated to customers?**

We're counting on the sales team to have one-on-one conversations as needed with group customers. Impacted sales team members will be asked to attend training beginning in April and offered through June.

Following the preparation of our internal salesforce, Blue Cross will issue a Field Alert and Agent Alert to notify external agents.

Agents will have an opportunity to participate in training. This will also be a discussion point at Agent Grand Slam in June. Beginning in May, the Marketing team will have communications tools available for one-on-one discussions with your group customers, including a customer presentation, customer FAQs and overview flier(s).

# EXHIBIT F





## Payment Integrity: Ensuring the Accuracy of Claims

Marcia Varner  
Director, Payment integrity Operations

Paul Ozdarski  
Manager, Payment Integrity Unit

Jennifer Kuhar  
Finess Systems Analyst, Payment Integrity Operations



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## Payment integrity program overview

Blue Cross' claims processing practices consistently deliver industry-leading outcomes with respect to claim payments, and average above 99% accuracy (*as measured by the Blue Cross Blue Shield Association's Independent measurement methodology*).

**Payment Integrity, an enterprise capability stream, takes actions to ensure health claims** are submitted, and paid accurately, proactively and correctly, by the responsible party, for eligible members, according to medical, benefit and reimbursement policies and contractual term. Not in error or duplicate and free of wasteful or abusive practices.

We currently deliver a broad range of services (base savings programs) within the current administrative fee that are designed to help manage claim costs. Blue Cross is working toward the ability to further define and report the value delivered under these services.

**Base savings programs included in administrative fee:**

- Overpayment data mining
- Provider audits
- Fraud, waste and abuse
- Coordination of benefits
- Voluntary credit balance
- Primary claims editor (value not included)

## Payment integrity program overview



In addition to base recovery programs, Blue Cross is focused on deploying services with longvalue prepositions that can be demonstrated in a transparent manner. These incremental programs, delivered under a shared savings model, will provide an enhanced level of review.

This is a risk-free value proposition as customers will not be charged unless savings are delivered under these programs.



### Slimed savings programs include:

- Prepay forensic review
- Advanced payment analytics
- Involuntary credit balance
- Subrogation

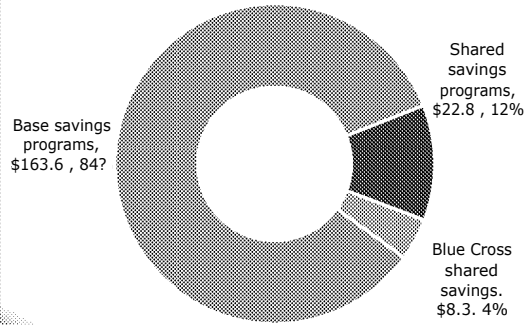




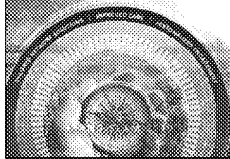
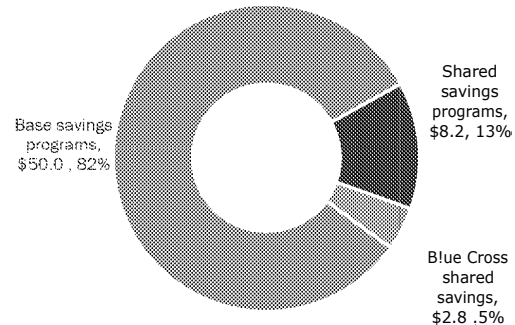
# Payment Integrity highlights



