UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TIARA YACHTS, INC.,

Plaintiff,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

Case No. 1:22-cv-603

Honorable Robert J. Jonker

Magistrate Judge Ray Kent

PLAINTIFF'S RESPONSE IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS PLAINTIFF'S COMPLAINT FOR FAILURE TO STATE A CLAIM

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I. INTRODUCTION

Plaintiff Tiara Yachts, Inc. ("Tiara") sponsors an ERISA-governed welfare benefit plan (the "Plan"). As Plan sponsor, Tiara is an ERISA fiduciary of the Plan. In its capacity as sponsor and fiduciary, Tiara transmitted millions of dollars to Defendant Blue Cross Blue Shield of Michigan ("BCBSM"), which BCBSM was supposed to use to pay for healthcare benefits of Plan participants and beneficiaries. The funds entrusted to BCBSM are ERISA-protected "plan assets." The United States Court of Appeals for the Sixth Circuit has repeatedly held that BCBSM is a fiduciary under these exact circumstances—it exerts "control" over ERISA plan assets and exercises "discretion" as to their disposition.

As a fiduciary, BCBSM owed Tiara's Plan a fiduciary duty of prudence and loyalty. Among other things, BCBSM must exercise the care, skill, prudence, and diligence under the circumstances that a prudent fiduciary acting in a like capacity would exercise, and has an obligation to discharge its fiduciary duties solely in the interest of the Plan. BCBSM breached that duty in several ways, including overpaying providers and failing to correct or report known systems failures that resulted in gross overpayments. BCBSM's own internal emails (already obtained in companion litigation) prove as much.

Tiara—as an ERISA fiduciary of its Plan—brings this lawsuit to rectify BCBSM's breaches of fiduciary duty, as expressly authorized by ERISA. This is not a breach of contract case because mismanagement of Plan assets is governed by ERISA and its remedial scheme; in fact, breach of contract claims are preempted. BCBSM seeks dismissal, but its arguments are nearly identical to those it filed over the last decade in similar cases, none of which have succeeded. This very brief cites to 13 cases where BCBSM was a party and in every case, BCBSM's arguments—denials of

fiduciary status, pleading standard objections, and statute of limitations defenses—have all been rejected (often by the Sixth Circuit itself). The outcome here should be no different.

II. BACKGROUND

A. THIS IS THE SECOND CASE CHALLENGING BCBSM'S MISMANAGEMENT OF PLAN ASSETS.[1]

In 2019, Comau LLC sued BCBSM for breach of fiduciary duty alleging mismanagement of plan assets. *Comau LLC v. BCBSM*, No. 19-CV-12623, 2020 WL 7024683, at *1 (E.D. Mich. Nov. 30, 2020).[2] Comau objected to BCBSM's payment of improper health care claims, failure to correct its claims processing system to avoid squandering plan assets, and concealment of improper payments of plan assets. *Id.* at *2. BCBSM moved to dismiss Comau's complaint on three grounds: 1) the complaint sounded in fraud and failed to meet Rule 9(b)'s pleading standard; 2) the complaint failed to meet the requirements of 8(a); and 3) the statute of limitations bars any claims that are based on payments made more than six years before the filing of the action. *Id.* The court denied BCBSM's motion on all grounds. *Id.* at *9.

In discovery, BCBSM produced Comau's claims data, which Comau's expert analyzed to assess the scope and nature of improper claims paid by BCBSM using plan assets. *See Comau LLC v. BCBSM*, No. 19-12623, 2021 WL 5989023, at *3 (E.D. Mich. Dec. 16, 2021). "Comau's expert identified $9 million in improper payments stemming from errors including duplicative payments, unbundling, upcoding or wrong code, medically unlikely services, and non-adherence to payment guidelines." *Id.* (emphasis added). Additionally, the internal BCBSM documents

[1] Although this is the second case addressing overpayment of provider claims, since 2011 there have been over 200 cases against BCBSM by plan sponsors seeking to rectify mismanagement and theft of plan assets. Many of the issues decided in those cases—such as BCBSM's status as an ERISA fiduciary—are applicable here.

[2] Unpublished cases are attached at **Exhibit A**.

produced in discovery revealed details of BCBSM's Shared Savings Program, described below. *Comau LLC v. BCBSM*, No. 19-12623, 2022 WL 2373352, at *1 (E.D. Mich. June 30, 2022). After this information came to light, the parties disputed the scope of the complaint. Comau amended its complaint to include more information and add a claim that the Shared Savings Program involved prohibited transactions. *Id.* at *3-4. The court compelled BCBSM to produce current and former employees for depositions (for the two and half years prior, BCBSM had refused to allow Comau to depose any of BCBSM's witnesses). *Id.* at *5. Shortly before the first BCBSM employees were to be deposed, the case settled.

The Complaint at issue here makes allegations and claims nearly identical to those made by Comau.

B. TIARA SUES BCBSM FOR THE SAME MISMANAGEMENT OF PLAN ASSETS.

On July 1, 2022, Tiara filed a Complaint against BCBSM, bringing two counts for breach of fiduciary duty and engaging in prohibited transactions. ECF No. 1. Tiara maintains a self-funded plan, through which it offers healthcare benefits to employees and dependents. ECF No. 1, PageID.2. Tiara hired BCBSM to administer its Plan. *Id.* at PageID.3. As the administrator, BCBSM was responsible for properly processing and paying health care claims on behalf of the Plan using Plan assets. *Id.* at PageID.4. BCBSM processed health care claims using money Tiara paid into a BCBSM-owned bank account. *Id.* The funds deposited into BCBSM's bank account were "plan assets" as defined by ERISA. *Id.* BCBSM had complete authority and control over the bank account and the Plan assets sent to BCBSM by Tiara. *Id.*

C. BCBSM SQUANDERED PLAN ASSETS.

While Tiara has only recently discovered the details of BCBSM's mismanagement, BCBSM has been aware of its misconduct for years, if not decades. In or about 2017, a senior

account manager at BCBSM alerted BCBSM executives to improper claims that BCBSM was processing and paying with its customers' assets, seemingly without detection or concern. ECF No. 1, PageID.6. After continuing to raise this issue with BCBSM, the manager was told to "stand down" and eventually fired. *Id.* at PageID.6, 9.

An internal email amongst BCBSM executives was circulated shortly after this manager's complaints that revealed damning information. *Id.* at PageID.7. BCBSM knew that the majority of, if not all, self-funded, non-auto customers on its NASCO platform, including Tiara, were impacted by its flawed claims processing system. *Id.* BCBSM attributed this particular issue to an intentional design in its programming called "flip logic," which was implemented in 1997. *Id.* BCBSM knew that this "ha[d] been an issue within the company for a number of years" 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.* at PageID.8. Compounding the issue, BCBSM identified 201 customers, Tiara included, whose plan assets were being used to pay for claims in contradiction to plan elected benefits. *Id.*

BCBSM calculated that in 2016 alone, BCBSM had made at least $23 million in improper payments using its customers' plan assets. *Id.* BCBSM further determined that if it had paid these claims according to its customers' elected benefits, the paid amount for such claims would have only been $7.1 million. *Id.* But instead of correcting the issue, BCBSM worked to conceal it. *Id.*

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 a failure to fulfill this responsibility." *Id.* BCBSM also expressly acknowledged that its "customers may not be fully

aware of the implications of the 'flipping' system logic," but continued to conceal the issue. *Id.* at PageID.9.

BCBSM impedes its self-funded customers', including Tiara's, ability to evaluate whether BCBSM is properly paying claims by significantly limiting access to (1) each customer's claims data and (2) other documents that set forth guidelines and rules for claims processing and pricing. *Id.* at PageID.12. Claims data is essential to identifying improper claims and payments and should reflect all information necessary to ascertain whether a claim was properly processed or paid. *Id.* at PageID.12-13. BCBSM maintains exclusive control and access to Tiara's claims data. *Id.* at PageID.13.

Nonetheless, the same "errors or deficiencies identified in claims associated with one customer can reasonably be expected to exist for other customers using the same system," because "BCBSM processes all claims for all non-auto NASCO customers, such as [Tiara], on the same claims processing system." *Id.* at PageID.15. As confirmed in the Comau litigation, "BCBSM's NASCO claims processing system has been found to consistently result in improper payments of claims." *Id.* "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." *Id.* "These processing errors result in wasted Plan assets in breach of BCBSM's fiduciary duty." *Id.*

D. BCBSM'S "SHARED SAVINGS PROGRAM" IS A SCHEME TO ENRICH ITSELF AT THE EXPENSE OF ITS SELF-FUNDED CUSTOMERS.

Well after BCBSM internally acknowledged its flawed claims processing system was squandering its customers' plan assets in breach of its fiduciary duty, BCBSM imposed a mandatory "Shared Savings Program" for its self-funded customers. *Id.* at PageID.9-10. Effective January 1, 2018, all self-funded customers, including Tiara, were opted-in the program. *Id.* at

PageID.10. This program allowed BCBSM to keep 30 percent of any "recoveries" of excessive claim payments—that is, claims that should not have been paid in the first place. *Id.*

The program was applied retroactively to claims processed before the program went into effect. *Id.* Essentially, the program allowed BCBSM to profit on its own mismanagement of plan assets. *Id.* The more improper payments BCBSM let slide through its system, the more money BCBSM would make fixing its own mistakes. *Id.*

E. THE COMPLAINT BRINGS TWO COUNTS UNDER ERISA.

Count I of the Complaint alleges breach of fiduciary duty against BCBSM. *Id.* at PageID.18-20. At all times relevant, BCBSM was an ERISA fiduciary. *Id.* at PageID.18. BCBSM breached its fiduciary duty in numerous ways, including but not limited to, by: (1) consistently using Plan assets to pay improper claims; (2) failing to implement proper controls and industry standard claims processing edits to prevent improper claims; (3) concealing the full implications of its systems flaws and the payment of improper claims; (4) capitalizing on its own misconduct by implementing a Shared Savings Program that kept a portion of excessive overpayments that should never had been made in the first place; (5) using its discretionary authority to advance its own interests; (6) concealing its methodology for exercising discretionary control over the use of Plan assets to pay claims, including the fact that its discretionary actions were contrary to the terms of the Plan; (7) paying claims without first having standard information necessary to properly adjudicate claims in accordance with BCBSM procedures and industry standards; and (8) 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 healthcare claims with Plan assets. *Id.* at PageID.19-20.

Count II of the Complaint alleges BCBSM engaged in prohibited transactions. *Id.* at PageID.21; *see also* 29 U.S.C. § 1106 (identifying certain transactions into which fiduciaries are prohibited from entering). As an ERISA fiduciary, BCBSM was prohibited from using plan assets to advance its own interest or for its own account. ECF No. 1, PageID.21. By instituting the Shared Savings Program, which allowed BCBSM to unilaterally control the amount of its compensation, BCBSM dealt with Tiara's Plan assets in its own interest and for its own account in violation of Section 1106 of ERISA. *Id.*

III. LEGAL STANDARD

The court rules do not "require heightened fact pleading of specifics, but only enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). Under Rule 12(b)(6), the complaint is viewed in the light most favorable to the plaintiff, the allegations in the complaint are accepted as true, and all reasonable inferences are drawn in favor of the plaintiff. *See Bassett v. Nat'l Collegiate Athletic Ass'n,* 528 F.3d 426, 430 (6th Cir. 2008). "[A] judge may not grant a Rule 12(b)(6) motion based on a disbelief of a complaint's factual allegations." *Saglioccolo v. Eagle Ins. Co.,* 112 F.3d 226, 228–29 (6th Cir. 1997) (quoting *Columbia Nat'l Res., Inc. v. Tatum,* 58 F.3d 1101, 1109 (6th Cir. 1995)).

IV. ANALYSIS

BCBSM seeks to dismiss on four primary grounds. First, BCBSM argues that Tiara cannot obtain relief under ERISA. ECF No. 12, PageID.114-120. Second, BCBSM argues that Tiara's allegations regarding "claims processing errors" fail to state a claim for breach of fiduciary duty. *Id.* at PageID.120-126. Third, BCBSM asserts that Tiara's allegations regarding the Shared Savings Program do not state a claim. *Id.* at 126-132. Fourth, BCBSM argues that Tiara's claims are time-barred. *Id.* at 132-134. Each argument should be rejected.

Notably, BCBSM's legal argument is missing any reference to the documents attached to the Complaint. The documents, which affirm BCBSM's mismanagement of Plan assets, should be considered when evaluating BCBSM's motion to dismiss. *See Cagayat v. United Collection Bureau, Inc*., 952 F.3d 749, 755 (6th Cir. 2020).

A. ERISA AUTHORIZES THE RELIEF SOUGHT IN THE COMPLAINT.

BCBSM argues that Tiara's Complaint as it relates to BCBSM's mismanagement of claims processing does not support relief under ERISA on three grounds. First, BCBSM argues that Tiara does not have standing to seek relief under ERISA. ECF No. 12, PageID.118. Second, BCBSM argues that ERISA does not support Tiara's claim for monetary relief. *Id.* at PageID.115. Third, BCBSM argues that breach of contract claims preempt ERISA causes of action. *Id.* at PageID.113-114. BCBSM's arguments are contrary to Supreme Court and Sixth Circuit precedent and the express statutory language of ERISA.

1. ERISA Expressly Provides Tiara Standing to Bring A Claim Against BCBSM For Losses BCBSM Caused to Tiara's Plan.

BCBSM argues that relief is not available under ERISA Section 1132(a)(2) because Tiara's Plan is not a named party. ECF No. 12, PageID.118-120. But Section 1132(a)(2) expressly authorizes fiduciaries, like Tiara as the Plan sponsor, to bring a civil suit for the relief specified in § 1109(a). 29 U.S.C. § 1132(a)(2). Section 1109, in turn, makes a fiduciary who breaches a fiduciary duty "personally liable to make good to such plan any losses to the plan resulting from each such breach." 29 U.S.C. § 1109(a). Notably, ERISA does not even empower the Plan itself to bring a civil action. 29 U.S.C. § 1132(a). Rather, ERISA relies on a structure of fiduciaries protecting a plan's interests. *See also Loc. 159, 342, 343 & 444 v. Nor-Cal Plumbing, Inc*., 185 F.3d 978, 983 (9th Cir. 1999) ("We have previously held that an ERISA plan itself does not have standing to sue under § 502(a) of ERISA because it is not a plan participant, beneficiary or

fiduciary."). Thus, BCBSM's observation that the Complaint "lists Tiara Yachts as the sole Plaintiff" is neither surprising nor relevant. ECF No. 12, PageID.119.

BCBSM has also made this *exact* argument before, unsuccessfully. In *Borroughs*, BCBSM "state[d] that because Hi–Lex and Burroughs [sic] are the named plaintiffs, rather than the plans themselves, no relief is available under ERISA. That is, Hi–Lex and Burroughs [sic] cannot recover money damages, according to Blue Cross, because any recovery must inure to the plans themselves." *Borroughs Corp. v. BCBSM*, No. 11-12557, 2012 WL 3887438, at *9 (E.D. Mich. Sept. 7, 2012). The court explained that this argument was "rejected by the Sixth Circuit in *Guyan*." *Id.* (citing *Guyan Int'l, Inc. v. Pro. Benefits Adm'rs, Inc*., 689 F.3d 793, 796 (6th Cir. 2012).

BCBSM cites to *Guyan* in its argument, but the case supports Tiara's position. ECF No. 12, PageID.119. In *Guyan*, the plaintiffs managed their own welfare benefit plans and sued the administrator for breach of fiduciary duty. *Guyan*, 689 F.3d at 796. The defendant advanced the same argument made by BCBSM, which the court deemed "unpersuasive." *Id.* at 800. The court explained the requirement "that a breach-of-fiduciary suit seek recovery on behalf of a plan was satisfied even though the plaintiffs 'did not specifically allege in their complaint that their plan suffered losses …'" *Id.* (quoting *Tullis v. UMB Bank, N.A*., 515 F.3d 673, 681 (6th Cir. 2008)). In quoting to the Supreme Court's decision in *Tullis*, the court recognized:

> Although the face of the complaint does not include the exact words "losses to the plan" (i.e. that the plan suffered damages), it clearly indicates that the plaintiffs … are seeking recovery for losses to their plan accounts caused by fiduciary breaches. … Moreover, the complaint clearly puts the defendant on notice that the plaintiffs are seeking recovery for losses that occurred to their plans. That the plaintiffs are seeking recovery on behalf of their plans is, therefore, implied by the language of the complaint—to wit, that the value of the ERISA plans diminished because of the defendant's actions. To hold otherwise would elevate form over substance, a result we have rejected in other contexts.

Guyan, 689 F.3d at 800 (quoting *Tullis*, 515 F.3d at 681) (emphasis added).

Thus, the Complaint need not allege that Tiara seeks to recover "on behalf of the Plan." *Guyan*, 689 F.3d at 800. The Complaint alleges that Tiara is seeking to recover losses that occurred to its Plan caused by BCBSM. ECF No. 1, PageID.15 ("These processing errors result in wasted Plan assets in breach of BCBSM's fiduciary duty."), PageID.19 ("BCBSM breached its fiduciary duties … [by] causing Tiara Yachts' Plan to overpay for benefits"), PageID.20 (BCBSM breached its fiduciary duty by "[f]ailing to implement industry standard claims processing edits to prevent Tiara Yachts' Plan assets from being used to pay improper charges").

The Court must construe the Complaint "in the light most favorable to the plaintiff, accept its allegations as true, and draw all reasonable inferences in favor of the plaintiff." *Handy-Clay v. City of Memphis,* 695 F.3d 531, 538 (6th Cir. 2012). BCBSM's argument improperly relies on a non-contextual reading of the Complaint. *See Mac v. BCBSM*, No. 16-CV-13532, 2017 WL 2450290, at *9 (E.D. Mich. June 6, 2017) (denying BCBSM's motion to dismiss, explaining BCBSM seeks "to hold Plaintiff to a very parsed, isolated and literal reading of the Complaint when characterizing his claim"). The Complaint here puts BCBSM on notice that Tiara is seeking to recover for losses to its Plan, thereby establishing Tiara's authority to bring suit under Section 1132(a). *Guyan*, 689 F.3d at 800.

2. Monetary Relief is Available Under Section 1132(a)(3).

BCBSM argues that "appropriate equitable relief" does not permit monetary compensation from BCBSM. BCBSM says that monetary compensation is "legal" relief when the money is not in the defendant's possession. ECF No. 12, PageID.116. BCBSM's argument is contradicted by well-established law that BCBSM fails to cite to the court. *CIGNA Corp. v. Amara*, 563 U.S. 421, 441 (2011) ("[e]quity courts possess[ ] the power to provide relief in the form of monetary

'compensation' for a loss resulting from a trustee's breach of duty"). In an ERISA claim *against a fiduciary*, a plaintiff may obtain "appropriate equitable relief," including "make-whole" monetary compensation. 29 U.S.C. § 1132(a)(3); *see CIGNA Corp.*, 563 U.S. at 441. "[T]he fact that … relief takes the form of a money payment does not remove it from the category of traditionally equitable relief." *Amara*, 563 U.S. at 440-42 (explaining that in claims against non-fiduciaries, by contrast, relief sought is not equitable unless the funds are in defendant's possession).

The monetary remedy sought here—recovery of losses to the Plan caused by BCBSM's breach of fiduciary duty—is equitable in nature and recoverable under ERISA. *Id.* Courts have routinely rejected BCBSM's argument. *See id.*; *Teisman v. United of Omaha Life Ins. Co*., 908 F. Supp. 2d 875, 880 (W.D. Mich. 2012) ("§ 1132(a)(3) authorizes the 'make-whole' equitable relief sought by Plaintiff because Jedco is a fiduciary"); *In re Iron Workers Loc. 25 Pension Fund*, No. 04-CV-40243, 2011 WL 1256657, at *15 (E.D. Mich. Mar. 31, 2011) (request for money damages, rather than return of specific money, is equitable in nature in a breach of fiduciary duty suit); *Van Loo v. Cajun Operating Co*., 64 F. Supp. 3d 1007, 1026 (E.D. Mich. 2014) ("make whole" equitable relief is available under § 1132(a)(3) where the defendant is a fiduciary).

The trilogy of Supreme Court cases relied on by BCBSM, *Mertens*, *Great-West*, and *Montanile*, is inapplicable because they all involve ERISA claims against non-fiduciaries. *See Mertens v. Hewitt Assocs*., 508 U.S. 248, 262 (1993) (§ 1132(a)(3)'s provision of "appropriate equitable relief" does not provide for the collection of compensatory damages from a non-fiduciary actuary); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 218 (2002) (claim against a plan beneficiary seeking to enforce the plan's reimbursement provision was based on a contractual obligation to pay money, and thus, sought legal relief unavailable under § 1132(a)(3)); *Montanile v. Bd. of Trs. of Nat. Elevator Indus. Health Benefit Plan*, 577 U.S. 136, 144 (2016)

(recovery sought from plan beneficiaries under § 1132(a)(3) was based on a contractual obligation). The Supreme Court emphasized the importance of this distinction in *Amara*, explaining that monetary relief is available in the context of ERISA claims against a fiduciary regardless of whether "the funds in question were *particular* funds or property in the defendants' possession." *Amara*, 563 U.S. at 439 (quoting *Great-West*, 534 U.S. at 213).

Under Section 1132(a)(3), the monetary relief sought by Tiara on behalf of its welfare benefit Plan against its fiduciary (BCBSM) is plainly available.

3. BCBSM's Argument That Contract Claims Preempt ERISA Claims Is Opposite of Law.

The theme of BCBSM's motion is that Tiara should and could have sought contractual claims against BCBSM, and thus Tiara's ERISA claims are "belated." ECF No. 12, PageID.113. In other words, BCBSM argues that if a plaintiff has a contract claim, that contract claim preempts an ERISA claim. This is the opposite of the law.

Here, ERISA would preempt a potential contract claim because ERISA provides the appropriate relief. *See* 29 U.S.C. § 1144(a); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). The Supreme Court has recognized that the "six carefully integrated civil enforcement provisions" under ERISA Section 502(a) offer "strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985). As a result, ERISA completely preempts "any state-law cause of action that duplicates, supplements, or supplants ERISA's civil enforcement remedy." *Davila*, 542 U.S. at 209. "The Sixth Circuit recognizes 'that virtually all state law claims relating to an employee benefit plan are preempted by ERISA.'" *Borroughs*, 2012 WL 3887438, at *10 (quoting *Cromwell v. EquicorEquitable HCA Corp.*, 944 F.2d 1272, 1276 (6th Cir. 1991)).

In *Borroughs*, an employer maintaining a self-funded plan brought breach of fiduciary duty and state law claims against BCBSM. *Id.* at *1. BCBSM argued that plaintiffs' state claims were preempted by ERISA (the opposite of the argument it makes now) and the court agreed. *Id.* at *10. The court explained, "ERISA preempts 'any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.' The scope of ERISA preemption is very broad." *Id.* (quoting 29 U.S.C. § 1144(a)). The court further explained that because "[p]laintiffs' state law claims arise out of the same operative facts as the ERISA claims," they "seek relief for the same conduct through 'alternative enforcement mechanisms.'" *Id.* (quoting *Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp*., 399 F.3d 692, 698 (6th Cir. 2005)). Thus, the court dismissed plaintiffs' state law claims with prejudice.

The Complaint alleges that BCBSM breached its fiduciary duty, in part, by consistently using Plan assets to pay improper claims. ECF No. 1, PageID.18-20. As set forth above, ERISA authorizes a plan sponsor, such as Tiara, to bring a breach-of-fiduciary suit to seek recovery on behalf of a plan. The relief sought in the Complaint is entirely within the scope of ERISA, so any breach of contract claim based on the same underlying conduct would be preempted. Furthermore, BCBSM cannot rely on a contract to negate its fiduciary responsibilities under ERISA. *See Hi-Lex Controls, Inc. v. BCBSM*, 751 F.3d 740, 746 (6th Cir. 2014) ("A fiduciary is established under ERISA by a party's functional role and that responsibility cannot be abrogated by contract" (citing *Mertens*, 508 U.S. at 262; *Briscoe v. Fine*, 444 F.3d 478, 492 (6th Cir. 2006)).

B. TIARA STATES A CLAIM FOR BREACH OF FIDUCIARY DUTY WITH RESPECT TO CLAIMS PROCESSING ALLEGATIONS.

BCBSM's second argument is that the Complaint's allegations regarding claims processing fail to state a claim for breach of fiduciary duty. ECF No. 12, PageID.120-126. BCBSM contends

that it is not an ERISA fiduciary, but to the extent it was, it did not breach its fiduciary duty. BCBSM's arguments lack legal merit and rely heavily on a mischaracterization of the Complaint.

1. As a Preliminary Matter, BCBSM Mischaracterizes the Complaint.

BCBSM's argument relies on a mischaracterization of isolated allegations. While the heading of BCBSM's argument suggests it disputes allegations of "claims processing errors," BCBSM's argument omits any reference to the claims processing errors expressly identified by BCBSM in its internal communications attached to the Complaint, in which BCBSM conceded its mismanagement of claims processing constituted a breach of its fiduciary duty. *Id.* at PageID.120; *see also* ECF No. 1-2, PageID.26-27 (discussing "the ramifications of the switch in processing" and recognizing that BCBSM's "lack of control over the issue was viewed as failure to fulfil its [fiduciary] responsibility"). Additionally, BCBSM focuses its argument on "clinical editing requirements," but the Complaint never references that phrase. ECF No. 12, PageID.121-125. BCBSM's argument fails to address and accept as true the allegations set forth in the Complaint and should be rejected.

2. The Complaint Alleges BCBSM's Fiduciary Status.

BCBSM argues that Tiara cannot maintain a breach of fiduciary duty claim "with respect to claims-processing because BCBSM does not act as a fiduciary when it negotiates payment requirements with providers." ECF No. 12, PageID.121. But Tiara's Complaint has nothing to do with BCBSM's *rate negotiation* with providers. For example, whether BCBSM negotiated to pay a provider $100 to apply a Band-Aid is not at issue. What is at issue, in part, is if that provider then applies a Band-Aid, submits an upcoded claim for the service (say billing $1,000 for applying the Band-Aid), and BCBSM then decides to process and pay such claim using Plan assets. The issue boils down to BCBSM's administration of claims processing—not BCBSM's rate negotiation

with providers. *See e.g.*, ECF No. 1, PageID.15-16. Indeed, the Complaint contains no discussion of BCBSM's "rate negotiation" with providers. BCBSM seemingly does not challenge its fiduciary status with respect to its administration of claims processing, which is the function at issue.

The Sixth Circuit has established that BCBSM functions as an ERISA fiduciary in its administration of self-funded plans. *See Hi-Lex*, 751 F.3d at 742 ("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."); *Pipefitters Loc. 636 Ins. Fund v. BCBSM*, 722 F.3d 861, 867 (6th Cir. 2013). Notably, the only published case relied on by BCBSM on this point, *DeLuca*, acknowledged that "BCBSM acted as a fiduciary" in its capacity "as the administrator and claims-processing agent for the plan." *DeLuca v. BCBSM*, 628 F.3d 743, 746 (6th Cir. 2010) (emphasis added).

BCBSM does not dispute that it acted as a fiduciary by administering the Plan and that conclusion is inevitable. BCBSM used the funds from Tiara's ERISA Plan to pay claims. BCBSM had discretion in the disposition of Plan assets; for example, BCBSM exclusively determined whether and how much to pay providers out of Plan assets. *See* 29 U.S.C. § 1002(21)(A); *see also* ECF No. 1, PageID.18 ("[a]t all times relevant, BCBSM was a fiduciary … 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.").

Indeed, BCBSM's own documents (attached to the Complaint) demonstrate BCBSM's control and discretion. For example, in its Payment Integrity Presentation, BCBSM warrants that

"it takes actions to ensure health claims are submitted, and paid accurately, proactively and correctly … according to medical, benefit and reimbursement policies and contractual term. Not in error or duplicate and free of wasteful or abusive practices." ECF No. 1, PageID.17. It was BCBSM's responsibility to make sure claims were paid using Plan assets "accurately" and "correctly."

As another example, in discussing a known flaw in its claims processing system that caused Tiara to overpay for claims, BCBSM executives attribute the problem to "the manner in which we [i.e., BCBSM] have coded our systems plus a lack of controls surrounding abusive billing practices." ECF No. 1-4, PageID.41. These documents illustrate that BCBSM had discretionary control over the design and implementation of its claims processing system through which it used Tiara's Plan assets to pay for claims. BCBSM admitted it has "fiduciary responsibility to [its] ASC customers" and that its "lack of control over the issue [would be] viewed a failure to fulfill this responsibility." *Id.* In short, "BCBSM had the 'flexibility to determine' when and how" Tiara's Plan assets were disposed of, and thus was an ERISA fiduciary. *Hi-Lex*, 751 F.3d at 740.

At best for BCBSM, its argument that it "did not act as a fiduciary when it addressed clinical editing requirements with providers" presents an issue of fact, which is not appropriately decided on a motion to dismiss. ECF No. 12, PageID.123; *see Little River Band v. BCBSM*, 183 F. Supp. 3d 835, 842 (E.D. Mich. 2016); *see also Rankin v. Rots*, 278 F. Supp. 2d 853, 868 (E.D. Mich. 2003) (recognizing the issue of fiduciary status "is more appropriately addressed at a later stage in the case"); *Hillman v. Atonne Grp., LLC*, No. 1:19-CV-1097, 2021 WL 5546708, at *2 (W.D. Mich. Mar. 5, 2021) (denying a motion to dismiss, explaining "[t]he test for a fiduciary is a functional one depending on the actions taken by the entity and not on the formal document describing the duties of the entity"); *Edmonson v. Lincoln Nat. Life Ins. Co*., 777 F. Supp. 2d 869,

884-85 (E.D. Pa. 2011) ("[I]f the parties dispute the facts that establish the defendant's fiduciary status, including whether the defendant had authority and control over the management and disposition of plan assets, then the issue should not be resolved at the motion to dismiss stage.").

In *Little River Band*, BCBSM moved to dismiss a complaint on the basis that the complaint failed "to allege sufficient specific facts to show the plaintiffs were entitled to have payments for hospital services capped at 'Medicare-Like Rates.'" *Little River Band*, 183 F. Supp. 3d at 842. Like here, BCBSM "contend[ed] that its fiduciary duty did not extend to ensuring that claims were paid at appropriate rates." *Id.* at 843. The court rejected BCBSM's argument, explaining that BCBSM's argument is merely a factual rebuttal to the breach of duty claim; it does not establish that the breach of duty claim is insufficiently pleaded in the first instance." *Id.* In denying BCBSM's motion, the Court recognized that "[t]he complaint sufficiently alleges an overpayment theory based on Blue Cross's obligation to avoid squandering Plan assets on the cost of services that should have been capped at Medicare-Like Rates." *Id.* at 844. The Court should reach the same conclusion here.

3. The Complaint Alleges Breach of Fiduciary Duty with Respect to Claims Processing.

Next, BCBSM argues that the Complaint's allegations with respect to claims processing fail to state a claim for breach of fiduciary duty on two grounds. First, BCBSM claims that the Complaint fails to plead any injury. ECF No. 1, PageID.123. Second, BCBSM contends that the Complaint fails to allege facts detailing how BCBSM breached its fiduciary duty with respect to claims processing. *Id.* at PageID.124. Both of BCBSM's arguments ignore the allegations in the Complaint.

a. The Complaint Alleges That BCBSM's Breach of Fiduciary Duty Caused Actual Harm to the Plan (i.e. Wasted Plan Assets).

BCBSM claims that "the Complaint fails to plead that Tiara Yachts actually suffered from any clinical editing errors."[3] ECF No. 12, PageID.123. Count I of the Complaint, however, explicitly alleges, "BCBSM breached its fiduciary duties … [by] [c]onsistently 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." ECF No. 1, PageID.19-20.

BCBSM makes the same argument with respect to allegations of deficient claims data—"nowhere does Tiara Yachts allege facts that BCBSM actually failed to maintain its data in an appropriate manner." ECF No. 12, PageID.126. Yet again, the Complaint expressly alleges that "BCBSM breached its fiduciary duties … [by] [p]aying 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." ECF No. 1, PageID.20.

BCBSM's assertions that Tiara's arguments are speculative ignore the allegations and consideration of the Complaint as a whole. Tiara is not speculating—it alleges these problems exist because an exhaustive expert analysis of a similarly-situated customer's claims data found them. As alleged in the Complaint, "BCBSM processes all claims for all non-auto NASCO customers, such as Tiara Yachts, on the same claims processing system. Thus, errors or

[3] The Complaint does not contain any allegations mentioning "clinical editing errors." BCBSM takes the liberty of creating this term supposedly to describe common "claims processing system" errors, which "include, for example: unbundling, upcoding, medically unlikely claims, non-adherence to payment guidelines, and BCBSM's flip logic." ECF No. 1, PageID.15 (emphasis added). However, the Complaint, not BCBSM, defines the issues at hand.

deficiencies identified in claims associated with one customer can reasonably be expected to exist for other customers using the same system." ECF No. 1, PageID.15. The improper payments and data deficiencies detailed at length in the *Comau* case plausibly, if not certainly, impacted Tiara's claims in the same manner because both customers' claims were processed by BCBSM using the same system. The plausibility standard "does not impose a probability requirement at the pleading stage; it simply calls for enough fact[s] to raise a reasonable expectation that discovery will reveal evidence of illegal conduct." *Cagayat*, 952 F.3d at 753 (internal citation and quotation omitted) (emphasis added).

Notably, BCBSM enjoys exclusive control over Tiara's claims data, a power it exercises to conceal its mismanagement. ECF No. 1, PageID.1 ("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."). Once Tiara's complete claims data is produced by BCBSM in discovery, then the parties will be able to fairly address BCBSM's factual dispute over the existence of improper claims and payments. Regardless, Tiara "need not specifically identify the allegedly fraudulent claims prior to discovery." *Grp. 1 Auto., Inc. v. Aetna Life Ins. Co.*, No. 4:20-CV-1290, 2020 WL 8299592, at *1 (S.D. Tex. Nov. 9, 2020).

This Court reasonably recognizes that "'ERISA plaintiffs generally lack the inside information necessary to make out their claims in detail unless and until discovery commences.'" *Garcia v. Alticor, Inc*., No. 1:20-CV-1078, 2021 WL 5537520, at *4 (W.D. Mich. Aug. 9, 2021) (quoting *Braden v. Wal-Mart Stores, Inc*., 588 F.3d 585, 598 (8th Cir. 2009)). "This has resulted in courts reading ERISA plaintiffs' complaints slightly more leniently, allowing discovery as long as plaintiffs have provided enough factual allegations to create reasonable inferences" that

defendants' conduct breached a fiduciary duty. *Garcia*, 2021 WL 5537520 at *4 (collecting cases). Taking into account the fact that BCBSM has exclusive possession of the claims data necessary to identify errors and deficiencies, coupled with the fact that the same issues have been concretely identified by other non-auto NASCO customers whose claims are processed on the *same system* as Tiara's claims, the Complaint plausibly alleges that BCBSM breached its fiduciary duty in administering the Plan.

b. The Complaint Alleges BCBSM Failed to Act as a Prudent Fiduciary In Processing and Paying the Plan's Claims.

BCBSM asserts that Tiara's allegations are insufficient to support a breach of duty because the Complaint does not specifically state "what standard ERISA imposes in the context of clinical editing" or "how BCBSM fell short of whatever standard that may be it processed claims for the Plan." ECF No. 12, PageID.124-125. BCBSM also claims that there is no "fiduciary obligation to process claims without error." ECF No. 12, PageID.124. The Complaint, however, does address BCBSM's fiduciary duty. The Complaint alleges that BCBSM had a duty to "preserve Plan assets, fully disclose its actions, avoid making false and misleading statements," and "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." ECF No. 1, PageID.18, 20.

The Complaint alleges, in part, that BCBSM's administration of the Plan fell below *its own representations and standards*. "BCBSM represents that its 'claims processing practices consistently deliver industry-leading outcomes with respect to claim payments, and average above 99% accuracy.'" ECF No. 1, Page ID.17. "BCBSM says that it 'takes actions to ensure health claims are submitted, and paid accurately, proactively and correctly … according to medical, benefit and reimbursement policies and contractual term. Not in error or duplicate and free of

wasteful or abusive practices.'" *Id.* An email attached to the Complaint shows that BCBSM executives expressly acknowledged BCBSM had a "fiduciary responsibility to [its] ASC customers" and that BCBSM's consistent practice of paying improper claims would be "viewed as a failure to fulfill this responsibility." ECF No. 1-4, PageID.42. Consistently paying claims that are by BCBSM's own definition fraudulent or erroneous is a clear breach of duty.

Claims for breach of fiduciary duty in claims processing are routinely recognized by courts. In *Group 1 Auto*, the plaintiff, Group 1, maintained a self-funded health benefit plan, to which Aetna served as the claims administrator. *Grp. 1 Auto.*, 2020 WL 8299592, at *1. Group 1 alleged that "Aetna failed to adequately investigate and reject a wide variety of claims despite the files reflecting well recognized indicia of fraud, waste or abuse, and the wrongful payment of these claims caused substantial financial harm to Group 1's benefit plan." *Id.* at *4. Like BCBSM, Aetna moved to dismiss the complaint on the basis that the complaint failed to "detail how Aetna's claims adjudication fell below an objective standard governing prudent claims processors" and did "not identify any flaws in Aetna's claims systems, policies or procedures (or any other Aetna conduct) that lead to improper claim adjudication." *Id.* at*3. The court denied Aetna's motion to dismiss, explaining:

> [A plan administrator], therefore, despite his own lack of skill and experience in claims administration, will be held to the standard of a skilled administrator. **It is quite obvious that no prudent administrator would approve claims payments for non-covered claims** ....
>
> The Court concludes that the Complaint contains factual allegations, though sparse, sufficient to state a plausible claim for breach of ERISA's fiduciary duty. … Group 1's Complaint **identifies well-recognized characteristics of potentially fraudulent or unjustified claims, and alleges that Aetna failed to account for one or more of these characteristics that appeared in many claims Aetna paid on Group 1's behalf**. Group 1 alleges **these red flags should have caused Aetna to deny, or at least investigate those claims**. Group 1 need not, at this preliminary stage, identify the specific Aetna policies and procedures (or lack thereof) that led to its allegedly improper approval of questionable claims. Group 1's Complaint

> contains sufficient factual allegations to state a plausible claim giving notice to Aetna how Group 1 contends Aetna breached ERISA fiduciary duties. Additional detail will have to be provided by Group 1 in the course of initial disclosures and discovery.
>
> ***
>
> In sum, Group 1 has pleaded basic facts sufficient to overcome Aetna's Motion and has stated a claim for breach of fiduciary duties under ERISA. **Group 1 need not specifically identify the allegedly fraudulent claims prior to discovery**.

Id. (internal citation and quotation omitted) (emphasis added).

Similarly, in *Guardsmark*, the plaintiff brought breach of fiduciary duty and prohibited transaction claims against defendant Blue Cross and Blue Shield of Tennessee (BCBST), alleging that BCBST "breached its fiduciary duties … by wrongfully approving and losing claims for payment" and "by substantially overpaying claims and overcharging for its services." *Guardsmark, Inc. v. BlueCross & BlueShield of Tennessee*, 169 F. Supp. 2d 794, 797 (W.D. Tenn. 2001). BCBST brought a motion to dismiss raising similar arguments to BCBSM here—namely, it was not an ERISA fiduciary and plaintiff failed to plead a breach of fiduciary duty claim. *Id.* at 798. The court rejected BCBST's arguments.

First, the court explained that BCBST was a fiduciary with respect to the overpayments because "[i]n the Sixth Circuit, when an insurance company administers claims for employee welfare benefit plans and has authority to grant or deny claims, the insurance company is a fiduciary for ERISA purposes." *Id.* at 800 (citing *Chiera v. John Hancock Mutual Life Ins. Co*., 2001 WL 111585 (6th Cir. 2001)). The court noted that BCBST "had final authority to approve and deny claims" and "also wrote checks, payable from Plan assets, to pay claims it had approved and denied [p]laintiffs the opportunity to review its decisions." *Id.* at 802. The court further concluded, "[BCBST]'s exercise of discretionary authority in carrying out these functions qualifies [it] as a fiduciary under the functional analysis test." *Id.*

The court also found that BCBST "breached its fiduciary duties under ERISA." *Id.* The court explained, "[a]s a fiduciary, [BCBST] may be held liable under ERISA for improper management, administration, and investment of plan assets as well as for failure to maintain proper records and disclose specified information." *Id.* The court found that BCBST "**overpaid, lost, and improperly handled claims**," and "**overcharged** the Plan for run-out fees, and **wrongfully increased its own compensation**" in breach of its fiduciary duty. *Id.* at 802-03 (emphasis added). The court also found that plaintiff stated a valid claim for prohibited transactions because in "wrongfully overpaying claims, [BCBST] dealt with Plan assets in its own interest and for its own account." *Id.* at 803.

The case law relied on by BCBSM is not instructive. BCBSM cites to *Meiners* to support its claim that Tiara failed to plead a benchmark for the standard of care. In *Meiners*, the court explained that when a complaint alleges breach of the duty of prudence in the context of investment fund selections, it is insufficient to simply point to one other fund with better performance to plead that a particular investment was imprudent. *Meiners v. Wells Fargo & Co*., 898 F.3d 820, 823 (8th Cir. 2018). There, the court dismissed the complaint because it "failed to allege sufficient facts to demonstrate that Wells Fargo [funds] were an imprudent choice." *Id.* at 824. Here, the Complaint alleges and demonstrates that BCBSM's consistent payment of improper claims was in and of itself imprudent.

Finally, the issue of whether BCBSM acted prudently in administering the Plan's claims is a question of fact. BCBSM argues that deviations from perfection do not support a breach of the duty of prudence. ECF No. 12, PageID.124-25. Aside from the fact that the Complaint contains no allegations regarding "perfection," BCBSM's argument improperly presents a question of fact. *See Grand Traverse Band of Ottawa & Chippewa Indians v. BCBSM*, No. 14-CV-11349, 2017

WL 3116262, at *3 (E.D. Mich. July 21, 2017) (denying BCBSM's motion to dismiss, explaining that "the issue of whether defendant should have sought a discounted rate in connection with the MLR regulations appears to be a question of fact, not of law. […] Plaintiffs in this case allege that defendant failed to act as a prudent person, to preserve plan assets, and act for the exclusive purpose of providing benefits to beneficiaries—in other words, breached a fiduciary duty—by failing to pursue an avenue to significantly reduce payments by the Plan"); *Sherrill v. Fed.-Mogul Corp. Ret. Programs Comm*., 413 F. Supp. 2d 842, 868 (E.D. Mich. 2006) ("[I]n the context of ERISA fiduciary litigation, other courts have not hesitated to find that the question of prudence is a question of fact and that it is error to decide that question as a matter of law." (collecting cases)).

The cases relied on by BCBSM further reflect this as they both involve motions for summary judgment. *See Senior Lifestyle Corp. v. Key Benefit Administrators, Inc*., No. 117CV02457JMSMJD, 2020 WL 2039928, at *2 (S.D. Ind. Apr. 28, 2020), *reconsideration denied*, No. 117CV02457JMSMJD, 2020 WL 3642512 (S.D. Ind. July 6, 2020); *Daniel F. v. Blue Shield of California*, No. C 09-2037 PJH, 2011 WL 830623, at *1 (N.D. Cal. Mar. 3, 2011).

C. TIARA ALLEGES CLAIMS REGARDING THE SHARED SAVINGS PROGRAM.

The Complaint details BCBSM's scheme to retroactively implement a "Shared Savings Program," through which BCBSM capitalized on its mismanagement of Plan assets. BCBSM makes three arguments: (1) the Complaint fails to satisfy Rule 9(b); (2) the Complaint fails to satisfy Rule 8; and (3) BCBSM was not a fiduciary with respect to the Shared Savings Program.

1. Rule 9 Is Inapplicable But Is Satisfied Nonetheless.

BCBSM argues that Tiara's allegations "sound in fraud." ECF No. 12, PageID.127. The Complaint does not allege fraud with respect to the Shared Savings Program. Instead, Tiara alleges that BCBSM breached its fiduciary duty by "implementing a Shared Savings Program when it

knew Tiara's 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" and engaged in prohibited transactions by "dealing with the assets of Tiara Yachts' Plan in its own interest or for its own account." ECF No. 1, PageID.19, 21.

"The heightened pleading requirement under Rule 9(b) will not be imposed where the claim is for a breach of fiduciary duty under ERISA." *See Rankin,* 278 F. Supp. 2d at 866; *In re CMS Energy ERISA Litig.,* 312 F. Supp. 2d 898, 909 (E.D. Mich. 2004). BCBSM has raised this argument before in *Comau*, which presented essentially the same allegations. In rejecting BCBSM's argument, the Court explained, "[t]he gravamen of Comau's [First Amended Complaint] alleges that BCBSM knowingly paid inflated healthcare claims to providers on behalf of Comau and that it failed to update its billing system to avoid the payment of improper claims. These allegations do not trace the elements of common-law fraud." *Comau LLC v. BCBSM*, No. 19-CV-12623, 2020 WL 7024683, at *5 (E.D. Mich. Nov. 30, 2020).

Regardless, the Complaint satisfies Rule 9(b)'s heightened pleading standards. As BCBSM acknowledges, the Complaint must plead "the who, what, when, where and how" to satisfy Rule 9(b). *City of Taylor Gen. Emps. Ret. Sys. v. Astec Indus., Inc*., 29 F.4th 802, 810 (6th Cir. 2022). The Complaint, which contains 22 pages of detailed allegations derived from BCBSM's internal emails and documents, clearly answers these questions: Who – BCBSM; What – BCBSM implemented a Shared Savings program "that would allow it to profit on its own mismanagement of plan assets"; When – Effective January 1, 2018, applying retroactively extending back to January 1, 2016; Where – Michigan; How – by implementing a mandatory and automatic program, which applied retroactively, allowing BCBSM to profit on its own mismanagement of plan assets. In sum, BCBSM automatically opted all of its self-funded customers into a program under which

the more BCBSM mismanaged claims processing, the more money BCBSM would make. ECF No. 1, PageID.9-12.

Tiara cannot be much more specific: it does not have unfettered access to BCBSM's internal communications and documents. To the extent BCBSM complains that the Complaint does not contain details which are in BCBSM's exclusive possession, the pleading requirements of Rule 9(b) "may be relaxed where information is only within the opposing party's knowledge." *Picard Chem. Inc. Profit Sharing Plan v. Perrigo Co.*, 940 F. Supp. 1101, 1114 (W.D. Mich. 1996) (quoting *Michaels Bldg. Co. v. Ameritrust Co.*, 848 F.2d 674, 680 (6th Cir. 1988)).

2. The Complaint Satisfies Rule 8.

Since the Complaint satisfies Rule 9(b), it satisfies Rule 8. BCBSM argues that the Complaint fails to satisfy Rule 8 because the allegations are contradictory. In essence, BCBSM claims that, because BCBSM recovered improper payments under the Shared Savings Program, allegations that BCBSM mismanaged claims processing are contradictory. This argument is nonsensical and ignores Tiara's allegations. Tiara engaged BCBSM to administer its claims from 2006 to December of 2018. ECF No. 1, PageID.3. After years of consistently mismanaging claims processing, BCBSM implemented a Shared Savings Program effective January 1, 2018, through which it positioned itself to profit on its mismanagement extending back to 2016. *Id.* at PageID.10-11. Tiara's allegations are not contradictory; they illustrate the design of BCBSM's plan to capitalize on its misconduct.

3. BCBSM Was A Fiduciary Regarding Fees It Collected Under The Shared Savings Program.

BCBSM argues that it was not a fiduciary with respect to the Shared Saving Program because BCBSM had the right to retain compensation per the terms of its contract with Tiara. ECF

No. 12, PageID.130. BCBSM has made this argument twice before relying on the same case law, and both times the Sixth Circuit has rejected it.

In *Hi-Lex*, the plaintiff brought a breach of fiduciary duty claim against BCBSM because BCBSM was collecting hidden administration fees with ERISA plan assets. On summary judgment, BCBSM argued that *Seaway* "supports its right to collect fees per the terms of its contract with [plaintiff]." *Hi-Lex*, 751 F.3d at 744 (citing *Seaway Food Town, Inc. v. Med. Mut. of Ohio*, 347 F.3d 610, 616–19 (6th Cir. 2003)). The Sixth Circuit rejected BCBSM's argument because BCBSM exercised discretion with respect to the fees it charged. *Id.* The Sixth Circuit explained that "BCBSM had the 'flexibility to determine' how and when access fees were charged to self-funded ASC clients" and thus the fees were discretionary. *Id.*

Similarly, in *Pipefitters*, the plaintiffs brought a breach of fiduciary duty claim against BCBSM for fees collected by BCBSM. *Pipefitters*, 722 F.3d at 863. Again, on summary judgment, the Sixth Circuit rejected BCBSM's argument that it was not a fiduciary with respect to the fees pursuant to *Seaway*. *Id.* at 866-67. BCBSM was an ERISA fiduciary with respect to its fee collection "[b]ecause 'an entity that exercises *any* authority or control over disposition of a plan's assets becomes a fiduciary." *Id.* at 867 (quoting *Guyan*, 689 F.3d at 798).

Here, the Complaint alleges that BCBSM had discretionary authority with respect to the compensation BCBSM collected pursuant to the Shared Savings Program. ECF No. 1, PageID.12 ("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."). The fact that the parties' contract set a 30 percent rate for BCBSM's compensation does not negate BCBSM's fiduciary status.

As pled in the Complaint, the amount BCBSM "recovered" pursuant to the Shared Savings Program was within the unilateral control of BCBSM. ECF No. 1, PageID.21. As the administrator, it was BCBSM's job to ensure claims were processed and paid correctly—a role over which it had complete discretionary control, as established above. *Id.* at PageID.3-4. The more improper claims BCBSM let slide through its claims processing system, the more money BCBSM would recoup under the Shared Savings Program. *Id.* at PageID.11. Simply put, BCBSM exercised control over the fees it collected on the back end, because BCBSM controlled how claims were processed and paid on the front end.

D. TIARA'S CLAIMS ARE NOT TIME-BARRED UNDER ERISA.

With one (very important) exception, ERISA provides two deadlines to commence suit for a breach of fiduciary duty, including engaging in prohibited transactions:

1) 6 years after either "(A) the date of the last action which constituted a part of the breach or violation" or (B) in the case of an omission the latest date one which the fiduciary could have cured the breach or violation; or

2) 3 years "after the earliest date on which the plaintiff had actual knowledge of the breach or violation."

29 U.S.C. § 1113. The exception to both of the above deadlines is that "in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation." *Id*.

In its motion, BCBSM represents that there are only two periods; BCBSM fails to disclose the overarching exception, which is undoubtedly applicable when accepting the allegations as true. ECF No. 12, PageID.12-13. Ignoring the exception, BCBSM argues that the three-year limitations period applies because Tiara "had actual knowledge of the claims paid on its behalf." *Id.* at PageID.133. However, when considering all of the limitations periods (which BCBSM ignores),

the allegations in the Complaint (which BCBSM ignores), and binding Supreme Court precedent (which BCBSM ignores), Tiara's claims are timely for several reasons.

1. BCBSM Concealed Its Imprudent and Inconsistent Claims Handling.

ERISA's fraud or concealment limitations period "should be applied to cases in which a fiduciary: (1) breached its duty by making a knowing misrepresentation or omission of a material fact to induce [a plaintiff] to act to his detriment; *or* (2) engaged in acts to hinder the discovery of a breach of fiduciary duty." *Hi-Lex Controls Inc. v. BCBSM*, No. 11-12557, 2013 WL 2285453, at *25 (E.D. Mich. May 23, 2013) (quoting *Caputo v. Pfizer*, 267 F.3d 181, 190 (2d Cir. 2001)). "[M]isrepresenting and omitting information" from disclosures constitutes "fraud or concealment" under ERISA § 1113. *Hi-Lex*, 751 F.3d at 748.

Tiara alleges that BCBSM concealed its mismanagement of Plan assets in numerous ways. *See* ECF No. 1, PageID.1, 8-9, 12-13, 19-21. For example, BCBSM knew its claims processing system was flawed since 1997 and acknowledged that "its customers may not be fully aware of the implications." Yet, BCBSM took active steps to conceal the problem, such as by deciding not to inform customers of the problem, manipulating its claims-processing system to keep the problem undetected, and terminating an internal whistleblower's employment. *Id*. at PageID.8-9. The Complaint also alleges that "BCBSM further conceals its misconduct by gatekeeping information necessary to identify improper charges" by limiting its customers', including Tiara's, "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." *Id.* at PageID.12.

Tiara's Complaint specifically alleges that BCBSM's conduct amounted to concealment of the fact that BCBSM was breaching its fiduciary duties to Tiara. *Id.* at PageID.19-20. Tiara's

Complaint is timely because Tiara filed it within six years of discovery of BCBSM's breach. *See id*. at PageID.1, ¶ 2 ("Tiara Yachts recently discovered. . . .").

2. BCBSM's Argument Regarding Actual Knowledge Disregards the Pleadings and Law.

BCBSM further disregards the facts pled by Tiara by asserting that "Tiara Yachts had actual knowledge of claims paid on its behalf because this information was routinely provided as required under the ASC." ECF No. 12, PageID.133. BCBSM points to the ASC to support its assertion, stating Tiara could access some nondescript claims information and had the right to conduct a very limited audit once a year of only 200 claims, which Tiara could not even select itself. *Id.*; ECF No. 12-2, PageID.144. But the ASC only reflects disclosures that BCBSM agreed to make, which are not indicative—either legally or factually—of Tiara's actual knowledge.

"A plaintiff does not necessarily have 'actual knowledge' under § 1113(2) of the information contained in disclosures that he receives but does not read or cannot recall reading. To meet § 1113(2)'s 'actual knowledge' requirement, the plaintiff must in fact have become aware of that information." *Intel Corp. Invest. Policy Comm. v. Sulyma*, 140 S.Ct. 768, 772 (2020) (holding that records showing an ERISA plaintiff had visited a website where disclosures were available does not mean that the plaintiff was aware of such disclosures such that the plaintiff had actual knowledge). The term "actual knowledge" for the ERISA statute of limitations is interpreted by its plain meaning; actual knowledge or actual awareness of an ERISA fiduciary's breach of duty. *Id*. at 772.

In *Sulyma*, an ERISA plaintiff worked at Intel Corporation from 2010 to 2012 and was the beneficiary of two retirement plans. *Id.* at 774. In 2015, the plaintiff sued the plan administrator for imprudent investments in breach of the plan administrator's ERISA fiduciary duties. *Id.* The plan administrator submitted records showing that the plaintiff had visited the benefits website,

where investment disclosures were available, but the plaintiff testified that he did not remember reviewing any such disclosures. *Id.* at 775. The plan administrator argued the plaintiff's apparent access to the disclosures gave the plaintiff "actual knowledge."

The Court explained that, an ERISA plaintiff does not have actual knowledge of a plan administrator's investment decisions where the plaintiff merely had access to such information without reviewing it. *Id.* at 777 ("As presently written, therefore, § 1113(2) requires more than evidence of disclosure alone."). Actual knowledge requires showing that an ERISA plaintiff was in fact aware of the breach and chose not to act on that awareness within three years. *Id*. at 772. Accordingly, that Court held that the three-year statute of limitations period based on actual knowledge did not apply. *Id.*

Here, contrary to BCBSM's argument, Tiara specifically alleges that it did not have actual knowledge of BCBSM's breach of fiduciary duties due to BCBSM's efforts to conceal the breach. For example, "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." ECF No. 1, PageID.12. Furthermore, "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." *Id.* at PageID.13.

BCBSM further argues that Tiara "concedes that other ASC customers had sufficient information to dispute overpayments made using flip logic." ECF No. 12, PageID.133. Tiara made no such concession. In fact, Tiara alleges that a *BCBSM account manager* was alerted "about a significant medical claim the customer received in excess of $250,000" and that the *BCBSM*

account manager "investigated the customer's complaint and discovered that BCBSM was overpaying for routine medical testing." ECF No. 1, PageID.6. Tiara's allegation is that a *BCBSM employee* investigated and discovered BCBSM's routine overpayment, not that another ASC customer made such discovery. *See id.*

BCBSM's argument that Tiara had actual knowledge because of Tiara's purported access to claims data and BCBSM's disclosures ignores Tiara's Complaint and the Court's holding in *Sulyma*. Nothing in the Complaint suggests that Tiara had actual knowledge of BCBSM's breach. ERISA's three-year statute of limitations period does not apply to Tiara's claims.

3. BCBSM's Statute of Limitations Argument is Premature.

Finally, BCBSM's statute of limitations defense is premature because such analysis requires the Court "to determine when the facts giving rise to the statute of limitations occurred." *Comau*, 2020 WL 7024683, at *9 (denying BCBSM's motion to dismiss in the Comau litigation because BCBSM's statute of limitations argument was premature); *Computer & Eng'g Servs., Inc. v. BCBSM*, No. 12-15611, 2013 WL 1976234, at *4 (E.D. Mich. May 13, 2013) (concluding that it was premature at the motion to dismiss stage to determine the applicable statute of limitations where it was unclear from the complaint when the plaintiffs acquired actual knowledge of the alleged ERISA violations); *E. Jordan Plastics, Inc. v. BCBSM*, No. 12-CV-15621, 2013 WL 1876117, at *6 (E.D. Mich. May 3, 2013) (same).

Indeed, Tiara does not have an affirmative obligation to plead facts to avoid the statute of limitations; the Complaint merely needs some basis to infer that Tiara could develop facts to defeat BCBSM's statute of limitations argument. *Ott v. Midland-Ross Corp.*, 523 F.2d 1367, 1370 (6th Cir. 1975).

Here, as alleged in the Complaint, the facts will show that BCBSM engaged in fraud or concealment to hide its breaches and that Tiara did not have actual knowledge of the breaches. Thus, BCBSM's argument is premature.

V. CONCLUSION

Based on the foregoing, Tiara respectfully requests that the Court deny Defendant's motion in its entirety.

Respectfully submitted,

VARNUM LLP
Attorneys for Tiara Yachts, Inc.

Dated: September 22, 2022

By: /s/ *Aaron M. Phelps*

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CERTIFICATE OF COMPLIANCE

Pursuant to L. Civ. R. 7.2(b)(i), I hereby certify that this document complies with L. Civ. R. 7.2(b)(ii) because this document, generated using Microsoft Word 2010, contains 10,142 words.

/s/ Aaron M. Phelps
Aaron M. Phelps

19972586

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TIARA YACHTS, INC.,

Plaintiff,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

Case No. 1:22-cv-603

Honorable Robert J. Jonker

Magistrate Judge Ray Kent

INDEX OF EXHIBITS

Exhibit	**Description**
A	Unpublished Cases

EXHIBIT A

2020 WL 7024683
Only the Westlaw citation is currently available.
United States District Court, E.D. Michigan, Southern Division.

COMAU LLC, Plaintiff,
v.
BLUE CROSS BLUE SHILED OF MICHIGAN, Defendant.

Case No. 19-cv-12623
|
Signed 11/30/2020

Attorneys and Law Firms

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OPINION AND ORDER DENYING DEFENDANT'S MOTION TO DISMISS PLAINTIFF'S FIRST AMENDED COMPLAINT [#19]

Stephanie Dawkins Davis, United States District Court Judge

I. INTRODUCTION

***1** Plaintiff, Comau LLC, brought the present action against Defendant Blue Cross Blue Shield of Michigan ("BCBSM") alleging breach of fiduciary duty for paying inflated claims to healthcare providers on Comau's behalf. Before the court is BCBSM's Motion to Dismiss Plaintiff's First Amended Complaint for Failure to State a Claim. (ECF No. 19). BCBSM contends that Comau's complaint allegations sound in fraud; therefore, the complaint must meet the heightened pleading requirements of Fed. R. Civ. P. 9(b). BCBSM asserts that the complaint does not meet the 9(b) requirements. Comau argues that its complaint alleges a breach of fiduciary duty claim and does not sound in fraud; as a result, the complaint is not required to meet Rule 9(b)'s heightened pleading standard. Pursuant to Local Rule 7.1(f)(2), the court has determined that this Motion is suitable for determination without a hearing. For the reasons discussed below, the Motion is DENIED.

II. FACTUAL AND PROCEDURAL BACKGROUND

Comau LLC develops and produces automation, manufacturing, and service products. (ECF No. 15, PageID.290). During the time period relevant to this case, Comau provided health care benefits to its employees through a self-insured benefit plan (the "Plan"). *Id.* Comau paid the health care costs of its employees up to a certain threshold instead of buying an insurance policy. *Id.* Comau retained Blue Cross Blue Shield of Michigan several years ago to administer its healthcare plan. *Id.* BCBSM used funds provided by Comau (in the form of prepayments to a BCBSM-owned bank) to pay covered employee healthcare claims. (ECF No. 15 PageID.291, ECF No. 21, PageID.493). Essentially, BCBSM processed and paid claims on behalf of Comau using Comau's funds. *Id.* Comau paid BCBSM an administrative fee to administer its healthcare plan. *Id.*

Comau alleges that since at least 1997, BCBSM has paid grossly inflated healthcare claims on Comau's behalf. (ECF No. 15, PageID.296). On September 6, 2019, Comau filed its first complaint in this court. (ECF No. 1). The complaint brought one count of breach of fiduciary duty for BCBSM's alleged failure to prudently oversee Comau's healthcare plan. *Id.* BCBSM filed its first motion to dismiss Comau's complaint on November 8, 2019. (ECF No. 9). BCBSM's motion to dismiss asserted that Comau's complaint failed to allege fraud with particularity pursuant to Fed. R. Civ. P. 9(b), that the complaint failed to state a claim for breach of fiduciary duty pursuant to Fed. R. Civ. P. 8(a), and that the claims for payments that were more than six years old were time-barred. *Id.* On November 22, 2019, without assessing the merits of BCBSM's motion, Judge Sean Cox entered an Order requiring Comau to either file an amended complaint or file a response to BCBSM's motion to dismiss. (ECF. No. 14).

Comau filed its First Amended Complaint ("FAC") on December 13, 2019. (ECF No. 15). The FAC states that Comau discovered that BCBSM was paying inflated claims when BCBSM's account manager, Dennis Wegner, informed Comau of the alleged improper payments. (*Id.* at PageID.297). A BCBSM customer alerted Wegner to a large medical bill, prompting Wegner to investigate the bill and discover that BCBSM was grossly overpaying the healthcare provider for medical testing. (*Id.* at PageID.298). The FAC alleges that Wegner discovered that BCBSM had overpaid this healthcare provider more than $600,000 within

a two-year period. *Id.* The FAC states that Wegner alerted BCBSM to the overpayment issue. In response, BCBSM's management informed Wegner it knew that it paid improper claims but had done nothing to stop it. *Id.*

***2** Wegner then researched claims and billing for two additional BCBSM customers and found similar overpayments, totaling $125,000 in one case and $75,000 in the other case. *Id.* According to the FAC, Wegner "has personal knowledge" of BCBSM's records and knows that BCBSM overpaid healthcare providers "many thousand dollars" on behalf of Comau. (*Id.* at PageID.299). Wegner brought his concerns about overpayment to BCBSM. However, BCBSM told him not to alert BCBSM customers about its payment of improper claims. (*Id.* at PageID.300). BCBSM terminated Wegner's employment on November 14, 2018. *Id.*

In its FAC, Comau alleges that Wegner had access to BCBSM's customer records, billing, accounting, healthcare claims information, healthcare claims processing system, software, and billing system. *Id.* Further, the complaint asserts that BCBSM used the same processing system, software, and billing system on all of its customer accounts. *Id.* The FAC asserts that BCBSM's systems are organized in a way that guarantees Comau was impacted by BCBSM's overpayment of healthcare claims. (*Id.* at PageID.298). Comau also alleges that many BCBSM employees knew about the improper payments, including Rod Begosa, Lori Shannon, Gary Gavin, and Ken Dallafior. (*Id.* at PageID.300).

Comau's FAC asserts one count of breach of fiduciary duty. (*Id.* at PageID.304). The alleged breaches include, "but [are] not limited to[,]" the following:

(a) [BCBSM] [i]ntentionally and knowingly pa[id] grossly inflated and knowingly inflated healthcare claims to Providers;

(b) [BCBSM] [f]ail[ed] to correct/update its Billing System to avoid Plan assets being used to pay improper charges and conceal[ed] from, and otherwise fail[ed] to disclose to[ ] Plaintiff the payment of improper claims; [and]

(c) [BCBSM] [f]ail[ed] 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 healthcare claims.

(*Id.* at PageID.305). Throughout the FAC, Comau consistently states that BCBSM knew that it was paying inflated claims. (*Id.* at PageID.296, 298, 300, 301). The FAC also posits that BCBSM recklessly paid healthcare providers with Plan assets. *Id.* at PageID.301). Additionally, the FAC alleges that BCBSM has misrepresented itself as a leader in fraud prevention. (*Id.* at PageID.303, 304). The FAC further asserts that BCBSM's payment of claims it knew were improper is inconsistent with health insurance industry standards. (*Id.* at PageID.302).

Comau's FAC states that, as an example, a Comau employee receives a urinalysis from a healthcare provider. (ECF No. 15, PageID.296). The provider then charges $18,000 for the test —a grossly inflated amount—and bills BCBSM. *Id.* BCBSM then uses Comau's Plan assets to pay the inflated bill. *Id.*

On January 31, 2020, this case was reassigned to the undersigned. BCBSM filed the present Motion to Dismiss Plaintiff's First Amended Complaint for Failure to State a Claim on January 15, 2020. (ECF No. 19). BCBSM accepts Comau's factual allegations as true for purposes of the Motion. (*Id.* at PageID.362). BCBSM argues that the FAC contains the same deficiencies as Comau's first complaint. According to BCBSM, the FAC's breach of fiduciary duty claim is grounded in fraud; therefore, Federal Rule of Civil Procedure 9(b) governs, and the FAC fails to meet 9(b)'s strict pleading standard. (*Id.* at PageID.369). Alternatively, if this Court finds that the FAC as a whole is not subject to Rule 9(b), BCBSM contends that the Court should dismiss any allegations of fraud that Comau has inadequately pleaded. (*Id.* at PageID.377). Next, the Motion states that the FAC also fails to adhere to the pleading requirements of Rule 8(a). (*Id.* at PageID.378). Finally, BCBSM contends that the statute of limitations bars any claims that are based on payments made more than six years before the filing of this action. (*Id.* at PageID.382).

***3** In response, Comau contends that the claims in its FAC do not sound in fraud. Therefore, the claims do not need to adhere to the particularity requirements of Rule 9(b). (ECF No. 21, PageID.498). However, if the court determines that 9(b) does apply, Comau asserts that this court can relax the requirements where information is only known by the opposing party. (*Id.* at PageID.501). Second, Comau argues that its FAC conforms to the requirements of 8(a). (*Id.* at PageID.501). Lastly, Comau states that the court cannot determine if its FAC is time-barred at this stage because the trier of fact must determine when BCBSM breached

its duty of care—and thus, when the statute of limitations has run. (*Id.* at PageID.507). Further, Comau states that a determination of what limitations period applies depends on the facts developed during discovery. (*Id.* at PageID.508). BCBSM filed a reply largely reiterating the points set forth in its original Motion. (ECF No. 22).

III. LEGAL STANDARD

Pursuant to Rule 8(a)(2) of the Federal Rules of Civil Procedure, a complaint must state "a short and plain statement of the claim showing that the pleader is entitled to relief." *Hensley Mfg. v. ProPride, Inc.*, 579 F.3d 603, 609 (6th Cir. 2009) (quoting *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007)). This standard does not require "detailed factual allegations." *Id.* However, it does require more than "labels and conclusions" or "a formulaic recitation of the elements of a cause of action." *Id.*

Federal Rule of Civil Procedure 12(b)(6) governs motions to dismiss. The Court must construe the complaint in favor of the plaintiff, accept the allegations of the complaint as true, and determine whether plaintiff's factual allegations present plausible claims. *See* Fed. R. Civ. P. 12(b)(6). To survive a motion to dismiss, a complaint must "allege enough facts to make it plausible that the defendant bears legal liability." *Agema v. City of Allegan*, 826 F.3d 326, 331 (6th Cir. 2016). The facts need to make it more than "merely possible that the defendant is liable; they must make it plausible." *Id.* "Bare assertions of legal liability absent some corresponding facts are insufficient to state a claim." *Id.* A claim will be dismissed "if the facts as alleged are insufficient to make a valid claim or if the claim shows on its face that relief is barred by an affirmative defense." *Riverview Health Inst., LLC v. Med. Mut. Of Ohio*, 601 F.3d 505, 512 (6th Cir. 2010).

Federal Rule of Civil Procedure 9(b) governs the pleading standards for fraud and mistake claims. The Rule requires that a party "state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). The Sixth Circuit has interpreted Rule 9(b) to require "plaintiffs to allege the time, place, and content of the alleged misrepresentation on which he or she relied; the fraudulent scheme; the fraudulent intent of the defendants; and the injury resulting from the fraud." *Cataldo v. U.S. Steel Corp.*, 676 F.3d 542, 551 (6th Cir. 2012).

IV. DISCUSSION

A. Applicable Pleading Standard

This court must first determine whether Fed. R. Civ. 8(a) or 9(b) applies to the allegations in Plaintiff's FAC. To do so, the court must ascertain whether the FAC alleges a breach of fiduciary duty or fraud claim. BCBSM asserts that the FAC sounds in fraud and should be governed by the pleading standards of Fed. R. Civ. P. 9(b). Alternatively, BCBSM contends that this court should dismiss the portions of the FAC that assert claims sounding in fraud. Comau responds that its claims do not sound in fraud and therefore do not need to meet the pleading requirements of 9(b). Alternatively, Comau argues that if the court finds that its claims do sound in fraud, it should not be required to meet the 9(b) standards because BCBSM holds all of the inside information relevant to this case.

The Sixth Circuit has looked to the elements of common-law fraud when assessing whether a complaint sounds in fraud. *See Cataldo v. U.S. Steel Corp.*, 676 F.3d 542, 551 (6th Cir. 2012). In *Cataldo*, the complaint alleged a breach of fiduciary duty, but the Sixth Circuit concluded that the primary theory of liability sounded in fraud where the plaintiffs alleged that defendants gave false representations about how plaintiffs' retirement would be calculated. *Id.* The Court noted that a different group of plaintiffs did not allege detrimental reliance on the defendants' alleged misrepresentations, which is "an essential element in a claim of fraud." *Id.* at n.7.

***4** The elements of common-law fraud are: "(1) a material false representation or omission of an existing fact; (2) knowledge of falsity; (3) intent to defraud; (4) reasonable reliance; and (5) damages." *Caputo v. Pfizer, Inc.*, 267 F.3d 181, 191 (2d Cir. 2001). Following the *Cataldo* court, this court will assess whether the allegations in the FAC meet the elements of common-law fraud in order to determine whether the FAC sounds in fraud.

The FAC alleges one count of breach of fiduciary duty and asserts that BCBSM breached its fiduciary duty in several ways. The alleged breaches include, "but [are] not limited to[,]" the following:

> (d) [BCBSM] [i]ntentionally and knowingly pa[id] grossly inflated and knowingly inflated healthcare claims to Providers;
>
> (e) [BCBSM] [f]ail[ed] to correct/update its Billing System to avoid Plan assets being used to pay improper charges and conceal[ed] from, and otherwise fail[ed] to disclose to[ ] Plaintiff the payment of improper claims; [and]

(f) [BCBSM] [f]ail[ed] 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 healthcare claims.

(ECF No. 15, PageID.305). Additionally, the FAC repeatedly states that BCBSM knew that it was paying inflated claims on behalf of Comau. (*Id.* at PageID.296, 298, 300, 301). It further asserts that BCBSM recklessly paid healthcare providers with Plan assets and that BCBSM has misrepresented itself as a leader in fraud prevention. (*Id.* at PageID.301, 303, 304). The FAC asserts that BCBSM's payment of claims it knew were improper is inconsistent with health insurance industry standards. (*Id.* at PageID.302).

Comau expressly disclaims that it is claiming fraud, and it cites several cases decided within this district in which the court concluded that ERISA breach of fiduciary duty claims did not sound in fraud and were subject to the 8(a) pleading requirements. For instance, in *Rankin v. Rots*, the plaintiffs alleged several breaches of fiduciary duty against the officers and directors of their employer. 278 F. Supp. 2d 853, 853 (E.D. Mich. 2003) (Cohn, J.). The plaintiffs alleged breaches of fiduciary duty, including, "[i]nvesting in an unreasonably large percentage of the Plans' assets[,]" "[f]ailing to investigate and monitor the merits of ... investments[,]" "[f]ailing to take steps to eliminate or reduce the amount of Company Stock in the Plan," "[f]ailing to give Plan participants accurate, complete, non-misleading and adequate information about the compositions of the Plan's portfolios and [the employer's] true financial condition[,]" "[a]llowing continued investment in the Company Stock Fund, when a reasonable fiduciary would have know[n] the investment was not prudent[,]" and "[c]ompelling continued investment of employer matching contributions in the Company Stock when a reasonable fiduciary would have know[n] the investment was imprudent[.]" *Id.* at 863. The court concluded that the plaintiffs' breach of fiduciary duty claims did not sound in fraud. *Id.* at 866. The court reasoned that some of the allegations that alleged providing false and misleading information in the complaint sounded similar to fraud claims, but the "gravamen" of the breach of fiduciary duty claim was grounded in ERISA. *Id.*

The court also found that the plaintiffs' breach of fiduciary duties claim did not sound in fraud in *In re CMS Energy ERISA Litigation.* 312 F. Supp. 2d 898, 909 (E.D. Mich. 2004) (Steeh, J.). The plaintiffs in *CMS Energy* were ERISA plan holders and the defendants were employers and the employers' officers. The plaintiffs alleged that the defendants communicated inaccurate information and failed "to disclose transactions which rendered the financial statements of the employers materially false." *Id.* The court reasoned that the plaintiffs' allegations asserted a breach of fiduciary duty, and not an intent to deceive. *Id.*

***5** However, the Sixth Circuit agreed with the district court that one count of plaintiffs' complaint sounded in fraud where the plaintiffs alleged that the defendant issued misleading statements about its revenues because the revenue numbers were inflated by non-compliance with Generally Accepted Accounting Principles. *Indiana State Dist. Council of Laborers & Hod Carriers Pension & Welfare Fund v. Omnicare, Inc.*, 583 F.3d 935, 941, 948 (6th Cir. 2009).

BCBSM also cites courts in the Northern District of California to advance their proposition that the FAC sounds in fraud. The Northern District of California found that a breach of fiduciary duty claim sounded in fraud where "the gravamen of the [p]laintiff's Amended Complaint [was] that [the defendants] breached [their] fiduciary duties to the Plan by disseminating misleading and incomplete information to Plan participants, and failing to inform participants ... of material information regarding participants' investments in Company stock." *In re Calpine Corp. ERISA Litig.*, No. C 03-1685 SBA, 2005 WL 3288469, at *7 (N.D. Cal. Dec. 5, 2005) (internal quotations omitted); *see also Vivien v. Worldcom, Inc.*, No. C 02-01329 WHA, 2002 WL 31640557, at *6 (N.D. Cal. July 26, 2002). In *Vivien*, the plaintiffs' complaint alleged that the defendants made "false, misleading, incomplete, and inaccurate disclosures and representations to the Plans' participants...." The court found that "[c]ontrary to plaintiffs' contention, the third claim clearly sounds in fraud." *Id.* at *7.

The gravamen of Comau's FAC alleges that BCBSM knowingly paid inflated healthcare claims to providers on behalf of Comau and that it failed to update its billing system to avoid the payment of improper claims. These allegations do not trace the elements of common-law fraud. Namely, the FAC's allegations do not assert a material false representation, an intent to defraud, or reasonable reliance.

