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 BRIEF IN SUPPORT OF MOTION TO ALTER OR AMEND JUDGMENT

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I. INTRODUCTION

Plaintiff's Complaint alleges Defendant Blue Cross Blue Shield of Michigan ("BCBSM") breached its ERISA fiduciary duties to Plaintiff's self-funded ERISA welfare benefits plan (the "Plan") by knowingly wasting Plan assets through overpayments to providers that contravened the Plan's terms, violated industry standards, and contradicted BCBSM's representations to Plan representatives. BCBSM also violated ERISA's prohibition against self-dealing and conflicts of interest by paying itself fees from Plan assets based on how much in Plan assets it wasted. As alleged in the Complaint, BCBSM accomplished its scheme through: (1) its discretionary authority to decide whether to pay claims, how much to pay providers, and how much to pay itself in fees; and (2) its complete control over Plan assets.

Despite these factual allegations and the evidence supporting them, this Court held that Plaintiff cannot proceed with its ERISA claims past the pleadings stage because it had a contract with BCBSM. According to the Court, Plaintiff should have brought a breach-of-contract claim, not ERISA claims. That is wrong. ERISA preempts ***all*** state-law claims having "a connection with or reference to" a plan, not the other way around. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). Further, "ERISA prevents [a court] from re-casting [a plaintiff's] ERISA claim as a breach of contract claim by simply rephrasing the source of [the defendant]'s obligations." *Hutchison v. Fifth Third Bancorp.*, 469 F.3d 583, 590 (6th Cir. 2006). That is what BCBSM convinced this Court to do here.

Further, at the pleadings stage, this Court opined Plaintiff did not articulate an ERISA fiduciary claim based solely on BCBSM's denials that it was a fiduciary when it overpaid claims or collected excessive fees from plan assets. That holding contradicts Sixth Circuit precedents—and numerous Michigan district court cases—holding BCBSM is a fiduciary when squandering

plan assets by overpaying claims and improperly collecting fees from plan assets it controlled and managed. *See, e.g.*, *SCIT v. BCBSM*, 32 F.4th 548, 563 (6th Cir. 2022) (BCBSM wasting plan assets by overpaying claims is actionable under ERISA); *SCIT v. Blue Cross Blue Shield of Michigan*, 748 F. App'x 12, 21 (6th Cir. Aug. 30, 2018) (same); *Hi-Lex Controls, Inc. v. BCBSM*, 751 F.3d 740, 742 (6th Cir. 2014) (BCBSM improperly collecting fees from plan assets is actionable under ERISA); *Pipefitters Loc. 636 Ins. Fund v. BCBSM*, 722 F.3d 861, 863 (6th Cir. 2013) (same).

The Court's ruling further turned on its head well-known standards applicable to motions filed under Fed. R. Civ. P. 12(b)(6). Because Tiara Yachts' Complaint pleaded numerous facts establishing (1) BCBSM's fiduciary violations by wasting Plan assets and self-dealing and (2) the Plan's extensive damages, BCBSM's Motion should have been denied. But the Court "***disagree[d]***" with Plaintiff's well-pleaded factual allegations and ***accepted as true*** BCBSM's blanket denials. It improperly concluded ***at the pleadings stage*** that Plaintiff's Plan was not damaged by BCBSM's misconduct, ***even though the Complaint specifically alleged the contrary and BCBSM admitted such in e-mails attached to Plaintiff's Complaint***. The Court should grant Tiara Yacht's Motion, reconsider its ruling, reverse its judgment, and deny BCBSM's Motion.

II. LAW AND ARGUMENT

A. GOVERNING LEGAL STANDARDS.

"A court may grant a Rule 59(e) motion for reconsideration if there is: (1) a clear error of law; (2) newly discovered evidence; (3) an intervening change in controlling law; or (4) a need to prevent manifest injustice." *Intera Corp. v. Henderson*, 428 F.3d 605, 620 (6th Cir. 2005) (citation omitted). "The purpose of Rule 59(e) is to allow the district court to correct its own errors, sparing the parties and appellate courts the burden of unnecessary appellate proceedings." *Howard v. United States*, 533 F.3d 472, 475 (6th Cir. 2008) (citation omitted).

B. TIARA YACHT'S COMPLAINT STATES AN ERISA BREACH OF FIDUCIARY DUTY CLAIM AGAINST BCBSM.

"To state a claim under ERISA [§ 1109(a)] . . . for breach of [a] fiduciary duty, plaintiffs must allege that (1) defendants were fiduciaries of the plan who, (2) acting within their capacities as plan fiduciaries, (3) engaged in conduct constituting a breach of an ERISA fiduciary duty." *In re Trans-Indus., Inc.*, 609 B.R. 608, 642 (Bankr. E.D. Mich. 2019). Plaintiff's Complaint satisfied each element relative to BCBSM's squandering, and illegally collecting fees from, Plan assets.

1. Plaintiff's Complaint plausibly alleges BCBSM breached its ERISA fiduciary duties by squandering Plan assets through its use of "flipping logic."

Plaintiff's Complaint plausibly alleges BCBSM breached its ERISA fiduciary duties by squandering Plan assets through overpayments to providers. Under Sixth Circuit case law, squandering of plan assets is actionable under ERISA. The Court erroneously ignored this legal and factual basis for Plaintiff's ERISA breach-of-fiduciary-duty claim, requiring that its judgment be amended and BCBSM's Motion denied.

a. BCBSM's squandering plan assets is actionable under ERISA.

The Court opined that the Complaint failed to state an ERISA breach-of-fiduciary-duty claim based on BCBSM's "flipping logic," believing Plaintiff was required to plead discrete "individual exercise[s] of discretion" by BCBSM. Order at 10 (ECF No. 23, PageID.475). Although Plaintiff's Complaint pleaded facts showing BCBSM exercised discretion in disposing Plan assets through "flipping logic," it was not required to do so.

"***[T]he threshold for acquiring fiduciary responsibilities is . . . lower for persons or entities responsible for the handling of plan assets than for those who manage the plan.***" *Briscoe v. Fine*, 444 F.3d 478, 491 (6th Cir. 2006) (emphasis added). "***Discretion in the disposition of plan assets is not required; it is irrelevant whether the administrator exercised discretion. Any***

authority or control is enough." *Pipefitters Loc. 636 v. BCBSM*, 213 F. App'x 473, 477 (6th Cir. 2007) (citation omitted) (emphasis added). Requiring Plaintiff to plead "some individual exercise of discretion" on BCBSM's part in denying, paying, or processing claims using Plan assets under its control or "specific decisions made about the Tiara Yachts' sponsored Plan" was reversible error. *See Briscoe*, 444 F.3d at 491 ("The district court therefore erred in requiring, as a condition of fiduciary responsibility, that the type of authority that PHP exercised over the plan assets be 'discretionary'"); *Guyan Int'l, Inc. v. Pro. Benefits Adm'rs, Inc.*, 689 F.3d 793, 798 (6th Cir. 2012) ("[D]iscretionary authority or control over plan assets is not required to become a fiduciary. PBA merely has to exercise any authority or control over plan assets, which it manifestly did.").

Plaintiff's Complaint adequately alleged that BCBSM controlled the Tiara Yachts Plan assets to process and pay claims for the Plan, and thus functioned as an ERISA fiduciary. Specifically, the Complaint alleges:

> 21. In essence, BCBSM would process and pay claims on behalf of Tiara Yachts using Tiara Yachts' Plan assets.
>
> 22. Tiara Yachts sent the required prepayments to a BCBSM-owned bank account, on a periodic basis, in order for BCBSM to pay claims on Tiara Yachts' behalf.
>
> 23. The required prepayments sent to BCBSM's bank account were "Plan Assets" as defined by ERISA. […]
>
> 24. BCBSM had complete authority and control over the bank account and the Plan assets sent to it by Tiara Yachts.

See Compl. at ¶¶ 21-26 (ECF No. 1, PageID.3-4). BCBSM controlled plan assets and used them to process and pay claims. *See Hi-Lex Controls*, 751 F.3d at 745 (employer pre-paid funds held by BCBSM to pay claims are "plan assets" under ERISA).

Binding Sixth Circuit precedent establishes that BCBSM is a fiduciary of the Plan based on factual allegations that it controlled Plan assets, *i.e.*, the pre-paid funds Plaintiff wired to

BCBSM's bank account, and disposed of Plan assets as it saw fit. *See Stiso v. Int'l Steel Grp.*, 604 F. App'x 494, 500 (6th Cir. 2015) ("MetLife also owes a fiduciary duty to plaintiff because it exercises control over the denial or payment of benefits under the plan. When an insurance company administers claims for an employee welfare benefit plan and has authority to grant or deny the claims, the company is an ERISA 'fiduciary' under 29 U.S.C. § 1002(21)(A)."); *Hi-Lex Controls, Inc. v. BCBSM*, 751 F.3d 740, 743 (6th Cir. 2014) ("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."); *Guyan*, 689 F.3d at 798 ("PBA was a fiduciary under ERISA because it exercised authority or control over Plan assets. PBA had the authority to write checks on the Plan account and exercised that authority. Moreover, PBA had control over where Plan funds were deposited and how and when they were disbursed."); *Smith v. Provident Bank*, 170 F.3d 609, 613 (6th Cir. 1999) ("Because Provident controlled Plan assets, it is liable under ERISA as a fiduciary.").

Further, under Sixth Circuit precedent, wasting plan assets through overpayments to providers is a breach of fiduciary duty under ERISA. *SCIT v. BCBSM*, 748 F. App'x 12 (6th Cir. 2018), is on point. There, citing *DeLuca v. BCBSM*, 628 F.3d 743, 747-48 (6th Cir. 2010), the Sixth Circuit ***reversed*** a district court's dismissal of an ERISA breach-of-fiduciary-duty claim against BCBSM for wasting plan assets under its control through overpayments to providers. It was enough, said the Sixth Circuit, to allege "that BCBSM failed to preserve plan assets by consistently causing the Tribe to overpay on claims that were eligible for a lower [rate]." *Id.* at 20-21. The district court in that case had held "that BCBSM had no fiduciary duty under ERISA to ensure payment of [lower rates] for eligible claims." *Id.* at 21. The Sixth Circuit reversed:

"[f]ailing to preserve plan assets can be actionable under ERISA" and that was "just what the [plaintiff] has alleged." *Id.* (citing *DeLuca*, 628 F.3d at 747-48). Last year, the Sixth Circuit reaffirmed its holding in *SCIT v. BCBSM*, 32 F.4th 548 (6th Cir. 2022), again citing *DeLuca* for support in holding that "[f]ailing to preserve assets can be actionable under ERISA." *Id.* at 563-64.

The Sixth Circuit's rulings in the *SCIT* cases are controlling. The Court erred in holding to the contrary. The Court's Order and Judgment must be altered or amended accordingly, and BCBSM's Motion denied.

b. The Complaint alleges misconduct involving BCBSM's fiduciary exercise of authority and control over Plan assets.