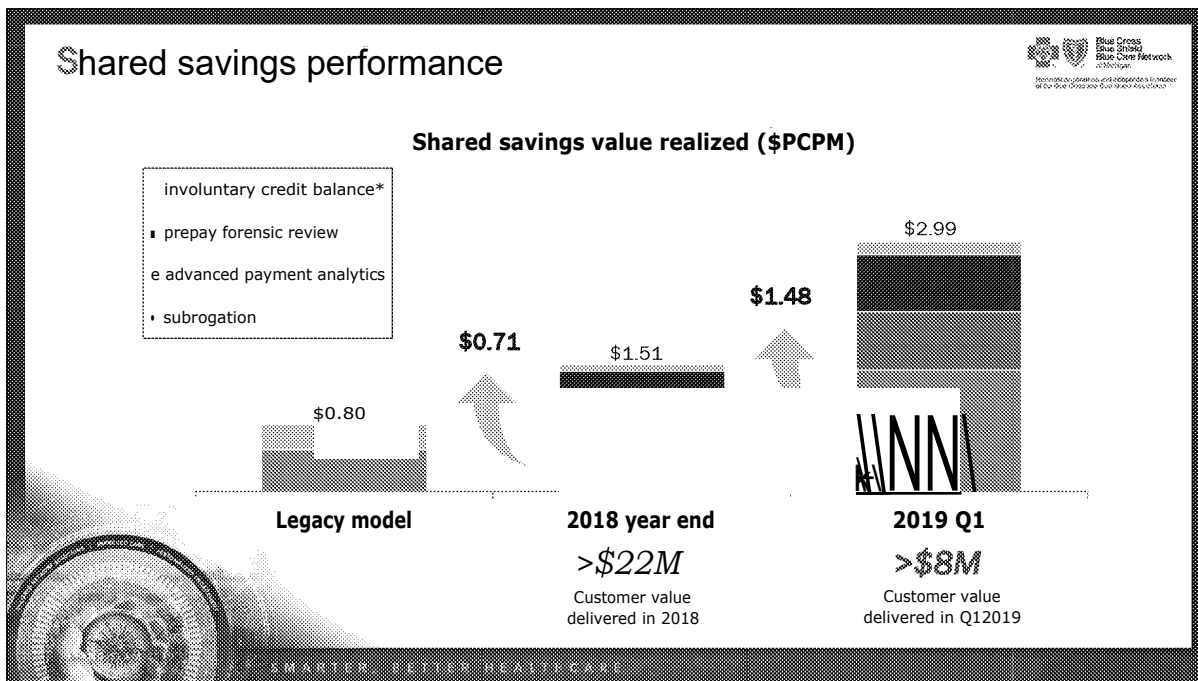
### 2018 Payment Integrity value



### 2019 Q1 Payment Integrity value



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2018 number is all credit balance - voluntary credit balance is still coming through under base and is not reflected in shared savings.

Note that the PCPM is related only to groups that have opted into the bundle (SavingsPackageOptn = Y). Large groups have been removed ) and 2018 only factors the last 8 months of year to account for ramp up in Q1 2018.

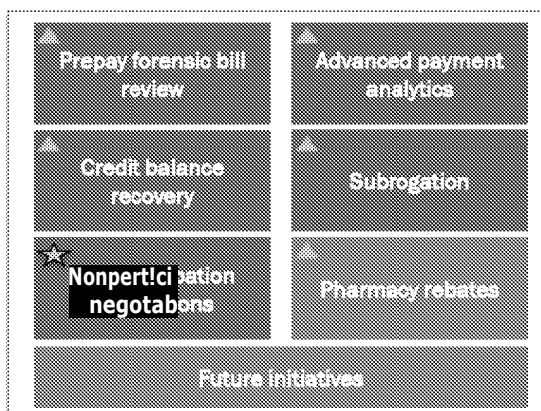
# Shared savings products



## Shared savings pipeline

▲ Launched in 2018

★ New for 2020



MI Payment Integrity

M Other shared savings



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**Nonparticipating claims spend**

While Blue Cross' broad network drives high in-network utilization, there is an opportunity to address nonparticipating claims spend

**\$88Million**  
Benefit expense with providers that are not contracted with Blue Cross or the host plan

**0.2%** in state  
**0.4%** Out of state  
of benefit expense

Most nonparticipating claims pay at host allowed with no held-harmless guarantee. Others pay at charge at the direction of the self-insured customer

Opportunity

**pricing and negotiation services** that can generate Psnet expense savings for our customers on nonparticipating claims with member hold-harmless guarantees (most scenarios)

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BCBSM's customers incur approximately \$88M annually in benefit expense with providers that are not contracted with BCBSM or the Host plan.