The FAC does use the word fraud in various spots throughout the complaint. *See, e.g.*, ECF No. 15, PageID.301, 302 ("Providers submitting [incorrect] claims are considered to be fraudulent[,]" "BCBSM's own website warns the public about the dangers of health care fraud."). However, the FAC's use of the word fraud is primarily used when it

describes the submission of incorrect claims by healthcare providers, and not BCBSM's actions. The FAC also alleges that BCBSM's payment of inflated claims is inconsistent with the representations that it makes to its customers, and that BCBSM provided Comau with "limited reporting information" concerning its practice of paying providers' inflated claims. (ECF No. 15, PageID.303). While the allegations about BCBSM's representations and limited reporting information may sound similar to a fraud claim, the FAC's breach of fiduciary duty claim is still grounded in ERISA, similar to the conclusion of the *Rankin* court. Unlike the allegations in *Omnicare, Inc.*, *In re Calpine Corp.*, and *Vivien*, the allegations in this case do not primarily allege that BCBSM issued misleading statements. The gravamen of the FAC does not allege an intent to deceive and therefore does not sound in fraud—this is similar to the conclusion reached by the *CMS Energy* court.

The FAC's allegations do not meet the elements of common law fraud, nor do the allegations primarily allege that BCBSM circulated misleading and incomplete information. The court finds that the FAC alleges a breach of fiduciary duty claim and not fraud. Therefore, the FAC is subject to the 8(a) pleading standard.

B. Sufficiency of the FAC Claims under Fed. R. Civ. P. 8(a)

***6** Next, BCBSM claims that the court should dismiss Comau's amended complaint because it does not meet the pleading requirements of Fed. R. Civ. P. 8(a). (ECF No. 19, PageID.378). BCBSM asserts that Comau's FAC does not meet the pleading requirements because the only facts alleged in the FAC are facts that are borrowed from Wegner's whistleblower complaint. (*Id.* at PageID.379). BCBSM contends that the FAC alleges that a provider fraudulently overbilled a different BCBSM customer for routine medical testing and then tries to tie these overbillings to Comau by alleging that BCBSM uses the same technology and software to process, bill, and pay all of its client healthcare claims. *Id.* BCBSM then argues that the bare allegation that it uses the same claims-processing software for all of its customers, without alleging how the software functions or how a prudent software system would function, cannot support an inference that it acted imprudently. *Id.* BCBSM asserts that Comau has failed to allege facts sufficient to establish that a prudent fiduciary would have prevented such overpayments. (*Id.* at PageID.380). BCBSM also states that Comau's lack of facts about BCBSM's alleged claims-processing system function failures is particularly striking because information regarding BCBSM's methods and actual knowledge is not only in BCBSM's possession, but also in Wegner's possession—and Wegner is working in cooperation with Comau. (*Id.* at PageID.381).

Comau argues that its FAC meets the pleading requirements. (ECF No. 21, PageID.501). Comau states that its allegations that Wegner discovered BCBSM overpayments, brought the overpayments to BCBSM's attention, confirmed that Comau was subject to the same system that overbilled other BCBSM customers, and confirmed that BCBSM paid overbilled claims on behalf of Comau sufficiently allege that BCBSM breached its fiduciary duty. (*Id.* at PageID.502). Comau also asserts that it is not required to plead specific facts that explain exactly how BCBSM's conduct was unlawful. (*Id.* at PageID.502–03).

To state a claim for breach of fiduciary duty under ERISA, a plaintiff must allege that "(1) the defendant was a fiduciary of an ERISA plan who, (2) acting within his capacity as a fiduciary, (3) engaged in conduct constituting a breach of his fiduciary duty." *In re Cardinal Health, Inc. ERISA Litig.*, 424 F. Supp. 2d 1002, 1016 (S.D. Ohio 2006); *see also* 29 U.S.C. § 1109. The parties in this case do not dispute that BCBSM was a fiduciary to Comau acting within its capacity as a fiduciary when it administered its benefit plan. (*See* ECF Nos. 15, PageID.291; ECF No. 19). Therefore, only the third element is at issue here.

The parties, having failed to identify any Sixth Circuit cases directly on point, cite cases from other circuits on the issue of the sufficiency of the pleadings. Upon review of the parties' cited authority, the court finds that Comau's complaint meets the 8(a) pleading requirements.

To survive a motion to dismiss, a complaint alleging a breach of fiduciary duties under ERISA must demonstrate facts that raise a plausible inference of misconduct. *Agema*, 826 F.3d at 331. In an ERISA case alleging that a benefit plan was mismanaged, "a claim alleging a breach of fiduciary duty may still survive a motion to dismiss if the court, based on circumstantial factual allegations, may reasonably infer from what is alleged that the process [by which the plan was managed] was flawed." This is because "ERISA plaintiffs generally lack the inside information necessary to make out their claims in detail unless and until discovery commences." *Pension Ben. Guar. Corp. ex rel. St. Vincent Catholic Med. Ctrs. Ret. Plan v. Morgan Stanley Inv. Mgmt. Inc.*, 712 F.3d 705, 718 (2d Cir. 2013) (quoting *Braden v. Wal-Mart Stores,*

Inc., 588 F.3d 585, 596 (8th Cir. 2009)) (internal quotations omitted).

***7** Therefore, a breach of fiduciary duty claim under ERISA can survive a motion to dismiss without "well-pleaded factual allegations relating directly to the methods employed by the ERISA fiduciary if the complaint alleges facts that, if proved, would show that an adequate investigation would have revealed to a reasonable fiduciary that the investment at issue was improvident." *St. Vincent*, 712 F.3d at 718 (quoting *In re Citigroup ERISA Litig.*, 662 F.3d 128, 141 (2d. Cir. 2011)) (internal quotations omitted). The court must be able to "infer more than the mere possibility of misconduct" from the factual allegations of a plaintiff's complaint. *St. Vincent,* 712 F.3d at 719. Comau's claim essentially asserts that BCBSM, in paying inflated or otherwise improperly-billed health claims out of its funds, mismanaged the Plan's funds. This is similar to cases challenging an administrator's improvident investments using plan funds. The Seventh Circuit analyzed the sufficiency of an ERISA breach of fiduciary duty claim alleging an improvident investment in *Allen v. GreatBanc Tr. Co.*, 835 F.3d 670, 678 (7th Cir. 2016). In *Allen*, the central allegation of the complaint was that GreatBanc did not conduct an adequate inquiry into the value of the employer's stock. *Id.* The plaintiffs' complaint did not describe in detail the process that GreatBanc used in order to value stock. *Id.* The Seventh Circuit held that detailing GreatBanc's process for valuing stock was not necessary in order for the complaint to be sufficient. *Id.* at 678–79. The court reasoned that it was enough that the plaintiffs "alleged that the stock value dropped dramatically after the sale (implying that the sale price was inflated), that the loan came from the employer-seller rather than from an outside entity (indicating that outside funding was not available), and that the interest rate was uncommonly high (implying that the sale was risky....)." *Id.* at 678. The court concluded that the complaint's facts supported an inference that GreatBanc breached its fiduciary duty by failing to conduct an adequate inquiry into the proper valuation of the shares of stock or by facilitating an improper transaction. *Id.* at 678–79.

Similar to the complaint in *Allen*, the complaint in this case also alleges that a process/system is flawed, but does not detail how BCBSM's processing system that pays healthcare providers works. The complaint here alleges that BCBSM grossly overpaid many claims on behalf of Comau, that BCBSM's processing system is organized in a way that guarantees that BCBSM overpaid claims on behalf of Comau, and that BCBSM was aware that it was paying inflated claims and failed to correct its billing system to avoid overpayments. These allegations, although not specific, contain comparable detail to the complaint in *Allen*.

The Eighth Circuit similarly found that an ERISA breach of fiduciary duty complaint met the 8(a) pleading requirements in *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 595–96 (8th Cir. 2009). The complaint in *Braden* alleged that the defendants failed to adequately "evaluate the investment options included in the benefit plan." *Id.* at 590. It also alleged that "the process by which the mutual funds were selected was tainted by [the defendants'] failure to consider trustee Merrill Lynch's interest in including funds that shared their fees with the trustee." *Id.* The complaint alleged that some or all of the investment options in the plan charged excessive fees as a result of the defendants' failures. *Id.* The *Braden* court noted that the plaintiff did not have to plead specific facts that explained exactly how the defendant's conduct was unlawful. *Id.* at 595. It was enough to plead facts that "indirectly show[ed] unlawful behavior," as long as the facts gave "the defendant fair notice" of the claim and "the grounds upon which" the claim rested. *Id.* Therefore, even though the allegations of the complaint failed to directly address the process by which the plan was managed, it was sufficient to withstand the defendant's motion to dismiss because the court could reasonably "infer from what [was] alleged that the [defendant's] process was flawed." *Id.* at 596.

Like *Braden*, this case alleges that a process was flawed. The *Braden* court concluded that the plaintiff did not have to state facts that specifically alleged how the defendant's conduct was unlawful; it was adequate to plead facts that indirectly showed unlawful behavior. In this case, the complaint does not allege how BCBSM's alleged defective processing system works; instead, it alleges that BCBSM knew that its system was faulty and resulted in the payment of inflated claims; however, BCBSM did not fix its system. These claims, accepted as true and in the light most favorable to Comau, are enough for the court to infer that BCBSM's process was flawed.

BCBSM asserts that Comau must do more than allege that BCBSM's claims-processing system failed to prevent the payment of all improper healthcare claims. (ECF No. 19, PageID.380). BCBSM contends that Comau cannot just focus on the results, but must focus on the fiduciary's conduct in arriving at a decision. (*Id.* at PageID.379). BCBSM cites the Seventh Circuit for this proposition. *DeBruyne v. Equitable Life Assur. Soc. of U.S.*, 920 F.2d 457, 465 (7th

Cir. 1990). The *DeBruyne* plaintiff alleged breach of fiduciary duty where the defendants lost money as a result of an investment strategy. *Id.* The court concluded that "the ultimate outcome of an investment is not proof of imprudence[,]" and dismissed the claim. *Id.* The *St. Vincent* court reached a similar conclusion. *St. Vincent*, 712 F.3d at 716 (stating that courts "cannot rely, after the fact, on the magnitude of the decrease in the [plan investment's] price" as evidence of imprudence). This case is distinguishable from *DeBruyne* and *St. Vincent* because Comau is not merely asserting that BCBSM made an imprudent investment decision/plan and overpaid money to providers. Comau is asserting that BCBSM's processing system is defective and led to many overpayments to healthcare providers. Comau also asserts that BCBSM knew about the defect in its processing system —thus implying that a prudent fiduciary would have fixed the defective system in order to prevent overpayments that it knew routinely occurred.

***8** In this case, the FAC alleges that Wegner discovered that BCBSM had paid inflated claims on behalf of several customers. Wegner brought the overpayments to BCBSM's attention and BCBSM told Wegner that it knew that its billing system paid improper claims from providers; however, BCBSM did nothing to stop the improper payments. It alleges that several other BCBSM employees knew that BCBSM was paying inflated claims from providers. Further, the FAC alleges that BCBSM used the same processing system to bill all of its customers; therefore, Comau was subject to the same overpayments on the claims that it paid on behalf of its employees. More important, the FAC states that Wegner has personal knowledge of BCBSM's records *and knows that it paid inflated claims on behalf of Comau.*

The facts alleged in the FAC, considered together and in the light most favorable to Comau, allow the court to reasonably infer that BCBSM's processing system was flawed and that it paid inflated claims to healthcare providers on behalf of Comau. If the allegations in the FAC are proved, then they would show that an adequate investigation would have revealed to BCBSM and a reasonable fiduciary that the system was flawed. *See St. Vincent*, 712 F.3d at 718. The facts alleged in the FAC also give BCBSM fair notice of Comau's claims against it—the payment of inflated claims and the failure to fix its processing systems in order to prevent the payment of inflated claims. *Braden*, 588 F.3d at 595. The facts additionally support an inference that BCBSM breached its fiduciary duty by failing to correct its processing system which it knew resulted in the payment of inflated claims. *Allen*, 835 F.3d at 678–79. Therefore, similar to the complaints in *Allen* and *Braden*, the FAC in this case pleads facts that allege a plausible breach of fiduciary duty.

BCBSM asserts that Comau is in possession of information about how the BCBSM claims processing system functions worked and therefore should have alleged those facts in its FAC. (ECF No. 19, PageID.381). However, it is not clear to the court that Comau is currently in possession of BCBSM's claims processing system information. The FAC alleges that BCBSM's payment of inflated claims became known to Comau after Wegner investigated BCBSM's system and discovered the overpayments. (ECF No. 15, PageID.297–98). It also states that Wegner has personal knowledge that Comau was affected by BCBSM's payment of inflated claims. (*Id.* at PageID.299). However, Comau does not claim currently to have any information about BCBSM's systems in its possession. Further, the FAC states that Wegner is no longer employed by BCBSM (ECF No. 15, PageID.300) —therefore, Wegner does not currently have access to information regarding BCBSM's systems and Comau's FAC need not include information about BCBSM's processing systems. For the reasons discussed above, the court concludes that the FAC meets the pleading requirements of Fed. R. Civ. P. 8(a) and it will not dismiss the FAC for failure to plead sufficient facts.

C. Statute of Limitations

Lastly, this court must address a statute of limitations issue. BCBSM asserts that Comau's claims that are based on payments made more than six years before Comau filed this action are untimely. (ECF No. 19, PageID.382). Comau contends that BCBSM's statute of limitations argument is premature because it asks this court to make factual determinations about the date of the last action that constituted an alleged breach of fiduciary duty. (ECF No. 21, PageID.506). ERISA contains the following limitations period:

> No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of-
>
> (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or

(2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;

***9** except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

29 U.S.C. § 1113. Here, it is unclear from the face of the amended complaint when the last action occurred that constituted an alleged breach of fiduciary duty, or the date on which Comau had actual knowledge of BCBSM's actual breach. *See e.g.*, *Computer & Eng'g Servs., Inc. v. Blue Cross Blue Shield of Mich.*, No. 12-15611, 2013 WL 1976234, at *4 (E.D. Mich. May 13, 2013) (concluding that it was premature at the motion to dismiss stage to determine the applicable statute of limitations where it was unclear from the complaint when the plaintiffs acquired actual knowledge of the alleged ERISA violations); *E. Jordan Plastics, Inc. v. Blue Cross & Blue Shield of Mich.*, No. 12-CV-15621, 2013 WL 1876117, at *6 (E.D. Mich. May 3, 2013) (same).

Because it is too early for this court to determine when the facts giving rise to the statute of limitations occurred, the court cannot determine at this time what the applicable statute of limitations is.

V. CONCLUSION

BCBSM brought this Motion to Dismiss moving the court to dismiss Comau's FAC for failure to meet the 9(b) pleading requirements. This court concludes that the FAC does not sound in fraud; therefore, it is subject to the pleading requirements of Rule 8(a) and not 9(b). Next, BCBSM moved the court to find that the FAC did not meet the pleading requirements of Fed. R. Civ. P. 8(a). However, this court finds that the FAC meets the plausibility standard required under 8(a) and puts BCBSM on notice of the claims alleged against it. Lastly, BCBSM moved the court to find that Comau's claims that are based on payments made more than six years before Comau filed this action are untimely. This court concludes that undecided factual determinations render it premature to decide when the statute of limitations runs in this case. This conclusion thus does not foreclose the possibility for the issue to be raised once greater factual development has occurred. For these reasons and the reasons discussed herein, the court will DENY BCBSM's Motion to Dismiss.

SO ORDERED.

All Citations

Slip Copy, 2020 WL 7024683

End of Document

2021 WL 5989023
Only the Westlaw citation is currently available.
United States District Court, E.D. Michigan, Southern Division.

COMAU LLC, Plaintiff,
v.
BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.

Case No. 19-12623
|
Signed 12/16/2021

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ORDER GRANTING IN PART BCBSM'S MOTION TO COMPEL ALIGNMENT OF EXPERT REPORT (ECF No. 88, 138, 139), GRANTING IN PART COMAU'S EMERGENCY MOTION TO EXTEND DISCOVERY (ECF No. 115), AND SCHEDULING STATUS CONFERENCE REGARDING DISCOVERY DISPUTES

Curtis Ivy, Jr., United States Magistrate Judge

I. BACKGROUND

A. Procedural History

***1** Comau LLC commenced this ERISA case on September 6, 2019. (ECF No. 1). Comau amended its complaint on December 12, 2019. (ECF No. 15). This matter was referred to the undersigned for all pretrial proceedings except dispositive motions. (ECF No. 91).

On September 29, 2021, Defendant Blue Cross Blue Shield of Michigan ("BCBSM") filed a sealed and unsealed but redacted copy of its Motion to Compel Plaintiff to Align its Expert Report with the Allegations in its Complaint and to Stay Discovery Until Plaintiff Does So. (ECF Nos. 87, 88). Along with the motion to compel, BCBSM filed numerous motions to seal briefs and exhibits related to this and other pending motions. The Court denied in part those motions to seal. (ECF No. 128). BCBSM then timely filed unsealed, unredacted copies of its motion to compel. (ECF Nos. 138, 139). In this Order, the Court references the opening brief filed at ECF No. 138 and response brief at ECF No. 97.

Comau filed an Emergency Motion to Extend Discovery which is also addressed below. (ECF No. 115).

The Court held a hearing on BCBSM's motion to compel on December 14, 2021. For the reasons explained below, the motion to compel is **GRANTED IN PART, DENIED IN PART**. The motion to extend discovery is **GRANTED IN PART**.

B. Amended Complaint Allegations

Comau develops and produces process automation, manufacturing, and service products. (ECF No. 15, PageID.290). During the relevant period, Comau provided health care benefits to its employees through a self-insured benefit plan (the "Plan"). (*Id.*). Comau paid the health care costs of its employees up to a certain threshold rather than buying an insurance policy. (*Id.*). Comau retained BCBSM several years ago to administer its healthcare plan. (*Id.*). BCBSM used funds provided by Comau (in the form of prepayments to a BCBSM-owned bank account) to pay covered employee healthcare claims. (*Id.* at PageID.291).

The current dispute centers on BCBSM's handling of plan assets. Comau alleges BCBSM has been paying grossly inflated healthcare claims from healthcare providers since 1997. (*Id.* at PageID.296, at ¶ 38). As an example, Comau provided: a provider charges $18,000 for a routine urinalysis on a Comau employee, but the actual cost of the routine urinalysis is $10.00 or less. BCBSM knows the bill is grossly inflated, but it used Plan assets to pay the grossly inflated bill anyway. (*Id.* at ¶ 39-40). Citing news articles related to inflated urinalysis bills, Comau asserts these "improper claims" are well-known in the health care industry. (*Id.* at ¶ 41-42).

According to Comau, BCBSM's account manager, Dennis Wegner, learned of gross overpayments for routine medical testing on other accounts. Wegner had access to customer records and billing, and to BCBSM's healthcare claims

processing system, software, and billing system, which were used universally on all customer accounts. (*Id.* at PageID.297, at ¶ 47-48). Wegner questioned claims processing for overpayments on three non-Comau accounts. Because BCBSM's systems are applied universally to its customers, Comau's healthcare claims would have been processed, billed, and paid using the same BCBSM systems as the other customers. As a result, Comau alleges the same systems failures that gave rise to the three other overpayment cases would have subjected Comau to the same issues. In fact, Comau alleges Wegner knows of and confirmed to Comau that it was affected by BCBSM's payment of improper claims. (*Id.* at PageID.298-99). Wegner allegedly alerted executives at BCBSM, yet the company did not act to stop the payment of improper claims. (*Id.* at PageID.300, at ¶ 66). Wegner was terminated from his employment during November 2018. (*Id.* at ¶ 68).

***2** Comau alleges payment of claims it knows to be improper is inconsistent with health insurance industry standards and breaches BCBSM's fiduciary duty pursuant to the Employee Retirement Income Security Act in the following not limited ways:

> (a) Intentionally and knowingly paying grossly inflated and knowingly inflated healthcare claims to Providers;
>
> (b) Failing to correct/update its Billing System to avoid Plan assets being used to pay improper charges and concealing from, and otherwise failing to disclose to[ ] Plaintiff the payment of improper claims;
>
> (c) 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 healthcare claims

(*Id.* at PageID.305, at ¶ 94).

C. BCBSM's January 15, 2020 Motion to Dismiss the Amended Complaint

BCBSM moved to dismiss the amended complaint. It argued (1) Comau did not allege fraud with the requisite Fed. R. Civ. P. 9(b) particularity, (2) Comau failed to state a claim for breach of fiduciary duty, and (3) the claims based on payments made more than six years before this action are untimely. (ECF No. 19). BCBSM argued the facts were borrowed from Dennis Wegner's whistleblower complaint and the amended complaint never alleges any specific fraudulent payments made using Plan assets or alleges facts to plausibly suggest such fraudulent payments occurred. Comau challenged each of these arguments. (ECF No. 21). Comau argued it sufficiently stated a claim to relief because it alleged facts from which to infer BCBSM's payment systems were flawed, resulting in misuse and loss of Plan assets, and that it is premature to determine the triggering date for the statute of limitations.

District Judge Stephanie Dawkins Davis denied the motion to dismiss. Judge Davis first concluded Comau alleged a breach of fiduciary duty claim, not fraud. Thus, Comau's amended complaint is subject to the Rule 8(a) pleading standard, not the Rule 9(b) pleading standard. (ECF No. 25, PageID.569-75). Next, Judge Davis found the amended complaint meets the pleading requirements of Rule 8(a). She noted "Comau's claim essentially asserts that BCBSM, in paying inflated or otherwise improperly-billed health claims out of its funds, mismanaged the Plan's funds." (*Id.* at PageID.578). That the amended complaint does not detail how BCBSM's alleged defective systems works did not undermine the sufficiency of the pleading because the court could reasonably infer from the allegations that BCBSM's process was flawed. (*Id.* at PageID.580-81). The Court described the amended complaint as follows:

> If the allegations in the [first amended complaint] are proved, then they would show that an adequate investigation would have revealed to BCBSM and a reasonable fiduciary that the system was flawed. The facts alleged in the FAC also give BCBSM fair notice of Comau's claims against it —the payment of inflated claims and the failure to fix its processing systems in order to prevent the payment of inflated claims. The facts additionally support an inference that BCBSM breached its fiduciary duty by failing to correct its processing system which it knew resulted in the payment of inflated claims.

***3** (*Id.* at PageID.583) (internal citations omitted).

Finally, the Court found it is too early to determine when the facts giving rise to the statute of limitations occurred, so

the Court did not determine what the applicable statute of limitations is. (*Id.* at PageID.585).

D. Instant Motion

BCBSM moves pursuant to Fed. R. Evid. 702 for an order excluding Comau's expert report drafted by Dawn Cornelis of ClaimInformatics. In the alternative, BCBSM seeks an order deeming waived Comau's "new theories presented in its expert report, which are wholly unrelated to the Amended Complaint," unless Comau amends a second time to include the purported new theories. (ECF No. 138, PageID.5104). And BCBSM seeks leave to file a dispositive motion without prejudice to potential later dispositive motions and for a stay of discovery until this motion is resolved.

BCBSM's argument for exclusion of the expert report is this: in the amended complaint, Comau alleged BCBSM breached its fiduciary duty by paying grossly inflated claims filed by non-participating providers for routine urine screening. (*Id.* at PageID.5114-17). Yet, despite the limited nature of the claim, Comau's expert identified "supposed coding deficiencies," including "allegedly improper bundling of claims, payments that were supposedly medically unnecessary or 'upcod[ed]' (with no indication of how that information could be derived from simply looking at claims), supposed 'duplicate payments,' and other supposed failures to adhere to coding guidelines." (*Id.* at PageID.5123). BCBSM asserts none of these issues bear any relation to the payment of grossly inflated urinalysis bills. (*Id.* at PageID.5123-25).

BCBSM argues the expert report should be excluded because it does not "fit with the facts of the case." It compares this case to *Argus & Assocs., Inc. v. Pro. Benefits Servs., Inc.*, 2009 WL 1297374, at *3 (E.D. Mich. May 8, 2009), a case in which it says the court sanctioned the plaintiff "by prohibiting use of certain expert testimony as proof at trial where the report failed to identify any examples of the healthcare claims at issue." (ECF No. 138, PageID.1527, 1528).

As to BCBSM's alternative request to deem the "new theories" of improper payments waived unless Comau amends the complaint to include them, (*id.* at PageID.5129), BCBSM says if Comau filed a second amended complaint to include these claims, it will be able to move to dismiss the new claims. According to the company, there are many problems with the proposed new claims, such as the fact that technical issues raised in the report are required to be addressed according to the audit procedures set forth in the contract between the parties, not in litigation in this Court. (*Id.*).

Comau insists its amended complaint allegations are not limited to payments of grossly inflated urinalysis bills submitted by non-participating providers. Rather, Comau asserts it alleged improper payments of grossly inflated healthcare claims *and* that the amended complaint defined "improper payments" to include "a payment for an incorrect amount (including overpayments and underpayments), a payment to an ineligible provider, double billing, payment for services not received, and payment for noncovered services. Providers submitting claims such as these are considered to be fraudulent." (ECF No. 97, PageID.2531, 2540; ECF No. 15, PageID.301). Comau's expert identified $9 million in improper payments stemming from errors including duplicative payments, unbundling, upcoding or wrong code, medically unlikely services, and non-adherence to payment guidelines. (ECF No. 97, PageID.2533). Comau argues its expert report identifies specific improper payments and thus is relevant to the claims in the amended complaint. (*Id.* at PageID.2541).

***4** In reply, BCBSM maintains the amended complaint is not about double billing or payment for noncovered services. BCBSM reiterates its position that the complaint is based on gross overpayments by non-participating labs, highlighting in an appendix all the references to urinalysis in both Wegner's employment complaint and Comau's amended complaint. (ECF No. 103, PageID.2955-56, 2959-61).

Apart from these arguments, Comau contends its expert could not conduct a comprehensive review of the claims data because of deficiencies in the data produced by BCBSM. The issues include missing provider information, missing payee information, and missing claims. (ECF No. 97, PageID.2533-36). In response, BCBSM asserts Comau has all the information it needs to identify these gross overpayments —the service provided, charged and paid amounts, and whether the provider was participating or non-participating. (ECF No. 103, PageID.2956-57). At the hearing, Comau asserted nearly $5.4 million in claims data are missing. Counsel for BCBSM represented on the record there is no more claims data to produce.

II. DISCUSSION

A. The Expert Report and Amended Complaint

Expert testimony is admissible if:

(a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;

(b) the testimony is based on sufficient facts or data;

(c) the testimony is the product of reliable principles and methods; and

(d) the expert has reliably applied the principles and methods to the facts of the case.

Fed. R. Evid. 702. [1] In this circuit, "[t]he Rule 702 analysis proceeds in three stages." *United States v. Rios*, 830 F.3d 403, 413 (6th Cir. 2016). "First, the witness must be qualified by 'knowledge, skill, experience, training, or education.' Second, the testimony must be relevant, meaning that it 'will assist the trier of fact to understand the evidence or to determine a fact in issue.' Third, the testimony must be reliable." *In re Scrap Metal Antitrust Litig.*, 527 F.3d 517, 529 (6th Cir. 2008) (quoting Fed. R. Evid. 702). Only the second step is at issue. "Expert testimony which does not relate to any issue in the case is not relevant and, ergo, non-helpful." *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 591 (1993) (quoting 3 Weinstein & Berger ¶ 702[02], p. 702-18).

[1] The Court's ruling on BCBSM's motion should not be construed as prejudicial to any future motion to exclude Comau's expert report on a basis different from that asserted here.

Comau's expert reviewed the existing claims data and identified potential breaches of fiduciary duty. To begin, the expert found 8,634 claims that had no provider information listed and 30,091 claims that had no payee information listed. The expert stated these issues raised fiduciary oversight concerns and these claims were excluded from its claims data analysis. (ECF No. 87-7, PageID.1722). [2] The remaining claims totaled an aggregate $109 million in paid claims. Of this amount, the expert identified $9 million in excessive payments among five error types: duplicate payments, unbundling/incidental/mutually exclusive, upcoding/wrong code, medically unlikely, and non-adherence to payment guidelines. (*Id.*).

[2] The Court references the expert report in the sealed filing at ECF No. 87. The Court recently stayed its Order directing BCBSM and Comau to file the report unsealed pending resolution of BCBSM's planned objection. Until the dispute regarding the report is resolved, it remains sealed.

***5** The expert report provides examples of unbundling and upcoding. "Unbundling" occurs when, for example, a provider bills for two services but one of those services is included in the second (codes A and B are billed but code A is included in code B) or both should be billed under a single, more comprehensive code (codes A and B should be billed as code C). (ECF No. 87-7, PageID.1727; *see id.* at PageID.1728 for examples of upcoding). "Upcoding" happens when services are billed at a higher-level service although a lower-level service is warranted or performed. For example, the expert identified an emergency department claim billed at the highest level of emergency department care, usually reserved for a life threatened event. Here, however, the patient was treated in the emergency department for "Laceration of lip and oral cavity without foreign body." The expert characterized this is a non-life-threatening lower-level emergency department visit. (*Id.* at PageID.1728). Unbundling and upcoding are essentially examples of overcharged provider bills.

There do not appear to be examples or explanations of the other purported claims errors—duplicate payments, medically unlikely, and non-adherence to payment guidelines.

BCBSM characterizes the amended complaint as alleging breach of fiduciary duty only by paying grossly inflated claims submitted by non-participating providers for urinalysis. BCBSM thus argues the expert report which speaks of "unbundling" or "non-adherence to payment guidelines" is irrelevant to overpayments for urinalysis. [3]

[3] BCBSM cites *Argus & Assocs., Inc. v. Pro. Benefits Servs., Inc.*, 2009 WL 1297374 (E.D. Mich. May 8, 2009), as a case that excluded portions of an expert report for failure to identify an inappropriately paid claim. (ECF No. 138, PageID.5127, 5128). BCBSM overreaches in its description of that case. The court excluded some of the expert report and evidence because the plaintiff did not timely provide the report or respond to discovery. The court previously warned the plaintiff failure to do so would result in a limitation on the presentation of proofs at trial. The report was not partially excluded because it did not identify the claims alleged in the complaint. *Argus*, 2009 WL 1297374, at *2-3.

The Court finds BCBSM's characterization of the amended complaint too narrow. As explained in the Opinion and Order denying the motion to dismiss, the amended complaint alleges BCBSM breached its fiduciary duty through "the payment of inflated claims and the failure to fix its processing systems in order to prevent the payment of inflated claims." (ECF No. 25, PageID.583). The amended complaint did not limit the factual basis to provider billing for routine urinalysis—urinalysis was used only as an example of a grossly inflated provider bill paid by BCBSM. The amended complaint is also not limited to claims submitted by non-participating providers. Comau defined "Providers" as "health care providers," without limitation to those who were non-participating. (ECF No. 15, PageID.296, at ¶ 38). The ruling on the motion to dismiss did not address a limitation to "non-participating" providers. (ECF No. 25).

Comau views its amended complaint too broadly. The repeated theme throughout the complaint is that BCBSM knowingly paid inflated healthcare claims. Comau began its complaint discussing Wegner's investigation into BCBSM's overpayment of routine lab testing. Comau asserted the overpayments came down to a system error that would have existed for Comau's healthcare claims as well. In Count I of the complaint, the alleged breaches include, but are not limited to, "Intentionally and knowingly paying grossly inflated and knowingly inflated healthcare claims to Providers." (ECF No. 15, PageID.305, at ¶ 94). The District Judge read the amended complaint to allege breach of fiduciary duty by making payments of inflated claims and failure to fix the system issue. She described the amended complaint as alleging "BCBSM, in paying inflated or otherwise improperly-billed health claims out of its funds, mismanaged the Plan's funds."[4] (ECF No. 25, PageID.578).

[4] See also Comau's response to the motion to dismiss in which it argued it sufficiently pleaded that its health care claims were subject to BCBSM's universal processing systems and the system failure giving rise to the other *overpayment* cases subjected to Comau to the same issues. (ECF No. 21, PageID.502). In other words, in defending its amended complaint the first time, Comau repeated its claim that BCBSM knowingly paid inflated healthcare claims.

***6** Comau relies on paragraph 75 of its amended complaint to support its position that the complaint captures all the errors identified in the expert report because those errors are "improper claims." In a section titled, in part, "BCBSM's Practice of Willingly Paying Improper Claims is Inconsistent with Industry Standards, ..." Comau alleges the health insurance industry has standards for evaluating improper claims payments. Next, at paragraph 75, Comau defines "improper payments" to "include a payment for an incorrect amount (including overpayments and underpayments), a payment to an ineligible provider, double billing, payment for services not received, and payment for noncovered services. Providers submitting claims such as these are considered to be fraudulent." (ECF No. 15, PageID.301, at ¶ 75). It is Comau's position that this paragraph defines improper claims for the entire complaint, and thus errors such as duplicate payments and payments to ineligible providers are encompassed in the amended complaint. (ECF No. 97, PageID.2537).

The Court is not convinced. Taken in context, paragraph 75 (which is the only paragraph to mention payments to an ineligible provider, double billing, payment for services not received, or payment for noncovered services in the entire amended complaint) is not a definition of "improper payments" to be applied to every instance in which Comau uses the term "improper claims" or "improper payments." Rather, paragraph 75 lays the ground for Comau's point that BCBSM's payment of improper claims goes against industry standards, is inconsistent with how BCBSM holds itself out to the public, and is inconsistent with representations BCBSM makes to its customers. (ECF No. 15, PageID.303-05). According to Comau, BCBSM holds itself out as a leader in the industry in identifying and rooting out health insurance fraud. Considering BCBSM's representations, Comau believed the insurance company was acting in its best interest, but as alleged elsewhere in the amended complaint, its belief was incorrect. (*Id.* at PageID.304, at ¶ 89).

The amended complaint survived the motion to dismiss because Comau adequately tied allegations of overpayments and systems issues to itself through Dennis Wegner's first-hand knowledge Comau was subject to the same errors. Comau made no similar attempt to tie the list of potential improper payments listed in paragraph 75 to Comau. There are no allegations supporting an inference, for example, that BCBSM paid an ineligible provider, paid a double bill, paid for services not received, or paid for noncovered services. As discussed above, the amended complaint is about payments of "grossly inflated" healthcare provider bills and a system-wide problem that should have been fixed.

The expert's discussion of claims paid that were improperly "unbundled/incidental/mutually exclusive" and "upcoding/wrong code" is relevant to the complaint. These alleged errors show inflated provider healthcare charges for which BCBSM made payments. ERISA plaintiffs are given some leeway in their pleading because they "generally lack the inside information necessary to make out their claims in detail unless and until discovery commences." *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 598 (8th Cir. 2009). The amended complaint gives BCBSM ample notice that the claims here center on overpayments for healthcare, and not just for urinalysis and/or claims submitted by non-participating providers. Discovery has revealed more details about inflated and overpaid healthcare charges. The Court finds nothing inappropriate about this. It is true Comau wrote of "grossly inflated" claims in the amended complaint, but "grossly inflated" was not defined. Whether the upcoding, unbundling, and so forth amounts to "gross inflation" can be determined at a later date. What matters here is these errors evince overpayments and the amended complaint is about overpayments. Thus, the expert report as it relates to these overcharges is relevant to the claims here.

The remaining errors making up the alleged $9 million in excessive payments identified in the expert report—duplicate payments, medically unlikely services, and non-adherence to payment guidelines—do not describe inflated claims paid for healthcare services and are essentially new claims about BCBSM's breach of fiduciary duty. Likewise, the expert's identification of further potential breaches of fiduciary duty with respect to missing claims data fields are not part of the amended complaint. (ECF No. 87-7, PageID.1722). Comau did not allege or even suggest BCBSM breached its fiduciary duty by excluding provider information or payee information in a small portion of its claims data. These findings by the expert are not relevant to this case.

***7** For these reasons, BCBSM's motion to compel is **GRANTED IN PART, DENIED IN PART**. The Court will not exclude the expert report in whole, but portions of the report are irrelevant to the claims here as discussed above. Those portions of the report should not be used later as proof of breach of fiduciary duty.

The Court will not order Comau to amend the complaint a second time. This case has been pending for more than two years. This litigation must move forward. Further, Comau has not moved to the amend the complaint and opposes amendment now. The claims in this case are as characterized by the Court in the Opinion denying the motion to dismiss—payments of inflated healthcare charges.

Now, the request to stay discovery pending resolution of BCBSM's motion to compel is moot. Discovery deadlines are addressed below.

The Court will **DENY WITHOUT PREJUDICE** BCBSM's motion to compel as it relates to the request for permission to file more than one motion for summary judgment. The Court is not inclined to grant permission to file more than one motion for summary judgment until one is filed and defeated.[5] BCBSM seeks leave to file a "preliminary" motion for summary judgment because Comau cannot identify any instance in which "BCBSM paid a grossly inflated charge to a non-participating provider for routine urine screenings." (ECF No. 138, PageID.5130). Again, the claims here are not so limited. Thus, it is not clear at this point BCBSM would still move on that basis.

5 Additionally, this case was not referred to the undersigned to address dispositive motions. Requests regarding dispositive motions should be addressed to the District Judge.

B. Discovery

Comau asserts its expert could not complete a comprehensive review of the claims data because of missing provider and payee information. Comau has also intimated it has not received a full production of claims data. At the hearing on the motion, Comau explained there are nearly $5.4 million in missing claims data that has yet to be produced. BCBSM's counsel stated on the record there is no more claims data to produce. Were this issue before the Court on a motion to compel production of claims data, the Court would be unable to compel production of documents that do not exist. This issue, however, is not before the Court on a motion, and so the Court will not make a ruling.

Discovery must continue on the claims as discussed above, and these claims only. The Court will **GRANT IN PART** Comau's Emergency Motion to Extend Discovery. (ECF No. 115). The following case management deadlines are extended by two months from the original dates set at ECF No. 35: the discovery deadline is moved to **January 24, 2022** and the dispositive motion cut-off is moved to **March 10, 2022**. The parties must work diligently to meet these deadlines and must work cooperatively to schedule the exchange of discovery, including scheduling depositions.

Comau has three motions to compel pending before the Court. (ECF Nos. 92, 121, 131). As it is possible the Court's ruling here impacts some of the relief requested in some or all of those motions, including BCBSM's responses, the parties are directed to confer on the remaining discovery disputes. Specifically, the parties must confer and determine whether any of the requests for discovery or objections to discovery requests should no longer be pressed considering this Order and can be resolved without Court intervention. The Court will hold a status conference about the discovery disputes on **December 27, 2021 at 11:00 a.m**. Call-in information will be filed separately.

***8 IT IS SO ORDERED**.

The parties to this action may object to and seek review of this Order, but are required to file any objections within 14 days of service as provided for in Federal Rule of Civil Procedure 72(a) and Local Rule 72.1(d). A party may not assign as error any defect in this Order to which timely objection was not made. Fed. R. Civ. P. 72(a). Any objections are required to specify the part of the Order to which the party objects and state the basis of the objection. When an objection is filed to a magistrate judge's ruling on a non-dispositive motion, the ruling remains in full force and effect unless and until it is stayed by the magistrate judge or a district judge. E.D. Mich. Local Rule 72.2.

All Citations

Slip Copy, 2021 WL 5989023

End of Document

2022 WL 2373352
Only the Westlaw citation is currently available.
United States District Court, E.D. Michigan, Southern Division.

COMAU LLC, Plaintiff,
v.
BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.

Case No.: 19-12623
|
Signed June 30, 2022

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ORDER ON MOTIONS (ECF Nos. 92, 121, 151, 160, 162)

Curtis Ivy, Jr., United States Magistrate Judge

***1** Plaintiff Comau LLC filed this Employee Retirement Income Security Act case on September 6, 2019 against Blue Cross Blue Shield of Michigan ("BCBSM"). (ECF No. 1). This matter was referred to the undersigned for all pretrial proceedings excluding dispositive motions. (ECF No. 91). Before the Court is Comau's motion for leave to file a second amended complaint (ECF No. 160), a motion to seal exhibits related to the motion for leave (ECF No. 162), and discovery motions filed by both parties (ECF Nos. 92, 121, 151). This Order first addresses the motion for leave to amend the complaint and motion to seal related exhibits. For the reasons discussed below, the motions for leave to amend and to seal exhibits are granted. Then, this Order addresses the discovery motions.

A. Motion for Leave to Amend the Complaint (ECF No. 160)

The exact claims being litigated here has been the subject of arguments and motion practice for some time. During discovery, BCBSM objected to some requests claiming that they were irrelevant because they did not pertain to the payment of grossly inflated urinalysis bills—the only claim it asserted was raised in the complaint. Comau sought discovery targeted at BCBSM's claims processing systems and issues raised by its expert about BCBSM's data. These issues included the payment of bills that were, for instance, upcoded, unbundled, or not medically necessary. BCBSM maintained that these issues were not part of the First Amended Complaint ("FAC"). So BCBSM filed a motion to compel Comau to align its expert report with the allegations in the FAC or to compel Comau to amend the complaint to add those claims. (ECF No. 88, 138, 139). The Court granted that motion in part. [1] (ECF No. 143). Comau's view of the FAC was too broad, while BCBSM's view was too narrow. The Court found that the FAC alleges that BCBSM breached its fiduciary duty by paying inflated healthcare claims and by failing to fix its processing systems to prevent payment of inflated claims. The FAC was not limited to claims for urinalysis testing and was not limited to claims submitted by non-participating providers. (ECF No. 143, PageID. 5550). Thus, the FAC related to claims concerning inflated provider bills, including bills that were upcoded, unbundled, or where the service codes were mutually exclusive. (*Id.* at PageID.5553). The other errors identified by the expert (duplicate payments, medically unlikely services, missing data fields, and non-adherence to payment guidelines) do not describe inflated claims for healthcare, and thus were found irrelevant to the FAC allegations. (*Id.* at PageID.5554).

1 This Order was affirmed by the District Judge after Comau filed objections. (ECF No. 154).

A little over a month after the Court issued that Order, Comau moved for leave to file a Second Amended Complaint ("SAC") under Fed. R. Civ. P. 15(a). [2] (ECF No. 160). The SAC includes information about those items found to be beyond the scope of the FAC, as well as a new claim about BCBSM's Shared Savings Program ("SSP") under which BCBSM retains 30% of amounts recovered from overpaid healthcare claims.

2 Comau did not file a copy of the proposed second amended complaint because it is the subject of

BCBSM's motion to seal. Below the Court orders Comau to file the second amended complaint.

***2** Rule 15(a) provides that leave to amend "shall be freely given when justice so requires." "Because Rule 15(a) envisions liberal allowance of amendments to pleadings, there must be some substantial reason justifying denial of the motion." *Sun Life Assurance Co. of Canada v. Conestoga Trust Servs., LLC*, 263 F. Supp. 3d 695, 697 (E.D. Tenn. 2017) (citing *Smith v. Garden Way, Inc.*, 821 F. Supp. 1486, 1488 n. 2 (N.D. Ga. 1993)). There are several factors courts consider in deciding whether to allow amendment: "the delay in filing, the lack of notice to the opposing party, bad faith by the moving party, repeated failure to cure deficiencies by previous amendments, undue prejudice to the opposing party, and futility of amendment." *Perkins v. Am. Elec. Power Fuel Supply, Inc.*, 246 F.3d 593, 605 (6th Cir. 2001).

1. Delay

The Sixth Circuit has noted that "delay alone, regardless of its length is not enough to bar" the amendment "if the other party is not prejudiced." *Duggins v. Steak 'N Shake, Inc.*, 195 F.3d 828, 834 (6th Cir. 1999) (quotation marks and citations omitted). Amendment after the close of discovery may be considered significant prejudice. *Id.*

Comau argues it did not delay—it did not have final production of documents until November 24, 2021, a prior discovery cut-off date, and it moved to amend one month after the Court's Order on the scope of the FAC. As to the timing of discovery, Comau asserts much of the details about the issues raised in the expert report and about the SSP did not surface until the November 24, 2021 production. And as to the scope of the FAC, it asserts it did not move for leave to amend sooner because it believed all of its claims, except the SSP claim, were encompassed in the FAC.

BCBSM insists it is too late to amend the complaint. It argues that discovery was not delayed, it simply did not get to Comau when Comau wanted it, that Comau knew the facts needed to plead its claim at the beginning of the litigation, and that courts routinely deny such motions this late into litigation.

The Court finds no undue delay. To begin, the January 20, 2022, motion comes before the close of discovery. The Court extended the discovery deadline to January 24, 2022 in the Order on the motion to align the expert report with the FAC. (ECF No. 143). On January 25, 2022, the Court held in abeyance the discovery motions addressed herein until resolution of the motion to amend. (ECF No. 161). So while the period of open discovery technically closed January 24, 2022, the discovery period is incomplete and there is no per se prejudice.

Second, Comau did not delay in bringing this motion. Throughout discovery motion practice it maintained that the FAC encompassed all its claims (except the SSP claim). It is reasonable, then, that Comau did not move for leave to amend until after the Court determined the scope of the FAC is smaller than it believed. And there is no reason to doubt that Comau did not learn all the details of its claims until the production of discovery on November 24, 2021. The motion to amend came about two months later.

2. Notice

As for notice, BCBSM cannot be surprised to see all but one of the claims in the proposed second amended complaint—Comau has been arguing those claims were part of the FAC for some time. The SSP claim is new, but BCBSM is in possession of the evidence it needs, or can obtain discovery from Comau, to defend against it. This factor does not weigh against allowing amendment.

3. Prejudice

Even if there were some undue delay, "[d]elay by itself is not sufficient reason to deny a motion to amend." *Wade v. Knoxville Utilities Bd.*, 259 F.3d 452, 458 (6th Cir. 2001). To deny amendment the Court would also have to find significant prejudice to BCBSM. *See Moore v. City of Paducah*, 790 F.2d 557, 562 (6th Cir. 1986). The Sixth Circuit "has held that allowing amendment after the close of discovery creates significant prejudice, and other Circuits agree." *Duggins v. Steak 'N Shake, Inc.*, 195 F.3d 828, 834 (6th Cir. 1999) (citations omitted). But again, this motion does not come after the close of all discovery, so there is no per se prejudice. In determining potential prejudice, the court considers whether the amendment would "require the opponent to expend significant additional resources to conduct discovery and prepare for trial [or] significantly delay the resolution of the dispute." *Phelps v. McClellan*, 30 F.3d 658, 663 (6th Cir. 1994).

***3** BCBSM argues it will suffer undue prejudice from late amendment. It contends the amendment would restart the clock on many aspects of the litigation and require it to build its case "from the ground up" two years into this litigation, especially as to the new SSP claim. BCBSM argues

amendment would add more time to the litigation. (ECF No. 164, PageID.6474-79).

The Court knows that this case has been pending since the latter part of 2019 and that allowing a second amended complaint now would add time to the litigation. But the Court is not convinced there will be significant further delay in resolution of this case. Claims that were deemed not part of the FAC and added to the SAC will require additional discovery for both parties, but some discovery has already taken place. For instance, BCBSM has already produced the claims data and Comau's expert has, likely by now, reviewed all the data. Discovery on the SSP claim will be required, but BCBSM likely has much of the information it needs to formulate its defense. And Comau's motions to compel depositions would likely have been granted, at least in part, even without amendment based on the scope of the claims in the FAC, so discovery would continue anyway. The amendment will cause delay in resolution of this case, although a large part of the reason this case has not moved quickly is that the parties have been disputing the sufficiency and scope of the claims since the beginning. Comau also says if leave is not granted it will file a new lawsuit with these claims, which will only serve to truly start the clock anew against BCBSM in a separate litigation. With this SAC, a final amendment, the claims are clear and the litigation will move towards completion. Of course, how much time will be added to the case is unclear. BCBSM asserts that it will likely file a motion to dismiss the SAC or some claims in it. If successful, that will obviate the need for discovery on the dismissed issues, speeding the case along.

BCBSM cites *Nolan v. Thomas*, 2018 WL 3122597 (E.D. Mich. June 26, 2018), in part to support the proposition that courts routinely deny these late-filed motions to amend, especially where the moving party has been aware of the facts giving rise to its claims. There, the court denied the motion for leave to amend the complaint because it was filed after oral argument on dispositive motions and because the plaintiff was aware of the necessary facts of the new claim when the original complaint was filed. *Id.* at *9-10. These facts are distinguishable from this case. This case has yet to pass the discovery phase, so it is not in its "late stages." All pending scheduling order dates have been adjourned (and discovery is extended below). (ECF No. 173). Second, the added detail to the proposed second amended complaint comes from discovery; it was not information known at the time of the original complaint. As for the SSP claim, the new claim, Plaintiff asserts they learned details about the program in the November 24, 2021 production, and those details form part of the claim. So unlike in *Nolan*, the Court cannot say Comau was aware of the facts necessary to state a viable claim when they filed the original complaint.

4. Bad Motive

The discussion above of Comau's actions shows it did not act in bad faith or with bad motive in bringing this motion. This factor does not weigh against allowing amendment.

5. Repeated Failure to Cure Deficiencies and Futility

***4** There have not been repeated failures to cure deficiencies. This factor does not weigh against amendment. BCBSM does not argue amendment would be futile except to assert that it will likely file a motion to dismiss the second amended complaint.

On balance, the factors counsel in favor of granting Comau leave to amend. The motion is **GRANTED**.

B. Motion to Seal Exhibits

As explained in the Court's Order on prior motions to seal (ECF No. 128), the Sixth Circuit has long recognized a "strong presumption in favor of openness" in court records. *Rudd Equipment Co., Inc. v. John Deere Constr. & Forestry Co.*, 834 F.3d 589, 593 (6th Cir. 2016) (citing *Brown & Williamson Tobacco Corp. v. FTC*, 710 F.2d 1165, 1179 (6th Cir. 1983)). The "heavy" burden of overcoming that presumption rests with the party seeking to seal the records. *Shane Grp., Inc. v. Blue Cross Blue Shield of Mich.*, 825 F.3d 299, 305 (6th Cir. 2016). The moving party must show that it will suffer a "clearly defined and serious injury" if the judicial records are not sealed. *Id.* at 307. This burden must be met even if no party objects to the seal, and it requires a "document-by-document, line-by-line" demonstration that the information in the document meets the "demanding" requirements for the seal. *Id.* at 308. In delineating the injury to be prevented, "specificity is essential." *Id.* Typically, "only trade secrets, information covered by a recognized privilege (such as attorney-client privilege), and information required by statute to be maintained in confidence (such as the name of a minor victim of a sexual assault)" are enough to overcome the presumption of access. *Id.*

Should the Court order a document to be sealed, the Court must articulate why the interests supporting nondisclosure are compelling, why the interests supporting public access are not

as compelling, and why the scope of the seal is no broader than necessary. *Id.* at 306.

The remaining dispute in BCBSM's motion to seal exhibits is over three sentences in a four-paragraph email chain and two slides in a 25-slide internal presentation, both marked "confidential" by BCBSM in discovery. It seems the parties could have come to an agreement on three sentences and two slides. All the same, the Court resolves the motion in BCBSM's favor.

BCBSM argues the three sentences in the email chain should be redacted because they describe a specific aspect of its claims processing logic that could be used as a roadmap by bad actors to perpetrate fraud, waste, and abuse. Specifically, these sentences describe information bad actors could include on submitted claims to try to increase their reimbursement. (ECF No. 162, PageID.6259-60). According to the defendant, the two slides describe red flags its investigation unit looks for to identify potential fraud, waste, and abuse and could be used as a roadmap to evade detection by the investigation unit. BCBSM insists the public need not view these sentences or slides to understand the SAC or the Court's ruling on the motion for leave to file the SAC. (*Id.* at PageID.6260-61).

Comau argues against sealing or redacting because the information in the three sentences is publicly available in other documents that BCBSM agreed to de-designate as confidential. (ECF No. 168, PageID. 6662). BCBSM rebuts this with compelling argument that the information in this particular email is more specific providing specific "indicators" a bad actor could use to try to game the system (should BCBSM begin using the logic again). (ECF No. 169). Comau also argues the information in the two slides is publicly available and presents only generic information about fraud detection. (ECF No. 168, 6663-64). Again, BCBSM argues what is on these two slides is more specific—they provide data points BCBSM uses to detect fraud. A bad actor might steer clear of these data points to avoid detection.

***5** BCBSM's requests are narrowly tailored to achieve their goal of preventing potential future fraud. It is conceivable that a healthcare provider with bad intent could use the information to tailor its payment submissions in a way to attempt to game the system. BCBSM's argument that both items to be redacted are more detailed than a generic statement about fraud and what is publicly available is well taken. BCBSM has also made the case that the public does not have great interest in viewing these portions of the record because the information does not help to understand the pleadings or arguments about leave to amend.

The motion is **GRANTED**. BCBSM is **DIRECTED** to file unredacted, unsealed versions of those exhibits no longer contested and a redacted, unsealed version of the two documents addressed here within **14 days** of this Order. Comau is **DIRECTED** to file an unsealed version of the SAC within **14 days** of this Order.

C. Plaintiff's Motions to Compel (ECF Nos. 92, 121), BCBSM's Motion for Protective Order (ECF No. 151)

In light of the Order granting Comau leave to file a second amended complaint, the arguments raised in Comau's motions to compel at ECF Nos. 92 and 121 and BCBSM's motion for protective order against depositions (ECF No. 151) are stale. At ECF No. 92, Comau seeks to depose various BCBSM employees or former employees. BCBSM's objections to those depositions largely revolved around its argument that the requests were irrelevant because they did not relate to the claims in the FAC. They filed a motion to prevent these depositions from going forward for that reason. The second motion seeks an order compelling responses to interrogatories and requests for documents. Here, too, BCBSM objected on the grounds of relevance and burden arguing the requests were not relevant to the claims in the FAC.

Since the SAC makes some changes to the claims, ruling on specific arguments in these three pending motions would not be an exercise in judicial economy. That said, BCBSM's arguments against the discovery alleging that they seek information not relevant to the FAC now appears moot. The Court will **GRANT** Plaintiff's motions to compel, but without prejudice to BCBSM objecting to those discovery requests that have not been addressed by the Court. BCBSM's motion for protective order is **DENIED AS MOOT**, but again without prejudice to the company raising proper objections to the noticed depositions. To allow for the completion of discovery, discovery will be extended three months from this Order, to **September 30, 2022**. Dispositive motion cut-off will be **October 31, 2022**, or a date to be set by the District Judge.[3] The parties should confer on remaining discovery disputes and anticipated lines of discovery to find the most efficient means to complete discovery by this deadline.

[3] Remaining case deadlines will be determined by the District Judge.

IT IS SO ORDERED.

The parties to this action may object to and seek review of this Order, but are required to file any objections within 14 days of service as provided for in Federal Rule of Civil Procedure 72(a) and Local Rule 72.1(d). A party may not assign as error any defect in this Order to which timely objection was not made. Fed. R. Civ. P. 72(a). Any objections are required to specify the part of the Order to which the party objects and state the basis of the objection. When an objection is filed to a magistrate judge's ruling on a non-dispositive motion, the ruling remains in full force and effect unless and until it is stayed by the magistrate judge or a district judge. E.D. Mich. Local Rule 72.2.

All Citations

Slip Copy, 2022 WL 2373352

End of Document

2012 WL 3887438
United States District Court,
E.D. Michigan,
Southern Division.

BORROUGHS CORPORATION and Borroughs Corporation Employee Benefit Plan, Plaintiffs,
v.
BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant,
and
Hi–Lex Controls Incorporated, Hi–Lex Corporation and Hi–Lex Corporation Health and Welfare Plan, Plaintiffs,
v.
Blue Cross Blue Shield of Michigan, Defendant.

Nos. 11–12565, 11–12557.
|
Sept. 7, 2012.

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ORDER GRANTING IN PART AND DENYING IN PART PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND GRANTING IN PART AND DENYING IN PART DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

VICTORIA A. ROBERTS, District Judge.

I. INTRODUCTION

***1** This matter is before the Court on cross-motions for summary judgment filed, on the one hand, by Defendant Blue Cross and Blue Shield of Michigan ("Blue Cross"), and on the other hand, by Plaintiffs Burroughs Corporation ("Burroughs") and Hi–Lex Corporation ("Hi–Lex").

The Complaints allege nine counts: (I) ERISA Breach of Fiduciary Duty–Defendant did not disclose fees it allocated to itself and made false or misleading statements concerning the fees; (II) ERISA Prohibited Transaction–Defendant engaged in self-dealing by charging a hidden fee and unilaterally determining the amount of the fee; (III–IX) various state and common law causes of action.

For the reasons that follow:

- Defendant's Motion for Summary Judgment is **GRANTED IN PART** and **DENIED IN PART.** The Court dismisses the state law claims (Counts IIIIX) with prejudice. Defendant's Motion is denied as to the ERISA claims (Counts I–II)

- Plaintiffs' Motion for Summary Judgment is **GRANTED IN PART** and **DENIED IN PART.** The Court grants summary judgment to Plaintiffs on Count II, ERISA prohibited transaction. The Court denies summary judgment to Plaintiffs on all other counts.

- Issues of material fact remain as to Count I, ERISA Breach of Fiduciary Duty, as well as Defendant's statute of limitations defense. These matters proceed to trial. The resolution of the statute of limitations issue will necessarily affect the extent of liability under Count II, and the extent of liability, if any, under Count I.

II. BACKGROUND

These cases are two in a series involving entities which entered into Administrative Service Contracts ("ASC") with Blue Cross for claims administration services and network access for their self-funded employee health benefit plans. Burroughs first contracted with Blue Cross in 1994, and executed its current ASC in 2000. Hi–Lex first contracted with Blue Cross in 1981, and executed its current ASC in 2002. Hi–Lex and Burroughs entered into identical ASCs with Blue Cross.

Under the ASCs, Blue Cross serves as third-party administrator of Hi–Lex's and Burrough's employee health benefit plans; Blue Cross processes and pays employee health claims, provides access to its network for covered employees, and negotiates with hospitals and health care providers throughout the state. Hi–Lex and Burroughs reimburse Blue Cross for claims paid on their behalf.

These cases are about certain fees that Blue Cross allocated to itself as additional administrative compensation. Plaintiffs refer to the disputed fees as "Hidden Fees"; Defendant refers to them as "Access Fees." The disputed fees, set forth in an

unnumbered and untitled provision of Article III of the ASCs, include "The Provider Network Fee, contingency, and any cost transfer subsidies or surcharges...." According to that provision, these fees will be "reflected in the hospital claims cost contained in the Amounts Billed."

At some point, Defendant began collectively referring to these fees internally and in reports to Hi–Lex and Burroughs as Access Fees. The term is misleading. The fees are not labeled Access Fees anywhere in the contract. In fact, an entirely separate and unrelated provision of the ASC, Article VI Section B, is labeled "Access Fees." This section has no bearing on this litigation, and is unrelated to the Access Fees that Blue Cross refers to throughout its pleadings. Thus, in order to avoid confusion, the fees that Plaintiffs refer to as Hidden Fees and Defendants refer to as Access Fees will be called "Disputed Fees" throughout this opinion and order. Going forward, the parties are to use the term "Disputed Fees" to eliminate confusion.

***2** In the late 1980s, Blue Cross was in poor financial shape. In order to increase revenue, it began charging its self-insured customers additional fees, known as the "Plan–Wide Viability Surcharge," "Other Than Group ("OTG") Subsidy," and "Group Retiree Surcharge." Understandably, the self-insured customers were dissatisfied with these new fees; in 1989 alone, Blue Cross lost 225,000 members to competitors. The customers were unhappy that these charges amounted to an add-on to their bill. They were also unhappy to be subsidizing insured customers. Many customers who stayed with Blue Cross simply refused to pay the fee because they did not believe it was fair. Blue Cross remained in poor financial shape.

In 1993, Blue Cross decided to hide the Disputed Fees by merging them with hospital claims on billing statements. A 1993 document entitled Executive Summary, attached as Exhibit A to Plaintiffs' summary judgment brief, explains the plan. The Summary reads, in relevant part:

> Reflecting Certain BCBSM business costs in hospital claim costs will provide long-term relief to the problems detailed above and will also satisfy short-term objectives of enhancing customer relationships while cutting operational costs. Inclusion of these costs in our hospital claim costs is actually more reflective of the actual savings passed on to customers as it will now include the hospital savings net of the costs incurred to provide these savings. This will also improve our operations efficiencies since mass mailings for subsidy amount changes will no longer be necessary. Changes to these costs will be inherent in the system and no longer visible to the customer. The same argument applies to risk charges and provider related expenses.

Thus, the various Disputed Fees were no longer visible on customers' billing statements, but were incorporated into bills submitted to the customer for hospital claims (after a reduction had already occurred because of Blue Cross's network discounts). The bills were not itemized to indicate how much money was owed for the hospital claim, versus how much was owed for the other fees; that would have defeated the purpose of the program. The program was known as "retention reallocation" with "retention" referring to money Blue Cross retains as opposed to money used to pay medical claims.

Plaintiffs say that from 1994 to present, Blue Cross employed a "bevy of artifices" to hide the fees. Indeed, on the various disclosures discussed in the pleadings and reviewed by the Court, the Disputed Fees are not itemized. Plaintiffs say they did not learn about the Disputed Fees until 2011. Defendants, on the other hand, point to the contractual language in the ASCs and renewals to argue that the Disputed Fees were fully disclosed, that Plaintiffs agreed to payment of the Disputed Fees, and that, therefore, they did not breach any duties in collecting the fees.

On June 5, 2012, the Michigan Court of Appeals issued an opinion in one of the many cases against Blue Cross alleging hidden fees. *See Calhoun County v. Blue Cross & Blue Shield of Michigan*, —— Mich.App. ——, —— N.W.2d —— (2012) (for publication). The case did not include ERISA claims, only state law tort and contract claims. Plaintiff argued that its ASC with Blue Cross was void due to indefiniteness, and that Blue Cross breached its fiduciary duty by unilaterally charging the Disputed Fees. The Michigan Court of Appeals disagreed. It held that "the language of the ASC expressly provided for the collection of additional fees

beyond the Administrative Charge and Stop Loss Coverage," and that, consequently, "the parties unequivocally agreed to the payment of the Access Fee."

***3** The Court ordered briefing on the effect of *Calhoun County* on this case. Defendant stated that *Calhoun County* disposes of Plaintiffs' ERISA claims and state law claims. Plaintiffs stated that *Calhoun County* does not affect any of their claims. At a subsequent phone conference, both sides agreed that they were prepared to file summary judgment motions.

III. STANDARD OF REVIEW

The Court will grant summary judgment if "the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(a); *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 250–57, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). When reviewing cross-motions for summary judgment, the court must assess each motion on its own merits. *Federal Ins. Co. v. Hartford Steam Boiler Insp. and Ins. Co.,* 415 F.3d 487, 493 (6th Cir.2005). "The standard of review for cross-motions for summary judgment does not differ from the standard applied when a motion is filed by only one party to the litigation." *Lee v. City of Columbus,* 636 F.3d 245, 249 (6th Cir.2011). "[T]he filing of cross-motions for summary judgment does not necessarily mean that an award of summary judgment is appropriate." *Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust,* 410 F.3d 304, 309 (6th Cir.2005).

IV. ANALYSIS

A. *Calhoun County* Does Not Control the ERISA Counts

Relying on the Michigan Court of Appeals decision in *Calhoun County,* Defendant says the Court need answer but one question to dispose of all the claims in this case: "Did the Administrative Services Contract ("ASC") between Blue Cross and Plaintiffs authorize Blue Cross to collect the charges known as 'Access Fees'?" In *Calhoun County,* the Michigan Court of Appeals answered that question in the affirmative. Defendant says the Court must apply *Calhoun County* and rule in its favor on the ERISA claims (Counts I and II) and the state law claims (Counts III–IX).

The Court disagrees that *Calhoun County* is dispositive for two reasons: (1) the court in *Calhoun County* did not address the precise issues before this Court; and (2) ERISA law is federal law; state rules of decision have no binding precedential effect.

Calhoun County was not an ERISA case. It involved state law contract and tort claims, and was decided under state common law. Indeed, because ERISA does not apply to any governmental employee benefit plan, Calhoun County could not have brought the case under the ERISA statute. 29 U.S.C. § 1003(b)(1). The court in *Calhoun County* limited its analysis to the contract itself, the ASC between the plaintiff and Blue Cross. The court found that, under the ASC, the parties agreed to the payment of the Disputed Fee, despite the fact that the ASC did not reference a specific dollar amount for the fee, or a means to calculate the fee. The contract was not void due to indefiniteness, the court reasoned, because the amount of the Disputed Fee was "reasonably ascertainable through defendant's standard operating procedures." *Calhoun County v. Blue Cross & Blue Shield of Michigan,* No. 303274 (Mich. Ct.App. June 5, 2012) (for publication).

***4** Though there is some overlap between the claims in *Calhoun County* and Plaintiffs' state law claims, Counts I and II, which assert violations of ERISA, 29 U.S.C. § 1001, *et seq.,* are the meat of Plaintiffs' complaints. The court in *Calhoun County* did not even consider any alleged false or misleading statements by Blue Cross which could constitute an ERISA violation. And, it is well-settled that parties cannot contract around the requirements of ERISA. *See Allstate Ins. Co. v. My Choice Med. Plan for LDM Techs., Inc.,* 298 F.Supp 2d 651, 654 (E.D.Mich.2004) (quoting *Prudential Ins. Co. of Am. v. Doe,* 140 F.3d 785, 791 (8th Cir.1998).

Moreover, Defendant's assertion that the *Erie* doctrine requires this Court to adhere to *Calhoun County* to decide the ERISA claims is misguided. All suits brought under ERISA are regarding as arising under the laws of the United States. *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 55, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). A civil enforcement suit under ERISA is a federal question for jurisdictional purposes. *Id.* at 56. Where the ERISA statute does not address a particular issue in a case brought under ERISA's civil enforcement provision, "federal courts are expected to develop a body of federal common law to fill the interstitial gap in the statutory mandate." *Regents of the University of Michigan v. Employees of Agency Rent–A–Car Hospital Ass'n,* 122 F.3d 336, 339 (6th Cir.1997) (*"Regents"*). The *Erie* doctrine is simply inapplicable to federal questions.

This is not to say that the *Calhoun County* decision is irrelevant. The Sixth Circuit in *Regents* noted that "[i]n developing such federal common law, the federal court may take direction from the law of the state in which it sits, or it may generally review law on the issue and adopt a federal rule." *Regents,* 122 F.3d at 339. In addition, if this Court were to find that this action was improperly brought under ERISA, then *Calhoun County* would control any surviving state law claims. But, to argue as Defendant does-that *Calhoun County* disposes of all of Plaintiffs' claims-vastly oversimplifies the analysis.

B. Is This an ERISA Case?

ERISA is a "comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85, 90, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983). The duties ERISA imposes on fiduciaries have been called " 'the highest known to law.' " *Chao v. Hall Holding Co.,* 285 F.3d 415, 426 (6th Cir.2002) (quoting *Howard v. Shay,* 100 F.3d 1484, 1488 (9th Cir.1996)).

Before the Court can consider whether Blue Cross breached any duties under ERISA, it must first find that Blue Cross was a fiduciary with respect to the plan; that Blue Cross exercised control of plan funds; and that ERISA could provide Plaintiffs their desired relief. The Court turns to these questions now.

1. Blue Cross Was a Fiduciary With Respect to the Plan

***5** Fiduciary status plays a critical role in the ERISA remedial scheme. This is because "[s]ection 1109 [of ERISA] ... makes any person found to be a fiduciary personally liable to the ERISA-covered plan for any damages caused by that person's breach of fiduciary duties." *Briscoe v. Fine,* 444 F.3d 478, 486 (6th Cir.2006); *see also McLemore v. Regions Bank,* 682 F.3d 414, 422 (6th Cir.2012) (explaining that the issue of fiduciary status is paramount because ERISA permits a plaintiff to obtain both damages and equitable relief against fiduciaries, but only equitable relief against non-fiduciaries). Importantly, claims for breach of fiduciary duty and prohibited transactions under ERISA §§ 404 and 406(b)-the exact claims in Plaintiffs' complaints-may only be brought against a fiduciary within the meaning of ERISA. *Mertens v. Hewitt Associates,* 508 U.S. 248, 252–53, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993).

In relevant part, ERISA provides that "a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets ...." 29 U.S.C. § 1002(21)(A). "Person" is defined broadly to include a corporation such as Blue Cross. *Id.* § 1002(9). Based on the second "or" clause in subsection (i), the statute imposes fiduciary status on two types of entities: (1) entities which exercise *discretionary* control over the disposition of plan assets; and (2) entities which exercise *any* authority or control over plan assets. *Briscoe v. Fine,* 444 F.3d at 490–91; *see also Guyan Int'l v. Professional Benefits Administrators, Inc.,* 689 F.3d 793, 2012 WL 3553281, No. 11–3126 (6th Cir. Aug. 20, 2012).

Determinations of fiduciary status must be made on a case-by-case basis; it is not an all-or-nothing question. The Sixth Circuit employs a "functional test" to determine fiduciary status. *Briscoe,* 444 F.3d at 486. Thus, the court must examine the conduct at issue, not whether there is a formal trusteeship in place. *Id.* (citations omitted). The relevant question is "whether an entity is a fiduciary with respect to the particular activity in question." *Guyan,* 689 F.3d 793, 2012 WL 3553281 at *2. The Sixth Circuit holds that a third-party administrator such as Blue Cross "becomes an ERISA fiduciary when it exercises 'practical control over an ERISA plan's money.' " *Id.* (quoting *Briscoe,* 444 F.3d at 494).

On at least two occasions the Sixth Circuit held that a third-party administrator of an employee health benefit plan was a fiduciary under ERISA. In *Guyan,* the plaintiffs entered into contracts with a third-party administrator which required the administrator to establish accounts for each plaintiff into which it would deposit funds received from each plaintiff for the purpose of paying medical claims. *Id.* at *1. The third-party administrator was authorized to pay medical claims by writing checks from this account. *Id.* The Sixth Circuit held that "when [the third-party administrator] received Plan funds from Plaintiffs and deposited them into an account of its choice, [it] exercised control over those funds, as demonstrated by [its] use of Plan funds for its own purposes ...." *Id.* It then added that "[the third-party administrator] was a fiduciary under ERISA because it exercised authority or control over Plan assets." *Id.* at *3. Among the evidence of the third-party administrator's control or authority were its ability to write checks on the Plan account, and its ability to determine where Plan funds were deposited, and how and when they were disbursed. *Id.*

***6** Similarly, in *Briscoe,* the plaintiffs entered into contracts with a third-party health benefits administrator which "would receive a claim from a healthcare provider, process that claim to determine whether it was covered by the Company's plan, and, if the claim was covered, [it] would advise the Company on a weekly basis of the money that needed to be deposited into the account from which [it] paid the service providers." 444 F.3d at 483. The account had no minimum balance and was designed to "zero out" after the administrator made payments on the claims. *Id.* The Sixth Circuit held that this was "sufficient evidence to demonstrate that [the third-party administrator] exercised control over the assets of the Company's healthcare plan ..." and that it was, therefore, an ERISA fiduciary. *Id.* at 491–92. One aspect the Court relied upon in finding that the administrator exercised control over plan assets, and was therefore a fiduciary, is that it "allott[ed] to itself an administrative fee ...." *Id.* at 494.

In a third case in this district, with nearly identical facts, Judge Tarnow held that Blue Cross was a fiduciary when it assessed an "other than group" ("OTG") fee, a type of cost-transfer subsidy. As quoted by the Sixth Circuit, Judge Tarnow ruled on the record:

> I find that [BCBSM], in fact, exercised authority or control over the Plan assets, and under ERISA it was a fiduciary. That's because the [Fund] had to advance funds to [BCBSM], which then paid the claims on the [Fund]'s behalf to the providers. Sometimes, as it has been mentioned here, [BCBSM] had to pay more than was advanced, but [the Fund] was responsible for making up the difference, which is an inherent nature of self-insuring arrangement.
>
> ....
>
> This shows that [BCBSM] exercised control over Plan assets, and there's really no factual dispute about this. The [Fund]'s knowledge of the OTG fee is not relevant or material to the question of whether [BCBSM] exercised control over the assets.
>
> Accordingly, [BCBSM] was a fiduciary in assessing the OTG fee.
>
> *Pipefitters Local 636 Ins. Fund v. Blue Cross Blue Shield of Michigan,* 654 F.3d 618, 626 (6th Cir.2011).

The Sixth Circuit did not disturb Judge Tarnow's ruling regarding the fiduciary status of Blue Cross, though it does not appear to have been at issue on appeal.

Applying the holdings of *Briscoe, Guyan,* and *Pipefitters,* Blue Cross was a fiduciary when it allocated the Disputed Fee from plan assets to itself. By accepting regular deposits from Plaintiffs for the purpose of paying health claims, Blue Cross exercised "practical control over an ERISA plan's money." *See Guyan* at *2. The fact that Blue Cross was able to allocate to itself an administrative fee demonstrates its control over plan assets. Indeed, the facts of this case are nearly identical to those in *Pipefitters,* where Judge Tarnow found that Blue Cross was a fiduciary. As in *Pipefitters,* this case involves the alleged failure of Blue Cross to disclose certain fees, as well as the alleged making of false and misleading claims about the fees. And, as in *Pipefitters,* this case involves Blue Cross's unilateral allocation of a hidden fee from plan assets.

***7** The Court is well aware that "mere custody or possession over the plans' assets" does not render an entity an ERISA fiduciary. *See Briscoe,* 444 F.3d at 494 (quoting *Chao v. Day,* 436 F.3d 234, 237 (D.C.Cir.2006)). The Court also recognizes that a third-party administrator does not become a fiduciary merely by performing ministerial functions or clear contractual obligations. *See Seaway Food Town, Inc. v. Medical Mutual of Ohio,* 347 F.3d 610, 619 (6th Cir.2003). Neither of these circumstances is present here; Blue Cross's arguments to the contrary are not persuasive.

Blue Cross primarily relies on two cases for its argument that it is not a fiduciary. In *Seaway,* the Sixth Circuit held that a third-party administrator of an employee health benefit plan was not an ERISA fiduciary where the contracts between the parties allowed the administrator to "retain any funds resulting from the provider discounts for its sole benefit." 347 F.3d at 618. The Court held:

> We agree with the Seventh Circuit's reasoning that where parties enter into a contract term at arm's length and where the term confers on one party the unilateral right to retain funds as compensation for services rendered with respect to an ERISA plan, that party's adherence to the term does not give rise to ERISA fiduciary status unless the term authorizes the party to exercise discretion with respect to that right.
>
> *Id.* at 619.

Blue Cross says that *Seaway* controls because the ASCs grant it the unilateral right to retain the Disputed Fees. The argument is as follows: Article III of the ASC states in relevant part that "[t]he Provider Network Fee, contingency, and any other cost transfer surcharges ordered by the State Insurance Commissioner as authorized pursuant to 1980 P.A. 350 will be reflected in the hospital claims cost contained in the Amounts Billed." The items in this section are what Plaintiffs call the Hidden Fees and Blue Cross calls the Access Fee. In Article I of the ASC, "Amounts Billed" is defined as "the amount the Group owed in accordance with [Blue Cross's] standard operating procedures for payment of Enrollees' claims." From these provisions, Blue Cross reasons that, like in *Seaway,* the contract grants it the unilateral right to retain the Disputed Fee, and adherence to these contractual terms does not give rise to ERISA fiduciary status.

Seaway does not control for one simple reason: Seaway holds that adherence to a contractual term does not give rise to fiduciary status *"unless the term authorizes the party to exercise discretion with respect to that right."* 347 F.3d at 619 (emphasis added). The ASC does not set forth a dollar amount for the Disputed Fee, nor does it set forth a method by which the Disputed Fee is calculated. In short, it grants Blue Cross discretion to determine the amount of the Disputed Fee, and the record reflects that Blue Cross did just that. Blue Cross argues that the "discretion" Seaway contemplates is discretion whether or not to charge a fee, not discretion to determine the amount of a fee that is authorized by the contract. This distinction is without a logical basis. At least one other district court agrees. *Charters v. John Hancock Life Ins. Co.,* 583 F.Supp.2d 189, 197 (D.Mass.2008) (citing *Seaway,* 347 F.3d at 619) ("If ... an agreement gives an insurance company control over factors that determine the amount of its compensation, that company becomes an ERISA fiduciary with respect to its own compensation.").

***8** The second case Blue Cross relies on, *McLemore v. Regions Bank,* 682 F.3d 414 (6th Cir.2012), is distinguishable. In *McLemore,* a bankruptcy trustee and former clients of an investment advisor sued a bank where the advisor maintained accounts of defrauded employee benefit plans, alleging that the bank knowingly or in bad-faith allowed the advisor to steal from the accounts in violation of ERISA. Among the evidence the plaintiffs offered as proof of the bank's fiduciary status was that it regularly withdrew fees from the plan accounts. In holding that the bank was not a fiduciary, the Sixth Circuit stated:

> Here, the Trustee alleges only that "[the bank] regularly withdrew its fees and analysis charges from the trust funds it held. Nothing suggests that [the bank] did anything other than collect contractually owed fees. Unlike the *Briscoe* plaintiff, the Trustee does not allege that [the bank] unilaterally exercised any power to pay itself fees ... [The bank] collected only routine fees authorized by its depository agreement ...
>
> *Id.* at 424.