Without citing any provision in the ASC or allegation in the Complaint, the Court concluded Plaintiff's claims were not actionable because, it believed, "this complaint is plainly covered by the contractual duties of the ASCs." Order at 9 (ECF No. 23, PageID.474). That is incorrect. The Complaint alleges BCBSM ***exercised fiduciary authority and control over Plan assets***, not a contractually compelled function. The Complaint alleges Plaintiff entrusted ***plan assets*** to BCBSM, which administered them within its authority "***as a fiduciary pursuant to 29 U.S.C. § 1002(21)(A) with respect to Tiara Yachts' Plan,***" not merely as a "contractor" performing ministerial functions. Compl. at ¶¶ 22-26, 107 (ECF No. 1, PageID.4, 18) (emphasis added). The Complaint alleges "***BCBSM had complete authority and control over the . . . Plan assets sent to it by Tiara Yachts.***" *Id.* BCBSM "breached its fiduciary duties in numerous ways, including, but not limited to:" (1) "[k]nowingly using Tiara Yachts' Plan assets to . . . ***overpay for benefits***" (*i.e.*, wasting plan assets), *id.* at ¶ 108(a), (f), (g), (h), (k), (l) (PageID.19) (emphasis added); (2) "causing claims to be processed at charges ***in contradiction with Tiara Yachts' elected Plan benefits***;" *i.e.*, violating plan terms; *id.* at ¶ 108(b) (emphasis added); and, among other things, (3) self-dealing

by using its improper payments from plan assets to make more money for itself; *id.* at 108(d)-(e). Under Rule 12(b)(6), the Court was required to "construe the complaint in the light most favorable to the plaintiff" and "accept all of the complaint's factual allegations as true." *Grindstaff v. Green*, 133 F.3d 416, 421 (6th Cir. 1998). The Court erred by entirely disregarding these allegations and favorable inferences flowing from them.

The ASC delegated to BCBSM "***discretionary authority***" to allocate and dispose of the transferred ***plan assets***; it did not compel any particular contractual function on BCBSM's part:

> [The] Group hereby ***delegates BCBSM the responsibility and discretionary authority as claims administrator to make final benefit determinations and plan interpretations*** necessary to make those benefit determinations, BCBSM's claims administrator responsibility extend only to the full and fair ***review of claims*** … [Claims] submitted to BCBSM shall be ***processed according to BCBSM's standard operating procedures for Claims***.

ASC at II.A (ECF No. 12-2, PageID.141-42) (emphasis added). Per the ASC, Plaintiff and its Plan could not access the transferred funds even beyond the agreement's termination.[1] *Id.* at IV.B.2 (PageID.149).

BCBSM's internal emails attached to the Complaint, added to the Complaint's allegations, demonstrate that BCBSM exercised ***discretion*** in how it made claims-processing decisions, and in how it controlled Plan assets. For example, "flip logic" was designed and unilaterally implemented *by* BCBSM. *See* BCBSM Email (ECF No. 1-4, PageID.41). BCBSM knew "flip logic" caused Plan assets to be used to pay claims indicative of "abusive provider billing practices." *Id.* BCBSM admitted "the ***manner in which we have coded our system plus a lack of controls*** surround[ing]

[1] Any attempt by BCBSM to disclaim ERISA fiduciary status in its ASC is void and has no effect. *See SCIT v. BCBSM*, 32 F.4th 548, 555 (6th Cir. 2022) ("We note ERISA fiduciaries cannot contract away their fiduciary status." (citing 29 U.S.C. § 1110(a)); *Hi-Lex*, 751 F.3d at n.7 ("A fiduciary is established under ERISA by a party's functional role and that responsibility cannot be abrogated by contract.").

abusive billing practices" was causing certain customers, including Plaintiff, to overpay health care claims. *Id.* (emphasis added). Further, "according to Tiara Yacht's Plan, Plaintiff should have been paying for out-of-state, non-par claims at a lower rate set by the applicable Host Blue plan." Compl. at 54 (ECF No. 1, PageID.8). BCBSM used "[f]lipping logic . . . ***in direct contradiction***" to the "group-elected benefit." *Id.* (emphasis added). "BCBSM knew that the majority, if not all, of self-funded, non-auto customers on its NASCO platform, including Tiara Yachts, were impacted by this systems flaw." *Id.* at ¶¶ 46, 108, (ECF No. 1, PageID.7, 19); *see also* BCBSM E-mail, (ECF No. 1-2, PageID.27). "BCBSM maintained lists of customers that were affected by this problem." Compl. at 47 (ECF No. 1, PageID.7). Plaintiff is amongst the customers impacted by this issue. Exhibit B to Compl. (ECF No. 1-3, PageID.31-39) (redacted).

Even BCBSM acknowledged its ***fiduciary*** (not contractual) responsibility in this capacity and its liability under ERISA for squandering plan assets: "***We have a fiduciary responsibility to our ASC customers. Our lack of control over the issue was viewed as failure to fulfill this responsibility and a settlement was requested [by another self-funded customer]***." BCBSM E-mail (ECF No. 1-2, PageID.27) (emphasis added). By its own admission, BCBSM had discretionary authority and control over the way it administered plan assets. *See id.* Thus, under Fed. R. Civ. P. 12(b)(6), the Court was required to "construe the complaint in the light most favorable to the plaintiff" and "accept all of the complaint's factual allegations as true." *Grindstaff*, 133 F.3d at 421. The Court erred by entirely ignoring these factual allegations and favorable inferences flowing from them.

The Court disagreed with the allegations in Plaintiff's Complaint and BCBSM's own admissions. Citing *DeLuca v. BCBSM*, 628 F.3d 743, 747 (6th Cir. 2010), it re-cast the Complaint's factual allegations as "simply complaints about BCBSM as a contractor," and it re-

styled BCBSM's knowing waste of Plan assets as a "systemwide BCBSM method for paying providers." Order at 10 (ECF No. 23, PageID.475) (citing *DeLuca*, 628 F.3d at 747-48). The Court's characterizations are inaccurate. BCBSM conceded, as alleged, that its conduct was a "***failure to fulfill***" its "***fiduciary responsibility***" to each individual customer (including Plaintiff) BCBSM E-mail (ECF No. 1-2, PageID.27) (emphasis added), not merely a so-called "contractual" or "systemwide method for paying providers." Order at 10 (ECF No. 23, PageID.475). "ERISA prevents [a court] from re-casting [a plaintiff's] ERISA claim as a breach of contract claim by simply rephrasing the source of [the defendant]'s obligations."[2] *Hutchison v. Fifth Third Bancorp.*, 469 F.3d 583, 590 (6th Cir. 2006). The Court erred by doing so here.

Unlike in *DeLuca*, Plaintiff's Complaint about "flipping logic" is not challenging BCBSM's contractual negotiations with third-party providers; it is challenging BCBSM's ***squandering*** of Plan assets by ***overpaying*** providers. Compl. at ¶¶ 37-109 (ECF No. 1, PageID.6-21). The Court's factual disagreement with what the Complaint clearly alleges is not a proper basis for granting BCBSM's Motion to Dismiss under Rule 12(b)(6). *Saglioccolo v. Eagle Ins. Co.,* 112 F.3d 226, 228–29 (6th Cir. 1997) ("[A] judge may not grant a Rule 12(b)(6) motion based on a disbelief of a complaint's factual allegations.").

[2] The Court believed Plaintiff should have brought contract claims against BCBSM instead of ERISA claims because, in its view, the dispute "sounds more like an ordinary contract dispute than an ERISA fiduciary duty case." Order at 2, 12 (ECF No. 23, PageID.467, 477). But that belief cannot be squared with ERISA's preemptive power: ERISA's statutory rights and obligations preempt and subsume ***any*** contractual rights and obligations connected to the Plan. *See* 29 U.S.C. § 1144(a); *see also Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004) ("[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted."); *Girl Scouts of Middle Tennessee, Inc. v. Girl Scouts of the U.S.A.*, 770 F.3d 414, 426 (6th Cir. 2014) ("ERISA, by virtue of its preemptive authority, subsumes the fiduciary obligations imposed by the Agreement.").

Further, *DeLuca* supports Plaintiff's position. The Sixth Circuit recognized that BCBSM was a fiduciary as "administrator and claim-processing agent for the plan" responsible "for the processing and payment of claims." *DeLuca*, 628 F.3d at 746. The Sixth Circuit in *DeLuca* explained that, had the plaintiff alleged that BCBSM "squandered plan assets under its authority and control," such allegations would implicate BCBSM's fiduciary status. *Id.* at 748.

Confirming this, the Sixth Circuit in *SCIT v. BCBSM*, 32 F.4th 548, 563-64 (6th Cir. 2022), recently cited *DeLuca* for ***support*** in reaffirming that "***[f]ailing to preserve assets can be actionable under ERISA.***" *Id.* (citing *SCIT*, 748 F. App'x at 20–21; *DeLuca*, 628 F.3d at 747-48). BCBSM's wasting of plan assets is the basis for Plaintiff's ERISA breach-of-fiduciary-duty claim. *See* Compl. at ¶¶ 37-109 (ECF No. 1, PageID.6-21).

In *SCIT v. BCBSM*, 32 F.4th 548 (6th Cir. 2022), the Sixth Circuit held BCBSM's "contractor" argument was inappropriate for resolution ***even at the summary judgment stage***. On appeal at the summary judgment stage, BCBSM asserted "that its actions [in overpaying claims] merely amounted to adherence to the terms of the Member and Employee Plans' contracts, which it argue[d] mean[t] there was no fiduciary act." *Id.* at 564. The Sixth Circuit rejected BCBSM's argument: "how the Administrative Services Contract defined Blue Cross's duties" presented "significant questions of law and material fact" not appropriate for summary judgment. *Id.* Given the Sixth Circuit very recently held that questions regarding BCBSM's "contractor" status, under an identical ASC, with a self-funded plan, in a similar ERISA breach-of-fiduciary-duty overpayment case were inappropriate for resolution ***at the summary judgment stage***, this Court's opinion that it could conclusively resolve those factual questions ***at the pleadings stage*** was wrong. *See id.*; *see also Pipefitters Loc. 636*, 213 F. App'x at 478 (6th Cir. 2007) ("Although BCBSM

asserts that this dispute is merely contractual in nature . . . there is nothing at this early stage that negates the Fund's assertions set forth in the complaint.").

c. Plaintiff's Complaint alleges sufficient facts establishing BCBSM squandered plan assets.

The Court also opined, in error, that Plaintiff's Complaint did not satisfy *Twombly* and *Iqbal* because Plaintiff's Complaint only "suggest[ed] there is a ***possibility*** that BCBSM's claims processing system meant that it processes Plaintiff's claims with improper codes or clinical edits" but did not "identif[y] any actual claim that BCBSM paid out that suffers from [the] alleged deficiencies." Order at 12 (ECF No. 23, PageID.477) (emphasis added). That is wrong.