This represents 0.2% of total benefit expense for customers in-state and 0.4% out-of-state.

Most non-par claims pay at host allowed with no hold harmless guarantee while some pay at charge at the direction of the self-insured customer.

MultiPlan delivers pricing and negotiation services that can generate benefit expense savings, via cost avoidance, for our customers on non-par claims with member hold harmless guarantees (most scenarios).

MultiPlan is the dominant market leader; clients include 9 of the top 10 U.S. health insurers and 9+ BCBS Plans.

Starting in 2020, self-insured customers will have the option to activate MultiPlan's services in a shared savings arrangement to further minimize non-par benefit expense.

# Proving practices: Augmenting our industry ending claims



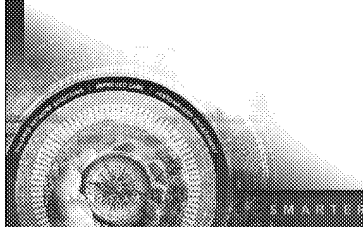
## Multi plan.

Market-leading vendor  
Clients include nine of the top 10 U.S. health insurers and more than nine Blue plans

\* Incremental service not included in the PCPM admin" fee

### Nonparticipation pricing and negotiation

- Comprehensive solution to price nonparticipating claims through Milt€plan's negotiaUon seMoes using clinimi and benchmerWng tools.
- Applies to commercial claims, in state and out of state (BlueCard®) and all claim types: facility and professional.

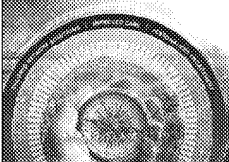


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## MultiPlan services available in 2020



Market positioning	Value (estimated) summary	Program scope	Terms and conditions
<ul style="list-style-type: none"> <li>Enhanced service that provides additional controls on claims spend</li> <li>Delivered by MultiPlan, the industry leader in nonparticipating pricing and negotiations</li> <li>Offered as optional stand-alone program (not integrated into 2018 Payment Integrity bundle)</li> <li>Available to ASC customers on renewal starting in <b>2020</b></li> </ul>	<ul style="list-style-type: none"> <li>Program is estimated to generate up to \$0.53 PCPM in savings (book of business) with ASC customers retaining 70% of the value created</li> <li>Value calculated as total reduction in original claim allowed amount (inclusive of member cost-sharing)</li> <li>Value will depend on nonparticipating pricing approach and utilization, host decisions and MultiPlan success rate</li> </ul>	<ul style="list-style-type: none"> <li>Using MdUpCan's negotiation services as well as their clinical and benchmarking tools.</li> <li>Applies to commercial claims; in state and out of state (BlueCard)</li> <li>All claim types are in scope, both facility and professional</li> <li>Claims from network PPO and Traditional network providers excluded</li> </ul>	<ul style="list-style-type: none"> <li>Program terms will be disclosed in Schedule A</li> <li>Renewals will assume customers will opt in, while providing an Opt out process</li> <li>ASC customers will retain 70% of value and Blue Cross will retain 30%</li> <li>Transparent monthly value reporting is provided, consistent with the Payment Integrity bundle</li> </ul>



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## Key takeaways



Blue Cross is committed **to helping customers effectively manage health care costs**

We continue to focus on adding **gen/Ices with strong value propositions** that can be **demonstrated to our customers In a transparent manner**

Customers are **realizing savings** generated by the **Payment integrity bundle introduced** in 2018

The **nonparticipating** negotiation **service**, delivered by MultiPlan, that will be launched in 2020, will generate incremental **benefit-expense savings** for customers

customers **will not be charged** if we do not deliver savings



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