Here, Blue Cross was not merely collecting routine fees when it paid itself the Disputed Fees. It exercised discretion in a deliberately opaque manner to determine the amount of fees to pay itself. Moreover, the Court in *McLemore* was concerned with the policy implications of extending ERISA fiduciary status to all banks which withdraw fees from customer accounts. It stated:

> The Trustee fails to proffer—nor have we found—any case extending fiduciary status to a bank under these circumstances. Construing the allegations in the light most favorable to the Trustee, Regions' withdrawal of routine contractual fees constitutes no more an exercise of control than any other account holder's request effectuated by a depositary bank.
>
> *Id.*

The holding in *McLemore* may properly be viewed as limited to banks. It does not apply to the facts of this case.

2. The Disputed Fees Were Paid from Plan Assets

Defendant next argues that Plaintiffs cannot establish a loss to the ERISA plans because the plans had no assets. A loss is required for an action to be brought under ERISA § 409. Defendant says, "It follows that Plaintiffs must establish that Access Fees were paid from 'plan assets' in order to demonstrate a remediable loss under § 409." According to Defendant, the weekly wire funds from Plaintiffs were not plan assets because the contracts explicitly disclaim that label. Defendant points out that the Burroughs Plan explicitly states that the plan has no assets, and the Hi–Lex Plan states that benefits are "paid directly out of the assets of the Company" and that "there is no special fund or trust from which self-insured benefits are paid."

Defendant's argument is an attempt to elevate form over function, and is unsupported by law. Parties are not free

to contract out of the requirements of ERISA. *West v. AK Steel Corp.,* 484 F.3d 395, 408 (6th Cir.2007). The test is a functional one; no magic words in a contract can shield an entity from fiduciary liability, as the Sixth Circuit recently explained. *Guyana* at *3 ("[The administrator] seeks to shield itself from fiduciary liability by pointing to portions of its agreement that expressly state that it is not a fiduciary. But *Briscoe* specifically reasoned that language in a contract purporting to limit fiduciary status does not 'override a third-party administrator's functional status as a fiduciary.") It follows that language in a contract purporting to de-fund an employee benefit plan does not override the court's duty to determine under a functional test whether the plan had assets.

***9** The funds Plaintiffs deposited with Blue Cross are plan assets. In *Pipefitters,* the plaintiff entered into a nearly identical funding arrangement with Blue Cross, which Judge Tarnow described as follows: "[T]he [plaintiff] had to advance funds to [BCBSM], which then paid the claims on the [plaintiff's] behalf to the providers. Sometimes ... [BCBSM] had to pay more than was advanced, but the [plaintiff] was responsible for making up the difference, which is an inherent nature of a self-insuring arrangement." 654 F.3d at 626. Judge Tarnow then held that "[t]his shows that [BCBSM] exercised control over Plan assets, and there's really no factual dispute over this." This ruling was not disturbed on appeal, and there is no factual distinction between *Pipefitters* and the case before this Court.

A second Sixth Circuit case, *Libbey–Owens–Ford Co. v. Blue Cross and Blue Shield Mut. of Ohio,* 982 F.2d 1031 (6th Cir.1993), further undermines Defendant's argument. Again, the facts regarding funding of the plan in that case are nearly identical to the facts here.

> Blue Cross provided monthly statements to Libbey–Owens–Ford of the amount paid to health-care providers and to other Blue Cross plans, as well as the amount of administrative charges that Libbey–Owens–Ford owed to Blue Cross. The amended agreement required Libbey–Owens–Ford to make a deposit with Blue Cross that represented approximately two months of claims and administrative fees calculated as a percentage of the claims paid.
>
> 982 F.2d at 1032.

The Sixth Circuit reversed a district court decision which held that because the plan had no assets, there were no funds for which Blue Cross would be obligated to account. The Sixth Circuit held: "[A] fiduciary duty is present because Blue Cross could earmark the funds that Libbey–Owens–Ford allocated to the plan." *Id.* at 1036.

Even if separate segregated accounts did not exist for plan assets from Hi–Lex and Burroughs, Blue Cross could "earmark the funds" that Hi–Lex and Burroughs allocated to the plans. Under *Libbey–Owens–Ford,* Blue Cross controlled "plan assets."

3. Relief is Available to Plaintiffs under ERISA

Blue Cross states that because Hi–Lex and Burroughs are the named plaintiffs, rather than the plans themselves, no relief is available under ERISA. That is, Hi–Lex and Burroughs cannot recover money damages, according to Blue Cross, because any recovery must inure to the plans themselves.

This argument was recently rejected by the Sixth Circuit in *Guyan.* In *Guyan,* the third-party administrator argued that "Plaintiffs have no claim for damages under 29 U.S.C. §§ 1109(a) and 1132(a)(2) because they seek to recover for themselves as individual entities rather than on behalf of each Plaintiff's respective plan...." 689 F.3d 793, 2012 WL 3553281 at *5. In finding that the plaintiffs could recover on behalf of the plans, the Sixth Circuit held:

> Plaintiffs' complaints and summaryjudgment briefs are more than sufficient in light of *Tullis [v. UMB Bank, N.A.,* 515 F.3d 673 (6th Cir.2008)] to demonstrate that Plaintiffs' actions seek recovery on behalf of each Plaintiff's respective Plan. Plaintiffs expressly state in these pleadings that they bring this action on behalf of each Plaintiff's respective Plan. And Plaintiffs allege harm to the Plans themselves and the Plan participants, some of whom have been refused medical care and received collection notices, all because PBA diverted Plan funds for its own use rather than pay the claims as it promised.
>
> ***10** *Id.*

Hi–Lex and Burroughs make clear that they seek to recover on behalf of the plans. In footnote 21 of their Response Brief, Plaintiffs state: "Any recovery can be credited by BCBSM against Plaintiffs' future claims or can be held in constructive trust for the benefit of the Plaintiff Plans." This is sufficient under *Guyan* to demonstrate that Plaintiffs seek relief on behalf of the plans.

C. Plaintiffs' State Law Claims are Preempted by ERISA

Having found that Blue Cross is a fiduciary and that ERISA governs, the Court revisits the issue of preemption of Plaintiffs' state law claims. The Court previously dismissed Plaintiffs' state law claims without prejudice but allowed discovery to proceed on them, stating that "at the close of discovery Plaintiffs may be able to reinstate them without regard to any statute of limitations concerns." (Doc. 22 of 11–12557) The Court now holds that the state law claims are preempted; they are dismissed with prejudice.

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The scope of ERISA preemption is very broad. The Sixth Circuit recognizes "that virtually all state law claims relating to an employee benefit plan are preempted by ERISA." *Cromwell v. EquicorEquitable HCA Corp.,* 944 F.2d 1272, 1276 (6th Cir.1991) (quoted in *Briscoe,* 444 F.3d at 497).

Plaintiffs' state law claims arise out of the same operative facts as the ERISA claims. Plaintiffs seek relief for the same conduct through "alternative enforcement mechanisms." *Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp.,* 399 F.3d 692, 698 (6th Cir.2005). As such, *Briscoe* requires that these claims be dismissed with prejudice. 444 F.3d at 501.

D. Liability

1. Count II–ERISA Prohibited Transaction

Section 1106(b)(1) prohibits a fiduciary from "deal[ing] with the assets of the plan in his own interest or for his own account." This is plainly what Blue Cross did when it unilaterally determined the amount of Disputed Fees to keep as part of its administrative compensation and collected those fees from plan assets. Because Section 1106(b)(1) sets forth "an absolute bar against self dealing" by a fiduciary, Blue Cross is liable. *See Brock v. Hendershott,* 840 F.2d 339, 341 (6th Cir.1988).

A case from the Ninth Circuit is directly on point. *Patelco Credit Union v. Sahni,* 262 F.3d 897 (9th Cir.2001). In *Patelco,* the Ninth Circuit ruled that a third-party administrator of an employee health plan engaged in prohibited self-dealing when he determined his own administrative fee. *Id.* at 911. The administrator alleged that he was entitled to keep a portion of the client's monthly payments as an administrative fee, but the court disagreed. The Court stated:

> By his own admission, it is also undisputed that [the third-party administrator] paid insurance premiums for [the client's] coverage but marked up those premiums when charging that expense to [the client], in violation of § 1106(b)(1). And, viewing the evidence in the light most favorable to [the third-party administrator], it is undisputed that at the very least he determined his own administrative fees and collected them himself from the Plan's funds, in violation of § 1106(b)(1) ... Thus, the undisputed facts establish, as a matter of law, that [the third-party administrator] breached his fiduciary duties by engaging in prohibited self-dealing.

***11** *Id.*

A district court opinion from the Seventh Circuit is in accord. *Chao v. Crouse,* 346 F.Supp.2d 975 (S.D.Ind.2004). In *Chao,* officers and directors of a corporation were alleged to have violated Section 1106(b)(1) by using the assets of an employee benefit fund for various personal and business expenses. The defendants argued that certain administrative costs that they unilaterally allocated to themselves from the plan were proper. The court disagreed, applying *Patelco:* "Defendants' argument is again unpersuasive. While ERISA provides that a fiduciary may defray reasonable expenses of administering the plan, it does not allow a fiduciary to set its own administrative fee and directly collect those fees from plan assets." *Id.* at 988.

It is undisputed that Blue Cross determined its own administrative fee and collected it from plan assets. Plaintiffs need establish nothing more to prove a violation of Section 1106(b) (1). The existence or non-existence of Blue Cross standard operating procedures for calculating the Disputed Fees-which remains in dispute-does not create an issue of material fact. Whether Blue Cross calculated its fee according to a set methodology or pulled numbers out of the sky, it still unilaterally dealt with plan assets for its own benefit. The ASCs do not set forth any standard operating procedures for determining the Disputed Fees; nor is there any evidence that standard operating procedures were incorporated by reference, or otherwise ascertainable to Plaintiffs. Blue Cross acted unilaterally with respect to the Disputed Fees. This sort of self-dealing is a *per se* breach of Section 1106(b)(1).

2. Issues of Material Fact Remain as to Count I and Defendant's Statute of Limitations Defense

Section 1104(a)(1) sets forth the duty of loyalty that ERISA fiduciaries owe the plan, beneficiaries, and the participants. It requires that fiduciaries discharge their duties "solely in the interests of participants and beneficiaries." *Id.* The Supreme Court holds that "[t]o participate knowingly and significantly in deceiving a plan's beneficiaries in order to save the employer money at the beneficiaries' expense is not to act 'solely in the interest of the participants and beneficiaries.' " *Varity Corp. v. Howe,* 516 U.S. 489, 506, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996). The Sixth Circuit holds that misleading communications to plan participants regarding plan administration support a claim for breach of fiduciary duty. *Krohn v. Huron Memorial Hospital,* 173 F.3d 542, 547 (6th Cir.1999) (internal citation omitted).

Issues of material fact exist regarding whether Defendant breached its fiduciary duty by lying to or misleading Plaintiffs about the Disputed Fees. A non-exclusive list of material factual disputes the Court identifies includes:

- Whether Blue Cross lied in a Hi–Lex bid form when it wrote "N/A" in the row entitled "Network Access / Management Fees."
- Whether the various reports and disclosures Blue Cross issued to Plaintiffs are false or misleading with respect to the Disputed Fees.

***12** • Whether the Value of Blue Reports accurately disclosed the Disputed Fees.

Issues of material fact also remain regarding Defendant's statute of limitations defense. These factual disputes are closely intertwined with Count I, since Plaintiffs allege that Blue Cross engaged in fraud or concealment to hide its breach of fiduciary duty.

"[A]n ERISA plaintiff alleging a breach of fiduciary duty generally has six years to file suit, [but] this period may be shortened to three years when the victim had actual knowledge of the breach or violation." *Brown v. Owens Corning Investment Review Committee,* 622 F.3d 564, 570 (6th Cir.2010) (construing 29 U.S.C. § 1113) (internal quotations and citations omitted). The ERISA statute of limitations increases to six years "after the date of discovery" of the alleged breach or violation "in the case of fraud or concealment." 29 U.S.C. § 1113. In order to rely on the fraud or concealment section, as Plaintiffs do here, they must show: "(1) that defendants engaged in a course of conduct designed to conceal evidence of their alleged wrong-doing and that (2) the plaintiffs were not on actual or constructive notice of that evidence, (3) despite their exercise of diligence." *Brown,* 622 F.3d at 573.

The issues of material fact identified above which go to Count I are also relevant to the first prong of *Brown'* s fraud or concealment test. Other issues of material fact which affect the statute of limitations issue include:

- Whether, and at what date, Plaintiffs gained actual knowledge of the facts constituting Blue Cross's alleged ERISA violations.
- Whether the Value of Blue reports constitute actual or constructive notice of the Disputed Fees.
- Whether the ASCs, annual renewals, or other reports issued by Blue Cross constitute actual or constructive notice of the Disputed Fees.
- Whether Plaintiffs' exercised diligence to uncover the alleged misconduct.
- Whether the Disputed fees were disclosed to Hi–Lex CFO, Tony Schultz, during a meeting with Blue Cross representative Ron Crofoot in August 1994.

Resolution of the statute of limitations is necessary to determine the extent of Defendant's liability under Count II, and the extent of its liability, if any, under Count I.

V. CONCLUSION

The Court **GRANTS** summary judgment to Defendant on Counts III–IX and **DISMISSES WITH PREJUDICE** Plaintiffs' state law claims. The Court **GRANTS** summary judgment to Plaintiffs on Count II, ERISA Prohibited Transaction. Issues of material fact remain as to Count I and Defendant's statute of limitations defense.

IT IS ORDERED.

All Citations

Not Reported in F.Supp.2d, 2012 WL 3887438, 53 Employee Benefits Cas. 2829

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2017 WL 2450290
United States District Court, E.D. Michigan, Southern Division.

David MAC, individually, and on behalf of all others similarly situated, Plaintiffs,
v.
BLUE CROSS BLUE SHIELD OF MICHIGAN and Dürr Systems, Inc., Defendants.

Case No. 16-cv-13532
|
Signed 06/06/2017

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OPINION AND ORDER DENYING DEFENDANTS' MOTION TO DISMISS (ECF NO. 13)

Paul D. Borman, United States District Judge

***1** In this ERISA benefits action, Defendants have moved to dismiss Plaintiff's Complaint, prior to this Court's receipt of the administrative record, arguing that Plaintiff mounts an impermissible challenge to the design of his employer's plan, rather than a challenge to the implementation of the terms of that plan. The matter is fully briefed and the Court held a hearing on May 2, 2017. For the reasons that follow, the Court DENIES the motion.

INTRODUCTION

Plaintiff David Mac files this putative class action under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*, seeking a declaration that the drug that his physician has prescribed for his Idiopathic Adult Human Growth Hormone Deficiency ("IAGHD") is covered by the self-funded health benefits plan sponsored by his employer, Defendant Dürr Systems, Inc. ("Dürr"), and seeking a reversal of a denial of benefits under ERISA. [1] Plaintiff also sues Blue Cross Blue Shield of Michigan ("BCBSM"), the third party contract administrator for the Dürr health benefits plan and the entity that issued the denial of coverage in this case. Defendants now move to dismiss the Complaint in lieu of filing an Answer and in advance of the Court's receipt of the Administrative Record.

[1] At this stage of the proceedings, the Court need not address Plaintiff's class claims. Therefore, this Opinion and Order does not discuss Plaintiff's class allegations, which seek to bring class claims (against Blue Cross Blue Shield of Michigan only) on behalf of a class of "all Michigan residents whose coverage for medically necessary HGH prescriptions were improperly denied." (Complaint ¶ 56.) Any decision regarding class certification will require an in depth analysis of the Fed. R. Civ. P. Rule 23 factors. *See, e.g. Wit/Alexander v. United Behavioral Health*, 317 F.R.D. 106 (N.D. Cal. 2016) (finding that plaintiffs met the requirements for class certification under Rule 23 on their ERISA claims that defendant improperly adjudicated their requests for coverage based on overly restrictive coverage guidelines that were not consistent with generally accepted standards of care).

I. BACKGROUND

Plaintiff alleges in his Complaint that he is employed by Dürr, a Michigan corporation that sponsors a self-funded health and welfare benefit plan providing medical, prescription, dental and vision coverage for its employees that is subject to ERISA, ("the Dürr Plan"). (Compl. ¶¶ 5, 10; Compl. Ex. A, Third Amended and Restated Welfare Benefit Plan for Dürr Systems, Inc., Summary Plan Description, Effective January 1, 2015; Pl.'s Resp. Ex. 1, Dürr Plan.) The Complaint alleges that Dürr entered into an administrative services contract with BCBSM to administer the Dürr Plan. (Compl. ¶ 11.) Plaintiff further alleges that both Dürr and BCBSM are named fiduciaries under the Plan. (Compl. ¶¶ 9, 12.)

Plaintiff alleges that he suffers from dysfunction of his pituitary gland that has caused him to experience a deficiency in one key pituitary hormone, somatropin or Human Growth Hormone ("HGH"). (Compl. ¶¶ 14, 17.) According to Plaintiff's Complaint, a deficiency in HGH is called Growth Hormone Deficiency ("GHD"), and when onset occurs during adulthood and without known cause, the condition is referred to as Idiopathic [i.e. "Without Known Cause"] Adult Growth Hormone Deficiency ("IAGHD"). Plaintiff alleges that his

physician documented his condition with the results of a growth hormone stimulation test and prescribed HGH in the form of Genotropin Cartridge, which is a form of somatropin administered by injection. (Compl. ¶¶ 21-23.)

***2** The Complaint further alleges that on February 10, 2016, BCBSM issued a denial of coverage for the Genotropin ordered by his physician. The denial was signed by "Pharmacy Services, Blue Cross Blue Shield of Michigan," and indicated:

- The coverage guidelines for your Custom Drug List benefit require criteria to be met before coverage can be authorized.
- Our criteria for coverage of this medication require documentation of a diagnosis of growth hormone deficiency with hypopituitarism when one of the following criteria (a or b) are met:
- a. Two pituitary hormone deficiencies (other than growth hormone) requiring hormone replacement such as TSH, ACTH, Gonadotropins and ADH and both of the following i. and ii:
- i. at least one known cause for pituitary disease or a condition affecting pituitary function, including pituitary tumor, surgical damage, hypothalmic disease, irradiation, trauma or infiltration disease (histoplasmosis, Sheehan syndrome, autoimmune hypophysitis, or sarcoidosis) is documented AND
- ii. ONE provocative stimulation less than 5 mg/ml. The insulin tolerance test is the preferred testing method. OR
- b. Three pituitary hormone deficiencies (other than growth hormone) requiring hormone replacement AND an IGF-1 level below 80 ng/ml.

(Compl. ¶ 25; Compl. Ex. B; Pl.'s Resp. Ex. 2.) Plaintiff appealed the determination, which was upheld on April 4, 2016, in a letter that essentially reiterated verbatim the reasons for denial set forth in the February 10, 2016 initial denial. (Compl. ¶ 26-27; Compl. Ex. C; Pl.'s Resp. Ex. 3.)

Plaintiff alleges in his Complaint that he has exhausted the claims process and that any further pursuit of his claim through that process would be "futile because BCBSM has an across-the-board policy and practice of denying coverage for HGH for the treatment of IAGHD." (Compl. ¶¶ 28-29.) Plaintiff alleges that "BCBSM's criteria for coverage for Plaintiff and for the putative class does not include Adult Idiopathic Growth Hormone Deficiency, notwithstanding that it is a well-recognized medical condition in many patients with GHD." (Compl. ¶ 31.) Plaintiff alleges that BCBSM wrongfully denies coverage for the "medically necessary treatment" for his IAGHD. (Compl. ¶ 34.) Plaintiff alleges that BCBSM denied coverage based on its published "Custom Drug List." (Compl. ¶ 38.) Plaintiff alleges that "BCBSM's denial of Plaintiff's claim was arbitrary and capricious as BCBSM did not consider that the medical community recognizes an idiopathic cause for GHD." (Compl. ¶ 44.) Plaintiff alleges that "BCBSM's exclusion from coverage of IAGHD is arbitrary and capricious as the decision is not rational, based on medical evidence...." (Compl. ¶ 53.) Plaintiff also alleges that he was not provided "with all of the documents required pursuant to the DSI Plan and ERISA and which he also requested." (Compl. ¶ 49.)

II. STANDARD OF REVIEW

Federal Rule of Civil Procedure 12(b)(6) provides for the dismissal of a case where the complaint fails to state a claim upon which relief can be granted. When reviewing a motion to dismiss under Rule 12(b)(6), a court must " 'construe the complaint in the light most favorable to the plaintiff, accept its allegations as true, and draw all reasonable inferences in favor of the plaintiff.' " *Handy-Clay v. City of Memphis*, 695 F.3d 531, 538 (6th Cir. 2012) (quoting *Directv Inc. v. Treesh*, 487 F.3d 471, 476 (6th Cir. 2007)). The court "need not accept as true a legal conclusion couched as a factual allegation, or an unwarranted factual inference." *Handy-Clay*, 695 F.3d at 539 (internal quotation marks and citations omitted). *See also Eidson v. State of Tenn. Dep't of Children's Servs.*, 510 F.3d 631, 634 (6th Cir. 2007) ("Conclusory allegations or legal conclusions masquerading as factual allegations will not suffice.").

***3** In *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007), the Supreme Court explained that "a plaintiffs obligation to provide the grounds of his entitle[ment] to relief requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do. Factual allegations must be enough to raise a right to relief above the speculative level...." *Id.* at 555 (internal quotation marks and citations omitted) (alteration in original). "To state a valid claim, a complaint must contain either direct or inferential allegations respecting all the material elements to sustain recovery under some viable legal theory." *LULAC v. Bredesen*, 500 F.3d 523, 527 (6th Cir. 2007).

The Supreme Court clarified the concept of "plausibilty" in *Ashcroft v. Iqbal*, 556 U.S. 662 (2009):

> To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to "state a claim to relief that is plausible on its face." [*Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 556, 570 (2007)]. A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged. *Id.* at 556. The plausibility standard is not akin to a "probability requirement," but it asks for more than a sheer possibility that a defendant has acted unlawfully. *Ibid.* Where a complaint pleads facts that are "merely consistent with" a defendant's liability, it "stops short of the line between possibility and plausibility of 'entitlement to relief.' " *Id.*, at 557 (brackets omitted).

Id. at 678.

Thus, "[t]o survive a motion to dismiss, a litigant must allege enough facts to make it plausible that the defendant bears legal liability. The facts cannot make it merely possible that the defendant is liable; they must make it plausible. Bare assertions of legal liability absent some corresponding facts are insufficient to state a claim." *Agema v. City of Allegan*, 826 F.3d 326, 331 (6th Cir. 2016) (citing *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)).

In ruling on a motion to dismiss, the Court may consider the complaint as well as (1) documents that are referenced in the plaintiffs complaint and that are central to plaintiffs claims, (2) matters of which a court may take judicial notice (3) documents that are a matter of public record, and (4) letters that constitute decisions of a governmental agency. *Thomas v. Noder-Love*, 621 Fed.Appx. 825, 830 (6th Cir. 2015) ("Documents outside of the pleadings that may typically be incorporated without converting the motion to dismiss into a motion for summary judgment are public records, matters of which a court may take judicial notice, and letter decisions of governmental agencies.") (Internal quotation marks and citations omitted); *Armengau v. Cline*, 7 Fed.Appx. 336, 344 (6th Cir. 2001) ("We have taken a liberal view of what matters fall within the pleadings for purposes of Rule 12(b)(6). If referred to in a complaint and central to the claim, documents attached to a motion to dismiss form part of the pleadings.... [C]ourts may also consider public records, matters of which a court may take judicial notice, and letter decisions of governmental agencies."); *Greenberg v. Life Ins. Co. Of Virginia*, 177 F.3d 507, 514 (6th Cir. 1999) (finding that documents attached to a motion to dismiss that are referred to in the complaint and central to the claim are deemed to form a part of the pleadings). Where the claims rely on the existence of a written agreement, and plaintiff fails to attach the written instrument, "the defendant may introduce the pertinent exhibit," which is then considered part of the pleadings. *QQC, Inc. v. Hewlett-Packard Co.*, 258 F. Supp. 2d 718, 721 (E.D. Mich. 2003). "Otherwise, a plaintiff with a legally deficient claims could survive a motion to dismiss simply by failing to attach a dispositive document." *Weiner v. Klais and Co., Inc.*, 108 F.3d 86, 89 (6th Cir. 1997).

III. ANALYSIS

***4** Plaintiff brings a claim for relief under § 1132(a)(1)(B), which allows a plan participant "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).[2] Plaintiff claims that Genotropin is a prescription medication that is covered under the Dürr Plan and that the decision to deny coverage in Plaintiff's case because he failed to meet "additional conditions," as expressed in the letters of denial, was arbitrary and capricious. (Pl.'s Resp. 12.) Indeed, Genotropin *is* a drug that appears on BCBSM's "Custom Drug List," which both parties appear to concede is incorporated into the Dürr Plan.[3] Defendants respond that the "additional conditions" to which Plaintiff refers are in fact "clinical coverage criteria" that are "terms of the Dürr Plan" and further respond that Plaintiff concedes that he does not satisfy these criteria. Plaintiff does appear to concede in his Complaint that he does not meet this "coverage criteria" because his AGHD is "idiopathic," i.e. without known cause. At the May 2, 2017 hearing on this motion, counsel for Plaintiff acknowledged that Plaintiff does not have the "condition" as it is limited in the letters he received.

2 Plaintiff's Complaint does not specify the subsections of § 1132(a) under which he proceeds, but his Response clarifies that he seeks relief under § 1132(a)(1)(B) for a denial benefits due under the plan terms and under § 1132(a)(3), a "catch all" provision for relief not otherwise available under ERISA. Plaintiff also suggests a claim under § 1133, asserting that Defendants failed to provide him with information required under the Dürr Plan.

3 The Custom Drug List, while referred to in Plaintiff's Complaint as the basis on which BCBSM

"upon information and belief" denied coverage, is not attached to Plaintiff's Complaint. However, the "Custom Drug List" is central to Plaintiff's claims because it is the basis for Plaintiff's claim that Genotropin was a covered drug under the Dürr Plan. Thus, the Court can consider the Custom Drug List, which in any event is incorporated into the Dürr Plan, in deciding this motion to dismiss. However, and notably, the "coverage criteria" on which BCBSM based its denial are not published in the Custom Drug List and appears in the present record only as quoted in the text of the BCBSM denial letters, which are attached to Plaintiff's Complaint.

In his Response, however, Plaintiff denies that he has acknowledged that BCBSM's "denial of his claim was *consistent* with the Plan's 'criteria coverage.' " (Pl.'s Resp. 11) (emphasis in original). Plaintiff insists in his Response that he "never states or even infers that the Plan itself specifies that Genotropin Cartridge for the treatment of AIGHD is not a covered benefit." (Pl.'s Resp. 11.) In support of this statement, Plaintiff offers the following "evidence" of an apparent inconsistency between the denial and the Dürr Plan terms:

- *Genotropin is listed as an available pharmaceutical on the BCBSM "2017 Custom Drug List."* (Pl.'s Resp. Ex. 4, Custom Drug List 53, PgID 250.) [4]
- *[Genotropin] is also listed as a "specialty drug" in Defendant BCBSM's "Specialty Drug Program RXBenefit Member Guide." Ex. 5.* (Pl's Ex. 5, Specialty Drug Program, RX Benefit Member Guide 5, PgID 296.) [5]
- *Genotropin is not listed on BCBSM's "Drug List exclusions for Blue Cross Commercial Plans."*
- *The "2016 Enrollment Benefits Roadmap" for Dürr Systems, Inc. does specify any limitations.* (Pl.'s Mot. Ex. 7.) [6]

4 This is a true but incomplete statement because the drug is listed in the Custom Drug List as an approved drug requiring "PA," or Prior Approval. Prior Approval is explained in the Custom Drug List as follows: "Prior approval may be necessary for coverage of certain medications. In these cases, the member must meet clinical criteria or additional information must be provided before coverage is approved. Clinical criteria are based on current medical information and approved by our Pharmacy and Therapeutics Committee." (Pl.'s Ex. 4, Custom Drug List 10, PgID 207.)

5 The noted "Exhibit 5" states at the header of the List on which Genotropin appears: "Coverage for these drugs will vary based on your Rx benefit. See your plan's drug list for specific coverage details."

6 The noted Exhibit 7 is a 60 page document that, as far as the Court can discern, does not mention any specific drugs one way or the other. Indeed, the page indicated in the Table of Contents as pertaining to Prescription Drugs, page 11, appears to be missing from Exhibit 7.

***5** In the end, this collection of "evidence" ultimately circles back to the Prior Approval notation for the drug Genotropin in the Custom Drug List and the explanation in the Custom Drug List that Prior Approval will require the member to meet "clinical coverage criteria" that "are based on current medical information and approved by [BCBSM's] Pharmacy and Therapeutics Committee in order to obtain coverage." (Pl.'s Resp. Ex. 5, PgID 207, 211) (alteration added).

The essence of Defendants' argument in this motion is that these "coverage criteria," which presumably are those criteria set forth in the April 4, 2016 Denial Letter sent to Plaintiff, were Dürr Plan terms and that in denying Plaintiff's claim for benefits, Defendants merely enforced the terms of the Dürr Plan as written, i.e. applied the governing coverage criteria (Plan terms according to Defendants that Plaintiff concedes he could not satisfy) to deny Plaintiff's claim for benefits, and therefore Plaintiff cannot establish that Defendants violated any term of the Dürr Plan. In support of this argument, Defendants assert that ERISA does not require employers to provide any health benefits at all and does not mandate what benefits they must provide if they do choose to sponsor a benefit plan. *See, e.g., Pegram v. Herdrich*, 530 U.S. 211, 226-27 (2000) (" 'Nothing in ERISA requires employers to establish employee benefit plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan.' ") (quoting *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996)). And Defendants are correct that claims under § 1132(a)(1)(B) necessarily must seek to enforce plan terms, not rewrite them. As the Sixth Circuit recently observed:

> It should be pointed out that we would just as likely dismiss Plaintiffs' argument on the merits as well. In *CIGNA Corp. v. Amara*, the Supreme Court made clear that § 1132(a)(1)(B) does not afford a court any "authority to reform [a] plan as written." 563 U.S. 421, 438, 131 S.Ct. 1866, 179 L.Ed.2d 843 (2011). "The statutory language speaks of enforcing the terms of the plan, not of changing them." *Id.* at 436, 131 S.Ct. 1866. By arguing that the terms of the Plan do not comply with the law, Plaintiffs tacitly concede that the relief they seek exists outside the scope of their plan. And an action attempting to re-write the terms of a plan is unavailable under § 1132(a)(1)(B). *See Pender v. Bank of Am. Corp.*, 788 F.3d 354, 361–62 (4th Cir. 2015) (holding that a cause of action could not be advanced under § 1132(a)(1)(B) when the plaintiffs sought to enforce the plan "not as written, but as it should properly be enforced under ERISA.").

Soehnlen v. Fleet Owners Ins. Fund, 844 F.3d 576, 583 n. 2 (6th Cir. 2016).

Defendants argue that the decision to limit the availability of Genotropin under the Dürr Plan through the clinical coverage criteria requirement was a matter of plan design and thus cannot be challenged under § 1132(a)(1)(B). Defendants assert that in denying Plaintiff's claim BCBSM was merely enforcing the terms of the Dürr Plan, and thus Plaintiff's claim is not one challenging plan interpretation or implementation (permissible under § 1132(a)(1)(B)) but rather one challenging plan design (impermissible under § 1132(a)(1)(B)). Defendants assert that Plaintiff's failure to identify a single Dürr Plan term with which Defendants have failed to comply is fatal to his claim under § 1132(a)(1)(B).

But Plaintiff disputes that the "coverage criteria" that were applied to deny his claim are "Dürr Plan terms" and disputes that these coverage criteria are consistent with the Dürr Plan term that expressly covers the prescription drug Genotropin that his physician has ordered. At this pleading stage, and on this limited record, as discussed more fully below, the Court cannot conclude as a matter of law that the coverage criteria applied to deny Plaintiff's claim were "Dürr Plan terms," or that the Plaintiff has failed to identify a possible conflict between those coverage criteria and a Dürr Plan term.

***6** Defendants rely on *Jones v. Kodak Medical Assistance Plan*, 169 F.3d 1287, 1292 (10th Cir. 1999) to support their argument that the coverage criteria imposed in connection with Plaintiff's coverage determination were "Dürr Plan terms" that are unreviewable under § 1132(a)(1)(B). In *Jones*, plaintiffs wife (plaintiff was the plan participant) was denied coverage for inpatient alcohol treatment. Under the ERISA plan at issue in *Jones*, treatment for mental health and substance abuse problems was subject to pre-certification requirements, and the plan expressly required prior approval for treatment coverage. 169 F.3d at 1289-90. The plan informed plan participants that expenses for services and items deemed to be medically unnecessary, experimental, or investigational were not covered. *Id.* at 1290. The self-funded plan appointed American PsychManagement ("APM") to manage the review process under which the medical appropriateness of substance abuse treatment is assessed. *Id.* APM determined medical appropriateness of substance abuse treatment according to six criteria, three of which the patient must meet before coverage would be approved. *Id.* Mrs. Jones did not meet the three mandatory criteria and APM denied pre-certification for her inpatient treatment. *Id.* The Tenth Circuit affirmed the district court's determination that "the unpublished APM criteria were part of the Plan's term and, hence, that it could not review them." *Id.* at 1292. The court of appeals reasoned that "the Plan Summary expressly authorized APM to determine eligibility for substance abuse treatment according to its own criteria ... [and] [t]he APM criteria did not need to be listed in Plan documents to constitute part of the Plan." *Id.* Because the court "consider[ed] the APM criteria a matter of Plan design and structure, rather than implementation," it determined that the coverage denial was unreviewable under ERISA. The Tenth Circuit affirmed the denial of coverage, reiterating the well-established principle that "ERISA does not mandate that employers provide any particular benefits," and that therefore "an employer may draft a benefits plan any way it wishes."

Jones does appear to be persuasive authority for the proposition that clinical coverage criteria, like the criteria required for prior approval of Genotropin, can become "plan terms" and thus denials pursuant to them can become unreviewable under § 1132(a)(1)(B). However, *Jones* was persuasively distinguished in *Alexander v. United Behavioral Health*, No. 14-cv-05337, 2015 WL 1843830, (N.D. Cal. April 7, 2015), a case that this Court finds instructive here, at least based on the minimal record presently before the Court. In *Alexander*, the court distinguished *Jones* as (1) involving a claim against the plan sponsor and not the plan administrator (Plaintiff sues both here), and (2) involving criteria that were determined to have been incorporated into the plan. The plaintiffs in *Alexander* argued that the plan administrator, UBH, "promulgat[ed] improperly restrictive guidelines that

are inconsistent with the terms of their plans and improperly den[ied] coverage of residential treatment for mental health and substance abuse on the basis of those guidelines." *Id.* at *2. UBH argued, as Defendants argue here, that "in adopting these guidelines it did not act as a fiduciary but rather, as a "settlor," because the guidelines are terms of the Plans themselves," and moved to dismiss relying on *Jones:*

> UBH relies heavily on *Jones v. Kodak Medical Assistance Plan*, 169 F.3d 1287, 1292 (10th Cir. 1999), but that case is distinguishable. In *Jones*, a plan participant sued a welfare benefits plan covered by ERISA for improper denial of benefits relating to inpatient substance abuse treatment. 169 F.3d at 1290. The claim was denied on the basis of internal criteria created by the plan administrator. *Id.* The plaintiffs sued the plan, challenging the criteria used by the administrator on the basis that they were arbitrary and capricious; however, the court found on summary judgment that the criteria were "a matter of Plan design and structure, rather than implementation" and therefore, were not subject to judicial review. *Id.* at 1292. In reaching this conclusion, the court acknowledged that the criteria were not included in the Plan Summary but reasoned that requiring disclosure of these "particularized criteria for determining the medical necessity of treatment for individual illnesses" would "frustrate the purpose of a summary." *Id.* The court further found that to the extent that "the Plan Summary expressly authorized [the administrator] to determine eligibility for substance abuse treatment according to its own criteria [ ] [t]he [administrator's] criteria did not need to be listed in Plan documents to be part of the Plan." *Id.*

2015 WL 1843830 at *7 (alterations in original). The court then distinguished *Jones:*

> Here, in contrast to *Jones*, Plaintiffs have sued the administrator of their Plans, not the Plan sponsors. While a plan can act as a settlor, setting the terms of coverage and determining the scope of the plan, it is less clear that a third-party administrator can play that role.... *Jones* also appears to be distinguishable to the extent that the court in that case found that the criteria at issue were expressly incorporated in the plan. Although the *Jones* court does not provide the specific Plan language that it found gave rise to incorporation of the administrator's criteria as plan terms, the Court agrees with Plaintiffs that the language in the Plans at issue here does not support the conclusion that the LOCs and CDGs were incorporated into the Plans. Not one of the Plans even refers to UBH's CDGs. Nor does the vague reference to "levels of care" in the Alexander and Haffner Plans suggest any intent to incorporate those guidelines into Plaintiffs' Plans.

***7** 2015 WL 1843830, at *7-8. The court reasoned that because the explicit plan terms required the level of care guidelines to be developed based on the "reasonable" judgment of the plan administrator consistent with "generally accepted standards of care," adoption of those guidelines necessarily required the exercise of discretion and therefore constituted a discretionary act, reviewable under ERISA. In reaching this conclusion, the court cited *Egert v. Conn. Gen'l Life Ins. Co.*, 900 F.2d 1032, 1037 (7th Cir. 1990), in which the Seventh Circuit reviewed a denial of coverage by Connecticut General, the plan administrator for a self-funded ERISA plan, for in vitro fertilization ("IVF") procedures. To administer the benefits program, Connecticut General had compiled internal memoranda, referred to as Current Claims Practices or "CCP," outlining how the plan should be applied to certain circumstances, including coverage for infertility treatments. The CCP clearly instructed Connecticut General to deny all expenses for IVF claims. The Seventh Circuit reasoned:

> There is little question that the CCP clearly instructs Connecticut General's offices to deny IVF claims: "All expenses relative to the following procedures should be denied as not essential and necessary care and treatment of an illness, injury or covered pregnancy.... 2) INVITRO FERTILIZATION AND EMBRYO TRANSFER." Appendix C at 7511/94 (emphasis removed). Nonetheless, the treatment of IVF claims by the CCP—a compilation of secret, internal guidelines not disclosed to Canteen or to participants or beneficiaries of the Plan—is not dispositive here. The CCP is not the Plan: it is simply a set of memoranda designed to provide guidance to those interpreting the Plan. We therefore must determine whether this guidance forbidding

> reimbursement for IVF treatments is consistent with the terms of the Plan.
>
> We have held that firms like Connecticut General cannot adopt any guidelines they choose and then rely upon these guidelines with impunity; rather, they may rely only upon those guidelines that reasonably interpret their plans. For example, in *Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F.2d 416 (7th Cir.), cert. denied, 488 U.S. 856, 109 S.Ct. 145, 102 L.Ed.2d 117 (1988), we concluded that a Plan could not grant complete discretion to an internal advisory committee to pick and choose which claims would be reimbursed: "ERISA's provisions do not permit such potential abuses; decisions and their rationales are reviewable [for reasonableness]." *Id.* at 423. The focus of our inquiry, as suggested previously, must be on the reasonableness of Connecticut General's interpretation in the CCP of the Plan itself.
>
> * * *
>
> Even if Connecticut General acts "unreasonably" by allowing one form of treatment that permits conception while disallowing another, that by itself does not violate the Plan in effect here between Canteen and the Plan's participants. Indeed, Kraft-Egert admits that Connecticut General can act "unreasonably" in just this way, so long as Connecticut General "specifically excludes" reimbursement for IVF treatments in the Plan. The only question we need address regarding "reasonability" is whether, in the absence of specific Plan language, Connecticut General reasonably denied Kraft-Egert's reimbursement claim for IVF treatments.

900 F.2d at 1036-37 (footnote omitted).

The Sixth Circuit, albeit in an unpublished opinion, relied heavily on *Egert* in determining whether a "corporate medical policy" regarding surgical weight loss procedures, which was developed by a plan administrator, "reasonably interpreted" the terms of the plan. *See Smith v. Health Servs. of Coshocton*, 314 Fed.Appx. 848, 858-59 (6th Cir. 2009). The "corporate medical policy" purported to interpret terms of the plan that expressly excluded from coverage "surgery and other services primarily to improve appearance or to treat a mental and emotional [c]ondition through a change in body form (including cosmetic [s]urgery following weight loss or weight loss [s]urgery), except as specified." *Id.* at 851 (internal quotation marks omitted) (alterations in original). Although the plan language thus excluded post-weight loss surgeries that removed excess fat (panniculectomies and abdominoplasties), the "corporate medical policy" provided that an individual could establish the medical necessity of such a procedure by demonstrating certain specific clinical criteria. *Id.* The plan administrator determined that plaintiff did not sufficiently document the clinical criteria and denied coverage for her planned panniculectomy as a non-reimbursable cosmetic procedure. *Id.* at 852. Plaintiff argued that the plan administrator acted arbitrarily and capriciously by applying the corporate medical policy to deny coverage:

> ***8** Plaintiff Smith argues that Defendant Medical Mutual acted arbitrarily and capriciously when it denied coverage for the requested panniculectomy because Medical Mutual allegedly "supplanted" the terms of the Plan with Policy # 96001, in contravention of 29 C.F.R. § 2560.503-1(b)(5). We determine that Policy # 96001 reasonably interpreted the terms of the Plan and conclude that the district court did not err in finding that Medical Mutual's use of the Policy in evaluating the medical necessity of the requested panniculectomy was appropriate and not arbitrary and capricious.
>
> According to 29 C.F.R. § 2560.503-1(g)(1)(v)(A), if an administrator makes an adverse benefit determination while relying on an internal rule or policy, "either the specific rule ... or a statement that such a rule ... was relied upon in making the adverse determination and that a copy of such rule ... will be provided free of charge to the claimant upon request[.]"
>
> A plan administrator can rely on internal rules or policies in construing the terms of an employee benefits plan only if these rules or policies reasonably interpret the plan. *See Tiemeyer v. Cmty. Mut. Ins. Co.*, 8 F.3d 1094, 1100 (6th Cir. 1993); *see also Egert v. Conn. Gen. Life Ins. Co.*, 900 F.2d 1032, 1036 (7th Cir. 1990); *May v. Roadway Express, Inc.*, 813 F. Supp. 1280, 1284 (E.D. Mich. 1993). In *Egert*, the Seventh Circuit held that the administrator's reliance on internal guidelines in construing the terms of the plan rendered the ultimate benefits decision arbitrary and capricious because the guidelines were substantially inconsistent with the terms of the plan-disallowing coverage seemingly in contravention of the plan's language-"and [their use] le[ ]d to contradictory dispositions of similarly situated claims." 900 F.2d at 1038.
>
> Unlike the internal guidelines in *Egert*, Policy # 96001 is not inconsistent with the Plan in defining medically necessary procedures.

314 Fed.Appx. at 858-59 (alterations in original). *See also S.M. v. Oxford Health Plans (N.Y.), Inc.*, 94 F. Supp. 3d 481, 507-08 (S.D.N.Y. 2015) (plan administrator was authorized to establish guidelines to assist with benefit determinations of "medical necessity" and such determinations were subject to arbitrary and capricious review under a "substantial evidence" standard).

Defendants assert, and reiterated multiple times at oral argument, that Plaintiff must point to a Dürr Plan term, such as "medical necessity," or "illness," that he claims Defendants have misinterpreted in denying his claim for benefits. Defendants distinguish cases such as *Egert* and *Smith* as involving just such ambiguous plan terms and assert that here Plaintiff's claim was denied not based on "medical necessity," or some similar ambiguous plan term but based on unambiguous plan terms, i.e. the medical coverage criteria, that Plaintiff concedes he does not satisfy. But of course this distinction presumes that the Court accepts Defendants' contention that the coverage criteria applied to deny Plaintiff's claim were incorporated into the Dürr Plan and were "plan terms" immune from judicial review. In this case, on this record, the Court cannot determine as a matter of law that these coverage criteria were incorporated into the Dürr Plan and became unreviewable plan terms. The Court has no information regarding the who, what, where, and when of the creation of these coverage criteria. Indeed, other than the denial letter sent to Plaintiff, the Court has not seen a document that sets forth these "coverage criteria." Defendants assert that these criteria were incorporated into the Dürr Plan and became unreviewable "plan terms," but absent a more robust record, the Court cannot make that determination. When were these coverage criteria adopted and how were they incorporated into the Dürr Plan? Were they incorporated by amendment? How often have they been revised? Are they available to Dürr Plan participants or need they be? What are the procedures for amending the Dürr Plan and who is authorized to make such amendments?

***9** At the May 2, 2017 hearing, counsel for Defendants knew very little about the coverage criteria that were invoked and applied to deny Plaintiff's claim and could not explain how these coverage criteria were adopted, or whether they were published somewhere or otherwise available to beneficiaries of the Dürr Plan to review. Defendants rely on *Jones, supra*, in support of their claim that these coverage criteria are "Dürr Plan terms," but the district court in *Jones*, and the Tenth Circuit on appeal, gave little insight into the exact plan language they deemed sufficient to incorporate the criteria at issue there into the plan as unreviewable "plan terms." Defendants in this case have simply offered insufficient evidence and argument, on the present record at this pleading stage, to enable the Court to find as a matter of law that the BCBSM Pharmaceutical Committee had "unfettered discretion" to develop, and perhaps modify or amend these coverage guidelines, which then became new "plan terms," immunized from judicial review. *Alexander*, 2015 WL 1843830, at *8 (holding that to interpret *Jones* so broadly to, as a matter of law, convert a plan administrator's creation of internal guidelines into an act immune from judicial review would undermine the very protections afforded by ERISA).

Apart from their argument that the coverage criteria are "Dürr Plan terms," and immune from judicial review, Defendants alternatively fault Plaintiff for failing to otherwise identify a specific Dürr Plan term that has been violated by the denial of his claim. However, Defendants improperly seek to hold Plaintiff to a very parsed, isolated and literal reading of the Complaint when characterizing his claim. In fact, the allegations of the Complaint must be read as a whole and harmonized to determine whether a plausible claim has been suggested. *See Pegram*, 530 U.S. at 230 (noting that "where specific allegations clarify the meaning of broader allegations, they may be used to interpret the complaint as a whole"). At a minimum, as established in *Egert* and *Smith*, any coverage criteria must "reasonably interpret the plan," yet Plaintiff's denial letter gave no information explaining how these coverage criteria were determined or by whom —certainly nothing that would indicate to the Plaintiff or this Court what "current medical knowledge," the standard by which additional clinical criteria are developed under the Dürr Plan, supports the adoption of these specific criteria. Plaintiff's allegation that he was wrongfully denied coverage for Genotropin (a drug that is listed as available on the Dürr Plan Custom Drug List), when read in conjunction with other allegations of Plaintiff's Complaint, such as paragraph 44 which alleges that the denial did not consider that "the medical community recognizes an idiopathic cause for GHD," and paragraph 53 which alleges that the denial of coverage for Genotropin for Plaintiff was not "based on medical evidence," plausibly suggest a claim that Defendants failed to reasonably interpret the Dürr Plan Custom Drug List Prior Approval terms that require clinical coverage criteria to be "based on current medical knowledge." *See, e.g. Alexander v. United Behavioral Health*, No. 14-cv-05337, 2015 WL 1843830, at *5-6 (N.D. Cal. April 7, 2015) (finding that allegations that internal criteria created by plan administrator failed to reasonably interpret the plan's requirement that such criteria

be based on "generally accepted standards of care" plausibly suggested both breach of fiduciary duty and wrongful denial of benefits claims under ERISA).

Having the full Administrative Record in this case may unearth additional Dürr Plan terms that may have relevance here or may disclose that indeed these coverage criteria were incorporated into the Dürr Plan as "plan terms" and are unreviewable matters of plan design. But even *Jones*, on which Defendants rely for the proposition that unpublished coverage criteria can be incorporated into a plan as unreviewable "plan terms," was decided in the trial court on summary judgment, not on a motion to dismiss devoid of any context or an administrative record. While ultimately, when a more robust record is explored in this matter, Plaintiff may not prevail at the summary judgment stage, his Complaint plausibly suggests a claim for wrongful denial of benefits under § 1132(a)(1)(B). [7]

7 The Court also denies Defendants' motion to dismiss Plaintiff's claim under § 1132(a)(3). The Court recognizes that a claimant may not "repackage" a wrongful denial of benefits claim as a claim for breach of fiduciary duty under § 1132(a)(3). *See, e.g., Wilkins v. Baptist Healthcare System, Inc.*, 150 F.3d 609, 615 (6th Cir. 1998) ("Because § 1132(a)(1)(B) provides a remedy for Wilkins's alleged injury that allows him to bring a lawsuit to challenge the Plan Administrator's denial of benefits to which he believes he is entitled, he does not have a right to a cause of action for breach of fiduciary duty pursuant to § 1132(a)(3)."). However, given the nature of his claims, he may proceed on both fronts at this pleading stage.

IV. CONCLUSION

***10** For the foregoing reasons, the Court DENIES Defendants' Motion to Dismiss (ECF No. 10), and Orders Defendants to Answer Plaintiff's Complaint within fourteen (14) days of entry of this Order. The Court will then issue its standard ERISA Scheduling Order.

IT IS SO ORDERED.

All Citations

Not Reported in Fed. Supp., 2017 WL 2450290, 2017 Employee Benefits Cas. 189,966

End of Document

2011 WL 1256657
Only the Westlaw citation is currently available.
United States District Court,
E.D. Michigan,
Southern Division.

In re IRON WORKERS LOCAL 25 PENSION FUND.

Nos. 04–cv–40243, 07–cv–12368.
|
March 31, 2011.

Attorneys and Law Firms

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OPINION AND ORDER DENYING PARTIES' MOTIONS TO STRIKE *(docket nos. 377, 381, 393, 395, 397, 398, 400, 401, 402, & 405)* ***AND CROSS–MOTIONS FOR SUMMARY JUDGMENT*** *(docket nos. 352, 361, 370, 373, & 374),* ***AND GRANTING SULLIVAN WARD'S MOTION TO STRIKE JURY DEMAND*** *(docket no. 331)* [1]

[1] Citations to docket numbers refer to the docket in case no. 04–cv–40243.

STEPHEN J. MURPHY, III, District Judge.

***1** In January 2007, Watson Wyatt & Company ("Watson Wyatt") agreed to settle the claims brought against it by the Iron Workers Local No. 25 Pension Fund ("Fund") and its board of trustees. Watson Wyatt agreed to pay $110 million in exchange for a full release of liability and dismissal of all claims with prejudice. Under the legal services agreement in place between the Fund and its counsel, Sullivan, Ward, Asher, & Patton, P.C. ("SWAP"), counsel was entitled to approximately $36 million of the $110 million settlement as its contingency fee.

At a hearing regarding the settlement, George Young, one of the Fund's trustees at the time, challenged the propriety of the contingency fee. He alleged that the fee was excessive and that the agreement permitting it was created while SWAP was under a conflict of interest. Young sought to intervene in the action to prevent the payment of the fee. After the hearing, with consent of the parties, the Court ordered the fee to be transferred to a separate savings account at SWAP's bank, and the funds placed in shortterm treasury notes until the Court had an opportunity to rule on Young's motion to intervene.

Shortly thereafter, Young, along with Harvey Weglarz and William Chakur, a participant (union member) and beneficiary (union retiree) of the Fund, respectively, ("Plaintiffs") filed a lawsuit against: 1) SWAP and Anthony and Michael Asher, two of the firm's attorneys ("Sullivan Ward"); and 2) James Hamric, James Edwards, Patrick Gleason, Steven Gulick, D. James Walker, Art Ellul, and J. Michael Rogers, trustees of the Fund at the time the fee agreement was negotiated and executed ("Trustees"). Plaintiffs alleged that Sullivan Ward breached its fiduciary duty and benefitted from a transaction prohibited by ERISA. [2] They also alleged that Trustees breached their fiduciary duties imposed by ERISA by agreeing to the contingent fee without first researching alternative counsel and fee arrangements.

[2] The Court later dismissed additional claims against Sullivan Ward for breach of contract and breach of common law fiduciary duty. *See* Order of Nov. 4, 2009 (docket no. 322).

Before the Court are sixteen motions. The parties have filed cross-motions for summary judgment and numerous motions to strike the testimony and reports of each others' expert witnesses. Sullivan Ward also moved to strike Plaintiffs' jury demand. For the reasons stated below, the Court will deny all of the motions to strike and all crossmotions for summary judgment, and will grant Sullivan Ward's motion to strike the jury demand. The Court will schedule a bench trial forthwith.

BACKGROUND

The genesis of this action is a professional malpractice claim brought by the Fund against Watson Wyatt, an actuarial consulting firm hired primarily to provide advice, analysis, and recommendations concerning the structure and costs of the Fund's benefits. The Fund is an employee pension fund for members of the Iron Workers Local No. 25 Union, which, at the time of the lawsuit, received contributions from approximately 400 employers under collective bargaining agreements. Contributions were remitted on a monthly basis

and then invested and used to pay benefits to the Fund's beneficiaries. The Fund hired Watson Wyatt specifically "for the purpose of procuring professional expertise and advice in evaluating the Fund's assets and liabilities, complying with statutory funding standards, and meeting certain ERISA filing requirements." Watson Wyatt compl. ¶ 13.

***2** In fulfillment of its obligations to the Fund, Watson Wyatt prepared annual reports purporting to value accurately the Fund's assets and liabilities, based on reasonably prudent actuarial assumptions, methods, and the Fund's past experience. *Id.* ¶¶ 19–20. Prior to 2002, Watson Wyatt advised that the Fund's continuing contributions from employers were sufficient to cover the Fund's liabilities. *Id.* ¶ 21. The Fund then used that advice to determine whether, or by how much, to increase contributions required from employers, and to make other important decisions regarding the Fund. *Id.* ¶ 24.

The advice was allegedly deficient. [3] Watson Wyatt advised that the Fund could maintain and, at times, increase benefits to members and still meet its goals for financial stability. Watson Wyatt apparently was wrong. Contrary to the advice provided, the Fund was actually *underfunded* and would be unable to meet its obligations. *Id.* ¶ 25.

3 Since the case settled before trial, there was no determination of liability.

Sullivan Ward was general counsel for the Fund at the time of Watson Wyatt's alleged misfeasance. On the Fund's behalf, Sullivan Ward filed a lawsuit against Watson Wyatt on July 6, 2004 [4] alleging negligence, fraud, and breach of contract all stemming from Watson Wyatt's errors in providing actuarial services and then concealing those errors.

4 The action was originally filed in April 2004 but was dismissed without prejudice shortly thereafter for lack of subject-matter jurisdiction. *Iron Workers' Local No. 25 Pension Fund v. Watson Wyatt & Company,* No. 04–cv–40109 (E.D. Mich. filed Apr. 14, 2004)).

Almost two and a half years after suit was filed, one month after a hearing on Watson Wyatt's motion for partial summary judgment (a motion which, if granted, would have limited the Fund's damages considerably), and three months before trial, the parties settled. *See* Mot. Enforce Settlement Agreement, 1 (docket no. 135). After a hearing on Sullivan Ward's later motion to enforce the settlement, the Court entered an order dismissing the entire action without prejudice and ordering Watson Wyatt to tender full payment before April 20, 2007, or the case would be reinstated and a hearing held the same day.

Four days prior to the deadline for payment, Young, represented by counsel, filed a motion to intervene solely for the purpose of challenging the contingent fee award on grounds of excessiveness and conflict of interest. Young did not object to settlement of the underlying action against Watson Wyatt, but simply asked that the $36 million contingency fee be set aside.

The Court held a hearing on Young's motion on April 18, 2007. Two days later, it entered a stipulated order dismissing the claims against Watson Wyatt with prejudice and ordering that the contingency fee be placed in a separate account held by Sullivan Ward while the Court resolved Young's motion to intervene. Nearly a year later, on April 30, 2008, the Court permitted Young to be added as a party in the action solely for the purpose of challenging Sullivan Ward's fee. The Court then denied Young, Weglarz, and Chakur's motion to formally intervene, finding their interests were adequately protected by joining Young as a party.

Meanwhile, on June 1, 2007, shortly after the Court ordered the fee to be held by Sullivan Ward in trust, Young, Weglarz, and Chakur filed a separate action against Sullivan Ward and the Trustees alleging breach of fiduciary duty under ERISA and other various causes of action, all primarily challenging the contingency fee agreement struck between the Fund and Sullivan Ward. *George Henry Young, et al., v. James Hamric, et al.,* No. 07–cv–12368 (E.D. Mich. .). The action was consolidated with the underlying action against Watson Wyatt, in which the only remaining issue was the propriety of the contingency agreement and resulting fee. The complaint was amended twice and various of the claims were dismissed with prejudice. The remaining claims involve breach of ERISA fiduciary duty against the Trustees and Sullivan Ward, and violation of ERISA's prohibition on certain transactions.

***3** Discovery has closed and all parties have moved for summary judgment. Plaintiffs have also filed a motion for summary judgment in the underlying action solely on the propriety of the contingency fee arrangement under Michigan law. Along with the summary judgment motions, the parties have also filed numerous motions to strike the testimony and reports of each others' expert witnesses used to support their requests for summary judgment. Sullivan Ward has also moved to strike Plaintiffs' jury demand.

The Court held a hearing on the cross-motions for summary judgment and took the motions under advisement. It advised the parties that it would decide the remaining pending motions without a hearing.

DISCUSSION

The Court will address the motions to strike first and the summary judgment motions second. Sullivan Ward's motion to strike Plaintiffs' jury demand is discussed last.

I. *Motions to Strike*

Collectively, the parties have filed ten motions to strike testimony and reports of each others' witnesses. The testimony and reports are used to support and oppose the summary judgment motions. The motions are addressed separately below.

A. *Trustees' and Sullivan Ward's Motions to Strike Reports and Testimony of Timothy Parsons and Charles Borgsdorf (docket nos. 377 and 381)*

Timothy Parsons and Charles Borgsdorf have offered expert opinions in support of Plaintiffs' claims. Trustees and Sullivan Ward both contend (in separate motions) that Parsons and Borgsdorf are not qualified to offer their expert opinions.

Rule 702 of the Federal Rules of Evidence governs expert testimony and provides:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

"[Rule 702] imposes a special obligation upon a trial judge to 'ensure that any and all scientific testimony ... is not only relevant, but reliable.' " *Kumho Tire Co. v. Carmichael,* 526 U.S. 137, 147, 119 S.Ct. 1167, 143 L.Ed.2d 238 (1999) (quoting *Daubert v. Merrell Dow Pharms., Inc.,* 509 U.S. 579, 589, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993)). This basic "gatekeeping" obligation applies to *all* expert testimony, not just testimony of a scientific nature. *Id.*

Expert testimony must meet three requirements to be admissible. First, the witness must establish his expertise by reference to knowledge, skill, experience, training or education. This requirement is treated liberally. *Pride v. BIC Corp.,* 218 F.3d 566, 577 (6th Cir.2000). Second, the witness must testify to scientific, technical or other specialized knowledge. *Id.* A district court's focus here is not on the conclusions of the expert, but rather on the principles and methodology underlying the testimony to ensure that the principles and methodology are valid. *Id.* Third, the testimony must assist the trier of fact. *Id.* at 578. There must be a connection between the principles and methodology used and the disputed factual issues in the case. *Id.*

1. *Timothy Parsons*

***4** Trustees and Sullivan Ward contend that Parsons's report and testimony should be stricken because: 1) he lacks knowledge of the background facts surrounding the fee agreement; 2) he is not qualified to opine on the propriety of the fee agreement governing actuarial malpractice litigation; 3) his opinions are unreliable because a) he misunderstands the basic ERISA concepts at issue here and b) they are based a misinterpretation of ERISA's regulations; 4) his report states only legal conclusions; 5) the probative value of his report and testimony is outweighed by the potential for unfair prejudice, confusion, and waste of time.

The Court disagrees with each contention, and will not exclude Parsons's report or testimony. First, Parsons does not lack knowledge of the background facts surrounding the fee agreement. The facts were discussed at length in the depositions of the trustees and Sullivan Ward's attorneys, the transcripts from which Parsons has reviewed. Parsons has also reviewed documentary evidence relating to the claims in this case and the claims asserted against Watson Wyatt. This is sufficient to formulate reliable opinions.

Second, Parsons is qualified to opine on the propriety of the fee agreement here. He will provide opinions in the field

of ERISA, especially related to the actions of trustees and fund counsel and the use of a service agreements with fund counsel. Parsons is an attorney who has represented ERISA funds for over 30 years. He has broad experience advising plan fiduciaries and administrators on issues of fiduciary responsibility, Labor Department investigations, compliance, and service contracts. He is a member of various pension plan organizations, and has published extensively in the field of ERISA, especially as it relates to the issues of trustee and attorney duties. His lack of experience specifically regarding actuarial malpractice litigation on behalf of pension funds does not render him unqualified to opine on whether Sullivan Ward and Trustees acted in compliance with established standards of care in this case.

Third, Parsons's opinions are not unreliable. Trustees and Sullivan Ward contend they are unreliable first because Parsons advocates for a "prudent expert" standard for purposes of defining ERISA's fiduciary duties. This argument misconstrues Parsons's deposition testimony. Parsons agrees that the ERISA statute sets the standard of care for ERISA fiduciaries. Parsons dep. 53–55. He simply labels the standard as calling for a "prudent expert" (using quotation marks around the phrase in his report) to account for the fact that the statute speaks not in terms of a prudent man generally but rather "a prudent man *acting in a like capacity and familiar with such matters."* He does not assert that ERISA holds fiduciaries to a standard higher than what is expressly stated in the statute. Moreover, Parsons states that he uses the label simply as a tool for teaching trustee prudence. *Id.* at 55. This does not mean he misunderstands the governing standard of care.

***5** Trustees and Sullivan Ward contend that Parsons's opinions are unreliable also because they are based on an admitted misunderstanding of ERISA regulations. A plan's contract for services with a party in interest or fiduciary is prohibited unless no more than "reasonable compensation" is paid. 29 U.S.C. § 1108(b)(2) and (c)(2). Under Labor regulations, a service contract is not "reasonable" if it does not permit the plan to terminate, without penalty, on reasonably short notice. 29 C.F.R. § 2550.408b–2(c). The regulations do not expressly require a contract to describe the plan's right to terminate. Some courts have recognized that such a right is implied in all fund contracts. *See, e.g., Bona v. Barasch,* No. 01 Civ. 2289, 2003 WL 21222531 *6 (S.D.N.Y. May 27, 2003). Parsons testified that in his experience the Department of Labor has a practice of requiring plan contracts to expressly describe termination rights. Parsons dep. 113. He agrees that the regulations do not expressly require this. *Id.* Parsons does not misunderstand what the regulations require.

Fourth, Trustees and Sullivan Ward contend that Parsons's report should be excluded because it contains nothing more than legal conclusions. "An expert opinion on a question of law is inadmissible." *Chavez v. Carranza,* 559 F.3d 486, 498 (6th Cir.2009). But an expert report is not inadmissible simply because it contains opinions on ultimate issues in the case. Fed.R.Evid. 704(a). In *Chavez,* the court precluded an expert from testifying about whether a foreign's country's law prohibits U.S. courts from exercising jurisdiction over the claims at issue in the case. The question was a legal one which was inappropriate for presenting to a jury. 559 F.3d at 498.

The Court does not agree that Parsons's report contains "nothing more than legal conclusions." While his report and testimony contain opinions on ultimate issues, they also include testimony on subsidiary issues such as the types of legal arrangements generally entered into by ERISA plans, the roles played by both trustees and fund counsel in ERISA plans, negotiations between plans and potential outside service providers, whether the legal arrangement at issue was reasonable, and whether Trustees met the standard of care. Testimony on these issues will assist the trier of fact in reaching ultimate conclusions in this case. *See In re Reliant Energy ERISA Litig.,* No. H–02–2051, 2005 WL 5989791, *2 (S.D.Tex. Aug.19, 2005) ("The experts' opinions on specific issues, such as whether Defendants were ERISA fiduciaries for certain relevant purposes, could also prove helpful to the Court as the trier of fact if they are supported by the evidence and the relevant legal authorities, *see* Fed.R.Civ.P. 702, and are not inadmissible simply because they address ultimate issues of fact.").

Finally, the probative value of Parsons's report and testimony does not appear to be substantially outweighed by their potential for prejudice, confusion, and waste of time. Fed.R.Evid. 403. Trustee's and Sullivan Ward's arguments under Rule 403 are simply a repackaging of their earlier arguments, which the Court finds unpersuasive.

***6** The Court will not strike the reports or testimony of Timothy Parsons.

2. *Charles Borgsdorf*

Plaintiffs also submit expert testimony from Charles Borgsdorf, which Trustees and Sullivan Ward seek to exclude on grounds substantially similar to the grounds raised with

respect to Parsons above. Borgsdorf has offered opinions on the reasonableness of the contingency agreement and resulting fee, among other issues. He admits he is not an expert in the field of ERISA.

Trustees and Sullivan Ward contend that Borgsdorf's testimony and report are unreliable because he opines on matters outside his area of professional expertise when he discusses ERISA. The Court disagrees. As Sullivan Ward expressly contends in its motion for summary judgment, whether the fee award is reasonable under ERISA depends in large part on whether it complies with Michigan's rules regarding attorney fees, Mich. R. Prof' l Conduct 1.5(a). Therefore, Borgsdorf's testimony is reliable insofar as he discusses reasonableness of the fee under Rule 1.5(a), an area in which he has expert knowledge. To the extent Borgsdorf offers testimony related to fiduciary duties under Michigan's common law, however, his testimony is irrelevant since all such claims have been dismissed.

Trustees and Sullivan Ward next contend that Borgsdorf lacks knowledge of the background facts surrounding the fee agreement, rendering his testimony and report excludable. As with Parsons, Borgsdorf has reviewed the depositions of all of the trustees involved in hiring Sullivan Ward as litigation counsel and the negotiation of the fee agreement. He has also reviewed the pleadings in the case and numerous other documents produced in discovery. And as with Parsons, his lack of familiarity with actuarial malpractice claims does not render him unqualified. He has sufficient familiarity with the facts to offer relevant and helpful testimony.

Trustees and Sullivan Ward contend next that Borgsdorf's report and testimony contain only legal conclusions. The Court disagrees. The paragraph specifically cited in support of this challenge (¶ 30) is located in the section entitled "Conclusion." Earlier portions of the report, however, contain opinions on subsidiary issues related to reasonableness of the fee that will assist the trier of fact.

Finally, the Court does not find the probative value of the report to be substantially outweighed by its potential for prejudice, confusion, or waste of time.

The Court will not strike the report or testimony of Charles Borgsdorf.

B. *Trustees' Motion to Strike Affidavit of Timothy Parsons (docket no. 393)*

In response to Trustees' motion for summary judgment, Plaintiffs submitted an affidavit from Parsons. The affidavit contains opinions substantially similar to those provided in Parsons's deposition testimony and expert report. Trustees move the Court to strike the affidavit because: 1) it was not timely disclosed; 2) it contradicts earlier testimony and his report; 3) it is unreliable. The Court disagrees with each contention.

***7** First, it is true that the affidavit was created after Parsons's deposition and submitted in response to Trustees' summary judgment motion. Were the affidavit a "rebuttal expert report," as Trustees contend, the affidavit would be untimely and therefore excludable under Rule 37(c)(1).[5] But the affidavit is not a rebuttal expert report. It is simply a reiteration of the opinions expressed in Parsons's report and deposition. The Trustees have from the beginning been aware of the opinions Parsons would offer. While the affidavit at times clarifies Parsons's deposition testimony regarding the governing prudence standard and Labor regulations concerning termination rights for service contracts, it does not contradict that testimony. *See Aeral, S.R.L. v. PCC Airfoils, L.L .C.,* 448 F.3d 899, 908 (6th Cir.2006) (noting that post-deposition affidavit that does not "directly contradict" deposition testimony must be considered on summary judgment unless court determines affidavit constitutes attempt to create a sham fact issue). Parsons's opinions in his affidavit are consistent with the opinions he expressed in his report and deposition. Therefore, there is no reason to strike them. Finally, Parsons's affidavit does not render him unqualified to testify as an expert. Trustees' assertion to the contrary is a reiteration of their earlier argument that Parsons is not qualified to testify, an argument the Court rejected.

5 All expert rebuttal reports were to be exchanged by October 30, 2009. *See* Scheduling Order (docket no. 315).

The Court will not strike Parsons's affidavit.

C. *Sullivan Ward's Motion to Strike Various Affidavits Submitted by Plaintiffs (docket no. 395)*

Sullivan Ward has moved to strike the affidavits of Timothy Parsons, Charles Borgsdorf, Bart Carrigan, and George Young. The grounds asserted with respect to Parsons's affidavit are the same asserted by Trustees in their motion, and will be denied for the reasons stated immediately above.

Sullivan Ward raises the same arguments with respect to Borgsdorf's affidavit. Sullivan Ward contends that Borgsdorf's affidavit was an untimely-disclosed rebuttal report and contradicts his initial report and testimony. The Court disagrees. As with Parsons's affidavit, Borgsdorf's affidavit contains the same opinions offered in his report and testimony. There is no direct contradiction. It is true that Borgsdorf's report does not include elaborate discussion of the factors under Rule 1.5(a) of the Michigan Rules of Professional Conduct. The report does, however, contain an opinion that the contingency fee was excessive under Rule 1.5. Sullivan Ward never questioned Borgsdorf about these factors at his deposition. His affidavit includes a discussion of each factor, but the discussion contradicts nothing he said in his deposition. It was permissible for Plaintiffs to obtain a supplemental affidavit regarding Borgsdorf's view on the individual factors for purposes of opposing Sullivan Ward's motion for summary judgment. *See Aerel,* 448 F.3d at 908. Nothing prevented Sullivan Ward from asking Borgsdorf to opine on how these individual factors applied in this case. And if Sullivan Ward thought the eight factors were at the heart of the claims against it, it should have asked about them in Borgsdorf's deposition.

***8** Sullivan Ward next contends that the affidavits from both Carrigan and Young should be excluded because they offer impermissible opinions. Testimony in the form of an opinion is permissible so long as it is 1) rationally based on the perception of the witness, 2) helpful to a clear understanding of the witness' testimony, and 3) is not based on technical knowledge within the scope of Rule 702. Fed.R.Evid. 701. Carrigan's affidavit meets these requirements. He was a Fund trustee from September 2005 to June 2007, was present for all board meetings during that time, and has personal knowledge of the events he describes in his affidavit. Carrigan Aff. ¶ 4. He states that during his tenure as trustee, he witnessed a large amount of influence and control exerted by Anthony and Michael Asher. *Id.* ¶ 5. His opinions are rationally based on his perceptions during meetings. They are not impermissible.

Young's affidavit is challenged for the same reason. Young was a Fund trustee from June 2006 to June 2009 and attended all board meetings during that time. Young Aff. ¶ 2. He too observed what he considers to be a large amount of influence over the trustees by Anthony and Michael Asher. *Id.* ¶ 3. His opinions are based on facts which he describes in subsequent paragraphs of his affidavit. They are not impermissible.

The Court will not strike the affidavits of Parsons, Borgsdorf, Carrigan, or Young.

D. *Plaintiffs' Motion to Strike Testimony of Leonard Garofolo (docket no. 397)*

Leonard Garofolo is a former San Francisco Regional Director of the U.S. Department of Labor's Pension and Welfare Benefits Administration, now known as the Employee Benefits Security Administration. In that capacity, he was responsible for enforcing portions of ERISA on the West Coast. He is the founder and principal of ERISA Consulting Group and has provided consulting services to attorneys in many legal actions brought under ERISA. He has served as an independent fiduciary and consultant for employee benefit plans. Trustees offer Garofolo's testimony in support of their defense in this case. Plaintiffs seek to exclude the testimony on various grounds, all of which lack merit.

Plaintiffs claim first that Garofolo's testimony should be excluded because he is engaging in the unauthorized practice of law by providing an opinion on the matters in this case. Not so. The applicable laws barring the unlawful practice of law contemplate advice-giving, not simply opining on the law or its application to a given set of circumstances. Garofolo is not providing legal advice simply by testifying or providing an expert report.

Plaintiffs claim next that Garofolo is not qualified to offer opinions in this case because he is not a lawyer, has never acted as a trustee to a pension fund, and has never hired attorneys for litigation involving a pension fund. Garofolo is eminently qualified to provide expert testimony based on his vast experience with ERISA plans. His lack of both a law degree and experience as a trustee do not render him unqualified to offer opinions in this case.

***9** Plaintiffs claim next that Garofolo's opinions are unreliable because they lack a factual basis. This argument lacks a factual basis. Garofolo has reviewed the deposition testimony from the witnesses in this case, as well as numerous documents and deposition testimony generated in the underlying action against Watson Wyatt. That is sufficient.

Finally, Plaintiffs claim that Garofolo's report contains nothing but legal conclusions. Plaintiffs have misread his report. While the report does contain opinions on ultimate issues in the conclusion paragraph, the remainder of the report

contains a discussion of subsidiary issues that will assist the trier of fact in reaching a conclusion.

The Court will not strike Garofolo's report or testimony.

E. *Plaintiffs' Motion to Strike Testimony of Owen Rumelt (docket no. 398)*

Owen Rumelt is an attorney whose expert opinion is offered by Sullivan Ward in support of their contention that they are not ERISA fiduciaries. Plaintiffs move to strike Rumelt's testimony and report on the basis that he is not qualified to offer expert testimony in this case. They offer three reasons, all of which lack merit.

Plaintiffs contend first that Rumelt is unqualified because he lacks the knowledge to determine whether and when fund counsel can be a fiduciary for purposes of ERISA. Prior to being hired by Sullivan Ward, Rumelt apparently had never researched the question, and, once hired, delegated the legal research on the question to an associate in his law firm. This lack of experience, Plaintiffs contend, is dispositive to his qualifications to testify. The Court disagrees. Rumelt has served as fund counsel to various ERISA plans for over 20 years. His experience includes litigating professional malpractice and fiduciary breach actions on behalf of fund trustees. He has lectured for the International Foundation of Employee Benefit Plans' Certified Employee Benefits Specialist program. Rumelt offers opinions regarding the routine functions of fund counsel generally and whether Sullivan Ward went beyond those functions here. His opinions are directly relevant to Plaintiffs' claims against Sullivan Ward and may assist the trier of fact in resolving them. The fact that Rumelt never previously researched whether fund counsel could be an ERISA fiduciary does not change his knowledge of the routine functions generally performed by fund counsel, testimony which will assist the fact-finder determine whether Sullivan Ward was an ERISA fiduciary here. *See* 29 C.F.R. § 2509.75–5(D–1) (indicating that attorneys performing usual "professional functions" ordinarily are not fiduciaries under ERISA).

Plaintiffs next contend that Rumelt's testimony is unreliable because the facts on which they rely contradict the evidence in this case. The Court disagrees. Rumelt's testimony regarding his experience as fund counsel is independent of the facts in this case and therefore cannot contradict them. Also, his opinion that Sullivan Ward was not a fiduciary to the Fund in this case is sufficiently based on the facts of this case. Rumelt has reviewed the deposition exhibits, Plaintiffs' second amended complaint, and other relevant documents supplied by Sullivan Ward. Contrary to Plaintiffs' assertions, Rumelt has not ignored dispositive facts in reaching his conclusion on fiduciary status. He reviewed the lengthy second amended complaint and concluded that the allegations failed to demonstrate that Sullivan Ward was a fiduciary. That conclusion is ultimately for the factfinder to make, but Rumelt will not be precluded from offering his opinion on the issue at trial.

***10** Plaintiffs finally contend that Rumelt's conclusions are unreliable because they circumvent the Court's earlier ruling that attorneys can be fiduciaries and that the allegations in the complaint regarding Sullivan Ward's conduct did not foreclose a finding of fiduciary status. In its earlier order, the Court merely restated the statute and the regulations defining and clarifying, respectively, when a service provider can be a fiduciary. The Court held that whether Sullivan Ward had exercised the level of control over the Fund's assets necessary to render it a fiduciary was a question of fact to be determined at trial, but that Plaintiffs had carried their burden to state a plausible claim of fiduciary status. That holding is by no means a conclusive finding that Sullivan Ward was an ERISA fiduciary. Rumelt has not circumvented the Court's order by opining that Sullivan Ward was not a fiduciary.