Actually, the Complaint and several attachments specifically state BCBSM improperly processed Plaintiff's claims under its flawed "flipping logic," resulting in significant losses to the Plan. *See* Compl. at ¶¶ 2, 45-58; (ECF No. 1, PageID.7-9); Ex. A to Compl., 9/14/2017 E-mail (ECF No. 1-2, PageID.25-29); Ex. B to Compl., 2017 List of Customers Impacted by Flip Logic (ECF No. 1-3, PageID.30-39); Ex. C. to Compl., 9/19/2017 E-mail (ECF No. 1-4, PageID.40-43). The Complaint does not merely "suggest" there was a "possibility" that this occurred; it states the ***fact*** that this occurred. *See, e.g.*, Compl. at ¶ 2 (ECF No. 1, PageID.7) ("BCBSM is aware of flaws in its claims processing system ***that caused it to overpay for claims with Tiara Yachts' money.***" (emphasis added)). The Complaint identifies ***specific Tiara Yachts claims improperly processed by BCBSM; as but one example: "claim[s] submitted associated with a non-participating provider.***" Compl. at ¶¶ 49, 54-55 (ECF No. 1, PageID.7-8) (emphasis added); *see also* BCBSM 9/19/2017 E-mail (ECF No. 1-4, PageID.41) ("The issue of 'Non Par Pay Sub Blue Card Claims' has been an issue within the company for a number of years . . . .").

Incorporated into the Complaint is BCBSM's internal 9/19/2017 e-mail wherein ***BCBSM specifically admits that its flawed "system logic . . . financial[ly] impacted" its self-funded, non-***

auto customers, including Tiara Yachts. 9/19/2017 E-mail (ECF No. 1-4, PageID.41) (emphasis added); *see also* Compl. at ¶ 46 ("BCBSM knew that the majority, if not all, of self-funded, non-auto customers on its NASCO platform, ***including Tiara Yachts,*** were impacted by this systems flaw." (emphasis added)). Robert Hopper, a BCBSM Director, attached to his e-mail "***a list of 201 ASC customers***" that were "***impacted by the system logic conflict currently in play.***" 9/19/2017 E-mail (ECF No. 1-4, PageID.41) (emphasis added). ***Plaintiff is amongst the customers impacted by this issue.*** Compl. at ¶¶ 46-47. (ECF No. 1, PageID.7) (redacted). It was error for the Court to conclude there was no plausible allegation Plaintiff's claims were affected by "flipping logic" when—attached and incorporated in the Complaint—is a BCBSM internal e-mail wherein BCBSM admitted Plaintiff and its Plan were "impacted by the system logic conflict currently in play" and suffered a "financial impact" as a result. 9/19/2017 E-mail (ECF No. 1-4, PageID.41).

Additionally, the Court stated that "the Complaint is sparse on alleged facts that would make up a fiduciary duty and breach," Order at 12 (ECF No. 23, PageID.477), but BCBSM admitted in the same e-mail chain that its mismanagement of plan assets through flaws in its "flipping logic" was a breach of its fiduciary duty to its ASC customers, including Plaintiff: "***We have fiduciary responsibility to our ASC customers. Our lack of control over the issues was viewed as a failure to fulfill this responsibility and a settlement was requested.***" Ex. C to Compl., 9/19/2017 E-mail (ECF No. 1-4, PageID.42) (emphasis added). Further, "[d]emonstrating effects of the 'flip' logic may cause groups to question their original consent to it." *Id.* Accordingly, ***where BCBSM itself conceded it had a "fiduciary responsibility" relative to the "flip logic" issue and that there was a "failure to fulfill this responsibility," 9/19/2017 E-mail (ECF No. 1-4, PageID.42), it was error for this Court to conclude there were no "alleged facts that would***

make up a fiduciary duty and breach." Order at 12 (ECF No. 23, PageID.477). The Court needed to look no further than BCBSM's own admissions.

Plaintiff was not required to ***prove*** its case ***in its Complaint***. Plaintiff was only required to allege sufficient facts to "state a claim to relief that is plausible on its face." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007). "***This 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]***.'" *Solo v. United Parcel Serv. Co.*, 819 F.3d 788, 793-94 (6th Cir. 2016) (quoting *Twombly*, 550 U.S. at 556). The Complaint's detailed allegations and BCBSM's admissions create a "reasonable expectation that discovery will reveal evidence of illegal conduct." *See id.* That was all Plaintiff was required to do at the pleadings stage. *See id.*

Regardless, the Complaint explains that "BCBSM maintain[s] exclusive control and access to Tiara Yachts' claims data." Compl. at ¶ 91 (ECF No. 1, PageID.13). "BCBSM continues to conceal its misconduct, in part, by maintaining exclusive control of Tiara Yachts' complete claims data . . . which is necessary to comprehensively identify all improper payments and other wrongdoing." *Id.* at ¶ 2 (PageID.1). When Plaintiff learned of BCBSM's malfeasance, the time to conduct any audit under the terminated ASC had expired; it had no way to access claims data. ASC (ECF No. 12-2, PageID.144). BCBSM should not be allowed to insulate itself from liability by concealing its malfeasance and preventing Plaintiff from accessing claims data about its own employees' healthcare. If such is permitted, "the remedial scheme of the statute will fail, and the crucial rights secured by ERISA will suffer." *Braden v. Wal-Mart Stores, Inc*., 588 F.3d 585, 597 (8th Cir. 2009).

If more detail were needed, the Court should have given Plaintiff an opportunity to provide it, not dismiss the Complaint outright. *See U.S. ex rel. Bledsoe v. Community Health Sys.*, Inc., 342 F.3d 634, 644 (6th Cir. 2003) ("[W]here a more carefully drafted complaint might state a claim, a plaintiff must be given at least one chance to amend the complaint before the district court dismisses the action with prejudice.").

2. Plaintiff's Complaint plausibly alleges BCBSM breached its ERISA fiduciary duties by squandering plan assets through knowingly making improper payments for claims using plan assets.

Plaintiff's Complaint also plausibly alleged BCBSM breached its ERISA fiduciary duties by wasting plan assets by knowingly making improper payments. The Court held Plaintiff's claim "fail[ed] to meet Rule 8's pleading requirements" because it gave credence to BCBSM's denials and opinion that Plaintiff's Complaint was "largely based on conjecture." Order at 12 (ECF No. 23, PageID.477-78). The Court believed Plaintiff had not "alleged that several indicia of fraudulent or unjustified claims appeared in some of the claims submitted to the administrator" and that "the administrator 'failed to account for one or more of these characteristics that appeared in many claims." Order at 13 (ECF No. 23, PageID.478) (citing *Grp. 1 Auto, Inc. v. Aetna Life Ins. Co.*, No. 4:2-cv-1290, 2020 WL 8299592, at *1 (S.D. Tex. Nov. 9, 2020).[3] ***But that is precisely what Plaintiff's Complaint alleged.*** Plaintiff alleged "several indicia of fraudulent or unjustified claims appeared in some of the claims submitted to the administrator," *i.e.*, BCBSM, including "missing provider information, missing payee information, rolled-up financials, financials that do not reconcile, claims showing as rejected but still paid, fields compromised by BCBSM's flip logic, or even claims that are altogether missing." Compl. at ¶ 93 (ECF No. 1, PageID.13). Plaintiff went even further and included ***thirteen*** paragraphs thoroughly explaining

[3] Unpublished cases are attached at **Exhibit 1**.

the problems affecting these "fraudulent or unjustified claims" submitted to BCBSM. *Id.* at ¶¶ 94-107 (PageID.13-15). Plaintiff identified the specific claims and explained the problems with those claims.

Plaintiff's Complaint also alleged ***at least six times*** that BCBSM "failed to account" for these characteristics:

- "***BCBSM processes all claims for all non-auto NASCO customers, such as Tiara Yachts, on the same claims processing system . . . BCBSM's NASCO claims processing system has been found to consistently result in improper payments of claims. These processing errors result in wasted Plan assets in breach of BCBSM's fiduciary duty.***" *Id.* at ¶¶ 101-102 (PageID.15) (emphasis added);

- "***The aforementioned improper payments are non-exclusive examples of improper payments BCBSM regularly makes when processing claims for NASCO customers, and therefore also made when processing claims for Tiara Yachts*** . . . ."; *Id.* at ¶ 108 (PageID.16);

- "***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.***" *Id.* at ¶ 108(g); (PageID.19-20) (emphasis added);

- "***BCBSM breached its fiduciary duties . . . [by] [f]ailing to implement industry standard claims processing edits to prevent Tiara Yachts' Plan assets from being used to pay improper charges***"; *Id.* at ¶ 108(h) (PageID.20);

- "***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.***" *Id.* at ¶ 108(k); (PageID.20);

The Court's conclusion that Plaintiff's Complaint is "speculative" and "does not allege, even at a broad level, that there were data deficiencies in the claims processed by BCBSM" is a fundamental mischaracterization and ignores the Complaint's well-pleaded allegations. Plaintiff is not speculating—its Complaint alleges these problems exist and directly harmed the Plan. 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 v. United Collection Bureau, Inc.*, 952 F.3d 749, 753 (2020) (internal citation and quotation omitted) (emphasis added). Plaintiff's Complaint meets this standard.

The Court did not apply the proper standard. *See* Order at 12 (ECF No. 23, PageID.478). *First*, it improperly ***adopted BCBSM's denials***, mischaracterizing the Complaint's ***factual*** assertions as "speculation." *Id.* at 12. *Second*, the Court read facts ***out of Plaintiff's Complaint***, asserting "[t]he Complaint makes no such assertion" about "fraudulent or unjustified claims," Order at 13 (PageID.478), when the Complaint makes numerous such assertions. *See* Compl. at ¶¶ 93-107, 101-102, 108-109 (ECF No. 1, PageID.13-20). *Third*, the Court made factual inferences ***in BCBSM's favor***, by, for example, musing that the so-called "data deficiencies" identified in the Complaint only affected "other BCBSM customers." That is speculation found only in BCBSM's briefing. The Complaint stated the improper payments "***wasted Plan assets" (i.e., Tiara Yachts' Plan assets)***. *See, e.g.*, Compl. at ¶ 108 (PageID.16) ("The aforementioned improper payments are non-exclusive examples of improper payments BCBSM regularly makes when processing claims for NASCO customers, ***and therefore also made when processing claims for Tiara Yachts*** . . . ."); *see also id.* at ¶¶ 102, 108(h) (PageID.15, 20) ("***These processing errors resulted in wasted Plan assets in breach of BCBSM's fiduciary duty.***"[4] (emphasis added)).

The Court's failure to follow Rule 12(b)(6) led it to make inaccurate statements about the Complaint that are contradicted by the Complaint. The Court repeatedly said "the allegations in the Complaint demonstrate that BCBSM paid actual claims submitted by actual providers at the actual rates charged by those providers for services actually provided to beneficiaries, some of which should allegedly have been at lower rates." Order at 2-3 (ECF No. 23, PageID.467-68, 475).

[4] The use of a capital "p" in "Plan" is intentional; this is identified as Tiara Yachts' Plan in paragraph 1 of the Complaint. Compl. at ¶ 1 (ECF No. 1, PageID.1).

Not true. The "upcoding" problem is an example. The Complaint alleges BCBSM "[c]onsistently pa[id] 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." Compl. at ¶ 108(g) (ECF No. 1, PageID.19-20). The Complaint explains "[u]pcoding occurs when health care providers submit inaccurate billing codes to insurance companies in order to receive inflated reimbursements." *Id.* at ¶ 106 (PageID.16). When, as alleged, BCBSM approves and pays a claim that has been upcoded, BCBSM is not paying the "actual rate[ ] charged by [the] provider[ ]" for the service "actually provided." BCBSM is paying for more than what was performed. Compl. at ¶¶ 106, 108(g) (ECF No. 1, PageID.16, 19-20). The patient never receives the more expensive service BCBSM reimbursed. *See id.* The Court's view of Plaintiff's Complaint is predicated on a misunderstanding of its content. *See id.* The Court's Order is clearly wrong and must be altered or amended, and BCBSM's Motion must be denied. *See Grindstaff*, 133 F.3d at 421 (under Fed. R. Civ. P. 12(b)(6), courts must "construe the complaint in the light most favorable to the plaintiff" and "accept all of the complaint's factual allegations as true."); *Saglioccolo,* 112 F.3d at 228–29 ("[A] judge may not grant a Rule 12(b)(6) motion based on a disbelief of a complaint's factual allegations.").