Finally, Plaintiffs contend that Rumelt's testimony should be excluded because he reaches legal conclusions. While Rumelt concludes that Sullivan Ward was not a fiduciary for purposes of ERISA, the Federal Rules of Evidence do not require exclusion of his testimony. *See* Fed.R.Evid. 704(a).

The Court will not strike Rumelt's report or testimony.

F. *Plaintiffs' Motion to Strike Testimony of Lawrence Fox (docket no. 400)*

Lawrence Fox is an attorney whose opinions regarding the legal services agreement between the Fund and Sullivan Ward and the contingency fee generated by the settlement are being offered in Sullivan Ward's defense. Plaintiffs challenge the admissibility of Fox's testimony on grounds that it is unreliable. None of the reasons cited by Plaintiffs supports excluding Fox's testimony. Fox has extensive experience in the field of legal ethics, including fee arrangements. He is specifically familiar with contingency fee agreements. He has published and lectured on the subject, has hired attorneys on a contingency basis in his capacity as trustee to various companies, and he contributed to ABA Formal Opinion 94–389, which represents the ABA's official opinion on continent

fee arrangements. In sum, Fox is qualified to testify as an expert in this case.

The Court will not exclude Fox's report or testimony.

G. *Plaintiffs' Motion to Strike Testimony of George Googasian (docket no. 401)*

George Googasian is an attorney whose opinions regarding the reasonableness of the contingency fee are being offered in Sullivan Ward's defense. Plaintiffs challenge the admissibility of Googasian's testimony on grounds that it is unreliable. None of the reasons cited by Plaintiffs supports exclusion. Plaintiffs contend primarily that Googasian's testimony is unreliable because he fails to account for the overlay that ERISA places on the determination of whether the continency fee was reasonable. An important question with respect to the claims against Sullivan Ward is whether the attorney fee charged to represent the Fund in the action against Watson Wyatt was reasonable under the circumstances. Googasian's 50–years experience as an attorney, negotiating fee arrangements including contingency agreements, qualify him to provide an opinion in this case. His lack of experience in ERISA matters does not render him unqualified. Plaintiffs' additional arguments for exclusion are similarly unpersuasive.

***11** The Court will not exclude Googasian's report or testimony.

H. *Plaintiffs' Motion to Strike Testimony of Marcia Proctor (docket no. 402)*

Marcia Proctor is an attorney whose opinions on ethical issues in the legal profession are being offered in support of Sullivan Ward's defense. Plaintiffs challenge the admissibility of Proctor's opinions on grounds that she is an unreliable witness. None of the reasons Plaintiffs put forth supports excluding Proctor's testimony. Plaintiffs' primarily contend, as they did with respect to the testimony of Fox and Googasian, that Proctor has failed to consider that the fee agreement here involved an pension fund governed by ERISA, not Michigan law. Again, whether the fee agreement was a prohibited transaction under ERISA will depend on whether it is reasonable under the circumstances. Proctor has experience with legal fee arrangements, having served for the last thirteen years as general counsel to Buztel Long, a prominent Detroit law firm, where she concentrated on professional responsibility matters and attorney compliance. She has also served as general counsel for the State Bar of Michigan, having been hired expressly for her expertise in professional responsibility matters. Proctor has reviewed the facts of this case and has formed opinions. Her testimony will be relevant to the issues in this case and helpful to the trier of fact. Plaintiffs' remaining grounds for exclusion are similarly unpersuasive.

The Court will not exclude Proctor's report or testimony.

I. *Plaintiffs' Motion to Strike Sullivan Ward's Exhibits Submitted in Support of Summary Judgment (docket no. 405)*

In support of their motion for summary judgment, Sullivan Ward submitted Rule 26(a)(2) expert reports from each of their experts. The reports are not sworn and were not created under oath. Plaintiffs pointed this out in their response brief. Sullivan Ward attached to their reply brief affidavits from each expert in an attempt to rectify the problem. The two-page affidavits by each expert witness state that the witness has personal knowledge of the contents of their report, and purports to incorporate the contents of the report into the affidavit. Plaintiffs move to strike the reports on the grounds that they constitute hearsay and may not be considered on summary judgment. Plaintiffs also move to strike an exhibit submitted for the first time in Sullivan Ward's reply brief. The Court will strike no document.

In response to Plaintiffs' evidentiary objection, Sullivan Ward contends that its experts' reports are admissible because Rule 26(a) (2) requires only that expert reports be signed, not sworn. Rule 26(a)(2), however, governs expert report disclosures. Rule 56 governs summary judgment, and requires that the reports be in the form of an affidavit or declaration. *See Sigler v. Am. Honda Motor Co.,* 532 F.3d 469, 488 (6th Cir.2008); Fed.R.Civ.P. 56(c)(4). As initially submitted, the reports are hearsay and the Court cannot consider them.

***12** The affidavits affirming the contents of each expert's report, however, cure any technical deficiencies associated with the submission of the original, unsworn reports. *See, e.g., Gordon v. Caruso,* No. 1:06–cv–571, 2010 WL 882855, *2 (W.D.Mich. Mar.9, 2010) (permitting moving party to supplement summary judgment motion with affidavit from expert witness that "affirms the contents of the expert report"); *see also Harnden v. Jayco, Inc.,* 496 F.3d 579, 583 (6th Cir.2007) (noting possibility of remanding matter for the submission of sworn expert report, but declining to do so finding consideration of unsworn report on summary

judgment was harmless error). And because Plaintiffs were aware of the contents of the reports well before dispositive motion practice began, Plaintiffs are not prejudiced if the Court considers the reports.

Sullivan Ward also attached to its reply brief a fee agreement between it and another pension fund. Plaintiffs ask the Court to strike the exhibit since it was submitted for the first time in a reply brief, which prevented them from responding to it. Plaintiffs were aware of the agreement before Sullivan Ward attached it to its reply brief, having originally obtained it through a third-party subpoena. Accordingly, it is not "new evidence" that caused any surprise. Moreover, the exhibit was offered in Sullivan Ward's reply brief as a *response* to Plaintiffs' argument that the reasonableness of the contingency fee agreement must be judged by reference to agreements entered into by funds and service providers for similar services, not simply by other litigants and attorneys generally. Thus, Sullivan Ward responded properly by including the exhibit.

II. *Cross–Motions for Summary Judgment*

All parties have moved for summary judgment on all claims, hoping to resolve this matter without a trial. "Summary judgment is proper if the evidence, taken in the light most favorable to the nonmoving party, shows that there are no genuine issues of material fact and that the moving party is entitled to a judgment as a matter of law." *Schreiber v. Moe,* 596 F.3d 323, 329 (6th Cir.2010) (citation and internal quotation marks omitted). "[T]he mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment." *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 247–48, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). For a dispute to be "genuine," the evidence must be sufficient to allow a reasonable jury to return a verdict for the non-moving party should the dispute be resolved in its favor. *Id.* at 248. The ultimate inquiry is "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so onesided that one party must prevail as a matter of law." *Id.* at 251–52. A court must view the evidence and draw all reasonable inferences in favor of the nonmoving party. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 574, 587, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986). "In considering a motion for summary judgment, the judge's function is limited to determining whether sufficient evidence has been presented to make the issue a proper jury question, and not to judge the evidence and make findings of fact." *Bultema v. United States,* 359 F.3d 379, 382 (6th Cir.2004) (alterations, citation, and internal quotation marks omitted).

***13** The fact that the parties have filed cross-motions for summary judgment does not necessarily mean that there are no facts in dispute and that summary judgment for one side or there other is necessarily appropriate. *See Parks v. LaFace Records,* 329 F.3d 437, 444 (6th Cir.2003); *see also Taft Broad. Co. v. United States,* 929 F.2d 240, 248 (6th Cir.1991) ("The filing of cross-motions for summary judgment does not necessarily mean that the parties consent to resolution of the case on the existing record or that the district court is free to treat the case as if it was submitted for final resolution on a stipulated record." (citation omitted)). "On cross-motions for summary judgment, 'the court must evaluate each party's motion on its own merits, taking care in each instance to draw all reasonable inferences against the party whose motion is under consideration.' " *B.F. Goodrich Co. v. U.S. Filter Corp.,* 245 F.3d 587, 592 (6th Cir.2001) (quoting *Taft Broad.,* 929 F.2d at 248). Even if there is no dispute as to many of the facts, it may still be possible to draw competing inferences and conclusions from the facts, in which case summary judgment is inappropriate. *Id.* at 593 n. 2.

A. *Case No. 04–cv–40243*

Young, as a party to the underlying action against Watson Wyatt, has filed a motion for summary judgment in that action on the sole issue of the propriety of the legal services agreement. He contends that the fee arrangement is void or unenforceable because it lacks consideration and because Sullivan Ward breached various ethical obligations in obtaining it. Neither Sullivan Ward nor the Trustees filed cross-motions on this issue.

It was originally contemplated by the parties that the Court would conduct an evidentiary hearing at which the parties could offer testimony, documentary evidence, and argument, all in support of their respective positions regarding the propriety of the contingency fee. *See* Mot. Hr'g Tr. 42–43, Apr. 18, 2007 (docket no. 148). For reasons presently unknown to the Court, the hearing never occurred. [6] Sullivan Ward filed a motion to expedite a hearing but the motion was terminated as moot by the Court in a minute entry on September 24, 2007.

6 On October 9, 2008, the matter was reassigned from District Judge Paul V. Gadola to the

undersigned. *See* Notice of Reassignment (docket no. 209).

Courts have broad authority in dealing with an allegedly excessive contingency fee. *See Green v. Nevers,* 111 F.3d 1295, 1302 (6th Cir.1997). This authority is generally exercised through a court's review of the fee in a postjudgment or post-settlement hearing. Indeed, such a proceeding was precisely what was contemplated by the parties in the beginning. Young, Weglarz, and Chakur later apparently concluded that such a proceeding would not fully protect their interests and decided to challenge the fee through a wholly new lawsuit.

In light of the filing of the second action, and given that the claims alleged in that action are substantially similar to the arguments raised in Young's motion for summary judgment on the reasonableness of the fee, the Court will deny Young's motion for summary judgment in the original action. There is no longer any need for a separate review within the confines of the original action. The purpose of permitting Young to join the underlying action was to provide him a procedural vehicle for challenging the fee. He now has that vehicle by way of a second, free-standing action. [7] Given the filing of the second action, the Court sees no reason to permit argument and presentation of evidence regarding the contingency fee in the context of the original action. Any relief to which Plaintiffs may be entitled shall lie solely in the second action. Their rights are fully protected therein.

[7] It appears that Young and his counsel eventually followed the proposal offered by Morley Witus, counsel for Watson Wyatt, at the April 18, 2007 hearing before Judge Gadola. *See* Mot. Hr'g Tr. 44–45. Witus recommended that the action be dismissed with prejudice and that Young file a brand new action challenging the fee. Watson Wyatt was dismissed with prejudice as a party, but the action continued nevertheless.

***14** Therefore, the Court will deny Plaintiffs' motion for summary judgment on the propriety of the fee agreement.

B. *Case No. 07–cv–12368*

The second action involves claims under ERISA exclusively. Four cross-motions have been filed, one each by Sullivan Ward and Trustees, and two by Plaintiffs on their claims against each set of defendants. Review of the briefing and the extensive record evidence submitted along with it readily demonstrates that there are genuine issues of material fact preventing the Court from resolving this case through summary judgment. The parties have viewed the facts and all reasonable inferences drawn therefrom in the light most favorable to themselves, thereby failing to carry their burden to demonstrate the absence of a genuine dispute as to the material facts.

While many of the underlying facts in this case may be undisputed, there is considerable dispute over the inferences and ultimate conclusions that should be drawn from them. *See, e.g., Taft Broad.,* 292 F.2d at 247–48 ("Both parties, as movants, rely on inferences favorable to their own positions in seeking to obtain summary judgment, but as noted the law provides that reasonable inferences must be drawn in favor of the nonmovant in the context of a summary judgment."); *see also* 10A Charles Alan Wright, Arthur R. Miller, and Mary Kay Kane, *Federal Practice and Procedure* § 2725, 433–36 (3d ed. 1998) ("Therefore, if the evidence presented on the motion is subject to conflicting interpretations, or reasonable people might differ as to its significance, summary judgment is improper.").

Most importantly, the nature of the ultimate inquiry in this case—whether the legal services arrangement and resulting fee was reasonable—makes resolution of the issue on summary judgment not possible. Based on the record evidence—and depending on the way the finder of fact resolves conflicting testimony and inferences from the evidence presented—the result in this case could easily go in favor of either side. Evidence and argument presented by Plaintiffs could support a finding that the fee arrangement was not reasonable, thereby subjecting both Trustees and Sullivan Ward to liability under ERISA. On the other hand, the evidence could also support a conclusion that the arrangement was reasonable under the circumstances, thereby defeating all liability. The parties' experts have reached contrary conclusions on the issue. It is certainly possible for the finder of fact to return either of those verdicts if supported by the evidence. The Court cannot say that, as a matter of law, the fee is reasonable or unreasonable. The resolution of this question of reasonableness is at the heart of every claim in the action, and therefore, summary judgment is not warranted on any claim.

Little utility would be served in discussing in detail here each and every issue of fact and possible inference to be resolved by the fact-finder. Suffice it to say that no party has carried its burden of demonstrating the absence of genuine issues

of material fact. The parties' cross-motions for summary judgment must be denied.

III. *Sullivan Ward's Motion to Strike Plaintiffs' Jury Demand (docket no. 331)*

***15** Finally, Sullivan Ward has moved to strike Plaintiffs' jury demand. Plaintiffs' original complaint contained claims for breach of contract, malpractice and common law breach of fiduciary duty, but these claims were later dismissed. The remaining claims involve ERISA exclusively. Because ERISA itself does not expressly permit jury trials and because the claims and relief Plaintiffs seek are solely equitable in nature, Plaintiffs are not entitled to a jury trial. The Court will grant Sullivan Ward's motion to strike Plaintiffs' jury demand.

Trial by jury is permitted if a right to one exists either by statute or by the Seventh Amendment. "The answer to the first question is clear: ERISA does not statutorily provide for trial by jury, either expressly or implicitly." *Lamberty v. Premier Millwork and Lumber Co., Inc.,* 329 F.Supp.2d 737, 744 (E.D.Va.2004) (citing *Berry v. Ciba–Geigy Corp.,* 761 F.2d 1003, 1007 (4th Cir.1985) and *Biggers v. Wittek Indus.,* 4 F.3d 291, 297–98 (4th Cir.1993)); *accord In re Vorpahl,* 695 F.2d 318, 321 (8th Cir.1982); *Ellis v. Rycenga Homes, Inc.,* No. 1:04–cv–694, 2007 WL 1032367, *1 (W.D.Mich. Apr.2, 2007). Moreover, "the Sixth Circuit has long held that no right to a jury trial attaches to a beneficiary's claim for benefits under an ERISA plan, a result that could not be reached if the statute itself conferred the right to a jury trial." *Ellis,* 2007 WL 1032367, at * 1 (citing *Wilkins v. Baptist Healthcare Sys., Inc.,* 150 F.3d 609, 616 (6th Cir.1998), *Bittinger v. Tecumseh Prod. Co.,* 123 F.3d 877, 882–83 (6th Cir.1997), and *Bair v. Gen. Motors Corp.,* 895 F.2d 1094, 1096 (6th Cir.1990)). Therefore, for a right to trial by jury to attach in this case, it must do so by virtue of the Seventh Amendment.

The Seventh Amendment provides that "[i]n Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved." U.S. Const. amend. VII. The right extends to all suits adjudicating *legal* rights. *Chauffers, Teamsters & Helpers, Local No. 391 v. Terry,* 494 U.S. 558, 564, 110 S.Ct. 1339, 108 L.Ed.2d 519 (1990). Where only equitable rights are ascertained and determined, however, no right to a jury trial exists. *Granfinanciera, S.A. v. Nordberg,* 492 U.S. 33, 41, 109 S.Ct. 2782, 106 L.Ed.2d 26 (1989). To determine whether a right exists in a given case, a court first determines how the action compares with 18th-century actions brought in the courts of England prior to the merger of courts of law and equity. Second, the court examines the remedy sought and determines whether it is legal or equitable in nature. The second step is more important than the first. *Id.* at 42.

The first step is straightforward, and suggests that no right to a jury trial exists here. "ERISA law is closely analogous to the law of trusts, an area within the exclusive jurisdiction of the courts of equity." *Borst v. Chevron Corp.,* 36 F.3d 1308, 1324 (5th Cir.1994) (citing *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101, 110, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989)); *see also Evans v. Pearson Enters., Inc.,* 434 F.3d 839, 848–49 (6th Cir.2006) ("[I]n colonial times, the English High Court of Chancery had exclusive jurisdiction over trusts." (citation omitted)). Plaintiffs focus primarily on their claims under 29 U.S.C. §§ 1132(a)(2) and 1109 for breach of fiduciary duty, which statutory provisions Plaintiffs assert permit traditionally legal relief. [8] But claims for breach of fiduciary duty too were within the exclusive province of the equity courts, even though it was possible to obtain an award of money in such actions. *See Mertens v. Hewitt Assocs.,* 508 U.S. 248, 256, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993) ("[A]t common law, the courts of equity had exclusive jurisdiction over virtually all actions by beneficiaries for breach of trust. It is also true that money damages were available in those courts against the trustee." (footnote and internal citations omitted)). Therefore, the first step in the analysis suggests no right to a jury trial exists here.

8 Plaintiffs do not contend that they are entitled to a jury trial on their prohibited transaction claims under 29 U.S.C. § 1106.

***16** The second step confirms that no right exists here. Specifically, the nature of the relief Plaintiffs seek against both sets of defendants here is equitable, not legal. Plaintiffs seek a determination that the contingency fee agreement between Sullivan Ward and the Fund was prohibited under ERISA § 406, 29 U.S.C. § 1106, and return of that portion of the fee which they deem excessive, currently being held in trust by Sullivan Ward. Plaintiffs also seek injunctive relief prohibiting Trustees and Sullivan Ward from continuing to serve as trustees and fund counsel, respectively. Such relief clearly is equitable and Plaintiffs do not argue otherwise.

Instead, as noted above, Plaintiffs focus on their claims against Sullivan Ward and Trustees for breach of fiduciary duty under 29 U.S .C. §§ 1132(a)(2) and 1109, arguing that these statutory provisions allow for money damages and thereby preserve a right to a jury trial here. Plaintiffs' request

for relief is not legal simply because they label the request as one for money damages, traditionally a form of legal relief. "[T]he constitutional right to trial by jury cannot be made to depend upon the choice of words used in the pleadings." *See Dairy Queen, Inc. v. Wood,* 369 U.S. 469, 477–78, 82 S.Ct. 894, 8 L.Ed.2d 44 (1962). Looking beyond labels then, the Court finds that Plaintiffs' request for damages is restitutionary and therefore sounds in equity. *See Crews,* 788 F.2d at 338 ("Historically, an action for restitution seeks an equitable remedy for which there is no Seventh Amendment right to a jury trial."); *see also Terry,* 494 U.S. at 570–71 (noting an exception to the general rule that a request for damages is by nature legal, where the request sounds in restitution). Using a claim for breach of fiduciary duty as one vehicle, Plaintiffs seek the return of the $36 million contingency fee to which Sullivan Ward was entitled under its agreement with the Fund. As against Sullivan Ward, such relief is quintessentially restitutionary and therefore equitable in nature. *See also Vargas v. Child Dev. Council of Franklin County, Inc.,* 269 F.Supp.2d 954, 957 (S.D.Ohio 2003) ("[I]t is also well settled that there is no right to a jury trial on ERISA claims for recovery of benefits or breach of fiduciary duty." (citing *Sprague v. Gen. Motors Corp.,* 133 F.3d 388, 406 (6th Cir.1998) (en banc)).

The Supreme Court's decision in *Great–West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204, 122 S.Ct. 708, 151 L.Ed.2d 635 (2002), does not change matters. Though *Great–West* did not involve the Seventh Amendment, some courts have read broadly the Court's discussion there of restitution, and have essentially concluded that a remedy is "legal," for purposes of the Seventh Amendment, anytime a plaintiff seeks damages rather than return of specific money or property in the defendant's possession. *See, e.g., Pereira v. Farace,* 413 F.3d 330 (2d Cir.2005) (not an ERISA case); *Bona v. Barasch,* No. 01 Civ. 2289, 2003 WL 1395932 (S.D.N.Y. Mar. 20, 2003) (ERISA case). The Court declines to apply this broad reading of *Great–West* to conclude that Plaintiffs are seeking legal relief simply because they seek damages from Sullivan Ward. Other courts have similarly declined to read *Great–West* broadly, and the Court finds their discussions persuasive. *See, e.g., In re YRC Worldwide, Inc. ERISA Litig.,* No. 09–2593, 2010 WL 4920919 (D.Kan. Nov.29, 2010); *George v. Kraft Foods Global, Inc.,* No. 07 C 1713, 2008 WL 780629 (N.D.Ill. Mar.20, 2008); *Abbott v. Lockheed Martin Corp.,* No. 06–cv–0701, 2007 WL 2316481, *2 (S.D.Ill. Aug.13, 2007); *Ellis,* 2007 WL 1032367. As these courts recognize, *Great–West* did not involve the Seventh Amendment, did not involve 29 U.S.C. 1132(a)(2) (claims for breach of fiduciary duty under § 1109), and did not involve a claim against a trustee or fiduciary who had breached its duties to participants or beneficiaries. Rather, "in *Great–West,* the Court was considering a claim more akin to a breach of contract action, arising from a contractual duty instead of a fiduciary duty, and the Court unremarkably determined that such a claim was a legal claim, distinguished from equitable claims that ordinarily involved imposition of constructive trusts." *In re YRC,* 2010 WL 4920919, at *4. Here, by contrast, there are no contract claims and Plaintiffs are claiming that Sullivan Ward breached its fiduciary duties in violation of § 1109. [9]

9 And even applying *Great–West's* discussion of restitution here does not yield a different result. The Court recognized that "not all relief falling under the rubric of restitution is available in equity," noting that restitution is available in actions in both equity *and* law. 534 U.S. at 213. "For restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession ." *Id.* at 214 (footnote omitted). Here, Plaintiffs seek to restore to the Fund "particular funds or property," i.e., the allegedly excessive portion of the contingency fee, currently in Sullivan Ward's constructive possession. This is restitutionary relief of an equitable nature. Thus, even applying *Great–West's* discussion of restitution to the Seventh Amendment analysis does not lead to the conclusion that Plaintiffs' claims against Sullivan Ward for breach of fiduciary duty are legal in nature.

***17** Equitable too are Plaintiffs' claims against Trustees for various alleged breaches of their fiduciary duties. In addition to injunctive relief (clearly equitable in nature), Plaintiffs seek to hold Trustees "responsible [for] mak[ing] good to the Fund all losses to the Fund resulting from" the Trustees' breach of their fiduciary duties to the Fund. SAC ¶ 306. In their briefing, they characterize this claim as one for damages for which a jury trial is preserved. While it may be difficult to characterize this claim as one for restitution, since Plaintiffs do not seek the return of identifiable money or property currently in Trustees' possession, that does not mean Plaintiffs' request is legal in nature. Damages at law are not obtainable in a claim for breach of fiduciary duty. *See Termini v. Life Ins. Co. of N. Am.,* 474 F.Supp.2d 775, 778 (E.D.Va.2007) ("[Claims for breach of fiduciary duty] are examined under trust law principles

and fiduciary standards, which are within the exclusive jurisdiction of equity courts."). "[T]he traditional rule is that virtually all remedies against a fiduciary are equitable in nature.... 'Except as stated in section 198 [of the Restatement (Second) of Trusts [10]], the remedies of the beneficiary against the trustee are exclusively equitable.' " *Ellis,* 2007 WL 1032367, at *2 (quoting Restatement (Second) of Trusts § 197 (1959)).

10 The sole exception was that the courts of law could enforce the duty of the trustee to pay money or deliver property "immediately and unconditionally to the beneficiary." Restatement (Second) of Trusts § 198. That exception is not applicable here since any recovery will go to the Fund itself, not to Plaintiffs personally.

Among these exclusively equitable remedies include actions to redress a breach of trust by payment into the trust estate of any loss resulting from the breach of trust. *Id.* This type of remedy should not be confused with a legal remedy for money damages. Such actions are not considered suits at law for the recovery of damages, but rather equitable actions to "surcharge" the trustee for breach of its fiduciary duty. *Id.* "A surcharge is an imposition of personal liability on a fiduciary for wilful or negligent misconduct in the administration of his fiduciary duty. Typically, surcharges are levied when trustees breach their fiduciary duties. In rarer instances, surcharges are assessed against individuals who hold positions of trust similar to a trustee ." *F.J. Hanshaw Enters., Inc. v. Emerald River Dev., Inc.,* 244 F.3d 1128, 1142 (9th Cir.2001) (internal citations and quotation marks omitted). This is precisely what Plaintiffs seek here. Therefore, any claim for money Plaintiffs make against Trustees for breach of their fiduciary duties is not one at law, but rather one in equity.

In *George v. Kraft Foods Global, Inc.,* a case very similar to this one, the district court struck the plaintiffs' jury demand after concluding that a claim under ERISA for breach of fiduciary duty was equitable. 2008 WL 780629. Like Plaintiffs here, the plaintiffs in *George* alleged that fiduciaries of an ERISA plan had breached their fiduciary duties by paying service providers excessive and unreasonable fees and expenses. The plaintiffs sought to have the defendants "restore to the Plan the losses it experienced as a direct result of the Defendants' breaches of fiduciary duty and [to hold the defendant] liable for any other available and appropriate equitable relief." *Id.* at *1 (alteration in original). In support of their demand for a jury trial, Plaintiffs claimed that their demand that the defendants "restore to the Plan the losses it experienced" was a request for a legal remedy, for which a jury trial is preserved under the Seventh Amendment. The court disagreed, relying on established precedent that claims under ERISA—including breach of fiduciary duty claims under 29 U.S.C. §§ 1132(a)(2) and 1109—permit only equitable relief. *Id.* at *2. Seeking to characterize their claim as one for "legal restitution," and relying on *Great West's* discussion of the dichotomy between legal and equitable restitution, the plaintiffs tried to describe their claim as one for legal restitution since there was no money the defendants were currently possessing as a result of the breach—the money had already been paid to the service provider. *Id.* at *3. The court disagreed that *Great–West* fundamentally changed the nature of the remedy sought in a claim for breach of fiduciary duty. *Id.* at *3–5. The court's reasoning is persuasive and is followed here. The Court will grant Sullivan Ward's motion to strike Plaintiffs jury demand.

CONCLUSION AND ORDER

***18** The Court will deny the motions to strike and cross-motions for summary judgment, and will grant Sullivan Ward's motion to strike Plaintiffs' jury demand. The case will proceed to a bench trial, which the Court will schedule forthwith.

WHEREFORE, it is hereby **ORDERED** that the parties' motions to strike (docket nos. 377, 381, 393, 395, 397, 398, 400, 401, 402, & 405) are **DENIED.**

IT IS FURTHER ORDERED THAT the parties' cross-motions for summary judgment (docket nos. 352, 361, 370, 373, & 374) are **DENIED.**

IT IS FURTHER ORDERED THAT Sullivan Ward's motion to strike Plaintiffs' jury demand (docket no. 331) is **GRANTED.**

SO ORDERED.

All Citations

Not Reported in F.Supp.2d, 2011 WL 1256657

2011 WL 1256657

End of Document

2021 WL 5546708
Only the Westlaw citation is currently available.
United States District Court, W.D. Michigan, Southern Division.

Coryne HILLMAN, Plaintiff,
v.
ATONNE GROUP, LLC Employee Benefit Plan, et al., Defendants.

No. 1:19-cv-1097
|
Signed 03/05/2021

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ORDER DENYING DEFENDANT ADMINISTRATION SYSTEMS RESEARCH CORPORATION INTERNATIONAL'S MOTION TO DISMISS

Paul L. Maloney, United States District Judge

***1** Plaintiff filed this lawsuit under the Employee Retirement Income Security Act (ERISA) following the denial of health care benefits. Defendant Administration Systems Research Corporation International (ASR) filed a motion to dismiss. (ECF No. 13.) The Court has reviewed the submissions by the parties and will deny the motion.

I.

ARS filed a motion to dismiss under Rule 12(b)(6) and Rule 12(c). The legal standards for the two rules are the same. *Lindsay v. Yates*, 498 F.3d 434, 438 (6th Cir. 2007). Under the notice pleading requirements, a complaint must contain a short and plain statement of the claim showing how the pleader is entitled to relief. Fed. R. Civ. P. 8(a)(2); *see Thompson v. Bank of America, N.A.*, 773 F.3d 741, 750 (6th Cir. 2014). The complaint need not contain detailed factual allegations, but it must include more than labels, conclusions, and formulaic recitations of the elements of a cause of action. *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007).

A defendant bringing a motion to dismiss for failure to state a claim under Rule 12(b)(6) tests whether a cognizable claim has been pled in the complaint. *Scheid v. Fanny Farmer Candy Shops, Inc.*, 859 F.2d 434, 436 (6th Cir. 1988). To survive a motion to dismiss, a plaintiff must allege facts sufficient to state a claim for relief that is "plausible on its face" and, when accepted as true, are sufficient to "raise a right to relief above the speculative level." *Mills v. Barnard*, 869 F.3d 473, 479 (6th Cir. 2017) (citation omitted). "A claim is plausible on its face if the 'plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.' " *Ctr. for Bio-Ethical Reform, Inc. v. Napolitano*, 648 F.3d 365, 369 (6th Cir. 2011) (quoting *Twombly*, 550 U.S. at 556).

II.

A.

The following facts are found in the complaint and must be accepted as true. Plaintiff obtained health insurance through her husband's employment at Defendant General Trends. (Compl. ¶ 14 PageID.3.) Defendant Atonne Group Benefits Plan (Defendant Plan) is the employee benefit plan. (*Id.* ¶ 2 PageID.1.) Either Defendant Atonne Group LLC or Defendant Atonne Group Inc. is the plan administrator. (*Id.* ¶¶ 3-4 PageID.1-2.) Defendant ASR is the claims administrator or claims administration designee. (*Id.* ¶ 17 PageID.3.)

Following a recommendation from her doctor, Plaintiff had breast reduction surgery as an attempt to alleviate back problems. (Compl. ¶15 PageID.3.) Plaintiff submitted her medical bills from the surgery to Defendant Plan and the claims were rejected. (*Id.* ¶ 17 PageID.3.) "These claims rejections were presumably done through the claims administration designee, Defendant ASR Health, on behalf of the Plan Administrator[.]" (*Id.*) Throughout the complaint, Plaintiff refers to decisions made the Plan Administrator and or its designee. (*Id.* ¶ 21 PageID.4; ¶ 23 PageID.4; ¶ 24 PageID.5; ¶ 25 PageID.5; ¶ 27 PageID.6.)

B.

ASR argues that it cannot be held liable in this ERISA action because, under the terms of the Employee Benefits Plan, it is not a fiduciary.

***2** ASR asserts that its relationship with the Atonne entities and with Plaintiff is identified in the Employee Benefits Plan. ASR asserts that Plaintiff, in her complaint, refers to and relies on the Employee Benefits Plan, which allows the Court to consider the document. Ordinarily, a court resolving a Rule 12 motion considers only the pleading and cannot consider matters outside the pleadings. *See* Fed. R. Civ. P. 12(d). A court may consider, however, certain exhibits attached to a complaint or to the defendant's motion to dismiss "so long as they are referred to in the complaint and are central to the claims contained therein[.]" *Rondigo, LLC v. Twp. of Richmond*, 641 F.3d 673, 681 (6th Cir. 2011) (citation omitted). The Employee Benefits Plan, which ARS attaches to its motion to dismiss, states that ASR Health Benefits is the claim administrator and further states that the "Claim Administrator is not a fiduciary." [1] (ECF No. 14-1 PageID.92.)

1 ASR also attaches to its motion the Administration Agreement between ASR and Atonne Group LLC. (ECF No. 14-2.) ASR contends the Court can consider the Administration Agreement because that agreement is referred to in the Employee Benefit Plan. For this motion, the Court will exclude from consideration the Administration Agreement. The Administration Agreement is not referred to in the pleadings and is not central to Plaintiff's claim.

ERISA "provides that not only the persons named as fiduciaries by a benefit plan, see 29 U.S.C. § 1102(a), but also anyone else who exercises discretionary control or authority over the plan's management, administration, or assets, see § 1002(21)(A), is an ERISA 'fiduciary.' " *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993). As the statute defines the term, fiduciaries can be held liable for breaches of the duties outlined by the statute. *Id.* at 251-52. The Supreme Court explained that the term "fiduciary" in ERISA is defined "not in terms of formal trusteeship, but in *functional* terms of control and authority over the plan, see 29 U.S.C. § 1002(21)(A), thus expanding the universe of persons subject to fiduciary duties—and damages—under § 409(a)." *Id.* at 262 (emphasis in original). Using this approach, whether a defendant constitutes an ERISA fiduciary depends on whether that defendant "performs one of the described functions[.]" *Hamilton v. Carell*, 243 F.3d 992, 998 (6th Cir. 2001); *see Hunter v. Calber Sys., Inc.*, 220 F.3d 702, 718 (6th Cir. 2000) ("Thus, we must examine the conduct at issue to determine whether it constitutes 'management' or 'administration' of the plan, giving rise to fiduciary concerns, ...").

The Court will deny ASR's motion to dismiss. Taking the factual allegations in the complaint as true, and construing them in favor of Plaintiff, Plaintiff pleads that ASR denied her claim or at least was involved in the decision to deny her claim. If true, ASR exercised discretionary control over the administration of the Employee Benefits Plan and can be held liable under ERISA. [2] ASR's reliance on the language of the Employee Benefits Plan does not resolve the dispute in its favor at this stage of the litigation. The test for a fiduciary is a functional one depending on the actions taken by the entity and not on the formal document describing the duties of the entity.

2 To his response, Plaintiff attached two exhibits. Because the Court resolves this matter by considering the pleadings only, the Court has not considered the exhibits attached to the response and excludes those exhibits for the purpose of this motion.

III.

Plaintiff has pled sufficient facts which, if true, would plausibly state an ERISA claim against Defendant ASR as a fiduciary.

Accordingly, the Court **DENIES** Defendant ASR's motion to dismiss. (ECF No. 13.)

IT IS SO ORDERED.

All Citations

Slip Copy, 2021 WL 5546708

End of Document

2020 WL 8299592
Only the Westlaw citation is currently available.
United States District Court, S.D. Texas, Houston Division.

GROUP 1 AUTOMOTIVE, INC., as Plan Administrator for the Group 1 Automotive, Inc. Comprehensive Health and Welfare Benefit Plan, Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY, Defendant.

Case No. 4:20-CV-1290
|
Signed 11/09/2020

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MEMORANDUM AND ORDER

NANCY F. ATLAS, SENIOR UNITED STATES DISTRICT JUDGE

***1** Before the Court is Defendant Aetna Life Insurance Company's ("Aetna's") Motion to Dismiss [Doc. # 27] ("Motion"). Plaintiff Group 1 Automotive, Inc., as Plan Administrator on behalf of the Group 1 Automotive, Inc. Comprehensive Health and Welfare Benefit Plan ("Group 1") has responded, [1] and Aetna has replied. [2] The Motion is ripe for decision. Based on the parties' briefing, pertinent matters of record, and relevant legal authorities, the Court **denies** Aetna's Motion.

1 Plaintiff's Response to Aetna's Motion to Dismiss and, in the Alternative, Motion for Leave to Amend Complaint [Doc. # 34] ("Response").

2 Aetna's Reply in Support of its Motion to Dismiss [Doc. # 35] ("Reply").

I. BACKGROUND

Group 1 operates an automotive retail business throughout the United States. [3] Group 1 is a Delaware corporation with its principal place of business in Houston, Texas. [4] Group 1 administers a self-funded health benefit plan for its employees under the Employee Retirement Income Security Act of 1974 ("ERISA"). [5] Aetna offers health insurance and third-party administration services for self-funded benefit plans. [6] Aetna is a Connecticut corporation with its principal place of business in Hartford, Connecticut. [7]

3 Complaint for Breach of Fiduciary Duty [Doc. # 1] ("Complaint") ¶ 1.

4 *Id.* ¶ 6.

5 *Id.* ¶ 1.

6 *Id.* ¶ 11.

7 *Id.* ¶ 7.

Group 1 executed an Administrative Service Agreement ("ASA") with Aetna effective March 1, 2002 for administrative services related to Group 1's self-funded employee health benefit plan. [8] Aetna served as third-party administrator for Group 1's benefit plan until the end of 2015. [9] The ASA contained an indemnification provision stating that Aetna would indemnify and hold harmless Group 1 for any loss caused by Aetna's willful misconduct, criminal conduct, breach of the ASA, fraud, or breach of fiduciary responsibilities (the "Indemnification Clause"). [10] The Indemnification Clause required that Group 1 assert any claims for indemnification against Aetna within two years of termination of the ASA. [11]

8 *Id.* ¶ 2; *see also* Administrative Services Agreement [Doc. # 1-2] ("ASA").

9 Complaint ¶ 11.

10 ASA § 13.

11 *Id.*

A few years after terminating its contract with Aetna, Group 1 raised concerns that Aetna breached the ASA by granting certain benefit claims that should have been denied. [12] In 2018, Group 1 commenced an arbitration against Aetna in

Connecticut, as required by an arbitration clause in the ASA (the "Connecticut Arbitration"). [13] Group 1 asserted two claims in that proceeding, a claim for breach of fiduciary duty under ERISA and a claim for breach of the ASA. [14]

12 Complaint ¶ 4.

13 Declaration of Theodore Tucci in Support of Defendant's Motion to Dismiss [Doc. # 27-3] ("Tucci Decl.") ¶ 5; *see also* Demand for Arbitration [Doc. # 7-3].

14 Tucci Decl. ¶ 5; Group 1's Third Amended Complaint in Arbitration [Doc. # 7-4] ¶¶ 38-48.

Aetna moved to dismiss Group 1's claims as untimely, and in an interim ruling on Aetna's motion to dismiss (the "Interim Ruling"), the arbitrator found that Group 1's claim for breach of fiduciary duty was in the nature of a claim for indemnity and therefore subject to the Indemnification Clause and certain other provisions in the ASA, but did not reach the issue of whether Group 1's breach of fiduciary duty claim was subject to the Indemnification Clause's two-year limitations period. [15] The arbitrator granted Group 1 leave to amend its complaint to more fully develop its claim that Aetna concealed its breach thereby tolling the statute of limitations. [16]

15 Interim Ruling re: Motion to Dismiss, *Group 1 Automotive v. Aetna Life Insurance*, American Arbitration Association No. 01-18-0003-4540 (October 1, 2019) [Doc. # 27-3] ("Interim Ruling"), at 3-5.

16 *Id.* at 5-6. The arbitrator set forth 6 subjects that Group 1 was to address in its Third Amended Complaint to clarify what claims it intended to assert. *Id.* at 7-8.

***2** Group 1 repleaded its breach of fiduciary duty claim under ERISA as Count One in a Third Amended Complaint, and Aetna re-urged its motion to dismiss. [17] In a March 23, 2020 ruling (the "Final Ruling"), the arbitrator held that Group 1's ERISA claim was not arbitrable and dismissed that claim without prejudice. [18] In the two succeeding sections of the Final Ruling, which were entitled "The ASA Indemnification Provision (Count Two)" and "Is Group 1's Non-ERISA Contract Claim Time-Barred (Count Two)," the arbitrator reaffirmed the interim conclusion that the ASA Indemnification Clause applied to the contract claim [19] and then held that claim was time-barred. [20] The arbitrator did not determine in the Final Ruling or elsewhere whether Group 1's breach of fiduciary duty claim (Count One) was time-barred.

17 Group 1 Pleaded its breach of contract claim as Count Two in the new complaint. Count One was a claim for breach of fiduciary duty under 29 U.S.C. § 1132(a)(2). Ruling on Respondent's Renewed Motion to Dismiss, *Group 1 Automotive v. Aetna Life Insurance*, American Arbitration Association No. 01-18-0003-4540 (March 23, 2020) [Doc. # 27-3] ("Final Ruling"), at 1.

18 Final Ruling at 2-4.

19 Final Ruling at 4-7.

20 *Id.* at 7-8.

Aetna filed a petition in the United States District Court for the District of Connecticut for confirmation of the arbitral award on April 13, 2020. [21] On July 9, 2020, the District Court entered final judgment for Aetna, confirming the Final Ruling. [22]

21 Tucci Decl. ¶ 10; Petition to Confirm Arbitral Award [Doc. # 7-7].

22 Tucci Decl. ¶ 11; Judgment, *Aetna Life Insurance Company v. Group 1 Automotive, Inc., Individually and as Plan Administrator for the Group 1 Comprehensive Health and Welfare Benefit Plan*, No. 3:20-CV-00494-RNC, Doc. # 22 (July 9, 2020) [Doc. # 27-3].

On April 10, 2020, Group 1 filed this lawsuit asserting its ERISA claim. [23] On May 12, 2020, Aetna moved to transfer this case to the District of Connecticut under 28 U.S.C. § 1404(a). [24] On July 15, 2020, the Court denied Aetna's motion to transfer. [25] On August 14, 2020, Aetna moved to dismiss Group 1's Complaint pursuant to Rules 8 and 12(b)(6) of the Federal Rules of Civil Procedure. [26]

23 *See* Complaint.

24 Aetna's Motion to Transfer Venue Under 28 U.S.C. § 1404(a) [Doc. # 7].

25 July 15, 2020 Memorandum and Order [Doc. # 24].

26 Motion at 1.

II. LEGAL STANDARD

A motion to dismiss under Rule 12(b)(6) is viewed with disfavor and is rarely granted. *Turner v. Pleasant*, 663 F.3d 770, 775 (5th Cir. 2011) (citing *Harrington v. State Farm Fire & Cas. Co.*, 563 F.3d 141, 147 (5th Cir. 2009)). The complaint must be liberally construed in favor of the plaintiff, and all facts pleaded in the complaint must be taken as true. *Harrington*, 563 F.3d at 147. The complaint must, however, contain sufficient factual allegations, as opposed to legal conclusions, to state a claim for relief that is "plausible on its face." *See Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009); *Patrick v. Wal-Mart, Inc.*, 681 F.3d 614, 617 (5th Cir. 2012).

When there are well-pleaded factual allegations, a court should presume they are true, even if doubtful, and then determine whether they plausibly give rise to an entitlement to relief. *Iqbal*, 556 U.S. at 679. Rule 8 "generally requires only a plausible 'short and plain' statement of the plaintiff's claim, not an exposition of his legal argument." *Skinner v. Switzer*, 562 U.S. 521, 530 (2011). Importantly, regardless of how well-pleaded the factual allegations may be, they must demonstrate that the plaintiff is entitled to relief under a valid legal theory. *See Neitzke v. Williams*, 490 U.S. 319, 327 (1989); *McCormick v. Stalder*, 105 F.3d 1059, 1061 (5th Cir. 1997).

III. DISCUSSION

Aetna argues that the Complaint should be dismissed because Group 1 has failed to plead specific facts supporting the elements of a claim for breach of fiduciary duty under ERISA. Aetna further argues that, even if the Complaint does state a claim for breach of fiduciary duty, the Complaint should be dismissed because the collateral estoppel effect of the Connecticut Arbitration bars Group 1's claims as untimely under the ASA's limitations period. Group 1 argues all of Aetna's requested relief is unwarranted.

A. Allegations Supporting ERISA Fiduciary Breach Claim

***3** ERISA provides that "[a]ny person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach ...." 29 U.S.C. § 1109. To state a claim for breach of fiduciary duty under ERISA, a plaintiff must plead facts showing that (1) the defendant was a plan fiduciary;[27] (2) the defendant breached its fiduciary duty; and (3) the breach resulted in harm to the plaintiff. *See Kopp v. Klein*, 894 F.3d 214, 219 (5th Cir. 2018); *McDonald v. Provident Indem. Life Ins. Co.*, 60 F.3d 234, 237 (5th Cir. 1995), *cert. denied*, 516 U.S. 1174 (1996).

27 Aetna also contests Group 1's claim that Aetna was a fiduciary with respect to Group 1's benefit plan. *See* Motion at 12 n.60. However, for purposes of this Motion only, Aetna does not challenge the Complaint's sufficiency with respect to allegations of fiduciary status. *Id.*

Aetna argues that Group 1's Complaint does not allege facts sufficient to plausibly establish the elements of breach or causation required for an ERISA fiduciary duty claim because the Complaint does not detail "how Aetna's claims adjudication fell below an objective standard governing prudent claims processors" under the ASA or ERISA, and does not identify "any flaws in Aetna's claims system, policies or procedures (or any other Aetna conduct) that led to improper claim adjudication."[28] Aetna contends the Complaint contains only conclusory allegations that are insufficient to put Aetna on notice of the policies and procedures Group 1 claims were inadequate.[29]

28 Motion at 2, 13.

29 *Id.*

1. Breach

Fiduciaries of ERISA plans must discharge their duties "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." 29 U.S.C. § 1104(a)(1)(B). "In short, prudence requires fiduciaries to consider the totality of the circumstances." *Schweitzer v. Investment Committee of Phillips 66 Savings Plan*, 960 F.3d 190, 196 (5th Cir. 2020) (citing *Bussian v. RJR Nabisco, Inc.*, 223 F.3d 286, 299 (5th Cir. 2000)).

"The prudence standard normally focuses on the fiduciary's conduct in making [the decisions at issue], and not on the results." *Main v. Am. Airlines, Inc.*, 248 F. Supp. 3d 786, 793 (N.D. Tex. 2017) (citing *Pension Benefits Guar. Corp. ex rel. St. Vincent Catholic Med. Ctrs. Ret. Plan v. Morgan Stanley Inv. Mgmt. Inc.*, 712 F.3d 705, 716 (2d Cir. 2013)); *see also Donovan v. Cunningham*, 716 F.2d 1455, 1467 (5th Cir. 1983), *cert. denied*, 467 U.S. 1251 (1984). ("[ERISA's] test of prudence ... is one of conduct, and not a test of the result ..."); *Metzler v. Graham*, 112 F.3d 207, 209 (5th Cir. 1997) ("Prudence is evaluated at the time of the [allegedly imprudent conduct] without the benefit of hindsight.").

"[A plan administrator], therefore, despite his own lack of skill and experience in claims administration, will be held to the standard of a skilled administrator." *American Fed. of Unions Loc. 102 v. Equitable Life Assur. Soc.*, 647 F. Supp. 947, 952 (M.D. La. 1985), *aff'd in part, rev'd in part*, 841 F.2d 658 (5th Cir. 1988). "It is quite obvious that no prudent administrator would approve claims payments for non-covered claims ...." *Id.*

The Court concludes that the Complaint contains factual allegations, though sparse, sufficient to state a plausible claim for breach of ERISA's fiduciary duty. The Complaint identifies the applicable fiduciary duty owed by Aetna, specifically, the duty of prudence mandated by § 1104(a)(1)(B). [30] The Complaint contains allegations about how Aetna allegedly breached these duties. Specifically, Group 1's Complaint identifies well-recognized characteristics of potentially fraudulent or unjustified claims, and alleges that Aetna failed to account for one or more of these characteristics that appeared in many claims Aetna paid on Group 1's behalf. [31] Group 1 alleges these red flags should have caused Aetna to deny, or at least investigate those claims. [32] Group 1 need not, at this preliminary stage, identify the specific Aetna policies and procedures (or lack thereof) that led to its allegedly improper approval of questionable claims. [33] Group 1's Complaint contains sufficient factual allegations to state a plausible claim giving notice to Aetna how Group 1 contends Aetna breached ERISA fiduciary duties. Additional detail will have to be provided by Group 1 in the course of initial disclosures and discovery.

30 Complaint ¶ 29 (citing 29 U.S.C. § 1104(a)(1)(B)); *see also id.* ¶ 39 (same).

31 *Id.* ¶¶ 30-34.

32 *Id.*

33 "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 663 (citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007)).

Aetna's attempt to analogize the case at bar to claims involving imprudent plan asset diversification is unpersuasive. Unlike the claims in this case, failure-to-diversify-investment claims are grounded on plan documents and periodic reports available for plan participants' review.

Aetna's reliance on *Rosenblatt v. United Way of Greater Houston*, 590 F. Supp. 2d 863 (S.D. Tex. 2008), *aff'd*, 607 F.3d 413 (5th Cir. 2010), also is unavailing. There, the plaintiff failed to state a claim because he did not link alleged inaccuracies in benefit statements to defendants' behavior and failed to explain how defendants' conduct violated ERISA. 590 F. Supp. 2d at 876. Here, Group 1 alleges Aetna repeatedly allowed the payment of claims with specific characteristics Group 1 alleges are indicia of fraud, waste, or abuse, and that payment of those claims violated Aetna's fiduciary duties under ERISA.

2. Causation

***4** Aetna also argues that Group 1's Complaint lacks factual allegations that Aetna's alleged ERISA breach of fiduciary duty caused injury to Group 1 because the Complaint "fails to identify a single paid benefit claim that would not have otherwise been reimbursed as a covered benefit." [34] This argument is unpersuasive and does not justify dismissal of Group 1's claims at this pleading stage.

34 Motion at 16.

"To establish a claimed breach of fiduciary duty, an ERISA plaintiff must prove a breach of a fiduciary duty and a prima facie case of loss to the plan. 'Once the plaintiff has satisfied these burdens, the burden of persuasion shifts to the fiduciary to prove that the loss was not caused by ... the breach of duty.' " *McDonald*, 60 F.3d at 237 (quoting *Roth v. Sawyer–Cleator Lumber Co.*, 16 F.3d 915, 917 (8th Cir. 1994)).

Group 1 has alleged Aetna failed to adequately investigate and reject a wide variety of claims despite the files reflecting well recognized indicia of fraud, waste or abuse, and the wrongful payment of these claims caused substantial financial harm to Group 1's benefit plan. [35] No more is required at this preliminary stage.

35 Complaint ¶¶ 33-34.

Aetna also argues that because Group 1 has not pleaded facts about when the allegedly improper claims were submitted, processed or paid, Aetna has been deprived of asserting a defense under ERISA's statute of limitations. [36] Group 1 need not identify the specific claims at issue at the pleading stage. *Cf. U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009). [37] This result does not prevent Aetna from asserting a defense under the statute of limitations once the exact claims at issue are identified through discovery. Notably, Group 1 seeks recovery only for those claims falling within the applicable statute of limitations, once that period is determined by this Court. [38]

36 Motion at 16-17.

37 In *Grubbs*, the plaintiff alleged that a hospital had improperly billed Medicare and Medicaid for services not performed. 565 F.3d at 183. The Fifth Circuit reversed the district court's dismissal of plaintiff's claims, noting that "a plaintiff does not necessarily need the exact dollar amounts, billing numbers, or dates to prove to a preponderance that fraudulent bills were actually submitted" at trial. *Id.* at 190. The court then reasoned that to require such detail at the pleading stage was "significantly more than any federal pleading rule contemplates," including Rule 9(b)'s heightened standard for claims sounding in fraud *Id.*

38 *See* Response at 13-14 (citing 29 U.S.C. § 1113(1), (2)).

In sum, Group 1 has pleaded basic facts sufficient to overcome Aetna's Motion and has stated a claim for breach of fiduciary duties under ERISA. Group 1 need not specifically identify the allegedly fraudulent claims prior to discovery.

B. Collateral Effect of Arbitral Award

Group 1's Complaint before this Court asserts one claim, a cause of action for breach of fiduciary duties under ERISA. Aetna argues that even if the Court finds Group 1's Complaint contains factual allegations supporting a plausible claim for breach of fiduciary duty under ERISA, collateral estoppel requires the Complaint be dismissed. Aetna contends the District of Connecticut's judgment confirming the arbitral award estops Group 1 from disputing that its ERISA breach of fiduciary claims are subject to the two-year limitations period in the ASA's indemnification clause and that the claims asserted in this case are untimely under that clause. In response, Group 1 argues that collateral estoppel does not apply because the arbitrator only determined, with respect to the ERISA breach of fiduciary claim, that Group 1's claim was not arbitrable.

1. Collateral Estoppel Does Not Apply to the Issues Presented

***5** "Collateral estoppel is appropriate where four conditions are met: (i) The issue under consideration in a subsequent action must be identical to the issue litigated in a prior action; (ii) The issue must have been fully and vigorously litigated in the prior action; (iii) The issue must have been necessary to support the judgment in the prior case; and (iv) There must be no special circumstance that would render estoppel inappropriate or unfair." *Kariuki v. Tarango*, 709 F.3d 495, 506 (5th Cir. 2013) (cleaned up) (quoting *United States v. Shanbaum*, 10 F.3d 305, 311 (5th Cir. 1994)); *see also Stripling v. Jordan Production Co., LLC*, 234 F.3d 863, 868 (5th Cir. 2000). Judgments confirming arbitral awards "have the same force and effect, in all respects, as, and [are] subject to all the provisions of law relating to, a judgment in an action; and ... may be enforced as if ... rendered in an action in the court in which it is entered." 9 U.S.C. § 13.

Aetna argues that Group 1 is estopped from relitigating: (1) whether Group 1's claims are subject to the ASA Indemnification Clause; and (2) whether Group 1's claims are timely under that clause. Group 1 responds that the arbitrator did not hold that its ERISA breach of fiduciary duty claim was time-barred. Rather, Group 1 responds, the arbitrator concluded that the tribunal did not have authority under the parties' agreement to adjudicate the ERISA fiduciary duty claim. The Court agrees with Group 1. As noted, to justify collateral estoppel, an issue must have been "identical to the issue litigated" in the prior action, "fully and vigorously litigated in the prior action" and "necessary to support

the judgment." *Kariuki*, 709 F.3d at 506. None of these requirements is met here.

In the Interim Ruling, the arbitrator held that Group 1's ERISA fiduciary duty claim was subject to the Indemnification Clause generally,[39] but did not reach the issues of whether that clause shortened the statute of limitations or whether Group 1's fiduciary duty claim was untimely.[40] Because of a lack of clarity in the then-pending complaint, the arbitrator directed Group 1 to file a Third Amended Complaint that articulated its claims more precisely.[41] Group 1 repleaded and Aetna re-urged its motion to dismiss.

39 Interim Ruling at 3-4. The arbitrator determined that Group 1's breach of fiduciary duty claim was a claim for direct indemnity. *Id.* at 2-3 (citing *Amoco Oil Co. v. Liberty Auto Electric Co.*, 262 Conn. 142 (Conn. 2002) (explaining that there are two types of indemnity under Connecticut law: direct indemnification, for losses incurred as a result of damage to a plaintiff's property, and indirect indemnification, for losses incurred as the result of legal liability to a third party)). The arbitrator then concluded that the ASA's Indemnification Clause applied to claims for both direct and indirect indemnification. *Id.* at 3.

40 At that time, Group 1 was arguing that any statute of limitations had been tolled because Aetna concealed its breach, a theory it has since abandoned. *Id.* at 4. The arbitrator granted Group 1 leave to amend its complaint to "[s]pecifically plead the facts relied upon which constitute 'self-concealment' of Aetna's claimed breach of fiduciary duty and the date of discovery of the alleged breach." *Id.* at 8.

41 *Id.* at 7-8.

In the Final Ruling, directed to the Third Amended Complaint, the arbitrator held that Group 1's ERISA breach of fiduciary claim was equitable in nature and therefore not arbitrable under the ASA.[42] The arbitrator concluded by stating:

> Group 1's ERISA claim for breach of fiduciary duty, contained in Count One of the Third Amended Complaint (Claim) is not arbitrable. *Having reached this conclusion, the tribunal does not reach the other issues and arguments raised concerning the ERISA claim.* Count One is referred to a court of competent jurisdiction.[43]

***6** The arbitrator expressly declined to reach the issues Aetna now contends are precluded.[44] Specifically, the arbitrator did not decide in the Final Ruling whether the Indemnification Clause applied to Group 1's ERISA breach of fiduciary duty claim or whether that claim was time-barred. Thus, for collateral estoppel purposes, the Final Ruling did not decide the questions now presented to this Court.

42 Final Ruling at 4.

43 *Id.* at 9 (emphasis added). To reach this conclusion, the arbitrator examined the nature of Group 1's ERISA claim and found that the "claim seeks compensation for a loss to the trust resulting from a trustee's breach of duty, which is a surcharge, not money damages, and is not a type of relief available in a court of law." *Id.* at 3 (citing *Amara v. Cigna Corp.*, 925 F. Supp. 2d 242, 255 (D. Conn. 2012), *aff'd*, 775 F.3d 510 (2d Cir. 2014)). The arbitrator surveyed case law on the restoration of plan losses, noting that "[t]he overwhelming number of [c]ourts that have considered whether a claim for restoration of plan losses or funds against a fiduciary seeks an equitable or legal remedy have determined that such a claim is equitable in nature." *Id.* at 4.

44 *See* Final Award at 9.

The Final Ruling was the only arbitral ruling confirmed by the District of Connecticut.[45] The arbitrator's Final Ruling did not adopt the observations in the Interim Ruling regarding the applicability of the ASA's Indemnification Clause to the fiduciary duty breach claim. Thus, the Interim Ruling's conclusions were not fully litigated, as required for collateral estoppel.

45 Aetna did not seek review of the Interim Ruling in its petition to confirm the arbitral award. *See* Petition to Confirm Arbitration Award [Doc. # 7-7]; Judgment, *Aetna Life Insurance Company*

v. Group 1 Automotive, Inc., Individually and as Plan Administrator for the Group 1 Comprehensive Health and Welfare Benefit Plan, No. 3:20-CV-00494-RNC, Doc. # 22 (July 9, 2020) [Doc. # 27-3].

The Final Ruling's analysis of the applicability of the Indemnification Clause refers solely to Group 1's breach of contract claim (Count Two).[46] That discussion appears in a section of the Final Ruling completely distinct from the arbitrator's analysis concluding that Group 1's ERISA claim (Count One) was not arbitrable.[47] Moreover, the arbitrator's interim finding (directed to a complaint that was superseded) that the fiduciary breach claim amounted to a claim for indemnification was in no way necessary to the final determination that the claim was not arbitrable.[48]

46 This analysis is in a section of the Final Ruling entitled "The ASA Indemnification Provision (Count Two)." Final Ruling at 4.

47 Final Ruling at 2-4. This conclusion appears in the first substantive section of the Final Ruling entitled "Is the ERISA Claim Arbitrable? (Count One)." This section of the Final Ruling concludes simply: "Because Group 1's claim for breach of fiduciary duty seeks equitable relief, it is not arbitrable under the parties' agreement." Final Ruling at 4.

48 Aetna points out that the Final Ruling included the statement, "[i]n its interim ruling on the earlier Motion to Dismiss, the tribunal ruled that the ASA's indemnification provision in Section 13 applied to Group 1's claims for breach of fiduciary duty and breach of contract." Final Ruling at 4. The comment was merely an introductory statement to the section of the Final Ruling analyzing the effect of the ASA's Indemnification Clause on Group 1's contract claim. Notably, the arbitrator did not adopt in the Final Ruling her interim conclusion regarding the ASA's application to the ERISA breach of fiduciary duty claim. The quoted statement in the Final Ruling thus is immaterial to the issue of collateral estoppel because it was not necessary to the arbitrator's conclusion that the ERISA claim was not arbitrable and her declining to decide other issues the parties raised concerning the ERISA claim. *Id.* at 4, 9.

***7** Aetna has failed to establish that any of the elements justifying collateral estoppel have been met. This Court is not precluded from consideration of whether the two-year limitations period in the ASA's Indemnification Clause applies to Group 1's ERISA breach of fiduciary duty claim or whether that claim is untimely.[49]

49 *See Jones v. Hartford Life & Acc. Ins. Co.*, No. 2:16-CV-316, 2016 WL 5887601, at *2 (E.D. Tex. Oct. 7, 2016) ("[T]he reasonableness of a contractual limitations period is properly considered by courts at the motion-to-dismiss stage.") (citing *Heimeshoff v. Hartford Life and Acc. Ins. Co.*, 571 U.S. 99, 108-09 (2013)).

2. Applicability of the ASA's Limitations Period

Aetna argues that the two-year limitations period in the ASA's Indemnification Clause, rather than the longer limitations period provided for by statute, governs Group 1's claims here. In response, Group 1 argues that controlling Fifth Circuit authority prevents parties from contractually shortening the statute of limitations for ERISA breach of fiduciary duty claims. The Court concludes that even if Group 1's ERISA breach of fiduciary duty claim was subject to the Indemnification Clause, the clause's two-year limitations period does not apply to Group 1's claim.

"[I]n the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than that prescribed in the general statute of limitations, provided that the shorter period itself shall be a reasonable period." *Order of United Comm. Travelers of Am. v. Wolfe*, 331 U.S. 586, 608 (1947). "We must give effect to the [ERISA] Plan's limitations provision unless we determine either that the period is unreasonably short, or that a 'controlling statute' prevents the limitations provision from taking effect." *Heimeshoff*, 571 U.S. at 109 (citing *id.*).

The Indemnification Clause provides that Aetna's obligation thereunder "shall terminate upon the expiration of this Agreement, except as to any matter concerning which a claim has been asserted by notice to the other party at the time of such expiration or within two (2) years thereafter."[50] In contrast, ERISA's statute of limitations for breach of fiduciary duty states:

> No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of—
>
> (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or
>
> (2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;
>
> except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

29 U.S.C. § 1113. ERISA also provides that "any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy." 29 U.S.C. § 1110(a).

50 ASA § 13.

In *Heimeshoff*, the Supreme Court held that a contractual limitations period in an ERISA disability benefits plan was enforceable. 571 U.S. at 104. That case, however, was a claim for plan benefits brought pursuant to 29 U.S.C. § 1132(a)(1)(B), which "does not specify a statute of limitations," and thus did not resolve whether statutory limitations periods for other ERISA violations, such as 29 U.S.C. §§ 1110 and 1113, are "controlling statutes" that supplant contractual limitations periods. *Id.* at 105.

***8** The Fifth Circuit, in *Kramer v. Smith Barney*, 80 F.3d 1080, 1085 (5th Cir. 1996), applied §§ 1110 and 1113 to facts similar to the case at bar. The Circuit held that those statutes voided a contract provision purporting to shorten the limitations period for ERISA claims. *Id.* The Circuit reasoned that "[t]o the extent the [contractual provision] renders ineligible for arbitration ERISA claims more than six years old which could otherwise be enforced on proof of fraud or concealment, it 'relieve[s] a fiduciary from ... liability.' " *Id.* (quoting 29 U.S.C. § 1110(a)).

Group 1 urges the Court to follow *Kramer* and find that §§ 1110 and 1113 are "controlling statutes" that prevent the Indemnification Clause's two-year limitation period from taking effect. Aetna attempts to distinguish *Kramer*, arguing that the holding was limited to agreements that would prevent tolling in cases of fraud or concealment. Aetna reasons that while the final clause of § 1113 creates an affirmative right to toll the statute of limitations in cases of fraud or concealment, subparts (1) and (2) of § 1113 are default limitation provisions which may contracted around.

The Court declines to adopt Aetna's tortured reading of § 1113. That section, including its two subparts, is one single sentence. There is no semantic or syntactic reason to treat the subparts differently than the rest of the section. No rule of construction supports Aetna's argument, and the Fifth Circuit did not make such a distinction in *Kramer*. [51] Even if subparts (1) and (2) could be treated differently from the remainder of § 1113, modifying them by contract in this case would "relieve a fiduciary from responsibility or liability" in violation of § 1110(a), thus placing this case within the ambit of *Kramer*'s admonition.

51 The Sixth Circuit also declined to treat the subparts of § 1113 differently than the rest of the Section in *Hewitt v. W. & S. Fin. Grp. Flexible Benefits Plan*, No. 17– 5862, 2018 WL 3064564 (6th Cir. 2018), discussed in more detail below.

Aetna next argues the Court should follow *Hewitt v. W. & S. Fin. Grp. Flexible Benefits Plan*, No. 17–5862, 2018 WL 3064564 (6th Cir. Apr. 18, 2018), an unpublished out-of-circuit decision in which the Sixth Circuit held that § 1113 was a default rule that could be shortened by contract. There, the plaintiff's breach of fiduciary duty claim was dismissed as untimely because it was brought after the six-month limitation period prescribed by his plan documents. *Id.* at *1. In a brief opinion, the Sixth Circuit affirmed the district court's dismissal because plaintiff/appellant, who was proceeding *pro se*, "ha[d] not identified any other potential 'controlling statute to the contrary' that would apply here.' " *Id.* at *2. The case does not cite to *Kramer* or § 1110 at all and is therefore of limited persuasive value. The Court concludes that even if Group 1's ERISA breach of fiduciary duty claim is subject to the ASA Indemnification Clause, the clause's two-year limitations period is void as to the extent it applied to Group 1's claim. [52] Aetna has not shown that Group 1's claim is untimely.

52 The Court does not reach the issue of whether Group 1's claim is subject to other portions of the Indemnification Clause.

IV. CONCLUSION

Group 1 has pled facts sufficient to state a claim for breach of fiduciary duty in violation of ERISA at this early stage of this litigation. The Connecticut Arbitration did not create an estoppel preventing this Court from reaching the issue of whether Group 1's ERISA breach of fiduciary duty claim was subject to the ASA Indemnification Clause's two-year limitations period. The Court concludes that the ASA's limitations period may not be applied to Group 1's ERISA breach of fiduciary duty claim and that claim is timely. It is therefore

***9 ORDERED** that Aetna's Motion to Dismiss [Doc. # 27] is **DENIED**. It is further

ORDERED that Group 1's Request for Leave to Amend [Doc. # 34] is **DENIED as moot**.

All Citations

Slip Copy, 2020 WL 8299592

End of Document

2021 WL 5537520
Only the Westlaw citation is currently available.
United States District Court, W.D.
Michigan, Southern Division.

Joshua GARCIA, et al., Plaintiffs,
v.
ALTICOR, INC., et al., Defendants.

No. 1:20-cv-1078
|
Signed 08/09/2021

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ORDER

Paul L. Maloney, United States District Judge

***1** This matter is before the Court on Defendants' motion to dismiss Plaintiffs' complaint (ECF No. 11). For the reasons to be explained, the motion will be denied.

I.

Defendants in this case are Alticor, Inc. ("Amway"),[1] the Board of Directors of Alticor (the "Board"), and the Fiduciary Committee of Alticor, Inc., (the "Committee"). The three named Plaintiffs (Joshua Garcia, Andrea Brandt, and Howard Hart) are now-retired Amway employees who participated in Amway's defined-contribution 401(k) plan (the "Plan") while they were employed by Amway.[2] The Plan is a defined-contribution plan, meaning participants' benefits are limited to the value of their investment accounts, which is determined by the market performance of employee and employer contributions, less expenses (Complaint, ECF No. 1 at ¶ 46). Plan participants may only invest in the investment options on the Plan's investment menu, but the Plan offers employees a range of options to invest in: during the relevant time period, the Plan has offered 22 to 23 investment options. The Plan has had at least a billion dollars in assets under management at all relevant times; on December 31, 2018, it had $1.19 billion dollars (*Id*. at ¶ 56).

1 Alticor is the corporate parent of the Amway family of businesses (Complaint, ECF No. 1 at ¶ 22). The Court uses the same naming convention that Plaintiffs use in their Complaint.

2 At the outset, the Court notes that these Plaintiffs are represented by the same counsel as plaintiffs in a similar lawsuit before this Court: *McNeilly v. Spectrum Health System*, No. 20-cv-870 (W.D. Mich.). The Court recently decided a motion to dismiss in that case on very similar grounds, and borrows much of the language in this opinion from the *McNeilly* opinion (*see* ECF No. 21 in *McNeilly*).

The Committee is the Plan's fiduciary and overseer: the Committee is responsible for selecting and monitoring the investments in the Plan (*Id*. at ¶ 33). The Committee has the authority to select, monitor, evaluate, and modify the Plan's investments, subject to the ultimate oversight and direction of Amway (*Id*. at ¶¶ 34, 55). The essence of the complaint is that the Committee did not give adequate attention to the investments in the Plan: Plaintiffs challenge the performance and/or fees of many of the investment options that the Plan has included since 2014 (*Id*. at ¶¶ 139-145).

A brief overview of the types of relevant fees is helpful. Investment-management fees are ongoing charges for managing the assets in the investment fund. These are often expressed in the form of an "expense ratio" which is a percentage deduction against a participant's total assets in their investment (*Id*. at ¶ 70). For example, a participant who invests $1,000 in a fund with an expense ratio of 0.10% will pay an annual fee of $1,000 × 0.001 = $1. Recordkeeping fees cover the "day-to-day" expenses of keeping the funds running (*Id*. at ¶ 63). One way to charge recordkeeping fees is via revenue sharing, which allows mutual funds to pay the administrator via the performance of the fund (*Id*.). For example, if an investment's expense ratio is 0.40%, the investment manager would "share" (pay) a portion of the 0.40% fee ("revenue") it collects with the plan's recordkeeper for the services that the recordkeeper provides.

***2** Plaintiffs allege that the Committee's failure to even attempt to provide better investments was a breach of the

fiduciary duties of loyalty and prudence (Count I). Plaintiffs also allege that Amway and the Board did not sufficiently monitor the Committee's decisions and actions (Count II). Plaintiffs have filed this action as a putative class action.

On March 3, 2021, Defendants filed a motion to dismiss for lack of subject-matter jurisdiction and for failure to state a claim upon which relief can be granted (ECF No. 11). Plaintiffs responded (ECF No. 14), Defendants replied (ECF No. 20), and the parties have each filed a document titled "Notice of Supplemental Authority" (ECF Nos. 16, 21). The Court has considered all of these pleadings and determined that oral argument on the motion to dismiss is unnecessary. *See* W.D. Mich. LCivR 7.2(d).

II.

When challenged by a motion filed under Rule 12(b)(1), the plaintiff bears the burden of establishing subject matter jurisdiction. *E.E.O.C. v. Hosanna-Tabor Evangelical Lutheran Church and School*, 597 F.3d 769, 776 (6th Cir. 2010), *rev'd on other grounds*, 565 U.S. 171 (2012). A motion to dismiss under Rule 12(b)(1) for lack of subject matter jurisdiction may take the form of a facial challenge, which tests the sufficiency of the pleading, or a factual challenge, which contests the factual predicate for jurisdiction. *See RMI Titanium Co. v. Westinghouse Elec. Corp.*, 78 F.3d 1125, 1134 (6th Cir. 1996) (quoting *Mortensen v. First Fed. Savings and Loan Ass'n*, 549 F.2d 884, 890-91 (3d Cir. 1977)). In a facial attack, the court accepts as true all the allegations in the complaint, similar to the standard for a Rule 12(b)(6) motion. *Ohio Nat'l Life Ins. Co. v. United States*, 922 F.2d 320, 325 (6th Cir. 1990). In a factual attack, the allegations in the complaint are not afforded a presumption of truthfulness and the district court weighs competing evidence to determine whether subject matter jurisdiction exists. *Id*.

A complaint must contain a short and plain statement of the claim showing how the pleader is entitled to relief. Fed. R. Civ. P. 8(a)(2). The complaint need not contain detailed factual allegations, but it must include more than labels, conclusions, and formulaic recitations of the elements of a cause of action. *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). A defendant bringing a motion to dismiss for failure to state a claim under Rule 12(b)(6) tests whether a cognizable claim has been pled in the complaint. *Scheid v. Fanny Farmer Candy Shops, Inc.*, 859 F.2d 434, 436 (6th Cir. 1988).

To survive a motion to dismiss under Rule 12(b)(6), the plaintiff must provide sufficient factual allegations that, if accepted as true, are sufficient to raise a right to relief above the speculative level, *Twombly*, 550 U.S. at 555, and the "claim to relief must be plausible on its face." *Id*. at 570. "A claim is plausible on its face if the 'plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.' " *Ctr. For Bio-Ethical Reform, Inc. v. Napolitano*, 648 F.3d 365, 369 (6th Cir. 2011) (quoting *Twombly*, 550 U.S. at 556). "The plausibility standard is not akin to a 'probability requirement,' but it asks for more than a sheer possibility that a defendant has acted unlawfully." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citation omitted). If plaintiffs do not "nudge[ ] their claims across the line from conceivable to plausible, their complaint must be dismissed." *Twombly*, 550 U.S. at 570.

***3** When considering a motion to dismiss, a court must accept as true all factual allegations, but need not accept any legal conclusions. *Ctr. For Bio-Ethical Reform*, 648 F.3d at 369. The Sixth Circuit has noted that courts "may no longer accept conclusory legal allegations that do not include specific facts necessary to establish the cause of action." *New Albany Tractor, Inc. v. Louisville Tractor, Inc.*, 650 F.3d 1046, 1050 (6th Cir. 2011). However, "a complaint attacked by a Rule 12(b)(6) motion to dismiss does not need detailed factual allegations"; rather, "it must assert sufficient facts to prove the defendant with 'fair notice of what the ... claim is and the grounds upon which it rests.' " *Rhodes v. R&L Carriers, Inc.*, 491 F. App'x 579, 582 (6th Cir. 2012) (quoting *Twombly*, 550 U.S. at 555).

III.

A.

Defendants argue that Plaintiff Howard Hart does not have standing. To satisfy the "irreducible constitutional minimum of standing" and demonstrate that a case or controversy exists, a plaintiff must establish that he has suffered: 1) a concrete and particularized, actual or imminent injury in fact; 2) a causal connection between the injury and the conduct complained of; and 3) a likelihood that the injury will be redressed by a favorable decision. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992).

Defendants' argument here is somewhat confusing, because they do not dispute that Hart has standing to bring a claim

based on excessive recordkeeping fees (*see* Reply Brief, ECF No. 20 at PageID.1354 n.20), instead arguing that he cannot bring a claim based on selection of challenged funds. But those are both arguments in Count I of Plaintiffs' complaint. The Court declines to split Plaintiffs' causes of action at this stage. Given Defendants' concession that Hart may have been injured by excessive fees, the Court concludes that Hart has satisfied the requirements of Article III because he has alleged actual injury to his Plan accounts. This injury is fairly traceable to Defendants' conduct, a causal connection between Defendants' alleged conduct and Hart's losses exists, and Hart has demonstrated a likelihood that his injuries will be redressed by a favorable judgment. Thus, the Court will deny the portion of the motion to dismiss based on subject-matter jurisdiction.

B.

That brings the Court to the merits of Plaintiffs' claims. At the outset, the Court rejects Defendants' argument that because Plaintiffs have retained counsel that have filed factually similar cases, their allegations are so generic that they cannot survive a motion to dismiss. There is no rule against hiring counsel that specialize in one cause of action or type of lawsuit, and the Court declines to dismiss the complaint on this ground alone.

The Court will first consider the allegation that the Committee breached the duty of prudence. Under 29 U.S.C. § 1104(a)(1),

> [A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and-- ... (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;....

Thus, ERISA requires the fiduciary of a pension plan to act prudently in managing the plan's assets. *Pfeil v. State Street Bank and Trust Co.*, 806 F.3d 377, 383 (6th Cir. 2015). "The test for determining whether a fiduciary has satisfied his duty of prudence is whether the individual trustees, at the time they were engaged in the challenged transactions, employed the appropriate methods to investigate the merits of the investment and to structure the investment." *Id*. at 384 (quoting *Hunter v. Caliber Sys., Inc.*, 220 F.3d 702, 723 (6th Cir. 2000) (quotation marks omitted)). This test is one of conduct, not of results, and a plaintiff must plausibly allege actions that were objectively unreasonable. *Ellis v. Fidelity Mgmt. Trust Co.*, 883 F.3d 1, 10 (1st Cir. 2018); *see also Davis v. Magna International*, No. 20-11060, 2021 WL 1212579, at *6 (E.D. Mich. Mar. 31, 2021); *Miller v. AutoZone, Inc.*, No. 2:19-cv-2779, 2020 WL 6479564, at *3 (W.D. Tenn. Sept. 18, 2020).