BCBSM enjoys exclusive control over Plaintiff's claims data, a power it uses to conceal its mismanagement. Compl. at ¶ 2 (ECF No. 1, PageID.1) ("BCBSM continues to conceal its misconduct, in part, by maintaining exclusive control of Plaintiff's complete claims data and other information, which is necessary to comprehensively identify all improper payments and other wrongdoing."). When Plaintiff's claims data is produced by BCBSM, Plaintiff will ***prove with additional evidence*** that improper claims payments occurred. At this early juncture, Plaintiff "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). All it needs to do is plausibly allege improper claims and payments, which the Complaint does. *See* Compl. at ¶¶ 93-107, 101-102, 108-109 (ECF No. 1, PageID.13-20). The Court erred by holding Plaintiff to a higher standard of having to ***prove*** its case before discovery.

This Court failed to account for the fact 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*, 588 F.3d at 598). This should lead to "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. *Id.* at *4 (collecting cases).

And again, if more detail were needed, the Court should have given Plaintiff an opportunity to amend its Complaint, not dismiss it outright. *See U.S. ex rel. Bledsoe*, 342 F.3d at 644.

3. Plaintiff's Complaint plausibly alleges BCBSM breached its ERISA fiduciary duties by paying itself fees based on the amount of plan assets it wasted.

Plaintiff's Complaint also plausibly alleges BCBSM breached its ERISA fiduciary duties by collecting fees from Plan assets at amounts based on the rate it wasted Plan assets. The Complaint details BCBSM's scheme to retroactively impose a "Shared Savings Program" on the Plan, through which BCBSM capitalized on its waste of Plan assets. The Court erred by holding Plaintiff's allegations do not plausibly state an ERISA breach-of-fiduciary-duty claim.

a. Rule 9(b) is inapplicable.

Without citing authority, the Court erroneously adopted BCBSM's unsupported suggestion that Tiara's allegations "sound in fraud" and therefore "Rule 9(b) properly applies" to the "Shared

Savings Program" claim. Order at 14 (ECF No. 23, PageID.479). "Courts, however, routinely apply only the general, liberal pleading standards of Rule 8 to ERISA claims," including ERISA breach-of-fiduciary-duty claims. *In re AEP ERISA Litig.*, 327 F. Supp. 2d 812, 821 (S.D. Ohio 2004); *see also In re Cardinal Health, Inc. ERISA Litig.*, 424 F. Supp. 2d 1002, 1015 (S.D. Ohio 2006) ("Unlike claims of fraud brought pursuant to Federal Rule of Civil Procedure 9(b), which require a heightened standard of pleading, claims brought under ERISA are subject only to the simplified pleading standard of Federal Rule of Civil Procedure 8."); *In re CMS Energy ERISA Litig.*, 312 F. Supp. 2d 898, 909 (E.D. Mich. 2004) (refusing to apply Rule 9(b) to ERISA breach of fiduciary duty claim); *Rankin v. Rots*, 278 F. Supp. 2d 853, 865-66 (E.D. Mich. 2003) ("The heightened pleading requirement under Rule 9(b) will not be imposed where the claim is for a breach of fiduciary duty under ERISA.").

The Complaint does not allege fraud with respect to BCBSM's "Shared Savings Program." Instead, Plaintiff alleges BCBSM breached its fiduciary duty under ERISA by "implementing a Shared Savings Program when it knew 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 "deal[ing] with the assets of Tiara Yachts' Plan in its own interest or for its own account." Compl. at ¶¶ 108(d), 115 (ECF No. 1, PageID.19, 21). Rule 9(b) is inapplicable. *See In re CMS Energy ERISA Litig.*, 312 F. Supp. 2d at 909 (refusing to apply Rule 9(b) to ERISA breach of fiduciary duty claim); *Rankin*, 278 F. Supp. 2d at 865-66 (same).

b. BCBSM breached its ERISA fiduciary duties to the Plan by assessing fees based on the amount of Plan assets it wasted.

The Court held the Complaint's allegations failed to state a claim "under Rule 9 or Rule 8" because they were "simply contractual complaints." Order at 14 (ECF No. 23, PageID.479). It

cited no provision of the ASC or Complaint to support this proposition. None exist. Instead, the Court cited *Seaway Food Town, Inc. v. Medical Mutual of Ohio*, 347 F.3d 610 (6th Cir. 2003), for the proposition that a party's "unilateral right to retain funds as compensation" is not ERISA fiduciary status, and it adopted as true ***BCBSM's*** description of its misconduct as mere "ret[ention] [of] a contractually fixed percentage of 30% of recovered third-party payments." *Id.*

The Sixth Circuit rejected BCBSM's identical argument in *Hi-Lex* and *Pipefitters*, distinguishing *Seaway*'s holding as inapplicable to the arrangements BCBSM uses for self-funded customers. *Hi-Lex*, 751 F.3d at 744-45; *Pipefitters*, 722 F.3d at 866-67 ("Unlike in *Seaway*, the ASC between Plaintiff and Defendant contains no such analogous language."). The Sixth Circuit rejected BCBSM's "attempt[] to characterize its arrangement with [the self-funded plan sponsor] as a service agreement between two companies—with no thought toward ERISA and its protections" as "unavailing." *Hi-Lex*, 751 F.3d at 746. The Sixth Circuit reasoned that, unlike the conduct at issue in *Seaway*, which was expressly authorized by the parties' agreement, the fees at issue in *Hi-Lex* and *Pipefitters* were discretionarily imposed and the ASC did not "set forth the dollar amount for the . . . fee or even a method by which the . . . fee is to be calculated." *Pipefitters*, 722 F.3d at 866; *see also Hi-Lex*, 751 F.3d at 744-45 ("BCBSM had the 'flexibility to determine' how and when access fees were charged to self-funded ASC clients"). Thus, the fees were discretionary and BCBSM was a fiduciary with respect to its collection of fees from the employers' self-funded plans. *See id.*

Hi-Lex and *Pipefitters* directly apply and require the Court to reconsider its Order and deny BCBSM's renewed attempt to escape fiduciary status relative to the fees at issue here. *See Varnum LLP v. United States Dep't of Lab.*, No. 1:18-CV-1156, 2021 WL 1387773, at *1 (W.D. Mich. Mar. 15, 2021) ("In *Hi-Lex Controls*, the Sixth Circuit affirmed a finding that BCBSM is an

[ERISA] fiduciary for self-funded administrative services contracts."). Under ASC terms identical to the *Hi-Lex* ASC, BCBSM possessed and controlled Plan assets. ASC, Art. III, ¶ B (ECF No. 12-2, PageID.147). BCBSM decided whether to pay each healthcare claim and, when it did, for how much, giving it discretion over any compensation based off the amount of claims payments. *Id.* at Art. II, ¶ A, C (PageID.141-42). Like the *Hi-Lex* and *Pipefitters* ASCs, which did not "set forth the dollar amount for the OTG fee or even a method by which the OTG fee [was] calculated," *Pipefitters*, 722 F.3d at 867, here BCBSM had discretionary authority with respect to the fees it collected from Plan assets pursuant to its so-called "Shared Savings Program." Compl. at ¶¶ 83-86, 111-115 (ECF No. 1, PageID.11-12, 21) ("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.").

Specifically, as pleaded, the amounts BCBSM took from the Plan under the Shared Savings Program were within its "unilateral control." Compl. at ¶¶ 83-86, 113, 115 (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. *Id.* at ¶¶ 22-26 (PageID.3-4). The more improper claims BCBSM let slide through its claims processing system, the more money BCBSM fleeced out of the Plan under its "Shared Savings Program" guise. *Id.* at ¶¶ 83-86, 111-115 (PageID.11-12, 21). 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. *See id.* What the Sixth Circuit relied on in finding BCBSM was a fiduciary in *Hi-Lex* is true here too: "BCBSM had the 'flexibility to determine' how and when [fees] were charged to self-funded ASC clients" and the fees were therefore discretionarily imposed. *Id.*

The Court "disagree[d]" with the above factual allegations, apparently because it did not believe "this happened to Tiara Yachts, or that the claims processing and data deficiencies were tied in any way to the Shared Savings Program." Order at 15 (ECF No. 23, PageID.480). But the Complaint repeatedly alleges that BCBSM ***forced Plaintiff into this program*** and ***milked it and its Plan through this program***, including in the first page of the record:

- "***Tiara Yachts recently discovered that BCBSM is aware of flaws in its claims processing system that caused it to overpay for claims with Tiara Yachts' money. Instead of fixing the system failures, BCBSM concealed them from Tiara Yachts for reasons that appear to advance BCBSM's own interests.***" Compl. at ¶ 2 (ECF No. 1, PageID.1);

- BCBSM deployed the program "for ***all of its self-funded customers***"; *Id.* at ¶ 71 (PageID.10) (emphasis added);

- "BCBSM also made it ***mandatory for its self-insured customers to participate and automatically opted all self-funded customers into the program***"; *Id.* at ¶ 81 (PageID.11);

- BCBSM's misconduct relative to the program "came at the expense of BCBSM's self-insured customers, ***including Tiara Yachts.***" *Id.* at ¶ 84;

- BCBSM's "***processing errors resulted in wasted Plan assets in breach of BCBSM's fiduciary duty.***" *Id.* at ¶ 102 (PageID.15).

Further, the Complaint alleges BCBSM's claims mismanagement ***is*** tied to the Shared Savings Program; the Complaint contains an entire section titled "***BCBSM Capitalized on Its Misconduct and Mismanagement of Its Customers' Plan Assets***," Compl. (PageID.9), devoted to that:

> 83. In effect, ***for any improper payments Cotiviti detected and recovered—including the improper payments BCBSM knew existed as a result of its flip logic and beyond—BCBSM would take a 30 percent cut.***
>
> 84. Essentially, ***BCBSM devised a scheme that would allow it to profit on its own mismanagement of plan assets. The more improper payments BCBSM let slide through its system, the more money it would make on the back end.*** Unfortunately, this came at the expense of BCBSM's self-insured customers, including Tiara Yachts.
>
> * * *

> 108. BCBSM breached its fiduciary duties in numerous ways, including, but not limited to: . . . (d) Misleading and deceiving Tiara Yachts by ***implementing a Shared Savings Program when it knew Tiara Yachts' Plan assets were being used to overpay for benefits, allowing BCBSM to capitalize on its own misconduct and mismanagement, which is a clear conflict of interest***.
>
> * * *
>
> 113. Whether Tiara Yachts agreed to pay 30 percent is immaterial, because the amount of the 'recoveries' were in the unilateral control of BCBSM.
>
> 114. ***The more improper claims that BCBSM failed to detect on the front end, the higher the recoveries on the back end, and the more it got paid.***
>
> 115. By instituting a system that allowed it to unilaterally control the amount of its own compensation, BCBSM dealt with Tiara Yachts' Plan assets in its own interest and for its own account in violation of Section 1106.