***4** Notably, "ERISA plaintiffs generally lack the inside information necessary to make out their claims in detail unless and until discovery commences." *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 598 (8th Cir. 2009). This has resulted in courts reading ERISA plaintiffs' complaints slightly more leniently, allowing discovery as long as plaintiffs have provided enough factual allegations to create reasonable inferences that defendants' process of selecting or monitoring funds was imprudent. *See, e.g., Pension Ben. Guar. Corp ex rel. St. Vincent Catholic Med. Centers Ret. Plan v. Morgan Stanley Investment Mgmt. Inc.*, 712 F.3d 705, 718-19 (2d Cir. 2013); *see also Magna*, 2021 WL 1212579, at *6; *AutoZone*, 2020 WL 6479564, at *3. Essentially, a plaintiff must plead facts sufficient to demonstrate that he is not going on a "fishing expedition," but the Court may also consider his limited access to information at this early stage. *Braden*, 588 F.3d at 598.

Broadly, Plaintiffs allege that Defendants failed to select the best investment options, either because the options offered had excessive fees, or because preferable alternatives were available. The complaint alleges that Defendants breached their duty of prudence by some combination of the following facts: the recordkeeping and administrative costs of the Plan were excessive; the majority of funds chosen by the Committee were more expensive than comparable funds; some funds underperformed; the Committee should have considered whether lower-cost comparable collective trusts[3] were available; the Committee could and should have selected at least one identical but lower-cost share class;[4] the Committee failed to consider materially similar but cheaper, passively-managed alternatives, and that a reasonable investigation (which Plaintiffs allege was not done) would have revealed the existence of these preferable alternatives. Plaintiffs support each of these arguments with tables and charts comparing various investment options (*see,*

e.g., Complaint at ¶¶ 85, 86, 88). The Court finds that the arguments fit into two main categories: challenges to investment selections and challenges to fees imposed.

[3] The complaint defines collective trusts as investment vehicles that are

> administered by banks or trust companies, which assemble a mix of assets such as stocks, bonds and cash. Regulated by the Office of the Comptroller of the Currency rather than the Securities and Exchange Commission, collective trusts have simple disclosure requirements, and cannot advertise or issue formal prospectuses. As a result, their costs are much lower, with lower or no administrative costs, and lower or no marketing or advertising costs.

(Complaint, ¶ 91 n. 10).

[4] The complaint explains share classes as follows: "Many mutual funds offer multiple classes of shares in a single mutual fund that are targeted at different investors. There is no difference between share classes other than cost—the funds hold identical investments and have the same manager." (Complaint, ¶ 102).

But before delving into the specifics of Plaintiffs' arguments, the Court must note the circuit split regarding what is necessary to plead a violation of ERISA's duty of prudence. The Third, Eighth, and Ninth Circuits have held that allegations regarding imprudent investment selections and excessive fees, such as the ones presented by Plaintiffs here, may state a claim for violation of ERISA.[5] The Sixth Circuit has not yet weighed in, but the Western District of Tennessee, the Middle District of Tennessee, and the Eastern District of Michigan have recently allowed similar claims to proceed.[6] The Seventh Circuit disagrees, but a petition for certiorari has been granted in the Seventh Circuit case. *See Hughes v. Northwestern Univ.*, No. 19-1401, 2021 WL 2742780 (Mem.) (July 2, 2021). Absent guidance from the Supreme Court or the Sixth Circuit, the Court finds the majority view to be more persuasive than the Seventh Circuit's position.

[5] *See Davis v. Washington Univ. in St. Louis*, 960 F.3d 478 (8th Cir. 2020); *Sweda v. Univ. of Pennsylvania*, 923 F.3d 320 (3d Cir. 2019); *Tibble v. Edison International*, 729 F.3d 1110 (9th Cir. 2013), *vacated on other grounds*, 575 U.S. 523 (2015).

[6] *See Magna*, 2021 WL 1212579; *McCool v. AHS Mgmt. Co., Inc.*, No. 3:19-cv-01158, 2021 WL 826756 (M.D. Tenn. Mar. 4, 2021); *AutoZone,* 2020 WL 6479564.

Investment Options

***5** Part of the duty of prudence under ERISA is a duty to exercise prudence in selecting investments, as well as an ongoing duty to monitor investments and remove imprudent ones. *Tibble v. Edison International,* 575 U.S. 523, 529 (2015). To establish a violation of this duty, a plaintiff must allege facts that, if true, "would show that an adequate investigation would have revealed to a reasonable fiduciary that the investment at issue was improvident." *St. Vincent*, 712 F.3d at 718.

The essence of this portion of Plaintiffs' claim is that the Committee retained a suite of actively managed target date funds[7] (the "Freedom Funds") despite the existence of lower cost and better performing investment options, primarily the FIAM Blend Target Date Funds ("FIAM Funds"). Plaintiffs allege that the fact that the Committee retained a worse investment option evidences the Committee's failure to monitor and review available investment options, which was a violation of its duty of prudence.

[7] Defendants explain target date funds as follows:

> The Freedom Funds are a suite of mutual funds, i.e., "target date funds," that invest a participant's contributions in a mix of stocks, bonds, and cash. Each fund's asset allocation—known as its glide path—is tailored based on a selected retirement date (in five-year increments, i.e., 2030, 2035, etc.) and gradually becomes more conservative over the participants' lifetime.

(Corrected Brief in Support of Motion to Dismiss, ECF No. 11 at PageID.1159).

Defendants bring several arguments in favor of dismissing this claim. First, Defendants argue that Plaintiffs' concession that the Plan changed from the Freedom Funds to the FIAM Funds in 2018 bars their claims entirely. Plaintiffs disagree, arguing that the FIAM Funds were available for eleven years before the switch was made, and Defendants breached their duty of prudence by not evaluating the investment landscape, identifying that the FIAM Funds were better options, and switching before 2018. The Court notes that a fiduciary has a constant duty to replace imprudent investments. *Tibble*, 575 U.S. at 529. The fact that Defendants eventually moved to

the FIAM Funds does not give rise to a blanket presumption of prudence, because Plaintiffs' allegation is that the action should have been taken earlier. *See, e.g., Johnson v. Fujitsu Technology and Business of America, Inc.*, 250 F. Supp. 3d 460, 466 (N.D. Cal. 2017) (finding that allegations regarding imprudence in 2013 and 2014 remained plausible despite removal of the plan's administrator in 2015). The 2018 change does not require dismissal of Plaintiffs' claims.

Second, Defendants argue that they were not required to cater to Plaintiffs' specific investment preferences, noting that ERISA does not mandate certain that funds (or even a certain mix of funds) are provided to employee-investors. To be sure, nothing in ERISA requires a fiduciary to find and offer only the cheapest funds. *Hecker v. Deere & Co.*, 556 F.3d 575, 586 (7th Cir. 2009). Nor does anything in ERISA require plan fiduciaries to include any particular mix of investment vehicles in their plan. *In re Honda of America Mfg., Inc. ERISA Fees Litig.*, 661 F. Supp. 2d 861, 866 (S.D. Ohio 2009). Defendants argue that they provided a sufficient mix of investment options, so if Plaintiffs wished to invest in a low-cost, passively managed fund or collective trust, they could have. In response, Plaintiffs argue that given the availability of less costly and better performing alternatives, Defendants did not satisfy their fiduciary duty to consider the power of the Plan to obtain "favorable" investment products. *Sweda*, 923 F.3d at 329. This is because simply having a "mix and range" of investment options, including those with varying expense ratios, is insufficient to dismiss a complaint because to do so "would insulate from liability every fiduciary who, although imprudent, initially selected a 'mix and range' of investment options." *Id.* at 334; *see also Tussey v. ABB, Inc.*, 746 F.3d 327, 335-36 (8th Cir. 2014).

***6** At this stage, the Court concludes that Plaintiffs' allegations are enough to survive the motion to dismiss: Plaintiffs allege that not only did Defendants provide unsuitable investments, they failed to sufficiently consider other alternatives. The *Sweda* logic is persuasive: If Defendants can skirt an allegation of imprudence simply by providing a "mix and range" of investment options, that would allow every imprudent fiduciary to avoid discovery simply because they offered at least one low-cost plan.

Next, Defendants argue that Plaintiffs cannot state a viable claim based on the comparisons they draw in the complaint because those comparisons are not perfect comparisons. Defendants focus on the different stock options involved in each fund and its comparator fund, arguing that the facts and evidence attached to their motion show that the proposed comparator funds are too distinct to be adequate comparisons. However, if anything, this makes clear that discovery is necessary: whether a certain fund is a good comparator for another fund is clearly a fact-intensive issue, and the Court cannot rule as a matter of law that the funds Plaintiff has identified as comparators are improper. *See, e.g., Nicolas v. Trustees of Princeton Univ.*, 2017 WL 4455897, at *5 (D.N.J. Sept. 25, 2017) (an inquiry into whether the alternative funds plaintiffs suggest are apt comparisons raise factual questions that "do not warrant dismissal—to the contrary, they suggest the need for further information from both parties."); *see also Magna*, 2021 WL 1212579, at *7.

Relatedly, Defendants contest each of Plaintiffs' proffered reasons for why their preferred funds are "better" investment options than the funds provided by the Plan. But, as with the meaningful-comparator argument, each of these arguments presents a detailed question of fact, relating to individual funds' performance, risk allocation, MorningStar rating, and outflow of assets. The Court declines to rule as a matter of law that Plaintiffs have improperly identified "better" funds. Indeed, more information and a full evaluation of the relevant facts are necessary before the Court is prepared to rule on this issue.

Defendants also argue that Plaintiffs' argument regarding the single fund that could have been replaced with an identical but lower-cost share class is improper because Plaintiffs challenge the fee data for a fund that was not ever offered by the Plan. Plaintiffs have identified the Vanguard Small-Cap *Growth* Index Fund as having allegedly excessive fees, but Defendants contend that the Plan only offers the Vanguard Small-Cap Index Fund. The record is unclear which is true: the publicly filed Form 5500s [8] show that Defendants offered the Growth fund, but Defendants have provided documents that show that they did not offer the Growth fund (contrast ECF No. 9-6 with ECF Nos. 9-8 though 9-14). There is a clear dispute of material fact, unsuitable for resolution at this early stage. Thus, the Court will accept Plaintiffs' allegation that there existed a fund that could have been replaced with an identical-but-cheaper share class. This survives the motion to dismiss because courts examining this issue have concluded that investment in a retail class fund where an identical institutional class fund with lower fees is available raises a plausible allegation that the Plan's administrator violated the duty of prudence. *Washington Univ.*, 960 F.3d at 483; *Disselkamp v. Norton Healthcare, Inc.*, No. 3:18-cv-48, 2019 WL 3536038, at * 4-5 (W.D. Ky., Aug. 2, 2019). Whether

the fiduciary failed to leverage its size to negotiate a cheaper cost or was simply "asleep at the wheel" and failed to notice cheaper options is irrelevant: either way is sufficient to state a claim for breach of duty of prudence. *Washington Univ.*, 960 F.3d at 483. Thus, the allegation that identical but cheaper funds were available is sufficient to survive the present motion. Indeed, "a prudent fiduciary – who indisputably has knowledge of institutional share classes and that such share classes provide identical investments at lower costs" should "switch share classes immediately." *Tibble v. Edison International,* No. 07-5359, 2017 WL 3523737, at *13 (C.D. Cal., Aug. 16, 2017).

8 This Opinion relies largely on just the Complaint and the well-pleaded allegations contained therein, despite both parties' requests that the Court take judicial notice of over 1,000 pages of supporting evidence. In this discrete instance, the Court has referred to publicly filed documents (these 5500s) as part of its decision. *See In re Omnicare, Inc. Securities Litig.*, 769 F.3d 455, 466 (6th Cir. 2014).

***7** Finally, Defendants argue that Plaintiffs cannot bring a "hindsight-based" claim to argue that some funds in the Plan were underperforming. ERISA's prudence standard is based on "circumstances then prevailing," so it is true that hindsight-based allegations are improper. 29 U.S.C. § 1104(a)(1)(B); *see also Graham v. Fearon*, 721 F. App'x 429, 437 (6th Cir. 2018). However, Plaintiffs bring allegations that the Committee failed for *years* to perform sufficient reviews or investigations into the Plan's performance. Thus, it is plausible that Defendants had access to performance data at various points throughout the relevant period, and Plaintiffs' allegation is that Defendants did not adequately consider that information. If this allegation is true, it is a breach of ERISA: The Supreme Court requires fiduciaries to continually monitor investments from the time the investments are selected to every moment during the Class Period. *See Tibble*, 575 U.S. at 529. Given that the Plaintiffs cannot see into Defendants' review process without the benefit of discovery, the Court finds that this issue is also sufficiently pleaded to withstand the motion to dismiss.

It is worth mentioning that Defendants slice-and-dice Plaintiffs' complaint. They take each allegation separately to attack them individually. The Court finds, as outlined above, that the motion to dismiss fails when considered in that way. But the Court must note that reading the complaint as a whole makes more sense: The "bigger picture" is the allegation that the Committee was not reviewing the Plan's options regularly, not acting in the best interest of Amway's employees, and using higher-cost vehicles to pay for revenue sharing. Taken together, Plaintiffs plausibly allege that the Committee breached its duty of prudence, so the motion to dismiss Count I will be denied. *See, e.g., McGowan v. Barnabas Health, Inc.*, No. 20-13119, 2021 WL 1399870, at *6 (D.N.J. Apr. 13, 2021) ("The complaint should not be parsed piece by piece to determine whether each allegation, in isolation, is plausible."). The Court reiterates that evaluation of Plaintiffs' claims will require "examination of particular circumstances, specific decisions, and the context of those decisions," which necessarily present questions of fact that cannot be resolved on a motion to dismiss. *McCool*, 2021 WL 826756, at *5. Taking Plaintiffs' allegations together with the reasonable inferences and suggested comparisons, the Court finds that Plaintiffs have pleaded sufficient facts regarding investment options for that portion of Count I to proceed past Defendants' motion to dismiss.

Fees Imposed

"It is beyond dispute that the higher the fees charged to a beneficiary, the more the beneficiary's investment shrinks." *Tibble v. Edison International*, 843 F.3d 1187, 1198 (9th Cir. 2016). "[A] fiduciary's failure to ensure that record-keepers charged appropriate fees and did not receive overpayments may be a violation of ERISA." *Cassell v. Vanderbilt Univ.*, 285 F. Supp. 3d 1056, 1065 (M.D. Tenn. 2018); *see also Sweda*, 923 F.3d at 328. As above, the "question whether it was imprudent to pay a particular amount of record-keeping fees generally involves questions of fact that cannot be resolved on a motion to dismiss." *Id*. at 1064.

Plaintiffs allege that the recordkeeping and administrative costs ranged from $201.53 per participant up to $335.09 per participant (Complaint at ¶ 66). Plaintiffs allege that comparable services were available for $35 per participant (*Id*. at ¶ 69). Plaintiffs allege that the Committee failed to ever investigate whether a different recordkeeper could provide lower fees (*Id*. at 72). Plaintiffs note that the recordkeeping fee market is competitive and fees, on average, are declining, so the reasonable inference is that the Committee's processes for selecting a recordkeeper and their review process for retention of the recordkeeper was flawed. Based on these arguments, the Court finds that the complaint adequately pleads a claim for breach of ERISA's duty of prudence. The facts Plaintiffs have alleged lead to the plausible inference that Defendants' review process was flawed, and that the Committee failed to adequately monitor the Plan's fees and expenses.

***8** Defendants make several arguments to avoid this conclusion. They first argue that the recordkeeping fees cited in Plaintiffs' complaint are improperly calculated, so the Court should dismiss this claim outright. Defendants argue that Plaintiffs have relied on improper documents or the wrong figures for "indirect payments" in their calculations. But the Court is bound to take Plaintiff's well-pleaded factual allegations as true, and this is a factual, not a legal, allegation. Thus, Defendants present an argument based on a question of fact, ill-suited for the motion to dismiss stage. But even accepting Defendants' argument as true—that only the "hard dollar" fee payment is the appropriate fee for the Court to consider—and dividing just the "hard dollar" payments by the number of Plan participants results in per participant fees ranging from $9 in 2014 to $85 in 2018. This supports Plaintiffs' allegation that the Plan charged excessive fees when compared to Plaintiffs' allegation that fees are decreasing year-to-year, not increasing, and that reasonable rates typically average around $35 per participant. That argument supports an inference that Defendants acted imprudently and survives the motion to dismiss.

Next, Defendants argue that Plaintiffs' allegations do not support an imprudence claim. Defendants condense Plaintiffs' argument down to three claims: 1) that revenue sharing is improper; 2) that dissimilar plans paid less, on average, for recordkeeping; and 3) that the Committee should have conducted a request for proposal ("RFP") for recordkeeping services. These, Defendants argue, are insufficient. The Court disagrees.

First, Defendants attack Plaintiffs' allegations that the recordkeeping fee structure itself was improper, arguing that revenue sharing is perfectly lawful. This legal statement is true. *See, e.g., Divane v. Northwestern Univ.*, 953 F.3d 980, 985 (7th Cir. 2020) (holding that there is "nothing wrong—for ERISA purposes—with plan participants paying recordkeeper costs through expense ratios."). But Plaintiffs do not allege that revenue sharing is *per se* improper; instead, they argue that that Defendants used higher-cost investments to generate revenue sharing to pay for the Plan (Complaint at ¶¶ 70, 136). The fact that Defendants retained higher-cost shares to provide more basis for revenue sharing supports the inference that funds were not selected on their merits. *See, e.g., AutoZone*, 2020 WL 6479564, at *9. Taken to its most extreme, Plaintiffs' allegation is that Defendants chose higher-cost share classes to generate higher revenues for Fidelity, without regard for the participants' best interest. This clearly would be a breach of the duty of prudence. The Court passes no judgment on whether this is what occurred or not, but the allegation is plausible, and Defendants remain able to disprove the allegation with the benefit of a developed record at summary judgment or trial.

Second, Defendants argue that Plaintiffs have chosen dissimilar plans as comparators. Similarly, Defendants reject Plaintiffs' choice to compare the Fund's investment options with Investment Company Institute fee data because that data is an inapt comparison. As with the comparator-fund issue discussed above, this presents a fact-intensive analysis, inappropriate for the motion to dismiss stage.

Third, Defendants argue that nothing in ERISA compels periodic competitive bidding, so a claim alleging that the Committee did not conduct an RFP does not support a claim that recordkeeping fees were excessive. If this were the sole allegation in Plaintiffs' complaint, perhaps dismissal would be warranted. But it is not: Plaintiffs allege that the fees were excessive, the investment options poor, and the Committee never so much as sought an RFP to evaluate whether they were providing employees with reasonably low fees. The Court finds that this allegation, taken together with the rest of Plaintiffs' complaint, supports the reasonable inference that Defendants were not acting in Plaintiffs' best interest. *See, e.g.*, *Short v. Brown Univ.*, 320 F. Supp. 3d 363, 370 (D. R.I. 2018) ("Plaintiffs' claim that a prudent fiduciary in like circumstances would have solicited competitive bids plausibly alleges a breach of the duty of prudence.").

***9** Finally, Defendants note that Plaintiffs admit that the Plan has been altered to obtain an annual administration fee of $53 per participant as of May 2020 (Complaint at ¶ 73). Defendants believe this is fatal to Plaintiffs' claim. Not so. Taking the complaint in the light most favorable to Plaintiffs, the inference is still that the Plans' fees were excessive prior to May 2020, and they are still excessive based on Plaintiffs' allegation that the market average fee is $35 per person. Indeed, this may indicate a breach of fiduciary duty, given that Defendants had an ongoing duty to monitor the Plan's expenses. *See, e.g., Creamer v. Starwood Hotels & Resorts Worldwide, Inc.*, 2017 WL 2909408, at *3 (C.D. Cal. May 1, 2017) (Because Starwood failed to exercise bargaining power to obtain lower fees for many years... "viewed in the light most favorable to Plaintiffs, the Court can infer from these facts that Starwood's recordkeeping and administrative fees were excessive prior to 2015 and are still excessive."). Taking this fact together with Plaintiffs' other allegations regarding

excessive fees, the Court finds this claim plausible, and it will survive the motion to dismiss.

The Court finds that Plaintiffs' complaint sufficiently states a claim for breach of the fiduciary duty of prudence in Count I.

C.

Count I also charges the Committee with breaching ERISA's duty of loyalty. "To state a claim for breach of the duty of loyalty, a plaintiff must do more than allege that a defendant failed to act for the exclusive purpose of providing benefits to participants. Rather, a plaintiff must allege plausible facts supporting an inference that the defendant acted *for the purpose* of providing benefits to itself or someone else." *Ferguson v. Ruane Cunniff & Goldfarb Inc.*, No. 17-CV-6685, 2019 WL 4466714, at *4 (S.D.N.Y. Sept. 18, 2019) (citations omitted).

Defendants argue that there are no allegations that Amway or the Plan acted in a way to benefit themselves. In response, Plaintiffs argue that Defendants chose a combination of high-cost investments and a revenue-sharing fee structure to use a portion of the fees to pay Fidelity's inflated fees. Plaintiffs argue that these facts support the inference that Defendants acted in a way that would save itself costs at the expense of the Plan's participants, or in a way that favored Fidelity over the Plan's participants. Either reason is inconsistent with the duty of loyalty. *See, e.g.*, *Johnson v. Providence Health & Serv.*, No. C17-1779, 2018 WL 1427421, at *9 (W.D. Wash. Mar. 22, 2018) ("While the complaint provides no direct evidence of self-dealing or preferential treatment for Fidelity, the inclusion and retention of various Fidelity investment products is circumstantial evidence that Defendants did not act "with an eye single toward beneficiaries' interests."); *Henderson v. Emory Univ.*, 252 F. Supp. 3d 1344, 1356 (N.D. Ga. May 10, 2017) ("Whether the [p]lans' fiduciaries intended to benefit TIAA, Fidelity, and Vanguard is an issue than can be better determined at the motion for summary judgment stage.").

The Court finds Plaintiffs' arguments convincing, and Defendant has made no persuasive counterargument. Therefore, the motion to dismiss will be denied as to the remaining portion of Count I.

D.

Count II alleges that the Board and Alticor failed to monitor the Committee's actions. Again, Defendants seek dismissal of this claim because they seek dismissal of Count I: if there was no substantive breach by the Committee, there could not have been a failure to monitor the Committee by the other Defendants. They do not raise any other argument here. Given that the allegations in Count I are plausible, and no other argument was made against Count II, the Court finds that Count II should not be dismissed at this stage. *See, e.g., Disselkamp*, 2019 WL 3536038, at *11 ("Plaintiffs, however, need not directly assert actions by Defendants that demonstrate their failure to monitor to survive a motion to dismiss, so long as the Court can plausibly conclude from the surrounding factual circumstances that a violation occurred.").

IV.

***10** The Court finds that Plaintiffs' complaint withstands Defendants' motion to dismiss. Accordingly,

IT IS HEREBY ORDERED that Defendants' motion to dismiss (ECF No. 11) is **DENIED**.

IT IS SO ORDERED.

All Citations

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3 Fed.Appx. 384
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Not for Publication in West's Federal Reporter See Fed. Rule of Appellate Procedure 32.1 generally governing citation of judicial decisions issued on or after Jan. 1, 2007. See also Sixth Circuit Rule 28. (Find CTA6 Rule 28)
United States Court of Appeals,
Sixth Circuit.

Ann CHIERA, Plaintiff–Appellant–Cross–Appellee,
v.
JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY, Defendant–Appellee–Cross–Appellant.

No. 99–3613, 99–3680.
|
Feb. 2, 2001.

Synopsis
Beneficiary under accidental death and dismemberment policy issued to insured's employer brought action against insurer seeking benefits under Employee Retirement Income Security Act (ERISA). The United States District Court for the Northern District of Ohio ruled that claim for dismemberment benefits was not timely filed but that policy covered claim for insured's loss of sight, and both parties appealed. The Court of Appeals, Clay, Circuit Judge, held that: (1) de novo standard of review applied; (2) insurer was a "fiduciary" under ERISA; (3) insured's loss of eyesight following surgery resulted from an "accident" under policy; and (4) beneficiary's claim was timely.

Affirmed in part; reversed and remanded in part.

Procedural Posture(s): On Appeal.

West Headnotes (10)

[1] Labor and Employment De Novo
231H Labor and Employment
231HVII Pension and Benefit Plans
231HVII(K) Actions
231HVII(K)5 Actions to Recover Benefits
231Hk684 Standard and Scope of Review
231Hk686 De Novo
(Formerly 296k139)
A denial of benefits challenged under ERISA is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility benefits or to construe the terms of the plan. Employee Retirement Income Security Act of 1974, § 502(a)(1)(B), 29 U.S.C.A. § 1132(a)(1)(B).

3 Cases that cite this headnote

[2] Labor and Employment Arbitrary and Capricious
231H Labor and Employment
231HVII Pension and Benefit Plans
231HVII(K) Actions
231HVII(K)5 Actions to Recover Benefits
231Hk684 Standard and Scope of Review
231Hk687 Arbitrary and Capricious
(Formerly 296k139)
When an ERISA plan expressly affords discretion to trustees to make benefit determinations, a court reviewing the plan administrator's actions should apply the arbitrary and capricious standard. Employee Retirement Income Security Act of 1974, § 502(a)(1)(B), 29 U.S.C.A. § 1132(a)(1)(B).

[3] Labor and Employment De Novo
231H Labor and Employment
231HVII Pension and Benefit Plans
231HVII(K) Actions
231HVII(K)5 Actions to Recover Benefits
231Hk684 Standard and Scope of Review
231Hk686 De Novo
(Formerly 296k139)
De novo standard of review applied in ERISA action challenging insurer's denial of beneficiary's claim for benefits under accidental death and dismemberment policy issued to insured's employer, where summary plan description did not expressly grant discretionary authority to insurer, so as to trigger the arbitrary and capricious standard of review. Employee

Retirement Income Security Act of 1974, § 502(a)(1)(B), 29 U.S.C.A. § 1132(a)(1)(B).

1 Cases that cite this headnote

[4] **Labor and Employment** Who Are Fiduciaries

231H Labor and Employment
231HVII Pension and Benefit Plans
231HVII(C) Fiduciaries and Trustees
231Hk460 Who Are Fiduciaries
231Hk461 In General
(Formerly 296k44)

For purposes of ERISA, a "fiduciary" not only includes persons specifically named as fiduciaries by the benefit plan, but also anyone else who exercises discretionary control or authority over a plan's management, administration, or assets. Employee Retirement Income Security Act of 1974, § 3(21)(A), 29 U.S.C.A. § 1002(21)(A).

5 Cases that cite this headnote

[5] **Labor and Employment** Insurance Companies and Agents

231H Labor and Employment
231HVII Pension and Benefit Plans
231HVII(C) Fiduciaries and Trustees
231Hk460 Who Are Fiduciaries
231Hk465 Insurance Companies and Agents
(Formerly 296k44)

When an insurance company administers claims for employee welfare benefit plans and has authority to grant or deny claims, the insurance company is a "fiduciary" for ERISA purposes. Employee Retirement Income Security Act of 1974, § 3(21)(A), 29 U.S.C.A. § 1002(21)(A).

7 Cases that cite this headnote

[6] **Labor and Employment** Insurance Companies and Agents

231H Labor and Employment
231HVII Pension and Benefit Plans
231HVII(C) Fiduciaries and Trustees
231Hk460 Who Are Fiduciaries
231Hk465 Insurance Companies and Agents
(Formerly 296k44)

Insurer that issued group accidental death and dismemberment policy issued to insured's employer was a "fiduciary" under ERISA, where it had authority to accept or reject claims for losses under the group policy, as evidenced by rejection letter that it sent to beneficiary in response to her attorney's letter. Employee Retirement Income Security Act of 1974, § 3(21)(A), 29 U.S.C.A. § 1002(21)(A).

4 Cases that cite this headnote

[7] **Labor and Employment** Arbitrary and Capricious

231H Labor and Employment
231HVII Pension and Benefit Plans
231HVII(K) Actions
231HVII(K)5 Actions to Recover Benefits
231Hk684 Standard and Scope of Review
231Hk687 Arbitrary and Capricious
(Formerly 296k139, 296k136)

Language of group accidental death and dismemberment policy, which required "written proof of loss" to be submitted to insurer, was insufficient to vest insurer with discretionary authority, so as to require application of arbitrary and capricious standard of review in ERISA action challenging insurer's denial of benefits; policy did not expressly bestow upon insurer any authority to determine whether such proof of loss was sufficient. Employee Retirement Income Security Act of 1974, § 502(a)(1)(B), 29 U.S.C.A. § 1132(a)(1)(B).

7 Cases that cite this headnote

[8] **Insurance** Heart Conditions

Insurance What Constitutes Accident

217 Insurance
217XX Coverage—Health and Accident Insurance
217XX(D) Accident Insurance
217k2585 Risks Covered or Excluded
217k2589 Diseases or Conditions; Medical Treatment
217k2589(2) Heart Conditions
217 Insurance
217XX Coverage—Health and Accident Insurance
217XX(D) Accident Insurance

217k2585 Risks Covered or Excluded
217k2590 External, Violent or Accidental Causes
217k2590(2) What Constitutes Accident

Insured's loss of eyesight when he went into a permanent vegetative state following a surgical procedure resulted from an "accident" under accidental death and dismemberment policy covered by ERISA; insured's vegetative state and resulting sight loss was caused by a surgery he underwent to correct a defective aortic valve he had since birth and was caused by an unintentional, non-volitional act. Employee Retirement Income Security Act of 1974, § 502(a)(1)(B), 29 U.S.C.A. § 1132(a)(1)(B).

2 Cases that cite this headnote

[9] Insurance Persons Giving Notice or Proof

217 Insurance
217XXVII Claims and Settlement Practices
217XXVII(B) Claim Procedures
217XXVII(B)2 Notice and Proof of Loss
217k3148 Persons Giving Notice or Proof
217k3149 In General

Employer's submission of claim form and other relevant materials following insured employee's death to insurer that issued group accidental death and dismemberment policy satisfied policy's requirement that the proof of loss be submitted within 90 days, although beneficiary did not personally submit the form.

1 Cases that cite this headnote

[10] Insurance Reasonable Time

217 Insurance
217XXVII Claims and Settlement Practices
217XXVII(B) Claim Procedures
217XXVII(B)2 Notice and Proof of Loss
217k3152 Timeliness
217k3156 Reasonable Time

Beneficiary under accidental death and dismemberment policy issued to insured's employer submitted claim for benefits within a reasonable time, as required by policy, where beneficiary submitted completed forms to employer within 90 days of insured's death, and employer submitted the forms to insurer shortly thereafter.

***386** On Appeal from the United States District Court for the Northern District of Ohio.

Before JONES, SILER and CLAY, Circuit Judges.

Opinion

CLAY, Circuit Judge.

****1** This is a consolidated appeal. In Case No. 99–3613, Plaintiff, Ann Chiera, the designated beneficiary and wife of the now-deceased James Chiera ("Chiera"), appeals from the district court's order granting summary judgment to Defendant, John Hancock Mutual Insurance Co., pursuant to Federal Rule of Civil Procedure 56. Plaintiff filed a claim pursuant to the Employment Retirement Investment Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), seeking benefits as the beneficiary under an ERISA governed insurance policy. For the reasons stated below, we REVERSE the district court's grant of summary to Defendant and REMAND with instructions to enter judgment in favor of Plaintiff.

In Case No. 99–3680, Defendant, cross-appeals the district court's judgment contending that (1) the district court improperly applied a *de novo* standard of review where it should have applied an arbitrary and capricious standard of review when assessing Defendant's denial of Plaintiff's claim for benefits; and, (2) the district court incorrectly determined that Chiera's loss of sight was covered under the accidental death and dismemberment ("AD&D") policy. For the reasons set forth below, we AFFIRM the district court's rulings as to these issues.

BACKGROUND

Chiera was insured with Defendant for life insurance benefits and AD&D benefits under an insurance policy issued to Premier Industrial Corporation ("Premier"), Chiera's then employer. On April 23, 1990, Chiera underwent surgery at the Cleveland Clinic Foundation ("the Clinic") to repair his aortic valve which had been ***387** defective since birth. On or about April 30, 1990, Chiera was discharged from the Clinic. On May 9, 1990, Chiera was admitted to Akron General where he went into cardiac arrest and suffered brain damage,

which left Chiera in a permanent vegetative state. Chiera died approximately five years later on March 25, 1995.

Shortly after Chiera lapsed into this permanent vegetative state in 1990, Plaintiff was provided with a copy of the Summary Plan Description ("SPD") explaining the various benefits administered under the insurance policy. Defendant admits that Chiera was insured under the life insurance policy and the AD&D policy at all times.

Shortly after Chiera's death in 1995, Plaintiff made claims for the benefits under the life insurance policy and alleges that she submitted claims for dismemberment benefits under the AD&D policy as a result of Chiera's loss of eyesight suffered when he went into his vegetative state. On July 17, 1995, Premier sent Defendant a letter requesting payment of the life insurance proceeds. Additionally, Premier informed Defendant that Plaintiff would not receive any dismemberment benefits under the AD&D policy because Chiera's death did not occur within 365 days of the accident; the accident which resulted in Chiera's permanent vegetative state was caused by an operation he underwent to correct a defective aortic valve. Plaintiff claims that she did not receive a copy of the letter that Premier sent to Defendant until a year later.

**2 On or about March 20, 1996, Jack Morrison, Plaintiff's attorney, sent Defendant a letter reiterating the claim for payment of the dismemberment benefits under the AD&D policy. Defendant denied the claim for accidental death benefits in a letter dated May 6, 1996. Because Defendant never addressed Plaintiff's claims under the dismemberment policy, and because the failure to address this specific claim was presumably a denial of the dismemberment claim, Plaintiff filed the instant action.

On March 26, 1998, Plaintiff filed a complaint in the instant case against Defendant in the Summit County Court of Common Pleas in Ohio. On May 1, 1998, Defendant filed a notice of removal removing the matter to the United States District Court for the Northern District of Ohio on the basis that the claims are governed by ERISA. On November 16, 1998, Defendant filed a motion for summary judgment. Plaintiff filed a brief in opposition to summary judgment and cross-motion for summary judgment on December 2, 1998. Apparently, it was not clear from Plaintiff's pleadings that she was seeking dismemberment benefits under the AD&D policy. Therefore, the district court mandated that the parties file supplemental briefs on the issue of Plaintiff's dismemberment claim on January 21, 1999. Thereafter, on April 8, 1999, the district court granted Defendant's motion for summary judgment and denied Plaintiff's cross-motion for summary judgment. Both parties appeal from the district court's order granting summary judgment to Defendant. Plaintiff appeals the district court's order granting summary judgment to Defendant on the basis that her claim for dismemberment benefits under the AD&D policy was not timely filed. Defendant cross-appeals from the district court's order claiming that the district court erred in applying a *de novo* standard of review in assessing whether Defendant's denial of Plaintiff's claims for benefits and finding that Chiera's loss of sight was covered under the AD&D policy.

STANDARD OF REVIEW

We review the district court's grant of summary judgment *de novo*. *See Smith v.* **388 *Ameritech,* 129 F.3d 857, 863 (6th Cir.1997). Summary judgment is appropriate when there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. *See* FED. R. CIV.P. 56(c). In deciding a motion for summary judgment, the court must view the evidence and draw all reasonable inferences in favor of the non-moving party. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 574, 587, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986). At the summary judgment stage, the judge is not "to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson v.. Liberty Lobby, Inc.,* 477 U.S. 242, 249, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). A genuine issue for trial exists when there is sufficient "evidence on which the jury could reasonably find for the plaintiff." *Id.* at 252, 106 S.Ct. 2505.

ANALYSIS

I.

**3 First we consider Defendant's cross-appeal as to whether the district court properly applied *de novo* standard rather than the arbitrary and capricious standard of review. We review the district court's determination *de novo. See Whisman v. Robbins,* 55 F.3d 1140, 1143 (6th Cir.1995).

[1] [2] A denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the

benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility benefits or to construe the terms of the plan. *See Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 109, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). In *Firestone,* the Supreme Court held that, under ERISA, absent the express delegation of discretion to a plan trustee, a court should conduct a *de novo* review of the trustee's benefit determination. *Id.* at 115, 109 S.Ct. 948. Conversely, when an ERISA plan expressly affords discretion to trustees to make benefit determinations, a court reviewing the plan administrator's actions should apply the arbitrary and capricious standard. *Id.* at 110–12, 109 S.Ct. 948.

[3] After reviewing the SPD, [1] the district court concluded that Defendant's denial of Plaintiff's claim for benefits should ***389** be reviewed *de novo* on the basis that Defendant was neither a plan administrator nor a fiduciary. Although we agree with the district court's decision to apply the *de novo* standard of review in this case, we disagree with the district court's basis for doing so. The *de novo* standard is the appropriate form of review in this matter because the SPD does not expressly grant discretionary authority to John Hancock so as to trigger the arbitrary and capricious standard of review.

[1] The language of the SPD provides in relevant part as follows:

> The Plan Administrator is: Corporate Insurance Department
> Premier Industrial Corporation
> 4500 Euclid Avenue
> Cleveland, Ohio 44103(216) 391–8300
> The Plan Administrator has authority to control and manage the operation and administration of the Plan and is the agent for service of legal process.
> This [SPD] outlines requirements for giving notice and proof of claim to the John Hancock Life Insurance Company. If a claim is denied, in whole or in part, the denial will be submitted to you in writing setting forth the following:
> 1. The basis for denial of the claim;
> 2. the Plan provision(s) upon which the denial is based;
> 3. a description of any additional information required of you or your dependants' and
> 4. an explanation of the procedure for reviewing the claim under the Plan.
>
> (J.A. at 410–11.)

The AD&D policy states in relevant part;

> Proof of Loss: John Hancock must be given written proof of the loss for which the claim is made. The proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of the loss, except that a claim will not be considered valid unless the proof is furnished within this time limit. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.
>
> (J.A. at 392.)

A. Scope of District Court's Standard of Review

1. Defendant's Fiduciary Status

[4] According to ERISA, a plan "fiduciary" is one who "exercises any discretionary authority or discretionary control respecting the management of [an ERISA] plan or exercises any authority or control respecting the management or disposition of its assets" or who "has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21)(A). This Court has found that "the definition of a fiduciary under ERISA is a functional one, [and] is intended to be broader than the common-law definition" such that the issue of whether one is considered a fiduciary does not turn upon formal designations. *Smith v. Provident Bank,* 170 F.3d 609, 613 (6th Cir.1999). Therefore, for purposes of ERISA, a "fiduciary" not only includes persons specifically named as fiduciaries by the benefit plan, but also anyone else who exercises discretionary control or authority over a plan's management, administration, or assets. *See Michigan Affiliated Healthcare Sys., Inc. v. CC Sys. Corp. of Mich.,* 139 F.3d 546, 549 (6th Cir.1998); *see also Grindstaff v. Green,* 133 F.3d 416, 426 (6th Cir.1998) (under ERISA a person is a fiduciary only with respect to those aspects of plan over which he or she exercises authority or control).

****4** **[5]** To that end, courts have distinguished employer actions that constitute "managing" or "administering" a plan from those actions that merely constitute "business decisions" which have an effect on an ERISA plan; the managing or administering the plan are deemed "fiduciary acts" while business decisions are not. *See Sengpiel v. B.F. Goodrich Co.,* 156 F.3d 660, 665 (6th Cir.1998). When an insurance

company administers claims for employee welfare benefit plans and has authority to grant or deny claims, the insurance company is a "fiduciary" for ERISA purposes. *See Libbey–Owens–Ford Co. v. Blue Cross & Blue Shield Mut. of Ohio,* 982 F.2d 1031, 1035 (6th Cir.1993).

[6] Indeed, Premier was named as the plan administrator; however, Defendant is a fiduciary for purposes of ERISA inasmuch as it had a role in administering the plan because it had authority to accept or reject claims for losses under the group insurance policy as evidenced by the rejection letter that it sent to Plaintiff in response to her attorney's letter. Consequently, the district court incorrectly determined that Defendant was not a fiduciary for purposes of ERISA.

2. Discretionary Authority

[7] Defendant argues that the language of the AD&D policy, which provides that "written proof of loss" must be submitted to Defendant, is sufficient to vest it with discretionary authority, such that the arbitrary and capricious standard of review should have been applied. Defendant relies on this Court's decisions in *Yeager v. Reliance Standard Life Insurance Co.,* 88 F.3d 376 (6th Cir.1996), and *Perez v. Aetna Life Insurance Co.,* 150 F.3d 550 (6th Cir.1998) (*en banc*). Defendant's reliance is misplaced inasmuch as the language used ***390** in *Yeager* and *Perez* gave the insurance companies subjective judgment to determine whether a claim was "satisfactory." No such language governs the claims submitted to Defendant here.

In *Yeager,* this Court concluded that the language "satisfactory proof of [t]otal [d]isability to us" in a pension plan was sufficient to vest the plan administrator with discretionary authority. 88 F.3d at 381. In reaching its conclusion, the *Yeager* Court reasoned that

> [a] determination that evidence is satisfactory is a subjective judgment that requires a plan administrator to exercise his discretion.... It would not be rational to think that the proof would be required to be satisfactory to anyone other than [the plan administrator]. Even if the phrase "to us" is interpreted as defining to whom the proof should be submitted, there is no reason to believe that someone other than the party that received the proof would make a determination regarding its adequacy.

Id.

In *Perez,* this Court held that the language "shall have the right to require as part of the proof of claim satisfactory evidence" sufficiently vested the plan administrator with discretionary authority requiring the court to apply to the arbitrary and capricious standard of review. 150 F.3d at 555. The *Perez* Court reasoned that

> ****5** [a]lthough many of our prior cases finding a clear grant of discretion involved ERISA plans which explicitly provided that the evidence be satisfactory "to the insurer," "to the company" or "to us," it does not automatically follow that in the absence of such language discretion has not been granted to the plan administrator. ... [T]his "right to require as part of proof of claim satisfactory evidence" means, semantically, that the evidence must be satisfactory to Aetna, the only named party with the right to request such evidence. It naturally follows that Aetna, the receiver of the evidence, would review that evidence to determine if it constitutes proof of total disability.

Id. at 556.

The language of the AD&D policy in the instant case is very different from the language this Court found sufficient to support a finding of discretionary authority in *Yeager* and *Perez.* Under the AD&D policy, "John Hancock must be given written proof of loss." Although Defendant must be provided with written proof of loss, the policy does not expressly bestow upon Defendant any authority to determine whether such proof of loss is sufficient. Unlike *Perez* and *Yeager,* there is no requirement under the AD&D policy that the proof of loss had to be "satisfactory" to Defendant. Moreover, *Firestone* and this Court's interpretation of *Firestone* mandate that the plan explicitly grant discretionary authority before an arbitrary and capricious standard of review can be applied. *See Yeager,* 88 F.3d at 380 ("This circuit has interpreted *Bruch* to require that the plan's grant of discretionary authority to the administrator be 'express.' "). That Defendant must be provided with "written proof of loss" does not explicitly grant it discretionary authority. Because Defendant was not expressly vested with discretionary authority under the AD&D policy, this Court concludes that

the district court properly applied *de novo* review rather than the arbitrary and capricious standard.

B. Coverage under Policy

[8] Next, Defendant challenges the district court's determination that Chiera's loss of sight was covered under the policy. Defendant argues that Chiera's loss of sight was due to "disease, infirmity or ***391** treatment of the same," which excluded his claim from coverage under the SPD. [2] Plaintiff contended, and the district court agreed, that her husband's loss of sight was covered under the policy because it resulted from his permanent vegetative state, the unforeseeable outcome of a surgical procedure. We believe that the district court correctly concluded that Chiera's loss of eyesight resulted from an "accident," as that term is commonly understood, and was therefore covered under the policy.

2 Exclusions: The [AD&D policy] does not cover loss that occurs more than 365 days after the accident, nor any loss resulting from war ..., suicide, attempted suicide, bodily or mental infirmity, or disease, an infection other than a pyogenic infection of an accidental cut or wound, participation in or as a consequence of having participated in the committing of a felony, or any duties relating in any way to an aircraft or its operation, equipment, passengers or crew on a non-occupational basis.
(J.A. at 392.)

Because the Plan is governed by ERISA, we apply federal common law rules of contract interpretation, guided by both state law and general contract principles, to determine whether Chiera's loss of sight is covered under the policy. *See Perez,* 150 F.3d at 556 (citing *Pitcher v. Principal Mut. Life Ins. Co.,* 93 F.3d 407, 411 (7th Cir.1996)). The general principles of contract law dictate that this Court interpret the provisions of an ERISA governed insurance policy according to the plain meaning, in an ordinary and popular sense. *See id.*

****6** Accident is defined as a "sudden event or change occurring without intent or volition through carelessness ...." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 11 (1993). It is undisputed that Chiera's vegetative state and resulting sight loss was caused by a surgery he underwent to correct a defective aortic valve he had since birth. It is also undisputed that Chiera's vegetative state and resulting eye loss was caused by an unintentional, non-volitional act. Moreover, Chiera's death certificate clearly states that the cause of death was an "accident." In addition, the term "infirmity," as used within the "Exclusion" portion of the AD&D policy, is an ambiguous term. General contract principles require that we construe the language of an ambiguous contract against the drafter. *See Tolley v. Commercial Life Ins. Co.,* 14 F.3d 602, 603 (6th Cir.1993). Since Chiera's permanent vegetative state clearly fits within the definition of accident, we conclude that Chiera's loss of sight was the result of an accident rather than some infirmity or disease. *Cf. Parker v. Danaher Corp.,* 851 F.Supp. 1287, 1295 (W.D.Ark.1994) ("accident" as used in AD&D policy meant something which a *common person* would regard as unintended, not according to the usual course of things, or not as expected). Thus, the district court properly determined that Chiera's loss of sight was covered under the AD&D policy. [3]

3 The district court also relied on the testimony of an expert, Dr. Charles Blatt, to determine that Chiera's loss of sight was the result of an accident. We find that this testimony was unnecessary. Moreover, because the doctor's testimony was not available to Defendant when it made its initial determination to deny Plaintiff's claim for benefits, the district court improperly considered this testimony. *See Miller v. Metropolitan Life Ins. Co.,* 925 F.2d 979, 986 (6th Cir.1991) (recognizing that a reviewing court may only consider the evidence available to the administrator at the time the final decision was made).

II.

[9] Finally, we turn to Plaintiff's claim on appeal that the district court erred in determining that her claim for benefits ***392** under the AD&D policy was untimely. Having reviewed the record, we conclude that district court erred in determining that Plaintiff's claim was untimely. Under the AD&D policy, written proof of loss must be submitted to Defendant within ninety days of such loss or, where it is not be reasonably possible to do so, within a reasonable time. We conclude that a claim was submitted on behalf of Plaintiff within a reasonable time.

Chiera went into a permanent vegetative state on or about April 23, 1990, and remained in this state until his death on March 25, 1995. On May 10, 1995, Plaintiff signed a completed beneficiary claim form given to her by Premier, which Premier submitted to Defendant on July 17, 1995. The claim form was accompanied by Chiera's death certificate; a group policyholder's statement; and a letter wherein Premier told Defendant that, pursuant to its contract, the AD&D benefits should be denied.

Based upon the express language of the plan, we find that claim for life insurance and AD&D benefits was timely submitted on Plaintiff's behalf when Premier sent Defendant a letter on July 17, 1995, accompanied by Plaintiff's claim form and other relevant documents. Notably, the AD&D policy only requires that proof of loss be submitted to Defendant; it does not require that the proof of loss be submitted by the beneficiary herself, nor any other designated individual. As a result, when Premier forwarded Plaintiff's claim form and other materials to Defendant, along with Premier's letter specifically indicating that Chiera's cause of death was an accident, Premier in fact submitted Plaintiff's AD&D claim to Defendant. Again, the fact that Plaintiff herself did not submit the claim to Defendant is of no moment where nothing in the AD&D policy suggests that the claim had to be presented to Defendant by Plaintiff. To hold otherwise would do nothing but put form over substance. [4]

[4] We are not persuaded otherwise by any contention that because we do not know the extent of Defendant's review of the materials sent by Premier, we cannot conclude that Defendant was made aware of Plaintiff's AD&D claim through the receipt of these materials. This argument, aside from being without merit, invites us to rule in Defendant's favor based upon its lack of diligence. For obvious reasons, this is an invitation that we decline to accept.

**7 Furthermore, the evidence in the record indicates that Defendant was previously made aware of Chiera's condition. First, there was correspondence from Premier to Defendant and Blue Cross Blue Shield of Ohio, dated in 1992, wherein Premier made Defendant aware of Chiera's vegetative state. This particular correspondence requested that Defendant intervene in a medical malpractice lawsuit filed on behalf of Chiera against the Clinic. Premier was attempting to recoup "any award made for covered medical expenses" paid to the hospital under Chiera's long-term disability benefits plan. (J.A. at 288.) Moreover, the March 20, 1996 letter from Plaintiff's counsel to Defendant indicates that a prior claim had been filed for the AD&D benefits.

Plaintiff argues that Defendant was given notice of the claim because Premier had notice of the claim and acted as an agent for Defendant. Although it is unclear whether Premier was acting as an agent for Plaintiff, Defendant or both, or just simply facilitating the filing of the claims of its employees in the ordinary course of business, we find it unnecessary to resolve this issue. It is clear that Premier submitted a claim on behalf of Plaintiff for both the life insurance benefits and the AD&D benefits. It is also clear that Defendant *393 was made aware of the nature of Chiera's death and injuries from both the death certificate and, we strongly suspect, prior communications between Defendant and Premier as indicated in the record. Thus we conclude that Defendant had timely notice of the claim and proof of the loss.

[10] We further conclude that Plaintiff filed the claim within a reasonable time. Defendant conceded at oral argument that Plaintiff was under no obligation prior to Chiera's death to file a claim on his behalf for the loss. It is also clear that Chiera was in no position to file the claim himself. The AD&D policy provides that when it is not reasonably possible to file a claim within ninety days of the loss, the claim may be filed within such time as reasonably possible. Because Plaintiff submitted the completed forms to Premier within ninety days of Chiera's death, which Premier submitted to Defendant soon thereafter, we find that the claim was submitted within a reasonable time.

CONCLUSION

For the above stated reasons, we hold that the district court did not err in applying a *de novo* standard of review and concluding that Chiera's loss of sight was covered under the AD&D policy, and therefore AFFIRM the district court in Case No. 99–3680. However, in Case No. 99–3613, we hold that the district court erred in granting summary judgment in favor of Defendant where a timely claim for AD&D benefits was filed on Plaintiff's behalf. Accordingly, we REVERSE the district court's grant of summary judgment in Case No. 99–3613 and REMAND with instructions to the district court to grant Plaintiff the dismemberment benefits due under the AD&D policy, along with interest and attorney's fees. [5]

5 As there is no genuine dispute of any material fact and both parties filed motions for summary judgment, we conclude that Plaintiff is entitled to judgment as a matter of law and that summary judgment should have been entered in her favor. *See Trustees of Mich. Laborers' Health Care Fund v. Gibbons,* 209 F.3d 587, 594–95 (6th Cir.2000).

All Citations

3 Fed.Appx. 384, 2001 WL 111585, Pens. Plan Guide (CCH) P 23,969B

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2017 WL 3116262
United States District Court, E.D. Michigan, Southern Division.

GRAND TRAVERSE BAND OF OTTAWA AND CHIPPEWA INDIANS and its Employee Welfare Plan, Plaintiffs,
v.
BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant/Third-Party Plaintiff,
v.
Munson Medical Center, Third-Party Defendant.

Case No. 14-cv-11349
|
Signed 07/21/2017

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OPINION AND ORDER GRANTING DEFENDANT'S MOTION TO DISMISS [94]

JUDITH E. LEVY, United States District Judge

***1** This ERISA case has been pending for over three years, and is currently before the Court on defendant Blue Cross Blue Shield of Michigan's motion to dismiss the amended complaint filed by plaintiffs Grand Traverse Band of Ottawa and Chippewa Indians and its Employee Welfare Plan. (Dkt. 94.)

For the reasons set forth below, the motion is granted.

I. Background

Plaintiffs are a federally-recognized tribe and have filed suit against Blue Cross Blue Shield of Michigan ("BCBSM") for breach of fiduciary duty under ERISA and have also brought five state-law claims allegedly relating to a contract between the tribe, BCBSM, and Munson Medical Center.

Plaintiffs' initial complaint was partially dismissed without prejudice to amend and clarify which actions of defendant are the subject of ERISA claims and which are the subject of state-law claims. (*See* Dkts. 73, 76.) [1]

1 Plaintiffs appear to seek leave to amend the complaint in the response brief to defendant's motion to dismiss. (Dkt. 96 at 21 n.7.) The Sixth Circuit has held that a party may not request "leave to amend in a single sentence without providing grounds or a proposed amended complaint" in a response brief. *Evans v. Pearson Enter., Inc.*, 434 F.3d 839, 853 (6th Cir. 2006). Accordingly, plaintiff's request for leave to amend is denied.

ERISA Agreement Between Plaintiffs and BCBSM

Plaintiffs maintain a self-funded employee welfare plan ("Plan") governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.* (Dkt. 90 at 1.) The Plan covers three groups of participants:

1. Members of the Tribe who are employed by the Tribe (Group #01019);

2. Members of the Tribe who are not employed by the Tribe (Group #01020); and

3. Employees of the Tribe who are not members of the Tribe (Group #48571).

In 2000, plaintiffs hired BCBSM to "provide administrative services for the processing and payment of claims" under the plan. (Dkt. 90-2 at 3.)

In 2007, new federal regulations implementing section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 went into effect (hereinafter "MLR regulations"). These regulations stated that "[a]ll Medicare-participating hospitals ... must accept no more than the rates of payment under the methodology described in this section as payment in full for all terms and services authorized by IHS, Tribal, and urban Indian organization

entities." 42 C.F.R. § 136.30(a); *see also id.* § 136.32. And "if an amount has been negotiated with the hospital or its agent," the tribe "will pay the lesser of" the amount determined by the methodology or the negotiated amount. *Id.* § 136.30(f). None of the parties disputes that these regulations apply to plaintiffs.

Plaintiffs allege that defendant was "well aware of the MLR regulations" and "systematically failed to take advantage of MLR discounts available to Plaintiffs." (Dkt. 90 at 3.) And "[a]s administrator of an ERISA plan, BCBSM owed a number of fiduciary duties" to plaintiff that were breached due to this failure to take advantage of the MLR discounts. (*Id.* at 2, 4–5, 18.) Plaintiffs seek restitution, statutory attorney fees, and other damages, costs, and interest permitted by law. (*Id.* at 23.)

Facility Claims Processing Agreement with Plaintiffs, BCBSM, and Munson Medical Center

***2** After the 2007 MLR regulations went into effect, plaintiffs allege they "asked BCBSM to ensure that Plaintiffs were obtaining Medicare-Like Rate discounts" for Groups #01019 and 01020. (Dkt. 90 at 14.) BCBSM said "it could not adjust its entire system to calculate MLR on those claims eligible for MLR discounts, but ... could provide GTB a rate which ... would be 'close to that which would be payable under the New Regulations' by providing a discount on Plaintiffs' claims for hospital services at Munson Medical Center" to Group #01020. (*Id.* at 15.)

"In reliance on this representation," plaintiffs and BCBSM entered into a Facility Claims Processing Agreement ("FCPA") with Munson Medical Center, effective March 1, 2009. (Dkt. 90 at 6; Dkt. 90-4.) The recitals to the FCPA indicate the purpose of the agreement was to facilitate the following: (1) "Munson desires to afford GTB most of the pricing benefits under the New Regulations"; and (2) "BCBSM is willing to accommodate the desire of both Munson and GTB by processing claims ... at a price they believe is close to that which would be payable under the New Regulations." (Dkt. 90-4 at 2.) This agreement applies only to Group #01020, members of the Tribe who are not employed by the Tribe. (*Id.*) Under the terms of the FCPA, Munson Medical Center agreed to accept as payment in full the discounted rate set by defendant. (Dkt. 90 at 6; Dkt. 90-4 at 3.)

The initial discount rate was eight percent, and defendant was to recalculate the rate each year in accordance with the formula set forth in the FCPA. (Dkt. 90-4 at 3.) Specifically, defendant was required to first calculate two ratios: (i) ratio of all BCBSM PPO payments to all BCBSM PPO charges for Munson claims for the prior calendar year, and (ii) ratio of all payments to all charges for all Medicare claims that Munson reported on its Medicare cost report for its prior calendar year. The new discount for the upcoming year would be the percentage difference between (i) and (ii), if positive. (*Id.*) The FCPA also states that the "arrangement ... does not require BCBSM to process Munson Claims as if they were, in all other respects, actual Medicare Claims," and "GTB [plaintiff] acknowledges that this arrangement described in this Agreement is satisfactory to it and is in lieu of any claim that the New Regulations apply to any Claims and that Munson and BCBSM are relying on this representation by GTB." (*Id.* at 4.)

Plaintiffs claim that, in 2012, they "decided to ... obtain a comparison of the costs of going with a different third-party administrator," and after an audit, discovered they were "not paying anything 'close to MLR' on claims." (Dkt. 90 at 16.)

Because plaintiffs were allegedly not receiving the promised discount that would make their payments "close to MLR," they filed suit alleging five state-law claims: breach of Health Care False Claims Act; breach of contract, and alternatively, covenant of good faith and fair dealing; breach of common law fiduciary duty; fraud/misrepresentation; and silent fraud. (Dkt. 90 at 22.)

II. Legal Standard

Under Fed. R. Civ. P. 12(b)(6), "[a] complaint must state a claim that is plausible on its face." *Johnson v. Moseley*, 790 F.3d 649, 652 (6th Cir. 2015). A plausible claim need not contain "detailed factual allegations," but it must contain more than "labels and conclusions" or "a formulaic recitation of the elements of a cause of action." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). In other words, a plaintiff must plead facts sufficient to "allow[ ] the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ctr. for Bio-Ethical Reform, Inc. v. Napolitano*, 648 F.3d 365, 369 (6th Cir. 2011). And a court considering a motion to dismiss must "construe the complaint in the light most favorable to the plaintiff and accept all allegations as true." *Keys v. Humana, Inc.*, 684 F.3d 605, 608 (6th Cir. 2012).

III. Analysis

***3** Defendant argues the amended complaint should be dismissed because the ERISA count is either time-barred or fails as a matter of law, and the remaining state law claims are either preempted by ERISA or improperly duplicative of other counts. (Dkt. 94.)

A. Count I: ERISA Violation

Defendant argues that the ERISA count fails as a matter of law and is time-barred.

Whether Plaintiffs State an ERISA Claim

Defendant argues that there is no fiduciary duty to obtain or pursue MLR under ERISA, and that it was not acting as a fiduciary when negotiating payment rates with providers. (Dkt. 94 at 17–24.)

First, defendant argues there is no fiduciary duty to pursue MLR, as set forth by Judge Ludington in *Saginaw Chippewa Indian Tribe of Mich. et al. v. Blue Cross Blue Shield of Mich.*, Case No. 16-cv-10317, 2016 WL 6276911 (E.D. Mich. Aug. 3, 2016) ("*SCI Tribe*"). In that case, plaintiffs pleaded a breach of fiduciary duty for "paying excess claim amounts to Medicare-participating hospitals for services authorized by a tribe or tribal organization carrying out a CHS program." (Case No. 16-cv-10317, Dkt. 7 at 31.) And the *SCI Tribe* court interpreted the complaint as alleging an independent fiduciary duty to pursue MLR. *SCI Tribe*, 2016 WL at *3 ("[Plaintiff] claims ... that the MLR regulations may have significant and material effects on the rates paid by its plan members, so BCBSM had a duty to be aware of those effects.").

Fiduciary duties under ERISA include three components: "(1) the duty of loyalty, which requires 'all decisions regarding an ERISA plan ... be made with an eye single to the interests of the participants and beneficiaries'; (2) the 'prudent person fiduciary obligation,' which requires a plan fiduciary to act with the 'care, skill, prudence, and diligence of a prudent person acting under similar circumstances,' and (3) the exclusive benefit rule, which requires a fiduciary to 'act for the exclusive purpose of providing benefits to plan participants.' " *Pipefitters Local 636 Ins. Fund v. Blue Cross & Blue Shield of Mich.*, 722 F.3d 861, 867 (6th Cir. 2013) (quoting *James v. Pirelli Armstrong Tire Corp.*, 305 F.3d 439, 448–49 (6th Cir. 2012)).

In this case, plaintiffs have made allegations similar to those considered by the *SCI Tribe* court. But construing the complaint in the light most favorable to plaintiffs, the allegations do not assert a fiduciary duty to obtain MLR, but instead a fiduciary duty to, among other things, preserve plan assets and make decisions with the care of a prudent person, which, as set forth above, are established fiduciary duties. Thus, the issue of whether defendant should have sought a discounted rate in connection with the MLR regulations appears to be a question of fact, not of law.

In a similar case, *Little Band of Ottawa Indians and its Emp. Welfare Plan v. Blue Cross Blue Shield of Mich.*, 183 F. Supp. 3d 835 (E.D. Mich. 2016), Judge Lawson held that plaintiffs stated a claim because they pleaded defendant "knew that the payments should have been capped" but failed to ensure the rates "were appropriately capped," and rejected BCBSM's argument that "its fiduciary duty did not extend to ensuring that claims were paid at appropriate rates" because that argument was "merely a factual rebuttal to the breach of duty claim." *Id.* at 843.

***4** The Court agrees with Judge Lawson's analysis. Plaintiffs in this case allege that defendant failed to act as a prudent person, to preserve plan assets, and act for the exclusive purpose of providing benefits to beneficiaries—in other words, breached a fiduciary duty—by failing to pursue an avenue to significantly reduce payments by the Plan (in this case "systematically fail[ing] to take advantage of MLR discounts available to Plaintiffs" (Dkt. 90 at 3)) despite knowing the regulations required providers to accept MLR as full payment even where the parties had negotiated service rates.

Similarly, the plaintiffs in *Little Band* alleged that they "should have been paying no more than Medicare-Like Rates ("MLR") for all levels of care furnished by Medicare-participating hospitals." *Little Band*, 183 F. Supp. 3d at 843. That there is also a separate contract at issue in this case does not alter this analysis. The FCPA is a contract separate from the ERISA plan, and the breach of contract claim therefore is distinct from the ERISA claim, which arises from the ERISA plan and Medicare regulations applicable to those plans, and not the FCPA.

Moreover, as the Supreme Court has recognized, "[t]here is more to plan (or trust) administration than simply complying with the specific duties imposed by the plan documents or statutory regime; it also includes the activities that are

'ordinary and natural means' of achieving the 'objective' of the plan." *Varity Corp. v. Howe*, 516 U.S. 489, 504 (1996). Here, although the plan does not expressly require pursuit of MLR, it is plausible that, in deciding whether to pay claims and whether the negotiated rate should apply, defendant should have requested the provider accept MLR as payment in full as an "ordinary and natural means" of preserving plan assets and providing benefits to plan beneficiaries. Accordingly, defendant's motion to dismiss on this ground is denied.

Second, defendant argues it was not acting as a fiduciary with respect to negotiating payment rates with providers, and therefore cannot be held liable for breach of fiduciary duty based on failing to pursue MLR.

To state a claim for breach of fiduciary duty, a plaintiff must allege that a defendant was acting as a fiduciary with respect to the conduct at issue. *Pegram v. Herdrich*, 530 U.S. 211, 746–47 (2000). A fiduciary is defined as one who "exercises any discretionary authority or ... control respecting management of [a] plan, or ... disposition of its assets," and who "has any discretionary authority or ... responsibility in the administration of [a] plan." *Akers v. Palmer*, 71 F.3d 226, 231 (6th Cir. 1995) (citing 29 U.S.C. § 1002(21)(A)(i)). Neither party appears to dispute that defendant exercised discretionary authority or control over the plan and its assets; they disagree as to whether defendant was acting in a fiduciary capacity by failing to obtain MLR for plan participants. Defendant argues that the *Pegram* precedent is fatal to plaintiffs' claims, and also that obtaining MLR is analogous to negotiating rates, which the Sixth Circuit has held is not subject to breach of fiduciary duty claims. *DeLuca v. Blue Cross & Blue Shield of Mich.*, 628 F.3d 743, 747 (6th Cir. 2010).

But defendant's reliance on *Pegram* and *DeLuca* is misplaced. In *Pegram*, the plaintiff argued her physician breached a fiduciary duty under ERISA by making treatment decisions while simultaneously subject to a financial incentive to withhold or reduce treatment. *Pegram*, 530 U.S. at 226. The Supreme Court held that such claims were not cognizable as breach of fiduciary duty claims because "these eligibility determinations cannot be untangled from physicians' judgments about reasonable medical treatment." *Id.* at 229.

***5** The circumstances at issue in *Pegram* are significantly different than the allegations in this case. Here, the parties are not debating whether certain services were medically necessary or covered by the ERISA Plan. Rather, plaintiffs' allegations address only whether defendant failed to preserve plan assets by continually and consistently overpaying claims that defendant found eligible for coverage. In other words, the parties in this case do not dispute whether treatment should have been given or if claims were eligible for coverage under the terms of the Plan, as was the case in *Pegram*. Thus, this is not a claim where "eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment." 530 U.S. at 229.

In *DeLuca*, plaintiff alleged that defendant breached its fiduciary duties by agreeing to increase the rates for PPO plans in exchange for decreases in HMO rates as a means of "equaliz[ing] the rates paid" between the types of plans. *DeLuca*, 628 F.3d at 746. The Sixth Circuit held that defendant "was not acting as a fiduciary when it negotiated the challenged rate changes, principally because those business dealings were not directly associated with the benefits plan at issue but were generally applicable to a broad range of health-care consumers." *Id.* at 747. More broadly, "a business decision that has an effect on an ERISA plan" is not subject to fiduciary standards, but conduct that "constitutes 'management' or 'administration' of *the plan*" does. *Id.*

Again, plaintiffs' allegations in this case vary from those addressed by the *DeLuca* court. Here, plaintiffs are not seeking rate renegotiation on behalf of their individual Plan or arguing that the rate negotiations constituted self-dealing, as in *DeLuca*. Instead, plaintiffs allege that defendant knew providers were required to accept MLR by regulation in lieu of other rates established via contract, and systematically failed to invoke the regulation, which would have preserved plan assets. In other words, their argument is that defendant "squandered plan assets under its authority or control," which the *DeLuca* court indicated would implicate fiduciary concerns. *See DeLuca*, 628 F.3d at 747–48. Moreover, the allegations involve the "trustee's most defining concern historically": "the payment of money in the interest of the beneficiary." *Pegram*, 530 U.S. at 231.

Defendant next argues that permitting this cause of action would create a "novel cause[ ] of action not expressly authorized by the text of [ERISA]," and "the Supreme Court has repeatedly warned courts against permitting" such suits. *Clark v. Feder Semo and Bard, P.C.*, 739 F.3d 28, 29 (D.C. Cir. 2014).

But permitting this cause of action would not create a novel cause of action of the kind at issue in *Clark* or the Supreme Court cases cited by the *Clark* court. In *Clark*, plaintiff attempted to argue the plan administrator breached its fiduciary duty pursuant to 29 U.S.C. § 1344, which imposed enforcement obligations on the Secretary of the Treasury. The D.C. Circuit held that section 1344's "authority for the Secretary" could not become "the source of a duty for a plan fiduciary." *Clark*, 739 F.3d at 30. And in *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), relied on by the *Clark* court, the Supreme Court held that plaintiffs were not entitled to damages under section 502(a)(3)(A) because the text envisioned only injunctive or "appropriate equitable relief." 534 U.S. at 209–10.

By contrast, requiring defendant to take into account regulations that directly affect how it administers and manages plan assets would not create new remedies or conflict with statutory text that entrusts enforcement to an agency. Instead, as the *Clark* court pointed out, "general principles of fiduciary law imported into ERISA ... set bounds on the distributions [fiduciaries] authorize[ ]," 739 F.3d at 30, which is precisely the type of action at issue here. Moreover, alleging that defendant should have taken the MLR regulations into account when determining how much to pay out of plan assets boils down to a basic legal proposition that is neither novel nor controversial: fiduciaries must administer plans in compliance with federal laws. And although ERISA is a comprehensive regime, "the existence of duties under one federal statute does not, absent express congressional intent to the contrary, preclude the imposition of overlapping duties under another federal statutory regime." *In re WorldCom, Inc.*, 263 F. Supp. 2d, 745, 766–67 (S.D.N.Y. 2003) (rejecting argument that "tension between the federal securities laws and ERISA" required dismissal, and holding ERISA fiduciaries cannot transmit false information to plan participants); *see also In re The Goodyear Tire & Rubber Co. ERISA Litig.*, 438 F. Supp. 2d 783, 792 (N.D. Ohio 2006) ("compliance with securities laws does not negate their requirement to comply with other laws, such as ERISA").

***6** In sum, plaintiffs assert that defendant acted as a fiduciary in determining how much to pay on claims that it knew were subject to the MLR regulations because it had discretion to pay the lower rate rather than the contractual rate, as the MLR regulations clearly state. And for the reasons set forth above, defendant has failed to demonstrate that such allegations are barred by precedent or would improperly interfere with ERISA's statutory regime. Accordingly, plaintiffs have sufficiently pleaded that defendant was acting as a fiduciary when it paid out claims eligible for MLR, and defendant's motion to dismiss this claim as to Group #01020 on this ground is denied.

Whether the ERISA Claim is Time-Barred

Defendant next argues that the ERISA claim is barred by the statute of limitations because plaintiffs had actual knowledge by March 2009 that they were not receiving Medicare-Like Rates ("MLR"), when they entered into the FCPA with the intention of obtaining MLR for Group #01020. (Dkt. 94 at 13.)

Plaintiffs claim they did not know the "full extent of BCBSM's wrongful conduct until 2013" because defendant misrepresented to plaintiff that the FCPA discount would provide them with rates close to MLR. (Dkt. 90 at 18; Dkt. 96 at 16.) They further argue that because of these representations, the six-year period applies, or equitable tolling should apply.

"ERISA specifies a three- or six-year limitations period for claims of breach of fiduciary duty." *Durand v. Hanover Ins. Grp., Inc.*, 806 F.3d 367, 376 (6th Cir. 2015) (citing 29 U.S.C. § 1113). The six-year limitations applies "after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation." *Id.* Thus, when the duty at issue is a continuing duty, such as the duty to inform, "so long as the alleged breach of the continuing duty occurred within six years of suit, the claim is timely." *Tibble v. Edison Int'l*, —— U.S. ——, 135 S. Ct. 1823, 1828–29 (2015); *Durand*, 806 F.3d at 376.

"[A]n accelerated three-year limitations period is triggered as of 'the earliest date on which the plaintiff had actual knowledge of the breach.' " *Id.* "Actual knowledge means 'knowledge of the facts or transaction that constituted the alleged violation,' " and a plaintiff is deemed to have actual knowledge "when he or she has 'knowledge of all the relevant facts, not that the facts establish a cognizable legal claim.' " *Brown v. Owens Coring Inv. Rev. Cmte.*, 622 F.3d 564, 570 (6th Cir. 2010).

Additionally, "in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation." 29 U.S.C. § 1119.

First, with respect to Group #01019, the complaint indicates that prior to entering into the FCPA in March 2009, plaintiffs asked defendant to ensure they were receiving MLR, and were informed "BCBSM replied that it could not adjust its entire system." Nothing in the complaint shows that defendant represented to plaintiff at that time or at a later date that it would pursue MLR for Group #01019.[2] Plaintiffs argue the burden is on defendant to prove the limitations period has expired, but when the face of the complaint indicates the claim is untimely, a plaintiff has an "obligation to plead facts in avoidance of the statute of limitations defense." *Bishop v. Lucent Tech., Inc.*, 520 F.3d 516, 520 (6th Cir. 2008). And because plaintiffs did not plead facts in the complaint that would plausibly indicate they lacked actual knowledge in 2009 or that defendant made misrepresentations to them regarding MLR for Group #01019, the claim should have been brought by March 1, 2012 at the latest. Accordingly, the ERISA claim as it pertains to Group #01019 is untimely.

2 Plaintiffs also attempt to introduce evidence not referred to in the complaint to argue defendant "consistently represented to Plaintiffs that BCBSM was developing a process to provide Medicare-Like Rate pricing to all Plan participants who were tribal members." (Dkt. 96 at 18.) But on a motion to dismiss, the Court may consider only the allegations in the complaint. Thus, the issue is whether it is clear from the face of the complaint that plaintiffs had actual knowledge in 2009 or 2013.

***7** Next, with respect to Group #01020, plaintiffs argue that they relied on defendant's representation that they would receive rates close to MLR, as evidenced by their decision to sign the FCPA, and defendant concealed from them the fact that they were not receiving such rates. But, as plaintiffs have taken pains to make clear, the FCPA is not governed by ERISA and is separate from the original agreement entered into with defendant. (*See* Dkt. 90 at 6 ("Plaintiffs' claims for breach of fiduciary duty under ERISA are separate and distinct from Plaintiffs' claim for breach of the FCPA"; describing FCPA as "separate contractual agreement").) In fact, plaintiffs entered in to the FCPA *because* they knew they were not receiving MLR under the Plan governed by ERISA. Thus, any fraud or concealment would relate to the FCPA, and not the ERISA claim, and the three-year statute of limitations applies.

Plaintiffs argue that the ERISA claim is broader than the breach of contract issue because the FCPA applied to services only from Munson Medical Center, while the Plan applied to all Medicare-participating hospitals. (Dkt. 90 at 6.) While this is true, as with Group #01019, the complaint alleges nothing that would permit the inference that plaintiffs lacked knowledge with respect to these other providers by March 2009.

In sum, plaintiffs had actual knowledge by March 1, 2009 that they were not receiving MLR for Group #01020, and because the case was filed in 2014, the ERISA claim as to Group #01020 is untimely.

B. Counts II-VI: State Law Claims

Defendant argues that ERISA preempts Count II, part of Count III (good faith and fair dealing), and Count IV. (Dkt. 94 at 24.) Defendant also argues that Counts V and VI are improperly duplicative of the breach of contract claim. (*Id.* at 26.)

Plaintiffs concur that ERISA preempts Counts II and IV (Dkt. 96 at 29), and these counts are dismissed.

Count III: Breach of Contract and Implied Covenant of Good Faith and Fair Dealing

Defendant argues ERISA preempts plaintiffs' claim that it breached the implied covenant of good faith and fair dealing, and also that Michigan does not recognize this covenant as an independent cause of action. Defendant does not challenge the breach of contract claim. Plaintiffs make no argument as to why their claim under the implied covenant should not be dismissed.

Under Michigan law, there is no independent cause of action for a breach of the implied covenant of good faith and fair dealing. This implied covenant "applies to the performance and enforcement of contracts," and a breach of this covenant may be invoked as a breach of contract claim only when one party "makes its performance a matter of its own discretion." *Stephenson v. Allstate Ins. Co.*, 328 F.3d 822, 826 (6th Cir. 2003). "Discretion arises when the parties have agreed to defer decision on a particular term of the contract," id. at 826, or "omits terms or provides ambiguous terms." *Wedding Belles v. SBC Ameritech Corp., Inc.*, Case No. 250103, 2005 WL 292270, at *1 (Mich. App. Feb. 8, 2005). "Whether a

performance is a matter of a party's discretion depends on the nature of the agreement." *ParaData Comp. Networks, Inc. v. Telebit Corp.*, 830 F. Supp. 1001, 1005 (E.D. Mich. 1993). "A party may not invoke the implied covenant of good faith and fair dealing to override express contract terms." *Stephenson*, 328 F.3d at 826; *Gen. Aviation v. Cessna Aircraft Co.*, 915 F.2d 1038, 1041 (6th Cir. 1990).

Here, the FCPA does not leave defendant with discretion as to whether to pay the discount or how to calculate it. There is a formula for calculating the discount, and defendant is obligated to pay that amount. Further, no terms appear to be omitted. Thus, plaintiffs may not rely on the implied covenant as an alternative to their breach of contract claim. Accordingly, defendant's motion to dismiss this part of Count III is granted.

Counts V and VI: Fraud and Silent Fraud

***8** Defendants argue that Counts V and VI must be dismissed as improperly duplicative of plaintiffs' breach of contract claim. (Dkt. 94 at 26.)