Id. at ¶¶ 83-84, 108, 113-115 (PageID.10-11, 21) (emphasis added).

The Court is required "to construe the complaint ***in the light most favorable to the plaintiff***" and "***accept all of the complaint's factual allegations as true.***" *Grindstaff*, 133 F.3d at 421 (emphasis added). The Court's factual disagreement with what the Complaint alleges is not a proper basis for granting BCBSM's Motion to Dismiss. *Saglioccolo*, 112 F.3d at 228–29 ("[A] judge may not grant a Rule 12(b)(6) motion based on a disbelief of a complaint's factual allegations."). The Court's Order and Judgment must be altered or amended and BCBSM's Motion denied. *See id.*

Finally, the Court adopted BCBSM's unsupported allegation that it could not have acted unilaterally in assessing fees because some aspects of its "Shared Savings Program" ***other than assessment of the fees at issue*** involve "third party vendors." Order at 15 (ECF No. 23, PageID.480). BCBSM misled the Court regarding the relevant conduct at issue. Vendor services are not the relevant conduct for purposes of Plaintiff's ERISA breach-of-fiduciary-duty claim; it is BCBSM's unilateral assessment of fees. Compl. at ¶¶ 71-84, 108(d), 113-115 (ECF No. 1, PageID.10-11, 19, 21). The "third party vendors" were not the ones assessing fees and bilking

Plaintiff's Plan; BCBSM did that. *See id.* BCBSM was an ERISA fiduciary when extracting money from the Plan because it had discretionary authority and unilateral control over the fees assessed. *See id.*

The Sixth Circuit rejected a similar argument by BCBSM in *Pipefitters Loc. 636 Ins. Fund v. Blue Cross & Blue Shield of Michigan*, 722 F.3d 861, 867 (6th Cir. 2013), where BCBSM attempted to "confuse the relevant activity for ERISA purposes." *Id.* Like it does here, in *Pipefitters* BCBSM tried to argue that third-party involvement rendered its assessment of fees contractual, stating "that it had no discretion in charging the OTG fee because it was the Michigan Insurance Commissioner who fixed the rate at one percent." *Id.* The Sixth Circuit broomed this argument, accurately noting it "confuses the relevant activity for ERISA purposes." *Id.* The Sixth Circuit reasoned that "the state did not fix the rate that Defendant charged each customer, and crucially, neither did the ASC between Plaintiff and Defendant." *Id.* So too here. The third-party vendors did not assess the fees at issue or bilk the Plan; BCBSM did that. Further, 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. Compl. at ¶¶ 83-84, 113-115 (ECF No. 1, PageID.11, 21). The ASC did not fix the amount BCBSM collected under its "Shared Savings Program" guise. Finally, "an entity that exercises ***any*** authority or control over the disposition of a plan's assets becomes a fiduciary." *Guyan*, 722 F.3d at 867 (emphasis added). Accordingly, BCBSM is a fiduciary for purposes of collecting fees under the guise of its "Shared Savings Program." *See Pipefitters*, 722 F.3d at 867 ("Because an entity that exercises *any* authority or control over disposition of a plan's assets becomes a fiduciary . . . the district court was correct to conclude that Defendant was an ERISA fiduciary with respect to Defendant's collection of the OTG fee from Plaintiff.") (emphasis in original)).

4. ERISA Sections 1132(a)(2) and (3) authorize the relief requested in the Complaint.

The Court also erred in concluding "the ERISA statute does not provide a pathway for Tiara Yachts to recover on the alleged overpayments." Order at 15-17 (ECF No. 23, PageID.480-482). Subsections 1132(a)(3), and 1132(a)(2) with Section 1109, both provide pathways for the recovery of Plan assets wasted through mismanagement.

a. Section 1132(a)(3) authorizes the relief sought in Plaintiff's Complaint.

Section 1132(a)(3) is an available avenue for recovery even if "the funds were paid out to providers" and "do not relate to funds that BCBSM allegedly retained from Plan funds." *Id.* at 15 (PageID.480). It does not matter that "[t]he complaint is that BCBSM paid out too much money out of plan funds, not that it retained any funds in its claims processing." *Id.* at 16 (PageID.481).

Preliminarily, though, Plaintiff's Complaint ***is,*** in part, that BCBSM illegally retained Plan assets for itself. Paragraph 84 specifically alleges:

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

Compl. at ¶ 84 (ECF No. 1, PageID.11); *see also id.* at ¶ 115 (PageID.21) ("***BCBSM dealt with Tiara Yachts' Plan assets in its own interest and for its own account in violation of Section 1106.***" (emphasis added)). The Court's assertion that Plaintiff is not alleging BCBSM lined its own pockets with Plan assets is false; the Complaint alleges BCBSM did exactly that. *See id.*

The Court also wrongly concluded that Section 1132(a)(3) does not allow for recovery of "any monetary relief." Order at 17 (ECF No. 23, PageID.482). "Equitable relief available under ERISA ***includes restitution of ill-gotten plan assets or profits.***" *Messing v. Provident Life & Accident Ins. Co.*, 48 F.4th 670, 682–83 (6th Cir. 2022) (emphasis added) (citation and quotation

marks omitted). "In other words, equitable restitution 'seeks to punish the wrongdoer.'" *Id.* at 683. That is literally what Plaintiff is seeking. *See* Compl. (ECF No. 1, PageID.22 (seeking an award of "restitution to Tiara Yachts for all improper misuses of Tiara Yachts' Plan assets.").

The Supreme Court and the Sixth Circuit have authorized this type of relief to plaintiffs under Section 1132(a)(3). In *Cigna Corp. v. Amara*, 563 U.S. 421 (2011), the Supreme Court commented on the various types of equitable relief under § 502(a)(3), including monetary relief under the doctrine of "surcharge." *Id.* at 441. Additionally, in *Stiso v. Int'l Steel Grp.*, 604 F. App'x 494 (6th Cir. 2015), the "[p]laintiff [sought] relief under two sections of the Employment Retirement Income Security Act: wrongful denial of benefits under the terms of the insurance plan in violation of Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and equitable claims of estoppel and breach of fiduciary duty under Section 502(a)(3), 29 U.S.C. § 1132(a)(3) . . . ." *Id.* at 496. The Sixth Circuit held that "[***o]n remand, plaintiff may seek the appropriate equitable remedy, including make-whole relief in the form of money damages.***" *Id.* at 500. Accordingly, the Court holding that this relief is "not available" under Section 1132(a)(3) to Plaintiff is contradicted by Supreme Court and Sixth Circuit precedent.

The Court attempted to sidestep *Amara* by asserting that "[t]he portion of *Amara* that Tiara Yachts relies on is dicta" and "it is inapplicable to this case" because "the remedy Tiara Yachts seeks is not the surcharge that was at issue in *Amara*." As a factual matter, that is incorrect; the Complaint seeks make-whole relief for the Plan, which was injured by BCBSM's ***overpayments***; the Plan and its beneficiaries are not whole. *See* Compl. at ¶ 54 (ECF No. 1, PageID.8) ("[A]ccording to Tiara Yachts' Plan, Tiara Yachts should have been paying for out-of-state, non-par claims ***at a lower rate set by the applicable Host Blue plan.*** BCBSM knew this, stating 'Flipping' logic is in direct contradiction with the ***group-elected benefit.***" (emphasis added)); *id.* at

¶ 102 (ECF No. 1, PageID.15) ("These processing errors result in ***wasted Plan assets*** in breach of BCBSM's fiduciary duty."); *id.* at ¶ 108(a) (PageID.19) ("BCBSM breached its fiduciary duties … [by] ***causing Tiara Yachts' Plan to overpay for benefits***"); *id.* at ¶ 108(h) (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").

Legally, this Court ***is*** obligated to follow *Amara* because it is the Supreme Court's most recent pronouncement on the relevant issue. *See Am. C.L. Union of Kentucky v. McCreary Cnty., Ky.*, 607 F.3d 439, 447-48 (6th Cir. 2010) ("Lower courts are 'obligated to follow Supreme Court dicta, particularly where there is not a substantial reason for disregarding, such as age or subsequent statements undermining its rationale.'"); *Gaylor v. United States*, 74 F.3d 214, 217 (10th Cir. 1996) ("[T]his court considers itself bound by Supreme Court dicta almost as firmly as by the Court's outright holdings, particularly when the dicta is recent and not enfeebled by later statements"); *McCoy v. Mass. Inst. of Tech.*, 950 F.2d 13, 19 (1st Cir. 1991) ("[F]ederal appellate courts are bound by the Supreme Court's considered dicta almost as firmly as by the Court's outright holdings . . . .").

The Court's holding is contradicted by the circuit courts and Michigan district courts that have considered the issue, which all followed *Amara*'s statements about the availability of equitable "make whole" monetary compensation under Section 1132(a)(3), regardless of whether a "surcharge" is at issue. *See, e.g.*, *Osberg v. Foot Locker, Inc.*, 555 F. App'x 77, 80–81 (2d Cir. 2014) ("Foot Locker construes *Amara* to hold that monetary relief is only available in ERISA cases via surcharge . . . . This interpretation is supported by neither *Amara*, . . . nor equity . . . ." (citations and quotation marks omitted)); *Silva v. Metro. Life Ins. Co.*, 762 F.3d 711, 724 (8th Cir. 2014) ("The request for make-whole, monetary relief under § 1132(a)(3) is supported by the case law of

other circuit courts of appeals."); *Gearlds v. Entergy Servs., Inc.*, 709 F.3d 448, 452 (5th Cir. 2013) ("The district court . . . dismissed the suit because Gearlds sought only money damages, which is ordinarily a legal remedy. After *Amara*, however, that is not the end of the inquiry into equity. Gearlds's complaint is viable in light of *Amara*."); *Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869, 891–92 (7th Cir. 2013) ("[*Amara*] substantially changes our understanding of the equitable relief available under section 1132(a)(3). [The plaintiff] has argued for make-whole relief in the form of monetary compensation for a breach of fiduciary duty . . . . We now know that, in appropriate circumstances, that relief is available under section 1132(a)(3)."); *McCravy v. Metro. Life Ins. Co.*, 690 F.3d 176, 182–83 (4th Cir. 2011) ("The Supreme Court has made quite clear that surcharge is available to plaintiffs suing fiduciaries under Section 1132(a)(3). We therefore agree with McCravy that her potential recovery in this case is not limited, as a matter of law, to a premium refund. Accordingly, we reverse the district court's determination to the contrary."); *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"); *Van Loo v. Cajun Operating Co*., 64 F. Supp. 3d 1007, 1026 (E.D. Mich. 2014) ("[M]ake whole" equitable relief is available under § 1132(a)(3) where the defendant is a fiduciary). 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 Section 1132(a)(3). *See id.* This Court's ruling must be altered or amended and BCBSM's Motion denied. *See id.*

b. ERISA Section 1132(a)(2) with Section 1109 authorizes the relief requested in the Complaint.

The Court also erred in holding that ERISA Sections 1132(a)(2) and 1109 do not authorize the relief requested in the Complaint. Order at 15-16 (ECF No. 23, PageID.480). It based its holding on the belief that Plaintiff only sought relief for itself, not on behalf of the Plan. That is

wrong factually and legally. Plaintiff's Complaint expressly alleged that it seeks relief for the Plan, on behalf of the Plan.

Section 1132(a)(2) authorizes fiduciaries, like Plaintiff 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). Where a plaintiff alleges that it seeks to recover Plan funds lost because of defendant's alleged breach, the plaintiff is seeking recovery on behalf of its plan. *See Guyan*, 689 F.3d at 800; *Tullis v. UMB Bank, N.A.*, 515 F.3d 673, 677 (6th Cir. 2008).

The Court nevertheless posited that Section 1132(a)(2) did not authorize this relief because "[t]he Complaint seeks relief for Tiara Yachts, the employer, and not the Plan." Order at 18 (ECF No. 23, PageID.483). Not so. The Complaint alleges that BCBSM consistently paid improper claims, which "result[ed] in ***wasted Plan assets*** in breach of BCBSM's fiduciary duty." Compl. at ¶ 102 (ECF No. 1, PageID.15) (emphasis added). BCBSM used "***Tiara Yachts' Plan assets*** to pay claims impacted by BCBSM's systems flip logic … causing Tiara Yachts' ***Plan to overpay for benefits***." *Id.* at ¶ 108(a) (PageID.19). BCBSM used "its considerable discretionary authority to advance interests other than those of ***Tiara Yachts' Plan or its members.***" *Id.* at ¶ 108(e). The Complaint seeks to recover "for all improper ***misuses of Tiara Yachts' Plan assets.***" *Id.* at PageID.22; *see also* Compl. at ¶ 3 (PageID.2) ("BCBSM's ***mismanagement of Plan Assets*** clearly constitutes a breach of BCBSM's fiduciary duty of care under ERISA."). The Complaint expressly requests an order that "BCBSM . . . provide ***a full and complete accounting of all payments and uses of Tiara Yachts' Plan Assets***," which is obvious relief for the Plan. Compl. at 21 (PageID.21).

The Complaint seeks restitution for "all improper uses ***of Tiara Yacht's Plan assets***." *Id.* at 22 (PageID.22).[5] Restitution literally means returning Plan assets to the Plan.

In reviewing a complaint, a court is required to "construe it 'in the light most favorable to the plaintiff, accept its allegations as true, and draw all reasonable inferences in favor of the plaintiff.'" *Mills v. Barnard*, 869 F.3d 473, 479 (6th Cir. 2017) (citation and quotation marks omitted). The Complaint repeatedly sought relief against BCBSM ***for the Plan***. The Court erred by not taking this as true. *See id.*

In response to BCBSM's motion, Plaintiff reiterated that its Complaint sought relief "on behalf of its welfare benefit Plan." Pl.'s Response at 8-10 (ECF No. 16, PageID.195-96). At the hearing on BCBSM's motion, Plaintiff's counsel said as much:

> My client is the plan sponsor of the plan. Under ERISA my client is a named fiduciary of the plan. Therefore, ***it may bring an action on behalf of the plan, and that's what it's doing in this case. Tiara Yachts is not seeking a recovery for itself.*** And in fact, in case after case after case that I have litigated against Blue Cross Blue Shield we have settled the cases and we have always made it clear that the recovery constitutes a recovery of plan assets, and that's what's going to happen here. ***So whether there is a judgment or a settlement, whatever, it will be a recovery of plan assets which need to be used for purposes of the plan.***

11/15/2022 Hearing Transcript at 26 (ECF No. 22, PageID.444) (emphasis added).

Under Sixth Circuit precedent, the Complaint sought relief for losses to the Plan.[6] *See Tullis v. UMB Bank, N.A.*, 515 F.3d 673, 677 (6th Cir. 2008); *see also Guyan*, 689 F.3d at 800-01. Like the Court here, the district court in *Tullis* "held that the plaintiffs did not have standing to

[5] The Complaint refers to Plaintiff's Plan 72 times. *Id.* at PageID.1-4, 7, 8, 9, 11, 13-16, 18-22).

[6] The Sixth Circuit has held plaintiffs may even recover for losses to a plan under ERISA if the plan is defunct and nonexistent. *See Pfahler v. Nat'l Latex Prod. Co.*, 517 F.3d 816, 827 (6th Cir. 2007) (noting that otherwise "a breaching fiduciary could escape liability merely by terminating a plan before a lawsuit is commenced or during its pendency").

pursue their § 1132(a)(2) claims after concluding the damages sought did not benefit the plan directly . . . ." *Id.* at 677. Like this Court, the district court pointed to the language of § 1109(a) regarding "any losses *to the plan*." *Id.* The district court held "this language only permits recovery where a plaintiff sues in a 'representative capacity.'" *Id.*

The Sixth Circuit reversed. *Id.* at 683. The Sixth Circuit held that the complaint alleged that the defendant's breach of fiduciary duty "resulted in losses to the value of [plaintiff's] pension plans," and thus, "alleged a harm cognizable under the plain language of ERISA." *Id.* at 680. Although the "complaint [did] not include the exact words 'losses to the plan," the Sixth Circuit held that the complaint put "defendant on notice that the ***plaintiffs are seeking recovery for losses that occurred to their plans***." *Id.* at 681 (emphasis added).

> 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 defendant's actions***. ***To hold otherwise would elevate form over substance***, a result we have rejected in other contexts. *Id.*

Similarly, the Court here ignored the Complaint's allegations and "elevate[d] form over substance." *Id.* The Complaint alleges that BCBSM breached its fiduciary duty by wasting Plan assets. *See e.g.*, Compl. at ¶ 102 (ECF No.1, PageID.15) ("These processing errors result in wasted Plan assets in breach of BCBSM's fiduciary duty."). And the Complaint alleges that Plaintiff is "seeking to recover for losses to [its] plan accounts caused by fiduciary breaches." *Tullis*, 515 F.3d at 681; *see also* Compl. at ¶ 3 (ECF No. 1, PageID.2) ("BCBSM's mismanagement of Plan Assets clearly constitutes a breach of BCBSM's fiduciary duty of care under ERISA.").

The Court incorrectly attempted to sidestep *Guyan* when it suggested that plaintiff's complaint there "expressly stated that the action was brought on behalf of each plaintiff's respective plan." Order at 17 (ECF No. 23, PageID.482). As the Sixth Circuit in *Guyan* explained, the "Plaintiffs' complaints ***and summary-judgment briefs*** . . . demonstrate that Plaintiffs' actions seek

recovery on behalf of each Plaintiff's respective Plan" and that "***these pleadings***" expressly state the same. *Guyan*, 689 F.3d at 800 (emphasis added). The Sixth Circuit explained that "[t]hese documents establish, and put [defendant] on notice, that Plaintiffs are seeking to recover for losses that occurred to the Plans …" *Id.* at 801. Even the caption in *Guyan* shows that several of the plaintiff-employers, like Plaintiff here, named themselves as plaintiffs without refence to their respective plans. *Id.*

Accordingly, even if the Court believed the Complaint was ambiguous (it is not), Plaintiff's brief in response to BCBSM's motion, along with its counsel's representations on the record, made clear that Plaintiff is seeking recovery for the Plan. *See* Response Br., at 8-10 (ECF No. 16, PageID.195-96); 11/15/2022 Hearing Transcript at 26 (ECF No. 22, PageID.444). Under *Guyan* and *Tullis*, the Court must accept those allegations as true and cannot disregard them. *See Guyan*, 689 F.3d at 800-01; *Tullis*, 515 F.3d at 681-83.

The Court's speculation that any recovery might go into Plaintiff's own bank account is inappropriate. *See* Order at 2, 17 (ECF No. 23, PageID.467, 482). Nowhere in the Complaint is that alleged. Plaintiff's counsel raised concern over the Court's departure from the pleadings, stating on the record that "[t]here's been a lot of conversation about things that are outside of the pleadings." Hearing Transcript at 25 (ECF No. 22, PageID.443). Nonetheless, Plaintiff's counsel addressed the Court's concerns and explained that "recovery of plan assets [will] need to be used for purposes of the plan." *Id.* at p. 26 (PageID.444).

The Sixth Circuit rebuffed a similar concern by the defendant in *Guyan*. There, several plaintiffs were employers, like Plaintiff. Like the Court here, the defendant complained that "the district court's judgment awarded money damages to Plaintiffs themselves." *Guyan*, 689 F.3d at

801. The Sixth Circuit, however, said "***this fact is immaterial***." *Id.* (emphasis added). The Court explained:

> Plaintiffs sought recovery on behalf of each Plaintiff's respective Plan. Viewing the damage awards in that context, the relief obtained by Plaintiffs—who are the Plan administrators—is on behalf of the Plans.

Id. Plaintiff's Complaint, briefing, and arguments on the record make clear that the Complaint seeks recovery on behalf of, and for losses to, the Plan. The Court's holding to the contrary is a clear error contradicting Sixth Circuit precedent. The Court's Order and Judgment must be altered and amended, and BCBSM's Motion to Dismiss denied.

If the Court needed more clarity on this point, it should have given Plaintiff an opportunity to amend its Complaint. *See U.S. ex rel. Bledsoe*, 342 F.3d at 644.

III. CONCLUSION

For the foregoing reasons, Plaintiff respectfully requests that the Court alter or amend its February 27, 2023 Order (ECF No. 23) and Judgment (ECF No. 24) and deny BCBSM's motion.

Respectfully submitted,

VARNUM LLP
Attorneys for Tiara Yachts, Inc.

Dated: March 27, 2023

By: /s/ *Chloe N. Cunningham*

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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 10,789 words.

/s/ Chloe N. Cunningham
Chloe N. Cunningham (P83904)

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EXHIBIT 1

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**.

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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.

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United States District Court, W.D. Michigan, Southern Division.

VARNUM LLP, Plaintiff,
v.
UNITED STATES DEPARTMENT OF LABOR, Defendant,
and
Blue Cross Blue Shield of Michigan Mutual Insurance Company, Intervenor.

Case No. 1:18-cv-1156
|
Signed 03/15/2021

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OPINION AND ORDER

JANET T. NEFF, United States District Judge

***1** Plaintiff Varnum LLP sues the United States Department of Labor (DOL) under the Freedom of Information Act (FOIA), 5 U.S.C. § 552, for disclosure of settlement information between Blue Cross Blue Shield of Michigan (BCBSM) and certain Administrative Service Only (ASO) clients pertaining to undisclosed fees BCBSM charged from October 1, 1993 through December 31, 2012 as an administrator of health benefit plans. As part of a settlement agreement between the DOL and BCBSM, DOL receives BCBSM's settlement assessment and information and oversees BCBSM's settlement with ASO plan clients affected by these fees.

The parties cross move for summary judgment. Pending before the Court are Plaintiff Varnum LLP's Motion for Summary Judgment (ECF No. 48), Defendant United States Department of Labor's Cross-Motion for Summary Judgment (ECF No. 52), and Intervenor Blue Cross Blue Shield of Michigan's Motion for Summary Judgment (ECF No. 55). For the reasons that follow, Plaintiff's motion is denied; and Defendant's and Intervenor's motions are granted because the information requested falls under Exemption 4 to the FOIA, 5 U.S.C. § 552(b)(4).