Under Michigan law, "[w]hen a contract governs the relationship between the parties, the plaintiff must allege a 'violation of a legal duty separate and distinct from the contractual obligation' to support a fraud claim." *Gregory v. CitiMortgage, Inc.*, 890 F. Supp. 2d 791, 802 (E.D. Mich. 2012) (quoting *Rinaldo's Const. Corp. v. Mich. Bell Tel. Co.*, 454 Mich. 65, 84 (1997)).

Here, plaintiffs argue defendant breached the contract by failing to provide it with the FCPA discount. They separately argue that defendant is liable for fraud and silent fraud by (1) representing repeatedly to plaintiffs between 2009 and 2012 that the FCPA discount would be close to MLR while knowing this to be false; and (2) failing to disclose that the FCPA discount was not close to MLR despite being obligated to do so. But any obligation to provide rates close to MLR and any obligation to disclose such discrepancies between the FCPA and MLR rates arise solely from the existence of the FCPA. Thus, there is no legal basis or duty separate from the contract that would permit plaintiff to plead fraud and silent fraud claims. *Leonor v. Provident Life and Acc. Co.*, Case No. 12-cv-15343, 2013 WL 1163375, at *2–3 (E.D. Mich. Mar. 20, 2013) (alleged fraud that plaintiff would receive benefits arose from contractual obligation to pay plaintiff and fraud claim was not actionable; collecting cases holding the same). Accordingly, defendant's motion to dismiss these counts is granted.

IV. Conclusion

For the reasons set forth above, defendant's motion to dismiss (Dkt. 94) is GRANTED as to Count I, Count II, Count III (implied covenant of good faith and fair dealing only), Count IV, Count V, and Count VI.

IT IS SO ORDERED.

All Citations

Not Reported in Fed. Supp., 2017 WL 3116262, 2017 Employee Benefits Cas. 253,492

End of Document

2020 WL 2039928
United States District Court, S.D.
Indiana, Indianapolis Division.

SENIOR LIFESTYLE CORPORATION, Plaintiff,
v.
KEY BENEFIT ADMINISTRATORS, INC., Defendant.

No. 1:17-cv-02457-JMS-MJD
|
Signed 04/28/2020

Attorneys and Law Firms

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ORDER

Hon. Jane Magnus-Stinson, Chief Judge

***1** On May 8, 2017, Plaintiff Senior Lifestyle Corporation ("SLC") filed a Complaint against Key Benefit Administrators ("KBA"), alleging that KBA breached its fiduciary duty under ERISA Section 502(a)(3), breached the contract it had with SLC, and acted with gross negligence resulting in SLC incurring extra expenses up to $1,000,000. [Filing No. 1 at 6-11.]

On September 23, 2019, SLC filed a Motion for Partial Summary Judgment, [Filing No. 283], in which it argues that it is entitled to partial summary judgment on the issue of KBA's liability under the breach of contract and ERISA claims. In response to SLC's Motion for Partial Summary Judgment, KBA filed a Cross-Motion for Summary Judgment, [Filing No. 304], alleging it is entitled to judgment in its favor on the claims against it. The parties have filed briefs in support of and in opposition to these motions, and SLC filed a Motion for Leave to File a Limited, Four-Page Surreply, [Filing No. 345], which KBA opposes, [Filing No. 350]. All of these motions are ripe for the Court's decision.

I.

LEGAL STANDARD

A motion for summary judgment asks the Court to find that a trial is unnecessary because there is no genuine dispute as to any material fact and, instead, the movant is entitled to judgment as a matter of law. *See* Fed. R. Civ. P. 56(a). As the current version of Rule 56 makes clear, whether a party asserts that a fact is undisputed or genuinely disputed, the party must support the asserted fact by citing to particular parts of the record, including depositions, documents, or affidavits. Fed. R. Civ. P. 56(c)(1)(A). A party can also support a fact by showing that the materials cited do not establish the absence or presence of a genuine dispute or that the adverse party cannot produce admissible evidence to support the fact. Fed. R. Civ. P. 56(c)(1)(B). Affidavits or declarations must be made on personal knowledge, set out facts that would be admissible in evidence, and show that the affiant is competent to testify on matters stated. Fed. R. Civ. P. 56(c)(4). Failure to properly support a fact in opposition to a movant's factual assertion can result in the movant's fact being considered undisputed, and potentially in the grant of summary judgment. Fed. R. Civ. P. 56(e).

In deciding a motion for summary judgment, the Court need only consider disputed facts that are material to the decision. A disputed fact is material if it might affect the outcome of the suit under the governing law. *Hampton v. Ford Motor Co.*, 561 F.3d 709, 713 (7th Cir. 2009). In other words, while there may be facts that are in dispute, summary judgment is appropriate if those facts are not outcome determinative. *Harper v. Vigilant Ins. Co.*, 433 F.3d 521, 525 (7th Cir. 2005). Fact disputes that are irrelevant to the legal question will not be considered. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

On summary judgment, a party must show the Court what evidence it has that would convince a trier of fact to accept its version of the events. *Johnson v. Cambridge Indus.*, 325 F.3d 892, 901 (7th Cir. 2003). The moving party is entitled to summary judgment if no reasonable fact-finder could return a verdict for the non-moving party. *Nelson v. Miller*, 570 F.3d 868, 875 (7th Cir. 2009). The court views the record in the light most favorable to the non-moving party and

draws all reasonable inferences in that party's favor. *Darst v. Interstate Brands Corp.*, 512 F.3d 903, 907 (7th Cir. 2008). It cannot weigh evidence or make credibility determinations on summary judgment because those tasks are left to the fact-finder. *O'Leary v. Accretive Health, Inc.*, 657 F.3d 625, 630 (7th Cir. 2011). The Court need only consider the cited materials, Fed. R. Civ. P. 56(c)(3), and the Seventh Circuit Court of Appeals has "repeatedly assured the district courts that they are not required to scour every inch of the record for evidence that is potentially relevant to the summary judgment motion before them." *Johnson*, 325 F.3d at 898. Any doubt as to the existence of a genuine issue for trial is resolved against the moving party. *Ponsetti v. GE Pension Plan*, 614 F.3d 684, 691 (7th Cir. 2010).

***2** "The existence of cross-motions for summary judgment does not, however, imply that there are no genuine issues of material fact." *R.J. Corman Derailment Servs., LLC v. Int'l Union of Operating Engineers*, 335 F.3d 643, 647 (7th Cir. 2003). Specifically, "[p]arties have different burdens of proof with respect to particular facts; different legal theories will have an effect on which facts are material; and the process of taking the facts in the light most favorable to the non-movant, first for one side and then for the other, may highlight the point that neither side has enough to prevail" on summary judgment. *Id.* at 648.

Despite the well-known nature of the foregoing standard, both parties appear to have disregarded their responsibility to demonstrate their entitlement to judgment by addressing the evidence in the light most favorable to the other party. Instead each argues its version of events and draws inferences in its own favor. This practice has proved particularly unhelpful to the Court.

II.

FACTUAL BACKGROUND [1]

[1] The parties filed several of their briefs and exhibits under seal. The Court recognizes that it is citing documents that were filed under seal; however, it attempts to do so without revealing any information that could be reasonably deemed confidential. If the Court does, however, discuss confidential information, it has done so because it is necessary to explain the path of the Court's reasoning. *See In re Specht*, 622 F.3d 697, 701 (7th Cir. 2010) ("Documents that affect the disposition of federal litigation are presumptively open to public view, even if the litigants strongly prefer secrecy, unless a statute, rule, or privilege justifies confidentiality."); *Union Oil Co. of Cal. v. Leavell*, 220 F.3d 562, 568 (7th Cir. 2000) (explaining that a judge's "opinions and orders belong in the public domain").

The following factual background is set forth pursuant to the standards outlined in Federal Rule of Civil Procedure 56, detailed above. *See* Fed. R. Civ. P. 56(a). The facts stated are not necessarily objectively true, but as the summary judgment standard requires, the undisputed facts and the disputed evidence are presented in the light most favorable to "the party against whom the motion under consideration is made." *Premcor USA, Inc. v. Am. Home Assurance Co.*, 400 F.3d 523, 526-27 (7th Cir. 2005). Because of the competing motions, that facts set forth below may at times appear contradictory. That inconsistency is simply a function of the presentation of certain facts in favor of the non-movant as required by law. It also underscores the basis of the Court's ultimate resolution of the motions.

In 2015—the time period relevant to this action—SLC managed approximately 170 senior living communities across the country. [Filing No. 285-1 at 34-35.] SLC's healthcare plan for its employees was self-funded by SLC, and SLC was the healthcare plan's sponsor. [Filing No. 305-3 at 4.]

KBA "is a third-party benefit administrator that supervises the operating of self-funded welfare benefits plans sponsored by the employers, such as SLC." [Filing No. 305-2 at 6.]

On November 19, 2014, SLC and KBA entered an Administrative Services Agreement for Medical Plan Administration (the "Agreement"), whereby KBA agreed "to provide administrative services with respect to [SLC's] Employee Welfare Benefit Plan ... in consideration of the payment by [SLC] of the fees and the agreements recited" in the Agreement. [Filing No. 284-1 at 2.] As part of this arrangement, SLC agreed to perform certain actions including: (1) "[d]etermine the eligibility of employees and dependents to receive benefits"; (2) "inform KBA of the addition or deletion of persons covered by the Plan"; (3) "[r]econcile eligibility and notify [KBA] of any discrepancies as soon as administratively possible, but no later than 60 days of the bill date"; and (4) "[p]ay all billings exactly as billed in a timely manner until any eligibility or billing issues are

resolved." [Filing No. 284-1 at 2.] In the Agreement, KBA agreed to: (1) "[r]econcile eligibility and rate discrepancies on bills following receipt of updated information from [SLC]"; (2) "[r]efund to [SLC] any overpayment of fees based on the reconciliation of employer's monthly billing with such refund to be limited to up to 90 days of overpayment"; (3) "[p]rovide appropriate billings for all services and insurance coverages and remit collected funds to the appropriate party"; (4) "[r]eport to [SLC] essential information with respect to the Plan and the procedures there under (sic) and assist in distribution of the material furnished"; (5) "[r]eport to [SLC] matters of general interest with respect to the Plan, e.g., problems of a recurring nature"; (6) "[s]ubmit to [SLC] a monthly accounting of payments made, with sufficient detail to provide for the tracking of funds used"; and (7) "[c]oordinate the purchase of stop-loss insurance coverage and provide stop loss claim administration." [Filing No. 284-1 at 4-5.] The Agreement also established the relationship between the parties, stating: "1. Nothing in this Agreement shall be construed as creating a fiduciary relationship between [KBA] and [SLC] or participants in the Plan," and "2. [KBA] shall act under this Agreement solely as agent of [SLC] in the administration of the Plan." [Filing No. 284-1 at 8.] The Agreement also included an anti-waiver provision that stated:

> ***3** Failure by either party to insist upon compliance with any term or provision of this Agreement at any time or under any set of circumstances will not operate to waive or modify that provision or render it unenforceable at any other time whether the circumstances are or are not the same. No waiver of any of the terms or provisions of this Agreement will be valid or of any force or effect unless in each instance the waiver or modification is contained in a written memorandum expressing such alteration or modification and executed by the parties.

[Filing No. 284-1 at 10.] The Agreement was for a one-year term, and SLC chose not to renew it for the 2016 plan year. [Filing No. 305-2 at 69.]

SLC received an Employer Administration Manual from KBA, which "was written to help [SLC] understand KBA, [SLC's] new medical benefits, and [SLC's] responsibilities as an employer to ensure the proper functioning of [its] plan." [Filing No. 314-2 at 107.] The manual states that "[o]n the 18th of each month, KBA will generate a monthly invoice for premiums and fees due for the following month." [Filing No. 314-2 at 112.] KBA would send the bill to SLC's designated representative via secure email, and the bill would "include a list of covered employees, the products they have selected, and the charges for each of these products." [Filing No. 314-2 at 112.] The manual also instructed that

> [t]he bill is due before the first of the next month. So a bill run on January 18th would be due on January 31st. It is important to pay as billed and on time. This allows for proper claim funding and prevents delays in claim payments.
>
> There is a 30-day grace period for each invoice before the client is terminated due to non-payment. However, late payments will result in a delay in claims payment. So always pay on time and as billed.

[Filing No. 314-2 at 112.]

As third-party administrator, KBA coordinated the purchase of stop-loss insurance coverage through a vendor, RGI, LLC ("RGI"), a managing general underwriter. [Filing No 305-4 at 11.] The stop-loss insurance carrier was Companion Life Insurance Company ("Companion"). [Filing No. 314-2 at 122-205.] SLC was the policyholder of the stop-loss insurance policy. [Filing No. 314-2 at 122-205.] SLC had a contractual relationship with Companion as SLC's stop-loss insurance carrier and had a contractual relationship with KBA as SLC's third-party administrator. [Filing No. 305-4 at 11.] KBA had a relationship with RGI as KBA's vendor for stop-loss insurance (for the benefit of SLC), and RGI had a relationship with Companion as a managing general underwriter. [Filing No. 305-4 at 11.] RGI and KBA are part of the "Key family of companies," which "is an informal [business name] for the collection of corporations and LLCs" that are used for conducting various business, and "[f]or W-2 purposes, all of the employees for the various companies are KBA employees," and KBA has "leasing arrangements with the companies to lease employees to the various companies." [Filing No. 305-2 at 6.] Larry Dust is the sole owner of KBA, and he also serves as KBA's CEO. [Filing No. 285-12 at 8; Filing No. 305-1 at 5.] RGI is owned by the Dust Family Trust, and Larry Dust is RGI's

CEO. [Filing No. 285-12 at 11.] Approximately 90% of RGI's business comes from KBA clients. [Filing No. 285-8 at 18.] For the 2014 plan year, approximately 92.9% of RGI's stop-loss clients were placed with Companion; for the 2015 plan year, approximately 85.5% of RGI's stop-loss clients were placed with Companion. [Filing No. 285-11 at 24.]

***4** KBA was responsible for billing and collecting fees from SLC and remitting those collected fees to the appropriate parties. [Filing No. 305-4 at 8.] SLC would make monthly payments to KBA, which included a flat administrative fee for KBA's services, as well as payments for stop-loss insurance premiums and to fund the claims for SLC's self-funded plan. [Filing No. 305-5 at 5.] The stop-loss premium payment was part of the collected fees, and KBA would remit that premium to RGI, who would then remit the premium to Companion. [Filing No. 305-4 at 7-8.] The stop-loss premium was due to Companion on or before the first day of each calendar month. [Filing No. 314-2 at 151.] Companion provided a thirty-day grace period for payment of the monthly premiums. [Filing No. 314-2 at 151.] However, if a premium was not paid during the grace period, the stop-loss insurance policy would "terminate without further notice retroactive to the date for which premiums were last paid." [Filing No. 314-2 at 151.] RGI relied on KBA "to manage the billing and collection of the premium," and if the premium was not collected in full, RGI relied on KBA to collect the remaining amount owed. [Filing No. 305-4 at 9-10.]

KBA's invoices were created based on information from SLC regarding "which of their employees has signed up for the coverages being offered by the employer," which changed month to month. [Filing No. 305-2 at 37.] The information was to be transmitted to KBA in specific file format, which would then be recognized by KBA's electronic data interchange program and provided to the billing expert to create the invoice. [Filing No. 305-2 at 38.] The specifications and system requirements for uploading the data were not included in the Agreement, the Plan manual, the application, or the Plan document itself. [*See* Filing No. 327 at 31.] There were ongoing problems with SLC's attempts to upload and transfer its eligibility information, due, in part, to multiple failures to meet KBA's system requirement by UltiPro, SLC's eligibility vendor. [Filing No. 305-2 at 40; Filing No. 305-2 at 42.] UltiPro was one of about 180 eligibility vendors and/or employers that had this problem. [Filing No. 305-2 at 46.] "KBA worked with [UltiPro] to try to correct these problems," and even processed SLC's information by having KBA's IT department manually input the eligibility information. [Filing No. 305-2 at 44.] In manually loading SLC's eligibility information, KBA believed it was going "above and beyond what [it was] contracted to do," but it did so to be able to generate an invoice for SLC. [Filing No. 305-2 at 44.] KBA could only use the information that SLC successfully provided. [Filing No. 305-2 at 42.]

The monthly invoices KBA sent to SLC included the following instructions:

> 1. Please pay as billed. Send page one of this invoice along with a check made payable to KBA Self Funded for the total amount due to the address on this invoice.
>
> 2. If this invoice needs adjustments, write each adjustment in the column "Employee Notes." Please continue to pay as billed.
>
> 3. Include copies of any pages of this invoice where you have noted needed adjustments.
>
> 4. All adjustments noted on the invoice will be reflected on your next invoice.

[Filing No. 285-17 at 2.] The invoices included the due date, the current amount due for that month, a balance forward (for any payments that remained outstanding), and a total amount due (which was the total of the current amount due and the balance forward). [Filing No. 285-17 at 2.] The balance forward section of the invoice "highlights the fact that that you haven't paid your entire billed amount. And that's the flashing light that you haven't paid in full and that you need to." [Filing No. 305-4 at 8.] The invoice did not separately set out the amount of the bill that was dedicated to the payment of the stop-loss premium. [Filing No. 305-1 at 17.]

***5** The invoices were sent to Dwana Battee, SLC's benefits administrator. [Filing No. 285-17 at 2; Filing No. 314-3.] When Ms. Battee would get an invoice, she would pull a data report of all of the people who were enrolled in the plan to make sure that the list of people in KBA's invoice matched SLC's records and to make sure that all of the information in the invoice was correct. [Filing No. 314-3 at 15.] She would then send that data to accounts payable, who would prepare the payment to KBA. [Filing No. 314-3 at 11.] Ms. Battee's "focus was to make sure that the number of people that [SLC was] being billed for matches the number of enrollees that [SLC had] enrolled for—because if not, then we'd have to figure out where the discrepancy is." [Filing No. 314-3 at 16-17.] Ms. Battee was aware that SLC was regularly paying less than KBA had identified as the current amount due and

the total amount due. [Filing No. 314-3 at 30-31.] Ms. Battee testified that SLC was not paying the bill "as billed," but was instead paying "for what SLC determined to be the amount that was owed" based on its census data. [Filing No. 314-3 at 31; Filing No. 305-3 at 5.] KBA's billing specialist testified that

> [e]very few months [Ms. Battee] had eligibility issues, and we generally were discussing the fact that [Ms. Battee] didn't pay for somebody because she didn't feel like they should have been on the bill.... I generally would always tell [Ms. Battee] that she still needs to pay the bill as billed, ... [and] I would fix the person so we can get it corrected on the next month's bill."

[Filing No. 305-9 at 28.]

When KBA received SLC's single monthly payment, it automatically allocated the funds among the Plan's component parts, including the premium owed to Companion for stop-loss insurance, using "a fixed ratio, using a mathematical formula." [Filing No. 305-6 at 4; Filing No. 285-4 at 26.] KBA would remit the amount for the Companion premium to RGI, who "would then record the payment and then make sure the payment was made to Companion." [Filing No. 285-4 at 26.] KBA would allocate, based on the formula, whatever was paid to all of the entities KBA owed so that all of the entities would be "shorted," not just one entity. [Filing No. 285-8 at 5.] RGI would not necessarily know that its portion was shorted, because KBA was the party that had access to SLC's census data, which determined the amount owed for the stop loss coverage. [Filing No. 285-8 at 5.]

On a few occasions, SLC asked KBA to manually update an invoice that had been automatically generated to reflect eligibility data that was different than the data previously provided by SLC. [Filing No. 305-11 at 3.] Making these manual updates caused delays in KBA sending the invoices to SLC. [Filing No. 305-11 at 3.] KBA's billing specialist recalls that this happened with the October 2015 and November 2015 invoices. [Filing No. 305-11 at 3.] When KBA would send the invoices to SLC, it originally did so by emailing Ms. Battee the invoice in two forms: PDF and Excel. [Filing No. 305-11 at 3.] However, beginning with the October 2015 invoice, KBA used the EZBenefits platform to make invoices available to employers online. [Filing No. 305-11 at 3.] KBA advised SLC of this change in a September 16, 2015 email, which provided SLC with a guide and credentials for accessing the portal and indicated that SLC would receive an automated email from EZBenefits "[i]mmediately following the upload of the invoice to EZB." [Filing No. 305-13 at 2-4.] When KBA uploaded the PDF and Excel versions of the invoice separately to the EZBenefits portal, an automatic email notification from EZBenefits for each separate upload would be sent to the employer's designated contact person notifying them that the invoice was available for viewing. [Filing No. 305-11 at 3.] KBA generated SLC's October 2015 invoice on September 16, 2015 and uploaded the PDF version to the EZBenefits portal on September 22, 2015. [Filing No. 305-11 at 3.] KBA uploaded the Excel version of the October 2015 invoice to the portal on October 5, 2015. [Filing No. 305-11 at 3.] KBA contends that other than the format of the file (PDF or Excel), there are no differences between the two invoices uploaded; however, the documents themselves are no longer available. [Filing No. 305-11 at 3.]

***6** In the Fall of 2015, RGI brought to Companion's attention the fact that several of the stop-loss policyholders from which KBA was collecting premiums were not paying their bills. [Filing No. 305-1 at 12.] KBA contends that, prior to notifying RGI, it was trying to work with the delinquent employers "to try to help them help themselves" and "get them to pay their bills and pay them on time," but there were "enough cases that were behind on their premiums that, in fact, as RGI, it was time to go talk to Companion about ... what KBA has been doing." [Filing No 305-1 at 12.] Companion instructed RGI to ensure that the past-due numbers were correct and, if so, then those stop-loss policies must be terminated. [Filing No. 305-1 at 13.] KBA asserts that it was interested in trying to save those accounts because that is how KBA gets paid (and RGI gets paid), so KBA lobbied with Companion to allow a second review of the past-due premiums, and: (1) if the termination was based on facts that were proven to be inaccurate, then the termination could be rescinded; or (2) if the termination was based on accurate information, the terminated policyholders would be given an offer to reinstate the stop-loss policy on new terms. [Filing No. 305-1 at 13-14.] Although this was not something that Companion had done before, it agreed to allow rescission or reinstatement offers following a second review of the past-due premiums. [Filing No. 305-1 at 14.]

Oliver Ayres (RGI's president) and Larry Dust (as CEO of RGI) met to review all of the employers with past-due premiums that were subject to termination by Companion. [Filing No. 285-8 at 21.] They reviewed a report provided by KBA listing the employers who were believed to have failed to pay their premiums in full and on time, and they confirmed which groups had failed to pay their premium in full and were outside the thirty-day grace period. [Filing No. 285-8 at 21; Filing No. 285-8 at 24.] If both factors were met, then RGI would send that employer a termination notice. [Filing No. 285-8 at 21.] RGI determined that SLC failed to make an October 2015 payment, and that the thirty-day grace period had passed, so it sent a termination notice to SLC on November 6, 2015. [Filing No. 285-8 at 22; Filing No. 285-8 at 24.] Although KBA would usually send an employer a "lapse letter" informing it that it was subject to termination of its contracts, KBA chose not to send a lapse letter to SLC because, according to KBA, "[SLC] had actual, firsthand knowledge through the discussions between [KBA's billing specialist] and [Ms.] Battee that [SLC was] behind in [its] payments." [Filing No. 285-4 at 19.] However, the billing specialist testified that she does not recall if she told Ms. Battee that there would be consequences if the invoices were not paid in full. [Filing No. 305-9 at 28.]

During the time that this review of employer payments took place, RGI was in communication with Sirius (Companion's reinsurer, who was an additional risk-taker in the stop-loss policies), and they discussed projections of a potential large loss if certain employers filed stop-loss claims, but RGI's President, Oliver Ayres, testified that this projection did not factor into his consideration of whether SLC's stop-loss policy should be terminated. [Filing No. 305-4 at 49-51.]

By November 6, 2015, Jarolynn Gadson had replaced Ms. Battee as SLC's benefit coordinator. [Filing No. 305-11 at 3.] Ms. Gadson started at SLC on October 12, 2015 and Ms. Battee left SLC on October 16, 2015 after giving one week's notice. [Filing No. 314-7 at 5.] When Ms. Gadson received the termination letter from RGI, she called Mr. Dust and advised him she would overnight a check to RGI "first thing on Monday" once RGI informed her of the amount that SLC owed. [Filing No. 314-12 at 61; Filing No. 314-2 at 206; Filing No. 314-7 at 13-14.] Mr. Dust advised her that he would notify RGI and Companion that SLC's payment would be coming and that he would lobby to have Companion provide a reinstatement offer. [Filing No. 314-12 at 61; Filing No. 314-2 at 206; Filing No. 314-7 at 13-14.] However, SLC did not make the payment to RGI. [Filing No. 314-11 at 2.] SLC made a partial payment toward the October invoice on October 29, 2015—28 days after the October 1, 2015 due date—which was insufficient to pay the full October 2015 balance. [Filing No. 305-12 at 2.]

***7** The review of SLC's payments to KBA "showed that, from the very beginning, the invoices that were sent to SLC were never paid in full, and that [the] amounts shown as balance forwards were not made up," and "there was no evidence that there had been some mutual mistake. It was a situation of the SLC people not paying the invoice in full and on time." [Filing No. 305-2 at 65.] SLC maintains that other than the balance forward section on the invoices, "KBA never informed SLC that any of its payments were deficient or in breach of the Agreement," and "never took issues with any of SLC's payments." [Filing No. 305-3 at 5.] However, KBA contends that during phone conversations with Ms. Battee, KBA's billing specialist discussed the issue of SLC not paying the full amount. [Filing No. 305-9 at 27.]

III.

DISCUSSION

The Court will first address SLC's breach of contract claim, then will consider the breach of fiduciary duty claim.

A. Breach of Contract Claim

1. The Parties' Arguments

Each party claims that the other party breached the Agreement. SLC argues that KBA breached the Agreement by failing to act solely as SLC's agent; instead, KBA acted in the interest of RGI and Companion. [Filing No. 287-1 at 20-21.] SLC argues that KBA's breaches of the Agreement include: (1) "recommending and facilitating a termination inconsistent with the parties' historical conduct"; (2) "not attempting to accurately account for SLC's Plan obligations"; (3) "not paying SLC's stop-loss policy premiums"; (4) "changing SLC's payment terms"; (5) "not informing SLC that its stop-loss policy was perceived as underpaid and at risk of termination"; and (6) "not acting in SLC's sole interest, as the Agreement required." [Filing No. 287-1 at 21.] SLC contends that these breaches caused SLC's stop-loss policy to be improperly terminated. [Filing No. 287-1 at 21.] SLC asserts that it did not miss the October 2015 payment and,

moreover, that KBA had previously accepted SLC's payments of what SLC believed was owed, without any comment to SLC about its payments being deficient. [Filing No. 287-1 at 21-22.] SLC argues that, under Indiana law, KBA acquiesced to SLC's conduct for nine months, and KBA should not be able to use SLC's alleged breach of the payment terms as a basis for KBA's actions. [Filing No. 287-1 at 22.] SLC argues that KBA cannot rely on the anti-waiver provision in the Agreement because it consistently accepted less than what it believed it was owed and then, without notice, changed its position on the matter. [Filing No. 287-1 at 22.] SLC argues that KBA has admitted that its invoices were inaccurate and not timely, which in and of itself is a breach of the Agreement. [Filing No. 287-1 at 23.] SLC argues that, in fact, it had actually overpaid its Plan obligation at the time its stop-loss policy was terminated. [Filing No. 287-1 at 24.] SLC also argues that KBA failed to disclose information that was essential, or at least of general interest, to SLC's Plan, which is a separate breach of the Agreement. [Filing No. 287-1 at 25.] SLC contends that KBA's relationships with SLC, RGI, and Companion were in conflict, and KBA breached its duty to act solely as the agent of SLC. [Filing No. 287-1 at 26.] SLC argues that KBA does not have the evidence necessary to prove that on November 6, 2015, SLC had not paid an invoice due October 1, 2015 or that SLC's stop-loss premium payments were otherwise deficient. [Filing No. 287-1 at 29.]

In response and in support of its Cross-Motion for Summary Judgment, KBA argues that "[i]f SLC had simply done what it was supposed to do under the [Agreement], none of the problems that SLC complains about in this lawsuit would have happened." [Filing No. 316 at 40.] KBA argues that SLC's breach of contract claim is foreclosed because SLC first breached the Agreement by failing to pay KBA's invoices as billed and failing to supply KBA with accurate eligibility and enrollment data. [Filing No. 316 at 41.] KBA argues that even though there were problems with KBA getting the eligibility data, KBA's invoices were accurate as to the data that SLC provided. [Filing No. 316 at 44.] KBA contends that the Agreement did not entitle SLC to do its own pre-payment reconciliation of the invoice using its own employee census data to determine what amount SLC believed it owed; instead, SLC was required—and was repeatedly reminded—to pay the invoice as billed. [Filing No. 316 at 45.] KBA also argues that it did not acquiesce in SLC's failure to pay on time and as billed. [Filing No. 316 at 46.] KBA points out that it was Companion—not KBA—that terminated the stop-loss contract, and KBA repeatedly reminded SLC to pay on time, as billed. [Filing No. 316 at 46.] KBA also argues that it did not breach the Agreement by failing to provide SLC with essential information about the Plan, including ongoing problems, because: (1) KBA was not required to remind SLC of its own contractual obligations; (2) KBA had communicated that a failure to pay its invoices on time and as billed would result in the Plan being underfunded; (3) SLC's stop-loss policy with Companion clearly stated that non-payment of a premium beyond the thirty-day grace period would automatically result in termination of the policy; and (4) KBA and SLC were in constant communication about SLC's failure to pay its invoices on time and as billed. [Filing No. 316 at 50.] KBA argues that the Agreement did not require KBA to avoid business relationships with RGI and Companion, and it did not establish any kind of fiduciary relationship that would create such a requirement. [Filing No. 316 at 51.] KBA argues that Section VI.2 of the Agreement "stands only for the proposition that KBA merely agreed to act as SLC's *agent* in providing certain services 'in the administration of the Plan' and did not *assume* SLC's duties (and liability) as the Plan's sponsor and administrator." [Filing No. 316 at 52 (emphasis in original).] KBA also argues that SLC's theory that KBA colluded with RGI, Companion, and Sirius (Companion's reinsurer) to terminate employers' stop-loss policies to save Companion and Sirius money is "based on nothing but pure speculation." [Filing No. 316 at 52.] KBA points to its Rule 30(b)(6) testimony indicating that RGI did not consider SLC's potential large stop-loss claim when RGI determined that SLC's stop-loss policy was eligible for termination. [Filing No. 316 at 52.]

***8** In reply and in support of its Motion for Summary Judgment, and in response to KBA's Cross-Motion for Summary Judgment, SLC argues that KBA is attempting to rewrite its contractual obligations to SLC and that Angela Cromer, a KBA senior executive, confirmed that Section VI.2 of the Agreement "means that KBA will not act on behalf of anyone other than SLC in the administration of the plan." [Filing No. 327 at 10 (citing Filing No. 285-3 at 14).] SLC argues that the language of the Agreement is clear and unambiguous, and, even if it were ambiguous, it would be construed against KBA as the drafter. [Filing No. 327 at 14.] SLC also argues that KBA does not dispute that it created conflicts of interest, nor does it dispute that it knew SLC's stop-loss policy was in danger of termination, but it did not say anything to SLC about it. [Filing No. 327 at 15-16.] SLC argues that KBA failed to properly communicate with SLC and it merely included a "balance forward" amount in "one line in the middle of the [KBA] invoice, in 5-point font," which does not qualify as compliance with its duty to

report critical information to SLC. [Filing No. 327 at 25.] SLC also contends that KBA failed to relay information to SLC from RGI about the stop-loss plan—specifically, RGI's President sent an email to KBA telling it that SLC had "a lot of claims on fund hold, and that needs to be addressed with [SLC]," but KBA said nothing to SLC. [Filing No. 327 at 25 (citing Filing No. 285-8 at 44).] Moreover, SLC argues, KBA deliberately decided not to send a lapse letter to SLC informing it that it was at risk of termination of its stop-loss policy due to its incomplete payments. [Filing No. 327 at 27.] Regarding KBA's alleged acquiescence, SLC argues that it does not matter that Companion was the party who could terminate the policy; instead, the issue is whether KBA's prior breach defense is valid. [Filing No. 327 at 29.] SLC argues that "[b]ecause [KBA] gave SLC no notice of default or of its intent to no longer accept SLC's adjusted payments, the law precludes [KBA's] theory that SLC breached the contract first." [Filing No. 327 at 29-30.]

KBA counters in its reply in support of its Cross-Motion for Summary Judgment by first arguing that, at a minimum, SLC's breach of contract claim fails because it has not provided any evidence that it fully performed its part of the contract or any evidence that it suffered damages that were caused by KBA's alleged breaches. [Filing No. 338 at 6.] KBA also clarifies that although SLC argues that it actually overpaid, what really happened was "that the year end reconciliation of eligibility performed by KBA created an overpayment as reflected on the last 3 invoices," but it is undisputed "that SLC did not even pay those invoices until January 2016, at which point the year-end reconciliation established that SLC still owed KBA $1.1 million for those invoices." [Filing No. 338 at 10.]

2. Construction of the Parties' Agreement

The Agreement provided that: "1. Nothing in this Agreement shall be construed as creating a fiduciary relationship between [KBA] and [SLC] or participants in the Plan," and "2. [KBA] shall act under this Agreement **solely as agent of [SLC] in the administration of the Plan**." [Filing No. 284-1 at 8 (emphasis added).] The parties dispute the meaning of the bolded language, and the Court finds that "a reasonable person could find the [language] susceptible to more than one interpretation"—either it means that KBA will act merely as an agent for SLC (not as a fiduciary) or it means that KBA must act only on behalf of SLC (not on behalf of any other parties). Accordingly, the language is ambiguous, and the Court must construe the meaning. *Four Seasons Mfg., Inc. v. 1001 Coliseum, LLC*, 870 N.E.2d 494, 501 (Ind. Ct. App. 2007) ("A contract is ambiguous when it is susceptible to more than one interpretation and reasonably intelligent persons would honestly differ as to its meaning.").

The Court notes that the word that KBA's general counsel chose to use was "solely," as opposed to "merely," and also notes that the contract must be construed against the drafter—here, KBA. *Buskirk v. Buskirk*, 86 N.E.3d 217, 224 (Ind Ct. App. 2017). For these reasons, the Court finds that the bolded language means that KBA promised to act on behalf of SLC only, as SLC's agent, and not in the interest of any other party. This interpretation is also in keeping with Indiana agency law, which provides that "[u]nless otherwise agreed, an agent owes a duty to his principal to act solely for the principal's benefit." *Bopp v. Brames*, 713 N.E.2d 866, 8711 (Ind. Ct. App. 1999) (citing *Egan v. Burkhart*, 657 N.E.2d 401, 404 (Ind. Ct. App. 1995)).

3. Analysis of Breach of Contract Claim

Under Indiana law, "[t]o recover for a breach of contract, a plaintiff must prove that: (1) a contract existed, (2) the defendant breached the contract, and (3) the plaintiff suffered damage as a result of the defendant's breach." *Morris v. Crain*, 71 N.E.3d 871, 880 n.5 (Ind. Ct. App. 2017) (citation omitted). In reviewing the parties' cross-motions for summary judgment, the Court is mindful that "[p]arties have different burdens of proof with respect to particular facts; different legal theories will have an effect on which facts are material; and the process of taking the facts in the light most favorable to the non-movant, first for one side and then for the other, may highlight the point that neither side has enough to prevail" on summary judgment. *R.J. Corman Derailment Servs.,* LLC, 335 F.3d at 648. This mutual insufficiency is present here. From KBA's perspective, it is undisputed that SLC failed to pay the KBA invoices on time and as billed as the Agreement required, which a jury could well find to be a breach of the Agreement. However, from SLC's perspective, it is undisputed that nobody at KBA explicitly warned SLC that it was facing imminent termination of its stop-loss policy, and a jury could well find the absence of such a warning violated KBA's contractual obligations including, but not limited to, the provisions requiring KBA to "[r]eport to [SLC] essential information with respect to the Plan and the procedures there under (sic) and assist in distribution of the material furnished"; "[r]eport to [SLC]

matters of general interest with respect to the Plan, e.g., problems of a recurring nature"; and "[s]ubmit to [SLC] a monthly accounting of payments made, with sufficient detail to provide for the tracking of funds used." [Filing No. 284-1 at 4.] Moreover, the undisputed evidence concerning the nature of KBA's relationship with RGI could be deemed by a jury as a breach of KBA's obligations as agent for SLC. *See Potts v. Review Bd. of Ind. Employment Sec. Div.*, 475 N.E.2d 708, 711 (Ind. Ct. App. 1985) ("Unless otherwise agreed, an agent is subject to a duty to his principal to act solely for the benefit of the principal. An agent may not place himself in a position wherein his own interests are potentially antagonistic to those of his principal.") (citations omitted); *Brannan v. Kelley*, 148 N.E. 157, 158 (1925) ("The agent must, as to his principal, exercise the utmost good faith. He cannot, without the knowledge and consent of his principal, serve two masters.")

***9** Nevertheless, because a successful breach of contract claim requires that the complaining party has performed its obligations under the contract, *U.S. Research Consultants, Inc. v. Cnty. of Lake*, 89 N.E.3d 1076, 1086 (Ind. Ct. App. 2017), also at issue is whether SLC performed its obligations under the contract, or whether its failure to do so is excused by KBA's alleged acceptance of partial, untimely payments. The Court acknowledges that Indiana courts have recognized that a party can forfeit its right to declare a breach of an agreement where the party has historically allowed the breaches to occur. *See Scott-Reitz Ltd. v. Rein Warsaw Assocs.*, 658 N.E.2d 98, 104 (Ind. Ct. App. 1995) ("[W]hen a party deviates from strict performance called for by the contract, the former cannot suddenly declare the deviation a breach of contract. Notice must be given to the other party that strict performance will be required in the future, then if the party continues to deviate, a default can be declared."). This principle has even been applied in cases where an anti-waiver provision was contained in the contract. *See T-3 Martinsville, LLC v. US Holding, LLC*, 911 N.E.2d 100, 116 (Ind. Ct. App. 2009) (finding that the anti-waiver provision was inapplicable to the circumstances because party's acquiescence was an issue of estoppel, not waiver).

Moreover, an issue remains as to which party's conduct caused the damages of which SLC complains. *See Wesco Distrib. Inc. v. ArcelorMittal Ind. Harbor LLC*, 23 N.E.3d 682, 708 (Ind Ct. App. 2014) ("In order to recover on a breach of contract claim, the alleged breach must be a cause in fact of the plaintiff's loss.... Where any injury arising from the breach of contract may have resulted from multiple causes, ... the test is ... whether the breach was a substantial factor in bringing about the harm.") (quotations and citations omitted).

A jury will have to determine the principal remaining issues in this case including: (1) whether one or both of the parties breached the Agreement; (2) whether SLC breached the Agreement first, thereby making it unable to bring a successful breach of contract claim against KBA because it has not performed its obligations; (3) whether KBA acquiesced to SLC's deficient payments thereby preventing KBA from claiming that SLC's untimely, insufficient payments are a default; and/or (4) whether SLC's or KBA's alleged breach caused the damages.[2] These are genuinely disputed issues and are fundamentally for the jury to decide. Therefore, the Court denies both parties' motions seeking summary judgment on SLC's breach of contract claim.

2 Although not raised in their briefs in support of their motions for summary judgment, the matter of SLC's financial stability (as a potential reason for SLC's underpayments in 2015) is also at issue and will need to be evaluated by a jury.

B. Claim for Breach of Fiduciary Duty Under ERISA

1. The Parties' Arguments

Both parties also seek the entry of summary judgment in their favor on SLC's ERISA claim. SLC argues that KBA was a fiduciary under ERISA because it "had authority to determine whether a claim is payable under the terms of the plan," and it "managed Plan assets by establishing an account for the Plan's assets and paying Plan-related expenses from that account including claims and payment of, among other things, stop-loss policy premiums." [Filing No. 287-1 at 31 (internal quotations omitted).] SLC argues that KBA breached its fiduciary duties of loyalty and care to the Plan because it created conflicts of interest and failed to act solely in the interest of the Plan's participants and beneficiaries, instead acting in its own interest by protecting its business relationship with Companion, and in the interest of RGI, Companion, and Sirius, who were facing a $1 million stop-loss claim if SLC's stop-loss policy was not terminated. [Filing No. 287-1 at 31-33.] SLC argues that KBA's failure to inform SLC and the Plan about the imminent termination of the stop-loss policy violated ERISA. [Filing No. 287-1 at 33.] Separately, SLC argues that KBA also violated ERISA

because it improperly paid claims, and SLC contends that KBA admitted it improperly paid claims. [Filing No. 287-1 at 33-34.] Finally, SLC argues that KBA violated ERISA by failing to timely provide requested claims information. [Filing No. 287-1 at 34.] SLC maintains that it "tried for years, starting in late 2015, to get claims data from [KBA], and [KBA] would not provide it until well into this lawsuit." [Filing No. 287-1 at 34.]

***10** In response, KBA argues that it is not an ERISA fiduciary and did not breach any fiduciary duties. [Filing No. 316 at 53.] KBA contends that SLC's ERISA claim fails because: (1) the relevant documents (such as the Agreement) do not name KBA as a fiduciary; (2) KBA provided SLC with claims data upon request; and (3) SLC has not shown that KBA exercised discretion in paying claims. [Filing No. 316 at 59.] KBA admits that its maintenance of an account holding SLC Plan assets makes KBA a fiduciary for the purpose of managing those assets; however, KBA argues that "SLC must prove that KBA 'was acting as a fiduciary (that is, performing a fiduciary function) when taking the action subject to the complaint.' " [Filing No. 316 at 54 (quoting *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000)).] KBA argues that SLC has mischaracterized KBA's role in the claims process; KBA asserts that it performed purely ministerial functions and only performed the first level of review of claims, which does not make it a fiduciary. [Filing No. 316 at 55.] KBA argues that even if it was a fiduciary for the limited purpose of claims administration, its erroneous payment of some claims would not constitute a breach under ERISA because a fiduciary is not required to administer claims with 100% accuracy—although KBA came close with 99.73% accuracy, according to an audit)—but, instead, "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man ... would use ..." [Filing No. 316 at 57 (quoting 29 U.S.C. § 1104(a)(1)(B)).] KBA also challenges SLC's argument that KBA failed to provide SLC with claims data, arguing that there is no evidence in the record to support this assertion. [Filing No. 316 at 59.] Instead, KBA points to evidence demonstrating that it did, in fact, respond to SLC's requests. [Filing No. 316 at 59.] KBA also argues that SLC's complaints do not arise from KBA's handling of plan assets. [Filing No. 316 at 59.] Additionally, KBA argues that SLC has not identified any authority that required KBA to ensure SLC's stop-loss premiums were paid above all other Plan obligations, such as claims that were already underfunded. [Filing No. 316 at 59-60.] KBA argues that such an action would go against the Agreement's guidance on how payments would be allocated across the Plan's component parts. [Filing No. 316 at 61.] KBA also argues that under ERISA, having a conflict of interest, on its own, does not create a breach of fiduciary duty, and "ERISA fiduciaries may 'wear different hats' without breaching fiduciary duties to plan beneficiaries, so long as the fiduciary 'wear[s] only one at a time, and wear[s] the fiduciary hat when making fiduciary decisions.' " [Filing No. 316 at 61-62 (quoting *Pegram*, 530 U.S. at 225).]

In reply, SLC argues that the language in the Agreement disclaiming a fiduciary relationship was rejected by the Court two years ago "because these disclaimer clauses are void *per se* under 29 U.S.C. § 1110(a)." [Filing No. 327 at 36 (citing Filing No. 55 at 6 and Filing No. 41 at 8-9).] SLC also challenges KBA's argument about its "purely ministerial functions," arguing that discretion is not required to be a fiduciary for the purposes of using Plan assets. [Filing No. 327 at 36-37.] In any event, SLC argues, KBA did have discretion because the plan documents gave discretion to SLC *or its designee.* [Filing No. 327 at 40 (emphasis in original).] SLC also argues that KBA was a fiduciary because it exercised authority over Plan assets, and it breached this duty when it improperly used Plan assets to pay for services and products that are not covered by the Plan. [Filing No. 327 at 38.] SLC argues that 29 U.S.C. § 1104(a)(1)(D) requires that a plan fiduciary act "in accordance with the documents and instructions governing the plan"—here, the Agreement—and KBA failed to meet this requirement, thereby breaching its fiduciary duty. [Filing No. 327 at 43.] SLC also challenges KBA's argument that a fiduciary can wear "different hats," noting that the "different hats" in *Pegram* dealt with an employer being a fiduciary in one context but not in another, as opposed to a fiduciary playing both sides of a transaction and acting as an agent for RGI and Companion, opposite the Plan. [Filing No. 327 at 44.]

KBA counters in its reply in support of its Cross-Motion for Summary Judgment by first arguing that SLC has mischaracterized the Court's earlier ruling on KBA's motion for partial summary judgment: The Court did not affirmatively void KBA's disclaimer of fiduciary status in the Agreement, but instead, "refrained from ruling on the relevance of the [Agreement's] fiduciary disclaimer and KBA's fiduciary status without the benefit of factual development through discovery, which it now has." [Filing No. 338 at 5 (citing Filing No. 55 at 6-7).] KBA also reiterates its argument that it "was not an all-purpose fiduciary" just because it held Plan assets. [Filing No. 338 at 14.] KBA further argues that SLC did not delegate its discretionary authority to KBA. [Filing No. 338 at 15.] KBA contends that

it did not breach any duties of loyalty, because it did not act in furtherance of a conflict of interest merely by providing Companion with facts about SLC's payments, as Companion was contractually entitled to those payments. [Filing No. 338 at 11.] KBA also argues that the termination of a stop-loss policy is not a prohibited transaction under ERISA, because assisting with the administration of a stop-loss policy is not a transaction "involving the plan." [Filing No. 338 at 16.] KBA argues that there is a distinction between SLC's Plan and SLC's stop-loss policy, such that nothing about the stop-loss policy involved the Plan, and although the termination of the policy might have been adverse to SLC's interests as the plan sponsor, it was not adverse to the Plan. [Filing No. 338 at 16-18.] KBA argues that the prudent man standard of care applies to all of the subsections of 29 U.S.C. § 1104(a)—meaning that a failure to follow the plan documents does create a per se ERISA violation—and KBA is not liable for any such failure because it "was aware of the Plan's terms, took reasonable and prudent measures to follow the Plan's terms, did not intend to violate the Plan's terms, and its measures resulted in near-perfect compliance with the Plan's terms." [Filing No. 338 at 19-20.]

***11** SLC sought leave to file a sur-reply in support of its Motion for Partial Summary Judgment, arguing that KBA's reply raised two new factual assertions that KBA did not previously address: (1) the stop-loss policy is not part of the Plan, [Filing No. 346-1 at 2]; and (2) "SLC had a chance to get current on its [stop-loss] premiums after SLC received the termination notice," [Filing No. 346-1 at 3 (quotation marks omitted) (alteration in original).] SLC argues that KBA repeatedly admitted in its cross-motion/opposition that the stop-loss policy was part of the Plan. [Filing No. 346-1 at 2.] SLC contends that the Agreement makes it clear that the stop-loss policy was part of the Plan because the Agreement required that KBA "provide administrative services with respect to [SLC's] Employee Welfare Benefit Plan," which included "[c]oordinat[ing] the purchase of stop-loss insurance coverage and provid[ing] stop loss (sic) claim administration." [Filing No. 346-1 at 2 (quoting Filing No. 284-1 at 1; Filing No. 284-1 at 5).] SLC also notes that "[KBA's] witnesses confirm that the stop-loss policy was an integral part of the Plan." [Filing No. 346-1 at 2.]

KBA opposed SLC's Motion for Leave to file a sur-reply, [Filing No. 350], arguing that "SLC is not entitled to a sur-reply because KBA did not 'cite[ ] new evidence' or 'object[ ] to the admissibility' of SLC's evidence in its reply," and "there is nothing new about the assertions SLC challenges in KBA's reply brief." [Filing No. 350 at 1.] KBA contends that it never "argued SLC had an opportunity to cure its breach of its payment obligations after the termination of its stop-loss policy"; what KBA was referencing was the undisputed fact "that SLC had many opportunities to pay its delinquent invoices long before it did so." [Filing No. 350 at 2.] KBA further challenges SLC's request to file a sur-reply by noting that KBA's position in its reply regarding the relationship between the stop-loss policy and the Plan is a legal distinction, not a factual one. [Filing No. 350 at 2.] KBA also argues that these issues were direct replies to SLC's own arguments—not brand-new arguments raised for the first time in KBA's reply. [Filing No. 350 at 2-3.]

In its reply in support of its Motion for Leave, SLC argues that KBA "disregards [Local Rule 56-1] and argues that it can make new arguments on reply so long as it does not introduce new evidence." [Filing No. 353 at 2.] SLC argues that because KBA raised these two issues for the first time in its reply brief and because KBA would not be prejudiced by the Court allowing SLC's short sur-reply, the Court should permit SLC to respond to the new issues raised in KBA's reply. [Filing No. 353 at 4.]

Local Rule 56-1(d) provides: "A party opposing a summary judgment motion may file a surreply brief only if the movant cites new evidence in the reply or objects to the admissibility of the evidence cited in the response." [LR 56-1(d).] The Seventh Circuit has stated that "[t]he decision to permit the filing of a surreply is purely discretionary and should generally be allowed only for valid reasons, such as when the movant raises new arguments in a reply brief." *Meraz-Camacho v. U.S.*, 417 Fed. Appx. 558, 559 (7th Cir. 2011). Although the parties characterize the issues differently, the Court finds that the issues presented in KBA's reply are distinct enough to be considered new arguments. Accordingly, the Court **GRANTS** SLC's Motion for Leave to file a sur-reply and will consider the issues the parties discuss in the sur-reply, opposition brief, and reply brief.

2. Analysis of ERISA Breach of Fiduciary Claim

To succeed on a claim breach of fiduciary duty under ERISA, a plaintiff must prove that: (1) it has a right of action under ERISA (*i.e.*, that it is acting either as a plan fiduciary, beneficiary, or participant); (2) the defendant was a plan fiduciary; (3) the defendant breached its fiduciary

duties; and (4) there is a cognizable loss to the plan flowing from that breach. *Sharp Electronics Corp. v. Metropolitan Life Ins. Co.*, 578 F.3d 505, 512 (7th Cir. 2009) (citations omitted). A defendant will be considered a plan fiduciary if it: (1) "exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of assets"; (2) "renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so"; or, (3) "has any discretionary authority or discretionary responsibility in the administration of such a plan." 29 U.S.C. § 1002(21)(A). "[A] fiduciary shall discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries and (A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." 29 U.S.C. § 1104(a)(1). "[A] person deemed to be a fiduciary is not a fiduciary for every purpose but only to the extent that he performs one of the described functions." *Klosterman v. W. Gen. Mgmt, Inc.*, 32 F.3d 1119, 1122 (7th Cir. 1994). A fiduciary must discharge its duties "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims," and "in accordance with the documents and instruments governing the plan insofar as such document instruments are consistent with the provisions of this subchapter and subchapter III." 29 U.S.C. § 1104(a)(1)(B), (D). A fiduciary also "shall not (1) deal with the assets of the plan in his own interest or for his own account, (2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries, or (3) receive any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan." 29 U.S.C. § 1106(b). If a plan fiduciary "breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter," it "shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary," as well as being "subject to such other equitable or remedial relief as the court may deem appropriate...." 29 U.S.C. § 1109(a).

***12** SLC alleges that KBA breached its fiduciary duties in several ways: (1) acting in the interests of itself, RGI, Companion, and Sirius; (2) failing to advise SLC that its stop-loss policy was going to be terminated; (3) improperly paying claims; and, (4) failing to timely provide requested claims data. However, only the first two alleged violations are related to SLC's alleged damages—the termination of the stop-loss policy and the accompanying costs and expenses it incurred as a result. The Court will first address these bases for SLC's breach of fiduciary claim before turning to the remaining two theories.

As noted, to prevail on its breach of fiduciary duty claim, SLC must establish that KBA's alleged breach resulted in a cognizable loss to the plan. Here, the Court finds that the alleged damages were instead incurred by SLC, not the Plan. Although SLC attempts to characterize the damages as ones suffered by the Plan by arguing that the stop-loss policy was an integral part of the Plan, this argument ignores key evidence demonstrating that SLC is seeking relief on its own behalf, not on behalf of the Plan. First, in its Motion for Partial Summary Judgment, SLC alleges that KBA's "breaches of its duties to SLC caused SLC's stop-loss insurance, a vital component of its employee healthcare plan, to be terminated, causing SLC damages." [Filing No. 287-1 at 1.] Second, the insured under the stop-loss policy was SLC, not the Plan. *See* Filing No. 314-2 at 122-205. There is no evidence that KBA's alleged actions in the interest of itself, RGI, Companion, and Sirius or its alleged failure to advise SLC that its stop-loss policy was going to be terminated led to "a cognizable loss to the plan." *Sharp Electronics*, 578 F.3d at 512. In *Sharp Electronics*, the Seventh Circuit upheld the dismissal of the plaintiff's ERISA breach of fiduciary duty claim, noting that "[a]t no point does Sharp explain how the alleged breach of fiduciary imposed (or could have imposed) a loss on the Plan," and explaining that the damages for which Sharp was suing were "plainly damages and expenses to Sharp, as a company, not to the Plan. They [were] therefore not appropriate items of damage under either [29 U.S.C.] § 1109(a) or § 1132(a)(3)." *Id.* at 512-13. Similarly, here, the damages that form the basis of SLC's Complaint are the termination of its stop-loss policy and money that SLC had to expend as a result. These are clearly damages incurred by SLC, not the Plan. *See Trujillo v. Am. Bar Ass'n.* 706 Fed. Appx. 868 (7th Cir. 2017) ("[T]o redress ERISA violations or to enforce provisions of ERISA or a benefit plan, ... [a plaintiff] must do so in the interest of the plan, not for his own benefit."); *see also Chua v. Shippee*, 2013 WL 4846689, *7 (N.D. Ill. Sept. 10, 2013) (citing *Mass. Mut. Life Ins. Co.*

v. Russell, 473 U.S. 134, 140 (1985)) ("Any recovery on a claim for breach of fiduciary duty inures to the benefit of the plan."). Therefore, SLC's claim for breach of fiduciary duty based on allegations that KBA acted in the interest of itself, RGI, Companion, and Sirius and/or failed to advise SLC that its stop-loss policy was going to be terminated fails, and KBA's Cross-Motion for Summary Judgment on these claims is **GRANTED**.

The Court now turns to SLC's allegation that KBA breached its fiduciary duty by improperly paying claims. As for the first element SLC must prove, the parties do not dispute that SLC has a right of action under ERISA based on its status as a plan fiduciary. [Filing No. 63 at 1] (admitting that "SLC is the named fiduciary and plan administrator ... for an ERISA governed employee welfare benefit plan (the 'plan')"). The second element—whether KBA was a plan fiduciary and whether it was acting in that fiduciary capacity—is also met because it is undisputed that KBA established an account for holding SLC Plan assets and exerted control over the management and disposition of the assets. The Court finds that KBA was acting in that limited capacity (managing and disposing of Plan assets) when it paid the erroneous claims. *Chi. Dist. Council of Carpenters Welfare Fund v. Caremark, Inc.*, 474 F.3d 463, 471-72 (7th Cir. 2007) ("To make out a claim for breach of fiduciary duty under ERISA, [plaintiff] must show that [defendant] was a fiduciary as that term is defined in the statute and that [defendant] was acting in its capacity as a fiduciary at the time it took the actions that are the subject of the complaint."). The next step, however, is to determine whether the erroneous payment of a few claims constitutes a breach of fiduciary duty.

***13** ERISA requires that a fiduciary act prudently in administering claims. Payment of a few erroneous claims does not automatically constitute a breach of fiduciary duty. *DeBruyne v. Equitable Life Assur. Soc. of U.S.*, 920 F.2d 457, 465 (7th Cir. 1990). It is undisputed that KBA administered the claims with 99.73% accuracy, and there is no evidence that KBA acted imprudently when it paid the erroneous claims. The Seventh Circuit has recognized that "[t]he fiduciary duty of care ... requires prudence, not prescience." *Id.* at 465 (citation omitted). SLC's claim that KBA breached its fiduciary duties by improperly paying claims fails because there is no evidence that KBA acted imprudently.

SLC's breach of fiduciary duty claim based on KBA's alleged failure to provide claims data also fails. There is no evidence that KBA failed to respond to requests for claims data. In fact, KBA has provided a detailed summary of the times it responded to requests for documents, and SLC has not challenged that list. Therefore, that claim fails as well.

Finally, SLC also argues that 29 U.S.C. § 1104(a)(1)(D) provides a separate basis for its breach of fiduciary duty claim. Specifically, SLC argues that 29 U.S.C. § 1104(a)(1)(D) requires that a plan fiduciary act "in accordance with the documents and instructions governing the plan"— here, the Agreement—and KBA failed to meet this requirement, thereby breaching its fiduciary duty. However, this claim fails because, again, SLC has failed to demonstrate there was "a cognizable loss to the plan." *Sharp Electronics*, 578 F.3d at 512. The damages for which SLC complains are damages incurred by SLC, not the Plan. [3]

3 The Court also notes that the fiduciary claim against KBA regarding its compliance with the terms of the Agreement raises an issue not addressed by the parties: preemption. This claim and the breach of contract claim are based on essentially the same conduct, so if the claim arose under ERISA, the breach of contract claim would be preempted. 29 U.S.C. § 1144(a) (ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."); *Ampere Automotive Corp. v. Employee Ben. Plans, Inc.*, 1992 WL 220912, *1 (N.D. Ill. Sept. 1, 1992) ("Even state law claims brought pursuant to state laws which do not specifically pertain to employee benefit plans are preempted if the claims arise directly or indirectly from the administration of such plans."). It is unclear why the parties did not address this issue. However, it is of no consequence, as this breach of fiduciary duty claim under ERISA fails because SLC is seeking relief for its own losses, and not any loss of the Plan.

For these reasons, SLC's Motion for Partial Summary Judgment is denied because the claims raised do not relate to "a cognizable loss to the plan," *Sharp Electronics*, 578 F.3d at 512, nor does SLC establish a breach of the duty of prudence or to provide information as a matter of law. KBA's Cross-Motion for Summary Judgment is granted as to all of SLC's ERISA claims.

IV.

CONCLUSION

The court has identified numerous genuine issues of material fact, which preclude the entry of summary judgment. Accordingly:

1. SLC's Motion for Partial Summary Judgment, [283], is **DENIED**.

2. KBA's Cross-Motion for Summary Judgment, [304], is **GRANTED IN PART AND DENIED IN PART**.

3. SLC's Motion for Leave to File Limited, Four-Page Surreply, [345], is **GRANTED**.

The Court requests that the Magistrate Judge confer with the parties as soon as practicable to discuss the resolution of this matter short of trial.

All Citations

Not Reported in Fed. Supp., 2020 WL 2039928, 2020 Employee Benefits Cas. 157,972

End of Document

2020 WL 3642512
United States District Court, S.D.
Indiana, Indianapolis Division.

SENIOR LIFESTYLE CORPORATION, Plaintiff,
v.
KEY BENEFIT ADMINISTRATORS, INC., Defendant.

No. 1:17-cv-02457-JMS-MJD
|
Signed 07/06/2020

Attorneys and Law Firms

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ORDER

Jane Magnus-Stinson, Chief Judge

***1** On May 8, 2017, Plaintiff Senior Lifestyle Corporation ("SLC") filed a Complaint against Key Benefit Administrators ("KBA"), alleging that KBA breached its fiduciary duty under ERISA Section 502(a)(3), breached the contract it had with SLC, and acted with gross negligence resulting in SLC incurring extra expenses up to $1,000,000. [Filing No. 1 at 6-11.]

On September 23, 2019, SLC filed a Motion for Partial Summary Judgment, [Filing No. 283], in which it argued that it is entitled to partial summary judgment on the issue of KBA's liability under the breach of contract and ERISA claims. In response to SLC's Motion for Partial Summary Judgment, KBA filed a Cross-Motion for Summary Judgment, [Filing No. 304], asserting that it is entitled to judgment in its favor on the claims against it. On April 28, 2020, the Court denied SLC's Motion for Partial Summary Judgment and granted in part and denied in part KBA's Cross-Motion for Summary Judgment. [Filing No. 382.]

On May 27, 2020, SLC filed a Motion for Reconsideration, asking the Court to reconsider its entry of summary judgment in KBA's favor on SLC's ERISA claim. [Filing No. 383.] That motion is ripe for decision.

I.

STANDARD OF REVIEW

A "district court possesses the power ... to alter or amend a judgment after its entry." Fed. R. Civ. P. 59(e) 1946 Committee Notes. Relief under Rule 59(e) is an "extraordinary remed[y] reserved for the exceptional case." *Childress v. Walker*, 787 F.3d 433, 442 (7th Cir. 2015) (quoting *Foster v. DeLuca*, 545 F.3d 582, 584 (7th Cir. 2008)). Rule 59 motions are for the limited purpose of "correct[ing] manifest errors of law or fact or ... present[ing] newly discovered evidence." *Rothwell Cotton Co. v. Rosenthal & Co.*, 827 F.2d 246, 251 (7th Cir. 1987) (citation and quotation omitted). "A 'manifest error' is not demonstrated by the disappointment of the losing party. It is the 'wholesale disregard, misapplication, or failure to recognize controlling precedent.' " *Oto v. Metropolitan Life Ins. Co.*, 224 F.3d 601, 606 (7th Cir. 2000) (quoting *Sedtrak v. Callahan*, 987 F. Supp. 1063, 1069 (N.D. Ill. 1997)). A Rule 59(e) motion "does not provide a vehicle for a party to undo its own procedural failures, and it certainly does not allow a party to introduce new evidence or advance arguments that could and should have been presented to the district court prior to the judgment." *United States v. Resnick*, 594 F.3d 562, 568 (7th Cir. 2010) (quoting *Bordelon v. Chicago Sch. Reform Bd. of Trustees*, 233 F.3d 524, 529 (7th Cir. 2000)). Nor may a party use Rule 59(e) to "rehash previously rejected arguments." *Vesely v. Armslist LLC*, 762 F.3d 661, 666 (7th Cir. 2014) (internal quotation omitted).

II.

BACKGROUND

In 2015—the time period relevant to this action—SLC managed approximately 170 senior living communities across the country. [Filing No. 285-1 at 34-35.] SLC's healthcare plan (the "Plan") for its employees was self-funded by SLC, and SLC was the healthcare plan's sponsor. [Filing No. 305-3 at 4.]

KBA "is a third-party benefit administrator that supervises the operating of self-funded welfare benefits plans sponsored by the employers, such as SLC." [Filing No. 305-2 at 6.]

***2** SLC and KBA entered an Administrative Services Agreement for Medical Plan Administration (the "Agreement"), whereby KBA agreed "to provide administrative services with respect to [SLC's] Employee Welfare Benefit Plan ... in consideration of the payment by [SLC] of the fees and the agreements recited" in the Agreement. [Filing No. 284-1 at 2.]

As third-party administrator, KBA coordinated the purchase of stop-loss insurance coverage with Companion Life Insurance Company ("Companion"). [Filing No 305-4 at 11; Filing No. 314-2 at 122-205.] SLC was the policyholder of the stop-loss insurance policy. [Filing No. 314-2 at 122-205.]

KBA was responsible for billing and collecting fees from SLC and remitting those collected fees to the appropriate parties, including stop-loss insurance premiums to Companion. [Filing No. 305-4 at 7-8.] If a premium was late and was not paid during the thirty-day grace period, the stop-loss insurance policy would "terminate without further notice retroactive to the date for which premiums were last paid." [Filing No. 314-2 at 151.]

In the fall of 2015, it was brought to Companion's attention that several of the stop-loss policyholders from which KBA was collecting premiums were not paying their bills. [Filing No. 305-1 at 12.] It was determined that SLC failed to make an October 2015 payment and the thirty-day grace period had passed, so SLC was sent a termination notice on November 6, 2015. [Filing No. 285-8 at 22; Filing No. 285-8 at 24.]

SLC filed a Complaint against KBA, alleging that KBA breached its fiduciary duty under ERISA Section 502(a)(3), and that the breach resulted in the stop-loss policy being terminated. [Filing No. 1 at 6-11.] The parties filed cross-motions for summary judgment, each arguing that it was entitled to judgment in its favor on SLC's ERISA claim. [Filing No. 283; Filing No. 304.]

To prevail on its ERISA breach of fiduciary duty claim, SLC was required to establish that KBA's alleged breach resulted in a cognizable loss to the Plan. *See Sharp Electronics Corp. v. Metropolitan Life Ins. Co.*, 578 F.3d 505, 512 (7th Cir. 2009). The Court, however, found that the alleged damages were instead incurred by SLC, not the Plan. [Filing No. 382 at 29.] The Court explained that "[a]lthough SLC attempts to characterize the damages as ones suffered by the Plan by arguing that the stop-loss policy was an integral part of the Plan, this argument ignores key evidence demonstrating that SLC is seeking relief on its own behalf, not on behalf of the Plan." [Filing No. 382 at 29.] The Court pointed to SLC's statements about the termination of the policy "causing SLC damages," [Filing No. 382 at 29 (quoting Filing No. 287-1 at 1)], and to the stop-loss policy documents themselves identifying the "Contractholder" as "Senior Lifestyle Corporation" for one policy (for the Minimum Essential Coverage ("MEC")), *see* Filing No. 314-2 at 129, and "Senior Lifestyle Corporation – MVP" for the other policy (for the Minimum Value Plan ("MVP")), *see* Filing No. 314-2 at 168, [Filing No. 382 at 29]. The Court found that there was "no evidence that KBA's alleged actions ... or its alleged failure to advise SLC that its stop-loss policy was going to be terminated led to 'a cognizable loss to the plan.' " [Filing No. 382 at 29 (quoting *Sharp Electronics*, 578 F.3d at 512).] The Court held that because the damages that formed the basis of SLC's Complaint—namely, the termination of its stop-loss policy and the money that SLC had to expend as a result—were clearly damages incurred by SLC, not the Plan, SLC's ERISA breach of fiduciary claims failed, and KBA was entitled to summary judgment on those claims. [Filing No. 382 at 30.]

III.

DISCUSSION

***3** In its Motion for Reconsideration, SLC argues that KBA did not meet its burden on summary judgment because it did not provide the Court with evidence showing that the stop-loss policy was a contract between Companion and SLC, and that only SLC—not the Plan—was injured. [Filing No. 383 at 1.] SLC points to one of KBA's previous filings, which, according to SLC, "showed SLC's *Plan* ('Senior Lifestyle Corporation – MVP' ...) was the contract holder." [Filing No. 383 at 3 (emphasis in original) (citing Filing No. 35-1).] SLC argues that any distinction between SLC and its Plan "raises form over function." [Filing No. 383 at 3.]

In response, KBA asserts that SLC's position in is inconsistent with the record, and the Court was correct in drawing the distinction between SLC's assets and the Plan's assets. [Filing No. 387 at 1.] KBA points to the following evidence in the

record that, it argues, supports the Court's finding that SLC was the injured party: (1) a provision in the Agreement stating that "[s]top-loss insurance protects self-funded plan sponsors, such as SLC, from heavy losses caused by unexpectedly high total Plan claims," [Filing No. 387 at 2 (quoting Filing No. 287-1 at 3)]; (2) the deposition testimony of Angela Cromer wherein she stated that SLC was the insured, [Filing No. 387 at 2-3 (citing Filing No. 305-5 at 13-15)]; (3) the stop-loss policy itself, [Filing No. 387 at 3]; and (4) the deposition testimony of SLC's Rule 30(b)(6) witness, who stated that the stop-loss policy identified SLC as the contract holder, [Filing No. 387 at 3]. KBA maintains that it is undisputed that the stop-loss policy would have paid benefits to SLC, not to the Plan, and that this undisputed fact was included in SLC's Complaint and is, therefore, a "binding admission[ ]." [Filing No. 387 at 4 (quoting *Jackson v. Marion Cty.*, 66 F.3d 151, 153 (7th Cir. 1995)).] KBA argues that SLC's motion should be denied because it is an attempt "to create a dispute out of an undisputed fact," and "it rehashes a legal issue (on grounds contrary to settled law under ERISA)." [Filing No. 387 at 7.]

In reply, SLC argues that KBA "had the burden to show that SLC, and not SLC's employee benefits Plan, was the stop-loss insurance contract holder, and that only SLC would receive the benefits of that policy, or suffer harm when it was wrongfully terminated." [Filing No. 393 at 1.] SLC notes that KBA did not plead as an affirmative defense that SLC lacked standing to pursue its ERISA claim, nor did it state that SLC was not the real party in interest. [Filing No. 393 at 1.] SLC challenges KBA's reliance on the 30(b)(6) witness testimony, noting that there are two stop-loss policies: one that identifies the contract holder as "Senior Lifestyle Corporation," (which was discussed in KBA's response) and one that identifies the contract holder as "Senior Lifestyle Corporation – MVP," which was confirmed by the 30(b)(6) witness. [Filing No. 393 at 2.] SLC argues that KBA did not identify any evidence showing that the Plan was not injured when the stop-loss policy was terminated, and SLC suggests that the Plan would have been injured because the policy was SLC's source of funding for the Plan. [Filing No. 393 at 3.] SLC contends that ERISA did not intend to leave a Plan without a remedy where the fiduciary breached its duties but the employer made the Plan whole, which SLC argues would be the result if the Court adopts KBA's position. [Filing No. 393 at 3.]

The Court disagrees with SLC's argument that KBA failed to meet its burden on summary judgment. The evidence in the record demonstrates that SLC, not the Plan, was the policyholder of the stop-loss policy. Specifically, in support of its Cross-Motion for Summary Judgment, KBA submitted the stop-loss policy documents identifying the "Contractholder" as "Senior Lifestyle Corporation." [Filing No. 314-2 at 129; Filing No. 314-2 at 168.] Accordingly, the termination of the stop-loss policy would cause damage to SLC as the policyholder. This conclusion is supported by: (1) several admissions by SLC found in the record, including the allegations in SLC's Complaint; (2) deposition testimony of multiple witnesses; and (3) documents like the Agreement. This evidence establishes as a matter of law that the Plan was not the insured. Because the Plan was not the policyholder, it was not party injured by the termination of the stop-loss policy. For that reason, SLC's ERISA claim fails because there is not "a cognizable loss to the plan." *Sharp Electronics*, 578 F.3d at 512.

***4** SLC has not demonstrated that the Court committed a manifest error of law or fact, nor has it presented newly discovered evidence requiring reconsideration. Having found that SLC has not presented any grounds under Rule 59(e) to set aside or vacate the Court's entry of judgment in favor of KBA on SLC's ERISA breach of fiduciary duty claim, the Court **DENIES** SLC's Motion for Reconsideration, [Filing No. 383].

IV.

CONCLUSION

For the foregoing reasons, the Court **DENIES** SLC's Motion for Reconsideration, [383].

All Citations

Slip Copy, 2020 WL 3642512, 2020 Employee Benefits Cas. 249,389

End of Document

2011 WL 830623
Only the Westlaw citation is currently available.
United States District Court,
N.D. California.

DANIEL F., et al., Plaintiffs,
v.
BLUE SHIELD OF CALIFORNIA, et al., Defendants.

No. C 09–2037 PJH.
|
March 3, 2011.

Attorneys and Law Firms

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ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT; ORDER DENYING PLAINTIFFS' MOTION FOR LEAVE TO AMEND COMPLAINT

PHYLLIS J. HAMILTON, District Judge.

***1** Defendant's motion for summary judgment came on for hearing on February 16, 2011. Plaintiffs' motion for leave to amend the complaint came on for hearing on December 22, 2010. At both hearings, plaintiffs appeared by their counsel Brian S. King and David M. Lillienstein, and defendant appeared by its counsel Craig S. Bloomgarden and Gregory Pimstone. Having read the parties' papers and carefully considered their arguments and the relevant legal authority, and good cause appearing, the court hereby GRANTS defendant's motion and DENIES plaintiffs' motion.

BACKGROUND

This is an action filed under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, et seq. ("ERISA"), challenging the denial of benefits under a health benefits plan. Defendants are California Physicians' Service d/b/a Blue Shield of California ("Blue Shield") and the Ogdemli/Feldman Design Group Benefits Plan ("the Plan"). The Plan is an employee benefits plan as defined under ERISA, and is funded through a group health contract issued by Blue Shield. Blue Shield is a not-for-profit health care service plan, regulated by the California Department of Managed Health Care ("DMHC").

Plaintiffs Daniel F. and Shan O. are the parents of plaintiff Geoffrey F. ("Geoffrey"). Daniel F. and Shan O. were both employed by the Ogdemli/Feldman Design Group, and were participants in the Plan. Geoffrey was a minor at the time of the events alleged in the complaint, and was a beneficiary of the Plan. The Plan provided health care coverage to plaintiffs during the time period in question (May 24, 2007 through February 27, 2008). Blue Shield is the claims administrator for the Plan.

Daniel F. and Shan O. adopted Geoffrey when he was 13 years old. Prior to that time, Geoffrey had been admitted for acute inpatient psychiatric treatment on several occasions. In 2005 and early 2006, Geoffrey participated in intensive outpatient therapy with Action Family Counseling. On December 20, 2005, Blue Shield received a call from Action Family Counseling on behalf of plaintiffs, inquiring about benefits available under the Plan. Blue Shield provided that information, and also advised the caller that residential treatment was not a covered benefit.

In April 2007, Geoffrey was admitted to a wilderness therapy program. Following his discharge from that program, he was admitted to Island View Residential Treatment Center ("IVRTC") in the State of Utah on May 24, 2007. He remained at IVRTC until February 27, 2008. Three days prior to Geoffrey's enrollment, Blue Shield received a call from IVRTC on behalf of plaintiffs, regarding whether residential treatment was covered under the Plan. Blue Shield informed IVRTC that residential care was not covered. IVRTC noted that "RTC is not a covered benefit" in its "Verification of Benefits Form" for Geoffrey.

At the time of Geoffrey's admission to IVRTC, plaintiffs received a letter addressed to "Parent/Guardian," advising generally that residential care at IVRTC might not be covered by insurance. The letter stated, "After any denial by insurance (non-contracted or contracted payers), you are expected to pay treatment costs.... By signing this agreement, you acknowledge that your insurance carrier has the right to deny services at any time...." Despite having received this

notice, and despite having been advised by Blue Shield that residential services were not covered under the Plan, plaintiffs enrolled Geoffrey at IVRTC.

***2** According to its website, IVRTC is a "high-impact, long-term residential treatment environment; one that can help troubled teens address and overcome the full spectrum of personal obstacles." IVRTC provides 24–hour daily care, including overnight care, on an extended stay basis. IVRTC operates an accredited on-campus private school, providing a full six-period day program, five days a week. IVRTC also provides recreational activities for its residents, including fitness programs, intramural team sports, community service activities, community-based activities (movies, bowling, swimming), and various outdoor activities (camping, hiking, river running, skiing/snowboarding, rock climbing).

IVRTC bills for its services on a per diem basis. The "all-inclusive" per diem rate includes charges for psychiatric evaluation and therapy, and medication management, as well as for the educational program at the private school, the recreational activity program, and room and board. IVRTC submitted bills to Blue Shield for Geoffrey's care, and all such claims described the services provided as "Room & Board RTC."

Blue Shield's Medical Director Dr. David Omerod reviewed the records relating to Geoffrey's stay at IVRTC, and concluded that under the Plan, "[r]esidential care is a benefit exclusion and not a covered benefit. Provider's assertion that residential care benefit exclusion is not applicable to 'parity' mental health diagnoses is incorrect." Blue Shield then issued Explanations of Benefits to plaintiffs and IVRTC denying the claims.

Plaintiffs filed the present action on May 8, 2009, as a proposed class action, challenging Blue Shield's practice of excluding coverage for residential care for treatment for mental health conditions. Plaintiffs allege in the complaint that the practice of excluding coverage for residential treatment services involving mental health conditions violates the terms of Blue Shield's policies, and the requirements of California Health and Safety Code § 1374.72 ("the Parity Act") and California Insurance Code § 10144 .5.