I. BACKGROUND

Plaintiff's Complaint for Declaratory and Injunctive Relief (ECF No. 1) comes before the Court on the denial of a request by the U.S. Department of Labor for FOIA, 5 U.S.C. § 522, materials. The DOL is withholding materials produced to the DOL as part of a settlement between the DOL and Blue Cross Blue Shield of Michigan (BCBSM) (ECF No. 53 at PageID.557). The DOL claims that these materials fall under Exemption 4 of the FOIA, 5 U.S.C. § 552(b)(4), which permits the withholding of commercial information that is confidential (*id.*; ECF No. 53).

Varnum LLP seeks a declaration that the DOL is violating the FOIA under 5 U.S.C. § 552(a)(3)(A) and that Varnum LLP is entitled to the materials requested; and an injunction requiring the DOL to produce the requested materials (ECF No. 1 at PageID.2). Below, the Court provides background to the FOIA request and the procedural posture of this case.

Plaintiff Varnum LLP directs the Court (ECF No. 51 at PageID.538-539) to *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Mich.*, 751 F.3d 740, 746 (6th Cir. 2014) for background on this case. In *Hi-Lex Controls*, the Sixth Circuit affirmed a finding that BCBSM is an Employee Retirement Income Security Act of 1974 (ERISA) fiduciary for self-funded administrative services contracts, and BCBSM breached its fiduciary duty by self-dealing in health plan assets. *Id.* at 744-49. The Sixth Circuit stated that "BCBSM committed fraud by knowingly misrepresenting and omitting information about ... Fees in contract documents" and "misled Hi-Lex into believing that the disclosed administrative fees and charges were the only form of compensation that BCBSM retained for itself." *Id.* at 748-49. Plaintiff Varnum LLP served as counsel in the case. *Id.* at 742.

The facts the Sixth Circuit addressed are relevant to this case as well. BCBSM is a third-party administrator of health benefit plans for corporate employees. *Id.* at 742-43. In 1993,

BCBSM began surcharging administrative services contract clients (ECF No. 51 at PageID.539). *Hi-Lex Controls*, 751 F.3d at 742-43. BCBSM retained an additional administrative fee on hospital claims. *Id.* As a result of the discretionary fee-taking, the Sixth Circuit affirmed that BCBSM is an ERISA fiduciary and breached its fiduciary duty. *Id.* at 743-49.

***2** Hi-Lex Controls is one of many corporate or ERISA-covered health plans affected by the excess fees. The DOL separately investigated BCBSM's Administrative Services Only (ASO) plans for "possible violations of the provisions of Title I of ERISA relating to Access Fees ... that BCBSM ... charged to some ASO Plans" (Settlement Agreement, ECF No. 49-1 at PageID.396-397; ECF No. 53 at PageID.559; ECF No. 56 at PageID.586). The investigation resulted in a settlement agreement between BCBSM and the DOL in August 2017 (ECF No. 49-1).

The Settlement Agreement defines "access fees" as "certain administrative fees included in certain ASO Plans' Michigan hospital claims processed on BCBSM's local operating platform from October 1, 1993, through December 31, 2012, including, but not limited to, charges for access to the BCBSM participating provider networks, contributions to the BCBSM contingency reserve, charges for the 'other than group' subsidies, retiree surcharges, and plan wide variability surcharges" (*id.* at PageID.397).

The settlement agreement requires BCBSM to submit monthly reports to the DOL, informing the DOL on Access Fee issues, including settlement agreements executed, litigation initiated, judgments obtained, and analyzing the eligibility of certain ASO plan clients for settlement (*id.* at PageID.398-399). The DOL supervises and reviews ASO plan settlement eligibility, reviews and compares settlement agreements, and following the settlement of outstanding ASO Plan claims, the DOL assesses a penalty of twenty percent of the applicable recovery amount as a civil penalty (*id.* at PageID.400-405).

As part of the DOL's superintending of the settlements between BCBSM and ASO Plans, the DOL provided in the settlement agreement that any request for disclosure of documentation obtained from BCBSM during the investigation and that BCBSM "designated and marked as confidential and proprietary in any way ... pursuant to Section 4 of the Freedom of Information Act ("FOIA"), 5 U.S.C. § 522(b)(4) (2006) ... will be handled in accordance with the regulation set forth in 29 C.F.R. § 70.26 [on confidential commercial information]" (*id.* at PageID.405-407).

On February 8, 2018, Plaintiff Varnum LLP submitted a FOIA request to the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor and DOL's Regional Solicitor's Office (RSOL) in Chicago, Illinois (ECF No. 50 at PageID.530; ECF No. 51 at PageID.540). Varnum LLP requested "a copy of any and all actual settlement agreement, consent order, or similar settlement document of claims/enforcement related to Blue Cross Blue Shield Michigan (BCBSM) in the past five years, evidencing resolution of the investigation/dispute" and "any list of companies that BCBSM was suggested to communicate or settle with to resolve this matter" (ECF No. 49-2 at PageID.411).

On March 7, 2018, the EBSA of DOL provided Plaintiff with a copy of the Settlement Agreement, executed on August 8, 2017 (ECF No. 53 at PageID.564). EBSA also responded that it is withholding "one thousand five hundred and eighty (1,580) pages, **in whole**, pursuant to Exemption 4 which permits the withholding of trade secrets and commercial or financial information," and "that this withholding is with respect to your [Varnum LLP's] request for documents identifying BCBSM clients" (ECF No. 49-3 at PageID.413) (emphasis in original).

On March 13, 2018, the RSOL of DOL also responded that it is withholding 609 pages of documents responsive to the request under Exemption 4 of the FOIA and provided an Exemption Chart showing the BCBSM Monthly Reports withheld as confidential commercial information. (*id.* at PageID.415, 417-418; ECF No. 50 at PageID.531). Plaintiff further submitted an appeal of the denial of the request to the DOL's Solicitor of Labor and received no response (ECF No. 51 at PageID.541-542).

***3** Plaintiff states that BCBSM's customers are "a matter of public record" and ostensibly seeks the information requested because Plaintiff finds the DOL investigation relevant to Plaintiff's client interests (ECF No. 51 at PageID.538). The Court conducted an in camera review of a BCBSM monthly report. The parties argue over whether the information requested from the DOL is commercial or financial information that is privileged or confidential under the Supreme Court's recent decision in *Food Mktg. Inst. v. Argus Leader Media*, 139 S. Ct. 2356 (2019). [1]

[1] The Court of Appeals for the Sixth Circuit has not had occasion to address Exemption 4 since *Food Mktg. Inst. v. Argus Leader Media*. The parties rely on case law from outside the circuit, mainly D.C. Circuit case law, where Exemption 4 cases are frequently litigated. This Court discusses contemporary case law, particularly post-*Food Mktg. Inst.*, applying Exemption 4.

II. ANALYSIS

A. FOIA Exemptions

The dominant objective of the FOIA is for full agency disclosure of government information and "to open agency action to the light of public scrutiny." *Dep't of Air Force v. Rose*, 425 U.S. 352, 361 (1976). Under the FOIA, "each 'agency' upon 'any request' for records shall make the records 'promptly available to any person,' " under 5 U.S.C. § 552(a)(3)(A), unless one of the statutory exemptions applies. *See Am. C.L. Union of Mich. v. F.B.I.*, 734 F.3d 460, 465 (6th Cir. 2013). The FOIA contains nine exemptions from compelled disclosure of agency information, which represent "the congressional determination of the types of information that the Executive Branch must have the option to keep confidential." *Rose*, 425 U.S. at 361 (quoting *EPA v. Mink*, 410 U.S. 73, 80 (1973)). The exemptions under 5 U.S.C. § 552(b) are intended to "balance the public's interest in governmental transparency" and "legitimate governmental and private interests [that] could be harmed by release of certain types of information." *Judicial Watch, Inc. v. U.S. Dep't of Def.*, 913 F.3d 1106, 1108 (D.C. Cir. 2019); *United Techs. Corp. v. Dep't of Def.*, 601 F.3d 557, 559 (D.C. Cir. 2010) (internal quotations omitted). The limited exemptions are to be construed narrowly, and there is a "strong presumption in favor of disclosure." *Nat'l Ass'n of Home Builders v. Norton*, 309 F.3d 26, 32 (D.C. Cir. 2002) (quoting *U.S. Dep't of State v. Ray*, 502 U.S. 164, 173 (1991)). This Court has the power to "enjoin the agency from withholding agency records and to order the production of any agency records improperly withheld from the complainant," where the information requested does not fall within one of the exclusive statutory exemptions. 5 U.S.C. § 552(a)(4)(B); *See Rose*, 425 U.S. at 360-61; *Am. C.L. Union of Mich.*, 734 F.3d at 465.

B. Motion Standard

This Court reviews the non-disclosure of a FOIA request *de novo*. *See* 5 U.S.C. § 552(a)(4)(B); *Elec. Privacy Info. Ctr. v. U.S. Dep't of Homeland Sec.*, 777 F.3d 518, 522 (D.C. Cir. 2015). "Most FOIA cases are decided on summary judgment, since the primary question is a legal one: whether the withheld documents are covered by one of the statutory exemptions." *Am. C.L. Union of Mich.*, 734 F.3d at 465 (citing *Rimmer v. Holder,* 700 F.3d 246, 255 (6th Cir. 2012)). "FOIA places the burden 'on the agency to sustain its action,' " 5 U.S.C. § 552(a)(4)(B); the agency "bears the burden of proving that it has not 'improperly' withheld the requested records" and an exemption applies. *Citizens for Responsibility & Ethics in Wash. v. U.S. Dep't of Justice*, 922 F.3d 480, 487 (D.C. Cir. 2019) (quoting *U.S. Dep't of Justice v. Tax Analysts*, 492 U.S. 136, 142 n.3 (1989)); *U.S. Dep't of Justice v. Landano*, 508 U.S. 165, 171 (1993). The burden does not shift if there are cross-motions for summary judgment because the government retains the burden of proving that each document has been produced or is exempt from disclosure. *See, e.g.*, *Buzzfeed, Inc. v. Fed. Bureau of Investigation*, No. 18-CV-2567, 2020 WL 2219246, at *3 (D.D.C. May 7, 2020).

***4** Under FED. R. CIV. P. 56(a), summary judgment is proper "if there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law," even where all reasonable inferences are construed in favor of the non-moving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986). "In FOIA cases, summary judgment may be granted on the basis of agency affidavits if they contain reasonable specificity of detail rather than merely conclusory statements, and if they are not called into question by contradictory evidence in the record or by evidence of agency bad faith." *Aguiar v. Drug Enf't Admin.*, 865 F.3d 730, 734–35 (D.C. Cir. 2017) (internal quotations omitted). "[T]he court's primary role is to review the adequacy of the affidavits and other evidence.... If the Government fairly describes the content of the material withheld and adequately states its grounds for nondisclosure, and if those grounds are reasonable and consistent with the applicable law, the district court should uphold the government's position." *Rugiero v. U.S. Dep't of Justice*, 257 F.3d 534, 544 (6th Cir. 2001) (quotations omitted).

C. FOIA Exemption 4

FOIA Exemption 4 exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." 5 U.S.C. § 552(b)(4). The DOL argues that Exemption 4 applies to the monthly reports BCBSM provided to the DOL pursuant to the Settlement Agreement (ECF No. 53 at PageID.557-558).

For Exemption 4 to apply, the government must show that the information requested by Plaintiff is: (1) commercial or financial; and (2) that the information obtained from BCBSM is privileged and confidential. *See Food Mktg. Inst.*, 139 S. Ct. at 2360 ("Congress has instructed that the disclosure requirements of the Freedom of Information Act do 'not apply' to 'confidential' private-sector 'commercial or financial information' in the government's possession.").

Plaintiff does not dispute that the BCBSM customer names it seeks are commercial information (ECF No. 51 at PageID.542-543). Customer information is commercial and/or financial information because BCBSM has a commercial interest in this information. *See, e.g.*, *Nikelsberg v. F.D.I.C.*, 640 F. Supp. 2d 55, 57 (D.D.C. 2009) (customer information, such as contact information of account holders F.D.I.C. obtained from banks, considered commercial and/or financial information); *COMPTEL v. F.C.C.*, 910 F. Supp. 2d 100, 115 (D.D.C. 2012) (for the proposition that commercial information is information in which the submitter has a commercial interest); *see also* Heikka Aff. ¶ 9, ECF No. 49-14 at PageID.527 ("Many, if not most, of the ASO Plan customers that appear in the Monthly Reports remain customers of BCBSM; and BCBSM considers all of them at least potential customers.").

Plaintiff states that the key issue on this appeal from the DOL's denial of its FOIA request is whether the settlement documents are confidential under Exemption 4 (ECF No. 51 at PageID.543). Both parties refer the Court to the Supreme Court's recent decision in *Food Mktg. Inst. v. Argus Leader Media*, interpreting Exemption 4's confidential requirement (*id.* at PageID.543-544; ECF No. 53 at PageID.566-567).

The Supreme Court discussed two conditions for information to be considered as "confidential." These two conditions are: (1) "information communicated to another remains confidential whenever it is customarily kept private, or at least closely held by the person imparting it;" and (2) "information might be considered confidential only if the party receiving it provides some assurance that it will remain secret." 139 S. Ct. at 2363. For Exemption 4 to apply to the documents withheld, the Supreme Court made clear that the first condition at the very least must apply. *Id.* Both conditions are satisfied here; but, primarily, the monthly reports BCBSM provided to the DOL is information that BCBSM customarily keeps private or closely held.

***5** The parties argue over whether the monthly reports or the information in the monthly reports, at a minimum the customer identities, are disclosable and public (ECF No. 51 at PageID.544, ECF No. 53 at PageID.568). According to Plaintiff, the monthly reports BCBSM submitted as part of its settlement agreement with the DOL contain the following non-confidential information: the customer names, but also information on judgments and litigation against BCBSM, information on ASO plan clients BCBSM contacted regarding settlement, and information on settlement agreements between BCBSM and ASO plan clients (ECF No. 51 at PageID.544-552).

As an initial proposition, Plaintiff contends that BCBSM's customer names are not always kept private (ECF No. 51 at PageID.545-546). Plaintiff asserts that BCBSM has previously produced customer information in "the underlying Access Fee litigation," where "BCBSM was compelled to produce ... lists of BCBSM's customers affected by the Access Fee scheme," and BCBSM's customers are identified in the public record (*id.* at PageID.545-546). Plaintiff also states that BCBSM's customers annually report on Form 5500, "Annual Return/Report of Employee Benefit Plan" to the DOL, 29 C.F.R. §§ 2520.130-1, 2520.103-2, on their service provider—records which are made publicly available (*id.* at PageID.546-547).

Plaintiff's argument fails because Plaintiff cannot in good conscience say that the information Plaintiff seeks is readily available outside the agency, for the whole reason Plaintiff seeks the information from the agency is because the information is private, not public. *See Gellman v. Dep't of Homeland Sec.*, No. 16-CV-635 (CRC), 2020 WL 1323896, at *11 (D.D.C. Mar. 20, 2020) (applying the principle that information that is confidential under Exemption 4 is information that is not "readily available" outside the agency). Broadly speaking, the information Plaintiff requests does not shed light on agency action—the policy of the FOIA—but aims in a roundabout way at accessing BCBSM's information, accessing information not released or disseminated to the public. *See Food Mktg. Inst.*, 139 S. Ct. at 2363. Plaintiff essentially argues that because BCBSM has disclosed customer names in other contexts that all of BCBSM's customers and the customer names contained in the monthly reports should be considered as non-confidential commercial information. *See, e.g.*, *Stevens v. United States Dep't of State*, No. 17 C 2494, 2020 WL 1330653, at *8 (N.D. Ill. Mar. 23, 2020) (course materials shared with students not considered information made available to the public and thus

exempt under Exemption 4). Plaintiff blurs the specific and general.

The affidavit of Michelle Heikka, Assistant General Counsel for BCBSM, provides further evidence to carry the government's burden that the information requested is closely held by BCBSM. As stated by Heikka, the customers in the "underlying Access Fee litigation" are "not co-extensive with the ASO Plan customers who had paid *Access* Fees" (Heikka Aff. ¶¶ 22, ECF No. 49-14 at PageID.528). The lack of availability of the reports and the information therein explains why Plaintiff is seeking the information. Further, the documents disclosed in the Access Fee litigation, cited by Plaintiff,

> did not contain the confidential commercial and financial information or internal assessments in the Monthly Reports; and in particular, did not assess potential liability of BCBSM to, or otherwise concern existing or potential disputes of BCBSM with, its ASO Plan customers who paid Access Fees.

(*id.* ¶ 22). The exception of the monthly reports and the information in the monthly reports is therefore manifold. First, the DOL required this information as part of the settlement agreement with BCBSM, and to induce BCBSM to enter into the agreement, the DOL provided an assurance that information marked and designated as confidential would be treated as such (Settlement Agreement, ECF No. 49-1 at PageID.405-407). *See Food Mktg. Inst.*, 139 S. Ct. at 2363 ("Presumably to induce retailers to participate in SNAP [Supplemental Nutrition Assistance Program] and provide store-level information it finds useful to its administration of the program, the government has long promised them that it will keep their information private."). Thus, BCBSM is entitled to expect that the information it provided would be kept in confidence. *See, e.g.*, *Nikelsberg*, 640 F. Supp. 2d at 58 ("Plaintiff concedes that the information (*i.e.*, deposit information coupled with contact information) is of a type 'customarily not to be released to the public.' "). The monthly reports BCBSM submitted to DOL are all designated, marked, and certified as containing confidential business information, according to the settlement agreement (ECF No. 53 at PageID.560; Heikka Aff. ¶¶ 14-18, ECF No. 49-14 at PageID.527-528). Each report bears the following statement:

> All the records provided today are non-public confidential business information, and are confidential commercial information pursuant to 5 U.S.C. Sec. 552(b)(4) and 29 C.F.R. Sec. 70.26. By accepting this information, Department of Labor ('Department') agrees to abide by its own policies and procedures for the protection of such information.

(Heikka Aff. ¶¶ 15, ECF No. 49-14 at PageID.528). The designations on the reports are evidence that the reports are confidential because of what the designations mean. Presumably, BCBSM would not have entered into the agreement with the DOL if the information it designated as confidential could be shared by the DOL with third-parties. The FOIA expressly recognizes that important interests are served by providing exemptions such as Exemption 4; the interest at stake here is the DOL's ability to engage in confidential settlement agreements with persons such as BCBSM. *See Food Mktg. Inst.*, 139 S. Ct. at 2366.

***6** The reports are marked as confidential, but they also treat information that is not disclosed to the public, and the reports are treated within BCBSM as containing confidential information. As attested by Heikka, only a "small group[ ] of employees have access to" these monthly reports, which is powerful evidence that the reports are not made publicly available (Heikka Aff. ¶ 12, ECF No. 49-14 at PageID.527). *See Food Mktg. Inst.*, 139 S. Ct. at 2363. The nature of the reports in whole and in part (in terms of the information contained therein) also suggest that they are confidential, since they are created, generated, and organized for a particular purpose, as monthly reports to the DOL in furtherance of BCBSM's settlement obligations (ECF No. 56 at PageID.601, 603). *See Goodyear Tire & Rubber Co. v. Chiles Power Supply, Inc.*, 332 F.3d 976, 983 (6th Cir. 2003) ("any communications made in furtherance of settlement are privileged"); *Gellman*, 2020 WL 1323896, at *11 ("The bulletins here are prepared for ODNI [Office of the Director of National Intelligence] under contract and there is no suggestion in the record that they are readily available outside of the agency. They are thus 'closely held' by the vendor.").

This evidence shows that the reports contain information of a kind that is secret or private and that BCBSM expects it to remain so. *See Food Mktg. Inst.*, 139 S. Ct. at 2363.

Portions of the reports could also not be safely extracted because the reports contain analysis (in furtherance of the settlement with the DOL) of the prospect for settlement with BCBSM customers. Even assuming the BCBSM customer names could be extracted safely from the reports, the edited document would produce little informational value (customer names without analysis on eligibility) because the "exempt and nonexempt information are inextricably intertwined" (*id.* at PageID.604). *Am. C.L. Union of Mich.*, 734 F.3d at 468 (6th Cir. 2013) (internal quotations omitted). Further, even accepting Plaintiff's argument that the information is available or selectively available in the public domain and that the government cannot insulate disclosure through settlement agreements and information labeled as confidential (ECF No. 51 at PageID.551), a distinction must be drawn between pearls of information and compilations (ECF No. 53 at PageID.575). In the FOIA context, and many others, it has long been recognized that information can be transformed through compilation. *U.S. Dep't of Just. v. Reps. Comm. For Freedom of Press*, 489 U.S. 749, 767 (1989) (recognizing "the basic difference between scattered bits of criminal history and a federal compilation[,] ... the privacy interest inherent in the nondisclosure of certain information even where the information may have been at one time public"). As a report and compilation of customer information, the information in the BCBSM reports is confidential and contains analysis closely held by the BCBSM; the customer names (all the names of customers mentioned) are also closely held as a rebus and otherwise cannot be safely extracted and desalinated wherever they have appeared in isolated form in the public domain. The Court thus determines that the monthly reports in toto are commercial information "both customarily and actually treated as private by its owner and provided to the government under the assurance of privacy." *Food Mktg. Inst.*, 139 S. Ct. at 2366. As such, the information requested is "confidential" under Exemption 4.

***7** Taking the evidence in the light most favorable to the requester Varnum LLP, the Court determines that there is no genuine issue of material fact and the agency has demonstrated that the information is exempt from disclosure. The Court finds that the DOL properly withheld the monthly reports under Exemption 4. The agency has carried its burden on this motion based on the record evidence and summary judgment is proper.

III. CONCLUSION

For the foregoing reasons,

IT IS HEREBY ORDERED that Plaintiff's Motion for Summary Judgment (ECF No. 48) is DENIED.

IT IS FURTHER ORDERED that Defendant's Cross-Motion for Summary Judgment (ECF No. 52) is GRANTED.

IT IS FURTHER ORDERED that Intervenor's Motion for Summary Judgment (ECF No. 55) is GRANTED.

An appropriate Judgment shall accompany this Opinion and Order.

All Citations

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