Health & Safety Code § 1374.72 is part of the Knox–Keene Health Care Service Plan Act, Cal. Health & Safety Code §§ 1340, et seq., which governs Blue Shield as a health care service plan. Insurance Code § 10144.5 governs policies of disability insurance. Health & Safety Code § 1374.72 and Insurance Code § 10144.5 include identical language requiring coverage of mental health on a par with coverage for other medical conditions. [1]

1 Plaintiffs appear to have abandoned any claim under Insurance Code § 10144.5. Accordingly, and because the Plan at issue in this case does not provide disability insurance coverage, the court addresses only the portion of the claim under the Parity Act, Health & Safety Code § 1374.72.

Health & Safety Code § 1374.72 requires, that

> (a) Every health care service plan contract issued, amended, or renewed after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).
>
> ***3** (b) These benefits *shall include* the following:
>
> (1) Outpatient services.
>
> (2) Inpatient hospital services.
>
> (3) Partial hospital services.
>
> (4) Prescription drugs, if the plan contract includes coverage for prescription drugs.
>
> (c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:
>
> (1) Maximum lifetime benefits.
>
> (2) Copayments.
>
> (3) Individual and family deductibles.
>
> * * *
>
> (e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a

primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

Cal. Health & Safety Code § 1374.72.

The complaint asserts two causes of action: a claim alleging that Blue Shield's refusal to provide coverage for residential treatment of mental health conditions violates the terms of the insurance contract, which provides coverage for appropriate medically necessary for mental health conditions that accords with the requirements of California insurance law; and a claim seeking a judicial declaration that Blue Shield's practice of denying coverage for residential treatment services violates the requirements of ERISA and the terms of the policies, and an order enjoining Blue Shield from excluding coverage for residential treatment services. [2]

2 At the hearing on Blue Shield's motion for summary judgment, plaintiffs' counsel clarified that the first cause of action is intended not as a state law claim, but as an ERISA claim, challenging the denial of benefits and seeking money damages, and that the second cause of action seeks declaratory relief under the same theory of liability.

In June 2009, Blue Shield moved to dismiss the complaint for failure to state a claim. In an order issued August 20, 2009, the court denied the motion, on the basis that Blue Shield was seeking a ruling on the merits of the claims, and that the parties' arguments went beyond the question whether the complaint adequately stated a claim under Federal Rule of Civil Procedure 8(a).

Following a period of discovery, Blue Shield filed a motion for summary judgment. The hearing date was continued to allow time to resolve various discovery disputes. As part of the resolution of those disputes, Blue Shield agreed to conduct a survey of 10 residential treatment facilities, selected by plaintiffs, and to determine the number of claims received and processed for the facility for individuals enrolled in an ERISA plan that had purchased group insurance from Blue Shield to fund the plan; whether the claims were paid; and if the claims were denied, the message codes in Blue Shield's database identifying the basis for denial (along with a key explaining the meaning of the codes).

Pursuant to the stipulation, Blue Shield completed the survey and provided the results to plaintiffs. The survey showed that certain bills submitted in 19 of 31 total claims reviewed were paid, either wholly or in part, by Blue Shield.

***4** Now before the court is Blue Shield's motion for summary judgment and plaintiffs' motion for leave to amend the complaint.

DISCUSSION

A. Blue Shield's Motion for Summary Judgment

1. Legal Standard

Under ERISA § 502, a beneficiary or plan participant may sue in federal court under ERISA "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. 29 U.S.C. § 1132(a)(1)(B). "If a participant or beneficiary believes that benefits promised to him under the terms of the plan are not provided, he can bring suit seeking provision of those benefits." *Aetna Health Inc. v. Davila,* 542 U.S. 200, 210, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004).

A claim of denial of benefits in an ERISA case "is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). If the plan confers such discretion, then the denial is reviewed for an abuse of discretion. *Metropolitan Life Ins. Co. v. Glenn,* 554 U.S. 105, 110–11, 128 S.Ct. 2343, 171 L.Ed.2d 299 (2008) (*"Glenn"*). [3]

3 In addition, when an administrator both evaluates and pays claims, a conflict of interest exists that must be weighed in determining whether the administrator met the arbitrary and capricious standard. *Id.* at 111–12; *Saffon v. Wells Fargo & Co. Long Term Disability Plan,* 522 F.3d 863, 868 (9th Cir.2008). In this case, however, plaintiffs do not point to any evidence showing that Blue Shield's decision to deny benefits for residential treatment was impermissibly influenced by a conflict of interest; and, indeed, do not even argue that this court should weigh any purported conflict of

interest in considering whether Blue Shield abused its discretion in denying their claim.

Under an abuse of discretion review, the dispositive issue is whether the denial of benefits was reasonable. *Winters v. Costco Wholesale Corp.,* 49 F.3d 550, 553 (9th Cir.1995); *see also Conkright v. Frommert,* —— U.S. ——, 130 S.Ct. 1640, 1651, 176 L.Ed.2d 469 (2010). An ERISA administrator abuses its discretion only if it renders a decision without explanation, construes provisions of the plan in a way that conflicts with the plain language of the plan, or relies on clearly erroneous findings of fact. *Boyd v. Bert Bell/Pete Rozelle NFL Players Retirement Plan,* 410 F.3d 1173, 1178 (9th Cir.2005). A finding is "clearly erroneous" when, even though it is supported by evidence, the reviewing court "is left with the definite and firm conviction that a mistake has been committed." *Id.* (quotations and citations omitted). A court must "uphold the decision of an ERISA plan administrator if it is based upon a reasonable interpretation of the plan's terms and was made in good faith." *Id.* (citing *Estate of Shockley v. Alyeska Pipeline Serv. Co.,* 130 F.3d 403, 405 (9th Cir.1997)).

Ordinarily, summary judgment is appropriate if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(a). However, "where the abuse of discretion standard applies in an ERISA benefits denial case, a motion for summary judgment is merely the conduit to bring the legal question before the district court and the usual tests of summary judgment, such as whether a genuine dispute of material fact exists, do not apply." *Nolan v. Heald College,* 551 F.3d 1148, 1154 (9th Cir.2009) (citation omitted). Nevertheless, the traditional rules of summary judgment do apply to evidence outside of the administrative record, including the requirement that the evidence must be viewed in the light most favorable to the non-moving party. *Id.* at 1150.

2. Blue Shield's Motion

***5** Blue Shield makes two main arguments. First, Blue Shield asserts it did not abuse its discretion by denying plaintiffs' claims for residential care, because the Plan explicitly states in three different places that it does not cover residential care. Blue Shield also notes that IVRTC advises prospective patients—including, in this instance, Geoffrey and his parents—that residential treatment might not be covered; and that Blue Shield advised IVRTC prior to Geoffrey's admission that it would not cover residential treatment at IVRTC.

Blue Shield asserts further that IVRTC is not a facility for which the Plan provides coverage. The Plan defines the types of facilities and services for which there is coverage for mental health benefits. The Plan provides inpatient mental health services when those services are provided at a "Hospital," and also covers mental health services at a "Partial Hospitalization/Day Treatment Program" and at an "Outpatient Facility," as those terms are defined in the Plan. Blue Shield contends that IVRTC does not qualify as either a hospital, or a partial hospitalization/day treatment program, or an outpatient facility. Thus, Blue Shield argues, it did not abuse its discretion in denying plaintiffs' claims for coverage for residential treatment.

In its second main argument, Blue Shield contends that it has fully complied with the requirements of the Parity Act, as the Plan provides parity of coverage between mental and physical conditions for all required categories under the Act. Blue Shield contends that residential care does not fall within one of the categories of services listed in Health & Safety Code § 1374.72(b) (outpatient services, inpatient hospital services, or partial hospital services). Blue Shield asserts that while the Parity Act requires "parity" between specified types of medical services and mental health services, it does not mandate coverage for any specific type of care and does not otherwise expand the terms of the Plan.

Nevertheless, Blue Shield asserts, regardless of whether residential care falls under one of those categories or not, there has been no violation of the Parity Act, because the Plan does not provide for residential treatment as a benefit—not for medical treatment, and not for mental health treatment. Thus, Blue Shield contends, the Plan provides complete parity between mental and physical conditions with respect to residential care.

In opposition to the motion, plaintiffs do not dispute that IVRTC does not provide outpatient services, and they also concede that it is not licensed in the State of Utah as a hospital, psychiatric hospital, or a psychiatric health care facility as defined under California law. Nevertheless, plaintiffs argue that the Parity Act requires Blue Shield to provide coverage for residential treatment, because residential treatment plays an important role in treating severely emotionally disturbed (SED) children, and because the Legislature intended that insurers cover "medically necessary" treatment.

***6** Plaintiffs contend that all aspects of the program at IVRTC, including the "educational" and "recreational"

components, are designed to complement and enhance the mental health and behavioral therapies provided for patients. They claim that residential treatment involves 24–hour supervision to ensure the safety of patients, as well as to ensure their compliance with treatment protocols, and argue that adolescents with serious and debilitating mental health conditions require a secure, residential treatment program in order to recover and begin functioning.

Plaintiffs contend that because the Parity Act requires that health plans provide coverage for the "diagnosis and medically necessary treatment ... of serious emotional disturbances of a child ... under the same terms and conditions applied to other medical conditions," Cal. Health & Safety Code § 1374.72(a), residential treatment should fall within the scope of the Parity Act. At the hearing, plaintiffs' counsel added that residential treatment for SED children is the mental health equivalent of treatment at a skilled nursing facility for physically injured patients, and that because Blue Shield covers treatment at skilled nursing facilities, the Parity Act requires that it cover residential treatment for SED children.

Finally, plaintiffs argue that information provided in discovery shows that Blue Shield has acted in an arbitrary and capricious manner in processing residential treatment claims under its policies. They claim that Blue Shield has paid for residential treatment for some patients at some other facilities, notwithstanding the fact that the Plans in those cases also provided that residential care was not covered; and that it has denied payment in others.

Plaintiffs contend this unequal treatment violates ERISA regulations, pointing to 29 C.F.R. § 2560.503–1(b)(5), entitled "Claims procedure," which provides as follows, under the heading "Obligation to establish and maintain reasonable claims procedures"—

> (b) Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan that will be deemed to be reasonable only if ....
>
> (5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

29 C.F.R. § 2560.503–1(b)(5). Plaintiffs assert that the same method of determining coverage has not been used by Blue Shield across the board, with every claimant under every health plan where Blue Shield is the insurer, and that Blue Shield's failure to pay for residential care for Geoffrey was therefore arbitrary and capricious.

***7** Blue Shield's motion is GRANTED. The Plan provides that "Blue Shield of California shall have the power and discretionary authority to construe and interpret the provisions of this Plan, to determine the Benefits of this Plan and determine eligibility to receive Benefits under this Plan." Accordingly, the court reviews Blue Shield's decision to deny benefits for abuse of discretion. That is, the court must determine whether Blue Shield's interpretation of the Plan was reasonable and in good faith; and whether Blue Shield rendered its decision without explanation, whether it construed provisions of the Plan in a way that conflicts with the plain language of the Plan, or whether it relied on clearly erroneous findings of fact in denying plaintiffs' claim for benefits for residential treatment.

First, the court finds that Blue Shield's interpretation of the Plan was reasonable and in good faith. The Plan covers inpatient mental health services, but only when those services are provided at a "Hospital," and also covers mental health services provided through a "Partial Hospitalization/Day Treatment Program" as defined in the Plan, as well as through an "Outpatient Facility" as defined in the Plan.

The evidence shows, and plaintiffs concede, that IVRTC is not licensed as a hospital, and is not accredited as a psychiatric hospital by the Joint Commission on Accreditation of Health Care Organizations. Nor is it a "psychiatric healthcare facility" within the meaning of California Health & Safety Code § 1250.2, as it is not licensed by the California Department of Mental Health. In addition it is not a skilled nursing facility, and does not provide "inpatient hospital services," "partial hospital services," or "outpatient services."

Rather, IVRTC is licensed by the Utah Department of Human Services to provide "intermediate secure care" for minors ages 11–17. The Office of Licensing in the Utah DHS defines "intermediate secure care" as "24–hour specialized residential treatment." Utah law defines an "Intermediate Secure Treatment Program" as "a 24–hour group living environment" that "offers room and board" and assists

individuals "in acquiring the social and behavioral skills necessary for living in the community." Utah Admin. Code R501–16–1, R501–16–2.

Moreover, the Plan unambiguously excludes coverage for "residential care." Under the section headed "Mental Health and Substance Abuse Benefits—Inpatient Mental Health Services," the Plan states, "Residential care is not covered." Under the section regarding payment for "Mental Health and Substance Abuse Benefits," in a section entitled "Professional (Physician) Services—Inpatient Care (including psychiatric Partial Hospitalization)," the Plan states, "Residential care is not covered." Again, in the section regarding payment for "Mental Health and Substance Abuse Benefits" in a section entitled "Hospital Facility Services," the Plan states, "Residential care is not covered."

***8** The court finds further that Blue Shield did not deny plaintiffs' claim for benefits without explanation. Not only did Blue Shield advise plaintiffs in advance of Geoffrey's enrollment at IVRTC that residential treatment was not a covered benefit under the Plan, but after plaintiffs submitted their claims for residential treatment at IVRTC, Blue Shield issued Explanations of Benefits to plaintiffs and IVRTC denying the claims as not covered under the Plan.

Nor have plaintiffs made any showing that Blue Shield construed the provisions of the Plan in a way that conflicts with the plain language of the Plan. While it is true that the Plan is subject to the requirements of the Parity Act (and certain other provisions of California law), the Parity Act does not mandate any specific benefits for mental health services —but simply requires that they be provided for on a par with other medical conditions.

In particular, the Parity Act does not require that insurers cover residential treatment, and does not *require* coverage for all "medically necessary health care service," as plaintiffs claim. Rather, it requires only parity of coverage for "outpatient services," "inpatient hospital services," and "partial hospital services," and only for a health care service (physical or mental) that is a benefit provided under a given plan. That is, if the plan at issue covers hospitalization for physical illness where medically necessary, it must cover hospitalization for mental illness where medically necessary.

Here, the Plan provides parity of coverage between mental and physical conditions for all required categories under the Parity Act. That is, Blue Shield provides benefits for mental health conditions on a par with those for other medical conditions, for outpatient services, inpatient hospital services, and partial hospital services. If a patient with mental health issues requires services in any of these three categories, Blue Shield will provide them, just as it will to a participant who has a physical illness. However, since IVRTC does not provide outpatient services, inpatient hospital services, or partial hospital services, Blue Shield is not required under the Parity Act to pay for the services that IVRTC does offer.

Plaintiffs argue that the intent of the Parity Act is to require parity for all "medically necessary" services, not just the categories of services that are listed in Health & Safety Code § 1374.72(b). However, as the court noted in the August 20, 2009 order, the use of "shall include, but not be limited to" in § 1374 .72(c) indicates that the items in subpart (c) of the statute were intended to be illustrative, to be distinguished from the use of "shall include" in subpart (b). Put another way, the four benefits listed in subpart (b) (outpatient services, inpatient hospital services, partial hospital services, and prescription drugs if included in the plan) are the only ones required by law to be provided on a par with other medical benefits. *See Wayne W. v. Blue Cross of Calif.,* 2007 WL 3243610 at *4 (D.Utah, Nov.1, 2007).

***9** DMHC is the California agency charged with monitoring health plans' compliance with Health & Safety Code § 1374.72. On its website, under the discussion of mental health benefits and the Parity Act, DMHC states, "Ask your plan if residential treatment is covered." DMHC has reviewed various health benefits plans, and, in a report issued in March 2005, concluded that the coverage and usage of residential treatment centers vary markedly among plans. DMHC characterized the limitation on residential treatment as "dependent on the benefit plan package that employers purchase for their employees"—and a "policy decision" made by the plan. *See* California Department of Managed Health Care, "Mental Health Parity in California—Mental Health Parity Focused Survey Project—A Summary of Survey Findings and Observations," attached as Exhibit E to Blue Shield's Request for Judicial Notice, at 55–56; *see also Wayne W.,* 2007 WL 3243610 at *4.

While statements on DMHC's website and in its report are not regulations under the Administrative Procedures Act, and do not have the force and effect of law, the court nonetheless considers the agency's "expertise" as relevant to the analysis of whether the Parity Act requires coverage for residential treatment. *See Yamaha Corp. of America v. State Bd. of*

Equalization, 19 Cal.4th 1, 11, 78 Cal.Rptr.2d 1, 960 P.2d 1031 (1998). The court concludes that in California, whether a specific plan offers residential treatment as a covered benefit is a matter of contract only, as such coverage is not mandated by the Parity Act.

Finally, plaintiffs' argument regarding Blue Shield's alleged "arbitrary and capricious" processing of claims is not sufficient to defeat summary judgment, and plaintiffs have not established that Blue Shield relied on clearly erroneous findings of fact. The processing of other claims for treatment of other individuals, covered by other plans, treated at other facilities, is not relevant to the question whether Blue Shield properly denied plaintiffs' claim for the residential treatment Geoffrey received at IVRTC while he was covered by the Ogdemli/Feldman Design Group Benefit Plan.

The ERISA regulation cited by plaintiffs does not provide support for their position. By its terms, the regulation sets "minimum requirements" for benefit plan "procedures" pertaining to claims for benefits, requiring that every employee benefit plan "establish and maintain reasonable procedures" governing three areas—the filing of benefit claims, the notification of benefit determinations, and the appeal of adverse benefit determinations. 29 C.F.R. § 2560–503–1(b)(5).

The regulation further provides that such "procedures" set by a particular plan will be considered "reasonable" only if they contain "administrative processes and safeguards," which are designed to ensure and verify (a) that benefit claim determinations are made in accordance with governing plan documents, and (b) that the provisions of that plan have been applied consistently with respect to similarly situated claimants. *Id.*

***10** Under subsection (1) of this regulation, where a plan fails to establish or follow reasonable claims procedures consistent with the requirements of the regulation, a claimant may "pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim." 29 C.F.R. § 2560.503–1(1). Here, however, plaintiffs do not claim that Blue Shield failed to establish or follow reasonable procedures regarding the filing of claims, the notification of benefit determinations, or the appeal of adverse determinations. Rather, plaintiffs assert "improper claims processing practices," based on Blue Shield's alleged "arbitrary and capricious" practice of paying some claims for residential treatment and denying other claims.

Blue Shield has shown that it paid claims for the patients identified in the survey only where the patient was identified as being at an acute inpatient level of care (not a residential level of care) at a licensed psychiatric hospital, or where the claim was inadvertently paid in error. The individuals in the first category were not "similarly situated" with Geoffrey, and thus it was not required to pay Geoffrey's claims in the same way as it did those others. As for the second category, Blue Shield asserts that processing errors are not considered inconsistencies that violate ERISA.

The regulation does not require that every employee benefit plan apply the same administrative processes and safeguards as every other plan, in a manner that is consistent with the application of the processes and safeguards by other plans to other claimants or beneficiaries under those other plans, if they are "similarly situated." At most, the regulation requires "reasonable" processes, not perfection, and does not create a violation for actions based on human error.

B. Motion for Leave to Amend the Complaint

1. Legal Standard

Once a defendant has answered, a plaintiff can amend the complaint only with consent of the defendant, or leave of court, "leave shall be freely given when justice so requires." Fed.R.Civ.P. 15(a); *Morongo Band of Mission Indians v. Rose,* 893 F.2d 1074, 1079 (9th Cir.1990) (leave to amend granted with "extreme liberality"). Leave to amend is ordinarily granted unless the amendment is futile, would cause undue prejudice to the defendants, or is sought by plaintiffs in bad faith or with a dilatory motive. *Foman v. Davis,* 371 U.S. 178, 182, 83 S.Ct. 227, 9 L.Ed.2d 222 (1962).

2. Plaintiffs' Motion

Plaintiffs seek to amend the complaint to allege a new cause of action against Blue Shield, based on "newly discovered evidence." In response to discovery requests, Blue Shield provided a survey of claims submitted for its insureds who had received treatment at ten residential treatment facilities during the period from May 1, 2005 to May 1, 2010. Plaintiffs assert that the results of this survey show certain bills in 19 of 31 claims for residential treatment identified in the survey were paid in full or in part by Blue Shield. Plaintiffs argue that this "inconsistent claims processing" violates "state and

federal statutes and regulations and contractual and fiduciary duties."

***11** Plaintiffs seek to amend the complaint to add a claim for "improper claims processing practices," which alleges as follows:

> 76. Blue Shield has routinely paid all or portions of residential treatment claims despite language in its policies purporting to categorically exclude coverage for residential treatment.
>
> 77. By treating similarly situated claimants in widely inconsistent and disparate fashion, despite language in the Blue Shield policies purporting to categorically exclude residential treatment, Blue Shield has violated the terms of its policies, the requirements of state and federal statute [sic] and regulations and fiduciary duty standards.
>
> 78. Blue Shield's actions have been arbitrary and capricious and have cause [sic] a loss to the Plaintiffs and the proposed class in the form of wrongly denied coverage for residential treatment claims.

Plaintiffs contend that the new allegations "have a solid basis in fact and in law;" that "undue delay" is not an issue, as granting leave to amend will not require moving the trial date or "unnecessarily drag out the course of litigation," and they did not delay unduly in seeking leave to amend after obtaining knowledge of the facts on which the proposed amended complaint is based.

Plaintiffs also argue that Blue Shield will not be prejudiced if plaintiffs are allowed to amend the complaint; and that the proposed amended complaint will not be futile, because the alleged inconsistent claims processing and payment practices relate to, among other things, "the propriety of Blue Shield's residential treatment exclusions" and "the ability of Blue Shield to strictly enforce the exclusion to deny all residential treatment claims."

In opposition, Blue Shield argues that the proposed amendment would be futile, for several reasons. First, Blue Shield argues that the alleged facts and claims are outside the administrative record to which the court's review of plaintiffs' denial-of-benefits claim is limited, as the basis of this proposed claim is the records of Blue Shield's processing of claims for other individuals at various facilities under other health plans.

Second, Blue Shield contends that plaintiffs have not suffered a cognizable injury based on the processing of other insured's claims, because a plaintiff who is not entitled to receive benefits under the terms of a plan will not be found to have suffered any prejudice due to procedural violations of ERISA. That is, since plaintiffs are not entitled to benefits for residential care under the terms of their Plans, they have not suffered any injury caused by any alleged procedural violations of ERISA in the handling of other claims. For this reason, Blue Shield argues, plaintiffs do not have standing to assert a cause of action based on the processing of claims for other individuals who were covered under other health benefit plans.

Third, Blue Shield contends that ERISA does not authorize or support a claim based on errors in processing the claims of others. ERISA's claims procedure regulation provides that a plan shall establish reasonable claims procedures that contain "processes and safeguards" so that, "where appropriate, the plan provisions have been applied consistently with respect to similarly-situated claimants." 29 C.F.R. 2560.503–1(b)(5). Blue Shield argues that this regulation mandates reasonable processes—but does not mandate perfection or create a violation based on human error.

***12** In a related argument, Blue Shield asserts that plaintiffs cannot rely on Blue Shield's payment of claims to other individuals as "evidence" that Blue Shield is forever bound to pay for all subsequent claims for residential care. That is, Blue Shield asserts, coverage under an ERISA health plan cannot be created by estoppel, and estoppel cannot be used to vary the express terms of a plan.

Blue Shield also contends that request for leave to amend is not supported by "substantial and convincing evidence." Blue Shield asserts that its evidence shows that where Blue Shield determined that a claim was for residential care, it denied the claim as not a "benefit," and that it paid claims for the patients identified in the survey in only two situations—either the patient was determined to be at an acute inpatient level of care (not a residential level of care) at a licensed psychiatric hospital (and thus was not "similarly situated" with plaintiff Geoffrey), or the claim was inadvertently paid in error (which does not amount to an inconsistency that violates ERISA).

In reply, plaintiffs assert that the proposed amendment is not futile. With regard to Blue Shield's argument that resolution of this proposed claim will necessarily involve facts and claims outside the administrative record, plaintiffs contend

that ERISA's "claims processing requirements," set forth in 29 C.F.R. § 2560.503–1(b)(5), "necessarily contemplate an evaluation of claims other than those brought by a particular plaintiff when identifying whether ERISA fiduciaries have satisfied their claims processing and fiduciary duties to treat similarly situated claimants in a consistent fashion when processing claims under the same policy language."

As for whether they have been injured, plaintiffs contend that there are "unpaid residential treatment expenses which were wrongfully denied by Blue Shield," and also contend that they have standing to bring their own claims based on damages they have incurred. (However, Blue Shield's argument was that plaintiffs have not suffered a cognizable injury based on Blue Shield's processing of *other claims.*)

Plaintiffs assert that Blue Shield's failure to maintain the safeguards identified in 29 C.F.R. § 2560.503–1(b)(5) to ensure that similarly situated claimants are not treated in a disparate manner is a procedural violation of ERISA, and that a systematic and persistent inconsistency in treatment of claimants subject to the same policy language is a substantive deprivation of plaintiffs' rights under ERISA.

With regard to the argument that an ERISA claim cannot be premised on errors in processing the claims of others, plaintiffs reiterate that they are not asserting a right to payment of benefits based on a single failure of Blue Shield's claims processing system, but rather that they are claiming that Blue Shield unpredictably deviates from claim to claim in processing residential treatment claims under the same policy language. Plaintiffs assert that this violates the fiduciary standards of ERISA and constitutes arbitrary and capricious behavior.

***13** With regard to the argument that coverage under an ERISA health plan cannot be created by estoppel, plaintiffs argue that both the original and the proposed amended complaints allege that the express terms of the Plan *require* Blue Shield to cover residential treatment. Plaintiffs contend that because California's statutory mandates are implicitly or by operation of law incorporated into the policy, and because the Parity Act requires that insurers provide coverage for residential treatment for mental illness, providing coverage for residential treatment is a requirement under the policy, not just a statutory requirement.

The motion is DENIED. The court finds that the proposed amendment would be futile. The issue to be decided in this case is whether Blue Shield improperly failed to pay for residential treatment for Geoffrey F., which in turn is dependent on whether the Plan covers residential treatment for mental health disorders, and if it does not, whether the Parity Act nonetheless requires such coverage.

As set forth above in the ruling on Blue Shield's motion for summary judgment, residential treatment is not a covered benefit under the Plan, and Blue Shield was not obligated under the Parity Act to offer coverage for residential treatment. Thus, Blue Shield is correct in asserting that plaintiffs are essentially arguing for coverage created by estoppel.

The court assumes that plaintiffs intend the proposed new cause of action as another ERISA § 502 claim, as state law common law causes of action arising from the improper processing of a claim are preempted by federal law. *See Spain v. Aetna Life Ins. Co.,* 11 F.3d 129, 131 (9th Cir.1993). Plaintiffs' proposed cause of action for "improper claims processing practices" clearly falls within the scope of ERISA § 502(a)(1)(B). *See Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 56, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987) (section 502(a)(1)(B) "embraces claims by ERISA plan participants asserting improper processing of insurance claims").

Nevertheless, the proposed claim of improper claims processing practices does not pose a challenge to the way in which Blue Shield exercised its discretion in processing their claim under the Plan. As explained above in the discussion of Blue Shield's motion for summary judgment, plaintiffs cannot show that Blue Shield violated the terms of the Plan, or that Blue Shield violated the Parity Act.

To the extent that plaintiffs are attempting to argue that Blue Shield was required to pay their claim because it paid certain claims of other claimants under other plans (whether in error or for some other reason), it is clear that ERISA coverage cannot be established by estoppel if recovery would contradict the written provisions of the plan. *Parker v. BankAmerica Corp.,* 50 F.3d 757, 769 (9th Cir.1995); *Greany v. Western Farm Bureau Life Ins. Co.,* 973 F.2d 812, 821 (9th Cir.1992).

Moreover, in order to recover benefits based on an alleged failure by Blue Shield to establish procedural safeguards to ensure that similarly situated claimants are treated the same under the same Plan, plaintiffs would have to show that the procedural violation caused a substantive violation. *Parker,*

50 F.3d at 769; *Bogue v. Ampex Corp.,* 976 F.2d 1319, 1326 n. 33 (9th Cir.1992). Here, since plaintiffs were not entitled to receive benefits for residential treatment under the Plan, they did not suffer a substantive harm. *See Hancock v. Montgomery Ward Long Term Disability Trust,* 787 F.2d 1302, 1308 (9th Cir.1986) (no substantive harm where plaintiff was not prejudiced by failure to comply with ERISA disclosure requirements).

***14** Unless plaintiff can point to a basis in ERISA to support a claim of "improper claims processing" in *this* case, the issue of what Blue Shield did or did not do in connection with other claims is simply not relevant. Any claim of "procedural unfairness," based on 29 C.F.R. § 2560.503–1(b)(5)), fails, as plaintiffs do not allege that Blue Shield failed to establish reasonable procedures regarding the filing of claims, the notification of benefit determinations, or the appeal of adverse determinations.

CONCLUSION

In accordance with the foregoing, the court finds that Blue Shield's motion for summary judgment must be GRANTED, and that plaintiffs' motion for leave to amend the complaint must be DENIED.

IT IS SO ORDERED.

All Citations

Not Reported in F.Supp.2d, 2011 WL 830623, 50 Employee Benefits Cas. 2933

End of Document

May 23, 2013.

2013 WL 2285453
United States District Court,
E.D. Michigan.

HI–LEX CONTROLS INCORPORATED, Hi–Lex America, Incorporated and Hi–Lex Corporation Health and Welfare Plan, Plaintiffs,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, Defendant.

No. 11–12557.

|

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CORRECTED FINDINGS OF FACT AND CONCLUSIONS OF LAW

VICTORIA A. ROBERTS, District Judge.

I. *INTRODUCTION*

***1** This is an action for alleged violations of the Employee Retirement Income Security Act of 1974 ("ERISA"). Plaintiffs filed suit on June 13, 2011. It is one in a series involving Administrative Service Contracts ("ASC") with Blue Cross and Blue Shield of Michigan ("BCBSM") for claims administration services and network access for self-funded employee health benefit plans. Under the ASCs, BCBSM serves as third-party administrator for Plaintiffs' employee health benefit plans. It processes and pays employee health claims; provides access to its network of physicians, hospitals, pharmacies, etc. for covered employees; and negotiates with hospitals and health care providers throughout the state. Plaintiffs reimburse BCBSM for claims paid on their behalf.

This case concerns certain fees that BCBSM allocated to itself as additional compensation ("Disputed Fees"). In essence, Plaintiffs argue that they did not know about the Disputed Fees until recently, and that BCBSM employed different ways to hide them. BCBSM says that it did not breach any duties in collecting the disputed fees because they were fully disclosed and Plaintiffs agreed to pay them.

Plaintiffs allege violations of § 1104(a)—breach of fiduciary duty (Count One)—and § 1106(b)—self dealing (Count Two)—under ERISA.

On September 7, 2012, the Court issued an order addressing the parties' cross-motions for summary judgment. The Court found that BCBSM is a fiduciary under ERISA, that the Disputed Fees were paid from plan funds, and that relief is available to Plaintiffs under ERISA.

The Court granted summary judgment to Plaintiffs on Count Two—ERISA prohibited transaction (self-dealing)—finding that BCBSM committed a *per se* breach of Section 1106(b)(1) when it allocated Disputed Fees to itself. The Court held that the self-dealing claim would proceed to trial on damages. It also held that Count One—ERISA breach of fiduciary duty—would proceed to trial because several issues of material fact remained regarding whether BCBSM breached its fiduciary duty.

In its September 7, 2012 ruling, the Court found genuine issues of fact related to BCBSM's statute of limitations defense. It recognized that resolution of the statute of limitations was necessary to determine the extent of BCBSM's liability under Count II, and the extent of its liability, if any, under Count I. The applicable statute of limitations also governs the amount of damages Plaintiffs would be able to collect from BCBSM.

BCBSM filed a second motion for summary judgment grounded on a statute of limitations affirmative defense. The Court denied it on April 17, 2013; it held numerous issues of material fact had to be decided before the Court could determine the appropriate statute of limitations.

The Court conducted a bench trial. It began on April 23, 2013 and continued for nine non-consecutive days, ending on May 8, 2013.

II. *FINDINGS OF FACT*

A. *PLAINTIFFS RETAIN BCBSM TO ADMINISTER THEIR SELF–FUNDED HEALTH BENEFIT PLAN*

***2** 1. Since at least 1991, BCBSM has served as the third party administrator of Plaintiffs' self-insured employee benefit plan, the Hi–Lex Corporation Health and Welfare Benefit Plan (the "Plan"). (Stipulated Fact ("SF") 2).

2. The terms under which BCBSM served as the Plan's third-party administrator are set forth in the parties' 1991 and 2002 ASCs. (SF 3).

3. The parties renewed the ASCs each year from 1991 through 2011 by executing a Schedule A document (the "Schedule As"). (SF 3). The ASCs and Schedule As are boilerplate documents created by BCBSM and used by BCBSM for the vast majority of its self-insured ASC customers. *Id.*

4. The Court admitted into evidence as joint exhibits, the 2002 ASC and a number of the Schedule As. Neither party can locate the 1991 ASC and certain Schedule As, but the parties crafted a stipulation concerning the relevant aspects of the Schedule As. (SF 4).

5. Pursuant to the ASCs and Schedule As, BCBSM administered the health care claims on behalf of the Plan from the Plan's assets. (SF 5).

6. The Plan's assets were pre-supplied by Plaintiffs; BCBSM wired funds to a BCBSM bank account. (Joint Trial Exhibit ("JTE") 1 at 8–9). That bank account and the Plan assets held in that account were under BCBSM's sole control.

7. The monies Plaintiffs provided to BCBSM also included employee contributions to their health care coverage under the Plan.

8. In exchange for its services to the Plan, BCBSM received an administrative fee in a per employee, per month amount set forth in the Schedule As ("Administrative Fee"). (JTE 2–11).

B. *BEFORE 1993: BCBSM UNDER PRESSURE TO INCREASE REVENUE; CUSTOMERS BALK WHEN BCBSM IMPLEMENTS NEW FEES*

9. In 1987 and 1988, BCBSM was in poor financial shape. (Testimony of John Paul Austin, BCBSM's former chief actuary ("Austin Test.")).

10. To regain financial stability, BCBSM started charging various fees of its self-funded customers such as Plaintiffs: the "Plan–Wide Viability Surcharge," "Other Than Group Subsidy," and "Group Retiree Surcharge." (*See id.;* JTE 80 at 276, ¶ 1).

11. BCBSM received "tremendous complaints from customers" in response to the new fees. (Austin Test.) This stemmed, in part, from the fact that "[t]he billing of these amounts to customers was an add-on to the bill, ***highlighted for all to see*** ...." (JTE 80 at 276, ¶ 2) (emphasis added).

12. BCBSM was unable to convince customers that the subsidies were fair:

> ***The advent of self-funding as an alternative to insured programs has highlighted administrative fees as a cost and a concern to customers purchasing a BCBSM ASC plan. Citing BCBSM's high costs, many customers have complained and have threatened to leave if relief was not provided.*** Indeed, some customers have cancelled BCBSM coverage for this reason. Many arguments have been presented to customers dissatisfied with our administrative costs. The costs of managing a network of hospitals and doctors as large as the Blue network, focusing on total costs and not just the small percentage reflective of administrative costs and the wide range of services provided by BCBSM have all been used at various stages to address case specific concerns. ***These arguments have been met with moderate success.***

***3** (JTE 80 at 277, ¶ 1) (emphasis added).

13. The charges were so unpopular that, in 1989 alone, BCBSM lost 225,000 members. (Austin Test.).

14. Many other customers refused to pay the fees. Mr. Austin confirmed that roughly half of these "add-on" fees were ***not*** being paid; it was BCBSM's policy not to sue customers. (*Id.*)

15. BCBSM was under enormous financial pressure. (Austin Test.).

16. According to BCBSM, these fees made it a "challenge to maintain customer relationships." (JTE 80 at 276, ¶ 2). By disclosing the fees, BCBSM was "its own worst enemy." (*Id.*)

C. *1993–94: BCBSM PLANS TO CHANGE ITS DISCLOSURES*

17. In 1993, BCBSM Executives suggested replacing the fees it disclosed with a "hidden" administrative fee buried in marked-up hospital claims. (*See id.;* Austin Test.).

18. The decision was made for this pricing arrangement to become effective for customers with their first renewal after October, 1993. The renewal was selected as the effective date for each group because that is when the group would sign a new Schedule A, which was revised to make Disputed Fees a contractual obligation. (JTE 81 at 219–220).

19. This solution offered several advantages to BCBSM:

> Reflecting certain BCBSM business costs in hospital claim costs will provide long-term relief to the problems detailed above and will also satisfy short-term objectives of enhancing customer relationships while cutting operational costs. Inclusion of these costs in our hospital claim costs is actually more reflective of the actual savings passed on to customers as it will now include the hospital savings net of the costs incurred to provide these savings. This will also improve our operations efficiencies since mass mailings for subsidy amount changes will no longer be necessary. ***Changes to these costs will be inherent in the***

> ***system and no longer visible to the customer. The same argument applies to risk charges and provider related expenses.***

(JTE 80 at 3, ¶ 2) (emphasis added).

22. BCBSM's senior management approved this proposal, known as "Retention Reallocation." (Austin Test.). It went into effect in October, 1993. (*Id.*)

23. Because the events pertinent to this lawsuit occurred over a time period of more than two decades, the terminology relevant to the dispute changed over time. The term "Disputed Fees" is synonymous with the terms "Retention Reallocation Fees" and "Access Fees."

24. However, the Access Fee terminology used to describe "Disputed Fees" is different from "Access Fee" as defined in the ASC. The ASC, Article VI, Section B is labeled "Access Fee," and is unrelated to the "Access Fee" which is subject to this litigation. In the ASC, "Access Fee" is explained as:

> If an access fee is charged by the Host Plan, the amount of the fee may be up to (10) percent of the negotiated savings obtained by the Host Plan from its providers but not to exceed Two Thousand ($2,000) Dollars. Access fees will be charged only if the Host Plan's arrangements with its participating providers prohibit billing the Enrollee for amounts in excess of the negotiated rate. However, providers may bill for deductibles and/or copayments.

***4** (JTE 1 at 13).

24. The Disputed Fees have the following components:

a. A charge for access to the Blue Cross participating provider and hospital networks (also described as "provider network access" and "Provider Network Fee");

b. A contribution to the Blue Cross contingency reserve (also described as "contingency" and "contingency/risk");

c. Other Than Group, or OTG subsidy;

d. Retiree surcharge (only for certain employers); and

e. Plan–Wide Viability, or PWV surcharge.

Items (c) and (d), and (e) are often referred to generally as "other subsidies" or "subsidies and surcharges." Item (e) has been set at zero since 1991 and so is not relevant to this case. (Austin test.; testimony of Cindy Garofali, BCBSM's manager in underwriting ("Garofali test."); Defendant's Trial Exhibit ("DTE") 1005 at 235).

26. The term "retention" refers to money BCBSM retains, as opposed to money used to pay medical claims. (Testimony of Paula Brawdy, former BCBSM Regional Sales Manager ("Brawdy Test.").

27. BCBSM continued to charge the "Other Than Group Subsidy" and "Retiree Surcharge." Austin Test. The "Retiree Surcharge" was assessed to customers who did not cover retirees health care, *id.;* Hi–Lex never covered retirees. (Testimony of John Flack, Hi–Lex's Director of Finance ("Flack Test.")).

28. After 1993, whenever BCBSM used the term "Hospital Claims" in contract documents, it intended that the term have the following components:

a. Charge for provider network access;

b. Contribution to contingency reserve;

c. OTG subsidy;

d. Retiree surcharge; and

e. PWV surcharge (0 since ′91)

29. The Post–1993 components under the heading "Hospital Claims" in contract documents are collectively referred to in this litigation as "Disputed Fees."

30. The term "Retention Reallocation" refers to the new pricing arrangement developed and implemented by BCBSM in 1993; then, Disputed Fees became part of the calculation for amounts to be billed for Hospital Claims. (JTE 80).

31. The Retention Reallocation fees were decided unilaterally by BCBSM; cost accountants and actuaries decided what expenses BCBSM wanted to recoup through the Disputed Fees. They then decided how much Hospital Claims had to be marked up to reach that goal. The percentages used to determine the fees are referred to as "Factors". (James Patrick Bobak Deposition, BCBSM's senior underwriting analyst, at 14:4–12; Austin Test.).

32. The Disputed Fees Factors were not reported to customers, but were known to BCBSM in advance of customer renewals. (Austin Test.; Plaintiffs' Trial Exhibit ("PTE") 580).

33. Internal documents from BCBSM confirm that BCBSM had complete discretion to determine the amount of the Disputed Fees, as well as which of its customers paid them. (PTE 561, Garofali Email ("[I]ndividual underwriters will have the flexibility to determine how we charge ... access fee on group"); PTE 562, Ken Krisan, BCBSM's senior underwriter, Email (explaining that trust funds have a unique arrangement)).

***5** 34. Under Ms. Garofali's oversight, the following strategy was developed in 1993 to educate groups about the new pricing arrangement:

a. Revised Schedule A included a new disclosure: "Effective with your current renewal, your hospital claims cost will reflect certain charges for provider network access, contingency, and other subsidies as appropriate." (JTE 81 at 220; testimony of Ken Krisan ("Krisan Test.")).

b. A tri-fold color brochure entitled "A new pricing arrangement" was created for the customer. (DTE 1008). This brochure was to be left with the customer at a meeting where the new pricing arrangement was explained. (Garofali Test.). The brochure identifies certain components of the Disputed Fee and explains that as a result of the new pricing arrangement, the fixed Administrative Fee would go down and the hospital differential would also decrease. (DTE 1008).

D. *1994–PRESENT: BCBSM EMPLOYS ARTIFICES TO HIDE THE DISPUTED FEES*

35. Following the implementation of "retention reallocation," BCBSM went to great lengths to ensure that the Disputed Fees were not disclosed to the customer.

1. *Monthly Claims Reports*

36. On a monthly basis, BCBSM provided Hi–Lex with detailed claims reports for every claim incurred. (Flack Test.)

37. Hi–Lex relied on this claims data, reviewed it, and incorporated it (manually in earlier years) into a master spreadsheet used for budgeting and internal auditing purposes. (Thomas Welsh Deposition, Hi–Lex's former Director of Finance, at 203:18–204:15; Flack Test.; PTE 594).

38. The claims data did not mention Disputed Fees; the Disputed Fees paid to BCBSM were actually included in the Hospital Claims numbers provided. (Austin Test.; Krisan Test.; Flack Test.).

2. *Quarterly Settlements*

39. BCBSM sent the Plaintiffs quarterly reports containing details about the plan's performance. (JTE 23–51). The parties do not have every quarterly settlement statement, but have stipulated to the content of them. (JTE 77).

40. The quarterly reports did not show customers the amount of Disputed Fees collected for each quarter, nor did they identify under what category or heading they were included. (Austin Test.; Testimony of Sophia Quinn ("Quinn Test."); Chris Winkler Deposition at 105:2–20).

41. In reality, the amount of Disputed Fees was added to the facility or hospital charges and altogether reported as Hospital Claims. (*Id.*)

42. This made it appear to customers, like Plaintiffs, that the savings from using BCBSM as its administrator were smaller than they truly were.

43. The amount of Disputed Fees was included in the line for "TOTAL CLAIMS EXPENSE." (Austin Test.; Quinn Test.)

44. This made it appear to customers, like Plaintiffs, that the claims paid to providers were higher than they truly were.

45. The amount of Disputed Fees also was excluded from the line for "TOTAL ADMINISTRATIVE FEE EXPENSE." (*Id.*)

***6** 46. This made it seem to customers that they were paying less Administrative Fees than they, in fact, paid.

47. Only beginning in April, 2011 did BCBSM refer to the Disputed Fees as "administrative compensation." (PTE 581). It was in a responsive letter from BCBSM to Plaintiffs.

48. Before then, BCBSM, through the quarterly settlements, represented to Plaintiffs that plan assets were only being used to pay: (1) actual claims, (2) disclosed Administrative Fees, and (3) stop loss premiums.

49. BCBSM had the technical capability to provide quarterly reports which specified the amount paid in the various subsidies and surcharges. (Austin Test.; Krisan Test.). BCBSM did make other projections that it shared with Plaintiffs.

50. BCBSM knew these reports were false when it gave them to Plaintiffs, and gave them to Plaintiffs with the intent to deceive them. (Austin Test.; Winkler Deposition at 87:2–14; Quinn Test.).

3. ***Renewal Documents***

51. In addition to the quarterly reports, BCBSM provided claims information at the time of renewal.

52. The first page purported to show claims amounts "passed on" to Hi–Lex by BCBSM. This promoted the belief that claims reports related to actual claims and nothing else.

53. Additionally, the "Benefit and Savings Review Summary" was given in two formats. (JTE 52–63).

54. Both formats showed amounts for either "Approved Charges and Payments" or "Amounts Billed" which consisted of actual claims plus the Disputed Fees. Similarly, both formats showed either the "Hospital Savings" or "Provider Reimbursement Savings" that were reduced by the Disputed Fees. (Austin Test.)

55. BCBSM provided misleading claim information in the "Provider Contract Savings" report supplied with each renewal. (JTE 52–63).

56. Those reports indicated amounts for "BCBSM Provider Savings" and "Total BCBSM Payments." The savings number, however, was not the full savings, but rather the savings reduced by the Disputed Fees; correspondingly, the "Total BCBSM Payments" were not the total payments actually paid by BCBSM, but rather that amount plus the Disputed Fees kept by BCBSM. (Austin Test.)

57. BCBSM also represented in the Renewals that its "Administrative Fee is all-inclusive." (JTE 52 at 819). That was not true; BCBSM also charged the Disputed Fees, a second form of administrative compensation, but not described as such before 2011.

58. BCBSM knew these reports were false when it gave them to Plaintiffs and gave them to Plaintiffs with the intent to deceive them.

59. In later years, BCBSM inserted an asterisk with misleading language into a claims projection. (JTE 58). These were not reviewed by Mr. Flack because BCBSM's claims projections were notoriously unreliable and Mr. Flack made his own projections. (Flack Test.).

4. ***Annual Settlements***

60. Roughly six months after the close of each plan year, BCBSM sent self-funded customers an annual settlement statement. The annual reports did not show customers the amount of Disputed Fees collected for each year, but they did show other fees collected. There was an "Administrative Fee Settlement," a "POS Incentive Fee Settlement," and a "Stop Loss Premium Settlement." But there was no "Disputed Fees / Retention Reallocation Fees Settlement." (JTE 12–22).

***7** 61. In some years, the amount of Disputed Fees was included (but not identified) on the line for "ACTUAL CLAIMS PAID BY BCBSM: FACILITY" in the "Stop Loss Premium Settlement." This was false and misleading because the Disputed Fees were compensation to BCBSM, not "Claims Paid by BCBSM."

62. The amount of Disputed Fees was not included in the "Administrative Fee Settlement" either. This was false and misleading because the Disputed Fees were "administrative compensation." (PTE 581).

63. According to BCBSM's own underwriter, Chris Winkler:

> Q. And this heading A. [of the annual settlement] ... refers to claims paid by BCBSM, correct?
>
> A. Correct.

Q. And the access fee is not a claim that is paid by BCBSM, correct?

A. Correct. * * *

Q. So the number provided by Blue Cross on the annual settlement for actual claims paid overstates what the actual claims paid to providers by Blue Cross was?

Q. Correct?

A. The number of actual claims paid includes the access fee. ***So, yes, it would be overstating true cost of claim.***

(Winkler Deposition at 85:1–10, 19–25; 86:1–4, 13–21) (emphasis added).

64. Reviewing this report, a reader could not determine whether Disputed Fees were charged, or in what amount. (*Id.* at 106:5–8).

65. BCBSM knew these reports were false when it gave them to Plaintiffs and gave them to Plaintiffs with the intent to deceive.

5. ***Form 5500 Certifications***

66. At or around the time that BCBSM sent its annual settlements to the Plaintiffs, BCBSM also provided a completed certification for the preparation of Form 5500 Schedule A, which is filed with the U.S. Department of Labor. (Austin Test.; Winkler Deposition at 10:22–11:4; Flack Test.).

67. Forms 5500 were developed by the Department of Labor, the Internal Revenue Service, and the Pension Benefit Guaranty Corporation to satisfy annual reporting requirements under ERISA's Titles I and IV and under the IRS Code. They are "intended to assure that employee benefit plans are operated and managed in accordance with certain prescribed standards and that participants and beneficiaries, as well as regulators, are provided or have access to sufficient information to protect the rights and benefits of participants and beneficiaries under employee benefit plans." (Annual Return/Report 5500 Series Forms and Instructions, United States Department of Labor, http://www.dol.gov/ebsa/5500main.html (last visited May 17, 2013)).

68. The Form 5500 certifications did not show customers the amount of Disputed Fees collected for each year. Rather, the amount of Disputed Fees was added to the amount of claims paid to providers and included in the line for "CLAIMS PAID." (JTE 15 at 032); Winkler Deposition at 95:21–25.

69. The amount of Disputed Fees should have but was not reported in the lines for "ADMINISTRATION," "OTHER EXPENSES (MANDATED SUBSIDY)," "RISK AND CONTINGENCY," "OTHER RETENTION (LATE FEE, STOP LOSS PREMIUM), or "TOTAL RETENTION INCLUDING STOP LOSS PREMIUM ." (JTE 12–22).

***8** 70. The line for "ADMINISTRATION" included only the disclosed Administrative Fees, not the Disputed Fees. (Austin Test.; Winkler Deposition at 96:1–5).

71. The lines for "OTHER EXPENSES (MANDATED SUBSIDY)" and "RISK AND CONTINGENCY" were either a zero (0) or "not applicable" in each year. (JTE 12–22). The Disputed Fees included charges for subsidy and risk/contingency. (PTE 592; Austin Test.; Winkler Deposition at 92:19–93:1, 94:6–16). The line for "OTHER RETENTION" included only a customer's stop loss premium and applicable late fees. (JTE 12–22).

72. A reader reviewing this report could not determine whether Disputed Fees were charged, or in what amount. (Winkler Deposition at 106:9–21).

73. The Form 5500 certifications were false and misleading because (1) the amount reported as claims was over-stated, (2) the amount reported as Administrative Fee was under-stated, and (3) the subsidies and risk/contingencies that were collected by BCBSM as part of the Disputed Fees were reported as zero or "not applicable." (Winkler Deposition at 95:14–96:15, 94:6–16).

74. Hi–Lex was misled into believing that BCBSM was paid less in Administrative Fees than it actually retained, because of the Disputed Fees. (Flack Test.).

75. To the extent BCBSM claims that contract documents gave Plaintiffs notice of what it ***might*** do in the future, the Form 5500 certifications were understood by Plaintiffs to show what BCBSM was ***actually*** doing: not charging additional administrative fees.

76. BCBSM knew the Form 5500 Certifications were false when it gave them to Plaintiffs, and gave them to Plaintiffs with the intent to deceive them.

E. ***1999 AND AFTER: THE NEW FEES WERE A SECRET EVEN TO BCBSM EMPLOYEES***

77. Sandy Ham became a BCBSM account representative in 1999, and began handling the Hi–Lex account in 1999. She testified that the training she received included several references to and an explanation of Disputed Fees. (DTE 1186 at 2625, 2642). Ms. Ham was able to identify her handwriting on her personal copy of the 1999 training presentation. She noted that Disputed Fees are a "small charge when your people access our providers to enjoy the discounts." (DTE 1186 at 2642; testimony of Sandy Ham ("Ham Test.")).

78. However, Ms. Ham's deposition testimony—taken before trial and read at trial—was unequivocal:

> Q. When you started in 1999, did you, fairly early on, learn about access fees?
>
> A. Not that I recall.
>
> Q. Was it 2005 when you first learned about access fees?
>
> A. Yes.
>
> * * *
>
> Q. Am I correct in understanding that the first time you learned about access fees was in connection with training that was done in 2005?
>
> A. Correct.
>
> Q. For example, you could have heard about access fees from a colleague and then coincidentally, at some later date in the same year, been trained about access fees. But if I'm understanding you, you're saying, I learned about access fees because I had training about access fees?
>
> ***9** A. Correct.

(Sandy Ham Deposition at 19).

79. Ms. Ham's lack of knowledge explains, in part, why according to a BCBSM commissioned survey, ***none*** of her customers knew about the Disputed Fees as of 2007. (PTE 524–527).

80. Ms. Ham was still confused as late as 2009, when she described the Disputed Fees as something "the provider [meaning the hospital, not the self-funded group] pays ... based on the experience of the group." (PTE 535).

81. Given the foregoing, it is not reasonable to: (1) conclude that Plaintiffs would have obtained any meaningful information about the Disputed Fees from their own BCBSM account executive, or (2) expect Plaintiffs to have learned about the Disputed Fees from the same documents that Ms. Ham reviewed, signed, but did not understand.

F. ***EARLY 2000S; RUMORS OF DISPUTED FEES EMERGE, BUT BCBSM DENIES THE EXISTENCE OF DISPUTED FEES***

82. In the early 2000s, Todd Stacy of ASR, a BCBSM competitor, told certain brokers that BCBSM had "hidden fees." (Wally Martyniek Deposition at 20:9–21:15). According to one broker, Wally Martyniek, those rumors led him to call a face-to-face meeting with BCBSM sales manager, Steve Hartnett. Mr. Hartnett denied the existence of Disputed Fees. (*Id.* at 40:2–15). Mr. Hartnett said that BCBSM self-funded customers get 100% of the hospital discounts:

> Q. What did you say at that face-to-face meeting?
>
> A. I said at the meeting that the reason that we're here is that I want to hear it from Steve Hartnett ... an employee [of BCBSM], that basically what Todd Stacy is saying about the access fee is not correct, because you had told me that it wasn't correct, but I wanted him to tell the client, I didn't want it coming from me.
>
> Q. What did Steve say?
>
> A. Steve said that there was no—that the hospital discount is the full discount that the client gets, that Blue Cross does not hold anything back.

(*Id.* at 40:2–15).

83. Jeffery Liggett also attended the meeting with Mr. Martyniek and corroborated this BCBSM representation. (Stipulation of Counsel on May 7, 2013).

84. Mr. Martyniek's experience mirrored that of an unrelated broker, David Young. Young recounted a presentation made by BCBSM, at which BCBSM falsely represented that it passed on 100% of the provider discounts to customers:

A. I said, I hear out in the market that you don't pass along one hundred percent of your discounts, and I said, can you respond to that? And the response back was, that's not true, we absolutely pass one hundred percent of our discounts.

Q. Who said that?

A. Steve Hartnett.

(Dave Young Deposition at 53 line 1–6).

85. BCBSM told Mr. Young that its Administrative Fee was "all inclusive" as well. (*Id.* at 81:15–22).

86. Similarly, an internal BCBSM report acknowledged that BCBSM "traditionally markets the Administrative Fees as all inclusive." (PTE 529).

87. BCBSM management described the Administrative Fees as "all inclusive:"

***10** • "We have used the term "all-inclusive" when describing our Administrative Fee." (PTE 545: 2007 Ken Krisan Email).

• "Contributions to reserves, the Medicare subsidy and claims processing are part of this Administrative Fee." (PTE 533: 2008 Kathleen McNeill Email).

88. BCBSM made similar misrepresentations to Hi–Lex in annual renewal documents. (JTE 52 at M00819: Hi–Lex ASC Renewal ("Your BCBSM Administrative Fee is all-inclusive.")).

89. Brokers understood BCBSM's Administrative Fee to be "all-inclusive," including Denise Sherwood, a former BCBSM employee and then later a broker with Spectrum Benefits and Aon. She testified:

A. All I know is Blue Cross's admin fee was comprehensive, everything was included in it.

Q. What's your basis for saying that?

A. Just experience. That's how Blue Cross marketed itself.

(Sherwood Deposition at 107:8–13).

90. BCBSM's representations to brokers and its description of its Administrative Fee as "all-inclusive" were false and misleading. BCBSM secretly charged a second fee—Disputed Fees—in exchange for its services.

G. *2003: BCBSM INITIALLY IGNORES HI–LEX'S INQUIRY ABOUT THE DISPUTED FEES AND THEN COVERS UP THEIR EXISTENCE*

91. In 2003, Hi–Lex hired health care consultant Marsh to review its benefit plan. This was a review of benefits, not of claims payments or monies paid to BCBSM. (PTE 503; testimony of Christine Warren ("Warren Test.").

92. One of Marsh's employees, Dave Mamuscia, noted the ambiguous language in paragraph 11 of the Schedule A and suggested "the Blues should demonstrate how this works...." (JTE 83 at 557).

93. Paragraph 11 states: "Your Hospital Claims cost reflects certain charges for provider network access, contingency, and other subsidies as appropriate." (JTE 2–4).

94. Mr. Mamuscia's reference to paragraph 11 was mentioned in a single paragraph of a larger six-page memo. (JTE 63 at 557–562).

95. The memo also came less than a month before Hi–Lex had to renew the ASC with BCBSM. With no other alternative claims administrators available, Hi–Lex's renewal was a foregone conclusion, regardless of what paragraph 11 meant. (Welsh Deposition at 168:16–170:1; Warren Test.).

96. Hi–Lex CFO, Tom Welsh, signed the May 1, 2003 Schedule A without any revision to the Disputed Fee disclosure. (JTE 3–4; per the stipulation in JTE 77 at ¶ 2, JTE 4 at 2 is the same as the missing page 2 of JTE 3).

97. Mr. Welsh forwarded Mr. Mamuscia's memo to BCBSM, which garnered this response, memorialized in an email written by a BCBSM sales manager:

Dave Mamucia [sic] wants disclosure, or a more detailed explanation regarding line 11 of the Schedule A. That is 'your hospital claims cost reflects certain charges for provider network access, contingency, and other subsidies as appropriate. ***You had warned us that this question was coming.*** We did tell the account that there is retention reallocation that reduces the net hospital discount. We do not want to respond with an inappropriate answer and would like support from your area as to what exactly we can say. ***We realize that Marsh is going to share our answer***

> ***with all their consultants and we want to give a well measured response.*** Please provide us with underwriting's suggestion to this question.

***11** (JTE 84: 2003 Dave Gay Email) (emphasis added).

98. BCBSM's reaction to Marsh's request for information demonstrates that it knew that neither Plaintiffs nor their consultant knew about Disputed Fees, and that disclosure of the fees would damage its business.

99. BCBSM did not adequately respond to Mamuscia's inquiry, prompting Marsh to email: "You haven't answered our question." (JTE 86).

100. Mr. Welsh forwarded Marsh's comment to BCBSM's account executive, Deborah Dickson; she does not remember responding. (Testimony of Deborah Dickson ("Dickson Test.")). The emails indicate that she would visit Hi–Lex in the next couple days, but Ms. Dickson's meeting notes reflect no conversation about Disputed Fees. (*Id.;* JTE 90–95).

101. Ms. Dickson does not recall discussing the memo with anyone, including anyone at Hi–Lex. (Dickson Test.).

102. Mr. Welsh denies being told about Disputed Fees. (Welsh Deposition at 163:1–164:8; PTE 603).

103. Ms. Dickson confirmed at trial that she could not recall a single instance when she provided Hi–Lex with any information about Disputed Fees, and her practice when meeting with Mr. Welsh was to review any changes in the quarterly or annual settlements from the prior year. (Dickson Test.). Ms. Dickson testified that she never received training on how to tell customers about Disputed Fees. (*Id.*)

104. According to Ms. Dickson, Mr. Welsh was a "financially savvy" CFO who was interested in the cost of the health plan. (*Id.*) He regularly negotiated over the disclosed Administrative Fees charged by BCBSM. (*Id.*)

105. BCBSM's own client profile reflects that Mr. Welsh was "close on numbers" and kept his own claims spreadsheet. (JTE 87).

106. Ms. Dickson admitted at trial that she never explained to Mr. Welsh that the "claims" reported in the quarterly settlements included Disputed Fees, despite having four meetings a year with him. (Dickson Test.).

107. Mr. Welsh was adamant that he had no knowledge of the Disputed Fees:

> Q. Did you ever have any understanding that the administrative services contract between Blue Cross and either Borroughs or Hi–Lex allowed Blue Cross to mark up hospital claims?
>
> A. No.
>
> Q. Did you ever have any understanding that the amounts reported by Blue Cross as claims were anything other than actual claims paid to health care providers?
>
> A. No.
>
> * * *
>
> Q. Did you understand paragraph 11 [of the Schedule A] to refer at all to administrative compensation that was going to be retained by Blue Cross in addition to the base admin. fee on the first page?
>
> A. ***No, because the way I read that and I read it today it still seems like it's hospital costs. It doesn't say anything about being paid to Blue Cross Blue Shield.***

(Welsh Deposition at 183:16–184:2, 186:20–187:4) (emphasis added).

108. In the fall of 2003, Marsh put out a Request for Proposal ("RFP") on Hi–Lex's behalf for its Plan. (PTE 505; Warren Test.). BCBSM was asked to respond to the RFP by September 15, 2003. (PTE 505 at 322).

***12** 109. The RFP specifically asked BCBSM to identify any "network access/management fees." (JTE 97 at 93). Indeed, Christine Warren testified that the purpose of page M00093 of the RFP was to understand the costs of the programs offered by the recipients of that RFP. (Warren Test.).

110. Generally speaking, "Access Fees" are not uncommon in the industry because many third-party claims administrators lack their own network; they lease one that causes them to incur access fees. (Warren Test.). BCBSM, however, owns its own network, and as one broker confirmed, BCBSM was thus presumed not to have such fees. (Sherwood Deposition at 16:15–17:18).

111. BCBSM responded to the Marsh RFP in September by denying there were Access Fees. (PTE 505 at 392)

(responding that network access fees were "N/A" and that there were no other fees); Warren Test.; Garofali Test. (testifying about PTE 505 and explaining that BCBSM personnel were "discouraged" from providing any information if nothing was requested)).

112. BCBSM's RFP response was false and misleading, and created the illusion that BCBSM was more cost competitive than the other third party administrators who responded to the RFP. In fact, Ms. Dickson testified that the completed bid form RFP response was not correct. (Dickson Test.).

113. Marsh took the false information provided by BCBSM and incorporated it into its marketing results summary on October 10, 2003. (PTE 507 at 261). In that summary, Marsh compares four potential claims administrators. With respect to BCBSM reports, the summary says, "access fees included in administration fee." (*Id* .)

114. Marsh's description of "access fees" as "included in administrative fee" was false. The access fees (Disputed Fees) were in addition to the Administrative Fee. Marsh, an expert in the field of self-insured health plans, was misled by BCBSM's response to the RFP.

115. Ms. Warren delivered her marketing results summary to Hi–Lex. (Warren Test.).

116. BCBSM intentionally misrepresented to Plaintiffs and Marsh that there were no Disputed Fees charged. This misrepresentation was material, and relied upon by Plaintiffs to their detriment.

117. BCBSM argues on one hand that the RFP response is not from it, but on the other hand that the RFP is correct because BCBSM did not charge the Disputed Fees on a "per employee per month" ("PEPM") basis. That argument is unavailing for two reasons: (1) the RFP asked whether there were any Access Fees, and, if so, asked that they be expressed on a PEPM basis, and (2) if BCBSM was not going to express the Access Fees on a PEPM basis, it should have explained how it did express them, just as BCBSM did in a similar RFP response six years later. (PTE 506).

118. Making BCBSM's argument all the more implausible is the fact that it regularly expressed Disputed Fees on a PEPM basis. (PTE 564–568).

119. BCBSM's misrepresentation that it did not charge separate access fees had the effect of dramatically understating the administrative costs associated with its proposal. According to page 18 of the RFP summary prepared by Marsh, (PTE 507 at 263), BCBSM was the second lowest cost bidder, with a total Administrative Fee expense of $505,068. If, however, BCBSM had disclosed that it was going to charge $460,698, in Disputed Fees in 2004 (stipulated in Joint Final Pre–Trial Order), then it would have been the most expensive bidder at ***$965,766,*** with the next lowest cost bidder at $532,192. (*Id.*)

H. *2003–2007: BCBSM DEBATES WHETHER TO DISCLOSE THE DISPUTED FEES FOR FIVE YEARS AND THEN DECIDES NOT TO*

***13** 120. Starting around 2003, a few BCBSM executives raised concerns about the lack of disclosure surrounding Disputed Fees, which according to former BCBSM Regional Sales Manager Paula Brawdy, led to an internal debate about what to do. (Brawdy Test.).

121. This debate was sparked by the City of Grand Rapids in 2004, which discovered the Disputed Fees and demanded disclosure. BCBSM ultimately developed Schedule A language that disclosed Disputed Fees in detail for the City, but refused to include this disclosure in other contracts. (PTE 512; Brawdy Test.).

122. A snapshot of this debate was captured in a 2004 email from Michael O'Neil to Ms. Garofali. Mr. O'Neil explained, "If we want to counter that perception [that we hide fees] and retain our credibility, we must be willing to disclose all our fees and stand behind them." (PTE 513).

123. Ms. Brawdy explained that she favored disclosing the amount of the Disputed Fees, but Mr. Austin and the new business sales staff did not want to do so because the Administrative Fees would be too high and BCBSM could not compete. (Brawdy Test.). This was because self-funded customers were focused on their fixed costs, namely the amount of the Administrative Fee. (*Id.*)

124. Ultimately, BCBSM rejected Ms. Brawdy's position.

125. BCBSM's true intentions are shown by the evolution of a proposed renewal exhibit that starts with a numeric disclosure of the Disputed Fees and is watered down over time to the point where all line items for Disputed Fees and any monetary reference are removed. (PTE 508–510).

126. BCBSM senior underwriter, Ken Krisan, was in charge of the strategy for "disclosing" the Disputed Fees without customers noticing. Mr. Krisan's emails confirm that actual disclosure of the Disputed Fees was not BCBSM's intent:

- "I think there is a need [to] ***downplay*** this [Disputed Fees] with respect to the outside world ... [corporate communications] may be helpful in developing some internal training materials or job aids that puts the proper 'spin' on what we want to say." (PTE 538: 2007 Email to Greg Mays) (emphasis added).

- "We want to keep this a little on the ***understated*** side so we don't want to include this in any mass communications. ***In many cases this is not going to [be] good news."*** (PTE 540: 2007 Email to Kathleen McNeill) (emphasis added).

- In referring to the "Talking Points" memo, "because we want to ***downplay*** the release of this information, it was decided that Agents and Customers should not receive any written materials." (PTE 543: 2007 Email to Kathleen McNeill) (emphasis added).

- "The Access Fee portion of the discussion is intended to be ***downplayed*** to the customer.... There is no plan to provide anything to customers or agents on this topic." (PTE 546: 2007 Email to Karen Butterfield) (emphasis added).

- "We want to stay away from identifying what is in the fee." (PTE 550: 2007 Email to Kathleen McNeill)

***14** 131. On August 21, 2007, Ms. Ham presented the 2006 annual settlement to Hi–Lex representatives John Flack, Mitch Freeman, and Liza Walling. (Ham Test.; DTE 1189). Ms. Ham presented the 2006 "Value of Blue" pie chart and pointed out to Mr. Flack a portion entitled "Access Fee," as well as the notation at the bottom of the chart showing the Disputed Fees as a percentage of total cost. (Ham Test.; JTE 17).

132. The Value of Blue charts were only provided at the time of annual settlement. This is significant because annual settlement occurs approximately six months after a plan year closes.

I. *2006–2007: BCBSM'S OWN INVESTIGATION CONCLUDED THAT HI–LEX (AND MOST OTHER CUSTOMERS) DID NOT KNOW ABOUT THE DISPUTED FEES*

133. In connection with the anticipated release of the Value of Blue, BCBSM undertook an investigation to determine which customers would be surprised to learn that they had paid the Disputed Fees the year before. (PTE 524–527).

134. The investigations resulted in detailed spreadsheets that identified whether BCBSM's customers, or their brokers, knew about the Disputed Fees. (*Id.*)

135. Hi–Lex is identified in at least four different spreadsheets, the latest of which was from December 14, 2007. Each one indicates that Hi–Lex did not know about the Disputed Fees. (PTE 527). They also indicated that Hi–Lex could not have been informed about the Disputed Fees through a broker because Hi–Lex did not have a broker. (*Id.*)

136. The results of BCBSM's formal investigation were consistent with anecdotal accounts from BCBSM employees:

- "The [Value of Blue] report will identify the ASC Access Fee which for most groups is something new." (PTE 542: 2007 Ken Krisan Email).

- "[N]ot all ASC groups are aware of BCBSM's Retention Reallocation Policy." (PTE 544: 2007 Kenneth Bluhm Email).

- "I know many of the smaller [groups] aren't aware [of access fees]." (PTE 532: 2007 James Bobak Email).

- "I agree that there is overwhelming confusion on access fees internally (and externally)." (PTE 537: 2009 Christine Farah Email).

- "[I]t is not certain [some accounts] were aware of the access fees when entering into the arrangement." (PTE 536: 2010 Ken Krisan Email).

J. *THE MISLEADING CONTRACT DOCUMENTS DID NOT DISCLOSE THE DISPUTED FEES*

137. BCBSM has not produced an ASC signed before 2002, nor did it offer any evidence that such an ASC would have contained any language that would have allowed it to charge the Disputed Fees.

1. *The Schedule As Are Misleading*

138. The parties stipulated that the 1994 Schedule A to the ASC would have been the same as the 1994 Borroughs Corporation ("Borroughs") Schedule A. (JTE 77 at ¶ 2). That Schedule A does not contain language related to Disputed Fees. (JTE 64).

139. The parties stipulated that the 1995–2000 and 2002 Schedule As would have been the same as the Borroughs Schedule As for the same years. (JTE 77 at ¶ 2). The Borroughs Schedule As contain a single sentence on the second page that reads: "Your hospital claims cost reflects certain charges for provider network access, contingency, and other subsidies as appropriate." (JTE 65–70).

***15** 140. This sentence is false and misleading, and did not disclose the Disputed Fees:

- The Schedule As have a heading entitled "Administrative Charge." It was under this heading that BCBSM's administrative compensation was to be disclosed. Hi–Lex expected all fees paid to BCBSM to be included in this section of the Schedule As. The Disputed Fees were "administrative compensation", (PTE 581), and were not noted under "Administrative Charge."

- The sentence omits the critical fact—that Plaintiffs would pay these fees as additional administrative compensation to BCBSM. Just the opposite, the language stated that the identified items would be "reflected" in the "hospital claims cost." "Hospital claims cost" is the cost paid ***to*** hospitals for services rendered. Thus, the "disclosure" represented that the amounts "ordered by the Insurance Commissioner" would be ***paid to*** the hospitals. In reality, the fees were ***not*** included in the claims paid to the hospitals—they were additional administrative compensation ***retained by BCBSM.***

141. BCBSM recognized that its contracts were confusing and that its "customers probably don't completely understand the Access Fees ." (PTE 516: 2004 Jack Gray Email).

2. *The 2002 ASC Was Misleading*

142. BCBSM did change the ASC language in 2002, but it, too, was misleading:

> The Provider Network Fee, contingency, and any cost transfer subsidies or sur-charges ordered by the State Insurance Commissioner as authorized pursuant to 1980 P.A. 350 will be reflected in the hospital claims cost contained in Amounts Billed.

143. The ASC contains a heading called "Financial Responsibilities," under which it says the customer will "pay BCBSM the total of the following amounts...." The "following amounts" are then identified in a ***numbered list*** of specific obligations (*e.g.,* administrative fees, late fees, and interest). ***Not one of the nine enumerated obligations includes Plaintiffs paying Disputed Fees.*** By not including Disputed Fees in the enumerated list of financial obligations of the customer, BCBSM effectively represented that the Hidden Fees were NOT something to be paid by the customer to BCBSM. (Burgoon Deposition at 36:12–37:17) (emphasis added).

144. The "disclosure" represented the fees as "ordered by the State Insurance Commissioner." This was a misrepresentation in three respects: (1) it is untrue; the Insurance Commissioner never ordered any BCBSM customers to pay these fees, [1] nor would the Insurance Commissioner have had that authority in the first place; [2] (2) by characterizing the fees as something "ordered" by state government, BCBSM represented that these were NOT any kind of compensation for it, but rather some kind of fee imposed by the State. As it turned out, these Disputed Fees were kept by BCBSM as additional administrative compensation, (*Id.* at 39:22–40:22); and (3) BCBSM recently disavowed any claim that it was ordered to collect the OTG subsidy from Plaintiffs in a brief to the Sixth Circuit. *See Response in Opposition to Leave to File Amicus Brief, Pipefitters Local 636 v. BCBSM,* No. 12–2265, Doc. 6111635985, at 15–17 (6th Cir. March 27, 2013).

1 BCBSM offered a 1992 Order of the Michigan Insurance Commissioner as its only evidence of this alleged obligation. (DTE 1002). But the Order contains no such requirement. On the contrary, in the Order, the Insurance Commissioner advised BCBSM to *pursue collection* of any *contractually agreed-upon* payments to meet the OTG Subsidy. (*Id.* ¶¶ 106–108). Nothing in that Order tells BCBSM that it must collect an OTG Subsidy Fee, in what amount it should collect the Fee, or from whom it should collect the Fee. Further, this alleged obligation rings hollow, as BCBSM did

not uniformly levy or collect OTG Subsidy Fees from its customers. (Garofali Test.) (Trust Funds were not charged OTG). Moreover, there was no contractual agreement to pay OTG.

2 Any such order by the Insurance Commissioner would have been preempted by ERISA. ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a); *see also Shaw v. Delta Airlines, Inc.,* 463 U.S. 85, 97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983); *Ingersoll–Rand Co. v. McClendon,* 498 U.S. 133, 138, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990). That includes state laws that "(1) mandate employee benefit structures or their administration ... or (3) bind employer or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself." *Briscoe v. Fine,* 444 F.3d 478, 497 (6th Cir.2006). Such an order by the Insurance Commissioner, regulating BCBSM's ERISA customers, would fall into both of these categories.

16** 145. This language also refers to "Amounts Billed." "Amounts Billed" is defined as "the amount the Group owes in accordance with BCBSM's standard operating procedures ***for payment of Enrollees' claims." (JTE 1 at 1) (emphasis added). The definition of "Amounts Billed" does not include fees paid to BCBSM.

146. The ASC, at Art. IV, B1 "Scheduled Payments," identifies seven payments to be made pursuant to the Schedule A. None of the seven includes the Disputed Fees. Further, by itemizing payments "listed in Schedule A," BCBSM represented that there were no other payments, and consequently, Plaintiffs would not have understood the language in the Schedule A to refer to more Administrative Fees.

K. *PLAINTIFFS LACKED KNOWLEDGE OF THE DISPUTED FEES UNTIL 2007*

147. BCBSM alleges that Plaintiffs were told about BCBSM's plan to charge the Disputed Fees in a meeting between former BCBSM account manager, Ron Crofoot, and former Hi–Lex CFO, Tony Schultz, in 1994. Mr. Crofoot's account of his conversation with Mr. Schultz cannot be believed for several reasons:

- The entire point of the Disputed Fees, according to BCBSM's own internal memo, was to obtain additional administrative compensation without customers knowing or, in BCBSM's own words—to charge fees that were "no longer visible to the customer." Since BCBSM just established a plan to charge hidden fees, it stretches credulity to think BCBSM would then tell its customers about that plan.

- BCBSM acknowledged that charging the Disputed Fees required a change in the ASC. Mr. Crofoot does not allege any amendments or modifications to the ASC were ever discussed, and testified at trial that he "did not have a lot of detail [about the Disputed Fees], frankly." (Crofoot Test.). If Mr. Crofoot had actually explained the Disputed Fees as a change to the way BCBSM was compensated, a conversation about contract terms would necessarily have followed.

- Mr. Crofoot carried a pre-printed form with him to confirm he had a conversation with Mr. Schultz. The existence of this form suggests BCBSM knew it may need "cover" sometime in the future about whether it verbally disclosed the Disputed Fees. That creates a strong inference that BCBSM knew what it was doing was subject to disagreement or challenge at some point in the future; if the fees were fully disclosed and agreed to as BCBSM contends, then there would have been no concern about future disagreements. Indeed, Cindy Garofali testified that she never saw anything like these forms in her 10 years before the Disputed Fees, and never in the 20 years since. (Garofali Test.).

- The timing of the alleged meeting is suspect. BCBSM began charging Hi–Lex the Disputed Fees on May 1, 1994. (SF 6). The 1994 Schedule A did not contain language related to the Disputed Fees. (JTE 64, 77). The alleged meeting with Mr. Crofoot did not happen until August 1994. This four month gap demonstrates that BCBSM intended to obtain the Disputed Fees without Plaintiffs' consent.

***17** • Mr. Schultz denies that the Disputed Fees were explained to him. (Testimony of Tony Schultz ("Schultz Test.)). Mr. Schultz testified that he is a detail-oriented person and focused on the financial aspects of the Plan. (*Id.*) Mr. Schultz says he would never have agreed to the Disputed Fees and, in fact, would have objected to them. He also would have required that the Disputed Fees be memorialized in a contract amendment.

148. Even if Mr. Crofoot's testimony is accepted at face value, he apparently represented to Mr. Schultz that the "new pricing arrangement" would be "revenue neutral." That was false. According to Mr. Austin the whole point of "Retention Reallocation" was to get BCBSM out of financial trouble (i.e., more revenue). (Austin Test.).

149. BCBSM does not allege any further mention of the Disputed Fees by its representatives until almost ten years later—in 2003. BCBSM alleges that Hi–Lex was told about the Disputed Fees in 2003. The evidence does not support BCBSM:

- Plaintiffs' consultant, Marsh, raised a question about paragraph 11 of the Schedule A. Marsh's inquiry, buried in a single paragraph of a six-page memo (which itself was one of at least three other exhibits), was forwarded to BCBSM. BCBSM's reaction to the email revealed its great concern over discovery of Disputed Fees and potential disclosure by Marsh to other consultants and customers. There is no evidence that BCBSM ever disclosed the Disputed Fees in response to these email inquiries. (Paragraphs 84–94; JTE 86).

- Shortly after this above email exchange, Plaintiffs issued a formal RFP to BCBSM that asked for disclosure of any "network access/management fees." BCBSM responded by indicating there were none. This response was interpreted by Marsh to mean Access Fees, if any, were included in the disclosed Administrative Fee. BCBSM's response was false and misled both Plaintiffs and their consultant, Marsh. (Paragraphs 108–119; JTE 97 at 093).

1. *Plaintiffs Exercised Due Diligence Until 2007*

150. Mr. Welsh carefully reviewed all financial reports from BCBSM and included the financial data in a master spreadsheet. (Welsh Deposition at 203:18–204:15). None of those reports gave any indication that claims included administrative fees paid to BCBSM. (Winkler Deposition at 45:6–25).

151. Hi–Lex hired a consultant, Marsh, to review its plan. When Marsh raised a question about paragraph 11, Mr. Welsh diligently followed up with BCBSM, only to never get a response. (Welsh Deposition at 165:7–166:14; JTE 86).

152. Shortly thereafter, Hi–Lex, through Marsh, issued an RFP that expressly asked whether BCBSM charged Disputed Fees. (JTE 97). BCBSM answered "N/A." (PTE 505). Hi–Lex's expert interpreted BCBSM's response to mean there were no Disputed Fees in addition to the disclosed Administrative Fee. (PTE 507). Hi–Lex was reasonable in relying on its expert.

153. When John Flack took over as CFO, he continued his predecessors' practices of carefully reviewing all financial reports provided by BCBSM. (Flack Test.). He also continued keeping the master spreadsheet of every single claim handled by BCBSM. (*Id.*) Again, none of these reports indicated there was a problem.

***18** 154. When John Flack took over as CFO, he had no reason to question the long-standing relationship between Hi–Lex and BCBSM. Hi–Lex had already asked about Disputed Fees through the RFP and had been told they were not applicable. The contract documents remained identical for several years, giving Mr. Flack no reason to question BCBSM.

a. Plaintiffs Did Not Have a Broker During Any Relevant Time Period

155. From 1994 until 2003, it is undisputed that Plaintiffs did not have an insurance broker or "agent of record." In 2003, Hi–Lex retained Marsh to conduct a health benefit review. (PTE 503). This was a limited scope project and Hi–Lex did not retain Marsh to be its "agent of record." (Warren Test.).

2. *A Hypothetically Diligent Company Would Not Have Discovered the Disputed Fees until 2007.*

156. Even if the Court concluded that Plaintiffs were not diligent—despite having carefully and fully reviewed every financial report from BCBSM—that does not end the inquiry. The question remains whether a reasonably diligent company in Hi–Lex's position would have discovered that BCBSM was taking a greater Administrative Fee than it reported, more than six years before Plaintiffs filed suit:

- No one could tell from the monthly claims reports, quarterly reports, annual settlements and Form 5500 certifications that BCBSM kept part of the money reported as claims for itself. (Winkler Deposition at 45:6–25).

• Mr. Flack was fully justified in not reading the boilerplate of the Schedule As, given the longstanding relationship between the parties and his understanding of the program based on his own historic involvement. Even if he had read the contracts, it would not have made a difference:

a) The contract documents are misleading. (Part III, Section J).

b) BCBSM's own account manager, Sandy Ham, read and signed numerous Schedule As over a six year period (1999 to 2005) and testified she did not understand anything about the Disputed Fees (including their existence). (Part III, Section E; Ham Test.). If BCBSM's trained account managers—charged with explaining the Schedule As to Hi–Lex—did not understand the contracts, then a "reasonably diligent" CFO could not be expected to understand them to authorize the Disputed Fees.

c) Not only did BCBSM's own employees not understand the contracts; neither did any of the six brokers who testified at trial. As noted more fully below, all brokers (each with years of experience dealing with BCBSM self-funded customers), testified that they had no understanding of these fees until around 2007/2008 (or in some cases after that). A "reasonably diligent" CFO cannot be expected to understand the contracts better than industry experts.

L. *WITH THE EXERCISE OF DUE DILIGENCE, PLAINTIFFS SHOULD HAVE BEEN ON SUFFICIENT NOTICE OF THE DISPUTED FEES IN 2007, THROUGH THE VALUE OF BLUE CHART*

157. Beginning in 2007, BCBSM produced yearly Value of Blue charts. [JTE 17–22].

***19** 158. In June, 2007, Plaintiffs received a 2006 annual settlement from Blue Cross that included the new "Value of Blue" report. This report disclosed the precise dollar amount of Disputed Fees paid in 2006. (JTE 18 at 2304).

159. The Value of Blue pie chart was developed in response to customer requests that BCBSM report the precise dollar amount of Disputed Fees. (Krisan Test.). The pie chart format was selected to show the customer the relationship between what it paid and the savings it received, hence the title "Value of Blue." (*Id.*) It took several years to finalize the Value of Blue format after a decision was made to develop such a report. (*Id.*)

160. Sales staff received training on the Value of Blue report in 2005. (*Id.;* DTE 1015 at 259, 1010).

161. On August 21, 2007, Ms. Ham presented the 2006 annual settlement to Hi–Lex representatives John Flack, Mitch Freeman, and Liza Walling. (Ham Test.; DTE 1189). Ms. Ham specifically recalled presenting at that meeting the parts of the 2006 Value of Blue pie chart in a clockwise direction, and that she pointed out to Mr. Flack the portion entitled "Access Fee," as well as the notation at the bottom of the chart showing the Disputed Fees as a percentage of total cost. (Ham Test.; JTE 17).

162. This Value of the Blue chart disclosed the precise amount of Disputed Fees paid in 2006. (JTE 17; SF 7).

163. Mr. Flack explained that he did not read the Value of Blue pie charts because they were "pictorial graphs." (Flack Test.).

164. No one at Blue Cross ever told Mr. Flack not to read the Value of Blue pie charts. To the contrary, Sandy Ham presented each and every page of the renewal packets to Mr. Flack and testified that she walked him through each "slice" on the Value of Blue pie charts. (Ham Test.).

165. Mr. Flack testified that if he had read the Disputed Fee disclosure in the renewal packets, (JTE 58–63), projections disclosures, and the Schedule A disclosures, he would have been "aware" of the Disputed Fee pricing arrangement and would have "asked questions" and "taken action" in response to those disclosures. (Flack Test.).

166. The Value of Blue chart was a sufficient change from other documents and an adequate disclosure of the Disputed Fees that BCBSM was charging. But, it only disclosed the fees for the prior year and is irrelevant to notice of Disputed Fees charged prior to 2006.

167. BCBSM has provided Value of Blue charts to Plaintiffs continuously since 2007.

M. *PLAINTIFFS ARE ENTITLED TO DAMAGES*

168. Plaintiffs are entitled to restitution in the amount of all Disputed Fees paid, beginning in 1994 to 2011.

169. The parties have stipulated that the Disputed Fees charged by BCBSM to Plaintiffs from 2002–2011 were **$4,035,134.** (SF 7).

170. BCBSM has not produced any data to establish what the Disputed Fees were for years 1994 through 2001.

171. Plaintiffs' damages expert, Neil Steinkamp, calculated estimated Disputed Fees using claims data and other documents provided by BCBSM or otherwise historically maintained by Hi–Lex. Using this data and Disputed Fee factors provided by BCBSM, Mr. Steinkamp estimates the Disputed Fees for years 1994 through 2001 to be $1,076,297. The estimates provided by Mr. Steinkamp are the result of reliable principles and methods and were accurately calculated. BCBSM failed to offer contrary evidence or otherwise dispute Mr. Steinkamp's estimates. Accordingly, the Court accepts Mr. Steinkamp's estimate of **$1,076,297** as a fair, reasonable, and accurate approximation of the Disputed Fees for 1994 through 2001. (PTE 582).

***20** 172. Plaintiffs are entitled to total damages in the amount of **$5,111,431.**

173. Plaintiffs are entitled to recovery of prejudgment interest, to compensate them fully for the loss of the Disputed Fees. Prejudgment interest shall be calculated pursuant to the rate under 28 U.S.C. § 1961.

174. Plaintiffs are entitled to postjudgment interest, calculated under 28 U.S.C. § 1961.

III. *CONCLUSIONS OF LAW*

A. *BCBSM IS AN ERISA FIDUCIARY (PREVIOUSLY DECIDED IN 9/7/2012 SUMMARY JUDGMENT ORDER)*

175. ERISA provides that a third-party administrator of an employee benefit plan is a fiduciary when it exercises any authority or control over the disposition of plan assets:

> "[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan ***or exercises any authority or control respecting management or disposition of its assets,*** (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan."

Summary Judgment Order [Doc. 112] at 10 (quoting 29 U.S.C. § 1002(21)(A) (emphasis added).

176. Thus, under § 1002(21)(A), "any person or entity that exercises control over the assets of an ERISA-covered plan, ***including third-party administrators,*** acquires fiduciary status with regard to the control of those assets." *Briscoe v. Fine,* 444 F.3d 478, 494 (6th Cir.2006) (emphasis added).

177. "The Sixth Circuit employs a 'functional test' to determine fiduciary status." Summary Judgment Order, at 10 (citing *Briscoe,* 444 F.3d at 486).

178. "The relevant question is 'whether an entity is a fiduciary with respect to the particular activity in question.' " *Id.* (quoting *Guyan Int'l Inc. v. Prof'l Benefits Adm'rs, Inc.,* 689 F.3d 793, 797 (6th Cir.2012).

179. "The Sixth Circuit holds that a third-party administrator such as Blue Cross 'becomes an ERISA fiduciary when it exercises 'practical control over an ERISA plan's money.' " *Id.* (quoting *Guyan,* 689 F.3d at 798).

180. Funds deposited by an employer with a third-party administrator of a self-funded employee benefits plan are "plan assets" under ERISA. Summary Judgment Order, at 17 (citing *Libbey–Owens–Ford Co. v. Blue Cross & Blue Shield Mutual of Ohio,* 982 F.2d 1031 (6th Cir.1993) and *Pipefitters Local 636 Ins. Fund v. Blue Cross Blue Shield of Mich.,* 654 F.3d 618, 626 (6th Cir.2011); *see also Briscoe,* 444 F.3d 478.

181. "BCBSM was a fiduciary when it allocated the Disputed Fee from plan assets itself. By accepting regular deposits from Plaintiffs for the purpose of paying health claims, Blue Cross exercised 'practical control over an ERISA plan's money.' " Summary Judgment Order, at 12 (citing *Guyan,* 689 F.3d at 798).

***21** 182. BCBSM was also a fiduciary because it exercised discretion over Plaintiff's Plan Assets when it determined the amount of any fees it would allocate to itself. Summary Judgment Order, at 14; *see also Charters v. John Hancock Life Ins. Co.,* 583 F.Supp.2d 189, 197 (D.Mass.2008).

B. *BCBSM VIOLATED ITS FIDUCIARY OBLIGATIONS (COUNT I)*

183. "ERISA is a 'comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans.' " Summary Judgment Order, at 9 (quoting *Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85, 90, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983)).

184. It was "designed to 'protect ... the interests of participants in employee benefit plans and their beneficiaries ... by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.' " *Akers v. Palmer,* 71 F.3d 226, 229 (6th Cir.1995) (quoting 29 U.S.C. § 1001(b)).

185. ERISA accomplishes its purposes by imposing "strict fiduciary standards of care in the administration of all aspects of pension plans and promotion of the best interests of participants and beneficiaries.' " *Id.* at 229 (quoting *Berlin,* 858 F.2d at 1162).

186. Indeed, "the crucible of congressional concern was misuse and mismanagement of plan assets by plan administrators and ... ERISA was designed to prevent these abuses in the future." *Mass. Mut. Life Ins. Co. v. Russell,* 473 U.S. 134, 140 n. 8, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985).

187. "Fiduciaries are assigned a number of detailed duties and responsibilities, which include 'the proper management, administration, and investment of plan assets, the maintenance of proper records, the disclosure of specified information, and the avoidance of conflicts of interest.' " *Mertens v. Hewitt Assocs.,* 508 U.S. 248, 251–52, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993) (quoting *Mass. Mut. Life Ins.,* 473 U.S. at 142–43 and citing 29 U.S.C. § 1104(a)).

188. "Clearly, the duties charged to an ERISA fiduciary are 'the highest known to the law.' " *Chao v. Hall Holding Co.,* 285 F.3d 415, 426 (6th Cir.2002) (quoting *Howard v. Shay,* 100 F.3d 1484, 1488 (9th Cir.1996)); *see also* Summary Judgment Order, at 9.

189. ERISA fiduciaries owe the Plan, the participants, and beneficiaries an undivided duty of loyalty under 29 U.S.C. § 1104(a) (1).

190. The duty "requires that 'all decisions regarding an ERISA plan must be made with an eye single to the interests of the participants and beneficiaries.' " *Krohn v. Huron Mem'l Hosp.,* 173 F.3d 542, 547 (6th Cir.1999) (quoting *Berlin v. Mich. Bell Tel. Co.,* 858 F.2d 1154, 1162 (6th Cir.1988)).

191. It encompasses a number of obligations, including the duty to avoid giving "misleading or inaccurate information," *Varity Corp. v. Howe,* 516 U.S. 489, 506, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996), and to "inform when the trustee knows that its silence might be harmful," *Krohn,* 173 F.3d at 551.

***22** 192. "[A] fiduciary may not materially mislead those to whom the duties of loyalty and prudence ... are owed." *Berlin,* 858 F.2d at 1163; *see also Varity,* 516 U.S. at 506 ("lying is inconsistent with the duty of loyalty owed by all fiduciaries and codified in [Section 1104(a)(1)] of ERISA").

193. A fiduciary breaches its duty of loyalty by providing misleading information regarding the costs of its services. *Gregg v. Transp. Workers of Am. Int'l,* 343 F.3d 833, 844 (6th Cir.2003); *Frulla v. CRA Holdings, Inc.,* 596 F.Supp.2d 275, 284–86 (D.Conn.2009).

194. An ERISA fiduciary has a duty under § 1104(a)(1) to disclose information to the principal about its compensation. *See Krohn,* 173 F.3d at 547 ("The duty to inform ... entails ... an affirmative duty to inform when the trustee knows that silence might be harmful.").

195. BCBSM violated its duty under § 1104(a)(1) to avoid supplying the Plaintiffs with misleading or inaccurate information about its administration of the self-funded ERISA plans. It did this by supplying false and misleading information to Plaintiffs about the nature and extent of the Disputed Fees. *Gregg,* 343 F.3d at 844; *Berlin,* 858 F.2d at 1163; *Frulla,* 596 F.Supp.2d at 284–86.

196. BCBSM also violated its fiduciary duty under § 1104(a)(1) to disclose information to the Plaintiffs about its compensation, which necessarily included information about the Disputed Fees, even if Hi–Lex did not make a specific request for information. *See Krohn,* 173 F.3d at 547.

197. BCBSM knew that Plaintiffs were required to file Form 5500s to the Department of Labor, and BCBSM was required under ERISA to provide the necessary information to Plaintiffs, so that Plaintiffs could supply accurate information to the DOL. 29 U.S.C. §§ 1021, 1023; 29 C.F.R. § 2520.103–4; 29 C.F.R. § 2520.103–5.

198. BCBSM violated its fiduciary duty under ERISA by supplying false information in Form 5500s to Plaintiffs. *See Frulla,* 596 F.Supp.2d at 288.

C. *BCBSM VIOLATED ERISA'S PROHIBITION OF SELF–DEALING (COUNT II) (PREVIOUSLY DECIDED IN 9/7/2012 SUMMARY JUDGMENT ORDER)*

199. A third-party administrator engages in self-dealing when it marks up insurance premiums when charging expenses to an ERISA plan. Summary Judgment Order, at 20 (citing *Patelco Credit Union v. Sahni,* 262 F.3d 897, 911 (9th Cir.2001)).

200. A fiduciary also engages in self-dealing by "determin[ing] his own administrative fees and collect[ing] them himself from the Plan's funds, in violation of § 1106(b)(1)." *Patelco,* 262 F.3d at 911; *see also* Summary Judgment Order, at 20.

201. BCBSM determined its own administrative fees by acting unilaterally with respect to the Disputed Fee; this type of self-dealing is a *per se* breach of Section 1106(b)(1). *See* Summary Judgment Order, at 21.

D. *PLAINTIFFS TIMELY FILED THEIR ERISA CLAIMS (STATUTE OF LIMITATIONS)*

***23** 202. The statute of limitations for ERISA claims under § 1104(a) and § 1106(b) is set forth in 29 U.S.C. § 1113:

> **§ 1113. Limitation of actions**
>
> No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of—
>
> (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or
>
> (2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;
>
> ***except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.***

29 U.S.C. § 1113 (emphasis added).

203. Under § 1113, if the case involves "fraud or concealment," then the limitations periods set forth in Subsections 1 and 2 will not apply. In that case, the limitations period is "six years after the date of discovery of such breach or violation." *Id.*

1. *Neither The Standard Six–Year Limitations Period Nor The Three–Year Limitations Period for "Actual Knowledge" Applies*

204. A claim for a fiduciary breach or violation as claimed here will be time barred upon the earlier expiration of two alternative time periods. One period expires six years from the last act constituting a part of the breach or violation; the other is for a period of three years from the earliest date on which the Plaintiff had actual knowledge of the breach or violation. 29 U.S.C. § 1113.

205. That a claim is time barred under 29 USC § 1113 is an affirmative defense; BCBSM raises it and has the burden of proof. *Blanton v. Anzalone,* 760 F.2d 989, 991–92 (9th Cir.1985).

206. BCBSM does not argue that the "standard" six year statute of limitations is in play here, only to say that "Even under a six year limitations period; Plaintiffs' claims were time barred in either 2000 or 2009." (Defendant's Proposed Conclusions of Law, ¶ 8). Hence, the Court focuses on BCBSM's actual knowledge argument.

207. In interpreting and applying § 1113, courts refer to the broad remedial purposes of ERISA; they express the view that "A fiduciary who violates the trust placed in him by the plan will not easily find protection from a time bar." *Useden v. Acker,* 734 F.Supp. 978, 979–80 (S.D.Fla.1989), 947 F.2d 1563 (11th Cir.1991), cert. denied, 508 U.S. 959, 113 S.Ct. 2927, 124 L.Ed.2d 678 (1993).

208. In keeping with the broad remedial purpose of ERISA, the standard six year limitations period provides potential

litigants with a long period of time from commission of a breach or violation, in which to file suit. However, to prevent litigants from unreasonably delaying the filing of suit once they have knowledge of the facts underlying their claims, § 1113 provides that a fiduciary claim will be time barred if it is not filed within three years after Plaintiff has actual knowledge of the breach or violation, even if the six year period has yet to expire. 29 U.S.C. § 1113(2).

***24** 209. As outlined above, the preponderance of the evidence shows that Hi–Lex:

(1) Did not have actual knowledge of the breach or violation until **August 21, 2007,** when the Value of Blue chart was presented by Ms. Ham to Hi–Lex representatives. So-called disclosures made by Mr. Crofoot in 1994 did not give Plaintiff's actual knowledge of Disputed fees. Nor did the audit and RFP process in 2003.

(2) So-called disclosures made in the 2002 ASC, 1995 through 2008 Schedule As, and the renewal packages for 2006 through 2008, did not unambiguously disclose the Disputed Fees.

210. The relevant "actual knowledge" "required to trigger the statute of limitations under 29 USC § 1113(2) is knowledge of the facts or transaction that constituted the alleged violations; it is not necessary that the Plaintiff also have actual knowledge that the facts establish a cognizable legal claim under ERISA in order to trigger the running of the statute." *Wright v. Heyne,* 349 F.3d 321, 330 (6th Cir.2003); *Bishop v. Lucent Techs, Inc.,* 520 F.3d 516, 519–20 (6th Cir.2008).

211. While the failure to read plan documents will not shield Plaintiffs from actual knowledge of the documents terms, *Brown v. Owens Corning Inv. Review Comm.,* 622 F.3d 564, 571 (6th Cir.2010), the documents that BCBSM say Plaintiffs should have read and which would have given them so called actual knowledge, failed to set forth Disputed Fees as an Administrative Fee, or in a manner which would have caused Plaintiffs to question the Disputed Fees. Further, the documents BCBSM relies upon do not clearly set forth the essential facts of the transaction or conduct which constitutes BCBSM's breach of duty. BCBSM's breach was supplying false, misleading, and inaccurate information to Plaintiffs about the nature and extent Disputed Fees, (*see* Part IV, Sections B and C). The manner in which the contract documents were written did not disclose all material facts necessary to understand that BCBS breached its duty or otherwise violated the statute.

212. As the Eleventh Circuit held and the Sixth Circuit recognized, it is not enough that an ERISA Plaintiff "notice that something was awry; he must have had knowledge of the actual breach of duty upon which he sues." *Brock v. Nellis,* 809 F.2d 753 (11th Cir.), cert. dismissed, 483 U.S. 1057, 108 S.Ct. 33, 97 L.Ed.2d 821 (1987); *see Rogers v. Millan,* 902 F.2d 34 (6th Cir.1990).

213. Based on the foregoing, the Court finds that BCBSM failed to meet its burden to prove that Plaintiffs gained actual knowledge of the Disputed Fees in 1994, 2002, 2003, or from 1995 up to August 21, 2007.

2. *The Six–Year Discovery Rule for "Fraud or Concealment" Applies and Allows Plaintiffs to Recover Damages From 1994 Through 2011*

a. The applicable standard for the application of "Fraud or Concealment" is an open question in the Sixth Circuit

214. Under ERISA § 1113, neither the expiration of six years from the last act constituting a fiduciary breach or violation, nor three years from actual knowledge of the breach or violation, will bar a claim where fraud or concealment is proven. 29 U.S.C. § 1113.

***25** 215. In the case of fraud or concealment, § 1113 gives a plaintiff six years after the date of discovery of the breach to file suit. *Id.*

216. Accordingly, Hi–Lex can preserve any claims that might otherwise be time barred under the normal three year limitations period, if it can show that BCBS engaged in conduct that constitutes fraud or concealment.

217. In a claim of breach of fiduciary duty based on fraud or concealment, the Circuits are not unanimous on what the elements are for such a cause of action; there are two approaches on this issue.

218. First, various Circuits hold that the "fraud or concealment" language cannot be read literally, and that the cause of action incorporates the federal concealment rule, or the "fraudulent concealment" doctrine.

219. The concealment rule was established by the Supreme Court in *Bailey v. Glover,* 21 Wall. 342, 88 U.S. 342, 22 L.Ed. 636 (1874). It grew from equitable estoppel principles,

and provides that when a defendant's wrongdoing "has been concealed, or is of such character as to conceal itself, the statute [of limitations] does not begin to run" until the plaintiff discovers the wrongful acts. *See id.* at 349–50.

220. Thus, to invoke the "fraud or concealment" limitations period, the Circuits that rely upon the concealment rule require that a plaintiff—in addition to alleging a breach of fiduciary duty (based on fraud or anything else)—must prove that the defendant committed either: (1) a self-concealing act, i.e., an act that has the effect of concealing the breach from the Plaintiff; (or) "active concealment"—an act distinct from and subsequent to breach, intended to conceal it. *See Kurz v. Philadelphia Elec. Co. .,* 96 F.3d 1544, 1552 (3d Cir.1996); *J. Geils Band Employee Benefit Plan v. Smith Barney,* 76 F.3d 1245, 1252 (1st Cir.1996); *Barker v. American Mobil Power Corp.,* 64 F.3d 1397, 1401–02 (9th Cir.1995); *Larson v. Northrop Corp.,* 21 F.3d 1164, 1172–1173 (D.C.Cir.1994); *Radiology Ctr. v. Stifel Nicolaus & Co.,* 919 F.2d 1216, 1220 (7th Cir.1990); *Schaefer v. Arkansas Med. Soc'y,* 853 F.2d 1487, 1491–1492 (8th Cir.1988).

221. A different approach in applying the "fraud or concealment" limitations period has been articulated in *Caputo v. Pfizer,* 267 F.3d 181 (2d Cir.2001). It does not require a plaintiff to prove fraudulent concealment. The Second Circuit declined to follow its sister Circuits on this issue, holding that "[t]he six-year statute of limitations should be applied to cases in which a fiduciary: (1) breached its duty by making a knowing misrepresentation or omission of a material fact to induce [a plaintiff] to act to his detriment; *or* (2) engaged in acts to hinder the discovery of a breach of fiduciary duty." *Id.* at 190 (emphasis in original).

222. *Caputo* breaks from the other Circuits for three reasons.

a. "[T]he genesis of this uniformly adopted theory is a footnote in a district court opinion that cites no legal support for the proposition." *Id.* at 189 (explaining that "The First, Third, Seventh, Ninth, and D.C. Circuits all cite the Eighth Circuit decision in *Schaefer,* 853 F.2d at 1491–1492, which, in turn, relied on *Foltz v. U.S. News & World Report, Inc.,* 663 F.Supp. 1494, 1537 n. 66 (D.D.C.1987) (noting that 'any claim under ERISA § 502(a)(3) may [...] be tolled under the fraudulent concealment doctrine incorporated in section 413, 29 U.S.C. § 1113.')").

***26** b. "[T]he 'fraud or concealment' provision does not 'toll' the otherwise applicable six-or three-year statute of limitations established in § 413(1) or (2); rather, it prescribes a separate statute of limitations of six years from the date of discovery." *Id.*

c. "[P]rinciples of statutory interpretation counsel strongly against merging" the terms "fraud" and "concealment," and each term should be given "independent significance" pursuant to their definitions and the provision's legislative history. *See id.* at 189–90.

223. BCBSM argues that the Court should follow the First, Third, Seventh, Eighth, Ninth, and D.C. Circuits, and directs the Court to *Larson v. Northrop,* 21 F.3d 1164 (D.C.Cir.1994), which held that that a plaintiff invoking the special fraud limitations period must prove that the defendant engaged in actual, fraudulent concealment. *See id.* at 1172–74.

224. In addition, BCBSM claims that this Court is bound to apply the majority of the Circuits' approach because *Brown v. Owens Corning Inv. Review Committee,* 622 F.3d 564 (6th Circuit 2010)—a Sixth Circuit case—allegedly mandates it because *Brown* quoted *Larson.*

225. The language to which BCBSM directs the Court's attention in *Brown* is: "ERISA's fraud exception to the statute of limitations 'requires the plaintiffs to show (1) that defendants engaged in a course of conduct designed to conceal evidence of their alleged wrong-doing and that (2) [the plaintiffs] were not on actual or constructive notice of that evidence, (3) despite their exercise of diligence." *Brown,* 622 F.3d at 573 (quoting *Larson,* 21 F.3d at 1172) (alteration in original).

226. However, a more recent Sixth Circuit case, *Cataldo v. U.S. Steel Corp.,* 676 F.3d 542 (6th Cir.2012), held that "whether a six-year limitations period applies in instances where the claim is based upon fraud and there are no allegations of separate conduct undertaken by the fiduciary to hide the fraud is an open question" in the Sixth Circuit. *Id.* at 550.

227. *Cataldo* held that *Brown* was dictum to the extent that it purported "to set forth the entire set of circumstances in which [the six year statute of limitations] can apply." *Cataldo* stated this because it believed the Sixth Circuit did not have to consider—for the ultimate holding in *Brown*—"whether a claim of fraud, by itself, would be subject to the six-year period because plaintiffs never pressed such a claim; they claimed ... *non-fraudulent* breach of fiduciary duty." *Id.* at 550–51.

228. *Cataldo* went on to find the *Caputo* approach persuasive. *Id.* ("[T]he Second Circuit has provided a persuasive contrary interpretation." (citing *Caputo* 267 F.3d at 188–190)). However, the *Cataldo* court did not pronounce it as Sixth Circuit authority because it was not necessary to the holding in *Cataldo;* the court found that the plaintiffs failed to plead fraud sufficiently, and concluded that any discussion on that issue would have been dictum. *Cataldo,* 676 F.3d at 550–51 ("[W]e assume, but do not decide, that a claim of fiduciary fraud not involving separate acts of concealment is subject to a six-year limitations period that begins to run when the plaintiff discovered or with due diligence should have discovered the fraud.").

***27** 229. Accordingly, neither *Brown* nor *Cataldo* binds this Court on the applicable statute of limitations.

230. The Court concludes that—pursuant to *Cataldo*—if the Sixth Circuit adopted a standard on this issue, it would follow the *Caputo* approach for the same reasons that *Caputo* rejected its sister Circuits' approach: (1) "fraud" and "concealment" are used in the disjunctive in the statute; (2) the "fraud or concealment" provision has its own statute of limitations running from the date of discovery, and is not intended to toll another statute of limitations; and (3) the majority of Circuits relied upon a district court decision which erroneously merged the term "fraud" and "concealment" to require an ERISA plaintiff to prove "fraudulent concealment" in a breach of duty claim before the plaintiff could reap the benefit of the longer statute of limitations.

231. In addition, several judges in this district have either used the *Caputo* standard for analyzing the fraud or concealment exception in § 1113 or cited it with approval. *See, e.g., East Jordan Plastics, Inc. v. Blue Cross & Blue Shield of Mich.,* No. 12–cv–15621, Dkt. No. 27, at Page ID 937 (E.D.Mich. May 3, 2013) (applying *Caputo*); *McGuire v. Metro. Life Ins. Co.,* 899 F.Supp.2d 645, 659 (E.D.Mich.2012) (citing *Caputo* with approval).

232. Nonetheless, the Court finds that whether the burden on Plaintiffs is to prove simple "fraud" or "fraudulent concealment" is of no moment; Plaintiffs satisfy their burden under either *Caputo* or the various other Circuits.

b. Plaintiffs Prove BCBSM Engaged in Fraudulent Conduct

233. *Caputo* allows the application of the "fraud or concealment" limitations period under § 1113 when, in relevant part, a defendant: "(1) breached its duty by making a knowing misrepresentation or omission of a material fact to induce [a plaintiff] to act to his detriment." 267 F.3d at 190.

234. Furthermore, under *Frulla v. CRA Holdings Inc.,* 596 F.Supp.2d 275 (D.Conn.2009), a plan administrator is guilty of fraud under § 1113 if it made "knowing omissions of material facts" that "misled plan participants" into believing facts that were not true. *Id.* at 288. *Frulla* involved ERISA claims under § 1104(a) that "in the course of administering the Plan ..., defendants engaged in actions that violated their fiduciary duties, failed to disclose material information to Plan participants, and concealed material information from them." *Id.* at 278.

235. The Court finds the rule in *Caputo* and the holding in *Frulla* applicable to whether BCBSM engaged in fraud for the purpose of § 1113.

236. Plaintiffs prove that BCBSM engaged in knowing misrepresentations and omissions of Disputed Fees in the contract documents, which misled Plaintiffs into thinking that the disclosed Administrative Fees were the only compensation that BCBSM retained. (*See* Part III, Sections D–J).

***28** 237. To comply with the particularity requirement of Federal Rule of Civil Procedure 9(b), "[w]ith regard to misrepresentations, a plaintiff must identify the time, place, speaker, and content of the alleged misrepresentations." *Frulla,* 596 F.Supp.2d at 288 (citing *Caputo,* 267 F.3d at 191). "With regard to omissions, a plaintiff must detail the omissions made, state the person responsible for the failure to speak, provide the context in which the omissions were made, and explain how the omissions deceived the plaintiff." *Id.* (citing *Eternity Global Master Fund Ltd. v. Morgan Guar. Trust Co. of N.Y.,* 375 F.3d 168, 187 (2d Cir.2004)). Plaintiffs met these requirements at trial, and BCBSM waived the particularity requirements under Rule 9(b). (*See* Paragraph 238).

238. BCBSM argues that Plaintiffs did not sufficiently plead fraud (or fraudulent concealment) under Rule 9(b), and should be foreclosed from trying these issues now. This argument is unavailing. BCBSM's main defense at trial was based on an absence of fraud. "When an issue not raised by the pleadings is tried by the parties' express or implied consent, it must be

treated in all respects as if raised in the pleadings. A party may move—at any time, even after judgment—to amend the pleadings to conform them to the evidence and to raise an unpleaded issue. But failure to amend does not affect the result of the trial of that issue." Fed.R.Civ.P. 15(b)(2).

239. "When a 'discovery rule' [such as that in § 113] applies, the statute of limitations begins to run from the date on which the plaintiff discovers, or with due diligence reasonably should have discovered, that he has suffered an injury." *Frulla,* 596 F.Supp.2d at 289; *see Caputo,* 267 F.3d at 190 ("[T]he final version of the statute adopted a six-year term and a discovery rule (i.e., the limitations period begins to run when the employee discovers or with due diligence should have discovered the breach)....").

240. When "discovery" is used in a statute, courts typically interpret the word to refer not only to actual discovery, but also to the hypothetical discovery of facts a reasonably diligent plaintiff would know. *Merck & Co., Inc. v. Reynolds,* 559 U.S. 633, 130 S.Ct. 1784, 1794, 176 L.Ed.2d 582 (2010).

241. Plaintiffs did not discover BCBSM's fraud until August 21, 2007. (*See* Part III, Section K).

242. Plaintiffs did not discover BCBSM's fraud until August 21, 2007, through their own exercise of due diligence. Importantly, a hypothetical diligent company would not have discovered BCBSM's fraud until August 21, 2007. (*See* Part III, Section K).

243. Accordingly, Plaintiffs had until August 21, 2013 to file their suit. Their claims are timely, and they are entitled to damages from 1994 through 2011.

c. Plaintiffs Prove BCBSM Engaged in Fraudulent Concealment

244. To rely on the "fraud or concealment" limitations period under *Larson,* Plaintiffs must show: (1) that BCBSM engaged in a course of conduct designed to conceal evidence of their alleged wrong-doing and that (2) Plaintiffs were not on actual or constructive notice of that evidence, despite (3) their exercise of diligence. *Larson,* 21 F.3d at 1172.

***29** 245. Under *Larson,* Plaintiffs must—in addition to proving a breach of fiduciary duty based on a failure to disclose—show that BCBSM engaged in a "course of conduct designed to conceal evidence of [BCBSM's] wrongdoing." *Id.* at 1172. " 'There must be actual concealment—i.e., some trick or contrivance intended to exclude suspicion and prevent inquiry.' " *Id.* at 1173 (quoting *Martin v. Consultants & Administrators, Inc.,* 966 F.2d 1078, 1095 (7th Cir.1992)).

246. Plaintiffs prove that BCBSM actively concealed their knowing misrepresentations and omissions in the contract documents in order to allay Plaintiffs' suspicion and prevent inquiry into Disputed Fees. (*See* Part III, Sections D–J).

247. Plaintiffs were not on actual or constructive notice of the evidence of BCBSM's wrongdoing until August 21, 2007. (*See* Part III, Section K).

248. Plaintiffs exercised due diligence until August 21, 2007. (*See* Part III, Section K).

249. Accordingly, Plaintiffs had until August 21, 2013 to file their suit. Their claims are timely, and they are entitled to damages from 1994 through 2011.

E. *BCBSM CANNOT ESTABLISH A STATUTE OF LIMITATIONS DEFENSE BASED ON ALLEGED IMPUTED KNOWLEDGE FROM MARSH*

1. BCBSM may not seek to impute knowledge in order to shield its ERISA violations.

250. The Court has found "that agency law is applicable in the context of ERISA, and adopt[ed] the imputed knowledge doctrine and its exception." (April 19, 2013 Order on Motions in Limine (Doc No. 235) ("Order on Motions in Limine")).

251. Thus, "[t]he rule imputing an agent's knowledge to the principal is designed to protect only those who exercise good faith, and is not intended to serve as a shield for unfair dealing by the third person." *Id.* (quoting 3 Am.Jur.2d Agency § 284); *see also, e.g., First Ala. Bank v. First State Ins. Co.,* 899 F.2d 1045, 1060 n. 8 (11th Cir.1990) (acknowledging the "universally accepted" rule); *Mut. Life Ins. Co. v. Hilton–Green,* 241 U.S. 613, 623, 36 S.Ct. 676, 60 L.Ed. 1202 (1916) ("The rule [of imputation] is intended to protect those who exercise good faith, and not as a shield for unfair dealing"); *Armstrong v. Ashley,* 204 U.S. 272, 283, 27 S.Ct. 270, 51 L.Ed. 482 (1907) (explaining that the rule of imputation applied because defendants did not have any connection with the agents' frauds); *Bass v. Equitable Life Assurance Soc'y of the U.S.,* 72 F. App'x 401, 404 (6th Cir. Aug.13, 2003).

252. "The Court interprets this doctrine to require the party invoking it to have acted in good faith." (Order on Motions in Limine).

253. "Defendant [BCBSM] has the burden to prove imputed knowledge and that it acted in good faith." (*Id.*)

254. Dave Mamuscia, who was not a subagent working with Hi–Lex in 2003, never testified at trial. There is no evidence as to what he knew about the Disputed Fees in 2003.

255. Accordingly, no knowledge regarding the Disputed Fees can be imputed to Hi–Lex.

***30** 256. BCBSM violated ERISA's prohibition against self-dealing and also breached its fiduciary duties. It also engaged in fraud and concealment to hide its violations from Plaintiffs. BCBSM exhibited bad faith that precludes imputation for the purpose of its statute of limitations defense or otherwise.

F. *PLAINTIFFS ARE ENTITLED TO A RETURN OF THE DISPUTED FEES, WITH INTEREST*

252. Under ERISA:

> [a] fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate ....

29 U.S.C. § 1109.

1. *Damages*

258. "Section 1109, in turn, makes any person found to be a fiduciary personally liable to the ERISA-covered plan for any damages caused by that person's breach of fiduciary duties." *Briscoe,* 444 F.3d at 486.

259. "[I]n measuring a loss, the burden of persuasion should be placed on the breaching fiduciary." *Sec'y of the U.S. Dep't of Labor v. Gilley,* 290 F.3d 827, 830 (6th Cir.2002).

260. Further, "to the extent that there is any ambiguity in determining the amount of loss in an ERISA action, the uncertainty should be resolved against the breaching fiduciary." *Id.*

261. The Court accepts the well-founded damage opinions set forth in Mr. Steinkamp's expert report (PTE 582 and 587) and awards the Plaintiffs the full amount of Disputed Fees, **$5,111,431,** pursuant to 29 U.S.C. § 1109.

2. *Prejudgment Interest*

262. There is no fixed interest rate for prejudgment interest under ERISA. Rather "the determination of the prejudgment interest rate [is] within the sound discretion of the district court." *Ford v. Uniroyal Pension Plan,* 154 F.3d 613, 619 (6th Cir.1998).

263. BCBSM offered no testimony—expert or otherwise—on this issue. Its critiques of Mr. Steinkamp's expert opinion (DTE 1240) fall flat in light of John Flack's testimony that BCBSM's attorneys' summary exhibit (DTE 1240) is entirely incorrect. Flack Test.

264. The goal of the district court in setting the rate should be to adhere to "ERISA's remedial goal of simply *placing the plaintiff in the position he or she would have occupied but for the defendant's wrongdoing." Id.* at 618 (emphasis added).

265. Prejudgment interest should "compensate a beneficiary for the lost interest value of money wrongfully withheld from him or her ." *Rybarczyk v. TRW, Inc.,* 235 F.3d 975, 985 (6th Cir.2000) (quoting *Ford,* 154 F.3d at 618).

266. "An award that fails to make the plaintiff whole due to an inadequate compensation for her lost use of money frustrates the purpose of ERISA's remedial scheme." *Schumacher v. AK Steel Corp. Ret. Accumulation Pension Plan,* 711 F.3d 675, 2013 WL 1235624, at *8 (6th Cir. Mar.28, 2013) (published, pagination forthcoming).

***31** 267. The Sixth Circuit has cited with approval, decisions that utilize expert testimony in determining the appropriate prejudgment interest rate under ERISA. *Rybarczyk,* 235 F.3d

at 986 (citing *Katsaros v. Cody,* 744 F.2d 270, 281 (2d Cir.1984)).

268. Equity requires that Plaintiffs be awarded prejudgment interest dating back to the date the Disputed Fees were kept by BCBSM. *See Ford,* 154 F.3d at 618 ("awards at prejudgment interest ... compensate a beneficiary for the lost interest value of money wrongfully withheld from him or her"); *Bricklayers' Pension Trust Fund v. Taiariol,* 671 F.2d 988 (6th Cir.1982) (awarding interest to ERISA-plan plaintiff).

269. Plaintiffs' damages expert, Neil Steinkamp, testified as to the interest rate which he believes would place Plaintiffs in the position they would have been in, had BCBSM not taken the Disputed Fees. (Steinkamp Test.) The Court does not accept the interest rate set forth in Mr. Steinkamp's expert report.

270. The Court applies the interest rate under 28 U.S.C. § 1961, and awards Plaintiffs prejudgment interest under § 1967.

3. *Post-judgment Interest*

271. The Court awards Plaintiffs post judgment interest according to 28 U.S.C. § 1961.

4. *Attorney Fees*

272. The Court will entertain a petition for Attorney Fees.

IV. *CONCLUSION*

These are the Findings of Fact and Conclusions of Law. Judgment enters in the amount of **$5,111,431,** together with costs, interest, and attorney fees.

IT IS ORDERED.

All Citations

Not Reported in F.Supp.2d, 2013 WL 2285453, 56 Employee Benefits Cas. 1047

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2013 WL 1976234
Only the Westlaw citation is currently available.
United States District Court,
E.D. Michigan,
Southern Division.

COMPUTER AND ENGINEERING SERVICES, INC. and C.E.S., Inc. and Trillium Staffing Welfare Benefit Plan, Plaintiffs,
v.
BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.

Civil Case No. 12–15611.
|
May 13, 2013.

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OPINION AND ORDER GRANTING IN PART AND DENYING IN PART DEFENDANT'S MOTION TO DISMISS UNDER RULE 12(b)(6)

PATRICK J. DUGGAN, District Judge.

***1** This case is one of a series brought by private entities and their self-insured health care plans against Blue Cross Blue Shield of Michigan ("BCBSM"), in which the plaintiffs allege that BCBSM violated federal and state law when it charged and collected certain purported hidden fees in administering the plans.[1] Plaintiffs Computer and Engineering Services, Inc. ("CES") and C.E.S., Inc. and Trillium Staffing Welfare Benefit Plan ("Plan") (collectively "Plaintiffs") initiated the present action on December 21, 2012. In their Complaint, Plaintiffs allege that by charging and collecting the fees, BCBSM violated the Employee Retirement Income Security Act of 1974 ("ERISA") and Michigan law. Specifically, Plaintiffs asserts the following claims against BCBSM: (I) breach of fiduciary duty in violation of ERISA; (II) engaging in prohibited transactions in violation of ERISA; (III) violation of Michigan's Nonprofit Health Care Corporation Reform Act; (IV) violation of Michigan's Health Care False Claims Act; (V) breach of contract or covenant of good faith and fair dealing; (VI) breach of common law fiduciary duties; (VII) conversion; (VIII) fraud and misrepresentation; and (IX) silent fraud.

[1] Currently there are at least twenty related cases pending in this District. In addition to the present matter, two others have been assigned to the undersigned: *Lumbermen's, Inc., et al. v. Blue Cross Blue Shield of Michigan,* Case No. 12–15606 (filed Dec. 21, 2012) and *Board of Trustees of the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund v. Blue Cross Blue Shield of Michigan,* Case No. 13–10415 (filed Feb. 1, 2013). On April 19, 2013, this Court denied Plaintiffs' motion to consolidate this action with nine related actions pending before the Honorable Victoria A. Roberts. (ECF No. 26.)

Presently before the Court is BCBSM's motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6), filed February 4, 2013. The matter has been fully briefed. On May 10, 2013, this Court issued a notice informing the parties that it is dispensing with oral argument with respect to the motion pursuant to Eastern District of Michigan Local Rule 7.1(f). For the reasons that follow, the Court now grants in part and denies in part BCBSM's motion to dismiss.

I. Rule 12(b)(6) Standard

A motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6) tests the legal sufficiency of the complaint. *RMI Titanium Co. v. Westinghouse Elec. Corp.,* 78 F.3d 1125, 1134 (6th Cir.1996). Under Federal Rule of Civil Procedure 8(a)(2), a pleading must contain a "short and plain statement of the claim showing that the pleader is entitled to relief." To survive a motion to dismiss, a complaint need not contain "detailed factual allegations," but it must contain more than "labels and conclusions" or "a formulaic recitation of the elements of a cause of action ..." *Bell Atlantic Corp. v. Twombly,* 550 U.S. 544, 555, 127 S.Ct. 1955, 1964–65, 167 L.Ed.2d 929 (2007). A complaint does not "suffice if it tenders 'naked assertions' devoid of 'further factual enhancement.' " *Ashcroft v. Iqbal,* 556 U.S. 662, 678, 129 S.Ct. 1937, 1949, 173 L.Ed.2d 868 (2009) (quoting *Twombly,* 550 U.S. at 557, 127 S. Ct at 1966).

As the Supreme Court provided in *Iqbal* and *Twombly,* "[t]o survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.' " *Id.* (quoting *Twombly,* 550 U.S. at 570, 127 S.Ct. at 1974). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* (citing *Twombly,* 550 U.S. at 556, 127 S.Ct. at 1965). The plausibility standard "does not impose a probability requirement at the pleading stage; it simply calls for enough facts to raise a reasonable expectation that discovery will reveal evidence of illegal [conduct]." *Twombly,* 550 U.S. at 556, 127 S.Ct. at 1965.

***2** In deciding whether the plaintiff has set forth a "plausible" claim, the court must accept the factual allegations in the complaint as true. *Id.; see also Erickson v. Pardus,* 551 U.S. 89, 94, 127 S.Ct. 2197, 2200, 167 L.Ed.2d 1081 (2007). This presumption, however, is not applicable to legal conclusions. *Iqbal,* 556 U.S. at 668, 129 S.Ct. at 1949. Therefore, "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." *Id.* (citing *Twombly,* 550 U.S. at 555, 127 S.Ct. at 1965–66).

II. Factual Background

CES, a staffing agency, is a Michigan corporation, located in Kalamazoo, Michigan. CES offers health care benefits to its employees through the Plan, which is a self-insured plan. Plaintiffs have engaged BCBSM to administer the Plan.

To that end, CES and BCBSM executed an Administrative Services Contract ("ASC") effective January 1, 1998.[2] (Def.'s Mot. Ex. A.) Pursuant to the ASC, the parties agreed *inter alia* that "BCBSM will process and pay, and [CES] ... will reimburse BCBSM for all Amounts Billed related to Enrollees' claims ...". (*Id.* at 3.) The ASC defines "Amounts Billed" as "the amount [CES] ... owes in accordance with BCBSM's standard operating procedures for payment of Enrollees' claims." (*Id.* at 1.) The ASC requires CES to assume the following financial responsibilities, in addition to the Amounts Billed:

> 2. The hospital prepayment reflecting the amount BCBSM determines is necessary for its funding of the prospective hospital reimbursement.
>
> 3. The actual administrative charge.
>
> 4. The group conversion fee.
>
> 5. Any late payment charge.
>
> 6. Any statutory and/or contractual interest.
>
> 7. Stop Loss premiums, if applicable.
>
> 8. Cost containment program fee, if applicable.
>
> 9. Any other amounts which are the Group's responsibility pursuant to this Contract, including but not limited to risks, obligations or liabilities, deficit amounts relating to previous agreements, and deficit amounts relating to settlements.
>
> The Provider Network Fee, contingency, and any cost transfer subsidies or surcharges as authorized pursuant to 1980 P.A. 350 will be reflected in the hospital claims cost contained in Amounts Billed.

(*Id.* at Art. III(B).) The ASC defines the "Provider Network Fee" as "the amount allocated to the Group for the expenses incurred by BCBSM in the establishment, management and maintenance of its participating hospital, physician and other health care provider networks." (*Id.* at Art. I(L).)

The ASC does not contain pricing terms. The specific fees to be paid by CES were enumerated in a "Schedule A," which was part of the ASC. (Compl.Ex. 1.) For each year's ASC there was a corresponding Schedule A. (*Id.*) The parties renewed the ASC year after year through 2013.

The ASC requires BCBSM to provide CES with detailed quarterly settlements showing Amounts Billed to and owed by CES. (Def.'s Mot. Ex. A at 9.) The quarterly settlements were used to determine the amount CES was required to pay BCBSM on an established periodic basis. CES made these payments by wiring funds, i.e. "plan assets", to BCBSM's bank account.

2 Although not attached as an exhibit to Plaintiffs' Complaint, the ASC is referred to therein and is central to Plaintiffs' claims. As such, the Court may consider the document when ruling on BCBSM's motion to dismiss. *Greenberg v. Life Ins. Co. of Virginia,* 177 F.3d 507, 514 (6th Cir.1999) (internal citations omitted).

***3** According to Plaintiffs, in 2012 they discovered that BCBSM previously had implemented a scheme to secretly bill self-insured plans higher administrative compensation fees. The scheme was outlined in an internal BCBSM memo. (Compl.Ex. 2.) Set forth in the memo is BCBSM's plan to lower its disclosed administrative fee (thereby giving the illusion of lower costs), while artificially inflating the amounts it reported as hospital claims cost. Then BCBSM retained as administrative compensation the difference between what it was actually paying hospitals for employee claims and what it reported it was paying for hospital claims. (*Id.*) BCBSM concluded that this plan was needed because customers were threatening to leave BCBSM and/or refusing to pay certain fees that previously were clearly reported. (*Id.*) By including the fees in the hospital claims cost, they were "no longer visible to the customer." (*Id.*) Plaintiffs believe that BCBSM also was including "subsidies" and "surcharges" in these "Hidden Fees." Plaintiffs believe BCBSM has engaged in this scheme since 2007, and maybe even since 1994.

Plaintiffs allege that these fees were not included in BCBSM's quarterly or annual settlement statements or Form 5500's. The latter is a form developed by federal agencies, which employers must file as part of their obligations under ERISA and the Internal Revenue Code. The Form 5500 requires disclosure of total "claims paid," but Plaintiffs assert that BCBSM included the actual claims paid to health care service providers and the undisclosed fees that BCBSM retained as additional administrative compensation.

III. The Parties' Arguments

In its motion to dismiss, BCBSM argues that Plaintiffs' ERISA claims are timebarred under the statute's three-year limitations period, 29 U.S.C. § 1113. BCBSM contends that Plaintiffs had actual knowledge of the disputed fees and the obligation to pay those fees in 2007, when CES entered into the ASC. BCBSM asserts that the ASC unambiguously provided for the payment of the fees. For that proposition, BCBSM relies on the language of the ASC and the Michigan Court of Appeals' interpretation of that contract in *Calhoun County v. Blue Cross Blue Shield of Michigan,* 297 Mich.App. 1, 824 N.W.2d 202, *leave denied,* 493 Mich. 917, 823 N.W.2d 603 (2012). As to Plaintiffs' state law claims, BCBSM argues that those claims are preempted by ERISA and, alternatively, fail on their merits.

Plaintiffs respond that the limitations period applicable to their ERISA claims is six rather than four years because BCBSM engaged in fraud and/or concealment. Plaintiffs argue that the "act" of charging the fees is what gives rise to the claims rather than the mention of the fees in the contract. As to their state law claims, while Plaintiffs maintain that ERISA does not preempt the claims, they accept Judge Victoria Roberts' contrary ruling in one of the related cases. *See* Order Granting in Part and Denying in Part Pls.' Mot. for Summ. J. and Granting in Part and Denying in Part Def.'s Mot. for Summ. J. (hereafter "Order"), *Borroughs Corp. et al. v. Blue Cross Blue Shield of Michigan,* No. 11–12565 (E.D.Mich. Sept. 7, 2012) (ECF No. 112).

IV. Applicable Law and Analysis

A. Statute of Limitations

***4** ERISA contains the following limitations period applicable to Count I and II of Plaintiffs' Complaint:

> No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of-
>
> (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or
>
> (2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;
>
> except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

29 U.S.C. § 1113. The longer statute of limitations for fraud or concealment " 'requires the plaintiffs to show (1) that [the] defendants engaged in a course of conduct designed to conceal evidence of their alleged wrong-doing and that (2) [the plaintiffs] were not on actual or constructive notice of that evidence, (3) despite their exercise of diligence.' " *Brown v. Owens Corning Inv. Review Comm.,* 622 F.3d 564, 573 (6th Cir.2010) (quoting *Larson v. Northrop Corp.,* 21 F.3d 1164, 1172 (D.C.Cir.1994) (alteration in *Larson*) (additional citation omitted)).

Both parties to the present action agree that application of ERISA's statute of limitations involves a "two-step" process. (Def.'s Br. in Supp. of Mot. at 11, citing *Ziegler v. Conn. Gen. Life Ins. Co.,* 916 F.2d 548, 550 (9th Cir.1990)); (Pls.'

Resp. Br. at 9); *see also Gluck v. Unisys Corp.,* 960 F.2d 1168, 1178 (3d Cir.1992). The first step is "the identification and definition of the underlying ERISA violation upon which the fiduciary breach claim is founded." *Gluck,* 960 F.2d at 1178. Next, "[t]wo temporal determinations must ... be made: the date of the last action which formed a part of the breach and the date of the plaintiff's actual knowledge of the breach." *Id.*

Plaintiffs allege that BCBSM violated ERISA by, among other things:

> a) Charging undisclosed fees;
>
> b) Failing to disclose those fees;
>
> c) submitting false and misleading quarterly settlement statements and annual summaries;
>
> (d) submitting false and misleading Form 5500 reports;
>
> ...
>
> g) Otherwise engaging in a pattern of conduct designed to mislead, confuse, deceive and otherwise trick Plaintiffs into paying more for its services than Plaintiffs were obligated to pay.

(Pls.' Compl. ¶ 80.) Plaintiffs allege that they only became aware that CES had been charged the disputed fees in 2012. (*Id.* ¶¶ 60, 83.)

Without looking beyond Plaintiffs' Complaint—as required in deciding BCBSM's Rule 12(b)(6) motion—the Court cannot determine whether the disputed fees BCBSM charged CES were in fact revealed in the ASC. This includes what specific fees could be charged and a basis for calculating what the fees would be. The Court does not find this question resolved by the Michigan Court of Appeals' decision in *Calhoun County v. Blue Cross Blue Shield Michigan,* 297 Mich.App. 1, 824 N.W.2d 202 (2012). Moreover, as Judges Roberts and Drain already have held in related cases, the resolution of the plaintiff's state law claims in *Calhoun County* does not control Plaintiffs' ERISA counts. *See* Order at 7–9, *Borroughs Corp.,* No. 11–12557 (E.D.Mich. Sept. 7, 2012) (ECF No. 112); Order Granting in Part and Denying in Part Def.'s Mot. to Dismiss at 9, *East Jordan Plastics, Inc., et al. v. Blue Cross Blue Shield of Michigan,* No. 12–15621 (E.D.Mich. May 3, 2013) (ECF No. 27). Furthermore, Plaintiffs allege that BCBSM violated ERISA by not only failing to disclose the fees, but by concealing the actual charges in the settlement statements and Form 5500's. According to Plaintiffs' Complaint, as a result of BCBSM's concealment, they only discovered that CES was in fact being charged the fees in 2012. Again, the Court may not look beyond Plaintiffs' pleading to find otherwise.

***5** In short, the Court cannot conclude at this stage of the proceedings when Plaintiffs acquired actual knowledge of the ERISA violations alleged. As such, it denies BCBSM's motion to dismiss Plaintiffs' ERISA claims based on the applicable statute of limitations.

B. State Law Claims

As indicated earlier, Plaintiffs accept Judge Roberts' ruling in a related case that ERISA preempts the state law claims asserted in their Complaint. *See supra.* In any event, this Court agrees with Judge Roberts.

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The Sixth Circuit and Supreme Court have recognized "the broad scope of ERISA's 'expansive pre-emption provision[ ]...." *Briscoe v. Fine,* 444 F.3d 478, 497 (6th Cir.2006) (quoting *Aetna Health, Inc. v. Davila,* 542 U.S. 200, 208, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004); *Cromwell v. Equicor–Equitable HCA Corp.,* 944 F.2d 1272, 1276 (6th Cir.1991) (recognizing "that virtually all state law claims relating to an employee benefit plan are preempted by ERISA")). Here, where all of Plaintiffs' state law claims arise out of BCBSM's alleged misconduct connected with its operation of the Plan, ERISA preemption applies. *See Briscoe,* 444 F.3d at 497–98.

As such, the Court is granting BCBSM's motion to dismiss Plaintiffs' state law claims.

V. Conclusion

For the reasons set forth above, the Court cannot conclude at this juncture that Plaintiffs' ERISA claims are time-barred. ERISA, however, preempts Plaintiffs' state law claims.

Accordingly,

IT IS ORDERED, that Defendant's motion to dismiss under Rule 12(b)(6) is **GRANTED IN PART AND DENIED IN PART** in that Plaintiffs' state law claims (Counts III–IX), only, are **DISMISSED WITH PREJUDICE.**

2013 WL 1976234, 56 Employee Benefits Cas. 2400

All Citations

Not Reported in F.Supp.2d, 2013 WL 1976234, 56 Employee Benefits Cas. 2400

End of Document

2013 WL 1876117
United States District Court,
E.D. Michigan,
Southern Division.

EAST JORDAN PLASTICS, INC. and East Jordan Plastics, Inc. Health and Dental Plan, Plaintiffs,
v.
BLUE CROSS AND BLUE SHIELD OF MICHIGAN, Defendant.

No. 12–cv–15621.
|
May 3, 2013.

Attorneys and Law Firms

Aaron M. Phelps, Varnum, Riddering, Grand Rapids, MI, for Plaintiffs.

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANT'S MOTION TO DISMISS UNDER RULE 12(b)(6) [# 18] AND DISMISSING PLAINTIFFS' STATE LAW CLAIMS WITH PREJUDICE

GERSHWIN A. DRAIN, District Judge.

I. INTRODUCTION

***1** Plaintiffs, East Jordan Plastics, Inc. ("East Jordan") and East Jordan Plastics, Inc. Health and Dental Plan ("Plan"), filed the instant action on December 21, 2012, alleging that Defendant, Blue Cross and Blue Shield of Michigan ("BCBS"), violated the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.,* as well as Michigan law by charging and hiding fees that were not a part of the parties' Administrative Service Contract ("ASC") for BCBS claims administration services. This case is but one of nineteen (19) cases currently pending before this Court raising claims that BCBS breached its fiduciary duty by skimming from monies entrusted to it to pay plaintiffs' healthcare claims. [1]

[1] On April 24, 2013, this Court denied Plaintiffs' Motion to Consolidate this action with nine actions currently pending before the Honorable Victoria A. Roberts as unauthorized under Federal Rule of Civil Procedure 42(a) and E.D. Mich. L.R. 83.11(b)(7)(D). *See* Dkt. No. 26.

Presently before the Court is BCBS's Motion to Dismiss under Rule 12(b)(6), filed on February 19, 2013. This matter is fully briefed and a hearing was held on April 30, 2013. For the reasons that follow, the Court grants in part and denies in part BCBS's Motion to Dismiss.

II. FACTUAL BACKGROUND

East Jordan is a manufacturer of plastic horticultural containers. East Jordan offers health care benefits to its employees through the Plan, which is a self insurance plan whereby East Jordan engages BCBS to administer and pay employee claims in exchange for East Jordan's agreement to pay BCBS certain fees and reimburse the cost of those claims. East Jordan also purchases "stop loss" insurance to cover health care claims that exceed a specified threshold.

On August 1, 2003, the parties executed the ASC, wherein the parties agreed that "BCBS[ ] will process and pay, and [EJP] ... will reimburse BCBS[ ] for all Amounts Billed related to Enrollees' claims...." *See* Compl., Ex. 1 at 3. Article III of the ASC describes East Jordan's financial responsibilities:

> [East Jordan] will, for each Contract year, pay BCBSM the total of the following amounts:
>
> 1. Amounts Billed for the current Contract Year.
> 2. The advance deposit representing the amount held by BCB SM to fund claims paid by BCBSM prior to reimbursement from the Group.
> 3. The hospital prepayment reflecting the amount BCBSM determines is necessary for its funding of the prospective hospital reimbursement.
> 4. The actual administrative charge.
> 5. The group conversion fee.
> 6. Any late payment charge.
> 7. Any statutory and/or contractual interest.
> 8. Stop Loss premiums, if applicable.
> 9. Cost containment program fee, if applicable.

10. Any other amounts which are [East Jordan]'s responsibility pursuant to this Contract, including but not limited to risks, obligations or liabilities, deficit amounts relating to settlements

The Provider Network Fee, contingency, and any cost transfer subsidies or surcharges ordered by the State Insurance Commissioner as authorized pursuant to 1980 P.A. 350 will be reflected in the hospital claims cost contained in the Amounts Billed.

Id. at 6–7. The ASC defines "Amounts Billed" as "the amount [East Jordan] owes in accordance with [BCBS]'s standard operating procedures for payment of Enrollees' claims. *Id.* at 1. The 2003 ASC and 2003 Schedule A were renewed each year through 2013.

***2** East Jordan alleges that it recently learned that starting in 1994, BCBS implemented a scheme to secretly obtain more administrative compensation than it was entitled to. An internal BCBS memorandum describes this alleged scheme. *Id.,* Ex. 3. The memorandum states in relevant part:

RETENTION REALLOCATION EXECUTIVE

Blue Cross and Blue Shield of Michigan (BCBSM) has revised its pricing methodologies for self-funded plans to address operational inefficiencies, promote customer satisfaction and respond to competitive demands.

* * *

ADMINISTRATIVE FEES

The advent of self-funding as an alternative to insured programs has highlighted administrative fees as a cost and a concern to customers purchasing a BCBSM ASC plan. Citing BCBSM's high costs, many customers have complained and have threatened to leave if relief was not provided.

* * *

RECOMMENDATION

Reflecting certain BCB SM business costs in hospital claims costs will provide longterm relief to the problems detailed above and will also satisfy short-term objectives of enhancing customer relationships while cutting operational costs. Inclusion of these costs in our hospital claim costs is actually more reflective of the actual savings passed on to customers as it will now include the hospital savings net of the costs incurred to provide these savings. This will also improve our operational efficiencies since mass mailings for subsidy amount charges will no longer be necessary. Changes to these costs will be inherent in the system and no longer visible to the customer.

Id. at 1–2. Thus, East Jordan maintains that BCBS's scheme was to lower its disclosed administrative fee to give the illusion of lower cost, while at the same time artificially inflating the amounts it reported as hospital claims costs. BCBS then kept the difference between what it was actually paying hospitals for employee claims and what it reported it was paying for hospital claims. The memorandum further stated that the new pricing method would eliminate the problems associated with reporting fees as "an add-on to the bill, highlighted for all to see." *Id.* at 1. East Jordan claims BCBS has charged these "hidden fees" since 2003.

East Jordan further alleges that BCBS provided false and misleading settlement statements and 5500 Forms. The 2003 ASC requires BCBS to provide East Jordan with "a detailed settlement showing the Amounts Billed to and owed by [East Jordan] ...." and "a settlement of the estimated and the actual administrative charges...." *See* Compl., Ex. 1 at 9. East Jordan maintains that the "hidden fees" were never disclosed in BCBS's settlement statements nor did BCBS disclose how much it was retaining as compensation for administration of the Plan. BCBS also provided false Form 5500 reports, which are reports developed by the Department of Labor that employers are required to file as part of their obligations under Title I and Title IV of the ERISA, as well as under the Internal Revenue Code. East Jordan argues that the 5500 Form Reports were false because they overstated the actual amount of payment for claims by failing to disclose that the amount of the total claims paid included the "hidden fees" that BCB S retained as administrative compensation. Lastly, East Jordan asserts that BCBS trained its sales representatives to intentionally conceal the "hidden fees" from customers.

***3** East Jordan alleges the following claims: Breach of Fiduciary Duty–ERISA, Count I; Prohibited Transaction under ERISA, Count II; Violation of Michigan's Nonprofit Health Care Corporation Reform Act, MICH. COMP. LAWS § 550.1101 *et seq.,* Count III; Health Care False Claims Act, MICH. COMP. LAWS § 752.1001 *et seq.,* Count IV; Breach of Contract, alternatively, Breach of Covenant of Good

Faith and Fair Dealing, Count V; Breach of Common Law Fiduciary Duty, Count VI; Conversion, Count VII; Fraud/ Misrepresentation, Count VIII; and Silent Fraud, Count IX.

III. LAW & ANALYSIS

A. Standard of Review

Federal Rule of Civil Procedure 12(b)(6) allows the court to make an assessment as to whether the plaintiff has stated a claim upon which relief may be granted. *See* Fed.R.Civ.P. 12(b)(6). "Federal Rule of Civil Procedure 8(a)(2) requires only 'a short and plain statement of the claim showing that the pleader is entitled to relief,' in order to 'give the defendant fair notice of what the ... claim is and the grounds upon which it rests.' " *Bell Atlantic Corp. v. Twombly,* 550 U.S. 544, 555, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007) (citing *Conley v. Gibson,* 355 U.S. 41, 47, 78 S.Ct. 99, 2 L.Ed.2d 80 (1957). Even though the complaint need not contain "detailed" factual allegations, its "factual allegations must be enough to raise a right to relief above the speculative level on the assumption that all of the allegations in the complaint are true." *Ass'n of Cleveland Fire Fighters v. City of Cleveland,* 502 F.3d 545, 548 (6th Cir.2007) (quoting *Bell Atlantic,* 550 U.S. at 555).

The court must construe the complaint in favor of the plaintiff, accept the allegations of the complaint as true, and determine whether plaintiff's factual allegations present plausible claims. To survive a Rule 12(b)(6) motion to dismiss, plaintiff's pleading for relief must provide "more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Id.* (citations and quotations omitted). "[T]he tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions." *Ashcroft v. Iqbal,* 556 U.S. 662, 668, 129 S.Ct. 1937, 173 L.Ed.2d 868 (2009). "Nor does a complaint suffice if it tenders 'naked assertion[s]' devoid of 'further factual enhancement.' " *Id.* "[A] complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.' " *Id.* The plausibility standard requires "more than a sheer possibility that a defendant has acted unlawfully." *Id.* "[W]here the wellpleaded facts do not permit the court to infer more than the mere possibility of misconduct, the complaint has alleged-but it has not 'show[n]'—'that the pleader is entitled to relief.' " *Id.*

B. BCBS's Motion to Dismiss Under Rule 12(b)(6)

In the present motion, BCBS argues that Plaintiffs' ERISA claims are time-barred since East Jordan had actual knowledge of the disputed fees in 2003 based on the ASC's disclosure of such fees. Thus, the claims in the Complaint are time-barred because Plaintiffs did not file the instant action until 2012, or more than nine years after they had actual knowledge of the disputed fees. East Jordan counters that these so called disclosures were, at best, ambiguous and misleading. Moreover, nothing in the alleged disclosures explain how much the fee would be nor how it would be calculated. Additionally, the applicable ASC sets forth East Jordan's financial responsibilities in Article III, and none of the delineated financial obligations identify the payment of these fees. Thus, Plaintiffs maintain that this action was filed well within the statute of limitations because they have alleged fraud and concealment of the hidden fees until Plaintiffs discovery of such fees in 2012.

1. Statute of Limitations

***4** Section 1113 of the ERISA contains three different limitations period, specifically: No action may be commenced under this title with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part ... or with respect to a violation of this part ... after the earlier of-

> (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or
>
> (1) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation; except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

29 U.S.C. § 1113. Application of the ERISA statute of limitations involves a "two-step" process. *Gluck v. Unisys Corp.,* 960 F.2d 1168, 1178 (3d Cir.1992). The first step is "the identification and definition of the underlying ERISA violation upon which the fiduciary breach claim is founded." *Id.* The second step involves "[t]wo temporal determinations [that] must then be made: the date of the last action which formed a part of the breach and the date of the plaintiff's actual knowledge of the breach." *Id.*

The early stage of these proceedings compels the conclusion that a decision on when Plaintiffs had "actual knowledge" of

the alleged ERISA violations would be premature. The parties have yet to receive a scheduling order in this case, and it is unclear whether initial disclosures have been exchanged. Thus, the parties have little to no facts to support their respective positions on this issue. In any event, this is a Rule 12(b)(6) motion, thus it is inappropriate for the Court to rely on evidence outside of the pleadings. The "actual knowledge" required under § 1113(2) has been described as a "high standard," a "stringent requirement," and a "rigorous ... requirement." *Gluck,* 960 F.2d at 1176. "This inquiry into plaintiffs' actual knowledge is entirely factual, requiring examination of the record." *Ziegler v. Conn. Gen. Life Ins. Co.,* 916 F.2d 548, 552 (9th Cir.1990). "[I]t is not enough that [a plaintiff] had notice that something was awry; he must have had specific knowledge of the actual breach of duty upon which he sues." *Id.*

"The six-year statute of limitations should be applied in cases in which a fiduciary: (1) breached its duty by making a knowing misrepresentation or omission of a material fact to induce [a party] to act to his detriment, or (2) engaged in acts to hinder the discovery of a breach of fiduciary duty." *Caputo v. Pfizer,* 267 F.3d 181, 190 (2d Cir.2001); *Cataldo v. U.S. Steel Corp.,* 676 F.3d 542, 550 (6th Cir.2012). For example, where plan administrators "engaged in actions that violated their fiduciary duties, failed to disclose material information to Plan participants, and concealed material information from them," there is "fraud or concealment" sufficient to invoke the six-year discovery statute of limitations." *Frulla v. CRA Holdings, Inc.,* 596 F.Supp.2d 275 (D.Conn.2009). Specifically, the *Frulla* court held that the six-year statute of limitations applied where the "defendants took affirmative steps to hinder their discovery by Plan participants, including by furnishing inaccurate Plan financial statements and From 5500 filings to Plan members. *Id.* at 288.

***5** Here, the Court cannot conclude as a matter of law that the ASC language disclosed the "hidden fees" providing "actual knowledge" of the fees to East Jordan in 2003. Specifically, BCBS relies on the following ASC language in support of its theory that East Jordan had actual knowledge of the disputed or "hidden" fees in 2003:

> The Provider Network Fee, contingency, and any cost transfer subsidies or surcharges ordered by the State Insurance Commissioner as authorized pursuant to 1980 P.A. 350 will be reflected in the hospital claims cost contained in the Amounts Billed.

However, taking Plaintiffs' factual allegations as true, as this Court must do in ruling on a motion to dismiss, this language is misleading because it is not listed as a numbered financial responsibility like all the other clearly identified fees in the ASC. This purported "disclosure" is further misleading because it appears to state that the amounts paid under this provision were for "hospital claims cost" ordered by the State Insurance Commissioner. It is likewise unclear from this provision that BCBS would be retaining the fees as administrative compensation. Rather, these fees would be "reflected" in the "hospital claims cost." "Hospital claims cost" is the cost paid to hospitals for services rendered. Thus, the ASC language could be construed to mean that all amounts ordered by the Insurance Commissioner would be paid to the hospitals.

BCBS also relies on Schedule A in support of its argument that Plaintiffs had actual knowledge of the fees in 2003. However, Schedule A does not disclose that the disputed fees were paid as "administrative compensation." Rather, it states in relevant part: "Your hospital claims cost reflects certain charges for provider network access, contingency, and other subsidies as appropriate." None of the terms contained in this sentence are defined in either the ASC or Schedule A.

Further, BCBS cannot rely on the decision in *Calhoun County v. Blue Cross Blue Shield of Mich.,* 297 Mich.App. 1, 824 N.W.2d 202 (2012), wherein the Michigan Court of Appeals concluded, relying on identical contract language, that "the ASC expressly provided for the collection of additional fees beyond the Administrative charge...." *Calhoun County,* 297 Mich.App. at 7, 824 N.W.2d 202. However, this Court, reviewing the same contract language and legal issues, has already determined that *Calhoun County* is inapplicable to the ERISA issues raised herein. *See Borroughs Corp. v. Blue Cross Blue Shield of Mich.,* No. 11–cv–12557, 2012 WL 3887438 (E.D.Mich. Sept.7, 2012).[2] In *Borroughs,* the Honorable Victoria A. Roberts concluded that "Calhoun County was not an ERISA case" and "state rules of decision have no binding precedential effect." *Borroughs,* 2012 WL 3887438, at *4. This Court agrees with the conclusion reached in *Borroughs*. The *Calhoun County* case did not raise ERISA claims, as such, the court did not consider whether BCBS's purported misleading statements violated ERISA. Borroughs, 2012 WL 3887438, at *4.

2 The parties refer to this case as *Hi–Lex Controls Inc. v. Blue Cross Blue Shield,* however the actual case caption is *Borroughs Corp. v. Blue Cross Blue Shield of Mich* igan.

***6** Lastly, the *Borroughs* court also rejected BCBS's identical statute of limitations argument in its decision granting in part and denying in part BCBS's Motion for Summary Judgment. *Borroughs,* 2012 WL 3887438, at * 11. The *Borroughs* court, relying on identical contract language, and identical cases relied on by BCBS in the present motion, held that "[w]hether, and at what date, Plaintiffs gained actual knowledge of the facts constituting Blue Cross's alleged ERISA violations" is one of the issues of material fact remaining as to BCBS's statute of limitations defense. *Borroughs,* 2012 WL 3887438, at *11. Likewise, this Court finds that a factual dispute exists as to whether Plaintiffs had actual knowledge of the disputed or "hidden" fees in 2003, thus a final resolution of BCBS's statute of limitations defense is unwarranted at this stage of the proceedings. Thus, BCBS's Motion to Dismiss Plaintiffs' claims pursuant to § 1113 of the ERISA is denied without prejudice.

2. ERISA preemption

BCB S also argues that Plaintiffs' state law claims are preempted by ERISA requiring their dismissal with prejudice. ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The scope of ERISA preemption is very broad. The United States Court of Appeals for the Sixth Circuit recognizes "that virtually all state law claims relating to an employee benefit plan are preempted by ERISA." *Cromwell v. Equicor–Equitable HCA Corp.,* 944 F.2d 1272, 1276 (6th Cir.1991). Here, all of Plaintiffs' state law claims arise out of the same operative facts as their ERISA claim. Thus, their claims are subject to dismissal with prejudice. *See Briscoe v. Fine,* 444 F.3d 478, 497 (6th Cir.2006). In response to BCBS's argument that all of Plaintiffs' state law claims are preempted by ERISA, Plaintiffs argue that they "believe [their] state law claims [are] proper. Nonetheless, Plaintiffs accept the prior ruling of this Court" in *Borroughs Corp. v. Blue Cross Blue Shield of Mich., supra,* wherein the court concluded that all of Plaintiffs' state law claims were preempted by ERISA and dismissed those claims with prejudice. *See Borroughs Corp.,* 2012 WL 3887438, at *10. Accordingly, Plaintiffs' state law claims are dismissed with prejudice.

IV. CONCLUSION

For the foregoing reasons, BCBS's Motion to Dismiss Under Rule 12(b)(6) [# 18] is GRANTED IN PART AND DENIED IN PART WITHOUT PREJUDICE. East Jordan's state law claims are hereby dismissed with prejudice.

SO ORDERED.

All Citations

Not Reported in F.Supp.2d, 2013 WL 1876117, 57 Employee Benefits Cas. 1173

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